Integrated Health Project Plus

in the Democratic Republic of Congo

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The Integrated Health Project Plus (IHPplus) was implemented in the Democratic Republic of Congo (DRC) from June 2015 to June 2018 by Management Sciences for Health (MSH) and Overseas Strategic Consulting, Ltd. (OSC), under a subcontract via Pathfinder/Evidence to Action. This USAID-funded project was designed to avoid a gap in services in USAID-supported health zones upon completion of the USAID Health Office's five-year flagship Integrated Health Project (IHP) in 2015. The two major project components were direct support for service delivery and health systems strengthening activities. The service component included increased use of high impact family planning, maternal, newborn, and child health (FP/MNCH), nutrition, malaria, tuberculosis (TB), HIV and AIDS, water, sanitation, and hygiene services (WASH), and adoption of healthy practices in targeted health zones. The health systems strengthening component included improved implementation of selected policies, program advocacy, and decision-making, particularly at the provincial levels. Ultimately, the project was designed to create better conditions for, and increase the availability and use of, high-impact health services, products, and practices for more than 31 million people in nine provinces of the DRC with 168 target health zones (an increase from the 78 health zones supported by IHP).

The Champion Community approach in DRC

A gold standard for community mobilization

Overview

The Champion Community approach was implemented to promote community mobilization to change behavior and increase uptake and access to high-priority services for maternal, neonatal, and child health (MNCH) in the Democratic Republic of the Congo (DRC).

The Champion Community Approach:

- IHP/IHPplus used a phased implementation of the Champion Community approach between 2012 and 2016
- 35 IHP/IHPplus Champion Communities were implemented with an additional 38 autonomous Champion Communities developed over the course of the project
- As of 2018, there are eight additional autonomous Champion Communities developing
- 85% of IHP/IHPplus Champion Communities and one autonomous Champion Community gained NGO status and obtained outside funding for sustainable community mobilization
- Champion Mamas, Champion Men, and Champion Youth developed as subgroups of the Champion Community approach to devote efforts to specific health issues
- Champion Communities had measurable statistical differences among health indicators when compared with areas with no Champion Communities
- The DRC Champion Community approach is now a gold standard for community mobilization

DRC–IHPplus
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MNCH in DRC is hindered by excess mortality from preventable causes, such as early marriage (18%), low contractive prevalence (8%), elevated rates of unmet contraceptive needs (28% for adults, 31% for adolescents), and the high prevalence and complications of pregnancy among adolescents.[1] However, many other factors in DRC lead to excess mortality and poor MNCH, including poor nutrition, lack of adequate services for antenatal (ANC) and postnatal care, poor immunization coverage for women and children, and elevated rates of malaria and low treatment rates.[1] In addition, the elevated sexual and gender-based violence (SGBV) rates in DRC have a profound effect on MNCH.[1,2,3,4]

The Champion Community approach, which is owned and sustained at the health area level, was established by the Integrated Health Project (IHP) and IHPplus to encourage community members to decide on their health priorities and to teach them to sensitize their communities on those priority health issues. The Champion Community approach fits within the *Plan National de Développement Sanitaire 2016-2020* (National Health Development Plan) to strengthen the community dynamics that promote health services and the health of communities. IHP and IHPplus implemented the Champion Community approach from 2012 to 2016.

The Champion Community Approach

The relationship between the Champion Community approach and major social and behavior change communication (SBCC) interventions is such that Champion Community approach serves as a supportive ("implementer") and additive approach to community stakeholders, which allows the effective application of multimedia and interpersonal communication interventions at household and community/village levels. The Champion Community approach promotes the involvement of the community in the activities. This approach aids in getting various communication channels (posters, leaflets, advice cards, audio-video microprograms, sketches, songs, picture boxes, etc.) and other information technologies (mobile phones and community radio) directly to the community through trusted partners at the village and household levels. Thus, the population becomes engaged to promote healthy behaviors and change negative social norms to more positive healthy norms. Working with grassroots community structures facilitates quick and efficient implementation of the Champion Community approach.

District and community stakeholders are asked to participate in specific supervisory roles. The community, covering three or four health areas, elects executive and steering committees to implement the Champion Community approach (figure 1). Members volunteer their time and expertise. Capacity building in community mobilization ensues after the Champion Community develops a work plan based on priorities identified by the community. Monitoring and evaluation of activities and adapting the work plan are continually practiced to ensure that positive behavior changes occur over time. Subgroups of the community can be implemented: Champion Mamas address specific women's health issues as Champion Youth address specific messaging and health concerns of youth. Champion Men can be implemented to address negative norms.

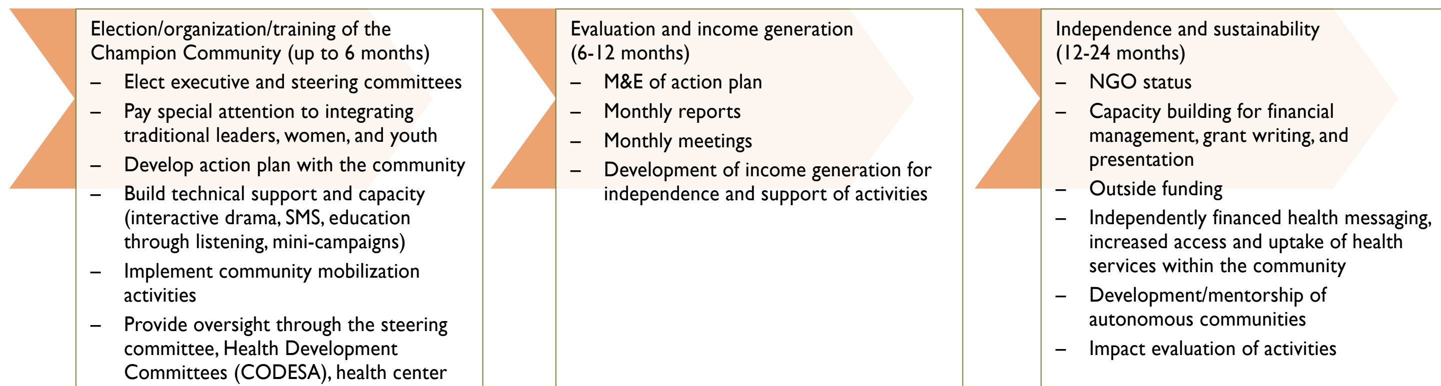

Figure 1. Timeline for implementing Champion Community approach

[1] Demographic and Health Survey, Democratic Republic of Congo (2013-2014). https://dhsprogram.com/publications/publication-FR300-DHS-Final-Reports.cfm.
[2] Johnson K, Scott J, Rughita B, Asher J, Kisielewski M, Ong R, Lawry L. Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of the Democratic Republic of Congo. JAMA. 2010. 304(5):553-562
[3] Scott J, Polak S, Kisielewski M, McGraw Gross M, Johnson K, Hendrickson M, Lawry L. A Mixed-Methods Assessment of Sexual and Gender-based Violence in Eastern Democratic Republic of Congo to Inform National and International Strategy Implementation. International J of Health Planning and Management. 2012; DOI: 10.1002/hpm.2144
[4] Campbell J, Garcia-Moreno C, Sharps P. Abuse During Pregnancy in Industrialized and Developing Countries. Violence Against Women. 2004; 10(7):770–89.

Methodology

Each Champion Community chooses a set of health indicators from its action plan to use as the basis for changing behavior and increasing uptake and access to high-priority services for MNCH. Because each Champion Community covers three or four health areas, a comparison is needed, also consisting of three or four health areas, where there are no Champion Communities. To limit any crossover effects from messaging in nearby health areas, the furthest health areas were chosen for comparison (figure 2).

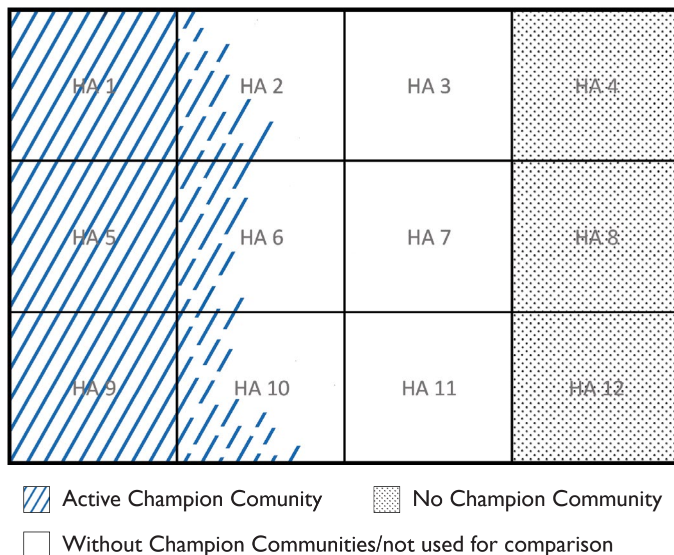

Figure 2. Champion Community messaging influence in health areas

Prior to 2017, only health-zone level data were available; therefore, it was not possible to compare the impact of Champion Communities since a Champion Community does not cover an entire health zone. The following analyses are for all of 2017 as this was the first year that the District Health Information System (DHIS 2) sub-grouped data by health area levels. Chi-square (proportions) and two-sided t-test (counts for the number of visits) analyses were used to compare Champion Community health area indicators with the same indicators in non-Champion Community health areas. As of 2018, not all Champion Community action plan indicators could be analyzed; for example, data were not collected or were too unreliable in the DHIS/DHIS 2 at health area levels for water, sanitation, and hygiene; tuberculosis; SGBV[5]; latrines; potable water; and HIV/STI indicators. Health area indicators available for analysis included ANC-1 (1 visit) or ANC-4 (4 visits), acceptance of modern family planning methods, vaccinations for DPT/HepB/HIB (3 doses of pentavalent diphtheria, pertussis, tetanus, hepatitis B, and *Haemophilus influenzae* type b) and measles for children 0-11 months, breastfeeding (exclusive for 6 months and breastfeeding up to 23 months), moderate malnutrition rates among children 6-53 months, and the number of malaria visits for diagnosis and treatment.

A statistically significant p-value of <0.05 was used in both the Chi-square and t-test analyses, which means that, if the p-value is less than 0.05, we are 95% sure the result did not occur by chance. The analysis cannot be construed to represent cause and effect. It is not possible to control for all confounders; only a randomized control trial or a longitudinal study could control for most confounders. Therefore, where both Champion Community health areas and non-Champion Community health areas have high rates, for example, for vaccination, it should be assumed that vaccination campaigns (health area/zonal/national-level campaigns) in those areas contributed to the rates and are not solely due to the Champion Community SBCC mobilization efforts. However, if there are statistically different rates of an indicator (such as breastfeeding) among indicators that do not have campaigns, it is reasonable to assume that the increased rates are associated with the work of the Champion Community behavior change efforts. These data show that Champion Communities are associated with changes in behavior and/or improvement in indicators. Because each Champion Community area is very different, context must be taken into account to explain the results coherently. Finally, for community mobilization efforts to succeed, there must be an equally functional health facility, or the SBCC efforts at the community level will not be effective.

Results

Figure 3 shows the percentage of Champion Community health areas (IHPplus and autonomous) with statistically significant improvements in various MNCH indicators. For example, 87% of IHPplus Champion Communities and 50% of autonomous Champion Communities had statistically significant increases in exclusive breastfeeding rates when compared with non-Champion Community health areas.[6]

[5] Although the number of cases that present in 72 hours and the number of cases that receive post-exposure prophylaxis are (in some health areas) collected, the data are highly unreliable and incomplete for all health areas.
[6] For more information about the collection and analysis of this data, please refer to pages 32-34 of the IHPplus Champion Community Approach Implementation Manual.

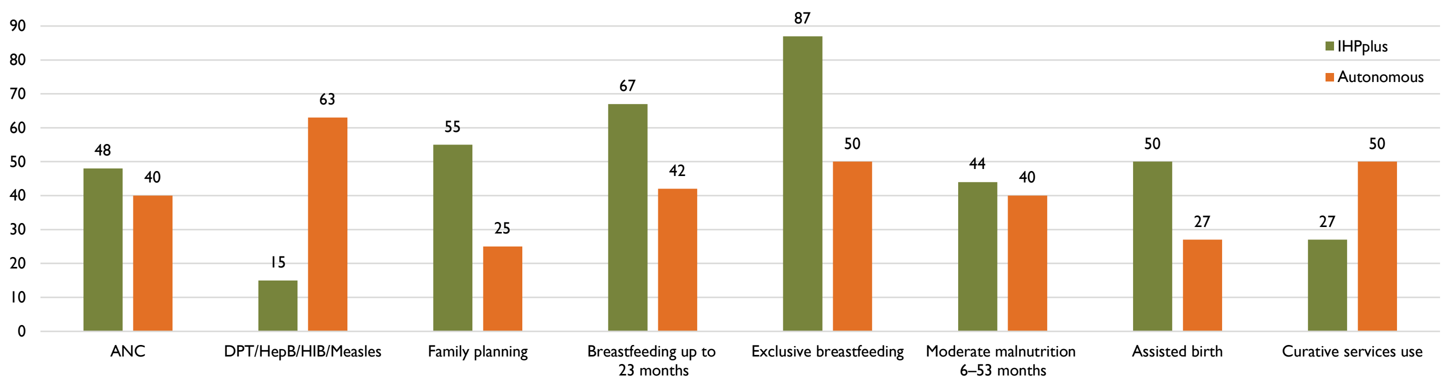

Figure 3. Percentage of Champion Community health areas (IHPplus and autonomous) with statistically significant improvements in indicator rates when compared to non-Champion Community health areas

Lessons Learned

Most Important Aspects of Champion Community Approach

Members elected for the Champion Community—and especially those engaged as part of the executive committee—should be vibrant, active, committed, imaginative, literate (can read and write), and engaging. They must have good community standing and listening skills and be good mediators and natural group leaders. They must have a sense of volunteerism and community and a desire to bring the community together around health priorities. Our experience has shown that helping the community elect these types of people ensures success. Failure happens when committee members are not team players, have power issues, or have other agendas that do not have community objectives in mind. This "bottom up" approach adds to, but does not duplicate, efforts that are focused at the health area, zonal, provincial, or national level. and allows communities to become agents of change for development and improved health outcomes.

Income generation and the development of NGO status was a transformative step to independence, autonomy, and sustainability of the approach for IHPplus compared with other projects. Over the course of the project, Champion Communities in the health zones of Dibaya, Katana, Lomela, Luiza, Mwene Ditu, Nundu, and Uvira were able to write proposals and obtain outside funding from other donors, including numerous NGOs, the World Bank, UNICEF, health zones, and the Ministry of Health, among others. Autonomous Champion Communities are applying for funding, and, as of March 2018, the first autonomous Champion Youth (RACOJ in Mwene Ditu) gained NGO status; a few others are now doing the same with mentorship from IHPplus-implemented Champion Communities.

Income generation gave the Champion Communities the ability to support activities and other priorities during the project and for the long term. Income generation was decided by the community and included collecting dues monthly, village savings and loan associations, agriculture projects, fish farming, livestock, and small animal breeding. Other examples included buying a motorcycle or bicycle that served as a community taxi, starting a community pharmacy, and selling time on computers for students and computer group members.

Significant Improvements in the Community

With income generation, Champion Communities were able to:

- Build and/or repair health facilities
- Add maternity wings to existing health facilities
- Build latrines at the household level or at markets
- Buy land for new health facilities or agriculture projects
- Buy computers for Champion Community work and to rent to students and computer group members
- Buy cell phones and credit to extend closed user groups and mobile health initiatives
- Repair and rebuild roads and bridges that improve access to health facilities
- Buy ambulances or other means of transport to aid in emergency transportation
- Pay or subsidize health facility fees for MNCH services for pregnant women
- Buy livestock and small animals for increasing breeding programs
- Build fish ponds for fish farming
- Buy seeds and agricultural equipment
- Pay school and immunization fees for Burundian refugee children
- Build and buy materials for schools

Key Actors and Enabling Factors

It is vital to incorporate community leaders (religious, traditional, and health) into the approach, including local (health zone) authorities so they can learn the approach and support the Champion Community on priorities and supervision of activities. Stakeholders at the provincial and health-zone levels play an important supportive role for the Champion Community. Decisions must be democratic, and women must

be represented and included in all levels of the process. The application of an executive committee within the Champion Community and the steering committee created a network of support, supervision, and accountability for activities. All individual and group initiatives that contribute to the advancement of health and development goals are welcomed within the Champion Community approach because there are many indicators of health. For example, education is a primary indicator of health; therefore, teachers are encouraged to be part of the approach. Women and youth add value by addressing issues specific to their groups, such as early marriage, alcohol and drug abuse, etc. All activities related to the achievement of the Champion Community action plan objectives revolve around the health center. In most cases, a health center nurse is part of the Champion Community and helps the community understand its health issues. In addition, local and international organizations (such as NGOs, community-based, civil society, and faith-based organizations), local authorities (such as police or judicial representatives), and private partnerships with companies can help build technical capacity by providing training.

Other Lessons Learned

The Champion Community approach demonstrates an economy of effort as Champion Communities are being contracted for their expertise by other USAID, international, and local partners, such as the Ministry of Health and health zone and provincial authorities, to aid in health campaigns and household sensitization. The development of autonomous Champion Communities was also cost-effective; on average, for every Champion Community implemented, three autonomous Champion Communities developed spontaneously to extend the reach of the approach to other health areas and health zones.

Based on the IHPplus experience and analysis, Champion Communities worked best in remote or insecure areas. These communities do not have easy access to messaging, other organizations, or upgraded health facilities. Despite remoteness or insecurity, Champion Communities are adept at describing and finding solutions to local problems.

Local problems and solutions included the following:

- Lomela noticed that as the climate changes, they find fewer bush animals.
- Lodja decided they needed capacity building in finance and management; they hired someone to come and train them.
- Uvira decided that unvaccinated Burundian refugee children put community children at greater risk; they used their funds to vaccinate all refugee children.
- Lomela needed funding for school construction and supplies; they waited by the river for the boat from Cordaid (Catholic Organization for Relief and Development Aid) to pass by to submit a proposal, and now they have the funding they needed.

Impact analysis should be periodically done to assess whether mobilization activities are working. Quarterly impact assessments allow incremental adjustments to the program and provide feedback to each Champion Community. With DHIS 2 data now available at the health area level, analysis is possible.

More than 85% (28/33) of the IHPplus-established Champion Communities are now registered NGOs. Unlike previous Champion Community approaches in DRC that did not continue after the cessation of funding, the IHPplus Champion Community approach has proven to be not only successful but sustainable and "naturally transitioning," which was largely due to capacity development for income generation projects and NGO status.

- The mindset of handouts versus "learning to fish" is important to reinforce from the beginning.
- Technical capacity building should be prioritized over funding or material support.
- Small grants from the project should be avoided; rather, assistance should focus on building capacity for grant writing, presentation, accounting, and transparency.
- A standard package of training, in addition to community mobilization techniques, would help ensure that capacity is uniform across communities implementing the approach.

The Future

The DRC Champion Community approach now serves as a model and a gold standard for community mobilization that is sustainable and is successfully being exported to other communities. As of 2018, there are eight new autonomous Champion Communities developing in the Kasaïs, Sud Kivu, and Uvira.

Capacity building, rather than project funding, to further expand the approach, should be stressed. Funding selected members or directly funding Champion Communities will undermine the independence and self-reliance instilled during IHP and IHPplus. With continued expansion of the approach, careful monitoring and evaluation to ensure that the approach is correctly implemented and that established Champion Communities are mentored adequately should be considered.