

Towards a Grand Convergence for child survival and health: *A strategic review of options for the future building on lessons learnt from IMCI*

COUNTRY ASSESSMENT: Democratic Republic of the CONGO

DRAFT – 31 May 2016

Prepared by Youssouf Gamatié, Nsibu Celestin, Kini Brigitte

CONTENTS

List of acronyms	2
I. Introduction	3
II. Organization and management of IMCI.....	4
III. Lessons learnt	11
IV. National outlook and action	15
V. Conclusions of international interest	18
Documents consulted	19
Annex 1: Timeline	21

List of acronyms

ACDI/VOCA	Agricultural Cooperative Development International/Volunteers in Overseas Cooperative Assistance
ACT	artemisinin-based combination therapies
DRC	Democratic Republic of the Congo
EPI	Expanded Programme on Immunization
ETAT	Emergency Triage Assessment and Treatment
GAVI	Global Alliance for Vaccines and Immunizations
GIBS	<i>Groupe Inter bailleurs de santé</i> (funding agency coordination group)
ICATT	IMCI Computerized Adaptation and Training Tool
iCCM	Integrated Community Case Management
IMCI	Integrated Management of Childhood Illness
IRA	Initial rapid assessment
MDG	Millennium Development Goal
MSH/SIAPS	Systems for Improved Access to Pharmaceuticals and Services/Management Sciences for Health
NGO	Non-governmental organization
ORS	Oral rehydration salts
RACe	Rapid Access Expansion
RMNH	Reproductive, Maternal and Newborn Health
SNAME	<i>Système National d'Approvisionnement des Médicaments Essentiels</i> (national system for provision of essential medicines)
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

I. Introduction

With an estimated population of over 70 million, the Democratic Republic of the Congo (DRC) has a large effect on the African Region's mortality rate for children under five. The main causes of child mortality have not changed over the past 20 years: malaria, diarrhoeal diseases, pneumonia and neonatal conditions such as suffocation, infections, prematurity and underweight at birth. Roughly half of all deaths are due to malnutrition. Neonatal mortality accounts for 31% of mortality in children under five, and has been decreasing more slowly than overall under-five mortality over the past twenty years.

As in other countries in the African Region, there are disparities in child health indicators between provinces, urban and rural areas and, of course, economic classes.

Table 1: Summary statistics on child health in the DRC (WHO/Countdown 2015)

Indicator	Value and (source of data)
Total population	67 514 000 million (WHO statistical profile 2013)
Total under-five population	13 875 564 million (WHO DRC Country Profile 2015)
Annual births	3 216 895 million (WHO DRC Country Profile 2015)
Neonatal mortality rate (per 1000 live births)	30.1 (WHO DRC Country Profile 2015)
Annual neonatal deaths	94 252 (WHO DRC Country Profile 2015)
Average annual rate of U5MR reduction, 1990-2015 (%)	7.3 (WHO DRC Country Profile 2015)
Under-5 mortality rate (per 1000 live births)	98.3 (WHO DRC Country Profile 2015)
Annual child deaths	304 555 (WHO DRC Country Profile 2015)

The high rates of infant and child mortality in the DRC are due to the following factors:

- Poverty
- Aging health infrastructure and insufficient equipment
- Lack of essential medicines and other inputs
- Lack of qualified staff to ensure proper care for sick children
- Large distances between households and health centres
- War and years of sociopolitical instability

Although the country has experienced growth of over 5% in the past decade, it is estimated that 63% of the population remains poor. Moreover, growth has not translated into improvements in the social sector. The percentage of the State budget for health has stayed very low: 5.8% in 2010, 3.5% in 2011, 7.8% in 2012 and 4.6% in 2013.

Between 1990 and 2015, infant and child mortality rates have gone from 225 per 1000 live births to 104 per 1000 live births. Although efforts have been made over past decades to accelerate the reduction of child mortality, the 7.3% annual rate of reduction has not been enough for the country to reach the target of 62 deaths per 1000 live births set by Millennium Development Goal 4. One thing credited with having reduced child mortality has been implementation of the strategy for Integrated Management of Childhood Illness (IMCI; French acronym PCIME).

The goal of this report is to assess what contribution IMCI has made in improving child health indicators in the DRC, which factors have been favourable and which obstacles remain, as well as possible means of expanding the coverage and use of quality health services for children. The mission was carried out in the framework of a strategic review of IMCI, the goals being to collect information on how it was implemented and take into account the most recent data on extending coverage of the most effective care for sick children, identifying options for improving access and use of health services for children both in the DRC and worldwide. Two methods were used to collect data:

1. A review of the relevant documentation (published and unpublished reports and articles)
2. Interviews, conducted from 10 to 20 May 2016, of roughly twenty key actors at the national, provincial and operational levels, in the capital Kinshasa and the Manza N'gungu health district in Kongo Central province.

Data were analysed as and when they were collected, by using information already collected and comparing different sources. At the end of the mission, a debriefing was held with the main actors (the Ministry of Health and other partners) to present the results and receive their feedback.

II. Organization and management of IMCI

IMCI was introduced in the DRC in 1999 as a way of reducing morbidity and mortality in children under five both in primary health care structures and in communities.

“Having committed to achieving the Millennium Development Goals, the DRC adopted a number of documents and frameworks on maternal, newborn and child health. These included a national policy on health and reproduction, a roadmap for reducing maternal and neonatal mortality, a series of rules and directives on reproductive health, standards for youth services, child health records incorporating new growth curves, the Integrated Management of Childhood Illness (IMCI) strategy for clinics and communities, and prevention of mother-to-child HIV transmission.”

The Ministry of Health's organizational structure includes an **Integrated Management of Childhood Illness office**, which is one of four offices of the Family Health Division within the Directorate on Family Health and Specific Groups. The other offices in the division are the office of women's health, the office of adolescent and youth health and the office of family planning.

IMCI is coordinated at the national level by the national programme coordinator for acute respiratory diseases, as stipulated by ministerial decree 1250/CAB/MIN/S/CS/29/2003 on the creation and coordination of integrated management of childhood illness in the DRC.

From a day-to-day technical and operational viewpoint, IMCI activities are split between the national coordinator – who is in charge of implementing the clinical component – and the national diarrhoeal diseases programme, which is responsible for implementing the community-based component.

At the province level, it is the division's head doctor who acts as the main contact for all implementation strategies. At the health district level, the focal point for IMCI varies by district, and can be either the head of the office of family and specific groups or the head of the primary care office, who is part of the

health district management team. Most often, however, it is the head doctor of the health district who fulfils this role.

According to many interviewees, it is the **integrated** aspect of the strategy that is most appreciated, because it offers a **holistic view of child health care** and a **systematic approach**. When the approach is complied with, the important problem of child health does not get left by the wayside. The systematic approach was acceptable to all interviewees, be they government staff or technical and financial partners. It was considered a good strategy for **improving access to quality health care** in a country with a large territory, sparse population and an insufficient number of health centres.

IMCI is the DRC's first planned strategy for accelerating the reduction of child mortality. With both clinical and community components, it targets the main causes of child mortality in health structures and communities: pneumonia, diarrhoea, malaria and malnutrition. In 2010, it was merged with the strategy on maternal, newborn and child health in order to promote synergy and make care more effective. It forms an important part of the Acceleration Framework for Millennium Development Goals 4 and 5, launched in 2013. Along with the MDGs, IMCI is part of the DRC's **minimum package of care** to be promoted in order to attain **universal health coverage**.

Figure 1: Health district normative documents on integrated maternal, newborn and child health care



Reducing neonatal mortality is currently a priority for the DRC. Action to reduce neonatal mortality is included in both the clinical component of IMCI through case management for babies under two months, and in the reproductive health programme's section on newborn care and emergency obstetric and neonatal care. At the community level, local health care volunteers are trained in detecting warning signs and refer newborns to health centres for care. Although neonatal care has always been part of IMCI, the Ministry of Health became strongly committed to reducing neonatal mortality starting in 2009, following the active advocacy of certain partners (particularly PROSANI and the Seventh Day Adventists). Several thousand health workers have since been trained in resuscitating newborns. The Ministry of Health, with partners' support, has also developed rules and directives for each specific group, the third volume being essential and emergency care for newborns.

Apart from IMCI, other action for child health and survival includes **vaccination** campaigns, carried out through the Expanded Programme on Immunization (EPI), and national programmes on: **nutrition, malaria control, preventing vertical HIV transmission**, the fight against AIDS, and the **neonatal care component** of reproductive health.

These national programmes exist alongside IMCI without conflicting with it. In principle, directives issued as part of the strategy are approved by the relevant programme, and revisions and updates are also done in collaboration with the different programmes. However, interviewees indicated that “the feeling is that IMCI has become another stand-alone, vertical programme”. There were “certainly overlapping efforts, particularly in training.

For example, health workers are trained through IMCI on uncomplicated malaria care, then the national malaria control programme trains the same workers on the same thing, although their training contains additional information.” For some, this was not a problem, since certain vertical programmes attracted more funding, which could then be used for underfunded activities, as was the case for the malaria and HIV programmes, which are mainly funded by the Global Fund.

A number of partners support action for child survival and health in the DRC:

the Global Fund, the World Bank, GAVI, USAID, the UK Department for International Development, ACDI/VOCA, Korea International Cooperation Agency, UNICEF, WHO, UNFPA, UNAIDS, as well as NGOs: SANRU, Save the Children, PROSANIplus, Caritas International, MCSiP, International Rescue Committee, SIAPS/MSH, Action Against Hunger, and more. Each partner supports one or more different health districts, and have “divided up the country between them” according to their interests. A group exists (Groupe Inter bailleurs de santé, GIBS) to ensure coordination among the different sponsors.

As part of the national health development plan 2011–2015 for the entire health sector, the Ministry of Health has put in place a national steering committee with a **technical coordination committee** and various subcommittees. Within the services subcommittee, a task force on maternal, neonatal and child health was created to reduce the fragmentation of services and offer more integrated care. The task force functions like a thematic group. It is overseen by the director of family health and specific groups, and brings together actors in the areas of maternal, newborn and child health, the Ministry of Health and various partners. Its mission, remit and working procedures are well defined. However, “**its functioning has been less than satisfactory over the past few years**, and its meetings are not held quarterly as stipulated originally, instead being held at long intervals.” Starting in 2013, several partnerships have been put in place to facilitate implementation of the Acceleration Framework for MDGs 4 and 5, including: UNICEF/RMNH Trust Funds–Global Fund–World Bank; UNICEF–European Union; UNICEF–MSH–USAID–Swedish International Development Cooperation Agency–Canadian International Development Agency; Global Fund–USAID–Department for International Development (UK); Department for International Development (UK)–IMA World Health–Caritas International–SANRU–World Vision; Canadian International Development Agency–WHO–International Rescue Committee; and

Figure 2: Warming table and scale provided through the Acceleration Framework for MDGs 4 and 5 to improve neonatal care



UNICEF– Korea International Cooperation Agency. The goal of these partnerships is to increase efficiency and complementarity in the use of resources.

The private health sector plays an important role in the provision of health care in the DRC. In many health districts, religious groups also manage a number of health centres. These non-profit, religious-run health centres are completely integrated into the health system, and their staff are briefed on IMCI directives. For-profit health sector staff participate in immunization activities, but, despite being trained in IMCI, do not apply its directives.

At the health district level, coordination among partners poses fewer problems, and meetings are more regular.

III. Implementation of IMCI and other child health strategies

A distinction is made in the implementation of the clinical and community components of IMCI. The following fall under the clinical component (developing the skills of health workers): i) integrated care course (6 or 11 days) for nurses and post-training follow-up in health centres and health posts; ii) Emergency Triage Assessment and Treatment (ETAT) course for health workers including doctors, nurses working in emergency units and referral hospital admission; iii) inclusion of IMCI on the syllabi of institutions where nurses, doctors and other health workers are trained.

Following a national orientation workshop in August 1999, the Minister of Health signed decree number 1250/CAB/MIN/AT/CK/020/99 engaging the country to adopt and implement the IMCI strategy to reduce morbidity and mortality in children under five through primary health care services. **There was an initial implementation period from 1999 to 2003, followed by an expansion period starting in 2004.** The main milestones are shown in the table below.

Table 2: IMCI implementation milestones in the DRC: clinical component

1999	First visit National orientation workshop Signing of the letter of commitment
2000	Implementation plan workshop
2001	Training of the first group of resource persons at the national level (inter-country class)
2002	Localization of training materials based on studies of local terminology and nutritional habits Orientation workshop on introducing IMCI into the training curriculum for health workers Orientation workshop on the community component Roll-out of IMCI in the first health districts
2003	Review of the pilot phase Implementation of national coordination
2004	Changeover to expansion phase Training of provincial teaching pools and service providers
2006	Inclusion of HIV/AIDS Development of a shorter, 6-day course
2007	Review of the expansion phase

	Inclusion of IMCI in the organizational structure of the health system Introduction of Emergency Triage Assessment and Treatment
2015	Orientation workshop on ICATT software

The focus areas of the clinical component of IMCI when it was adopted in 2002 were: acute respiratory diseases, malaria, measles, diarrhoeal diseases, throat and ear infections, malnutrition, anaemia, and the required immunizations. Infants under two months were included in the “newborns” segment. HIV/AIDS was added in 2006, and other revisions and updates were made to integrate treatments recommended by WHO, such as zinc and low osmolarity oral rehydration salts, artemisinin-based combination therapies (ACTs) and rapid diagnostic tests and dispersible amoxicillin tablets. However, transmitting the updated directives takes time owing to a lack of resources to print them. Updates for service providers are given during supervisory visits. Following studies into local terminology and infant feeding practices, in 2002 an advice sheet was developed to help health workers provide information to parents when they leave a health centre after receiving care.

The clinical component has been introduced in all provinces of the country. Expansion is being carried out according to a pre-established plan but depends on the resources allocated by the partner supporting each individual health district. The central office does not have the most recent information, but **coverage is known to be only partial.** For example, training has been carried out in 22 of the 35 health districts in Kinshasa, in 23 out of 31 districts in Kongo Central and in 16 out of 52 in Bandundu. In total, it is estimated that training sessions have been held in 222 of the 516 health districts. Within a given health district, not all centres have trained health workers, and within a given health centre, the proportion of staff dedicated to children’s care is low. Starting in 2006, training sessions were shortened from 11 days to six.

Given the cost of training working staff and the high degree of health worker mobility, starting in 2004, **the DRC mandated IMCI training in medical teaching institutions** in line with WHO recommendations. This proved unsuccessful at the Kinshasa medical university and in Lubumbashi, where professors considered the strategy inappropriate for future doctors who would be working in an environment with the means to conduct proper diagnostics. IMCI training was also introduced in four medical technical colleges for nurses and other health workers but has been maintained in only two of them. Since 2004, the medical technical college in Kinshasa has given the training regularly, reaching some 13,000 students. The training is given in a **9-day “block”** at the end of the third and final year, just before the students begin their internships. IMCI training was also introduced at the nursing institute in Gemena and is ongoing. The main challenges remain the number of students to train, lack of training materials, too few trainers, cost, and lack of hands-on practice time. The training’s impact on the ground has not been evaluated.

The DRC has also introduced **Emergency Triage Assessment and Treatment (ETAT)** training in general referral hospitals, and several sessions have been organized in the east of the country during the emergencies in 2007 and 2008. (Documentation in this area is lacking, and we did not receive any more details.)

The main obstacles and challenges in implementing the clinical component are: training costs considered to be very high; lack of funding due to lack of interest from partners and the absence of government funding; lack of an implementation plan; and little or no coordination between the clinical and community components, which means that funding cannot be reallocated from the community component.

Originally “limited” to information for parents after a consultation (through use of the advice sheet), the **community component of IMCI** took on more importance starting in 2004. This followed the worldwide publication of study results showing that community health workers, if well trained and monitored, could provide suitable care to children within their communities and thus make quality care more accessible and help reduce mortality rates. Senegal’s successful community management of initial rapid assessments also provided a model. The community component (based on integrated community case management or iCCM) is meant to complement the clinical component to ensure continuity of care. It was introduced in 2003, beginning with the promotion of key iCCM practices, was later conceived of as IMCI “extended to the level of local volunteers”.

As with the clinical component, the community component was introduced in phases: advocacy, initial training and scale-up:

Table 3. IMCI implementation milestones in the DRC: community component

Advocacy and launch of the approach	
2003	- National diarrhoeal disease control programme designated to coordinate activities of the community component
2004	- Knowledge-sharing with Senegal on community management of IRA - Ministerial decision to integrate management of three fatal diseases and malnutrition at the community level
2005	- Establishment of the steering committee; first choice of sites - Letter from the secretary-general of the Ministry of Health officially launching the community-based approach
Initial training	
2005	- Training of a nation-wide pool of instructors - Adoption of ACTs for managing simple malaria (progressively, depending on availability)
2006	- Training of province-level pools of instructors - Updated treatment of diarrhoea with zinc and low osmolarity ORS
2007	- Review of community-based care - Inter-country meeting in Kinshasa - Updated implementation guide for community care sites
Expansion phase	
2008	- Expansion of implementation to 10 of 11 provinces
2009	- Mobilization of churches to spread key messages about child health
2010	- Introduction of family planning at community care sites
2013	- Launch of the Acceleration Framework for MDGs 4 and 5

There is considerable enthusiasm for implementing the community component. There are directives, rules and tools for implementation and monitoring the progress of local volunteers.

The community component comprises two sub-projects: **promotion of essential best practices** by local volunteers and **case management** in the community health sites. These sites are run by local volunteers trained in managing fatal diseases (malaria, diarrhoea and pneumonia) and in detecting malnutrition. Complicated cases are referred to the nearest health facility. Sick newborns are routinely referred once warning signs have been detected. Unfortunately, registered nurses working in health centres are not trained to manage these cases as initially planned to ensure continuity of care.

In order to accelerate achievement of MDGs 4 and 5, the DRC decided in 2013 to **add a “home” component** to the IMCI package of care by introducing family kits (medical kits for children under five and birth kits for pregnant women). The medical kits contain oral rehydration salts (ORS), zinc, paracetamol, multi-micronutrient packets for preventing malnutrition in children aged 6-23 months and a form to be used during consultation if the child becomes sick. These kits serve to complement the package of care offered at the community health sites. Since 2013, the activities of local volunteers also have a family planning component.

To date, there is no overall strategic plan for implementing IMCI in the DRC.

In 2015, **446 health districts out of a total of 516 had community health sites.** But the **complete package of care** (community health sites and key family practices) **is available in only 105 districts.** It is estimated that **6554 local volunteers** were active in 2015, and 3390 are expected to be trained by the end of 2017 as part of the Acceleration Framework for MDGs 4 and 5, with funding from the the Global Fund, UNICEF and SANRU.

IMCI in the DRC has not been evaluated, but progress reviews on implementation were carried out in 2007 for the clinical component, and for the community component, with support from USAID as part of its documentation of community action on IMCI in countries of the African Region in 2010, and in 2013 for the launch of the Acceleration Framework for MDGs 4 and 5.

Positive factors for scaling up the strategy and the obstacles encountered are presented in the table below.

Table 4: Positive factors and obstacles to IMCI implementation and scale-up

Positive factors	Obstacles/challenges
<ul style="list-style-type: none"> • Compliance, strong engagement and leadership at the national level for introducing IMCI, particularly the community component • Consensus on the added value of IMCI in improving the accessibility of care • Technical and financial support from partners • Worldwide enthusiasm for accelerating reductions in maternal, neonatal and infant mortality as the MDGs come to conclusion 	<ul style="list-style-type: none"> • Lack of an IMCI strategic plan • Insufficient centralized coordination of the clinical and community components • Insufficient quality and quantity of human resources, medicines and other inputs, and health information systems • Unsustainably heavy dependence on external funding • Limited planning and management capacities at the

<ul style="list-style-type: none"> • Existence of clear rules and directives on implementation • Development and implementation of the MDG Acceleration Framework in 2012, and its application in the DRC starting in 2013 	<ul style="list-style-type: none"> • provincial level and in health districts • Insufficient/lacking health workers and local volunteers • Insufficient training before employment • Unequal pricing between community health sites and the health centres to which children are referred • Insufficient documentation of activities • Difficulties in speeding up communication of updated directives due to lack of funding
--	---

III. Lessons learnt

All actors on the ground agree that **IMCI is relevant in the DRC, that it is useful and that its implementation has helped improve children’s health and, according to some, reduced mortality rates.** The management team of the Mbanza Ngungu health district unqualifiedly attributes a reduction in mortality to the implementation of IMCI: “In our health district, the mortality rate has dropped from 104 per 1000 live births in 2013 to 44 per 1000 live births in 2015, thanks to IMCI.” We heard anecdotes testifying to communities’ attachment to their health sites (such as inhabitants’ anger when their community health site was shuttered by the funding partner because funds were misappropriated in Tanganyika province) and to their effectiveness, such as the frustration of nurses in health centres whose revenue dropped with the number of referrals: “since the community health sites have entered into service, there are no more serious anaemia cases, and we no longer have transfusions to do.”

At the national level, political will is manifest. It has been particularly strong over the past few years and likely contributed to the adoption and introduction of the community component of IMCI and its scale-up. The Minister of Health and his staff showed their personal investment in the project by being present at the launch of activities and through official declarations: “It was ministerial leadership in 2005 that made it possible for the DRC to draw on Senegal’s experience in community-managed IRAs and begin integrated management of malaria, diarrhoea and pneumonia.”

However, **this has not been enough to bring about the expected results.** Despite the desire to improve maternal, newborn and child health indicators, **there is no overall implementation strategy** that would translate this into a concrete reality by setting out a vision, clear objectives, results to be obtained, implementation framework, responsibilities of different actors and expansion procedures, all with a defined budget. As it is, implementation is rather disparate, and depends largely on the partner providing support in a given province or health district. There is no budget line for IMCI, and total health care expenses are largely covered by external financing and from the pockets of families. According to the national health accounts report, in 2013, external financing covered 37% of total health spending, households paid 41% and the State only 13%. This reveals the country’s **deep dependence on external financing, which threatens the sustainability of the system and weakens its development.** Although the health sector received significant support from development partners over past years, there has been relatively little harmonization and coordination between partners on the levels and types of health

district financing, and the **resources provided by partners have proved insufficient to cover the entire country.**

Although at the time of its introduction, IMCI was conceived as a three-part strategy, **its three components have never been implemented in a coordinated, simultaneous and harmonized fashion.** Initially, the component aimed at developing health workers' skills had the greatest support. But since 2005, and especially since 2013 with the Acceleration Framework for MDGs 4 and 5, the community component has attracted the most attention and support from partners. Although its importance has always been implicitly understood, **the clinical component has always presented one of the main challenges,** particularly the **availability of medicines and other inputs.**

There exists a national programme for the provision of essential medicines that coordinates the national system for that purpose (SNAME). IMCI clinical interventions depend entirely or partially on this system, which is perfectly structured in theory but in reality only, since in reality its functioning is far from optimal. **Inputs are frequently out of stock,** which has led to parallel provisioning and delivery systems being developed. Several partners buy health inputs directly and distribute them through NGOs. Often, **health centres buy their supplies locally, and the quality of medicines is not always guaranteed.** Estimates of the needed inputs are not made in a harmonized way. Needs in respect of tropical diseases research and ACTs are estimated by the national malaria control programme, while estimates for amoxicillin and ORS and zinc are made individually by the partners providing them. For this reason, there is no estimate for the total inputs needed for IMCI nation-wide.

The health information system is of interest to, and receives support from, partners. Efforts are being made to facilitate real-time data collection and centralized transmission. But frequent power outages have prevented the expected results from being achieved as of yet. **Data are also incomplete and not received on a timely basis, making it impossible to receive quality data in time to make decisions.**

As for health worker skills development and quality of service, norms and directives are available, including for supervision. The country also has a monitoring system— known as “improved monitoring for action” – for tracking progress on effective coverage of maternal, newborn and child health interventions. Monitoring is carried out by health workers with the participation of local health care volunteers from the communities being served.

Figure 3: Ex. of improved monitoring for action (Kanza): data from 5 health districts

TABLEAU DE BORD DES INTERVENTIONS POUR CIBLE DE 0-59 MOIS

Déterminants	Seuils d'acceptabilité	ACCOUCH ASSISTE	CPNr	SEN	VACC 0-11 mois	PLANNING FAMILIAL	PNEUMONIE	DIARRHÉE	FIEVRE	PALUDISME
Commodités	50-80%	52%	52%	32%	70%	17%	60%	53%	57%	57%
Ressources humaines	50-80%	59%	82%	51%	67%	30%	57%	57%	57%	57%
Accès géographique	50-80%	68%	77%	68%	79%	76%	75%	75%	75%	75%
Utilisation	40-70%	54%	74%	33%	96%	3,6%	38%	3%	7%	5%
Continuité	40-70%	54%	21%	20%	86%	1,1%	36,9%	2,0%	6,6%	5,1%
Couverture effective	40-70%	2%	6%	6%	40%	1,0%	9,3%	0,3%	0,9%	2,4%

[Table:

Left column top to bottom: Determinants, Commodities, Human resources, Geographic access, Utilization, Continuity, Effective coverage

Top row left to right: Determinants, acceptable levels, assisted childbirth, refocused prenatal consultations, SEN, immunization 0-11 months, family planning, pneumonia, diarrhoea, fever, malaria

The development and launch of the Acceleration Framework for MDGs 4 and 5 in 2013 has helped accelerate and redynamize activities for reducing maternal, newborn and child mortality at all levels of the health pyramid. It has mobilized financing, including from the Muskoka Initiative, Alliance for RMCH, the World Bank, the Canadian International Development Agency and Swedish International Development Cooperation Agency; it has also created strategic partnerships for maternal, newborn and child health. One platform in particular has proved useful: the H4+ partnership. Created in 2009 by the United Nations, WHO, UNICEF, UNFPA and the World Bank to help governments improve maternal, newborn and child health, it later expanded to become H6+ with the addition of UNAIDS, UN Women and the World Food Programme.

At the district level, the large number of actors on the ground – although positive in terms of the human and financial resources mobilized – has occasionally led to unequal implementation. “The disparities are not only geographic (piecemeal coverage of health districts and provinces), but also exist in terms of implementation methods (varying numbers of people covered by

Figure 4: The Acceleration Framework for MDGs 4 and 5 gave a real boost to implementation of IMCI in the DRC.



community health sites and varying content of the IMCI kit).” Results at this level **essentially depend on the energy and planning capacities of the district’s management team**. Insufficient support from the partner(s), out-of-stock medicines and other inputs, and a mobile workforce are all challenges the management teams must constantly face. Here also, solutions often depend on the partner.

In health facilities, appreciation was expressed for the IMCI informational charts and case-management forms for identifying and systematizing treatment. Challenges include **lack of staff trained in IMCI and out-of-stock case-management forms** (which leads to directives not being followed), insufficient supplies and **staff turnover**. Aging facilities are also a problem.

At the community level, the main challenge remains the lack of **motivation among local health care volunteers. They are unpaid**, but depending on the district and partner in question, several means of motivating them have been identified: providing bicycles for their trips to the health centre to pick up medicines, providing a meal stipend during meetings, etc. Supervision of volunteers was particularly appreciated. “Because supervision takes place within the community, it draws positive attention to the volunteer. (...) Also, we are receiving more and more complaints from outreach volunteers who are not supervised in this way and feel left out. This could have a negative impact on outreach activities”.

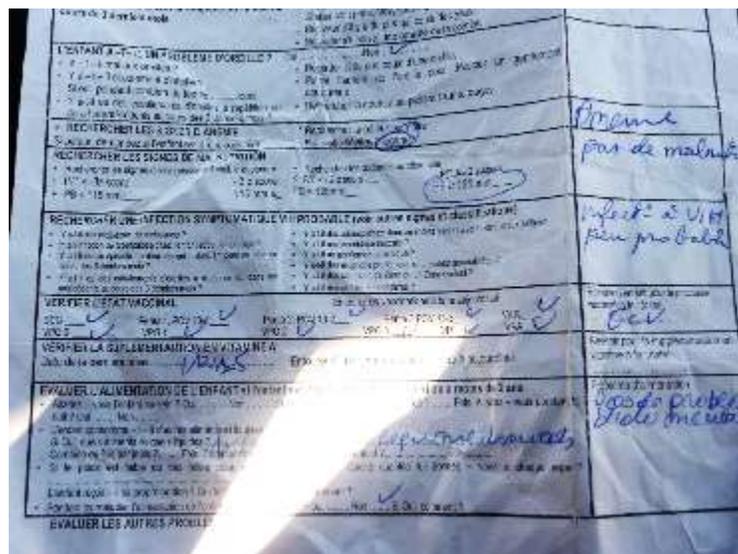
In districts where the system is well established – with regular supervision and stock outages kept to a minimum – **the district management teams report a significant reduction in serious cases referred to health centres**. But there are also reports of refusals or resistance to referrals, essentially owing to the cost of care in a health centre, when care is free (subsidized by the partners) at the community health sites. Another challenge for continuity of care is a lack of support for the health centres that supervise community health sites. Nurses in these centres are not all trained in IMCI, despite being responsible for supervising local volunteers,

admitting referrals and managing their cases.

Figure 5: Example of a case-management form (May 2016) at the Loma health centre. Health workers appreciate these forms and say they make routine evaluation of children’s care easier

No real technological innovations have been introduced for maternal, newborn and child health. The use of mobile phones to collect information in the field and send it to a central location for analysis and real-time decision-making is being tested, but only for emergencies and not yet for maternal, newborn and child health.

In December 2015, WHO organized an orientation workshop on ICATT software in the DRC. The IMCI national coordination team found it very interesting and believes it could



prove useful for training purposes, in schools and for managers in the Ministry of Health, provinces and health districts. Lack of funds remains the main constraint.

Interesting developments are also underway that could be considered **innovations for improving the management and quality of care**. The Ministry of Health has put in place a **coaching system for its teams in the provinces**, to help them plan and monitor activities in their regions. National public health experts have been identified and assigned provinces where they are to provide regular follow-up. They are themselves supervised by a national director. Also at the provincial level, the ministry has put in place a **“single-contract”** system, whereby partners sign a written commitment with the provincial government binding them to implement and monitor health interventions in their regions, in order to reinforce leadership. Since 2013, the ministry has also conducted **improved monitoring for action** in order to monitor the progress made on implementation of primary care both in health facilities and in communities. The different pillars of the health system are evaluated: governance, financing, availability of medicines, human resources for health, supervision, etc.

To contribute to the correct usage of ACTs and reduce antimicrobial resistance, with the support of USAID/Management Sciences for Health, private-sector pharmacists in two health districts have been trained on rapid diagnostic tests (provided free of charge by the malaria control programme) and their routine use before administering ACTs to patients. The first results are positive and the country is considering expanding this activity over time. Similar action has been taken for recognizing the early signs of pneumonia and dehydration, with pharmacists trained to give customers advice and prescribe medicines more rationally.

IV. National outlook and action

At the national level, engagement for and interest in reducing maternal, newborn and child mortality must translate into a **considerable increase in financing** for the strategy, continued advocacy among funding agencies so they do not reduce their contributions and, most importantly, the **allocation of resources in the country’s own budget**. One promising idea being explored by the Ministry of Health is the possibility of expanding the mandate of the parliamentary lobbying group originally established for obtaining counterparty funds for GAVI financing (within the framework of the Initiative for Vaccinal Independence) and the World Bank; its mandate would be extended to all areas of health, including maternal, newborn and child health. This group has exercised its right to examine budget votes and successfully had the share of the State’s budget dedicated to health increased.

Any increase in the State’s health budget would need to be paired with significant improvements in the Ministry of Health’s disbursement rates. This would put the government in better position to ensure its leadership and strengthen cooperation with partners. In this scenario, the unequal distribution of partners throughout the country would also need to be better managed, among other things.

Current efforts need to be continued, with support from partners, in order to strengthen the other pillars of the health system. All of the following would improve the coverage, quality and utilization of maternal, newborn and child health services: strengthening and national deployment of the health information management system to collect more complete data, faster (with support from USAID, the

UK Department for International Development, WHO and partners); systems strengthening for the supply, distribution and regulation of pharmaceutical products (with support from UNICEF, the World Bank, the European Union, the Belgian Development Agency, GAVI, the World Bank, USAID and the Canadian International Development Agency); and better management of human resources, incentive measures and motivation for health workers through performance-based pay (with support from the World Bank, SANRU and other partners). Without a minimum of robustness in the health system, there is no hope that implementation of the activities described here will have a real impact.

Another important issue is the role and place of IMCI in the health system. Although on paper there is no conflict between the various programmes, it is to be hoped that further integration of activities will continue to be discussed: in a sector lacking sufficient resources, synergy and efficiency must be improved to meet the considerable needs.

The national IMCI coordination team seems well aware of the unequal support for the different components, and of the **need to come up with a strategy and means for the clinical component to attract more support**. For IMCI to live up to its full potential and impact, **its three components must be implemented in a harmonized, balanced way**. Strong advocacy must be directed at partners so that they will take into consideration the importance of building strong ties between communities and the health system, which will require supporting health centres in developing their staff's skills (training must include follow-up; proper supervision must include observation of case management). The implementation directives are clear, and roles and responsibilities have been clearly established at the community level: registered nurses are responsible for training and supervising local volunteers, and community health sites must refer serious cases to health centres. However, it would appear that the health districts, provinces and national leadership are all unable to ensure the strict application of these provisions.

It is therefore necessary to **improve the skills of health workers** in health facilities once they are already working (e.g. through IMCI clinical training in first-tier health facilities and Emergency Triage Assessment

Figure 6: Staff in a health centre. Developing their skills is a serious challenge in scaling up care for mothers, newborns and children



and Treatment training in paediatric clinics and referral hospitals), and to **find a means of supporting IMCI training in medical schools**.

A budgeted strategic plan is needed for use in advocacy. The moment is ripe, given the forthcoming health development plan 2016–2020, which has been drafted and is undergoing final amendments.

Recent studies on the cost of integrated care in Sud-Ubangi province provide a useful starting point for an estimated budget of the community component of IMCI.

Enthusiasm and interest for improved monitoring for action among the management teams at the district, health-centre and community levels must be maintained, in spite of many “red” results and the occasional complaints that the established criteria for meeting certain indicators are too strict. Coaching must continue and data should continue to be regularly analysed and appraised. More is needed, however: the system must manage to ensure that corrective measures are followed through with whenever possible, and sufficiently early. Otherwise, there is a serious risk that data will once again be blindly collected by health workers with no follow-through. A number of partners have called for **data from community health sites to be presented separately**, so that their contribution can be appraised more objectively. For the moment, these data are aggregated with those of the referral health centre.

The community health sites were set up to make care more accessible given the inaccessibility of health centres. But in many health districts, owing to insufficient funding, there are not enough sites to serve the entire population, who cannot then be referred to a health centre should the case become more serious. **The sparse placement of community health sites means that many still do not have access to care, and the sites’ impact is thus limited.** This is what the Rapid Access Expansion (RACe) programme is working to correct, with technical support from WHO and funding from the Canadian International Development Agency. In the health district that falls under this programme, it has been ensured that the population is fully served by installing the necessary number of community health sites and maintaining ties with the health centres, whose registered nurses are responsible for training representatives. An impact study will soon be carried out, and if the results from the region are positive, it will provide a prospective model for proper implementation IMCI. Partners could – and should – be called upon to work together to provide proper coverage in terms of community health sites.

It has been proven that involving the community in decision-making contributes considerably to compliance. For this reason, **work with religious leaders should continue**, so that they help inform their communities about children’s health. It is also necessary to discuss the question of how to boost motivation among so-called outreach representatives, so that they fully participate in promoting key practices.

The problem of motivating community health representatives is ongoing and recurrent. The solution will certainly not be one-size-fits-all. It will have to be discussed locally, once the authorities have established a framework.

Many interviewees underscored the **problem of sustainability**, considering the **heavy dependence on support from external partners**. Although the system has slowed or even stopped in some districts, in others, such as South Kivu, the population has agreed to contribute financially to allow services to continue. Community participation is therefore one possible solution for ensuring activities are made permanent.

But the public already bears 40% of health costs, and understandably, some actors are therefore reluctant to ask for additional contributions. **The issue of pricing and universal health coverage is pressing**, and the government, with support from partners, is in fact drafting a law on the subject.

V. Conclusions of international interest

The majority of interviewees considered the **content and approach of IMCI to be good, and thought it helped in the fight against lethal children's diseases**. However, they found the requirements for the training sessions too restrictive (ratio of trainers/participants, course director, large number of modules and readings, etc.) and too difficult to maintain in scaling up the activity. For these reasons, the training has been simplified and shortened in the DRC.

Interviewees also found the entire **process quite strict** and said it did not allow the country enough leeway in adapting it to their unique context. In sum, countries like the DRC certainly need directives, but these should be flexible enough to be adapted to different contexts and needs.

IMCI is a collection of technical case-management directives, but **it should have been paired with clear guidance as to the best way to integrate the strategy with all the pillars of the health system** to increase its actual coverage. It may have seemed as though the health system was capable of implementing the strategy, but in fact this was not the case. What is needed on the operational level are clear indications of the best way to ensure the various pillars of the health system contribute efficiently to expanding effective IMCI coverage.

The principles of the Paris Declaration on Aid Effectiveness are well understood internationally. However, countries have often observed that their high-level partners do not set the best example, and they wish to advocate for **greater respect for countries' priorities**. They are put in the position of having to accept aid without being truly able to negotiate, given their need (and perhaps a lack of leadership).

In order to better communicate with funding agencies, interest them in maternal, newborn and child health and keep the issue on the agenda, it would be useful if international actors (such as WHO, UNICEF or the World Bank) developed periodic or annual coverage indicators resembling the score cards used by Countdown to 2015. These would be circulated to give funders an idea of the progress made in the country.

According to interviewees, **the question of renaming IMCI** (French acronym: PCIME) **is not a priority**. "We are used to this acronym, and it contains the idea of 'integration', which is very important."

Documents consulted

1. UNICEF, Levels & Trends in Child Mortality: Report 2015 Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation, 2015, UNICEF, World Health Organization, The World Bank and United Nations: New York
2. Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité (MPSMRM), Ministère de la Santé Publique (MSP) et ICF International, 2014. Enquête Démographique et de Santé en République Démocratique du Congo 2013-2014. Rockville, Maryland, USA: MPSMRM, MSP et ICF International
3. République Démocratique du Congo, Enquête par grappes à indicateurs multiples, MICS RDC 2010, Ministère du Plan, Institut National de la Statistique en collaboration avec le Fonds des Nations Unies pour l'Enfance (UNICEF) – Septembre 2010
4. République Démocratique du Congo, Ministère de la Santé Publique, Secrétariat Général, Programme National des Comptes de la santé (PNCNS), Comptes de la santé RDC 2013, Rapport narrative, Kinshasa, mars 2015
5. République Démocratique du Congo, Ministère de la Santé Publique, Secrétariat Général, Normes de la zone de santé relatives aux interventions intégrées de santé de la mère, du nouveau-né et de l'enfant en République Démocratique du Congo – Vol 3 : Soins essentiels et d'urgence au nouveau-né. Edition 2012
6. République Démocratique du Congo, Ministère de la Santé Publique, Secrétariat Général, Plan National de Développement Sanitaire PNDS 2011-2015, mars 2010
7. République Démocratique du Congo, Ministère de la Santé Publique, Secrétariat Général, Coordination Nationale de la PCIME. Historique et situation de la mise en œuvre de la PCIME Clinique en RDC de 1999 à 2015.
8. République Démocratique du Congo Ministère de la Santé Publique, Ministère de la santé, Secrétariat Général. Termes de référence de la Task Force « Santé de la mère du nouveau-né et de l'enfant » en République Démocratique du Congo. Edition 2012
9. UNICEF et République Démocratique du Congo : Documentation de la Prise en Charge des Maladies de l'Enfant au niveau Communautaire (PCIME-C) en RDC. Processus de mise en œuvre y compris dans le cadre de l'accélération des OMD 4 et 5 et lien avec la note conceptuelle paludisme. Novembre 2014
10. République Démocratique du Congo, Ministère de la Santé Publique, Secrétariat Général, Normes de la zone de santé relatives aux interventions intégrées de santé de la mère, du nouveau-né et de l'enfant en République Démocratique du Congo – Vol 8 : Interventions à base

communautaire pour la santé de la mère, du nouveau-né et de l'enfant. Edition 2012

11. USAID, Maternal and Child Health Integrated Program: Indicator guide, Monitoring and Evaluating Integrated Community Case Management. July 2013

12. USAID, Maternal and Child Health Integrated Program : Prise en Charge Communautaire Intégrée des Maladies de l'Enfant : Documentation des meilleures pratiques et des goulots d'étranglement à la mise en œuvre du programme en République Démocratique du Congo. Revu et présenté janvier 2012 à l'Agence des États-Unis pour le Développement international

13. République Démocratique du Congo, Ministère de la Santé Publique. Rapport d'avancement de monitoring amélioré pour action : Septembre à novembre 2013

14. Joshua Davis, Léopold Buhendwa. Rapport final d'évaluation de la qualité des données, Comité international de secours (IRC) République Démocratique du Congo. Elaboré par ICF International pour le compte du Programme de l'Organisation mondiale de la santé pour l'élargissement de l'accès rapide.

15. Alison WITTCOFF, Pascal NGOY, Jennifer O'KEEFFE, International Rescue Committee (IRC) : deuxième Rapport annuel sept 2014-Août 2015, Projet RAcE, RDC, District sanitaire de Tanganyika, Nov 2015.

16. République Démocratique du Congo, Ministère de la Santé Publique, Secrétariat Général, Cadre d'Accélération de la Réduction de la Mortalité de la Mère et de l'Enfant en République Démocratique du Congo. Appel à l'action pour tenir nos promesses. Mai 2013

17. Kanza Nsimba, Evaluation de la phase pilote de PCIME dans le secteur pharmaceutique privé dans deux zones de santé de Kinshasa. Rapport d'évaluation Sept-Oct 2011. USAID/SPS

18. Jarrah, Z., M. Klein, and D. Collins 2014. The Cost of Integrated Community Case Management in Sud- Ubangi District, Democratic Republic of Congo.

