REPUBLIQUE DEMOCRATIQUE DU CONGO
Ministère de la Santé Publique
Division Provinciale de la Santé Tanganyika

Implementing iCCM in a conflict-affected, remote province of Eastern DRC

Canadian International Development Agency

World Health Organization

INTERNATIONAL RESCUE COMMITTEE

Abuja, October 24th

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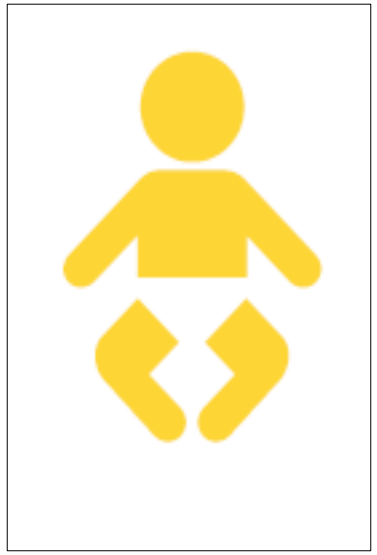
Country Info- DRC

- **Capital: Kinshasa**
- **Population** 80 million (around 12 million under five)
- **Area** 2.34 million sq km (905,354 sq miles)
- **Major languages** French, Lingala, Kiswahili, Kikongo, Tshiluba
- **Life expectancy** 58 years (men) 62 years (women)
- **Number of IDPs** 3.8 million
- **Poverty** 82% of the pop lived on less than $1 a day in 2015

Under Five-Deaths and Care-Seeking in DRC

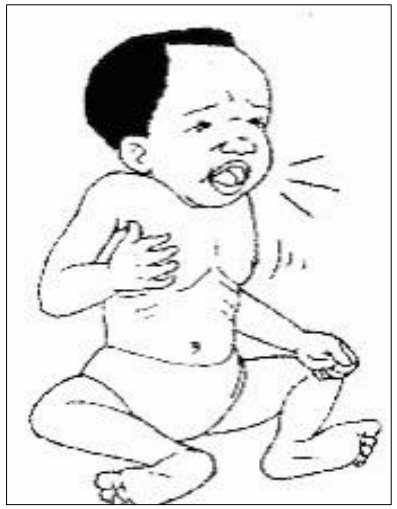


104 per 1000 live births

- One of the highest rates of child mortality globally

According to DHS 2014:

- Only 39% of children under five received ORS for diarrhea
- 30% received antibiotics for diarrhea
- Only 39% received antibiotics for pneumonia
- Only an estimated 17% of children received appropriate treatment for malaria with ACT



Barriers to accessing care:

- Long distances, no means of transport, impoverished communities that can’t afford care

Policy Framework for iCCM in DRC

- iCCM included as part of primary health care strategy
- Decision in 2004 to integrate management of four diseases: pneumonia, malaria, diarrhea and malnutrition
- MOH-SG established steering committee in 2005 to implement iCCM strategy
- iCCM sites established 2006
- MOH finalizes implementation guide for iCCM sites in June 2007

RAcE DRC - Tanganyika Province

Project location

- Tanganyika Province, Eastern Congo

Implementation period

- Sept. 2013-Nov. 2017

Area

- 134,940 square kilometers

Population

- 2.6 million- 18 inhabitants per Km2

Scale-up

- Year 1 project covered 7 out of 11 health zones
- Year 2 scaled up to 10 of 11 health zones
- Year 3 RAcE active in all 11 health zones of province with around active 1,600 CHWs

RAcE DRC - Tanganyika Province cont.

- Communities >5km from a HF or separated by geographical barrier
- CHW covers pop. of about 500
- Elected by community/ work as volunteers
    - 1837 Reco Trained, 1475 reported Oct
    - 234/264 health area covered
- Free treatment for three iCCM conditions
- MOH-endorsed tool package contains 7 tools that CHWs must complete
- OR on simplified tools and training package

CHW Profile (based on MOH criteria)

- Live in the community
- Know the local language
- Able to read and write
- Available to community
- Model citizen
- Capable of mobilizing the community
- Sense of responsibility and leadership
- Have a source of income
- Less than 10% are female CHWs

Training

- ToT conducted Dec. 2013 in Kalemie – central, district and Zonal Health Bureau
- Training of nurses – facilitated by ZHB and IRC at ZHB
- 6-day training for CHWs facilitated by Zonal Health Bureau (focal points) and IRC staff
- CHW Trainings held at or near the Health Center
- Training ratio: around 20 CHWs with 2-3 facilitators (IRC and ZHB)
- 5 hours of training dedicated to clinical practice to observe and assess CHW skills

Training (cont.)

- Head nurse participates in CHW training to support CHWs as necessary
- Pre and post-test given to CHWs
- Additional ToT conducted in 2015 in Kalemie to include new zones
- Suivi post-formation: follow-up that takes place
- 3 months after CHWs are trained (Zonal Health Bureau, IRC and MOH national level reps)

CHW Supervision

- Supervised directly by head nurse monthly
- ZHB and IRC focal points also responsible for monthly supervision visits
- Quarterly supervision from Provincial Health Dept.
- Supervision visits
  - Review of tools with CHWs (MOH supervision checklist)
  - Observe medication stocks/conduct spot-checks
  - IRC insisted on observation of sick child being treated (not part of checklist)
- Nurses provided with bicycles
- ZHB and IRC provided with motorcycles
- Weak CHWs to receive coaching visits from head nurse and ZHB focal points

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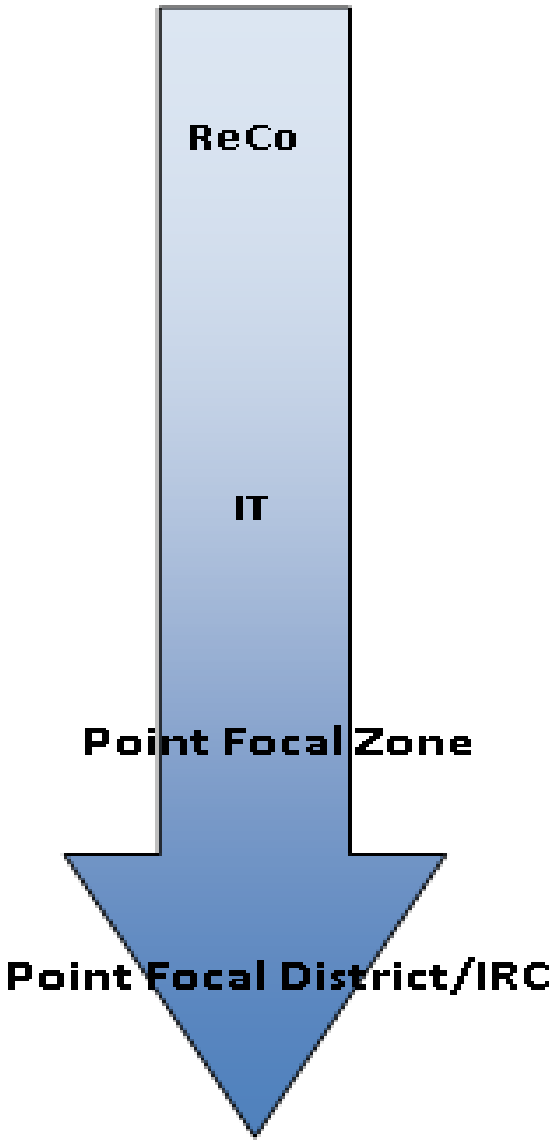
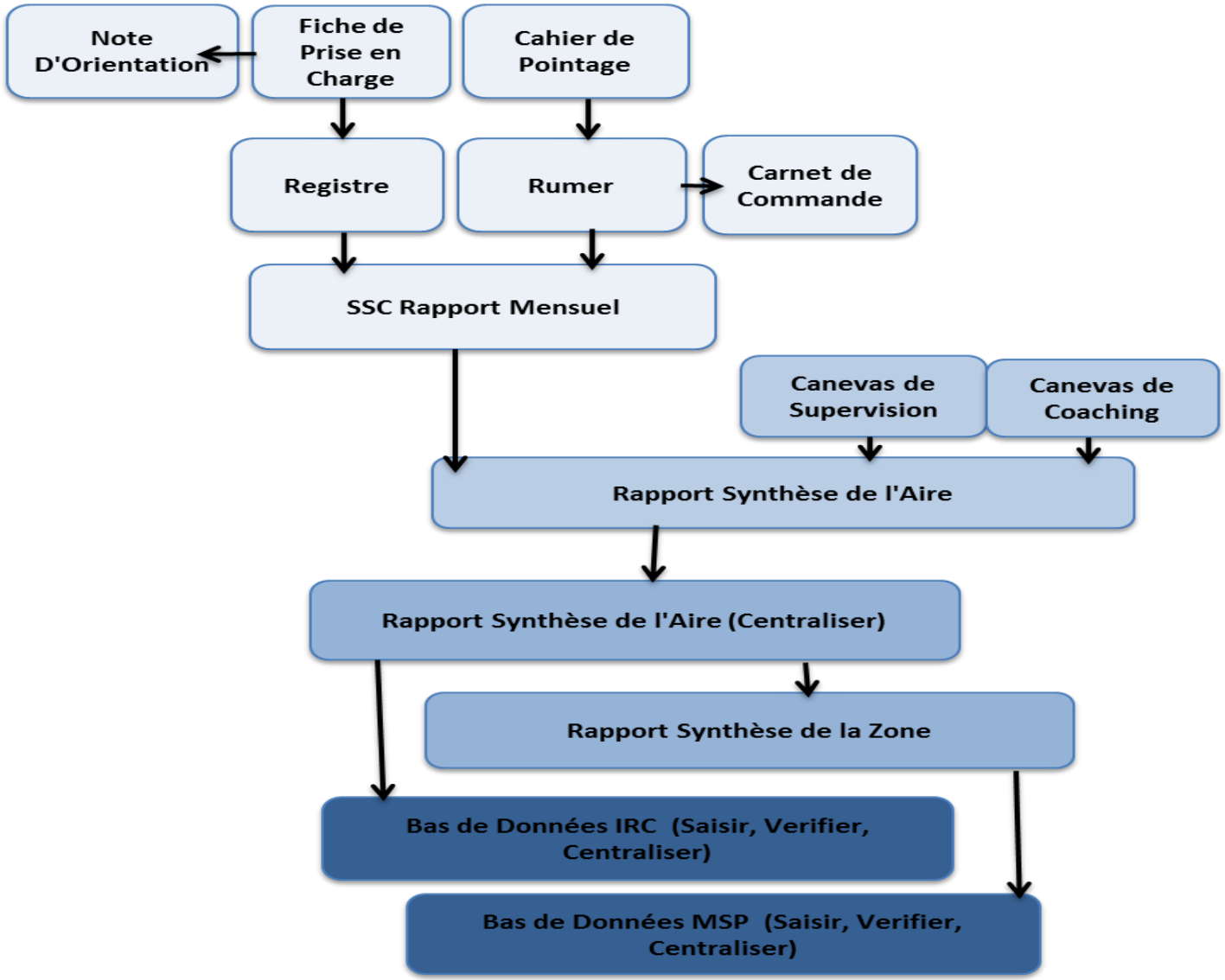
Monitoring and Evaluation

- CHWs- 7 data collection tools
- Head Nurses- 2 data collection tools
- Head Nurses send monthly report to BCZS
- BCZS focal points enter data into Excel database and send to IRC Health Manager (for final review/cleaning) and DPS
- DPS shares data captured in SNIS with central level
- Assessment of QoC
- Quartely review

WHO/G. Tapper

M&E- Data Flow


ReCo
IT
Point Focal Zone
Point Focal District/IRC


Note D'Orientation
Fiche de Prise en Charge
Cahier de Pointage
Registre
Rumer
Carnet de Commande
SSC Rapport Mensuel
Canevas de Supervision
Canevas de Coaching
Rapport Synthèse de l'Aire
Rapport Synthèse de l'Aire (Centraliser)
Rapport Synthèse de la Zone
Bas de Données IRC (Saisir, Verifier, Centraliser)
Bas de Données MSP (Saisir, Verifier, Centraliser)

RAcE project database

- Captures key project info including indicators from PMF on a monthly basis
- Designed to highlight issues/inconsistencies automatically (cells turning red or blue to signal a problem during data entry)
- Example: the respiratory movements column (MR total) is red because it does not match the number of children with cough/cold symptoms

Plaintes Signes de Danger Total	PlaintesToux /RumeTotal	Plaintes Fievre Total	Plaintes Diarrhée Total	MRTotal	TDRTotal	PB Total
7	5	16	5	3	16	0
2	0	4	3	0	4	0
5	19	81	10	19	81	0

Supply Chain

- Procurement of drugs by IRC
- Drugs procured internationally and locally
- Reception by IRC, housed in warehouse of CADMETA (govt. distributor) in Kalemie
- IRC requests quantities to transport to each HZ to CADMETA
- Drugs arrive and are housed at ZHB warehouse
- Head nurse requests drugs from ZHB based on CHW consumption
- CHWs make monthly drug requests to nurse

Community Engagement

- Challenge in the DRC context
- Some communities have motivated their CHWs, but not the norm
- Examples of motivation :
  - Helping CHWs farm their land
  - Building post for CHW to treat children
  - The community gathering money together to buy pens or flashlights for CHWs

- Misconception by communities that CHWs are paid
- Great appreciation for project even if communities did not show appreciation of CHWs

Country Achievements

- Strategic/political contribution
  - Revision/Alignment of DRC iCCM protocols to WHO norms
    - Use of Amoxycilline
    - Management of negative RDT

- Program and Health System Contribution
  - Increased capacity of both BCZS and Tanganyika DPS on iCCM implementation
  - Close collaboration with the DPS and BCZS
  - Introduction of counting beads
  - Translation of tools into Swahili
  - Collaboration with CADMETA (govt. drug distributor)
  - Investments in the infrastructure of sites
  - Investments in BCZS (motos, computers)
  - Engagement of MSP at all levels (national, provincial and zonal) in the iCCM strategy and implementation

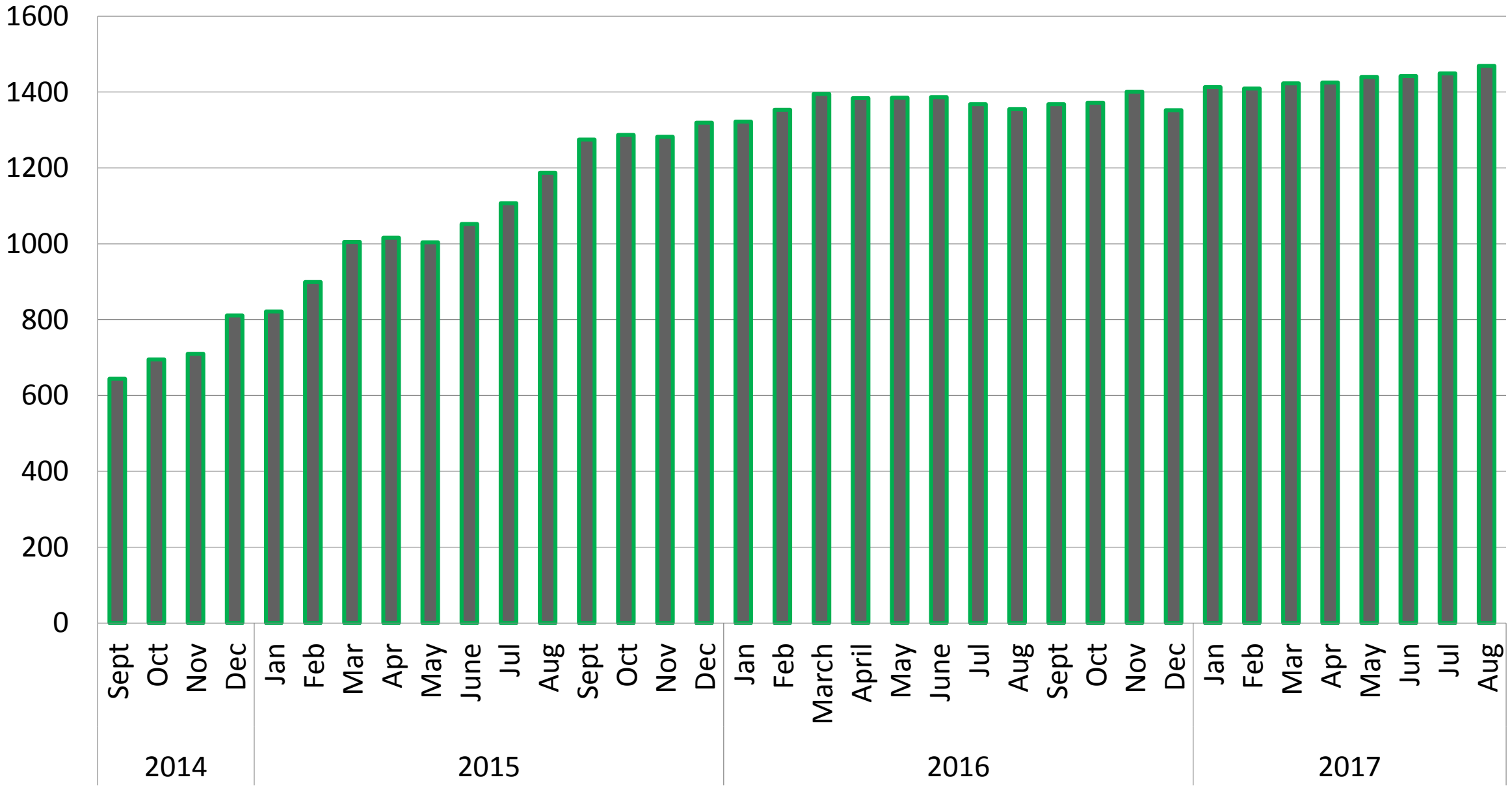
Project results

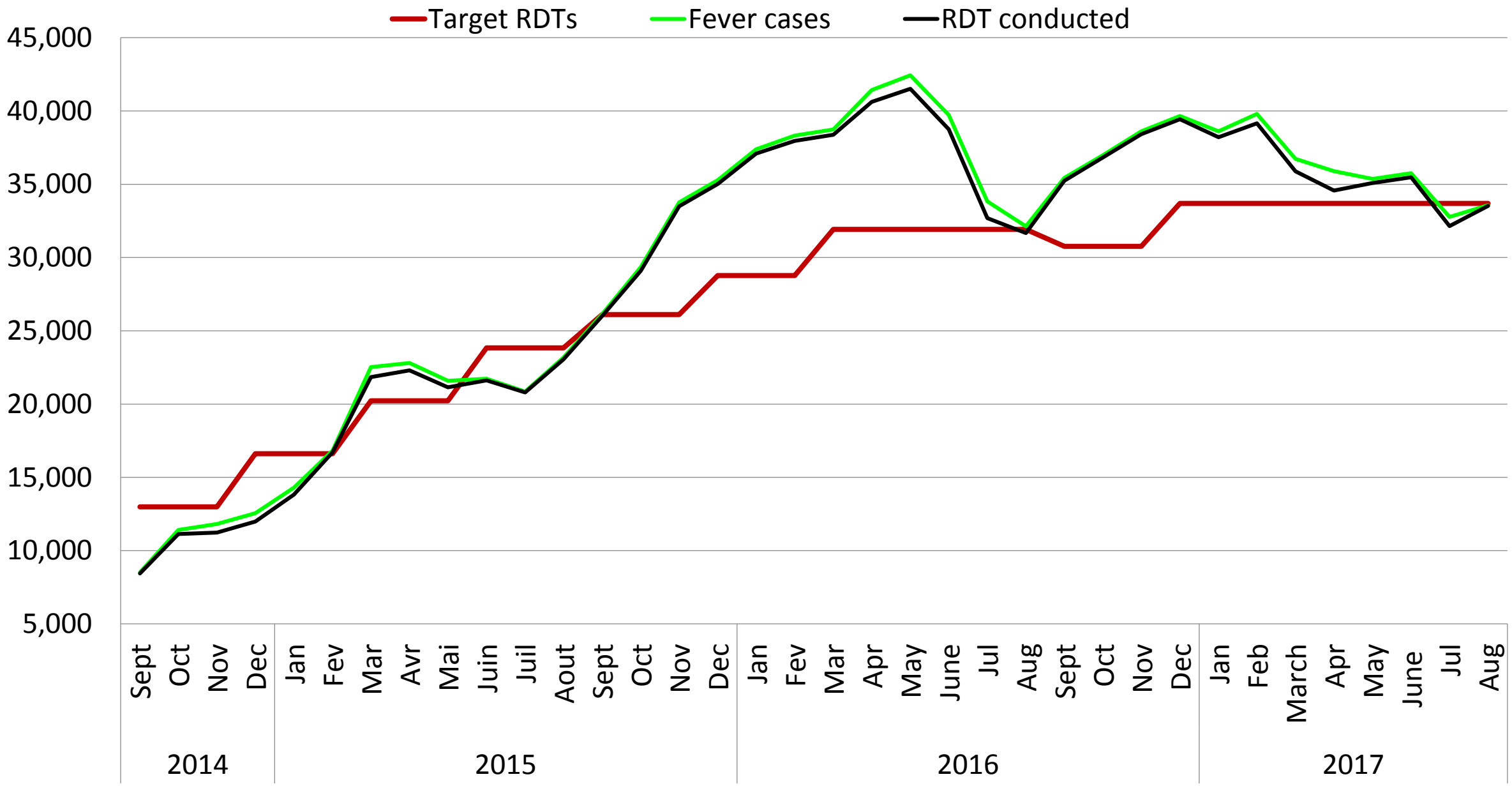
Between January 2014 and June 2017, a total of 1,343,353 treatments were **provided** , which included:

- 870,783 confirmed malaria treatments;
- 14,077 suspected malaria treatments;
- 276,942 diarrhea treatments; and
- 181,551 pneumonia treatments.

- 1,039,130 Rapid Diagnostic Tests for malaria were **administered**

Active CHWs, Sept 14- August 17




Fever Cases Tested with RDT, Sept 14 – August 17
Target RDTs
Fever cases
RDT conducted
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
Sept
Oct
Nov
Dec
Jan
Fev
Mar
Avr
Mai
Juin
Juil
Aout
Sept
Oct
Nov
Dec
Jan
Fev
Mar
Apr
May
June
Jul
Aug
Sept
Oct
Nov
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Jan
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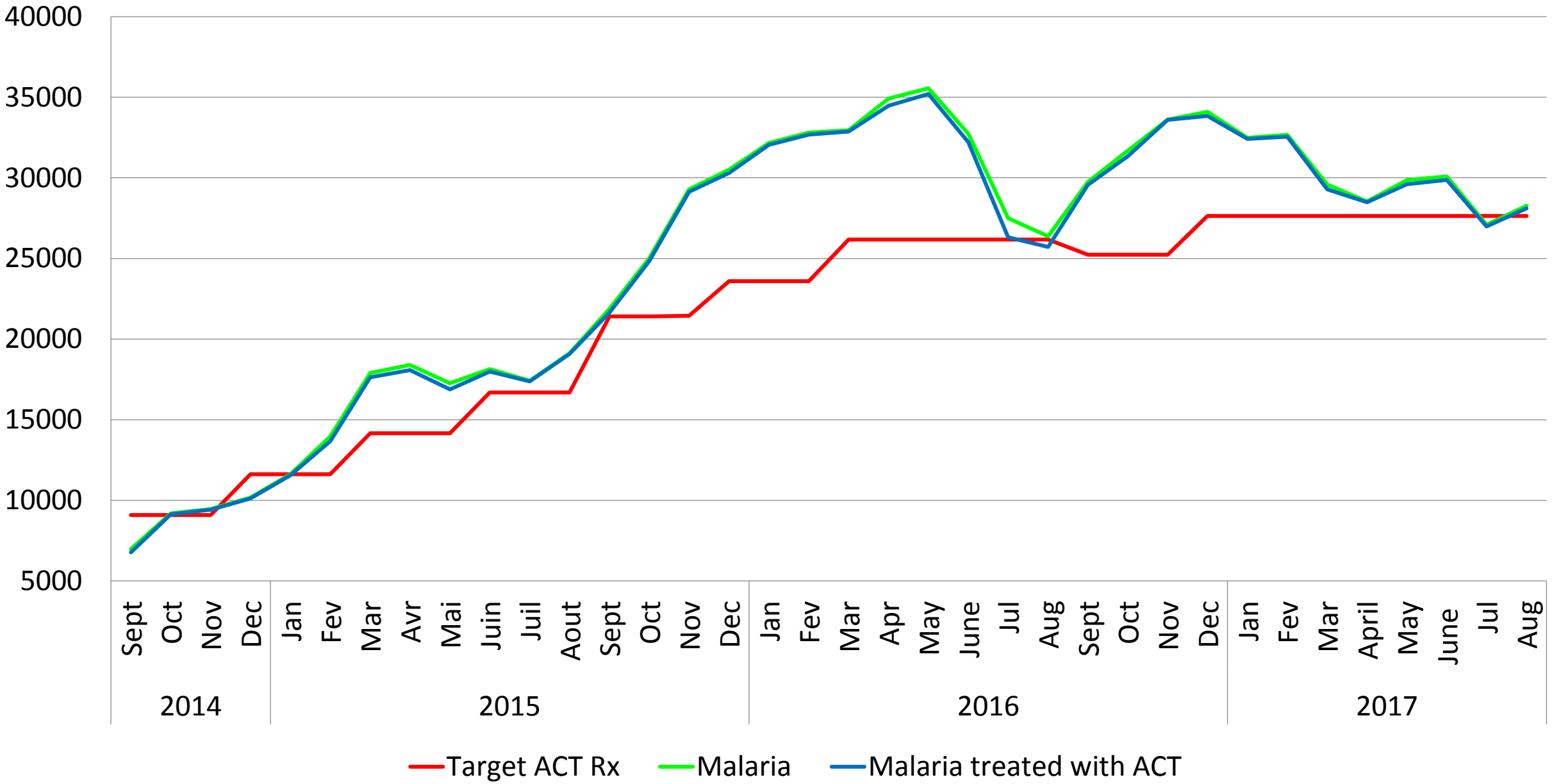
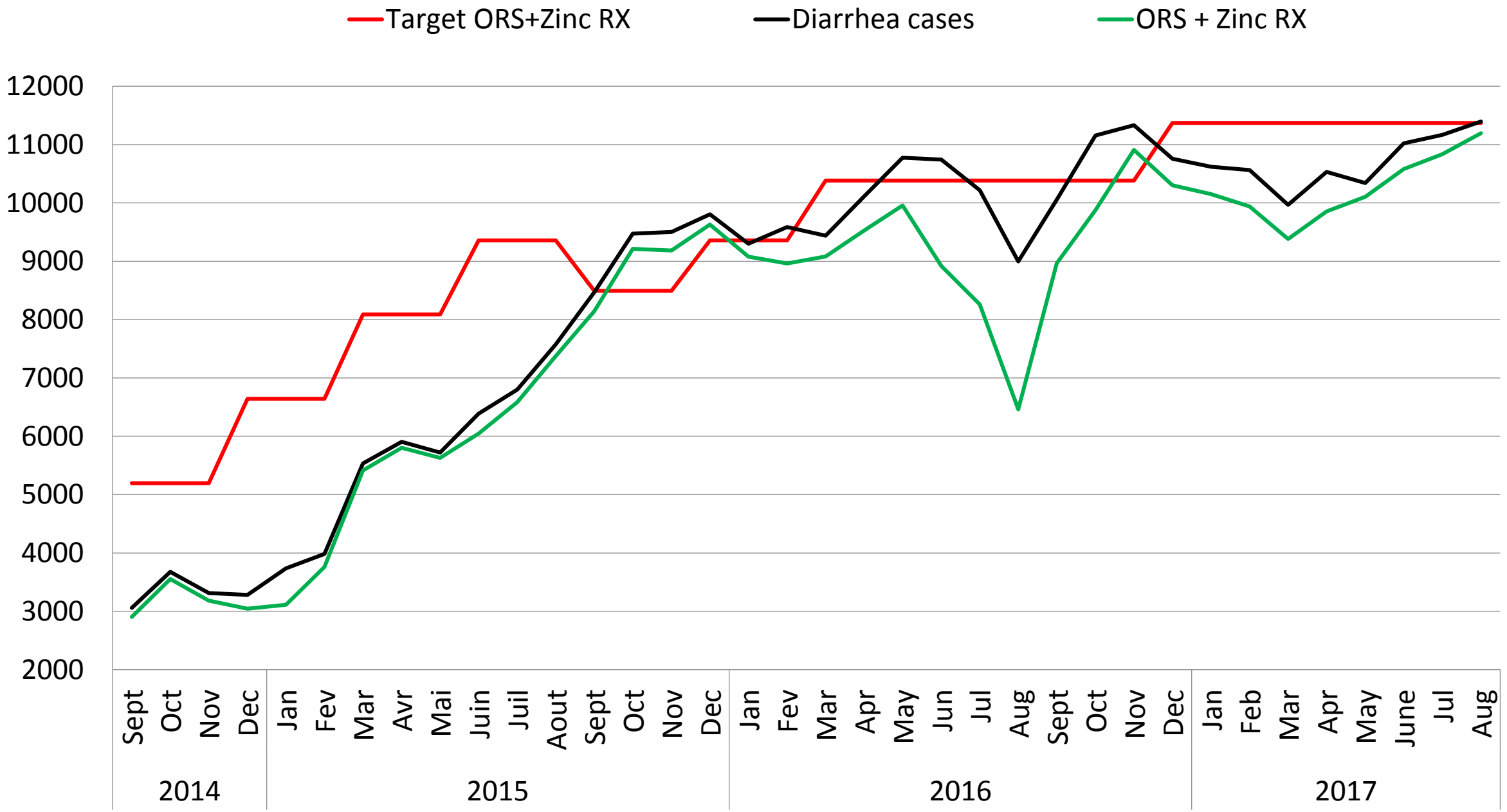
March
Apr
May
June
Jul
Aug
2014
2015
2016
2017

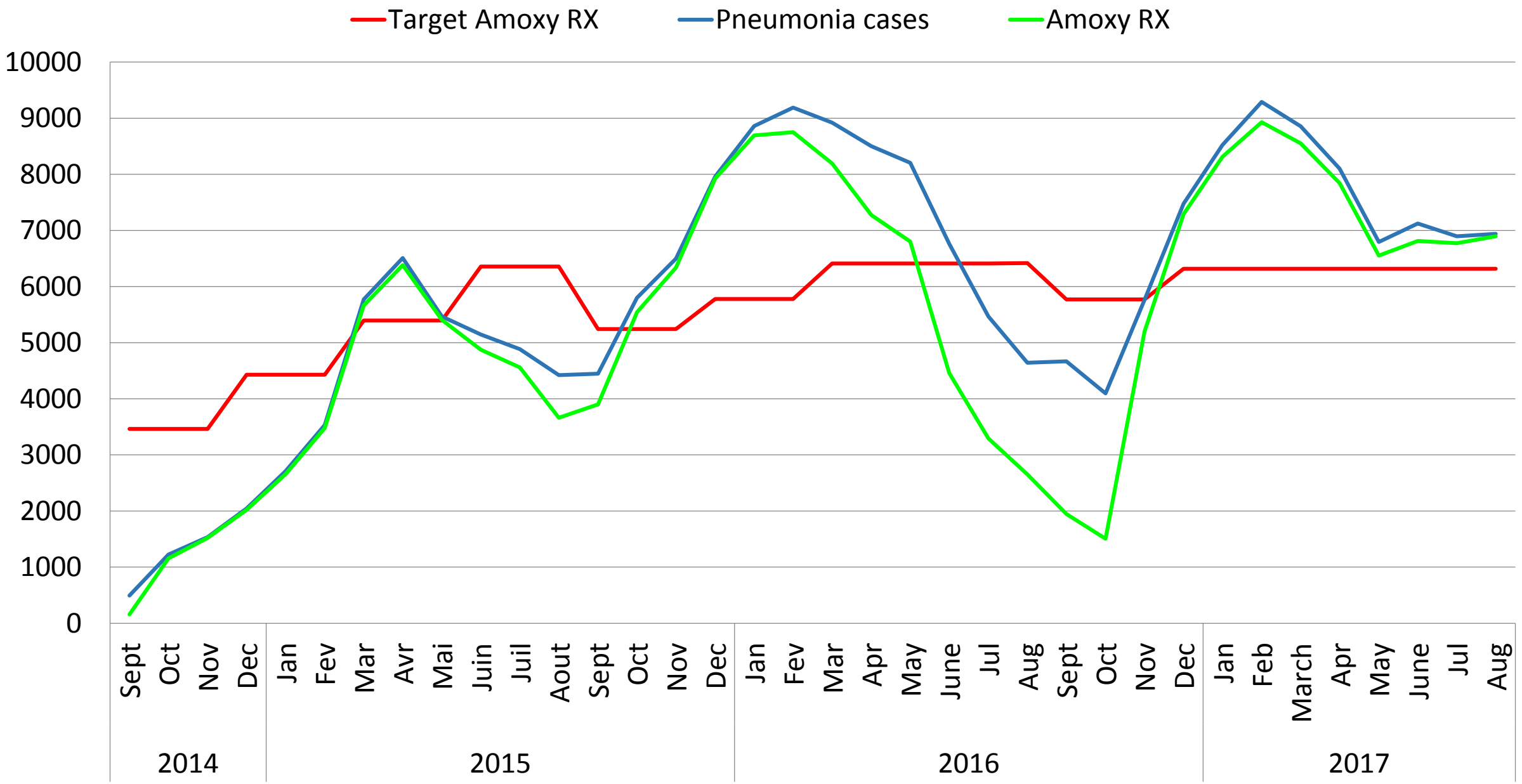
Confirmed Malaria Cases Treated with ACT, Sept 14 – August 17



Diarrhea Cases Treated with ORS+Zinc, Sept 14 – August 17



Pneumonia Cases Treated with Amoxicilline, Sept 14 – August 17



Contribution to National iCCM Vision and Scale-up

- Simplified tools from OR study modified and adopted nationwide
- Capacity-building of MOH staff at central and provincial level
- Best practices and lessons learned disseminated to central MOH officials and key partners during semester review meetings

Challenges/Opportunities

- **Insecurity due to interethnic conflicts-** displaced large populations
- Implementation in vast province with **large distances and poor infrastructure**—difficult to ensure availability of medications
- **Lack of resources** for the continuation of the project at the end of November 2017
- **IHP project likely to include iCCM** but unclear how much support will be offered
- **Sustainability of project activities by DPS** in Tanganyika after RAcE closure unlikely—program had huge impact on saving lives of children and support is needed for continuation
- **iCCM strategy supported** by MOH central level, provincial and zonal level

AKSANTI SANA!

QUESTIONS?