MCHIP Country Brief: Democratic Republic of Congo

Health and Demographic Data for Democratic Republic of Congo	
Maternal mortality ratio (deaths/100,000 live births)	540
Neonatal mortality rate (deaths/1,000 live births)	47
Under-5 mortality rate (deaths/1,000 live births)	148
Infant mortality rate (deaths/1,000 live births)	92
Contraceptive prevalence rate	5.8%
Total fertility rate	6.3
Skilled birth attendant coverage	79%
Antenatal care,4+ visits	45%
Sources: UNICEF, WHO, World Bank, MICS	

Health Areas:

- Newborn Health
- Child Health
- Immunization

Program Dates	April 2009-July 2011					
Total Mission Funding	Redacted					
Geographic Coverage:	No. (%) of provinces	27%	No. of districts	4	No. (%) of facilities	N/A
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INTRODUCTION

The Democratic Republic of Congo (DRC) experiences more than half-a-million deaths of children under five and between 20,000 and 30,000 maternal deaths each year. The country's maternal, newborn and under-five mortality rates have improved over the past decade; however, they are still among the highest in sub-Saharan Africa, and the country will not achieve either MDG 4 or MDG 5 by 2015.

The causes of maternal and child death in the DRC are largely preventable. Children die most frequently from malaria, pneumonia, diarrhea and newborn causes (prematurity, sepsis, birth asphyxia), and the majority of maternal deaths are the result of hemorrhage, eclampsia, sepsis and post-abortion complications.

The DRC has relatively high rates of institutional birth (70%) and delivery with a skilled birth attendant is common (74%), but the quality of antenatal, obstetrical, newborn and postpartum care is poor. Most women (85%) seek antenatal care, but fewer than half report attending four or more ANC visits during their last pregnancy, and many women who deliver in health facilities report no postpartum/postnatal care (87%). The country's total fertility rate (6.3 births per woman), adolescent fertility rate (24%) and unmet need for family planning (24%) are all high, while contraceptive prevalence is very low (6% modern methods).

Immunization coverage improved dramatically after 1995, but data quality is poor and for a variety of reasons, coverage has been over-reported in recent years. According to the most recent household surveys, DTP3 coverage was 45 percent in 2006 and 61 percent in 2009. Official coverage estimates were 80 percent or higher for all of the traditional vaccines during this same period, but over the past three years routine immunization coverage appears to have fallen.

DRC's malaria rate (31%), diarrheal disease (16%) and pneumonia (15%) are similar to those in other countries, but access to appropriate care for children is limited. An underlying cause of child death is malnutrition. The DRC has a high rate of stunting (46%), low rate of exclusive breastfeeding (36% to 6 months of age) and the proportion of children, 6-23 months of age, receiving a minimally acceptable diet is one of the lowest in the world.

The country's poor health infrastructure, lack of human resources and problematic access to existing health services – due to geographic, culture, gender, and poverty related challenges – all contribute to the DRC's high rates of maternal, infant and child death. There is a pressing need to increase the coverage of high-impact maternal, newborn and child health interventions and to address the quality of existing health services. Reassuringly, the DRC has support from many different donors and agencies in the health sector including USAID, UNICEF, WHO, UNFPA, the World Bank, the European Union, the GAVI Alliance, and other non-governmental (NGO) and faith-based organizations (FBOs) and networks.

MCHIP has been active in the DRC since April 2009, when activities started by several earlier global projects – BASICS, IMMUNIZATIONbasics, POPPHI and POUZN – and the staff who had worked for these projects in the DRC and the U.S. were brought together under the MCHIP umbrella. The MCHIP project was completed in July 2011.

MCHIP worked at the national level with the Ministry of Health (MOH) and its integrated management of childhood illness (IMCI), immunization (Expanded Programme of Immunization, EPI) and reproductive health (PNSR) programs. In addition, MCHIP collaborated with international and NGO partners who support these programs and have worked hand in hand with USAID's AXxes and Leadership, Management and Sustainability (LMS) projects for a number of years to improve the coverage and the quality of specific maternal, newborn and child health (MNCH) interventions in high-need health zones. MCHIP

staff members were active participants on the many different steering committees, interagency coordinating committees and technical working groups that directed policy and program development and implementation.

In Fiscal Year 2009 (FY'09), MCHIP's work was co-funded by the Health, Infectious Disease and Nutrition office of USAID's Global Bureau (G/HIDN) and the Africa Bureau's Office of Social Development (AFR/SD). MCHIP fully expended the Mission's field support by the end of July 2011. HIDN and AFR/SD approved the use of up to Redacted in immunization core funding in Fiscal Year 2011 (FY '11). This allowed MCHIP to continue to support immunization activities in the country and helped facilitate an orderly transition of strategic MCHIP activities to the new USAID bilateral health project – IHP/PROSANI.

MCHIP's goal in the DRC was to contribute to improved maternal, newborn and child health by providing technical support to the Ministry of Health and strengthening the capacity of USAID-supported projects to deliver evidence-based MNCH interventions.

MCHIP identified five objectives for its work in the DRC:

1. Increase access to child health services through Community Case Management by supervising existing CCM Community Health Workers (CHWs), working with the MOH and other partners to establish new CCM sites and advising on the integration of family planning counseling and service provision at CCM sites.
2. Strengthen case management of diarrhea in partnership with the MOH, UNICEF and local partners by promoting ORT and introducing zinc, by revitalizing ORT corners in hospitals and health centers, increasing awareness among community members and training CHWs and health providers to correctly assess and treat diarrheal disease.
3. Scale up declining immunization coverage rates in high-burden health zones and support new vaccine introduction by improving delivery systems in low-performance health zones.
4. Improve maternal and newborn health through the expansion of an integrated package of Essential Newborn Care (ENC) and the Active Management of Third Stage Labor (AMTSL) and other maternal health interventions.
5. Expand the promotion of a distribution of point-of-use water purification products (i.e., PUR and Aquatabs) and improve hygiene practices in cholera-endemic health zones.

Under each of these objectives, the DRC team assisted the MOH in updating relevant national policies and convening and mobilizing national and international partners to improve program coverage and quality. In FY '10, MCHIP also worked hand-in-hand with USAID's bilateral health project, AXxes, and with the global Leadership, Management and Sustainability (LMS) project to rollout updated policies, train and supervise health providers in hospitals, health centers, and communities and improve the quality of care provided in 80 Health Zones.

KEY ACHIEVEMENTS

Objective 1: Child Health – Community Case Management of Childhood Illness

The DRC is one of six countries that, together, contribute to over half of all childhood deaths in the world each year. Many of these deaths could be prevented through increased access to child health services and scaled up Community Case Management (CCM) of pneumonia, diarrhea, malaria and malnutrition. From October 2009 through June 2011, MCHIP worked with the MOH, AXxes and other partners to introduce CCM sites in 23 new health zones and expand CCM training and support to new communities in 9 health zones where the CCM treatment sites had already been established. As shown below (Table 1), by the end of June 2011, this brought the total number of

health zones providing CCM services to 101 (19.6%) of the total 515 health zones in the country. It also resulted in the creation of 513 new treatment sites (including 44 sites in health zones that already had some CCM activity) and raised the total number of CCM sites with trained CHWs to 1,357 by the end of June 2011.

Table 1: Expansion of CCM sites Fiscal Years 2008–2011

National CCM Indicators	FY'08	FY'09	FY'10	June 2011
Provinces with CCM sites	9	10	10	10
Total health zones with CCM sites	52	78	94	101
Number of new CCM sites established	286	206	401	138
Number of new CHWs trained in CCM	508	429	715	213
Cumulative number of CHWs trained end of Fiscal Year	929	1,358	2,073	2,286

MCHIP also supported the development of human resources to support CCM, offered post-training support and supervision to CHWs, monitored the quality of community health services, enhanced the technological capacity of provincial health offices and tested an integrated CCM and family planning (FP) service delivery model. MCHIP partnered with and trained members of local faith based communities to maximize community impact. At times, challenges with drug supply, provincial support and CCM data management hindered MCHIP's progress.

Objective 2: Child Health – ORT and Zinc in Diarrhea Case Management

According to the most recent DRC DHS data, diarrhea is still the third leading cause of mortality among children under five. Although the DRC was one of the first countries in Sub-Saharan Africa to incorporate zinc into national treatment guidelines for diarrhea, it is still not widely used as part of the diarrheal treatment regimen. Therefore, scaling up ORT and zinc utilization was a key priority for MCHIP.

MCHIP's strategy to revitalize and strengthen the case management of diarrhea through the promotion of ORT and the introduction of zinc included the following key activities: training health workers and CHWs to manage diarrheal disease according to best practice; establishing ORT corners in health facilities to ensure an expeditious start to rehydration therapy and to train mothers in home administration; increasing the supply of zinc in the health system; monitoring the quality of diarrheal case management in target health facilities and zones; supporting behavior change communication (BCC) activities to improve home-care and care-seeking; and scaling up marketing to increase the population's knowledge.

Through these activities, MCHIP trained 694 clinical care providers and 715 CHWs in ORT and zinc administration. MCHIP was also able to successfully establish ORT corners in hospitals across all 29 target health zones. Through a partnership with UNICEF, MCHIP procured over 25 million zinc tablets, which were distributed among all 11 provinces. Through a collaborative effort with UNICEF, the University of Kinshasa, WHO and the National Program for Diarrheal Control (PNLMD), MCHIP also supported the rollout of a national multimedia campaign to increase public awareness of diarrheal disease and to drive demand for treatment.

Objective 3: Routine Immunization and New Vaccine Introduction
Promoting routine immunization and introducing new vaccines in the DRC has been a consistent challenge. After nearly a decade of steady gains, immunization coverage fell in 2008 and 2010 – due in part to vaccine stock-outs and budgetary constraints. When USAID's IMMUNIZATIONbasics (IMMbasics) program ended in 2009, MCHIP continued to provide technical support to the national immunization program (EPI) through monthly technical meetings held by the DRC's Inter-Agency Coordination Committee (ICC) and ad hoc working group meetings. MCHIP contributed to the development of the annual Memorandum of Understanding (MOU) between the MOH and its immunization partners and collaborated on the enhancement of the DRC's EPI program. In addition, MCHIP provided direct support for the release of the Pneumococcal Conjugate Vaccine (PCV-13). Despite successes, immunization progress was delayed because of continuing stock shortages, an aggressive polio outbreak and the national government's inability to meet funding commitments.

Objective 4: Integrated Maternal and Newborn Health
Despite significant decreases in maternal mortality and slight decreases in under-five mortality, there have been minimal changes to the neonatal mortality rate (NMR) in nearly two decades. The primary causes of death in the neonatal period include sepsis, birth asphyxia and trauma and complications from prematurity. MCHIP built on the early achievements of several predecessor programs and aimed to update national MNH policies, adapt MNH tools for the DRC, train clinicians and CHWs in ENC/AMTSL and design an integrated CCM, family planning counseling, and contraceptive distribution model for AXxes health zones. The trial implementation of the integrated maternal and newborn care model showed positive potential for national implementation.

Objective 5: Point-of-Use Water Treatment
MCHIP designed and implemented a safe water, hygiene and sanitation model in four target health zones. During implementation, CHWs were trained on water treatment practices and key personal and household hygiene practices. A variety of communication tools were used to raise awareness, and MCHIP collaborated with partners to ensure that the supply of PUR, a point-of-use water treatment product, was able to meet rising demand. Distribution of PUR was carried out through community-based channels. Over 300,000 packets of PUR were sold through new and existing PUR sales points, enabling an estimated 4,100 people to produce their own safe drinking water over a one-year period. In addition, 14 percent of caregivers of children were able to show that they had PUR in the household at the time of survey, compared with just 2 percent in 2007. Infrastructure advancements are still necessary in many of DRC's provinces to ensure a readily accessible supply of water to communities.

WAY FORWARD

MCHIP's goal at the global level and in the DRC was to accelerate the scale up of high impact, evidence-based MNCH interventions. Across program areas, MCHIP has done this by helping the DRC's MOH put enabling policies and programs in place. It disseminated new information, and leveraged and coordinated the resources of USAID's projects and other bilateral, multilateral and NGO partners working in the health sector to scale up and refine program approaches, guidelines and tools. There is a continued need for technical support to expand the coverage and improve the quality of key intervention packages, monitor the results of program activities and the quality of MNCH care, and to strengthen the support systems required to sustainably increase the coverage of interventions across the technical areas.