Save the Children

SIGNATURE PROGRAMME IN DRC: THE DIFFERENCE WE'VE MADE

Saving mothers' and babies' lives in DRC

PROJECT OVERVIEW

TIMING:

FIVE-YEAR PLAN INITIATED IN

2013

GOAL:

SAVE BABIES AND MOTHERS LIVES ACROSS FOUR HEALTH ZONES IN DRC

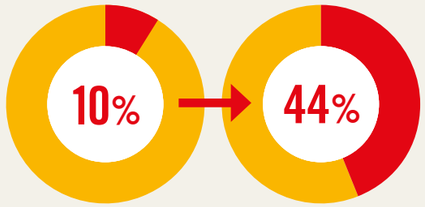
BUDGET:

£15M

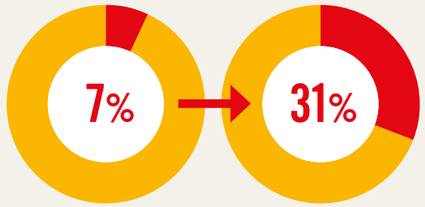
Key successes:

In the programme areas, it was the norm for women to give birth in extremely precarious circumstances. Over the project span we've seen:

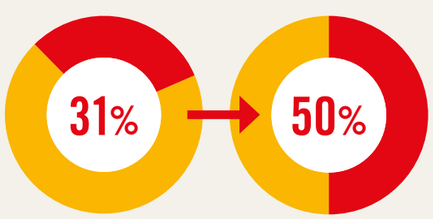
AN INCREASE IN SKILLED BIRTH ATTENDANCE OF



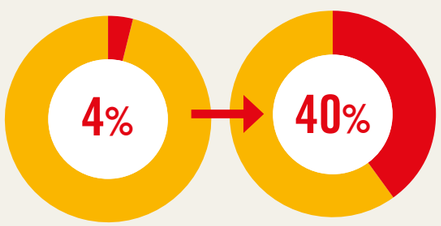
PROVISION OF ESSENTIAL NEWBORN CARE GO FROM



FULL IMMUNISATION COVERAGE JUMP FROM



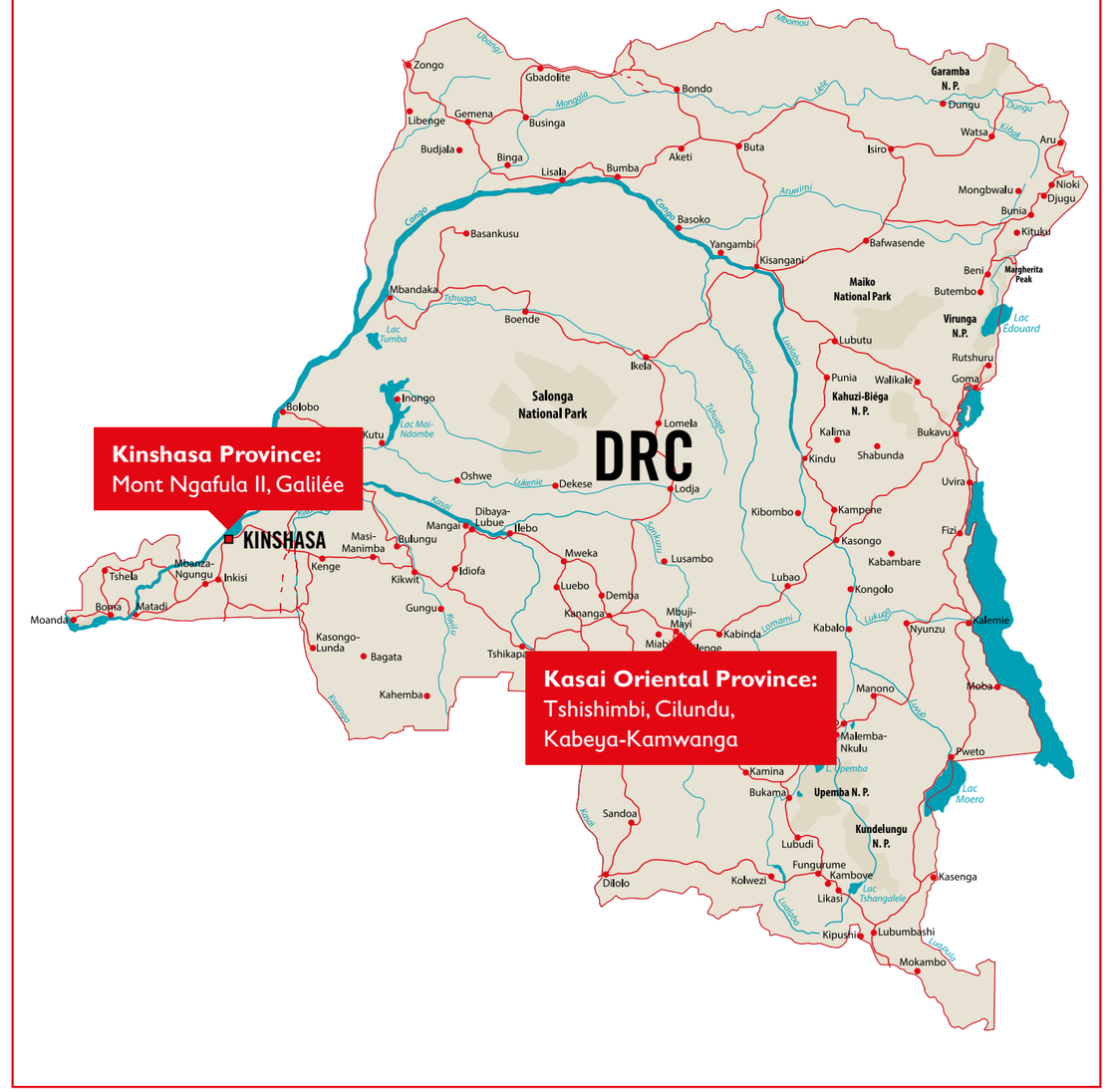
DIAGNOSIS AND TREATMENT OF PNEUMONIA IN HEALTH FACILITIES SOAR FROM



DESIGNING THE PROGRAMME

Save the Children and GSK have a shared value: we recognise that strengthening health systems, and making essential services available to all, is good for everyone in the long term – communities, ministries of health, corporate pharma and international NGOs. This flagship programme was to bring this common belief to life by tackling and reducing maternal, neonatal and child mortality in three health zones of the Kasai Oriental province and one health zone of the Kinshasa province.

HEALTH ZONES



The programme was first conceived to join up solutions along the 'continuum of care', from late pregnancy to early childhood, covering all post-partum and neonatal stages.

In extremely deprived parts of Kasai Oriental, and the capital Kinshasa, there was a clear need for significant construction work to build or rehabilitate health facilities. Then there was the provision of basic equipment and essential drugs, along with the training of health workers, and helping communities protect their own health as well as seek out healthcare when needed. We also knew we'd need to advocate for increased funding for quality healthcare for all.

Our aim was to strengthen the health system on four key levels:

- **The provincial level,** through targeted and tailored advocacy and technical support.
- The secondary healthcare level, through a package of technical support to the zone referral hospitals and the health zone officers, particularly on the management and use of Health Information Systems.
- **The primary healthcare level** – this was the largest part of the programme's activity, taking up the biggest share of the budget – involving a comprehensive package of support including construction; training of health workers on Integrated Management of Childhood Illnesses (IMCI), newborn care and supportive supervision; strengthening routine immunisation and providing supplies of essential drugs.
- **The community level**, revolving around the introduction of Integrated Community Case Management (ICCM) for pneumonia, malaria and diarrhoea, and the design and implementation of tailored approaches to create social and behaviour change within communities, such as forming women's groups and appointing community health advocates.

Redesign and evolution

The Signature Programme underwent a significant redesign in 2014. After the initial baseline study and budgeting exercise were completed, we realised the programme covered too ambitious a span of the continuum of care. The scope of work was too broad and would have meant funding was spread too thinly.

So, to achieve greater impact, we took the decision to refocus the project on newborn and child health, stripping out activities related to family planning, HIV control and some elements of maternal health whilst maintaining the same level of geographical coverage.

In 2015 the restated ambition of our Signature Programme acted as a pull factor for other partners, including DFID and the TV channel ITV, both of whom committed funding to help us scale up our work.

How we're evaluating the programme

In 2016, a mid-term evaluation was commissioned to health research consultancy HERA. They used an established, government-endorsed methodology ('Monitorage Amélioré pour l'Action'), to measure the rates of effective coverage of key services along the continuum of care, using a combination of:

- facility-based surveys
- household surveys
- bottlenecks analysis across three levels of the health system
- key informant interviews.

In 2018 a final evaluation was commissioned, using the same research partner as well as the same methodology, to track progress.

The limitations of our measures

1. **No baseline** – Unfortunately, because we had to refocus our resources to achieve our best impact, the indicators captured in the baseline study in 2013 no longer reflect the scope and intended impact of the programme. So these couldn't be used to track our progress. This document can only capture the progress achieved across our coverage indicators between the midline evaluation in 2016 and the endline evaluation in 2018.
2. **No counterfactual** – The evaluation design doesn't include analysis of what hasn't happened or isn't the case. So no inferences can be made on whether the programme in general or any particular intervention is the direct cause of any impact. All that can be inferred from these before-and-after figures is that the programme has contributed to the changes we've seen in the effective coverage of health services we've directly or indirectly supported.
3. **Effective coverage as a proxy for improved health outcomes** – Although the programme's ambition is to help save lives in the two target provinces, we couldn't measure the programme's impact in terms of a reduction of mortality rates. This is largely because measuring impact on mortality is technically very difficult, requiring experimental research designs and very large sample sizes that would have been beyond our budget. This was acknowledged early on, and the decision was made to use effective coverage as a key metric of success for the programme, and a proxy for improved morbidity and mortality outcomes. Effective coverage is a composite indicator that measures not only people's access to services, but also their sustained use of them. It therefore combines supply and demand assessments and represents comprehensively how far services are available to, and used by all.

Photo: Ken Bobolo / Save the Children

Reverend Sister Justine - General Manager at Cilundu, in a pharmacy equipped with the support of GSK

Findings: mixed results and a complex picture

This section summarises and explains the findings of these two evaluation studies to the best of our ability, looking at trends in effective coverage in different practices across two years of the programme. The results cover the full scope of the programme, although more detailed results are available for health areas where there was more intensive support from the partnership with GSK.

Progress on maternal, newborn and child health

Over the past two years, as programme activities gradually increased across the four target health zones, significant gains have been achieved on key **maternal and newborn health** indicators:

- The effective coverage of skilled birth attendants has increased from 10% to 44%.
- Coverage of essential newborn care – including immunisation, early initiation of breastfeeding, resuscitation, management of prematurity and more – has jumped from just 7% to 31%.

These levels of effective coverage are still far too low. We're a long way from the 80% targets DRC is aiming for nationally. But the increases are substantial in the context of the Kasai Oriental province in particular, where it's still the norm for women to give birth at home and in extremely precarious conditions.

We've also seen significant gains on several key indicators for child health:

- Full immunisation coverage stands at nearly 50% in the target zones, compared with just 31% two years earlier.
- Effective coverage of diagnostic care and treatment of pneumonia in health facilities increased ten-fold, from 4% in 2016 to 40% in 2018, a remarkable increase.

These results suggest that the Signature Programme's focus on safe deliveries, newborn care and IMCI is paying off and improving both access and use of these key services.

THE PROGRAMME AT A GLANCE

MATERNAL & NEWBORN CARE

CHILD HEALTH

NATIONAL ADVOCACY & TECHNICAL ADVICE

Coalition building, in particular leadership of

Planning and Budgeting: Advocate for prioritisation of basic health services and a roadmap to Universal Health Coverage

PROVINCIAL LEVEL SYSTEM STRENGTHENING

Planning and Budgeting: Advocate for efficiencies in use of allocated funds and release of allocations

Trained and supervised several cadres of health workers including nurses, midwives and community health workers

Strengthen Health Information Systems to address under-reporting of disease and strengthen referral pathways, including by piloting the use of, and building the capacity of health zone officers to use the digital platform DHIS

REFERRAL HOSPITAL

Strengthen Maternal & Newborn health services including safe deliveries, antenatal and postnatal care, and high quality newborn care

Treatment of Severe & Acute Malnutrition

Strengthen Integrated Management of Childhood Illnesses (IMCI) in primary healthcare facilities

PRIMARY HEALTH CARE

Built and refurbished primary health centres including maternities

Community mobilisation for uptake of vaccination

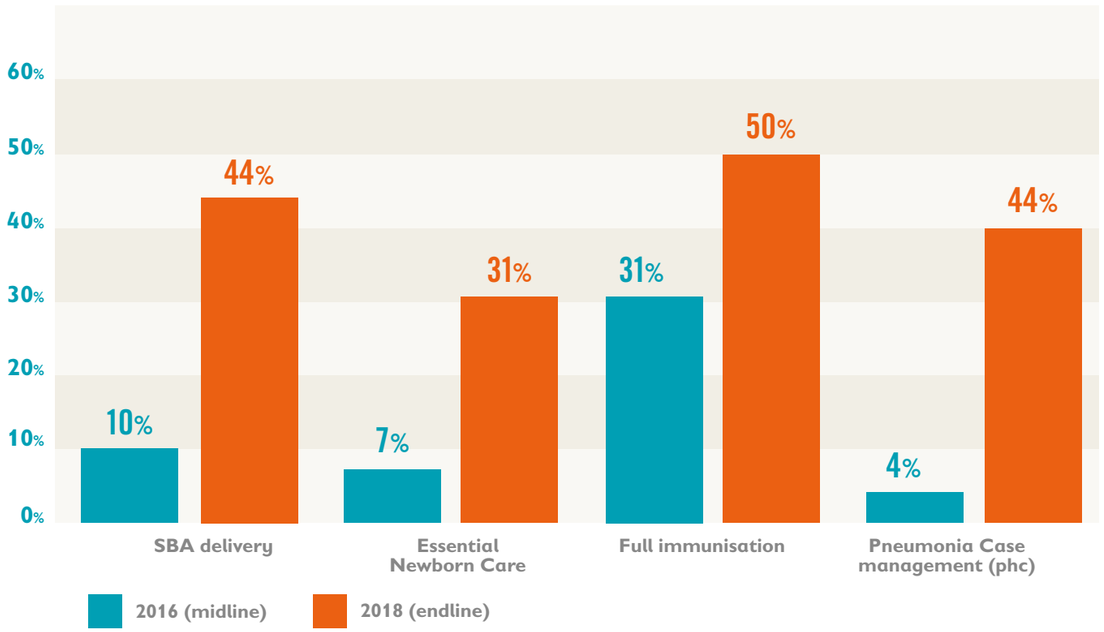
Introduced Integrated Community Case Management in Kasai Oriental and Kinshasa for diagnosis, treatment & referral of childhood pneumonia, malaria and diarrhoea at community level

COMMUNITY

Social Accountability – People knowing their rights and holding service providers accountable

Intensify vaccination outreach sessions

Qualified Successes



Malaria coverage

Malaria remains a significant danger for families here. While rates of effective coverage have increased markedly, they're still very low. This is worrying, given that malaria is the largest cause of illness and death among children under five in the target health zones.

It's important to note, though, that access to a health centre equipped for the management of malaria stands at 93%. The issue seems to be not availability but uptake of services – the number of cases actually managed is far lower than we'd expect, given the known caseload in the region. These findings are consistent across the health centre and community levels and suggest that a lot more work is needed to get people using these services.

There are clearly significant barriers to take-up that we need to break down. Some barriers are behavioural – caregivers aren't taking their children to be seen as quickly or habitually as we'd hope – but there are also **very significant financial barriers**. Our household survey data shows that the take-up of relevant malaria services **varied greatly with affluence**, from 24% among the poorest caregivers interviewed to 55% among those who are better off.

Malaria: an uphill battle

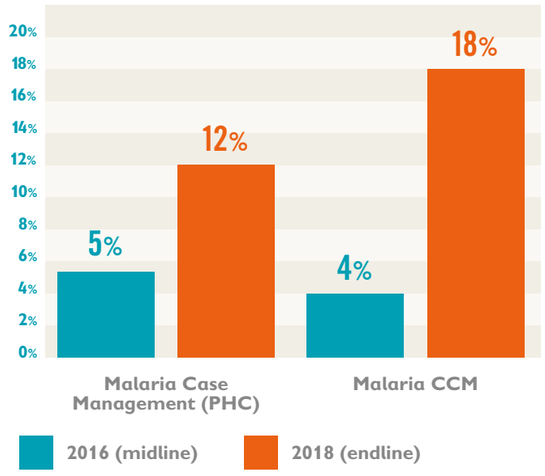


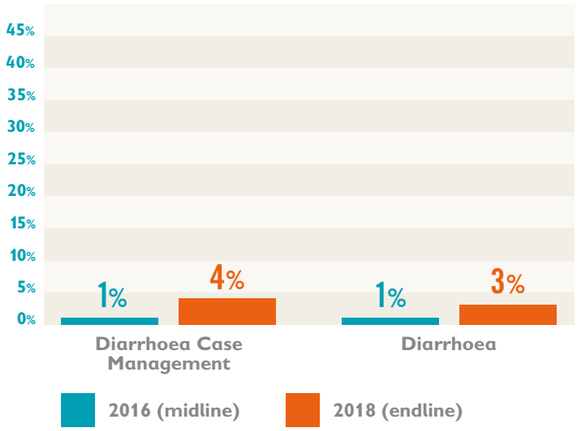
Photo: Charlie Forgham-Bailey / Save the Children

Head nurse, Hubert Matondo, at the Centre de Santé et Maternité, Galilée, a health centre on the outskirts of Kinshasa, DRC.

Diarrhoea coverage

The effective coverage of diarrhoea case management is also stuck at extremely low levels. The number of children experiencing symptoms who are seen by nurses or community health workers is extremely low. This suggests a major lack of use of health services for childhood diarrhoea, for reasons similar to those discussed above, relating to malaria control.

Diarrhoea: hardly a dent



Community mobilisation and behaviour change

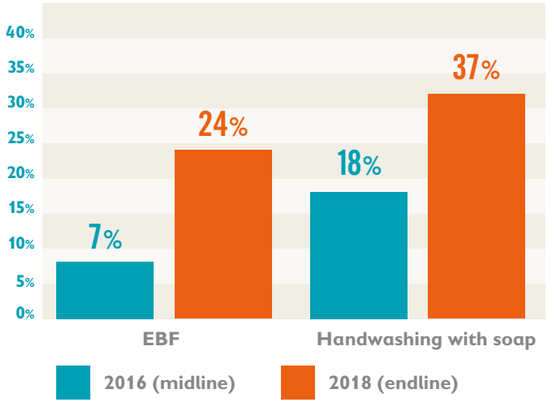
Our work to get communities changing their behaviour and taking up health services got off to a slow start, but began ramping up from 2016. The effect of women's groups and the deployment of community health advocates seems to have been positive on two behaviours crucial to reducing diarrhoea, pneumonia and malaria: exclusive breastfeeding for infants up to six months, and handwashing with soap.

These family and community practices are notoriously difficult to promote and sustain. A lot more work is needed to improve the effective coverage of these critical practices, but progress so far has been encouraging. The programme is now reviewing the results of formative research commissioned earlier this year, which will be used to design and implement a more comprehensive and sophisticated social and behaviour change strategy in the second phase.

Photo: Ken Bubala / Save the Children

One of the assistant nurses at Bakuasumba health centre gives a mother and her child a checkup, Cilundu Health Zone

Community practices: a good start



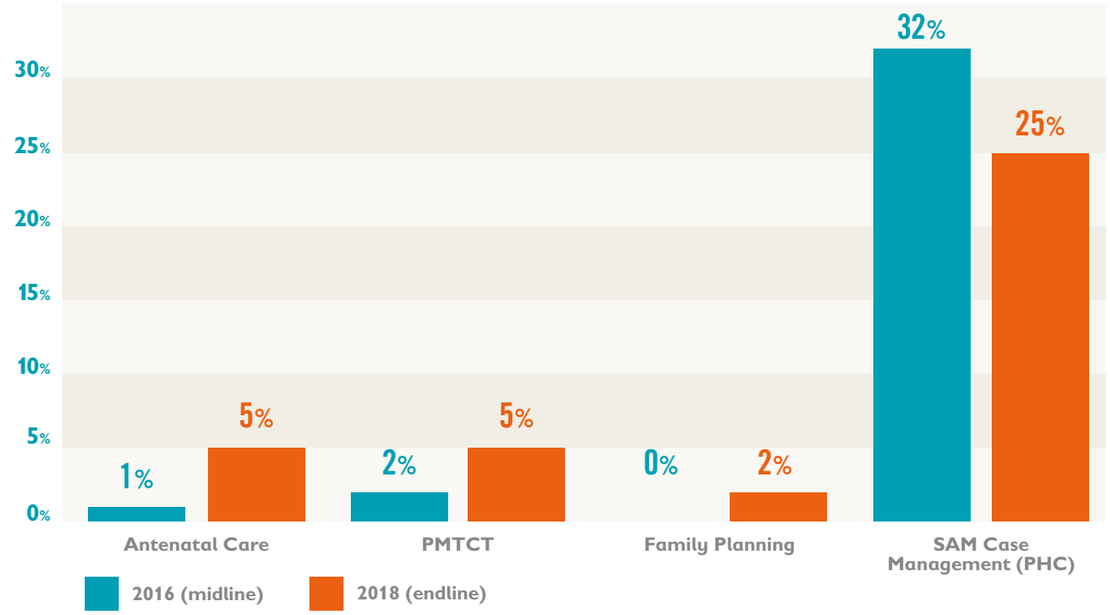
Key insight for policy and advocacy

The evaluation found that financial barriers remain the most cited obstacle to seeking care: 65% of mothers say that they're not seeking care because of the cost of services; 40% because of the cost of transport. It's critical, if we want to create long-lasting change through our efforts and interventions, that we advocate and influence policy to address the very significant expenses communities face when seeking care. While advocacy work isn't covered in this report, there are clear areas of focus for the Signature Programme that have started and should be expanded on.

The programme works at health zone level to ensure facilities are clear on their official pricing schedules for key services, We work with the community health committees to negotiate and set a subsidised price for essential services. And we'll keep campaigning to inform communities about children's right to free healthcare.

At regional and national level, advocacy efforts will focus on promoting steps towards universal health coverage through working on policy issues such as innovative health financing, conducting budget advocacy and strengthening supply chain mechanisms.

Battles of the future (not supported by the programme)



Health needs beyond the programme: a case for partnerships

There is still a huge amount of need in areas such as maternal health and antenatal care, as well as family planning and HIV. All have extremely low rates of effective coverage.

It's also a big concern for us that the effective coverage of severe and acute malnutrition (SAM) has actually decreased from 32% to 25% over the past couple of years.

This is another area we've been unable to directly support through the programme, and the evaluation shows that the main bottleneck relates to the supply of therapeutic foods, despite the support provided in this area by other partners including UNICEF.

We believe this shows a need to form partnerships and seek out synergies with others working in the DRC and these two provinces. Malnutrition is a major underlying factor for most childhood illnesses, wiping out their ability to fight their way back to health. To protect families from illness for good it needs to be tackled. A boost to family planning provision is also sorely needed in this region. Women of reproductive age are having up to eight children on average in some parts, which is a key driver of maternal and child mortality.

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Cover image: one year old Suriya prepares to receive his Yellow Fever vaccination in the Binza Ozone district of Kinshasa

Photo: Tommy Trenchard / Save the Children

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