IMA WORLD HEALTH

UKaid from the British people

COVID-19
in the Democratic Republic of Congo
ASSP and ASSR - 2013 to 2022

ASSR SUPPORT TO THE NATIONAL COVID-19 RESPONSE

BACKGROUND

With the notification of the first cases of COVID-19 in the DRC in March 2020, the Congolese government took a number of measures to reduce the chain of contamination. A National COVID-19 Response Plan was produced and shared with various partners working in the health sector to help the country finance response and mitigation activities.

The National Plan had the following four objectives:

Strengthen the technical and operational coordination of the preparedness and response activities of the disease to CoVid-19.

Improve detection capabilities at different levels.

Ensure response activities, in particular epidemiological investigation, evacuation, isolation and testing, optimized psychosocial and medical care, infection prevention and control measures and monitoring of pre-listed contacts.

Strengthen risk communication as well as the participation and commitment of local communities to prevent and respond to the epidemic across all pillars of the health system.

Given the low level of preparation of the DRC's health system, particularly with glaring deficits in oxygen therapy and emergency services throughout the the country, it was important to be able to contain the spread of the virus in order to avoid the saturation of health care structures and high mortality.

FCDO RESPONSE THROUGH ASSR

Despite DRC emerging from a long Ebola epidemic in the east and enormous strain on donor countries fighting their own COVID-19 challenges, in March 2020, FCDO accepted IMA World Health's proposal to support the national plan in the response to Covid-19 in the capital Kinshasa as well as the three provinces already supported by ASSR.

With a starting budget estimated at USD 4.5 M, FCDO's

Crowded markets make it difficult to prevent the spread of Covid-19 in Kinshasa.

support through ASSR covered 45 percent of the population of the City Province of Kinshasa, targeting 4.8 M people living in peripheral areas with a fairly high poverty rate. This population is distributed in 183 health areas in 35 health zones. The Provincial Health Division was directly responsible for the COVID-19 response in fifteen (15) Health Zones, including 10 health zones of the former Tshangu district, the two health zones of the commune of Mont-Ngafula, the Health Zones of Kingabwa, Matete and Ndjili. In addition, populations around the urban centres of Kasai, Kasai-Central and North-Ubangi, were also covered.

At the end of March 2022, two years after the start of the pandemic, and after three waves of Covid-19, the City Province of Kinshasa alone accounts for just over 50% of the 87,000 confirmed cases and 1,400 deaths recorded to date in DRC. It is generally felt, however, that these statistics are understated and do not reflect the reality of the burden of COVID-19 in the DRC. Major challenges in the governance and management of the National Plan included demotivation of personnel assigned to the response due to lack of payment for several months. This greatly disrupted epidemiological surveillance, diagnosis and care of patients, and contact tracing, and thus, hampered the entire system of collection, data analysis and sharing of data on Covid-19.

Nevertheless, available statistics still show success in the response activities, particularly in the Kinshasa health zones supported by ASSR and other actors. In these poor, densely populated neighborhoods, the number of confirmed cases has remained at less than 13 percent of all cases recorded in the city, despite proximity to the large markets of Liberté, Pascal, Matadi Kibala, Matete, and Hindou, and the large ports of Kingabwa, Kinkole and Maluku where large crowds buyers and travelers congregate daily.

SUCCESSES AND LESSONS LEARNED

FCDO's support through ASSR was reportedly some of the most consistent support received by health facilities during the response in the DRC. Not only was the grant diversified in terms of the package of interventions, but also the duration of the emergency support continued for more than a year, unlike the other partners' aid. ASSR integrated most of the activities within the National Plan and covered system strengthening aspects such as coordination of response activities, capacity building of key actors, support for response activities and operations, improvement of health care and water, hygiene and sanitation infrastructures and, of course, vaccination. Key successes and lessons learned are as follows:

Coordination

The coordination of activities and actors at the operational level was essential to ensure maximum results and reduce the scattering and waste of the limited resources that were made available through multiple projects that sometimes shared the same geographical spaces. ASSR financially supported multisector coordination meetings at the level of the province and health zone with an average of three meetings per month through the duration of the project. These meetings allowed stakeholders to meet and discuss interventions with regard to the needs expressed by the various task groups. In addition to meetings, the project provided support for fuel and per diem for field supervision missions and distributed six Yamaha motorcycles to the very large peripheral health areas of Kinshasa such as Maluku and Mont-Ngafula, to improve service coverage in hard-to-reach health areas.

Training and Capacity development

Capacity building in the management of epidemics at the operational level is central to enhancing system responsiveness. Provinces such as North Kivu or

Equateur, who recently had Ebola outbreaks, were much more agile in the response to COVID-19 than Kinshasa, which not had previous epidemic management experience. Thus, with the rapid increase in cases in Kinshasa and other ASSR-supported provinces, it was necessary to ensure the capacity building of clinical, paraclinical and community providers for effective management of the epidemic.

Knowledge and management deficits were observed from the start by many different funding partners. Many organized punctual trainings of a small number of service providers without taking into account the training needs on other interdependent topics. This piecemeal, uncoordinated approach disrupted the management of the epidemic insofar as front-line providers were often held for several days away from their workstation for the trainings. To address this challenge, IMA proposed and facilitated, in collaboration with the Ministry of Health, the development of one training module integrating all the key themes of epidemic response (e.g. surveillance, clinical management, psychological management, risk communication, Community Engagement (CREC), Infection Control Prevention, and WASH). This module was produced in Kinshasa and pre-tested in the

COVID-19 TRAINING	# TRAINEES
Risks communication nd Community engagement	2,785
Management of Covid-19	620
Epidemiology Surveillance and data reporting using DHIS 2	155
Testing with GenExpert	178

province of North Ubangi before being validated and used nationwide. The comprehensive module reduced training to three days, limiting time away from patient care and limiting costs.

Due to travel restrictions, IMA's trainings were 'hybrid', that is, combining both in-person sessions with online training via zoom since the confinement greatly limited travel to the provinces. However, this format still limited access for many remote providers. IMA therefore worked with partner organisation Viamo to experiment with a more flexible mobile training model to reach clinical and non-clinical providers directly, using cell phone, when available. This model uses the telephone service of SMS and Voice messaging for delivery of five pre-recorded training modules on Covid-19. The program includes

Phases	Period	# of people reached
Pilot in Kinshasa	September-November 2020	2,443
Kinshasa and Kasai	December 2020-February 2021	4,766
Scale in Kinshasa	June-July 2021	5,577

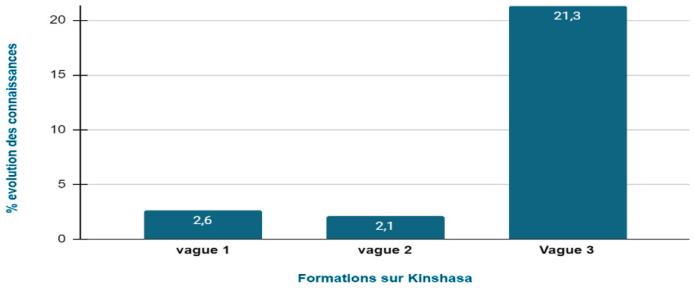


Figure 1. Evolution of Knowledge

a knowledge assessment at the end of each module. Community animators, health care providers and community health workers (RECO) piloted the mobile training in three phases and demonstrated knowledge improvements after each phase.

In collaboration with the INRB , ASSR also supported training of laboratory technicians to increase the number of Covid-19 screening units with PCR throughout the city, in addition to the existing sites at INRB, the University Clinics of Kinshasa and the HJ Hospital. Given extremely high demand for testing, these structures were unable to deliver with appropriate turnaround times on tests. Supplied with GenExpert Covid-19 cartridges provided by WHO and other organizations, this training reached more than 150 medical biologists and laboratory technicians from Kinshasa, Kongo Central and three provinces supported by the ASSR project. This has enabled more health facilities with GenExpert modules received from HIV/TB control projects to carry out Covid-19 PCR tests and reduce the overload of the INRB system.

Epidemic Surveillance

ASSR support to epidemiological surveillance in Kinshasa was coupled with the distribution of more than 140 Android phones in 183 health areas and 15 health zone offices. Mobile phones were essential to ensure the communication between zones and collaboration in reporting of epidemiological data in DHIS2. All supported health zones also received printed materials and other reporting tools as well as the financial support for contact tracing in the communities.

Health Structure Readiness

In anticipation of a surge of COVID-19 cases in Kinshasa, the Ministry of Health identified three referral facilities in each urban health zone to accommodate large patient flow. Within this framework, ASSR supported rehabilitation of 19 selected referral facilities, including hygiene and sanitation support across the majority of facilities. ASSR's largest rehabilitation investment supported the Pierre Fokom regional hospital of Kimbanseke. Here, abandoned construction of a new wing was transformed into a new emergency ward with a 10-bed capacity. FCDO funds also supported installation of an emergency solar system for power supply in Pier Fokom Hospital and four other structures (HGR Kinkole, HGR Liziba, CSM Mbankani, CSM Maziba). A reliable emergency power system is essential for operating oxygen concentrators and electric microscopes, donated by the ELAN project, also funded by FCDO.

Health facility rehabilitation also improved the WASH structures. Seven wells were drilled and equipped with solar pumps. Three health centres were newly connected to the city's water distribution network. Over 27 tanks holding > 2500 litres, each, were installed, where needed most. Finally, toilets with showers, incinerators and placenta pits were built or rehabilitated as part of this intervention.

Clinical Service Provision

ASSR supported clinical services and healthcare infrastructure by ensuring continuity of integrated care of children's diseases and common pathologies in adults while COVID-19 took hold. In addition to ensuring uninterrupted availability essential generic medicines, this support allowed continued service delivery, utilisation and revenue generation, which allowed care structures to continue to operate. It also made it possible for health centres to maintain community trust, while many patients began to desert the hospitals for fear of being declared COVID-19 positive and then quarantined.

DRUGS DISTRIBUTED	# TABLETS
Artemether+Lumefantrine, 80mg+480mg, B/6 Tablet, Cure	19,210
Paracetamol 500 mg 10 Tablets pack	856
Amoxicillin 500 mg	10,757
Artemether+Lumefantrine,20mg+120mg, B/12 Tablet Disp, Cure	6,403
Metronidazole 500 mg Tablet	1,076

Most Kinshasa health facilities lacked essential equipment to manage severe COVID-19, and many international donors, such as the World Bank, the AfDB and WHO, invested in industrial production of medical oxygen in Kinshasa, Goma, and Lubumbashi. The first oxygen unit newly built was inaugurated in May 2022 at the Kinshasa Mama Yemo Hospital. In this context, ASSR

distributed 80 oxygen concentrators with oximeters, 1,000 nasal cannulas with adult and child tubing, and 500 adult masks. In addition, spare parts such as filters and modular plates were provided to 38 health facilities including 20 regional hospitals and 18 health centres. In each beneficiary structure, at least one medical staff was trained in the basic use and maintenance of the concentrators and oximeters.

Production and Distribution of PPE and Hand-washing Stations

Distribution of personal protective equipment (PPE) and sanitation products was also an essential activity. ASSR established "triage stations" for Covid-19 cases in all supported health facilities. Triage station "kits" included a sunshade/tent, a table and four plastic chairs, one infrared thermometer, batteries and a set of megaphones with spare batteries, surgical masks and loincloths, goggles and protective screens, caps, shoe protectors, disposable gowns, Tyvek boots, nitrile gloves, and sterile bottles of hydroalcoholic solutions, soaps, hand and room disinfection products such as disinfectants, chlorine as well as hand washing stations.

DISINFECTION AND SANITATION	QTY
Lave mains complet avec robinet	550
Table plastique	510
Parasoleil GF	510
Garbage bins	890
Water bucket	2,187
Chaises plastique	1,870
Solution Hydro alcolique 100ml	5,000
Solution Hydro alcolique 500ml	5,000
Thermometer infrared	400
Detergent genie 400gm	750
Sac poubelle, 100l, 70um moir	6,950
Sac poubelle, 30l, 70um moir	1,000
Broom	750

Local craftswomen set up production lines of face masks using local fabrics, a rapid response to needs on the ground. The important contribution of the women's groups of the Protestant Church of Congo (ECC) under the direction of Mrs. Jill and Christy Boys who coordinated the production of thousands of masks to be distributed to healthcare providers, community workers, teachers and students in Kinshasa and in the provinces at a time when the DRC, like most African countries, had problems obtaining PPE from international sources.

Similarly, the rapid local production of washbasins was also an element of success in the ASSR response. Taking advantage of iron bars remaining from construction during ASSP, IMA contracted local craftsmen to produce more than 1,500 hand-washing stations that were distributed throughout the city of Kinshasa. This, at a time when local production was severely lacking given the needs created by their use in all public places.

The production of fabric masks and washing stations contributed to reducing precariousness and ensuring the livelihoods of women and craftsmen at a time when sources of stable income evaporated due to the pandemic.

Community Acceptance of Prevention Measures

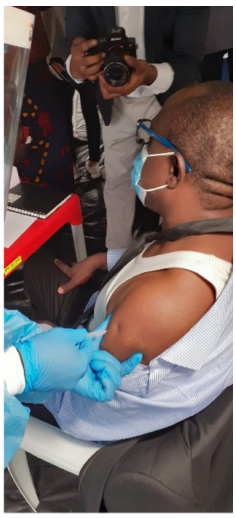
For the first 18 months of the pandemic in DRC there was widespread misinformation and poor adherence with public health prevention measures. This caused new cases of contamination especially for many people who did not believe in its existence. With the rapid increase in the number of confirmed cases in Kinshasa, the ASSR team worked collaboratively with the National Health Communication Program, the Community Risk Communication and Engagement Commission (CREC), and provincial health divisions, in planning and implementing outreach activities to counter misinformation and promote respect for

PROTECTION EQUIPMENT DISTRIBUTED	QNTY
Masque chirurgicale	260,000
Masque en Tissus Pagne	163,325
Gant non sterile	550,000
Bottes de securité	300
Lunettes de securité	1,500
Ecrant faciale	2,000
Tyvek	2,025
Bonnet	10,000
Protégé chaussure	10,000
Gant nonsterile	50,000
Blouses de protection	8,200





barrier measures and acceptance of vaccination, a highly effective and safe prevention measure. IMA first organized a preparatory meeting of community relays and distributed several awareness materials including megaphones, vests, dowry bags, masks, and hydro-alcoholic solution for protection. IMA also distributed leaflets in four national languages for communication before launching a 40-day mass awareness campaign between July and September 2020. The campaign was carried out in collaboration with community radios in all 15 Kinshasa health zones supported by the project. The campaign involved home visits and events in public places such as markets, ports, car parks, churches, and so on. The campaign made it possible to inform more than 640,000 households and over 3.8 million people about the risks and symptoms of COVID-19. It also helped but also to helped in the identification of suspected cases and their referral to appropriate facilities, counseling for screening, acceptance of results and support for patients and their families in care. Contract tracing and follow up was also an important part. During the third wave in February 2021, a second campaign was carried out which made it possible to reactivate community surveillance and reduce the impact of the disease. The results of these campaigns are given in the TABLE.



Vaccination

When vaccines finally arrived in DRC, there was widespread skepticism and extremely low uptake among the population, including IMA staff. IMA experimented with an awareness campaign through peer education. This campaign first started internally with the encouragement of senior managers to get vaccinated to set an example for the rest of the employees. To date, these efforts have yielded interesting results and have brought the internal vaccination rate to more than 80% among IMA personnel.

Subsequently, this approach was extended in collaboration with the Provincial Health Division to vaccination sites in health zones supported by ASSR in Kinshasa. Messages first targeted people with high-risk comorbidities, such as diabetes and high blood pressure, who agreed to get vaccinated at available sites. IMA empowers these people to serve as role models to encourage other patients at the sites to accept vaccination as well. The first data were very encouraging and allowed the extension of this strategy to other vaccination sites.

REMAINING CHALLENGES AND FUTURE PROGRAMMING

Despite many good efforts in response to Covid-19, many challenges remain and should be addressed in future programming. Most striking is the continued low vaccination coverage in the general population. Second, weak testing and reporting skews data and undermines

good decision-making for mitigating the impact of the epidemic on local communities. Finally, poorly trained, inadequately supported and uncompensated health workers can only deliver a mediocre response. Unfortunately, the problem of a poorly managed health workforce in DRC is as endemic and lethal as COVID-19. Here, there is not an easy fix. Fortunately, momentum is increasing at all levels of the health system to initiate reform and address this challenge in a sustainable way.

INDICATORS	SENSITIZATION CAMPAIGN IN ALL 15 HZS	FOLLOWUP CAMPAIGN IN 5 MOST AFFECTED HZS
Number of community relays trained	2,745	
Number of community relays actively working	14,922	1,075
Number of streets visited	43,041	864
Number of Households visisted	643,448	13,913
Number of people sensitized at home	3,326,897	75,110
Number of people sensitized in public places	525,808	8,076
Number of communities' leaders involved	11,313	393
Number of feedbacks received from communities	8,368	318
Number of sick people refered to treatemnet centers	1,422	2