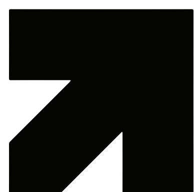
FROM EMERGENCY RESPONSE TO RECOVERY AND DEVELOPMENT: RETHINKING CHILD HEALTH



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WHY OUR WORK ON CHILD HEALTH MATTERS

Remarkable progress has been made in the last 25 years to reduce under-five mortality by 50%. Despite this, there remains a significant unmet need. According to the World Health Organization (WHO), in 2017 alone, nearly 15,000 children under five died each day totaling 5.5 million lives lost. These deaths were largely due to preventable and easily treatable conditions such as malaria, pneumonia and diarrhea, which account for more than 44% of under-five deaths. Furthermore, 50 million children suffer from acute malnutrition which is linked to nearly half of all deaths of children under five. In many of the countries where the International Rescue Committee (IRC) works, under-five mortality remains high, particularly in Sub-Saharan Africa. Countries including Chad and Mali have under-five mortality rates that are three times higher than the global average. Inequities in under-five mortality between high-income and low-income countries remain large. The IRC's goal is to end preventable childhood deaths. We believe that every child, no matter where they live, has the right to life-saving, quality health services.

HOW WE CHANGE LIVES

The IRC is committed to ensuring that all children under five have access to quality life-saving care, regardless of where they live. We do this by supporting child health service delivery through health facilities, mobile health clinics – for those displaced by conflict – refugee camps, and through community health workers who deliver services to children living in remote and hard-to-reach areas. These communities are often located in fragile states and crisis-affected settings, where children are twice as likely to die before reaching their fifth birthday as children in the rest of the world. During emergencies, pneumonia and malaria each account for 20% of all child deaths.

The IRC's child health programs span the arc of a crisis, from direct service delivery during acute emergencies to life-saving and preventative services across the nexus of humanitarian response and development. This approach helps to extend the reach of services to the hardest to reach communities and initiate early resilience-building to ensure sustainability of gains made in child health despite the risk of continuous shocks and crisis. In line with the Global Bargain commitments to localization, the IRC's approach aims to challenge the traditional humanitarian paradigm that has prioritized rapid deployment by external actors over building local capacity and resilience.

THE NEXUS

The IRC defines the 'nexus' as the interlinkages between our humanitarian and development programming, comprising of direct service delivery to clients and systems strengthening of public institutions, including local health authorities, and civil society, as well as community accountability to support the effective delivery of services.

IRC INTERVENTIONS TO REDUCE CHILD MORTALITY

Integrated community case management (iCCM)

Since 2004, the IRC has pioneered iCCM among displaced populations in fragile, conflict-affected settings and development contexts in hard-to-reach regions including DRC, South Sudan, Somalia, Cote d'Ivoire, Myanmar, Yemen, Ethiopia, Uganda, Rwanda, Liberia, and Sierra Leone. Through iCCM, community health workers (CHWs) are trained and supported to provide treatment for pneumonia, malaria and diarrhea, to children under-five in the community while also referring complicated cases to health facilities, and counseling care givers. By working in diverse contexts – from conflict to post-conflict – the IRC has developed a deeper understanding of the challenges of delivering iCCM in different settings and has gained contextual learning regarding best practices for successful implementation. The IRC has supported adapted tools and a training curriculum for low-literate CHWs to more effectively and efficiently provide quality services to their communities. In 2020, the IRC trained/supported nearly 17,000 CHWs, of which more than 5,500 went on to deliver more than 202,000 life-saving treatments for malaria, pneumonia and/or diarrhea in their communities. The IRC also supports Ministries of Health to scale up community health/iCCM using a comprehensive approach to systems strengthening and capacity building.

Integrated Management of Newborn and Childhood illnesses (IMNCI)

IMNCI is an evidence-based strategy utilizing both preventive and curative elements to reduce death, illness and disability and to promote improved growth and development among children under five years of age. Through direct observation of consultations, the IRC has conducted quality of care assessments to measure the quality of IMNCI and iCCM services provided by health providers and CHWs respectively. Based on the assessment results, the IRC works with the providers to develop action plans and quality of care checklists. This also allows the IRC staff to more effectively build the capacity of CHWs and providers through structured, on-the-job coaching. IRC is also committed to ensuring that all supported providers are trained on IMNCI, have access to IMNCI protocols and receive on-the-job coaching to ensure national protocols are adhered to. In 2020, the IRC supported 1,909,570 outpatient consultations for children under 5, a large majority of which were IMNCI consultations. The IRC supports this program in 19 countries across Sub-Saharan Africa, the Middle East, Latin America and Asia.

Immunization

According to WHO, every year, 15% of children worldwide do not receive their basic vaccinations –a large majority of which live in low-income countries and countries affected by conflict. In 2017, 19.9 million children under 12 months worldwide did not receive the three recommended doses of the DTP vaccine (Diphtheria, Tetanus, and Pertussis) and 20.8 million children in the same age group failed to receive a single dose of the measles vaccine. Children that remain unvaccinated are the most vulnerable to disease outbreaks. The IRC is committed to bringing life-saving immunization to children in the most challenging and hard-to reach areas. To address this, the IRC developed a mobile health platform (mReach) that enables health workers in communities and at health facilities to register all eligible children and track their immunization status. This app has been used in Uganda and Somalia to provide alerts for children who have missed an immunization appointment. In Ethiopia, the IRC developed a color-coded calendar to help caregivers plan their children's follow up visits to health facilities. Through these interventions, the IRC counted more than 4,600 children fully immunized across Ethiopia in 2016.

Improving aid through research uptake and advocacy for policy change:
The IRC leads research to influence iCCM programming and policy at national and international levels. In the DRC, for example, the IRC conducted a randomized controlled trial to assess whether the WHO iCCM guidelines for a child with a simple fever (no danger signs and a negative assessment for malaria, pneumonia and diarrhea) should return to a CHW three days later for follow-up. The study revealed that the health outcomes remained the same regardless of whether the caregiver was told they had to return for a follow-up visit after three days or only had to return if symptoms persisted. The IRC published the results of this study and has advocated with WHO to modify the guidelines to lessen the burden of unnecessary follow-up visits for both caregivers and CHWs. The IRC also conducted operational research to determine whether a set of simplified tools and an adapted training package would be more effective than the existing tools for low-literate CHWs in the DRC. The study found that the CHWs who received the simplified set of trainings tools were three times more likely to provide correct case management and took on average 10.6 minutes less time to complete a consultation than CHWs using the more complicated MOH package. The simplified package resulted in a cost savings of $4,418 per 100 CHWs supported during year one of the project. The IRC participated in policy dialogues with the central MOH and partners to promote iCCM and support strategies including simplified tools and training materials, to expand coverage and improve cost-efficiency at scale.

ADDRESSING PNEUMONIA IN CHILDREN UNDER FIVE

Pneumonia, a preventable and easily treatable disease kills an estimated 1.4 million children under the age of five each year and remains the leading cause of infectious disease deaths of under-fives. IRC's goal is to end preventable childhood deaths, especially from pneumonia, by facilitating the identification of pneumonia in children under five for low-literate CHWs providing child integrated community case management. By piloting and scaling up the Philips' children's automatic respiratory monitor (ChARM) with CHWs in Palabek Refugee Settlement in Uganda and Guera Region in Chad, where IRC supports delivery of iCCM to vulnerable populations affected by humanitarian crises, we will ensure CHWs are accurately identifying children under five with pneumonia to provide timely life-saving treatments. If the tool is proven successful, IRC will advocate for use of the tool in other countries where we are supporting CHWs.

Enusring continuous care throughout th pandemic

As part of responding to the COVID-19 pandemic, the IRC swiftly adapted our programs to ensure minimum disruption to essential childhood services including routine immunizations and IMNCI. We deployed surge capacity to ensure adequate staffing, adapted programs to ensure patient safety, and strengthened infection prevention and control measures in health facilities to reduce the risk of transmission.

Following MoH policies, the IRC supported the distribution of personal protective equipment (PPE) supplies for CHWs and trained them on low-touch or no-touch iCCM to allow for the life-saving treatments for malaria, pneumonia, and diarrhea to be safely provided throughout the pandemic.

SPOTLIGHT: MAKING A DIFFERENCE IN REMOTE COMMUNITIES

Years ago, a mother named Kilumba watched her child grow sicker and sicker, knowing she could not afford her care or medication. She earned a meager income as a farmer in the rural province of Tanganyika, DRC, and her husband brought in approximately one U.S. dollar per day selling mats. In desperation, they set out for the health clinic. By the time they arrived, their child had died.

Recently, Kilumba's youngest child fell ill with a fever, which appeared to be caused by malaria. Once again, she couldn't afford care from the health facility. Unlike the previous time, however, she was able to visit the CHW living in her village. Within the CHWs hut, just a short walk from Kilimba's home, her child was diagnosed with malaria and provided with treatment – free of charge. Her child fully recovered, demonstrating the live-saving work of CHWs providing services in hard to reach communities. Given the likelihood of continued shocks in fragile contexts similar to the DRC, investment in community health systems allows for the continuity of services, as they are more resilient and people may be more willing to trust members of their own community in the aftermath of conflict and displacement.

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