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| **Feasibility and Design**  **of an NGO-Umbrella Project**  **to Assist Health Zones**  **in DR Congo**  Trip Report by Franklin Baer  June 6 - 21, 2000  This trip was funded as part of the  USAID-funded Tulane Project in DR Congo |

## Table of Contents

Acronyms and Abbreviations

Executive Summary

* 1. Background and Scope of Work page 1
  2. Methodology and Schedule page 2
  3. Feasibility Assessment page 3
     1. Current MOH policy
     2. Human Resources
     3. Planning and Coordination
     4. NGO project management capacity
     5. The NGO network throughout Congo
     6. Transportation and Communications System
     7. Partnership with a U.S.-based NGO
     8. Conclusion
  4. Concept Paper for SANRU III page 9
     1. Goals and Objectives
     2. Project management
     3. Three Budget Scenarios
     4. Number of Health Zones to be Assisted
  5. Training Needs for Malaria page 18
     1. Objectives of PNLP
     2. A Recent Needs-Assessment for Malaria
     3. Training needs at the health zone level
     4. Training strategies
  6. Lessons Learned from SANRU and ECZORT page 22
     1. Promotion of primary health care within the framework of Alma-Ata
     2. Decentralized health zones were the key operational unit for PHC
     3. Community participation should be encouraged but not exploited.
     4. NGOs provide efficient management of health zones and PHC
     5. Registration of NGOs with USAID requires several approaches
     6. Poor communications systems can facilitate decentralization
     7. A project-of-projects environment can encourage decentralized ownership
     8. Decentralization means accepting diversity at the local level
  7. An Annotated Bibliography for SANRU page 26

**Annexes:**

Annex A: List of Meetings and Contacts

Annex B: Analysis of the Health Situation in DR Congo

Annex C: Health Zone Database for DR Congo

Annex D: Tentative Budget for SANRU III

## Acronyms and Abbreviations

BCC Bureau Central de Coordination (for HIV/AIDS)

BDOM Bureau Diocessen d’Oeuvres Medicales (Catholic)

CONAS CONAS (National Committee for Coordination of Health

CRS Catholic Relief Services

ECC Eglise du Christ au Congo (Protestant Church of Congo, formerly ECZ)

ECZORT Eglise du Christ au Zaire and Organization for Rehabilitation through Training

(a 1985-86 partnership project to assist forty NGO-managed health zones )

FOMETRO Fonds Medical Tropical

IMA Interchurch Medical Assistance

MCZS Medical Chief of a Health Zone

Memisa-B Memisa (Belgium)

MSF-B Medecins Sans Frontiers (Belgium)

MOH Ministry of Health

NGO Non-Governmental Organization

OTI Office of Transitional Initiatives

OMS Organization Mondial de la Santé (WHO)

PAT The Transitional Action Plan 2000-2002 (of the MOH)

PEV Programme Elargi de Vaccination (EPI)

PCA Package of Complementary Referral Activities (of the MOH for PHC)

PMA Minimum Package of Activities (of the MOH for PHC)

PNLP Programme National de la Lutte Contre Paludisme (Malaria)

SANRU Soins de Santé Primaires en Mileu Rural

## Executive Summary

1. **Scope of Work**

USAID has been contacted by the Church of Christ of Congo (ECC) about submitting an unsolicited proposal to assist health zones throughout Congo. This project would build on ECC’s previous experience and expertise in the successful management of the SANRU I and II projects (1981-1992).

USAID requested this trip primarily to 1) assess the feasibility of using the umbrella NGO structure of ECC to manage a grant-funded project to provide resources to NGO-assisted health zones in Congo, and 2) assist ECC in developing a concept paper for an umbrella-NGO project that identifies potential strategies, types and levels of assistance and an administrative structure.

**B. Methods**

This trip took place from June 6 to 21, 2000. The work consisted of numerous meetings with national programs and agencies that are providing assistance to health zones.

The umbrella NGO feasibility assessment examined:

1. whether such a project was consistent with existing MOH policy;
2. the capacity of human resources at the national and health zone level;
3. the planning and coordination capacity at the national level;
4. the capacity of ECC as an umbrella NGO to manage such a project;
5. the status of the NGO network throughout Congo to implement such a project;
6. the current status of the transportation and communications system; and
7. the potential for a partnership with a U.S.-based NGO to manage the project.

The development of a concept paper for a possible project included:

1. goals, objectives, activities, and indicators;
2. project management and administrative arrangements;
3. three budget scenarios (High, Mid, Low); and
4. a tentative list of health zones to be assisted.

**C. Findings**

1. Feasibility Assessment

A SANRU III project managed by the NGO umbrella ECC is feasible given the existing capacities at the national level and would be entirely consistent with MOH policy. While the degradation of the transportation system and rebel occupation of much of the country will make implementation difficult, the existence and persistence of the NGO network is a workable mechanism to get much needed assistance to health zones throughout the Congo. ECC has identified a capable U.S.-based partner agency to handle procurement and overall financial management for the project.

Here is a summary of the findings for each of the assessment areas:

1. The top priority of the MOH is to reinforce and sustain health zones. This is consistent with the previous work of SANRU I and II. Building of these strategies for SANRU III would be entirely consistent with MOH policy.
2. Development capacity in terms of human resources at the national level is surprisingly good, especially with regards to coordination and collaboration with an umbrella-NGO project. This is because 70-80% of the national programs, projects and agencies have at their direction, or as a key technical person on their staff, a former medical chief of a health zone or a former SANRU employee.
3. The planning and coordination capacity at the national level is better than expected. The planning unit of the Ministry of Health has maintained and improved the database of health zones created in the mid-1980s. The database distinguishes between “principal partners” and “complimentary partners” and will be quite helpful in identifying and coordinating assistance for an umbrella-NGO project.
4. During the 1990s, ECC-SANRU has continued to manage development assistance to health zones. For example, ECC is currently managing a five-year $5,000,000 project to provide assistance to 15 health zones. An umbrella-NGO project could build on ECC’s current projects and capacity to increase the number of health zones assisted and the level of assistance provided to health zones.
5. The size of the church-related NGO network has not changed significantly during the past nine years, but is functioning at a greatly reduced level. The existence of this informal NGO network, and the knowledge of how to work through it to get assistance to health zones, even in rebel-controlled areas of Congo, will be a particular strength of an umbrella-NGO managed project.
6. The massive degradation of the transportation system in Congo has had a negative impact on the performance of health zones and of the NGO network, both at a local intra-health zone and at a regional inter-health zone level. It may be necessary for the umbrella-NGO project to set up “regional” offices in certain areas of the country or work through a decentralized office within an assisted health zone or decentralized NGO-managed pharmaceutical depot.
7. ECC has identified a capable U.S.-based partner agency, Interchurch Medical Assistance (IMA), through which grant funding for an umbrella-NGO project could be channeled. IMA is a non-profit association of Christian relief and development agencies specializing in the solicitation, packing, shipping and on-site management of pharmaceuticals and medical supplies. Given the importance of creating a functional supply line to health zones, IMA would be an excellent partner for an umbrella-NGO project.
8. Concept paper for SANRU III

While there appears to be a general agreement and enthusiasm for a SANRU III umbrella-NGO project, the scope the project is a matter of considerable debate, i.e., as to the appropriate scale of such a project at this time, i.e., given available funding and the continued political instability in Congo. The development of this concept paper is based on three scenarios - High, Mid, and Low.

1. The overall goal of a SANRU III project should be to strengthen and sustain the capacity of health zones for the management of priority primary health care program interventions and support systems. This goal is compatible with all three project scenarios. However, the emphasis and funding level for program interventions and support systems would vary between scenarios.
2. SANRU III would be a partnership between the Congo-based NGO ECC (Church of Christ of Congo) and a US-based NGO. The SANRU III project offices would be located at ECC in the buildings constructed by SANRU I/II. This may require ECC to terminate lease agreements with some organizations currently occupying ECC-SANRU.
3. The three budget scenarios for SANRU III include:

- High-End: assistance to 60 health zones with a budget of $5 million per year;

- Mid Range: assistance to 40 health zones with a budget of $3.1 million per year; and

- Low-End: assistance to 25 health zones with a budget of $1.5 million per year.

1. It is recommended that SANRU III include a 50/50 mix of “currently assisted” and “not-assisted” health zones because:

- Most currently assisted health zones are not receiving sufficient assistance;

- 33% of currently assisted health zones were at one time assisted by SANRU I/II;

- SANRU III could expand from a “currently-assisted” health zone to neighboring “not-assisted” health zones to create a zonal cluster that shares project resources.

The report concludes with separated sections for each of the secondary components of the scope of work:

- Assess training needs of health zones for diagnosis and management of malaria;

- Identify lessons learned from the SANRU and ECZORT

- An annotated bibliography of documents from SANRU and ECZORT

1. **Background and Scope of Work**

USAID is in the process of reestablishing a development assistance program in Congo. In this context, USAID is assessing the feasibility of building on the past experiences and structures of USAID-funded projects that had to be closed in 1992, e.g., the SANRU Basic Rural Health Project.

Earlier this year, USAID was contacted by the representatives of the Church of Christ of Congo (ECC) about submitting an unsolicited proposal to provide assistance to health zones in Congo. This project would build on ECC’s previous experience and expertise in the successful management of the SANRU I and II projects (1981-1992).

Given this context, USAID requested this trip to:

1) Assess the feasibility of using the umbrella-NGO structure of ECC to manage a grant-funded project to provide resources to NGO-assisted health zones in Congo, and

2) Identify potential project strategies, types and levels of assistance and an administrative structure for such an umbrella-NGO project.

Secondary objectives for this trip were to:

1. Identify training needs of MOH, NGO's, labs, and health facilities for appropriate diagnosis and management of malaria as per PNLP country strategy.
2. Identify lessons learned from the SANRU and ECZORT projects as an input in developing USAID's country strategy and for getting assistance to NGO-assisted health zones via an umbrella-NGO structure.
3. Compile an annotated bibliography of reports and key documents from the SANRU/ECZORT period that could be useful in preparing USAID's country strategy and/or in the development of a proposal by an umbrella-NGO.
4. Update the database of 306 health zones in Congo to reflect, as much as possible, their current functional status.
5. **Methodology and Schedule**

The trip took place from June 6 - 21, 2000. The initial briefing and discussion of the scope of work with the USAID director indicated that if it was feasible to use the NGO umbrella structure of ECC for a project to assist health zones that USAID/Kinshasa would like to have a draft proposal in hand by early August.

Given this timetable, the methodology was adjusted to concentrate on the two primary objectives, and to go beyond simply “identifying potential project strategies, types and levels of assistance” to developing a concept paper for a possible “SANRU III” project.

The feasibility assessment examined:

1. whether such a project was consistent with existing MOH policy;
2. the capacity of human resources at the national and health zone level;
3. the planning and coordination capacity at the national level;
4. the capacity of ECC as an umbrella-NGO to manage such a project;
5. the status of the NGO network throughout Congo to implement such a project;
6. the current status of the transportation and communications system; and
7. the potential for a partnership with a U.S.-based NGO to manage the project.

The concept paper for a possible SANRU III project included a preliminary development of:

1. goals, objectives, activities, and indicators;
2. project management and administrative arrangements;
3. three preliminary budget scenarios; and
4. a tentative list of health zones to be assisted.

The work involved numerous meetings with the representatives of the following organizations:

1. key agencies: USAID, MOH and ECC
2. national programs: PEV, PNLP, BCC, and MOH Planning Unit
3. NGO agencies/projects: Mimesa, CBM/Onchocerciasis, Catholic Relief Services, OTI (Office of Transitional Initiatives), and CONAS (National Committee for Coordination of Health NGOs).
4. Other agencies: World Bank Health team, OMS, FOMETRO, and BASICS

A complete list of contacts made and meetings during this trip is provided in Annex A.

1. **Feasibility Assessment**

1. Current MOH policy

The health system of Congo has regrettably deteriorated during the past ten years. Annex B provides the “Current Analysis of the Health Situation in Congo” as part of “The Transitional Action Plan 2000-2002 (PAT)” of the MOH . Reinforcing and sustaining health zones is the number one priority of the MOH. The complete list of priorities of the PAT are as follows:

1. Health Zones (Revitalization and reinforcement of institutional capacity)
2. Environmental health
3. Infectious diseases
4. HIV/AIDS
5. Maternal and Child Health
6. Nutrition and Food Security
7. Pharmaceutical sector
8. Epidemic control crisis management
9. Social Mobilization

The PAT also highlights three important strategies with regards to assisting health zones:

1) *Sustainability*: assistance to health zones should be comprehensive (all structures of the health zone in all program areas) and provided through a durable structure (an action plan prepared by all of the health zone partners).

2) *Vertical and Horizontal Integration*: During the past decade there has been a proliferation of vertically managed programs at the regional and district (sub-regional) levels. These programs need to integrate their management structures in order to reduce unnecessary duplication of effort.

3) *Definition of Norms:* The priorities of the MOH and of the Health Zone action plans need to be consistent with the concepts of a Minimum Package of Activities (PMA) and a Package of Complementary Referral Activities (PCA). The central level must define and disseminate PMA and PCA norms and mechanisms for their application.

These MOH priorities and strategies are consistent with the previous work of the SANRU I and II. SANRU provided one of the most comprehensive assistance “packages” for health zones, integrated planning and coordination at the health zone level, assisted national programs in developing, and implementing national norms, and served as the primary advocate of liaison for working with and through NGO-managed health zones. Building of these strategies for SANRU III would be entirely consistent with MOH policy.

2. Human Resources

The development capacity in terms of human resources at the national level is surprisingly good. In fact, I think that might even be better then it was in 1990, especially with regard to the potential for coordination and collaboration with an NGO-umbrella project.

I estimate that 70-80% of the national programs, projects and agencies have at their direction, or as a key technical person on their staff, a former medical chief of a health zone or a former SANRU employee. In addition, almost all of the former Medical Chief of a Health Zone (MCZS) that I met had worked in health zones managed or co-managed by an NGO and assisted by SANRU. Dr. Makina of PNLP, Dr. Bongo of BCC, and Dr. Othepa at BASICS are several examples.

These people have an excellent understanding of conditions within health zones, and a great empathy for getting assistance to the health zone level. Their previous experience in an NGO-managed health zone will greatly facilitate planning, coordination and implementation of national policies and programs through an NGO-umbrella project.

The situation at the health zone level is another story. With the movement of MCZS up through the system and/or out of the country, there is a big management capacity gap at the health zone level, especially for medical directors. The situation for nurses is perhaps a bit better, only because they are generally less mobile than doctors.

Any project to assist health zones must include an important component for training in planning an management of health zones. In the long-term some this training could be provided by the degree program at UNIKIN. There will also be need, however, for a short-term training, perhaps a two week modular training program similar to the one that was developed and used during the 1980s. The modules still exist for that program, and could be updated and used fairly quickly.

3. Planning and Coordination

The planning and coordination capacity at the national level was found to be better than expected. The ISA (Information Sanitaire) project coordinated by the Damien Fondation, MSF Belgium and Memisa Belgium published a volume of “Recueil d’Informations Sanitaires” in 1999 that provides an excellent summary of the functional status of health zones on a regional and zonal basis. The document includes a one-page summary for most of the 306 health zones of Congo. While there are obvious gaps in the information provided, especially for health zones in Eastern Congo, this is a much better resource than was available ten years ago.

Additionally, the planning unit of the Ministry of Health has maintained and improved upon the database of health zones which was created in the mid-1980s.This database provides up to date information for the coordination of assistance to health zones and has been used in the development of the MOH Transitional Action Plan. Currently 99 health zones (32% of the 306) are receiving structural assistance (see Table 1). The database also distinguishes between the concept of “principle partner” and “complimentary partners.” This will be quite helpful in identifying and coordinating assistance provided through an umbrella-NGO project. The database does not, unfortunately, identify the role of NGOs in managing or co-managing health zones. Since this concept is important to the design of a project to assist NGO-managed health zones, I merged the MOH database with the original SANRU database, and extracted the pertinent information into a separate file. Annex C provides this information in Excel format.

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| Table 1: Health Zones Receiving Structural Assistance | | | | | |
| **Province** | **Total**  **Number of Health Zones** | **Health Zones currently being assisted** | | **Health Zones programmed for assistance** | |
| **Nbr** | **%** | **Nbr** | **%** |
| KN- Kinshasa | 22 | 19 | 86 | 3 | 14 |
| BC- Bas Congo | 27 | 14 | 52 | 0 | 0 |
| BD- Bandundu | 38 | 19 | 50 | 5 | 13 |
| KOR- Kasai Oriental | 27 | 0 | 0 | 5 | 19 |
| KOC- Kasai Occidental | 31 | 1 | 3 | 1 | 3 |
| KT- Katanga | 40 | 12 | 30 | 0 | 0 |
| EQ- Equateur | 33 | 18 | 55 | 0 | 0 |
| PO- Prov. Oriental (Haut-Congo) | 47 | 5 | 11 | 2 | 4 |
| MN- Manika | 8 | 3 | 38 | 0 | 0 |
| NKV- North Kivu | 19 | 5 | 26 | 0 | 0 |
| SKV- South Kivu | 14 | 3 | 21 | 0 | 0 |
| **Total** | **306** | **99** | **32** | **16** | **5** |

4. NGO project management capacity

The SANRU project was a bilateral project for which the MOH and USAID delegated the management to the umbrella-NGO, the Church of Christ of Congo (ECC). There was no formal US-based institutional contractor for SANRU. Rather, USAID hired technical assistance via personal services contracts to reinforce and development the management capacity at ECC.

Since the closing of the SANRU project in 1992, ECC-SANRU has continued to demonstrate its capacity to manage development assistance to health zones (see Table 2). While the number of personnel working at ECC-SANRU has been greatly reduced, there is a well trained management team.. For example, ECC is currently managing a five-year $5,000,000 project in collaboration with a Belgium-based NGO, Solidarité Protestante, to provide assistance to 15 health zones. An umbrella-NGO project could build on ECC’s current projects and capacity to increase the number of health zones assisted and the level of assistance provided to health zones.

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| **Table 2: ECC-SANRU Project Management (1981-2000)** | | | | |
| **Project** | **Dates** | **Funding** | **Budget** | **Activity** |
| The SANRU I & II projects | 1981 - 1991 | USAID | $32,283,000 | Development and support of a decentralized PHC system in 100 health zones, including training, supervision equipment, hospital and health center repairs, health center construction, essential medicines and equipment, cold chain equipment, water projects, family planning, etc. |
| ECZORT | 1985-1987 | USAID through ORT | $2,000,000 | Assistance to 45? health zones through NGOs co-managing or working in those health zones. Assistance provided was similar to that of SANRU. |
| MAP International project | 1991 - 1992 | Map International | 36 tons of medicines | Distribution of essential medicines to 38 health zones |
| Pass project | 1992 - 1994 | World Bank | $450,300 | This program for 105 health zones had a planned loan budget of $22,943,712, but the gov’t defaulted on loan |
| ZCAT project | 1993 | World Council of Churches | $124,000 | Distribution of essential medicines to 22 health zones. |
| ZUAC project | 1994 | World Bank | $230,000 | Distribution of essentials medicines in Kinshasa. |
| Project MBF and CRS Essential Medicine Project | 1994 - 1995 | OFDA | $ 2,310,000 | Distribution of essential meds to 46 HZs with displaced people in Kasaï and Katanga. Other activities included spring capping in the Luputa and printing/distribution of PHC books. |
| PATS I project | 1995 - 1997 | European Union | $1,320,000 | Revitalization of 6 health zones in Kinshasa and 5 in Kasaï, including mgmt training, supervision equipment, hospital & health center repairs, essential meds/equip, & cold chain equipment. |
| Ebola outbreak coordination | 1996 | US Government | $1,500,000 | Coordination center for all NGO and gov’t agencies for the Ebola outbreak, including radio e-mail services for CDC, vehicles, receiving and distributing two DOD planes worth of medical materials and training/surveillance with CDC. |
| Residency project | 1997 to present | EZE | $870,000 | Training of medical residents in Family Medicine at six training hospitals throughout Congo. |
| Family Planning project | 1996 - 1998 | World Bank & PC (USA) | WB $65,000  PC $42,000 | The integration of family planning services throughout the health services of Kinshasa and with independent NGOs |
| Soliderité Protestant project | 1997 -  2002 | Belgium Government | $4,071,000 | Revitalization of 15 health zones in Bas Congo, Bandundu and Equator, including management training, supervision equipment, hospital and health center repairs, essential medicines and equipment, and cold chain equipment. |
| PATS II project | 1998 - 2001 | European Union | $730,000 | Support for PHC in 4 health zones and 27 health centers in Kinshasa, including management training, supervision equipment, health center repairs, essential medicines and equipment, and cold chain equipment. |

5. The NGO network throughout Congo

Any discussion of NGOs in Congo needs to distinguish between church-based NGOs and other secular not-for-profit NGOs. It is the church-based NGOS (catholic, protestant and Kimbanquist) who are the most important partners to the MOH in the provision of health services and in the management/co-management of health zones. Together the church-related NGOs probably account for more than 90% or more of health services that are provided via NGOs.

The number and network of church-related NGOs has not changed significantly during the past nine years. For example, the Presbyterian communities of ECC were actively involved during the 1980s, in collaboration with their sister church in the U.S., in the creation and management of five health zones (Bulape, Tskkaji, Dibindi, Bibanga, and Lubondai). This assistance and network is still in place today, albeit functioning at a greatly reduced level.

The existence of this informal network, and the knowledge of how to work through it to get assistance to health zones, even in rebel-controlled areas of Congo, will be a particular strength of an umbrella-NGO managed project.

6. Transportation and Communications System

The massive degradation of the transportation system in Congo has had a serious negative impact on the performance of health zones and of the NGO network, both at a local intra-health zone and a regional inter-health zone level. For example, where it was previously possible for a project like SANRU to get assistance from Kinshasa to all regions of Congo by boat, truck or airplane, it is now be necessary to use other entry points, e.g., Central African Republic for Equateur Province, Kenya for Eastern Congo, and Zambia or South Africa for Katanga Province.

The current occupation and control of much of Congo by rebel groups will make it extremely difficult to coordinate and supervise activities from Kinshasa. However, this is not an insurmountable problem. Poor communications and transportation systems were also a major problem during the 1980s. In fact, one of the lessons learned from SANRU was that a poor communication system can be a positive contributing factor that encourages decentralization, i.e. “The poorer the communication system, the less temptation and capacity there is to centralize the process of decentralization.”

It may be necessary for the umbrella-NGO project to set up “regional” offices in certain areas of the country or work through a decentralized office within an assisted health zone or decentralized NGO-managed pharmaceutical depot.

7. Partnership with a U.S.-based NGO

Because there was no U.S.-based institutional contractor for the SANRU project, USAID/Kinshasa served as the dollar procurement agent for technical assistance, training and commodities. In the case of a umbrella-NGO project it will be necessary to identify a U.S.-based partner who can provide not only procurement services, but also assume responsibility for overall financial management of the project.

One possibility for such a partner would be Catholic Relief Service (CRS) since they are already working in Congo and rent office space in the ECC-SANRU building. CRS is working primarily with community-based initiatives for health interventions, e.g. growth monitoring, nutrition and immunizations, and in provision of disaster assistance. Recently they have started providing assistance to two neighboring health zones in Bas-Congo (Ngidinga and Kimvula). CRS sees their mandate as working with hard to reach populations. CRS is not a procurement specialist, but depends on another agency, Catholic Medical Mission Board, to handle their procurement needs.

Another possible partner would be IMA, InterChurch Medical Assistance. IMA has forty years of experience in the solicitation, packing, shipping and on-site management of pharmaceuticals and medical supplies for on-going member-sponsored health facilities, refugee services, and disaster relief programs. While IMA does not have a direct physical presence in Congo, they are represented indirectly by several member agencies – Adventist Development and Relief Agency (ADRA), American Baptist Churches (USA), Church World Service, Mennonite Central Committee (MCC), Presbyterian Church (USA), and United Methodist Church/GBGM. IMA does not have experience in health systems project management, but has played a leading role in managing the NGO side of the National Onchocerciasis Control Program in Tanzania.

Ultimately, the choice of U.S.-based partner is for the umbrella-NGO to determine. In the case of ECC they have proposed IMA to be their partner. The choice seems to be a logical given the financial and procurement experience of IMA, and the importance of creating functional supply lines to health zones. According to ECC, IMA has responded positively to their invitation to become a project partner. IMA has invited the ECC medical director to come to their headquarters in New Windsor, Maryland in August to pursue discussions and proposal development.

8. Conclusion

A SANRU III project managed via the NGO umbrella structure of ECC is feasible given the existing capacities at the national level. The project would be entirely consistent with MOH policy. While the degradation of the transportation system and presence of rebel groups will make implementation difficult, the existence and persistence of the NGO network is a workable mechanism to get assistance to health zones. ECC has also identified a qualified U.S.-based partner agency to assist in procurement and overall financial management.

**D. Concept Paper for SANRU III**

While there appears to be a general agreement and enthusiasm for a SANRU III project, the scope of such a project is a matter of considerable debate. On one hand, given the urgent needs, it is tempting to push ahead with a larger and comprehensive program to assist many health zones as quickly as possible. On the other hand, given the continued political instability and implementation problems in certain areas of Congo, it may be necessary to focus SANRU III, especially during the first year or so, on a few priority objectives and in a limited number of health zones.

The development of this concept paper is based on three scenarios:

1. Low-End: assistance to 25 health zones with a budget of $1.5 million per year;
2. Mid Range. assistance to 40 health zones with a budget of $3.1 million per year; and
3. High-End: assistance to 60 health zones with a budget of $5 million per year.

1. Goals and Objectives

The overall goal of SANRU III project should be to strengthen and sustain the capacity of health zones for the management of priority primary health care program interventions and support systems. This goal is compatible with all three project scenarios.

The specific program interventions for could include some or all of the following:

1. PMA: Minimum package of primary care: CPN, CPS, PEV, family planning and curative care;
2. HIV/AIDS and STDS, e.g., health education, testing procedures, and preventive measures;
3. Malaria, e.g., appropriate treatment at households and health centers;
4. Nutrition, e.g. community-based nutritional rehabilitation and income generating activities;
5. Water and Sanitation, e.g., spring capping and village sanitation; and
6. Re-merging Disease Control, e.g., Onchocerciasis and Tuberculosis

Project components to strengthen health zone support systems should include:

1. Supply Lines to decentralized depots to supply essential medicines to health zones;
2. Management training to develop transparent management with participating communities;
3. Training Resources to reinforce health zone capacity for local training and supervision. This would also include national level, e.g. training of trainers and MPH programs at UNIKIN.
4. Equipment: provide essential equipment for health centers, hospitals and zone offices;
5. Communications systems such as Radio Phonie communication and E-mail systems;
6. Health Information System improvements to encourage and support data collection, analysis and local decision-making; and
7. Health Education resources and strategies to encourage Behavior Change Communications.

2. Project management

SANRU III would be a partnership between the Congo-based NGO ECC (Church of Christ of Congo) and a US-based NGO.

The U.S.-based partner would be responsible for:

1. Official communications, liaison, coordination and progress/financial reporting to USAID;
2. External management of grant funding including dollar procurement for vehicles, medicines, and equipment and the timely transfer of funds to the ECC-SANRU account; and
3. Coordination and provision of technical assistance to the ECC-SANRU team, including
   1. long distance technical backstopping from the U.S.;
   2. regular supervision visits from the U.S. to Congo;
   3. short-term technical assistance, e.g. computerized financial management system; and
   4. long-term technical assistance in financial management.

The ECC-SANRU team would be responsible for:

1. Official communications, liaison, coordination and progress reporting to the Ministry of Health, selected national programs; and to NGOs assisting health zones selected by SANRU III.
2. Management of funds transferred to the ECC-SANRU accounts (dollar and counterpart) for local procurement and timely transfer of funds to NGOs/health zones. The signatures on the ECC-SANRU accounts will be shared by the project director, the ECC president and treasurer, and a IMA-representative working as part of the ECC-SANRU team.
3. Coordination and provision of technical assistance to NGOs and health zones including
4. regular supervision of health zones participating in SANRU III;
5. organization of national/regional activities involving multiple health zones, e.g. training programs or PHC conferences.
6. coordination of assistance to health zones from national/regional programs, e.g. malaria, HIV/AIDS, Onchocerciasis, and EPI.
7. Identification and provision of short-term locally available technical assistance for project activities, e.g., income generation activities.

The SANRU III project offices would be located at ECC in the buildings constructed by SANRU I and II. This office space would be an in-kind contribution of ECC, and include use of the warehouse, library, storage containers, access to the downstairs conference room, and an adequate number of offices and office space to accommodate the current and future staff for SANRU III. This may require ECC to terminate lease agreements with some organizations currently occupying office space in the SANRU building.

3. Three Budget Scenarios

Current projects like Mimesa Belgium are providing an assistance package of approximately $25,000 per year to health zones. The “Plan Transitoire du Ministere de la Santé (2000-2002) estimates that the annual operating costs for a typical health zone is around $100,000 (not counting investment costs). A SANRU III project could, therefore, play an important role to complete, increase and improve development assistance to health zones. Table 3 compares three scenarios for SANRU III in terms of objectives, number of health zones, and budget.

A “low-end” project might assist 25 health zones and four decentralized pharmaceutical depots with a few priority program interventions, e.g., MPA, HIV/AIDS, and malaria. The project would include a minimum of assistance for rehabilitation and equipment. This scenario would provide$32,000 per year to ten co-assisted health zones and $50,000 per year in fifteen health zones where SANRU III is the principle partner. Most of this assistance would be provided in the form of commodities. Project management cost is estimated to be 35% of the total assistance. The total cost of the project would be $1,500,000 per year or $7,500,000 over five years.

|  |  |  |  |
| --- | --- | --- | --- |
| Table 3: Three Scenarios for a SANRU III Project | | | |
|  | **Scope of Project Objectives and Resources** | | |
| **Low** | **Mid** | **High** |
| **Objectives**  **for program interventions** | PMA  HIV/AIDS  Malaria | PMA  HIV/AIDS  Malaria  Oncho | PMA & PCA  HIV/AIDS  Malaria  Nutrition  Water/Sanitation  Oncho, TB |
| **Objectives**  **to reinforce**  **support systems** | Supply Lines  Training  Equipment  Communications  Health Education | Supply Lines  Training  Equipment  Communications  Health Education  Health Info System | Supply Lines  Training  Equipment  Communications  Health Education  Health Info System |
| **Health Zones** | 25 | 40 | 60 |
| **Amt/HZ/year** | $39,000 | $53,500 | $60,000 |
| **Budget per year** | $1,500,000 | $3,100,000 | $5,000,000 |
| **Project Management** | 35% | 33% | 30% |

A “mid-range” project might assist forty health zones and six decentralized depots with an expanded program of assistance for nutrition, water/sanitation, hospital rehabilitation and equipment. This scenario would provide of $42,000 per year to twenty co-assisted health zones and $67,000 per year in twenty health zones where SANRU III is the principle partner. Most of this assistance would be provided in the form of commodities. Project management cost is estimated to be 33% of total assistance. The total cost of the project would be $3,100,000 per year or $15,500,000 over five years.

A “high-end” project could assist sixty health zones and eight decentralized depots with a fairly comprehensive assistance for most programs interventions and support components. This assistance would average $45,000 per year in thirty co-assisted health zones and $75,000 per year in thirty health zones where SANRU III is the principle partner. Most of this assistance would be provided in the form of commodities. Project management cost is estimated to be 30% of total assistance. The total cost of the project would be $5,000,000 per year or $25,000,000 over five years. The summary line item budget for this scenario is shown in Table 4:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Table 4: Tentative Budget for SANRU III for 60 Health Zones (in 1000s of dollars) | | | | |
|  | **30 HZ** | **30 HZ** | **8 depots** | **Total** |
| **Supervision** | $810 | $1,950 | $200 | $2,960 |
| **Rehabilitation** | $450 | $1,500 | $40 | $1,990 |
| **Solar Systems** | $45 | $240 | $32 | $317 |
| **Water/Sanitation** | $765 | $765 | $0 | $1,530 |
| **Equipment** | $758 | $1,395 | $120 | $2,272 |
| **Training** | $1,440 | $1,800 | $30 | $3,270 |
| **IEC/PHC Promotion** | $330 | $330 | $0 | $660 |
| **Medicines/Supplies** | $1,500 | $2,250 | $600 | $4,350 |
| **Programs** | $285 | $285 | $0 | $570 |
| **Oper. Research** | $203 | $203 | $0 | $405 |
| **Contingency (5%)** | $324 | $531 | $51 | $906 |
| **Subtotal** | $6,909 | $11,248 | $1,073 | $19,231 |
| **Project Management** (approximately 30 %) | | |  | $5,769 |
| **Grand Total** | | | | $25,000 |

Annex D includes these three budget scenarios in Excel format. The electronic version of this file makes it possible to develop revised or alternative budget scenarios.

4. Number of Health Zones to be Assisted

The Brooke Amendment currently blocks USAID assistance to or through the Ministry of Health. This is one reason why a USAID-funded project via an umbrella-NGO is appropriate at this time. However, it also means that the health zones assisted by the project must be managed or co-managed by an NGO. This is somewhat similar to the situation in 1985 when ECC managed the ECZORT project in parallel to SANRU to provide supplemental assistance to and through forty NGO-managed health zones.

NGOs have played an important and pioneering role in the development and management of most of the health zones in Congo. In 1981 there were only eight pilot health zones in Congo. Six of these were developed and managed in collaboration with an NGO.

Between 1981 and 1984 the number of functional health zones in Congo increased from 8 to 87 with 70% of them managed or co-managed by an NGO (see Table 5). “Functional” was defined in a minimal sense to mean that there was a reference hospital with basic curative services, an appointed Medical Chief for the Health Zone present, and at least three health zones providing the Minimum Package of Activities for CPN, CPS, PEV, Curative Care and Health Education.

It is estimated that the number of functional health zones peaked around 1987 at 220. By 1990, however, there were only 179 health zones identified as sufficiently functional by the MOH to receive supervision subsidies. Of these health zones, 66% were managed or co-managed by an NGO.

Today, approximately 100 health zones could be considered functional based on the same criteria and definition as described above. An estimated 66% of those health zones are currently managed or co-managed by an NGO.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Table 5: Number of Functional Health Zones by Year | | | | |
| **Year** | **Functional Health Zones** | | **NGO managed or co-managed** | |
| **Number** | **PerCent** | **Number** | **PerCent of Functional HZ** |
| 1981 | 8 | 3% | 6 | 75% |
| 1982 | 41 | 13% | 32 | 78% |
| 1983 | 64 | 21% | 44 | 69% |
| 1984 | 87 | 28% | 61 | 70% |
| 1985 | 112 | 37% | 74 | 66% |
| 1987 | 220\* | 72% | 130\* | 59% |
| 1990 | 179 | 58% | 117 | 65% |
| 2000 | 100\* | 33% | 60\* | 60% |
| \* = estimated | | | | |

According to the MOH 119 health zones are currently receiving “structural” assistance from a principle partner agency (see Table 6). It is recommended that SANRU III include a 50/50 mix of “currently assisted” and “not-assisted” health zones. There are several reasons for this approach:

1) Most currently assisted health zones are not receiving sufficient assistance. Given the comprehensive and integrated approach of SANRU III could play an important role to complete, increase and improve development assistance to health zones.

2) Thirty-nine (33%) of the currently assisted health zones were at one time assisted by SANRU I/II. This provides an opportunity for SANRU III to build on a previously established and positive relationship.

3) SANRU III could expand assistance from a “currently-assisted” health zone to neighboring “not-assisted” health zones and create a zonal cluster that shares training resources. The SANRU I/II experience in using this approach was quite positive.

|  |  |  |  |
| --- | --- | --- | --- |
| Table 6: Current Assistance to Health Zones | | | |
| **Partner Agency** | **Health Zones**  **Assisted** | **Previously assisted by SANRU I/ II** | **Proposed for Assistance by SANRU III** |
| MSF-Belgium | 19 | 3 | 0 |
| Memisa -Belgium | 18 | 11 | 10 |
| Solidarité Protestante/ECC | 16 | 12 | 13 |
| FOMETRO | 12 | 2 | 3 |
| BDOM or CRS | 8 | 2 | 1 |
| Horizon Santé | 7 | 0 | 0 |
| Salvation Army | 4 | 0 | 0 |
| WHO | 4 | 0 | 1 |
| Medicus Mundi | 3 | 2 | 0 |
| Other Partners | 28 | 7 | 1 |
| Other Health Zones |  | 61 | 31 |
| **Total** | **119** | **100** | **60** |

The selection of health zones should also include, as much as possible, a balance of those managed by community members of ECC and by other NGOs. Table 7 shows a tentative selection of 60 health zones to be assisted for the high-end scenario. The distribution of these health zones is shown in the map. This map also indicates whether the health zone is currently managed or co-managed in collaboration with a protestant or catholic-related NGO.

| **Table 7: Tentative List of Health Zones to be Assisted by SANRU III** | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| **Nbr** | **Region** | **Health Zone** | **Managed by** | **Assisted by** | **SANRU** | **Population** |
| 1 | Bandundu | Bokoro | BDOM | MEMISA-B | 1986 | 138827 |
| 2 | Bandundu | Bolobo | ECC/CBFC | ECC/SP | 1986 | 156210 |
| 3 | Bandundu | Bonga-yasa | BDOM | MEMISA-B |  | 156389 |
| 4 | Bandundu | Bosobe | ECC/CBB |  | 1984 | 124000 |
| 5 | Bandundu | Bulungu | ETAT/BDOM | OMS |  | 214533 |
| 6 | Bandundu | Djuma | BDOM | MEMISA-B | 1983 | 135400 |
| 7 | Bandundu | Ipamu | BDOM | MEMISA-B | 1987 | 158584 |
| 8 | Bandundu | Kajiji | ECC/CEFMZ | MEMISA-B | 1982 | 179126 |
| 9 | Bandundu | Kasongolunda | ETAT/BDOM | MEMISA-B | 1983 | 96837 |
| 10 | Bandundu | Kikongo | ECC/CBCO | MEMISA-B | 1983 | 104007 |
| 11 | Bandundu | Kingandu | BDOM | MEMISA-B |  | 90000 |
| 12 | Bandundu | Moanza | ECC/CBCO |  | 1984 | 250000 |
| 13 | Bandundu | Mokala | BDOM |  | 1987 | 182168 |
| 14 | Bandundu | Mukedi | ECC/CMC | ECC/SP | 1984 | 162500 |
| 15 | Bandundu | Vanga | ECC/CBCO |  | 1982 | 216326 |
| 16 | Bas Congo | Gombe-matadi | z.KIMBANG. | FOMETRO |  | 84198 |
| 17 | Bas Congo | Kangu | BDOM | FOMETRO |  | 73590 |
| 18 | Bas Congo | Kibunzi | ECC/CEZ | ECC/SP |  | 43800 |
| 19 | Bas Congo | Kimpese | ECC/IME | ECC/SP | 1982 | 95130 |
| 20 | Bas Congo | Kinkonzi | ECC/CEAZ | ECC/SP | 1982 | 86600 |
| 21 | Bas Congo | Luozi | ECC//CEC |  |  | 58693 |
| 22 | Bas Congo | Mangembo | BDOM | FOMETRO |  | 65000 |
| 23 | Bas Congo | Ngidinga | BDOM | CRS | 1989 | 74392 |
| 24 | Bas Congo | Nselo | ECC/CBCO | ECC/SP | 1986 | 76009 |
| 25 | Bas Congo | Nsona-pangu | ECC/CBCO | ECC/SP | 1982 | 95000 |
| 26 | Bas Congo | Sona-bata | ECC/CBCO | ECC/SP | 1982 | 116492 |
| 27 | Bas Congo | Vaku | BDOM |  |  | 50759 |
| 28 | Equateur | Karawa | ECC/CEUM | ECC/SP | 1982 | 378340 |
| 29 | Equateur | Loko | ECC/PCMP | ECC/SP | 1982 | 116910 |
| 30 | Equateur | Pimu | ECC/CBFZ | ECC/SP | 1984 | 99999 |
| 31 | Equateur | Tandala | ECC/CECU | ECC/SP | 1982 | 298327 |
| 32 | Prov. Oriental | Boga | ECC/CME |  | 1989 | 45386 |
| 33 | Prov. Oriental | Doruma | ETAT/BDOM |  | 1986 | 61559 |
| 34 | Prov. Oriental | Drodro | BDOM | MEMISA-B | 1983 | 306512 |
| 35 | Prov. Oriental | Dungu | ETAT/BDOM |  | 1984 | 146625 |
| 36 | Prov. Oriental | Nyankunde | ECC/CME |  | 1982 | 150000 |
| 37 | Prov. Oriental | Pawa | ETAT/BDOM | FOPERDA | 1984 | 187396 |
| 38 | Prov. Oriental | Rethy | ECC/CECA |  | 1984 | 303199 |
| 39 | Prov. Oriental | Tchomia | BDOM | MEMISA-B | 1987 | 65425 |
| 40 | Prov. Oriental | Yakusu | ECC/CBFZ |  | 1983 | 122003 |
| 41 | Kaisi Occidental | Bulape | ECC/CPCA | ECC/SP | 1983 | 133595 |
| 42 | Kaisi Occidental | Demba | ETAT/BDOM |  |  | 106956 |
| 43 | Kaisi Occidental | Kalonda-Ouest | ECC/CMC |  | 1982 | 294266 |
| 44 | Kaisi Occidental | Kamonia | z.AVOMET |  | 1989 | 204643 |
| 45 | Kaisi Occidental | Kitangwa | BDOM |  | 1989 | 164240 |
| 46 | Kaisi Occidental | Luambo | BDOM |  |  | 146024 |
| 47 | Kaisi Occidental | Luebo | ETAT/BDOM |  | 1986 | 244161 |
| 48 | Kaisi Occidental | Luiza | ETAT/BDOM |  |  | 93122 |
| 49 | Kaisi Occidental | Ndekesha | BDOM |  |  | 106000 |
| 50 | Kaisi Occidental | Tshikaji | ECC/IMCK |  | 1982 | 139367 |
| 51 | Kaisi Oriental | Bibanga | ECC/CPCA |  | 1982 | 156098 |
| 52 | Kaisi Oriental | Dibindi | ECC/CPCA |  |  | 95000 |
| 53 | Kaisi Oriental | Kole | ETAT/BDOM |  | 1983 | 67700 |
| 54 | Kaisi Oriental | Lodja-nord | ETAT/BDOM |  | 1986 | 120000 |
| 55 | Kaisi Oriental | Wembonyama | ECC/CMCC |  | 1982 | 110000 |
| 56 | Nord Kivu | Katwa | ECC/CBK |  | 1983 | 245310 |
| 57 | Nord Kivu | Musienene | BDOM |  | 1983 | 142506 |
| 58 | Nord Kivu | Oicha | ECC/CECA |  | 1982 | 141900 |
| 59 | Sud Kivu | Kaziba | ECC/CELZ |  | 1983 | 80000 |
| 60 | Katanga | Songa | ECC/CEASJ |  | 1987 | 144155 |
|  |  |  |  |  |  |  |
|  |  |  |  | **Total Population** | | **8,501,294** |



**E. Training Needs for Malaria**

The original scope of work for this assignment was amended to include an assessment of training needs of the MOH, NGO's, labs, and health facilities for appropriate diagnosis and management of malaria as per PNLP country strategy. The time frame and contacts of this assignment did not permit a full assessment of training needs. However, a preliminary assessment of training needs with respect to health zones was possible.

Based on discussions with the director of the National Program to Combat Malaria (PNLP), a recent needs-assessment for malaria by BASICS II, and discussions with ECC-SANRU personnel, this report concentrates on an assessment with regards to training needs at the health zone level and possible training strategies to meet training needs.

1. Objectives of PNLP

Africa accounts for 90% of malaria cases in the world, while Congo, with 4.5 million cases per year, accounts for 10% of the malaria cases in Africa. According to a 1991 study, the average child under five years of age will have ten malaria episodes per year. Similarly Africa accounts for 90% of mortality due to malaria, with Congo registering 300,000 malaria deaths per year.

The Objective of the National Project to Combat Malaria is to:

*Reduce the morbidity and mortality rates for malaria while targeting high risk groups of children under fives years of age, pregnant women and non-immune persons.*

The strategies of PNLP with respect to these objectives are consistent with primary health care and within the framework of the “Roll Back Malaria” initiative. These basic strategies include:

1. early diagnosis and correct treatment;
2. chemo-prophylaxis for pregnant women;
3. vector control, especially large-scale promotion for the utilization of Insecticide Treated Materials (ITMs) and environmental sanitation;
4. epidemiological surveillance and epidemic control;
5. Behavioral Change Communications and Information, Education, Communications methods
6. Research, and
7. Institutional Strengthening.

Support activities and systems to implement the basic strategies will include a combination of training, supervision, evaluation, and partnerships.

2. A Recent Needs-Assessment for Malaria

A recent trip and preliminary report by Mike McDonald concerning the malaria component of BASICS II reported the following training-related findings:

* There is a wide variation in treatment guidelines. All begin with chloroquine as a first line treatment, but some then go to amodiaquine, some to sulfadoxine-pyremethamine and some directly to oral quinine.
* Diagnostic facilities were also extremely variable, with some mission networks with what sounded like a good system of supervision and retraining – and others with really no quality assurance or retraining for either the laboratory or clinical services.
* All the major NGOs said they would welcome guidelines if they were available. One international NGO said that they included Fansidar in their drug kits for Burundi and Rwanda, but not in DRC, simply because there was no national policy.
* Key to the entire [Roll Back Malaria] project is the ability to form “partnerships” and collaborative activities between the policy setters: the PNLP, and the implementers: Mission networks, and NGOs.

3. Training needs at the health zone level

The training needs of a typical health zone for malaria are shown in Table 8. This example assumes a health zone with twenty health centers and a personnel that includes a Medical Chief of Health Zone (MCZS), a zonal trainer and nursing school instructor; a water & sanitation coordinator, 3 lab technicians; 20 health center nurses, and 20 community outreach workers.

Table 8 also suggests the relative training importance for each of these persons with regards to the strategic objectives of PNLP. This is illustrative, but does suggest and provide a practical framework for quantifying training needs with respect to PNLP objectives.

Based on the above training profile for one typical health zone, it is possible to estimate training needs for all health zones, by region or by project. For example, a SANRU III project to assist 60 health zones would need to train approximately 60 MCZS, 90 trainers, 60 water & sanitation coordinators, 180 lab technicians, 1,200 health center nurses, and 1,200 community outreach workers.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Table 8: Training Needs at the Health Zone Level | | | | | | |
| **Training Aspect** | **Medical Chief of Health Zone** | **Trainer & Nursing Instructor** | **Water & Sanitation Coordinator** | **Lab**  **Technician** | **Health Center Nurse** | **Community Outreach**  **Worker** |
| Training  Perspective | Planning, Management  Technical | Training of Trainers | Vector Control & Community Mobilization | Training of Trainers | Curative & Preventive Care; IEC | BCC, IEC &  Community Mobilization |
| Number per HZ | 1 | 1.5 | 1 | 3 | 20 | 20 |
| *Training Emphasis* |  | | |  |  | |
| Early diagnosis & correct treatment | XXX | XX | X | X | XXX | XX |
| Chemo-prophylaxis pregnant women | XXX | XX | X | X | XXX | XX |
| Vector control: ITMs & Env. San. | XX | XX | XXX |  | X | XX |
| BCC & IEC | XX | XX | XXX |  | XX | XXX |
| Epidem. surveillance & control | XXX | XX | X | X | X | X |
| Research | XXX | X | X |  | X |  |
| Institutional Strengthening | XXX | X | X |  | X |  |
| Other |  | Training of Trainers |  | Lab |  |  |

1. Training strategies

There is no one approach or strategy for training that can accommodate the variety of personnel and training materials. Therefore, a training strategy is suggested for each group of trainees using SANRU III as an example. In general, however, training for a disease specific program like malaria could and should be included within a broader training program to encourage vertical and horizontal integration as recommended by the PAT of the Ministry of Health.

The training of Medical Chiefs of Health Zones (MCZS) could be included as a malaria module within a two-week training in planning and management of health zones. Training modules for planning and management of health zones already exist and could be easily updated. UNIKIN and SANRU III drawing on a national pool of former MCZS and consultant trainers could organize such training. If such a course took place twice a year, with 15 participants per session, the training of 60 MCZS could be completed in two years. These training sessions could also be decentralized to a regional level. For example, a training session at Nyankunde (near Bunia) could be organized for 15 MCZS from health zones in Province Oriental and North Kivu. A training team of 3 or 4 trainers would travel to Nyankunde to facilitate the training.

The training of a zonal trainer and nursing instructor could use the same strategy as for MCZS, i.e., include a malaria module as part of a general training of trainers program. The curriculum for such a trainer course already exists at SANRU. Approximately 25% of health zones have a nursing school. In the case of SANRU III, 50% of the 60 proposed health zones have a nursing school. The training could be done at, or at least organized by, UNIKIN in collaboration with SANRU III.

At one time most health zones had a water and sanitation coordinator trained by the SANRU project. This was a three part training program developed in collaboration with WASH, i.e., three two week training sessions separated by at least six months of implementation. A refresher course for existing Water and Sanitation Coordinators could include a malaria module with emphasis on vector control and community mobilization. Given the environmental nature of this work, this training would best done at the health zone level with participants grouped by region or sub-region.

With regards to laboratory testing, it is assumed, for the purposes of this assessment, that testing for malaria in not being done at the health center level, but only in hospital and reference health center labs. This type of training could be done as an in-service training by an itinerant lab trainer moving from health zone to health zone. It may be possible for neighboring health zones to train lab technicians from two zones at the same time.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Table 9: Training Strategies for SANRU III (60 Health Zones)** | | | | | |
| **Trainee** | **Nbre** | **Venue** | **Duration** | **Content** | **Trainers** |
| Medical Director of Health Zone | 60 | Nat/Reg | 2 weeks | Planning, Management  + Malaria Module | Organized by UNIKIN and SANRU with pool of MCZS and Mgmt trainers |
| Trainer & Nursing Instructor | 90 | Nat/Reg | 2 weeks | Training of Trainers + Malaria Module | UNIKIN organized  with National pool of TOT specialists |
| Water & Sanitation Coordinator | 60 | Regional | 2 weeks  refresher course | W/S + Vector Control & Community Mobilization | SANRU organized  with National pool of  W/S trainers |
| Lab  Technician | 120 | Health Zone | 1 week  refresher course | All lab tests + malaria tests | Itinerant Lab Trainers  train 4-6 lab techs  at a time |
| Health Center Nurse | 1200 | Health Zone | 1 week  refresher course | Curative & Preventive Care; IEC | Organized by HZ trainer  with outside facilitator  ( if required) |
| Community Outreach  Worker | 1200 | Health Zone | 1 week  refresher course | BCC, IEC &  Community Mobilization | Organized by HZ trainer  with outside facilitator  ( if required) |

The training of health center personnel and community outreach (or community-based) workers requires a training strategy within the health zone. The training of the MCZS and at least one zonal trainer or nursing school instructor should take place before this training occurs (unless the health zone has adequate existing training personnel). A general rule of thumb is that there should be one in service training session per person per year. That training should include a malaria module to review and explain national guidelines for treatment and prevention of malaria, including information on ITMs. The training would need be followed by supervision at the field level.

**F. Lessons Learned from SANRU and ECZORT**

The purpose of this component of the SOW was to identify lessons learned from the SANRU and ECZORT projects as an input in developing USAID's country strategy and for an umbrella-NGO project. Here are some of the major lessons learned.

1. *Primary health care in Congo during SANRU I/II was well-defined and popularized within the conceptual framework of Alma-Ata*.

The basic design of SANRU Basic Rural Health embraced all eight components of primary health care as defined at Alam-Ata in 1978. This design resulted in the comprehensive approach that SANRU used to encourage integrated planning and implementation at the health zone level. Had SANRU been designed two years later, it would probably have been entitled the “Rural Child Survival Project,” and, at least in my mind, would not have been as effective or successful.

SANRU's efforts to define and popularize the concept of primary health care and health zones throughout Congo was probably the least expensive and most effective activity of SANRU I. It firmly established SANRU's reputation in the area of PHC documentation and helped convinced many rural hospitals managed by NGOs to become involved in the national PHC strategy. Even the most isolated rural program learned that they were not working in isolation, but were an important geographical component of a much larger effort.

1. *Decentralized health zones were the key operational unit for primary health care development.*

The health zone decentralizes the planning and management of primary health care to the local level where the involvement of community action groups and health centers are the building blocks for curative, preventive and promotive care. Decentralized health zones are the keys to translating primary health care theory into the practical and manageable implementation of accessible and affordable primary health care programs.

The 1991 SANRU evaluation commented that

*The concept of the health zone is a strong building block for the future development of the Zairian health system. By keeping this concept viable, SANRU can offer to a future, more development-minded GOZ a model, based on the health zone concept, on which to build a sustainable, effective, and efficient national health system.*

SANRU’s lessons learned within the framework of health zones include the following:

o Boundaries of health zones are best determined with respect to population, existing medical infrastructure as well as ethnic and/or geographical areas.

o The health zone provides uniformity of planning, supervision and statistical reporting of all medical activities within a defined geographical area.

o Resources provided in adjacent health zones do not result in a duplication of services for the same population as they might if there were no health zone limits.

o Coordination of government, non-government, and international donor organizations is possible by clearly identifying which donors are to assist which health zones or which assistance a donor might provide across all health zones.

o The health zone concept permits the definition by the MOH of an assistance package for international donor assistance and project proposal development.

o The health zone decentralizes the planning and management of primary health care to the local level where the involvement of community action groups and health centers are the building blocks of a health zone.

o The inclusion of non-government organizations such as churches and private enterprise in the management of health zones encourages international health assistance directed at the private voluntary and private enterprise sectors.

o A Health Information System based on geographically defined health centers and health zones provides the denominator for monitoring and evaluation of health care service activities.

o The health zone provides a infrastructure for inter-sectoral development and the integration of other development activities such as agriculture, water and sanitation.

1. *Community participation and financing of primary health care are essential to program sustainability and should be encouraged but not exploited.*

Community participation is not simply going to the health center, or taking your child to the under-fives clinic or mobilizing materials for spring capping. True community participation must result in community empowerment to discuss, plan, and organize actions to resolve health problems. Some of the lessons learned from communities during SANRU I and II are that:

o The number one expressed need by communities is usually to have an improved water supply.

o Community perception of development needs provide an excellent entry point to encourage community empowerment, e.g., via a water and sanitation program.

o Community perception of improved health conditions relate primarily to decreases in morbidity and mortality.

o Community financing through user fees has been the primary source for sustaining health centers and primary health care in Congo.

o Creative motivation mechanisms to stimulate community empowerment are best designed at the health zone level rather than imposed by regional or national levels.

1. *Non-Governmental Organizations (NGOs) provide efficient management and important contributions to health zones and primary health care.*

The strengths and lessons learned from NGO involvement in primary health care in Congo are that:

o The medical work and infrastructure of NGOs in Congo evolved through three generations from hospital to community to health zone systems, and provided support for the development and sustainability of primary health care.

o Church NGOs are particularly effective in their emphasis on community involvement that cares for the wholeness of individuals and families and not just medical ailments.

o Health zones managed in collaboration with NGOs demonstrate significantly higher access to primary health care and utilization of services as demonstrated by vaccination coverage rates.

o NGO management or co-management of health zones is a excellent example (although problematic) of church/state collaboration in the delivery primary health care.

o NGO collaboration with national and international partner organizations is an important financial support for health zones and primary health care, including emergency relief efforts.

5. *Registration of NGOs with USAID requires several approaches.*

ECZORT was a partnership project (1985-86) between the ECC (then ECZ) and the Organization for Rehabilitation through Training to assist NGO-managed health zones. The funding source for the ECZORT required that all assisted health zones be officially registered as an NGO with USAID. In the case of ECC this only required one registration, i.e., by registering the umbrella-NGO, ECZ, all of its 60 member communities were considered to also be officially registered. ECZORT tried unsuccessfully to do the same thing with the Catholic Church. Finally ECZORT moved to the peripheral, diocese level to find that registration with USAID was much more easily accepted at that level. As a result a number of dioceses were registered and their health zones were assisted by ECZORT.

6. *Poor communication and transportation systems can actually facilitate decentralization.* The poorer the communication system, the less temptation and capacity there are to centralize the process of decentralization.

Congo successfully decentralized to health districts despite having only six short (and badly maintained) paved roads in the whole country, and a telephone system that worked part-time. However, this weakness became an advantage for decentralization. This expert from “Management and Machiavelli” says it all:

*It is arguable that one reason why the Roman Empire grew so large and survived so long - a prodigious feat of management - is that there was no railway, automobile, airplane, radio, paper, or telephone. Above all, no telephone. And therefore you could not maintain any illusion of direct control . . .*

7. *A project-of-projects environment can encourage decentralized ownership of primary health care programs and management.*

Too much planning for decentralization at the national level can lead to centralized decentralization. On the other hand, a "project of projects" environment can facilitate decentralization without dictating all the implementation details. Each decentralized health zone should pull resources from the project, rather having resources pushed on them.

SANRU found that this project-of-projects strategy was a more efficient use of resources because it provided assistance as health zones were ready for it, rather than trying to bring everyone up to the same standard before providing a certain type of assistance. This strategy also helps to define the role of project staff as facilitators to get resources to sub-projects, rather than telling sub-projects what to do. SANRU also found that the "fast-track" development of several health districts served as a catalyst and "classroom" for other districts, and create a healthy competition between health districts.

8. *Decentralization is power sharing and must accept some diversity of program adaptation and management at the local level.*

Many countries have failed in decentralizing their health systems because they have tried to impose one health district model, including program interventions and management procedures, on all health zones. This results in a situation where the health zone personnel are implementers rather than planners. As a result program ownership at the local level is weak, and programs are poorly adapted to the local context – cultural, epidemiological, geographic, and management.

The Ministry of Health in Congo has generally been very supportive and successful in allowing decentralization to develop from a bottom-up or middle-out approach. While the national level is clearly responsible for establishing technical norms and supervising their implementation, it at the same time as allowed a great deal of flexibility and adaptation at the local level in the area of health services delivery and health zone management and co-management in collaboration with NGOs.

**G. An Annotated Bibliography for SANRU**

The purpose of this component was to compile an annotated bibliography of reports and key documents from the SANRU/ECZORT period that could be useful in preparing USAID's country strategy and/or in the development of a proposal by an umbrella-NGO.

1. **Etude d’Impact des Services des Soins de Santé sur l’Etat de Santé de la Population, Munkatu Mpese, et al, SANRU, Dec 1990.** This study establishes the research protocol and baseline data to measure the impact primary health care in five health zones – Vanga, Mokala, Tsudi-Loto, Lusambo, and Kabongo. A followup study at least in the neighboring health zones of Vanga and Mokala would be of interest.
2. **SANRU I Mid-Term Project Evaluation, 1984.** Findings, recommendations and lessons learned from SANRU I.
3. **SANRU II Mid-Term Project Evaluation, 1987.** Findings, recommendations and lessons learned from SANRU II.
4. **La Gestion des Soins de Santé Primaires: Rapport Final de la Conference Annuelle 1989, SANRU, 1989**.
5. **Rapport du Seminaire de Formation des Coordinateurs en Eau et Assainissement, Itoko Y’oluki et al, 1991.** This is a typical training report for the training of Water and Sanitation Coordinators. Important to look at before future training in this area.
6. **Comparative study of Vaccination Coverage in Health Zones for 1986 and 1988.** This study demonstrated that vaccination coverage was significantly higher in health zones managed and co-managed by an NGO.
7. **SANRU Activity Report, January-June, Nlaba-Nsona et al., SANRU, 1982.** This was the first activty report of SANRU, and important for historical perspectives as to how the project was originally organized. Similar reports exist for most project years.
8. **Planning primary health care Resources for Zaire, Baer et al, 1985.** This article describes the planning process for developing several scenarios for the implementation of health zones by the Ministry of Health and Ministry of Plan.
9. **Wibange: Traditional Birth Attendants - Training and Supervision (film). Galloway et al. 1988.** This 16mm film documents the training of TBAs in the health zone of Karawa (Equateur). A copy of the film is located in the SANRU documentation center.
10. **Counseling For AIDS: An approach for rural areas (in French), Duale et al., 1990.** This booklet describes strategies for developing counseling progrrams for AIDS appropriate for rural health zones.
11. **SANRU - Lessons Learned (1981-1991), Baer, Apr. 1992.** This document summerizes the history, activities, evolution and lessons learned for SANRU I and II.
12. **"A" is For Alma-Ata: A Primer for Primary Health Care, Baer, 1989.** This booklet explains the principles of Alma-Ata for the lay person. It includes the graphics of PHC, A to Z and the illustrated story “The Village and the Lions.”