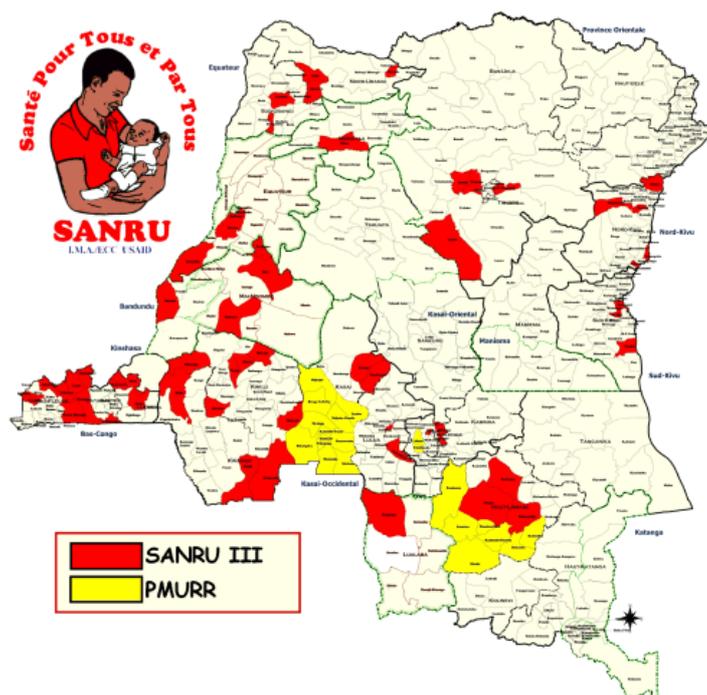


SANRU III FINAL EVALUATION



by
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ABOUT THE AUTHORS

This final evaluation report was prepared by a team comprised of Malonga Miatudila (Senior Public Health Specialist, Team Leader), Jean Kidinda-Shandungo (Senior Education Specialist, Consultant), and Franklin Baer (Senior Advisor to IMA & ECC for DR Congo).

Malonga Miatudila holds a M.D. (from Lovanium University, Kinshasa, Congo, 1971) and a MPH degree (from Tulane University, NOLA, USA, 1976). He recently retired from the World Bank as a Senior Public Health Specialist. His expertise includes the design, implementation, monitoring, and evaluation of health policies, strategies, and projects. Since 1971, he has led the management of many health development activities. He participated in the design of SANRU I and served as the first representative of the National Government in the project before moving to head the *Naissances Desirables*, the country's national family planning program. Miatudila is a medical doctor with significant experience in the areas of stakeholder involvement and decentralization. During his 16 year association with the World Bank (from January 1989 to June 2005), he integrated these and other critical concerns in the design and management of population, health, nutrition, and HIV/AIDS projects in over 15 countries.

Jean Kidinda-Shandungo holds a PhD from Vanderbilt University, Nashville, TN, USA. He held a position of Coordinator of the Department of Training and Documentation at SANRU I and II in the period 1984-1992 before moving to the academic field where he became Rector of the Universite Chretienne de Kinshasa and Head of the Department of Management and School Administration at the Universite Pedagogique Nationale. Later on, he became involved as Governor of the Bandundu Province in the integration of health activities into other programs at the territorial level. Presently, he is Coordinator of the Health Training Project at WHO-Kinshasa.

Franklin Baer has graduate degrees from Antwerp (Diploma of Tropical Medicine), Johns Hopkins (MSH-TM) and Tulane (DrPH) Schools of Public Health, but says he learned primary health care management through 30 years of work in Africa. He began in the 1970s in DR Congo (then Zaire) as a volunteer with Mennonite Central Committee when he helped create the first FBO co-managed health zone. He later became the project manager for the SANRU Basic Rural Health I/II projects (1982-1991) to create 100 decentralized health zones. He has worked as an independent consultant since 1991 with a special interest in developing decentralized health systems involving MOH and FBO collaboration. A 2002 national study on Stewardship and Health Systems Development in DR Congo listed Baer among the ten most frequently cited persons who shaped Congo's national health system. Dr. Baer currently serves as senior advisor to Interchurch Medical Assistance for partnership projects in a number of countries.

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The present evaluation would not have been possible without the contribution of colleagues from SANRU, USAID, and MOH. SANRU staff members devoted a sizable amount of their time to meet with us and provide the necessary documentation and information on the project's activities. Under the leadership Dr. Felix Minuku, SANRU Technical Director, the project's technical advisors have been supportive throughout this evaluation process both in Kinshasa and during field visits. SANRU staff members in charge of support services, including the drivers, have also been instrumental in providing much needed logistical assistance.

The Evaluation Team wishes also to express gratitude to the colleagues of the MOH for their valuable contribution, particularly to the representatives of the following national programs: PNT, PNLS, PNTS, BNT, PNTHA, and PNLP for providing insight information not only on the MOH strategy regarding health care in DRC but also on their impression on SANRU's specific contribution. The Team's appreciation is extended to Dr Lokadi, Directeur de Cabinet of the Minister of Health and Dr. Kalambay, Directeur des Etudes et de la Planification of MOH.

The final evaluation methodology was adapted from the current Child Survival Final Evaluation guidelines as published at ChildSurvival.com. These guidelines are specifically for centrally funded projects of the Child Survival and Health Grants Program (CSHGP). IMA/ECC has, however, opted to use and adapt these guidelines as the recommended assess methodology for the final evaluation of SANRU III.

It is worth mentioning that the Evaluation Team carried out its duties primarily through desk work of documents (see **Annex 1**) and interviews. The team met with a large number of representatives from both national institutions and donors' agencies. However, it visited only two health zones outside Kinshasa, the capital city, namely Masa and Kimpese. Less of a need to visit many health zones was felt given the various evaluation and reports that had been recently completed, such as the January 2005 SANRU Conference and the May 2005 External USAID. Most of the Team's conclusions are based on these and other reports.

ACRONYMS

AIDS	Acquired Immuno-deficiency Syndrom
APOC	African Project for onchocerciasis control
ASRAMES	Association Régionale d'Approvisionnement en Médicaments Essentiels
BASICS	Basic support for institutional child survival
BCC	Behavior change communication
BCZ	Bureau central de zone
BDOM	Bureau des oeuvres medicales catholiques
BNLO	Bureau national de lutte contre l'onchocercose
BNT	Bureau national de la trypanosomiase
BOD	Burden of diseases
CAMEKI	Centrale d'achat des medicaments essentiels de Kisantu
CBM	Christofell Blindel Mission
COSA	Comite de sante
CPF	Counter-part fund
CRAFOD	Centre Regional d'Appui a la Formation et au Developpement
CRS	Catholic relief services
CYP	Couple-year of protection
DALY	Disability-adjusted life years
DFID	Department for International Development
DOTS	Directly observed therapy strategy
DRC	Democratic Republic of Congo
DTC	Vaccin contre la diphterie, le tetanos et la coqueluche
ECC	Eglise du Christ au Congo
ECD	Equipe-Cadre de District
FBO	Faith-Based Organization
GOC	Government of Congo
HGR	Hopital general de reference
HIS	Health information system
HIV	Human immuno-deficiency virus
IMA	Inter-church medical agency
ITN	Insecticide-treated bed-net
KPC	Knowledge, practice, and coverage survey
MCZ	Medecin-Chef de Zone
MOH	Ministry of Health
MTCT	Mother-to-child transmission of HIV
NGO	Non government organization
OFDA	Office of Foreign Disaster Assistance
OR	Operation research
PARSS	Programme d'Appui pour la Rehabilitation du Secteur de la Sante
PCIME-C	Prise en charge integree des maladies de l'enfance a base communautaire
PCUSA	Presbyterian Church of United States of America
PHC	Primary health care
PMA	Paquet minimum d'activites
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-child transmission of HIV
PMURR	Projet Multisectoriel d'Urgence pour la Rehabilitation et la Reconstruction
PNLS	Programme National de Lutte contre le SIDA
PNTHA	Programme National de Lutte contre la Trypanosomiase Humaine
PNTS	Programme National de Transfusion Sanguine
PVO	Private voluntary organization
RC	Relais communautaire
SANRU	Project "Sante rurale"
SNHR	Service National d'Hydraulique Rurale
STI	Sexually transmitted infection
THA	Trypanosomiase Humaine Africaine
USAID	US Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

1. Brief Description of the Program and its Objectives.

SANRU III was established to reach about 10 million persons with primary health care (PHC) services with a cost of \$25,000,000 to USAID. Initially, the specific objective of this five-year operation was to strengthen and sustain the capacity of 63 dispersed health zones for the management of priority PHC program interventions and support systems.

SANRU III was organized into twelve components, namely: (1) minimum package of primary health care activities (PMA, *Paquet minimum d'activites*); (2) activities for the control of HIV/AIDS and sexually transmitted infections (STI); (3) nutrition improvement; (4) activities for the control of three emerging diseases, namely: tuberculosis (TB), trypanosomiasis (THA, *Trypanosomiasis humaine africaine*), and onchocerciasis; (5) malaria control activities; (6) water and sanitation; improved access and maintenance (7) health zone planning and management; (8) training and supervision; (9) financial sustainability; (10) behavior change project communication; (11) essential drugs and medical materials system; and (12) Health information system (HIS), monitoring, and evaluation.

2. Main Accomplishments of the Program.

SANRU achieved the following:

- 1) **Significant** increase in the capacity of 56 health zones to provide a range of primary health care activities, including- basic curative care, immunizations, growth monitoring, prenatal care, safe deliveries, family planning, and health education;
- 2) **Moderate** increase in the capacity of HZs to combat STIs and **significant** increased capacity to combat HIV/AIDS through blood transfusion (near 100% safety of transfused blood and community awareness).
- 3) Implementation of **significant** nutritional interventions aimed at decreasing childhood morbidity and mortality;
- 4) **Moderate** increase in the capacity of 56 health zones (HZ) to control Tuberculosis, 8 HZs to control Trypanosomiasis and 14 HZs to control Onchocerciasis;
- 5) **Significant** expansion of malaria control activities at the household (particularly through use of insecticide treated bed-nets), community, health center and hospital levels (particularly through intermittent preventive treatment of pregnant women and adequate case management);
- 6) **Significant** increase access to potable water and other clean village programs aimed at reducing the prevalence of water-borne diseases;
- 7) **Moderate** development of transparent management systems together with the participating communities;
- 8) **Moderate** increase in the health zone capacity for local training for specific program interventions and for supervision-formation to personnel;
- 9) **Limited** improvement of sustainability and financial accessibility of health services;
- 10) **Significant** reinforcement of the capacity of 56 health zones to encourage behavior change communications (BCC);
- 11) **Moderate** increase of the population access to a secure supply of essential medicines;

- 12) **Moderate** improvement of data collection, analysis and decision-making for the Health Information System (HIS) as part of local planning and operations research.

3. Highlights from the Comparison of the Baseline and Final Evaluation Surveys

The activities planned under SANRU III have been satisfactorily carried out in spite of the difficult circumstances in the country as shown in data from SANRU-assisted health zones. Comparison of the baseline and final evaluation surveys indicates the striking progress which the project achieved between 2001-2005. The project greatly expanded provision of various primary health care services. As shown in Table 1 below, the service expansion impacted on mortality and morbidity, particularly of children and mothers.

Table 1: SANRU Results and Targets

Indicator	2006 Target	2001	2005	
		Actual	Actual	Actual/ Target (in%)
Results Indicators				
Utilization of prenatal services (as number of new prenatal visits per 100 expected pregnant women)	80	73.2	85.2	106.50
Percent of assisted deliveries	80	45.9	64.3	80.38
Utilization rate of well baby services (as Number of new well-baby visits per 10000 inhabitants)	80	78.0	94.7	118.38
Number of new curative contacts per 100 inhabitants per 12 months	40	26.6	34.4	86.00
Immunization coverage rate, BCG	80	55	80	100
Immunization coverage rate, DTC3	70	51	74	105.71
Immunization coverage rate, Measles	70	49	68	97.14
Immunization coverage rate, Polio	75	53	73	97.33
Contraceptive coverage rate (as cumulative number of couples-years-of-protection provided)	108,000	n.a.	60,720	56.22
Contraceptive coverage rate (as % of women 15-49 years old using a modern contraceptive method)	n.a.	0.5	11.4	n.a..
Blood transfusion safety level	100	69.0	96.7	96.70
Coverage rate with regard to services for the prevention of mother-to-child transmission (MTCT) of HIV (as % of HIV+ mothers provided with adequate MTCT)	n.a..	0	18	n.a.
Percent of population with access to potable water	n.a.	33	68	n.a.
Case-fatality rate for measles (%)	2.5	n.a.	n.a.	n.a.
Case-fatality rate for malaria (%)	n.a.	n.a.	n.a.	n.a.
Tuberculosis detection rate (in %)	n.a.	41	70	n.a.
Tuberculosis cure rate (in % of)	n.a.	69	85	n.a.
Percent of household with insecticide-treated bed nets	60	0	20	33.33
Percent of at risk villages covered with tse-tse fly traps	n.a.	n.a.	n.a.	n.a.
Impact Indicators				
Percent of babies weighing less than 2500 grams at birth	n.a.	10.6	8.0	n.a.
Incidence of malaria (as % of children with fever in the previous 14 days)	n.a.	25	KPC	n.a.
Incidence of diarrhea (as % of babies with diarrhea in the previous 14 days)	n.a.	10.3	KPC	n.a.
Percent of babies weighing less than 2500 grams at birth	n.a.	10.6	8.0	n.a.
Percent of women 15-19 years old who are HIV sero-positive	n.a.	N.D.	n.a.	n.a.
Number of deaths from tuberculosis per 100,000 inhabitants per year	n.a.	N.D.	n.a.	n.a.
Neonatal Mortality Ratio (as number of hospital deaths among children aged 0 to 7 days per 1,000 live births)	n.a.	17	11.7	n.a.
Maternal Mortality Ratio (as number of maternal deaths in hospitals and maternities per 100,000 live births)	n.a.	370	240	n.a.

Note : KPC. stands for « Data will become available after publication of the final KPC Report”.

Sources: SANRU : KPC, 2002 ; Richard Green : Field Assessment of SANRU III, 2002 ; SANRU : Synthèse des rapports des zones de santé appuyées par SANRU III, 1^{er} Semestre 2005

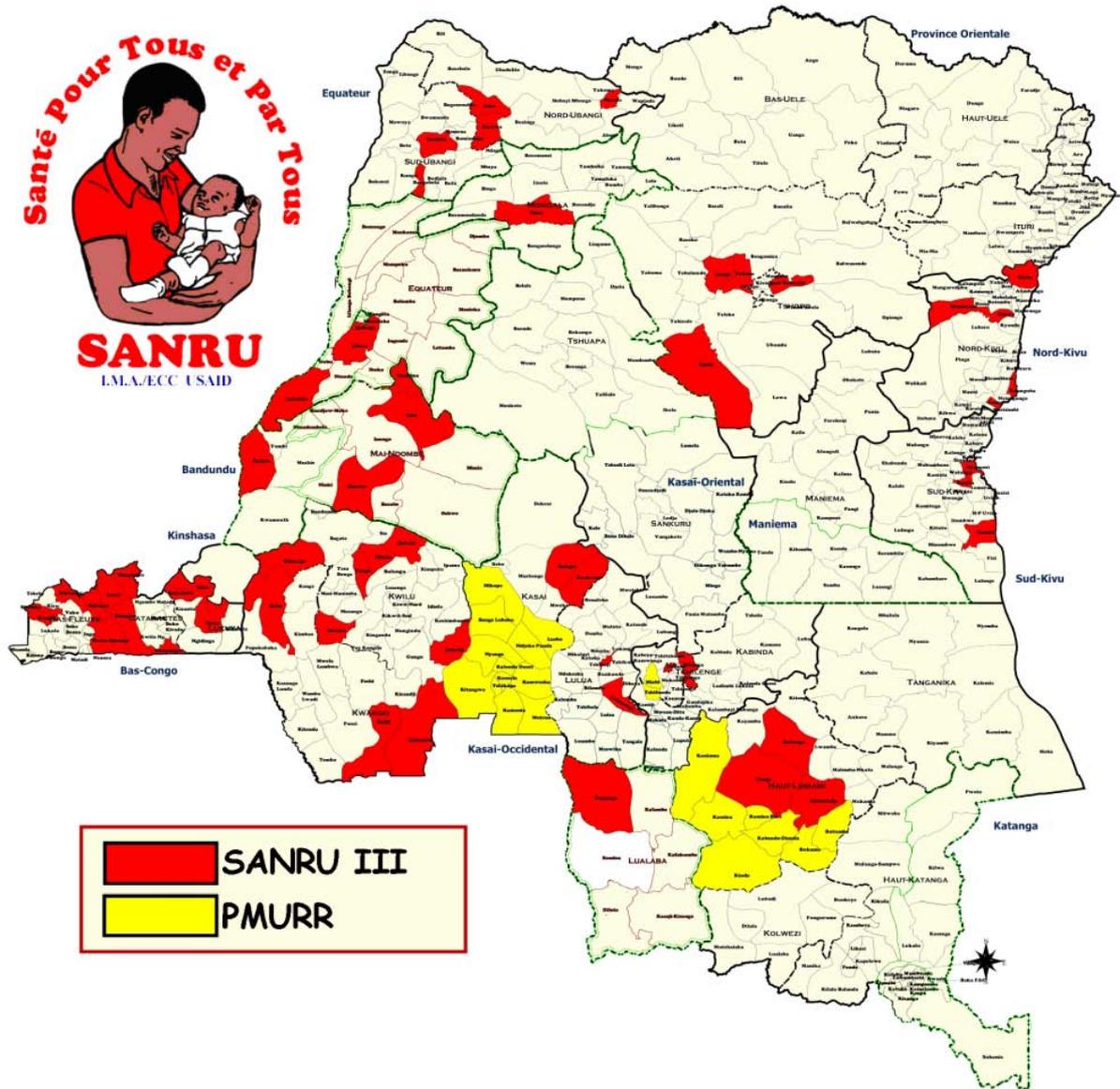
4. Main Conclusions and Lessons

Overall achievement of the SANRU's objective was highly satisfactory and above initial expectations. The project could have achieved even more imposing results had some constraints – namely: pervasive poverty, inadequate incentives for health workers, donor government regulations, excessive centralization, and needless delays - been adequately addressed.

The implementation of SANRU III made it possible to draw a set of very useful lessons. The project has clearly indicated among other things that:

- 1) Development-minded models are more cost-effective than short term disaster responses.
- 2) Success is possible in a volatile situation and in a context of weak administrative and institutional capacity if innovative, adequate mechanisms are established to address major constraints;
- 3) The need for adequate incentives for health workers is crucial in all operations;
- 4) Fantastic health results can be derived from a number of simple but effective technologies.
- 5) Partnership, including with faith-based organizations (FBO) is tremendously beneficial;

Figure 1: Map of SANRU III Assisted-Health Zones



1. Project Data

Table 1: Project Data Summary

Project Type	Cooperative Agreement
Project amount	
Initial budget	\$25,000,000
Latest budget	\$26,564,850
Actual expenditure	
Date of Signature	May 2001
Expected Closure Date	May 2006
Implementing Agency	ECC-IMA
Main Donor Agency	USAID

2. Assessment of Development Objective and Design

SANRU III was established in May 2001 to reach about 10 million persons with primary health care (PHC) services with a cost of \$25,000,000 to USAID, its donor, making it one of the largest USAID-supported health project worldwide. Initially, the specific objective of this five-year operation was to strengthen and sustain the capacity of 65 dispersed health zones for the management of priority PHC program interventions and support systems. The project's ultimate goal was to decrease the burden of diseases (BOD) and loss of disability-adjusted life years (DALY).

In May 2001, the five-year \$25,000,000 cooperative agreement, that USAID signed with Inter-church Medical Association (IMA) and ECC (*Eglise du Christ au Congo*) for SANRU III was based on the understanding that assistance would begin with 65 health zones, but with plans to increase to 80 health zones. The project objective was pertinent and feasible. It targeted and concentrated on a set of issues that contribute to the unacceptably low performance of the health sector, an issue that prevents DRC and most other poor countries from enjoying health results commensurate with their spending in the sector.

SANRU III rightly adopted the concept of the health zone as a building block to respond to Congo's emergency needs and prepare for the future development of the country's health system. This approach supports the principles of integrated medicine (primary health care) and the establishment of geographically defined zones. The concept was discussed and adopted in 1975 during a national seminar organized by the churches and with full MOH participation. The health zone makes it possible for planning and management of primary health care to be decentralized to the level where communities can become effectively involved around local health facilities. This also improves planning, accountability as well as ownership, and avoids duplication of services. By keeping this concept viable and resisting the drive for short term disaster response, SANRU III offered the Democratic Republic of Congo (DRC) a more development-minded model and a strong foundation on which to build a sustainable, effective, and efficient national health system.

Later on, the same model was adopted by other donors, including the World Bank for its two recent interventions, namely the PMURR (*Projet multisectoriel d'urgence pour la rehabilitation et la reconstruction*) and PARSS (*Programme d'appui pour la rehabilitation du secteur de la sante*). A functioning decentralized health care system has constantly proven to be one of the best ways to prevent and respond to disaster situations. By 2001, the disruption of agricultural and health systems had made the Congo people extremely

vulnerable to disease and death. A more accessible and affordable health care system became a requirement for restoring the well-being of at risk populations and avert the need for costly disaster responses. Short term disaster responses have proven to be more costly than developing long term health care systems with the capacity to handle the disaster situations similar to the ones found in DRC. A functioning health zone would not only have the ability to handle medical needs, but would be able to respond to water and sanitation needs and expand activities required for nutrition promotion through a global and integrated assistance.

The SANRU III objective was fully consistent with the country's health sector policy priorities, as well as with the USAID DRC Action Plan for 2001. The Project was achievable within its time limit (2001-2006 or five years) despite, the worsening economic situation, the AIDS epidemic of the late 1980s, and the increasing political instability of the 1990s, that had robbed the country of most of the gains it had achieved. The potential for a SANRU III project was good for several reasons, including the following: (i) strong support of the Ministry of Health (MOH) to the idea of the project; (ii) existence of many directors of national programs, projects and agencies who were former medical chiefs of health zones assisted by SANRU or even former SANRU employees; and (iii) establishment of partnership with Interchurch Medical Assistance (IMA), an U.S-based organization with forty years of experience in the solicitation, packing, shipping and on-site management of pharmaceuticals and medical supplies.

At the time of project proposal, some risks were identified and appropriate mitigation measures were proposed. The identified risks included: (i) chronic instability and mismanagement of health zones run by the Government of Congo (GOC); and (ii) absence of a logistical system capable of ensuring rapid importation and distribution of essential commodities, including disaster assistance materials. To minimize the risk of failure and accommodate the Brooke Amendment, which blocked USAID assistance to or through the GOC, it was decided and agreed that SANRU III would shun away from State-run health zones and rely preferably on the NGO whose network has not changed significantly during the past turbulent years. The paramount importance of a working logistical system led SANRU III to plan its work through a network of decentralized NGO-managed pharmaceutical depots.

2.1 Project Components

As shown in Table 2, SANRU III was initially organized into twelve components, namely: (1) the minimum package of primary health care activities; (2) activities for the control of HIV/AIDS and sexually transmitted infections (STI); (3) nutrition improvement; (4) activities for the control of three emerging diseases, namely: tuberculosis (TB), trypanosomiasis (THA, *Trypanosomiasis humaine africaine*), and onchocerciasis; (5) malaria control activities; (6) water and sanitation; information and health; (7) planning and management; (8) training and supervision; (9) financial sustainability; (10) behavior change project communication; (11) Essential drugs and medical materials system; and (12) Health information system (HIS), monitoring, and evaluation. Activities for the control of onchocerciasis and trypanosomiasis were downgraded from SANRU III following recommendations made during the project assessment that USAID carried out in 2003.

Table 2: SANRU III Project Components and Objectives

Project Component	Component Objective
01: Minimum Package of PHC Activities	To increase the capacity of health zones to provide minimum packages of activities (PMA) for primary health care, including: basic curative care, immunizations, growth monitoring, prenatal care, safe deliveries, family planning (FP), and health education
02: HIV/AIDS and STIS	To increase the capacity of health zones to combat HIV/AIDS and STIs
03: Nutrition	To improve and promote nutritional interventions to decrease childhood morbidity and mortality
04: Re-Emerging Diseases	To increase the capacity to control Tuberculosis, Trypanosomiasis and Onchocerciasis in health zones where these are priority diseases.
05: Malaria	To promote an appropriate diagnosis, treatment and prevention for malaria at the household, community, health center and hospital levels.
06: Water and Sanitation	To reduce the prevalence of water-born disease by increase access to potable water and clean village programs.
07: Planning and Management	To promote the development of transparent management systems together with the participating communities
08: Training and Supervision	To reinforce the health zone capacity for local training for specific program interventions and for supervision-formation to personnel.
09: Financial Sustainability	To improve the sustainability and financial accessibility of health services
10: Behavior Change Communications	To reinforce the capacity of Health Zones to encourage behavior change communications (BCC)
11: Essential Drugs and Medical Materials System	To increase population access to a secure supply of essential medicines
12: Health Information System, Monitoring and Evaluation	To improve data collection, analysis and decision-making for the Health Information System (HIS) as part of local planning and operations research.
ALL COMPONENTS	To decrease the burden of diseases (BOD) and loss of disability-adjusted life years (DALY).

Each of the above mentioned components was highly pertinent to addressing health needs in the DRC – both perceived and observed - and highly strategic. Indeed, in putting emphasis on family planning, nutrition, and control of HIV/AIDS and a few other infectious diseases, SANRU III took into account three major constraints facing Congo, namely excessive fertility rates and unacceptably high prevalence of nutritional deficiencies and communicable diseases in the country’s population.

The idea of minimum package of health services (or PMA), strongly promoted by MOH, particularly in its May 2002 document untitled “*Normes Sanitaires de la Zone de Sante*”, is a cost-effective way for providing health services. Unfortunately, the idea was included in SANRU III as a central and critical concept despite persisting lack of agreement on, and clarity about the exact content of this package. In 2002, an MOH Working Group prepared initial proposals for the minimal list of activities to be delivered by primary health care

facilities with plans ultimately include essential work of the health zone general hospitals (HGR, *Hopital general de reference*), zone health team (ECD or *Equipe Cadre de District*); and regional and national hospitals (Cfr Annex 2). In December 2005, SANRU proposed to MOH to revise the PMA in collaboration WHO and other agencies. On January 25, 2006, the MOH organized a preliminary workshop with the view to progress toward formal adoption of the country's PMA. It is worth mentioning that most SANRU-assisted zones had already implemented the PMA as defined in the norms which MOH proposed in May 2002.

The organization of the project in twelve components was determined primarily by the need to accommodate an erratic availability of donor funds rather than to respond to the priorities of the health sector. This pragmatic, realistic drive had a major setback. The design that was adopted as a result of a sequential process led to juxtaposition, fragmentation, verticalization, overlapping, and inefficient use of resources. A more appropriate design would have been to combine interventions and allocate them between two levels, namely a service delivery and a management one.

The service delivery level would have been charged with the provision of a standardized package of health services. The content of this package was to be finalized and formally adopted by the MOH in agreement with by partners involved in the health sector in the country. The costing, financing, and introduction of the standard package in the assisted health zones should have been integrated among the central operational objectives of SANRU III. Ideally, the actual introduction of services at the local level was to be driven by requests from health zones formulated in their respective development plans. These plans were to specify infrastructure rehabilitation, re-equipment, and- where necessary- new construction for zone headquarters (BCZ, *Bureau central de zone*), primary health care centers (CS, *centres de santé*) as well as for HGRs; refresher and on-the-job training; disease surveillance and reporting; behavior change communication (BCC); and recapitalization of drug stocks where necessary. It was also to be understood that success with the package of services implied not only delivery of quality health care services but also the financial and cultural and financial accessibility of available services to the intended beneficiaries.

The management level (i.e national headquarters, provinces, and districts) was to provide support required for the smooth provision of the above mentioned package of services by health zones, including action research, studies, training, procurement of drugs and other essential supplies. Special attention needed to be taken to prevent high levels from getting involved in activities which can be implemented by lower levels.

Initially, the work under SANRU III privileged supply above response to community demand. As a result of this top-down approach – which could be partially explained by the urge to respond to the humanitarian needs in the 2001 DRC - , health zones were not asked to prepare and submit plans. Moreover, the inclusion of health zones in the Project was decided by the implementing agency with minimal input from the selected zones. Later on, the project started taking into consideration plans which health zones had prepared, particularly with regard to water and sanitation, EPI, nutrition, and community-based integrated management of child's illnesses.

2.2 *Quality at Entry*

Overall, quality at entry was satisfactory. As stated above, the project objective was relevant and consistent with health sector priorities of the Government as enshrined in the

Government's National Health Development Policy and the USAID Action Plan for Congo. Support for a better health care program and excellent diagnostic of key issues confronting the health sector were all positive aspects of quality at entry.

As indicated in Table 2, measurable indicators were identified and clearly defined for the activities of all components and the results of these activities. However, the initial project document failed to clarify targets for many indicators. In addition, no indicator was spelled out to assess the impact of achieving the objective. Moreover, targets went through numerous revisions during project implementation.

As indicated above, relevant lessons learned from two previous operations, namely SANRU I (1981-1986) and SANRU II (1986-1991), were taken into consideration in the design of the Project, particularly in the focus on decentralization and partnership between the Government and NGOs.

A major setback of design was an excessive optimism with regard to the economic recovery of DRC. SANRU III was faced with the unrelenting rising poverty and the dwindling capacity of the health system to recover parts of costs through fees-for-services. Under SANRU I, the high percentage of households' contributions to cost-recovery - more than 60 % - made it possible to satisfy the annual financial needs of a health zone with an additional external influx of 20,000 dollars. SANRU III budgeted a complement of 60,000 dollars per health zone and per year while a genuine evaluation could have shown that the actual requirements amounted at around 250,000 dollars as indicated in similar operations financed by the World Bank in DRC. A more realistic planning could have led SANRU III to decrease the number of health zones to be assisted with the 25 million dollar grant which USAID committed to provide. In June 2003, a USAID field assessment recommended that SANRU concentrate its efforts on a small number of high impact interventions and reduce its beneficiary population from 10 million to 7 million. An additional \$25,000 per health zone per year was deemed necessary and sufficient for the Project to achieve its public health targets. However, the proposed complement turned out to be insufficient to completely finance and develop the PMA.

2.3 Project Financing

As explained in details at Annex 3, SANRU III budget was based on the conclusion of a concept paper to provide assistance to up to 60 health zones. The paper had prepared three budget scenarios, namely: (i) a low-end scenario (with an annual budget of \$1,500,000 to assist 25 zones); a middle scenario (with an annual budget of \$3,100,000 to assist 40 zones); and high-end scenario (with an annual budget of \$5,000,000 to assist 60 zones). USAID indicated that their willingness to consider an unsolicited proposal for a high-end scenario. In May 2001, a five-year \$25,000,000 cooperative agreement was signed between USAID and IMA for SANRU III to provide assistance to 65 health zones, but with plans to increase to 80 health zones. The project went through various assessments and amendments. Its budget for the period 2001-2006 is summarized in **Table 3**. The details by year are available in **Annex 4**. It is worth mentioning that the Project leveraged additional assistance funds from a number of sources, including OFDA, DFID, Global Fund, APOC, and Pfizer (see Table 3 below for details).

TABLE 3: SANRU III Budgets by Earmark, 2001-2006

Project Component	Child Survival / Primary Causes	Micro-Nutrients	EPI	Polio	Malaria	HIV/AIDS	TB	Population	Eau/Asn & Making Cities Work	IDS: Disease Surveillance
Health Zone Support Systems	2,616	45	360	586	350	442	446	1,699	54	0
Program Interventions	6,264	312	381	418	2,372	683	548	1,369	377	47
Project Management – ECC	2,001	12	158	290	328	203	194	546	52	0
Project Management – IMA	1,079	10	26	30	118	56	35	88	10	0
Indirect Grant Mgmt Costs	1,018	28	67	86	239	108	96	279	36	3
Total Received from USAID	12,978	407	991	1,411	3,407	1,492	1,319	3,981	529	50
Earmark from USAID	14,122	85	200	1,500	3,400	1,400	1,400	4,063	675	650

Note: SANRU III received additional financing from OFDA (\$150,000 to support transition from relief to development); PMURR (\$17.7 million to support 19 additional health zones); Global Fund (\$1.9 million per year to support activities for the control of HIV and malaria in 25 health zones); DFID (about \$1 million to support purchase of ITNs); Pfizer (\$100,000 to support HIV control activities); and APOC (about \$ 250,000 to support community-directed distribution of ivermectin in 14 health zones).

3. Achievement of Activities and Objective

3.1 Achievement of Activities

Available data indicate that activities planned for SANRU III have been satisfactorily carried out in spite of the difficult circumstances in the country. Table 4 summarizes achievement under various activities. Pictures of some realizations are available at Annex 5.

Table 4: Achievement of Project Components

Project Component	Achievement
01: Minimum Package of PHC Activities	Significant increase in the capacity of 56 health zones to provide a range of primary health care activities , including, basic curative care, immunizations, growth monitoring, prenatal care, safe deliveries, family planning, and health education
02: HIV/AIDS and STIS	Moderate increase in the capacity of health zones to combat HIV/AIDS and STIs despite significant increase in number of pooled blood tested for HIV and implementation of PMTCT projects in over 24 sites.
03: Nutrition	Implementation of significant nutritional interventions aimed at decreasing childhood morbidity and mortality
04: Re-Emerging Diseases	Moderate increase in the capacity of a number of endemic health zones to control Tuberculosis, Trypanosomiasis and Onchocerciasis in health zones where these are priority diseases.
05: Malaria	Significant expansion of malaria control activities at the household, community, health center and hospital levels.
06: Water and Sanitation	Significant increase access to potable water and other clean village programs aimed at reducing the prevalence of water-born diseases.
07: Planning and Management	Moderate development of transparent management systems together with the participating communities
08: Training and Supervision	Moderate increase in the health zone capacity for local training for specific program interventions and for supervision-formation to personnel.
09: Financial Sustainability	Limited improvement of the sustainability and financial accessibility of health services

Project Component	Achievement
10: Behavior Change Communications	Significant reinforcement of the capacity of health zones to encourage behavior change communications (BCC)
11: Essential Drugs and Medical Materials System	Moderate increase of the population access to a secure supply of essential medicines
12: Health Information System, Monitoring and Evaluation	Moderate improvement of data collection, analysis and decision-making for the Health Information System (HIS) as part of local planning and operations research.
ALL COMPONENTS	To decrease the burden of diseases and loss of productive years of life due to communicable diseases and premature death.

Component 1: Minimum Package of PHC Activities. This component satisfactorily implemented a wide range PHC activities. Efforts made under this component included the following: village sanitation; rehabilitation of health facilities; supply of equipment, drugs and other essential consumables; provision of training for doctors, nurses, community workers and other personnel; organization of supervision visits; expansion of some simple but effective technologies; and elaboration of manuals capable of increasing the capacity of health workers to carry out their technical and managerial duties. By the end of 2005, a core of national and district trainers had been trained. In January 2006, an algorithm manual, which the Project had helped elaborate for blood transfusion security in 2004 with technical support from PNTS (*Programme national de transfusion sanguine*), was circulation in most health zones. SANRU III promoted a number of simple technologies at the community level. The technologies included spring capping, hand washing stands, traps, and micro-projects. As shown in Table 5, these efforts have resulted in rapid, impressive improvement in the provision of various sets of activities for primary health care, including basic curative care, immunizations, growth monitoring, prenatal care, safe deliveries, family planning, BCC and Community-based Integrated Management of Child Illnesses (PCIME-C, *Prise en charge intégrée des maladies de l'enfance au niveau communautaire*). With regard to family planning, SANRU ensured provision of an equivalent of 28,543 couples-years of protection (CYP) between January 2002 and September 2005, representing 47.01 % of the initial target of 30,000 CYPs (See Annex 5 for details). This contributed to increasing contraceptive prevalence from 0.5 to 11.4 in the project-assisted zones, corresponding to a yearly increase of 545%. Concerning PCIME, the period of July 1st 2005 through September 30th witnessed the implementation of following activities in 22 health zones that had been selected as PCIME-C pilot zones: (i) supervision of activities; (ii) distribution of SANRU fabric, cards and badges to community health workers; (iii) evaluation of hygiene component in 4 new health zones; (iv) distribution of education material on malaria, hygiene, immunization, family planning in the PCIME zones; (v) distribution of the “ten commandments for health” soccer balls and ballons. The implementation of primary health activities has been particularly significant in the SANRU-assisted health zones. In addition, actions that the Project carried out at the national level induced some ripple effect outside these zones.

Table 5: Evolution of Primary Health Care Services

Indicator (Definition)	2001	2005	Yearly Change (in %)	Result (as % of Initial Target)
Utilization rate of prenatal care services (<i>% of pregnant women with at least three prenatal visits in last twelve months</i>)	73.2	85.2	+4.10	
Utilization rate of maternity services (<i>% of assisted deliveries</i>)	42.3	64.3	+13	
Utilization rate of well baby services (<i>% of baseline population</i>)	78.0	94.7	+5.35	
Utilization rate of curative services (<i># of curative contacts per 100 inhabitants per 12 months</i>)	26.6	34.4	+7.33	86%
Immunization coverage rate, DTC3 (<i>% of children aged 0 to 12 months with three doses of DTC vaccine</i>)	51	74	+11.27	148%
Immunization coverage rate, Measles (<i>% of children aged 0 to 12 months immunized against measles</i>)	49	68	+9.69	136%
Immunization coverage rate, Polio 3 (<i>% of children aged 0 to 12 months with three doses of Polio vaccine</i>)	53	73	+9.43	146%
Contraceptive prevalence rate (<i>% of women 15-49 using any modern contraceptive method provided through health facilities</i>)	0.5	11.4	+545.00	114%
Blood transfusion safety level (<i>% of blood units transfused after being tested for HIV</i>)	69.0	96.7	+10.04	97%
Accessibility rate to potable water (<i>as % of population living within 3 kms from a potable water source</i>)	33	68	+26.52	124%
Tuberculosis detection rate (<i>% of expected BK+ cases which have been detected in the last twelve months</i>)	41	70	+17.60	93%
Tuberculosis cure rate (<i>% of treated BK+ cases which have been cured in the last twelve months</i>)	69	85	+5.80	100%
Utilization rate of ITNs (<i>% of households with at least one ITN</i>)	n.a.	20	n.a.	n.a.
Utilization rate of tse-tse fly traps (<i>% of risk villages with tse-tse fly traps</i>)	n.a.	n.a.	n.a.	n.a.
Utilization rate of Ivermectin (<i>number of APOC supported TIDC projects funded</i>)	3	3	100%	100%

Source: SANRU: Synthèse des rapports des zones de santé appuyées par SANRU III, 1^{er} Trimestre 2005

Component 2: HIV/AIDS. To increase the capacity to combat HIV/AIDS and STDs, SANRU III assisted the PNLs (*Programme national de lutte contre le SIDA*) in revising norms, guidelines, and training modules, including for blood transfusion, prevention of mother-to-child transmission of the virus that causes AIDS, management of STIs, and use of anti-retroviral drugs (ARV). The project trained health workers to effectively prevent, diagnose and treat HIV cases, and equipped HZs with appropriate guidelines. In addition, SANRU III took an active part in the preparation of two major projects that GOC submitted respectively to the World Bank –in the context of the Multi-country AIDS-control Project (MAP) and to Global Fund. The project also provided test kits and condoms to support activities for the control of STIs, including HIV infection. As shown in Table 5 and Annex 5, SANRU significantly improved blood transfusion safety in all the health zones which it assisted. Prevention of mother-to-child transmission (PMTCT) of HIV was not included in the original project proposal. It was added in 2003 with assistance from Axios International and later Global Fund. SANRU started with 12 pilot projects in 24 HZs and scaled up to 24 sites. By January 2006, a total of 26,571 women had been seen in 28 CPN clinics which offer PMTCT services according to the SANRU Quarterly Report of January 2006. Of these 16,579 women received counseling and 13,501 were tested. To date 313 women were found to be HIV positive and 124 of these have delivered and received a full course of Nevirapine, i.e., for mother and child.

Component 3: Nutrition. SANRU III excelled in the implementation of nutritional interventions required to decrease childhood morbidity and mortality. Notable among those interventions are the following: dissemination of guidelines and material for nutrition promotion; provision of funding to train health zone personnel in nutrition; vitamin A supplementation; and support to community-based nutritional activities. The positive impact

of these interventions is evidenced by a decrease in the incidence of low birth weight from 10.8 in 2001 to 8.6 in 2005 in the SANRU assisted zones.

Component 4: Re-emerging Diseases. Attempts to decrease the burden of three selected re-emerging diseases - namely TB, Trypanosomiasis (THA), and Onchocerciasis - led SANRU III to support selected interventions in HZs where these infections constitute serious public health problems. The support consisted, among other, in the training of various health zone personnel in disease management; provision of microscopes and other essential equipment; and organization of supervision visits. Trypanosomiasis was recognized as a major public health problem among 29 of the project-assisted HZs. The MOH commended SANRU's outstanding collaboration with BNT (Bureau National de la Trypanosomiase) for the provision of 1,000 tse-tse fly traps to five health zones, namely Luozi, Karawa, Kangu, Isangi, and Bulape. As a result, some villages in these areas have witnessed a drastic reduction in the population of glossinas. Concerning onchocerciasis, SANRU III was expected to bring treatment to over 500,000 persons in 14 selected health zones in line with the strategies of the National Onchocerciasis Program (BNLO, Bureau National pour la Lutte contre l'Onchocercose) and the African Project for Onchocerciasis Control (APOC). The SANRU project provided co-funding to support community-directed distribution (TIDC) of Ivermectin in three districts, namely Bas-Congo, Bandundu, and Tshopo. As shown in Table 6, this collaboration between SANRU, APOC and BNLO ensured distribution of 1,346,603 doses of Ivermectin to a total of 518,000 persons in 9 high-risk zones in the first three years of the project, which was in line with project objectives. Unfortunately, the incidence of serious side effects from Ivermectin led to a suspension of distribution in Bas-Congo and Tshopo in 2004 pending a WHO/APOC review of the program. In 2005, APOC gave the green light to proceed with phase II of treatment which is expected to double the number of those who have received treatment. The effective control of Onchocerciasis is a huge public health endeavor requiring sometimes an entire generation to see results. The impact of TIDC cannot be realistically measured during a five-year window period. The challenge will be finding donors to continue these endeavors after project closure.

Table 6: Distribution of Ivermectin

PROJECT	HEALTH ZONE	TARGET POPULATION	NUMBER OF PERSONS TREATED	NUMBER OF TABLETS DISTRIBUTED
TSHOPO	YAKUSU	124, 708	80, 308	284,074
	KABONDO	57, 003	31, 545	82,614
	OPALA	110, 964	69, 988	158,915
	<i>Sub-Total 1</i>	292,675	181,841	525,603
BAS-CONGO	NSONA MPANGU	77, 708	41, 069	110,346
	MANGEMBO	61, 775	46, 257	124,864
	KIBUNZI	49, 585	34, 743	93,419
	NSONA BATA	76, 987	18, 606	29,151
	<i>Sub-Total 2</i>	266,055	140,675	357,778
BANDUNDU	MOANZA	250, 000	127, 712	292,764
	MOKALA	150, 519	67, 837	170,458
	<i>Sub-Total 3</i>	400,519	195,549	463,222
TOTAL		959,249	518,065	1,346,603

Notes :

1. SANRU III eventually covered 9 health zones in three districts. Yet, its initial intention was to cover 14 health zones (of which 8 in Bas-Congo, 2 in Bandundu, and 4 in Tshopo). In the context of APOC and the National Oncho program, the number of high-risk zones to be covered in these three districts by the community-directed distribution of ivermectin totaled 38 (of which 14 in Bas-Congo, 9 in Bandundu, and 15 in Tshopo).

2. Data regarding populations refer to 2004 estimates. They do not include changes which followed recent revision of HZ limits.

Component 5: Malaria. To improve diagnosis, treatment and prevention for malaria at the household, community, health center and hospital levels, SANRU III has financed the following: (i) technical and financial assistance in the conduction of a study on the therapeutic efficacy of drugs combining amodiaquin and artenusate (ii) provision of appropriate test kits and drugs required to prevent, diagnose, and treat malaria; and (iii) organization of intermittent preventive treatment for pregnant women. The study on the amodiaquin/artenusate combination contributed to bringing the DRC policy and strategy in line with the norms adopted by WHO and the World Bank for the management of malaria cases. Between January 2003 and December 2004, SANRU sponsored two national conferences with the view to moving DRC toward the utilization of long lasting ITNs. Prior to these meetings, some studies had been done by the PNLP (*Programme national de lutte contre le paludisme*) and PCUSA (Presbyterian Church of USA) and these studies had showed that ITNs could be very effective in Congo even though their redipping was problematic. When the GOC accepted to integrate ITNs in the national strategy, SANRU III started putting any unspent money in the project towards buying long lasting ITNs. The net coverage went up albeit slowly as availability of money was extremely limited at first. To improve supply to the SANRU-assisted zones, a \$1.028,000 proposal was worked out with DFID for distribution of nets in the SANRU assisted zones. In January 2006, the ITNs were available in more than 75% of target homes in some areas. By the end of the project, SANRU will have distributed some 950,000 ITNs.

Component 6: Water and Sanitation. SANRU III implemented a wide range of activities with the view to increasing access to potable water and ensuring village sanitation, including a Clean Community Awards initiative (See set of pictures at **Annex 6**). The initiative sought to encourage health zones to organize clean village (protected village) campaigns. This was a competition, with a limited number of winners, but rather a campaign to reward all villages that successfully meet the following minimum criteria: 90% of households have a functional pit latrine; 75% of households have access to safe water; and 75% of households have easy access to properly maintained rubbish pits. Villages which successfully meet and maintain these criteria were to receive a “clean village” flag to display in their village. An annual monitoring by the health center and village development committee was carried to measure if they maintain the standard. Successful villages were provided with an annual “merit badge” to indicate the continuation of their work. Villages that did not meet the criteria were put on “probation” and given three months to correct identified problems. The Water and Sanitation Component of SANRU III also provided 56 health zone water/sanitation coordinators with training in the establishment of simple water/sanitation devices, such as spring capping, shallow wells construction, rainwater catchment, ventilated improved pit (VIP) latrines and the implementation of village sanitation programs. For more complex interventions, such as adduction systems and drilled wells are required, SANRU linked health zones with other partners or projects that could provide appropriate technical or financial assistance, such as the National Service for Rural Water (SNHR, *Service national d’hydraulique rurale*), TEAR fund, Oxfam, and Bwamanda well-drilling teams. By January 2006, SANRU had accomplished the following: (i) construction/rehabilitation of 2,133 clean water sources (springs) out of 1,500 planned; (ii) installation of 115 water pumps out of 150 planned; (iii) construction of 121 ventilated latrines out of the 210 planned; (iv) integration of Water and Sanitation in PCIME-C in 2,520 villages out of the 2,640 planned; (v) distribution of some 2,000 Clean Community Awards;

(vi) construction and installation in HGRs of 19 incinerators, 16 of which in iron and 3 in masonry; and (vi) initiation of micro-credit projects for clean villages in 9 villages out of the 9 planned. As a result of these and other efforts, the percentage of population with access to safe potable water has increased from 32.6% in 2001 to 68.3 % in 2005, i.e. far above the national average. Available data also indicate that this component has succeeded in reducing the incidence and prevalence of water-born diseases in many sites and contributed to improving credibility and utilization of health services (See Annexes 4 and 5).

Component 7: Planning and Management. This component promoted the development of transparent management systems through various techniques, including organization of training in management, provision of assistance in planning, support for monitoring and evaluation, operational research (OR) and promotion of community participation. SANRU III financed the training at the local, district and national levels to increase the capacity to correctly define health problems, identify needs and resources, establish priority goals, and set out the administrative action required to reach those goals (See Annex 5). OR was considered to be an effective method to ensure Quality Assurance and facilitate problem solving, and fundamentally different from clinical research or operational support. Health zone management teams received a basic training in the three steps of OR, namely: (i) Problem Identification, (ii) Solution Development, and (iii) Solution validation. The teams were encouraged to apply use OR for formative supervision and/or special research.

With regard to community participation, SANRU III conformed the national health policy which codifies this concept, i.e., which calls for the establishment of community health committees (COSA, *Comite de sante*) and a network of outreach workers (RC, *Relais Communautaires*). One RC is to be assigned per 10-15 households within an *aire sanitaire*; members of COSAs work with health center staff to manage the finances of the facility and participate in making other crucial operational decisions. Under SANRU III, outreach workers were instrumental in mobilizing communities for health campaigns, health education, and surveillance of key diseases, such as polio and measles. The Evaluation Team had the opportunity to meet and discuss with such RCs in the Kimpese Health Zone. The team was told that the village has witnessed improvement in its health status since the beginning of the RC program. At Kavalo, one of the villages that the team visited, a female member of COSA credited the reduction in morbidity and mortality from diarrhoeal diseases to the BCC program carried out at the community level by outreach workers.

Component 8: Training and Supervision in Management. The component sought to reinforce the health zone capacity for local training for specific program interventions and for supervision-formation to personnel and promote the development of effective and transparent management systems. To that effect, SANRU III organized training in planning and management of health zone support systems various cadres, including for 60 Medical Directors of Health Zones; 60 Administrators- Managers; and 90 Trainers, Supervisors & Nursing Instructors (See Annex 2 for additional information). For its training sessions, SANRU III used training modules that the MOH had developed for planning and management of health zones. SANRU contributed to the development of national training manuals and other materials. For example, PNLs staff reported to the Evaluation Team that their program has been using an organogram that they had developed in collaboration with SANRU beyond the SANRU-assisted health zones. SANRU's training activities drew a national team of former MCZ and consultant trainers. SANRU organized its training sessions at national, district and local levels to reach its objectives. In January 2005, SANRU III held an annual meeting of MCZ from 56 supported health zones to analyze past performance in

order to optimize SANRU's support to health zones. The meeting used a methodology known as SWOT (strengths, weaknesses, opportunities, and threats) strategy. The analysis of responses lead to identification of ten priorities forces, weaknesses, opportunities and threats (see Table 7). The results of this workshop has provided SANRU with an important background information to better evaluate the effectiveness and impact of SANRU as well as consider and develop future innovative strategies. The Evaluation Team strongly felt that this strategy should be included in the training module of planning for MCZ.

Table 7: The Top Ten Results from the SANRU SWOT Analysis

 Forces / Strengths	 Opportunités / Opportunities
1) Implémentation de l'approche RED dans les ZS 2) Renforcement des capacités des prestataires 3) Fonctionnalité des organes de gestion 4) Disponibilité des matériels logistiques pour superviser 5) Disponibilité des médicaments essentiels 6) Implication des RC dans les activités 7) Acquisition des matériels des soins et consommables 8) Aménagement des sources en eau potable 9) Intégration de planification dans le paquet ZS 10) Tenue régulière des réunions de revue mensuelle	1) Retour de la paix 2) Existence d'autres partenaires dans la ZS 3) Bonne implication des autorités politico administratives 4) Entretien des routes de desserte agricole 5) Redécoupage qui réduit les distances a parcourir 6) Access a email, documentation & recherche Internet 7) Organisation des revues provinciales trimestrielles 8) Reprise des activités socio-économiques 9) La ZS considérée pilote pour les partenaires et le ministère 10) Existence des Zones de Santé voisines jugées performantes
 Insuffisances / Weaknesses	 Menaces / Threats
1) Manque de motivation du personnel 2) Insuffisance des engins et budget pour fonctionnement 3) Méds: faible/irrégulière dotation, recyclage difficile 4) Faible couverture en eau potable 5) Insuffisance des moyens de communication 6) Faible planification avec niveau intermédiaire 7) Insuffisance des formations 8) Faible appui des hopitaux 9) Manque de budget pour la réhabilitation 10) Subside insuffisant et retard de transmission	1) La dégradation des voies de communication 2) L'inégalité de l'appui avec des ONG et partenaires aux ZS 3) Le faible pouvoir d'achat de la population 4) L'affectation irrationnelle des personnel au niveau du BCZ 5) La guerre entraînant l'insécurité 6) L'instabilité politique 7) Le conflit religieux et coutumier (coutumes et croyances) 8) Les catastrophes naturelles 9) L'arrêt brusque du projet 10) La démotivation entraînant la fuite du personnel

SANRU's training efforts (see Table 8 and Annex 2) resulted in all Health centers and health zones being well staffed in the SANRU-assisted areas. Most of trained health zone personnel, whom the Evaluation Team met, were able to describe their job responsibilities. The support package, which was provided by USAID's implementing partners and other donors targeting BCZ (*Bureau Central de Zone de Santé*), has been instrumental in motivating staff to supervise health center services and, in some cases, health centers' outreach activities.

Table 8: SANRU III Training Activities

Trainees	Objective	Realization	Realized Objectives (%)
Medical Directors of Health Zones	60	74	133%
Administrators- Managers	60	66	110%
Trainers, Supervisors & Nursing Instructors	90	226	251%
Water & Sanitation Coordinators	90	106	117%
Lab Technicians	120	32	26%
Health Center Nurses	1,200	1,232	126%
Community Outreach Workers	1,200	683	57%
All categories	2,820	2,419	

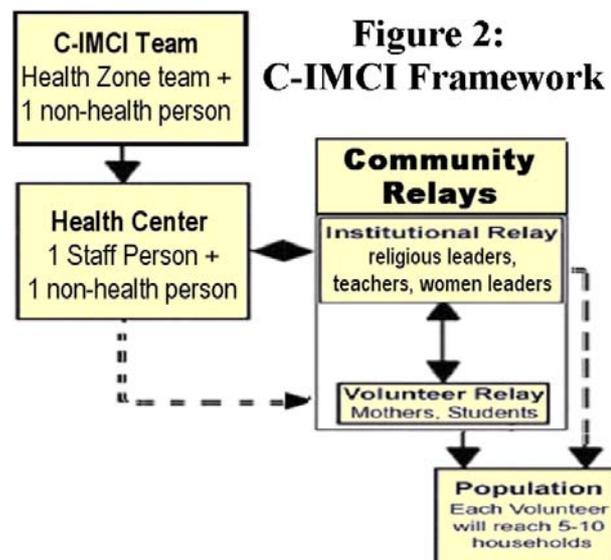
Notes:

1. Mobility of health personnel resulted in frequent departure of staff trained earlier and in the need to train new staff. This explains why more cadres were trained than initially planned;
2. With regard to community outreach workers, figures refer only to staff trained by the national SANRU team; they not include the health workers trained by local trainers;
3. SANRU did not perform well (only 26%) for the training of lab technicians.

Component 9: Sustainable Financing. Lack of financial sustainability constitutes one of the greatest weaknesses of health projects and institutions in Congo. In the DRC projects historically function as long as there is external funding; they stop as soon as that funding ends. SANRU III carried out a set of activities to improve the health sector’s financial sustainability in association with CRS and BDOM. These activities included: (i) development of an effective distribution system for low-cost essential drugs and medical materials; (ii) training of key personnel in material, financial and human resource management; (iii) conduction of operational research with the view to developing ways the health system can better address the needs of the poor; and (iv) provision of catalyst money to initiate micro projects capable of supporting health care services. By January 2006, SANRU III had financed a total of 9 micro-projects with an amount equivalent to \$500 per project. In Kimpese, the Evaluation Team was impressed by the collaboration between the Health Zone and CRAFOD (*Centre regional d’appui a la formation et au developpement*) for the improvement and diversification of crops in the context of the micro-project initiative. Among other things, these activities have resulted in the following: (i) a moderate increase in the percentage of health facilities that may be considered operationally self-financing based on MOH criteria; and (ii) significant improvement of average utilization of the health system.

Component 10: Behavior Change Communication (BCC). This component sought to improve the health of children, mothers and the community by promoting healthy key behaviors. The focus was on mothers and health center personnel given their influence on child health, but also included community leaders, traditional practitioners, and health care professionals, particularly those who provide advice and counsel to mothers. Among other things, the BCC component developed and financed the following:

- An integrated conceptual framework (Figure 3) for Community-Based Integrated Management of Childhood Ill-nesses (C-IMCI) with the MOH, Environmental Health Project, BASICS, and WHO.
- Provision of WHO Blue Libraries to 27 HZs, and mini-reference libraries (based materials available from Kangu-Mayombe), to 1,300 health centers, 56 HZ offices, and 30 nursing schools
- Promotion of SANRU’s “Ten commandments of health” (including soccer balls) as an educational and promotional tool for BCC and post-conflict rehabilitation of youth (see Figure 3);
- Training 88 C-IMCI teams/trainers in BCC for priority health interventions, including SANRU’s Ten Commandments of Health;
- Interventions to improve caretaker behaviors for child survival with Special attention given to EPI, nutrition, malaria, early detection of illness, home care of the sick child,



and appropriate and timely care seeking. The interventions were carried out in collaboration with BASICS.

- Approaches for mobilizing community support for activities such as EPI, community-based environmental sanitation and hygiene or Clean Village program; and
- Various interventions to motivate health workers to change their behaviours on a sustainable basis, correctly manage sick children's cases, and effectively communicate with caretakers.

Figure 3: SANRU's Ten Commandments of Health

				
<p>1. Allaitons exclusivement au sein notre bébé jusqu'à six mois.</p>	<p>2. Faisons vacciner complètement nos enfants avant leur 12^e mois.</p>	<p>3. Amenons nos enfants à la CPS pour suivre leur croissance et y recevoir la Vitamine A.</p>	<p>4. Faisons dormir nos enfants sous la moustiquaire imprégnée d'insecticide.</p>	<p>5. Allons vite au centre de santé en cas des signes de danger chez l'enfant.</p>
				
<p>6. Donnons beaucoup de liquides à l'enfant malade pour éviter la déshydratation.</p>	<p>7. Lavons toujours les mains après le WC et avant de manger.</p>	<p>8. Prenons nos deux doses de SP à la CPN pour éviter la malaria.</p>	<p>9. Espaçons les naissances pour la bonne santé de notre famille.</p>	<p>10. Evitons le SIDA: Abstinence avant le mariage, Fidélité dans le mariage.</p>

Les Dix Commandements de la Santé



For example, the Water and Sanitation component promoted five key behaviors, namely: (i) the washing of hands before eating or after defecation using water running from a container, soap and dry air; (ii) storage of drinking water out of the reach of children; (iii) disposal of children's feces immediately after defecation in latrines; (iv) enclosing of goats, pigs and other domestic animals in adequate enclosures; and (v) ensuring that pregnant women and under-fives sleep under ITNs. Project files indicate that SANRU III succeeded in effectively improving these and other healthy behaviors in some 2000 villages (See **Annex 5**). In the Kimpese HZ, the evaluation team visited Kavalo, a village where these impressive changes had materialized. The project files contain a sizable number of pictures which provide visual testimony to these achievements and a set of which is included in **Annex 6**.

Component 11: Essential Drugs and Medical Materials. This component aimed at, and succeeded in increasing population access to a secure supply of essential medicines. The component activities, the development of which is summarized in Table 9, started in December 2000 in the context of an emergency program funded by the the Office of Foreign Disaster Assistance (OFDA). A \$150,000 advance funding from PCUSA made it possible for drugs to be available by February 2001. At first, SANRU III distributed drugs directly to health zones using standardized kits. Subsequent gathering of extensive data on the utilization of services allowed a move toward a depot system for drug distribution. By December 2004, SANRU had developed an effective distribution system for low-cost essential drugs and medical materials through seven depots, respectively in Kisantu, Kinshasa, Vanga, Karawa, Kisangani, Kamina, and Tshikapa. This development benefited from a close collaboration with PMURR, CRS, ASRAMES, and BDOM. Toward the end of project life, 86% of HGRs

were buying their drugs through the group purchase system; and most of the SANRU-assisted health centers had at least one month's stock of the five most used drugs.

Table 9: Development of the Essential Drugs and Medical Materials System

Program Element	2001	2002	2003	2004	2005
Number of HZ and HGR supplied by IDA kits	52	53	17	3	3
Number of HZ and HGR buying through Regional Depots	0	10	34	48	48
Number of HZ and HGR covered by others	0	0	5	5	5
Percentage of HZ/HGR buying through group purchase system (or Regional Depots)	0	16	61	86	86
Percentage of health facilities with at least one month stock for the five most used drugs	n.a.	n.a.	n.a.	n.a.	n.a.
Number of functional Drug Depots (Planned: 6)	1	1	4	4	4

Component 12: Health Information System. SANRU III project invested time and efforts to improve collection and analysis of health related data as well as their use for decision-making. To that effect, the Project financed the production and distribution of the various forms that MOH has adopted for SNIS the Health Information System (SNIS, *Système national d'information sanitaire*) in DRC. In addition, it organized four training sessions in SNIS for a total of 171 participants from 11 health zones. As a result of these and other efforts, most health zones have been using adequate standard forms for their quarterly reports, based on monthly reports that health centers and hospitals have been made able to adequately submit. In January 2006, some serious obstacles and weaknesses were still confronting the country's SNIS, including in the project-assisted zones. The issues included poor quality of data collected; insufficient use of health information collected for decision making at all levels; marginal attention given to impact indicators. The Evaluation Team is of the opinion that the country must restructure its SNIS to make it responsive to the felt needs of the users, particularly at the lower levels and, thus, improve use of collected information. In addition, the evaluators strongly believe in the benefit of improving the SNIS through strengthening the links health actions and their impact on the health status. SANRU has integrated the impressive set of indicators selected in the context of SNIS and the USAID-funded Performance Management Plan (PMP). This has allowed the project to collect useful information on the amount and quality of its efforts. However, the project has been tepid with regard to the gathering of impact indicators despite the fact that these data constitute stronger motivators for health providers than input or process indicators. For instance, Water and Sanitation Coordinators, who have put tremendous efforts in the implementation of a hygiene promotion program, have given negligible attention to the tremendous impact of their activities on the incidence of diarrheas and fevers. The marginal attention to these aspect of monitoring and evaluation explains most of the blanks in tables in the present document.

3.2 Achievement of objective

Overall achievement of the objective under SANRU III was highly satisfactory and above initial expectations. Data from various sources indicate that in general, SANRU III assisted health zones had the best scores. The Project has greatly strengthened the capacity of 56 health zones for the management of priority PHC program interventions and support systems. By December 31, 2005, the project had significantly contributed to reinforcing the foundation for universal availability of cost-effective, technically and culturally appropriate health services that are affordable and sustainable to the people and the country as a whole. The

project, which was primarily conceived as a development program has also expanded the actual provision of various primary health care services. The service expansion greatly impacted on mortality and morbidity, particularly of children and mothers as evidenced in Table 10 and Figure 4 below. The Evaluation Team was able to perceive the impact in some of the villages they visited in January 2006. At Kavalo, one sanitized village in the Kimpese Health Zone, satisfied villagers were happy to report drastic reduction in the number of episodes of diarrhea and fever in their village following the introduction of hand-washing devices and long-lasting ITNs. In another village, people expressed gratitude for the tse-tse fly traps that had greatly reduced the number of noxious bites by these insects. Annex 6 contains some of the pictures that the project has gathered to best visualize its achievements.

It is worth mentioning the important role that SANRU III played in the DRC national recovery process. The project bolstered the health care system thus strengthening an essential mechanism that communities needed to cope with vital challenges. During the first years of its life, SANRU III worked on both sides of the battle lines, thus facilitating national reconciliation and addressing some of the deeper causes of the crisis.

SANRU's impressive achievements resulted in the Project Director being named by Time Magazine, Inc. as one of their 2005 Global Health Leaders. In addition, the Global Health Summit which was held in New York City in November 2005, recognized Dr Leon Kintaudi for his leadership of the IMA/ECC managed health projects in DRC including the flagship, SANRU III project and the impact these have had on the health of over 9 million persons.

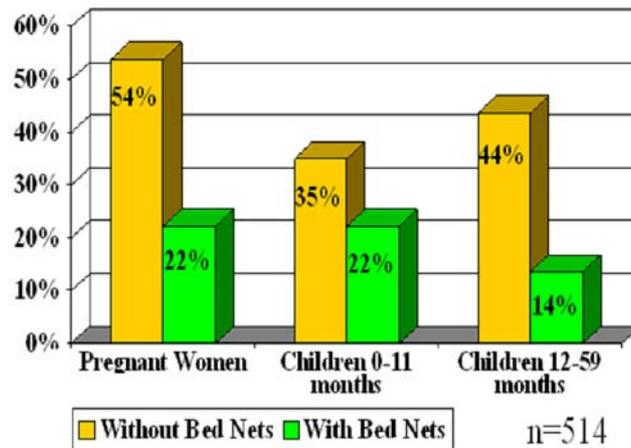
Table 10: Evolution of Morbidity and Mortality Rates

Indicator (Definition)	2001	2005	Yearly Change (in %)	Result (% of Target)
Incidence of low weight at birth (<i>% of babies weighing less than 2500 grams at birth</i>)	10.6	8.0	-6.13	n.a.
Incidence of malaria (<i>% of children with fever in the previous 14 days</i>)	25.8	KPC	KPC	KPC
Incidence of diarrhea (<i>% of babies with diarrhea in the previous 14 days</i>)	10.3	KPC	KPC	KPC
Incidence of HIV infection (<i>% of women 15-19 years old who are HIV sero-positive</i>)	n.a.	n.a.	n.a.	n.a.
Tuberculosis-specific mortality rate (<i># of deaths from tuberculosis per 100,000 inhabitants per year</i>)	n.a.	n.a.	n.a.	n.a.
Neonatal Mortality Rate	17.0	11.7	-7.79	n.a.
Maternal mortality Ratio (<i># of maternal deaths per 100,000 live births</i>)	370	240	-8.78	n.a.

Note: KPC stands for "Data will become available with production of the final KPC report"

Source: synthese des rapports des zones de sante appuyees par SANRU 1er semestre 2005

Figure 4: Fever during the Last 14 Days among Households With and Without Bed Nets



4. Major Factors Affecting Implementation and Outcome

Like SANRU I/II, SANRU III made impressive achievements, but could have achieved even more imposing results had some constraints been removed. The constraints included pervasive poverty, inadequate banking system, inadequate incentives for health workers, donor’s strict regulatory procedures, excessive centralization, and budgetary constraints.

Poverty. Project performance was limited by the continuous expansion of poverty among households, making them less and less able to access some of services that were made available by SANRU III, even when fees-for-service were kept to minimum. In the past, “cost-recovery” used to contribute for about 60% to the financing of health facilities. This source has dramatically shrunk as a result of expanding poverty making it vital to invent and instate innovative financing mechanisms. The deepening crisis has not prevented the country from witnessing an explosive expansion of some commercial activities, particularly by sophisticated cellular phone companies and church-related businesses. The concomitant growth of these services seems to indicate that the Health Sector owes part of its financing problems to limited ability to adapt and innovate.

Inadequate Banking System. The Project evolved in a context where the banking system was not functioning. As a result transfer of funds to the periphery constituted a formidable challenge, and was compounded by the large number and dispersion of the SANRU-assisted zones (See health zone map in Figure 1). The project had to devise mechanisms and strategies taking into consideration the need to ensure both speed and safety of transfers. Eventually, huge amounts of money were hand carried by poorly paid people out using risky means of transportation, such as cars, boats, and motorcycles. The permanent quest for balance between speed and safety resulted in slowing the implementation of some activities.

Inadequate incentives for health workers. Throughout project implementation, the Government failed to ensure payment of regular and decent salaries to service providers. This also resulted in lowering project performance as health workers had to develop various survival mechanisms, including over-prescription of drugs and lab tests and pernicious drive for per diems. As cost recovery fees directly benefited the staff and provided for most operating expenses, staff developed a tendency to over-prescribe drugs and lab tests so to generate income and circumvent cost containment issues, especially in overstuffed hospitals and zonal offices. High recovery fees contributed to restricting access to services, depressing utilization of facilities, and creating a dysfunctional drug supply system. The indecent and inconsistent salaries also led many trainers at the National level to monopolize the training activities at the local level for per-diem motive fueling frustration among the trainers at the

local level. The inability of MOH to finance supervision visits resulted in various levels of the ministry (particularly the central, provincial, and district levels) to refuse to participate in most supervision activities carried out under the project.

Donor's strict regulatory procedures. Various donors have been seeking alternative ways to provide health workers with adequate incentives to perform and produce the expected results. To that end, the World Bank and the European Union introduced the concept performance-based contracts. The effects of this alternative way were so striking that SANRU III explored the possibility of doing the same. Citing a US Congressional law that forbids the use of US Government funds to pay civil servants in any USAID-assisted countries, USAID was not able to sanction the payment of performance-based contracts, fueling frustration in local health zone personnel in SANRU-assisted health zones often working aside other zones supported by the WB where such contracts were paid.

The Evaluation Team felt that the following recommendations made by the USAID evaluation of 2005 should have been implemented, namely to:

- Initiate a dialogue with the MOH, World Bank and other interested donors to examine which cost-recovery activities allow for the best balance between sufficient payment of staff and improved access to affordable health services;
- Standardize fees within health zones and visibly post fee schedules for health services, drugs or commodities at SANRU and CRS supported health facilities to increase transparency and promote governance; and
- Address the issue of *primes* payments in conjunction with the MOH and other donor agencies. It is clear that while USAID cannot pay salaries to foreign civil servants, it should actively participate in the discussion of this policy. Should the GOC declare the payment of *primes* as a universal practice, and set standards of implementation, USAID should partner with interested donors in current program areas so that a more equitable system of payment can be initiated nationwide.

During the course of implementation, the USAID insisted on strict adherence to US regulations regarding wavers. These and other legal constraints created some delays in the implementation of certain project activities and procurement of pharmaceuticals. Other earmarked activities such as 'Family Planning' came 'late to the program' and with separate earmarked funds that needed to be tracked and justified separately but yet in the end made up part of the total funding package. i.e. family planning activities were implemented to the expense of other non-prioritized interventions such as resurgence of certain epidemic diseases. It took USAID only three months i.e. from August to October 2001 to give SANRU its first waiver to get drugs. This combined with the fact that IDA took six months to deliver the drugs resulted in the first consignment to arrive in DRC in May 2002. However wavers needed to be renewed for each purchase. SANRU got its second waiver in July 2001. The drugs were ordered in October 2001 and received in March 2002. In 2003, USAID changed their contract officer. This caused the third waiver to be delayed until February 2004. This final waiver however covered the duration of the project; a recommendation of the current CTO which was much appreciated.

Overcentralization. Arrangements under Cooperative Agreement obligated ECC-IMA, the implementing agency, to establish a management structure and style where some administrative decisions were to be made in Windsor, the IMA headquarters. As indicated in **Annex 3-2**, SANRU III was based on an unsolicited proposal that IMA and ECC prepared

and submitted. Unlike the two previous operations (SANRU I and II), SANRU III was not a USAID-designed and competitively bid projects (see Table 11). There was, therefore, less management of SANRU III by USAID. In addition, all its funding was in dollars whereas SANRU I and II were funded through a combination of US dollars and locally generated Counterpart Funds (CPF). Under the previous operations, USAID managed the dollar budget and ECZ managed the CPF budget. The CPF is considered to be a GOZ contribution, their management is not reportable to U.S. Congress. This provided a great deal of flexibility for the SANRU I and II projects to disburse assistance in cash to health zones without being legally accountable to U.S. Congress as how those funds were used (or mis-used) within the health zone. Under SANRU III, IMA was ultimately and legally responsible to the U.S. Congress for how 100 percent of project funds are used at all levels. These characteristics obligated the Project to centralize procurement and minimize the amount of cash sent to Health Zones. SANRU III was therefore perceived as being centralized and more rigid than SANRU I and II, particularly in its planning, management and disbursement of project funds.

Table 11: Comparison of SANRU I/II and SANRU III

Factor	SANRU I/II	SANRU III
Type	Bilateral Project between USAID and Gov't of Zaire	Cooperative Agreement (Grant) between USAID and I.M.A./ECC
Design	Project designed by USAID	Unsolicited Project designed by IMA/ECC
Management	USAID, MOH and ECZ provide significant management input.	I.M.A./ECC provides all management
Funding	Approx. 50% in dollars and 50% in Counterpart Funds (CPF)	100% funding in USD. This creates added rigidity
Financial Management	USAID manages the dollar budget; ECZ manages CPF	All funds managed by IMA/ECC. IMA does int'l procurement and transfers while ECC manages local disbursements.
Health Zones	Assistance to 50-100 HZs	Assistance to 56 HZs co-managed by FBOs/NGOs (36% non-ECC)
Level of Assistance	\$20,000-40,000 per year	Budgeted at ~ \$60,000 / year Revised to \$80-100,000 / year

Budget Constraints. As stated in Section 3.5, the amount of \$60,000 that SANRU III budgeted per health zone and per year was grossly insufficient to completely support the activities planned under the project. The resulting budget constraints combined with the donor's rigidity to dampen SANRU's eagerness to maximize its results. In particular, the constraints greatly limited expansion of some cost-effective technologies, such as ITNs, micro-projects and family planning commodities to a small number of zones. In January 2006, Family Planning and promotion of ITNs were far from reaching most of the SANRU-assisted zones. In 2003, budgetary constraints also contributed to a decision to curtail onchocerciasis and trypanosomiasis activities in SANRU III. The Evaluation Team strongly believes that the results that SANRU III achieved with regard to contraceptive prevalence, utilization of ITNs – to name just a few examples – reflect the availability of commodities rather than the demand of the population. The observed needs, as well as the perceived ones far exceeded the level for which SANRU's financial resources could provide.

5. Sustainability

Two major factors (peace and national financial self-sufficiency) are essential to sustain project activities. The sustainability will depend on smooth implementation of the peace process leading to social, economic and political stability, particularly in the war-thorn areas in Eastern Congo. Financial self-sufficiency will take some years to materialize. In other words, most gains made under SANRU III will be erased including in the more mature zones in Western Congo if adequate follow-up operations are not promptly implemented. Given the foreseeable excess dependency on external sources for the financing of sector expenses, particularly the recurrent ones, donors' inconsistency cannot allow the country to envisage a long-lasting solution to health needs in DR Congo.

6. Lessons Learned

The overall achievement of the SANRU III was highly satisfactory and above expectations. The implementation of SANRU III and the final evaluation process made it possible to draw a set of very useful lessons which are summarized below.

Main lessons:

- 1) **Development-minded models are more cost-effective than short term disaster responses.** These models should be given priority wherever and whenever possible. By resisting the drive for short term disaster response and keeping the health zone concept viable, SANRU III offered DRC a strong foundation on which to build a sustainable, effective, and efficient national health system.
- 2) **Success is possible in a volatile situation, and in the context of weak administrative and institutional capacity provided that innovative, adequate mechanisms are established to address major constraints.** The average disbursement time for DRC and many other African countries country is long. This project of \$25 million disbursed in only five years. Faced with total destruction of the country's logistical capacity, the Project was realistic enough to resort to the establishment of partnership with an U.S-based organization with forty years of experience in the solicitation, packing, shipping and on-site management of pharmaceuticals and medical supplies.
- 3) **The need for adequate incentives for staff is crucial in any operation.** Failure to create conditions that encourage or motivate workers to provide services to clients is costly and detrimental to projects. Placed in frustrating and asphyxiating conditions, most workers find themselves forced to develop survival mechanisms which can lead to gross mismanagement of the project's financial and material resources. They may also devote their time to personal business rather than to the project. Under SANRU III, frantic hunt for per diems has been the primary motive for most seminars, training sessions, and supervision visits. SANRU III -and indeed all projects- should ensure establishment of mechanisms required for health workers to behave in line with project goal.
- 4) **Fantastic health results can be derived from a number of simple but effective technologies.** SANRU III promoted a number of simple technologies at the community level. SANRU III expanded to all health zones some technologies (spring capping and hand washing stands, PCIME) while others were missed opportunities (tse-tse fly traps and micro-projects). All these simple technologies proved to be more cost-effective than most of the more sophisticated ones.
- 5) **Partnership pays.** As shown in Annex 2, SANRU III promoted partnership among an amazingly wide range of agencies and institutions which are active in the Congo health sector, particularly the ministries in charge of Health, Agriculture, and Energy; (iii) health institutions owned and/or operated by more than forty protestants churches affiliated to ECC; (iv) health institutions owned and/or operated by some 50 catholic dioceses and other catholic faith-based organizations (FBO); IMA; KSPH, CDC, UNICEF, WHO, CRS, BAISCS, UNFPA, MONUC, ASRAMES, COOPI, MEDAIR, MSH, ADVANCE AFRICA, PSI. Despite multiplicity of partners, no major conflict

could be documented by the Evaluation Team. These partnerships generated more than one million dollars additional funding and in-kind assistance each year. The associations allowed best utilization of each partner's comparative advantages and minimized needless competition and duplication. Under the project, seven regional drugstores (five of which developed with financial support from USAID and two under PMURR) were established and charged with providing drugs primarily to health facilities in their respective areas regardless of the ownership of the facility.

Other important lessons:

- 1) **The need for a proper analysis of the socio-economic context in which the health system operates is crucial when planning health operations.** The impact of economic recovery or lack of it should have been examined realistically and budget determined accordingly. More realism should be applied when planning and costing for future operations. Special treatment and more support should be envisaged for the health zones that are land-locked given the particularly high unit costs of conducting business in those areas.
- 2) **The need for flexibility is crucial when planning operation in countries with special difficulties.**
- 3) **The need for involving the various levels of the MOH (districts, provinces, and national level) should be integrated in the implementation of project to improve the likelihood for sustainability**
- 4) **Significant contribution to developing practical working tools is more easily realized by using field experience, problem solving, and on-the-job training rather than through theoretic and didactic methods.** In his approach to training, SANRU heavily resorted to field experience, problem solving, and on-the-job training.
- 5) **Behavior change communication (BCC) activities are most effective when implemented as part of a community-based approach.**
- 6) **FBO-managed health facilities should be treated as a public sector resource rather than a private sector resource.** FBOs are often "lost" in the private sector versus public sector dichotomy. In fact, they have much more in common with the public sector than with the private sector. Establishing a dialogue and working relationship with FBOs as public sector partners is a key factor to successful collaboration.
- 7) **FBOs and NGOs can establish important management precedents for developing health systems.** In Congo, around 50% of the 306 Health Zones are managed by or in collaboration with NGOs, primarily those of the catholic and protestant churches. These NGOs take on a much larger responsibility for managing primary health care than is found in most countries. In fact, of the first 85 health zones to become functional during the 1982-1984 period, 88% were managed by NGOs (mostly FBOs) or received important NGO/FBO management assistance.

- 8) **Health System building in collaboration with FBOs can result in accelerated development.** Many health zones in Congo were "built" on the existing infrastructure of functional hospitals and primary health care activities. Using these existing structures greatly accelerated the development of PHC and health zones in Congo. It also established important precedents in the areas of cost-recovery, local budgeting and financial management, and the control of vehicles.
- 9) **Decentralization in collaboration with FBOs require more geographic administrative flexibility.** In Congo, and other countries, State-run hospitals tend to be in urban administrative centers, while FBO hospitals tend to be in scattered rural areas. A delimitation of health districts that takes into account FBO hospitals may, therefore, results in geographic units that emphasize service area boundaries even though they may not strictly follow administrative boundaries.
- 10) **FBOs can provide an important role in health systems management, in addition to health services provision.** The co-management of HZs in Congo is a special partnership in which the MOH has contracted co-management of health districts to FBOs, especially to FBOs who own/manage the reference hospitals. This may not be easily replicated in other countries, but has been a key factor in health systems decentralization and management in DR Congo. FBOs can provide additional channels for integrated approaches to BCC via church-affiliated health facilities and community-based health workers, They can offer also congregational and school networks as additional channels for effective BCC. FBO-related programs have access to funding not available to governments. Church groups can receive funding from international partners who do not normally provide assistance through Ministries of Health. This can provide a supplemental and complementary assistance to the development of a health district.
- 11) **FBO networks and umbrella groups can be effective project-of-projects managers.** The case of ECC's role in the management of the SANRU projects illustrates this case in Congo. Might it not also be replicated by projects managed by Christian Health Associations in other countries, e.g. CHAM in Malawi, CHAK in Kenya or CHAS in S. Sudan?
- 12) **FBOs (unlike many PVOs or NGOs) are a permanent resource that can contribute significantly to sustainability of health systems in times of crisis.** The medical work of these groups will continue long after other international health projects and agencies are withdrawn. The durability and survival of the health zone system in Congo is due in large part to the FBOs that have continued PHC services even (or especially) during times of crisis.