Field Assessment of CRS

I. Executive Summary and introduction

Purpose of Assessment: USAID/DRC requested an assessment of the management and delivery of health services conducted in CRS-assisted health zones in order to (1) determine the minimum level of resources required to effectively implement the activities outlined in the Mission's new strategy; and (2) help enhance the grantee's performance.

Team Composition: The Team included: Richard Greene, Team Leader, USAID/W, Senior Advisor to DRC and Director of HIDN; Karen Cavanaugh, USAID/W, PHR+ CTO and health systems specialist; Nancy McCharen, USAID/W, Africa Specialist in Regional and Country Support; Lina Piri Piri, USAID/Kinshasa, Activities Manager for the CRS Project; Dr. Denis Matshifi, Health Coordinator, CRS Kinshasa

Methodology: Methodology included field visits to two rural health zones (Luiza and Luambo) in Kasai Occidental and meetings following an interview guide tailored to the three levels of health services: health centers and posts, reference hospitals, and health zonal offices.

CRS Program: CRS assists three rural health zones in Bas Congo and 16 (now 23 following the recent MOH remapping exercise) in Kasai Occidental and Kasai Oriental under a five year cooperative agreement that ends in September 2007. The total estimated cost of the grant is $8.6 million. The Kasai cooperative agreement is for five years of assistance (2002-7) at a total cost of $8.6 million. The purpose of the project is to reduce child and maternal morbidity and mortality by:

- Having local partners, MOH structures and community organizations ensure quality PHC in the targeted health zones.
- Making available key life –saving preventive health activities and ensuring their full utilized by communities.
- Ensure that communities have access to and fully utilize quality essential curative health services.
- Integrate essential HIV/AIDS preventive activities into PHC services.

Accomplishments to date

- *Availability of care and medicines*: UNICEF medicines arrived in health centers in April, 2003. This one action has allowed the revitalization of essential, community-financed services, the motivation of staff, and the reactivation of community health committees (COSAs) which had gone dormant from lack of resources to manage.
- *Work conditions*: provision of office supplies (pens, pencils, paper, registers etc.), motorcycles, bicycles has encouraged staff and enabled them to carry out their duties
- *EPI program*: measles and DPT coverage have increased significantly, and systems have been put in place to assure that the vaccinations continue. Radio communications have greatly facilitated reporting of both vaccinations and surveillance of cases at community level.

- *Supervision and health information*: monthly supervision of health centers on site, monthly meetings with head nurses at the zonal level and monthly meetings with selected relais have been established and allow for updating and feedback. There has also been an improvement in the frequency of health information reporting.
- *Training* of service providers, health zone managers, and BDOM staff in a variety of topics.

Major Operational Problems
- Under-utilization of health services due in part to the inability to pay;
- Over-prescription of drugs and lab tests that contribute to the high costs to consumers
- Need to expand preventive services beyond EPI to include other high impact maternal and child services such as malaria, pneumonia treatment, and child spacing
- Inability by health zone staff to analyze and use data collected from supervision and the health information system.
- Inadequate planning and oversight of rehabilitation and construction projects
- Limited community participation, especially among women.

The assessment report recommends actions to begin to address these problems and estimates the costs of their implementation. The team recognizes that some of these recommendations are already being planned or are process.

The assessment team recommends that CRS undertake or facilitate the following steps to further enhance program impact:

Basic Package of Services:
- To reduce under-five and maternal mortality, focus on achieving minimum coverage levels for a core package of high impact interventions that includes: 80% coverage for DPT3, measles and vitamin A supplementation; 65% of all pregnant women and infants have insecticide treated nets in their homes; 60% of all pregnant women receive intermittent preventive therapy for malaria; and 70% of pregnant women have their births attended by a trained provider in a health facility. The core package would also include the introduction of family planning/child spacing information and services (with the assistance of another USAID partner) and improved diagnosis and treatment of acute respiratory infections.
- To achieve these targets, provide additional support for malaria, ARI, and maternal health (especially for basic obstetric care).
- Ensure that health center staff and their supervisors track the above indicators and that they are reflected in health center performance contracts.

Child Spacing:
- Ensure that BDOM accelerates training of personnel at all levels in the standard days method, providing educational materials and beads for use of the method.
- USAID should engage another partner to work with the BCZS to assure contraceptive supplies in health facilities, training of staff, and some quality assurance.

HIV/AIDS:

- To better implement its core HIV/AIDS activities (e.g., blood safety, universal precautions at health facilities, and awareness raising activities), distribute the MOH guidelines and flowcharts on blood testing, HIV diagnosis, and counseling and ensure that staff are trained in their use.
- If additional HIV/AIDS funds become available, in their higher risk zones, train hospital and health center nurses on syndromic diagnosis and treatment of STIs and ensure that appropriate drugs are available.
- Based on the latest epidemiologic data, USAID should review whether CRS zones should be targeted for more intense activities. For any CRS zones so identified, USAID (through an appropriate HIV/AIDS partner) should consider introducing in large maternities syphilis screening of pregnant women and prevention of mother to child transmission.

Community Based Delivery of Information and Services

- In their program description, CRS has described a strong and participatory community component. Because of the program emphasis on EPI and the WHO training of a few of the *relais*, the *strategie avancé* work of the *relais* is largely disease surveillance and mobilization for vaccinations.
- Assure that the upcoming training of *relais* will prepare them for a broader role in working with communities, women's groups, local NGO's and in expanding the *strategie avancé* to address problems other than immunizations. The COSA should be trained in educational and behavior change roles as well as the management functions with the health center.
- BCZS work with the Head nurses to enumerate relais so that planning of training and provision of supplies and educational materials can be done accurately and gaps in coverage can be identified.

Drug management:

- Develop guidance to limit the number and type of lab tests now being conducted in health centers. In addition, CRS should make fees from lab tests ineligible for staff *primes*.
- Over-prescription of drugs should be addressed in supervision protocols, refresher training, collaborative QA exercises, community education programs, and the new performance contracts to be developed between HZs and health facilities.
- Review and reset the margins on drugs at both the health center and BDOM levels based on real management costs. Supervisors should routinely review the *Fiches de Consummation* of drug stores and depots to avoid abuses.

Supervision:

- Formative supervision is performed regularly and the EPI clearly demonstrates that effective supervision has been provided. However, other technical and management areas need to effectively addressed through supervision.
- Revise existing supervision protocols to better reflect the full core package of services, drug and financial management, and community mobilization activities. Payment of perdiems should be contingent upon submission of completed supervision checklists.

Training

- Offer re-trainings to increase the number of nurses trained per Health Area.
- Ensure that adequate material assistance (commodities, job aides) are made available to training participants when they complete instruction to permit immediate application of newly acquired skills.
- Study possibilities to integrate training topics as much as possible.
- Experiment with the use of quality assurance collaboratives to improve performance of health workers and managers.

Financing

- Experiment with mechanisms to subsidize access to health care for the poor at community level, either through *mutuelles de sante* or through community subsidy funds. Work together with the MOH *5ieme Direction*, SANRU, the School of Public Health to implement and assess these experiments for broader application.
- Document CRS' experience with support for PHC, its cost and its impact, with a view toward comparing its effectiveness with other models, such as those supported by the World Bank or implemented by SANRU. Share information with MOH 5th Directorate to foster uptake of lessons learned.

Health Information

- Now that basic health information collection is underway, train zonal and health facility staff to critically analyze routine information in the areas of core technical intervention, financing, and drug management, and service utilization with a view to benchmarking performance and identifying and solving problems.

Human Resources:

- Introduce a competitive small grants program at HZ level to provide health centers (and local leaders) with resources for projects to improve community health.

Gender:

- Although the CRS program description devotes considerable attention to gender, there is little evidence of gender playing a role in program implementation.
- Set gender objectives for staff composition (including for BDOM), participation in training, disaggregation of data by sex, male participation in reproductive health activities, etc. Select appropriate indicators for progress, track and report on them.

CRS Management

- CRS' sub-contracts with BDOMs to support HZs in isolated rural areas. Because of the need to build the capacity of its local partner, there have been some delays in project implementation. In addition, the lack of a dedicated CRS administrative officer for the project has slowed procurement and management support.
- Engage a new staff member to handle procurements, oversee rehabilitation, and manage project information.

- Utilize the unfilled supervisior slot and hire an additional supervisor to serve as on-site coordinators in the two largest BDOM offices.
- Hire a shared finance advisor to conduct analyses and design interventions to address financial constraints on the poor.
- Amend performance contracts (as planned) to align contract terms more closely with project objective (e.g coverage of core service interventions) and to reinforce key management practices. Use the new contracts as basis for supervision and provide recognition and awards for meeting performance expectations.
- Foster community participation and appropriate designs. Ensure appropriate and transparent contracting arrangements. CRS should approve all designs and contracts over a minimum level.

Optimal Number of Zones for CRS Support: At present, the Mission budgets approximately $2,000,000 per year for the two CRS grants (with a total value of $2,150,000 with the CRS matching contribution). Assuming no increases in Mission budgets, the Assessment team recommends that CRS provide the following levels of support:

- Full support to the 18 originally targeted zones (two remaining in Bas Congo and 16 in the Kasais). Each zone would receive approximately $70,000 of support per year including CRS management costs (excluding NICRA). This level of support is consistent with present budgets.
- Partial support ($25,000 per zone per year covering supervision, management training, information systems, etc.) to the 7 Kasai zones that were created following the MOH remapping exercise.
- After the NICRA is paid, there would be less than $100,000 available to begin to cover the cost of some of the recommended actions of this assessment.

The team believes that with the present funding available for CRS, it would be better to provide a package of support of about $70,000 per zone (present projections) than to dilute assistance and cover more zones.

Costs of Proposed Recommendations:
The actions proposed in this assessment will cost approximately $20,500 per zone per year to implement (about a 22% increase in present cost estimates). The total additional annual cost is estimated at approximately $370,000 per year.

II. The Basic Package of Services

A. The core set of high impact intervention

Observations: According to its proposal, CRS plans to support a core service package that includes child health interventions (immunization, malaria prevention and control, vitamin A supplementation); maternal health (ANC, attended births), and selected HIV/AIDS interventions (e.g., safe blood transfusion, universal precautions). CRS also plans to provide lesser levels of support for exclusive breastfeeding (through community education), growth monitoring (through provision of scales and growth cards), nutrition promotion (through introduction of positive deviance programs in demonstration health areas). In addition, CRS expects to support the implementation of several national level interventions including semi-annual vitamin A supplementation and directly observed treatment strategy (DOTS) to control TB.

Issue: CRS has made an excellent start improving vaccination services (with DPT3 coverage increasing from a baseline of about 30% (for DPT3) to an estimated 50%, as well as helping to sustain relatively high vitamin A coverage. However, in order to achieve public health impact and reduce child mortality, other core interventions need to be implemented at scale. In addition, there appears to be a total lack of family planning services.

Recommendations:

- To reduce under-five mortality and to begin to address maternal mortality, CRS needs to concentrate upon achieving minimum coverage levels for a core package of high impact interventions that are feasible to implement in the DRC. Consistent with the Mission strategy and PMP, the list of key interventions and their targets are as follows:
  - ❖ DPT3 and measles vaccination coverage exceeding 80%;
  - ❖ Semi-annual vitamin A supplementation coverage exceeding 80%;
  - ❖ 65% of all pregnant women and infants have insecticide treated nets in their homes (denominator: All pregnant women and infants in CRS zones).
  - ❖ 60% of all pregnant women receive intermittent preventive therapy (denominator: All pregnant women in CRS zones);
  - ❖ 70% of pregnant women have their births attended by a trained provider in a health facility.
  - ❖ The core package would also include the introduction of family planning/child spacing information and services (with the assistance of another USAID partner) and improved diagnosis and treatment of acute respiratory infections.

- The above indicators should be tracked by every health center and health zone through the UNICEF designed wall chart that will soon be distributed.
- Recognition should be provided when these public health indicators are reached or sustained for the year.
- Health center performance contracts should be modified to include these five core indicators.

- Supervisors should monitor progress on these indicators during their monitoring visits using a standard checklist to be developed.

In addition to these core indicators, CRS should:

- Facilitate measles vaccination campaigns (when the Kasais are targeted) to achieve high coverage rates and help ensure that planned follow-up campaigns are conducted.
- Promote the use of WHO-recommended diagnosis and treatment recommendations for child pneumonia (as outlined in the ordinogramme) in all health facilities.
- Facilitate the efforts of another organization (perhaps SANRU) to introduce a package of family planning information and services.

Malaria control activities:

Background: Routine utilization of key preventive health services provides opportunities to increase access and use of key malaria interventions. - for instance, 60% of pregnant women make at least one visit to a formal ANC and about the same percentage of infants complete their DPT series – providing an important opportunity to provide insecticide treated nets (ITNs) and intermittent presumptive treatment (IPT), as well as key messages on malaria prevention and care.

Recommendations:

To achieve the public health targets for ITNs and IPT in section II above, CRS plans to fully exploit the high utilization rate of key preventive services. It is recommended that:

- CRS provide a long-lasting ITN to all pregnant women at the time of their first ANC visit and an additional ITN to the mothers of all infants that complete their DPT3 injection. These nets should be provided as part of the standard CPN and CPS services at no additional cost to the client.
- CRS should fully implement intermittent presumptive treatment of pregnant women with SP including the provision of a special stock of SP for this purpose.
- Key messages on care and prevention should be provided at all points of contact.
- CRS and SANRU should produce a job aide to succinctly communicate guidelines (presently being reviewed by CDC and the national program) on the treatment of severe malaria.
- Due to its importance, CRS should aim to fully launch malaria activities during the upcoming year.

Immunization

- With SANRU, develop a one page job aide summarizing the most important elements of the recently approved national immunization guidelines. Key information such as the upper age limit for vaccinations and the open vial policy (how long an opened vial can be used) should be included.
- Continue implementation of the "reaching every zone" program. Broaden the impact of the program by adding malaria and perhaps one other intervention to the health center microplans (to be done on a trial basis).

Vitamin A: Continue to facilitate the program of semi-annual vitamin A supplementation with the objective of sustaining greater than 80% coverage. Support the

provision of vitamin A to postpartum women (at the new recommended dose of 400,000 IU) and to selected categories of sick children (e.g., post measles).

Maternal Health: The percent of pregnant women giving birth at a health facility in CRS zones is fairly high (in many places over 60%). This provides an opportunity to deliver quality maternal health services at scale.

Recommendations:

- Improve the quality of ANC services by providing adequate supplies of iron-folate and mebendazole for deworming at the time of each visit (free of charge) and helping the women develop birth preparedness plans.
- Include recognition of danger signs and symptoms of pregnancy complications in community education materials.
- *Labor and delivery*: Health providers should be trained in active management of the third stage of labor, an intervention that helps prevent postpartum hemorrhage, consisting of immediate ocytocin, controlled cord traction, and uterine massage. In addition, the partogram should by introduced to better address obstructed or prolonged labor.
- CRS and SANRU should review the appropriateness of including ergometrine as an essential drug during child birth.

Acute Respiratory Infections (helping health providers implement the MSP guidance on child pneumonia in the ordinogramme).

- Introduce timers in all health centers and hospitals to permit providers to accurately count respirations in order to diagnose child pneumonia;
- Design and distribute a job aide for child pneumonia that includes instructions for diagnosis and treatment.

Child spacing

Observations: We encountered the head nurse in the Centre de Santé de Ngovo "close by" the health center working alongside the community making bricks – an estimated 20,000 being required for construction of the maternity. His wife is a member of the COSA, and when asked about family planning, she proudly declared that they had a planned family. However, no center offers child spacing services or products, other than condoms which are provided through the national HIV/AIDS program. If a woman (or man) were to ask about family planning, they would be counseled, the calendar method explained, and referred to Lwiza or other BCZS. As one gentleman informed us, "on nous conseil de respecter le cycle, mais il y a toujours des imprévus", that is to say, they advise us to respect the cycle, but there are always unplanned moments.

Issues

- These are very hard to reach areas. If the health system under the supervision of the BDOM does not provide child spacing services, they simply are not available for men and women who might be interested in using them. If provider attitudes are not supportive, this becomes an additional barrier to the cost and effort necessary for couples to space their births.

- Even the standard days method is not well understood nor available to women either post-partum or during other consultations. CRS materials and lessons from their pilot zone for the standard days method will prove useful in introducing the method in their other zones.

Recommendations
- CRS should provide reference and resource material on the standard days method to BDOM and BCZS staff, and introduce the discussion on child spacing. BDOM needs to accelerate training of personnel at all levels in the standard days method.
- USAID should consider using another partner to work with the BCZS to assure contraceptive supplies in health facilities, training of staff and some quality assurance.

Recommendations
- Ensure that BDOM accelerates training of personnel at all levels in the standard days method, providing educational materials and beads for use of the method.
- USAID should engage another partner to work with the BCZS to assure contraceptive supplies in health facilities, training of staff, and some quality assurance.

B. Other important interventions that will receive limited support:
Some potentially important interventions are not ready to be implemented effectively at scale because of level of difficulty, lack of funding, or other constraints. These include positive deviance nutrition promotion, therapetic feeding programs, and exclusive breastfeeding. Other interventions are already integrated into most health facilities and will receive only limited additional support (e.g., oral rehydration therapy, growth monitoring). Finally, any additional support for TB to CRS supported health zones will be provided under the direction of the National TB Program.

HIV/AIDS: The CRS program supports a limited set of HIV/AIDS activities consisting of ensuring blood transfusion safety, universal precautions at health facilities, and awareness raising activities (including counseling training for health providers). HIV tests provided by CRS are being used by hospitals for both screening blood and diagnosis.

Observations: Discussions with the staff at the Luiza Reference Hospital indicated that:
- Patients are tested without their knowledge, consent or counseling
- Hospital staff are alerted to patients who test positive so that they can take the proper precautions
- Family members are also notified when a patient tests positive
- Hospital staff have no idea what happens to those people when they leave, or the social implications of a positive diagnosis, or even of having been tested.

Issues:
- MSP guidelines on blood testing, HIV diagnosis, and counseling have not been disseminated or applied in CSR supported hospitals.

Recommendations:

- To better implement its core HIV/AIDS activities (e.g., blood safety, universal precautions at health facilities, and awareness raising activities), distribute the MOH guidelines and flowcharts on blood testing, HIV diagnosis, and counseling and ensure that staff are trained in their use.
- Include in the supervision checklist for hospitals and health centers verification of implementation of universal precautions.
- Make it a priority to use some of the rehabilitation funds for the building or rehabilitation of incinerators at referral hospitals and safe disposal pits at health centers.
- If additional HIV/AIDS funds become available, in their higher risk zones, train hospital and health center nurses on syndromic diagnosis and treatment of STIs and ensure that appropriate drugs are available.
- Based on the latest epidemiologic data, USAID should review whether CRS zones should be targeted for more intense activities. For any CRS zones so identified, USAID (through an appropriate HIV/AIDS partner) should consider introducing in large maternities syphilis screening of pregnant women and prevention of mother to child transmission.

III. Community Based Delivery of Information and Services

Observations: Although the CRS Project is intending to expand into additional areas, the main focus to date has been on increasing utilization of EPI services. Health Centers have well organized programs which provide for immunizations within centers on a weekly basis and at health posts in the *strategie avancé* on a monthly basis. Community *relais* seem to be competent in promotion of EPI and community mobilization for vaccinations, though it is not clear how many *relais* are actually functional. The COSA seem to be primarily involved in logistic and management questions, and very little in terms of expressing community needs, organizing educational activities or in defining quality of services.

Local NGO's other than church groups exist. The Profam women's groups are widespread. In Lueta where an influx of Congolese repatriated from Angola have increased needs for emergency assistance, an NGO has formed to provide help to "Personnes Oprimés". It currently has 15 members, each contributing 1500 fc ($4) a month to provide emergency relief. The BDOM in Luiza carries a considerable responsibility for emergency relief as well.

For the most part, community participation centers around making bricks for health center and health post construction, and providing the labor to build. The BCZS told us that they pass through the village chefs to reach the population, and through commanders to reach military when they encounter resistance. However, we did not find any systematic attempt to work with other local NGO's or women's groups other than the COSA. The COSA has primarily a management role with regards to the health center rather than an educational role with the community.

We did not see flip charts in the centers, though we were told that EPI flip charts have been (or will be provided). There were also wall posters in most places relating to TB, community surveillance, cases of paralysis, malaria treatment, malaria spraying, coughing (TB), vitamin A, MONUC, ABC, but none related to child spacing.

CRS uses a performance improvement contract at two levels: between BDOM and BCZS, and BCZS and the COSA/Centre de Santé. This process engages the partners in carrying out their activities to achieve agreed upon objectives. Committee members and health staff on both sides must participate in the development of the contract and sign it.

Issues:

- In their program description, CRS has described a strong and participatory community component. Because of the program emphasis on EPI and the WHO training of a few of the *relais*, the *strategie avancé* work of the *relais* is largely disease surveillance and mobilization for vaccinations rather than preventive or educational activities.
- Although some relais have received WHO surveillance training, most have not been trained. It is not even known how many relais are functioning in some health zones. BCZ "animateurs" hold monthly meetings with relais, but only 1 or 2 per health area.
- Relais seem to receive more effective supervision from the BCZS animateur than from the health center in their area.
- The Performance Improvement Contracts are helpful in focusing attention and making certain specific actions an obligation on the part of both parties. However, some of the entries are not easily defined nor measured, and completion of certain tasks does not necessarily trigger a response from the other party. It was not clear if or how contracts are monitored for performance.

Recommendations

- Assure that the upcoming training of *relais* will prepare them for a broader role in working with communities, women's groups, local NGO's and in expanding the *strategie avancé* to address problems other than immunizations. The COSA should be trained in educational and behavior change roles as well as the management functions with the health center.
- Carry out an enumeration of relais, identified by sex, to be able to effectively plan for trainings and to provide the necessary registers and educational materials. This census can be carried out at health center level, using the "messengers" who are already on staff and the strategy avancé outings for vaccinations. It is sufficient for health center staff to meet and plan based on their list of villages covered, and then for the BCZS to aggregate the data at the monthly meeting of infirmiers chefs.
- The monthly reports to BCZS need to include questions about relais and other community and IEC work.
- Build a community participation strategy which more effectively involves women, which addresses client satisfaction and community defined quality and which works with local NGO's and groups to provide educational activities. This can be done through inclusion of community participation themes in the other trainings being

developed, and does not need to be the objective of a separate, costly set of trainings. It should be included in the infirmier chefs meeting as well as the monthly meetings of *relais.*

- CRS, BDOM and BCZS in developing the training plans for the *relais* should explore social marketing as a strategy for increasing utilization of services, and determine if *relais* have a role in socially marketing certain products in their villages
- As the second year ends, review contracts to discuss progress, monitoring in the future, identify clear indicators, and the relationship between the actions of each party. Current contracts are more like workplans than contracts.

III. Management Systems

A. Drug management:

CRS supports a drug management system that consists of:

- pharmacies at health centers and hospitals that are managed by health facility staff;
- Drug depots at Health Zonal offices that resupply the health facilities;
- Drug facilities managed by the regional BDOM offices that service a number of health zones;
- Resupply of BDOM depots through the PATS-supported CODEPAK drug supply centers in Kananga and Mbuji Mayi.

The total markup of drugs from CADIMEK is 30%. All initial stocks of drugs came from UNICEF donations.

Issues:

- Health facilities are in need of periodic supplements of drugs in order to keep from raising prices and to cover cost of indigent services;
- The existing registers (*fiche de consummation*) that document use of drug revenues for approved resupply costs (e.g., transport to drug depot) are not consistently used nor reviewed by supervisors.
- There appears to be inadequate monitoring of drug stocks and decapitalization of most pharmacies.
- Lab tests are over-prescribed and appear to be used as a revenue generating device.
- There appears to be serious over-prescription of drugs that drives up the costs of health care for consumers and depresses health facility utilization.

Recommendations:

- USAID should verify with UNICEF that requested drug donations (four increments for each health facility on a sliding scale) will be provided through the life of the project. If UNICEF is unable to provide the remaining drugs, USAID should plan now to procure the needed stocks. The options for doing this are as follows: provide funds to UNICEF obtaining any needed waivers perhaps in a cost share arrangement; order drugs directly through a mission purchase order obtaining USAID/W waivers; obtain permission from CRS' Regional Contracting Officer to purchase drugs directly from approved sources. In addition, CRS needs

to review its calculation of the quantities of drugs provided in each increment and make any needed adjustments.

- Once the planned four increments of drugs are provided to health centers, CRS should consider providing additional donations only to those facilities that demonstrate solid drug management (e.g., low decapitalization, good prescription practices).
- CRS and SANRU should conduct a review of health center laboratory tests conducted in USAID-supported zones and establish guidance that will reduce the number of unneeded lab tests. At the same time, fees from lab tests should be considered part of drug revenues and reserved for reorder of reagants. This measure will reduce incentives to prescribe lab tests by making the funds generated an ineligible source for staff *primes*.
- To address the over-prescription of drugs, CRS should ask Health Zonal supervisors to review the health center drug dispensary sheets and compare prescription patterns to what is in the *ordinogramme*. In addition, supervisors should routinely compare the physical stocks and stock cards for at least three drugs during health center visits. These measures should be elements in the supervision checklist that the Assessment Team recommends developing. In addition, over-prescription of drugs should be addressed in scheduled refresher training, collaborative QA exercises, community education programs, and the new performance contracts to be developed between HZs and health facilities.
- CRS should introduce simple forms to document the use of drug revenues for transport and other approved drug resupply costs to improve accountability of these funds. CRS should review and reset the margins on drugs at both the health center and BDOM levels based on real management costs.

B. Supervision:

Observations: The CRS Project has done an excellent job of making supervision regular and effective at all levels that the team visited. Staff in all project health centers reported monthly supervision visits, and the one non-project health center reported a last visit in May of 2003. BCZS and BDOM staff carry out supervision visits together. The PEV program is effectively supervised.

Within health centers, the Centre de Santé de Lueta was particularly noteworthy in that the Head Nurse holds staff meetings every morning to discuss cases from the night before or any other needs in the health center. This affords supportive and corrective supervision, and assures that the Head nurse is well able to assure satisfactory provision of services.

Supervision of BDOM and in turn of rehabilitation of structures has been problematic in certain circumstances. BDOM provides primarily a coordination, administrative and logistics role with technical support mostly to the PEV program. The maternity rehabilitation at the Lwiza hospital clearly would have benefited from greater technical direction and participation from beneficiaries. It is CRS role to supervise BDOM both in the plan and design of such work as well as the implementation phase. This maternity has been constructed with about 20 small cells with a high window – no water, and toilets

and showers located at some distance. For a single nurse on duty at the night it would be impossible to provide good observation of patients. A larger, multiple bed room with a nurse station, lighting and ventilation might be better for both the women and the nurses.

Issues

- Better supervision of rehabilitation projects and more involvement of beneficiaries to assure best use of resources for the desired outcome
- Supervision of *relais* (see community approach) by the closest health center

Recommendations

- Formative supervision is performed regularly and the EPI clearly demonstrates that effective supervision has been provided. However, other technical and management areas need to be effectively addressed through supervision.
- Revise existing supervision protocols to better reflect the full core package of services, drug and financial management, and community mobilization activities. Ensure that the revised supervision protocols are used during supervision visits.

C. Training

Observations: CRS provides a series of trainings throughout the life of the project. These trainings primarily target the personnel at different levels of health structures (BCZS[1], General Referral Hospitals and Health Centers) as well as the technical staff of the partner BDOM[2]. Since the beginning of this project, the following trainings have been conducted:

TRAINING	TRAINING TARGET	# OF PARTICIPANTS
Primary Health Care Management	Technical staff of BCZS, Referral Hospital, Referral HC and HC	313
Vaccination techniques	Technical staff of BCZS, Referral HC and HC	311
Treatment algorithms including IMCI principles	Technical staff of BCZS, Referral Hospitals, Referral HC and HC	306
Malaria case management	Technical staff of BCZS, Referral Hospitals, Referral HC and HC	267
Blood transfusion safety and universal precautions	Hospital and Referral Health Center transfusing staff	148

[1] BCZS (Bureau Central de la Zone de Santé) is the Central Office of the Health Zone.
[2] BDOM (Bureau Diocésain des Oeuvres Médicales) means Diocesan Medical Office.

For all trainings CRS collaborates closely with MOH agencies and programs at the national and provincial level as well as with other international agencies (e.g. BASICS) to assure training content is compliant with national policies and standards. In addition, pre- and post-tests conducted during the trainings reveal that the participants adequately understood the training topics.

In December 2003, the MOH restructured the Health Zones in the Sankuru District, thereby creating three Health Zones from the original eight supported by this project. Although these newly created Health Zones did not benefit from the full complement of material support during the current fiscal year due to budgetary constraints, the BCZS, hospital and health center staff from these "daughter Health Zones" were included in all trainings in order to reinforce their technical capacity until more material assistance is possible.

Issues

During the planning, realization and evaluation of these trainings, CRS identified the following issues:

- Facilitation: Securing the commitment of training facilitators was at times challenging due to competing obligations on the part of the facilitators and difficulties in reaching the training sites.
- Number of nurses (IT) trained: Although all of the Health Areas (AS) were covered by these trainings, financial and logistical constraints permitted only one IT to be trained per AS.
- Equipment to apply training concepts: The scarcity of certain types of material assistance was a hindrance in applying training concepts/techniques in the field.
- Integration of trainings: In Sankuru health zones, trainings of malaria case management and treatment algorithms including IMCI principles were integrated during five days instead of six as previously planned. This experience allowed the project to save time and money.

Recommendations:

The following recommendations have been identified by CRS to address the abovementioned issues.

- Compile a list of potential training facilitators from national and/or provincial level for future trainings.
- Coordinate with SANRU to have a standardized contract between training facilitator and CRS or SANRU.
- Ensure sufficient time and resources to adequately plan trainings well in advance and make provisions for unforeseen circumstances.
- Offer re-trainings to increase the number of IT trained per Health Area.
- Ensure that adequate material assistance (e.g. ITBN, SP, HIV test kits, etc.) is made available at the operational level to enable training participants to apply their newly acquired skills and knowledge once they return to their place of work.
- Study possibilities to integrate multiple topics during trainings sessions.

D. Financing:

Observations: The CRS Kasai primary health care project is undertaking interventions that impact favorably on the financing of primary health care. First and foremost, by rehabilitating facilities and providing them with basic drugs, equipment, supplies and vehicles, the project increases the availability and quality of services. Participating health centers experience increases in utilization leading to increased revenues and increased staff bonuses. Also, the project trains health staff in primary health care management and the use of standard protocols. This training contributes to more efficient case management and reduces the costs associated with over-prescribing of drugs and lab tests. By strengthening zonal supervision of health centers, the project increases transparency and accountability. Both increased patient revenues and increased oversight are likely to contribute to reducing negative practices such as supplementary employment or underreporting of patient income.

The Kinshasa School of Public Health indicates an interest in working collaboratively on the issue of access to services by the poor in rural areas. Additional experiences that may provide lessons are those of the BDOM in Kinshasa under Sister Close Benedicte and the experience in Bwamanda. Dr. Munyanga of the SPH will lead the initiation of a new pgram in health system management to train economists with support from the MOH and the Dutch NGO CORDET.

Issues:

- Congo's primary health care system is severely undercapitalized. Health centers have practically no medical, laboratory, or office supplies or equipment; furniture, drugs, or vehicles. They operate out of rudimentary facilities not served by running water, electricity, functional roads, radio or telephone, and poorly illuminated and ventilated.
- Health workers, while nominally civil servants, function as concession holders, with the authority to earn income from patient fees. Health center staff retain 60% of revenues from patient fees (excluding drug sales) as staff bonuses. Some health staff work fewer days in health facilities to earn income elsewhere.
- Severe undercapitalization means health centers cannot meet patient needs, so people use their services less. With fewer patients, health centers are inclined to provide each patient with more and more expensive services in order to raise money.
- The price of health services is a serious constraint for the poor and for households with seasonal income or limited cash. This is especially problematic for labor and delivery services. At $2.70 per normal delivery, this is one of the most expensive services that primary health centers provide.[3] While some of the poor opt not to use services, others end up pawning household items to the health center until they can pay their debts. Thus health centers are full of clothes, radios and even guns that patients leave until they can pay their bills. Often months go by without patients being able to retrieve their belongings. Because 60% of patient fees go to pay health center staff, each $10 not collected from patients effectively means a

[3] A recent MOH study estimates average rural household daily income at $0.23.

$6 cut in staff salaries. The financing system does not make any formal provision for fee exemptions[4]. With limited flow of information and limited supervision, it is not clear whether low patient revenues are a result of low utilization, staff underreporting of patient income, or non-payment by poor patients.

- Neither health center staff nor zonal supervisors fully exploit financial information routinely collected and reported through the SNIS.

Recommendations

- Assess the impact of indigents on overall primary health care financing and develop experimental options with communities to subsidize the poor (possibly based on agricultural products rather than cash). Build on community organization(s) that already collect funds for shared purposes. Develop collaborative network with CRS, BDOMs, SANRU, MOH 5th Directorate, World Bank and School of Public Health to explore this challenge together. Develop capacity in at least one of these organizations (possibly School of Public Health) to provide technical assistance in this area.
    - Test feasibility of *mutuelles de sante* in rural zones. Participate in November Bamako meeting of *Concertation.*
    - Set up community fund to subsidize services for the poor. Explore Yangala and Micope health zone experiences for lessons learned.
- Document the content and cost of CRS core service package and its impact on health services. Share lessons learned with MOH and partners. CRS can build on the work SANRU has done in this area based on PHRplus technical assistance.
- Improve analysis of financial information at health center and zonal level and benchmark performance to foster greater accountability.
- Help BDOMs and health zones with business planning/fundraising to diversify their funding sources by attracting resources from additional sources such as the Global Fund, the World Bank MAP, foundations and churches.

E. Health Information:

Observations

Primary health care staff keep surprisingly good records considering their circumstances. In the absence of prepared forms, typewriters, writing supplies or carbon for copies, their improvised registers of patient consultations, fees, drug stocks, laboratory tests and inventories of goods and equipment are generally thorough and up-to-date. They submit monthly reports to zonal authorities following the structure of the *Systeme National d'Information Sanitaire (SNIS)*. The SNIS provides thorough information on health services, human resources, drugs and finances. For the Expanded Program for Immunizations, the health center staff set annual targets and track monthly progress with graphic wall charts.

The CRS Project has begun to cultivate a culture of information in the primary health care system in the Kasais through training, population surveys, technical assistance and

[4] The system does allow for exemption from payments for drugs, through the use of the *rumeur* form.

the provision of formats. Thanks to project efforts, health center staff now have a clearer idea of their catchment areas and target populations. They track laboratory tests and drug use and post their fee schedules. Once the MOH finalizes reporting formats, CRS plans to reproduce and distribute them. EPI information is particularly well managed. Overall, health centers submit timely and complete reports to zonal authorities who in turn maintain up-to-date consolidated reports.

Issues

- Neither health center staff nor zonal authorities fully exploit available information to identify trends, spot potential or actual problems or benchmark progress.
- The severe scarcity of inputs such as carbon paper, paper and formats poses a real constraint to good data collection and reporting. Health centers do not retain copies of the reports they submit that would allow them to analyze their own information. With the exception of the EPI program, health centers do not use any graphic techniques for analyzing or presenting information.

Recommendations

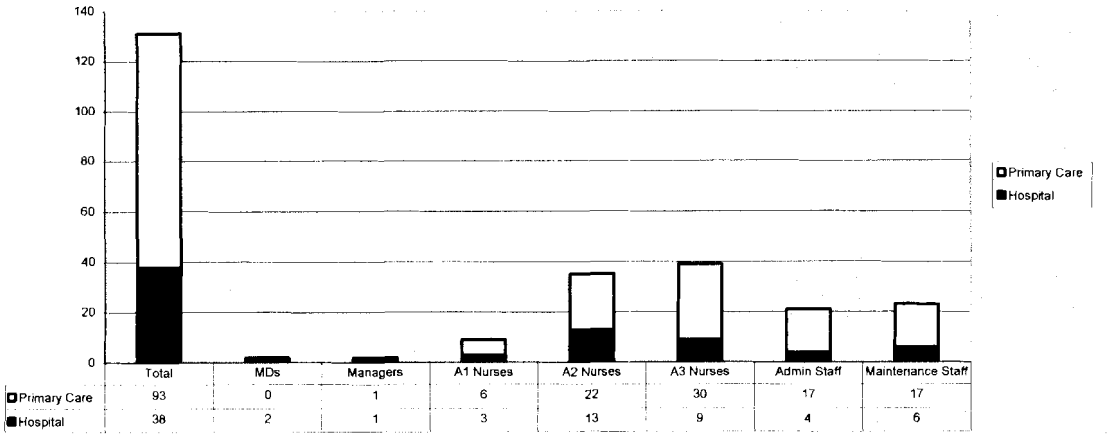
- Provide each health center with ample supplies of paper, carbon paper and writing supplies. Establish a practice of retaining copies of all reports submitted.
- Ensure the use of the new UNICEF graphic tools modeled on those used for EPI for other key services such as prenatal, delivery, vitamin A, and malaria prevention (coverage of ITNs and IPT). Train health center staff to establish expected values, identify and find the reasons for deviations and develop solutions.
- At the zonal level, work with authorities to establish benchmarks for health center services and to analyze reports for variations from these benchmarks. Use the observations about these reports as the basis for supervision visits.

F. Human Resources

Observations

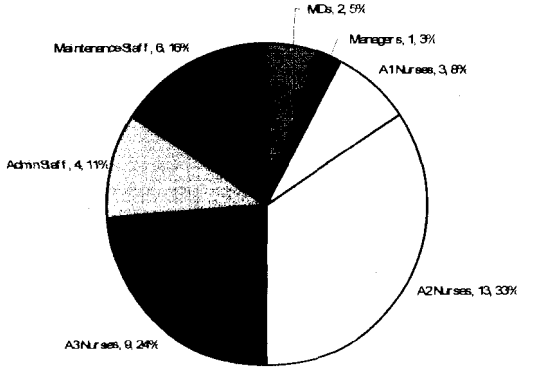
At the zonal level, Congo's primary health care system is not overstaffed based on observations of staffing patterns in Luiza, which has 131 staff to serve 122,127 people. Overall, 30% of all nurses and both of Luiza's two physicians work at the reference hospital. The health centers operate with a total of 93 staff, including only one nurse or auxiliary for every 2100 people.

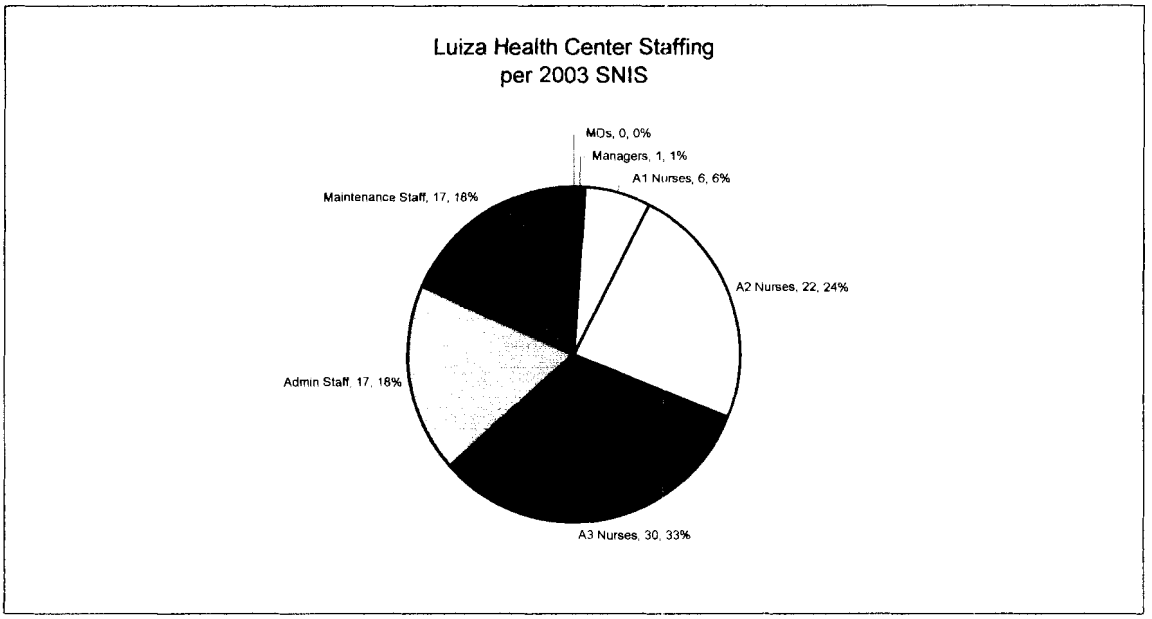
Luiza, Congo PHC Staffing per 2003 Zonal SNIS Report to serve population of 122,127



	Total	MDs	Managers	A1 Nurses	A2 Nurses	A3 Nurses	Admin Staff	Maintenance Staff
Primary Care	93	0	1	6	22	30	17	17
Hospital	38	2	1	3	13	9	4	6

Luiza Hospital Staffing per 2003 SNIS





The CRS project is improving health worker skills and motivation. The project has provided staff with training as discussed elsewhere in this report. Most health center staff demonstrate awareness and indicate use of up-to-date practices in these areas.

By offering supervision, access to training, drugs, equipment and the possibility of rehabilitation, the project provides staff with tangible evidence that things can improve, thereby substantially improving motivation. Health center staff have had such limited access to support that the CRS project support makes a tremendous difference for them. In one center, staff recounted the exact date and time their first shipment of CRS-provided drugs arrived last year.

Issues

- Hospital staff productivity is extremely low, with 2 physicians and 25 nurses producing fewer than 3000 patient days of service in 2003. On any given day, this 108 bed hospital had fewer than 8 inpatients.[5]
- Health center staff productivity is also low, with health centers frequently reporting fewer than 10 patient visits a day. This is likely due to both the very low availability of complementary inputs and financial constraints on demand. Production of services seems to be increasing with the project, as staff training and complementary inputs improve and health center prices decline.
- Because of the dearth of support over long periods of time, health workers and the communities they serve are not accustomed to identifying their needs and taking steps to improve services. Health workers have no outside incentive to take special initiative.

[5] This may reflect underreporting of service production by hospital staff who stand to benefit financiallyfrom such a practice.

Recommendations

- Establish competitive grants fund that the BDOM would manage in collaboration with the zonal office to allow health centers to carry out projects with community support to improve health.
- Use performance contracts to reward health center teams for good performance

IV. Gender:

Observations: Although gender is highlighted in the CRS program document, there is little evidence on the ground of attention to gender in activities. It was noted that for a maternal and child health project, none of the 11 BDOM staff are women. It is not clear how many *relais* are women, though the intention was to identify teams including one man and one woman of whom one would be literate. There was no evidence of focus on male participation in project activities, and in the one case of maternal mortality discussed, the cause identified was a husband who was unwilling to provide the money so the woman could deliver in Lwiza. Participation by women's groups, discussions at community level to address problems and active participation by men would seem to be useful in achieving project objectives.

Issues

- Project staffing and positions at all levels should involve women and men more equitably
- Consultation and participation by women in rehabilitation of maternities and facilities which serve primarily women and children would benefit the project

Recommendations

- Set gender objectives for staff composition (including for BDOM), participation in training, disaggregation of data by sex, male participation in reproductive health activities, etc. Select appropriate indicators for progress, track and report on them. USAID/DRC has requested a gender tdy, scheduled in July, 2004, to assist with identifying appropriate gender indicators in the strategy.

V. CRS Management

Background: The CRS office is located in Kinshasa and there are no provincial/district level offices in the country. However, the Kasai Project is implemented in remote rural areas by three BDOMs (Luiza, Kole, and Tshumbe). Because of the size of the country and poor means of communication (poor roads, few airports, inadequate telephone system), it is hard to for the CRS Office in Kinshasa to closely supervise the three BDOMs which manage the project. In addition, the CRS administrative/logistics staff in Kinshasa is unable to provide the three BDOMs with the management support they need.

Financial management: Project spending from October 2002 through June 2004 including pending requisitions is about $1.65 million, of which about 11% is for direct CRS operations, about 22% for the operation of 4 BDOMs and about 51% for goods and

services for the 18 health zones. FY02 and FY03 obligations of about $2.5 million leave the project with a pipeline as of July 2004 of $850,000 of which $236,000 is in use as operating cash. Because BDOM operations are such a significant share of total project costs, CRS needs to ensure that BDOM costs match the value they add to the health zones. CRS needs to ensure that project goods and services reach the health zones to the greatest extent possible. To do so, it would be helpful if CRS would track expenditures by principal beneficiary and by purpose (e.g., training, supervision, rehabilitation, etc.) as well as by spending site.

***Issue*:**

- The lack of CRS staff in the field results in inadequate supervision of BDOM offices.
- The overburdened CRS administrative staff cannot handle the project's management needs in a timely fashion.

***Recommendations*:**

- CRS' sub-contracts with BDOMs to support HZs in isolated rural areas. Because of the need to build the capacity of its local partner, there have been some delays in project implementation. In addition, the lack of a dedicated CRS administrative officer for the project has slowed procurement and management support.
- Engage a new staff member to handle procurements, oversee rehabilitation, and manage project information.
- Utilize the unfilled supervisior slot and hire an additional supervisor to serve as on-site coordinators in the two largest BDOM offices.
- Hire a shared finance advisor to conduct analyses and design interventions to address financial constraints on the poor.
- Amend performance contracts (as planned) to align contract terms more closely with project objective (e.g coverage of core service interventions) and to reinforce key management practices. Use the new contracts as basis for supervision and provide recognition and awards for meeting performance expectations.
- Foster community participation and appropriate designs. Ensure appropriate and transparent contracting arrangements. CRS should approve all designs and contracts over a minimum level.
- Because BDOM operations are such a significant share of total project costs, CRS needs to ensure that BDOM costs match the value they add to the health zones. CRS needs to ensure that project goods and services reach the health zones to the greatest extent possible. To do so, it would be helpful if CRS would track expenditures by principal beneficiary as well as by cost center. The Kinshasa School of Public Health indicates an interest in building capacity in the area of improvement collaboratives for quality assurance. Professor Okito has worked in quality assurance.

Other Recommendations:

Quality Assurance: suggest experimentation with the use of collaboratives to achieve and spread quality improvements. Collaboratives use teams of providers (from as many as 30 facilities or units) to analyze how they provide care and then develop and test potential improvements. The teams volunteer to work on a single area of care (such as malaria or over-prescription of drugs) and to share their results with the entire collaborative on a regular basis (usually monthly). This approach would potentially work well in health zones where monthly meetings of the chiefs of all health facilities already take place. The Kinshasa School of Public Health indicates an interest in building capacity in the area of improvement collaboratives for quality assurance. Professor Okito has worked in quality assurance.

- ***Coordination with SANRU:*** CRS should hold regularly scheduled meetings with SANRU, the MOH, and other PHC implementers to share best practices and approaches and to resolve common problems together.
- ***Collaboration with the MOH/DEP:*** CRS should take actions to improve its collaboration and relations with the DEP. Possibilities include inviting DEP staff on selected supervision trips, making sure the DEP receives copies of project reports, and meeting periodically with the directorate.
- ***Review of project indicator targets***: At project midpoint based on progress achieved, CRS and USAID should review project indicator targets and make any needed revisions.
- ***Oversampling of PHC-supported zones in upcoming MISC survey:*** USAID should discuss with UNICEF, the MOH, and other partners the possibility of oversampling the donor-assisted health zones during the upcoming UNICEF Multiple Indicator Cluster Survey scheduled for 2005/6.

VII. **Optimal Number of Zones for CRS Support:** At present, the Mission budgets approximately $2,000,000 per year for the two CRS grants (with a total value of $2,150,000 with the CRS matching contribution). Assuming no increases in Mission budgets, the Assessment team recommends that CRS provide the following levels of support:

- Full support to the 18 originally targeted zones (two remaining in Bas Congo and 16 in the Kasais). Each zone would receive approximately $70,000 of support per year including CRS management costs (excluding NICRA). This level of support is consistent with present budgets.
- Partial support ($25,000 per zone per year for supervision, management training, health information, etc.) to the 7 Kasai zones that were created following the MOH remapping exercise.
- After the NICRA is paid, there would be $100,000 available to begin to cover the cost of some of the recommended actions of this assessment.

The team believes that with the present funding available for CRS, it would be better to provide a package of support of about $70,000 per zone (present projections) than to dilute assistance and cover more zones.

Costs of Proposed Recommendations:

The actions proposed in this assessment will cost approximately $20,500 per zone per year to implement (about a 22% increase in present cost estimates). The total additional annual cost is estimated at approximately $370,000 per year.

Assessment of CRS Kasai PHC Revitalization Project 7/04 Estimated Costs of Recommended Actions			
Item	**Basis of estimate**	**Total Additional Cost**	**Annual Additional Cost**
Insecticide treated nets (ITNs)	already budgeted	$0	$0
SP for intermittent presumptive treatment (IPT)	$1200/zone/100,000 popln./year	$64,800	$21,600
Guides for severe malaria and EPI		$1,500	$500
Timers and guides for ARI diagnosis	$5000/zone	$90,000	$30,000
Iron-folate, training, job aides for maternal health		$135,000	$45,000
AIDS	already budgeted		
child spacing	already budgeted		
Community component	already budgeted		
Introduce, disseminate new lab test policy		$3,000	$1,000
New supervision guide	$500/zone	$9,000	$3,000
New SNIS form and training	$1500/zone	$27,000	$9,000
Training	already budgeted		
Document cost effectiveness of project approach		$10,000	$3,333
Studies to review drug margin and spending on indigents		$5,000	$1,667
Refresher training of health zone staff to improve data analysis and supervision		$20,000	$6,667
Fund for special projects	$3000/zone/year	$162,000	$54,000
2.5 FTEs CRS new mgmt. staff with support costs (2 supervisors, 0.5 finance)	$25,000/FTE/year	$187,500	$62,500
Business plans for BDOMs	$30,000	$30,000	$10,000
30 days of short term technical assistance (for contracts, etc.)	$1000/day fully loaded	$30,000	$10,000
development cost of mutuelles de sante & indigent funds	$50,000 included in mission mgmt.; School of Public Health pipeline	$0	$0
Net additional costs		**$774,800**	**$258,267**
Total additional costs (with 30% indirect costs)		**$1,007,240**	**$335,747**

Net additional costs per zone	**$43,044**	**$14,348**
Total additional costs per zone (with 30% indirect costs)	**$55,958**	**$18,653**