

**Final Performance Report**  
**SANRU III Phase I: Emergency Response Services**  
**December 1, 2000 through December 1, 2001**

**Executive Summary**

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Program Title: SANRU III Phase I: Emergency Response Services

Award No.: AOT-G-00-01-00031-00

Country: Democratic Republic of Congo (DROC)

Disaster: DROC Civil War

Time Period Covered by This Report: December 1, 2000 to December 1, 2001

The project team established 6 regional coordination units to supervise provision of emergency response services; provided medicines, equipment and training for 30 participating health zones; rehabilitated 219 water sources, and set up regional group purchasing systems for economical procurement of drugs and other medical supplies. Despite the wartime conditions in D.R. Congo, the project exceeded almost all of the output indicators established in the project plan.

**Objective #1:** *(Establish four coordination units and provide emergency response services in 25 health zones)*

The four coordination units originally planned (Equateur, Orientale/Kivu, Kasais/Katanga, Bandundu/Bas Congo) became six with establishment of separate units for Bandundu and Bas-Congo and the projection of a “new” cluster of SANRU zones in the Kisangani area, necessitating a separate coordination unit. The units in northern Equateur and in Kisangani are designated “sub-coordination units” because of the relatively small number of zones involved. Emergency response services were rendered in 30 health zones through this award.

**Indicators and Current Measures:**

1. *Indicator: 4 regional coordination units established.* We achieved 150% of the indicator by establishing 6 regional coordination units.
2. *Indicator: 25 health zones supervised.* Coordinators visited 28 of a final total of 30 project health zones during the grant period (112% of the original indicator, 93% of the revised goal). Coordinators were unable to visit the zones of Rethy and Boga in Orientale (Ituri) because of the dire security situation at the time of the planned visit, but held thorough supervisory meetings with these zones’ management staff.
3. *Indicator: 250 water/sanitation systems rehabilitated* (200 were budgeted in December). Rehabilitation of 224 water sources was funded, and we have confirmation that 219 of these have been completed (86% of the original indicator, 107% of the number finally budgeted).
4. *Indicator: 25 hospitals, 250 health centers, and 4 regional medical depots supplied...*  
All thirty of the health zones participating in this project (120% of indicator) received medicines, thus at least 30 hospitals (120% of indicator) and about 390 health centers (190% of indicator) received purchased and donated medicines. Three group purchasing sites (75% of indicator) received medicine allotments. We arranged with the organization ASRAMES in Goma to cooperate on a group-purchasing system based at their depot in Goma. This depot already had a stock of drugs, and will be replenished as part of the Phase 2 program. In addition to the drug distributions, the project distributed 100 health center equipment kits valued at \$10,793, Grants in Kind valued at \$1,018,069, and over 660 books on public health and primary health care.

**OFDA Resources:**

Budget for Objective #1: \$464,852

Expended in final quarter: \$29,505

Total Expenditures: \$382,761

Underspent by \$82,090

**Objective #2:** *(Train 50 health zone personnel in health zone management and provision of emergency services)*

Four training workshops were held, one in Kinshasa in June for management staff from the health zones in the government-held areas; one in Goma in July for medical officers from the eastern health zones; one in Bangui, Central African Republic in September for medical officers from the zones in northern Equateur; and one in Kinshasa in September for resident physicians under training at medical centers in the participating zones of Tshikaji (Kasai Occidental), Vanga (Bandundu), and Kimpese (Bas Congo). Savings in other portions of the budget, particularly free transport of medicines on UN flights, enabled us to spend more than anticipated on this portion of the budget.

**Indicators and Current Measures:**

1. *Indicator: 50 health zone management persons trained.* We have provided training for 64 health zone staff members (128%) of the indicator. Nineteen of these trainees were physician residents under training in rural health zones.
2. *Indicator: % of health zones assisted that develop an emergency response action [plan].* All of the health zone management teams were provided training in formulation of strategic action plans and emergency response or disaster plans. At least 25 of the 30 health zones, or 83% of the project zones, have presented action plans and/or emergency response plans to project management. In addition to providing a blueprint for local action, these action plans are providing a basis for funding to the health zones under SANRU III Phase 2. The volcanic eruption which devastated Goma Zone has been the occasion for extensive emergency response planning and an appeal for donations from church agencies.

**OFDA Resources:**

Budget for Objective #2: \$127,253

Expended final quarter: \$10,700

Total Expenditures: \$173,527

Overspent by \$ 46,274

**Objective #3:** *(Establish and implement decentralized purchasing systems for procuring essential medicines for 28 health zones in 4 clusters)*

Three group purchasing sites (Kimpese, Vanga, and Tshikaji) have been supplied with medicines. Rehabilitation of the designated depot buildings is currently underway with funding from SANRU III Phase 2 in order to bring these depots into full operation. A fourth depot arrangement has been established in cooperation with the organization ASRAMES (L'Association Régionale d'Approvisionnement en Médicaments Essentiels) in Goma, and the facility there has escaped the volcanic eruption. The SANRU III team is discussing sharing of depot locations in Mbuji mayi and Nyankunde/Beni with Pharmaciens sans Frontières and MedAir, respectively.

**Indicators and Current Measures:**

1. *250 health centers will be provided with essential medicines.* Approximately 390 health centers (195% of the indicator have been supplied (see indicator #4 of objective #1 above).
2. *Number of group purchasing systems established.* Four medical group-purchasing systems have been set up.
3. *Types, quantities and Dollar value of drugs purchased and delivered, as defined on Exhibit No. 1 of the project plan.* The \$132,614 worth of drugs purchased for this project using OFDA funds has been distributed to the health zones. Attachment 1 shows the distribution of drug kits worth \$226,014 (including those purchased by the Presbyterian Church (USA)) A total of 88 hospital kits and 677 health center kits, as detailed in Exhibit 1 of the Project Document, have been distributed. In addition, the project team distributed 100 health center equipment kits valued at \$10,793 and Grants in Kind valued at \$1,018,069.

**OFDA Resources:**

Budget for Objective #3: \$407,895

Expended final quarter: \$78,629

Total Expenditures: \$443,712

Overspent by \$35,816

## **Program Overview**

The goal of the SANRU III, Phase I, Emergency Response Services Project was to strengthen and sustain the capacity of health zones throughout DROC to provide curative, preventive and promotive health care to the long-suffering Congolese population. The implementation plan involved establishment of regional coordination units, training in provision of emergency response services for health zone management personnel, and the establishment of a decentralized group purchasing system for procuring essential medicines in the project health zones.

The thirty health zones targeted for assistance through SANRU III Phase 1 are located in several areas of the Democratic Republic of Congo, identified by yellow dots on the accompanying health zone map. Along with the rest of the DROC (population about 50 million), these areas (population over 5 million) have endured 30 years of economic deterioration and have been traumatized by two successive civil wars in the past five years. The current war has led to over 2.5 million excess deaths in eastern DROC alone (International Rescue Committee study). Gross Domestic Product per capita in DROC has been estimated at under \$100 (World Bank, 1999) and life expectancy is approximately 45 years (World Health Organization, 1998).

## **Program Performance**

Objective # 1 (*establishment of four coordination units and provision of emergency response services in 28 health zones*)

In order to adequately address the coordination needs of the widely-spaced project intervention areas, a total of six regional coordination units have been established under the SANRU III, Phase I, Emergency Response Services Project, two of which (Kisangani and northern Equateur) are designated “sub-coordination units” because they served relatively small clusters of health zones. These coordination units are designated by blue squares or triangles (for sub-coordination units) on the accompanying project map. Three of the coordination units (Bas-Congo, Bandundu, and Kasais/Katanga) are in the areas held by the central government and 3 (Eastern Congo, Kisangani area, and northern Equateur) are in the rebel-held/ occupied areas.

Regional coordination activities were made particularly risky by the difficulties and dangers of travel in the project areas. In all areas the roads and small-plane landing strips tend to be in poor condition. In the eastern zones, widespread banditry and fighting among various armed groups continues despite the official ceasefire. Headquarters staff made most of the initial coordination contacts with the health zones, while seeking suitable candidates for the regional coordination positions. This involved several journeys between government-held and rebel-held areas; the I.M.A. representative, Dr. Bill Clemmer undertook much of this risky cross-country travel because, as an expatriate, he was considered to be somewhat immune from the animosity between the rival administrations.

The regional coordinators now in place have proven to be dedicated, organized, and resourceful. The four full coordination units have been provided with 4-wheel drive vehicles, as budgeted in

Phase 1, and all have funding for transport and office expenses as well as salaries. Having seen the Phase I project to a successful completion, they are now coordinating project activities of the 5-year SANRU III project, which is currently serving 52 health zones (including the Phase 1 zones) and is to eventually serve 60 to 80 zones.

Savings on in-country transportation due to the generous assistance of MONUC (the UN DROC peacekeeping force) have enabled us to provide additional assistance to health zone teams. In addition to the 10 motorcycles budgeted, we have purchased 5 motorcycles and 100 bicycles for use in the health zones. These will enable increased visitation of outlying villages and coordination of health centers of health zone bureaus, which will be especially beneficial for vaccination coordination and distribution of medicines.

The coordinators have provided concise analyses of health zone organizational structures, interventions, and needs, and have provided recommendations for ameliorative action. For instance, Dr. Zambite, coordinator for Bandundu province provides a list of recommendations for Vanga Zone covering planning, budgeting, accounting, drug management, supervision strategies, and data collection.

Drugs with a total wholesale value of \$226,014 have been provided to all 30 of the project health zones and depots, including \$132,614 purchased with OFDA funds and \$93,400 purchased with funds from the Presbyterian Church (USA). All of the health zones had received their drug and equipment allotments; we estimate that 390 health centers in the participating health zones have received drugs from these shipments to the health zones. In most cases, the health centers come to the health zone office monthly to receive a monthly drug allotment, for which they pay considerably less than the local market rates (see objective 3).

The 100 health center equipment kits were distributed to the following zones: Kinshasa (10), Wapinda (10), Karawa (10), Loko (10), Tandala (10), Kimpese (10), Sona Bata (10), Luozi (10), Mangembo (10), and Yakusu (10). The gifts in kind were distributed to the following zones: Vanga, Kinshasa, Mukedi, Kajiji, Kahemba, Sona Bata, Nselo, Nsona Mpangu, Kimpese, Yakusu, Kikongo, Karawa, Kangu, Kinkonzi, Kuimba, Kibunzi, Luozi, Mangembo, Kasonga Lunda, Bokoro, Bolobe, Bosobe, Kiri, Bolenge, Pimu, Loko, Wapinda, Banga Bola, Tandala, Lubondaie, Kisantu, Kimvula, Ngidinga, Moanza, Djuma, and Goma. One will note from these lists that project benefits were extended well beyond the 30 health zones that were fully enrolled in the project.

In the final quarter we contracted with the Tear Fund to rehabilitate an additional 44 water sources in Bandundu province, for a total of 224 water sources funded. We have confirmed completion of 219 of these rehabilitations, for which local communities provided labor under health zone staff or Tear Fund supervision. This activity was carried out in the 17 health zones in government-held areas. We unfortunately were not able to initiate planned water source rehabilitations in the occupied regions because of the difficulties we have encountered in exchanging information and transferring funds to these areas. Environmental health activities in these areas will be funded through the SANRU III Phase 2 project.

Objective # 2 (*train 56 health zone personnel in health zone management and provision of emergency services*)

A total of 64 health zone personnel were provided training in health zone management and provision of emergency services.

A two-week training workshop was held in Kinshasa in June for the administrators and medical directors from 18 health zones in the government-held areas. In addition to OFDA-funded activities, a Church World Services consultant, Ivan Dekam, led a 7-day workshop on Emergency Response and Disaster Planning, using the Sphere Project Manual. This was followed by a weeklong conference in Health Zone Management led by the I.M.A. international consultants and lecturers from the University of Kinshasa School of Public Health. The feedback and response by the 34 participants and other invited guests was overwhelmingly positive.

A training for management teams from the rebel-held/ occupied zones was planned for Kinshasa in August but had to be cancelled when the DROC government rescinded its permission to bring personnel from these areas into the national capital. Training sessions were then set up in Goma and in Bangui (Central African Republic) to fulfill the training plans for these areas.

The Goma training from July 20-22 involved health zone medical officers from Nyankunde, Rethy, and Boga in Ituri (Oriental) province and Oicha, Musiennene, Katwa and Goma in North Kivu province. Dr. Clemmer, the I.M.A. representative, and Dr. Minuku, the ECC/SANRU Technical Coordinator, presented the training. The condensed program included an orientation to the SANRU program, drug distribution policies, specific disease interventions, and consideration of the specific crises facing the participating health zones.

The Bangui training of September 5-10 involved chief physicians from the health zones of Banga-Bola, Karawa, Loko, Pimu, Tandala and Wapinda in occupied northern Equateur (the zones of Pimu and Banga-Bola are included in Phase 2 of SANRU III). Instruction was provided by Dr. Clemmer, Dr. Minuku, Mr. Larry Sthresley (Presbyterian Church (USA) health consultant) and Mr. Basanga, the ECC/SANRU training coordinator. The curriculum was similar to that of the Goma training, in somewhat more depth. The participants studied and presented sections of the Sphere emergency response manual, discussed the procedures, and modeled emergency response strategies in classroom exercises.

The training for medical residents from Kimpese, Vanga, and Kimpese health zones took place in Kinshasa from September 24 to 29. This session was developed around an established residency training program that the ECC (Eglise du Christ au Congo) has been carrying out with help from German organizations. SANRU project management agreed to sponsor this previously planned training when it became evident that adequate funding for this training session was otherwise not available. The arrangement seemed particularly appropriate because the residents are all working in health zones involved in this project, the curriculum was clearly focused on provision and management of emergency services, and the participants are slated to provide leadership in the rural health zones. Two faculty members of MEDUNSA, a medical school in South Africa, and Dr. Murray Nickel, an American Mennonite mission physician,

provided instruction. The curriculum included sessions on emergency care, growth monitoring, immunization, medical ethics, and health care management.

Each of the trainings featured assistance in developing long-term strategic action plans as well as short-term plans to deal with specific emergency situations. Project regional coordinators continue to assist the health zone management teams in developing these plans, and at least 25 of the 30 zones have presented action plans.

The trainings provided under this project are now being supplemented by the extensive training curriculum of SANRU III Phase 2, with 17 components covering a wide range of management, environmental health, support services, and disease-specific activities.

*Objective #3 (establish and implement decentralized purchasing systems for procuring essential medicines for 28 health zones in 4 clusters)*

Group purchasing arrangements were instituted at Kimpese (for Bas-Congo Province), Vanga (for the Bandundu Province) and Tshikaji (for the Kasai Provinces and Katanga). These three depots were supplied with an initial stock of thirty-three health center drug kits each to serve as a low-cost source of drugs for health institutions in case of stock-outs at before the next major drug orders. Kimpese depot has sold its stock and is preparing additional drug orders, but none of these depots have yet completed additional cycles of ordering, purchasing, receiving and distributing medicines. The designated depot buildings are currently being rehabilitated with funding from SANRU III Phase 2. We expect the depots to come into full operation with completion of the depot buildings and generation of drug orders from the health zones as current stocks run low.

A 4<sup>th</sup> depot arrangement has been set up in Goma in cooperation with ASRAMES (Association Regionale d'Approvisionnement en Medicaments Essentiels au Nord Kivu). Under the agreement signed between ECC-SANRU and ASRAMES in August 2001, ASRAMES' facilities in Goma will serve as the central depot and distribution center for SANRU medical shipments to North and South Kivu provinces and possibly Province Oriental (Kisangani). The arrangement seems ideal because ASRAMES already has group purchasing arrangements with the International Dispensary Associations (IDA), where I.M.A. and most of the Congolese health zones have been procuring drugs. ASRAMES provided storage for the subsequent shipments of medicines in transit to Goma, Katwa, and Musienene health zones. As this depot was already stocked, we did not provide stock under this project, but we plan to do so under SANRU III Phase 2.

Other depots and group purchasing arrangements will likely be needed to cover drug procurement in areas distant from the four depots already established. Two additional group purchasing arrangements which SANRU project management are actively considering would be based in Mbuji mayi (Kasai Oriental) and Bunia (Ituri, Oriental), in cooperation with Pharmaciens sans Frontieres and MedAir (an NGO based in Switzerland), respectively.

Meanwhile, other donors and projects have expressed increased interest in this approach. For example, the Belgian Cooperation agency has recently (mid-Feb 2002) completed a feasibility study to create approximately 30 “Centrals d’Achats” and group purchasing systems throughout the country. The SANRU project will need to assess the placement of its group purchasing sites with respect to this long-term development.

Under the group-purchasing plan, a steadily increasing percentage of the wholesale value of drug allotments to health zones and depots is to be recovered and recycled into project activities. Adjustments have been made to this plan to address the varying conditions in different areas of the country. Health zones in the western government-held areas have sought to recover the drugs’ wholesale cost and recycle 20% of the proceeds into project activities. In some zones recovery rates are not as high, especially in the rebel-held/occupied areas where the devastation of the war is particularly severe and where health zone drug distribution policies have been influenced by guidelines on other donations. In many cases the drugs are distributed free of charge to the general population in these areas. We continue to reexamine project policies as we seek to meet the immediate medical needs of the population while helping to build more sustainable systems to meet their future needs. Economic and financial studies being prepared under SANRU III Phase 2 will provide a basis for assessment and fine-tuning of drug distribution policies.

## **Challenges and Advantages**

### **A. Finance**

#### *Challenge: Delays in approval and funding*

The planning team had expected to launch implementation of the project in 2000, but approval was not received until January 18, 2001, with the start date backdated to Dec. 1, 2001. I.M.A. could not afford to commence activities without prior funding, but the first money transfer was not received by I.M.A until March 26, 2001, 4 months after the official starting date. Project activities were delayed, and the approval of the \$25 million SANRU III Phase 2 project in May brought considerable pressure to complete the Phase 1 project in order to devote attention to the Phase 2 project.

#### *Advantage: Donated Resources*

A \$150,000 contribution from PC(USA) in December, 2001 enabled the project to begin activities while waiting for funding from OFDA. Medicines purchased with this contribution were distributed to half of the project health zones well before medicines funded by OFDA arrived.

Large gifts in kind, including medical equipment and medicine, greatly increased the SANRU package of assistance. We were able to respond quickly with a material aid shipment when Goma was hit by the volcanic eruption because we had some remaining items from these Phase 1 gifts on hand in Kinshasa, along with a \$273,209 gift of medical supplies from Project Cure (shipped under the SANRU III Phase 2 Project).

## **B. Management**

### *Challenge: personnel transitions*

As soon as OFDA funds were received, the ECC medical division had to hire several staff to administer the project, having operated with a minimal budget for the past 10 years. These staff had to move promptly to implement the project.

We had planned to hire Dr. Katele, a veteran of the earlier SANRU projects, as project manager. Unfortunately he became involved in a project in Afghanistan and was unable to join the SANRU team.

The administrative coordinator was released due to his mismanagement of funds in another project. His first replacement was found inadequate, and a satisfactory candidate, Mr. Pascal Munkatu began work in October.

### *Advantage: veteran staff at ECC headquarters*

The project was able to get underway rapidly and efficient because of the availability of experienced, talented, highly motivated local staff working under the inspirational leadership of Dr. Leon Kintaudi. In addition to the seasoned staff already in place in Kinshasa, ECC hired back individuals with considerable SANRU I& II experience. For example, Dr. Felix Minuku, who was trained under SANRU I and II and has served long as health zone health officer and medical inspector, moved quickly and efficiently into the role of Technical Coordinator. Pascal Munkatu, who was a SANRU II management staff member, has brought a great deal of institutional memory and creativity to the post of Administrative Coordinator.

### *Advantage: expatriate management assistance*

I.M.A.'s member agencies were generous in providing excellent management assistance for the project. This support in the form of human resources, in addition to cash grants from I.M.A. Member agencies for purchase of pharmaceuticals, has very significantly leveraged the financial resources provided by the OFDA Grant.

For example, the American Baptist Churches seconded Dr. William Clemmer, a veteran missionary physician, to serve as I.M.A. Representative, and he has also served as Project Manager. The Presbyterian Church (USA) donated the services of Larry Sthreshley, a health program consultant who has worked with ECC/DOM on similar projects over several years.

In addition, we were very fortunate to have the services of Dr. Franklin Baer, who planned and managed SANRU I and II through the 1980's, and is playing a central role as senior consultant in SANRU III.

### **C. Planning**

*Challenge: settling on a list of beneficiary health zones*

In the face of the huge need for health care assistance and the great demand for inclusion in the SANRU III program, it was very difficult to limit and finalize the list of beneficiary health zones. Health zone management, the Ministry of Health, the US Embassy and USAID all contributed to the determination of the final list. The list grew as we expanded the project focus to include areas under rebel/occupying force control.

*Advantage: USAID Approval of the 5-year Phase 2 project*

The award of a 5-Year grant from USAID for a Phase 2 initiative was, of course, a wonderful development for the SANRU III team and our beneficiaries. In terms of Phase 1 planning, it enabled us to focus on a limited list of health zones and activities, knowing that other areas and activities would be addressed in the Phase 2 project.

### **D. Logistics**

*Challenge: Transportation*

Many of the health zone teams lacked reliable transport. For those with access to motorized vehicles, the decrepit dirt roads made travel slow and harrowing. Commercial air travel was expensive and dangerous. Much travel under the project was accomplished on foot, motorcycle, or dugout canoe.

*Challenge: Crossing battle lines*

The project involved health zones on all sides of the DROC war. Project personnel had to get travel permits from the Kinshasa government and from the "rebel" authorities in the north and east of the country in order to travel to the far-flung health zones. Depending on the political and military situation, this was sometimes difficult. The rival administrations were jealous of the project's allegiance and sometimes suspicious of our involvement with the "enemy." We had to cancel a Kinshasa training session for participants from the "occupied" health zones due to the Kinshasa government's security concerns. A regional coordinator from occupied northern Equateur was arrested on arrival for a coordinator's meeting in Kinshasa and held for weeks on suspicion of treason.

On the local level, project personnel had to endure harassment at military checkpoints and had to postpone missions to some zones due to nearby fighting.

*Advantage: Free air travel provided by United Nations (MONUC)*

The United Nations enabled us to bridge the gap between government-held and occupied areas by providing free travel on the frequent MONUC (UN mission in DROC) flights. Traveling under the wing of the international body smoothed the way logistically and diplomatically and saved the project a lot of money.

*Advantage: rapid response on drug orders*

Working through the International Dispensary Association (IDA) in the Netherlands, we received high-quality drugs and medical supplies in Kinshasa within a few weeks, rather than the delays of several months we experienced in working with other international suppliers.

## **E. communications, information**

*Challenge: Lack of means of communication with health zones*

The government mail service in the DROC is rarely used because it is extremely unreliable. Some health zones had short-wave radios, but scheduling, interference by “pirates”, and poor reception make communications by short-wave difficult. Only a very few health zones had e-mail or cell phones. Communications were insecure. In some areas the governing authorities have banned electronic communications and confiscated equipment.

*Challenge: lack of health data for decision-making*

In addition to the communication problems listed above, other factors made access to health data difficult. Though a national health information system had been established a few years ago, many health zones were collecting little or no relevant data. Due to the lack of transport within health zones, health zone bureau often were short of information on the health situation in outlying areas of the zones. There was a widespread lack of baseline data on which to gauge progress.

*Advantage: electronic communications for project management*

Project management at ECC and I.M.A. headquarters coordinated activities with the use of electronic mail. There were system breakdowns on both ends, and ECC had to change service providers, but for the most part the system worked very well and helped project implementation to proceed efficiently.

## **F. Regional coordination**

*Challenge: Excessive workload*

Traveling to the various isolated health zones, keeping up communications, and maintaining an office proved to be a very onerous combination of assignments for one person. We have budgeted for additional regional coordination personnel under SANRU III Phase 2.

*Challenge: recruiting and retaining coordinators*

The requirements and challenges of the coordinator position made it hard to recruit and retain competent regional coordinators, and headquarters had to fulfill these responsibilities until the positions were filled. The most difficult situation was in northern Equateur, where our first choice, Dr. Mbala of Bwamanda resigned to focus on his ongoing health zone responsibilities. His replacement, Dr. Ngossi of Karawa, was arrested and incarcerated for weeks in Kinshasa on his arrival for the coordinator's meeting in October; the authorities suspected him of collaborating with their enemies. He stepped down and was replaced by Dr. Ndombe Mopeya of Loko Zone.

*Advantage: extending the project's presence*

With regional coordinators now in place, monitoring, supervision, planning and communications can be carried out much more extensively and efficiently between the far-flung areas served by the project. As was demonstrated in the October conference of regional coordination meeting, the coordinators are able to articulate well the particular needs of the regions they serve and help to develop appropriate regional strategies.

## **G. Local Participation**

*Advantage: Communities and health zone personnel were motivated and eager to participate in the project*

The participatory response has been impressive. Community volunteers labored to rehabilitate water sources. Health zone management personnel undertook arduous, risky journeys to participate in project training sessions.

Though poverty and turmoil have taken their toll on health zone management as on other aspects of the Congolese system, many of the health zones had been able to accomplish a great deal with minimal resources and were well prepared.

As an example, Lubondai health zone in Kasai Occidental has taken on new life in the past several years in spite of hard times. The local community founded a nursing school that has succeeded against the odds, with little outside assistance. Dr. Albert Kalonji, the health zone medical officer, has been able to revive public health activities. Dr. Kalonji is currently undergoing a year of Public Health training in Kinshasa with sponsorship

from SANRU III Phase 2, after which he plans to bring his new knowledge and ideas back to Lubondai. Meanwhile, Medical Residents from Tshikaji health zone who participated in the September training will be performing 3-month rotations at Lubondai, filling in for Dr. Kalonji and putting their training into practice. The local health community is organized and determined to make the best use of the resources provided by the project.

## **H. Donor relations**

*Advantage: Help from USAID and the embassy for importation of materials*

The expensive and time-consuming task of importing materials into DROC for the project was made many times easier when the US Embassy decided to provide exoneration for SANRU shipments and arranged for transport of materials from the port of Matadi to Kinshasa. USAID provided crucial assistance in helping project personnel to get permits for travel to the project health zones.

*Advantage: Helpfulness of OFDA – DC*

Our OFDA contacts in Washington DC (especially Tim McRae, the CTO) were particularly helpful in helping us to sort out our relationships and responsibilities under this, I.M.A.'s first US government award of this magnitude.

## **Trial by Fire**

The volcanic eruption that poured 200 million metric tons of molten lava into the town of Goma in North Kivu on January 17, 2002 provided a dramatic test of the emergency response systems established through this project. The Goma health health system did not escape the general devastation: 2 health posts, 3 health centers, 1 referral health center, 1 specialized clinic, and numerous private clinics were destroyed.

We have been able to bring timely assistance to the affected population using the systems, materials and personnel put in place with funding from OFDA over the past year. In addition to the involvement of Goma health zone in SANRU III, we had established a regional coordination office there and were sharing a medical depot with the organization ASRAMES. The SANRU III regional coordinator, Dr. Meli, and the Goma health zone chief medical officer, Dr. Lusi, have been addressing the needs of the survivors and have kept us informed of the situation on the ground from the early hours. Since the health zone vehicles were in disrepair, the coordination vehicle provided by OFDA under this award was pressed into service for the critical tasks of delivering medicines, vaccines and supplies to the remaining health centers. The day after the eruption, the SANRU team in Kinshasa dispatched several tons of disaster relief materials to Goma, using the remaining stock of donated materials that had been shipped to Kinshasa with OFDA funds. In the U.S., donors gave promptly and generously to fund additional shipments and relief coordination efforts, knowing that we had the capacity as well as the motivation to

deliver appropriate assistance efficiently. To date, corporate donors have provided in excess of \$3.1 million of GIK medical products for the I.M.A./SANRU relief effort; I.M.A. Members, friends and corporations have provided nearly \$100,000 in cash grants to facilitate shipment of the GIK into the Goma project. The ability of I.M.A. to generate this magnitude of a disaster response for Goma, all funded from private sources, would not have been possible without prior OFDA/USAID support for SANRU III.

## **Lessons learned**

*The universal desire for improved health is a strong basis for cooperative action*

To implement this ambitious project in several areas of the DROC, we continually had to deal with the military and political obstacles that divide the war-torn country. Though we encountered frustrating and sometimes harrowing situations, the warring authorities were for the most part unusually cooperative. All parties recognized the urgency of improving the public health situation and wanted to have a hand in bringing about improvements.

*The health zone continues to be a strong building block for health programs.*

The health zone teams assured equitable local distribution and appropriate use of the resources we provided. The responsiveness of these geographic management units was key to the ability of this project to touch the lives of people across the “impassable” expanse of DROC within a few months.

*Having the ability to draw upon funds from complementary partners can be the key to getting a project off the ground quickly.*

The \$150,000 contribution from PC(USA) that enabled the project to begin activities while waiting for funding from OFDA is an excellent example of both the importance of diversifying funding sources and the advantage of having complimentary partners. SANRU III (phase 2 and beyond) should strive to maintain and increase the diversity of partnerships and funding sources.

## **Conclusion**

The geographic expanse, the logistical obstacles, the wartime conditions, and the short time span of this project made it a very ambitious undertaking. The success of this cooperative effort has demonstrated the underlying strength of the beleaguered DROC health system and has provided the building blocks for greater efforts.

The Staff and Directors of Interchurch Medical Assistance, Inc., (I.M.A.) and the Protestant Church of Congo (ECC) wish to express to the Office of U.S. Foreign Disaster Assistance and to the U.S. Agency for International Development our profound appreciation for the confidence placed in us to implement the SANRU III, Phase 1 initiative and for the significant grant that enabled us to succeed in our mission.

### Health Zones to be Assisted by SANRU III

Reg	SubReg	Health Zone	Phase 1	Phase 2		Orders		Autres Partenaires	Appui Structurel	Health Zone Co-Gestion	Est. 2001 Population
			Start 2000	Start 2001	Start 2002	UNICE F Grant	IDA Order				
BC	Bas-Fleuve	Kangu		01-06				01-02	FOMETRO /CB	BDOM	81,118
BC	Bas-Fleuve	Kinkonzi		01-06				01-02	Sol. Prot. (ending '02)	ECC/CEAZ	75,352
BC	Bas-Fleuve	Kuimba		01-06				01-02		BDOM	75,985
BC	Cataractes	Kibunzi		01-06				01-02	Sol. Prot. (ending '02)	ECC/CEZ	49,729
BC	Cataractes	Kimpese	2001	01-06			01-02		Sol. Prot. (ending '02)	ECC/IME	106,845
BC	Cataractes	Luozi	2001	01-06			01-02			ETAT/ECC/CEC	69,476
BC	Cataractes	Mangembo	2001	01-06			01-02		FOMETRO /CB	BDOM	71,650
BC	Cataractes	Nsona-Pangu		01-06			01-02		Sol. Prot. (ending '02)	ECC/CBCO	80,264
BC	Lukaya	Nselo		01-06				01-02	Sol. Prot. (ending '02)	ECC/CBCO	83,785
BC	Lukaya	Sona-Bata	2001	01-06				01-02		ECC/CBCO	128,697
BD	Kwango	Kahemba	2001	01-06			01-02			ETAT/ECC	238,097
BD	Kwango	Kajiji	2001	01-06			01-02		Memisa-B/CB	ECC/CEFMZ	99,031
BD	Kwango	Kasongo Lunda		01-06			01-02		Memisa-B/CB	ETAT/BDOM	83,674
BD	Kwilu	Djuma	2001	01-06				01-02	Memisa-B/CB	BDOM	149,252
BD	Kwilu	Kikongo		01-06				01-02	Memisa-B/CB	ECC/CBCO	114,647
BD	Kwilu	Moanza	2001	01-06				01-02		ECC/CBCO	275,576
BD	Kwilu	Mokala	2001	01-06				01-02		BDOM	200,804
BD	Kwilu	Mukedi		01-06				01-02	Sol. Prot. (ending '02)	ECC/CMC	179,124
BD	Kwilu	Vanga	2001	01-06				01-02		ECC/CBCO	238,457
BD	Mai-Ndombe	Bokoro		01-06				01-02	Memisa-B/CB	BDOM	145,200
BD	Mai-Ndombe	Bolobo		01-06				01-02	Sol. Prot. (ending '02)	ECC/CBFC	172,191
BD	Mai-Ndombe	Bosobe		01-06				01-02		ECC/CBB	136,156
BD	Mai-Ndombe	Kiri		01-06				01-02		ETAT/BDOM	162,117
EQ	Mbandaka	Bolenge		01-06			01-02			ECC/Disciples	135,790
EQ	Mongala	Pimu		01-06			01-02		Sol. Prot. (ending '02)	ECC/CBFZ	458,558
EQ	Nord-Ubangi	Karawa	2001	01-06			01-02		Sol. Prot. (ending '02)	ECC/CEUM	429,143
EQ	Nord-Ubangi	Loko	2001	01-06			01-02		Sol. Prot. (ending '02)	ECC/PCMP	132,607
EQ	Nord-Ubangi	Wapinda	2001	01-06			01-02			BDOM	133,379
EQ	Sud-Ubangi	Bangabola		01-06			01-02			BDOM	157,358
EQ	Sud-Ubangi	Tandala	2001	01-06			01-02		Sol. Prot. (ending '02)	ECC/CECU	326,289
EQ	Tshuapa	Ikela		01-12			01-02			BDOM	177,792
KE	Mbuji-Mayi	Dibindi	2001	01-06				01-02	ECC/PATS/UE (ending '02)	ECC/CPCA	440,921
KE	Sankuru	Wembonyama			02-06		01-02			ECC/CMCC	112,914
KE	Tshilenge	Bibanga	2001	01-06			01-02		ECC/PATS/UE (ending '02)	ECC/CPCA	146,453
KT	Haut-Lomami	Kabongo	2001	01-06			01-02			ECC/CMSC	186,179
KT	Haut-Lomami	Kinkondja			02-06		01-02			BDOM	219,148
KT	Haut-Lomami	Songa	2001	01-06			01-02			ECC/CEASJ	180,949
KT	Lualaba	Kapanga	2001	01-06			01-02			ECC/CMSC	152,849
KW	Kananga	Tshikaji	2001	01-06				01-02	ECC/PATS/UE (ending '02)	ECC/IMCK	153,625
KW	Kasai	Bulape	2001	01-06			01-02			ECC/CPCA	133,398
KW	Kasai	Kalonda-Ouest			02-06		01-02			ECC/CMC	324,370
KW	Kasai	Kamonia			02-06		01-02			AVOMET	232,346
KW	Kasai	Kitangwa			02-06		01-02			BDOM	186,229
KW	Kasai	Luebo			02-06		01-02			ETAT/BDOM	205,028
KW	Kasai	Nyanga			02-06		01-02			ECC/CMC	130,623
KW	Lulua	Lubondaie	2001	01-06			01-02			ECC/CPCA	96,082
MN	Maniema	Kampene			02-06		01-02			BDOM	200,161
NK	Nord Kivu	Katwa	2001	01-06			01-02			ECC/CBK	287,185
NK	Nord Kivu	Musienene	2001	01-06			01-02			BDOM	161,774
NK	Nord Kivu	Oicha	2001	01-06			01-02			ECC/CECA	176,755
NK	Nord Kivu	Rwanguba		01-06			01-02			ECC/CEBK	163,156
NK	Nord Kivu	Goma	2001	01-06			01-02			ETAT/NGO	183,494
PO	Ituri	Nyankunde	2001	01-06			01-02			ECC/CME	166,069
PO	Ituri	Boga	2001	01-06			01-02			ECC/CME	44,621
PO	Ituri	Rethy	2001	01-06			01-02			ECC/CECA	299,121
PO	Tshopo	Yakusu	2001	01-06			01-02			ECC/CBFZ	138,124
PO	Tshopo	Opala		01-06			01-02			ETAT/BDOM	268,558
PO	Tshopo	Isangi		01-06			01-02			ETAT/BDOM	99,497
PO	Kisangani	Kabondo		01-06			01-02			ETAT/BDOM	199,388
SK	Sud Kivu	Kaziba		01-06			01-02			ECC/CELZ	230,848
SK	Sud Kivu	Nundu			02-06		01-02			ECC/CLMZ	175,926
SK	Sud Kivu	Nyangezi			02-06		01-02			ETAT/BDOM	431,726
SK	Sud Kivu	Shabunda			02-06		01-02			ETAT/BDOM	123,728
		<b>TOTALS</b>	<b>30</b>	<b>52</b>	<b>11</b>	<b>45</b>	<b>18</b>				<b>11,219,388</b>