Evaluation of ECHO´s Global Plans 2000 and 2001
Democratic Republic of Congo

Report on the Drug Supply

Country:	Democratic Republic of Congo (DR Congo)
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Acknowledgements

The fact that indispensable elements of a sound pharmaceutical sector policy –concerning the ECHO Global Plans 2000/2001 for the Democratic Republic of Congo– have been made, a special aspect of the Global Plans evaluation must be recognised as “an honourable burden involving great responsibility". In this respect the open-minded discussion with the Evaluation Unit and other relevant Units of the European Commission Aid Office during the briefing session in Brussels was most valuable.

Irrespective of this particular support, we are duly grateful to all the other interlocutors, i.e. the Directorate General for Development and EuropeAid, the EU Delegations in Kinshasa and Nairobi, the ECHO representatives in DRC and the staff members of the NGOs, and also officials from UN-organisations, other donors and from the government. They assisted and contributed to the efficient realisation of the evaluation and to the now presented result, through their patient listening and generous information, explanations and answers.

Executive Summary

Between the 3rd of July and the 7th of August, the consultant, as a member of a team of four external consultants, evaluated at the request of the European Commission (EC), the 'ECHO 2000 and 2001 Global Humanitarian Plans in the Democratic Republic of Congo".

Purpose and Methodology
The general purpose of the evaluation was to assess the appropriateness of the strategic approach of the 2000 and 2001 ECHO Intervention Plans. The specific evaluation focused on the major elements of an Essential Drug Policy: drug supply and rational use of drugs both addressed in GP2000/GP2001 under "Public Health" and –more marginally– under Nutrition/Food Security.

After a 4 day briefing in Brussels and a week for visits to the Kinshasa offices of EU, EU Member States, other donors, UN, NGOs and DR Congo Government, the team paid visits to the majority of the ECHO funded projects (GP 2001) during a 3 week field trip. Discussions were held with members of staff from the respective NGOs as well as with their counterparts or representatives of the local administration, health service and community. Finally the special evaluation covered about two thirds –or in terms of budget figures about 80%– of all PHC/drug projects. At the end of the field mission, the team had the chance to discuss its findings with the ECHO technical assistance staff in Goma and with the ECHO Regional Support Office for the Great Lakes Region in Nairobi, Kenya.

Due to the intense schedule, the individual projects could not be analysed in detail. However, the excellent organisation of the field mission gave sufficient opportunity to obtain a diverse picture of different local conditions, opportunities of the different approaches in place and the interest or willingness of the population to make use of the health care delivery system in the offered quality. The presented report tries to assess to what degree the objectives pursued have been achieved as well as to quantify the impact of the GPs in terms of outputs, to analyse the possible LRRD links to other EU funds, in particular PATS, and to propose possibilities for improving the effectiveness of future ECHO operations in the DR Congo.

Main Conclusions

Relevance **-** It is evident that the situation of the population is unlikely to change in the short-term and that the assistance of the international donor community and the presence of its humanitarian operators will be necessary to assist the people in their struggle. With regard to the Eastern Congolese context, the GP 2001 correctly stated that community participation is one cardinal element that has to be combined with good governance. This means capacity building at a grass roots level.

The GPs' text repeatedly directs to the rationalisation of drug use and the WHO policy of "rational ***use*** of drugs". Unquestionably, during the urgency phase and at the initial rehabilitation phase (OCHA criteria 1 and 2), the availability of drugs is an indispensable precondition for any health ***care*** activity.

In general, the GPs 2000&2001 refer to a model –deriving from the "Bamako Initiative"– where the availability of quality drugs at affordable conditions is used for co-financing matters. One may however, understand this as a local tax paid by low (or lowest) income sectors. On the other hand, there is no doubt that without a financial contribution, i.e. private/public co-financing, a sustainable primary ***health care system*** cannot be established. For this objective the amount of 0.5 US$ –indicated in the GPs– sounds realistic. Consistently the GPs initiate the re-vitalization of local or regional *centrale/s d'achat* (CdA) by supporting ***drug procurement*** through centralised systems.

Basic remark concerning inconsistencies resulting from the Framework Partnership Agreement (FPA)

Unfortunately, the positive intention and impact of the GP for the DR Congo is counteracted by the text of the Partenariat Contract –in particular **rule 17.3**, which supposes that WHO has legal power

and therefore does not reflect the European legislation. Hence, the text of 17.3 does not guarantee drug quality[1]. Therefore ECHO should rethink their demands on drug quality (rule 17.3).

In addition, it has become a common habit to avoid **rule 16.3** of the Partenariat Contract (Framework Partnership Agreement FPA), which obliges the launch of a tender if the value of an order exceeds EUR 45,000. When looking at the non-profit/low-profit European drug market, resulting from the methods of drug purchasing from ECHO funds, one has to consider that instead of competition there is a growing monopoly, and –as a consequence– manufacturers –previously engaged in production of low price quality drugs– are going to retire from the market due to continuously shrinking sales resulting from the unfair purchase/sales practices (because: quality has a price which needs to pay off).

Effectiveness and Efficiency – The GPs' strong financial support directed to avail essential drugs in sufficient quantities, reflects the realisation that the availability of drugs is an indispensable element for any health care system. The quality of care and the user rate will rise wherever user contribution and reliable drug supply become a constituent factor. This is the strategy of success.

Malteser Ariwara, MEDAIR and MERLIN (together representing more than 50% of the drug turnover of projects visited for evaluation) apply successfully a mixture of drug sales (at reduced costs) and consultation fees as ***cost recovery/co-financing approach*** (indicator: impact on the user rate). The application of a pure "prix forfaitaire system" does not concordantly fulfil the expectations; there are both positive and negative experiences.

The calculation of an average standard treatment of all projects resulted in US$ 0.51 (range from US$ 0.43 to 0.58, due to varied circumstances the differences are not significant). This amount equals the 0.5 US$ proposed by the GP for one curative consultation. In areas which fulfil the OCHA criteria 3 or 4, this payment would be at an affordable level for patient's co-financing contribution.

The ***efficiency of the project approaches*** applied for drug supply system/systems, depends in particular on three factors, which have been used as evaluation criteria:

1. Application of appropriate drug quality control and quality assurance (QC/QA) measures for the whole "lifetime" of a certain drug when (and after) entering the "project environment"
2. Measures and devotion invested into contributing to the aim of "rational use of drugs"
3. The prevention of losses from drugs and funds by theft or embezzlement

The results showed that the majority of all NGOs do not take ***drug quality*** considerations seriously. Whether this is a result of the text of rule 17.3 of the FPA and the neglecting of rule 16.3 may be discussed. – The results also show that the majority show good performance with regards to the GP 2000&2001 basic objective of ***rational use of drugs,*** as far as it concerns the activities of the partners directed to change the present bad treatment/prescription habits. This is a time consuming process, which requires continuous mid-term education. The ***prevention of losses*** through theft or embezzlement is particularly poor for the distribution step from project/central level down to ZS. The resulting ***general efficiency*** of the different approaches of Supply Systems of PHC Drugs showed the highest scores for three projects: Malteser Ariwara, MEDAIR and the CDI area of MEMISA. They also reveal very low losses from non-paying patients. It is interesting that all three apply the best community involvement and also have the best co-financing effect. The 3 approaches, coupled with effective community participation seem to exhibit a uniformly positive trend. This needs further detailed observations.

[1] Common key criteria for drug quality are: safety and efficacy (active compound), stability and bio-availability (formulation), all of them are checked for during the European drug licensing procedure.

Co-ordination, coherence and complementarity **-** During the visit it became obvious that there is a great need for an exchange of experiences from the fieldwork of the various NGOs. Budgeting for health costs, management & organisation of drug systems, and effective community participation seem to be topics of common interest.
Internal professional ***co-ordination*** and communication between ECHO partners should be given high priority. If well organised, this would also contribute to better ***coherence*** of the GP's special objectives with the strategic approach and an easy "phasing over" to PATS sponsored projects as well as to develop ***complementary*** strategies together with other major donors.

Impact and strategic implications **-** As a general statement, one can predict that there is little chance of sustainable health financing as long as the external costs (e.g. ME-G) are not covered through local revenues. The question of what may be a realistic solution to compensate the health staff for the rendered services still remains to be answered. However, (i) there is no possible and satisfactory way of financing health personnel, unless the number of staff is cut down substantially. (ii) There is no argument for a salary-like payment unless there are good treatment habits, i.e. quality of care (an indicator of which is the grade of rational use of drugs).

As the sustainable financing of health systems will not be guaranteed by donors in the long-term, the only "institution" remaining that could take the lead, seems to be the community (as long as there is no or no proper government). The community should organise its own interests –here: the availability of (affordable) drugs as a precondition of functional PHC services– through a bottom-up structured hierarchy. – From ECHO's point of view this is a mutual starting point for an exit scenario in line with the LRRD approach.

Horizontal Issues **–** The growing willingness of the population to pay for health care and the possibility to group the project areas in line with the criteria of the 4 OCHA categories should be continuously observed.

Visibility **–** The common message is "the NGO project for the local/regional/provincial population" is assisted with money from ECHO. But the understanding should be that "the ECHO support programme for the DR Congo population" is implemented by the NGO as an ECHO partner.

General recommendation
ECHO should review the criteria for the purchasing of drugs as laid down in the FPA under 16.3, 16.4 and 17.3 as well as 17.4. as soon as possible and bring them in line with the European Drug Legislation. Also, ECHO should do all it can to avoid the installation and/or support of supplier monopolies.

Recommendations concerning the GP for the DR Congo
A sustainable strategy for the (re-) installation of a public private mixed non-profit health care delivery system should be developed. In this context, the common rules of economy have to be applied. All activities should be adjusted in a way that a continuous transition from "urgency" to "rehabilitation", "pre-development" and finally "development" is taken into account from the very first moment. The LRRD approach should be taken into account immediately after the disaster oriented first phase of Humanitarian Aid is finished. As a first supportive step, a standardised simple scheme for accounting and budgeting of health costs should be introduced and made obligatory – starting with the drug budget.

There is no concrete proof to say that the prix forfaitaire should be used as a tool for cost recovery. Therefore, during the GP's re-programming, one should review carefully the present co-financing approach and introduce the mixed cost system (payment for ME-G and for treatment fees) as an alternative concept to the pure prix forfaitaire system. When reviewing, it should be taken into consideration that the average full cost recovery price for a standard treatment with ME-G is at an affordable level (0.51 US$). This amount equals the ECHO proposal for the prix forfaitaire of a curative consultation.

The community participation policy should be further developed and the final goal of good governance should be taken into account.

1. Introduction

The European Commission Humanitarian Aid Office (ECHO) has during the past five years (1997 – 2001) funded about 81 MEURO[2] for humanitarian operations in the Democratic Republic of Congo (DR Congo). ECHO is currently one of the major funding agencies in DR Congo. From an estimated total of 100 MEURO[3] in 2001, contributed by the international donor community for humanitarian operations in DR Congo, the ECHO contribution accounts for about 35 % of the funding. The contribution of the USA (USAID/ODFA) accounts likewise for about 35% and the European Member States assistance for about 13 %.

The ECHO funded activities in the years 2000 and 2001 concentrated on two priority sectors: (i) the public health system –with focus on PHC and supply of essential drugs & medical materials– and (ii) nutrition/food security activities. The funds for Generic Essential Drugs (*médicaments essentiels sous forme generique* – ME-G) & medical materials represented about 50% of the whole health budget. They have been channelled mainly through NGOs using/referring to the ECHO-NGO Framework Partnership Agreement (FPA) rules (16.4 and 17.3). Only minor ME-G quantities were supplied through UNICEF and the IRC/ICRC.

The present evaluation includes the analysis of the two successive Global Plans of the years 2000 and 2001 at a total value of 55 MEURO.

The evaluation took place during the period of 3rd July and 7th August 2001 and concentrated on projects in the eastern part of the country (rebel held territories), where the majority of the funds (about 60%) under the Global Plans have been spent. For the public health system, i.e. PHC plus ME-G, GP 2000 provided 7 MEURO (= 38.5 %), GP 2001 15.4 MEURO (= 44 %) – followed by nutrition & food security 5.6 MEURO (= 28 %) and 11.7 MEURO (= 33.4 %) respectively[4]. The choice of the priorities reflects the assessment of the international donors community on needs and priorities in DR Congo, which was re-confirmed during the DR Congo Donors Contact Group Meeting[5] in Geneva this July.

The purpose of the evaluation, as defined in the TOR for the evaluation assignment, was:

- *to assess the appropriateness of the 2000 and 2001 ECHO Intervention Plans*
- *to assess the degree to which the objectives pursued have been achieved and the effectiveness of the means employed;*
- *to quantify the impact of the Global Plans in terms of outputs;*
- *to analyse any possible link between emergency, rehabilitation and development and the areas in which this may be feasible (LRRD aspects; opportunities for a handing over to PATS);*
- *to establish precise and concrete proposals on the future of ECHO's funding by sector and activities.*

and for the special report on the drug supply:

- *to analyse and assess the different approaches for drug supply systems applied by single operators;*
- *to analyse the cost efficiency of the drug supply systems;*
- *to look into quality assurance aspects applied (drug licensing status; storage/expiry; purchase procedures)*

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[2] ECHO contribution to DR Congo: 1997-1,5MEURO, 1998-11,6 MEURO, 1999 – 13,3 MEURO, Global Plan 2000 – 20 MEURO, Global Plan 2001 – 35 MEURO (planned)

[3] Rough estimate from information gathered during the field mission. Currently no centralised system for the collection of information on donations exists. / For a more detailed break down of activities see Annex 7 of the Synthesis Report

[4] For a more detailed break down of activities see Annex 7 of the Synthesis Report

[5] DRC Donors Contact Group Meeting, Geneva 9-10 July 2001, co-chaired by Belgium and UNOCHA with the participation of the USA, EC, Belgium, France, UK, Sweden, The Netherlands, Canada and the UN agencies HCR, WFP, UNICEF, WHO, FAO and representatives from the NGO community: MEMISA, MSF, IRC (US) and Save the Children (UK).

2. Methodology

Schedule and content of Evaluation

Between the 3rd of July and the 7th of August, the consultant –as member of a team of four external consultants– evaluated, at the request of the European Commission (EC), the 'ECHO 2000 and 2001 Global Humanitarian Plans in the Democratic Republic of Congo" (referred to hereafter as GP2000 / GP2001 – or simple GPs).

After a 4 day briefing in Brussels (ECHO, DG-DEV, EuropeAid – to garner information on the GPs and the individual projects / desk study) and a week for visits to the Kinshasa offices of EU, EU Member States, other donors, UN, NGOs and DR Congo Ministry of Health (MOH), the team paid visits to the majority of the ECHO funded projects (GP 2001). During a 3-week field trip, discussions were held with staff members of the respective NGO as well as with their counterparts or representatives of the local administration, health service and community (see Annex 2; Provinces: North Katanga, North and South Kivu, Maniema, Orientale, Equateur). About two thirds of the ongoing projects PHC/Drugs were visited. In terms of budget figures the evaluation covered about 80% of all PHC/Drug projects (8.67 MEURO out of 11.09 MEURO) – not counting UNICEF because of its special/global approach.

The specific evaluation focused on the major elements of an Essential Drug Policy: drug supply and rational use of drugs[6] both addressed in GP2000/GP2001 under "Public Health" and more subordinate facets under Nutrition/Food Security. The purpose of the evaluation exercise was to assess the appropriateness of the strategic approach embodied in the 2000 and 2001 ECHO Intervention Plans and its possible links to relief, rehabilitation and development (LRRD), as well as to evaluate opportunities of handing over projects or parts thereof to another EU fund, e.g. PATS (currently only operational in West DRC).

At the end of the field mission, the team took the opportunity to firstly discuss its findings with the ECHO technical assistance staff in Goma and with the ECHO Regional Support Office for the Great Lakes Region in Nairobi, Kenya.

Resulting Conclusions of Evaluation

The findings and results of the evaluation are based on those projects visited and studied. Due to the intense schedule the individual projects could not be analysed in detail and did not allow for the in-depth evaluation of single operations. Therefore, the evaluation is clearly limited in this respect. However, the excellent organisation of the field mission gave sufficient opportunity to obtain a diversified picture of different local conditions, opportunities of the different approaches in place and the interest and/or willingness of the population to make use of the health care delivery system in the offered quality.

Nevertheless, the presented report tries to assess, to which degree the objectives pursued have been achieved, to quantify the impact of the Global Plans in terms of outputs, to analyse the possible links between relief, rehabilitation and development and to establish proposals for future ECHO funding with a view to improving the effectiveness of future operations.

[6] See Briefing Note as amendment to the TOR / Annex 1.

3. Context and Humanitarian Situation

3.1 General Context

Economic information

The DR Congo (ex-Zaire) has the third-largest land area in Africa, with a population of approximately 55 million. The country is rich in natural and human resources, including sufficient arable land to nourish the population, ample rainfalls, the second biggest rainforest in the world, the wild waters of river Congo –representing huge power reserves– and rich mineral resources (maybe the most problematic good).

The country has experienced the steady decline of its economy in the past decades due to mismanagement and instability. Today the country's formal economy has literally collapsed. The latest IMF/WB[7] report on the economical situation reports on a per capita GDP of US$ 85 (or 23 cents a day) in 2000[8]. The report states a dramatic decline in output and income that has been the result of misdirected economic and financial policies, pervasive corruption and, especially in the past decade, political turmoil, civil strife and (since 1998) outright war, implying, among other things the de facto collapse of government control over public finances and public enterprises. Since 1990, the negative trends have been compounded by an unprecedented cycle of hyperinflation, currency depreciation, insufficient saving, financial disintegration, etc. – leading to a generalised impoverishment of the population, followed by the well known vicious circle of shrinking economy and growing health risks, e.g. spread of epidemics like HIV/AIDS.

The instability context

The reality in the DR Congo today is predominated by a complex and chronic emergency situation characterised by intense violence and human suffering in most of the provinces. Coming from a 32-year regime of absolute power of Joseph-Desire Mobutu, (who virtually destroyed the country's economy), the DR Congo entered into two successive wars involving many of it's neighbouring countries. Today, the country is practically split into two parts, the so called governmental controlled West, and the East, which is controlled by two major rebel movements, the Uganda supported FLC and the Rwanda supported RCD-Goma. In addition, several so called armed non-state actors[9] (Mai-Mai, ex-FAR/Interahamwe, ADF) are destabilising the eastern parts of the country, which limits the humanitarian space and leads to continued internal displacement of the affected population.

The two major forces in power in the East (FLC, RCD-Goma) appear to be completely incapable and to a certain degree unwilling, or simply disinterested in the welfare of the population. Their aim was "to take Kinshasa" and not to set-up a "civil administration"[10]. This had the effect that no budget for social services or public infrastructure (health care, road rehabilitation, etc.) has been made available by the rebel movements, although funds are expected to be available from mining activities revenues and other sources of income from the warring parties. *De facto* the international donor community has taken over the responsibility for the entire support of the population in East DR Congo.

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[7] IMF-Background Information for the Periodic Consultation with the Member Country (DRC), 3 July 2001

[8] Development of GDP: 1985-US$ 380; 1990 – US$ 224; 2000 – US$ 85

[9] ANSAs- Armed Non-State Actors /Groups not signatory to the Lusaka Agreement – Report of a Research Project commissioned by UN-OCHA (October 2000)

[10] So explained by a highly placed representative of the FLS management in August 2001.

Humanitarian Situation

As explained above, the humanitarian situation in the eastern part of the country is still dominated by one main factor, the unstable security situation of the population –resulting in two major effects: (i) continuous internal displacement which does not allow the reaching of subsistence level (cultivation of land plots not possible) and (ii) an economic situation which is heavily hampered by the poor accessibility of market places (road access, rail & river transport). Thus, the future remains grim for the affected population in large parts of East DR Congo.

Despite vague positive signs from the inter-Congolese dialogue, it has to be suspected that the destabilisation of the region is set to continue: (i) The frontline in DR Congo moves eastwards (withdrawal of foreign troops); (ii) Subsequently neighbouring countries are (re-) affected; e.g. ongoing fighting between armed rebel groups and the army and infiltration of rebels from DR Congo and Tanzania is reported from *Burundi*. Instability is also growing in *Rwanda* due to recent Interahamwe and ex-FAR infiltration in the northwest and southern parts of the country; (iii) Furthermore, recent developments show that the internal structure of power in the rebel movements (e.g. conflict in the FLC-President Bemba/ RDC Kisangani) is also fragile, which adds to the overall instability of the region and makes any forecast of developments nearly impossible.

Refugees and Internally Displaced Persons (IDPs)

The continuation of the creeping conflicts have led to large-scale displacements of the population in the country. UN-OCHA estimates a figure of 2,040,000 internally displaced people (IDPs) within the country. This means an increase of about 240,000 since November 2000. It is furthermore estimated that less than half of the IDPs have access to humanitarian assistance. More than 90% of the IDPs are located in East DR Congo with the highest proportion in North Kivu, South Kivu, Katanga and Oriental[11]. The still increasing number of IDPs is a sign of continued insecurity and the related displacement in many regions. The groups most affected are: women, children and elderly people, who are forced to move from their home with literally nothing, and find refuge in the forest or with their families or friends in other villages. The effect of these movements is that in some places the resident population has doubled or tripled in size and such places are simply not capable of handling the influx of IDPs. In addition, an estimated 340,000 people have left DR Congo and fled into neighbouring countries (Congo-Brazzaville, Rwanda, Tanzania, Zambia, etc.).

Expectations

These circumstances make the people of the DR Congo one of the poorest populations of the world with grim prospects for the future, since to date none of the so-called efforts undertaken by the parties in power and the supportive intervention of the international community have proven to be capable of introducing change and stability to the country. The persistent insecurity in most parts of eastern DR Congo and the deteriorated road network in the entire country does not even allow the achievement of subsistence levels for large numbers of the population. At present, a large part of the population relies on informal economic activities to survive (small scale trading and cultivation of small plots of land).

Any prognostic outlook on the future of DR Congo and the Great Lakes Region appears to be very difficult due to the complex structure of the conflict, the numerous “interested” parties involved and the obvious geopolitical and economical interest in the country. It is evident, that the situation of the population is unlikely to change in the short-term and that the assistance of the international donor community and the presence of its humanitarian operators will be necessary at least in the mid-term – to assist the people in struggling through and creating their own little elements of hope and a better future.

[11] For details see Annex 7 of the Synthesis Report. OCHA states that the margin of error for some regions is considerably high (at about -+20%).

The core problem

The core problem holding the lead to all the chaotic and selfish development seems to be the absence of the spirit of good governance –since the times of Mobutu–, a defective self-reliance of major parts of the population and the lack of a common and workable subsistence approach has existed. The only stable and stabilising factor is –ironically– the population –if they take their fate and interests into their own hands.

3.2 Health Sector Related Context

General situation[12]

As in the context of the country's economy, the health status of the population, too, is characterised by negative parameters – Life expectancy: 45.8 years; mortality of the under 5: 207; infant mortality: 128; vaccination coverage: 22% BCG, 15% measles[13]. The parameters show undoubtedly the severity of the situation which in general applies to all the different regions and the existing sub-groups: (i) people still staying in their home village, (ii) IDPs living in neighbouring villages or with members of their extended family, and (iii) IDPs having fled into the forests.

During the time of our visit, the security situation in general and the health situation of the IDPs had somehow stabilised in the major parts of the eastern DR Congo. Even if no exact data was available, the team tried to classify the areas visited by using the OCHA criteria[14]. Taking the health status as a major aspect, the results show the whole spectrum: Critical conditions still persist in the regions of Uvira and Djugu (sites of the Hema/Lendu conflict), while the very East of Ituri already profits from relatively acceptable socio-economic circumstances (influence from the near Uganda).

The health care system of the public sector

- After the two wars and 10 years of a chronic emergency situation and intense looting and violence, the health system infrastructure is rotten and needs urgent rehabilitation.
- In the rebel held Eastern DR Congo, the health system is deprived of continuous supervision and control measures, and thus lacking the capacity and the authority to link with the former national health policy (even if somehow everybody refers to the MOH in Kinshasa[15]) and/or to further develop the system in accordance with the present circumstances.

  Besides the lack of authority, the non-existence of any health (or drug) budget represents a major obstacle.
- For the last 10 years the health staff have not been paid. This has resulted in an often doubtful proficiency of the medics and, in particular, paramedical personnel to creatively develop strategies for sufficient private income generating medical activities, such as “appendicitis surgery” as the best intervention against “chronic” (because of improper diagnosis) gastro-intestinal problems (as it is applied by a good number of infirmiers in Eastern Orientale). Or the “organisation” of drugs (most of doubtful origin and questionable quality) for their own private clinics. This has paved the way for the current, often “deviating” cheap or free drugs to the same destination.
  However, where things can be turned to the benefit (not to say: profit) of the health staff –in particular of the MDs–, existing regulations are overruled. One common example is the composition of the CoGe at HGR level: usually one will not find any representative of the local population but a lot of ex-officio members of the health system hierarchy and the “new” local

[12] A more detailed description can be found in the Special Health Sector Report of this Evaluation.
[13] Data for 2000 / Source UNICEF
[14] See Annex 1 the Special Health Sector Report of this Evaluation.
[15] In one form the term « Kinshasa East » was used.

administrative hierarchy[16]. Exceptions from this "new CoGe composition", –noticed during the evaluation, – have been found in the Eastern Orientale and in the region of Bwamanda (Northwest of Equateur).

- Progress can be noticed in coverage and use of the Primary Health Care (PHC) system as intended and fostered by the GPs 2000&2001. – This is expressed by the GPs' targeted attendance rate of new cases (NC): 0.25 or 0.5 respectively (for results/values achieved see Annex 9).
- However, flourishing private organised medical and paramedical education leads to doubtful results. The majority of the health staff are demoralised, poorly qualified and used to call on their "rights as civil servants". In particular the really old infirmiers –who should have already retired– often destroy the last aspect of subsistence, as they live in a quasi-autonomous environment where nobody has the power of punishment.
- Still, in the present times of hardship, civil servants, health staff and their family members, and soldiers (who have had a lot to do with the development of the current troublesome situation) claim "their right" to free health services (inclusive of the necessary drugs for treatment).
- Under such circumstances, one may find it rather difficult to implement a sustainable PHC drug supply system or introduce the idea of rational use of drugs successfully within the near future. But even in this aspect, one can also find progress and positive examples –resulting already from the GPs' intervention(s) (see Annex 13).

The health care system of the private non-profit sector

Parallel to the public health care system both churches offer well established health care services. In most cases their regional health network is vested with a legal status, e.g. various BDOMs (e.g. at Bukavu, see Annex 6; or at Ariwara where they collaborate with Malteser) or institutions like CME Nyankunde (at present collaborating with MEDAIR). In addition, non profit charity organisations – like the Salvation Army in Kinshasa– or the religious oriented rural development centre Bwamanda (CDI) assist the population with health care delivery offers. These systems offer their services at a certain well-known level of quality, but only against payment –usually at affordable conditions. Nevertheless, they frequently tend to be very money oriented.

A sometimes-problematic aspect of the private health care providers results from the fact that they are not supposed/obliged to accept the public supervision authority, the BIP (Bureau d'Inspection Provincial). However, in the ECHO project areas all health care providers learn to collaborate under the same conditions and to apply the same criteria, e.g. standard treatment schemes deriving from the WHO policy element "rational use of drugs".

The present situation of non-profit essential drug supply

- In the western DR Congo the former public drug supply systems, the DCMP and the major church structures of the private non-profit sector, CARITAS and CEPAM, have collapsed. At present PATS is giving support to a new joint initiative under the guidance of PSF (see Annex 6).
- At the end of 2000 GTZ financed a study for the development of a new strategic approach to install a self sustainable drug supply system based on two major elements: (i) the drug revolving fund idea and (ii) the principle of social franchising. (Unfortunately the study of the two authors M. Kuper/Berlin, Germany and Dr. A. Makamba/MOH, Kinshasa has not been published yet.)
- In the East most of the remaining suppliers depend more or less on the financial support coming from ECHO funds. An exemption may be BDOM Bukawu.

[16] As a rule, nowadays the CoGe is headed by the MCD but the old counterbalance of power through representatives of the local community does not exist anymore. This set of only hierarchy "reps" does not allow for a transparent Drug Revolving Fund management (if any) nor is there any limiting factor, which assures that the scale of charges and fees, takes into account the interests and the economic situation of the population.

3.3 Health Sector Oriented Interventions of Other Donors

- At present OFDA/ US-AID is (e.g.) financing a PHC project run by IRC in Orientale (region of Kisangani) with about 500,000 inhabitants and co-financing the MERLIN activities.
- US-AID is launching the Programme Santé Rurale (SANRU) again, in about 70 ZS in the whole of DR Congo. Major criteria for the selection of the ZS refer to the existence of church (mostly protestant) run health care facilities. A certain missionary approach cannot be neglected.
  Problems might result from overlaps (with the present ECHO intervention areas) and from an earmarked drug supply approach, which sounds close to drug dumping. If the latter would be the case, the project will do more harm than good. Indeed, it would certainly affect the slightly recovered CdA groups. But there is still time to review the details and find a suitable approach, which fit in with the ECHO programme and the development already achieved.
- The Dutch Government assists ASRAMES with about € 750,000 and the Belgian Government assists e.g. the MEMISA supported CDI Bwamanda as well as the Trypanosomiasis control programme(s) run by FOMETRO.
- WHO and UNICEF have a strong collaboration directed to "eradicate Polio" and to EPI. Unfortunately these interventions create a variety of problems: (i) they buy their staff with excessively high salaries (US$ 1,500 compared to a MD-salary at about US$ 350–450 in Kinshasa) disregarding the bleeding out of local non-profit health care providers (a "game" which can be also met with some NGOs); (ii) during the vaccination campaigns they pay per diems to paramedical (and non-medical) staff which add up to the amount of a usual average monthly salary; (iii) they ask for the support of the local health structures (e.g. epidemiological data) but here they do not pay; (iv) they still use the outdated vertical programme strategy of "hit and run" instead of joining the efforts to install a cost effective and sustainable integrated health care approach; (v) they promise a lot but often being not sufficiently stocked with vaccines (*exempla trahunt* – but bad examples have dire consequences); they claim to be the people's 'caretaker' in health, but they don't raise a finger to review the obsolete Malaria treatment scheme using chloroquine with a reported 30% resistance in DR Congo.

4. Relevance and Appropriateness

The expectations of the Global Plans 2000/ 2001

As far as it concerns pharmaceutical care aspects, both the GPs indicate a major expectation, which is realistically put in this element being part of a sound Primary Health Care (PHC) approach:

The pharmaceutical care activities mentioned in the **Global Plan 2000** are:

- for CS/CSR and PS:
  Provision of drugs and medical supplies; training in rationalisation of drug use (…).
  Related output: rationalisation of drug use / concerning a "minimal health care package"
  Indicators: prescription analysis shows improvement of efficient use of essential drugs.
- for selected HGR:
  Provision of essential drugs, surgical kits and medical supplies;
  Related output: Re-established basic reference capacity
  Indicators: number of in-patients, surgical interventions, etc.

The activities should lead to the realisation of the specific objectives, which together contribute sufficiently to reach the General objective (for drug only), which is:
to provide ♦ essential drugs and medical supplies, ♦ training in rationalisation of drugs, (…), ♦ support to centralised drug management systems and revolving drug systems.

The activities mentioned in the **Global Plan 2001** are:

- for curative PHC (i.e. CS/CSR):
  Provision of drugs, medical supplies & distribution logistics; training/ supervision in rational drug use, (…)
  Related output: drug use rationalised / concerning a "minimal package of health needs"
  Indicators: prescription analysis shows more efficient use of drugs.
- for curative "secondary" health care (i.e. HGRs):
  Provision of essential drugs, kits, medical supplies & equipment;
  Related output: Re-established basic reference capacity in a number of key hospitals in war-affected health districts
  Indicators: number of in-patients (bed occupancy rates): … , surgical interventions, etc.
- for the Health District/s:
  Inputs: Fee(s) for services paid by the population
  Expected outputs: Regular provision of drugs of high quality used in a rational way; functioning CoSa.s at ZS and CS/CSR level; motivated personnel (…).

The activities should lead to the realisation of the specific objectives, which together contribute sufficiently to reach the General objective (for drug only), which is:
to reduce the mortality rates from common pathologies (…) by improving access to basic health care facilities through the provision of ♦ essential drugs and medical supplies, ♦ support to centralised drug procurement and decentralised cost recovery systems, ♦ training in rational drug management.

The GP 2001 explicitly subscribes *"ECHO's intention to respect the spirit of the Bamako Initiative … while tailoring it to the requirements of a chronic conflict situation. Thus, inputs … will consist of … rational drug management, …, locally organised management structures (CoSa.s)."* The fees estimated at 0.5 EUR per episode are for cost recovery up to 30%.

Relevance and appropriateness of the Global Plans' intentions and expectations

The GPs' text repeatedly points to the rationalisation of drug use (i.e. the way to gain the best economic efficiency of value for money) rather than to the appropriateness of the drug's usage –which is the meaning of the WHO "rational ***use*** of drugs" strategy (i.e. the reasonableness of a drug indicated to treat a certain disease under limited conditions). For the period of urgency or for areas, which still show serious signs of urgency, this simplification, may be useful. Unquestionably, during the urgency phase and at the initial rehabilitation phase (OCHA criterion 2) of a health care system the availability of drugs is an indispensable precondition for any health ***care*** activity.

The GPs 2000&2001 refer to a model deriving from the "Bamako Initiative", where the availability of quality drugs at affordable conditions is used for co-financing matters. However, if the population's required financial contribution does not refer to a visible good (like drugs) but to a fee for using/receiving the health facility's services (a promise of sometimes unclear quality), the co-financing is more a local tax paid by low (or lowest) income sectors of the population and mainly directed to guarantee salaries of the health staff. In particular, in situations such as this prevailing in the Eastern DR Congo which call for humanitarian aid (for the whole population; not only for a single group) this kind of tax paying should not only be avoided (as it installs new inequities in the community). On the other hand, there is no doubt that without a financial contribution, i.e. private/public co-financing a sustainable primary ***health care system*** cannot be established. For this objective the amount of 0.5 US$ or a volume of one third, indicated in the GPs, sounds realistic.

In the GP 2001 it is correctly stated that community participation –which is certainly the background for the pre-development criteria of OCHA– is one cardinal element to establish durable health systems (required also: the government and external donors). Consequently it is proposed to revive the local *Comité(s) de Santé* (CoSa.s). In addition, the GPs' support of *drug procurement* (and distribution) through *centralised systems* initiates the re-vitalisation of local or regional *centrale/s d'achat* (CdA).

But it still needs reflection on a suitable design for putting both aspects into appropriate practice (e.g. by creating strong regional CdA properly linked to "The Regional CoSa.s"). The approach of Malteser Ariwara may serve as an example (see Annex 7).

Funding agencies should strongly advocate local capacity building (Buyck, 1991[17]; Jaycox, 1993[18]). This requires an intensive dialogue between the three key partners: government, donors and communities (Bennet, 1989)[19]. Such a dialogue gives way for sustainability. Unfortunately one will hardly find a "relevant" government in the present Congolese political environment, and there is no sign that there will be one in the near future. Therefore, in the Eastern Congolese context, community participation means capacity-building at a grass roots level. It has to be combined with good governance, which is, in particular, an essential desire of the population in the *chronic conflict situation.*

Relevance and appropriateness of the underlying ECHO rules and regulations

The execution of the GPs through NGOs refers to and needs the existence of the FPA. In Article 17.3 the Contract tries to arrange a guaranteed drug quality, while Article 16.4 defines a certain range for the country of origin. Finally, rule 16.3 makes tender procedures obligatory for *"purchases exceeding EUR 45,000"*.

Unfortunately the text of **rule 17.3** *"The … organisations shall guarantee that medicines supplied are in accordance with WHO rules"* local rules apply *"where these prove to be more restrictive"*, does not reflect the European legislation nor does it reflect the WHO legal situation: The WHO is not a legislative body. Thus, all WHO rules are only recommendations (written on UN organisation paper), which means: to put them into *legal* practice they have to be officially adopted by a country; or: any country's legal requirements are more restrictive than the WHO rules because they are legally binding. The text of 17.3 does not guarantee a certain degree of drug quality. The current procedure is, in a best-case scenario, an appeal on good willed people. It should at least have been made obligatory to apply the >WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce<[20] for any drug purchased. Certificates of this scheme inform about (national / not international) the GMP status of the manufacturer and the fact whether or not the sold product is licensed (in accordance with national quality requirements / not international ones[23]) in the country of origin. With respect to quality, common key criteria for the selection of essential drugs are: safety and efficacy (active compound), stability and *bio*-availability (formulation)[21]. The European drug licensing procedure checks for all these aspects.

As the ECHO funds result from European tax payments, the European drug quality requisites have to be respected. They require a GMP licensed manufacturer[22] and a marketing authorisation of the respective Drug Regulatory Authority (DRA) for the drug in question (drug license)[23]. When buying drugs, as a rule, the batch certificate has to be attached (which gives the documentary proof that the final product (= lot/batch) meets the licensed drug quality parameters). If felt necessary and appropriate (e.g. for blood and blood derivatives or for sera and vaccines) a special form or declaration

[17] Buyck B (1991) The Bank's use of technical assistance for institutional development. *World Bank*.
[18] Jaycox EVK (1993) Capacity building: The missing link in African development. *World Bank.*
[19] Bennet F.J (1989) The dilemma of essential drugs in primary health care. *Soc.Sci.Med* **28** (10), 1085-1090.
[20] Created by resolution WHA28.65: *WHO Official Records*, No. 226, p. 35 and Annex 12, p. 99.
[21] *Bioavailability* is a specific problem that is of particular importance for products of low solubility or narrow therapeutic index. In addition, unsatisfactory drug formulation can result in therapeutic failure due to lack of absorption into the patient's body fluids.
[22] Without special control or evaluation measures, only for PIC member states it may be assumed that the required European GMP standard (of the manufacturer) is met. - The Pharmaceutical Inspection Convention (PIC) is signed by about 50 states; some have equivalent agreements with the PIC: USA, Switzerland and Japan. China and India are not PIC members.
[23] Here *Bioavailability* is a key criteria on the application of which widely differs from PIC to non-PIC member states.

has to be established showing that the product is free of hazardous contaminants (e.g. HIV or Hepatitis viruses).

In addition, it has become commonplace to avoid **rule 16.3** which is the obligation to launch a tender if the value of an order exceeds EUR 45,000. One just refers to the price of ***single drug items*** instead of referring to the value of the whole drug order.

In the PHC context, this is incorrect –if not illegal. One cannot argue in such a way that rule 16.3 does not apply. That is why a drug order of a project has to be directed to avail ***all drugs*** necessary for rational treatment of the local ***pattern of endemic diseases*** for making the complete PHC system run. Consequently, the ECHO project funds are earmarked *de facto* to ensure the well functioning of the ***PHC delivery system***[24] as a whole (not only for one single disease). Accordingly, the funds for ME-G (and medical supplies & lab reagents) have to be used for the purchase of the ***drug basket*** in the locally indispensable composition to assure all standard treatments are subject to the intended/supported locally sound curative PHC approach.

Furthermore, one should also consider seriously the purchase of domestically manufactured drugs (as a reflection of **rule 16.4**). Then the two realistic local options, PHARMAKINA Bukawu and BDOM Bukawu (see Annex 6), have to be carefully considered as a priority option.

The reality of drug purchase resulting from the present usage of ECHO funds is that at least 60% of all drugs originate from IDA Amsterdam. As the aggregated total of GP 2000&2001 drug budgets is about 7 MEURO, the volume of the drug orders placed with IDA is in the range of 2.5 MEURO[25] per year. This is far more than EUR 45,000, the amount which –if exceeded– obliges to launch a tender. It seems realistic to assume that in the context of ECHO Global Plans for other countries, NGOs also apply the same way of drug purchasing; then the annual ME-G turn over washed up from ECHO funds onto the IDA account is in the range of more than only 2.5 MEURO, thus creating an uncontrolled monopoly.

When looking at the facts resulting in the European non-profit (or low-profit) drug market from such a way of monopolistic drug purchase from ECHO funds, one has to consider that (i) instead of competition (in quality and price) there is an IDA monopoly, –as a consequence– (ii) there is an increasing number of small scale suppliers which can only keep up with the IDA prices by not making the aspect of drug quality a priority, and (iii) certain manufacturers, who were previously engaged in the production of low price drugs at European quality standards, are going to retire from the market with their products at European quality. They cannot compete anymore with IDA prices because of continuously shrinking sales due to the unfair purchase/sales practices resulting from the neglect of rule 16.3 and of European drug legislation with its distinct quality requirements.

As a ***first conclusion*** it can be stated that ECHO, as such, is in a troublesome situation as far as it concerns the financing of the purchase of essential drugs for Humanitarian Aid projects. Rule 17.3 has to be revised and rule 16.3 has to be re-enforced without exception.

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[24] ECHO GP 2001 defines in Annex II, p.2 "Programme 2: Health" the following context: ♦ specific objective (project): access to curative PHC; ♦ activities proposed: provision of drugs, medical supplies & distribution logistics; ♦ inputs - estimated costs: cost/new contact ECHO: € 0.8; ♦ outputs basic health needs are covered via provision of minimal package
As a conclusion: The GP's "minimal curative package" is constituted by the rational curative service provided for all major locally relevant diseases (respectively composed of: anamnesis; diagnosis; treatment decision; dispensing of the appropriate drug).

[25] according to information received from the ECHO partners

Relevance and appropriateness of the GP strategy for health financing

As suggested above, the proposed co-financing approach by flat user rates (prix forfaitaire) does not guarantee or support the sustainability of local CdAs initiated by the GP's activities. Further proof is the different project approaches applied and their experience (see below).

As a ***second conclusion*** it can be stated, that a sustainable strategy for the (re-) installation of a public private mixed non-profit health care delivery system has to apply, at least in the pharmaceutical part, the common rules of economy. All activities have to be adjusted in a way that a continuous transition from "urgency" to "rehabilitation", "pre-development" and finally "development" is taken into account from the very first moment, as an option for a LRRD oriented approach immediately after the disaster oriented first phase of Humanitarian Aid is finished.

5. Effectiveness

Availability of drugs

More or less all NGOs report drug stock-outs; and all of them notice a decrease of the patient attendance rates due to drug shortage (see example Annex 8). This correlation shows simply but impressively the sensitive impact of the GP's activities concerned with drug supply.

The experience in Nyrambe ZS, reported by Malteser Ariwara, shows that the sales of drugs at the "free market" has substantially decreased since drugs are continuously available at all health facilities at affordable prices.

As a ***third conclusion*** it can be stated, that the GPs' strong financial support directed to avail ME-G in sufficient quantities at the health facilities within the project area, reflects the common experience that the existence of drugs is an indispensable precondition for success (Annex 9). The quality of care and the user rate will rise wherever user contribution and reliable drug supply become a constituent factor of the health care system (Litvak & Bodart 1993)[26]. This is the strategy of success even if policy debates generally focus on the revenue aspect rather than on drug availability and in the Eastern DR Congo context, they seem to concentrate on "salaries" for the health staff.

Cost recovery approach – prix forfaitaire* contra *drug sales

ASRAMES statistics show that the patient attendance rates increased after the introduction of flat rates for treatment(s) (prix forfaitaire system). In addition, their observations indicate that "felt financial accessibility" (willingness to pay) is directly linked to availability of drugs and affordability of prices/ price system.

Malteser Bukavu reported: The reduction of the flat rate for curative consultations from 1 US$ to 0.5 US$ had only minor effects on the (increase of) patient attendance rates. – As an estimate, only 50–10% of the population living in rural areas are able to pay this small amount.

Malteser Ariwara reported: A pilot project using flat rates for fees (prix forfaitaire CC: 1 US$), initiated by BDOM, has caused a major decline of patient attendance rates at the 5 respective health facilities; the effect was reduced after the rate was set at 0.5 US$.
For comparison: In the "other Ariwara project area" the CC is usually between 0.2 and 0.4 US$ *plus* 0.15 – 0.25 US$ for a "fiche de malade". To this basic amount of about 0.5 US$, the average payment for drugs is added, currently about 0.3 US$ (the latter equals to about 30% of the CIF drug price). Malteser reports no negative response from the population. Indeed, the population is (co-)financing about 75% of the local basic PHC system costs (see Annex 14).

26 Litvak JI & Bodart C (1993) User fees plus quality equal improved access to health care: results of a field experiment in Cameroon. *Soc.Sci.Med*. 37(3), 369-383.

Malteser Ariwara, MEDAIR and MERLIN apply successfully the mix of drug sales, which are at a reduced cost. They together represent more than 50% of the drug turnover within the projects visited during the evaluation.

As a ***fourth conclusion*** it can be stated, that the "prix forfaitaire system" does not concordantly fulfil expectations. There are both positive and negative experiences. However, the mixed cost recovery / co-financing approach, e.g. applied by Malteser Ariwara has very positive results when using the improvement of "rational drug use" as an indicator. (The development was demonstrated by the month and ZS during the visit in Ariwara using a spreadsheet programme developed by Malteser Ariwara. See Annex 14)

Further arguments for an application of the mixed co-financing approach derive from the medical care aspects explained in detail in the Special Health Sector Report (see Annex 15).

Costs and cost effectiveness

The purchasing and distribution of drugs for health care systems always raises certain questions:

1. Is the composition of the drug basket appropriate?
2. Are the opportunities taken to spend the drug budget, made in an almost rational way?
3. Are cost aspects taken into account, when deciding about (a) where to buy and (b) which means of transport to use?
4. Is the cost per treatment in line with the WHO approach for "rational use of drugs"?

Ad 1:
All projects apply an EDL composed to their project area and the "treatment tasks" of the project. There are differences but they are all appropriate.

Ad 2:
As all projects apply the use of ME-G from the WHO EDL, the precondition for a rational way of drug budget usage is fulfilled.

Ad 3a:
A simple comparison of (e.g.) the ratio "cost per new case" will give no satisfactory answer as the treatment aspects to be covered obviously vary from project to project; example: ALISEI covers a large number of severe malnutrition and paediatric cases due to malnutrition → this is a rising type and quantity of expensive treatment cases and the respective drugs, they are using ASRAMES as one major supplier, but the delivery from Goma has to be covered by local air transport. // On the other hand: ASRAMES HQ (and the related warehouse(s) is next door to a good number of ASRAMES supported ZS → thus, minimising the current costs for drugs is embedded in an optimal context.
There is no major influence (range) in the development of treatment costs deriving from the prices of major local suppliers (as can be deducted from Annex 11).

Ad 3b:
The access to the different project areas varies greatly (often within individual areas as well). In particular, the bad road conditions and the unsuitable general connection to the international transport infrastructure (air, sea & river, road) widely differ from area to area (even within one project) and the delays related to these difficulties have also got to be taken into account in order to avoid stock outs and losses, which mostly have inappropriate storage conditions.

However, it can be stated that the decision on the "route of the international transport" seemed to follow almost rational arguments (no excessive or highly disproportionate expenditures were discovered). As far as the internal/local distribution strategies are concerned, (a) the airdrop (used by MSF-B) and (b) the bike and 4X4 distribution (used by MEMISA/CDI) in almost the same region of Orientale need to be compared in relation to their effectiveness in detail, and need to be discussed based on the comparison of results.

In general it could be said that *per se* the different situations relating to access to the (international) transport infrastructure causes vast differences in transport costs from (a) "expensive mixed" (as explained above for MEMISA/CDI) and/or " international air" (areas of: MSF-B, both Gbadolite and Kisangani) via (b) "sea/road" access (NOVIB/ASRAMES; Malteser, both Ariwara and Bukavu; MEDAIR) to (c) "sea/road plus local air" (ALISEI, FOMETRO, MERLIN). Therefore it is of a more statistical interest to take (i) drug costs (at CIF prices) or (ii) the ratio >drugs at ex-store prices< : >transport costs<, as basic indicators of comparing the cost effectiveness of the different projects.
In addition, such comparison does not take into account the variation of drug baskets per project (see below: ad 4). It seems better to compare the outcome expressed as "cost per average standard treatment" (see Annex 12).

Nevertheless if the situation in eastern DR Congo stabilises and the road transport network is rehabilitated, it might be worth thinking about a mixed purchase strategy involving different local suppliers (according to best price per individual item / Annex 11).

Ad 4:
As the examples ALISEI and ASRAMES show (see 3a) the composition of the drug basket per project results in variant cost values per project. In addition, the vast differences of transport conditions (3b) add an unequal cost element on the drug costs. Therefore the simple calculation of “cost per new case” is no appropriate indicator of a project's cost effectiveness in drug procurement, an indicator that also depends on the rationality of treatment habits.
A certain answer may be found from the comparison of the different project's costs for an average (somehow rational) standard treatment (see Annex 12). The underlying full cost prices for an average standard treatment range from US$ 0.43 (MEDAIR) to US$ 0.58 (FOMETRO) with an average of US$ 0,51 (+/- 20%)[27].

As a ***fifth conclusion*** it can be stated, that the full cost price for an average standard treatment would be at an affordable level (0.51 US$). This amount equals the GP's prix forfaitaire proposed at 0.5 US$ for a curative consultation. The cost charts of Malteser Ariwara also show results in the same range (Annex 14).

6. Efficiency

The resulting efficiency of the different NGOs when putting into practice the GP 2000&2001 approach depends in particular on three factors:

1. Application of appropriate drug quality control and quality assurance (QC/QA) measures for the whole “lifetime” of a certain drug when (and after) entering the “project environment”
2. Measures and devotion invested into contributing to the aim of “rational use of drugs”
3. The prevention of losses from drugs and funds by theft or embezzlement

The performance of the drug supply and delivery system of the different NGOs

When using a standardised scale for measuring the impact of the procedures taken by the different NGOs in their (sometimes also differing) project areas, it becomes possible to compare the efficiency of the various approaches applied –with regard to the drug supply system as such and its performance (see Annex 13).

Concerning the ***QC/QA aspects***, one has to state clearly, that the majority of all NGOs do not take quality considerations seriously; whether this is an effect born by the unprofessional text of the FPA (see above: relevance and appropriateness) may be discussed. MEMISA (CDI area only) and –with a certain respect Malteser Ariwara and MSF-B Kisangani– show an appropiate standard.

[27] Because of varied circumstances the differences are not significant.

The quality of drugs purchased and delivered from ECHO funds is assured by a mixture of believes and trust instead of by compliance with legal requirements and facts. The NGOs seem to be biased by a pretension that northern hemisphere NGOs carry out their work with good (if not high) performance/quality. Thus they assume/believe that IDA (as a non-profit foundation) delivers guaranteed drug quality (even if a good fraction of the products come from India or China, and even if one pharmacist assumed that the cheap prices of IDA result from "no quality control measures").

On the other hand NGOs seem to be sure, that analytical results from local quality control facilities are "plucked_out of the air". They just file control certificates as in the case of MSF-B Kisangani. Therefore, nobody in MSF knows whether the documented results had represented the reality. If the results were correct, then all three products were absolutely sub-standard. Therefore at least a counter analysis should have been recommended. But the results were not even looked at and no reaction was taken into consideration at all.

Concerning the GP 2000&2001 basic objective of ***rational use of drugs***, the majority of all NGOs show good performance (with regards to the activities of the partners directed to change the present bad treatment/prescription habits). This is a time consuming process, which requires continuous mid-term education. – FOMETRO and MSF-B Gbadolite were greatly below the sufficient standard; relatively low were ASRAMES and Malteser Bukavu. The reason for the poor results of FOMETRO may result from the fact that the expat LTC is a medical/pharmaceutical non-professional. The low standard of MSF-B Gbadolite seems to result from a complex situation, on the one hand MSF-B does expressively not intend to run development projects (and the long lasting urgency in East DR Congo tends already to transition or pre-development), on the other hand the project region in Orientale still show general lines of an early post-war situation. Also, the 6-monthly changes of the international project staff members contributes little to a future oriented educational approach, which is a major aspect within all the activities directed to change poor prescription habits and to implement an attitude directed to "rational use of drugs".

The ***prevention of losses*** by theft or embezzlement shows in particular weaknesses caused by the method applied for the distribution from project/central level down to the periphery (CS/CSR) via the BCZS. A present negative experience of ASRAMES confirms such weaknesses. However, it was somehow predictable that such a misuse for private interests would involve a MD and would happen at the BCZS level. – Low scores appear with ASRAMES, FOMETRO, and the both MSF-B. This can also be assumed for the "non-CDI" areas of the MEMISA project.

The different approaches of the NGOs visited lead to an interesting picture of the ***General Performance of Supply Systems of PHC Drugs***. Those projects, which show the highest scores, i.e. Malteser Ariwara, both MEDAIR and the CDI area of MEMISA, apply the best community involvement and they also show low losses from non-paying patients. Two facts which go nicely together. This is an approach aiming at institution and capacity building at a grass roots level and focusing on the patient's economic abilities, i.e. the population.

On the other hand, in Kasongo HGR the highest non-payers percentage ever encountered appears. In May 2001 the following situation applied: Payers: 42.7%; non-payers: 57.3 %, i.e. health staff (and families): 26.5%; soldiers: 19.1 %; credits (after re-payment of about 1/5): 8.1%; real indigents: 2.1%. At the same time at Kasongo HGR the ratio >health staff<: >in-patients< is about 1:2. This leads to the deduction that the FOMETRO project approach is health structure directed, i.e. focused on the fair living conditions of the entire existing health staff.

ASRAMES, FOMETRO, Malteser Bukavu and MSF-B Gbadolite show scores largely below average. In particular, this should raise questions for the ASRAMES asbl as it also acts as an important supplier of ME-G for other projects[28], in which they may assume that they receive good quality drugs – unaware that there is no appropriate QC/QA awareness.

[28] As far as it concerns the price level ASRAMES asbl is a competitive local supplier. See Annex 11.

Conclusions drawn from the performance evaluation

Concerning the present evaluation data, it seems that there is no other road to success except for the installation of a bottom up hierarchy of community participation composed of: (i) local CoSa.s, (ii) area GoGe.s which are not only composed of ex-officio members of the health system, and (iii) a community controlled CdA at central/regional level. This fits with the OCHA criteria for pre-development. Such efforts are directed to promote good governance, and the way/process used may be the only one applicable under the given circumstances of a chronic conflict situation.

As a ***sixth conclusion*** the following can be stated: Considering the approaches of the 3 top project approaches (i.e. Malteser Ariwara, both MEDAIR and the CDI area of MEMISA) in terms of *health*, *efficiency* and *equity*, indicators which measure the effects and characteristics intended by PHC-related activities – such as the continuous availability of most-needed drugs, uniform geographical coverage, fairness of price-setting, economic viability and community participation (Schrettenbrunner & Harpham 1993)[29] – then inputs, processes, outputs and results of the above mentioned 3 approaches of co-financing through drug sales (plus treatment fees) paired with an effective community participation seem to exhibit a uniformly positive trend. This needs further detailed observations.

7. Co-ordination, Coherence and Complementarity

During the visit made to the ECHO partners, who play a major role in the implementation of drug supply systems in the context of the GP 2000&2001 strategic approach, it became more and more obvious that there is a great ***need for an exchange of experiences from the field work*** of the various NGOs and their different approaches applied. The representatives of most of the NGOs also feel this need. Budgeting for health costs, management & organisation of drug systems, and effective community participation may be three issues of common interest.

Such exchange of experience is not just a felt need, it also avoids the application of diverging strategies which may not contribute to a unique development for the future of the whole country, or – in other words– ***professional co-ordination*** within the "ECHO partners community" is necessary to develop a ***coherence*** in the phasing of the ECHO GP inputs, and to be prepared and ready for a ***complementarity*** to other major donor programmes and inputs such as the US-AID sponsored SANRU programme.

The co-ordination (meetings) can also assist (i) to make use of old and/or external experiences for designing activities, procedures and structures, and (ii) to avoid inventing the wheel again – several times and in various sizes by some or all of the ECHO partners. If organised in meetings or workshops, the co-ordination could also bridge the communication and co-ordination gaps between the East and West of DR Congo.

As a ***seventh conclusion*** it can be stated, that internal professional co-ordination and communication between ECHO partners should be given high priority. If well organised, this would also contribute to better coherence of the GP's special objectives with the strategic approach and the easy "phasing over" to PATS sponsored projects, as well as the development of complementary strategies in cooperation with other major donors.

[29] Schrettenbrunner A & Harpham T (1993) A different approach to evaluating PHC projects in developing countries: how acceptable is it to aid agencies? *Health Policy and Planning* **8**(2), 128-135.

8. Impact and Strategic Implications

Aspects of health financing - directed to future development of the public private (non-profit) mix in the (primary) health care delivery system

Bearing in mind that the sustainable financing of health systems –in particular where there is no proper government and/or very limited (or no) public resources– cannot and would not be guaranteed by donors, then the only "institution" remaining to take the lead, seems to be the community. In other words, the community through the CoSa has to organise its own interests; here: the availability of (affordable) drugs as a precondition of functional public (and private non-profit) health services. In doing so, the population is taking care of their own well-being. – From ECHO's point of view this is a mutual starting point for an exit scenario in line with LRRD.

A precondition for the road from the present cost sharing/co-financing to health system financing is to be continuously aware of the financial standing. At present most of the projects/NGOs have no idea of their "local" budget. Therefore, as a first step one should introduce a common obligatory system of budgeting (a) for the pharmaceutical care aspects in particular composed of costs for: ♦ CdA staff; ♦ drug purchase; ♦ freight; ♦ local drug distribution transport; ♦ warehouse; ♦ (minimal) maintenance; ♦ general current costs; (an example is shown in Annex 16) and (b) for the medical care aspects in particular composed of costs for: ♦ health staff; ♦ diagnosis (mainly lab reagents & consumables); ♦ merely free of charge preventive services (EPI, MCH); ♦ training; ♦ supervision; ♦ (minimal) maintenance; ♦ general current costs.

Based on actual budget figures a budget forecast should be developed for revenues and expenditures of the existing and the envisaged health care system (per unit level and per health area, i.e. ZS level).

As a general statement one can predict that there is no chance of sustainable health financing whilst the non-influencable (external) costs are not covered through local revenues. In other words, there is no way of reaching a certain independence whilst the costs for goods to be purchased (e.g. ME-G) are not covered. (Also see below: "8. Impact and strategic implications".)

As an ***eighth conclusion*** it can be stated, that health costs should be kept, to get a grasp of the volume of the different cost accounts (which allows for an assessment whether the result/contribution is worth the financial value) and to prepare for mutual LRRD exit scenario(s).

Requirements for the preparation of the Global Plans

As expected, the systematic supply of ME-G contributes effectively to an increasing acceptance of the public (and private non-profit) health care services in general. In addition, the experience from the cost recovery component shows that all in all for the drug supply component, full cost recovery can be reached as such (see conclusions 6 and 8).

According to “existing experience,”[30] drug supply can be organised as a sustainable venture, yet guaranteeing affordable prices. This should be reflected when discussing further development of the GPs, as it is known that people are usually willing to pay for “their own interests” but not for “common goals”. In the health financing strategies, two groups of health services are characterised: (i) treatment of common diseases (understood as “private interests” - and usually the core curative services of the PHC approach) and treatment of communicable diseases as well as promotion of FP (defined as “public benefits”). The latter are usually subsumed under government obligations. When it comes to review the sensitive budget element of salaries, one should consider carefully the rescheduling of the cost accounts, which are partly or fully covered by income from drug sales and/or treatment fees. It seems to be a realistic expectation, that the representatives of the local population

[30] Von Massow F, Korte R, Cheka C, Kuper M, Tata H, Schmidt-Ehry B (1998) Financially Independent Primary Health Care Drug Supply System has been Functional in the North West Province of Cameroon for 10 Years. *Tropical Medicine & International Health,* **3 (10)**, 788-801.

may rally for payments of drugs (resulting in guaranteed stock presence of ME-G for treatment at affordable conditions) but not so much for the payment of fees (resulting in guaranteed salaries of health staff). Also the arguments from the special health sector report (see Annex 15) are fully supported without exception.

The General Objective (for the aspects of pharmaceutical care) of the ***Global Plan 200X*** may then read: "to regain and improve trust and confidence of the population in the quality of the public (and private non-profit) health services"

To reach this objective the following results (special objectives) are necessary (*inter alia*):
♦ *essential drugs and medical supplies continuously available;* ♦ *rational use of drugs progressively applied by the health staff;* ♦ *local community effectively promotes and progressively manages their own health interests;* ♦ *appropriate cost sharing / cost recovery scheme for essential drugs in place and regularly reviewed (jointly by the community, the health service representatives and the project implementing group);* ♦ *non-payers (inclusive of the indigents) defined by the local CoSa or CoGe.*

The question of what may be a realistic and fair solution to guerdon and compensate the health staff for the rendered services still remains to be answered. However two aspects should be clear: (i) there is no satisfactory concept of health personnel financing possible unless the number of staff is cut down by at least half of the present staff members. (ii) There is no argument for a salary-like payment unless there are good treatment habits, i.e. quality of care (an indicator of which is the grade of rational use of drugs).

9. Visibility

There is no distinct visibility of the ECHO input. The first logo visible is that of a certain NGO, and the understanding of the population is more that the given help and support is coming from the ECHO partner who is assisted by ECHO (in one way or the other). In most cases the fact that the support (e.g. with ME-G) is given by the "European body ECHO" is not brought home to the recipient population.

The message is "the NGO project for the local/regional/provincial population" is assisted with money from ECHO. The understanding should be "the ECHO support programme for the DR Congo population" is implemented by the NGO as an ECHO partner.

10. Horizontal Issues

The growing willingness of the population to pay for health care and the possibility to group the project areas in accordance with the criteria of the 4 OCHA categories should be seriously observed. PATS should be regularly informed (as a routine issue) about projects/areas, which are progressively facing the pre-development stage. Where and if necessary or appropriate, PATS should be invited to comment on ECHO partner proposals for projects getting close to OCHA phase 4. These contacts would be directed to support a smooth handing over of the relevant projects from ECHO to PATS responsibility. (Realisation of LRRD theory)

11. Lessons Learned

Planning procedures
During the visits the evaluation team was confronted with the fact that in the majority of proposals submitted by ECHO partners the necessary knowledge and skills needed to construct a logical framework, which is logic in deed, were missing, In addition, the proposed indicators are often descriptive tools only.

When introducing and/or using professional terminology like "rational use of drugs" the correct wording and understanding/meaning should be applied. This avoids misunderstandings. Sometimes it

is better to be simple and clear than to run into semantic or professional discussions during which the fundamental intention is harmed or even lost.

Drug quality
The procedures applied and based on the FPA do not assure the availability of safe quality drugs. The existing habits do not comply with the historic European tradition of principle ethics in health care as laid down in the Hippocratic oath. There is no room for any consideration of whether a certain (unknown) quality drug at a low price is better than a drug with proved quality and efficacy at a (slightly) higher price. The patient's best interest is the focus. Thoughts have to concentrate on the rational selection of the appropriate treatment, which is a constituent part of the WHO strategy on "rational use of drugs".

Price per tablet considerations might be worth thinking about for economists but the risk / the price one has to pay is the patient's health if not his life. The one and only driving force must be the indubitable safety of the patient. Indeed, maintaining the present behaviour is only a stage away from the often-incriminated irresponsible local habits such as "appendicitis surgery" used for treatment of gastro-intestinal symptoms. Both practices are simply profit oriented. There should be no double standard argument where, local health professionals have to renounce from bad habits while expat professional can maintain their lazy practices. (Besides: the first group need money, the latter have.)

It is felt that immediate action should be taken if one is to genuinely improve on the quality of care.

Community participation
The present results indicate two facts which compliment each other well: Where there is strong basic community involvement, the best examples of the improvement of the quality of care can be found. Projects of this type also show very low losses from non-paying patients. This approach seems to aim at and support effectively institution and capacity building at a grass roots level; they are focused on the patient's economic abilities, i.e. the population.

12. Recommendations

- ECHO should review the ***criteria for the purchase of drugs*** as laid down in the FPA under 16.3, 16.4 and 17.3 as well as 17.4. and bring them in line with the European Drug Legislation as soon as possible. Also, ECHO should do all it can to avoid the installation and/or support of supplier monopolies. An opportunity to close the gap due to the present wording of rule 17.3 can be the introduction of accrediting manufacturers and their products (either directly or through authorized suppliers). The procedure could refer to European quality requirements (as explained above / p. 16) and should be renewed/up-dated every two years.
- A sustainable strategy for the (re-)installation of a public private mixed non-profit health care delivery system should be developed.
  In this context the common rules of economy have to be applied. All activities should be adjusted in a way that a continuous transition from “urgency” to “rehabilitation”, “pre-development” and finally “development” is taken into account from the very first moment. The ***LRRD approach*** should be applied immediately after the disaster oriented first phase of Humanitarian Aid has finished. As a first supportive step, a standardised simple scheme for accounting and budgeting of health costs should be introduced and made obligatory – starting with the drug budget.
- There is no concrete proof for the appropriateness of the prix forfaitaire as a tool for cost recovery. Therefore during the GP's re-programming one should review carefully the present ***co-financing approach*** and introduce the mixed cost system (payment for ME-G and for treatment fees) as an alternative concept to the pure prix forfaitaire system. When reviewing it should be taken into consideration that the average full cost recovery price for a standard treatment with ME-G is at an affordable level (0.51 US$). This amount equals the ECHO proposal for the prix forfaitaire of a curative consultation.

- The ***community participation*** policy should be further developed and take into account as the final goal of good governance.
  When planning the next GP one should pay regard to the fact that community involvement and low losses from non-paying patients occur jointly. The strategic approach for community participation should refer to the recent positive results of Malteser Ariwara and MEDAIR. The more than 25 years of "historic" experience of CDI should also be taken into account. The approach should aim at institution and capacity building at a grass roots level and be focussed on the patient's economic abilities, i.e. the population.