Evaluation Report
Baptist community in northern Congo (CBCN) Health project
In Bas Uélé
04th – 16th September 2008

Presentation plan:

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      ("Communauté Baptist du Congo Nord" = CBCN)
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0. Short presentations:

a) The Baptist Community in Northern Congo (CBCN)

Bas Uélé is one of the districts situated in the Oriental Province in the North-western part of the Democratic Republic of Congo (DRC). The 14th Baptist community of Northern Congo (CBCN) is one of the principal religious communities intervening in the area in several fields, including health services - in cooperation with the DRC government. The CBCN receives financial support from the Norwegian Baptist Union (NBU) and NORAD in order to cover the populations needs for health services . The Bas Uélé counts approximately 713.000 inhabitants The area is covered with tropical rain forest and is sparsely populated - the average is less than 10 people per km2.
The region passes among the less developed in the DRC.
The CBCN manages 15 medical institutions in Bas Uélé.

b) Health Centres managed by the CBCN

1 General reference Hospital:
Monga (population 5763)

3 Reference Health Centres:
Makala in the health zone (ZS) of Likati (population 8215),
Bulumasi in the ZS of Bili (population 5272)
Bondeko in ZS of Monga (population 5715)

8 Health Centres:
Makala in ZS of Buta (population 8743)
Mobati in the ZS Aketi, (population 6131);
Danbu and Tobongisa in ZS Likati (population 11782)
Timibikisa and Dengu in the ZS of Bondo (population 14037)
Dumobata in the ZS of Bili (population 6416)
Mongbaya in the ZS Gangadingila (population 4468)

3 Health Stations :
Nangua in the ZS of Bondo (population 3800),
Maluwe in the ZS of Likati (population 2700)
Basiliga in the ZS of Gangadingila (population 3830)

The total population served by the medical structures of the CBCN is approximately 85.000

1. The evaluation process:

a) Constitution of the team:

1. Dr. Harald HURUM: Consultant .Pediatric departement ,Sykehuset Ostfold Fredrikstad (SOF) Norway

2. Dr. LeBon Barhwamire Rubeshuza , MD . National medical coordinator of the 5th CELPA (Pentecostal church), based in Bukavu R.D. Congo.

Assisted by:

- Miss Lise Kyllingstad, Project coordinator, Norwegian Baptist Union
- Mr. Nzaba Pierre (Nurse, Local Project Coordinator/Director)
- Mr. Jean Blaise Gbebanga (cold chain technician)
- MR. Remy Mafungu (nurse)

Last three all being members of the coordinating (and planning) committee of this project

b) Health Centres Visited:

For reasons based on geographical accessibility, the time available and variations in size and quality level, the following Health structures where chosen. This choice was taken by the local coordinating committee in collaboration with Lise Kyllingstad (Norwegian Baptist Union):

- The Nangau Health station ,
- The Tomibikisa Health Centre in Bondo,
- The Tobongisa Health Centre in Likati,
- The Makala Health Centre in Buta
- The General Reference Hospital in Monga

c) Background documents:

To make this report we were presented the following background documents:

- Main Project Document worked out by the CBCN
- Annual reports from 2006 and 2007
- Action plans for various years 2006, 2007 and 2008
- Budgets for the years 2006, 2007 and 2008
- Terms of Reference made in Aalgaard on July 4, 2008

d) Duration of the mission:

The evaluation visit lasted from the 04th to the 16th of September 2008

e) Working Methods:

- Visits in the above mentioned health structures,
- Checking the statistical figures,
- Dialogues with the personnel in the different centre
- Dialogues with the members of health committees (CoSa) and the Community contacts,
- Observations of the patients, meetings with the chief consultants in health districts,
- Dialogues with the local coordinating committee and the coordinator of the projects of the Norwegian Baptist Union

During our mission, we had to deploy much time for practical preparations, very long displacements with motorbikes (approximately 500 km), multiple presentations with several administrative authorities and formal visits to different important personalities often absent (!).

II. Results - answers to the questions posed in the Terms of reference:

Fifteen main questions were posed and we formulate brief replies according to information collected on the ground. They are as follows:

1. How do the project follow the project document?

In our opinion, the project follows only partially the document, and with an important delay.
The project seeks to deal with and solve three main medical problems, considered as the three pillars of the project;

-*Malaria*
-*Sexually Transmitted Diseases (STD) including HIV infection*
-*Mother and child health* (by applying the national protocols for primary health care, vaccinations etc)

- **Malaria:**

One of the activities in the project is the distribution of impregnated mosquito nets to women who follow prenatal consultations and give birth in CBCN health centres.
But the conditions to fulfil for the receivers seem rather strict.
On the other hand, even if they are fulfilled they aren't always respected by the centres themselves; Sometimes the reasons given is that the nets are out-of-stock, sometimes other reasons are given – anyhow this leads to disappointments.

Antimalaria drugs is available, and is given free of charge to the high-risk children (0 to 24 months of age)
One of the capital objectives of the project is the reduction in the death rate caused by malaria. But it is difficult to measure and to quantify any reduction without a reliable diagnostic instrument .For example examination of blood smears – the gold standard to set the diagnosis - has not been done at the Monga hospital and Makala health centre for the last 5 years! ("Because they miss the reagents - the Giemsa colouring liquid")

- **STD and the HIV/AIDS:**

Preventive health education is offered to the population, but in a less effective way (see also the answer to question number 9 below).
Voluntary HIV testing does not exist. This is a problem, but on the other hand, in the region it doesn't exist a program for free treatment of opportunistic infections, and more important ,antiretroviral treatment (HAART) is practically non-accessible and/or very expensive in the area. This makes general HIV testing (screening) difficult to defend and it may be considered as a non-ethical measure for the time being.
Testing blood donors prior to blood transfusions is covered by the project. The results - positive or negative - are not transmitted to the potential donors concerned.
Other STDs have neither diagnostic protocols nor treatment protocols, which is followed by the centres.

- **Mother and infant welfare:**

According to the project document, an increase in vaccine coverage to 80% is one of the objectives. Each health area (region) has an estimated population rather reliable (after census and annually corrected by multiplying the total figure by a factor of 1.03 which is the official natural rate of population increase in the DRC). According to standards of the ministry of health in the DRC the children aged 0-11 months (target group for the vaccination) represent at any moment 4% of the country's total population. In each health area these 4% serve like denominator to evaluate the vaccine coverage in a given area.

In a subjective way, we have the impression that the vaccine coverage improves, but documentation to confirm it is incomplete. One problem is that standard vaccination cards for children and prenatal consultation cards for pregnant women do not exist in the circuit. Another problem is that comparing documentation from before them 2006 is difficult to obtain .

2. What activities have been implemented?

The following activities are organized:

- Purchase and supply essential and consumable medical drugs.

In the beginning of the project, the drugs were distributed free of charge to the health centres. The intention was then that the health centre should sell the drugs and refund 70% to the coordination in order to renew their stock.
This system was not respected and therefore one month before our visit (!) they changed the system:
The budget envisaged by the project - and the supplementary budget provided by the Norwegian Baptist Union - for each health centre for the free treatment of children from 0 to 24 months remains at the direction of the project, which divides it into two parts;
70% remains at the direction of the project and the drugs of corresponding value are served to the centres according to their needs and commands.
30% are given in cash to the health centre for its function (10 % for the centre and 20% for the personnel's salaries).

- Purchase and distribution of materials such as:

Refrigerators: 19
Solar panels: 28
Batteries: 48
Motor bikes of various categories 125 CC: 11
Bicycles: 13
Safes: 12
Binocular and monocular microscopes: 3 + 3
Impregnated mosquito nets: 1000
Balances: 30
Tensiometers with stethoscopes
Eyeglasses etc
Materials for dentistry

- Education (3 days seminary) in accountancy. One person per centre

- Training of three nurses as specialized educators in HIV/AIDS (see also question n° 9)

- One visit per year by the planning committee in each centre and elaboration of annual action plans

- Preventive and curative activities as described below.

3. Have activities been implemented according to plans?

See replies for the n° 1 question

4. What results have been achieved?

With no doubt, the medical situation of the population in Bas Uélé is improving. This is according to testimonies given by the population, the health workers and the authorities.
The vaccine coverage improves also due to improved access to vaccines and improving and securing the "cold chain" (even though most of the refrigerators in the project aren't installed yet!).

There is increased use of the CBCN health centres compared to the to other surrounding structures.
It also seems to be a strong reduction in diseases that are preventable by vaccines (Measles, poliomyelitis, Diphtheria, Tetanus in mother and child)
Essential drugs are available in all the (visited) CBCN health structures.

5. Do we see changes in the health situation for children and women in particular in Bas Uélé?

According to information presented to us by the population especially the mothers but also by the health committees (COSA) and various authorities, there is a very great change:
-Strong decrease in the infant morality rate
-Strong decrease in morbidity related to the diseases which are prevented by vaccination,
-The women come to give birth in the CBCN maternities,
-The population is slightly more informed concerning the HIV/AIDS epidemics

Though it is difficult to document this change since health statistics in the area – both within and without the CBCN system is incomplete and difficult to achieve.

6. The frequency of people visiting the centres?

- **Consultations made by nurses**

In all the visited health centres we noted a strong and more or less sudden reduction in frequentation after the year 2006.

Medical institution	**Total Consultations 2006**	**Total Consultations 2007**	**January to September 2008**
Tomibikaisa health centre/Bondo	Statistics not presented	Statistics not presented	2058
Nangau health station	1450	800	240
Monga general Hospital	3379	3033	1560
Tomibikasa health centre/Likati	5238	3221	2361
Makala health centre/Buta	6060	2200	2410

This fall seems to be partially explained by the change in rules for offering free treatment to children;
Until the end of 2006 this included children age 0- 36 months.
After 2006 this includes children aged 0 – 24 months.

- **Consultations made by Doctor** (Monga General Hospital only)

Statistics not presented

- **Childbirth:**

Medical institution	**Total births 2006**	**Total births 2007**	**January to September 2008**
Tomibikaisa health centre/Bondo	Statistics not presented	Statistics not presented	Statistics not presented
Nangua health station	Statistics not presented	22	13
Monga general hospital	141	123	72
Tomibikaisa health centre/Likati	Statistics not presented	48	66
Makala health centre	155	230	285

Surgery (Monga General Hospital only):

2006: 48 surgical interventions carried out
2007: 38 surgical interventions carried out
2008: 21 surgical interventions carried out from January to September

Prenatal consultations (PNC)

Statistics are generally not presented and/or difficult to read.

- **Pre-school consultations (PSC)**

Statistics are generally not presented and/or difficult to read.

- **Vaccination:**

Statistics correlated with the two preceding activities (PNC and PSC)

In a short way, we can note that the global statistics of health centres are neither available in the respective health Centre nor at the coordinating committee / direction of the project.
The correlating statistics from before the beginning of this project i.e. before 2006 are impossible to obtain for the comparison.

7. Has there been a change of attitude amongst the nurses that work in the centres?

A change of attitude is difficult to confirm; however on the basis of feedback from the population and the COSAs we have the impression that the nurses attitude and their behaviour when receiving the patients has improved much and that they are superior to other competing/collaborating health institutions in the region in this matter.

8. Are people content with the service at the CBCN health centres?

The population is very satisfied and grateful to the CBCN health centres for their services. Our impression is based on interviews with the COSA, the health workers and officials (administrative or health)
Even though – there has been a progressive decrease in frequentation in the CBCN health institutions since the beginning of 2007.
This may have different explications - including also dissatisfaction with some of the services given.

9. How does the informational work on HIV/AIDS go?

Popular health education concerning HIV/AIDS issues is very basic, badly organized and not systematic. Didactic materials are rare in the health centres; Information is occasionally given during the prenatal consultations (PNC), sometimes during curative consultations.
We were informed that education sometimes was transmitted in the churches and the schools, but without any further details or documentation given to explain this more.
No seminary seems to have taken place so far and the three nurses who received special training in Kinshasa don't seem to by used regularly and dynamically in the project.
There was a formation of 24 educators in Mars 2006 (activity not financed by the project, but rather by the PNLS Kisangani)
This year a round of sensitizing took place from May 5 to June 7 in different villages, - according to a report presented by M REMY. This was in Titule, Bambesa ,Dingila, Ango, Bili, Bulumasi, Yakpa, Bendo and Dengu with a total of 1015 participants. 8 local committees for the fight against the HIV/AIDS were installed.
A 10 days-seminar of sensitizing and education on this subjects (for 1-2 nurses per medical institution)is programmed for the month of October at Buta this year. The seminary is organized in cooperation with the national program for fight against AIDS – "Program National Lutte contre SIDA" (PNLS)

10. Do we see any changes in attitude towards HIV/AIDS in the population?

The HIV/AIDS is considered as a disgraceful disease in the region,
The little of information available would come from the activities of the CBCN (again according to the nurses, COSA and the authorities in the medical district)
During our visit we saw no educative public signs or posters concerning the HIV epidemic, no T-shirts with written or visual messages or no educating broadcasting (radio) programs. In many cases local radio emissions are not available in the area.

11. Has there been internal or external factors that have affected the implementation of the project?

a) External factors:

The poverty is very marked in the area (more than 90% of the population lives by traditional hunting, agriculture and fishing, the portion of illiteracy is also high.)

- Climatic hostility (much rain in a very forested region)
- Lack of infrastructure of communication (roads, telephone, radio television….)
- Vaccines often out-of-stock at the health zone headquarters, which then become unable to supply the different health institutions in each zone with vaccines.
- No existence of vaccination cards - neither for the children nor for the pregnant women (for a good follow-up)

b) Internal factors:

- The affaire with a collaborator in the project who, in the beginning of the project carried out a purchase of a great quantity of materials, - materials that were expensive and some of them not even applicable for the project. This affaire slowed down the progression of the activities on the project.

- Treatment free-of-charge for the personnel of the church (currently they profit free consultations only and pay for the medicaments).

12. The contact/confidence between the direction of the project and the health centres?

The confidence between the direction of the project and the health centres seems apparently good (according to the declarations of nurses in the visited health centres);
The 3 members of coordinating team make follow-up visits once a year in each institution. (Reliable information given by the coordinating team and confirmed by the nurses in the health centres - but without any documentation presented) together with the two Norwegian nurses (advisers) who come out once a year to support the coordinating team with which they turn all together to visit the CBCN health institutions being part of this project. (Planning team = the 3 members of the coordinating team with assistance of the two Norwegian nurses Mrs AB Leines and Mrs S Håland)
The method used during follow-up seems to be mostly informal. No standard form or report is used and filled in systematically during the visits.
According to the team members, they supervise mainly the three pillar activities of the project in a more of less individual way (each member does as he feels like – no standard procedure exists) The coordinator (the direction) receives no global standard report of the activities in the various centres - neither monthly nor annual; and the he does not have an overall vision of the activities in the health centres.
Apart from this annual visit, the visits made by the members of the coordinating team seem to be irregular and rare.

13. Is there a need for changes in the project for the last 2,5 years?

See "Suggestions" below.

14. Is there anything to be done to make the the CBCN health centres self-supported for the future?

It is difficult - maybe impossible – to see how the CBCN health centres in Bas Uélé can become financially independent and self-supported in the near future. This assumption relies on the following facts:

- The economic level is extremely low in the population
- The health centres are located very distant from/to each other (often around 100 km), connected by almost non-existent roads, which makes transport of medical equipment and medicaments as well as monitoring very difficult and expensive, specially in the rainy season

- Certain important and essential activities in the centres do not generate receipts (they are free), this is the case for: vaccination, preschool consultations, prenatal Consultations and popular health education.

15. The Gender aspect of the project?

It is to be recalled that among the three pillar (main) activities of the project, pregnant women and children are given first priority.

On the other hand the female representation in the personnel in the various visited institutions was noted as follows:

Medical institution	Total staff	Female	Female percentage
Coordination of the project	3	0	0%
Health centres	26	8	30%
Monga hospital	17	6	30%
Health Committee (CoSa)	85	19	22%
Total (visited institutions only)	131	33	**25%**
Total (the whole CBCN health project)	**103**	**30**	**29%**

Observation:
No women were found to be president or vice president in CoSa, or holder of a Health centre.
The women are not easily given responsibility in spite of their competence.
This seems to correspond with the general praxis /tradition in the region (independent of the CBCN policy).

III. Conclusions.

Bas-Uélé is an area often neglected by the Congolese authorities and the NGOs intervening in the region are few. On this background the medical services offered by the CBCN institutions are very important for the public health.
The project undoubtedly improves the medical situation in the Bas-Uélé area and especially for its target groups (mothers and children).

Nevertheless, the standard of care given by the centres in the project is very variable and there is need for improvement concerning medical competence, equipment and management (see suggestions below).
It is also necessary to improve the function of the coordinating committee Unfortunately, it is difficult to understand how the CBCN medical institutions will function after the year 2010 when the NORAD financial support is supposed to come to an end.

IV. Suggestions:

Concerning the coordinating committee:

The coordinating committee of the project seems to be a weak point:

- Too many responsibilities depend on the coordinator alone (purchase, management and distribution of drugs and materials, budget planning supervision of the health centres including annual rounds…)
- Two other members of the coordinating committee are 100% engaged by the project but they aren't both of them fully qualified to supervise independently the institutions and they often remain without occupations when their annual tourney with the planning committee is over.
- The coordinating committee has no regular meetings or working sessions apart from the tourney.
- The coordinator often makes the decisions alone without consulting the other members.
- The supervision of the centres is no satisfactory and insufficient (in quantity and quality).
- Absence of tools of follow-up of the activities in the institutions: no supervision "manuals", no standard reports, and missing statistics for monitoring.

We understand that the coordinating committee must respect the church hierarchy and that the many important decisions concerning personnel and organisation is taken by the church executive committee in cooperation with the director (Mr Nzaba) who represent the health sector in the committee

Nevertheless, to improve the situation we propose:

- All the members of the committee must have a written "job description" and the qualifications (or profile) to be named supervisors must de defined.
- Supervision of the centres must be regular and systematic, if possible each three months (by one of the qualified members of coordinating

committee). Standard reports should be worked out after each visit so that all-important information arrives at coordinating office for the "monitoring" of the project.

- The Coordinating committee must organize regular meetings and working sessions to discuss and dissolve problems related to the project and to take part in the meetings with other partners.
- The purchase and handling of essential drugs is an important activity. In the area, the CBCN "pharmacy" in Buta is perhaps the only local source of drugs supply. In our opinion the "pharmacy" could become an important and interesting source of income for the project. In particular by making marketing towards the other health structures (non-CBCN) in Bas-Uélé and increasing its activities.
  To have a trained pharmacist would be a great advantage.

- Our proposals may ask for a reinforcement of competence in the coordinating committee and also a more effective use of the existing personnel.

<u>Concerning the different medical institutions:</u>

Management of drugs:

We noted that in certain visited centres; the management and storage of drugs are not in conformity with the standards.

It should be made sure that in all the centres, the person in charge understands how to manage the medical products (secure storage with protection from sun, heath and humidity, monitoring the stock etc…).

Statistics:

Often the data presented were insufficient or not reliable and incomplete.
It should be made sure that the persons in charge in each centre understand how to fill in the statistics correctly and what the statistics give as useful information to evaluate the activity in each institution.

The Monga General Hospital:

At the Monga hospital, the frequentation seems to be very week.
During our visit, there were only two (02) in-patient and according to statistics' presented, the activities drop.

The hospital with its large staff (18 people) is almost completely dependent on the financial support coming form the project. This is the case in spite of the fact that, the hospital activities go beyond the principal activities defined by the project (fight against malaria, STD/AIDS/HIV and mother and infant welfare). Since the Monga Reference Health Centre was fused with the General Reference Hospital it continue to behave like a simple health centre even though it is part of a hospital that should offer more advanced services to a whole health zone. So we propose to separate the reference health centre (institution defined according to the national medical standards), from the hospital.
The Health Centre then will continue to be supported by the project according to its activities.
The hospital on the other hand, will have to take care of real "hospital activities" more complex than those of a health centre.

Health Committees (CoSa):

To make sure that there is a good cooperation between a health centre and its population concerned, it is of great importance that the COSAs are active and that they actually represent the people. During our visit, we noted that their spectrum of activities was very variable, and where CoSa were active, they increased the frequentation and the quality of care in the medical institution concerned.

Free treatment of the church personnel (CBCN):

This increases the economic burden carried by the health centres. Must not continue

Three pillars of the project:

1. Malaria

If possible diagnosis should be confirmed by blood smears. Lack of reagents (Giemsa colouring liquid) during several years, isn't an excuse valuable to explain why the diagnosis is based uniquely on signs and symptoms in most centres
The free malaria treatment (in particular drugs) for the children aged 0 - 24 months is highly solicited by the population and must continue.
Nevertheless we noted that this element in the project and the income, which it generates for the medical institutions, has become one of the principal activities in the project - and also a condition for the CBCN health institutions to survive economically.

2. Prevention of STD/AIDS:

The activities are weak, sporadic and must improve much to make it possible to reach the objectives of the project.

- It will be necessary to define a common strategy, a well defined program which specifies which topics should be covered and which are the target groups (for example schools, the parishes, youth clubs, tradesmen, mines…) Three nurses are trained for this work and their competence should be used efficiently and regularly. In addition the follow-up and more recycling of health personnel on the topics are desirable.
- In addition, it is necessary on the one hand, to multiply the volunteer community health agents/contacts ("relais communetaires") and on the other hand, to ensure their education (for example in the form of seminars). There is also a need for didactic materiel and gadgets, for example; distribution of T-shirts with visual messages concerning HIV/AIDS to be distributed in the area, printed folders or posters with messages in local languages. (See also question no 9 over)

3. Mother and infant welfare:

The health centres should be supplied with vaccination cards and standard health charts used for pre-natal consultations. This exists in other part of DRC and should be able to get also for use in Bas-Uélé

We also propose to re-view the criteria to fulfil in order to get a free mosquito net. In our opinion they seem too strict and limit the spread and use of nets.

There are national protocols for handling of different common infectious diseases, and it is important that the CBCN nurses know them and follow them. (For example for malaria, respiratory infections, sexually transmitted infections and gastroenteritis.)

The delivery rooms visited during our tourney were often found in and bad condition with lack of instruments and hygienic standards. We understand that they aren’t attractive for the pregnant women and they need to be improved.

Personnel Management

The female percentage is low, but probably corresponds to the general situation/status of the women in the region.

To improve the contact between the medical institutions and the population and the target groups (mother and child) in particular, it is necessary to retain the female personnel present and to give women the priority when recruiting new personnel in the future.

Moreover it is important to ensure the stability of the personnel in the CBCN medical institutions i.e., to limit the movement of the personnel (in particular, assignments without obvious professional reason).
This is necessary in order to gain the confidence of the target populations and to assure that they utilise the services given by the CBCN medical institutions.

Concerning the NORAD / The Norvegian Baptist Union (UBN).
It is quite clear the the CBCN health institutions depend on the financial support coming through this project.
The population in this poor and under developed region is on their hand dependent on the services offered by these institutions.
Often there is no alternative – especially for the target groups of this project ; mother/child
Even if it will be necessary to improve certain sides of the project , there is no doubt that it plays an important role in offering this population its basic right to medical care and health
If external finances is brought to an end after 2010, the health centres will not survive – especially not in the poorest regions of the Bas Uele.
We propose therefore that the NORAD/UBN continue to finance this project also after 2010 given that the CBCN respect the intentions of the project and show ability and will to resolve the problems recovered during this evaluation. The size and the duration of this financing must be studied further, but the CBCN should take a larger responsibility for financing the project after 2010

Dr. Harald Hurum
Consultant, Pediatric departement.
Ostfold Hospital Fredrikstad, Norway
Mobile phone: +4748099971
Phone office: +4769860000
e-mail: harald.hurum@so-hf.no

Dr. LeBon Barhwamire R.
Medical coordinator 5th CELPA, DR Congo
Mobile phone: +243815315310
e-mail: lebarhdo@yahoo.fr

Signed in Fredrikstad/Bukavu 27th December , 2008