

**CASE STUDY 3: REVIEW OF THE EU INTERVENTION IN THE HEALTH SECTOR IN THE DEMOCRATIC REPUBLIC OF CONGO FROM 1994 - THE « PROGRAMMES D'APPUI TRANSITOIRE AU SECTEUR DE LA SANTÉ » PATS I AND PATS II**

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This paper reviews an intervention of the European Union in the health sector in the Democratic Republic of Congo (DRC), which took place in the context of the very difficult political transition process that the DRC has faced since the 1990's and which has evolved in conflicts that are not yet resolved.

## **7 COUNTRY CONTEXT**

### **7.1 A difficult environment**

At the beginning of the 1990's, in a context of economic crisis, the Zaire (now DRC) entered into a very difficult political transition process, where the country sank into a period marked by complex internal conflicts involving neighbouring countries.

The current image of DRC is indeed related to catastrophes: conflicts, refugees, poverty, human rights violations, collapse of public services, deterioration of the public health system, spread of HIV infection, massive re-emergence of trypanosomiasis (while this disease had been considered to be controlled) without mentioning EPI targeted diseases ...which makes the DRC a sadly typical example of a difficult environment.

### **7.2 Historical phases for last 20 years**

The current catastrophic image of DRC tends to obscure another image, based on the reputation of the health system of this country. During the 1970's and even the 1980s the Zaire was considered as one of the most advanced African countries in terms of public health. It was one of the first to elaborate a PHC charter, to institute a policy based on the health district (the "zones de santé") in 1975 before Alma Ata (actually the concept of the health district was partially based on experiences developed in DRC) and to expand cost recovery. It was taken as an example of good practice by professionals and universities, who had conducted renowned research projects in the country. Low investment by government in the health sector was bolstered by donors, with many zone de santé and clinics run by non-state providers.

In the 1990s the country faced a very difficult political transition. The then President Mobutu decided to shift from his one-party system to a multi-party system. But he remained very reluctant to pursue democratisation. A national conference was established. The Mobutu government was opposed to the national conference as the conference was imposed on the government by donors and civil society. The country sank into disorder characterised by Army mutinies, lootings, and human rights violations. Following the violent suppression of the students' demonstration in Lubumbashi (1990), the different partners of the government successively suspended their structural cooperation while humanitarian aid was maintained and channelled through IO, INGOs and national NGOs.

Armed conflict emerged with rebels in Shaba and North Kivu resulting in population displacements. The genocide and the coming into power of the Rwanda Patriotic Front in neighbouring Rwanda caused a massive influx of refugees into Kivu. The economy was ruined. Public services stopped functioning. The public health system deteriorated and a larger informal sector emerged.

After the collapse of the Mobutu regime and the coming into power of Kabila, in 1998, the country was still in a war situation with a partitioned control of the territory and the armed interventions of different neighbouring countries.

Successive negotiations in the framework of the *Dialogue Inter-Congolais* allowed the reunification of the country and hope for a new start. Development cooperation resumed in

2002 and international relations normalised. But violent conflicts have restarted in parts of the country and the economic difficulties have persisted.

### **7.3 Will / capacity analysis:**

In the nineties the environment was an example of “no will, no capacity” type of situation. The situation was aggravated by conflict and population displacements. Progressively the situation has evolved towards a “will but no capacity” situation.

#### *7.3.1 The initial situation (1990's)*

**No will, no capacity: The government has uncertain control of its territory and is regarded as unresponsive. State capacity for service delivery is weak or non existent**

Policy makers: *Weak policy making or oversight capacity and state perceived as unresponsive*

In the nineties the context was marked by the reluctance to democratise, important human rights violations, a negligence of the social sector, bankruptcy of the public administration and suspension of payment of public services (Maintenance, supply, salary). There was also loss of territory control, major economic crisis with hyperinflation and eventually a suspension of international cooperation.

Providers: *Few if any state structures do deliver services. Those that do operate are not pro poor*

Providers experienced an important degradation of public health services: degradation of infrastructure and equipment, shortage of consumables. The personnel have operated a sort of “privatisation” from inside the health service; requesting money from patients outside any regulating framework with a probable difficulty in access for the poor (it is very difficult to document this issue).

The remaining operational providers were those of faith based organisations and some actors of the associative sector. But the pyramidal structure of the collapsing health system remained in place.

Citizens: *No expectation from certain groups that the state will deliver. Probable insecurity*

In the project literature, the analysis of the demand side is weak (as is often the case). It is obvious that confidence in the state to meet citizen needs was completely lost. The insecurity was obvious; army mutinies, lootings, and emergence of armed conflicts. Displacement of populations and refugees from neighbouring countries aggravated the situation. Those populations could only expect assistance from the international community.

### 7.3.2 The situation after 2001

**Will but no capacity: The government has uncertain control of its territory but is regarded as responsive. It is willing to develop partnerships with the international community to introduce pro-poor policy reforms, but lacks state capacity to implement**  
Policy maker: *Weak policy making. Unable to hold monitor or resource providers*

The successive negotiations in the framework of the *Dialogue Inter-Congolais* allowed the reunification of the country and hope for a new start. The dialogue and the relationship with the international community resumed and international development cooperation restarted in 2002. Conflicts have revived and the government has not really taken back control over the entire territory. The economic difficulties have persisted.

Provider: *Limited human resources for frontline provision; Lack of organisational providers.*

Frontline provision of services remained far below the needs but the EU PATS program (described in detail below) managed to prevent further regression and to maintain health personnel in post in some places, not only in private run structures but also in the public structure belonging to Zone de Santé, where partner operators intervene. At a different level of the pyramid, if most of the organisational and regulating functions had been effectively degraded, the PATS programme has contributed to restore some activities at the level of the "bureau central de Zone de santé", and at the level of the "Inspections Médicales Régionales". But there is still a huge deficit in human resources to support adequately the "zones de santé"

Citizens: *Low expectations; Limited information about rights with respect to services.*

The only information providing some hints on the citizens' expectations and confidence in services are the utilisation indicators. They show some progress in service utilisation or at least the maintenance of health care activities. But the levels remained low.

The will/capacity framework provides a useful tool to analyse difficult environments. This type of analysis should also apply to situations without obvious conflict and/or displaced populations. It seems practical to consider these two factors as aggravating factors in addition to the will/capacity framework.

### 7.4 Indicators

There are no reliable statistics in the DRC. In the databases consulted for this report most of the health indicators have no real value. Here are values published by the World Bank for a few health indicators in 2002. They must be considered with caution.

Population total	51.6 million
Population growth (annual %)	3,00
Life expectancy (years)	45,30
Fertility rate (births per women)	6,70
Infant mortality rate (per 1000 live births)	129,00
Under five mortality rate (per1000 children)	205,00
Child immunization, measles (% of under 12 months)	45

## **8 ACTORS IN SERVICE DELIVERY AND SERVICE DELIVERY APPROACHES EMPLOYED**

### **8.1 Types of actor**

#### *8.1.1 Foreign governments*

Following the patent human rights violations illustrated by the violent suppression of the students' demonstration in Lubumbashi perpetrated by the government (1990), the different bilateral development partners of the Zaire government successively suspended their structural cooperation. Humanitarian aid was maintained and channelled through International Organisations, INGOs and national NGOs.

After the coming into power of Kabila and the successive negotiations in the framework of the *Dialogue Inter-Congolais* the cooperation resumed (in 2002) and international relations were re-established even though violent conflicts have reignited.

Bilateral cooperation has started again in this difficult context. Most interventions tend to consolidate achievements of humanitarian aid and share some common features

- The use of INGOs and national NGO or FBO channels
- A privileged provision of basic needs with the concern of maintaining a basis for further sustainability.
- A concern to involve local authorities and communities
- A mix of support to horizontal (global support to health zone) and vertical (EPI, fight against AIDS) actions

#### *8.1.2 International organisations*

International Organisations such as WHO and UNICEF have remained present: WHO in a role of coordination and monitoring (HIS, survey) and UNICEF in a more operational role in collaboration with the other actors (INGOs and national NGOs).

#### *8.1.3 International Non Governmental Organisations (INGOs)*

Traditional INGOs and international church organisations are present throughout the country. They form a mix of humanitarian and development organisations.

For example in Goma support is provided by Caritas, the International Rescue Committee, MERLIN, Medicos en Catastrophe, Médecins du Monde, SANRU, Save the Children Foundation, and MSF-Spain.

#### *8.1.4 National organizations*

The DRC (ex Zaire) has a strong, well-developed national associative sector – to the point where some describe the: “NGO-sation” of society. There is a long tradition of private sector involvement in health care delivery in Zaire/DRC. Catholic and protestant FBOs have always had an important place (even private companies were involved in care delivery). With the collapse of public services, the associative sector has progressed. When the “government to government” cooperation was suspended, a certain amount of “Aid” was maintained through these private actors. Most of the still operational services are run by the non-state or private sector. It offers a particularly efficient channel to reach the population rapidly and efficiently.

## **8.2 Difficulties of documenting interventions and their impacts**

There is a huge amount of literature available on the interventions of these actors but usually documents do not show the relation between the way the intervention is set up and its impacts on the different issues under study (effectiveness in reaching targeted beneficiaries, accountability of national authorities, sustainability...). For example the review of some interventions financed by USAID as those of BASICs (child survival with an important focus on immunisation), Advance Africa (family planning), NGOS such as Medai only provides some information on the targeted zone, the type of activities (global support to health zone, EPI, ...), the output in terms of number of beneficiaries but remains too general about the approaches and strategy.

Interesting reflections on the use of QSPs (quick start programmes) by DFID (for example "The provision of basic health services and referral services through a hospital in Kindu province") addresses the issues of Government legitimacy, effective delivery of services and sustainability but still it remains difficult to draw lessons from that example as the document does not show how this project practically differs from any traditional project and how it adapts to the changing situation.

## **8.3 The example of the UE intervention in the health sector since 1994 (The PATS programmes)**

As a member of AEDES (an organisation which has provided technical assistance for about ten years to the EU intervention in the health sector in DRC), the author could access a certain amount of grey literature on the EU PATS programme and make an attempt to review the features of this intervention in relation to the particularly difficult context of DRC and its evolution:

The European cooperation with the Zairian government was suspended at the same time as bilateral partners in the beginning of the 1990's (1992). In order to respond to the humanitarian crisis, besides the use of traditional instruments such as those of ECHO, the European Union initiated priority programs to address the immediate population needs in sensitive sectors such as Health. These programs followed an approach, which intended to be a first phase of transition to larger rehabilitation and development interventions (to be implemented when structural cooperation resumed). The health sector support programme is known as the "Programme d'Appui Transitoire au Secteur de la Santé" (PATS). Implementation, though under EDF funding, was channelled through civil society organisations.

PATS started in 1994 and was implemented during 3 years. Starting in a health emergency context, it progressively moved towards more developmental activities. It was based on partnership with INGOs and national NGOs.

As the national situation did not allow the resumption of structural cooperation with the government, a second program (PATSII) started in 1998 to maintain the level of access and quality of care that the first PATS achieved. PATS II is still currently in force.

The PATS programmes provide good examples to look at service delivery in difficult environment because:

- They were designed with the idea of reconciling the need to respond to the immediate needs of the population versus the preservation of a sound basis for development support when the situation normalises;
- The interventions are large enough to produce a tangible impact on service delivery;

- They use the channel of civil society in separate projects but ensure a global coherence between the different projects
- They cover a long period (from 1994 to 2005) and have had to adapt to the particularly difficult socio-economic context of the DRC and to its political evolution. As such, they took into account the progressive restoration of the role of the state and of the cooperation with the international community (2002)
- The design of these programs was considered as very innovative when launched.

### 8.3.1 PATS I

#### **Objective**

The objective of PATS I was to provide transitional support to the health sector through civil society to meet the immediate needs of the population: to maintain access to care for the populations of Kinshasa, Northern and Southern Kivu, Western and Eastern Kasai regions.

The choice was made to support services that were still operational to prevent further deterioration of the health system and keep staff in post as much as possible (No regression/no extension).

#### **Set up of the program:**

The program was directly managed by the European Commission (acting as the national authorising officer). There was no convention between the government of Zaire and the European Commission. The programme document is entitled "Conditions de financement entre la communauté Européenne et la population du Zaïre".

The programme covered a set of projects implemented by INGOS, national NGOs and FBOs.

The projects were supposed to be as short (2 years) as QSP, though the duration could be extended or the project renewed.

Support was also provided to "Inspections Médicales Régionales" (which did not receive any funds from the State) to ensure coherence and integration into national policy. A decentralised Fund (Fonds d'appui au Bureaux d'appui transitoire, FABAT) was set up to support selected activities implemented in association with the regional medical inspector (workshops, surveys, training sessions).

Three "Bureaux d'appui Transitoire (BAT)" provided close technical assistance to support project design, select operators and follow up projects (one for Kinshasa, one for the two Kasai regions and one for the two Kivu regions). General coordination was ensured by a technical advisor in the EC delegation.

#### **Budget and duration**

27 MECU (sources: EDF (5 and 6), support to refugees budget line (art 255), development countries rehabilitation budget line and NGOs co-financing budget)

The duration was 3 years starting in August 1994

### **Implementation:**

Projects and Partners operators:

Some fifty projects have been implemented by some thirty partner organisations. The average budget of the project is 470 000 Ecu (+/-100 000 to +/-1MECUS) Half of the projects are signed with national organisations (FBOS and NGOs). Some smaller NGOs are sponsored by INGOs. The other half are signed with INGOs who may be very different from one another (different countries of origin, philosophies and objectives).

Fields of intervention:

The main fields are strengthening health districts (zone de santé) and health services network in urban settings; strengthening disease control programs, and the fight against HIV/AIDS.

Some specific activities complete the intervention in the fields of nutrition, water and sanitation, electricity.

More than half of resources are devoted to strengthening health districts (32 "zones de santé").

Public structures

The PATS supports indirectly many public structures (hospitals, health centres) within the "zone de santé" where NGOs operate. Some projects provide support to regional supervision and even national supervision. All projects are made in accordance with the national health policy and national offices of the ministry, which are regularly informed about PATS activities. The FABATs allow support to health personnel training activities in association with the regional inspector as well as supporting workshops contributing to coordination of health activities.

#### *8.3.2 PATSII*

At the end of PATS I, as the situation did not allow the resumption of structural cooperation, a second program (PATSII) was initiated (1998) to maintain the level of access and quality of care that the first PATS had achieved. There was no formal evaluation of the first PATS as a preliminary to PATS II.

### **Objective**

The general objective is the continuation of the programmes of the first PATS.

The convention stipulates that support must be provided at the different levels of the health pyramid:

- Support at the peripheral level: continuation of support to PHC through civil society operators
- Support to the key functions of the intermediary level (region): coordination, supervision, health information
- Support at the national level: legal text for the functioning of the health system, coordination of national programs
- The zone of intervention has been extended: Kinshasa, Badundu, Bas Congo, the two Kasai regions and the two Kivu regions were added in PATS II

## Set up

Basically the set up has remained unchanged. :

- Non governmental operators.
- Close technical assistance (BAT) in charge of support to project design, coordination of partners, promotion of projects and partners, technical, administrative and financial follow up and training.
- The scope of FABAT has been extended: support to activities on request (as from the Ministry) to prepare projects, support to training activities, support to evaluations of projects, support to activities of the PATS itself and requests for design of procedures and regulating documents.

## Budget and duration

45M EUROS (+ 9M EUROS extension).

The duration is of 7 years: starting in 1998 the ending in 2005, extension included.

## Implementation:

Projects and Partners operators:

81 projects have been implemented by some 42 partner organisations.  
The mean budget of the project is 584 000 EURO (88,570 to 1,5M EURO)

72% are signed with INGOs, 15 % with national FBOs, 8% with National NGOs. The rest is made of contracts with technical assistance companies or medical schools.

Level of intervention

Level	%
- Peripheral	42,5%
- District (management/supervision) Including supervision by the regional level	44,7%
- Regional (other)	2,4%
- National	10,4%

Fields of intervention:

The planned fields of intervention were: strengthening health districts (zones de santé); strengthening disease control programs (including the fight against HIV/AIDS); drugs access; institutional support; and water and sanitation.  
The observed implementation is in accordance with that planning.

### 8.3.3 Summary of the rationale for the strategic approaches chosen

These successive programs intend to reconcile at the same time a response to immediate needs and the preservation of a sound structural and technical basis to build on when the political and security situation allows it.

To allow the population access to a minimum of services in the context of continuing degradation, the programme must stop further declines in service delivery capacity. This may be at the detriment of trying to meet the real needs of communities, which are out of the scope of the intervention and could dilute efforts at strengthening existing services. Survival

of service and preservation of the national health policy (which used to be a beacon for health policy developed in Africa) is the first priority.

As already mentioned, most of the still operational services are run by the non-state sector. It offers a particularly efficient channel to reach rapidly and efficiently the population.

To take into account the disparity between regions and keep flexibility, the coordination must be decentralised (BAT) and provide ongoing, supportive and technical assistance.

The program was supposed to be transitional. The civil society channel is seen as the way to preserve the peripheral services in waiting for the resumption of governmental institutions.

In the meantime interventions must target different levels of the service and policy pyramid in order to favour the persistence of an organisation of the health system and of the accountability of regional and even national administrations.

## **9 ANALYSIS OF APPROACHES AND IMPACT**

### **9.1 Analysis of approaches and entry points of the PATS programs**

#### **No will, no capacity**

##### *9.1.1 Strengthen humanitarian co-ordination - through the UN and the CAP process*

The reviewed intervention is only a component of the UE global intervention and is downstream of the overall coordination of humanitarian aid. But the program played an important role in the coordination in the health sector involving WHO to create the necessary link between the three pillars involved in the health system (the state or at least the remaining functional structures of the public institution, the donors and the partner NGO providers). The coordination took place pragmatically during the crisis to respond to precise needs and has evolved in small steps. Technical Sub committees with very concrete objectives (such as the emergency sub commission following indicators to confront rumours and establish procedures to provide a rapid reaction to emerging crises) have been progressively put in place. The PATS program maintained close contacts with WHO and aided in the coordination work.

Working through NGOs and FBOs of very unequal quality needed a great deal of coordination as well. A “Comité de concertation de l'appui sanitaire au Zaïre (CCAS) “ was set up. PATS provided support to the CCAS and sits in that committee as an observer. Even if the government was purposely left out of programme management, support was provided to the public organisational structures mainly at the regional level (supervision, health information and coordination). Some support to national supervision was also provided.

The FABAT was useful and provided flexible tools to contribute to this coordination. At the level of the “zone de santé” PATS support the “bureau central” and has introduced the concept of global consolidated support involving all partners.

Strengthen capacity of INGOs and UN agencies to provide services to the poor – need to strike the right balance between humanitarian and development approaches

Strengthening international and national NGOs, is the main strategy of the program.

Strengthen capacity of communities to access services – employ social protection mechanisms

The intervention at the community level is less clear from the reviewed literature but the program interventions were compliant with the health policy, which included the participation of communities through health committees. However, a closer look suggests that community involvement and the demand side were not paid enough attention.

Payment for care by the end user was introduced in Zaïre long before the country entered into recession and has been questioned in terms of access to care in difficult situations for the population, but this concern is shared across all health related projects in DRC.

#### **Will, no capacity**

##### *9.1.2 Strengthen oversight capacity and responsiveness of central government*

From the start, PATS has kept up contact with the ministry and support has been given to supervision from the national level in relation to the “zones de santé” benefiting from support from the program. When the situation allowed it, more formal support was provided to the

national level. The programme contributed to the redefinition of the role of the ministry as the regulating authority and its different essential functions ("code sanitaire, procedures and regulating documents, health information system, etc).

A particular accent was put on the formalisation of the relationship between the Ministry and the partner operators from civil society (contracting). The FABAT, whose scope has been extended in PATS II, was one of the ways to provide this support: It allows flexible responses to requests from the Ministry.

Strengthen the state's relationship with non-state providers – through partnership agreements

As mentioned above the program contributed to the formalisation of the relationship between non-governmental service providers and the ministry through support to the establishment of contracts and conventions as well as training in contract management.

#### *9.1.3 Strengthen responsiveness of providers to the service needs of the poor – who are the poor?*

The actual service delivery to the poor is a difficult issue to assess. The problem of reaching the poor needs first that the service to be delivered exists and is operational. In DRC health services were partially based on cost recovery involving a contribution from the patient. There is a long tradition of payment for health care in DRC. It is clear that the question became more acute when a major economic crisis with hyperinflation hit the country with the subsequent impoverishment of the population.

One of the ideas of the program is to preserve the existing services and their organisation, including financial management and as well as a certain financial contribution by the patient. The preservation of the existing service delivery model is a first step to reach the needs of the population and by consequence the poor. From the literature available it is difficult to assess which mechanism has been put in place to reach the poor. It would need a deeper review of each individual project. This is beyond the scope of the present review.

Some indications seem to show however that this aspect could have been more developed in particular at the hospital level. The problem was actually more acute in the Northern Kivu region where, due to insecurity, the programme had to stop its activities temporarily and ECHO intervened in the health sector. ECHO provided an important subsidy to drugs delivery favouring free distribution regardless of the organisation of the health services. Following the ECHO intervention, PATS, well aware of the under-financing of the health sector, initiated a system of subsidy of the health structures. The mechanism is close to a social fund and is connected to the regional drugs store.

#### *9.1.4 Strengthen responsiveness of local government to community demand for services*

One of the important features of the program, which became explicit in the program document of PATS II, the interventions at all levels of the health pyramid, the main target being the zone de santé with its organisational structure but also all health structures (with their health committees) within the targeted "zone de santé".

Since the beginning regional inspection has benefited from such support.

The involvement of other governmental structures such as municipalities does not appear in the reviewed literature.

## **9.2 Impact of the PATS programs**

### *9.2.1 Effective delivery of services*

In a first period, activities were too spread out as the programme took place in an “empty” room and needs were large.

It is undeniable that the PATS programs contributed to prevent further degradation of health care delivery and had a real impact on maintenance of access to health care within the supported “Zones de santé”. In some cases access has even improved. But when the level of initial “operationality” was lower, as in Kasai Province with a particularly difficult context, it was difficult to restore health activity levels to their former state. Also, the choice of working with still existing operational services did not allow the programme to address some needs where the services had completely deteriorated.

Besides this mainstreaming direction, the support provided to the programme of control of endemic diseases and AIDS as well as the attention paid to water and sanitation has brought an added value in the services provided and has been considered as a very positive point. The programs have also brought a significant contribution to the availability of drugs.

There are however some limitations in effective service delivery

- Results are very unequal due to the differences in the capacity of the partner operators. Some argue that support to health structures in particular at the hospital level and support to organisational functions (bureau central de zone de santé) must be separate as they require different qualifications. This would allow better selection of implementing partners.
- Not enough attention was paid to community involvement and to the demands of the population. The access of the poor (discussed above) is uncertain.
- The issue of under funding of the health sector was certainly beyond the scope of a single program but as this problem remained un-addressed support to the health sector was sometimes too diluted.

### *9.2.2 State accountability*

In the beginning the program faced the limits of a health care system without any state involvement. The use of non-governmental channels under the management of a parallel structure could have had a negative impact on the surviving governmental organisation. But the program in its design and implementation has managed to preserve organisational function of the public health system by providing support to regional structures and by taking into account the progressive restoration of the state. It also contributed to the redefinition of the role of the state and to strengthening the relationship between the state and the non-state providers.

This support provided at different levels of the health pyramid (regional and national) underline the importance given to the health system as a whole and to the need of a national regulating body.

### *9.2.3 Sustainability*

Sustainability is often seen in terms of finances. After an initial investment the targeted structure must be self supported. This interpretation does not strictly apply in DRC and the under-funding of the health sector is a huge problem that is beyond the scope of the programme, with external funding required for a long period of time to come.

But sustainability also means establishing structures that are able to perform a certain function with trained staff under efficient management. One may add that it is also necessary to guarantee the conditions that will secure financing or to establish financing mechanisms which last over time. For example, one could conceive of pooling all sources of funding (state budget, cooperation, humanitarian aid, population contribution etc) into a medical supply procurement unit with good management systems. This unit could sell drugs at an acceptable price to health structures. If the health structures cannot pay they could be subsidised but the procurement unit will not need direct subsidy: it will be paid for a service.

Indeed, the PATS programmes, in the field of drugs procurement, not only facilitates increased drugs availability but serves as a basis for reflection to initiate innovative proposals, which have actually been funded by other donors when their cooperation programme resumed (e.g. regional medico supply store federated around a common buying office).

Even in a difficult environment the way the project is set up can have a significant impact on sustainability.

Concerning PATS, there was an overall idea of preserving operational services so that they could form a solid basis for when the political situation normalised. This could be seen as a sustainable approach. In fact at first, each individual project was not designed with a long-term vision. The maximum duration was supposed to be 2 years. They can be seen as quick start projects. As the crisis lasted some projects were extended or renewed. But a collection of 2-year projects does not make a long-term project.

In this review it is impossible to appreciate the sustainability of each project, which varies from project to project depending on the partner organization.

In general the projects are, as is often the case, more planned on the organisation of inputs than planned on strategy to produce outputs and performances. This does not favour sustainability.

But this review shows that the specific design of PATS overall and certain activities can contribute to sustainability

- The preservation of operational services: Even if in themselves some projects do not pay a particular attention to sustainability, the preservation of existing services is a step toward sustainability. Most of the projects have health staff training activities, and support is given to the “bureaux central des zones de santé”
- The Zone de santé concept: the PATS programmes have contributed to the survival of the “Zone de santé” concept.
- The global support to a zone: PATS has also introduced the concept of global support to a zone with the support of all partners; this approach is now followed by others, such as the World Bank in its PMUR program.
- The strengthening of national civil society
- The support given to regional inspections
- The FABAT allowing the organisation of training, workshops and preparatory study to design projects
- The set up of regional drugs procurement units (medical supply stores) federated around a centralised buying office
- The establishment of a quasi fund to finance the health structure in Northern Kivu
- Support to the Ministry of Health, and the supervision of regulating texts
- The formalisation of contracts between the Ministry and partner organisations

#### 9.2.4 Other considerations

In one evaluation of PATS, the reviewer pointed out:

- The need for long term vision and a better targeting of the projects
- The need for a better sector analysis
- The need for a better selection of partners and of a separation between support to health structures and to organisational structures
- The burden of EC procedures, which put too heavy a weight on the partners and on the coordination in the BAT and in Kinshasa to the detriment of technical support. It also brought out some tensions between partners and the BAT. Some procedures through global envelope based on results, such as those employed by Dutch Cooperation instead of essentially based on input and control of expenses, may be better adapted and more flexible.
- At the EC level: the lack of coherence between support provided through ECHO and through PATS.

#### 9.2.5 Conclusions

The PATS programmes give an example of an innovative approach to service delivery in difficult environments, which could be considered as globally positive. These programmes have managed to achieve results in directions, maintaining immediate health care access and preserving the basis, or even providing a new basis on which to build when the situation normalises.

Some interesting features of the program set-up contributing to achieve these results are

- Preservation of operational services
- Services and/or support provided through civil society allowing a certain flexibility and reactivity
- The program is made up of a set of separate projects but within a global coherent framework
- Decentralised coordination with close technical assistance (Bureaux d' appui transitoire, BAT)
- Support provided at all levels of the health pyramid
- Reconciling with government institutions when possible
- The use of decentralised funds to support some exceptional activities - FABAT (Fonds d'appui au Bureaux d' appui transitoire)
- The set up of an NGO - run drugs procurement unit federated around a common buying office
- A quasi social "Fund" mechanism in Kivu, to finance health structures.

The program as a whole did not specifically target the poor. The effective reaching of the poor is difficult to assess and is uncertain. It probably varies from one project to another according to the partner strategy. The assumption being if services function the poor will benefit.

The program follows a two-track strategy: response to immediate need within parallel activities contributing to rehabilitation and development.

But it seems that the potential conflict of these two objectives was not really perceived by all operators.

It favours a better reconciliation between non-state providers and governmental health authorities. The programmes then took the opportunity the situation provided to contribute to the redefinition of the role of government health authorities (regulating role, health

information, coordination). Contracting out (between the ministry and private partners) has been progressively more formalised. PATS also provided an original model of drugs management and of consolidated global support to district level, which is reproduced by other Cooperation Institutions (World Bank).

This review demonstrates that the partners are not only of unequal capacity but must also be selected more in relation with specificities: It suggests making a divide between support to health care delivery structures and to organisational structures. If funds are not sufficient then priority should be given to supporting health care delivery structures with a particular attention to hospital level.

The review suggests also that, even if the situation is difficult, it does not prevent undertaking a global and thorough analysis of the sector and developing a long-term vision. This could be made in parallel to implementing some more immediate, concrete actions.

At the level of the EC, if coordination exists, the review has revealed a lack of a global vision which would have allowed a better use of ECHO and PATS funds in a coherent and complementary manner.

Finally, this review has also shown that, often, it is difficult to document programmes and draw lessons from the experience. Proper monitoring procedures should be planned from the start.

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