Emergency response

Clear shift to public health needed

Health care in DRC must be redirected from the current facility-based curative care to a public health approach focused on the main killer conditions if humanitarian interventions are to address the unacceptable mortality and morbidity evident in the country. This was the key message of a joint WHO-UNICEF mission which spent late July in DRC.

The mission found that, despite good intentions, up to 70% of the population is now excluded from accessing basic health services, while all forms of preventative public activities are severely curtailed, not least because salaries of health service workers are linked to curative care. This observation led to the mission’s second key recommendation: that “health worker remuneration must be separated from payment by patients…and linked to performance of a package which directly targets the main killers, both in the health centre and at household level.”

The nine-person mission presented their findings to a donor contact group meeting focused on health and food security in Geneva in early July. They also called for a ‘massive effort’ on HIV/AIDS and malnutrition which, they say, provides an increasingly frightening underlay to the situation.

As follow up, WHO is now working on a plan of action to kick start the necessary radical shift to public health care.

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More hands for emergency action

WHO hopes soon to recruit a second specialist in emergency and humanitarian action to join its office in Kinshasa thanks to funding from the Swedish government. Currently the area is covered by WHO communicable disease expert Dr Tshioko Kveteminga, who has begun training local health zone chiefs in Kinshasa in the management of emergency situations. With extra hands on deck, the office hopes to extend this training to both provincial health authorities and WHO’s district medical epidemiologists in the near future, and to take a stronger role in helping all actors in health strategically co-ordinate their activities and gain better impact.

HIV/AIDS

Interest raised but money slow

Donor interest in the struggle against HIV/AIDS in DRC has been rising, but a new plan of action drawn up by the Programme Nationale pour le Lutte contre SIDA in collaboration with an committee of UN organisations and international NGOs has yet to garner firm commitments.

DRC was the first country to design and implement an HIV/AIDS programme with the support of the World Bank and UN agencies, but in recent years funding has faltered.

The Government of Norway recently donated $400,000 to WHO to improve surveillance and testing for HIV/AIDS (see below), but proposals for supporting supplies, health education and palliative care for related conditions such as oral candidiasis at home remain on the starting blocks.

Meanwhile, the situation around the country in terms of contraceptive supplies and blood security means is dire. In Katanga province, for example, the availability of safe blood has slipped from almost 90% of health districts in the province in 1989 at the height of a UNAIDS/EU funded programme, to partial coverage in less than 10 zones today, according to WHO’s provincial medical epidemiologist Dr Edmond Magazani.

The remaining services are well maintained by MSF-Belgium, which also supports one of the few
Malaria

Co-ordinated focus is crucial

Two experts have been recruited to help drive the Roll Back Malaria Campaign* in DRC which is the latest development in the fight to reduce death and illness from malaria. Dr Mantshumba Bikete Iyombo takes up the post of RBM coordinator for the west of the country while Dr Nadine Ezard is RBM coordinator for the east based in WHO Goma.

Accurate figures overdue

Improving capacity to assess the impact of HIV and testing capacities is the goal of a $400,000 dollar Norwegian donation. Currently five sentinel sites are producing HIV/AIDS information, in Kinshasa, Karawa (Equateur), Mikalay (Kasai Occidental), Kabando (Orientale) and Sendwe (Katanga). These are the remnants of a 14-site project set up by UNAIDS in 1992. But in-depth investigation of country-wide prevalence is long overdue, say experts.

National figures collected through the health information system cite just under 10,000 new cases of HIV for 2000. But public health authorities estimate the real figures, based on the sentinel site information, are more like 173,000 new cases a year, with a total of almost 1.3 million adults and children already living with HIV.

Similarly, prevalence rates are believed to be much higher than the quoted average of 5% across the country. Recent investigations among apparently healthy family blood donors in Kalemie, North Katanga, found over a third were HIV positive, while a study of patients in the General Hospital in Bukavu found a prevalence of 32% among adult males, 54% among adult females and 26.5% among children.

Multiple troop movements and displacement in recent years to and from neighbouring countries where prevalence ranges from 12% (Central African Republic) to 27% (Rwanda and Zambia) has made DRC "well prepared for an explosion of HIV/AIDS," says WHO focal point Dr Tshioko Kweteminga. "I can hardly think of better vector than tens of 1000s of young men with hard currency roaming around the country," adds another observer.

WORLD HEALTH ORGANIZATION

centres for voluntary testing and counselling, but their reach is limited.

Health education too is also barely taking place with health zones and national NGOs citing lack of simple equipment, like paper and pens, as morale-sapping obstacles to even voluntary work.

Having spent the past month visiting the provincial capitals of eastern DRC in a rapid analysis of malaria control activities, Dr Ezard says the magnitude of the problem is "nearly overwhelming".

"Malaria is the number one cause of mortality for the population of nearly 20 million in the east. There are big problems of security, logistics and infrastructure, low access to health services, no preventative activities and a real lack of standardisation of approach to surveillance and treatment."

At the same time however, she says, there is "huge enthusiasm" among national and international NGOs, local authorities and UN agencies to address the problem.

Meanwhile in Kinshasa, the national programme committee, supported by the USAID-funded BASICS (Basic support for Institutionalising Child Survival), WHO and other NGO partners, has started working on a new national consensus strategy which is likely to insist on preventative action as well as a re-defined treatment protocol, based results of resistance studies (see below).

* The Roll Back Malaria Initiative, instigated by WHO, aims to galvanise partnership between local authorities, national and international NGOs, UN agencies and communities to work across all sectors and to implement strategies in prevention, education, access to treatment and environmental action.

New protocols to fight resistance

Five studies into the effectiveness of common malaria treatments in Western DRC show there is 25-35% resistance to chloroquine and less than 5% resistance to sulphadoxine-pyrimethamine (Fansidar).

However, studies in the east are essential before the development of new treatment protocols so as to ensure new approaches are not quickly over-run by resistance problems, and work has started in three sites which already have experience in malaria research.

Resistance patterns tends to move from East to West across Africa, says Roll Back Malaria co-ordinator for the eastern provinces, Dr Nadine Ezard. In Burundi, for example, 80 to 90% of malaria is resist to chloroquine and a worrying 30-50% to sulphadoxine-pyrimethamine (Fansidar). The latter is currently the official second line treatment in DRC and one of the few remaining cheap treatment options.

"There is widespread use of chloroquine of dubious quality and dubious dosing in eastern DRC . On top of this people often don’t complete
their courses. There is also likely to be significant resistance to sulphadoxine-pyrimethamine because of the high rate of transmission," says Dr Ezard.

Chloroquine is still the first line treatment in the national protocols, but many health workers move straight to quinine, if patients can afford it. However, where drug fees make up a significant part of health worker ‘salaries’, there is also widespread multiple prescribing.

In the African region, there is an increasing drive towards combination therapies involving particularly sulphadoxine pyrimethamine, artemesinin derivatives or amodiaquine. But, with each combination treatment costing the equivalent of an insecticide impregnated bed net, sheer economics is likely to force a shift towards preventative measures.

Reproductive health

Good start falters for lack of funds

An 18-month project designed to introduce integrated reproductive health care programming throughout DRC drew to a close in June as funds finished.

Funded through UNFPA and implemented by WHO, the programme has involved workshops in seven provinces for all those involved in improving reproductive health outcomes and family planning, including health staff, national NGOs, university lecturers, community leaders and traditional health workers. It also included the development of a 10-day practical updating course for nurses which has been piloted in Kinshasa.

The provincial workshops focused on discussion of care for at-risk mothers, strategies for intervention and the resources needed to take action. They also started the process of defining a minimum package of reproductive and family planning services, based on the national policy, for all levels of the health system.

“It’s necessary for people to talk the same language and work to the same strategy,” says Dr Mwela, a local gynaecologist and co-ordinator of the workshops for WHO.

However, lack of funds is delaying the further roll out of these projects, while severe problems with medical supplies and equipment has limited the impact of the practical course.

“The training was very good – it reminded me of many things I learnt at college and it introduced me to new ideas. But it’s very difficult to put it into practice because we have so little means,” explained one participant.

“People are motivated and enthusiastic but now they need equipment, supplies and supervision, and at present there is no money to continue the project,” says Mrs Flora Chirwisa, WHO’s national officer for reproductive health.

Current calculations suggest 1837 women per 100,000 die in childbirth in DRC, over three times the African average and more than 42,000 a year. Anaemia, malaria, sexually transmitted disease, poor spacing of pregnancy, a high rate of adolescent pregnancy and late attendance are major contributors to the death rate.

Child Health

Training in essential care for children

The first training of trainers based on the newly adapted protocols for the integrated management of childhood diseases in DRC took place last month.

The 10 day workshop involved 24 potential trainers, seven international consultants, local ministry child specialists, and WHO national officer for child health Dr Brigitte Kini.

Health centre level training will be piloted in October 2001 in two health zones in Kinshasa, one in Bas Congo, and two in Kasai Oriental. All will receive basic supplies as part of the project, which is funded by UNICEF, WHO and international NGOs such as ‘Horizon Santé’

Currently under fives in DRC are estimated to suffer five to six episodes of diarrhoea a year, 10 episodes of malaria-like fever and 14 episodes of acute respiratory tract infection.

Immunisation up but a long way to go

Although average figures for routine vaccination rose slightly in 1999-2000 according to figures from WHO’s Expanded Programme on Immunisation unit, overall the picture is grim.

The rise stems largely from intensive efforts in NGO-supported health zones and improvements in cold chain due to the expansion of the polio programme. But still fewer than one third of children routinely receive childhood vaccination and averages for some antigens fall as low as 18% while in Orientale Province, rates run at 0 to 10%.

NGO and WHO efforts to improve the cold chain and training of staff are continuing. But as one logistician explains succinctly: “If you have the fridge, you don’t have the kerosene to run it. When you have the kerosene, you don’t have the vaccine. Then the fridge breaks down because of poor maintenance, or there are no vaccine cards. There always seems to be something.

On top of this, NGOs are reporting frequent reluctance among health workers to give childhood vaccination, or indeed provide any preventative care, free of charge because their pay is mostly derived from fees for service.
Both short term solutions and long term thinking is required according to the key partners in childhood health, and a five year strategic plan for the development of EPI activities has just been completed by local health authorities, thanks to the technical and financial support of the US funded group Basic Support for Institutionalising Child Survival (BASICS) and WHO.

Communicable Diseases

**Antennae to improve epidemic radar**

In the past nine months, WHO has set up 11 provincial ‘antennae’ staffed with medical epidemiologists, logisticians and radio communications and recruited 42 epidemiologists to work at district level. Both levels are funded by the Global Polio Campaign but are charged in their terms of reference with addressing the much broader brief of strengthening surveillance of all epidemic-prone diseases as well as polio. There is a lot to strengthen: two thirds of the health zones in the country still file no reports and the remaining 30% file a minimum of one report a year. Staff motivation is a key issue at all administrative levels.

"By the time you get the information of an epidemic, it's often too late to do anything – people have either recovered or died," says one MSF head co-ordinator.

In certain areas, where health zones are more accessible or are directly supported by epidemiologically-minded NGOs, reporting is better. In Kinshasa for example, French NGO Epicentre supervises a surveillance system in 12 sentinel sites throughout the city, while out in the provinces the Médecins Sans Frontières branches place heavy emphasis on surveillance and rapid response, and are part of the weekly Ministry/WHO monitoring group that meets in Kinshasa.

WHO tracks epidemic prone-diseases via its provincial and district epidemiologists who have also been involved in communicable disease training for health workers in 10 provinces. According to WHO focal communicable disease focal point Dr Tshioko, there are also plans to extend training to community leaders once new WHO African Regional Office case definitions for community reporting are finalised.

**Sorting out the data streams**

Obtaining accurate medical information in DRC is difficult, not only because of difficult communications but also, ironically, because there are just too many systems attempting to gather data. Currently health workers throughout the country are asked to file information into four separate unconnected databases, all of which use different criteria to produce figures. These data streams are linked to the Expanded Programme for Immunization, the ‘Quatrieme Direction’ in charge of communicable diseases, the WHO-led polio surveillance system, and National Health Information System or SNIS.

The fact that the first two of these, though in the same building, produce entirely different measles figures due to the different statistical criteria they use, is an evidence of the confusion this situation can cause.

WHO, a major donor and the ministry are currently discussing the possibility of developing one central surveillance centre which would work to standardise and streamline all forms of reporting, which would not only to produce more accurate data but also less arduous reporting routes for health workers.

Currently only 30% of health zones submit at least one health report a year, and this report does not necessarily involve data from every facility in the zone.

**Free drugs bode well for tryps teams**

DRC’s fight against sleeping sickness is to get a significant boost from a $25 million initiative between WHO, international NGO Médecins Sans Frontières and pharmaceutical manufacturers Aventis Pharma and Bayer. The new project assures continued manufacture of crucial drugs and free supply to countries in need, and will release funds to increase the number of mobile teams working in the field whose role in seeking out infected people is crucial element in combating the disease.

“This initiative has changed the situation dramatically," says Dr Simon Van Nieuwenhove, WHO’s African regional adviser for trypanosomiasis or sleeping sickness.

“First it gives us the drugs we thought would disappear. And secondly, since most of the cost of the sleeping sickness control programme at present is drugs, and the pharmaceutical companies are now giving them free, much of the money donated will be able to be reallocated to increase active screening.”

Mobile teams, which have managed to continue functioning in many areas despite the war, are co-ordinated by the national Bureau Central de la Trypanosomiase which is supported by WHO and funded by Belgium to tune of $2.5 million a year. The Belgian Government has also given $1.5 million to WHO’s African regional programme for trypanosomiasis, currently based in Kinshasa, to co-ordinate and develop similar
programmes in other affected countries over the next two years. NGOs such as MSF Belgium strongly support the programme, and manage mobile teams particularly in Equateur, one of the focal points of the disease.

DRC is one of the largest reservoirs of trypanosomiasis. Forty years ago cases were down to just a few thousand but the breakdown of health services, withdrawal of bilateral aid and, finally, war halted the active screening of vulnerable populations that is the only way to stop transmission. In 1998 reported new cases reached 26,000 a year, though real figures are likely to be more than 100,000 people affected but not yet diagnosed, since the current 35 mobile screening teams are reaching less than 12% of the population at risk.

It is hoped that increasing access to previously inaccessible areas, the new climate for funding activities in DRC, and the advent of the trypanosomiasis initiative will all contribute to increasing this reach.

▶️Health care financing

Community participation excludes

International NGO Merlin has managed to more than double attendance at their clinics by dropping the consultation fee (which is the only source of salary for the centre staff) from 10 Franc Congolese (approximately 6 USc) to 5FC including drugs. But they believe they are still excluding large numbers of people who cannot afford even that.

“Cost recovery is a nightmare: people pretend they do it so that people don’t become dependent but the reality is that we don’t have enough money to pay staff to work even though we know that cost recovery reduces access,” says eastern DRC head of mission fir British NGO Merlin, Susan Lillicrap.

In Kisangani IRC head of mission Sebastian Fessneau says while the objective is “auto-financement, sustainability is very difficult”.

Most NGOs try to police exemption systems for indigents and free essential services such as vaccination, but without the ability to supervise daily many report difficulties in ensuring the most vulnerable have access.

The scope of family difficulties has been further highlighted by household surveys carried out by OCHA in Kinshasa province which suggest that the majority of the population are living on an average of 20 cents per person per day. Other surveys in North Kivu show daily per-person expenditure ranging from $0.68 in Goma, $0.29 in Butembo, $0.18 in Kayna.

Adding this to insecurity and lack of external support for day-to-day functioning of health centres in many zones, it’s now estimated that over 70% of the population of Congo does not have access to basic primary health care.

Both the Belgian Government and a joint WHO-UNICEF health mission recently called on donors attending a strategic conference in Geneva in July to consider other mechanisms for funding health care, including supporting the government to pay health care worker salaries, not only to reduce exclusion, but also to remove the perverse incentive to carry out fee-carrying curative care at the expense of preventative and public health activities.

But one major donor representative in Kinshasa noted “There is a painful disconnect: we as donors are willing, for example, to pay refugees a salary to provide health service in refugee camps, but we are not willing to do the same with those who are equally impoverished but have remained for whatever reason in their own country.”

▶️Health zone coverage

Initiatives target the unsupported

After 10 years absence, the US Government is re-establishing support to health zones in DRC. Over the next five years it will put US$25 million into 60 health zones via SANRU III, a project which like its predecessors SANRU I and II will target its support at rural areas via health services run by the churches.

Likely to be managed by the umbrella NGO Interchurch Medical Assistance, SANRU aims to provide global assistance to health zones, from drugs, vaccines and medical supplies to training and management support. The 60 health zones span east and west DRC but the first to receive support are likely to be predominantly in the West.

The European Union is also rehabilitating and supporting some 500 health structures in roughly 50 health zones through its Programme d’Appui Transitoire au Secteur de santé (PATs)

Focused mainly on Greater Kinshasa and its hinterland provinces of Bas-Congo and Bandundu, half of the project’s US$38 million goes to supplying health zones via various church and local NGOs with the remainder destined to support particular programmes in areas such as water and sanitation, trypanosomiasis and HIV/AIDS.

Newly accessible areas draw NGOs

With the agreement of the belligerents to withdraw last July, previously inaccessible areas close to the ‘old’ frontline have begun to open up to those health NGOs with enough logistical flexibility to get there.

In the far west of Province Orientale, for example,
the International Committee of the Red Cross recently began shipping drugs and supplies to Ikela, a health zone where the majority of the town’s 50,000 population continues to be displaced into the forest onto the eastern side of the old frontline. Access to the area, 260 km as the crow flies from Kisangani, is only by boat, motorbike and bicycle. Though the initial exploration team found no major epidemics and no visible deprivation of food, they reported “zero” availability of medication and no routine immunisation for three years.

For their part MSF Holland are hoping to open up a new emergency site 300km north west of Kisangani, in Yahuma health zone where, says MSF-H Kisangani head of mission Joseph Leberer, “intervention is more or less justified across the whole area, even on emergency criteria.”

“It’s not that people are so sick, but that there is no recourse for any even small medical problem,” he adds.

Further south, British emergency health NGO Merlin is extending its programme from the jungle province of Maniema into frontline Lodja in Kasai Oriental. and MSF Spain has reopened a health centre and three health posts in the battle-scarred health zone of Pweto in North Katanga and is exploring the possibility of expanding into other areas of opposition-controlled North Katanga. In the west, MSF Belgium are moving to re-establish activities in Equateur.

Drug logistics are nightmare

Drug and medical supply

How to maintain drug and medical supplies in the face of tortuous terrain, starved economy and no central essential drugs distribution is a major issue in the health zones of Congo.

In most areas UN agencies, international NGOs and church organisations work to provide for their supported health zones through individual suppliers and logistics which not only eliminates the possibility of economies of scale in purchasing but also leads to duplication in storage, transport and supervision. And even in supported centres, drug ruptures are frequent leaving patients self medicating from unregulated private pharmacies.

One exception is North Kivu where ECHO is supporting – to the tune of $100,000 a month – a central drug supply system run by local NGO ASRAMES which supplies 19 health zones via international NGOs.

Drugs are supplied free, and organisations and/or health centres decide whether or not to levy a user fee. Most currently charge a global ‘episode of illness’ fee which is dedicated to paying salary and running costs of the health centre. The problem is that charges are generally calculated on the amount needed to give staff a basic salary rather than the capacity of the population to pay.

“What we ask is that NGOs don’t just drop drugs, or user charges into the health system but that they have a system of management of user charges and exemptions to maximise access,” says an ECHO spokesperson.

Rehabilitation

More than just a paint job

A $3 million rehabilitation project funded by UNDP and implemented by WHO which includes an innovative income generation component has seen use of the targeted health facilities more than double in the past year.

The programme focused on six health zones in Bandundu, Katanga and Bas Congo, and involved rehabilitating and re-equipping parts of district hospitals, health centres, and the provincial health authority offices.

WHO and Ministry of Health staff also trained doctors, health workers and technicians in health service management, epidemic surveillance and laboratory techniques, and community leaders and local organizations in setting up health committees, small project management, and social mobilisation for health.

But the more unusual element of the programme was injections of cash for income generation projects. “When we asked why they didn’t use the health facility, people said it was because they couldn’t afford it. There’s no point in rehabilitating a health centre which can’t survive without minimal fees if people can’t afford to use it,” says WHO project leader Professor Ngo Bebe.

In the small community of Kisanfu in Katanga, the health committee used their $1500 grant from the project to buy haricot beans and fertiliser for a two hectare plot which last month produced a harvest of eight times the original input.

This has been divided between the health committee who will use the income to ensure an adequate supply of drugs and materials in the centre and to subsidise patients, and local small farmers to use part as food and part for income and seed return next year.

“We want to see the impact of the new source of income on the use of this health centre and on the public health of this community,” says Dr Jean de Dieu Illunga, the health zone’s medical officer. “If it works, we want to spread the idea to other health centres by giving them seed beans from our harvest to start their own.”
According to Professor Ngo Bebe, the increased use of health facilities is due to the combination of factors including supplies and confidence. “The population has more confidence in their health facility, but it’s more than just the rehabilitation. Even without the war, the situation of the health centres was in crisis. Everyone basically forgot about them because they didn’t have any supplies. “We’ve done a lot of work to sensitise the population as to why they should use the health centres and to improve their access. It’s too early to know whether projects like the haricot beans are having an effect on people’s actual health, but the dramatic increase in use of the centres is encouraging.”

USAID, Cooperazione Italiana and UNICEF have all contributed to the rehabilitation projects in addition to UNDP and WHO, and the European Union funded an introductory conference last year.

Similar income generation projects are being piloted with the Association of Young Handicapped People for Artistic Progress in Lumbumbashi and an organisation for orphans in Kolwezi.

### Laboratories

**Ten new labs needed for basic service**

Laboratories in DRC have suffered long years of neglect. Many function barely with old dysfunctional equipment and constant search for reagents and supplies.

Working with some funds from its African Regional Office, its regular budget and Rotary International, and in the hope of attracting new donor funds, WHO has assessed and planned the creation or rehabilitation of 10 laboratories throughout the territory. Only one of these, Amikivu in Goma, is currently functioning with any capacity, thanks to support from UNHCR, WHO and the European Union. Five need to be created from scratch – Bukavu, Mbuji Mayi, Kikwit, Kindu, Matadi – while Lumbumbashi, Mbandaka, Kisangani, Kananga labs all need to be extensively rehabilitated and equipped.

In the meantime, WHO has started a series of updating seminars for laboratory staff around the country, which is followed by the provision of a limited amount of essential supplies. “The trouble is we can reinforce capacity but it’s difficult to maintain supplies so that those trained can carry out the work when they get back to their laboratory,” says Prof. Kandolo. Maintaining supplies and motivating workers where salaries are often irregular or non-existent is a issue throughout the health service in DRC.

### National Reference Laboratory

WHO, together with the Governments of Belgium, France, Japan and the US, is also putting funds into rehabilitating, equipping and improving the function of the national reference laboratory, the Institute National de la Recherche Biomedical in Kinshasa. Three staff from the INRB and one from Lumbumbashi are currently being funded on WHO’s new laboratory training programme in Lyon, France. The aim is to develop the INRB into high level virology lab.

### Polio eradication

**First round down – two to go**

Over 11.5 million children were reached in the first round of the 2001 National polio immunisation days giving a “more than satisfactory” coverage in all the 11 provinces, according to WHO’s polio campaign team leader Dr Matthieu Kamwa.

More than 150,000 people are estimated to have been involved with this year the Red Cross of the Democratic Republic of Congo mobilising all its volunteers for the effort. They joined local NGOs, church groups, health workers in a massive campaign that saw vaccinators moving deep into the country by foot, by bike, by outboard-powered canoe, by punt, and even, DRC’s few roads allowing, by car.

Second and third rounds are due to take place in August and September, and in a small number of high risk health zones where logistics allow, the final round in October will include measles vaccination to test the viability of using the polio structure as a foundation for campaigns to fight this childhood disease.

### Negotiations across borders

This year’s NIDs were part of a synchronised effort across a large swathe of Central Africa including Angola, DRC, Republic of Congo and Gabon. While high level negotiations brought expressions of support from all parties, at local level teams worked to make the connections between warring parties, tribal chiefs and communities in order to reach 127,000 under fives living in border or insecure zones.

Neither level is simple, as WHO polio team leader Dr Matthieu Kamwa notes. “There are armed groups that can be identified but there are also many unidentified armed groups. We must not be over-optimistic about our ability to reach all children this year. The big picture of peace can be deceptive on the ground.”

Indeed, the effort to reach every under-5-year old was sadly marked by the death of a social mobiliser as a result of hostile forces in North
Kivu, and the arrest and beating of five others along Equateur and Province Orientale border.

Security concerns also reach beyond immunisation days, says WHO epidemiologist Mr Yon Fleerackers. “Ensuring health workers have security for surveillance and investigation of acute flaccid paralysis cases is an ongoing concern because this work doesn’t take place on a clearly identified timetable.”

**Building on the investment**

The polio programme has substantial economic implications for health workers and others whose monthly salaries are often only just in double dollar figures.

Over the three months of planning and implementing 2001 NIDs, some US$15 million of the total US$32 million budget raised from international donors is poured into the country in the form incentives, per diems, and payments for goods and services. The remainder is spent largely on vaccines and investment in infrastructure like transport, cold chain and communication equipment.

Getting the best value out of that money is a headache in such a large and impoverished country, says WHO polio team leader Dr Matthieu Kamwa. “We are using supervision and spot checks, controls during and after activities, but we are not thousands of people.”

An important aspect of the investment, he adds, is the logistical resources put in place by the global campaign should be used to strengthen and re-establish basic primary health care services.

This year the core programme team has grown to 180 people including 15 expatriates, 11 Congolese epidemiologists at provincial level and 42 at district levels, supported by logisticians, radio operators and drivers. All staff are employed by the polio programme to ensure working standards are met, but work alongside local health inspectors in polio and integrated surveillance activities.

**DRC Health on the web**

For further documents on the Democratic Republic of Congo, please visit:
- [www.who.int/eha/disasters](http://www.who.int/eha/disasters) Emergency and Humanitarian Action Dept, WHO Geneva
- [www.reliefweb.int](http://www.reliefweb.int) OCHA
- [www.intrescom.org/index.cfm](http://www.intrescom.org/index.cfm) International Rescue Committee

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