# Collaboration between a TB control programme and NGOs during humanitarian crisis: Democratic Republic of the Congo

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Rudi Coninx's paper addresses the challenges facing tuberculosis (TB) control programmes in countries undergoing complex emergencies, particularly the difficulties involved in applying the DOTS strategy during humanitarian crises. This commentary outlines the fruitful results of the development of effective partnerships in such a situation in the Democratic Republic of the Congo (DRC).

## The humanitarian crisis

The socioeconomic situation of the DRC deteriorated progressively as a result of wars (1996-1997, 1998-2003) in which several million people died. Health services were disrupted completely in the areas affected directly by the war: a number of health centres and hospitals were looted and their staff were forced to flee. The DRC was divided for several years and government staff from the central level could not reach the eastern provinces. However, work was resumed once the acute phase of the war was over in a particular area, including visits by supervisory staff living in the eastern part of the country. Currently, the country is reunited; security has improved but remains problematic in some areas. The socioeconomic situation remains extremely bad. Public service salaries are below subsistence level, resulting in poorly functioning health services except where they are supported by external donors.

## The answer: partnership

Four international and two domestic nongovernmental organizations (NGOs) have been supporting the national tuberculosis and leprosy control programmes for many years, usually taking responsibility for supporting one or several of the 23 *coordinations provinciales lèpre et tuberculose* (CPLTs). Together, they have progressively covered the whole country. Now the National Tuberculosis Programme (NTP) also benefits from the support of the Global Drug Facility (GDF); the Global Fund to Fight AIDS, Tuberculosis and Malaria; and bi- or multilateral cooperation.

## NGO roles and contributions

Most of the contributing NGOs have signed a memorandum of understanding with the ministry of health, describing the rights and responsibilities of each partner. Several have a coordinating office in Kinshasa, including the largest – the Damien Foundation, Belgium (DFB). This foundation supports 12 CPLTs and has a staff of 20 in the coordinating office.

The TB central unit receives varied support: financial (allowances for staff salaries, supervision, training, running costs), material (means of transport, computers, laboratory material) and technical (support for the definition of programme norms, development of training materials and so on).

At the intermediate level, every doctor in charge of a CPLT is a civil servant who also signs a convention with the supporting NGO and is therefore accountable to both the health ministry and the NGO. The NGO guarantees an adequate monthly salary; monthly premiums paid to other staff at this level (e.g. supervisors, laboratory technicians) raise their government salaries to subsistence level. This income provides stability for staff members and enables them to concentrate on their professional responsibilities. Means of transport, computers, laboratory and office materials and budgets to cover training, supervision and other operating costs are also provided.

At peripheral level, NGO support includes salary premiums for the district supervisors; a motorcycle; microscopes

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and other laboratory materials; and budgets to cover supervision, training and running costs. Small salary premiums for the personnel, and laboratory and other materials are also provided at health-centre level.

## Coordination of activities

The directors of the national tuberculosis and leprosy control programmes and representatives of the main partners have formed a forum of partners. The main orientations and decisions concerning both programmes are discussed and a consensus is sought to ensure that all partners strive to implement faithfully the national policies and strategies. The different partners also share information on budgets in order to ensure transparency and complementary support.

A coordinated calendar for training and supervision is prepared and a number of missions (training sessions and supervisions) are carried out jointly. The national tuberculosis and leprosy control programmes organize an annual national meeting, with the participation of the central units, doctors in charge of the CPLTs (financed by their respective partners) and representatives of all partners.

Some of the activities foreseen in the Global Fund budget are also implemented by partners: *La Ligue Nationale Antituberculeuse et Antilépreuse du Congo* (LNAC) develops health education material, while DFB coordinates the training programme for the country.

Until 2001, NGOs purchased anti-TB drugs and laboratory supplies through the DFB, which handled the international tender and quality control, and delivered the drugs to Kinshasa. Since then, the GDF has been providing two-thirds of the country's anti-TB drugs; the remainder is provided by other partners coordinated by the DFB. The NTP and its partners manage stocks and distribution. When war made it impossible for the NTP to send drugs and material to the eastern provinces, they received supplies that entered the country via neighbouring Rwanda and were stored in Goma under DFB responsibility. National-level supervision of these provinces was carried out exclusively by NGO staff, since civil servants from Kinshasa were unable to gain access to these facilities.

## Results

The fruitful collaboration between the NTP and the NGOs has produced one of the country's best-functioning health programmes. It is estimated that DOTS services cover about 75% of the population[1] and the case notification rate was 176 per 100 000 population for all forms of tuberculosis, and 117 per 100 000 for sputum smear-positive cases in 2005. New positive patients in the 2004 cohort had an 84% treatment success rate.

## Limitations of the collaborative system

The national programme's dependence on external donors (e.g. for staff salaries or premiums) presents a potential risk to its sustainability. The multiplicity of actors in the field, with differing priorities (e.g. the balance between leprosy and tuberculosis) or policies (e.g. salaries or premiums), may make it difficult to standardize implementation of the national programme throughout the country.

It may appear that one partner has taken control of the national programme, as it covers the largest number of CPLTs and provides substantial technical and financial support. However, autonomy in the central unit has been preserved through mechanisms for dialogue and coordination, and through financial support provided by other partners and international institutions.

## Conclusions

Effective collaboration has enabled appreciable results in TB control despite the country's very poor socioeconomic situation and disorganized state. Successful collaboration requires mechanisms for consultation and dialogue to be in place and functioning. These should involve all partners with clearly defined roles and responsibilities. ■

**Competing interests:** None declared.

### References

1. *Global tuberculosis control: surveillance, planning, financing.* Geneva: WHO; 2006 (WHO/HTM/TB/2006.362).