

A C T I V I T Y - R E P O R T  
S A N R U - 8 6

June 1982 - March 1984.

BASIC RURAL HEALTH  
PROJET DES SOINS DE SANTE PRIMAIRES  
EN MILIEU RURAL  
(660 - 0086).-



By:  
Cit. NLABA-NSONA  
Dr. MIATUDILA MALONGA  
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## CONTENTS

	Page
I. BACKGROUND INFORMATION:	1
A. Introduction	1
B. PHC and the Health Zone Concept	1
II. PROJECT IMPLEMENTATION:	5
A. Implementation Plans	5
B. Selection of Participating RHZs	5
C. Project Resources.	10
III. PROJECT ACTIVITIES OF SANRU/KIN:	13
A. Personnel	13
B. Consultants	13
C. Collaboration with other Health Agencies	15
D. Donor Coordination	18
E. SANRU Activities in Promoting PHC	18
IV. PROJECT MONITORING AND EVALUATION:	21
A. Evaluation Strategies	21
B. Evaluation of 82-83 Activities	24
V. FINANCIAL REPORTS	43

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FIGURES AND APPENDICES

	Page
<i>Figure 1:</i> Components of the Rural Health Zone Composants d'une Zone de Santé	3
<i>Figure 2:</i> Regional Distribution of Health Zones Assisted by SANRU-86	11
<i>Appendix 1:</i> Rural Health Zones Assisted by SANRU-86	46

## TABLES

	Page
Table 1 : Primary Health Care Activities	1
Table 2 : Ten Major Diseases Requiring PHC Intervention	2
Table 3 : Project Implementation Plan	6
Table 4 : Implementation Plan for Model RHZ	7
Table 5 : Hospitals Contacting SANRU for Assistance	9
Table 6 : SANRU Proposed Budget	10
Table 7 : Resources Available to RHZs through SANRU	12
Table 8 : SANRU Administrative Personnel	13
Table 9 : SANRU Consultants	14
Table 10 : International Agencies/Projects Collaborating with SANRU	16
Table 11 : Health Organizations/Programs Represented on SANRU Advisory Committee.	17
Table 12 : Primary Health Care Donor Agencies	19
Table 13 : SANRU/KIN Activities in PHC Promotion	20
Table 14 : SANRU Project Objectives	22
Table 15 : Calculation of RHZ-Project Months	23
Table 16 : Current Status of SANRU Project Objectives	25
Table 17 : Financial Report on the Use of Counterpart Funds 1982-1983	44
Table 18 : SANRU Counterpart Budget 1984	45

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## I. BACKGROUND INFORMATION

### A. Introduction.

The Basic Rural Health Project (660-0086) is known locally as SANRU 86 (Projet des Soins de Santé Primaires en Milieu Rural). It is a bilateral project between the government of Zaire represented by the Ministry of Health (MOH) and the United States of America represented by the Agency for International Development (USAID). The project is administered on behalf of the MOH and USAID by the medical office of Protestant Church of Zaire (ECZ).

The project purpose is to assist in establishing 50 self-sustaining rural health zones to promote community based primary health care activities in combatting the ten most prevalent diseases. Project assistance is provided in the form of basic equipment and medicines for transforming 250 dispensaries into health centers, educational materials and funds for training health personnel, and office equipment and vehicles to establish supervisory capacity for the Rural Health Zone (RHZ).

The project was signed in August 1981, become operational in January 1982, and is scheduled to run through September 1986. The first project report covered the period August 1981-June 1982. This present document reports on the period June 1982-March 1984.

### B. Primary Health Care and the Health Zone Concept.

The MOH of Zaire officially adopted in 1981 the Alma Ata strategy of "Health for All" and promotion of decentralized primary health care activities. Primary Health Care (PHC) is defined as the integration of curative, preventive and promotional health care services which are available, accessible, acceptable and affordable to the general population. Specific activities which comprise PHC are shown below.

Table 1.  
Primary Health Care Activities.

Health Education	Vaccinations
Promotion of Nutrition and Agriculture	Control of Endemic Diseases
Under-Five Consultation	Water & Sanitation
Pre-Natal Consultation	Basic Curative Care
Maternity Service	Training/Continuing Education
Family Planning	Provision of Essential Supplies
	Supervision of Services.

These Primary Health Care activities furnish the support mechanism for combatting major diseases in order to reduce disease incidence and prevalence. While many diseases merit attention, the ten major diseases identified under the SANRU project are listed in the following table.

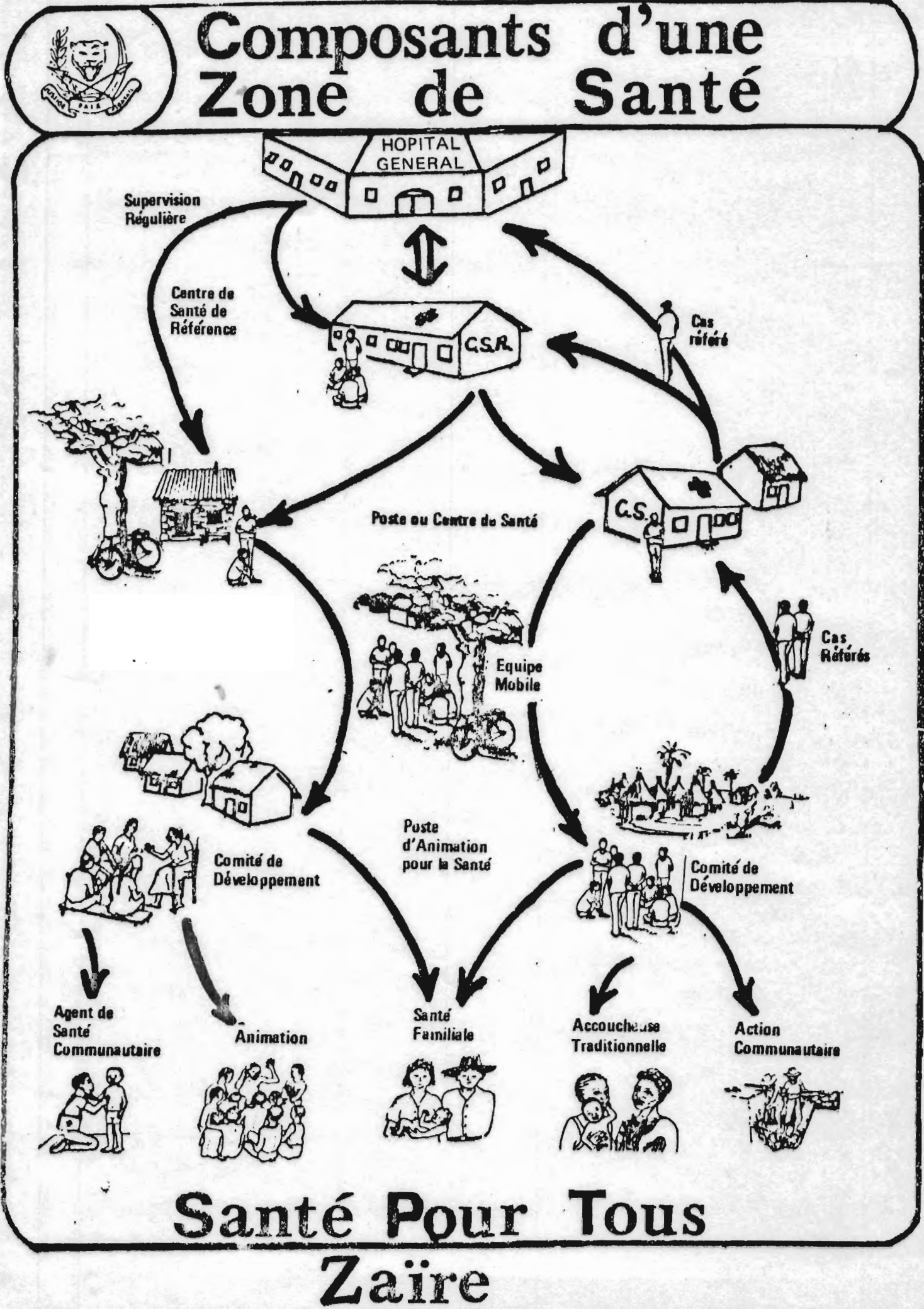
Table 2  
Ten Major Diseases Requiring PHC Intervention

Malnutrition	Respiratory Infections
Malaria	Intestinal Parasites
Measles	Tuberculosis
Diarrhea	Complications of Pregnancy
Anemia	Regional Diseases: Cretinism/Schisto/Oncho, etc.

The MOH has proposed a Five Year health plan 1982-1986 for Zaire which specifies the creation of health zones. Each zone is to cover a well defined geographical area and target population of approx. 100,000 inhabitants. A typical Rural Health Zone (RHZ) consists of a reference hospital with the central office of the RHZ and a decentralized system of health centers. Each health center staffed by a nurse and several aids is responsible for coordination and promotion of PHC activities for its surrounding communities (approx. 3,000 - 10,000 inhabitants). Community based activities are coordinated by a village development committee and may also include Village Health Workers (VHWs) and Traditional Birth Attendants (TBAs). The health zone structure may also include an optional reference health center which corresponds to a "mini-hospital" and permits the decentralization of supervision activities with the health zone. The components of the Rural Health Zone are illustrated in Figure 1.

An important concept of the health zone is to uniformize the technical supervision of all medical services with the health zone area. Historically protestant, catholic, state and private dispensaries have operated independantly of each other (and sometimes in conflict). This included independant supply lines, separate supervision support, and non-uniformized statistical reporting systems. The creation of MOH sanctioned health zones would give the central office of the reference hospital authority to coordinate and supervise all medical services within their geographically defined area. While most agencies agree with the intent of this concept pragmatic problems which arise in integrating medical services will take many years to resolve.

Figure 1





This concept recognizes that a RHZ belongs to its respective population and not to any one donor agency or mission group. While a RHZ may be Catholic-run or Protestant-run or State-run in the sense that the reference hospital is owned and managed by a specific group, this does not make the RHZ either catholic, protestant or state. References to the "Catholic health zone of \_\_\_\_\_" or the "SANRU zone of \_\_\_\_\_" are completely inappropriate. The RHZ must become ecumenical if it is to function in the interests of the population rather than any one group or agency. We must be attentive that our terminology and labels reflects this ecumenical spirit. It must also be noted that SANRU assistance to a "Protestant-run" health zone for example, is not limited to protestant managed dispensaries within that zone but is available to all existing dispensaries within that zone but is available to all existing dispensaries willing to promote PHC and collaborate in organizing the RHZ.

## II. PROJECT IMPLEMENTATION

### A. Implementation Plans

The overall project implementation plan has been expanded and updated. The current status of the project with respect to this plan is outlined in Table 3. Delay of some activities has been caused principally by:

- 5 month delayed start-up time due to arrival of project technician in Jan. 1982
- 9 month financial "drought" when project was under Brooke amendment - and unable to initiate dollar funded activities.
- Sporadic and irregularity of counterpart fund distribution necessary for local training expenses.
- Delayed arrival of project commodities - some as much as 18-24 months after placement of order.
- Delay of MOH in official recognition of Rural Health Zones.

Each Rural Health Zone represents a separate project, and must thus develop its own implementation plan. These plans vary according to RHZ, - personnel, infrastructure and existing PHC activities. The implementation plan for a typical RHZ over a three year period would include many of the activities as listed in Table 4.

### B. Selection of Participating Rural Health Zones.

The SANRU project implementation plan calls for assistance to 50 rural hospitals during three phases. The phase concept permits that a new group of hospitals enters the program each year. Thus 15 hospitals began participation in 1982, 21 were added in 1983 and 14 more are scheduled for 1984.

Hospitals are selected from among those whom have contacted the SANRU project and requested assistance. Criteria for selection of hospitals are based on the following:

- a functioning reference hospital with good management record
- at least one medical doctor on full-time resident staff
- an expressed interest in PHC demonstrated by existing activities
- capacity for training personnel
- demonstrated need for SANRU type assistance.
- capacity for program sustainability

Table 3  
Project Implementation Plan

<u>Action</u>	<u>Action Due</u>	<u>Action Completed</u>
1. PP approval	Aug. 1981	Aug. 1981
2. Proag signed	Aug. 1981	Aug. 1981
3. Approval of personal Services Contractors and Commodity Waivers.		
4. Arrival of contract technical consultant in Zaire (contract signed)	Sept.1981	Jan. 1982
5. Preparation of PIO/Cs for FY 81, order vehicles, motorcycles, bicycles, and first tranche other commodities.	Sept.1981	Nov. 1981
6. Set up local currency account	Oct. 1981	Nov. 1981
7. Request advance counterpart fund for local procurement activities.	Oct. 1981	Jan. 1982
8. Advisory Committee formed	Nov. 1981	Mar. 1982
9. First local seminars/retraining held in participating hospitals.	Dec. 1981	May 1982
10. First short-term consultant begins work Medical Information System.	Jan. 1982	June 1983
11. Identification of hospitals for second phase	Jan. 1982	Dec. 1982
12. A. Annual Proag for FY 82 obligation B. Preparation of PIO/Cs for FY 82 funded commodities.	Jan. 1982	Sept.1982
13. Identification and initiation procedures for first group of long-term participants.	Jan. 1982	Sept.1982
14. Identification of short-term participants	Feb. 1982	July 1982
15. Identification planning of in-country recyclage courses.	Feb. 1982	July 1982
16. First meeting of Project Advisory Committee	Mar. 1982	May 1982
17. Biannual report	Mar. 1982	Aug. 1982
18. Short-term experts arrive for work	May/June/ July 1982	Oct. 1982
19. Data collection system tested	July 1982	Nov. 1982
20. First group of participants for long-term training.	Aug. 1982	Aug. 1983
21. First evaluation	Sept.1982	Sept.1982
22. Second meeting of Advisory Committee	Sept.1982	Jan. 1983
23. Second biannual report	Sept.1982	Dec. 1983
24. First annual health conference	Nov. 1982	Mar. 1983
25. Amend proag for FY 83 obligation	Jan. 1983	Sept.1983
26. FY 83 commodities ordered	Jan. 1983	Apr. 1983
27. Training MDs-UNIKIN	July 1982 July 1983 July 1984	July 1982 July 1983
28. Training Nurses-Supervisors	July 1982 Aug. 1983	July 1982 Cancelled
29. Obligation of GOZ funds 1983	Jan. 1983 Apr. 1983 July 1983 Oct. 1983	Feb. 1983 May 1983 Aug. 1983
30. Selection Phase III hospitals	Dec. 1983	Feb. 1984
31. Planning Mtg for Phase III MDs	Apr. 1984	
32. Second Annual Health Conference	Apr. 1984	
33. Mid-Project Evaluation	May 1984	
34. Impact-Evaluation Study begins	Jan. 1984	Cancelled
35. Obligation of GOZ funds 1984	Jan. 1984 Apr. 1984 July 1984 Oct. 1984	Feb. 1984
36. 2nd Group Long-term participants	Sept. 1984	Jan. 1984
37. WASH Workshops	Jan. 1984	Jan. 1984
38. JHPIEGO Formation des Infirm. Sup.	Apr. 1984 Sept.1984 Apr. 1985	Apr. 1984
39. PRICOR operational research	Oct. 1983	Begun
40. AVS equipment phase I	Jan. 1983	Aug. 1983

Table 4.  
Implementation Plan for Model RHZ

Year One:

- Reference hospital directors decide to develop RHZ.
- Initial contact at national level to obtain info on PHC, health zones and steps necessary in start-up of a RHZ.
- Meetings with other hospitals of the sub-region and med. director of the sub-region to tentatively define boundaries of the RHZs.
- Meetings with representatives of all existing dispensaries within the limits of the RHZ.
- Inventory assessment of existing and required resources for development of the RHZ (personnel, equipment, training, PHC activities).
- Establish central office of the RHZ to coordinate PHC training and supervision.
- Establish PHC activities around the reference hospital as prototype for future activities of health zones.
- Village Development Committee organization and "concientization".
- Establish map of RHZ with respective health circles (aires de santé) and identification of dispensaries scheduled for transformation into health centers.
- Training of initial group of nurses to head up health centers and work in central office administration.
- Identification of donor agencies to assist in RHZ development and of types of assistance to be provided.
- Opening of at least one health center.

Year Two:

- Refinement of implementation plan, RHZ map and health secteur planning.
- Limits of RHZ submitted to regional medical inspector and the national direction of PHC.
- Training of group of nurses to open 2-3 health centers per year.
- Integration of some PHC activities into existing health centers usually beginning with health and nutrition education, vaccinations, under-fives clinics, prenatal clinics, sanitation programs and basic curative medicines.
- Organization of village development committees in villages attached to each health center.
- Pilot training of VHVs and/or TBAs as prototypes for future community based activities.
- Census of villages attached to each health center to identify population denominators.
- Specialized training for supervisory staff of the RHZ in management of PHC programs.
- Completion of an annual report of the RHZ providing statistical info on existing accessibility and coverage of PHC activities throughout the RHZ.

Year Three (and successive years):

- Integration of additional PHC activities into the health center such as family planning, tuberculosis control, maternity services and training activities.
- Transformation of 2-3 dispensaries into health centers per year.
- Active and ongoing training of village based health workers.
- Upgrading of select health centers to status of a reference health center to permit decentralization of supervision activities.
- Systematic centralization of health center reports providing accurate data on accessibility, coverage and impact of PHC services.
- Operational research activities to document select PHC approaches of the health zone.
- Assume auto-financing capability at the health center level.
- Continuing education of RHZ personnel

The criteria of a functioning reference hospital and presence of a medical doctor should not be construed as putting too much importance on curative medicine. While the referral nature of the reference hospital is important, of equal importance is that of serving as the location for the central office of the RHZ. The medical doctor is required in order to full-fill duties as "Medical Director of the RHZ". He may also serve as Director of the reference hospital particularly when he is the only doctor present.

An expressed interest in PHC is usually demonstrated by a minimum of a mobile team operating in the immediate area around the reference hospital with activities such as under-fives clinics, vaccinations, and health education. Some health zones have already begun programs for transforming dispensaries into health centers before entering the SANRU program. SANRU assistance helps them continue to enlarge their programs and to legitimize it as an official RHZ.

Capacity for training and continuing education of personnel is best demonstrated by a RHZ with a nursing school. Acceptable alternatives are reference hospitals with a staff experienced in health training or proximity to a RHZ which could assist in training activities.

A demonstrated need for assistance is generally not difficult to justify given a country-wide need for approx. 300 health zones and some 6,000 health centers. SANRU strategy is not meant to supply 100% of the assistance for a RHZ or to establish "SANRU zones". Project resources for 250 health centers are enough to meet approximately 25% of the actual needs of 50 RHZs. SANRU often works in collaboration with other donor agencies to supply complementary assistance to RHZs. This is particularly desirable given specialized interests, skills and varying types of available resources among donor agencies.

The SANRU project paper proposed a tentative list of hospitals from 50 administrative zones to be assisted. These were to include primarily protestant hospitals and select state hospitals. Assistance to catholic-run hospitals was not originally planned because of alternative resources available through the catholic church and the Belgian Technical Cooperation.

A list of hospitals which have contacted SANRU for assistance is shown in Table 5. Those hospitals participating in the SANRU project to create

Table 5.  
Hospitals Contacting SANRU for Assistance

<u>Bas-Zaïre</u>	<u>Bandundu</u>	<u>Equateur</u>
Kinkonzi (1)	Vanga (1)	Karawa (1)
Kimpese (1)	Kajiji (1)	Tandala (1)
Nsona-Mpangu (1)	Djuma (2)	IME-Loko (1)
Nsona-Bata (1)	Kasongo-Lunda (2)	Businga (2)
Kisantu (3)	Kikongo (2)	Bosobolo (2)
	Mukedi (3)	Pimu (3)
	Panzi (3)	
<u>Haut-Zaïre</u>	Bosobe (3)	<u>Shaba</u>
Nyankunde (1)	Moanza (3)	Kongolo (2)
Drodro (2)		Kaniama (2)
Yakusu (2)		Kapanga (2)
Nebobongo (3)	<u>Kivu</u>	Kamina (3)
Rethy (3)	Oicha (1)	Pweto (3)
Dungu (3)	Katwa (2)	
	Musienene (2)	
<u>Kasai-Occidental</u>	Rutshuru (2)	<u>Kasai-Oriental</u>
Kalonda (1)	Rwanguba (2)	Bibanga (1)
Tshikaji (1)	Kirotshe (2)	Wembo-Nyama (1)
Bulape (2)	Kaziba (2)	Kole (2)
Mushenge (2)	Uvira (2)	Lubao (2)
	Nundu (2)	Kabinda (3)
	Lemera (3).	

- (1) = Phase I  
 (2) = Phase II  
 (3) = Phase III.

a RHZ are noted by a following parentheses indicating whether they are part of Phase 1, 2, or 3. See Appendix 1 for a detailed breakdown of project hospitals by population, number of health centers required and affiliation of RHZ management. The regional distribution of project RHZs is shown in Figure 2.

### C. Project Resources

SANRU depends on USAID, GOZ, Peace Corps and RHZs for project resources. USAID assistance is for procurement of materials and technical services from abroad. The GOZ contribution is in counterpart funds to support in-country costs and in-kind contribution of personnel working in RHZs. Peace Corps contributes 540 man-months in-kind contribution represented by PCVs attached to RHZs. The contribution of the RHZ itself (in this case principally communities of the ECZ) is provision of salaries for their national and non-national health personnel plus in-kind labor and materials for local activities. The estimated dollar value for each of these contributions is shown below:

Table 6.

<u>Source</u>	<u>SANRU Proposed Budget Dollar Equivalent</u>	<u>Type of Assistance</u>
USAID	4.864.000	Vehicles, equipment, technicians.
MOH/GOZ	2.324.000	Training materials, transport, operating costs.
ECZ	2.795.000	Salaries of personnel of RHZ
Peace Corps	350.000	540 man-months PC volunteers.

The SANRU project was designed to concentrate its assistance at the level of health centers. Basic medical equipment can be made available to transform an empty dispensary into a functioning health center. It was also planned that an initial stock of 20 basic medicines be supplied to each health center sufficient for at least six months. Each health center was also to be supplied with two bicycles and sets of health educational materials.

Assistance to the reference hospital is limited to creation of the central office of the RHZ primarily in the form of office equipment such as typewriter, duplicating machine, projector and calculators. Motorcycles and 4 wheel drive trucks along with a subsidy for mileage costs (decreasing over a period of 3 years) are provided for supervision of health centers.

ZONES DE SANTE RURALES ASSISTEES PAR SANRU  
 RURAL HEALTH ZONES ASSISTED BY SANRU




 Projet des Soins  
 de Sante Primaires  
 en Milieu Rural  
 SANRU 85



SANRU is not involved at this time in major construction or renovation projects. Some funds are available for class room renovation and construction materials (ciment, plastic pipe) for spring capping activities.

Financial assistance is available for training programs. SANRU policy is that 30-50 % of training costs be supported by local contribution, particularly for participant travel, lodging and salaries of local trainers. SANRU support is primarily for teaching materials/supplies, food, and transport/per diem of trainers requested from neighboring health zones.

A resumé of ressources provided by the project is shown below:

Table 7.

Ressources Available to RHZs through SANRU

Construction/Rehabilitation:

- limited funds for rehabilitation of central office and classrooms
- construction materials for spring capping.

Basic Equipment and Medicines:

- office equipment - duplicating machine, typewriter, calculators
- basic medical equipment for health centers
- initial stock 20 basic medicines for health center
- midwifery kit for traditional birth attendants.

Training Programs and Materials:

- reference library for health zone and health centers
- training of doctors, administrators, supervisors (at regional and national level)
- training of nurses in PHC (funds to support local training)
- training of VHW (funds to support local training)
- upgrading work of TBAs (funds to support local training)
- health education materials for all of above
- diversés publications of recent PHC information.

Supervision:

- 4 wheel drive vehicule
- 2 motocyles - Yamaha 175
- 2 bicycles per health center
- subsidy for supervision costs (decreasing over period of 3 years).

### III. PROJECT ACTIVITIES - SANRU/KIN.

#### A. Personnel.

The SANRU project is administered on behalf of the GOZ/MOH and USAID by the medical office of ECZ. The choice of a non-governmental office to administer a bilateral governmental project underlines the important role that NGOs play in delivery of health services throughout Zaire and recognizes their keen interest in primary health care.

SANRU activities are coordinated out of project offices in the ECZ building. The administrative staff is listed below:

Table 8.  
SANRU Administrative Personnel.

<u>Name</u>	<u>Title</u>	<u>Percent Time</u>
Cit. NLABA-NSONA	Project Director	half
Dr. MIATUDILA MALONGA	Representant of GOZ/MOH	half
Dr. FRANKLIN BAER	Project Manager	full
Rev. RALPH GALLOWAY	Planning Coordinator	full
Mme. FLORENCE GALLOWAY	Training Coordinator	full
Cit. BAKAJIKA MAKASA	Assistant Administrator	full
Cit. DIANZOLA LUFWAKASI	Secretary	full
Cit. NLABA MAMBU	Logistics Coordinator	full.

#### B. Consultants.

The small SANRU staff is supplemented by the use of part-time consultants hired locally by the project or provided by centrally funded projects. Table 9 lists the consultants who have made invaluable contributions to the project to date particularly in the areas of training and development of project strategies.

Table 9  
SANRU Consultants

<u>Name</u>	<u>Organization</u>	<u>Function</u>
Cit. Kalonji Nsenga	CIDEP Hydrologie	Trainer-spring capping
Cit. Kalala Muamba	CIDEP Hydrologie	Hydrological Map of Zaire
Cit. Sowa	Hydraulique Rural	Trainer for rehabilitation of wells.
Mr. David Goff	WASH	Trainer-spring capping
Mr. David Yohalem	WASH	Trainer-rainwater harvesting
Mr. Tin Sy Nguyen	WASH	Trainer-rainwater harvesting
Mme. Jocelyn Carlson	WASH	Trainer-training of trainers
Mr. Craig Hafner	WASH	Advisor-planning water programs
Mme. Gilberte Vansin-tejan.	ACNM	Trainer-training of TBA trainers
Cit. Itoko Y'Oluki	ZSR Kasangulu	Trainer-spring capping
Dr. Kidinda Shandungu	IPN	Trainer-communications, Printer of "Santé Rurale"
Dr. Kashala Tumba D.	DSP/UNIKIN	Professor-planning
Dr. Lusamba Dikassa	UNIKIN	Professor statistics Co-investigator PRICOR.
Cit. Lukangu Batwache- ngame.	PRICOR	Research administrator
Cit. Munkatu Mpese	INS	Research associate PRICOR
Cit. Saidi Misangu	ISTM	Trainer/consultant-training nurse supervisors.
Cit. Bula Bula	ISTM	Trainer-management for doctors and supervisors
Mme. Bala Dossogne	ISTM/CTB	Trainer-statistics for supervi- sors. Consultant-MIS
Ms. Michele Fernan	JHPIEGO	Consultants/trainer-management of MCH programs
Ms. Margaret Parlato	PCS	Consultant-mass media
Ms. Joyce Holfeld	AVS	Consultant-VSC/OR Equip.
Mr. Beverly Ben Salem	AVS	Consultant-VSC/OR Equip.
Ms. Nadine Burton	FHI	Reporting system for TBAs
Dr. William Minkowski	INTRAH	Consultant-training of trainers
Mr. Michael Deming	INTRAH	Consultant-training of trainers
Ms. Wilson Melinda	PRICOR	Consultant-operations research
Dr. J.L. DeVries	PRICOR	Consultant-operations research
Miss Marty Pipp	PRICOR	Consultant-operations research
Dr. Luvivila Kapata	UNIKIN/5e Direction	Professor-epidemiology
Dr. Esakwa	UNIKIN	Professor-health education
Mr. Steve Brewster	Ex-PCV	Consultant-logistics coordinator for training stage
Mr. Barry Pollock	Ex-PCV	Trainer-trainers manual for spring capping
Mr. Randy Jacunski	Ex-PCV	Trainer-technical guide for spring capping
Dr. Stanley Yoder	Anthropologist	Consultant-comparative study of VHWs.
Mr. Mutombo Mpanya	PRICOR	Preparation of PRICOR draft proposal

### C. Collaboration with other Health Agencies.

Primary Health Care requires the integration of health care activities at the community level. Instead of a vertical approach where a specialized team passes from community to community for one activity (eg. vaccinations, sanitation) the polyvalent health team of the health center is responsible for coordinating all PHC activities within their radius of action. In the same fashion all PHC activities within a RHZ are coordinated by the staff of the central office of the RHZ. The medical director of the RHZ then has the task of maintaining contacts with national level programs and outside donor agencies which desire to promote/integrate their activities into the RHZ model.

SANRU as a horizontal national project has a significant role to play as a liaison between RHZs and various national/international health agencies. This role has been enhanced by USAID policy that any centrally funded projects working in Zaire must go through an existing bilateral project. Since SANRU is the principal USAID project concerned with PHC, much of the responsibility for relating to outside agencies has been delegated to SANRU.

SANRU has developed during the past two years a working relationship with many national and international health agencies. This relationship varies from a simple exchange of information and resource materials to the financing of supplementary projects to be administered by SANRU. Table 10 presents a summary of international agencies and how they relate to SANRU.

Coordination of health programs and agencies at the national level has become the responsibility of the 5ème Direction (Direction of Primary Health Care) within the MOH. Created in mid-1982 this administrative office led by Dr. Luvivila Kapata is struggling with the formidable tasks of donor coordination, uniformizing health care statistics, and updating the national - regional - RHZ hierarchy. SANRU sees the 5ème Direction as its counterpart with whom to work in setting up a long term capability at the national level for centralizing PHC information and maintaining supervision of RHZs. Table 10 lists the various health organizations/programs with whom SANRU relates at the national level. All of these have representation on the advisory committee of the SANRU project.

## International Agencies/Projects Collaborating with SANRU.

Agency	Type of Collaboration
Johns Hopkins Program for International Education in Gynecology and Obstetrics. (JHPIEGO)	<ul style="list-style-type: none"> <li>- short term training abroad for doctors and nurses in family planning and laparoscopy.</li> <li>- funding of \$96,000 for short term in-country training of 120 participants in management of maternal child health projects.</li> </ul>
Primary Health Care Operations Research (PRICOR)	<ul style="list-style-type: none"> <li>- funding of \$143,000 for a 2 year operations research project in 6 RHZs to study financing mechanisms of rural health centers.</li> </ul>
Water and Sanitation for Health Project (WASH)	<ul style="list-style-type: none"> <li>- supply technical consultants for training of trainers, spring capping and rainwater harvesting workshops.</li> <li>- furnished shallow well pumps for field testing in Zaire.</li> </ul>
American College of Nurse-Midwives (ACNM)	<ul style="list-style-type: none"> <li>- furnished consultant Gilbert Vansintejan who has made 3 trips to Zaire to initiate training of trainers of TBA program.</li> </ul>
International Project/Association for Voluntary Sterilization, INC (IPAVS)	<ul style="list-style-type: none"> <li>- supplied operating room equipment to upgrade care in 15 hospitals to facilitate emergency operations and voluntary surgical contraception.</li> </ul>
Organization for Rehabilitation and Training (ORT)	<ul style="list-style-type: none"> <li>- funded \$1,700,000 project through ECZ as a parallel to SANRU to set up 200 supplementary health centers.</li> </ul>
Population Communication Services (PCS)	<ul style="list-style-type: none"> <li>- funding printing of family planning flipcharts for RHZs and health centers.</li> <li>- furnish consultants for developing and pretesting family planning media messages.</li> </ul>
Oxford Famine Relief (OXFAM)	<ul style="list-style-type: none"> <li>- cofinancing of a flipchart for "hygiene and water".</li> <li>- cofunding projects activities within same RHZs.</li> </ul>
Program for International Training in Health (INTRAH)	<ul style="list-style-type: none"> <li>- furnished training materials and books for reference library of RHZs.</li> </ul>
Teaching Aids at Low Cost (TALC)	<ul style="list-style-type: none"> <li>- able to supply (at cost) teaching materials for RHZs: color slides, flannographs, books.</li> </ul>
World Neighbors	<ul style="list-style-type: none"> <li>- able to supply (at cost) slide/filmstrip projectors, teaching filmstrips and flipcharts.</li> </ul>
United Nations Children's Fund (UNICEF)	<ul style="list-style-type: none"> <li>- cofinancing of health conferences and water development activities.</li> </ul>
American Public Health Association (APHA)	<ul style="list-style-type: none"> <li>- supplies "Salubritas" and "Mother &amp; child" newsletters on regular basis.</li> </ul>
Christian Medical Commission (CMC)	<ul style="list-style-type: none"> <li>- supplies "Contact" magazine on a regular basis</li> <li>- interest in promotion of an ONG non-profit organization to procure and distribute basic medicines.</li> </ul>
Hans Seidel	<ul style="list-style-type: none"> <li>- joint activities in RHZs in northern Equator region.</li> </ul>
Family Planning International Assistance (FPIA).	<ul style="list-style-type: none"> <li>- supplies family planning educational materials and equipment for RHZs.</li> </ul>
Pan African Institute of Development (PAID)	<ul style="list-style-type: none"> <li>- interested in development of training of health trainers program in Cameroun and Zaire.</li> </ul>
World Health Organization (WHO)	<ul style="list-style-type: none"> <li>- supplies reference materials for all components of PHC.</li> </ul>
Family Health International (FHI)	<ul style="list-style-type: none"> <li>- interested in evaluation of TBA programs</li> <li>- supplies reference texts for family planning.</li> </ul>
The Rockefeller Foundation	<ul style="list-style-type: none"> <li>- furnished books for reference library of RHZs.</li> </ul>
The Pathfinder Fund	<ul style="list-style-type: none"> <li>- furnished books for reference library of RHZs.</li> </ul>

Table 11:

Health Organizations/Programs represented on SANRU  
Advisory Committee.

BNT	: Bureau National de la Tuberculose
BOMS	: Bureau des Oeuvres Médicales Catholiques
BOMK	: Bureau des Oeuvres Médicales Kimbanguistes
CEPAS	: Centre d'Etudes de Promotion et d'Action Sociale
CEPLANUT	: Centre National de Planification de Nutrition Humaine
CNND	: Comité National de Naissances Désirables
GTC	: Groupe Technique Central
PEV/CCCD	: Programme Elargi de Vaccination/Combating Childhood Communicable Diseases
OXFAM	: Oxford Famine Relief
Peace Corps	
FOMETRO	: Fonds Médical Tropical
UNICEF	: United Nations Children's Emergency Fund
WHO	: World Health Organization
USAID	: United States Agency for International Development
UNIKIN	: Université de Kinshasa
5ème Direction	: Direction des Soins de Santé Primaires.

#### D. Donor Coordination.

There does not exist a national "formalized" coordination of donor agencies/projects working in the area of Primary Health Care. Since Alma-Ata 1978 there has been an increasing interest on the part of religious organizations, non-governmental development agencies, bilateral donors and multi-lateral groups to increase funding for Primary Health Care. The result has been an explosion of financing for PHC at all levels and in terms of equipment, training, construction, medicines, supervision, and salaries.

The development of the health zone concept should play an important role in defining the type of assistance required from donor agencies and to standardize as much as possible the approaches/techniques to implement PHC programs.

Coordination of donor agencies has been left to the RHZs who request assistance directly from any agency of their choice. A basic principal should be that all donor assistance be coordinated by the central office of the RHZ. No outside group should be funding PHC programs within a RHZ without approval of the Medical Director of that RHZ.

At the same time the various donor agencies need to be aware of what other groups are doing in order to avoid duplication of efforts and to develop complementary donor assistance. A first step should be to identify the types of assistance provided by each donor agency and the regions of Zaire where they are concentrating their work. This is being done to some extent at the project level with the creation of advisory committees with representatives from donor agencies. Table 12 presents a very limited analysis of donor agencies financing PHC activities in Zaire, but may serve as a basis for initiating increased donor coordination.

#### E. SANRU Activities in Promoting PHC.

As a horizontal PHC project SANRU activities encompass many diverse activities. In an effort to give a flavor of the wide scope of the project, Table 13 summarizes for each component of PHC some of the specific activities accomplishments of the SANRU/Kin office.

Table 12  
Primary Health Care Donor Agencies

Name	Type of Assistance						Region of Zaire
	Const	Equip	Train	Salar	Meds.	Sup.	
WV- World Vision		x	x	x		x	BZ, Kivu
TH- Terre des Hommes				x			Kivu
UNICEF- United Nations Children's Fund		x	x		x	x	KOr, Kivu, BZ
APD- Amis du Père Damiens		x	x				HZ, Shaba
OXFAM- Oxford Committee for Famine Relief		x	x		x	x	BAN, KOc, KOr
CIDA- Canadian Inter Develop. Agency							Kivu, BAN
SIDA- Swedish Inter Develop. Agency							BZ, BAN
CTB- Technical Cooperants of Belgium		x	x	x	x	x	All regions
HS- Hans Seidel	x	x	x	x	x	x	North Equateur
SIMAVI	x						BAN
YOUNG- Young. Foundation		x					Kivu
PEV- Programme Elargi de Vaccination		x	x	x			All regions
ICCO- Interchurch Coordination Committee for Development Projects.	x	x	x	x	x	x	All regions
CBM- Christoffel Blinden Mission							
MBF- Medical Benevolence Foundation	x	x			x	x	KOc, KOr
HCR- High Commiss. of Refugees		x			x	x	BZ, HZ, Shaba
EZE- Protestant Organization for Development Aids.		x			x	x	
GTZ- German Coop. Tech.	x	x	x	x	x	x	BAN



HEALTH EDUCATION:

- distribute flipcharts for TBC, Malaria, Worms, Nutrition, Alcoholism, Family Planning.
- distribute flipcharts for growth chart and nutrition
- distribute tapes of public health songs
- record radio program explaining PHC
- distribute reference books for health education methods
- distribute slide/filmstrip projectors
- development of flipchart for hygiene and water.

PROMOTION OF NUTRITION AND AGRICULTURE:

- collaboration with CEPLANUT
- presentation of paper "Role of Nutrition in PHC"
- distribute nutrition flipcharts and flipcharts
- published programmed text "Manger Bien"
- printed nutrition course in "Mashi" for VHWS.

UNDER-FIVES CONSULTATION:

- distributed 198,000 Road to Health Charts
- distribute flipchart for Road to Health Chart
- distributed 410 baby scales to rural health centers
- distributed text "Enfant et Santé" to all health centers
- participated in national conference to uniformize growth charts.

PRENATAL CONSULTATION:

- distribute text "Maternité et Santé" to all health centers
- distribute instruments for CPN consultation
- distribute health education materials appropriate for CPN.

MATERNITY SERVICES:

- 3 training of trainers of TBAs - Karawa, Vanga, Nyankunde
- developed manual for training of TBAs
- provided OB kits to health centers with maternities.

FAMILY PLANNING:

- printed 25000 posters on 5 FP themes
- distributed FP commodities - pills, condoms, IUDs, foam
- participated in study group to develop FP mass media
- 2 seminars in Reproductive Health - Kaziba, Kimpese organized with JHPIEGO
- collaborate with CNND in monitoring family planning activities.

VACCINATIONS:

- distributed 450 bicycles to facilitate vaccine transport
- distributed 5 kerosene/12 v refrigerators
- required health officers of RHZs to participate in PEV training seminars.

CONTROL OF ENDEMIC DISEASES:

- promote subscription to "Diarrhea Dialogue"
- distribute health education materials for combatting diarrhea
- promotion of village sanitation to improve water quality
- collaboration with national office of tuberculosis in drafting national strategy for TB control.

WATER & SANITATION:

- financing tools, cement, pipe for spring capping
- development/printing of technical guide and training guide for spring capping
- development of Hydrological Water Resources Planning Map
- WASH workshop for rainwater harvesting & wells rehabilitation
- organized "Voix du Zaïre" radio broadcast series concerning water and sanitation from a village in ZSR Kasangulu.

BASIC CURATIVE CARE:

- distribute text "Treatment Strategies" to all health centers
- equipped health centers with basic curative equipment
- distributed AVS operating room equipment.

PROVISION OF ESSENTIAL SUPPLIES:

- participation in "Comité Pharmaceutique National" to plan system for drug procurement and distribution
- study to identify what essential drugs are available for local purchase.

SUPERVISION OF SERVICES:

- distributed 18 "Chevy" vehicles for supervision of RHZ
- distributed 85 motorcycles Yamaha 175 for supervision of RHZ
- participated in sub-committee for development of a national policy for supervision of Health Zones
- assisted Seme Direction in development of a uniform statistical reporting system for PHC
- published "Santé Rurale" journal

TRAINING/CONTINUING EDUCATION:

- translated/published Werners "How to Plan a Training Program"
- held national health conference for 85 participants on "Qui se Forme Forme"
- organized with JHPIEGO five regional training sessions for management of

#### IV. PROJECT MONITORING AND EVALUATION

##### A. Evaluation Strategies

The measure of success of a Primary Health Care project should be a reduction of disease incidence and prevalence. That is to say that the program has a positive impact on improving the health status of the population. Measurement of project impact is very difficult due to the time required (years) to see results, the complexity of intervening variables and extreme cost (perhaps as much as the interventions themselves). The SANRU project design did not emphasize impact measurement but rather the creation of a PHC service delivery system (Rural Health Zone) capable of intervening in the control of major disease syndromes. The assumption is made, based on experience of previous PHC projects, that these interventions will have a positive impact on health.

Acceptable alternative measures to impact, are monitoring of PHC coverage and accessibility. Accessibility is defined as the percent of the target population residing in a RHZ that has easy access to PHC services. One could determine for example the percent of pregnant women living within access of regular prenatal consultation.

Coverage goes one step further to specify the percent of the target population having access to PHC which actually participates in those activities. For example, given a total population of 5,000 people (and approx. 250 pregnant women per year) within access of a health center promoting prenatal care, the measure of coverage would be the percent of pregnant women who are registered and attend prenatal clinics. The calculation of coverage requires a fraction - a numerator, health center records showing number of persons participating; and a denominator, the total number of pregnant women residing in the target area.

Establishing a uniform record keeping system with registers and monthly reports can determine the numbers of persons participating in activities. The size of the target population should eventually be determined by a house-to-house census, but an acceptable alternative is to estimate the size of a village by counting the number of occupied houses and then multiplying by the average number of persons per household (this varies from 5-7 by region but is constant within any one RHZ). Knowing the total population

living around a health center permits calculation of the size of target groups such as pregnant women (eg. apprx. 50 pregnant women/year per 1,000 inhabitants).

Measures of accessibility and coverage are useful tools in monitoring PHC projects but necessitate a uniform statistical reporting system to assure that everyone calculates the same way. Such a system did not exist in Zaire at the time of SANRU project design and thus detailed measures of accessibility and coverage were not included. However the project objective to establish 250 functioning health centers indicates that a major project objective is that the inhabitants living in the radius of action of those centers (apprx. 1,250,000 total) have access to PHC activities.

The measurement of "outputs" as included in the SANRU project design stresses a quantification of infrastructure to be established in setting up the health zone, training of personnel, and creation of a Management Information System. SANRU project objectives are listed in Table 14.

Table 14.  
SANRU Project Objectives

1) Training:

- 1500 Village Health Workers (VHWs)
- 400 Traditional Birth Attendants (TBAs)
- 750 Nurses
- 3000 Development Committees
- 50 Supervisors
- 50 Administrator/Doctors (short-term)
- 30 Adm/MDs (long term MPH)

2) Infrastructure:

- 50 Rural Health Zones functioning
- 250 Health Centers functioning
- 25000 Latrines built
- 1500 Springs capped
- 500 Wells dug/rehabilitated
- 1000 Vaccination programs established
- 1000 Propharmacies established
- 20 Laparoscopes installed
- 12 Classroom built/rehabilitated
- 150000 Family Planning acceptors.

3) Management Information System

- Uniform reporting of PHC statistics
- Annual health conferences
- Distribution of PHC information
- Ongoing supervision of RHZs.

The project design does not specify benchmarks for monitoring of the project objectives, however a straightforward mechanism to permit this can be based on a calculation of "RHZ project-months". The idea is to calculate for the 50 participating RHZs the total number of active months of expected participation. This calculation is shown in the following table based on a calendar year where a phase I hospital participates 5 years (82-86), a phase II hospital 4 years (83-86) and a phase III hospital 3 years (84-86).

Table 15.  
Calculation of RHZ-Project-Months

Phase	Dates of active participation	Project Months/ RHZ	Number of RHZs	Total RHZ months 82-86	Current RHZ months 82-83
I	1982 - 1986	60	15	900	360
II	1983 - 1986	48	21	1008	252
III	1984 - 1986	36	14	504	0
				<u>2412</u>	<u>612</u> 25%

This calculation demonstrates that through Dec. 1983 the project has completed 612 active RHZ project months out of a possible total of 2412 months to be accumulated by the end of 1986. This indicates that 25% (612/2412) of project outputs should have already been accomplished. Clearly this is a rough estimate since some activities will have a faster (or slower) start-up times. For instance it is logical to expect that training of nurses should proceed more quickly than training of VHWs or the number of family planning acceptors since the nurses play a major role in promoting the subsequent PHC activities of a health center.

The present report uses this 25% benchmark as a measure of progress in attaining SANRU project objectives. It is recommended, however, that additional measures of accessibility and coverage be included in future project monitoring as viable indicators can be developed as part of the national Information System.

## B. Current Status in Achievement of Project Objectives.

Annual reports are requested from each RHZ to evaluate measures of accessibility, coverage, and progress in achievement of SANRU project objectives.

Table 16 presents the current status of project activities collectively for the 15 Phase I RHZs for 1982-1983 and 21 Phase II RHZs for 1983. The subsequent section then explains each objective individually detailing:

- Life of Project (LOP) Objective
- Strategy for objective attainment
- Current Status in achievement of LOP objective
- Constraints encountered
- Recommendations for future action.

Table 16  
Current Status of SANRU Project Objectives

<u>Project Objective</u>	<u>Anticipated over LOP.</u>	<u>1982-1983 Output.</u>	<u>% of LOP Objective</u>
Village Health Workers	1,500	528	35%
Traditional Birth Attendants	400	127	32%
Village Development Committees	3,000	802	27%
Nurses	750	428	57%
Supervisors	50	19	38%
MD/Admin.	50	33	66%
M.P.H.	30	4	13%
Rural Health Zones	50	36	72%
Health Centers	250	85	34%
Latrines	25,000	52,000	200 + %
Spring Capping	1,500	325	22%
Wells	500	5	1%
Vaccination Program	1,000	381	38%
Propharmacies	1,000	155	16%
Family Planning Acceptors	150,000	15,200	10%
Laparocator/Minilap	20	11	55%
Classrooms	12	3	25%
Health Information System	-	-	-

OBJECTIVE: 1,500 VILLAGE HEALTH WORKERS TRAINED.

STRATEGY: Long term improvements in health require special efforts in PHC promotion at the community level. While the village development committee is the focus for discussion and planning of the PHC program there is a need for responsible individuals to promote certain activities within the community such as:

- assist at under-fives clinics
- supervise latrine and water source construction
- follow-up on special feeding for malnourished children
- diagnose and treat select diseases.

Some of these activities require specialized training while others are a matter of identifying someone willing to volunteer time. The approaches to training VHWs vary from having the development committee members collectively performing functions of a VHW to identifying and training one person to perform multiple tasks. In general the more tasks one person performs the more percent of his time is spent in PHC activities and the more reason for the VHW to request compensation for his services. SANRU policy is that VHWs should work as volunteers and that any compensation should come from the community and not the health center or RHZ.

CURRENT STATUS:

528 VHWs have been trained during 1982-1983. This represents 35% of the LOP objective. About one-half of RHZs opt for training of VHWs. SANRU funded a comparative study by a medical anthropologist of the training and status of VHWs in five RHZs which has been helpful to document the different types of VHWs which are in existence.

CONSTRAINTS:

- 1) Compensation and motivation of VHWs is always a problem and has been discussed above.
- 2) There is divided opinion as to whether VHWs should be authorized to maintain a village pharmacy and to treat for select common diseases. Some feel that long distances between village and health center justify this approach while others fear that the VHW will develop a private dispensary (see objective pro-pharmacies for further discussion).
- 3) The training of VHWs is developed at the RHZ level often by non-professionals. As a result the training often has a heavy medical orientation and does not conform to current principles of adult education.

RECOMMENDATIONS:

- 1) SANRU supports the idea that the tasks performed by a VHW should be defined by the community and RHZ. Zaire is too vast to have a national standardized profile for VHW.
- 2) SANRU feels that more assistance is required by RHZs in training VHWs. It is proposed that national and regional training of trainees courses be developed to assist RHZ in developing VHW training programs. At the same time a trainers manual should be developed which would show trainers how to go about teaching each VHW task.

OBJECTIVE: TRAINING OF 400 TRADITIONAL BIRTH ATTENDANTS.

STRATEGY: The vast majority of children are delivered at home usually in the presence of a traditional birth attendant. In most regions of Zaire it is impractical to expect that health centers with upgraded maternities will decrease drastically the percent of home deliveries. The emphasis should rather be on identification of high risk pregnant women to be delivered at the maternity while upgrading the techniques of TBAs to improve home deliveries.

Official training programs for TBAs are not sanctioned by the MOH. However, TBAs can practice freely as traditional practitioners. SANRU strategy is to upgrade the skills of TBA to recognize and refer high risk cases to the maternity and to provide safer home deliveries. TBAs can also be trained as health educators and as promoters of family planning.

SANRU organizes regional training of trainers seminars in conjunction with ACNM, finances local training of TBAs, and provides TBA midwife kits.

CURRENT STATUS:

Three regional training of trainer sessions have been held at Karawa, Nyankunde and Vanga with a total of 54 midwife participants. Subsequently 127 TBAs have been trained to date. This represents 32% of the LOP objective.

CONSTRAINTS:

1) Effective supervision of TBAs should be from the health center preferably by a nurse midwife working out of a maternity. The fact that most health zones are just now setting up health centers and that most health centers do not yet have nurse midwives explains why many RHZs have not begun full scale TBA training programs.

2) Some RHZs are not interested in training of TBAs at this time either because they are not yet convinced of their effectiveness or are not willing to accept the responsibility of supervising the work of TBAs at the village level.

3) A3 level nursing schools which have traditionally trained nurse midwives are being replaced by A2 level schools forming polyvalent nurses. This is resulting in a shortage of A3 level nurse midwives to staff health center maternities and who would in turn supervise village-based TBAs.

RECOMMENDATIONS:

1) SANRU should continue regional training and monitoring of TBA activities in collaboration with ACNM

2) SANRU should encourage RHZs to attempt pilot training of several TBAs to evaluate their potential effectiveness and establish a training potential for a subsequent full-scale training program.

3) Alternative approaches should be explored by RHZs who are hesitant to supervise village-based TBAs. One possibility is that TBAs be assigned to a health center either as a paid health auxiliary or as a private practitioner.

4) SANRU recommends that RHZs who have a shortage of nurse midwives set up a local training "stage" of approx. one year duration to train general nurses in midwifery.



OBJECTIVE: TRAINING OF 750 NURSES IN PRIMARY HEALTH CARE.

STRATEGY: Traditionally nurses received little public health orientation as part of their formal training process. A "recyclage" of nurses is therefore required before they work in a health center to teach them how to organize and direct PHC programs. This training must include not only the technical aspects of PHC (eg how to weigh and chart weight of a child) but also the administrative aspects (eg reporting systems and RHZ policies).

CURRENT STATUS:

Recyclage of nurses is done by the RHZ staff. While no standard curriculum exists, SANRU recommends the text "Comment Bâtir la Santé" and has distributed 1400 copies to date. RHZs generally develop additional materials as documentation for treatment strategies and administrative guidelines.

To date 372 nurses have been trained in PHC. This represents 50% of the LOP objective. It is of interest to note that SANRU objectives of 750 nurses and 250 health centers will result in three nurses for every health center. Actually most health centers are staffed by usually one, at most two nurses. The extra nurses who are being trained are those working at dispensaries which have not yet arrived at the health center status or at the reference hospital. This "surplus" training is important in order that the PHC mentality permeates all levels of the health system and that a reserve of trained nurses is available to step in to assist at the health center level.

CONSTRAINTS:

- 1) MOH emphasis on A2 (4 year) rather than A3 (2-3 year) nurse training programs will result in a lack of nurses willing to work in rural conditions.
- 2) Newly created RHZs often lack the capacity for training health personnel.
- 3) Training of nurses is seen by some as a one-shot input rather than as continuing education.

RECOMMENDATIONS:

- 1) The SANRU objective of training 750 nurses is reasonable and should be maintained. If the number of health centers to be created is increased (as in ECZORT supplemental assistance for 200 health centers) the numbers of nurses trained should be increased in a proportion of 2:1 (eg 400 nurses for 200 health centers).
- 2) There should be at the national level a recognized agency responsible for each component of PHC to establish technical guidelines, standards of care, and curriculum materials for training nurses. This is being done now by PEV and BNT and to a lesser extent by CEPLANUT and CNMD. These groups should work through horizontal projects like SANRU or with the RHZ director to integrate their PHC component into the local training of nurses.
- 3) RHZs lacking capacity for training their own personnel should link up with a neighboring "model" RHZ to either send them nurses for training or invite trainers from other RHZ to assist in giving sessions.
- 4) RHZs should be encouraged to establish training "stages" for A3 hospitalier nurses (graduating from a 2 year program) to give them specialized training in midwifery and public health. Such training could be decreased only when it is demonstrated that 4 year A2 nurses accept to work at the health center level.
- 5) Continuing education of nurses should be scheduled annually with a minimum of one week continuous or sequential training.

OBJECTIVE: 3000 ACTIVE VILLAGE HEALTH (DEVELOPMENT) COMMITTEES FORMED AND FUNCTIONING.

STRATEGY: The success of the primary health care approach depends on villagers taking responsibility for their own health and improving health habits. "Conscious-raising" at the community level is an essential element to assure community support in establishing health centers, participation in PHC activities, and effective health education programs. The village development committee is the central focus for PHC within the community (Note: The term "development committee" rather than "health committee" was adopted at the 1983 SANRU national health conference to assure an integrated development approach). The members of the development committee are responsible for discussing health problems, as well as proposing and carrying through with PHC interventions. The village development committee plays a major role in promoting health education, supervising the village sanitation program, and assuring participation in PHC activities (CPS, CPM, PEV, END, etc.).

CURRENT STATUS:

To date 920 active village development committees have been formed. This represents 31% of the LOP objective. Each committee has an average of 6-8 members usually with a mixed representation of men, women, pastors, teachers, etc. SANRU finances weekend seminars organized by the RHZ for committee members and supplies health education materials for use within the community. SANRU recognizes that motivation of committee members is important. To this effort SANRU has designed and printed 22,000 cloth badges "Santé Pour Tous - Comité du Développement" for distribution to committee members.

(Note: SANRU has also designed and printed 3,200 cloth banners "Santé Pour Tous Au Zaïre" to be presented to village development committees once their village has successfully completed their sanitation program (latrines, water source, and general village cleanliness).

CONSTRAINTS:

- 1) Sustained motivation of village development committees is difficult because of demands by members to be paid salaries or some form of compensation for their work. Motivation is also hampered if nurses do not make regular visits to meet with the development committee.
- 2) Some RHZ directors do not place much importance on the role of the village development committees. They relegate them to carrying out directive/policies of the central office of the RHZ rather than being the focus of initiating PHC at the community level.

RECOMMENDATIONS:

- 1) The goal of 3000 development committees is reasonable and should be maintained.
  - 2) Members of village development committees must accept to serve as volunteers. Their "compensation" should not be in the form of any special favors (such as free medical treatment) but rather in an increased status and respect within their community. RHZ personnel should experiment with innovative methods for sustaining motivation such as health committee badges or ID cards, weekend seminars, annual fetes, and health education materials.
- RHZ staff should spend more time nurturing VDCs. While it is tempting to set up a PHC delivery service with only token approval of communities, the long term sustainability and community participation will depend on the effort placed on village development committees.

OBJECTIVE: IN-COUNTRY SHORT-TERM TRAINING FOR 50 MEDICAL DOCTORS AND 50 HEALTH ZONE SUPERVISORS.

STRATEGY: Formal training of medical doctors and nurses is traditionally weak in management and health planning skills. As the medical director of the RHZ and nurse supervisor have heavy responsibilities in both areas, it was decided to organize in-country training activities in collaboration with UNIKIN's (University of Kinshasa) department of Public Health. This training is seen as supplementary to the three-week modular training organized by PEV/CCCD which gives a broader and more general focus to preparation of a health zone project paper. Topics covered at UNIKIN included epidemiology, biostatistics, health planning, management, and health communications.

The UNIKIN training sessions were also useful in testing the interest and feasibility of creating a graduate-level training curriculum in public health at UNIKIN to become eventually a national school of public health.

CURRENT STATUS:

Two 4-week national training sessions were held at UNIKIN in July 1982 and 1983. A total of 33 medical doctors and administrators and 19 nurse supervisors were trained under this program. This represents respectively 66% and 38% of the LOP objective. Coursework was given by UNIKIN faculty supplemented by SANRU staff and short-term local consultants.

All activities including lodging of participants took place at UNIKIN. A great deal of effort went into rehabilitation of the Department of Public Health/UNIKIN classrooms and lodging facilities at the nearby nursing school to accommodate these courses. These renovation costs were justified by the fact that no rental for classrooms or rooms was charged to SANRU, and resulted in a significant upgrading of facilities and morale of the UNIKIN staff.

CONSTRAINTS:

- 1) Training at the national level is more expensive than local or regional training due to the high costs of transportation, food and lodging.
- 2) In 1982 doctors and nurses were "team trained" simultaneously. While the concept was appreciated it was felt that there is justification for a separate course focused on needs of the supervisor.
- 3) Continuing education for medical directors of RHZs should be organized at the regional or sub-regional level in order to accommodate all RHZs rather than those assisted by SANRU.

RECOMMENDATIONS:

- 1) Future short-term training courses at UNIKIN should be organized as part of the School of Public Health project (660-101) rather than the SANRU project. Needs are for long-term (12 month) training of medical doctors/administrators in public health and short-term (2-3 month) training for supervisors in management training of trainer skills.
- 2) SANRU should concentrate on organization of regional level training seminars (1-3 weeks) as a continuing education for select components of PHC. For example JHPIEGO has funded 5 regional conferences for 1984-1985 for Reproductive Health update in management of MCH programs.
- 3) SANRU should be supportive of co-financing regional and sub-regional planning conferences organized by the MOH Direction of PHC and regional medical authorities. This has been done in several regions with excellent success in defining RHZ boundaries and uniformizing administration of PHC activities.

OBJECTIVE: 30 DOCTORS/ADMINISTRATORS WITH LONG-TERM TRAINING IN PUBLIC HEALTH.

STRATEGY: There is a critical lack of trained manpower in Zaire for PHC administration. While approx. 100 competent medical doctors graduate from UNIKIN each year (many of which are assigned to bush hospitals) their training in public health and management skills is inadequate for direction of a RHZ. SANRU will train 30 doctors and administrators at the graduate level (MPH) in PHC administration to permit continuity of RHZs.

SANRU strategy in meeting this objective is to make limited use of out-of-country training programs while promoting the creation of LT in-country graduate training in public health.

CURRENT STATUS:

Four medical doctors are currently in training at Tulane University. This represents 13% of the LOP objective. Five more have been identified to begin training in 1984.

CONSTRAINTS:

- 1) LT abroad was not possible in 1982-1983 because of the Brooke amendment which prevented SANRU from initiating dollar funded training activities.
- 2) USAID preference has been to send candidates to the US for training rather than francophone Africa or Europe (Antwerp). It is difficult to find candidates with sufficient English skills who can complete an MPH program in 12 months. As a result LT MPH training in the US usually requires 18 months.
- 3) Zairian physicians play a key role in organization of a RHZ, often without much backup staff. It is difficult to identify RHZs with sufficient depth of personnel where the program will not collapse when the doctor is sent abroad for LT training.
- 4) LT training abroad is generally not oriented to the needs and problems of working in Zaire.

RECOMMENDATIONS:

- 1) The objective of training 30 persons at the MPH level by September 1986 is desirable but unrealistic. It is recommended that this project objective be maintained during an extension of the SANRU project, eg training 30 persons through 1988. Should the SANRU project be terminated in 1986 this training objective should be transferred to the SPH/UNIKIN project.
- 2) SANRU should continue out-of-country training in the US for candidates who can satisfy English requirements. SANRU recommends that candidates be sent to the US at least two full months before classes begin for concentrated English training and adaptation to the US environment.
- 3) Doctors who merit training but who can not meet English requirements should be sent to UNIKIN for the 12 month MPH program.
- 4) With the expected opening of the SPH at UNIKIN in October 1985 priority should be given to training candidates from SANRU supported RHZs.

OBJECTIVE: 50 RURAL HEALTH ZONES.

STRATEGY: The Five Year Health Plan of the MOH calls for creation of 120 RHZs by the end of 1986. SANRU is active in creation of 50 RHZs. The strategic steps involved in setting up a RHZ have been detailed in Table 4.

CURRENT STATUS:

During Phases I and II SANRU has helped set up 36 RHZs. While this represents 72% of the project objective, these zones are not fully functional. Current coverage ranges from 83% in the most advanced RHZs to less than 5% in some zones which began activities in 1983.

CONSTRAINTS:

1) The GOZ has not yet passed legislation to recognize the legal status of health zones. This means that the local authorities of the health zone have no real power to direct and coordinate PHC activities.

2) Some RHZs seek assistance from multiple donor agencies. While this seems desirable to assure adequate resources it creates problems in avoiding duplication of efforts.

3) RHZs generally feel that they can auto-finance PHC activities at the health center level. This includes salaries of health center personnel and restocking of medicines. It is a much greater problem for the central office of the RHZ to auto-finance its activities (salaries and supervision costs).

RECOMMENDATIONS:

1) USAID and its projects must pursue actively the passing of legislation recognizing the legal status of health zones. Since such legislation creates GOZ health zones managed officially in most cases by NGOs, it is essential that NGO representatives are involved in the elaboration and approval of this legislation.

2) Donor coordination is required to make best use of limited resources. This should be at a national planning level to identify spheres of influences throughout the country. At the local level this must involve a careful division of responsibilities between donor agencies assisting the same health zone.

3) The GOZ should provide annual subsidies to RHZs to assure adequate supervision of health centers and PHC work. It has been estimated that a annual subsidy based on Z 10 (\$.33) per inhabitant per year should be requested from the GOZ.

OBJECTIVE: TRANSFORMATION OF 250 DISPENSARIES INTO HEALTH CENTERS.

STRATEGY: Most regions of Zaire possess an existing infrastructure of rural dispensaries which are non-functioning or providing minimal curative services. To become functioning health centers these dispensaries requires rehabilitation of buildings, training of nurse and auxiliary workers, an initial one-year stock of basic medicines, medical equipment for PHC promotion, and local bicycle transport.

The majority of resources of the SANRU project are targeted at the health center level in an effort to increase accessibility to services and promote PHC activities at the community level.

CURRENT STATUS:

During 1982-1983 65 health centers were established with SANRU assistance. This represents 26% of the project objective. Most RHZs can be expected to open health centers at a rate of 2-3 per year. The transformation from dispensary to health center usually requires a period of several years before all PHC activities are fully integrated and become operational.

CONSTRAINTS:

1) The SANRU project resources for 250 health centers do not meet the actual need within 50 RHZs of 1,000 centers (20 centers/RHZ). The creation of 250 centers by 1986 could be expected to increase the accessibility to PHC services from 15% to 40%. Additional resources will be required to further promote PHC.

2) SANRU has received requests for assistance from some 100 rural hospitals wanting to establish RHZs, but can not respond even in part to such requests because of project limitation to work in 50 RHZs.

3) SANRU has had considerable difficulty in procurement of medical equipment and medicines. Delivery of medical equipment from the US often takes 18-24 months. The cost of an initial stock of basic medicines from the US is apprx. \$8,000-10,000 compared with the project budget of \$1,000 per health center.

RECOMMENDATIONS:

1) SANRU should work in collaboration with other agencies such as OXFAM, UNICEF, HANS-SEIDEL in creation of health centers within the same RHZ. Supplemental funding should be channeled through SAIIRU and/or ECZ (such as the ECZORT project) to increase their capacity to assist more health centers.

2) The number of RHZs to be assisted by SANRU should be increased from 50 to 86 beginning in the year 1986. This would extend the project through 1989 and permit addition of 12 RHZs per year. Supplemental funding for 36 RHZs and apprx 500 health centers should be provided as part of this project extension.

3) SANRU and/or ECZORT should provide immediate small grant assistance to select developing RHZs (not assisted formally by SANRU) to set up a pilot health center. This will permit RHZs to accelerate their planning and implementation of PHC activities. Eventually SANRU could select from these RHZs those to be assisted formally with major assistance in the 1986-1989 extension.

3) SANRU should continue purchase of medical equipment from the US using current supplies and/or private enterprise purchasing agents. SANRU should not purchase medicines from the US but obtain waivers for purchase from Europe and/or use counterpart funds to enable RHZs to purchase medicines locally through their existing suppliers.

OBJECTIVE: CONSTRUCTION OF 25,000 LATRINES.

STRATEGY: Many diseases are transmitted by the fecal-oral route. Construction and use of latrines is an important aspect of a village sanitation program. While the impact of latrines on health requires many years, a village sanitation program is an important accomplishment of the village development in demonstrating that they can improve their health conditions by their own local efforts.

Techniques for simple pit latrine construction are generally understood throughout Zaire. It is not a question of teaching people how to construct a latrine but why to construct. Improved latrine construction techniques such as a cement floor latrine, or a ventilated-improved-pit (VIP) latrine or a water flush latrine are not practical on a wide scale program (within 50 RHZs the actual need is approx 1,000,000 latrines!).

SANRU strategy is to encourage village development committees to establish a village sanitation program stressing latrine construction, improved water sources, and general village cleanliness. Motivation is provided by regular meetings with villagers, health education, mass worm treatments, and/or "Health for All" flags.

CURRENT STATUS:

It is estimated that 50,000+ latrines have been constructed since 1982. This represents 200+ % of the LOP objective. SANRU support for this program has been to provide demonstration models of latrine (post-hole) diggers to permit digging latrine pits from outside the hole, and in providing health banners to be presented to villages that successfully complete the sanitation program.

CONSTRAINTS:

Counting latrines can result into a meaningless numbers game. It is more important to count villages that have completed a village sanitation program since having 100 latrines in 1 village is more important than having 1 latrine in each of 100 villages.

RECOMMENDATIONS:

1) SANRU should abandon counting latrines as a measure of project success. This should be replaced by having RHZs report the number of villages which have successfully completed a village sanitation program where at least 90% of households have a usable latrine. A project objective of 1,000 villages successfully completing sanitation programs should be established (Note: This would be equivalent to approx. 100,000 latrines).

2) SANRU should encourage RHZs to experiment with VIP latrine construction techniques at the reference hospital and health centers. SANRU could provide commercial construction materials (cement, pipe, diggers) to encourage these demonstration latrines. This could provide local initiative for villagers who already have a latrine to opt the next higher class of latrine.

OBJECTIVE: 1,500 WATER SOURCES PROTECTED

STRATEGY: Protection of water sources involves both protecting the source from contamination and increasing water availability. This results in cleaner water, less time spent in drawing water and an increased use of water at the household level which in turn should decrease morbidity due to water borne diseases.

Water source protection is accomplished using either a semi-durable construction consisting of an earthen dam and bamboo pipe or durable construction using cement and plastic pipe.

The protection of water sources is a component of the village sanitation program which also includes latrine construction and general cleanliness of the village. The village development committee is responsible for the organization of this program, and assuring that the contribution of the population in supplying labor and local materials (sand, gravel, etc) is met.

CURRENT STATUS:

325 water sources have been protected in 1982-1983. This represents 22% of the LOP objective. Approximately half of these have been using durable construction methods.

A great deal of effort during the past two years has been in the development of technical guides, educational materials and training sessions to promote water source work. These include:

- Guide Technique Pour la Construction des Sources d'Eau;
- Manuel de Formation dans l'Assainissement d'Eau
- Hygiène et l'Eau (large format flipchart)
- Carte de Planification des Ressources en Eaux
- Spring Capping Training of Trainers workshop with PC/WASH
- 4 regional spring capping workshops for 7 RHZs
- "Santé Pour Tous Au Zaïre" Health banners.

CONSTRAINTS:

1) There is no recognized national coordinator for Rural Water programs. Various ministries are interested in water - Dept. Ag. and Development Rural (bureau d'Hydraulique Rurale), Dept. de l'Energie (REGIDESO), Dept. de la Santé Publique (SANRU), Comité National d'Action de l'Eau et l'Assainissement (DIEPA) - but none has yet developed a clear leadership capability.

2) Procurement of construction materials (cement, pipe, rebar) has been hampered by 300% inflation and transportation difficulties. When a RHZ must import materials from Kinshasa rather than purchase them locally they are less likely to develop an active program.

3) RHZs lack water technicians who can devote full time to promoting water and sanitation programs. This responsibility is often delegated to a nurse who already has other full time responsibilities and no technical training.

RECOMMENDATIONS:

1) The objective of 1,500 protected water sources (either durable or semi-durable) is seen as desirable and feasible and should be maintained.

2) SANRU should work with Hydraulique Rural in development of a National Rural Water program emphasizing water source protection techniques, and organization of regional training programs for water technicians of RHZs.



OBJECTIVE: REHABILITATION/CONSTRUCTION OF 500 WELLS.

STRATEGY: While sources and spring capping represent the principal water intervention, wells play a minor role in providing access to water in certain regions where sources are sparse.

Historically the F.B.I. (Fonds du Bien-Etre Indigène) drilled large diameter wells in areas of Shaba and Kasai-Oriental. These were capped and installed with pumps. Nearly all of these wells are now in disuse due to lack of maintenance. It is felt that rehabilitation of these wells could provide a low cost intervention in providing more access to water.

SANRU has not pursued actively a wells construction program for the following reasons:

- 1) WASH consultants have recommended that SANRU concentrate on spring capping and rainwater harvesting interventions. They feel that the high cost of drilling, equipping and maintaining wells and pumps exclude well construction as a priority intervention.
- 2) Very few RHZs have expressed any interest in either wells construction and/or rehabilitation.
- 3) The technology and capability within Zaire for a wells construction and rehabilitation program is not well enough established to merit a full scale program.

CURRENT STATUS:

To date only 5 wells have been constructed by RHZs. This represents 1% of the LOP objective.

SANRU organized a 4 day session with Peace Corps Volunteers and RHZ water technicians in early 1984 to study the feasibility of wells construction and rehabilitation. It was proposed that RHZs interested in wells rehabilitation experiment with various technologies to develop a strategy which could have widespread application.

CONSTRAINTS:

- 1) Neither SANRU nor RHZ personnel have at this time the technical capability for a major wells construction/rehabilitation program. It is not simply a matter of providing funding for purchase of construction materials but also providing the technical guidelines and training personnel in well construction techniques. The technical uses involved surpass the capabilities of a horizontal PHC project such as SANRU.
- 2) Well drilling represents a major investment in equipment, requires a full time drilling and maintenance staff and diminishes the community participation.
- 3) The maintenance of pumps is a weak link in the wells approach. No pump nor spare parts are manufactured in Zaire.
- 4) Rainwater harvesting systems have greater potential than wells but were not included as a SANRU objective.

RECOMMENDATIONS:

- 1) The objective of construction/rehabilitation of 500 wells should be redefined. It is proposed that the objective be to finance "alternate water systems" to include construction/rehabilitation of 100 cisterns or wells for health centers and communities and fieldtesting pilot household rainwater catchment systems. The estimated cost for financing construction materials for this activity is Z 6,000,000.
- 2) SANRU should be supportive of Peace Corps, WASH, and "Hydraulique Rurale" efforts to develop technical capabilities in construction/rehabilitation of wells. This may include financing construction activities, procurement of experimental pumps, and development/publication of technical manuals.

OBJECTIVE: ONE THOUSAND VACCINATION PROGRAMS ORGANIZED IN VILLAGES.

STRATEGY: Immunizations are an extremely important activity of PHC. Vaccination against measles is probably the intervention which most dramatically impacts the health of a RHZ and is usually one of the first activities to be promoted by health centers.

PEV provides the technical and material logistics support for implementation of vaccination programs throughout Zaire. This is the classic example of a national program integrating a traditionally vertical program into the horizontal approach of RHZs. Whereas PEV strategy was previously to set up their own mobile vaccination teams, chiefly in urban areas, the emphasis now is in establishing cold chain capability at each reference hospital and eventually at select health centers throughout the RHZ.

The SANRU objective of 1,000 vaccination programs should not be seen as an objective separate or even supplemental to that of the PEV program, but rather the result of PEV input into RHZs which are at the same time assisted by SANRU.

CURRENT STATUS:

The definition of "vaccination program" is not well defined or well documented in RHZ reports. At best estimation there are 381 vaccination programs which have been established. This represents 38% of the LOP objective.

SANRU input has been in financing training programs at the RHZ level which include vaccination and to supply basic medical equipment to health centers which could be used in the vaccination program (needles, syringes, basins, etc).

CONSTRAINTS:

1) The definition of "vaccination program at the village level" is not well defined, well understood or very useful as an indicator for the SANRU project.

2) The major constraint in promotion of vaccination programs is in establishing and maintaining of the cold chain, eg how to assure that kerosene is always available to operate refrigerators.

3) Many RHZs continue with the "mobile team" philosophy by having a team from the reference hospital travel by truck to do monthly vaccinations at health center and village level. Such a program can never be self-supporting because of the tremendous costs for transportation by vehicle.

RECOMMENDATIONS:

1) While the intent of the project to establish vaccination programs in 1,000 villages is laudable, it is not a useful measure of project achievement and should be dropped as a SANRU project objective. It is recommended that objectives for measuring accessibility and/or coverage of vaccination services be established, eg that 50% of the total population of RHZs assisted by PEV and SANRU have access to vaccination services by the end of 1986.

2) Field testing of solar refrigerator systems should be pursued by PEV and SANRU. While the initial investment is high, the low maintenance cost and assurance of a realisable cold chain may be worth the expense.

3) RHZs should decentralize vaccination services to the health center level. A comparative study to document how this has been done in various RHZs could provide useful guidelines for those struggling with this problem.

OBJECTIVE: ONE THOUSAND PRO-PHARMACIES ESTABLISHED.

STRATEGY: Access to health care is a question of distance. Should access mean basic medicines in every house, in every village, or at every health center? The establishment of pro-pharmacies is best suited for areas where access is difficult to the health center such as RHZs of low population density where distances between scattered villages and a health center may surpass 15 km.

Village Health Workers (VHW) can be trained in the use of select basic medicines (aspirine, chloroquine, ORS, soaps, and perhaps cough syrup). With a health center providing technical supervision and the village development committee providing financial control, the VHW would provide local treatment at cost.

CURRENT STATUS:

To date 155 pro-pharmacies have been established. This represents 16% of the project objective. SANRU input has been in financing training programs of VHWs some of which include the pro-pharmacy concept. 50% of RHZs have experimented with the pro-pharmacy concept but only 4 have trained more than 10 VHWs to maintain pro-pharmacies.

CONSTRAINTS:

1) Many RHZs are not convinced that VHWs should have a function in diagnosing and distribution of medicines. The example of Red Cross volunteers who set up private dispensaries at the village level has been cited as a reason for not establishing pro-pharmacies but relying rather on treatment at the health center level.

2) The long term viability of pro-pharmacies has not yet been proven particularly as concerns methods of compensation for VHWs.

3) Pro-pharmacies could increase dramatically the treatment and consumption of basic medicines. The procurement system of the RHZ, health centers and villages must be well maintained to assure that services are not interrupted.

RECOMMENDATIONS:

1) Pro-pharmacies should still be considered as experimental rather than as a tried-and-proven intervention suitable for wide application in Zaïre. SANRU should support RHZs who want to experiment with pro-pharmacies and make every effort to facilitate a sharing of experiences.

2) Because of the experimental nature of pro-pharmacies, the objective to establish 1,000 by 1986 is considered inappropriate at this time and should be reduced to 250 pilot pro-pharmacies.

OBJECTIVE: UPGRADE 20 REFERENCE HOSPITAL SERVICES TO INCLUDE TUBAL LIGATIONS VIA LAPAROSCOPE AND/OR MINILAP.

STRATEGY: Voluntary Surgical Contraception (VSC) is an effective method of contraception sought most by couples who want to limit the number of children. SANRU supports VSC by arranging JHPIEGO funded short-term training for physicians at Tunis to learn laparoscopy and mini-laparotomy techniques. JHPIEGO consultants follow-up with field visits for installation of laparocators at select sites and development of surgical standards. AVS assists in upgrading operating room conditions to accomodate emergency surgery and VSC by mini-lap.

CURRENT STATUS:

Of the 36 hospitals participating in phase I and II of SANRU, 11 are in possession of laparocator or laparoscopic equipment. This represents 55% of the LOP objective. While several additional RHZs have mini-lap capabilities they have not yet received formal training in mini-lap for attainment of the LOP objective. JHPIEGO has financed training for 13 doctors and 7 nurses from Phase I/II RHZs. AVS has supplied basic operating room equipment to upgrade facilities in 15 phase I hospitals.

CONSTRAINTS:

- 1) The usefulness of a laparocator in rural health zones has been questioned because of a generally low demand for VSC. While the laparocator does provide the advantage of diagnosing causes of sterility, it does not provide an effective method for curing sterility problems since micro-surgical techniques are generally unavailable in RHZs.
- 2) In several cases a doctor trained by JHPIEGO has left the RHZ to which the laparocator was assigned. Clarification is needed as to who is authorized to continue use of the laparocator.
- 3) Training and standards use of minilaps and organization of a VSC program using minilap procedures have not yet been established for Zaire. Such a program should go hand-in-hand with ASV assistance to upgrade OR facilities to accomodate minilap procedures.

RECOMMENDATIONS:

- 1) SANRU/JHPIEGO should provide laparoscopic training (and laparocators) only for select regional and sub-regional reference hospitals where demand merits service. Minilaparotomy should be the procedure of choice for most RHZs.
- 2) In-country short-term training programs should be arranged by PSND with JHPIEGO/AVS support to train physicians in mini-lap procedures and standards.
- 3) AVS should support upgrading of ORs in phase II/III RHZs to provide a minimum of mini-lap VSC capability.
- 4) Doctors trained by JHPIEGO who are leaving their RHZs should train a replacement doctor in laparoscopi methods before his departure. A subsequent site visit should then be made by a JHPIEGO representative to verify standards of care.

OBJECTIVE: REHABILITATION/CONSTRUCTION OF 12 CLASSROOMS.

STRATEGY: Training of personnel on a continuing basis is an important activity of PHC. RHZs with nursing schools make use of existing facilities during vacation months for training, but this limits the expansion of training programs for training VHWs and health auxiliaries which train over a period of several weeks to several months. A need exists in many RHZs for a training center which would include classroom/office space and perhaps lodging for short-term trainees.

SANRU funding is for the purchase of commercially available construction materials such as cement, rebar, and roofing.

The RHZ assures technical supervision of construction activities as well as provide local labor and materials (sand, gravel, stones, etc).

CURRENT STATUS:

SANRU has provided funding for rehabilitation of classrooms. Three rehabilitation projects in Kajiji, Nyankunde and Kalonda have been partially funded by SANRU at the cost of Z 185,000. This represents 25% of LOP objectives. Other requests are pending release of CPF for 1984.

CONSTRAINTS:

- 1) Rehabilitation projects are limited primarily by CPF availability. When CPF are scarce, rehabilitation funds are usually the first to be reduced.
- 2) Costs of rehabilitation projects have increased dramatically in 1983. Since the devaluation, prices for these construction materials have tripled.
- 3) Rehabilitation needs exist for other than classrooms, such as a central office of RHZ, cistern construction, lodging for short-term trainees.

RECOMMENDATIONS:

- 1) The rehabilitation/construction of 12 classrooms appears to be realistic and should be maintained as a SANRU objective.
- 2) CPFs for rehabilitation/construction activities for 1984 - 1986 estimated at apprx. Z 2,250,000 (9 x Z 250,000) should be set aside for this activity.
- 3) Rehabilitation needs apart from classrooms are to be included in the ECZORT project and to provide 23,500,000 for rehabilitation of buildings at health center, reference health center and reference hospital levels.

OBJECTIVE: 150,000 NEW FAMILY PLANNING ACCEPTORS.

STRATEGY: Family Planning (Desirable Births Program) emphasizes spacing births to lengthen the birth interval as a measure to protect the health of the child and mother. SANRU works in close collaboration with the CNND to integrate all methods of contraception (artificial + natural) first at the RHZ level and subsequently to the health center and village levels.

CURRENT STATUS:

Approximately 15,200 new acceptors have been registered during 1982-1983. This represents 10% of the project objective. Of the RHZs in phases I/II, the most active family planning programs are those which have been running for 6-10 years. It generally requires 3-4 years to build up a program of 500+ acceptors/year.

CONSTRAINTS:

1) Health Education materials for family planning are practically non-existing. IPPF produced at one time an excellent mini-flipchart which has been extremely popular in Zaire but which SANRU has been unable to obtain in sufficient quantities.

2) Injectable contraceptives are one of the most popular methods but are always in short supply.

3) Many RHZs place a lower priority on starting a family planning program than on other PHC components such as vaccinations. While they initiate family planning activities at the reference hospital during year one, it may not be until year two or three that these activities are fully integrated into the health center level.

4) LOP objective of 150,000 new acceptors is out of proportion with other project objectives and resources. By 1986 SANRU is to establish PHC services to a population of approximately 1,250,000 = living within geographic access of 250 health centers. Of that population approx. 250,000 are women of fertile age in risk of conception. The objective to have 75,000 registered continuing users of artificial methods would mean a user rate of 30%. Taking into account registered and non-registered users of natural family planning methods a total user rate of 40-60% of the MWRA (Married Women of Reproductive Age) would be required. This is certainly unrealistic and far beyond the CNND estimate that in rural areas a user rate of artificial methods of 2-5% is the best that can be expected.

RECOMMENDATIONS:

1) SANRU has requested Population Communication Services to fund printing of the IPPF flipchart for use in Zaire and other African countries.

2) SANRU should continue to organize regional conferences with JHPIEGO support to promote integration of family planning at the health center and village levels.

3) The LOP objective of 150,000 new acceptors by end of 1985 should be redefined as "75,000 registered new acceptors for artificial & natural family planning methods by the end of 1986. This calculation is based on a population base of 2,250,000 (250 SANRU + ECZORT health centers), an estimated 450,000 MWRA, and a goal of 8% continuing user rate for registered artificial family planning methods. Details are presented in the following table:

	1982	1983	1984	1985	1986	Total
Registered New Acceptors	5000	9500	14000	19500	26500	75000
Continuing users		7500	14500	24250	37500	37500

OBJECTIVE: ESTABLISH A SYSTEM FOR COLLECTING, ORGANIZING AND SHARING EXPERIENCES IN THE ECZ AND GOZ SYSTEM.

STRATEGY: SANRU philosophy is that national agencies have no right to request reports from RHZs unless they have something to offer. The creation of a Health Information System should offer:

- uniform reporting of PHC statistics
- centralization and access to PHC reports and resource materials
- distribution of PHC information to RHZs
- regular supervision of RHZs from a regional and national level.

CURRENT STATUS:

SANRU has placed a great deal of effort on creating a Health Information System with the following results:

- 1) A draft proposal of an PHC annual report for RHZs was elaborated with the National Direction of PHC and other national health programs. It is currently being pretested in RHZs, will be revised in Sept.- Oct. 1984 and initiated formally in Nov. 1984 on a nationwide basis.
- 2) SANRU is trying to centralize reports, teaching curriculum and health education materials which are elaborated by RHZ and make them accessible to anyone seeking information.
- 3) SANRU has published a journal entitled Rural Health (Santé Rurale) to be distributed to RHZ personnel. The journal contains articles on components of PHC either those extracted from international journals or from local authors.
- 4) SANRU tries to visit each RHZ once a year for supervision and exchange of information. This has been difficult due to lack of sufficient personnel.

CONSTRAINTS:

- 1) The Health Information System must be institutionalized at the national level. While the National Direction of PHC exists on paper, it does not yet have the capacity to administrate the Information System.
- 2) There is a need for a national resource center for PHC to include open files, library, audio-visuals, journals, etc. This would permit RHZ personnel visiting Kinshasa to obtain current information on PHC.
- 3) Many different health agencies are making visits to RHZs to supervise activities. But reports are not standardized or shared between agencies.

RECOMMENDATIONS:

- 1) SANRU should work hand-in-hand with the MOH and National Direction of PHC to institutionalize the Health Information System at the national level. To this effort SANRU should match efforts made by the MOH in providing some resources for a PHC resource center.
- 2) Supervision of RHZs should be centralized under the Direction of PHC using a standardized report form acceptable to all health agencies. A team of supervisors made up of select personnel from each health agency should be trained to assure regular supervision and of RHZs.

## V. FINANCIAL REPORT

Local costs for the SANRU project are supported by the GOZ through their counterpart fund system. SANRU received 2,500,000 zaires in 1982 and 5,000,000 zaires in 1983. The financial report for 1982-1983 CPFs distribution is shown in Table 17.

The projected CPF budget for 1984 activities is Z 18,000,000 and is shown in Table 18. It is anticipated that a supplemental amount of 15,400,000 (\$400,000 equivalent) will be allocated for 1984-1985 to permit local purchase of basic medicines for 200 health centers.



FINANCIAL REPORT ON THE USE OF  
COUNTERPART FUNDS 1982-1983

	<u>1982</u>	<u>1983</u>
<b>I. SALARIES:</b>		
A. Personnel	75.916,86	179.558,00
B. Consultants	23.395,00	180.802,50
C. Local Hire	(1)	21.870,50
D. Personnel Training	(1)	18.228,00
<b>II. TRANSPORT:</b>		
A. Field Visits	146.944,00	84.449,50
B. Transfer of Equipment & Medicines	60.047,46	298.984,45
C1 Cost Mileage Trucks	-	458.313,11
C2 Cost Mileage Motor Bikes	-	67.812,08
D. Local Transportation	61.074,00	72.924,24
<b>III. TRAINING:</b>		
A1. Rural Health Zone Nurses	300.965,00	298.692,00
A2. Village Health Workers	80.000,13	248.017,00
A3. Traditional Birth Attendants	29.045,00	114.595,00
A4. Village Committees	9.000,00	23.690,00
A5. Doctors for M.P.H.	-	30.810,00
B. UNIKIN Seminars	410.819,74	204.218,20
C. Annual Health Conferences	88.017,50	476.782,60
D. Water Workshop with Wash	-	148.415,00
<b>IV. MATERIAL &amp; EQUIPMENT:</b>		
A. Manuals & Posters	148.922,75	320.985,71
B. Information System	(2)	357.547,00
C. Construction Material	171.859,50	231.272,00
D. Pharmaceutical Products	442.482,00	157.850,30
E1. Equipment Central Office	348.190,98	73.141,50
E2. Equipment Rural Health Zone	(3)	209.607,54
F1. Supplies Central Office	(3)	227.852,18
F2. Supplies Rural Health Zone	(3)	122.876,08
G1. Upkeep-vehicles Central Office	(3)	122.376,50
G2. Upkeep & Handling Vehicles H.Z.	(3)	168.592,35
<b>V. RESEARCH</b>		
A. Contraceptive Prevalence	-	100.000,00
Annual totals	Z 2.396.679,92	Z 5.020.263,34
Total Counterpart Funds Received 1982 - 1983:-----		Z 7.500.000,00
Total Counterpart Funds Expended 1982 - 1983:-----		Z 7.416.943,26
Balance Carried Over TO 1984:-----		Z 83.056,74

(1) These expenses for 1982 were included in category of "personnel"

(2) This expense for 1982 was included in "manuals &amp; posters"

(3) These expenses for 1982 were included in category "equipment central office".

Table 18.

## SANRU COUNTERPART BUDGET 1984

	<u>Zaires</u>
I. <u>SALARIES:</u>	
A. Personnel	252,000
B. Consultants	186,000
C. Local Hire	24,000
D. Personnel Training	18,000
II. <u>TRANSPORT:</u>	
A. Field Visits	975,000
B. Transfer of Equipment & Medicines	1,650,000
C1/2. Cost Milage Trucks/Motos	3,250,000
D. Local Transportation	150,000
III. <u>TRAINING:</u>	
A1. Rural Health Zone Nurses (200)	800,000
A2. Village Health Workers (400)	800,000
A3. Traditional Birth Attendants (200)	400,000
A4. Village Committees (1,000)	500,000
A5. Doctors for M.P.H. (6)	100,000
B. UNIKIN Seminars	600,000
C. Annual Health Conferences	1,070,000
D. Water Workshop with Wash	100,000
IV. <u>MATERIAL &amp; EQUIPMENT</u>	
A. Manuals & Posters	800,000
B. Information System	600,000
C. Construction Material	2,250,000
D. Pharmaceutical Products	600,000
E1/2. Equipment	500,000
F1/2. Supplies	725,000
G1/2. Upkeep-vehicles	750,000
	<u>18.000,000</u>
	=====

NOM DE ZONE DE SANTE	CODE	ZONE ADMINISTR	REG ION	PHA SE	GER ANT	POPULA TION	#CS PREVU	#CS EXIS	#PER/ CS PREV	CS FON
BIBANGA	8241	MBUJI MAYI	KOR	1	ECZ	160,770	23	3	6,990	13%
BOSOBÉ	3242	OSHWE	BAN	3	ECZ	70,000	24	9	2,917	38%
BOSOBOLÓ	4541	BOSOBOLÓ	EQU	2	ETAT	116,831	24	2	4,668	8%
BULAPE	9341	MWEKA	KOC	2	ECZ	110,000	15	2	7,333	13%
BUSINGA	4531	BUSINGA	EQU	2	ETAT	81,300	11	3	7,391	27%
DJUMA	3311	BULUNGU	BAN	2	CATH	47,063	17	12	2,768	71%
DRODRO	5532	DJUNGU	HZA	2	CATH	90,000	12	6	7,500	50%
DUNGU	5432	DUNGU	HZA	3	ETAT	135,000	40	10	3,375	25%
IME LOKO	4533	MÓBAYI	EQU	1	ECZ	100,000	18	11	5,556	61%
KABINDA	8411	KABINDA	KOR	3	CATH	120,000	25	3	4,800	12%
KAJIJI	3531	KAHEMBA	BAN	1	ECZ	30,000	7	1	4,286	14%
KALONDA	9321	TSHTKAPA	KOC	1	ECZ	180,000	20	4	9,000	20%
KAMINA	7511	KAMINA	SHA	3	ETAT	200,000	30	0	6,667	0%
KANIAMA	7521	KANIAMA	SHA	2	ETAT	67,600	16	3	4,225	19%
KAPANGA	7431	KAPANGA	SHA	2	ECZ	75,000	28	1	2,679	4%
KARAWA	4532	BUSINGA	EQU	1	ECZ	112,000	24	17	4,667	71%
KASANGULU	2521	KASANGULU	BZA	1	ECZ/E	70,700	40	15	1,768	38%
KASONGO LUNDA	3541	KASONGO LUND	BAN	2	CAT/E	104,479	19	4	5,499	21%
KATWA	6331	LUBERO	KIV	2	ECZ	140,000	12	3	11,667	25%
KAZIBA	6412	WALUNGU	KIV	2	ECZ	160,000	26	14	6,154	54%
KIFONGO	3331	BAGATA	BAN	3	ECZ	100,000	23	2	4,348	9%
KIMPESE	2422	SONGOLOLO	BZA	1	ECZ	101,400	32	19	3,169	59%
KINKONZI	2312	TSHELA	BZA	1	ECZ	55,780	30	4	1,859	13%
KIROTSHE	6361	MASISI	KIV	2	CEM/E	200,000	30	15	6,667	50%
KISANTU	2511	MADIMBA	BZA	3	ETAT	160,000	25	20	6,400	80%
KOLE	8321	KOLE	KOR	2	CAT/E	67,629	24	3	2,818	13%
KONGOLO	7651	KONGOLO	SHA	2	ETAT	167,291	12	6	13,941	50%
LEHERA	6421	UVIRA	KIV	3	ECZ	100,000	10	0	10,000	0%
LUBAO	6421	LUBAO	KOR	2	ETAT	110,733	27	3	4,101	11%
MOANZA	3322	NASI MANIMBA	BAN	3	ECZ	112,000	24	0	4,667	0%
MUKEDI	3351	GUNGU	BAN	3	ECZ	80,000	16	0	5,000	0%
MUSHENGE	6342	MWEKA	KOC	2	ETAT	110,000	18	2	6,111	11%
MUSIENENE	6332	LUBERO	KIV	2	CATH	116,000	20	6	5,800	30%
NEBOBONGO	5463	TSIRO	HZA	3	ECZ	50,000	13	0	3,846	0%
NSUNA MPANGU	2421	SONGOLOLO	BZA	1	ECZ	120,000	30	8	4,000	27%
NUNDU	6431	FIZI	KIV	2	ECZ	73,130	18	1	4,063	6%
NYANKUNDE	5511	ITURI	HZA	1	ECZ	130,000	14	7	9,286	50%
OICHA	6345	BEHI	KIV	1	ECZ	128,898	15	6	8,593	40%
PANZI	3542	KASONGO LUND	BAN	3	CAT/E	104,500	24	5	4,354	21%
PINU	4631	BONGANDANGA	EQU	3	ECZ	100,000	28	6	3,571	21%
PWETO	7751	PWETO	SHA	3	ETAT	125,000	25	0	5,000	0%
RETHY	5533	DJUNGU	HZA	3	ECZ	230,000	25	0	9,200	0%
RUTSHURU	6351	RUTSHURU	KIV	2	CEM/E	110,000	20	2	5,500	10%
RWANGUBA	6352	RUTSHURU	KIV	2	ECZ	100,000	10	1	10,000	10%
TANDALA	4313	GENENA	EQU	1	ECZ	150,000	14	5	10,714	36%
TSHIKAJI	9151	KANANDA	KOC	1	ECZ	135,000	22	4	6,136	18%
UVIRA	6421	UVIRA	KIV	2	ETAT	142,000	24	6	5,917	25%
VANGA	3312	BULUNGU	BAN	1	ECZ	231,000	48	40	4,813	83%
WEMBO NYAMA	8741	KATAKO KÓMBE	KOR	1	ECZ	64,000	16	4	4,000	25%
YAKUSU	5141	TSHOPÓ	HZA	2	ECZ	127,000	29	0	4,379	0%
TOTAL						5,772,104	1,097	298	5,262	27%