Basic Rural Health II Project (660-0107) - SANRU II

Interim Evaluation

USAID Zaire

September 1991

Eval '91

<u>Average Annual Exchange Rates: US$-Zaire</u>[1]

1986: 1= 60
1987: 1=110
1988: 1=190
1989: 1=400
1990: 1=730
1991 (Jan.-July): 1=4,000 approx.

[1]The exchange rates were provided by USAID Zaire's Program Office (PEP).

Acknowledgements

The team acknowledges and greatly appreciates the hospitality and information provided by many people. SANRU staff were uniformly helpful in responding to the team's many requests for documentation, clarifying information, and logistical assistance. Their active and thoughtful participation testifies to their commitment to carrying out the mandate of improving the infrastructure of the rural health zones, the technical capacity of the health staff, and the involvement of the local communities. USAID Zaire facilitated visits to the health zones, provided a wide array of documentation and prepared financial and managerial reports requested by the team. Health zone staff and members of the communities they serve responded cordially and candidly to the many questions posed by the evaluators.

Zairian citizens are currently confronting political and economic crises of historical proportion that directly affect their current and future well-being. In this context, an evaluation of a donor-assisted project would seem minimally relevant to them. Consequently, the energy and commitment invested in the evaluation by the Zairians contacted and interviewed by the team must be seen as an extraordinary act of faith in the value of the project.

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Summary

Project Purpose. The Basic Rural Health II Project (SANRU II) was to establish sustainable community-supported preventive, promotive, and basic curative primary health care services in 50 new rural health zones and to strengthen the 50 health zones assisted during SANRU I (1982-1986).

Purpose of the Interim Evaluation. The Interim Evaluation was undertaken to: (1) review the technical accomplishments (outputs) of the project and assess progress toward accomplishments of project goal and purpose: (2) address key issuess affecting project implementation, and (3) review project successess and failures and "lessons learned," and make recommendations to guide USAID Zaire in the design of the primary health care component of the projected integrated health and population project.

Evaluation Methodology. The evaluation began on August 5, 1991 and concluded on Spetember 12, 1991, The team reviewed documents, interviewed persons participating in or familiar with the project, and visited selected health zones.

Principal Conclusion and Recommendations. Conclusions. SANRU has initiated or extended primary health care activities in 42 of the 50 rural health zones targeted for assistance under the project. In addition, support has been continued to 49 of the 50 zones assisted during SANRU I (1982-1986).

SANRU's "package of assistance" to the zones has included training, vehicles and spare parts, physical rehabilitation of health centers, offices, and hospitals, infrastructure improvements (e.g., spring-cappings), medical and office furnishings and supplies, and operating subsidies. Included as well is the commitment to primary health care.

In the current economic and political crisis SANRU assistance is insufficient to enable most of the health zones to consolidate or expand operations, that is to achieve a "sustainable system of community-supported preventive, promotive, and basic curative" services. In the zones which only receive GOZ assistance, (primarily in the form of salary payments to a limited number of staff or the PASS subsidies), SANRU assistance is essential but at best a "holding" or "relief" action that allows the zones to maintain minimal levels of service to the population. In the zones with greater resources, served by different religious NGOs for example, SANRU material assistance is usually less essential. It complements other available operational assistance and, especially in the areas of training and supervision, enables the zones to provide more accessible services.

Recommendations to PACD (October 31, 1992). In light of the current and projected shortfalls in financial assistance, including the GOZ, SANRU should immediately develop a "survival" strategy that continues assistance to the current health zones, at levels sufficient to maintain operations as long as possible. The strategy should consider giving relatively larger amounts of assistance to zones with fewer outside resources. SANRU central operations may have to be reduced to the minimum required to sustain the current level of zone activities. This approach may prohibit the hiring of all new staff as currently planned and require some staff reductions in selected divisions.

The strategy should also find ways to re-program all remaining funds (US$ and CPF) to ensure that the zones continue to make primary health care services accessible to the rural population. The commodity list should be immediately reviewed. This is the only line item in the US$ budget that has significant "unearmarked" resources. Only those items deemed essential to maintain operations in the zones should be procured.

USAID Zaire should instruct SANRU to develop the strategy within one month of the acceptance of this evaluation report. SANRU should be requested to re-program funds to support the operations in the zones as long as possible. USAID Zaire should extend the PACD of the project accordingly. Finally, USAID Zaire should make every effort to provide "new" funds to allow SANRU to maintain health zone operations.

Recommendations for the New Project. The proposed new project is based in part on the successes and lessons learned from the SANRU Projects. It outlines a SANRU-like "package of assistance" designed to strengthen rural health infrastructure and improve and expand maternal and child health services. At least three major issues need careful review in the course of developing the rural health component of the new project: (1) the organizational character of SANRU; (2) the program focus, and (3) USAID Zaire systems for supporting SANRU activities.

Basic Rural Health II Project (660-107) - SANRU II

Interim Evaluation

1. Introduction

1.1 **Project Background and Purpose.** The Basic Rural Health II Project (USAID Zaire 660-0107), more commonly known as SANRU II and referred to throughout this report as SANRU (Project de Soins de Santé Primaries en Milieu Rural), was launched on October 1, 1985 as the successor to the Basic Rural Health Project (USAID Zaire 660-0086) or SANRU I.

In operation from 1981 through September 1986, SANRU I was designed to establish "a sustainable community-supported primary health care (PHC) system in 50 rural [health] zones (RHZ) to combat the 10 most prevalent public health problems in Zaire."[2] The project provided the basic equipment and medicines needed to transform 250 dispensaries into health centers, the educational materials and funds required to train health center personnel, and the office equipment and vehicles necessary to establish a supervisory capacity in the assisted RHZs. With total project financing of almost US $10 million, SANRU I was designed to concentrate assistance at the level of the health center and to establish a uniform supervisory system for all medical services in the assisted health zones.[3] By the Project Activity Completion Date (PACD - September 30, 1986), SANRU I had successfully initiated assistance in 50 zones.[4]

SANRU II's seven-year mandate (PACD - October 30, 1992) was far more ambitious than its predecessor SANRU I. As defined in the Project Paper, SANRU was to:

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[2]Basic Rural Health II Project (660-0107) - Projet des Soins de Santé Primaires en Milieu Rural (SANRU), Project Paper, August 1985, p. 1. Hereinafter cited as SANRU Project Paper. A rural health unit is defined as a geographically limited area consisting usually of three principal health structures, i.e, the zone office, the general reference hospital, and health centers/health posts.

[3]Historically, Protestant, Catholic, State and private dispensaries operated independently from each other in the same areas. Sometimes the units were in conflict. Each dispensary had separate supply lines, supervisory systems, and health information systems.

[4]Ibid., p. 19. See also "Assistance SANRU par Année que l'assistance a commencée," SANRU, 1991, p. 1.

[1] provide technical assistance and commodities to increase the number of functioning RHZs and health centers and to upgrade the preventive, promotive, and basic curative services . . . available. . . . [Major] emphasis was to be directed toward 50 new RHZs [although] continued supported [was also to] be provided to further strengthen the 50 RHZs assisted by SANRU I;

[2] strengthen national and regional planning and management, regional supervision, and the coordination of diverse health services at all levels, and

[3] assist the Government of Zaire (GOZ) to institutionalize a sustainable national health care system that is acceptable to and supported by the population.[5]

1.2 **Dates and Purpose of the Interim Evaluation.** Initially scheduled for June 1989, the interim evaluation of SANRU was carried out from August 5 to September 12, 1991. As defined in the Scope of Work (Appendix A), the objectives of the interim evaluation were to:

a. review the technical accomplishments (outputs) of the project and assess progress toward accomplishment of project goal and purpose;

b. address key issues [specified in the SOW] affecting project implementation, and

c. review project successes, failures and "lessons learned," and make recomendations to guide USAID in the design of the primary health care component of the projected integrated health project.

In conducting this SOW the team also examined the evolution and operation of the SANRU project management structure and the relationships between the SANRU and the following: USAID Zaire, the RHZs, and other national level entities participating in and benefiting from the project.

1.3 **Composition of the Evaluation Team.** The evaluation team was composed of professionals with extensive knowledge of Zaire, its health conditions and health management systems, and the SANRU Project. Listed below are the names and a brief statement of the Zaire and SANRU-related experiences of the members of the evaluation team.

Judith E. Brown, Ph.D., is the Directrice du Centre d'Etudes et de Recherche of the Intitut Médical Chrétien du Kasai at

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[5]SANRU Project Paper, pp. 22-23.

Kananga. A resident of Zaire since 1972, Dr. Brown was the team leader for the evaluation of SANRU I and a participant on the team that designed SANRU II.

Richard C. Brown, M.D., M.P.H., is the Directeur du Department de Santé Communautaire of the Institut Médical Chrétien du Kasai at Kananga. A former USAID Population Officer in Zaire, Dr. Brown has extensive familarity with A.I.D.'s policies and procedures, primary health care and family planning, and the workings of the health zones in Zaire.

Marty Makinen, Ph.D., of Abt Associates, is the Technical Director of the Health Financing and Sustainability Project, financed by the Office of Health, A.I.D./Washington. Dr. Mackinen was a member of the team that designed the SANRU II Project.

Miakala mia Ndolo, M.D., M.P.H., is Médecin Chef de Division de Gestion des Soins et Recherche Opérationnelle du Projet Santé Pour Tous à Kinshasa. Before joining Santé Pour Tous, Dr. Miakala was Médecin Inspecteur Régional in the Region of Kasai Oriental. He has also served as Inspecteur Sous-Régional in Mai-Ndombe and as Médecin Chef de Zone in Kiri and Inongo.

Othepa Okit'osodu, M.D., M.P.H., is the Médecin Coordonnateur du Volet PEV of the Programme Elargi de Vaccination/ Lutte contre Les Maladies Transmissibles de l'Enfance (PEV/LMTE) based in Kinshasa. Dr. Othepa is the former Médecin Chef de Zone for Kole in the region of Kasai Oriental.

John B. Tomaro, Ph.D., M.P.H., is a Senior Health Adviser in the Health Services Division of the Office of Health, A.I.D./Washington. Team Leader for this Interim Evaluation, Dr. Tomaro was a member of the team that carried out the mid-term evaluation of the water component of SANRU in April-May 1990.[6]

1.4 **Evaluation Methodology.** The team reviewed documents (Appendix B), interviewed persons participating in or familiar with the project (Appendix C), and visited selected rural health zones (Appendix D). The visits included zones that have been assisted by SANRU I and SANRU II. Some zones have received continuous support from Protestant, Catholic or Kimbanguist missions and/or private voluntary organizations(PVO)/non-governmental organizations (NGO); other zones have been exclusively supported by the GOZ and have not benefitted from outside religious or non-governmental assistance. The evaluation

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[6] "Internal Evaluation of USAID Assistance to the Rural Water Supply and Sanitation Sector in Zaire," WASH Field Report No. 313, June 1990. Hereinafter cited as WASH Field Report 313.

team, assembled in three sub-units, visited or met with personnel from 28 of the 81 (35%) health zones currently assisted by SANRU.

Rural health zones in three regions of Zaire (Shaba, North and South Kivu, and Equateur) were not visited. Several zones in Shaba had been visited in 1990 when the water component of SANRU II and the activities of the Shaba Refugee Water Project (660-0116) were assessed. A number of zones in the Kivus have frequently been visited, most recently when SANRU II was designed (1985). Also, several zones in Equateur were examined during the 1986 evaluation of SANRU I.

To obtain information systematically on the assistance provided by SANRU and others in the zones visited, the team prepared a questionnaire for use in interviewing médecins chefs de zone, as well as others, e.g, staff of the zone office (bureaux centrals), Peace Corps volunteers, community members, etc., living and working in the rural health zones (Appendix E). The data obtained during the visits to the health zones were reviewed and analyzed by all team members. These findings, along with others, were incorporated below in Sections 2 and 3.

2. General Findings

2.1 Accomplishments to date. With implementation 61% complete on December 31, 1990, the most recent month for which figures on all activities are available, SANRU has registered many significant achievements.

1. SANRU has initiated activities in 42 of the 50 health zones (84%) targeted for assistance under the project and continues to provide focused support in 49 zones assisted under SANRU I.[7] Table 1 presents the proposed versus actual rate of assistance to SANRU II health zones, by type of zone, for the period 1986 to 1990.

Table 1
Proposed vs Actual Rate of SANRU Assistance To the Health Zones by Type of Zone 1986-1990[8]

Year	Proposed Rate of Execution	Type of Zone and Actual Rate of Execution			
		NGO	NGO/State	State	Total SANRU
1986	15	3	4	7	14
1987	15	5	1	5	11
1988	10	3	2	0	5
1989	10	7	2	1	10
1990	0	0	1	1	2
Total	50	18	10	14	42

Of these 42 new zones assisted by SANRU, 43% were managed and receive support from NGOs, 24% have NGO and GOZ assistance, and 33% rely primarily on GOZ resources.

In addition, SANRU II has continued to provide ongoing support to the 49 health zones sponsored under SANRU I. Table 2 summarizes

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[7]At the time of the evaluation, assistance had been temporarily suspended to four zones that began activities under SANRU I -- Mukedi, Musienene, Pangi, and Uvira -- and four that began under SANRU II -- Dilolo, Lolwa, Sandoa and Tshudi-Loto. The reasons were poor management or instability. See July 22, 1991 memorandum of Dr. Bongo, Chief of the Division of Program and Supervision.

[8]SANRU Project Paper and "Assistance SANRU - Par Année que l'Assistance a commencée," SANRU, 1991.

SANRU I assistance to the health zones by type of zone.

Table 2 SANRU I Assistance to the Health Zones by Type of Zone 1982-1985[9]				
Year	Type of Zone			
	NGO	NGO/State	State	Total SANRU
1982	15	0	0	15
1983	11	4	7	22
1984	7	3	2	12
1985	0	0	0	0
Total	33	7	9	49

Sixty-seven percent of SANRU I zones receive assistance from NGOs, while 14% have NGO and GOZ support, and 18% rely on the GOZ.

In a majority of the zones assisted by SANRU the project is viewed as the catalyst that created local awareness of the importance of primary health care and as the agent that fostered the development and continuing operation of primary health care services. In many if not all of the zones assisted by SANRU, primary health care was said to be poorly understood and minimally implemented prior to the initiation of the project. In the health zones assisted by SANRU, health centers and reference hospitals are providing vaccination, growth monitoring, pre-natal, oral rehydration therapy and, in some locations, family planning services.

Table 3 indicates that SANRU-assisted health zones make preventive and curative health care services accessible to 43% of the estimated total rural population.

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[9] Op. cit.

Table 3 Estimated Rural Population Total Health Zones per Region SANRU assisted Health Zones per Region - 1990 Estimated Population Assisted by SANRU[10]				
Region	Total Est. Pop. (Rural)	Health Zones (Total)	Health Zones (SANRU)	Est. Pop. SANRU Zones
Bas Zaire	1,450,000	22	8	635,000
Bandundu	3,556,000	27	17	1,889,000
Equateur	3,217,000	38	8	1,153,000
Haut Zaire	3,776,000	33	13	1,370,000
Kasai Occ.	1,764,000	47	11	1,216,000
Kasai Or.	1,660,000	31	11	1,075,000
Nord Kivu	2,450,000	19	7	860,000
Sud Kivu	2,144,000	14	5	602,000
Maniema	673,000	8	0	0
Shaba	2,610,000	40	11	1,144,000
Total	23,300,000	306	91	9,944,000

While service statistics are less than comprehensive and mortality and morbidity data are incomplete in a number of SANRU-assisted zones, available evidence suggests that "there has been a demonstrated trend for reduction in the morbidity and mortality burden in the childhood population."[11]

Perhaps even more signficant than the existence of operational primary health care programs in the zones is the fact that a significant portion of local operating expenses are offset by revenues generated within the zones. An estimated 60% of the operating costs in the health zones are being met with locally generated income. The concept of self-financing (auto-financement) is well-understood and universally implemented, even

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[10]Taken from "Alimentaton en Eau Potabale en Milieu Rural," Section 2, CNAEA, 1991, p. 8, and Op. cit.

[11]M. Pollack, "Assessment of the USAID Child Survival Strategy in Zaire: Epidemiologist's Report," The Pragma Corporation, 1990. p. 36.

if the revenues generated are as yet insufficient to cover all operating expenses.

2. SANRU has recruited, trained, and maintains a dedicated managerial and technical staff.[12] The average length of service for SANRU personnel is 4.3 years for those in positions of chef de bureau or higher. Ten of the 27 current "key" managers have been with the project six or more years. Until 1990, four years into the project cycle, an average of only one key manager per year left the project. In 1990, when salaries began to lag behind inflation, two managers left. In the first eight months of 1991, four persons with almost ten years of combined service, accepted positions with other organizations offering larger salaries and other benefits, e.g., a vehicle.

3. SANRU has established and maintains reliable financial and management information systems and effective internal controls. Information on such activities as the distribution of funds, the purchase and delivery of equipment, the cost of construction/rehabilitation, training, studies, and general operations, e.g., personnel policies and procedures and compensation levels, is readily available, accurate, and routinely consulted by top management for decision-making purposes.[13]

There are some indications, however, that feedback to the zones, defined as acknowledging or responding to a request for information or assistance, may not be provided according to a set schedule. A brief inspection of the commodities depot at SANRU headquarters found that there had been no action taken on nine requests, received within the previous one to five weeks and approved by an authorizing officer. The requests were for books, fiches, contraceptives, badges, and photocopied material.

4. SANRU is operating within budget and implementing activities at a unit cost that in most cases is within range of the estimates suggested in the Project Paper. In addition, SANRU continues to strive to achieve the objectives of the project, although the resources (CPF) provided by USAID Zaire and the GOZ have been less than projected in the Project Paper.

2.2 **Outputs to date.** Appendix F contains tables presenting SANRU's progress to date compared to final project targets. The tables on "Training" and "Studies and Operations Research"

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[12]SANRU's current total personnel complement is 80 (August 1991).

[13]See "Projet US AID No. 660-107, Soins de Santé Primaries en Milieu Rural (SANRU): Rapport des Auditeurs (1 avril au 30 novembre 1990)," Coopers & Lybrand, Décembre 1990, pp. 2-3.

activities (Tables F-1 through F-3) indicate that SANRU has largely met or exceeded the target of 61% completion, expected by December 31, 1990.

In most cases, the Infrastructure Division has financed activities at the expected level (Tables F-4 through F-6). In some cases, the rate of completion is below the expected level. At times, commodities were not available, e.g, solar refrigerators. At other times, the funds advanced were insufficient to complete all the work planned or diverted by the zones to finance other health-related activities, e.g, the purchase of pharmaceuticals.

With the exception of the provision of vehicles and the financing of supervisory visits, the Program Implementation and Supervision Division is well behind what had been expected (Tables F-7 and F-8). In some cases, delayed commodity procurement by USAID Zaire has been the constraint, e.g., kits for the 50 General Reference Hospitals. The vacancy at the level of the Division Chief for almost two years also affected the implementation of planned activities.

SANRU assistance to the zones was designed to ensure that the accessibility and coverage targets defined below in Table 4 were ultimately achieved.

Table 4
Service Accessibility and Coverage Indicators[14]

Output Indicator	Achieved
3000 village development and health center committees formed and active	5750[15]
100% of SANRU-assisted zones reporting 1% of women of reproductive age in RHZ accepting FP each year after the second year of SANRU assistance	11%
52% of children in SANRU II-assisted zone have access to under-five clinics	56%
52% of women of child-bearing in SANRU II-assisted zones have access to pre-natal clinics	55%

[14]SANRU Project Paper, Annex 3.

[15]The 1989 Annual Reports from 67 SANRU-assisted zones showed a total of 5750 health and village development committees. Although some of the zone figures seem doubtful, the total probably does exceed the project target of 3000 functioning committees.

It is important to emphasize that beyond providing a basic package of assistance, SANRU has limited ability to influence directly the service delivery activities of the zones. Still, as noted above in Table 4, SANRU assistance has enabled the zones to achieve or surpass the accessiblity and coverage targets, with the exception of family planning.

2.3 **Inputs Provided vs Expected Inputs.** Tables 5 and 6 compare the contributions projected in the SANRU Project Paper and expected from the GOZ budget d'investissement with the estimated US Dollars and the actual CPF contributed to the project since 1986.

Table 5
Budgeted vs Estimated and Actual Contributions to SANRU by Project Year
(1 October 85 (FY 86) - 31 December 1990)[16]
(US$ 000s)

Year	Projected		Estimated	
	USAID	GOZ/CPF	USAID	GOZ/CPF
1986	2,242	1,255	1,800	1,717
1987	2,809	1,989	2,200	1,331
1988	2,389	2,174	2,478	2,124
1989	2,260	2,442	2,578	2,063
1990	1,529	2,158	2,678	1,115
Total	11,229	10,018	11,734	8,350

Earmarked expenditures for the US Dollar budget appear to be on target, if not slightly ahead of schedule. However, SANRU received US $1.6 million less in CPF than projected; there was a shortfall of US $1 million (in CPF) alone in 1990. As indicated below in Table 6, this shortfall was not covered by contributions

[16]The Budget Projections are taken from the SANRU Project Paper, p. 43. It was not possible to obtain precise figures for the actual US$ expenditures for project years prior to 1989 from the Controller's Office at USAID Zaire. Data for this period were culled from Project Implementation Reports (PIRs). The Summary Project Financial Report by Project Element provided the data for 1989 and 1990. The Program Office prepared the figures on the counterpart funds (CPF). The amounts presented were calculated using the **average** exchange rate in effect for the year and do not correspond directly with the figures generated by SANRU, which appear to be slightly lower.

from the GOZ. After receiving almost US $3 million in CPF and budget d'investissement in 1989 to support local activities in the zones, SANRU had only US $1.2 with which to work in 1990.

Table 6 GOZ Assistance to SANRU Budget d'Investissement[17] (US$ 000s)			
Year	Budgeted	Received	% Received
1986	2,510	0	0
1987	3,290	0	0
1988	321	171	53
1989	2,905	684	24
1990	2,058	137	7
1991	1,416	0	0
Total	12,500	992	8

Since CPF is used to offset local costs, the recent shortfalls have severely hampered the ability of the project to initiate new activities, e.g., studies, rehabilitations, spring-cappings (see Table 9), or to maintain some operating subsidies in the zones, e.g., pharmaceutical subsidies (see Table 10). Also, as noted below in Section 2.4, the reduced level of funding had a marked effect on SANRU's ability to maintain the previous years' rate of implementation (See Table 9).

A close examination of the US Dollar earmarks through December 31, 1990 (Table 7) reveals that significant resources remain only in the commodity line item of the budget. The other major categories are overexpended (training) or have few resources remaining (technical assistance, other).

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[17]These figures are taken from SANRU's revenue/expenditure budgets for the years 1986-1991.

Table 7 US Dollar Budget (000s) SANRU Project - December 31, 1990[18]			
Line Item	Obligation	Earmarked	% Earmarked
Tech. Asst	4,407	4,130	93
Training	800	820	102
Commodities	10,785	7,350	68
Other	328	290	88
Evaluation	80	0	0
Total	16,400	12,590	77

This analysis indicates that unless "new" funds can be found, the only resources available to support future SANRU operations are USAID/CPF and the US Dollars currently obligated for commodity procurement. Contributions from the GOZ budget d'investissement are expected but may not be forthcoming.

2.4 **Unit Costs for Work Financed and Completed and the Rate of Project Implementation.** As Table 8 indicates, SANRU has attempted to keep the unit cost for work financed at or below the amount budgeted in the Project Paper.

[18]USAID Zaire Controller's Office, "Summary Project Report by Project Element," December 31, 1990.

Table 8 Projected vs Actual Unit Costs for Selected Infrastructure Projects (US$)			
Item	Projected Unit Cost (US$)[19]	Actual Unit Cost (US$)[20]	
		Financed	Completed
General Ref. Hosp	17,000	14,500	21,650
General Off.: RHZ	15,000	8,500	13,250
Health Center: RHZ	2,600	2,765	4,110
Pharmacy Depot	20,000	23,300	23,300
Springs Capped	350	81	175
Wells: SNHR	1,000	n/a	n/a
Piped-water: SNHR[21]	17,000	n/a	n/a
Rainwater systems	-	n/a	1,835
VIP Latrines	50	41	174

It appears that SANRU has tried to contain costs by financing activities at the level estimated in the project paper and looking to the local communities to provide whatever is needed to complete the project, e.g., labor, materials, and/or cash. For example, the SANRU costs on spring-cappings are for materials, such as cement and pipe, paid in local currency. These costs do not include labor and other contributions provided by the local communities. SANRU engineeers estimate that community participation could add as much as 78% to the cost of springs and

[19]SANRU Project Paper, Annex 6.

[20]The figures relect the total amount disbursed divided by the number of projects financed. The figure for the projects completed equals the total number disbursed divided by the number of projects completed.

[21]WASH Field Report 313, p. 26. Most of the piped-water systems have been constructed by SNHR at an estimated cost of US $14,600 per kilometer.

70% to the cost of latrine construction."[22]

In many cases, the unit cost of the work completed is 50% more than the work financed. Based on observations and anecdotal evidence collected during visits to the zones, it is speculated that the zones are using the funds advanced by SANRU for specific projects to finance other health-related activities in the zone, e.g., the purchase of pharmaceuticals.[23] This appears to be a relatively recent phenomenon which has taken place as zone operating costs have begun to sky-rocket. However, the effect of this action is to distort unit cost calculations and to make future budgeting very difficult.

Table 9
Selected Infrastructure and Training Activities
Initiated/Completed by Project Year

Item	1986	1987	1988	1989	1990
General Reference Hospitals	4	9	6	6	4
General Office: RHZ	8	15	11	12	0
Health Centers	18	35	64	50	5
Pharmacies	1	1	0	1	0
Springs	863	481	451	1000	304
Rainwater Catchment Systems	6	10	3	22	2
Latrines	58	122	310	335	205
National and Regional Training	11	12	15	16	5
Local Training	99	108	116	104	23

Table 9 clearly indicates that the rate of implementation of project activities has slowed appreciably in 1990, largely as a result of reduced financing by SANRU and increasing capital and

[22]SANRU has financed a few hand-dug wells at an average cost of US $832/well. However, most of the wells financed have been drilled and equipped by the Service National d'Hydraulique Rurale (SNHR). Ibid. p. 28.

[23]Kamonia, for example, used the funds for spring capping to purchase pharmaceuticals. The staff of the health zone hoped to raise enough revenues to replace the pharmaceuticals purchased and to procure the local materials, i.e., cement and rebar, needed to cap the springs.

operating costs in the zones.

Table 10 presents the pharmaceutical and superivision subsidies distributed by SANRU to the zones since 1986. These data clearly show that SANRU has attempted to support supervision activities in the zones, in spite of reduced financial circumstances. Indeed, in the later years of the project, SANRU has made an effort to provide a larger amount for supervision to an increasing number of zones (See Table 1). This level of support for primary heath care activities is commendable, although well below the target set by SANRU and required by the zones.[24]

Table 10
Supervision and Pharmaceutical Subsidies
to SANRU-assisted Health Zones[25]
(Average per zone in US$)

Subsidy	1986	1987	1988	1989	1990
Pharmaceutical Subsidy	--	932	839	1,331	507
Supervision Subsidy	1,388	903	913	1,204	1,133

2.5 **Economic and Political Situation in Zaire (August 1991).** The true magnitude of SANRU's present financial difficulties and the project's acomplishments in the health zones must be understood and appreciated in the context of the current economic and political chaos in Zaire. In the period immediately preceding the launch of SANRU II (1983-1986), the GOZ conducted a strong economic adjustment program which produced positive results for overall and per capita growth. The adjustment program was discontinued in 1986-88 resulting in economic decline and inflation.

In 1989-90 the GOZ restarted and then discontinued earlier adjustment efforts, defaulted on external loan obligations, and allowed the country to slide into economic chaos. As a consequence, external support to Zaire has virtually ceased, prices are currently increasing at an annual rate approaching 1000 percent and, until the exchange rate was allowed to float on August 16, 1991, a black market in foreign exchange was flourishing. Real output and employment are contracting; purchasing power for health goods and services (especially

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[24]Memorandum of F. Baer to R. Martin, December 17, 1990. See also A. E. Elmendorf, "Zaire: Health Sector Public Expenditure Review," World Bank, June 27, 1990, p. 14.

[25]Data provided by the Division of Programmation et Supervision.

pharmaceuticals) is declining.

The GOZ is currently preoccupied with orchestrating the National Conference, a representative assembly called to facilitate Zaire's transition to a multi-party democracy, and shows no interest in re-starting a program of economic stabilization. In the words of many Zairians, the GOZ has largely withdrawn from governance.

Since late 1990, the consequences of political and economic uncertainity have been manifest in:

- increases in consumer prices in Kinshasa at the following annual rates:
  - overall - 987 percent
  - health and hygiene items - 1078 percent
  - drugs - 1114 percent
- disruptions in supplies of inputs (especially imports) in turn causing disruptions in transport and production;
- the virtual cessation of private investment;
- food riots (Kinshasa - November 1990) and strikes for higher pay among public sector workers;
- declines in retail credit and consumer real purchasing power, and
- declines in consumer purchasing power for health and hygiene items and drugs that are more severe than average, i.e.,
  - health and hygiene 9.2 percent higher than average inflation for 1991 and 29.6 percent higher than average since 1988, and
  - drugs 12.9 percent higher than average inflation for 1991 and 70.8 percent higher than average since 1988.[26]

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[26]See Ministere du Plan, "Hausse Accentuée des Prix à Kinshasa en Juillet 1991: 38.3%," Institute National de la Statistique, Direction des Prix et Indices, Division des Autres Indices, aôut 1991; S. Haykin (USAID/Kinshasa Economist), "Talkling Points for Senior Staff," (USAID Zaire), March 3, 1991, and B. G. Crowe (Assistant to the U.S. Executive Director, World Bank), "Country Strategy Review - Zaire," memorandum to Treasury, State, USAID, U.S. Executive Directors of IMF and AFDB, August 5, 1991.

Activities in the health zones are highly sensitive to fluctuations in the exchange rate, because most pharmaceuticals are imported and must be purchased with foreign exchange. Drugs constitute a high percentage of the operating costs of the zones but also generate the largest percentage of revenues. In the early years of the project, the zones were able to adjust prices to offset the increased cost of curative and preventive services. The zone authorities appear to have used changes in the price of pharmaceuticals to adjust the prices for health services. So far, the zones have been able to raise prices routinely and rapidly to cover operating costs. However, since salaries and incomes are not keeping step with inflation, it may not be possible to continue this practice. Higher prices may now be excluding more and more citizens who simply cannot pay for health zervices.

To date, SANRU-assisted zones have continued to operate and to finance a significant portion of operations with revenues generated by the services provided and the goods sold. Without a strong GOZ stabilization program, increased external support is unlikely and hyperinflation is expected to continue.

2.6 **Donor Assistance to the Health Sector.** Some bilateral and multilateral donors have eliminated or are reducing their levels of support to the health sector because the GOZ has failed to maintain the structural adjustment program and pay its external debts, and has disregarded civil rights. In 1989, Belgium and the United States provided almost 80% of donor assistance to the health sector, an estimated 70% of which went for primary health care.[27]

Belgian Assistance (La Coopération Technique Belge) was withdrawn in 1990. In June 1991, when Zaire defaulted on loan payments, USAID Zaire began to scale-back operations to comply with the Brooke Amendment, the provision of the U.S. Foreign Assistance Act which prohibits granting development assistance to countries which do not pay their debts. Three major health activities (PEV, PSND, and SANRU) have significant U.S. funding only through September/October 1992.

UNICEF plans to continue to provide esential vaccines and some other equipment (refrigerators, sterilizers, etc.) at the national level but will limit near-term (1990-1993) program operations to the eastern regions of Zaire. WHO will continue to support the management training program for médecins chefs de zone. However, WHO's level of assistance has never been more than 4% annually of past donor assistance. The World Bank has

[27]Most Belgian assistance supported expatriates working in the 67 health zones, the Projet Santé Pour Tous, or central-level divisions and programs of the MOH.

suspended its major lending activities in Zaire, but has approved a small credit (US $30 million - IDA) for health and education (P.A.S.S.). Since the GOZ has not satisfied all conditions of the new World Bank IDA loan, the funds approved have not been disbursed.

Some donors have withdrawn or are reducing their assistance; others continue to play a role but cannot replace previously available resources. The absence or reduction of donor support and the certainty that it will not return to past levels in the next one or two years compounds the difficulty of keeping many health zones functional in the near term.

3. Key Issues

This section comprises the review and analysis of the key issues defined in the Scope of Work (SOW).

3.1 Financial Viability of the Rural Health Zones. The concepts that local populations should pay for health services and that individual health zones should do everything possible to generate locally the resources necessary to meet operating expenses are well ingrained in the minds of those who manage the zones and use the services. Most of the zones visited are very successful at generating revenues. Indeed, the zones have proven to be remarkably resilient in the face of economic chaos and the withdrawal or reduction of donor assistance (See Section 2.6). In the short-term, the zones seem capable of maintaining solvency by

- adjusting prices rapidly to account for inflation while generating margins sufficient to be able to resupply pharmaceuticals;

- hiring, adjusting hours, and laying-off personnel;

- setting margins above costs (including transport and handling) on drugs and pre-school and pre-natal care forms at the central office and health center levels to ensure sufficient operating revenues;

- arranging surplus-generating contracts with employers for services to their employees, and

- searching for and finding lower-priced pharmaceutical suppliers.

Still, the zones lack the basic financial management skills and tools needed to do more with the resources on hand.

At this moment, the need to increase prices, especially for drugs, to contend with inflation has excluded some poorer people from health services.[28] Few if any zones have structured procedures to identify indigents and ensure their access to care. In some cases, informal means tests are applied, but rarely if ever is their effectiveness evaluated. At some hospitals, credit is given to patients who are unable to pay their bills. In the zones with access to fewer outside resources, SANRU assistance in the form of subsidies and other support is of critical importance.

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[28]Philip D. Harvey, "In Poor Countries, 'Self-Sufficiency' Can be Dangerous to Your Health," Studies in Family Planning, Vol. 22, No. 1, Jan/Feb 1991, pp. 52-54.

3.1.1 Expansion, Consolidation, Reduction of SANRU's Operations in the Health Zones. Most of the health zones assisted by SANRU are having a very difficult time maintaining their activities. Visits to the zones confirmed that any reduction in the level of SANRU assistance would result in drastic cutbacks in health zone activities. Few of the zones visited were able to identify a readily available means for replacing SANRU assistance.

SANRU has made a concerted effort to maintain the supervision subsidies at a constant level. Yet, a good number of the zones, primarily state-assisted, find even this level of assistance inadequate.

Resources available to SANRU from USAID Zaire and the GOZ are below the anticipated levels. At current levels of financing, SANRU cannot meet its target of covering 25% of the operating costs of the zone offices of the currently assisted zones.[29] If SANRU attempts to expand operations beyond those currently assisted, many zones may have to reduce levels of service delivery.

3.1.2 Proposed Criteria for SANRU Assistance. Analysis of the resources available indicates that SANRU should consolidate operations in those zones currently assisted. However, there is considerable disparity in the performance of the health zones, largely as a function of the qualities of the médecin chef de zone. In some cases, it may be worthwhile for SANRU to reduce or suspend assistance to some zones. This practice would allow the project to contribute extra resources to well-managed zones and to encourage the poorly managed zones to improve operations. SANRU has already suspended assistance to eight health zones.[30] The effect of this action should be closely monitored.

The médecin chef de zone is currently the critical figure in the management of most zones. Any criteria for continuing or reducing SANRU assistance must take into account his performance. SANRU might consider the following criteria when choosing to continue or suspend assistance:

- médecin chef de zone is present in the health zone and has a "clean" record of behavior;

- primary health care services are available in the majority of health centers;

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[29]See memorandum of F. Baer (SANRU) to R. Martin (USAID Zaire), December 17, 1990.

[30]See memorandum of Dr. Bongo, Chief of the Division of Program and Supervision, July 22, 1991.

- supervision is conducted regularly;

- there is community support for and participation in the management and implementation of health zone activities

- the equipment and supplies provided by SANRU are in use in the general reference hospital and the health centers of the zone, and

- the health zone has proposed or adopted "innovative" approaches to service delivery, financing, etc.[31]

3.1.3 Demands from Regional and Sub-Regional Offices for Financial Contributions from the Health Zones. Some Regional and Sub-Regional Offices have attempted to recuperate operating costs from the health zones. In most cases, the health zones have met such demands with active and passive resistance. In some areas, the health zones have had to contribute as much as 1 million *zaires*. In these zones, there has been some impact on the financial viability of the health zone.

Financial requests are only one of the demands made on the zones by regional, sub-regional or local authorities. The zones routinely receive requests -- demands -- for the use of SANRU-and other donor-supplied resources, e.g., vehicles, construction materials, and pharmaceuticals. There are reports of many creative responses to such demands. For example, in some zones the *médecin chef de zone* has instructed the chauffeur to remove the tires and inform the requesting office that the vehicle is "out of order."

3.1.4 Pharmaceutical and Contraceptive Subsidies. Willingness to pay for pharmaceuticals is well established and widely accepted. Most health zones appear to charge and receive a price for pharmaceuticals equal to the replacement cost. Pharmaceutical sales represent the majority of the revenues generated in most health zones. Furthermore, in some parts of the country, e.g., the diamond mining areas around Mbuji-Mayi and Tshikapa, private for-profit pharmacies are thriving. In some cases, the price of pharmaceuticals might affect the number of pills purchased and, as a consequence, the efficacy of the therapy. At the moment, however, this has not been reported as a significant problem.

With the exception of condoms, used to prevent AIDS transmission, the demand for modern contraceptives may be weak in the rural areas. Very few of the private pharmacies had family planning supplies other than condoms. In most health zones, modern

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[31]See "Présentation des Resultats du Groupe de Travail: Selection des Zones de Santé a Financer," n.d.

contraceptives were only available at the general reference hospital and/or the zone office.

The team that visited Bandundu and Kasai Occidental surveyed condom (Prudence) sales at five sales points in six different towns.[32] Each seller was asked six questions:

1. how long have you sold Prudence?

2. how many customers, on average, do you have per day? are there more customers on one specific day?

3. what is the selling price of Prudence?

4. have you had any Prudence sales training?

5. why do you sell Prudence?

6. where do you get your stock?

Responses were not confirmed by other methods, e.g., reviewing sales receipts, customer interviews, etc. In addition, the survey team did not actually buy condoms, nor have time to collect information on the vendors or the communities each served. The findings of this very small sample are not statistically significant but do suggest that:

- Most vendors charge more than the "official" price for Prudence. (Reported prices ranged from as low as 200 zaires to as high as 5000 zaires. The average for all vendors was 1735 zaires; the median was 1000 zaires.)

- Locations of high demand have higher prices. (There are indications that AIDS awareness is very high in the diamond mining regions of Kasai Occidental and less of a concern in Bandundu. The average number of clients per vendor in Kasai Occidental was 10 per day; in Bandundu, the average was 4 per day. The average sales price at the sites in Kasai Occidental was 2500 zaires; at the Bandundu sites the average price was 800 zaires.)

- Price is related to supply source. (All Kasai respondents purchased their condoms from Kinshasa, while half of the Bandundu respondents had local sources of supply.)

- Training appears to lower the price significantly. (Only

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[32] T. Brown, B. Bongo, and L. Mize, "Summary of Informal **Prudence** Condom Survey in Kasai Occidental and Bandundu," August, 1991.

three of the vendors were trained. It is noted that these would be more likely to know the "official" price and report that number or a close approximation.)

These results confirm other reports that there is a significant demand for condoms and that "official" prices could be increased. Regrettably, this same conclusion does not apply to other contraceptive methods, for which additional promotion and subsidies appear necessary.

3.2 **Health Zone Management.** The evolution of the health zones during SANRU II has taken place in an environment where the needs of the communities exceed the available resources. At the same time, the management of the available resources has been hampered by the absence of an effective accord among the three principal partners, i.e., the GOZ, NGOs, and the local community. Without this accord, the médecin chef de zone sometimes appears as the "big boss" (le grand patron) in the zone.

In the early 1980s, health authorities drafted a statut that would recognize the health zone as a legal entity. The GOZ never approved the proposed statut. Over time, it became apparent that this statut was too rigid to reflect the multiple effective management structures that existed in the zones. SANRU has made many attempts to clarify the legal standing of the health zones. In 1987, for example, SANRU attended a workshop at Mbanza-Ngungu which documented most of the problems causing conflict and proposed some solutions.[33] At the health zone level, however, activities continued as if the Mbanza-Ngungu document never existed.

During visits to the zones the following was observed:

- some conflicts continue to exist;
- team spirit and collaborative management are sometimes weak, and
- community participation in health zone management is insufficient.

3.2.1 Conflicts in Health Zones. In most of the zones visited some conflicts were mentioned. The conflicts are multi-dimensional and due to the personalities of those working in the zone and/or the absence of the above-mentioned common accords. The following types of conflicts were reported:

- médecin chef de zone vs médecin directeur de l'hôpital;
- NGO vs médecin chef de zone;

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[33]"Charte de Mbanza-Ngungu: une strategie de collaboration intrasectorielle entre les partenaires du secteur santé au Zaire," mars 1987.

- NGO vs NGO within the zone;
- NGO vs GOZ within the zone;
- the local community vs health center nurse (<u>infirmier titulaire</u>);
- the local residents vs outsiders assigned to the zone;
- <u>médecin chef de zone</u> vs the local community,[34] and
- the health zone personnel vs the <u>médecin sous-regional</u> or <u>médecin inspecteur regional</u>.

In the zones visited, several different management models have been developed to address and resolve these conflicts. The arrangement of the organizational structures is different in each model. Still, each reflects a managerial structure which functions effectively in that zone and was developed by the partners responsible for managing the zone.

3.2.2 <u>Health Zone Management</u>. In general, there are three levels of management within the health zone:

- <u>conseil d'administration</u> (board of directors);

- <u>bureau central de la zone de santé</u> (zone office), and

- <u>centres de santé</u> (health centers) and their committees.

These managerial units carry out the operations of the health zone. For example, the <u>conseil d'administration</u>, should function as the representative body that defines zone policy and oversees zone operations. However, most meet infrequently and are usually chaired by the <u>médecin sous-regional</u>. In most cases, the health zone policy-making and managment units do not function according to written documents that define the authority and responsibility of the partners operating in their zones. As a consequence, the zone office, composed of the <u>médecin chef</u> and his personal staff, frequently manages the zone without answering to an oversight body.

3.2.3 <u>NGO and Community Involvement in Zone Management</u>. NGO partners have a significant influence on the management of many health zones. Frequently, NGOs are responsible for the management of the general reference hospital and a number of health centers. In some cases, there is active and effective collaboration between the units assisted by the NGOs and the other health units operating in the zone. Where good

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[34]The local community's displeasure with the frequent absences of the <u>médecin chef de zone</u>, especially in those zones with only one doctor, is an example of one type of conflict. In most of the zones visited, the <u>médecin chef de zone</u> was away an average of six weeks per year, primarily for training. If there is only one doctor in the zone, the community feels abandoned.

collaboration is in effect, the zone functions well, e.g., Ipamu. In other cases, the NGO-assisted units function almost autonomously.[35] Most private clinics and pharmacies also operate independently from zone office authority.

Rural inhabitants' participation is limited to village-level development or health committees of varying strength, though rarely very strong. In many health zones, the local community has been involved in the construction of the health center or health post, and in the capping of water sources. In some cases, the local community has built a house for the health center nurse. Some local communities have actively defined their health needs and routinely participate in motivating the population to accept and support health services. However, this degree of community involvement appears to be limited to certain regions. For example, it might be more common in the health zones of Bas Zaire than those of the Kasais.

3.2.4 Peace Corps Assistance with Zone Financial Management. The health zones appear to appreciate the assistance in financial management provided to date by the Peace Corps Volunteers (PCVs). In addition, there is a demand for additional assistance. The skills and experience of the PCVs involved in the program are impressive and appropriate. It is noted that some volunteers may be overqualified and others have expressed frustration over being unable to use their skills. Still, this frustration may result from missing some opportunities to provide assistance to the zones.

The skills of PCVs might be better used if the volunteers involved in the program are better prepared. Consideration should be given to inviting members of the Health Financing and Sustainability Project, in collaboration with SANRU, to conduct a pre-service training program in Zaire for the financial management PCVs and their counterparts (administrateurs). The training should focus on technical matters in health zone financial management, and include examples of appropriate areas of assistance and methods for developing client ownership in the proposed work.[36]

3.3 **SANRU's Health Information System.** The Annual Report (Rapport Annuel) is the core of the SANRU Health Information System (HIS). Data in this report are compiled by the zone office and used to make the annual workplan (plan d'action). The reports are sent to SANRU headquarters where staff use the data

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[35]It is noted that the NGO centers may be the best-functioning in the zone and could serve as models.

[36]"Conclusions de la Conférence des Volontaires du Corps de la Paix - Conseillers Administratifs," Kisantu, mai 1991.

to assess the status of health zone operations. The Annual Reports allow SANRU managers to identify problems and trends in health services. The Annual Reports rely on the collection, organization and analysis of data, and its transformation into useful information. The SANRU HIS also consists of data collected during supervision visits made by headquarters staff.

3.3.1 Data Collection in the Health Zones. The majority of the zones visited receive information on health center activities through monthly reports. Some data are collected during routine supervision visits, and some data are provided verbally when health center nurses visit the central office. However, many zones have experienced difficulty in collecting data. Some health centers cannot routinely deliver the monthly reports to the central office. These centers lack bicycles or motorcycles and in the rainy season, when road conditions are especially difficult, these health centers cannot get to the central office. In some zones, the health centers farthest from the central office are not routinely visited and supervised. This finding is becoming increasingly common as SANRU supervision subsidies are unable to cover the full cost of visiting all sections of the zone.

3.3.2 The Use of Data at the Health Zone Office. Most of the zone offices reported that the data received were analyzed and that feedback was sent to the health centers. Zone offices also included the data in the Annual Reports sent to SANRU and others, e.g., médecin sous-regional. Visits to the zones were unable to confirm that zone office staff routinely analyzed the data and gave feedback to the health centers.

3.3.3 SANRU Annual Reports (1990). More than half of the 28 health zones visited had sent the 1990 Annual Report to SANRU. In the majority of cases, the superviseur or the coordinateur des Soins de Santé Primaires had prepared and submitted the first draft of the report to the médecin chef de zone or other zone office staff for final revision and transmittal to SANRU. For those zones which did not submit reports, the following reasons were cited:

- the médecin chef de zone did not have sufficient time to prepare the report;
- the staff of the zone office was new and unfamiliar with the process;
- the zone office staff did not receive the form from SANRU;
- the report is still being prepared, and
- the médecin chef de zone did not like the format of the

SANRU form.

3.3.4 Observations on the SANRU Annual Report Form and Total Reports prepared annually by the Health Zones. Most of the médecins chefs de zone observed that the SANRU Annual Report form was satisfactory but somewhat limited. Many noted that the form did not record epidemiological, financial or curative data. Others found it difficult to quantify the degree of health center operational effectiveness. For example, checking the appropriate boxes describing the quality of consultation pre-scolaire in each health center was considered a very subjective exercise.

The number of reports prepared annually by health zones varies between 13 and 100. In most of the zones, each report form is different and sent to a specific program in the Ministry of Health, e.g., TB or Leprosy, or to a donor. The following receive reports from the health zones: Bureau National de Tuberculose (BNT), Programme Elargi de Vaccination (PEV), Programme National de Lèpre (BNL), Inspection Medicale Regionale et Sous-Regionale, FONAMES, FOPERDA, TDCI, and SANRU.

3.3.5 Receipt and Use of Annual Reports by SANRU Headquarters. SANRU records show that more than 50% of the health zones do not deliver the Annual Report on time. As of August 15, 1991, only 37% of the zones had submitted an Annual Report. Reportedly, SANRU rapidly reviews the Annual Reports and sends feedback to the health zones. This initial review of individual Annual Reports is carried out to assess the degree to which the data presented are consistent and reliable. The data are then entered into the SANRU computer and analyzed across health zones in terms of specific indicators. The findings are shared with the relevant SANRU divisions and other institutions. This process takes about six months.

Visits to the zones indicate that SANRU infrequently acknowledges receipt and/or provides feedback on the Annual Reports to the health zones. Almost all the health zones visited expressed a desire for feedback.

3.3.6 SANRU Health Information System (HIS). The SANRU HIS provides valuable information on the accessibility of primary health care services to rural residents. It also provides some limited information on health service coverage, for example, data on immunizations and family planning acceptors. However, the system does not allow an assessment of the impact of services on rates of mortality and morbidity, nor is it intended to do so.

3.3.7 SANRU HIS links with other national health information systems. The Projet d'Etude de Renforcement Structurel (ETRI) is in the process of implementing a national health information system, système national d'information sanitaire (SNIS). SANRU has actively participated in the development of this system,

specifically in the selection of key health indicators. Currently, the SNIS form is being tested in a limited number of health zones, e.g, Nselo. Some personnel interviewed preferred the SNIS form; others suggested that completing the SNIS form was too time-consuming. All noted that feedback in the SNIS system was much slower than in the SANRU system. A few médecins chefs de zone felt that some effort should be made to accommodate the two forms, selecting the most useful aspects of each.

3.4 **Training.** The SANRU Project Paper provided for regional training and continuing education conferences for zone personnel, long-term training at the School of Public Health, local training done by the zones themselves, and some out-of-country training. In addition, the project evaluation of January 1987 recommended three training emphases: standard curriculum, training evaluations, and visits between zones.[37]

3.4.1 Regional and national training.

Targets. In all categories except nursing school instructors, zone secretaries, and candidates for the school of public health, the training was on schedule (at least 61% completed) as of December 1990. Exact figures are shown in Table F-1.

Nursing school instructors: SANRU held an important national workshop of nursing school professors in 1990 at which the current curriculum was reviewed and a very useful document, "Integrating and reinforcing primary health care in nursing schools of Zaire," was produced. The document concluded that most elements of primary health care are already included in the curriculum and that adequate texts exist in most topics; a few new materials must be written; teaching aids (books, flipcharts, scales, standard preschool cards, etc.) must be provided to the schools; and the courses should offer more practicum and few lectures. The Sixieme Direction of the Ministry of Health (charged with nursing school education) participated in the curriculum review but has taken little initiative in implementing recommendations.

SANRU does not need to wait any longer, since the improvements recommended by the workshop require mainly the input of teaching materials and the training of nursing school instructors, not major policy or curriculum changes. The Training Division will proceed immediately to provide necessary materials and to train instructors in nursing schools in SANRU zones (and in neighboring

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[37]SANRU Project Paper, Logical framework and Annex 8. A June 1991 review of USAID-sponsored training programs contains a detailed analysis of SANRU I and SANRU II training. The evaluation team acknowledges the large amount of useful information found in that report.

zones, if possible).

Secretaries: This category has been dropped from the SANRU training strategy, since zone secretaries are trained on the job by their superiors.

School of Public Health (SPH). By the end of project (October 92), fewer than 70 people of the targeted 88 will have been trained at the SPH. SANRU staff (and SPH staff) have found it difficult to identify enough qualified candidates each year. Several reasons have been cited:

- The entrance requirements are high. A candidate must have a doctorate or license and be working in the public health sector.

- Physicians are reluctant to take a temporary drop in income, leave their families behind for ten months, and even risk losing their position while they are away.

- Potential candidates are uncertain of the value and equivalency of the diploma from the School of Public Health. SANRU has discussed with the SPH various possibilities, such as a two-year program leading to a recognized master's degree, perhaps with the second year being field research conducted back in the health zone. However, an acceptable solution has not been found.

Continuing education. The SANRU Project Paper (annex 8) called for continuing education through 50 annual regional conferences for médecins chefs de zone and 50 bi-annual regional conferences for zone supervisors and zone trainers. All zones of a given region, not just SANRU-assisted zones, were to participate in these conferences; other national or donor agencies were to share the costs. In addition, SANRU was to sponsor four national conferences for water engineers.

As of December 1990, SANRU II had co-sponsored (with UNICEF) 12 regional conferences for all the médecins chefs de zone of those regions. SANRU also held four national conferences for personnel from the SANRU zones only. Four conferences for water engineers were held. SANRU has held no regional conferences for zone supervisors or trainers.

Evaluation of training programs. The staff of the Training Division of SANRU has developed a series of questionnaires to evaluate a participant's on-the-job performance against the stated objectives of the course. Training staff have made some follow-up visits to trainees' posts; they have written evaluations and recommendations for future courses.

Development of standard curriculum. SANRU staff and consultants have played a major role in developing the modules now in use for primary health care training in Zaire. All regional courses have standard modules. Modules for local training of nurses, traditional birth attendants (TBAs), and community health workers (ASCs) now exist, but none are available for health center and village committees.

New focus on team learning. SANRU training staff have noted two shortcomings of individual training. First, some individuals tend to regard their new knowledge, books, and certificates as private property, to be guarded carefully and to be used for private benefit. Second, newly trained persons, even with the best intentions, are unable to implement their new learning if their colleagues do not understand what it is all about, and if their superiors do not enable them to put it into practice.

These findings have prompted SANRU to initiate several types of team learning that seem to be working well:

- Zone management courses are now taught to a pair of participants from each zone, usually the médecin chef de zone and the hospital medical director or administrator.

- Zone supervision courses are also offered for pairs--the médecin chef de zone and the zone nurse-supervisor.

- Family planning courses now invite the médecin chef de zone and a nurse to be trained together. This strategy has inspired several zones in Bas-Zaire to plan serious family planning activities for the first time.

- The "health zone forum" strategy has recently been tried by the operations research (OR) division. A SANRU team spends several days in the zone working with zone personnel and representatives of the community on group management and problem-solving techniques, including operations research. The OR staff and the pilot zones are enthusiastic about the seminars, but the impact has yet to be evaluated.

Basic PHC training for Médecins Chefs de Zone and administrators. PEV began this training the early 1980's. SANRU helped develop teaching modules and co-financed courses with UNICEF from 1986 to 1989. Since that time, Fonds National Médico-Sanitaire (FONAMES) has completely taken over this training, with financing from UNDP and WHO. However, SANRU staff and field personnel point out three current shortcomings:

first, the 20 training modules cover too many topics superficially;

second, the choice of candidates is often made arbitrarily, without applying appropriate criteria, and

third, regional and national authorities tend to stress centralization and conformity, rather than encouraging diversity and innovation in the zones.

Training for SANRU I and SANRU II zones. The SANRU II zones have not received their share of training. For example, the SANRU Project Paper called for 70% of the trainees to come from SANRU II zones. To date, the proportion is only 40%.

Personnel movement. Visits to the zones found that 63% of personnel trained in SANRU courses are still working in the zone, nearly all in the job for which they were trained. Some are working in neighboring zones or in sub-regional positions. Still, the zones consider their losses high and feel they have no control over the re-assignment of trained personnel. SANRU can probably do little to affect this movement of nurses, administrators, etc., and can only recognize that continual training and retraining is necessary to build a large pool of trained, experienced primary health care workers to serve the country.

Less than half of the graduates of the School of Public Health return to their posts at the zone, sub-regional, and regional level for any length of time. Of the 48 students sponsored by SANRU who began the course in 1986, 1987, 1988, and 1989, 30 came from rural health zones. In mid-1991, 15 (50%) were back at their same post. Nine were working at sub-regional or regional positions and six were in private practice or otherwise "lost" to the public health sector.

Of the 18 SPH students recruited from sub-regional, regional, and national posts, five were still in their original jobs in mid-1991. Ten were working in new jobs in the public health sector, and three were no longer in public health.

It is obvious that graduates of the School of Public Health are forming a pool of well-trained candidates for important posts throughout the public health system. However, the zones and bureaus which sent personnel for training receive little benefit if they are moved to other posts during or just after their training, or if they return for only a short time.

Visits between health zones. The 1987 project evaluation recommended that personnel from new or weak zones visit strong zones. In addition, persons from strong zones were to be invited to visit the weaker health zones to assist with activities or management. SANRU training staff, though recognizing the potential value of such interchanges, has done little to encourage zones to take advantage of available funds and

opportunities.

3.4.2 Local training in the zones.

Targets. By December 1990, SANRU had met nearly all targets for supporting the zones in the basic training of health center nurses, village health workers and traditional birth attendants. See Table F-1. However, the SANRU Project Paper foresaw that each worker should attend several courses, an average of nearly three courses per person.[38] Thus, the annual projections add up to a very large total of participants:

Table 11
Status of Local Training and Re-training in the Zones

Category of Trainee	No. of Participants		% Achv'd
	Target	Dec. 90	
Health Center Nurses	5970	2910	49
Village Health Workers	5400	2368	44
Traditional Birth Attendants	2700	1370	51

Village Committees. The long-awaited research on successful cases of village organization is at last producing useful findings. For example, it appears that members of village development committees sometimes provide better preventive services than trained village health workers.

Training slowdown in 1990 and 1991. During 1990, the training division organized or paid for only one-third of the regional training courses and only one-fourth of local zone training courses sponsored in previous years (See Table 9).

The training staff attribute the slowdown to the late receipt of counterpart funds (CPF). However, the evaluation team notes that even when funds did arrive, office procedures were very slow. Staff was preoccupied with planning the national conference. The training division currently is holding large numbers of unanswered outstanding requests for training from the health zones. Meanwhile counterpart funds for training are sitting unused in Kinshasa.

3.4.3 Out-of country training

Targets. The project had nearly met its targets for

[38]Ibid., Annex 8.

international courses and conferences by the end of 1990 (See Table F-2).

Training for women. Of the 72 persons who attended out-of-country conferences and training courses, only 11 were women (15%). Women are very rarely appointed as médecins chefs de zone or to sub-regional and regional positions, the most common categories for out-of-country and in-country upper-level training. Nevertheless, qualified women candidates are being sought and sent for training.

International Conferences and Courses. SANRU has guidelines governing participation of SANRU staff at international conferences and courses. Conference travel is funded primarily for those who make presentations.

3.5 **Family Planning and AIDS.** Family Planning did not receive as much attention in SANRU I as other primary health activities, eg., vaccinations and diarrhea disease control. For that reason, it was recommended that SANRU II emphasize the introduction and use of modern contraceptive methods in the health zones. This activity was to consist of:

- ensuring regular supplies of contraceptives to the health zones;
- incorporating communication strategies in the programme des naisances désirables, and
- developing family planning and AIDS training modules.

As a measurable output objective of these three activities, SANRU II called for at least one percent of the women of childbearing age in each health zone to accept family planning each year after the second year of SANRU assistance to the zone.[39] Of the 30 zones submitting Annual Reports for 1990, only three reported family planning registrations equal to 1% of the women of childbearing age.

3.5.1 Contraceptive Supplies to the Health Zones. SANRU, in collaborating with AZBEF and PSND, drafted a plan to establish a network of contraceptive depots. The network was to begin with seven existing pharmaceutical depots and add nine more over a planned period. This plan was never implemented. Eight-five percent of the zones visited had contraceptives on hand, even

[39]Ibid., p. 24.

without a large network in place to supply contraceptives.[40] This encouraging finding was due to two factors:

1. the existing seven depots are doing a good job of supplying contraceptives in the areas where they are located, and

2. SANRU initiated a "stop-gap" measure, sending a carton of contraceptives to each health zone.

Other networks exist for expanded contraceptive distribution. AZBEF has a loose system of voluntary "antennae" in eight regions of Zaire, some of which stock contraceptives for their own clinical use. AZBEF is being reviewed by USAID Zaire to determine whether it can have greater participation in nationwide family planning activities. PEV has a network of 31 vaccine depots across the country; these already supply every SANRU health zone with vaccines and could distribute contraceptives as well. Zone staff know PEV people at the sub-regional level and deal with them monthly. PEV officials are open to the idea of adding contraceptive supply to the responsibilities of depot personnel. PSND depots in eight regions vary greatly in effectiveness and their operations may be uncertain after September/October 1992.

3.5.2 <u>Family Planning Communication Strategies</u>. In September 1986 SANRU participated in an Information, Education and Communication (IEC) Strategy Development Workshop with PSND, AZBEF, FONAMES, RATELESCO, the Department of Education, and the Department of Condition Feminine. This workshop produced a comprehensive and excellent strategy document. FONAMES was charged with coordinating IEC activities but has not carried out this mandate. As a result, some organizations worked alone or, in some cases, collaborated to develop IEC materials. However, since 1986, little attention has been given to implementing an overall strategy and major components have been overlooked.

The activities carried out in IEC to date include:

1. A draft of a portable flipchart, under development by PSND since 1986, which SANRU hopes to use in the health zones;

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[40] Surgical sterilization is performed in a number of zone hospitals, usually at the time of a Caesarean section. Surgical sterilization does not depend upon a supply of contraceptives but only on the instruments and anesthetics required for any abdominal surgery. Any surgeon who operates on the abdomen can perform sterilization without special training.

2. Posters and banners developed principally by PSND which are distributed widely, through not exclusively by SANRU;

3. A calendar promoting contraception, developed by AZBEF, which SANRU distributes and displays;

4. Promotional materials -- signs and t-shirts about Prudence condoms -- which were developed and distributed by the Social Marketing Project (PMS) and are often visible in SANRU-assisted health zones, and

5. IEC training, included as an integral part of five clinical training courses which have been held for zone family planning workers.

Still, there is no concerted SANRU strategy to promote vigorously the use of contraception. One very rarely sees a family planning poster in a rural health center and seldom in the zone office of a SANRU-assisted health zone. Although technically knowledgeable about contraception, a number of médecins chefs de zone have a naive understanding of population dynamics and of the compelling need for contraception as an essential component of good maternal and child health care. At SANRU headquarters in Kinshasa, one senses a tolerant but less than enthusiastic attitude toward family planning.

In fairness to SANRU, family planning is not enthusiastically embraced by most village people. Visits to health zones confirmed that the largest numbers of contraceptive users were in the zones located in or near cities and large towns. The visits also confirmed the existence of cultural barriers to family planning. It was often observed that people regard children as a gift from God and that the Catholic Church was opposed to contraception. However, some Catholic clergy working in the zones expressed a tolerant attitude toward modern contraceptive methods.

3.5.3 Family Planning Training Modules. The family planning training module used for SANRU doctors and nurses was developed by PSND with assistance from the Program for International Training in Health (INTRA). The module requires four weeks to complete. Less than 20% of the teaching time is devoted to contraception. Other subjects covered include: politics and legislation (10 hours), sterility (4.5 hours), infections (10 hours), management and statistics (10 hours).

From 1987 through 1989 médecins chefs de zone and nurses from SANRU-assisted zones attended five training courses hosted by PSND, AZBEF or IMCK. Regrettably, the zones which sent personnel for these trainings do not show an increase in contraceptive acceptors compared to zones without trained personnel. This

suggests that training may be a necessary element in a successful family planning program, but alone is not sufficient. Perhaps it is the overall enthusiasm of the health zone staff that makes the difference.

In mid-1991, most SANRU zones received a subsidy to finance activities in family planning. Several zones plan to train health center personnel and will use zone personnel (usually the physician) to teach the course. However, there is no specific training module for this course. The trainers will probably use printed materials already on hand (Brown and Brown) which are appropriate for very practical zone-level personnel. Continuing the subsidy for family planning training may lead to increased enthusiasm for family planning among zone staff and to larger numbers of family planning acceptors.

3.5.4 AIDS. Every zone physician interviewed reported confirmed or suspected AIDS cases. Cases were more prevalent in zones near diamond mining areas (e.g., Tshikapa), gold mining areas (e.g., Dungu), large population centers (e.g., Tshikaji) or near major transportation routes (e.g., Kisantu). Every zone physician reported that zone staff gave information on HIV transmission and that people in general were fairly knowledgeable about the disease and the role that condoms play in its prevention.

However, few zones had the laboratory tests needed to confirm the diagnosis of the disease or to test blood intended for transfusion. Virtually every hospital gives blood transfusions, usually to children with severe hemolytic malaria. The transfusion is frequently a life-saving measure. Physicians try to minimize the risk of AIDS by using blood from a member of the child's family. In an area like Kananga with an HIV infection rate of 3% in the adult population (Brown), three percent of the children transfused will die of preventable AIDS if blood is not tested first. This situation can be repeated to a greater or less extent over all of Zaire. SANRU and other purveyors of health services should study the feasibility of providing a HIV test kit.

3.6 **Research Activities.** SANRU was directed to develop a research capability.[41] Research was undertaken both centrally and at the zone level. Studies at the central level were of three types: impact studies, finance studies, and operations research. Twenty-nine of these studies were planned, of which 26 were financed and completed (See Table F-4, Appendix F). The central studies received assistance from consultants provided by the centrally-financed PRICOR and REACH projects. Results were disseminated in a professional format. It is less clear that findings were incorporated in SANRU or zone policies and

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[41] Op. cit., p. 36.

practices.

SANRU invited médecins chefs de zone to submit proposals for research at the zone level. Ninety operations research micro-projects were proposed to encourage the zones to find concrete solutions to problems associated with managing primary health care; only 12 OR micro-projects were submitted and completed. Of the 20 "other studies," 15 are complete.

Financial constraints limited the number of zone-level studies undertaken. Results of the research were to be presented at the SANRU Annual Conference. Since funds were limited and the conference postponed, brochures will be prepared and distributed to personnel in the SANRU-assisted zones and to others.

The quality of these studies vary greatly. In some cases, the results are noteworthy, e.g., the study of Oral Rehydration Solution (ORS) use in Pawa. For most of the médecins chefs de zone involved in the program, this was their first experience with field research. It is of some significance that most of the studies were proposed and conducted by médecins chefs de zone who had received some research training at the School of Public Health.

In many respects, the results of the zone-level research were less important than the opportunity given zone personnel to approach local problems using research methodology. Publication of the methods and the findings, which could be done at a relatively low cost, could be of interest to other health personnel in Zaire.

3.7 **Commodity Procurement and Tracking.** Equipment and supplies were deemed essential to achieve SANRU's primary focus of developing and/or strengthening the health zones.[42] Medical equipment and supplies were to be furnished to 720 health centers and 50 general reference hospitals. Basic office equipment and related accessories were to be sent to 50 health zone offices; 21 regional and sub-regional inspection officers and six regional and/or sub-regional pharmacies were to receive the same office furnishings as well as micro-computers and related accessories. Four-wheel drive vehicles were to be available to 21 regional and sub-regional inspection offices and 50 health zones. This brief list contains only a few of the items that the project was to procure and send to zones. Also, it does not list the items to be procured for SANRU headquarters nor the systems needed to order and ship equipment and train personnel in its proper use and maintenance.

At project start-up the commodity list set forth in the Project

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[42]Ibid., p. 25.

Paper was reviewed and refined by SANRU and USAID Zaire staff. The personnel of the health zones had little if any input in the process of defining the commodities required to enhance their capacity to provide preventive, curative and promotive health services. Yet, most were entirely satisfied with what they received.

3.7.1 CPF Financed Commodities: SANRU Procurement. A 1991 review of the procurement procedures indicates that SANRU staff have been able to move rapidly to procure locally available materials with counterpart funds (CPF). Until recently, when hyperinflation hit Zaire, the project was able to provide SANRU headquarters and the zones with adequate funds to purchase in Zaire and transport to the site the materials to cap springs, rehabilitate hospitals or construct health zone offices and health centers (rebar, cement, brick, block, wood, tools, etc). Requests from the zones for materials were generally submitted in the zones' annual workplan and were financed by SANRU within twelve months of receipt.

Currently, while SANRU continues to respond within 12 months, the amount provided is routinely less than the total needed to complete the proposed scope of work. The local currency (zaire) is losing purchasing power rapidly. For example, one zone submitted a budget for 1991 based on estimates that were adequate to cap 30 springs in 1990. When the funds arrived, the zone was only capable of completing 8 or 10 springs.[43]

3.7.2 US Dollar Financed Commodities: USAID Zaire Procurement. The limited available data on the timing of US Dollar obligations to the commodity line item of the SANRU Project budget leads to speculation that the procurement plan was based on the availability of funds (US$) at given points during implementation. Since procurement activities are still underway in the final fiscal year of the project, it appears that funds for commodity procurement were available over time, a standard USAID practice, and not "front-end loaded."[44] Apparently, Dollar funds became available for commodity purchase in installments; thus, the pattern of procuring one or two large

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[43] See above Section 2.4 and Table 9. Since SANRU must await the receipt of CPF from USAID Zaire, the ability of some zones to execute projects has been related to the availability of the local currency sent from SANRU. However, the declining purchasing power of the amount provided has had a more significant impact on the rate of execution and the number of projects completed.

[44] Only $7.4 million of the authorized LOP amount of $16.4 million was obligated to the SANRU project on September 30, 1987. No figures are available on the line item breakdown. Project Implementation Report, September 30, 1987.

items and many small items in any given purchase cycle is understandable. The project's desire to serve the health centers and health offices in the zones as quickly as possible, leaving the equipping of hospitals and regional and sub-regional offices to a later date, may explain the order in which given items were chosen and ordered.[45]

Standard USAID policies -- "Buy America" and competitive procurement -- were used to obtain the items procured with US Dollars by USAID Zaire. The procurement timeframes for the SANRU procurement seem equivalent to those common for most USAID Missions in Africa.[46] Still, from the point of view of project implementation, past procurement practices have been neither timely nor efficient.

As of July 31, 1991, 14 months prior to the PACD, only US $7.5 million of the US $10.7 million allocated for commodity procurement had been earmarked.[47] According to the Procurement Status Report, dated July 21, 1991, more than one year generally passes between the time an order is placed and the time it arrives in Zaire. This does not take into account the time spent preparing and processing the order (PIO/C), frequently 3 or 4 months, or the time between arrival in Zaire and arrival at its final destination.[48]

With some significant exceptions, namely small items and repeat orders (e.g., vehicles - 7 months), it frequently takes 24 months to complete the procurement process. In several cases, the process has taken significantly longer. For example, all pharmaceutical requests must be reviewed by the USFDA and procured by the Veterans Administration, GSA, or another USFDA approved purchasing agent. Frequently, a portion of the items requested are unavailable in the United States; at times, waivers

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[45]If commodity procurement had been fully funded at project launch, SANRU would have had most of the items much earlier in the project's life cycle and been able to distribute material to the zones when needed. In addition, the project could have obtained certain economies of scale by procuring the majority of the items in one cycle.

[46]Communication from P. Lacerte, Commodity Management Officer - USAID Zaire.

[47]USAID Zaire, "Summary Project Financial Report by Project Element," July 31, 1991.

[48]In the case of some Dempster Handpumps, for example, the shipment arrived on July 21, 1990 but was not picked up until January 21, 1991, six months later. This order was for SNHR, not SANRU. See Procurement Status Report, July 21, 1991.

must be obtained to purchase the items from UNIPAC/Copenhagen, the UNICEF facility, or from another qualified supplier.[49]

Additional examples of the lengthy procurement process can be cited. For unexplained reasons, probably related to the value (US $1 million) and complexity of the order, the medical kits for the 50 general reference hospitals remain to be ordered almost five years after project launch. In addition, the order for 30 solar refrigerators, initiated in July 1987, only left Zaire in April 1991. This order still remains to be processed in the US, shipped, received in Zaire and delivered to the zones.[50] Such delays are unacceptable.

3.7.3 Commodity End-use Tracking Systems. SANRU has very good records on which commodities were shipped to which zones and the amounts (in local currency) that were sent to purchase locally available goods and support zone-level activities. Most of the zones visited by the members of the evaluation team had records of what had been received from SANRU. All were able to verify that SANRU's records were accurate. However, neither SANRU nor the zones have completerecords indicating the location and condition of the equipment shipped and received. In addition, many zones candidly stated that recently, due to hyperinflation, local currency forwarded by SANRU to implement projects was frequently used instead to buy pharmaceuticals. The revenues generated included a margin that allowed the zones to maintain operations. While SANRU's end-use tracking system is partially in place, USAID Zaire has only begun to develop and implement a system for tracking the end-use of project commodities.

3.7.4 Oversight of Commodity Use. While SANRU can easily confirm that zones have received the commodities and local funds, neither SANRU nor USAID Zaire can verify that the zones are using all commodities for their intended purpose. In the zones visited by the evaluation team, the medical equipment, as well as pharmaceuticals and office equipment, were at the proper locations and in use. It was rare to find a non-functional health

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[49]In the case of one order for pharmaceuticals, the UNICEF component was received three months after the order was placed, on the same date that a procurement agent in the U.S. notified HPO that the request for bids for the other portion of the pharmaceutical order was about to be released. Given UNIPAC's reputation as a less than prompt supplier, this delivery schedule is commendable. The procurement agent's performance is probably well within standard norms.

[50]On August 13, 1991, the Mission was advised by the Procurement Service Agent (PSA) that a "request for bids" was about to be placed.

center equipped with SANRU equipment.[51] In addition, most médecins chefs de zone and administrators gave clear, if undocumentable, reports on the distribution, location, and use of medical supplies and equipment, instructional material, forms, etc. In most cases, this material was directly under the control of the médecin chef de zone and distributed during (or following) supervision visits to the health centers and health posts.

It is more difficult to document the use of project vehicles, primarily the Toyota Land Cruiser. SANRU has instructed the zones on the proper use and maintenance of the vehicles.[52] However, few if any zones keep adequate records of vehicle use. Most vehicles appear to be in fair to poor condition, owing to miserable roads, poor maintenance, and frequent driver changes. In addition, most appear to be subject to uses different from those approved in the SANRU transmittal letter. Many are subject to "requisition" by zone authorities, e.g., commisaire de zone. Some operate as "bush taxis" to transport passengers and goods within and outside the zones and to generate revenues needed to offset zone operating costs.[53]

3.7.5 Numbers of Technicians and Spare Parts Inventories. Training manuals were developed to ensure the proper operation and maintenance of the four-wheel drive Land Cruisers, as well as the motorcycles and bicycles. Forty-four drivers/mechanics were trained in three separate sessions. The number trained corresponds fairly closely with the number of Land Cruisers sent to the zones.

Unfortunately, since the number of trainers was insufficient to conduct all sessions before the vehicles were delivered, many drivers began to use the equipment before being trained. In addition, SANRU soon learned that the drivers charged with operating and maintaining the vehicles did not have total control of their use. Very frequently the Land Cruiser or motorcycles

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[51]The sub-group of evaluators visited a non-functioning health center in Kamonia that had received some components of the basic health kit. The nurse in charge had been away several months and the heatlh center was not service.

[52]See, for example, the letters of the SANRU Project Director to the médecins chefs de zone entitled "Don d'un vehicule à Zone de Santé."

[53]Some of the information on vehicles also applies to motorcycles. There are two important differences. First, those motorcycles used exclusively by Peace Corps Volunteers are reportedly in the best condition. Second, since the zones often have several motorcycles, one unit can be cannibalized for spare parts, allowing the rest of the fleet to stay in service.

were "borrowed" by other zone authorities and used for other purposes. Consequently, many are in poor condition and some are non-operational.

A brief review of the list of spare parts ordered suggests that the parts procured and delivered to the zone are sufficient. However, few if any zones have spare parts inventory records; most have boxes, located in more or more zone depots, filled with a wide variety of parts. There are unconfirmed reports of spare parts being sold. The use and replacement of spare parts for vehicles appears to be a problem area.

3.8 USAID Zaire Management Structures and Practices

3.8.1 Managing the Workload and Internal Consensus. Numerous examples could be cited to indicate that USAID Zaire is not managing the workload for the SANRU Project in an effective, proactive and harmonious manner. Furthermore, the absence of internal consensus among Mission personnel affects project implementation, in spite of the existence of written and well-established policies and procedures. As noted above, commodities that should have been purchased two years ago, when the funds became available, still remain to be ordered. Training outside Zaire takes as much as three and one-half months to process.[54] This processing delay eliminates candidates who receive late information about courses or who must obtain passports. As a consequence, participants attend short courses or conferences without adequate reservations, travel orders, or per diem.

The cancellation of the HealthCom buy-in further documents the absence of internal consensus among Mission support offices. HealthCom, a centrally-financed child survival initiative in health communication, was initially scheduled to receive a buy-in from SANRU. The Health and Population Office (HPO) decided to cancel the buy-in; different Mission support offices have offered conflicting instructions on what must be done. As a result, the cancellation process, initiated in April 1991, remains incomplete in September 1991.

Finally, inadequate communication and concensus among HPO, the Mission support offices, e.g., the Controller's Office, EXO, etc., and SANRU, frequently generates conflicts, crises, and hard feelings. Time did not allow an in-depth assessment of the underlying causes of these difficulties. Undoubtedly, hiring PSCs who have little or no experience in A.I.D. procedures and policies to manage a very large and complicated project has increased the complexity of the management burden. At the same time, the relatively inflexible and uncreative posture of the

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[54]See, for example, PIO/P #660-0107-1-00133, (Dr. Mbala Nsimba of FONAMES).

Mission support offices -- PEP, Commodities Procurement, Controller, etc., -- has compounded the managerial demands on HPO and SANRU. While well within their rights to insist that projects be "managed according to the book," it is equally clear that divisions often have different interpretations of "the book." Many examples could be cited. The development and application of the personnel payment policy (Directive 306 and the FSN schedule) for the SANRU Project is the one most frequently cited.

There is some evidence that Mission support offices have forgotten that each exists to facilitate, not constrain, project implementation. Development assistance is the rationale for operating in Zaire. All too often it appears that SANRU activities are constrained, delayed or impeded by niggling "red tape," e.g., boxes on PIO/T forms incorrectly checked, or by the conflicting interpretations of the different support offices.

3.8.2 USAID Zaire Document Processing (PIO/Ts and PIO/Cs) and Adherence to Established Guidelines and Schedules for Project Implementation and Monitoring. As noted above, USAID Zaire has established clear, written procedures for processing project-related documents (PIO/Cs, PIO/Ts, PILs, procurement waivers, etc.), clearing communications, and monitoring project implementation.[55] However, during project implementation (1985-1991), several procedures have changed. In addition, the steps involved in the clearance and approval process are many and complicated. For example, a PIO/C originates in HPO and must be cleared by PDO, EXO, CONT, PEP and RCMO, before being approved by the Deputy Mission Director. All "clearing" offices are requested to review the material quickly and pass it along.

An examination of selected files suggests that at least one month is required to process most documents. For example, the PIO/T to "reserve funds for an interim evaluation of the Basic Rural Health II (SANRU) Project" was signed by HPO on April 26, 1991, EXO on May 10, 1991, PEP on May 23, 1991, CONT on May 23, 1991, and the Deputy Mission Director on May 28, 1991. In some cases, the period required to clear and approve the PIO is even longer.[56] In routine cases these timeframes may be acceptable and allow project management to proceed at a planned pace. In unforeseen cases, where prompt action is required, this timeframe adversely affects project implementation.

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[55]See, for example, USAID Zaire Mission Orders 504 and 1107, dated 8 July 1989.

[56]PIO/C 660-0107-4-80144 to procure solar assemblies took just short of two months to clear and approve (May 29 to July 26, 1991).

USAID Zaire staff are following established procedures for processing the paperwork. However, given the mountain of paperwork, certain project monitoring guidelines are not routinely followed. For example, Section III of USAID Zaire Mission Order 504, dated July 8, 1989, states that site visits are an "essential element of any monitoring program." Site visits may be more important than paperwork. Project Officers are instructed to visit sites "not less than quarterly [and] in instances where project implementation takes place at a multitude of locations, rotating monthly visits to sub-project activities should be considered." The SANRU Project Officer has visited the field less frequently than stipulated in the Mission Order. Yet, her visits to project locations may be more frequent than those of others in the same office, and certainly far more frequent than field visits made by Mission support staff.

The Project Committee, consisting of representatives of the Mission support offices (PDO, GDO, CONT, EXO, PEP) and chaired by the technical office seems an appropriate forum in which Mission and project personnel (SANRU) can develop a common understanding of project objectives, develop annual, rolling implementation strategies and timelines for processing project-related documents, schedule the execution of project monitoring activities, and resolve differences of opinion and fact. Unfortunately, the SANRU Project Committee has not met in the last ten months.

SANRU EVALUATION
Sept. 1991 (pre riot)

4. Conclusions, Recommendations and Lessons Learned

4.1 Conclusions. Only the principal conclusions are presented below. Additional findings appear above in Section 3.

SANRU has been dramatically successful in initiating or extending primary health care activities in 42 of the 50 rural health zones targeted for assistance under the Basic Rural Health II Project. In addition, support has been continued to 49 of the 50 zones assisted during SANRU I (1982-1985).[57]

SANRU's "package of assistance" to the zones has included training, vehicles and spare parts, physical rehabilitation of health centers, offices, and hospitals, infrastructure improvements (e.g., spring-cappings), medical and office furnishings and supplies, and operating subsidies. Included as well is the commitment to primary health care.

SANRU has recruited, trained, and maintains a dedicated managerial and technical staff who have implemented and continue to use reliable financial and management information systems and effective internal operational controls. SANRU is operating within budget and conducting most activities at a unit cost that is within the range set forth in the Project Paper.

Review and analysis of the data available at the start of the evaluation or collected during visits to the health zones indicates that in the current economic and political crisis SANRU assistance is insufficient to enable most of the health zones to consolidate or expand operations, that is to achieve a "sustainable system of community-supported preventive, promotive, and basic curative" services.[58] In the zones which only receive GOZ assistance, (primarily in the form of salary payments to a limited number of staff or the PASS subsidies), SANRU assistance is essential but at best a "holding" or "relief" action that allows the zones to maintain minimal levels of service to the population. It could be concluded that SANRU is serving as a "shadow" Ministry of Health in these zones. One has the image of a person on a treadmill, running very hard just to keep in place.

In the zones with greater resources, served by different religious NGOs for example, SANRU material assistance is usually less essential. It complements other available operational assistance and, especially in the areas of training and supervision, enables the zones to provide more accessible services.

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[57]Assistance to eight zones was temporarily suspended at the time of the evaluation.

[58]SANRU Project Paper, p. 23.

Below are the principal findings for each of the "key issues" defined in the Scope of Work.

4.1.1 Financial Viability

The concept of the health zone is a strong building block for the future development of the Zairian health system. By keeping this concept viable, SANRU can offer to a future, more development-minded GOZ a model, based on the health zone concept, on which to build a sustainable, effective, and efficient national health system.

Currently, in both the GOZ-assisted zones and those receiving support from others, patient fees are a measurable portion of the revenues generated, primarily through the sale of pharmaceuticals. Zones assisted solely by SANRU and the GOZ are more dependent on patient fees to cover the cost of operations. All zones are routinely raising prices to match or exceed inflation and the increasing cost of operations. To date patients have probably been able to respond to the increases. Higher prices may soon become a barrier to service for the poor and may lead to reduced utilization rates at zone facilities, especially in the GOZ zones, and increased amounts of self-medication. There is some anecdotal evidence of this trend.

The quantity of resources currently available to SANRU is insufficient to allow it to provide a program of assistance to all 306 health zones in Zaire. SANRU would be stretched too thin to have much impact anywhere if it attempted to give nationwide assistance. Indeed, available resources suggest that the SANRU "package of assistance" can be provided most effectively in no more than the zones currently receiving assistance (September 1991).

4.1.2 Management

There are many different health zone management structures. These have been developed independently from one another and reflect local operating conditions and understandings. Most of them are effective. Irrespective of the structure, there are often conflicts. These are due to personalities and to differences of opinion on the definitions of zonal autonomy and the authority and responsibilities of intra-zonal partners, e.g., NGOs, local communities, hospital personnel.

Villagers are participating in the management of the health centers and in the execution of development projects, e.g., spring-cappings, the building or rehabilitation of health centers. The management committee of the zone is usually comprised of the staff of the Health Office (Bureau Central) and directed by the médecin chef de zone. The policy-making and

oversight body for the zone meets infrequently, if at all; it is usually comprised of local authorities, presided over by a representative of the national government, and seldom includes representatives of the consumers of health care. The infrequent meetings of the oversight body allows the médecin chef de zone, as the senior member of the health zone staff, extraordinary powers to do good or otherwise.

4.1.3 Health Information Systems

Health zone offices (bureau central) collect information during supervision visits, and some routinely receive monthly reports from the health centers. There appears to be an inverse relationship between the frequency of supervision visits and the health center's distance from the health zone office. In some cases, the health zone office also receives verbal reports from health center staff who are visiting headquarters. Health zone offices use the data collected mainly to prepare the annual reports submitted to SANRU and others, e.g., médecin inspecteur regional. Some zones are routinely reviewing the information received and, in certain cases, taking appropriate actions.

The Annual Report Form is the core data-collection instrument in the SANRU information system. Most of those interviewed judged the form adequate in determining accessibility to health service. However, those seeking data on coverage and health impact found the form deficient.

SANRU files contain only 30 of the expected 91 (37%) Annual Reports (1990). More than one-half of the health zones visited sent the 1990 Annual Report to SANRU. None of the zones visited reported receiving any acknowledgement that their report had been received or any specific comments on the content of that report.

4.1.4 Training

With the exception of the target for the School of Public Health, SANRU will probably meet its targets for all categories of regional and national training courses. SANRU has developed and uses standard modules for all categories of trainees and has instituted evaluations of course effectiveness. For some training courses, SANRU has introduced a team-learning approach in which two or more persons from the same zone attend a course together.

SANRU II zones are somewhat under-represented in the training courses. While the initial training courses have been conducted on schedule, SANRU has lagged in continuing education efforts at the regional level. Finally, for a variety of reasons, almost one-third of the persons who received SANRU training have left their zones.

SANRU will not meet its training target at the School of Public Health. Qualified and willing candidates are in short supply, partly because the academic equivalency of the diploma remains in question.

Local training in the zones is on schedule for the first courses in primary health care but is behind in the continuing education program. Since 1989, the number of zone-level training courses has declined dramatically. The CPF necessary to finance the courses was slow in arriving and SANRU's training division has not moved expeditiously to respond to zone requests.

4.1.5 Family Planning

Family planning did not receive as much attention in SANRU I as other primary health activities, e.g., vaccinations and diarrhea disease control. For that reason, it was recommended that SANRU II emphasize the introduction and use of modern contracpetive methods in the health zones.

It still appears that family planning is not a primary health care priority in SANRU headquarters nor in SANRU-assisted health zones, nor with many *médecins chefs de zone*. There have been five family planning training sessions for health zone personnel. However, SANRU leadership in promoting contraception as an indispensable part of good primary health care has been weak. This weakness is reflected in low contraceptive use in zones and health centers. Contraceptives are available at most zone headquarters and some reference health centers but rarely in health centers. Cultural and religious barriers impede contraceptive acceptance but not extensively.

4.1.6 Commodity Procurement

Procurement with the US Dollar portion of the budget has been lengthy, problematic and remains incomplete. A four-year period for ordering solar refrigerators is, for example, unacceptable. Approximately one-third of the amount obligated (US $3 million) is still to be committed and disbursed.

Items procured locally in CPF by SANRU have been obtained and delivered expeditiously. However, the diminished purchasing power of the local currency has reduced the number and frequency of activities carried out in the zones, e.g., supervision visits, spring-cappings, etc. SANRU has maintained good records on the location and, in some cases, the condition of most items procured. USAID Zaire's current system does not record the final location of the items procured and cannot track end-use. (USAID Zaire could ask for copies of the SANRU documents.) Neither SANRU nor USAID have good systems for ensuring that items procured are used *only* for the purposes intended.

In the current hyper-inflationary situation, the policy of providing four-wheel drive vehicles to all zones needs review. Most zones do not have the resources necessary to maintain the vehicle properly. Zone personnel interviewed reported that the SANRU "supervision" subsidy was insufficient to allow the zone to buy fuel and maintain the vehicle. The zones must either use an increased amount of the revenues generated from health activities to keep the vehicle in service or employ the vehicle as a transportation service, a practice that generates revenues but reduces the vehicle's active lifespan.

4.1.7 USAID Zaire Management Structures and Practices

USAID Zaire currently follows adequate procedures and guidelines for project implementation. The timeframe for clearance and approval does not impede implementation in the majority of cases.

In the past, however, USAID Zaire has changed procedures and report forms several times. This practice has adversely impacted project implementation. At present, the different and conflicting interpretations formulated by Mission support offices (EXO, PDO, CONT, etc.) has delayed implementation and created tensions and misunderstandings among those responsible for managing the project within USAID Zaire and at SANRU. For example, the application of personnel payment policies (Directive 306 and the new FSN schedule) has been confusing and inconsistent.

4.2 Recommendations to PACD (October 31, 1992)

SANRU II's final year of activities will be significantly influenced by the current economic and political crisis in Zaire and by the provisions of the Brooke Amendment prohibiting new U.S. funds for Zaire. In light of the current and projected shortfalls in financial assistance, including the GOZ, SANRU should immediately develop a "survival" strategy that continues assistance to the current health zones at levels sufficient to maintain operations as long as possible.[59] SANRU's raison d'etre is the initiation and strengthening of the health zones' ability to render primary health care to rural populations. To ensure that all the currently-served zones are able to operate at equivalent levels of effectiveness, the strategy should consider giving relatively larger amounts of assistance to zones with fewer outside resources. SANRU central operations may have to be reduced to the minimum required to sustain the current level of zone activities. This approach may prohibit the hiring of all new staff as currently planned and require some staff reductions in selected divisions.

The strategy should also find ways to re-program all remaining funds (US$ and CPF) to ensure that the zones continue to make primary health care services accessible to the rural population. The commodity list should be immediately reviewed. This is the only line item in the US Dollar budget that has significant "unearmarked" resources. Only those items deemed essential to maintain operations in the zones should be procured. Probably only a small number of new vehicles should be purchased; the amounts of other commodities will have to be reduced or eliminated, such as computers ($280,000), national office equipment ($220,000), didactic materials ($150,000), etc.

USAID Zaire should instruct SANRU to develop the strategy within one month of the acceptance of this evaluation report. SANRU should be requested to re-program funds to support the operations in the zones as long as possible. USAID Zaire should extend the PACD of the project accordingly. Finally, USAID Zaire should make every effort to provide "new" funds to allow SANRU to maintain health zone operations.

These recommendations are put forward reluctantly following a detailed and thoughtful consideration of all feasible options. Given that additional resources and political and economic change are unlikely in the near term, SANRU must make every effort to keep primary health care services operating in the zones. SANRU

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[59]SANRU has already reached the conclusion that "priority for the next two years . . . should be to sustain the operations of existing and functional health zones." See memorandum of F. Baer (SANRU) to Ray Martin (USAID Zaire/HPO), dated December 17, 1990.

has done good long-term work and it is regrettable that factors beyond the control of the project force the formulation and adoption of this emergency recommendation.

The recommendations below should be reviewed and implemented in the context of the "survival" strategy to be developed by SANRU.

4.2.1 Financial Viability. USAID Zaire should instruct SANRU to maintain the "package of assistance" to those zones currently served but not to extend operations to new zones. SANRU should consolidate assistance on the reduced number of health hones to ensure their survival and continued service delivery as long as possible. In serving the current number of zones, SANRU should consider reducing assistance to those with duplicate sources of support from other donors. Where marginal costs are low, e.g., inviting personnel from non-assisted zones to attend training sessions or conferences, providing manuals and flipcharts, SANRU should not be precluded from offering limited assistance.

4.2.2 Health Zone Management. Given the diversity of effective management and organizational structures among the zones assisted by the project, SANRU should assist each zone in the development of a written agreement that defines the autonomy, responsibility and authority of the managing partners. In the execution of this task, SANRU should strengthen the local governing body's ability to formulate zone policy and oversee zone operations.

SANRU should develop and promote the "zone forum" methodology to help local governing boards, e.g., conseil d'administration, to fulfill their roles in setting policy and overseeing zone activities. This methodology can also be used to resolve conflicts in zones where organizational or interpersonal differences jeopardize zone functioning.

4.2.3 Health Information System. SANRU should institute procedures to ensure that requests and reports received from the zones are rapidly distributed to and reviewed by the responsible technical divisions. Receipt should be immediately acknowledged and feedback provided within two weeks of receipt.

SANRU should use the opportunity of the national or regional conferences to encourage the prompt submission and analysis of the Annual Report by the médecins chef de zone and to provide feedback on the reports received.

4.2.4 Training. SANRU staff should make an all-out effort to recruit the full quota of candidates for the 1991-92 and 1992-93 classes at the School of Public Health. USAID Zaire should continue efforts to resolve the diploma equivalency problem as soon as possible. The solution must be acceptable to the SPH faculty, potential students, and to sponsoring organizations (SANRU, WHO, UNICEF, etc.).

SANRU's Training Division should attempt to become active again in the technical aspects of training zone cadres, perhaps through financing certain candidates or sessions. SANRU's Training Division Training should make a special effort to recruit trainees from SANRU II zones for regional training during the final year of the project.

To slow down the rapid job changes after attending the School of Public Health, SANRU should consider requiring course candidates and the MOH to sign an agreement that the candidate will return to the zone for two years.

SANRU should disseminate the recent research findings on village organization and turn them into appropriate training materials for zone supervisors, trainers, water-sanitation coordinators, health center nurses, and village committees.

SANRU should immediately use available CPF to reimburse the zones for courses already given and to underwrite courses that they have scheduled but postponed.

SANRU should include a family planning element in every training activity underwritten in 1991-92 (e.g., water and sanitation, gestion de la zone de santé, comité de developpement).

4.2.5 Family Planning and AIDS. SANRU should maintain the contraceptive distribution arrangements currently in place: supplies to regional depots and kits to the zones. SANRU should hold additional regional training courses in naissances désirables for médecins chefs de zone and a family planning nurse from each zone. These courses should concentrate mainly on contraceptive methods and IEC techniques for encouraging contraceptive use. The courses should also include practical clinical experience. This could be accomplished in one to two weeks.

SANRU should continue to provide the zone subsidy for training in family planning. SANRU should give extra supplies, training, and encouragement to any health facility which demonstrates initiative in providing family planning services.

SANRU should provide a minimum quantity of rapid HIV test kits (100 tests per zone per year) to every assisted health zone. USAID should agree to a flexible mechanism to assure procurement of these commodities on a regular basis.

4.2.6 Commodity Procurement. SANRU should immediately review the commodity list and select essential items for USAID Zaire to order. The number of vehicles ordered should be reduced or eliminated. USAID Zaire should place orders for the final items before the end of the current fiscal year (September 30, 1991) and take measures to ensure that all items arrive in Zaire no

later than April 1992.

USAID Zaire should obtain and maintain current copies of SANRU's records documenting the location and condition of all items procured.

USAID Zaire should initiate a brief audit to ensure that the items procured are used primarily, not necessarily exclusively, as intended and that significant abuses, e.g., appropriation of vehicles for non-health related activities, are recorded and kept to a minimum.

4.2.7 USAID Zaire Management Structures and Practices. The SANRU Project Officer in HPO should immediately call a meeting of the SANRU Project Committee. This committee should begin to meet regularly to review the objectives and content of the project and to agree on and implement the actions that must be taken to ensure timely execution of project activities.

Meetings of the project committee should be among the most important regularly convened at the Mission. Mission support staff have an obligation to become informed and involved in the project. Support staff visits to SANRU-assisted health zones are encouraged. All members of the project committee must readily and rapidly agree on what needs to be done. In collaboration with SANRU representatives, the members should develop a workplan that assigns individual responsibility for the execution of agreed-upon tasks, or the resolution of outstanding issues, and approaches all tasks with a creative, "can do" attitude that facilitates project implementation within A.I.D. guidelines and procedures.

4.3 Lessons Learned

1. Development Assistance correctly calls for close collaboration between USAID-sponsored projects and government institutions. However, when counterpart funds or leadership are not forthcoming, projects should be permitted (and given the resources necessary) to pursue alternate implementation strategies.

2. Accept and support the locally-sponsored, endorsed, and diverse systems that serve the needs of the local communities.

3. Management Training is an essential component of all development programs. To be effective it must deal with local realities, i.e., customs, power structures, tribalism, prejudices, religions, loyalities, etc.

4. Projects procuring commodities should have the commodity line item fully funded before the end of the second year of the project cycle.

5. Family Planning Programs have no momentum of their own. They must be pushed constantly.

6. The two-way flow of information is an extremely difficult process. Still, efforts to develop and sustain simple and rapid information systems are worth it.

4.4 Future Directions

It will be at least two years before substantial new A.I.D. funds begin to flow to Zaire. During this period of economic and political uncertainty SANRU has been asked to focus on supporting the currently assisted health zones as long as possible. USAID Zaire should extend the PACD of the SANRU project and provide additional funds if possible.

The Project Identification Document (PID) for the new Integrated Health and Population Project (IHPP) has a significant rural health component. The proposed new project is based in part on the successes and lessons learned from the SANRU Projects. It outlines a SANRU-like "package of assistance" designed to strengthen the rural health infrastructure and improve and expand maternal and child health services.

At least three major issues need careful review in the course of developing this component of the new project:

- the organizational character of SANRU;
- the program focus, and
- the USAID Zaire system for supporting SANRU activities.

4.4.1 Organizational Character. In the present project, SANRU staff carry out activities in the name of the Eglise du Christ au Zaire (ECZ) as the implementing agency of the MOH. Apart from some GOZ contributions from the budget d'investissement, SANRU operations are wholly dependent on USAID Zaire financial support and subject to the vagaries of USAID policies and procedures. The existing arrangement has been necessary but often managerially difficult.

The advantages and limitations of incorporating SANRU as an autonomous, non-profit Zairian institution (personalité civile) should be assessed. Incorporation would allow SANRU to compete for support from many different public and private donors. As an institutions with its own policies and procedures (e.g., salary and benefit package), SANRU would be less subject to the USAID Zaire regulations and their changing interpretations. At the same time, SANRU needs to consider carefully the effect of altering its current relationship with ECZ.

4.4.2 Program Focus. For the next two to three years and until the new MOH can pay a more significant role in health services in Zaire, SANRU must continue to support health zone operations. In the first phase of the new project SANRU will need to remain a "shadow" MOH in a limited number of zones. During this period, SANRU will continue to develop zone management models on which the new government can base approaches for supporting (not

controlling) the zones and serving the citizenry.

Plans must also be made for day when the new MOH is fully functional and SANRU begins to play a different role. The new role needs to be defined, as well as the conditions that should be in effect before SANRU alters it current assistance strategy. The options for SANRU in the later phase of the new IHPP need to be explored; two come immediately to mind. Should SANRU begin to think of playing a nationwide role, implementing one or more specialized tasks, e.g., training, logistics, family planning, etc., or should SANRU begin to work with Santé pour Tous to extend its current package of assistance to the growing urban centers of Zaire? Without question, there are many other possibilities.

4.4.3 USAID Zaire support for SANRU Activities. Current SANRU activities have been affected significantly by USAID Zaire's commodity procurement with US Dollars and the amounts and availability of counterpart funds (CPF). The current practices for procuring commodities with US Dollars have not been satisfactory. New approaches need to be explore. Should, for example, the U.S. Dollar commodity line item of the new budget be fully funded in the first two years, allowing all procurement activities to begin immediately and to be complete no later than year four of the new seven-year project? Should a procurement service contract be awarded or should SANRU be authorized to procure with US Dollars?

Lower than budgeted levels of CPF and their delayed deposit to the SANRU bank account have slowed and/or altered the rate and number of activities carried out in health zones. The new project needs to devise creative approaches to ensuring that SANRU has adequate amounts of local currency available to implement monthly program plans. Could USAID Zaire, for example, provide a US Dollar guarantee to a local bank in return for stipulated monthly disbursements of local currency to SANRU? With a planned amount available monthly, SANRU would not have to suspend or reduce operations until USAID provides CPF. Creative thinking is needed to address this problem and ensure swift and smooth project implementation.

Table F-1
Status of Training Outputs - 31 Dec 1990[1]
(within Zaire)

Specified Outputs: Regional Training	Achieved by 31 Dec '90	% Achieved
70 Médecins chefs de zone	81	116
90 Zone administrators	120	133
200 Zone supervisers	124	62
100 Zone trainers of VHWs	104	104
50 Zone trainers of TBAs	57	114
16 Water and Sanitation Trainers[2]	16	100
125 Zone Water/Sanitation Coordin.	108	86
20 Water Station Engineers	11	55
70 Zone Nurse-Pharmacists	104	149
100 Family Planning Service Prov.	65	65
70 Chauffeur-mechanics	44	63
100 Nursing School Instructors	40	40
100 Zone secretaries	13	13
Long-term Training at S. P. Health		
88 MDs and administrators (nine-month training)	53	66
Local Training in the Zones[3]		
2140 Health Center Nurses	2182	102
2000 Village Health Workers	1776	89
1000 Traditional Birth Attend's	1027	103

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[1]SANRU Project Paper, Annex 8.

[2]This new category of trainee was recommended by a WASH consultant in 1986.

[3]Zone reports on courses do not distinguish between persons attending their first course and those attending for the second or third time. These figures show persons attending for the first time and were estimated as 75% of the total of course participants.

Table F-2 Status of Training Outputs - 31 Dec 1990[4] (Outside Zaire)		
Specified Outputs: **Out of Country Training**	Achieved by 31 Dec '90	% Achieved
75 Nat'l health officials, SANRU staff, RHZ medical chiefs, & sub-reg. WS&S technicians attend short courses and confs.	67	89%
14 faculty members of nursing and medical schools sent for 3-month training in Africa region.	5	36%
6 National health officials (incl. 2 WS&S engineers) sent to US for 1-2 year masters degree.	9	150%

[4]Ibid., Annex 8.

Table F-3
Status of Outputs for
Studies and Operations Research - 31 Dec 1990[5]

Outputs:	Achieved: Dec '90		% Achieved	
	Financed	Complete	Financed	Complete
10 Impact Studies	6	6	67	67
15 Operational Res. Studies (PRICOR)	15	15	100	100
5 Health Financing Studies (REACH/HFS)	5	5	100	100
20 Other Studies	15	15	75	75
90 Micro-projects	12	12	13	13

[5]The outputs are defined in Project Paper - SANRU, p. 25 and Annex 6. The Achievements are recorded in the report prepared by the Division Etudes et Recherches Operationnelles, Février 1991.

Table F-4
Status of Infrastructure Outputs - 31 Dec 1990[6]

Outputs:	Achieved: Dec 90		% Achieved	
	Financed	Complete	Financed	Complete
1. **Rehabilitate and or construct health zone facilities**				
40 Gen'l Ref. Hosp	29	20	73	50
50 Cen'l Off. for RHZones	46	28	92	56
540 Health Centers	172	112	32	21
6 Sub-regional Pharmacies	3	3	50	50

[6]The outputs are defined in Project Paper - SANRU, p. 25 and Annex 6. The Achievements are recorded in the 3 reports prepared by the Division des Infrastructures (SANRU), Février 1991.

Table F-5 Status of Infrastructure Outputs - 31 Dec 1990[7]				
Outputs:	Achieved: Dec 90		% Achieved	
	Financed	Complete	Financed	Complete
2. Construct and/or rehabilitate WS&S systems				
3000 springs capped (SNHR)[8]	3099	1721	103	57
1600 wells dug or drilled (SNHR)	206	137	13	9
172 gravity or hydraulic-ram systems (SNHR)[9]	19	12	11	7
105 Rainwater catchment systems	43	20	41	19
2000 VIP "demo." latrines	1030	246	52	12
1000 villages assainis[10]	N/A	1246	--	--

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[7]The outputs are defined in Project Paper - SANRU, p. 25 and Annex 6. The Achievements are recorded in the 3 reports prepared by the Division des Infrastructures (SANRU), Février 1991.

[8]There may be some double-counting of springs capped. Both SANRU and SNHR (Service National d'Hydraulique Rurale) have the same output objective for springs. Most of the drilled wells and piped-water systems have been constructed by SNHR. See "Internal Evaluation of USAID Assistance to the Rural Water Supply and Sanitation Sector in Zaire," Field Report No. 313, WASH, June 1990, table 5, p. 12.

[9]SANRU records the number of kilometers that each piped-water system covers. SANRU estimates each system will average 5 km, or 860 kms for the 172 planned systems. However, the 12 complete systems already cover 112 kms, slightly more than 9 km/system.

[10]Village assaini has been a problematic concept for the SANRU. (Elaborate)

Table F-6 Status of Infrastructure Outputs - 31 Dec 1990[11]				
Outputs:	Achieved: Dec '90		% Achieved	
	Financed	Complete	Financed	Complete
3. Install solar refrigerators and 5-7 lighting systems per zone				
150 solar refrigerators and 5-7 lighting systems/zone[12]	40	30	27	20

[11]The outputs are defined in Project Paper - SANRU, p. 25 and Annex 6. The Achievements are recorded in the 3 reports prepared by the Division des Infrastructures (SANRU), Février 1991.

[12]An objective of the ECZORT Project (PVO Economic Support Project: 660-0097), this activity was taken over by SANRU.

Table F-7 Status of PHC Program Implementation and Supervision Outputs 31 Dec 1990[13]				
Outputs:	Achieved - '90		% Achieved	
	Financed	Complete	Financed	Complete
1. Medical Equipm't and Office Furnishings				
720 Kits for H'lth Centers and Ref. H'lth Ctr's	275	253	38%	35
10 Equip offices: Inspec. Medicales Regionales	10	10	100	100
11 Equip offices: Inspec. Medicales Sous-Regionales	11	11	100	100
50 Equip Hôpitaux Gen. de Refer.	0	0	0	0
2. Phamaceutical Supplies				
50 Kits for Hop. Gen. de Refer.	0	0	0	0
6 Basic supply kits for sub-regional pharmacies	3	3	50	50
720 Basic medicine kits for H'lth Ctrs	292	292	41	41

[13]The outputs are defined in Project Paper - SANRU, p. 24 and Annex 6. The Achievements are recorded in the report prepared by the Division de Programmation et de Supervision, SANRU, Juillet 1991.

Table F-8 Status of PHC Program Implementation and Supervision Outputs 31 Dec 1990[14]				
Outputs:	Achieved - '90		% Achieved	
	Financed	Complete	Financed	Complete
3. Vehicules				
83 All terrain	76	76	92	92
328 Motorcycles	265	259	81	79
2160 Bicycles	1900	1687	88	78
4. Supervision Subsidies				
450 Supervisory visits	364	364	81	81

[14]The outputs are defined in Project Paper - SANRU, p. 24 and Annex 6. The Achievements are recorded in the report prepared by the Division de Programmation et de Supervision, SANRU, Juillet 1991.