

1. BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS.
 2. USE LETTER QUALITY TYPE, NOT "DOT MATRIX" TYPE.

IDENTIFICATION DATA

A. Reporting A.I.D. Unit: Mission or AID/W Office <u>USAID/ZAIRE</u> (ES# _____)	B. Was Evaluation Scheduled in Current FY Annual Evaluation Plan? Yes <input type="checkbox"/> Skipped <input checked="" type="checkbox"/> Ad Hoc <input type="checkbox"/> Evaluation Plan Submission Date: FY <u>89</u> <u>Q4th</u>	C. Evaluation Timing Interim <input type="checkbox"/> Final <input checked="" type="checkbox"/> Ex Post <input type="checkbox"/> Other <input type="checkbox"/>
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D. Activity or Activities Evaluated (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report.)

Project No.	Project /Program Title	First PROAG or Equivalent (FY)	Most Recent PACD (Mo/Yr)	Planned LOP Cost (000)	Amount Obligated to Date (000)
660-0107.00	Basic Rural Health II	1985	9/30/92	16,400	16,400

ACTIONS

E. Action Decisions Approved By Mission or AID/W Office Director	Name of Officer Responsible for Action	Date Action to be Completed
<p style="text-align: center;">Action(s) Required</p> <p>As a result of a military uprising and civil unrest a few weeks after this evaluation was completed, as well as continuing economic and political deterioration, AID decided to terminate assistance to Zaire.</p> <p>For the record, the action decisions that would have been implemented had the project continued normally are shown in the next page.</p>		

(Attach extra sheet if necessary)

APPROVALS

F. Date of Mission or AID/W Office Review of Evaluation: (Month) 9 (Day) 15 (Year) 1991

G. Approvals of Evaluation Summary And Action Decisions:

	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
Name (Typed)	Lucy S. Mize	N.A.	Ron Harvey	Charles Johnson
Signature	<i>Ray Martin</i>		<i>Ronell Harvey</i>	<i>Charles Johnson</i>
Date	April 18, 1993			

a.

Continuation of Section E, page 1: Actions that would have been required if project implementation would have continued normally.

ACTION REQUIRED	Name of Officer Responsible for Action	Date Action to be Completed
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1. Analyze projected CPF allocations to establish regular financial in-put to the zones.	C.Anderson L. Mize	11/91
2. Terminate assistance package to marginal zones after reviewing their efficiency.	F.Baer R. Martin L. Mize	10/91
3. Re-evaluate 1992 training schedule and select new candidates to increase number of women receiving training and number of first time candidates receiving training.	GDO L. Mize F.Baer/CTG	10/91
4. Coordinate with UNICEF and PEV to reduce duplicate assistance efforts in the zones.	C. McDermott Utsheudi	12/91
5. Finish all commodity procurement, with all of the PIO/C's drafted, cleared and submitted.	L. Mize P. Lacerte	10/91
6. Re-align the dollar budget so that surplus commodity funds can be programmed for supervision and support activities in the zones.	L. Mize B. Krell	11/91
7. Modify the assistance package currently offered to the health zones, in order to sustain essential activities such as vaccinations, essential drugs, and family planning.	L. Mize R. Martin C. McDermott	11/91
8. Improve delivery of data collection and MIS system to provide better statistical in-put for follow-on project and continual monitoring of project goals.	F.Baer L. Mize S. Brewster	2/92
9. Improve distribution of family planning materials to health zones.	B. Martin L. Mize	1/92
10. Convene the project committee on a more frequent basis to ensure smooth communication between the support and technical offices.	L. Mize	10/92

ABSTRACT

H. Evaluation Abstract (Do not exceed the space provided)

The SANRU (Soins de Sante au Milieu Rural) Project aims to help the Government of Zaire (GOZ) build on the established self-sustaining primary health care (PHC) system by adding fifty more rural health zones (RHZ) to it. The project is being implemented by the Church of Christ in Zaire (ECZ) and the GOZ's Ministry of Health (MOH). This evaluation was conducted by a team of six people. They visited thirty-six zones, interviewed project, MOH and other development agency personnel and reviewed project documents from 1986 to 1991. The purpose was to assess whether or not the expansion into 100 health zones could be sustained despite hyper-inflation, political instability and funding limitations secondary to the Brooke Amendment (effective June 1, 1991). The major findings and conclusions were:

- SANRU has been dramatically successful in initiating or extending PHC activities in 42 of the planned 50 RHZ's.
- SANRU is serving as the "shadow" MOH because of the lack of GOZ assistance in the zones. This lack of partnership has put great stress on zone resources.
- Family Planning is not a PHC priority in SANRU headquarters.
- Because of the delay in commodity procurement, notably the solar equipment, implementation of vaccination activities at the zone level was significantly affected.
- Zones are continuing to adjust pharmaceutical prices to reflect inflation. This is a significant cost-recovery mechanism but it will not be able to be sustained if hyper-inflation continues.

The evaluators noted the following lessons:

1. Development Assistance calls for close collaboration between USAID-sponsored projects and government institutions. However, when counterpart funds or leadership are not forthcoming, projects should be permitted 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 structure, tribalism, religions, etc.
4. Projects procuring commodities should have the commodity line item fully funded before the end of the second year of the project.
5. Family planning programs have no momentum of their own. They must be pushed constantly.

COSTS

I. Evaluation Costs

1. Evaluation Team		Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (U.S. \$)	Source of Funds
Name	Affiliation			
John Tomaro, Ph.D	AID, Office of Health	36 per/day	\$17,120	AID/Washington
Marty Makinen, Ph.D	Abt Associates	660-0107-3-0009	8,100	Project Buy-in
Dick Brown, MD	Brown Consultants	C.O/660-0107-	23,000	Project
Judith Brown, Ph.D	for Africa	C-00-1367		
Miakala Mia Ndolo, MD	Sante pour Tous	660-0107-C-00-1471	2,625	Project
Othepa Okitosoudu, MD	Programme Enlargi pour Vaccination	660-0107-C-00-1472	2,625	Project
2. Mission/Office Professional Staff Person-Days (Estimate) <u>85 person days</u>		3. Borrower/Grantee Professional Staff Person-Days (Estimate) <u>16 person days</u>		

A.I.D. EVALUATION SUMMARY - PART II

SUMMARY

J. Summary of Evaluation Findings, Conclusions and Recommendations (Try not to exceed the three (3) pages provided)

Address the following items:

- Purpose of evaluation and methodology used
- Purpose of activity(ies) evaluated
- Findings and conclusions (relate to questions)
- Principal recommendations
- Lessons learned

Mission or Office:	Date This Summary Prepared:	Title And Date Of Full Evaluation Report:
USAID/Zaire	April 15, 1992	SANRU II Project Evaluation, 9/1991

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 evaluation was undertaken to: (1) review the outputs of the project and assess progress toward accomplishments of project goals; (2) address issues of project implementation, and (3) review project successes and failures and "lessons learned," and make recommendations to USAID Zaire on the design of the primary health care component of the new integrated health and population project.

A fourth purpose for the evaluation became apparent after Zaire went into Brooke in June of 1991. It was clear that the SANRU II project was going to be one of the few remaining projects in the Mission portfolio and that the Mission had to protect its investment in primary health care as much of possible. Therefore, a critical eye needed to be cast on what components of SANRU met basic needs for the greatest population, and what elements of SANRU could effectively continue under the Brooke.

Evaluation Methodology. The evaluation began on August 5, 1991 and concluded on September 12, 1991. The team included six people, all of whom had been involved in the SANRU project before. Dr. Marty Makinen had been instrumental in designing some of the project health care financing capability, Dr. Judith Brown had assisted on an earlier evaluation, Dr. Richard Brown had been instrumental in providing family planning guidance and John Tomaro had participated in an evaluation of water activities. Dr. Othepa and Dr. Miakala had each held various administrative positions, including chief medical administrator of a zone. They were well versed in translating project aims into actual implementation at the zone level.

The team reviewed documents, interviewed persons participating in or familiar with the project, and visited selected health zones. During the zone visits, each team used a standard questionnaire to elicit approximately the same kind of information. The questionnaire was developed in Kinshasa during the first week of the evaluation. It was designed after intensive review of the evaluation scope of work and discussion with the SANRU management committee. Its purpose was to hone in on the key administrative and managerial difficulties that zone personnel experienced.

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.

In the current economic and political crisis SANRU assistance is insufficient to enable many health zones to expand operations, that is to achieve a "sustainable system of community-supported preventive, promotive, and basic curative" services. In the zones which receive only GOZ assistance, (primarily in the form of salary payments to a limited number of staff or the PASS subsidies [Programme d'Adjustment dans le Secteur Social]), SANRU assistance is essential but at best a "holding" 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 assistance is usually less essential. It complements other operational assistance and, especially in the areas of training and supervision, enables the zones to provide more accessible services.

Recommendations to PACD (September 30, 1992). In light of the current and projected shortfalls in financial assistance, especially from 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 require some reorganization at SANRU headquarters.

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 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.

Lessons Learned

1. Community participation is essential, beginning with an exercise to define health priorities as they are perceived within the group affected. This allows more active "ownership" of project goals, with subsequent willing participation to combat obstacles or setbacks in project implementation.

2. A decentralized project allows for community differences and ensures that implementation will be focused on the actual needs of the community and not on academic ideals. However, supervision from headquarters is essential to prevent sites from straying too far from project goals and subverting the project intent. SANRU had eight "rogue" zones that did not communicate regularly and were not effective in implementing goals.

3. Computer systems and questionnaires are effective planning tools and a good feedback system for evaluating whether the actions taken are actually resolving the problems described. Despite arguments that computers and research don't have a priority place in basic primary health care project, this aspect of the SANRU project was invaluable. For example, data collected from Kivu proved conclusively the decreased incidence of diarrheal disease after spring capping systems were put in place. However, if an effort is going to be made to collect data, then an equal effort must be made to analyze the data quickly so sites can benefit from the information gleaned.

4. Procurement should be the first priority when implementing a project. Design teams should take special note of what material will be needed and specifications should be drawn up as soon as possible. It is more effective to pay warehouse charges on site than to do successive ordering of stock items (i.e., baby scales, needles, office equipment). Due to difficulties in getting supplies to Africa, there can be significant time delays between when something is ordered and actually received at the site. Dr. Baer, the project manager, estimated that 200,000 to 400,000 women and children didn't have access to vaccinations as planned because solar equipment was delayed two years. If procurement is extensive, the idea of setting up a special procurement division to facilitate the process should be entertained.

Caveat

The evaluation ended on September 12, 1991. On September 28, USAID project personnel were evacuated due to the worsening political situation. As of April, 1992, SANRU exists in a much diminished form, fighting incredible odds to continue delivering health care to Zairians. The process is getting funding from UNICEF and from remaining USAID Zaire dollar obligation. The fact that the project continues, despite anarchy, hyper-inflation and limited external support, is testimony to how well it was implemented in better times.

K. Attachments (List attachments submitted with this Evaluation Summary; always attach copy of full evaluation report, even if one was submitted earlier; attach studies, surveys, etc., from "on-going" evaluation, if relevant to the evaluation report.)

Evaluation with all Annexes

COMMENTS

L. Comments By Mission, AID/W Office and Borrower/Grantee On Full Report

The following are comments and responses brought up during the four de-briefing meetings that the evaluation team held. One of de-briefings was given to the development community at large, this served the Mission plan of greater coordination and communication with other donors. In general, the response was very positive.

The success of the evaluation was a function of the careful selection of team members made by the Mission. All the team members were already familiar with both the project and Zaire, enabling them to skip the "down-time" of adapting to the country and the project. One of the evaluators was only able to be in-country for ten days because of a tight schedule. However, all ten days were productive because he knew the financial management goals of the project and he went into the field the day after he arrived. A project officer in the Agriculture division wanted John Tomaro to lead the evaluation of her project because she was so impressed by the presentation of the team.

There was some criticism of the breadth of the scope of work, it seemed impossible that five pages of issues could be adequately evaluated. In order to overcome this limitation, a review session was held the first week of the evaluation and the scope of work was pruned. This allowed the team to focus on priority issues. The least successful aspect of the scope of work was the emphasis on family planning. Family planning was a priority for the Mission but had a lesser role in the SANRU project. Nonetheless, the Mission felt that it was important to have this aspect of the project reviewed. The result was that the family planning portion seemed out of sync with the evaluation focus on management, administration and supervision.

Site selection for evaluation was particularly good. To avoid the problem of always reviewing "good zones", a deliberate attempt was made to review zones that were having difficulty. Furthermore, all geographic areas were covered so that the team could evaluate the impact of either proximity to Kinshasa or geographic isolation in implementing project goals.

An innovative solution that had a beneficial impact on the logistics of the evaluation was hiring a short term logistics coordinator. With a team of six consultants, in a country the size of Zaire, and with such poor communications, this service proved invaluable. Some of his duties were to arrange travel, get the necessary permits for visiting limited access areas and arrange local transportation. Support offices in the Mission agreed that for future evaluations, this service would be replicated.

Generally, the evaluation was consistent with the beliefs of both the Mission and project management. SANRU was felt to be an impressive project, meeting many of its goals under difficult circumstances. There were some management problems at the project site, and some administrative obstacles at the Mission, but overall the project was on target to meet its objectives by PACD.

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Basic Rural Health II Project (660-0107)

SANRU II

PROJECT EVALUATION

USAID Zaire
September 1991

Average Annual Exchange Rates: US\$-Zaire¹

1986: 1= 59.6

1987: 1=112.4

1988: 1=187.1

1989: 1=381.4

1990: 1=718.0

1991 (Jan.-July): 1=4,000 approx.

¹The 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 issues affecting project implementation, and (3) review project successes 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 September 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.

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 receive only 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 (September 30, 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 require some reorganization at SANRU headquarters; new hires may have to be postponed and some reductions in staff may be necessary.

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 Primaires 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 (RHZs) 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 health zones. 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 49 zones.⁴

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

²Basic 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.

³Historically, 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.

⁴Ibid., 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 rural health zones and health centers and to upgrade the preventive, promotive, and basic curative services . . . available. . . . [Major] emphasis was to be directed toward 50 new rural health zones [although] continued supported [was also to] be provided to further strengthen the rural health zones 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 recommendations to guide USAID in the design of the primary health care component of the projected integrated health project.

The team examined the evolution and operation of the SANRU project management structure and the relationships between SANRU and the following: USAID Zaire, the rural health zones, and some national level entities participating in and benefiting from the project, e.g., Fonds National Médico-Sanitaire (FONAMES). The team also asked SANRU staff to review the SOW prepared by USAID Zaire and to highlight or add areas of special interest and/or concern. Seven areas were identified for review: commodity procurement under the US Dollar budget; management structures and practices in the health zones; the quality, quantity and timing of SANRU assistance to the health zones; the level of community participation; the quantity and timing of GOZ assistance to the health zones; the extent of SANRU collaboration and cooperation

⁵SANRU Project Paper, pp. 22-23.

with other health programs, and human resource management at SANRU. The team considered each of these points in some detail.

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 team members.

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

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.

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. The team gave priority to visiting zones which had been assisted during SANRU II and had not been visited previously by outside evaluators.

Some of the zones visited 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 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 centraux), 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 75% complete on December 31, 1990,⁷ 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.⁸ Table 1 presents the proposed versus actual rate of assistance to SANRU II health zones, by type of reference hospital in the zone, for the period 1986 to 1990.

Table 1 Proposed vs Actual Rate of SANRU Assistance To the Health Zones by Type of Reference Hospital in the Zone 1986-1990 ⁹					
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.

⁷December 1990 was the sixty-third month of this eighty-four month project (October 1, 1985 - September 30, 1992).

⁸At 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.

⁹SANRU Project Paper and "Assistance SANRU - Par Année que l'Assistance a commencée," SANRU, 1991.

In addition, SANRU II has continued to provide ongoing support to the 49 health zones sponsored under SANRU I. Table 2 summarizes SANRU I assistance to the health zones by type of reference hospital in the zone.

Table 2 SANRU I Assistance to the Health Zones by Type of Reference Hospital in the Zone 1982-1985 ¹⁰				
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.

¹⁰Op. cit.

Table 3
Estimated Rural Population
Total Health Zones per Region
SANRU assisted Health Zones per Region - 1990
Estimated Population Assisted by SANRU¹¹

Region	Total Est. Pop. (Rural)	Health Zones (Total)	Health Zones (SANRU)	Est. Pop. SANRU Zones
Bas Zaire	1,450,000	22	8	635,000
Pandundu	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."¹²

Perhaps even more significant 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

¹¹Taken from "Alimentation en Eau Potable en Milieu Rural," Section 2, CNAEA, 1991, p. 8, and Op. cit.

¹²M. 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.¹³ 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" technical staff 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.¹⁴

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

¹³SANRU's current approved (by USAID) personnel complement is 80 persons (August 1991). Only 54 staff were on the payroll at the end of August 1991. Staffing has never exceeded 60 persons.

¹⁴See "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.

tables on "Training" and "Studies and Operations Research" activities (Tables F-1 through F-3) indicate that SANRU has largely met or exceeded the targets 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 were 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 Indicators¹⁵		
<u>Indicator</u>	<u>Output</u>	<u>Achieved</u>
Village Development and health center committees formed and active	3000	5750 ¹⁶
SANRU-assisted zones reporting 1% of women of reproductive age in zone accepting FP each year after the second year of SANRU assistance	100%	11%
Children in SANRU II zones have access to under-five clinics	52%	56%
Women of child-bearing age in SANRU II zones have access to pre-natal clinics.	52%	55%

¹⁵SANRU Project Paper, Annex 3.

¹⁶The 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 accessibility and coverage targets, except for 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 (Project Paper) Compared with Estimated US\$ Earmarks and Actual CPF Contributions to SANRU by Project Year (1 October 85 (FY 86) - 31 December 1990)¹⁷ (US\$ 000s)				
<u>Year</u>	<u>Budgeted</u>		<u>Estimated/Actual</u>	
	US\$	GOZ/CPF	US\$	GOZ/CPF
1986	2,510	1,406	1,800	1,717
1987	3,294	2,332	2,200	1,331
1988	2,933	2,669	2,478	2,124
1989	2,905	3,139	2,578	2,063
1990	2,058	2,892	2,678	1,115
Total	13,700	12,438	11,734	8,350

¹⁷The Budget Projections are taken from the SANRU Project Paper, p. 43 and Annex 6. 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, based on Department of Plan average exchange rates, which appear to be slightly lower.

Earmarks¹⁸ for the US Dollar budget through December 31, 1990 appear to be close to the target. However, SANRU received US \$4 million less in CPF than projected; there was a shortfall of US \$1.7 million (in CPF) alone in 1990. As indicated below in Table 6, this shortfall was not covered by contributions 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'Investissement¹⁹ (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 USAID Zaire review of the US Dollar earmarks through December 31, 1990 revealed that significant resources remained only in the commodity line item of the budget (Table 7); other major categories were overexpended (training) or had few resources remaining (technical assistance, other). As a result, USAID

¹⁸An earmark takes place when all appropriate approvals have been established by signatures on Project Implementation Orders (PIOs) or Project Implementation Letters (PILs), and includes the verification that funds are available.

¹⁹These figures are taken from SANRU's revenue/expenditure budgets for the years 1986-1991.

Zaire revised the Project Agreement on April 5, 1991, shifting US 900,000 from commodities to other line items (Table 7).

<p align="center">Table 7 SANRU US\$ Budget (000s) Comparison of Earmarks to Obligations December 31, 1990 and July 31, 1991²⁰</p>						
<u>Line Item</u>	<u>Through December 31, 1990</u>			<u>Through July 31, 1991</u>		
	<u>Obl'tion</u>	<u>E'mark</u>	<u>%E'mark</u>	<u>Obl'tion</u>	<u>E'mark</u>	<u>%E'mark</u>
Tech. Assist.	4,407	4,130	93	4,907	3,287	67
Train'g	800	820	102	1,000	881	88
Commod.	10,785	7,350	68	9,884	7,475	76
Other	328	290	88	429	327	76
Eval.	80	0	0	180	115	64
Total	16,400	12,590	77	16,400	12,085	74

Re-aligning the budget has enabled SANRU to carry out some new international training activities and to cover some additional unspecified "costs and contingencies."²¹ However, the US Dollars obligated for commodities remain the largest pool of resources available to sustain project activities. Since contributions from the GOZ budget d'investissement are planned but may not be forthcoming, the currently available US Dollar funds and USAID/CPF will be the principal means of project support for the immediate future. This assumes that it will be difficult for USAID Zaire to provide "new" funds to SANRU.

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. However, in many cases, the actual unit cost of the work completed is 50% more than the estimated cost.

²⁰USAID Zaire Controller's Office, "Summary Project Report by Project Element," December 31, 1990 and April 30, 1991, and Project Implementation Letter #20, April 5, 1991.

²¹The US \$505,000 discrepancy between December 31, 1990 and July 31, 1991 is noted.

Table 8
Projected vs Actual Unit Costs
for Selected Infrastructure Projects
(US\$)

<u>Item</u>	<u>Projected Unit Cost (US\$)</u> ²²	<u>Actual Unit Cost (US\$)</u> ²³	
		<u>Financed</u>	<u>Completed</u>
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 ²⁴	17,000	n/a	n/a
Rainwater systems	-	n/a	1,835
VIP Latrines	50	41	174

SANRU has tried to contain costs by financing activities at the level estimated in the project paper while 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 add as much as 78% to the cost of springs and 70% to the cost of latrine construction."²⁵

²²SANRU Project Paper, Annex 6.

²³The figures reflect 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.

²⁴WASH 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.

²⁵SANRU 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.

Based on observations and anecdotal evidence collected during visits to the zones, it is speculated that the actual cost is frequently higher because the cost was under-estimated or because 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.²⁶ 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 clearly indicates that the rate of implementation of project activities has slowed appreciably in 1990. SANRU's ability to finance projects has been reduced while operating costs have increased.

Table 9 Selected Infrastructure and Training Activities Initiated/Completed by Project Year ²⁷					
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 Sessions	11	12	15	16	.5
Local Training Sessions	99	108	116	104	23

Table 10 presents the pharmaceutical and supervision subsidies distributed by SANRU to the zones since 1986. These data clearly show that SANRU has attempted to support supervision activities.

²⁶Kamonia, 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.

²⁷See Appendix F for targets.

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 health care activities is commendable, although well below the target set by SANRU and required by the zones.²⁸

Table 10					
Supervision and Pharmaceutical Subsidies					
to SANRU-assisted Health Zones²⁹					
(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 accomplishments 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 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 2000 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 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

²⁸Memorandum 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.

²⁹Data provided by the Division of Programmation et Supervision.

interest in re-starting a program of economic stabilization. In the words of many Zairians, the GOZ has largely withdrawn from governance.

Between December 1990 and July 1991 the consequences of political and economic uncertainty 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 1988.³⁰

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

³⁰See ~~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, août 1991; S. Haykin (USAID/Kinshasa Economist), "Talking 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.

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 services.

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 known donor assistance to the health sector, an estimated 70% of which went for primary health care.³¹

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.

UNICEF plans to continue to provide essential vaccines and some other equipment (refrigerators, sterilizers, etc.) at the national level but will limit other 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 suspended its major lending activities in Zaire, but has approved a small credit (US \$30 million - IDA) for health and education

³¹Most Belgian assistance supported expatriates working in the 67 health zones, the Projet Santé Pour Tous, or central-level divisions and programs of the Ministry of Health. Significant donor support was sent directly to the health zones through NGOs. For example, some German aid went to the zones through Misereor and EZE. However, the total amount of this assistance is unavailable.

(P.A.S.S.). Since the GOZ has not yet 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.³² 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.

³²Philip 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 (in CPF) and the GOZ are below the anticipated levels.³³ At current levels of financing, SANRU cannot meet more than 5% of the operating costs of the zone offices of the currently assisted zones.³⁴ 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.³⁵ 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;

³³GOZ assertions that all salary and supervision costs of the health zones would be covered have never been seriously initiated. See Tables 5 and 6, Section 2.

³⁴See memorandum of F. Baer (SANRU) to R. Martin (USAID Zaire), December 17, 1990.

³⁵See memorandum of Dr. Bongo, Chief of the Division of Program and Supervision, July 22, 1991.

- primary health care services are available in the majority of health centers;
- 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.³⁶

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 zaïres. In these zones, there has been some negative 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.

³⁶See "Présentation des Resultats du Groupe de Travail: Selection des Zones de Santé a Financer," n.d.

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 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.³⁷ 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 zares to as high as 5000 zares. The average for all vendors was 1735 zares; the median was 1000 zares.)
- 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 zares; at the Bandundu sites the average price was 800 zares.)
- Price is related to supply source. (All Kasai respondents purchased their condoms from Kinshasa, while

³⁷T. Brown, B. Bongo, and L. Mize, "Summary of Informal Prudence Condom Survey in Kasai Occidental and Bandundu," August, 1991.

half of the Bandundu respondents had local sources of supply.)

- Training appears to lower the price significantly. (Only 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.³⁸ 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

³⁸"Charte de Mbanza-Ngungu: une strategie de collaboration intrasectorielle entre les partenaires du secteur santé au Zaire," mars 1987.

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;
- NGO vs NGO within the zone;
- NGO vs GOZ within the zone;
- the local community vs health center nurse (infirmier titulaire);
- the local residents vs outsiders assigned to the zone;
- médecin chef de zone vs the local community,³⁹ and
- the health zone personnel vs the médecin sous-regional or médecin inspecteur regional.

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 Health Zone Management. In general, there are three levels of management within the health zone:

- conseil d'administration (board of directors);
- bureau central de la zone de santé and/or management committee (zone office), and
- centres de santé (health centers) and their committees.

These managerial units carry out the operations of the health zone. For example, the conseil d'administration, should function as the representative body that defines zone policy and oversees zone operations. However, most meet infrequently and are usually chaired by the médecin sous-regional. In most cases, the health zone policy-making and management 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 médecin chef and his personal staff, frequently manages the zone without answering to an oversight body, or in collaboration with a management committee that rubberstamps most decisions.

³⁹The local community's displeasure with the frequent absences of the médecin chef de zone, especially in those zones with only one doctor, is an example of one type of conflict. In most of the zones visited, the médecin chef de zone 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.

3.2.3 NGO and Community Involvement in Zone Management. 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 collaboration is in effect, the zone functions well, e.g., Ipamu. In other cases, the NGO-assisted units function almost autonomously.⁴⁰ 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. Some frustration may result from overlooking 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.⁴¹

⁴⁰It is noted that the NGO centers may be the best-functioning in the zone and could serve as models.

⁴¹"Conclusions de la Conférence des Volontaires du Corps de la Paix - Conseillers Administratifs," Kisantu, mai 1991.

3.3 SANRU's Health Information System. The Annual Report (Rapport Annuel) is the core of the SANRU Health Information System (HIS). It was developed in 1983 by a multi-agency commission consisting of donor representatives and staff from GOZ national programs, e.g., PEV. 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 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-régional. 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 Institutionelle (ETRI) is in the process of implementing a national health information system, systeme 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 medecins 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.⁴²

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

⁴²SANRU 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.

(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 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 (September 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 MD 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 regional conferences for médécins chefs de zone and 50 regional conferences for zone supervisors and zone trainers during the year. 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 médécins 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 SANRU. 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 SANRU 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.

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 these trainees 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.⁴³ 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			
<u>Category of Trainee</u>	<u>No. of Participants</u>		<u>% Achv'd</u>
	<u>Target</u>	<u>Dec. 90</u>	
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).

⁴³Ibid., Annex 8.

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 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 naissances 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.⁴⁴ Of the 30 zones submitting Annual Reports for 1990, only three reported

⁴⁴Ibid., p. 24.

family planning registrations equal to 1% of the women of childbearing age (see Table 4).

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. Eighty-five percent of the zones visited had contraceptives on hand, even without a large network in place to supply contraceptives.⁴⁵ This encouraging finding was due to two factors:

1. the one functional depot (kananga) is doing a good job of supplying contraceptives in its catchment area, and
2. SANRU initiated a "stop-gap" measure, sending a carton of contraceptives to each health zone.⁴⁶

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; selected well-functioning depots could distribute contraceptives as well. 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 Family Planning Communication Strategies. 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,

⁴⁵Surgical 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.

⁴⁶SANRU distributed contraceptives that were provided at no cost by The Family Planning Services Project (PSND). See memorandum of Bill Martin (HPO) to Lucy Mize (HPO), September 11, 1991.

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;
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.⁴⁷

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

⁴⁷Enthusiasm for family planning may be increasing at SANRU headquarters. Two staff members (Dr. Bongo and Mutala) recently attended a three-week training course in family planning at the University of California - Santa Cruz.

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 (INTRAH). 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. AIDS awareness in the zones is in part attributable to SANRU's efforts. The project has played a central role in providing HIV tests, initiating IEC activities, and emphasizing the importance of counselling.

However, few zones currently have 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.⁴⁸ 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, PRITECH and REACH projects. Results were disseminated in a professional format. It is less clear that findings were incorporated in SANRU or zone policies and 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 varies 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.

⁴⁸Op. cit., p. 36.

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.⁴⁹ 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 level of health zone satisfaction or dissatisfaction regarding the equipment provided during SANRU I was taken into account when developing the commodity list for SANRU II. This list, based on SANRU I experience in 50 health zones, was reviewed and refined by SANRU and USAID Zaire staff. Site visits confirmed that most zones are entirely satisfied with what they have received during SANRU II.

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, USAID 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.⁵⁰

⁴⁹Ibid., p. 25.

⁵⁰See above Section 2.4 and Table 9. Since SANRU has had to await receipt of CPF from USAID Zaire, the ability of some zones to execute projects has been related to the availability of the local

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."⁵¹ Apparently, Dollar funds became available for commodity purchase in installments; thus, the pattern of procuring one or two large 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.⁵²

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.⁵³ 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 \$9.8 million allocated for commodity

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. To correct this problem, SANRU now converts the request into a US Dollar value and readjusts the amount when payment is made in zaires.

⁵¹Only \$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.

⁵²If 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.

⁵³Communication from P. Lacerte, Commodity Management Officer - USAID Zaire.

procurement had been earmarked (Table 7).⁵⁴ 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.⁵⁵

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 must be obtained to purchase the items from UNIPAC/Copenhagen, the UNICEF facility, or from another qualified supplier.⁵⁶

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.⁵⁷ Such delays are unacceptable.

⁵⁴USAID Zaire, "Summary Project Financial Report by Project Element," July 31, 1991.

⁵⁵In 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.

⁵⁶In 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.

⁵⁷On August 13, 1991, the Mission was advised by the Procurement Service Agent (PSA) that a "request for bids" was about to be placed.

SANRU's experience with procurement through an institutional contractor suggests that the current timeframe can be reduced significantly. Over half of the material procured by ECZORT, a SANRU I "sister" project, was ordered and received in less than ten months. The longest it took to receive any item was twenty months.

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 the items or subsidies received from SANRU. All were able to verify that SANRU's records were accurate. However, neither SANRU nor the zones have complete records 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 center equipped with SANRU equipment.⁵⁸ 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

⁵⁸One 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 health center was not service.

zones on the proper use and maintenance of the vehicles.⁵⁹ 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.⁶⁰

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 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 one 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.

⁵⁹See, for example, the letters of the SANRU Project Director to the médecins chefs de zone entitled "Don d'un véhicule à Zone de Santé."

⁶⁰Some 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.

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.⁶¹ 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 consensus 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 increases the complexity of the management burden at the start of their period of service.

Overall, it appears that the relatively inflexible and uncreative posture of the Mission support offices -- PEP, Commodities Procurement, Controller, etc., -- compounds 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 Mission support offices 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 example most frequently cited in the past year.

⁶¹See, for example, PIO/P #660-0107-1-00133, (Dr. Mbala Nsimba of FONAMES).

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.⁶² 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 CMO, 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.⁶³ 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.

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

⁶²See, for example, USAID Zaire Mission Orders 504 and 1107, dated 8 July 1989.

⁶³PIO/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).

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.

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).⁶⁴

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.⁶⁵ 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.

⁶⁴Assistance to eight zones was temporarily suspended at the time of the evaluation.

⁶⁵SANRU 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 contraceptive 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 (September 30, 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.⁶⁶ 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

⁶⁶SANRU 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 zones 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.

SANRU should continue to encourage the health zones to accept Peace Corps Volunteers in financial management in health, wherever appropriate. USAID Zaire should invite staff from the centrally-funded Health Financing and Sustainability Project to work with SANRU to train new health volunteers and their counterparts (administrateurs) and to finance selected activities (i.e., zone-level studies).

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 développement).

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 drastically reduced. USAID Zaire should place orders for the final items before the end of November 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 review 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, loyalties, 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 Family Health Project 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 (personnalité civile) should be assessed. Incorporation would allow SANRU to compete for support from many different public and private donors. As an institution 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 the 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 its current assistance strategy. The options for SANRU in the later phase of the new USAID health project 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 explored. 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.

Statement of Work
For the Interim Evaluation of the
Basic Rural Health II (SANRU) Project

I. Background

The Basic Rural Health II (SANRU) Project (660-0107.00) aims to establish in 100 rural health zones a sustainable system of community supported preventive, promotive, and basic curative primary health care services to combat the most prevalent public health problems in rural Zaire. While further strengthening the fifty rural health zones established under SANRU I, expansion into fifty additional zones is programmed under SANRU II. Project assistance includes provision of basic medical equipment and medications to transform dispensaries into full-service health centers, rehabilitation of reference health centers and hospitals, technical assistance, educational materials and training for health professionals and village health workers, and office equipment and vehicles to permit supervision of health zone activities. The SANRU II project includes a water and sanitation component as well as support for national and regional coordination of primary health care activities. Efforts to improve financial management and self-financing of regional and sub-regional health services are also an important part of the SANRU assistance package.

The Basic Rural Health II project is implemented by the Zairian Church of Christ (Eglise du Christ au Zaire) under a bilateral agreement between USAID and the Government of Zaire signed on 31 August 1985 and most recently amended on 7 July 1990. Authorized life of project dollar funding is \$16,401,000; an additional \$18,232,000 is to be provided in local currency. Government of Zaire contributions include investment budget monies to support rehabilitation and construction activities and to pay salaries for Ministry of Health personnel at the national, regional and zone levels. The project assistance completion date (PACD) is 30 September 1992.

The project is currently active in 90 of Zaire's 306 health zones and works in collaboration with Peace Corps, UNICEF, OXFAM, the National Rural Water Service (SNHR), as well as other national and international agencies involved in primary health care and most national health programs. Approximately 4,968,000 rural inhabitants have access to full service health centers. This represents an increase of over one million inhabitants with access to primary health care as compared to the situation at the onset of SANRU I. In addition, currently 1,677,000 people are benefitting from SANRU financed water systems.

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II. Objectives

The objectives of this interim evaluation are:

- a.) to review the technical accomplishments (outputs) of the project and assess progress toward accomplishment of project goal and purpose;
- b.) to address key issues affecting project implementation;
- c.) to review project successes and failures and "lessons learned" and make recommendations to guide USAID in the design of the primary health care component of the projected integrated health project.

III. Methods and Procedures

The evaluation will be conducted by a six person team over a six week period beginning 1 August. The evaluation team will be based in Kinshasa but will travel to field sites throughout the country which will be determined in consultation with HPN and SANRU Project staff.

To facilitate the evaluators' task in assessing SANRU's progress toward achieving the project goal - "improving the health status of the rural population by increasing the proportion of rural Zairians that have access to basic health services" - the HPN Office and SANRU will provide the following background material:

- a. A comparison of the project's outputs with its stated objectives as outlined in the Project Paper. This comparison, to be prepared by SANRU's technical divisions (training, research, program/supervision, and infrastructure), will be presented in tabular, graphic, and narrative form.
- b. A copy of the 1986 SANRU Project evaluation and a synopsis of status of actions taken in response to recommendations issuing from this evaluation.
- c. The results of a pre-evaluation inspection of health center construction and hospital rehabilitation activities in the Kivu Province, where construction activities have been concentrated since the 1986 SANRU Project evaluation.
- d. A report emerging from an internal review of USAID Zaire water and sanitation projects, including those water related activities implemented by the SANRU Project, conducted in June 1990.

IV. Evaluation Key Issues

The Evaluation Team will be required to collect necessary data and information to address and make recommendations concerning

the following issues affecting project implementation and the future direction of USAID primary health care interventions. The following list is not inclusive and may be revised during the course of the evaluation.

A. Financial Viability/Quality of Service Delivery

Given reduction in the availability of counterpart funds and unreliability of programmed GOZ investment budget releases, is expansion into the ten remaining health zones prudent? If subsidies to assisted health zones are substantially reduced or eliminated due to budgetary constraints, what will be the consequences to the health zone? Would consolidation of Project efforts to fewer health zones result in more judicious use of resources and improved quality of services? If the number of health zones to be assisted is reduced, what criteria of triage should be employed?

Conversely, given desire to increase access to primary health care services, is it appropriate to limit assistance to a discrete number of health zones? Should SANRU be a nation wide program offering assistance to any health zone regardless of the presence of other donors (e.g. UNICEF, GOZ, etc...) in the same health zone? Great disparity exists in the quality of services delivered by "functioning" health zones; recognizing this disparity how should project assistance be prioritized? Should assistance be accorded to zones with the "best performance" or to zones most in need? FONAMES is the government organization that is charged with coordinating assistance to health zones and will be a source of information for these issues.

B. Management

Currently, there is a conflict over health zone management authority between NGOs and the GOZ. To what extent does this conflict compromise primary health care service delivery in SANRU assisted health zones? What, if any, steps can USAID take to resolve NGO/state conflicts? To what degree do rural inhabitants and local NGO partners have an opportunity to express their concerns and participate in the management of health centers and the health zone? What health zone management structures are most viable and how can the SANRU project sustain these structures? How has assistance provided by various NGOs influenced the management and sustainability of the health zone and how can the SANRU project benefit from their experiences? The evaluation team will be able to examine these questions by comparing health zones with different types of management. There are zones that have not received any subsidies and others that have been continuously supported despite severe budgetary constraints. Furthermore, zones with financial management systems supported by Peace Corps volunteers will serve as comparison for zones that do not have well defined financial analysis systems, allowing the team to evaluate the impact of

sustained intervention.

To what extent are attempts by regional/sub-regional offices to recuperate operating costs from the health zones jeopardizing health zone auto financing? To what degree has the GOZ abided by Project accords outlining MOH responsibility for salaries of health zone personnel as well as costs for supervision activities? How successful are current zone activities to generate revenues? What are the pros and cons of introducing subsidized contraceptives and medications to generate additional funds?

C. Health Information System (HIS)

Do health centers submit reliable health statistics to zone personnel on a timely basis? Is data routinely analyzed and used by decision makers at the zone level, SANRU, and USAID to improve project implementation? Cite examples of how collection, analysis, reporting of data contributed to or facilitated the decision making process. Is information shared with other national health programs and donor agencies? Is the HIS effective in identifying outcomes trends useful in determining Project "impact"?

D. Training

Is criticism that current national/regional training strategies for health zone personnel focus too much on individuals and not enough on team building valid? The project is currently experimenting with a "health zone seminar" approach to promote health zone teams in zone management, supervision, operations research, and community participation. What are the initial results of this approach? Is there a need to emphasize family planning in regional level training of health center nurses and in village level seminars for community development workers? A more in-depth training analysis is being conducted by GDO, this information will be available to the evaluation team so they do not duplicate previous work.

E. Family Planning and AIDS

A recent evaluation of the Mission's Family Planning Services Project concluded that SANRU has the infrastructure, staff and interest to expand its activities in family planning. Evaluate how SANRU can most effectively assure delivery of regular supplies of contraceptives to health centers and incorporate family planning communication strategies into the health center program. How can existing family planning activities be best integrated into the SANRU Project? What actions can SANRU take to promote increased collaboration among PSND, AZBEF and other key players in Family Planning? Assess progress made in establishing decentralized contraceptive supply depots to make contraceptives available to service delivery points operating in health zones assisted by SANRU. Discuss the feasibility of

instituting a family planning supervision subsidy to provide additional money to health zones with family planning programs.

F. Future USAID Zaire Focus

Future USAID assistance in the health sector is to focus on redefining current HPN project initiatives as well as defining new strategies in primary health care, child survival, nutrition, family planning, AIDS prevention, and water and sanitation. Given eight years of project experience, which of SANRU successes or failures and "lessons learned" would be of most value in the design of the new project? What have been the assistance packages and experiences of other donors and how do they contrast with those of SANRU? What primary health care strategies have been the most effective?

G. Commodity Procurement

Has an appropriate mix of dollar/CPF financed commodities been procured, delivered, and distributed to SANRU assisted health zones in a timely and efficient manner? What has been the performance of USAID, the SANRU central bureau, and the health zones in the procurement process? How effective is the commodity end-use tracking system and is there an adequate flow of information from the zones concerning distributed commodities? Is the oversight provided by USAID effective and sufficient to ensure that project commodities are used as intended? Are there adequate numbers of trained technicians and spare parts inventories to ensure maintenance of vehicles, medical equipment, and solar refrigerators?

Final Report. The evaluation final report is to provide quantitative as well as qualitative findings to address these questions; conclusions (interpretations and judgments) that are based on the findings; and commendations and recommendations for the agencies and institutions involved in the project.

V. Estimated Personnel Requirements

The Evaluation Team will consist of the following:

Development Generalist/Team Leader

Financial/Management Expert

Family Planning/Aids Specialist

Social Scientist

Zairian MD/MPH

Zairian MD/MPH, Zairian Health Policy and Administration Expert

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English and French language fluency equivalent to FSI R3/S3 is required of all team members. Evaluators must be physically fit and able to undertake work in the interior of the country. This implies long road trips over difficult terrain and modest accommodations. Additional qualifications and responsibilities for individual team members follow.

Development Generalist/Team Leader - An advanced degree in public health, or a social or medical science; a minimum of ten years experience in the formulation of development policies and in the design, implementation and evaluation of development activities, preferably in francophone Africa; familiarity with primary health care strategies and programs; demonstrated writing skills including the ability to organize a large volume of material into a succinct, readable report; effective interpersonal and leadership skills essential!

The Team Leader will be responsible for the overall conduct and products of the evaluation. To ensure that the objectives of the evaluation are properly addressed in the evaluation, the Team Leader will prepare the design and data collection methodologies for the evaluation, assign specific key issues to individual team members, and prepare a schedule for the duration of the evaluation for each team member. He/she will be responsible for coordinating the team's work for a timely completion of the evaluation. The Evaluation Team Leader will give an oral presentation of findings and recommendations as well as draft, edit, and submit the final report to USAID/Zaire.

The team leader will report to the SANRU Project Officer at USAID Zaire's Office of Health and Population. All team members, although recruited and paid by USAID, will be responsible to and under the supervision of the Team Leader for the duration of the evaluation.

Financial/Management Expert - Master's degree in health economics or administration, public administration, financial management or related field; 5 years experience in management or evaluation of primary health care programs, preferably in francophone Africa; thorough knowledge of health care financing and economic issues, such as cost-efficiency analysis, budgeting and programming, resource allocation issues, feasibility assessment.

The financial/management expert shall have primary responsibility for evaluation issues A (financial viability/quality of service delivery) and B (management).

Social Scientist - An advanced degree in one of the social sciences; five years experience in field research and evaluation and thorough knowledge of sub-Saharan Africa culture; previous socioeconomic research including the use of comparable quantity indicators across interventions and sectors; prior experience with USAID evaluations highly desirable.

The social scientist will utilize strong analytical skills and broad exposure in public health to address crosscutting issues and synthesize information for the evaluation report.

Family Planning/AIDS Specialist - An advanced degree in public health, or a social or medical science discipline related to population/family planning; five years experience with population/family planning programs in the developing world; prior experience with USAID evaluations highly desirable. The family planning/AIDS specialist will concentrate on issue E (family planning) and training issues related to family planning.

Zairian MD/MPH - Experience and knowledge in primary health care program implementation; thorough understanding of the Zairian zone level rural health care delivery system; prior experience with USAID evaluations highly desirable.

It is anticipated that the Zairian physician chosen for this position will have had direct professional experience at the health zone level and thus will be able to assess the success/shortcomings of various health strategies implemented at that level. His/her input regarding NGO/state conflict over zone management authority (issue B) will also be crucial to the evaluation.

Zairian MD/MPH, Health Policy and Administration Expert - Thorough understanding of national health policy issues and experience in administration of health programs at the national and regional level; familiarity with key players in the health sector; prior experience with USAID evaluations highly desirable.

The individual chosen for this position will be expected to make a significant contribution to the evaluation concerning health zone management (issue B).

In addition USAID will negotiate a contract with an individual residing in Kinshasa or a local firm to provide or arrange for the many support services required during the course of the evaluation. These services include transportation in Kinshasa and to the interior, computer rental, and commercial secretarial, translating and photocopying services. The contractor will be provided with sufficient funds to secure all needed services and will be responsible for making all arrangements including payments in a reliable and timely fashion.

USAID Zaire will provide directly the following.

For evaluators recruited offshore:

- all U.S. and international air travel and all per diem and transfer costs including visas;
- an expeditor and transport to and from the Kinshasa airport;

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- arrange for lodging at the Embassy Guest House (to be paid for from per diem);

- USAID ID cards, temporary AERWA membership for recreation facilities and commissary, currency exchange privileges, and use of the embassy medical unit for emergency medical treatment.

For all evaluators:

- office space within walking distance of USAID.

Evaluators will be hired directly by USAID. Each evaluator will negotiate his/her contract directly with the USAID contracts officer to establish fair remuneration for his/her contribution to the evaluation.

VI. Required Reports

The evaluation team leader shall provide the following reports in English to USAID Zaire:

- a Workplan and Schedule detailing activities for all team members within 5 days of the commencement of the evaluation;
- five copies of a Draft Outline of the final evaluation report within 10 days of the commencement of the evaluation;
- five copies of a Draft Report no less than 7 days prior to the termination of the evaluation;
- two Oral Presentations, one in English and one in French, covering major findings, conclusions, and recommendations of the evaluation during the final week of the evaluation;
- one original and two copies of the Final Report to USAID the last day of the evaluation.
- a Table of Contents;- Body of the Report detailing purpose and study questions of the evaluation, economic, political, and social context of the project, team composition and study methods, and recommendations based on evaluation findings to improve project performance and future implementation of primary health care interventions. The Body of the Report shall not exceed forty pages;
- Appendices including the Evaluation Scope of Work, the Project logical framework matrix, list of reference documents and persons interviewed, and technical appendices.

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The final report will be translated to French once approved and accepted by USAID.

VII. Illustrative Evaluation Schedule

Thirty-six workdays (to include Saturdays) are required of the six member team to complete the evaluation.

<u>Dates</u>	<u>Activities</u>
9-16 May	Pre-evaluation assessment of construction activities in Kivu (USAID & SANRU)
28 June	Briefing packet with pertinent background material distributed to all team members (USAID Zaire)
15 July	Logistics coordinator begins preparations for Evaluation including arrangements for in-country services
1 August	Initial assembly of evaluators in Kinshasa, preliminary meetings with USAID, SANRU
5 August	Submission of work plan and schedule
5-17 August	Review of documentation, interviews, data collection in Kinshasa
12-16 August	SANRU Annual Conference, Kinshasa - evaluators will be expected to attend and interact with participants
17 August	Submission of draft outline of final report
17-27 August	Team travel to field sites
28 Aug-10 Sept	Analysis of travel results/report drafting
29 Aug	Draft reports of team members departing 1 Sept due
1 Sept	Departure of Financial/Management Expert, Family Planning/AIDS Specialist, and one Zairian MD/MPH. Termination of contract of resident-hire logistics coordinator; the SANRU Project Officer will assume responsibility for any outstanding arrangements or payments
5 Sept	Draft report of Social Scientist due
8 Sept	Departure of Social Scientist

10 Sept Submission draft final report
11-12 Sept Formal presentations
13 Sept USAID comment on draft
13-14 Sept Revision of final draft
14 Sept Final report submitted, departure of second
 Zairian physician and Team Leader

Appendix B

Documents Reviewed

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Contact List

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J. Schumacher, Water and Sanitation - Ngidinga
G. Daigle, Health - Ngidinga

Association Zairoise pour le Bien-Etre Familial

M. Kazadi, Directeur

Projet des Services des Naissances Désirables (PSND)

Ngoie Mbuyi, Directeur

United Nations Fund for Population Activities (UNFPA)

Mpoi Mankonda, Administrateur du Programme National

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Centre Protestant d'Approvisionnement Medical (CEPAM)

Matundu-Mbambi, Directeur Adjoint

Santé pour Tous (Kinshasa)

Dr. Makamba Mbona-Riba, Directeur

Projet Marketing Social (PMS)

Jay Drosin, Director
Carolyn Randall, Technicienne

Zones de Santé Rurale (Z.S.R.)

Dr. Mpia, Inspecteur Regional du Kasai Oriental

Dr. Nsangu Enabio Bisengo, Médecin Chef de Zone - Kamonia
Mukinay Tumb'Tumb', Président et Représentant Légal de l'ONG
Association des Volontaires Pour Les Oeuvres Medicales
(AVOMET), Gestionnaire Z.S. - Kamonia

Mulumba Izuela, Administrateur Z.S. - Kamonia

Malumba Badibangi, Superviseur Z.S. - Kamonia

Noaya-Anukendi, Directeur de Nursing HGR - Kamonia

Dr. Bilenga Lumbala, Polyclinique de Kamonia - Kamonia

Dr. Mukendi-Mukala, Médecin Chef de Zone - Kitangwa

Dr. Kalambay-Ntembua, Médecin Chef de Zone - Tshikapa

L. Bajrach, N'Kita Zaire - Tshikapa

R. Van Der Herten, Afridiam - Tshikapa

Dr. Keta Binze, Médecine Chef de Zone - Kalonda Ouest

Dr. Mukinay-Dizal, Médecin Directeur HGR - Kalonda Ouest

Nzamba Manza, Phamacien (Pharmacie Centrale) - Kalonda Ouest

Nupura Mbonanadjoko, Secrétaire Z.S. - Kalonda Ouest

Kabunde Badbanga, Coordinateur Eau/Assainissement - Kalonda O.

Katshimuanga, Superviseur - Kalonda Ouest

Soeur Emma DeBaene, Infirmière, (C.S.-Ditekemine) - Kalonda O.

Dr. Lodi, Médecin Chef de Zone - Nyanga

Melo Ngongo, Superviseur Z.S. - Nyanga

Kikunga Nvudi, Coordinateur Eau/Assainissement - Nyanga

Kikonda Manbulu, Infirmier (A2), C.S.R. Kabola - Nyanga

Dr. Ebeng Mgal'a-Nbel, Médecin Chef de Zone - Idiofa

Kolongo Ntambwe, Administrateur Z.S. - Idiofa

Mungombo-Yum, Superviseur Z.S. - Idiofa

Dr. Temor Mukiar N'Ton, Médecin Chef de Zone - Ilebo

Kwasungu Bey, Administrateur Z.S. - Koshi Banda

Ikunsungi Efriko, Superviseur Z.S. - Koshi Banda

Wendo Sam, Intendant - Koshi Banda

B

Dr. Odio Saba, Médecin Chef de Zone - Ipamu
Dr. N'Dala Mukung, Médecin - Ipamu
Dr. Murekezi Emmanuel, Médecin - Ipamu
Pikadjo Pumbulu, Administrateur Z.S. - Ipamu
Gadiene Ana Matadi, Infirmier Superviseur - Ipamu
Kimwanga Matsiala, Infirmier Superviseur - Ipamu
Kindindi Muluba, Secrétaire de Bureau Central - Ipamu

Dr. N'Danbu Woleng, Médecin Chef de Zone - Mokala
Umba Kasongo, Administrateur Z.S. - Mokala
Molo Kasongo, Superviseur Z.S. - Mokala
Kialanga, Statisticien Z.S. - Mokala
Kitoko, Secrétaire de Bureau Central - Mokala
Sek-Liyangunu, Superviseur de PEV/LMTE - Mokala

Mayolle Jerome, Médecin Chef de Zone - Kabinda
Muamab'ukabomba Tshiondo, Coordinateur des Supervisions Z.S. -
Kabinda
Katunga Loshi, Administrateur Gestionnaire Z.S. - Kabinda
Kopepula Nerubi, Superviseur Z.S. - Kabinda
Nogier Claire, Médecin Z.S. - Kabinda

Dr. Kwata Ewando, Médecin Chef de Zone, Kikongo

Nasibu Adbulu, Médecin Chef de Zone, Tshofa

Dr. Malaba Tshikala, Médecin Inspecteur Sous-Regional - Kasai
Oriental

Dr. Uvoya Chanuroma, Médecin Chef de Zone - Lubao

Dr. Mutombo Tshiamu, Médecin Chef de Zone - Tshilundu
(Ancien Médecin Chef de Zone - Lubao)

Nkinda-May, Intendant Z.S. - Tshilundu

Kadinda-Tshihi, Coordinateur des Services Communautaires, Z.S.
Tshilundu

Kabunda-Kayembe, Coordinateur Eau/Assainissement - Tshilundu
Yowa-Tshianyi, Pharmacienne Z.S. - Tshilundu

Dr. Mukena Tshimankinda, Médecin Chef de Zone - Bibanga
Rev. Kapiamba Dibue, Administrateur Gestionnaire - Bibanga
Ntumba Mupidia, Infirmier Superviseur Z.S. - Bibanga
Kashala-Nkongola, Coordinateur Eau/Assainissement - Bibanga
Mbenga-Nusangi, Infirmier de Planning Familiale - Bibanga
Itabula Muenbokayi, Secrétaire

Tshibang Ntite, Intendant Comptable Z.S. - Bibanga

Dr. Tsasa-Thubi Mabilia, Médecin Chef de Zone - Ngidinga
Kimbondo-Manayano, Superviseur - Ngidinga
Matondo-Mangani, Secrétaire B.C. - Ngidinga
Nimfundu-Ndongala, Commis-dactylographe - Ngidinga
Saula Nzoko, Infirmier titulaire (CSR - Kimpenba) - Ngidinga
Lubaki Makiadi, Infirmier Adjoint (CSR - Kimpenba) - Ngidinga

Dr. Bakagnana Vakanda, Médecin Chef de Zone - Kimvula

Dr. Panzu Hwala, Médecin Directeur (CSR-Kasangulu) - Sona Bata
Mujinga Nkonga, Infirmière A3 (CSR-Kasangulu) - Sona Bata
Tupachu-Ukundji, Superviseur Z.S. - Sona Bata
Bokam-Bokam, Administrateur Z.S. - Sona Bata
Dr. Boy Moke, Médecin Chef de Zone - Sona Bata
Nutuza-Nuyololo, Secrétaire Z.S. - Sona Bata
Kunda-Nzazi, Caissière/Pharmacie Z.S. - Sona Bata
Nbala bi Nabango, Superviseur du Comité de Santé - Sona Bata

Matutu-M\Uassanbo, Infirmier superviseur Z.S. - Nselo
Makabi-Bamikina, Coordinateur Eau/Assainissement Z.S. - Nselo
Nisingi Kiman, Administrateur Z.S. - Nselo
Dr. Kwilu Mondo, Médecin Chef de Zone - Nselo
Mavinga Nabiala, Infirmier superviseur Z.S. - Nselo

Dr. Luwuwawu Mayemba, Médecin Chef de Zone - Kisantu
Lukoki Mbala, Propriétaire Pharmacie FALAXI (Lemfu) - Kisantu
Ngagu Mbala, Secrétaire, Comité de Développement (C.S. Kipasa)
Kisantu
Mzuzi-Bukaka, Infirmière (C.S.R.-Lemfu) - Kisantu
Luvoto-Maviluka, Infirmier (C.S.R.-Lemfu) - Kisantu

Ngamundu Betere, Infirmier Titulaire (C.S.-Ekibondo) - Dungu
Tuba Yangara, Garçon de Salle (C.S.-Ekibondo) - Dungu
Kamagitu Mumbombo, Comité de Santé (C.S.-Ekibondo) - Dungu
Soeur Wilma, Directrice de BDOM - Dungu
Dr. Nimo Bima, Médecin Chef de Zone - Dungu
Gom-Ngulu, Infirmier Superviseur Z.S. - Dungu
Kelekusu-Bungwa, Coordinateur Eau/Assainissement - Dungu
Yangalayo Amigwali, Secrétaire B.C.Z.S. - Dungu
Dr. Gumbawua-K.I., Médecin de H.G.R. - Dungu
Bakote Tungada, Administrateur Gestionnaire Z.S. - Dungu

Dr. Mbikale, Docteur en Médecine, H.G.R. - Isiro
Akonangana-Angyese, Infirmier Superviseur Z.S. - Isiro
Dr. Nweshi Ibanda, Médecin Chef de Centre (Nayogo) - Isiro
Dr. Nembunzu-Maraka, Médecin Chef de Zone - Isiro
Tandema-Dramile, Chef d'antenne PEV/LMTE - Isiro

Dr. Atua-Matandii, Médecin Chef de Zone (1990-91) - Doruma
Dr. Kebela-Ilunga, Médecin Chef de Zone - Doruma

Dr. Ngandu Buta, Médecin Sous-Regional de Haut-Uélé

Napeya Inguambiro, Accoucheuse Resp. de la Maternité (C.S.
Abiangama) - Pawa
Makobita Odimisa, Infirmier Titulaire, (C.S. Abiangama) - Pawa
Dr. Bola Ngebe Nsansi, Médecin Chef de Zone - Pawa
Kingani-N'Kien, Secrétaire de Z.S. - Pawa
Kumbatulu-Kubemboli, Leon, Infirmier Coordinateur Z.S. - Pawa
Abongoni Alema, Infirmier A2, Z.S. - Pawa
Semekombo-Anakinye, Infirmier Superviseur Z.S. - Pawa

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Mangini-Banga, Coordinateur Eau/Assainissement Z.S. - Pawa
Kantu Mwene, Administrateur Z.S. - Pawa
Asumani Gogode, Infirmière A2, Coord. Pharmacie Z.S. - Pawa

Dr. Nzale Baraka-al-Akbar, Médecin Chef de Zone - Aba

Dr. Bianzenza Minimbu, Médecin Chef de Zone - Niangara
Kumboli-Myaroza Azoya, Intendant Z.S. - Niangara
Baise Boliti, Secrétaire Z.S. - Niangara
Amalebondra Mazindra, Commissaire de Zone - Niangara

Appendix D

Evaluation Team Visits to SANRU-assisted² Health Zones

<u>Teams</u>	<u>Cluster Location¹</u>	<u>Dates of Visits</u>	<u>Dates for Lodging</u>	<u>Zones Participating</u>
Team 1				
R. Brown J. Brown S. Kidinda S. Panza	Isiro	August 13-20	August 13-19	Isiro Doruma Niangara Pawa Dungu
Team 1 in Kinshasa evenings of August 18-21				
	Kisantu	August 22-24	August 22-23	Kimvula (*) ² Ngidinga Nselo Kisantu Sona Bata
Team 2				
L. Mize N. Miakala J. Tomaro B. Bongo	Tshikapa	August 15-20	August 15-19	Thhikapa Luebo (*) Nyanga Kamonia Kitanwa Kalonda Ouest

¹Travel will be arranged by USAID. Lodging and local vehicles will be arranged by SANRU.

²The * means the zone is not accessible.

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<u>Teams</u>	<u>Cluster Location³</u>	<u>Dates of Visits</u>	<u>Dates for Lodging</u>	<u>Zones Participating</u>
	Idiofa	August 20-23	August 20-22	Idiofa Ilebo Mokala Ipamu Koshi Banda Oshwe (*) Mukedi Mikope
Team 3				
M. Makinen O. Othepa N. Kasongo H. Munkatu	Mbugi-Mayi	August 16-23	August 16-22	Lupata Tshilundu Lusambo Minga (*) Bibonga Kabinda Kalonda Est Tshofa Lubao

JBT/8-VIII-91
Kinshasa

³Travel will be arranged by USAID. Lodging and local vehicles will be arranged by SANRU.

Questionnaire: Zone de Santé

Evaluation du projet SANRU
Aout 1991

Région _____ Zone de Santé _____

Année prévue pour démarrage _____

Date de l'entrevue _____

Répondants (nom et fonction)

Depuis quand êtes-vous dans la zone? _____

Enquêteurs: _____

=====

1. Qu'est-ce que vous voyez comme l'objectif de SANRU?

2. Avant votre première assistance de SANRU, comment est-ce que votre zone à fonctionné?

3. Quelle est la contribution la plus importante de SANRU à votre zone?

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4. Quel type d'assistance a reçu votre zone des autres donateurs en 1990 et 1991? Par qui? Quand?

Type

Donateur

formation

équipement:

medicaments:

personnel (long terme, court terme):

construction:

finances:

autres (spécifiez):

5. Comment obtenez-vous les informations des centres de santé? A quel rythme?

6. Que faites-vous avec ces informations?

7. Avez-vous envoyé le rapport annuel (1990) chez SANRU? Si oui, qui l'a rédigé?

Sinon, pourquoi pas?

8. Quelles sont vos impressions (utilité, clarté, etc) sur les formulaires du rapport annuel SANRU?

9. Combien de rapports vous rédigez au cours de l'année? Pour qui rédigez-vous ces rapports?

10. Nous avons ici une liste du personnel de votre zone qui ont assisté aux formations régionales ou nationales soutenues par SANRU.

Pourriez-vous indiquer a côté de chaque nom si cette personne fait toujours un travail dans votre zone?

Est-ce que SANRU a effectué des visites de suivi, ou utilisé d'autres moyens pour évaluer les résultats du cours?

11. Est-ce que votre personnel a bénéficié d'une formation en 1990-1991 financé par d'autres organismes? Quel organisme? (église, UNICEF, OMS, PEV, OXFAM, Corps de la Paix, FONAMES, etc.)
12. Depuis juillet 1990, combien de temps est-ce que votre MCZ à passé dans la formation ou dans les réunions hors de la zone (assister au cours, donner cours, réunion, etc)

Dates

Lieu

But

13. Nous avons ici une liste des cours de formation soutenus par SANRU au sein de votre zone. (ASC, AT, infirmiers, comités)

Avez-vous essayé d'évaluer l'impact du cours sur le travail des participants? oui/non

si oui, comment?

14. Votre zone a-t-elle tenue d'autres formations financées par d'autres fonds? Lesquelles et par qui?

15. Est-ce que votre personnel a assisté aux cours à l'étranger?

Si oui, quelle formation?

financée par qui?

Où est-ce que cette personne travaille-t-elle maintenant?

16. Avez-vous reçu des visiteurs ou stagiaires des autres zones?

Quand?

Combien?

Dans quel but?

17. Où est-ce que vous vous approvisionnez en médicaments?

18. Où est-ce-que vous vous approvisionnez en contraceptifs?

19. Est-ce-qu'il-y-a des contraceptifs disponibles dans votre zone de santé? oui/non

si oui, lesquels?

20. Est-ce que la quantité disponible est suffisante pour répondre a la demande courante? oui/non

21. Est qu'il-y-a quelques barrières culturelles à l'acceptation des contraceptifs modernes? oui/non

si oui, lesquelles?

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22. Avez-vous des documents de promotion sur les naissances désirables? oui/non

si oui, à quel niveau? bureau central _____, hôpital général de référence _____, centres de santé _____

23. Où est-ce que vous vous obtenez vos documents de promotion (IEC) sur les naissances désirables?

Est-ce que ces documents permettent de transmettre efficacement le message sur les naissances désirables?

24. Formation du personnel de la zone de santé en naissances désirables

<u>nom</u>	<u>niveau</u>	<u>lieu de formation</u>	<u>quand</u>	<u>pratique</u> (oui/non)
------------	---------------	--------------------------	--------------	------------------------------

25. Est-ce que la plupart de vos centres de santé a des contraceptifs? oui/non

Est-ce que le personnel de vos centres de santé fait la promotion (IEC) pour les naissances désirables? oui/non

Y-a-t-il des villageois qui distribuent les contraceptifs modernes dans leur communauté (village)? oui/non

Est-ce que ces villageois font la promotion (IEC) pour les naissances désirables? oui/non

26. Comment peut-on augmenter l'utilisation des contraceptifs modernes dans votre zone? _____

[plus de IEC, plus de formation (à quel niveau)?
amélioration du système de l'achat des contraceptifs
modernes?] comment?

27. Pour augmenter l'utilisation des contraceptifs modernes dans votre zone, pensez-vous qu'il faut utiliser une personne à temps plein pour cette activité?

28. La zone de santé a-t-elle un organigramme?

(si oui, prendre une copie)

29. Existe-t-il des mécanismes pour générer des fonds en faveur de la zone de santé? (activités médicales ou non médicales?)

oui/non _____

si oui, lesquels _____

30. Est-ce que la région ou la sous-région vous impose une contribution financière? oui/non

si oui, payez-vous cette contribution? oui/non?

que pensez-vous de cette contribution?

31. Dans toute société humaine on peut avoir des problèmes, existe-t-il un conflit entre certains partenaires (MCZ, MIR, ONG, autorités administratives (commissaire de zone, chef de collectivité, etc.,) dans votre zone de santé? oui/non?

si oui, de quelle nature est ce conflit?

qui sont concernés par ce conflit?

de quand date ce conflit?

32. Est-ce que ce conflit influence les services fournis par la zone de santé? oui/non?

si oui, comment?

33. Avez-vous un mot à dire sur le choix du type d'assistance envoyée par SANRU dans votre zone de santé? oui/non?

si oui, quel type?

personnel? _____

matériel? _____

finances? _____

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34. Si SANRU arrête toute son assistance dans votre zone, qu'est-ce que vous allez faire?

premiere reponse:

en profondeur:

Pourriez-vous continuer? oui/non?

si oui, où pensez-vous avoir le financement et le materiel pour:

activité

source de financement

formation

supervision

matériel

finances

autres (spécifiez)

35. Si SANRU réduit son financement pour votre zone à une seule activité, laquelle serait la plus importante pour vous?

36. Y a-t-il des comités aux villages dans votre zone qui fonctionnent extrêmement bien? oui/non

si oui, decrivez

a quoi attribuez-vous leur succès?

37. Est-ce que SANRU vous a aidé dans le domaine de l'organisation communautaire (formation, modules, visites, fonds, etc.)?

Table F-1 Status of Training Outputs - 31 Dec 1990¹ (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 supervisors	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)	58	66
Local Training in the Zones³		
2140 Health Center Nurses	2182	102
2000 Village Health Workers	1776	89
1000 Traditional Birth Attend's	1027	103

¹SANRU Project Paper, Annex 8.

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

³Zone 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.

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Table F-2
 Status of Training Outputs - 31 Dec 1990⁴
 (Outside Zaire)

<u>Specified Outputs:</u> Out of Country Training	<u>Achieved by</u> <u>31 Dec '90</u>	<u>% Achieved</u>
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%

⁴Ibid., Annex 8.

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Table F-3
Status of Outputs for
Studies and Operations Research - 31 Dec 1990⁵

<u>Outputs:</u>	<u>Achieved: Dec '90</u>		<u>% Achieved</u>	
	<u>Financed</u>	<u>Complete</u>	<u>Financed</u>	<u>Complete</u>
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

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

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<u>Table F-4</u> Status of Infrastructure Outputs - 31 Dec 1990 ⁶				
<u>Outputs:</u>	<u>Achieved: Dec 90</u>		<u>% Achieved</u>	
	<u>Financed</u>	<u>Complete</u>	<u>Financed</u>	<u>Complete</u>
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

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

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Table F-5				
Status of Infrastructure Outputs - 31 Dec 1990⁷				
<u>Outputs:</u>	<u>Achieved: Dec 90</u>		<u>% Achieved</u>	
	<u>Financed</u>	<u>Complete</u>	<u>Financed</u>	<u>Complete</u>
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 <u>villages assainis</u> ¹⁰	N/A	1246	--	--

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

⁸There 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 WASH Field Report 313, p. 12, Table 5.

⁹SANRU 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.

¹⁰Village assaini has been a problematic concept SANRU. When two types of criteria have been satisfied, a village is declared sanitary and given the SANRU drapelet. Some criteria are satisfied when infrastructure is in place, e.g., a capped spring or a VIP latrine. Others are met when the villagers adopt new behaviors, e.g., using latrines and burying their solid waste. At present, when one or more conditions are in default, the village is no longer sanitary. Hence, the status of "sanitary village" is dynamic and difficult to maintain.

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Table F-6				
Status of Infrastructure Outputs - 31 Dec 1990¹¹				
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

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

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

CV

Table F-7
Status of
PHC Program Implementation and Supervision Outputs
31 Dec 1990¹³

<u>Outputs:</u>	<u>Achieved - '90</u>		<u>% Achieved</u>	
	<u>Financed</u>	<u>Complete</u>	<u>Financed</u>	<u>Complete</u>
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

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

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Table F-8
Status of
PHC Program Implementation and Supervision Outputs
31 Dec 1990¹⁴

<u>Outputs:</u>	<u>Achieved - '90</u>		<u>% Achieved</u>	
	<u>Financed</u>	<u>Complete</u>	<u>Financed</u>	<u>Complete</u>
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

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

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The following are comments and responses brought up during the four de-briefing meetings that the evaluation team held. One of de-briefings was given to the development community at large, this served the Mission plan of greater coordination and communication with other donors. In general, the response was very positive.

The success of the evaluation was a function of the careful selection of team members made by the Mission. All the team members were already familiar with both the project and Zaire, enabling them to skip the "down-time" of adapting to the country and the project. One of the evaluators was only able to be in-country for ten days because of a tight schedule. However, all ten days were productive because he knew the financial management goals of the project and he went into the field the day after he arrived. A project officer in the Agriculture division wanted John Tomaro to lead the evaluation of her project because she was so impressed by the presentation of the team.

There was some criticism of the breadth of the scope of work, it seemed impossible that five pages of issues could be adequately evaluated. In order to overcome this limitation, a review session was held the first week of the evaluation and the scope of work was pruned. This allowed the team to focus on priority issues. The least successful aspect of the scope of work was the emphasis on family planning. Family planning was a priority for the Mission but had a lesser role in the SANRU project. Nonetheless, the Mission felt that it was important to have this aspect of the project reviewed. The result was that the family planning portion seemed out of sync with the evaluation focus on management, administration and supervision.

Site selection for evaluation was particularly good. To avoid the problem of always reviewing "good zones", a deliberate attempt was made to review zones that were having difficulty. Furthermore, all geographic areas were covered so that the team could evaluate the impact of either proximity to Kinshasa or geographic isolation in implementing project goals.

An innovative solution that had a beneficial impact on the logistics of the evaluation was hiring a short term logistics coordinator. With a team of six consultants, in a country the size of Zaire, and with such poor communications, this service proved invaluable. Some of his duties were to arrange travel, get the necessary permits for visiting limited access areas and arrange local transportation. Support offices in the Mission agreed that for future evaluations, this service would be replicated.

Generally, the evaluation was consistent with the beliefs of both the Mission and project management. SANRU was felt to be an impressive project, meeting many of its goals under difficult circumstances. There were some management problems at the project site, and some administrative obstacles at the Mission, but overall the project was on target to meet its objectives by PACD.