

P.D. BAT 220

OFFICIAL PROJECT DOCUMENT

OFFICIAL PROJECT Report Symbol U447

CLASSIFICATION PROJECT EVALUATION SUMMARY (PES) - PART I

1. PROJECT TITLE <p>Basic Rural Health</p>	2. PROJECT NUMBER <p>660-0086</p>	3. MISSION/AID/W OFFICE <p>USAID/Zaire</p>
4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Center - Fiscal Year, Serial No. beginning with No. 1 each FY) <u>4-4</u> <input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION		

5. KEY PROJECT IMPLEMENTATION DATES <table> <tr> <td>A. First PRO-AG or Equivalent FY <u>81</u></td> <td>B. Final Obligation Expected FY <u>83</u></td> <td>C. Final Input Delivery FY <u>86</u></td> </tr> </table>	A. First PRO-AG or Equivalent FY <u>81</u>	B. Final Obligation Expected FY <u>83</u>	C. Final Input Delivery FY <u>86</u>	6. ESTIMATED PROJECT FUNDING <table> <tr> <td>A. Total</td> <td>\$ 10,700,000</td> </tr> <tr> <td>B. U.S.</td> <td>\$ 4,864,000</td> </tr> </table>	A. Total	\$ 10,700,000	B. U.S.	\$ 4,864,000	7. PERIOD COVERED BY EVALUATION <table> <tr> <td>From (month/yr.)</td> <td>August 1981</td> </tr> <tr> <td>To (month/yr.)</td> <td>April 1984</td> </tr> <tr> <td>Date of Evaluation Review</td> <td>May 1984</td> </tr> </table>	From (month/yr.)	August 1981	To (month/yr.)	April 1984	Date of Evaluation Review	May 1984
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Date of Evaluation Review	May 1984														

8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
Major Recommendations		
1. The Basic Rural Health Project should increase the number of Rural Health Zones to be developed from 50 to 100, and the Rural Health Centers to be converted from 250 to 650. The project should be extended 4-5 years, with new funds starting in FY 86.	R. Thornton	June 86
2. The target outputs of the project should be revised as recommended by the project direction, with exceptions noted in the narrative.	R. Thornton	Dec. 84
3. Nursing instructors from RHZones should be sent to appropriate institutions in Francophone countries for advanced training in primary health care.		
4. The project should stress regional Training of Trainers centers for supervisors, nurses, and village health workers.	R. Thornton	June 86

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS <table> <tr> <td><input checked="" type="checkbox"/> Project Paper</td> <td><input checked="" type="checkbox"/> Implementation Plan e.g., CPI Network</td> <td><input type="checkbox"/> Other (Specify) _____</td> </tr> <tr> <td><input checked="" type="checkbox"/> Financial Plan</td> <td><input checked="" type="checkbox"/> PIO/T</td> <td>_____</td> </tr> <tr> <td><input checked="" type="checkbox"/> Logical Framework</td> <td><input type="checkbox"/> PIO/C</td> <td><input type="checkbox"/> Other (Specify) _____</td> </tr> <tr> <td><input checked="" type="checkbox"/> Project Agreement</td> <td><input type="checkbox"/> PIO/P</td> <td>_____</td> </tr> </table>	<input checked="" type="checkbox"/> Project Paper	<input checked="" type="checkbox"/> Implementation Plan e.g., CPI Network	<input type="checkbox"/> Other (Specify) _____	<input checked="" type="checkbox"/> Financial Plan	<input checked="" type="checkbox"/> PIO/T	_____	<input checked="" type="checkbox"/> Logical Framework	<input type="checkbox"/> PIO/C	<input type="checkbox"/> Other (Specify) _____	<input checked="" type="checkbox"/> Project Agreement	<input type="checkbox"/> PIO/P	_____	10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT <table> <tr> <td>A.</td> <td><input type="checkbox"/> Continue Project Without Change</td> </tr> <tr> <td>B.</td> <td><input checked="" type="checkbox"/> Change Project Design and/or <input type="checkbox"/> Change Implementation Plan</td> </tr> <tr> <td>C.</td> <td><input type="checkbox"/> Discontinue Project</td> </tr> </table>	A.	<input type="checkbox"/> Continue Project Without Change	B.	<input checked="" type="checkbox"/> Change Project Design and/or <input type="checkbox"/> Change Implementation Plan	C.	<input type="checkbox"/> Discontinue Project
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C.	<input type="checkbox"/> Discontinue Project																		

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles) <p>Dr. Matudila Malonga, GOZ Representative to Project Mr. Richard Thornton, USAID/Zaire Cit. Nlaba Nsona, Project Director Dr. Luvivila Kapata, Director of Primary Health Care, Dept. of Public Health, GOZ</p>	12. Mission/AID/W Office Director Approval Signature: <i>[Signature]</i> Typed Name: R. Podol, Director, USAID/Zaire Date: 7/9/84
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PROJECT EVALUATION SUMMARY, PART I (CONT'D)

5. Study tours to other African countries should be organized for SANRU staff, GOZ, and Medical Chiefs of Zones to examine approaches to self-financing, family planning and training. They should also visit between RH Zones in Zaire. Utshudi Dec. 84
6. SANRU should diversify the U.S. Schools of Public Health selected for MPH training of physicians and administrators. F. Baer Dec. 85
7. The annual National Health Conference should be continued without fail and should be a USAID budgetary priority. Other agencies should share the cost if necessary. Regional Conferences should also be considered. R. Thornton June 84
8. SANRU evaluation strategy should focus on a few indirect indicators of improved health service such as accessibility, coverage and participation of villages in health programs; the Health Information System should be reduced to a few key items. F. Baer Dec. 84
9. SANRU staff should be expanded in order to maintain quality of performance and to take on recommended new activities. A Zairian health information system manager is particularly needed. F. Baer Dec. 84
10. SANRU should offer help to RHZ in improving regional supply systems. R. Thornton
F. Baer June 86
11. USAID/Zaire should engage a procurement officer instead of technicians to purchase project commodities. J. McCabe Dec. 85
12. Pharmaceuticals purchased with USAID funds should be limited to one basic effective drug per category (ex: one antibiotic, one antimalarial). Utshudi Dec. 84

13. Technical assistance in financial management should be given to Health Centers. F. Baer Jan. 85
14. SANRU should furnish more technical expertise to Rural Health Zones for improved latrine construction and water source protection. F. Baer Dec. 85
15. USAID should enter discussions with the GOZ to resolve issues about the legal status of Health Zones. L. Thornton Oct. 84
16. Assistance should be provided to the Fifth Direction of the DPH in coordinating Primary Health Care in Zaire. L. Thornton Dec. 85

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BASIC RURAL HEALTH PROJECT
MID-TERM EVALUATION

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PROJECT EVALUATION SUMMARY (PES) - PART II

13. SUMMARY.

The Government of Zaire Health Care plan calls for dividing the nation into well-defined Health Zones, with the health of the entire population covered by Health Centers and reference hospitals. The current 5-year plan calls for 146 Health Zones to be functioning by 1986.

The USAID Basic Rural Health Project (SANRU) is well-conceived and is in accord with the government plan. It is well-designed as a strategic project that provides technical assistance to 50 Health Zones rather than services directly to the population. The service providers are existing church and government institutions that are willing to take responsibility for entire geographical areas and are committed to the primary health care approach.

The project is organized as a grant to the Government of Zaire with a cooperative agreement to the Eglise du Christ au Zaire (ECZ) to manage the project. The project office has a staff of five. The related government bureau is the Primary Health Care office ("Fifth Direction") of the Department of Public Health. This new office has a staff of four.

SANRU and the GOZ cooperate well with a variety of private voluntary organizations and with other donor agencies to promote primary health care in Zaire. They work to manage resources so there is little duplication and RHZs receive the assistance they need.

The Project Paper calls for converting 250 curative dispensaries into Health Zones (RHZ) and providing preventive services in addition to improved curative care. Committees for villages and for Health Centers are to serve as a sustainable resource for making the health system at least partially self-financed. Services, curative and preventive, are to be provided by nurses or Village Health Agents. Sanitation and health education are to be the job of village animateurs.

SANRU supports all these activities with technical advice, commodities, seminars and materials for teaching, construction of water sources and classrooms, and transportation (vehicles and fuel). The project headquarters takes direct responsibility for training the Medical Chiefs of Zones and Zone Supervisors. Each year a National Health Conference discusses project concepts, progress, issues and problems. This meeting is highly effective in promoting the primary health care concept and gathering support for the project.

SANRU assists Rural Health Zones with management of the Health Centers, training the nurses and Village Health Agents, logistics including pharmaceutical supplies and transport, health information collection and analysis, and supervision of the health workers and the village development committees.

SANRU project is making excellent progress in helping groups establish 50 Rural Health Zones and 250 Health Centers which emphasize preventive as well as curative services. While there was some delay in starting administration of the project and prolonged delays with procurement of commodities, project objectives are being achieved in a timely manner. Thirty-six Health Zones are already established, and 85 dispensaries have been converted to Health Centers. Hundreds of health workers and village committees have been trained and placed in operational settings. The project should thus achieve the majority of its stated objectives by the end of USAID assistance in 1986.

The difficulty in clarifying Rural Health Zone limits and responsibilities has hampered progress in some parts of the country. In general, though, SANRU has served as a stimulus and catalyst for government, private, bilateral and multilateral agencies to work toward the common goal of Health for All in Zaire using primary health care strategies.

14. EVALUATION METHODOLOGY. An evaluation team organized by the GOZ Department of Public Health and USAID/Zaire was composed of:

Dr. Kalambay Kulula - Public Health Physician; Fifth Direction/Department of Public Health/GOZ; Evaluation team leader

Dr. Judith Brown - Medical Anthropologist, Kinshasa

Cit. Utshudi Lumbu - Pharmacist; SANRU Project Officer, USAID/Kinshasa

Dr. James Shepperd - Public Health Physician; Regional USAID Health Officer, REDSO, Abidjan, C.I.

The team was assisted by four facilitators:

Dr. Franklin Baer - Project Manager; SANRU, ECZ

Cit. Niaba Nsona - Medical Assistant; ECZ Medical Director; SANRU Project Director

Dr. Miatudila Malonga - Public Health Physician; GOZ representative to SANRU Project; Administrator of Comité National des Naissances Désirables (CNND)

Mr. Richard Thornton - Health Officer, USAID/Zaire

The evaluation team reviewed the scope of work prepared by USAID/Zaire and used the following methods to evaluate SANRU. All four evaluators participated in all of these steps.

1. Review of documents including Project Paper, internal reports, an AID Inspector General Report. See appended list of documents.
2. Interviews with personnel in the Kinshasa offices of SANRU, USAID, ECZ, OXFAM, WHO, GOZ, and PEV. List is appended.

3. Field site visits to 9 Rural Health Zones in Kivu, Haut-Zaire and Bas Zaire. Interviews with Regional Medical Inspectors, Medical Chiefs of Zones, officers of reference hospitals, Peace Corps Volunteers, nurses and rural health workers. Maternities, health centers and health posts were surveyed, including several not yet integrated into RHZ activities. Meetings were conducted with three village health committees and numerous sites of water source protection were seen. Some latrines were visited. Reports on each Rural Health Zone are appended.

4. Analysis of training materials, data collection forms, clinical records and statistical reports.

5. As the April 1984 SANRU Activity Report (Document 14) contained many valuable observations and recommendations, the evaluators attempted consistently to state their concurrence or non-concurrence and to offer their own assessments, conclusions and recommendations.

6. Finally, the Evaluation Team discussed their findings, agreed upon the conclusions and recommendations, and finalized the report.

15. EXTERNAL FACTORS. SANRU's appearance on the stage of primary health care development in Zaire was very well-timed. The most important supportive event was the adoption of the GOZ 1982-86 health plan, calling for the establishment of Rural Health Zones, placing priority on preventive services over curative, requiring user fees instead of free care and accepting the role of paramedical health workers. The project was furthered by the timely return of USAID/Zaire-sponsored MPE trainees to staff vital Department of Public Health positions and to provide consultants to SANRU's training efforts.

The political stability of Zaire continues in spite of serious economic woes that contribute to the arguments for user financing of health services. The country has been spared serious droughts, famine or natural disasters. The Eglise du Christ au Zaire has been steadfast in their support of the project, both in their headquarters and in the field.

In January 1982, Zaire defaulted on several payments to American institutions and was under the Brooke Amendment until September 1982. This caused a 9-month delay in project implementation.

The GOZ has recently suffered across-the-board budget cuts. Despite earlier promises to assist 25 of the Rural Health Zones financially, the Department of Public Health has sent funds to only two. However, this has had only minor negative impact on the SANRU project, since it was designed with little financial input from the GOZ. The Rural Health Zones continue to function as planned and do not depend heavily on GOZ subsidies. Some salaries, medicines and daily operations are covered by user fees. Training, technical assistance, and some initial commodities are provided by SANRU (and sometimes by other international health agencies). Finally, many of the Zones are related to churches and can request occasional help from partner churches elsewhere.

16. INPUTS. With the exception of Brooke Amendment delays, USAID, ECZ and GOZ contributions to the project have flowed with reasonable smoothness. While commodity deliveries have delayed some field operations, training and technical inputs have prepared RHC and Health Centers for their effective use. Training inputs have come from diverse sources with mixed results. Training of physicians and supervisory nurses is very well done. Long term out-of-country training for physicians and administrators has lagged. Some improvements in training technology are required to strengthen retraining of front-line nurses, Village Health Agents and village committees.

Adjustments are needed in pharmaceutical selection, to target AID resources on the most effective drugs to be used at the most remote service level.

17. OUTPUTS. The Project Activity Report of April 1984 gives the following levels of completion for each output.

<u>Project Objectives</u>	<u>Anticipated over IOP</u>	<u>1982-1983 Output</u>	<u>% of LOP objective</u>
<u>Training</u>			
Village Health Workers	1,500	528	35%
Traditional Birth Attendants	400	127	32%
Village Development Committees	3,000	802	27%
Nurses	750	428	57%
Supervisors	50	19	38%
MD/Administrator	50	33	66%
Master of Public Health	10	4	40%
<u>Infrastructure</u>			
Rural Health Zones	50	36	72%
Health Centers	250	85	34%
Latrines	25,000	52,000	200+
Springs Capped	1,500	325	22%
Wells	500	5	1%
Vaccination Programs	1,000	381	38%
Propharmacies	1,000	155	16%
Family Planning Acceptors	150,000	15,200	10%
Laparoscope/Minilap	20	11	55%
Classrooms	12	3	25%
Health Information System	-	-	-

The Evaluation Team concluded that the project will meet most of its objectives as planned.

A few output figures need to be changed due to doubts that targets were realistic (family planning) or that the approach was viable (wells). Changes recommended by project management in their April 1984 Report (Document 14) are generally accepted by the evaluation team, with the exception of family planning and vaccination programs (see pages 27 and 28 below). No additional outputs are needed to achieve project goal.

18. PURPOSE. The Project Logical Framework states that the project purpose is to "establish a self-sustaining community-supported system of primary health care effectively offering prevention and treatment for the 10 most prevalent health problems in 50 zones in Zaire".

The End of Project Status (EOPS) calls for a system offering basic prevention and cure for diseases to be in place and functioning on a self-financing basis.

Three major activities can be identified:

First, to help the existing hospitals develop Rural Health Zones which have a preventive and curative focus;

Second, to help these zones convert their existing curative dispensaries into prevention-oriented Health Centers;

Third, to develop the participation of the affected communities in the support of these Health Centers so that they become self-financing at least in terms of drugs.

For the first two activities the project is clearly well on the way toward successful implementation. Too little attention, however, has been paid to the development of the Committees expected to sustain the work at the village and Health Center levels. The original assumption that physicians and nurses could organize and train committees seems to be invalid and needs re-thinking.

Furthermore, self-financing procedures need to be encouraged and studied. Most Health Center users pay a consultation fee and something for drugs. In some centers the fees barely cover the cost of drugs. Elsewhere the fees are said to pay drugs, salaries, and some costs of central supervision. The project needs to focus on these questions and assist the Health Zones with financial management procedures. A financing study is being conducted in some RHZ by an AID project (PRICOR). Its results should prove useful to many RHZ.

19. GOAL. The overall project goal is "to improve the health status of the rural population by increasing the proportion of rural Zairians that have access to basic health services".

The Project is contributing to this goal by successfully organizing Rural Health Zones and converting dispensaries to Health Centers. The reporting system is designed to measure access to and use of health services. No studies of health impact have been undertaken, but the Evaluation Team recommends local studies on specific impacts.

20. BENEFICIARIES. The project will organize Rural Health Zone systems for a population of 1.25 million people scattered throughout the country (250 Health Centers x 5000 people each). The major beneficiaries will be women and children who are the target of preventive services and curative care. Entire communities will benefit from such project activities as water source protection, village sanitation and human waste disposal, hygiene and nutrition.

education, and general economic development. Promotion of self-financing will help assure continuation of the village health system after project assistance has been terminated. The indirect beneficiaries are Zaire health workers who have been trained to manage and evaluate Primary Health Care. The organizations for whom they work are also beneficiaries, including GOZ, ECZ, and others.

21. UNPLANNED EFFECTS. There were three major positive unplanned effects as a result of the SANRU project. (1) The stimulation of the government's Department of Public Health to establish the 5th Direction (Primary Health Care) to be the focal point of Primary Health Care system development. This office has been reinforced with recently returning US-trained public health physicians. (2) SANRU's 50 Rural Health Zones included several Catholic hospitals. The national Catholic medical bureau has now gone ahead with the training and development of Rural Health Zones around 28 additional Catholic hospitals. (3) The revision of the health development policies of other donors such as the German cooperation agency. This agency has shifted its focus in Zaire from hospital-based medical care to village-based health care.

One negative unplanned effect has been the exclusion of the important Kimbanguist Church from qualifying to manage a Rural Health Zone. Despite their many primary health care activities, they have no Reference Hospital in their geographical area of Nkamba, so they cannot by definition manage a RHZ.

22. LESSONS LEARNED

- 1) Send local leaders for training as soon as the PID is agreed upon, using AMDP or old project funds.
- 2) An annual national health conference provides an opportunity for national health policy dialogue. Zairian health workers from the field and national planners play major roles in presenting and discussing the issues involved. Thus nationally-accepted policies, plans, priorities and definitions are likely to result. In addition donors have an opportunity to find sub-projects to support or study.
- 3) SANRU is a strategic project, that is to say, it develops health capabilities (such as planning, training and infrastructure) rather than delivering services in the field. Because SANRU has not focused its resources at the micro level, hundreds of Zairians are now prepared to work with others (missions, donors, etc) in large health systems (Health Zones of 60,000 - 200,000 people) and in national management. SANRU has provided an outstanding opportunity for reinforcement of existing policy dialogue and institution building.

23. SPECIAL COMMENTS

- 1) We anticipate that many of our recommendations will not be full enacted before the end of the Project in 1986.
- 2) SANRU provides a critical organizational framework for trainees returning from abroad

3) SANRU central personnel are regularly consulted by all government and private agencies involved in primary health care in Zaire.

4) The GOZ Health Plan calls for the establishment of 250 Health Zones by 1990. The roles of GOZ in primary health care are to orient health policy, to determine priorities, to standardize strategies, to exchange information, to evaluate and coordinate all primary health care activities. The implementation of these activities is carried out by different national and international agencies.

The Fifth Direction of the Department of Public Health is supposed to play the role of coordination, but unfortunately this new Direction is not yet fully functioning. SANRU is helping this Direction in various ways, such as the establishment of PHC activities, training, information system, and evaluation.

5) There is no likely substitute for the strategic role played by SANRU in training development, until local institutions are strengthened and the School of Public Health is a reality.

6) Other USAID/Zaire projects (School of Public Health, nutrition, family planning, and childhood diseases) are greatly assisted by SANRU's strategic role. Their success is highly dependent on the continuation of Rural Health Zone and Health Center activities. Many of their plans can be implemented only when a vehicle like SANRU can distribute their technologies to rural areas.

Therefore, the Evaluation Team recommends without reservation that the project be extended for 4-5 years to cover a total of 100 Rural Health Zones.

Two aspects of the project need to be stressed:

--infrastructure development in terms of pharmaceutical and medical supplies

--Training of Trainers of nurses and village level health workers

DETAILED EVALUATION REPORT

I. INTRODUCTION

The Basic Rural Health (SANRU) Project grew out of the concept of primary health care development put forward in Zaire as early as 1926 in Kisantu. That Administrative Zone organized a system of Rural Health Centers linked to a reference hospital. The model was followed later by several member hospitals of the Eglise du Christ au Zaire (ECZ). In 1980 numerous ECZ hospitals approached USAID/Zaire for assistance, but because of the large number of requests the mission preferred a group approach. The 1981 Project Paper called for USAID assistance in forming 50 Rural Health Zones (RHZ) and converting 250 curative dispensaries into Health Centers providing preventive services in addition to improved curative care. Committees for villages and Health Centers were to serve a sustainable resource for making the health system self-financing for pharmaceuticals. Services, curative and preventive, were to be provided by nurses or Village Health Agents. Sanitation and health education were to be the job of village animateurs.

To date, 96 hospitals (Protestant/ECZ, Catholic, and GOZ) have contacted SANRU for assistance in developing their Rural Health Zones. Fifteen Zones were selected for Phase I of the project, twenty-one for Phase II, and fourteen for Phase III (just beginning).

SANRU assists Rural Health Zones with management of the Health Centers, training the nurses and Village Health Agents, logistics including pharmaceutical support and transport, health information collection and analysis, and supervision of the health workers and the village development committees.

SANRU supports all these activities with technical advice, commodities, organization of training seminars and materials for teaching, construction of water sources and classrooms, and transportation (vehicles and fuel). The project headquarters takes direct responsibility for training the Medical Chiefs of Zones and Zone Supervisors. Each year a national Health Conference discusses project concepts, progress, issues and problems. This meeting is highly effective in promoting the primary health care concept and gathering support for the project.

SANRU Project is well-conceived and is in accord with the GOZ 5-year Primary Health Care plan calling for 146 Health Zones by 1986. The project is also well-designed as a strategic project that provides technical assistance rather than services.

Finances

There are two main source of finance for the Basic Rural Health Project:

A. USAID in the form of a Grant which totals \$4,864,000. These funds cover the following major categories of expenditures:

- Purchase of vehicles motorcycles, bicycles, medicines and medical equipment
- Training of health person ^{nel} overseas
- Payment of technical services

- B. GOZ provides three kinds of financial support:
- Counterpart funds which at the time of initial implementation of the project were estimated to total Zs. 2,324,000. To date GOZ has contributed about Zs. 10,000,000. These figures appear to have greatly exceeded the GOZ contribution but inflation factors should be taken into account when reviewing the figures.
 - GOZ pays the salaries of health personnel in GOZ hospitals and dispensaries. GOZ also pays the salaries of Zairian doctors and some nurses in church-related institutions.
 - GOZ plans to assist some 25 functioning Rural Health Zones with funds. The Department of Public Health has suffered across-the-board budget cuts which have allowed the support of only 2 Rural Health Zones to date.

Unpredictable factors such as inflation and budget cuts make GOZ contributions uncertain, but this does not seem to have had a negative impact on the Project's outputs and progress. Autofinance systems have been accepted by most RHZs, and some of the Zones receive support from church organizations abroad or from international health agencies.

II. SANRU INPUTS

A. Organization

The project is organized as a grant to the Government of Zaire with a cooperative agreement to the Eglise du Christ au Zaire (ECZ) to manage the project. The government focus for project management is called the "Fifth Direction" of the Department of Public Health. This new office has a staff of four.

The USAID Project Officer, Cit. Utshudi, is a Zairian with 5 years experience with AID projects.

The Project Director for the ECZ is a Nurse-Administrator, Cit. Nlaba, who has been with the ECZ for 15 years.

A USAID Personal Services Contractor, Dr. Franklin Baer, is the Project Manager and thus chief executive officer. He has a doctoral degree in public health and 7 years experience working in Zaire.

The ECZ staff also includes a training and family planning director (Ms. Florence Galloway), a comptroller (Rev. Ralph Galloway), an administrative assistant, and a secretary. The Galloways are supported as missionaries by their U.S. church.

SANRU and the GOZ Primary Health Care Office (5th Direction) cooperate with other donors to promote primary health care in Zaire. They work to manage resources so there is little duplication and RHZs receive the assistance they need. A very active GOZ Agency is the P.E.V. (Program to Expand Vaccination) which provides training and commodities to the Zones for immunizations, malaria control and diarrheal disease control. UNICEF provides large quantities of material - vehicles, refrigerators and pharmaceuticals, while WHO supports training and planning. OXFAM offers technical assistance and commodities in four regions. The U.S. Peace Corps places trained volunteers in Rural Health Zones, where they promote health education, train and retrain health workers, and help with water projects.

The budget of the project is managed as follows: U.S. funds are handled by the USAID officers. Zaire counterpart funds are jointly managed by GOZ, ECZ and USAID, and Peace Corps funds by their office. The GOZ receives no direct funds for the project, but signs the authorization for both U.S. and counterpart funds.

B. Training

1. Introduction: The SANRU training inputs probably have the most far reaching impact in terms of people and organizations affected. The training program carries much of the responsibility for attainment of project goals and objectives. While the budget for training is modest, the time and effort spent on seminars, workshops, conferences, courses, teaching, equipment and education materials probably represent the largest amount of SANRU activities.

2. At the start of the project, existing Rural Health Zones (RHZ) were operating training programs for A2 and A3 nurses to staff their existing hospitals, curative-oriented dispensaries, and maternities. One zone (Nyankunde) had already started training Village Health Agents before SANRU assistance became available. Very few zones had retraining capacity. At the executive level, no training had been institutionalized for physicians, nurses or administrators of public health programs, although hospital administrators were being trained at the Institut Supérieur des Techniques Médicales (ISTM). Periodic courses in public health topics had been offered by various donors such as UNICEF, World Health Organization and Belgian Cooperation.

• The SANRU project strategy is to support training at the Rural Health Zone, Health Center, and village levels. The categories of persons to be trained are as follows:

Rural Health Zone

- Medical Chief of Zone (physician)
- Administrator (physician or A1 graduate nurse)
- Supervisor (often A2 diploma nurse)

Health Center

- Nurse (A2 diploma nurse or A3 auxiliary nurse)
- Aide in nursing or sanitation
- Health Committee (representatives from surrounding villages)

Village
Village Health Agent (VHA)
Animateur (health teacher)
Traditional Birth Attendant (TBA)
Village Development Committee (local residents).

The project training strategies are several. At the executive level, the Medical Chief of Zone is given a 1-5 week training program in primary health care topics including planning, disease control, community development and training methodology. Additional workshops are given on technical topics. Zairian M.C.Z. or deputy M.C.Z. are eligible for training in the U.S. in public health subjects with an emphasis on management courses.

For supervisors, the training strategy is to send a team of instructors to each region to train groups of 10-15. Senior nurses, physicians or dentists from the RHZs are the target group. Kivu, and Bas Zaire and Bandundu supervisors have been trained to date.

The strategy for existing nurses (A3) is to retrain them for their primary health care role. Their training course is developed by the MCZ and the existing nursing faculty within the RHZ. The nursing school curriculum for new A2 and A3 nurses was revised by the DPH in 1982 to include significant primary health care content. SANRU's role is to assist these two training programs with material and technology.

The "Training of Trainers" (TOT) approach was adopted for upgrading Traditional Birth Attendants.

4. Resources available. SANRU is making use of numerous resources for training:

- a) SANRU training director is Ms. Florence Galloway, a nurse-midwife trainer with long African experience. She manages teams of local consultants in the fields of midwifery, management, nutrition, public health nursing, etc. SANRU provides extensive amounts of training material, equipment, and technical advice. There have been problems of finding material in French. Ms. Galloway receives (but has not yet assessed) training programs developed by the RHZs. Dr. Baer also serves as a training advisor and teacher.
- b) The GOZ Program to Expand Vaccinations (PEV) is augmented by the USAID project "Combatting Childhood Communicable Diseases" (CCCD). The project provides significant training manpower on a variety of PHC topics.
- c) Several centrally-funded USAID projects are used, including INTRAH, Johns Hopkins International Program (JHPIEGO), Water and Sanitation for Health (WASH), PRICOR, CEDPA, and FPIA.
- d) A variety of non-church based PVOs are available including OXFAM, Organization for Rehabilitation through Training (ORT) and American Medical Research and Education Foundation (AMREF).

e) United Nations agencies such as World Health Organization and UNICEF make modest contributions to training, usually in the form of fellowships. WHO links SANRU participants to a somewhat similar AID/WHO regional project for west and central African countries, entitled Strengthening Health Delivery Systems (SHDS).

f) GOZ educational institutions utilized in SANRU training include the Medical School at the University of Kinshasa (UNIKIN), Institut Supérieur des Techniques Médicales (ISTM), and the Center of Studies for the Promotion of Social Action (CEPAS).

C. Commodities:

Provision of essential commodities to RHZs is the biggest budget item under the Basic Health project. Some commodities have been procured locally with counterpart funds, including cement and plastic pipes for water sources. Most of the commodities are imported and paid with USAID dollars. For example, medicines and equipment assist in the conversion of 250 curative services dispensaries into health centers. Educational materials, health manuals and office equipment establish and support the training of health workers. Motorcycles and vehicles assure the supervision of Rural Health Zones. (The Evaluation Team notes that helmets were included in the motorcycle order, but seat belts for some vehicles were neglected. No project personnel or collaborators should be denied these preventive health measures. Both should be routinely provided.)

A variety of problems have been encountered with the import of commodities:

1. There has been delay of 12-24 months in obtaining some essential commodities. This may have delayed the conversion of dispensaries among the Phase I RHZs. In Kivu, some Phase I and II RHZs complained in particular about the long delays in receiving microscopes, scales and medicines imported from the U.S.
2. One reason for the delays lay in the USAID/Zaire procurement system. The USAID project officers, untrained in purchasing procedures, had to write, re-write, and handle orders and supplies themselves.
3. Product substitution occurred. A simplified system of standard treatments by low-level nurses and village health workers cannot tolerate substitutions. For example, a product containing tylenol was sent by the supplier, instead of the aspirin specified in the PIO/C. The project and USAID/Zaire were not consulted about this substitution, and it was discovered only after the shipment was received at the Kinshasa warehouse.

Recommendations:

- a) USAID/Zaire needs a qualified Procurement Officer to place orders directly to suppliers or through a Purchasing Service Agent.

- b) SANRU should use counterpart funds to enable RH2s to purchase medicines locally through their current suppliers. SANRU can continue purchasing medical equipment from the US using current suppliers and/or private purchasing agents.
- c) Pharmaceuticals provided by SANRU should give efficacious and simple treatment or prophylaxis for common diseases. Only one treatment choice should be available for the least-trained health personnel, for example, one anti-malarial and one antibiotic.
- d) The good working relationship that SANRU has developed with the various international health agencies such as UNICEF and OXPAM should facilitate specialization in ordering procedures. Each donor agency could provide items it can get most quickly and easily. SANRU assistance would be for items which are obtainable through USAID ordering processes with the least constraints.
- e) Future orders for health project vehicles should specify seat belts.

III OUTPUTS DUE TO SANRU INPUTS

After field visits, the Evaluation Team is unanimous in recognizing positive results in training health workers at all levels, creating and organizing Rural Health Zones, converting curative dispensaries into Health Centers, and establishing a health information system. The project is on target and is making good progress toward its objectives.

A. Training

1. Training programs taking place in Zaire

1.1. Training Medical Chiefs of Zones (MCZ) and Administrators.

Two types of training have been offered. Courses were given in 1982 and 1983 at UNIKIN for Phase I and II RHZones. These MCZ received a 5-week course which helped them understand primary health care strategies and services, planning methodology, training programs, epidemiology and biostatistics, and community organization. This course was considered excellent by the participants and resulted in more rapid evolution of RHZs into preventive-oriented organizations with considerably augmented levels of health management capability.

In addition, seven-day planning seminars were held for MCZ following the annual National Health Conference. The MCZ interviewed indicated that they had been helped in terms of (1) better comprehension of PHC, (2) ability to plan their zone operations, training, logistics, etc. and (3) identifying sources of information and a variety of other valuable resources. As usual, the opportunity to share experiences and compare notes was educational for MCZ from both Phase I and Phase II and other participants.

Technical health sciences and tropical medicine continuing education are not provided by SANRU. There is a continuing need for frequent technical updates for physicians and nurses in all areas. Particular attention must be paid to the various tropical diseases of high prevalence in the RHZ. For instance, the various conflicting therapeutic modalities for treating malaria indicate a lack of current information at the RHZ level. The orientation course for reproductive health provided by JHPIEGO is typical of the type of course needed. (Comment on the Continuing Medical Education content of courses given to Phase I and Phase II MCZ cannot be made for lack of documentation.)

MCZ and others have received three-week courses given by the PEV program. These courses include management, PHC and vaccination, epidemiology, therapy for malaria and diarrhea diseases. These courses are reported to be very effective and useful. Modules for this course were prepared in cooperation with the U.S. Centers for Disease Control as part of the CCCD project.

1.2 Training of supervisors

SANRU has organized an excellent system for training supervisors of the Health Zones. The participants are A1 and A2 nurses, some physicians and dentists. A consultant team of instructors includes: an administration trainer experienced with the World Health Organization, a senior nurse-graduate of Tulane School of Public Health, and a statistician from the University of Kinshasa. The course objectives are clear and relevant. The course content is appropriate to Zaire's districts, covers problems supervisors can expect to meet working in rural primary health care systems, and applies modern management principles. The teaching methods, case studies, problem solving, practical exercises, role play and field work represent up-to-date educational technology for teaching, learning and evaluation of student and teacher performance. The faculty interviewed were greatly pleased with the attentiveness and application of the students and their achievement. Students likewise expressed enormous satisfaction with all aspects of the course and saw its subject matter as immediately applicable to their daily responsibilities in primary health care systems. The teaching material and references are considered to be of highest quality.

This training program was far superior in technical quality and content to any others examined by the Evaluation Team. Because of this outstanding course, SANRU plans to make greater use of similar consultant trainers resident in Zaire (rather than continuing the extensive use of AID centrally-funded training groups), thus institutionalizing this capability. The Evaluation Team agrees with this approach.

1.3 Training of nurses

Nurses represent the frontline preventive and curative health care providers in all Zones. In some Zones they are assisted by Health Agents and Animateurs, but in most they are not. Their role is felt to be the most critical to PHC. It is around the training of nurses for their new role that much of the success of the GOZ (and SANRU) primary health care strategy revolves.

Basic nurses training is available in most Rural Health Zones at nursing schools. In 1982, the Department of Public Health revised the required curriculum to include more public health. The following table reveals that the number of hours devoted to public health topics nearly doubled for A3 nurses. The A2 nursing curriculum received even greater increases in public health training. The community health course includes the following topics - epidemiology, zoonosis, insects and vectors, community diagnosis, family planning, parasitic infections, and management.

Public Health in Nursing School Curriculum
(Figures represent required number of hours)

A - 3 Auxiliary Nurses

	Before 1982			After 1982		
	1st	2nd	3rd	1st	2nd	3rd
Community health	60	-	-	60	120	100
Nutrition	45	-	-	15	60	60
Sanitary education	-	60	-	-	30	30
Sanitatio.	-	30	-	-	-	-
Practical work in community	100	100	100	100	100	100
Maternal and child health	-	-	-	30	60	60
Sub-totals	205	190	100	205	370	370
Totals		495			945	

Teaching is by classroom lecture and practical "stage". Teaching content and methods for Primary Health Care subjects are not as well developed as older topics such as anatomy, medicine, surgery, pediatrics and of course nursing practice. The MCZ and SANRU agreed that the nutrition courses are woefully inadequate and poorly taught.

The program is overloaded with topics. There is little or no assimilation time after 31-40 hours of class time. This course organization does not reflect the best in educational methodology. A great deal of help is needed by the nursing schools to teach these expanded topics in public health.

"Retraining" (continuing education) is now given to A2 and A3 nurses posted at Health Centres. Most RHZ give the nurses several sessions of retraining to cover the wide spectrum that they are now being asked to emphasize. Sessions in most places last 1-2 weeks. Subjects frequently include water, water transmissible diseases, organization of the RHZ, hygiene, school health, pre-school health, nutrition, worms, health education, pharmacy, family planning, anemia, sterilizing and antisepsis, causes of diarrhea, gynecology, malaria, tuberculosis, oral rehydration, sanitation education, leprosy, vaccinations, training of village workers and committees, and field practice.

SANRU has done an excellent job of providing training materials, including several books of 200 pages on building health and various other topics. Other handouts range in quality and appropriateness. Nevertheless the courses are too full to permit the nurses to assimilate the material, and the material is not being used to its best advantage. It is the evaluators' judgement that a two-week course with this breadth of content is beyond the learning ability of the best-educated. It is faulty from an educational viewpoint and faulty in terms of achieving project purposes.

SANRU should seek ways to assist the RHZ develop more appropriate basic nurses training and retraining for PHC. Some instructors could be sent to the Centres d'Enseignement Supérieur Scientifique des Infirmiers (CESSI) in Yaoundé and Dakar that offer faculty training and retraining in primary health care nursing. They also offer consultation to other nursing institutions. Upper level nurses training is available in French at Montreal School of Nursing.

Nurses at the A2 and A3 levels are expected to be able to train aides, Village Health Agents and animateurs, but they are not taught how to do this training. There is no relevant Training of Trainers (TOT) program in Zaire. One possibility would be to send nursing instructors to the Lomé Regional Training Center (organized by WHO and Boston University). This TOT course is of 2-3 months duration. Apprentice trainers return from Lomé prepared to establish in-country Training of Trainers (TOT) courses. Zaire would probably require several TOT centers, which would use existing buildings and retrained faculty and provide field experience in surrounding Health Centers and villages.

Recommendations:

- a) SANRU should assist nursing instructors from Rural Health Zones to get appropriate primary health care training at the various institutions in Francophone countries.
- b) SANRU should help to develop regional Training of Trainers centers for supervisors, nurses, and village health workers.

1.4 Training of Traditional Birth Attendants (TBA)

The training program for Traditional Birth Attendants is well developed and uses the "Training of Trainers" strategy referred to above. This program has been developed by the SANRU training director, the American College of Nurse Midwives, and Zairian midwives. The course uses clear, concise training material, a well-tested user manual and has a trainers guide. Training of TBAs takes place in villages.

The strategy used for this category of health worker needs to spread to the other categories. Unfortunately for all, the effort to retrain TBA is being resisted by the MCZ who do not feel they can supervise TBA's. Only six zones train and use TBA.

1.5 Training of Village Health Agents (VHA) and Animateurs.

These categories of health workers are used in many, but not all zones. Both are expected to concentrate their efforts on preventive care, sanitation, water source protection, and organizing pre-natal and pre-school clinics.

In some zones the Village Health Agent (VHA) has a small supply of common drugs for prophylaxis of malaria and treatment of common illnesses. In one zone, a very accomplished VHA has the same drugs as an A3 nurse in other RHZs. All are expected to work closely with Village Development Committees.

The training of Animateurs and VHA varies even more widely than their tasks. SANRU has helped the Zones with teaching materials but has not been involved in the training programs, nor does SANRU routinely review and comment on training reports provided to their headquarters.

SANRU staff recognize that the VHA and Animateur training lacks the quality and consistency of the TBA course. They were disappointed when a consultation provided by INTRAH focused more on family planning than on problems of training Village Health Agents.

In 1983 a study was done of five existing RHZ programs by Dr. Stanley Yoder. The study questioned whether physicians and nurses are prepared to teach village workers health education, sanitation, community organization, environmental and water source protection, or how to organize for financial self sufficiency. As a result of this report and internal reviews, SANRU is strongly considering a program for Training Trainers of village health workers.

While experimentation and individual approaches to village level care are appropriate at the early phase of the project, there is too much excellent material and too many technical advisors available to let each zone conduct its own experiment. Consultation might be obtained from AMREF in Nairobi or SHDS in Abidjan.

Recommendation:

SANRU must work on how to make the training programs for village level workers more effective. The use of the TOT approach is again recommended.

I.6 Training of Village Committees

SANRU terminology, agreed upon at the 1983 National Health Conference, recognizes 2 types of Committees:

- Village Development Committees
- Health Committee with members from the several villages covered by one Health Center.

During the initial part of the project, village and Health Center committees were formed in several RHZ. This was very successful, but apparently depended on a considerable investment by energetic and perhaps charismatic people. Unfortunately, no effective mechanism was developed to train committee members. One zone spelled out clear guidelines for committee structure and function, but did not organize a routine method by which they could be formed and maintained. SANRU has not provided assistance to the zones on the subject of committee training and development.

Again materials and technical assistance are available. For instance, training village committees is part of the TOT program offered at Lomé Regional Training Center. In addition, SANRU and DPH might explore the resources of the Department of Rural Development to help this development activity.

Recommendation

SANRU needs to obtain consultation on training village committees.

2. Training outside Zaire

Out-of-country training of 30 Zairian physicians and administrators was mandated in the PID approval cable of 1981. Three physicians and one nursing instructor were sent for training in the United States at Tulane SOPH. These MPH level workers have played an extraordinary, valuable role in the SANRU success. Two are placed in the new GOZ/DPH 5th Direction, and another is a regular SANRU consultant trainer. With SANRU support, four physicians are now being trained in the U.S., while 5 others are in the final process for the fall of 1984. There is a need for up to 300 MPH-level health workers to serve as managers of Rural Health Zones and to staff GOZ agencies charged with implementation and monitoring the Primary Health Care system. SANRU's small contribution of fellowships will be felt nationally.

It is highly unlikely that the planned UNIKIN School of Public Health will be able to accept students before October 1986, thus SANRU should send as many students abroad as possible. The residual funds not committed for this purpose can send students to UNIKIN if it opens before the current SANRU PACD of 30 September 1986.

SANRU staff, the Rural Health Staff and the GOZ staff have seen little of Primary Health Care development in other parts of Africa, or on other continents. These health workers should be provided study tours of relevant projects. The SANRU staff could profit by visiting the headquarters of the "Strengthening Health Delivery Systems" Project in Abidjan and its Regional Training Center. Those working in family planning would benefit by seeing rural programs in Latin America, Thailand and Indonesia, and in other parts of the world where there was initial reluctance to accept family planning. Other PHC workers should see successful projects such as those in Senegal, Upper Volta and Niger.

Recommendations:

a) SANRU should continue to send physicians, nurses and administrators to the U.S. for master-level training with emphasis on health planning and management. A better job of recruitment is required. More government physicians, administrators and nurses should be sent.

b) The selection of a variety of U.S. schools or public health and programs of health administration is advisable. Some choices:

- University of North Carolina SOPH - General Public Health Administration, Health Education
- University of Hawaii SOPH - Maternal and Child Health, International Health, Health Education
- Johns Hopkins and Harvard for senior executives, teachers and researchers in all P.H. Fields.
- University of Minnesota - Sanitary Engineering
- Yale Medical School - Epidemiology and Viral studies
- Columbia - Health Administration and Family Planning
- Michigan - Health Planning and Family Planning
- Boston University - Health Economics and African Program
- University of California at Berkeley - Health Education
- University of South Carolina - Tropical Diseases
- University of Montreal - General Public Health - In French

All the above schools have many African students and international health programs.

c) Study tours should be arranged to explore successful approaches to rural primary health care in other countries.

B. Infrastructure: Of the 300 Health Zones projected by the National Health Plan (Document 4), SANRU is developing 50. The Evaluation Team visited nine Health Zone Offices plus Health Centers and Health Posts in some of the Zones. They were:

1. Zone of Drodro (Catholic) + 2 HC (Phase II)
2. Zone of Kasangulu (GOZ) + HC (Phase I)
3. Zone of Kaziba (ECZ) (Phase II)
4. Zone of Kirotsha (GOZ/CEMUBAC) + 2 HC (Phase II)
5. Zone of Nyankunde (ECZ) + 3 HC (Phase I)
6. Zone of Oicha (ECZ) (Phase I)
7. Zone of Rutshuru (GOZ/CEMUBAC) (Phase II)
8. Zone of Rwanguba (EC) (Phase II)
9. Zone of Uvira (GOZ) + 2 Health Centers (Phase II)

We also met in Kinshasa with Medical Chiefs of four other Rural Health Zones:

- Zone of Kalonda (ECZ) (Phase I)
- Zone of Karawa (ECZ) (Phase I)
- Zone of Kajiji (ECZ) (Phase II)
- Zone of Lubao (GOZ) (Phase II)

Most of the observations and recommendations made in the SANRU Activity Report of April 1984 (Document 14) were judged valid and are seconded by the Evaluation Team. Two objectives (concerning vaccination programs and family planning) were revised.

1. The creation of 50 Rural Health Zones

Of the Zones scheduled for SANRU's Phase I and Phase II, 36 are already organizing, that is 72% of the initial objective. These different Zones are not totally functional. The level of activities varies from 83% in the most advanced Zones to less than 5% in Zones that have just begun activities in 1983.

In the field, many rural Health Zones have organized themselves, delineated boundaries, and assigned areas of responsibility. However they feel insecure about their plans because the central government (DSP) has not officially recognized the legal status of Rural Health Zones.

Recommendations:

- a) USAID should enter discussion with the GOZ in order to resolve issues remaining about the legal status of Health Zones.
- b) Assistance should be provided to the Fifth Direction of the Department of Public Health in coordination of Primary Health Care in Zaire.
- c) The number of RHZs to be assisted by SANRU should be increased from 50 to 100 beginning in the year 1986. This would extend the project until 1990 or 1991 and permit addition of 12 RHZs per year. Supplemental funding for 50 more RHZs and approximately 400 more Health Centers should be provided as part of this project extension.

2. Transformation of dispensaries into Health Centers

There are still shortages of money and materials in some Zones. For conversion of existing curative dispensaries, SANRU assists in starting primary health care activities by offering materials and medicines. For new Health Centers created by the population themselves, the lack of funds sometimes blocks the completion of the building.

Recommendation

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

3. Construction of latrines

Building latrines of local materials poses problems of durability. At Nyankunde, for instance, village residents are discouraged by the fact that the number of latrines required by the Medical Chief of Zone will never be reached, because so many cave in.

Recommendations:

- a) SANRU should abandon counting latrines as a measure of project success. Instead RHZs should report the number of villages which have successfully completed a village sanitation program with at least 90% of households having a usable latrine. A project objective of 1,000 such villages should be established.
- b) SANRU should furnish technical assistance to the Zones in latrine construction, such as sanitary technicians and appropriate tools.
- c) SANRU should encourage RHZs to experiment with new and improved latrine construction at the reference hospital and Health Centers (for example, the VIP technique). SANRU could provide commercial construction materials (cement, pipe, diggers).

4. Construction and rehabilitation of water sources and wells

Following education on hygiene and environmental health, village committees have improved more than 325 water sources. The lack of appropriate techniques in certain villages, though, renders this effort short-lived (ex: Drodro).

Recommendations:

- a) The objective of 1,500 protected water sources (either durable or semi-durable) should be maintained.
- b) The objective of construction/rehabilitation of 500 wells should be redefined to "alternate water systems". This would include 100 cisterns or wells for health centers and communities, as well as household rainwater catchment systems.
- c) SANRU and USAID should continue to work with Hydraulique Rurale to develop a National Rural Water program emphasizing water source protection techniques, and to organize regional training programs for water technicians of RHZs.
- d) SANRU should support Peace Corps, WASH, and Hydraulique Rurale efforts to develop technical capabilities in construction/rehabilitation of wells. This may include financing construction, procuring of experimental pumps, developing technical manuals, and expanding the use of Peace Corps Volunteers in Zones with the most difficult problems of water supply.

5. Village vaccination programs

Various programs and agencies such as PEV, UNICEF, and OXPAM furnish refrigerators, cold boxes, vaccines, needles, etc., for vaccination activities. Solar refrigerators are being tried in some Zones. Initial investments may be high, but the low maintenance cost and assurance of a realisable cold chain may be worth the expense.

Recommendations:

- a) RHZs should continue to decentralize vaccination services to the Health Center level. A comparative study to document how this has been done in various RHZs could provide useful guidelines for others struggling with this problem.
- b) The original objective of vaccination programs in 1000 villages appears to be the most feasible indicator for SANRU to measure, given its limited inputs.
- c) Field testing of solar refrigerator systems should be pursued by PEV and SANRU.

6. Creation of pro-pharmacies

Through April 1984, 155 pro-pharmacies were reported by SANRU - related Zones. We note that SANRU seems to envisage only one type of pro-pharmacy, the Village Health Agent trained to handle a limited number of medicines.

Recommendation:

Models of village-based drug systems from other countries should be considered, for example family pharmacies and pharmacies managed by Village Development Committees.

7. Construction and rehabilitation of classrooms

SANRU has helped 3 Rural Health Zones construct classrooms. At Nyankunde we visited 2 classrooms financed by SANRU. The objective of 12 classrooms can be attained by 1986.

Other rehabilitation activities are to be included in the ECZORT project that will provide 23,500,000Z for rehabilitation of buildings at health centers, reference health center and reference hospitals.

8. Laparoscopes

The Zones visited by the Evaluation Team did not have laparoscopes. We are unable to assess this output.

9. Family planning

This activity is considered a routine part of primary health care in SANRU documents and training courses. A gentle pressure is put on Zones to make family planning a regular part of their health education and to offer services in hospitals and Health Centers. SANRU, along with JHPIECO, is organizing a series of regional seminars in reproductive health, with special emphasis on family planning. Physicians and supervisory nurses learn about contraceptive technology, as well as how to equip and organize family planning services.

Family planning programs pre-dating SANRU are strong in several zones, notably Karawa, Kimpese, Nsona-Mpangu, Tshikaji, and Vanga, each of which reported over 800 new acceptors during 1982 and 1983. Altogether, the Phase I zones reported 14,000 new acceptors, while Phase II zones reported only 2000. Several zones reported fewer than 50 acceptors, so one can assume that they do not yet have active programs of services and education. In some zones, personnel are not convinced that family planning should be a priority, because of high rates of sterility, or because of misgivings by the Catholic Church.

SANRU should take a more active role in starting programs in slow or reluctant zones. Experience shows that health personnel need to see people doing face-to-face family planning education and then to try it themselves. Only then are they enthusiastically convinced of its importance. Furthermore, the project objective of 150,000 new acceptors needs to be revised, as explained in the April 1984 Activity Report (Document 14, p. 41). We suggest an objective that counts the number of Zones with active programs. The best indicator of program activity is the number of new acceptors expressed as a proportion of the target group. For example, a zone of 100,000 people has 20,000 women of reproductive age. An objective of 1% of the women would be 200 women.

Recommendations.

a) SANRU should arrange for personnel from Zones without family planning programs to visit Zones with programs. Teams from active programs should go to reluctant and slow-moving Zones to help the local personnel start educational campaigns.

b) The family planning objective should be revised as follows: 40 rural Health Zones registering 1% of the women of reproductive age as new acceptors of contraceptive methods during each year of project participation.

C. Health information system

1) Information from RHZ to national office: SANRU has worked closely with other Zaire health programs to develop a standard annual report form that is now being pretested. Only 23 of 36 SANRU zones submitted the 1983 annual report. The other zones plead the usual problems - forms not received in time, change of personnel, etc.

The Evaluation Team suspects that the sheer size of the report is discouraging: 308 blanks to fill in for the whole RHZ plus 45 for each Health Center or Post. The form is accompanied by 12 pages of instructions on how to fill out the form plus 6 pages on how to analyze the data (to calculate accessibility, coverage, and impact).

The form and instructions are excellent from a logical, statistical and epidemiological point of view. Their practicality is very questionable however. In most cases the basic statistics are collected by A3 nurses in isolated Health Centers and Posts, and every zone has its own system of record keeping at this level. The overall Zone report is written by a A2 nurse or a physician who may not have attended a course on how to fill out the forms.

Recommendations:

a) SANRU and its national collaborators should review the purpose and use of each item on the report and the difficulties experienced in collecting data. A clear statement of the key indicators of accessibility, participation and impact should help to eliminate superfluous or secondary items.

b) SANRU should consider designing and offering a model record - keeping system for Health Centers. A simplified system could increase greatly the reliability and completeness of annual Zone reports.

2) Information from national office to RHZ's

The team heard over and over the comment, "The real value of SANRU has not been the commodities but rather its information, stimulation, and encouragement to the Health Zones and to other PHC organizations". Besides organizing training courses and conferences, the national staff distributes books and newsletters (including SANRU's own Santé Rurale). The staff also replies to a steady stream of requests from letters and visitors to the central office.

They have personally visited all the Phase I and Phase II Zones, several Zones more than once.

The central SANRU staff, particularly the Project Manager, has earned wide respect for technical expertise and excellent personal relationships with PHC personnel at all levels.

This very strength of the project, however, could be its major weakness in the long term. Too much of the information exchange (to and from the RH Zones) and too much of the in-depth understanding appear to lie with one or two expatriates.

Recommendations:

a) SANRU should add to its staff a Zairian expert in data management. This person should design and perform analyses of data collected from the Zones. He or she should be able to report and interpret the data to USAID, GOZ, and other donors.

b) SANRU should assist the GOZ in developing a systematic approach to supervising Rural Health Zones. This might include training supervisors and evaluators located in various GOZ/DSP agencies and in educational institutions.

3) Information exchange between Health Zones:

Numerous people praised SANRU's role as a catalyst for all the various agencies, missions and individuals interested in primary health care development. The annual National Health Conference is proving a highly successful mechanism for information exchange. The 1983 conference provided a forum to present SANRU's achievements and to air diverse and sometimes conflicting ideas and beliefs. The conference's valuable work toward a rational consensus cannot be under-estimated. SANRU is to be applauded for organizing the conference on a regular basis. The level of interest is extremely high, and this year 100 RHZs seek representation at this conference. (SANRU staff might study the experience of the Lampang, Thailand, PHC project annual review meetings, as they led to national consensus and World Bank financing of a National PHC System.)

In the field, the Evaluation Team found certain RH Zones functioning in unnecessary isolation. They had no contact with Zones only a few hours away who were solving or facing very similar problems. Avenues are needed for more exchange of ideas and experiences.

Recommendations:

- a) Every effort should be made to continue the National Conference each year. Other donors may have to be encouraged to share the cost.
- b) Regional conferences might relieve some of the pressures on a Kinshasa meeting. They should be partially financed by the participants or participating RHZ.
- c) SANRU can offer travel funds for Medical Chiefs of Zones and supervisors to make study visits to other zones.
- d) The newsletter Santé Rurale can carry more articles about Zaire programs that are working.

IV. PROGRESS TOWARD PROJECT PURPOSES

The purpose of the project is to "estab. a self-sustaining, community-supported system of primary health care effectively offering prevention and treatment for the 10 most prevalent health problems in 50 zones in Zaire."

A. Sustainability of the Primary Health Care system

1. Sustainable supply lines for pharmaceuticals and medical equipment: For more than two decades, DCMP (Dépôt Central Médico Pharmaceutique) has been the main source of supplies to the GOZ hospitals and dispensaries, representing 30% of Zaire's health delivery system. Since 1980, the role played by the DCMP has become increasingly difficult to fulfill. Zaire's 1982-1986 National Health plan stopped the system of cash receipts from GOZ medical facilities being turned over to the central Treasury department. Funds now remain at the hospitals. The new policy of autofinancing requires hospitals and Health Centers to buy their own supplies, from DCMP or other sources.

The team observed that each Rural Health Zone now obtains drugs and supplies from multiple sources. Some Zones buy from reliable pharmaceutical warehouses (Catholic, Protestant, and private) in their areas. Some zones place orders for drugs from Kenya, Europe, and the U.S. Some receive gifts of drugs from UNICEF, OXFAM, and sister organizations abroad. All receive vaccines from PEV and contraceptives from international agencies. Most of the Rural Health Zone hospitals and Health Centers we visited seemed to have adequate supplies and medicines, while the dispensaries and maternities not yet integrated into Health Zones often lacked adequate stocks.

Recommendation:

SANRU should request assistance from USAID centrally - funded projects to help Rural Health Zones organize sustainable supply systems. Area-wide warehouses serving several RHZs should be particularly encouraged.

2. Sustainable financing: The Project Paper (p. 10 and p. 24) calls for the cash receipts of a Health Center to replenish its stock of medicine and disposable supplies. The GOZ or the sponsoring churches were to continue paying the salaries of Health Center staff. Most of the Health Centers we visited are now paying for their own medicines. Some centers are paying the salaries of their nurses and aides. Some are said to pay also for supervisory services provided by the Rural Health Zone office. In sum, auto-financing has often gone beyond the expectations of the SANRU project and the GOZ. Some Health Zones, however, have not developed financing plans in any detail and need guidance.

The current PRICOR study of several zones will offer valuable comparisons of methods of payment for health services: fee per episode vs. fee for each visit and each medicine.

The March 1984 audit report cites the lack of a financial management system at the Health Center level. We observed the same problems, for example, where a receipt book was the only financial document in the Health Center.

Recommendation:

SANRU should provide technical assistance in financial management of Health Centers.

3. Sustainable training programs: In the Rural Health Zones many of the Hospitals have existing Schools of Nursing supported by GOZ faculty salaries, donations from abroad, and tuition fees. The addition of retraining courses is an expense now borne in part by SANRU. It is doubtful that the RHZ will be able to continue retraining without subsidy from external sources. Training in the villages is expensive (fuel and salaries) and will likely disappear without GOZ or SANRU support. Some upper-level training will be absorbed into the UNIKIN School of Public Health Program, starting in the near future. The supervisor program is likely to be continued by GOZ.

B. Community involvement

The Project Paper (p. 22-23) spells out that financial contributions and decision-making are expected from residents of a Health Zone. The principal mechanism for community involvement is the Village Development Committee.

Some Zones, notably Nyankunde and Vanga, consider the Village Development Committee the basic building block of the Zone; a committee must be formed and functioning before training or services are offered to the village. Other Zones concentrate first on Health Center functioning and only later encourage nurses to organize committees in surrounding villages to undertake latrine or water projects or to do health education. Many other zones seem to have only vague notions about the importance and role of village committees, and very little idea of how to help and work with them.

SANRU to date has offered little training or help in this area. For example, the textbook Infirmier, Comment Bâtir la Santé contains a few pages on the topic, but its specific formulas (such as the membership list for a village committee) seem to be based on experiences at Vanga which may not be appropriate in other parts of Zaire. The 1983 report by anthropologist Stanley Yoder indicates something of the variety found in 5 different Zones. It becomes clear that organizing communities is a dynamic process requiring a great deal of thought, experimentation, and adaptation to local customs and ways of doing things.

Here are four issues in community organization that have barely been raised in SANRU literature and training to date:

- a. What is the prime purpose for organizing a village committee -- to get members of the community working together for the common good or to improve health? (These two purposes are sometimes in opposition to each other.)
- b. Who should be members -- a standard cross-section of the community (women and men, young and old, educated and illiterate, wealthy and poor) or a membership based on local groups and customs (clans, age sets, hierarchical chiefdoms, village sections, etc.)?

c. Who decides on the activities -- the Health Zone staff (who know the health problems, how to attack them, and who are working toward certain SANRU objectives) or the village committee (who may prefer to build a bridge, hire curative nurse, or start a coffee growers cooperative)?

d. What is expected of committee members -- to discuss needs and make decisions or to do the actual work?

SANRU should give appropriate emphasis and attention to helping Zones achieve community involvement. This means an investment in training, supervision and other resources.

C. Prevention and treatment of 10 most prevalent health problems.

SANRU has assisted RHZ's to deal with the 10 most prevalent health problems by:

a) Short-term training in public health (at UNIKIN 1982 and 1983) for Medical Chiefs of Zones and nurses, which helped them to identify and list the 10 most prevalent health problems in their Zones.

b) Organizing appropriate preventive and curative health activities in the village and at Health Centers.

V. GOAL

The overall goal of the SANRU project is "to improve the health of the rural population by increasing the proportion of rural Zairians that have access to basic health services". Specific indicators, reduction in mortality rates and reduction in birth rates, were listed in the Logical Framework.

No studies of SANRU's impact on health are being done or planned. At one point, Tulane University proposed baseline and endline studies in several Phase III zones. USAID/Washington approved the idea but could not fund the studies. USAID/Kinshasa eventually decided to make this activity part of the project (660-0101) developing a national School of Public Health, which means it will not be done before the end of the current SANRU project.

The experts remain divided on the questions of whether the health impact of SANRU can and should be measured. Opponents of impact studies maintain that --SANRU's inputs are only part of the influences on Rural Health Zones, so SANRU's impact cannot be separated from impact due to other donors, government policies, economic factors, etc.

--The only intervention likely to affect mortality within a few years is vaccination against measles and tetanus, and the input is provided by PEV, not by SANRU.

--SANRU's main inputs are commodities and training offered to Zones, not interventions directly affecting the population.

--Impact studies are expensive, time-consuming and irrelevant in a project designed to introduce strategies.

On the other hand, proponents of impact studies argue that

--Baseline-endline studies done in SANRU Zones and simultaneously in control zones can provide valid data on SANRU's particular impact.

--Many of the strategies espoused in the project have never been shown to improve health. Positive impact should not be assumed, but remains to be examined.

--Large, expensive studies are not necessary. Small, careful studies of the impact of a particular strategy in a few Zones can provide information valuable to programs in Zaire and elsewhere.

Recommendations:

a) SANRU should focus on a few indirect indicators, such as coverage, accessibility, and participation in a few selected programs. They should review the current information system to be sure the key indicators are clearly defined and accurately reported at all levels.

b) SANRU should organize resources to do local impact studies on specific health problems.

DOCUMENTS REVIEWED

USAID Documents

- (1) USAID-Zaire Country Development Strategy Statement, Jan. 1984
- (2) "Zaire Population Strategy synopsis", USAID, 2p
- (3) "Zaire Health Strategy Synopsis", USAID Zaire, 2p

Government of Zaire Documents

- (4) Plan d'Action Sanitaire du Zaire 1982 - 1986, Jan. 1982
- (5) Report of Activities of Program to Enlarge Vaccinations (REV), June 1983, and training materials
- (6) GOZ, Role of the Fifth Direction, Department of Public Health, April 1984

SANRU Documents

- (7) Project Identification Document (PID)
- (8) Project Paper 660-0086 Basic Rural Health, USAID, August 1981.
- (9) SANRU Project Report, - January - June 1982
- (10) "Santé Rurale" - Journal of SANRU Project, April - July 1983
- (11) "Rapport préliminaire du projet de recherche opérationnelle sur le financement des soins de santé primaires par la communauté en République du Zaïre, SANRU-86/FRICOR, October 83, 18p.
- (12) "Soins de santé primaires au Zaïre: une comparaison de cinq zones de santé rurale" par S. Yoder, SANRU-86 1983, 13p.
- (13) Report of the AID office of the Inspector General (Nairobi), on SANRU Project, March 1984.
- (14) "Activity Report, SANRU 86, June 1982 - March 1984", SANRU, April 1984, 46p.

Training materials

- (15) Basic Curriculum for A2 and A3 Nurses, GOZ 1982
- (16) Fountain D. + Courtojoie J. Infirmier - Comment Bâtir la Santé, Zaire 1982.
- (17) Curricula used by SANRU - related zones
 - a) Kalonda, - A4 Auxiliaires
 - b) Kaziba Supervisors course, - May 1984
 - c) Kaziba Reproductive Health - April 1984
 - d) Kaziba - Recyclage A3 nurses
 - e) Lubao - Recyclage A3 nurses, March 1984
 - f) Kirotshe - List of topics Recyclage A2 nurses, December 1983
 - g) Traditional Birth Attendants 82-83, SANRU in 6 zones
 - h) Nyankunde - Recyclage A3 nurses, 1983; Agent de Santé Communautaire
 - i) Drodro - Recyclage A3 nurses

INTERVIEWS IN KINSHASA

USAID/Kinshasa Mr. Richard Podol, Director
 Mr. Richard Thompson, PID

Government of Zaire, Department of Public Health, Fifth Direction
 Dr. Luwivila Kapata, Director

SANRU Cit. Nlaba Nsona, Director
 Dr. Franklin Baer, Project Manager/Technician
 Dr. Miatudila Malonga, Representative of COZ
 Ms. Florence Galloway, Training Supervisor

ECZ (Eglise du Christ au Zaire)
 Dr. Maxini Bodho, Vice-President
 Pastor Ilunga, Director of Christian Education

OXFAM Mr. Paul Simon, Director

Program Elargi de Vaccination (PEV)
 Dr. Kalisa, Director

Comité National de Naissances Désirables (CNND)
 Dr. Miatudila Malonga, Executive Director

World Health Organization (WHO)
 Dr. Konté, Program Coordinator

INTERVIEWS AND VISITS IN 9 RURAL HEALTH ZONES

	Med. Chief RHZ	Super- visors	HC Nurses	HC Aides	Vill. Dev. Cmtes	Agents or Anim.	Health Ctrs	Posts or Disp.	Water sources
<u>KIVU REGION</u>									
Kaziba	1	1	5	5	0	0	4	2	2
Kirotshe	1	1	2	1	1	0	2	0	0
Uvira	1	1	2	2	1	2	2	0	0
Oicha	1	1	0	0	0	0	0	4	1
Rutshuru	1	1	0	0	0	0	0	0	0
Rwanguba	1	0	0	0	0	0	0	0	0
<u>HAUT-ZAIRE</u>									
Drodro	1	2	1	1	1	0	1	1	3
Nyankunde	1	3	0	0	1	4	0	4	0
<u>BAS-ZAIRE</u>									
Kasangulu	1	0	1	0	1	0	1	1	0

Note: A zero (0) in the above table means that no such place or person was visited. A zero does not necessarily mean that the activity did not exist.

W
A

DRODRO RURAL HEALTH ZONE
Haut-Zaire Region
Hospital of the Catholic Church

The Health Zone of Drodro is located approximately 100 kilometers northeast of Bunia. The Zone comprises elements of state (GOZ), Catholic and Protestant health systems. The most important of these are:

- Hopital Général/Drodro (Hopital de Zone) - Catholic
- Centre de Santé de Référence - Blukwa - Protestant
- Hopital de Feshi - Catholic

The zone has a more than 100 medical/health installations which serve a population estimated at more than 500,000. The present zonal Medecin Chef has been working in the area for 7 years. The zone is densely populated and has a high incidence of diarrheal diseases and bubonic plague. There is relatively good coverage via medical installations because of their number and the relative compactness of the zones.

The Rural Health Zone has not yet been definitively delineated. There is still some disagreement between the old administrative zone and the proposed Zone de Santé of Drodro. This problem is being reviewed by the Medecin Sous Régional. While there is a general acceptance of the RHZone policy of PH care, there is a strong history of independent action by each major provider (State, Catholic, Protestants). The RHZ will probably have to develop a system of aires de Santé which are acceptable to each organization.

II. SANRU INPUTS

A. Training:

- Medecin Chef de Zone and two nurses trained in Public Health/Zone Management in Kinshasa 1983.
- Several Medecin des Zones participated in the 1983 SANRU Conference.
- Animateurs trained in Water Source Construction
- TOT's of TBA's at course at Nyankunde 1983

B. Commodities:

- Small library with training materials, projector, typewriter, 20 bicycles, 2 motos, 1 vehicle 4wd (arrived 15 May 1984)
- baby and adult scales; books; very few medicines.

C. Other:

- supervision costs - just starting with arrival of vehicle.

Technical Assistance:

- 2 visits project team
- several visits to Nyankundé.

III. OUTPUTS DUE TO SANREU INPUTS

A. Training:

-Medecin Chef de zone has organized Drodio training for:

1. 28 TMA's (Nyankunde)
2. 5 animateurs, 2 nurses in water source Mgt (Nyankunde)

B. Infrastructure:

Zone delineated in draft; several areas still under discussion; final resolution planned for June 1986.

-C.S.R.: -Visited one at Blukwa; functioning with full range of activities;

- C. S.: -Visited State Dispensary between Blukwa - Drodio - some education work begun; mainly curative; not yet functioning as C.S. Confirmed that zone had plans for converting 5 additional centers.

Water Sources: One of the major accomplishments of this Zone to date. Using training of nurses and animateurs, Drodio has completed two springs and has begun a third (in the immediate area of Drodio); it has been a very effective "point d'entrée" for mobilizing/organizing village communities in those areas visited.

No detailed information was gathered on latrines, pro-pharmacies, vaccinations; however these activities are all-part of the ZSR strategy. Family planning is generally limited to natural methods at Drodio Reference Hospital but all methods are being actively expanded at Blukwa C.S.R. and its satellites.

C. Information system

Annual report completed; comments on report format not solicited; Medecin Chef much appreciated receipt of library and participation in conference; He referred to discussions/exchange of information at this conference on several occasions.

IV. PROGRESS TOWARD PROJECT PURPOSES

A. Sustainability:

1. Supplies. The Zone benefits from access to two major professional outlets for pharmaceuticals/supplies and one major private system. Nyankunde Hospital and the Diocese of Bunia both operate regional pharmaceutical supply centers. Basic drugs are in adequate supply at all times. There is little reason to believe that, concerning supplies, what has been started will not continue.

2. Financing. The Zone benefits from long term commitments by Protestant and Catholic Health Organizations. The Zone also has sufficient cash crops to generate currency to pay for curative services. Concept of auto-financing will be accepted and supported at all levels.

3. Organization.

4. Training. At the EOP, retraining on a limited basis for zonal workers at all levels should not be beyond zonal capacity.

B. Community Involvement:

Committee of gestion organized and meeting (albeit infrequently). Medecin Chef de Zone has the confidence of the major service providers and religious communities; areas visited showed village committee involvement in all decisions.

C. Ten most common health problems

Standard list; malaria further down on list than most other zones.

(Thornton)

KASANGULU RURAL HEALTH ZONE
Bas-Zaire Region
Hospital of GOZ and Hospital of CBZO/ECZ

INTRODUCTION

Kasangulu Hospital is a GOZ Hospital created in 1958. The Rural Health Zone is composed of the following:

1. Kasangulu Hospital as Reference Health Center
2. Sonabata Hospital as Reference Hospital
3. 42 Health Centers have been opened and among them 25 are doing well
4. 8 Health Centers to be created by Salvation Army with USAID funds.

The total population to be served is about 85,000 to 100,000 inhabitants. So the average by health center is only 2000 inhabitants.

Organization

-The MCZ is responsible for organizing PHC activities by converting old dispensaries into health centers, and by supervising them.

-Private and church supervised dispensaries are well integrated, except SNEL's dispensary

-The health zone is well covered, except for the eastern part, where roads are impracticable and cut off by rivers. Supervision to the east can be done by travelling via Kinshasa, Nsele which is expensive, and the RHZ cannot afford it.

II. SANRU INPUTS

1. TRAINING

SANRU organized training at UNIKIN, Nganda, and Kimpese. Most health personnel, at all levels-Medecin Chef de Zone, Nurses A2 - A3 - A4, and VHA-had attended some of these training sessions.

2. Commodities

The RHZ received from SANRU:

- 1 vehicle
- 2 motos
- 10 bicycles
- medicines
- medical equipment

III. OUTPUTS:

From training organized by SANJU, health personnel at the RHZ level have organized their health zone by:

- delineating the Rural Health Zone
- supervising Health Centers
- converting dispensaries into Health Centers
- organizing family planning clinics
- organizing health committees and teaching them sanitation.

IV. OBJECTIVES: FINANCING

Since July 83, they have an autofinancing system. A poor contribution (60 zaires/month) from Health Centers makes this autofinance difficult. Most of the Health Centers are still handled by their previous owners (church or government) who take care of maintenance, salaries, drugs, equipment and supplies.

VI. CONSTRAINTS:

Kasangulu Health Zone is getting too much assistance from outside. Some donors don't consider other Health-Centers in the area, and build new ones. As a consequence, some Health Centers have less than 800 inhabitants to serve; so they have difficulties autofinancing themselves, and continue to seek for outside assistance. Example: Nkala, a Health Center support by Salvation Army.

VII. DRUG SUPPLIES

The main provider of drugs is CARITAS, however each Health Center has its own means to get drugs locally or from abroad.

(Kalamby)

KAZIBA RURAL HEALTH ZONE
Kivu Region
Hospital of Communauté des Eglises Libres au Zaïre (CELZ/ECZ)

I. INTRODUCTION

- Dr. Reidar Solkrohm, Medical Chief of Zone
- Dr. Safari
- 17/27 Health centers are opened and are functioning at about 70% of PHC activities. 2/17 have opened maternity (CM) activities and one of the functioning maternities has about 50-60 deliveries per month (Chiburhi/Luhwinja Health Center).
- Anglican Church is the organization which supervises the Reference Hospital plus a handful of Health Centers staffed by personnel (A-3 Nurses) trained by the hospital's nursing school.
- RHZ office exists but to date there is no supervisor for this RHZ. MCZ does the supervision of the Health Zone and is occasionally assisted by a trained Zairian doctor (Dr. Safari). Although training in PHC has been offered to some Zairian staff at the Reference Hospital, their participation in the supervision of the RHZ has not been initiated.

II. SANRU INPUTS

- A. Training
 - MCZ (Dr. Reidar) was trained at the Nganda 1983 annual conference and seminar
 - Dr. Safari was trained at UNIKIN in 1982 summer program.
 - SANRU has organized training of Drs and Nurses in F.P. and Management of RHZ financed by JHPIEGO (March 1984)
 - Regional training session for supervisors has also been organized/financed by SANRU at Kaziba (April/May 1984)
- B. Commodities (SANRU-Assistance)
 - One vehicle (Received 5/4/84)
 - 2 Motorcycles
 - 10 Bicycles
 - Medical equipment (limited quantity), more are still needed to supply the newly opened Health centers
 - Medicines: limited quantity which include some contraceptives.
 - Training manuals.

III. OUTPUTS DUE TO SANRU INPUTS

- A. Training:
 - Village health workers have been trained and are working at about 7 already functioning Health Centers. These VIH work closely with Development Committees which have played major role in water and sanitation programs.

Handwritten initials or mark.

TBA activities not favored in this RHZ because over 95% of deliveries take place at the maternities

Nurses: A-3 mostly (about 20) plus a few A-2 level nurses have been retrained

Supervisors: One supervisor for Kaziba plus 16 others from other RHZ have been trained.

Development Committees: - are active at about 7 of the functioning Health Centers.

Adm/Doctors (short term): 5 Doctors have taken part in the JHP/IEGO assisted training program in April 1984.

Long-term MPH training: No candidate from Kaziba RHZ has been selected for this training program.

B. Infrastructure:

- Kaziba RHZ is defined but areas to be covered by individual Health Centers are still to be worked out.
- The RHZ will include one Reference Health Center of Nyangezi (45,000 inhabitants) where two A-2 nurses plus seven A-3 nurses work under Catholic supervision.
- RHZ working at about 70% at the overall PHC activities.
- Vaccination programs are established at the functioning Health Centers.
- Pharmacies will not be considered by this RHZ.
- 5 gravity-fed sources have been organized but work remains to be completed by September 1984.
- About 90% of households in the RHZ have and use latrines.
- No laparoscope has been installed at the Reference Hospital.
- Family Planning is a slow-developing activities in the RHZ. 13 acceptors have been registered by one Health Center.
- Ref Hospital of Kaziba plans the construction of one classroom to be used for seminars.

IV. PROGRESS TOWARD PROJECT PURPOSES:

A. Sustainability

1. Supplies: pharmaceuticals and equipment for the RHZ come through the Catholics for Health Centers still supervised by them, and through imports from Holland for Health Centers controlled by the Anglican Church (Kaziba Hospital). Some medicines are also bought from the local market.
2. Financing at the various Health Centers is working at 100% to cover salaries, medicine costs plus operational expenses. Subsidies are still being received by the Reference Hospital to assist with imports of medicines and equipment.

B. Community involvement is considerable in the RHZ. Health centers plus water programs have been organized at various communities with the help of the population.

C. Ten most common health problems
-High morbidity and mortality rates among children and adults is related to the following:

1. gastroenteritis (parasites)
2. measles
3. other infections
4. malnutrition.

V. FINAL REMARKS

One can say that although problems still exist with the integration and the supervision of the Health Centers in the Kaziba RHZ, there is hope that the system will work because there is less dependence on outside help.

(Utshudi)

I. INTRODUCTION:

Kirotshe Hospital was built around 1952 by the Belgian Congo Government. Around 1954, the Hospital Administration was turned over to CEMUBAC. In 1983 the Kirotshe Rural Health Zone was created and Kirotshe Hospital was to serve as a reference center.

- Population + 180,000 inhabitants
- Area = 1600 Km²

Particularities of the Kirotshe RHZ

- RHZ's management is in the hands OF CEMUBAC
- The relief map of Kirotshe RHZ shows mountains in and around the zone.
- There are few roads in and around the zone and these do not give easy access to traffic during the rainy seasons.
- RHZ contains parts of North Kivu and South Kivu sub-regions, and parts of Masisi and Kalehi zones. It includes 3 tribal groups (Hunde and Tembo in Masisi and Havu in Kalehi).

Pathology of the zone

- diarrhea, cholera, shigellosis
- schistosomiasis (mansoni)
- malnutrition
- helminthiasis

Major constraints

- Geographic accessibility,
- Insufficiency of arable land (there is low ratio between arable land and population)
- Numerous behaviors (hygiene, taboos and beliefs) which work against the promotion of health.

II. INPUTS: SANRU CONTRIBUTION

A. Training

-Medical Director of Hospital took part in the UNIKIN training session of 1982, in the SANRU annual conference of March 1983 and in the regional training session at FP of Kaziba in April 1984.

-The nurse supervisor has also been trained in FP management at Kaziba (April 1984) and he participated in supervisor's training course at Kaziba (May 1984).

B. Commodities:

SANRU has provided the following commodities to Kirotshu RHZ.

- one duplicator
- 10 bicycles
- medical equipment for HC (Kerosene stove, equipment for gynecology and obstetrics etc...)
- 2 motorcycles (Yamaha 175)
- 1 vehicle (AMC Jeep)
- health training manuals and books with a value of 5,500 Zs (2,000 Zs in December 83 and 3,500 Zs in January 84).

C. Other:

SANRU has assisted Kirotshu RHZ with 4,800 Zaires for training within the zone in December 1983 and the sum of 26,200 Zaires for training which took place in January 1984.

III. OUTPUTS

A. Training

- 11 Health Center nurses received 5-day training in December 1983.
- since January 1984, 7 persons have been receiving training for the A4 level nurse. The session will last 180 days.

B. Infrastructure

-The training received at the UNIKIN in 1983 and the administrative zone map provided to RHZ leaders have enabled them to delineate the RHZ area and to determine areas around individual HC in order to plan the PHC activities throughout the zone.

-Centers which have been organized:

- 1 Reference Hospital (DPH and CEMUBAC assistance)
- 1 Reference Health Center (CSR), (UNICEF assistance)
- 14 Health Centers, some were opened with SANRU assistance
- 7 Health Posts some opened with assistance from SANRU

Other accomplishments with SANRU assistance:

- 0 Propharmacies
- 0 Potable water sources
- 0 Latrines.

(Miatudila)

Hospital of Communauté Evangélique du Centre de l'Afrique (CECA/EC)

I. INTRODUCTION

The Nyankunde Rural Health Zone started its primary health care program in 1979. When SANRU started in 1982 it was selected to participate as a Phase I Hospital. The economic base of Nyankunde is agriculture, cattle raising, and limited gold mining. There are 185,000 people in the zone which covers an area the size of two zones elsewhere. The land is mostly lowland and savannah. There is very little money in circulation. Trade is carried out through a barter system.

The primary health care strategy used in Nyankunde is the development of Village Committees which then select an "Agent de Santé Communautaire" (ASC). The ASC is trained by the RHZ staff to organize community activities such as village sanitation, latrine building, building a community health posts holding clinics for preschool children and pregnant women. He is promised a complete pharmacy after he and the village have completed construction at the health post and a latrine for each house in the village. When the ASC starts work he is given a supply of Daraprim for malaria prophylaxis. The work of VHC and the ASC is supervised monthly by the Medical Chief of the Zone or an A3 nurse trained in supervision.

Traditional Birth Attendants were also trained for many villages to do home deliveries, to send difficult cases to the health center, and to discuss family planning with women. This group is relatively small for a variety of reasons as will be described below.

The many village Health Posts are supported from 7 Health Centers in the zone which have been converted from curative dispensaries. The center of reference and referral and the administrative control point is the 440-bed Nyankunde mission hospital. This mission was established in 1929 by a group of 7 American Protestant churches. Called the Centre Médical Evangélique, this reference center is 12 hours by road from its most distant Health Center.

The functions carried out by the Rural Health Zone (assisted by SANRU inputs) are to (1) manage the zone, (2) train and supervise nurses in Health Centers, and ASC in health village health post, (3) provide logistical support in terms of drugs, medical supplies, health education materials, 4) provide transport including maintenance of vehicles, motorcycles and bicycles, 5) collect and analyse epidemiologic surveillance, and management information, 6) provide construction materials and tools for latrine building and water source protection, 7) provide continuing education for physicians, nurses auxiliaries, ASC, TBA and the 42 Health Committees.

II. SANRU INPUTS

A. Training:

Med. Chf. de Zone, 1 supervisor at annual conference 1983

B. Commodities

1 Land Rover
8 Motorcycles, 15 Bicycles
26 microscopes
33 baby scales
7 cold boxes
9 Refrigerators.

Some drugs, family planning materials, condoms, IUDS, foam, and educational materials

C. Help with construction of a maintenance garage, the drug depot, classrooms and an office building,

III. OUTPUTS DUE TO SANRU INPUTS

A. Training:

A review of the training of nurses, ASC and UHC was made and is reported on in training section of body of this report.

B. Infrastructure:

The team visited three villages with health committees and ASC. In Mukia the prenatal and preschool were held monthly. The ASC recorded the sale and purchased dazaprim (his only drug). A more complete drug supply was not provided because the village had not completed the health post or built enough latrines.

At the village of Kilimania 2 Km distant but more isolated, the village health committee and ASC and TBA held a lively impromptu meeting with us. While there, the village teacher was drilling children on nutrition. The community appeared well organized. The ASC records showed the ASC saw 2-3 patients per day, and charged 3 Z for consultation and 1-20 Z for medication. His pharmacy included ASA, chloroquine, iron, Belladonna, antibiotics etc. Prenatal clinics are held every 5-6 mos (Pop 300-400), vaccinations every three (3) month, with child weighing and charting of growth. The ASC can keep 1/3 of the cost of medicines he sells as compensation. There was much argument between the ASC and the Village Committee over this point. Local money control was limited. The TBA who receives 20 Z for a delivery complained that patients were being siphoned off to the nearby maternity. At Ndoya village, two ASC work together in a post building constructed by the village. It is well furnished and has a complete stock of medicines, syringes, minor surgical tools and Family Planning materials. They also provide regular nutrition education, prenatal and preschool clinics. Home visits are made. User fees are collected.

The last village health committee was attended by 61 people who sang the health songs and chants. Thirty (30) members of the village pay a fee for membership and work to help with the post work.

The ASCs were trained at Nyankunde and receive continuing education. SANRU material was present in all posts. Other outputs of the RHZ include - a) 25 nutrition education sessions, b) 59 water sources protected and c) 6 family planning programs in HC with about 700 active clients. Two vasectomies and 90 laproscopies have been performed.

C. Information System

Data is collected during supervisory visits. A report form is completed by the ASC or Nurse. Reports on sanitation efforts, clinic preschool and prenatal are reported along with curative care. The reports are compiled at Nyankunde headquarters into monthly, then annual, summaries.

IV. PROGRESS TOWARD PROJECT PURPOSES

A. Sustainability

1. Supplies. Nyankunde has a well established pharmaceutical supply system. A few medications, supplies and equipment, and family planning material are stored in the headquarters. Most other medications, etc. were distributed from a central medical supply depot which also supports other Rural Health Zones nearby - Drodro, and Oicha.

2. Financing. The Nyankunde model of village level care required user payment for services from the inception of the project in 1979. This model of organizing primary health care was to be replicated by other Zones.

According to records studied in the Post for "Agent de Santé", patients pay 3 zaires for consultations and from 1-20 Zaires for medication. According to the annual report prepared for the region there is an average cost of 20 Z for a visit. This suggests that although user fees are being collected, the posts and health centers operate at a loss. One health center operating at a loss found itself 6000 Z in debt. This was easily corrected by closer outside supervision and greater involvement of the village committee in supervision. Analysis of costs suggests that most Nyankunde health centers and posts, are or can be self sufficient in drug supplies. The use of these funds to compensate the ASC would appear feasible in a few locations with an adequate economic base. Unfortunately, much of Nyankunde district operates on a nearly cashless economy.

A significant portion of the operating funds for the hospital and Health Centers comes from other donors (Germany and UNICEF) and from contributions from churches abroad.

3. Organization. Nyankunde is very well organized. Its infrastructure development started at least 50 years ago. The Primary Health care program has a separate organizational arrangement from the Hospital. The Medical Chief of Zone has no hospital patient care responsibilities. The staff consists of a chief (Dr. Jean Marcus of Luxembourg), an A2 nurse responsible for prenatal and preschool clinics and training TBAs. She has two subordinate nurses as staff. Another A3 nurse acts as field supervisor and assistant administrator. Four additional nurses (A4) are trainers.

The program receives complimentary assistance from UNICEF and Germany.

4. Training. Nyankunde has a well established program for training A2, A3 (Inf + Accoucheuses) and A4 nurses, ASC, village committees, and traditional birth attendants. Continuing education is offered for each of these groups. The training programs are well described in project documents. Teaching methods include didactic and practical exercises - many at the village level. ASC are trained at same time as village committees (comments are included in the body of the report).

B. Community involvement is a very strong feature of the Nyankunde RHZ. According to the 1983 reports, village committees have been started in at least 24 villages. The success of these committees has been variable. Villages were required to organize themselves sufficiently to select a ASC for training, construct a health post building and construct latrines for 90% of the homes. For well-led, well-organized villages, this system worked well. For many other communities the requirement to complete this work before receiving medications and equipment proved too difficult to achieve. Most villages required a great deal of work on the part of supervisors to assure some measure of success. On the whole, the results are very encouraging. There did not appear to be much SANRU input to training CSV.

C. Ten most common health problems reported by cases were: malaria (13,089), measles (579), respiratory (9463), malnutrition (147), tuberculosis (91) pregnancy (3723), gastro-intestinal disease (13745), leprosy (309).

REMARKS

There are two issues for the Zone to resolve. First is the question of how to handle ASC's and committees that fail to meet RHZ standards for building posts and latrines. ASC and village committees felt that the demands were too high and that the ASC loses credibility when he cannot deliver curative as well as preventive services. Some villages were to be dropped out of the program for not meeting the standard. The question for the RHZ is to find strategies that will be inclusive rather than exclusive and that will keep the program going or replace malfunctioning ASCs or committees.

Issue number two is that the RHZ had not yet been able to include Catholic health programs or convert a nearby GOZ maternity into a HC. The maternity was housed in an old Belgian Dispensary building which could be restored.

(Shepperd)

OICHA RURAL HEALTH ZONE

Kivu Region

Hospital of Communauté Evangélique du Centre de l'Afrique (CECA/ECA)

I. INTRODUCTION

Oicha was originally selected as a SANRU Phase I zone. The hospital, however, had had no physician since the mid 1960's. Health activities, including a mobile team, were being carried out by nurses under Citizen Kyusa.

Dr. Kambale arrived in October 1983 to begin duties as medical director of the hospital and of the Rural Health Zone. He is a native of the Oicha area, trained in Zaire and England (in public health).

Since Dr. Kambale's arrival, plans for the RHZ have developed more rapidly. The Health Zone personnel are well trained and highly motivated. Each one, however, is responsible for three different jobs and can devote only part-time to development of the RHZ.

Oicha Hospital traditionally supervised four distant dispensaries which offered mostly curative services. With the recent geographical defining of Health Zones, only one of the dispensaries is in Oicha's Zone of responsibility. This dispensary, Luanoli, has been converted to the Zone's first Health Center. Supervision from Oicha, though, is difficult by road. The doctor and supervisor have visited only once, in December 1983, by plane.

To date, the major activity of the Zone staff remains the mobile team that travels each month by car or motorcycle to 14 points with 25 kilometers of the hospital. They offer Pre-School Consultations and vaccinations.

The newly-defined Zone includes a Catholic dispensary - maternity staffed by A-3 and A-4 level nurses; a few other church - related dispensaries; and several dozen private dispensaries and pharmacies. The Health Zone plan calls for conversion of some of these dispensaries, into three Health Centers and eight Health Posts. The procedure will be to identify qualified and interested A-3 nurses, then retrain and assign them to supervised Health Centers and Posts. The delicate process of contacting the various owners and supervisors of the dispensaries is slowed down by the lack of full time Health Zone Staff.

II. SANRU INPUTS

A. Training:

Medecin Chef de Zone (National Health Conference and Seminar 1983)

Supervisor (UNIKIN 1982, National Health Conference and Seminar 1983)

A3 nurse from CS Luanoli (at Oicha seminar)

B. Commodities received:

Pick-up truck, 2 motorcycles, 10 bicycles, scales, 1 refrigerator, duplicator, typewriter, medicines, books (many in English). An 8-24 month delay in delivery of commodities contributed to delay in opening health center.

C. Other:

90% of first year's kilometrage for mobile Health Team.

III. OUTPUTS DUE TO SANRU INPUTS

A. Training:

Luanoli Health Center: 2 auxiliaires de santé, 8 village animateurs and one development committee

B. Infrastructure:

Rural Health Zone planned, in beginning stages.
Conseil d'administration functioning, to be expanded.
1 Health Center functioning

Note: Other health activities include vaccination programs, spring capping, encouraging latrines, family planning services. No outputs to date, however, can be directly attributed to SANRU inputs.

C. Information System:

The existing record-keeping systems of the hospital, dispensaries, and mobile team enable staff to fill out SANRU reports without difficulty. The staff knows how to handle statistics and epidemiological calculations. They receive and use PHC information from SANRU.

IV. PROGRESS TOWARD PROJECT PURPOSES

A. Sustainability:

1. Supplies: Oicha buys most of its drugs from two reliable sources: the CECA central pharmacy in Nyankunde and Caritas in Butembo. Oicha is also in touch with several international donors and can expect occasional assistance of drugs, food, and supplies in the future. The staff seems to know how to manage several sources simultaneously.

2. Financing: Hospital receipts currently pay all salaries (including the physician), drugs, maintenance of buildings and vehicles. Outside donors have given vehicles and may support a hospital and community water system. The Luanoli Health Center pays its own nurse and drugs. Detailed plans have not been developed for financing future Health Centers or supervisory staff and transportation.

3. Organization: System not developed yet

4. Training: System not developed yet.

B. Community involvement:

This aspect of the Oicha program is minimal to date. Much more needs to be planned and done.

C. Prevention and treatment of 10 most common health problems:

The nine general problems, plus schistosomiasis and leprosy are all being dealt with in current programs and future plans.

V. FINAL REMARKS

Oicha Rural Health Zone has its own set of priorities and objectives (according to plan of January 1984). Several correspond closely with SANRU project purposes and outputs. However, Oicha is likely to contribute significantly to SANRU's outputs only if personnel can be assigned full-time to the Rural Health Zone supervisory staff.

(Utshudi & Brown)

RUTSHURU RURAL HEALTH ZONE
Rutshuru Administrative Zone, Kivu Region
Hospital of COZ/CEMUBAC

I. INTRODUCTION

Rutshuru is a COZ hospital with ties to CEMUBAC (University of Brussels). It is staffed by 3 Zairian doctors. Rutshuru was included as a Phase II SANRU-assisted RHZ along with Rwanguba with which it divides part of the administrative zone. The original Medecin Chef RHZ (Dr. Rwabuzizi) died in Dec 1983 and has just recently been replaced. The program is just now adjusting to that change.

In Feb 1984 a high level team visited Rutshuru (and Kimotshu) to evaluate CEMUBAC impact and future. Pending results of that visit the future of CEMUBAC assistance is in question.

Rutshuru has advanced well in definition of RHZ limits, setting up 10 CS/PS, and developing a program of monthly supervision. The biggest problem appears to be the supply line which forces them to buy products locally and prevents their setting competitive fee services to allow auto-financement and availability of services to the general population.

II. SANRU INPUTS

- A. Training - Dr Rubuzizi - Nganda 1983
Dr Kamanji - UNIKIN 1983
Dr Piko - Kaziba 1984
Cit. Tendam, Cit Kanyangwa - Kaziba 1984

B. Commodities

- 2 motorcycles
- 10 bicycles
- 8 recharge petrol
- 8 balances d'enfant
- reference books
- contraceptives
- medical/lab equipment (1 cs)
- posters, calendars, journals, etc
- 1 typewriter
- 1 jeep vehicule (at Kinshasa)

Other Inputs

- 1) UNICEF - 4 refrigerators (1 elc + 3 petrol), vehicule, OR Equip
- 2) PEV - vaccines, vaccination equipment
- 3) CEMUBAC - sporadic and limited assistance of equipment medicines, training.

III. OUTPUTS DUE TO SANRU INPUTS

A. Training: No sessions organized to date.

B. Infrastructure

RIE has been geographically defined in negotiation with Rwanguba to create 2 RIEs within E. Rutshuru administrative zone. This was a major issue discussed and resolved at Nganda 1983. These limits have been accepted by the regional medical authorities.

A Conseil d'Administration with representatives from all medical services does not yet exist. A comité de gestion made up of the 3 doctors, asst medical, and ANEZA representative does function. Comités de Santé exist for two health centers.

15 Aires de Santé are planned but have not been mapped out by census. 5 CS and 5 PS are now functioning. Each CS has two A3 nurses + one A4, while a PS has one A-3 nurse.

Village Development Committees - not yet well developed with only 5 operating around one center.

Integration of Services - The 10 CS/PS include Protestant and Catholic centres under Rutshuru supervision. Despite a close proximity to Rwanguba there does not appear to be good communication or collaboration in simultaneous development of the two health zones.

ASN/EAU - UNICEF Brigade Hydraulique based at Rutshuru has assisted with several adduction projects including the hospital. This group is no longer very active. Springs exist which could be capped if funds were available. Suggest that SANRU provide finances.

PND - few activities, with 11 acceptors recorded for 1981. Doctors seem somewhat pessimistic and feel that a family planning program will not be accepted by the local population.

C. Information system: Annual report forms received late and not yet completed. It is doubtful they will submit a 1983 report.

IV. PROGRESS TOWARD PROJECT PURPOSES

A. Sustainability

1. Supplies. - nearly all medicines are purchased locally. Nothing received from DQMP. Difficulty in locating all required medicines. Medicines are resold at same price to be able to compete with the local pharmacies. All in all, an insecure supply line.

2. Financing. - Many of employees were paid by CEMUSAC but this has been discontinued. GOC personnel have not been paid since October. This means that hospital receipts must be increased to cover these employees. At the CS level, receipts cover salaries and medicines but not supervision costs.

3. Organization. The future of CEMUSAC input is in doubt. However since their contribution has generally been sporadic, a withdrawal of CEMUSAC would not hinder program sustainability.

As a state hospital the RIZ is assured of partial support for salaries of its personnel.

4. Training. not yet developed enough to judge sustainability.

V. Community involvement: Still working at Health Center level. Have not yet decentralized activities to village level.

Final remarks:

Given a withdrawal of outside support, it is my estimation that the RIZ at this time would continue to function with limited curative activities at the hospital and dispensaries, but that the public health emphasis would diminish drastically.

(Baer)

I. INTRODUCTION:

Prior to 1980, Rwanguba Hospital offered mainly curative care and tried to supply and supervise about 20 functioning church dispensaries in the area from Oicha to Bukavu. The recent delineation of Rural Health Zones caused all these dispensaries to fall outside Rwanguba's zone, so they are no longer officially the hospital's responsibility. A major change of emphasis is occurring as Rwanguba studies in detail the health care situation close at hand. Since 1980, Pre-School Consultations and vaccinations have been offered at the hospital.

The RIZ is densely populated with perhaps 240 persons per square kilometer. No Health Center is likely to be more than 90 minutes by road from the reference hospital. Contact and supervision will not be difficult.

Another positive feature of the Zone is a large Catholic dispensary-maternity at Jomba. The personnel there are aware of the Health Zone plans, but to date they have not been asked to participate in any sense. We did not visit Jomba, but back in Kinshasa we learned that OXFAM has provided a vehicle and two motorcycles. Integrated planning is essential. Jomba could well serve as a Centre de Santé de Référence and supervise several Health Centers in the eastern side of the Zone.

II. SANRU INPUTS**A. Training:**

Zairis physician (no longer at Rwanguba): National Health Conference 1983

Medecin Chef de Zone Dr. Randolph Bulger, and Dr. Roberta Bulger: Reproductive Health and Planning Seminar in Kaziba 1984.

Supervisor Citoyen Sebahana: National Health Conference 1984, Reproductive Health and Planning Seminar, Kaziba, 1984

B. Commodities:

1 Motorcycle arrived, 1 en route

1 Jeep arrived the day before our visit

Bicycles

Note: The Medical Director states that SANRU commodities are appreciated but have a minor impact on the zone. On the other hand, SANRU's inspiration and encouragement (through training, information and visits) have been very valuable.

III. OUTPUTS DUE TO SANRU INPUTS

A. Training: none to date.

B. Infrastructure:

Rural Health Zone: delineated on map, sub-areas not yet delineated; partial census list; conseil d'administration not yet organized.

Health Centers: none functioning now. Rwanguba Hospital itself hopes to develop and supervise 10. Jomba may be able transform and supervise 5.

Vaccination programs: None due to SANRU. At Rwanguba hospital since 1980. Jomba has a mobile vaccination program at an undetermined number of sites.

Propharmacies: none now, none planned.

Water and latrines: none due to SANRU. Latrines will be a priority program in the Zone, since only 5% of the households have them.

Family planning: a few subal ligations and IUD's upon demand, no education program yet.

C. Information system:

Received SANRU educational materials but not much used yet. 1983 annual report not submitted yet.

IV. PROGRESS TOWARD PROJECT/PURPOSES

A. Sustainability

1. Supplies. Most items are bought in Kenya, flown to Goma. System is dependent upon an expatriate expeditor.

2. Financing. Hospital is heavily dependent on donations. The expatriate staff includes 4 doctors, 1 nurse anesthetist, 1 laboratory technician and 3-4 short-term workers. Buildings, equipment, some supplies, vehicles, and kilometrage are all donated. Hospital receipts cover Zairois salaries and nearly all drugs. Hospital and Health Zone plan to accept and increase outside aid for the foreseeable future.

Plans have not yet developed for financing of Health Centers.

3. Organization. Few activities to date, so cannot judge sustainability.

4. Training. Few activities to date.

B. Community involvement:

Little to date, need guidance and encouragement.

V. FINAL REMARKS

Rwanguba Zone is slowly moving in its initial stages. The Zone staff includes only the expatriate physician (part-time) and one Zairian nurse (probably full-time from now on). The personnel, vision, plans and activities of the Zone can be enlarged rapidly by integrating the Catholic facility at Jomba. In addition, the adjacent Rural Health Zone of Rutshuru (which has more personnel and more advanced plans and activities) can serve as a collaborator, particularly in conducting joint training courses.

(Brown)

I. INTRODUCTION

HISTORY: Uvira Hospital is a GOZ facility which is responsible for 171,339 inhabitants. Uvira RHZ is divided into 15 health areas, four of which are functional at this time. The four areas are in turn subdivided into eight (8) health centers, six of these are functional.

Primary Health Care activities commenced in 1977 with the initiative of Dr. Faussa, a Catholic missionary. Presently five doctors run the hospital and the Rural Health Zone.

The Uvira medical team is composed of:

- 1 Sub-Regional Medical Inspector, Dr. Mayifwila
- 1 Hospital Medical Director, Dr. Badibanga
- 1 Medical Chief of the RHZ, Dr. Liambi
- 1 Dr. Supervisor of HC, Dr. Sikayenda
- 1 Medical Staff Director, Dr. Mamoni

Organization

Although each doctor has a well defined responsibility, they rotate in the supervision of the health areas, and report to the medical staff in regular meetings.

MCZ is responsible for the RHZ activities which include the following:

- Delineation of the RHZ into areas
- Creation or conversion of existing curative service dispensaries into Health Centers
- Supply line for pharmaceuticals and medical equipment
- The solving of problems inherent in primary health care
- Training or retraining of medical personnel

Functioning of the RHZ office

The RHZ office fills the role of secretariat and coordinating office where reports from Health Centers are received, treated and passed to higher echelon of RHZ administration. It also oversees the correct distribution of instruments and medical equipment to Health Centers.

A Health Center is staffed by

- one A 3 nurse who is responsible for all the curative and preventive health activities in the area covered by the Health Center.
- one clerk who gathers statistical information and maintains records of the Health Center.

-one A 4 aide who treats returning patients and makes home visits for follow-up purposes.

Problems encountered by the RHZ:

1. Complete integration and conversion of dispensaries into Health Centers.
 - a) Kiliba Hospital (Private) still refuses to be included in the RHZ activities.
 - b) Catholic personnel are favorable on the condition that they control all finances (salaries, supplies, maintenance) of their Health Centers. GOZ and Protestant Health Centers are the only ones that have accepted complete integration into the RHZ.
2. Supply line for medicines: the Catholic diocesan pharmacy has difficulty supplying the Uvira RHZ. Shortages and partially filled order have had negative impact on the autofinancing system of Health Centers.
3. Training of nurses: the lack of training materials, funds, classroom space and equipment handicap the success of the program.

Major constraints

1. Lack of official recognition of the RHZ by the GOZ central government.
2. Lack of investment budget to support the effort of participation by the rural population.

II. INPUTS: Contributions received from SANRU

1. Training

- one MCZ trained at Nganda in 1983 and at Kaziba April 1984
- two nurse supervisors were also trained at Kaziba (10 days in April-May 1984)

2. Commodities

- one vehicle
- some training materials, projector (film strips/slides)
- some medical equipment, blouses, infant weighing scales, etc.
- medicines (list not complete)

III. OUTPUTS

1. Training at RHZ or HC level

2. Infrastructure

- Organization of the RHZ: delineation of the Zone
- Reinforcement of activities at the 6 functioning Health Centers is required. This will include CPN, CPS, vaccination, etc.

3. Information System

- Document received by the RHZ: Annual Report form
- Document sent to SANRU: -Activity report
 - Report on training in PHC
 - Annual Report

4. Supervision of Health Centers

100% of integrated Health Centers are supervised once a month by the Doctor and a Nurse-Supervisor.

IV. PROGRESS TOWARDS PROJECT'S OBJECTIVES

-Uvira RHZ is part of the Phase II RIZs. SANRU assistance to this particular zone is only beginning, nevertheless, it has allowed the start up and especially the reinforcement of activities such as prenatal and preschool consultations, vaccinations, hygiene, health education, and census in the whole RHZ.

-The team spirit, the service organization of the staff, and the community participation offer a guarantee of program success.

V. RECOMMENDATIONS

1. Administrative work at Health Centers (18 notebooks to be filled out) should be reduced to improve the quality of the statistics to be gathered.
2. The RIZ medical staff should concentrate effort on the functioning Health Centers and leave aside temporarily the ones that still have problems.
3. Mini-Project requests should be submitted to SANRU for the construction of classrooms, unfinished construction work on Health Centers financed by the community, and training or retraining of nursing personnel.
4. Further consultations should be made with OXFAM and Bukavu Diocese to come to an agreement about creating a central pharmacy to improve the supply line of pharmaceuticals.

(Kalambay)

EVALUATION EXECUTIVE SUMMARY FOR AFRICA BUREAU

Date: 22 May 1984

Project: Zaire Basic Rural Health (660-0086)

Project Period: 1981 - 1986

I. What constraint did the project attempt to relieve?

This project attempts to relieve the constraint to primary health development caused by lack of planning, training and commodities, and poor attitudes towards preventive health, leading to lack of preventive health resources being applied and lack of access to health services.

II. What technology did the project promote to relieve this constraint?

Existing curative hospitals are enabled to organize large Rural Health Zones and train public health manpower and village committees. Technologies included health planning and management, training information and skills, and health informations systems. Specific family planning, public health and tropical medicine technologies are transferred in numerous training programs at all levels.

III. What technology did the project attempt to replace?

The project replaces unscientific methods of preventing and treating illness, pregnancy, malnutrition and tropical diseases. It replaces unrealistic systems of health data collection.

IV. Why did project planners believe that intended beneficiaries would adopt the proposed technology?

Previous rural health projects in Zaire had demonstrated the acceptance of the project's technology. Those project implementors participated in project design.

V. What characteristics did the intended beneficiaries exhibit that had relevance to their adopting the proposed technology?

The village level beneficiaries demonstrated a willingness to use these resources of time, labor and finances to collectively improve the quality of their lives.

The intermediate beneficiaries, physicians and nurses, had the requisite academic background and interest, as well as relevant work positions to apply their technology as Zone directors and supervisors.

VI. What adoption rate has this project achieved in transferring the proposed technology?

The adoption rate has been good. There were good and close working relations with all trainers, planners and their counterparts.

VII. Has the project set forces into motion that will induce further exploration of the constraint and improvements to the technical package proposed to overcome it?

The project is credited with having served as a catalyst for many factions, government, church donors, PVO's etc. The development of PHC should be able to continue with or without SANRU. It has also set in motion applied research studies to solve some implementation problems.

VIII. Do private input suppliers have an incentive to examine the constraint addressed by the project and to come up with solutions?

The project was initiated by a request from a private group of protestant churches.

IX. What delivery system did the project employ to transfer technology to intended beneficiaries?

The project used classroom and on-the-job training to transfer planning and preventive medicine technologies.

X. What training techniques did the project use to develop the delivery system?

Multiple training techniques are used. They include long and short term training of physicians, administrators and nurses, and retraining of nurses in short courses in RHZ training centers. Various village health workers are trained in Health Centers and in their villages.

XI. What effect did the transferred technology have upon those impacted by it?

Medical Chiefs of Health Zones can implement RHZ plan. Too early to tell at the village level. In some villages curative and preventive care given.