SANRU-I

PROJET DE SANTE PRIMAIRE EN MILIEU RURAL
(projet de l'AID/GOZ/ECZ numéro 660-0086)

DESCRIPTION DU PROJET

A. Historique

Ce Projet répond à la décision politique prise récemment par le Gouvernement du Zaïre d'améliorer l'état de santé de la population rurale en donnant à une plus grande proportion de la population la possibilité d'avoir accès aux services ruraux de santé publique de base. Ce projet se rapporte directement au but du Gouvernement du Zaïre de "santé pour tous d'ici l'an 2000". Ce Projet fait complément à l'effort déployé récemment par le réseau des hôpitaux de la Mission Protestante pour donner une nouvelle orientation à leurs services en faveur de zones rurales qui ne bénéficient pas de services de santé publique. Le Projet aidera, d'autre part, les formations sanitaires tant de l'ECZ que du Gouvernement du Zaïre, à exécuter un programme de réorientation qui tend à faire du système sanitaire actuel qui est essentiellement curatif un système mettant l'accent sur la prévention des maladies, la promotion de la santé publique et les services curatifs primaires.

Le Projet est le résultat d'un travail de collaboration entre le Département de la Santé et l'AID. Avec l'ECZ en tant que son agent d'exécution, le Projet aidera, parmi les systèmes d'hôpitaux du Gouvernement du Zaïre et de l'ECZ, ceux qui ont démontré leur capacité d'absorber et d'administrer l'aide reçue et ceux et dont la philosophie et les projets de programmes en matière de santé publique correspondent à la nouvelle orientation de la politique du Gouvernement du Zaïre.

Spécifiquement, le Projet aidera le Gouvernement du Zaïre et l'ECZ à transformer des dispensaires curatifs en centres de santé offrant tous les services de santé publique Ces centres sanitaires offriront des services de prévention, de promotion et de traitements curatifs qui répondront à la plus grande partie des besoins en matière de santé publique de la population servie. Les services mis à la disposition de la population varieront légèrement entre eux mais ils devront tous prévoir l'éducation en santé publique et en nutrition, des services de planning familial, des consultations prénatales

et pour enfants de moins de cinq ans, notamment les vaccinations, et des services curatifs primaires pour le paludisme, les parasites intestinaux, les maladies des voies respiratoires, la diarrhée, l'anémie et la tuberculose. De plus, ces centres aideront la population rurale, par le moyen des communautés de santé des villages, à réduire le nombre des manifestations et les risques des maladies que l'on peut prévenir en prenant des mesures d'hygiène de base dans l'environnement. Afin de réaliser ce qui précède, ces centres formeront des agents de santé volontaires pour qu'ils apprennent ce qui cause ces maladies, qu'ils puissent traiter des problèmes de santé en se servant de quelques produits pharmaceutiques de base, et envoyer, le cas échéant, les malades au niveau suivant de la formation sanitaire.

Le Projet va créer un système qui permettra de recycler les employés, trouver, recruter et former des agents de santé volontaires. Ce système de formation sera basé sur l'expérience de systèmes hospitaliers prototypes de Vanga, Wembo-Nyama et Nyankunde. Environ 2.730 employés du corps médical ou paramédical seront formés au cours de la durée du projet.

Par ailleurs, le Projet établira un mécanisme officiel pour tirer profit des expériences des systèmes hospitaliers qui participent à ce projet, et capitaliser sur les innovations qui auraient fait leurs preuves. L'établissement et la coordination de ce mécanisme seront la responsabilité du Bureau Médical de l'ECZ à Kinshasa.

Le Projet fournira au Bureau Médical de l'ECZ une aide technique à long terme et à court terme. Il sera passé commande des équipements requis par le Projet pour permettre au personnel formé de fonctionner au niveau maximum de ses compétences techniques. On mettra l'accent sur l'achat d'équipements qui n'ont besoin que d'un entretien facile.

L'aide aux formations sanitaires participant à ce projet sera attribuée en trois phases. La première phase sera concernée par les hôpitaux qui sont relativement avancés dans leur programmation de santé publique et qui ont commencé leur réorientation en prévention rurale ou se préparent à la commencer au cours de 1981. La Phase II commencera en 1982 et la Phase III aussitôt après.

B Description détaillée du Projet

Le Projet de santé rurale de base aidera les formations sanitaires participant au projet, tant du Gouvernement du Zaïre que de l'ECZ, à transformer leurs dispensaires et postes de santé qui dispensent des soins curatifs en centres de santé orientés vers la prévention, avec tous les services, tels qu'ils sont définis dans la stratégie de santé du Gouvernement du Zaïre. Les centres de santé serviront généralement une population de 10.000 à 40.000 personnes et seront prêts à faire face aux besoins les plus importants de la population rurale en matière de santé publique.

Les services spécifiques varieront selon les centres. Toutefois, les services suivants seront généralement à la disposition du public:

-- consultations prénatales pour instruire les mères en matière de régime alimentaire et soins à prendre au cours de la grossesse, et pour identifier les grossesses présentant de grands risques et nécessitant des soins spéciaux, ou pour adresser les femmes enceintes à des établissements appropriés (centre de santé ou hôpital)

-- accouchements normaux ;

-- surveillance d'enfants d'âge pré-scolaire ;

-- éducation en nutrition ;

-- services de planning familial (contraceptifs oraux, stérilets, mousse, préservatifs, Depo-Provera, et envoi à d'autres formations sanitaires pour les ligatures de trompes) ;

-- éducation sanitaire générale ;

-- vaccination d'enfants ;

-- traitement curatif de problèmes de santé, en utilisant des produits pharmaceutiques de base qui sont disponibles, et transmission de cas dont le traitement dépasse les compétences techniques du centre ;

-- maintien de statistiques en matière de santé ;

-- formation et supervision des agents de santé des villages, et

-- aide aux villages dans la création de comités de développement sanitaire et conscientisation des intéressés quant aux paramètres des interventions en santé publique.

Dans les circonstances les meilleures, chaque centre de santé publique aura un personnel composé d'un infirmier de santé publique, d'une infirmière/sage-femme, et d'un infirmier auxiliaire

En plus de la fourniture de ces services, le personnel du centre instaurera un travail d'extension aux communautés environnantes Le comité de développement sanitaire du village sera le point de départ de ce travail et représentera toutes les couches sociales de la communauté.

Le comité de santé publique du village remplira les fonctions générales suivantes :

-- servir d'intermédiaire et de moyen de communication entre la communauté et la structure officielle de la santé publique. Ce comité servira au centre de santé pour transmettre des renseignements sur les causes des problèmes de santé et servira à la communauté pour exprimer ses besoins aux centres de santé ;

-- organiser des réunions pour expliquer le concept de prévention et de promotion en matière de santé publique et pour obtenir l'accord général et l'engagement de la communauté d'entreprendre des actions pour répondre aux problèmes de santé ;

-- surveiller et coordonner les actions une fois que l'accord général et l'engagement auront été donnés ;

-- aider la communauté à choisir un agent de santé volontaire, ou plusieurs.

Les qualifications requises pour ces volontaires pourront varier mais, en général, les communautés seront encouragées à choisir quelqu'un qui :

-- ait le respect de la communauté ;

-- ait des racines solides dans la communauté et envisage de continuer à y vivre ;

-- ait déjà participé dans les affaires de la communauté en faisant preuve de certaines qualités de leadership ;

-- ait une compréhension totale des croyances, coutumes et valeurs de sa population ;

-- soit désireux de donner de son temps à la communauté, à titre de volontaire. ;

-- sache lire et écrire et,

-- ait des revenus réguliers.

Une fois que ce volontaire de santé publique aura été choisi par la communauté, il ou elle recevra une formation. Cette formation sera dispensée par le personnel de formation du système hospitalier. La formation sera simple, directe, et portera essentiellement sur les causes des problèmes de santé et sur les actions concrètes que la communauté peut entreprendre pour réduire ou éliminer ces problèmes. Un recyclage périodique, rapide, sera assuré au lieu de résidence des agents volontaires en santé publique.

Financement des Centre de Santé Publique et des Agents de santé volontaires

On prévoit que les centres de santé publique seront auto-financés. Les salaires des employés des centres de santé seront payés par le Gouvernement du Zaïre, ou par la Mission ECZ de la place, s'il s'agit d'un centre attaché à l'ECZ Les centres de santé publique seront construits par la population de la communauté. L'équipement de base durable sera fourni.

Des prix fixes seront imposés pour les services et pour les produits pharmaceutiques, et la liste des prix sera affichée au centre bien

en vue. Au bout d'un certain temps qui sera précisé, habituellement entre un et trois mois, l'infirmier responsable utilisera les recettes pour réapprovisionner le stock de médicaments et de petites fournitures

Chaque centre instituera des comités de développement dans les villages importants faisant partie de son domaine d'action. Les villageois, par l'intermédiaire des comités, seront alors à même d'entreprendre de simples actions comme :

-- construction de latrines ;

-- protection de la source d'eau du village (construction de puits/ aménagement des sources) ;

-- élimination de mares d'eau stagnantes qui favorisent la multiplication des moustiques ; et

-- prise de dispositions sanitaires pour les ordures qui attirent les mouches et autres vecteurs.

Les rapports du centre de santé publique et de l'hôpital

Le centre de santé sera supervisé par l'hôpital de zone L'hôpital de zone chargé de la supervision aura les responsabilités spécifiques suivantes :

-- visites régulières à chaque centre et aux villages satellites pour s'assurer du progrès qui a été réalisé et pour apporter son aide en cas de problèmes techniques ;

-- vérification des recettes de comptabilité des produits pharmaceutiques, et de l'application des tarifs autorisés ;

-- recyclage périodique du personnel du centre ;

-- servir de centre de dépôt et de distribution des marchandises du projet et des achats de produits pharmaceutiques dans le cadre d'un système d'auto-financement; et

-- planification du programme et fonctions d'évaluation

Ce Projet sera entrepris en trois phases avec approximativement 15-18 centres hospitaliers dans chaque phase. Dans la première phase le Projet concentrera ses actions sur un premier groupe de 15 hôpitaux avec leurs centres de santé publique, dispensaires et centres de protection maternelle et infantile. Ces hôpitaux ont été choisis pour les raisons suivantes :

-- ils s'intéressent à donner de l'expansion à leur travail d'extension en santé publique et sont disposés à réaligner leur personnel de façon à mieux servir les besoins des zones rurales qui n'ont pas de services de santé publique ;

-- ils peuvent entrer rapidement dans le programme qui leur a été préparé en 1981 ;

-- ils ont une infrastructure de base et une certaine expérience en extension de santé publique ; et

-- ils ont la capacité de former leurs propres employés, le personnel des systèmes voisins ainsi que des représentants des hôpitaux qui participeront aux Phases II et III du Projet.

La Phase I comprendra les centres hospitaliers suivants :

1. Nselo
2. Nsona Pangu
3. Kinkonzi
4. Kasangulu (GZ)
5. Nsona Bata
6. Nyankunde
7. Blukwa
8. Oicha
9. Tandala
10. Karawa
11. Wembo-Nayama
12. Kalonda (Tschikapa)
13. **Bibanga**
14. **IME-LOKO**
15. Vanga
16. **Kajiji**

La Phase II commencera en 1982 et prendra en considération les centres hospitaliers qui seront prêts à lancer leur action à ce moment-là. Jusqu'à présent, les hôpitaux suivants ont été acceptés comme candidats pour la Phase II :

1. A. B. A
2. **Luiza (GOZ)**
3. Katwa
4. Businga (GZ)
5. **Kamina**
6. Tshikadji (Kananga)
7. Kapanga
8. Sandoa (GZ)
9. Lubao (GZ)
10. **Katwa**

Les autres centres hospitaliers à retenir pour la Phase II seront choisis par des visites sur le terrain, dans la seconde partie de 1982.

C. Grille d'analyse logique

Résumé

Le but du Projet est d'améliorer la situation de santé de la population rurale zaïroise en donnant à une plus grande proportion de la population la possibilité d'avoir accès aux services de santé primaire. L'objectif de ce projet est d'établir un système de santé publique de base, avec l'appui de la communauté, système qui pourra se maintenir par ses propres moyens et permettra la prévention et le traitement, dans 50 zones rurales, des dix problèmes les plus répandus en matière de santé publique.

Extrants du Projet

1. Un système, fonctionnant bien, pour former du personnel en matière de santé publique avec l'appui de la communauté.

Cet extrant comprend les objectifs spécifiques suivants de la formation :

	Phase I	Durée du Projet
Infirmiers/sages-femmes ayant une formation/ recyclés, professionnels	300	750
Sages-Femmes (traditionnelles), formées	200	400
Médecins ayant suivi stage/recyclés	15	50
Planificateurs de santé communautaire Instructeurs en Santé, formés	10	30
Agents de santé de village	500	1,500.

L'ECZ et le Gouvernement du Zaïre ont des effectifs dont la formation professionnelle a été largement ou uniquement curative et orientée sur le travail de l'hôpital. La présente formation permettra au staff actuel d'élargir ses compétences techniques pour y incorporer la santé publique et les activités d'extension. Le programme de base pour chaque formation sanitaire sera modifié par les centres hospitaliers participant au projet, en fonction des besoins spécifiques locaux.

II. Etablissement d'un système pour la réunion, l'organisation et la diffusion des données obtenues.

Il existe une abondance de données et d'expériences en matière de soins primaires de santé publique qui n'a pas été utilisée de façon effective Le Gouvernement du Zaïre révise actuellement son système d'informations de management avec l'aide du Projet de Développement des Systèmes de Santé (0057). Le Projet de Santé Rurale de base contribuera aussi à cet effort. Les réseaux individuels hospitaliers, dont certains ont oeuvré au Zaïre depuis cent ans, n'ont pas actuellement de moyens systématiques d'enregistrer et de faire part de leurs expériences aux autres formations sanitaires ou organisations de soins de santé.

Le Bureau Médical Central de l'ECZ sera le coordinateur pour la réunion, l'organisation et la diffusion de données Le Bureau Médical Central de l'ECZ aura les objectifs spécifiques suivants :

1. Début d'une méthode systématisée de réunion et de traitement de données pour les statistiques courantes de service. Ceci se fera en coordination avec les hôpitaux participant au projet. Ces statistiques porteront sur ce qui suit :

   - morbidité et mortalité ;
   - consultations, selon le genre ;
   - produits pharmaceutiques utilisés, selon le type ;
   - employés formés/recyclés ;
   - bénéficiaires de planning familial, selon la méthode ;
   - vaccination d'enfants ;
   - protection des sources ; et
   - construction de latrines.

2. Un rapport annuel pour les hôpitaux participant au projet et pour les autres dispensateurs de soins de santé publique sera publié. Ce rapport fera le résumé des activités de l'année écoulée et mettra l'accent sur l'expérience acquise, les leçons apprises et les actions prévues pour l'année suivante.

3. Organisation d'une conférence annuelle sur la santé. Cette conférence continuera le processus de diffusion des données pour permettre aux membres du Gouvernement du Zaïre, de l'ECZ et de l'AID et aux coopérations de discuter de sujets spécifiques qui sont à propos et d'un intérêt global. Cette conférence sera organisée et coordonnée par le Bureau Médical de l'ECZ avec des intrants des hôpitaux participant au projet. En plus de la communication des données, ces conférences auraient les objectifs spécifiques suivants :

   - discussion de la collaboration, présente et future ;
   - identification de problèmes techniques, recommandations et demandes d'aide technique spécifique ;
   - évaluation du rôle du Bureau Médical central de l'ECZ et définition/révision de son rôle ; et
   - formulation de stratégies spécifiques, plans d'action, déclarations de politiques.

4 Liaison avec les coopérations. Le Bureau Médical Central de l'ECZ présentera des propositions individuelles de projets et s'occupera de l'administration du projet, des rapports et de l'évaluation.

III Deux cent cinquante centres de santé publique seront ouverts, nouveaux centres ou dispensaires reconvertis, qui mettront l'accent sur des pratiques de prévention et de promotion de santé publique.

Ces centres de santé publiques formeront l'épine dorsale du système de soins de santé publique et donneront les extrants spécifiques suivants :

- 150. 000 bénéficiaires du planning familial. Le planning familial est une composante intégrante des soins primaires de santé publique. Les centres offriront une éducation en planning familial

et des services de contraception. Ces centres assureront certains services de contraception au village et, pourront adresser les clients au centre sanitaire, ou à l'hôpital, pour d'autres services Certains centres pourront offrir des stérilets si l'infirmière responsable a reçu la formation requise pour ce genre de service. Les centres de santé publique enverront des femmes aux hôpitaux pour des ligatures de trompes.

Au niveau du village, les Agents de Santé du Village bénéficieront d'une formation afin d'être en mesure de faire connaître les avantages et les méthodes du planning familial. Ils distribueront également quelques contraceptifs et enverront les femmes désireuses d'utiliser d'autres moyens de contraception dans les centres médicaux compétents les plus proches.

- Vingt laparoscopes installés Le Projet aidera les hôpitaux centraux à améliorer leurs services de contraception en y incluant les ligatures des trompes au moyen de laparascope et/ou "minilap".

- Trois mille comités de santé actifs formés. Ces comités étendront les services de santé des centres de santé aux villages.

- Mille cinq cents sources d'eau aménagées et protégées. Les comités de santé aménageront au moins une source d'eau par village.

- Cinq cents puits creusés

- Mille programmes de vaccination organisés dans les villages.

- Mille centres de distribution de produits pharmaceutiques seront installés dans les régions où l'accès au centre de santé est difficile Ces centres de distribution seront administrés par les Agents de Santé de Village, surveillés par le comité de santé du village et le centre de santé. Les centres de distribution possèderont les médicaments essentiels de base.

- Vingt-cinq mille latrines construites

Intrants du Projet

Assistance Technique

A AID

Une assistance technique à court terme et à long terme sera fournie par le Projet. Un Administrateur de Projet engagé à temps plein et possédant de l'expérience dans le développement communautaire et l'administration sanitaire sera affecté au Bureau Médical de l'ECZ. L'Administrateur du Projet coordonnera les activités du Projet et fournira une assistance technique pour la planification de la mobilisation de l'aide financière au village et pour former/recycler les membres du personnel des hôpitaux et des centres de santé.

En outre, le Projet fournira une assistance à court terme. Cette assistance sera donnée en réponse à la demande des hôpitaux membres de l'ECZ et/ou aux demandes du GZ en compétences professionnelles dans les domaines suivants :

-- systèmes de rassemblement des données et d'information médicale ;

-- formation en planning familial ;

-- formation des sages-femmes du secteur traditionnel et moderne ;

-- formation des guérisseurs traditionnels ;

-- construction de puits et aménagement des sources d'eau ;

-- démarrage/administration des centres de distribution de produits pharmaceutiques de base ; et

-- préparation de films produits sur place.

B. Corps de la Paix

Le Corps de la Paix prévoit la mise à disposition de 720 mois/personnes dans le cadre d'une assistance technique à long terme. Un

total de dix volontaires du Corps de la Paix est prévu pour les Phase I et II du Projet, plus dix volontaires supplémentaires pour la Phase III. Les volontaires seront affectés aux systèmes hospitaliers participant au Projet et fourniront une assistance technique en mobilisant les ressources de la communauté et en dispensant une formation et un support logistique.

C. Le Bureau Central de l'ECZ fournira un Directeur de Projet Zaïrois, un Spécialiste en Planning Familial, et un Coordinateur pour la Logistique. Le Directeur du Projet sera responsable de l'ensemble de la direction du Projet, et constituera la personne de liaison entre le bureau central de l'ECZ et les missions membres. Le Spécialiste en Planning Familial coordonnera les intrants pour les composants du planning familial/sages-femmes du Projet, et fournira une assistance technique pour la formation des sages-femmes et les agents d'extension. Le Coordinateur pour la Logistique fournira une aide administrative dans les domaines de la comptabilité, le rassemblement des données, les rapports, et l'achat des marchandises.

D. Gouvernement du Zaïre.

Le Département de la Santé Publique du Gouvernement du Zaïre participera activement en nommant un représentant qui travaillera en tant qu'homologue du Directeur du Bureau Médical de l'ECZ. Les responsabilités et les tâches de l'homologue seront les suivantes :

-- agir en tant qu'agent de liaison entre le Département de la Santé Publique, l'ECZ et l'AID ;

-- représenter le Gouvernement du Zaïre au Comité Consultatif du Projet ;

-- en collaboration avec le Directeur de l'ECZ et le Bureau Médical, préparer la liste des besoins en marchandises pour les systèmes d'hôpitaux du GZ participant au Projet ;

-- établir les recommandations sur les programmes d'action pour l'ECZ et le GZ ;

-- aider les hôpitaux du GZ participant au Projet à préparer leurs plans d'action et s'assurer que ces plans sont bien mis à exécution ;

-- adopter et diffuser le matériel et les cours de formation élaborés aux termes du Projet ; et

-- identifier les candidats valables travaillant dans les hôpitaux du GZ afin de leur donner une formation aux termes de ce Projet.

-- utiliser l'expérience acquise par ce projet pour améliorer la planification, le contrôle et l'évaluation du programme de la stratégie de santé rurale récemment décrite par le GZ.

Au cours de l'accomplissement de ces tâches, le représentant devra visiter chaque système d'hôpitaux du GZ au moins une fois par semestre, et fournir un rapport après chacune de ces visites. Le rapport devrait comprendre une brève évaluation des progrès réalisés dans ces hôpitaux.

Les nationaux possédant les compétences requises seront aussi mis à la disposition du système au moyen d'un programme de financement de contrepartie du GZ. Ceci permettra d'utiliser au maximum les Zaïrois déjà formés et travaillant dans leur domaine technique spécifique. Les domaines d'assistance technique comprendront la formation en planning familial, l'éducation sanitaire, et le traitement des données. En outre, le financement de contrepartie sera utilisé pour payer les salaires d'un secrétaire/assistant administratif engagé localement, et d'un assistant en achats/logistique engagé localement. Tous deux seront affectés au bureau central de l'ECZ.

Formation

A. AID

L'un des besoins critiques dans l'élaboration d'un programme de santé publique est la formation adéquate et fonctionnelle des nationaux qui planifieront, commenceront et poursuivront le travail après que les expatriés aient terminé leurs services. Il y a un manque de main-d'oeuvre formée dans tous les domaines de spécialisations de la santé publique.

Ceci est particulièrement vrai dans les domaines de Santé Communautaire, Education Sanitaire et Planification/Administration Sanitaire. L'AID organisera une formation à long terme dans un pays tiers, dans les domaines précités pour un maximum de 30 participants. Tous les efforts seront déployés afin que cette formation puisse avoir lieu en Afrique Francophone, dans des institutions administrées par des Africains et où les cours sont donnés également par des Africains.

Outre cette formation à long terme, l'AID organisera une formation à court terme dans un pays tiers afin de faire face aux besoins techniques spécifiques des hôpitaux du GZ et du ECZ participant au Projet.

Ces besoins seront variés, mais comprendront probablement l'aménagement des sources d'eau, l'épidémiologie, les statistiques médicales, la démographie, l'éducation sanitaire, et la mobilisation communautaire.

B. ECZ

Plusieurs des hôpitaux les plus avancés de l'ECZ offriront une formation à court terme aux employés du GZ et de l'ECZ. Cette formation permettra aux représentants des autres systèmes d'hôpitaux d'observer et d'étudier le système de santé publique développé par ces hôpitaux avancés avec l'intention d'appliquer ces systèmes à leur propre système d'hôpitaux.

Aide en Marchandises

L'élément "aide en marchandises" du Projet est destiné à fournir uniquement les articles durables (articles nécessitant peu d'entretien ou un entretien simple), ainsi que les articles qui serviront de stock initial qui sera remplacé par la suite grâce au système d'auto-financement local après que les intrants du Projet soient terminés. L'exeption éventuelle à ce principe général sera le cas des contraceptifs qui seront fournis d'une manière continue par l'AID.

A AID

L'AID fournira (sous réserve de la Section 2.2. de cet Accord), les marchandises au cours de la vie du Projet. Les marchandises comprendront

1. Véhicules : Cinquante véhicules tous terrains, un pour chacun des systèmes d'hôpitaux principaux participant au Projet. Ces véhicules permettront à l'hôpital d'approvisionner et de superviser le réseau éloigné des centres de santé et de former leur personnel. Dans quelques cas, des motocyclettes seront également mises à la disposition des hôpitaux. Deux véhicules seront mis à la disposition du Bureau Médical de l'ECZ pour le transport du personnel et la distribution des marchandises.

2. Motocyclettes : Cent motocyclettes seront fournies afin de permettre aux agents des centres de santé de visiter régulièrement les villages éloignés, d'aider les Agents de Santé de Village de superviser/approvisionner les centres de distribution de produits pharmaceutiques de base, et organiser les séances de vaccinations et les consultations prénatales et des enfants d'âge pré-scolaire,

3. Bicyclettes : Cinq cents bicyclettes avec porte-bagage, seront utilisées par les agents des centres de santé qui se trouvent à proximité des villages visés en vue de réaliser l'extension comme noté ci-dessus. Les bicyclettes seront également à la disposition des Agents de Santé des Villages qui sont responsables de plus d'un village ou qui auront besoin de ce moyen de transport et effectuent de nombreux déplacements vers le Centre de Santé.

4. Produits Pharmaceutiques : Un premier stock de médicaments de base sera mis à la disposition des 250 centres de santé prévus aux termes du Projet. Ces médicaments seront destinés à la prévention et au traitement, à un coût peu élevé, des maladies les plus courantes dans les régions desservies par le Projet. Le stock réel du centre variera en fonction du genre de maladies prédominantes. Le premier stock de produits pharmaceutiques permettrait de débuter le système d'auto-financement. En plus des centres de santé, l'AID mettra aussi à la disposition de 1000 Agents de Santé de Village Volontaires un premier stock de cinq médicaments de base.

5. Equipement d'Enseignement Audio-Visuel : Les 50 hôpitaux participant au Projet et les 250 centres de santé recevront une quantité minimum de tableaux, livres, manuels de formation, et dans quelques cas, des projecteurs de cinéma et de diapositifs fonctionnant sur batterie. Les aides à la formation seront conformes aux besoins locaux.

6. Moyens de Contraception : L'AID fournira d'une manière continue les moyens de contraception de base pour les hôpitaux, les centres de santé, et pour les Agents de Santé de Village Volontaires.

7. Matériel Médical : L'AID fournira le matériel médical aux centres de santé et aux Agents de Santé de Village. Le Matériel sera destiné aux examens des malades et au traitement des maladies, aux services de planning familial, et aux campagnes de vaccination.

8. Equipement de Bureau : L'AID fournira l'équipement de bureau pour les hôpitaux participant au Projet et le bureau central de l'ECZ. Cet équipement comprendra des machines à calculer, classeurs, machines à écrire, machines à reproduction par stencils, machines à photocopie, et équipements divers de bureau. Cet équipement permettra aux hôpitaux participant au Projet de rassembler et de présenter leurs données et leur expérience au bureau central pour compilation et diffusion. L'équipement permettra aussi de préparer quelques aides à l'éducation audio-visuelle, les manuels de formation, les programmes de séminaires et les programmes de recyclage.

9. Autres Frais : Ceci comprendra les conférences, les voyages, les allocations journalières, les matériaux de construction, les outils, et les pièces de rechange.

Dispositions concernant la Mise à Exécution.

Le Bureau Médical de l'ECZ sera responsable de la mise à exécution du Projet. Ce bureau travaillera directement avec les systèmes des hôpitaux participant au Projet.

Les responsabilités spécifiques du Bureau Médical de l'ECZ seront les suivantes :

-- organisation et présidence du Comité Consultatif du Projet ;
-- Identification et sélection des participants en vue d'une formation à long terme et à court terme ;

-- liaison avec les autres organisations ;

-- élaboration de séminaires de formation à court terme ;

-- élaboration d'un programme de formation pour les Agents de Santé de Villages et les sages-femmes traditionnelles en planning familial ;

-- élaboration d'un système de statistiques de planning familial dans le cadre des systèmes de GZ et de l'ECZ ;

-- préparation des rapports réguliers ;

-- concevoir et développer un programme pour l'introduction de l'éducation en vie familiale dans les écoles secondaires ; et

-- obtention et distribution des marchandises du projet.

Pour mettre ce Projet à exécution, le Bureau Médical de l'ECZ aura l'aide des services suivants de l'ECZ :

A. Organisation protestante pour l'entreposage et la distribution :

L'Agence de secours protestant du Zaïre, (ZPRA) créée en 1969, est une agence de transit de l'ECZ, à but non lucratif et exonérée du paiement des impôts. Elle emploie deux agents au port de Matadi et a un effectif de 15 personnes. Elle a un vaste dépôt dans la ville de Kinshasa, à Gombe. Les marchandises destinées au projet pourront être entreposées dans cette installation, moyennant un prix, jusqu'au moment de leur expédition dans l'intérieur. Le ZPRA a un élévateur à fourche, un camion de 5 et 8 tonnes, et peut manutentionner plus de 1000 tonnes de matériel. Les achats de l'AID/Ambassade, le stockage au ZPRA, et l'expédition dans l'intérieur se feront par le système de MAF. Les marchandises du Projet pour le Haut-Zaïre et le Nord Kivu seront entreposées dans les dépôts à Nuankunde CME. Les marchandises du Projet pour les deux Kasai seront stockées aux installations dans la ville de Kananga de l'Institut Médical Evangélique de Kananga. Pour le Bas-Zaïre, IME Kimpese servira d'entrepôt secondaire. Pour les hôpitaux participant à la première phase, le service direct par avion de la MAF sera possible.

Le système de distribution a été utilisé, dans le passé, par le réseau des formations sanitaires protestantes, particulièrement pour les médicaments, l'équipement médical , et les véhicules.

Les véhicules du projet seront entreposés au ZPRA jusqu'à ce qu'un arrangement puisse être conclu avec l'hôpital participant qui devra les recevoir pour faire conduire le véhicule à sa destination ou l'expédier par bateau

B. Système de transport et de distribution par avion des Missionnaires.

Le système ECZ a son propre réseau de transport aérien qui consiste en plus de 30 avions. La Mission Aviation Fellowship (MAF) couvre le Bas-Zaïre, Kinshasa, l'Equateur, le Bandundu et des parties du Kivu et des Kasai. Les Méthodistes et les Presbytériens ont leurs propres avions. Les avions dans l'intérieur sont basés aux complexes hospitaliers. Nyankunde au Haut-Zaïre, centre médical protestant, emploie deux avions, ce qui lui permet d'avoir une liaison hebdomadaire avec Nairobi. Nyanga dans le Kasai du Nord, Vanga dans le Bandundu, Kimpese au Bas-Zaïre, Karawa dans l'Equateur sont toutes des stations médicales missionnaires qui ont des avions. Les médicaments et l'équipement du Projet seront facilement transportés et la surveillance du projet sera facilitée grâce à ce réseau aérien.

C Aménagements de garage et de réparations.

L'ECZ, sans frais périodiques supplémentaires, est déjà capable d'avoir un stock considérable de pièces de rechange L'ECZ a un garage pleinement équipé à Kinshasa, avec un mécanicien expatrié, spécialiste en diesel, une équipe de 10 mécaniciens et un groupe de stagiaires. Le garage dispose de bons emplacements de stockage pour les pièces de rechange.

D. Aménagements pour bureaux

L'ECZ fournira, comme partie de sa contribution en nature, des locaux pour bureaux pour le Directeur du Projet, trois assistants techniques et deux assistants-secrétaires.
L'adresse du secrétariat national est la suivante :

Secrétariat de l'E. C. Z.
Avenue de la Justice (derrière le Royal)
B. P. 4938
Kinshasa, Gombe.

Organisation du Comité Consultatif

Le Bureau Médical, en coordination avec le Département de la Santé, formera un Comité consultatif qui aura, entre autres, les fonctions suivantes :

-- conseiller en matière de directives générales, questions techniques et juridiques ;

-- faire la coordination avec les autres formations médicales pour partager leurs expériences, s'entraider, etc. ;

-- faire rapport des résultats et des conclusions de ces expériences de façon à ce que d'autres agences publiques et privées puissent en bénéficier ; et

-- servir de contact principal pour la liaison avec les autres coopérations et d'autres agences du Gouvernement du Zaïre.

Ce Comité Consultatif se réunira deux fois par an ; il aura des sous-commissions ou des groupes de travail se réunissant ad hoc pour traiter de tâches ou problèmes spéciaux. Le Comité Consultatif devrait comprendre :

-- le Directeur Général de l'Agence de l'ECZ ;

-- un représentant de la présidence de l'ECZ ;

-- le directeur du Bureau Médical de l'ECZ ;

-- deux représentants des formations sanitaires qui participent au Projet ;

-- un représentant du Gouvernement du Zaïre, Département de la Santé ;

-- un représentant de l'AID ; et

-- un représentant du Corps de la Paix

Par ailleurs, d'autres représentants seront invités, en fonction des besoins.

EXEMPLE

Pièce A, Annexe I

PLAN FINANCIER DU PROJET

(Source et utilisation des fonds -- en milliers de dollars)*

Jusqu'en juin 1981

Projet No.660-0086

MONTANT POUR UN PROJET FINANCE PAR AUGMENTATIONS

INTRANTS DU PROJET	Engagements et obligations cumulés jusqu'en juin 1981			Prévisions pour Années à venir			TOTAL		
	AID	GZ	ECZ	AID	GZ	ECZ	AID	GZ	ECZ
Assistance Technique	334	77	38	602	273	153	936	350	191
Formation	-	132	-	1.033	526	-	1.033	658	-
Marchandises	541	100	-	2.234	150	-	2.775	250	--
Autres	25	316	520	95	750	2.084	120	1.066	2.604
TOTAL	900	625	558	3.964	1.699	2.237	4.864	2.324	2.795

* La contribution du Gouvernement du Zaïre et de l'ECZ en zaïres figure dans ce tableau sous forme de son équivalent en dollars des Etats-Unis.

EXEMPLE

Pièce B, Annexe 1

BUDGET DE LA CONTRIBUTION DE L'USAID
(en milliers de dollars)

	AB 81	AB 82	AB 83	AB 84	AB 85	TOTAL
ASSISTANCE TECHNIQUE	(333)	(135)	(378)	(45)	(45)	(936)
Long terme	288 (24mh)		288 (24mh)			576(48mh)
Court terme	45 (3mh)	135 (6mh)	90 (6mh)	45 (3mh)	45 (3mh)	360(24mh)
FORMATION		(442)	(321)	(200)	(70)	(1033)
A long terme à l'étranger		302 (168mh)	216 (120mh)	130 (72mh)		648(360mh)
A court terme à l'étranger		140 (40mh)	105 (30mh)	70 (20mh)	70 (20mh)	385 (110mh)
MARCHANDISES	(541)	(1304)	(530)	(400)		(2775)
Véhicules	456	494				950
Motocyclettes	30	120				150
Bicyclettes	30	90	30			150
Autres (contraceptifs, produits pharmaceutiques, matériel médical, aides audio-visuelles, équipement de bureau)	25	600	500	400		1525
AUTRES FRAIS	26	24	25	25	20	120
TOTAL	900	1905	1254	670	135	4864

* mh = mois/hommes

EXEMPLE

Pièce C, Annexe I

BUDGET DE LA CONTRIBUTION DU GOUVERNEMENT DU ZAIRE
AU MOYEN DES FONDS DE CONTREPARTIE
(en milliers de zaires)

Dépenses du Personnel du Bureau Médical Central (Total 1.060)	1e An.	2e An.	3e An.	4e An.	5e An.	Durée du Projet
A) Salaires et Allocations pour le Personnel à engager pour le Bureau Central de l'ECZ, et Primes.						
a) assistant administratif temps plein Z16.000/an						
b) secrétaire/dactylo temps plein, Z8.000/an						
c) prime pour le Directeur du Bureau Médical de l'ECZ, Z8.000/an						
d) prime pour le représentant du GZ Z8.000/an	40	40	40	40		160
B) Contrats ou Services de Consultants à Court Terme						
Reproduction et révision des manuels de formation, des directives, rapport spécial, etc.; études et évaluations.	200	200	150	150	200	900
Marchandises (Total 750)						
Manuels de Formation 25						
Posters 75						
Documentation 75						
"Chemin vers la Santé" 125						

		1e An.	2e An.	3e An.	4e An.	5e An.	Durée du Proje
Livres de Bibliothèque	25						
Fournitures de Bureau	25						
Matériaux de Construction	200						
Produits Pharmaceutiques							
Locaux	200	300	300	50	50	50	750
Formation (Total 1.975)							
a) Stage de formation pour les formateurs dans les hôpitaux ou à Kinshasa, 50 formateurs x 1 an de sessions de formation.		50	50	50	50	50	250
b) Stage à l'hôpital pour les médecins, infirmiers, sages-femmes, agents de santé de village - 15 hôpitaux x 1 an de sessions de formation x 20.000 sessions		300	300	300	300	300	1.500
c) Formation à court terme dans des lieux choisis pour 15 participats.		45	45	45	45	45	225
Autres Frais (Total 3.200)							
a) Voyages à l'intérieur du pays pour le personnel du Bureau Central de l'ECZ, les représentants des hôpitaux, le personnel du GZ, le Comité Consultatif.		300	300	100	100	50	850
b) Frais sur place pour cinq conférences annuelles sur la santé et campagne d'information.		100	100	100	100	100	500
c) Frais de transport locaux des marchandises		100	100	50	50		300

	1e An.	2e An.	3e An.	4e An.	5e An.	Durée du Projet
d) Allocations journalières pour l'assistance technique locale, le Comité Consultatif, le personnel de l'ECZ et du GZ.	50	100	50	25	25	250
e) Affranchissement, pièces de rechange, ciment.	50	50	50	25	25	200
f) Essence, huile, lubrifiants, pendant les trois premières années des activités sur le terrain.	400	300	300	50	50	- 1.100
TOTAL	1.935	1.885	1.285	985	895	6.985

Personnel Administratif du Projet Santé Primaire Rurale

Cit. NLABA SONA	Directeur du Projet
Dr. FRANKLIN BAER	Project Manager
Dr. MIATUDILA MALONGA	Representant du Gouvernement
Mr. RALPH GALLOWAY	Planning Coordinator
Mme. FLORENCE GALLOWAY	Training Coordinator

le Bureau Central est situé dans le battiment
de l'Eglise du Christ au Zaire (ECZ);
Ave. de la Justice,
(derrière le Royal)

August 13, 1981

ACTION MEMORANDUM

TO: Norman L. Sweet, Mission Director

FROM: Walter W. Boehm, PRM

SUBJECT: Project Authorization -- Basic Rural Health (660-0086)

Problem:

Your approval is required to authorize a grant of $4,364,000 from the health appropriation to the Government of Zaire (GOZ) for the Basic Rural Health (660-0086) Project subject to the availability of funds in accordance with the USAID OYB/allotment process. We intend to obligate $900,000 in Fiscal Year 1981 for this Project.

Discussion:

A. Project Background

The Project responds to a recent policy decision by the GOZ to improve the health status of the rural population by increasing the proportion of residents that have access to basic health services. The increased access will result from a planned reorientation of the present predominantly urban curative health care delivery system to one emphasizing prevention, promotion, and basic curative services in rural areas. The reorientation will emphasize preventative and curative measures for the ten most prevalent health problems in Zaire. The reorientation will focus on the two elements of the health care system that impact on the most people. These are the health centers and village level health workers.

The Project will assist those GOZ and ECZ hospital systems that have demonstrated a capacity to absorb and manage assistance and whose own public health philosophy and program plans correspond to the new GOZ policy orientation.

Specifically, the Project will assist the GOZ and ECZ to transform curative dispensaries into full service health centers. These centers will offer preventive and promotive curative services that will meet the majority of the needs of the population served.

B. Project Description

The purpose of this Project is to establish a system of self-sustaining community-supported primary health care effectively offering prevention and treatment of the ten most prevalent public health problems in fifty rural zones.

The Project conforms with general AID priorities as well as those presented in the Country Development Strategy Statement.

C. Financial Summary

The total USAID contribution to the five year life-of-project cost is $4,864,000. In addition, the GOZ and ECZ will contribute funds, personnel, and facilities. Total USAID, Peace Corps, ECZ, and GOZ life-of-project costs is estimated at $10,700,000.

D. Covenants

The following covenants will be included in the Project Agreement:

1. The Grantee agrees that the ECZ will be the primary implementing agent for the Project.

2. The Grantee covenants to make available all necessary budgetary and human resources needed at the GOZ participating hospitals in a timely manner.

E. Implementation

The Project will be a collaborative effort between the GOZ, USAID, and the ECZ. There will be a bilateral agreement with the GOZ Department of Health, with the ECZ as the implementing agent.

F. Committee Action and Congressional Notification

The Project was reviewed by the Project Committee. As there were no unresolved issues, the Project Committee concluded that the Project should be forwarded to you for authorization. A Congressional Notification was sent to Congress noting our intention to obligate $900,000 in FY 1981 for this Project. The Congressional Notification waiting period expired with no comments from the Congress.

Recommendation:

That you sign the attached Project Authorization and thereby authorize the Project.

August 13, 1981

PROJECT AUTHORIZATION

Name of Country: Zaire

Project Name: Basic Rural Health

Project Number: 660-0086

1. Pursuant to the Foreign Assistance Act of 1961, as amended, I hereby authorize the Basic Rural Health Project with the Government of Zaire involving planned obligations of not to exceed $4,864,000 in grant funds over the planned life of project of five years from the date of initial obligation subject to the availability of funds in accordance with the AID OYB/allotment process.

2. The Project consists of the establishment of a self-sustaining community-supported primary health care system offering prevention and treatment of prevalent public health problems in fifty rural zones.

3. Source and Origin of Goods and Services

Goods and services, except for ocean shipping, financed by AID under the Project shall have their source and origin in the United States except as AID may otherwise agree in writing.

Ocean shipping financed by AID under the Project shall, except as AID may otherwise agree in writing, be financed only on flag vessels of the United States or the Republic of Zaire.

4. Condition Precedent to Disbursement

Prior to the first disbursement of funds under the Grant, or to the issuance by AID of documentation pursuant to which disbursement will be made, the Grantee will, except as the Parties may otherwise agree in writing, furnish to AID in form and substance satisfactory to AID:

(a) a statement of the name of the person designated as the Department of Health representative, together with a specimen signature of the person specified in such statement, to interface with USAID and the ECZ on project implementation activities.

5. Covenants

The cooperating country shall covenant:

(1) to make available all necessary budgetary and human resources needed at the GOZ participating hospitals in a timely fashion; and

(2) to agree that the ECZ will be the primary implementing agent for the Project.

Norman L. Sweet
Mission Director
USAID/Zaire

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT PAPER FACESHEET

1. TRANSACTION CODE: [A] (A ADD, C CHANGE, D DELETE) — PP

2. DOCUMENT CODE: 3

3. COUNTRY ENTITY: Zaire

4. DOCUMENT REVISION NUMBER: [ ]

5. PROJECT NUMBER (7 digits): 660-0086

6. BUREAU OFFICE: A SYMBOL: AFR; B CODE: 06

7. PROJECT TITLE (Maximum 40 characters): Basic Rural Health

8. ESTIMATED FY OF PROJECT COMPLETION: FY 86

9. ESTIMATED DATE OF OBLIGATION: A. INITIAL FY 81; B. QUARTER 4 (Enter 1, 2, 3, or 4); C. FINAL FY 85

10. ESTIMATED COSTS ($000 OR EQUIVALENT $1 -)

A. FUNDING SOURCE	FIRST FY B. FX	FIRST FY C. L.C	FIRST FY D. TOTAL	LIFE OF PROJECT E. FX	LIFE OF PROJECT F. L.C	LIFE OF PROJECT G. TOTAL
AID APPROPRIATED TOTAL	900		900	4864		4864
(GRANT)	(900)	( )	(900)	(4864)	( )	(4864)
(LOAN)	( )	( )	( )	( )	( )	( )
OTHER U.S. 1. Peace Corps	75		75	350		350
OTHER U.S. 2.						
HOST COUNTRY		625	625		2691	2691
OTHER DONOR(S) ECZ		558	558		2795	2795
TOTALS	975	1183	2158	5214	5486	10700

11. PROPOSED BUDGET APPROPRIATED FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE C. GRANT	PRIMARY TECH. CODE D. LOAN	E. 1ST FY 81 F. GRANT	E. 1ST FY 81 G. LOAN	H. 2ND FY 82 I. GRANT	H. 2ND FY 82 J. LOAN	K. 3RD FY 83 L. GRANT	K. 3RD FY 83 M. LOAN
(1) PH	534	510		900		1905		1254	
(2)									
(3)									
(4)									
TOTALS				900		1905		1254	

A. APPROPRIATION	N. 4TH FY 84 O. GRANT	N. 4TH FY 84 P. LOAN	Q. 5TH FY 85 R. GRANT	Q. 5TH FY 85 S. LOAN	LIFE OF PROJECT T. GRANT	LIFE OF PROJECT U. LOAN
(1) PH	670		135		4864	
(2)						
(3)						
(4)						
TOTALS	670		135		4864	

12. IN-DEPTH EVALUATION SCHEDULED: MM 09 YY 83

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA, BLOCKS 12, 13, 14, OR 15 OR IN PRP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PID FACESHEET. [1] (1 NO, 2 YES)

14. ORIGINATING OFFICE CLEARANCE

SIGNATURE: Norman L Sweet

TITLE: Norman L. Sweet
Director, USAID/Zaire

DATE SIGNED: MM 08 DD 13 YY 81

15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

AID 1330-4 (3-76)

A. TABLE OF CONTENTS

PART I. Summary and Recommendations

A.	Face Sheet	1
B.	Glossary	3
C.	Recommendations	5
D.	Brief Description of the Project	6
E.	Summary Findings	8
F.	Project Issues	9

PART II. Project Background and Detailed Description

A.	Background	16
B.	History	20
C.	Detailed Description	21

PART III. Project Analysis

A.	Technical Analysis	34
B.	Financial Analysis and Plan	43
C.	Social-Cultural Analysis	48
D.	Economic Analysis	51
E.	Environmental Analysis	53

PART IV. Implementation Planning

A.	Administrative Arrangements	55
B.	Implementation Plan	64
C.	Evaluation Plan	66

ANNEXES

I. Logical Framework
II. Description of ECZ System
III. Organizational Chart of ECZ
IV. ECZ-GOZ Hospitals Participating in Phases I and II
V. Zones reached in Phase I
VI. Zones reached by EOP
VII. List of Basic Equipment to be provided Health Centers
VIII. List of Basic Pharmaceuticals for Health Centers
IX. List of Basic Pharmaceuticals for VHW
X. Basic Midwife Kit for Traditional Birth Attendants
XI. List of Training Aids
XII. Job Descriptions and Qualifications for three Technical Consultants
XIII. Data Sheets for Participating Hospital Systems
XIV. PID Approval Message
XV. Grantee Request for Assistance

B. Glossary

Basic Health Care - The most elementary health care directed toward treating and preventing the most common health problems of a community.

Dispensaries - Lowest health care unit, usually offering limited curative services and no preventive services; sometimes referred to as "health posts."

PEV - Programme Elargi de Vaccination (also EPI)

Expanded Program of Immunization (EPI) - Worldwide WHO/CDC sponsored program against polio, measles, tuberculosis, diptheria, whooping cough, and tetanus.

GOZ - Government of Zaire

Health Center - A rural, primary health care facility staffed in principle by three health workers (curative nurse, public health nurse, sanitarian or nurse/midwife). Offers both curative and preventive services.

Hospital - System made up of hospital with dependent satellite health centers.

MCH - Maternal and Child Health

Propharmacy - A community owned and operated drug outlet in areas where there is no commercial pharmacy and/or no accessible health care institution.

Village Health Worker - (VHW) - The provider of basic health services at the village level on a voluntary basis.

Village Health Committee - (VHC) - Village organized and operated committee composed of village members to promote health activities and programs within the village.

PID - Project Identification Document - A short, preliminary document indicating a USAID Mission's intention to consider developing a project.

PP - Project Paper - The final detailed document describing a proposed project and responsibilities of each of the participating parties.

Recurrent Cost - Anticipated additional costs resulting from the initiation or expansion of activities as the result of a project.

Self-Financing	-	Accrued funds from a system being continually recycled back through the system to permit operation without outside subsidy.
Family Planning Acceptor	-	Individuals or couples using a modern contraceptive method on a continuing basis.
Traditional Midwife	-	Indigenous woman who has been instructed in birth delivery practices by other indigenous women and who usually lacks formal training.
OPG - Operational Program Grant	-	Formal process by which USAID assists private voluntary organizations to implement development projects.
Long Term Training	-	Training that lasts 6 months or more; usually of one year duration.
Short Term Training	-	Training that lasts less than 6 months.
IE and C	-	Information Education and Communication.
Centre de Bien Etre Communantaire	-	CEBEC Community Welfare Center - Name applied to a center which provided curative health care and prevention activities. These centers are now referred to as Health Centers by the GOZ.
IPPF	-	International Planned Parenthood Federation
CNND	-	Committee for Desired Births
UNFPA	-	United Nations Fund for Population Activities
FPIA	-	Family Planning International Association
AVS	-	Association for Volunatry Sterilization
JHPIEGO	-	Johns Hopkins Program for Information and Education in Gynecology/Obstetrics

C. Recommendations

It is recommended that the attached PP be approved by September 1, 1981, in order for project activities to coincide with the planned GOZ and ECZ expansion of public health services into the rural areas which will begin in the fall, 1981.

Request authorization of a grant for a 5 year project in the amount of $4,864,000.

Request approval of following source/origin waivers:

Vehicles: one 4-wheel drive utility vehicle for Nyankunde

Motorcycles: 100 motorcycles with small displacement motors

Also request approval of a sole-source Personal Services Contract waiver.

D. Summary Description of the Project

The project responds to a recent policy decision by the GOZ to improve the health status of the rural population by increasing the proportion of residents that have access to basic health services. The increased access will result from a planned reorientation of the present predominantly urban curative health care delivery system to one emphasizing prevention, promotion, and basic curative services in rural areas. This reorientation will emphasize preventative and curative measures for the 10 most prevalent health problems in Zaire. This reorientation will focus on the two elements of the health care system that impact on the most people. These are the health centers and village level health workers.

The project will be a collaborative effort between the GOZ, USAID, and the ECZ. There will be a bilateral agreement with the GOZ Department of Public Health, with the ECZ as the implementing agent. The project will assist those GOZ and ECZ hospitals systems that have demonstrated a capacity to absorb and manage assistance and whose own public health philosophy and program plans correspond to the new GOZ policy orientation.

Specifically, the project will assist the GOZ and ECZ to transform curative dispensaries into full service health centers. These centers will offer preventive and promotive curative services that will meet the majority of the needs of the population served. The services offered will vary slightly from center to center but will generally include the following:

health and nutrition education;

prenatal and preschool clinics;

immunizations;

curative services for malaria, intestinal parasites, respiratory diseases, and anemia;

normal deliveries and referral of high risk pregnancies; and

family planning services.

In addition, these centers will assist the rural population in reducing the incidence and risk of preventable diseases through basic environmental sanitation measures. To do this, they will train village volunteer health workers to understand disease causality, to treat minor health problems using a stock of a few basic medicines, and to make proper referrals to the next level of health care.

To assist with the implementation of the expanded health center system, the project will develop an approach for retraining employees and for identifying and training volunteer health workers. The training will be based on the

perience of prototype hospital systems in Vanga, Wembo-Nyama, and Nyankunde.

In addition to the training system, the project will set up a formal mechanism to share the experiences of participating hospitals and to capitalize on those innovations that have proven successful. The establishment and coordination of this mechanism will be the responsibility of the ECZ Medical Bureau in Kinshasa.

The project will fund one full-time technical consultant/manager for the ECZ medical office and several short-term technical consultants to assist with specific problem areas during the life of the project. The ECZ and GOZ will provide personnel to work on the project.

Since the health policy reorientation will require a change in attitudes, philosophy, and technical skills of current health care providers, training will be a major aspect of this activity. The project will train/retrain 2,730 people who will provide supervision and/or support for the health care system.

The project will purchase basic commodities that will permit the people trained to function to the maximum level of their technical competence. Emphasis will be placed on providing those commodities that need little maintenance and can be maintained after the end of USAID project inputs.

The project will assist the participating hospital systems in three time phases. The first phase will include those hospitals that are relatively advanced in their public health programming and have either started their preventive/rural reorientation or are preparing to start during 1981. The first group of 15 hospitals for Phase I has already been identified. (See Annex IV.). The second phase will include those hospitals that are preparing to initiate their reorientation and outreach activities in 1982. Eight hospitals have been tentatively identified for Phase II, which will begin in 1982. The last Phase will include those remaining hospitals that will be preparing their plans in the next 3 years. Phase III will begin in 1983 and continue through 1985.

E. Summary Findings

The project provides timely assistance to a long awaited orientation towards rural health emphasizing prevention and cure of the most prevalent diseases in Zaire. Considering the general economic milieu of Zaire and limited capacity of the formal central health care delivery structure, the strategy of mobilizing local resources to improve helath status is particularly appropriate.

The project also follows and supports the health care philosophy and strategy recently articulated by the GOZ at the National Health Conference at Nsele in February, 1981.

The project also will take timely advantage of the recent successful innovations in the delivery of health care at the village level. The implementing agent for the project, ECZ, is well suited to provide administrative control and program accountability at the central level, while still permitting individual hospital centers the flexibility to design and implement local programs within a general framework adapted to local conditions.

This project conforms with general AID priorities as well as those presented in the CDSS. Because of its size and planned impact, the project will permit USAID to make mixmum use of its limited direct hire personnel in compliance with recent AID directives.

F. Project Issues

The PID review committee raised the following concerns/questions to be addressed in the PP. These included:

1. The recurrent costs to hospital systems as a result of project activities and their capacity to absorb these costs and continue activities after the termination of project assistance.

The project design team has determined that the recurrent costs to the participating hospital system will be minimal.

The project will not add personnel to hospital systems but rather will work through staff already on the payroll or through staff that would be added in any event as part of the normal expansion even without this project. The project will concentrate on giving the staff the technical skills and public health orientation necessary to implement the new direction of health care in Zaire. The medical and other supplies provided will consist of basic equipment that requires little or no maintenance. Table I gives the estimated annual recurrent costs for some medical and other supplies.

The remainder of the basic equipment to be supplied does not require recurrent costs. In addition, the equipment is durable. This equipment includes pans, basins, bowls, microscopes, examining tables, specula, stethoscopes, scissors, forceps, tape measures, books, pamphlets, flip charts, and typewriters.

The input that will require the highest recurrent costs is motor vehicles. The project plans to provide funding for fuel and spare parts for the participating hospital systems for 3 years. This will permit the frequent training and supervisory visits necessary to initiate the program while also permitting the hospitals to establish budgets to underwrite these recurrent costs begining with the fourth year of project activities. Also, it is anticipated that the frequency of supervisory training visits will decrease as experience is gained over the 3 year period. Thus, the amount of fuel needed should be reduced at the end of that period. Both the ECZ and GOZ have understood post third year costs and are prepared to underwrite them. Table II gives the estimated annual recurrent costs for motor vehicles, motorcycles, and bicycles.

The project design team noted that to this end the ECZ managed hospitals and clinics have an annual operating budget in excess of $50,000,000. Therefore, they are quite capable of absorbing these costs with a minimum of budget reallocation.

The GOZ managed hospitals, on the other hand, may have a problem in meeting the vehicle operational costs. The GOZ has stated its firm intent, however, to move resources from urban to rural hospital systems. It also has assured USAID that it will make a special effort for those GOZ managed

hospital systems participating in the project. The GOZ plans an increase in their funding allocation as well as in the capacity to receive their allocations directly from the Ministry of Public Health/Kinshasa, rather than through regional health offices. The design team further notes that no more than 7 project vehicles will be assigend to GOZ managed hospitals.

Although the project will increase recurrent costs for supervision and retraining, these additional costs are accepted by the ECZ and GOZ as part of their commitment to move resources to the rural areas. The concept of self-financing of pharmaceuticals is accepted by both the GOZ and ECZ. The ECZ currently practices self-financing of pharmaceuticals. This concept will be continued with inputs initiated under the project and will be introduced into the GOZ participating hospital systems. Pharmaceuticals supplied under the project will provide a first stock to initiate the expansion of this system. The self-financing system will follow the models developed by project areas Wembo-Nyama and Nyankunde.

2. The adequacy of funding for the 1,500 water systems and 30,000 latrines.

The project will achieve these two outputs by educating the villagers to the need for potable water and sanitary disposition of human excrement as preventive health measures. The villagers themselves will construct both the water sources and the latrines using locally available resources. This will eliminate the need for personnel costs and costly construction materials.

The project estimates a requirement of 1,000 shovels at $15 per shovel for a total cost of $15,000. These shovels will be the only project-furnished commodities required for latrine construction.

Each protected water source will require commodity inputs of approximately $50 (5 sacks of cement at a cost of $10 per sack). A total of $75,000 is planned to finance 1,500 water sources. The design team notes that the ECZ hospital system has had experience with this type of construction as well as in-house technical competence. In Nyankunde, a community health outreach system recently constructed over 200 village latrines at no cost to the hospital except for several shovels and wheelbarrows that were made available to the villages.

The project plans to draw on short-term technical assistance in planning and initiating this aspect of the project. Technical assistance also will be requested for training Zairians in water source management.

3. The feasibility of "volunteer" VHWs.

Two of the more advanced ECZ hospitals (and one Catholic hospital) have begun training of volunteer VHWs. To date, 72 have been trained or are in training in Kisantu, Nyankunde, and Wembo-Nyama. These village workers

were chosen by their village health/development committees to receive training in the village or health center by hospital staff. Their activities are mainly preventive and promotive. In this connection, however, they do use a small medicine chest that contains a first aid kit and a stock of basic medicines for the five most prevalent diseases. Based on this experience, the ECZ and GOZ see the training of these people as feasible and desirable if the following conditions are met:

- The village first must form a village health/development committee and identify the most serious health problems;

- The proposed village health volunteer worker must be literate and must live and plan to continue to reside in the village;

- The volunteer must have a routine means of support and be prepared to spend only a small part of each day on his health promotion/curative activities;

- The volunteers understand that they will not be compensated for their services; and

- There will be frequent supervisory visits from health center or hospital staff during the first few months of the volunteers' activities.

The "remuneration" of the volunteer is the prestige that accrues to his new position of teacher/healer in the village as well as occasional traditional gifts for his services such as poultry, produce, and assistance in his own village work. In spite of the usual problems involved in initiating programs of this sort, such as identifying suitable candidates and the time lag between identification of candidate and implementation, the ECZ and GOZ consider the village volunteer worker program as a feasible means to extend health care to the villages. Also it is believed that the program is one that can be replicated in other hospital systems, provided the necessary groundwork is done.

A comparable approach has been successfully demonstrated in the following areas of Zaire over the last five years:

Nyankunde - This hospital center has a series of outlying dispensaries. However, in 1979, it recognized that its curative hospital based system was merely treating the results of the health problems rather than doing anything to reduce or prevent them. It began to reorganize basic promotive and preventive health activities in the 25km radius around the hospital. The plan was to have all of the major villages form VHCs, identify and prioritize their health problems, identify "animateurs" who would receive training to help them resolve the health problems, and to have the community begin specific prevention and promotion activities.

After the village successfully began its preventive activities, the animateur was trained in the use of a basic stock of five medicines to treat the most prevalent, easily diagnosed and curable diseases. His stock of medicines included:

1. anti-malarials for cure of malaria and prophylaxis in children under 5;

2. a simple first aid kit - for treatment of cuts and burns and an oral rehydration packet (made at the hospital);

3. aspirin for common headaches, pains, colds, etc.;

4. cough syrup - for coughing due to colds; and

5. [illegible] medication and soap.

To date, 20 VHWs are in training from 10 villages. Ten animateurs already have compelted training and are functioning effectively in their villages. In 8 out of 10 villages, the VHWs work without regular monetary compensation, receiving only the rewards of increased esteem and status as well as occasional traditional gifts (chickens, food) from their fellow villagers. In the 2 remaining villages, the VHC has voted them a small monthly stipend out of the proceeds fo the sale of the basic medicines.

Kisantu - This mission has experimented over the last few years with the use of Mama Bongisa and Mama Ntwadisi concepts. These Mamas are mature women who act as a bridge between the health center and the villagers. Their specific functions are to encourage participation in mobile MCH clinics and to insure that the villagers were ready to receive the care that the mobile teams would provide. Both Mama Ntwadisi and Mama Bongisa received only occasionally traditional gifts. To date, there have been 52 Mamas trained in the Kisantu system.

Wembo Nyama - This hospital recently has started its program (January, 1981) under a USAID $50,000 OPG. It is forming VHCs and training VHWs. Four villages already have formed committees and initiated latrine construction and water source protection. Six VHWs have been identified and have begun training. Two of these are traditional midwives. To date, no pro-pharmacies have been initiated, but 4 are planned within the next 3-6 months. Wembo-Nyama plans to expand the system to at least 8 other villages during the next 18 months.

In addition to these hospitals that have trained volunteers, many more have recycled their curative nurses to include public health outreach as part of their job description. These latter hospitals include Kongolo, Kimepse, Vanga, Kinkonzi, Nsona Bata, and Kamina. These programs have been successful and the project will make possible the extension of this system.

The project will build upon the experiences of the Health Systems Development project (660-0057), which presently is initiating/perfecting similar community outreach activities in the zone of Kongolo. This experience has demonstrated the villager's desire to initiate activities designed to improve their health status. It has demonstrated that:

a) villagers can organize themselves to attack common problems when given information and some guidance; and

b) individual villagers will work part-time without monetary compensation to assist their villages to initiate certain public health interventions.

4. That family planning be an integral part of the project and the ECZ system.

The ECZ medical office has a full-time expatriate nurse/midwife who is responsible for coordinating family planning activities in the ECZ hospitals. This nurse/midwife participated in the PP design. All training activities planned in the project will include family planning as well as the provision of full family planning services in all hospital systems. The project plans to increase the current number of family planning acceptors in Zaire from approximately 25,000 to 150,000. Recently, as a result of a hospital survey, the ECZ medical office estimated that the increase to 125,000 acceptors projected in the PID was extremely conservative. It now expects to reach at least 150,000 women in need. Several ECZ hospitals recently have experssed a strong desire to begin training traditional midwives to deliver family planning services. The Technical Analysis Section discusses in detail the role of family planning in the project.

Other concerns

One concern that was brought up during the PID review meetings in September, 1980, was that the Mission would be supporting and strengthening the missionary system in lieu of reinforcing the GOZ's health structure. As a result of this concern, the Mission has re-examined the approach and has developed a compromise alternative mechanism with the GOZ and ECZ. In lieu of an OPG, which was proposed in the original PID, the Mission now is proposing a bilateral USAID/GOZ project. The ECZ will be the grantee's implementing agent. The parameters within which the ECZ would operate as the implementing agent of the GOZ are to be itemized in a Memorandum of Understanding. The project now includes both GOZ and ECZ managed hospitals. This approach has been accepted by the GOZ and ECZ.

This project will permit the GOZ Central Planning Unit and the medical directors of the participating hospitals, the majority of whom are Ministry of Health civil servants, to participate in all phases of project planning, implementation and evaluation. A more detailed analysis of the GOZ role in the project is presented in the Detailed Project Description.

TABLE I

Item	Replacement Parts	Maintenance	Yearly Cost	Total Yearly Estimated Cost for GOZ Managed Hospitals & Health Centers (35)	Total Yearly Estimated Cost for ECZ Hospitals & Health Centers (235)
Baby Scales	Cloth strap for holding children	Replacement of strap every two years	Z 3.00 per scale	Z 105	Z 705
Microscopes	a) slides & coverslips	Replace broken slides/coverslips	Z 50.00 per microscope	Z 1,750	Z 11,750
	b) stains	Replenish	Z 100.00 per microscope	Z 3,500	Z 23,500
Syringes	Replace		Z 200.00 per health center	Z 7,000	Z 47,000
Needles	Replace		Z 100.00 per health center	Z 3,500	Z 23,500
Thermometers	Replace when broken		Z 30.00 per health center	Z 1,050	Z 7,050
Kerosene Refrigerator	a) replace wicks	Clean entire system	Z 60.00 per refrigerator	Z 2,100	Z 14,100
	b) provide kerosene		Z 100.00 per refrigerator	Z 3,500	Z 23,500
Kerosene Burner	None	Provide kerosene	Z 30.00 per burner	Z 1,050	Z 7,050
Copying Machines	Paper	Maintenance contract	Z3,000.00 per machine	Z -0-	Z 6,000
Mimeograph Machines	Paper	General maintenance	Z 500.00 per machine	Z -0-	Z 2,000
TOTAL				Z23,555	Z166,155

TABLE II

Estimated Annual Recurrent Costs (Zaires) for Vehicles and Bicycles

Item	Maintenance/Spare Parts	Fuel[1/]	Total Each	Number/ Cost	Number/ Cost
4-wheel drive 3/4-ton diesel pickup	5,000	5,750	10,750	7 75,250	43 462,250
motorcycles	1,000	1,200	2,200	15 33,000	85 187,000
bicycles	100	-0-	100	75 7,500	425 42,500
TOTAL				115,750	691,750

1/ 5,000 liters x Z1.15 per liter for a total of 20,000 Km/yr of travel.

PART II PROJECT BACKGROUND AND DETAILED DESCRIPTION

A. Background

Health Background

Zaire's total population is estimated at 30 million. This makes it the most populated nation in Central Africa and the fourth most populated nation on the continent. The present crude birth rate is 46 per 1,000 and the crude death rate is 19 per 1,000. This results in an annual population growth rate of 2.8 percent. This means that the population of Zaire will double in 25 years and will have passed 48 million by the year 2000. If current trends continue, Zaire could overtake Ethiopia and become the third most populated nation in Africa by the year 2000.' Just keeping pace with the increased demands of the population for minimal health services would require real budget increases of at least 2.5 percent. Based on performance in recent years, this has not happened, nor is there evidence to suggest that it will happen in the foreseeable future, given the budget restrictions imposed by the International Monetary Fund.

As in many LDCs, Zaire has many endemic disease which account for much of its morbidity and mortality. Among these are malaria, measles, intestinal parasitism (hookworms, ascaris, amoebae), tuberculosis, schistosomiasis, and whooping cough. As a result of (or cause of) these, malnutrition is also widespread. The Nutrition Planning Center (CEPLANUT), developed through the collaboration of the GOZ and USAID, estimates that 50% of the morbidity and mortality of the Zairian population can be directly attributed to malnutrition. Recent studies have shown that, while caloric intake is estimated at 85% of FAO recommended levels, protein intake is only one half of the FAO daily recommended amount. As a result, an estimated 40% of the children under age 5 are chronically malnourished, while 6-10% are acutely malnourished. Kwashiokor is a significant nutritional disease in parts of Zaire.

Malnutrition has its most serious and debilitating effects on infants, children under 5 years of age, and pregnant women. The high rate of premature births and prenatal and infant mortality is strongly related to maternal malnutrition. Moreover, these groups are further assaulted by endemic diseases against which their resistance is low. This results in a cycle which eventually produces a population in chronically poor health. The number one cause of admittance to Kinshasa's Mama Yemo Hospital (national hospital) is malnourished children. Much of this malnutrition is related to birth interval and family size.

In addition to (and largely a result of) the endemic diseases and malnutrition, there is a high maternal mortality rate due to childbirth complications. These also are related to the low level or lack of prenatal care, untrained traditional midwives, unsanitary delivery conditions, close birth interval, parity and maternal age.

As a result of the interacting and interrelated factors of malnutrition and endemic diseases, the most prevalent diseases (malaria, measles, intestinal parasites, pneumonia, and whooping cough), which are not usually considered fatal, are responsible for an estimated 80% of the infant mortality. Currently, this is estimated at 160-200 per 1,000 per year. For most of these diseases, the methods of prevention and treatment are well known yet they are not currently in practice for the majority of the population, especially in rural areas. Two factors that impeded the evolution of an effective GOZ health care system were the political turmoil of the 1960's and the economic problems of the 1970's.

Since independence the GOZ has been attempting, without much success, to continue and expand the colonial system in an effort to reach the majority of the population. It is estimated that the present system utilizes 80% of its budget in the capital and other urban areas, with the result that the current system reaches no more than 15% of the total population with very limited hospital based curative services.

The problems confronting both GOZ and other organizations in Zaire in meeting the health needs of the population are numerous and similar to those of other developing countries. These include a lack of appropriately trained personnel (especially in areas of health education and primary health care management), poor transportation system, limited financial resources (especially foreign exchange), and a stagnating or declining operating budget for the health sector.

In recent years the GOZ has realized that, using the present system, these continuing problems will not permit any further coverage of health services to the Zairian population. As a result, the Department of Public Health has studied several approaches that would permit the Zairian population to have access to at least basic health care without substantial increases in the DSP budget. The GOZ presented the results of this research at the National Health Conference at Nsele in February, 1981. The conference spelled out the major problems in Zaire, the reasons behind these problems, and formulated the GOZ strategy for combatting them country-wide.

The major health problems listed were:

malaria;

protein malnutrition;

intestinal parasites (hookworms, ascaris, amoebae);

measles;

tuberculosis;

diarrheal diseases;

respiratory infections (pneumonia, whooping cough);

anemia;

pregnancy and birth complications; and

other local endemic diseases: trypanosomiasis, schistosomiasis, leprosy, onchocerciasis.

The major causes for these diseases and problems were listed as:

lack of potable water for majority of the population;

lack of environmental sanitation;

lack of global health strategy;

insufficient vaccination coverage;

population unaware of health principles;

poor management of health resources; and

high fertility and inappropriate child spacing.

The basic startegy is to do something at the local rural level, where more than 70% of the population resides. It consists of providing basic care for these preventable diseases. It is the GOZ strategy for delivering health care to all by the year 2000. The matrix below, which depicts health coverage at various levels, was developed by the GOZ and is the accepted general working model for rural health care delivery.

Rural Health Zone			
Level	Facility	Approximate Population Served	Remarks
Rural Health Zones	General Hospital	90,000 to 120,000	Supervises 3-12 Health Centers
Sous-zones	Centre de Santé	10,000 to 40,000	20-40 villages
Communaute de Base (village)	Animateur de Santé Animatrice de PMI	400-1000	

This general model will be modified as needed to conform to local situations and structures.

The goal of the system is to provide the amount of health services necessary at each level with only a small percentage of patients being referred to the next higher level. In practice, the GOZ will concentrate on reinforcing the health centers and the village level VHWs.

It is to this GOZ strategy for providing basic health services and expansion of health care to the rural areas that all health care providers in Zaire will be required to address themselves. It is to the implementation of this strategy that the project will lend its assistance.

The Role of Missionary Groups in Health Care in Zaire

Protestant missionary groups have been active in the health sector in Zaire for over 100 years. The Kimbanguists began somewhat later. The Protestant missions established themselves in the rural areas, while the Catholics have tended to concentrate on the urban areas.

The Protestant mission system presently is strongest in rural areas with a network of 67 hospitals, 500 dispensaries, and some 2,000 employees. While many of these hospital systems are independent in their funding and programming, they have joined together in a country-wide organization for better communication, coordination, and representation with the GOZ in Kinshasa. This organization is known as the Eglise du Christ au Zaire (ECZ) and has its central office in Kinshasa. It is the legal representative of all Protestant church activities in Zaire.

The ECZ hospital system, like all health care systems in Zaire, is a part of the overall national GOZ health system. The GOZ permits certain hospital systems to be managed by the missionaries. Within these missionary managed hospitals, the GOZ supplies nurses, physicians, and laboratory personnel. The state also supplies some medicines and operating costs. The ECZ managed hospital systems supply the much needed management and supervision in addition to training Zairian nurses. Recently, in an effort to more completely Zairianize their staff, the ECZ system has been requesting that recent graduates from the national medical school be assigned to their hospitals to begin taking over much of the work from missionary expatriate physicians. This is being done with an eye to having Zairians become medical directors of these hospital systems. In several missions, such a transformation already has taken place.

The Protestant mission hospital in recent years has become aware of the limitations of their hospital-based curative approach. The dispensaries have served mainly as extensions of the hospital system and have been dispensing medicines in a largely curative mode.

In the past several years a few of the hospital systems have begun to concentrate more on preventive and promotive activities, including family planning. Several additional hospitals have followed, or are attempting to follow, this initiative with their own programs. Most hospitals have accepted this orientation but have not yet begun implementation, and it is to this task that this project can lend some timely assistance.

B. Project History

As noted in the background section, both the GOZ and ECZ have understood the need to do more in health promotion and prevention in rural areas in addition to their hospital based curative services. Various members of the ECZ had been approaching USAID and other donors on a regular basis for assistance with their public health efforts. Although their requests were different in some respects, a definite commonality emerged from these requests. These included:

-assistance with training at various levels for local employees in the management of family planning service delivery and health education;

-assistance with certain commodities for public health outreach, audio-visual materials, bicycles, vehicles, medical equipment, contraceptives, microscopes;

-requests for information on other experiences with outreach and training of volunteer VHWs and traditional midwives; and

-short-term technical assistance.

Many of these requests for mini-projects also shared common desired outputs. Usually, they included the following:

-family planning clinics opened and family planning services initiated in existing clinics;

-latrine construction and water source protection; and

-a health committee initiated and "animateurs" trained and working in the villages.

As a result of these requests from individual ECZ hospitals, the ECZ and USAID entered into a dialogue on the possibility of USAID's funding one large project which would meet the needs of these ECZ member hospitals with their initiation and/or expansion of community health activities. This dialogue resulted in the joint preparation of a preliminary PID-like document for an OPG to the ECZ. This document was delivered to AID/W for review on August 4, 1980.

In the interim period between the PID-like document (OPG) submission in August, 1980, and the AID/W formal cable response in March, 1981, the project environment changed. The GOZ/DSP recognized its limited absorptive capacity and the heavy demands on its system due to the large number of projects already underway. However, by participating in this project the DSP also has recognized that it could gain much needed experience in the provision of primary health care. This was true especially for participant training. As a result of this desire, a dialogue was initiated between GOZ/DSP, ECZ, and USAID which resulted in a modification of the project.

This modification contains the following points:

1. The GOZ, after careful and lengthy consideration, detailed its health priorities and strategy in February, 1981;

2. The GOZ/DSP would nominate a permanent representative to the project advisory committee that would be composed of representatives from USAID, ECZ, and other organizations. This committee would be charged with, inter alia, planning, periodic review, and evaluation of the project as well as the transfer of lessons learned and recommendations to other ECZ and GOZ systems;

3 The GOZ/DSP would be involved in the planning and preparation of the final project document;

4. Although the project would concentrate on ECZ hospitals, also it would include some DSP hospital systems that are ready and capable of initiating a public health outreach program; and

5. The project mode would be a bilateral one between the GOZ/DSP and USAID, with ECZ designated as the major implementing agent.

In addition to these modifications, Peace Corps will participate, subject to availability of funds and personnel, by assigning volunteers to those participating hospital systems that have a need for them. Detailed job descriptions and qualifications for these volunteers will be prepared during the first 90 days of project activities. These volunteers would have the following general project responsibilities in the project:

health education;

training of VHWs and traditional midwives;

logistic support for the pro-pharmacy systems;

technical assistance for the water source protection and a well construction program; and

technical assistance and logistic support for vaccination programs.

C. Detailed Project Description

The project's 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 goal relates to both the GOZ's recent health goal of "health for all by the year 2000" and to USAID's mandate to develop programs to improve the quality of life of the rural poor. It also complements the recent thrust by the Protestant mission network to reorient their services toward presently unserved rural areas.

Project Purpose: The project will attain its goal by assisting GOZ with the development and reinforcement of these elements of the health care delivery system that impact on the most people. These elements are the health center and the VHW. The purpose of this project is to establish a system of self-sustaining community-supported primary health care effectively offering prevention and treatment of the 10 most prevalent public health problems in 50 rural zones. The project will assist the GOZ and ECZ hospital system with the transformation of their current curative dispensaries and health posts into full service prevention oriented health centers as designed in the GOZ national health strategy.

Each health center will serve populations of 10,000 to 40,000. They will be designed to meet the majority of the health needs of the population in each of their localities. The specific services will vary slightly from center to center, depending on local geographic differences, locality specific diseases, and local infrastructure. However, the centers will generally provide the following range of services:

prenatal consultations to instruct mothers on proper diet, care during pregnancy as well as identification of high risk mothers for special treatment;

referral of high risk pregnancies to appropriate facility (health center or hospital);

delivery of normal pregnancies;

surveillance of preschool children;

nutrition education for mothers;

provision of family planning services: pill, IUD, foam, condom, Depo-Provera, and referral for tubal ligations;

general health education;

vaccination of children;

curative treatment of top 10 most prevalent health problems using basic, inexpensive and available medicines. Referral of cases beyond local technical competence;

maintenance of health statistics;

training and supervision of VHWs; and

assist villages in developing health/development committees and sensitizing them to the parameters of public health interventions.

Optimally, the health center will be staffed by a public health nurse, a nurse/midwife, and an auxiliary nurse or sanitarian.

In addition to these services, the center staff will initiate outreach work to the surrounding community. The village development/health committee will be the starting point for this work. The committees will be formed to represent a cross section of the community.

The committee will have the following general functions:

-Acting as a bridge and conduit between the community and the formal health care structure. This bridge will be used by the health center to transmit information on causes of health problems as well as a means for the community to express their needs to the health centers.

-Organizing regular meetings to explain the concept of preventive, promotive health and to obtain consensus and commitment for initiating community activities to address health problems.

-Monitoring and coordinating those activities once commitment and consensus has been reached.

-Assisting the community in selection of a VHW (animateur de sante). There may be one or more per community, including a midwife.

Qualifications for these volunteers will vary, but in general communities will be encouraged to choose someone who:

has respect of the community;

has strong roots in the community and plans to continue to live there;

has already participated in community affairs and has displayed some leadership qualities;

has a thorough understanding of beliefs, customs, and values of the local people;

is willing to devote some time on a voluntary basis to the community;

is literate; and

has a regular means of income.

Once the VHW has been selected by the community, he or she will receive training from the hospital system's staff. It will be simple, direct, and focused on giving an understanding of the causes of the community's health problems and the concrete actions that the community can take by itself to reduce or eliminate these problems. After initial training, periodic retraining will be provided at the VHWs place of residence.

Financing of Health Centers and VHWs

It is planned that as far as possible the health center and the VHWs will be self-financing. The salary of the health center workers will be paid either by the GOZ or the local mission. The planned health centers will be built by the community, with GOZ counterpart funding to provide materials that are necessary but unavailable locally (such as cement for floors and tin roofing, etc.) The basic non-disposable equipment will be provided by USAID funding. (See Annex VII for listing of health center equipment.)

Fixed prices will be charged for services/medicines and these prices will be posted in a prominent place at the center. At the end of a designated time period, usually from 1 month minimum to 3 months maximum, the responsible nurse will use the receipts to replenish the stock of medicines and other disposable supplies. Wherever possible, transport to villages around the health center will be by bicycle, because of the recurrent costs for motorized vehicle operation and difficulty of maintenance at the center level.

Each center will initiate a village development committee in each of the major villages within their area of action. It is planned that the villagers will take the initiative when given sufficient education and information to take some simple action. These will vary village to village, but will generally include:

construction of latrines for sanitary disposal of human excreta;

protection of the village water source;

construction of wells, spring boxes, and protection of other water sources;

elimination of standing pools of water that act as breeding places for mosquitoes; and

sanitary disposal of other refuse likely to attract flies and other vectors.

The Relationship of the Health Center to the Hospital

The health center will be supervised by a zonal hospital. Each supervising zonal hospital will have the following specific responsibilities:

regularly visiting each center and satellite villages to ascertain progress on work to date and assist with technical problems;

verifying accounting receipts for medicines given and insuring that approved tariff is being followed;

periodically retraining center staff at the hospital or the center;

serving as depots and distribution centers for project commodities and pharmaceutical purchases; and

program planning and evaluation.

The project will be undertaken in three time phases with approximately 15-18 hospital centers in each phase. In the first phase, the project will concentrate its activities on 15 hospitals with their dependent health centers, dispensaries and PMIs. These hospitals were selected by the project design team because of their:

1. demonstrated interest in expanding public health outreach work combined with their willingness to realign their present personnel to better meet the needs of the unserved rural areas;

2. capacity to absorb and manage the assistance necessary for this outreach expansion;

3. ability to move quickly into their prepared program in 1981;

4. strength of the basic infrastructure and previous public health outreach experience;

5. capacity to train their own employees, the staff from surrounding systems, as well as representatives from hospital centers who will be participating in Phases II and III of the project.

It is anticipated that Phase I will include the following hospital centers:

1. Nselo
2. Nsona Pangu
3. Kinkonzi
4. Kasangulu (GOZ)
5. Nsona Bata
6. Nyankunde
7. Blukwa
8. Oicha
9. Tandala
10. Karawa
11. Wembo-Nyama
12. Kalonde (Tschikapa)
13. Luiza (GOZ)
14. Kamina
15. Vanga

Phase II will be initiated in 1982. It will consider those hospital centers that will be ready to launch their activities at that time. To date, the following hospitals have been identified as candidates for Phase II:

1. Aba
2. Kajiji
3. Katwa
4. Businga (GOZ)
5. Ime-Loko
6. Tschkadji (Kananga)
7. Kapanga
8. Sandoa (GOZ)
9. Lubao (GOZ)

The remaining hospital centers for Phase II will be selected by on site visits in late 1982.

Project Outputs

The project will realize a series of specific outputs that will contribute to the realization of the project purpose.

I. A functioning system for training of personnel in the delivery of community based health care.

This output includes the following specific training objectives:

	Phase I	Total LOP
Nurse/midwives trained or retrained (professionals)	300	750
Midwives (tradtional) trained	200	400
Physicians trained/retrained	15	50
Community health planners, health educators trained	10	30
VHWs trained	500	1500

Both the ECZ and GOZ are staffed with personnel whose professional training was largely or solely curative and hospital oriented. The training planned under the project will permit the existing staff to broaden their technical capacity to include public health and outreach activities. The basic curriculum for each hospital system will be modified by the participating hospitals to meet local needs.

II. A system for collecting, organizing, and sharing experiences in the ECZ and GOZ system.

At present, inside the ECZ and GOZ health care systems there exists a wealth of information and experience in the provision of primary health care in rural areas. To date, this has not been effectively utilized. The GOZ persently is overhauling its own management information system, with assistance from the Health System Development Project (0057). The Basic Rural Health Project will assist with this. The individual hospital networks that have been working in Zaire for 100 years do not presently have a systemized means for recording their experiences and sharing them with other hospitals or health care providers outside the system.

The Central Medical Bureau of the ECZ is the logical coordinator for this information gathering, organization, and distribution. The Central Medical Bureau of the ECZ will have the following responsibilities in establishing a management information system:

1. The initiation of a systemized method of data collection and processing for routine service statistics. This will be done in coordination with

all participating ECZ and GOZ hospitals. These statistics will include:

morbidity and mortality by cause;

consultations by type;

pharmaceuticals used by type;

employees trained/retrained;

family planning acceptors by method;

children vaccinated;

children receiving malaria chemoprophylaxis;

water sources protected; and

latrines constructed;

2. The production of an annual report for the ECZ member hospitals and for other health care providers. This report will summarize the activities for the previous year with emphasis on experiences, lessons learned and planned activities for the following year.

3. The organization of an annual health conference. This conference will further the information sharing process by permitting members of the ECZ, GOZ, and donor community to discuss on a regular basis certain specific topics which are of timely and global interest. This conference would be organized and coordinated by the ECZ medical bureau with input from member hospitals and the GOZ. In addition to the general objective of information sharing, these conferences would have the following specific objectives:

discussion about GOZ/ECZ collaboration, present and future, in the health sector;

identification of technical problems with recommendation for solving them and needs assessments for specific technical assistance;

evaluation of the role of the ECZ Central Medical Bureau and definition/ revision of its role;

formulation of specific strategies, action plans, policy statements; and

formulation of specific requests to donors for assistance with implementation of these specific startegies, plans.

4. Effective liaison with the donor community. The ECZ Central Medical Bureau will have the unique capacity to present individual hospital needs as a part of a continuing ECZ health care strategy. The central office will be capable of preparing project proposals and of handling project administration and reporting as well as evaluation tasks.

III. Two hundred fifty health centers opened or converted from dispensaries and focusing on preventive, promotive health practices.

The health centers will form the backbone of the health care system. The health centers, in turn, will produce the following specific outputs:

One hundred fifty thousand new family planning acceptors.

Family planning has been accepted by the GOZ as an integral component in the provision of primary health care. The health centers will offer family planning education and contraceptive services to the limits of the technical competence of the center staff. These will provide some contraceptives at the village and will refer clients to the health center or hospital for others. Some centers also will offer IUDs if the nurse has been trained in the provision of this service. The health centers will make hospital referrals for tubal ligations.

At the village level, VHWs will be trained in communicating the advantages of child-spacing and explaining the various methods. They also will distribute some contraceptives. The VHW will refer women desiring other contraceptives to the nearest facility competent to provide them.

Twenty Laparoscopes

At the hospital level, the project will assist the central hospitals in upgrading their contraceptive services to include tubal ligations, via laparoscope and/or minilap.

Three thousand active health committees formed and functioning.

As a result of a well-functioning health center, these committees will extend health services from the health centers to the individual villages.

One thousand five hundred sources protected.

As a result of the health committees formed, the project will construct at least one source in each village.

One thousand five hundred VHWs.

Each health center will train an average of 6 VHWs over the life of the project.

Four hundred traditional midwives trained.

They will be trained in sanitary delivery practices and in the use of the midwife basic delivery kit. Since these women deliver at least 80% or more of the babies in rural areas, this is a necessary part of the MCH system.

One thousand vaccination programs organized in villages.

One thousand pro-pharmacies initiated in those areas where access is difficult to the health center. These pro-pharmacies will be run by the VHW and supervised by the VHC and the health center. The pro-pharmacy will include a stock of the most basic medicines to treat the most common health problems.

Twenty-five thousand latrines constructed.

Project Inputs

Technical Assistance

A. USAID

Up to 48 months of long-term technical assistance and 24 months of short-term technical assistance will be made available to the project. One full-time project manager with experience in community development and in health management will be assigned full-time to the ECZ medical bureau for 4 years. This technician will provide a wide range of advice and planning for mobilizing village support and for retraining health center and hospital personnel. A detailed job description is found in Annex XII.

In addition to the one full-time technician, the project will supply up to 24 PM of short-term assistance. This assistance will be in response to ECZ member hospitals and/or GOZ demands for expertise in the following areas:

data collection and medical information systems;

training in family planning;

training of traditional and modern sector midwives;

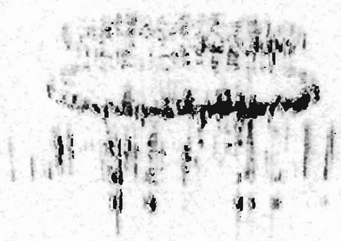
training of traditional healers;

well construction and water source management;

pro-pharmacy initiation and management;

preparation of locally produced films on nutrition and family planning; and

training for nutrition education.



B. Peace Corps

Peace Corps will make available up to 540 PM of long-term technical assistance. Up to 10 volunteers are planned for Phases I and II of the project with an additional 10 for Phase III. Volunteers will be assigned to participating hospital systems and will provide assistance in mobilizing community resources and in training and logistic support.

C. ECZ

The ECZ central bureau will provide the project with a Zairian project director, a family planning specialist, and a logistics coordinator. The project director will be responsible for the overall direction of the project, the liaison between the ECZ Central Office and the member missions. (Detailed job description in Annex XII.) The family planning specialist will be responsible for coordinating the inputs for the family planning/midwife components of the project and will provide technical assistance for training of midwives and outreach workers. The logistics coordinator will provide administrative support in areas of accounting, collection of data, reporting, and community procurement.

D. GOZ

The GOZ Department of Health will actively participate by nominating a representative who will work as counterpart to the Director of the ECZ medical bureau. The counterpart will have the following duties and responsibilities:

act as liaison between the Department of Health and the ECZ and USAID;

represent the GOZ on the Project Advisory Committee;

prepare in collaboration with the Director of the ECZ medical bureau the commodity needs for the participating GOZ hospital systems;

make policy recommendations to the ECZ and GOZ;

assist GOZ participating hospitals with the preparation of their action plans and insure that these plans are carried out;

adapt and disseminate training materials and curricula developed under the project;

identify suitable candidates from GOZ hospitals for training under the project;

assist with the design of the management information system and insure that the system meets GOZ/DSP needs;

insure that training capacity developed by the project is institutionalized in the DSP system;

identify appropriate members of the DSP Planning Unit for participation in specific project activities; and

utilize experience gained in this project to improve the program planning, monitoring, and evaluation of the GOZ's recently delineated rural health strategy.

In the performance of these tasks, it is expected that the GOZ representative visit each participating GOZ hospital system at least once every six months and that a report of each visit be made. The report should include a brief evaluation of progress to date in these hospitals.

Local technical expertise also will be made available through the GOZ's counterpart funding program. This will make maximum use of Zairians already trained and working in their technical field. The areas of technical assistance will include training in family planning, health education, and data processing.

Training

A. USAID

One of the critical needs in the development of any public health program is functional, relevant training for nationals who will plan, initiate, and continue the work after expatriates have terminated their services. As is the case elsewhere in African LDCs, there is a lack of trained manpower in all health specialities.

This is especially true in Zaire for the areas of Community Health, Health and Nutrition Education, and Health Planning/Administration. It is to this critical need that the project will aim its training inputs. USAID will make available long-term out-of-country training (usually 1 year) in these areas for up to 30 participants. Every effort will be made to have this training done in Francophone Africa, in institutions managed and staffed by Africans. The project is exploring the possibility of doing all or most of this training in the recently developed graduate program in public health in Cotonou. The project will make use of these trained nationals on their return to plan, organize and present short-term, in-country training seminars for GOZ and ECZ hospital staff.

In addition to this long-term out-of-country training, USAID will make available short-term out-of-country training to meet specific technical needs of the participating ECZ and GOZ hospitals. These needs will be varied but will probably include water source management, environmental health, epidemiology, health statistics, demography, health and nutrition education, and community mobilization.

B. ECZ

Several of the more advanced ECZ member hospitals will offer short-term training for Zairian employees of both the GOZ and ECZ. This training will

permit representatives of other hospitals to observe and study the successful public health programs developed by these advanced hospitals, with the intention they will plan and implement similar programs as far as possible in their own hospitals.

Commodity Support

The commodity support element of the project is designed to provde those items necessary for the initiation of the activities planned and only those items that are durable (long life without maintenance or simple maintenance) and those items that will serve as a first stock that can and will be replaced by local self-financing, after the project inputs have terminated. The one possible exception to this general principle will be contraceptives which will be supplied on a continuing basis by USAID.

A. USAID

USAID will provide the following commodities over the life of the project. The general commodities include:

1. Vehicles: Up to 50 4-wheel drive vehicles. One each for the major participating hospitals. Each vehicle will permit the hospital to supply, supervise, and train the staff of its outlying network of health centers. In a few cases, motorcycles also will be put at the disposition of the hospitals for this work. Estimated cost of this input is $950,000.

2. Motorcycles: One hundred motorcycles will permit the health centers to visit regularly their outlying villages, to assist the VHWs to supervise/supply the village level pro-pharmacies; and to organize vaccinations and prenatal and preschool consultations. Because of the distance involved, motorcycles will be needed for some of the health centers, while others may only require bicycles. Total estimated cost of this input is $150,000.

3. Bicycles: Five hundred bicycles with luggage racks will be used for outreach by those health centers in close proximity to their target villages, as noted above. Bicycles also will be available for those VHWs who have responsibility for more than one village or who will need to travel to the health centers frequently. Total estimated cost is $150,000 for this input.

4. Other Commodities:

a) Pharmaceuticals - A first stock of basic medicines (see Annex VIII for the complete list) will be made available to the 250 health centers to be opened and/or converted under the project. These medicines will be aimed at the low cost prevention and cure of the 10 most prevalent diseases in the areas served by the project. Actual center stock will vary from region to region, depending on disease patterns. They may also include a few other low cost medicines for other diseases.

The USAID input of a first stock of pharmaceuticals would initiate the self-financing system. In addition to the health centers, USAID input will also make available to the 1,000 volunteer VHWs to be trained under the project a first stock of five basic medicines. These too would vary from region to region. Total estimated cost of this input is $350,000. (Two hundred fifty centers x 1,000 per center plus 1,000 VHWs , $100 per VHW.)

b) Audio-Visual Educational Supplies - All 50 participating hospitals and all 250 health centers will receive a basic set of flip charts, books, posters, training manuals, and in some cases, battery powered slide projectors and slides. Total cost of this input is estimated at $275,000. (Two hundred fifty centers x 750 per center plus 50 hospitals x 1,750 per hospital.) Specific training aids will be responsive to local needs.

c) Contraceptive Commodities - It is planned that AID will furnish on a continuing basis contraceptives for hospitals, health centers, and for the village VHWs. Total estimated cost of this input during the life of the project is $325,000. (Two hundred fifty health centers x $600 per plus 50 hospitals x $1,500 per plus 1,000 VHW x $125.)

d) Medical Equipment - AID will furnish medical equipment to the health centers and VHWs. Equipment is oriented towards examination and treatment of top ten diseases, provision of family planning services, and vaccination campaigns. A detailed list is presented in Annex VII. Total estimated cost of this input is $500,000. (Two hundred fifty centers x $1,900 per plus 1,000 VHWs x 25 per.)

e) Office Equipment - AID will furnish office equipment for the 50 participating hospitals and the ECZ central office. Equipment will include calculators, filing cabinets, typewriters, stencil cutters, copying machines, and miscellaneous office equipment. This equipment will facilitate participating hospitals in the collection and presentation of their data and experience. This will be fed into the central office for compilation and dissemination to other ECZ and GOZ hospitals. The equipment also will make possible the preparation of some visual education aids, training manuals, and curricula for seminars and recyclage programs. Total estimated cost of this input is $75,000. (Fifty hospitals x $1,400 plus 1 ECZ central office $5,000.)

f) Other Costs - AID will fund, over the life of the project, miscellaneous dollar costs. This will include conferences, travel, per diem, construction materials, tools, and spare parts. Total estimated cost of this input is $120,000.

PART III PROJECT ANALYSES

A. Technical Feasibility

The Basic Rural Health Project (660-0086) is appropriate for Zaire at this time. It is consistent with the GOZ and ECZ recently re-emphasized policy and program planning that emphasizes rural development and the improvement of the health status of the rural population through the provision of basic curative and preventive services.

The project proposes nothing new, but helps support efforts to develop and strengthen the two health care elements of the delivery system that impact on the most people. It also reinforces the already accepted concept of self-financed health care. It is consistent with USAID's desire to promote the welfare of the poorest segments of the population, especially women and children. To do this, the project proposes to address the major disease patterns in Zaire by using the most cost-effective strategies of prevention, promotion, and simple cure.

The project follows closely the health sector strategy for Africa that concentrates USAID assistance in the areas of primary health care (health, nutrition, family planning, environmental sanitation), selected disease control programs (malaria, measles), and health planning. Within these general areas of assistance, the project provides training, basic medicines, and medical equipment.

The project supports basic rural health and family planning in the health sector as well as nutrition and agriculture, all high priorities in the USAID Country Development Strategy. The target areas that will benefit from this project are agricultural producing and exporting centers. Improved health status will permit farmers to have more energy for their work and fewer days lost through preventable illness. The result could be increased agricultural production and evacuation to the urban areas.

The Basic Family Health Project will extend improved health services to rural populations by using several key strategies that already have been tested and shown to work in Zaire. One of these strategies is to help villagers help themselves to improve their health situation. This includes:

a) formation of VHCs;
b) use of part-time VHWs;
c) establishment of community operated and supervised pro-pharmacies; and
d) training of traditional midwives.

Techniques such as these have been successfully demonstrated in the hospitals at Nyankunde, Kisantu and Wembo Nyama as discussed in detail in the Project Issues Section in Part I as well as in the data sheets of Annex XIII.

The Basic Rural Health Project also will continue to strengthen the capacity of the GOZ/DSP to plan, monitor, and evaluate rural primary health care programs. The Basic Rural Health Project will do this in the following manner:

- The primary health experiences of the participating hospitals will be jointly studied and evaluated by the ECZ central medical office and the GOZ/DSP Planning Unit.

- The GOZ/DSP Planning Unit will participate through its representative on the Project Advisory Committee in planning and implementation of project activities.

- The GOZ/DSP representative will be directly responsible for all planning, implementation, and evaluation of project activities in the GOZ participating hospitals.

- The management information system to be developed under the project will include both GOZ and ECZ information needs.

- GOZ/DSP personnel will participate in short and long-term training, the project plans to have at least two DSP central office personnel trained at the Masters level in health planning.

The project also will capitalize on the traditional health care system by training traditional healers and midwives in modern techniques. For the majority of illnesses the rural resident often consults first the traditional healer and then the modern health care system. Traditional midwives currently deliver more than 80 percent of the babies born in rural areas.

For initiating these activities at the health center and village level, the ECZ system offers both central administrative support and program accountability. At the same time it permits the individual participating hospitals to design and implement their own strategies for delivering the basic services, taking into consideration the local customs and environment. This is necessary and desirable in a country as large and diverse as Zaire. Thus, the project will have a commonality of objectives with a flexibility of strategy at the local level.

The training component is particularly well tuned to assist the strong ECZ commitment of giving qualified Zairians the technical training needed to prepare them to exercise the planning and directing responsibilities that are presently held by missionary expatriates.

The project also will be poised to take advantage of the household contraceptive distribution research that presently is being pursued by the USAID funded ECZ-Tulane Operations Research Project in Nsona Pangu. This preject is, inter alia, training local village women who will have many of the functions of "Mama Ntwadisi" in the Kisantu system. Such women will have the following specific responsibilities:

- educating mothers on the importance and technique of oral rehydration;

- stocking and sale of rehydration packets;

- educating women re benefits of child spacing and contraceptive methods available;

- stocking and sale of certain contraceptives; and

- referral of women desiring those contraceptives that can only be provided by trained personnel.

The concept of widespread use of village opinion leaders to communicate the advantages of child spacing, as well as for the actual distribution of contraceptives, is consistent with the current ECZ-GOZ philosophy of maximum utilization of local resources. If successful, it will be integrated country-wide by the Basic Rural Health Project.

The project will collaborate with the Endemic and Communicable Disease Project (660-0058) for vaccination program training and for evaluation of malaria chemoprophylaxis program.

Family Planning

Rationale

The GOZ perceives family planning as an integral and necessary part of the delivery of health services. This was recently formally restated in Zaire's presentation on primary health care at the WHO/UNICEF conference at Dakar, Senegal in February, 1981. Other favorable official views and actions on family planning have appeared in speeches by the President, newspaper articles, and in various GOZ health documents.

The provision of family planning services is an essential element of the basic rural health strategy to which this project will lend its assistance.

This approach also is supported by CEPLANUT (the National Center for Nutrition Planning). The center has established that chronic malnutrition in the under 5 age group children in Zaire is around 40 percent while the acute malnutrition rate is six to ten percent. There is an average of two malnourished children in each family. The infant mortality is estimated to be 160-200 per 1,000. In its final report, Tulane University, which provided technical assistance to CEPLANUT from 1978-80, suggested that family planning be integrated into the national health system as the most effective, immediate nutrition intervention.

The basis of this recommendation is that a significant reduction in malnutrition in Zaire must await improved economic conditions, increased agricultural production, a more efficient food distribution system, as well as improved health care. All of these are likely to

take a decade or more to achieve. By contrast, provision of family planning is a relatively inexpensive and simple intervention that could have an immediate impact on family nutrition.

The basis of this recommendation is that provision of family planning services is a simple, relatively inexpensive intervention. Other interventions such as increased agricultural production, improved health and nutrition education, and improved food distribution systems may take a decade or more to achieve.

While reliable statistics are lacking it is estimated that 90 percent of Zairian women enter a stable conjugal condition and begin bearing children between the ages of 15-20. As the Total Fertility Rate is 6.1 it is reasonable to expect Zairian women will bear between six and eight children during their reproductive years. Birth intervals are not known, but it has been established that the traditional child spacing methods -- prolonged breast feeding, enforced abstinence -- are disappearing with a suspected consequential reduction in the time between births. This excessive child bearing, coupled with hard physical labor, generally poor nutrition, food taboos prohibiting protein intake during pregnancy, malaria, and iron deficiency anemia and other diseases endemic to Zaire rapidly break down the mother's health. Availability, knowledge, and use of modern contraceptives to space wanted children and avoid unwanted children markedly improve the health status of women and children.

Contraceptives: Methods, Standards, Supply

At the present time, most contraceptives entering Zaire are channeled through the National Committee for Desired Births (CNND), an IPPF affiliate. Logistics management at CNND is limited and their distribution outside Kinshasa is uneven. Moreover, reporting of family planning statistics from the interior to CNND is irregular and incomplete. FPIA is presently working with CNND to address this situation and to project future contraceptive needs.

The Basic Rural Health Project will rely on CNND for initial stocks, while awaiting arrival of USAID procured contraceptives. Stocks will be delivered to the ECZ hospitals by the Mission Aviation Fellowship (MAF) and their affiliates. The hospitals will then distribute them to satellite health centers and finally to the VHWs. The CNND is presently preparing a detailed inventory of those contraceptive commodities on hand as well as projections for receipt for the next five years. Based on this inventory/projection and the planned contraceptive needs for project activities, ECZ and USAID will prepare a contraceptive commodity procurement plan.

The projected rates of use that follow are based on reasonable expectation of the mix of contraceptives that reflects present rural program patterns. It also reflects possible difficulties in procurement of preferred injectables. Quantities indicated and estimated LOP costs

reflect the fact some hospitals already have stocks of contraceptives and that there will be some initial supplies coming from CNND. The following table presents a conservative estimate of needs that will require yearly review and adjustment.

Contraceptive Users

	1981	1982	1983	1984	1985	Total
New acceptors	5,000	15,000	30,000	40,000	60,000	150,000
Continuing users of pills, condoms, IUDs, injectables	2,500	10,000	25,000	45,000	75,000	75,000
Sterilizations per year (considered continuing users for 5 years)	250	750	1,500	2,000	3,000	7,500

1986 continuing users	75,000
Sterilizations	7,500
Total continuing	82,500

Pill & Condom Needs for the Bilateral Program
Beginning Mid-FY 81

	1981	1982	1983	1984	1985
Pills cycles	100,000	290,000	290,000	390,000	590,000
IUD pieces	2,000	4,500	4,500	6,000	8,000
Condoms	150,000	450,000	450,000	600,000	900,000

The estimated cost for these commodities is $325,000.

The project plans that 150,000 acceptors will be served from hospitals, health centers, and villages. The project does not expect to affect a visible change in the birth rate on a national basis over the next five years. Accordingly an evaluation would not be done on this basis. However, the project will have favorably effected a change in life style through improved health for 150,000 families and will begin the process of fertility reduction in the project areas. Evaluation will be made on the basis of service statistics and contraceptive prevalence increase. Early in the project, a Contraceptive Prevalence Survey will be made. It will include several basic questions on health knowledge and practices as well as on abortion and contraceptive knowledge.

Surgical Contraception

Zairian physicians have been trained by Johns Hopkins (JHPIEGO) at Baltimore and Tunis and have been well satisfied with the program. Institutions also have appreciated the follow-up training for installation of equipment and development of surgical standards. Similarly, client satisfaction generally has been good. Close attention must be given to clarifying hospital standards and insuring that they are followed. In collaboration with the DSP, the medical bureau at ECZ in Kinshasa will draw up standards, based on the AVS and JHPIEGO guides, and will monitor their use. The same will be true for standards of training and conditions of hospitals and clinics where IUDs are inserted. In accordance with AID policy, surgical contraception will be offered only if other contraceptive methods are unavailable and on the basis of voluntary, informed consent.

Contraceptives will be distributed by the VHWs and supplies will be available at the pro-pharmacies. In the training process (described elsewhere) the VHW will receive instruction on identification of counter-indications and will be taught how to use a counter-indication checklist. It is planned that contraceptives will be supplied at a low, subsidized price.

Training

The ECZ arranged for a substantial number of its personnel to participate in international training programs in family planning over the past several years. They have identified 65 persons who are presently working in the ECZ system and available for consultation on training or service delivery. These people have been trained in various skills including surgical procedures, management of family planning programs, organization of maternal child health/family planning programs, and community distribution of contraceptives. Many service providers have also been trained in short courses or on-the-job training in-country.

The ECZ and GOZ are continually updating training their personnel. Presently the director of social services is scheduled to attend the Columbia University health/nutrition/family planning course. One person is scheduled for the University of Connecticut Management Course in May 1981. Two more employees are scheduled to attend the University of Chicago communication workshop. Additional surgeon and surgical nurse training will be carried out by JHPIEGO in 1981. Some emphasis on international training will continue, but the bulk of the training will be carried out in-country. Specifics of family planning training needs will be included in the overall training plan being developed by the ECZ medical bureau.

Information, Education, and Communication

The need for a program in IE and C as a necessary part of the project is recognized. Attention must be given to consciousness

raising at the leadership and community levels, as well as to providing some of the basic health/family planning concepts and techniques for user instruction. This program will be carried out through person-to-person contact and village group meetings at the local level. Posters and signs that stress the visual rather than written messages, will be used. Additionally, radio spots and films in local languages will be used. RENAPEC, the National Radio and Television Network, will conduct this activity. RENAPEC has proven itself capable of producing these materials through its involvement in the media campaign being carried out by the Nutrition Planning Center, another AID supported GOZ health institution.

Other Donor Activities

JHPIEGO, AVS, PATHFINDER, and FPIA are active in Zaire. JHPIEGO has trained a number of physicians in Tunisia and the U.S. in laparoscopic techniques and in other skills. ECZ is constantly seeking additional candidates for this training. JHPIEGO will be asked to step up its activities and to coordinate them with the project, i.e., to select trainees from project sites where conditions permit surgical procedures. FPIA has projects in operation with two more planned. These include introduction of family planning into the trade union system and into nutrition activities of the Nutrition Planning Center. Both organizations have been asked to coordinate their activities more closely with those of USAID.

At this time UNFPA is concentrating primarily on demographic training. However, it will be exploring the provision of family planning services under an MCH program to be designed in late 1981 or early 1982.

Expected Impact

To some, 150,000 cumulative acceptors over the life of project seems an ambitious and perhaps an overly optimistic goal. Indeed, it will require considerable attention to priorities to reach this level. However, it must be recognized for what it is -- just a start. By 1986, this project will be operating in and around 50 hospitals in areas of the country where approximately 12,000,000 Zairians will be living. Although in some way this project could be expected to influence them all, it is reasonable to suggest that some 6,000,000 would live within true geographic access to these programs. Of that 6,000,000, slightly over 1,000,000 will be women of fertile age in union and at risk of conception. In reaching a cumulative level of 150,000 new acceptors, it is expected there will be 75,000 new acceptors in 1986 or only about 7-1/2 percent of the MWRA (Married Women of Reproductive Age) -- approaching the 10 percent level which could be called the start of "building momentum." From a different perspective, in that year there are expected to be 82,500 continuing users of contraceptives or 8.25 percent of the MWRA. One would not expect significant reductions in fertility until these figures reach 20 percent. An optimum level of 65 percent is obviously sometime in the future. Nevertheless, this is a beginning that will

be related to some small reduction in fertility in the area. This level of contraceptive use should also be considered from the point of view of its cost efficiency. One might estimate that less than 1/5 of the cost of the project will be aimed at providing family planning services (about $1,000,000). If, as expected during the course of the project, approximately 158,000 couple years of protection will be provided, this will cost about $6.32/couple years of protection. In this case, the cost for new acceptors (150,000) would be about the same ($6.66). The cost to achieve a continuing user (82,500 at the end of the project) would be about $12. These are all well within accepted standards of costs.

Nutrition

The conditions of malnutrition in Zaire have been well documented in other reports. Suffice it here to repeat the stark conclusion of the final report of a Tulane University team which provided technical assistance to the National Nutrition Planning Center (USAID Project No. 660-0055). "In some of the three areas where CEPLANUT (the National Nutrition Planning Center) has systematically collected data (Kinshasa, Bas-Zaire, Popokabaka), malnutrition rates have moved below 40 percent of children less than five years of age . . . In most sites the average is closer to 50 percent and in some cases even higher." Other reports from the Kivu area show that 12 percent of children are acutely malnourished and 49 percent are chronically malnourished. Approximately 9 percent have kwashiorkor, the highest rate for those African countries that have measured malnutrition.

The GOZ has increasingly come to recognize the pervasive nature of malnutrition and available data strongly suggests the need for broad, far-ranging and very basic economic development actions for the eventual solution of this problem. To reduce malnutrition rates via economic development will take a long time. There is an obvious need for some immediate actions that will mitigate these problems in the short run for those most critically at risk.

The recommendation from Tulane's final report that family planning is a very practical nutrition intervention is one that can be implemented in a short time. This project's actions in expending family planning services will be directly responsive to these concerns.

In dealing with the problem of acute malnutrition, CEPLANUT also views nutrition education as an important and practical means of dealing with the problem within the present constraints. Many mothers neither recognize malnutrition nor know how to deal with it. CEPLANUT encourages education as a broad effort and identifies for its own action several priorities that are relevant to the project:

- continue to support RENAPEC in a nationwide mass media nutrition information dissemination;

- provide extensive support assistance to all levels of the Zairian education system in basic nutrition education; and
- develop and distribute nutrition education modules to ECZ and Catholic education systems.

CEPLANUT has also developed and tested a nutrition course for PCVs which will be given to arriving volunteers.

In reviewing the specific findings of the National Nutrition Center on determining causes of malnutrition, the linkages with the objectives of the project are clear. For example, the center has identified several other variables, in addition to family size, that show a statistically significant relationship to malnutrition. These are:

- the degree to which the mother utilized the health service;
- the amount of knowledge about diarrhea; and
- the amount of knowledge about nutrition.

These are among the strongest relationships found in predicting the incidence of malnutrition. They can and will be dealt with by the project, since

- nutrition education is a strong component of the action planned at the local level;
- diarrhea and its relation to malnutrition can be handled both indirectly through education and directly through household sanitation campaigns, worm medicine, and oral rehydration for severe cases; and
- a major objective of the project is to increase access to the health services, particularly prevention, and especially for mothers and children.

Another linkage with CEPLANUT is the Famine Early Warning System, which provides information on crops, foodstuffs grown, amounts of available food in the marketplace, prices, weather conditions, etc. This will be regularly consulted. Conditions of famine or near famine exacerbate health problems and early notification of approaching famine will be invaluable for participating hospital systems that are affected.

In addition to those actions that were given special attention by the Nutrition Center, the project will reinforce breastfeeding and educate mothers to introduce solid foods at an early age.

Control of communicable diseases and efforts to encourage the development of school, community, and household gardens will also have a beneficial effect on reducing the incidence of malnutrition and the severity of its impact.

Particular emphasis will be given to nutrition education in the training courses of the project. CEPLANUT's experience in preparing

training modules for other entities, as noted above, will be called upon to provide similar materials for the project's retraining activities.

B. Financial Analysis and Plan

The proposed grant financed project is non-revenue producing. The pro-pharmacies will generate some funds which will be entirely reinvested in the continuation of the system. They will not show a profit. While the goal cannot be quantitatively stated in monetary terms, the quality of life will certainly be raised and increased productivity is expected due to a reduction in debilitating diseases. Since the target areas are rural and agricultural producing/exporting, the improved health status should result in an increase of crops produced for local consumption as well as for export to the urban areas.

The recurrent costs of the project will be minimal. The majority of other inputs (training, technical assistance, supervision) will not make substantial, continued demands on future budgets. As noted in the Issues Section, both the GOZ and ECZ should be able to absorb these limited ongoing costs. The project is designed to make maximum use of the human resources that already are at work in the health care delivery system through increased technical competence (training) and basic, non-consumable equipment. Pharmaceuticals will only be provided as a first stock of a self-financing system.

On a larger plane, the project presents the possibility of providing the maximum benefit for the most people at the least cost. This will be done by treating 80 percent of the population's illnesses with a basic stock of simple medicines. In addition, the project will reduce the incidence of the most prevalent preventable health problems by using low cost or no cost environmental interventions. Even if the present system were to receive a quadrupling of the present allocations for health, it could not hope to make a significant impact on the majority of the rural population. To be cost effective, every task should be performed at the lowest level compatible with an acceptable quality of care. The project proposes to do this through the extensive use of village volunteer workers to perform a few basic curative and promotive tasks that will impact on a relatively high percentage of village level health problems. It is estimated that more than 80 percent of consultations at local dispensaries are the result of malaria, various diarrheal diseases, and respiratory complaints. The VHW will be able to deal with at least 60 percent of these with a basic stock of 5 medicines. In addition, the VHW can take action to reduce their absolute incidence.

Table I

Illustrative Budget for USAID Contribution ($000)

	Yr 1		Yr 2		Yr 3		Yr 4		Yr 5		LOP	
TECHNICAL ASSISTANCE	(333)		(135)		(378)		(45)		(45)		(936)	
Long-term	288	(24mm)*			288	(24mm)					576	(48mm)
Short-term	45	(3mm)	135	(6mm)	90	(6mm)	45	(3mm)	45	(3mm)	360	(24mm)
TRAINING			(442)		(321)		(200)		(70)		(1,033)	
Long-term out of country			302	(168mm)	216	(120mm)	130	(72mm)			648	(360mm)
Short-term out of country			140	(40mm)	105	(30mm)	70	(20mm)	70	(20mm)	385	(110mm)
COMMODITIES	(541)		(1,304)		(530)		(400)				(2,775)	
Vehicles	456		494								950	
Motorcycles	30		120								150	
Bicycles	30		90		30						150	
Other (contraceptives, pharmaceuticals, medical equipment, A-V aids, office equipment)	25		600		500		400				1,525	
OTHER COSTS	26		24		25		25		20		120	
TOTAL	900		1,905		1,254		670		135		4,864	

*mm - Man Months

Table II

Illustrative Budget for GOZ Contribution via Counterpart Funds (Z000)

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	LOP
Central Medical Bureau Personnel Expenditures (Total 1,060)						
1) Salary and Benefits for Personnel to be hired for ECZ Central Office and Primes						
a) full time administrative assistant, Z16,000/yr						
b) full time secretary/typist, Z8,000/yr						
c) prime for director of ECZ Medical Bureau, Z8,000/yr						
d) prime for GOZ representative, Z8,000/yr	40	40	40	40		160
2) Short-term contracts or consultancies						
Reproduction and review of training manual, guidelines, special report, etc., surveys and evaluations	200	200	150	150	200	900
Commodities (Total 750)						
Training manuals 25						
Posters 75						
Informational 75						
Road to Health 125						
Library Books 25						
Office Supplies 25						
Building Materials 200						
Local Pharmaceuticals 200	300	300	50	50	50	750

		Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	LOP
Training	(Total 1,975)						
a) Training stage for trainers at hospitals or Kinshasa, 50 trainers x 1 training session yr		50	50	50	50	50	250
b) Hospital based training for physicians, nurses, midwives, village health workers - 15 hospitals x 1 training session yr x 20,000 per session		300	300	300	300	300	1,500
Technical short-term training at selected sites for 15 participants		45	45	45	45	45	225
Other Costs	(Total 3,200)						
In-country travel for ECZ central staff, hospital representatives, GOZ staff, Advisory Committee		300	300	100	100	50	850
In-country costs for five annual health conferences and information campaign		100	100	100	100	100	500
Local transport costs for commodities		100	100	50	50		300
Per diem for local technical assistance, Advisory Committee, and ECZ and GOZ staff		50	100	50	25	25	250
Postage, spare parts, cement		50	50	50	25	25	200
Petrol, oil, lubrication for the first three years of field activities		400	300	300	50	50	1,100
TOTAL		1 935	1 885	1 285	985	895	6 985

TABLE III

Summary Counterpart Fund Budget (thousand Zaires)

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Personnel	230	230	180	180	230	1060
Training	395	395	395	395	395	1975
Commodities	300	300	50	50	50	750
Other Costs	1000	950	650	350	250	3200
- in-country travel - Per diem - seminars - Health Conferences - POL						
TOTAL	1925	1875	1175	875	925	6985

C. Social-Cultural Analysis

1. Social Setting of the Project

Although this project is not directed to any particular social or cultural group in Zaire, it is designed to change institutions and the behavior of those people in and connected to these institutions. Thus, it is important to consider the socio-cultural implications of this project.

Zaire consists of over 200 tribal groups spread over an area the size of the continental United States east of the Mississippi. These tribes can be classified under the three major ethnic groups in Zaire. The Nilotic group is found in parts of Kivu and Upper Zaire. The Sudanic group is found in the northern-most areas of Equateur and Haut Zaire regions. The largest, and most important grouping in Zaire, however, is the Bantu group. This group covers more than 80 percent of the population. In addition, Zaire has four major languages in addition to French. These are Lingala, Kiswahili, Kikongo, and Tshiluba. The three major religious groups are the Catholics, the Protestants, and the Kimbanguists.

Social structures in Zaire vary widely from one tribe to the next. Families in general can be described as being extended. Village and tribal structures range from egalitarian to autocratic chieftain systems. Some of these may be matriarchal, others patriarchal. Some may be single chieftain systems, others may be multiple. Women, in general, have the predominate role in family planning and health care. Men, in general, make the political decisions. However, it is the women who either carry out or decide not to carry out these decisions.

Village volunteerism is not an unknown concept in Zaire. The extended family system includes the notion that there is a sharing of burdens and benefits within the family. "Salongo" is a Zairian tradition that stresses working together for the common good.

Examples of the successful reliance on volunteerism can be found in three Zairian hospital systems at this time. Seventy-two VHWs have been trained in Kisantu, Nyankunde, and Wembo-Nyama. Peace Corps volunteers, as part of the Health Systems Development Project, have found also that individual villagers will work part-time without monetary compenstation to initiate certain public health interventions. In order for volunteerism to work, the following conditions were found to be necessary:

- the village first must form a village health/development community and identify the most serious health problems;
- the proposed VHW must be literate and must continue to reside in the village;
- the volunteer must have a routine means of support and be prepared to spend only a small part of each day on his health promotion activities;
- the volunteer understands he will not be compensated for his services;
- there will be frequent supervisory visits from health center or hospital staff during the first few months of the volunteer's activities;

- the volunteer is remunerated by the prestige that accrues to his new position as well as the occasional traditional gifts for his services.

The ECZ and GOZ have found the village volunteer worker programs to be a feasible means to extend health care to the village.

Innovation and change are not new to the project areas. Before independence, the Belgians, with the help of 100 years of Protestant and Catholic missionaries, had established a health infrastructure that reached almost all villages in Zaire. Thus, most villagers in the project area accept and seek modern medicines, even though they may not have had access to them for a number of years. In the absence of modern medicines, the villagers continue to use traditional rituals and herbs. Some villagers have found that the traditional methods are more effective than so-called modern medicines in treating certain ailments.

The Bantu believe that the survival and the protection of the individual is a continuum. Actions of the extended family are linked to earlier ancestors and to future generations. Thus, illness is not viewed fatalistically by the Bantu. Rather, the Bantu believe that something can and should be done about one's health and that magic, ritual, and medicines can be used to manipulate the spirits and vital forces.

The booklet, La Medicine Traditionelle au Zaire, Fonctionnement et Contribution Potentielle aux Services de Sante, written by a team of Zairian and expatriate anthropologists, makes a number of interesting observations. The study showed that urban people often go first to modern medicine and then have recourse to the healers when they are not satisfied. The villagers, however, often have access only to the healers. The research also showed the "holistic," or psycho-socio-physical approach of the healers is consonant with Zairian beliefs and traditions.

For the purpose of the project, then, it can be said that:

- People are accustomed to injections and will accept them without difficulty. This acceptance is especially important for family planning activities that use depo-provera contraceptive.

- Healers have resorted to medicines for centuries so villagers are prepared to take external medicines.

- Poison potions were once used quite frequently to force out the spirits that cause stomach illnesses. Therefore, modern vermifuge can be used to deal with a number of varieties of hookworm, ringworm, tapeworm, as well as enteritis and forms of amebiasis.

- Traditionally, the village healer has multiple types of treatments against fertility and impotence. Therefore, the villagers will not

find totally alien the concepts of taking the pill to regulate fertility, nor being referred to hospitals for tubal ligations.

- Village hygiene and sanitation, including the construction of latrines and protecting sources of water can be encouraged by appealing to the villagers beliefs in collective welfare.

2. Project Assessment

While this project is designed to deal with the cultural diversity found in Zaire and described previously, this project will capitalize on the common traditions of Zairians.

The project will build upon the traditional health system that is already in place. The ECZ and GOZ hospitals will be the structure upon which the interventions will be built. Both the ECZ and the GOZ concur with project's emphasis on preventive medicine, family planning, nutrition, and hygiene. Midwives presently deliver more than 80 percent of the children born in Zaire. The project will attempt to incorporate these midwives, as well as other traditional healers into the VHCs. Hospital extension workers will train and upgrade these people in their traditional roles. It will be up to these extension workers to interact with the VHCs and allow the village health systems to evolve in the context of tribal mores. In some tribes, health committees can be run democratically. In others, such a mode of operation would be unacceptable, chaotic, and ineffective. Thus, the project reflects sound development methods that call for the evolution of the existing structures, rather than the top-down imposition of new ones.

The project will directly benefit the rural Zairians who will have access to improved health services. Secondary beneficiaries will be the village health workers and other workers who will receive training, equipment with which to do their work. Village health workers especially women will receive an increase in their community status as a result of project activities.

If the project fails, there could be some negative impacts to the project areas. If a dependency on certain modern medicines is created by destroying the mystique attached to some traditional methods and the delivery system of these "modern" medicines breaks down, then the people may be worse off. If supplies and medicines are distributed without proper checks and balances on a regular basis, then the project risks becoming a source of power and profit to the unscrupulous.

In a village around the Nyankunde Medical Center in Upper Zaire, for example, a village chieftain began night inspection visits of family latrines and fining, on the spot, those families that were out of "compliance." Civil authorities were finally brought in to correct this abuse of power by the unpopular chief. However, the chief

retaliated by trying to turn everyone against the health project by saying that it was out to undermine the traditional authorities.

In addition, if the project does not make sure that the medicines are used properly, then the villagers will end up worse off than when they started. Not only might the misapplication of medicines make the villagers sick, but the villagers will be poorer since they must pay for the treatments.

The success of this project is dependent upon many factors. The most important of the social factors previously has been listed as conditions necessary for volunteerism to function in Zaire. In general, the social analysis finds that this project stands a good chance of meeting its objectives, if the project design is followed.

3. Suggestions for Design and Implementation

Since women make most decisions about health care (they fetch water, care for the children, administer medicine at home, grow and harvest food to feed the family, and train children in terms of hygiene and eating habits), there is a need to consider ways of involving women in decisions about priority community health activities and their implementation. Even where traditional social hierarchies suggest male predominance, women need to be involved in VHCs. One possible compromise that would comply with local customs might be to split village health activities according to traditional social groups. For example, men might participate in environmental health projects while women would attend health education and nutrition seminars.

4. Spread Effects

The project includes only fifty GOZ/ECZ hospitals and their surrounding areas. The project does not attempt to cover all of Zaire. It particularly omits areas that are under Catholic supervision. The project will, however, develop training materials and extension methodologies that can be applied to the remaining hospital zones that are not covered in the project. In addition, villages that are in proximity to those that have set up health committees will learn about the project and will, it is anticipated, be able to form health committees on their own. The church systems in Zaire have existed for years and are very stable. They will continue long after the project ends. They, in our judgment, will be able to spread the materials and methodologies that have been developed.

D. Economic Analysis

The project is designed to provide health services to presently unserved and underserved rural areas. This is to be accomplished without a significant increase in the GOZ's budget for health. Since 1974, the general decline in the demand for Zaire's major exports has contributed to the GOZ's inability to increase, in real terms, allocations for public health services.

The GOZ's first priority, at least for the next five years, is agricultural production. This overriding priority, coupled with IMF restrictions on GOZ spending, precludes the likelihood of any near term real increases in GOZ health sector allocations. The project will, inter alia, enable the citizens of Zaire to undertake self-help measures to reduce the levels of morbidity resulting from the most prevalent health problems and to have access to simple treatment on a community supported (self-financing) basis. The project also will permit interventions at the village and health center levels where centrally-funded GOZ resources traditionally have not reached. These interventions are designed to be financed largely by the communities involved and will not require significant increases in the GOZ/DPH budget.

The project will make substantial use of the voluntary labor available in rural Zaire in providing many of these services. The project especially will enlist the services of women, a presently underemployed service resource, to participate as VHWs, traditional midwives, pro-pharmacy managers, members of VHCs, and distributors of contraceptives.

The project specifically will support implementation of the recent GOZ policy decision to move a higher percentage of its health resources to the rural areas. By extending its activities to some 50 rural zones, and working through the two lowest echelons of the health care system, the project will foster a broader distribution of resources than was possible under the previous system.

Alternatives to this project include:

1. assistance to the central hospitals;
2. assistance to combat individual diseases in vertical programs;
3. assistance to the GOZ alone;
4. assistance through the Catholic or Kimbanguist religious mission networks; and,
5. provision of medicines and equipment alone in lieu of technical assistance and training.

Each of these options is discussed below.

1. Assistance to large urban and rural hospitals, with their predominantly curative services, produces a system that treats a relatively few people (normally those within a 25 kilometer radius of the hospital) at a relatively high cost. At present, 80 percent of the GOZ budget for health is absorbed by urban hospital systems, which impact on the health status of no more than 25 percent of the population of Zaire. Hence, this is not an attractive alternative.

2. Assistance to combat specific diseases could be cost effective and be a feasible alternative if the targeted disease or diseases could be eradicated. The smallpox eradication program is an example of the attractiveness of this approach. Unfortunately, present medical technology is not capable of eradicating the ten most prevalent diseases in Zaire. They need to be controlled and treated on a regular basis. This requires a low cost system capable of providing continuing prevention and treatment as required.

3. The DSP already is straining its capacity to directly manage health activities. USAID alone is supporting three other major health projects which are taxing the DSP's management capacity to the limit.

4. The Catholic system, while well-established in the urban areas, is less active in the health sector in the rural areas than the ECZ. Furthermore, the Catholic system generally limits the extent of contraceptive services to the natural methods. The Kimbanguist medical system is relatively undeveloped and serves only a few zones. Its management capacity is limited. ECZ has demonstrated its management capacity, especially in the rural areas where the GOZ system is weakest.

5. Provisions of medicines and equipment alone. Several donors including USAID have done this in the past with poor results. The major constraint to health system delivery in Zaire continues to be a lack of good management and trained personnel.

The project will be able to maintain the flexibility to alter both resource allocations and health strategy at the local level in response to local needs or changes in the health and work environment. The village community and rural health centers, by virtue of their size and constitution, will be better able to adjust to the numerous variables that affect health programs than would be large urban hospitals or vertical disease specific programs.

The VHC system will permit the village and health centers to have immediate feedback on effectiveness, receptivity of interventions undertaken, and modifications that are needed in the evolution of the program.

Thus, the Basic Rural Health Project represents the most feasible means to provide a more effective use of health sector allocations and a broader distribution of services represented by those allocations. Emphasizing prevention and promotion in preference to costly cure, the project will deliver the most care to the most people for the money.

E. Environmental Analysis

The Basic Family Health Project will assist the Zairian population in improving their health status. This will be done by providing training for health workers, general health education for the rural population, and initiation of some basic village level environmental sanitation interventions. The project will also provide some pharmaceuticals and medical equipment for the diagnosis and treatment of the most prevalent diseases.

The impact on the natural environment will be minimal. The specific impacts are as follows:

1. Land Use - The only land use anticipated in the project will be the community plots required to construct a simple building for pro-pharmacies and health centers. The area of these buildings does not exceed 100 square meters and construction will be done by the communities themselves within accepted local environmental practices.

2. Water Quality - The only foreseeable effects of the project will be beneficial protection of water sources. Construction of new wells will serve only to improve the quality and quantity of water for human consumption.

3. Air Quality - The only significant question of air quality will be the possible increase of air pollution due to the introduction of 150 motor vehicles to Zaire. Since these vehicles will be dispersed throughout the rural areas of Zaire where there are currently few motor vehicles, it is reasonable to assume that the project will not adversely affect air quality.

4. Noise Impact - The project is not expected to impact on current noise levels.

5. Cultural Impact - The health education activities of the project will have an impact on traditional theories of disease and their causality. There is no way of avoiding this change in belief, since the change is basic for understanding health problems and for initiating specific interventions. The result is considered worth disturbing these traditional beliefs.

PART IV IMPLEMENTATION ARRANGEMENTS

A. Analysis of the Recipients' and USAID's Administrative Arrangements

The project mode will be bilateral between the Government of the United States represented by USAID/Kinshasa and the Government of Zaire represented by the Department of Public Health. These parties will sign a bilateral project agreement which will name the Eglise du Christ au Zaire as the implementing agent for the execution of this project.

The central Secretariat of the ECZ is the national coordinating agency for the education, medical, evangelical, service and development activities of the 58 official member Protestant communities in Zaire.

The context of the creation of the ECZ was Zairianization and authenticity. The ECZ is run by African church leaders. The legal representatives of the 58 communities, the nine regional bishops, gather in Synod periodically to make important decisions. The Director Generals at the National Secretariat make the daily administrative decisions together with Bishop Bokeleale, the President of the ECZ. The National Secretariat currently has 76 employees. At present there are only six expatriates and they occupy subordinate positions as technical consultants at the National Secretariat. Thus, this project will be supporting a Zairian institution.

The project will build on a successful record of 67 functioning hospital systems, of 30 transport aircraft that serve them, and a reception, customs, warehousing, transport and distribution system that has proven to be quite effective since 1968. The project will contribute ongoing systems that predate it and will continue after it expires. It will reinforce the ability of the ECZ to handle continuing activities after the end of the project. The project will help channel ECZ efforts in a more systematic fashion toward solving problems of primary health care delivery. To carry this out specific action plans must be developed and guidelines articulated.

A main source of expertise for the project and a major responsibility for implementation resides in these cooperating institutions. They will receive project assistance in training and supervision and the start up commodities. The central Medical Bureau level must be strengthened as well to fulfill the coordinating/facilitating role mentioned above, more specifically defined as follows.

1. Specific Responsibilities

a) Financial Management

The Medical Bureau of the ECZ will be responsible for the receipt, expenditure, and accountability for counterpart funds for local costs. These will be expended for specific project needs. The ECZ Medical Bureau will establish a separate bank account, bookkeeping, and reporting procedures and guidelines for participating hospitals. These

procedures will conform to USAID regulations. ECZ Medical Bureau will also be responsible for the preparing of a detailed budget for the expenditure of the counterpart funds to be used. An illustrative budget for each counterpart funded local cost is contained in Part III, Section B of the PP.

b) Development of Work Plan

The PP contains the broad outline, the general objectives, and the types of actions to be carried out under this project. It will be the task of the Medical Bureau of the ECZ, collaborating closely with representatives of the participating hospitals, to develop a detailed action plan and a time frame for its implementation.

c) Development of Training Plan

The numbers and types of service providers to be trained are included in various portions of the PP and in summary form in the input/output section of the logical framework. It is apparent that most of this training will be provided by the participating hospitals. However, some further development of the training plan will be necessary in order to:

- identify the specific hospitals where training for service providers will be carried out and the timing and the approximate numbers by type of trainees;

- identify the institution or training courses where training of trainers and training for supervisors will be carried out, together with timing of courses and the numbers of trainees;

- provide an outline of the subjects to be covered in each type of the various training courses. There should be enough detail so that it is clear that the training is skill-oriented and has adequate provision for practical experience;

- identify the arrangements to be made for the development and reproduction of necessary training materials; and,

- identify the courses and numbers of candidates for long and short-term training outside the country. (Specific nominations will be made later.)

d) Development of Supervision Plan

This plan will identify the expected method and timeliness of supervision. It will spell out who will provide the supervision for what specific purpose at each level. In general it is expected that hospitals will be visited each 3-6 months as needed, and health centers and village health centers will be visited by their supervisors every 1-3 months. Supervision will emphasize technical assistance in family

planning, health education, training and as information gathering for sharing throughout the system. It will provide assistance in problem solving, as well as in the preparation of periodic reports, review of commodity supplies, identification of needs for special assistance, and planning. Each visit to a hospital system will include visits to health center and village levels. Provision must be made to insure that persons who are identified as supervisors are not tied down with other responsibilities that preclude their travel. Adequate financial support must be available to support their travel.

3) Development of Guidelines and Standards

It is recognized that the hospitals included in Phase I already embody many of the skills and experience to carry out the activities contemplated, with little external guidance or instruction. However, a major objective of this project is to draw on their experience, select among the most promising approaches and develop suggested standards to guide the planning and development of programs in other hospitals and public health systems throughout the private and public sector.

For this purpose, the ECZ Medical Bureau, together with administrators of several of the local programs, will develop a series of guides or standards dealing with the following areas:

- Minimum standards of personnel, facilities, and equipment for hospitals to participate in such a program. Observations should be included about the number of outlying posts and villages that can be supervised effectively by a hospital, and the geographic and population coverage each element can serve.

- Guides and standards for training programs for various types of personnel, including subjects, methodology, duration and location of course, and type of instructions.

- Guides for type (specific purposes) and amount of supervision needed.

- Technical guides indicating the several key positive actions needed and the most common errors to be avoided so as to deal most effectively with public health problems such as:

  -household waste disposal (latrines and composts);
  -water supply protection;
  -communicable disease control;
  -malaria treatment and means to determine parasite susceptibility to drugs utilized;
  -tuberculosis;
  -malnutrition;
  -provision of family planning services (include standards for clinical/surgical practice as well as simple instruction/checklist for village workers);
  -intestinal parasite treatment;
  -treatment of diarrhea and use of oral rehydration; and
  -prenatal, obstetric and post natal care (emphasis on actions at the health center and village level).

f) Commodity Management

The ECZ Medical Bureau will develop the detailed lists of commodities and amounts required for project initiation and continuing implementation. Policies will be established for initial supply and restocking of cooperating hospital systems. Pricing policies will be established as well as procedures for inventory control and receipt and distribution of commodities at the various levels of the system. Contraceptive needs will be coordinated with CNND, IPPF, Pathfinder, FPIA, and USAID, reviewing inventories, expected shipments, and planned distribution levels. Attention will be given to special needs for such items as injectable contraceptives that cannot be purchased by this project.

g) Information, Education, and Communication Plan

The Medical Bureau will arrange for the development and reproduction of materials and will prepare a plan of action for an appropriate informational campaign. It will have the following objectives:

- to inform government and private sector leaders, church leaders, and hospital administrators about this program, its objectives and its progress;

- to inform, motivate, and educate service providers so as to facilitate their continuing effective participation; and,

- to inform potential users of the availability and the utility of project services and to provide necessary information to supplement the basic person-to-person information provided by hospital health centers and village volunteer personnel.

h) Service Statistics, Information System, and Biannual Report

The ECZ Medical Bureau will develop an appropriate service statistics reporting process for use throughout the system. It will provide information about the receipt and distribution of commodities at the several levels, on the numbers of personnel trained, the numbers of health centers and village activities established, and the health services delivered. A report of this information, together with a report of supervisory visits performed and general findings, plus a general financial statement, will be provided to the USAID twice yearly. The format for the biannual report will be developed jointly with the USAID in the first three months of the project implementation. An essential element of the reporting system will be an analysis of information received from the hospital and community level and a system of feedback to these reporting levels.

i) Provision of Short-Term Technical Assistance

Short-term consultants and contractual services will be needed frequently at the hospital or national level to provide special technical guidance or to perform special services in such areas as

training, information and education, preparation of materials, surveys or evaluations, and the preparation of special reports. These needs will be identified by the hospitals and the ECZ Medical Bureau. The ECZ will make the appropriate requests and/or contacts and arrange the necessary support services to take full advantage of these consultancies. An initial identification of these needs should be developed soon with the expectation that changes and additions will be made frequently.

j) Evaluation and Review of Objectives

In addition to any external evaluation of the project, the Medical Bureau will develop a simple system of continuing internal evaluation with provision for a yearly reexamination of objectives, coverage targets, and all appropriate elements of the ECZ plan of action.

k) Organization of Advisory Committee

The Medical Bureau will form an Advisory Committee and arrange project financing to defray the costs of participation for the following purposes:

- advise on policy, technical, and legal matters;
- coordinate with other providers of services to share experience, develop mutual support, etc.;
- report findings and conclusions of this experience so other public and private agencies can gain from it; and
- provide a major contact for liaison with the government.

This Advisory Committee will meet twice a year with subcommittees or work groups meeting on an ad hoc basis to deal with special tasks or problems.

The Advisory Committee should consist of, among others:

- the Director General of the service agency of the ECZ;
- a representative of the presidency of the ECZ;
- the Director of the Medical Bureau of the ECZ;
- a representative of the Central Technical Committee of the ECZ;
- one or more technical advisors of the Medical Bureau;
- two or more representatives of local hospital systems;
- a representative of the GOZ Ministries of Health, Education, Agriculture, and Social Services;
- a representative of the National Nutrition Center;
- a representative of USAID; a representative of CNND;
- as available, representatives of WHO, IPPF, Pathfinder, FPIA;
- legal counsel to the ECZ; and
- a representative of the Peace Corps.

l) ECZ Medical Bureau Resources to Fulfill these Functions

As noted, only very limited personnel resources are being added to the project to fulfill a great many new responsibilities. Considerable thought has been given to these possibly conflicting considerations:

- having enough personnel to do a difficult job well;
- not creating a "super organization" within the ECZ which distorts its institutional structure; and
- not developing dependency on an infrastructure that cannot be maintained following termination of external support to the project.

A tentative compromise resolution of these issues involves the following elements:

- although the Director of the Medical Bureau will be only a part-time project director, he can utilize trips, seminars, and contacts made while exercising his other responsibilities so as to serve the needs of this project;

- the addition to the project of a full-time technical assistant for administration and project management and two Zairian staff persons will facilitate project planning and management;

- the addition by the ECZ of a full-time administrative assistant to the central technical group will facilitate improved management of the ECZ;

- a vigorous effort will be made to engage and defray the costs of local hospital administrators as consultants in implementing many functions outlined here under the responsibility of the Medical Bureau;

- extensive use will be made of short-term consultant services and short-term contracts for specific tasks that are the responsibilities of the Medical Bureau; and,

- study will be given to the use of PCVs as appropriate.

The medical office is under the Director General of the service agency. Besides the medical work, the service agency (called DIACONIE at ECZ) includes the warehousing and distribution operation, Zaire Protestant Relief Agency (ZPRA), the central pharmaceutical operations system, the refugee office, the family work institution. The ECZ medical office has direct contact with the 67 hospitals in the ECZ network. It works directly through them. Additional coordination is done by regional medical directors in the nine regions of Zaire. The project will work through the medical office in reaching the hospitals and their network of 500 dispensaries and 2,000 medical personnel.

The medical office that will have the direct responsibility for project execution is presently staffed with the following personnel:

- Citizen Nlaba - Director and responsible for all ECZ medical programs. Diploma nurse with specialized training in management and primary health care and family planning.

- Florence Galloway - Technical assistant for nursing/family planning - nurse/midwife with a specialization in family planning and health education training.

- Ralph Galloway - Technical assistant for planning, administration, and logistics, in addition to education and family planning.

Besides this staff, the project will add:

- one full-time technical assistant for administration and project management;
- one full-time administrative assistant;
- one full-time secretary/typist.

In implementing the project, the ECZ medical office will have the assistance of the following ECZ organizational units:

Protestant Warehousing and Distribution System - ZPRA, begun in 1969, is an ECZ non-profit, tax-exempt church transit logistics agency. It employs two agents at the Port of Matadi and a staff of 15 people, including one American. It has a large warehouse located in the Gombe section of Kinshasa. Project materials may be stored in this facility at cost until shipment upcountry. The ZPRA has a forklife, a five-ton and an eight-ton truck. This is easily accessible to the American Embassy administrative offices, where most of the materials will arrive. The ZPRA warehouse can handle over 1,000 tons of materials. The distribution plan for the project materials calls for duty free arrival of USAID procured commodities, storage at the ZPRA, and shipment upcountry through the Missionary Aircraft Transportation system. The trucks of ZPRA will be used to transport commodities to where the MAF aircraft will depart. Project materials for Upper Zaire and North Kivu will be stored at the warehouse facilities at Nyankunde. Project materials for the Kasais will be temporarily stored at the Institut Medical Evangelique de Kananga (IMEK) while awaiting transport to their final destination. The Protestant mission at Kimpese will serve as the secondary warehouse facility for Bas-Zaire. For Karawa and Tandala and some of the other hospitals in Phase I of the project, direct delivery by air is possible.

Generally the distribution procedure described above is what the Protestant hospital network has been using, particularly for medicines, medical equipment, and vehicles.

The project vehicles will be safely stored at ZPRA until arrangements can be made with the recipient public health center to drive them to their final destinations or shipment by river is made.

Missionary Aircraft Transportation and Distribution System

The ECZ system employs its own air transport system. It consists of a fleet of over 30 aircraft. The MAF is the largest group in the system and covers Bas-Zaire, Kinshasa, Equateur, Bandundu, and parts of Kivu and the Kasais. The Methodists and Presbyterians have their own aircraft in the Kasais and Shaba. Other mission groups also have one or two aircraft. The MAF constitution states the following objectives in the medical sector:

- to ensure transport of medicines to the hospital network;
- to ensure medical evacuations; and,
- to transport medical and missionary personnel.

The aircraft in the interior are based at hospital complexes rather than in the regional capitals. Nyankunde, in Upper Zaire, employs two aircraft. This permits weekly liaison with Nairobi. Nyanga in North Kasai, Vanga in Bandundu, Kimpese in Bas-Zaire, and Karawa in the Equateur are other medical mission stations with aircraft. Project medicines and equipment will be easily transported and project monitoring will be facilitated by this air network. The Church of Christ will be able to take on upcountry and Kinshasa warehousing and distribution of project inputs.

Garage and Repair Facilities

Without further recurrent costs, the ECZ is capable of repair and maintenance for the project vehicles, as well as of managing a considerable stock of spare parts. These parts will be one of the project inputs. ECZ has a fully-equipped garage in Kinshasa, complete with an expatriate mechanic (diesel), a staff of ten Zairian mechanics, and a group of auto mechanic trainees. The garage has good storage space for spare parts and it can handle the repair and maintenance of the project vehicles.

In addition, Nselo, Nsona Pangu, Sona Bata, Kimpese, and Vanga are serviced by a CBZO (American Baptist) garage in Kinshasa with an American mechanic and five Zairian mechanics. Karawa has its own garage which services vehicles from IMELOKO and Tandala. Thus, within the ECZ system, facilities already service the vehicles.

Office Facilities

As part of its in-kind contribution, the ECZ will provide office space for the Zairian project director, the three technical assistants, and two secretarial assistants.

The offices of the project national secretariat will be located at:

ECZ Secretariat
Avenue de la Justice
B.P. 4938
Kinshasa

The project will utilize the following system for the procurement of commodities, payment of salaries, and funding participant training and technical assistance:

a) Local Currency for In-Country Costs - The ECZ Medical Bureau will request that an initial advance from the Ministry of Planning, Counterpart Funds Secretariat be transferred to a separate ECZ project account. Thereupon the account managers may request the ECZ for advances according to programmed activities. Under signature of the Project Director and one technical assistant, funds from the account will be transferred by check, bank transfer or hand-carried to the participating hospital. All recipients will sign for the arrival of the monies and return signed receipts to the ECZ Project Secretariat. As expenditures are justified to the Ministry of Plan and USAID, additional blocks of local currency can be requested. Salaries for the two project local hires will be paid out of this account.

b) Commodity Procurement in Foreign Currency - Standard USAID procurement procedures will be followed. The Project Director and the technical assistant will prepare the documents necessary for USAID procurement. USAID will arrange direct payment to the suppliers per standard procedures.

c) Participant Training - In accordance with established USAID procedures, payment will be arranged directly to the training institutions. Monthly living allowances will be provided directly to the candidates.

d) Technical Assistance (AID Funded via Personal Services Contract) - The USAID voucher system will be used for direct payment to the technical assistant. The USAID/PHO will certify that services have been rendered.

B. IMPLEMENTATION PLAN -- FOR FIRST 18 MONTHS OF PROJECT

Action to be Taken	Responsibility	Date
1. PP approval	USAID	Aug. 1981
2. ProAg signed	USAID/GOZ	Aug. 1981
3. Approval of Personal Services Contractor and Commodity Waivers	USAID	Aug. 1981
4. Arrival of contract technical consultant in Zaire (contract signed)	USAID	Sept. 1981
5. Preparation of PIO/Cs for FY 81, order vehicles, motorcycles, bicycles, and first tranche other commodities	ECZ/PHO	Sept. 1981
6. Setup local currency account	ECZ/USAID	Oct. 1981
7. Request advance counterpart fund for local procurement activities	ECZ/GOZ	Oct. 1981
8. Advisory Committee formed	ECZ/GOZ	Nov. 1981
9. First local seminars/retraining held in participating hospitals	ECZ/GOZ	Dec. 1981
10. First short-term consultant begins work Medical Information System	USAID/ECZ	Jan. 1982
11. Identification of hospitals for second phase	ECZ/GOZ/USAID	Jan. 1982
12. A. Annual ProAg for FY 82 obligation B. Preparation of PIO/Cs for FY 82 funded commodities	ECZ/USAID	Jan. 1982
13. Identification and initiation procedures for first group of long-term participants (out of country)	ECZ/GOZ/USAID	Jan. 1982
14. Identification of short-term participants	ECZ/GOZ/USAID	Feb. 1982
15. Identification planning of in-country re-cyclage courses Vanga, Nyankunde	ECZ	Feb. 1982
16. First biannual meeting of Project Advisory Committee	ECZ	Mar. 1982
17. Biannual report	ECZ	Mar. 1982
18. Short-term experts arrive for work	ECZ/USAID	May/June/ July 1982
19. Data collection system tested	ECZ/Short-term tech. assistant	July 1982
20. First group of participants leave for long-term training (Cotonou)	ECZ/USAID	Aug. 1982
21. First evaluation	ECZ/USAID/GOZ	Sept. 1982

Action to be Taken	Responsibility	Date
22. Second meeting of Advisory Committee	ECZ	Sept. 1982
23. Second biannual report	ECZ	Sept. 1982
24. First Annual Health Conference	ECZ/GOZ	Nov. 1982
25. A. Amend ProAg for FY 83 obligation	USAID	Jan. 1983
B. FY 83 commodities ordered	USAID/ECZ	Jan. 1983

C. Evaluation Arrangements

The evaluative process will be integrated into the activities of the project from the outset. It will serve as a guide for ongoing programming as well as a reference for future changes or modifications in project direction.

The elements of the evaluation strategy will be program specific, relate to the quality and status of outputs, indicate program relevance and verify scheduled activity completion.

In view of the importance attributed to evaluation and continuous monitoring to help make a more effective use of scarce resources, as well as to assure that funds, personnel, equipment, and commodities are used in accordance with the project agreement, all assessments will be collaboratively structured and executed. That is, all participating entities will be involved in the process from start to finish. The evaluation and monitoring strategy, including inventory schedules, will evolve from a series of joint meetings between GOZ, ECZ, and USAID.

Project assessments will fall into two categories: periodic formal evaluations with the participation of qualified outside observers, and routine, continuous monitoring for management by objective.

The initial formal evaluation will review project purpose against objectives and targets to assess the appropriateness of those targets as steps toward the achievement of the purpose. The first year's project experience will be reviewed as a guide to any restructuring indicated to assure attainment of purpose. This evaluation will be conducted jointly by USAID and project management (GOZ/ECZ).

The second evaluation is scheduled for mid-point in the project (approximately March 1984). The main purpose of this evaluation will be to prepare an in-depth assessment of project achievements to date and a correlative prognostication of end-of-project status of the multiple component activities. This evaluation will employ the services of health care experts to be recruited for the purpose.

The third evaluation will be conducted shortly before project conclusion (approximately June, 1986) to record lessons learned, identify replicable

project activities, assess cost effectiveness, and recommend future AID-assisted undertakings in the health sector. The evaluation team will include professionals capable of fully assessing the import of the project.

In addition to these formal exercises, the project will build in an ongoing review and monitoring capability. Staff from GOZ, ECZ, and USAID will make periodic trips to project sites for the purpose of examining and affirming performance targets, progress made, and general management considerations.

The project evaluations will look at, inter alia, the following purpose indicators:

1. A functioning system for training personnel in the delivery of community based health care.

Measure - trainers, curriculum and educational materials in place and operational.

Activity - visit training centers to review and record content, length of courses; monitor registration and medical records; examine pre and post-course results; visit graduates to ascertain the relevance effectiveness of course materials as well as of instructional techniques.

2. A system for collecting, organizing, and sharing experiences in the GOZ and ECZ system.

Measure - informed personnel throughout the health system.

Activity - make periodic visits to project sites for interviews; send out infrequent questionnaires to solicit mass feedback; inspect records at central level.

3. Two hundred fifty health centers opened or converted from dispensaries and focusing on preventive and promotive health practices.

Measure - beginning of project status compared to end of project status or time of evaluation status using planned figure as a guide.

Activity - review end of month status reports at central level, as well as make periodic visits to designated areas.

4. One hundred fifty thousand family planning acceptors.

Measure - registered recipients at village level, health centers, hospitals.

Activity - periodic visits to above agencies to check records.

5. Twenty laproscopes installed.

Measure - instruments in place and functioning.

Activity - periodic visit to hospitals to view procedure and interview clients to determine their satisfaction.

6. Three thousand active health committees formed.

Measure - registered groups.

Activity - inspect health center records; visit random sample of villages for confirmation of existence as well as effectiveness.

7. Fiftenn hundred water sources protected.

Measure - numbers of water sources registered at villages and health centers.

Activity - periodic visit to village sites.

8. Fifteen hundred VHWs trained.

Measure - beginning of project status measured against end of project or percentage of total at time of assessment.

Activity - review end of month reports of health centers; as well as make periodic visits to health centers and villages for record assessment.

9. Four hundred fifty traditional midwives trained.

Measure - beginning of project status measured against end of project or percentage of total at time of assessment.

Activity - review end of month reports of health centers; as well as make periodic visits to health centers and villages for record assessment.

10. One thousand vaccination programs organized.

Measure - prevalence, incidence, and contact records.

Activity - review records at central and appropriate agency levels; field visits for verification.

11. One thousand pro-pharmacies initiated in areas not served by health centers.

Measure - personnel, materials in place.

Activity - visit select sites and verify health center and hospital records.

In addressing the impact of project activities on morbidity and mortality, three representative areas will be selected during the first year to serve as tracers of project impact. In each a comparison and experimental group will be identified and a survey carried out to measure nutritional status, diarrheal disease prevalence, and Health Knowledge, Attitudes and Practices. In addition, information will be collected on:

- village perceptions of VHW;
- availability of traditional health workers in the community; and,
- current health services utilization patterns and costs to each family.

This initial survey will be analyzed independently and quickly in order to provide basic data useful in project planning. Approximately 750 (325 comparison, 325 experimental) individuals will be interviewed in each of the two or three sites. The project will use personnel recruited from the site plus trained field supervisors from CEPLANUT and/or the university. Outside technical assistance in sampling, questionnaire design, and data analysis will be used as needed. In the final year of the project, this survey will be repeated and the comparison and experimental populations examined for differential effects. In combination with the Management Information System the survey will provide inputs to outgoing project activities and overall evaluation.

In addition to the assessment of these planned indicators, the project also will accumulate reference materials in response to some of the more universal questions regarding VHWs. These will cover such areas as:

- village perceptions of VHWs;
- the role of volunteerism in a health delivery system;
- VHW attrition rates and causes considering demographic, economic, and social variables;
- education background and success of VHWs;
- optimum scope of work for VHWs;
- limits of community action of VHCs;
- most effective selection procedure for VHWs;
- minimum and maximum costs in training, retraining, and supervising VHWs;
- social status and frequency usage of VHW system;
- role of traditional medicine in delivery of community based health services; and
- optimum curriculum and training time for VHWs.

The project will assist the GOZ DSP Planning Unit by providing feedback on a number of specific problems facing Zairian health care providers.

One problem that will be considered by the project will be the effectiveness of chemotherapy and chemoprophylaxis for malaria. The latter is especially important for the project's planned distribution of malaria suppressants to children under age five.

Another area of concern is the possibility of parasite resistance to anti-malarials as a result of widespread prophylactic chemotherapy. The project will consider, in collaboration with the Endemic Disease Control Project (0058) and other organizations parasite sensitivity testing.

ANNEX I. LOGICAL FRAMEWORK

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Assumptions
A.1. Goal To improve the health status of the rural population by increasing the proportion of rural Zairians that have access to basic health services.	A.2. Measurement of Goal Achievement -Infant mortality and child mortality rate reduced by 20% in project areas. -Mortality due to measles and neonatal tetanus reduced 50% in those areas served by hospitals. -Births reduced by 5% in project areas.	-Sample surveys -Review of death records -Review of birth records	Political stability continues. Economic situation does not worsen. There are no famine, draughts, or other natural disasters.
B.1. Purpose 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.	B.2. EOPS -System offering basic prevention and cure for diseases in place and functioning on a self-financing basis.	-Reports -On site visits -Sample surveys	ECZ system continues current level of support to health sector.
C.1. Outputs A well functioning instutionalized system of retraining low and mid-level workers in the delivery of community based primary health care. A system for collecting, organizing and sharingthe experiences of ECZ and GOZ hospital systems in the provision of primary health care. 250 Health Centers opened or converted from dispensaries following the GOZ Nsele Model.	C.2 Output Magnitude 250 Family Planning clinics opened 150,000 new acceptors in Family Planning 250 MCH Clinics opened/converted 1,000 vaccination programs in villages 750 nurses trained/retrained 50 physicians retrained 3,000 health committees formed and active 500 wells dug 1,500 water sources protected 30,000 latrines constructed and in use 20 leprascopes installed and in use 1 data collection system (service records) installed.	-Reports - Field visits/persons fulfilling jobs - Review of dispensary records and planning records - Interviews with village committees	GOZ policies on Family Planning does not change. ECZ hospitals are permitted to expand their program as planned. Project inputs are provided in a timely fashion. Villagers will be motivated to undertake latrine and water source construction

D.1 Inputs	D.2 Budget	D.3 Assumptions
I. AID (dollars U.S.)		
A. Technical Assistance - One (1) LT - Technical Advisor for four years (48 MM) at 12,000 MM	(936,000) 576,000	Project receives funding at requested levels
- Short term technical advisors (24 MM) at 15,000 per MM	360,000	Specialists with necessary skills identified, recruited
B. Training	(1,033,000)	
LT Academic Training (1 yr.) at Masters level outside country in Health Education, Health Administration for 30 (360 MM) at 1,800 per MM	648,000	Appropriate waivers granted
ST Academic Training outside country for 55 (110 MM) at 3,500 per MM	385,000	Qualified candidates identified available for training
C. Commodities	(2,775,000)	
50 4-wheel drive vehicles at 19,000 ea with spares	950,000	
100 motorcycles at 1,500 ea with spares	150,000	
500 bicycles at 300 ea with spares	150,000	
Audio-visual supplies (projectors, flipcharts, books)	275,000	
Contraceptive commodities for 150,000 acceptors	325,000	
Pharmaceuticals for 250 Health Centers and 1,000 village health workers	350,000	
Medical equipment (examining tables, Ob-Gyn materials, microscopes, scales, freezers and refrigerators)	500,000	
Office equipment (copying machines, stencil cutters, mimeograph machines)	75,000	
D. Other Costs		
Foreign exchange costs in connection with conferences, travel, per diem, other misc. costs, transport, seminars, construction costs, cement, tools, pumps, spare parts	120,000	
Total AID	4,864,000	
II. ECZ (Central Organization) - (Equivalent in dollars U.S.)		
A. Technical Assistance - 1 Project Director (part time) 1,650/yr x 5 yrs. (30 MM)	24,750	
- 1 Family Planning Trainer/co-ordinator (60 MM) 16,500/yr x 5 yrs.	82,500	
- Operations Officer/Logistics Coordinator (60 MM) 16,500/yr. x 5 yrs.	82,500	

B. Office space in Kinshasa - $3,300 yr/for 5 yrs.		16,500
C. Salaries support costs of ECZ staff in 50 hospitals to support project		2,589,000
	Total ECZ	2,795,250
III. GOZ (Zaires)		(8,595,000)
A. Counterpart Funds Total		(6,995,000)
A1. Personnel		
A2. Commodities		
A3. Training		
A4. Other Costs		
B. Direct Budget Support		
B1. Personnel - salaries for DSP Kinshasa project representative; salaries for personnel in GOZ participating hospitals; support costs for GOZ participating hospitals		1,600,000
IV. Peace Corps (dollars U.S.)		
Subsistence, training and support costs for 540 MM of volunteer services		350,000

1,000 pro-pharmacies installed and operating on a self-financing basis
15 health educators trained at Masters level and working in their field
15 health planners at Masters level trained and working in their field
5 National Health Conferences held ✓
5 Comprehensive annual reports (ECZ) ✓
400 traditional midwives trained ✓
2 health education/family planning films produced
? 5,000 rural villages benefiting from health services / ? 3000 H. committees.
4,000,000 total population benefiting directly or indirectly
? 1,500 village health workers trained
? 50 mobile medical teams initiated/(supervision) expanded
12 classrooms constructed

ANNEX 1. LOGICAL FRAMEWORK

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B.1. Purpose	B.2. EOPS		
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.	-System offering basic prevention and cure for diseases in place and functioning on a self-financing basis.	-Reports -On site visits -Sample surveys	ECZ system continues current level of support to health sector.
C.1. Outputs	C.2 Output Magnitude		
A well functioning instutionalized system of retraining low and mid-level workers in the delivery of community based primary health care. A system for collecting, organizing and sharingthe experiences of ECZ and GOZ hospital systems in the provision of primary health care. 250 Health Centers opened or converted from dispensaries following the GOZ Nsele Model.	250 Family Planning clinics opened 150,000 new acceptors in Family Planning 250 MCH Clinics opened/converted 1,000 vaccination programs in villages 750 nurses trained/retrained 50 physicians retrained 3,000 health committees formed and active 500 wells dug 1,500 water sources protected 30,000 latrines constructed and in use 20 laprascopes installed and in use 1 data collection system (service records) installed.	-Reports - Field visits/persons fulfilling jobs - Review of dispensary records and planning records - Interviews with village committees	GOZ policies on Family Planning does not change. ECZ hospitals are permitted to expand their program as planned. Project inputs are provided in a timely fashion. Villagers will be motivated to undertake latrine and water source construction

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A4. Other Costs		
B. Direct Budget Support		
B1. Personnel - salaries for DSP Kinshasa project representative; salaries for personnel in GOZ participating hospitals; support costs for GOZ participating hospitals		1,600,000
IV. Peace Corps (dollars U.S.)		
Subsistence, training and support costs for 540 MM of volunteer services		350,000

Annex II
The Church of Christ in Zaire

The Church of Christ in Zaire is the National Protestant Church and is one of the three National churches officially and legally recognized by the Government of the Republic of Zaire.

These three churches, the Roman Catholic Church, the Church of Christ in Zaire, and the Kimbanguist Church, work closely with the GOZ for the development of the country and the Zairian people. Since the churches are located in Zaire, their goal is to help the people by working closely with the Zairian government.

The GOZ helps the christian churches in Zaire in many ways: by granting land for the construction of church buildings, schools, hospitals and other service centers. The GOZ facilitates the entry into the country of material needed for development and social services of the church. The Zairian government provides subsidies for schools and hospitals. It gives the churches many responsibilities for participation in the moral, spiritual and material development of the Zairian people. The three churches participate modestly but effectively in the development and well-being of the people.

The Church of Christ is made up of 58 Protestant communities which began work in 1878. Today the church is composed of: more than eight million members -- 58 communities (former denominations and missions); 11,220 parishes; 7,784 ministers with bible school training; 1,117 foreign fellow-workers; 9 Zairian bishops.

Throughout the country, the Church of Christ in Zaire has 67 hospitals, five-hundred dispensaries, and several development projects.

There is a national secretariat in Kinshasa. The supreme body of the church is the National Synod, which meets every two years. Between the national synod meetings, national issues are dealt with by the National Executive Committee. There are nine regional synods, with a regional president in each region. Each one of the 58 communities has a legal representative as its head. There is one Theological Seminary on the university level, and five theological institutes for the training of pastors.

Relations are good between the three sister churches, Catholic, Protestant, and Kimbanguist. In several areas activities are coordinated in order to participate in working for the well-being of the Zairian people.

The national secretariat of the Church of Christ in Zaire is organized as follows:

1. The Presidence

   Bishop Bokeleale, President and legal representative

   Dr. Marini Bodho, Vice President

   Rev. Kakule Molo, Director of the Presidence Department

2. Accountant, Citoyen Mavinga Dubu

3. Central Technical Committee

   Citoyen Kazadi, Director, and Secretary of Projects

   Citoyen Mbenga, motivation and research, and training

   Citoyen Dr. Kabeya, Communications

   Mr. Wilke, Architect

   Mr. Jaoudas, agronomy

   Mr. Franz, garage

4. Information Department, Citoyen Musene

5. Education, National Coordinator, Citoyen Bosunga

6. Evangelism Department, Rev. Muzaba, Director

7. The Life of the Church, Rev. Muludiki, General Secretary

8. Chaplaincy, Zairian Army, University Campus

9. General Services Department (Diaconie)

   Citoyen Mbualungu, General Secretary

   CEPAM, Medical Supply Center

   ZPRA, Importing, customs, and transport service

   Refugee Service

   ADF (Action Diaconal et Familiale)

   Medical SErvice Coordinating Office, Citoyen Nlaba, Secretary

There are more than 2,000 medical and paramedical personnel registered with the ECZ. They are as follows:

57 Zairian physicians

45 expatriate physicians

2 expatriate pharmacists

6 Zairian pharmacists

51 nurse midwives (expatriate)

4 nurse midwives (Zairian)

235 nurses, 140 of whom are Zairian

961 auxiliary nurses, of which 946 are Zairian

3 Sanitary agents, two of whom are Zairians

44 Lab technicians

1 radiologist (an expatriate)

1 physiotherapist
250 nurses aides and assistant midwives
400 other employees in health sector

The expatriates are paid by their sponsoring churches outside Zaire and the Zairian personnel are paid by local receipts.

To date the GOZ has put 55 Zairian physicians at the disposition of the ECZ. They have been appointed to the following hospitals:

Methodist Hospital at Kapanga, Shaba, 4
IME Kimpese, Bas-Zaire, 3
IMCK Tshikaji, West Kasai, 3
Methodist Hospital at Wembo Nyama, East Kasai - 3
C.E.U.M. Hospital at Karawa, Equator - 2
Menonite Community of Zaire Hospital at Kalonda, West Kasai - 2
C.F.G.G. Hospital at Kasaji, Shaba - 2
Disciples of Christ Hospital at Lotumbe, Equator - 2
C.M.E. Nyakunde, Haute Zaire - 2
C.B.Z.O. Hospital at Nsona-Mpangu, Bas-Zaire - 2
Swedish Baptist Hospital at Bosobe, Bandundu - 1
Presbyterian Hospital at Bulape, West Kasai - 1
C.E.B.Z.O., Kivu - 1
C.E.Z.O - Hospital at Kaziba, Kivu - 2
C.E.Z. Hospital at Kibunzi, Bas-Zaire - 1
C.B.Z.O. Hospital at Kikongo, Bas-Zaire - 1
C.E.A.Z. Hospital at Kinkonzi, Bas-Zaire - 1
Swedish Pentacostal Hospital at Lemera, Kivu - 1
I.M.E. Loko, Equator, - 1
Region of Sankuru Community Hospital at Loto, East Kasai - 1
Presbyterian Hospital at Lubondai. West Kasai - 1
Presbyterian Hospital at Luebo, West Kasai - 1
Disciples of Christ Hospital at Mondombe, Equator - 1
Disciples of Christ Hospital at Monieka, Equator - 1
Menonite Community of Zaire Hospital at Mukedi, Bandundu - 1
Presbyterian Hospital at Mutoto, West Kasai - 1
Menonite Community of Zaire Hospital at Ndjoko-Punda, West Kasai - 1
C.B.Z.O. Hospital at Nselo - 1
Menonite Community of Zaire Hospital at Nyanga, West Kasai - 1
B.B.F.Z. Hospital at Pimu, Equator - 1
C.E.B.Z. Hospital at Pinga, Kivu - 1

C.B.Z.O. Hospital at Sona-Bata, Bas-Zaire - 1

C.B.C.U. Hospital at Tandala, Equator - 1

Methodist Hospital at Tunda, Kivu - 1

C.B.Z.O. Hospital at Vanga, Bandundu - 1

C.B.F.Z. Hospital at Yakusu, Haut Zaire - 1

E.E. Z. Maternity of Kingoyi, Bas Zaire - 1

Menonite Community of Zaire maternity at Mutena, West Kasai - 1

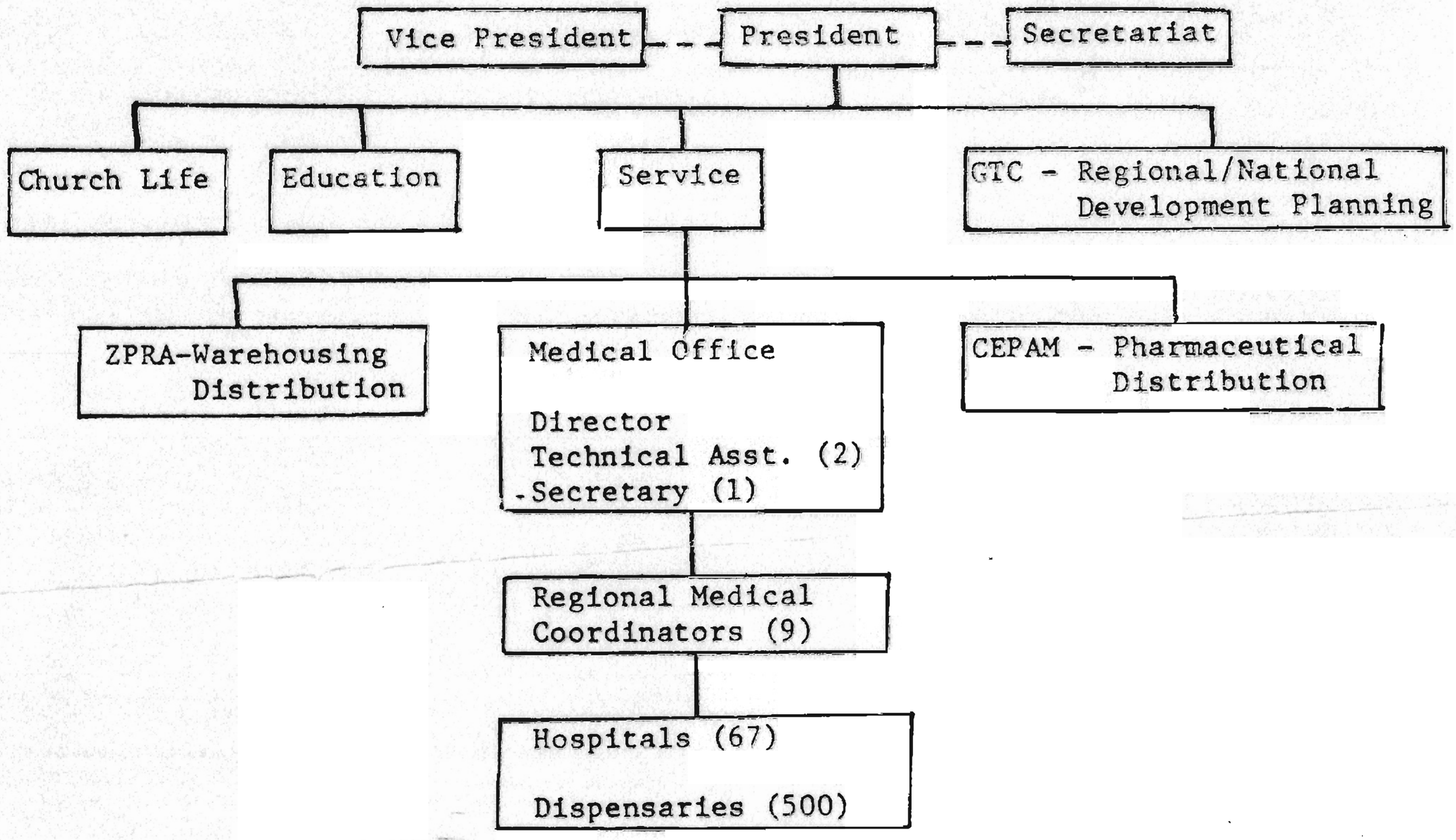
C.B.F.Z. Maternity at Tondo, Equator - 1

The medical work of the Church of Christ in Zaire is not only recognized by the GOZ but has been subsidized by the GOZ as follows:

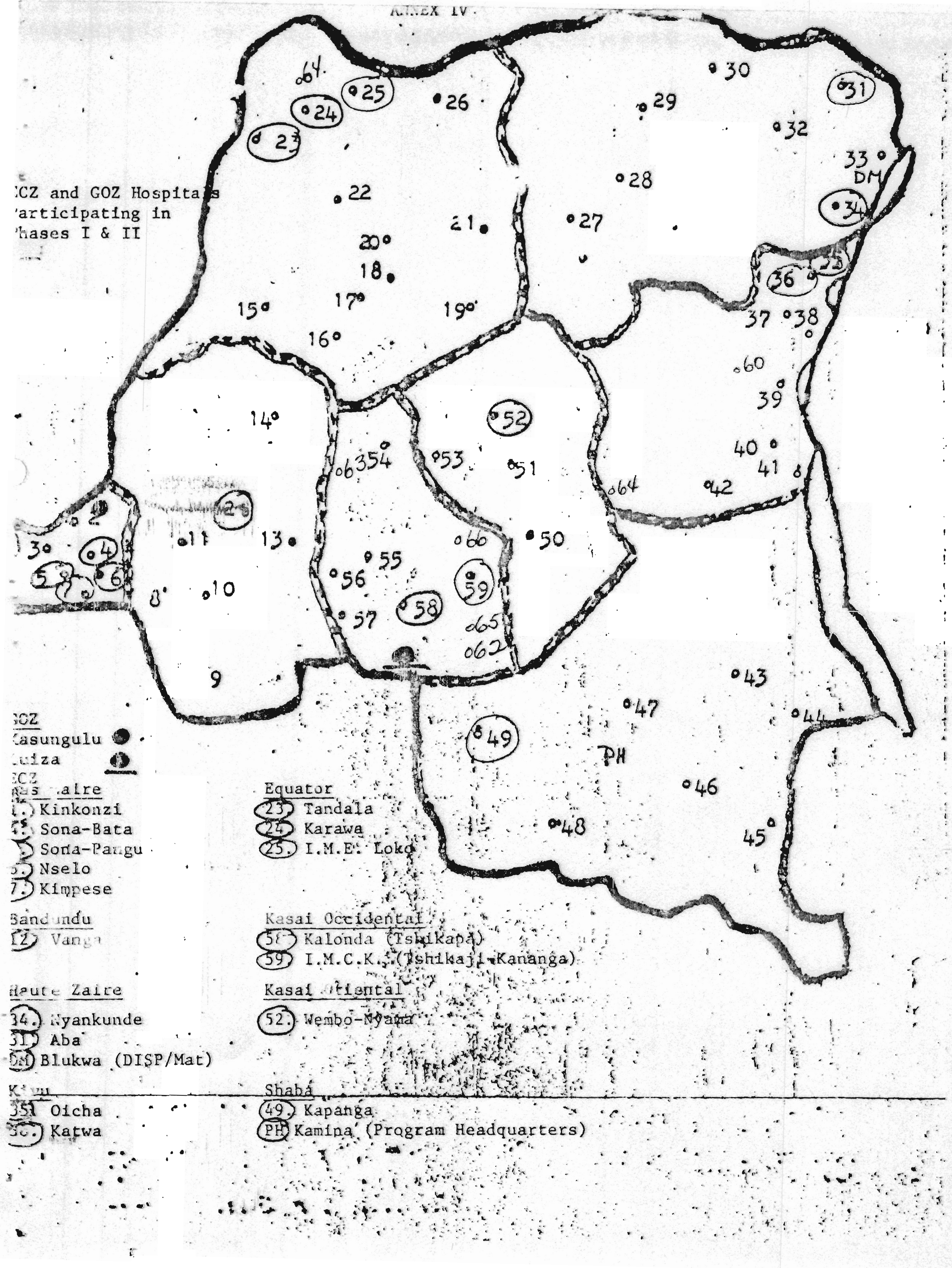
The first year a subsidy was given in 1973	Z343,070.00
In 1974	Z382,841.00
In 1975	Z473,988.00
In 1976	Z550,991.20
In 1977	Z655,630.04
In 1978	Z -0-
In 1979	Z459,047.20
In 1980	Z459,047.20

The variation and reduction in the amount of the subsidies reflects the economic and budget crises in Zaire rather than the change in GOZ attitude or philosophy toward the ECZ. The fact that the ECZ did continue to receive subsidies when GOZ resources were extremely scarce does underline the GOZ's commitment to assist the ECZ as far as its resources will permit.

Annex III - Organization Chart of ECZ Secretariat



ICZ and GOZ Hospitals
Participating in
Phases I & II



ICZ
Kasungulu
Luiza

ICZ
Bas Zaire
1. Kinkonzi
4. Sona-Bata
6. Sona-Pangu
5. Nselo
7. Kimpese

Bandundu
12. Vanga

Haute Zaire
34. Nyankunde
31. Aba
DM Blukwa (DISP/Mat)

Kivu
35. Oicha
36. Katwa

Equator
23. Tandala
24. Karawa
25. I.M.E. Loko

Kasai Occidental
58. Kalonda (Tshikapa)
59. I.M.C.K. (Tshikaji-Kananga)

Kasai Oriental
52. Wembo-Nyama

Shaba
49. Kapanga
PH Kamina (Program Headquarters)

ANNEX V

THE LIST OF ZONES WHICH WILL BE REACHED
BY FIRST 15 HOSPITALS IN THE BASIC FAMILY HEALTH/
MCH/FP OUTREACH PROJECT

A. In the Region of Bas Zaire

1. TSHELA - Kinkonzi Hospital (C.E.A.Z.)
2. LUKULA - Kinkonzi Hospital (C.E.A.Z.)
3. SONGOLOLO - Nsona-Pangu Hospital (C.B.Z.O.)
4. MADIMBA - Nselo Hospital (C.B.Z.O.)
5. KASANGULU - Sona-Bata (C.B.Z.O. and G.O.Z. Hôpital Massa)

B. In the Region of Bandundu

6. BULUNGU - Vanga Hospital (C.B.Z.O.)

C. In Equator Region

7. GEMENA - Tandala Hospital (C.E.C.U.)
8. KUNGU - Tandala Hospital
9. BUDJALA - Tandala Hospital
10. BUSINGA - Karawa Hospital (C.E.U.M.)

D. In West Kasai Region

11. LUIZA - G.O.Z. Hospital at Luiza (C.P.Za. Hospital at Moma is nearby)
12. TSHIKAPA - Kalonda Hospital (C.M.Za.)

E. In East Kasai

13. KATAKO-KOMBA - Wembo-Nyama Hospital (C.M.Z.C.)

F. In Haute Zaire

14. IRUMU - Nyankunde Hospital - 5 communities
15. DJUNGU - Blukwa Maternity-Dispensary (C.E.C.A.)

G. In Kivu Region

16. BENI - Oicha Hospital (C.E.C.A.)

H. In Shaba Region

17. KAMINA - Methodist Rural Health program (C.M.S.Z.)
18. KABALO - Methodist Rural Health Program
19. NYANZU - Methodist Rural Health Program
20. MANONO - Methodist Rural Health Program
21. BUKAMA - Methodist Rural Health Program
22. KABONGO - Methodist Rural Health Program
23. KANIAMA - Methodist Rural Health Program
24. MALEMBA-NKULU - Methodist Rural Health Program

ANNEX VI

FIFTY ZONES WHICH WILL BE IN THE BASIC FAMILY HEALTH/MCH/FP OUTREACH PROJECT

A. BAS ZAIRE

1. TSHELA (Kinkonzi Hospital) (1)
2. LUKULA (Kinkonzi Hospital)
3. SONGOLOLO (Nsona-Mpangu Hospital) (2)
4. MADIMBA (Nselo Hospital) (3)
5. KASANGUKU (Sona-Bata Hospital and G.O.Z. Hospital of Massa) (4) (5)
6. LUOZI (Hospital at Kibunzi or Sundi Lutete - all the same community) (6)
8. BANZA NGUNGU (Kimpese I.M.E.) (7)

B. BANDUNDU

9. BULUNGU (Vanga Hospital) (8)
10. MASI-MANIMBA (Muanza Hospital) (9)
11. MAHEMBA (Kajiji Hospital) (10)
12. NGUNGU (Mukendi Hospital) (11)
13. KUTU (Bosobe Hospital) (12)

C. EQUATOR

14. GEMENA (Tandala Hospital and Karawa Hospital) (13) (14)
15. KUNGU (Tandala Hospital)
16. BUSINGA (Karawa Hospital and I.M.E. Loko) (15)
17. BEFALE (Hospital at Baringa) (16)
18. DJOLU (Yoseki Hospital) (17)
19. BONGANDANGA (Pimu Hospital) (18)
20. INGENDE (Lotumbe Hospital) (19)
21. IKELA (Mondombe Hospital) (20)

D. WEST KASAI

22. LUIZA (G.O.Z. Hospital and eventually CPZa Hospital Moma) (21) (22)
23. TSHIKAPA (Kalonda Hospital) (23)
24. MWEKA (CPZa Hospital at Bulape + Luebo-same outfit) (23)
25. DIBAYA (CPZa. Hospital Lubondai) (24)
26. KANANGA (I.M.C.K. Tshikaji) (25)
27. BEMBA (I.M.C.K. + Mutoto Hospital) (26)
28. LUEBO (Njoko-Punda Hospital) (27)

E. EAST KASAI

29. KATAKO-KOMBE (Wembo-Nyama Hospital) (28)
30. MBUJI-MAYI (Bibanga Hospital) (29) (Perhaps now called Zone de Tshilenge)
31. GANDAJIKA (G.O.Z. Hospital)

F. HAUT ZAIRE

32. IRUMU (C.M.E. Nyankunde) (30)
33. DJUNGU (DM Blukwa) (31)
34. FARANDJE (Aba Hospital) (32)
35. MAHAGI (Rethy Hospital) (33)
36. ISANGI (Yakusu Hospital) (34)
37. WAMBA (Nebabongo Hospital) (35)

G. KIVU

38. BENI (Oicha Hospital) (36)
39. LUBERO (Katwa Hospital) (37)
40. RUTSHURU (Ruanguba Hospital) (38)
41. FIZI (Nungu Hospital) (39)

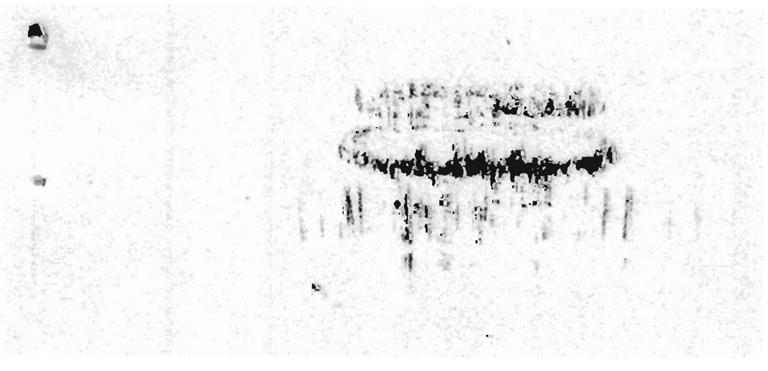
H. SHABA

42. KAMINA (Methodist Rural Dispensary Program) (40)
43. KABALO (Methodist Rural Dispensary Program)
44. NYANZU (" " " ")
45. MANONO (" " " ")
46. BUKAMA (" " " ")
47. KABONGO (" " " ")
48. KANIAMA (" " " ")
49. MALEMBA-NKULU " " ")
50. KAPANGA (Methodist Hospital at Kapanga) (41)
51. SANDOA (G.O.Z. Hospital - could be supervised from Kapanga) (42)

ANNEX VII

BASIC EQUIPMENT TO BE PROVIDED HEALTH CENTERS

Quantity	Item
2	Basins, Kidney, 16 oz., stainless steel
4	Basins, Utility, 3 Ltr. 240MM x 110MM Deep
2	Basin, rectangular, w/cover, stainless steel, for dressings, syringes, needles, instr.
3	Bocal (wide-mouth container) w/cover, stainless steel, for gloves, catheters, compresses, tweezers or foceps)
3	Bowl, Sponge, Stainless steel
5	Bulb syringe - 100 ml, rubber
5	Bulb syringe - 400 ml, with nozzle (avec canule en ebonite)
5	Brush, hand, surgeon's white nylon bristles
3	Pitcher, solution w/cover 1 ltr., stainless steel
3	Pan w/cover to boil instruments, stainless steel, large
2	Kerosene burner
5	Speculum, vaginal, Graves, Bi-valve, Small SS
5	Speculum, vaginal, Graves, Bi-valve, medium SS
5	Speculum, vaginal, Graves, Bi-valve, large SS
1	Sphygmomanometer, Mercurial, desk type
2	Sphygmomanometer, Aneroid 300MM w/Bandage Cuff
4	Stethescope, Bi-aural, Littman model
1	or Ford Tupe Bi-aural
3	Scale, Hanging, kilogram scales, infant
2	Scales, kilogram, adult
100	Gloves, surgeons latex, size 7



200	Gloves, surgeons latex, size 7½
50	Gloves, surgeons latex, size 8
10	Thermometer, adult, oral, rectal and armpit, 35 to 42C
10	Thermometer, infant, rectal, oral and armpit,35 to 42C
5	Tumblers, 8 oz. stainless steel
4	Waste pail with cover, stainless steel, 12 liters
15	Syringes: interchangeable, 2 ml., glass, Luer
15	Syringes: interchangeable, 5 ml., glass, Luer
15	Syringes: interchangeable, 10 ml., glass, Luer
10	Syringes: tuberculin, granduee en 1/100, glass, Luer
100	Needles, injection, 40 mm 8/10 biseau court, Luer
100	Needles, injection, 50 mm 8/10 biseau court, Luer
100	Needles, injection tuberculin, Luer
50	Needles suture, ½ circle, round
100	Catgut chrome, No. 0
100	Suture nylon, No. 0
5	Scissors, surgical, straight, (a vis) blunt 13 cm
5	Scissors, surgical, straight, (a vis) blunt 18 cm
5	Forceps Dressing Spring-Type 200MM SS
5	Forceps Curved Kelly 140MM SS
5	Forceps Hemostat Straight Kocher 140MM SS
1	Gyn/Ob Examining/Delivery table with stool
1	Pelvimeter (to measure height of fundus)
5	Tape measures (metre ruban)
1	Cord ties (cotton string) spool of cotton thread No. 1

1	Dilator Uterine Double-ended Hank SS - Set of 6
1	Ventouse vacuum extractor
6	Rubber sheeting (yard of)
2	Fetascope - Stethescope, bi-auticulaire, Delee-Hills model
10	- Fetal horns, metal or wood
1	- Lefscope - large stethescope for detecting faint fetal heart tones
	Instruments - 2 Foceps - Kocher, Hemostst, straight jaws 9½"
	2 Sponge - Foester, curved, serrated jaws 9½"
	straight, serrated jaws 9½"
10	Catheters, rubber, female
1	IUD Kit No. 1
1000	Microscope slides

ANNEX VIII

LIST OF PHARMACEUTICALS TO BE PROVIDED HEALTH CENTERS

ANTIBIOTICS

Ampicillin capsules 250 mg

Penicillin G/Proc peni 4M IU

Tetracycline 250mg, tablets

Sulpha

ANTIMALARIALS

Chloroquine phosphate 100 mg, tablets

Pyrimethamine, DARAPRIM, 25mg tablets

ANALGESICS, ANTIPYRETICS

Acetylsalicyclic acid (aspirin) 500 mg tablets

ANTHELMINTIC DRUGS

Decaris 50mg tablets (Levamisole) child

Decaris 150 mg tablets (Levamisole) adult

ANTIANEMIC DRUGS

Ferrous sulphate tablets 300mg or 200mg

Folic acid tablets 5mg

ANTIDIARRHOEAL

Oral rehydration (Oralyte) Salt, Sugar, Sodium Bicarbonate

OPHTALMIC-PREPARATIONS

Tetracycline 1% Eye ointment

Argyrol, silver nitrate, eye drops, 2%
newborns - 1%

ANTISEPTICS, EXTERNAL USE

Mercurochrome powder, 500 g

Savlon 5L Container

OXYTOCICS (OB)

Ergometrine maleate 0.2 mg tablets

Ergometrine maleate 0.5mg/ml, 1 ml
(methergine)

Trunk with padlock

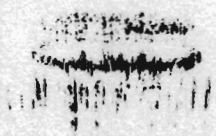
VACCINES (Possibly furnished by PEV)

BCG Vaccine

Poliomyelitis vaccine (oral)

Measles vaccine

DTPertussis



Annex IX

Pharmaceutical List for Village Health Workers

- Decaris - child - 1-6 years
- Daraprim
- Chloroquine
- Aspirin
- Contraceptives - pills, condoms, foam
- Oralyte

ANNEX X

1. Contents of the basic UNICEF midwife kit

One basin
One bowl
One pouch
Sheeting
Three bottles
One bag
Brush
Cotton
Gauze pad
Soap box
Soap
Towel
Forceps
Scissors

This kit comes with a canvas case for $22.82
with an aluminium box for $24.23

2. There is an intermediary kit for the traditional midwife with several additional items.

This kit comes to $32.34 with a canvas carrying bag.
or to $38.68 with an aluminium carrying case.

3. The most complete kit is designed for a trained auxiliary midwife

A-3 and includes a few medicines.

This kit comes to $45.75 with the canvas carrying bag
or to $51.13 with the aluminium carrying bag.

Annex XI

Bibliographical Materials (to be stocked at ECZ and USAID for Primary Health Health Care Project)

Werner, Where There is No Doctor, Swahili version
French version
English version

Kangu Majumbe,
Centre pour la Promotion de la Sante
Dr. Courtejoie

Flip Charts - Malaria
- Nutrition
- Sanitation

Macagba, Refino, Health Care Guidelines for use in developing countries
MARC, 919 West Huntington Dr., Monrovia, CA. 91016

CRDI, Ottawa, La Medecine Traditionnelle au Zaire; Fonctionnement et Contribution Potentielle Aux Services de Sante. Ottowa, Ont. CRDI, 1979
63 pp.

King, et. al., Nutrition for Developing Countries, Oxford University Press, Lusaka, London

Filmstrips, Family Planning
(entire Rabbit Raising, set)

World Neighbors
5116 North Portland Avenue
Oklahoma City, Oklahoma 73112 U.S.A.

Material Realise a l'Atelier
de Material Didactique
B.P. 18, Nogizi, Burundi

Flip charts
(entire series)

NADES, Development Education by correspondence

Entire series, CEPAS, Kinshasa GOMBE, Zaire

National Food and Nutrition Commission
P.O. Box 2669
Lusaka, Zambia

Posters
Teaching material on nutrition

F.A.O.
Nutrition and Home Economics Division
Rome, Italy

Village level material

Newell, Kenneth, Health by the People, WHO, Geneva

Medical Care in Developing Countries, (Symposium-Makerere Univ.) Oxford University Press, 200 Madison Avenue, New York, N.Y.

Brock, Betsy, Family Education (Kinshasa)

Omran, Abdel, Community Medicine in Developing Countries, Springer Publishing Co., 200 Park Avenue, So., N.Y. 10003

Visual Communications Handbook, 30 Guilford St. London, WCIN 1EH

Morley, David, Pediatric Priorities in the Developing World, Butterworth Publishers, Inc. 161 Ash Street, Reading, MA. 01867

ANNEX XII

JOB DESCRIPTION - PROJECT DIRECTOR

General Description of Responsibilities

The Project Director will have overall responsibility for implementation of the project. He will chair the Project Advisory Committee and will be the principal liaision between the GOZ, USAID, the Peace Corps, and the participating hospital systems. He will be responsible for setting project policy and insuring that project activities conform to the general GOZ and ECZ health policy and strategy.

Specific duties and responsibilities will include:

-- Liaision with other health care providers; keeping them informed on project activities and reporting on other health care programs.

-- Supervision of the work of the Project Manager, Family Planning Training Specialist, and Program Planner.

-- Representation of the ECZ and the project at donor committee meetings.

-- Recommending health policy changes to ECZ and GOZ.

-- Developing guidelines for ECZ hospitals in training, family planning nutrition education.

Qualifications

The incumbent Director of the ECZ Medical Office will be Project Director. He is a Diploma Nurse with many years of both curative and preventive health experience. He is fluent in French and several Zairian languages.

JOB DESCRIPTION - FAMILY PLANNING/TRAINING SPECIALIST

General Description of Responsibilities

The Family Planning/Training Specialist will be assigned to the ECZ Medical Office and will report to the Director. She will have overall responsibility for the project's family planning and training activities. She will develop, in collaboration with the participating hospitals, the general plans for project training. She will assure that all participating institutions have appropriate curriculum and materials. She will supervise the implementation of the training plan and prepare training reports.

Specific responsibilities and duties will include:

-- Identification and processing of participants for long and short term training.

-- Liaison with other organizations working in family planning.

-- Development of short term training seminars for nurses and other health care professionals.

-- Development of a curriculum for training village health workers and traditional midwives in family planning.

-- Developing with short term technical assistance a system for family planning statistics within the ECZ and GOZ systems.

-- Preparation of regular reports on training and family planning activities.

-- Developing a curriculum for introducing family life education in secondary schools.

-- Assisting the Operations Officer with inventory, procurement and distribution of contraceptive commodities.

-- Development and evaluation of a system for community distribution of contraceptives in collaboration with the Tulane Family Planning Operations Research Project.

-- Assisting Project Manager and hospitals in developing local action plans.

-- Assist Project Manager in preparing project reports.

-- Assisting hospitals to develop suitable audio-visual training aids.

-- Development and distribution of a kit of basic materials to permit village midwives to deliver babies under more sterile and hygienic conditions.
-- Liaison with National Nutrition Center to assure coordination and collaboration in family planning activities.
-- Other duties as aassigned by the Project Director.

Qualifications:

This specialist shall be fluent in French and English. She should have considerable experience living in Africa and demonstrate understanding of African family life and culture. She should be a nurse-midwife with experience and background in family planning. She should have experience in the development and implementation of training programs.

JOB DESCRIPTION - PROJECT MANAGER/
COMMUNITY DEVELOPMENT ADVISOR

General Description of Responsibilities

The Project Manager will be responsible for the day to day operations of the project activities. He will be assigned to the Central Medical Office of the ECZ and will report to the Project Director.

He will have general responsibility for the development of the medical information system and for the initiation and management of the counterpart funded local currency project account.

Specific duties and responsibilities will include:

-- Recruiting, hiring and supervising the work of the Administrative Assistant and the Secretary/Typist.

-- Monitoring financial disbursement procedures including cosigning checks of the special project counterpart fund

-- Project reporting, monitoring, and evaluation, including preparation of the annual counterpart budget request.

-- Analyzing short term personnel needs and preparing appropriate documentation.

-- Strengthening the planning capacity of ECZ.

-- Coordination of ECZ and GOZ data collection systems.

-- Orienting hospital public health personnel to project objectives, methods, and reporting.

-- Assisting hospitals in developing their action plans for project implementation.

-- Assisting Operations Officer in planning and organizing health conferences.

-- Collaborating with the Operations Officer and Training Specialist for identifying candidates for training.

-- Providing technical advice on acceptability of planned interventions in village milieu.

-- Analyzing and recommending acquisition of commodities required to meet project objectives; preparing of appropriate documentation.

JOB DESCRIPTION - OPERATIONS OFFICER

General Description of Responsibilities

The Operations Officer will have overall responsibility for logistics planning, commodity procurement, transportation and financial reporting. He will be assigned to the ECZ Central Medical Office and will report to the Project Director.

Specific duties and responsibilities will include:

-- Serving as Executive Secretary of the Project Advisory Committee.

-- Planning and organizing the Annual Health Conference.

-- Liaison with the pastors of the ECZ system for the dissemination of family planning information.

-- Developing the overall plan for project commodity management in coordination with the hospitals, USAID, CNND, PATHFINDER, EPIA, UNFPA, IPPF and UNICEF.

-- Reception, storage and transshipment of project commodities.

-- Arranging for and supervising commodities procured in Zaire.

-- Development of a system of inventory and reporting for all commodities as well as a system for monitoring their use.

-- Liaison with MAF, for coordination of project transport.

-- Development and maintenance of a system of accounting and financial reporting; preparation of project vouchers (in collaboration with the Project Manager); liaison with USAID Controller.

-- Assisting the Project Manager in the preparation of hospital action plans.

-- Assisting the Project Manager with the preparation of project reports.

-- Other duties as assigned by the Project Director.

Qualifications:

The Operations Officer should be fluent in English and French and should have experience in dealing with the ECZ and GOZ. He should have experience in implementing projects in rural health and family planning.