Zaire Integrated Family Health Project

Project Identification Document

Glossary of Terms Used

ACSI-CCCD	:	African Child Survival Initiative-Combatting Childhood Communicable Diseases
AIDS	:	Acquired Immune Deficiency Syndrome
AZBEF	:	Association Zairoise pour la Bien-etre Familial
BCG	:	Tuberculosis Vaccine
CBD	:	Community-Based Distribution
CNND	:	Comite National des Naissance Desirables
CP	:	Contraceptive Prevalence
CPF	:	Counterpart Funds
CSM	:	Contraceptive Social Marketing
CYP	:	Couple Years of Protection
DFA	:	Development Fund for Africa
DPT	:	Diptheria, Pertussis, Tetanus vaccine
ECZ	:	Eglise du Christ au Zaire
FP	:	Family Planning
FSN	:	Foreign Service National
GOZ	:	Government of Zaire
IC	:	Institutional Contractor
IE&C	:	Information, Education and Communication
IMR	:	Infant Mortality Rate
IPPF	:	International Planned Parenthood Federation
KAP	:	Knowledge, Attitudes and Practice
MOH	:	Ministry of Health
NGO	:	Nongovernmental Organization
ORS	:	Oral Rehydration Solution
ORT	:	Oral Rehydration Therapy
PASS	:	Social Sector Adjustment Program
PEV	:	Programme Elargi de Vaccination (Expanded Program for Vaccinations)
PHC	:	Primary Health Care
P/M	:	Person Month
PP	:	Project Paper
PSI	:	Population Services International
PSND	:	Projet des Services des Naissances Desirable or Family Planning Services Project
PVO	:	Private Voluntary Organization
RAPID	:	Resources for the Awareness of Population Impacts on Development
REACH	:	Resources for Child Health (centrally-funded)
SANRU	:	Basic Rural Health Project, French acronym "Sante Rural"
STD	:	Sexually Transmitted Diseases
UNFPA	:	United Nations Fund for Population Activities
UNICEF	:	United Nations Children's Fund
WHO/GPA	:	World Health Organization/Global Program on AIDS

EXECUTIVE SUMMARY

Since the mid-1970s, USAID has been a major contributor to Zaire's key preventive and promotive health activities. Over the last 15 years, the public health sector has established one of the largest national vaccination cold chains on the continent, and supported private sector efforts to significantly expand rural primary health care, contraceptive social marketing, and a comprehensive program to reduce human immunodeficiency virus (HIV) transmission. In addition, one of the more remarkable achievements, completed in 1985, was the delineation of 306 decentralized health care zones based on a cost-sharing, user-fee strategy. Zaire's national, decentralized user-fee system is unprecedented among Sub-Saharan nations and represents a model which many countries are currently attempting to emulate.

Despite considerable achievements, health service accessibility is decreasing, infant mortality rates remain at approximately 110 per 1000, and the population growth rate at 3.1% has not abated. Current HIV seroprevalence in Kinshasa is estimated at 6-8%, relatively low compared to that of neighboring countries. However, rural seroprevalence is unknown. Although the Government of Zaire (GOZ) has exemplified a timely responsiveness toward the support and expansion of anti-AIDS programs, this disease hangs like a specter threatening to undermine further advancements in lowering morbidity and mortality. Moreover, primary health care (PHC) program sustainability is constrained by inadequate GOZ funding and economic deterioration. A cost-sharing model is only as sound as the government's recognition that this concept does not obviate its fiscal responsibility toward the health sector. The substantial degree to which health care activities have been privately financed in Zaire is a function of an unconscionable neglect on the part of the GOZ.

Currently, Zaire's future remains uncertain. In April 1990, the President announced the end of 25 years of one-party rule, and laid the foundation for moving toward a multi-party system. Although initially seen as a dramatic and positive step, the ensuing "transitional" period has been a time of political and economic upheaval. The government has abandoned an International Monetary Fund - World Bank medium term program, and there are widespread doubts about the President's seriousness in developing a democratic policy. The economy is in a state of rapid decline, unprecedented in Zaire's history. This economic situation has had a negative impact on the food security of the urban population, and in the accessibility of affordable health care for many Zairians.

Despite the chaotic political and economic environment, USAID is moving ahead -- building on the knowledge and experience gained from working in a wide spectrum of health activities, consolidating gains and attempting to reduce losses. These are, however, difficult times for planning. Following a review of

several options, the mission has concluded that the most rational approach is to design a long-term project. Achieving significant improvements in the health status of the population will depend on a sustained commitment. This project will become the core of a reduced USAID portfolio focusing on basic human needs.

Therefore, this document proposes a seven year, $80 million project to be executed in two phases. The first phase would represent a three year, $35 million effort to support ongoing project activities programmed to end September, 1992. **The primary aim of this effort is to protect vulnerable groups from the adverse effects of a declining economic situation and to maintain, in collaboration with other donors, critical family planning and selected health interventions.** During this phase, the Mission will work closely with the World Bank to help the new government focus on policy issues currently impeding service delivery and to enhance the private sector's capacity to expand delivery channels. The second phase would proceed pending an evaluation of the prevailing situation and the GOZ's progress in fulfilling its responsibilities -- particularly with regard to increased health sector investments. The FY 1992 project start date is contingent on Zaire's resumption of a stabilization program with the International Monetary Fund since without such a program there is no prospect of further Paris Club debt reschedulings.

This Integrated Family Health Project does not propose any major new components. USAID's Health and Population Program has a long history of encompassing all aspects of primary health care. Rather, this project aims **to integrate and streamline USAID's assistance into one project with four core components: (1) Family Planning; (2) AIDS Prevention; (3) Maternal and Child Survival; and (4) Rural Primary Health Care.** The incorporation of these activities under one project will provide economies of scale in commodity procurement and significantly improve financing and planning flexibility. It will enhance the integration of essentially interlinked activities and reduce duplication of technical assistance efforts.

The goal of the project is to improve maternal and child health and to lower the fertility rate and HIV transmission. The project purpose is to increase access to, and the effectiveness of, family planning and selected health services. Building on existing projects and programs, USAID aims to strengthen support systems for the public and private sectors, to continue to improve financial management and risk-sharing mechanisms, and to capitalize on the momentum of successful delivery approaches. A greater proportion of assistance for family planning, the weakest link in Zaire's primary health care (PHC) program, will be shifted to private sector implementing agencies. Health interventions include reduction of vaccine-preventable diseases, control of diarrheal disease, prevention and treatment of malaria, and the reduction of HIV transmission.

1. PROGRAM FACTORS

1.1 Conformity with Recipient Country Strategies and Programs

The current National Health Policy promotes universal access to primary health care through a wide network of health facilities and public health programs. The Government has a well-articulated AIDS prevention policy and a population policy which, although not yet officially adopted, supports birth spacing and maternal and child health interventions. By targeting key AIDS prevention activities, and the expansion of family planning, rural services and other basic PHC interventions, this USAID project supports the current priorities of the Government and the MOH.

The Government is also placing an increased emphasis on involvement of the private sector in Zaire's development. Zaire has a long history of endorsing private health activities. Approximately 80 percent of health services are provided by religious nongovernmental organizations (NGOs), donor-supported and community-based programs and the medical departments of private enterprises. Recent efforts by USAID to extend private programs, especially in contraceptive social marketing, AIDS mass media and rural primary health care services, have resulted in a strengthening of private implementing agencies and improved working relationships between the private and public sectors.

In 1989, the GOZ, in collaboration with the World Bank, completed the design for a major Social Sector Adjustment Program (known in Zaire by its French acronym PASS) aimed at re-engaging the government in the role of: (1) policy maker; and (2) an efficient source of financing for socially justifiable investments. Specifically, health sector objectives include: (1) increasing expenditures to implement targeted maternal and child health interventions; (2) delineating the respective roles of the Government of Zaire (GOZ), para-statal and private sector entities in health care delivery; and (3) establishing regulatory mechanisms to ensure an equitable distribution of medical services and commodities.

Nevertheless, a definitive development plan is not expected until after elections and the establishment of a new stabilization program. Thus a comprehensive plan is unlikely to appear before 1992 at the earliest. USAID believes, however, that the core health sector strategies and principles currently expressed by the GOZ will remain intact.

1.2 Relationship to AID and Mission Policy and Strategy Statements

For a decade, AID has supported the advancement of specific "maternal and child survival" interventions. The 1982 AID Policy Papers on Health and Population Assistance focused on expanding

the availability of these interventions by prioritizing self-financing health programs, the integration of activities at all levels and the use of cost-effective, appropriate technology. AID's 1990 report to congress on AIDS activities stressed the need to support: (1) government and public awareness of AIDS and the options for HIV prevention; (2) the design and implementation of HIV prevention programs; and (3) the implementation of intervention-oriented applied research to improve the means of prevention availability. The proposed project will strengthen and expand targeted family planning and health interventions, work to further integrate these activities through Zaire's cost-sharing health program and support new technologies, especially in the areas of family planning and the fight against HIV transmission.

More recent AID high-level statements and Agency documents have reaffirmed the U.S. Government's commitment to child survival and voluntary family planning efforts. The 1987 Child Spacing for Child Survival document defined family planning as a key child survival intervention. In the fifth annual report to Congress (April 1990) on the Agency's program to promote child survival, AID paid special tribute to the contributions of the private sector, and expressed continued support to private voluntary organizations as well as the for-profit sector in the advancement of child survival objectives. This project is consistent with all articulated Agency and Bureau policies and strategies.

Furthermore, since this project emphasizes expanding the private sector's role in service delivery, and targeting policies aimed at redistributing public resources toward key social sector investments, it is consistent with the 1989 Action Plan for the Development Fund for Africa (DFA). It is also in concert with new initiatives proposed by the Agency Administrator in his recent address to the Foreign Affairs Committee concerning the proposed 1992 AID budget. Key initiatives which correspond to the project's underlying strategies include: (1) enhancing "partnerships " with private sector entities; (2) strengthening the "family" as a basic unit of development; and (3) improving management techniques for better administration of USAID programs.

The Zaire Mission's program goal is to contribute to sustainable, broad-based, market-oriented economic growth and development. The proposed project is consistent with this goal, and reaffirm's the mission's intention to improve the well-being of Zaire's poor majority by providing opportunities to increase families' productive capacity, consumption, and access to health services. A more productive population requires health care investments starting in utero and continuing through adulthood. Thus, USAID aims to reduce maternal and child mortality and morbidity in the short term and to strengthen

institutions and systems that will lead to lower rates of mortality and population growth in the long term.

1.3. Donor Coordination and Resource Allocation

In 1988, external donor assistance for the health sector was approximately $44 million, with an estimated 67% devoted to the delivery of PHC programs. The majority of assistance was for capital investments. Presently, the government's "transitional" period has resulted in a decrease of foreign assistance funds to the public sector pending resumption of the GOZ's structural adjustment program. Nevertheless, with the exception of Belgium, all other bi- and multi-lateral donors are continuing to support policy reforms, institutional changes and selected family health interventions. The African Development Bank and World Bank are providing significant support to improve management structures and to create or redefine policies aimed at facilitating private and public sector service delivery. UNICEF, in collaboration with USAID, assists over 180 health zones. UNICEF's major contributions are in the area of technical and financial assistance for the vaccination program, material support for oral rehydration salts (ORS) production, rural water supply, growth monitoring and pharmaceutical supply and distribution. USAID is the primary donor for family planning and AIDS. However, the United Nations Population Fund (UNFPA) is providing contraceptives and support for population policy and planning efforts. The International Planned Parenthood Federation (IPPF) also supports nongovernmental family planning programs. The National Bureau for the Coordination of AIDS receives technical and financial assistance from the World Health Organization, the United Nations Development Program and the World Bank. Support for urban blood screening activities is provided through the German Cooperation Agency and the European Economic Community. Although less well documented, there is a substantial contribution of health personnel, equipment and financing from American and European churches.

Donor coordination is improving, but there is a great need to institutionalize coordinating mechanisms through the establishment of an inter-organizational coordinating committee. USAID and other donors are encouraging GOZ initiatives in this direction. Planning efforts for the World Bank Social Sector Adjustment Program are creating an excellent opportunity to review GOZ, donor and private sector priorities, to compare objectives and to share experiences. The design of this project has been developed in consultation with key contributing bi- and multi-lateral donors. Activities requiring additional analyses in collaboration with other donors prior to the PP design are outlined in this document. In addition, owing to the large absorptive capacity of some programs, which is greater than GOZ and donor resources, USAID is attempting to interest new donors, e.g. Japan, in contributing to selected interventions.

2. PROJECT DESCRIPTION

2.1 Perceived Problem

2.1.1 History of Previous USAID Projects

USAID's emphasis in the health sector has shifted dramatically during the past two decades. While health, population and nutrition projects accounted for less than 20% of all projects started in the 1970s, they accounted for about 50% during the last decade. Similarly, in terms of a percentage of total mission funding, the amount spent on health projects has increased from less than 10% in the 1970s to almost 30% in the 1980s. USAID obligated approximately $10,000,000 per year for all health-related activities in 1989 and 1990.

The Mission strategy in the health sector also varied between the two decades. The 1970s were characterized by experimentation in alternative health care delivery systems with an emphasis on central-level vertical programs. The GOZ was the most frequent implementing institution and technical assistance was provided via institutional contracts.

During the 1980s, Mission support, in concert with evolving Ministry of Health (MOH) strategies, coalesced around integrated primary health care. Specifically for USAID, the 1980s marked the advent of an expansion into family planning, rural health services, AIDS prevention and water supply. This expansion was accompanied by continuing support to the public sector in selected child survival activities, the introduction of several private sector initiatives, an increased reliance on personal services contractors within the Mission to accommodate the large management burden, and long-term project commitments.

Family Planning and AIDS: Historically, Zaire assumed a pronatalist stance which was reinforced by colonial attitudes and the Catholic Church. However, in 1972 the GOZ officially endorsed the concept of "desired births" when it established the Comité National des Naissances Desirables (CNND). Although this policy change permitted experimentation in approaches to family planning interventions by donors and PVOs in the 1970s, it did not result in any significant adoption of family planning services until 1982. At that time, the USAID-sponsored Family Planning Services Project (PSND) catalyzed the MOH's recognition that family planning is an integral part of primary health care.

Over the last eight years, this public sector project has taken on a role not envisioned in the original project design and become the de facto national agency for managing, coordinating and implementing family planning activities. PSND has achieved some successes in creating a favorable policy environment for

population activities, conducting family planning training (850 nurses and physicians trained), and testing community-based distribution (CBD) of contraceptives and selected treatments. Despite these successes, contraceptive years of protection provided by health clinics remain low. More work is needed to: (1) decentralize management structures; (2) better integrate FP into zone-level health services; and (3) establish a secure contraceptive supply line for Zaire's urban and rural health system network.

In the private sector, Population Services International (PSI), an American private voluntary organization, has developed a contraceptive social marketing (CSM) network of over 4,000 traditional and non-traditional commercial outlets. Originally designed to promote condom usage for the prevention of HIV transmission and unwanted pregnancies, CSM added spermicides in 1989 and plans to begin oral contraceptive distribution in 1991. The success of this project has been extraordinary. Last year CSM sold 9.5 million contraceptive units, and sales are continuing to rise. The project is currently operating in 15 large urban sites, but is believed to have a "halo effect" whereby urban marketing strategies spread into peripheral peri-urban and rural areas. A significant proportion of the project's success is attributed to the use of an aggressive point-of-purchase advertising campaign, as well as a one-to-one interpersonal communication program.

In conjunction with CSM, PSI's AIDS Mass Media Information, Education and Communication (IE&C) Project has served as an important adjunct to condom promotion efforts in reducing HIV-transmission. Initiated in 1988, this project is helping the GOZ to produce and disseminate an effective AIDS educational program through electronic media, popular theater, local musicians and print channels. AIDS prevention messages have progressed from concentrating on dispelling the myths surrounding casual transmission (1989), to the explicit, open treatment of sexual transmission and safe sexual behavior. During 1990, the project launched a major effort to decentralize the AIDS IE&C program, working closely with broadcasters and GOZ regional coordinating offices in four pilot regions. Given Zaire's cultural and linguistic diversity, local production of AIDS mass media materials ensures their cultural appropriateness.

Although misconceptions persist, recent knowledge, attitude and practice (KAP) studies conducted in selected urban areas show that over 90% of urban dwellers who had ever heard of AIDS spontaneously identified the four major modes of HIV transmission. The proposed project will adapt lessons learned from PSI's electronic and print media strategies to create a more integrated and effective decentralized family planning and child survival IE&C program.

Child Survival Interventions and Rural PHC Services: In the public sector, USAID assists the government's vaccination program through the Africa Child Survival Initiative - Combatting Childhood Communicable Diseases (ASCI-CCCD) Project. Its goal is the reduction of child mortality and morbidity through vaccination against preventable diseases, oral rehydration therapy (ORT), presumptive malaria treatment of children and chemoprophylaxis during pregnancies to reduce insufficient birth weight.

Estimates show that in Kinshasa alone measles immunizations, conducted under the project and its predecessor activity, have prevented between 500,000 and 800,000 measles cases and averted between 27,000 and 41,000 deaths. Outbreaks of polio have greatly diminished nationwide, including a 75% reduction in notified cases in Kinshasa. Reported cases of tetanus have decreased almost 50% since the start of the project in 1982. The national cold chain now has the capacity of meeting the needs of 206 health zones through 20 decentralized sub-regional depots.

Depot staff provide free vaccines and sell ORS and chloroquine to the zones. Ideally, profits from the sale of these two commodities should provide each depot with the means for replenishing stocks and for recuperating some operating expenses. The GOZ is supposed to pay depot staff salaries. However, sales proceeds have been frequently used for advances against unpaid GOZ salaries, thus decapitalizing revolving funds.

Basic Rural Health II (SANRU) is Zaire's largest not-for-profit private sector health activity. Designed to establish a system of sustainable community-supported primary health care services, it is currently working in 80 zones benefitting approximately 4.8 million rural poor. SANRU is implemented by the Church of Christ of Zaire, an indigenous PVO encompassing 62 Protestant affiliates.

SANRU focuses on rebuilding and strengthening the rural health infrastructure with an emphasis on improving and expanding maternal and child services. Through its support of immunizations, ORT, growth monitoring, nutrition education, child spacing, improved water and sanitation, and malaria treatment and prophylaxis, the project extends services to over 1.9 million women and children (women of child-bearing age and children aged one to five). To improve the quality and sustainability of health services, the project has trained over 4,500 medical workers and community members in basic management and supervisory concepts and promotive health interventions. In collaboration with a local accounting firm and Peace Corps Volunteers, SANRU is working to improve health zone financial management systems and cost-recovery strategies. Lastly, SANRU officials are at the forefront of dialogue with GOZ representatives regarding the decentralization of services and the clarification of roles

between the public and private sectors in the provision of zone services. Their continued support and negotiating skills will be critical for resolving the ongoing conflicts surrounding this important policy issue.

2.1.2. Current Situation

Family Planning: Zaire is the fifth most populous African nation with 36.6 million people. The growth rate has increased from less than 1% in 1950 to 3.1 % in 1990. If these rates continue, the population will double by the year 2013, creating unbearable demands on the economy. For the past 20 years, the population growth rate has been twice as high as the GDP increase, accounting for more than half of the decline in the GDP per capita.

The total fertility rate is estimated to be 6.1. Use of modern contraceptives is still very low, although not notably out of line with other pronatalist, Francophone African countries. A contraceptive prevalence (CP) survey conducted in 1982-84 in four urban and two rural areas indicated a CP rate of less than 2%. Current estimates are 4% for urban areas and 1% for rural. Recent special surveys in Kananga and Matadi show prevalence rates of 17% and 23% respectively, where urban clinic-based services are supplemented by a network of community-based distribution sites or a social marketing program. These two successes suggest that there is a latent demand for family planning and that contraceptive prevalence will increase if reliable services are available.

According to the 1982-84 CP survey, knowledge of modern contraceptives is quite high with 86-97% of married women knowing at least one modern method. However, knowledge does not necessarily translate into either favorable attitudes or demand. Principle barriers to more widespread contraceptive prevalence are believed to be strong pronatalist tendencies, limited access to services, lack of shared reproductive decision-making, and fear of side-effects.

USAID, in collaboration with the Centers for Disease Control and UNICEF, is conducting a National Health Survey which will include contraceptive prevalence and fertility questions. Baseline data from the survey will be available by May 1991, prior to the PP design.

AIDS. As of January 1990, Zaire had reported 11,732 AIDS cases to WHO. This places Zaire second only to the United States (124,282 cases) in the number of reported cases. HIV sero-prevalence in the adult population of Kinshasa is estimated to be 6-8%. Eighty percent of HIV transmission occurs through sexual contacts, and is almost equally divided between men and women.

Perinatal transmission is believed to account for another 10%, with the remaining 10% attributed to exposure to HIV-infected blood or blood products. Reliable data on rural seroprevalence is unavailable. However, judging by the increased demand for assistance in rural blood-screening and for confirmation of suspected cases, controlling HIV transmission in the rural areas will be a formidable challenge for the 1990s.

Since 1985, urban blood-screening programs have been largely the domain of the German Cooperation, and the European Economic Community through the use of hospital-based, machine-independent blood testing procedures. In 1990, USAID funded a pilot activity which evaluated a number of rapid HIV-screening tests to determine their effectiveness in rural settings. Results showed high specificity and sensitivity for two of the tests. Plans are under way to expand the use of this cost-effective, appropriate technology into 20 SANRU-assisted rural hospitals.

Maternal and Child Health. Estimates of the infant mortality rate (IMR) vary widely from 98 to 160 per 1000 live births. UNICEF estimates an IMR of 110 and an under-five mortality rate of 164 in 1988. This represents a decline of under-five mortality of 35% since 1960 when the rate was 251. Recent impact studies indicate tremendous variation between specific groups (e.g. urban vs rural), as well as among disparate regions in the country.

The major cause of morbidity and mortality for children is malaria. Most infants become infected during the first year of life and are estimated to have approximately five febrile episodes per year from ages one to five. The number of cases of children hospitalized with malaria has remained relatively constant over the last five years. However, fatalities in 42 sentinel site hospitals appear to be increasing from 200 in 1985, to 680 in 1988. Reasons for this increase are unknown but are probably a combination of improved reporting, the increasing prevalence of chloroquine-resistant plasmodium falciparum, and a decrease in the proportion of the population able to pay for early and prompt treatment. In addition, the severe anemia caused by malaria in children often requires transfusion. Reducing the burden of malaria on children should also reduce their risk of contracting the human immunodeficiency virus.

Rising from a level of under 10% in 1982, vaccination coverage rates for 1989 were: (1) BCG, 59%; (2) Measles, 44%; (3) DPT (third dose), 41%; and (4) Polio (third dose), 41%. Although measles, polio and tetanus have been dramatically reduced since 1982, coverage rates have stagnated over the last few years. Expansion has been impeded by the lack of rural infrastructure, inadequate management and supervision capacity, insufficient

financial support for personnel and other operating costs, and lack of adequate cold-chain equipment.

According to the national urban sentinel site reporting system, diarrhea is the third largest cause of infant mortality following malaria and respiratory diseases. Great strides have been made in promoting the use of oral rehydration therapy, with 44% of mothers in Kinshasa reporting the use of ORS or other liquids during diarrheal episodes. Annual household surveys from reporting sub-regional offices indicate a positive change in giving treatment. However, the proportion of mothers giving appropriate treatment amounts is still low.

The maternal mortality rate is estimated at 6-8 per 1000 live births, more than 50 times the rate observed in industrialized countries. The primary cause of maternal mortality is childbirth complications, which are often aggravated by endemic disease and malnutrition. These complications are the result of a number of factors including ineffective or nonexistent prenatal care, unsanitary delivery conditions, close birth intervals, maternal age at delivery, and untrained traditional birth attendants. Illegal abortion is also a factor.

2.1.3 Policy Issues

In Zaire, major constraints to family planning program implementation stem from the cultural ideologies of many of the political elite and a large proportion of the population. The tendency to view population efforts as a diversion from fundamental structural changes; hostility to all policies affecting change in women's traditional roles; religious opposition to family planning; competing claims by government ministries over the allocation of scant resources; and the lack of motivation and skills needed to effectively implement programs impede advancement. Arguments based on the fact that Zaire has vast uninhabited tracts of land coupled with the overall low population density continue to fuel pronatalist beliefs.

Since 1986, USAID and the United Nations Population Fund (UNFPA) have sought to reinforce population planning and policy formulation. In that year, a National Population Committee was established and charged with assisting the GOZ in defining a population policy consistent with Zaire's socioeconomic and cultural conditions. A 35-member interministerial and academic group drafted the National Population Policy in late 1986. Over the last four years, USAID and UNFPA provided technical assistance and supported a series of population planning and budgeting workshops. In October of 1990, the Minister of Plan announced that the policy was being included as an integral part of the second National Development Plan (1991-1995). However, the policy is not yet a formally approved, Government-wide policy.

Although an important advance for Zaire's population efforts, the policy does not adequately address all relevant issues. Specific policy objectives for family planning include the implementation of "child spacing" programs, but fall short of pronouncing the politically unacceptable goal of reducing the fertility rate, i.e. birth limitation. This project will further family planning efforts by strengthening existing FP planning and management capabilities, and stimulating a "bottom-up" demand for contraceptives through a decentralized IE&C campaign and an expanded CBD and contraceptive social marketing program. At the same time, USAID will continue to provide technical assistance and to sponsor policy-level collaborative forums toward the enhancement and acceptance of key population issues.

Other policy issues are important to the success of this project and related interventions in the health sector. USAID has worked closely with the World Bank to assist the GOZ in developing a set of social sector adjustment policy measures. Examples of key reform issues directly pertaining to the proposed project include:

* the establishment of special budgetary allocations to primary health care services;

* the creation of a law vesting the health zones with legal status; providing for their semiautonomous standing, and the harmonization of the relationships between administrative authorities, medical authorities and NGOs;

* the total or partial privatization of certain large urban hospitals that impose a heavy financial burden on the government;

* the establishment of a national policy and implementation plan on the supply of essential drugs; and

* the development of an intersectoral policy on women in development which includes the following objectives: (1) to prevent sex discrimination in access to employment and education; (2) to lighten the burden of women's work by providing increased access to appropriate technologies; and (3) to promote women's health through better and more targeted preventive care.

Initial analyses of several of these issues have been completed. The World Bank plans a study on the reorganization of the Ministry of Health which would lead to the drafting of a Loi-Cadre defining the legislative, administrative and operational roles of all parties concerned with the health sector, both governmental and nongovernmental. USAID will continue supporting the GOZ's Social Sector Adjustment Program by providing technical

assistance to selected policy reforms. Specific policy objectives are outlined in Section 2.4.3.

Efforts over the last four years to inform high-level officials about the effects of population growth on development successfully resulted in the formulation of a policy. This project proposes to transfer lessons learned from that experience to other critical health intervention areas. Tentative proposals include utilizing RAPID Model (storyboard) approaches to better inform policy-makers about: (1) long-term implications of AIDS; (2) the costs and economic effects of malaria; and (3) the consequences of various GOZ budgeting options on the utilization of services at the zone level.

2.1.4. Sustainability

Foremost in any discussion regarding project sustainability is the GOZ's historically inadequate contribution to the health sector. There have been a number of key events over the last year which have placed significant pressures on the government to increase health funding. Chief among these events are (1) the abrupt withdrawal of all Belgium social sector support; (2) the withholding of the World Bank social sector adjustment loan pending direct evidence of increased GOZ allocations to PHC services; (3) widespread strikes by physicians and nurses demanding higher salaries; and (4) a new freedom of the press which is resulting in weekly editorials condemning the government for its chronic neglect of the health needs of the population. Following U.S. congressional appropriations legislation which states that "None of the funds appropriated by this (appropriations) act ... shall be transferred to the government of Zaire...", USAID withdrew direct financial assistance to certain public sector activities. At the same time, USAID is phasing out the practice of paying counterpart fund salary subsidies to public sector employees, and is reducing the amount of counterpart funds utilized for basic operating costs.

The aggregate result of these actions has been an increased external as well as internal pressure on the government's social sector allocation practices. Since January 1991, the GOZ has for the first time contributed operating funds to approximately 140 health zones. Allocations are programmed to increase from year to year as the number of zones supported increase and service quantity rises. Likewise, following negotiations between USAID and the Ministry of Plan in February of this year, the GOZ stated its intention to deposit public investment budget monies dedicated to USAID-assisted projects into the counterpart fund. These monies will be distributed through a joint programming process subject to USAID accountability procedures. The Mission regards these actions and negotiations as significant advances. The fact that the government is implementing a core social sector adjustment program despite the present economic and political

situation demonstrates the GOZ's seriousness to maintain its development dialogue and to initiate overall adjustments in health sector spending.

2.1.5. Areas of Project Concern

Current national health strategies, which aim to provide universal access to PHC services through an extensive network of decentralized, low-cost delivery systems, are considered sound. An advantage of this "bottom-up" approach is that it places both responsibility for planning services and the authority to retain monies collected through cost-recovery mechanisms at the most appropriate level. Thus the approach engenders strong "ownership" of the system by health providers and communities. Nevertheless, Zaire faces a number of obstacles in its implementation of a primary health care program. Of paramount concern are:

- GOZ budget allocations to the health sector are sporadic and have historically been woefully inadequate;
- the availability of quality PHC services is still limited, particularly in the rapidly deteriorating rural areas;
- the provision of clinic-based family planning services is seriously constrained by the lack of a secure, decentralized contraceptive supply line and a viable IE&C program;
- physician and nurse in-service training does not provide a balance between technical, supervision and management concepts, lacks coordination among implementing agencies, and is not institutionalized at the MOH level; pre-service training is curative-oriented and inadequate;
- private sector performance is hampered by inappropriate policies and regulations, and lack of understanding by GOZ agencies as to how the private sector functions;
- zone-level financial systems lack personnel trained in systems management, price differentiation, targeted subsidies, and other cost-recovery alternatives.

To address these constraints, USAID proposes this Integrated Family Health Project which will focus on strengthening support systems, health care financing options and policies aimed at establishing a more viable primary health care program.

2.2 Project Goal and Purpose

The goal of this project is to improve maternal and child health and to lower the fertility rate and HIV transmission. Improved health status and progress toward reducing the total fertility rate are critical to the mission's overall goal of sustainable, broad-based economic growth and development. Maintaining the current substandard quality of life, much less increasing per capita income growth, will be impossible if the population continues to double every 23 years. This project should contribute to a reduction in the total fertility and population growth rates, a decrease in HIV transmission, and a reduction in infant, child and maternal morbidity and mortality.

The purpose of this project is to increase access to, and the effectiveness of, selected family planning and health interventions. To achieve this purpose, the major emphasis will be directed toward expanding and strengthening private sector implementing agencies and delivery channels and public sector management, planning and support structures. USAID, in collaboration with other donors, will take a more active role in supporting national-level policy reforms designed to facilitate both public and private sector primary health care efforts.

2.3 Expected Achievements and Accomplishments

By the end of this two phase, seven-year project, it is expected that information, commodities and services for family planning and family health will be more widely available at low-cost. As a result of an expanded service delivery network and the provision of subsidized commodities:

* modern-method contraceptive prevalence will increase from an estimated 4% to 12% in urban areas, and from 1% to 4% in the rural population;
* use of ORS or household solutions per diarrheal episode in children under five years will increase from approximately 44% to 60%;
* use of proper anti-malarial treatment per febrile episode in children will increase from 46% to 65%;
* vaccine-preventable morbidity and mortality will be reduced by:
  - increasing measles vaccine coverage rates from 44% to 75%
  - increasing polio vaccination (third dose) coverage rates from 41% to 70%

- increasing diptheria, pertussis, tetanus vaccine (third dose) coverage rates from 41% to 70%

* condom distribution in high-risk urban areas will increase from 8,000,000 to 20,000,000 per year; and

* the capacity to screen blood for HIV via rapid screening tests will be available in 30 rural hospitals plus selected urban centers with high transfusion loads.

Benchmarks will be confirmed in the Project Paper.

Products and information for family planning, and selected maternal and child treatment interventions will be available in approximately seven thousand traditional and nontraditional commercial delivery points. Equally critical to achieving project and Mission objectives is the strengthening and expansion of health center clinics providing regular and integrated PHC services. The project will provide a core package of assistance to approximately 80 rural zones -- the majority of which are managed or co-managed by nongovernment organizations. Family planning services will be established or strengthened in approximately 120 urban clinics and 800 rural health centers. Seventy-five percent of children under five in 200 rural and urban zones will have access to under-five clinics. Services will include: growth monitoring; vaccination programs; oral rehydration therapy, counseling and follow-up; and malaria treatment and chemoprophylaxis. Seventy-five percent of women of child bearing age in 80 rural zones will have access to prenatal and maternity services. Through community development projects, water supply systems will be constructed for an estimated 600,000 rural inhabitants by simple technologies such as hand-dug wells and capped springs.

To improve services, the project will focus on strengthening a number of support systems. Priority assistance will be given to decentralizing a logistical system for the supply and distribution of contraceptives, and strengthening the regional depots charged with managing the distribution of ORS, chloroquine and vaccines to public and private sector clinics. Both systems will require increased funding by the GOZ for regional level operations and supervision. Utilizing national training teams, facilities at the USAID-assisted School of Public Health and regional training centers established under predecessor programs, the project staff will continue to support and revise in-service training programs. By the end of the project, several hundred physicians, nurses and water coordinators will receive training in the areas of management, supervision, counseling, evaluation and technical aspects of PHC. Building on a successful training-of-trainers approach, trained medical workers will be given additional resources to provide training programs for thousands of zone-level community

development workers, village health workers, and traditional birth attendants. Project outputs will be confirmed during the PP design phase.

More emphasis will be placed on standardizing inventory and reporting procedures among implementing agencies and organizations. Efforts to measure project impact will continue through the use of ongoing sentinel site survey systems, annual program reports, KAP surveys and focus group studies. In conjunction with recent Mission initiatives to improve impact evaluation, all special surveys and research studies implemented at the project level will be reviewed by appropriate Mission personnel in an effort to coordinate research, minimize duplication of effort, and reduce costs. USAID is developing its data bases and analysis guidelines in collaboration with Zaire's National Institute of Statistics, the School of Public Health, and other informational units such as those contained in USAID's area development projects. A national Demographic and Health Survey (DHS) is proposed for 1993, which will represent the public health sector's first definitive national database.

Achievement of these objectives will require close collaboration among all donor agencies and participating private and GOZ organizations. One major advantage in the design of this project is that with the exception of two new activities (urban blood screening and the establishment of a national sexually transmitted disease program), all proposed component activities are operational and many have extensive histories. Over the last five years, USAID alone has contributed an estimated $3 million for evaluations and operations research studies. Strengths and weaknesses of each activity have been identified, and many excellent recommendations have emerged which have not yet been implemented. The following project outline reflects a careful examination of past experiences and seeks to incorporate relevant evaluation and research recommendations.

2.4 Project Outline and How it Will Work

2.4.1. Project Design Issues

Historically, the mission has supported a large number of individual projects encompassing all areas of primary health care. Project Assistance Completion Dates (PACD) for the Family Planning Support Project and Basic Rural Health II Project are September 30, 1992. USAID supported AIDS and child survival activities, channeled through the Africa Regional HIV and AIDS Prevention Project and ACSI-CCCD Projects, are also funded through September 30, 1992. Faced with the options of continuing under separate bilateral agreements versus activity consolidation, the Mission decided on an integrated approach. USAID is seeking to reduce its management burden and to enhance coordination. Owing to the overlapping relationship among PHC

activities, as well as financial, research and policy issues, this approach should encourage greater collaboration. The School of Public Health Project, with a PACD of 1994, is not included in this design.

For this consolidation to work, it will require engaging an institutional contractor to provide management and selected technical assistance. The Mission is well aware of both advantages and disadvantages in the establishment of large omnibus projects managed through institutional contractors. Disadvantages most frequently cited include a slow project start up while new contractors become familiar with project activities and implementing agencies, and confusion regarding reporting relationships. However, project activities are continuing and do not require an extensive start up effort. Implementing agencies are accustomed to working with multiple personal services contractors with a relatively rapid turnover rate. Reporting relationships will be clearly defined according to the type of management task assigned to the management unit. Plans are under way to create an operations manual dedicated to the delineation of responsibilities and relationships. The availability of long-term technical assistance in selected cross-cutting areas should be a significant improvement over the plethora of short-term contractors currently providing critical assistance.

The advantages of an integrated design are primarily to enhance coordination and programming flexibility. Zaire's PHC activities become integrated at the zone health center level. However, at the central level, activities are divided into discrete areas under special programs with separate administrative and management offices. Program coordination depends largely on individual initiative or ad hoc committees. As a result, the central level is characterized by duplication of services and a proclivity toward competing agendas. Over the years, USAID may have, albeit inadvertently, contributed to this situation. Establishing discrete budgets requiring separate technical assistance, procurement channels, etc., could be reinforcing a fractionated central system in need of better coordination. Although the creation of an integrated project with one budget will not resolve all of these problems, it will reduce duplication of technical assistance efforts and will promote standardization and economies of scale in commodity procurement, logistical systems and research and evaluation studies.

Furthermore, the project will encourage linkages between the various activities. In Zaire, it is unacceptable to support family planning unless it is within the context of primary health care services. Consolidating supply channels, such as the utilization of community-based distribution programs and CSM's commercial networks to supply contraceptives plus ORS and other treatments, reinforce an integrated approach. Successful IE&C

innovations, under the AIDS Mass Media Project, now have the potential to make major contributions to the implementation of other maternal and child survival IE&C programs. The project will promote coordination between interlinked, mutually reinforcing activities.

Given the difficulties in achieving significant health status impacts within a limited timeframe, a seven year design is presented. Zaire's current political and economic environments preclude authorization of an expensive, long-term project. In response to this situation, USAID proposes to divide this project into two phases. The first phase would represent a three-year, $35 million effort aimed at maintaining essential PHC programs, mobilizing and expanding private sector service channels, and protecting vulnerable groups against a declining economic situation. Pending the resolution of Zaire's political situation, and proof of a sustained and increased commitment on the part of the GOZ to the health sector, USAID would be prepared to proceed with phase II.

Specific targets for the first 3 year and second 4 year phases will be established during the project paper design. The design team will also differentiate the magnitude of outputs for each activity within each respective phase. Comprehensive design matrices and detailed yearly budgets have been completed which should facilitate this part of the design effort (See Annexes C and D).

2.4.2 Project Strategies

Building on existing projects and national programs, this project primarily aims to strengthen support systems for the public and private sectors and expand service coverage by capitalizing on the momentum of successful delivery approaches. Guiding principles for project design are as follows:

Decentralization. The MOH has been very successful in its organizational reform efforts to decentralize. Recognizing its inability to adequately manage remote services from a central authority, the MOH endorsed the establishment of 306 zones, the system's smallest operational units. Zones are supervised by approximately 32 subregional offices and 11 regional inspectorates. Zone managers have the delegated authority to make decisions regarding planning, management and implementation. This strategy has significantly enhanced the GOZ's capacity to provide PHC services throughout the country. However, several individual interventions requiring a secure commodity and information supply line do not have adequate decentralized bases. The vaccination program worked 12 years to establish its 23 subregional depots, and now has the capacity to accommodate two-thirds of Zaire's health zones. Lessons learned from this approach must be applied to the provision of contraceptives and

materials for clinic-based family planning services. Wherever possible, supply line consolidation with existing distribution networks should be implemented.

Needs-Based Planning. All public sector project evaluations recommend an increased effort to incorporate peripheral managers' inputs into central planning activities. As recently stated by a project technical representative, " Our vision tends to stop at our own gates." Zaire's inadequate communication and transportation infrastructure, the prohibitive costs of frequent air travel for supervisory visits, and deficient planning skills all contribute to a Kinshasa-oriented planning approach. The follow-on project will address participatory strategies for translating national objectives into more meaningful and attainable objectives at the regional and zonal levels. A greater emphasis will be placed on decentralized strategic planning, and reinstating program bulletins and feedback mechanisms to stimulate provider performance.

Expansion of Service Delivery Networks. Successes from the CSM Project and experimental urban-based CBD programs have opened previously untapped channels for service delivery. Plans for expansion are twofold: (1) increasing the number of nontraditional distribution channels; and (2) adding new treatment commodities to the program's current package. CSM networks for the sale of condoms, oral contraceptives and spermicides currently include private pharmacies, clinics, parastatal companies with medical services, hotels, bars, and a number of ambulant vendors such as truck and taxi drivers and prostitutes. Anticipated channels include a number of "special interest groups", e.g. "mutuals", neighborhood associations, and labor unions. **The project proposes to add ORS to CSM's commodity venue and will experiment with extending CSM's urban-based distribution of ORS to selected rural zones.** Approaches will be examined that develop community-based distribution of contraceptives and selected curative treatments (ORS, chloroquine and vermox) in conjunction with operational private sector programs. Project designers will carefully study the absorptive capacity of implementing agencies so as not to critically overburden management.

Women's Issues. Numerous, closely spaced pregnancies, as well as the labor and time required to meet family needs for food, water, fuel and child care, take a heavy toll on women's health. Cultural and political ideologies impede women's opportunities to participate in the planning and management of development activities and education programs. Traditionally, project and program reporting systems and special studies have failed to collect information and data necessary to adequately plan appropriate interventions and to determine project impact on women. This project aims to incorporate women's issues at all levels of project design and implementation. All project

component activities either directly or indirectly benefit women's health status and well-being. A greater emphasis will be placed on collecting gender-disaggregated information in routine project reporting systems and special demographic and socioeconomic studies. **No less than 35% of all participants receiving short-term and advanced international training will be women.** Similar targets will be established for in-country training levels. Targets are constrained owing to the predominately male physician and nurse resource base. A special working group of professional women with health and social sector backgrounds will be engaged as consultants during the PP design stage.

Strengthening Rural Services. Approximately 60% of Zaire's population lives in rural areas. In the last decade, significant progress has been made in expanding maternal and child services and in rehabilitating a deteriorating health infrastructure. However, the current inflationary environment, with spiraling medication and fuel costs, is creating an enormous burden on the zones' self-financing capacity. Owing to rising costs, and the extremely low income levels of the rural poor, zones are losing ground in the battle to maintain and expand services. A published study (1989) from one rural zone demonstrated a 15% reduction in demand for health center services. The situation is now believed to be much worse. This project will continue to target commodities, technical assistance, and supervision, reconstruction and training grants to rural zones.

General Sustainability Issues. In 1989, AID/W sponsored a five-nation sustainability study which included an extensive review of Zaire's portfolio from 1972-1988. The factors found to have the greatest influence on project sustainability were: integration into ongoing administrative structures; project design negotiation through a mutually respectful process; human resource development for all levels of project activities; community participation, especially with regard to cost-recovery mechanisms; demonstrated effectiveness; strong technical assistance throughout life-of-project; and cost-recovery mechanisms established during the project. The project design will incorporate all of the above, with a special emphasis on enhancing cost-recovery strategies. However, financial sustainability will not preclude considerations of social equity. Thus, cost-recovery measures are being designed to minimize adverse impacts on utilization, particularly by the poor.

2.4.3. Project Implementation

The project will consist of four core components: (1) family planning; (2) AIDS prevention; (3) maternal and child survival; and (4) rural primary health care. The following section

presents a brief description of core project activities and support systems improvements.

Family Planning:

Family planning, the weakest link in Zaire's PHC program, will undergo the most extensive examination throughout project design. Although the current mix of contraceptive methods and delivery modes is considered appropriate, serious efforts will be made to shift USAID support for selected activities from public to private sector agencies.

The follow-on project aims to capitalize on CSM's successful sales record to extend both: (1) distribution points; and (2) the mix of contraceptives sold -- particularly oral contraceptives. Community-based distribution programs, currently managed under public sector auspices, were initially quite successful, but supplies and supervision have not been maintained. The potential for expanding CBD through CSM's commercial program will be examined. Critical to increasing contraceptive prevalence is the redynamization of both central and regional IE&C efforts. The project plans to refocus IE&C activities through a local, private sector IPPF affiliate, AZBEF, which has an extensive experience in supporting family planning information campaigns. Other private entities interested in contributing to urban FP efforts include the Women's Workers Association of Zaire's Labor Union, the National Nurses Association, for-profit companies, and church affiliated PVOs.

Rural family planning programs will be expanded through SANRU, the Basic Rural Health Project implemented by the Eglise du Christ au Zaire (ECZ). SANRU will increase its FP nurse-trainer staff; reestablish regional training-of-trainers programs; subsidize FP supervision and zone-level training; and help coordinate the decentralized contraceptive distribution system.

The government-based family planning program (PSND) will continue to play a major role. However, USAID assistance will be more sharply defined to specific tasks such as providing field support and contraceptive supply management. PSND serves as the leading agency in data collection, analysis and training.

Additional support service activities will include:

- establishing 11 regional "centers of excellence" to demonstrate model clinic services, and to provide training in the areas of counseling, follow-up and promotion;

- coordinating IE&C efforts with UNFPA and the AIDS Mass Media program;

- expanding commercial sales programs, particularly oral contraceptives, through nontraditional outlets and community-based distribution channels;

- developing and refining management and communication courses for all social marketing providers; and

- establishing a phased, decentralized contraceptive distribution system for clinic-based services; and consolidating supply lines with existing distribution channels where feasible.

AIDS.

AIDS prevention activities will focus on expanding electronic and print mass media programs, the social marketing of condoms, and rural blood screening. Presently, the mass media project is working in six regions targeting young adults aged 12-19 and 20-29. Future objectives include expansion into "high risk" areas (regions with heavy levels of trade, mining, and transportation links to Zambia and Angola), and closer collaboration with the condom social marketing program to target specific high-risk groups. Special emphasis will be placed on determining the needs of women, developing gender-oriented messages and disseminating information through women's groups. Condom distribution will be expanded from 15 to 24 urban centers thereby achieving nationwide regional coverage. Point-of-purchase studies indicate that an estimated 75% of condom sales are for the purpose of reducing sexually transmitted diseases (STDs) including AIDS. The mass media and CSM programs are implemented by Population Services International (PSI). PSI is investigating the possibility of obtaining official local NGO status.

Rural blood screening will be expanded to 30 rural zones. The project paper design team will review the experiences of the 1991 initiative with a special emphasis on incorporating counseling guidelines and cost-recovery options.

Two new activities will be examined during the course of project design: (1) urban blood screening; and (2) regional pilot studies to assess the problem of sexually transmitted diseases. The latter would be in preparation for establishing a national STD program.

Additional support service activities will include:

- enhancement of local production capacity to produce quality audio-visual IE&C materials;

- expansion and refinement of research, production and message development skills for program staff and broadcast technicians;

- expansion of materials distribution to rural areas through zones and PVO networks;

- development and dissemination of blood transfusion guidelines, and their integration into pre- and in-service training modules; and

- strengthening the capacity to screen blood with HIV rapid tests in 30 rural general hospitals.

Maternal and Child Survival Interventions.

The project targets vaccine-preventable diseases, control of diarrheal diseases, and prevention and treatment of malaria. Responsibility for policy formulation, data collection and analysis, cold chain maintenance, and distribution of equipment and supplies are under the MOH's national Programme Elargi de Vaccination (PEV) program. PEV will serve as the primary coordinating agency for maternal and child interventions.

Given the attenuated rate of increase in vaccine coverage, escalating fatality rates for malaria, and continued high case fatality rates owing to dehydration, improving child survival and family health will require a sustained, coordinated effort among all relevant public, private, and donor agencies. USAID will redirect its assistance toward strengthening and consolidating the MOH's cold chain supply and distribution system. Technical assistance will be provided to improve PEV's financial, logistic and administrative systems in formats that can better serve as management tools. More emphasis will be placed on strategic planning and coordinating resource needs with UNICEF and other contributing organizations.

Phase I of the project will emphasize the correct treatment for diarrheal illness by increased consumption of fluids, e.g. locally-available home solutions, continued feeding, continued breast feeding and the proper mixing and use of ORS. Anticipated high sales of ORS through CSM's commercial distribution channels should significantly increase treatment availability.

Additional support services activities proposed for this component are:

- develop and refine "integrated" primary health care in-service and pre-service curricula for all levels of health care providers;

- improve supervision of decentralized depots;

- revise, strengthen and expand health information and sentinel surveillance systems; and

- develop and refine policies, action plans, protocols and procedures for service delivery.

Rural PHC Services.

SANRU's PVO-based network continues to be the strongest conduit for reaching Zaire's remote rural areas. The integration of activities into one core program should enhance interagency coordination and the potential for rural zones to benefit from IE&C technologies and promotive materials currently concentrated in urban areas. Target objectives are to strengthen and expand health center services in 80 rural zones with a primary focus on developing and sustaining prenatal, under-five, family planning and maternity clinics. Specific assistance includes the provision of medical and laboratory equipment kits, medications, and vehicles, motorcycles and bicycles to enhance supervision and community outreach efforts. SANRU will continue to support decentralized training for all levels and will refocus in-service training toward the technical aspects of PHC. A SANRU evaluation, scheduled for August of 1991, will examine the possibilities of expanding selected activities, e.g. training and IE&C programs, into adjacent, non-PVO assisted zones. In conjunction with PEV, there will be a greater emphasis on expanding the cold chain and continued experimentation with the use of solar-powered refrigeration.

Over the last decade, SANRU has made a substantial contribution to the rehabilitation of the rural infrastructure. In collaboration with local communities, this project will continue to provide small grants for the rehabilitation of rural health centers and hospital maternities. SANRU is also the leading force in promoting community participation. Village development committees organize a variety of health activities such as basic environmental sanitation programs (latrine construction), small- scale water source improvements (hand-dug wells and capped springs), and participation in maternal and child services. Many serve as administrative committees assisting with the management and financial planning of health centers. The project will reinforce these efforts and continue to work closely with Peace Corps in the placement of water, health education and financial administrative assistant volunteers in SANRU-assisted zones.

The rural component is dropping large scale and expensive water activities such as well-drilling and the construction of gravity-fed adduction systems. The remaining small scale projects are expected to be implemented at the rate of approximately five projects per zone per year. These activities depend on the availability of local currency, and the initiative of zone level rural water coordinators and community members.

Nutrition.

Approximately 25% of children and 13% of women are undernourished. While these figures are average for low-income African countries, recent worsening trends are a matter of concern. The World Bank PASS Project is planning to provide technical and operational support to Zaire's National Nutrition Planning Center to finalize a nutrition and food security policy which addresses two major sets of issues: (1) the food security situation (including food expenditures and repartitions at the household level, food production and distribution); and (2) the prevalence of health and other social conditions contributing to malnutrition (diseases, close pregnancies, overwork of women, etc.). Although this project does not have a separate nutrition component, several of the proposed activities have a positive impact on nutrition: (1) reducing infectious diseases that interfere with food absorption and cause diarrhea; (2) encouraging birth spacing to ensure prolonged breastfeeding; (3) supporting growth monitoring programs (infant and child weighing scales, growth-weight charts); and (4) training health personnel and community members in nutrition. Health sector nutrition interventions are linked to overall mission objectives such as increasing food availability through PL 480 Title III sales, increasing food crop production and farmer incomes (agricultural portfolio), introducing new and more nutritionally beneficial crops to reduce dependence on manioc (56% of total caloric intake), and enhancing movement of food from producer to consumer (transport portfolio).

2.4.4. Project Policy Issues.

USAID continues to monitor and support World Bank policy reform measures. The GOZ is demonstrating its intention of meeting loan conditionalities, particularly in the area of increased budget allocations for operating costs. The Mission has identified a number of other specific issues which directly relate to project activities and objectives. During project development, these areas will be examined with regard to feasibility, costs and benefits, and interest expressed by other donors and implementing agencies. Policy areas to be addressed include: (1) prohibition of brand name advertising of pharmaceutical products and condoms in mass media; (2) lack of interministerial and donor coordination committees; (3) regulations on contraceptive and pharmaceutical pricing; and (4) the absence of an ordinance vesting the health zones with legal status.

2.4.5. Health Financing Initiatives.

Recognizing the importance of improving financial management systems and cost-recovery strategies, personnel from current USAID-assisted projects have increased their efforts to

incorporate financing initiatives. For example, proceeds from CSM contraceptive sales are now covering all regional office operating expenses. Plans to introduce a new "up-scale" condom brand should boost receipts, and serve as a mechanism for shifting costs from poorer to richer segments of the population.

This project will continue to place a high priority on examining supply-side costs and service delivery variables in relation to demand. In the current inflationary environment, the ability of the population to pay for services is decreasing. To address these issues, the project will examine: price elasticity for contraceptives, ORS and chloroquine; different fee scales for HIV screening services; and the costs to zones of immunization and family planning activities. Building on current initiatives, zone-level financial management and information systems development will be expanded. Targets include increasing the number of zones using effective single and double entry accounting procedures, and establishing three regional teaching zones offering hands-on training and internship programs in financial management.

3. Factors Affecting Project Selection and Further Development

3.1 Social Considerations.

Several activities proposed for this project deal with culturally sensitive issues. Most notable are those concerning family planning and AIDS-related behaviors. The situation is further complicated by Zaire's size and heterogeneity. Issues to be addressed in the PP include:

3.1.1. Socio-Cultural Context and Feasibility.

Family Size Traditionally, large numbers of children are coveted in Zaire. Although the cultural determinants of family size are complex, they include low literacy rates, perceived economic value of children (particularly in rural zones), and high infant and child mortality rates. Maternal and child survival interventions proposed in this project should help mitigate the negative causal relationship between high mortality and high birth rates. IE&C and product advertising approaches must be simple and adapted to regional variances. Family planning promotion should include men, and be presented as an integral part of primary health care. There is evidence that inflation, urban food shortages, and environmental degradation may be contributing to an increased desire for family planning.

Heterogeneity. There are many different ethnic groups in Zaire, with different languages, customs and beliefs. IE&C messages and images will continue to be pretested in different

parts of the country, translated into the five major national languages and adapted to rural and urban settings. To the greatest extent possible, message development should be decentralized, utilizing regional personnel and focus group analysis.

Illness Concepts. A study concerning local concepts of diarrhea and dehydration, conducted by the HEALTHCOM Project in Lubumbashi, determined that women classified diarrhea and dehydration into six distinct sets of symptomatology, each with a different name. If message designers for ORS had not known to include all names, they would have missed constellations of symptoms which include more severe forms of dehydration. This example illustrates the importance of understanding illness concepts prior to initiating educational programs.

3.1.2 Beneficiaries. The primary beneficiaries will be the millions of urban and rural Zairians who will receive information, commodities and services. An estimated six million women and children will benefit from improved support systems and the increased availability of clinic-based maternal and child interventions. Approximately 600,000 rural inhabitants will benefit from improved water sources. Other direct beneficiaries include the public and private sector managers, clinicians, and technicians who will receive training, technical assistance and supplies to enhance job performance.

3.1.3 Participation.

The MOH and all public and private sector implementing agency personnel will be actively involved in project design. The design team will visit all types of organizational structures (Ministry to health center) in both urban and rural settings, solicit input from health providers, technicians, and community members, and have the advantage of discussing needs with the current class at the School of Public Health. Each class is composed of approximately 15 physicians representing all regions and management levels.

USAID will solicit the counsel and participation of specific private groups (churches, professional groups, voluntary associations) who are expected to participate in implementation and directly benefit from project resources. Given the size of Zaire, it will not be possible to solicit design input from all "target groups" (diverse urban and rural populations) identified as beneficiaries. USAID's rich base of research data, surveys, KAP and case studies will be used to help identify the needs and capabilities of local people.

Many of the project activities are designed to enhance community involvement such as CBD programs, one-to-one personal communication campaigns, material support for the establishment of community development committees, and others. Overall, project activities exhibit a number of characteristics believed to ensure wider and sustained participation: probability of benefits; program complementary; program flexibility; and compatibility with the socio-economic environment.

3.1.4. Impact.

This project is designed to meet AID's primary objective to help people meet their basic human needs through equitable, sustainable growth. It addresses the issues of social equity, the special needs of women, children and men, urban-rural differences, and broad geographical distribution.

3.2. Financial and Economic Considerations

The economic situation in Zaire is rapidly deteriorating. In 1989, the GOZ's macroeconomic stabilization program fell apart as the Government failed to contain public expenditures and resorted to monetary financing of its budget deficit. This, in turn, crowded out credit to the private sector, fueled inflation and caused a decline in real incomes. Inflation reached 242% in 1990 and per capita incomes declined by an estimated 5%. Over the last 10 years, GDP growth (estimated at 2.6%) has remained below the population growth rate (approximately 3.1%), and per capita incomes remain among the lowest in Africa. A 1988 USAID-funded survey of 1100 rural households demonstrated an average reported annual per capita household expenditure of $79. World Bank estimates are that total (public and private) recurrent expenditures in health care are about $6 per capita. Public spending for health (including salaries) has declined from 5% of Government recurrent expenditures in 1978 to less than 2% in 1989. As a result, the government contribution represents less than 5% of the recurrent expenditures of this sector, an extremely low figure as compared to the Sub-Saharan Africa average of 35%.

Declining per capita incomes and the rapid three percent annual growth rate of the population are reflected in the poor socioeconomic status of the Zairian population. High population growth poses serious constraints to the GOZ's ability to provide education and health services, housing, food, and productive employment opportunities. Poor health status of the population reduces productivity and drains public resources.

The proposed interventions directly enhance opportunities to increase families' productive capacity, consumption, and access to health services. Benefits of a macroeconomic nature include potential improvement in food self-sufficiency and

aggregate benefits in terms of increased GNP. More specific direct benefits associated with increased access to contraception and family health interventions are: (1) more effective birth spacing and use of treatment modalities which are in turn linked to improved health status of mothers, infants and siblings; and (2) decreased risks of maternal mortality from improved accessibility to services, as well as reduced exposure to risks of pregnancy.

Additional benefits derived from expanded service and information networks include: (1) increased freedom of choice to control fertility, thus improving the capacity to plan family size according to economic ability; and (2) increased capability to make informed decisions regarding personal health and illness behavior practices. Owing to the project's focus on extending services in rural areas, project activities enhance distributional benefits to lower income groups and to geographical areas currently underserved by either private or public systems.

Since this project will contribute to decreased morbidity, mortality, and fertility, it is likely to have economic benefits. However, many of the benefits do not lend themselves to the application of traditional cost-benefit analyses. Rather, the project paper's economic and financial analysis should focus on identifying and measuring the effectiveness of project interventions in terms of alternative channels of delivery and alternative intervention packages using the same resources.

The funding levels for components were derived from a preliminary examination of a number of criteria including: (1) current levels of impact and internal efficiencies proven in predecessor projects; (2) identified deficiencies in selected service delivery performance; (3) anticipated resource availability from the government, private sector, donor organizations and the population; (4) geographic coverage; and (5) social equity. The project paper will further examine the relative proportions of planned levels based on the above as well as other selection criteria. The financial analysis should focus on the sources of financing to pay for resources, and current cost recovery strategies.

Issues to be examined in the project paper are:

* Least cost, highest impact strategies for delivering commodities and services to different population groups (e.g. urban-rural, high income-low income, high risk-low risk);
* Alternative financing mechanisms:
  (a) the capacity of the consumers to pay for services in light of declining real incomes,

(b) degree to which costs are shared by the consumers, the GOZ and donors,
(c) insurance schemes and current revolving fund practices;

* Financial (profitability) incentives for different segments of the private sector to become more involved in family planning and health services;

* Options for price differentiation and cross-subsidization;

* Optimal pricing strategies for health and family planning commodities.

Of particular importance are the costs of delivering ORS and antimalarials to the population. For those costs borne by the population, should funds be obtained from direct fees to the user, from fees retained at the health facility, or some other modality? Prior to the PP, USAID plans to conduct a study to evaluate current procurement, inventory, distribution, costing and pricing mechanisms for these two commodities.

3.3 Relevant Experience with Similar Projects

In addition to the predecessor projects discussed above, project activities will continue to be closely linked to the USAID-assisted School of Public Health. The School is an essential component of the Mission's strategy to provide qualified personnel at the middle and upper levels of the health system. To date, the School, in collaboration with local projects and programs, has conducted research on the sociocultural aspects of AIDS, environmental health problems, nutrition and growth monitoring, and has been the host agency for over 30 operational research studies on child survival activities. The project will continue to encourage use of the School's facilities and expertise for future research, and will support approximately 10 students per year in a one-year public health diploma program.

3.4. Proposed Grantee

The grantee will be the Government of Zaire, signed by the Minister of Health on its behalf. However, per U.S. law, no appropriated monies will be transferred to the GOZ. The project will be implemented through several private sector entities (ECZ, PSI, AZBEF) and the MOH's vaccination and family planning programs. Implementing agencies will continue to plan, monitor progress and conduct evaluations in close association with various Ministry of Plan and MOH offices and statistical bureaus. Personnel from anticipated implementing agencies are in agreement with the identified needs and activities proposed in the project.

3.5. AID Support Requirements and Capability

Integrating activities into one core project represents a significant departure from the current organizational configuration. Health activities have achieved a high level of program impact and USAID wishes to maintain that success. However, there are a number of constraints affecting Mission and project performance. Chief among those identified include:

* large management burden for HP's direct hire, contractor and foreign service national (FSN) staff;
* unwieldy number of short-term technical assistance contracts (approximately 80 p/m annually);
* inadequate project supervision and direct contact with the field;
* unsatisfactory coordination among essentially interlinked projects; and a
* poor procurement record.

To reduce the consequences of the above-mentioned constraints, USAID proposes to establish a management and technical unit to be managed by an institutional contractor. Owing to the wide range of management and technical skills required, the Mission anticipates that the contract will be awarded to a consortium of firms. The management component of the unit will be staffed by a Chief of Party, a Management-Financial Administrator and host country national support personnel. The magnitude of the commodity procurement level proposed for these activities necessitates a review of current Mission procurement practices. Management requirements related to procurement, delivery and the tracking of commodities will be carefully examined throughout project design. Current proposals include a division of procurement responsibilities: the institutional contractor handling the more technically complex medication, contraceptive and medical equipment procurements, and the Mission procuring vehicles, spare parts, and other supplies. USAID can procure some items more quickly and more cheaply through federal supply and embassy-to-embassy routes.

The technical component will comprise a team of long-term technical specialists in the areas of: epidemiology; commodity supply and distribution (for both public and private sector supply systems); IE&C; and health care financing. The advantages of having long-term technical assistance specialists placed in a unit encompassing all component activities are threefold: (1) to reduce the numbers of short-term contracts, thus reducing the management load; (2) to enhance continuity in specialty areas; and (3) to promote coordination among linked activities.

Reducing the number of separate management tasks within the Health and Population Office should allow direct hires and FSN staff to be used more effectively for sector analysis, policy dialogue, field-level project monitoring, and searching for mechanisms to better consolidate and integrate project activities. Furthermore, the incorporation of all activites under one budget will significantly improve financial and planning flexibility. The inability to shift resources-- especially technical assistance-- has impeded efforts to assist activities requiring additional critical support. The project will continue working with a number of local private sector implementing agencies, and will review options for buy-ins to centrally- and regionally-funded projects on an individual basis. The roles and relationships among the institutional contractor and local agencies will be carefully planned and specified by the Project Paper.

3.6. Estimated Costs and Methods of Financing

Estimated AID Contribution
(Development Fund for Africa - $000s)

Element	Phase I	Phase II	Total
Technical Assistance (short-term, 70 person months @ $26/pm)	780	1040	1820
Commodities: Contraceptives, Materials, Supplies, Vehicles, Equipment	18300	26260	44560
Training (int'l short- and long-term)	1000	1100	2100
Technical Assistance (long-term project level)	5000	4600	9600
Institutional Contractor (management & technical unit)	5250	6600	11850
Other Costs (including IC overhead, evaluations and audits)	670	560	1230
Inflation - Contingency	4000	5000	9000
Total	35000	45000	80000

The government contribution is estimated at the dollar equivalent of $62 million which includes operating costs (for those not generated through cost-recovery sales of project subsidized commodities and the portion recovered through fee-for-services), in-kind, and investment budget contributions for infrastructure rehabilitation. An estimated $37 million of the GOZ's contribution will be from government owned counterpart funds which are jointly programmed with USAID. These funds will be generated from PL 480 and commodity import programs if the GOZ resumes a medium-term program. Counterpart funds will no longer be used to supplement local salaries or basic administrative costs as was the case under previous project financial arrangements. Rather, CPFs will be disbursed to enhance the achievement of specific objectives such as training programs, IE&C campaigns, operations research, and to ensure timely, in-country transportation of commodities and supplies. Preliminary detailed budgets for dollar and counterpart fund requirements are presented in Annex D.

The methods of financing for procurement of technical assistance will be by direct payment and federal reserve letter of credit where appropriate. Commodity procurement will be primarily direct payment, direct letters of commitment and limited bank letters of commitment. All other project costs will be financed by direct payment. Limited local cost financing will be authorized in the PP with authority for approval on a case-by-case basis resting with the Mission Director.

3.7. Design Strategy

Prior to PP design the mission plans to conduct a number of selected studies. Issues to be addressed, mechanisms for completing studies and anticipated resource levels are as follows:

(In process under current project funding)

1. local capacity, constraints and cost/benefit analysis for the production of ORS;

2. nationwide health survey: contains questions pertaining to contraceptive prevalence and fertility levels and use of ORS and household solutions, AIDS, and vaccination coverage;

(To be completed prior to PP design phase)

3. study of private sector capacity to produce audio-visual and print materials; analysis of public and private sector IE&C needs -- $20,000 (contracted through buy-in to HEALTHCOM Project);

4. analysis of current urban blood bank and blood screening capabilities to detect HIV, including costs, resources and donor involvement -- (contracted through CDC, regional funds);

5. feasibility study to rehabilitate regional radio infrastructures -- (local personnel);

6. study to evaluate current procurement, inventory, distribution, costing and pricing of ORS and chloroquine for PEV's system $40,000 -- (contracted through a buy-in to the centrally-funded Health Financing and Sustainability Project);

7. final evaluation of Basic Rural Health II Project -- $100,000 (contracted through local contracts and possibly an IQC); and

8. management analysis of the private sector family planning agency, AZBEF, in collaboration with IPPF and other USAID centrally-funded projects -- (financed by IPPF, central funds)

The Project Paper design team will include:

USAID-Zaire:	HP Project Officers, PDO, Program, Cont
AID/W:	Family planning specialist
IQC or Disadvantaged Enterprises:	Maternal and Child Survival specialist (MD) Economist and Financial Analyst Public Health Generalist - PP Coordinator Management Specialist
ZAIRE:	Government counterparts from MOH and private sector implementing agencies; beneficiaries; advisory committee of women from health and social sectors; coordination with other donors.

Proposed design schedule:

PID approval by AID/W	May 15, 1991
PP preparatory studies completed	October 15 1991
PP team in field	October 15, 1991
PP completed	January 31, 1992
PP authorized by AID/W	April 30, 1992
Project Agreement signed	June 30, 1992

3.8. Recommended Environmental Threshold Decision

The Initial Environmental Examination (IEE) is attached as annex B. The IEE concludes that the project components dealing with technical assistance and training are eligible and recommended for categorical exclusion pursuant to 22 CFR 216.2(c)(2)(i), while those components dealing with health care, population, and family planning are eligible and recommended for categorical exclusion under 22 CFR 216.2(c)(2)(viii). The small-scale water source improvements, limited building rehabilitations, and commodity procurement are eligible and recommended for negative determination.

3.9. AID Policy Issues

There are no AID policy issues for discussion. USAID supports the provision of all types of family planning methods including natural family planning. No project funds will be used for abortion or abortion-related activities.

3.10. Disadvantaged Enterprises Considerations

USAID fully supports the intent of the disadvantaged enterprises (Gray Amendment) legislation. To that end, small business concerns, as well as other eligible disadvantaged entities, will be encouraged to participate to the fullest extent possible in both project design and implementation. For the project design, once scopes of work have been written detailing the types of expertise needed for PP development, the Mission will contact the Africa Bureau Minority-Small Business Advisor for the names of disadvantaged enterprises that might be able to supply the required experts. The Mission will contact the disadvantaged firms directly, offering them the opportunity to propose candidates for the positions to be filled. The proposals received will be considered along with other nominations that will be solicited from IQC firms, some of which may themselves be disadvantaged enterprises. All selection evaluation criteria being equal, disadvantaged enterprise status may be a determining factor for selection.

For the implementation phase, the Mission encourages the participation of disadvantaged enterprises and organizations as prime contractors or subcontractors. Under Section 579 of the 1990 Foreign Operations Appropriations Act, all contracts in excess of $500,000 must contain a provision requiring that no less than 10% of the dollar value of the contract be subcontracted to disadvantaged entities. Because of the wide range of expertise and skills that will be required from the institutional contractor to manage the project, there is a strong possibility that the winning proposal will come from a consortium

of firms and organizations. This should allow ample scope for participation by disadvantaged enterprises. The Request for Proposals will specifically state that all proposals must include plans calling for no less than 10% subcontracting with qualifying U.S. disadvantaged organizations and individuals; business concerns owned and controlled by socially and economically disadvantaged individuals, including women; historically Black colleges and universities; colleges and universities having a student body in which more than 40% of the students are Hispanic-American; and private voluntary organizations which are controlled by individuals who are socially and economically disadvantaged. Proposals received that do not allocate a minimum of 10% subcontracting to such entities will be deemed nonresponsive.

ZAIRE INTEGRATED FAMILY PLANNING AND HEALTH PROJECT
PRELIMINARY LOGICAL FRAMEWORK

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Project Goal To improve maternal and child health and to lower the fertility rate and HIV transmission	**Measure of Goal Achievement** 1. Reduce infant mortality rate from 110 per 1000 to 90 per 1000 2. Reduce child mortality rate from 54 per 1000 to 40 per 1000 3. Reduce maternal mortality rate from 8 per 1000 4. Lower total fertility rate from an estimated 6.1 5. Stabilize urban and rural HIV seroprevalence rates in targeted areas	1. DHS Survey 2. National and international socioeconomic reports 3. Special ongoing surveillance studies 4. SANRU impact study	1. Economic and political stabilization occur 2. GOZ resumes IMF/World Bank Structural Adj. Program 3. GOZ policies continue to emphasize decentralized PHC activities 4. GOZ increases investments to health sector 5. Use of FP, maternal and child health interventions and AIDS prevention activities will improve overall health status of population 6. GOZ will encourage and facilitate the expansion of services through the private sector
Project Purpose To increase access to, and the effectiveness of, family planning and selected health services.	**End of Project Status** 1. Modern contraceptive prevalence increased from 4% to 12% in urban areas; and from 1% to 4% in rural areas 2. Proper use of ORS or household solutions for diarrheal episodes increased from 44% to 60% 3. Proper use of anti-malarial treatments increased from 46% to 65% in 1-5 age group	1. DHS Survey 2. Commodity (contraceptive, ORS and antimalarials) supply reports 3. National vaccination sentinel survey system 4. KAP, focus group, special household surveys 5. Implementing agency reports; private sector sales reports	1. GOZ policies continue to emphasize decentralized PHC activities 2. GOZ will facilitate the expansion of services through the private sector 3. GOZ will increase investments to PHC activities on a timely basis 4. GOZ increases priority to family planning

ANNEX B

INITIAL ENVIRONMENTAL EXAMINATION

or

CATEGORICAL EXCLUSION

PROJECT COUNTRY: The Republic of Zaire

PROJECT TITLE: Integrated Family Health Project (660-0128)

FUNDING: FY 1993 - 2000 US$80 Million

IEE PREPARED BY: Richard A. Macken
Mission Environmental Officer
USAID Zaire

ENVIRONMENTAL ACTION RECOMMENDED:

Positive Determination	
Negative Determination	X
Categorical Exclusion	X
Deferral	

SUMMARY OF FINDINGS:

The technical assistance and training components of the Integrated Family Health Project are eligible and recommended for categorical exclusion pursuant to 22 CFR 216.2(c)(2)(i). The project components dealing with health care, population, and family planning are eligible and recommended for categorial exclusion pursuant to 22 CFR 216.2(c)(2)(viii). The water source improvements, the limited building rehabilitations, and the acquisition of commodities are eligible and recommended for negative determination. The small-scale water source and building rehabilitation activities and the commodity procurement will have no significant adverse impact on the environment.

CLEARANCE:

Mission Director: Charles W. Johnson Date: March 23, 1991
Charles W. Johnson

CONCURRENCE:

Bureau Environmental Officer: Approved: _____
Disapproved: _____
Date: _____

CLEARANCE:

GC/Africa: _____ Date: _____

The maternal and child survival interventions component will target the use of vaccinations against vaccine-preventable diseases, the control of diarrheal diseases, and the prevention and treatment of malaria. USAID will direct its assistance toward strengthening and consolidating the Ministry of Health's cold chain supply and distribution system in order to extend services and reduce the incidence of vaccine stock-outs. This component will develop and refine integrated primary health care in-service and pre-service curricula for all levels of health care providers; improve the supervision of decentralized health facilities; revise, strengthen and expand health information and sentinal site surveillance systems; and develop and refine policies, action plans, protocols and procedures for service delivery.

The rural primary health care services component will concentrate on strengthening and expanding prenatal, under-five, family planning and maternity clinics in rural health centers. The project will continue to support decentralized training of trainers and will refocus in-service training toward the technical aspects of primary health care. Emphasis will be put on expanding the cold chain, including further experimentation with the use of solar-powered refrigeration. The project will continue to promote the participation of village development committees in such areas as environmental sanitation, water source improvement, and maternal and child health care services.

2. ISSUES AND IMPACTS

The Integrated Family Health Project is a follow-on activity to a series of health interventions that have been undertaken during the past decade through a series of discrete projects. These ongoing health projects, whose activities will be subsumed by the new project, have produced measureable positive results in health status in targeted health zones with no significant adverse environmental impact. In the same way, positive impacts from the Integrated Family Health Project are expected to result in: 1) increased access to health care facilities, 2) increased disease treatment opportunities, 3) improved HIV awareness, 4) better access to family planning commodities, and 5) improved availability of potable water.

During the process of project identification, a number of potential adverse environmental impacts that could occur as a result of project implementation have been identified. These possible negative impacts, which are discussed separately below, are: 1) environmental degradation caused by building rehabilitation, 2) dangers to wildlife and villagers from vehicles, 3) freon leaks from refrigerators, 4) improper disposal of used health care products, 5) environmental damage caused by improving water sources, and 6) increased energy use from vehicles and refrigerators.

Building rehabilitation: A limited number of health centers, hospital maternities, and zone central health offices will have small-scale rehabilitation work carried out on them under the project. No new construction is planned. All work will be of limited scope, with no more than three or four small rehabilitation activities taking place per zone. The amount budgeted for building rehabilitation for the entire country is the equivalent in local currency of $150,000 a year. Most of the required building materials--cement, corregated steel, and reinforcement bars--will be brought to the sites from distant sources of supply. Possible local contributions to rehabilitation work will be clay for brick making and wood for beams. The rehabilitation work will have no significant adverse impact on the environment.

Vehicles: During its seven-year life span, the project will provide about 230 diesel, four-wheel drive, long-axle vehicles to support health activities serving 200 zones in all of Zaire's 11 regions. A maximum of two vehicles will be allocated to any one zone. The vehicles will be used for project supervision, the delivery of medical equipment and supplies, and, in some cases, emergency medical evacuations. Because the vehicles will be dispersed over a very wide area and become available over a long period of time, they will have no significant adverse impact on the environment, presenting no new, unusual or special dangers to wildlife or people.

Refrigerators: The project plans to procure 175 kerosene and 160 solar refrigerators to maintain the cold chain needed for vaccines and to preserve the quality and shelf life of various other health care products. The most common cooling agent in refrigerators is freon. Among the 869 project refrigerators--575 kerosene and 294 solar--currently in use in Zaire, there have been no known cases of freon leakage. Were a leak to occur, the amount of freon lost would be extremely small and would have no consequential effect on the atmosphere. The project refrigerators will have no significant adverse impact on the environment.

Disposal of health care products: Owing to severely limited resources, Zaire's health care facilities do not have the luxury of using disposable products. For example, all needles and syringes are reusable. This project will continue to provide U.S. Government regulation sterilizers and other equipment used for cleaning purposes. In-service training programs provide instruction on the proper use of sterilizers and disinfectant solutions, and the importance of using a one-to-one needle:patient ratio. Once equipment, such as needles, are worn out, they are generally collected by the zone central office staff, broken and destroyed in order to prevent continued use. Technologies used in health centers are simple and do not include the use of radioisotopes or other forms of radiation for treatment purposes. Health care products provided under this project will have no significant adverse impact on the environment.

Water sources: The project will improve the availablility of potable water to rural dwellers by capping springs and hand digging wells in approximately 80 health zones. All of these water supply improvements will be extremely small scale. There will be no more than one per village, and the maximum number of people served per improved water source will be 250. All of the capping will take place at artesian springs, and hand pumps will be supplied for the wells. These water source improvements will take place only in villages with established village development committees. Specific village development committee members will be designated to be responsible for the long-term management and maintenance of the improved water sources. This system has worked well in the villages where it has already been implemented, ensuring ongoing local interest in seeing that water source improvements continue to function properly. Improving water sources through small-scale, simple technologies will have no significant adverse impact on the environment.

Increased energy use: The limited number of vehicles (230) and refrigerators (335) that will be bought under the project will place no significant new demands on energy supplies. The vehicles will be spread all over Zaire and will be phased in over a number of years. The addition of a maximum of two vehicles per any one health zone can easily be accommodated by the existing fuel distribution system, despite its inefficiencies and periodic shortages. Similarly, the addition of 175 kerosene refrigerators can easily be handled by the present distribution system. The procurement of 160 solar refrigerators will, of course, cause no new fuel demands. The energy needs of the vehicles and refrigerators to be bought under the project will have no significant adverse impact on the environment.

Other concerns: The project will have no significant adverse impact in any other area of environmental concern. The project will not impact significantly on endangered or threatened animal species. There will be no expansion of disease exposure opportunities or vector habitats. There will be no significant adverse environmental impact on either global climate change or water quality. Short-term, localized increases in levels of noise, vibration and dust during building rehabilitation are expected to be insignificant. The project is not expected to have any adverse impact on historically or archaeologically significant sites, areas of religious importance, at risk populations, plant species, or rare or unique ecosystems. Pesticide acquisition, importation or use is not planned or needed under this project.

ANNEX C

- DESIGN MATRICES -

3. RECOMMENDED ENVIRONMENTAL ACTION

The technical assistance and training components of the project are eligible and recommended for categorical exclusion pursuant to 22 CFR 216.2(c)(2)(i). The technical assistance part of the project will involve advising and monitoring, and can include suitable environmental guidance and controls in the job descriptions of the advisors. The training component will have no direct impact on the environment. Most project activities are also eligible and recommended for categorical exclusion pursuant to 22 CFR 216.2(c)(2)(viii) as they involve health care, population and family planning services.

The water source improvement and building rehabilitation activities are recommended for a negative determination. The water source improvements are all small-scale, serving a maximum of 250 people each, while the building rehabilitations will involve limited repairs to existing buildings. The acquisition of commodities is also recommended for a negative determination since no significant impact on the environment is foreseen resulting from procurement. In the unlikely event that the commodity imports include pesticides--which are totally unneeded under the project--such procurements would be subjected to review pursuant to 22 CFR 216.3(b).

PUBLIC SECTOR

	SERVICES PRODUCTS	SUPPORT SYSTEMS	POLICY ISSUES	Financing Initiatives
AIDS	A. STDs: Strengthen clinic based diagnosis and treatment of STDs.	A. Up-date pre- and in-service training modules for all levels of health care providers B. Establish monitoring and data collection reporting systems.	Technical: Establish national protocals for the diagnosis and treatment of STDs.	
	B. Communications: Expand interpersonal communication campaigns into x primary and x secondary schools.	A. Train regional IEC coordinators in basic interpersonal communication techniques; Supply teaching modules with lecture series. B. Establish mechanism for supplying regional IEC trainers with education and regularly up-dated preventive materials.	National: Using local data, create Zaire-specific computerized AIDS-Model showing demographic impact of AIDS epidemic Update annually and use as tool for informing national decision makers.	

	D. Continue both quantitative and qualitative research, i.e. formative (focus gp./pretesting), program and evaluative such as longitudinal KAP for media impact.
*Expand interpersonal communication campaign into x primary and x secondary schools in 50 rural zones	A. Train zone level health providers in basic interpersonal communication techniques; Supply teaching modules with lecture series.
	B. Establish mechanisms for supplying zones with on-going education materials and regularly up-dated preventive materials.

PRIVATE SECTOR

AIDS

SERVICES PRODUCTS	SUPPORT SYSTEMS	POLICY ISSUES	HEALTH CARE FINANCING ACTIVITIES
A. Contraceptive Social Marketing: Strengthen and expand urban commercial sales program traditional and non-traditional). Products: 1.Condoms 2.Contraceptive Packaging materials 3. Promotional Items	A. Training: 1. New and refresher courses for central and regional office marketing managers and supervisors. 2. Continuous training for for all social marketing providers. B. Establishment of operational logistical system for the supply and distribution of contraceptives and promotional items. C. Development of on-going reporting systems for evaluation, impact analysis. D. Improved methods for the design, testing and production of product-specific promotional materials.	National: Obtain approval to advertise condoms and contraceptives using mass media channels. Current constraint: only point-of-purchase legal. Enhance private sector capacity by establishing mechanism for private groups to buy cheaper condoms through WHO/GPA via national committee (BCC).	Test ways to increase operating cost recovery, e.g. examine price elasticity of demand for contraceptives, introduce second "up-market" condom brand, etc.

1. Expand HIV Rapid Test capacity for bld. transfusion and confirmation of sero-positive suspected cases in x urban and x rural zones.

2. Coordinate with other donors regarding establishment of blood banking centers capable of Elisa Testing in x major urban areas.

Products:
1. HIV Rapid Tests
2. Elisa Tests
3. Western Blot

C. Communication
* Strengthen and expand AIDS prevention mass media programs into x regions.

Products:
1. Audio-visual equipment
2. Promotional items: Tee-shirts, badges hats, posters, etc.

A. Training
1. Rapid & Elisa test application for laboratory technicians

2. Counseling training for associated service providers.

B. Development of logistical system for supply and distribution of HIV test products.

Establish reporting system for on-going data collection, analysis, and dissemination

A. Establishment of a central media center

B. Rehabilitation of regional radio systems in x regions.

C. Training:
Continuing training for media technicians re: the design, testing, and production of electronic and printed materials.

Test and document different fee scales for rapid test services. Investigate revolving fund possibility to cover in-country storage/transport costs.

PRIVATE SECTOR

	Services Products	Support Systems	Policy Reforms	Financing Initiatives
FAMILY PLANNING	A. Clinic Services Strengthen and expand family planning services in X urban and X rural service clinics. x HCs x Hospitals Products: 1. AV Materials 2. Community-level printed educational materials	A. Training: 1. Support x number of regional TOTs per year (technical, supervision, management). 2. Continue specialized training for x physicians in VSC, IUD and Norplant insertion. B. Contraceptive Supply and Distribution 1. Establish an operational decentralized distribution system in x Regional-S/Regional depots. 2. Support development of standardized inventory and reporting procedures. C. Establish one "Center of Excellence" in each of 11 regions.		Assist rural zones in evaluating costs, determining appropriate prices, and developing a methodology for adjusting prices. Conduct a comprehensiv cost-effectiveness analysis of delivery modes and contraceptiv methods.

	OR studies to investigate FP program implementation. E. Provide additional supervision subsidies to zones with FP programs. Link subsidies to CYP levels.		
B. Contraceptive Social Marketing: Strengthen and expand urban commercial sales programs {traditional and non-traditional}. Establish CBD in x major urban areas. Products: 1. Condoms 2. Spermicides 3. Oral Contraceptives 4. Contraceptive packaging materials and promo items	A. Provide continuous training to all social marketing providers B. Establish supply and distribution system for contraceptives and promotional items. C. Develop reporting system for evaluation, impact analysis and information dissemination. D. Improve methods for the design, testing and production of product-specific promotional materials.	National Obtain approval to advertise condoms and contraceptives using mass media channels. Enhance private sector capacity by establishing mechanisms for private groups to buy cheaper condoms through WHO via national committee (BCC).	Test ways to increase operating cost recovery, e.g. examine price elasticity of demand for contraceptives, introduce second "up-market" condom Brand, etc.

FAMILY PLANNING

PUBLIC SECTOR

Services Products	Support Systems	Policy Reforms	Financing Initiatives
A. Clinic Services:			
Strengthen FP services in X ur x urban public sector service clinics.	A. Contraceptive Supply and Distribution	National:	
	1. Establish an operational decentralized distribution system in x regional and S/Regional depots.	Re-establish the Comite National des Naissances Desirables (coordinating committee).	Conduct a comprehensive cost-effectiveness analysis of service delivery modes and contraceptive methods.
Products: 1. Contraceptives 2. AV materials	2. Develop standardized inventory and reporting procedures.	Establish a donor, inter-agency coordinating committee for all key players in FP. Elected members could serve as "Family Planning Task Group" to GOZ to assist with policy and programmatic decisions.	Assist zones in evaluating costs, determining appropriate prices, and developing a methodology for adjusting prices.
	B. Training:		
	1. In-Service (a) Develop basic condensed" technical, supervision, and management module.	Technical:	Examine advantages of providing STD-Infertility services in concert with FP services in selected service delivery points.
	(b) Continue basic in-service training for x physicians and x nurses (an equipe from each zone) using two established regional training centers.	Establish standardized FP protocals (algorithms).	

C. IEC Pro

Revitalize printed and electronic FP mass media campaigns in x urban and x rural zones.

Enhance FP components of regional and zone level IEC training programs.

A. Train local service providers in basic IEC techniques; Focus on the accessibility message.

B. Establish mechanism for on-going supply and distribution of IEC materials.

C. Produce regular radio/TV "spots" and programs at the national and regional levels.

	Services Products	Support Systems	Policy Reforms	Financing Initiatives
Rural Primary Health Care	A. Health Center Services			
	Strengthen and expand PHC services in x rural zones. –Establish x number of health centers providing: *Prenatal Clinics *Preschool Clinics – Vaccinations – Growth Monitoring * Family Planning * Basic Curative and Laboratory Services * Maternity Services Products: 1. Essential medication package for HC level 2. Essential medication package for hospital level	A. Training 1. Continue supporting MPH training at the School of Public Health for x number of Regional and Sub–Regional; x no. of rural zone physicians. 2. Continue and expand regional TOTs for x number of zone "equipes" in PHC resource and financial management/ supervision. 3. Refocus nurse super–visor training of trainers programs on condensed technical info mation. e.g. vaccination growth monitoring, nutrition, malaria, ORT AIDS, family planning. Conduct x regional TOTS per year. 4. Support zone–level in–service training for x number of health center nurses in all key PHC technical areas.	National: Continue to assist with the preparation and official adoption of a "loi cadre" which aims to define and clarify public and private (NGO) management roles at the zone level. Encourage the creation of an ordinance vesting the health zones with legal status. Current non–legal status permits no access to credit which constitutes serious barrier to private sector financing initiatives. Influence GOZ decision makers to increase financial contributions toward PHC activities, particularly selected maternal and child health interventions.	Systems Development * Develop zone–level accounting–procedures manuals and financial–management notes for: (a) single–entry accounting systems; and (b) double entry accounting system * Assist health zones to improve their financial management informatio systems (FMIS). (1). Prepare case studies and training materials. Identify zones with progressive FMIS. (2). Establish regional teaching zones offering hands–on training and internship programs on FMIS development.

(c) Install and maintain AV equipment in training centers as adjuncts, e.g. provider client interviews, TOT exemplary sessions, etc.

(d) Continue specialized training for x physicians in VSC, IUD insertion.

C. Establish reporting systems for on-going data collection, data analysis, dissemination and targeted feedback.

B. Reinforce supervision system through targeted subsidies.

C. Continue zone-level OR studies aimed at identifying practical interventions toward the improvement of PHC management and service delivery.

D. Strengthen rural infrastructure through construction and rehabilitation of deteriorating facilities.

E. Expand vaccine cold chain by installing x solar frigos.

F. Train x technicians to operate and maintain solar equipment.

B. Water and Sanitation:

Strengthen capabilities of RHZ staff and community members to plan, implement and maintain water and sanitation activities.

A. Training:

Continue in-service training (TOTs) for rural water supply and sanitation coordinators in community organization.

National:

Support the adoption of O & M strategy as a national policy.

and sub-regional depots to develop management systems for pharmaceutical products i.e. procurement, inventory management, distribution, costing and pricing (differential).

* Establish health insurance systems (pre-payment) in selected health zones.

Monitoring Costs:

* Develop a central information system to monitor costs, cost-recovery and the general financial situation in the project's targeted zones.

* Evaluate the costs of adequate supervision in rural health zones and identify financing strategies.

Support construction of water systems to improve water quality and to the greatest extent possible, quantity and accessibility.

- x springs
- x hand-dug wells
- x gravity-fed systems

Support construction of model "VIP" latrines

- x VIP latrines
- x% of HHs per village have usable latrines

D.Community Participation:

Support fundamental principle of GOZ strategy to decentralize control of health services and to ensure that community members are informed and actively involved in organization, planning, and management.

Support the National Water and Sanitation Training Team through annual seminars and regular in-service training.

B. Continue development of community level IEC materials, especially in systems operations and maintenance.

C. Conduct studies to determine service and training impact, changes in women's productivity levels, etc.

D. Improve current reporting system regarding numbers of beneficiaries per WS system; documenting associated water-born diseases and trends.

A. Training:

Support zone-level in-service training for x number of health center nurses in community organization, education and communication.

Initiate dialogue with the Ministry of Health to register RWCs as Functionnaires d'Etat. Encourage GOZ to add this cadre as public sector employees thus ensuring base salaries.

Research:
Determine costs to zone of immunizations and family planning activities at different levels of output, and alternative financing strategies.

Examine the cost-effectiveness of water improvement interventions on diarrheal diseases.

Study and document different mechanisms for financing the operations and maintenance of water systems requiring spare parts, etc.

C. Malaria Prevention & Treatment		
1. Increase number of fixed facilities using proper doses of anti-malarials	Revise protocols re: use of malarial prophy-laxis in pregnancy	Examine chloroquine pricing systems; elasti-city of demand
2. Increase supply and steady distribution of anti-malarials		
D IE&C		
1. Establish an IE&C program; line-item in budget		
2. Strengthen collobora-tion with AIDS & FP IE&C activities		
3. Produce x posters, printed materials; x TV and radio spots per yr.		
4. Establish a mechanism for steady supply and distribution of materials to urban and rural zones		
5. Train local personnel in urban zones IE&C techniques for community level		
E. Information Systems		
1.Continue strengthening sentinel site surveillance system; coordinate info obtained with other PHC programs, standardize reporting forms		

	Services Products	Support Systems	Policy Reforms	Financing Initiatives
MATERNAL & CHILD SERVICES	A. Health Center Services Strengthen maternal & child services in 200 zones. –Establish xx health centers providing: * Vaccinations * ORT * malarial treatment	A. Vaccination Services 1. Cold chain working at all levels: (a) national; (b) 23 depots; (c) 200 zones 2. Quantity and stock of vaccines adequate; steady supply line operational 3. HC nurses trained in sterilization procedures, vaccine calandar, cold chain maintenance, & follow–up for children with incomplete doses 4. Increased supervision depot staff to x visits per year B. ORS 1. Increase number of fixed facilities using ORT as first line treat–ment for diarrhea and rehydration 2. Increase supply and steady distribution of ORS to facilities 3. Train medical personnel re: proper use of ORS	Increase GOZ budget allocations to PEV operating costs Revise as necessary vaccine protocols, cold chain recommendations Revise as necessary protocols concerning ORT	Determine costs to the zones of immunization activities at different levels of output, and alternative financing strategies Evaluate the existing number and location of regional and subregional depot teams; determine improved configurations Examine ORS pricing systems; elasticity of demand

2. Strengthen 100 HH survey; add questions in collaboration with other PHC programs.

3. Re-instate epidemiology bulletin; feedback mechanisms

ANNEX D

- DETAILED BUDGETS -

FAMILY PLANNING INTERVENTIONS

(in 000's)

	92–93	93–94	94–95	3 YRS	95–96	96–97	97–98	98–99	TOTAL
URBAN CLINIC SERVICES									
PUBLIC :									
* National Office Equipment	10	10	10	30	10	10	10	10	70
–Medical Equipment Kits for FP/Maternal/Child Services (Incentive and assistance for initiating FP clinics; primarily for deteriorating public services) [Speculums; stethoscopes; BP Cuffs; tape measures; baby scales; utility bowls; catheters; limited lab equipment; mid–wifery kits]									
120 clinics x $2,000	35	35	35	105	35	35	35	35	245
* Contraceptives									
Condoms: 1,500,000 yr. x 0.05 x 1st 3 yrs.	75	75	75	225					225
2,500,000 yr x 0.05 x 4 yrs.					125	125	125	125	500
Oral Contraceptives: 500,000 x .20 x 3yrs.	100	100	100	300					300
Oral Contraceptives : 1,000,000 x .20 x 4					200	200	200	200	800
Spermicides: 500,000 x .15	75	75	75	225	75	75	75	75	525
* Supply and Distribution Depot upgrade (equipment; computers; air condo etc.) 10 depots x $8,000 x 2	40	40		80		40	40		160
* Vehicles 10 x $20,000					200				200
Spares = 10 kits x $1000					10				10
* Bicycles: (CBD) 200 x $200	20	20		40		20	20		80
Sub–total	355	355	295	1005	655	505	505	445	3115

* National Office Equipment	20		20	40		20		20	80
* Vehicles: 5 x 2 x $20,000	50	50		100		100			200
Spares = 10 kits x $1500	8			8		8			16
* Vehicles Regional: x 10 x 2 x $20,000	200			200	200				400
Spares = 20 kits x $1,500	15			15	15				30
* Regional Coordinators Office Equipment/Rehabilitation: 10 offices x $4,000	20	20		40					40
* Centers of Excellence Medical equipment/AV equip/ Lab equip/furniture 11 centers x $15,000	42	41	41	124	41				165
Sub–Total	355	111	61	527	256	128	0	20	931
CONTRACEPTIVE SOCIAL MARKETING									
* Contraceptives									
a. Condoms: +Transport .05 ea x 20,000,000 x .20	200	200	200	600	200	200	200	200	1400
b. Condom Packaging: .01696 x 20,000,000 x .20	68	68	68	204	68	68	68	68	476
c. Spermicides .15 x 3,000,000 c	450	450	450	1350	450	450	450	450	3150
d. Spermicide Packaging .0175 x 3,000,000 c	53	53	53	159	53	53	53	53	371
e. Oral Cont: .20 x 500,000 x 3yrs c	100	100	100	300					300
f. Oral Cont: .20 x 1,000,000 x 4yrs					200	200	200	200	800
g. Oral Cont. Packaging .0261 x 500,000 x 3yrs	13	13	13	39					39
h. Oral Cont: Packaging .0261 x 1,000,000 x 4yrs					26	26	26	26	104
Sub–Total	884	884	884	2652	971	971	971	971	6536

TRAINING – CONFERENCES									
International participants 10 per year x $6000	60	60	60	180	60	60	60	60	420
TOTAL	1654	1410	1300	4364	1942	1664	1536	1496	11002
CONTINGENCY	132.	112.	104	349.	155.	133.	122.	119.	880.1
5% INFLATION	82.7	70.5	65	218.	97.1	83.2	76.8	74.8	550.1
GRAND TOTAL	1869	1593	1469	4931	2194	1880	1735	1690	12432
			Commodities	4184			Commodities:		10686
			Training	180			Training:		420
			T.A.	0			T.A.:		0
			Sub–total	4364			Total		11106
			Contingency	349.					
			Inflation	218.			Contingency		888.4
			Total	4931			Inflation		555.3
							GRAND TOTAL		12549
LOCAL COSTS:									
PUBLIC SECTOR (PSND)									
* Training Regional TOTs	100	100	100	300	100	100	100	100	700
* Regional Supervision 2 pers x 9 regs x 2 trips x $600 rt	22	22	22	66	22	22	22	22	154
2 pers x 10 regs x 2 trips x $40/day x 6	10	10	10	30	10	10	10	10	70
* Program: Statistical Reporting; Supervision; Publications	80	80	80	240	80	80	80	80	560
* Operations Research	80	80	80	240	80	80	80	80	560
* In–Country Transport: Contraceptives/Equipment	115	115	115	345	115	115	115	115	805
Sub–Total	407	407	407	1221	407	407	407	407	2849
PRIVATE SECTOR (AZBEF)									
* Local Consultants/Tuition	10	10	10	30	10	10	10	10	70
* Transport									
1. Travel & PerDiem	20	20	20	60	20	20	20	20	140
2.Vehicle Maintenance & Fuel	30	30	30	90	30	30	30	30	210
* Office Utilities/Supplies/ Maintenance	50	50	50	150	50	50	50	50	350

* Training									
Regional TOTs	100	100	100	300	100	100	100	100	700
National Seminars	50	50	50	150	50	50	50	50	350
* Regional supervision	32	32	32	96	32	32	32	32	224
* Centers of Excellence 11 x $8,000 maintenance per year	88	88	88	264	88	88	88	88	616
* IEC local production and distribution	200	200	200	600	200	200	200	200	1400
* Kin Radio/TV	50	50	50	150	50	50	50	50	350
* In-Country Transport	115	115	115	345	115	115	115	115	805
Sub-Total	745	745	745	2235	745	745	745	745	5215
Public & Private Total	1152	1152	1152	3456	1152	1152	1152	1152	8064
Contingency	92.1	92.1	92.1	276.	92.1	92.1	92.1	92.1	645.1
5% Inflation	57.6	57.6	57.6	172.	57.6	57.6	57.6	57.6	403.2
GRAND TOTAL	1301	1301	1301	3905	1301	1301	1301	1301	9112.

AIDS INTERVENTIONS

(in 000's)	92–93	93–94	94–95	3 YR	95–96	96–97	97–98	98–99	TOTAL
MEDIA & SOCIAL MARKETING:									
* Home Office – Salaries/Fringes	45	45	45	135					135
* Field Staff – Salaries CSM Manager (100%) Com. Manager (100%) Com Technician (100%)	148	148	148	444	148	148	148	148	1,036
* Allowances	125	125	125	375	125	125	125	125	875
* Indirect Costs (31%)	45	45	45	135					135
* Home Office Overhead @ 140%	330	330	330	990					990
* Travel & Transportation: –Fares & Freight									
a. Home Office	10	10	10	30					30
b. Field Staff	11	11	11	33	11	11	11	11	77
* Equipment, Materials, Promos Equipment:									
a. Com. Vehicles		60		60					60
b. CSM Vehicles		200		200					200
Materials/Promos									
a. CSM Condoms (+trans) .05 ea x 20,000,000 x .80	800	800	800	2,400	800	800	800	800	5,600
b. CSM Condom Packaging .01696 x 20,000,000 x .80	272	272	272	816	272	272	272	272	1,904
c. PEM–SIDA Print	152	152	152	456	152	152	152	152	1,064
d. CSM Promos	170	170	170	510	170	170	170	170	1,190
* Training International	17	17	17	51	17	17	17	17	119
* Other Direct Costs (communications/DBA/etc.)	87	87	87	261	87	87	87	87	609
Sub–Total	2,212	2,472	2,212	6,896	1,782	1,782	1,782	1,782	14,024
BLOOD SCREENING (RURAL)									
* HIV–Check = 3.56 ea x per 1 GRH x 30 zones	75	75	75	225	75	75	75	75	525
= 3.56 ea x 200 yr. per 2 RHC x 30 zones	43	43	43	129	43	43	43	43	301
* SERODIA–HIV = 1.76 ea x 800 per 1 GRH x 30 zones	27	27	27	81	27	27	27	27	189
= 1.76 ea x 300 yr per 2 RHC x 30 zones	32	32	32	96	32	32	32	32	224
* Laboratory Equipment $2,000 x 30 zones	60			60		60			120

AIDS INTERVENTIONS

(in 000's)	92–93	93–94	94–95	3 YR	95–96	96–97	97–98	98–99	TOTAL
* Storage & Transport $800 x 30 zones	24	24	24	72	24	24	24	24	168
* Prospection/Training (Initial) $2,650 x 30 zones	80			80					80
* Inservice Training $2,500 x 30 zones			75	75			75		150
* Supervision and Evaluation 2 pers. x 1 visit x 2 days x 30 zones x $60/day	7	7	7	21	7	7	7	7	49
2 pers x 1 visit x 30 x $600 per round trip	36	36	36	108	36	36	36	36	252
* Administrative (photocopies, communications, carburant)	9	9	9	27	9	9	9	9	63
Sub–Total	393	253	328	974	253	313	328	253	2,121
BLOOD SCREENING (URBAN)									
* pending outcome of urban study	200	100	100	400	200	200	200	200	1,200
REGIONAL RADIO EQUIPMENT REHABILITATION									
* 20,000 per transmitter x 5 regions Pending outcome of feasibility study	50	50		100					100
NATIONAL MEDIA CENTER									
* Pending outcome of urban media study	200	200	75	475	75	75	75	75	775
SEXUALLY–TRANSMITTED DISEASES									
* Four Pilot treatment studies x 30,000 ea	120			120					120
* National Seminars/ Conferences	10	10		20					20
* Modules – Tx Strategies	8			8					8
* Inservice Training 3 Regions per yr x $15,000 per region (collaborate with FP)	45	45	45	135					135

AIDS INTERVENTIONS

(in 000's)	92–93	93–94	94–95	3 YR	95–96	96–97	97–98	98–99	TOTAL
* Supervision & Evaluation									
With HIV test (SANRU)	0	0	0	0	0	0	0		
–urban zones (PSND/AZBEF)									
2 pers x 1 visit									
x 9 regional sites (urban)									
x 4 days x $60/day	15	15	15	45					45
2 pers x 1 visit									
x 9 regions x $600 RT	4	7	11	22					22
Sub–Total	202	77	71	350					350
TOTAL	3,257	3,152	2,786	9,195	2,310	2,370	2,385	2,310	18,570
Contingency	261	252	223	736	185	190	191	185	1,486
5% Inflation	163	158	139	460	116	119	119	116	929
GRAND TOTAL	3,680	3,562	3,148	10,390	2,610	2,678	2,695	2,610	20,984

Commodities	6,080	Commodities	13,620
Training	341	Training	484
T.A.	2,774	T.A.	4,466
Sub–Total	9,195	Sub–Total	18,570
Contingency	736	Contingency	1,486
Inflation	460	Inflation	929
Total	10,390	TOTAL	20,984

AIDS INTERVENTIONS

(in 000's)	92–93	93–94	94–95	3 YR	95–96	96–97	97–98	98–99	TOTAL
LOCAL COSTS									
MEDIA & SOCIAL MARKETING									
* Local Office Expenses	275	275	275	825	275	275	275	275	1,925
* Local Staff Salaries	185	195	195	575	195	195	195	195	1,355
* Travel & Transportation –Local Fares: 10 Regions	117	117	145	379	145	145	145	145	959
* Special Media Events	30	30	30	90	30	30	30	30	210
* PEM–SIDA Radio/TV	93	93	93	279	93	93	93	93	651
* PEM–SIDA Regional	80	105	105	290	105	105	105	105	710
* Interpersonal IEC	30	30	30	90	30	30	30	30	210
* Training National									
a. CSM	5	5	5	15	5	5	5	5	35
b. PEM–SIDA @ 10 regions per year x $4,000	30	40	40	110	40	40	40	40	270
* Evaluation and Impact	100	100	100	300	100	100	100	100	700
Sub–Total	945	990	1,018	2,953	1,018	1,018	1,018	1,018	7,025
PRIMARY AND SECONDARY SCHOOL COMMUNICATION PROGRAM									
* TOT – 6 regions x 15,000	45	45		90					90
TOTAL	990	1,035	1,018	3,043	1,018	1,018	1,018	1,018	7,115
Contingency	99	104	102	304	102	102	102	102	712
5% Inflation	50	52	51	152	51	51	51	51	356
GRAND TOTAL	1,139	1,190	1,171	3,499	1,171	1,171	1,171	1,171	8,182

INTERVENTIONS

(in 000s)	92–93	93–94	94–95	PHASE I	95–96	96–97	97–98	98–99	TOTAL
Commodity Element									
* Electric Freezer – cold chain product x 6 x $340	2	2	2	6	2	2	2	2	14
* Kerosene & electric refrigerator x 60 x $1100 x3yrs; 175 frigos x 4 yrs	60	60	60	180	193	193	193	193	952
* Bicycles – 500 x $200	100	100	100	300	100	100	100	100	700
* Motorcycles x 60 x $2500	150	150	150	450	150	150	150	150	1050
Spare kits x 60 x $500	30	30	30	90	30	30	30	30	210
* Sterilizers – Prestige U99–080–00,S + U99–081–00,D 1000 x $80	80	80	80	240	80	80	80	80	560
* Vaccine Carriers, Thermos 5 liter 600 x $25	15	15	15	45	15	15	15	15	105
* Vaccine carriers, Thermos 45 Liter x 116 x $280	33	33	33	99	33	33	33	33	231
* Outboard Motors x 15 x $2000 x 2	30			30		30			60
* Sterilizer syringe/needle kits ASGL x 3000 x $25	75	75	75	225	75	75	75	75	525
* Sterilizer syringe/needle kits BDBL x 3000 x $45	135	135	135	405	135	135	135	135	945
Sterilizer Parts: – Timers 7510 x 100 x $10 – Gaskets 7522 x 100 x $2 – Safety Valves x 600 x $2 – STM CTRL valves 66 x $3 – Handles 7517 x 200 x $3 – Thermom. 475 x 600 x $3	5	5	5	15	5	5	5	5	35
* Refrigerator Parts – Wicks – Lamp Glass x 300 x $8 – Flue Brush x 600 x $14 – Electric Heater x60 x $22 – Burners x 300 x $25 – Ice Packs x 115 pkgs.x 78	29	29	29	87	29	29	29	29	203
* Chloroquine 100mg. tabs x 20,000 boxes x $13 x 3 yrs	260	260	260	780					780
* Chloroquine 100mg. tabs x 20,000 boxes x $13 x 4 Yrs.					260	260	260	260	1040
* Fansidar 527 mg tabs x 10,000 boxes x $26	260	260	260	780	260	260	260	260	1820
* ORS. 75 cl packets, 800,000 pkts x .12	96	96	96	288	96	96	96	96	672

Spares – 25 x $1000	10			10	25				35
RAINING – CONFERENCES									
* International x 4 x $6000	24	24	24	72	24	24	24	24	168
A – CDC									
* One Long–term Technical Assistant	150	150	150	450	150	150	150	150	1050
TOTAL	1749	1504	1504	4757	1960	1667	1637	1637	11658
CONTINGENCY	139.	120.	120.	380.56	156.	133.	130.	130.	932.64
5% Inflation	87.4	75.2	75.2	237.85	98	83.3	81.8	81.8	582.9
GRAND TOTAL	1976	1699	1699	5375.41	2214	1883	1849	1849	13173.5
		Commodities		4235			Commodities		10440
		Training		72			Training		168
		T.A.		450			T.A.		1050
		Sub–total		4757			Sub–Total		11658
		Contingency		380.56			Contingency		932.64
		Inflation		237.85			Inflation		582.9
		Total		5375.41					
							Total		13173.5
OCAL COSTS:									
* Transport:									
Vehicle maintanance, fuel	150	150	150	450	150	150	150	150	1050
In–country transport	30	30	30	90	30	30	30	30	210
* National & Regional Offices									
Equipment maintenance	4	4	4	12	4	4	4	4	28
Office Supplies	2	2	2	6	2	2	2	2	14
Printed materials	25	25	25	75	25	25	25	25	175
* Supervision	55	55	55	165	55	55	55	55	385
* Coordination – Audits	5	5	5	15	5	5	5	5	35
* Training	65	65	65	195	65	65	65	65	455
* Operational Research	30	30	30	90	30	30	30	30	210
* Internal Monitoring	2	2	2	6	2	2	2	2	14
* IE & C	50	50	50	150	50	50	50	50	350
* Information, Financial and Administration System	20	20	20	60	20	20	20	20	140
TOTAL	438	438	438	1314	438	438	438	438	3066
CONT:	35.0	35.0	35.0	105.12	35.0	35.0	35.0	35.0	245.28
INFLATION	21.9	21.9	21.9	65.7	21.9	21.9	21.9	21.9	153.3
TOTAL	494.	494.	494.	1484.82	494.	494.	494.	494.	3464.58

*Training: International Courses/ Conferences: 25 per yr. x $6000	150	150	150	450	150	150	150	150	1050
TOTAL	2437	1832	1745	6014	2210	2315	2272	2152	14963
CONTINGENCY	194.	146.	139.	481.1	176.	185.	181.	172.	1197.
INFLATION	121.	91.6	87.2	300.7	110.	115.	113.	107.	748.1
GRAND TOTAL	2753	2070	1971	6795.	2497	2615	2567	2431	16908
		Commodities		3809			Commodities		9818
		Training		450			Training		1050
		T.A.		1755			T.A.		4095
		Sub–Total		6014					
		Contingency		481.1			Sub–Total		14963
		Inflation		300.7			Contingency		1197.
		TOTAL		6795.			Inflation		748.1
							Total		16908
LOCAL COSTS									
* Local Consultants/Tuition	10	10	10	30	10	10	10	10	70
* Transport									
1. Travel + Per Diem	120	120	120	360	120	120	120	120	840
2. Vehicle Maintenance/ fuel	75	75	75	225	75	75	75	75	525
* Office Utilities/Supplies/ Maintenance	85	85	85	255	85	85	85	85	595
* Training									
1. National MPH 10 x 8000	80	80	80	240	80	80	80	80	560
2. National & Regional	375	375	375	1125	375	375	375	375	2625
3. Zone Training 550 persons per yr.	200	200	200	600	200	200	200	200	1400
* Documentation Center									
1. Promo Items/Bulletins	40	40	40	120	40	40	40	40	280
* Infrastructure									
1. Water & Sanitation	180	180	180	540	180	180	180	180	1260
2. Rehabilitation	150	150	150	450	150	150	150	150	1050
3. Solar Installation: 160 frigos x $800 ea	20	20	20	60	20	20	20	20	140
* Supervision & Planning									
1. Supervision subsidies	225	225	225	675	225	225	225	225	1575

RURAL PHC SERVICES

(in 000s)	92–93	93–94	94–95	3 YRS	95–96	96–97	97–98	98–99	TOTAL 7 Yrs
*Local Salaries	375	375	375	1125	375	375	375	375	2625
*Medical Care – Taxes	210	210	210	630	210	210	210	210	1470
*Central Office Equipment	25	25	25	75	25	25	25	25	175
*Basic Equipment									
Zone Health Office $2000 x 70	35	35		70			35	35	140
Reg. & Sub–Reg. Offices $2000 x 23	12	12		24			12	12	48
*Medical Equipment									
Health Center: 70 zones x 8 centers x $2500	140	140	140	420	140	140	140	140	980
Reference Hospitals: 80 x $5000	50	50	50	150	75	75	50	50	400
Hospitals: 70 x $15000	150	150	150	450	150	150	150	150	1050
*Medications and Chemicals									
General Hospitals x 70 x $7000 x 2	140	140	140	420	140	140	140	140	980
*Transport:									
National office plus MOH support: 14 x $20000	120			120	40	40	40	40	280
RHZ + Sub–Reg & Reg: 100 x $20000	480			480	400	400	400	320	2000
Vehicle Spare Parts: 100 kits x $1500	45			45		105			150
Motorcycles: 70 zones x 3 x 2 + 60PCVs+23 Reg/ Sub Reg. = 500 x $2500	180	180	180	540	180	180	180	180	1260
Moto Spare Parts: 500 x $500 per kit	36	36	36	108	36	36	36	36	252
Bicycles x 70 x 12 x 2 + 1680 x $200	48	48	48	144	48	48	48	48	336
Outboard Motors: 20 x 2 x $2000		40		40			40		80
*Cold Chain Equipment									
Solar Refrigerators: 160 x $10,000	230	230	230	690	230	230	230	230	1610
*RHZ Water & Sanitation									
Pumps for hand–dug wells 250 x $450 ea	11	11	11	33	11	11	11	11	77

2. Medicines	265	265	265	795	265	265	265	265	1855
3. Office Supplies	50	50	50		50	50	50	50	350
* In-country Transport: Equipment	300	300	300	900	300	300	300	300	2100
* Research	100	100	100	300	100	100	100	100	700
TOTAL	2275	2275	2275	6825	2275	2275	2275	2275	15925
CONTINGENCY	182	182	182	546	182	182	182	182	1274
INFLATION	113.	113.	113.	341.2	113.	113.	113.	113.	796.2
GRAND TOTAL	2570	2570	2570	7712.	2570	2570	2570	2570	17995