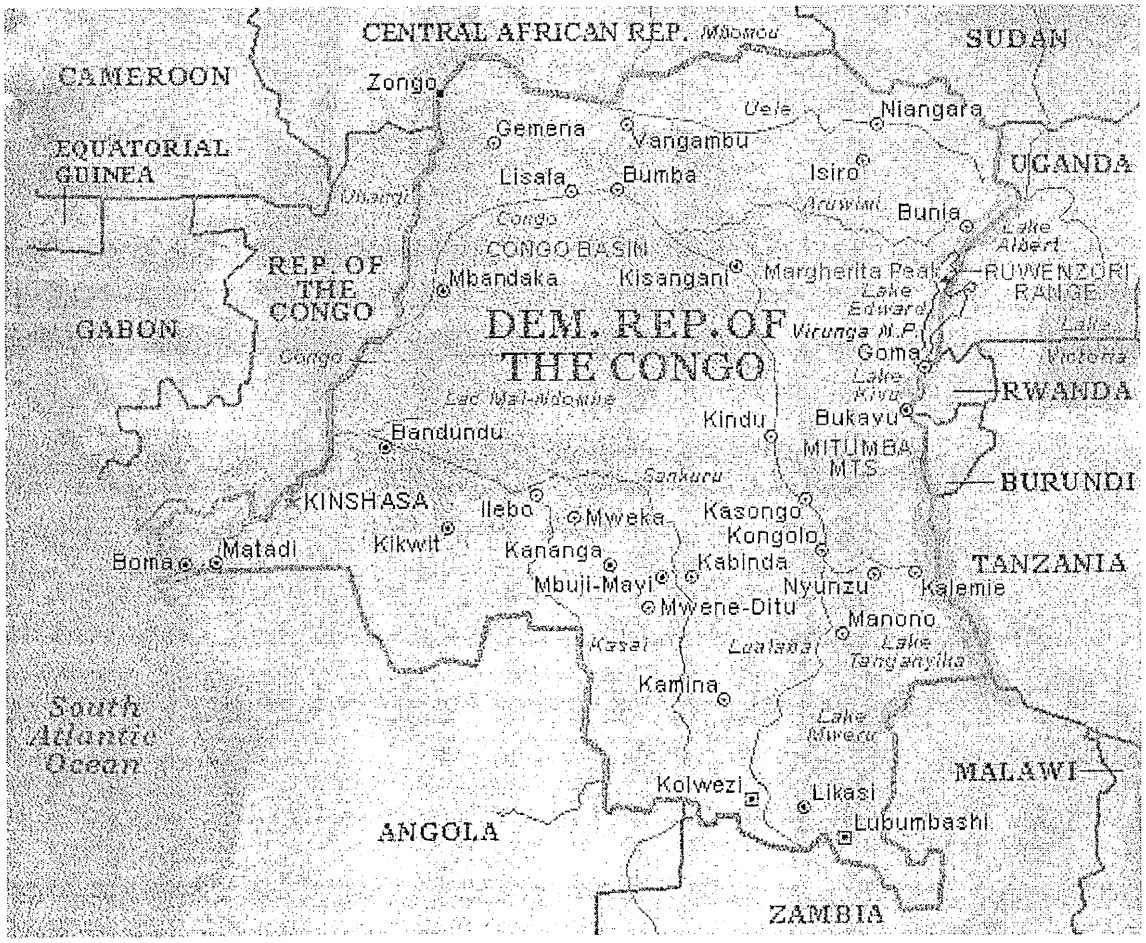
USAID/DRCongo

Integrated Health/Humanitarian Action Plan: 2001

"Bridging life-saving interventions and foundations for development"



October 2000

EXECUTIVE SUMMARY

FRAMEWORK

This document outlines a proposed 12-18 month action plan for USAID/Democratic Republic of Congo (DRC), encompassing health and nutrition development, Food for Peace, and Office of Foreign Disaster Assistance activities. In response to the deteriorating humanitarian situation in the DRC, the fundamental goal of this action plan is to reach as many people in need as access will allow with services to reduce mortality while, at the same time, building a foundation for development.

The Action Plan complements the existing Mission Strategy by identifying and articulating specific activities that fit the present deteriorating situation in the DRC. The Plan outlines priority activities under four funding scenarios; clearly explains proposed changes in the present program; integrates health, Food for Peace, and OFDA activities; and outlines expected results for both the immediate and medium-term.

In this plan, essential activities are laid out under a "Base Level" funding scenario ($13.5 million Child Survival and Disease funds). These activities provide the core plan under any funding scenario. Higher funding scenarios follow, which outline expanded activities that would serve to both strengthen core programs and increase the number of beneficiaries. Scenario four lays out the programs that could feasibly and effectively be programmed by the Mission if there were no funding restrictions.

BACKGROUND

The people of the DRC have been in a chronic state of hardship, suffering years of political, economic and social mismanagement. This situation was exacerbated in August 1998 when rebel forces, backed by Rwanda and Uganda, launched an attack to overthrow the government of President Kabila. Today, more than 2 years later, the conflict continues to ravage the country, exemplified by economic collapse, widespread food insecurity and unprecedented mortality rates.

The recent crisis has resulted in massive numbers of internally displaced populations, estimated in September 2000 to be approximately 1.8 million people, a disproportionate number of whom are children. The death toll has been consistently underestimated and the humanitarian response remains insufficient to reverse or even stabilize the poor health and nutritional conditions.

The food security situation has steadily worsened over the past decade. Average caloric intake has fallen to an estimated 1,845 kilocalories, far below the African average of 2,200 kilocalories per day. A 1998 survey found 61% of children 6-36 months to be Vitamin A deficient, a condition that can significantly contribute to increased child mortality, particularly when combined with other factors such as poverty and rampant infectious diseases.

A recent mortality survey completed by the International Rescue Committee estimated that an excess 1.7 million deaths have occurred over the past 22 months, or 2,600 excess

deaths per day. The vast majority of these deaths were not attributed to violence but to endemic and epidemic diseases that have been exacerbated by displacement and accelerated impoverishment. Even more telling was that young children were simply missing from the demographic profile, suggesting excessively high infant and maternal mortality rates. A 1998 study conducted by WHO reported a national maternal mortality rate of 1800 deaths/ 100,000 live births. One of the highest ever recorded.

ACTION PLAN OBJECTIVE

To contribute to the reduction of the excess mortality and suffering resulting from the humanitarian crisis while at the same time establishing a base for sustainable development.

STRATEGY FRAMEWORK FOR USAID ASSISTANCE

Excess Mortality: Available data indicate that there is substantial excess mortality, especially among children. Malaria is of paramount importance. Measles, tetanus, and other vaccine preventable diseases are also leading causes of death. In addition, diarrheal diseases and acute respiratory infections are rampant. The DRC is an incubation zone for epidemic diseases including tuberculosis, meningococcal meningitis, Marburg hemorragic fever and shigella. Data indicate that HIV prevalence is higher than the reported 5%, and is rising.

Strategy: The USAID strategy, as outlined in this plan, seeks to deliver a package of the highest impact, most cost effective services to reduce excess mortality, with special attention on children. Emphasis will be placed on greatly expanding access to services 1) by providing care to needy, under-served areas (where security permits) and; 2) by making services more economically accessible to the population by addressing the high cost recovery fees at health facilities.

Our emergency assistance (through OFDA and FFP) will seek to move beyond a life-saving humanitarian response, where possible, to improve livelihoods and food security, and stimulate the economy.

Operationalization: With CSD funds, USAID will deliver high impact services by promoting the development of health zones (each consisting of a zonal team, referral hospital, health centers, and community action groups - covering on average about 150,000 persons) and the management systems necessary to make them function. Health zones are the building blocks of a viable health system for the DRC.

With its emergency funds, USAID will, whenever possible, also deliver its life-saving health services through viable health zones.

Three Situations for Assistance: USAID's support to reduce excess mortality will vary depending upon whether the area is in dire emergency, vulnerable but stabilized, or capable of sustaining development activities.

Emergency areas: For areas which are in a state of emergency, USAID, through OFDA funding and FFP commodities, will support international NGOs and International Organizations to deliver lifesaving services including supplementary and therapeutic feeding, essential drugs and health care, immunizations, water and sanitation, and shelter.

Vulnerable but Stabilized: For areas which are stable enough to consider transitional assistance, USAID, through OFDA and FFP commodities, will support supplementary/therapeutic feeding, delivery of high impact health services through the health zone structure (where it exists), supply basic agricultural inputs (seeds and tools), and otherwise stimulate livelihoods.

Areas Ready for Development: Through CSD funding, USAID will support the development of sustainable health zones (and the management systems needed to make them function), as well as critical support from higher levels (e.g., logistic support and supervision for immunizations) in order to help to build a viable health system for the DRC.

Above all, donor assistance to the DRC during this time of crisis needs to be flexible and adaptable.

BASE SCENARIO

(Overall CSD $13.5 million, FFP $12-15 million, OFDA approx. $11 million)

Support will be provided, by CSD funds, to expand access of rural and needy populations to basic PHC services, national immunization coverage will be improved, disease surveillance (including HIV) will permit better response to disease outbreaks and program planning, TB programs will be strengthened, and persons at high risk for HIV/AIDS will be targeted with education and condom promotion. Under the FFP program, USAID will provide a maximum 30% contribution to the World Food Program's 2001-2 Protracted Relief and Recovery Operation as well as a possible $1 million contribution to ICRC. For areas in a state of emergency, USAID, through OFDA, funding will support the delivery of lifesaving services. In vulnerable but stabilized areas, OFDA will also support a broader strategy intended to stimulate livelihoods and agricultural production.

Under this core plan, USAID will provide about 9 million persons access to a basic package of primary health care services (including immunization, malaria treatment, nutrition promotion, antenatal care, essential drugs). Another 560,000 will benefit from strengthened routine immunization services and at least 80% of the population would benefit from polio immunization and vitamin A supplementation. At least a million condoms per month will be marketed to persons at high risk of HIV/AIDS. An expected 810,000 children less than 5 years and about 360,000 pregnant women will benefit from improved case management for malaria.

Core interventions include:

- **Access to Basic Primary Health Care Services.** The proposed rural health program (SANRU) will target 60 health zones in predominantly vulnerable, under-served

areas, with a streamlined package of high priority PHC services. SANRU will develop and implement revised cost recovery policies to improve access of indigents to services. The School of Public Health (SPH) will train zonal health managers and provide technical support in key public health areas, including nutrition, health financing and HIV/AIDS.

- **Reducing Mortality from Vaccine Preventable Diseases.** Through the G/PHN BASICS program, USAID will improve national vaccination coverage by technically supporting the central Expanded Program of Immunization (EPI) as well as immunization services in Bandundu province. Through a grant to CRS, USAID will provide dedicated support to EPI services in 3 poorly performing health zones in Bas Congo.
- **Polio Eradication.** Focus will be placed on supporting quality supplementary immunization rounds (National Immunization Days) and enhanced surveillance. Special attention will be paid to improving micro-planning at the health zone level, improved logistics, and social mobilization.
- **Nutrition Promotion.** Guidelines will be developed and materials provided to improve nutrition promotion in both non-emergency and emergency situations, including supplementary feeding. BASICS will support vitamin A supplementation.
- **HIV/AIDS and STIs**. USAID efforts will support surveillance to fill the current gap in existing HIV and behavioral data, target vulnerable and high risk groups, increase social marketing of condoms, improve blood safety and management of STIs, and initiate selected behavior change communication activities.
- **Strengthening and Expanding Access to Tuberculosis Care**. Through NGOs, USAID will provide support to the National Tuberculosis Program to ensure improved and expanded implementation of the directly observed treatment short-course (DOTS) strategy.
- **Expanding Access to Improved Case Management and Prevention of Malaria**. With CDC assistance, USAID will support drug sensitivity surveillance sites. The data generated will be used to develop a national malaria drug policy. The standard treatment guidelines developed will be disseminated to SANRU sites, other health zones, and to NGOs supporting emergency operations. Improved malaria treatment will be operationalized through training of health providers and provision of essential anti-malarial drugs.
- **Improving Epidemic Surveillance and Response at the Health Zone Level**. Health zone personnel in selected provinces will be trained in the identification, response, prevention, and reporting of diseases with epidemic potential. To improve response to outbreaks, contingency emergency medications will be stocked in provincial depots and internet connectivity will be set up in selected SANRU sites.
- **Emergency Food Assistance.** Through the WFP PRRO, the food assistance program will target 1.4 million beneficiaries in 2001, to include: 424,500 malnourished children, 383,500 IDPs, 223,850 food for work participants, 187,600 resettling IDPs, 164,200 food for training participants, 26,000 vulnerable people such as the elderly and handicapped, and 10,000 refugees. WFP will continue to operate in all of the provinces of the DRC, with most attention placed on areas with the greatest concentrations of IDPs.

- **OFDA supported Humanitarian Assistance.** OFDA will continue to support life-saving interventions in 2001, including food security, provision of health services, water, sanitation as well as humanitarian logistics, coordination support and natural disaster preparedness and response activities. OFDA will seek ways to expand beyond life-saving humanitarian emergency assistance through non-traditional programs.

HIGH LEVEL SCENARIO

(Overall CSD level $21.5 million, FFP $12-15 million, OFDA about $14 million)
This scenario includes all of the elements of the base scenario. With the additional funds, USAID will expand access to basic PHC services for another 1.5 million rural residents (10.5 million total) by supporting an additional 10 health zones (70 total). HIV/AIDS activities will expand by increasing condom sales by at least 10 million annually, targeting high-risk behavior populations. The epidemic preparedness and response system will expand beyond SANRU sites. Tuberculosis and malaria programs will become more comprehensive and support for polio eradication will be expanded. Additionally, diarrheal disease prevention activities through the SANRU program will be reinforced with priority water and sanitation activities.

HIGHER SCENARIO LIMITED ONLY BY ABSORPTIVE CAPACITY

($28.8 million of CSD and $1.5 million of Pop funds, FFP $12-15 million, OFDA about $14 million). This scenario includes all elements of the base and high scenarios. With the additional funds, USAID would expand access to basic PHC services for another additional 1.5 rural residents (12 million total) by supporting an additional 10 health zones (80 total). Support to routine immunization will be expanded. A comprehensive HIV/AIDS program will be implemented, strengthening the 6 areas of intervention identified in the base scenario, enabling a national level impact. The tuberculosis program will be strengthened and expanded through improved transport for supervisors in rural areas, quality control activities and increased services and medications. Support will be provided to establish a viable national safe motherhood/maternal mortality reduction program including some support for family planning services. A new initiative in urban water and sanitation will further reduce morbidity and mortality due to diarrheal diseases.

NEXT STEPS

Over the next six months, there will need to be important technical assistance visits to follow-up and further define important elements of this plan, regardless of which scenario is selected for funding. Some of the key follow-up actions include addressing the technical and management issues related to the SANRU program, including reselection of sites; conducting more in-depth assessments for HIV/AIDS and TB; and discussions by Food for Peace with ICRC headquarters regarding a possible commodity donation to this organization.

Conclusion: A funding scenario for USAID/DRC needs to be determined so that the USG response to the tragedy in this country can he enhanced and made fully operational. The time to act is now.

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I. BACKGROUND

This purpose of this document is to outline a proposed 12 - 18 month action plan for USAID/DRC which encompasses health and nutrition development activities and support from BHR's Food for Peace and Foreign Disaster Assistance offices. This action plan, which will complement the approved mission strategy, is needed to address the deteriorating humanitarian situation in the DRC.

Specifically, the plan is an integrated humanitarian-health transition program that focuses on critical health and food security interventions with increased emphasis on decentralized service delivery. The Plan has a 12-18 month outlook with the identified health and food security activities expected to serve as the foundation for on-going health transition and development programs. Due to the dual nature of the program, the Plan identifies both immediate (12 months) and medium term (2-3 years) results for each priority activity. The goal of the program is to reach as many people in need as access will allow. In view of this, interventions will emphasize essential services that reduce mortality but which could also serve as a base for longer-term development.

The Action Plan complements the existing Mission Strategy by identifying and articulating specific activities that fit the present deteriorating situation in the DRC. The Plan outlines priority activities under four funding scenarios (outlined in the table below); clearly explains proposed changes in the present program; integrates health, Food for Peace, and OFDA activities; and outlines expected results for both the immediate and medium-term.

FUNDING SCENARIOS: FY2001

1. MINIMUN LEVEL	2. MEDIUM LEVEL	3. HIGH LEVEL
$13.6 MILLION	$15.5 MILLION	$25 MILLION
EST. CSD $11.1	EST. CSD $13.5	EST. CSD $21.5
CSD BREAKDOWN	CSD BREAKDOWN	CSD BREAKDOWN
-POLIO $1.3	-POLIO $1.5	- POLIO $3.5
-INFECT DIS $0.5	-INFECT DIS. $1.5	-INFECT DIS. $4.0
-CHILD SURV $5.5	-CHILD. SURV $6.5	- CHILD SUR. $8.0
-HIV/AIDS $3.5	-HIV/AIDS $4.0	-HIV/AIDS $6.0
-POPULATION $0.3		
$1 .0 ENVIRONMENT	-1.0 ENVIRONMENT	-1.0 ENVIRONMENT
		-1.0 AGRICULTURE
$1.5 DEMOC/GOVERN	-$1.0 DEMOC/GOVER	-$1.5 DEMOC/GOVER

FOOD-FOR-PEACE FY2001 $12-15 MILLION
OFFICE OF FOREIGN DISASTER ASSISTANCE FY2001 $11 MILLION

Notes:

- Scenarios 4 is a higher level scenario based on what could effectively be programmed by the Mission.

This Plan is limited to CSD account, Food for Peace and OFDA resoures. It does not propose activities funded under the Environment, Economic Growth, or Democracy Governance accounts.

II. METHODOLOGY

The Action Plan was developed through the collaborative efforts of USAID/DRC and a 6-member team from USAID/W and contract staff who visited the DROC from September 23 – October 15, 2000. The team was led by Richard Greene (G/PHN/CS), and included Reggie Hawkins (Mission Health Officer), Jim Wright (BHR/FFP), Kristen Frank (G/PHN/OFPS), Connie Davis (AFR/HRD), Kirsti Lattu (BHR/OFDA), Amy Bloom (G/PHN/HIV/TB), Claudes Kamenga (Family Health International, Washington) and Lina Piripiri (Mission Health Advisor). The team also benefitted from the work of Chris McGahey of the Environmental Health Program (EHP) and Ellyn Ogden (G/PHN/CS), USAID's worldwide polio coordinator, during recent visits to the DRC.

The team assessed the needs and the feasibility of different interventions through extensive discussions with more than a hundred individuals throughout the country, including relief and development workers, government and rebel leaders, and representatives from USAID and other donor agencies. The team visited North Kivu, Katanga, and Bas-Congo as well as Kinshasa and viewed first-hand supplementary and therapeutic feeding centers, health centers, reference hospitals, and NGO programs. Several health zones were visited, all potential SANRU sites. The team met individually and as a group with the UN team in Goma, and consulted with and briefed the donor/NGO community in Kinshasa. The list of contacts is included as an annex to this document.

III. SITUATION

A. Context

The current crisis in the DRC dates from August 1998 when rebel forces, backed by Rwanda and Uganda, launched an attack to overthrow the government of Kabila. Today, more than 2 years later, the conflict continues to ravage the country. The main cause for increased displacement during the first of 2000 has been fighting between different ethnic groups and fighting within the eastern DRC involving the three main rebel forces, their Rwandan and Ugandan allies, and several militia groups (NRC 7/00). At the end of September 2000, rebel forces occupied approximately 60% of the country in the northeastern region. Forces lead by Bemba, backed by Uganda, have gained strong popular support and control roughly 15% of the country in the Equateur region. Professor Wamba's forces, also backed by Uganda, control roughly 10% of the country in the Ituri region. The RCD controls roughly 35% of the country in the most violent areas including Orientale, Kivu, Maneima, Kasai and Katanga (UNOCHA, 9/00).

B. Internally Displaced and Refugee Populations

The chronic state of conflict has resulted in massive numbers of internally displaced populations (IDPs), estimated in September 2000 to be approximately 1.8 million people. During recent months, different confrontations throughout DROC have displaced even greater numbers of people (UNOCHA, 9/00). Just one year ago, the number of IDPs was estimated at 600,000 (NRC, 7/00). The IDP caseload is greatest in the Kivus, and as of September 2000, the estimated number of IDPs had increased to 1,076,000 of which roughly 300,000 have been displaced since June 2000 (UNOCHA, 9/00). Recent clashes in Kisangani between Ugandan and Rwandan troops displaced more than 60,000 people in June 2000. The July-August 2000 offensive in Equateur by Government troops led to the displacement of approximately 120,000 people in MLC controlled areas (most of whom fled to neighboring countries). Furthermore, in some areas approximately 60% of the displaced population are children (NRC, 7/00).

Additionally, the DROC hosts approximately 300,000 refugees from six of its nine neighboring countries, including Angolans in Bas-Congo, Sudanese in Orientale and Burundians in the Kivus, among others (NRC, 7/00). Annex MAP.

C. Humanitarian Situation

There is ongoing and increasing need for humanitarian assistance against the backdrop of recently collapsed peace talks with no political solution on the visible horizon. The death toll has been consistently underestimated and the humanitarian response remains insufficient to reverse or even stabilize the poor health and nutritional conditions. UNOCHA estimates that 60% of the displaced populations in eastern Congo are in accessible to humanitarian assistance, yet current resources allow aid agencies to reach only half of those who are accessible (UNOCHA, 9/00). In May 2000, the International Rescue Committee published the results of 5 mortality surveys in accessible areas of eastern Congo. The study found that the rates of mortality were at least three times higher than the assumed baseline mortality for DRC of 1.5 deaths/ 1000/ month. When extrapolated over the eastern region, this translates to an excess 1.7 million deaths that have occurred over the past 22 months, or 2,600 excess deaths per day. The report further notes that only a fraction of deaths directly resulted from violence. The vast majority was attributed to endemic and epidemic illnesses exacerbated by displacement and accelerated impoverishment. Even more telling of the catastrophic health and nutritional conditions is that young children are simply missing from the demographic profile. An estimated 34% of the excess deaths are among children under 5 years of age and in some areas 30-40% of the excess deaths occur among children under 2 years. Based on the mortality surveys, IRC presumes that excessively high infant and maternal mortality rates have contributed to this change in the demographic profile (IRC, 2000). In short, the loss of roughly 900 children under 5 years every day during the past 2 years, primarily due to exacerbated endemic and epidemic illnesses, has resulted in the loss of an entire cohort of children. These results are further believed to be a conservative estimate of mortality in eastern Congo, as the data were collected in accessible areas that had suffered less from the war than other areas. However, even if these high rates of mortality are exaggerated, the report still highlights the fact that the Congolese people are

in a situation where they are no longer able to cope with the violence and impoverishment to which they are subjected and have been subjected to for many years.

D. Current Food Security Situation

Over the past decade, food security has steadily worsened in the DRC. A dismal macro-economic environment, characterized by high inflation and negative growth, combined with decreasing agricultural production have reduced average daily caloric intake to an estimated 1,845 kilocalories, far below the African average of 2,200 kilocalories. Since 1998, armed conflict has further exacerbated the situation, and the UN World Food Program estimates that more than 2 million people are in the DRCongo are now critically food insecure. The deterioration in food security in the DRC results from constraints to both availability and access. Chronic urban food security has been worsened by the war, which has cut off the urban population from its normal sources of supply from rural areas. Reduced supplies have resulted in higher prices, and low incomes have greatly limited consumers purchasing power. In rural areas, adequate availability of arable land and rainfall have generally allowed for the maintenance of subsistence. The most badly affected are recently displaced populations who have been forced from their homes and can no longer avail of their normal coping strategies. In some cases, families have been uprooted several times, particularly in North and South Kivu where more than half a million people are unable to meet their basic food needs. Northern Katanga and southern Equateur also harbor displaced populations facing severe food shortages.

NGOs and IOs are providing effective humanitarian assistance that meets immediate food needs, while promoting self-sufficiency. WFP has provided food to NGOs for nutrition centers, IDPs and refugees, but its supply has been highly irregular. Consequently, NGOs have often used their own funds to purchase food locally, giving a boost to the local economy. Nutrition centers, offering therapeutic and supplementary feeding for children under five, have been established in many areas of the country, and are operated by NGOs and churches. Kinshasa alone has over fifty such centers. FAO and NGOs have also undertaken project to help supply urban populations by supporting market gardens. Relief efforts have been greatly hampered by lack of physical access to many of the areas where the most needy are located, such as southern Equateur. In addition, the logistics of delivering food aid are extremely difficult, due to insecurity, the great distances that food must be transported and the poor quality of the roads. Nonetheless, WFP and ICRC have both established effective systems for delivering food where it is needed.

IV. HEALTH AND NUTRITION EPIDEMIOLOGICAL SITUATION

Based on all available health and nutrition data and other credible reports, the team has assembled the following epidemiological profile for the DRC.

Under-nutrition:

Protein-energy imbalances and micronutrient deficiencies are matters of major public health concern. They are widespread. CEPLANUT, the national Nutrition Agency, indicates that protein-energy malnutrition prevails among preschool children 0-5 years at rates of 6.5% for acute malnutrition, 27.1% for chronic malnutrition and 24.4% for

underweight children. Many women and children are iron-deficient, with consequent retarded physical growth and lower cognitive abilities. Iodine deficiency rates have been curbed from 42% in 1993 to 5% in 1998 (goiter prevalence), which demonstrates a capacity for positive change (UNICEF). Anecdotal reports from field visits suggest that most mothers do not exclusively breast-feed during the first 6 months, which contributes to increased rates of malnutrition and disease.

The 1998 National Vitamin A Deficiency Prevalence Survey (MOH/ UNICEF) revealed 61% subclinical VAD (serum retinol <0.7uM) and 22% severe deficiency (serum retinol <0.35uM) in children 6-36 months of age. This survey revealed that VAD prevalence in the DRC is among the highest in the world (highest is Zambia with 66% VAD). Vitamin A Deficiency can cause an increase in child mortality by 23-26%, particularly when combined with other factors of accelerated impoverishment, conflict and population displacement, as is occurring in Congo. Vitamin A distribution was included with polio sub-NIDS for the first time in January 1999. The distribution in August 2000 achieved an estimated >75% coverage nationally.

Several nutritional surveys have been recently completed in eastern Congo and Kinshasa. The results suggest that malnutrition is on the rise, particularly amongst displaced populations and in urban areas. A survey completed by CEPLANUT in Kinshasa in June 2000 revealed that 24% of households have caloric consumption less than 1000 kcal/person/day and 53% consume only between 1000 – 1800 kcal/person/day. Malnutrition rates in the Ituri region are , "close to catastrophic", according to relief workers operating in the northeastern part of the country (NRC 7/00). Realizing that these are not representative of national nutritional status, the following are a selection of recent nutritional surveys:

Region	SOURCE	Date	Results:	
			Moderate	Severe
Masisi – Kitshanga	MSF	4/00	12.8%	9.4%
Goma- Mugunga	SCF UK	5/00	10.9%	2.6%
Ituri	NRC	2/00	11.6%	9.1%
National	CEPLANUT	1995	6.1%	3.5%

Measles and Vaccine Preventable Diseases

The recent decline in health conditions has been associated with more frequent vaccine-preventable disease outbreaks in unimmunized populations. Last year, 26,976 measles cases were reported nationally (MOH 1999). This is a sharp increase from previous years; 1998 showed 15,271 cases and 1996 just 9,511. The increase in measles morbidity is associated with decreased vaccination coverage: from 1995 to 1998, measles vaccination coverage decreased nationally from 40% to 20% (BASICS, 9/00). Furthermore, measles case fatality is reportedly high, as 10% of cases result in death (UNOCHA, 9/00). In some areas, Kenya-Kamalondo in Katanga Province for example, measles is the number one killer of children under 5 years.

Incidence of neonatal tetanus is similarly high, and 553 cases were reported nationally in 1999. Neonatal tetanus also has the highest reported case fatality rate among vaccine preventable diseases in Congo, as 30% of cases reportedly result in death (MOH 1999).

Recently, a pertussis outbreak occurred in Inongo, the northern area of Bandundu province, in which 1136 cases and 23 deaths were reported between January 1999 and February 2000. Approximately 70% of the cases occurred in children under 5 years of age and less than 10% of the cases had received one or more doses of DPT vaccine (BASICS, 9/00).

The DRC is one of the largest reservoirs of wild poliovirus in the world and is key to the eradication of polio in Africa. Limited routine surveillance revealed 129 cases of acute flaccid paralysis nationally from January – June 1999, again likely representing only a small part of the situation (MOH 1999).

Malaria

Malaria has been shown in numerous reports to be the greatest cause of morbidity and mortality throughout the DROC. In the recent IRC mortality report, approximately 29% of deaths were attributed to malaria in some areas. In eastern Congo, malaria incidence was 21 cases per 1000 persons in 1998 and reflected roughly 22% of all reported morbidity (UNOCHA, 9/00).

Maternal Mortality

Maternal mortality was recently estimated to be the highest in the world: 1,800 deaths/ 100,000 live births (WHO, 1998 national survey). Again a sharp increase since 1990 when WHO reported a MMR of 870/ 100,000 live births. Anecdotal reports from field visits in both eastern and western Congo reaffirm these high figures.

HIV/AIDS

HIV/AIDS is a major public health problem in the DR Congo. Although the overall reported HIV prevalence for the DR Congo is about 5.07% (UNAIDS/WHO epidemiological fact sheet, 2000), data from the 1999 sentinel surveillance suggest rates of 6.5% and 6.8% among pregnant women in a maternity in Kinshasa (Kingasani) aged 20-29 and 30-34 years successively. From the same report, rates of 9.8%, 10.1%, 8.3%, and 11.1% are recorded in a maternity in Lubumbashi (Sendwe) women aged 20-24, 25-29, 30-34, and 40-44 years respectively. Data from the 2000 UNAIDS report suggest that by the end of 1999, more than 1,000,000 adults and children were infected with HIV, 95,000 adults and children have died of AIDS, and an estimated 46,000 children are living without their mother or both parents due AIDS. Furthermore, UNAIDS estimates that life expectancy has dropped 9 percent during the 1990s as a result of HIV/AIDS.

Diarrheal Disease

Diarrhea is a major cause of morbidity and mortality in Congo. In 1999, cholera outbreaks were reported in Orientale, North and South Kivu, Katanga and Kinshasa with a high concentration of cases reported from the Kivus. An total of 9590 cholera cases were officially reported in 1999, with a 6.4% case fatality rate (MOH 1999). Again,

these data represent only official reports, which we estimate to be just 10% of the real situation. In the IRC mortality report, approximately 19% of deaths were attributed to diarrhea in some areas. In eastern Congo, diarrheal incidence was 6 cases per 1000 persons in 1998 and reflected roughly 7% of all reported morbidity (UNOCHA, 9/00).

Acute Respiratory Infection

In eastern Congo, acute respiratory infection incidence was 8 cases per 1000 persons in 1998 and reflected roughly 8% of all reported morbidity (UNOCHA, 9/00).

Tuberculosis and other Infectious Diseases

Tuberculosis is one of the leading causes of infectious deaths in the DRC, and particularly affects individuals in their prime, between 15 and 45 years of age. There are between 135,000 and 150,000 new cases of TB each year, of which 60,000 to 75,000 are pulmonary (infectious) TB. In fact, according to WHO's list of countries which contribute 85% of the world's TB burden, DRC ranks 12th; 4th in Africa. Although the DOTS strategy was adopted as a national program in 1996, only 45-50% of the country is currently covered by this policy, mostly in areas around major cities like Kinshasa (97% coverage). Cure rates (60%) fall short of the internationally set standard of 85% and only 45% of expected cases are identified.

The DRC has a long litany of epidemics that have surfaced in repeated outbreaks including measles, cholera, meningococcal meningitis and Marburg hemorragic fever. In 1998, meningitis outbreaks were reported in Western Kasai and Bandundu region. The IRC mortality report uncovered epidemic outbreaks of measles, cholera, shigella and meningitis. In 1999, the Marburg hemorragic fever was confirmed in the gold mining area of Durba in the northeastern region of Congo.

From January – June 1999, 51 cases of hemorragic fever were reported nationally, with an 86% case fatality rate. Last year, 3502 cases of meningitis were reported with a 15% case fatality rate. Again, as these data represent only the official reports (roughly 30% coverage nationally) and only the cases that presented to health facilities, they reflect only a small part of the situation.

V. OPERATING PRINCIPLES AND SELECTION CRITERIA FOR INTERVENTIONS

In identifying activities for support under the funding scenarios, the team followed the following general principles:

- The Plan will address identified needs and select those interventions which best address these. These needs are determined based on an analysis of the best available data supplemented by credible anecdotal information (see Section II Situation of this report).
- Interventions proposed under the different scenarios will be by order of priority. Thus, higher funded scenarios will always include priority activities included in lower funded scenarios.

- To the extent feasible, proposed activities will try to reach as many persons in need as access will allow. As a result, the Plan tries to avoid pilot, demonstration, or untested activities which have a small number of potential beneficiaries in the immediate and medium-term.
- The appropriate use of CSD and other funds would be according to established agency guidelines.
- The focus will be on reducing excess mortality while laying a foundation for medium to long-term interventions.

Based on these principles, each proposed intervention will be reviewed according to the following criteria. Since it is unlikely that interventions would score highly in all categories, selection will be made based on overall responsiveness to the criteria taken as a whole.

1. Potential contribution towards mortality reduction, especially in the near term;
2. Targeting accessible areas;
3. Extent to which activities complement other donor activities and fill an identified gap.
4. Feasibility of achieving results (technical feasibility, USAID's manageable interest, a potential implementing organization, feasibility within the Congolese context, etc.);
5. Ease of conversion from humanitarian to development focus and potential to expand activity;
6. Extent to which activities impact the regions and populations most at need (geographic focus).

VI. CONSTRAINTS

- Eroding socioeconomic and environmental conditions cause people to focus on basic needs - food, health, and physical survival.
- Limited and intermittent access due to fluid security situation and travel restrictions.
- Inaccesibility of some areas of need due to a near-total lack of transport systems and infrastructure.
- Difficulties in working through governmental and various rebel authorities in the Congo, for a wide variety of reasons.
- Non-payment of most government salaries and operational support for government facilities leading to policies which favor the application of high service fees at health centers and hospitals to provide compensatory income. These fees effectively deny services to those who are unable to pay, a good percentage of the population.

VII. ACTION PLAN OBJECTIVE

To contribute to the reduction of the excess mortality and suffering resulting from the humanitarian crisis while at the same time establishing a base for sustainable development.

VIII. STRATEGIC FRAMEWORK FOR USAID ASSISTANCE

Excess Mortality: Available data from surveys, surveillance reports, and other sources indicate that there is substantial, excess mortality throughout the DRC (some in every province), especially children.

Causes of Excess Mortality: Using available sources, the team collected available data to understand the causes of the excess mortality, especially among children. Consistent with section III above, the following key conditions were identified: malnutrition including micronutrient deficiencies; malaria; measles, tetanus, and other vaccine preventable diseases; diarrheal diseases, pneumonia and other acute respiratory infections; and HIV.

USAID's Strategy: To deliver a well-focused package of the highest impact, most cost effective services to reduce excess mortality with special (although not exclusive) attention to children. Emphasis will be on greatly expanding access to services. Access will be expanded two ways: by providing services to needy, under-served areas (where security permits) and; by making services more economically accessible to the large proportion of indigents in the population by addressing the issue of the high cost recovery fees being applied throughout the country.

Our emergency assistance (through OFDA and FFP) will seek to move beyond a life-saving humanitarian response, where possible, to stimulate livelihoods, improve food security and basic agricultural production, and, if possible, stimulate the local economy.

How the strategy will be operationalized: With CSD funds, USAID will deliver high impact services by promoting the development of the country's health zones (each consisting of a zonal team, referral hospital, outlying health centers, community action groups - covering on average of about 150,000 persons) and the management systems necessary to make them function. Health zones are the building block of a future viable health system in the DRC. At present about 90 of 306 are considered minimally functional. Donors are now placing a high priority on progressively increasing this number.

With its emergency funds, USAID will also try, wherever possible, to deliver its life-saving health services through health zones (where they exist or there is the potential for their development).

Three Situations for Assistance: USAID's support to reduce excess mortality will vary depending upon whether the area is in dire emergency, vulnerable but stabilized, or capable of sustaining development activities.

Emergency areas: For areas which are in a state of emergency, USAID, through OFDA funding and FFP commodities, will support international NGOs and International Organizations to deliver lifesaving services including supplementary and therapeutic feeding, essential drugs and health care, immunizations, water and sanitation, and shelter.

Vulnerable but Stabilized: For areas which are stable enough to consider transitional assistance, USAID, through OFDA and FFP commodities, will support supplementary/therapeutic feeding, delivery of high impact health services through at least part of the health zone structure (existing health centers or the referral hospital), supply basic agricultural inputs (seeds and tools), and other measures to stimulate livelihoods.

Areas Ready for Development: Through CSD funding, USAID will support the development of sustainable health zones (and the management systems needed to make them function), as well as critical support from higher levels (e.g., logistic support and supervision for immunizations) in order to help to build a viable health system for the DRC.

Flexibility: A fundamental principle of USAID's assistance to the DRC during this time of crisis is flexibility.

IX. BASE SCENARIO

(overall CSD level $13.5 million as broken down as follows: Polio $1.5 million, Infectious Diseases $1.5 million; Child Survival $6.5 million, HIV/AIDS $4 million; FFP $12-15 million; OFDA about $11 million)

What USAID Buys with this Scenario: CSD funds will support significant expansion of access of rural populations to basic PHC services, national immunization coverage will be improved, disease surveillance (including for HIV) will permit better response to disease outbreaks and program planning, and persons at high risk for HIV/AIDS will be targeted with education and condom promotion. Under the FFP program, USAID would provide a maximum 30% contribution to the World Food Program's 2001-2 Protracted Relief and Recovery Operation as well as a possible $1million contribution to ICRC.

Expected Beneficiaries: Under this scenario, USAID will provide access to about 9 million persons with a basic package of primary health care services (immunization, malaria, nutrition promotion, ANC, etc.), another 560,000 with strengthened routine immunization services, about 70% of the population with polio and vitamin A supplementation, and provide access to about 30% of the country's high risk populations for condoms for AIDS prevention. In additon, through development of new protocols and training materials in nutrition and malaria, the program will help improve the delivery of nutrition (including supplementary and therapeutic feeding) by NGOs delivering services in emergency and non-emergency situations. Finally, national disease surveillance systems for both infectious diseases and a HIV/AIDS will be established which will permit detection and response to disease outbreaks and permit improved planning of resources.

X. INTERVENTION BRIEFS FOR BASE SCENARIO

A. Access to Basic Primary Health Care Services

Rationale: A major cause of the excess mortality experienced in the DRC is the lack of access of vulnerable populations to basic, high impact PHC services.

Background: From 1981-4, the MOH established 306 health zones which typically comprise a referral hospital, about 20 health centers, community action groups, and covers on average about 150,000 people. By 1987, 220 health zones became functional, about two-thirds were managed (or co-managed by NGOs. Begun in 1982, the USAID-funded Basic Rural Health Project (known as SANRU) was the key national project for the development of health zones supporting at its peak 80 functional health zones throughout the DRC. The 1991 evaluation of SANRU found that "SANRU has been dramatically successful in initiating or extending PHC activities ..."

Other Donor Activities and Gap Analysis: At the present time, only an estimated 90 health zones out of a total of 306 are considered functional (i.e., at least three health areas out of 15-20 in the zone providing a basic PHC services, an appointed Medical Chief for the zone, and an operational referral hospital) or are targeted for assistance. At present, the Belgian cooperation is supporting 15 zones, UNICEF 12 (with an additional 8 in 2001) and the local NGO BDOM supported by the European Union supporting 52. The remaining approximately 216 zones are in need of support. In addition, many minimally functional zones need to expand the reach of their services. To be effective, health zone managers need basic public health and management training and supervisory support.

USAID's Role:
SANRU (Rural Health Program): USAID will support a revamped version of the submitted SANRU proposal targeting 60 health zones in predominantly vulnerable, under-served areas, with a streamlined package of high priority PHC services. In addition, based on studies of the populations ability and willingness to pay for services, SANRU will develop and implement revised cost recovery policies which will improve access of indigents to basic services.

School of Public Health (SPH): SPH will play a critical role in establishing functional health zones by training zonal health managers (medical director, chief nurse, and administator) in public health and management as well as providing technical support in key public health areas (e.g., nutrition, health financing). More than in the past, USAID will utilize the school's strong, technical capabilities in support of health zones as well as to strengthen key national programs (e.g., nutrition and HIV/AIDS). The EU, which supports 52 health zones, also depend upon the SPH to train their zonal health teams.

Justification based on Criteria: With key preventive PHC services in 60 vulnerable districts, SANRU will be able to contribute to mortality reduction in needy areas, develops a base for viable district health structures, and fills an important gap in donor

support. Also, the prior success of the programs testifies to the feasibility of this approach.

Description of Major Elements: *SANRU*

- Delivery of a minimum package of PHC services delivered in approximately 60 health zones with emphasis on high impact, preventive interventions. The basic package places greatest emphasis on routine immunization, malaria treatment, nutrition promotion including vitamin A provision, and diarrheal disease control, and antenatal care. Other priority services will be integrated within the structure of child health and antenatal services. Other activities will be phased in over time once the initial package is functional.
- To address the extremely high maternal mortality, the following new activities are proposed: refresher training of nurses who perform deliveries at health facilities (using the UNFPA curriculum), provision of UNFPA basic obstetric care kits, and assuring that referral hospitals (with qualified staff) can perform ceaserian sections and transfuse safe blood.
- Management support including in-service technical updates, strengthened supervision, health information system improvements, provision of basic equipment and development of a viable essential drug system.
- Appropriate study of the prevailing cost recovery framework and revisions in this system to ensure that indigent populations are not excluded from services.

School of Public Health:

- The School of Public Health (SPH) will train 25 persons in one-year masters level course who, upon completion, will become health zone leaders.
- The SPH will provide local, appropriate, and low cost expertise to SANRU and other health delivery programs in their areas of established expertise including nutrition, malaria, HIV/AIDS, water and sanitation, and operations research. In addition, through the support of its partner, Tulane University, and the G/PHN Partnerships for Health Policy Reform program, the SPH will develop and test study protocols on the ability and willingness to pay for health services which can be used by SANRU and other organizations to help set revised cost recovery policies.

Expected Results:

- **Short-term**: Within 18 months, about 40 of the 60 health zones will be operational providing access to basic PHC services to approximately 6 million vulnerable persons.
- **Medium-Term**: Within 3-4 years, a total of 60 health zones will be operational providing access to basic PHC services to approximately 9 million vulnerable persons.
- **Impact**: in both the short- and medium-term there will be a reduction of the high infant and child mortality and reduced overall mortality from malaria. Impact will be measured through improved vaccination coverage, increased utilization rates for child health services, antenatal care, and overall health services.

Issues: We are proposing several important changes in the original proposal:

- Major changes in the proposed list of health zones to refocus support on the most vulnerable, accessible health health zones.
- Reduction in proposed list of interventions. Lower impact services would be de-emphasized or eliminated including most proposed laboratory tests (not considered essential for PHC), onchocerciasis control, most operations research, support for complex curative services at the referral hospital (including some proposed hospital equipment). In addition, the proposed drug list needs to be reviewed.
- The present policies on cost recovery needs to be reviewed and data needs to be collected (through existing protocols) on people's willingness and ability to pay for health services. Revisions to the policies may need to be made to assure services are not priced out of the range of indigents.
- Diagnostic and treatment protocols can be updated and made consistent with WHO guidelines and best practices (e.g., control of acute respiratory infections, malaria, nutrition promotion including vitamin A, etc.).
- A plan to provide the initial stock of essential drugs to health zones and to assure their resupply without stock ruptures is needed. USAID needs to determine how these drugs will be procured.
- SANRU needs to develop viable decentralized supervision and logistic plans to support their health zones.
- OFDA is considering providing SANRU with a $1 million bridge grant including: 1) establishing four coordination units to plan and supervise provision of emergency response, 2) training of health zone management, and 3) establishing and implementing decentralized group purchasing system for procuring essential medicines for 25 health zones.
- Possible criteria for selection of SANRU sites include: vulnerable or at risk populations, under-served, accessible, population density, minimal health infrastructure and staffing. In addition, consideration will be given to geographic clustering of assisted health zones. Possible location of decentralized drug depots are Katanga, Maniema, Bandundu, and Equateur.
- The FY 2001 budget for the SPH will be limited to training of health zone managers and direct technical support of key USAID-supported initiatives (nutrition guidelines, HIV/AIDS studies, health financing). SPH would benefit from additional TA beyond what Tulane can provide.

Estimated Cost: *SANRU:* Approximately $4 million in FY 01. Savings from submitted budget can be achieved through the proposed streamlining of services proposed above. However, these will be partially offset by some additional costs resulting from choosing districts in more vulnerable areas which may be less accessible and require more renovation/equiping. The large contingency line item would not be funded.
SPH: $600,000.

Further Analyses/Review:
- ECC in conjunction with the Mission needs to revise the list of proposed sites.
- ECC/IMA needs technical assistance from a PHC expert versed in the latest technical developments to help scale back the proposed service package and update diagnostic and treatment protocols.

- ECC/IMA and USAID need determine how initial stocks of essential drugs will be procured and how the system will function to avoid stock-outs.

B. Reducing mortality from vaccine preventable diseases

Rationale: Mortality from vaccine preventable diseases (especially measles, pertussis, and neonatal tetanus) is very high in the DRC. Improved national immunization coverage will prevent many childhood deaths.

Background: Immunization services, including technical and logistical support, are provided in the DRC through a national program office, a system of 33 Expanded Program of Immunization (EPI) antennas, and the 306 demarcated health zones. In 1995, measles coverage in the DRC was reported at 40% and DPT3 at 27%. In 1998, measles coverage had declined to 20% and DPT3 to 18%. This low vaccine coverage is associated with increases in vaccine preventable diseases and major outbreaks. Most recently, a pertussis outbreak occurred in Inongo, the northern area of Bandundu province in which 1136 cases and 23 deaths reported, with approximately 70% of the cases occurring in children under 5 years of age.

Other Donor Activities and Gap Analysis: USAID (through BASICS and Catholic Relief Services) and UNICEF are the major donors of the EPI. BASICS provides support to the national program in developing annual plans, training, EPI information, and social mobilization. UNICEF's technical support in the areas of logistics and vaccine procurement. UNICEF is providing or will provide support to reinvigorate EPI services in the provinces of Katenga, Kasai Occidental, South Kivu, Kasai Oriental (2001), and Maniema (2001). In addition, USAID, in 2000, provided initial funding to CRS to reinforce EPI in 3 health zones in Bas Congo.

Gap Analysis: Continued support is crucial at the central EPI to assure that logistics, cold chain, training, social mobilization and other key functions are in place to support the decentralized delivery of EPI services. A national strategy to address measles is urgently required. In addition, generalized support is needed at the provincial and the EPI antenne level. Only 5 provinces are targeted for such support. All programs such as SANRU which reinforce health zones need to have strong EPI components, integrated within their systems.

USAID's Role: Through a more focused BASICS program, USAID will provide key technical support to the central EPI and as well as targeted support to Bandundu province and its 4 EPI antenna. Through the USAID grant to CRS, USAID will provide dedicated support to EPI services in 3 poorly performing health zones in Bas Congo.

Justification based on Criteria: Technical support to EPI services at the central and provincial levels are critical to improving national immunization coverage and EPI performance by health zones. This intervention not only reduces excess mortality in the near term but also helps build a viable immunization system that eventually can be expanded to include other antigens.

Description of Major Elements:

BASICS:

- Technical support for EPI policy and planning including annual planning, finalization of EPI training guides and orienting staff at provincial/antenna levels in their use.
- Support to improve social mobilization by conducting KAP studies, design of communication messages and materials, pretesting of messages, and dissemination of communication products to provinces.
- With the EPI Interagency Coordination Committee (ICC), develop a mid and long-term strategies for measles control including guidelines for need for supplementary measles vaccination, measles case management, and outbreak investigation. Pilot test, finalize, and help operationalize new measles strategies.
- Strengthen EPI in Bandundu province including training of staff on quality service delivery, logistics, and social mobilization/communication. In addition, improve supervision, collection and use of EPI statistics, and the quality of planning at the antenna and health zone level.

CRS

- Improve immunization services in three poorly performing health zones in Bas Congo. Support will be provided in the areas of training, supervision, logistics, EPI information, social mobilization and planning.

Expected Results:

- **Short-term**: Within one year, a strengthened EPI which will lead to increased national immunization coverage, a viable national measles strategy and its initial implementation, and improved immunization coverage in Bandundu province potentially benefiting a population of 500,000 children and women of child bearing age. The CRS program will directly benefit about 60,000 children and women.
- **Medium-Term**: Within 2-3 years, substantial increases in vaccination coverage will occur including rationally planned supplementary measles activities leading to reduced mortality from this disease.
- **Impact**: a reduction of the high infant and child mortality from vaccine preventable diseases especially measles, neonatal tetanus, and pertussis. Impact will be measured through improved national vaccination coverage (to at least 50% for measles).

Issues:

- The BASICS Program will be predominantly focused on support for routine immunization services and nutrition. Efforts will be made to reduce the relatively high overhead costs of the program.
- The CRS program, which received initial funding in FY00, is a comprehensive EPI program targeting a relatively small population. Both CRS and USAID need to carefully review how this novel program will work.

Estimated Cost: BASICS - $1 million immunization (including about $250,000 for polio activities).

C. Polio Eradication

Rationale: The DRC, with one of the largest remaining reservoirs of wild poliovirus in the world, is key to the eradication of polio in Africa.

Background: Polio eradication is based on three major strategies: high routine immunization coverage, supplementary immunization, and strong surveillance. Routine coverage is estimated at about 27%. In 1999, the 3 rounds of supplementary immunization effectively reached 298 of 307 health zones. Although the government officially reports 96% coverage, many children were missed nationwide according to anecdotal reports and the findings of the USAID polio coordinator. Intensive surveillance activities will be launched with the placement later this year by WHO of 42 surveillance officers.

Other Donor Activities and Gap Analysis: UNICEF, WHO, CDC and Rotary International are the four major polio partners globally. USAID, at $25 million per year worldwide, is also an important partner. The estimated USAID support for polio eradication in the DRC, including USAID/W core contributions, is at least $1.5 million annually, which will need to be sustained for at least the next 3 years. For interruption of wild poliovirus transmission to be achieved in the DRC by 2002 and certification by 2005 (WHO target) activities will need to be intensified and accelerated. USAID anticipates a budget shortfall, globally and in the DRC, based on current pledges.

USAID's Role: Support to WHO/AFRO and UNICEF from USAID/W grant mechanisms, a small combined grant to SANRU and CRS from the USAID/W CORE Group Polio project, and possible USAID/DRC support to BASICS.

Justification based on Criteria: The eradication of polio is a worldwide priority, endorsed by all countries in the 1988 World Health Assembly. The 22 remaining endemic countries (including DRC) are expected to interrupt wild polio transmission no later than the end of 2002 in order to complete worldwide eradication by the target date of 2005.

Description of major Elements: USAID funds will be focused on supporting quality supplementary immunization rounds (National Immunization Days and mopping up) and enhanced surveillance. Special attention will be paid to improving micro-planning at the health zone level, improved logistics, and social mobilization.

Expected Results: Interruption of wild poliovirus transmission by the end of 2002 and certification by 2005.

Estimated Cost: As an agency, USAID has a $25 million earmark for polio eradication. The expectation is that virtually all direct USAID support for polio eradication will be out of this earmark. These funds are programmed by USAID/W (Global and regional bureaus) in consultation with WHO and UNICEF. Under this scenario a total of $1.5

million would be programmed bilaterally. No discretionary child survival funds should be used to directly support polio activities in the DRC.

Issues:

- While progressing well, the national polio program is not functioning at a level capable of interrupting virus transmission by 2002. The program will rapidly need to accelerate the quality and coverage of NIDs. Extra rounds (beyond the 3 planned in 2001) will need to be conducted. Logistics, micro-planning, and supervision need to be improved.
- Additional recommendations include the need for: WHO and UNICEF to hire additional expatriate and national staff; increase emphasis on training and supervision; include NGOs in all zonal micro-planning efforts to improve their support for the program; and institute rapid assessments and external observers for all NIDs.
- USAID/W (Global and AFR/SD) in consultation with the mission will decide how much of the total agency $25 million earmark should be allocated to the DRC and how much of that will be programmed bilaterally.

D. Nutrition Promotion

Rationale: Malnutrition, including protein-energy and micronutrient deficiencies, are widespread and contribute both directly and indirectly to excess mortality, particulary in children.

Background: The following are critical life savings interventions for the populations at risk in the DRC.

(1) Breastfeeding and complementary feeding: These practices can reduce the risk of diarrheal and acute respiratory and diarrheal mortality several-fold, and reduce bouts of malnutrition among the under two-year olds.

(2) Vitamin A: Vitamin A supplementation is a highly cost-effective, high mortality payoff intervention for the 6-59 month age-group.

(3) Assuring dietary adequacy in the populations at high risk: This involves adequate nutrition surveillance and monitoring in both food-assisted an non-food assisted populations.

Other Donor Activities and Gap Analysis: Through BASICS, USAID led a coordinated effort to develop a national nutrition policy, and to provide recommendations on mechanisms to improve organizational efficiency, and development of a nutrition action plan and national nutrition program within the Ministry of Health. Vitamin A supplementation was added to polio NIDs in 1999 and 2000, with reported coverage in 2000 exceeding 75%. BASICS has piloted vitamin A supplementation into routine PHC services through health facilities in three health zones. UNICEF is now planning to organize a second dosing of children with vitamin A (following the recommended interval of 6 months) in February 2001 and again in February 2002. UNICEF is also supporting a national salt iodization program and some breastfeeding promotion

activities. Growth monitoring is a standard part of well child services in functioning health centers.

USAID's Role: Develop guidelines and materials to improve nutrition promotion in both non-emergency and emergency situations. Promote nationwide vitamin A supplementation and exclusive breastfeeding practices.

Description of Major Elements:

- To promote exclusive breastfeeding for the initial 6 months of life and effective complementary feeding, USAID, through the School of Public Health, will lead the design of technical guidelines for nutrition education/promotion, growth monitoring, vitamin A for case management, complementary feeding, and exclusive breastfeeding. In addition, the SPH will lead the design of new education materials, training materials, and job aides in these areas. These materials are badly needed to improve the quality of both non-emergency and emergency nutrition promotion and supplementary feeding efforts.
- BASICS will promote vitamin A supplementation through the following strategies: supporting UNICEF in delivering the second dose of vitamin A in both February 2001 and 2002, supporting the delivery of vitamin A in association with the August 2001 NID, and expanding its health facility based vitamin A supplementation program to 22 health zones. BASICS will also help coordinate vitamin A activities among partners.

Expected Results:

- National Vitamin A supplementation benefiting about 70% of children 6-59 months, contributing to significant (23-36%) decreases in under-five mortality.
- Improved technical guidelines and materials for breastfeeding, complementary feeding, growth monitoring, and vitamin A for use in all nutrition promotion and supplementary feeding locations.
- Increased awareness of natural sources of vitamin A and appropriate food preparation techniques.

Estimated Cost: $200,000 through BASICS for Vitamin A; $200,000 through the School of Public Health.

E. HIV/AIDS and STIs

Rationale: The HIV epidemic is a serious public health problem in the DRC. With an estimated 1 million living with HIV and more than 500,000 people already with AIDS (UNAIDS/WHO epidemiological fact sheet, 2000), HIV disease is already significantly contributing to excess mortality experienced in the country and has the potential to worsen in the coming years if not appropriately checked. Although strong data are not available, the limited existing data suggest that AIDS is the 3rd cause of mortality among those aged 20-49 years after malaria and tuberculosis. In 1999 alone, an estimated 95,000 adults and children died of AIDS (UNAIDS/WHO epidemiological fact sheet).

Recognizing the weakness of the diagnostic capacity in the country and the fact that the diagnosis of AIDS is not always mentioned in patients files due to stigma and discrimination, many cases identified as TB may well be dual cases of HIV/TB. In addition, because of the weakness of the blood transfusion services in the country, large number of mothers who receive blood during childbirth and other gynecological reasons and young children who receive blood transfusion for anemia secondary to malaria run a very high risk of contracting HIV. It is therefore critical to design a robust response to the HIV epidemic in the DRC.

Background: The DRC was one of the very first countries on the African continent to design a strong and coordinated response to the HIV epidemic. In fact, in the late 1984, with the late Johnathan Mann as it first director, Projet SIDA was created. This project was the very first HIV research and prevention project in Africa supported by the government of Congo with support from the US Centers for Disease Control and Prevention, the National Institute of Health, the Armed Forces Institute of Pathology, and the Belgian Institute of Tropical Medicine. This project played a very strong scientific leadership role until the withdrawal of the international partners following the political unrest of the early 1990s. To mention a few examples, Projet SIDA provided data on the natural history of HIV infection, the rate and risk factors for mother-to-child transmission of HIV, and the impact of HIV infection on TB clinical futures and response to therapy.

1986 saw the creation of the Congolese National AIDS Program (Programme National de Lutte Contre le SIDA). The Central Coordination Bureau (commonly called BCC) of this program was very ably directed by the late Bosenge Ngaly until mid 1989. The BCC created a significant level of public awareness about HIV/AIDS and a model program of aggressive social marketing of condoms, both of which may have played a role in the slow progression of the epidemic from 1984 and the early 1990s when systematic epidemiologic data were available. Unfortunately, in the early 1990s, the national program was significantly diminished in its leadership role due to the growing political and economic crisis in the country and the withdrawal of support from international donors as a disapproval of the Mobutu regime.

At present, the situation of the HIV epidemic in the DRC is very uncertain due to a minimally functioning national AIDS control program, limited ongoing HIV prevention and care interventions, the deepening poverty of the population, and the past and current political instability (wars) with the accompanying movement of local and foreign troops and displacement of populations. It is clear that if appropriate measures are not taken the HIV epidemic and its many consequences on the individuals, families, and communities will worsen. To illustrate this point, although the overall reported HIV prevalence for the DRC is about 5%, data from the 1999 sentinel surveillance suggest rates of 6.5% and 6.8% among pregnant women in a maternity in Kinshasa (Kingasani) aged 20-29 and 30-34 years respectively. From the same report, rates of 9.8%, 10.1%, 8.3%, and 11.1% are recorded in a maternity in Lubumbashi (Sendwe) among women aged 20-24, 25-29, 30-34, and 40-44 years respectively.

Given the context described above, the interest and efforts by USAID to initiate interventions to address the HIV epidemic in the Congo as part of this humanitarian initiative on the Congo is timely and critical. Recognizing the urgency of the situation, a number of interventions are identified which will serve as the basis for long-term HIV prevention and care programs.

To facilitate implementation in the long run and maximize sustainable results from the interventions suggested in this document, it is critical to recognize that major structural/environmental interventions such as efforts to put an end to the current war and returning both displaced populations and the various troops to their original milieus of life are indispensable. Bringing prevention messages, condoms, and other interventions to people will not be enough in an environment where individuals have no power to negotiate access and use of these interventions. The many powerless women being raped, especially in the war zones are very unlikely to have the chance to negotiate condom use.

Other Donors Activities and Gap Analysis: The support from donors for HIV prevention and care programs has generally been limited since the early 1990s. The European Union, one of the 2 largest donors (with USAID), provides support for HIV prevention and care activities mainly through non-governmental organizations. Agencies of the UN family including UNAIDS, UNICEF, WHO, UNFPA, and UNDP have provided limited funding either directly to the national AIDS control program or though a selected number of NGOs. The German cooperation (GTZ) has been involved in supporting blood safety activities in Kinshasa and sponsoring STD control programs in the country. Médecins Sans Frontières has been supporting STI prevention activities among sex workers and will soon be supporting blood safety in Lubumbashi with funds from the European Union. The government of the DRC has provided limited financial support to HIV/AIDS programming.

USAID's Role: With its ongoing support to social marketing of condoms through AIDSMARK (PSI), USAID is one of the two largest donors (the other being the European Union) for HIV/AIDS activities in the Congo. USAID is very well positioned to play a leadership and catalytic role among other donors. USAID must coordinate and foster linkages between the interventions proposed below and other activities proposed as part of the present humanitarian initiative. Pending available funds, USAID will support surveillance to fill the current gap in existing HIV and behavioral data, revitalize BCC activities with geographically focused and targeted high risk groups, increase social marketing of condoms, improve management of STIs, promote care and support activities, and improve blood safety.

Justification Based on Criteria: The HIV/AIDS component of this humanitarian initiative has the potential to contribute to the reduction of current and future mortality. It offers the possibility to target areas with specific needs and reach vulnerable and at risk groups. With sufficient national commitment, effective coordination, appropriate funding and technical assistance HIV/AIDS prevention and care interventions have proven to be effective.

Description of Major Elements: The major areas of interventions suggested in this document reflect the result of our review of existing data, discussions and recommendations from various actors and stakeholders, and are in line with the HIV/AIDS/STI results package previously developed by the USAID mission and the priorities identified in the DRC national strategic plan. Current programming will be reoriented to target identified high-risk populations, approximately 1 million people. It is understood that cross-cutting issues such community mobilization and participation, policy and advocacy, capacity building, active involvement of people living with HIV/AIDS, and operations research will be addressed as part of any package of interventions implemented.

- **Surveillance**: In order to be appropriately addressed, a problem must be well defined. Well-designed and conducted surveillance (both biological and behavioral) will help to better define the magnitude of the HIV/STI epidemic, describe risk factors, and orient prevention and care interventions. Specific activities include: strengthening of the capacity in second generation surveillance through training of key staff, supporting the conduct of both biological and behavioral surveys in selected geographic areas and target groups, and ensuring the dissemination and use of the collected data.

- **Behavior Change Interventions**: BCI will target identifiable high-risk groups for maximum impact. Behavior change interventions are a critical cross-cutting component of HIV prevention and care activities. Because of the reported gap between awareness and behavior change in the Congo, it is critical to make effective use of behavior change communication to influence the individual and social context in order to reduce high-risk sexual behaviors.

- **Social Marketing of Condoms**: The current social marketing of condoms being implemented by PSI have been very successful in Kinshasa. Condom social marketing will be expanded in terms of geographic reach and will target groups at high risk for HIV infection. The availability of condoms is one of the key elements of HIV prevention. Sexual transmission can be avoided by abstinence and mutual monogamy between two uninfected sexual partners. Because very few abstain and/or are mutually monogamous, correct and consistent use of condoms can greatly reduce sexual transmission.

- **Management of STIs**: Improved management of curable STIs has been shown to be effective in reducing HIV transmission, especially among well-selected target populations. Strengthening management of STIs involves improving the capacity to accurately diagnose and effectively treat STI, increasing access to STI care for particular high-risk groups, including sex workers, truckers, military, and displaced population, and improving referral and treatment of STIs at points-of-first encounter for STI care.

- **Care and Support**: As stated elsewhere in this document there are an estimated 1 million HIV infected and about 600,000 people with AIDS. The need for care and

support is already important and will continue to grow. HIV care and support must be provided through all stages of HIV infection. Illustrative specific activities include: HIV voluntary counseling and testing, prevention of mother-to-child transmission, prevention and management of opportunistic infections including TB, palliative care, community and home-based care, development of effective referral systems, socioeconomic support, legal support, and reduction of stigma and discrimination.

- **Blood Safety**: Transmission of HIV after transfusion with contaminated blood is close to 100%. It is estimated that at least 5% of HIV infection in the Congo occur through transfusion of contaminated blood or blood products. This number is likely to be higher given the weakness of the national blood transfusion services and the increase need for transfusion (because of the increase in cases of anemia due to malaria, malnutrition, trauma, and other causes). Merlin, an OFDA funded NGO in Maniema province, reported no HIV screening for blood products due to lack of test kits for at least the last eight months. It is critical to strengthen the national capacity to establish safe blood supplies to prevent HIV transmission as well as other blood borne diseases.

Expected Results

Short-term: within 12-18 months, 1) improved quality of epidemiological and behavioral data to inform the design and implementation of HIV prevention and care activities and be used for policy and advocacy work, 2) Reduction in the number of unscreened blood sample transfused in targeted areas, 3) Increased number of people reached with implemented interventions in the target areas and among target groups.
Medium-term: within 2-3 years the above results must be expanded to at least 3 additional geographic areas.
Impact: reduction in high-risk behaviors, reduction of HIV transmission, and reduction in morbidity and mortality due to opportunistic infections and other HIV-related illnesses.

Issues/assumptions

STI management requires a good supply of STI drugs. It is recognized that blood safety is not among the key priority areas for USAID. However, intervention in the area of blood safety is strongly recommended on the basis of the particular context in the DRC. High rates of anemia among mothers and children and a general increase in the occurrence of traumas require a large number of transfusions. However, a large proportion of all performed transfusions is not screened for HIV and other blood born diseases. For example, up to 70% of transfused blood in Matadi are not screened for HIV.

Because of the complexity of the various areas proposed, it may be necessary for the mission to identify an organization with technical and programmatic experience in designing, implementing, and evaluating large scale HIV prevention and care programs to support implementation.

Implementing agencies (IAs) with expertise and experience in HIV prevention and care activities will be used and provided with technical assistance (if needed) to implement one or several of the suggested activities. For example: 1) Surveillance: the School of

Public Health and Projet SIDA; 2) STI management: Projet SIDA and MSF-B; 3) Blood Safety: MSF, CNTS, although not an IA, GTZ must be involved given their long experience supporting blood transfusion services in the Congo; 4) Care and support: BDOM, AMO-Congo, Femmes+, ALPI+; 5) Social Marketing: ASF/PSI, PSI may also be considered to channel funds to local organizations.

Activities proposed in this HIV/AIDS component assume that TB aspects are covered under the TB section of this document. Appropriate linkages must be established during the implementation of the 2 components.

Estimated Cost: $4,000,000
For the following activities:

Second generation surveillance: $300,000

- One round of well-designed and conducted sero-surveillance in the current sentinel sites and depending on feasibility in an additional site in the occupied territories (eg. Goma) = $125,000
- One round of behavioral surveillance survey in 2 of the 3 current geographic areas for sentinel sites and in Goma if feasible. Target groups for the behavioral surveys may include sex workers, truckers, youth in and out of schools. The final decision on target groups must be made in consultation with the national authorities and depending on the feasibility of such surveys in each setting. = $175,000

Improving Blood safety: $400,000

- Support the improvement of blood transfusion services (training, refurbishment of blood transfusion centers, donors mobilization and fidelization, equipment, test kits, and other supplies) in selected geographic areas such as Bas-Congo where a very high proportion of transfused blood is not screened for HIV and other blood borne diseases, the 2 Kasai, and the occupied territories. Selection of the intervention province(s) must be done in consultation with the newly established national blood transfusion program (Centre National de Transfusion Sanguine)

Expanding STI management among target groups: $400,000

- Support target groups' "friendly" clinics in high-risk communities in Mbuji-Mayi, Lubumbashi, Matadi, and Kinshasa and conduct training of appropriate health staff in syndromic management of STIs.

Expanding social marketing of condoms: $2,000,000

- Support the extension of social marketing of condoms to cover one other city in addition to Kinshasa targeting people at high risk for HIV.

Initiate selected behavior change communication activities: $400,000

- Support NGOs and CBOs to develop and implement appropriate behavior change interventions for specific populations such as displaced people. = $250,000
- Support awareness and behavior change campaign in at least one occupied territory (eg. Mass media campaign may be conducted in occupied territory, complemented by the distribution of condoms during food distribution). = $150,000

Initiate selected Care and Support activities: $500,000

- Strengthening of HIV counseling capacity through development of VCT guidelines, training curriculum, and training of appropriate individuals in HIV counseling. = $100,000

- Reinforcing care and support referral systems (inventory of existing services, development of service directory, and establishment of formal referral mechanisms). = $100,000
- Training of health care providers in management of patients with HIV infection, especially the management of opportunistic infections and other HIV-related illnesses. = $100,000
- Initiate efforts to prevent mother-to-child transmission. = $200,000

Further Analysis
It is recommended that at least two consultants with broad and complementary expertise on HIV/AIDS/STI conduct an in depth assessment, develop a realistic implementation plan, identify appropriate sites for implementation and implementing agencies in consultation with the mission and the government of the DR Congo. The scale of this implementation plan will depend on the level of funding available.

F. STRENGTHENING AND EXPANDING ACCESS TO TUBERCULOSIS CARE

Rationale: Tuberculosis is one of the leading infectious causes of morbidity and mortality in the DRC, and will likely increase significantly due to migration patterns, ongoing conflict, and escalating HIV/AIDS rates. Ensuring early diagnosis, treatment, and cure is essential to preventing unnecessary deaths in the most productive segment of the DRC population.

Background: In 1980, the DRC instituted a National TB Program (NTP), and in the early 1980s, the TB and leprosy programs became one integrated program. In 1996, the Directly Observed Treatment-Short Course strategy (DOTS) was adopted. This five component strategy (government commitment, diagnosis by smear microscopy, a sufficient and regular supply of quality anti-TB drugs, direct observation of treatment, and a recording/reporting monitoring system) is recommended by all of the major international health organizations working to control TB globally. Although this strategy has been adopted as a national program, only 45-50% of the country is currently covered (mostly in areas around major cities like Kinshasa with 97% coverage). Pockets of excellence exist, but cure rates (60%) fall short of the internationally set standard of 85%, as do case notification rates (only 45% of expected cases are identified vs. the standard of 70%). These statistics are not suprising given the lack of financial support, erratic drug supply, and country conflict.

Other Donor Activities and Gap Analysis: The NTP, while having a very strong and capable leader, is hampered by a lack of human and financial resources. As a result, despite well-developed and accepted guidelines and implementation schemes, the NTP must rely on NGOs to execute its directives. These organizations have agreed to work through the health zone system, avoiding the development of a parallel system for TB care, and facilitating integration into the existing health network. The NTP has created a geographic patchwork in which a specific NGO partner covers each area. Unfortunately, several areas are currently inaccessible due to the ongoing conflict, and services have been curtailed or halted in these locations. The Damian Foundation continues to provide

the bulk of TB care both in Kinshasa and in other provinces, treating approximately ¾ of newly identified cases each year. Other active organizations include BDOM, The Leprosy Mission, The Anti-TB League, MERLIN, MSF, MEMISA, and various religious organizations.

The IUATLD (International Union Against TB and Lung Disease) is planning a 2 week assessment in mid-November to assist the NTP in defining current gaps and needs, and the WHO is planning to post an officer to assist the NTP in early 2001. Donors are currently working at capacity given existing human and financial resources, although most contend that they would be able to enlarge their activities given sufficient funding (e.g., in one province, 4000 newly identified cases remain untreated due to lack of medications). Expanded activities would remain health center based, but would allow greater coverage at more centers

Lastly, the NTP, despite a shortage of government support, has identified areas of need including quality assurance programs and operations research to examine barriers to optimal treatment outcomes. It has also requested support to initiate innovative activities based on the findings of this research.

USAID's Role: USAID will provide support to the NTP via NGOs, particularly local NGOs such as the Anti-TB League, to ensure better and expanded implementation of the DOTS strategy. This would include improved diagnostic and treatment facilities through the provision of training, supervision, and equipment.

Target Population: Selected underserved areas throughout the Congo, particularly those not already covered by strong NGO programs. Efforts will be concentrated in areas capable of supporting a fully integrated DOTS program with extension to more marginal areas in a second stage (programs should not be initiated in areas clearly unable to sustain complete treatment regimens).

Justification based on Criteria: TB is a leading cause of infectious deaths in DRC. A proven cost-effective tool (DOTS) has already been implemented in areas throughout the DRC. Support for improved DOTS programs to augment existing activities can result in decreased disease-related morbidity and mortality. Expanding the program now is especially important in light of expected increases in cases due to migrating populations, areas of conflict, and escalating HIV rates.

Description of Major Elements: There are multiple potential areas in which USAID might play an important role in improving and expanding TB diagnosis and treatment in the DRC, and meeting the stated goals of the NTP (90% coverage, equipped laboratories, regular supply of medications, implementation of all aspects of DOTS, and education regarding TB). Efforts would concentrate on strengthening the NTP and its partners to fully implement DOTS throughout the country, monitor disease trends, and investigate ways to tailor the strategy to the DRC. Activities might include:

1. Training and supervision of providers at all levels: physicians, nurses, community workers, treatment supervisors, and laboratory technicians.
2. Improvement of diagnostic facilities; provision of materials and quality assurance.
3. Enhancement of communication among the partners providing TB care—between the health centers, health centers and patients/patient advocates, the central NTP and peripheral units, the NTP and NGOs/donors.
4. Education of health care workers and the general population to improve knowledge about the disease, treatment options, and potential for cure.
5. Monitoring treatment outcomes, and disease trends, including development of multidrug resistant TB (MDRTB).
6. Technical assistance to support NTP efforts to improve program outcomes through quality assurance and operations research, and innovative integrative programs such as those addressing HIV/TB co-infection.

It is essential that a more complete assessment of current and potential NGO and NTP activities be undertaken prior to initiation of any new USAID TB program. The IUATLD assessment in November will be of great assistance in determining the best use of USAID resources as it identifies strengths, weaknesses, and gaps in the current program.

Expected Results:

- **Short term**: Improved access to, and identification and treatment of infectious TB cases; greater epidemiologic information to guide program implementation.
- **Long term**: Within 5 years, 90% coverage with quality DOTS programs (predicated on continued and increased funding)

Estimated Costs: $500,000

- 250,000 for training, supervision of health workers at provincial and central levels (providers, lab, etc.)
- 125,000 for OR to further investigate community-based care options, integrated TB/HIV programs, improved outcomes
- 100,000 for lab equipment and clinic treatment aids.
- 25,000 for public education campaigns

Issues:

Patients currently must pay for their TB drugs. Although the sum for the 8 month treatment is relatively modest, competing needs (e.g., school fees), and the fact that many patients fail to see the need for treatment (especially one which costs money) after their symptoms dissipate, leads to poor adherence and poor outcomes. To prevent multi-drug resistant (MDR) TB, it is essential to ensure treatment completion, and the current system, which relies on self-treatment after the initial phase, is particularly risky.

Although expansion to severely underserved areas is important, many of these areas lie within regions of conflict and/or have a large number of mobile, displaced persons. To provide appropriate care for these individuals (and their communities) it is imperative that prior to initiation of treatment programs, extensive work is done to ensure that

systems are set up to accommodate transfer of patients so that treatment completion rates do not suffer. Incomplete regimens and attendent MDR strains pose an even greater threat to these individuals and others in their community and must be avoided at all costs, even if it means withholding treatment until a proper treatment program can be developed.

Pilot projects such as extension of health workers through community members have demonstrated great success in other African countries. The NTP has designed it's own intervention, and evaluation of community-based care in the DRC could be extremely helpful in determining future program design.

G. Expanding Access to Improved Case Management and Prevention of Malaria

Rationale: Malaria is the leading cause of morbidity and mortality in the DRC and it disproportionately affects children under five and pregnant women.

Background: Although the surveillance system for epidemic diseases is very weak in DRC, data from the 1999 annual Weekly Epidemic reporting system (4eme Direction, Kinshasa), shows that 87.9% of all epidemic disease notifications and 50.8% of all deaths were due to malaria. Improved malaria treatment and prevention is an important issue in the DRC. The Ministry of Health (MOH) and CDC, Atlanta estimate that in a total national population of 50m, there are each year, 2.87m cases and 200,000 deaths, and that on average, each Congolese child suffers 10 malaria episodes a year. Note that the June 2000 survey by Dr. Les Roberts of the International Rescue Committee puts the mortality figures for malaria far higher. Whatever the exact number, malaria is a significant contributor to the acute and continuing humanitarian disaster in DRC.

The MOH National Malaria Control Program, known as the Programme National de Lutte Contre Le Paludisme, (PNLP) has been in existence since 1977 to guide and coordinate malaria control activities in Kinshasa and the rest of the country. Recognizing the need for broader societal support for malaria control, WHO in 1999 launched the "Roll Back Malaria" initiative or RBM, which DRC is joining as part of a regional effort. The goal of USAID support for malaria control has been to strengthen the capacity of the MOH to develop rational treatment and prevention policies, and then to facilitate their implementation through the government health system, through facility and community activities supported by missions, NGOs, and other private organizations.

Other Donor Activities and Gap Analysis: At the present time WHO is funding the initial launching of RBM ($84,000) for the years 2000-03. BASICS has committed to funding drug sensitivity testing in three geographical sites. A provisional budget of $8 million has been projected covering case management, insecticide treated bednets (ITNs), surveillance and epidemics and social mobilization. The resources for this budget are still being sought.

USAID's Role: Malaria case management will be strengthened through the new SANRU program through the training of the health personnel and provision of essential anti-

malarial drugs such as chloroquine and quinine. Training materials such as *fiches techniques,* job aids, and other health information aids will be supported through WHO/RBM. USAID will also support up to three drug sensitivity surveillance sites through the technical assistance of CDC and the PNLP. As drug resistance study data become available, a national consensus drug policy will be developed under the coordination of the RBM Task Force on Malaria Treatment policy. Standard treatment guidelines developed will be disseminated to all concerned SANRU health facilities. Training materials and job aids will also be made available to the European Union supported NGO health zones in Kinshasa, which comprises 10% of the Congolese population and to other NGOs (including in emergency areas).

Justification based on Criteria: A minimum package of key preventive PHC services, including malaria case management, will be delivered in SANRU- assisted health zones. Other donor supported health programs will also be using new protocols to improve malaria treatment.

Description of Major Elements:

- Support to WHO/RBM to develop and disseminate standard malaria case management protocols for children under five and pregnant women. Training materials, fiches techniques, etc. will be available for use by all RBM partnership organizations and NGOs.
- Support for training of health personnel in SANRU health zones sites for malaria case management.
- Ensure that OFDA funded IOs and NGOs have access to malaria treatment policy guidelines and training materials, and that antimalarials included in treatment policy are part of the essential drugs list.
- Support to WHO/RBM Task Force on Prevention to conduct a situation analysis on the likely opportunities to develop a public-private partnership to import netting materials and insecticide for insecticide treated bednets (ITNs) for the DRC.

Expected Results:
Short term: Within 12-18 months the malaria case management guidelines will be developed, and training for health staff provided to all SANRU sites. Essential drugs, including antimalarials will be ordered, delivered, and distributed to health zones.
MediumTerm: Within 2-3 years, appropriate diagnosis and treatment of malaria is provided in 80% of SANRU and other RBM partner NGO sites, according to national malaria policy. It is understood that the current malaria drug policy may change dependent on the drug sensitivity tests to be conducted in different geographic areas. When the policy is changed a "recyclage" of personnel will be conducted.
Impact - Expected Beneficiaries: Nationwide, a potential 10 million children less than five and 1.6 million pregnant women could benefit from improved case management of malaria. Because SANRU sites are expected to be clustered to provide a high density of population with appropriate malaria drug treatment, a reduction in the malaria mortality in the selected SANRU health zones should be noted from data from the weekly epidemic reporting system.

Issues:

- Currently malaria treatment regimens vary from NGO to NGO and by region. There is the need for consensus to standardize malaria treatment guidelines.
- It is envisioned that the NGO groups supported under SANRU will need technical support to increase technical capacity of the various implementing partners in malaria treatment.

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Estimated Cost: $500,000

RBM	Development of malaria case management protocols, training materials	$120,000
Training	TOT, health personnel in SANRU	$180,000
Drug Sensitivity testing, (CDC, PNLP)		$150,000
Situation Anal. ITN public-private partnership		$ 50,000

Further Analyses/Review: Three-week consultancy to conduct situation analysis on ITN public-private partnerships.

H. Improving Epidemic Surveillance and Response At the Health Zone Level

Rationale: Epidemiologic surveillance is key to determining the incidence and prevalence of major diseases and whether the interventions introduced are producing the outcomes desired. Epidemic surveillance and response are crucial during the humanitarian and health transition phase.

Background: The DRC has a long litany of epidemics, with repeated outbreaks from measles, cholera, meningococcal meningitis, and viral hemorrhagic fever (Marburg). Most recently, cholera outbreaks were reported twice in 1998, and again in 1999 in Orientale Province, Bukavu, Kisangani, and Kinshasa. In 1998, meningitis outbreaks were declared in Western Kasai, and Bandundu Region next to Angola. Information from the mortality survey conducted by IRC in May 2000 from five areas in eastern DROC uncovered epidemic outbreaks of measles, cholera, shigella, and meningitis. And in addition in 1999, Marburg hemorrhagic fever was confirmed from the gold mining area of Durba in the northeastern part of DRC. Clearly the Congo is an incubation zone for disease. Based on previous history, we know that epidemics will recur in the most vulnerable populations; we just don't know the when, where, and how.

Other Donor Activities and Gap Analysis: Epidemiological surveillance at the central level is supported by EPICENTRE (Groupe Europeen d'expertise en epidemiologie). WHO supports polio surveillance in the placement of 11 provincial epidemiologists and 42 district epidemiologists to perform polio AFP and EPR surveillance. Epidemiological surveillance comes under the direction of the *4eme Direction* of the Ministry of Health. Surveillance is weak with only 28% of the health zones reporting to the central level.

USAID's Role: The prevention, response, and control of epidemics will be key to reducing the excess mortality in the Congo. The health zone is crucial in any system of

epidemic preparedness and response (EPR). USAID would support the EPR training of key health zone staff (medecin chef) in a province. The chief medical doctor is then responsible for training the nurses in EPR in the health centers in his health zone. Improved surveillance and reporting is done weekly on the epidemic report form sent to the provincial medical inspector and on to the central level 4eme Direction. In case of epidemic outbreaks, the health zone staff provide the first line of investigation and response. SANRU sites would be key to improved surveillance reporting and response. As a basic underlying principal, SANRU sites would agree to improve monitoring and surveillance and selected sites would have internet connection.

Internet connectivity is being provided in DRC under the Leland initiative. Hardware and internet service provider (ISP) capability is already provided and up and running in Kinshasa, Lumbumbashi, and Matadi. By Nov. 2000 additional internet connectivity will be available in Bandundu, and Kasai (oriental and provincial). Selected SANRU sites will piggyback on the Leland initiative to take advantage of internet connectivity and cost will be minimal. Internet will provide rapid transmission of epidemic surveillance information, ability to download scientific and health information from the web, and set the stage for email transmission of monthly health information system. NGOs that provide a wide range of development activities particularly with health, school education, and micro-credit projects will be particularly interested in internet possibilities.

Justification based on Criteria: Provision of EPR training for health zones in all provinces would have a significant impact on the rapid identification and response to epidemics. EPR training would occur first in provinces supporting SANRU sites, but USAID would provide training in all 10 provinces plus Kinshasa. Policy dialogue will ensure that 42 medical epidemiologists at district and provincial levels will provide continuing epidemic preparedness and response at the health zone level.

Description of Major Elements:

- Provincial EPR training of health zone personnel in the identification, response, prevention, and reporting of diseases with epidemic potential.
- Provision of a contingency stock of EPR medicines and supplies would be placed in several areas in large provinces with difficult terrain.
- Internet connectivity provided in selected SANRU sites, provincial medical inspector offices in provinces supported by SANRU. This has the potential to dramatically strengthen surveillance reporting and response in the province.
- Provision of funding to the School of Public Health (SPH) to evaluate WHO EPR training given at the provincial level. The evaluation will make recommendations for improving EPR supervision and monitoring. SPH would also evaluate the rapidity of placement of contingency EPR supplies and review strategy for use and turnover of supplies before they expire.

Expected Results:

- **Short-term**: Within 12 months all SANRU provinces would have received EPR training and would be monitoring and reporting weekly to the provincial medical inspector. Early detection and rapid response to potential epidemic diseases would

prevent disease outbreaks and reduce morbidity and mortality. Within 12 months, selected SANRU sites would have internet connectivity and reporting regularly through email in accordance to the reporting format.

- **MediumTerm**: Within two years all SANRU sites would regularly monitor and report epidemic diseases according to the MOH protocol. These sites would be key to the introduction of the integrated disease surveillance system (IDS) for monthly reporting of diseases.
- **Impact**: The epidemic preparedness and response (EPR) surveillance would benefit a total population of around 14 million persons. In both the short and medium term there would be a reduction of child and adult mortality due to shorting of response time and notification. This would reduce case fatality rate (CFR). Impact measured by response time for notification, CFR, percent of reporting units doing surveillance and monitoring.

Issues:

- Training will need to be provided to health staff in the use of email and the possibilities of the Internet.
- WHO is the best placed for conducting the EPR training. However, to ensure that funds for surveillance are efficiently utilized, it is proposed to use the School of Public Health as a means to evaluate the outcome of the training and to report to the wider Donor audience on the activities conducted in strengthening surveillance.
- Surveillance is always difficult to promote. Therefore one of the conditions of the SANRU grant is that NGOs agree to improving monitoring and supervision in general, and that the weekly epidemic report is completed in time and sent according to the proper route to authorities.

Estimated Cost: $500,000

EPR Training of Health Zones, Province level, 20,000/province,	$140,000
Contingency stock, EPR medicines, supplies (6 zones)	$ 60,000
Internet connectivity, 30 sites	$ 200,000
School of Public Health (evaluation EPR training)	$ 100,000

Further Analyses/Review: The need to evaluate the fastest way to order EPR contingency stocks for WHO.

I. Emergency Food Assistance

Rationale: Emergency food needs must be met to increase food security, decrease and prevent malnutrition, and reduce mortality.

Background:

The UN Food and Agriculture Organization estimates that 10 million people are living in conditions of food insecurity. Other estimates are considerably higher. The situation is most critical for the estimated 1.8 million internally displaced who have lost their normal sources of livelihood. Host communities have also been badly affected, as they have depleted their limited resources to assist the IDPs.

In fiscal year 2000, the Office of Food for Peace has provided the UN World Food Program (WFP) $1.2 million of PL 480 Title II food aid for Angolan refugees living in Congo, and $2.1 million for IDPs and other vulnerable groups. In addition, the US Department of Agriculture has given WFP $7.5 million of section 416(b) commodities.

Through its existing programs, WFP is aiming to feed 350,000 displaced and vulnerable Congolese, and 45,000 refugees. The International Committee for the Red Cross is also supplying food to the displaced.

The World Program has prepared a Protracted Relief and Recovery Operation (PRRO) for the period January 1, 2001 to December 31, 2002.

Other Donor Activities and Gap Analysis: Humanitarian agencies active in Congo have consistently commented that WFP is providing crucial food assistance, but is constrained by inadequate resources. WFP has not received sufficient donations to maintain a regular uninterrupted supply of food to its implementing partners.

USAID's Role

a. Target Population

The WFP PRRO targets 1.4 million beneficiaries in 2001, divided into the following categories: 424,500 malnourished children, 383,500 IDPs, 223,850 food for work participants,187,600 resettling IDPs, 164,200 food for training participants. 26,000 vulnerable people such as the elderly and handicapped, and 10,000 refugees.

b. Expected Geographic Focus

WFP will continue to operate in all of the provinces of the Democratic Republic of the Congo. The most attention will be placed on those provinces with the largest concentrations of IDPs. The expected geographic breakdown and beneficiaries is as follows: North Kivu 329,000, South Kivu 259,600, Kinshasa 252,800, Katanga 155,800, Orientale 123,000, Equateur 112,760, Maniema 58,900, Kasai Oriental 51,300 Bas-Congo 38,700, Kasai Occidental 22,050, Bandundu 16,000.

Justification based on criteria: Emergency food assistance will contribute toward near-term mortality reduction by improving the nutritional status of vulnerable groups. In addition to the decrease in deaths from malnutrition, the beneficiaries will become less susceptible to other diseases. Food assistance will complement numerous ongoing NGO activities in the fields of agricultural production and primary health care. In conjunction with basic support for agricultural production, food aid will allow the targeted population to establish a minimal level of subsistence, and serve as a basis for implementation of future social and economic development programs.

Description of major elements: FFP will provide PL 480 Title II commodities in support of WFP's PRRO, as well as funding for the cost of ocean freight, internal transport, storage and handling. FFP will likely also supply Title II commodities to ICRC for assistance to new IDPs.

Expected results:
Short and Long Term: The objective of emergency food aid is to allow beneficiaries to maintain or improve their nutritional status. Assistance to IDPs will allow them to meet their minimum nutritional requirements, while they acquire the means to become self-sufficient.

Estimated cost: The total amount of funding sought by WFP for the PRRO from all donors is approximately $56 million per year. Food for Peace provides resources to WFP for all of its PRROs worldwide through a biennial pledge process. In this manner, within a global figure agreed to between the two parties WFP is free to determine the amount of FFP resources allocated to any given PRRO. Thus, it is not possible for FFP to commit to a specific level of funding for the Congo PRRO. However, a contribution of 25% ($14 million is recommended) under scenario #2. Under scenario #1, the percentage could drop to 20% ($11.2). For scenario #3 a maximum contribution of 30% ($16.8) could be considered. (30% is a standard maximum USAID contribution to a PRRO).

Additional support of up to $1 million to ICRC should also be considered.

Assumptions/Alternatives/Issues
- Full implementation of the PRRO will require substantial contributions from other donors. If its funding requirements are not fully met WFP will have to reduce its intended beneficiary levels and targets its assistance to the most needy, concentrating on life-saving activities such as therapeutic feeding and assistance to new IDPs while curtailing plans for food for work and other recovery programs.
- The importation of food commodities is not expected to have adverse effects on local agricultural production as most regions of the country are experiencing significant deficits. In the Kivus, a mixture of imports and local purchase has been recommended by some technicians. However, FFP resources cannot be used for this purpose.
- Use of SANRU as a mechanism for delivery of food assistance is not recommended due to its lack of experience and capability in this area, and because it would overburden existing staff.

Next Steps: FFP will inform WFP of its interest in supporting the Congo PRRO, and recommend its inclusion in the FY 01 resource request for the biennial pledge.

FFP will discuss with ICRC headquarters in Geneva whether commodity donations are sought for its Congo operations.

J. OFDA-supported Humanitarian Assistance

Rationale: Reduce mortality and alleviate conflict-related suffering. OFDA's strategy is to assist the most affected vulnerable (IDP and non-IDP) populations with rapid humanitarian assistance.

BHR/OFDA Role:

(a) Emergency Response: Continued OFDA support to life-saving interventions in FY01. These include food security, provision of health services, water, sanitation as well as humanitarian logistics, coordination support and natural disaster preparedness or response activities. In FY99-00 OFDA responded to disaster declarations for flooding, an airplane crash, epidemics of Marburg Hemorrhagic fever and malaria in addition to the ongoing complex emergency. If and when affected populations at the frontlines in northern Kasai, Katanga, Equateur, Ituri and the Kivus, who are at greatest risk become accessible, there will be an additional need for emergency assistance to these populations.

(b) Non-Traditional Humanitarian Activities: In vulnerable but stable areas, OFDA, in FY01, will seek new ways to expand beyond life-saving humanitarian emergency assistance through non-traditional programs that mitigate the effects of conflicts. OFDA will explore holistic approaches. One example is a program of food security enhancement through a rehabilitation of a bridge that should increase farmers' profits by reducing transport costs. In addition, OFDA will expand livelihoods or quick-impact approaches by supporting programs that work with and through local Congolese partners. Where possible, OFDA will actively seek ways to link to or integrate HIV/AIDS prevention and control measures. Finally, OFDA will encourage strong Kinshasa-based partners to expand their programs to under-served regions.

Other Donors and Gap Analysis:
The Office of Coordination and Humanitarian Assistance (OCHA) estimates that while 60% of vulnerable communities are accessible, humanitarian activities only reach about half of these. There are limited international and Congolese resources to respond to the needs. The EU is the largest donor of humanitarian assistance in conflict–affected areas. Three-quarters of their funding focuses on the east (especially the Kivus).

Description of Major Elements of Both Emergency Response and Non-traditional Programs:

I. Health Services

- Restore health services through provision of basic medical equipment and essential medicines; direct delivery of PHC including strengthened EPI; epidemiological surveillance and response; and refresher training of health personnel, etc.
- Establish therapeutic nutritional programs and conduct assessments of nutritional status.
- Rehabilitate reference labs in Kisangani including establishing capacity to test blood for HIV, isolate shigella, and type meningitis species.
- Improve sanitation and access to potable water for individuals and as part of minimal health facility rehabilitation.
- Improve access to health services through functioning, often church-based, health zone networks (proposed bridge grant for start-up of a rural health program - SANRU).

II. Food Security

- Improve food security through seed multiplication and distribution of seeds and tools.
- Maintain and repair key roads and bridges to facilitate trade and markets.
- Expand targeted assistance to help restore livelihoods.

III. Coordination and Logistics:

- Through funding of OCHA, improve coordination of humanitarian programs, enhance safety for aid delivery, and generate information about conflict-affected at-risk populations.
- Provide air services that enable transport of life-saving cargo such as food, fuel; facilitate emergency evacuation; and support on-going epidemiological surveillance and response.

IV. Mitigation

The following are specific programs that proactively or, in the wake of a disaster declaration, mitigate against further negative effects on vulnerable populations. Support will be provided to:

- Extremely vulnerable children in Kivu through reintegration of child soldiers, reunification of separated children and improved follow-up of children at risk (bridge grant to PHN/Displaced Children and Orphans funding for SCF-UK).
- Prevent flooding and improve cholera control and sanitation practices in at-risk neighborhoods of Kinshasa.
- Volcano and seismological surveillance including emergency preparedness.

Expected results (6-18 months): Decreased mortality, prevention of malnutrition and improved food security at the community and household level in targeted areas.

Issues:

- The poorest, most needy persons are often effectively denied servies because of prevailing, high cost recovery fees. There needs to be review and revision of fees structure so that the principle of cost recovery can be maintained while not excluding those in need of humanitarian aid.
- There needs to be more work to determine the best ways to increase the integration of humanitarian and development health assistance in the DRC.

Estimated Cost: Up to $11 million IDA funding for FY01 through OFDA

XI. LINKAGES AND SYNERGIES

The entire country of DRC is in a state of crisis. Vulnerable populations exist in every region, whether state or rebel-controlled territory. Because needs are great among widespread populations, the humanitarian reaction must be fully integrated, to the fullest extent possible, into a framework for development so that the impact of humanitarian assistance is maximized. Critical linkages and synergies among U.S. Government (DA, OFDA, FFP) and other donor programs need to be established.

It would be impossible to detail all the many linkages which are essential to promote development. However, the underlying assumption of USAID health assistance is that this aid will be provided by strengthening functional health zones (zonal management structure, referral hospitals, health centers, community activities, etc.,) including working with other sectors to provide a broad based approach and response. Even in emergency situations, the NGOs report that they can effectively use their support to buttress partially functioning health zones (e.g., one staffed health center in reasonable physical shape).

In emergency situations, OFDA will continue to encourage NGOs to provide a package of basic health services including support for routine immunization (including measles), essential drugs (antimalarials, ORS, antibiotics for pneumonia, vitamin A, IV fluids, etc.), and referral to adequate reference facilities. In addition, as stated in the OFDA section, this support will be supplemented by some basic food security inputs and other targeted assistance to stimulate livelihoods.

Below are some specific examples of how the humanitarian and development aspects of the program will be linked.

1. ***Nutrition promotion***

Nutrition promotion messages and materials (for exclusive breastfeeding, complementary feeding, growth monitoring and nutrition surveillance, supplementary feeding, vitamin A) developed under the nutrition component will be used in both routine child services in functioning health zones and in emergency situations.

In particular, supplementary feeding centers will benefit from these new nutrition promotion materials, permitting mothers and caretakers to improve the nutrition of their children, preventing relapses. At present, many such centers have no educational materials or nutrition promotion guidelines. In addition, in areas where supplementary feeding centers are supported, OFDA funded NGOs will also consider bolstering food security through provision of seeds, seed protection, and tools.

2. Malaria treatment/prevention modalities

The planned development of new diagnostic and treatment guidelines for malaria will be used in multiple situations in which malaria is likely to be encountered (both emergency and non-emergency situations).

3. Disease surveillance and Epidemic preparedness.

This is another intervention which will improve health services and address epidemic diseases in all populations nationwide. Early detection of disease outbreaks (measles, cholera, meningitis, etc.) and strategic stockpiling of emergency medicines and vaccines will allow more rapid and effective responses to these situations, reducing mortality and possible spread of infectious diseases.

4. HIV/AIDS and Tuberculosis

As USAID develops its tuberculosis activities, there will be efforts to assure effective linkages with HIV/AIDS programs. For example, as voluntary counseling and testing is expanded, these services will become entry points for tuberculosis screening and care.

SANRU assisted health zones will have rapid HIV screening kits to assure that transfusions for conditions including anemia and obstretic emergencies will be done safely.

5. School of Public Health

The SPH will be a key crosscutting institution for USAID assistance. In addition to training the health zone managers, the school will also provide key technical assistance and operations research in the areas of nutrition, disease surveillance, health financing (with the assistance of Tulane), HIV/AIDS, etc as its capacity allows.

Finally to engender collaboration and coordination across USAID partners, the Mission may wish to convene regular (e.g., quarterly) meetings of its development and emergency partners to discuss linkages and synergies, common management problems, etc.

Illustrative Budget For CSD Funds (FY 01 in millions):

Polio Funds:	
• Polio (through WHO/UNICEF/USAIDW CORE Program)	$1.5
Child Survival Discretionary Funds	
• SANRU	$4.0
• BASICS USAID/W (immun and nutrition)	$1.2
• School of Public Health	$0.6
• Mission TAACS and CS Fellow	$0.7
Sub-total	$6.5
HIV/AIDS Funds	
• Social Marketing	$2.0
• HIV Surveillance	$0.3
• Blood Safety	$0.4
• STI management	$0.4
• Behavior Change Communication	$0.4
• Care and Support	$0.5
Sub-total	$4.0
Infectious Diseases	
• Emergency Preparedness and Response	$0.5
• Malaria	$0.5
• Tuberculosis	$0.5
Sub-total	$1.5

Grand Total CSD Funds: $13.5 million

XII. HIGH LEVEL SCENARIO

(overall CSD level $21.5 million as broken down as follows: Polio $3.5 million, Infectious Diseases $4 million; Child Survival $8 million, HIV/AIDS $6 million; FFP $12-15 million; OFDA about $14 million)

What USAID Buys with this Scenario: This scenario includes all elements of the base scenario. With these addition funds, USAID will expand access to basic PHC services for rural residents, expand HIV/AIDS activities, support more comprehensive tuberculosis and malaria programs, and significantly expand USG support for polio eradication. In addition, USAID will support a greatly expanded epidemic preparedness and response program. Also, under this scenario, the SANRU program will be reinforced with priority water and sanitation activities.

Additional Beneficiaries: Beyond those reached under the base program, this scenario will (a) expand rural health services to an additional 1.5 million rural inhabitants in vulnerable, under-served areas (ten additional health zones); (b) increase condoms sales targeted at people exhibiting high risk behavior by about 10 million annually; (c) expand

the epidemic preparedness and response system beyond SANRU areas; (d) and improve the quality and coverage of polio national immunization days.

Interventions:

A. Access to Basic Primary Health Care Services

What the Base Scenario Supports: the delivery of a basic package of PHC services delivered in 60 health zones with emphasis on high impact, preventive interventions. Functional health zones will be put in place consisting of operational health centers, a minimally functioning referral hosptial (providing essential support services), and health zone leaders capable of providing supervisory, management and technical direction to the zone.

Additional Elements funded under this Scenario: Support for ten additional health zones which would provide access to basic PHC services to an estimated additional 1.5 million persons. In addition, the maternal mortality prevention program would be upgraded.

Estimated additional cost: $1 million. Total cost under high scenario: $5 million.

Issues: Careful attention will be paid to establishing a decentralized management and supervisory system to support this increased number of SANRU sites. A reasonable timetable for bringing on new zones needs to be established.

B. New Intervention Brief – SANRU Diarrheal Disease Prevention Through Environmental Health Improvement

Rationale: Endemic and epidemic preventable diarrheal diseases in children, including cholera, have been identified as a principal cause of excess mortality in rural areas of the DRC. Environmental health improvement focused on proper sanitation and hygiene behaviors is a proven, community-based method to reduce diarrheal diseases in developing countries.

Background: USAID/DRC has established environmental health improvement as a priority initiative. The mission is currently implementing an Environmental Health Strategy in urban areas aimed at preventing diarrheal diseases. It intends to broaden the application of the Strategy to rural areas as a component of the SANRU project.

Other Donor Activities and Gap Analysis: No donors or assistance organizations other than USAID are currently implementing activities in the DRC which explicitly target diarrheal disease reduction in children through environmental health interventions. Multiple organizations are, however, implementing water and sanitation activities. However, they are implementing these in the traditional way with a focus on hardware interventions – pumps, wells, springs, and latrines – and a limited amount of health education.

USAID's Role: USAID/DRC has adopted an integrated Environmental Health Strategy focused on sanitation improvement, financial sustainability, community-based ownership and management, and household and community-level hygiene behavior change. Under SANRU, USAID is in a position to support broad institutionalization of this Strategy within the Ministry of Health, international and local NGOs, and a network of rural health centers cooperating with the project.

Target population: USAID/DRC's Environmental Health Strategy to reduce diarrheal diseases targets households and communities – particularly women and children under the age of five.

Expected geographic focus: USAID/DRC's overall diarrheal disease prevention strategy focuses both on urban centers and rural areas. Under SANRU, the focus would be in rural areas where the project is active.

Justification Based on Criteria: Diarrheal diseases, including cholera, are major causes of morbidity and mortality in children under the age of 5 in the DRC. Sanitation improvement and hygiene promotion have been shown to be the principal components of successful, sustainable initiatives to reduce diarrheal disease and mortality in developing countries. Hygiene promotion will prevent diarrheal diseases through widespread adoption of safe hygiene behaviors. This approach has been applied in developing countries in numerous locations and has proven to be a technically feasible, cost effective method to reduce diarrheal diseases. USAID has had a history of successful environmental health programs with the University of Kinshasa, School of Public Health and the Environmental Health Project (EHP). The School of Public Health is especially well positioned to become a Congolese center of excellence to provide environmental health services and training to local activities over the short and long terms.

Description of Major Elements and Estimated Cost: To achieve the objectives of local institutionalization of hygiene promotion and diarrheal disease reduction in rural areas, the following broad activities would be required under SANRU during the time period addressed in this Action Plan:

- Community-based water supply, sanitation, and hygiene behavior improvement
- Needs-based international technical assistance
- Needs-based technical assistance from the School of Public Health
- Development of new and reproduction of existing IEC materials
- Promotion of latrine construction, spring capping; and well repair, and construction of ventilated Improved Pit Latrines in hospitals.

Expected Results:

Short-term: Within one year, the principles and components of USAID/DRC's Environmental Health Strategy would be refined and applied to support the objectives of SANRU. This initiative will also institutionalize an understanding of the importance of sanitation improvement, financial sustainability, community participation, and hygiene promotion in rural health centers involved in water supply or sanitation projects to ensure widespread positive health impacts of these on-going activities.

Long-term: Environmental health activities would contribute to reduction in diarrheal diseases in children by increasing the quantity of water used per capita per day, increasing the percentage of child caregivers and food preparers with appropriate hand washing behavior, and increasing the percentage of the population using hygienic sanitation facilities.

Issues:

- A viable network of health centers and Water and Sanitation Coordinators would need to be mobilized under SANRU to serve as the institutional structure for rural application of the Environmental Health Strategy, and

Estimated Cost: $500,000

C. Polio Eradication

What the Base Scenario Supports: Supporting high quality national immunization days and enhanced surveillance with an emphasis on improved micro-planning at the health zone level, logistics and social mobilization.

Additional Activities under this Scenario: Enhanced funding of these same activities.

Additional Cost: $2 million

Total Cost of Polio Eradication Activities under the High Scenario: $3,500,000

D. HIV/AIDS

What the Base Scenario Supports: USAID will support efforts in the following areas: surveillance to fill the current gap in HIV and behavioral data, revitalization of BCC activities with geographical focus and targeting vulnerable and high risk groups, increased social marketing of condoms, improved management of STIs, improving blood safety, and initial assistance to care and support activities.

Additional Activities and Costs under this Scenario:
Further expand social marketing: $1,000,000
Further expand STI management: 200,000
Further expand blood safety: $300,000
Expand voluntary counseling and testing activities in coordination with other care and support activities: $500,000

Total Cost of HIV/AIDS activities Under the High Scenario: $6 million

E. Malaria Control

What the Base Scenario Supports: Development and dissemination of malaria case management protocols for children under 5 and pregnant women; direct support to improve malaria services in SANRU health zones; feasibility assessment of use of insecticide treated materials for the prevention of malaria.

Additional Activities Under this Scenario: procurement of second line antimalarial drugs to functioning health zones; operations research in Kinshasa into the feasibility of ITMs including exploring various marketing options; supporting the WHO/Roll Back Malaria program by enhancing capacity to do social mobilization and information, education, and communication by means of training, technical assistance, and material production; piloting of ITMs distribution programs based on results of operations research.

Additional Cost: $900,000

Procurement of Antimalarial drugs, second line	$200,000
Operations Research, insecticide treated nets (ITNs) (Kinshasa)	$200,000
WHO/Roll Back Malaria, Social mobilization, IEC	$250,000
Piloting of ITNs including provision	$250,000

Total Cost of Malaria activities under High Scenario: $1.4 million

F. Tuberculosis

What the Base Scenario Supports: training and supervision of providers at all levels; improvement of diagnostic facilities, including provision of materials and quality assurance; enhancement of communication among the partners providing TB care; education of health workers and the general population to improve knowledge about the disease; and technical assistance to the National Tuberculosis Program (NTP).

Additional Activities and Costs under the High Scenario: $600,000

- $200,000 for training, local supervision
- $150,000 drugs to cover expanded areas--bridge/emergency, drug management training
- $50,000 to support quality assurance for the laboratory and health providers
- $100,000 for monitoring and surveillance and multi-drug resistance surveillance assessment
- $100,000 for additional operations research

Total cost for tuberculosis under the High Scenario: $1.1 million

G. Epidemic Preparedness and Response

What is funded under the Base Scenario: Provincial epidemic preparedness and response training (EPR); provision of emergency stocks of EPR medications in provincial depots; internet connectivity (where hardware is already in place) for selected SANRU sites; support to the School of Public Health to evaluate EPR training and use of emergency stocks.

Additional Activities and Costs under the High Scenario:	$1,000,000
EPR training, provinces (3 provinces)	$60,000
Contingency stocks EPR drugs	$300,000
Internet hookups (60 sites)	$340,000
Provincial Laboratory supplies (6 zones)	$300,000

Total funding for disease surveillance under the High Scenario: $1.5 million

H. OFDA

If there are increased levels of IDA funding above $11 million, OFDA could expand humanitarian activities by:

Food Security

- Increasing the number of food security programs providing farmers with seeds, tools and the means by which to farm and to prevent malnutrition.
- Linking therapeutic and supplementary nutritional programs to create a safety net for most vulnerable.
- Funding quick-impact projects through umbrella mechanisms that will improve livelihoods.

Health Services

- Increasing access to basic health services including therapeutic nutrition programs to reach those IDPs who have been more isolated.
- Expanding HIV/AIDS control through education and prevention and treatment of STIs.
- Increasing urban mitigation activities such as cholera prevention and preparedness

Coordination And Logistics

- Supporting additional OCHA offices and monitors to facilitate information exchange.
- Supporting additional air service to humanitarian operations.

Illustrative Budget For CSD Funds (FY 01 in millions):

Polio Funds:

• Polio (through WHO/UNICEF/USAIDW CORE Program)	$3.5

Child Survival Discretionary Funds

• SANRU	$5.0
• BASICS USAID/W (immun and nutrition)	$1.2
• School of Public Health	$0.6
• Water and Sanitation (USAID/W EHP and SANRU)	$0.5
• Mission TAACS and CS Fellow	$0.7
Sub-total	$8.0

HIV/AIDS Funds

• Social Marketing	$3.0
• HIV Surveillance	$0.3
• Blood Safety	$0.7
• STI management	$0.6
• Behavior Change Communication including care and support	$1.4
Sub-total	$6.0

Infectious Diseases

• Emergency Preparedness and Response	$1.5
• Malaria	$1.4
• Tuberculosis	$1.1
Sub-total	$4.0

Grand Total CSD Funds: $21.5 million

XIII. HIGHER SCENARIO LIMITED ONLY BY ABSORBTIVE CAPACITY

Under a more expanded funding scenario, a series of expanded activities and some new activities could be supported.

What USAID Buys with this Scenario: This scenario includes all elements of the base and high scenarios. With these additional funds, USAID will expand access to basic PHC services for rural residents, expand HIV/AIDS, infectious disease, water and sanitation, immunization, tuberculosis, and safe motherhood activities.

Additional Beneficiaries: Beyond those reached under the base and high programs, this scenario will (a) expand rural health services to an additional 1.5 million rural inhabitants in vulnerable, under-served areas; (b) increased immunization coverage in 6 additional health zones; (c) speed the eradication of polio in the DRC; (d) allow the HIV/AIDS program to have a nationwide impact; (d) help develop a viable national safe motherhood program; launch a new initiative in urban water and sanitation to reduce diarrheal diseases; allow family planning to be effectively integrated into all functional health zones.

Major new and/or expanded activities:

- Expand the number of health zones supported under SANRU from 70 to 80, reaching an additional 1.5 million persons (12 million total). Additional Cost: $1.2 million;
- Enhance routine immunization by funding expansion of immunization and management support program to 6 additional health zones. Additional cost: $1 million.
- Speed interruption of wild poliovirus by adding $1 million to the USG contribution to eradicate polio in the DRC.

- Expand the capacity of the School of Public Health through programs to enrich the faculty, additional operations research, and targeted short training programs. Additional cost: $400,000.
- Fully implement comprehensive HIV/AIDS activities in the 6 main areas of intervention identified in the base scenario: surveillance to fill the current gap in HIV and behavioral data, revitalization of BCC activities with geographical focus and targeting vulnerable and high risk groups, increased social marketing of condoms, improved management of STIs, improving blood safety, and first phase assistance to care and support activities. Additonal cost: $5 million.
- Expand Tuberculosis activities through improved transport for supervisors of health workers, and patient supervision in rural areas. In addition, laboratory and program quality control activities would also be upgraded. As education for patients increases and HIV/AIDS increases, more demand on the system will require increasing services and medications. Additional cost: $1 million.
- Expand activities to prevent maternal mortality by helping UNFPA to launch a viable national safe motherhood program comprising the following elements: advocacy, emergency obstretic care, birth preparedness, maternal nutrition, and reproductive health. Additional cost: $1 million.
- If population funds become available, promote family planning in SANRU sites and in other functional health zones. Additional cost: $1,500,000.
- Improved water and sanitation in urban centers and expanded rural areas supported by SANRU. This new intervention is described below:

New Intervention Brief – Diarrheal Disease Prevention Through Environmental Health Improvement in Urban Areas and expanded SANRU Sites

Rationale: Endemic and epidemic preventable diarrheal diseases in children, including cholera, have been identified as a principal cause of excess mortality in urban locations, rural areas, and areas of the DRC affected by on-going violence. Environmental health improvement focused on proper sanitation and hygiene behaviors is a proven, community-based method to reduce diarrheal diseases in developing countries.

Background: USAID/DRC has established environmental health improvement as a priority initiative. The mission is currently implementing an Environmental Health Strategy aimed at preventing diarrheal diseases. The Strategy is guided by certain general principles, including cost-effectiveness, maximized use of local partners, community involvement, income generation, targeting high risk populations including HIV/AIDS, scientific basis for intervention and evaluation, and financial sustainability.

Within this set of principles, USAID/DRC has identified eight components which form an integrated and comprehensive approach including: community participation, hygiene behavior change, targeting priorities, decentralized service delivery, microenterprise support, cooperation with health facilities, education and training, and alternative techniques for environmental sanitation improvement.

Other Donor Activities and Gap Analysis: No donors or assistance organizations other than USAID are currently implementing environmental health improvement activities in the DRC which explicitly target diarrheal disease reduction in children through environmental health interventions. Multiple donors and assistance organizations are, however, implementing water and sanitation activities. However, they are implementing these in the traditional way with a focus on hardware interventions – pumps, wells, springs, and latrines – and a limited amount of health education. These education activities typically use conventional package approaches. Both the hardware focus and the package educational approaches have been demonstrated to have questionable health impacts and are inconsistent with the Environmental Health Strategy supported by USAID.

USAID's Role: USAID/DRC has adopted an integrated Environmental Health Strategy focused on sanitation improvement, financial sustainability, community-based ownership and management, and household and community-level hygiene behavior change. USAID is in a position to support national-level institutionalization of this approach within knowledgeable and active Congolese organizations with which it has long-term relationships, such as the School of Public Health of the University of Kinshasa, and international organizations.

Target population: USAID's Environmental Health Strategy to reduce diarrheal diseases targets households and communities – particularly women and children under the age of five.

Expected geographic focus: USAID's overall diarrheal disease prevention strategy focuses both on urban centers and rural areas under consideration for intervention under the SANRU project. It has been widely shown that the urban poor are at least as susceptible to infectious diseases, poverty, and lack of health services as rural populations. Field experience also has shown that similar approaches can be applied and results expected in the two locations. USAID/DRC has initiated activities in Kinshasa and Kananga under its Urban Environmental Health Strategy, and the mission expects to build on the lessons learned in these activities to expand its urban portfolio during the time frame of this Action Plan. Application of the Strategy in rural areas is addressed under the intervention brief for environmental health under the SANRU project.

Justification Based on Criteria: Diarrheal diseases, including cholera, are major causes of morbidity and mortality in children under the age of 5 in the DRC. Sanitation improvement and hygiene promotion have been shown to be the principal components of successful, sustainable initiatives to reduce diarrheal disease and mortality in developing countries. Hygiene promotion will prevent diarrheal diseases through widespread adoption of safe hygiene behaviors. This approach has been applied in developing countries in numerous locations and has proven to be a technically feasible, cost effective method to reduce diarrheal diseases. USAID has had a history of successful environmental health programs with the University of Kinshasa, School of Public Health and the Environmental Health Project (EHP). The School of Public Health is especially

well positioned to become a Congolese center of excellence to provide environmental health services and training to local activities over the short and long terms.

Description of Major Elements and Estimated Cost: To achieve the objectives of national-level institutionalization of hygiene promotion and diarrheal disease reduction, the following broad activities would be required over the time frame of the Action Plan:

- Behavior Change Workshops and Training of Trainers $100,000
- Capacity building for Univ. of Kinshasa School of Public Health $120,000
- Needs-based international technical assistance for urban activities $750,000
- Needs-based technical assistance from the School of Public Health $150,000
- Direct field support to expand current activities and support new initiatives $1,000,000

Expected Results:
Short-term: Within one year, capacity would be established within the University of Kinshasa, School of Public Health to design, implement, monitor, and evaluate environmental health interventions to reduce diarrheal diseases. USAID/DRC would support institutionalizing an understanding of the importance of sanitation improvement, financial sustainability, community participation, and hygiene promotion in donor, humanitarian assistance, and other organizations involved in water supply or sanitation projects to ensure positive health impacts of these on-going activities.

Long-term: Environmental health activities would contribute to reduction in diarrheal diseases by increasing the quantity of water used per capita per day; increasing the percentage of child caregivers and food preparers with appropriate hand washing behavior; and increasing the percentage of the population using hygienic sanitation facilities. Additional long-term results would include expansion of urban environmental health programs beyond the pilot efforts currently supported by USAID.

Assumptions, Alternatives, and Issues: Only one priority issue must be considered prior to implementing the elements described in this Brief. This is the following:

- Following already held discussions, the formal commitment of the University of Kinshasa, School of Public Health to serve as a national center of excellence in environmental health and provide regular technical assistance to field interventions should be obtained.

Need for Further Analysis and Timing of Start-up: In order to advance the proposed agenda, only one item requires further analysis: discussions should be held with leadership of the University of Kinshasa School of Public Health to formally confirm their interest in filling the role of a national center of excellence in environmental health. Implementation of other elements described in this section could occur with little advance notice in any designated and available area of the country because USAID/DRC is currently engaged with partners in the field implementing environmental health activities.

Illustrative Budget For CSD Funds (FY 01 in millions):

Polio Funds:

• Polio (through WHO/UNICEF/USAIDW CORE Program)	$4.5

Child Survival Discretionary Funds

• SANRU	$6.2
• BASICS USAID/W (immun and nutrition)	$1.2
• School of Public Health	$1.0
• Water and Sanitation (USAID/W EHP and SANRU)	$1.5
• Mission TAACS and CS Fellow and local hire	$0.9
• Expansion of zonal level immunization support	$1.0
• Maternal Mortality	$1.0
Sub-total	$12.8

HIV/AIDS Funds

• Social Marketing	$4.0
• HIV Surveillance	$0.5
• Blood Safety	$1.0
• STI management	$1.5
• Behavior Change Communication including care and support	$4.0
Sub-total	$11

Infectious Diseases

• Emergency Preparedness and Response	$1.5
• Malaria	$1.4
• Tuberculosis	$2.1
Sub-total	$5.0

Population Funds	$1.5

Grand Total CSD/Pop Funds: $34.8 million

XIV. LOW SCENARIO

(overall CSD funding of $11.1 million as broken down as follows: polio $1.3 million; infectious diseases $500,000; child survival $5.5 million; HIV/AIDS $3.5 million; population $300,000)

Description of Activities:

- USAID's activities in support of polio eradication would be slightly reduced (by $200,000);

- Infectious diseases would be limited to the base malaria scenario (development and dissemination of a new malaria diagnostic and treatment guidelines).
- The SANRU program would be limited to 50 rather than 60 health zones.
- All HIV/AIDS components would be funded except for the revitalization of behavior change communication (i.e., support for NGOs to develop and implement BCC interventions, support for a behavior change campaign in at least one occupied territory, and the development of voluntary counseling and testing pilot activities);
- Population funds would permit integration of some family planning activities into SANRU sites.

The following major programs would not be funded: tuberculosis activities and epidemic preparedness and response.

Illustrative Budget For CSD Funds (FY 01 in millions):

Polio Funds:	
• Polio (through WHO/UNICEF/USAIDW CORE Program)	$1.3
Child Survival Discretionary Funds	
• SANRU	$3.0
• BASICS USAID/W (immun and nutrition)	$1.2
• School of Public Health	$0.6
• Mission TAACS and CS Fellow	$0.7
Sub-total	$5.5
HIV/AIDS Funds	
• Social Marketing	$2.0
• HIV Surveillance	$0.3
• Blood Safety	$0.3
• STI management	$0.3
• BCC and care and support	$0.6
Sub-total	$3.5
Infectious Diseases	
• Malaria	$0.5
Population	$0.3

Grand Total CSD/Pop Funds: $11.1 million

XV. NEXT STEPS - ADDITIONAL NEEDED TECHNICAL ASSISTANCE OVER NEXT SIX MONTHS

Basic Primary Health Care

- ECC in conjunction with the Mission needs to revise the list of proposed sites.
- ECC/IMA needs technical assistance from a PHC expert to scale back the proposed service package and revise diagnostic and treatment protocols.
- ECC/IMA and USAID need determine how initial stocks of essential drugs will be procured and how the system will function to avoid stock-outs given high currency inflation.

HIV/AIDS

- It is recommended that at least two consultants with broad and complementary expertise on HIV/AIDS/STI conduct an in depth assessment, develop a realistic implementation plan, identify appropriate sites for implementation and implementing agencies in consultation with the mission and the government of the DRC. The scale of this implementation plan will depend on the level of funding available.

Tuberculosis

- It is essential that a more complete assessment of current and potential NGO and NTP activities be undertaken prior to initiation of any new USAID TB program. The

IUATLD assessment in November will be of great assistance in determining the best use of USAID resources as it identifies strengths, weaknesses, and gaps in the current program.

Epidemic Surveillance

- There is a need to evaluate the fastest way to order EPR contingency stocks for WHO.

Emergency Food Assistance

- FFP will inform WFP of its interest in supporting the Congo PRRO, and recommend its inclusion in the FY 01 resource request for the biennial pledge.
- FFP will discuss with ICRC headquarters in Geneva whether commodity donations are sought for its Congo operations.

Cost Recovery

- A technical assistance visit from a health financing expert (perhaps from the G/PHN Partnerships in Health Care Reform Program) is needed to propose a process for the development of more effective cost recovery fee structures in USAID-assisted areas.

Maternal Mortality

- Given the importance of maternal mortality and the lack of activities of address it, a technical assistance visit from a staff member of the G/PHN Maternal Health Division would be useful to propose a more comprehensive maternal mortality reduction activities for the SANRU program.

XVI. Additional Thoughts/Recommendations from Team Leader

All evidence (including my field trips to North Kivu and Bas Congo) clearly indicates that the economic situation in the Congo is dire. The economy now fails to sustain the livelihoods of increasingly large numbers of people. Access to food and medical services are extremely limited. The mean per capita income (GDP) is less than $100 per year, one of the lowest worldwide, and an estimated 75% of Congo's population live in absolute poverty (less than $ 1 per day per person). As mentioned above, we recommend that our emergency assistance, where possible, move beyond a life-saving humanitarian response to improve livelihoods and food security, and stimulate the economy.

In view of this situation, I believe that the DRC would benefit from a program which provides food and generates local currency which could be used for a variety of emergency and development purposes including helping subsidize health care for the poor (presently denied services due to high cost recovery fees).

Recommendation No. 1: The Team Leader recommends that USAID/W consider approving a PL- 480 Title II Food Aid Monetization program, consistent with Section 202(e) of the Law, to generate local currency for development activities in health, agricultural production, income generation, infrastructure rehabilitation, and to subsidize

and reduce the high cost of current medical services. The use of monetization is a more cost-effective approach than the use of foreign exchange provided through other appropriated funds to accomplish emergency humanitarian assistance objectives.

Recommendation No. 2: The Team leader recommends that the Mission hire a qualified PSC/fellow/TAACS to manage the complex SANRU program. In addition, I recommend that Mission staff be expanded to include a full-time USDH humanitarian officer.

Recommendation No. 3: Based on this document, USAID/W should approve a funding scenario for USAID/DRC so that the USG response to the tragedy in the DRC can be enhanced and fully operational. This should be done as soon as possible.

ACRONYMS

ACF	Action Contre le Faim (Action against hunger)
ACOLSI	Action Contre le SIDA
AIDS	Auto Immune Deficiency Syndrome
ALPI Plus	Apostolat pour la Liberation des Personnes vivant avec le VIH/SIDA
AMO-Congo	Avenir Meilleur pour les Orphelins
BASICS	Basic Support for Institutionalizing Child Survival
BCC	Central Coordination Bureau for the DRC National AIDS Program
BDOM	Bureau Diocesiau des Oeuvres Medicales
BHR	Bureau for Humanitarian Response
CBCA	Communaute Baptiste au Centre de l'Afrique
CEMUBAC	Centre Scientifique et Medicale d'Universite Bruxelles pour ses Activities de Cooperation
CNTS	Centre National de Transfusion Sanguine
CRS	Catholic Relief Services
CSD	Child Survival and Disease
DOTS	Directly Observed Therapy Strategy
DPT	Diptheria, Pertussis and Tetanus
DRC	Democratic Republic of Congo
ECC	Eglise du Christ au Congo (Christ's Church of Congo)
EPI	Expanded Program for Immunizations
ESP	Ecole de Sante Publique (School of Public Health)
FAO	Food and Agriculture Organization of the UN
FFP	Food for Peace
HIV	Human Immunodeficiency Virus
ICRC	International Committee of the Red Cross
IDP	Internally Displaced Persons
INGO	International non-governmental organization
INRB	Institut National de Recherche Biomedicale
IRC	International Rescue Committee
LNAC	Ligue Nationale Anti-Tuberculose au Congo
LNGO	Local non-governmental organization
MMR	Maternal Mortality Rate
MSF	Medecins Sans Frontiers (Doctors without Borders)
NIDS	National Immunization Days
OFDA	Office of Foreign Disaster Assistance
OTI	Office of Transition Initiatives
PATS-UE	Programme d'Appui Transitoire au Secteur de la Sante - Union Europeenne
PHC	Primary Health Care
PNLP	Programme Nationale de Lutte contre le Paludisme

PNLT	Programme Nationale de Lutte contre le Tuberculose
PRRO	Protracted Relief and Recovery Operation
PSI	Population Services International
SNIDS	Sub-National Immunization Days
SPH	School of Public Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
TLM	The Leprosy Mission
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Childrens Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
USAID	United States Agency for International Development
VAD	Vitamin A Deficiency
WFP	World Food Program
WHO	World Health Organization
WVI	World Vision International

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ECC	Mampaka, Administrative Director
ESP	Dr. Okitolonda, Director
FAO	Marco Giovannoni, Emergency Coordinator
Femmes Plus	Ms. Mulelebwe
Fondation Damien	Dr. Lubamba
GTZ	Dr. Danny Denolf
ICRC	Country Director
INRB	Dr. Muyembe, Director
International Rescue Committee	Country Director
Italian Embassy	Paolo Urbano, Chef de Section de la Cooperation
Lisanga Nutrition Center	
LNAC	Dr. Kaboto
Minister of Planning	Secretary General
Ministry of Health	Mr. Mashako Mamba, Minister of Health
MSF- Belgium	Dr. Mayala
NACP	Dr. Kawunda, Kitapindu
Oxfam	Tom Berg
PATS-UE	Dr. Dominique
PNLP	Dr. Makina, Director
PNLT	Dr. Wembanyama, Director of PNLT
Projet SIDA	Dr. Minlangu, Director
PSI	John Loftin, Country Director
Solidarity Action for Children in Distress	
TLM	Dr. Ndombe, Director
UNHCR	

UNICEF	Martin Mongwanja, Representative
UNOCHA	Grigor Houhannisyan, Charge d'Affaires
WFP	Kees Tuinenburg, Country Director
WHO	Dr. Tapsoba, Representative

Lubumbashi, Katanga

ACF	
BDOM	
Commissariat General a la Reinsertion	
FAO	Michel Ngongo, Charge des Operations Agricoles d'Urgence
ICRC	Juerg Eglin, Sub-Office Chief
Kenya-Kamalondo Health Zone	
Mayor	
MSF	
MSF Belgium	Saidou Diallo, Provincial Medical Coordinator
OTI	Jay Nash
Provincial Medical Inspector	
UNICEF	
WFP	Zacharie Bagula, Assistant a la Logistique
World Vision	David Kayombo Ntambwe, National Director

Goma, North Kivu

ACOLSI	Mr. Fikiri, AIDS Advisor
CBCA	JPK Makelele, Medical Advisor
CEMUBAC	Etienne Mangaiko, Medical Director
ECC	Ezecca Tshongo, Provincial Director North Kivu
Kirotsche Health Zone	
Projet SIDA	Adolophe Gashinge, Representative
Provincial Health Office	Alain Alingi, Provincial Medical Inspector
UNICEF	Mirindi Mulikuza, Sub-Office Chief
WHO	Ncharre Chouaibou, Medical Officer

Kimpese, Bas-Congo

BDOM- Kisantu
ECC

Kimpese Health Zone

Sister Emily
Dr. Meli, Medical Director of the Reference Hospital
Dr. Ngongosieme