660-0057 (2) pp 4

PROJECT PAPER FACESHEET

TO BE COMPLETED BY ORIGINATING OFFICE

[X] ORIGINAL [ ] CHANGE [ ] ADD [ ] DELETE

DOCUMENT CODE

2. COUNTRY/REGIONAL ENTITY/GRANTEE: ZAIRE

3. DOCUMENT REVISION NUMBER: PD-AAB-865-B1

4. PROJECT NUMBER: 660-0057

5. BUREAU: A. SYMBOL: AFR; B. CODE: 1

6. ESTIMATED FY OF PROJECT COMPLETION: FY 78

7. PROJECT TITLE - SHORT (STAY WITHIN BRACKETS): HEALTH SYSTEMS DEVELOPMENT

8. ESTIMATED FY OF AUTHORIZATION/OBLIGATION: A. INITIAL MO. 2 YR. 76; B. FINAL FY 77

9. SECONDARY TECHNICAL CODES (MAXIMUM SIX CODES OF THREE POSITIONS EACH)

10. ESTIMATED TOTAL COST ($000 OR EQUIVALENT, $1= ____)

A. PROGRAM FINANCING	FIRST YEAR B. FX	C. L/C	D. TOTAL	ALL YEARS E. FX	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL	150		150	675		675
(GRANT)	(150)	( )	(150)	(675)	( )	(675)
(LOAN)	( )	( )	( )	( )	( )	( )
OTHER U.S. 1.						
U.S. 2.						
HOST GOVERNMENT	-	115		-	440	440
OTHER DONOR(S)						
TOTALS	150	115	150	675	440	1115

11. ESTIMATED COSTS/AID APPROPRIATED FUNDS ($000)

A. APPROPRIATION (ALPHA CODE)	B. SECONDARY PURPOSE CODE	C. PRIMARY TECH. CODE	FY 76 D. GRANT	E. LOAN	FY 77 F. GRANT	G. LOAN	FY 78 H. GRANT	I. LOAN	ALL YEARS J. GRANT	K. LOAN
PH	429	530	150	-	-	-	525	-	675	-
TOTALS			150	-	-	-	525	-	675	
12. ESTIMATED EXPENDITURES			10	-	40	-	200	-	[illegible]	

13. PROJECT PURPOSE(S) (STAY WITHIN BRACKETS) [ ] CHECK IF DIFFERENT FROM PID/PRP

To strengthen the GOZ's institutional capacity to deliver health services

14. WERE CHANGES MADE IN THE PID/PRP FACESHEET DATA NOT INCLUDED ABOVE? IF YES, ATTACH CHANGED PID/PRP FACESHEET.

[X] YES [ ] NO

15. ORIGINATING OFFICE CLEARANCE

SIGNATURE: Fermin Spencer

TITLE: USAID Director

DATE SIGNED: MO. 12 DAY 11 YR. 75

16. DATE RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MO. 12 DAY 15 YR. 75

AID 1330-4 (5-75)

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B. RECOMMENDATION

Grant	$675,000
Total new AID obligations	$675,000

C. DESCRIPTION OF PROJECT

Recognizing the essential role of management in the effective planning and implementation of any program, the Government of Zaire has specifically requested assistance from USAID in the development of a health systems management capacity.

Moreover, Zaire is committed to a permanent generalized improvement in the health status of Zairian families throughout the entire country. To achieve this objective requires the establishment of an integrated national health delivery system. This program goal has resulted in a separate request for AID assistance in planning for, and implementing, an integrated family health program through a Health Development Zones program.

The primary purpose of this project is to assist the Government of Zaire in strengthening its institutional capacity to deliver health services generally, with specific emphasis on the country's Health Development Zones.

To achieve its goal, this project will seek to link the several health sector projects currently being developed and implemented through USAID/Zaire assistance. The collective effort is to result in an improved health management systems capability to increase the effectiveness of Zaire's overall health delivery system.

Implementation over the two-year life of this project will require:

1. Long-term (one Project Manager) and short-term (41 man-months) technical assistance in the form of health care specialists in several health related disciplines.

2. Long-term and short-term participant training (63 man-months) for selected GOZ health personnel.

3. Commodity and equipment support to insure efficient utilization of the technical assistance and to initiate improved services in the first Health Zones.

Technical assistance will be provided to, and at the request of, the NHC in its responsibility for the development of policies and programs in health care, including basic family health services, public health, and paramedical education. Specifically, the project will assist the National Health Council to carry out its responsibilities for:

1. Health sector analysis.

2. Program development and resource allocation.

3. Establishment of medical data and population statistical programs.

4. Creation of a national system for the acquisition and distribution of supplies and material.

5. Provision of those support and infrastructure services necessary to permit expanded government health services nationwide for low-cost, integrated maternal/child health, desired births, and other preventive health service programs.

6. Health education and communication systems.

7. Manpower development.

The technical assistance will be administered through a contractor who will respond to specific requests from the NHC for specialists in the fields of:

- health care planning and economics
- health care administration
- public health and integrated health delivery systems
- health data
- health education and communications
- logistics, supply, and maintenance
- health facilities design and construction
- pharmaceutical production and supply management
- manpower development

The AID-financed Project Manager assigned to the National Health Council (NHC) will himself be expert in public health administration and will help the NHC orchestrate and coordinate consultant inputs.

The end-of-project status wil entail (1) the existence of an NHC structure capable of formulating and delivering improved health services throughout Zaire; (2) a trained Zairian staff working on various aspects of health services delivery; and (3) initiation of a program for integrated family health care, including the establishment and servicing of initial Health Zones.

To achieve the project purpose a series of plans and/or systems will have been delineated for the NHC's new organizational structure, its personnel, statistics, logistics, maintenance and supply systems.

Through these outputs it should be possible to reduce operating costs and/or make them more cost effective, which will in turn make it possible to:

1. Extend existing services to a greater number of people.

2. Improve the quality and quantity of existing services.

3. Lower the cost of medical care to the patient.

4. Reduce the human and economic impact of sickness by lowering morbidity and mortality.

At the end of the project, the GOZ's NHC will have had the opportunity to utilize a variety of health care specialists to:

- help plan its programs

- assist in the identification of problem areas in management, and

- to structure management procedures for improving the health care system.

In addition, a plan for the development of a model integrated family health care program will have been prepared. This will allow GOZ and USAID to move more expeditiously in the implementation through the GOZ Health Zones of the Basic Family Health Services project that is currently under review in Kinshasa and Washington.

D. SUMMARY FINDINGS

The GOZ is well aware of its needs in the area of health care planning and management. It is prepared to make full use of short-term consultant expertise in a wide variety of health related areas. This is particularly true for the early planning stages of the GOZ's new initiative in integrated basic family health services.

AID experience in providing centrally funded short-term consultants to the GOZ has been successful, and there is every reason to believe that a formalization of the process in the health field will prove beneficial to the GOZ. It will also make such consultation and technical assistance easier to manage for both AID and the GOZ. The project will make AID more responsive to expected future GOZ requests, which is extremely important in this preliminary stage of health development.

On a worldwide basis, it has been common to build technical assistance consultative services into a project proposal, and it is a standard way of carrying out short-term work assignments. The AID experience, on a worldwide basis, has similarly been satisfactory with this type of service arrangement.

USAID/Zaire believes that this project as presently designed will make health care experts available to the GOZ on short notice and within a quick response time. Such flexibility is earnestly desired by the GOZ and strongly supported by the Mission. Under these circumstances, this project is ready for implementation as soon as a Project Agreement is signed.

E. PROJECT ISSUES

Response to the initial discussions of a health systems project identified two areas needing further elaboration. This Project Paper addresses these following two areas:

1. The Role of the National Council of Health and Well-Being

The NHC is defined in the "Implementation Arrangements" section of this paper. Roles of and coordination with other health care providers and international assistance agencies are also discussed in that section.

2. Management of Technical Assistance Input

The discussion in the "Implementation Arrangements" section presents a detailed outline of technical assistance that will be needed by the new Zairian health care structure.

In this context, the importance of the NHC as the organization responsible for managing the technical assistance input is analyzed. Alternative strategies for coordinating project implementation are discussed.

This project is so planned as to help lay out the groundwork and action program for a new Basic Family Health Services project to commence in FY 1977. Issues raised concerning the GOZ's proposed basic family health services program include:

1. Financial feasibility of new construction activities over a short period of time and the GOZ ability to maintain the AID-supported effort. This question is addressed in the "Financial Feasibility"section of this paper.

2. Manpower capabilities of Zaire in effectively planning for and carrying out the project. In response to this question, the present project will enable the GOZ to deal with identified health planning needs through the use of outside experts and the training of counterparts.

3. Supply adequacy of a hard-pressed Zairian system which does not have enough health supplies to operate current programs, let alone new health centers. The identification of the supply needs for the integrated family health program will be one of the early outputs of this project. This will allow the GOZ and USAID to plan how they will finance and distribute supplies long before the basic family health project becomes operational.

PART II: PROJECT BACKGROUND AND DETAILED DESCRIPTION

A. BACKGROUND

1. Health Background

a. Population Factors

Although the availability of current, accurate population data for Zaire is lacking, Zaire's population is estimated at 22 million, which is the largest population in central Africa. The present crude birth rate is approximately 45.2 per 1000 and the death rate is 20.5 per 1000, resulting in a corresponding growth rate of about 2.5%. This is a .5% point increase from the 2.0% rate estimated in 1955. These figures indicate that the Zairian population will double in the next 28 years. Even if it were only to maintain its present level of health services, Zaire would have to double the size of its present health system over the next 28 years just to keep pace with existing population growth rates. Such service growth would be only a "holding action," and the net result would not be an expansion of the quantity or quality of available health services.

The GOZ realizes that the overall health care system must be improved to meet the real health needs of the people. Although there are some excellent health services available in some of the urban areas, the majority of the population of Zaire is rural and, therefore, has very little access to quality health services. Even in areas where good health services exist, the availability of these services may be limited because of socio-economic conditions. A study of the Kinshasa area undertaken by the Office of the Presidency revealed that of the 55% of the population falling in the lowest socio-economic category, only 19% had access to medical facilities, in contrast to 100% of those in the higher socio-economic levels.

b. Endemic Disease and Population Specific Mortality and Morbidity

As in most LDC's, Zaire has endemic diseases which are severe. Among these are malaria, trypanosomiasis (sleeping sickness), schistosomiasis, onchocerciasis, measles and tuberculosis. Each of these is compounded by general infections and parasites, deficiency diseases, and complications

of pregnancy and childbirth. Overall data from the Mama Yemo Hospital in Kinshasa, for example, revealed that there are an average of 2.7 diseases per person. A separate project is proposed for initiation in FY 1976 for five years to work specifically on the problems of endemic diseases in general and on the control and monitoring of malaria in particular (Endemic Disease Control Project No. 660-0058).

According to the U.S. Bureau of Census statistics, the infant mortality rate in Zaire ranges between 150 and 200 per 1000 live birth. Child mortality, including infants through five years of age, may be as high as 500 per 1000 persons. It is believed that infant and child deaths account for approximately 80% of the total annual deaths in Zaire. This fact, coupled with a general high maternal mortality rate, indicates maternal-child health problems of large proportions.

c. Malnutrition

The majority of the morbidity and mortality of the Zairian people can be directly attributed to malnutrition, particularly protein deficiency. Studies have indicated that although caloric intake is estimated to be 85% of the FAO recommended level, protein intake is only one-half, or 35 grams, of the recommended 70 grams per day. Kwashiorkor is a serious nutritional disease in parts of the country.

Malnutrition has its most debilitating effects upon infants and children under five and pregnant women. The high rate of premature births and the excessive rates of perinatal and infant deaths can be traced directly to maternal malnutrition. These two population sub-groups, already weakened by nutritional deficiencies, are further assaulted by endemic diseases, resulting in a population which is in chronically poor health. The poor health status is compounded by the lack of adequate environmental sanitation and the scarcity of existing health care facilities. The GOZ and AID are moving forward with the approved Nutrition Planning Project (No. 660-055) which should make a significant contribution to nutrition programming in Zaire. This project is beginning its implementational phase in FY 1976.

d. Maternal-Child Health and Family Planning Services

The GOZ has given first priority to the creation of an integrated health program with emphasis on maternal-child health which will include both preventive and public health activities. Emphasis is being placed on improved maternity care, health education, and under-five clinics. Major MCH/FP activity has occurred through FOMECO (Medical Coordination Fund) at the Mama Yemo Hospital (MYH). Coverage under this program has been expanded in a decentralized fashion through the AID-sponsored pilot MCH/FP project (No. 660-049) begun in 1972.

In addition to the services provided through the FOMECO program, some MCH/FP services are available through other existing dispensaries and hospitals, but the impact of such services is currently difficult to assess. Contraceptives are available through some of the organized programs, through commercial sources, and through private physicians. Much work remains to be done in the effort to coordinate these programs. The current MCH/FP project has demonstrated that such services are wanted and accepted by urban women and children.

Zaire is traditionally pro-natalist. The family remains the most important unit of the Zairian society and in the Bantu philosophy, the main purpose of marriage is procreation. Nevertheless, the need for, and value of, family planning has been officially recognized by the President of Zaire through the creation of the Desired Births Committee (Naissances Desirables) (Ordnance No. 73-089). This committee is directly under the National Health Council, which has appointed its officers. The Desired Births Committee had its first official meeting in November 1975 and has submitted its first budget with a view to obtaining IPPF support.

Explicit support for an integrated health program can be found in statements made on various occasions by President Mobutu. In his 1972 address on Health and the Desired Births Program, he stated, "The State's role is to reduce infant mortality to a minimum in order that the number of actual births corresponds closely to the number of desired births." Also, in 1974 he stated that "the control of the evolution of our population will also permit the mastery of our national development."

2. The Concept of the Urban and Rural Health Zones

The new system for delivering health services was devised by the National Health Council with the intent of integrating curative and preventive medicine into the overall developmental effort. Until now, health activities focused primarily on curative medicine in the urban areas. Besides being expensive, this system did not reach the most needy people. Up to 80% of the rural population was unable to visit a medical facility because of distance. The new health delivery system will attempt to overcome this problem. The entire country will be divided into sections called Health Zones (Urban and Rural).

In March 1975, the National Health Council convened a workshop of doctors and nurses with years of experience in delivering rural health services within Zaire to elaborate the details of the organization and function of the rural health zones. The report of this workshop, "Organization and Functions of the Rural Health Zones" (see Annex), has been drafted and will serve as the blueprint for the development of the initial pilot rural health zones. A similar document is in preparation and will serve as a blueprint for the development of the urban health zones.

These rural and urban zones would coincide as much as possible with Zaire's existing administrative zones. They, in turn, will be divided into sub-zones, the sub-zones into localities, and the localities into villages. The system, based on four different levels of health care, is to be directed at four different groupings of the population. The smallest segment of the population base communities or villages (500 inhabitants), will be served by male and female village health animateurs who will perform specific basic preventive and curative medical functions. Localities (5000 population, or about 10 villages) will be served by nursing and auxilliary personnel who will perform prescribed duties for their inhabitants in Community Welfare Centers.

Health Centers (including a maternity unit) will serve the population of the Rural Health Sub-Zones (30,000 to 40,000 people), and general hospitals will provide overall medical care to the group of sub-zones which comprise the Rural Health Zone (50,000 to 250,000 inhabitants). The hospital in the rural health zone will serve as a center of reference for the Zone and as the administrative base for all medical activities in that Zone.

When the system is in effect, it will resemble a pyramid. Villages will be responsible for referring patients to Community Welfare Centers. Community Welfare Centers, in turn, will send patients to the Health Centers, and the Health Centers will refer special cases to the designated zone hospital. (In urban areas, it may be necessary for several zones to utilize the services of one hospital so that there will not be a hospital for each urban health zone). Personnel requirements at the various levels will be as follows:

a. In the Rural Health Zone, the hospital will have three doctors. They will have the responsibility for the direction of the hospital for services to the Rural Health Zone and for training. There will also be a need for paramedical, administrative, and support personnel.

b. In the Rural Health Sub-Zones, the Health Centers will be staffed by two nurses (one public health nurse and one nurse to tie the Community Welfare Center to the Health Center), two nurses' aides midwives trained for the program of desired births, two or three community health aides, and an administrative secretary.

c. In the Community Welfare Center, the ideal staff will consist of a nurses' aid trained in community health, with two or three assistants, one or two women to instruct and consult with mothers and preschool children, and one handyman to oversee the buildings and grounds.

d. Each village or base community of 500 inhabitants will have a male and female village health worker to instruct the residents individually on community health and sanitation and the principles of desired births.

Facilities and equipment will become progressively more sophisticated as one goes from the village to the hospital level.

Each Rural Health Zone is governed by a Managing Committee comprised of the doctors, managing administrator, and the Commissaire du Zone or his representative. The groups meet once a month and at the request of the head doctor.

Zaire's new five-year health plan proposes to institute and begin to operate 5 Rural Health Zones by the end of 1976 or early 1977 and 25 by the end of 1979. It is planned that ultimately all of Zaire will be covered by the system of Rural and Urban Health Zones. This project will help the NHC prepare plans and procedures for initiation of these Health Zones under the proposed Basic Family Health Project. It will also support the improvement of health delivery in the first Zones.

3. Management Systems

The development of health planning and delivery systems shares many of the problems which underlie most other sectors in Zaire.

a. Historical Factors

Prior to independence, health management was in the hands of the Belgian colonial regime. Although the health delivery system was extensive, fairly well managed, and relatively effective in endemic disease control, it was particularly hard hit by the political and social upheavals that occurred in the early 1960's. Moreover, the major underpinnings of this infrastructure were European, and facilities were modeled on European curative health systems. Native Zairian input was only at the lowest levels.

In 1960 before independence, there was not a single Zairian physician in the country. After independence, the destruction of facilities was compounded by a massive exodus of foreign health personnel. The result was not only a serious health void, but also a total inability to replace or create new health services. Health planning and management were similarly affected due to the dearth of trained local management and health manpower.

Although the system's devastation and the obvious need for effective health programs was obvious in early post-independence years, the continuous political and economic crisis besetting the new government took greater precedence in development priorities. All national health inputs in physical, human, and financial terms remained limited; the major responsibility for health programs reverted to private groups, particularly missionaries.

While the missions provided basic services, they were of limited benefit for structuring a national Health Service. Similarly, the missions provided some training for local health manpower, but could not hope to fulfill rational health manpower needs. The mission centers were largely focused in dispersed rural areas with little interregional coordination or communication and little or no provision of services to the urban areas to which vast numbers of rural residents were migrating.

b. Current Changes in Priorities

With the institution of internal peace and security, the GOZ was able to turn its attention to the problems afflicting the health sector. As early as 1969, the GOZ was aware of the need to re-establish sound administrative procedures and basic planning from which national policies could result. With this in mind, the President established FOMECO--the Medical Coordination Fund.

By 1973, economic improvement seemed on the horizon as world raw materials prices rose rapidly and, consequently, Zaire's main resource in copper became the major money-earner for the nation's economy and its national budget. Together with continuing domestic tranquility, this circumstance allowed President Mobutu Sese Seku to turn his attention to specific development needs.

In November of 1973, President Mobutu identified the health sector as a priority for development planning. This set the stage for a major effort to revitalize the health system. In that same year, a "Ten-Year Plan for National Health Services" was delineated which identified the following objectives:

(1) Reduction in major causes of mortaility and morbidity, with emphasis on mothers and children, who comprise 75% of the population through:

(a) improvement of environmental sanitation including provision of potable water;

(b) relieving malnutrition and overpopulation in highest density areas; and

(c) preventive care against malaria, tuberculosis, measles, sleeping sickness and leprosy.

(2) Creation of a desired births program within the context of a national network of Maternal Child Health Centers.

(3) Reorientation of medical and paramedical training programs to produce manpower able to meet national health needs.

(4) Creation of Health Centers for training and provision of health care in highly populated and high mortality areas supported by satellite centers and small rural units.

More recently, there has been a refinement of the Health Plan with the publication of a more detailed "National Health Plan - 1975-1980" (see Annex). This plan provides more specific direction than found in the earlier document. Included in the five-year health plan is the following:

(1) The framework for the design of a plan to increase the basic health care services through the creation of rural and urban development zones. (This framework will be discussed in more detail in a later section.)

(2) The integration of desired births (Naissance Desirables) services, including related training activities, into all relevant health sectors of Zaire, i.e., MCH services, medical-paramedical training, etc.

(3) The permanent control of endemic diseases through a system of prevention and early case identification and treatment on an ambulatory basis within a patient's own community.

(4) The further development of a dedicated, well-trained corps of Zairian physicians.

(5) The further development of a corps of well-trained paramedical Zairian personnel.

(6) The development of a national system for the routine collection of medical and vital statistics and for the collection and analysis of demographic data.

(7) The development of a national pharmaceutical system.

(8) The development of a national licensing system for all physicians and paramedical personnel and for all health institutions (hospitals, pharmacies, etc.) including medical and paramedical training centers.

(9) The development of a national health and medical planning, research, and evaluation unit.

(10) The production and distribution of health-related audio-visual materials.

The specific objectives of the five-year plan are by 1979 to achieve through community and health development projects in selected rural and urban areas the following:

(1) The reduction in infant mortaility (0-12 months) from a level of more than 150 to less than 50 per 1000 live births.

(2) The reduction of child mortaility from a level of 500 to less than 100 per 1000 (children aged 1-4 years).

(3) The reduction of maternal mortality to a level of less than 5 deaths per 1000 live births.

Despite these policy determinations, management capability and organized support systems remained inadequate. Coordination among health providers, public and private, had been non-existent until the 1974 creation of the National Health Council This council represents the major potential for reorienting Zaire's national health delivery system. One of the Council's major priorities, as expressed in its manifesto, is the development of adequate management policies and practices. Nevertheless, the country's evolving health system still lacks personnel of all types--from managers through rural workers--and adequate planning/organization techniques derived from pragmatic principles and tailored to the country's specific needs and character.

c. Existing General Health Care Resources

The National Health Council, established in November of 1974 by Presidential decree, serves as the national health planning body and is responsible for overseeing the execution of these plans. It is responsible for developing national health care and welfare policies, setting national health priorities and formulating and implementing programs in health care and manpower training. It also is responsible for preparing and supervising the budgets for all public health programs, including health manpower training. The Council has overall administrative control of, and is responsible for assuring coordination of, all national health activities.

The major policy objectives of the Council in providing health services are stated as follows:

(1) Priority of mothers and children in receiving health care services.

(2) Importance of both curative and preventive health services with emphasis on preventive health programs, particularly for mothers and children.

(3) Importance of extending curative and preventive services into communities through the employment of new types of community health works.

(4) Critical importance of proper management practices within the health system.

(5) Importance of the people's participation in improving their own health.

(6) Importance of an integrated global approach to solving health problems, with an emphasis on community development.

The relationship between the National Health Council, the Ministry of Health, and FOMECO is obvious when it is realized that the President en Exercise of the National Health Council is the Minister of Health, that the Executive Vice President of the Council is the Director General of FOMECO, and that the Secretary of the Council is the Director of Presidential Medical Services and also the President of the Board of Governors of FOMECO. This ensures that those responsible for making policy are in senior executive positions to execute that policy through the operating agencies.

FOMECO (Fonds Medical de Coordination) is the largest public health care provider in Kinshasa. While the primary goal is the research and development of an effective nationwide health care delivery system, its major orientation to date has been urban centered. Currently it operates the 1800 bed Mama Yemo Hsopital in Kinshasa and the 101 bed rural hospital at Bolobo, which has an auxiliary nurses' training school. FOMECO also operates two maternal/child health centers, the Institut Medical Tropical laboratory, and a hospital ship.

Other health services are provided by parastatal health organizations, university clinics, certain large industries, the military, missionary groups, and private and voluntary health agencies. There are also indigenous practitioners (Guerisseurs) throughout rural and urban areas.

Significant among the current health care providers are the religious missions (Catholic and Protestant) which have been providing services in many rural areas throughout the country. The missionaries maintain many facilities such as hospitals (95), maternity dispensaries (258), general dispensaries (328), TB sanitoria (2), and leprosaria (10). Missionary health activity has been a significant factor in the provision of services to the rural population of Zaire. It is estimated that about 75% of all care has been through this service mechanism in the rural areas. A major drawback of this system has been the inadequate coordination among the missions themselves, and also between the missions and government sponsored or supported efforts. The first government policy paper put out by the National Health Council had major input from several of the most effective missions. From the administrative point of view, the problem of coordination is no longer present.

d. Manpower Resources

There is a severe shortage of qualified medical, paramedical and health management personnel in Zaire. This fact has affected the planning and implementation of the current MCH/FP project. Although there has been improvement during the past few years, particularly in the number of Zairian health personnel, coverage is still far from adequate and is skewed towards the urban areas.

About two-fifths of all doctors in Zaire are located in Kinshasa. The rural areas have almost no physician-provided health care. As of October 1972, there were approximately 811 physicians serving 22 million people; 334 of these were Zairian, 161 of whom were serving with private or mission groups and 303 were located in Kinshasa. Further, 60% of all doctors are practicing in regional capitals.

At the present time, emphasis in medical education and post-graduate medical training is still heavily oriented to curative medicine. However, this policy is being changed by the Council, which has already sent three physicians to the U.S. for training in public health under the current AID-assisted MCH/FP project. It also created a Department of Community Health at Mama Yemo Hospital which is developing a new public-health orientation to the delivery of urban health care. The Minister of Health, who is a Professor of Public Health as well as Director of the Council, recognizes that a cadre of Zairian doctors and para-professionals should be created with a recognized career structure and training program to prepare them for work in zonal community health programs. The Council also recognizes the imperative need for a new force of managerial, logistics, repair, maintenance, records, and other specialists.

e. Health Manpower Training Needs

The primary need seems to be for a number of different categories of health personnel. Significant numbers of persons must be trained and retrained, and, equally important, they must be stationed in areas where there is greatest need.

Belgian emphasis had been entirely on the training of less skilled health personnel. Since independence there has been an increase in medical training programs in Zaire. However, the emphasis has been on physician training, and there is an urgent need for relevant nurse training. Although there has been some increase in training programs, there has not necessarily been an increase in the quality of training.

These problems are being attacked by the NHC. It is concentrating on an entirely new approach to paramedical education in terms of the time required for education and the curricula. A team,composed of a Ph.D. in Nursing Education (provided and funded by the Rockefeller Foundation), the Senior Nurse in Community Health Nursing in FOMECO, and the Director of Nursing at the University, is working with this problem.

The National Health Council is also addressing itself to revising nursing school training and especially to retraining existing nurses, with the emphasis on community medicine.

The religious missions operate 21 schools for training of health manpower at one level or another. All of the missions' health facilities are staffed by more than 2000 health personnel, including about 80 physicians. Additional training has occurred through TOMECO and its program at the Mama Yemo Hospital. Specific MCH/FP training has occurred with some AID-sponsored assistance.

Moreover, training of system planners and managers is essential to effective assignment and utilization of the above health manpower categories. Equipment technicians, personnel managers, inventory control specialists, statistics/records managers, health economists, and logistics and maintenance experts are only some of the skilled manpower required.

f. Source and Supply of Pharmaceuticals

The NHC recognizes that reliance on the internationa market must be diminished by the local production of bas c pharmaceutical preparations. Today, imports account for 90% of the total market. The remaining 10% of pharmaceutical supplies comes from local production of 50 basic pharmaceutical products which are dependent on the importation of raw materials. The hard currency now being used for the importation of luxury drugs can be better used to support an expanded in-country pharmaceutical industry. Here again, good planning and administration for such a program is a prerequisite.

4. Background Summary

Zaire enters its second decade as a new republic under President Mobutu with high hopes that it can deal with the many health care problems besetting its people. The GOZ wants to translate these aspirations into plans and viable programs. Already a number of important changes are taking place in the nation's health care delivery system. Primary among these is the restructuring of the organizational framework for the government's new health system. The GOZ recognizes that it will require the help of outside expertise to assist it in its efforts to deal with the country's heal h problems. This project is designed to provide the GOZ w th a mechanism for obtaining such expertise in the areas of health management and planning.

B. DETAILED DESCRIPTION

The proposed project is aimed at achieving the GOZ's development goals, outlined above, by assisting their health planners and program managers in adapting modern organizational and management techniques to authentic Zairian health and welfare concepts. This will ensure that the programs meet the standards elaborated by the National Health Council.

This project is directly related to AID's New Initiative Program (AIDTO CIRC A-1136 dated November 20, 1973) and the Congressional Mandate, which provides that missions work with host governments in developing programs to improve the quality of life and the standards of health and well-being of the people.

The project is also designed to link its activities with the efforts of the GOZ, multilateral agencies, other bilateral agencies and with other USAID/Zaire project activities in the health field. For example, the proposed project interlocks with the project on Endemic Disease Control which has been submitted to AID/W. That project will focus on assisting the GOZ's programs aimed at dealing with malaria and other endemic diseases.

Another important link will be to the proposed GOZ/USAID Basic Family Health Project, which is currently being designed (PRP under review in Washington, November/December 1975). This follow-on project will seek to implement an important new initiative of the National Health Council--the provision of integrated family health services through health development zones. The Health Systems Development Project will make available consultant expertise to assist the GOZ in developing detailed plans for the early implementation of the model integrated health program.

The project is also designed to complement the efforts of the World Health Organization (WHO) and other United Nations organizations in their efforts to assist the GOZ in the development of health services throughout the country. It will do so by providing assistance in those areas of health management which may not be available within the UN activity structure for Zaire. For example, the WHO has a large input into the Medical School at the University of Zaire and is providing 19 professors to assist that institution. The AID project would not duplicate any of these services, instead it would concern itself in other areas such as health manpower training of paramedical workers where WHO is not specifically involved.

Mutual coordination, through the National Health Council, with all multilateral and bilateral agencies dealing with health development in Zaire is thus basic to this project. For their part, the IBRD and UNDP have stated that they would be willing to commit resources to Zaire for health in a multi-donor context. The prospect of such additional commitments makes the objectives of this management project that much more important.

1. Program Goal

The project's program goal is to establish an integrated national health delivery system under the aegis of the GOZ's National Health Council (NHC). The establishment of the NHC was itself a first step in this direction, as it provides for the overall coordination and monitoring of the various Zairian organs working in the health field.

The system to be established is an integrated one, in that it will link preventive with curative services in the areas of family health and its MCH/FP components, together with general medical care, endemic disease control and nutrition improvement throughout the country. The degree of goal achievement will be measured by reviewing the change in people's access to health services, the amount of reduction in mortality and morbidity rates, and the level of popular acceptance of the government's desired births program.

It must be clear that this two-year project with its relatively modest inputs will not, in and of itself, lead to the accomplishment of the program goal, but rather only to its advancement as other projects pick up the task and carry it forward.

Certain basic assumptions must be made if the project purpose is ever to achieve the above program goal. A stable political situation and continued GOZ commitment to health services development are critical. In addition, it is assumed that the development of increased management capabilities and improved systems will in fact be focused by top leadership on the actual delivery of health services to the general population, both urban and rural.

2. Project Purpose

The purpose of the project will be to strengthen the GOZ's institutional capacity to deliver health services. This implies that at the end of the project the structure of the National Health Council and its constituent organizations should be such that it will be capable of formulating and delivering improved health services throughout Zaire, and that it will actually be doing so in those Health Zones which, by that time, will have been effectively developed. The NHC should have, therefore, a trained staff working directly on the various aspects of health services delivery which have been delineated as project outputs. Additionally, the NHC should have initiated a program for integrated family health care through the establishment and servicing of those Health Zones to be initially established. These will serve as models for replication under the proposed Basic Family Health Services Project to start with FY 1977 financing. The foundation thus laid will serve the larger program goal as presented above.

For the project's purpose to be achieved it must be assumed that the GOZ will support the specific plans developed by the NHC for improving health management and delivery. The same is true for establishing and developing the infrastructure of the Health Zones, with all their constituent health centers. At the same time, this overall GOZ support will need to be backed up with specific authorization of adequate budgets to implement those plans and systems retained by the NHC. At a deeper level, it is also assumed that project outputs will be such that they will be fully understood by the concerned individuals and communities and that they in turn will support and/or participate in the establishment and operation of the necessary services, whether at the national or at the local or zonal level.

3. Project Outputs

A series of very specific outputs are expected to result from the inputs provided by both AID and the GOZ. The technical assistance and training components when added to the ingredient of overall NHC direction and guidance should produce a minimum of six operational plans for systems improvement: general organization/administration; manpower training and personnel; logistics and maintenance; supply management; vital statistics reporting; and procedures for the delivery of basic family health services through the Zones to be created and developed. Each proposed system improvement should have a specific written plan, which, when approved by the NHC, will be ready for implementation. In

addition, each system improvement should be the responsibility of a specifically designated GOZ health official who will, in fact, initiate the authorized improvements. These will entail the introduction of new management or planning techniques to correct deficiencies or to remedy problem areas.

One of the improtant outputs listed above will be the refinement of existing NHC plans for the integrated basic family health program. This effort is a high priority for the GOZ and the NHC. USAID/Zaire strongly supports this approach as evidenced by the efforts now under way to develop a future project in that area. To ensure that the integrated family health services project gets under way as soon as possible, detailed plans for the implementation of this new initiative will be required. This is one area where the services of short-term consultants will be used at an early date. The consultant reports (i.e., output of this project will have an important bearing on how the proposed Basic Family Health Project will ultimately be structured.

Indeed,it is anticipated that the Health Systems Development Project could be the vehicle for the early implementation of the integrated family health program in two model areas--one urban and one rural. This would, of course, depend on how quickly consultants could be brought to Zaire to work with GOZ planners. Their work should result in NHC plans which are simple and pragmatic, and as such can easily lead to the implementation of a model integrated health program in the Health Zones. Commodities would then be made available through this project to help initiate the model program, and test its replicability. Additional consultants could subsequently be called in to help the GOZ organize and initiate the project and evaluate its operations. Participant training, also available through this project, could be used to give working experience to professionals who would be involved in the model program. In this way, the integrated family health program could be started at an earlier date than had been previously contemplated.

The above example demonstrates how the general and specific inputs and outputs of this project will interrelate. In addition, it shows that USAID/Zaire's health projects are closely linked in a way that insures:

- maximum GOZ and AID flexibility in the use and provision of assistance

- maximum coordination of total AID health inputs

- minimum duplication of efforts

For the project outputs to be achieved, it will be necessary for the GOZ to support the NHC in its plan to proceed with health infrastructure development and management improvements. The NHC would itself provide the expected leadership and direction for the effective use of technical expertise afforded it, with a view to developing an improved health delivery system for Zaire. At this point the counterpart relationship becomes critical. The NHC will decide which operational plan can best benefit from ad hoc technical assistance on a short-term basis and which ones will require longer working relationship and on-the-job training of pertinent staff. The provision of additional long-term management expertise may be requested of the donor communi y generally. Conjointly, it is assumed that the NHC will assign qualified Zairians to approved staff positions. Such officials will have received special or on-the-job training for their new functions. A further assumption of the project is that inputs and resources generally be focused on national health systems planning and on making the initial Health Zones a success. The question of resource dissipation vs. overconcentration is one which top management will face as it confronts the challenge and problems of creating model health zones whose replication will in fact be feasible. As such, this project will help develop the guidelines for the proposed Basic Family Health Project.

4. Project Inputs

a. AID

Technician Services

Up to 48 man-months of short-term consultation will be made available to the GOZ under this two-year project. These experts will be drawn from public and private institutions and organizations throughout the United States and other countries. They will be invited to Zaire at the request of the GOZ to perform specific short-term assignments provided that the consultants' expertise falls within the purview of this project. The consultants' work could involve any sector of the GOZ health care system. An indicative listing of categories and duration is given in the Budget Tables.

To assist the GOZ in the administrative management of the project, a full-time Project Manager will be made available under the project. His/her responsibilities will include:

- Assisting the GOZ to identify appropriate areas where consultant assistance might be useful.

- Assisting the GOZ to identify qualified experts to perform the consultant assignments.

- Expediting the necessary documentation, consultant agreements and travel arrangements to obtain the experts' services.

- Providing secretarial and other support services to the consultants during their stay in Zaire.

- Coordinating the specific inputs into an overall NHC program for management systems improvement.

- Evaluating the results of the consultants' work with the GOZ in order to insure that the needs of the GOZ and the purposes of the project are being fulfilled.

The Project Manager himself should be a health care professional, most likely in the field of health administration. In this way, additional expertise would be made available through the project at no real increase in cost. The AID-financed Project Manager would be assiged to the NHC for the two-year life of the project,thus providing the requisite continuity necessary to achieve project outputs.

The Nature and Function of Project Training Inputs

One of the critical needs in the development of any national public health program is functional, action-oriented training. This is especially true for a project to improve the overall management and delivery of health services. This said, there are two pitfalls to a program of participant training undertaken out of country:

(1) That the training will be too academic in nature and little focused on the pragmatic needs of Zaire.

(2) That participants having been trained and titled abroad will tend not to return to the specific jobs for which they are most needed.

The training program to be established under this project will attempt to forestall such a negative outcome by the following means:

(1) With regard specifically to long-term training, no one participant will be sent for more than one year.

(2) His or her training will not be degree oriented, but rather specially designed at AID's and the GOZ's request, with the emphasis on the planning and implementation of public health programs. Fields of training will be in line with the kinds of consultant expertise provided, such as statistics and records, systems analysis, budgeting, supply management, and logistics.

(3) All sources for the implementation of such functional training will be investigated, whether in the U.S. or in some suitable French-speaking country.

(4) In addition, a special emphasis will be placed on short-term courses for operational personnel. Some of the monies programmed for short-term training may in fact prove best spent on the establishment of in-country workshops, drawing on expatriate and/or in-country training expertise.

(5) Candidates for training will come directly from the GOZ Health Services (either of career standing or of new recruitment) and will return to specific functional slots for which budgets and facilities will have been provided.

The specific training program proposed under this project is laid out in the Financial Plan section. Over the two-year life of this project it provides a total of one year of training for each of 24 participants, and 15 man-months of short-term training.

Commodity Support

The commodity element of this project will be grant funded: $35,000 for FY 1976 and $200,000 for FY 1977. Commodities will include drugs, medical supplies, clinical equipment, audio-visual materials and possibly some support vehicles. These commodities will be used primarily for the

development of the initial Zones to be established under the NHC program. As such, they will provide the substantive inputs for testing the new management systems with regard to supply and resupply, stock, logistics and maintenance management. This new system will need to function both between the NHC and the new Zones, and among the units of each Zone. At the same time, commodity funding will also be available for resolving ad hoc problems and bottlenecks that might be uncovered by project consultants and the NHC during their work on specific plans for improved management systems.

This project is Phase I (the design and test stage) of a three-phased health development program. As such, it is expected that the commodity element will be expanded in Phase II, under the Basic Family Health Services project.

Communications aspect of technical assistance

An integral part of delivering health care services is the communication aspect. A significant part of the Health Systems Development project, therefore, will deal with this aspect, and provision will be made for the availability of consultants in this area.

The GOZ has stated that the main goal of radio, for example, is to provide international and national news, to entertain and to educate. Likewise, the main purpose of the television network is to educate the population.

Publication or broadcast of information concerning health care services will, naturally, be channeled through the Ministry of Health or National Health Council. It will be responsible for planning, preparation and evaluation of health communication materials in the major languages of Zaire.

The national media, whether in the form of print or boradcast, will be utilized to advertise, instruct and promote various aspects of health care services. Communication outlets which will be utilized will include:

(1) Use of billboards, posters and/or pamphlets to be placed in health facilities.

(2) Use of the national Zaire radio and television stations to broadcast public announcements.

(3) Use of newspapers to run advertisements.

(4) Use of the other common articles, such as calendar backings, to publicize governmental health efforts.

Emphasis will be on visual techniques and simplicity of the message. Printed articles will be designed so that the individual may understand, without an educational instructor present. Broadcast will be kept simple in language and brief in content.

b. GOZ

The inputs provided by the National Health Council will in the first instance support the work of the project consultants. These will entail both administrative support and the costs of Zairian counterparts as they are added by the NHC to the staff of the new management structure. As such, it is expected that the GOZ budgetary input will rise appreciably in CY 1977.

In a second stage, also heavily weighed towards 1977, GOZ funding inputs will entail the administrative, operating and supply costs required for the proper functioning of the initial Zones to be established and developed in execution of NHC plans. For purposes of budgetary tabulation, it is assumed that this first phase project for the new health zone program will cover a minimum of two zones, one urban and one rural, at an average annual cost to the GOZ of some $100,000 per zone.

The GOZ administrative inputs will also cover the costs of international travel for participants.

PART III: PROJECT ANALYSES

A. TECHNICAL ANALYSIS AND ENVIRONMENTAL ASSESSMENT

1. Technical Analysis

The management/organizational techniques to be used to develop the health systems of Zaire are derived from modern methods of health organization. Yet, they will draw on key aspects of Zairian health problems and capabilities to insure that the system developed is tailored to local needs and, therefore, implementable.

GOZ health planners and administrators are heavily involved in restructuring the health system of their country They recognize the need for technical assistance to strength n the planning and management aspects of that system. Thus, i is quite appropriate that health management systems and plan ning expertise be made available to Zaire at this time. As currently envisioned, the cost of the proposed program is well within the normal range for similar projects.

Regarding the technical assistance component of this project, AID experience in providing centrally funded, short term consultants has been very successful in the health fiel l. There is every reason to believe that a formalization of the process through this project will prove beneficial to the GO . It will also make such consultation and technical assistance easier to manage for both AID and the GOZ. The project will make AID more responsive to expected future GOZ requests, which is extremely important in this preliminary stage of health development.

Similarly, AID has extensive experience in developing an implementing integrated health delivery systems. During the past decade, AID has supported several projects which sought to improve the delivery of health care and family planning services in developing countries. Such projects in Asia, Latin America and Africa have amply demonstrated the feasibility of including health care projects in a total program of AID support to LDC development efforts. Notable examples of AID-assisted health projects are Narangwol (India), Danfa (Ghana) and the Child Health Clinic in Lagos (Nigeria).

2. Environmental Assessment

The ecological impact of the project should be minimal, as the management system does not impact directly on the environment. To the extent that the management system leads to effective health programs, it will indirectly affect the environment through increased labor and productivity.

In terms of the ecological impact of the total project, the potential for negative environmental impact is possible, since successful health programs increase demands for space and services as well as increase productivity on rural land and, therefore, the intensiveness of cultivation. With highly leachable soil, Zaire could face erosion problems as a primary effect of intensive cultivation. However, the GOZ is extremely sensitive to the ecology, not only as a national asset, but also as a factor in the health of its people. A proper soils policy and increased agricultural education can be expected to offset these downstream negative impacts. GO awareness of the need for such policies was amply evident at a recent conference on ecology in Zaire.

Potable water and an effective sewage system are critica needs, and these problems are being addressed by the government with expert help from the World Bank and other multinational organizations. Environmental sanitation improvement is one of the important features of the Rural and Urban Development Zones. This proposed project could make expertise in environmental sanitation available to the GOZ.

3. Summary

The overall technical design of this project is reasonable. It utilizes a simple and straightforward approach to providing coordinated short-term technical assistance in a most expeditious way. This permits the GOZ to have great flexibility in choosing the consultant assistance it requires, and allows AID to be responsive in a timely manner.

In conclusion, USAID/Zaire believes that this project is technically feasible, is reasonably priced, and is appropriately designed. It will help USAID/Zaire demonstrate in a most efficient way that it is committed to supporting and advancing the GOZ's priorities in health care.

B. FINANCIAL ANALYSIS AND PLAN

1. Financial Rate of Return/Viability

The proposed grant-financed project is non-revenue producing. While its social and health benefits cannot be quantitatively stated in monetary terms, it is possible to assess the proposed budget.

A grant totaling $675,000 is proposed for the project and extends for a period of two years AID's role consists of grant funding for commodities, training programs, short-term consultants and one long-term technical advisor. Detailed breakdowns of the AID budget are contained in the "Financial Plan" section of this Project Paper.

When the USAID role in developing health management systems is completed, the GOZ will be responsible for maintaining and implementing the outputs of this program. Project costs to be absorbed by the GOZ include, but are not limited to:

- Continuing training in administration, management and delivery.

- Commodity support for health management, education, transport and media programs.

- Salaries of Zairian counterparts and of any retained specialists.

- Operating and resupply expenses for the initial Health Zones to be established.

The GOZ will be able to finance those components of the ongoing costs which require domestic currency. While imported commodities and expertise are not anticipated to be inordinate after 1978, even a modicum of foreign exchange demand may present a problem for Zaire, whose foreign exchange position has deteriorated in the past three years. Analysis of the GOZ's ability to assume import costs is contained in the "Economic Analysis" section of this Project Paper.

One consideration affecting financial viability of the project is the ability of the GOZ to manage the funds involved in project financing, both currently and at the termination of USAID involvement. Some training funds in the project itself will be used to increase the management capacity of the GOZ to deal with this problem.

2. Recurrent Budget Analysis

Implementing agencies will, for the two-year duration of their commitment, bear annual recurrent costs for their inputs. These costs will include:

- Commodities needed for systems development in various areas (e.g., data, records, education, family health).

- Salaries for short- and long-term consultants.

- Training programs for Zairian managers, administration and health specialists.

All of the above categories are annually recurring costs. However, the nature of the substance of the categories may vary from year to year. For instance, the types of short-term consultants needed in one year may differ from those needed in other years, yet the total costs of consultants are an expense. Of particular interest are those costs which must be absorbed on a regular basis by the GOZ at the termination of the project. These costs will include:

- Training programs for all types of health planners and administrators

- Family health and MCH/FP planning

- Health education and education materials

- Multi-media materials for information programs

- Transport system

- Facility design and construction expertise

Fortunately, the major part of these costs can be met with domestic currency. The GOZ, therefore, can maximize its available resources and minimize any recurrent drain from this project on its hard currency position.

The whole question of recurring costs for the effective operation and resupply of centers in the various Health Zones to be established will be dealt with under this project as part of the planning for such a family health delivery system. Of critical concern will be the modeling of the initial Zones structure in such a way that it can in fact be replicated throughout the country over time, given current and expected GOZ budgetary and personnel resources.

Totals and yearly breakdowns for the GOZ financial role are detailed in the "Financial Plan" section of this Project Paper.

3. Financial Plan/Budget Tables

The breakdown of the Health Systems Development Project budget includes detailed presentation of the financial roles of AID and the GOZ.

TABLE I

SUMMARY COST ESTIMATE AND FINANCIAL PLAN

(US $ 000)

Source	AID		HOST COUNTRY		OTHER(s)+		TOTAL
	FX	IC	FX	IC	FX	IC	
Technicians	325	-	-	-	-	-	325
Counterparts	-	-	-	175	-	-	175
Training	70	-	-	-	-	-	70
Commodities	235	-	-	-	-	-	235
Administrative Costs	-	-	-	20	-	-	20
Operating Costs (2 zones)	-	-	-	245	-	-	245
Inflation factor	45	-	-	-	-	-	45
Total	675			440			1115

TABLE II

AID Inputs
($000)

	FY 1976		FY 1977		Total	
	$	(mm)	$	(mm)	$	(mm)
A. Technicians	95	(19)	230	(46)	325	(65)
Long-Term						
Health Administrator/Project Manager	30	(6)	90	(18)	120	(24)
Short-Term						
(See Table III)	65	(13)	140	(28)	205	(41)
B. Training	20	(18)	50	(45)	70	(63)
Long-Term						
Public Health Planning & Administration	13	(12)	40	(36)	53	(48)
Short-Term	7	(6)	10	(9)	17	(15)
C. Commodities	35	-	200	-	235	-
D. Inflation	-		45		45	
Total	150		525		675	

The major components of the AID budget can be further detailed.

The Project Manager is both an administration/management specialist and administrator of the project. Under the direction of the NHC, his/her role is both as a GOZ planner/advisor and as a project manager for liaison between the GOZ and USAID. FY 1976 technician costs are less than subsequent years since the period involves only six months.

The short-term consultant skills needed are varied and will differ as the project progresses. An estimate of types, lengths of consultation and cost is contained in Table III:

TABLE III

Short-Term Consultants
($ 000)

Type	FY 1976		FY 1977		Total	
	(mm)	$	(mm)	$	(mm)	$
Health Planning	(2)	10	(2)	10	(4)	20
Statistics/Med. Records	(2)	10	-	-	(2)	20
Systems Analysis	(2)	10	(2)	10	(4)	20
Family Health	-	-	(5)	25	(5)	25
Endemic Diseases	(2)	10	(1)	5	(3)	15
Health Education	(1)	5	(1)	5	(4)	20
Economics & Budgeting	(2)	10	(4)	20	(6)	30
MCH/FP	-	-	(4)	20	(4)	20
Transport/ Maintenance	(2)	10	(3)	15	(5)	25
Multimedia/ Communications	-	-	(2)	10	(2)	10
Facility Design/ Construction	-	-	(2)	10	(2)	10
Total	(13)	65	(28)	140	(41)	205

If any one consultant, of course, fulfills more than one speciality, the time for which he/she would be available would be a combination of the man-months of the categories which he/she fulfills. The initial management systems development plan established by the NHC in collaboration with the Project Manager may provide for modification of the above schedule of short-term inputs.

The GOZ contribution will include funding of counterparts for consultants, office and supply support, and the initial operating budgets of a minimum of two Zones. The breakdown by calendar year is as follows:

TABLE IV

GOZ Inputs
($ 000)

	CY 1976	CY 1977	Total
Counterparts	55	120	175
Administrative Costs	10	10	20
Operating Costs (two Zones)	50	195	245
Total	115	325	440

Other donors can be expected to coordinate and cooperate with AID and the NHC in this management systems effort. Their specific financial role in this regard will be quantified during the initial phase of the project.

4. Summary Opinion

Proposed AID funding is a majority portion of the resources needed to develop a more efficient and effective health management system in Zaire.

As a percent of the total budget, the GOZ's contributions represent a participation level of 39%. For FY 1976 this commitment to the implementation of the project, especially for the Health Zones, will form part of the project agreement. For FY 1977, it represents a current estimate which will be refined through the assistance provided under this project.

That AID is, overall, the larger contributor to the project is advisable and justifiable due to its nature, i.e., training and planning for improved management systems. AID's experience in Africa qualifies the Agency for this major role in assisting the GOZ to strengthen its planning and management capabilities. Moreover, such an effort lends support to the development of an efficient and effective Basic Family Health and an Integrated Health Zones program, both of which are priority goals of the GOZ.

TABLE V

Costing of Project Outputs/Inputs
($ 000)

Project Inputs	Management Plans	Trained Staff	Model Health Zones Developed	Total
AID Appropriated				
Technicians	175	50	100	325
Training	-	50	20	70
Commodities	35	-	200	235
Inflation	10	5	30	45
Host Country				
Counterparts*	75	25	75	175
Administrative Costs	10	5	5	20
Operating Costs	-	-	245	245
TOTAL	305	135	675	1,115

*It is estimated that the time, and therefore the cost, to the GOZ of counterparts will be divided as shown.

C. SOCIAL ANALYSIS

1. Socio-cultural Feasibility

Improved health care for the people of Zaire is a recognized national priority which is strongly supported by President Mobutu. The President's "desired births" speech emphasized the need for improved health care in all areas of health. It can thus be expected that modern health techniques will be more widely accepted and more easily integrated into the Zairian life style as time goes on.

The Health Systems Development project will, of course, require local community support. This support has been and will continue to be forthcoming, as the people of Zaire recognize the governmental concern for improved health care in the country. Because this project will be geared towards expressed community needs, there is every reason to believe that participation in and acceptance of innovative health services will continue to grow. Since the Health Systems Development project will be administered through the National Health Council, the endorsement of the government toward health efforts will be apparent to community leaders.

This project will supply short-term consultants and will provide a training capability in health management. The program will be geared toward the eventual replacement of consultants with properly trained local Zairians, which is in keeping with the GOZ concern for national identity and authenticity.

2. Spread Effect

The Health Systems Development project is organizationally structured so that it will improve the effectiveness of health care service planning and delivery in both urban and rural areas. The critical factor in this respect will be the establishment of operational plans for the Health Development Zones. As these Zones are established and made operational, they will in fact augment the delivery of integrated services to the poor majority. This current project will establish the indispensable systems and working models for such replication throughout the country. By infusing practical concepts into the management of its health systems, the NHC will be able to provide the type of health care services which are most suitable to the country's needs.

The project's ability to expand successful urban efforts into the rural areas is, of course, dependent on other variables inherent in the scope of the program. Provision of equipment, in particular vehicles, will assure that a network of services may eventually extend out of the city and into the villages. Another part of the project will be the communications phase. Whether by word of mouth or by coordinated media efforts, the message of health care, which originates in the urban areas, will gradually filter out into the rural districts.

3. Social Consequences and Benefit Incidence

The need for improved planning and administration in the field of health care is felt by all Zairians. The National Health Council, with the help of the Health Systems Development project, will provide an efficient and economical system of health care services to the poorer socio-economic sections of the country. Through modern management planning and operational practices, it is felt that these efforts will meet the Council's established priorities in the health field.

The benefits which the people of Zaire will derive from a strong health management program are enormous. Foremost, families will be able to enjoy a greater hope for an increased standard of health. This is, of course, one of the essential factors underlying program efforts for any developing country.

Equally important, however, will be the eventual participation of the local community in better managed health care activities. As more people are reached by the improved health system, the people will have increased pride and confidence in their own efforts, as well as their government's activities in this area.

The participation of women in the health systems development will be an important element of this project. Only a small percentage of women, as compared to men, ctually leave the home and enter the formal labor force. Their main responsibilities traditionally have been childbearing, child rearing, and management of household affairs. The contribution which women can make in the health field, inside and outside the home, is being encouraged, for the role of women is critical for the family's well-being. The emerging expanded role of women in this area has been recognized by President Mobutu. His recent appointment of Mrs. Mobutu to head the Committee of Social Works (Les Oeuvres du Mama Mobutu) is evidence of this support.

The Health Systems Development project will place emphasis on the further inclusion of women in health care activities. Qualified women will be sought out for placement and job training to meet the staffing requirements set by the NHC's management plans.

In the area of maternal and child health and family planning, the role of the Zairian woman in educating fellow countrywomen in proper health care is substantial. Means will be investigated under this project to formalize and expand this role.

Training and educating women in health care also increases the importance of the female role in maintaining the well-being of her family. The Zairian woman is, indeed, in a unique position to improve her own family's welfare and, at the same time, provide vital assistance to community efforts in the health care field. In this way, the accepted traditional role of the woman in the Zairian culture will be complemented by a greater sense of participation in and contribution to the entire area of health care. This project will foster careful planning for the full use of women's resourses in this sense.

D. ECONOMIC ANALYSIS

In terms of cost-benefit or cost-effectiveness analysis, direct costs of the project to AID are $675,000. The GOZ's budgetary input will be approximately $440,000.

The economic effect of both the GOZ's direct expenditures and USAID's budget must be analyzed on three counts:

1. Project benefits to the economy as compared to project costs.
2. Project effects on income and employment.
3. Project demands on GOZ scarce resources.

1. Project Benefits

Recognizing the non-revenue producing nature of the project and the lack of adequate economic data in Zaire, it is impossible to calculate a quantitative cost-benefit analysis of the project's economic effects, especially as the project is only preparatory to actual delivery of services. With regard only to this one limited project, and not to its critical purpose of laying the groundwork for an improved and integrated national health delivery system, the project's outputs have only limited direct benefits. These benefits will nevertheless be meaningful in that the training to be provided, both in country and abroad, will produce a definite return to the economy. Likewise, the commodities to be provided will directly improve the health status of those who will directly benefit from them during the pilot and start-up phase of delivery through the Health Zones.

Turning, however, to the project's cumulative and multiplier effects, the benefits to be gathered will eventually be very substantial. It is in these terms that project costs, both to the GOZ and AID, find their true justification.

Prior to independence, public health expenditures represented some 10% of the national budget. In contrast, GOZ health expenditures since 1970 have been considerably lower in absolute amount, but an increasing percentage of the total. In 1973, PH expenditures, through the Ministry of Health and FOMECO, totaled some $20 million (not including National Medical School and parastatel organizations). This figure of $20 million provides a very direct indicator of the importance of this project. If the management and allocation of such sums can even in part be improved and integrated into a total program of basic family health, the return on the limited AID investment of $675,000 contained in this project will be truly appreciable. In addition, such an improved system and absorptive capacity will better attract multi-million dollar aid programs from the IBRD and other donors.

In terms of the monetary and revenue producing sectors of the economy, the project makes little direct demand on resources, yet provides the potential for large benefits, since well-managed health programs and subsequent improvements in health status will increase productivity.

Regarding the non-monetary section of the economy, the demands and effect are much the same as in the monetary sector. Efficient health delivery will increase output through healthier farmers and workers.

Socially, the project benefits all groups in society which come in contact with GOZ health programs. A more detailed discussion of those benefits is presented in the "Social Analysis" section of this Project Paper.

A most important benefit is derived from the project's expected improvement in the efficiency and effectiveness of budget management and administration. The National Health Council recognizes the importance of substantially strengthening its capacity to use effectively additional funding for health. The training and management systems introduced by this project will provide the basis for the improvement of Zairian health delivery management and administration capability.

Thus, the potential benefits from project implementation are great.

2. Income/Employment

Similarly, income and employment would benefit from an effectively managed health program.

Assuming that current levels of production in Zaire are capable of absorbing increases in productivity, any program which increases the quality of the people in the labor force will result in higher production levels as the employees become capable of producing greater output. Such an increase in production will lead to a higher National Income.

An effectively managed health program would lead to greater delivery of preventive and curative services to the population. Assuming that a portion of these services reach the actual or potential labor force, effective health management would reduce their morbidity. This would increase productivity among the employed, leading to increased production and income.

Thus, effectively managed health programs would lead to three economic benefits: increased productivity levels, increased production, and increased National Income.

3. Scarce Resources

A major consideration in assuming the desirability of any project is the demand it makes on Zaire's scarce resources. Previous analyses in this Project Paper have indicated that domestic currency costs of the proposed project can be absorbed by Zaire. A major consideration, however, is recurrent foreign currency demand after outside donors terminate their project involvement, and responsibility for project programs rests with the GOZ.

Such a demand must take into account Zaire's ability to assume any foreign exchange commitment. According to IMF statistics, Zaire's position in all types of foreign exchange and reserves has deteriorated immensely in the last two years, particularly since the drop in copper prices. The table on the following page indicates the current foreign exchange position.*

Fortunately, the demands of this one project on those constrained resources are minimal. After the GOZ assumes full responsibility for project continuity, a small amount of commodity import and a small number of outside short-term technical advisors will be the only inputs not financed with domestic currency. Thus, the economic impact of the project will not overly strain the GOZ's limited international economic resources.

In summary, then, the economic impact of the project is positive on all counts with minimal demand on scarce resources Moreover, the GOZ should have little financial or economic difficulty in assuming full responsibility for the project after USAID involvement is terminated.

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*Exchange rates are fixed by the Central Bank at .5 Zaires per dollar.

International Liquidity	1973				1974				1975							
	I	II	III	IV	I	II	III	IV	Ja	Feb.	Mar.	Apr.	May	Je	July	Ag.
International Reserves	167.76	148.81	179.23	234.60	194.88	280.68	185.58	140.18	105.51	94.32	105.73	90.50	75.04	47.81	32.76	--
Gold	61.60	61.73	61.80	61.83	61.83	61.83	60.85	21.41	21.66	22.04	11.33	11.28	11.33	11.23	10.82	-
SDR's	8.88	8.30	8.30	8.30	8.80	7.71	7.59	7.82	7.92	8.05	7.97	6.12	5.84	11.63*	11.20	11.16
Reserve Position in Fund	34.08	34.08	34.08	34.08	34.08	34.08	33.54	34.59	35.00	35.61	35.24	--	--	--	--	-
Foreign Exchange	63.20	44.70	75.05	130.39	190.67	177.06	83.60	76.36	40.93	29.12	49.19	73.10	57.87	24.95	10.7	-

*reflects the special oil facility creation.

PART IV. IMPLEMENTATION ARRANGEMENTS

A. ANALYSIS OF THE RECIPIENT'S AND AID'S ADMINISTRATIVE ARRANGEMENTS

1. Recipient

The major agency and focal point of the project within the GOZ is the National Council of Health and Well-Being (NHC). The NCH has a mandate, by Presidential decree, to be responsible for the development of national policy on health care, welfare and training of medical and paramedical personnel. The NHC is also responsible:

- for the preparation of proposed budgets for public health and medical education, and
- for insuring that these budgets are used rationally.

The Council, nominally headed by President Mobutu, is comprised of:

- the Commissioner of State for Health
- the Director of FOMECO
- the Director of Presidential Medical Services
- the Commissioner of State for Education
- the Dean of the Medical Faculty of the University of Zaire

In practice, the Commissioner of State for Health, Dr. Ngwete, has presided over the Council's meetings and activities.

The Council's scope of organizational responsibility at the present time includes:

- the Ministry of Health
- the Medical School of the University of Zaire
- paramedical training institutions
- FOMECO (Fonds Medical de Cooperation)

The functions of the Council are to plan health policy for Zaire and to supervise and coordinate its implentation.

Overall supervision of the project will be through the GOZ's appointed Project Director. This person will be named from among the three senior members of the National Health Council so as to insure that the consultant needs of that organization receive priority attention.

The AID-financed Project Manager will report on a regular basis to the GOZ's Project Director. He will be responsible for keeping the Project Director informed about the status of the project, the consultants' activities and the amount of consultant man-months used/ remaining in the project.

The GOZ's ability to utilize effectively the technical assistance, participant training and commodity support available through this project will greatly depend on the GOZ Project Director. While USAID will retain certain administrative responsibilities for the project, the GOZ will have day-to-day management authority. This will insure that the NHC has the flexibility to obtain the ad hoc technical expertise that it requires on short notice and with a minimum of paperwork.

2. AID

AID's role in this project will be to provide overall administrative supervision. As the funding agency, AID will insure that the project staff is carrying out its mandate and that it is responsive to the day-to-day direction from the NHC's Project Director. The Office of Public Health, USAID/Zaire will be the focal point in the Mission for this project. The GOZ and the USAID office will receive the appropriate quarterly and annual reports from the project. In addition, the Chief Public Health Officer will be in constant touch with the NHC's Project Director to determine that the project is operating smoothly. Since the USAID's Public Health Office will have a professional staff of three, it is not envisioned that any additional AID staff will be required for this project monitoring role.

This project has been designed so that it will closely interrelate with USAID/Zaire's other health projects. As was noted in the Technical Analysis section of this PP (Part III.A.), this project will assist in the early planning stages for the integrated

Basic Family Health Project and could potentially provide additional short-term manpower resources for the Endemic Disease Control Project.

In addition, this project will complement the WHO and IBRD health efforts in Zaire.

Normal AID disbursement procedures will be employed for project commodities and participants. Disbursements for technical services under host-country contract will be made upon submission of signed vouchers. It is possible that one contract may be the most expeditious way of providing the technical services. Voucher procedures will be used for in-country training, except that an advance of funds may be made as warranted.

B. IMPLEMENTATION PLAN

1. Project Approval and AID/GOZ Commitment (FY 1976)

Submission of PP to AID/W	December 1975
Approval of PP	January 1975
Preparation of Project Agreement (final)	February 1976
Signing of ProAg ($150,000)	February 1976
Selection and approval of contractor to manage project	March 1976
Signature of host-country contract	April 1976
Initiation of Project	May 1976

2. Technical Consultant Services

Arrival of contract Project Manager in Zaire	May 1976
Delineation of work plan for GOZ use of consultants	June 1976
Development of further baseline data for eventual evaluation of Goal and Purpose of project	May - September 1976
First ST consultants arrive (13 mm)	July-December 1976
Submission of plans for new health administration, organization and procedures; personnel, logistics and supply management systems; and vital statistics reporting, among others	October 1976 - March 1977
Consultant management plans reviewed, modified and approved by NHC	January - May 1977
Development of plan for delivery of basic family health services through Health Zones	September - December 1976
Specific Health Zone Plan adopted by NHC	December 1976
Staff selected/designated for existing and new positions as identified in management plans	January - May 1977
All approved positions under NHC and in initial Zones are filled	June 1977

Contract consultants (same or new ones) work with NHC staff as counterparts (average of 3 months for each functional category)	January - December 1977
NHC requests additional LT and/or ST technicians as deemed necessary for 1978-1980 under Phase II Basic Family Health Services Project	Continuing
NHC continues to draw on ST consultants to help clear remaining bottlenecks in new management system	January - May 1978

3. Training

Project Manager delineates participant training program with USAID and NHC	May - June 1976
First special training programs are ordered to start in fall of 1976	June - July 1976
FY 1976 funded LT and ST participants selected from NHC staff	July 1976
One LT participant departs for training of up to 12 months (max).	October 1976
FY 1977 funded LT and ST participants selected from NHC staff	November - December 1976
Short-term training program established in Zaire, USA, or third country (2-3 months; 2-3 participants)	January 1977
FY 1976 funded participants return to NHC and are effectively reintegrated into health management and delivery system - ST April, LT September	September 1977
Three LT participants depart for training of up to 12 months each (max)	March 1977
Additional ST training courses established	April-June 1977
Final participants return to Zaire. They work as counterparts with last consultants	February 1978 February-May 197

4. Commodities

First commodities to include basic equipment, medical supplies, health delivery vehicles, are ordered from FY '76 funding ($35,000) thus establishing pipeline	March 1976
First commodities arrive in Zaire	Sept.-Dec. 1976
Management plans provide detailed commodity requirements for resolution of ad hoc supply problems and for preliminary equipping of centers in intial two zones	October 1976
First tranche of FY 1977 commodities are ordered	November 1976
Arrival in Zaire of this commodity order	April 1977
Second and final tranche of project commodities is established and ordered	July 1977
Final commodities arrive in Zaire and are effectively in use in initial Zones	January - May 1978

5. Follow-through Commitments and Evaluation

Contractor submits quarterly reports to USAID and NHC - 1st report	September 1976
GOZ/NHC establish budget or budget supplements for improved health delivery in CY 1977	Second Half 1976
Start of FY 1977 - new project agreement negotiated for continuation of technician services and participant training, partial commitment on commodities to maintain suitable pipeline flow	October 1976
USAID PUblic Health Officer discusses reports with contractor and NHC	Beginning September 1976
Preliminary conclusions result in affirmation/ changes in work plan	Continuing
First Project Appraisal Report (PAR) prepared in conjunction with NHC and contractor	May 1977
PAR submitted to AID/W	June 1977

GOZ/NHC establish health budget for CY 1978	June 1977
Negotiation and signature of ProAg amendment adding remainder of FY 1977 funds programmed for commodities	June 1977 (3rd Quarter)
Special Evaluation of progress with AID/W assistance	December 19'7
Second PAR prepared and submitted	April 1978
AID-financed Project Manager completes assignment and departs Zaire; Phase II Project for Basic Family Health Zones already in full swing	May 1978
Third PAR reviewing accomplishments of Phase I six months after termination (end of FY 1978)	September 1978

C. EVALUATION PLAN

The new USAID Chief Public Health Officer arrived on assignment in Kinshasa at the beginning of December 1975. It is obvious that he, in conjunction with the USAID and NHC generally, will make required changes in the PP's Evaluation Plan either with regard to scheduling or to ad hoc assessments of project bottlenecks as they may reveal themselves.

The scheduling of this preliminary Evaluation Plan is set out in the Implementation Plan which precedes this section. It calls for two regular Project Appraisal Reports during the implementation span of the project, plus a final PAR six months after the last technician has finished his assignment, the last participants have returned to positions under the NHC, and the final commodities have arrived in the country and been put into effective use. These PAR's are scheduled for May 1977 and April 1978, respectively.

In addition, it is proposed that one Special Evaluation be undertaken during the life of this project, drawing on AID/W or PSC consultants. These evaluators will work closely with the USAID, NHC, and AID-financed Project Manager, under the guidance of the USAID Chief Public Health Officer. The Special Evaluation is scheduled for December 1977.

This project is basically a pre-pilot Phase I effort, which is part of a larger multi-year program for improved management and delivery of basic family health services through the Health Zones. Project evaluations and appraisals will thus provide the critical feedback necessary for modification of the Phase II project, Basic Family Health Services, as and if new findings and conclusions result.

The basic concepts of evaluation are critical not only for project improvement, but also for the training of host government counterparts in management, the very raison d'etre of this project. As such, it is planned to institute a short seminar in project/program evaluation for select GOZ counterpart staff.

Finally, it should be noted that the periodic evaluations of contractor performance, both by USAID and the NHC, will supplement the findings of the project appraisals and more clearly focus attention on courses of action required of all parties.

D. CONDITIONS, COVENANTS AND NEGOTIATING STATUS

It is expected that the GOZ and its National Health Council will establish adequate budgets and staffing patterns for CY 1977, CY 1978 and beyond in support of this project as defined in the financial/budget tables. Greater precision will be made on this point in the corresponding Project Agreement.

Since the new USAID Chief Public Health Officer arrived on assignment during the finalization of this Project Paper, it is considered fitting that he should have an opportunity to prepare his own draft version of the Project Description for inclusion in the proposed Project Agreement. For this reason the cor. sponding Annex is reserved.

The GOZ, through the intermediary of theNHC, has officially requested and approved this Health Systems Development Project, by letter from the GOZ Minister of Health, dated December 5, 1975 (Annexed).

ANNEX B

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: From FY 76 to FY 77
Total U. S. Funding $675,000
Date Prepared: Dec. 1975

Project Title & Number: HEALTH SYSTEMS DEVELOPMENT

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: Establishment of an integrated national health delivery system.	Measures of Goal Achievement: 1. Increased access by Zairians through Zaire to health services. 2. Reduction in mortality and morbidity rates. 3. Desired Births program being implemented (This project will prepare basis for a family health services program, which in turn, will advance this goal).	1. Review of number of people receiving health services. 2. Evaluation of statistics compiled by the NHC and other health organizations. 3. Periodic on-site evaluations of services by GOZ, USAID and outside consultants.	Assumptions for achieving goal targets: 1. A stable political situation. 2. Continued GOZ commitment to health services development. 3. Increased management capabilities and improved systems focused on actual delivery of health services to general population.
Project Purpose: Strengthening of GOZ institutional capacity to deliver health services.	Conditions that will indicate purpose has been achieved: End of project status. 1. NHC structure capable of formulating and delivering improved health services countrywide. 2. Trained Zairian staff working on various aspects of health delivery. 3. Initiation of family health program through initial health zones.	1. Annual reports of the National Health Council. 2. Joint AID/GOZ evaluations. 3. Development plans of the National Health Council.	Assumptions for achieving purpose: 1. GOZ supports NHC plans for systems improvement plus development of Health Zones. 2. Timely GOZ authorization of adequate budgets. 3. Interested individuals and communities support the establishment and operation of services.
Outputs: 1. Plans for improving a. Organization and administration; b. personnel system; c. vital statistics reporting d. logistics/maintenance system; e. Supply mgmt system; f. delivery of family health services through the Health Zones. 2. Trained staff integrated into new health administration. 3. Centers in initial Zones adequately supplied and equipped, and serving as models for replication.	Magnitude of Outputs: 1. Each proposed system improvement will have a specific written plan ready for implementation. 2. Each system improvement will be the responsibility of a specifically designated GOZ health official. 3. Each such official will have initiated authorized improvements.	1. Joint AID/GOZ assessment and evaluation of the project quarterly, annually and at its completion in CY 1978. 2. USAID records on participants. 3. Reports from the National Health Council. 4. Review of draft plans.	Assumptions for achieving outputs: 1. The GOZ supports NHC plan to proceed with health structure development. 2. The NHC provides the expected leadership and direction for new system. 3. The NHC uses consultants for its program and will assign trained Zairians to approved staff positions.
Inputs: AID 1. Technician services: Project Manager in health administration; ST consultant services. 2. Training: one year in PH planning and admin ST training courses. 3. Commodities and equipment in support of management plans and the first Health Zones. 4. Inflation Totals GOZ-Counterparts, administrative support operating expenses of 2 zones (minimum)	Implementation Target (Type and Quantity) FY76 $000 (mm) / FY 77 $000 (mm) / Total TA 30 (6) / 90 (18) / 120(24) 65 (13) / 140 (28) / 205(41) TR 13 (12) / 40 (36) / 53(48) 7 (6) / 10 (9) / 17(15) C. 35 / 200 / 235 INF. - / 45 / 45 150 / 525 / 675 FY 76-115 ; CY 77 325	Review of AID project documentation and performance; review of GOZ/NHC budgets, staffing, and expenditures.	Assumptions for providing inputs: AID-suitable consultants can be located and assigned expeditiously proper training programs can be provided; proper commodities arrive when needed. GOZ-effective counterparts can be provided for administration; suitable candidates can be located for training.

ANNEX C

.5

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT REVIEW PAPER FACESHEET

TO BE COMPLETED BY ORIGINATING OFFICE

1. TRANSACTION CODE (X) APPROPRIATE BOX)
☐ ORIGINAL ☒ CHANGE
☐ ADD ☐ DELETE

DOCUMENT CODE 2

2. COUNTRY/REGIONAL ENTITY/GRANTEE
Zaire

3. DOCUMENT REVISION NUMBER

4. PROJECT NUMBER
660-0057

5. BUREAU
A. SYMBOL AFR
B. CODE 1

6. PROPOSED PP SUBMISSION DATE
MO. YR.

7. PROJECT TITLE - SHORT (STAY WITHIN BRACKETS)
[Health Systems Development]

8. ESTIMATED FY OF AUTHORIZATION/OBLIGATION
A. INITIAL FY 76 B. FINAL FY 77

9. SPECIAL CONCERNS CODE (MAXIMUM OIX CODES OF FOUR POSITIONS EACH)

10. RECORD PURPOSE CODE

11. ESTIMATED TOTAL COST ($000 OR EQUIVALENT, $1 =)

PROGRAM FINANCING	FIRST YEAR A. FX	FIRST YEAR B. L/C	FIRST YEAR C. TOTAL	ALL YEARS D. FX	ALL YEARS E. L/C	ALL YEARS F. TOTAL
AID APPROPRIATED TOTAL	150		150	675		675
(GRANT)	(150)	( )	(150)	(675)	( )	(675)
(LOAN)	( )	( )	( )	( )	( )	( )
OTHER U.S.						
HOST GOVERNMENT		115			440	440
OTHER DONOR(S)						
TOTALS	150	115			440	115

12. ESTIMATED COSTS/AID APPROPRIATED FUNDS ($000)

A. APPROPRIATION ACCOUNT	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE	FY D. GRANT	FY E. LOAN	FY F. GRANT	FY G. LOAN	FY H. GRANT	FY I. LOAN	ALL YEARS J. GRANT	ALL YEARS K. LOAN
PH	429	530	150	--	--	--	525	--	675	
TOTALS			150	--	--	--	525	--	675	

13. PROJECT PURPOSE(S) (STAY WITHIN BRACKETS) ☐ CHECK IF DIFFERENT FROM PID

To strengthen the GOZ's institutional capacity to deliver health services.

14. WERE CHANGES MADE IN PID FACESHEET DATA NOT INCLUDED ABOVE? IF YES, ATTACH CHANGED PID FACESHEET.
☐ YES ☐ NO

15. TRAINING RESOURCE REQUIREMENTS (STAFF/FUNDS)

16. ORIGINATING OFFICE CLEARANCE

SIGNATURE Fernando Herrera

TITLE USAID Director

DATE SIGNED MO. 12 DAY 17 YR. 75

17. DATE RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS DATE OF DISTRIBUTION
MO. DAY YR.

AID 1330-3 (5-75)

ANNEX D .60

PLANNED PERFORMANCE TRACKING REVERSE CHART

COUNTRY: ZAIRE	PROJECT NUMBER:	PROJECT TITLE: HEALTH SYSTEMS DEVELOPMENT	DATE: DECEMBER 18, 1975	ORIGINAL ☒ REVISION ☐	APPROVAL:

PROJECT ACTIVITY	CY 75 DEC	CY 76 JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC	CY 77 JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC	CY 78 JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEP
1. PROJECT APPROVAL																																		
Submission of PP to AID/W	—																																	
Approval of PP		—																																
Preparation and Signing of Pro. Ag.																																		
Selection/Approval of Contractor																																		
Host Country Signature																																		
Initiation of Project																																		
2. TECHNICAL CONSULTANT SERVICES																																		
Arrival in Zaire of Project Manager																																		
Delineate Work Plan																																		
Baseline Data Development for Evaluation																																		
First Consultants Arrive																																		
Plans Submitted in Key Health Areas																																		
Plans Reviewed, Modified, Approved by MHC																																		
Development Of Basic Family Health Service Plan																																		
Specific Health Zone Plan Adopted by MHC																																		
Staff Selection/Designation Indicated in Plans																																		
3. TRAINING																																		
Participant Training Plan Delineated																																		
FY 76 Participant Selection																																		
One Long-Term Participant Departs																																		
FY 77 Participants Selected																																		
Short-Term Training Begins																																		
FY 76 Participants Return																																		
FY 77 Participants Depart																																		
Additional Short-Term Training Established																																		
Final Participants Return																																		
4. COMMODITIES																																		
First Commodities Ordered																																		
First Commodities Arrive																																		
Commodity Management Plans Developed																																		
First FY 77 Commodities Ordered																																		
FY 77 Commodities Arrive																																		
Second FY 77 Commodities Ordered																																		
Final Commodities Arrive																																		
5. FOLLOW-THROUGH COMMITMENTS AND EVALUATION																																		
GOZ/MHC Establish Budget																																		
FY 77 New Pro. Ag.																																		
First PAR Prepared and Submitted																																		
GOZ/MHC Establish CY 78 Budget																																		
Negotiation and Signing FY 77 Pro. Ag.																																		
Special Evaluation																																		
Second PAR Prepared and Submitted																																		
AID Financed Project Manager Departs Zaire																																		
Third PAR Prepared and Submitted																																		
Progress Reports																																		

6. FINANCIAL PLAN ($ 000)

	CY 76	FY 77
Technicians		
Long-Term	20	90
Short-Term	65	180
Training		
Long-Term	13	40
Short-Term	7	10
Commodities	35	200
Inflation	—	45
TOTAL	150	525

ANNEX E
61

MOUVEMENT POPULAIRE DE LA REVOLUTION

REPUBLIQUE DU ZAIRE
CONSEIL NATIONAL DE SANTE
ET DU BIEN-ETRE

B.P. 1197 -- KINSHASA I

Réf. : CNSBE/34/75

Annexes :

Kinshasa, le 5 décembre 1975

A Monsieur Fermino SPENCER
Directeur
USAID
à
Kinshasa

ACTION TAKEN:
.....
.....
N.A. ..... DATE .....

Objet : Projet de gestion des systèmes de santé

Monsieur le Directeur,

J'ai le plaisir de vous informer que le projet de gestion des systèmes de santé soumis au Conseil National de la Santé et du Bien-Etre a été approuvé par le Département de la Santé Publique.

Je vous demande de bien vouloir agir le plus rapidement possible pour que ce projet soit mis en exécution.

Veuillez agréer, Monsieur le Directeur, l'expression de mes sentiments distingués.

LE COMMISSAIRE D'ETAT
A LA SANTE PUBLIQUE

DEC 9 - 1975

USAID/ZAIRE

ACTION	INFO
	DIR
	PR
	CO
	EH
	PDA
	CAMO
	Action Due

REPUBLIQUE DU ZAIRE
Conseil National de Santé et du Bien-Etre

Best Available Document

Chapitre Premier	Introduction
Chapitre Deuxième	Soins Ruraux et Zones de Développement Rural
Chapitre Troisième	Soins Urbains et Zones de Développement Urbain
Chapitre Quatrième	Naissances Désirables
Chapitre Cinquième	Maladies Endémiques
Chapitre Sixième	Corps Médical Zaïrois
Chapitre Septième	Personnel Paramédical
Chapitre Huitième	Statistiques Médicales et Démographiques
Chapitre Neuvième	Système Pharmaceutique National
Chapitre Dixième	Agrément du Personnel Médical et Paramédical et des Institutions Sanitaires.
Chapitre Onzième	Recherche, Planification et Evaluation
Chapitre Douzième	Moyens Audio-Visuels

PROJET DE PLAN SANITAIRE NATIONAL

République du Zaïre

1975-1980

Chapitre Premier - Introduction

I But du Premier Plan Sanitaire National - Améliorer le niveau de santé et de bien-être de la population zaïroise, conformément au Manifeste du CNSBE.

II Stratégie du Premier Plan Sanitaire National -

1. Mise en place d'un système de soins ruraux et urbains capable de satisfaire les besoins de santé de la population zaïroise, système qui :

   (1) aide les individus, les familles et les communautés à prendre leurs responsabilités dans la conservation et l'amélioration de leur santé;

   (2) s'efforce de prévenir les maladies à leur source, c'est-à-dire là où vivent les gens, dans leurs communautés, avec une attention particulière pour les femmes et les enfants de moins de cinq ans;

   (3) soit authentiquement zaïrois; autrement dit un système de soins propre au Zaïre, englobant ce qu'il y a de meilleur dans la médecine traditionnelle et dans la médecine occidentale;

   (4) donne des soins de la meilleure qualité possible au plus grand nombre possible de gens, dans la limite des ressources disponibles;

   (5) cherche à comprendre les individus et leurs communautés en travaillant avec les gens eux-mêmes afin de satisfaire leurs aspirations et leurs besoins, au lieu de leur imposer des solutions technocratiques.

   (6) mette les services de médecine curative à la portée des usagers, sur leurs lieux mêmes d'existence;

   (7) coordonne les activités des secteurs publics et privés de la santé;

   (8) oeuvre pour le développement socio-économique total du peuple zaïrois;

   (9) soit correctement administré (cf. Chapitres 2 et 3).

2. Intégration des services de Naissances Désirables et de leurs activités de formation dans tous les secteurs relevant de la santé au Zaïre (services ruraux et urbains "Mère-Enfant", formation médicale et paramédicale,etc.), (cf. Chapitre 4).

3. [illegible] des maladies endémiques [illegible] au [illegible] tuberculose, [illegible] [illegible] lèpre, onchocercose, [illegible] [illegible] et [illegible] variole, par la mise sur pied :

   (1) de programmes aux niveaux communautaires, régionaux et national pour enrayer la diffusion de ces maladies;

   (2) d'un programme de dépistage précoce des individus qui en sont atteints;

   (3) d'un programme de traitement des personnes atteintes, à base de soins ambulatoires et de surveillance dans les communautés mêmes;

   (4) d'un programme de mesures prophylactiques et préventives contre les agents vecteurs, chaque fois que cela sera possible (cf. Chapitre 5).

4. Constitution d'un corps de médecins zaïrois qui :

   (1) aient pour objectif primordial de "servir et non pas se servir";

   (2) considèrent qu' "il faut mieux prévenir que guérir";

   (3) considèrent que leur client privilégié est la communauté au service de laquelle ils oeuvrent;

   (4) rejettent le "triomphalisme" médical;

   (5) soient correctement formés aux techniques de la médecine curative et préventive afin que soient satisfaits les besoins sanitaires du Zaïre et non pas ceux des autres pays;

   (6) soient rompus au travail en équipe pour le plus grand bien du peuple zaïrois;

   (7) soient d'un haut niveau éthique et d'une intégrité professionnelle indiscutable (cf. Chapitre 6).

5. Constitution d'un corps de personnel paramédical zaïrois qui soit doté des mêmes qualités que les médecins zaïrois (cf. Chapitre 7).

6. Mise sur pied d'un système national et normalisé d'enregistrement des statistiques médicales et de recueil et d'analyse des statistiques démographiques qui :

   (1) soit adapté en priorité aux besoins sanitaires du Zaïre;

   (2) puisse produire des données valides relatives à la morbidité, à la mortalité et à la natalité (cf. Chapitre 8).

7. Mise sur pied d'un système pharmaceutique national qui assure efficacement l'importation et la distribution des médicaments et du matériel de base à toutes les unités sanitaires agréées, aux prix les plus bas possibles et qui contrôle l'importation et la distribution des médicaments dans le secteur pharmaceutique privé (cf. Chapitre 9).

[illegible] - Soins ruraux et Zones [illegible] Plan

but - Mise sur pied d'un système de soins ruraux capable de satisfaire les besoins sanitaires de la population zaïroise.

II Objectifs - Avoir créé et mis en état de fonctionner 5 Zones de Développement Rural (ZDR) à la fin de l'année 1975 et 25 ZDR à la fin de l'année 1979.

III Plan d'Action -

1. Normalisation par le CNSBE des fonctions de toutes les unités sanitaires et de leur personnel, dans chaque ZDR.

2. Choix de 5 ZDR, avant la fin de l'année 1975. Ce choix sera fait en tenant compte de l'intérêt manifesté par le personnel des unités sanitaires et de l'expérience acquise dans le domaine des soins communautaires.

3. Discussion avec des responsables médicaux locaux des tâches incombant aux ZDR et du choix des médecins et du personnel qui en auront la responsabilité.

4. Mise au point conjointe d'un plan et d'un budget des ZDR, par le CNSBE et les responsables des ZDR. Cette tâche exigera un inventaire des unités sanitaires existantes et la détermination de leurs besoins actuels (en personnel, en bâtiments, en équipement, en médicaments, en moyens de transport, etc.) afin que soient respectées les normes établies par le CNSBE.

5. Recyclage de tous les infirmiers(ières) travaillant dans les ZDR, au siège des hôpitaux des ZDR (de 6 à 8 semaines). Des dispositions devront être prises pour assurer le logement et la subsistance de ces infirmiers(ières) pendant la durée du recyclage. Le contenu du programme et les manuels correspondants seront établis par les soins du CNSBE. Une supervision des travaux pratiques sera assurée. Il serait souhaitable de disposer d'au moins 1 Centre de Recyclage Court par ZDR au début. La sélection se fera par moyen de tests. Des procédures devront être mises au point afin de juger des connaissances cliniques et de la capacité des infirmiers(ières) avant de les soumettre au recyclage. On sait qu'un certain nombre d'infirmiers(ières) en poste dans les dispensaires ruraux ne possèdent pas de diplôme officiel délivré par une école de formation infirmière et que d'autres ignorent pratiquement tout de leur métier. A l'issue de tests de sélection, on prendra des dispositions pour envoyer les recalés dans un Centre National de Recyclage Long plus important où on leur demandera de se soumettre à 12 mois au moins de formation infirmière intensive pour pouvoir recevoir l'autorisation d'exercer. Ils bénéficieront d'un nouveau statut administratif et salarial.

[illegible] agents - Quatre [illegible] niveau d'a[illegible] [illegible]pement Communautaire devron[illegible] formés dans des Centres d'Enseignement en Bien-Etre Communautaire, (à raison d'un centre par Centre de Bien-Etre Communautaire) :

(1) Animateurs de Santé;

(2) Animatrices de PMI;

(3) Animateurs Agricoles;

(4) Auxiliaires de Soins Communautaires.

Le logement et la subsistance devront être fournis aux stagiaires. Les programmes et les manuels de formation seront mis au point par les soins du CNSBE. Une supervision des travaux pratiques sera assurée.

7. Réalisation du plan par étapes.

8. Mise sur pied de tournées d'inspection et d'approvisionnement, au moins mensuelles, dans tous les Centres de Bien-Etre Communautaire.

Des véhicules seront fournis et l'on prévoiera leur entretien régulier au niveau du ZDR. On mettra au point un système d'approvisionnement qui assure des stocks permanents de médicaments et de matériel aux CEBEC. Il sera nécessaire de former des équipes comprenant un Cadre du Bien-Etre Communautaire, pour accomplir ces tournées d'inspection.

9. Programmation et évaluation des ZDR - Le CNSBE mettra au point les procédures appropriés à l'intention des responsables des ZDR afin de leur permettre d'évaluer en permanence les progrès réalisés et de préparer des programmes pour l'avenir.

Chapitre Troisième - Soins urbains et Zones de Développement Urbain

I But - Mettre au point un système de soins urbains qui soit capable de satisfaire les besoins de la population zaïroise.

II Objectifs

1. Mettre sur pied et faire fonctionner 2 Zones de Développement Urbain (ZDU) à Kinshasa, pour la fin de l'année 1975 et 5 ZDU pour la fin de l'année 1979.

2. Envisager pour la fin de l'année 1976 un programme d'études destinées à la construction d'un système d'adduction d'eau et d'assainissement pour la ville de Kinshasa, en liaison avec le plan d'urbanisme.

3. Avoir achevé pour la fin de l'année 1976 les études préalables à la création d'un système d'enlèvement et d'incinération des ordures ménagères, pour la ville de Kinshasa.

III Plan d'Action

1. Normalisation des fonctions des CEBEC et du personnel des ZDU, par les soins du CNSBE.

2. Choix de 2 zones dans lesquelles on lancera les ZDU, avant la fin de l'année 1975.

3. Subdivision des ZDU en CEBEC.

4. Mise au point conjointe d'un plan et d'un budget des ZDU, par les responsables des ZDU et le CNSBE. Il sera nécessaire de faire l'inventaire des unités sanitaires existant dans les ZDU choisies et de déterminer leurs besoins (en personnel, en bâtiments, en équipement, en médicaments, en moyens de transport, etc.) afin que soient respectées les normes établies par le CNSBE à l'intentions de ces unités sanitaires.

5. Recyclage des infirmiers(ières) qui travailleront dans les ZDU (de 6 à 8 semaines); cf. ZDR - "Recyclage". Il y aura une Ecole de Recyclage et d'Enseignement du Bien-Etre Communautaire pour la ville de Kinshasa.

[illegible] - deux [illegible] agents [illegible] développement communautaire seront formés par l'Ecole de Recyclage et d'Enseignement du Bien-Etre Communautaire de Kinshasa, afin d'être mis à la disposition des ZDU :

(1) Auxiliaires de soins communautaires.

(2) Animatrices de PMI.

Cf. ZDR - "Formation de nouveaux agents".

7. Réalisation du plan par étapes.

8. Mise sur pied de tournées d'inspection et d'approvisionnement, au moins mensuelles, dans tous les Centres de Bien-Etre Communautaire. Pour plus de détails, cf. les ZDR. Il sera nécessaire de créer une unité centrale de gestion et d'intendance pour fournir aux ZDU l'appui administratif et matériel dont elles auront besoin (gestion du personnel, blanchisserie, cuisines, pharmacie, véhicules, etc.).

9. Programmation et évaluation des ZDU. Pour plus de détails, cf. les ZDR.

Chapitre Quatrième - Naissances Désirables

But - Intégration des services de Naissances Désirables et de leurs activités de formation dans tous les secteurs relevant de la santé au Zaïre.

I Objectifs -

1. Promotion des Naissances Désirables dans les communautés rurales (ZDR) et urbaines (ZDU), par les Animateurs de Santé et les Animatrices de PMI (cf. Chapitres 2 et 3).

2. Mise sur pied de services de Naissances Désirables dans tous les Centres de Bien-Etre Communautaire, ruraux et urbains, et dans les Hôpitaux des Zones de Santé (cf. Chapitre 2 et 3).

3. Introduction de la formation aux techniques des Naissances Désirables dans les cours de recyclage destinés aux médecins zaïrois et dans les programmes de formation médicale (cf. Chapitre 6).

4. Introduction de la formation aux techniques des Naissances Désirables dans les cours de recyclage destinés aux infirmiers(ières et dans les cours de formation pour Animateurs et Animatrices. Poursuite à Kinshasa d'un programme destiné à former le personnel paramédical zaïrois aux techniques des Naissances Désirables (cf. Chapitre 7).

5. Mise sur pied d'un système d'enregistrement des données relatives au fonctionnement et aux résultats des services de Naissances Désirables ainsi que d'évaluation, de recherche et de programmation (cf. Chapitre 8).

6. Contrôle de l'importation et de la distribution des contraceptifs, par l'intermédiaire de la Division Pharmaceutique du CNSBE. (cf. Chapitre 9).

7. Réalisation des recherches, des évaluations et de la programmation relatives aux Naissances Désirables par l'organe de planification du CNSBE (cf. Chapitre 11).

8. Production et distribution de matériel audio-visuel relatif aux Naissances Désirables et à la santé et au bien-être communautaire par l'unité responsable de la production audio-visuelle du CNSBE (cf. Chapitre 12).

Plan d'Action -

1. Intégration du Conseil National pour la Promotion du Principe des Naissances Désirables dans le CNSBE.

2. Le Conseil National des Naissances Désirables se chargera de mettre au point une politique de Naissances Désirables qu'il soumettra au CNSBE, ainsi qu'un plan national de promotion des Naissances Désirables. Ce plan englobera les services de Naissances Désirables, la formation, l'emploi du matériel audio-visuel, l'évaluation, etc.

Chapitre Cinquième - Maladies Endémiques

But - Contrôler les maladies qui sévissent à l'état endémique au Zaïre.

II Objectifs -

1. Pour la fin de l'année 1976, avoir achevé les études permettant la confection d'un plan national de lutte contre la tuberculose, la rougeole, le paludisme, la lèpre, la trypanosomiase, la schistosomiase, le goître et d'éradication totale de la variole, au Zaïre.

2. Mise en place de programmes de lutte contre ces maladies endémiques dans toutes les ZDR et les ZDU.

III Plan d'Action

1. Une commission sera formée sous les auspices du CNSBE qui étudiera le problème des grandes endémies au Zaïre et élaborera un plan détaillé de lutte contre ces maladies.

2. La lutte contre les grandes endémies sera l'une des fonctions essentielles des ZDR et des ZDU. Par exemple, en ce qui concerne la tuberculose, on donnera la priorité aux actions suivantes :

   (1) dépistage précoce des cas actifs, y compris dans l'entourage familial,

   (2) traitement ambulatoire des cas actifs,

   (3) limitation de l'hospitalisation aux cas résistants, graves ou compliqués,

   (4) suivi de tous les cas,

   (5) prophylaxie INH des malades présentant des risques élevés,

   (6) vaccination au BCG des nouveaux nés et des enfants de moins de 15 ans qui n'ont pas encore été vaccinés.

   Pour la lutte contre la lèpre, on donnera la priorité aux actions suivantes :

   (1) dépistage précoce des cas actifs, y compris dans l'entourage familial,

   (2) traitement ambulatoire des cas actifs,

   (3) limitation de l'hospitalisation aux cas résistants, graves ou compliqués,

   (4) suivi de tous les cas,

   (5) programmes de réhabilitation.

Pour la lutte contre le paludisme, on donner la priorité aux actions suivantes :

(1) Education communautaire visant à diminuer le nombre des sites propices à l'éclosion des larves de moustiques et à améliorer les conditions de logement afin d'accoître la protection contre les moustiques;

(2) inclusion de l'emploi domestique des insecticides dans les programmes communautaires d'amélioration des conditions de vie;

(3) recours à la chimioprophylaxie et emploi d'anti-paludiques pour tous les enfants de moins de 5 ans;

(4) traitement précoce des accès aigus de paludisme.

Chapitre Dixième - Corps Médical Zaïrois

But - La constitution d'un corps de médecins zaïrois qui :

1. aient pour objectif primordial de "servir et non pas se servir".
2. considèrent qu' "il vaut mieux prévenir que guérir";
3. considèrent que leur client privilégié est la communauté au service de laquelle ils oeuvrent;
4. rejettent le "triomphalisme" médical;
5. soient correctement formés aux techniques de la médecine curative et préventive afin que soient satisfaits les besoins sanitaires du Zaïre et non pas ceux des autres pays;
6. soient rompus au travail en équipe pour le plus grand bien de la population zaïroise;
7. soient d'un haut niveau éthique et d'une intégrité professionnelle indiscutable.

II Objectifs -

1. Avoir re-orienté tous les médecins zaïrois avant la fin de l'année 1976, au cours de séminaires de 4 à 8 semaines tenus à l' "Ecole du Parti" et portant sur les principes exposés dans le Manifeste du CNSBE.
2. Avoir refondu la totalité des programmes de la Faculté de Médecine de l'UNAZA, avant la fin de l'année 1976, en conformité avec les principes du Manifeste du CNSBE.

III Plan d'Action -

1. Le recyclage des médecins zaïrois sera organisé et dirigé par le CNSBE.
2. Une commission sera formée sous les auspices du CNSBE afin d'examiner le contenu des programmes actuels, le rendement des étudiants et de la Faculté de Médecine et de recommander les changements nécessaires, en conformité avec les principes du Manifeste du CNSBE.

Chapitre Septième - Personnel Paramédical

I **But** - La constitution d'un corps de personnel paramédical zaïrois qui soit doté des mêmes qualités que les médecins zaïrois (cf. Chapitre 6).

II **Objectifs** -

1. Pour la fin de l'année 1976, avoir crée une Ecole de Recyclage Long pour Infirmiers(ières) de niveau 1 et 2 (durée: 12 mois) et pour la fin de l'année 1979 au moins 10 Centres de Recyclage Court. Les stages de recyclage court seront destinés aux infirmiers(ières) des niveaux 1 et 2 et dureront environ 8 semaines. L'orientation vers l'un ou l'autre mode de recyclage se fera au moyen de tests.

2. Avoir créé pour la fin de l'année 1976 une Ecole des Cadres du Bien-Etre Communautaire (durée de la formation: 2 ans).

3. Avoir créé pour la fin de l'année 1976 une Ecole des Techniciens Paramédicaux pour :

   (1) les pharmaciens assistants (durée: 2 ans)

   (2) les dentistes assistants (durée: 2 ans)

   (3) les assistants de radiologie et de laboratoire (durée: 2 ans)

4. Faire fonctionner avant la fin de l'année 1979 10 Ecoles officiellement agréées d'Infirmiers(ières) en Soins Communautaires, du niveau 2, avec une formation durant 2 ans, à raison d'une école par région, et 3 Ecoles officiellement agréées d'Infirmiers(ières), de niveau 1, avec une formation de 3 ans. Ces dernières écoles seront attachées aux Grands Hôpitaux de Référence et d'Enseignement.

III **Plan d'Action** -

1. Un Centre de Recyclage Court sera situé dans chacune des 10 régions du Zaïre, soit 9 centres dans des zones rurales et 1 centre dans une zone urbaine (Kinshasa). Chaque centre remplira la fonction suivante : recyclage court (8 semaines) pour les infirmiers(ières) admis(es) au bénéfice de cette formation (cf. Chapitre 10).

2. Un Centre de Formation par ZDR et par ZDU, avec les fonctions suivantes :

   (1) la formation des Animateurs de Santé (2 mois en plusieurs stages),

   (2) la formation des Auxiliaires de Développement (6 mois en plusieurs stages),

   (3) la formation des Animatrices de PMI (6 mois en plusieurs stages),

   (4) la formation des Animateurs Agricoles (3 mois en plusieurs stages).

Les problèmes matériels et pédagogiques suivants devront être résolus pour chaque Centre :

(1) bâtiments (salles de cours, dortoirs et réfectoires),

(2) nourriture des stagiaires,

(3) personnel enseignant et moniteurs de travaux pratiques,

(4) contenu des programmes et matériel pédagogique (fournis par le CNSBE, exception faite de la formation des Animateurs Agricoles qui sera contrôlée par le Département de l'Agriculture),

(5) préparation du corps enseignant,

(6) transport des stagiaires.

3. Une Ecole d'Infirmiers(ières) pour Recyclage Long (12 mois) devra être créée afin de reprendre la formation des infirmiers(ières) qui auront été admis au bénéfice de cette formation (cf. Chapitre 10). Ce recyclage sera destiné aux niveaux 1 et 2. Les mêmes problèmes matériels et pédagogiques que cités supra (cf. Section 2) devront être résolus. Il est possible que l'on puisse transformer une école existant déjà à Kinshasa en Ecole d'Infirmiers (ières) pour Recyclage Long.

4. Une Ecole des Cadres du Bien-Etre Communautaire (durée: 2 ans) devra être créée afin de préparer jeunes gens et jeunes filles aux tâches spécifiques du développement communautaire intégré. Les mêmes problèmes matériels et pédagogiques que cités supra (cf. Section 2) devront être résolus. Cette école sera vraisemblablement installée en zone rurale, dans l'une des premières ZDR qui auront été choisies.

5. Il sera nécessaire d'ouvrir une Ecole des Techniciens Paramédicaux afin de former des pharmaciens assistants, des dentistes assistants et des assistants de laboratoire et de radiologie (durée: 2 ans). Les même problèmes matériels et pédagogiques que précédemment signalés devront être résolus. Il est vraisemblable que cette école sera installée à Kinshasa. Il sera nécessaire d'examiner les écoles existantes de techniciens paramédicaux afin de déterminer leur rôle futur.

6. Dix Ecoles d'Infirmiers(ières) existantes (niveaux 2) et 3 Ecoles d'Infirmiers(ières) existantes (niveau 1) seront choisies pour être transformées en Ecoles d'Infirmiers(ières) en Soins Communautaires (de niveau 2). Ce choix sera fait par une commission du CNSBE, conjointement avec le personnel médical des écoles. La même commission étudiera le rôle des autres Ecoles d'Infirmiers (ières) existantes: certaines devront sans doute être fermées tandis que d'autres (officielles ou missionnaires) pourront être utilisées pour le contrôle des travaux pratiques des élèves. Les mêmes problèmes matériels et pédagogiques que précédemment signalés devront être résolus.

Chapitre Huitième - Statistiques Médicales et Démographiques

I But - Mise sur pied d'un système national et normalisé d'enregistrement des statistiques médicales et de recueil et d'analyse des statistiques démographiques.

II Objectifs -

1. Avant la fin de l'année 1975, on devra avoir mis au point, sous les auspices du CNSBE, un système normalisé d'enregistrement des données médicales qui puisse être utilisé dans les ZDR et les ZDU choisies.

2. Avant la fin de l'année 1975, on devra avoir mis au point une méthode de collecte des données relatives à la natalité et à la mortalité, dans les zones rurales et urbaines, au niveau des communautés.

3. Avant la fin de l'année 1976, on devra avoir créé un Bureau National de recueil et d'analyse des données relatives à la morbidité et à la natalité, en provenance des ZDR et des ZDU.

III Plan d'Action -

1. Créer, sous les auspices du CNSBE, une commission d'étude et de programmation d'un système national et normalisé d'enregistrement des statistiques médicales et démographiques et de mise au point des formulaires qui seront utilisés par les unités sanitaires des ZDR et des ZDU choisies.

2. Emploi de ce système d'enregistrement des données médicales et démographiques dans les ZDR et les ZDU pilotes.

   (1) Formation des responsables des ZDR et des ZDU à la méthode et aux techniques d'enregistrement des données,

   (2) Formation aux techniques d'enregistrement des données, dans les Centres de Recyclage et d'Enseignement, à l'occasion des stages pour infirmiers(ières) et de la formation des nouveaux agents en développement communautaire. Etant donné que la majorité des informations relatives à la morbidité et aux mouvements démographiques proviendront des Animateurs de Santé et des Infirmiers(ières) en Soins Communautaires, il est absolument nécessaire qu'ils aient parfaitement compris et le système de recueil des données et l'importance qu'elles revêtent pour les communautés locales.

(3) Envoi mensuel des données médicales [illegible], la communauté au Centre de Bien-Etre Communautaire (urbain et rural), puis à l'Hôpital de ZDR ou de ZDU, au Médecin Inspecteur Sous-Régional, et, enfin, au Bureau de Statistiques du CNSBE.

3. Inclusion du nouveau système d'enregistrement des statistiques médicales dans les programmes de recyclage destinés aux médecins zaïrois, dans les programmes des écoles médicales, dans ceux des stages de recyclage long pour infirmiers(ières), dans les cours des Ecoles d'Infirmiers(ières) en Soins Communautaires et dans ceux de l'Ecole des Cadres du Bien-Etre Communautaire.

4. Création au sein du CNSBE d'un Bureau National chargé de la collecte et de l'analyse des données relatives à la morbidité, à la mortalité et à la natalité, provenant des ZDR et des ZDU.

[illegible] Deuxième - Système Pharmaceutique [illegible]

But - Mise sur pied d'un système pharmaceutique national.

II Objectifs -

1. Avoir créé, avant la fin de l'année 1975, une Division Pharmaceutique au sein du CNSBE, ainsi qu'un comité consultatif pour les problèmes pharmaceutiques. Cette Division sera responsable de l'importation, de la distribution, de la production et du contrôle des médicaments pour l'ensemble du Zaïre.

2. Avoir achevé, pour la fin de l'année 1975, une étude des problèmes actuels du DCMP, assortie de propositions d'assainissement qui seront soumises à la Division Pharmaceutique. Le DCMP devrait être en mesure de fonctionner de façon nettement plus efficace qu'actuellement vers la fin de l'année 1976.

3. Avoir entamé la réalisation d'un plan de contrôle des importations de la distribution et de la fixation des prix des médicaments dans le secteur privé, pour la fin de l'année 1976.

III Plan d'Action -

1. Création d'une Division Pharmaceutique au sein du CNSBE.

2. Etude du DCMP et présentation d'un plan d'action et de financement à la Division Pharmaceutique.

3. Réalisation du plan, comprenant l'embauche de personnel nouveau, le recyclage d'une partie du personnel actuel, l'obtention d'équipements nouveaux, etc.

4. Réalisation du plan de contrôle des importations, de la distribution et de la fixation des prix dans le secteur privé.

Annexe - Agrément [illegible]
des Institutions Sanitaires

I But - Mise au point et fonctionnement d'un système d'agrément officiel des médecins et du personnel paramédical, zaïrois et expatriés et d'autorisation officielle de toutes les unités sanitaires (hôpitaux, CEBEC, pharmacies) et institutions de formation médicale et paramédicale.

II Objectifs -

1. Pour la fin de l'année 1975, avoir créé au sein du CNSBE un service chargé d'octroyer l'agrément du Conseil au personnel et aux institutions sanitaires du Zaïre.

2. Pour la fin de l'année 1975, avoir mis au point un programme d'agrément du personnel et des institutions sanitaires du Zaïre, ainsi que le budget correspondant.

3. Avoir largement entamé les opérations d'agrément pour la fin de l'année 1976.

4. Etre en mesure, à la fin de l'année 1979, d'exiger que seul le personnel dûment agréé puisse exercer au Zaïre, et à la fin de l'année 1976 que seules les institutions sanitaires officiellement agréées (hôpitaux, CEBEC, pharmacies, écoles de formation) puissent fonctionner au Zaïre.

III Plan d'Action -

1. Création d'un service d'agrément officiel au sein du CNSBE.

2. Réalisation d'une étude afin de déterminer les méthodes à suivre dans l'examen des institutions et du personnel candidats à l'agrément officiel. A titre d'exemple, il sera probablement nécessaire de recourir à un examen écrit et pratique pour les candidats désirant être agréés en tant qu'infirmiers(ières) de niveaux 1 et 2. A la suite de ces examens, les candidats seront admis soit au bénéfice d'un recyclage court soit à celui d'un recyclage long soit purement et simplement refusés. Les candidats qui auront réussi aux épreuves finales du stage de recyclage, obtiendront le permis officiel. Dans le cas des infirmières de niveaux 1 et 2, récemment diplômées, elles seront examinées par les responsables d'écoles de formation reconnues afin d'obtenir l'autorisation d'exercer en tant qu'infirmières diplômées. Les mêmes méthodes

[illegible] techniciens paramédicaux. Les [illegible], les animatrices et les auxiliaires de développement recevront un agrément identique à l'issue de leurs stages, s'ils ont réussi aux épreuves finales. Le renouvellement annuel du permis sera nécessaire pour tout le personnel sanitaire. Les institutions seront agréées en fonction de critères variant selon le type de l'institution et à la suite d'une inspection des lieux par le service d'agréement officiel du CNSBE.

3. Application des procédures d'agrément et d'autorisation.

[illegible] Troisième - Recherche, Planification [illegible]

I But - Mise sur pied d'un organisme national de recherche médicale, d'évaluation et de planification.

II Objectifs -

1. Créer une commission qui, avant la fin de l'année 1975, aura étudié et présenté un plan de création et de financement d'un organisme national de recherche médicale, d'évaluation et de planification.

2. Mise en route de cet organisme avant la fin de l'année 1976. L'évaluation des premières ZDR et ZDU devrait être en cours à ce moment, en coordination avec le Bureau des Statistiques Médicales et Démographiques.

3. A la fin de l'année 1978, l'organisme de planification du CNSBE devrait avoir soumis un projet de Plan Sanitaire National, 1980 - 1984, au CNSBE.

4. L'organisme de planification du CNSBE devrait avoir exécuté plusieurs recherches relatives aux problèmes de santé et aux maladies endémiques sévissant au Zaïre (par exemple: connaissances, attitudes et pratiques contraceptives, études comparées des techniques traditionnelles et médicales; enquête comparative sur les enfants de moins de 5 ans, vivant dans et hors des ZDR,etc.)

III Plan d'Action -

1. Constitution de la commission chargée d'étudier et de présenter un plan de création et de fonctionnement de l'organisme de planification.

2. Création de l'organisme de planification et réalisation de ses objectifs.

[illegible] - Moyens Audio-Visuels

Buf - Production et distribution de matériel audio-visuel relatif à tous les domaines sanitaires, dans les principales langues en usage au Zaïre.

II Objectifs -

1. Avoir réalisé avant la fin de l'année 1975 une étude traduisant par un plan et un projet de budget pour la création et le fonctionnement d'une unité, qui, au sein du CNSBE, serait responsable de la production et de la distribution du matériel audio-visuel sanitaire, dans les principales langues en usage au Zaïre, y compris la diffusion par la radio, la télévision, les journaux et les périodiques.

2. Mettre cette unité en état de fonctionner avant la fin de l'année 1976.

III Plan d'Action -

1. Réalisation de l'étude de programmation et de financement devant permettre la création d'une unité audio-visuelle au sein du CNSBE.

2. Réalisation du plan.

LE PROJET DE REFORME DE L'ACTION MEDICALE
DANS LES ZONES DE DEVELOPPEMENT RURAL AU ZAIRE

Note officieuse établie par le Bureau des Oeuvres Médicales sur base de renseignements obtenus auprès du Département de la Santé Publique

La nouvelle politique de santé, qui est en voie d'élaboration auprès du Département de la Santé Publique et au Conseil National de la Santé et du Bien-Etre (CNSBE), a pour but d'intégrer la médecine curative dans l'action globale pour l'élévation du bien-être collectif.

Jusqu'à maintenant, l'action pour la santé se concentrait trop unilatéralement sur les soins curatifs, tandis que la population souffre de maladies endémiques que l'on peut toutes éviter. Le système revient à donner de coûteux soins curatifs au seul profit de la minorité de la population, tandis que 80 % de la population rurale ne fréquentent pas les hôpitaux et les dispensaires, à cause de l'éloignement, de l'absence de moyens de transport et de l'ignorance.

Le "Manifeste de la Santé et du Bien-Etre du Peuple Zaïrois", document de politque générale du "Conseil National de la Santé et du Bien-Etre" de la République du Zaïre, accorde la priorité aux soins sanitaires à donner au niveau des communautés de base urbaines et rurales.

En application de ce principe, un "Projet de Plan Sanitaire National" a été préparé qui a pour but essentiel de mettre en place un système de soins rural et urbain, capable de satisfaire les besoins de santé de la population zaïroise.

Les deux piliers de ce système sont la Zone de Santé Rurale (ZSR) et la Zone de Santé Urbaine (ZSU). Leur contenu ayant été seulement esquissé dans le Projet de Plan Sanitaire National, il était nécessaire d'en préciser rapidement l'organisation et les fonctions, et, ce faisant, de proposer des normes qui puissent être appliquées à toutes les formations sanitaires, publiques et privées, du Zaïre.

Dans ce but, le CNSBE a constitué un premier groupe de travail auquel il a donné mission de proposer une standardisation de l'organisation et des fonctions de la santé communautaire dans les Zones de Développement Rural du Zaïre.

Lorsqu'elles auront été adoptées par le CNSBE, les normes ainsi établies constitueront un guide officiel pour la mise sur pied des Zones de Santé Rurale et leur fonctionnement.

Les méthodes et les procédures en vigueur dans les différentes formations médicales du Zaïre seront unifiées en conséquence.

Ce guide n'en conservera pas moins pendant quelque temps un caractère provisoire. D'une part, les structures préconisées sont encore neuves, dans de nombreux aspects, pour pouvoir être généralisées à l'ensemble du pays sans une expérimentation préalable. Cette dernière entraînera des modifications. D'autre part, il existe entre les différentes régions du Zaïre des variations telles qu'il sera nécessaire d'en tenir compte dans la mise au point définitive du document.

[illegible] de base urbaines et rurales. Elle prévoit à cet [illegible], en milieu [illegible] d'abord, une restructuration des centres de soins, en établissant une organisation rationnelle qui descend de l'hôpital jusqu'à la communauté de base, priorité étant accordée à celle-ci.

Au niveau de la communauté de base, des "animateurs de santé" et des "animatrices de PMI" bénévoles, émanant de la population et formés lors de stages pratiques, sont chargés surtout de l'action de médecine préventive et de donner les premiers soins en cas d'accident ou de maladie.

Le "Centre de Bien-Etre Communautaire" (CEBEC), situé au niveau de la localité, supervise l'action des animateurs et animatrices, veille à la santé des mères et enfants - qui constituent un groupe prioritaire - et traite les affections courantes des adultes.

Les cas plus compliqués sont envoyés au "Centre de Santé" situé au niveau de la Sous-Zone de Santé Rurale.

Au niveau de la "Zone de Santé Rurale", enfin, se trouve l'hôpital général équipé pour assurer tous les soins nécessaires, ainsi qu'un Bureau Central, planifiant et coordonnant l'action dans l'ensemble de la Zone (qui coïncide dans la mesure du possible, avec la zone administrative).

Dans la nouvelle orientation, la médecine curative ne sera pas négligée mais intégrée à l'action préventive, comme un recours normal lorsque la prévention se sera montrée insuffisante. L'accent se trouve placé sur la prévention et l'assainissement du milieu de vie, les naissances désirables et les équipements collectifs des communautés de base.

Les méthodes de formation du personnel médical et paramédical et la tarification des services médicaux curatifs seront revisés dans l'optique d'une médecine communautaire.

Nous donnons ci-dessous un tableau synthétique des structures prévues aux différents niveaux, pour donner ensuite des détails sur l'action au niveau des communautés de base.

I. TABLEAU SYNTHETIQUE DE L'ORGANISATION DE LA SANTE COMMUNAUTAIRE DANS LES ZONES DE DEVELOPPEMENT RURAL AU ZAIRE

NIVEAU	ZONE DE SANTE RURALE (ZSR)	SOUS ZONE DE SANTE RURALE (SZSR)	LOCALITE	COMMUNAUTE RU
	(coïncide, dans la mesure du possible, avec la Zone administrative)			
	50.000 - 250.000 habitants	30.000 - 40.000 habitants	5.000 habitants	500 habitants
	180 à 240 villages	60 à 80 villages	10 villages en moyenne	partie d'une localité
	10 à 14 CEBEC	6 à 8 CEBEC		
SERVICES DE SANTE	HOPITAL GENERAL (fonctionne comme un CEBEC pour les villages environnants)	CENTRE DE SANTE (CS) (fonctionne comme un CEBEC pour les villages environnants)	CENTRE DE BIEN-ETRE COMMUNAUTAIRE (CEBEC)	ANIMATEUR DE S ANIMATRICE DE
Clientèle	Malades référés de 3 Centres de Santé + ceux des villages proches de l'hôp.	Malades référés de 6 à 8 CEBEC + ceux des villages environnants	Malades des villages de la localité	
Référence		Hôpital de la ZSR	CS de la SZSR Hôpital de la ZSR	CEBEC
Supervision		par ZSR	par chef de la SZSR	par infirmiers du CEBEC
	BUREAU CENTRAL DE LA ZSR			
FONCTIONS	de l'hôpital général :	A.Médecine communautaire	A.Médecine communautaire	
	1. Service Médecine interne chirurgie générale, maternité, pédiatrie, soins dentaires simples	1.Pédiatrie Cas trop compliqués pour les CEBEC	1. Pédiatrie - Surveillance croissance enfants préscolaires - Education sanitaire et nutritionnelle des parents - Prophylaxie - Traitement des maladies infantiles - Surveillance à domicile de certains cas	Voir ci-dessous
	2.Services de diagnostic: - radiographie simple - laboratoire			
	3. Services ambulatoires de base pour la population environnante (cfr CEBEC)			

ZONE DE SANTE RURALE

4. Evacuation à niveau supérieur de cas nécessitant diagnostic ou traitement spécialisés

du bureau central

1. Education sanitaire et nutritionnelle à l'hôpital.
2. Planification des actions sanitaires, des actions de développement communautaire.
3. Coordination de la lutte contre les endémies, des programmes de vaccination.
4. Recueil, évaluation et expédition des données statistiques..
5. Administration des formations subordonnées.
6. Préparation et surveillance de l'exécution des budgets ordinaires et extraordinaires.
7. Approvisionnement de la ZSR en médicaments, matériel et équipement.

SOUS ZONE DE SANTE RURALE

2. Soins aux mères

Maternité pour accouchements compliqués exigeant ventouse et symphisiotomie

3. Adultes

Cas compliqués exigeant diagnostic et traitement plus complexe, petites opérations chirurgicales

4. Maladies chroniques

Diagnostic surtout pour cas douteux référés par CEBEC.

Contrôle des traitements dans CEBEC

Surveillance épidémiologique

5. Secourisme

Comme dans CEBEC + transfusion, perfusion, traitement états de choc, traumatologie courante.

LOCALITE

2. Soins aux mères

- Modifier le comportement des femmes dans les domaines de la nutrition, des accouchemen.
- Réduire les problèmes de sant. qui se posent à la femme ence te et à son enfant
- Dépister le groupe de femmes encaintes présentant un risqu. élevé pour l'accouchement et les adresser aux centres de r. férence.
- Etudier et améliorer les cond tions de l'accouchement à domi cile.
- Superviser le travail des animatrices de PMI

3. Adultes

- Traitement des affections cou rantes selon schéma thérapeutique clair et standardisé.
- Référence à l'échelon supérie des affections plus compliquée

4. Maladies endémiques et chroniques

- Diagnostic de la tuberculose, maladie du sommeil, lépre, à confirmer au CS.
- Traitement ambulatoire et contrôle des cas.
- Dépistage secondaire
- Vaccination VAV et BCG

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	ZONE DE SANTE RURALE	SOUS ZONE DE SANTE RURALE	LOCALITE
		B. Développement communautaire - Programmation, coordination et supervision du DC dans les CEBEC - Formation des animateurs de santé et animatrices de PMI	B. Développement com Pour instaurer une d progrès dans les vil composent la localit dispose de : 1. Comités de développe dans chaque village 2. Animateurs de santé, de PMI 3. Comité de CEBEC, issu tés de développement; responsable de - la gestion du CEBE - la santé de la popul de la localité.
PERSONNEL	1. Idéalement 3 médecins, travaillant en équipe : a. Médecin-chef de l'hôpital général médecine interne et chirurgie courante b. Médecin-chef de la ZSR Supervision des formations subordonnées, des activités de santé publique et de DC c. Médecin-directeur de la formation Enseignement, cours de recyclage et de perfectionnement Un des trois sera médecin-chef de la ZSR, de préférence celui qui a la responsabilité de la santé publique et du développement communautaire 2. Personnel para-médical de niveau infirmier, infirmier-auxiliaire, et niveau auxiliaire	1. Deux infirmiers diplômés - un, diplômé en santé publique, dirige la SZSR et la formation des animateurs et animatrices - l'autre tient le CEBEC du Centre de Santé, assure les consultations ambulatoires, traite les cas référés par les CEBEC 2. Deux infirmiers auxiliaires au moins 3. Deux infirmières auxiliaires-accoucheuses au moins, formées aux techniques des naissances désirables: pour accouchements, consultations PMI au CEBEC du CS, formation des animatrices PMI, consultations naissances	1. Un infirmier auxili soins communautaires responsable du CEBE 2. Deux à trois auxili soins communautaire - aident au CEBEC - participent aux so taires - participent à l'as - assurent liaison e et village 3. Une ou deux auxilai nes de PMI - surveillance des so nels; - consultations présc ire - animation sanitaire 4. Receveur de recette - reçoit sommes v malades; - leur délivre une qu

ZONE DE SANTE RURALE	SOUS ZONE DE SANTE RURALE	LOCALITE
3. Personnel administratif - Médecin-chef de la ZSR (pm) - Administrateur-gestionnaire avec personnel - Infirmier-chef du BCZSR avec personnel 4. Personnel subalterne nécessaire pour l'administration et le fonctionnement. Le Conseil de gestion assure l'administration de la ZSR. Il est composé - des médecins, - de l'administrateur gestionnaire - du chef du Bureau Central - du Commissaire de Zone ou son représentant. Il se réunit une fois par mois et sur convocation par le médecin-chef de la ZSR	4. Deux ou trois auxiliaires de soins communautaires dont un tient le laboratoire du CS, 1(es) autre(s) remplit (sent) des tâches de médecine et DC, comme dans les CEBEC 5. Deux auxiliaires féminines de PMI assistent l'infirmière auxiliaire accoucheuse. 6. Secrétaire administratif -reçoit rapports des CEBEC -prépare rapports de la SZSR -assure correspondance	5. Planton - assure propreté, entretien bâtiments et environs, - les surveille la nuit, - transporte la correspondance
BATIMENTS Le logement du personnel travaillant à l'échelon central de la ZSR sera considéré comme prioritaire. On prévoira au moins 6 bureaux pour le personnel du BC de la ZSR et les services de l'administrateur gestionnaire, soit dans les bâtiments existants, soit dans des bâtiments à construire.	- Locaux suffisants pour abriter au moins 20 lits - Salle d'accouchement - Petite salle de traitement et de chirurgie - local pour le laboratoire - Local pr consultat. ambulatoires - Local pour pharmacie - Magasin - Bureau pour infirmier chef SZSR et secrétaire administratif - Logement pour personnel - Réservoir à impluvium - Village des femmes enceintes - Logement pr animateurs et animatrices en formation - Case de passage pr médecin-chef ZSR et équipe	- Là où la création d'un dispensaire se justifie, celui-ci devra être construit en matériaux locaux par la populati La construction dans un deuxième temps d'un bâtiment en matérieux durables devra se faire en collaboration avec ZSR, selon un plan unique p tout le Zaïre. Les bâtiments doivent être véranda pour les consultatio préscolaires et prénatales. Ils comporteront : - un local pour consultation - une salle de traitement - un local pour 5 lits d'observation - une pharmacie

	ZONE DE SANTE RURALE	SOUS ZONE DE SANTE RURALE	LOCALITE
			- un laboratoire - un local pour réc[illegible] registrement - un magasin pour e[illegible] des stocks d'arachi[illegible] soja, les vélos... - logements pour l'in[illegible] et sesauxiliaires
MOYENS DE LOCOMOTION	- Au minimum deux véhicules à quatre roues motrices dont un a disposition du médecin-chef de la ZSR plus un stock de pièces détachées.	- Une motocyclette - Une bicylette-ambulance (à mettre au point selon modèle inventé au Nord-Vietnam) - Trois vélos au moins vendus par ZSR au personnel à prix inférieur au prix coûtant; indemnité payée mensuellement pour couvrir frais d'utilisation et d'entretien.	- Trois vélos vendus [illegible] personnel à prix in[illegible] prix coûtant; indem[illegible] mensuellement pour [illegible] frais d'utilisati[illegible] tien.
FINANCES	- Etat paie salaires personnel médical formations publiques et agréées. - Etat accorde crédit global pr paiement personnel auxiliaire engagé par ZSR. - Système d'autofinancement pr achat médicaments, matériel, frais de fonctionnement, grâce à tarif standard pour tous médicaments (traitements endémies et vaccinations sont gratuits) et soins préventifs. - Le comptable de la ZSR tient les comptes de la ZSR, vérifiés mensuellement par l'administrateur-gestionnaire et présentés au Conseil de gestion.	- Personnel SZSR tient comptabilité simple des recettes et dépenses des CEBEC; - Les recettes des CEBEC sont versées mensuellement au CS - Le chef de la SZSR verse les recettes mensuellement, après vérification, au comptable de la ZSR, déduction faite des petites dépenses autorisées, afin de couvrir le montant des réquisitions.	- Infirmier du CEBEC [illegible] recettes des - consultations ord[illegible] - consultations pr[illegible] - consultations pr[illegible] - programmes d'ass[illegible] dans journal de c[illegible] fié chaque semai[illegible] firmier auxiliair[illegible] - Recettes versées [illegible] ment à la ZSR, vi[illegible] une partie peut êt[illegible] au Comité CEBEC [illegible] projets locaux de [illegible] ment. - Entretien des bâ[illegible] struction de nou[illegible] est prise en cha[illegible] avec particip[illegible] [illegible]

	ZONE DE SANTE RURALE	SOUS ZONE DE SANTE RURALE	LOCALITE
RAPPORTS	BC établit annuellement rapport synthétisant ensemble activités ZSR; approuvé par Conseil de gestion, envoyé au CNSBE par le canal du médecin sous-régional et du médecin inspecteur régional.	SZSR reçoit mensuellement rapports du CEBEC SZSR envoie trimestriellement au BC de la ZSR : - rapports des CEBEC - rapports démographiques - propre rapport	Infirmier du CEBEC [illegible] à l'occasion de ses vis[illegible] diques les rapports [illegible] expédie mensuellem[illegible] à la SZSR, tient à [illegible] des responsables de la su[illegible] vision un cahier dans le[illegible] consigne ses activités j[illegible] lières, problèmes et diff[illegible] tés.
APPROVISIONNEMENTS	Administrateur gestionnaire envoie commandes semestrielles ou trimestrielles au DCMP, selon les besoins et fonds disponibles.	Chef de la SZSR envoie réquisition trimestrielle, sauf urgence, au BC de la ZSR.	Infirmier du CEBEC envoi[illegible] quisition mensuelle au C[illegible] de Santé; reçoit les médi[illegible] ments de la SZSR, l'équip[illegible] directement de la ZSR, fou[illegible] mensuellement les médicam[illegible] aux animateurs et a[illegible]
SUPERVISION ADMINISTRATIVE	-Personnel administratif supervise mensuellement comptabilité de chaque SZSR -Service des Finances de la Sous-Région supervise trimestriellement comptabilité de la ZSR.	Chef de la SZSR supervise mensuellement administration et finances des CEBEC	
SUPERVISION MEDICALE	Personnel administratif visite mensuellement chaque SZSR et trimestriellement chaque CEBEC, en compagnie du chef de la SZSR. Les médecins organisent régulièrement des cours de recyclage et de perfectionnement pour le personnel parareédical de la ZSR.	Chef de la SZSR supervise mensuellement activités médicales et développement de chaque CEBEC, et tous les 3 mois chaque village. L'infirmier diplômé responsable du Centre de Santé supervise le personnel auxiliaire du Centre de Santé. Le Chef de la SZSR organise semestriellement une rencontre des infirmiers auxiliaires du CEBEC.	Infirmier du CEBEC [illegible] mensuellement activ[illegible] auxiliaires, du per[illegible] ministratif subalter[illegible] animateurs et animat[illegible] Infirmier auxiliai[illegible] supervise mensuelle[illegible] animateurs et animat[illegible] les villages.

1. L'[illegible]

a. La communauté de base n'a pas de "fonctionnaires" et de "personnel" sanitaires comme aux échelons supérieurs. Ce n'est pas une unité administrative du point de vue de la santé, mais un groupe social qui a choisi certains de ses membres pour devenir des animateurs de santé et des animatrices de PMI, en son sein, et prendre la responsabilité de la promotion de la santé au village.

b. Pour que leur action ne soit pas isolée mais constamment intégrée dans le développement communautaire, il est nécessaire qu'ils fassent partie tous les deux, du Comité de développement de la communauté villageoise.

c. Tous les membres du Comité de Développement (sauf le secrétaire-comptable, éventuellement) doivent être originaires du village et y résider. Le travail des membres du Comité est strictement bénévole. Cependant, on peut admettre que l'animateur de santé et l'animatrice de PMI soient dédommagés pour le temps qu'ils consacrent au service de la population. Cette indemnité, qui ne devrait pas apparaître comme un salaire, serait prélevée sur les ressources du Comité de développement, selon un barême fixé par lui.

2. Critères de choix des animateurs

a. L'animatrice de PMI doit :
- être une femme influente dans le domaine "des femmes et des naissances";
- avoir un ou plusieurs enfants;
- avoir des capacités d'animatrice (traits de personnalité, antécédents);
- résider en permanence dans le village;
- être proposée par l'ensemble des femmes du village et choisis par l'infirmier-chef de la SZSR, après approbation de l'infirmier titulaire du CEBEC;
- avoir suivi avec succès la formation qui sera dispensée au Centre de Santé de la SZSR.

Il n'est pas indispensable qu'elle sache lire et écrire.

b. L'animateur de santé doit :
- avoir des capacités d'animateur;
- être capable de communiquer efficacement dans son milieu, sans être autoritaire;
- être originaire du village;
- résider en permanence dans le village et ne pas avoir de motifs apparents de le quitter dans un délai proche;
- savoir calculer, lire et écrire en langue vernaculaire;
- être marié, et, de préférence, avoir un ou plusieurs enfants;
- être proposé par l'ensemble de la population (en même temps que d'autres candidats) et choisi par l'infirmier-chef de la SZSR;
- avoir suivi avec succès la formation qui sera dispensée au Centre de Santé de la SZSR.

3. Formation des animateurs et animatrices

La durée totale de la formation, qui aura lieu au Centre de Santé de la SZSR, sera de un à deux mois. En fait il s'agit de plusieurs stages d'une durée variant entre deux et sept jours, entrecoupés d'interruptions de plusieurs jours, pour tenir compte du caractère bénévole de l'animation et des autres tâches qui incombent dans leur village aux stagiaires. Une session de reprise, de courte durée, pour les animateurs déjà formés, aura lieu une fois par an, au Centre de Santé.

a. L'animatrice de PMI est chargée des tâches suivantes :
- [illegible] sanitaire et nutritionnelle;
- éducation nutritionnelle intensive aux mères qui ont des enfants mal nourris;
- consultations prénatales et préscolaires;
- assurer la chimioprophylaxie de la malaria et certains traitements de longue durée aux enfants d'âge préscolaire et aux femmes enceintes;
- assister aux accouchements normaux et convaincre les femmes à risque de dystocie d'accoucher à l'endroit indiqué lors de la dernière consultation prénatale;
- soins aux nouveaux-nés;
- assainissement.

b. L'animateur de santé est chargé d'appuyer l'animatrice de PMI dans ses activités d'éducation sanitaire et nutritionnelle. Des tâches de médecine curative ne pourront lui être confiées que progressivement. L'introduction soudaine de la "médecine aux pieds nus" présente trop de dangers dans un milieu déjà fortement prédisposé à la médecine curative, ce qui ne va pas sans de nombreux abus, comme la pratique générale des injections, médicamenteuses ou pas, par des amateurs très souvent vénaux et toujours irresponsables. Il serait pourtant très utile que l'animateur de santé soit progressivement mis en mesure de remplir les tâches curatives suivantes :
- soins d'urgence en cas d'accident;
- quelques actes médicaux simples, afin de soigner quelques maladies courantes et sans gravité, mais en se conformant strictement aux instructions du superviseur;
- assurer les soins aux malades chroniques référés par le CEBEC ou les traiter directement, selon les instructions reçues du CEBEC;
- contribuer à la détection rapide des maladies contagieuses graves;
- contribuer à l'évacuation d'urgence des personnes atteintes d'une maladie grave et aigue.

5. Administration

a. La supervision des animateurs et des animatrices est assurée par l'infirmier auxiliaire du CEBEC qui visite chaque village au moins une fois par mois
b. Leur approvisionnement est assuré par le CEBEC, une fois par mois;
c. Les recettes financières proviennent des soins que donne l'animateur, soins payables en fonction d'un tarif établi par la ZSR. A titre d'exemple:
- 5 K. pour le traitement d'un enfant d'âge préscolaire;
- 10 K. pour le traitement d'un enfant d'âge scolaire;
- 15 K. pour le traitement d'un adulte (ponctuels ou de plusieurs jours ;
- 50 K. pour un accouchement à domicile, assisté par l'animatrice de PMI.

Ces recettes sont gardées par le secrétaire-comptable du Comité de Développement. Les dépenses sont décidées par le Comité de développement et destinées à des activités telles que l'achat de ciment pour aménager une source ou construire des latrines communes, etc. Une somme est versée au CEBEC afin de renouveler la provision de médicaments de la boîte de secours.
d. Les rapports des Comités de développement des villages sont recueillis par l'infirmier du CEBEC à l'occasion de ses visites périodiques. L'animateur doit avoir un cahier où il consigne :
- la composition familiale de chaque ménage du village;
- les naissances et les décès, l'âge des décédés et la cause probable du décès,

[illegible] cahier [illegible] et [illegible] enfants, les venues à sa connaissance [illegible] toutes ses activités curatives. Si l'animatrice de PMI est illettrée ou si elle a des difficultés pour écrire, l'animateur de santé l'aidera à enregistrer ses activités.

6. Equipement

L'animateur ne dispose pas d'un dispensaire. Il fait les petits soins chez lui, à la maison. De la même façon, l'animatrice ne dispose pas d'une maternité.
Elle fait les accouchements à domicile des parturientes ou bien là où l'on a coutume de les faire.
L'animateur doit disposer d'une petite boîte de secours, dont le contenu varie suivant les conditions locales. C'est le médecin-chef de la ZSR qui décide à cet égard.

-=-=-=-

[illegible] the Health and Welfare [illegible]

[illegible] Policy Paper [illegible] the National Council for Health and Welfare of the Republic of Zaïre

1. A Revolutionary Decision

By creating the National Council for Health and Welfare, the Zaïre has become the fore-runner of countries planning policies for national integrated health and welfare programs. The revolutionary decision to create the National Council is in response to the ideal of humanism so often evoked by the President of the Republic

Until now, the political and administrative health care delivery structures in Zaïre were the heritage of a western system, which, in spite of its undeniably good intentions, had only managed to provide costly curative health care for the priviledged minority of the population. As a true Father of his Natin, the President of the Republic has always been very concerned with the improvement of the quality of life of his people, and the creatin of the National Council for Health and Welfare is yet another proof of his concern.

2. Preventable Diseases

2.1 A pathogenic environment and a weakened population

The struggle of the man in a developing tropical country like Zaïre is that of a deprived and weakened man against a pathogenic environment. The outcome of his struggle is either health and well-being, or sickness and death.

75% of the morbidity in Zaïre is caused by 10 diseases - all of which could be prevented. The high incidence of disease is due to the agressions and the inadequacies of the environment and to man's lack of resistance.

The environment is characterized by inadequate infrastructures for health and sanitation, the lack of water for drinking and washing, and the presence of specific diseases, such as malaria, tuberculosis, measles, venereal diseases, sleeping sickness, parasitic diseases, bilharzia, leprosy, goiter, and and extremely high incidence of road accidents.

Man's resistance is considerably weakened by malnutrition, [illegible] ignorance of the ways of fighting disease, and the poverty, [illegible] the absence, of his economic resources.

Malnutrition increases susceptability to disease. Disease brings on loss of productivity, weakness and more malnutrition. Insufficient nutrition is a major indirect cause of death, particularly in the most vulnerable segment of society - the under-five children and their mothers.

2.2 The multiple effects of disease on the development of Zaïre

The effects of a high morbidity rate are synergistic and far-reaching :

- the rate of infant mortality remains at over 150 per thousand and is subject to sudden and violent variations.
- a large proportion of babies are born prematurely - resulting most probably in a permanent lessening of their cerebral capacities.
- curative medical services are swamped with patients whose illnesses could be prevented, and the cost of their treatment weighs heavily on the Health budget. The demand for new and more expensive hospitals is ever-increasing, and satisfying this demand delays preventive measures which are vastly more efficient and less costly.
- the pace of economic development is slowed down due to the low productivity of the labor force, absenteeism and premature death.
- School education is adversely affected : the ability to learn, to imagine, to seek and to invent is impaired.
- the tourism potential of the country can be undermined if tourists fear contracting an exotic disease.

Constraints hindering the improvement of the health situation of Zaïrian people

The National Council is fully aware of the fact that it will not be enough to develop realistic programs and to put them into pr[illegible] [illegible] the health situation of Zaïre. Many constraints

3.1 An explosive population growth : [illegible] per year at the present time. It may well increase to 3% during the next ten years. Health planning must not only remedy the defficiencies accumulated during so many years, but also follow the population growth, before being able to anticipate it.

3.2 An acceleration of urban development : which is already high (30% of the population live in towns) and particularly fast growing (6 to 11% per year according to the town). In the future, this urban development can only increase. The health problems of rural populations are imported into the urban centers where they take on new dimensions because of a high concentration of the population in the poorer areas. This complicates the planning, financing and coordination of health care delivery systems and sanitation programs.

3.3 Management : The organism which, by law, was responsible for coordinating all health and welfare organizations in Zaïre, has, until the revolutionary decision to create the NCHW, been the worst equipped for doing so. In fact, huge functinal and geographic sectors had for years escaped the control of the Ministry of Health. Since no other health organization in Zaïre had the power or the means to be a substitute for the Ministry, health planning has never got beyond the stage of generalized statements. Moreover, the health centers in the public sector are very badly managed. Wastage, loss through carelessness, and particularly theft are widespread. The global and unit cost-effectiveness of health measures are generally unknown, as is the structure of health expenditures. This situation will be radically changed by the National Council.

3.4 Health personnel : In spite of the reform proposed in 1971, medical and paramedical education is still rigid and unsuited to the needs in this country. The present system produces mediocre doctors and practically unqualified nurses and auxiliaries. Training has always been oriented towards curative medicine and is essentially theoretical. Self-improvement and refresher courses are practically unheard of for paramedical personnel. The number of doctors is way out of proportion with the number of nurses and auxiliaries.

3.5 Salaries : The salaries of paramedical [illegible] working in the public sector are 2 or 3 times lower than those in the private sector. The best trained and the most competent therefore choose to work for private organizatins. In the public sector, inadequate salaries make way for venality and corruption.

3.6 Lack of data : A true demographic census of the population of Zaïre does not exist. The estimation of most studies varies considerably according to their source. Morbidity statistics are so piece-meal and inaccurate that they too must be considered inexistant. Statistics on hospital equipment are not kept up to date, and therefore show neither the true health potential of Zaïre, nor the problems of infrastructure. Medical census have been carried out here and there, but their results cannot be generalized for the nation as a whole. As a result, health planning has been committed to a steadily worsening situation, which the NCHW will remedy as soon as possible.

3.7 Location of health centers : It is estimated that 80% of the rural population of Zaïre have no access to a dispensary or hospital. This is due just as much to distance as to lack of transport. As for those people who manage to reach a medical center, they find them all too often without qualified staff or medical supplies. The absence of coordinatin between the public and private sectors (missions and industry) makes the patient's situation even worse. The NCHW will restore the vital unity between all sectors of health action.

3.8 Ignorance of the population - the causes of most diseases are unknown to the population, particularly those which are transmitted by water and faecal contamination. The same ignorance is rife where nutrition is concerned.

The Principle Goals of the National Council for Health and Welfare

4.1 Better health is a humanistic goal : Although it contributes to increased productivity, better health should not just be considered a means to this end. It is a legitimate goal in its own right - on the same level as a higher standard of education or a more profitable exploitation of natural resources. The price to pay for better health is a less advanced development of other possible projects.

To ensure the best use of budgets for health and well-being, the National Council will :

- establish a national policy for the development of standardized systems for health care delivery and for medical and paramedical education.

- achieve, through strict planning and management techniques, the maximum benefits possible from Government funds available, by always favoring the most efficient, most productive and least costly solutions.

4.2 The priority group of mothers and children

In a situation of explosive population growth, health planning must include not only the large numbers of the living, who have been neglected for so long, but also the ever-increasing number of children yet to be born. Health planning must therefore be directed at 5 groups : (1) pregnant women; (2) children under school age and their mothers, who are often also pregnant; (3) children of school age and adolescents; (4) productive adults; (5) old people. It is out of the question to exclude any one of these groups from health planning. However, with a better quality of life and general well-being as a primary goal, priority must be given to unborn babies, pre-school age children, and their mothers. For them, as for all the other population groups, the National Council will take the necessary action to lower the incidence of disease - especially those diseases which are known to be preventable and which are responsible for 7[illegible] of morbidity.

4.3 Preventive measures and better sanitation

The policy of a better quality of life clearly shows the choice made by the National Council for Health and Welfare in favor of : preventive medicine, a program of desirable births, and systems for water supply and sewage disposal for all towns and villages in Zaïre.

Curative medicine will not be ignored, if only because without it no preventive action will ever be accepted by the people. However, it will take second place to prevention. It will be regarded as an auxiliary discipline of preventive medicine - something to turn to when preventive measures are proved insufficient. This means that each time the National Council is faced with a health problem, they will give priority to preventive solutions. It is only if these solutions are not proved cost-efficient, that hospital curative medicine will be considered.

4.4. Priority care for communities

Increasing urban development in Zaïre means that big towns will get more and more over-crowded. The health situation in rural areas is also very serious. Therefore, the National Council plans to develop and finance health actions both for urban centers and rural areas. There is always a danger that big towns mobilize the majority of the available financial resources and health personnel to the disadvantage of smaller rural areas, who have difficulty in making known their desperate situation and priority needs. To avoid this risk, which would upset its planning and defeat its natinal policy, the National Council has decided that in the big urban centers of Zaïre, preventive measures will have priority over curative medicine. This means that no new hospitals will be built unless they meet a real and long recognized need. It also means that both in towns and rural areas, public health activities and personnel will be where the need is greatest - amongst the population in the villages for rural communities and in the poor areas for urban communities.

4.5 Rejection of the "medical status-symbol"

The National Council for Health and Welfare rejects the concept of the medical status-symbol projects which lead to actions being undertaken for reasons of prestige for the benefit of a priviledged minority. The big hospital complexes must in future justify their existance by implementing programs for community health, and for education of health personnel.

Thus, the changes that the National Council pledges to bring about in the areas of health and well-being are not simple reforms. They constitute a revolutionary transformatin of the whole health delivery system of Zaïre - including the restructuring of the existing systems of medical and paramedical education.

4.6 Training systems based on community health care

In the perspective of the humanistic philosophy of the MPR, the National Council for Health and Welfare considers that every man is responsible for the fate of the community in which he lives. Therefore, the basic community, urban or rural, becomes the starting point for all health and sanitation activities, instead of being the last in line as at present. The pillar of the new health personnel system is the community health promoter. The entire system of health training must be transformed and restructured to produce health personnel able to meet the needs of the communities, be they rural villages, or urban poor sections.

Health training will start within the community with the community health promoter, chosen by the members of the community themselves, and will work up through the grades of community health nurses, community welfare officers, and community health doctors, to health personnel in the big referral hospitals and teaching complexes.

Since the success of the new health care delivery system depends on health personnel, the restructuring of medical and paramedical education will be one of the first transformations [illegible] the National Council will undertake. [illegible] edu-

4.7 [illegible]

In all its health activities, sanitation programs and health personnel training systems, the National Council will strive to maximize benefits for the communities and to minimize unit and global costs. It will recommend the national use of standard treatments, using a limited number of drugs which can be mass produced in Zaïre itself. The National Council will impose the simplest and most cost-effective sanitation and water-supply systems, which can be rapidly developed to benefit the majority of the population. Health training will be carried out amongst the health consumers themselves - within the communities.

4.8 Pricing of health services

The National Council will develop a system of pricing curative health services, which, while providing extra funds for preventive measures, will direct the majority of health consumers to outpatient care. The cost of a visit to a community-based health promoter should be lower than the cost of a visit to a dispensary; this in turn should be less than the cost of a visit to a medical center. Finally, the cost of inpatient hospital treatment should be several times higher than outpatient treatment. A scale of charges will be fixed whereby the poor and underpriviledged segments of society pay minimal charges, while the salaried and priviledged sectors pay the cost-price of the care they receive, so helping to finance care given to the less fortunate.

4.9 Community involvement in programs for better health and living conditions

The National Council for Health and Welfare respects the wisdom, good sense and dignity of the Zaïrois people. It will always take into consideration the people's ability to develop their own community programs. Its work is to stimulate, encourage and back up the community's initiatives for improving their own health and living conditions.

is [illegible] that the community [illegible] financing and self-help labor, to the improvement of their own situation: house-hold and community sanitatin, village water supply systems. This involvement will increase the community's responsibility towards their own collective equipments and will facilitate maintenance and replacement. To enable financial participation, the National Council will favorize health and sanitation activities which are closely integrated in agricultural and artisanal projects. Priority will be given to food production and livestock breeding, which will not only bring in extra money to the community, but will also supplement the nutritional value of their food through increased calories and proteins.

Once the community masters its own resources, it will begin to consider better health as a benefit which it has worked to obtain and which is worth conserving.

4.10 Health promotion is a national and integrated activity

The well-being of the population of Zaïre does not only depend on the improvement of their health and sanitatin systems. It is very closely conditioned by a number of factors, such as housing, collective equipment, social centers, the promotion of Zaïrian women, adult literacy, help for the physically handicapped and the fight against poverty. All of these factors will be covered in national programs to be developed by the National Council for Health and Welfare.

Through the revolutionary policies of the National Council for Health and Welfare, founded on the ideal of community humanism taught by the President of the Republic, Zaïre will become one of the leading countries, whether developing or industrialized, in planning integrated programs for the well-being of its population.

The National Council for Health and Welfare considers that health promotion from within the community is the best way to significantly improve the health situation of the majority of the population. The Conseil Exécutif and the National Council commit themselves to this

AID 320-28 (1-72)

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 76 to FY 77
Total U. S. Funding $675,000
Date Prepared: Dec, 1975

Project Title & Number: HEALTH SYSTEMS DEVELOPMENT

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: Establishment of an integrated national health delivery system.	Measures of Goal Achievement: 1. increased access by Zairians through Zaire to health services. 2. Reduction in mortality and morbidity rates. 3. Desired Births program being implemented (This project will prepare basis for a family health services program, which in turn, will advance this goal).	1. Review of number of people receiving health services. 2. Evaluation of statistics compiled by the NHC and other health organizations. 3. Periodic on-site evaluations of services by GOZ, USAID and outside consultants.	Assumptions for achieving goal to gets: 1. A stable political situation. 2. Continued GOZ commitment to health services development. 3. Increased management capabilities and improved systems focused on actual delivery of health services to general population.
Project Purpose: Strengthening of GOZ institutional capacity to deliver health services.	Conditions that will indicate purpose has been achieved: End of project status. 1. NHC structure capable of formulating and delivering improved health services countrywide. 2. Trained Zairian staff working on various aspects of health delivery. 3. Initiation of family health program through initial health zones.	1. Annual reports of the National Health Council. 2. Joint AID/GOZ evaluations. 3. Development plans of the National Health Council.	Assumptions for achieving purpose: 1. GOZ supports NHC plans for systems improvement plus development of Health Zones. 2. Timely GOZ authorization of adequate budgets. 3. Interested individuals and communities support the establishment and operation of services.
Outputs: 1. Plans for improving a. Organization and administration; b. personnel system; c. vital statistics reporting d. logistics/maintenance system; e. Supply mgmt system; f. delivery of family health services through the Health Zones. 2. Trained staff integrated into new health administration. 3. Centers in initial Zones adequately supplied and equipped, and serving as models for replication.	Magnitude of Outputs: 1. Each proposed system improvement will have a specific written plan ready for implementation. 2. Each system improvement will be the responsibility of a specifically designated GOZ health official. 3. Each such official will have initiated authorized improvements.	1. Joint AID/GOZ assessment and evaluation of the project quarterly, annually and at its completion in CY 1978. 2. USAID records on participants. 3. Reports from the National Health Council. 4. Review of draft plans.	Assumptions for achieving outputs: 1. The GOZ supports NHC plan to proceed with health structure development. 2. The NHC provides the expected leadership and direction for new system. 3. The NHC uses consultants for its program and will assign trained Zairians to approved staff positions.
Inputs: AID 1. Technical services: Project Manager in health administration; ST consultant services. 2. Training: one year in PH planning and admin ST training courses. 3. Commodities and equipment in support of management plans and the first Health Zones. 4. Inflation Totals GOZ-Counterparts, administrative support operating expenses of 2 zones (minimum)	Implementation Target (Type and Quantity) FY76 $000 (mm) / FY 77 $000 (mm) / Total TA 30 (6) / 90 (18) / 120(24) 65 (13) / 140 (28) / 205(41) TR 13 (12) / 40 (36) / 53(48) 7 (6) / 10 (9) / 17(15) C 35 / 200 / 235 INF. - / 45 / 45 150 / 525 / 675 FY 76-115 ; CY 77 325	Review of AID project documentation and performance; review of GOZ/NHC budgets, staffing, and expenditures.	Assumptions for providing inputs: AID-suitable consultants can be located and assigned expeditiously proper training programs can be provided; proper commodities arrive when needed. GOZ-effective counterparts can be provided for administration; suitable candidates can be located for training.

PLANNED PERFORMANCE TRACKING NETWORK CHART

COUNTRY:	PROJECT NUMBER:	PROJECT TITLE:	DATE:	APPROVAL:
ZAIRE		HEALTH SYSTEMS DEVELOPMENT	DECEMBER 15, 1975 — ORIGINAL ☒ REVISION ☐	

CY 75 — CY 76 — CY 77 — CY 78

PROJECT ACTIVITY

1. PROJECT APPROVAL

   Submission of PP to AID/W
   Approval of PP
   Preparation and Signing of Proc. Ag.
   Selection Approval of Contractor
   Host Country Signature
   Initiation of Project

2. TECHNICAL CONSULTANT SERVICES

   Arrival in Zaire of Project Manager
   Delineate Work Plan
   Baseline Data Development for Evaluation
   First Consultants Arrive
   Plans Submitted in Key Health Areas
   Plans Reviewed, Modified, Approved by NHC
   Development of Basic Family Health Service Plan
   Specific Health Zone Plan Adopted by NHC
   Staff Selection/Designation Indicated in Plans

3. TRAINING

   Participant Training Plan Delineated
   FY 76 Participant Selection
   One Long-Term Participant Departs
   FY 77 Participants Selected
   Short-Term Training Begins
   FY 76 Participants Return
   FY 77 Participants Depart
   Additional Short-Term Training Established
   Final Participants Return

4. COMMODITIES

   First Commodities Ordered
   First Commodities Arrive
   Commodity Management Plans Developed
   First FY 77 Commodities Ordered
   FY 77 Commodities Arrive
   Second FY 77 Commodities Ordered
   Final Commodities Arrive

5. FOLLOW-THROUGH COMMITMENTS AND EVALUATION

   GOZ/NHC Establish Budget
   FY 77 New Proc. Ag.
   First PAR Prepared and Submitted
   GOZ/NHC Establish CY 78 Budget
   Negotiation and Signing FY 77 Proc. Ag.
   Special Evaluation
   Second PAR Prepared and Submitted
   AID Financed Project Manager Departs Zaire
   Third PAR Prepared and Submitted
   Progress Reports

6. FINANCIAL PLAN ($ 000)

	FY 76	FY 77
Technicians		
Long-Term	30	90
Short-Term	65	140
Training		
Long-Term	13	40
Short-Term	7	10
Commodities	35	200
Inflation	--	45
TOTAL	150	525

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