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660-0067

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PD-AAG-804-B1

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PROJECT REVIEW PAPER FACESHEET

TO BE COMPLETED BY ORIGINATING OFFICE

ORIGINAL

ADD

DELETE

PROJECT CODE

2

2. COUNTRY/REGIONAL ENTITY/GRANTEE ZAIRE 3. DOCUMENT REVISION NUMBER 2

4. PROJECT NUMBER 660-0067 5. BUREAU A. SYMBOL AFR B. CODE 1 6. PROPOSED PP SUBMISSION DATE MO. YR. 10/5/76

7. PROJECT TITLE - SHORT (STAY WITHIN BRACKETS) [ BASIC FAMILY HEALTH SERVICES ] 8. ESTIMATED FY OF AUTHORIZATION/OBLIGATION A. INITIAL FY 7/7 B. FINAL FY 7/9

9. SPECIAL CONCERNS CODE (MAXIMUM SIX CODES OF FOUR POSITIONS EACH) BR BU PVO EQ 10. SECURITY CODE

11. ESTIMATED TOTAL COST (\$000 OR EQUIVALENT, \$1 = 0.50)

PROGRAM FINANCING	FIRST YEAR			ALL YEARS		
	B. FX	C. L/C	D. TOTAL	E. FX	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL						
(GRANT)	( 1.2 )	( - )	( 1.2 )	( 3.7 )	( - )	( 3.7 )
(LOAN)	( - )	( - )	( - )	( - )	( - )	( - )
OTHER 1.						
U.S. 2.						
HOST GOVERNMENT	-	.6	.6	-	1.9	1.9
OTHER DONOR(S)						
TOTALS	1.2	.6	1.8	3.7	1.9	5.6

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

A. APPRO- PRIATION ALPHA CODE	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE	FY 77		FY 78		FY 79		ALL YEARS	
			D. GRANT	E. LOAN	F. GRANT	G. LOAN	H. GRANT	I. LOAN	J. GRANT	K. LOAN
PH			.8	.	.9	.	1.2	.	2.9	.
POP			.4	.	.3	.	.1	.	.8	.
TOTALS			1.2	.	1.2	.	1.3	.	3.7	.

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

To assist the Government of Zaire in the development of a model integrated health system based upon the urban and rural health zone infra-structure.

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

[X] Yes [ ] No

15. PLANNING RESOURCE REQUIREMENTS (STAFF/FUNDS)

TDY STAFF ON CONTRACT 3 MAN MONTHS \$23,500

16. ORIGINATING OFFICE CLEARANCE SIGNATURE: Fermin J. Spencer TITLE: USAID DIRECTOR DATE SIGNED: MO. DAY YR. 11/2/75 17. DATE RECEIVED IN AID/W. OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MO. DAY YR. 11/2/75

PROJECT REVIEW PAPER

TITLE: BASIC FAMILY HEALTH SERVICES IN  
RURAL AND URBAN HEALTH ZONES

PROJECT No.: 660-0067

CATEGORY: HEALTH DEVELOPMENT

PROJECT  
DEVELOPMENT  
TEAM W.E. POPP, R. ROBERTSON, AND  
G. COOK, USAID/KINSHASA  
Dr. D. NEWKIRK, Dr. B.L. McCULLOUGH, GOZ  
A. GETSON, Dr. G. CONTIS, MSCJ.

FISCAL YEARS  
PROPOSED FOR:  
FINANCING FY 1977 - 1979

I. PRIORITY AND RELEVANCE

A. Project Purpose

This project is designed to assist the GOZ in improving the availability and quality of basic family health services through the development of a regionalized health care delivery system in selected rural and urban health development zones (BFHS/HZ).

This project is phase II of a three stage project designed to develop and implement a system of basic family health services in rural and urban health development zones throughout Zaire. Phase I consists of the development of a detailed program plan as part of the AID-sponsored "Health Systems Development Project." Phase II, this project, will develop a series of pilot projects in selected health development zones and Phase III, utilizing primarily a sector loan as AID input, will consist of the expansion of programs developed in Phase II in other rural and urban areas throughout the country.

Specifically the primary objectives of this project are:

1. To reduce mortality and morbidity in all groups but particularly mothers and infants.

2. To test a method for integrating family health services in rural and urban settings.
3. To encourage desired births and decrease the necessity for multiple pregnancies to achieve desired family size.

The ultimate objective (when total country coverage is achieved) would be a permanent generalized improvement in the health status of the Zairians, especially mothers and children, and a reduced, stabilized population growth rate throughout the country.

Initially, objectives will be achieved through the provision of basic health services, including MCH and family planning services, in community health centers to be established in 3 pilot project rural health development zones (such as Kisantu, Uanga, and Bolobo) and 2 urban health development zones (such as Kinshasa and Kisangani). The total project period will be three years.

#### 1. Sector Goal Addressed

For USAID/ZAIRE, health has been selected as a mission sector of concentration. The BFHS/HZ project is directly relevant to this overall sector goal and is consistent with the current AID strategy of assisting the GOZ in the health sector.

Also this project is an integral part of other projects currently being considered and funded by AID. (Nutrition Planning, Endemic Disease, and Health Systems Management). It is expected that all health programs in the country will fall within the concept of rural and urban health development zones which is the primary focus of this current project.

#### 2. Relationship to Zaire's Overall Development Plan

##### a. National Development Plan

Information provided by the GOZ indicates that this project is relevant to the stated National Development Plan of Zaire. The four major development areas are health, education, transportation and agriculture.

Health planning in Zaire is in a basic stage of development. There are some encouraging signs of progress. In 1973, a "Ten-year Plan for National Health Services" identified the following objectives:

- 1) Reduction in major causes of mortality 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) Re-orientation of medical and paramedical training programs to produce manpower able to meet national health needs.
- 4) Creation of Medical-Social Centers for training and provision of health care in highly populated and high mortality areas supported by satellite centers and small rural units.

b. National Health Plan

More recently there has been a refinement of the Health Plan with the publication of a more detailed "National Health Plan - 1975-1980." This plan provides more specific direction than found in the earlier document. Included in the five year health plan are 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 birth (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 (leprosy, tuberculosis, measles, malaria, schistosomiasis, trypanosomiasis, and goiter) through a system of prevention and early case-finding, 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 para-medical personnel and for all health institutions (hospitals, pharmacies, etc.), including medical and para-medical 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 mortality (0-12 months) to a level of less than 50 per 1000 live births;
2. the reduction of child mortality to a level of less than 100 per 1000 children aged 1-4 years; and

3. the reduction of maternal mortality to a level of less than five deaths per 1000 live births.

Further support for the BFHS/HZ 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 maximum 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 permit also the control of our national development." President Mobutu recently (November, 1974) established the National Health and Welfare Council which is responsible for the development and execution of practical national health policies for Zaire.

c. Health and Welfare Manifesto

The newly established Council has indicated through its "Health and Welfare Manifesto" that priority will be given to the establishment of integrated health and social services with emphasis on preventive maternal-child health (desired births/nutrition). The Council is nominally headed by President Mobutu with membership comprising the Commissioner of State for Health; Director of FOMECCO; Commissioner of State for Education; Dean of the Medical Faculty, University of Zaire; and the Director of Presidential Medical Services. In practice, the Commissioner of State for Health, Dr. Ngwete, presides over the Council meetings and activities.

The purposes and functions of the Council are to coordinate, plan and implement health activities and health policy within Zaire. 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.

d. Plan for Urban and Rural Health Zones

In April of 1975, a task force of the National Health Council completed a plan for rural health development zones. A similar plan currently is being developed for urban health development zones. This BFHS/HZ program will be an integral part of both these plans. The urban and rural health development zone concept is discussed in more detail in a later section.

B. Background

1. Population Factors

Although the availability of current and accurate population data for Zaire is lacking, its 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 death rate is 20.5 per 1000, resulting in a corresponding growth rate of about 2.5%. This is a .5% increase from the 2.0% rate present in 1955. These figures indicate that the Zairian population will double in the next 28 years. This increase in growth rate is due to:

- a. the rising fertility among an early child-bearing population;
- b. high fertility among the women aged 20-29 and continuing high but tapering off after the age of 30; and
- c. possibly a decreasing mortality brought about by slight increases in new health measures in addition to improved agricultural methods.

Even if it were to maintain its present level of inadequate health services, Zaire will have to double the size of its present health system over the next 28 years 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 overall health care system is insufficient 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 status.

A study by the Office of the Presidency in the Kinshasa area 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 having such access.

2. Endemic Disease and Population Specific Mortality and Morbidity

The infant mortality rate in Zaire ranges between 150 and 200 per 1000 live births. Child mortality, including infants through five years of age, may be as high as 500 per 1000 persons. 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 staggering proportions. As in most LDC's, Zaire has endemic diseases which are rampant. Most major health problems can be attributed to the following diseases or conditions:

- a. general infections and parasites
- b. deficiency diseases
- c. 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.

### 3. Malnutrition

Much of the morbidity and mortality of the Zairian population can be directly attributed to malnutrition, particularly, protein deficiency. Although caloric intake is estimated to be 85% of the GAO recommended level, protein intake is only one-half or 35 grams of the recommended 70 grams per day.

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 peri-natal and infant deaths can be traced directly to maternal malnutrition. These two population sub-groups, already weakened by nutritional deficiencies, are further assaulted by the diseases indicated earlier, 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.

AID and GOZ are developing a Nutrition Planning Project (660-055) which should make a significant contribution to nutrition programming in Zaire.

### 4. Existing Health Care Administration and Resources

The National Council of Health and Welfare, established in November of 1974, serves as the national health planning body. It is responsible for developing national health care and welfare policies, setting national health priorities, formulating and implementing programs in health care and education, and preparing and supervising the budgets for all public health programs and health manpower education. The Council has overall administrative control of and is responsible for assuring coordination of all national health activities.

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 and efficient nationwide health care delivery system, its major orientation to date has been urban centered. Currently it operates the 1800 bed Mama Yemo Hospital in Kinshasa and 100 bed rural hospital

at Bolobo which has an auxiliary nurses training school. FOMECO also operates two maternal/child health centers, the Institute Medical Tropical laboratory, and a hospital ship.

There is a unique relationship among officials of the National Health Council, the Ministry of Health, and FOMECO. The President en Exercise of the National Health Council is the Minister of Health; the Executive Vice President of the Council is the Director of FOMECO; and the Secretary of the Council holds the position of Director of Presidential Medical Services, as well as being President of the Board of Governors of FOMECO.

Those responsible for making policy decisions, clearly, are in the senior executive positions necessary to execute policies through the operating agencies.

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) widely spread in rural and urban areas.

Significant among the current health care providers are the religious missions (Catholic and Protestant) which have been providing some services in many rural areas throughout the country. The missionaries maintain many facilities such as hospitals (95); maternity dispensaries (258); general dispensaries (328); TB sanatoria (2); and leprosaria (10). The missionary health activity has been a significant factor in the provision of service to the rural Zairian population. 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. With the formation of the National Health Council, the first government policy paper put out by the National Health Council had major input from the best of all missions. From the administrative point of view, the problem of coordination is no longer present.

5. Maternal-Child Health and Family Planning Services

The GOZ has given first priority to the creation of a national 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. For example, zonal health centers (health sub-zones) developed under this project, will have a maternity unit where, in addition to obstetrical services, there will be adequate family planning educational and clinical services. Also pre-and post-natal services will be provided.

Major MCH/FP activity has occurred through FOMECA with the MCH/FP program established at the Mama Yemo Hospital (MYH). Coverage under this program has been expanded in a decentralized fashion through the AID-sponsored pilot MCH/FP (660-049) program begun in 1972.

In addition to the services provided through the FOMECA 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. To date, many of these efforts seem to be uncoordinated, diffuse, and, in many instances, unidentified, let alone measured. The current MCH/FP project is now in its final phase (FY 1976) and has revealed and tested, on a pilot basis, some of the requirements for a coordinated service delivery network.

6. Family Planning Role

Zaire is traditionally pro-natalist; however, the need for, and value of family planning has been officially recognized by the President and the GOZ through the creation of the Desired Birth Council (Ordinance No. 73-089). This Council is directly under the National Health Council which has appointed its officers. The family remains the most important unit of the Zairian society, and in the Bantu philosophy, the main purpose of marriage is procreation. This concept is slowly modifying.

7. Manpower Resources

The planning and implementation of the current MCH/FP project has been affected by the severe shortage of qualified medical and paramedical personnel in Zaire.

After independence, there was a major exodus of skilled expatriate medical personnel, especially physicians and nurses, which left the country virtually unprepared to handle its own health care. The Zairian health manpower supply still contains a significant number of expatriates, although there has been an increase in the number of Zairian health personnel during the past years.

Despite improvements in the health care system, coverage is still far from adequate. There is a significantly higher physician to population ratio in urban areas, as compared to rural areas. For example, it is estimated that 60% of all doctors are practicing in regional capacity, about 2/5 of all doctors in Zaire are located in Kinshasa. In contrast, 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 of whom were located in Kinshasa. Still, in some hospitals, there were, in fact, no doctors at all.

Although at the present time emphasis in medical education and post-graduate medical training is still heavily oriented to curative medicine, this policy of the Council has already been implemented by the training of 3 physicians in public health, under the MCH/FP project, and the creation of a Department of Community Health which is developing an entirely new approach to the delivery of health care. In addition, the Minister of Health is also the Professor of Public Health. It is critical that a cadre of Zairian doctors be created with a recognized career structure and training program which will prepare them for work in zonal community health programs.

#### 8. Health Manpower Training Needs

The primary problem seems to be in the numbers of different categories of health personnel required and the distribution of these needed personnel. Significant numbers of persons must be trained and retrained, and equally important, they must be stationed in areas where there is greatest need.

The large scale exodus of expatriate health personnel during the 1960's left a major gap in the personnel qualified to practice medicine. At independence, when the Belgian government began to

depart, there was not one trained Zairian physician. 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. Some physicians have received inadequate education, in some cases irrelevant to the current needs of Zaire. These problems are being attacked by the GOZ. 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, the Senior Nurse in Community Health Nursing in FOMECO, and the Director of Nursing at the University is working with this problem.

Thus, there is a real need to retrain existing nurses. The National Health and Welfare Council is addressing itself to revising nursing school training, and specially to retraining existing nurses with emphasis on community medicine.

The religious missions operate 34 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 FOMECO and its program at the Mama Yemo Hospital. Specific MCH/FP training has occurred through AID-sponsored programs with the ORT organization.

### C. The Concept of the Urban and Rural Health Zones

The new system for delivering medical services was devised by the National Council for Health and Well-Being 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. There are, then, huge geographic gaps in medical coverage.

The new health delivery system will attempt to overcome that problem. The entire country will be divided into sections called Health Zones (Urban and Rural). In March, 1975, the National Health Council formed a workshop of doctors and nurses, who had had 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" has been drafted and will serve as the blue-print for the development of the initial pilot project rural health zone. A similar document is in preparation and will serve as a blue-print 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. These rural health zones would, in turn, 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 preventive and curative medical functions. Localities (5000 population or about 10 villages) will be served by nursing and auxiliary 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), and general hospitals will provide overall medical care to the group of sub-zones which comprise the Rural Health Zone (50,000 - 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 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:

1. In the Rural Health Zone, the hospital will have three doctors. They will have the responsibility for the direction of the hospital, the Rural Health Zone, and training. There will also be a need for paramedical personnel, administrative personnel and support personnel.
2. 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 and see patients); two nurses' aides midwives trained for the program of desired births; two or three community health aides; and an administrative secretary.
3. In the Community Welfare Center, the ideal staff will consist of a nurse's aid trained in community health, with two or three assistants, one or two women to instruct and consult mothers and pre-school children; and one handyman to over-see the buildings and grounds.

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 principle of desired births.

Likewise, facilities and equipment get progressively more complete and sophisticated as one goes from the village to the hospital.

Each Rural Health Zone is governed by a Managing Council comprised of the doctors, managing administrator, and the Commissaire du Zone or his representative. The groups will 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 five Rural Health Zones by the end of 1976-77 and 25 by the end of 1979. In principle, all of Zaire will be blanketed by the system of Rural and Urban Health Zones.

## II. PROJECT DESCRIPTION

### A. Project Overview

The Republic of Zaire is divided into 9 regions, each of which is further subdivided into rural and urban administrative zones. It is proposed that these political and economic zones also form the basic unit for the restructuring of Zaire's health care delivery system.

On the proposed project, AID will assist the GOZ in establishing and operating up to 2 model health zones in urban areas and up to 3 model health zones in rural areas. This project will be for three years.

The services to be provided in the hospitals and health centers in each zone will represent the complete spectrum of curative and preventive care, and will be available to adults and children alike. The health care delivery system will be based on a referral system starting at the community level and the animateur or outreach worker. The next higher level of referral will be to the community health center which will serve approximately 7,500 people. More complicated health care will be referred upwards to a health center-maternité and above that to the zone hospital which may or may not be within the health zone.

The GOZ intends to apply several principles in operating these urban and rural zones:

1. Coordination of medical activities from all sectors (government and private) within the zones.
2. Retraining and training of health personnel on a regular basis.
3. Regular supply of drugs and equipment.
4. Regular supervision and support for health personnel in the zones.
5. Financing of the operating expenses through GOZ resources and patient fees.

To implement this project, capital and operating expenses will be required. In general, the GOZ is looking to outside sources for assistance with capital and initial expenditures (non-recurrent). These expenditures will be for:

- Erection or rehabilitation of buildings to be used for health sites.
- Retraining of existing personnel and training of new types of health workers.
- Initial medical supplies and equipment for the health centers at the various levels.
- Vehicles such as ambulances to transport patients to referral clinics, and jeeps for health care staff to visit the community.

Operating expenditures will be for:

- Health staff salaries including administrative, professional, and para-professional staff.
- Replenishment of drugs and equipment.
- Other direct costs such as gas, vehicle and building maintenance.

Because AID support is being requested for the repair or construction of several health centers within a development zone, it is appropriate to include additional financial information for a typical rural zone. Although the budget categories may differ for urban zones, it is expected that the costs may be similar. Figure 1. illustrates a typical budget and indicates the areas of anticipated financial support from AID and other donors.

#### B. Specific Program Description

The GOZ has already begun to set up one model urban health zone (Bumbu) in Kinshasa. It has plans to develop one more urban model health zone in Kinshasa by the end of CY 1976, and begin preparations to establish other health zones in other cities in Zaire in CY 1976.

Figure 1.

TYPICAL ZONAL BUDGET, RURAL AREA

(35 centers and 1 hospital, Population 200,000)

<u>Budget Category</u>	Amount and Anticipated Source of Revenue (in \$ U.S.)		
	<u>GOZ</u>	<u>AID or Other Donor</u>	<u>Self- Financed</u>
<u>Capital Expenditures</u>			
--Center Renovation \$1500 Center x 30 centers		\$45,000	
--Center Construction \$6000 Center x 5 centers		\$30,000	
Hospital Renovation/Personnel Housing		\$60,000	
Training Facility Construction		\$10,000	
		<u>\$145,000</u>	
<u>Vehicles</u>			
--2four-wheel-drive vehicles		\$14,000	
--other vehicles - motorcycles and bicycles		\$ 8,000	
		<u>\$22,000</u>	
<u>Equipment</u>			
--Clinical Equipment \$1000 x 35 centers		\$35,000	
--Office Equipment \$200 x 35 centers		\$ 7,000	
--Audio-visual Equipment \$200 x 35 centers		\$ 7,000	
		<u>\$49,000</u>	
<u>Initial Medical Supply and Drug Costs</u>		\$50,000	
<u>Operating Expenses</u>			
<u>Personnel</u>			
--3 physicians @ 6000Z/Year	\$36,000		
--6 diploma nurses @ \$3,000/year	\$18,000		
--60 auxiliary nurses @ \$1200	\$72,000		
--1000 health auxiliary workers @ \$600/year	\$60,000		
Fringe Benefits	\$ 9,300		
	<u>\$195,300</u>		

<u>Budget Category</u>	Amount and Anticipated Source of Revenue (in \$ U.S.)		
	<u>GOZ</u>	<u>AID or Other Donor</u>	<u>Self- Financed</u>
<u>Supplies</u>			
--Drugs and Medical Supplies			\$150,000
--Office Supplies			\$ 8,000
			<u>\$158,000</u>
<u>Travel</u>			
			\$ 20,000
<u>Building Maintenance</u>			
			\$ 20,000
<u>Vehicle Maintenance</u>			
(Supervisory Visits)			\$ 20,000
<u>Training Costs</u>			
--Re-training, Auxiliary Nurse @ \$2,000/session x 2		\$ 4,000	
--New Training, Health Aux. 20/year		\$12,000	
--Animateur/Animatrice @ 40 / year		\$ 4,000	
--Nurse Auxiliary @ 20/year		\$10,000	
		<u>\$30,000</u>	
TOTALS:	<u>\$195,300</u>	<u>\$296,000</u>	<u>\$200,000</u>

Grand Total: \$691,300

In addition, the GOZ wishes to establish model rural health zones in three areas (Kisantu, Vanga and Bolobo) by the end of CY 1976. Three more rural health zones would be completed by the end of CY 1979.

YEAR	RHZ	UHZ	TOTAL
End CY 77	1	-	1
End CY 78	1	1	2
End CY 79	1	1	2
TOTAL	3	2	5

The specific inputs to be provided by the GOZ for this project include:

- Personnel to staff the various health posts.
- Salaries and administrative up-keep for the health staff.
- Operational costs for replenishment of drugs.
- Maintenance of vehicles, up-keep of buildings, etc.
- Ongoing training program.

It is proposed that AID provide funds for:

- The repair and/or renovation of approximately 100 health centers in the pilot rural and urban health zones and the construction of approximately 8 health centers. (Although the number of centers appears to be high, many of these units do not require much repair. Some may need only to be re-painted or to have a new roof. An average repair cost would be approximately \$1,500. Similarly, the construction of a new center would be a rather modest effort with an average cost of approximately \$6,000 each).
- Short-term and long-term technical assistance in such areas as data systems, logistics systems, audio-visual programs and training of Zairian trainers.
- Vehicles, including multi-purpose vehicles for referral of patients, and jeeps for health care personnel.
- Initial training costs for short-term out of country training of trainers and participants.
- Initial medical supplies and equipment.

The duration of the project will be for three years. It will be phased in gradually in keeping with GOZ manpower and funding resources.

AID's initial effort in each urban health area or rural zone will be focused on assisting the GOZ in the development and implementation of an effective supply and logistics system. The second priority area for support will be in training of the health care training staff.

Funding will be as follows:

- Commodities for medical supplies and equipment including support equipment.
- A project grant for technical assistance, renovation and or construction of demonstration health centers, participant training and in-country training.
- It is hoped that should there be evidence of significant progress with this project that there will be enough AID flexibility to move forward with arrangements for a sector loan.

C. Conditions Expected at the End of Project

1. A fully operational model health care system in up to 2 urban and up to 3 rural areas
2. Developed Zairian training expertise in the areas of family health care, with about 15 physicians, 300 nurses, 600 paramedical personnel and support and supply personnel trained.
3. An increase in understanding of basic health care and family planning in the Zairian context among 15% of the project populations.
4. A general receptiveness to the need for family health and family planning on the part of those Zairians in urban and rural areas, with at least 20% participation in that health care delivery system.
5. An effectively operating medical supply distribution network in 2 urban and 3 rural areas, including staff, vehicles, management systems and support equipment.
6. The establishment of a Bureau Central operational in each of the model rural and urban areas.

7. Increased coordination between GOZ health directives and private and public sector activities in each of the urban health areas and rural zones.

D. Critical Assumptions

The following assumptions are being made and are essential to the success of this project:

1. The GOZ will have sufficient financial resources to match the AID proposed funding.
2. The GOZ will have sufficient financial resources for on-going maintenance of the BFH/HZ program upon completion of the project.
3. It will be possible to recruit and train sufficient levels of health manpower to staff the proposed clinics and the staff will stay with the project after training.
4. There is the potential for developing the administrative management capability in the GOZ health system to effectively operate the developed system.
5. There will be a strong actual emphasis on preventive health.
6. The GOZ interest in family health is genuine.
7. The GOZ will actually allow the provision of family planning services and information to the public.

### III. AID AND OTHER RELEVANT EXPERIENCE

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).

Combining the delivery of several health services, such as maternal-child health with family planning, has been found to be particularly relevant in Africa for several reasons. While most new nations have some previous understanding of and appreciation for MCH or other curative programs, many countries are suspicious or apprehensive about family planning. Some see the control of rapid population growth as genocide, while others view it as a threat to an avowed pronatalist national policy.

AID-sponsored projects in Ghana and Nigeria, however, have shown that family planning is a sought-after service when placed in an MCH context. Furthermore, the dual delivery of these two forms of health care is reasonably inexpensive, and does not place undue strain on limited funding and manpower resources.

In addition to AID's general experience with similar projects, USAID/Zaire has been conducting a pilot project in MCH/Family Planning Services since 1972 (Project No. 660-11-531-049). This project of over a million dollars includes a contract with the American ORT Federation. The purpose of the existing MCH/FP Project is to assist the Government of Zaire to:

- establish a focal point and model for MCH/FP services in Kinshasa;
- develop plans for the staffing and operation of MCH/FP clinics and train local personnel to operate the clinics; and
- develop a network to distribute MCH/FP materials and information through personal contact and the use of mass media.

The existing project is now in its final year of funding. During this time, the following has been accomplished:

- Two (of a planned six) MCH/FP centers are operational, and two additional ones will be opened next year.
- A training program for paramedical MCH/FP personnel has been developed.
- 100 (of a planned 200) paramedical personnel have been trained.
- Medical guidelines for nursing techniques in the centers have been developed and are in use.
- A health services inventory is being conducted to identify existing MCH services in Kinshasa, and to pinpoint problem areas that require correction.
- Preliminary work has begun on the use of mass media for MCH/FP health education and motivation.
- A contraceptive distribution system has been implemented in two centers.

In addition to its positive accomplishments, the project has also identified several important problem areas in the delivery of health care that are particularly relevant to the proposed project. These include:

- The inadequacy of a categorical (i.e. MCH) health program to meet the health care needs of Zaire.
- The need for specific guidelines for the use of motivational mass media in health education campaigns.
- The constraints placed on program planning, implementation and evaluation by limited capability to collect and analyze data.
- The definite need for more health care and motivational efforts in any health care program in Zaire.

In summary, previous AID-supported projects in Africa and in Zaire have demonstrated the usefulness of combining maternal and child health with family planning services. Future health programs in Zaire, however, should be made a part of a more comprehensive health care system. USAID/Zaire believes that the implementation of the proposed family health project will be considerably easier because of the previous USAID experience in the MCH/FP project.

#### IV. BENEFICIARY

##### A. Beneficiary Population

The primary program beneficiaries will be both the adult and child population of selected rural and urban areas. Special emphasis will be placed on the maternal (women 15-35 years of age) and child (children 5 years of age or less) population. The maternal-child population in the project areas has been emphasized because of the serious health problems experienced by this group. These problems have been well-documented and are discussed in Section IB. Although the initial program beneficiaries will be persons in the selected rural and urban zones, it is expected that the ultimate beneficiaries will include persons outside these pilot zones (as programs expand).

Benefits will accrue to these groups upon completion of the various health centers (including equipment and supply procurement) in the BFHS/HZ program and upon completion of the needed staff training. The tentative time table for this project is included in Section VII Project Implementation. Benefits will spread from the initial to the ultimate target groups through the provision of additional financial resources.

There has been participation of the GOZ in the development of this plan. Knowledgeable health personnel having experience with the target groups receiving services have acted as patient representatives. Further patient involvement in the planning of these projects is possible should the need arise. The relative success of current clinical programs at the Mama Yemo Hospital and of satellite projects such as pilot MCH/FP project is evidence that this project is responsive to the expressed needs of the Zairian population. Clinic attendance in current centers is increasing, and patient acceptance of service is very high.

##### B. Social Soundness Analysis

###### 1 Societal Factors

The adaptation of Zairians from a traditional to a modern lifestyle is becoming evident, the President's speech on "desired births" being an indication of this

The growing urbanization, the increased industrialization of the country, and the development of a money economy are all factors in the transition.

The decline in kinship groups and the nuclear family, though most prevalent in the cities, is now beginning to reach the rural areas.

The rural area attitude of "letting nature take its course" is also dying out. As mentioned before, people are migrating to the city to find employment. Migration may well account for the fact that Zairians are marrying outside their ethnic groups. In addition, divorce rates are increasing and the general family structure is weakening.

However, when family planning is tied with a program of more comprehensive health care, there is every reason to believe that this will lead to a greater appreciation of each individual's role in the maintenance of good health.

Comprehensive health care given by physicians and medical auxiliaries in Zaire is demonstrating to the people that their government cares enough about their well being to do something about it.

## 2. Communication Factors

Radio and television is assuming an increasingly important role in communicating health care to the Zairian population. This can be an important source of education for health and family planning efforts.

Language, however, is somewhat of a barrier. Though French has been adopted by the GOZ as the official language, not all of the Zairian population speak it or understand it. In various educational efforts, it does not seem likely that French will replace the local dialects (20 - 30 of them) used by most people. For this reason, health education efforts, particularly in rural areas, will be hampered.

### 3. Environmental Factors

The GOZ is extremely sensitive to the ecology not only as an national asset but also as a factor in the health of its people. Potable water and an effective sewage system are critical needs and these problems are being addressed by the government with expert help from the World Bank and other multinational organizations.

### 4. Political Factors

Historically, Zaire began to enjoy political calm in 1965, at which time then Lt. Gen. Mobutu Commander-in-Chief of the National Army became President.

Zaire adopted a formal Constitution in 1970. The following year President Mobutu replaced the Belgian name "Congo" and declared the Second Republic of Zaire. Moreover, to create a sense of national identity, he introduced a new flag and national anthem. President Mobutu initiated a movement to valorize authentic African culture and to provide authentic African solutions to African problems.

The Constitutional changes of 1974 established a formal governmental structure. Zaire now has a one-party, presidential type system, with the MPR (Popular Movement of the Revolution) being the political arm. Also under the President is the Legislative Council and the Executive Departments.

Since President Mobutu's emergence into power, the U.S. has enjoyed a good cultural, commercial and educational exchange with Zaire. Through 1974, total U.S. bilateral economic and military aid to Zaire has been \$500 million. An aid package of \$60 million is currently being considered by the U.S. Congress, in order to offer assistance to a country on which the United States places much importance.

### 5. Summary

A number of social factors presently undergoing profound change will play an important role in the success or failure of this proposed project. The introduction and expansion of health services will be occurring at a time when Zairian social values are themselves in a

state of transition. The expansion of curative services, the acceptance of preventive services for mothers and children, and the practice of family planning will affect further changes. In a complex and dynamic situation such as this, it would be difficult to predict the ultimate changes that would occur in the beneficiaries' lives.

C. Role of Women in Zaire

In Zaire, preference is given to males for education and employment, as cultural and religious traditions dictate that girls should stay at home to help their mothers. This is changing, as this is one of President Mobutu's major interests. The GOZ now recognizes the need to educate women in the areas of better health care for themselves and their families. However, in many areas of Zaire, less exposed to health and family planning information and services, women do not have much interest in areas other than housekeeping and child rearing, in addition to the agricultural work they must do.

The answer is not simply to offer better methods of health care and family planning alternatives to women in urban and rural districts. Rather, more emphasis should be given toward training Zairian women so that they may better communicate to their own countrywomen the knowledge which will insure the proper health care for their families. This project should make a contribution in this area because of the role women will have in providing services. For example, many of the project health centers will have women MCH/FP workers (Animatrices).

The emerging expanded role of women in Zaire has been recognized by President Mobutu. His recent appointment of Mrs. Mobutu to head the Committee of Social Works is evidence of his support. This committee is currently reorganizing the Department of Social Welfare.

## V. FEASIBILITY ISSUES

### A. Economic Feasibility

Comprehensive health care services combine preventive care measures with curative services for all groups. As such, they are generally more expensive to implement and operate than preventive health care programs. In comparison with either preventive or curative services alone, comprehensive care is perhaps more readily accepted by a target population, and specific data regarding patient utilization, costs and effectiveness can more readily be generated.

The components to be financed in a comprehensive health care project are:

- personnel
- participant training
- supplies and equipment
- buildings
- operational costs

There are several issues regarding the economic feasibility of these components of the project that must be considered. The first is related to the availability of Zairian personnel for the project. While there should be no great difficulty in finding U.S. technicians for the training aspects of the project, there will be some problem in recruiting skilled Zairian professionals and paraprofessionals for the clinic operations. Health professionals are in short supply in Zaire, and health paraprofessionals have a high turnover rate in related projects. To cope with the problem of manpower shortages, the proposed project will be able to draw upon the training experience (including curriculum and materials) from the present AID sponsored MCH/FP project.

A second issue relates to the cost of construction or renovation of the proposed clinic facilities. In the urban areas, suitable buildings should be readily available for renovation. Furthermore, efforts will be made to use existing health facilities, particularly in rural areas, even though it is understood that many are in disrepair.

A third economic factor to be considered is the cost of equipment and supplies for comprehensive

programs. By and large, the equipment (examining tables, lights, etc.) required is relatively simple and inexpensive, and the supplies (i.e. drugs, contraceptives, vaccines) are easily available.

The recurrent operational costs should also be reasonably low. Once the initial capital expenditures are made, operating costs will be primarily for personnel salaries, supplies, maintenance, and some participant training. The GOZ feels confident that patients fees will help offset some of the operating costs.

AID's input into the project will be for technicians to advise in the establishment of the comprehensive health zones, for construction and renovation, for supplies, and for participant training. The GOZ's input will be for operating costs, for in-country training of personnel, and for travel related to participant training.

The key economic feasibility issue is whether the GOZ will be able to commit the required resources to initiate and maintain a project of this magnitude. In its preliminary negotiations with officials of the GOZ, USAID/Zaire has been reassured of GOZ's firm intention of moving ahead with the implementation of its integrated health care program and of providing the necessary input into the project.

#### B. Technical Feasibility

Existing studies have shown that developing countries, generally, and African countries, particularly, have a great need for integrated health care programs. The individual components of the program are already accepted. This demand for curative care in Africa has traditionally been unable to keep up with the supply. Many of the prevalent and endemic diseases of Zaire have and can be dealt with through carefully constructed maternal-child health programs. Furthermore, desirable birth services are wanted and accepted whenever they are offered.

The technology needed to implement an integrated health program has been worked out reasonably well. The component programs, such as vaccination programs for mothers and children have been conducted in most African countries including Zaire, with excellent results. Also, family planning services have been

introduced in several African nations with minor modifications to accommodate local needs. Contraceptive technology (pills, condoms, IUD's, etc.) is also appropriate to African nations. It is for this reason that this modest model project is of critical importance, for it will lay the groundwork for what will become the national health care system in Zaire.

Another key variable is the availability of a support unit to deal with maintenance, supply, and communications problems, including housing and transport.

The adverse environmental effects of the proposed program should be negligible. Instead, as the demand for curative care is met, and as certain communicable diseases and rapid population growth are brought under control, the overall effect on the environment will be positive.

#### C. Financial Feasibility

It is doubtful that the average rural or urban family will be able to afford the cost of the services it will receive through this project. This is so because of the relatively high initial capital expenditures in constructing the required facilities.

Once the clinics are established, however, some portion of the recurring operational costs (especially for supplies) can be recovered from patient fees. The experience of most missionary hospitals has been that a small fee for service helps ensure the continued participation of patients in their health care.

Revenue generated by patient fees will probably not be able to sustain the total ongoing operations of the integrated health system. The GOZ will be required to underwrite a substantial portion of the recurring costs. The part of the program supported by AID should gradually be assimilated into the overall health system. It is too early to tell what the total recurring costs will be once the program has been expanded from the presently proposed model stage.

## VI. OTHER DONOR COORDINATION

The area of health and family planning in Zaire is beginning to receive attention from other donors. The WHO is now participating in the planning of several projects, as have the IBRD and UNDP.

The World Health Organization has a program in Zaire and concentrates its efforts on five areas of activity - Development of Health Services, Communicable Disease Control, Smallpox, Training of Health Personnel and Manpower, and Fellowships. The proposed WHO budgets for the CY 1975, 1976 and 1977 are \$1,370,000; \$1,430,000; \$1,481,000 respectively. There are a total of 44 WHO personnel positioned for Zaire for the period 1974 to 1977. Approximately \$25,000 per year is spent on fellowships.

The IBRD and the UNDP have both expressed interest in the health sector in recent months. The IBRD carried out a water supply survey with WHO in selected areas of Zaire in 1973 and is considering a project in this field. At present, the UNDP does not have an active project in health in Zaire, but has proposed to spend approximately 2 million dollars in health activities for 1972-1976 if suitable projects can be identified. Within the Office of the Presidency, there is a newly formed Service du Plan funded by UNDP, working with a World Bank (IBRD) 8-person team. Part of its function will be to ensure that Zaire's health care program is integrated into the total national developmental effort.

Other assistance includes:

Denmark - Red Cross Hospital, Kinshasa  
China - Staff assistance in Kintambo Hospital  
France - Leprosy Control assistance

In 1973, 11% of the total Belgian assistance was for public health. The Belgian Technical Assistance Program spent \$550,000 in 1973 for trypanosomiasis and is expected to continue this funding.

Officials of the World Bank have recently completed a preliminary study of the feasibility of an MCH/FP project in Zaire. The proposed project would involve the support of services primarily in rural areas.

with some involvement in urban centers. Support is being considered for:

- construction
- equipment including vehicles
- manpower training
- technical assistance
- operational costs

It should be stressed that the World Bank proposal is in the preliminary stages of development only, and that there is no commitment from either side at this time.

The National Health and Welfare Council has the responsibility for coordinating the efforts of all donors.

A. AID Input

	<u>Title X</u>	<u>Health</u>	<u>Total</u>
1. <u>Personnel - Long Term</u>			
5 technicians @ \$80,000/ yr x 3 yrs		1,200,000	1,200,000
<u>Personnel - Short Term</u>			
36 Manmonths @ \$5,000/ manmonth		180,000	180,000
2. <u>Participant Training</u>			
Short term training for 3 Zairois each year x 3 years	20,000	40,000	60,000
3. <u>Commodities</u>			
Drugs, vaccines, order- ed supplies, contra- ceptives, family health kits, etc	530,000	320,000	850,000
Audio-visual Equipment	20,000	30,000	50,000
Clinic Equipment	30,000	120,000	150,000
4. <u>Other Costs</u>			
Rehabilitation/cons- truction of new or ex- isting health facilities and purchase of multi- purpose support vehicles	200,000	700,000	900,000
5. <u>Inflation Factor</u>		310,000	310,000
TOTAL	800,000	2,900,000	3,700,000

B. GOZ Input1. Personnel

Salaries and administrative expenses for all Zairois professional, para- professional administrative and support staff	\$ 1,384,000
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2. Training

In-country training for Zairois health personnel	\$ 75 000
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3. Operating Expenses

Maintenance of vehicles and buildings, replenishment of drugs, supplies, etc.	\$ 440 000
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Total GOZ Input	\$ 1,900,000
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Total Project Input	\$ 5,600,000
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Table I, on the following page, illustrates additional details on AID Inputs.

TABLE I  
AID INPUTS  
 (\$ 000)

	<u>FY 77</u>	<u>FY 78</u>	<u>FY 79</u>	<u>Total</u>
	<u>\$ MM</u>	<u>\$ MM</u>	<u>\$ MM</u>	<u>\$ MM</u>
A. <u>Technicians</u>				
Long Term	400 (60)	400 (60)	400 (60)	1,200 (180)
Short Term	60 (12)	60 (12)	60 (12)	180 (36)
B. <u>Participant Training</u>	20 (12)	20 (12)	20 (12)	60 (36)
C. <u>Commodities</u>	420 --	270 --	360 --	1,050 --
D. <u>Other Costs</u>	300 --	300 --	300 --	900 --
E. <u>Inflation</u>	-- --	150 --	160 --	310 --
	<u>          </u>	<u>          </u>	<u>          </u>	<u>          </u>
TOTAL:	<u>1,200</u>	<u>1,200</u>	<u>1,300</u>	<u>3,700</u>

## VIII. PROJECT IMPLEMENTATION

### A. Major Implementation Issues

#### 1. Site Locations

The initial project site locations will be Kinshasa and should be explored in Kisangani for the other urban areas and Kisantu, Vanga, and Bolobo for the rural areas. Other project sites may be considered but the specific locations are not yet known. It is expected that the project will involve each of the health zones in the areas mentioned above.

#### 2. Construction and Renovation

The construction - renovation of health buildings will be phased in according to the plan development for each zone.

#### 3. Equipment and Supply Procurement

AID will be expected to provide commodity support in terms of the following:

- a) Basic clinical equipment such as exam tables, sterilizers, lamps, etc.
- b) Selected basic medications including contraceptives for the initial project start-up in each project area. Long-term procurement and support is expected to occur in part through the establishment of a fee system.
- c) Ambulances and small transport vehicles for patients and project staff.

#### 4. Staffing

GOZ staffing will follow the pattern described in an earlier section (Section I.B.5).

AID staffing will consist of five long-term technicians. They will have expertise in disciplines such as the following:

- a) Health Administration
- b) Health Education with special emphasis on training.

- c) Data Collection and Analysis
- d) Health Systems Management
- e) Logistics-supply

These technicians will be under the technical direction of the GOZ. Administrative direction of the project would be the responsibility of the Mission's Chief of Public Health.

## 5. Training

Because of the scope of this project, there will be a need for increased training assistance for all levels of health personnel, physicians, nurses, animateurs, animatrices, community welfare workers, and other paramedical personnel. Training activity will emphasize "Training of Zairian Trainers" to enable the GOZ to eventually conduct its own training without the need to rely on outside assistance. It is expected that this training could occur through the use of outside short-term technicians initially, but that the GOZ will develop the capacity to conduct its own training.

Some short-term participant training is anticipated; however, the stress must be on programs of 3 - 4 months duration emphasizing specific on-the-job type situations either in the U.S. or in other developing countries.

AID will provide support for the initial project training activity as programs are established. On-going training programs will be the responsibility of the GOZ.

## 6. Project Negotiations

The GOZ is concerned about AID's long lead time, its paperwork requirements, and its lack of flexibility in the development and implementation of projects. USAID/ZAIRE is proposing that the project be phased in gradually over a three-year period at a pace set by the GOZ. USAID/Zaire is also willing to adopt a rather flexible funding strategy (see below) for the project in an effort to demonstrate its commitment to assisting the GOZ in meeting its health

care needs. This strategy will allow the GOZ to obtain significant amounts of medical supplies and equipment at the outset of the project, as well as technical assistance in setting up its logistics and supply systems. It is hoped that this initial input will help overcome some of the inertia observed at the beginning of most projects. USAID/Zaire believes that this strategy will assist it in obtaining GOZ assurances regarding the host country's inputs into the project.

#### 7. Funding Actions

USAID/Zaire proposes the following approach to funding its share of the project:

- Commodities assistance to be provided at the beginning of the project for the purchase of medical supplies and clinic equipment.
- A grant of \$3.7 million over a three-year period to cover technical assistance, participant training in the U.S., certain commodities, support equipment, and construction or renovation of health centers for the health zones. It is anticipated that POP monies will be utilized primarily for commodity assistance such as contraceptives and family health kits; however, it is projected that approximately \$400,000 will be used to contribute to the construction and or renovation of the MCH units of the proposed health centers.

#### 8. Program Monitoring and Review

The US/GOZ personnel will be responsible for developing an evaluation plan for their part of the project within six months of the initiation of the project's activities. Thus, the Logistics and Supply Technician will draw up an evaluation plan for reviewing the project's accomplishments in supplying the health facilities with drugs and equipment. Similarly, the Administrative Officer will be responsible for creating an evaluative method for monitoring the construction/rehabilitation aspects of the project.

9. Logistical Support

This project will not require that any additional USAID staff be added to the Mission.

10. Program Evaluation

Quarterly progress reports will be prepared jointly by the US/GOZ counterparts and submitted to USAID/Zaire and the National Health Council. It is anticipated that there will be a need for a special project review team to assess the effectiveness of the project after a sufficient amount of time has elapsed, possibly after two years.

11. Project Closeout

This project is intended to serve as a model upon which a national family health care program can be built, using the urban and rural zone infrastructure. The GOZ is not interested in undertaking a long academic experiment to identify all the fine details that will go into a national health program. Instead, it wishes to gain experience in the pragmatic problems that it will face as it seeks to expand its health care services to all its people. Thus, the three year period for this project appears to be a definite goal of the GOZ.

Within this three year "model" project framework, USAID's inputs for technical assistance and short term participant training have a predictable and specific end point. The remaining USAID input of supplies and construction/renovation expenditures are one time only costs. The GOZ is committed to underwriting the operational costs for the model health care zones. Thus, at project closeout, the GOZ should be totally responsible for the on-going implementation of the project.

B. Program Management Considerations

1. Development of Program Management Structure

One of the technicians will be the coordinator and will be responsible for administrative matters related to the contract. Administrative direction of the project would be the responsibility of the Mission Chief of Public Health. The technicians will receive their professional direction from the GOZ.

The project itself could be operated in one of three ways:

- a. As an operational project of the Mission using USAID Technicians for the five technical assistance positions.
- b. As a USAID contract to a private institution or firm that would supply the technicians.
- c. As a host country contract with a private firm or institution that would supply the technicians, or with individuals.

The provision of commodities would be according to the usual AID procedures, as would the supervision and review of any construction/renovations.

## 2. Assignment of Major Program Responsibilities

### a. AID Responsibilities

The Mission's Chief of Public Health will have the administrative responsibility for the project.

### b. Host Country Responsibilities

The project preparation, implementation, and evaluation will be through the National Council of Health and Welfare. The Council's organization has been described in an earlier section of the PRP (Section I).

GOZ management responsibilities will be assumed by a Program Coordinator assigned by the National Health and Welfare Council.

## 3. Assessment of Host Country Agencies

As with most developing countries, Zaire has a shortage of trained personnel and resources. During the past several years, Zaire has been taking steps to correct its deficiencies in health care.

To deal with these important problems, a National Council of Health and Welfare has been created to develop national health care policy and plans. This key organization, working

together with the Department of Health, is responsible for overseeing the expansion of Zaire's health care system. This expansion, through the rural and urban zone infrastructure, is one of the first health plans to emerge from this organization. While the staff within these agencies is not large, there are several highly skilled and dedicated professionals who are committed to giving this proposed model the resources and personnel support that will be required.

4. Anticipated Problems or Issues Related to the Development of the Project Paper

The following problems/issues will require resolution before a Project Paper can be prepared:

- The identification of the initial rural and urban zones in which the project will begin functioning.
- The identification of the GOZ staffing patterns for the health system to be introduced into each zone.
- The assessment of existing facilities in each zone, and the extent of new construction or rehabilitation that will be required.
- The identification of medical and contraceptive supplies that will be needed, as well as the clinic equipment that will be required.
- The exact organizational entity within the GOZ which will have responsibility for this project.
- The nature of the GOZ commitment of resources and supplies.
- The phasing-in of the project and the schedule of project implementation over the three-year project period.
- The definition of specific project goals in terms of services delivered, health systems established, construction/renovation accomplished, etc.

The identification of data needs, and an assessment of the GOZ's capability to collect, process, and analyze project data.

Given the magnitude and complexity of this proposed project, it would appear reasonable to schedule sufficient time for the development of the Project Paper (30-45 days) and to involve several professionals (health systems specialist, logistics specialist, public health physician). The Mission's Public Health Officer will supervise the preparation of the project paper in coordination with the GOZ.

## IX. PROJECT DEVELOPMENT SCHEDULE

### A. Pre-Authorization Work

PRP submission to AID/Washington: Nov. 15, 1975  
 Revision Submitted : Dec. 15, 1975

PRP approval : Jan. 15, 1976

Identification PP Team : Feb. 15, 1976

Preparation of PP : March 15 - May 15, 1976

Submission of PP to AID/Washington : May 30, 1976

Approval of PP : July 30, 1976

Approval of ProAg : September 30, 1976

Identification of Project contractor/AID staff:  
 November 15, 1976

Initiation of Project:\* January 1, 1977

### B. Studies Required for Preparation of Project Paper

It is the intent of the GOZ to use this project as a model upon which to expand its national health care system. Before embarking on this project, however, it would be wise to make some preliminary assessments as to what resources a national health care program in Zaire would require in the near future. Thus, it would seem appropriate to perform an economic analysis and feasibility study of the resource requirements for a national health program before the Project Paper was prepared. A study of this type would probably involve 1-2 man months of professional work.

### C. Resources Required for Preparation of Project Paper

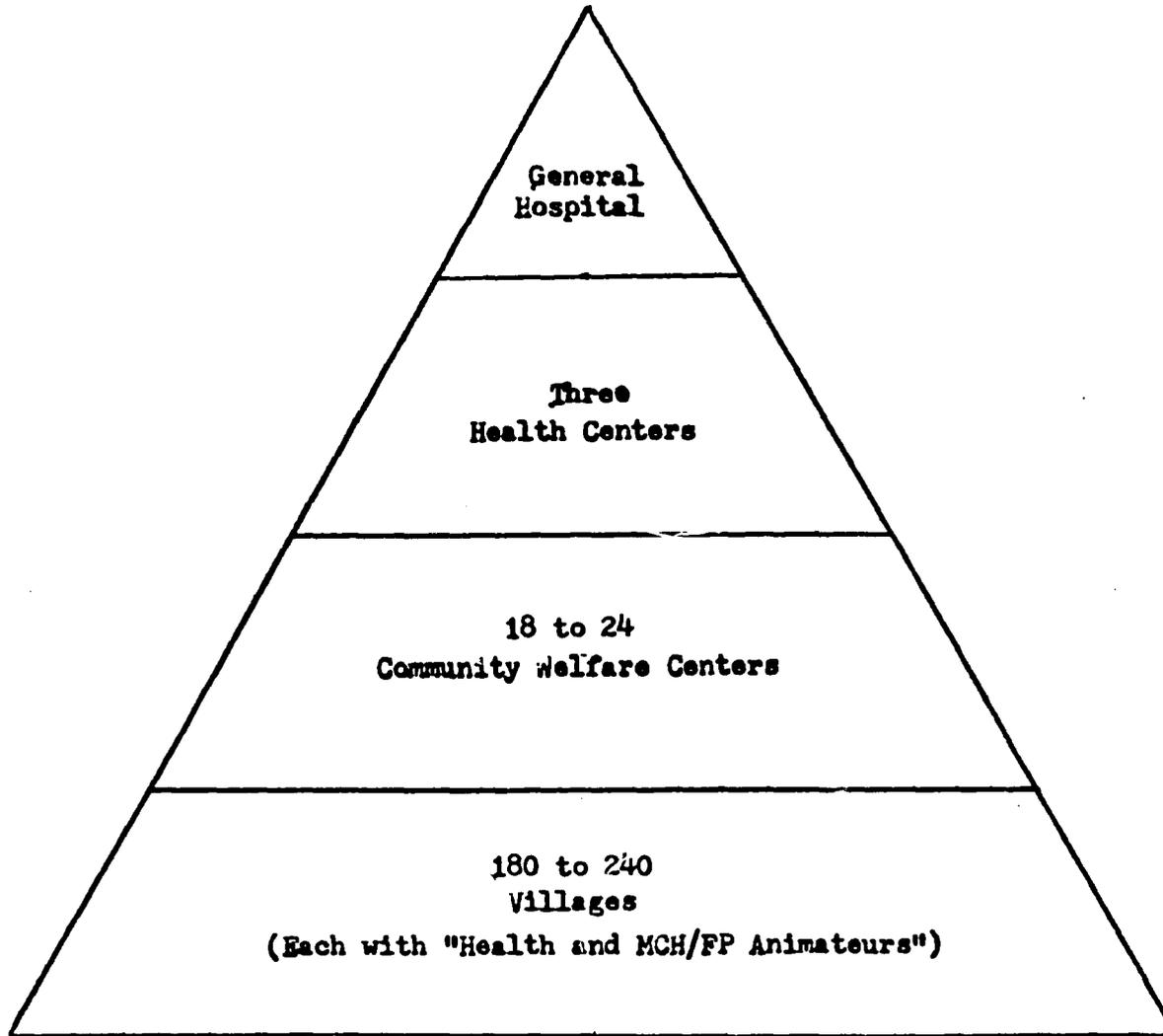
- Technical assistance: 3 man months of professional assistance @ \$5,000/man month =	\$15,000
- Travel costs, per diem for PP develop- ment team @ \$25000/professional =	7,500
- Other costs (supplies, secretarial services, etc.) =	1,000
Total Project Paper Development costs=	\$23,500

\* It is expected that much of the design work for this project will occur during Phase I of the Health Systems Development project.

SCHEMATIC CHART FOR THE ORGANIZATION OF RURAL AND URBAN HEALTH ZONES

<b>Level:</b>	<u>Rural Health Zone (RHZ)</u>	<u>Rural Health Sub-Zone (RHSZ)</u>	<u>Locality</u>	<u>Base Community</u>
	(Coinciding as much as possible with Zaire's Administrative Zones)			
	50,000-250,000 inhabitants	30,000-40,000 inhabitants	5,000 inhabitants	500 inhabitants
	180 to 240 villages	60 to 80 villages	Approx. 10 villages	Part of a locality
	18-24 Community Welfare Centers	6 to 8 Community Welfare Centers		
<b>Health Services:</b>	<u>General Hospital</u>	<u>Health Center</u>	<u>Community Welfare Center</u>	<u>Health Animator/MCH/FP Animator</u>
	(Functioning as a Community Welfare Center for surrounding villages)	(Functioning as a Community Welfare Center for surrounding villages)		
<b>Refers Patients and is Responsible to:</b>	Managing Council	General Hospital of the Zone	Health Center of the Sub-Zone	Community Welfare Center

**RURAL HEALTH ZONE**



In Urban Health Zones the General Hospital may serve several health zones.

AID - 70-2011-75

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORKLife of Project:  
From FY 1977 to FY 1980  
Total U. S. Funding \$ 8 MILLION  
Date Prepared: 11-10-75

Project Title &amp; Number: BASIC FAMILY HEALTH SERVICES/RURAL - URBAN HEALTH ZONES

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><b>Program or Sector Goal:</b> The broader objective to which this project contributes: To improve the general family health status of the Zairis and stabilise population growth through:</p> <ol style="list-style-type: none"> <li>1. a reduction in general morbidity and mortality</li> <li>2. a reduction in maternal and infant morbidity and mortality</li> <li>3. encouraging the desired births program and decreasing the necessity for multiple pregnancies.</li> </ol>	<p><b>Measures of Goal Achievement:</b></p> <ol style="list-style-type: none"> <li>1. The development of an effective and efficient service delivery system in specified areas</li> <li>2. Measurable significant reduction in age and disease specific mortality and morbidity rates.</li> <li>3. Measurable demographic data</li> <li>4. Patient service data including number of active FP patients, continuation, contraceptive distribution and usage rates</li> </ol>	<ol style="list-style-type: none"> <li>1. Evaluation of statistics compiled by GOZ and other health groups.</li> <li>2. Periodic on-site evaluations of services by GOZ, AID and other outside consultants.</li> <li>3. Review of quarterly and annual program progress reports.</li> <li>4. Individual case record review.</li> <li>5. Development plans and annual reports of the National Health and Welfare Council</li> </ol>	<p><b>Assumptions for achieving goal targets:</b></p> <ol style="list-style-type: none"> <li>1. Continued and increased commitment of GOZ to health, MCH and family planning.</li> <li>2. Collection analysis of health and program data.</li> <li>3. Availability of GOZ financial support</li> </ol>
<p><b>Project Purpose:</b></p> <p>To assist the GOZ in the development of a pilot integrated health care project based on an urban and rural health zone infrastructure. This project would be the model upon which the entire national health system would be restructured.</p>	<p><b>Conditions that will indicate purpose has been achieved: End of project status.</b></p> <ol style="list-style-type: none"> <li>1. Integrated health zones operational in 9 rural and 6 urban zones.</li> <li>2. GOZ compiling and analyzing data regarding utilization, costs, resource requirements for integrated health services.</li> <li>3. GOZ preparing initial plans for national health system expansion.</li> </ol>	<ol style="list-style-type: none"> <li>1. Monthly and annual operations reports.</li> <li>2. Availability of special reports describing costs, utilization of services, etc.</li> <li>3. Draft of national plan for integrated health services.</li> </ol>	<p><b>Assumptions for achieving purpose:</b></p> <ol style="list-style-type: none"> <li>1. Timely GOZ funding for personnel and other operating costs.</li> <li>2. Technical capability in collection, processing and analysis of data.</li> <li>3. A planning capability within the GOZ health infrastructure.</li> </ol>
<p><b>Outputs:</b></p> <ol style="list-style-type: none"> <li>1. The establishment of operating integrated health care centers</li> <li>2. The assignment of health care personnel.</li> <li>3. The development of various health care management systems.</li> <li>4. The training of professional personnel.</li> </ol>	<p><b>Magnitude of Outputs:</b></p> <ol style="list-style-type: none"> <li>1. 6 Urban and 9 rural health care zones.</li> <li>2. 30 MDs, 150 nurses, 150 auxiliary personnel, 30 support personnel in place.</li> <li>3. Approximately 150 professionals and paraprofessionals trained.</li> <li>4. The establishment of operating logistics, financial, personnel and data systems.</li> </ol>	<ol style="list-style-type: none"> <li>1. Site visits and analysis of utilization/cost data.</li> <li>2. Training records and controllers reports on participant training.</li> <li>3. Staffing patterns for each health zone.</li> <li>4. Monthly or annual reports generated by each system.</li> </ol>	<p><b>Assumptions for achieving outputs:</b></p> <ol style="list-style-type: none"> <li>1. GOZ funding of operational and maintenance costs.</li> <li>2. Availability and assignment of trained personnel.</li> <li>3. Availability of training curriculae, materials and trainers, as well as participants.</li> <li>4. Availability of professionals to plan and operate the various management systems.</li> </ol>
<p><b>Inputs:</b></p> <p><u>AID</u></p> <ol style="list-style-type: none"> <li>1. Personnel</li> <li>2. Participant training</li> <li>3. Commodities</li> <li>4. Construction/Renovation of Buildings.</li> </ol> <p>GOZ</p> <ol style="list-style-type: none"> <li>1. Personnel</li> <li>2. Training</li> <li>3. Commodities</li> <li>4. Operations</li> </ol>	<p><b>Implementation Target (Type and Quantity)</b></p> <p><u>AID</u></p> <ol style="list-style-type: none"> <li>1. -5 contract technicians</li> <li>-36 MM consultants</li> <li>2. 9 short term participants</li> <li>3. \$1.05 million - medical supplies, contraceptives, and equipment.</li> <li>4. - 900,000 ren./constr.</li> </ol> <p>GOZ</p> <ol style="list-style-type: none"> <li>1. 200 health personnel hired.</li> <li>2. 915 health personnel trained</li> <li>3. Replenishment of supplies</li> <li>4. \$1.9 million for operations</li> </ol>	<p><u>AID</u></p> <ol style="list-style-type: none"> <li>1. Annual contractor's report</li> <li>2. Annual contractor's report</li> <li>3. USAID program documents</li> </ol> <p><u>GOZ</u></p> <ol style="list-style-type: none"> <li>1. Yearly health budget submission.</li> </ol>	<p><b>Assumptions for providing inputs:</b></p> <p><u>AID</u></p> <ol style="list-style-type: none"> <li>1. Development of a contract with a qualified organization or institution.</li> <li>2. Interest of GOZ in obtaining sector loan.</li> </ol> <p><u>GOZ</u></p> <ol style="list-style-type: none"> <li>1. Provision of adequate funds from governmental revenues.</li> </ol>

AGENCY FOR INTERNATIONAL DEVELOPMENT  
**PROJECT IDENTIFICATION DOCUMENT FACESHEET**  
 TO BE COMPLETED BY ORIGINATING OFFICE

1. TRANSACTION CODE (CHECK APPROPRIATE BOX)  
 ORIGINAL     CHANGE  
 ADD     DELETE

PID  
 DOCUMENT CODE  
 1

2. COUNTRY/REGIONAL ENTITY/GRAANTEE  
 Zaire

3. DOCUMENT REVISION NUMBER

4. PROJECT NUMBER  
 660-0067

5. BUREAU  
 A. SYMBOL AFR    B. CODE 1

6. PROPOSED NEXT DOCUMENT  
 A.  PRP     PP    B. DATE MO. | YR. |  
 0 | 1 | 7 | 6 |

7A. PROJECT TITLE - SHORT (STAY WITHIN BRACKETS)  
 Urban MCH/FP Services   

8. ESTIMATED FY OF AUTHORIZATION/OBLIGATION  
 A. INITIAL FY [7|7]    B. FINAL FY [8|1]

7B. PROJECT TITLE - LONG (STAY WITHIN BRACKETS)  
 Urban Maternal Child Health/  
 Family Planning Services   

9. ESTIMATED COST (LIFE OF PROJECT)  
 (\$000 OR EQUIVALENT, \$1 = \_\_\_\_\_)

PROGRAM FINANCING		AMOUNT
A. AID APPROPRIATED		5,195
B. OTHER U.S.		400
C. HOST GOVERNMENT		15,600
D. OTHER DONOR(S)		250
TOTAL		21,445

10. ESTIMATED COSTS/AID APPROPRIATED FUNDS (\$000)							11. OTHER U.S. (\$000)		
A. APPRO- PRIATION (ALPHA CODE)	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE	FIRST YEAR		ALL YEARS		A. PROGRAM TYPE	B. FIRST YEAR	C. ALL YEARS
			D. GRANT	E. LOAN	F. GRANT	G. LOAN			
PH	340	440	915		5,195		Title X	100	400
TOTAL			915		5,195		TOTAL	100	400

12. PROJECT GOAL (STAY WITHIN BRACKETS)  
 Assist the Government of Zaire in shifting from a pro-natalist  
 to a desirable births policy.   

13. PROJECT PURPOSE(S) (STAY WITHIN BRACKETS)  
 Make Maternal Child Health/Family Planning services available  
 to interested families in Zaire's major population centers.   

14. PLANNING RESOURCE REQUIREMENTS (STAFF/FUNDS)  
 Detail or Contract Staff - \$9,000

15. ORIGINATING OFFICE CLEARANCE

SIGNATURE: *T. L. ...*    *P. ...*

TITLE: USAID Director

DATE SIGNED: MO. | DAY | YR. |  
 0 | 6 | 3 | 0 | 7 | 5 |

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

