

~~HE/TC/H~~ AER

August 13, 1981

ACTION MEMORANDUM

~~444~~ ERK/DR
CCWR

TO: Norman L. Sweet, Mission Director
FROM: *W. Boehm*
Walter W. Boehm, PRM
SUBJECT: Project Authorization -- Basic Rural Health (660-0086)

Problem:

Your approval is required to authorize a grant of \$4,864,000 from the health appropriation to the Government of Zaire (GOZ) for the Basic Rural Health (660-0086) Project subject to the availability of funds in accordance with the USAID OYB/allotment process. We intend to obligate \$900,000 in Fiscal Year 1981 for this Project.

Discussion:

A. Project Background

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

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

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

B. Project Description

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

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

C. Financial Summary

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

D. Covenants

The following covenants will be included in the Project Agreement:

1. The Grantee agrees that the ECZ will be the primary implementing agent for the Project.
2. The Grantee covenants to make available all necessary budgetary and human resources needed at the GOZ participating hospitals in a timely manner.

E. Implementation

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

F. Committee Action and Congressional Notification

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

Recommendation:

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

August 13, 1981

PROJECT AUTHORIZATION

Name of Country: Zaire

Project Name: Basic Rural Health

Project Number: 660-0086

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

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

3. Source and Origin of Goods and Services

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

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

4. Condition Precedent to Disbursement

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

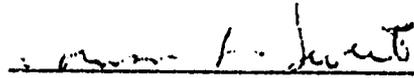
- (a) a statement of the name of the person designated as the Department of Health representative, together with a specimen signature of the person specified in such statement, to interface with USAID and the ECZ on project implementation activities.

5. Covenants

The cooperating country shall covenant:

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

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

A handwritten signature in cursive script, appearing to read "Norman L. Sweet", is written over a horizontal line.

Norman L. Sweet
Mission Director
USAID/Zaire

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT PAPER FACESHEET		1. TRANSACTION CODE <input type="checkbox"/> A. ADD <input checked="" type="checkbox"/> C. CHANGE <input type="checkbox"/> D. DELETE		PP 2. DOCUMENT CODE 3
3. COUNTRY ENTITY Zaire		4. DOCUMENT REVISION NUMBER <input type="checkbox"/>		
5. PROJECT NUMBER (7 digits) [660-0086]		6. BUREAU OFFICE A SYMBOL: AFR B. CODE: [06]	7. PROJECT TITLE (Maximum 40 characters) [Basic Rural Health]	
8. ESTIMATED FY OF PROJECT COMPLETION FY [8] [6]		9. ESTIMATED DATE OF OBLIGATION A. INITIAL FY [8] [1] B. QUARTER [4] C. FINAL FY [8] [5] (Enter 1, 2, 3, or 4)		

10. ESTIMATED COSTS (\$000 OR EQUIVALENT \$1 -)						
A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. TOTAL	E. FX	F. L/C	G. TOTAL
AID APPROPRIATED TOTAL	900		900	4864		4864
(GRANT)	900		900	4864		4864
(LOAN)						
OTHER U.S. 1. Peace Corps	75		75	350		350
OTHER U.S. 2.						
HOST COUNTRY		625	625		2691	2691
OTHER DONOR(S) ECZ		558	558		2795	2795
TOTALS	975	1183	2158	5214	5486	10700

11. PROPOSED BUDGET APPROPRIATED FUNDS (\$000)									
A. APPROPRIATION	B. PRIMARY PURPOSE CODE	PRIMARY TECH. CODE		E. 1ST FY <u>81</u>		H. 2ND FY <u>82</u>		K. 3RD FY <u>83</u>	
		C. GRANT	D. LOAN	F. GRANT	G. LOAN	I. GRANT	J. LOAN	L. GRANT	M. LOAN
(1) PH	534	510		900		1905		1254	
(2)									
(3)									
(4)									
TOTALS				900		1905		1254	

A. APPROPRIATION	N. 4TH FY <u>84</u>		O. 5TH FY <u>85</u>		LIFE OF PROJECT		12. IN-DEPTH EVALUATION SCHEDULED
	Q. GRANT	P. LOAN	R. GRANT	S. LOAN	T. GRANT	U. LOAN	
(1) PH	670		135		4864		MM YY [0] [9] [8] [3]
(2)							
(3)							
(4)							
TOTALS		670		135		4864	

13. DATA CHANGE INDICATOR. WERE CHANGES MADE IN THE PID FACESHEET DATA, BLOCKS 12, 13, 14, OR 15 OR IN PRP FACESHEET DATA, BLOCK 12? IF YES, ATTACH CHANGED PID FACESHEET.

[1] 1 NO
 2 YES

14. ORIGINAL OFFICE CLEARANCE		15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION	
SIGNATURE			
TITLE	DATE SIGNED		
Norman L. Sweet Director, USAID/Zaire	MM DD YY [0] [8] [1] [3] [8] [1]		

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B. Glossary

- Basic Health Care - The most elementary health care directed toward treating and preventing the most common health problems of a community.
- Dispensaries - Lowest health care unit, usually offering limited curative services and no preventive services; sometimes referred to as "health posts."
- PEV - Programme Elargi de Vaccination (also EPI)
- Expanded Program of Immunization (EPI) - Worldwide WHO/CDC sponsored program against polio, measles, tuberculosis, diphtheria, whooping cough, and tetanus.
- GOZ - Government of Zaire
- Health Center - A rural, primary health care facility staffed in principle by three health workers (curative nurse, public health nurse, sanitarian or nurse/midwife). Offers both curative and preventive services.
- Hospital - System made up of hospital with dependent satellite health centers.
- MCH - Maternal and Child Health
- Propharmacy - A community owned and operated drug outlet in areas where there is no commercial pharmacy and/or no accessible health care institution.
- Village Health Worker - (VHW) - The provider of basic health services at the village level on a voluntary basis.
- Village Health Committee - (VHC) - Village organized and operated committee composed of village members to promote health activities and programs within the village.
- PID - Project Identification Document - A short, preliminary document indicating a USAID Mission's intention to consider developing a project.
- PP - Project Paper - The final detailed document describing a proposed project and responsibilities of each of the participating parties.
- Recurrent Cost - Anticipated additional costs resulting from the initiation or expansion of activities as the result of a project.

C. Recommendations

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

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

Request approval of following source/origin waivers:

Vehicles: one 4-wheel drive utility vehicle for Nyankunde

Motorcycles: 100 motorcycles with small displacement motors

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

D. Summary Description of the Project

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

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

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

health and nutrition education;

prenatal and preschool clinics;

immunizations;

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

normal deliveries and referral of high risk pregnancies; and

family planning services.

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

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

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

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

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

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

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

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

E. Summary Findings

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

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

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

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

F. Project Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. The feasibility of "volunteer" VHWs.

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

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

- The village first must form a village health/development committee and identify the most serious health problems;
- The proposed village health volunteer worker must be literate and must live and plan to continue to reside in the village;
- The volunteer must have a routine means of support and be prepared to spend only a small part of each day on his health promotion/curative activities;
- The volunteers understand that they will not be compensated for their services; and
- There will be frequent supervisory visits from health center or hospital staff during the first few months of the volunteers' activities.

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

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

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

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

1. anti-malarials for cure of malaria and prophylaxis in children under 5;
2. a simple first aid kit - for treatment of cuts and burns and an oral rehydration packet (made at the hospital);
3. aspirin for common headaches, pains, colds, etc.;
4. cough syrup - for coughing due to colds; and
5. scabies medication and soap.

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

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

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

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

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

- a) villagers can organize themselves to attack common problems when given information and some guidance; and
- b) individual villagers will work part-time without monetary compensation to assist their villages to initiate certain public health interventions.

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

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

5. Other concerns

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

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

TAB

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

TABLE II

Estimated Annual Recurrent Costs (Zaires) for Vehicles and Bicycles

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

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

PART II PROJECT BACKGROUND AND DETAILED DESCRIPTION

A. Background

Health Background

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

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

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

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

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

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

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

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

The major health problems listed were:

malaria;

protein malnutrition;

intestinal parasites (hookworms, ascaris, amoebae);

measles;

tuberculosis;

diarrheal diseases;

respiratory infections (pneumonia, whooping cough);

anemia;

pregnancy and birth complications; and

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

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

lack of potable water for majority of the population;

lack of environmental sanitation;

lack of global health strategy;

insufficient vaccination coverage;

population unaware of health principles;

poor management of health resources; and

high fertility and inappropriate child spacing.

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

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

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

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

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

The Role of Missionary Groups in Health Care in Zaire

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

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

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

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

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

B. Project History

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

- assistance with training at various levels for local employees in the management of family planning service delivery and health education;
- assistance with certain commodities for public health outreach, audio-visual materials, bicycles, vehicles, medical equipment, contraceptives, microscopes;
- requests for information on other experiences with outreach and training of volunteer VHWS and traditional midwives; and
- short-term technical assistance.

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

- family planning clinics opened and family planning services initiated in existing clinics;
- latrine construction and water source protection; and
- a health committee initiated and "animateurs" trained and working in the villages.

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

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

This modification contains the following points:

1. The GOZ, after careful and lengthy consideration, detailed its health priorities and strategy in February, 1981;
2. The GOZ/DSP would nominate a permanent representative to the project advisory committee that would be composed of representatives from USAID, ECZ, and other organizations. This committee would be charged with, inter alia, planning, periodic review, and evaluation of the project as well as the transfer of lessons learned and recommendations to other ECZ and GOZ systems;
3. The GOZ/DSP would be involved in the planning and preparation of the final project document;
4. Although the project would concentrate on ECZ hospitals, also it would include some DSP hospital systems that are ready and capable of initiating a public health outreach program; and
5. The project mode would be a bilateral one between the GOZ/DSP and USAID, with ECZ designated as the major implementing agent.

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

health education;

training of VHWs and traditional midwives;

logistic support for the pro-pharmacy systems;

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

technical assistance and logistic support for vaccination programs.

C. Detailed Project Description

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

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

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

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

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

delivery of normal pregnancies;

surveillance of preschool children;

nutrition education for mothers;

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

general health education;

vaccination of children;

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

maintenance of health statistics;

training and supervision of VHWs; and

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

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

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

The committee will have the following general functions:

- Acting as a bridge and conduit between the community and the formal health care structure. This bridge will be used by the health center to transmit information on causes of health problems as well as a means for the community to express their needs to the health centers.
- Organizing regular meetings to explain the concept of preventive, promotive health and to obtain consensus and commitment for initiating community activities to address health problems.
- Monitoring and coordinating those activities once commitment and consensus has been reached.
- Assisting the community in selection of a VHW (animateur de sante). There may be one or more per community, including a midwife.

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

has respect of the community;

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

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

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

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

is literate; and

has a regular means of income.

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

Financing of Health Centers and VHWs

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

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

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

- construction of latrines for sanitary disposal of human excreta;
- protection of the village water source;
- construction of wells, spring boxes, and protection of other water sources;
- elimination of standing pools of water that act as breeding places for mosquitoes; and
- sanitary disposal of other refuse likely to attract flies and other vectors.

The Relationship of the Health Center to the Hospital

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

- regularly visiting each center and satellite villages to ascertain progress on work to date and assist with technical problems;
- verifying accounting receipts for medicines given and insuring that approved tariff is being followed;
- periodically retraining center staff at the hospital or the center;
- serving as depots and distribution centers for project commodities and pharmaceutical purchases; and
- program planning and evaluation.

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

1. demonstrated interest in expanding public health outreach work combined with their willingness to realign their present personnel to better meet the needs of the unserved rural areas;
2. capacity to absorb and manage the assistance necessary for this outreach expansion;
3. ability to move quickly into their prepared program in 1981;
4. strength of the basic infrastructure and previous public health outreach experience;
5. capacity to train their own employees, the staff from surrounding systems, as well as representatives from hospital centers who will be participating in Phases II and III of the project.

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

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

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

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

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

Project Outputs

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

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

This output includes the following specific training objectives:

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

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

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

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

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

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

all participating ECZ and GOZ hospitals. These statistics will include morbidity and mortality by cause;
consultations by type;
pharmaceuticals used by type;
employees trained/retrained;
family planning acceptors by method;
children vaccinated;
children receiving malaria chemoprophylaxis;
water sources protected; and
latrines constructed;

2. The production of an annual report for the ECZ member hospitals and for other health care providers. This report will summarize the activities for the previous year with emphasis on experiences, lessons learned and planned activities for the following year.
3. The organization of an annual health conference. This conference will further the information sharing process by permitting members of the ECZ, GOZ, and donor community to discuss on a regular basis certain specific topics which are of timely and global interest. This conference would be organized and coordinated by the ECZ medical bureau with input from member hospitals and the GOZ. In addition to the general objective of information sharing, these conferences would have the following specific objectives:

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

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

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

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

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

4. Effective liaison with the donor community. The ECZ Central Medical Bureau will have the unique capacity to present individual hospital needs as a part of a continuing ECZ health care strategy. The central office will be capable of preparing project proposals and of handling project administration and reporting as well as evaluation tasks.
- III. Two hundred fifty health centers opened or converted from dispensaries and focusing on preventive, promotive health practices.

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

One hundred fifty thousand new family planning acceptors.

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

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

Twenty Laparoscopes

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

Three thousand active health committees formed and functioning.

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

One thousand five hundred sources protected.

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

One thousand five hundred VHWs.

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

Four hundred traditional midwives trained.

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

One thousand vaccination programs organized in villages.

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

Twenty-five thousand latrines constructed.

Project Inputs

Technical Assistance

A. USAID

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

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

data collection and medical information systems;

training in family planning;

training of traditional and modern sector midwives;

training of traditional healers;

well construction and water source management;

pro-pharmacy initiation and management;

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

training for nutrition education.

B. Peace Corps

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

C. ECZ

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

D. GOZ

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

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

represent the GOZ on the Project Advisory Committee;

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

make policy recommendations to the ECZ and GOZ;

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

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

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

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

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

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

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

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

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

Training

A. USAID

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

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

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

B. ECZ

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

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

Commodity Support

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

A. USAID

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

1. Vehicles: Up to 50 4-wheel drive vehicles. One each for the major participating hospitals. Each vehicle will permit the hospital to supply, supervise, and train the staff of its outlying network of health centers. In a few cases, motorcycles also will be put at the disposition of the hospitals for this work. Estimated cost of this input is \$950,000.
2. Motorcycles: One hundred motorcycles will permit the health centers to visit regularly their outlying villages, to assist the VHWs to supervise/supply the village level pro-pharmacies; and to organize vaccinations and prenatal and preschool consultations. Because of the distance involved, motorcycles will be needed for some of the health centers, while others may only require bicycles. Total estimated cost of this input is \$150,000.
3. Bicycles: Five hundred bicycles with luggage racks will be used for outreach by those health centers in close proximity to their target villages, as noted above. Bicycles also will be available for those VHWs who have responsibility for more than one village or who will need to travel to the health centers frequently. Total estimated cost is \$150,000 for this input.
4. Other Commodities:
 - a) Pharmaceuticals - A first stock of basic medicines (see Annex VIII for the complete list) will be made available to the 250 health centers to be opened and/or converted under the project. These medicines will be aimed at the low cost prevention and cure of the 10 most prevalent diseases in the areas served by the project. Actual center stock will vary from region to region, depending on disease patterns. They may also include a few other low cost medicines for other diseases.

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

- b) Audio-Visual Educational Supplies - All 50 participating hospitals and all 250 health centers will receive a basic set of flip charts, books, posters, training manuals, and in some cases, battery powered slide projectors and slides. Total cost of this input is estimated at \$275,000. (Two hundred fifty centers x 750 per center plus 50 hospitals x 1,750 per hospital.) Specific training aids will be responsive to local needs.
- c) Contraceptive Commodities - It is planned that AID will furnish on a continuing basis contraceptives for hospitals, health centers, and for the village VHWs. Total estimated cost of this input during the life of the project is \$325,000. (Two hundred fifty health centers x \$600 per plus 50 hospitals x \$1,500 per plus 1,000 VHW x \$125.)
- d) Medical Equipment - AID will furnish medical equipment to the health centers and VHWs. Equipment is oriented towards examination and treatment of top ten diseases, provision of family planning services, and vaccination campaigns. A detailed list is presented in Annex VII. Total estimated cost of this input is \$500,000. (Two hundred fifty centers x \$1,900 per plus 1,000 VHWs x 25 per.)
- e) Office Equipment - AID will furnish office equipment for the 50 participating hospitals and the ECZ central office. Equipment will include calculators, filing cabinets, typewriters, stencil cutters, copying machines, and miscellaneous office equipment. This equipment will facilitate participating hospitals in the collection and presentation of their data and experience. This will be fed into the central office for compilation and dissemination to other ECZ and GOZ hospitals. The equipment also will make possible the preparation of some visual education aids, training manuals, and curricula for seminars and recycling programs. Total estimated cost of this input is \$75,000. (Fifty hospitals x \$1,400 plus 1 ECZ central office \$5,000.)
- f) Other Costs - AID will fund, over the life of the project, miscellaneous dollar costs. This will include conferences, travel, per diem, construction materials, tools, and spare parts. Total estimated cost of this input is \$120,000.

PART III PROJECT ANALYSES

A. Technical Feasibility

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

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

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

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

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

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

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

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

- The primary health experiences of the participating hospitals will be jointly studied and evaluated by the ECZ central medical office and the GOZ/DSP Planning Unit.
- The GOZ/DSP Planning Unit will participate through its representative on the Project Advisory Committee in planning and implementation of project activities.
- The GOZ/DSP representative will be directly responsible for all planning, implementation, and evaluation of project activities in the GOZ participating hospitals.
- The management information system to be developed under the project will include both GOZ and ECZ information needs.
- GOZ/DSP personnel will participate in short and long-term training, the project plans to have at least two DSP central office personnel trained at the Masters level in health planning.

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

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

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

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

- educating mothers on the importance and technique of oral rehydration;
- stocking and sale of rehydration packets;
- educating women re benefits of child spacing and contraceptive methods available;
- stocking and sale of certain contraceptives; and
- referral of women desiring those contraceptives that can only be provided by trained personnel.

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

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

Family Planning

Rationale

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

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

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

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

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

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

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

Contraceptives: Methods, Standards, Supply

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

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

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

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

<u>Contraceptive Users</u>						
	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>Total</u>
New acceptors	5,000	15,000	30,000	40,000	60,000	150,000
Continuing users of pills, condoms, IUDs, injectables	2,500	10,000	25,000	45,000	75,000	75,000
Sterilizations per year (considered continuing users for 5 years)	250	750	1,500	2,000	3,000	7,500
1986 continuing users	75,000					
Sterilizations	<u>7,500</u>					
Total continuing	82,500					

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

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

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

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

Surgical Contraception

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

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

Training

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

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

Information, Education, and Communication

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

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

Other Donor Activities

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

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

Expected Impact

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

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

Nutrition

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Financial Analysis and Plan

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

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

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

Table I

Illustrative Budget for USAID Contribution (\$000)

	<u>Yr 1</u>	<u>Yr 2</u>	<u>Yr 3</u>	<u>Yr 4</u>	<u>Yr 5</u>	<u>LOP</u>
TECHNICAL ASSISTANCE	(333)	(135)	(378)	(45)	(45)	(936)
Long-term	288 (24mm)*		200 (24mm)			576 (48mm)
Short-term	45 (3mm)	135 (6mm)	90 (6mm)	45 (3mm)	45 (3mm)	360 (24mm)
TRAINING		(442)	(321)	(200)	(70)	(1,033)
Long term out of country		302 (168mm)	216 (120mm)	130 (72mm)		648 (360mm)
Short-term out of country		140 (40mm)	105 (30mm)	70 (20mm)	70 (20mm)	385 (110mm)
COMMODITIES	(541)	(1,304)	(530)	(400)		(2,775)
Vehicles	456	494				950
Motorcycles	30	120				150
Bicycles	30	90	30			150
Other (contraceptives, pharmaceuticals, medical equipment, A-V aids, office equipment)	25	600	500	400		1,525
OTHER COSTS	26	24	25	25	20	120
TOTAL	900	1,905	1,254	670	135	4,964

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*mm - Man Months

Table II

Illustrative Budget for GOZ Contribution via Counterpart Funds (2000)

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

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

C. Social-Cultural Analysis

1. Social Setting of the Project

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

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

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

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

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

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

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

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

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

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

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

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

- People are accustomed to injections and will accept them without difficulty. This acceptance is especially important for family planning activities that use depo-provera contraceptive.
- Healers have resorted to medicines for centuries so villagers are prepared to take external medicines.
- Poison potions were once used quite frequently to force out the spirits that cause stomach illnesses. Therefore, modern vermifuge can be used to deal with a number of varieties of hookworm, ringworm, tapeworm, as well as enteritis and forms of amebiasis.
- Traditionally, the village healer has multiple types of treatments against fertility and impotence. Therefore, the villagers will not

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

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

2. Project Assessment

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

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

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

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

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

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

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

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

3. Suggestions for Design and Implementation

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

4. Spread Effects

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

D. Economic Analysis

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

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

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

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

Alternatives to this project include:

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

Each of these options is discussed below.

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

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

3. The DSP already is straining its capacity to directly manage health activities. USAID alone is supporting three other major health projects which are taxing the DSP's management capacity to the limit.
4. The Catholic system, while well-established in the urban areas, is less active in the health sector in the rural areas than the ECZ. Furthermore, the Catholic system generally limits the extent of contraceptive services to the natural methods. The Kimbanguist medical system is relatively undeveloped and serves only a few zones. Its management capacity is limited. ECZ has demonstrated its management capacity, especially in the rural areas where the GOZ system is weakest.
5. Provisions of medicines and equipment alone. Several donors including USAID have done this in the past with poor results. The major constraint to health system delivery in Zaire continues to be a lack of good management and trained personnel.

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

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

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

E. Environmental Analysis

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

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

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

2. Water Quality - The only foreseeable effects of the project will be beneficial protection of water sources. Construction of new wells will serve only to improve the quality and quantity of water for human consumption.
3. Air Quality - The only significant question of air quality will be the possible increase of air pollution due to the introduction of 150 motor vehicles to Zaire. Since these vehicles will be dispersed throughout the rural areas of Zaire where there are currently few motor vehicles, it is reasonable to assume that the project will not adversely affect air quality.
4. Noise Impact - The project is not expected to impact on current noise levels.
5. Cultural Impact - The health education activities of the project will have an impact on traditional theories of disease and their causality. There is no way of avoiding this change in belief, since the change is basic for understanding health problems and for initiating specific interventions. The result is considered worth disturbing these traditional beliefs.

PART IV IMPLEMENTATION ARRANGEMENTS

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

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

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

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

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

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

1. Specific Responsibilities

a) Financial Management

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

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

b) Development of Work Plan

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

c) Development of Training Plan

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

- identify the specific hospitals where training for service providers will be carried out and the timing and the approximate numbers by type of trainees;
- identify the institution or training courses where training of trainers and training for supervisors will be carried out, together with timing of courses and the numbers of trainees;
- provide an outline of the subjects to be covered in each type of the various training courses. There should be enough detail so that it is clear that the training is skill-oriented and has adequate provision for practical experience;
- identify the arrangements to be made for the development and reproduction of necessary training materials; and,
- identify the courses and numbers of candidates for long and short-term training outside the country. (Specific nominations will be made later.)

d) Development of Supervision Plan

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

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

3) Development of Guidelines and Standards

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

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

- Minimum standards of personnel, facilities, and equipment for hospitals to participate in such a program. Observations should be included about the number of outlying posts and villages that can be supervised effectively by a hospital, and the geographic and population coverage each element can serve.
- Guides and standards for training programs for various types of personnel, including subjects, methodology, duration and location of course, and type of instructions.
- Guides for type (specific purposes) and amount of supervision needed.
- Technical guides indicating the several key positive actions needed and the most common errors to be avoided so as to deal most effectively with public health problems such as:
 - household waste disposal (latrines and composts);
 - water supply protection;
 - communicable disease control;
 - malaria treatment and means to determine parasite susceptibility to drugs utilized;
 - tuberculosis;
 - malnutrition;
 - provision of family planning services (include standards for clinical/surgical practice as well as simple instruction/checklist for village workers);
 - intestinal parasite treatment;
 - treatment of diarrhea and use of oral rehydration; and
 - prenatal, obstetric and post natal care (emphasis on actions at the health center and village level).

f) Commodity Management

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

g) Information, Education, and Communication Plan

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

- to inform government and private sector leaders, church leaders, and hospital administrators about this program, its objectives and its progress;
- to inform, motivate, and educate service providers so as to facilitate their continuing effective participation; and,
- to inform potential users of the availability and the utility of project services and to provide necessary information to supplement the basic person-to-person information provided by hospital health centers and village volunteer personnel.

h) Service Statistics, Information System, and Biannual Report

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

i) Provision of Short-Term Technical Assistance

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

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

j) Evaluation and Review of Objectives

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

k) Organization of Advisory Committee

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

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

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

The Advisory Committee should consist of, among others:

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

l) ECZ Medical Bureau Resources to Fulfill these Functions

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

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

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

- although the Director of the Medical Bureau will be only a part-time project director, he can utilize trips, seminars, and contacts made while exercising his other responsibilities so as to serve the needs of this project;
- the addition to the project of a full-time technical assistant for administration and project management and two Zairian staff persons will facilitate project planning and management;
- the addition by the ECZ of a full-time administrative assistant to the central technical group will facilitate improved management of the ECZ;
- a vigorous effort will be made to engage and defray the costs of local hospital administrators as consultants in implementing many functions outlined here under the responsibility of the Medical Bureau;
- extensive use will be made of short-term consultant services and short-term contracts for specific tasks that are the responsibilities of the Medical Bureau; and,
- study will be given to the use of PCVs as appropriate.

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

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

- Citizen Nlaba - Director and responsible for all ECZ medical programs. Diploma nurse with specialized training in management and primary health care and family planning.
- Florence Galloway - Technical assistant for nursing/family planning - nurse/midwife with a specialization in family planning and health education training.
- Ralph Galloway - Technical assistant for planning, administration, and logistics, in addition to education and family planning.

Besides this staff, the project will add:

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

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

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

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

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

Missionary Aircraft Transportation and Distribution System

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

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

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

Garage and Repair Facilities

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

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

Office Facilities

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

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

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

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

- a) Local Currency for In-Country Costs - The ECZ Medical Bureau will request that an initial advance from the Ministry of Planning, Counterpart Funds Secretariat be transferred to a separate ECZ project account. Thereupon the account managers may request the ECZ for advances according to programmed activities. Under signature of the Project Director and one technical assistant, funds from the account will be transferred by check, bank transfer or hand-carried to the participating hospital. All recipients will sign for the arrival of the monies and return signed receipts to the ECZ Project Secretariat. As expenditures are justified to the Ministry of Plan and USAID, additional blocks of local currency can be requested. Salaries for the two project local hires will be paid out of this account.
- b) Commodity Procurement in Foreign Currency - Standard USAID procurement procedures will be followed. The Project Director and the technical assistant will prepare the documents necessary for USAID procurement. USAID will arrange direct payment to the suppliers per standard procedures.
- c) Participant Training - In accordance with established USAID procedures, payment will be arranged directly to the training institutions. Monthly living allowances will be provided directly to the candidates.
- d) Technical Assistance (AID Funded via Personal Services Contract) - The USAID voucher system will be used for direct payment to the technical assistant. The USAID/PHO will certify that services have been rendered.

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

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

Action to be TakenResponsibilityDate

- 22. Second meeting of Advisory Committee
- 23. Second biannual report
- 24. First Annual Health Conference
- 25. A. Amend ProAg for FY 83 obligation
B. FY 83 commodities ordered

ECZ

Sept. 1982

ECZ

Sept. 1982

ECZ/GOZ

Nov. 1982

USAID

Jan. 1983

USAID/ECZ

Jan. 1983

C. Evaluation Arrangements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Measure - informed personnel throughout the health system.

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

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

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

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

4. One hundred fifty thousand family planning acceptors.

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

Activity - periodic visits to above agencies to check records.

5. Twenty laproscopes installed.

Measure - instruments in place and functioning.

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

6. Three thousand active health committees formed.

Measure - registered groups.

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

7. Fifteen hundred water sources protected.

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

Activity - periodic visit to village sites.

8. Fifteen hundred VHWs trained.

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

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

9. Four hundred fifty traditional midwives trained.

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

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

10. One thousand vaccination programs organized.

Measure - prevalence, incidence, and contact records.

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

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

Measure - personnel, materials in place.

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

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

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

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

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

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

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

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

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

ANNEX I. LOGICAL FRAMEWORK

<u>Narrative Summary</u>	<u>Objectively Verifiable Indicators</u>	<u>Means of Verification</u>	<u>Assumptions</u>
<u>A.1. Goal</u> To improve the health status of the rural population by increasing the proportion of rural Zairians that have access to basic health services.	<u>A.2. Measurement of Goal Achievement</u> -Infant mortality and child mortality rate reduced by 20% in project areas. -Mortality due to measles and neonatal tetanus reduced 50% in those areas served by hospitals. -Births reduced by 5% in project areas.	-Sample surveys -Review of death records -Review of birth records	Political stability continues. Economic situation does not worsen. There are no famine, draughts, or other natural disasters.
<u>B.1. Purpose</u> To establish a self-sustaining community supported system of primary health care effectively offering prevention and treatment for the 10 most prevalent health problems in 50 zones in Zaïre.	<u>B.2. EOPS</u> -System offering basic prevention and cure for diseases in place and functioning on a self-financing basis.	-Reports -On site visits -Sample surveys	ECZ system continues current level support to health sector.
<u>C.1. Outputs</u> A well functioning institutionalized system of retraining low and mid-level workers in the delivery of community based primary health care. A system for collecting, organizing and sharing the experiences of ECZ and GOZ hospital systems in the provision of primary health care. 250 Health Centers opened or converted from dispensaries following the GOZ Nsele Model.	<u>C.2 Output Magnitude</u> 250 Family Planning clinics opened 150,000 new acceptors in Family Planning 250 MCH Clinics opened/converted 1,000 vaccination programs in villages 750 nurses trained/retrained 50 physicians retrained 3,000 health committees formed and active 500 wells dug 1,500 water sources protected 30,000 latrines constructed and in use 20 laprascopes installed and in use 1 data collection system (service records) installed.	-Reports - Field visits/persons fulfilling jobs - Review of dispensary records and planning records - Interviews with village committees	GOZ policies on Family Planning do not change. ECZ hospitals are permitted to expand their program as planned. Project inputs are provided in a timely fashion. Villagers will be motivated to undertake latrine and water source construction

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

D.I. InputsD.2 BudgetD.3 Assumptions

I. AID (dollars U.S.)

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

II. ECZ (Central Organization) - (Equivalent in dollars U.S.)

A. <u>Technical Assistance</u> - 1 Project Director (part time) 1,650/yr x 5 yrs. (30 MM)	24,750
- 1 Family Planning Trainer/co-ordinator (60 MM) 16,500/yr x 5 yrs.	82,500
- Operations Officer/Logistics Coordinator (60 MM) 16,500/yr. x 5 yrs.	82,500

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

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Annex II
The Church of Christ in Zaire

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

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

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

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

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

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

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

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

1. The Presidency
 - Bishop Bokeleale, President and legal representative
 - Dr. Marini Bodho, Vice President
 - Rev. Kakule Molo, Director of the Presidency Department
2. Accountant, Citoyen Mavinga Dubu
3. Central Technical Committee
 - Citoyen Kazadi, Director, and Secretary of Projects
 - Citoyen Mbenga, motivation and research, and training
 - Citoyen Dr. Kabeya, Communications
 - Mr. Wilke, Architect
 - Mr. Jaoudas, agronomy
 - Mr. Franz, garage
4. Information Department, Citoyen Musene
5. Education, National Coordinator, Citoyen Bosunga
6. Evangelism Department, Rev. Muzaba, Director
7. The Life of the Church, Rev. Muludiki, General Secretary
8. Chaplaincy, Zairian Army, University Campus
9. General Services Department (Diaconie)
 - Citoyen Mbualungu, General Secretary
 - CEPAM, Medical Supply Center
 - ZPRA, Importing, customs, and transport service
 - Refugee Service
 - ADF (Action Diaconal et Familiale)
 - Medical Service Coordinating Office, Citoyen Nlaba, Secretary

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

- 57 Zairian physicians
- 45 expatriate physicians
- 2 expatriate pharmacists
- 6 Zairian pharmacists
- 51 nurse midwives (expatriate)
- 4 nurse midwives (Zairian)
- 235 nurses, 140 of whom are Zairian
- 961 auxiliary nurses, of which 946 are Zairian
- 3 Sanitary agents, two of whom are Zairians
- 44 Lab technicians
- 1 radiologist (an expatriate)

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

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

To date the GOZ has put 55 Zairian physicians at the disposition of the ECZ.

They have been appointed to the following hospitals:

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

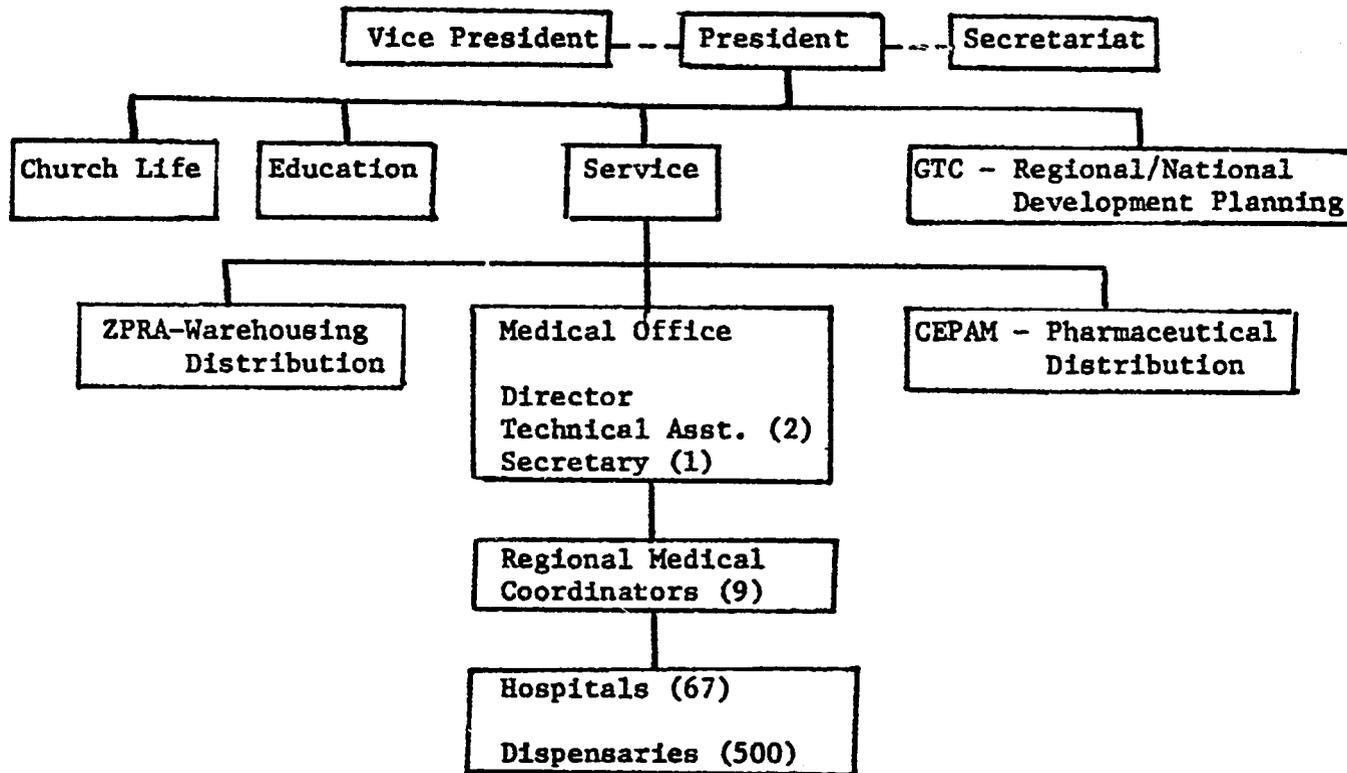
- C.B.Z.O. Hospital at Sona-Bata, Bas-Zaire - 1
- C.B.C.U. Hospital at Tandala, Equator - 1
- Methodist Hospital at Tunda, Kivu - 1
- C.B.Z.O. Hospital at Vanga, Bandundu - 1
- C.B.F.Z. Hospital at Yakusu, Haut Zaire - 1
- E.E. Z. Maternity of Kingoyi, Bas Zaire - 1
- Menonite Community of Zaire maternity at Mutena, West Kasai - 1
- C.B.F.Z. Maternity at Tondo, Equator - 1

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

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

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

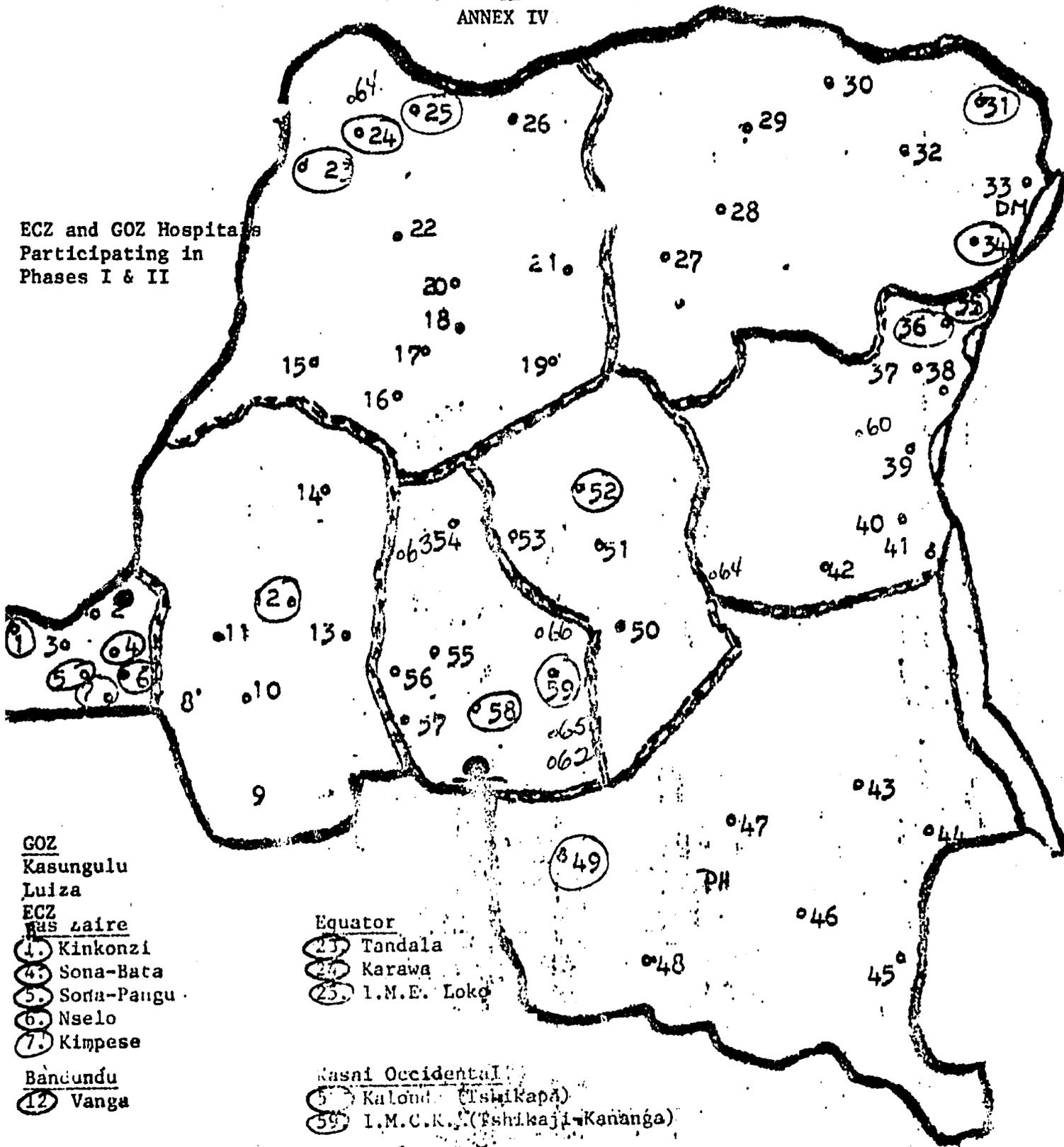
Annex III - Organization Chart of ECZ Secretariat



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ANNEX IV

ECZ and GOZ Hospitals
Participating in
Phases I & II



GOZ
Kasungulu
Luiza

ECZ
Bas Zaire

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

Bandundu

- 12. Vanga

Haute Zaire

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

Kivu

- 35. Oicha
- 36. Katwa

Equator

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

Kasai Occidental

- 51. Kalond (Tshikapa)
- 59. I.M.C.R. (Tshikaji-Kananga)

Kasai Oriental

- 52. Wembo-Nyatra

Shaba

- 49. Kapanga
- PH. Kamina (Program Headquarters)

ANNEX V

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

A. In the Region of Bas Zaire

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

B. In the Region of Bandundu

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

C. In Equator Region

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

D. In West Kasai Region

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

E. In East Kasai

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

F. In Haute Zaire

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

G. In Kivu Region

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

H. In Shaba Region

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

ANNEX VI

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

A. BAS ZAIRE

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

B. BANDUNDU

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

C. EQUATOR

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

D. WEST KASAI

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

E. EAST KASAI

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

Annex VI (continued)

F. HAUT ZAIRE

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

G. KIVU

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

H. SHABA

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

ANNEX VII

BASIC EQUIPMENT TO BE PROVIDED HEALTH CENTERS

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

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

Annex VII (continued)

3.

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

ANNEX VIII

LIST OF PHARMACEUTICALS TO BE PROVIDED HEALTH CENTERS

ANTIBIOTICS

Ampicillin capsules 250 mg

Penicillin G/Proc peni 4M IU

Tetracycline 250mg, tablets

Sulpha

ANTIMALARIALS

Chloroquine phosphate 100 mg, tablets

Pyrimethamine, DARAPRIM, 25mg tablets

ANALGESICS, ANTIPYRETICS

Acetylsalicylic acid (aspirin) 500 mg tablets

ANTHELMINTIC DRUGS

Decaris 50mg tablets (Levamisole) child

Decaris 150 mg tablets (Levamisole) adult

ANTI-ANEMIC DRUGS

Ferrous sulphate tablets 300mg or 200mg

Folic acid tablets 5mg

ANTIDIARRHOEAL

Oral rehydration (Oralyte) Salt, Sugar, Sodium Bicarbonate

OPHTHALMIC PREPARATIONS

Tetracycline 1% Eye ointment

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

ANTISEPTICS, EXTERNAL USE

Mercurochrome powder, 500 g

Annex VIII (continued)

2.

Savlon 5L Container

OXYTOCICS (OB)

Ergometrine maleate 0.2 mg tablets

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

Trunk with padlock

VACCINES (Possibly furnished by PEV)

BCG Vaccine

Poliomyelitis vaccine (oral)

Measles vaccine

DTPertussis

Annex IX

Pharmaceutical List for Village Health Workers

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

ANNEX X

1. Contents of the basic UNICEF midwife kit

One basin

One bowl

One pouch

Sheeting

Three bottles

One bag

Brush

Cotton

Gauze pad

Soap box

Soap

Towel

Forceps

Scissors

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

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

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

3. The most complete kit is designed for a trained auxiliary midwife A-3 and includes a few medicines.

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

Annex XI

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

- Werner, Where There is No Doctor, Swahili version
French version
English version
- Kangu Majumbe, Flip Charts - Malaria
Centre pour la Promotion de la Sante - Nutrition
Dr. Courtejoie - Sanitation
- Macagba, Refino, Health Care Guidelines for use in developing countries
MARC, 919 West Huntington Dr., Monrovia, CA. 91016
- CRDI, Ottawa, La Medecine Traditionnelle au Zaire; Fonctionnement et
Contribution Potentielle Aux Services de Sante. Ottawa, Ont. CRDI, 1979
63 pp
- King, et. al., Nutrition for Developing Countries, Oxford University Press,
Lusaka, London
- Filmstrips, Family Planning World Neighbors
(entire Rabbit Raising, set) 5116 North Portland Avenue
Oklahoma City, Oklahoma 73112 U.S.A.
- Material Realise a l'Atelier Flip charts
de Material Didactique (entire series)
B.P. 18, Nogizi, Burundi
- INADES, Development Education by Entire series, CEPAS, Kinshasa GOMBE, Zaire
correspondence
- National Food and Nutrition Commission Posters
P.O. Box 2669 Teaching material on nutrition
Lusaka, Zambia
- F.A.O. Village level material
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Co., 200 Park Avenue, So., N.Y. 10003
- Visual Communications Handbook, 30 Guilford St. London, WCIN IEH
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ANNEX XII

JOB DESCRIPTION - PROJECT DIRECTOR

General Description of Responsibilities

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

Specific duties and responsibilities will include:

- Liaison with other health care providers; keeping them informed on project activities and reporting on other health care programs.
- Supervision of the work of the Project Manager, Family Planning Training Specialist, and Program Planner.
- Representation of the ECZ and the project at donor committee meetings.
- Recommending health policy changes to ECZ and GOZ.
- Developing guidelines for ECZ hospitals in training, family planning nutrition education.

Qualifications

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

JOB DESCRIPTION - FAMILY PLANNING/TRAINING SPECIALIST

General Description of Responsibilities

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

Specific responsibilities and duties will include:

- Identification and processing of participants for long and short term training.
- Liaison with other organizations working in family planning.
- Development of short term training seminars for nurses and other health care professionals.
- Development of a curriculum for training village health workers and traditional midwives in family planning.
- Developing with short term technical assistance a system for family planning statistics within the ECZ and GOZ systems.
- Preparation of regular reports on training and family planning activities
- Developing a curriculum for introducing family life education in secondary schools.
- Assisting the Operations Officer with inventory, procurement and distribution of contraceptive commodities.
- Development and evaluation of a system for community distribution of contraceptives in collaboration with the Tulane Family Planning Operations Research Project.
- Assisting Project Manager and hospitals in developing local action plans.
- Assist Project Manager in preparing project reports.
- Assisting hospitals to develop suitable audio-visual training aids.

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

Qualifications:

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

JOB DESCRIPTION - PROJECT MANAGER/
COMMUNITY DEVELOPMENT ADVISOR

General Description of Responsibilities

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

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

Specific duties and responsibilities will include:

- Recruiting, hiring and supervising the work of the Administrative Assistant and the Secretary/Typist.
- Monitoring financial disbursement procedures including cosigning checks of the special project counterpart fund
- Project reporting, monitoring, and evaluation, including preparation of the annual counterpart budget request.
- Analyzing short term personnel needs and preparing appropriate documentation.
- Strengthening the planning capacity of ECZ.
- Coordination of ECZ and GOZ data collection systems.
- Orienting hospital public health personnel to project objectives, methods, and reporting.
- Assisting hospitals in developing their action plans for project implementation.
- Assisting Operations Officer in planning and organizing health conferences.
- Collaborating with the Operations Officer and Training Specialist for identifying candidates for training.
- Providing technical advice on acceptability of planned interventions in village milieu.
- Analyzing and recommending acquisition of commodities required to meet project objectives; preparing of appropriate documentation.

Qualifications:

The Project Manager should be fluent in French and English. He should have experience in health project implementation in Africa. He should be familiar with the ECZ, USAID, and GOZ. He should be familiar with community organization, health planning, and have a background in administration and planning. He should be qualified by experience to deal with levels of society from village chieftans to religious and civil authorities. He should be familiar with family planning philosophy, technology, and service delivery.

JOB DESCRIPTION - OPERATIONS OFFICER

General Description of Responsibilities

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

Specific duties and responsibilities will include:

- Serving as Executive Secretary of the Project Advisory Committee.
- Planning and organizing the Annual Health Conference.
- Liaison with the pastors of the ECZ system for the dissemination of family planning information.
- Developing the overall plan for project commodity management in coordination with the hospitals, USAID, CNND, PATHFINDER, EPIA, UNFPA, IPPF and UNICEF.
- Reception, storage and transshipment of project commodities.
- Arranging for and supervising commodities procured in Zaire.
- Development of a system of inventory and reporting for all commodities as well as a system for monitoring their use.
- Liaison with MAF, for coordination of project transport.
- Development and maintenance of a system of accounting and financial reporting; preparation of project vouchers (in collaboration with the Project Manager); liaison with USAID Controller.
- Assisting the Project Manager in the preparation of hospital action plans.
- Assisting the Project Manager with the preparation of project reports.
- Other duties as assigned by the Project Director.

Qualifications:

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

9/6

ANNEX XIII

HOSPITAL DATA SHEETS

CEUM Hospital, Karawa
B.P. 140
Gemena
(Communaute Evangelique de l'Ubangi Mongala)

Region: Equator
Sous-Region: North Ubangi
Zone: Businga

1. Background:

In 1937, the Evangelical Covenant Church of America was invited to open the first hospital in Karawa. In 1960, the hospital was placed under the ECZ network. In 1980, a \$22,000 subsidy was received from the GOZ in addition to \$5,000 worth of medical supplies. The hospital has 162 beds, five physicians (two Zairians), a dental hygienist, a pharmacist, a physiotherapist, seven registered nurses (two Zairians), and 20 auxiliary nurses. Annual local expenditures average \$224,688.

2. Senior Staff:

Barbara Johnson, Director, Nursing School, Public Health Outreach-Mobile Team

Bob Thornbloom, Director, Technical Services

Dr. Helen Berquist, MPH

Mlle Marian Algren, RN

Mlle Grace Nelson, RN midwife (interested in training traditional midwives)

Dr. Kongawi Kinde, M.D.

Cit. Buhi Bella, Assistant Director for General Services

Cit. Bange-ya/Nguilume, Physiotherapist

Dr. Lanoie, Medical Director

3. Training Facility:

The hospital's nursing school is accredited by the GOZ and has graduated 90 nurses in three specialities.

4. Major Public Health Problems:

Malaria, measles, verminose, malnutrition, TB, diarrhea, yaws, leprosy

5. Economic, Agricultural and Cultural Information:

Located in the northwest of Zaire, the hospital is approximately 160 air miles east of Bangui. The area served by the hospital is mostly transitional agricultural area, made up of grassland with light forest areas. The nearest city, Gemena, has a population of 30,000 and is 75 km from the hospital. The hospital's own medical facility serves a population of roughly 10,000 to 15,000 persons, 2,000 of whom live within a 2-3 km radius of the hospital. The hospital serves as a referral center for a population of over 250,000 whose primary care and health needs are met by a network of dispensaries and traditional practitioners of various sorts.

6. Public Health Outreach Project:

To date, most of the activities have centered around the extension of basic curative activities from the hospital center to those areas in the hospital's immediate vicinity. During the next five years the hospital plans to concentrate more of its resources on prevention and treatment of the major health problems. To this end, the hospital is planning, inter alia, to initiate an extensive outreach program focusing on the formation of village health committees and training of volunteer village health workers. The hospital has recently initiated formation of village health committees and identification of midwives.

It is planned that a VDC (Village Development Committee) will be formed within each target village. This VDC selects the VHW (Village Health Worker), works with him/her and controls him/her so that the VDC is responsible for seeing that the VHW fulfills his functions and does not abuse his position.

VHW Training. A four-week program will be offered two times a year (or a two-week program four times a year) for approximately 30 VHWs per year. The men selected by the VDC will be brought to Karawa and exposed to an array of topics related to basic health services. They will receive

training in health education, health and nutritional education, recognition and treatment of certain simple diseases, family planning and recognition of health problems needing referral. The program is being developed and will be translated into Lingala at Karawa. The course outline is attached. All VHWs will receive on going support, supervision and continuing training, through monthly visits by their nurse supervisor and by regular visits by the hospital mobile team. Educational materials will be made available on a loan basis to the VHW to explain health concepts to the people.

Supervision: Direct supervision of the VHW will be the responsibility of the responsible nurse at the nearest dispensary/health center. The nurse will call the VHWs together from time to time for training and discussion. The nurse supervisor will be retrained every year at the hospital. The nurse will start with two VHW, expanding as more are trained. The Karawa Hospital Public Health staff will train and supervise the nurses and have ultimate responsibility for the VHWs. The VHW will be visited by a mobile team periodically.

The hospital is aware of the experimental nature of this undertaking and will carefully document the entire process. Information gathered will include:

- Numbers of VHWs trained
- Ability of VHWs to do routine tasks and provide correct information
- Percentage of VHWs retained over time
- Percentage of village population using VHWs
- Health of village population evaluated
- Morbidity/mortality statistics
- Family planning acceptors by method and continuation rates of new acceptors.

7. Family Planning:

Initiated in 1978 by the hospital. It presently serves approximately 100 acceptors.

8. Outputs Planned for 1981-85 (with Project Assistance):

30 VHWs identified and trained per year - 150 VHWs trained by 1985
75 Village Health Committees initiated and active
1,500 new acceptors of family planning
20 water sources protected
20 wells constructed/reopened
500 latrines constructed
75 villages with improved sanitation
75 pre-natal clinics
1 additional mobile medical team working in Public Health
20 nurses retrained in Public Health
20 traditional midwives trained

9. Inputs Needed:

1 diesel four-wheel drive vehicle with spare parts
2 Yamaha 125 or 175 trail motorcycles
25 bicycles

Basic Pharmaceuticals for start up stock of pro-pharmacies:

· Anti-malarials
Aspirin
Decaris
Oresol rehydration fluid
30 bulb syringes
30 thermometers

Tools and Equipment:

5 bore hole diggers
Cement and pipe
10 tons of cement
Large electric frigerator for keeping vaccines at Karawa
15 isothermic boxes
2 Ped-o-jets

Obstetrical Needs:

Leffscope for each health center 30
30 ventouse
1 doptone for fetal monitoring
Hematocrit centrifuge
15 microscopes

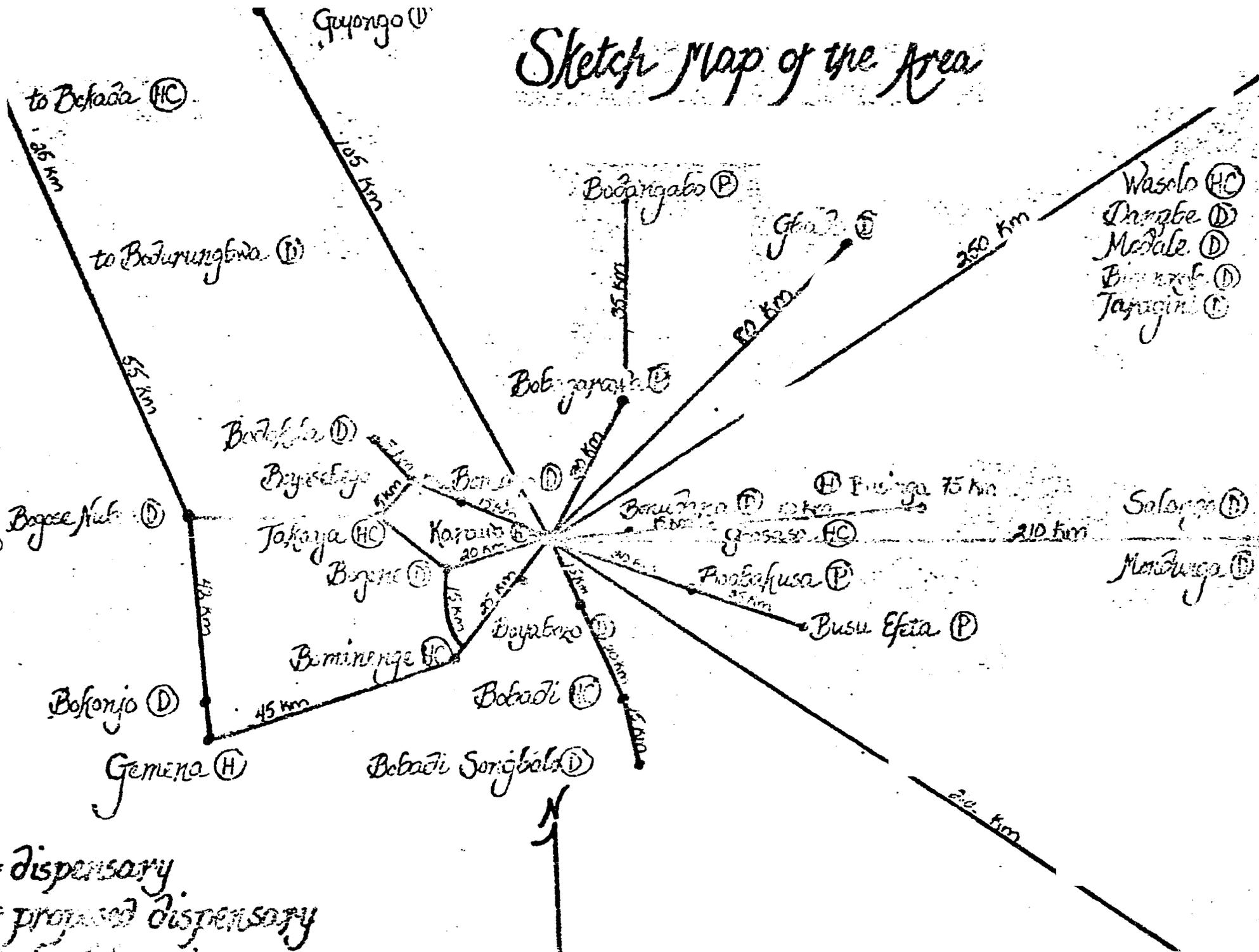
Other Needs:

15 suspension baby scales
Retraining expenses (zaire 25,000/yr x five years equals zaire 125,000)
Material for training village midwives: silver nitrate
razor blades
cord ties
ergot pills
iodine swabs
1 yd flannel cotton

Contraceptive Commodities:

For five years operation including 48,000 doses/year (ICC) of Depo-Provera

Sketch Map of the Area



- 6 -

(D) = dispensary
 (P) = proposed dispensary
 (HC) = health center

CME Hospital (NYANKUNDE)
R.P. 55
Bunia
Haute Zaire

Region: Haute Zaire
Zone: Bunia

1. Senior Staff

Dr. John Kyle, Administrator
Cit. Mondoboy, Coordinator, Nursing Training
Dr. Kambale Soheranda, Medicine Prefet
Marie-Jeanne Delessert, R.N., MPH, Public Health

2. Background

The CME (Centre Medical Evangelique) is an ecumenical grouping of six Protestant communities in terms of joint medical work in the area: CECA, CEHZ, CAFEZA, CECCA, AEBK, and ADZ. It gathers Zairians, Swiss, Canadians, Americans, Irish, and British. Presently, there is one Zairian M.D. and 5 expatriate M.D.s, 2 pharmacists, 1 dentist, 30 nurses, 9 midwives, and 66 other hospital personnel. The electrical power is furnished by a station of the Kilo-Moto Gold Mine some 13km distant. The Mission station connected the electrical cables for that entire distance, and the fuel costs have been cut in half, as a result. They were able to recuperate poles from an abandoned gold mine with the permission of the Commissaire of Mines.

In 1980 there were 5218 patients hospitalized, 1366 deliveries, and 3474 operations.

Funding is received from ICCO, Holland, I.L. Young Foundation, the EZE in Bonn, World Vision in Nairobi, and other donors.

Nurses Training School

Nine diplomas were awarded in 1980. School fees amounted to a total of 63,669 zaires in 1979-80. Nurses receive training in hospital nursing, public health and midwifery. Feeding the nursing students is becoming an increasing problem. The hospital receives salaries for certain personnel from the State, and occasional medicines from the DCMP. The annual budget for CME local current costs is 900,000 zaires per year.

3. Principal Public Health Problems

Malaria, worms, anemia, malnutrition, leprosy, TB, measles, enteritis.

4. Public Health Outreach System (see maps)

The community health activities were begun in 1979. Activities at present include:

20 Health Centers planned or in operation, each visited one time per month

40 Village Health Workers trained or in training (8 weeks)

24 clinics - pre school

- pre natal

(included vaccinations - V.A.V., B.C.G., D.P.T., Polio and measles) total of 67,044 consultations in these clinics.

5. Agro/Econo/Socio/Ethnic

Basic food crops are cassava, corn, bananas, and plantain. Coffee is the main cash-export crop. People also eat peanuts, rice and meat to the extent available. Cattle raising is also important.

World Vision has funded CAFEZA to run an animal raising project with about 200 head of cattle. The cattle dip serves all the herders in the zone.

The World Bank has an even larger Ituri Cattle project with the same purpose. Local tribes have sedentary herding traditions.

A lot of clandestine gold digging goes on, as well as the official mines at Kilo-Moto. The people prefer gold-digging to cultivating because it can bring faster returns.

The zone is a patchwork mixture of savannah and forest. Malnutrition is present in both areas, but more prevalent in the savannah. The pygmies inhabit the Ituri zone. They catch okapis and sell them to zoos all over the world. The area has one of the last large elephant herds in Zaire; poaching and blackmarketing of ivory is still a big business. Mount Hoyos Inn is run by Tourtel and the region attracts many tourists, whose numbers are held low by the minimal transport and infrastructural facilities.

6. Outputs

20 FP clinics opened; 4000 new acceptors for FP

5 midwives per year x 5 years trained

80 nurses recycled

20 VHW formed

30 sources protected; 2000 latrines dug

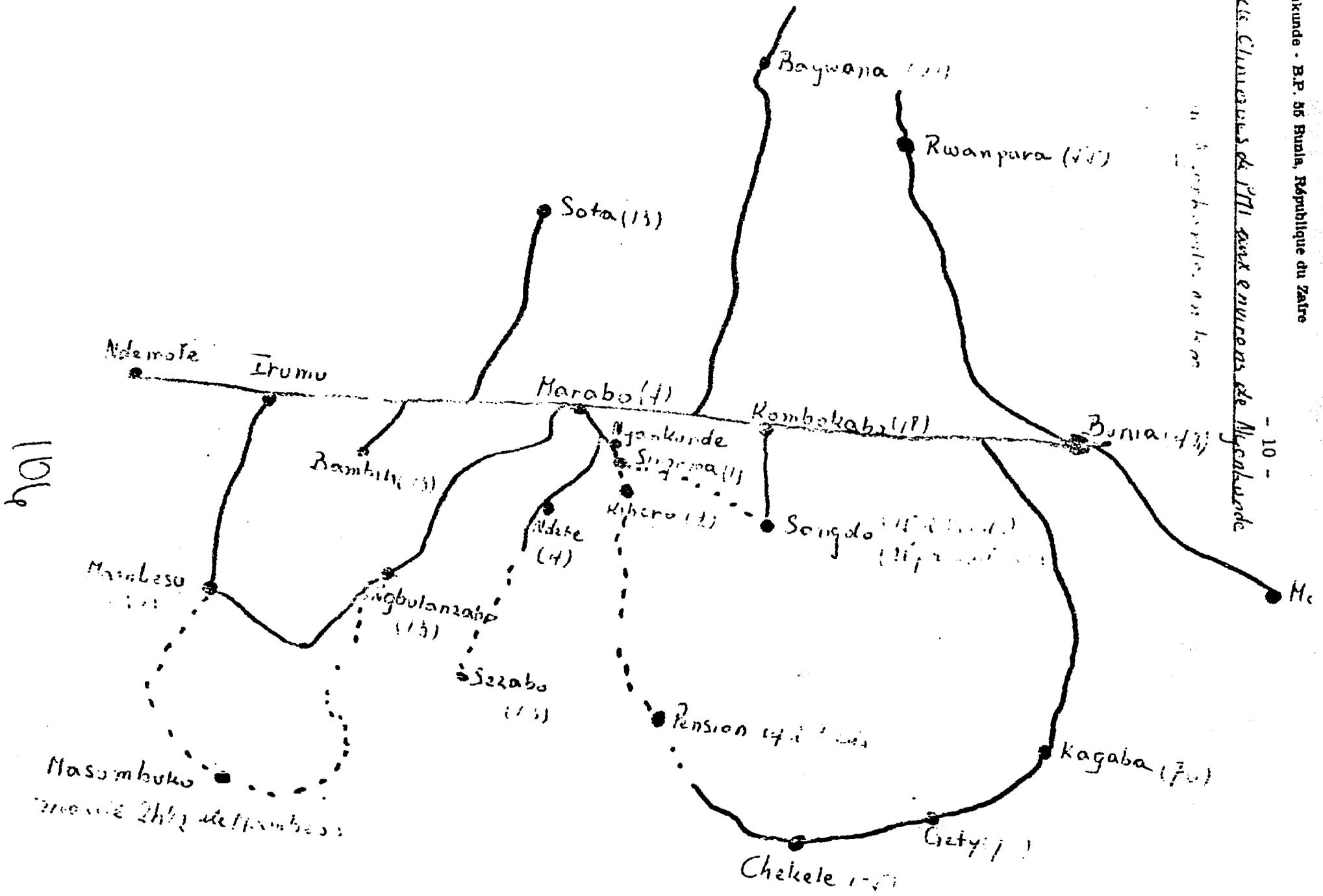
104

20 pro-pharmacies initiated
130,000 villagers helped in 5 years
2 classrooms built
1 National Meeting held
2 MPH formed abroad
5 films produced - AV aids
vaccinations

6. Inputs

1 diesel 4-wheel drive vehicle - Land Rover is preferable
20 bicycles
FP hardware - 5 year supply
1 refrigerator (petrol)
1 small freezer
1 electric freezer - 50 liters
2 12-volt batteries
1 typewriter, manual, large carriage, French
2 Yamaha 175 motorcycles
50 baby scales
Frais de déplacement 15,000/year - tighten Nyankunde surveillance of participating
satellite hospitals and health centers
2 classrooms - as Formation Centers - 10,000 zaires each
Recycling of VHW - 3000 zaires/yr and nurses
2 scholarships MPH
1 8mm projector
1 camera with battery
11 1/2 by 13 1/2 paper - 500 reams
4 sets of flip charts in nutrition, Public Health Education
Yearly conference at Kinshasa ECZ-GOZ Project Centers, 100,000 zaires

Nyankunde - Clivages de l'ITI aux environs de Nyankunde



Aba Hospital
B.P. 143
Bunia
Haute Zaire

Region: Haute Zaire
Sous-Region: Haute Uele
Zone: Farandja

1. Background:

Aba Hospital was built about 50 years ago by African Inland Mission. It has 65 beds and belongs to the C.E.C.A. It has one missionary nurse, one Nyankunde graduate nurse, one state certified midwife, one leprosy worker, three maternity helpers, five hospital helpers, two office workers, and two maintenance workers.

There is a GOZ hospital 3km from Aba. Aba Hospital serves as a center for five outlying dispensaries plus its own dispensary. Its annual approximate operating budget for local costs is zaires 51,600, 1/3 of this pays personnel. It presently receives no help from the GOZ for salaries or medicines. The system averages 30 deliveries per month.

2. Director: Carolyn Nebel

3. Prevalent Diseases: malaria, worms, anemia, diarrhea, TB, leprosy, measles, polio, cataracts, and various tumors.

4. Public Health Outreach:

Dispensaries:

Adja
Aru

Todro

Adi

Maitulu

Clinics:

Pre-scholar, 50 per clinic

Vaccinations: DPT, polio, measles, smallpox, BCG as available

Pre-natal

Leprosy

5. Agro/Econo/Ethno/Socio:

The Kakawa, Logo and Mundu are the main tribes but people of Sudanic origin come from as far as Juba, as refugees or nomads, for treatment. Women do not eat eggs or monkey meat according to local taboos. There is much superstition, and many local healers whose curses are said to make people sick. Food taboos relate to fertility.

The Aba Hospital water source is a spring which has been piped and cemented. The water is potable.

Agricultural activities consist of gardens for personal use as well as commercial value. Coffee is the main cash crop. Food crops are corn, sorghum, rice, beans, peanuts, tomatoes, manioc leaves, manioc, spinach, papaya, oranges, and pineapples. Chickens and wild meat are also consumed.

Family Planning: There are presently 40 acceptors.

6. Outputs:

5 expanded pre-natal clinics

5 pre-school clinics

Vaccination clinics, 5 villages intensified/expanded

5 Pro-pharmacies

200 new Family Planning acceptors

200 latrines constructed

7. Inputs Needed:

1 motorcycle

1 nurse, trained at Nyankunde

5 baby scales, hanging

5 isothermic containers

5 refrigerators (petrol)

Basic medicines: vermox, IMH, antimalarials, iron, vitamins, antidiarrhea

Vaccines: measles, DPT, BCG, antipolio 600 ea/year x 5 years

Contraceptives

1 minilaproscopy

Nsona-Pangu Hospital
B.P. 4728
Kinshasa 2

Region: Bas-Zaire
Sous-Region: Cataractes
Zone: Songololo

1. Background:

This 120-bed hospital, sponsored by CBZO (American Baptist Community, Valley Forge, PA), has 27 employees. Two doctors, one A-2 nurse, six A-3 nurses, two nurse associates, one nurse/midwife, and 15 practitioners. The annual budget from the Zaire government is zaires 2000. The operating budget (local currency) for 1979-80 was zaires 106,000. The GOZ pays the salaries of the two Zairain doctors as well. About zaires 6000 worth of medicine from the DCMP arrived last year. There are about 30,000 people in the zone.

2. Senior Staff:

Dr. Nlandu Mangani, Director

Dr. Mbakulu

Cit. Basidi Yungulu, Chief of Service for Community Health

3. Most Prevalent Public Health Problems:

Intestinal parasites, enteritis, pulmonary problems, measles, malnutrition

4. Agro/Econo/Ethno:

The area produces a wide variety of agricultural products which are exported by truck to Matadi, other areas of Bas-Zaire, and Kinshasa. Major food crops are bananas, plantain, lemons, and manioc. The farmers in turn buy clothing, salt, sugar, soap and other basic necessities. Farmers do tend to sell most of their produce. This does cause some malnutrition.

5. Other Activities:

a) USAID has sent Robert Thornbloom to study the possibilities of improving a dam, left by the Belgians long ago, in order that the hospital could have hydroelectric power. The results are under study.

b) Tulane University has initiated a study on a community based contraceptive distribution program. This study, which began in late 1980, will complete its work in 3 years.

Medical Network of Kamina

Region de Shaba
Sous-Region de Haut-Lomani
Zone de Kamina

1. Background: While the Methodist Medical facility at Kamina includes a dispensary and a maternity, as well as plans for a hospital, it also represents a coordinated system of outreach. The Ecole des Infirmieres run by this same United Methodist Community of North Shaba, has 16 students in training for an A-2 level. This community is related to the United Methodist Church of the USA, headquartered in New York. The 20 dispensaries have all been opened in the last 5 years, and are located in small towns and villages. The nursing school, mentioned above, called the Institut Technique Medical Cretien Lupandilo was recently opened in November, 1980. It is a 4 year program and will graduate its first group in 1984. 35 Zairian nurses are involved in this medical network; 2 laboratory technicians and 25 other employees. The total personnel budget is 12,000 zaires a month and the operating budget is 24,000 zaires a month. They receive nothing from the GOZ as of the moment. The network plans to serve as much of the North Shaba population as possible.

2. Staff: Dr. Bruce Obenshain, Medical Director for Methodists, North Shaba; Citoyenne Mungedi, R.N. Prof. IMEK, Family Planning (trained New York); Bishop Ngoi, Methodist bishop, North Shaba; Pastor Kazadi, Parish of Kamina (with Dispensary and Maternity); and a new Zairian M.D. is due to arrive in September 1981.

3. Principal Public Health Problems: 1) Malaria, 2) Diarrhea/dehydration, 3) Malnutrition, 4) Measles, 5) Intestinal parasites, 6) Shistosomiasis, 7) Whooping cough.

4. Socio-economic-ethnic-agricultural data: North Shaba is a region of ranches, animal raising and agriculture as well as its mineral reserves. Manioc (cassava) and corn are the staple foodcrops. The Shaba Governor's Commission fixes the price of corn each year - often to the detriment of the small producer. The USAID North Shaba Project is focused on increasing corn production and using non motorized agricultural tools. The Lulaba river provides a good supply of fish to the local diet. There was a manioc epidemic five years ago but by now the resistant varieties have been established and are taking over. People also cultivate peanuts and vegetables. GECAMINES runs KANIAMA which is a plantation to produce corn. INERA does research in animal husbandry, provoked by the proneness to sleeping sickness of the cattle in the Shaba.

The Methodists in North Shaba have three agronomists (Padhila in Kamina; Hammer in Kabongo; and Malemba in Luena.) Goat herding is done at Luena by Enright;

Kamina specializes in promoting chicken raising by subsidizing inputs to the farmers.

Kalemie and Mikia are in pastoral zones where the local tribespeople, the ZANarwanda have followed these ways for generations. Kiabukwa is a state ranch center with over 5,000 head of cattle. Shaba has imported corn and grain from South Africa and from Zimbabwe in past years, particularly for the GECAMINES workers in the copper belt. Cotton is exported from the area by FILTIZAU which both cultivates and buys from the people.

The Baluba who speak Kiluba (not Tshiluba) are the dominant group.

5. Public Health Outreach System (see map annexed)

20 dispensaries at present

20 new to be added (4 per year)

Pre natal clinics - 2

Pre school clinics - 2

Mobile Medical team - 1

Medical Village Committess - 20

40 acceptors at present of FP

<u>Village</u>	<u>Dispensaries</u>
Kamina	Nyunzu
Kanene	Maneno
Kasanya	Kabale
Zaila	Kaniama
Lwembe	Muleba
Kabongo	Kimba
Nkimbi	Luena
Kitenge	Butumba
Mwanza Seya	Kisamphu
Lwamba	
Kalemie	
Vyura	
Mutea	

6. Outputs

10 new FP clinics

30 new MCH clinics

30 village vaccination programs

15 traditional midwives trained

25 nurses/yr recycled

30 village animators formed

120 village health committees organized

20 school sex education programs started

1 health planner trained at MPH level

200,000 villagers helped

100 pro-pharmacies initiated

2,000 latrines constructed

1,000 Family Planning Acceptors

7. Inputs Needed

1 Landrover diesel 4-wheel drive

15 bicycles

1 French typewriter

2 motorbikes - Yamaha 175

20 baby scales

20 fetascopes

20 petrol frigos

metal roofing for 15 new dispensaries (people build walls)

cement - 75 sacks of cement for dispensary reinforcement

2 brick presses - SIVURAM

Flip charts - 20 sets

FP hardware - depo-provera - for 20 dispensaries/5 years

IUDs

vaginal speculums (35)

uterine sounds

scissors (35)

oral contraceptives

Vaccine Carriers - 35

Nurses training - 5,000\$/yr. x 5 years

Stage for Village Health Agents - 5,000\$/yr.

2 scholarships abroad for MPH (Sanitation and Health Planning)

Basic Drug stock and basic vaccine stock - possibly placed in each parish

Kits for traditional midwives - 35

Region of Kasai Occidental
Sous-Region of Lulua
Zone of Luiza

Hospital of Luiza (State)

1. Background: Founded in 1956, the hospital of Luiza has 240 beds in 7 hospital pavillions and an administrative center. It also has a maternity facility. The region (zone) of Luiza is densely populated with 208,263 residents.

2. Staff

a) Hospital

Dr. Padingany Muabilay, Medcin Dir. de la Zone Medicale de Luiza

Mambuela Tshibuabua,

Tshituala Ngudie, Infirmier Chef de l'Hopital

5 diploma nurses

15 nurses aides, nursing students and other employees

b) Rural Dispensaries

13 nurses work in 13 rural dispensaries

3. Principal Public Health Problems

Malaria	Syphilis
GC	Rhumatism
Internal Parasites	Enteritis
Kwashiorkor	Gastritis
TB	Anemia

4. Agro/Economic Sociological Data

The zone is primarily an agricultural one whose principal food crops include cassava (manioc), corn and peanuts. Some animal raising also takes place. ONAFITEX is a private cotton-growing and buying company. It distributes seeds to the people who then cultivate cotton in their own fields and sell it to ONAFITEX at 50 Makuta/kilo. Since Kananga is over 200 kms. away and a river must be crossed to get there, the people do not have the option of selling their cotton elsewhere. The other border is Angola, and there is a lot of seasonal migration. The HCR (High Commission for Refugees) in Angola seems well organized and the people are able to obtain some medicines over on that side from time to time. The GOZ/DCMP allotment of medicines for the whole zone of Luiza for two years was 7 cartons of bicarbonate. Presently inpatients are not taken into the hospital. The diesel generator has been broken for two years and the hospital has no electricity. The watertower is not functioning and there is no water for the hospital. The x-ray/surgical equipment does not function.

The tribes of the zone are the Basala, Bakete and Balualua. They use traditional medicine with village healers. Women do the agricultural work.

5. Training Capacity ITM (Institut Technique Medicale)

Two cycles, long and short, with 150 students, and 5 professors, including a Prefet, offers A-2 level courses with an option for hospital nursing or midwifery. The Institute does not have an appropriate building and does not receive food, as other institutes in Zaire.

6. Outreach System

The hospital has supervisory responsibility for dispensaries at:

Luiza	Mbunza
Tulane	Bambaie
Muala Ntumba	Samuanda
Ntende	Mayimbu
Kanelekese	Yao
Kabuluku	Kalala Diboko
	Luiza Prison

Four of the dispensaries have been closed for lack of supervising personnel and medicine. 21 nurses in all work in the zone of Luiza.

7. Outputs

Mobile Medical Team to survey dispensaries and give nutritional/sanitation education: 1 ITM student; Sanitary Educator; Dispensary nurse. 130 "agents de sante" local formed in 10 villages around each dispensary. 1,200 latrines dug. 10 water sources cleaned up

Vaccination campaigns in villages - 13 dispensary villages - smallpox
measles
BCG
Tetanus (as needed)

13 nurses recycled in Public Health/Nutrition/FP

13 dispensaries equipped

1 water tower repaired

13 clinics equipped with FP materials/100 new acceptors

8. Inputs Needed:

Vehicle - 1 4-wheel drive diesel vehicle

2 Motorcycles

11 bicycles

15 baby scales

8 flip charts for health education

2 petrol refrigerators

22 white uniform blouses

Tetanus serum

1 hand stencil copier

Repair water tower

Repair generator

2 scholarships in Public Health

12 microscopes

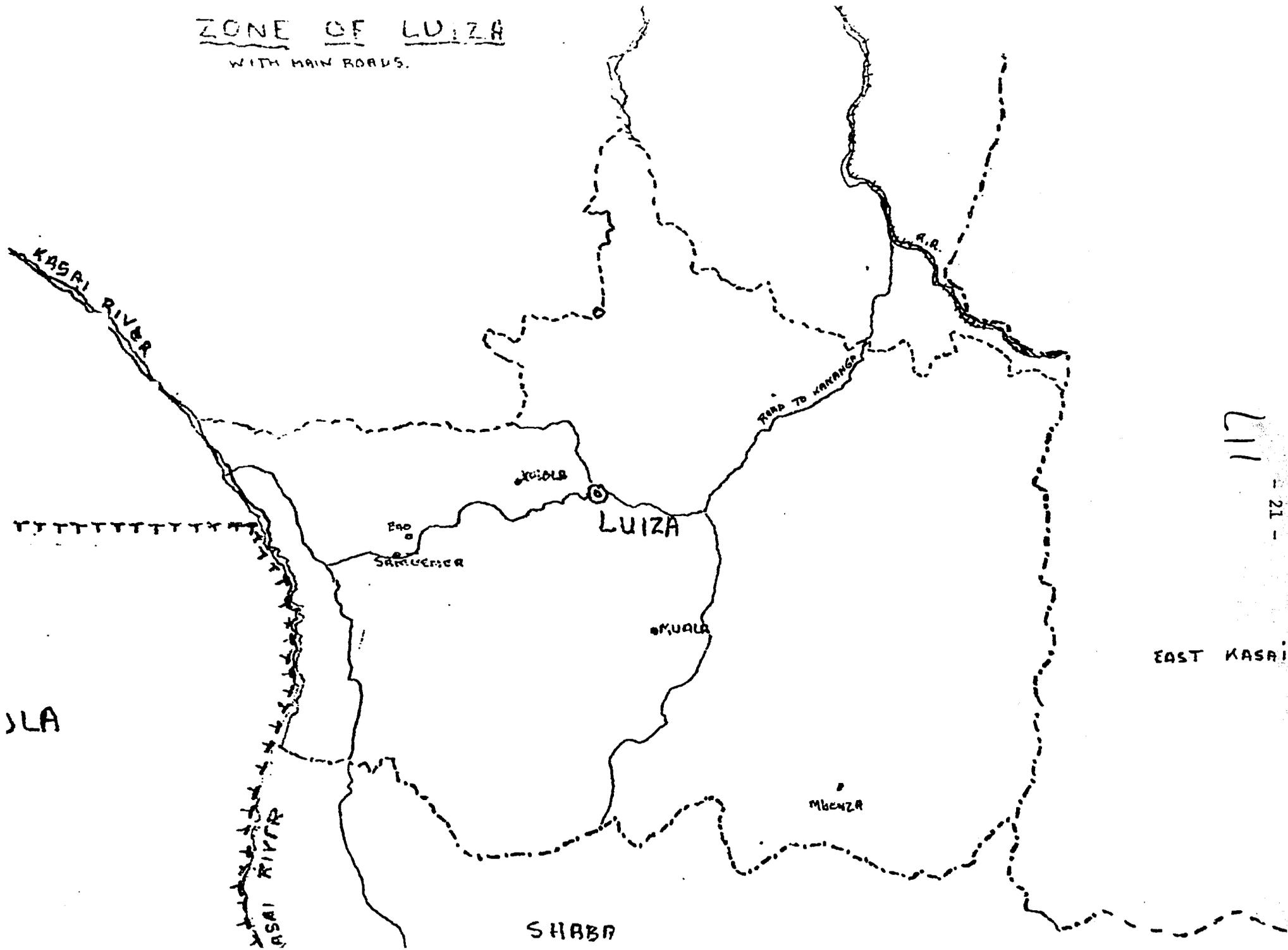
12 stethoscopes

Vaccines: BCG

Recyclage - nurses in 11 dispensaries

ZONE OF LUIZA

WITH MAIN ROADS.



Kolanda Hospital
 CMZ
 B.P. 18
 Tshikapa

Region: Kasai Occidental
 Sous-Region: Kasai
 Zone: Tshikapa

1. Background:

This 173 bed hospital was founded in 1950 by the Forminiere Diamond Company. It is located 115 miles west, southwest of Kananga in West Kasai. After independence in 1960, the hospital was turned over to the Mennonite Community of Zaire, whose stateside headquarters is in Elkhardt, Indiana. Several staff members have worked at the hospital since independence and have a good understanding of the local people, the culture, and the public health problems. The hospital receives an annual subsidy of zaires 30,000 from the GOZ. The local currency operating budget is zaires 400,000.

2. Staff:

a) Senior Staff:

Dr. Dennis Ries, M.D., Medical Director

Dr. Bakole Wakedi

Citoyenne Kakoyi, Responsible for Family Planning (trained at Metropolitan Hospital, New York)

Citoyen Kalshimnanga, Responsible for Public Health

Cit. Kabuniti

Cit. Kalumba

Cit. Zamyiyo

Cit. Tshiwuapa

b) Other Staff:

25 nurses and other employees

3. Socio/Econo/Ethno/Agri Data:

The principal ethnic groups are the Tshikwe, Pendi, Babendji, Bakwanyambi and Luluwa.

Difficulties of transport and gas/diesel fuel availability has provoked a serious interest in the installation of a hydroelectric turbine which would pay for itself (\$200,000 estimated cost) over a 10-15 year period. The hospital administration will make contact with the agriculture office of USAID on

this subject to effect a feasibility study.

Tshikapa zone is rich in diamonds, enjoys two official British diamond purchasing counters. Artisanal diamond exploration runs a parallel apparatus to the official diamond mines. People are generally much more interested in mining diamonds than in doing cultivation in the fields. Thus, agricultural products are imported to the zone, and the price is very high. Corn from as far away as Kongolo in North Shaba is sold in this area. The change of money in December, 1979, hit very hard in this area as the traffickers in diamonds are accustomed to accumulating large amounts of local currency. North of Kalonda at Nyanga in the same Kasai Occidental, the same Mennonite Community runs a Rural Development Center called SEDA. SEDA has 35 extension agents who have promoted the raising of rabbits and chickens in the entire region of Kasai. This has been a precarious process because if rain shortfall produces an animal feed shortfall, the rabbits and the chickens are rapidly consumed, as happened in 1978, after which the program had to reconstitute its stock from almost the zero point. There is great interest by the Mennonite authorities of the region to begin a low-cost self-help housing project. The first set of houses will be begun before the end of 1981. The agricultural extension agents of SEDA often reinforce the Public Health agents of Kalonda in the villages, and the housing program will reinforce both and promote a sanitary environment.

MEDA (Mennonite Economic Development Agency), based in Kikwit, has made many loans in this region for sawmills, grinders, and other activities.

Manioc and corn are the staple food crops along with peanuts and beans.

The population for the zone is approximately 340,000.

Fish ponds are promoted in this region with a large degree of success, coordinated through the Gandijika stock ponds and training program in south Kasai through a USAID Grant.

4. Principal Diseases:

Malaria, intestinal parasites, anemia, malnutrition, TB, and GC.

5. Public Health Outreach System:

5 hospitals, 4 with M.D.s

20 rural dispensaries, 12 actively involved in Public Health

15 nurses with some training in Public Health

3 vaccination teams

4 MCH clinics

10 pre school clinics

16 pre-natal clinics

4 mobile medical teams

10 Village Health Committees

N.B. see list of 20 dispensaries classed by type of Public Health activity in Annex.

6. Family Planning Activities:

Begun in 1976 and has served 786 acceptors to date.

7. Outputs Planned:

2 new Family Planning clinics opened

1100 new Family Planning acceptors (220 per year x 5 years)

15 nurses retrained

15 midwives retrained

30 Public Health Workers (village level) identified and trained

20 Village Health Committees formed

Sex/health education courses begun in 2 local schools

Poultry/fish/garden activities promoted in 20 villages

Vaccination programs expanded to 20 villages, 500 plus people in each village vaccinated.

8. Inputs Needed:

1 diesel 4-wheel drive vehicle

2 Yamaha 175 motorcycles

20 Raleigh bicycles

10 nurses retrained, 5000Z/yr

15 midwives trained, 5000Z/yr

1 classroom complex built, 30,000Z

10 baby scales

15 sets of flip charts; other education materials

2 scholarships at the MCH level, public health administration (Cit. Mushimbele Ikutu)

30 Public Health animateurs trained locally at 5000z/yr

40 village midwife kits

Contraceptive commodities: Copper Ts

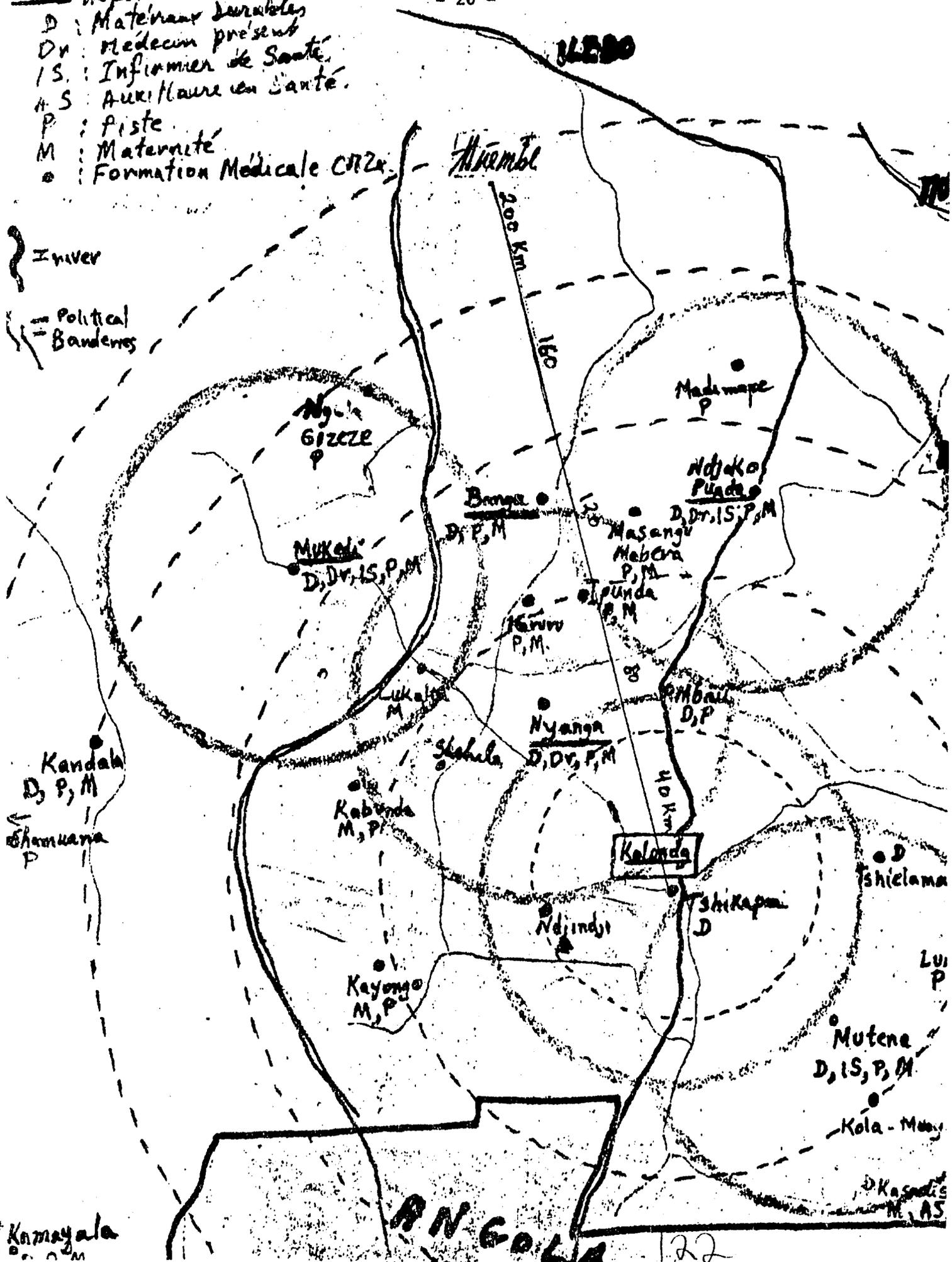
Condoms

Depo-provera (5 year supply)

- Hospital maternité
- D : Maternité durable
- Dr : Médecin présent
- I.S. : Infirmier de Santé
- A.S. : Auxiliaire en Santé
- P : Piste
- M : Maternité
- : Formation Médicale CRZA

— Inver

— Political Borders



Kamayala

ANGOLA 122

Dispensary/Maternity of Blukwa
B.P. 143
Bunia, Haute Zaire

Region: Haute Zaire
Sous-Region: Ituri
Zone: Djungu

1. Background:

This dispensary/maternity with 48 beds, is located halfway between Bunia and Rethy. It originates with the African Inland Mission, now the C.E.C.A., and is a satellite institution affiliated with the CME at Nyankunde. It was built in 1948.

The annual operating budget is zaires 32,000 of which half goes for salary. Nothing is received from the state either for salaries or medicines. The densely populated zone of Djugu has 500,000 inhabitants.

2. Senior Staff:

Viola Gifford, RN, Director

6 nurses

1 laboratory technician

4 other mission employees

3. Prevalent Diseases: Intestinal parasites, anemia, malnutrition, infected scabies, malaria, enteritis, bronchitis, measles, whooping cough, schistosomiasis.

4. Agro/Econo/Socio/Ethnic:

The Walendu and Wahema are the major tribes in this area. They have tribal, village localit , and collectivit  chieftains. Women are forbidden by taboo to eat eggs, chicken and pork. Housing is primarily mud brick with grass thatch roofs.

Manioc, sweet potatoes, beans, corn and grain are the food crops. Coffee, tobacco and beans are the cash crops. Ninety percent of coffee and 75% of the beans are exported. Soy beans have been successfully introduced. The people also weave baskets and sleeping mats to sell.

5. Public Health Outreach System:

All points visited at least once every 3 months.

Linga (Disp./Mat.) 31 clinic points (see maps)

Theu (Disp/Mat.) 3 pre natal clinics

33 pre school clinics
1 vaccination team

6. Family Planning:

Activities were initiated on a small scale in 1979. To date, the system has 30 acceptors.

7. Outputs:

33 FP clinics opened 1000 new acceptors in 5 years
30 pre natal clinics opened
33 expanded vaccination programs in villages
2 midwives trained
1 MPH trained
30 health committees formed
30 water sources protected
300 latrines dug
200 villages helped totaling 120,000 population with prophylactic medicines
15 village health workers formed

8. Inputs Needed:

1 motorcycle
10 bicycles for VHW
first stock of basic preventive medicines
10 sets of flip charts, posters, A/V aids
10 IUD kits
10 baby scales
10 adult scales
10 sphygmomanometers
10 fetascopes (horn-type)
3 ventouses
books - 6 sets Courtjoie
 - 6 sets Fountain
5 small refrigerators (petrol)
6 thermal boxes
1 portable refrigerator

6 canteens for centers (to store medical equipment)

1 MPH scholarship

contraceptive commodities for 5 years

expenses for training 15 village health workers

Hospital of Wembo-Nyama
B.P. 560
Kananga

Region: Kasai Oriental
Sous-Region: Sankuru
Zone: Katoko-Kombe

1. Background

This 125-bed hospital of the C.M.Z.C. (Communaute Methodiste de Zaire Central), is related to the United Methodist Church of the USA, headquartered in New York. It was founded in 1914. It has a planned outreach system and since Sept. 1980 has benefited from a pilot grant No. 660-0067 for implementing primary village health care. The hospital supervises 46 dispensaries in the Sankuru sub-region of Kasai Oriental, of which 19 receive more intensive care as they are in walking distance of the hospital. The project has zeroed in on four villages for in-depth village phase 1 activities. This experience has proven the feasibility of volunteer village health workers and village health committees.

2. Senior Staff

Dr. Lisangola

Dr. Leke -Lokombe

Cit. Dikoma-Shungu, RN, Responsible for Public Health

Mlle Josie Saprid, RN

Other staff - 46 nurses

3. Ethnic/Socio/Agro/Economic Data

The Batetela is the principal tribe.

Rice is a staple food crop. Two Peace Corps volunteers and an American Methodist agronomist have introduced irrigated rice culture into 15 villages. Food storage is a big problem. The people do not have enough food to last themselves through the dry non-harvest months. The Ambassador's Self-Help Fund allowed the construction in Katoko-Kombe of five large cement food storage silos under Alan Landis. This proved a clear failure, since the people had not enough cooperative experience to trust each other to store their food in the same silo; the silos stand empty today. The Family Basic Health project can learn by this experience

in promoting traditional family-size food storage granaries, instead of the little storing people do in the rafters of their homes. Men do the rice work, because it is considered a heavy, hard work, and they get rice harvest 2 1/2 times per year. Normally, men would only do the clearing, burning, cutting, and preparing of the mounds for millet planting, but in rice, men work.

Village traditional midwives are able to identify themselves in this region without fear of penalty or fine, and a course is being prepared to form them.

The village of Patrice Lumumba is 7 km from the Mission Hospital. The Otatela were favored by the Belgians for scholarships because of their brains, and a jealousy exists against them until today in Zaire. The UNAZA has a disproportionately high percentage of Otatela, - particularly among the professors. The Batetela were the last group subdued by the Belgians.

4. Principal Public Health Problems

Intestinal parasites	Measles	Enteritis
Malaria	Anemia	Birth complications

5. Training Institutions

One nursery school for A-3 nurses with 80 students.

6. Public Health Outreach

The hospital supervises 46 dispensaries. Of these four are target for expanded public health activities during the next 18 months. These are Shinguyuyu, Ngoma, Ukongo, and one other yet to be determined. For this work Wembo-Nyama has received a Vespa motorbike, some POL, office supplies, audio-visual equipment, and some basic medicines.

7. Family Planning Activities

Wembo-Nyama has recently expanded family planning activities. A survey of two villages has shown that:

- 38% of the women had some knowledge of modern contraceptives
- 75% of these women were favorably inclined to use of one of the methods

8. Outputs

a) Next 18 months

- 10 midwives trained
- 8 VHW identified and trained
- 4 village health committees formed
- 4 village vaccination programs
- 1 Family Planning clinic opened
- 10 new Family Planning acceptors/month at hospital

b) Next five years

- 24 water sources protected
- 24 wells dug
- 240 latrines constructed
- 24 pro-pharmacies opened
- 4000 villagers helped

9. Inputs Requested

Dollar costs for the Wembo-Nyama program will be financed through the OPG signed in September 1980. Wembo-Nyama will receive counterpart funds for some local training costs under the Basic Family Health Project.

Hospital of Oicha
B.P. 73
Beni
Kivu

region: Kivu
Sous-Region: Nord-Kivu
Zone: Beni

1. Background

This 200-bed hospital was founded in 1938 by the African Inland Mission, now C.E.C.A. (Communaute Evangelique en Centre-Afrique), based in Nairobi, and ultimately in England.

It is now staffed entirely by Zairians, and includes three (3) nurses with diplomas, five (5) auxiliary nurses, 5 paramedical personnel, and two (2) lab technicians. One Public Health nurse runs the outreach which includes 46 employees. The annual approximate operating budget is 300,000.Z. The DCMP furnishes about 1000Z worth of medicines yearly. The number of monthly deliveries averages about 150. The zone of Beni is densely populated with 554,469 people.

2. Senior Staff

The M. Bamuhiga, Administrative Director of the Hospital
Kambale Kyusa, Responsible for Community Health
Others mentioned above

3. Agro/Ethno/Socio/Economic Data

The major tribes in the area served are the Banande, Bambuba and the Babila. Each speaks its own language and Swahili. Each village has a "capita" and each locality has a Chef de Localite.

Polygamy is common, and traditional child spacing is practiced. A wide range of traditional medicine is also practiced. The region is predominantly agricultural. Cassava, banana beans and rice are the major food crops. Coffee and palm oil are the main cash crops. These are exported. Some gold is also found in the area. PHARMAKINA, B.P. 1240, Bukavu, Kivu, does have some fields under cultivation in this area. It is important to know that Pharmikina in Bukavu has anti-malarials for sale for local currency.

4. Most Prevelant Public Health Problems

Malaria, respiratory diseases, intestinal parasites, hernia, dysentary, anemia, and measles.

5. Public Health Outreach System

The Community Health team visits the four dispensaries and the one leprosy center at least once every three months.

<u>Dispensaries</u>	<u>Leprosy</u>	<u>Vaccination Clinics and Sanitation Education</u>	
Manguina	Mbimbi	Tenambo	Mukakira
Lume		Mbimbi	Mavivi
Mwenda		Masosi	Eringeti
Luanoli		Kisikivi	
		Victori	

The statistics for activities in these centers are available in the hospital's data. Hygiene, weighing the babies, sanitary education, Pre-School Clinic activities, Vaccinations (DPT Anti-polio, Anti-Measles) and prophylactic medicines (to the extent available) are distributed.

6. Outputs Planned

12 Village Health Committees formed

24 VHW trained

12 water sources managed

5000 latrines constructed

1000 new acceptors of family planning

46 medical employees recycled

In-depth vaccination and prophylactic medicines in 15 villages

1 MPH trained in Public Health

12 VHW trained in Pro-Pharmacy management

15,000 villagers receive nutrition and sanitation education

7. Inputs Needed

1 4-wheel drive diesel vehicle

2 Yamaha motorcycles (175cc)

15 bicycles - Raleigh

First stock of basic medicines for the 12 villages (8 clinics plus
4 dispensaries)

5 baby scales

5 adult scales

5 isothermic vaccine carriers

2 frigos à petrol

5000 baby charts (fiches graphiques)

Flip Charts of Kangu Mayumbe - 15 copies of all 4 sets

Books: Where there is No Doctor (French edition)

How Disease Travels

Funds for retraining courses for 46 medical employees (outside teacher
input needed as no formation of nurses exists at Oicha. Nyankunde can
help).

Scholarships: 1 at MPH level

vaccines

contraceptive supplies (especially DEPO)

Hospital at Kapanga
B.P. 76
Kapanga
Shaba RQZ

Region: Shaba
Sous-Region: Lualaba
Zone: Kapanga

1. Background

This hospital was built in 1914 by the United Methodist Church of the U.S.A., C.M.S.Z. (Communauté Methodiste de Shaba au Zaïre). It has 120 beds, 4 physicians, 22 nurses, a large nursing school with over 100 nursing students, offering both hospital nursing and public health. The DCMP supplies about 1/4 of the medicines and the state helps with salaries. The annual personnel budget runs about zaires 500,000.

2. Major Diseases:

Malaria, malnutrition, anemia, measles and intestinal parasites.

3. Senior Staff:

Dr. Pauline Chambers, MPH

Dr. Frazer, surgery

Dr. Mbuya Katenga, Medcin Chef de la Zone, Methodist Medical Coordinator Administrator of the Hospital

Dr. Kakoma Samukimba, Dispensary supervisor

4. Socio/Ethno/Econo/Agro:

The MWAT YAV of Kapanga is the most important chief of the Lunda in the area. He has 241 village chiefs who owe him allegiance. He was recently named by Pres. Mobutu to the Overseeing Committee of the MPR. In Belgian administration, the MWAT YAV was Commissaire of the Sous-Region.

Manioc and corn are the food crops, whose production is presently down due to a small drought from January through March 1981 in the Kapanga zone. Most war refugees who fled in 1978 have returned and settled down to subsistence agriculture. Seeds are often in short supply. The HCR transit station set up for the repatriation of Zairian refugees in Angola has been closed down while life in the area is attempting to return to a normal pace. The zone has been subject to periodic measles epidemics, beginning in 1968, due to insufficient vaccines to cover the area. Very little is exported since the poor conditions of the roads makes evacuation almost impossible.

NASA/USAID Mission in 1980 retained Kapanga as a location for extensive solar pannels to provide the station with electricity, etc, for its needs.

5. Public Health Outreach System

18 dispensaries:

Muyumba	Panda-Mwila	Kambamba
Chala	Sachikoy	Kalamba
Tshitazu	Masevu	Tshiyinga
Rubiwiz	Mwad-Muteb	Kamwang
Kambangu	Anyinga	Kabaj
Panda-Kalend	Dinying	

Chiying

30 vaccinations clinics

30 pre-natal clinics

Each location is visited by the mobile medical team at least once every three months. Student nurses participate in the visits as a part of their training and to do part of the work.

Kapanga has identified several traditional midwives and one is presently being trained at the hospital. Kapanga hopes to train additional traditional midwives if this approach proves successful.

6. Family Planning

Recently begun, this program now has 37 acceptors. Depo-Provera is the most popular method with Pills as second choice. IUDs are not readily accepted.

7. Outputs Planned:

40 new Family Planning acceptors/year

1500 latrines constructed

10 sources protected

19 nurses trained

10 traditional midwives trained

Nutritional/sanitary education in 15 villages

vaccinations - 15 villages x 500 persons/village

15 village health workers trained

8. Inputs Needed:

20 isothermic containers

15 baby scales

1 4-wheel diesel vehicle

vaccines

15 bicycles

Basic stock medicines, initial

19 nurses retrained (expenses for)

1 MPH scholarship

PEV vaccine relay-transport system via Luumbasni to Kapanga

FP material for 5 years; Depo-Provera, Pills

Flip charts; 15 each of set for the dispensaries

Recycling: training village health workers, 15 villages

10 traditional midwife kits

IMEK Hospital at Tshikaji
B.P. 205, Kananga
Kasai Occidental

Region: Kasai Occidental
Sous-Region: Lulua
Zone: Nganza

1. Background

This 126-bed hospital, 10 miles southeast of Kananga, was founded in 1954 for training nurses. In 1964, the Presbyterian Church was offered an ex-Belgian training school which had been used for the training of tribal chiefs' sons. There are 9 M.D.s, 3 of whom are Zairian.

The hospital has received a grant through the Presbyterian Benevolence Foundation, negotiated in the States with USAID, and the German EZE, to build a hydroelectric dam for hospital electricity needs. It is half completed and is scheduled to be finished in 1983.

2. Senior Staff:

Dr. John Miller, MPH

Lizabeth Stephens, RN, PCV in Public Health

Dr. Walter Hull, Family Planning Services

Dr. Rambo

Dr. Nelson

Dr. Ngoyi

Dr. Mpovi Tshibanda

Dr. Mutshipayi Kakelele

Cit. Batibanga, RN A-2, Public Health

Cit. Musamadi, Public Health

3. Ethno/Socio/Econo/Agro

The Benalulua are the principal tribal group. The idea of village/community collaboration is very weak. Many past attempts to organize villages around the hospital have failed. Perhaps the attempt should have been made further from the hospital, where the villagers could not have been so assured of the hospital services substituting for their own efforts. In addition, a training course for village midwives was attempted, but, it was discovered, that all women served as midwives. There was no specialized function for this in the Benalulua. The water sources are all down in the valleys, whereas the people live high on the hills. The distances are great that the women and children walk to get

the water. No pumping system has been tried, as of yet. The IMEK surveys a network of dispensaries and secondary hospitals.

4. Public Health Outreach System

The Presbyterians are preparing plans for transforming their rural dispensaries into Rural Health Centers. Five supervisory centers are planned:

Mutoto

Bulape

Mbuji Mayi

Lubondai

Bibanga

In addition, in the Tshikaji area, there will be 4 CE BECs (Centre de Bien-Etre Communautaire) at:

Konka

Nkandi (see map)

Bumba

Tshibambula

All are within a 15km radius. A thorough research is under way in these groupments to see exactly what the problems are. The people are asked if they wish to collaborate to improve their health standards. Groups of second and third year nursing students are recruited for this work.

In the past, Dr. Miller had done Public Health Programs such as:

TB research

Leprosy research

Pre-natal clinics

Vaccination clinics

Nutritional Education

There are 50 total Presbyterian dispensaries which can be included as this experimental pilot program of CE BEC's grows. The important thing for the moment is to watch the pre-funded research and results of the first 4 groupments.

5. Outputs

(To be prepared in action plan in late 1981.)

6. Inputs

Nothing in Phase I; Minimal request for Phase II.

Printing of materials at Kananga Presbyterian Press

5000 copies - color - for cost of zaires 10,940 (approximate)

Nutrition Sanitation posters

FP materials - Depo-provera and Pills

Hospital de Kasangulu
(Massa)

Region: Bas-Zaire
Sous-Region: Lukaya
Zone: Kasangulu

1. Background

This 45 bed hospital comprising 5 buildings was built in 1958. It has an 18-bed maternity, a 12-bed Pediatric Pavillion, a dispensary, and an administration building. It has 7 nurses, one A-2 and 6 are A-3. Forty births are registered per months. DCMP sends some medicines and the GOZ pays the salaries. Annual receipts run around Z10,000.

2. Senior Staff

Dr. M'Panzu Hwala, Hospital Director

Cit. Massamba, R.N. does Pre-school clinics

9 midwives

7 nurses

(N.B. Dr. Minuku of Sona Bata, as Chief Medical Officer for the Zone, supervises this hospital.)

3. Public Health Outreach System

Cercle Medicale de Kasangulu

Dispensaries

Kiloso Kasangulu - GOZ

Mpono Kas. Red Cross

Sal. Army - Kasangulu

CBZO-Kasangulu

Kingantoko - State

" - Red Cross

Kinsambi - Red Cross

Bisha-Kimbanguist

Kinkanga - Kimbanguist

Sabuka - State

Massa Hospital

4. Agro/Econo/Socio/Agro USAID Project No. 698-0407.10 Pilot 4-H Youth Project Intends to set up 25 school gardens. Its 35km proximity to Kinshasa leaves the zone open to the businessmen who buy up all produce to transport it to Kinshasa and sell at a higher price. The Salvation Army distributes soya and other foods to the people at their dispensary, and the people complain that all the dispensaries do not do the same. Manioc is the basic food crop. But one must go

15km from the city of Kasangulu to be able to find decent soil to cultivate it, as most of the soils near the village are leached. This presents a problem. Even the locally-cultivated peanuts and locally-caught fish are sold to Kinshasa. Basic Sickneses: Malaria, Schistosomiasis, Anemia, TB, gastro-enteritis, mal-nutrition, measles and dermatological diseases.

5. Outputs

10 village health committees formed
10 VHW trained
10 nurses recycled
50 new acceptors FP/year
500 latrines dug
5 water sources preserved
10 villages received nutrition/sanitation education
1 Zairian formed at MPH level
Pre-natal clinics 20
Pre-school clinics 20
Vaccination clinics 20

6. Inputs

1 Honda motorcycle
10 bikes
10 baby scales
10 adult scales
Basic medicines
Vaccines; DPT, measles, BCG, etc. from PEV
Isothermic containers
5 refrigerators (petrol)
10 sets of flip charts
FP hardware for 5 years, including speculum, gloves
1 scholarship - MPH
10 village health workers
recyclage - 10 nurses

O F WILSON

- 45 -

BRATISLAVA

KINSHASA

SOUKA

KINSAMA KINGATOKO

BOGIKA

KASANGULU

KINKANGA

BANI

KINZANI

TAMPA

OMPUTU

KINHOZI

LUILA

SANA-BATA

MERIA

MADINZA

MISANTU

NSOLA

.....

Hospital of Vanga
B.P. 4728
Kinshasa 2

Region: Bandundu
Sous-Region: Kwilu
Zone: Bulungu

1. Background

This hospital, 215 miles east of Kinshasa, was built in 1912 by the American Baptist Community, headquartered in Valley Forge, PA. Vanga Hospital, spear-headed for 20 years by Dr. Dan Fountain, MPH, serves a zone of 250,000 inhabitants in 7000 km, a density of 35-55 persons per km. It has 180 beds, 6 physicians, 20 nurses, 3 laboratory technicians, 7 Public Health workers, and 7 other mission employees. The total personnel budget is zaires 300,000/year and the operating budget is zaires 700,000/year. About zaires 25,000/year comes from the GOZ. 1800 births were registered last year in the hospital and its 14 dispensaries. Dr. Fountain is working in collaboration with the Medecin Chef de la Zone to survey all dispensaries in the zone. The enclosed map shows Protestant, state and Catholic medical formations in the zone of Bulungu supervised from Vanga.

2. Senior Staff:

Cit. Mwanabulu T. Tshiam, Administrator, Community Health Program

Dr. Dan Fountain, MPH

Dr. Steve Collins

Dr. Makwanga Ma Mkiew, Director, Family Planning Project

Citoyenne Adombo Nkiya, Midwife (New York trained)

3. Training Facility:

Nursing school, A-3 level since 1962, option Midwifery and Public Health, presently 45 students are enrolled.

Training for Auxiliaries in Public Health, 8 weeks in Community Health, Agriculture, Laboratory analysis, etc.

This is a strong element which Vanga can offer from January 1982 to train Public Health personnel from other hospitals in Zaire.

4. Public Health Outreach System (See map)

Vanga supervises 14 of its own CBZO dispensaries, each of these "health centers" has a team of 4-7 persons, under the direction of a nurse, auxiliary nurse trained in community health, auxiliary nurse midwife, and a guard.

There are two mobile medical teams which survey these health centers.

Pre natal clinics with Family Planning - 30 weekly

Under five clinics - 200 weekly

MCH Clinics - 14 Protestant Health Centers; 50 GOZ clinics/dispensaries to be made into Health Centers.

200 water sources being worked on

Environmental sanitation in 200 villages

200 Village Health Committees established

5. Socio-cultural/Economic/Agronomic Data

The main tribes are Huangana, Mbala, Yangi and Songa. Kituba is the major local language. There are village chiefs and "Chef de groupement" who may rule over 6-12 villages. There are herbalists, diviners, some of the latter specialized in mental health problems. Cough, sterility, diabetes and liver diseases are among the typical sicknesses treated with local medicines. There is an ancient tradition of separating the wife from her husband until the child is weaned. There are many unwed and neglected mothers. The experience of the Vanga Nutrition Center was that these women were happy to have their child nourished on the hospital compound in the nutrition center. But when they returned to the village, the women again neglected the nourishment of their children and they regressed to a state of malnutrition again. This experience has shown them the need for doing the nutrition education in the villages themselves and not waiting for the undernourished in the hospital. The rural exodus of men contribute to the excess of neglected mothers and children.

The PLZ has important palm oil plantations in the Bulungu region. It uses local workers on its plantations and buys 5 or 6 cuttings from the peasants for about 2e 90 makuta. Basic food crops are manioc, peanuts, corn, gourds, fish, and greens. Cash crops are sisal, palm nuts and oil and excess food crops. Trucks from the Kinshasa region often buy out the Bandundu zones and leave the local people with little to eat. Exports move toward Kinshasa via Kikwit.

Since 1961 the Institut Polytechnique, built in Lusekele with USAID funding, has been offering agricultural training. Lusekele is only 7km from Vanga and is staffed with British Baptists funded through CIDA. The ECZ is the sponsoring agency of the present Lusekele school. They train 9 agricultural agents per year in a two-year program. Thirteen of such agents work in the surrounding

villages and have been taken on the payroll of the Zaïre government, They receive their salaries through the Ministry of Agriculture. Four of the 80 manioc varieties perfected at Mvuasi in Bas-Zaire have proven effective in the Bandundu. Variety No. 17 has proven best. It is resistant to the millibug disease, resistant to bacterial blight, and gives a high production yield in a shorter period (9 months). The Lusekele school produces these agents who collaborate often in the villages with rural health centers for the better nutrition of the people. Unfortunately, the GOZ fixes the price of manioc each year to the detriment of the terms of trade for the rural sector.

The Lusekele is awaiting a zaire 20,000 request from the U.S. Self Help Fund to promote chicken raising. The women do the agriculture in this zone, and are then a target group for the nutritional aspects of the project.

7. Family Planning - since 1970 in Vanga

Now: 20 clinics, 1000 acceptors

1985: 60 clinics, 5000 acceptors

8. Outputs

Family Planning clinics, 40 added

New acceptors, 5000

MCH Clinics, additional 200

Vaccinations, 50,000/year

Midwives trained, 20 additional

Nurses recycled, 20 to 30/year

Physicians recycled, 1 to 4/year

Health Committees, 200 additional

Water sources protected, 300 additional

School health/sex education, 50 schools

Latrines constructed, numerous

Laprosopes installed, 2

Unified data collection system initiated

Health planners at MPH level - Dr. Milabu to be trained

Expanding rural health zones covered, 2 more collectivitees per year

9. Inputs Needed:

Other present donors include OXFAM in Public Health and Nutrition, CIMAVI for printing health education materials and doing training for regional needs, and EZE in Bonn, Germany for buildings, etc.

1 4-wheel drive diesel vehicle

2 scholarships for MPH level in Cotonou or Brussels

2 Olympia French-keyboard typewriters

1 mimeo-machine

2 classrooms for expanding teaching(5000Z x 2 equals 10,000Z)

Filing cabinets, envelopes

Office furniture

Stencils (40 packages) and paper for duplicating machine

Recyclage to retrain A-2 and A-3 nurses in Public Health 5000Z/year

Create Urban Health Zone around Bulungu State Hospital (Phase II of project)

Form health personnel from other ECZ/GOZ participating hospitals 5,000Z/year

Institut Medical Evangelique Loko
B.P. 140
Gemena
Republique du Zaire

Region: Equator
Sub-Region: North-Ubangi
Zone: Gemena

1. Senior Staff

Dr. Roger Moxon, Hospital Administrator
Cit. Bupele, Nutritionist/Nurse
Dr. Masukidi, Medical Director
Cit. Ndote, Director of Public Health
Cit. Bobo, Director, Naissances Desirables

2. History

This hospital was built by the Belgians at the cost of \$500,000 before the rebellion, and was never activated until after the rebellion. It was turned over to the Paul Carlson Foundation as a treatment center for leprosy, TB, physical therapy and reconstructive surgery. It has 150 beds, a Nutrition Center, 9 dispensaries, and serves the 385,000 people in the North-Ubangi region. It is affiliated with the Church of Christ in Zaire through the CEUM (Communaute Evangelique de l'Ubangi Mon.) Its headquarters is in Chicago at the American (Swedish-origin) Free Covenant Church.

The hospital has participated in the Imeloko Rural Development Project (660-0082).

3. Major Public Health Problems:

Verminose	Measles	Filariose
Malaria	TB	Anemia
Malnutrition	Anemia	Goiter

4. Socio-Economic Agricultural Information

The Ngbaka tribe is the major ethnic group in the area. They are fierce and independent. The area produces and exports agricultural products to Businga and Gemena. These include coffee, peanuts, cotton and manioc. Fish culture has been introduced and is spreading.

5. Public Health Outreach System - (See map annex) was begun in 1971.

In the past year, discussion in the Medical/Public Health Committee has focused on strengthening the community health effort at the village level, concentrating first on villages closest to the hospital which are without existing dispensaries, and extending out to a wider area. The methodology to do this developed at Imeloko is the following:

- 1) initial inquiry, in cooperation with village leaders, to determine level of village interest and the areas of greatest need in that village.

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- 2) Selection of village health committee
- 3) Selection, by this committee, of a village health worker, or "animateur"
- 4) Cooperative efforts by the community health team in health, nutrition, and family planning education of the village population.
- 5) Training of the village health worker in simple primary care, concentrating on maternal/child health, nutrition, sanitation, and family planning;
- 6) Establishment of under-five clinic, with immunization program in target villages
- 7) Promotion of proper practices in regard to water, latrine construction, and waste disposal

The Imeloko project activities will be a logical extension of the nutrition and health activities begun under the earlier USAID grant, with special attention to promoting the seed center for beans, winged-beans and soya and the furtherance of fish-culture practices. Both these aspects promote better nutrition.

The map of outreach activities shows eight (8) dispensaries and six (6) health centers:

<u>Dispensaries</u>	<u>Health Centers</u>
Mindu	Mbwasenge
Bongala	Buda
Ngako	Bogofu
Bokarawa	Molengo
Bobagarawa	Maniko
Bodzokola	Boyasewelmo
Bodzokola II	
Bageambo	

The Imeloko Center is proposing an in-depth outreach to all villages in a 25 km radius, in addition to the villages named above, which have had an institutional input from Imeloko. Another vehicle would permit the mobile medical team to visit the villages more often. Presently the dispensaries are visited once per month. The mobile medical team is only 8 days/month on the road. More "Centres de Sante" would be set up with village health workers and the village health committee. They would benefit from: 1) Pro-pharmacies, 2) Prenatal Clinics, 3) Health and Sanitation Ed., and 4) Family Planning.

6. Outputs Planned for 1981-1985 (with project assistance):

- 15 new villages reached - 15,000 people
- 30 village health workers trained
- 2 mobile medical teams working
- 1 Sanitation agent trained abroad

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- 1 Public Health MPH trained abroad
- 15 village pro-pharmacies
- 2 health centers built
- 8 dispensary nurses recycled
- 15,000 persons with improved nutritional status due to soya, winged bean, bean and fish consumption
- 450 new acceptors of Family Planning
- 15 village health committees
- 15 water sources managed for potable drinking water
- 15 new under five clinics
- 150 latrines dug

7. Inputs Requested:

- 1 Zairian M.D. to be assigned to the hospital
- 1 diesel powered 4-wheel drive pick-up
- 2 scholarships for Zairians in Public Health/Sanitation
- 12 bicycles plus spare parts for village health workers
- 1 Yamaha 125 with parts
- Retraining expenses for nurses in dispensaries (8) and village health workers
20 per year
- Construction of 2 primary health care centers - zaires 8000
- Parts for 2-wheeled litters for patient transport - zaires 3000
- Educational/audio/visual materials - zaires 2000
- Office supplies - zaires 2500
- Basic pharmaceuticals for first stock for pro-pharmacies/health centers
- Basic medical equipment for health centers
- Refrigeration equipment - isothermic boxes (portable 12v, with storage batteries for frigos)
- Contraceptive commodities
- Pumps for village wells

Centre Medical de Tandala
E.P. 145
Tandala via Gemena

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Region: Equateur
Sub-Region: South Ubangi
Zone: Gemena

1. History: The Tandala Medical Center was founded by the Evangelical Free Church of America whose headquarters are in Minneapolis. In Zaire it is called the C.E.C.U. (Communaute Evangelique du Christ de l'Ubangi) and is a member of the E.C.Z. (Eglise du Christ au Zaire). The entire area of work is within the rain-forest area of the Zaire River basin. The savannah area begins 20-30 miles north of the center. The yearly rainfall averages 100 inches.

2. Senior Staff

Dr. Frank Sult, Pediatrician, Public Health Outreach
Dr. Elizabeth Sult, Pediatrician. Public Health Outreach
Dr. Cairns, Medical Director
Dr. Colby, Medical Staff Doctor
Dr. Mombita, Medical Staff Director
Cit. Mpangli, Director of Public Health
Molombo Bbawalambongo Buba, Administrato

3. Hospital Data: 171 beds. It receives 16,000Z from the state annually in salaries and medicines. Its annual operating budget is approximately 50,000 U.S. dollars and 200,000Z in local currency. Administratively, within the GOZ system they are under the supervision of Chef Medcin de la Zone, Dr. Njila, at Gemena. Logistically, since they are only 70 miles from Bangui they use that connection for supplies. Many of their supplies come overland from Douala, or up the river through Brazzaville. This route is faster and more efficient than passing from Matadi.

4. Social/Economic/Agronomic/Cultural Data

The population of the two adjacent collectivites is 200,000, and growing at the rate of 83% per decade. Villages are situated along the road since the days of Belgian forced labor, and range in population from 300 to 2,000. Because of the state of the roads and the extended rainy season, four-wheel drive vehicles are essential.

The Ngbaka (Gwaka) tribe covers the area with over 1 million members. Part of the hospital outreach is in Ngbaka territory. These people are amenable to health care. Village chiefs exercise very limited authority and most disputes are settled in one of about 10 existing tribunals. Although 75% of the men and 25% of the women speak Lingala as a second language, their native tongue is Ngbaka.

Main crops in this agrarian area are corn, manioc, peanuts, cotton and coffee. A large amount of palm oil is harvested from a few plantations. Small shopping centers of 2-5 stores are located every 20-30 km along the road, in which people buy soap, kerosene, cloth, rice and machettes. Merchandise has been scarce during Zaire's recent years of economic crisis. The few plantations give employment for a small number of people, and a few are on the government payroll, but most are not employed in the formal sector, and depend on the sale of coffee and palm oil for cash.

Cibse Zaire, based in Karawa is the principal authorized purchasing and exporting agency for coffee and palm oil. It was recognized in 1980 as the largest single exporter of coffee, in all of Zaire. It provides the link to the monetary economy for the peasant cultivator who sells his coffee and palm oil for cash to Cibse, Zaire. Cargo planes of the company export the coffee. The main dietary staples are corn, manioc, in that order, with a few leafy vegetables. Protein intake is based on fish and peanuts with occasional meat. Soy production has not yet been widely accepted. A project output would be to increase production of peanuts and soya for local consumption, and less cash cropping for sale to Cibse, Zaire.

Female circumcision has been a tribal custom in this area, based on vulvectomy or excision of the labia and clitoris, but is now forbidden by both church and GOZ. Doctors estimate 40% of the adult women in the area have been circumcized but that the practice is declining.

Two-thirds of the children of elementary school age attend school; about 20% of the total population is literate.

5. Prevalent Public Health Problems:

Malaria
Malnutrition
Intestinal Parasites
Filariasis
Hepatitis (Fulminant B)
EBOLA Hemorrhagic Fever

Goiter is endemic to the area. The University Libre of Brussels research has shown that bitter manioc, chewed by the people, is filled with excess manganese which absorbs and neutralizes the iodine in the system. Possible solutions: the manioc should be soaked to leach out the manganese before eating; people should use iodine-salt; treatment for goiter via iodine injection.

6. Training Facility - Nursing School

Options A-3 for hospital nursing and midwifery; public health option will soon

be added. The school is called the Institut Technique Medical Molende

About 25 nursing students are under training.

7. Public Health Outreach Program

In 1976 the hospital targeted a 40 km radius of action for initiating a public health outreach program. This program is reaching the following villages:

Bosekula	Bombia I
Bogbadomo	Bombia II
Bogbadomao II	Bozele
Bogbatu	Bominenge
Bozombali	Bozade
Bogbazola	Bokole
Bogbak.undu	Bongalua
Boyakoti	Bozene
Bonzale	Boyambelema

Activities for these villages include:

21 Pre school child clinics with 5,700 children enrolled. These clinics provide vaccinations, malaria prophylaxis, iron, vitamins and health education.

The Tandala hospital also services three GOZ dispensaries.

8. Outputs Planned with Project Assistance (1981-1985)

- Expansion of Public Health Activities to following villages:

Bosengbia	Bogbakele
Bowambili	Bogbasele
Bozambele	Bondiuro
Bodube	Bobam
Bumbwa	Bogbena
Bozenbene	Bodeo
	Bobawale

- Consolidation of existing village structure into health development committees in 50 villages.
- Extension of MCH clinics in above thirteen villages.
- Ten village health surveys
- Ten health centers opened
- Thirteen prenatal clinics initiated
- Thirteen Family Planning Clinics initiated
- Training of 50 village health workers where suitable candidates can be identified/recruited.
- Formation of a second public health team
- Fifty pro-pharmacies initiated
- Ten schools with health and sex education programs initiated.

9. Inputs Requested

1 diesel 4-wheel drive vehicle with spare parts

2 Yamaha 125 cc Motorcycles

20 bicycles - Raleigh

Recycling courses - nurses, 1 time/yr x 5 yrs. \$25,000

Books/booklets for nurses \$5,000

Scholarships for (2) in Hygiene/Sanitation or
Public Health

Pharmaceuticals for start up stock for pro-pharmacies and
health centers:

Vitamins

Daraprim

Folic Acid (anti-anemia)

Chloroquine

Aspirin

Vaccines

Office Supplies:

Registers

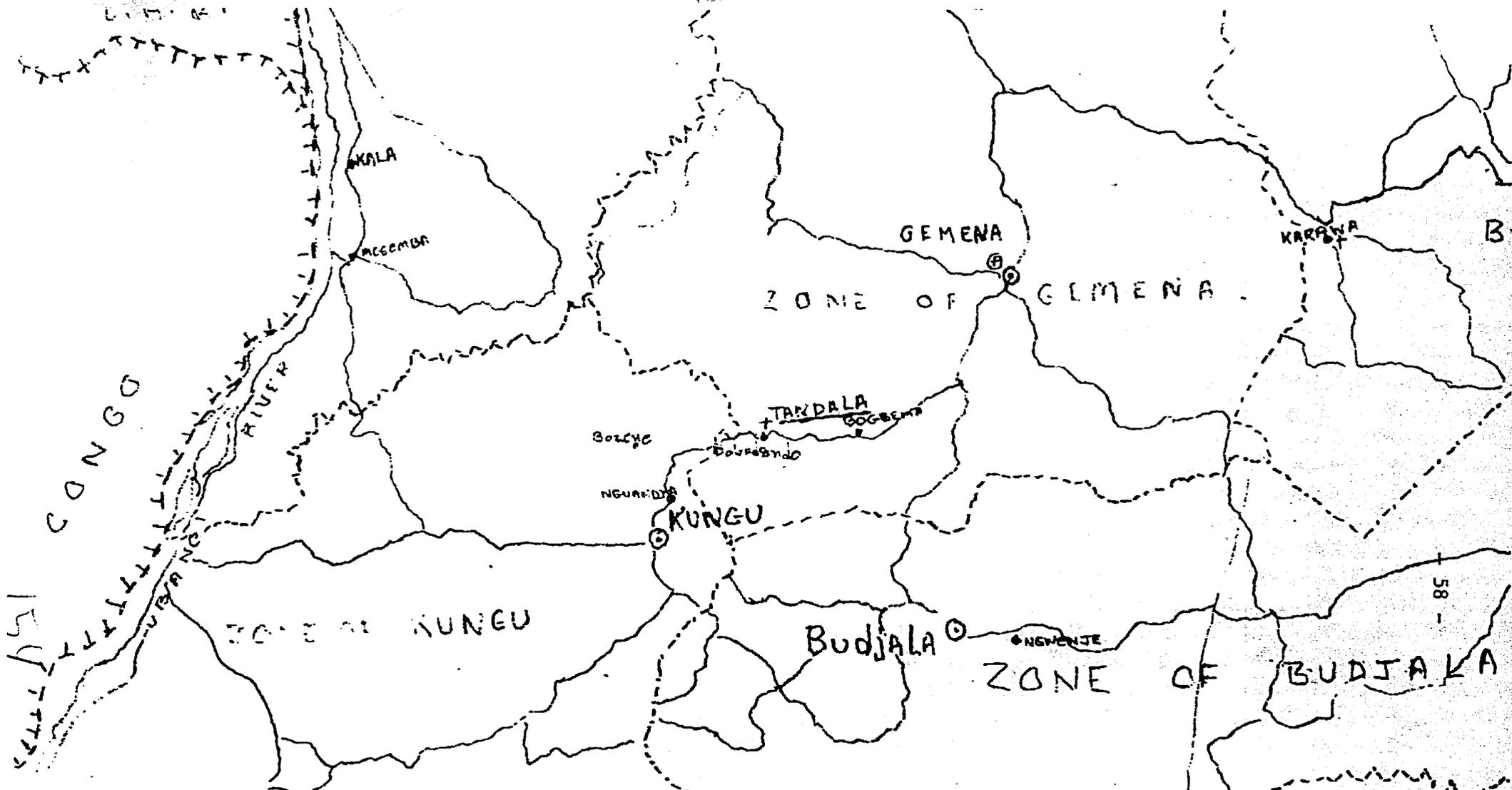
Stencils

Papers

Prenatal forms

15,000 road to health cards

Notebooks



Villages in Tandale outreach

- | | |
|---------------------|-------------|
| Bosekula | Bokole |
| Bogbadono | Bongalua |
| Bogbadomo II | Bozene |
| Bogbatu | Boyambelema |
| Bozombali | |
| Bogbazola | |
| Bogbakunau | |
| Boyhaoti | |
| Bonzale | |
| Bombia I | |
| Bombia II | |
| Bozele | |
| Bominenge | |
| Bozade | |

New Villages Proposed

- Bosengbia
- Bowambili
- Bozambele
- Bodube
- Bumbwa
- Bozenbene
- Bogbakele
- Bogbasele
- Bondiuro
- Bobam
- Bogbena
- Bodeo
- Bobawale

Hopital de Sona Bata
B.P. 4728
Kinshasa II

Region: Bas Zaire
Sous-Region: Lukaya
Zone: Kasangulu

1. History: This hospital, one of the first hospitals built by the American Baptist Community, is known in Zaire as the C.B.Z.O., (Communaute Baptiste de Zaire Ouest).

2. Senior Staff:

Dr. Minuku Kinkonzi, Medcin Prefet de l'Institut Medicale de Nsona Bata and also Chef Medcin de la Zone de Kasangulu. He supervises the hospital and its dispensaries as well as the GOZ hospital at Kasangulu and the GOZ dispensaries in the region. He has been trained in Public Health and Family Planning at John Hopkins, Baltimore.

Dr. Nico van Suchtelen, Dutch OB/GYN specialist - 9 months in Zaire

Mme. Dissu, Nurse trained at Metropolitan Hospital in Family Planning

Cit. Kimpiatu, Hospital Administrator, Director General of Nsona Bata Hospital

3. Hospital Data

This hospital has 102 beds. Its staff consists of the above-named personnel plus a surgeon, a kinestherapist, two nurses, two nurse-aide midwives, one nurse-aide in health, two laboratory technicians and 24 practitioners. There were 500 deliveries in the hospital last year. The annual budget assets (intake) was Z449,262.

4. Major Public Health Problems:

malaria	iron-deficiency anemia
worms	malnutrition
measles	

5. Ethnic/Demographic/Agronomic/Social/Economic Data

The Bakango tribes in the zone of Kasangulu are the Balemfo, the Bantandu and the Banfunuka. Kikongo serves as a second vehicular language for these tribes in their dealings with the hospital and the public health teams.

The zone of Kasangulu includes 3,700 km² and a population of 93,975 inhabitants. The population growth rate of 3% in Zaire means a doubling of the population of Kasangulu in 25 years which will make 36 persons per km² in 2,006.

Principal exports from the zone include firewood, pineapples, manioc leaves, peanuts and some coffee. Only coffee is exported. Kasangulu's proximity by paved road to Kinshasa (70 km) results in the export of nearly all agricultural

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produce to this urban center. As a result there is some malnutrition in the zone.

Even the river serves as a means of transport for the people, despite some of the falls.

Village midwives deliver 90% of the children. Herbalists use leaves for amoeba, dysentery, and gastro-enteritis. The sap of certain trees is used for cuts and bruises. Mental problems usually are referred to the traditional healers.

Protein malnutrition is present. Manioc roots is the staple crop and preferred diet of the people.

The migration of large numbers of Angolans to the Bas-Zaire area has created more tribal tensions and put more population pressure on the land. The Angolans are perceived to be preferred because of the free-food and agricultural tools they received from the High Commission of Refugees of the United Nations. This has created resentment between these groups. At the moment the Angolan population of Bas-Zaire has stabilized, and the HCR is phasing out its program.

Dr. Mbwete, a Zairian M.D., tried to encourage traditional medicine but the village healers and medicine men, whose practices were mixed with magic, animism and fetishism, are usually reluctant in Bas-Zaire to divulge their secrets. They fear reprisal, punishment, or ridicule from the modern sector. Thus, identifying them and bringing them into the modern system, with the exception of the village midwives, has proven difficult. No significant studies have as yet been carried out on the chemical validity of traditional herbs, nor the cure of the mentally ill through the traditional system.

6. Training Facility - Nsona Bata trains nurses with specialization A3 in midwifery, community health or hospital nurse. There are presently 52 nurses enrolled.

7. Public Health Outreach System

The system was initiated in 1976. Of the 38 dispensaries in the zone of Kasangulu surveyed by Dr. Minuku, eleven belong to CBZO. The others belong to 1) the State, 2) Red Cross, 3) Kimbanguists, 4) Catholics and 5) Salvation Army. One is private.

In the medical hierarchy, Dr. Minuku, as Chef Medicin de la Zone immediately responsible to the Chef Medicin de la Sous-Region who is responsible to the Chef Medicin de la Region at Matadi, who is responsible to the national health authorities.

The Project activities planned for Nsona Bata includes the following outreach system.

Centre de Sante:	Lukungu	Luila
Dispensaries:	Mputu (Etat)	Kikuama (Etat)
	Kinkombo (Etat)	Madimba-Mao (Etat)
	Kitundulu (Kim)	Boko-Ngoy (CBZO)
	Mpela (Etat)	Makunga (Etat)

These Health Centers were chosen because of:

- their integrated curative health services: pre-natal and pre-school consultations; regular consultations; nutritional activities; naissances desirable activities;
- each responsible nurse has assisted in at least three updating and training sessions,
- they cover the population of their region,
- the responsible nurse is capable of going beyond his normal radius of eight (8) km and extent his supervision to other smaller dispensaries.
- there is a complete team - nurse, nurses-aide, microscopist, auxiliary PMI helper;
- the project envisages the development of a "naissance desirable" in each health center and a "nutrition rehabilitation" unit

8. Family Planning - Activities begun in 1976. There are presently 213 acceptors by the following methods:

Pill 74

Depo-Provera 50

Tubal ligation 78

Vasectomy 0

IUD 0

Condom 0

9. Outputs Planned 1981-85 (with project assistance)

40 Family Planning Clinics Opened

40 Village vaccination programs

40 Nurses Recycled

2 Physicians recycled

12 Pro-Pharmacies initiated

1 Laproscope installed

500 Latrines constructed

100 Water sources protected

20 Village Health Workers Travel

10. Inputs Requested:

1 4-wheel drive diesel pick-up; 25 tons cement

25 bicycles

1 Retraining course each year - 15,000Z

Construction of two Health Centers 15,000 EA = 230,000 - The population will contribute the manpower for the construction

4 Petrol frigos

Basic stocks of medicines for "Mama Twadisi" system (pro-pharmacy)

15 microscopes
20 stethoscope
20 adult scales
15 baby scales
20 obstetrical stethoscopes
20 tensiometers (pressure)
200 syringes and needles
20 basins reniforme
20 basins ordinary
80 scissors - straight and curved
30 speculum
500 pair of gloves
40 official registers
4 isothermique cold boxes (for vaccines)
12 IUD kits

Hospital of Nselo
B.P. 24
Inkisi, Bas Zaire

Region: Bas Zaire
Sous-Region: Lukaya
Zone: Madimba

1. Background:

In 1970 this 50-bed hospital was constructed by the local population. It is within the C.B.Z.O. (American Baptist) network, and CBZO provided the funds for the roof and the medical equipment needed for the hospital. The village is 50km from Kisantu on a rough dirt road; it is inaccessible, on occasion, by vehicle during the rainy season for some days. Dr. Kela Di-Lumbemba has been there for one year. The hospital falls within the rural health outreach zone of the Catholic hospital of Kisantu where Dr. Lamboret suggested that our project reinforce Nselo to better do its outreach job. Its yearly budget is zaires 52,978.

2. Director: Dr. Kela-di-Lumbemba, Zairian physician and graduate of UNAZA

3: Ethno/Agro Data:

The region produces and exports flour, tsafu, advocados, and manioc roots. The tribal group, a subdivision of the Bakongo, are the Bantandu. The film, made by the Catholics, "Maladie de la Faim" has been well received in nearby areas for nutritional education, and could be used in this system. Pisciculture has been slowly spreading through the traditional methods.

4. Public Health Outreach System:

There are 6 CBZO dispensaries and 9 GOZ dispensaries which Dr. Kela supervises, monitors:

CBZO

Kimbata-Mfinda

GOZ

Ndembo

Kimdeba	Hof-Nselo
Yongo-Kitula	Kibambi
Kilumbu	Mpese
Masikila	Lula-Nsele
Kimsunde	Ntadi
	Kimyengo
	Kimdundu
	Nseki-Mbisi

These dispensaries will be shifting their focus toward primary rural health.

Their activities would include:

1. Initiation of pro-pharmacies, establishment of a Mama Ntuadisi village pharmacist with 5 basic preventative and curative medicines.
2. Vaccinations - DPT, measles, polio
3. Initiation of Family Planning Centers/clinics
4. Establishment of Health Committees in each village to (a) dig latrines, (b) manage potable drinking water source
5. Nutritional education
6. Retraining of nurses

5. Family Planning:

Has been initiated in January 1981, and there have been 15 new acceptors in recent months. Family Planning activities will be an integrated part of the planned Public Health Expansion

6. Outputs Planned 1981-1985:

(with Project Assistance)

10 nurses retrained

1 mini-laproscope installed

15 pro-pharmacies created
15 village water sources developed
5000 additional vaccinations
15 health committees created
1000 latrines dug
15 villages with nutrition education
1000 new acceptors of family planning

7. Inputs Requested:

2 motorcycles, Yamaga
6 bicycles, Raleigh
6 isothermique boxes for vaccines
2 frigos à petrol
6 baby scales
100 pr. rubber gloves
6 thermometers
100 needles
contraceptive commodities for 15 dispensaries for 5 years
90 sacks of cement, Mpangi village water source; plus other water sources
1 mini-laproscope
retraining courses zaires 2000/yr x 5 yrs (for 6-10 nurses) zaires 10,000
Vaccines
2 microscopes
6 "Sahli" hemoglobinmeters
30 syringes
8 heating gas small stoves
8 boiling pots (for needles, etc.)

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8 metal instrument cases

500 meters barbed wire (water source)

1 scholarship for MPH

10 basic medicines for start-up stock for 15 pro-pharmacies

Hopital Evangelique de Kinkonzi
B.P. 50, Tshela

Region: Bas-Zaire
Sous-Region: Bas Fleuve
Zone: Tshela

1. Background:

This hospital was built in 1945, by the Christian Missionary Alliance, headquartered in Nyack, New York (C.E.A.Z. Communauté Evangelique de l'Alliance au Zaire). It has a 150-bed curative facility, and 12 rural dispensaries serving a radius of fifty (50) km.

2. Senior Staff:

Dr. Konde Mwanza, M.D., is Medical Director of the hospital and is highly motivated and interested in Public Health. He is also Chef Medicin de la Region for all state facilities.

Dr. Robert Green, M.D., Orthopedic specialist

Susan Strahahan, MPH, 11 years experience in the Tshela zone, speaks Kiyombe, and recently finished her MPH at University of Hawaii.

3. Teaching Facility: The Nursing School, adjacent to the hospital, presently has 42 students and in an A-3 option of "Community Health." They would like to add the option of Midwifery, but this would involve classroom facilities and equipment for 22 more students.

4. Hospital Data: The annual local currency budget is zaires 230,000 of which 150,000 goes for personnel. They have 7 expatriate nurses, 1 expatriate doctor, 1 expatriate laboratory technician, and 5 local laboratory technicians. The dental clinic serves three sub-regions and has 4 local dental technicians and 1 expatriate and 1 local dentist. The state contributes about zaires 11,000 annually, in terms of payment of salaries and some medicines through DCMZ. The maternity delivers 40-60 babies a month. In addition, there are 15 dispensary workers that are supervised by the hospital.

5. Major Public Health Problems:

Malaria

Enteritis

Tuberculosis

Measles

Malnutrition

Anemia

6. Ethnic/Demographic/Socio/Agro/Econo Data:

The Bakongo are members of the Congo-Kordofan family, the Niger-Gongo sub-family and the Bantu genus. The Bakongo in the Miome forest region of the Bas Fleuve are a subdivision called Bayombe who speak Kiombe, a dialect of Bakongo. The Tshela zone is homogeneous in the sense that all its 250,000 people are Bayombe who speak Kiombe.

Food Crops Like all Bas Zaire, the high prices offered by traders from Kinshasa tend to drain the region, even of its basic food crops. Exports from the zone include banana, plantain, peanuts, manioc leaves, manioc fermented and prepared at chikwangue, farine or cossettes, are the principal staple. Sweet potato, yam and taro are also consumed in this forest zone. These roots are protein deficient, and their predominance has led to malnutrition.

SCAM, Societe Commerciale d'Agriculture de la Miome, operates a Belgian/Zairian plantation in the Miombe.

For nutritional purposes, manioc leaves, tsafu seeds, and chicken raising should be encouraged. The hospital plans to do an in-depth survey of 2 villages from which the majority of their malnutrition cases have come lately. The International Institute for Tropical Agriculture sub station for manioc at Mvuasi in Bas Zaire is developing manioc hybrids which are both more nutritious and disease resistant.

Since the 1978 drought in the Miombe, Bas Fleuve region, the crops have begun to come back to the earlier levels. Tulane nutritional studies in Bas Fleuve subregion have carefully documented the state of malnutrition in Tschela in 1978, comparing it to the Sahel countries in 1973.

7. Public Health Outreach System:

There are presently 12 rural dispensaries in the service of the Kinkonzi Hospital. The hospital trains the nurses deployed in these dispensaries, supervises them, supplies their medicines and equipment and receives their referrals. The project proposes to extend these services to the rural population through these dispensaries by turning them into Rural Health Centers. Each rural health center would be responsible for villages in a 10km radius. Each

community would have a village health worker who would be able to refer cases to the dispensary and would in turn be supervised by the dispensary. The village would choose the worker, designate a place to work, and cooperate with him/her in implementing decisions regarding rural health care.

The role of the Village Health Worker in his community would be to:

1. Provide education in health, nutrition, family planning and sanitation.
2. Control the sanitation of the village; disposal of fecal material; provision of safe water.
3. Gather basic demographic statistics and keep a register of people treated.
4. Treat certain common diseases - malaria, intestinal parasites, scabies, and enteritis.
5. Act as liaison between village and the Health Center.
6. Organize elementary pre natal and under-five clinics.
7. Refer complications to the Health Center.
8. Distribute some contraceptives and make referrals for others.

The plan at present is to turn three dispensaries per year into Health Centers. Each new HC would take on two new villages per year. In five years, the first three health centers would have taken on a total of 30 villages. The total would be 84 new villages covered at the end of five years by 12 health centers.

Present Dispensaries:

Kuimbe	Nyandi Ndiugi	Kitsiengo-Vumuge (Seke-Banza Zone)
Khode	Maduda	Kinzau-Vuete " " "
Yema	Kiobe-Ngoi	
Kai-Ndunda (Boma)	Sumbi (Seke-Banza Zone)	
Moanda	Bata Siala "	
	Seke Banaa "	

Pre-natal clinics are now in two dispensaries.

Pre-school clinics are in two dispensaries.

8. Family Planning Activities:

Activities were begun in 1978. There are presently 75 acceptors.

9. Outputs Planned for 1981-1985:

(with Project Assistance)

84 new villages reached

5000 new Family Planning acceptors

100,000 Total population reached with services

7 new vaccination programs in villages

60 midwives trained (formal A-3 nurses)

18 nurses retrained

30 village health workers trained

30 health committees formed

12 schools with health/sex education programs initiated

40 pro-pharmacies initiated

84 villages with improved sanitation and nutrition practices

2 mobile health teams circulating regularly

60 new fish ponds constructed

10. Inputs Requested:

1 4-wheel drive diesel vehicle

18 bicycles

15 isothermiques boxes (for transport of vaccine)

10 small frigos à petrol

1 large frigo à petrol

1 laparoscope

Recyclage courses (in-country) frais de déplacement zaires 25,000; food zaires 75,000 (5 years)

Long-term (out-of-country) training at MPH level for 1 Zairian

Construction of 2 classrooms, zaires 15,000 each, total of zaires 30,000

Visual aids

Flip charts

30 baby weighing scales (metric)

5 adult scales

Teaching equipment: 1 photocopy machine, electric stencil cutter, 2 slike projectors; 1 plastic model of human body, 2 microscopes (1 monocular, 1 binocular) and books

30 IUD kits

Basic Pharmaceuticals for start of pro-pharmacies/health centers

-- Anti-scabies cream

-- Aspirin

--- Chloroquine

--- Vermox

-- Diaprim

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PROJECT SHOULD BEGIN ON A PILOT BASIS WITH OUTSIDE ASSISTANCE IN DESIGN AND CAREFUL MONITORING DURING THE INITIAL PERIOD OF OPERATION TO ASSURE CONTINUITY OF THE SYSTEM. AID/W SUGGESTS THAT USAID UTILIZE ASSISTANCE OF SUCH CENTRALLY-FUNDED MECHANISMS GROUPS AS APFA TO LOCATE EXPERTISE IN DESIGNING AND OPERATING THE PRO-PHARMACIES;

D. THE OUTPUT OF 30,000 LATHINES AND 1,500 WATER SOURCES FOR DOLS 500,000 STRIKES AID/W AS OPTIMISTIC, BOTH IN THE NUMBER TO BE INSTALLED AND IN THE AMOUNT OF FUNDS REQUIRED TO ACCOMPLISH THIS PURPOSE. TO HELP ASSURE SUCCESS OF THIS COMPONENT WE SUGGEST THAT USAID INCORPORATE THE ASSISTANCE OF THE CENTRALLY-FUNDED WATER FOR SANITATION AND HEALTH (WASH) PROJECT INTO THE PP. THE WASH PROJECT CAN PROVIDE SHORT-TERM CONSULTANTS, AT NO COST TO THE PROJECT, TO HELP PLAN AND IMPLEMENT THIS PORTION OF THE PROJECT.

2. USAID/KINSHASA MAY AUTHORIZE THE PROJECT IN ACCORDANCE WITH APPROPRIATE DELEGATIONS OF AUTHORITY. THE AUTHORIZATION MAY NOT EXCEED DOLS 5,000,000. FAIG

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REPUBLIQUE DU ZAIRE
Département de la Santé-Publique
CABINET du Commissaire d'Etat

ANNEX YV: GRANTED REQUEST FOR ASSISTANCE
Kinshasa, le 27-7-77

N° DS 1250/1073/81.-

Réf.
Annexe
Objet

A Monsieur Norman L. Sweet
Directeur de l'USAID
à KINSHASA.-

Monsieur le Directeur,

J'ai examiné la proposition de projet intitulé "Projet de Soins de Santé Primaires en Milieu Rural (660-0086)" qui a été élaboré par le Département de la Santé Publique, l'Eglise du Christ au Zaïre et l'USAID. Ce projet est conforme à la politique sanitaire du Zaïre relative aux soins de santé primaires et apportera une contribution importante à l'atteinte de notre objectif de santé pour tous en l'an 2000.

Par conséquent, je soutiens ce projet et je demande l'assistance de l'USAID dans le cadre de ce projet.

Veillez agréer, Monsieur le Directeur, l'expression de ma considération distinguée.-

LE COMMISSAIRE D'ETAT,
[Signature]
KINSHASA.-