

CLASSIFICATION  
PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol U-447

1. PROJECT TITLE  Combating Childhood Communicable Diseases (CCCD Zaire)		2. PROJECT NUMBER 698-0421-60	3. MISSION/AID/W OFFICE USAID/ZAIRE
4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY) 05		5. REGULAR EVALUATION <input checked="" type="checkbox"/> SPECIAL EVALUATION	
6. KEY PROJECT IMPLEMENTATION DATES A. First PRO-AG or Equivalent FY 8-31-82 B. Final Obligation Expected FY 6/86 C. Final Input Delivery FY 12/31/87		6. ESTIMATED PROJECT FUNDING A. Total \$ 14,333 B. U.S. \$ 4,849	7. PERIOD COVERED BY EVALUATION From (month/yr.) 8/82 To (month/yr.) 2/85 Date of Evaluation Review April 1985

8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airmgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
<u>Issue</u>	<u>Action Office</u>	<u>Date</u>
1. Extend project assistance completion date	GOZ/USAID/AFR/RA/CDC	10/85
2. Revise ProAg to reflect effect of 1983 devaluation and clarify GOZ obligations and purpose of counterpart funds	USAID/DSP	10/85
3. Increase GOZ budgetary contribution to the project	GOZ/DSP	1/86
4. Stretch out AID dollar contribution and/or reduce counterpart fund contribution to project if GOZ contribution fails to increase	USAID/DSP	2/86
5. Improve budget-preparation process	USAID/PEV-CCCD	12/85
6. Perform studies on cost-recovery system	PEV-CCCD	7/86
7. Simplify the current CDC personal suballocation accounting system	CDC/AFR	2/86
8. Nominate an interim project director	DSP	done 7/85
9. Computerize commodity inventory system and personnel and payroll systems	PEV-CCCD	2/86
10. Increase and improve assistance to rural health zones (RHZs) in training, logistics, health education, and supervision	PEV-CCCD	2/86
11. Institute in-service training courses on CCCD technologies for RHZ physicians	PEV-CCCD	2/86
12. Organize an ORT Training Center at Mama Yemo hospital for physicians	AFR/WHO/PEV-CCCD/ Mama Yemo	2/86
13. Improve and extend the disease surveillance system	PEV-CCCD	2/86

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

<input type="checkbox"/> Project Paper	<input type="checkbox"/> Implementation Plan e.g., CPI Network	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Financial Plan	<input type="checkbox"/> PIO/T	_____
<input type="checkbox"/> Logical Framework	<input type="checkbox"/> PIO/C	<input type="checkbox"/> Other (Specify)
<input checked="" type="checkbox"/> Project Agreement	<input type="checkbox"/> PIO/P	_____

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT

A. <input type="checkbox"/> Continue Project Without Change
B. <input type="checkbox"/> Change Project Design and/or
<input checked="" type="checkbox"/> Change Implementation Plan
C. <input type="checkbox"/> Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)

1. Dr. M.S. Lichnevski: WHO Consultant, 2. Dr. Nicole Guerin: EPI Consultant, 3. DR. James D. Shepperd: RHO REDSO/WCA Abidjan, 4. Mr. Marty Makinen: Economist/ Consultant, 5. Mr. Harvey E. Gutman: Mgt Consultant, 6. Dr. Mambu ma-Disu: PEV-CCCD Director, 7. Felix Awantang: Project Officer USAID/Zaire, 8. Joe Davis: Project Officer AFR/RA

12. Mission/AID/W Office Director Approval

Signature *W. Pouch*

Typed Name  
Mission Director

Date  
24 Jun 85

AID 1330-15 (3-78)

Based on 86 million Zaires Estimate in ProAg at 1982 exchange of \$1=6Z

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## memorandum

DATE: July 24, 1985

REPLY TO  
ATTN OF: Richard L. Podol, Mission Director, USAID/Zaire

SUBJECT: COCD Zaire Project Mid-term Evaluation

TO: See Distribution

USAID/Zaire has reviewed the attached evaluation report and the forty-six recommendations. Attached are specific comments on most of the recommendations.

In general we believe the recommendations fall into three main categories: recommendations dealing with project financing and the GOZ financial obligations as detailed in the ProAg, recommendations on the technical and management aspects of the three project services (vaccinations, ORT, malaria treatment and prophylaxis), and recommendations dealing with management relationships between AID/W AFR/RA, USAID/Zaire, CDC Atlanta and the GOZ.

After a careful review of all these recommendations, USAID has decided to focus on 13 of them selected from the three groups of recommendations in the evaluation report, and considered the critical ones for Project success by USAID.

These 13 recommendations are summarized in the Project Evaluation Summary (PES) form. They deal with actions that are planned for implementation or are already being implemented, new ideas to strengthen the program, and corrective actions.

Although the other recommendations are not addressed in the PES, as detailed in the attached "Specific Mission Comments," they are being reviewed and dealt with as appropriate.

Actions to implement the evaluation recommendations began directly after the evaluation team left Kinshasa. The project staff has taken action on and continues to address ways to improve training and management activities in order to enhance the quality of services offered. USAID representatives met with project staff to review current budgetary problems and their impact on project operations. Meetings were also held with the new Minister of Health to determine how to deal with some of the financing problems. Recently, the Ministry of Health appointed a new Director for the project.

Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

OPTIONAL FORM NO. 10  
(REV. 7-78)  
GSA FPMR (41 CFR) 101-11.6

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We believe progress has been made in implementing these recommendations and that most of the feasible recommendations will have been fully or partially implemented by the first quarter of 1986 when the annual review for the project is due.

We will be closely monitoring the implementation of the 13 recommendations summarized in the PES through discussions and reminder cables to action agents identified in the PES.

We will also appreciate comments from AID/W, CDC, and others regarding follow-up on these points and the evaluation in general.

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July 24, 1985

Subject: Specific Mission Comments on Recommendations

The evaluation team made a total of forty-six recommendations, composed of sixteen principal recommendations, twelve general recommendations and eighteen management recommendations. Three of the major recommendations (1,3 and 11) are addressed primarily to the USG and the GOZ who are parties to the ProAg. The remaining thirteen major recommendations are directed primarily to project staff and address a variety of technical and management issues. The management consultant also made recommendations that are addressed for the most part to USAID, AID/W and CDC. Some of these recommendations overlap each other.

A. Major Recommendations to the AID and the GOZ

- 1) The team recommended an extension of the financing of the project after December 1986 for a period to be determined to permit the achievement of the project objectives, i.e., reduction of childhood mortality by 50%.
- 3) The Project Agreement should be revised to correct for the problems caused by the 1983 devaluation, to clarify the use of counterpart funds, and to clarify the terms and responsibilities of the agreement.
- 11) The Government of Zaire ordinary budget should be increased to the level necessary to achieve the project objectives. USAID should assist the GOZ as much as possible but should be ready to withdraw or reduce its investments in the project if the GOZ is incapable of supporting current or future project recurrent costs.

Background for AID response to Recommendations 1,3 and 11. The USG and the GOZ agreed to combine resources in the CCCD project in order to utilize three simple and relatively inexpensive technologies (vaccinations, ORT, and malaria chemotherapy) to solve some of Zaire's most serious health problems.

During the design of the project both governments emphasized the need for the GOZ to incrementally assume project-generated costs. This emphasis was intended to avoid unrealistic project expansion financed by the grant budget to a level which the GOZ would be unable to sustain at the end of the project agreement. It was for this reason that the ProAg specifically stated that the GOZ would incrementally assume project costs at a level of 25% during the second year, 50% during the third year and 75% during the fourth year. The ProAg goes on to add that "USAID financing proposed is predicated upon the ability of the project to expand to cover 58% of the population within four years and the ability of the GOZ to incorporate into their budget costs of vaccines, vaccination supplies and antimalarial and diarrheal medications by the end of the project."

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After two years of project implementation it is to be noted that the GOZ has not purchased from its own budget any vaccines, vaccination supplies, anti-malarials or diarrheal medications. The GOZ ordinary budget (OB) contributions for the project are summarized below.

CCCD Project Budget (Z 000 000)

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total Project budget including counterpart funds and other donor contributions	12.907	16.4	23.3
GOZ OB contribution	7.2	7.7	4.8
% GOZ OB contribution	55.8%	46.9%	20.6%

The decreasing GOZ OB contributions go to pay primarily salaries of PEV-CCCD staff. The 1985 contribution of 4.8 million is inadequate even to pay the salaries (estimated at 7 million zaires) of 158 personnel. During the first quarter of 1985, counterpart funds (intended primarily for training) had to be used for salaries when the GOZ cut off temporarily all salaries. IMF-imposed budget ceilings have caused a reduction of funds available to development projects. CCCD has taken its share of cuts along with other programs. The idea of increasing GOZ contributions in real terms is unrealistic for the next few years. But in dealing with this recommendation we will seek as high a CY-1986 budget level as seems realistic. USAID agrees however, to extending the project for an additional year without additional dollar funding since the GOZ is currently unable to finance the cost of the infrastructure needed to achieve current project objectives. Any additional extensions will be determined as appropriate.

Regarding recommendation three, USAID agrees that the ProAg needs to be revised to clarify several issues which include:

1. GOZ obligation in terms of investment costs and project-generated recurrent costs. It is an accepted practice in development financing to insist that the recipient government be responsible for assuming all recurrent costs. The current ProAg language implies that the GOZ should also assume on an incremental basis all capital costs by the end of the project. In modifying the language of the ProAg, we intend to stress the GOZ's responsibility for recurrent costs, rather than for capital costs. Given the GOZ's foreign exchange situation, it is unrealistic to expect them to pick up such items as vehicles, cold chain equipment, etc., within the life of the project.
2. The issue of project sustainability is a key one and the role of counterpart funds needs to be addressed. Since this funding terminates when the ProAg expires, these funds should not be used to expand the project to a level that the GOZ cannot support through OB appropriations.
3. With the evolution of the health services system in Zaire since project initiation, the GOZ contributions need to be redefined and apportioned at levels where project implementation is critical to achieving project objectives. It has become evident after two years of implementation that although the PEV central office and its 19 regional and sub-regional offices are the implementing organization of the project, the project has to rely on the performance of zonal physicians and their staff (over whom PEV-CCCD has no direct managerial authority) to achieve morbidity mortality and vaccination coverage objectives. PEV-CCCD does not provide direct services.

It has also become evident that whenever PHC services have been organized in a health zone, it is relatively easy for the zonal medical officers to implement PEV-CCCD objectives. This being the case, GOZ grant financing of health zones can legitimately be considered contribution which support the PEV-CCCD objectives. This also being the case, more project financed resources will have to be provided to Health Zone staff who meet minimum performance standards to be established by the project staff.

USAID is responding to recommendation number 3 by slowing down the rate of project implementation and by extending the project through 1987 without an increase in funds. Project commodities that were to have been used over two years will be spread over a three-year period. Expansion of PEV-CCCD services within health zones currently served will take priority over extending services to new health zones where start-up costs are higher. As stated earlier, given post-devaluation IMF expenditure controls under which the GOZ is operating, the GOZ can be expected to have difficulty absorbing project generated recurrent costs if they are generated too fast.

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## B. Other Principle Recommendations

Given the current and projected low funding levels for the project, it is still possible for PEV-CCCD project staff to implement most of the technical and managerial improvements contained in the thirteen principle recommendations. These recommendations are, for the most part, non-controversial and USAID supports them. It is important to point out, however, that improvements that can be obtained in the quality of services through managerial and technical reform (without additional resources) are limited. The GOZ would eventually have to increase its primary health care funding to the health zones to bring about any significant increases in the level and quality of services that this project can potentially offer to its target groups.

## C. Management Recommendations

These recommendations are reviewed in the order they appear in the Annex III.

1. Recommendation No. 1 (p. 157): This recommendation is identical to recommendation No. 3 in the list of major recommendations. USAID agrees to it and has initiated action on it.
2. Recommendation Nos. 1+ 2 (p. 161): The USAID Health Officer wrote to CDC IHPO on March 19, 1985 requesting that position descriptions of the CDC TOs be revised to conform to the understandings set forth in State 365369. USAID has a letter from CDC promising new position descriptions by August 1985.
3. Recommendation (p. 163): In Kinshasa 18899 the Mission brought up the need to simplify the current accounting system so as to eliminate some of the problems encountered in the past two years. USAID is still waiting to hear from CDC and AFR/RA what measures have been or are to be implemented to resolve this issue.
4. Recommendation Nos 1, 2, and 3 (p. 164): With the acceptance of a one-year extension through 1987 mission believes additional long-term and short-term assistance will be needed. Additional need for TA will have to be negotiated between AFR/RA, CDC, USAID and the GOZ.
5. Recommendation (p. 167): AID/W to respond
6. Recommendation (p. 168): USAID has been participating in policy dialogue with central GOZ officials on various PHC issues. It is expected that this continuing dialogue will culminate in a reorganization of the central Ministry into a more responsive and functional organization. Specifically support and coordination of all PHC activities would be carried out through the proposed restructuring of FONAMES, which has broad multilateral support.
7. Recommendation (p. 169): Mission believes this issue should be considered if and when there is a Phase II.
8. Recommendation (pp. 169-70): The GOZ has appointed a project Director.

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9. Recommendation (p. 170): Since the evaluation two senior project officers have been sent to the U.S. for MPH degrees. Two other senior PEV staff members have returned from long-term study in Europe. Personnel, payroll and the commodity information is being computerized and this is expected to improve project administration.
  10. Recommendation (pp. 171-72): USAID is opposed to the use of CP funds for selective salary supplements. Our plan since 1984 has been to progressively decrease the use of CP funds to finance GOZ salaries. PEV salaries, benefits, and per diems are, on the average, better than most GOZ salaries for comparative levels. Increases in per diem and payment of more salaries from CP funds will only contribute to an increased dependence of project implementation on an unreliable source of funding. This recommendation will not be implemented.
  11. Recommendation (p. 172): USAID will work with PEV to see if such an awards system can be initiated.
  12. Recommendations (pp. 172-73): The project staff has initiated action on this recommendation but more needs to be done. Immediately after the evaluation, all regional PEV supervisors attended a workshop in Kinshasa on planning and workplan preparation. USAID will prepare a written clarification on the use of counterpart funds.
  13. Recommendation (p. 173): Action has already been initiated on this recommendation. Commodities in stock as well as personnel and payroll systems are being computerized.
  14. Recommendation (p. 174): Project staff is routinely informed of AID-sponsored training programs and project officials frequently attend appropriate training courses.
  15. Recommendation (p. 175): USAID agrees with this recommendation. The mission has been working on promoting the PHC concept and dialogue on PHC issues will continue, particularly in the context of FONAMES.
  16. Recommendation (p. 175): CDA coordination and sponsorship is desirable and is supported by the Mission, but ultimately the GOZ has to provide the much needed management leadership to make the health system work.
  17. Recommendation (p. 176): The USAID Director meets periodically with Zairian project staff and the Minister of Health to discuss critical project issues. The Director met with the Minister on April 29, 1985 after the CCCD evaluation to discuss CCCD project problems as well as those of other health projects. The USAID Director will continue to meet with the Minister of Health as needed to resolve project issues.
  18. Recommendation (p. 176): USAID agrees with this recommendation but plans no specific action.
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## Chapter Six Recommendations

- 6.1. The five points mentioned address points either covered by the major recommendations or are planned for implementation or are already being implemented.
- 6.2.3. Most of the important points here have been covered. regarding project budget preparation, the USAID Program Office has issued guidelines on the use of counterpart funds in projects. Appropriate sections of this document will be translated for use by PEV-CCCD project staff. Although USAID will assist in program budget preparation as recommended, the Mission will not involve itself in defending this budget at the Ministry of Finance. We believe this is an internal GOZ process that USAID should not get involved in.
- 6.4. The main points in these recommendations have been covered in the main recommendations.
- 6.5. Actions initiated in response to this recommendation include
  - a. the search for smaller fuel-efficient refrigerators
  - b. refrigerator maintenance courses planned
  - c. a speed-up of commodity delivery to regional offices
- 6.6. All significant actions recommended here are already being implemented.
- 6.7. All actions recommended are already being implemented
- 6.8. No information feedback bulletin has been published to date. Due to the expense involved, the implementation of this recommendation will probably depend on an increased budget for PEV-CCCD activities. The other recommended actions are being implemented.
- 6.9. The health education component of the project continues to be intensified through a multi-media campaign and TA. The project staff feels (and we agree) that while diarrhea prevention is an important aspect of PHC, a diarrhea prevention program as such is outside the scope of this project.
- 6.10. Operational research activities are being stepped up in response to this recommendation.
- 6.11. Activities recommended are either planned for implementation or are already being implemented.
- 6.12. Mission agrees that an impact evaluation after two years of implementation is premature. However, we hope that the project staff and CDC will perform this evaluation at the end of the project.

H

MOUVEMENT POPULAIRE DE LA REVOLUTION  
REPUBLIQUE DU ZAIRE  
DEPARTEMENT DE LA SANTE PUBLIQUE  
PROGRAMME ELARGI DE VACCINATION  
« P.E.V. »

**PROGRAMME DE LUTTE CONTRE LES MALADIES  
TRANSMISSIBLES DE L'ENFANCE**

**RAPPORT DE L'EVALUATION P.E.V. C.C.C.D. 1985**

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ENGLISH

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CCCD 1985 EVALUATION REPORT

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SUMMARY OF FINDINGS AND MAIN RECOMMENDATIONS

The goal of the CCD/PEV project is the reduction of child mortality due to vaccine preventable diseases, malaria, insufficient birth weight and diarrheal diseases. The project objectives are to be achieved through cooperation between the PEV (Programme Elargi de Vaccinations) and the national primary health care program. The objectives and sub-objectives aim at increasing: vaccine coverage; use of oral rehydration therapy (ORT) for children under the age of five and use of ORS (complete formula) for treating dehydration; the treatment of presumptive cases of malaria in children; and chemoprophylaxis of pregnant women in order to reduce low birth weight.

The project provides training at all levels and includes: village health workers (VHW), Peace Corps volunteers (PCV), doctors, nurses and technicians, both within Zaïre and abroad. The project organizes health education activities, provides vaccines, ORS chloroquine and equipment, develops cold storage facilities, health information and disease surveillance systems, performs surveys, provides planning and management assistance, provides epidemiology consultants, does operational research, supports user financing in primary health care, and provides assistance to the development of rural and urban health zones.

The project started in 1982, as part of an effort in much of Africa, to control childhood communicable diseases. It was organized in conjunction with the "Cooperation for African Development" group of countries (CA or Coopération pour le Développement en Afrique), which encourages western developed countries to collaborate and concentrate their resources in Africa. In this project, the United States, France, Belgium, UNICEF and the WHO collaborate with the government of Zaïre.

USAID contributed \$4.8 million toward implementation of this project. The collaborating agency responsible for technical cooperation is the Centers for Disease Control (CDC), the Health and Human Services Department of the US Government. A technical officer was assigned to Zaire 2 months after the grant agreement was signed. The project, although of wider scope, builds on assistance provided by the US to Zaire since 1977. Between 1982 and 1984, the number of health zones with access to the program increased from 17 to 25 in urban areas and from 14 to 105 in rural areas. FEV/CCCD activities have become self-supporting in 9 of the 13 health zones visited. The rate of recovery of funds was very encouraging.

Various schemes have been retained for possible replication.

The well developed zones showed high rates of vaccine coverage whereas the more recently established zones showed slight decreases after switching from mobile to fixed centers vaccinating strategies.

The use of oral therapy has been rapidly accepted and expanded. The adoption of ORS (special WHO formula) has been slower due to inadequate or delayed health education campaigns and due to the reluctance of users at the health center level.

The treatment of presumptive cases of malaria seems wide-spread but chemoprophylaxis for pregnant women is less so for at least two reasons: mothers' reluctance to spend money on prophylaxis, and late prenatal consultations (8th or 9th month). It seems that at this mid project point the vaccination and access goals are being reached, but achievement of objectives for reducing diarrheal diseases and malaria will take more time than previously planned.

The evaluation team found that the project was well organized and well run, with a few exceptions which are mentioned in the text. One major concern relates to Zairian Government financial support of the project in the light of financial circumstances occurring over the last two years.

The principal recommendations made by the evaluation team are the following (the others can be found in paragraph 6):

1. An extension of project funding and increased funding after December 1986 should be considered, for a period yet to be determined, so as to achieve the program's objectives, namely a 50% reduction in childhood mortality. The Mission should be consider participating more actively in the financial and management aspects of the project.
2. The project must be reorganized so as to support the national strategy of providing help to the rural health zones, through the regional HEV/CCCD offices, especially in the following spheres: training, logistics, health information system, operational research, health education, and supervision.
3. The Project Grant Agreement be revised to rectify the problems caused by economic factors (devaluation), the use of counterpart funds, and for a better comprehension of the norms by all parties.
4. A training course for trainers should be proposed for the zone medical officers and to nurses' supervisors, it should be organized at first by the central office of the HEV/CCCD until regional offices can institutionalize this training.

5. Technical training in ORI should be organized at the Mama-Yemo hospital in Kinshasa for the clinician doctors responsible for hospitals in the regions, sub-regions and zones. A small construction undertaken to facilitate training and the delivery of services could thus become a national and international center for rehydration treatment.
6. The PEV/CCCD should ensure a correct and free distribution of material, vehicles, medical equipment, and small instruments, and keep in its regional offices an emergency stock of spare parts.
7. The FEV/CCCD should put chloroquine and oral rehydratation salts on the market and more intensively promote their sale to the zones.
8. The FEV/CCCD should promote the national strategy vis-à-vis the campaign against diarrheal disease and malaria.
9. FEV/CCCD should increase and improve the system of supervision.
10. The PEV/CCCD should improve the procedure for drawing up its budget, under the responsibility of the Director (or acting Director) of the FEV and include all the main team leaders, the CDC team and the USAID project officer. The budget should be formulated on the basis of investment objectives.
11. The support given to the PEV/CCCD from the ordinary budget of the Zaïrian Government should be increased up to the level necessary for the accomplishment of the project's planned operations. USAID should help to the utmost degree possible, but be ready to reduce its investments in the project if the Zaïrian Government proves incapable of supporting the recurrent costs of the current, future, or revamped project.

12. The various existing Zairian systems for recovering costs, the demand for primary health care services, the cost, and the interventions of the PEV/CCCD should be studied. These studies would determine ways of improving the Zairian primary health care program's facilities for recovering costs, and would be organized by AFR/RA.
13. The disease surveillance system and the system for notification of illnesses should be strengthened and rapidly extended to health centres, through the training of zone medical officers and of nurses, and through the clarification, standardization and dissemination of data collection forms.
14. The data collected by the zones and the regional offices of the PEV should be sent to the central office without delay. An information feedback system initiated at the national level must be recommended.
15. Health education messages must concentrate more on preventive information than on curative treatment, if visible progress is to be realized in terms of a reduction of sickness/mortality.
16. The Peace Corps should be instructed to draw up a technical data sheet on health education, community participation, the organization of the community and the promotion of oral rehydration salts and chloroquine.

## 2. INTRODUCTION

### 2.1 Population and health data for the Country

This report presents the mid-term evaluation of the bilateral Zaire/USAID project (No. 698-0421) for combatting childhood communicable diseases (CCD). The project agreement was signed in August 1982 after an initial evaluation of its different components. An agreement was signed between USAID and the United States Centers for Disease Control (CDC) for the implementation of this project in collaboration with the Department of Public Health represented by the "Programme Elargi de Vaccination" (PEV). USAID's contribution was estimated at \$4,789,000 for four years. This project was designed so that the Zairian Government could increase vaccination of children against communicable diseases; treat dehydration associated with diarrheal diseases; - and to reduce the morbidity and mortality due to malaria. This project is in fact a continuation of previous collaborative efforts between USAID/CDC and the PEV.

Zaire, situated in the centre of the African continent, both north and south of the equator, covers an area of 2.4 million square kilometers. The jungle covers a good part of the country. The climate is tropical. Its population of over 30 million, is 35% urban (including the 3 million inhabitants of Kinshasa) and 65% rural. The annual rate of migration to the cities is estimated at 7%.

The approximate population distribution by age group is the following:

0-11 months: 4.23%	2-5 years : 11.02%
12-23 months: 3.75%	0-15 years: 46.00%

Health conditions are characterized by a high birth rate, much sickness, high mortality rate, and a short life expectancy.

Crude birth rate: 4%

Crude mortality rate: 1.8%

Infant mortality rate: 18%

Child mortality rate: (under 5 years): 35%

Life expectancy at birth: 45 years

The principal causes of infant mortality are measles, malaria, diarrheal diseases, and low birth weights.

## 2.2 Project Background

The Programme Elargi de Vaccination (FEV) had its origins in a presidential ordinance in 1968 which created the National Campaign for the Eradication of smallpox and for the immunization of children against tuberculosis (C.N.E.V.). In 1977, immediately after the country obtained certification of the eradication of smallpox, the program was extended to include vaccine for other preventable communicable diseases. An agreement was signed with AID to assist in the control of measles. The program changed names and became the FEV. AID and other donors contributed to varying extents to this effort to combat communicable diseases. In 1982, AID, through its Regional Africa Bureau, signed an agreement with the Centers for Disease Control, (CDC) to provide technical assistance in Africa for the control of childhood communicable diseases. The project has a regional component and 12 bilateral cooperative projects. Regional cooperation provides assistance in the fields of training, health education, operational research and epidemiology, with regional epidemiologists based in Zaire, the Ivory Coast, and Malawi. The bilateral component, - as is usual in programs between The United States and host countries, - provides technicians, training, equipment, vaccines, medicines, etc.

In Zaire, an initial evaluation of activities - which serves as a planning document - was carried out in 1982, and the Project Agreement signed in August 1982. At the end of the same year project implementation was begun, with the arrival of the technical officer. The regional epidemiologist took up his post in January 1983.

### 2.3 Objectives, Strategies and Geographic Expansion of the Project

The objectives contained in the Project Agreement between The United States of America and the Republic of Zaire relate to the definition of the project, its goals, its objectives and sub-objectives. In its definition, the project "will consist of strengthening the capacities of the Department of Public Health's Program to offer, as part of its basic health services, children's vaccinations, the treatment of severe diarrhea in children, the treatment of malaria in children, and prophylaxis for malaria in pregnant women. This definition is given in the follow-up to the text of the agreement as follows:

#### Goals, Objectives and sub-objectives of the CCCD/Zaire Program.

##### Goals

1. Prevent avoidable childhood diseases through vaccination (measles, diphtheria, whooping-cough, tetanus (DPT), poliomyelitis, and tuberculosis).
2. Reduce mortality and sickness due to diarrhea.
3. Reduce mortality and sickness due to malaria, mainly in children.
4. Strengthen the national capacity to improve children's health through the prevention and control of diseases.

5. In doing this, to improve the overall state of health of the communities reached by the project and promote a more rapid national development.

Objectives\*

1. Reduce by 50% the mortality rate of children under five years old in the project zones, within 4 years of the starting date of the project.
2. Reduce by 50%, in the zones offering vaccinations, sickness and death from neonatal tetanus, measles and poliomyelitis.
3. Reduce by 50% in the zones served by the project, death from acute diarrhea.
4. Reduce by 50%, in the zones where antimalarial medicines will be made available, a) the mortality rate from malaria, and b) the deaths of fetuses and of children with low birth weights.

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\*Quantified data represent current estimates and will be revised periodically during the life of the project.

Sub-objectives\*

1. Increase vaccine coverage to at least 80% for BCG, 70% for measles and 50% for DPT and Polio within the 4 years of the project in the zones covered.

2. Increase the percentage of fixed medical facilities using oral rehydration as first line treatment in cases of diarrhea and dehydration from less than 5% in 1982 throughout the country to at least 70% within 4 years in the zones participating in the project.
3. Increase the percentage of the population with access to rapid treatment in case of diarrhea and acute malaria from under 20% in 1982 to more than 70% in the zones covered by the project, within 4 years.
4. Increase the percentage of standard treatment by oral rehydration in cases of acute diarrhea from less than 20% in 1982 to more than 70% in the zones covered, within 4 years.
5. Increase the percentage of children with access to chloroquine treatment in cases of fever presumed to be malaria, and the percentage of pregnant women with access to malaria chemoprophylaxis, from less than 20% in 1982 to more than 70% in the zones covered, within 4 years.
6. Increase the percentage of children suffering from an acute crisis of malaria who receive an early presumptive treatment, and the percentage of pregnant women who follow a malaria chemoprophylaxis, from less than 20% in 1982 to more than 70% in the zones covered, within 4 years.

Note that the intermediate sub-objectives for the periods of less than 4 years are the following:

	<u>1st Year</u>	<u>2nd Year</u>	<u>3rd Year</u>	<u>4th Year</u>
- B C G	70%	75%	80%	80%
- MEASLES	40%	50%	60%	70%
- DPT AND POLIO	25%	30%	40%	50%
- ORS	40%	50%	60%	70%
- TREATMENT OF MALARIA	50%	50%	60%	70%

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\*Quantified data represent current estimates and will be revised periodically during the life of the project.

PEV/CCCD Strategy and National Health Plan.

In 1982, the Zairian government prepared its first national development plan for primary health care. This plan requires the creation of 300 rural health zones, based on successes demonstrated since the 1920s.

This model is based on the organization of the rural health zones around a referral hospital and the transformation of health posts and dispensaries into health centers offering various preventive care services. These include health and hygiene education, the upgrading of water sources, nutritional education, prenatal and preschool consultations, family planning, and the treatment of common diseases such as malaria and diarrhea.

A document developping the national health strategy was prepared in July 1984. It likewise places emphasis on the implementation of primary health care by advocating the integration of different preventive and curative interventions of the CCCD program into primary health care activities. Paragraph 26 refers to the development of a health system on a unified and integrated basis. It also alludes to reforms of a political, administrative and socio-economic nature, and to a changing mentality and a modification of attitudes.

Paragraphs 41, 42 and 54 stipulate that vertical programs such as the service for major endemic diseases shall continue to operate if the need is felt. Their activities will be integrated and coordinated by the zones.

The strategy proposes to make FONAMES (National Health Fund) and specialized services responsible for the overall development of Primary Health Care (Annex 3 of the document "Stratégie Nationale en Matière de Santé").

The PEV/CCCD is one of these specialized services, as are the tuberculosis, malaria, trypanosomiasis, monkeypox and leprosy services, and the nutrition service and family planning programs. The national strategy aims to integrate all these services at the zone level.

### Strategies

The project strategies consist of providing equipment and materials to the "Program" to increase vaccine coverage in health zones. As services are currently offered by fixed centers and no longer by mobile teams, this equipment and materials were made available to the zonal medical officers, who placed them in health centers and health posts. For example, the Zonal Medical officer and the supervising nurse are trained by the PEV-CCCD central staff; they in turn prepare training programs in the health zones for nurses

from the health centers. These latter will subsequently train village health workers. Equipment and materials are distributed by the central PEV/CCCD office to the PEV regional teams for distribution to the health zones.

The zones obtain their supplies of vaccines, chloroquine, and ORS by making requisitions. However, the equipment is provided only to the zonal medical officers who have been trained by PEV/CCCD. The cost of transporting the material is borne by the zone.

The health education strategy includes many methods - communication at village level, mass-media, posters, fold-outs, school health, formal and informal training for a broad range of health and lay communities.

The system of financial self-supporting advocated in the zones will initially receive support to cover the cost of CCCD activities (vaccinations, treatment and other expenditures to do with the delivery of services.)

A system of health information based on the existing systems was developed, so as to have data for planning and management, with an emphasis on rapid collection and analysis of epidemiological data on vaccine preventable diseases, diarrhea, and malaria.

#### Geographical Expansion of the Project

The PEV/CCCD project is based on previous efforts to control the diseases that can be prevented by vaccination. Zaïre has received assistance in this program by USAID and other donors. The campaign for the eradication of smallpox, which terminated successfully in 1977, left a working basis for current efforts to increase the number of urban health zones from 17 to 25 and the number of rural health zones from 14 to 105 during the period 1983-1984 covered by this evaluation. Forty per cent of the population of Zaïre thus has access to types of interventions that the PEV/CCCD implements.

3. OBJECTIVES AND EVALUATION METHODS

In conformity with the terms of the CCCD Project Agreement signed between the Governments of The United States of America and Government of Zaïre, an evaluation of the CCCD Project was carried out at the end of the project's second year by an international team, from the 28th of January to the 22nd of February 1985.

The objectives of the evaluation were the following:

1. To examine project progress to date towards the attainment of objectives as defined in the Project Agreement.
2. To examine the progress made in each project component of the project including the administration of vaccinations, the fight against diarrhea and malaria. To examine the activities carried out in support of basic project components such as the development of a system of health information and the monitoring of diseases, training, efforts to promote health education, special surveys, and operational research.
3. To examine the management of the project and its capacity to support a higher level of activities when AID support is withdrawn.
4. To estimate to what extent the activities of the PEV-CCD have been integrated into the existing structures of primary health care.
5. To make recommendations for the improvement and expansion of the project.
6. To measure the impact of health of the CCCD's activities to date.

From 28 January to 2 February, the team reviewed project documents, determined the indicators of progress, prepared a questionnaire for field trips and interviewed many central office personnel. The team subsequently split up into four groups which visited 7 of the 9 regions of the country, interviewing the staff of 8 PEV/CCCD teams and observing the activities of 18 health zones and 26 rural and urban health centers. Representatives of the team also visited and observed the activities of the Oral Rehydration Unit at the Mama-Yemo Hospital in Kinshasa, the model urban health center in Kikimi, and the ORS production unit at the pharmaceutical laboratory of Kinshasa (LA. PHA. KI). Later the team met the representatives of the SANRU project.

On their return from field trips, the four groups systematized their observations, summarized in tables, and reviewed conclusions and recommendations in plenary sessions.

Questionnaires (for the central/regional/zone/health center level) were used as a common starting point for all the groups. At the next stage, conclusions and recommendations were assembled. They were then revised and clarified by the core evaluators, and used as the basis for the evaluation report.

4. MANAGEMENT AND FINANCES

4.1 Pertinence and Adequacy of Project Programming and Administrative Structures.

There are two main sources of funds for the local currency expenses of the program: the ordinary budget (O.B.) of the Government of Zaire and the counterpart funds managed by USAID and the GOZ. Proposals for financing the program's activities from the O.B. are prepared by the Chief Administrator of the PEV under the supervision of the PEV Director. Proposals concerning counterpart funds have to date been prepared by the CDC's technical advisor to PEV, in collaboration with the director of the PEV/CCCD.

Ordinary Budget (O.B.) proposals are prepared as a function of the personnel and equipment available, instead of the needs planned for the year. The proposed O.B. request is submitted to the Department of Finance where PEV has to defend it. Sometimes, and especially for the 1985 budget, the PEV Administrator was the highest ranking PEV representative present to defend the proposal before the Department of Finance's much higher ranking representatives.

Proposals for the 1984 O.B. allocations were made before Zaire's September 83 devaluation (which was followed by an increase in fuel prices and salaries for the whole public sector). This fact was used to explain the inadequacy of the 1984 O.B. resources. The 1985 O.B. request was made with full knowledge of the effects of the devaluation, the amount allocated by the Department of Finance is smaller in absolute terms, and much smaller in real terms, than that allocated in 1984.

Counterpart funds budget proposals are submitted to the Department of Plan through USAID's Public Health Division. There is a disagreement between the USAID project officer and the PEV technical officer concerning a ceiling

on the amount requested. It was agreed that counterpart funds would be used to support operating costs at a progressively decreasing rate starting in 1985. Counterpart funds are to be used for investment expenses. The 1985 counterpart budget reflects this reorientation.

Recommendations have been made to alleviate some of the above problems. The first series concerns budgetary requests for O.B. funds made by the PEV to the Department of Finance. (See section on Recommendations)

#### 4.2 Budgeting and Cost

The first budget table shown here indicates present totals and local recurrent costs in 1984. The second table shows an estimate of operating funds needed in 1985 to operate at approximately the same level as 1984. The planned local currency investment expenditures are also shown in the second table. Assumptions used to estimate the 1985 operating costs are given at the bottom of the table.

Even considering the inflation of salary and fuel costs, operating costs estimated for 1985 are at approximately the same absolute level as in 1984 because of improvements made to program performance in 1984 (personnel reduction and use of a smaller pool of diesel vehicles).

In 1984, counterpart funds (CP) supported approximately half of the operating costs. Starting in 1985, CP funds contribution to operating costs will decrease, but will increase in the local currency financing of investments. Thus, in 1985, a larger contribution to the operating costs must come from the Government of Zaïre to maintain the program's activities at the 1984 level.

The following table shows all the GOZ expenditures, expenditures for health, and PEV allocations in 1984 and 1985. The amount allocated to PEV for 1985 is practically the same as it was in 1984. This amount will not be sufficient to cover the estimated operating costs for maintaining PEV activities at the 1984 level.

GOZ Budget (in millions of zaires)

	<u>1984</u>	<u>1985</u>
Total Expenditures	21,306.2	35,510.4
Health related expenditures	442.1	916.0
As a percentage of the total	2.0%	2.6%
O.R. allocation to PEV	6.1	6.1
As a percentage of expenditures on health	1.4%	0.7%

Source: USAID Program Office

The amount allocated to PEV remained unchanged from 1984 to 1985 although total expenditures for health increased. PEV's share in health expenditures has been reduced by half (from 1.4 to 0.7 percent).

#### 4.3 Project Structure and Operation

The CCCD project is a larger version of the "expanded vaccination program" (PEV). The project is called PEV, CCCD or PEV/CCCD. It is usually referred to as PEV, its historic name, as the implementation agency. The major difference between the two projects is the addition of oral rehydration therapy and of chloroquine preventive and curative treatments. PEV is an autonomous service sponsored by the Department of Public Health, and has its own budget. It has the same hierarchical level (Direction) as the office of Primary Health Care (PHC) which covers a limited number of components usually considered as part of PHC.

PEV/CCCD has national (Kinshasa), regional and sub-regional levels. On December 1 1984, the organization employed 146 persons, including 6 doctors. Virtually the whole team is contractual, since PEV, created by presidential decree, is not part of the civil service. In addition, the team includes 4 Peace Corps volunteers, one technician, one CDC regional epidemiologist, and one Belgian technician.

The 9 regional offices, constitute, along with the sub-regional offices, the lowest level of the national PEV/CCCD operation. They train, supply and guide the health zones.

These zones have one or several regional hospitals which in turn supports the health centers and non-professional village or community health posts which are at the lowest level. This scale of responsibilities operates in urban and rural areas. The whole structure is practically in place. As discussed in other chapters, much remains to be done in the field of training, as well as in other areas. Likewise, the chronic restriction on operating funds must be lifted.

The PEV/CCCD teams lack the qualified personnel to ensure a sufficient operational capacity. This leads to supply, training, health

information, disease monitoring, maintenance and management problems in general, which are compounded by inadequate operating budgets.

As far as AID/Washington is concerned, the regional program and the bilateral programs are the responsibility of the regional bureau for Africa (AFR/RA). CDC is responsible for implementing the program, and provides two professionals to AFR/RA. They participate in program activities and also serve as liaison with CDC/Atlanta and USAID. In this agency, continued support and control activities are implemented through a project officer in the public health office.

He is in direct contact with PEV/CCCD, often through the CDC technician attached to PEV at the central level. The multiplicity of partners attached to various agencies and the sometimes "hectic" communication channels have led, at times, to misunderstandings which are discussed in greater depth in the annexes. The dollar funds are provided by USAID, the local currency funds are financed by the GOZ central budget and counterpart fund. Although counterpart funds belong to the GOZ, they can only be used with USAID's specific approval.

The counterpart fund concept and procedures need to be clarified. They are not totally understood by PEV and maybe by other Zairian Government entities.

PEV/CCCD's capacity to operate politically and operationally has been hampered by the director's frequent and extended absences. It is imperative that the position of deputy director, whose incumbent could act on behalf of the director, be filled quickly (it is provided for in the revised 1982-1986 operational plan) or that another officer, probably the chief of technical services, be given the necessary authority to act on behalf of the director in his absence.

## 5. IMPLEMENTATION

### 5.1 State of Progress

#### 5.1.1 Supply, Logistics and Cold Chain.

The total quantity of vaccines received and distributed in 1984 is given in Table 9. Delivery times (3 months) are almost always respected.

The quantities of materials and medicine received since the beginning of the project are given in Table 10. The distribution upon request policy explains the size of the undistributed stock. A large portion of this material constitutes an initial investment essential to the sound operation of the project and is not a repetitive expenditure.

Oral rehydration salts are now manufactured by the Laboratoire Pharmaceutique of Kinshasa (LAPHAKI) which has a semi-automatic unit. The components are measured to be mixed with 0.75 l of water (a Primus beer bottle) and presented in two compartments: glucose, sodium chloride, potassium chloride on one side, bicarbonate on the other. This slightly more expensive process ensures better preservation and allows an easy substitution of citrate for bicarbonate. Personnel's attention should be drawn to the quantity of liquid needed for this mixture, 0.75 l, which is different from that of UNICEF packets.

The distribution of vehicles among PEV/CCCD central, regional and subregional offices is described in the table. In addition to the vehicles distributed as part of the project, one must take into account the vehicles allocated directly to the Health Zones as part of the primary health care program by SANRU, UNICEF, Belgian Cooperation,....

### Cold Chain

With two cold storage rooms one 20 m<sup>3</sup> and +4<sup>o</sup>, and one 30 m<sup>3</sup> and -20<sup>o</sup>, the central depot can insure good conservation of all vaccines needed nationwide. Each PEV/CCCD regional or sub-regional office has refrigerators and freezers, for a total capacity of 600 to 800 liters allowing them to act as depots. Small equipment (ice boxes, cold accumulators) has been distributed to regional or sub-regional teams and to the zones which participate in the project. These zones have also received refrigerators and bicycles. The distribution by region is shown in Table 4.

#### 5.1.2 Training

The training material used to orient the chief doctors of the health zones was prepared in 1983 by PEV/CCCD with assistance from an international team of experts. This material consisting of 12 modules is used to organize three week long seminars. Training covers planning, management and evaluation of the three components of CCD and their integration with Primary Health Care at the health zone level.

To facilitate the job in the field, a handbook containing 28 data sheets was also prepared that same year. It shows in detail how PEV/CCCD activities can be rationally carried out. Later, two posters relating to the clinical aspects of severe diarrhea were prepared using WHO criteria. The posters and data sheets have not yet been distributed to most health zones visited by the evaluation team.

During the seminars, WHO course modules on diarrheal diseases and PEV are also used.

According to the 1982-1986 Operational Plan, these seminars are held regularly and have allowed the training of various categories of health personnel, i.e.: 37 medical inspectors and sub-regional doctors, 138 health zone doctors (including the participants selected by SANRU and the German Technical Cooperation and 25 supervisory nurses. (table 12).

The training of satellite personnel is the responsibility of the zonal medical officers. In most cases, it is done with assistance from PEV/CCCD regional/sub-regional teams. Several courses were organized in 1982-1984. In total, 293 doctors and nurses from satellite health centers were trained (Table 13). During this training, each participant received a copy of the data sheets, basic document for the course and a reference document to be kept at the work place. The progress of this training has been somewhat hampered in many zones due to lack of financing or lodging infrastructure.

Clinical training in oral rehydration for doctors and nurses recently started at Mama Yemo Hospital in Kinshasa. This training will cover 130 basic health centers in Kinshasa.

PEV/CCCD training is included in the annual 12 week Peace Corps course given in Bukavu and was designed for the new health volunteers. In 1984, this course had little success in orientating Peace Corps volunteers (PCV) who had no health training in PEV/CCCD operations. The Peace Corps volunteers were trained by using the 12 modules of the course designed for zonal medical officers. In addition, the regular 3 week course was condensed into a two week course. Everyone agrees that this approach was not satisfactory for 98% of the Peace Corps Volunteers.

An unknown number of nurses have been trained and retrained, using PEV/CCCD training material. It is not possible to assess their knowledge and performance.

5.1.3. Auto-financing: Fund allocation

The financial resources available to cover PEV/CCCD's operating costs are insufficient to allow the continuation of activities at the level necessary to reach the project objectives. In 1983, counterpart funds were used to cover operating costs. In 1984, the effects of the devaluation of the zaire rendered the GOZ's OB resources inadequate to cover operating costs. PEV was obliged to reduce its activities to stay within budget limits. In 1985, OB resources allocated to PEV were even lower than those allocated in 1984 in absolute terms and much lower in real terms. The Department of Plan and USAID/Kinshasa have agreed that counterpart funds would be used primarily for investments, which would result in a progressive restriction of operating budgets. Thus, fewer activities can be executed in 1985 than in 1984 with the resources available to support operating costs.

PEV laid off approximately 60 employees who became superfluous after the change in strategy (several from the central offices) in 1984, and added two new doctors to the central administration. However, these two doctors went abroad for one year of training. This leaves the PEV central office under-staffed.

Auto-financing

The cost recovery system for ORS and chloroquine implemented by PEV/CCCD in 1984 has generally been very successful. PEV sold a rather large quantity of ORS (460,514 packets which covered total costs in 1984). They have grasped the principle of varying the sale price as a function of the cost price.

Less chloroquine was sold (743,000 100 mg pills), for there are several well established supply sources in Zaire most of which sell chloroquine at a lower price than PEV.

In the health zones, observations made during visits in the field indicate that several different systems are used by health centers to recover part of the costs of PEV/CCCD or other interventions. In general, by recovering costs, centers have been able to acquire new supplies of ORS and antimalarials for curative treatment and to pay part of the health centers' personnel salaries. Total cost for vaccinations (vaccines, syringes, needles) was not covered, but in general, mothers were willing and able to pay something for this preventive intervention. In just a few cases it was noted that health centers were able to pay part of the cost of supervision by health zone personnel, out of these recovered costs. Self support of PEV/CCCD activities is only partially implemented.

#### 5.1.4 Provision of services

Vaccinations. Children are vaccinated at preschool consultations, or during special vaccination sessions. This depends on the number of children to be vaccinated per session and on how far away the vaccine depot is.

Pregnant women receive antitetanus vaccination during prenatal consultations, or during special sessions, - the PEV teams have completely stopped their mobile activities. The only mobile activities remaining in the country are carried out on the decision of the head doctor of the zone, who can use this temporary solution to bring services to health centers which are too far away or too poor to support the maintenance costs of a cold chain. In any case vaccinations are performed as part of prenatal or preschool consultations.

The earlier vaccination schedule recommended by the WHO's consultative group to PEV in 1983 and 1984, and indicated on PEV/CCCD project data sheets is beginning to be applied (oral polio vaccination at birth, then DPT and Polio at 6 - 10 - 14 weeks)... Vaccination of sick children must be performed whenever possible (hospital consultation) and at least an

appointment for the next session must be given to the sick children who have not been vaccinated.

On the graph indicating vaccines administered since 1977, (14) the apparent stagnation between 1983 and 1984 corresponds to a rescheduling of vaccinations around the first 2 years of life instead of the first 3 (vaccinations in the so-called catching-up phase) and to the shift from mobile to fixed strategy.

#### Combatting childhood diarrheal diseases

As planned by the project, preventing diarrhea begins at home through the use of home made sugar-salt solutions to prevent dehydration. The dehydrated child with diarrhea presenting in a health center would receive either the complete oral rehydration salts solution, an intravenous perfusion, or both depending on the degree and severity of the dehydration.

The creation of a special oral rehydration unit supported by HEV/CCOD to combat diarrheal diseases is planned in all urban hospitals. This activity was initiated at Mama-Yemo hospital in August 1984, actually involving the head of the Pediatrics department and his team. Under difficult physical conditions, an oral rehydration unit has been assembled, evaluation and treatment sheets have been developed and tested, the experience acquired in training health personnel and educating mothers has been disseminated. To date, 30 urban centers have been set up for oral rehydration for diarrheal children. The creation of a national training center is becoming a priority and arrangements must be made to institutionalize the oral rehydration activities.

The only measurable factor specific to the implementation of the program is the number of oral rehydration salts packets distributed over the years; their increase since the beginning of the project is evident. (Table 14 B).

Combatting malaria includes two components : single dose curative chloroquine treatment of all fever cases presumably caused by malaria in children under five years of age, and weekly chemoprophylaxis of women during pregnancy.

Here again, curative treatments that predate the project, the different sources of chloroquine, and the variety of medications used for all age groups, make it difficult to assess the degree of implementation of the program. The teams observed that chloroquine was available at the satellite level. But the team in the field also noted wide variations in the application of treatment schedules for children under 5 years of age;

- 5 mg/Kg/d for 5 days.
- 10 mg/Kg/d for 1/2 or even 5 days.

Single dose chloroquine of 10 mg/Kg/day recommended by the project is far from being accepted by all doctors. They recognize that this strategy does decrease temperature, but relapses are more frequent than with prolonged treatment. A Nationwide research study addressing this question would appear to be needed.

The efficacy of malaria prophylaxis of pregnant women is recognized, but only exceptionnally practiced. The reasons given are:

- economic (women cannot support the cost of a preventive treatment);
- logistic (the zones only have a stock for curative treatment).

#### 5.1.5 Monitoring of Target Diseases and System of Health Information.

To measure to what extent the objective of a reduction of sickness and mortality due to the target diseases has been achieved, the FEV has developed a sentinel monitoring system based on information provided by 103 sentinel posts located in 17 towns where the FEV/CCCD teams are based. A third of these sentinel posts are hospitals, the rest are health centers (table 1 a).

These sentinel posts submitted monthly statements during 1980-1982 on the total number of deaths due to measles, whooping-cough, poliomyelitis, and tetanus, to the regional/sub-regional teams, who forward a compiled report of regional data to Kinshasa (table 15 b).

In 1983 - 1984, this system was extended to the rural health zones covered by the program. Diarrheal diseases and malaria were added to the list of notifiable diseases.

However it must be noted that in rural zones, the monitoring system currently includes hospitals only (table 16 a). In the towns, on the other hand, it also includes health centers which declare only cases of measles and whooping-cough. (table 16 b)

In addition, surveillance in urban areas includes the use of a standard form, listing various epidemiological indicators such as the distribution of cases by age, seasonal variations, the ratio of cases to deaths, etc.

This data, and the figures for vaccinations performed, are assembled by the health zones and given to the regional/sub-regional PEV/CCCD teams, who do a monthly synthesis which they send to the management of the PEV/CCCD in Kinshasa, where data is centralized.

In order to maintain active and regular contact with the health units which participate in the PEV/CCCD program, a system for feedback information is being developed. Experimentally, the synthesis of the reports from 1981 to 1983, was distributed in 1984 to the regional PEV/CCCD teams and to the sentinel posts.

#### 5.1.6. Health Education

1. Introduction The achievement of the goals and objectives of the project depends on two major factors:

- 1) Changing the behaviour, attitudes and practices as regards health, of the target population.

- 2) Satisfaction by health services of the needs created by this change in behavior.

The messages of the project must reach pregnant women and the parents (fathers and mothers) of children under 5. This essential part of the project is examined below, to determine what was expected to occur under the project agreement, and the extent to which the plan and the budget have been realized. It will appear clearly from the analysis that the goals of the projects will remain unattainable unless much more specific attention is paid to the part of the project devoted to health education.

2. The project agreement aims at objectives in the fields of the prevention of vaccine-preventable diseases, the reduction of the impact of diarrheal diseases and malaria, the strengthening of national capacities to prevent and combat communicable diseases, and an improvement in the state of health of the populations participating in the project so as to accelerate their economic development. Mothers and children must change their health practices concerning vaccination, malaria, and the prevention and treatment of diarrheal diseases.

The proportion of vaccine coverage must be increased by 5% to 10 % annually: the utilization of antimalarials and ORS by 10% annually. These objectives should be achieved through:

- 1) Health education incorporating a variety of mass media. Formal and informal training on a one-to-one basis (the evaluator supposes that this means the nurses and village agents will play this role.) And written material will be planned, developed, produced and evaluated. By the end of the project, an entirely operational system will exist.
- 2) The training of the 895 professionals involved in the health zones of the project will include a section devoted to health education.
- 3) According to the project description, "after public confidence in the health posts and health centers has been won, oral rehydration therapy will be introduced to the villages by village health agents."

- 4) The training of participants in Health Education may be financed by the project.
- 5) The cost of equipment for Health Education is evaluated in the budget at 13,750 dollars in 1983 and 8,000 dollars in 1984.

3. In February 1984, the Health Education team of the project carried out a feasibility study and recommended an action program outlining specific approaches to obtain the goals and objectives of PEV/CCCD. This report initially concentrates on oral rehydration therapy. An action plan for the combatting diarrheal diseases was later outlined by Mayer and Moore, of the PEV/CCCD. One member of the team was attached full time to the office of PEV/Kinshasa in August 1984. One should remember that the Peace Corps also has a role to play in the implementation of this plan.

#### 4: Achievements of the CCCD

After the development of the health education plan, the PEV/CCCD team did some radio presentations, and numerous "Classified advertisement" and Health Education posters were prepared and distributed to the regions and the zones. UNICEF strongly supported these activities. However during field trips, the performance of Health Education activities was found to be variable. Few centers had PEV/CCCD materials.

Less than a third of the zones had any form of village health agent, "Mama" or animator. The principal role of the village health agents, most of whom had been trained by nurses, was health education and in the organization of the community.

One Peace Corps volunteer carried out exemplary Health Education activities in the Zone of Yakusu. She had done a diagnosis of the community and mobilized the community to action against schistosomiasis.

## 5. Discussion

The major health education problem for ORS is that prevention and combatting diarrheal diseases are not emphasized. If nothing is done to reduce the incidence of diarrhea at its source, efforts to treat it will be less and less accepted by parents.

The budget reflects the low priority placed on Health Education in the USAID Project CCCD (21,500 dollars out of 4,700,00). The lack of resources could be the leading factor making it impossible for the project to render CCCD interventions acceptable to Zairian families.

The approaches envisaged by the project are adequate mass-media, posters, school health, training of teachers. It has not been demonstrated that these methods reach rural fathers and mothers, who are for the most part illiterate, and speak a wide variety of local languages.

The absence of any major effort to train village health agents and organize the community must be corrected. The team found that these approaches posed problems, as the acceptance of the village health agents' rôle varies between regions and between zones, and the responsibility of the PEV/CCCD in the organization the zones is at most, marginal.

No Health Education Plan for vaccination or combatting malaria has yet been prepared.

5.1.7. Surveys and Operational Research

The surveys to be carried out in the context of the program are designed (see table 17):

to study the progression of the utilization of services. This involves 24 similar surveys on vaccine coverage by different methods (random samples in the cities, cluster surveys in health areas, studies of records, etc..) It also involves surveys permitting an estimate of the utilization of ORT for the treatment of diarrheas and of chloroquine in cases of fever in children.

to gather epidemiological data on the incidence or the prevalence and mortality rates of CCD's target diseases, and their repercussions on hospital and health center attendance.

to modify as necessary, the strategies concerning the vaccination of sick children, the preparation of solutions in the home (sugar-salt solution), the treatment of malaria, (resistance to chloroquine, efficacy of the single dose in children etc...).

These surveys are of the highest interest to the program and must be continued and strengthened. They permit an estimate of the real utilization of oral rehydration therapy and of chloroquine in the cases of supposed malarial fevers in children. The latter should be carried out in zones where the program has existed for two years, in particular so as to know the degree of attainment of the sub-objectives laid down in the USAID/Government of Zaïre agreement.

## 5.2 Cost Effectiveness and Efficiency

### 5.2.1 Adequacy of equipment, material, logistic support and supervision.

- i) The quantity and the stock of vaccines are sufficient. There was a deplorable disruption at central level in the supply of measles vaccines in mid 1984, with repercussions on peripheral levels. Considering AID/W's assurances that all necessary measures have been taken to ensure that such a incident will not recur, no recommendation will be made on this subject.

- ii) the quantity of material and medications available centrally is adequate. However problems do occur in the distribution to peripheral levels, probably due in part to the lack of information on the available stock of spare parts and also to the use of syringes and needles for other activities besides those of the project. Some of the zones visited by the evaluation team do not get their supplies from the FEV teams. The price of chloroquine is generally higher than that charged by various religious and other organizations.

- iii) Transport.

Though there appears to be a sufficient number of vehicles at the disposal of the project, their use is limited by:

- a delay in the distribution of spare parts,
- the impossibility of using petrol vehicles in most of the regions because of a lack of supplies on the market and because of the high cost of gasoline, (about twice the price of diesel). The reclassification of these vehicles with the donors agreement is indispensable.
- penury and the cost of fuel for diesel vehicles.

All these constraints, added to operating and maintenance expenses result in limited travel, and a consequent lack of supervision and training. A greater attention to planning, and a greater availability of locally generated funds should gradually help to alleviate the problem. The project has, as much as possible, begun replacing vehicles which have high running costs with motorcycles and bicycles.

iv) The cold chain

The means made available to the project are sufficient, adequate, and suitably maintained and supervised, centrally, regionally, and sub-regionally. However, there is no maintenance data sheet concerning cold storage chambers at the central depot, and it would be desirable to establish one and follow its directives.

The refrigerators made available to zones and health centers work well, but the problem of financing their kerosene consumption is crucial and often dissuasive. As their capacity is often much greater than needed it seems important to consider the possibility of acquiring smaller refrigerators which consume less kerosene.

In the meantime the available equipment should be distributed only to those health centers which can reasonably undertake to keep it functioning. The cost of transporting this material to the place where it will be used must be considered as an investment cost and paid out of counterpart funds.

Particular attention should be paid to the results of current tests of solar energy for refrigerators, both technically and economically.

For the centers which have no refrigerators, the means of transporting vaccines, thermos and cold accumulators are available in sufficient quantities at the vaccine depot.

The freeze indicators are not often used and when they are, their use is not very well understood. They should be brought into general use, at least within the regional and sub-regional depots of the HEV, and training in their utilization also seems indispensable.

v) Supervision by the central office of its regional teams was carried out during 1984, from July onwards according to precise terms of reference.

- evaluation of the supervisors' and team leaders' ability to execute the tasks assigned to them.
- technical up-dating of the projects
- strengthening of the methods of supervision and evaluation, conjointly with the extension of the project.

Though the Kinshasa team benefits from regular supervision regional supervision can be variable:

one team has received 3 times,  
two teams have received 2 visits,  
twelve teams have received 1 visit,  
and the teams at Bunia and Kindu have never been visited at all.

The central team also supervised 28 of the 71 health zones whose staff had been retrained before 1984, and regional and subregional teams supervised 42.

Supervisory trips took place in spite of transport difficulties and totally insufficient per diem allowances, and a decision should be made on this subject.

Although supervisory activities have made considerable progress over the last few years, they remain insufficient. Significant improvement will occur only by increasing and decentralizing the human skills and competence.

At zone level the limitations on supervision of health centers are linked more to problems of transport, the lack of reference lists etc., though certain zones are more advanced in this area.

5.2.2. Personnel Utilisation. Adequacy of Training Plans.

The national technical team of the PEV/CCCD consists of 10 people. However, due to long term training needs (past, current, or planned,) the team is reduced to only 7 or 8 active members. Their ability to manage the project seems adequate, and their enthusiasm and tenacity are evident, but the abbreviated team cannot guarantee the full efficiency needed to reach project objectives.

The technical staff is not trained in budgeting, and has not participated in the budget process.

The regional teams are capable of managing stock, gathering data, and within certain limits, of training. The presence of a well trained doctor in each team would permit the completion of training and supervision capacities, and would confer on the team the autonomy necessary for contact with other doctors. This would be a first step towards decentralization.

Since the beginning of the PEV program, all central technical officers, and the regional supervisors and PEV team leaders have taken training courses in management and planning. (table 9) It can therefore be said that the level of technical competence of the PEV/CCCD personnel is satisfactory.

But only 8 (all central officers) participated as facilitators and thus attended training sessions for trainers. This central level group is actively involved in regional and sub-regional PEV/CCCD training, during their supervisory visits. But within the regional and sub-regional PEV/CCCD teams master training capability is lacking.

However this seems justified, given the new role assigned to these teams since 1983, namely that of supply, supervision, and training. It seems that to ensure continuity in the implementation of these tasks, it is

indispensable that the same training be given to Zone supervision personnel, for example the some supervising nurses. The modules of the WHO course "Supervision Techniques" including the "Guide du Facilitateur" could be used in this training.

The utilization of the head doctors of health zones already trained by the PEV/CCCD is shown in Table 20. It emerges that the vast majority of this personnel stay in their jobs, (94%) and have submitted their action plan for the zone to PEV-CCCD (89%), and that in a third of the retrained health zones a follow-up has been carried out by the central office and by PEV/CCCD teams.

At present only a minority of health zones notify the PEV teams of their training activities. The observations of the international evaluation team in the field show that these activities are satisfactorily carried out in only a limited number of health zones. (see the reports in annex).

The rhythm for retraining of zone medical officers, as provided for in the Operational Plan of the PEV/CCCD for 1985-1986, seems adequate. On the other hand the training of supervising nurses and of cold chain managers should be accelerated. For the former, training could be carried out in phases, covering teaching methods and supervision.

It is also important that training plans provide for clinical courses on oral rehydration. The extension of these courses from Mama-Yemo Hospital in Kinshasa to regional and sub-regional hospitals and to health zones is to be considered a priority training action aimed at ensuring the promotion and correct utilization of oral rehydration method in rural and urban health zones outside Kinshasa.

WHO teaching material, (e.g. the "Manual for Treatment of Diarrhea") could be used in these courses. Each health center should have a poster "Evaluation - Treatment of Diarrhea". Given the need to intensify the training of Health Center staff, this activity should likewise find its place in PEV/CCCD training plans and in the reports of the zone medical officers.

The use of Peace Corps volunteers at the regional level is being stopped because of the unsatisfactory experience of all except one, who holds a Master's degree in Public Health. The generalists in basic science do not get enough out of the 2 week course to allow them to function correctly as manager-trainers at the regional level. Future Peace Corps volunteers who may be used in the health sector will be trained to work in zones where the Zairian head doctors have been assigned and where the long satisfactory experience of Peace Corps in community participation can be useful. They will work in close collaboration with the supervising nurses of zones. Their collaboration will extend to the implementation of the training plan for the zone, supervision, and community organisation. If the PEV/CCCD plan to develop regional offices succeeds, Peace Corps will consider placing 3rd year volunteers in these offices.

5.2.3. Adequacy of resources: cost-effectiveness of services:

Cost-effectiveness and efficiency of the auto-financing system:

Adequacy of resources and cost-effectiveness of services:

The key to the final achievement of PEV objectives is to be found in the sufficient quantity of financial resources necessary to undertake planned needs. This means that the Government of Zaïre must increase the contribution from its regular budget to cover the operating expenses of the PEV/CCCD. To be certain that the resources requested from the ordinary budget are sufficient to satisfy planned needs of the PEV/CCCD, its proposals for financing from the regular budget should be based on actual needs.

PEV will have to live with fewer real resources for operating expenses in 1985 than it had in 1984. Some economies have already been made through the improved efficiency of operations, in diminishing the personnel, and in using uniquely diesel vehicles (diesel is considerably cheaper than gasoline). However, most of these reductions were already instituted for a part of 1984, so more reductions will have to be made in 1985.

- Regional level -

The laying off in 1984 of vaccinators who were no longer needed in the new PEV strategy represents an improvement in cost-efficiency. However, the absence of a doctor at the head of the regional team limits the credibility of PEV vis-à-vis the zonal medical officers. Consequently, cost-efficiency could be improved by the addition of a doctor at the head of the regional teams currently without one.

- Zone Level -

The interventions promoted by the PEV/CCCD are generally considered to be efficient as to cost. Only the vaccination component is totally functional in the health centers: ORS and combatting malaria are less well developed at this level. On the whole, cost-efficiency will be improved by the training of more health center personnel in these latter two activities, so that those who currently practice only one of these activities can become capable of all three.

Cost-effectiveness and efficiency of the self-support system:

The different systems for recovering costs in Zaïre are an under-exploited resource. The systems in operation have a varying degree of success in the recovering of costs, probably because of the system used, the customs of the population of the region, the socio-economic status of the population served, or certain of a range of other factors. Existing systems must be studied to determine their strengths and weaknesses, so that this

knowledge may be used in the preparation and the modification of cost recovery systems elsewhere in Zaïre, and elsewhere in the world. It was noted during field trips that certain cost recovery systems are capable of covering more of the costs of delivery of services than were others. This could be due to the model of the system, or to the characteristics of the population served, as mentioned above. However, one important factor in the determination of the proportion of costs covered would be excluded from any study of the self-support systems alone. This factor is the willingness and ability of the population to pay for services offered. An economic survey of demand could take this element of the image of cost recovery and show the effects of the different price-fixing strategies on the services utilised by an income or a socio-economic group.

#### 5.2.4. Availability of services (vaccinations ORS, chloroquine).

A service is said to be available when it is offered by the health center to the population situated in its area of action. By definition, all the services of the PEV/CCCD are offered to the population in the health centers said to be complete. Elsewhere, certain vaccinations are offered by the mobile teams that come from the zone to vaccinate in the context of preschool or prenatal mobile consultation.

One can thus appreciate the availability of services by evaluating the cover of the zone in operational health areas. The evaluation team found that the proportion of the population served by complete health centers in 14 of the zones visited varied from 30 to 79% and was on average 51.5%.

Amongst the retrained zones which were visited this year, the proportion of the population served was 60%, which signifies a net improvement over the situation at the beginning of the project, when most of the zones didn't know how many their zone served; for those who did know, the rate was about 20%. (see the tables which follow the reports of field trips.)

5.2.5 Availability and use of statistical data on target diseases:  
Adequacy and feasibility of the planned health information system

The regularity of reports on the target diseases is good (90%), but delays in transmission to the central office are considerable, usually between 3 and 6 months. This means that the system is not useful for detecting abrupt changes (for example epidemics). Nevertheless in towns where monitoring has been in operation for a long time, the system permits the study of the epidemiology of target diseases. The ability to distinguish between ambulatory and hospitalized cases allows a more precise judgement to be made of the proportion of severe cases; allows one to determine risk factors for cases of diarrhea, malaria, measles and neonatal tetanus, the reduction of which constitutes the immediate objective.

The regularity of the monthly reports on vaccinations performed by 18 PEV/CCCD teams is not in question, but there are many delays in their transmission. Thus at mid-January 1985, 85%, (184 out of 216 expected) of the reports had reached Kinshasa (the year in question goes from December 1983 to November 1984). For the PEV teams, the reports expected from the health zones do not arrive as desired, medical centers from south Kivu sent 381 reports out of 568 expected (67%); in Kinshasa, 997 reports were received out of 1264 expected (79%).

Field trips have shown that data on the target diseases at the zone level are only partially collected and sent in late.

To improve data collection on the target diseases, forms have recently prepared for peripheral medical formations. These forms are apparently practical, because they are clearly designed and ask for only a minimum of information certainly available in the hospitals.

Additionally, a coded system is proposed for information and data analysis at the central level. This system was recently tested, and the first results show that it will bring certain important advantages: data analysis will be more rapid, precise and complete. It is also easy to envisage using this system to evaluate the performance of the regional teams, using a certain number of criteria recently established by the central PEV/CCCD staff.

The system aims likewise to measure the impact on the reduction of mortality from the target diseases in urban and rural zones. It seems justified to hope that the reduction of the number of cases and of the persons hospitalized because of diarrhea, malaria, neonatal tetanus and measles could serve as an indicator of the utilization of PEV/CCCD services.

To be able to measure this impact more directly, two basic surveys on sickness and mortality due to the target diseases were carried out in two rural communities in the region of Bandundu before the start-up of PEV/CCCD activities.

In the light of high rates of incidence and specific mortality and, the rapid expansion of PEV/CCCD activities, a repeat of these surveys would be justified so as to measure the impact on the reduction of mortality after 4 - 5 years of PEV/CCCD activities.

#### Impact

The impact of the program was measured in terms of reduction of sickness, as indicated by the information system. For example, in Kikwit with a steady increase of vaccine coverage against measles from 55% (1978) to 91% (1982) the number of declared cases of measles has diminished: 474 (1981), 101 (1982) and 55 (1983). In Kinshasa, as coverage with the first dose of poliomyelitis vaccine has increased from 43% (1977) to 70% (1983) and as the percentage of children having received 3 doses has likewise increased from 24%

(1977) to 54% (1983), the number of cases of poliomyelitis has fallen from 247 (1980) to 92 (1984). In order for a health system to determine the impact, the coverage should be raised significantly to reduce the transmission of diseases, and the system should have functioned consistently for a sufficiently long time, to permit annual comparisons and to reduce the artificial variation in the declarations.

The system of routine monitoring is less likely to determine a reduction of mortality, such as deaths due to neo-natal tetanus or to diarrheal diseases or malaria. In order to be exact, the measurement of the reduction of mortality must be done by special surveys. However, as many factors influence mortality, the impact of the CDD strategy on mortality can be shown only indirectly, either by the comparison of one region or in the case where a significant increase of the coverage provided by CDD activities coincides with a period of lowered mortality rates.

#### 5.2.6. Efficiency of Health Education

The health education program of CDD was tardy compared to the service delivery part of the project. A plan for combatting diarrheal disease was prepared in July 1984, a little after one PEV team member took up the function of health education. During the following six or seven months, a great number of health education activities were begun, but it is too early to determine the results and the achievements of projected goals. A review was made in Kingandu and Pay-Kongila in a study of mortality and of the utilization of services. These surveys confirmed the low level of comprehension of the causes of diarrhea and of the utilisation of the ORS for rehydration treatment. These studies serve as basic surveys of the way in which the PEV/CDD should proceed to obtain acceptance by mothers of the CDD approaches and of oral rehydration therapy.

These studies also point out the difficulties illiterates have in understanding health messages. Ninety-seven per cent of messages on the ORS were communicated by word of mouth rather than by radio, written, or by posters. It is thus very clear that if "face to face" is the only medium used, it will be difficult to reach the target population and to obtain any behavioural changes. The following plans were prepared by the PEV/CCCD to increase the recognition and use of oral rehydration therapy into a common household:

1. Production of health education material for Health Centers and Zones
2. Posters and T-shirts, stickers and calendars, and other advertising products.
3. Film shown in urban cinemas.
4. Educational material for school health services.
5. Messages for radio advertisement announcements.
6. Slides and flannelgraphs.
7. Training program for mothers and teachers.

An examination of these materials at the PEV office shows that current products are of good quality, and that they will probably be very effective for public information. A great number of radio messages has been proposed. The frequency of broadcasts depend more on the programmer than on the PEV budget. A budget of 1,500,000 Zaires is needed for the 1985 program.

#### Commentaries

Emphasis was not placed on recommendations for avoiding diarrhea, but rather on the treatment of dehydration. The health education program will envisage this aspect. Posters, fold-outs, radio messages etc... must explain preventive and curative measures. The health education plan prepared by MAYER in July 1984 for the control of diarrheal diseases is well done, and covers the project's approach in detail. The result of the health education program should be discernable in follow-up surveys. The project's impact and efficiency will then be measurable in terms of any change in the morbidity and mortality rates.

Availability of oral rehydratation therapy:

The instructions concerning rehydration therapy were distributed to nearly all the zones of the program. Although these instructions are extremely clear as to an indication of the salted sugared solution, and of the complete solution of rehydration salts, they are not followed, for various reasons; the head doctors do not want to create a dependence on the packets for fear of an interruption of stock, and all other reasons evoked witness to a reluctance concerning the utilisation of the packets. The reasons for these reluctances and the ways to overcome them could be the subject of a survey. However we must note that the acceptance by doctors is very variable from one region to the other, and all the zones in Bas-Zaïre for example use the ORS when indicated; however some errors in preparation reflect a lack of basic technical skills.

The actual principle of oral rehydration is well understood in the zones and a minimum of conviction and training will suffice to perfect the services.

Availability of chloroquine for the treatment of presumed malarial fever attacks in children.

The stocks of chloroquine used in the health centers are sufficient to treat all feverish patients, including children under 5 years. The availability of chloroquine for the chemoprophylaxis of pregnant women is more subject to caution and it seems that the stocks would not be sufficient in the health centers if it was systematically distributed to pregnant women. Finally, the impossibility of including its cost in the current price of the "prenatal consultation", and the reluctance of mothers to pay for a medicine when they are not sick, means that in reality this service is not available.

5.2.7. Adequacy of Operational Research and use of Findings

Some studies aiming to resolve the problems were carried out by the PEV/CCCD with local financing. Four agreements were perfected by the regional epidemiologist and four scientists, three Zairian and one Congolese (Table 18). These agreements are sent to the group of experts for French West Africa, which is met in Abidjan in March 1985. The operational research effort has two main goals:

1. Solutions to problems in the PEV/SSP's field of intervention.
2. Training of Zairian scientists to conduct scientific studies on ORS.

The objectives are valid, and the situation progresses. The long time taken for the preparation of the agreement is routine in French West Africa. This is due in large part to the fact that Zairian scientists are not familiar with the American system for the preparation of proposals.

5.2.8. Utilization of Services

The sub-objectives of coverage have been fixed for the 2nd year of the CCD project at:

- B C G	75%
- DTP	30%
- Measles	50%
- ORS	50%
- Anti-malarial treatment	50%

1. Table 21, established on the basis of demographic data for 1984 and the number of doses administered to children under 1 year in the zones where the program is operational, shows that the sub-objectives concerning vaccine coverage have been reached.

2. In the current state of affairs it is impossible to measure exactly the degree of utilization of oral rehydration services for the treatment of diarrhea, and malarial treatment for cases of fever. The estimates given during field trips by the zone medical officers, (not based on any figures) indicate a wide variation, between 30% and 80%, in the rate of utilization by the populations served.

Socio-anthropological surveys carried out in two regions before any installation of PEV/CCCD activities show that 50% of the children suffering from diarrhea and 50% of children with fevers are referred to a health unit. However though the chloroquine treatment of fever attached is well known, accepted and applied, treatment by rehydration salts is partially insignificant. Special surveys on the utilization of services should be carried out systematically in all the regions, to make better forecasts of needs and to measure the degree of attainment of the sub-objectives of the program.

One can expect a net improvement in the estimates of the utilization of the services in the near future, thanks to the inauguration of a standardized system of data collection, and centralized computer analyses.

### 5.3. Impact and prospects.

In this section the evaluation team attempts to consider the project in terms of achievement of its goals, objectives and sub-objectives at the half-way point in its implementation. Questions concerning realistic accomplishment and the measurement of goals and objectives will be treated, and some of the team's perspectives will be presented.

5.3.1. Goals, Objectives and Sub-objectives;

A. Goals

The goal is to prevent the childhood vaccine-preventable diseases, diarrheal diseases and malaria, through a strengthening of the national capacity to improve children's health, by prevention and control thus endowing Zafre with generations of children who will enter school and the working world not handicapped by infirmities, and capable of participating in school activities and becoming an effective part of the living force for national socio-economic development.

B. Objectives

The reduction of child mortality by 50% in 4 years through this project seems unrealistic, as the approach needed for combatting the main cause of mortality (malaria) is seriously delayed in its implementation, and the acceptance of the ORT by health workers and users is going ahead more slowly than expected. The change from the mobile to the fixed strategy for the delivery of vaccination services has resulted in a temporary drop in the vaccine coverage. On the other hand, there has been an improved access to the vaccination program particularly in rural zones, but a reduction by 50% of the mortality rate will take more than 4 years. There are technical problems in the delivery of antimalarial prophylaxis for pregnant women, due to the fact that most new clients do not show up at the prenatal service centers before the 8th or 9th month, thus preventing them from taking advantage of the anticipated weight gain for the unborn child.

The presumptive chloroquine treatment of fever in children is well accepted, but the utilization figures are still considerably lower than the figures of declared sickness. It is thus probable that it will take more than 4 years to achieve project objectives. The evaluation team concluded that a prolongation and extension of the project is necessary, rather than a reduction of the project targets.

C. Sub-objectives

The levels of vaccine coverage indicated by the sub-objectives appear very optimistic considering the large and dispersed rural population to be served, and the rapid growth in the number of operational rural zones. The coverage in urban zones where activities were started earlier has shown very good progress. It will not be possible to achieve the target number of facilities using ORS (70%), though there has been a rapid growth in the use of ORS in the health zones, health centers and homes. The achievement of this target depends largely on the "Health Education" component of the project, because acceptance by the family is an important in attaining the target of 70%. The same applies to the presumptive treatment of malaria, and even more so for the prophylaxis for pregnant women.

Medications have been supplied to the health centers, and it is up to the population (health workers and clients) to start accepting these new efficient methods of treatment.

The utilization of ORS for diarrheal diseases is common practice at all levels visited by the evaluation team, however, its acceptance by the health workers and patients is not as clear as one would have hoped. Until ORS with at least the salt and sugar solution becomes "a common household medicine" for diarrhea, dehydration will still be a problem, besides, the project needs to carry out the control and prevention of diarrheal diseases with as much energy as it puts into its work on vaccine preventable diseases and malaria.

The integration of PEV/CCCD interventions into primary rural health care adds significantly to the zone's ability to overcome endemic and recurrent health problems. Many zones are capable of taking some preventive measures against diarrheal diseases, such as the protection of water sources, appropriate weaning foodstuffs, the storage of foodstuffs, food supplements and the treatment of specific nutritional deficiencies.

Impact on the implementation of the national declaration of health strategies of 1982 and 1984.

It seems that the PEV/CCCD has played a major role in the achievement of a national reorganisation plan for 300 rural health zones. The HEV/CCO was responsible for the training of numerous managers (head doctors of zone) of urban and rural health zones. This training has also been incorporated into the SANRU project designed to set up public health services in rural areas, and has been adopted by other donor agencies - UNICEF and certain bilateral programs.

The development of rural health zones has already exceeded the targets of the project. There is a significant integration of the CCO interventions into basic health facilities. However much remains to be done to make the new services more acceptable, to promote their correct usage, and to achieve the planned quantifiable results. The national strategy envisages the integration of PEV services into primary health care. One major structural constraint to success and to current efforts to provide services is the lack of regional infrastructure sufficiently close geographically to the zones to permit the provision of regular services.

The project plan did not take into account PEV's achievements in developing the regional offices and did not give sufficient support to training, supply, management, information systems etc...

The potential impact has been greatly diminished, and the Government of Zaire was not able to redevelop these offices.

Concerning the auto-financing of the PEV/CCCD - 9 out of 13 zones have made some efforts in this direction without PEV participation. The proportion of operating expenses financed is not known, but it covers a part of the expenses for fuel for vehicles and refrigerators, for medications

and personnel. This is a very encouraging finding, although it is recognized that certain zones would have more difficulties than others in covering operating costs.

All the zones should be helped by the PEV/CCCD to make this effort. The sum collected varies from 120,000 to 6,000,000 Zaires. The project's impact on user-financing is not clear, but it is clear that the population is willing to pay for ORS and chloroquine for the treatment of sick children.

### 5.3.2. Prospects.

The project is at mid-term. It has built an infrastructure, albeit still weak and deficient in some respects whose performance varies at its different levels and in localities. The program has made substantial progress, which makes more CCCD services available to mothers and children, particularly as far as the distribution of support supplies and equipment is concerned.

Most of the project, including operating costs, is financed by sources other than the GOZ budget. Counterpart funds generated by imports financed under the US Assistance Program cannot be relied on for long term financing.

So far, the project does not seem to have been given the funding priority which would allow the GOZ to financing operating costs as of January 1, 1987.

The evaluation team is concerned that heavy budget constraints could hamper the progress of activities during the remaining two years of project life. The evaluation team requests that the GOZ and the donor community study ways and means to overcome these obstacles. Ways must be found to offer CCCD services as either a self supporting development project or a relief program. The team believes that present performance and the activities planned until the end of 1986, (adequate finance permitting) provide a basis and

justification for further assistance after 1986. Without additional assistance, the project will certainly undergo, as is presently apparent, a rapid deterioration of its capacity to provide CCD services. Thus, the continuation of efforts for a phase II is appropriate. At the present time, it is not possible to forecast the resources, funding and technical assistance required especially given the changes which could result from the recommendations made by this evaluation.

As a basis for a request to Washington, the American Ambassador might wish to request the President personal assurance that PEV/CCD remains one of his very high priorities and that the GOZ will be prepared to release financial resources for phase II, despite other priority budgetary demands which are very understandable.

The President's personal assurance should help provide the Department of Health the necessary weight in the GOZ's budgeting process, which it presently lacks.

## 6. RECOMMENDATIONS

### 6.1. Programming and organizing.

The program concept should be modified and budget requests should be made according to planned activities. This will ensure budgets based not on fuel needs for available vehicles, but on what is needed to achieve the specific objective during the planned budget period.

Together, USAID and PEV should revise the Project Agreement, clarify the grey areas, (including the role and utilization of counterpart funds) and modify the quantified objectives of annex 1, as provided for under Article 2.1 of the Agreement.

The integration of all primary health care services, including PEV/CCCD should be a long term objective. Presently, until the structures are firmly established, and other primary health care components have the capacity to progress together, a close coordination seems preferable to a complete integration.

Integration at the zone level should take place as soon as possible and PEV/CCCD activities should be closely coordinated in all areas with other health projects (SANRU, etc...) and other donors for mutual reinforcement and in order to avoid overlaps.

PEV/CCCD should be continued with additional funding as of the end of 1984. The new project plan should consider decentralization towards the regions.

6.2. Management.

PEV/CCCD must continue to increase the quality of its team rather than the number of its members. Some essential professional skills are present but they lack sufficient depth. PEV/CCCD should institute a reward system, with small financial awards, accompanied for example by "team of the month", "center of the month", "nurse of the month" certificates. This would promote the "esprit de corps". Another activity could be in the form of a monthly bulletin.

The recently installed computer should be put to greater use as quickly as possible for purposes including:

- planning
- inventory
- personnel
- finances and accounting
- state of progress of operations
- supply forecasts
- health information system
- operational research.

PEV/CCCD should establish a project component to develop its regional offices. They should be able to help implement the PEV/CCCD project in the zones, and especially to manage the procurement of vaccines, medicine, ORS, supplies, equipment and training material from the Central Depot.

The PEV/CCCD regional office must be represented in the two regional committees mentioned in the national plan. These committees are the Regional Health and Welfare Committee, and the FONAMES Regional Council. Each PEV/CCCD regional team should be led by a doctor, even if other expenses must be curtailed to pay his salary.

PEV/CCO should prepare a new budget and a new operational plan taking into account the project's investment objectives, and the 10.7 million Zaires (4.7 million from counterpart fund and 6 million from the ordinary budget) which will be available to cover operating costs in 1985.

Each year, the regional and sub-regional teams should submit their operational plans in time to help formulate the budget. As soon as budget resources for the year are known, the Central Office should provide assistance to the teams to revise the operational plans according to available resources.

To ensure correct supervision of health zones, either the 1985 operating budget funds should be redistributed for regional teams fuel requirements, or the rate of expansion should be decreased.

#### 6.2. Budgeting and cost

- USAID should play a bigger role in helping PEV formulate its budget and then defending it before the Department of Finance.

- Each of the PEV team members (including the CDC technical advisor) should be assigned the task of preparing parts of the budget related to his technical field of responsibilities, with assistance from the Chief Administrator. The Administrator should then prepare the required global budget, from the elements prepared by each team member. The Director and the Administrator, along with the USAID Project Officer, should then recommend changes to the global budget if necessary. The recommended changes should then be presented to the team for comments. The Director, the Administrator, and the USAID representative, should formulate the final budget proposal.

- The Director should assist in defending the budget proposal before the Department of Finance.

- USAID should assist the PEV/CCCD team in its contacts with the Departments of Plan, Finance and Health to ensure that the PEV/CCCD budget proposal receives the attention it deserves and that the request is within the limits of what can reasonably be expected.

- The USAID Project Officer should give the PEV Chief Administrator written explanations, in French, on the types of expenses which can be covered by counterpart funds, on the ceilings to observe and on all other existing constraints applicable to requests for counterpart funds.

- The PEV team (including the CDC technical officer) should prepare counterpart funds requests for investment expenditure, by technical sector. The Chief Administrator should coordinate this activity with the Director's help. The Administrator, the Director and the USAID Project Officer should propose to the whole team changes to be made to the whole project. After comments and discussion, the Administrator, with the Project Officer and the Director's guidance, should prepare the final budget proposal. The Administrator, the Director and the Project Officer should be present to defend the counterpart budget proposal.

- The PEV Chief Administrator, with assistance from the CDC Technical Officer and from the Director or his replacement, should submit an additional request for counterpart funds to finance the cost of distributing the investment material (refrigerators, motorcycles, etc...) from Kinshasa to the health zones. A draft request could be transmitted to the USAID Project Officer for comments before the final version is proposed.

6.4. Adequacy of resources; cost/effectiveness and auto-financing system.

The Zaïrian Government should increase its contribution to the operating costs to a level permitting the achievement of the investment objectives of the project.

For 1986, PEV/CCCD should prepare a budget proposal reflecting the needs to be met in order to achieve the investment objectives.

If the Government of Zaïre is not prepared to support the operating costs of the investments planned by the project, the amount of USAID funding allocated to investment expenditures should be reviewed to counterbalance the GOZ's ordinary budget allocation level.

If a second phase is planned for the CCCD project, the level of GOZ funding for operating costs should be the key factor to determine if the project will be self sustainable after USAID funding is removed. If there is no large increase of the GOZ input, then it is believed that the project cannot be self sustaining.

Because of the low levels of resources available for PEV/CCCD operating expenses in 1985, any recommendation for a new activity requiring financial resources should be accompanied by a recommendation indicating which implemented activity should be sacrificed to make funds available for the new activity.

PEV/CCCD must consider hiring temporary replacements for the team members in training. The cost of these replacements would be considered part of participant training cost for the permanent team. Counterpart funds could then be used to pay these salaries.

The methods used for recovering costs should all be studied so that during the training courses, successful systems could be suggested, while those less successful could give warning. This review and study of cost coverage should be part of SANRU's operational research.

PEV/CCCD should use funds from fee paying services or other sources, to contribute towards fuel and maintenance costs for the vehicles and refrigerators.

A separate cost effectiveness study should be made for each of the PEV/CCCD interventions, as well as a comparison with the cost effectiveness of the whole program.

A study of the total cost for vaccinations should be conducted by short term consultants. A draft protocol for such a task is attached.

#### 6.5 Supply and logistics

PEV/CCCD should inform its regional teams as to the availability of small material (thermometers, needles, syringes, spare parts) to facilitate requisitioning and distribution and avoid interruptions of activities.

PEV/CCCD, with the donors' approval, should consider reclassifying gasoline vehicles which cannot be used presently.

PEV/CCCD should study the possibility of using more economical refrigerators in the health centers (smaller capacity, solar energy, etc...) and, in any case, not distribute this material before insuring that operating expenses will be covered.

The strategy of providing motorcycles to the zones instead of four wheel drive vehicles for supervision purposes should be continued wherever possible.

GOZ assistance in the financing of expenses related to fuel and maintenance of vehicles and refrigerators should be studied in depth in order to find a constructive solution.

Data sheets should be developed on the following subjects:

- maintenance of cold storage rooms;
- daily check of temperature of refrigerators
- measures to be taken to insure good functioning of refrigerators;
- use of cold indicators if it is generalized.

A stock of spare parts for vehicles, motorcycles, bicycles, refrigerators and audio-visual equipment provided by CCOD should be kept at the regional and sub-regional office level.

PEV/CCOD must promote more intensely the sale of chloroquine and ORS in the regions.

The number of technicians capable of maintaining and repairing refrigerators must be increased.

#### 6.6. Training

The central PEV/CCOD team must participate directly in the training activities of trainers, of regional team supervisors, and of health zones. To this end, courses will be organized at regional and sub-regional level. The central team should also dispense technical training during any visit to regions and/or sub-regions.

Oral rehydration training recently started at Mama-Yemo Hospital in Kinshasa should rapidly be extended to regional, sub-regional and health zone hospitals. On the job training courses should be quickly organized at Mama-Yemo Hospital for the regional and sub-regional doctors concerned.

Some PEV/CCCD data sheets should be simplified, better adapted to the local conditions, and more widely distributed.

PEV/CCCD regional teams and head nurses of zones must take a more active part in the training of health zones' personnel. One could consider using modules of the WHO "Supervision Techniques" course designed for regional heads of diarrheal diseases control programs, including the "Guide d'animateur"

Training of head doctors of health zones must continue in 1985-1986 at the rhythm planned in the 1982-1986 operational plan. Data concerning training activities should be included in the monthly reports sent by the zone medical officers to the regional PEV/CCCD teams to allow them to monitor the implementation of training plans in the health zones.

The financial management module of the training course for zone medical officers should be updated to incorporate the results of the operational research conducted by SANRU - the methods of studying cost prices - the utilization of fee-paying health services when they are available.

The head doctors thus trained will have to inform the directors of health centers in their zones about the management of cost price mechanisms.

6.7. Provision of services and supervision

In general, the new PEV/CCCD strategies should be followed.

The vaccination calendar as presented on the PEV/CCCD data sheets must be memorized and applied (first vaccinations at 6 weeks).

Sick children must be vaccinated whenever possible.

Attention must be drawn to the national policy: using ORS for dehydrated children in the health centers, salt and sugar solution in other cases.

PEV/CCCD must energetically promote the uniformization of SSS recipes nationwide.

Personnel's attention must be drawn to the volumes necessary for reconstitution: one liter of solution for OR salts provided by USAID, 0.75 l for those which will be provided by Laphaki.

PEV/CCCD must develop an implementation strategy or plan to combat malaria and promulgate it down to the health zone level. A uniformed supervision mechanism should be developed and used.

Supervision must allow the reinforcement of technical competence in the areas of vaccinations calendar, ORS, SSS composition and other PEV/CCCD activities.

The two most recent components of the PEV/CCCD program (combatting diarrhea and malaria) must be energetically promoted to reach all health centers and make the program more cost effective.

6.8. Information and Surveillance System

The central office must distribute the standardized forms recently developed by PEV/CCCD, in adequate quantities to the regions and zones covered by the program.

At the central level, the data processing system which ensures a more complete, precise and creative data analysis, should incorporate a system of feedback to regional teams, sentinel sites and health zones.

Publication of a quarterly or yearly information bulletin should be considered at the national level.

The regional PEV/CCCD teams must:

- increase their participation in the implementation of a better health information system in the health zones;
- make the zone medical officers aware of the importance of this activity;
- promote the use of PEV/CCCD forms and the extension of sentinel posts to the rural health zones;
- help zone medical officers evaluate the health center activities once a year;
- insure that the zones' reports are sent to the central level without delay;

The zone medical officers should receive health information systems.

The zone medical officers must insure that all health facilities in their zones have received the PEV/CCCD forms and that pertinent data are collected to fill them out. They should receive these correctly filled forms without delay at the end of each month, and they should send their summary reports as quickly as possible to the PEV/CCCD regional teams.

6.9. Health Education

PEV/CCCD must now draw more attention to the prevention of diarrheal diseases and to nutritional aspects, and no longer limit its program to treatment.

Health education efforts must also be directed toward PEV and the control of malarial.

Implementation of the health education plan and strategy recommended by the PEV/CCCD health education consultant must be speeded up.

Health education must be conducted with the participation of all existing social organizations.

6.10. Surveys and Operational Research

Bilateral funds should be included in the Project Agreement to quickly finance small informal operational research surveys which are necessary to solve problems associated with implementation and daily operations.

Identify researchers and train them in the preparation of research protocols and the implementation of operational research projects associated with the program. The priority areas for this research would pertain to PEV/CCCD specific activities, research on the use of ORT and studies of cost effectiveness of malaria chemoprophylaxis during pregnancy, including the population's attitude toward payment for preventive treatment.

6.11. Utilization of Services

- Annual sample surveys in the cities must be continued and questions added concerning the use of ORT and curative services for fever attacks thought to be caused by malaria.

- PEV/CCCD should promote studies on the reasons why certain doctors are reluctant to use ORS in health centers and the ways to counterpart this reluctance.

- Promote chemoprophylaxis for pregnant women and study acceptable means of supporting its cost.

6.12. Impact and prospects

The program's impact on the sickness and mortality from target diseases cannot be measured after two years of implementation, considering the data collection means available.

A reinforcement and a thorough study of data collection and analysis techniques, and an increased awareness on the part of the personnel involved, may permit measurement of impact on a long term basis.

The team considers that the annual precise impact measurement as detailed in the agreement is not currently feasible. Such a measurement could be made, at the earliest, at the end of the project.

1. The evaluation team is concerned about the impact of budget restrictions on PEV in 1985 and asks the government of Zaïre, USAID and other donors to ease the situation.

2. The evaluation team recommends that the ongoing project be modified taking into account the evaluation's conclusions and recommendations as well as the changes necessary to reconcile objectives/operations with the financial resources available.

3. Based on current forecasts, the team believes that the project will need further assistance after December 31, 1986. It recommends that a phase II of the project be built on the current project's achievements. Phase II should be preceded by the President's assurance that HEV/CCCD remains a very high priority for the Zairian Government, and that the resources required for the success of the project will be available and provided.

4. The evaluation team recommends that in the case where the CCCD effort could not be continued as a development project, the donor community provide CCCD services to Zaire's target group, in the form of a relief program.

#### 7.0. ACKNOWLEDGEMENTS

The evaluation team expresses its warmest thanks to the Executive Council of the Republic of Zaire represented by the Minister of Public Health, to the PEV/CCCD chief a.i. and to all his staff, to the regions' and zones' administrative and health authorities for the welcome and accommodations offered during the visits.

The team wishes to particularly thank the PEV/CCCD management personnel for the quality of the documentation made available.

Finally, special thanks go to the Secretariat for the speed with which the present document was typed.

ATTENTION: THE REMAINDER OF THIS REPORT (ANNEXES I, II, III, IV, V, and VI) ARE TAKEN FROM THE FRENCH VERSION OF THE REPORT AND RETAIN THE PAGINATION OF THE FRENCH VERSION. ANNEX I THEREFORE BEGINS WITH PAGE 45.

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TABLEAU 1

EXTENSION DU PROGRAMME PEV-CCCD ZAIRE

	PEV REALISE		PEV-CCCD PROGRAMME					PEV-CCCD REALISE					
	1977	1981	1982	1983	1984	1985	1986	1982	1983	1984			
	Mise en oeuvre	Mise en oeuvre	Année/cumulée	Année/cumulée	Année/cumulée	Année/cumulée	Année/cumulée	Formation et planification année	mise en oeuvre cumulé	Formation et planification année	Mise en oeuvre cumulée	Formation et planification année	Mise en oeuvre cumulée
Zones de Santé Urbaines.	1	16	1/17	4/21	3/24	3/27	3/30	2	(18)*	2	(20)	5	(25)
% de la Population urbaine du pays	26	56	57	58	59	59	60	-	57,5	-	60	-	64
Nombre de Zones de Santé Rurales	-	-	14/41	20/34	30/64	30/94	30/124	29	43	21	64	41	105
% de la population rurale du pays	-	-	6	15	29	44	58	-	16%	-	28%	-	42
Population à desservir (en 1000)	1.940	5.450	6.917	9.113	12.918	15.309	18.665	-	10,0	-	12	-	15
% de la population du pays	8	20	24,6	31,3	40,7	49,4	52	-	33,0	-	41,0	-	50,0**

\* y compris les 16 zones mise en oeuvre 1977-81

\*\* selon l'estimation de la population 1984: 30 million d'habitants

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TABLEAU 2

BUDGETS CCCD POUR LES COÛTS LOCAUX 1984 - 1985  
(en milliers de zaires)

-----Designation-----	-----1984-----				Totaux Depenses
	Selon PROAG	C/partie	GOZ	Autres Donateurs	
2 Sal, indem, per diem	3,328	2,167	4,835	0	7,002
6 Carb et Lubr	3,718	1,562	667	0	2,229
5 Entr des vehicules	3,507	867	126	0	993
7 Equipement	232	762	165	0	927
13 Soins medicaux	0	212	319	0	531
8 Fourn bureaux	3,689	435	138	0	573
8 Transp et exped	254	686	167	0	853
9 Formation	1,014	649	1	1,106	1,756
1 Batiments (Loyer)	936	0	105	0	105
10 Anti-paludiques	390	0	0	0	0
11 Assurance veh	0	0	0	0	0
12 Ed pour la sante	0	0	0	471	471
13 Composantes SRO	0	0	0	270	270
<b>TOTAL</b>	<b>17,068</b>	<b>7,338</b>	<b>6,523</b>	<b>1,847</b>	<b>15,709</b>
Pourcentage du TOTAL		47	42	12	100
<b>TOTAL COÛTS RECURRENTS</b>		<b>5,928</b>	<b>6,522</b>	<b>0</b>	<b>12,450</b>
Pourcentage des Coûts Rec		48	52	0	100

-----Designation-----	-----1985-----				Totaux Depenses
	Selon PROAG	C/partie	GOZ	Autres Donateurs	
2 Sal et indem	3,615	1,450	5,352	0	6,802
3 Per Diem	712	1,100	498	0	1,596
6 Carb et Lubr	4,833	800	728	0	1,528
5 Entr des vehicules	4,560	500	40	0	540
7 Equipement	301	100	50	0	150
13 Soins medicaux		100	380	0	480
8 Fourn bureaux	4,797	600	400	0	1,000
8 Transp et exped	329	600	167	0	767
9 Formation	1,318	3,200	0	3,696	6,896
1 Batiments (Loyer) ..	2,541	50	115	0	165
11 Assurance veh	0		181	0	181
11 Ed pour la sante	0	1,500	0	0	1,500
<b>TOTAL</b>	<b>23,006</b>	<b>10,000</b>	<b>7,912</b>	<b>3,696</b>	<b>21,608</b>
Pourcentage du TOTAL		46	37	17	100
<b>TOTAL COÛTS RECURRENTS</b>		<b>4,700</b>	<b>7,912</b>	<b>0</b>	<b>12,612</b>
Pourcentage des Coûts Rec		37	63	0	100

HYPOTHESES DU BUDGET DES COÛTS RECURRENTS 1985 :

1 BATIMENTS (Loyer Corps de la Paix) 165,000

2 SALAIRES & INDEMNITES

TABLEAU 2

	Nbre	Coût
Kinshasa	56	2.272.647
Matadi	8	199.577
Kikwit	8	244.206
Bandundu	8	231.577
Boma	6	93.068
Kananga	5	195.349
Mbuji-Mayi	6	181.481
Lubumbashi	7	183.098
BuKavu	6	242.692
Kisangani	7	167.768
Mbandaka	6	201.008
Isiro	5	139.289
Bunia	5	86.569
Kamina	5	108.087
Goma	6	108.076
Kalemie	5	76.657
Gemena	6	142.057
Kindu	5	122.420
<b>T O T A L</b>	<b>160</b>	<b>6.802,050</b>

(y compris une augmentation de 25 pourcent le 1 mars)

3 PER DIEM

	Pers	Nbre voy	Jours	Taux	Total
Medecins	2	8	5	1.000	80.000
Superviseurs	18	4	15	750	810.000
Chauffeurs	18	4	15	500	540.000
Billets et colis					168.000
<b>T O T A L</b>					<b>1.598.000</b>

4 FOURNITURES DE BUREAUX

1.000.000

5 ENTRETIEN DES VEHICULES

	Nbre Vehicules	Repar- ations	Coût	TOTAL
	27	8	2.500	540.000

6 CARBURANT ET LUBRIFIANT

Vehicules	27			
Km/mois	1.500			
Gasoil (1)/100km	15			
Prix du gasoil	19			
<b>T O T A L G A S O I L</b>			1.348,650	
Huile moteur (1)/1000km	4			
Prix de l'huile	74			
<b>T O T A L H U I L E</b>			143,856	
Liquide frein (1)/an	4			
Prix de liquide frein	300			
<b>T O T A L L I Q U I D E F R E I N</b>			32,400	
Eau distillee (1)/an	2			
Prix de l'eau distillee	40			
<b>T O T A L E A U D I S T I L L E E</b>			2,100	
Acide batterie (1)/an	1			
Prix de l'acide	50			
<b>T O T A L A C I D E</b>			1,350	
<b>TOTAL CARBURANT ET LUBRIFIANT</b>			<b>1.528.416</b>	

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TABLEAU 2

7 EQUIPEMENT (Reparation et Entretien)

	Nbre	Coût	TOTAL
Chambre froid			49.000
Climatiseurs	7	3.000	21.000
Stencileuse	2	5.000	10.000
Machines à écrire	25	800	20.000
Produits d'entretien		.	50.000
<b>T O T A L</b>			<b>150.000</b>

8 TRANSPORT

équipement PEV aux zones	400.000
vaccins PEV aux zones	167.000
<b>T O T A L</b>	<b>767.000</b>

9 FORMATION

	Coût	TOTAL
<b>Niveau national</b>		<b>1.119.800</b>
Medecins Chefs	854.600	
Revision du cours national	55.000	
Redaction des modules	100.000	
Corps de la Paix avant engagement	40.000	
Corps de la Paix materiel didactique	35.000	
Corps de la Paix cours d'emploi	35.200	
<b>Niveau regional</b>		<b>832.200</b>
Formation equipes PEV/CCCD	420.000	
Formation medecins chefs et infirmiers superviseurs	155.000	
Formation Reg/S-Reg à Kinshasa	120.600	
Cours de chaine du froid	136.600	
<b>Niveau de la zone</b>		<b>1.000.000</b>
Formation de 50 zones	825.000	
Materiel didactique	75.000	
Medecins Chefs/animateurs	100.000	
Imprevus		248.000
<b>T O T A L</b>		<b>3.200.000</b>

11 ASSURANCE DES VEHICULES

76 vehicules assures	181.140
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12 EDUCATION POUR LA SANTE

Materiel didactique	890.000
Developpement des messages educatifs	15.000
Transport	113.000
Fournitures de bureaux	170.000
Personnel temporaire	171.900
Distribution de materiels	80.000
Imprevus	60.100

**T O T A L** 1.500.000

13 SOINS MEDICAUX

	mois	cout/mois	TOTAL
	12	40.000	480.000

TABLEAU 3

-----COUTS EN DEVISES: DSP ET BAILLEURS DE FONDS-----

		-----Budget d'Assessment 1983-----			
-----Materiel-----		Unites	Cout Unitaire	Cout Total	
\$ .4	Vehicules/Pieces	6	18,000.00	108,000	
\$ .7	Refrigerateurs	30	600.00	18,000	
SOUS-TOTAL				126,000	
\$ .22	10% Imprevus			12,600	
TOTAL en \$US				138,600	
		-----Realise 1983-----			
-----Materiel-----		Unites	Prix Unitaire	Cout Total	Acheteur
\$ .1a	Autres Vaccins			196.105	UNICEF
\$ .1b	DTCco	2,700,000	0.02		
\$ .1c	Antitetanique	1,900,000	0.01		
\$ .1d	BCG	1,800,000	0.05		
\$ .1e	Antipolio	2,700,000	0.01		
\$ .2	Seringues			3,160	
\$ .2a		2,000	0.78		UNICEF
\$ .2b		660	1.86		UNICEF
\$ .3	Aiguilles			214	
\$ .3a		480	0.03		UNICEF
\$ .3b		1,320	0.03		UNICEF
\$ .3c		6,000	0.03		UNICEF
\$ .4	Vehicules/Pieces			34,638	
\$ .4a	Land Rovers	2	9,463.00		UNICEF
\$ .4b	Nissan Patrols	2	7,856.16		OMS
\$ .7	Refrigerateurs			14,280	
\$ .7a	Congelateur	1	650.00		OMS
\$ .7b	Refrigerateurs	22	564.10		UNICEF
\$ .7c	Refrigerateurs	3	340.00		OMS
TOTAL en \$US				246,397	
		-----Budget d'Assessment 1984-----			
-----Materiel-----		Unites	Prix Unitaire	Cout Total	
\$ .1	Vaccins rougeoleux	300,000	0.30	90,000	
\$ .2	Seringues	29,167	1.60	46,667	
\$ .3	Aiguilles	9,733	0.90	8,760	
\$ .4	Vehicules/Pieces	8	20,000.00	160,000	
\$ .7	Refrigerateurs	42	660.00	27,720	
SOUS-TOTAL				333,147	
\$ .22	10% Imprevus			33,315	
TOTAL en \$US				366,462	

Best Available Document

TABLEAU 3

		-----Realise 1984-----			
-----Materiel-----		Unites	Prix Unitaire	Cout Total	Acheteur
\$ .1	Vaccins rougeoleux	0	0.10	0	
\$ .1a	Autres vaccins				
	\$ .1b BCG	1,900,000	0.04	77,200	UNICEF
	\$ .1c DTCoq	3,000,000	0.02	50,800	UNICEF
	\$ .1d Antipolio	3,240,000	0.01	44,800	UNICEF
	\$ .1e Antitetanique	1,400,000	0.01	16,000	UNICEF
\$ .2	Seringues et aiguil	?	na	18,600	UNICEF
\$ .4	Vehicules/Pieces	0	na	0	UNICEF
\$ .7	Refrigerateurs	20	700.00	14,000	CEE
TOTAL en \$US				221,400	

		-----Budget d'Assessment 1985-----			
-----Materiel-----		Unites	Prix Unitaire	Cout Total	
\$ .1	Vaccins rougeoleux	750,000	0.33	247,500	
\$ .2	Seringues	75,000	1.80	135,000	
\$ .3	Aiguilles	25,000	1.00	25,000	
\$ .4	Vehicules/Pieces	12	22,000.00	264,000	
\$ .7	Refrigerateurs	42	725.00	30,450	
SOUS-TOTAL				701,950	
\$ .22	10% Imprevus			70,195	
TOTAL en \$US				772,145	

		-----Attendu 1985-----			
-----Materiel-----		Unites	Prix Unitaire	Cout Total	Acheteur
\$ .1	Vaccins rougeoleux	400,000	0.07	27,600	UNICEF
\$ .1a	Autres vaccins				
	\$ .1b DTCoq	600,000	0.02	10,800	UNICEF
	\$ .1c BCG	300,000	0.05	16,400	UNICEF
	\$ .1d Antipolio	1,200,000	0.01	17,400	UNICEF
\$ .2	Ser. et aig.	?	na	13,200	UNICEF
\$ .4	Vehicules	0	na	0	UNICEF
\$ .7	Refrigerateurs	0	0	0	
\$ .8	Mat. Ch. de Fr.	?	na	5,100	UNICEF
TOTAL en \$US				90,500	

		-----Budget d'Assessment 1986-----			
-----Materiel-----		Unites	Prix Unitaire	Cout Total	
\$ .1	Vaccins rougeoleux	1,350,000	0.36	486,000	
\$ .2	Seringues	150,000	2.00	300,000	
\$ .3	Aiguilles	5,000	12.02	60,100	
\$ .4	Vehicules/Pieces	12	24,000.00	288,000	
\$ .7	Refrigerateurs	42	800.00	33,600	
SOUS-TOTAL				1,167,700	
\$ .22	10% Imprevus			116,770	
TOTAL en \$US				1,284,470	

		-----Attendu 1986-----			
-----Materiel-----		Unites	Prix Unitaire	Cout Total	Acheteur
\$ .1	Vaccins rougeoleux	?	na	0	UNICEF
\$ .2	Seringues	?	na	0	UNICEF
\$ .3	Aiguilles	?	na	0	UNICEF
\$ .4	Vehicules	?	na	0	
\$ .7	Refrigerateurs	?	?	0	
TOTAL en \$US				0	

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TABLEAU 4

-----BUDGET BILATERAL-----			
-----Budgetise 1983-----			
-----Designation-----	Unite	Prix Unitaire	Total
\$.1 Vaccins rougeoleux	1,000,000	0.27	270,000
\$.2 Seringues	100,000	1.40	140,000
\$.3 Aiguilles	400,200	0.06	25,013
\$.4 Vehicules/Pieces	18	18,000.00	324,000
\$.5 Motos	50	500.00	25,000
\$.6 Avion Prive			18,000
\$.7 Refrigerateurs	90	600.00	54,000
\$.8 Boite isotherme	750	22.00	16,500
\$.9 Acc. de froid	3,750	0.80	3,000
\$.10 Imprevus Ch. de Froid			10,000
\$.11 SRO			50,000
\$.12 Equipement IV & Sol			50,000
\$.13 Anti-palu (000)			20,000
\$.14 Equipement Laboratoire			15,000
\$.15 Radiophonies	14	5,500.00	77,000
\$.16 Antenne			1,000
\$.17 Photocopieuse			5,000
\$.18 Equipement Stencile			3,000
\$.19 Machines a ecrire	2	1,350.00	2,700
\$.20 Megaphones	150	75.00	11,250
\$.21 Haute Parleur Veh.	10	250.00	2,500
SOUS TOTAL			1,122,963
\$.22 10 % Imprevus			112,296
TOTAL EN \$US			1,235,259
TOTAL EN ZAIRES			7,288,027

-----Realise 1983-----			
-----Designation-----	Unite	Prix Unitaire	Total
\$.1 Vaccins rougeoleux	750,000	0.26	193,650
\$.2 Seringues	220,000	0.86	190,080
\$.3 Aiguilles	112,200	0.09	9,853
\$.4 Vehicules/Pieces	18	18,611.11	335,000
\$.5 Motos			5,201
\$.6 Avion Prive			0
\$.7 Refrigerateurs			0
\$.8 Boite isotherme	90	1,377.69	123,992
\$.9 Acc. de froid	750	35.72	26,790
\$.10 Imprevu Ch. de Froid	750	0.99	743
\$.11 SRO			0
\$.12 Equipement IV & Sol	1,000,000	0.10	95,138
\$.13 Anti-palu (000)			0
\$.14 Equipement Laboratoire			0
\$.15 Radiophonies			0
\$.16 Antenne	19	4,024.68	76,469
\$.17 Photocopieuse			0
\$.18 Equipement Stencile	1	3,401.00	3,401
\$.19 Machines a ecrire			7,958
\$.20 Megaphones	3	1,312.00	3,936
\$.21 Haute Parleur Veh.	15	274.23	4,113
SOUS TOTAL			
\$.22 10 % Imprevus			1,076,324
TOTAL EN \$US			26,076
TOTAL EN ZAIRES			1,102,400
TOTAL IN Zs			6,504,160

(a) Tableaux noirs (16); transformateurs (2); autocollants (7,000); et Wang-ordinateur (1).

TABLEAU 4

-----Designation-----	-----Budgetise 1984-----		Total
	Unite	Prix Unitaire	
\$.1 Vaccins rougeoleux	900,000	0.30	270,000
\$.2 Seringues	87,500	1.60	140,000
\$.3 Aiguilles	29,200	0.90	26,280
\$.4 Vehicules/Pieces	24	20,000.00	480,000
\$.5 Motos	50	550.00	27,500
\$.6 Avion Prive			18,000
\$.7 Refrigerateurs	125	660.00	82,500
\$.8 Boite isotherme	650	24.00	15,600
\$.9 Acc. de froid	3,250	0.85	2,763
\$.10 Imprevus Ch. de Froid			10,000
\$.11 SRO			50,000
\$.12 Equipement IV & Sol			50,000
\$.13 Anti-palu (000)			55,000
\$.14 Equipement Laboratoire			15,000
\$.15 Radiophonies			
\$.16 Antenne			
\$.17 Photocopieuse			
\$.18 Equipement Stencil			
\$.19 Machines a ecrire			
\$.20 Megaphones	100	80.00	8,000
\$.21 Haute Parleur Veh.			
SOUS TOTAL			1,250,643
\$.22 10 % Imprevus			125,064
TOTAL EN \$US			1,375,707
TOTAL EN ZAIRES			45,398,323

-----Designation-----	-----Realise 1984-----		Total
	Unite	Prix Unitaire	
\$.1 Vaccins rougeoleux	775,560	0.09	68,399
\$.2 Seringues			0
\$.3 Aiguilles	102,480	0.12	12,529
\$.4 Vehicules/Pieces	20	19,500.00	390,000
\$.5 Motos	100	1,500.00	150,000
\$.6 Avion Prive			3,000
\$.7 Refrigerateurs	125	1,720.00	215,000
\$.8 Boite isotherme	652	25.25	16,466
\$.9 Acc. de froid	3,250	compris au dessus	
\$.10 Imprevus Ch. de Froid			6,919
\$.11 SRO	1,000,000	0.11	111,623
\$.12 Equipement IV & Sol			
\$.13 Anti-palu (000)	3,800	4.96	18,849
\$.14 Equipement Laboratoire			
\$.15 Radiophonies			
\$.16 Antenne			7,668
\$.17 Photocopieuse			
\$.18 Equipement Stencil			
\$.19 Machines a ecrire			
\$.20 Megaphones			0
\$.21 Haute Parleur Veh.			
SOUS TOTAL	500	230.00	115,000
\$.22 10 % Imprevus			850
TOTAL EN \$US			1,116,303
TOTAL EN ZAIRES			

TABLEAU 4

-----Budgetise 1985-----			
-----Designation-----	Unite	Prix Unitaire	Total
\$.1 Vaccins rougeoleux	750,000	0.33	247,500
\$.2 Seringues	75,000	1.80	135,000
\$.3 Aiguilles	25,000	1.05	26,250
\$.4 Vehicules/Pieces	18	22,000.00	396,000
\$.5 Motos			
\$.6 Avion Prive			18,000
\$.7 Refrigerateurs	125	725.00	90,625
\$.8 Boite isotherme	300	26.00	7,800
\$.9 Acc. de froid	1,500	0.90	1,350
\$.10 Imprevus Ch. de Froid			10,000
\$.11 SRO			
\$.12 Equipement IV & Sol			
\$.13 Anti-palu (000)			90,000
\$.14 Equipement Laboratoire			15,000
\$.15 Radiophonies			
\$.16 Antenne			
\$.17 Photocopieuse			
\$.18 Equipement Stencil			
\$.19 Machines a ecrire			
\$.20 Megaphones	50	85.00	4,250
\$.21 Haute Parleur Veh.			
SOUS TOTAL			1,041,775
\$.22 10 % Imprevus			104,178
TOTAL EN \$US			1,145,953
TOTAL EN ZAIRES			37,816,433

-----Budgetise 1986-----			
-----Designation-----	Unite	Prix Unitaire	Total
\$.1 Vaccins rougeoleux	450,000	0.36	162,000
\$.2 Seringues	50,000	2.00	100,000
\$.3 Aiguilles	16,700	1.20	20,040
\$.4 Vehicules/Pieces	18	24,000.00	432,000
\$.5 Motos			
\$.6 Avion Prive			18,000
\$.7 Refrigerateurs	125	800.00	100,000
\$.8 Boite isotherme	300	28.00	8,400
\$.9 Acc. de froid	1,500	0.95	1,425
\$.10 Imprevus Ch. de Froid			10,000
\$.11 SRO			
\$.12 Equipement IV & Sol			
\$.13 Anti-palu (000)			125,000
\$.14 Equipement Laboratoire			15,000
\$.15 Radiophonies			
\$.16 Antenne			
\$.17 Photocopieuse			
\$.18 Equipement Stencil			
\$.19 Machines a ecrire			
\$.20 Megaphones			
\$.21 Haute Parleur Veh.			
SOUS TOTAL			991,865
\$.22 10 % Imprevus			99,187
TOTAL EN \$US			1,091,052
TOTAL EN ZAIRES			36,004,700

TABLEAU 4

-----BUDGET BILATERAL-----			
-----Budget Revise 1985-----			
-----Designation-----	Unite	Prix Unitaire	Total
\$.1 Vaccin Anti-rougeole	1,200,000	0.08	96,000
\$.2 Seringes	220,000	0.75	165,000
\$.3 Aiguilles	264,000	0.08	20,900
\$.4 Vehicules/Pieces	10	20,000.00	200,000
\$.5 Casquettes motos	100	45.00	4,500
\$.6 Avion prive			
\$.7 Refrigerateurs	125	1,840.00	230,000
\$.8 Boite isotherme	300	26.00	7,800
\$.9 Acc. de froid	1,500	(compris au dessus)	
\$.10 Imprevus Ch. de Froid			10,000
\$.11 SR0	0		0
\$.12 Equipement IV & Sol	0		0
\$.13 Anti-palu (000)	27,000	5.00	135,000
\$.14 Equipement Laboratoire			30,000
\$.15 Radiophonies	0		0
\$.16 Antenne	0		0
\$.17 Photocopieuse	0		0
\$.18 Equipement Stencile	0		0
\$.19 Machines a ecrire	0		0
\$.20 Megaphones	0		0
\$.21 Haute Parleur Veh.	0		0
\$.23 Velos	500	250.00	125,000
\$.24 Autre (a)			2,531
TOTAL EN \$ U S :			1,026,731

(a) Equipement de bureaux et livres.

-----Budget Revise 1986-----			
-----Designation-----	Unite	Prix Unitaire	Total
\$.1 Vaccin Anti-rougeole	1,000,000	0.09	90,000
\$.2 Seringes	220,000	0.85	187,000
\$.3 Aiguilles	528,000	0.08	44,000
\$.4 Vehicules/Pieces..	10	21,000.00	210,000
\$.5 Casques motos	50	1,500.00	75,000
\$.6 Avion prive			0
\$.7 Refrigerateurs	125	1,960.00	245,000
\$.8 Boite isotherme	300	28.00	8,400
\$.9 Acc. de froid	1,500	(compris au dessus)	
\$.10 Imprevus Ch. de Froid			0
\$.11 SR0	0		0
\$.12 Equipement IV & Sol	0		0
\$.13 Anti-palu (000)	27,000	5.00	135,000
\$.14 Equipement Laboratoire			0
\$.15 Radiophonies	0		0
\$.16 Antenne	0		0
\$.17 Photocopieuse	0		0
\$.18 Equipement Stencile	0		0
\$.19 Machines a ecrire	0		0
\$.20 Megaphones	0		0
\$.21 Haute Parleur Veh.	0		0
\$.23 Velos	500	250.00	125,000
\$.24 Autre (a)			0
TOTAL EN \$ U S :			1,119,400

(a) Equipement de bureaux et livres.

TABLEAU 4

SOMMAIRE DES BUDGETS BILATERAUX :  
PROAG, ACTUEL, ET REVISE 1983 - 1986

Annee	PROAG	Actuel/Revise
1983	1,235,950	1,173,400
1984	1,375,400	1,026,731
1985	1,146,950	1,116,303
1986	1,090,800	1,011,183
DUREE DU PROJET	4,849,100	4,327,617
Fonds non-programmes*		521,483

\* Resultat des prix plus bas que prevus.

TABLEAU 5  
KILOMETRAGE ET CARBURANT PEV/CCCO 1984

Equipe		Premier Trimestre	Deuxieme Trimestre	Troisieme Trimestre	Quatrieme Trimestre	Total 1984
BAHUNDU	Nbre Vehicules	1	1	1	1	
	Kms.	455	695	535	3325	21814
	Mazout Recu (l)	560	400	1000		1960
GOMA	Nbre Vehicules	2	2	2		
	Kms.	4145	2344	2754		9263
	Mazout Recu (l)	1000	1000	1000		3000
BUKAVU	Nbre Vehicules	3	3	3		
	Kms.	5445	3224	4540		15431
	Mazout Recu (l)	1000	1000	1000		3000
KALEMIE	Nbre Vehicules	0	0	1		
	Kms.	0	0	2334		2334
	Mazout Recu (l)	0	400	0		400
MATADI	Nbre Vehicules	2	2	2		
	Kms.	485	1524	0		2011
	Mazout Recu (l)	500	310	350		1160
KAMINA	Nbre Vehicules	1	1	1	1	
	Kms.	0	0	0	0	0
	Mazout Recu (l)	400	200	200		1000
KISANGANI	Nbre Vehicules	1	1	1	1	
	Kms.	1491	2996	4735		9422
	Mazout Recu (l)	1000	1000	1000		3000
LUBUMBASHI	Nbre Vehicules	2	2	1		
	Kms.	5311	5445	4237		15013
	Mazout Recu (l)	1000				1000
KIKWIT	Nbre Vehicules	1	1	1		
	Kms.	7274	1314	5089		13679
	Mazout Recu (l)	560	400	1000		1960
ISIRO	Nbre Vehicules	1	1	1	1	
	Kms.	4191	1235			7424
	Mazout Recu (l)	1000	1000	1000		3000
MBUJI-MAYI	Nbre Vehicules	3	3	3		
	Kms.	na	na	na		0
	Mazout Recu (l)	1000	1000	1000		3000
BUNIA	Nbre Vehicules	1	1	1		
	Kms.	4480	2598	1723		9001
	Mazout Recu (l)	405	400			805
GEMENA	Nbre Vehicules	2	2	1		
	Kms.	na	2498	4849		7347
	Mazout Recu (l)					0
SUBTOTAL	Nbre Vehicules	20	20	19	4	
	Kms.	41981	29519	38136	3325	112941
	Mazout Recu (l)	8425	7110	7550	0	23285
	Essence Recu (l)	2253	2173	0	0	0
TABLEAU 5						
KINDU	Nbre Vehicules	1	1	1		
	Kms.	1783	569	945		3318
	Mazout Recu (l)	357	135			492
MBANDAKA	Nbre Vehicules	1	1	1		
	Kms.	4285	3703	2701		10689
	Mazout Recu (l)		200	1000		1200
BOMA	Nbre Vehicules	1	1	1		
	Kms.	5877	7447	7850		21174
	Mazout Recu (l)	1000	1000	1000		3000
KANANGA	Nbre Vehicules	na	na	na		
	Kms.	na	na	na		
	Mazout Recu (l)	1000	1000	1000		
KINSHASA	Nbre Vehicules	na	na	na		
	Kms.	na	na	na		
	Mazout Recu (l)	2780	3807	15743		
TOTAL PEV	Nbre Vehicules	3443	3036	944		
	Kms.	53924	52388	40204	3325	148142
	Mazout Recu (l)	13742	9445	11350	0	27977
	Essence Recu (l)	4253	3344	944	0	12541

(b) le cable kilometrique d'un vehicule est casse  
(c) le vehicule a ete affecte a Bunia de janvier a avril

TABLEAU 6

SOMMAIRE DES DEPENSES DU BUDGET ORDINAIRE  
1984

Détails de Transaction	Caisse Entrée	Equipes	Salaires	Carburant et lubrif	Vehicule Réparation Entretien	Matériel longue durée	Soins Médicaux	Frais et fourniture bureau	Expédit Transport	Frais Séminaires	Loyer	Diver	TOTAL
Solde 1 janvier 1984											30,000		775,724
Janvier	810,305	273,250	289,996	92,480	19,112	12,124	18,790	11,861	28,111				642,100
Février	641,817	379,800	41,578	119,346	6,022	27,883	24,632	32,615	10,224				461,321
Mars	651,847	196,000	131,317	100,583	6,849	8,628	16,969		975				569,001
Avril	469,340	194,000	162,140	115,290	12,906	23,622	23,396	31,436	4,760	1,451			433,682
Mai	479,653	217,000	146,258	41,257	995	8,305	11,837	766	7,264				478,087
Juin	582,016	54,000	225,861	66,846	25,551	18,638	12,222	8,145	66,824				637,166
Juillet	625,693	280,600	300,271	19,531		8,448	20,741	7,050	525				403,741
Aout	543,709	210,100	181,276	3,015			8,380	750	220				606,799
Septembre	482,439	362,200	200,413	825			29,175	3,831	10,355				545,710
Octobre	474,440	369,001	146,730		2,469	750	17,177	6,223	3,360				322,403
Novembre	469,160	82,000	171,016	2,428	5,577	4,453	46,230	9,029	1,670				635,782
Décembre	464,980	169,125	379,399	20,687	9,332	6,438	48,929	1,872					
Solde 31 décembre 1984													
TOTAL B. O. 1984	6,715,399	2,787,076	2,376,255	582,288	88,813	119,289	278,478	113,578	134,288	1,451	30,000		6,511,516

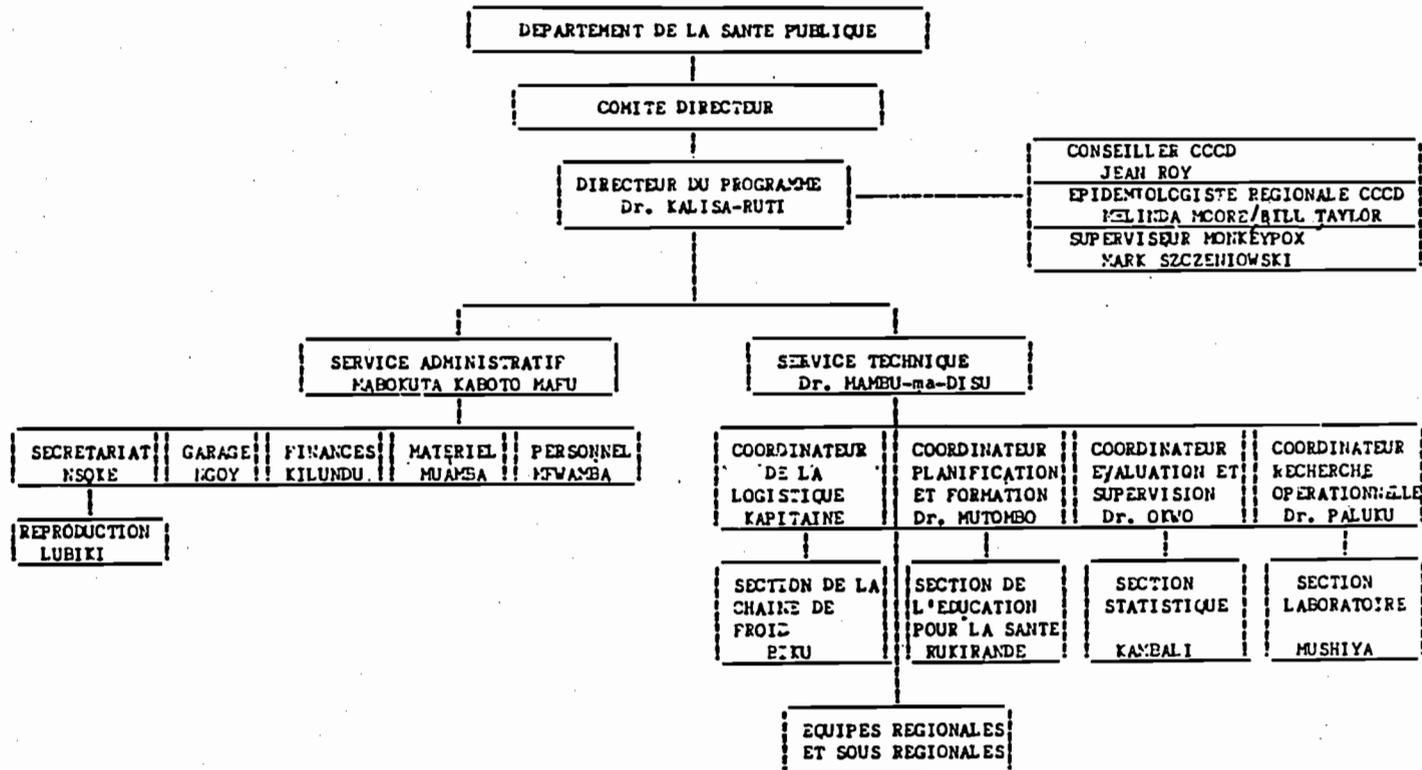
TABLEAU 7

## SOMMAIRE DES DEPENSES DU FONDS DE CONTREPARTIE 1984

	Banque Entrée	Banque Paiement	Caisse Entrée	Caisse Paiement	Salaires	Carburant et lubrif	Vehicule Réparation Entretien	Matériel longue durée	Soins Médicaux	Frais et fournitures bureau	Expédit Transport	Frais Séminaires	Loyer	Divers	Entrée Compte Bloqué	TOTAL
Solde 1 janvier 1984	124,967		288													
Janvier	86,300	210,303	54,793	21,082	-1,323	147,550	140	3,437	4,755	5,935	16,098	0	0	0		176,592
Février	1,065,000	795,379	420,701	427,312	288,222	106,095	79,121	17,156	27,723	24,794	30,312	0	0	0		573,423
Mars	0	267,113	246,765	281,386	178,725	41,300	5,168	4,472	13,469	27,386	28,054	0	3,160	0		301,734
Avril	1,000,000	828,460	490,680	409,441	156,083	244,599	62,546	124,437	22,044	21,399	105,241	0	3,400	2,294		742,043
Mai	0	170,884	120,530	136,773	43,377	60,144	4,127	13,279	4,258	453	59,959	0	0	0		185,597
Juin	2,000,000	155,518	128,710	418,767	277,014	47,360	21,933	53,948	13,080	19,323	12,917	0	0	0		445,575
Juillet	125,200	1,185,599	810,096	551,331	32,606	69,645	73,140	52,511	10,376	22,874	188,456	0	54,000	0	33,996	537,604
Aout	2,200,000	737,640	745,720	1,013,574	327,836	81,323	26,195	40,836	19,491	15,062	58,647	443,804	0	0		1,013,194
Septembre	0	1,554,441	1,115,198	934,115	223,037	385,653	178,416	201,851	31,800	48,594	64,122	205,050	31,500	0		1,370,023
Octobre	0	458,755	442,700	539,940	31,629	96,140	56,077	118,926	19,637	15,783	43,663	0	0	0		381,855
Novembre	2,000,000	970,940	736,200	614,844	251,913	141,853	295,028	53,349	11,830	40,835	20,776	0	0	0		815,584
Décembre	0	712,849	414,356	694,120	291,969	140,326	64,681	77,524	29,996	192,090	58,127	0	0	0		854,713
Solde 31 décembre 1984	316,450		32,018													
TOTAL C/P 1984	8,476,500	8,047,881	5,726,449	6,042,685	2,101,088	1,561,988	866,572	761,726	208,459	434,528	686,372	648,854	92,060	2,294	33,996	7,397,937

TABLEAU 8

PROGRAMME DE LUTTE CONTRE LES MALADIES TRANSMISSIBLES DE L'ENFANCE.



JANVIER 1985.-

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TABLEAU 9

MOUVEMENT DES VACCINS EN 1984.

VACCIN	PREVU	RECU + STOCK FIN 1983	DISTRIBUE	SOLDE FIN NOV.1984
B C G	1.900.000	3.467.600	1.667.600	1.800.000
V A R	1.450.000	1.050.000	816.280	233.720
V A T	1.400.000	2.756.680	1.413.480	1.343.200
V A P	3.240.000	3.791.840	1.940.360	1.841.480
DTCOQ	3.000.000	4.095.800	1.761.660	2.334.140

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TABLEAU 10

MATERIEL RECU EN 1982, 1983 ET 1984

N°	TYPE DU MATERIEL	QUANTITE RECUE 1982	QUANTITE RECUE 1983	QUANTITE RECUE 1984	DISTRIBUEE	STOCK ACTUEL	DUREE PREVUE DE STOCK
01.	Chloroquine	-	-	3.800.000	3.716.000	84.000	
02.	S.R.O.	14.600 sachets	300.000	1.917.182	517.307	1.714.475	+ 3 ans
03.	Seringues	2.245	2.860	234.952	10.000	230.057	+ 2 ans
04.	Aiguilles	120.460	112.200	108.480	15.000	326.140	+ 2 ans
05.	Moto Type 100 (OMS)	-	-	20	14	6	-
06.	Moto Type 175 (CCCD)	-	-	100	15	85	-
07.	F r i g o s	-	81	134	100	115	+ 1 an
08.	V é l o s	240	-	-	210	30	-
09.	Boîtes isothermes	50	750	652	-	-	+ 5 ans
10.	Radiophonie	-	-	14	12	2	-
11.	Appareil Motorola	-	-	7	7	-	-
12.	Thermomètre-Frigo	191	-	850	550	491	-
13.	"- Chambre-Froide	7	3	3	3	10	-
14.	Stérilisateurs	151	-	-	-	151	-
15.	Accumulateurs	500	3.750	3.300	-	-	-
16.	Ordinateur	-	-	1	1	-	-
17.	Véhicule	2	2	18	18	-	-
18.	Machine duplicateur	-	1	-	1	-	-
19.	Machine à écrire IBM	-	-	2	2	-	-
20.	Stencileuse	-	1	-	1	-	-
21.	Pièces de rechange (Jeeps)	-	-	4 caisses + 1 carton	10	-	-
22.	Verres pour frigos	106	40	550	3	693	+ 4 ans
23.	Mèches pour frigos	41	-	-	12	29	+ 1 an
24.	Photocopieuse	-	1	-	1	-	-

Kinshasa, le 14 février 1985,

LE CHEF DU MATERIEL PEV,



TABLEAU 11  
VEHICULES/VEHICLES CCCD

R E G I O N	NO OF 4 WHEEL VEHICLES	ORGIN - ORIGINE							
		OMS - WHO		UNICEF		USAID		CONSEIL EXECUTIF - EXECUTIVE COUNSEL	
	N° DE VEHICULES	N°	EN MARCHE WORKING	N°	EN MARCHE WORKING	N°	EN MARCHE WORKING	N°	EN MARCHE WORKING
KINSHASA	31	11	5	7	4	10	10	3	0
BANDUNDU	4	1	1	2	2	1	1	-	-
BAS-ZAIRE	2	-	-	2	2	-	-	-	-
KASAI-OCC.	4	-	-	3	1	-	-	-	-
KASAI-ORIENT.	6	2	2	2	1	2	1	-	-
S H A B A	4	1	0	3	3	-	-	-	-
HAUT-ZAIRE	6	-	-	3	3	3	3	-	-
EQUATEUR	7	3	3	4	3	-	-	-	-
K I V U	6	1	0	4	4	1	1	-	-
T O T A L	70	19	11	30	23	17	16	3	0

DONNEES DISPONIBLES AU 25 JANVIER 1985  
DATA AVAILABLE AS OF JANUARY 25, 1985.

TABLEAU 11B

MATERIEL DE CHAINE DE FROID ET VELOS  
DEJA DISTRIBUE AUX EQUIPES PEV/CCCD  
ET DANS LES ZONES DE SANTE RECYCLEES  
ENTRE 1981-1983.

REGION	FRIGOS	CONGELATEURS	BOITES ISOTHERMES *		VELOS
			45 litres	5 litres	
KINSHASA	8	-	27	58	-
BAS - ZAIRE	11	2	22	114	19
BANDUNDU	19	3	65	155	30
EQUATEUR	7	-	47	87	29
HAUT - ZAIRE	9	-	21	50	32
K I V U	8	-	13	45	43
KASAI OCCIDENTAL	4	-	7	29	13
KASAI ORIENTAL	8	-	21	58	15
S H A B A	5	1	14	36	15
EQUIPES PEV-CCCD	37	-	-	-	22
T O T A L	116	6	237	632	218
TOTAL RECU UNICEF/CCCD/OXFAM	240		300	1.588	240

\* Matériel retiré par les Zones de Santé à partir de la direction du PEV. Certaines ont été servies.

Tableau 12. FORMATION : ETAT D'AVANCEMENT.

CATEGORIES DU PERSONNEL A FORMER	DUREE DU COURS	NOMBRE DE PERSONNES A FORMER PAR ANNEE										
		PREVU				REALISE				PREVU		
		1981-1982	1983	1984	TOTAL	1981-1982	1983	1984	TOTAL (%)	1985	1986	TOTAL
Médecins-Inspecteurs Régionaux et Médecins Sous-Régionaux	4 jours	30	10	-	40	35	2	0	37	-	-	-
Responsables des services de santé de base	4 jours	50	40	30	120	0	0	0	0	20	10	30
Médecins-Chefs de Zones	20 jours	35	30	30	95	50	26	62	138	30	30	60
Chefs des Cercles médicaux et/ ou Infirmiers encadreurs de Zones	20 jours	60	90	90	240	25	0	0	25	90	90	180
Gestionnaires de la Chaîne du Froid	14 jours	40	-	40	80	0	0	2	2	-	40	40

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TABLEAU 13

TRAINING  
LA FORMATION

TRAINING ORGANIZED BY PEV/CCCD			
CATEGORIE DU PERSONNEL, ANNEE CATEGORY OF PERSONAL , YEAR	SUJET COURSE SUBJECT	DUREE,-- JOURS DURATION, DAYS	NOMBRE DE PARTICI- PANTS NUMBER OF PARTICI- PANTS
Physicians, 1983	Hospital use of ORT	1	15
Nurse Supervisors at Health Zone, 1983	CCCD strategies	5	17
Nursing Students	Survey interviewing techniques	6	12
Nurses, 1984	Hospital and health center use of ORT	1	23
Nurses, 1984	Vaccination techniques	13	11
Nurse Supervisors at Health Zone, 1984	CCCD Strategies	6	17
Peace Corps Volunteers, 1984	CCCD Strategies	5	10
Health Center Nurses, 1984	CCCD Strategies	6	5
Nursing Students, 1984	Survey interviewing techniques	8	5
Peace Corps Volunteers, 1984	Trained in CCD Strategies to assist Zonal Medical Officers	48	23
Health Center Nurses, 1984	CCCD Strategies	1 - 3	30
Physicians, 1984	Hospital and out-patient use of ORT	1	33
Nurses, 1984	Hospital and out-patient use of ORT	1	72
Mortality Survey Supervisors and Interviewers, 1984	Survey and Interviewing Methods	10	14
T O T A L			293

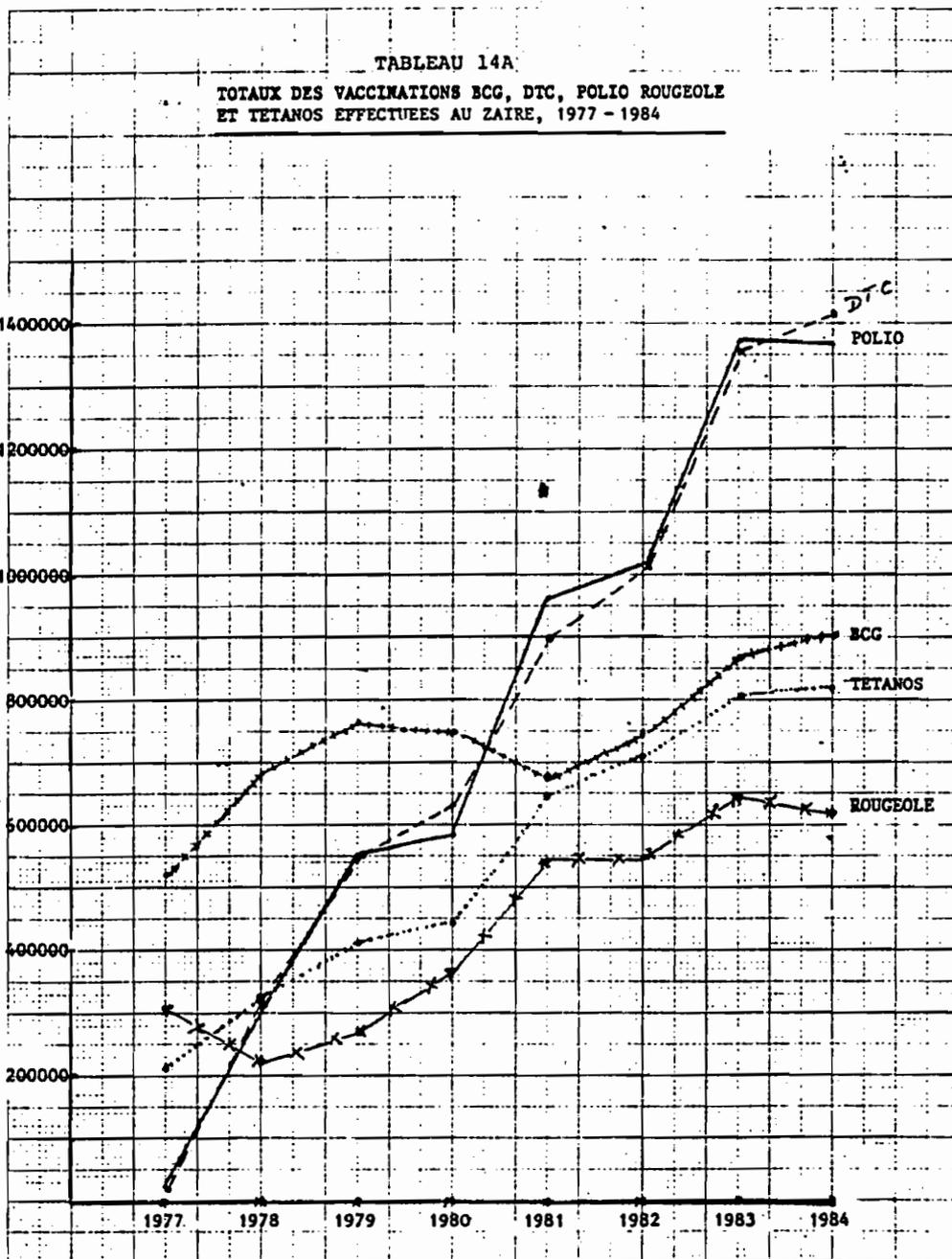


TABLEAU 14B

DISTRIBUTION DES SACHETS SRO DANS LES FORMATIONS MEDICALES AU ZAIRE

ANNEE	SOURCE	P.E.V.	UNICEF	OEUVRES ME- DICALES CA- THOLIQUES	OEUVRES ME- DICALES PRO- TESTANTES	LAPHAKI	FOMETRO	AUTRES (1)	T O T A L
1981	-	-	50.000	120.000	100.000	-	70.000	230.000	570.000
1982	-	-	50.000	120.000	100.000	115.780	70.000	80.000	535.780
1983	202.000 (2)	202.000 (2)	50.000	120.000	100.000	230.920	70.000	80.000	852.920
1984	460.514 (3)	460.514 (3)	50.000	120.000	50.000	135.000	70.000	80.000	965.514
T O T A L		662.514	200.000	480.000	350.000	481.700	280.000	470.000	2.832.214

(1) Fondation Hans Seidel, Cembac, Fomilac.

(2) Fournis par l'UNICEF

(3) Fournis par l'UNICEF & l'USAID.

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TABLEAU 15A  
 SYSTEME D'INFORMATION ET DE SURVEILLANCE  
 (HEALTH INFORMATION AND DISEASE SURVEILLANCE SYSTEM)

POSTES SENTINELLES PAR EQUIPE PEV/CCCD  
SENTINEL SITES BY EPI/CCCD TEAM

VILLES (TOWNS)	POPULATION (1981)	POSTES SENTINELLES (SITES)			
		NOMBRE (NUMBER)	HOPITAUX ou CLINIQUES	CENTRES DE SANTÉ (HEALTH C.)	CENTRES DE REE- DUCATION (REHAB. CENTERS)
KINSHASA	2.338.246	14	4	9	1
BANDUNDU	103.549	4	1	3	-
KIKWIT	154.981	5	1	4	-
MATADI	164.650	5	2	3	-
BOHA	114.634	7	2	5	-
MBANDAKA	167.932	5	2	3	-
LISALA	101.114	5	1	3	1
KISANGANI	329.548	5	3	2	-
BUNIA	52.301	5	1	4	-
ISIRO	71.902	4	2	2	-
KANANGA	492.156	11	3	8	-
MBUJI-MAYI	348.372	5	1	4	-
BUKAVU	158.477	6	1	5	-
COMA	77.245	6	2	3	-
KINDU	69.710	5	-	5	-
LUBUMBASHI	623.250	6	5	1	-
KAMINA	112.484	5	4	1	-
TOTAL	5.489.551	103	35	65	2

CASES AND DEATHS REPORTED BY EPI/CCCD TEAMS, DECEMBER 1982 - NOVEMBER 1983

CAS ET DECES DECLARES PAR LES EQUIPES DU PEV/CCCD, DECEMBRE 1982 - NOVEMBRE 1983

EQUIPES TEAMS	POPULATION (1981)	NOMBRE DE POSTES SENTI- NELLES (SITES)	NOMBRE DE RAPPORTS MENSUELS (MONTHLY)	ROUGEOLE (MEASLES)		COQUELUCHE (PERTUSSIS)		P O L I O		T E T A N O S	
				CAS	DECES	CAS	DECES	CAS	DECES	CAS	DECES
BANDUNDU	103.549	4	7	80	8	30	0	0	0	3	2
KIKWIT	154.981	5	12	55	0	13	0	2	0	3	3
MATADI	164.650	5	12	475	35	7	0	0	0	1	0
B O M A	114.634	7	7	21	0	22	0	0	0	0	0
MBANDAKA	167.932	5	12	345	27	21	0	0	0	20	4
L I S A L A	101.114	5	12	209	32	93	3	15	0	10	5
KISANGANI	329.548	5	8	141	16	8	0	2	1	15	6
B U N I A	52.301	5	11	17	0	27	0	1	0	2	1
I S I R O	71.902	4	5	21	0	13	0	1	0	7	2
KANANGA	492.156	11	12	738	24	70	5	14	0	12	1
MBUJI-MAYI	348.372	5	12	2106	143	113	3	58	7	54	27
KINSHASA	2.338.246	14	12	8689	748	240	7	114	6	90	41
B U K A V U	158.477	6	12	1073	12	56	4	4	0	14	1
G O M A	77.245	4	12	94	2	10	0	3	0	8	3
K I N D U	69.710	5	10	42	0	7	0	1	0	5	3
LUBUMBASHI	623.250	6	12	1316	118	19	0	8	0	17	13
K A M I N A	112.484	5	10	110	4	159	10	4	0	5	3

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TABIEAU 15B

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TABLEAU 16A

CAS HOSPITALISES ET DECES DECLARES PAR LES  
POSTES SENTINELLES PENDANT L'ANNEE 1984.

HOSPITAL CASES AND DEATHS REPORTED BY SENTINEL  
SITES DURING 1984)

EQUIPES (TEAMS)	NBRE POSTES SEN- TINELLES (*) (NUMBER OF SITES)	ROUGEOLE (MEASLES)		PALUDISME (MALARIA)		DIARRHEE		P O L I O		COQUELUCHE (PERTUSSIS)		TETANOS	
		Cas	Décès	Cas	Décès	Cas	Décès	Cas	Décès	Cas	Décès	Cas	Décès
BANDUNDU	1	23	2	55	4	41	0	3	0	0	0	7	5
KIKWIT	1	117	21	248	5	83	5	1	0	2	0	8	7
HATADI	2	49	1	318	16	219	17	0	0	3	0	7	2
B O M A	2	327	27	445	14	255	15	3	0	12	0	6	3
MBANDAKA	2	84	5	108	0	171	4	0	0	3	0	17	4
L I S A L A	1	2	1	24	0	55	2	0	0	3	0	1	1
KISANGANI	7	193	28	326	25	154	10	2	0	6	0	20	12
BUNIA	3	0	0	38	0	23	0	0	0	0	0	0	0
I S I R O	2	138	4	1.129	19	684	10	3	0	57	1	9	1
K A N A N G A	3	31	2	59	0	41	0	0	0	0	0	0	0
MBUJI-MAYI	1	921	25	2.713	1	270	3	2	0	42	2	10	0
KINSHASA	4	3.913	546	1.603	107	4.090	213	92	0	112	4	124	67
B U K A V U	1	7	1	2	0	94	8	9	0	0	0	5	3
G O M A	2	21	1	40	0	42	0	4	0	7	0	3	1
K I N D U	1	122	28	208	5	285	37	8	1	9	0	30	14
LUBUMBASHI	5	734	92	682	2	1.515	24	2	0	16	1	17	9
K A M I N A	4	40	4	1.684	5	917	9	3	0	80	0	4	3
T O T A U X	35	6.722	788	9.682	203	8.939	357	132	1	352	8	268	132

(\*) Hôpitaux et Cliniques.

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TABLEAU 16B  
 SYSTEME D'INFORMATION ET DE SURVEILLANCE  
 (HEALTH INFORMATION AND SURVEILLANCE SYSTEM)

CAS AMBULATOIRES DECLARES PAR LES EQUIPES  
 DU PEV/CCCD PENDANT L'ANNEE 1984

AMBULATORY CASES REPORTED BY EPI/CCCD  
 TEAMS DURING 1984.)

EQUIPES (TEAMS)	ROUGEOLE (MEASLES)	COQUELUCHE (PERTUSSIS)
BANDUNDU	2	1
KIKWIT	148	12
MATADI	13	1
BOMA	225	41
MBANDAKA	113	5
LISALA	1	7
KISANGANI	55	14
BUNIA	6	14
ISIRO	58	27
KANANGA	273	16
MBUJI-MAYI	-	-
KINSHASA	3.177	124
BUKAVU	278	10
GOMA	107	3
KINDU	206	7
LUBUMBASHI	-	-
KAMINA	1	1
TOTAUX	4.663	283

TABLEAU 17  
ENQUETES SPECIALES

<u>Sujet de l'enquête</u>	<u>Lieu</u>	<u>Méthode</u>	<u>But</u>
Traitement du paludisme et à la résistance à la chloroquine	Kinshasa Mbuji-Mayé	Temps d'élimination des parasites in-vitro et in-vivo	D'établir l'efficacité du traitement à dose unique recommandé.
Prévalence de la fièvre et de la diarrhée et l'état vaccinale parmi les consultants à la clinique.	Kinshasa	Enquête descriptive faite à la clinique	De déterminer la fréquence des visites relatives aux maladies CCCD.
Epidémiologie de la rougeole	Kinshasa	Revue des registres de l'hôpital, enquêtes d'évaluation, rapports des vaccinations.	D'étudier la tendance de la rougeole, les problèmes de rougeole parmi les enfants trop jeunes pour être vaccinés, identifier les aires où la transmission est grande, et estimer l'âge de la vaccination.
Faisabilité de la politique de vacciner les enfants malades.	Kinshasa	Enquête faite à la clinique	Déterminer si la stratégie de vacciner les enfants malades augmenterait effectivement la couverture vaccinale.
Mortalité et utilisation des services de santé	Kinshasa	Enquête à domicile	D'établir le taux de mortalité infantile et les causes de décès et d'estimer l'incidence des maladies et l'utilisation des services de santé pour les stratégies du CCCD.
Connaissance et altitude à l'égard de la diarrhée et de la fièvre.-	Kivu	Interview à domicile	Déterminer le traitement utilisé dans les zones rurales pour la diarrhée et la fièvre.
Variation dans la préparation de la solution TRO à domicile et test des messages.	Kinshasa	Interview des mères	D'établir les méthodes pour uniformiser la formule de la solution sucre-sel et de tester l'efficacité des messages à passer à la radio et à publier sous formes d'affiches.
L'unité hospitalière de la réhydratation orale	Kinshasa	Etudes prospective des consultations à l'urgence pour la diarrhée	De déterminer la distribution du degré de déshydratation et l'efficacité du traitement par voie orale.
Enquêtes rurales de base sur la mortalité.	Bandundu	Echantillon représentatif des ménages.	D'établir le taux de mortalité de base afin de mesurer l'impact des stratégies du CCCD avec une deuxième enquête après l'exécution du programme.

TABLEAU 18  
OPERATIONAL RESEARCH PROTOCOLS

TITLE OF PROTOCOL	PRINCIPAL INVESTIGATOR	COUNTRY	DESCRIPTION	DATE SENT
1. Study of the efficacy of chloroquine in malaria treatment. Specificity and sensitivity of fever as presumptive diagnosis of malaria in children under 5 in Kinshasa	Dr. Ngimbi, University of Kinshasa	Zaire	Prospective study of malaria-sensitive to chloroquine treatment.	9/84
2. Prospective study of childhood diseases, nutrition, preventive measures and mortality.	Pierre Duboz	Congo	Prospective rural study of incidence of childhood diseases and child mortality.	11/84
3. Therapeutic Behavior of families in rural settings.	Mubiala Katala	Zaire	Anthropologic study of preceptions of diarrheal and febrile disease and treatment practices.	Pending
4. Study of risk factors of dehydration among hospitalized children under five years of age.	Kahozzi and Kalambay	Zaire	Hospital-based study of risk factors for cases of dehydration due to diarrhea.	Pending

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TABLEAU 19

TRAINING RECEIVED BY PEV/CCCD STAFF			
CATEGORY OF PERSONAL	NAME OF COURSE, YEAR	DURATION OF COURSE, DAYS	NUMBER OF PARTICIPANTS
PEV-central staff and team members	WHO senior course of PEV	12	40
PEV-central staff	WHO course of PEV, 1981	12	2
PEV team members	Medical Zone Officers course, 1981	15	2
PEV-central staff	WHO course of PEV, 1982	12	2
PEV team	Medical Zone Officers course, 1982	15	1
PEV-central staff	CCCD Upperlevel course, 1982	15	2
PEV team members	Training in CCCD Strategies, 1983	3	42
PEV physicians	WHO Diarrheal Disease Control - Upperlevel, 1983	10	8
PEV physicians	Medical Zone Officers course, 1983	15	2
PEV team members	WHO course of PEV, 1984	12	2
PEV team members	WHO refrigerator repair course, 1984	5	2
PEV team members	WHO Diarrheal Disease Control Mid-level, 1984	12	8
PEV team members	Training in CCCD strategies	10	1
PEV physicians	Long-term training in Public Health	300	2

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TABLEAU 20

TRAINING FOR MEDECIN-CHEF DE ZONE ORGANIZED BY PEV/CCCD				
CATEGORY OF PERSONAL, YEAR	NUMBER TRAINED	STILL ARE ZONAL MEDICAL OFFICER	HEALTH PLAN RECEIVED BY PEV/CCCD	NUMBER FOLLOWING VISIT BY PEV/CCCD CONTROL LEVEL PERSONAL
Zonal Medical Officer, 1981	15	15	14	11
Zonal Medical Officer, 1982	35	30	32	18
Zonal Medical Officer, 1983	26	23	20	10
Zonal Medical Officer, 1984	62	62	57	6
T O T A L	138	130	123	45

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TABLEAU 21

COMPARAISON ENTRE LES SOUS-OBJECTIFS DU PROJET ET L'UTILISATION DES SERVICES  
DANS LES ZONES ET VILLES COUVERTES PAR LE PROGRAMME CCCD APRES DEUX ANS.

VACCIN	POPULATION CIBLE	DOSES ADMINISTREES	REALISATION	OBJECTIFS DE L'ANNEE 84
B C G	603.421	562.217	93 %	75 %
ROUGEOLE	603.421	349.562	58 %	50 %
DTC 1	603.421	322.392	53 %	-
DTC 3 (2)	603.421	211.765	35 %	30 %
POLIO 1	603.421	312.609	59 %	-
POLIO 3 (2)	603.421	207.687	34 %	30 %
ANTITETANIQUE (1) ( 2 DOSES)	709.020	823.329	58 %	-

(1) En supposant que le nombre de femmes enceintes à vacciner correspond au taux de natalité.

(2) Pour le vaccin DTC et POLIO, le formulaire de déclaration de vaccination ne permet pas de distinguer les doses administrées avant un an et après cet âge. Nous avons utilisé la proportion vaccinée avant 1 an avec le vaccin antirougeoleux conseillé à 9 mois alors qu'en réalité elle est beaucoup plus importante pour le DTC-POLIO qui se donne à 3 mois.

TABLEAU 22

SCHEMA d'AUTOFINANCEMENT  
AUTOFINANCING SCHEMES

NOM DE LA ZONE NAME OF ZONE	REVENUE INCOME	DEPENSE EXPENSES	ACHATS/PURCHASES			
			CARBURANT FUEL	FRIGO REFRI	PHARMA DRUGS	PERS.
1. BUKAVU URBAIN	NO REPORT		PAS DE RAPPORT			
2. WALUNGU	OUI/YES	3,000 Z'S*			X	X
3. UVIRA	NO REPORT		PAS DE RAPPORT			
4. KASONGO	BELGE		X	X		
5. KALANDA	\$74,000	NO BUDGET	X	X	X	X
6. KABINDA	Z329,000	299,000			X	X
7. BIBANGA	Z510,710		X	X	X	X
8. BONZOLA URB.	Z6,,871,000	2,338,000	X	X	X	X
9. KWIMBA	Z477,578	Z233,000	X	X	X	X
10. BENGAMISA	NO REPORT/PAS DE RAPPORT		TARIF PAR EPISODE CHARGES PER EPISODE			
11. YAKUSU	Z285,000	Z256,500	X	X	X	X
12. LUKULA	Z122,192	Z109,920			X	X
13. KABONDA	Z207,752	Z190,629	X	X	X	X

\*mensuel/monthly

TABLEAU 23

Draft Protocol for a Study of the Cost of Vaccination

This is a very preliminary and incomplete draft of a protocol for a study of the costs of vaccination. It is presented here to give a head start to someone formally preparing such a study.

Health Center Level

1. Number of vaccinations given in 1984 (by type)? How many doses of vaccine did you receive in 1984?
2. How many times/yr supervised? By whom?
3. How long do the supervisory visits last?
4. Which of the workers at the center work on vaccinations?
5. What are their monthly salaries? Do they receive any other allowances? How much?
6. How many vaccination sessions do you hold per month?
7. How many hours per session?
8. Who goes to get the vaccine? What is his/her monthly salary?
9. How long does it take?
10. What means of transport is used?
11. Is it (the means of transport) used for anything else? What? How often?
12. How much cotton and alcohol did you use for vaccinations last year? How much do they cost (per unit)?
13. How do you sterilize your needles?
14. What kind of fuel do you use? How much do you use per vaccination session? How much does it cost (per unit)?
15. What container do you use for sterilization? Is it used for anything else? If so, for how much of the time?
16. How much does the container cost? How long does one last?
17. How long do your needles and syringes last?
18. Where is the vaccination session held?
19. If in a building, what percentage of space is used for the session?
20. How much would it cost to build a similar building today?
21. How long does a building like this last?
22. What were the costs of maintaining the building last year?
23. What furniture is used during the vaccination session?
24. How much does it cost? How long does it last?
25. Where do you store vaccination supplies and cards?
26. What proportion of space do vaccination supplies and cards take up?
27. How much does the storage place (shelves, cupboard) cost? How long does it last?
28. How many vaccination cards did you order in 1984? How much do they cost?
29. How many cards were distributed?

Zone Level

1. How many record ledgers do you use for vaccinations?
2. What vehicle is used to transport vaccine from regional PEV depot to the zone?
3. How often was vaccine picked up last year?
4. How far is a roundtrip from the zone to the PEV depot?
5. Do you do other things when you travel to pick up vaccine? What percentage of time is devoted to vaccine pickup? (Trying to be able to allocate costs to vaccine pickup)
6. What are the salaries of the people used in supervision of the health centers?

Best Available Document



ANNEXE II.B RESUME DES VISITES SUR LE TERRAIN

PEV/CCCD EVALUATION 1985

GROUPE	REGIONS VISITEES	EQUIPES PEV VISITEES	ZONES DE SANTE VISITEES	CENTRES DE SANTE VISITES	SIEGES VISITES
	REGIONS VISITED	EPI TEAMS VISITED	HEALTH ZONES VISITED	HEALTH CENTERS VISITED	HEALTH POSTS VISITED
I SHEPPERD KAPITAINE GAMBOA GUTMAN LICHNEVSKI POST	BAS-ZAIRE HAUT-ZAIRE	2	5	6	-
II OKWO SERUZINGO MAKINEN	S H A B A BANDUNDU	2	3	6	1
III UJOODHA ECKERSON AWANTANG	KASAI- ORIENTAL KINSHASA	1	5	3	1
IV BALDWIN GUERIN TAYLOR	KIVU	3	5	11	1
	7	8	18	26	3

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GRANDES LIGNES DES RAPPORTS DE GROUPE

- I. Organisation des composantes de soins de santé primaires
- II. Collaboration intersectorielle
- III. Participation de la communauté
- IV. Finances
- V. Personnel
- VI. Structures
- VII. Supervision
- VIII. Transport
- IX. Approvisionnement équipement & matériel
- X. Système d'information
  - A. Déclaration de routine
  - B. Postes sentinelles
  - C. Enquêtes spéciales
- XI. Formation
- XII. Education sanitaire
- XIII. Recherche Opérationnelle
- XIV. Indice d'utilisation des services
  - A. Couverture PEV
  - B. SRO
  - C. Paludisme
- XV. Impact du programme
  - A. Sur les maladies PEV
  - B. Sur les diarrhées
  - C. Sur les paludisme

ANNEXE II.C REGION DU KIVU

ZS-Bukavu (urban)

C. S. Cimpunda (Catholic)

C. S. Bagira (State)

- I. Organization of Primary Health Care  
The *medecin chef de zone* was trained in 1983 and has developed a plan for implementating primary health care. Bukavu has a population 171,491. Of the 14 health centers and one health post, 11 health centers offer services of vaccination, diarrheal disease control, and malaria treatment, and cover a population of 135,110, or (79%) of total. No system of reference from the health center to the hospital exists.
- II. Intersectorial Collaboration  
None at the level of the zone, but one health center was engaged in providing affordable high-protein flours.
- III. Community Participation  
Both health centers had health committees. One health center has 14 health committees, one for each quartier, that meet each month. *Animateurs*, trained by the health center, are used for detecting and following up cases of malnutrition. The second health center had one health committee but had not yet trained *animateurs*.
- IV. Finances  
The health zone itself has not budget. One health center received external aid that permitted it to make capital expenditures. The other depended entirely on its own receipts and was autofinanced, possible because of the adjoining maternity which provided 60% of receipts. Neither of health centers had a planned budget. Tarifs for services varied by health center. The cost of consultation varied by diagnosis and by medications prescribed.
- V. Personnel  
The *Medecin chef de zone* lacked support staff. The health centers were adequately staffed.
- VI. Structures  
The health centers visited were both well-designed and adequate.
- VII. Supervision  
No active supervision was performed by the zonal medical officer due to lack transport, but a monthly coordination meeting was held to discuss policy and problems. One health center actively supervises the *animateurs* monthly.
- VIII. Transport  
No transportation at level of zone. In an urban zone taxi transport is available but the zone had no budget. One health center had a vehicle; the second has no transportation.

- IX. Supply, Equipment, and Material  
One health center had a refrigerator, the other picked up the vaccine at PEV/Bukavu before each vaccination session. One center had only a single syringe for each antigen with an adequate supply of needles.
- X. Health Information System  
At the health center level, the number of vaccination given by antigen are regularly available, but no routine data is collected on cases of diseases. The zonal medical officer did not have information on the zone. However, PEV-Bukavu maintains a system of 6 sentinel posts. No special studies were conducted.
- XI. Formation  
The zonal medical officer was trained in 1983. He in turn had trained 20 nurses in diarrheal disease and malaria control and 14 nurses in vaccination. He photocopied and distributed the fiches techniques to all nurses and continues to provide training during the monthly meetings. One health center had trained their animateurs for working with malnourished children.
- XII. Health Education  
Educational materials were abundant in both health centers.
- XIII. Operational Research  
None.
- XIV. Indicators of Use of Services  
Coverage figures are available from the annual PEV coverage survey in Bukavu. Estimates of utilization of SRO and malaria treatment are not available.
- XV. Impact  
Not available.
- XVI. Problems  
Lack of transport for supervision, no policy of chemoprophylaxis of pregnant women, inadequate health information system, insufficient vaccination supplies at health center, centers not able to purchase an initial supply of SRO or chloroquine from PEV, health centers in this urban zone were antonomous making zonal management difficult. Strengths - Planning & coordination at zonal level, training.

Z. S. Walungu  
C. S. Lubona (State)  
C. S. Mubumbano (Catholic)

I. Organization of Primary Health Center

Population 269,210

21 health centers and 2 health posts (11 centers give services of vaccination, diarrheal disease control, malaria treatment; however, only four centers are independent, and 7 depend on a visit by a mobile team). 136,624 (=51%) have access to primary health care.

II. Intersectorial Collaboration

None.

III. Community Participation

At one health post the health committee met 3 times per year and was upgrading the construction of the center. The other health center's committee met monthly but wanted to receive payment for their services. No animateurs were used by these health centers. The zonal medical officer felt the health committees were not motivated and the system was working poorly.

IV. Finances

The health post, which offered only curative services, and the health center was autofinanced. The hospital received external aid to pay for all medications. The population was too poor to pay the cost of services at the level of the hospital, so these were subsidized.

V. Personnel

The zonal medical officer was in training overseas, so the acting one had responsibilities at the hospital leaving insufficient time for supervision. The health post with only a single nurse was understaffed.

VI. Structures

The health post was inadequate but was being redesigned and rebuilt.

VII. Supervision

Four of the 21 health centers are visited regularly, but the others are not.

VIII. Transport

One vehicle and one moto were available at the zonal level but this was not sufficient for supervision.

IX. Supply, Equipment, Materiel

Adequate.

- X. Information System  
Well-developed system of reporting vaccination utilization and cases of vaccine - preventable diseases.
- XI. Training  
The zonal medical officer was trained in 1982 but was receiving post-graduate training in Europe. The Acting one trains the nurses once per month at the hospital. A nursing school is located in the hospital. The fiches techniques were available but had not been distributed to health centers.
- XII. Health Education  
The mobile team was well-equipped with educational materials, as was the health center.
- XIII. Operational Research  
A study had been conducted on the number of surviving children born to those women who received prenatal care.
- XIV. Indicators of Use of Health Services  
Coverage estimates are available for vaccination. Only sugar-salt solution is used at health centers. At the hospital a complete solution is prepared in the pharmacy, but no utilization estimates were available. Chloroquine usage is available for the hospital and only those centers supplied by the hospital.
- XV. Impact  
Impression that the number of measles cases has been reduced.

Problems.

Acting zonal medical officer can only visit 4 of 21 centers regularly for supervision, integration of services at health center is not well developed, mobile team strategy is still important in this zone, enough health centers exist but access to primary health care is limited, health committees were said to be ineffective.

Strengths.

Health information system, Training

Z. S. Uvira  
C. S. Kabimda  
C. S. Sangé

- I. Organization  
State zone exclusively zairian run  
242,812 population (1980)  
6 health centers functioning  
15 health posts  
90,000 covered (37%) Plan established for the zone in Feb. 1983  
3 health centers to be opened 1985  
Received aid from SANRU, UNICEF
- II. Intersectorial Collaboration  
None.
- III. Community Participation  
Health committees for each health center with representatives from each village. Cotization to construct health center and for the initial stock of medicines. Identified problems included potable water, measles vaccination, payment for committee member. Some slowness in developing community participation for the new centers which require cotization before being established.
- IV. Finance  
SANRU had given 45,000 Z for 6 months of supervision.  
UNICEF had given 280,000 Z to construct a training room.  
The zone's monthly budget was 100,000 Z.  
All six centers are autofinanced 5,000 Z receipts per month is the minimum required to be self-sufficient. 40% is required for salary and 30% for medications.  
Each health center contributes 300 Z per month to the zone for supervision. The 4 health centers that use a single refrigerator each pay for the cost of petrol from their receipts.  
At the hospital the receipts were divided 40% for the physicians, 20% for other personnel, 20% for medications, 5% intravenous solutions, 5% maintenance, 5% office supplies and 5% for fuel. The salaries for personnel paid by the state are not included.
- V. Personnel  
The zonal medical officer and four physicians at the hospital divide responsibilities for the training and supervision of the personnel in the health centers. Each health center visited had 5 persons and was adequately staffed.

- VI. Structures  
Adequate.
- VII. Supervision  
Well done, a monthly, observations recorded by the nurse in a notebook, long enough to permit training on the job.
- VIII. Transport  
2 vehicles and 2 motos were available. 40% of transport was used for supervision, routine maintenance was provided by a local garage. Gasoline is expensive, 20 l costs 800 Z, and is not always available. Both health centers had a bicycle.
- IX. Supply, Equipment, Materiel  
The zone currently has 7 refrigerators, but only 2 are operating because the cost of running additional ones is too expensive. Also, 10 bicycles remain to be distributed to health centers. Because of the high cost of gasoline, the zone would like to act as a sub-regional depot to serve other neighboring zones and thereby reduce the frequency of visits to the PEV regional team. Shortage of syringes.
- X. Health Information System  
Vaccination utilization data is available. No regular system exists to report diseases; consultation registers at health centers are record symptoms but these are not systematically reported.
- XI. Training  
The Regional Medical Inspector was trained by PEV in a 5 day course in 1982. Two of the doctors were trained by SANRU in 1983 and 1984. In 1984 the doctors trained 10 nurses in a one-week course in primary health care. The nurses in turn have trained the animateurs. One of the nurses was trained in Kasiba in primary health care during 3 weeks. A nursing school A3 adjoins the hospital. The zone has the Fiches Techniques but had to photocopy them for distribution. The treatment strategies used at each health center were standardized and based on the model at Kasongo.
- XII. Health Education  
Adequate at health center level.
- XIII. Operational Research  
A special study was conducted on 100 hospitalized children - 70-80% of causes were diarrhea and a high rate of intravenous solutions was used.

XIV. Indicators of Use of Services

Vaccination utilization data is available.

1,128 packets of ORS mixed with 5 liters were used in 1983 during an outbreak of cholera. CCCD strategies have not been uniformly adopted, ORT strategy is to use a locally-prepared packet for adults and sugar-salt solution for children; Daraprim prophylaxis is given for malaria prevention (13,500 tablets in 1983); recommended treatment for fever is 10 mg/kg for 2 days and chemoprophylaxis of pregnant women is not recommended. No index of chloroquine use was available.

XV. Impact

Not available.

Problems

CCCD strategies are not applied, the zone has received supplies too quickly with respect to its rate of expansion, high cost of having to restock vaccines each month at PEV Bukavu, no health information system.

Strengths - Supervision, good working relationship among the team of physicians, training is well developed, community participation was functioning well, autofinancing is working.

Z. S. Kasongo  
C. S. Kipaka  
C. S. Kasongo 3

- I. **Organization of Primary Health Care**  
Zone supported by University of Antwerp. Began in 1972; current population is 220,000; 16 functioning health centers which cover 69% of the zone's population. All health centers are managed by the health zones.
- II. **Intersectorial Collaboration**  
Collaborates with the Development Committee which deals with water sources and availability of soya.
- III. **Community Participation**  
Well organized, one for each health center. They are responsible for determining the cost of health services and the salary of health center personnel, regular meetings are held with published minutes.
- IV. **Finances**  
Extremely detailed system of accounting standardized at the zone level, supervised monthly. Charge is by episode of disease and varies by health center. Autofinancing is feasible if there are 400 new cases per month, which represents a population of 8000 per health center. All of the health centers were autofinanced which included all salaries, medications payment to hospital of 3 Z per case referred, and petrol for the refrigerator. At the hospital level the Belgian Cooperation provides all medications, the salaries of 4 expatriate physicians, 1 vehicle for supervision and spare parts and gasoline. Average cost of medication for a health center visit was 15-18 Z. Each time the cost of consultation has been raised a drop in utilization occurred so that in the last 4 years, a 20% reduction in utilization resulted. Average number of visits for curative services per person per year is 0.5.
- V. **Personnel**  
Well staffed at zone (6 physicians) and health center level (5-6 persons)
- VI. **Structures**  
Adequate.
- VII. **Supervision**  
Ideal, monthly, a full day of observation is used for training the nurses, all records are systematically reviewed (management, activities), list of problems is maintained. Regular meetings are held by the physicians of problems and solutions at health centers and to discuss observations made during supervisory visits. Supervision responsibility is given to each physician on the team, he visits the same center for 1-2 years.

VIII. Transport

Adequate, but fuel is expensive and the allotment is not always sufficient. In 1984 this interfered with supervisory visits for one and a half months. Each health center has 2 bicycles but no spare parts - life expectancy of a bicycle in this zone is 6 months.

IX. Supply, Equipment, Materiel

Inadequate supply of measles vaccine in 1984 (3 months rupture of stock). Insufficient amount of needles and syringes for BCG. 3 refrigerators in health centers and 2 at the hospital provide good coverage.

X. Health Information System

System is designed to gather management information at the level of each health center. However, no epidemiologic data is routinely gathered. A family record is kept at each health center based on a census of the population. This is updated with each consultation visit. Information on primary symptom is available in the health center register and in hospital records but is not readily available. Declaration of hospitalized cases of diseases (PEV report form) was available in 1984. Beginning in 1984 Kasongo completed the CCCD Health information forms for hospitalized and ambulatory cases. Vaccination data was available for 1984.

XI. Training

The previous zonal medical officer and another physician participated in the CCCD training course. In the zone, training is given on site, at the health center during supervisory visit. In 1984 a training of several days was given to all nurses regarding health center management and treatment strategies. Fiches techniques were available at all health center. Treatment strategies are applied systematically.

XII. Health Education

Adequate.

XIII. Operational Research

Studies were conducted on effectiveness of measles vaccination, the appropriateness of referring cases from health center to the hospital, the effect of costs of services on utilization.

XIV. Indicators of Use of Services

Coverage estimates are available for vaccination. Health centers are limited to only 3 packets of ORS per month and sugar-salt solution is advocated for use at health center and hospital level. In 1984, 3,600 packets were used in the zone. Chloroquine 25,000 - 30,000 100mg tablets per month. 77% of chloroquine is used at the health center level. Estimated average of 500-600 mg of chloroquine is prescribed for each episode which means overutilization.

XV. Impact  
Not available.

Problem

CCCD strategies are not uniformly applied, considerable external aid required to finance hospital and supervision, information not available to measure impact.

Strengths

Information for management, autofinancing at health center level, supervision, training, quality and number of personnel, operational research.

Kindu

C. S. Kasuku

C. S. Lumbulumbu

C. S. Mikilege

I. Organization

Zone supported by the Belgian Cooperation

119,379 population

7 urban health center and 1 rural health center, 2 under construction

71,789 have access to primary health care (60% of total population)

All health centers are managed by the health zone.

II. Intersectorial Collaboration

Unknown.

III. Community Participation

Health committees, first difficult, are now functioning well for each health center. They decide the salaries and tariff at the health center.

IV. Finances

2 physicians are paid by Coopération Belge, 3 million Belgian francs external aid per year.

Hospital budget is 100,000 Z per month distributed as follows: 10% operation costs, 40% for 2 physicians and one administrator, 40% personnel, 10% reimbursed to health center for care given to employees of private companies.

All but one health center are autofinanced. The health center had difficulty obtaining enough consultations to be profitable - lack of community participation.

V. Personnel

Well staffed at zone (4 physicians) and at health centers (4-5 persons). This permits active supervision and complete record keeping at the health center (full-time clerk).

VI. Structures

Adequate.

VII. Supervision

One visit per week for a half-day each. During 1984, 28 visits were made to one of the HC's. Nurses are trained during supervisory visits. All the physicians participate in supervision. Each gives 8 hours per week to zone activities - supervision, training.

VIII. Transport

Now adequate, 7 of 8 health centers are urban and easily accessible; future health centers will be rural and more difficult to manage.

- IX. Supply, Equipment, Materiel  
Supplied directly by PEV/Kindu. Adequate.
- X. Information System  
For Immunizable diseases more information is collected than demanded by PEC/CCCD - vaccination status, location of residence - which complicates reporting. Management information available but not epidemiologic measures of impact or disease reduction. This could be actively gathered from registers at the health center. Hospitalized cases of disease are available for 1984. Sentinel Surveillance system exists in the urban area (PEV/Kindu).
- XI. Training  
The zonal medical officer was trained in 1983 by PEV/CCCD. Nursing school A2 adjoins the hospital. Health center staff are trained during 3-4 months; the nurses are trained at the nursing school how to run a health center. Once per week all nurses attend a training session at the hospital. Standardized fiches techniques were available in all HC. Treatment strategies were applied.
- XII. Health Education  
Posters for treating diarrheal diseases were present in health center. Health education sessions were integrated in all pre-school clinics.
- XIII. Operational Research  
Study of reasons for using consultation services - 50% had one of three symptoms - fever, cough, abdominal pain. 75% had one of ten symptoms.
- XIV. Indicators of Use of Services  
Vaccination coverage data is available. In 1984 200 packets of SRO were used. Sugar-salt solution is recommended at both hospital and health center level. For chloroquine - 143,691 tablets (100 mg) were used in 1984. On the average 350mg of chloroquine is used for every consultation visit - overutilization. Strategy for malaria exclude chemoprophylaxis of pregnant women; malaria treatment of children is 10mg/kg per day for two days. Daraprim prophylaxis is given in the pre-school clinic.
- XV. Impact  
Not available.
- Problems  
CCCD strategies not applied, external aid required to finance hospital and supervision.
- Strengths  
Autofinancing of health centers, quality and staffing of Personnel, supervision, training.

PEV Bakavu

1. Responsibility of team.

The PEV team is responsible for Bukavu and for 15 zones in South Kivu. The regional responsibilities include consolidating reports from Kindu and Goma. The PEV team participates in a regional development committee and in a committee to prevent malnutrition. Good cooperation exists between PEV and the Regional Medical Inspector.

2. Management

The team has formulated a plan of activities for 1985 which is submitted to Kinshasa for approval. All decisions regarding personnel are referred to Kinshasa.

3. Personnel

The PEV/Bukavu team consists of a regional statistician, secretary, driver and sentinel. The position of team leader is vacant.

The size of the team is insufficient. If another team member was added, they would be able to leave the office for supervision. Salaries of team members are occasionally delayed but this has improved with the system of selling ORS and chloroquine and using receipts to pay personnel..

4. Supervision

Although a plan exists, visits are usually made whenever an opportunity occurs, such as a visit by UNICEF or central personnel of PEV. Reduced staff has prevented adequate supervision. Five zones were visited in 1984.

5. Training

Training courses in PEV/CCCD were held for nurses both in Bakavu and in Uvira, and for Peace Corps volunteers being trained to work in health zones. PEV team members felt inadequately trained in the strategies for diarrheal disease control and malaria treatment.

6. Transport - Transport includes two landrovers (gasoline) only of which works; one land-rover (diesel) and one moto. No gasoline supply exists so only the diesel vehicle is used.

7. Supplies and Stock

Supplies arrive on the average every three months and by the Belgian military flights at no cost for transport. Communication and response by Kinshasa is satisfactory but delivery depends on the schedules of military flights. This resulted in reduced activities only once during 1984.

8. Cold Chain

The team has 3 electric refrigerators which operate well and have sufficient capacity. The stock records and temperature charts were well maintained. Ice chests, cold boxes, and cold packs are adequate for distribution.

9. Finances

The team has sold 10,287 packets in 8 months (7 of 15 zones purchasing) and 7,000 chloroquine in 3 months. The region first used oral rehydration during cholera epidemics, so oral rehydration is readily accepted, but some zones manufacture their own or rely on sugar-salt solutions. Most zones purchase chloroquine elsewhere at a cheaper price.

10. Health Information System

The sentinel surveillance system with 6 posts operates well. Vaccination reports by the 85 medical facilities are sometimes delayed but are eventually collected when the zones come to PEV to pick up vaccine. A checklist of reports received is maintained. A bulletin is distributed every 3 months to all health zones providing feedback.

11. Problems

Inadequate number of team members, supervision was insufficient due to lack of personnel, transport - only one of three landrovers function because no gasoline is available, expressed need for training of team members.

Strengths

Cold chain, management of stock and supplies, quarterly bulletin summarizing PEV/CCCD data and activities.

PEV KINDU

1. Responsibility of team  
The team is responsible for 8 zones in the Maniema sub-region of Kivu with a population of 1 million. Two zones are functioning quite well, a third delivers vaccinations but not integrated primary health care, and 2 other zones have written their plan. All reports by the team are sent both to the Regional team in Bukavu and the central level in Kinshasa.
2. Management  
All decisions regarding personnel and finance are made by Kinshasa. The team has the latitude to determine their activities regarding training and supervision. The team would like authority to engage temporary help when necessary to cover for vacations or illnesses.
3. Personnel  
The team contains of one team leader, one secretary, a driver, and 2 sentinels. This size is adequate.
4. Supervision - The team visited 5 of the 8 zones in 1984. However, most were visited in the last 3 months of the year. Inadequate supplies of fuel restricted planned visits of supervision. Regular visits of supervision are made to all vaccination centers in Kindu. The team was last visited by someone from Kinshasa in 1983.
5. Training  
The team participated in 2 training courses at the zonal level for diarrheal disease control.
6. Transport  
The team has 1 Jeep, 1 Landrover, 2 motos and 2 bicycles. No spare parts were available for the Jeep. Transport was considered adequate but fuel supply was not.
7. Supplies and Stock  
Adequate and well maintained records.
8. Cold Chain  
Two refrigerators (petrol) and one mixed electric-petrol. Cold boxes, ice chests, and cold packs were kept at PEV/Kindu in adequate numbers for regular transport to all centers in Kindu. Inadequate supply of thermometers for distribution.
9. Finances  
The team sold 3,000 boxes of chloroquine and 13,000 SRO during 1984. The system of autofinancing is working well.

10. Health Information System

The sentinel surveillance system of five posts in Kindu works well. All reports had been received for 1984 and the data was available.

11. Problems

Supervision from the central level or regional level is too infrequent, lack of fuel prevented adequate supervision, vehicle was not sent with spare parts, only two zones served by the team have developed primary health care.

Strengths

Management of stock, supplies, cold chain.

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ANNEXE II.D

REGIONS OF BAS-ZAIRE AND HAUT-ZAIRE

REGIONAL LEVEL

1. ORGANIZATION : The Médecin Inspecteur Regional is responsible for the overall coordination and supervision of all health activities carried out in the region. The Regional PEV/CCCD teams are supposed to work in close collaboration with him.
2. INTERSECTORIAL COLLABORATION : None
3. COMMUNITY PARTICIPATION : Community participation in planning is low. With the installation of health committees in the villages, this might increase.
4. AUTOFINANCING : Autofinancing exists in various forms throughout the region.
5. PERSONNEL : Seems to be adequate; but there is need further the use of village health workers.
6. SUPERVISION : Supervision of PEV activities is linked to the problem of transportation + funds. Both in the context of PEV itself and the Regional Medical Inspector's level. In short it is deficient.
7. TRANS PORT : PEV/Regional (Central) should pay/arrange delivery non-expendable items to other echelons, when where necessary.  
  
Other: PEV/Regional could serve as depot for (cheaper) bulk purchases of fuel, spare parts, central repair facility (eg. frigo's), provide temporary replacements (eg. frigo's) and serve generally as intermediary w/garages etc...
8. LOGISTICS AND SUPPLIES : This level was well-supplied and able to provide sub-ordinate units a dependable source of CCD vaccines, ORT packages and of chloroquine. In fact, the very assurance of regular availability enables lower procure smallest quantities, of vaccine at a time and echelons to buy smaller

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quantities, of ORT sachets and of chloroquine with less drain on operating funds and reduced hazards of spoilage; especially in the case of vaccines. While FEV chloroquine prices appear to be more expensive than alternate procurement channels, lower echelons are willing to pay the difference for the sake of the convenience of having steady and immediate access to supplies in quantities reflecting near-time needs. The situation regarding big ticket (vehicles, frigos), hard ware and training supplies is less satisfactory, essentially due to the cost of transportation. The lack of FEV HQ funds shifts this expense to the benefiting level which is frequently unable to defray the transportation costs. In fact, some have difficult to even marshal the "seed" money for the initial purchase of ORT packages and chloroquine.

RECOMMENDATION

- 1. If necessary, CP funds be used for the transportation cost of supplying FEV echelons with larger items. These are note recument costs but l-shot inputs.
- 2. Consider an arrangement under which FEV Regional levels can extend initial credits for the purchase of ORT packages and chloroquine by installations without start-up funds.

9. INFORMATION SYSTEM

: Weak surveillance systems are often internally inconsistent and reporting is often not timely. Reporting furniture should be reviewed at Inspect. Med. level for integration with other (sub) regional health reporting requirements.

10. TRAINING

: Training was perceived as meak. This clearly represents a major constraint towards achievement of FEV/CCD objectives. The lacuna range from a lack of funds to the absence of materials and more important to a lack of trainers and to a systematic approach to this project component. These deficiencies must be addressed urgently.

The entire regional functions require review and reorganisation. The following recommendations include facets to be considered.

RECOMMENDATIONS

1. MD's training requires a "prestige" trainer, not a RN. MD's should not receive their training/familiarization together with lower-level professionnels (eg. joint 4 day courses).
2. Training, once accomplished, of subordinate echelons requires follow-up, monitoring, correction, up-grading etc... The feasibility of adding a circuit riding trainer at Reg/Sub-regional levels should be closely examined including the utilization of qualified Peace Corps Volunteers.
3. FEV/Kinshasa needs to step up the distribution of training materials and be responsive to field requests.
4. Clarification is needed re who pays what in the context of training costs.

RECOMMENDATIONS

- : 1) Integrate FEV/CCCD training into community health activities.
- 2) FEV/Regional to provide lectures + lecturing materials.
- 3) Review possibility of entrancing community/village health workers' status by providing them some drugs (e.g. chloroquine/aspirin) for distribution/sale.

11. HEALTH EDUCATION

- : This element requires considerable strengthening. We saw few indications of a systematic approach to the integration of FEV/CCCD training into general community health activities (to the extent of their existence).

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12. UTILIZATION

: The number of vaccinations done in 1984 is as follows:

	<u>HAUT-ZAIRE</u>	<u>BAS-ZAIRE</u>
B C G ·	49.518	58.910
D T C 1	59.489	47.264
D T C 2	30.544	40.754
ROUGELE	29.030	62.745
FOLIO 1	57.894	46.380
FOLIO 3	27.712	39.971
A. T. 1	44.216	22.007
A. T. 2	36.551	33.334

13. OPERATIONAL RESEARCH SURVEYS : No indication of activities found.

RECOMMENDATION

: CDC's unique competency in this area should be more exploited, eg. by requesting short term assistance for specific activities under this heading.

REGIONS OF BAS-ZAIRE AND HAUT-ZAIRE

Health Zone and Health Center levels

1. ORGANIZATION : Services in the zones were commonly delivered at a "Hôpital de Référence" in rural areas and at a "Polyclinique" in urban. The health posts were the most rudimentary delivery points. Supervision was provided at the posts with wide variation on method and frequency. FEV/CCD impact appeared with on supporting supervision. Curative services still seem to overshadow preventive in most places. Village health workers were not common (2 centers has 0 and few had plans to use or train any). This leaves zones, HC's without a systematic means of outreach to deal with epidemics, preventive medicine and hygiene efforts, community water supply and sanitation. These health workers are now usually poly thus the question arises as to FEV role i.e., primary ? or supportive to organizers of RHZ in developing VHN.
2. INTERSECTORAL COLLABORATION : None.
3. COMMUNITY PARTICIPATION : Appears to be low.
4. FINANCE : Autofinancing was reported by all zones and health centers. Reports of income ranged from 120,000 to 800,000 Z's per year. One center had a surplus of \$1000 for 1984. Money was collected and accounted for in various ways. The most common method was a (tariff) for each episode of illness, including medicines or laboratory. Unique "carte d'avance" system and several "cotisation" schemes were reportedly successful. People were willing to pay for vaccinations, prophylaxie chloroquine. Recovery of cost for all medications, some salaries, carburant and training was common.

RECOMMENDATIONS

- : 1. This important issue should be the subject of an Operational Research study. The basic methods used should be described and shared with all zones as soon as possible.
- 2. FEV/CCCD should prepare some standards for financial management for the zones and HC's which guard against theft and corruption.

5. PERSONAL

- : There is a need for having more village health workers.

6. SUPERVISION

:

7. TRANSPORT

:

8. LOGISTICS AND SUPPLY

- : The supply of vaccines, SRO packets, and chloroquine was found to be well done. Supplies are now stable and consistent. No program of CCCD had to be interrupted because of a breakdown in the provision of the above. Furthermore, many zones were taking advantage of 1) lower price, 2) regular supply, 3) used local currency no foreign exchange, 4) smaller stock on hand. Equipment is not being delivered to the zones or health centers by CCCD due to requirement for zone level financing of transportation costs. This was reported last year by Mackinen and Foster (Mar '84).

RECOMMENDATION

- : Use of CCCD Project funds on AID-PL480 counterpart funds for transport of equipment to zones.

ALTERNATE SOURCES

- : Several zones currently purchasing from Europe and elsewhere indicated an interest in purchasing from FEV. Several also receive drugs from UNICEF and FOMETRO.

RECOMMENDATION

- : Promote purchases from FEV more aggressively.

9. INFORMATION SYSTEM

: No surveillance systems were noted. Several zones and sub regional offices collected health-epidemiologic utilization, coverage and other data. There were vast differences in interpretation of the EEV reporting requirements and little consistency of differentiating formulas for calculation. No one reported EEV support in this area.

RECOMMENDATION

: Develop a model reporting system and make regional bureaus responsible for implementation support and completion of data from health zone reporting systems.

10. TRAINING

: The training of Medecin Chef de Zone was found to be very useful. There is still a large unmet need for training and continuing education of MCZ's. A few MCZ's have not had EEV training. Very few MCZ's have implemented training of nurses and village health workers. Some nurses training was being done by the regional EEV. The Training Fiche Techniques were not generally available in the region or the zone. The adequacy of the training for supervisory HQRN's and MD's and ACV's must be questioned if their compliance with EEV recommendations are a reflection of the success of the training. It is noted that neither the EEV or MCZ have been trained in teaching methods.

RECOMMENDATIONS

1. More training of MCZ and infirmier to regional level and include
  - 1) didactic re: CCCD diseases
  - 2) Clinical - ORT
  - 3) Teaching Methodology
  - 4) Health education - preventive
2. Other consultant to deal with teaching and training methodology.

11. HEALTH EDUCATION

: There was limited evidence of CCCD/PEV generated health education. A few AEGICHE were noted, as well as two "bofte d'images". Worse, what was provided focused making solutions on treatment of existing diarrhea-dehydration and there was nothing on causes and prevention of diarrhea diseases.

RECOMMENDATIONS

1. Attempt to action on health education plan and strategy, recommended by CCD Health education consultant.
2. Prevention of D.D. - H. Ed. material.

12. SURVEYS AND OPERATIONAL RESEARCH

: No information on surveys or operation research was obtained. The group recommends the following potential operation research topics for study.

RECOMMENDATIONS

1. Auto-financing of PEV interventions.
2. Factors in decreasing use of IV fluids when SRO is appropriate and available.
3. Home use of S.S.S.

ZONE OF LUKULA

1. ORGANIZATION : The zone has a reference hospital and 14 health centers and posts with 6 of them operational. It is not clear how vaccines are distributed.
2. INTERSECTORAL COLLABORATION : None.
3. COMMUNITY PARTICIPATION : Community not involved in planning.
4. FINANCE : The centers collect fees for services and drugs and report these monthly to the MCZ, SRO sells for 4 Z, Chloroquine 0,50 Z; vaccination cards 10 Z. The zone collected 120.000 Z in 1984 which paid for drugs, personal, kerosene for refrigerators. The hospital loaned money for buying the first supply of medicine for the health centers.
5. PERSONAL : Appears adequate.
6. SUPERVISION : Supervision is virtually non-existent due to lack of transport.
7. TRANSPORT : No transport available.
8. MATERIALS AND EQUIPMENT : Vaccines, SRO, Chloroquine and vaccine carriers are available. The distribution system for these items is not clear.
9. INFORMATION SYSTEM : Only one center sends reports regularly to the zone. Reports from other centers are expected for January 1985 since EEV began in 1984. No morbidity or mortality data were available.
10. TRAINING : The MCZ was trained in August 1984. The nurses were trained by PEV.
11. HEALTH EDUCATION : Some health education is done not difficult to get reliable information.
12. UTILIZATION : It is estimated that 40% of the population has access to immunization, 70% have access to ORT and antimalarial therapy. Vaccine coverage in the city of Lukula ranged from 17% for measles to 47% for DPT.

ZONE OF YAKUSU

1. ORGANIZATION : The limits of the zone have not yet been defined. It pursues immunization by the use of mobile teams.
2. INTERSECTORAL COLLABORATION : None.
3. COMMUNITY PARTICIPATION : Health committees exist.
4. FINANCE : It has a good system of autofinancing curative and preventive services. The model is worthy of further study and perhaps replication. The system features the use of a "carte d'adhérence", a sliding fee schedule, and a record keeping cross-check for providers, supervision and health committees.
5. PERSONAL : Appears adequate, their knowledge of PEV/CCCD could not be assessed.
6. SUPERVISION : Seems to be done to some extent. How satisfactory it is could not be assessed.
7. TRANSPORT : Transport exists and seems to be adequate for activities carried out.
8. MATERIALS AND EQUIPMENT : Vaccines, ORS and Chloroquine are obtained from PEV/CCCD.
9. INFORMATION SYSTEM : It is deficient and defective. SANRU or PEV should provide assistance for this activity.
10. TRAINING : MCZ has not been trained and does not seem to be interested in PEV/CCCD training.
11. HEALTH EDUCATION : Is not done.
12. UTILIZATION : No estimate is available.
13. SURVEYS AND OPERATIONAL RESEARCH : Not done.

REGION DE BANDUNDU

INTRODUCTION

: La Région de Bandundu (4.000.000 hab.) comprend deux équipes PEV/CCCD installées respectivement dans la ville de Bandundu et dans celle de Kikwit. L'équipe d'évaluation a visité l'équipe régionale installée à Bandundu.

38 Zones de Santé ont été récemment délimitées. 18 parmi elles sont estimées fonctionnelles, dont 6 situées dans l'aire de l'équipe de Bandundu.

Dans l'ensemble, les soins de santé sont gérés par les missionnaires et l'Etat; une seule zone de santé appartient à une société.

L'équipe d'évaluation a visité les lieux et rencontré les personnes ci-après:

BANDUNDU

1. Dr EKWANGALA MOSIANA, Médecin Inspecteur
2. Citoyen BWANAMDO GO, Superviseur Régional EEV
3. Dr BODART, Médecin Chef de ZSU de Bandundu
4. Citoyenne ABULEBE, Titulaire de CS Lwani-Salaminta

BOKORO

5. Dr. MBI, Médecin affecté à l'Hôpital de Bokoro et remplaçant le Médecin Chef de Zone absent;
6. Citoyen KABONDO MBEJ, Infirmier titulaire du C.S. Kempa;
7. Citoyen MOMBIE IYENDA, Infirmier titulaire du C.S. de Nsanga-Nsanga;
8. Citoyen , Gouverneur de la Région de Bandundu

ORGANISATION DES SOINS DE SANTE : Comme dit plus haut, certaines composantes des SSP ont été intégrées dans les dispensaires et Centres de Santé, d'Etat ou des Missions, de 18 Zones de Santé sur 38 qui existent dans la région.

Les activités qui ont été intégrées sont les suivantes: les CFS, CPN, LMD, PALU, EPS et N.D. Elles sont sous le contrôle direct des médecins chefs des zones, celles-ci étant des entités juridiques compétentes.

COLLABORATION INTERSECTORIELLE : Elle existe, notamment au niveau régional avec le Service de l'Environnement et de l'hydraulique rural, mais a besoin d'être promue aux autres niveaux, c'est-à-dire les Zones et les Centres de Santé.

LA PARTICIPATION DE LA COMMUNAUTE: La population participe réellement aux activités PEV-CCCD, et pour cause, l'équipe a noté l'existence d'un comité de santé dans tous les Centres de Santé visités. Bien plus, elle contribue à l'autofinancement de divers services offerts aux Centres de Santé.

LES FINANCES : Le système d'autofinancement a été compris et accepté par la population et permet aux différentes structures de bien fonctionner. Cependant, l'équipe PEV-CCCD est dotée d'un budget insuffisant, ce qui réduit le nombre annuel de supervisions à cause du manque de carburant et vu les grandes étendues qu'il y a à parcourir. De plus, elle ne peut assurer l'extension des activités à d'autres Zones et Centres de Santé par manque d'un fonds de départ.

LE PERSONNEL : Au niveau régional, L'équipe PEV-CCCD souhaiterait avoir deux chefs d'équipe sous-régionaux, un pour Bandundu et un autre pour Kikwit, en vue de remplacer ceux qui ont été licenciés. Au niveau des Centres de Santé visités, deux ont accusé une carence en personnel. Un infirmier titulaire d'un centre devait vaguer aux activités d'un travailleur avant de se mettre à ses propres tâches.

LES STRUCTURES

: Nous pouvons les résumer dans l'organigramme suivant:

LA SUPERVISION

: Elle est effectuée à tous les niveaux. Au niveau régional, le médecin inspecteur effectue des tournées de supervision en compagnie du superviseur régional de l'équipe PEV-CCD. Au niveau des Zones, les médecins chefs de Zone font la supervision une fois par mois, et au niveau des Centres de Santé, des visites se font dans la mesure du possible dans les Collectivités. L'équipe régionale du PEV-CCD souhaiterait qu'il ait une formation des médecins sous-régionaux et des infirmiers superviseurs au niveau des Zones de Santé en vue de les faire participer dans les activités de supervision surtout lorsque leurs chefs hiérarchiques ne sont pas présents.

LE TRANSPORT

: Les moyens de transport existent, mais il y a un manque chronique de carburant.

APPROVISIONNEMENT DE L'EQUIPE  
ET DU MATERIEL

: D'une façon générale, l'équipe d'évaluation n'a pas constaté de gros problèmes, néanmoins certains Centres de Santé exhibaient de très faibles quantités de matériels de vaccination, tel que les seringues et les aiguilles.

SYSTEME D'INFORMATION

: - Déclaration de routine: l'équipe reçoit la totalité des rapports (100%).  
- Déclaration des postes sentinelles: si nous considérons la date du début de l'intégration des activités CCCD, c'est-à-dire depuis 6 mois, la déclaration est optimale (100%).  
- Enquête spéciales: aucune.

FORMATION

: Au niveau régional, une conférence sur la promotion des Soins de Santé Primaires regroupant une cinquantaine de médecins s'est tenue à Bandundu du 22 au 25 octobre 1984. Le Médecin Chef de Zone de Bandundu a dispensé un enseignement en cours d'emploi à 25 participants, infirmières A<sup>3</sup> depuis le début de l'intégration des activités. Il a également pu assurer jusqu'en janvier 1985, la formation de 6 infirmières accoucheuses de niveau A<sup>3</sup>.

EDUCATION SANITAIRE

: De façon générale, le matériel d'Education Sanitaire fait complètement défaut. Néanmoins, de timides séances d'Education Sanitaire ont lieu lors des EMI.

RECHERCHE OPERATIONNELLE

: Aucune.

INDICES D'UTILISATION DES SERVICES:

A) Couverture P. E. V.\* en %

**ANTIGENE** : 4.5.1984  
**B.C.G.** : 67  
**D.T.C. 1** : 49  
**D.T.C. 3** : 35  
**FOLIO 1** : 49  
**FOLIO 3** : 40  
**V.A.R.** : 40

\* Zone de Bandundu

Vaccins distribués par l'équipe EVV/CCD - Bandundu en 1984

<u>ANTIGENE</u>	<u>DOS ES RECUES</u>	<u>DOS ES DIS TRIBUEES</u>
B. C. G.	50.000	42.580
D. T. C.	50.000	41.640
POLIO	50.000	42.020
ROUGEOLE	40.000	32.110
V. A. T.	50.000	41.840

B) SRO et Chloroquine en 1984

	<u>RECUS DIS TRIBUES</u>	
- Sachets S.R.O.	28.000	16.130
- Comprimés chloroquine	199.650	14.000

REMARQUE

: Concernant l'impact du programme CCD, nous pensons qu'il faudra attendre quelques années encore afin de voir le rayonnement des résultats des activités sur la santé globale du peuple Zaïrois.

ANNEXE II.F

RAPPORT D'EVALUATION DE LA REGION DU SHABA

Principales observations et recommandations

1. L'avancement des activités de vaccination dans le rayon d'action du PEV/CCCD-Lubumbashi est montré dans le tableaux X repris en annexe. Le progrès réalisé est relatif au nombre de vaccinations effectuées, au taux d'achèvement des vaccinations DTC et VAP et à la proportion des enfants vaccinés avant leur première année. Quant aux activités IMD, elles s'étendent progressivement dans les formations médicales qui ont déjà introduit les vaccinations (90): actuellement 39 parmi elles s'approvisionnent en sachets SRO auprès de cette équipe.
2. Les responsables des grandes sociétés d'Etat visitées au Sud-Shaba ainsi que ceux de Pédiatrie Sociale de la Faculté de Médecine de Lubumbashi, paraissent motivés quant à l'intégration des activités de médecine préventive et promotionnelle (en particulier les activités de programme CCD). Ils reconnaissent en ce qui concerne les activités CCD, "L'autorité technique" du P. E. V.
3. Recycler davantage des médecins dans la région du Shaba, sans négliger ceux des sociétés importantes comme la GECAMINES, la SNZ, la SODMIZA et la Clinique Universitaire. En particulier le Médecin Responsable de la CEESA, le Médecin Superviseur du Centre de Santé Ruashi.
4. Le Médecin Inspecteur Régional ne joue pas son rôle en tant qu'autorité sanitaire régionale. Surtout dans le sens d'orienter les différents intervenants dans l'application de la nouvelle politique zairoise en matière de santé. Le Comité régional de santé mis en place l'an dernier ne se réunit plus depuis plusieurs mois.
5. L'équipe régionale PEV/CCCD-Lubumbashi, composée d'un personnel motivé et dynamique, ne reçoit pas tout les appuis nécessaires de la direction PEV/CCCD, notamment en ce qui concerne l'approvisionnement en carburant et la disponibilité de fonds pour lui permettre d'assurer des tournées de prospection, de supervision des activités et de formation du personnel. Ce dynamisme était montré par le plan d'action pour l'année 1985, formulé par l'équipe indépendamment de la direction centrale.
6. Peut-être il serait mieux que la direction centrale approvisionne l'équipe PEV/CCCD-Lubumbashi en carburant durant la saison des pluies pour qu'il n'y ait pas de rupture de stock en saison sèche.
7. L'équipe PEV/CCCD ne semble pas bien assurer la diffusion des informations techniques relatives au projet, notamment auprès des grandes sociétés et de l'Université.
8. Il a été remarqué que la participation de la population sur le financement des activités de vaccination et TRO (par l'achat respectivement des cartes de vaccination et de sachets SRO) est généralement répandue et bien acceptée.

9. Le Service Pédiatrie Sociale de la faculté de Médecine de L'Université de Lubumbashi est bien avancée dans la conception et la réalisation des messages éducationnels relatifs au CCCD. Ces messages sont diffusés sous diverses formes, notamment par de petites scenettes (avec troupes théâtrales professionnelles), et des chansons.
10. Le projet PEV/CCCD doit entreprendre les démarches nécessaires pour assurer l'enregistrement des chansons éducatives et des scenettes mises au point à Lubumbashi en vue de leur diffusion à une plus large échelle.
11. Le projet doit également assurer un appui technique et logistique au Centre hospitalier de Rwashi pour y développer véritablement une Zone de Santé.

#### TEXT

#### INTRODUCTION

: La Région du Shaba compte 3 équipes PEV/CCCD basées à Lubumbashi, Kalemie et Kamina. L'équipe d'évaluation a visité seulement l'équipe PEV/CCCD-Lubumbashi, les deux autres étant d'accès difficile à partir de Lubumbashi.

PEV/Lubumbashi a la charge de 3 sous-régions administratives urbaines (Lubumbashi, Kolwezi et Likasi) et 2 sous-régions administratives rurales (Lualaba et Haut-Shaba). Dans ces 5 sous-régions administratives, une seule zone de santé est fonctionnelle et est située à une journée de route de Lubumbashi. Notons que PEV/Kamina supervise la sous-région du Haut-Lomami où existe une zone de santé fonctionnelle distante de 3 jours de voyage de Lubumbashi et PEV/Kalemie les sous-régions de Tanganika avec 2 zones de santé fonctionnelles distantes de 2 jours de voyage.

L'équipe d'évaluation a eu à visiter les lieux et rencontrer les personnalités ci-après mentionnées:

#### 1. Inspection Régionale de la Santé

- Dr LYAGABO, Médecin Inspecteur Régional
- Mr BARKER BRAD, Superviseur Adjoint PEV/CCCD-Shaba
- Citoyen BUKASA MUSUAMBA, Chef d'Equipe PEV/CCCD-Shaba

2. Dispensaire de KATUBA
  - Citoyen KANYIMBO, titulaire de Dispensaire
3. Hôpital SENDWE (GECAMINES)
  - Dr MBUYU
4. Clinique Universitaire de Lubumbashi
  - Professeur TALLYRAND
5. Centre de Santé de Rwashî (Université de L'bshî)
  - Dr TSHIULA
  - Dr LUBUYA
6. Centre de Santé de MUSOSHI (SODIMIZA)
  - Dr NAWEZI, Médecin Directeur
7. Centre de Santé de Masaidiano
  - Sr MARIE RAPHAEL, Titulaire de Dispensaire
  - Sr MUILA ILUNGA
8. Clinique SN CZ
  - Dr NJLOKO, Directeur Médical
  - Dr ALLEGRE, Chef de EMI
  - Cit
9. Centre Nutritionnel de RWASHI
  - Père BERNARD ANDRE
  - Citoyenne

ORGANISATION DES SOINS DE SANTE : Les grands intervenants dans le système des soins de santé dans le sud du Shaba sont constitués par les importantes sociétés d'Etat, à savoir la GECAMINES, la SN CZ, la SODIMIZA. En outre, la faculté de Médecine de l'Université de Lubumbashi joue un rôle non-négligeable dans l'application du concept des soins de santé primaires. Il en est de même des missionnaires. Les formations médicales étatiques ont un rôle minime.

L'intégration des activités SSP auprès des différents intervenants se présente de la manière suivante:

	GECAMINES	SN CZ	SODIM IZA	MISSIONAIRES	UNIVERSITE	ETAT
C P S	-	+	+	+	+	+
CPN	-	+	+	+	+	-
N D	+	+	-	-	+	-
P E V	+	+	+	+	+	+
L M D	+	-	-	+	+	-
PALU	-	-	-	-	-	-
Curatif.	+	+	+	+	+	+
Ed. Sanit.	-	+	-	+	+	-

Au Shaba, l'application de la stratégie des SSP basée sur les zones de santé n'est pas encore réalisée. La région n'est pas encore délimitée. Une proposition de délimitation soumise au Département de la Santé par le Médecin Inspecteur Régional a été rejetée parce qu'elle a été faite sans tenir compte des normes établies par le Département. C'est ce qui explique les contraintes à l'expansion des activités CCOD dans la région.

Les différents intervenants n'ont pas encore intégré toutes les composantes dans la mesure où ils n'ont pas été intéressés à assurer les stratégies des SSP telles que mises au point par le Département de la Santé. Il semble que la politique nationale n'a pas clairement défini le rôle des privés et des sociétés dans l'organisation des zones de santé. Pour les composantes déjà intégrées, les différents responsables rencontrés mentionnent l'effort déployé par le EEV/CCOD Régional pour leur implantation (surtout pour les CPN, CES, EEV, LMD, ...).

COLLABORATION INTERSECTORIELLE : Elle n'existe pratiquement pas.

LA PARTICIPATION COMMUNAUTAIRE : D'une façon générale, la population participe avec enthousiasme aux activités EEV/CCOD, contribue même à l'autofinancement des services en payant les cartes de consultation de nourrissons, les vaccinations par endroit, et les sachets de SRO. Cependant, l'équipe d'évaluation n'a pas pris connaissance de la création éventuelle d'un comité de santé.

FINANCES

- : L'équipe EEV/CCD est dotée d'un budget insuffisant, ce qui ne lui permet pas d'assurer la prospection et la supervision dans son rayon d'action, notamment à cause du manque de carburant.

Pour ce qui est de sociétés, les différentes composantes des SSP, de même que leur supervision, sont fortement subventionnées par elles, même pour le carburant. Le système d'autofinancement a été compris et apprécié par les missionnaires, contrairement aux sociétés qui donnent presque tout gratuitement. Le seul centre de l'Etat que l'équipe a pu visiter n'avait plus de recettes pour assurer son reapprovisionnement en SRO, alors qu'on avait vendu des sachets offerts par le EEV.

LE PERSONNEL

- ; Au niveau régional, l'équipe EEV/CCD souhaite avoir un 2ème secrétaire, car celui qui est en place est débordé par le travail des statistiques et rapports mensuels exigés par la Direction Centrale. Probablement son besoin se ferait moins sentir, si l'on parvenait à modifier quelques éléments dudit rapport. Dans les sociétés, le problème de personnel ne se pose pas, il y a même pléthore de personnel. Au niveau des dispensaires d'Etat et des missionnaires, le personnel est pléthorique, mais le Département de la Santé n'a pas encore pu nommer un médecin chef de zone pour le suivi de leurs activités.

SUPERVISION

- : La supervision est partiellement assurée par l'équipe EEV/CCD; les contraintes sont énumérées plus haut. Notons qu'il y a une carence quasi-totale de supervision aux autres niveaux de système de santé, à savoir le Médecin Inspecteur et le Médecin Chef de Zone.

TRANSFERT

- : Les moyens de transport sont présents, mais il manque de carburant. Peut-être serait-il mieux que le niveau central les

approvisionne suffisamment durant la saison des pluies pour qu'il n'y ait pas de rupture de stock en saison sèche, ce qui serait préjudiciable aux visites de supervision.

APPROVISIONNEMENT DE L'EQUIPMENT  
ET DU MATERIEL

: Il ne se pose aucun problème.

SYSTEME D'INFORMATION

- : - Déclaration de routine: l'équipe reçoit presque la totalité des rapports (97 %).
- Déclaration des postes sentinelles: elle se fait à la grande satisfaction de l'équipe (100 %).
- Enquêtes spéciales: aucune.

FORMATION

: En 1984, l'équipe EVV/CCCD a effectué les activités de formation suivantes:

<u>S/Région</u>	<u>Nbre Personnel</u>	<u>EVV</u>	<u>IMD</u>
Lubumbashi	12	x	x
Likasi	0	-	-
Kolwezi	29	x	x
Lualaba	0	-	-
Haut-Shaba	0	-	-
Tanganika	1	x	x
Rép. Centrafricaine	1	x	x
TOTAL :	43		

60 étudiants en éducation sanitaire à l'école EVV/CCCD  
60 étudiants en IMD à Lubumbashi (séminaire).

EDUCATION SANITAIRE

: Quelques intervenants sont bien avancés dans la conception et la réalisation des messages éducationnels, notamment le service de Pédiatrie sociale de la faculté de Médecine de l'Université de Lubumbashi pour les petites scenettes théâtrales, les affiches, et les chants: et le Centre Nutritionnel de Rwashî et la Clinique SNCZ pour les chants.

RECHERCHE OPERATIONNELLE

: Aucune.

INDICE D'UTILISATION DES SERVICES: A) Couverture P. E. V.

Couverture atteinte en % à:

	L'shi en:		Likasi en:		Kolwezi en:	
<b>Antigènes</b>	7/83	6/84	8/81	11/83	7/82	11/83
V A R	71	64	74	23	74	13
B C G	89	92	87	67	34	51
DTC 1	86	78	44	41	47	20
2	79	73	37	33	44	12
3	69	64	26	24	41	8
VAP 1	86	78	44	42	47	19
2	78	73	36	33	44	11
3	69	64	27	24	41	8
ECV*	58	56	20	12	10	6

Vaccine distribués par l'équipe PEV/CCCD-Lubumbashi en 1984

Antigène	Doses reçues	Doses distribuées
BCG	130.000	113.250
VAT	100.000	102.620
DTC	135.000	152.020
VAP	135.000	158.020

B) SRO et Chloroquine

En 1984 : SRO (sachets) : 51.139 reçus; 41.215 distribués  
Chloroquine  
(comprimés) : 100.000 reçus; 6.000 distribués

\* ECV = Enfants complètement vaccinés

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ANNEX 1

Vaccinations pratiquées en 1984 par dose et par Zones

Antigène	Age/Dose	Lubumbashi	Recyclées	Non recyclées	Totaux
B.	0-11 mois	19.644 (66%)	10.113 (68%)	20.702 (69%)	50.459 (68%)
C.	1-14 ans	9.979	4.738	9.322	24.039
G.	Total	29.623	14.851	30.024	74.498
V.	9-11 mois	13.255 (86%)	6.682 (57%)	12.067 (52%)	32.044 (63%)
A.	12-24 mois	2.026	4.575	8.074	14.857
R.	24 et plus	205	366	3.205	3.776
	Total	15.486	11.805	23.346	50.637
D.	1 <sup>è</sup> dose	19.378	13.003	21.913	54.294
T.	2 <sup>è</sup> dose	16.444	8.744	16.917	42.105
C.	3 <sup>è</sup> dose	14.264	3.182	12.671	30.117
	Total	50.086	24.929	51.501	126.516
	T. A.	74%	24%	58%	55%
P	1 <sup>è</sup> dose	19.140	11.072	21.159	51.371
O	2 <sup>è</sup> dose	15.941	8.718	16.545	41.204
L	3 <sup>è</sup> dose	13.948	2.682	11.982	28.612
I	Total	49.029	22.472	49.686	121.187
O	T. A.	73%	24%	57%	56%
V.	1 <sup>è</sup> dose	18.987	5.665	17.991	42.643
A.	2 <sup>è</sup> dose	12.348	3.889	10.430	26.667
T.	Total	31.335	9.554	28.421	69.310

(1) T. A. = taux achievement

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ANNEX 2

Tableau comparatif des vaccinations faites en 1983 et 1984

Antigène	Group d'age/ doses	1983	1984	Variation	
				Nombre	%
B.	0-11 mois	33.134	50.459	+ 17.325	+ 52
C.	1-14 ans	25.178	24.039	- 1.139	- 4
G.	Total	58.312	74.498	+ 16.186	+ 28
V.	0-11 mois	23.111	32.004	+ 8.893	+ 38
A.	12-24 mois	12.590	14.857	+ 2.267	+ 18
R.	24 et plus	5.474	4.776	- 1.698	- 31
	Total	41.175	50.637	+ 9.462	+ 23
D.	1 <sup>è</sup> dose	35.968	54.294	+ 18.326	+ 51
T.	2 <sup>è</sup> dose	25.741	42.105	+ 16.364	+ 64
C.	3 <sup>è</sup> dose	21.233	30.117	+ 8.884	+ 42
	Total	82.943	126.516	+ 43.574	+ 53
V.	1 <sup>è</sup> dose	32.676	51.371	+ 18.695	+ 57
A.	2 <sup>è</sup> dose	24.595	41.204	+ 16.609	+ 68
P.	3 <sup>è</sup> dose	21.282	28.612	+ 7.330	+ 35
	Total	78.553	121.187	+ 42.634	+ 54
V.	1 <sup>è</sup> dose	15.627	42.627	+ 27.016	+173
A.	2 <sup>è</sup> dose	13.834	26.667	+ 12.833	+ 93
T.	Total	29.461	69.310	+ 39.849	+135

ANNEXE II.G

RAPPORT D'EVALUATION DE LA REGION DU KASAI ORIENTAL

RECOMMENDATIONS:

1. According to the current structure of the project, the regional PEV/CCCD teams link the vertical and horizontal aspects of the project. This regional linkage is critical. In order for the PEV/CCCD project to meet its objectives. It needs to be the strongest part of the PEV/CCCD organization.

We feel that this linkage is very weak in the Kasai Oriental region. We believe it is one of the factors inhibiting PEV/CCCD operations in the region.

To strengthen this regional PEV/CCCD linkage we recommend that:

- 1) PEV/CCCD define fully and clearly the function of the regional team.
  - 2) PEV/CCCD insure that regional personnel have adequate training and seniority to implement the functions as defined.
2. Regional teams are required to submit a work plan to the central office at the end of each year to budget and plan their next year's operations.

These plans should be reviewed and approved with or without amendments, and resources need to be made available for their implementation. Provision should be made for regional personnel to spend at least 15 days per month in the field.

Criteria to prepare work plans by the regional teams need to be developed.

3. Considering the financial constraint faced by many health zones, PEV/CCCD should insure in-country transportation costs of all materials to the closest regional depot in the region.
4. An expansion program should be developed in each region. Priority should be given to zones with PHC activities in place.
5. More training should be given in the technical aspects of ORT and malaria prophylaxis and treatment. Training is also needed for Medecin Chef de Zones in areas of program planning, and financial and commodity management .

6. Follow-up visits from central level personnel are necessary to assist newly trained Medecin Chefs de Zone to initiate PEV/CCCD activities in their zones.
7. Supervision should provide opportunity to reinforce technical competence in vaccination schedules, ORS, SSS composition, and other technical aspects of PEV/CCCD activities. Standardized supervision mechanisms should be developed and implemented.
8. Information collected by PEV/CCCD should be clearly defined. Emphasis should be on the collection of simple and easily available data necessary for program monitoring and planning.
9. Regional teams should study zone by zone the possibility to provide refrigerators at strategic points to reduce difficult transportation problems. The regional office should accent the provision of more syringes, needles and cold chain spare parts.
10. PEV/CCCD should accelerate efforts to provide ORT health education materials, and training in their use, to health zones and health facilities. Health education efforts should be focused as well on PEV and malaria aspects of the project.

REGION OF KASAI ORIENTAL:

12 zones out of 23 in the region carry out PEV activities. 8 zones deliver a full range of PEV/CCCD services. Vaccinations are carried out at fixed centers, outreach sites and by mobile teams. Chloroquine is available throughout the region. Chloroquine prophylaxis for pregnant women is recommended by some health facilities. ORT is known throughout the region. ORS distribution is not widespread.

1. Organization:

Under the direction of a dynamic Medecin Inspecteur de Region, a Comité Regional de Bien-Etre was recently established by law to coordinate health activities in the region. PEV/CCCD is well integrated into this structure. Ranges of PHC services offered, quality of services delivered and PEV/CCCD program planning vary throughout the region in relation to resource availability and levels of PHC activity within respective zones.

2. Intersectoral Collaboration:

The Regional Comité de Bien-Etre will coordinate actions among the Departments of Education, Condition Feminine, Agriculture and Social Affairs.

3. Community Participation:

Village health and development committees exist throughout the region. Their actual participation in program planning is minimal.

4. Finance:

Financial support from missions, the private sector and donor organizations to health zones and facilities is not evenly distributed in the region. Different approaches to auto financing of PHC activities include drug sales, CPS/CPN card sales, consultation card sales, consultation fees, and supervisory taxes on health centers. Money received is used to pay salaries, operate cold chains, pay transport costs, refurbish supplies, and pay incentive bonuses. Depending on the approach and situation, auto-financing supported 25-100% of program costs.

5. Personnel:

Many health personnel are paid irregularly or insufficiently in the region, leading to low moral and productivity. A need exists in some areas for training in vaccination schedules and technologies, ORT/ORS, program planning and supply management.

6. Supervision:

PEV/CCCD supervision within regional zones varied in direct relation to available resources. Constraints to supervision included fuel availability, logistics and road infrastructure, the level of support given to PEV/CCCD activity by individual Medecin Chef de Zones, and regulation from central PEV/CCCD office. Standardized supervision procedures, checklists and feedback mechanisms are not widely utilized in the region.

7. Transport:

In functioning health zones, PEV/CCCD has judiciously added appropriate bicycles, motorcycles and vehicles to compliment existing resources. Road conditions and recurrent costs from fuel, repair, maintenance and replacement are constraints to transport.

8. Materials and Equipment:

In functioning health zones, supplies of PEV/CCCD materials and equipment generally seem to be adequate. More refrigerators could be positioned to extend cold chains. Cold dogs and vaccine carriers were scarce in a few places. More needles and syringes could have been distributed if mention had been made by PEV/CCCD about their availability. Program expansion to poorer zones will be limited by PEV/CCCD insistence that zones pay equipment transport costs from Kinshasa or regional capitals. In some zones, training in management and supply of PEV/CCCD materials is needed.

9. Information System:

92% of PEV/CCCD reports from postes sentinelles were received in 1984. From January to July of 1984, 87% of monthly vaccination reports were received. Information is not collected to permit program planning and evaluation of ORT and malaria activities. Disease incidence and morbidity and mortality information is not available at the regional level.

10. Training:

In functioning health zones visited, at least one Medecin Chef de Zone was trained by PEV, SANRU, or Santé Pour Tous. All had organized training sessions for zones staff. In many areas, in-service training is carried out on a regular basis. Technical training updates are still necessary. PEV/CCCD fiches techniques were not always present at health facilities to back up technical training.

11. Health Education:

Health education materials in various forms were available throughout the region. There was no particular focus on PEV/CCCD activities, except in some facilities where PEV/CCCD health education materials for ORT were available.

12. Utilization:

Within the 4 zones visited (one being urban), 69% of the population had access to PEV/CCCD services. Measles vaccination coverage (0-11 months) in the zones visited was 35%. Coverage for third dose of polio was 40%. DTP third dose coverage was 39%.

Zone of Bonzola:

Urban health zone of Mbuji Mayi composed of 7 health centers, 4 of which are run by a privately financed mining company (MIBA). Vaccinations carried out at fixed centers and outreach sites. Chloroquine and ORS available in all health centers. Chloroquine prophylaxis for pregnant women recommended.

1. Organization:

Range of PHC services adequate. All PEV/CCCD services offered. Quality of services good. Good program planning.

2. Intersectoral Collaboration:

Good, involving agriculture and community development.

3. Community Participation:

High. Development committees exist and meet on regular basis.

4. Finance:

4 out of 7 health centers in zone totally financed by MIBA and offer free services. Non-MIBA residents pay fee for service. MIBA offers significant budgetary support.

5. Personnel:

Highly motivated. Technically competent. Well paid. Adequate in number.

6. Supervision:

Regular and standardized in MIBA centers. Inadequate supervision in non-MIBA centers due to administrative arrangements between MIBA and the regional government that have yet to be resolved.

7. Transport:

Adequate. Full maintenance and replacement provided by MIBA.

8. Material and Equipment:

Adequate and well managed.

9. Information System:

Information system good. 79% and 100% of two routine reports received regularly and on time from MIBA centers. Other centers in the zone need to be brought into the information system. CCCD data not suitable for program planning and evaluation.

10. Training:

Medecin Chef de Zone trained by Santé Pour Tous and WHO/Geneva in PEV/CCCD/PHC. Held three week training course for 19 nurses in PEV/CCCD/PHC. All nurses trained remain in the program. On-going in-service training is provided monthly.

11. Health Education:

Functioning health centers and outposts provide PEV/CCCD services to 100% of Zone population. Measles vaccination coverage (0-11 months) reported to be 96% in MBA centers. Coverage for third dose of polio reported to be 58%. DTP third dose coverage reported to be 56%

Zone of Bonzola

Centre Chrétien de Santé:

Urban health center in Mbuji Mayi that operates 25 vaccination outreach sites. Chloroquine and ORS available. Chloroquine prophylaxis for pregnant women recommended.

1. Organization:

Range of PHC services adequate. All PEV/CCCD services offered. Quality of services good. Program planning based on past performance, rather than on objectives.

2. Intersectoral Collaboration:

Good, involving agriculture and community development.

3. Community Participation:

High. Development committees exist and meet on regular basis.

4. Finance:

Heavy subsidization from Presbyterian Church and UNICEF. Community financing through fee for service contributes to program support. Financial situation uncertain due to planned withdrawal of church support in 1986.

5. Personnel:

Highly motivated. Technically competent. Large staff of 13 nurses paid regularly.

6. Supervision:

Absence of technical supervision from Zone pending resolution of administrative arrangements.

7. Transport:

Inadequate, considering limited means and high level of outreach activities.

8. Material and Equipment:

Adequate and well managed.

9. Information System:

Adequate.

10. Training:

PEV fiches techniques not available. PEV training session held on ORT. Weekly in-service training provided on PHC/PEV/CCCD.

11. Health Education:

PEV/CCCD materials available. Active program.

12. Utilization:

Functioning health centers and outposts provide access to PEV/CCCD services to 100% of surrounding population. Measles vaccination coverage (0-11 months) reported to be 64% in service area. Coverage for third dose of polio and third dose of DTP was greater than 100%, suggesting that service delivery extends well beyond defined service area.

Zone of Dibanga:

Six functioning health centers and 2 health posts. Vaccinations carried out by mobile teams at health centers and outreach sites. Chloroquine available in all health centers. SSS preferred strategy for ORT. Chloroquine prophylaxis for pregnant women not recommended.

1. Organization:

Range of PHC services adequate. All PEV/CCCD services offered. Quality of services good. Excellent program planning.

2. Intersectoral Collaboration:

Yes, in water and agriculture.

3. Community Participation:

High. Village health committees exist and meet on regular basis.

4. Finance:

Significant subsidies from SANRU, OXFAM, and the Catholic church. Community financing accounts for 27% of program operations.

5. Personnel:

Highly motivated. Well trained. Supervisory staff may need to be increased.

6. Supervision:

Regular supervision programed, but staff size limiting factor. Not standardized.

7. Transport:

Adequate with OXFAM vehicle used for supervision and PEV/CCCD activities. OXFAM subsidy for vehicle replacement. Fuel availability a limiting factor.

8. Material and Equipment:

Adequate. Fixed centers will require cold chain extension.

9. Information System:

Reports regular and on time. Well developed and up to date reporting system. 100% of monthly reports received.

10 Training:

Medecin Chef de Zone at long term training in United States. Medicin Manager trained in PEV and PHC. Organized 3 training sessions to train 25 nurses in PEV and PHC. 21 nurses still in the program.

11. Health Education:

Extensive range of materials available. No particular focus on PEV/CCCD activities.

12. Utilization:

Functioning health centers and outposts provide PEV/CCCD services to 79% of Zone population. Measles vaccination coverage (0-11 months) reported to be 18% in service area. Coverage for third dose of polio reported to be 30%. DTP third dose coverage reported to be 31%.

Zone of Kabinda:

Six functioning health centers and 14 health posts. Vaccinations carried out from fixed centers and outreach sites. Chloroquine and ORS packets available in all health centers. Chloroquine prophylaxis for pregnant women recommended. ORT activities at beginning stages.

1. Organization:

PHC services adequate. All PEV/CCCD services offered. Quality of service delivery good. Program planning could be strengthened.

2. Intersectoral Collaboration: No.

3. Community Participation:

Some health committees function in zone.

4. Finance:

Significant community participation in program financing. Subsidies from SANRU, OXFAM and religious community to sustain program operations. Credit extended to health centers. Health centers contribute to supervisory costs. Drug system operates at a deficit.

5. Personnel:

Adequate. Paid a bonus for good work. Motivated. Technically competent.

6. Supervision:

Regular. Checklist forms exist and are used. Financed by health centers.

7. Transport:

New SANRU vehicle and 2 motorcycles. Fuel is a constraint. No provision for vehicle maintenance or replacement.

8. Material and Equipment:

Adequate. Could take better advantage of PEV supplies, especially vaccine carriers. Weak supply management system. Will need to extend cold chain to two periphery centers.

9. Information System:

64% of monthly reports received since beginning of program activities in August. Information retrieval and management weak.

10. Training:

Medecin Chef de Zone trained in PEV and PHC. Organized 3 training sessions totaling 35 days to train 8 nurses in PEV and PHC. Seven nurses still in the program. Two nurses were also trained by PEV/CCCD in 1983. All staff undergo 2 days of in-service training per month in PEV/CCCD/PHC activities. Need exists for management training.

11. Health Education:

Materials were available. No real focus on PEV/CCCD activities.

12. Utilization:

Functioning health centers and outposts were assumed to provide access to PEV/CCCD services to 39% of Zone population. Measles vaccination coverage (0-11 months) reported to be 19% in service area. Coverage for third dose of polio reported to be 17%, DTP third dose coverage reported to be 21%.

Zone: Kabinda  
Bemane Mpaza:

Health Center maintaining 8 outreach posts. Vaccines collected at zone. Chloroquine and ORS available. Malaria prophylaxis recommended for all pregnant women.

1. Organization:

PHC services adequate. All PEV/CCCD services offered. Quality of service delivery good. Program planning coordinated with Zone.

2. Intersectoral Collaboration: No.

High. Village health committee functioning.

4. Finance:

Significant community participation. Two staff on government payroll. Salary shortfall for five CHW and five health center staff supported by program. Supervision fee of 300 Z/month paid by health centers to Zone. Medicines given on credit. Program appears unable to sustain re-provision of medicines.

5. Personnel:

Adequate. Motivated. Technically competent.

6. Supervision:

Regular. Standard form and checklist utilized. Bonuses for good work. Technically adequate.

7. Transport:

Adequate with one bicycle and an occasional motorcycle.

8. Material and Equipment:

Adequate. Large geographic coverage may warrant cold chain extension.

9. Information System:

Reports timely and of good quality. CCCD information not sufficient for program planning and evaluation.

10. Training:

PEV/CCCD fiches techniques available. In-service training every month.

11. Health Education:

Materials available. No real focus on PEV/CCCD activities.

12. Utilization:

Vaccination coverage low at 2% for measles, 1% for 3rd dose of polio, and 2% for third dose of DTC after 5 months of program operation.

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Zone of Kalenda:

Five functioning health centers and one health post. Vaccinations carried out from fixed centers, outreach sites and by mobile teams. Chloroquine available in all health centers. Chloroquine prophylaxis for pregnant women not recommended. ORT activities at beginning stages.

1. Organization:

Range of PHC services adequate. All PEV/CCCD services offered. Quality of services questionable. Zone PHC activities in beginning stage. No formal expansion plan exists to increase functioning health centers in the zone to 18.

2. Intersectoral Collaboration: No.

3. Community Participation:

Little community participation in program planning.

4. Finance:

Significant community participation in program financing. Little financial support from government or other sources. Most services are auto financed at a deficit.

5. Personnel:

Adequate for scale of operation. Most salaries dependant on PHC revenue. Many personnel not paid regularly or in full.

6. Supervision:

Irregular du to road infrastructure, lack of funds, and fuel. Not standardized. Aquisition of new motorcycle may improve situation.

7. Transport:

Adequate with UNICEF vehicle, a motorcycle and 4 bicycles. No provision for vehicle maintenance or replacement. Vehicle breakdown (and lack of money to repair it) led to disruption of PEV/CCCD activities for 2 months in 1984.

8. Material and Equipment:

Supply problems exist due to poor procurement planning and high transport costs. No inventory and management system.

9. Information System:

Whole information system needs extensive organization. Reporting periods and reporting channels need to be standardized.

10. Training:

Medecin Chef de Zone trained in PEV and PHC. Organized one training session to train 8 nurses in PEV and PHC. All nurses still in the program. No regular in-service training. PEV/CCCD activities integrated into nursing school curriculum.

11. Health Education:

Materials were available. No real focus on PEV/CCCD activities.

12. Utilization:

Functioning health centers and outposts provide PEV/CCCD services to 38% of Zone population. Measles vaccination coverage (0-11 months) reported to be 24% in-service area. Coverage for third dose of polio reported to be 34%. DTP third dose coverage reported to be 19%.

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Zone: Kalenda

Luputa

Health center with no outreach. Vaccines collected from Zone. Chloroquine available. ORT efforts minimal. ORS not available, SSS recommended. Chloroquine prophylaxis for pregnant women not practiced.

1. Organization:

PHC services adequate. All PEV/CCCD services offered. Technical deficiencies noted in the quality of services delivered. PEV/CCCD program planning not coordinated with PEV or Zone staff.

2. Intersectoral Collaboration: No.

3. Community Participation:

Low. Little involvement in program planning.

4. Finance:

Excepting one salary, fees for service and payments for drugs completely finance health center operations. Drugs are purchased on credit from central mission stocks.

5. Personnel:

Deficient knowledge of vaccination schedules, treatment of malaria, and composition of salt, sugar, water solution for ORT. Adequate in number.

6. Supervision:

Regular supervision just beginning from Zone. Non-integration of health center operations with Zone and PEV/CCCD activities.

7. Transport:

Mission vehicle transports vaccines from Zone twice monthly.

8. Material and Equipment:

Cold chain not reliable due to old refrigerator, kerosene availability, and cost. Spare parts are a problem.

9. Information System:

Routing of reports need clarification. Data was questionable. Reported giving more 3rd doses of polio and tetanus vaccine than first doses. CCD information not suitable for program planning and evaluation.

10. Training:

PEV/CCCD fiches techniques not available. Staff not sufficiently trained in CCD/PEV program.

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11. Health Education:

Materials were available, some locally produced. No real focus on PEV/CCCD activities.

12. Utilization:

Vaccination coverage for measles in children from 0-11 months reported to be 10%. BCG vaccinations of children 0-11 months reported to be 80%, perhaps due to an exceptional maternity facility.

Zone: Muendituya  
Kaseya

Health post with 2 outreach centers. Vaccines collected at Zone. Chloroquine available. ORT efforts minimal. ORS not available, SSS recommended. Chloroquine prophylaxis for pregnant women not practiced.

1. Organization:

PHC services adequate. All PEV/CCCD services offered. Technical deficiencies noted in the quality of services delivered. Absence of program planning.

2. Intersectoral Collaboration: No.

3. Community Participation: Low. Little involvement in program planning.

4. Finance:

Community financing used to support one staff member and core organizational and supervisory staff. Program reliant upon donated medicines.

5. Personnel:

Deficient knowledge of vaccination calendars and treatment of malaria. Adequate in number.

6. Supervision:

Frequency of supervision was adequate. Technical quality questionable. Financially focused. Need for integration into Zonal program.

7. Transport:

Bicycle suitable but in need of extensive repair. Motorcycle used to transport vaccines from Zone.

8. Material and Equipment:

Poor management of cold chain and poor planning led to stoppage of vaccination activities for 4 months.

9. Information System:

Routine information collected in un-usable form.

10. Training:

PEV/CCCD fiches techniques not available. Staff not sufficiently trained in CCD/PEV program.

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11. Health Education:

Materials were available. No real focus on PEV/CCCD activities.

12. Utilization:

PEV difficult to assess. Roughly 5% of the population assumed to be covered by the health facility could have received curative treatment.

TABLEAU II.1.A.

L'INTEGRATION DU PEV-CCCD DANS LES SOINS DE SANTE PRIMAIRES

- La synthèse d'observations faites par l'équipe internationale d'évaluation, Février 1985

A. Niveau Régional

REGION	SOUS-REGION	Médecin Inspecteur recyclé par PEV-CCCD	NOMBRE DE ZONES DE SANTE	NOMBRE DE Z.S. RECYCLEES PAR PEV-CCCD (%)	Z.S. AVEC ACTIVITES PEV-CCCD INTEGREES			APPROVISIONNEMENT			SYSTEME D'INFORMATION			
					Planification (%)	Mise en oeuvre (%)	Supervision (%)	COMBIEN DE ZONES		Sur vaccins, SRO utilisés		Sur maladies par postes sentinelles		
								Reçoivent les vaccins par le P.F.V.	Achètent du PEV-CCCD	S.R.O.	Chloroquine	% de rapports reçus en 1984	% de rapports arrivés à temps	Nombre de rapports reçus en 1984
KASAI-ORIENT (MBUJI-MAYI)	KA	NON	23	0	0	8	8	12	10	10	92	11A	91 %	NA
S H A B A	L'SHI	OUI	43	7	7	7	7	7	31	39	97	97	100 %	100
BANDUNDU	BDD	NON	36	18	18	18	18	18	18	18	100	100	100 %	100
BAS-ZAIRE	BAS-FLEUVE	NON	6	6	6	6	6	6	-	-	8	8 (annuels)	21 %	Tres peu
HAUT-ZAIRE	-	OUI	39	7	7	7	6	39	21	21	62	78	48	75

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TABLEAU H.1.B.

Tableau n° : Niveau d'intégration des activités PEV/CCCD dans les zones de santé visitées.

NOM DE LA ZONE DE SANTE (Région, Etatique ou Mission)	POPULATION	NOMBRE DE CENTRES DE SANTE ET DE POSTES DE SANTE.	MEDECIN CHEF DE ZONE (FORME AU PEV-CCCD (ANNÉE))	ACTIVITES INTEGREES					VACCINATIONS FAITES PAR LES CENTRES FIXES ( % )	UTILISATION DES S.R.O. A L'HOPITAL	FORMATION PEV-CCCD		APPROVISIONNEMENT PAR PEV - CCCD	SUPERVISION (NOMBRE MOYEN DES VISITES PAR MOIS)	RAPPORTS DES C.S. EN 1984	
				PRIMO-VACCINATIONS DES ENFANTS	VACCINATION ANTI-TETANIQUE DES FEMMES ENCEINTEES	UTILISATION DES S.R.O.	TRAITEMENT ANTI-PALUDIQUE DES ENFANTS	CHIROPROPHYLAXIE DU PALUDISME CHEZ LES FEMMES ENC.			NOMBRE DES C.S. QUI ONT RECU LES FICHES TECHNIQUES PEV-CCCD	NOMBRE (%) D'INFIRMES DES C.S. RECYS LES SUR PEV - CCCD			PROPORTION RECUE	PROPORTION ARRIVEE A TEMPS.
BUKAVU	171,491	15	OUI (83)	11	11	14	15	0	100 %	-	-	15	14	0	94 %	92 %
MALUNGU	269,210	23	NOE	4	4	0	15	0	?	?	?	OUI	11	IRREGULIER	100 %	100 %
UVIRA	242,812	21	NOE	6	6	6	21	0	100 %	OUI	6	10	6	1	100 % (6)	100 % (6)
KASONGO	220,000	16	NCF	16	16	0	16	0	100 %	OUI	16	16	16	1	100 %	100 %
KINDU	119,379	8	OUI (83)	8	8	0	8	0	100 %	OUI	8	8	8	2	100 %	100 %
BONZOLA	165,000	7	NOE	7	7	7	7	7	OUI	OUI	NA	19	VACCINE	1	79 %	NA
KASINDA	129,000	20	OUI (84)	6	6	6	6	6	OUI	OUI	NA	8	VACCINE SRO	1	65 %	NA
BIBANGA	165,000	7	OUI (82)	7	7	7	7	7	EQUIPE MOBILE	NON	NA	25	VACCINE	1	100 %	NA
KALENDA	98,000	5	OUI (83)	5	5	5	5	5	OUI	OUI	NA	8	VACCINE CHLOROQUINE		NA	NA
KUMBA (Bas-Zaïre, Mission Cath.)	61,468	2 C.S. 9 P.S.	NON (Son pré-décès en 1982 oui).	5 (1982)	2	11	11	2 (1/10 des Femmes)	80 %	OUI			VACCINS 1-MOTO TOUS LES 15 MOIS	1 FOIS	72 %	80 %
LUMBA (Bas-Zaïre, Etat)	104,000	6 C.S. 9 P.S.	1984	6 (1982)	3	9	6	0	100 %	OUI			VACCINS IRREG. INSUFFIS.	1 FOIS	20 %	NON DISPONIB.
YAKUSU (Haut-Zaïre, Bapt., Mission)	120,000	3 C.S. 15 P.S.	SANKU-OUI PEV-NON	9 (1968)	6	8 (depuis long-temps)	11	0	100 %	OUI	0	0 (Zone n'est pas bien délimitée)	VACCINS TOUS LES 1-2 MOIS INSUFFIS.	1 FOIS	100 %	100 %
BENGAMISA (Haut-Zaïre, Catholique)	50,423	4 C.S. 2 P.S.	1984	1 (1983)	1	1	1	1	100%	OUI	11	0	VACCINS 1 FOIS PAR MOIS	1 FOIS	N/A	N/A Zone n'est délimitée qu' Octobre 1984
KABONDO (Haut-Zaïre, Catholique)	120,000	2 C.S. 1 PMI	Il n'est encore nommé	3	3	2	2	3	100 %	SSS	0	0	VACCINS 1 FOIS PAR SEM.	1 FOIS	100 %	100 %
MANDUNDU (Etat).	100,000	6	OUI	3	3	3	3	3	100 %	OUI	?	31	OUI	1	100 %	?

TABLEAU II.1.C. : INTÉGRATION DES ACTIVITÉS SSSP-11V/CCU  
DANS LES CENTRES DE SANTÉ VISITÉS.

ZONE DE SANTÉ	NOM DU CENTRE DE SANTÉ	POPULATION	NOMBRE DE VILLAGES (Sièges)	NOMBRE DU PERSONNEL	LE PERSONNEL EST PAYÉ RÉGULIÈREMENT ?	SERVICES PEV-CCU OFFERTS										STOCK ADEQUAT				RAPPORTS MENSUELS A L'HOPITAL RÉGULIERS		
						PRIMO VACCINATIONS	VACCINATION ANTITECHNIQUE DES FEMMES ENCEINTES	TRAITEMENT PAR DIAPODE		TRAITEMENT PALUDISME ÉTAT < 5 ANS	CHIMIOPROPHYLAXIE DU PALUDISME AUX FEMMES ENCEINTES	ÉDUCATION SANITAIRE	OBJECTIFS QUANTITATIFS	COMITÉ DE SANTÉ (NOMBRE)	AGENT DE SANTÉ COMMUNAUTAIRE (NOMBRE)	TRANSPORT	VACCINS	S.R.O.	CHLOROQUINE		SERINGUES, AIGUILLES, C. VACC.	
								PAR SAC	PAR I/V													
BURAVU	Cingundu	14.477	14 quart.	10	OUI	OUI	OUI	OUI	OUI	OUI	NON	OUI	NON	OUI	14	OUI	OUI	OUI	OUI	NON	OUI	
	Bagira	17.316	3 quart.	20	NON	OUI	OUI	OUI	NON	OUI	NON	OUI	NON	OUI	NON	NON	-	OUI	OUI	OUI	OUI	
WALUNGU	Lubona	7.498	17	1	NON	NON	NON	OUI	NON	OUI	NON	OUI	NON	OUI	NON	NON	-	NON	OUI	-	NON	
	Mulumbano	9.581	11	5	OUI	OUI	OUI	NON	OUI	OUI	NON	OUI	NON	OUI	NON	NON	OUI	-	OUI	OUI	OUI	
UVIRA	Kabinba	11.300	7	5	OUI	OUI	OUI	OUI	OUI	OUI	NON	OUI	NON	OUI	OUI	OUI	-	NON	OUI	NON	OUI	
	Sangé	12.798	18	5	OUI	OUI	OUI	OUI	-	OUI	NON	OUI	NON	OUI	OUI	OUI	OUI	NON	OUI	NON	OUI	
KASONGO	Kipaka	15.286	3 groupmt	6	OUI	OUI	OUI	OUI	NON	OUI	NON	OUI	NON	OUI	OUI	OUI	OUI	NON	OUI	NON	OUI	
	Kasongo 3	14.902	-	6	OUI	OUI	OUI	OUI	OUI	OUI	NON	OUI	NON	OUI	NON	OUI	-	NON	OUI	NON	OUI	
KINDU	Kasuku 1	7.234	-	5	OUI	OUI	OUI	NON	NON	OUI	NON	OUI	NON	OUI	NON	OUI	-	NON	OUI	-	OUI	
	Lumbumbu	10.851	-	4	OUI	OUI	OUI	NON	NON	OUI	NON	OUI	NON	OUI	NON	OUI	-	NON	OUI	-	OUI	
	Mukilenge	8.860	-	3	OUI	OUI	OUI	NON	NON	OUI	NON	OUI	NON	OUI	NON	OUI	-	NON	OUI	-	OUI	
BONZOLA	Mbugi Maye Centre Protestant (Urbain)	101.000	25	16	OUI	OUI	OUI			OUI	OUI	OUI	NON	OUI	5	6	1 VÉH.	OUI	OUI	OUI	OUI	OUI
KABINDA	Mbenane-Mpaza	12.000	6	7	NON	OUI	OUI	NON	NON	OUI	OUI	OUI	NON	OUI	1	5	1 VÉH.	NA	NA	OUI	NON	OUI

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MINISTRE S.E.C. INVENTAIRE DES ACTIVITES SESP-PEV/CCD PAR LES CENTRES DE SANTE VISITES.

ZONE DE SANTE	NOM DU CENTRE DE SANTE	POPULATION	NOMBRE DE VILLAGES (Sièges)	NOMBRE DU PERSONNEL	LE PERSONNEL EST PAIE REGULIEREMENT ?	PRINCIPALES VACCINATIONS	TRAITEMENT DE DIARRHEE		TRAITEMENT DU PALUDISME PAR UN ESPECE < 5 ANS	CHEMIOPROPHYLAXIE DU PALUDISME AUX FEMMES ENCEINTEES	EDUCATION SANITAIRE	OBJECTIFS QUANTIFIES	COMITE DE SANTE (NOMBRE)	AGENT DE SANTE COMMUNAUTAIRE (NOMBRE)	TRANSPORT	STOCK ALORS QU'...				MATERIELS NECESSAIRES A L'HOSPITALISER
							PAR SR.	PAR I/A								VACCINS	S.R.O.	CHLOROQUINE	SERINGES, AIGUILLES, C. VACC.	
KALENDA	Luputa	13.000	0	5	OUI	OUI	OUI	NON	OUI	NON	OUI	NON	NON	0	1 Véhic.	NA	NA	OUI	OUI	OUI
MWENE-DITU	Kaseya	5.749	2	2	OUI	OUI	OUI	NON	OUI	NON	OUI	NON	NON	0	1 Véhic.	NA	NA	OUI	OUI	OUI
BANDOUNDU	C.S. Lwanu	11.000	2	6	OUI	OUI	OUI	-	OUI	OUI	OUI	NON	OUI 1	NON 1	1 Véhic.	OUI	OUI	OUI	OUI	OUI
BOKORO	C.S. Kempa	4.500	6 (2)	3	OUI	OUI	OUI	-	OUI	OUI	OUI	NON	OUI 1	5	1 Véhic.	NON Hôp.	OUI	OUI	OUI	OUI
BOKORO	Sanga-Sanga	7.250	4 (15 v.)	4	OUI	OUI	OUI	-	OUI	OUI	OUI	NON	OUI 1	NON 1	1 Véhic.	NON Hôp.	OUI	OUI	OUI	OUI
KWIMBA	Tsanga-Nord	4.600	13 (2)	2	OUI	OUI	NON	OUI	NON	OUI	OUI	OUI	OUI 1	NON 1	1 Véhic.	Hôp.	OUI	OUI	OUI	OUI
KWIMBA	Kajakwinla	4.876	12	3	OUI	NON	NON	OUI	NON	OUI	NON	NON	OUI	NON	NON	Hôp.	+	+	+	OUI
LUKULA	Kinbianga	8.500	37 (4)	4	OUI	OUI	OUI	OUI	OUI	OUI	OUI	OUI	NON	NON	NON	Hôp.	OUI	OUI	OUI	OUI
LUKULA	Patu	5.000	25 (1)	2	OUI	OUI	OUI	NON	OUI	NON	+	NON	NON	NON	NON	Hôp.	NON	OUI	NON	+
YAKUSU	Yelenge	1.500	3 (2)	2	OUI	OUI	OUI	NON	OUI	OUI	OUI	NON	OUI	NON 1	1 Véhic.	Hôp.	OUI	OUI		

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ANNEXE I.C. : SITUATION DES ACTIVITES DESP-DES, AFD  
 AVEC LES OUTILS DE TRAVIL VISITES.

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ZONE DE SANTE	NOM DU CENTRE DE SANTE	POPULATION	NOMBRE DE VILLAGES (Secteurs)	NOMBRE DE PERSONNE	LE PERSONNEL EST IMAE REGULIEREMENT ?	MATERIEL DISPONIBLE										AGENTS DE SANTE COMMUNAUTAIRES (NOMBRE)	TRANSPORT	STOCK ANTI-KAT				EQUIPEMENT DISPONIBLE A L'HOSPITAL (PERSONNEL)
						PRIMO VACCINABLES	VACCINATION ANTITYPHOIDIALE FEMMES ENFANTES	PAS S.C.	ANTIBIOTIQUES	TRAITEMENT DE PALUDISME EGAL A 3 ANS	CHIMIOPREVENANT DU PALUDISME AUX FEMMES ENFANTES	EDUCATION SANITAIRE	OBJETS QUANTITIFS	COMTE DE SANTE (NOMBRE)	VACCINS			S.R.O.	CHLOROQUINE	SERINGUES, AIGUILLES, C. VACC.		
LUBUM-BASHI	Masaidiamo	n.d.	2	9	OUI	x	x	x	?	NON	NON	x	NON	NON	NON	NON	NON	OUI	OUI	OUI	OUI	N.A.
"-	Katuba	n.d.	1	4	NON	x	x	x	NON	NON	NON	NON	NON	NON	NON	NON	*	NON	NON	*	N.A.	
"-	Kisenda	10.000	2	4	OUI	x	x	NON	?	NON	NON	OUI	NON	NON	NON	**	OUI	NON	OUI	OUI	N.A.	

\* Fait par une équipe du Médecin Inspecteur Régional.  
 \*\* Il emprunte l'ambulance de l'hôpital.

TABLEAU II.2  
UTILISATION DES SERVICES PEV/CCCD OFFERTS  
PAR LES ZONES DE SANTE VISITEES

Niveau Zone de Santé

N°	NOM DE LA ZONE DE SANTE (Région, Etatique, Mission)	ACCES AU PEV/CCCD (% Population totale)	TAUX D'UTILISATION DES SERVICES DISPONIBLES (%)	COUVERTURE VACCINALE																LES S.R.O.			CHLOROQUINE NOMBRE DE COMPRIMES DISTRI-BUES
				BCG		DTC-1		POLIO-1		ROKEDOL		DTC-3		POLIO-3		AT-1		AT-2		NOMBRE DE SACTIETS DISTRI-BUES	NOMBRE DES CAS TRAITES	NOMBRE DES MALADES DIAR-RIETI-QUES TRAITES	
				1982	1984	1982	1984	1982	1984	1982	1984	1982	1984	1982	1984	1982	1984	1982	1984				
1.	BUKAVU	79 %	-																				
2.	WALUNGU	51 %	-	5.264	6.636	-	4.787	-	3.941	2.825	3.881		4.402		3.621		8.717		7.295	-	-	-	
3.	UVIRA	37 %	-		10 %		1.339		1.338		4 %		143		343		2.185		1.359	-	-	-	
4.	KASONGO	69 %	-		5.679		-		-		3.835		(J doses) 11.861		(J doses) 10.479		(VAT 142=6.513)		3.600	-	-	-	450.000
5.	KINDU	60 %	-		39 %		36 %		35 %		27 %		-		-		46 %		25 %	200	-	-	143.691
6.	BONZOLA	69 %	-		NA		NA		NA		35 %		39 %		40 %		NA		NA	19.960	NA	NA	99.000
7.	BIBANGA	79 %	-		23 %		38		41		14		24		24		18		11	NA	NA	NA	48.000
8.	KALENGA	38 %	-		17 %		13 %		13 %		9 %		7		13		13		18	NA	NA	NA	3.000
9.	KABINDA	39 %	-		15 %		22 %		17 %		7 %		8 %		17		6		5	100	NA	NA	32.600
10.	BANDUNDU	30 %	30 %		42,3		25,4		25,2		24		16		16,4		35,2		27	3.500	453	453	66.000

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ANNEXE II.H.3

MATERIEL DE CHAINE DE FROID DEJA DISTRIBUE AUX EQUIPES PEV/CCCD ET DANS LES ZONES DE SANTE RE-CYCLES ENTRE 1981-1983.

REGION	FRIGOS	CONGELATEURS	BOITES ISOTHERMES *		VELOS
			45 Litres	5 Litres	
KINSHASA	8	-	27	58	-
BAS - ZAIRE	11	2	22	114	19
BANDUNDU	19	3	65	155	30
EQUATEUR	7	-	47	87	29
HAUT - ZAIRE	9	-	21	50	32
K I V U	8	-	13	45	43
KASAI OCCIDENTAL	4	-	7	29	13
KASAI ORIENTAL	8	-	21	58	15
S H A B A	5	1	14	36	15
EQUIPES PEV-CCCD	37	-	-	-	22
T O T A L	116	6	237	632	218
TOTAL RECU UNICEF/CCCD/OXFAM	240		300	1.588	240

\* Matériel retiré par les Zones de Santé à partir de la direction du PEV. Certaines ont été servies.

TABEAU H.4. ZONES DE SANTE ACHETANT LES PRODUITS FEV/CCCD

Z O N E

NOM DE LA ZONE DE SANTE	PARTICIPENT DANS L'ACHAT DES PRODUITS AUPRES DES EQUIPES FEV/CCCD	S.R.O. / SACHET		CHLOROQUINE/COMPRIME		CARTES DE VACCINATION		C.S. ACHETANT LES PROD.	
		PRIX D'ACHAT	PRIX DE VENTE	PRIX D'ACHAT	PRIX DE VENTE	PRIX D'ACHAT	PRIX DE VENTE	FONCTIONNEL	NON FONCTIONNEL
Bukavu (Kivu)	OUI	3,00 Z	3,00 Z	*	*	*	*	-	-
Walungu	NON	*	*	*	*	*	*	4	-
Uvira	NON	5 Z pour 5 l.	10 Z pour 5 l.	0,25 K	0,50 K	1,00 Z	10,00 Z	6	0
Kasongo	NON	3,00 Z	**	0,30	**	-	*	16	0
Kindu	OUI	3,00 Z	**	-	**	-	*	7	0
Kalenda	OUI	-	-	0,35 Z	1,00 Z	NA	20,00 Z	4	-
Bonzola	NON	30,00 Z	30,00 Z	0,2 Z	0,2 Z	1,00 Z	1,00 Z	-	-
Bibanga	NON	No	No	0,25 Z	1,00 Z	NA	10,00 Z	8	-
Kabinda	NON	4,00 Z	5,00 Z	0,42 Z	0,75 Z	NA	2,00 Z	6	-
Bandundu	NON	3,00 Z	3,00 Z	0,30 Z	0,5 Z	3,00 Z	10,00 Z	6	1
Kuimba (B/Z.)	OUI	-	3,00	-	0,5 Z	-	25,00 Z	2	8
Lukula (B/Z.)	NON	-	4,00 Z	-	0,5 Z	-	10,00 Z	5	-
Yakusu (H/Z.)	OUI	-	3,00 Z	0,35 Z	0,4 Z	-	12,00 Z	3	5
Bengami (H/Z)	NON	-	-	-	-	-	-	-	-
Kabondo (H/Z)	NON	-	-	-	-	-	-	-	-

\* Variation par Centre de Santé dans une Zone.

\*\* Paiement à l'épisode, pas à la médication.

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TABLEAU II.5. : COÛT DES PRODUITS PEV/CCCD ET UTILISATION DES REÇEPTES GÉRÉS PAR LES CENTRES DE SANTÉ.

CENTRE DE SANTÉ

CENTRE DE SANTÉ	PARTICIPENT DANS L'ACHAT DES PRODUITS PEV/CCCD	S. R. O.		CHLOROQUINE		CARTES DE VACCINATION		1. APPROVISIONNEMENT 2. SALAIRES 3. SUPERVISION EMPLOI DE REÇEPTES	(OUI/NON) SYSTEME DE PROTECTION DES INDIGENTS
		PRIX D'ACHAT	PRIX DE VENTE	PRIX D'ACHAT	PRIX DE VENTE	PRIX D'ACHAT	PRIX DE VENTE		
<b>(BUKAVU)</b>									
Cimpunda	Non	3 Z.	1 Z.	26 m.	50 m.	-	6 Z.	1,2	Oui
Bagira	Oui	3 Z.	1 Z.	15 m.	50 m.	6 Z.	10 Z.	1,2	Oui
<b>(WALUNGU)</b>									
Lubona	Non	-	-	-	50 m.	-	20 Z.	1,	-
Mubumbano	Non	-	5 Z.	-	50 m.	-	20 Z.	1,2	Non
<b>(UVIRA)</b>									
Kabimba	Non	5 Z pour 51	10 Z pour 51	25 m.	50 m.	3 Z.	10 Z.	1,2,3	Oui
Sange	Non	5 Z pour 51	10 Z pour 51	25 m.	50 m.	3 Z.	10 Z.	1,2,3	-
<b>(KASONGO)</b>									
Kipaka	Non	3 Z.	*	30 m.	*	-	25 Z.	1,2	Oui
Kasongo	Non	3 Z.	*	30 m.	*	-	40 Z.	1,2	Oui
<b>(KINDU)</b>									
Kasuku 1	Oui	3 Z.	*	-	*	-	30 Z.	1,2	-
Lumbumbu	Oui	3 Z.	*	-	*	-	30 Z.	1,2	-
Mikelele	Oui	3 Z.	*	-	*	-	30 Z.	1,2	-
<b>(BAS-ZAIRE)</b>									
Tsanga-Nord	Oui	-	0,5 Z	0,4 Z	0,4 Z	-	25 Z. (Carte CIS)	A l'hôpital 20 \$ salaire - 30 \$ médicament 50 \$	-
<b>(BAS-ZAIRE)</b>									
Kajakwinla	Oui	-	Inconnu	-	Inconnu	-	Inconnu	-	-

\* Paiement par épisode, pas par médicaments prescrits. ( ) Zone de Santé.

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TABLEAU II. 1 : NIVEAU DES PRODUITS PEV/CCCD ET UTILISATION DES  
 REVENUS GÉNÉRÉS PAR LES VENTES DE CROÛTES.

CENTRE DE SANTÉ

VILLE DE SANTÉ	PARTICIPATION DANS L'ACHAT DES PRODUITS PEV/CCCD	S. R. O.		CHLOROQUINE		CARTES DE VACCINATION		1. APPROVISIONNEMENT 2. SALAIRES 3. SUPERVISION EMPLOI DE REVENUS	(OUI/NON) SYSTÈME DE PROTEC- TION DES INDIGENTS
		PRIX D'ACHAT	PRIX DE VENTE	PRIX D'ACHAT	PRIX DE VENTE	PRIX D'ACHAT	PRIX DE VENTE		
(BAS-ZAIRE) Mbiangji	Oui		3 Z.		0,6 Z.		10 Z. (Carte CPS)	Salaires	
(HAUT-ZAIRE) Kau	Oui		5 Z.		-		-	à l'hôpital	
(HAUT-ZAIRE) Menge	Non		-		-		10 Z. (Carte CPS)	à l'hôpital	
(HAUT-ZAIRE) Bingabo	Non (Pas de fonds)		-		0,5 Z.		1,5 Z. (Carte CPS)	-	
(MBOU-MAYI) Centre Protestant	Oui	3 Z.	5 Z.	0,25 Z.	1 Z.	2,3 Z.	5 Z.	(For all, but big deficit)	Non
Mbenza Mpaza	Non	4 Z.	10 Z.	0,50 Z.	1 Z.	2 Z.	10 Z.	(For all, but big deficit)	Non "Ici les gens vien- nent bien armés"
Kakoya	Non	1 Z.	20 Z.						Non
(IKOKOHO) Kapi	Oui		4 Z.		1 Z/00		20 Z.	1,2,1	

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TABLÉAU II.9. : COUT DES PRODUITS PEV/CUD ET UTILISATION DES  
 RECETTES GÉNÉRÉES PAR LES CENTRES DE SANTE.

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CENTRE DE SANTE

CENTRE DE SANTE	PARTICIPENT ILS A L'ACHAT DES PRODUITS PEV/CUD	S. R. O.		VENDROUQUE		CAMPES DE VACINATION		1. APPROVISIONNEMENT 2. SALAIRES 3. SUPERVISION EMPLOI DE RECETTES	(OUI/NON) SYSTEME DE PROL- TICHI DES INDIGENS
		PRIX D'ACHAT	PRIX DE VENTE	PRIX D'ACHAT	PRIX DE VENTE	PRIX D'ACHAT	PRIX DE VENTE		
(BANDUNDU) Luani	Oui		3 Z.	50 K/cè		10 Z.		1,2,3	
(BOKORO) Sanga-Sanga	Oui		4 Z.	1 Z./cè		20 Z.		1,2,1	
(LUBUMBASHI) Masaidiano	Oui	3,0	7 **	-	-	-	-	Salaires	Oui ***
Katumba	Oui	3,0	3,0	-	-	-	15	Non-gardées	Non
SODIMIZA	Oui	3,0	Grat.	-	Grat.	-	Grat.	n.a.	n.a.

\*\* Y compris la consultation  
 \*\*\* Système de petit crédit.-

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ANNEXE III

MANAGEMENT OF THE CCCD PROJECT

Task No. 4 of the Management Consultant's Statement of Work reads:

"Analyze in detail the management of the CCCD project both from the government of Zaire and the AID perspective and make recommendations for improvements. Particular attention is to be paid to needs for improvement of Zaire and to the current division of management responsibility between USAID, AFR/W and CDC." (see Attachment 1)

It should be noted that the Contract does not provide for consultation, interviews, nor review of files of AID (AFR/R), nor of CDC/Atlanta either before or after the Kinshasa evaluation phase. The following paragraphs therefore represent the subject exclusively from the Kinshasa perspective.

The Project Agreement

The CCCD project consists of a regional component and a number of discrete country projects including the one in Zaire. The latter provides initial (1983 and 1984) funding of \$2,600,000 and a life-of project commitment of \$4,849,000. An amendment, dated May 23, 1983, increased the U.S. contribution by \$1,500,000 to \$4,100,000.

The original bilateral Project Agreement was signed on August 29, 1982. The files would indicate that this date signified primarily AID/W's desire to place the \$2.6 million obligation on the books prior to August 31, apparently to compensate for "delays in obligation of Agency 1982 Health account." (State 228358 of August 14, 1982). The negotiations on the GOZ side seem to have been largely conducted by the Director of PEV. (Unfortunately, the Director was out of the country on a long-term WHO assignment and, thus, could not serve as a resource person during the evaluation.) Senior PEV/CCCD personnel are of the opinion that the GOZ signatory, the Commissioner of Health (who, meanwhile has had several successors) did not have the opportunity to study the GOZ's commitments in the Proag in depth and signed the agreement without fully realizing the magnitude of the financial responsibilities he was assuming on behalf

of the GOZ. The feeling is that he may have concentrated primarily on the level of AID's commitments. The grant agreement itself is somewhat unusual as it was not preceded by a PP with detailed work and financial plans. USAID files would also indicate the absence of a "Logical Framework" for the bilateral project showing verifiable indicators for achievements at different levels. Various communications denote that the spirit or intention of the agreement was for the GOZ national budget and autofinancing at the Health Zone level to assume progressively a larger share of the project's recurrent costs. The Proag language, however, is ambiguous in several respects (a certain latitude in the interpretation of some clauses may have been considered desirable at the time of the Proag's execution). Section 4.2 makes future AID financing contingent on, i.a. "the ability of the GOZ to incorporate into their budget (underlining supplied) 75% of recurrent budget costs of vaccines, vaccination supplies and anti-malarial and diarrheal medications by the end of the project." Annex 1 "Amplified Description of the Project," however, lists the GOZ budget as merely one of several potential sources by stating that financing "will be increasingly provided by the GOZ...75% of total costs in year 4 will be expended from GOZ funds, autofinancing sources or other donor support as AID support proportionately declines." This paragraph omits any reference to GOZ budget funds and uses instead the term GOZ funds. These, of course, include counterpart funds that are titled to the GOZ. The Country Assessment, on which the Proag is based, considers CP availabilities an additional resource rather than a substitution for a major part of the GOZ's LOP contribution (Z 85 million). This Proag (and others as well) contains no maintenance of value clause even though a forthcoming devaluation was under discussion with the IMF. The GOZ's commitment of Z 85 million at the time of the Proag signing equaled US \$15 million. Its current value would be less than \$2.0 million. The file would indicate that this amount has never been adjusted to reflect the effects of the 500 percent devaluation of October 1983.

As documented in other parts of the Evaluation Report, many of the targets specified in Annex 1 of the Proag are no longer realistic. The Proag text states clearly "the quantifications represent current estimates and will be periodically revised during the life of the project." Section 2.1 of the Proag provides that within the definition of the Project, Annex 1 may be changed by written agreement without formal amendment.

#### Recommendation

1. Amend/modify the Project Agreement.
  - a. Change project targets (and define verifiable indicators) to reflect past and anticipated progress in the light of technical, social-economic and financial experiences during the first two years of the project as reflected in those findings and recommendations of the Evaluation that the GOZ and USAID agree to adopt. This may call for a more basic redesign of the project during its residual life, especially in the light of presently inadequate GOZ contributions and USAID's appraisal of the GOZ's ability/willingness to provide sufficient funding in 1986.
  - b. Modify Annex 1 to redefine amounts and modalities of the GOZ contributions.
  - c. Make other revisions required to complement, update and/or clarify clauses that are no longer valid or have led to differing interpretations.
  - d. Amend Annex 1 to show financial tables for years 1985 and 1986.

#### A Note on GOZ-USAID Project Execution

In Zaire, project agreements are generally signed by the technical minister concerned rather than by a coordinating authority, such as the Commissioners of Cooperation, Finance, or Plan. Neither of these appears to have reviewed or cleared the project. There presumably was a procedural delegation by the Commissioner of Foreign Affairs and Cooperation to

the Commissioner of Health although the available files are mute on this point. In the course of a social contact, the Commissioner of Plan explained that his official concern was essentially limited to the investment budget (which includes CP).

Thus, when the GOZ national budget makes inadequate provisions for PEV/CCCD (as in 1984 and 1985), it would be easier for the Commissioner of Health to appeal for a larger allocation if a central Ministry's co-signature, especially that of Finance, appeared on the Proag. It would be unreasonable to assume that GOZ/AID procedures could/will be changed to accommodate PEV/CCCD. However, a high level exchange of letters with the President or Prime Minister reconfirming the project's priority and GOZ willingness/ability to make its contributions could/should be part of the PEV file (maybe also of other project files). This should provide added leverage at budget time.

#### The Project

The U.S. contribution supplies vaccines, vaccination and laboratory equipment, office and communications equipment, and vehicles. In addition, without cost to the bilateral project, the regional project is providing the services of a technical officer for four years, various short-term consultants, and training for a number of Zairis outside the country. The technical officer and a regional epidemiologist (and, therefore, not shown in the Proag) who is resident in Zaire are employees of CDC/Atlanta, the contractor (PASA). The other parties involved in the implementation/administration/monitoring of the Zaire bilateral project are USAID/Zaire and AID/AFR/Regional. Thus, there are four players on the U.S. side. In Washington, AFR/R manages both the CCCD regional and the Zaire bilateral projects. The principal personnel involved are - based on information available in Kinshasa and rounded out by the contractor's AID background - a full-time technical officer, an assistant technical officer, and a project manager (who, presumably, oversees several activities). The technical officer and the assistant technical officer are employees of the contractor (CDC) working for AID under a RSSA arrangement. This, in

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in the perception of the Mission, rightly or wrongly - but maybe understandably - evokes the impression of a fifth player: "CDC/W." The record would indicate that most communications from AFR/R are drafted by the technical officer (whose professional competency seems universally acknowledged). It is generally assumed that communications or discussions between AFR/R and CDC/Atlanta are usually conducted by the technical officer. This is all for the best when purely technical matters are involved. When, however, management or policy issues exist (or are perceived as such) between a USAID and a contractor (such as CDC/A), Missions generally look to their AID/W backstop office for partisanship support. Even with the best of intentions and unquestioned integrity, it is almost impossible for an individual to efface the appearance of loyalty to his/her employing agency, the source of pay, PER's and promotions. Seen in this perspective, it is understandable that the Mission, on occasions, has felt that discussions between AFR/RA and CDC/A were communications between CDC staffers. The USAID files document some instances where USAID felt it had not been consulted fully on matters directly affecting the bilateral project. These instances are well known to all concerned and need not be "rehashed" here. It should be emphasized that Mission criticism is of issues and not of individuals. In summary, the impression exists that at times AFR/RA defers more readily to the views of CDC/A than the Mission's in matters of CCCD management.

In USAID, responsibilities for the project are vested in the Public Health Office(r). Under his oversight and policy guidance, project administration and monitoring is handled by a highly qualified health professional who serves under a PSC arrangement. This contract employee maintains regular weekly contact with the Zarois and the CDC staff working with the project. His reports on field trips address the strong and weak points of the CCCD project, locally also known as PEV (Programme Elargi de Vaccination) and include constructive recommendations. Copies should be made available routinely to AFR/RA and CDC/A (via the technical officer or directly) if this is not already being done. The employee serves as project procurement officer as well as general focal point and facilitator for visitors with project-related concerns.

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There are two CDC employees based in Kinshasa. Both are funded under the regional project. The regional epidemiologist is based in Zaire and spends more time on the Zaire bilateral project than on other assignments in the region. The technical officer is furnished to the project under the Project Agreement as part of the U.S. bilateral contribution. He is not funded from the project's bilateral portion as he is to be available for occasional short-term assignments in other countries participating in CCCD. The technical officer works with PEV both in an OPEX, training, and advisory capacity. In most of his activities, he works closely with the PEV counterpart responsible for the task addressed. The record indicates some past misunderstanding as to the role of USAID in the line of authority and communications. A recent exchange of messages with AFR/RA presumably has clarified the relationship and reaffirmed the authority of the USAID Director with respect to the CDC technical officer. The same message details three deviations from the standard authorities (discussed below) exercised by USAID over its bilateral project portfolio. It goes on to say that "all other implementation details are to be carried out under the guidance of the Mission Director." The cable does not specifically mention the Regional Epidemiologist. However, by extension, this officer while in Zaire, would also be subject to the USAID Director's guidance and authority when working in conjunction with the bilateral CCCD program. These arrangements are not reflected in the current position descriptions of the incumbents. (Attachments 2a and 2b). The technical officer's Form 8 under "II. Duties and Responsibilities" in listing nine discrete tasks, mentions USAID only once, i.e., under No. 7 "provides routine and special information regarding program activities to the USAID Mission, CDC and WHO. "...Par. III "Supervision and Guidance Received" states: "Within the guidelines of the country specific CCCD PASA and Project Agreement incumbent is responsible for determining own priorities and work plan in consultation with African counterpart. Incumbent's work is monitored, in terms of achievement of objectives by Deputy Director, R&D, IHPO: who also provides technical guidance as necessary."

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The recent AID/W cable clarifying relationships also states that CDC/Atlanta will request USAID inputs for the technical officer's PER. (There is no indication in the officer's 1983 PER - which he made available on his own initiative - that this approach was then followed.)

Similarly, the Regional Epidemiologist's "Billet Description," (dated September 1984) while showing Kinshasa as duty station makes no reference to the officer's relation to the USAID nor to REDSO/W, a subject treated at length in the same cable.

Recommendation:

1. The CDC Technical Officer's position description should be amended to conform to the understandings set forth in State 365369.
2. The Epidemiologist's "Billet Description" should be amended to show the officer's relationship to USAID/Zaire and to REDSO/W.

Accounting Problems:

The USAID Controller pointed out that the project employs three funding methods:

1. Bilateral Project Agreements which obligate funds, mainly for commodities, for a specific project.
2. Central Regional Funds managed by CCD. These funds, among other things, cover the cost of the CDC technicians.
3. Individual sub-allocations to cover the support costs of each CDC technician.

These different funding mechanisms result in increased workload and cause petty disputes between USAID and the CDC employees.

Examples of the types of controversies are drawn from a memo prepared by the Controller:

(a) Differences of opinion on whether an item should be charged to bilateral funds or to the sub-allocation.

(b) Disputes on what are proper charges to the sub-allocation:

(i) USAID recently moved into a new apartment building. A CDC employee who was moved into the new building had to buy new drapes. A dispute arose over whether the new drapes should be charged to the sub-allocation or to some other mission funds.

(ii) In connection with (i) above, the USAID had to pay a one year advance rent. Since the CDC employee was scheduled to leave before the year was up, discussion arose as to the propriety of charging the one year advance rent to the sub-allocation.

(iii) Security grills were installed in the building. The Controller received the bill from the management office and split charges among various occupants. The CDC technician objected to the charge to his sub-allocation because the grills were not on his windows. (he lived on an upper floor).

The memorandum goes on to point out that such disputes in conjunction with other funding aspects considerably increase the Controller's workload:

(a) The sub-allocation is under an individual's name; thus, the employee feels personally responsible for every dollar spent and demands copies of supporting documents for each payment made. Sometimes the payments charged to the sub-allocation are made at other USAID's. Locating and copying the supporting documentation are time consuming tasks.

(b) Keeping sub-allocations by individuals increases the possibilities for errors. Both the technicians and the Controller's office have spent considerable time correcting mistakes.

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The Controller's office estimates that the keeping of individual records for each USAID employee in a fashion similar to that now used for the CDC sub-allocation would require five times as many employees and twice as much office space.

The Controller offers several options for changing the present procedures:

1. Include funds for local support costs under the bilateral project agreements. Funds would be obligated at the time the agreements are signed and earmarked annually. This would lessen the number of accounting transactions and reduce the number of errors as support costs for all technicians in one location would be charged to the same account. This would also eliminate the problem of having to coordinate and reconcile two sets of accounting records located 10,000 miles apart.

2. A second option would be to provide one sub-allocation for each location to cover support costs of all technicians. This would reduce accounting errors and the number of disputes. The CDC employees would feel less proprietary concerning the funds if the sub-allocations were combined.

3. A third option would be to allot the funds for the support of the CDC staff to the USAID. USAID would then obligate and disburse the funds in the same manner as operations expenses.

The contractor wishes to point out the last option was already recommended by the North Evaluation in 1983 (p. 32) and has been adjudged positively by M/FM/BUD.

Recommendation:

AFR/RA and CDC should promptly consider simplifications of the present cumbersome sub-allocation system by adopting one of the suggested options. Comments should be transmitted to USAID as soon as possible.

### Technical Assistance Requirements

The question has been raised how long the project will require technical assistance. A reading of the Evaluation findings will show that - notwithstanding progress - the PEV/CCCD organization and its implementing capacity still show marked weaknesses. These include areas such as training, planning, logistics, information system, etc. At the same time, one should not forget that the project - considering start-up time - is only at the halfway mark. There seems little doubt that the technical assistance now provided by the two CDC officers will be required throughout the remaining project life. Beyond this point, there will probably be a need for, at least, some technical assistance whether or not U.S. dollar support will be provided. Conceivably, the technical officer's position could be replaced by TDY's or the position merged into that of the USAID project manager. The feasibility of these options should be considered as part of the 1986 evaluation. Without preempting the recommendations of the 1985 evaluation which are still being finalized, it is likely that more rather than less assistance is needed in areas of defined deficiencies, at least for the residual life of the current project.

#### Recommendation:

1. Continue present technical assistance during the LOP period.
2. In line with some of the Evaluation findings (e.g., in the areas of operational research), CDC should provide additional specialized short-term assistance.
3. At the time of the next evaluation, the need for and form of future technical assistance should be addressed.

#### Bilateral vs. Regional Management Aspects

USAID has been assured from the beginning that, subject to three exceptions, it would manage the bilateral program in the same manner as any other project in its portfolio. These exception clauses do not appear

to create any major problems. In fact, two of these, i.e., LOP funding level changes and changes in project goals and objectives, generally require AID/W approval and, frequently, prior Congressional notification. The third exception, timing of evaluations, should be readily accommodated by AID/W and present no vexing issues if justifications are properly submitted.

It can be argued that the management of bilateral projects conceptually and by definition falls outside the terms of reference of AFR/RA. Cables and other documents almost emphatically and continuously stress the bilateral character of the Zaire CCCD project. Several communications from AID/W advise USAID that any follow-on project, i.e., a Phase II CCCD activity, would need bilateral Mission funding. AID/W's initial decision to fund all CCCD activities from a single regional account is understandable. Presumably the approach included both end-of-FY obligation considerations and the need/desirability to introduce the largest number of common denominators into the structure and technologies of bilateral CCCD projects. However, as these projects begin to mature, each country conforms the CCCD effort to its own situation and formats. Organizational bases, financial capacities, the availability of trained and trainable cadres, socio-economic factors, and governmental priorities differ widely among cooperating countries. Zaire, for example, has undergone a 500 percent devaluation since the project was signed. Prices have shot up more or less proportionally; the Government's LOP contribution in local currency, shown in the Country Assessment as equaling \$15 million, has meanwhile shrunk to \$2 million. And while the assessment in its financial feasibility section considered counterpart an additive resource, the GOZ is increasingly substituting these funds for projected contributions by the national budget. These have shrunk from 29/100,000ths (sic) of the 1984 GOZ budget to 17/100,000ths in 1985; the Ministry of Health designated 1.45 percent of its 1984 budget for CCCD; in 1985, this figure becomes .66 percent. IMF limitations on budget expansion and a pause in the post-devaluation recovery may have forced the GOZ to institute these additional cuts in the allocation, especially in the face of a 20 percent inflation rate. The GOZ has many priorities among its priorities. One

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of the Evaluation sub-teams encountered a band of unpaid soldiers roaming the countryside indicating the existence of higher priorities than CCCD. Counterpart accumulations on which the project depends increasingly may require even more stringent programming. There exists the possibility of reduced PL 480 availabilities as a result of the Administration's proposed reform of farm subsidies. Concurrently, L/C generation through CIP's - while the U.S. dollar continues its climb - is lagging in most ESF countries.

These grave problems affect the Mission's program in major ways. They require constant dialogue with AID's geographic offices and through them with other interested agencies. AFR/RA cannot possibly follow the twists and turns of these bilateral developments in every country. It would seem appropriate at this point to fully validate earlier acknowledgements of the bilateral character of the Zaire CCCD project. This implies the transfer of stewardship for the Zaire-bilateral project from AFR/RA to the office/desk responsible for all projects and other aspects of the Zaire program in AID/W. This action should be taken early to permit fullest consideration of present and future requirements of the bilateral CCCD project within GOZ and USAID funding availabilities and priorities. Equally important, the transfer at this time would permit a smoother transition rather than an abrupt change after December 31, 1986. The transfer should be accompanied by appropriate personnel shifts, if any, continuing close cooperation/coordination with the regional project, and a deob/reob exercise transferring unobligated and unliquidated "bilateral" funds from the regional CCCD account to the Zaire account. This should involve comparatively simple computer runs.

Of course, arguments against the transfer are likely to emerge when the proposal is viewed from the AFR/RA and CDC/Atlanta perspectives. The contract does not provide the scope for a balanced analysis (see Introductory Note). Questions of technical backstopping, central procurement, linkages to the regional effort and others must be considered, of course. At the same time, USAID and AFR/RA should analyze the type and extent of future backstopping required by the advanced and relatively mature Zaire bilateral project.

Recommendation:

AID/W should consider the feasibility and merits of placing a bulk purchase order for drugs, especially measles vaccine, with approved foreign supplier(s) and authorize USAID(s) to procure requirements directly from such source(s) in quantities reflecting phased country requirements.

Note: The problem of undistributed stocks of refrigerators, bicycles, etc. is addressed in the Report itself.

PEV/CCCD

Integration:

There is universal agreement that the CCCD project, conceptually, is a part of primary health care. This makes integration of CCCD activities into PHC structures and activities both necessary and desirable. The validity of this approach is not in dispute. Integration at the Health Zone level and, to a lesser extent, at higher echelons is progressing. The accomplishments, trends, and existing deficiencies are discussed in the body of the report. At the national level, PEV/CCCD is shown on the Department of Health chart of organization at the level of an office ("Direction"). It occupies the same hierarchical position as the Office of Primary Health Care. Under the former Commissioner of Health (replaced during the Evaluation), PEV occupied a preferred position as its Director simultaneously served as the Commissioner's technical advisor. PEV/CCCD was created by Presidential decree, has an autonomous budget, and generally is staffed by contractors rather than civil servants. PEV/CCCD is understandably jealous of its prerogatives and strongly objects to losing its office-level position through merger with or subordination to the Office of Primary Health. There are indications of a forthcoming reorganization of the Ministry that may notably affect the administration of health services at the zone level. However, the options under consideration are not sufficiently clear to permit comments. USAID may want to suggest that Primary Health be raised to, what in AID would be called, a bureau. All primary health services, such as Nutrition, Family Planning,

SANRU, Leprosy, Sleeping Sickness, and PEV/CCCD would then fall under the new bureau. PEV could continue to receive its budget and special status. However, a competent Bureau leadership could ensure greater emphasis on coordinated planning, training, etc. of the various elements composing primary health services.

Recommendation:

In its ongoing policy dialogue with the Ministry of Health, USAID should emphasize the conceptual, policy, and operational advantages of bringing all offices (Directions) which contribute to PHC together in one bureau under strong and competent leadership. This would not need to affect the autonomous budgets under which some of these offices (including PEV/CCCD) operate.

Administration:

The PEV/CCCD Director has been absent from Zaire for some time. Since the start of the project, consultations for international organizations, attendance at conferences, etc. have taken him abroad for close to 50 percent of the time. His future plans are said to be uncertain. The most recent PEV organization chart (Report Annex -) does not show a position for a Deputy Director. However, the "1982-1986 Revised Plan for PEV Operations" - (Prepared by the Director and members of his staff) in an organization chart with accompanying commentary (P. 24-25) provides for a Deputy Director. (There exist rather detailed job descriptions for all professional positions except for those of the Director and Deputy Director.) The lack of a Deputy Director has greatly delayed policy and operational decisions. Most of them had to await the Director's return. Prior to his most recent departure, the Director orally authorized the Chief of Medical Services to take necessary actions in his absence. There is, however, no written delegation of authority. It is imperative that either a Deputy Director be appointed or, as a minimum measure, another position (rather than a particular individual) be designated to act automatically for the Director in case of his absence. The evident choice at this time would seem to be the position of the Chief of Medical Services.

Another aspect to be weighed is, of course, the future of the project, including especially the probability of a Phase II under various assumptions of GOZ ability/willingness to increase its financial support. In this context would USAID and/or AFR/RA visualize AFR/RA backstopping of a bilaterally funded project after 1986? What is AFR/CWA's position? Do USAID and/or AFR/RA automatically project a new contract with the present contractor (CDC) or would a Phase II activity involve a RFP that might result in other proposals, e.g., one from the SANRU contractor?

Recommendation:

Consider carefully the pro's and con's of transferring responsibility for management of the Zaire bilateral CCCD project from AFR/RA to CWA together with appropriate shifts of staff and funds.

Procurement:

On the whole, files and interviews would indicate project procurement has been efficient. Cooperation between the CDC technical officer (who usually provides the linkage between CCCD/PEV and USAID) and the USAID project manager has been good. A serious gap in 1984 in the supply of Measles vaccine is said to have been partly caused by a switch to centralized purchasing of this item by AID/W for the entire project. The MO's placing procurement responsibility for drugs, pesticides, etc. into AID/W are well understood. The Mission has previously suggested a system under which AID concludes a master contract with the approved foreign supplier(s). The Mission would then place sub-contracts directly, without using AID/W procurement channels, for quantities and at intervals reflecting changing project needs.

Recommendation:

The Director/PEV (or other authorized senior official of the Ministry of Health) should immediately appoint a Deputy Director or, at least,

designate a position whose incumbent would have full delegation of authority to act for the Director in his absence. The position of Chief of Medical Services would seem an appropriate choice.

Personnel:

The Central Office of PEV/CCCD is thinly staffed by a handful of professionals. Some of these are slated to leave in 1985 for additional training. Two MD's are to return from tropical medicine studies in Belgium. There has been a helpful trend to trade quantity for quality. Approximately 50 low-level positions, overall, were abolished in 1984. The presently on-board professional staff is the minimum complement needed to guide and manage the program. However, the staff lacks depth. Absences or attrition, for whatever reasons, leave deep holes.

Recommendation:

PE should continue to sacrifice quantity for quality by strengthening its professional cadre until the project's structure is firmly in place. For example, use of the new computer may permit additional reductions in clerical and semi-skilled positions (see below).

Compensation - Top-Offs

GOZ salaries are extremely low. At the professional level, they are a mere fraction of their private sector equivalents. For example, the Chief of Medical Services (U.S.-trained physician with specialization in pediatrics) earns - all inclusive - Z 108,000 (\$2,500), annually; the Deputy Chief (who is also the chief evaluation officer) receives Z 76,600 (\$1,770) per year; the Coordinator of Logistics gets slightly less (\$1,600/year). Most GOZ physicians are forced to moonlight; they open a practice or work in private clinics in their spare time. If, e.g. the above individuals - two extremely motivated, idealistic MD's - felt forced

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to supplement their GOZ salaries, they would, of course, become reluctant to work unpaid overtime or to go on field trips. As to travel, GOZ per diems are insufficient to pay lodging costs - not to mention food - in provincial capitals. Training, supervision, field observation and monitoring are some of the project's Achilles heels. Disincentives to travel, i.e., below break-even cost per diems, will further retard the day when the project structure is in place.

Topping-off salaries of host country officials working with AID-supported projects raises the obvious question of what will happen when U.S. contributions to the project end. On the other hand, USAID must consider the possibility that key professionals may be forced to reduce their present above-the-call-of-duty daily involvement in the project or be forced to quit to seek higher wages elsewhere. The PEV/CCCD program - as pointed out previously - functions barely at the break-even point at the professional level. It cannot continue to perform at its present rate - not to speak of the projected geographic expansion - if staff quantity or quality were reduced. Unless the GOZ raises professional salaries and realistically augments travel per diems, USAID may have to decide how badly it wants the project to continue and to progress in the absence of adequate GOZ compensation scales. Most observers, including notably members of the Evaluation team - off the record - believe that it will be years before the GOZ can and will take over financial responsibility for the program. In the meantime, these observers feel the international community will find ways and means to continue its support for this quintessentially humanitarian program. Thus, the moment of truth - i.e., what happens to topped-off emoluments after the phase-out of donor support - may not present itself for years.

Recommendation:

USAID should, without delay, consider the advantages and disadvantages of using CP for selective salary supplements for designated professional key positions and for some increases in the GOZ per diem level.

This is a difficult balance-of-advantage decision; however, it must be addressed soon (unless, of course, the GOZ is making the necessary adjustments).

Incentives:

The pay system in many francophone African countries has provisions for incentive payments (variously called primes d'incitation or primes d'encouragement). In the CCCD context, one could imagine the creation of an awards system featuring a "PEV Team of the Month" or a "Health Center of the Month" and/or a "PEV Employee of the Month." The monetary premium would be small and accompanied by a certificate. This could be linked to a newsletter reporting successes, problems, and personal happenings. Contributions from the field would be solicited. CCCD must continue to build its esprit de corps. In this area, it has done a good job to date under difficult circumstances.

Recommendation:

PEV/CCCD should establish an incentive awards system and consider issuing a monthly newsletter to build and increase the organization's esprit de corps.

Financial Management:

Budgeting: Major improvements in conceptual operational approaches are indicated and feasible.

Recommendations:

(1) The budget preparations should be based on work plans from the zones; these should be reviewed (and, in future years, consolidated) at the regional level. After technical review at the central level and preparation of administrative and operational cost projections for this echelon, the total requirements should be costed out, prioritized, and contingency budgets for various reduction percentages prepared.

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(2) There should be clear distinctions between capital and recurrent costs preliminary to proposing the amounts to be funded by the GOZ national budget, respectively by CP..

(3) The Mission (Controller, Program and/or PHO) should participate and assist in these tasks. There is some confusion at PEV/CCCD and possibly at higher levels regarding items that can be financed with CP. Written instructions including copies of correspondence setting forth pertinent understandings between USAID and Plan should be made available to PEV/CCCD.

Accounting:

Records seemed to be in good order and up to date. The Chief of Administrative Services felt that he had received excellent assistance from USAID/Controller. He found the USAID CP accounting system so efficient that he adopted it for all of PEV/CCCD's financial accounting operations.

Computer:

PEV very recently installed a computer. The CDC Technical Officer agreed that utilization of the equipment for inventories, accounting, record keeping, budgeting, operations planning and monitoring of teams, procurement, etc. should be pushed. This will take some time.

Recommendation:

Accelerate utilization of the computer for financial, managerial, programming, and logistic operations by elaboration of a time-phased plan setting forth the activities that can be usefully computerized together with training requirements. At some point, this may call for short-term TDY assistance by a CCCD expert.

Training:

The Consultant and the CDC Technical Officer agree that properly qualified employees would benefit from one or more of AID's regionally sponsored seminars in recurrent costs, project management, and financial management. These subjects are touched upon in various training courses but, presumably, are not as intensively addressed as in the specialized seminars.

Recommendation:

The PEV-CCCD Technical Officer should discuss AID sponsored regional training opportunities for PEV/CCCD employees in the fields of management, planning, and finance. For example, CILSS (Interstate Committee for the Sahelian Drought located in Ouagadougou) sponsors (AID-financed) seminars on recurrent costs. Alternatively, some of these and other AID developed modules could be integrated into CCCD in-country and inter-country training sessions.

Coordination:

The PEV/CCCD Coordinating Committee meets quarterly to review project plans and progress. The few reports in the file did not indicate that the agenda ever dealt with the project's financial problems. Other donors may consider that these fall more in the area of bilateral PEV/CCCD-USAID relations. There also appeared to be little, if any, discussion of inter-project coordination and cooperation. At least the meeting reports reviewed did not show participation by other project representatives nor by officials from the Office of Primary Health or related autonomous offices (Nutrition' FP, etc.). Undoubtedly, there are a good many informal contacts especially among American project managers. However, to reinforce the fact that these are GOZ projects, it might be well to arrange for primary health care sector meetings, preferably chaired by the Secretary General of the Ministry of Health. (Note: The Office of PHC is at the same hierarchical level as such offices as PEV, Nutrition' FP, Leprosy,

Sleeping Sickness, all of which conceptually fall under primary health care.) Unfortunately, coordination, at least in the past (the Commissioner of Health has been replaced since this evaluation began) appears to have been tenuous.

Recommendation:

USAID should encourage senior Ministry of Health officials above the level of office (Direction) director to convoke regular primary health care meetings. (It should be emphasized that PEV - while a vital element - is only one component of PHC).

CDA:

The files show that this organization plays an important and continuing role in the Africa-regional context of CCCD. Yet, neither in the many meetings of the Evaluation Team nor in outside interviews regarding the project was CDA mentioned even once. Several officials, both U.S. and non-U.S., had not even heard of the organization.

Recommendation:

Greater emphasis on CDA's sponsorship of the CCCD program initiative should increase local coordination efforts by CDA members.

U.S. Presence:

PEV receives most of its foreign support (technical advice, commodities, and budget support (CP) through the American assistance program. It is only natural that PEV/CCCD is generally considered a U.S.-sponsored project with comparatively minor inputs by others. In addition, the stringent controls that USAID/Zaire exercises over the CP account, both its allocations to and within projects, further highlight the American role and dominant contribution. Lagging GOZ budget support unavoidably leads to the constant query, "What will you do when U.S. support ends in 1986?" Evidently, PEV/CCCD personnel - particularly in the absence of

the Director - have no control over GOZ budget allocations and little access to those who do. They are keenly aware of their government's commitments and the shortfalls in this respect.

Recommendation:

USAID and CDC advisors should make every effort possible to underline that PEV/CCCD is a GOZ project in spite of its present dependence on USAID support. Questions regarding the future of the project should be addressed to the GOZ policy level by the USAID Director rather than by USAID and CDC staff to PEV/CCCD operational level personnel who cannot influence GOZ budget decisions.

Reinvention of the Wheel:

Some Zarois and expatriates (medical missionaries) appeared annoyed by the appearance that ORT and chloroquine administrations (especially the former) were recent "revelations" made to AID and WHO. They pointed out that they had been applying these procedures for years (not realizing that their subject knowledge may be incomplete). It might be better to explain that the use of these interventions has been greatly systematized and refined in recent years by building on the experiences of practitioners in Africa and elsewhere. PEV/CCCD is now able to familiarize primary health care personnel with these latest findings, etc.

Recommendation:

CCD/WHO/AID should lower their profile and sublimate their egos in dealings with field practitioners. They should tie ORT and chloroquine project components more to existing practices (deficient as they may be) rather than give the impression of proclaiming a recent invention.

Conclusion:

In summary, one might say that the project has exceeded various targets set by the Proag and has met others as one would define them today with the benefit of hindsight. The fact remains, however, that the GOZ

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Conclusion:

In summary, one might say that the project has exceeded various targets set by the Proag and has met others as one would define them today with the benefit of hindsight. The fact remains, however, that the GOZ

has been unwilling or unable to give CCCD the funding - even in inflated currency - that the letter and, especially, the spirit of the Project Agreement call for. It would seem appropriate to bring this stark fact together with the positive findings of the evaluation to the attention of the GOZ Ministries (Commissaires) of Health, Plan, and Finance. The American Ambassador may want to consider a letter to the President. Referring to the latter's inaugural address with its specific mentioning of CCCD/PEV, the letter might point out that the longer term success of the joint project is in danger due to underfunding by the GOZ. If this situation persists, it would be impossible for the Embassy/USAID to justify any requests to Washington to continue support of the project (e.g., a Phase II effort) after 1986 in its present form. A positive answer could be used by the Ministry of Health as leverage in future budget negotiations.

Many, if not most, of AID's previous, multimillion-dollar vaccination projects in Africa have failed upon phase out of AID support. Suffice it to recall several of the West African vaccination (measles) projects going back to the early 1960's with which the consultant is personally familiar. Similarly, the Cameroon CCCD project started to regress within one year of the 1982 EDP. The underlying cause of these failures has generally been insufficient funding by the countries' national budgets.

Hopefully, the GOZ will escalate its financial effort. If this were not the case, what are AID's options?

- (a) Reduction of the project in size (e.g., geographic extension) to fit GOZ funding levels with appropriate cut-backs in the remaining \$749,000 of the USAID commitment and stretch-outs in unsubobligated PIO/C balances. (The contractor did not check their status.) If the project's expansion were slowed, it is quite possible the pressure from less favored areas may focus GOZ attention on the program and its problems.

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- (b) Greater inputs by AID to compensate for the GOZ's (temporary?) contribution shortfall. In practical terms, this would presumably mean USAID's agreement to an increase in the CP allocation to the program.
- (c) By considering the project a relief program for children, its political importance (i.e., provision of a vital service) may justify ESF support until the conditions for an eventually self-sustaining development project exist.
- (d) Support for the project might be ended as planned and future support be concentrated on the reinforcement of related efforts (SANRU).
- (e) Mobilize additional support by other donors. The humanitarian nature of CCCD and CDA sponsorship may favor a (U.S.-supported) GOZ appeal to the donor community for (additional) assistance.
- (f) These and other options can be combined and permutated in various forms.

The important task is to find a way of providing continued CCCD services, be it within or outside an effort that meets AID's developmental criteria. The appointment of a new Health Commissioner should provide an excellent opportunity to review the situation and to begin a new high-level dialogue.

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ANNEXE IV : LISTE DES DOCUMENTS SUPPLEMENTAIRES A USAID/KINSHASA

1. PROJECT PAPER: Combatting Childhood Communicable Diseases
2. "Accord de Don Pour Project entre La Republique du Zaïre et les Etats-Unis d'Amérique pour la Lutte Contre les Maladies Communicables de l'Enfance" (Project Agreement) 31 Août, 1982.
3. Révision du Plan d'Opération du Programme Elargi de Vaccination du Zaïre 1982-1986.
4. "Country Assessment", Combatting Childhood Communicable Diseases Project, Zaïre.
5. "Executive Summary: CCCD Zaïre Economic and Financial Aspects", Marty Makinen, July 1984.
6. Health Education Component CCCD Zaïre, Trip report, Joan C. Mayer.
7. "Zaïre CCCD Project Consultation February 24 - March 25, 1984", Stanley O. Foster, M.D., M.P.H, 1984.
8. "MEMORANDUM: Colleen Conroy CCCD Project Director, OTAPS to Dick Wall, Peace Corps Director, Zaïre." Subject: CCCD Consultant Report.
9. "Scope of Work for CCCD Finance and Economic Consultant Martin Makinen", 1984.
10. "Financial and Economic Consultant Report, Zaïre CCCD Project", Martin Makinen 1984.
11. "Programme Elargi de Vaccination (PEV), Plan d'Opération 1980-1984."
12. "Rapport d'Activité PEV pour l'Année 1982."
13. "Rapport d'Activité pour l'année 1983" Programme de Lutte Contre les Maladies Diarrhéiques.
14. "Plan du Programme de Lutte Contre les Maladies Transmissibles 1984."
15. "Report of Consultation on ORS and Health Education in Zaïre and Congo", Melinda Moore.
16. Minutes: "AID Malaria Strategy Meeting, Columbia, Maryland" June 1983.
17. "CCCD Regional Project Description and Workplan for Fiscal Years 1983-1984 (October 1, 1982-September 30, 1984)".

18. "CCCD Regional Project Annual Report Fiscal Year 1983".
19. Compte Rendu: "Réunion du Comité Directeur du PEV, 25 Février, 1983".
20. "Rapport de Fin de Mission à Kinshasa au Directue PEV/CCD", Kathy Parker; CDC Atlanta, Février, 1984.
21. "Zaire FY 84 CCCD Annual Report".
22. "Rapport de Mission au Shaba de Mambu ma Disu et Felix N. Awantang", September 1984.
23. "CCCD Status Report on Implementation of Foster-Makinen Recommendations".
24. Evaluation du Système de Surveillance Sentinelle à Kinshasa, Taylor 1983.
- 25 a Rapport Activités Annuel PEV-CCCD 1983, 1984
26. Etude de la Prévalence de la Diarrhée et de la Fièvre ainsi que des Vaccinations Antirougeoleuses dans un Centre de Santé an Milieu Urbain, Taylor, 1983.
27. Etude sur les Cas Hospitalisés de Rougeole à l'Hôpital Mama Yemo, Taylor, 1983.
28. Etude sur la Mortalité à Kinshasa, Taylor, Décembre 1983.
29. Etude sur la Mortalité et Utilisation de Services en Milieu Rural au Zaire, Taylor, Octobre-Novembre, 1984.
30. Système d'Analyse des Données de Vaccinations Administrées.

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31. Guide pour l'Evaluation des Activités des Equipes Régionales et Sous-Régionales du PEV.
32. Explication du Système de Traitement des Données de Vaccination et de Surveillance des Maladies par l'Ordinateur.
33. Instructions sur l'Utilisation des Formulaires de Recueil des Données Relatives au Programme CCCD.
34. Evaluation du Système de Surveillance Etabli par le PEV/Zaire, 1981-1983.
35. Plan d'Action des programmes UNICEF-Conseil Exécutif pour l'Année 1984.
36. Rapport Technique sur l'Utilisation de la TRO à l'Hôpital Mama Yemo à Kinshasa.
37. Fiches Techniques du PEV/CCCD à l'Usage du Personnel des Centres de Santé.
38. Liste des Zones de Santé délimitées au Zaire 1984.
39. Rapports des Evaluations Internationales du PEV/Zaire faites en 1979; 1980; 1982.
40. Rapports Annuels des Activités du PEV pour les Années 1982, 1983, 1984.
41. Jeu de Modules du Cours National de Recyclage pour les Médecins Chefs de Zones de Santé, 2<sup>ème</sup> Edition, Mars 1984.
42. Stratégie Nationale en Matière de Santé Cabinet du Commissaire d'Etat à la Santé Publique, Juillet 1984 - non publiée.

43. Correspondence du Projet: 1982-1983-1984.
44. Gestion Fonds Contre-Partie: 1982-1983-1984.
45. PEV reports 1982, 1983, 1984
46. Evaluations du PEV, 1980, 1982
47. Fiches techniques du PEV-CCCD Programme de lutte contre les maladies diarrhéiques au Zaïre, 1982
48. "Cost Study of Expanded Program on Immunization in the Zambia," R.L. Robertson, I. Ujoodha, K. Ahmed, J. H. Davis, L. Sanoh, March 1982.
49. "An Operational Framework for Discussion Recurrent Costs in the USAID/CCCD Project," J. Ferster, January 1985.
50. "Conclusions Générales des Travaux de la Table Ronde sur les Soins de Santé Primaires," Département du Plan, Décembre 1984.
51. The Comeroon EPI Program on year after project Termination - Trip Report by Felix Awantang Public Health Advisor, USAID/Zaire.

ANNEX V - Personnages Contactées

Persons Contacted by The Evaluation Team

A. Kinshasa

Dr. Tshibasu Mubiayi, Commissaire d'Etat à la Santé Publique  
Cit. Mushobekwa wa Katana, Commissaire d'Etat à la Santé Publique  
Dr. Pangu Kanza, Conseiller Médicale  
Cit. Mibikay, Conseiller Financier et Administratif  
Cit. Rukirande Nkanda, Health Educator, CCOD  
Cit. Mushyia, ORT Implementor, CCOD  
Mark Szczencowski, Supervisor Project Monkypox  
Dr. Celestin Gantin, Coordinnateur Programmes OMS  
Dr. Simone Bernard, Médecin de l'OMS  
Dr. Kalamba Kalula, Médecin Projet SANRU  
Dr. Franklin Baer, Project Manager SANRU  
Mr. Richard L. Podol, Director, USAID  
Mr. Arthur S. Lezin, Asst. Director, USAID  
Mr. Richard Wall, Peace Corps Director  
Ms. Robin Steinward, Asst. Peace Corps/Health  
Dr. Kabamba Kamany, Director CEPLANUT  
Dr. Richard Brown, Technical Advisor CEPLANUT  
Dr. Frank Davachi, Chief Pediatrics, Mama Yemo Hospital  
Cit. Serevugo, Chef d'Equipe, Salle d'urgence Mama Yemo  
Ludo Martens, Industrial Pharmacist, LAPHAKI  
Mlle Marty Pipp, Consultant Operations Research, SANRU

B. During Field Visit

Dr. Lyagabo, Médecin Inspecteur Régional, Shaba  
Mr. Barker Brad, Superviseur Adjoint PEV/CCCD, Shaba  
Cit. Bukasa Musuamba, Chef d'Equipe PEV/CCCD, Shaba

Dispensaire de Katuba

Cit. Kanyimbo, Titulaire de Dispensaire

Hôpital Universitaire de Lubumbashi

Professeur Tallyrand

Centre de Santé de Rwashî (Université de Lubumbashi)

Dr. Tshiula  
Dr. Lubuya

Centre Nawezi, Médecin Directeur

Centre de Santé de Masaidiano

- Sr MARIE RAPHAEL, Titulaire de Dispensaire
- Sr MUILA ILUNGA

Clinique SNCZ, Lubumbashi

- Dr. NJOLOKO, Directeur Médical
- Dr. ALLEGRE, Chef de PMI
- Cit.

Centre Nutritionnel de RWASHI

- Père BERNARD ANDRE
- Citoyenne
  
- Dr. MIAKA MIA BILENGE
- Gouverneur KONDE VILA KIKANDA
- KUKADI TSHIALU BETU: Chef d'Equipe PEV/CCCD
- Dr. NCOYI LUBAMVU, Médecin Sous-Régional
- Cit. DILINGI, Directeur de Région
- Cit. FALIALA SHAFALI, Commissaire Urbain, Mbuji-Mayi
- BRUCE KENVEDY, UNICEF
- ILUNGA KALENDA, Directeur Centre Protestant
- MFOYI WA MFOYI, " " "
- TSHISUAKA MPENGA " " "
- KABEYA NKASHAMA " " "
  
- Dr. KABAMBA ABILI, Médecin Chef de Zone \_\_\_\_\_
- NTUMBA NDUMBI, Technicien d'Assainissement Miba

Zone Kalenda

- MUSAU KASOLO, Pharmacienne HGR Kalenda
- TSHIBANDA TSHIBANDA, Secrétaire HGR Kalenda
- MUTOMBO KAZOMB, Infirmier superviseur de ZSR Kalenda
- Dr. MULAMBA TSHIKELE, Médecin superviseur de l'HGR Kalenda
- Dr. MUTOMBO KAWANA KATOMB, Médecin Chef de Zone de Santé Kalenda

Zone Kibanga

- NSOMBA NICITA, Secrétaire
- NZEMBOU KABUALA, Superviseur
- MICI PAYI NDUMBI, Superviseur
- KAZADI MULUBA, Administrateur
- Dr. KANKONDE MUTOMBO, Menager Interimaire.

Centre de Santé Kaseya

- Cit. MUTOMBIA TAMINA, Infirmier, Kaseya Health Center

Centre de Santé Luputa

- Sister KATI, Chief Nurse, Luputa Health Center

Zone de Santé Kabinda

- Commissaire Sous-Régional de Kabinda
- JEROME MAYOLLE, Médecin de Zone
- Alain MERLOT, Doctor Hospital
- NSENDE TSHISUMBULE, Docteur de l'hôpital
- KASONGO KIMPO, Superviseur PEV
- MUAMBA TCHUNDO, " SSP
- KIBONGE MADIMBA, Administrateur Régional
- Soeur GERTRUDE, Centre de Santé Diocésien Mama Mobutu

Bemame Mpaza

Chef de Centre: MBEBE MULENDA  
Accoucheuse: MITSIEDI KASAMBA  
Animateur: EPANDU NDJIBU  
Commis: TSHIBAMBE NGOMA

Bandundu

- Dr. EKWANGALA MOSIANA, Médecin Inspecteur
- Citoyen BWANAMDOGO, Superviseur
- Dr. BODART, Médecin Chef de ZSU de Bandundu
- Citoyenne ABULEBE, Titulaire du CS Iwani-Salaminta

Bokoro

- Dr. MBEJ, Médecin affecté à l'Hôpital de Bokoro et remplaçant le Médecin Chef de Zone absent
- Citoyen KABONDO MBEJ, Infirmier titulaire du CS Kempa
- Citoyen MOMBIE IYENDA, Infirmier titulaire du CS de Nsanga-Nsanga
- Citoyen Gouverneur de la Région de Bandundu

Katana

- Dr. MARIAM MALENGREAU, Médecin Directeur, Zone de Katana
- Mr/ MUKIZA RUTEMANA, Secretary of PEV Team Bukavu
- Mme KAROMBA, Asst Coordinator PEV Team
- Dr. KABONGO MUTAPIKAY, Médecin Chef de Zone Urbaine Bukavu
- Cit. MWANDO NSIMBA, Gouverneur de Région de Bukavu
- Père DOMINO GIOVANNI, Director CS Cimpunda, Bukavu
- Mr. M. MUSAMBA, Infirmier Titulaire CS Bagira, Bukavu
- Dr. J. M. DONNAY, Médecin Chef de Zone p. 1 - Walungu
- Soeur EMILIA MARIE CROMBE, Chief of Nursing Staff, Walungu Hospital
- Cit. BAHATI BIN MANINGA, ROBER, Administrateur " "
- Soeur GEORGETTE, Director, CS Mubumbano
- Dr. SAMU, Médecin, Zone de Goma
- Dr. ROSELYN GLICKSMAN, P.C Doctor, Kinshasa
- PATTY KISSINGER, Reg. PC Rep. Goma
- Cit. HAKIZAMUNGU, JEAN, Vaccinator PEV TEAM, Goma
- Dr. LIAMBI - M.C. de Zone Uvira
- Dr. VINCENT DE BROUWER, IMT Kasongo
- Dr. SEKAGANDA HABYARIMANA, Uvira Hospital
- Dr. MIFILA
- Dr. MAMONI EMUNGA, Médecin Directeur, Uvira Hospital

- Cit. GIGWISIYA-MUMBINGU, Chief PEV Team Kindu
- Dr. SOLANGE MELOTTE' IMT Kasongo
- Dr. TAMBWE, Médecin Chef de Zone Kasongo
- Dr. LUC BONNEUX, IMT Kasongo
- Dr. BART CRIEL, " "
- Dr. BADIBANGA, " "
- Cit. OMARI KITOKO, Infirmier Titulaire CS 3 Kasongo
- Dr. XAVIER DE BETHUNE, Asst Med. Chef de Zone, Kindu
- Dr. MAKAMBA MBONA RIBA, MD Sous Regional, Kindu
- Dr. JOHAN VAN DEN BRANDT, Chief Trypanosomias Team Kasongo
- Cit. SHANGO, Commissaire Sous Regional Assistant, Sous Region de Manyema (Kindu)

ANNEXE VI.

Equipe Mixte d'Evaluation: Liste des Participants International Evaluation  
Team: List of Participants.

A. Les Evaluateurs Principaux/Core Group of Evaluators

1. Dr. M. S. Lichnevski, Fonctionnaire de l'OMS/Siège, Genève.
2. Dr. Nicole Guerin, Chef de Service des Maladies Transmissibles et Vaccination, Centre International de l'Enfance, Paris, France.
3. Dr. James D. Shpperd, Regional Health Officer USAID/REDSO-WCA, Abidjan, Ivory Coast.
4. Mr. Marty Makinen, Economist, Consultant, ABT Associates Cambridge, Mass., USA.
5. Mr. Harvey E. Gutman, Management Consultant, Checchi Co., Washington, DC, USA.

B. Groupe de Ressource/Resource Group

1. Mr. Felix N. Awantang, CCOD Project Officer, USAID/Kinshasa
2. Mr. Robert J. Baldwin, Supervisory Public Health Advisor, Centers for Disease Control, Atlanta, GA, USA.
3. Dr. Okwo Bele, Coordonnateur Chargé de l'Evaluation PEV/CCOD, Zaire.
4. Mr. David Eckerson, Health/Nutrition Advisor HNE, AID, Washington, DC, USA.
5. Dr. Ruben Gamboa, Administrateur des Projets, Développement du Jeune Enfant, UNICEF, Kinshasa.
6. Cit. Kapitaine Khantaway, Assistant Chef de Service Technique PEV/CCOD, Kinshasa.
7. Dr. Mambu-ma-Disu, Médecin Chef de Service Technique PEV/CCOD, Kinshasa.
8. Dr. Glenn L. Post, Chef, Public Health Division, USAID/Kinshasa.
9. Dr. Seruzingo Didace, Directeur du PEV, Burundi, OMS/AFRO.
10. Mr. Jean Roy, Technical Officer, CCOD/Kinshasa.
11. Dr. William Taylor, CCOD Field Epidemiologist CCOD/Kinshasa.
12. Mr. Imachul Ujoodha, Technicien des Opérations OMS/AFRO, Brazzaville, Congo

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