CLASSIFICATION

PROJECT EVALUATION SUMMARY (PES) — PART I

Report Symbol U-447

1. PROJECT TITLE	2. PROJECT NUMBER	3. MISSION/AID/W OFFICE
Combatting Childhood Communicable Diseases	698-0421	AFR/TR

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) 86

XX REGULAR EVALUATION ☐ SPECIAL EVALUATION

5. KEY PROJECT IMPLEMENTATION DATES	6. ESTIMATED PROJECT FUNDING	7. PERIOD COVERED BY EVALUATION
A. First PRO-AG or Equivalent FY 81 B. Final Obligation Expected FY 88 C. Final Input Delivery FY 89	A. Total $150,000,000 B. U.S. $ 58,000,000	From (month/yr.) Nov. 1983 To (month/yr.) March 1986 Date of Evaluation Review

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., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. AFR/TR/HPN is requesting an amendment to the CCCD project paper authorizing an extension through Sept. 30, 1991 and an increase in LOP funding by 42 million dollars.	AFR/TR/HPN Roseberry	August, 1986
2. AFR/TR/HPN will provide guidance to the field in a cable to be authorized by AA/AFR regarding actions to be taken by USAID on supporting governments to adapt auto-financing systems.	AFR/TR/HPN Roseberry	August, 1986
3. AFR/TR/HPN has requested CDC/Atlanta to develop, on a priority basis, a senior management training program.	CDC Atlanta Agle	March, 1987
4. AFR/TR/HPN will forward a memorandum to S&T/HEA, USAID's, CDC, Health Com, PRITECH and REACH specifying management procedures for cooperative endeavors between CCCD and the S&T funded projects.	AFR/TR/HPN Roseberry	July, 1986
5. AFR/TR/HPN has reached agreement with Health Com to provide additional resources in order to accelerate health education activities.		

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

- [X] Project Paper
- [X] Financial Plan
- [X] Logical Framework
- [ ] Project Agreement
- [X] Implementation Plan e.g., CPI Network
- [X] PIO/T
- [ ] PIO/C
- [ ] PIO/P
- [ ] Other (Specify) _____
- [ ] Other (Specify) _____

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT

- A. [ ] Continue Project Without Change
- B. [ ] Change Project Design and/or
  [X] Change Implementation Plan
- C. [ ] Discontinue Project

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

AFR/TR/HPN, Wendy Roseberry
CDC/IHPO, A. Agle
Dr. Marc La Force
Mr. Vincent Brown
Ms. Christine Meyers

12. Mission/AID/W Office Director Approval

Signature: Keith W. Sherper

Typed Name: Keith Sherper
Director, AFR/TR

Date: 8/15/86

AID 1330-15 (3-78)

6. AFR/TR/HPN and CDC have decided not to implement the recommendation to WHO/AFRO for review of Operational Research protocols but to facilitate the development of national review procedures.

7. AFR/TR/HPN and CDC/Atlanta have decided to concentrate the development of the WHO/AFRO epidemological bulletin as an essential prerequisite to consideration of futher support to the Health Information System component of the AID - WHO/AFRO grant agreement.

Secondary Recommendations:

8. Field staff will be directed to work with teams planning UNICEF and/or CDA member contributions to national immunization, ORT or malaria treatment programs. — AFR/TR/HPN Roseberry, August, 1986

9. Various country specific recommendations for Togo, Ivory Coast, Malawi and Congo WHO/AFRO will be and responded to by country specific memos. — AFR/TR/HPN Roseberry August, 1986

10. AID/W cannot accept the recommendation for shortening country external reviews to 5 working days due to lack of evidence that the evaluation can be performed in such a brief period. This suggestion will be reconsidered after careful review of the upcoming evaluations in Lesotho, Swaziland, Rwanda, Malawi and CAR. — AFR/TR/HPN Roseberry Nov. 1986

11. AFR/TR/HPN and CDC have considered the recommendation to conduct training in the preparation of research grants in each bilateral country and decided that the expected scope of the CCCD supported operations research portfolio does not warrent CCCD supported training. Such training available through other sources will benefited.

12. AFR/TR/HPN has already obtained agreement from Health Com to assist in health education implementation of bilateral projects.

13. AFR/TR/HPN plans to continue mortality studies in a sample of countries and will expore the feasibility of carrying out such studies in Malawi and Nigeria. — Jones CDC/Atlanta Dec. 1986

International Science and Technology Institute, Inc.

FOURTH ANNUAL (SECOND EXTERNAL) EVALUATION OF COMBATTING CHILDHOOD COMMUNICABLE DISEASES (CCCD) PROJECT (698-0421) IN AFRICA

Prepared for:

Office of Regional Affairs
Bureau for Africa
Agency for International Development
Washington, D.C.
(Contract No. PDC-1406-I-09-4068-00)

May 1986

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May 1986

COMBATTING CHILDHOOD COMMUNICABLE DISEASES IN AFRICA

Fourth Year Evaluation Report

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I. EXECUTIVE SUMMARY

The AID Combatting Childhood Communicable Diseases (CCCD) project, authorized in September 1981, is maturing nicely and has been well received in Africa. Twelve countries have signed bilateral agreements and interest in the program is still growing. AID has a unique opportunity to contribute to an important international African health program. Continuation of the program over the next 5-10 years can make a major contribution to the reduction of African childhood morbidity and mortality.

The objective of the project is to increase the ability of African governments to:

- prevent measles, polio, tuberculosis, diphtheria, pertussis and neonatal tetanus;
- provide simple and effective treatment for diarrheal disease;
- provide treatment of malaria in children under five and pregnant women;
- control diseases of local importance, such as yaws and yellow fever.

CCCD is designed to strengthen ministries of health to implement their primary health care plans which have been developed in accordance with WHO's worldwide programs and policies.

AID in the administration of the CCCD project should:

1. Extend CCCD project by three years through fiscal year 1991 and increase life of project funding by 20 million dollars.

2. Assure continuation of the CCCD project interventions after the end of the project by working with governments on auto-financing systems.

3. Ask that CDC/WHO/AFRO develop, on a priority basis, a senior management training program.

4. Codify the operating principles to be used by USAID, CDC, HEALTHCOM and PRITECH in the United States and in those countries which have CCCD bilateral programs.

5. Accelerate health education activities including mass media to create a demand for project interventions.

6. Encourage the development of an agreement between USAID and WHO/AFRO whereby operational research protocols for CCCD will be reviewed in Brazzaville.

7. Development better criteria for the implementation of Health Information Systems component of the AID/WHO/AFRO agreement.

II. SCOPE AND METHODS USED DURING EVALUATION

The Evaluation Team consisted of Dr. F. Marc LaForce, Associate Chief of Staff for Education, Denver V.A. Medical Center and Professor of Medicine, University of Colorado School of Medicine, Denver, Colorado; Mr. Vincent W. Brown, Senior Associate, Devres, Inc., Washington D.C.; and Ms. Christine Myers an independent health education consultant. Mr. Andrew Agle, CCCD Technical Coordinator from the Centers for Disease Control (CDC), accompanied the team and provided background information.

The Scope of Work (SOW) set out the team's objectives as follows:

> "To evaluate the accomplishments of the CCCD project, compare the accomplishments with the objectives stated in the project paper, project description and bilateral project agreements; identify problems which may have impeded project implementation and make recommedations for their amelioration."

The SOW further specified an evaluation of operations research, health information systems and health education aspects of the CCCD project as well as an evaluation of the administrative and management aspects.

Principal tasks spelled out in the SOWs for the team members were:

(A) Review the CCCD project paper, project description, evaluations completed at the end of the first, second and third year of the CCCD

project and special reports relating to health information system, operations research or health education components of the CCCD project.

(B) Conduct interviews of relevant project staff in CDC/Atlanta, AID/Washington and WHO/Geneva.

(C) Review, in field visits to Togo, Ivory Coast, Malawi, and Congo,[1] in country field activities in health information systems, operations research and health education.

(D) Review the national management of CCCD projects in Togo, Ivory Coast, Malawi, and Congo; identify and study management and administrative problems and develop recommendations for CCCD project modifications to ameliorate problems.

(E) Review health information systems aspects of the CCCD grant agreement with WHO/AFRO.

(F) Attend the 3rd annual CCCD consultative meeting and briefly report on evaluation findings.

The review included briefings at AID/Washington, the International Health Program Office (IHPO) at CDC Atlanta, WHO/Geneva and WHO/AFRO. Bilateral programs in Ivory Coast, Togo, Malawi and Congo were visited where CCCD, USAID and national personnel were interviewed.

The Evaluation Team attended the Third Annual CCCD Consultative Meeting which was held in Brazzaville from 24 to 27 March 1986, and briefly reported on its findings. Since all bilateral national program coordinators, Technical

[1]Swaziland was included in the original list of countries to be evaluated but was dropped just before the evaluation began since the USAID could not receive the team at the scheduled time.

Officers, Field Epidemiologists and IHPO staff were present, this meeting allowed for verification of data and clarification of questions that arose during the review.

Background documents on health education, operational research, health information systems and program reviews of Malawi, Togo, Ivory Coast and Congo were reviewed. Extensive discussions were held with AID/Washington CCCD Project Officer, Dr. Joe Davis in Atlanta, Washington and Brazzaville. The Evaluation Team paid particular attention to recommendations made after the First External Review in 1983 and the 1985 Third Annual Evaluation.

III. MAJOR CONCLUSIONS AND RECOMMENDATIONS

Management Issues

The CDC management of the CCCD program, both regionally and in the 12 countries with bilateral agreements, has matured and is going well. For example, all of the 17 overseas posts are filled; 12 Technical Officers (TOs), 4 Field Epidemiologists (FEs), and one WHO/AFRO Liaison Officer. Relationships in the field between USAIDS, UNICEF and WHO Country Representatives with CCCD TOs and FEs have improved, and now range from good to excellent in most countries. National Coordinators of various components of the CCCD program went out of their way to stress the usefulness and value of the TOs and FEs in helping carry out their program and management responsibilities.

The lack of clearly defined procedures for AID's two contractors HEALTHCOM and PRITECH could lead to misunderstandings and a blurring of program responsibility. AID/W should spell out, in writing, the operating principles to be used by AID/W, USAIDs, CDC, HEALTHCOM and PRITECH, both in the US and in those countries which have CCCD bilateral programs. Documents should reiterate that the CDC TO in each CCCD bilateral country is responsible for the overall administration and management of the program with HEALTHCOM or PRITECH furnished personnel operating under the TO's general guidance, except on technical matters where they would report directly to their home office.

In all countries visited, the CCCD National Coordinators and other government officials cited the need for increased management capabilities among senior officers at the national, regional, and district level as a major

constraint. Of particular importance were horizontal management skills in planning, setting of priorities, establishing time phased action plans, matching tasks to resources and preparing budgets. WHO/AFRO and CDC should agree within the next six months on a general approach to senior management training stressing horizontal management skills, and a qualified management training firm should be subcontracted by CDC to provide these services.

Length of CCCD Bilateral Projects

Present life-of-project times for CCCD bilateral projects should be extended from four to five years. Initial estimates of time required to achieve the project targets and goals did not take into account that roughly one year would be needed to train staff, order materials, purchase equipment and do basic studies. Project Agreements (ProAgs) should be amended to reflect the correct time frame i.e. a life-of-project of 60 months rather than 48 and progress indicators should be amended accordingly.

Three Year Extension

The team carefully examined the recommendation of the Third Year Evaluation team proposing that the CCCD project be extended from 1988 to the end of FY 1991, and concurs fully in this recommendation. Such a step is more consistent with the amount of time required to carry out the CCCD objectives, and will allow for the addition of other countries under bilateral programs. Further, some of the CCCD bilaterals signed in FY 1985 will still be operating in 1990, and the extension period corresponds to the UNICEF "Universal Childhood Immunization" program which ends in 1990, a time of intense EPI activity. Nigeria is under consideration to become a new CCCD bilateral country. It should receive priority given its population of over 100 million.

Therefore, it is recommended that steps be taken immediately to revise the CCCD project authorization extending it until the end of FY 1991 (September 30, 1991), and that $20.0 million in additional funding be obligated for this purpose bringing the total life-of-project financing to $67 million.

Sustainability (Recurrent Costs)

The general outlook for the CCCD countries to be able to cover their recurrent costs from budgetary funds and adhere to the auto financing schedules in the ProAgs is grim. Almost all of the participating countries have long term economic problems of a structural nature that will not be solved in the short term. While recognizing this difficult situation, it would be a mistake to ignore or waive completely the self-help targets in the ProAgs. At some point in the future donor interest may waiver or move on to other activities and if a CCCD country has not developed techniques to finance its own child survival initiative, programs will have to be either curtailed or stopped.

It is recommended that USAID and CCCD work with governments to start or continue auto financing systems appropriate to their country. Technical assistance should be supplied when needed. While there should be some flexibility in the amount of government payment required in a given year, government refusal to make any cash contribution towards the CCCD program should result in cessation of AID support for the project.

Health Informations Systems (HIS)

Major progress has been made in simplifying HIS country data. Computer software has been developed, requirements for reported data have been simplified and personal computers have been introduced to simplify data processing. This effort is a major step forward and data presented at the consultative meeting provided a good summary of the status of CCCD activities. Surveillance data on CCCD diseases have improved considerably and requests for computer support of national statistics and epidemiologic units should be supported.

Mortality studies should be continued. It is unlikely that CCCD process indicators in Liberia will attain high enough levels so that the impact of the CCCD program can be tested. Therefore, more emphasis needs to be placed on Togo and Zaire mortality survey areas and efforts should be made to increase CCCD services in these areas so that the mortality studies can be repeated within a reasonable time.

The HIS component of the AID/WHO/AFRO agreement has not progressed as well as might have been hoped. The proposed WHO/AFRO Epidemiological Bulletin has not begun and plans for developing HIS are not terribly clear. More emphasis needs to be placed on how HIS will be developed in WHO/AFRO. Publication of the Epidemiological Bulletin should be considered a major priority for the coming year.

Health Education

Health education activities have progressed more rapidly in the past two years. It is now time to emphasize promotional, mass communication and social

marketing approaches to health education in order to realize a greater impact of the interventions on the target audiences. More emphasis on systematic data gatering, strategy, materials development and monitoring techniques is needed to complement training activities that are already under way. Long-term relationships with consultants should be established to provide continuity in technical assistance. Long-term technical assistance through the HEALTHCOM project should also be explored in selected bilateral countries.

Operational Research

The operational research component of CCCD has evolved quite differently in East and West Africa. Few research proposals have been submitted by West African investigators and the great bulk of the 88 operational research applications have come from East and Southern Africa. Consultation in the preparation and assistance in data analysis has consumed a disproportionate amount of FE time. The East and West African Research Review Committees should be dissolved and negotiations between AID, CDC and WHO/AFRO should be initiated so that the CCCD operational research grant review process be transferred to the WHO/AFRO Research Development Committee.

IV. MANAGEMENT ISSUES

A. Regional Activities

1. Project Expenditures and Pipeline

The CCCD project authorization was signed on 28 September 1981 with a project life of eight years and a project assistance completion date of 30 September 1989.

Subobligations to date amount to $30.6 million dollars or 65% of the total of $47 million obligated for the project. The regional project pipeline is small with money drawn down from time to time as needed. The pipeline for the $12 million dollars sub obligated for individual bilateral projects is longer since it was judged desirable to fully fund the 12 grant agreements which have a project life of 48 months from the date of signing.

Of the $18.0 million spent regionally, about $15.0 million has gone to support CDC, its regional project activities, and backstopping of the bilateral programs. The remaining $3.0 million is primarily for purchase of measles vaccines, costs of evaluation teams and a PASA with the Peace Corps.

Conclusion

The CCCD project is proceeding normally and the 65% subobligation rate is about right. At the present rate of activitiy there should be enough funds to fund the project until its completion date on 30 September 1989.

2. Extension of the CCCD project

The Third Annual Evaluation of the CCCD project recommended that the CCCD life-of-project be extended by three years, an additional $20.0 million be

made available, and a new target of 16 countries established for bilateral assistance from AID. It further recommended that AFR/RA (now AFR/TR) seek an amendment to the current authorization to extend the project through FY 1991 and increase the LOP funding by $20.0 million to $67 million.

The Evaluation Team has carefully considered these recommendations, and fully endorses the extension and additional financing for the following reasons:

(a) While good progress has been made in a number of countries, in others the bilateral Project Agreements were only signed in FY85. If one assumes the first year is for start up activities followed by four operational years, the FY85 projects will not be finished before mid 1990.

(b) Some CCCD priority programs such as diarrheal disease control may require more time in some of the countries, since necessary health education support activities for these programs are just getting underway.

(c) Valid measurements of reductions in mortality rates utilizing Mortality and Utilization of Health Services (MUHS) surveys cannot be done until certain levels of coverage are reached, therefore it may be well into 1990-1991 before these studies can be repeated.

(d) Additional countries could benefit from CCCD bilateral programs. The most notable of these is Nigeria with a population of over 100 million. Given Nigeria's size and complexity, it is estimated that the CCCD program there will require a management effort by CDC equal to at least three additional countries. If Nigeria is included only one more country should be added. However, if some of the bilateral

programs which are already well along, such as Malawi and Togo, finish or shift over to other project financing, then additional bilateral CCCD countries should be considered.

(e) In addition to the extension of the CCCD project through FY 1991, a careful re-examination of the current 12 bilateral country programs is needed to determine if their progress, and host government commitment are sufficient to merit their continuation.

Recommendation

That the CCCD life-of-project be extended by three years until 30 September 1991, and that the current authorization be amended to extend the project through FY 1991 and increase the LOP funding by $20 million to $67 million.

That a new target be set for bilateral countries of 14 with Nigeria as one of those countries. Should one or more of the current twelve graduate from the bilateral program, then additional countries could be added.

3. UNICEF initiatives and CCCD

UNICEF is introducing or providing major increases in support for EPI/MCH initiatives into countries with CCCD bilateral programs. UNICEF finances mainly training, health education materials production, vehicles, vaccines, refrigerators, syringes and needles and other equipment, supported by limited amounts of technical assistance. Payment of gasoline, kerosene, and per diem for field visits is also possible with these funds.

Given the constraints on government funds and personnel there is concern about the absorptive capacity of CCCD countries and the negative impact that these funds can have on auto financing schemes. These concerns underline the need of the countries for the kind of experienced technical help provided by the TO's, and other services available under the CCCD regional and bilateral programs. National Coordinators in two of the bilateral countries visited by the team expressed their need for TO and FE help in establishing priorities and working out plans for the use of these new resources.

Recommendation

TOs should make special efforts to work closely with the UNICEF teams preparing the program proposals, and help the new UNICEF TO's and Epidemiologists. In this way, the new additional UNICEF activities can be integrated into ongoing activities with a minimum of difficulty.

B. Bilateral Projects

1. Length of Projects and Evaluation Targets

At present all of the bilateral Project Agreements are for 48 months divided into four operational years against which certain targets are set. However, these targets are not realistic in that every bilateral project requires a "start up" period of roughly a year to become operational. As a result, it is unlikely that most projects will be complete their objectives in less than five years.

The Evaluation Team has chosen to compare results of the Togo, Congo, and Malawi programs using four full operational years after the start up period. The results of these evaluations follow. (Note: The Ivory Coast bilateral

program was not formally evaluated since it had not finished its first year of operation. Informal comments are given in Annex III).

Recommendations

The Project Agreements for the 12 bilateral projects should now be amended to allow for a "start up" year plus four operational years and the project funding adjusted accordingly. Given the fact that the bilateral expenditures are very low during the start up year, this change should have little effect on total bilateral financing.

The regional budget of the CCCD project should be adjusted to make allowances for the additional cost of salary for the TO's extension from four to five years.

2. Bilateral Program Sustainability (Covering Recurrent Costs)

The general outlook for the CCCD countries to be able to cover their recurrent costs and adhere to the self-help schedules in the Project Agreements is grim. Almost all of the bilateral countries are in serious economic difficulties, and have IMF/World Bank agreements which place severe budgetary and personnel ceilings on them.

The temptation is to ignore or waive the auto financing targets in the ProAgs, especially in light of new UNICEF funds which will finance a variety of local costs such as per diem, kerosene and transport. However, the danger in agreeing to a strategy which does not oblige the government to make serious efforts to meet at least part of its local cost financing commitment is that in five to ten years when donor interest has gone on to other areas of need,

the government will not have the necessary funds in place to sustain CCCD programs.

Recommendation

USAID and CCCD should work with governments to start or continue their auto financing systems. In cases where the government refuses to make any contribution to its CCCD program, assistance should be stopped until a contribution is negotiated and received.

3. Togo

(a) Overview

The Togo bilateral CCCD program is now in its second operational year, and in its third year since the signing of the project agreement on April 5, 1983. The program is well managed and is progressing satisfactorily. Training is on target and will easily meet its goals, except for senior management training where it is waiting for the regional project to develop such a program.

Financially speaking, the outlook over the next several years is good. There are sufficient funds in the bilateral project to continue the project for at least one year beyond the current life-of-project ending in April 1987. UNICEF is expanding its contributions to Togo under its Universal Child Immunization Program and is expected to provide $1.7 million over the next 2 1/2 years, starting in April of 1986. In the medium term USAID is in the process of preparing a major health sector project which will begin in early 1988 and continue through 1993. It will include a component with CCCD type activities.

Specific findings and recommendations concerning the program and its management are discussed in the following sections.

(b) Project Timing and Evaluation Targets

Evaluations done for this project should be on the basis of a five-year life-of-project rather than four. The ProAg for the Togo CCCD project was signed on April 5, 1983, and provided for a life-of-project through April 4, 1987. Project field operations started in July 1984, some 15 months after signing, thus placing the project in its 20th month of effective operations in March 1986. This start-up time was necessary in order to allow time for field studies, purchase of equipment and supplies, training, etc.

Therefore, the team evaluated the CCCD targets for increased immunization coverage, access to oral rehydration therapy, malaria chemotherapy (children) and chemoprophylaxis (pregnant women) in the target populations against the following revised schedule:

Start-up*	Year 1	Year 2	Year 3	Year 4
4/83	7/84	7/85	7/86	7/87

Using the original targets as a guide, it was possible to assess the progress of the Togo program in the first year and half. The activities were concentrated in the Maritime Region as follows:

MARITIME REGION - TOGO

Services	Start-up 4/83-7/84	Year One 7/84-7/85 Target	Actual
DPT	14%	30%*	57%*
DPT3	3%		32%
Malaria			99%
Measles			35%
ORT			100%/34%**

*Above percentages are based on a population in the Maritime Region of 1,039,088 with 36% in Lome.

**100% of the centers had ORT available; 34% used these services.

The above data shows that the 30% general target for the Maritime Region was exceeded in all categories. Drop-off between the first and third DPT continued to be a significant problem. Malaria chemotherapy for children and chemoprophylaxis for pregnant women was widely used and tablets were easily available in the marketplace. Measles vaccination for children over nine months was a respectable 35%. Information was available in all of the centers for ORT packets and sugar/salt solution, but demand lagged at 34%. The overall national first year target of 10% coverage was clearly exceeded if one takes into account the progress in other regions of Togo.

Recommendation

The ProAg life-of-project should be increased by 15 months to July 1988 to allow for four operational years. Evaluation dates should be adjusted accordingly.

(c) Proposed Financing

The financial outlook over the short and medium term is promising for the bilateral project, with USAID funds already in place, UNICEF funds promised for spring 1986, and the USAID Health Sector Project now being developed to begin in 1988.

(d) USAID CCCD Bilateral Project

There will be savings at the end of the fourth year (April 1987) of about $274,000. Funds should be sufficient for a 15-month extension, to July 1988. During the extension, regional project funds will finance the TO and short-term assistance. The Togo national coordinator has expressed a strong desire to have a TO in residence during the full period of the extension. The priority areas are: a contract for CCCD vehicle maintenance, purchase of spare parts, and a private health education contractor.

Recommendation

The ProAg budget should be amended to provide for a 15 month extension from April 1987 to July 1988.

(e) UNICEF's Proposed 1986/87 Program

UNICEF, working with the GOT, has proposed to the Italian government an immunization project for Togo which is part of its "Universal Childhood

Immunization" program, in the amount of $1.7 million over two and half years. The UNICEF/GOT program will also include oral rehydration therapy with goals similar to those in the Togo CCCD program. Final approval is expected by April 1986 and given UNICEF's flexible funding procedures, there should be a fairly rapid start-up.

The UNICEF project is expected to cover the costs for the following immunization activities: health education materials production, replacement of vehicles and refrigerators, and purchase of vaccines, ORS packets and malaria tablets. In addition, it will include per diem for travel of those supervising and monitoring the immunization and ORT programs, plus short-term technical assistance.

The GOT has expressed the need to continue strong technical support through the CCCD project, even though UNICEF will be financing commodities and equipment formerly provided by the USAID-financed CCCD project.

(f) USAID Health Sector Grant FY 1988

This grant is now being developed and is expected to begin in early FY 1988, and will include follow-on activities from the CCCD project. The time phasing of the USAID health sector project is excellent from the standpoint of avoiding a hiatus after the finish of the CCCD project in July 1988, assuming that the recommended life-of-project extension is accepted.

In spite of the substantial funds being provided via UNICEF, the know-how, in-depth experience and backstopping capability of CDC/CCCD for this activity is irreplaceable. The Togolese government has stressed its need for continued CCCD services. USAID has expressed its desire to have the CCCD TO

come under the bilateral health sector grant in early 1988 when the funds are provided and obligated.

Recommendation

Assuming that program needs remain the same or increase and the USAID health sector grant is approved, USAID in 1988 should consider a PASA directly with the CDC for a TO to assure continuity and full technical backstopping.

(g) Sustainability (Recurrent Costs)

In the longer term, sustainability is a cause for concern, although there are some examples of village self-financing of malaria tablets, immunization and purchase of kerosene for refrigerators. In 1985, the GOT contribution to the CCCD program was 15 million CFA ($37,500) or 9% of the total costs; in 1986 the GOT contribution is 20 million CFA or 10% of estimated total costs.

Dr Marty Makin, economist on the 1985 CCCD Evaluation Team, estimated that payment of 50 CFA (13 cents) per vaccination, prenatal consultation, chloroquine treatment or ORS packet would cover costs of all those elements (US $219,000), and would leave $198,000 for the supply budget of the GOT. If 75 CFA (19 cents) were charged all costs including EPI would be covered.

The severe economic constraints on the GOT makes it unlikely that it will be able to increase its contribution for CCCD activities significantly in the foreseeable future. This situation puts a priority on helping the government develop feasible plans and techniques to encourage private financing of health care.

Recommendation

In agreement with GOT, a short-term French-speaking specialist with hands-on experience in self-financing of health programs in developing countries should be recruited to help work out a viable system for Togo.

(h) CCCD accounting and administrative procedures

Deloitte Haskins and Sells Inc. (DHS) was hired by USAID under the bilateral CCCD project to develop an accounting and administrative system for the CCCD project. DHS was also to train the central and regional personnel to operate the system satisfactorily.

So far, 221 Chief Medical Officers and their assistants from 124 health centers out of the 216 with CCCD programs (about 57% of the health centers) have received training. The reception of the new system by the Togolese field personnel has been very favorable. One unique feature includes a system of tokens used to count the kind and number of treatments administered to women and children at the health centers. These will be 16 different sizes, shapes and colors of tokens, and 130,000 locally-made tokens will be required for the country as a whole[2].

The major management problem with installing the DHS management system nationwide is that the training is not finished. Funds to train the remaining 43% of CCCD personnel in the use of the new system are not available. Given

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[2]The token system works as follows: A woman coming to the health center for treatment is given a different token for each kind of treatment or service she and/or her child will receive (DPT3, measles, ORS, etc.). As the vaccine is administered, she turns in her token. The tokens turned in are kept in a jar. At the end of clinic hours the tokens are separated and counted, thus producing an accurate count of the number and kind of services provided that day.

the complete change-over involved, the new system is not likely to work well without adequate training.

Recommendations

Additional funds should be made available for DHS to supervise the training of the remaining 90 to 100 CCCD personnel. A follow-up system should be installed to assure that the new integrated accounting and reporting system, once installed, is being used properly.

(i) Training

The Togo training program has gone well at the middle and general training levels. The project agreement sets a target of 1000 health personnel to be trained over the life of the project, with first priority to those in the health delivery system. The following table shows the number trained, broken down by the categories listed in the ProAg.

CCCD TRAINING - TOGO

Category	4/83 - 7/84	7/84 - 7/85	
Senior level superviser	2		
Mid-level	30	21	
Supply and maintenance personnel	5	0	
Casual health staff	300	521*	
Total (1983-1985)	337	541	Total: 878

(Note: *Includes DHS management courses but does not include the training of 180 health education people).

The training program at the end of the second year, had trained 878 health personnel. However, only 0.2% of those trained have received senior management instruction. At present, no materials designed specifically for the senior management level are available in French. The senior management training need has been specifically cited in the last two regional evaluations.

Recommendations

CDC/Atlanta should give high priority to develop, test and install a suitable CCCD senior management training program.

(j) Country constraints to carrying out the CCCD program

Logistics, personnel and management-related problems were cited as major constraints by Dr Karsa, CCCD National Coordinator and head of the Epidemiology Division of the Ministry of Health. Planning and delays in availability of basic statistical data were also mentioned.

From time to time there have not been sufficient gasoline rations to cover the travel connected with supervising, monitoring and teaching, by the Chief Medical Officers, particularly in the Savanne and Central Region where distances are great.

Morale problems among supervisory personnel have resulted from long (12-15 hour) days on the road with no per diem or money for lodging. A growing personnel problem is caused by a IMF mandated freeze on hiring new government personnel when existing staff retire or take other jobs outside government. The number of doctors and assistant doctors grew slightly from

169 in 1983 to 183 in 1985. Assistant doctors grew from 101 in 1983 to 108 in 1984. No data were available for 1985. However, all other categories fell (midwives, nurses, health assistants, mobile health workers and chauffeurs). The largest drop in personnel was in chauffeurs - 36% from 1983 to 1985. This dramatic decrease has meant that many centers have more vehicles than chauffeurs to operate them. Unless something is done about declining personnel, the expansion of coverage hoped for by increased UNICEF funding may not be possible.

Another problem is that government does not have an overall primary health care (PHC) plan into which CCCD activities can be placed. A draft PHC plan is circulating for clearance in the ministry.

Recommendation

WHO/UNICEF and USAID should work together with the GOT and the IMF to see if a solution can be worked out for the operational problem of inadequate Togolese support personnel, particularly chauffeurs. For example, permission could be given to hire a certain number of non-establishment personnel on contract with no long term commitment from the government. These persons would be for specific projects and not chargeable to personnel ceilings.

4. Malawi

(a) Overview

The CCCD program in Malawi is in the fourth quarter of the first operational year, and in its second year since the signing of the ProAg on 9 June 1984. The project is well managed, and is progressing very satisfactorily.

The Malawi program is different from the Togo and the Ivory Coast programs in that it is designed to strengthen an existing Malawian public health program in preventive and primary health care. The CCCD elements of the GOM programmes are worked out annually with the responsible departments in the Ministry of Health, and then are integrated into their respective national programs. This two-way dialogue within the framework of an existing programme is an integral part of the CCCD public health strategy and assures that the CCCD program is institutionalized. This approach is working satisfactorily and augurs well for the medium and long terms.

The Control of Diarrheal Disease (CDD) program is moving slowly on the demand side. While most of the district hospitals and fixed health centers have "ORT Corners" for the mothers, there has been less demand than anticipated from the mothers. Health education activities are being intensified and a full-time health educator advisor to be supplied by HEALTHCOM has been approved and is waiting for GOM clearance.

EPI surveys in 1985 showed that the number of fully immunized children decreased by 20% when compared to 1982 data; 35% of under 1's were fully immunized compared to 55% in 1982. Lack of gasoline for vehicles, kerosene for refrigerators and vaccines for immunization in 1983-1984 is reported to be the reason for this decrease.

The malaria program is well managed with special attention being paid to treatment schedules in light of chloroquine resistance.

UNICEF is planning a major EPI/MCH project with the GOM of US $4.7 million. The UNICEF project will be using Italian funds from 1986 to 1989 as part of its "Universal Child Immunization" program.

Government officials at central and regional levels expressed to the team their high regard for the CCCD TO and the FE and stressed the value of their counsel and assistance. The GOM's strong desire for the continued services of the CCCD experts was reinterated to team members at the team's debriefing.

The following recommendations are based on discussions with Malawian government officials at central, regional and district levels, representatives of WHO, UNICEF, and the USAID health officer. Field visits were carried out and the Malawian five-year health sector plan, the CCCD FY 1985-1986 work plans and budgets, as well as the first year evaluation report, were reviewed.

(b) Project timing and evaluation targets

Evaluations done for this project should be on the basis of a five-year life of project rather than four. The bilateral project agreement (ProAg) for the Malawi CCCD project was signed on 9 June 1984 and provided for a life of project of 48 months from date of signing. However, field operations did not start in a major way until January 1985, some six months after signing of the ProAg thus placing the project in its 15th month of effective operations in March 1986. This start-up period was obligatory in order to allow time for field studies, purchase of basic equipment and supplies, and training. Therefore, the team evaluated the progress of the Malawi bilateral CCCD program against the following revised schedule:

Operational Years

Start-up*	Year 1	Year 2	Year 3	Year 4
June 1984	Jan/1985	Jan/1986	Jan/1987	Jan/1988

The following shows the estimated end-of-project percentage reductions of childhood morbidity and mortality:

Disease	Decrease in Morbidity	Decrease in Mortality
Pertussis	40%	30%
Polio	60%	-
Measles	40%	30%
Diarrhea		60%
Malaria		30-35%

In addition it is intended to link these programs at the community level with the primary health care system (PHC) using a strengthened health information system vide the community health science unit.

(c) GOM planning and financing

The GOM's five-year planning document for 1986-1990 was submitted to donors in January 1986. It describes the government's plans, and establishes goals, targets and priorities. The financial outlook for this five-year plan is favourable with much of the external financing in place from the USAID bilateral and regional CCCD programs, the UNICEF proposed project, and the World Bank health sector IDA loan. In addition significant private health

services are provided by "The Private Hospital Association of Malawi" (PHAM). These activities are discussed below:

1. GOM planning, 1986-1989

During the past two years the Ministry of Health (MOH) has undertaken a comprehensive review of its health sector and a draft plan for the development of health services in Malawi has been prepared for the ten years 1986-1995. Recognizing that it is not possible to implement all plan activities immediately the MOH has developed a more detailed five-year implementation plan which was sent to donors in January 1986. This plan attempts to address priority health problems in the cc text of financial constraints, and is consistent with CCCD objectives.

The 1990 goals are as follows:

(a) To reduce IMR from a national coverage of 151/1 000 live births to 110/1000 live births.

(b) To reduce 1-4 year mortality from 330/1000 population to 210/1000 population.

(c) To reduce maternal mortality from 16/000 births to 10/1000 through increased access to antenatal and postnatal services.

(d) To improve maternal health and nutrition by achieving a contraceptive prevalence rate of 10%.

The issuance of a five-year plan by the GOM fulfils one of recommendations of the first year's review of the Malawi bilateral CCCD program. There are no interim goals prior to the end of the project in the project agreement with which to assess progress towards project goals.

Recommendations

The ProAg life-of-project date should be extended by six months to December 1988 to allow for four full operational years.

The TOs working with the National Coordinator and the USAID Health Officer should establish interim morbidity and mortality goals for the second and fourth operational years. EPI targets in the UNICEF/WHO proposal (1986-1989) should be considered in carrying out this recommendations.

2. USAID CCCD bilateral for Malawi

This US $1.4 million bilateral project moved slowly during the start-up period and first operational year. Subobligations were US $350,000 or 25% of the total bilateral budget in FY85. Expenditures in FY85 were US $62,000 or only 4.3% of the total budget. FY86 will see the project activity pick up with subobligations totalling US $797,000 or 56% of the total budget. Expenditures are estimated at US $807,000 or 57%. This means that cumulative sub obligations and expenditures in FY86 will be 81% and 61% respectively.

Funding for specific line items has been shifted in FY86 to provide funding for a HEALTHCOM health education advisor (US $124,000) and increased CDD/ORT activity (US $478,000). These changes reinforce health education activities which have been lagging, and give more emphasis to the CDD/ORT program which is at a stage where it can absorb additional inputs. These funds were previously earmarked for vehicles, refrigerators, vaccines, and other equipment which are expected to be financed by UNICEF. A detailed breakdown of subobligations and expenditures by category is given in Annex

II(a). The regional USAID CCCD project will continue to cover the costs of long and short term technical assistance in Malawi and finance certain materials. The annual regional costs are estimated at US $400,000.

It was not possible to determine the percentage of GOM contribution to the project in FY85/86 since the government accounts are kept for the entire health sector and do not break out CCCD costs. The TO has asked the GOM to provide this information.

Recommendation

The TO should see that sufficiently detailed accounting is done of CCCD activities to determine GOM contributions.

3. UNICEF/MOH's EPI/MCH Plan of Operations, 1986-1989[3]

The UNICEF/MOH proposal totals US $4.7 millions, and if approved, will be financed by Italian funds channelled through UNICEF. Approval is expected in late Spring. The project aims to phase in immunization as an integral function of PHC/MCH in collaboration with other health services. UNICEF services will include an EPI TO, a logistics/supply officer, and funds for the purchase of vaccines, refrigerators, vehicles, petroleum and kerosene. These inputs are freeing resources from the USAID CCCD budget which have been reprogrammed into health education and CDD.

GOM officials stressed the importance of careful planning in the use of these additional resources given the restrictions on enlarging the staff.

[3]Government of Malawi, EPI/MCH Plan of Operation, 1986-1989, prepared with UNICEF/JSl, Lilongwe, Malawi, January 1986.

CCCD TO, FE and CDC/Atlanta advice will become even more important to the GOM in helping it utilize these additional resources and in providing necessary training. GOM officials have emphasized their desire to continue these resident CCCD advisory services.

Recommendations

The regional CCCD project should take special care in the next four to five years to assure continuity of long-term personnel, other technical assistance, and training services.

4. World Bank/IDA Loan for Health

On 28 March 1983, the World Bank granted a soft loan to Malawi of US $6.8 million to assist the MOH to:

(a) improve the ability to plan, monitor and evaluate health programs and policies;

(b) strengthen MOH's capacity to carry out epidemiological studies with supporting laboratory services;

(c) improve the system for procuring and distributing pharmaceuticals;

(d) extend primary health care to selected districts and

(e) introduce child spacing as an element of the MOH's maternal and child health program.

One element that affects the CCCD project directly is the World Bank commitment to rehabilitate and/or build facilities to house the Community Health Sciences Unit (CHSU) as well as providing staff housing, equipment and

vehicles, overseas fellowships and technical assistance. The CHSU facility in Lilongwe has been identified and plans for refurbishing and construction are in final stages of approval in the GOM.

Recommendations

The TO should monitor and support the CHSU facility.

5. The Private Hospital Association of Malawi (PHAM)

PHAM operates 20 hospitals, 39 primary health centres and 85 other health units and makes a considerable contribution to the health sector in Malawi. PHAM hospitals account for just over one-third of all admissions and in-patient days. PHAM has fewer health centres than the MOH and its contribution is weighted towards in-patient care, although this is changing rapidly in view of the support being given to primary health care.

Income to PHAM is derived principally from government allocations, fees, and overseas donations. Income to PHAM was approximately K3.3 million in 1981, the last year for which data is available. Government contributions (primarily for Malawian staff employed by PHAM and for selected drugs) amounted to approximately 34.7% of total PHAM income. Fees and donations from overseas made up about 33.7% and 25.8% of revenue respectively.

Recommendations

PHAM should be encouraged to increase its emphasis on preventive services and be included in CCCD planning activities.

(d) Sustainability (recurrent costs)

The GOM has provided substantial local cost funding. However, it does not keep separate accounts for CCCD activities which are integrated into its MOH budget. It was not possible, therefore, to determine the amount of funding provided by the GOM for CCCD activities from its own resources in FY85. The ProAg states that the GOM over the life of project (LOP) will expend no less than US $4,200,000 in local cost financing. Budgetary constraints make it unlikely that the government will be able to increase its level of contribution over the next few years significantly above the US $400,000 estimated as its first year's contribution.

Despite the severe economic constraints of the government, it is very important for the GOM to work out suitable auto-financing arrangements as there are already precedents for payment of medicine and clinical services; many families purchase chloroquine in the open market; mothers and children using the PHAM hospitals are asked to pay a fee for services; some government hospitals have a special waiting line which provides priority services, and charges a modest fee for this privilege. A modest fee for vaccination cards, vaccinations ORT, and prenatal visits might well cover the out of pocket costs.

Recommendation

The GOM should be asked to keep a separate account or identify within existing accounting system the amount it spends on the CCCD program. The GOM should start now to develop a time phased program of self-help for its CCCD programs which will ultimately assure sufficient income to cover the local costs of its CCCD activities. Technical assistance should be provided to help in this effort.

(e) Training

Since the signing of the Project Agreement in June 1984, 2381 participants have received 7994 days of training or an average of 3.3 days per participant Annex II(b).

Most programs were based on training modules furnished by CDC/WHO which were modified to fit the local situation in Malawi. No senior/executive management courses were carried out. The national coordinator and CCCD program managers expressed the need for training in horizontal management skills such as planning, establishment of priorities, matching resources to tasks, establishing time phased action plans and budgeting. In addition, absences of key government officials to attend international conferences and training courses tended to slow down the implementation of the CCCD program.

Recommendations

Senior/executive level management training should be adapted for Malawia stressing horizontal management skills in planning, setting priorities and task lists. Donors should try to schedule participant training in a way that minimizes the absences of key MOH officials from their jobs.

(f) National constraints

Funding

Government officials highlighted shortage of funds as their number one problem. The Malawian Government has been under severe budgetary constraints

in line with World Bank agreements. Lack of funds in 1983 and 1984 resulted in significant shortage of gasoline and kerosene which compromised the EPI program.

Recommendations

In the short-term, donors should continue their support to the GOM for local costs for such things as gasoline, kerosene, purchase of refrigeratorsand vehicles. However, the GOM should be asked to give high priority for planning and implementing a self-help program. Appropriate technical assistance by an expert or firm with "hands on" experience in designing and implementing self-help auto-financing primary health care systems should be made available.

Management

Management was stressed as a major problem in all discussion about constraints to successful implementation of the CCCD programs. Officials called upon to manage major programs may have excellent public health or medical qualifications, but have had little or no training in management skills.

Recommendation

Same as in section (e).

Manpower

There are severe personnel constraints because of personnel ceilings linked to GOM budgetary difficulties. The Minister of Health is obliged to show how he will continue the salary and benefits of anyone hired for CCCD

activities after foreign assistance is exhausted. The shortages caused by these constraints were most severe for support personnel such as chauffeurs, laboratory and refrigerator repair technicians.

The expansion in EPI/MCH activities as a result of the $4.7 million UNICEF project will require additional personnel to absorb these additional resources. Relief might be possible if new positions could be limited to the life of the project.

Recommendation

Those jobs which are project specific and only needed through 1990/1991 should be converted to, or established as non-establishment posts or personal services contracts with the duration of the appointment or contract limited to the life of project. Such a procedure, should help provide adequate Malawian management staff for the CCCD and UNICEF projects.

5. Congo

A. Overview

The program is well managed, and the TO has excellent relations with the Congolese National and Deputy National Coordinators for the CCCD program. France, another CDA country, is a full member of the CCCD project and is contributing roughly 20% of the exernal resources. The TO's relationships with the French CCCD TO are excellent, and very close liaison exists with the UNICEF Representative.

The rate of program progress in 1985 accelerated as newly appointed Congolese staff assumed greater responsibility for project direction and

administration. A new Director for Preventive Health/National Coordinator was appointed in January as well as new program chiefs for diarrheal diseases and malaria. An Assistant National Coordinator assumed responsibility for day to day project activities in mid-year. Thus, earlier problems were resolved through new staff appointments and further delegation of program responsibilities.

However, going into 1986 two major problems remained:

(1) Minimal financial support by the Ministry of Health

No Congolese Government funds were made available to the project in 1984. Minimal funds (31%) were made available in 1985. No funds for CCCD were included in the 1986 budget. The TO has been working closely with USAID/Kinshasa and the American Ambassador to the Congo on ways to resolve lack of financial support by the Congolese Government. On 28 January.1986 USAID, Kinshasa froze the local fund account for the project until GOC interest and financial support was clarified.

(2) Lack of coordination of primary health care activities

There is no centralized Coordinating Committee for CCCD or primary health care activities within the Ministry of Health in spite of attempts made by the project staff. Although a PHC Coordinating Committee was established by a ministerial note in October, this committee has yet to meet.

Recommendations

The USAID/Kinshasa freeze on the release of local funds should be continued until the Congolese Government makes a reasonable contribution to its share of the costs of the CCCD program.

Strong encouragement should be given to the Minister of Health by USAID, and by the US Ambassador to convene the PHC Coordination Committee and to expand its mandate to include coordination of the CCCD activities.

6. Ivory Coast

There was no evaluation requested for the Ivory Coast bilateral program since it had not yet finished its first year of operation. However, informal discussions were held with the CCCD TO and his REDSO back stop which are given in Annex III.

C. CCCD/USAID/Government Relations

TO and FE relationships with the USAID Project Officers ranged from good to excellent in the four countries visited. TO and FE relationships with national coordinators were excellent in the countries visited as they were with the UNICEF and WHO representatives. TO's showed considerable ingenuity and savoir faire in accommodating to frequent changes of key government personnel and logistic problems.

As USAIDs direct hire staff are reduced, they are looking more to the TOs and FEs for help with the paper work. Knowledge of AID documentation and procedures shortens USAID response time, and contributes to better working relationships. TOs and FEs are highly skilled technical personnel who should

spend most of their time on substantive matters. However, if sufficient attention is not given to administrative matters, administrative actions will become more difficult, and the bilateral CCCD program will be hampered.

USAID are very sensitive to establishing adequate accounting systems for local purchases, government managed local currency revolving funds, use of vehicles and gasoline expenditures.

Recommendations

New TOs should take the one week AID project implementation course at the earliest opportunity after arrival at post.

If inadequate accounting procedures exist on the host government side to account for local cost financing under the CCCD project, the TO should work with the USAID and CDC to bring in the necessary technical assistance to resolve the problem.

D. CDC

1. Staffing: CDC Direct Hire and Personal Services Contracts

At the present time about 50% of the CCCD staff overseas is under Personal Services contract. CDC does have sufficient direct hire (FTE's) to fill these positions from its staff working in Atlanta, in States or in other government agencies. However, CDC FTE personnel ceilings preclude recruiting more than 50% of its overseas staff from among its own personnel. While there may be an occasional need to go outside (e.g. French language capabilities or

a special epidemiological skill), in general it is preferable to fill these posts with experienced, regular employees, and thus benefit to the fullest from CDC's institutional backing and many years of experience.

Recommendation

That CDC and AID explore the possibility of obtaining a temporary life-of-project increase in FTE ceilings of four positions which would reduce the reliance on outside personal services contract people to about 33%. Those extensions should be until 1991, assuming the recommended extension of the CCCD project is approved. Another possibility would be to utilize WHO's Associate Professional Officer Program.

2. Senior Level Management Training

In all countries visited the National Coordinators and other government officials cited the need for increased management capabilities as a major constraint. The original CCCD project paper (based on estimates of training needs projected by WHO/Geneva) estimated that approximately 800 persons would need senior level training in EPI and CDD. The project paper envisaged WHO/AFRO playing a strong role. However the Project Agreement with CDC and WHO/AFRO was not signed until January 1985 and no major steps were taken during 1985 to provide this training despite its inclusion in the 1985 WHO/AFRO/CCCD work plan.

CDC could start by subcontracting with a management training firm skilled in senior management training to develop and field test training materials. The subcontractor, under CDC direction, would work closely with WHO/AFRO in developing these training programs with a view to joint approval and

sponsorship of the final product. WHO/AFRO would coordinate the use of these training modules throughout the region once the training programs were written, approved and field tested.

While it would be up to the management firm working with CDC/WHO/AFRO to develop the most effective approach, the course might be divided into two major modules:

(a) A course for managers at regional and national levels having important coordination and policy making responsibilities at their respective organizational levels; and

(b) A course for officers at district level having responsibilities involving nurses, health workers, mobile health teams, vehicles, medical supplies, equipment and a variety of inpatient/outpatient services.

Recommendation

(a) WHO/AFRO and CDC should agree within the next six months on a general approach to senior management training stressing horizontal management skills.

(b) CDC should obtain the services of an experienced management expert with experience in the health field to prepare a scope of work for a subcontract with a management training firm to work with CDC and WHO/AFRO in developing and testing training programs, materials, seminars and course material.

(c) Once this scope of work has been developed and agreed by CDC and WHO/AFRO, a subcontract should be signed with a qualified management training firm to provide these services.

(d) Given the past delays that have occurred in this important element of the CCCD project, the team recommends that CDC take the initiative in close cooperation with WHO/AFRO to obtain the necessary skills and services needed to make senior management training an operational reality.

3. CCCD/HEALTHCOM/PRITECH Relationships

The team reviewed the relationships of CDC with two other AID contractors, HEALTHCOM and PRITECH working in CCCD bilateral countries in those cases where HEALTHCOM will supply the health education advisor and/or PRITECH supply the CDD/ORT advisor.

There appeared to be no established procedures setting forth how AID and the three contractors should work together in countries with CCCD bilateral programs for which CDC is responsible. In Malawi, working arrangements were clarified by a Project Implementation letter (PIL) from USAID to the CCCD TO for Malawi spelling out the organizational relationships. In this PIL the CDC TO's position in overall charge of the CCCD project was reaffirmed with the health education advisor supplied by HEALTHCOM reporting to the TO on administrative and project management matters. On technical matters the health education advisor was responsible to his home office. This instruction assured overall coordination of the different components which make up the CCCD project.

Under this new arrangement described above it is assumed that the roles of the CDC health education advisor and the CDC Director for the CDD/ORT program (in cases where PRITECH is involved) in Atlanta would change with the emphasis moving from operational backstopping to policy considerations and general oversight of the country's health education and CDD/ORT program. In those countries with CCCD bilateral programs where HEALTHCOM and/or PRITECH will not supply full time resident personnel, CDC would function as before with the CDC health education advisor, and CDC Director for the CDD/ORT program responsible for necessary program development and backstopping.

AID/W, CDC, HEALTHCOM and PRITECH procedures for working together in the US are less clear. Telegram clearances vary according to workload of individual officers and travel schedules; distribution of telegrams, memos and letters is spotty. While there appears to be a fairly high degree of understanding among the principal officers in the different contract organizations, these ad hoc arrangements should be formalized on paper. Once this is done, no matter what changes in personnel occur, the correct operating procedure will be known to all.

Recommendations

AID/W should spell out in writing the operating principles to be used by AID/W, USAIDs, CDC, HEALTHCOM and PRITECH in the US and in those countries which have CCCD bilateral programs. Such things, as basic clearance procedures to assure full coordination should be set forth so there is no doubt about how to proceed among the participants.

The write-up should reiterate that the CDC TO in each CCCD bilateral country is responsible for the overall administration and management of the program, with HEALTHCOM or PRITECH furnished personnel operating under the TO's general guidance. The possibility of using PILs issued by the USAID to the TO should be considered as a useful mechanism to set forth the operating relationships between the host government, CDC, HEALTHCOM and/or PRITECH.

CDC/Atlanta should adjust its internal operating procedures, and spell out headquarters staff responsibilities to reflect the new emphasis in backstopping responsibilities in countries where HEALTHCOM and PRITECH will be supplying resident experts.

4. CDC Staff Relations and the Annual Staff Meeting

Prior to the 1986 CCCD Consultative Meeting CDC held a two to three day staff meeting with its 12 TOs, 4 FEs and the Brazzaville CCCD Liaison Officer with WHO/AFRO. This meeting is an important element in effective management of the CCCD program. The complex social/technical/ economic issues involved in the various programs add to the significance of the annual staff meeting.

Presentations made at the Staff Meeting by the TOs on their respective bilateral programs were structured and emphasized accomplishments and problems. IHPO staff presentations dealt with problems, and new initiatives in the major program priority areas (EPI, CDD, HIS, Operational Research, Health Education, Malaria, etc.). Exchanges were frank and lively.

Conclusions

CDC is managing its staff well and is doing a good job of replacing those finishing their terms of duty. Staff relations appear excellent with open dialogue. Current staff is adequate for the existing programs. However, if additional countries are added additional personnel may well be required in order to properly service and backstop the new programs.

E. Evaluations

The Third Annual CCCD Evaluation recommended changes in evaluation of CCCD projects. This Evaluation Team endorses a decrease (indicated below) in the number and extent of evaluations.

Recommendations

Bilateral programs should undergo two external reviews, one at two years and a second three months before the end of the project. The health information systems data, annual work plans, annual meeting and monthly reports should suffice to keep AID/Washington and IHPO informed as to progress in CCCD projects. Of course, if projects are having difficulties or request assistance, evaluations and/or consultancies could be arranged using CDC and USAID staff. Regional programs should be reviewed biannually as well and for the sake of efficiency, the biannual country reviews should be arranged sequentially.

Country reviews should be reevaluated, shortened and coordinated with other reviews. Documents should be reviewed in the U.S. prior to arrival in the country. In programs which are progressing well an evaluation taking 5 to 7 working days should suffice. Longer or more detailed evaluations may be

necessary in larger programs or those which are having problems. Evaluation reports need to be shortened, standardized and more focused. The availability of microcomputers in all the bilaterals should facilitate implementation of this recommendation.

V. OPERATIONAL RESEARCH

A. General Comments

The CCCD project has included several categories of operational research activities:

(i) intercountry research studies done by African researchers designed to answer operational problems and develop African research capabilities;

(ii) FE directed research;

(iii) collaborative research protocols with other research groups such as CDC/Atlanta; and

(iv) bilateral project problem solving.

The intercountry research activities in West and East Africa have evolved in very different ways. The West African regional operational research has not generated many grants whereas the East African program has progressed so swiftly as to create unacceptable time demands on the FE. Hence these regional activities will be discussed separately.

A few general comments which do not fit readily under East or West African operational research activities but have general applicability include:

(a) Publication of research data

It is important that operational research data be published. To assist in this process it would be useful to invite one or more

editors of African medical journals to annual consultative meetings. The editor would hear research presentations and could offer advice as to the type of material being sought by his journal. If at all possible, research results should be summarized in the proposed WHO/AFRO Epidemiological Bulletin and sent to WHO/Geneva for publication in the Weekly Epidemiological Record.

(b) Research priorities

A clearer statement of research priorities is needed from African program managers. The Evaluation Team suggests that CCCD use the annual consultative meeting as a forum to discuss research priorities. A nominal group exercise with program managers could identify research goals common to several countries such that collaborative studies could be undertaken.

The Evaluation and Research Division of IHPO has prepared a list of operational research priorities (March 1986) and responsibilities. The Evaluation Team reviewed this list and agrees that the topics chosen for emphasis have great relevance to CCCD and would only suggest that studies on sterilization procedures and vaccination techniques be made a top priority.

(c) Publication of scholarly work by Field Epidemiologists

All FEs are expected to conduct research projects. It is important that these projects be published whenever appropriate. Some research activities by CCCD FEs may not be suitable, because of length or subject matter, for publication in standard journals. The Evaluation Team recommends that IHPO consider publishing some of these studies as monographs*.

* The Health Information Systems work by Dr William Taylor is a good example of a body of work which might be best published as a monograph under the AID/CDC/CCCD label.

B. West Africa Regional Operational Research

The Evaluation Team reviewed funded and unfunded grants at the Regional CCCD Office in Abidjan. Meetings were also held with the two funded Ivory Coast investigators, Dr Connie Davis, Field Epidemiologist, and REDSO/Abidjan personnel.

The regional operational research program has not progressed well in West Africa. In March 1985, the West African Research Review Committee had its first meeting and reviewed 12 grants of which four were approved. Several problems were identified.

(1) Paucity of research grants. Despite widespread dissemination of information pertaining to CCCD operational research, few grant applications have been received. One reason cited was the lack of training of potential African investigators in research methodology.

(2) Insufficient FE time to help Africans develop research projects, particularly in non-bilateral countries.

(3) Lack of a plan to institutionalize the operational research component of CCCD. Under the current agreement, the regional and bilateral research programs end with the termination of the CCCD project.

The Strengthening of Health Delivery Services (SHDS) project is a regional AID sponsored project which has had the training of African researchers as one of its goals. To this end, SHDS has prepared training material and has given several courses on the preparation of research projects (Health Services Research Course: How to develop proposals and design research to solve priority health problems, WHO/AFRO, SHDS, 1983). This

three-week course is taught in small groups by former course participants and SHDS epidemiologists. SHDS also developed a small grants "applied research" component. Participants have been encouraged to submit their grants to WHO/AFRO, and awards of up to US$ 10,000 were given to funded grants. Several research projects have been completed and are in various stages of preparation for publication.

Recommendations

CCCD should conduct training in the preparation of research grants. A "how to do it" course using the SHDS material should be given in each bilateral country. Such courses could be contracted or managed in collaboration with SHDS staff and discussions should be held with SHDS staff to see how this could be best accomplished.

The operational research component of CCCD should be institutionalized through WHO/AFRO (see section IV D) and the West African Research Review Committee should be dissolved.

C. East Africa Operational Research Activities

The regional operational research component for East and Southern Africa has progressed swiftly. In 1983 a Research Review Committee was established and 18 grants were awarded in 1983 and 1984. Grant applications have come predominantly from non-bilateral countries; of the first 41 proposals submitted in 1984, 30 came from non-bilaterals.

Two external consultants, Dr Frank Polk from Johns Hopkins School of Hygiene and Public Health and Dr James Chin from the University of California,

Berkeley, reviewed the East and Southern African operational research portfolio in 1985. Both evaluations lauded Dr David Heymann's industry in getting the operational research component of CCCD started, but felt that there were significant problems:

(i) variability in quality of research protocols;

(ii) inadequate supervision of research protocols by the FE;

(iii) inadequate administrative support for regional operational research protocols;

(iv) delay in funding of projects; and

(v) no plans to institutionalize CCCD operational research activities.

The Evaluation Team agreed with most of the observations and suggestions proposed by Drs. Chin and Polk. However, the team felt that the quality of the research projects was less of a problem as the operational research component of CCCD was designed to encourage the development of research skills by African investigators and it seemed understandable that early proposals vary in quality.

Recommendations

Negotiations should begin with WHO/AFRO to institutionalize the CCCD East and Southern Africa operational research activities in Brazzaville (see section IV D). An evaluation of the need for training courses for potential medical investigators should be conducted in bilateral countries.

D. WHO/AFRO

WHO/AFRO has a functioning Research Development Committee which meets every three months and is under the direction of Dr A. Tekle. The health research program is aimed specifically at funding research grants which focus on strategies to attain the goal of "Health for All by the Year 2000". Thus the mission is entirely in keeping with CCCD operational research activities.

Dr Tekle has attended two CCCD East African Research Review Committee meetings and was very familiar with CCCD sponsored research activities. He expressed interest in the concept that WHO/AFRO's Research Development Committee become the reviewing mechanism for CCCD operational research activities. Under such a system CCCD bilateral operational research projects would be forwarded to the WHO/AFRO Research Development Committee where grants would be screened and evaluated. Assistance in preparation of grants from CCCD bilaterals would continue to be the responsibility of FEs who would also assist in data analysis as necessary.

Recommendation

The Evaluation Team recommends that WHO/AFRO become the reviewing body and secretariat for CCCD operational research projects. The presence of a CCCD Liaison Officer at WHO/AFRO is particularly advantageous to such an arrangement. AID should be prepared to review a proposal on this matter from WHO/AFRO. Specific details on the review process could then be worked out between AID, CDC and WHO/AFRO.

The Evaluation Team recommends that all bilateral operational research grants be reviewed through WHO/AFRO. Currently each bilateral program has

operational research funds which are awarded after local review and submission to IHPO for Internal Review Board (IRB) approval when necessary. The Evaluation Team feels that local review has the potential for a conflict of interest. The Evaluation Team does not wish to decrease flexibility of operational research funds and would propose that KAP projects requiring less than $5,000 be exempted from the proposed WHO/AFRO review. However, any research project involving a therapeutic intervention or the collection of clinical material should go through outside review at WHO/AFRO and IRB clearance at CDC/Atlanta. IHPO staff should explore the possibility that WHO/AFRO Research Development Committee function as the IRB for CCCD operational research projects.

The Evaluation Team also recommends that support for operational research activities in nonbilaterals not be completely discontinued. While a renewed focus on bilateral operational research activities is appropriate, the regional operational research activities in nonbilateral countries have been well received in East and Southern Africa. These funds have been very helpful in funding young and established investigators. If WHO/AFRO agrees to serve as a reviewing body for CCCD operational research proposals, it would seem perfectly appropriate for funds to be also set aside for CCCD grant proposals from nonbilaterals. In such circumstances advice in grant preparation and assistance in data analysis would have to be the responsibility of WHO/AFRO epidemiologists.

VI. HEALTH EDUCATION

A. General Comments

Each of the bilaterals faces unique health education problems, depending on the priorities of each CCCD project, the strength of the counterpart health education/training/materials development organization, and the skills and interests of the field staff. There are, however, certain generally accepted approaches to the health education that can address the peculiar challenges faced by each project.

(i) Reliable formative research data should be collected and analyzed at the outset of each project. The value of collecting this information early on cannot be underemphasized as it plays a very important role in later decisions about policy, strategy and evaluation indicators.

(ii) A health education/communication strategy must be developed based on the informational needs and behavior of each target group (mothers, health workers, doctors, etc.). The formative research will provide the data base from which strategy decisions are made.

(iii) Materials should be developed with specific purposes in mind that support the education/communication strategy. These materials must be pretested extensively with the target audience, then revised according to pretest results. Only after this process has been undergone should materials be produced and distributed.

(iv) Finally, health education evaluation indicators that will guide the phasing and mid-course corrections of the strategy must be developed early in the planning stage according to the agreed-upon behavior goals. The information that will then be provided by mid-point monitoring will increase the effectiveness of the health education component.

For a variety of reasons, these steps are not being followed in most of the CCCD projects. Many of the observations and recommendations of this evaluation will focus on ways to integrate formative research, strategy, materials development and monitoring into the CCCD bilateral projects.

1. Formative research

Formative research encompasses the collection of data that are used to determine policy, strategy and objectives, not only for health education, but for training as well. Techniques that are used are largely qualitative, and include observational studies, focus groups, behavioral trials, perceptual measurements, open-ended interviews and simple market surveys. Formative research is quick and inexpensive, and is the single most important component of program strategy and health education planning. This research should not be confused with baseline, MUHs or 'P' surveys; rather, it complements those quantitative methods as well as operational research. Its effectiveness depends on collecting pertinent data quickly, then using the information to shape the program accordingly. With a few notable exceptions, formative research has been severely neglected to date throughout CCCD.

Recommendations

Formative research studies of 4-8 weeks duration must be conducted before public education strategies are undertaken in each of the bilateral countries. Because the information that will be collected depends on the individual bilateral program, health status of the population and cultural situation, it is not appropriate to develop a single generic protocol that can be used in all CCCD countries. However, when there are cultural and program similarities, some of the protocols may be appropriate for sharing and local adaptation. Because timeliness is an essential ingredient, technical assistance in protocol development and initial implementation should be made available to TOs as soon as possible.

2. Strategy

Coherent communication strategies are vital to the success of health education programs. They consist of behavior-based specific messages designed to inform or persuade specific target audience with the intention of producing specific effects. This approach requires a behavior analysis, segmentation of audience, definition of messages and selection of channels for the messages (including print, face-to-face and radio). When the strategy is developed, behavioral goals and their accompanying monitoring indicators are also set.

While CCCDs TOs are for the most part aware of the need for more systematic health education goals and strategies, they have not had access to sufficient formative data to properly design them. Health education counterparts may have been exposed to this approach, but they are also constrained by the lack of formative data.

Recommendation

After having collected formative data, technical assistance should be made available to TOs and health education counterparts to develop communication strategies. Selected information from health information systems, operational research and other projects may also contribute to strategy development.

3. Materials Development

Despite a growing awareness of the need for more professional materials development techniques, essential steps are being left out of the process. Pretesting messages with target groups, specification of target groups and definition of clear messages need to be done.

Recommendation

Greater effort must be made to institutionalize target specific message development and thorough audience pre-testing procedures. When available, training workshops are recommended for health education counterparts. Technical assistance should also be made available, especially when mass media are part of the communication strategy.

4. Social Marketing

A need has been expressed in several bilateral programs for social marketing programs to create a demand for immunization or ORS.

Recommendation

Social marketing may be a good approach to solve specific problems in bilateral countries. The techniques previously presented could lay the

appropriate ground work for social marketing campaigns. When this approach is used, additional assistance in designing appropriate mass media and publicity materials should be provided.

5. Monitoring

Questions continue to arise about the indicators that can be used to evaluate the success of the project. In health education, indicators are not always obvious, but progress can be quantified. Nonetheless, the key to monitoring and evaluation in health education is to have specific research-based goals from which to develop indicators.

Recommendation

. Develop simple means to track communication strategy progress in conjunction with health information systems data collection both on in order to make mid-course corrections and to evaluate eventual impact. Some examples of such indicators are knowledge of correct chloroquine dose for fever, correct use of ORS (quantity and quality) and DPT1/DPT3 drop out rates.

6. Training

Good progress has been made in training health workers through the development of a training module and funding for workshop participants. The proposed training course at University of Ibadan is also seen as a positive step toward the professionalization of health education.

Recommendation

Continue planned training activities for health educators. More French training materials are also needed.

7. Mass Media and Promotional Activities

The Evaluation Team generally agrees with the definition of health education goals set forth by the CDC health education specialist, as well as the work plans drawn up in bilateral countries through her efforts. There are, however, certain problems with the scheduled implementation of these activities, such that the contribution of health education has not been well integrated to CCCD goals.

The Evaluation Team is concerned that, because of the priority initially given to training activities, the promotional and public education potential of health education/communication has not been tapped. Training is an important part of institutionalizing the project and has been commendably and conscientiously carried out in the bilaterals; however, it is an exercise that must be complemented by simultaneous materials development and communication activities. Until now there seems to have been a willingness to neglect materials development until and after training is finished, without realizing that a good communication program takes at least a year to develop, with another six months to a year before its impact will be felt. Thus, if CCCD does not accelerate its approach to health education no real health education effects will be seen for the next 2-3 years.

Recommendation

If the individual CCCD bilaterals expect to attain significant gains in public education, mobilization and behavior change in the next 2-4 years, health education/communication activities will have to be undertaken. In many cases, this will mean integrating use of mass media into project strategies.

This recommendation should not be construed to mean that unsystematic materials development should be encouraged to hurriedly address the problem in those bilaterals that have existed the longest time; it does mean that those bilaterals are most vulnerable to the program stagnation that can result from insufficient public education. As such, the Evaluation Team recommends immediate short-term technical assistance to those countries in the areas of formative research and subsequent health education/communication strategy before further materials development takes place. Skills required for different types of technical assistance are presented in Annex I.

8. Technical Assistance

Field staff understand that health education/communication support is necessary. TOs however, do not, for the most part, have the requisite skills or training to judge the professional quality of materials development in their individual projects, nor do they have the time to adequately supervise extensive health education or materials development activities.

Recommendations

In keeping with the continued professionalization of the health education/communication component, we recommend the increased use of short and long-terms technical assistance in this field. Consultants should provide assistance to a specific country over an extended period of time.

B. Bilateral Projects

1. Togo

(a) Peace Corps/SNES

Togo's CCCD Health Education component, which had been stalled for several years, seems now to be making good progress. Two Peace Corps specialist volunteers (PCVs) were assigned to the central health education unit (SNES) in September, 1985, under a PASA between USAID Washington and the Peace Corps; since that time they have worked with SNES staff. The PCVs have introduced a fresh perspective to materials development that will be crucial to CCCD's reaching its goals. The materials development process is seen to be particularly important in order to legitimize and create a demand for ORS. It is equally important in order to increase the number of fully immunized children, both by attracting mothers of unprotected children to clinics and by sensitizing defaulters to the need for a full series of immunizations.

Recommendations

CCCD's support of SNES constitutes the only health education activity in the project. As such, we recommend continuing this relationship.

(b) Training

The most striking accomplishments of the past six months have been in the training arena. A great deal of effort has been put into the development of appropriate training materials and approaches for health agents who have direct contact with the public. Training sessions for newly-appointed health coordinators, agents and trainees, which will take place during the next six months, will provide a regional network of health educators; these regional workers will in turn become resources for the central unit's activities, especially in materials development.

Recommendations

Training activities should continue to be supported and SNES should receive support in the development of appropriate French language training materials.

SNES

Although the central unit's health educators lack sufficient professional training, the PCVs have addressed this constraint by providing expertise and guidance. At this point the SNES central staff have received orientation lectures, but have not yet begun to produce educational graphic materials.

Recommendations

These constraints could be overcome by stronger support of the unit by medical personnel both at the field and central levels. The appointment of a full-time SNES counterpart to the PCVs, who would be able to participate in field activities, would be especially helpful and important in light of the fact that the PCVs assignment will end in September 1987. A counterpart should be named before that time in order that the project's health education activities will be able to continue. Both regional and central staff should begin to receive hands-on experience in the materials development process.

(d) Formative research

Earlier evaluations recommended the creation of a central coordinating committee to develop clear health education strategies. While a committee has

been named and has met twice, little progress has been made from a health education standpoint. If well-founded strategy options were introduced for the committee to consider, the group could work more effectively.

Recommendations

To develop clearer options, formative field research related to health education must first be conducted. Technical assistance described in the annex and below should be provided to implement the formative research, which would clearly define the health education needs of both health center personnel and the community. In addition, this research should be acknowledged as a high priority and supported by staff and vehicles to carry it out.

(e) Technical Assistance

After reviewing the 1 1/2 year plan of the PCVs, which includes training, graphic materials production and information campaigns, two areas for technical assistance were identified; the production of publicity materials and public information campaigns.

Recommendations

In order to meet the needs of the SNES work plan, technical assistance should be provided to perform at least three specific tasks: (1) assist in the development and implementation of formative research protocols,
(2) assist in the development of a health education/campaign strategy, and
(3) assist in the social marketing and radio message production aspects of carrying out the strategy. While formative research, strategy design and message production could constitute three separate short-term consultancies,

the assistance would certainly be within the abilities of a single health communication advisor during a 12-18 month period. The Evaluation Team recommends that a bilateral program relationship with the HEALTHCOM project be explored by CDC and USAID Washington.

2. Malawi

Clearance for a HEALTHCOM resident advisor is anticipated momentarily. Long range health education plans are being held until the arrival of this person.

3. Congo

A combination of technical assistance, developmental research and counterparts has created a strong clearly defined health education workplan. Unfortunately, none of the activities foreseen in the workplan has yet commenced because of the present suspension of funding.

Recommendations

Assuming that the project activities are reinstated immediately, it appears that the maternal/child health counterpart will be able to proceed with the workplan, which includes a mobilization campaign for EPI in October. In that case, technical assistance in mass media production should be provided in June-July.

Another constraint faced in health education is the laek of regional-level designated animators or mobilization teams, and the lack of people to train them. If possible, money should be reallocated to training of health education trainers, who would in turn strengthen health center ability to inform and communicate with the target audiences.

C. CDC

TOs have relied on visits from the Health Education Specialist based in Atlanta to coordinate the health education component of their projects. With the exception of a few short-term consultants, national counterparts, and some peace corps support, most of the bilaterals are without other health education design resources. As the number of bilaterals has increased to 12, this system has become impractical.

Recommendations

The focus of health education guidance from Atlanta should be shifted to strengthening the projects through orientation of TOs, evaluation of health education in initial country assessments, continued development of training strategies, and management of short-term technical assistance as requested by each bilateral project. Health education/communication consultants should be "assigned" to bilateral projects, providing short-term assistance over an extended period of time. The Evaluation Team recommends that CDC and USAID explore the possibility of expanding CCCD collaboration with the HEALTHCOM project to provide long-term communication assistance in several more bilaterals.

VII. HEALTH INFORMATION SYSTEMS

A. WHO/AFRO

The USAID/WHO/AFRO agreement included a health information systems component with a general emphasis on:

(i) strengthening national epidemiological services;

(ii) development of country specific indicators which could be used to track progress towards the goal of HFA/2000;

(iii) facilitate analysis and dissemination of this information to other countries.

Priority was to be given to the diseases most relevant to CCCD activities.

To this end Cameroon, Mali, Togo and Zimbabwe were visited during 1985 by a team of two WHO consultants who were to assess existing managerial mechanisms and were to identify areas for implementing a unified managerial process (Managerial Process for National Health Development). A WHO short term consultant has also reviewed epidemiological data at AFRO, OCEAC, OCCGE and the three WHO/AFRO Subregional Offices. The report is in draft form and was not available for review by the Evaluation Team.

The Evaluation Team reviewed these country reports and had difficulty with the proposed recommendatings which were so general as to make their implementation difficult.

The proposed WHO/AFRO Epidemiological Bulletin has not yet begun publication. Unavoidable but nonetheless regrettable delays have occurred because of scheduling conflicts with consultants. This project is an important one for both WHO/AFRO and CCCD since country specific health information systems data are now becoming available that should be published and disseminated.

Recommendation

The team is concerned about the health information systems component of the USAID/WHO/AFRO Grant Agreement. The goals and proposed workplan are imprecise and should be defined much more concretely. As stipulated in the Grant Agreement more attention needs to be given to CCCD activities.

Publication of the Epidemiological Bulletin should be a major priority for this year.

B. Bilateral projects

1. Togo

(a) Process and outcome indicators

Togo has a well-functioning surveillance system which relies on monthly reports prepared by health center nurses. Over 90% of these reports are received at the Statistical Unit in Lome. These reports are forwarded to the Medecin Chef de Prefecture, and after review, are forwarded to the Ministry of Health and from there to the Statistics Office. The major bottleneck is at the Statistics Office. Nonetheless, relevant data have been manually abstracted there by CCCD personnel and used for HIS reports.

The surveillance system has been reviewed in detail by two CCCD consultants who concluded that the data generated by the system were accurate. Consequently, CCCD in Togo has been able to use national surveillance data as outcome indicators of intervention strategies. These data have shown a generalized decrease in measles cases and diarrheal illnesses. Poliomyelitis data are obtained from a national rehabilitation center in Lome and show a definite drop in new cases. There is no feedback system because of the delay in processing information at the Statistics Office.

Plans have been made to funnel surveillance data which are of particular importance to CCCD directly to the Epidemiology Office where they would be entered on an IBM/PC/XT computer. Such a system would generate quarterly reports and would be the basis of a feedback loop to the Medecins Chef and their nurses.

Recommendation

The Evaluation Team strongly encourages that this initiative be continued and that computer support and training be provided to the Epidemiology and Statistics Offices as such support now will pay handsome dividends in the future.

(b) Special studies

A time-consuming but important study of under-five mortality was done in the Plateaux Region in November 1984. This effort was part of a CCCD project

to develop accurate and feasible methods to measure under-five mortality. This effort is particularly relevant to the CCCD project because of its major goal of lowering under-five mortality.

Results of the 1984 study were controvertial, with major differences in infant mortality rates as measured directly (33 per 1000) when compared to indirect estimates (95 per 1000). Because the directly measured mortality seemed inappropriately low, it was decided to conduct a reliability survey one year later in six of the original 30 clusters. One important difference was that the reliability survey used complete pregnancy histories rather than the truncated birth history used in the first survey. Results of the verification study were clear; infant mortality rates in the resurvey using direct and indirect measures were at about 100 per 1000. A careful comparison of data from both surveys suggested that omitted deaths, particularly during the first two weeks of life, accounted for the discrepancy between the two studies.

The issue of what process indicators will be used to determine that the program has been successful enough to warrant the remeasuring of under-five mortality has not yet been resolved. The revalidation study gave the following age-at-death data:

1978-1985 MORTALITY BY AGE (REVALIDATION STUDY)

Age	0-7d	8-15d	15d-12m	1-5y	over 5y	Total
	41					
Number	30	11	43	44	2	130
%	23	8.5	33	34	1.5	
	31.5					

CCCD impact on mortality would be most dramatic for infants above eight weeks, assuming that most DPT1 innoculations are given after six weeks. CCCD could have an impact on under-15 day mortality in cases where tetanus neonatorum is a major problem, and where active chloroquine prophylaxis program for pregnant women is initiated. In any case, the disease-specific measures against measles, oral rehydration, and presumptive therapy of febrile episodes with chloroquine are likely to more dramatically affect mortality after three months of age.

Vaccination coverage in the mortality study area showed that about one quarter of children had received measles vaccine and that about 9% of children were completely vaccinated. In addition, only 1% of diarrheal episodes were treated with oral rehydration salts. Given these data, certain process indicators need to be chosen so that when these indicators have been reached, a cohort can be identified for the repeat mortality survey.

Because of the rather low coverage rates with measles vaccine and the non-use of ORS, two process indicators that appear to be reasonable would be:

(1) 75% under-one coverage with measles vaccine and

(2) 75% of all diarrheal episodes in children under five years treated with ORS.

Using cause-specific mortality data from the Maritime Province one might expect that the above indices in the Plateaux Region would result in at least a 22% decrease in mortality. Thus, it would seem appropriate for CCCD to specifically target the survey area to reach these objectives. As soon as these coverage objectives have been attained, the post-intervention mortality study can be said to have begun. As long as the process indicators, as measured on a yearly basis, are maintained, the study could continue. After three or four years have elapsed, the repeat mortality study can be conducted. If the interventions have resulted in a greater than 25% reduction in mortality, it should be measurable.

Recommendation

The Evaluation Team favors continuation of the mortality study; if the study is continued the presence of a TO will be necessary in Togo.

2. MALAWI

Disease surveillance activities in Malawi currently include hand tallies of monthly reports from clinics and hospitals. Out-patient and under-five clinic MCH data are forwarded to district, regional and central levels.

Hospital discharge data are forwarded from district and mission hospitals to the regional office and from there to the Statistics Section of the Ministry of Health. The data collection system is partially computerized and the Statistics Office has finished analysis of 1984 data.

A comprehensive analysis of the CCCD Health Information System (HIS) was completed in 1985. The review consisted of a listing of (1) all forms used in the Health Information System, (2) data that were necessary for the HIS component of CCCD, and (3) an evaluation of the flow of information from the periphery to the central level. The review found major strengths and weaknesses. On the positive side, about 90% of all reports that were expected to be received had arrived. On the negative side, some forms were redundant while others could be simplified.

CCCD staff felt that the surveillance system provided insufficient data on certain indicators important to the CCCD project. Furthermore, it was felt that demands for new data collection were not appropriate for all 406 Health Centers. Twelve Health Centers were selected as sentinel surveillance sites on the basis of geographic distribution and past history of completeness in reporting. Special reporting forms were developed for these centers and health center staff were trained to use these forms in January 1986. The expanded forms contain more detailed information on knowledge, attitudes and practices as they relate to ORT and fever treatment.

Working with the statistics section at the Ministry of Health, an inventory of data processing capability was done. It was felt that four IBM/PC/XT computers were needed to insure that health center and hospital data

could be processed. The computers should arrive by 1 May 1986, and a computer expert is on site to train statistics personnel in data entry, retrieval and analysis.

A checklist emphasizing CCCD activities for regional supervisors has been developed. Information form this checklist will be computerized so that an accurate record of supervisory visits can be maintained. These checklists contain information on cold chain, vaccine stocks, immunization techniques and supplies of chloroquine and ORS.

Recommendation

The disease surveillance system in Malawi has promise and the modest investments in equipment and training required to improve the flow of information have high likelihood of paying future dividends.

C. IHPO

1. MIS

A new CCCD Management Information System was introduced in 1985. These changes were made after the 1985 internal evaluation and stressed graphic presentations of program data, simplification and reduction in the number of tables and reduction of the frequency of reporting to once a year. Menu driven data base and graphics software were furnished to TOs and for the most part the bilateral country summaries at the 1986 Consultative Meeting used this new format.

The Evaluation Team was very impressed with the quality and completeness of the data presented. The data chosen for presentation were relevant and

clearly identified problem areas when they were present. The Evaluation Team feels that the entire MIS system should be published and that country summaries should be distributed to WHO/AFRO.

2. Mortality studies

An excellent review of the mortality and validation studies was prepared by Dr Douglas Ewhank from the Population Studies Center, University of Pennsylvania. He recommended that a follow-up survey in Liveria be given the highest priority. While it is true that the initial mortality level in Liberia was high and therefore offered the greatest chance of finding a significant change if the program was successful the Evaluation Team does not feel that the CCCD program in Liberia has the capacity to achieve targets that are high enough to make a resurvey appropriate in a reasonable amount of time.

The mortality studies that have been done in Zaire are extremely important since a control group was included in the initial survey. In addition mortality in the 6 to 59 month age group was twice as high as that measured in Togo. Since the age group from 6 to 59 months is most likely to be positively affected by a well functioning CCCD program with high coverage rates with vaccine ORT and chloroquine therapy there are ovious advantages to emphasizing improved CCCD activities in the study area so that the cohort of children to be restudied can be begun.

Recommendation

Indicators should be developed and mortality studies should be continued. The Ivory Coast is just initiating its CCCD activities. Baseline data show very low vaccination coverage and almost no ORT use. Because of the potential

for growth of the CCCD program in the Ivory Coast serious consideration should be given to doing a mortality survey there. A national census is planned for later this year and data from the census could serve as a mortality baseline. The Evaluation Team supports a more extensive collaboration between U.S. Bureau of the Census and the CDC.

ANNEX I

Health Education Technical Assistance

The first task would require skills in conducting qualitative and quantitative social marketing research, including focus group interviews, in-depth interviews, mixing trials for ORS, clinical observations, and service-provider assessments such as a simple market survey. The technical assistance will develop protocols and train researchers in implementation. This assistance should require about two months' time.

The second task, conceptualizing the communication strategy, will require expertise in four areas: defining what behaviors exist and how messages should be defined to address them (behavior analysis); dividing up the target population by group characteristics relative to messages and target behaviors (audience segmentation); choosing the appropriate medium and amount of exposure for each message (media mix); and developing indicators that will guide mid-point revisions of the strategy (monitoring). After having completed the behavior analysis and defined the possible messages, the advisor and health education unit will work with CCCD and the coordinating committee to agree upon a communication strategy including the prioritization of messages. The advisor would then assist unit counterparts with appropriate audience segmentation and media mix. Finally, mid-point monitoring and evaluation indicators must be developed that reflect the behavior goals, in order to adjust the strategy and redefine messages as necessary one year after the beginning of the campaign. This assistance, which should be scheduled 1-2 months after the formative research takes place, and will require about 6-8 weeks' time.

Depending on the strategy, media mix and behavior goals that are chosen, assistance may also be needed in the design and production of publicity materials and radio spots. This assistance could include a workshop for unit counterparts should be scheduled 1-3 months after the completion of the second task, and will require 3-5 weeks' time. The advisor should also define monitoring indicators that can be collected at a mid-point evaluation.

ANNEX II(a)

MALAWI (BILATERAL CCCD PROJECT)
(Sub-obligations and expenditures, 1985/1986)

(in US dollars)

Input Category	USAID Bilateral Project Agreement	FY85 Sub-obligations	FY86 Sub-obligations	FY85 + FY86 Subobligations (cumulative)	Balance available for subobligations	FY85 Expenditure	Estimated FY86 expenditure
1. Expanded Programme on Immunization (EPI)	$311 450	$163 426	$40 000(1)	$203 426(2)	-	$12 712	Assumptions: All of remaining FY85 subobligation ($288 728) will be expanded and 65% of FY86 subobligations ($478 019) will be expended.
2. Control of Diarrhoeal Diseases (CDD)	$125 550	$3613	$478 211	$481 824	-	$3038	
3. Malarial Control (MAL)	$145 550	$7400	$20 000(1)	$27 400(3)	-	$3038	
4. Primary Health Care (PHC)	$211 675	$77 200	$64 375(1)	$141 575(4)	-	$1201	
5. Community Health Science Unit	$405 625	$75 345	$189 400	$264 745	$140 880	$15 358	
6. Project Coordination and Management	$48 750	$23 435	-	$23 435	$25 315	$26 345	
7. Contingency	$114 500	-	$5000	$5000	$109 500	-	
Total	$1 423 100	$350 420	$796 985	$1 147 405	$275 695	$61 692	$806 768
% of Project Agreement obligated and expanded	100%	24.6%	56%	80.6%	19.4%	4.3%	56.7% (est.)

(1) Funding for Academy for Educational Development = US $124 375.
(2) US $168 024 moved to Fund ORT program in line 2 CDD.
(3) US $118 150 moved to Fund ORT program in line 2 CDD.
(4) US $ 70 100 moved to Fund ORT program in line 2 CDD.

Source: CCCD Malawi FY85 and FY86 budgets, January 1986, Lilongwe, Malawi.

ANNEX II(b)

LIFE-OF-PROJECT TRAINING ACTIVITIES
MALAWI

Type of personnel	Number of participants trained	Number of person days of training	Average number of days trained
MCH supervisors	123	615	
Peace Corps volunteers	18	135	
Long-term training	2	360	
Survey interviewers	67	390	
Statistical clerks	15	75	
Medical researchers	5	50	
	230	1625	Av. 7.1 days
Medical officers	9	27	
Clinical officers	78	234	
Health inspectors	69	207	
Registered nurses	236	708	
Medical assistants	372	1116	
En/nurse midwives	849	2547	
Health assistants	141	423	
Health surveillance assistants	118	354	
Homecraft workers	33	99	
Hospital servants	40	120	
	1945	5835	Av. 3 days

Source: CCCD Office, Lilongwe, Malawi, 10 March 1986.

ANNEX II(b)

Type of personnel	Number of participants trained	Number of person days of training	Average number of days trained
Laboratory assistants	9	27	
Pharmacy assistants	2	6	
Others (that is unspecified but same as above)	87	261	
	98	294	3.0 Av. days
SENTINEL SURVEILLANCE TRAINING			
En/nurse midwives	2	10	
Registered nurse	2	10	
Medical assistant	5	25	
Clinical officer	3	15	
	12	60	4.2 Av. days
PCV IN-SERVICE			
Registered nurse	4	20	
PCV's	7	35	
	11	55	5.0 Av. days
GMO/MATRON ORIENTATION			
Medical officer	30	30	
Matron	55	55	
	85	85	1 Av.
Grand total	2381	7944	3.3 days Av.

ANNEX III: Ivory Coast

(a) Overview

The CCCD program is in its ninth month after the signing of the Project Agreement and the sixth month after the arrival of the TO. The project is off to a good start, with preliminary studies, work plans, government contacts moving nicely. There are, however, several points of note from a program management standpoint:

1. An examination by the TO of the existing vehicle fleet assigned to the CCCD program suggests that if the existing Peugeot 404 pickups could be repaired and made operational that there would be no need to purchase most of the 26 vehicles provided for in the ProAg. The TO's Ivorian counterpart agrees.

Recommendations

The ProAg should be amended, in agreement with the government, to provide funds for repair of the existing vehicle fleet, and provide funds to purchase spare parts to keep the fleet running for the next several years.

A short term consultant should be obtained to prepare a detailed report on the maintenance and spare part needs, and a reliable cost estimate.

2. Discussions with the UNICEF representative for the Ivory Coast indicate that the funds available to UNICEF for its entire program in 1986 will be around $500,000. This reduced amount over earlier estimates means that UNICEF support to the CCCD program will sharply reduced. There will be less funds

for purchase of vaccines, refrigerators and cold boxes, and for follow-up of the health education activities which is needed to support the demand side of the combatting of diarrheal diseases. The present ProAg was drafted with strong support expected from UNICEF in these areas. Savings from a decision to eliminate or severely reduce purchase of new vehicles could be used to fill this gap.

Recommendation

The relevant sections of the Project Agreement should be reviewed, discussed with the government and UNICEF with a view adjusting the financial support and other services provided under the Project Agreement to cover the UNICEF shortfall in vital areas.

3. The original project budget of $1.69 million for the Life of Project of which $880,000 has been fully obligated, may be underestimated by as much as 25% given the change in exchange rate from 450 CFA = $1.00 in November 1984 to 340 CFA = $1.00 in March 1986. Since almost 70% of the purchases for goods and services will be in local or European currencies, there will be a significant shortfall in funds required to carry out the planned program.

Recommendation

The sharp reduction in the purchasing power of the dollars currently obligated over the life of the project should be taken into account now in discussions with the government as detailed plans for project implementation are developed.

4. The morbidity, mortality and utilization surveys (MJHS) on target diseases as planned for in the ProAg will not be done. Instead Knowledge, Attitudes, and Practices (KAP) surveys will be done.

Recommendation

The ProAg should be changed to reflect this change in plans.

5. Given the conflicting demands for the Project Development Officers at REDSO, and the additional workload of a major new bilateral project supplemental assistance to the REDSO project officer will be required.

Recommendations

It is recommended that REDSO take advantage of the offer made under the regional CCCD project to finance a PSC or local hire for an Assistant Project Development Officer to help REDSO service the program/administrative needs of the CCCD project.

PROJECT EVALUATION SUMMARY (PES) — PART I

Report Symbol U-4

1. PROJECT TITLE	2. PROJECT NUMBER	3. MISSION/AID/W OFFICE
Combatting Chilhood Communicable Disease Project	698-0421.79	Kinshasa

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) 86/05

☒ REGULAR EVALUATION ☐ SPECIAL EVALUATION

5. KEY PROJECT IMPLEMENTATION DATES			6. ESTIMATED PROJECT FUNDING	7. PERIOD COVERED BY EVALUATION
A. First PRO-AG or Equivalent FY 85	B. Final Obligation Expected FY 85	C. Final Input Delivery FY 86	A. Total $ 684 B. U.S. $ 647	From (month/yr.) May 1984 To (month/yr.) April 1986 Date of Evaluation Review May 1986

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., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. Documentation of expenditures of USAID and FAC funds allocated for local purchases will be transferred from the technical officer to an adequate structure within the MHSA. This action will help the GPRC to assume full responsibility for all costs at the end of the project.	DPM CCCD USAID/PHO	July 1987
2. Additional bookkeeping records will be kept that classify expenditures to the activity they support.	MHSA GPRC USAID/PHO	July 1987
3. The Director of Preventive Medicine will establish a Financial Reporting System that informs each partner of the use of all funds allocated to the program.	DPM	July 1987
4. The Project will implement an auto-financing system based on user fees.	CCCD AID/AFR/RA	July 1987
5. The delivery of ORS and chloroquine will be integrated into the EPI distribution system. The supervision of these activities will be combined as much as possible at the regional level.	DPM	July 1987
6. Trimestrial supervisory visits to the regions by technical personnel accompanied by the CCCD program manager or coordinator will be made.	DPM	July 1987

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

- ☐ Project Paper
- ☐ Financial Plan
- ☐ Logical Framework
- ☐ Project Agreement
- ☐ Implementation Plan e.g., CPI Network
- ☐ PIO/T
- ☐ PIO/C
- ☐ PIO/P
- ☐ Other (Specify) _____
- ☐ Other (Specify) _____

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT

- A. ☐ Continue Project Without Change
- B. ☐ Change Project Design and/or ☒ Change Implementation Plan
- C. ☐ Discontinue Project

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

Felix Awantang, Project Manager
Mary L. Harvey, MPH, Evaluator
Robert Dewolfe, MA, Evaluator
Anne Marie Wonters, MA, Evaluator

12. Mission/AID/W Office Director Approval

Signature: RLPodol

Typed Name: Richard L. Podol

Date: 27 Jun 86

AID 1330-16 (3-78)

7. An ORT demonstration and training unit will be established in Loubomo and Point-Noire.	MSHA	July 1987
8. CDC Atlanta will provide a consultant to help establish a nationally standardized health information system. The Regional Epidemiologist in Kinshasa will also assist in this task.	CDC MSHA	July 1987
9. A full-time training coordinator will be designated to plan, coordinate, and assure the implementation of all training activities.	DPM	July 1987
10. Health Educators will be nominated in EPI, Malaria and Diarrhea disease services, to work on a full time basis with the CCCD Health Education Coordinator.	MSHA	July 1987
11. Central Health Education personnel will be trained as facilitators for the regional training efforts.	CCCD MCH HE	July 1987
12. A set of priority activities will be chosen from the action plan and given full financial, material, and technical support.	CCCD MCH	July 1987

CONTINUING CONCERNS*

1. When GPRC funds are made available, USAID should continue to support CCCD activities but at a level consistent with the amount of funds. A significant reduction in the contribution by the GPRC risks having the USAID reconsider its position.

2. Phase II should be delayed until CCCD activities are well established in the Phase I regions.

3. When and if new vehicles are purchased they should be designated to those areas outside of Brazzaville where lack of transportation is the binding constraint to implementation of CCCD activities.

4. To ensure that standardized methods are used to prevent/treat the childhood diseases covered in CCCD, national policies for EPI, diarrheal disease control and malaria should be introduced nationwide.

5. Bearing in mind the organigram and the existing structures in the Ministry of Health and Social Affairs, the team recommends that national coordination of CCCD activities remain with the Director of Preventive Medicine as called for in the Project Agreement. If the original agreement is modified, the different participants must be consulted in advance.

6. The CCCD Health Education Coordinator should work closely with the Training Coordinator to assure the integration of HE into the regional training courses.

MISSION COMMENTS

In June 1986 the GOC requested that the CCCD project commit itself in writing to provide support to the October 1986 Congolese Vaccination Compaign. Ironically this is the kind of activity the CCCD project has been hoping to support very strongly. However, our input was suspended because the GOC was not supporting the activity. This request comes at a time when the GOC still has not deposited its 1986 contribution (promised since January 1986) into the project account. If and when the GOC provides its 1986 contribution, we believe CCCD should in concert with UNICEF, FAC, and who support the compaign to the maximum extent possible.

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*Actions without specific implementation dates are listed under this heading.

EVALUATION REPORT

of

COMBATTING CHILDHOOD COMMUNICABLE DISEASES - PROJECT

in the

PEOPLES REPUBLIC OF THE CONGO

by

Westinghouse - Public Applied Systems

May 15, 1986

AID/W Contract PDC-1406-I-00-4062, Work Order No. 14

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1.0 EVALUATION TEAM

Mary L. Harvey MPH	Epidemiologist - Westinghouse Public Applied Systems
Robert DeWolfe MA	Health Education Training Consultant - Westinghouse Public Applied Systems
Annemarie Wouters MA, ABD	Health Economist Consultant - Westinghouse Public Applied Systems

The team was assisted by the following resource persons:

Harry Godfrey	Public Health Advisor, CDC Atlanta
Felix Awantang	Assistant Project Chief, USAID/Kinshasa

The team wishes to acknowledge the assistance and support received from the Ministry of Health and Social Affairs (MHSA) of the Government of the People's Republic of The Congo (GPRC) at all levels, AID, and CDC which made the evaluation possible. The team thanks the above and UNICEF and FAC for their cooperation and patience.

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2.0 EXECUTIVE SUMMARY

In accordance with the conditions stipulated in the Project Agreement signed in May, 1984 between the Governments of the Peoples Republic of the Congo (GPRC) and the United States of America, a mid-term evaluation of the Tripartite (i.e. Congo, FAC, AID) Combatting Childhood Communicable Disease Project (CCCD) was conducted from the 14th of April through the 2nd of May 1986.

While the scope of work for this evaluation team was stated in the Project Agreement, and in a cable from AID/AFR/RA, it was agreed in a meeting with the Director of Preventive Medicine (DPM), who is also the Project Coordinator for CCCD, that the following areas be addressed:

- Management
- Supervision
- Finance
- Logistics
- Overall Program Operations
- Health Education
- Training
- Program Monitoring and Evaluation

In order to achieve the project goal of reducing morbidity and mortality in children less than five years old resulting from specific communicable childhood diseases, the intention of this four year project is to strengthen and expand the ability of the existing health activities, i.e. Immunizations (EPI), Control of Diarrheal Diseases (CDD) and Malaria.

To ensure the continuation of all activities included under the CCCD project, the project agreement stipulates that the GPRC must be able to assume full responsibility for the project by the time of the Project Assistance Completion Date (PACD May 1988). This means programming activities that can be reasonably expected to be assumed by the government, given its current and expected financial situation. Close financial and programmatic collaboration and support from all directions of the Ministry of Health and Social Affairs (MHSA) and the other ministries, political groups, private sectors, international donors and Private Voluntary Organizations are therefore needed. This issue of sustainability has been the primary point addressed in each area of this evaluation.

Based on the progress that has been made the evaluation team believes this project is one that merits continued support by the MHSA.

The team was favorably impressed by:

- The compétence and enthusiasm of the CCCD personnel;

- The increase in the number of fixed centers offering vaccinations and ORS;

- The increase in the percentage of children under one year receiving all vaccinations and the subsequent reduction in the number of pertussis cases;

- The initial efforts to integrate the training, supervision, logistical functions of all CCCD activities under one CCCD direction;

- The various surveys and special studies that have been completed to obtain baseline information that will help the development of this project;

The problems identified during the course of the evaluation, which are outlined in this summary and further delineated in the body of this report, center around finance, management and supervision.

FINANCE

The GPRC has from the start of the Project commited less than the funds called for in the Project Agreement. Due to a reorganization within the MHSA at the end of 1984, CCCD activities were delayed until March 1985. Lack of GPRC funding has also slowed the schedule of activities. In 1984, the GPRC should have allocated 5,257,200 FCFA, but these funds were never made available. In 1985, only 31 percent of GPRC Project Agreement requirements were allocated such that Congolese funds composed only 9 percent instead of 45 percent of the USAID/GPRC total project budget that year. No CCCD funds were provided nor was it identified as a line item in the Division of Preventive Medicine budget in 1986; as a result, USAID funds were frozen on January 28, 1986.

With the current economic crisis, it is not expected that the government will be able to provide the financial resources called for in the Project Agreement. Petroleum revenues are expected to decline by more than 50 percent in 1986. Depreciation of the dollar (in which petroleum revenues are paid) has exacerbated this loss. In March 1986, the government announced its intention to reduce spending in the State budget by 50 percent. The MHSA has been promised 25 percent of its original operational budget. Nevertheless, for the project to continue it is necessary that the GPRC renew its commitment to the terms of the Project Agreement which call for the Congo to assume an increasing share

of project costs over the four year period after which it will assume full responsibility for all costs to insure continuation of field activities.

MANAGEMENT/SUPERVISION

The fact that many of the programmed CCCD activities have been only partially implemented cannot be totally attributed to the lack of funds, materials and supples available to the project. Important aspects that need to be addressed are the management and supervision of personnel and the coordination of CCCD activities with and through the other directors of the MHSA. These management, supervisory and coordination problems are magnified by the fact that no formalized national policies exist for EPI, ORT and Malaria. Two important attempts to implement special efforts to vaccinate children against measles have been less than successful.

While the team was favorably impressed by the creation of a National Primary Health Care Program (PHC) and with the formation of a PHC Coordinating Committee, they regret the lack of coordination and collaboration between the PHC Divison and the Division of Preventive Medicine.

Finally, field visits by the team highlighted the need for more supervisory visits to the regional and district level by central level staff. Funds expended for supervision are cost-effective because successful completion of placed activities without supervision is unlikely.

3.0 RECOMMENDATIONS

Those recommendations from the first annual review which have not been implemented but which the team feels are still important are included below.

1. Scope of work:

With the current economic crisis faced by the People's Republic of the Congo, it is not expected that the Government will be able to provide the financial resources called for in the project agreement; nevertheless, for the project to continue, it is necessary that the GPRC reaffirm its commitment to the terms of the project agreement which call for the grantee to assume an increasing share of the project costs during the four year period.

In light of this situation, the evaluation team recommends that when funds are made available, USAID should continue to support CCCD activities but at a level consistent with the amount of funds made available by the GPRC. A significant reduction in the contribution by the GPRC risks having the USAID reconsider its position.

* Since the project was slow to start and was disrupted by the economic turn of events, it is reasonable that the timetable be extended to a fifth year.

* Phase II should be delayed until CCCD activities are well established in the Phase I regions. Substantial resources and effort are still required to meet CCCD objectives in Brazzaville, Pointe-Noire and Loubomo. The rural regions of Brazzaville, Kouilou and Niari have very limited EPI activities and no malaria or ORT programs.

  Action Agents: GPRC, MHSA, USAID

2. Financial Management:

2.1 Since the GPRC will assume full responsibility for all costs at the end of the project, it is reasonable that responsibility for the documentation of expenditures of USAID and FAC funds allocated for local purchases should be transferred from the technical officer to an adequate structure within the MHSA. USAID should provide assistance on the necessary procedures.

Action Agents: DPM, CCCD Technical Officer, USAID

2.2 In order to define a scope of work consistent with the reduced level of funding, planned activities should be identified as line items. To measure the extent to which these activities have been completed during

the course of the year and to obtain guidance for future planning, additional bookkeeping records should be kept that classify expenditures to the activity they support.

Action Agents: GPRC, MHSA, USAID

2.3 The team also recommends that the Director of Preventive Medicine establish a Financial Reporting System that informs each partner of the use of all funds allocated to the program.

Action Agents: DPM

3. Auto-Financing:

In order to assure the continuity of CCCD activities, the team recommends the implementation of an auto-financing system based on user fees.

> Significant short term technical assistance through the end of the project will be required to examine the current unofficial auto-financing activities already in place in the Congo, to calculate the average recurrent costs for those services to be self-financed and to determine at what level and in which regions auto-financing is most appropriate.

Action Agents: CCCD, AID/AFR/RA

4. Distribution System:

Since the EPI infrastructure is the most developed and reliable, delivery of ORS and chloroquine should be integrated into the EPI distribution system. Moreover, distribution and supervision activities should be combined as much as possible at the regional level.

When and if new vehicles are purchased they should be designated to those areas outside of Brazzaville where lack of transportation is the binding constraint to implementation of CCCD activities.

Action Agent: DPM

5. Policy:

To ensure that standardized methods are used to prevent/treat the childhood diseases covered in CCCD, national policies for EPI, diarrheal disease control and malaria (i.e. antimalarial treatment/prophylaxis) should be introduced nationwide. Without these policies, training plans and health education activities cannot be finalized.

These policies should address the difficulties observed during field visits, most notably:

* The low measles coverage rate (52%) of the susceptible population and consequently the high morbidity and mortality rates of the disease.
* The over-use of intravenous solutions and expensive non-essential drugs for treatment of mild to moderate cases of diarrhea.

* The disparate antimalarial treatment methods that are currently being followed and the overuse of Quinimax.

Action Agents: MHSA, DPM, DPHC

6. Supervision:

Active supervision of program activities by the Central and Regional level staff, is essential especially during the developmental phases of the program. This supervision by central level personnel should include:

* Trimestrial supervisory visits to the regions by technical personnel accompanied by the CCCD program manager or coordinator. It is also recommended to use standardized supervision forms.

Action Agents: DPM

7. Coordination

Bearing in mind the organigram and the existing structures in the Ministry of Health and Social Affairs, the team recommends that national coordination of CCCD activities remain with the Director of Preventive Medicine as called for in the Project Agreement. If the original agreement is modified, the different participants (FAC, UNICEF, USAID) must be consulted in advance.

Action Agents: MHSA, DPM, DPHC

8. ORT:

Per recommendation number six of the 1985 program review report "An ORT demonstration and training unit should be quickly established in order to accelerate the promotion of ORT throughout the country. This could be used for the training of health personnel at the national as well as the regional and peripheral levels". Consideration should be given to the development of similar demonstration and training units in Loubomo and Pointe-Noire.

Action Agents: MHSA, DPM

9. Health Information:

A nationally standardized health information system operable by health workers at the various levels should be instituted. Data collected from the regions should be analyzed and reported on a regular basis to all concerned.

A consultant should be provided by CDC/Atlanta as soon as possible to assist with the development of this activity.

Action Agents: MHSA, DPM, CDC

10. Training:

In recognition of the Project Grant Agreement which states that "Training will be the most important activity undertaken to strengthen the health delivery system", a full time training coordinator should be designated to plan, coordinate, and assure the implementation of all training activities. This should be done immediately, so the maximum benefit can be realized from a short term consultant for training to arrive in June 1986. A comprehensive training work plan should be elaborated at this time.

Action Agent: DPM

11. Health Education:

In recognition of the fact that an effective program of health education is essential to the realization of CCCD project objectives, the following measures should be implemented:

> Health Educators should be nominated in EPI, Malaria and Diarrhea disease services, to work on a full time basis with the CCCD Health Education Coordinator. Under her supervision they can receive practical on the job training in health education techniques and principles, and aid in the execution of CCCD health education program activities.
>
> The CCCD Health Education Coordinator should work closely with the Training Coordinator to assure the integration of HE into the regional training courses. Central Health Education personnel should be trained as facilitators for the regional training efforts.

Action Agents: CCCD, MCH & HE

12. <u>Health Education</u>:

Given the slow start of the CCCD health education program and financial constraints, it is unlikely that the full range of activities called for in the Health Education action plan can be realized. Therefore, a set of priority activities must be chosen from the action plan and given full financial, material and technical support. The priority activities should be those which provide the health and community personnel who implement CCCD interventions with the techniques (training) and reinforcing educational materials to conduct effective and uniform health education in direct support of EPI, CDD and Malaria programs.

Action Agent: CCCD, MCH

4.0 EVALUATION METHODOLOGY

The basic team consisted of an epidemiologist, a health education training specialist and a health economist. The team worked in the People's Republic of the Congo from April 13th through May 3rd and was accompanied throughout by a public health advisor from CDC, Atlanta. Orientation for the mission took place in Washington from April 11-12 under the direction of Dr. Joe Davis and Wendy Roseberry. Documents were made available for review (Annex 1).

The first week in the PRC was largely devoted to working meetings with national officials of the Ministry of Health and Social Affairs in Brazzaville. Site visits were also made to several health centers in Brazzaville including Makelekele (hospital and MCH), Ex-Adventiste, MCH, the General Hospital and Blanche Gomez (MCH) (Annex 2).

During the second week the team flew to Pointe Noire and Loubomo, the political centers of the Kouilou and Niari regions. In each region, meetings were held with regional officials of the MHSA, and site visits were made to health centers. In Pointe Noire the team saw Hospital A. Sice, CNPS Fucks, SMI M'Bota and SMI Jeane Vialle. In Loubomo some members visited the Loubomo Hospital, an SMI, and the Salvation Army health center. Others accompanied representatives of the GTZ Primary Health Care Project to a small village approximately one hour from Loubomo.

The third week of the evaluation was spent drafting the report, verifying data and developing a team consensus. The executive summary and the recommendations were distributed to the Director of Preventive Medicine, CCCD and FAC officials. These were reviewed in a meeting at the Director of Preventive Medicine. The final presentation of the executive summary and recommendations was made to the Minister of Health and Social Affairs on the last day of the mission.

The team is appreciative of the assistance of both the outgoing and incoming technical officers who had prepared a comprehensive briefing book for the team and had prearranged meetings with all MHSA officials involved with CCCD activities. In addition the Director of the Preventive Medicine Division, his assistant and division chiefs along with representatives of FAC and UNICEF were very helpful in providing the necessary documents for the evaluation.

The team was limited in its evaluation by a time constraint such that in-depth investigation of all the aspects of the scope of work was not possible; however, sufficient information and insight was obtained on which to make recommendations.

5.0 OBSERVATIONS AND FINDINGS

5.1 PROJECT PLANNING ADMINISTRATION AND MANAGEMENT

The basic planning document for the CCCD project was the Country Assessment done in 1983. It is a very comprehensive and detailed document and provided concise information on the status of all CCCD activities that were being conducted prior to the implementation of the CCCD project. It also provided guidance as to how the management of the program should be effectuated and recognized the need for and importance of a Primary Health Care Director, under the direction of the Director General for Health. This, it was hoped, would bridge the administrative division between curative and preventive health.

The structure of the Ministry of Health and Social Affairs is shown in the organigram found in Annex 3. As shown, the CCCD project is under the direction of preventive medicine and its activities at the regional level are the responsibilities of the Medicines Chefs des Grandes Endemies. As stated in the Project Agreement (ProAg) (Article 4.1.c):

> For the purpose of efficient implementation of the project, the Grantee will assure the implementation of the project and its coordination with established health services....

These services, as stated in the Proag, basically consist of health care divisions found in the organigram. Additionally on the regional level, all activities are to be coordinated with Primary Health Case and health projects supported by private and other organizations.

The management integration and coordination of CCCD activities with other services have been a slowly evolving process. As most of the CCCD activities have only been truly operational since mid to late 1985, many of the managerial problems relating to the operational integration of these activities are only recently being addressed. It is the opinion of the evaluation team that the Director of Preventive Medicine, who is also the CCCD Project Coordinator, and the Assistant Coordinator have foreseen some of the problems in managing this project and are trying to develop a system of integrating the functions of these activities, which are basically training, guidance, supervision and logistics. In response to the terms of the Proag and in light of the necessity to work closely with the other health divisions, the CCCD Project Coordinator has tried to convoke meetings with these various health divisions and with private and voluntary organizations and international donors. Unfortunately these meetings have not taken place. It is viewed by the evaluators that this lack of a CCCD coordinating committee has had a negative effect on the implementation of many of the activities, policies and procedures that the CCCD project had hoped to achieve. Although a National Program for

Primary Health Care was established in 1985 (Annex 4), its relationship to the direction of preventive medicine is difficult to understand.

For the moment, the division of Primary Health Care appears to be an autonomous program relating only to the Minister of Health with activities that appear to run parallel to those of CCCD. The program plan which describes the objectives, strategies and action plan of this new direction (Annex 5) was elaborated by the national director and selected others with no input from the persons responsible for the management and administration of the three basic PHC components of CCCD. Furthermore, a technical coordinating was formed and met in February of 1986, however persons responsible for CCCD were not present at that meeting (Annex 6).

While the CCCD country assessment recognized the need for a National Primary Health Care Division and the evaluation team strongly supports such a concept and the use of it to coordinate health services, it regrets the lack of planning and coordination between the Directions of PHC and Preventive Medicine. While this new direction at the cabinet level may eventually achieve the coordination between the various health divisions and other ministries, the evaluation team strongly recommends that the coordination of CCCD project activities remain with the Director of Preventive Medicine as agreed to in the Project Agreement.

5.2 STAFFING AND DISTRIBUTION OF CCCD ACTIVITIES

As previously stated, the CCCD project is under the Director of Preventive Medicine and its activities are integrated into many of the services conducted by the MCH clinics and hospitals. At the regional level the Medicins Chefs des Grandes Endemies are responsible for the coordination and implementation of project activities, again working with and through the established health system. The distribution of medical services and personnel are shown in Annex 7. CCCD efforts have been concentrated in the most populous areas of the country, i.e. Brazzaville (pop. = +500,000), Pointe Noire (pop. = +300,000) and Loubomo (pop. = +50,000). The EPI activities are being carried out throughout the country in fixed and outreach centers which are supervised and sometimes staffed by the personnel of the Grandes Endemies (Annex 8). As for ORT, according to the 1985 CCCD annual report there were 26 units throughout the Congo that were functioning. It is believed that personnel in those centers have been trained either through the CCCD project or through the ORT training course sponsored by WHO in 1984. To date Malaria activities under the direction of CCCD have been limited to basically four centers located in Brazzaville.

Supervisory activities are in principle carried out by the CCCD central level staff and the regional level staff assigned to the Grandes Endemies. Supervisory visits by the central level staff have been limited due to lack of funds for gasoline and per diem. It is hoped that

this situation will be rectified as supervision is one of the most essential parts of all health activities.

The allocation of funds for supervision is cost-effective because without it, success of planned activities is unlikely. Increased vertical integration may have prevented the poor results of the measles vaccination campaigns in Pointe-Noire and Loubomo (See EPI section). The cost advance of 200,000 FCFA plus 1000 liters of fuel at 3000 CFA/liter allocated for the Pointe-Noire campaign, which succeeded in vaccinating a little over 1,000 children, yields a minimum estimate of 500 FCFA/vaccine ($1.67). Considering that this estimate does not include the cost of vaccines, personnel and other medical supplies, it is very high compared to Qualls more comprehensive calculation of 474 FCFA/vaccine for six centers in Brazzaville.

Supervisory forms have been developed (Annex 9) however they need to be simplified. The supervision of central level technical personnel should include prospective review of their detailed monthly work plans. These plans should be based on and evaluated in terms of: the epidemiologic data collected from the sentinel surveillance sites; they should address problems observed during routine supervisory visits and delineate processes to be carried out to achieve stated longterm goals. Trimestrial supervisory visits by central level technical personnel accompanied by the CCCD program manager or coordinator to the regions are necessary. These visits should include meetings with all concerned personnel in the region (i.e. regional directors of health and social affairs, FRC, MCH, curative medicine and PVO's). The distribution of supplies to the region should also be coordinated with these visits. Supervision by the regional personnel is also important. To enable this, the vehicles that are proposed to be bought for the CCCD project should be dispatched to the regions actively implementing CCCD activities when they arrive. The vehicles in Brazzaville, if effectively used should be sufficient for CCCD activities. This necessarily implies the close collaboration between the division chiefs responsible for CCCD activities. THis close collaboration can only ensure that all CCCD activities are viewed and treated as an integral part of everyone's job.

5.3 EPI

An EPI program has been operational in the PRC since 1981. The goal of the program is to achieve an 80% reduction in morbidity and mortality due to the six target diseases by 1990. The objective for the program as stated in the 1980 action plan, is to achieve a vaccination coverage rate of 35% of the population between the ages of 0-35 months by 1985, and to increase this coverage each year thereafter by 10%. The results of the 1985 nationwide vaccination coverage survey show that the program is on its way to achieving its goal (i.e. national coverage 40% - Table 1). Table 1 also shows the effect that the current CCCD program has had on

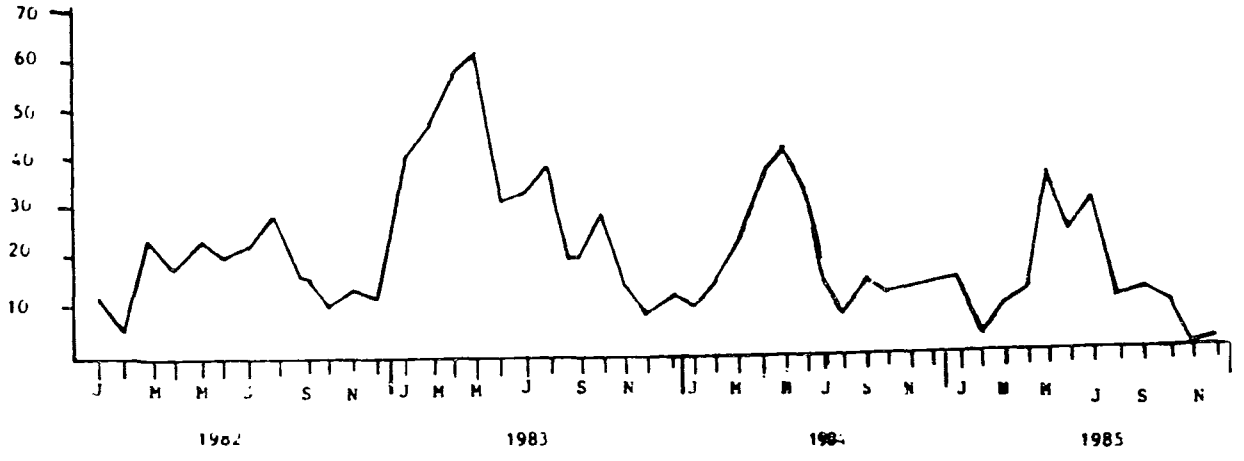
increasing the coverage for all vaccines in Brazzaville and the high rates achieved in Point-Noire.

RESULTS OF THE NATIONAL VACCINATION COVERAGE SURVEYS
(Children 12 to 23 Months)

Year and Month/Site		BCG	DPT-1	DPT-2	DPT-3	Measles	All Vaccines	Vacc. Card
1980	Brazzaville	84%	72%	65%	45%	27%	N/A	N/A
1982	Brazzaville	92	74	69	42	49	32%	N/A
1983	Brazzaville	89	80	80	75	54	47	N/A
1985 MAR	Brazzaville	94	89	86	80	62	56	92%
1984 MAY	Dist. de Moutamba	33	57	48	33,9	57,8	N/A	N/A
1985 MAY	Dist. de Moutamba	80	87,5	70	57	59	36,6	89
1985 FEB	Pointe-Noire	92	77	75	70	54	50	84,8
AUG	Dist. de Mindouli	75,5	54	45	39	27	26	68
SEP	Loubomo	88	27	51	47	45	38	59
OCT	Enquete Nationale	80	70	66	59	52	40	81
	*rural zone 51%	(67)	(54)	(45)	(37)	(39)	(23)	(69)
	*urban zone 49%	(94)	(88)	(88)	(81)	(64)	(57)	(94)

Studies presented in the 1985 country summary report show that most vaccines are being given to children in the proper age group and that 54% of all children receiving their first dose of DCT return for their third. The impact that this has had on the reported cases of pertussis in children under the age of 5 is shown in Figure 1. The number of reported cases of polio in Brazzaville and Pointe Noire has also decreased from a high of 13 in 1983 to only one case each for 1984 and 1985.

FIGURE 1
REPORTED CASES OF PERTUSSIS, CHILDREN UNDER THE AGE OF 5, 1982-1985



Sources : PEV (Brazzaville - 5 sentinel posts : 3 hospitals and 2 health Centers
(Pointe-Noire - 3 sentinel posts : 1 hospital and 2 health Centers

Immunizations are given on a nationwide basis and a coverage of well over 80% of the population has been obtained. The EPI aspect of the CCCD program has basically been concentrated in the most populous areas of the country, i.e. Brazzaville, Pointe-Noire, and Loubomo. The program operates on a fixed and outreach basis. In Brazzaville vaccinations are being given in all 25 MCH centers. In Pointe-Noire, 6 out of the 8 health centers are fixed centers and 2 are operated by the vaccination team from the Grandes Endemies. In Loumobo, there are only two fixed centers providing vaccination services, the other two health centers are headed by the Grandes Endemies team.

With the exception of a few centers visited by the team most vaccinations are not given on a daily basis. The schedule established at the inception of the EPI program, that is providing different vaccines on different days is still adhered to. A national EPI policy has been drafted (Annex 10) however it has not been disseminated. Therefore, in spite of the fact that there is a policy to vaccinate newborns with BCG and polio and to vaccinate all children on a daily basis (including the sick) at nine months against measles, most centers are not doing this. Also for the most part different vaccines are given on different days. As stated in the 1985 program review two problems arise as a result of providing different antigens on different days. When a 10 month old child in need of his third DPT-Polio and measles vaccine arrives on the day scheduled for DPT-Polio he/she receives that and is asked to return later in the week for measles. One of two things may then happen; either the child will not be brought back and therefore an opportunity to protect him/her against measles is missed or if the child does return later in the week there is the risk that the measles vaccination may be ineffective due to the prior challenge of antigens administered a few days earlier. Therefore as stated last year "Vaccines should be administered simultaneously or a sufficient time interval should be respected between vaccinations - preferably one month." A better method of providing vaccines may be to select certain health centers that attract a large target population and have them provide all vaccines every day.

As previously stated, there are 25 fixed centers in Brazzaville which offer vaccinations anywhere from twice a week to a few which hold daily sessions. The target population, of children 0-5 years old in Brazzaville is approximately 100,000 with 30,000 of these children between the ages of 0-12 months. This means that on any given day (based on 260 work days/year) one could expect to see approximately five children aged 0-12 months or 16 children aged 0-5 years attending any one of the 25 health centers. This is not a cost-effective or efficient utilization of staff. Consideration should be given to reducing the number of centers offering vaccination services to those places which are easily accessible to the majority of the population and concentrate on providing all vaccines every day. Of course this implies informing the public of the health centers where vaccines are being given and

motivating them to attend those health centers. However, as measles transmission rates are quite high, all health centers and hospitals should provide measles vaccine to any child between 9-36 months whom they come in contact with. The target group for measles vaccine (i.e. 9-36 months) should be stipulated in the national policy and adhered to. The surveillance data shown in Tables 2 and 3 show that the age group between 9 and 36 months accounts for 52% of all the cases in Brazzaville and 68% of all reported deaths. Until such time that coverage rates for children in those age group reach a level of 70-80% vaccinating children out of this age range should not be done.

TABLE 2

DISTRIBUTION OF MEASLES CASES AND DEATHS BY AGE GROUP
REPORTED BY THE 5 SENTINEL SURVEILLANCE SITES IN BRAZZAVILLE - 1985

Trimester/Age Group	0-8 Months		9-23 Months		24-35 Months		36+ Months		Total	
	Cases	Deaths	C	D	C	D	C	D	C	D
1st Trimester	333	10	565	35	463	16	409	9	1770	70
2nd Trimester	133	2	233	9	111	4	269	2	746	17
3rd Trimester	95	3	155	6	69	2	217	3	536	14
4th Trimester	49	1	108	3	24	2	79	6	260	12
Total	610	16	1061	53	667	24	974	20	3312	113
	(18%)	(19%)	(32%)	(47%)	(20%)	(21%)	(29%)	(18%)		

Death Rate = 3%

TABLE 3

DISTRIBUTION OF MEASLES CASES AND DEATHS BY AGE GROUP
REPORTED BY THE 5 SENTINEL SURVEILLANCE SITES IN POINTE-NOIRE (1985)

Month/Age Group	0-8 Months		9-23 Months		24-35 Months		36+ Months		Total	
	Cases	Deaths	C	D	C	D	C	D	C	D
JANUARY	61	13	68	12	91	21	226	20	450	66
FEBRUARY	84	15	148	27	74	12	119	7	425	61
MARCH	59	10	146	33	100	13	90	7	395	63
APRIL	28	2	87	16	42	13	78	5	235	36
MAY	20	4	44	5	20	1	53	2	137	12
JUNE	9	2	48	10	16	2	29	3	102	17
JULY	21	3	37	12	14	4	37	5	109	17
AUGUST	14	2	25	4	4	2	16	2	59	24
SEPTEMBER	9	1	19	0	7	2	13	0	48	10
OCTOBER	10	2	19	2	9	0	10	2	48	3
NOVEMBER	19	3	30	2	12	2	19	1	80	8
DECEMBER	17	2	14	2	0	1	17	1	56	6
TOTAL	355	59	685	125	397	73	706	55	2143	312
	(17%)	(19%)	(32%)	(40%)	(19%)	(23%)	(33%)	(18%)		

Death Rate: 14.8%

Recently two attempts were made to increase the coverage and disrupt the transmission of measles in Pointe-Noire and Loumobo. Unfortunately as shown in Tables 4 and 5, these attempts were failures. Possible explanations are that the areas covered were not properly informed or encouraged to bring their children to be vaccinated. In spite of the fact that vaccinations were conducted for one month in Pointe-Noire only 1235 children were vaccinated and of these a large percentage were above 36 months old. Lessons have been learned by these two attempts and it is hoped that the National Vaccination Program, that is tentatively planned for October 1986, will address the areas that caused these two recent failures. It is obvious that supplementing cars, fuel and vaccines is not enough. Political people and others (i.e. district and block level personnel) must be involved and identify those households where children are unvaccinated and get them to the vaccination teams.

TABLE 4

MEASLES CAMPAIGN - LOUBOMO
(MARCH 3-10, 1986)

DATES	CENTERS	BOYS	GIRLS	TOTAL
		9 months to 3 1/2 years		
03/3/1986	Comite du Quartier no 1 - - " - - " - - " no 2 - - " - - " - - " no 3	32	33	65
04/3/1986	Comite du Quartier no 4 - - " - - " - - " no 5 - - " - - " - - " no 6	33	46	79
05/3/1986	Comite du Quartier no 7 - - " - - " - - " no 8 - - " - - " - - " no 9	16	16	32
06/3/1986	Comite du Quartier no 10 - - " - - " - - " no 21 - - " - - " - - " no 22	17	33	50
07/3/1986	Comite du Quartier no 23 - - " - - " - - " no 24 - - " - - " - - " no 25			
08/3/1986	TSILA - MANGANZI YOULOUMPOUNGUI (plateau)	14	7	21
10/3/1986	LISSANGA	14	7	21
		126	142	268

TABLE 5

CHILDREN VACCINATED DURING MEASLES CAMPAIGN - POINT-NOIRE
(FEB. 6 - MARCH 11, 1986)

CIRCONSCRIPTION	CHILDREN TO VACCINATE	CHILDREN VACCINATED	% OF CHILDREN VACCINATED
ARRONDISSEMENT I	6016	172	2,86 %
ARRONDISSEMENT II	5217	87	1,66 %
ARRONDISSEMENT III	13.442	521	3,8 %
ARRONDISSEMENT IV	5.640	455	8,06 %
T O T A L	30.315	1.235	4,07 %

Another problem that needs to be closely monitored and addressed, is that of vaccination techniques. In several of the centers visited, the techniques used were not satisfactory; vaccinating children with the same needle was observed. Also the practice of using the same syringe and only replacing the needle seems to be fairly common. This may be due in part to the shortage of needles and syringes that currently exist as well as the lack of understanding on the part of the vaccinators as to why a separate needle and syringe should be used for each child. As Hepatitis and other viral diseases are spread this way it should be insisted that only one needle and one syringe be used per child.

Another recommendation to be made is that BCG and polio be given at birth. As most (80%) of all births are delivered at a hospital it would be an effective use of personnel and would insure coverage of all babies to give these vaccinations then. This would alleviate the need to use personnel with health centers and grandes endemies teams to attend to this service. Time could better be spent offering other vaccines. This would also insure a good integration of activities. As this policy would need to be enforced by the direction of Curative Medicine, coordination between DPM and DCM is needed.

5.4 ORT

The ORT program began in 1984 when WHO sponsored a training course. While many people were trained, the program did not continue to develop due to a lack of ORS packets. In March, 1985, the program was relaunched through CCCD. Since that time, 30 ORT centers, located in hospitals, maternal and child health clinics are functioning. At present close to 40% of the target population (0-5 years) now have access to ORS. Since the ORT centers in Pointe-Noire and Loubomo became operational towards the end of 1985 and the beginning of 1986 it is not possible to provide an estimate on the usage of ORS. During the course of 1985 the number of ORT centers in Brazzaville grew from 3 to 20 and the number of reported case treated by ORS increased, respectively from 251 to 4189 cases (94%) however no adjustment was made for seasonal variation). In total 9819 cases of diarrhea were treated using ORS packets in Brazzaville. To date, the proposed demonstration and training center that was to be established at the General Hospital in Brazzaville has not been established. The creation of this center is viewed as being most important and would be an asset to the program. This center should help, though hands on experience, the physicians and other clinic personnel appreciate the effectiveness of ORS if given properly and therefore limit the overreliance on I.V.'s and antibiotic treatments.

The basic problems that have been observed in the treatment of diarrheal cases have been that of improper monitoring of diarrhea cases both at the clinic and hospital level and improper and overuse of antibiotics (see ORT KAP survey results in Report of Maternal Practices Relating to Acute Diarrhea and Fever in Children "A Community-Based

Survey in the Mossendjo District - Congo - F. Dabis). In some clinics visited there was no place for diarrheal cases to sit while taking the ORS solution so mothers were told how to prepare the mixture, when to give it to the child and asked to return the next day. Follow-up was therefore not very good. For hospitalized cases, implementing a monitoring system in a ward with scarce resources and personnel appeared to be a difficult task. The main problems faced were systematic data collection by each shift and the close monitoring of ORS quantities administered, subsequent weight gain and correct prescription and recommendations for the next 6-12 hour period. These problems appear to arise most frequently with the night shifts. The effective use of ORS can not only save lives but also provide a substantial economic savings to a medical system that is extremely under-funded. Supervisory visits are currently being carried out on a biweekly basis and a supervisory form (Annex 7) has been prepared but, the form needs to be revised and simplified. Also the number of supervisory visits, to those centers that have been in operation for some time should be limited to once a month. The National Policy on Diarrheal Diseases is still in draft form (Annex 11). It closely follows the WHO policies for the treatment of diarrhea and specifies the procedures the health worker should follow in the treatment of diarrheal cases. This policy also includes a section on the use of antibodies, health education, supervision and methods of evaluation. It appears to be an adequate policy and should be adopted and disseminated to all health facilities in the near future. This is especially important as the regional primary health care committees, set up under the direction of Primary Health Care, are in the process of developing their training programs for regional and village level health workers and it is important that the treatment methods used in these training course are in agreement with those developed by the Division of Preventive Medicine.

5.5 MALARIA

The Malarial aspect of the CCCD project has been the slowest in getting started. To date four health centers located in Brazzaville are operating under the close supervision of the CCCD/Malaria team. This aspect of the program also appears to be the one that will be the most difficult to implement. In a KAP study carried out in 1985 in Brazzaville and rural areas, the results showed that children received many different types of medication for fever (Table 6).

TABLE 6

MEDICATIONS GIVEN FOR FEVER TREATMENT OF 20 CHILDREN

Antipyretic only	Injectable anti-malarial drug (antipyretic)*	Antimalarial tablets (+ antipyretic)		No Response
		4-aminoquinolines	other**	
5 (2.3%)	36 (16.4%) (including 21)	204 (92.7%) (including 156)	3(1.4%) (inc. 2)	2 (.9%) (0)

Visits to the various health centers by the evaluation team also confirmed this. The KAP survey also showed that doses of chloroquine varied considerably but were in the therapeutic range in 56% of the children (i.e. 46% were given 10± 2.5 mg/kg and close to 25 mg/kg in 10% of the cases). The study showed that the cumulative dose given over the total course of the treatment varied even more than the dose on day one. That is, 20% of the treatment was likely to be insufficient, 11% were close to the standards of 10 mg/kg and 17.8% were close to the 25 mg/kg regimen. The 25 mg/kg is the new regimen being recommended by CCCD in light of the studies showing the resistance of plasmodium falciparium to chloroquine. A national polity for malaria has been drafted but has not been finalized (Annex 12). This policy recommends the presumptive treatment of fever in children 0-5, following the new regime of 25 mg/kg over a three day period, and chemoprophylactic treatment of all pregnant women. Again, given the fact that the Direction of Primary Health Care has proposed its policy, in its November 1985 program of development, of being one of chemoprophylactic treatment of all children 0-5 years it is important that coordination and standardization of the prescribed policies between PHC directors and the direction of Preventive Medicine be obtained. Presumptive treatment of fever in children as opposed to total chloroquinization is the preferred method. Not only is it more cost-effective, but given the fact that there is resistance to P. falciparium, the chemoprophylactic treatment of all children may only achieve generating greater resistance. Also, the use of injectable antimalarials (i.e. quinimax) should be discouraged at the clinic level. As shown in the KAP survey, 16.4% of all children surveyed had received injectable antimalarials. The role of injectable antimalarials should be limited to severe cases and be done only in hospitals. The risk to sciatic nerve damage and paralysis is great and therefore closer attention should be focused on the need for injections. The cost of such drugs is also prohibitive.

5.6 PROCUREMENT, DISTRIBUTION AND QUALITY CONTROL OF ORS AND OTHER COMMODITIES:

In the past year, the distribution and supply of most CCCD related vaccines and drugs (exception being needles and syringes) has been proceeding without any interruption in service. However improvements in the efficiency of the distribution of, ordering, and control over medical supplies is needed. A review of inventory control sheets and amount of vaccines, ORS products and chloroquine distributed indicates that tighter control is needed. Tables 7 and 8 show the amount of vaccine that has been received, distributed and used for the years 1981 - 1985 and for three specific regions. The figures noted here were taken from data presented in the country CCCD assessment, the 1985 CCCD annual report, the 1985 EPI annual report and reports provided by the CCCD program manager. A review of these tables show that for the years 1984-1985 more vaccine has been distributed than received and in two regions more vaccine was used than distributed. While there probably was some carry over from 1984 to 1985 it is still hard to account for the recorded differences. As previously stated, similar problems in control of ORS and chloroquine supplies were also observed.

The creation of a separate storage unit that is kept under lock and key has been established at the Pharmapro bureau in Brazzaville. It is highly recommended that the ORS packets sitting in the open at pharmapro and the chloroquine tablets currently being held at UNICEF be placed in this locker and that only a limited number of people be given access. Also better and more consistent recording from the regional health centers is needed. Currently it does not appear that the regional levels have a good understanding of how to calculate their supply needs for the month and risk either over or understanding their supply needs.

The distribution of supplies has relied on donor support. FAC has contributed 250,000 FCFA to distribute vaccines to the regions. UNICEF shipped its ORS packets from Pointe-Noire to Brazzaville. In addition Lina Congo has momentarily agreed to deliver vaccines free of charge to the North. The train authority ATC, however, refuses to transport supplies because of the substantial debt accumulated by Pharmapro (the state-run pharmacy responsible for the purchase and distribution of medical supplies). In 1985, many of the regions received their supplies only if they picked them up themselves or were brought when supervisory visits from the central level were made. A plan is currently in operation in Brazzaville to coordinate the distribution of supplies with the supervisory visits of the CCCD team. It is hoped that sufficient funding can be found to provide for frequent supervisory visits to the region which when coupled with the distribution of vaccines, ORS packets, chloroquine tablets and other needed supplies will create a more efficient and cost-effective distribution system.

TABLE 7

NUMBER OF REPORTED DOSES RECEIVED, DISTRIBUTED AND USED (1981-1985)

VACCINE/YEAR	1981	1982	1983	1984 +	1985 ++
BCG					
Received xx	29,925	79,000	133,440	65,000	64,700
Distributed	N/A	N/A	N/A	100,300	93,690
USED	14,381	65,339	N/A	67,445	72,397
DTP					
Received xx	62,345	93,670	228,420	236,240	180,000
Distributed	N/A	N/A	N/A	156,230	190,640
USED	21,265	104,429	127,041	159,537	167,125
Polio					
Received xx	64,715	109,650	221,740	218,000	280,000
Distributed	N/A	N/A	N/A	187,400	185,380
USED	21,265	104,429	N/A	157,537	161,335
Measles					
Received xx	67,200	66,930	101,720	74,300	225,200
Distributed	N/A	N/A	N/A	82,830	112,220
USED	50,728	42,124	55,578	57,871	59,849
Tetanus Toxoid					
Received xx	108,180	101,620	163,410	40,800	170,000
Distributed	N/A	N/A	N/A	84,150	107,030
USED	69,380	85,286	109,299	61,534	82,242

Note for 1981-1982: The number of DTP and Polio doses administered were not differentiated. Also the number of measles doses given as stated in the country assessment is substantially below that listed in the February 1986 annual report.

+ - The number of doses distributed in 1984 was obtained from the 1985 Program Review.

++ -The number of doses distributed in 1985 was obtained from the 1985 annual EPI activities report.

xx -The number of doses received was also obtained from the 1985 annual EPI activities report.

TABLE 8

NUMBER OF DOSES DISTRIBUTED AND USED IN THE REGION OF BRAZZAVILLE, KOUILOU AND NIARI (1985)

VACCINE	REGION Brazzaville	Kouilou	Niari
BCG			
Distributed	28,150	10,750	5,300
Used	23,763	13,727	9,322
DTP			
Distributed	68,200	24,500	8,400
Used	73,943	30,096	17,381
POLIO			
Distributed	69,550	27,500	8,500
Used	63,666	36,304	16,487
MEASLES			
Distributed	22,610	15,550	12,500
Used	17,020	7,935	9,549
TETANUS TOXOID			
Distributed	40,580	16,850	7,800
Used	43,829	12,678	7,412

Another problem affecting the distribution system is that of an insufficient cold chain. In one of the regions visited the freezer is an antiquated Westinghouse model. While the temperature recorded at the time of the visit was correct, it was only stocked for a one month's supply as personnel at the central level feared that it might not work and did not want to risk a three-month's supply of vaccine spoilage. Also, the storage capacity of the refrigerators in Pointe-Noire and Loubomo were insufficient to hold a three-month's supply of vaccine. In no place but the central level were temperatures being monitored at any point in time. Some of this may be due in part to the lack of thermometers. More and better (i.e. ice-lined) freezers and refrigerators should be purchased. This would enable the regional levels to handle a 3 month supply of vaccine, which should consequently reduce the cost of delivering vaccines once a month. Also, certain centers are now operated by the Grandes Endemies teams in part because they are not equipped with refrigeration units. Again it may be more cost-effective and efficient to supply those health centers that can be operated on their own with refrigerators.

The Congo should made every attempt to purchase commodities at the lowest price available. It should be noted that Lapco, the government-owned pharmaceutical manufacturer is an expensive source for chloroquine. The Lapco price for one box of 1000 FCFA (100mg) tablets is 4675 FCFA. Unicef sells the equivalent at 1330 FCFA.

Lapco has expressed an interest in producing locally made ORS packets. This supply should be considered if its price is competitive.

It was noted on field visits that the supply of needles was especially limited. Although a PIOC was written by USAID in 1985, an oversight by USAID/Zaire has delayed the delivery. This should be resolved soon.

5.7 PROGRAM MONITORING AND EVALUATION

The routine data collection system in the MHSA consists of each regional health division (i.e. MCH and HE, Curative Preventive Medicine, Grandes Endemies) preparing monthly reports which are forwarded to the Regional Director of Public Health who in turn forwards the reports to the Division of Planning and Statistics where they are compiled and presented in an annual report. The last published annual report was in 1984. Copies of these reports are also sent to the respective central level divisions where they are analyzed by the Division's own statistical chiefs and at least for the Division of Preventive Medicine, routine surveillance data are presented in an annual report prepared by each program chief. The completeness of reporting received at the National level is estimated to be 20%.

Sentinel surveillance sites have been established for EPI, ORT and Malaria. These sites are monitored by the programmatic people in charge of these activities who are working under the service of Grandes Endemies. Monthly reports from all health services (national and private) receiving vaccines, ORS packets, chloroquine tablets are also required to be given to the central level personnel in charge of these activities prior to receiving a new supply. Because the various reporting systems do not use standardized forms (Annex 13) information that is received is not comparable for tabulation. Age and disease specific morbidity and mortality is not routinely collected from all reporting centers.

The MCH centers only require cases to be reported on measles, malaria,diarrhea, malnutrition and pulmonary infections for children 0-12 months of age. Hospitals report on all cases seen and deaths occurring due to the CCCD specific diseases, however no differentiation is made as to whether these cases were first seen and recorded on an outpatient or in-patient basis. Therefore, some cases may be overreported.

The Bureau of Statistics of the Epidemiological Service of the Grandes Endemie is responsible for collecting data from each of its 10 sectors. The system uses a standardized form, which is in the process of being adopted so the data it collects for the CCCD related activities concurrs with the data required to be collected by CCCD. Sentinel surveillance sites for the vaccination programs, ORT, and malaria have been established. Since 1980, sentinel surveillance sites for vaccine-preventable diseases have been in existance in Brazzaville (5) and in Pointe-Noire (3). More recently, sentinel sites have been established in Loubomo, Kimkala, Djombala and the region of the Cuvette. With the exception of Brazzaville and Pointe-Noire the annual reporting from these sites have been only about 50-75% complete. Data from sentinel sites established from ORT has been collected since March 1985 (beginning with 3 centers) Sent' reporting sites have been estblished in four sites in Brazzaville since 1986 for malaria.

Vaccination coverage surveys have been conducted in Brazzaville since 1980 and in other regions since 1984 (See EPI section). KAP surveys for ORT and malaria were conducted in 1985. Since the inception of the EPI program in 1980, the number of vaccinations given has steadily increased (See Table 7). Since 1984, total increases for each antigen have not exceeded 10%, however increases for children under 12 months have improved by 7% for DPT, 16% for BCG and 29% for measles. While the percentage of children vaccinated against measles is 52% nationally (See Table 1), and has increased by 35% since 1980 for the region of Brazzaville, the number of reported cases of measles has not shown a dramatic decrease (Table 9), and the case fatality rate has held more or less constant at 3%.

ABLE 9

NUMBER OF REPORTED CASES AND DEATHS OF VACCINE-PREVENTABLE DISEASES
FROM FIVE SENTINEL POSTS, BRAZZAVILLE

	1980			1981			1982			1984			1985		
/YEAR DISEASES/	Cases	Deaths	Case Fatality Rate	Cases	Deaths	Case Fatal. Rate	Cases	Deaths	Case Fatal. Rate	Cases	Deaths	Case Fatal. Rate	Cases	Deaths	Case Fatal. Rate
Measles	3,953	130	(3%)	4,370	122	(3%)	4,166	135	(3%)	5,572	213	(4%)	3,312	113	(3%)
Whooping Cough	265	11	(4%)	126	0	(0%)	161	0	(0%)	106	1	(0%)	47	1	(2%)
Polio Myelitis	35	0	(0%)	16	1	(6%)	5	1	(20%)	0	0	(0%)	2	0	(0%)
Diptheria	1	1	(100%)	0	0	(0%)	0	0	(0%)	1	1	(100%)	0	0	(0%)
Neonatal Tetanus	12	10	(83%)	9	6	(67%)	-	-	-	0	0	(0%)	20	0	(0%)

For Pointe-Noire, while the number of measles cases reported in 1984 and 1985 increased from 1160 to 2154 (46%) the percentage of cases occurring in the age group 9-23 months decreased by 7% and the number of deaths in this age group also decreased by 10% (Table 10).

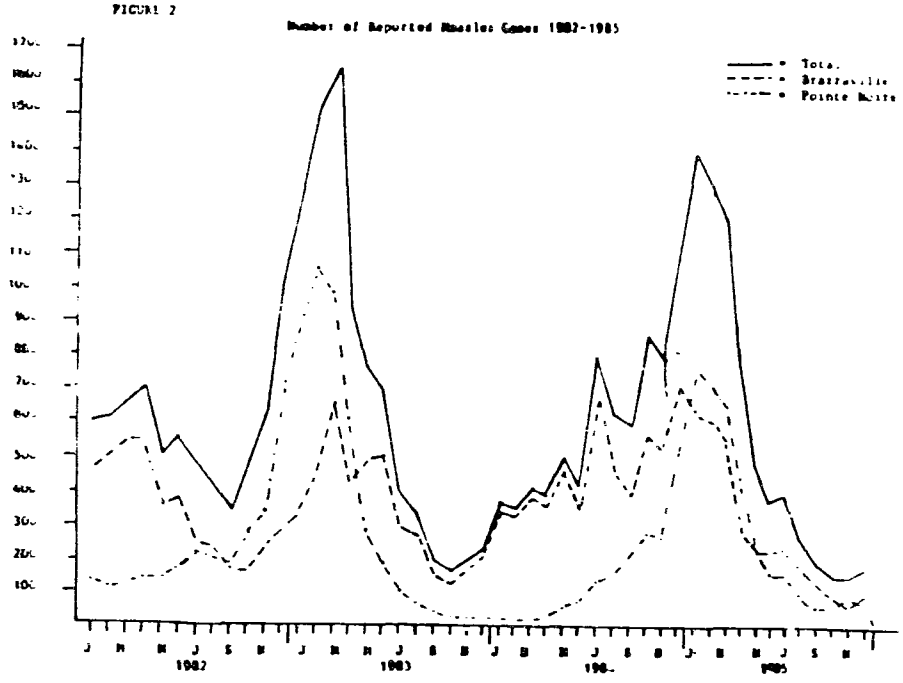
TABLE 10

HOSPITALIZED MEASLES CASES IN POINTE-NOIRE

	1984			1985		
AGE(in mo.)/YEAR	C(%)	D(%)	CFR(%)	C(%)	D(%)	CFR(%)
0-8	21(18.7%)	30(20.4%)	14%	355(16%)	65(20%)	18%
9-23	500(43.1%)	83(56.3%)	17%	786(36%)	146(46%)	19%
24+	443(38.2%)	30(23.6%)	8%	1013(47%)	107(34%)	11%
T O T A L	1660	148	12.8%	2154	318	15%

From 1985 Program Review and 1985 Annual Report for the Region Kouilou.

Figure 2 shows the number of Reported Measles Cases for the areas of Brazzaville and Pointe-Noire for the year 1982-1985. As can be seen by this graph little impact on the cases of reported diseases has been felt despite a measles coverage of 62% for Brazzaville and 54% for Pointe-Noire. Therefore, an intensified effort should be put into increasing the measles coverage rate for children between the ages of 9-36 months. As previously stated, this has been attempted in Pointe-Noire and Loubomo but the results were less than satisfactory (See EPI section).



The impact of the EPI program can best be seen by its effort on pertussis. As shown in Table 9, the number of reported cases for Brazzaville since 1980 has decreased from 265 to 47 cases (82%). Decreases have also been seen in the number of reported cases for neonatal tetanus and polio.

In order to get a better estimate on the impact the program has had on polio, it is recommended that the retrospective survey conducted in 1983 at the rehabilitation center be repeated within the next two years and that a school-entry prevalence survey also be conducted. A neonatal tetanus survey might also be considered.

At this time it is not possible to judge the impact that the introduction of Oral Rehydration treatment centers are having on the treatment and prevention of Dehydration. In 1985 a KAP survey was conducted in four areas of the Congo For the Mossendjo District the crude incidence rate for diarrhea was 13% which is equivalent to 3.4 diarrhea episodes per child/per year. In three of the areas surveyed only 1/3 of the cases were taken to a MCH center. The exception being in Brazzaville where 75% of the cases were taken to an MCH center (23.25) however none were treated with ORS.

Most reports received by the regional Director for Diarrheal Disease and Malaria have been in complete therefore no valid statement on the rates for these diseases can be studied.

In order to measure the impact of the ORT and malaria programs it will be necessarey to

1. Continue to conduct KAP surveys to monitor CCCD programs.

2. Closely monitor all centers now collecting data on the treatment and follow-up of diarrheal disease and malaria cases. As these CCCD activities are expanded into new centers weekly monitoring should be done.

As stated previously, information collected for CCCD activities is also being collected, in one form or another by the other health care divisions. In order to increase and improve the reporting that is now being done, the systems of data reporting have to be refined and streamlined. If health personnel realize that efforts are being made in their interest to reduce the burden of data reporting and if they are given feedback via a Health Information Newsletter, it is likely that the attitude toward data collection would improve. In order to combine reports a coordinated effort in involving staff from various divisions within the MOH is necessary.

The assistance of a short-term consultant from CDC/Atlanta to develop an HIS System for the Division of Preventive Medicine that will complement and or assist in improving the National HIS System is recommended.

5.8 HEALTH EDUCATION (HE)

Within the structure of the MHSA, health education is the responsibility of the Director of Maternal/Child Health and Health Education (DMCHHE). Accordingly, the decision was made to coordinate the CCCD HE program through this division. A CCCD HE coordinator from the DMCHHE was named in September, 1985, and given full responsibility for the program.

In collaboration with a short term consultant, a comprehensive and appropriate HE action plan/strategy was developed and approved. However, very little progress has been made toward the implementation of the activities described in the action plan. It now seems unlikely that the full range of activities described in the action plan can be accomplished within the life of the project.

The recommendations made for HE are intended to: provide guidelines for the selection of priority activities from the HE action plan which can realistically be accomplished within the life of the project; strengthen the central level HE staffing; and assure a mechanism for training of peripheral level health personnel to conduct effective HE. The CCCD HE unit and coordinator are housed in, and are part of the DMCHHE. Although a graphic artist is employed at the DMCHHE, and available for CCCD materials development, the HE coordinator is the only staff designated specifically to the CCCD HE program. The HE coordinator's job description has been clearly defined and covers:

- research and evaluation
- training for HE
- education materials development/production
- supervision of HE activities.

In theory the DMCHHE's institutional capacity to develop and implement HE programs is combined and coordinated with CCCD/DPM's technical inputs, as well as efforts of other relevant organizations, to create a mechanism through which the CCCD HE program is implemented.

With the assistance of a STC the CCCD action plan was developed and approved in November, 1985. This plan establishes eight program objectives reflecting desired behaviors with respect to EPI, diarrheal disease, and malaria. The action plan also describes:

- technical and organizational strategies;
- research activities;
- development/production of educational materials
- suggestions for mass-media use;
- HE training strategy;

- supervision;
- collaboration with other organizations;
- program evaluation.

The overall approach of the plan calls for a combination of HE in health facilities, community-based HE through non-health organizations, mass-media, and various printed materials (see Annex 14 CCCD HE Action Plan). Subsequent to approval of the action plan a schedule of activities for 1986 and a draft budget were established by the coordinator.

A HE consultative committee has also been formed. Members include representatives from the Direction of Public Health, Direction of Social Affairs, National Union of Congolese Women, Radio Rural, UNICEF, DMCHHE, CARE/Congo, and CCCD. While the potential impact of the committee is great, it has only met once in November, 1985 and thus has had a negligible impact on national HE efforts.

Prior to the appointment of the HE coordinator in September, 1985, there were no significant HE activities to report. The STC for HE arrived in late October, 1985 for a one month mission. During this time the following were accomplished.

1. Action Plan developed and approved
2. Formation and meeting of HE Consultative Committee
3. Testing of SSS recipe in Brazzaville
4. Testing of a series of 10 drawings on SSS in a rural area
5. Elaboration of a model format for a practical HE guide for health personnel
6. Development and testing of a project emblem.

Since, a rough draft of a flipchart on diarrhea, hygiene and SSS has been drawn up but not tested. The flipchart's messages apparently overlap with one that the CARE/Congo NUTED project is developing. The possibility of combining the two is being discussed. The HE coordinator is currently working on a practical HE guide for health personnel based on the STC's model.

The following table lists activities scheduled for the 1st semester, 1986, their respective dates of scheduled start and completion and the current status of each activity. The activities schedule on which this table is based was established no earlier than 11/85. Note: The decision was made early on to concentrate first on CDD related messages.

TABLE 11

SCHEDULED H.E. ACTIVITIES AND STATUS:
1st SEMESTER 1986

ACTIVITY	DATES: START - FINISH	STATUS
1. Prepare messages, drawing photos, flyers on SSS, dehydration and hygiene	1/1 to 1/30/86	on-going
2. Elaborate form to pre-test ed. materials	1/1 to 2/11/86	done
3. Pre-test ed. materials in project action zones	2/1 to 3/1/86	not started
4. Order & production of ed. material, T-shirts, stickers	1/1 to 3/1/86	started, not done
5. Develop mass media spots documentaries, skits	1/1 to 7/1/86	not started
6. Air radio and television spots	2/1 to 7/1/86	not started
7. Appoint 2 agents to be responsible for HE in Project Action Zones	2/1 to 3/1/86	not started
8. Elaborate objectives and activities for HE training modules	1/1/to 3/1/86	on-going
9. Secure materials for HE training	2/1 to 3/1/86	not done
10. Elaborate planning and preparation guides for HE sessions	2/1/to 3/1/86	on-going
11. Distribute and Diffuse HE material and HE guides	4/1/to 7/1/86	not done
12. Start HE sessions in the project action zones	4/1 to 7/1/86	not done
13. Organize working sessions with CDD team & HE consultative group	1/86	not done
14. IBID.	3/86	not done
15. Contact UNEAC for songs relative to project	1/86	not done
16. Turn over instructions on SSS to UNEAC	1/86	not done

The fact that so many activities from a schedule established in late 1985 remain undone, and for the most part unstarted, indicates very clearly that there exist some serious constraints and that certain adjustments must be made.

Those associated with the project and its HE program cited financial constraints as the reason for lack of progress. With respect to the production of education materials, lack of funds is certainly a binding constraint. Financial difficulties also effect routine operations, and undoubtedly is a major factor in the HE program's lack of progress.

Financial constraints alone, however, do not fully account for the program's slow start. Even in the absence of funds, much more could have been done in preparation for the availability of funds. If the HE program were to receive its entire budget tomorrow, it would be largely unprepared to use that money. Certainly, more could have been done in the preliminary stages of materials development including pre-testing in Brazzaville. More frequent meetings of the HE consultative committee may also have catalyzed more progress.

The lack of staff designated to work on the CCCD HE program has also contributed to its slow start. The HE coordinator is currently the only person specifically assigned to the CCCD HE program, and even she has other responsibilities within the DMCHHE. Given these facts it is recommended that an agent from each of the three CCCD technical services (EPI, CDD, Malaria) be assigned to work on a full-time basis, and under the supervision of the HE coordinator. In addition to providing much needed additional human resources to the HE program, this will provide a tangible coordinating link between the CCCD technical services and the HE program. These three agents will need some on-the-job training with respect to HE techniques and principles which, coupled with their technical expertise in their respective areas (EPI, CDD, Malaria), will considerably strengthen the CCCD HE program.

It would also be highly desirable to give the HE unit office space at the DPM. Not only is office space scarce at the DMCHHE, but the close proximity to other members of the CCCD team would enhance contact, coordination and supervision. After discussion with interested parties, this was not retained as a bonafide recommendation, but the idea has been advanced.

As mentioned earlier, and taking into consideration recurrent financial constraints, it is unlikely that the full range of activities described in the HE action plan can be completed within the life of the project and sustained after project completion. It is now necessary to select a set of activities from the overall plan that can realistically be implemented in full. Factors considered in this selection include the potential impact, both short and long term, and the likelihood that the MHSA/GPEC can sustain and support these activities in the future.

The current HE action plan calls for a highly integrated and multi-faceted approach. Components include: mass-media (radio, TV); printed materials; HE in health facilities; and HE in the community through non-health organizations (women's union, social affairs, literacy program). Those components recommended to be retained in full are: health education in health facilities; and printed materials. More specifically, peripheral health personnel, who are the implementors of CCCD interventions should receive the training and reinforcing educational materials to conduct effective and uniform health education in support of CCCD programs. An additional recommendation calls for central HE staff to work closely with the CCCD training coordinator to assure the integration of an appropriate HE component into the upcoming regional training effort.

It is reasonable to expect that these recommended activities can be implemented in their entirety. A mechanism for training health personnel with respect to CCCD activities is currently being developed and HE can easily be integrated into it. A modest start has also been made on the development of educational materials which are applicable to the recommendation. Pending a resolution of project financial difficulties, and the strengthening of central HE staff, materials development can be accelerated at a faster pace than to date.

The recommended activities are sustainable. Well-trained personnel will maintain their skills well into the future regardless of MHSA/GPRC financial status. While the future capacity to continue producing new educational materials is dependent on financial limitations, those materials produced in the life of the project can be used well into the future. Mass media, on the other hand, has the same limitations as far as future production, and while short-term impact may be considerable, the long-term impact is questionable.

Furthermore, given the high concentration of population in the urban areas and the high rate of DTP-Polio vaccination coverage, it is reasonable to assume that most of the target audience for HE is having regular contact with the health service delivery system and therefore are subject to exposure to HE efforts within that system. It then makes sense to strengthen the HE technique and provide materials to exploit this exposure and promote desired behaviors.

While the value of the proactive nature of mass media and community-based HE is fully recognized, much of their value lies in their ability to provide extensive exposure and create health service-seeking behavior. Further, while it would be ideal to combine mass media, community and health service-based HE, a choice in this case, must be made. The population seems to be seeking health services already, and a by-product of this behavior is good exposure to health service-based health education.

Note: If an accelerated short-term vaccination effort does materialize in PRC, a mass media promotional campaign is definitely warranted. In this case careful consideration should be given to utilizing STC for mass-media.

5.9 TRAINING

The Project Agreement states that "...training will be the most important activity undertaken to strengthen the health service delivery system." It also calls for approximately 500 health personnel to receive varying degrees of technical training, and for the development and adaptation of training materials.

The project has developed an in-country training strategy which responds well to the Project Agreement. However implementation of this strategy has been seriously delayed due to unavailability of short-term technical assistance, financial restrictions and the lack of a responsible person(s) to plan, coordinate and follow-up on training activities. No detailed life of project work plan has been developed to date.

The original strategy calls for a national mid-level managers (MLM) training course in Brazzaville, to be followed by regional training courses for peripheral health personnel in each of the 10 regions. Those trained in the mid-level managers course were to facilitate the regional courses. This strategy was somewhat modified during the visit of a training consultant. The new strategy calls for the adaptation of MLM training materials to better suit regional needs and a training of trainers course in Brazzaville to be followed by the regional training courses, one per quarter, in each of the 10 regions.

The national MLM training course which was originally scheduled for January, 1985, took place in July, 1985 with the assistance of a short-term training consultant. Twenty-five MLM's from six regions were trained in this 12-day course which had a stated goal: to train managers involved in CCCD as well as to prepare them to organize the HE, ORT, EPI and Malaria activities. The extent to which the training received was applied is variable and difficult to analyze. Most noteworthy is the number of ORT treatment centers (30) since the training. From this view point the training is definitely worthwhile. No new activity in HE or Malaria was observed or documented as a result of this training.

Prior to the MLM course a 6-day facilitators workshop was conducted. These facilitators (11) conducted the MLM course.

To date no regional training courses have taken place, nor are they definitively scheduled. They were originally (start of project) scheduled to take place at one per quarter for 10 quarters starting in

August, 1985. A revised schedule, developed in July 1985 by the STC called for one per quarter starting in December 1985.

The following table is taken from the 1985 CCCD Country Summary.

TABLE 12

CCCD MANAGEMENT INFORMATION SYSTEM COUNTRY: CONGO 1985

TRAINING

	1985 TRAINING ACTIVITIES		LOP TRAINING ACTIVITIES	
Type of Personnel	No. Trained	Person Days	Cum. No. Trained	% LOP Realized
Peripheral health staff				0%
Mid-level Managers	25	300	25	50%
CCCD Facilitators	11	60	11	100%
Senior level Officials	2	36	2	100%
Others				
Survey interviewers	31	93		
ORT Training	365	365		
Chloroquine Resistance studies (Congo)	9	324		
PEV Vaccinators Recyclage - fixed centers (Brazzaville and Pointe-Noire)	90	270		

The base from which the percentage LOP realized was calculated is not documented. It was presumably extrapolated from he ProAg figure of 500 health personnel to be trained. The two senior level officials trained were the Director and Deputy Director of the DPM who participated in the MLM course and facilitator's workshop. The ORT Training consisted of one day on the job training to open ORT treatment centers. It is unclear why 365 people were trained as there are 30 ORT centers nationwide. That means an average of 12 people per center were trained. The evaluation team observed no more than 3 staff members administering ORT in any given center. The PEV vaccination recyclage were two day on-the-job refresher courses in fixed vaccination centers.

Other training, not reflected in the table include: participation of the chief of CDD in a WHO senior level managers course in Lome (10 weeks); and the Director of DPM helped facilitate a WHO/CCCD MLM course in Bamako March, 1985.

Clearly the major thrust of the CCCD/Congo training program is yet to come. Plans are now being made to adapt/develop training materials in all aspects of CCCD for the regional training effort. Negotiations have started with the National Administrative School (ENAM), which has two or three SHDS trained professors, to develop these materials and conduct a training of trainers course in Brazzaville. A STC for training is arriving in June to work with ENAM and develop a detailed training plan for the remainder of the project. The apparent success in the field of EPI training in 1982-3 and WHO ORT training in 1984 leads us to believe that CCCD regional training courses will have a positive impact once they are implemented. However, the DPM is currently lacking a full-time training coordinator to plan, organize and follow-up on training efforts. The importance of logistical and organizational arrangements that need to be made for successful training courses cannot be overstated. It is therefore imperative for the CCCD/Congo project to designate or hire someone to coordinate every aspect of this training strategy. A job description for such an individual has been developed (see "Proposition pour l'integration d'un volet formation dans le LUTE" Sarah Fry 11/85).

Technical competence at the central level of CCCD Congo is high. Therefore, international training of senior level personnel should not be considered a priority.

It should also be noted that if the recommendations for the CCCD HE program are to have a positive effect on the overall project, it is imperative that HE staff and the training coordinator and consultants make every effort to integrate a HE component into the regional training strategy.

While efforts are reportedly underway to incorporating CCCD interventions into the curriculums of medical and para-medical institutions, this should be followed closely.

5.10 FINANCING

Since 1985 the Congo has faced a severe economic crisis due to falling oil revenues and growing debt service. Petroleum revenues are expected to decline by more than 50% in 1986. Depreciation of the dollar (in which petroleum revenues are paid) has exacerbated this loss.

Under these pressures, the government is calling for strict financial discipline. In March 1986, the government announced its intention to reduce spending under the 1986 state budget by 50%. The MHSA has been promised 25% of its original operational budget. Below is a list of the operational budget cuts faced by those divisions directly involved with CCCD activities (CFA):

	Original	Revised	Available
Dept. of Preventive Medicine	39,000,000	19,378,300	19,121,700
Dept. of Curative Medicine	7,700,000	4,967,244	1,690,202
Dept. of Maternal/Child Health	9,400,000	4,791,180	4,600,820
Pharmapro - Pointe-Noire	743,389,000	376,194,886	240,000,000
Pharmapro - Brazzaville	6,117,000	3,000,000	3,177,000

The issue of economic sustainability of CCCD activities is a question of the ability of the GPRC to provide or cause to provide funds to cover the recurrent costs of the project. The project agreement stipulates the following schedule for the GPRC portion of Project costs:

Year 1	22%	(1984)
Year 2	45%	
Year 3	64%	
Year 4	78%	
Year 5	100%	(1988)

In actuality, GPRC's portion of project costs has been:

Year 1	0%
Year 2	9%
Year 3	0%

The GPRC has from the start of the project committed less than the funds called for in the Project Agreement. Due to a reorganization within the MHSA at the end of 1984, CCCD activities were not put in operation until March 1985. In 1984, no GPRC funds were made available for CCCD activities. In 1985, only 31% of GPRC-ProAg funds were made available such that Congolese funds composed only 9% of the USAID/GPRC total project budget that year. No CCCD funds are allocated nor is CCCD established as a line item in the Division of Preventive Medicine in 1986; as a result, USAID funds have been frozen since January 28, 1986.

In response to the low level of GPRC funding, USAID disbursements have been less than those budgeted for in the ProAg. Comparisons between ProAg requirements and actual expenditures for USAID for 1984-1986 are given below (400 CFA/$):

	(84-86) ProAg	(84-86) Actual	% of ProAg
Local costs	96,113,600	25,823,519	27%
Offshore costs	138,742,400	109,200,000	79%
Total costs	234,856,000	135,023,519	57%

The following donors have also contributed funds to the project:

FAC: FAC expenditures for CCCD have also been less than the amount allotted in the FAC/CCCD budget. Representatives of FAC in Brazzaville have voiced serious concern about sustainability by GPRC of the project given the low levels of GPRC funding. Additional FAC support for CCCD activities has come through FAC/Grandes Endemies and FAC/Follereau: however, it is FAC's intention to reduce funding for CCCD activities during each of the next two years until the project ends (See Table 19).

UNICEF: Although not an official partner in the ProAg, Unicef has made major contributions to CCCD activities primarily in the form of medical equipment and just recently 200,000 ORS packets. Unicef is also initiating plans for an accelerated vaccination effort scheduled for October/November 1986 covering the six target diseases. The GPRC has been asked to participate in this effort.

For the project to continue it is necessary that the GPRC renew its commitment to the terms of the Project Agreement which call for the GPRC to provide an increasing share of project costs over the four year period, after which it will assume full responsibility for all costs. During the last week of this evaluation, a verbal commitment was made by MHSA that 10,000,000 FCFA would be made available for CCCD activities for 1986. This represents a decreasing rather than increasing share of

project costs. Also it is less than the minimum level of GPRC funding required to cover 1985 activity levels (16,045,968 CFA) (See Table 26). It is important that the GPRC recognize that insufficient funding will force USAID to reconsider its support of CCCD activities in the Congo.

Based on the criterion stipulated in the ProAg that all project costs be sustainable by GPRC by PACD, it is clear that ProAg objectives are overly ambitious. The GPRC has been unable to finance even the small portion of recurrent costs it has been assigned during the initial years of the project. To date, the GPRC has not funded any offshore recurrent costs. Given foreign exchange constraints, GPRC will find it increasingly difficult to purchase the level of imported commodities required. Complementary funds from the departments into which CCCD activities are integrated have also been cut by 50%. The budgets of Pharmapro/Pointe-Noire and Pharmapro/Brazzaville, the state-run pharmacies responsible for the purchase and distribution of medical supplies have been similarly reduced. In addition, the FAC/CCCD funding schedule is based on annual reductions in FAC contributions. In spite of these financial difficulties, MHSA has not acted on the recommendation made in the first annual review that possibilities for auto-financing be explored.

Given the current financial situation, the evaluation team recommends that the objectives for the Project Agreement be reduced by delaying Phase II activities until CCCD activities are well established in the Phase I population centers. Substantial resources and effort are still required to meet CCCD objectives in Brazzaville, Pointe-Noire and Loubomo. Expansion of CCCD activities into rural areas will significantly increase recurrent costs because inaccessibility makes supervision and distribution more difficult. The rural regions of Brazzaville, Kouilou and Niari have very limited EPI activities and practically no malaria or ORT programs.

This modified scope of work should also take place on a five rather than four year timetable. The slow start-up due to the reorganization within the MHSA and the disruption caused by the economic turn of events justify an additional year. Also auto-financing strategies will take time to develop and implement. A rough estimate of the funds required under this extended timetable is given in Table 28. The projections assume that GPRC will provide the minimum 16,045,968 CFA required to maintain current activities in Phase I regions and the USAID unspent balance to date will be available through 1989.

In light of the economic situation described in the section above, the development and implementation of an auto-financing strategy per the ProAg Section 5.3 is necessary immediately. The operational research planned on this topic for June/July 1986 should not be delayed.

Several countries studies show that in Africa individuals prefer to use health facilities that have adequate and reliable stocks of medication and that in fact people are willing to pay for these services. The evaluation team has noted that this holds true for the Congo as well. This suggests that it is both reasonable and feasible to formally introduce a system of auto-financing which generates revenues that are targeted to cover same of the local direct costs, especially distribution costs, for two of the three CCCD activities.

In every region visited a price was charged for vaccination cards ranging from 100 CFA to 500 CFA. In Brazzaville and Pointe-Noire, the typical price was 250 CFA. In some cases,the women were asked to buy two cards. EPI has been charging fees for vaccination cards since 1982. In one facility in Pointe-Noire, women were willing to buy vaccines at a local pharmacy when the facility stocks were inadequate. In rural villages outside of Loubomo, women were sensitized to the importance of vaccines and willing to pay for cards, regardless of whether they gave birth in a hospital or at home with a traditional mid-wife.

It is worthwhile to note that the total cost of vaccines required by CCCD protocol for one child is approximately 221 FCFA.

Vaccine Requirement		Unit Price	Total Cost
Polio	4 doses	15.60 FCFA	62.40 FCFA
BCG	1 dose	4.76 FCFA	4.76
DTCoq	3 doses	18.26 FCFA	86.69
Measles	1 dose	67.20 FCFA	67.20
			221.05 FCFA

Unit Price: 1985 UNIPAC catalogue with 40% surcharge for packaging, processing and freight (see Qualls cost study - Appendix C).

This is not to suggest that 221 CFA is the correct price to charge but it gives some indication of what costs can be covered. In fact, since most of these vaccines are being provided by donors, it is more reasonable to target auto-financing revenues to cover distribution costs which as will be discussed later are sericusly underfunded. It was not possible to provide an estimate of distribution costs for this presentation.

The amount of revenues generated through the purchase of vaccination cards in 1985 in Brazzaville, Pointe-Noire, and Loubomo is 8,122,500 CFA. These revenues are equal to 54% of GPRC financial allocation to CCCD in 1985.

	DTCoq 1	% Vaccination Cards	# Cards	Revenues
Brazzaville	22,700	92%	20,884	5,221,000
Loubomo	6,061	59%	3,576	894,000
Pointe-Noire	9,477	85%	8,030	2,007,500
			TOTAL REVENUE:	8,122,500

*250 CFA/card
*DTCoq 1 vaccinees are most likely to have bought a vaccination card.

Clearly auto-financing could significantly alleviate financial constraints if these revenues could be targeted to fund recurrent costs. Currently facilities cannot identify precisely how revenues are being used nor can they explain how the price of the card was set. It is important to note, however, that to ensure use of preventive services the full marginal cost of the vaccines should not be charged. Clearly, 250 FCFA is below marginal cost since the 221 FCFA calculated before represents only the cost of vaccines and not distribution of personnel costs. A cost analysis of recurrent cost per vaccine would provide a basis for setting the price of vaccination cards.

The evaluation team also noted that many individuals are paying for chloroquine as a curative treatment for malaria. Since the new malaria protocol has not yet been formally introduced and implemented and since the use of the more expensive quinimax injection is still widely used, the price of chloroquine should also initially be set below marginal cost to encourage wider use. Compare the prices below of these two anti-malarial treatments which CDC experts consider to be equally effective.

Average Dose		Price/25mg
Chloroquine	25mg/kg	3.13 FCFA
Quinimax	25mg/kg	86.88 FCFA

Price: SEP Price, Government self-financing pharmacy.

In spite of this price differential, quinimax is still widely used. This suggests that in addition to price incentives health education that discourages the use of quinimax is essential.

Unlike vaccines and chloroquine, ORS packets are rarely purchased. Given the novelty of ORT treatment in the Congo, it is not recommended that it be sold, at least initially. Both doctors and patients need to be convinced of its effectiveness and be discouraged from using IV's.

A short-term consultant needs to be hired to design and begin implementation of an experimental auto-financing strategy. The German organization GTZ is currently designing an auto-financing system in the Niari Region. They should be contacted. The scope of work for this consultant should include determining prices for chloroquine and vaccination cards, developing a protocol for charity care, targeting direct costs to be paid by revenue earned and setting up a supervision and bookkeeping systems.

It is important to recognize that different auto-financing schemes will be appropriate for different regions. Moreover, considering that in the Congo, individuals are already burdened with costs of curative care, the degree to which they can be asked to pay for CCCD activities is somewhat limited.

5.11 COST STUDIES

The cost study by Qualls in June/July 1985, furnishes a preliminary estimate of total costs of the EPI, Grandes Endemies and CARE/Congo vaccination programs.

Comparison of these delivery systems based on total cost figures are necessarily very limited (as Qualls recognizes) because the quantity of output (vaccinations) they produce differ. Instead this study should be viewed as a basis for (1) calculating the average cost (fixed plus recurrent) per vaccine for each antigen and (2) calculating the average recurrent cost per vaccine for each antigen.

Qualls makes a rough estimate of the average cost (fixed plus recurrent) per vaccine for each program, however, she does not include national/central costs in the local average cost. Nor does she include all in-country distribution costs, training and education costs, and building maintenance costs (utilities, repairs). Most of these omissions are due to lack of data; nevertheless, given their importance they should be estimated for the more complete study. This research will be a useful tool for measuring the efficiency of vaccination services and will facilitate a cost-effectiveness study for the cost per death avoided.

The completion of the smaller cost study: average recurrent cost per vaccine for each type of vaccine, is of more immediate concern, because it will provide the basis for an auto-financing strategy. This work could be undertaken by the same consultant team responsible for developing the auto-financing strategy. Note these combined tasks will require significant technical assistance through the end of the project.

5.12 FINANCIAL MANAGEMENT

The three recommendations made relating to financial management are designed to:

1) Prepare the GPRC for assuming full responsibility for project costs
2) Provide tools for planning the use of increasingly scarce resources and
3) Ensure coordination of expenditures between USAID, FAC, and GPRC.

In particular, an adequate structure within the Ministry of Health and Social Affairs should assure responsibility for the documentation of expenditures of USAID and FAC local funds. Second, budgets and bookkeeping records for FAC, USAID, GPRC should identify planned activities as line items. Third, disbursement of CCCD/USAID funds, CCCD/FAC funds and CCCD/GPRC funds should be approved in writing by representatives of USAID, FAC and GPRC.

TABLE 13 1984

USAID - LOCAL COSTS (CFA)

Classification	ProAg	Budget(2)	Actual
Vehicle spare parts (1)	0	750,000	191,988
Other equipment + supplies	0	1,400,000	17,787
Training seminars	12,914,400	900,000	620,000
Operational problems	5,000,000	0	0
Transport	2,742,800	500,000	361,836
Emergency gas/oil funds	2,800,000	1,726,686	82,000
Printing	0	300,000	0
Durable goods	0	2,000,000	44,854
Contingency	13,028,400	4,458,314	1,600
TOTAL	36,485,600	12,035,000	1,320,063
% of ProAg			3%
% of Budget			11%

(1) Maintenance

(2) Budget of planned activities

TABLE 14 1985

USAID - LOCAL COSTS (CFA)

Classification	ProAg	Budget(1)	Actual
Vehicle spare parts	0	3,308,012	1,405,541
Other equipment + supplies	0	2,232,215	1,105,138
Training seminars	11,485,600	9,380,000	8,714,825
Operational problems	5,000,000	0	0
Transport	0	2,238,164	1,309,675
Emergency gas/oil funds	3,000,000	2,418,000	1,908,195
Printing	0	2,500,000	1,239,000
Durable goods	0	4,555,146	2,522,894
Contingency	13,828,400	6,083,400	4,867,302
TOTAL	33,314,000	32,714,937	23,072,570
% of ProAg			69%
% of Budget			70%

(1) Cumulative budget of 12/85 - budget allocated 1984 + unspent balances

TABLE 15 1986

USAID - LOCAL COSTS (CFA) (Jan. - March)

Classification	ProAg	Budget(1)	Actual
Vehicle spare parts	0	1,902,471	585,374
Other equipment + supplies	0	1,127,0770	167,002
Training seminars	12,057,200	665,175	79,265
Operational problems	5,000,000	0	0
Transport	0	928,489	30,055
Emergency gas/oil funds	3,200,000	509,805	316,600
Printing	0	1,261,000	0
Durable goods	0	2,032,252	58,145
Contingency	6,056,800	1,216,098	4,867,302
TOTAL	26,314,000	9,642,367	1,430,886
% of ProAg			5%
% of Budget			14%

(1) Budget = unspent 1985 balances

Note: USAID funds suspended January 28 1986

TABLE 16

USAID - FOREIGN EXCHANGE COSTS ($)

Classification	1984 ProAg	1984 Actual (4)	1985 ProAg	1985 Actual(3)
Vehicle spare parts	0	0	3,000	0
2 wheel motorized vehicle	24,857	(local)	20,000	45,000(4)
Cold Chain(1)	20,571	0	25,714	44,000(1)
Chloroquine	50,000	0	54,857	50,000
ORS	40,000	0	0	40,000
Vaccination(2) equipment	34,857	0	15,000	36,000(2)
Other equipment and supplies	12,000	0	2,000	0
To project car	0	0	0	8,000
TOTAL	182,285	0	120,571	223,000
% of ProAg		0%		185%

(1) Refrigerators
(2) Equipment 27,000 (including needles on route)
Syringes 9,000
(3) From PIO/C status records, amount obligated
(4) PIOC funds used for local purchase

TABLE 17 1986

USAID - FOREIGN EXCHANGE ($)

Classification	ProAg	(Jan - March) Actual	LOP
Vehicle spare parts	4,000	0	12,750
2 wheel motorized vehicle	0	0	44,857
Cold chain	25,143	0	94,714
Chloroquine	0	0	104,857
ORS	0	0	40,000
Vaccination equipment	14,857	0	64,714
Other equipment + supplies	0	50,000(1)	14,000
TOTAL	44,800	50,000	375,892

(1) All purpose PIOC, first order chloroquine resistance study lab materials

TABLE 18: LPRC - ALL COSTS

Item	1984 ProAg	1984 Actual	1985 ProAg	1985 Actual	1986 ProAg	1-3/86 Actual	1987 ProAg
Measles vaccine (offshore cost)	0	0	4,000,000	0	8,000,000	0	24,400,000
Chloroquine	0	0	12,000,000	4,000,000	16,000,000	0	48,000,000
ORS	0	0	16,000,000	0	18,000,000	0	54,000,000
Equipment, vaccination	0	0	5,000,000	0	7,000,000	0	22,000,000
Fuel repair	5,257,200	0	8,000,000	1,504,241 (1)	9,142,800	748,600 (3)	32,342,800
Perdiem, transport	0	0	3,000,000	4,740,000 (2)	3,400,000	358,000 (4)	10,400,000
Office supplies	0	0	0	2,146,260	4,000,000	943,381	8,458,000
Total (% of Prob)	5,257,200	0 (0%)	48,000,000	12,390,521 (26%)	65,542,000	2,049,981	199,600,800

(1) Fuel and oil = 960,240
Maintenance = 544,021

(2) Transport of vaccines = 359,000
Per diem = 4,381,000

(3) Fuel and oil = 722,000
Maintenance = 26,362

(4) Transport of vaccines = 10,000
Per diem = 348,000

TABLE 19

FAC - EXPENDITURES FOR CCCD FROM CCCD/FAC FUNDS

Classification		Expenditures (1984-1986)
Vehicles		17,282,000
Gasoline		1,230,000
Maintenance		1,000,000
ICORT Conference		975,000
BCG 50,000		3,525,000
VAT 20,000 does		1,062,000
TOTAL		25,074,000
FAC CCCD Budget:	1984	25,000,000
	1985	18,500,000
	1986	12,500,000
	1987	6,250,000

TABLE 20

FAC EXPENDITURES FOR CCCD FROM PEV/FAC FUNDS 1984-3/86

Classification	Expenditures
Maintenance of electric generator	1,400,000
Vehicle spare parts	79,200
Maintenance of cold chain	808,489
TOTAL	2,287,689

TABLE 21

FAC - EXPENDITURES FOR CCCD FROM SEGE/FAC 1984-3/1986

Vehicles	2,897,000
Office supplies (including photocopies)	4,395,800
Vehicle insurance	200,000
TOTAL	7,492,800

TABLE 22

TAC - EXPENDITURES FOR CCCD FROM FONDS FOLLEREAU/FAC

Distribution of vaccines into regions	250,000

TABLE 23

OTHER DONORS

UNICEF:

35 Scales
10 Microscopes
3 Laboratory kits for chloroquine resistance record
200,000 (Approx.) ORS packets

ROTARY CLUB:

Vaccines (polio)

TABLE 24

GLOBAL BUDGET 1985 (CFA)

Allocated Remaining	Original Spent
USAID	119,797,570
119,797,570	119,797,570
0	
FAC	25,000,000
25,000,000	18,512,000
6,488,000	
GPRC	30,000,000
15,000,000	12,390,521
2,609,579	
TOTAL	174,797,570
159,797,570	150,700,091
(USAID	
FAC-GPRC)	
% GPRC	17%
9%	
8%	
TOTAL	149,797,570
134,797,570	132,188,091
(USAID	
+ GPRC)	
% GPRC	20%
11%	
9%	

TABLE 25

PROJECT AGREEMENT GLOBAL BUDGET (CFA)

	1984	1985	1986	1987
USAID Offshore costs	72,914,000	48,228,400	17,600,000	11,614,400
USAID Local costs	36,485,600	33,314,000	26,314,000	12,342,800
GPRC Offshore costs (measles vaccines)	0	4,000,000	8,000,000	12,400,000
GPRC Local costs	5,257,200	44,000,000	57,542,800	68,743,600
TOTAL	114,656,800	129,542,400	109,456,800	105,100,800
% Congo	5%	37%	60%	77%

TABLE 26

MINIMUM* GPRC LOCAL FUNDS TO MAINTAIN 1985 ACTIVITY LEVELS THROUGH 1986
(FCFA)

Fuel	3,840,000 CFA	
Oil	239,190	
Vehicle maintenance		883,350
Per diem	3,612,000	
Transport	642,600	
Office supplies	2,500,000	
TOTAL	11,717,140	
Chloroquine (8 Brazzaville Centers)		235,876
Accelerated vaccination program	2,000,000	
TOTAL	13,953,016	
15% Contingency	2,092,952	
GRAND TOTAL	16,045,968 CFA	

* This minimum cost figure pertains to maintaining given 1985 level of activity in Brazzaville, Pointe-Noire and Loubomo without including any of the special activities called for in the 1986 plan of activities except the accelerated vaccination program scheduled for October/November 1986. This program was included because it is felt that GPRC participation is crucial to maintain donor support of CCCD activities in the future. Note 15% rather 10% contingency rate was used because the total 13,953,016 CFA is truly a minimum estimate.

TABLE 27

ASSUMPTIONS FOR MINIMUM GPRC LOCAL FUNDS: 1986

Fuel and Maintenance

- 4 CCCD vehicles
- 20,000 km/yr
- 0.16 liters/km
- 300 CFA/liter
- Oil 239,190 CFA [2/3 country assessment, 357 CFA = 2$]
- 5% purchase price of 4 vehicles (17,667,000) = maintenance

Supervision	Regional	Local
Per diem	7000 CFA/day	7000 CFA/day
# Persons	4	4
Length of trip	7 days	1 day
# Trips/yr	3	36
# Regions	-	3
TOTAL	588,000	3,024,000

Airfare (CFA) 53,550 (Brazzaville/Pointe-Noire/Loubomo/Brazzaville)

Office Supplies

GPRC/CCCD Budget expenditure 2,500,000 CFA

Chloroquine

- 4 malaria centers, Brazzaville (3140 reported cases)
- 300 mg/treatment (country assessment)
- 3.13 CFA/25mg (UNIPAC 1985 catalogue, Qualls study)
- Anticipate doubling # centers

Accelerated Vaccination Program

- Minimum contribution required by GPRC as estimated at UNICEF Meeting, April 18, 1986 (2,000,000 CFA)

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Accelerated Vaccination Program

- Minimum contribution required by GPRC as estimated at UNICEF Meeting, April 18, 1986 (2,000,000 CFA)

TABLE 27 (CONTINUED)

Other Supplies:

It is assumed that vaccines, ORS and some chloroquine will be supplied by donors. Also, GPRC will continue to supply personnel and the base infrastructure (i.e. buildings, utilities). Depreciation of capital goods is not included.

TABLE 28

ESTIMATED PROJECTIONS: GPRC, USAID FUNDS

	86	87	88	89
GPRC	16,045,968*	32,724,146	52,730,963	87,749,266
USAID	48,137,904	39,996,179	29,661,166	5,994,430
TOTAL OPERATING COSTS	64,183,872	72,720,326	82,392,130	93,350,283
% GPRC	25%	45%	64%	94%
USAID Unspent	75,651,777	35,655,597	5,944,430	0

USAID Unspent balances as of 3/86

local:	82,632,881
offshore:	41,156,800
TOTAL:	123,789,681

Assumptions:

All the projections above are mathematical constructs using
1. GPRC minimum level 1986 funding as starting point *
2. A schedule of GPRC burden of generating costs: 25%, 45%, 64%, 94%
3. The amount of unspent USAID balances as of 3/86
4. Inflation 10%, population growth 3%: TOTAL Project Operating Costs

The level of activity in Brazzaville, Pointe-Noire and Loubomo supported by these projections cannot be precisely stated at this point. A detailed analysis using epidemiological and cost information is required to do this.

A N N E X # 1

DOCUMENTS REVIEWED

Second Year Project Evaluation Briefing Book

Planning Documents

1. Project Implementation Letters 1 and 2
2. Life of Project Activity Plan (1984-1988)
3. Annual Activity Plan 1985
4. Annual Activity Plan 1986

Activity Reports

1. 1985 Country Summary Report
2. Rapport d'Activites - Annee 1985
3. Technical Officers Monthly Reports

Coordination/Cooperation

1. Life of Project Budget (1984-1988)
2. Coordinating Committee CCCD
3. Quarterly Financial Reports on Local Fund Account
4. Status of PIOCs

GPRC Budget/Funding Problem

1. Status of Government Revenues
2. Correspondence

Other General Articles

1. First Annual Project Review CCCD/Congo (May 1985)
2. Country Assessment CCCD/Congo (May 1983)

Epidemiology: Special Documents

1. Annual Program Reports: Malaria, Diarrheal Diseases, EPI Direction de la Sante Publique (GPRC 1984-1985)
2. Annual Report Grandes Endemies: Niari, Kouilou (1985)

DOCUMENTS REVIEWED (CONT.)

3. Reports of Grandes Endemies for vaccination Campaigns in Pointe-Noire, Loubomo (1986)
4. Consultant Report: Measles in Pointe-Noire
   Dr. F. Dabis (Oct. - Nov. 1985)
5. Consultant Report: Measles in Brazzaville
   Dr. W. Taylor (Feb. 1985)
6. Dossier Soins de Sante Primaire au Niari
7. Programme de Development des Soins de Sante Primaires au Republique Populaire du Congo (Nov. 1985)

Health Education/Training: Special Documents

1. Health Education Mission Report
   Sarah Fry (Oct. - Nov. 1985)
2. Health Education Action Plan for CCCD in PRC
   Sarah Fry (Nov. 1985)
3. End of Mission Report (July 1-5, 1985)
   Kathy Parker, CDC Atlanta
4. End of Mission Report (July 2 - August 3, 1985)
   Thomas C. Leonhardt, CDC Atlanta

Economics: Special Documents

1. Cost Study Report, CCCD/Congo (June/July 1985) and Addendum (October 7, 1985) - Noreen Qualls
2. Financial Records, CCCD/Congo (1984-1985)
   Direction des Services Administratifs et Finance
3. FAC Synthese de Depenses (1984 - 18 Avril 1986)
4. Budget: Direction Generale de la Sante Publique (1986)

A N N E X # 2

PERSONS CONTACTED

American Embassy of Brazzaville

The Honorable Ambassador Alan Lukens
David Bassett CCCD - WHO Liason
Christy Collins USAID Liason
USAID Kinshasa

Ministry of Health and Social Affairs

1.	Dr. C. Bouramoue	The Honorable Minister of Health and Social Affairs
2.	Dr. A. Gando	General Director of Public Health
3.	Dr. G. Madzou	Director of Preventive Medicine
4.	Dr. S. Nzingoula	Director of Maternal Child Health and Health Education
5.	Dr. A. Ezanza	Director of Curative Medicine
6.	Dr. Niatty-Benze	Director of Primary Health Care
7.	Dr. R. Coddy	Chief of Service for Research Planning and Training
8.	Dr. P. Eozenou	Chief of Service Endemic Diseases (Grands Endemies)
9.	Dr. L. Loueko	Chief of Service EPI
10.	Mr. M. Biahoua	Bureau of Statistics EPI
11.	Mr. L. Obe	Chief of Service - Diarrheal Disease Control
12.	Mme. H. Bany	Chef de Service Education Pour La Sante (DSMIES)
13.	Mlle. E. Niamikessy	CCCD-EPS Coordinator (DSMIES)
14.	Mr. F. Biahoula	Deputy Chief of Service Malaria DMP
15.	Ms. K. Hawkins-Reeds	CCCD Technical Officer (leaving)
16.	Mr. B. Fitzgibbon	CCCD Technical Officer (arriving)
17.	Mme. Ngembi	Chief of Administrative and Financial Services
18.	Dr. Samba-Lefevre	Chief of Infectious Diseases - Hospital Makelekele
17.	Mr. Louhouamou	Interim Director of PHARMAPRO RPC

PERSONS CONTACTED (CONTINUED)

Region of Kouilou

1.	Dr. J. Senga	Chief of Grands Endemies
2.	Mr. D. Kimbatsa	Deputy Chief Grands Endemies
3.	Mme. Houmba	Director Regional DSMIES
4.	Dr. Nicolas	Chief of Pediatrics General Hospital a Sice
5.	Team Members	Regional Direction of PHC
6.	Dr. Nakahormda	Deputy Regional Director of Health and Med. Chief, SMI-MBOTA

Region of Niari

1.	Dr. Malalow	Regional Director of Health
2.	Dr. Goma	Med. Chief - Grands Endemies
3.	Dr. M. Manhoungou	Regional Director, SSP
4.	Regional Director	Affaires Social
5.	Mlle. A. Backouma	Chief of CDD - Grands Endemies
6.	Mr. T. Likibi	Chief of Malaria - " " "
7.	Mr. P. Mahoungou	Chief of PEV - " " "
8.	Dr. T. Sounda	Co-Project Director PHC-GTZ
9.	Dr. R. Menoli	Technical Coordinator PHC-GTZ
10.	Mr. Moukouavile	Training Coordinator - PHC-GTZ

UNICEF

1.	Mr. Juan Fernando Aguire	Director
2.	Mr. Ken Olivola	Program Officer

FAC

1.	M. Boissart	Director of Health Projects

Brazzaville

1. SMI Makelekele
2. Hospital General - Makelekele
3. SMI Poto-Poto
4. SMI CNPS Bacongo
5. SMI Ex-Adrientiste
6. SMI Lonzolo
7. SMI Talangai

PERSONS CONTACTED (CONTINUED)

Pointe-Noire

1. Hospital A. Sice
2. SMI CNSP Foucks
3. SMI M'Bota
4. SMI Jean Vialle

Loubomo

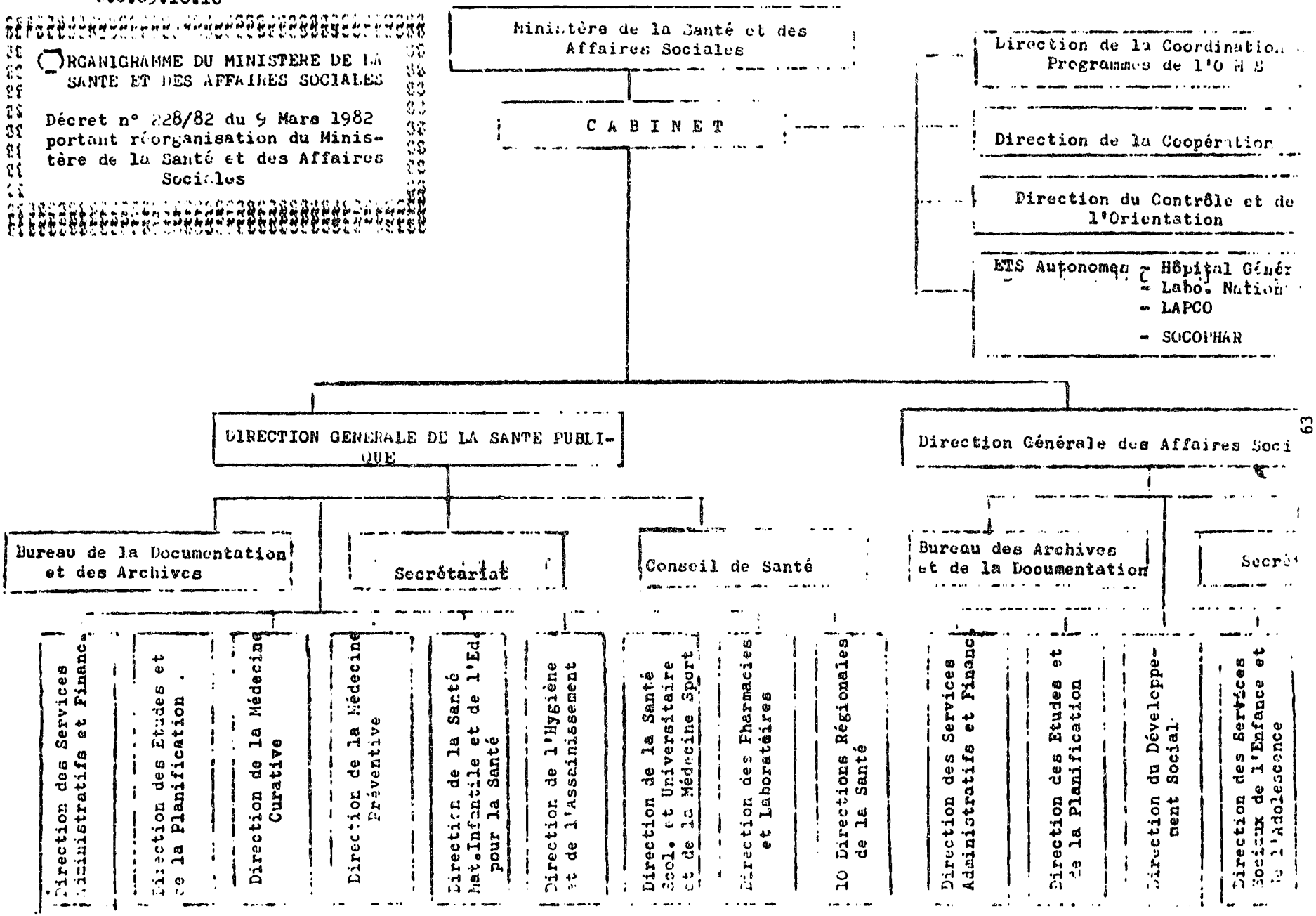
1. Hopital de Loubomo
2. SMI de Loubomo
3. SMI Armee de Salut

A N N E X # 3

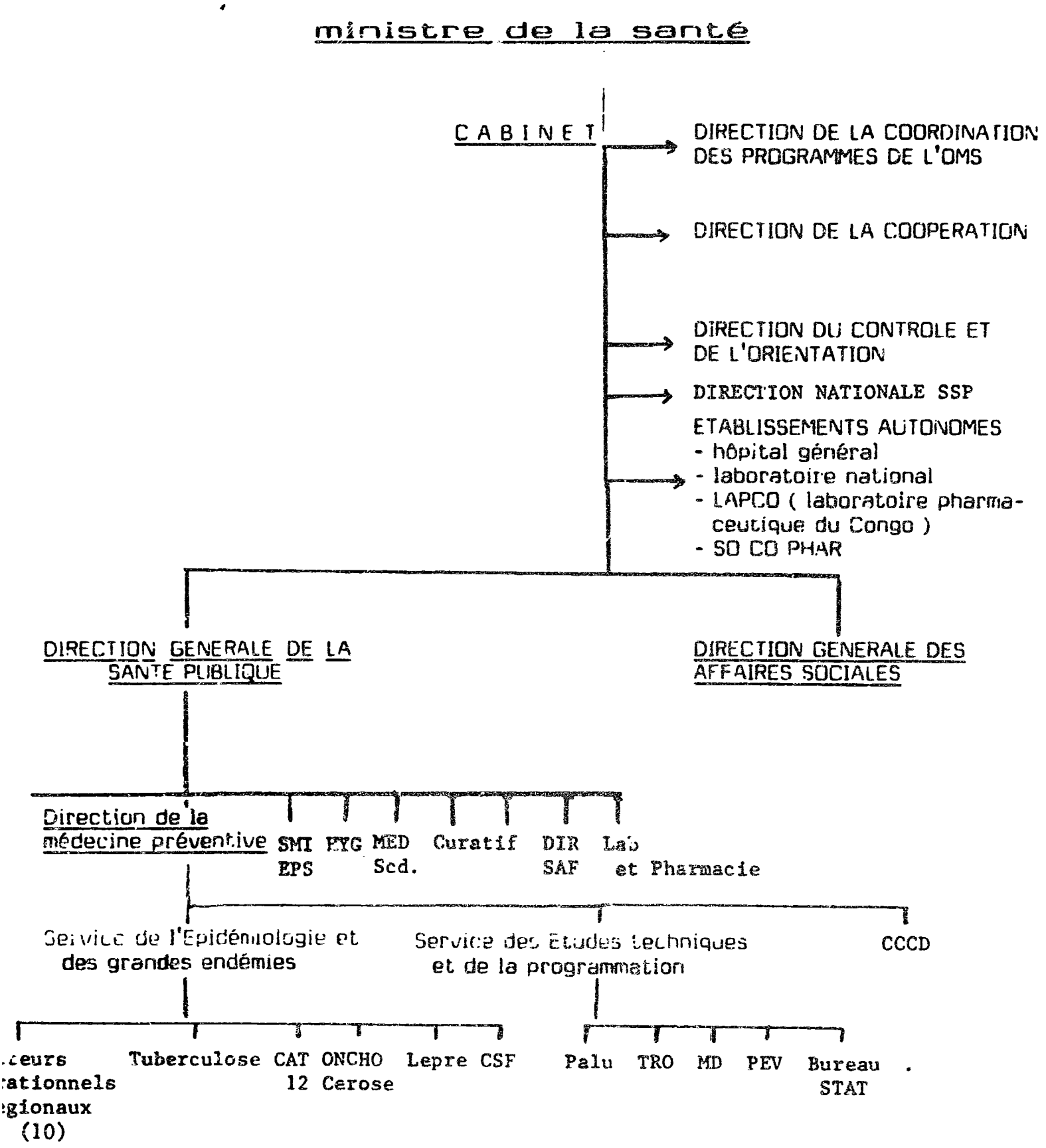
O.C.85.10.16

ORGANIGRAMME DU MINISTERE DE LA SANTE ET DES AFFAIRES SOCIALES

Décret n° 228/82 du 9 Mars 1982 portant réorganisation du Ministère de la Santé et des Affaires Sociales



organigramme du ministère de la santé et des affaires sociales



A N N E X # 4

M.V.

MINISTERE DE LA SANTE ET DES AFFAIRES SOCIALES

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C A B I N E T

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REPUBLIQUE POPULAIRE DU CONGO
Travail - Démocratie - Paix

- - - - -

COPIE

NOTE DE SERVICE N°1220/85

PORTANT DEFINITION, ORGANISATION, ATTRIBUTIONS ET FONCTIONNEMENT DU RESEAU D'APPLICATION DU PROGRAMME NATIONAL DES SOINS DE SANTE PRIMAIRES

==========

LE MINISTERE DE LA SANTE ET DES AFFAIRES SOCIALES

Vu le Décret n°82 - 228 du 9 Mars 1982, portant réorganisation du Ministère de la Santé et des Affaires Sociales,

Vu le Décret n° 82/595 du 18 Juin 1982, fixant les indemnités de fonctions allouées aux titulaires de certains postes administratifs,

Vu le Décret n° 84/856 du 8 Août 1984, portant nomination du Premier Ministre,

Vu le Décret n° 84/858 du 13 Août 1984, portant nomination des Membres du Gouvernement,

La Conférence des Directeurs Généraux et Directeurs Centraux entendue,

DECIDE

==========

Article 1er : La présente note de service définit l'organisation, les attributions et le fonctionnement du réseau d'application du Programme National des Soins de Santé Primaires.

Article 2 : Les Soins de Santé Primaires constituent une approche intégrée de la prestation socio-sanitaire et comportent à cet effet plusieurs composantes.

Les composantes de Soins de Santé Primaires retenues comme essentielles en République Populaire du Congo sont :

1) l'éducation pour la santé
2) la médecine préventive (vaccinations, lutte contre les endémo-épidémies, surveillance épidémiologique)
3) la santé maternelle et infantile
4) l'hygiène et l'assainissement
5) les soins curatifs
6) l'alimentation/Nutrition
7) l'approvisionnement en eau potable
8) l'assistance sociale
9) l'approvisionnement en médicaments essentiels
10) la lutte contre les épidémies
11) la tenue des statistiques sanitaires

Article 3 : Le réseau d'application du Programme National des Soins de Santé Primaires comprend, outre le système d'orientation/recours qui n'est pas traité dans la présente Note (Hôpitaux régionaux, Hôpitaux généraux et C.H.U.) :

- Les Services Centraux du Programme National des Soins de Santé Primaires
- Des Services Régionaux des Soins de Santé Primaires, à raison d'un service par Région
- Un Comité Consultatif Régional des Soins de Santé Primaires par Région
- Des Comités de Santé institués aux trois (3) niveaux de base.
- Les formations sanitaires des trois niveaux de base.

Article 4 : Les Services Centraux suivants et leurs sections sont organisés au sein du Programme National des Soins de Santé Primaires.

1°/Service des Etudes et de la Planification avec la Section Statistiques et la Section Projets, Programmation et Recherche.

2°/ Service de la Coordination, du Contrôle et de l'Evaluation comprenant la Section Organes de Gestion et la Section Organes d'exécution aux Trois Niveaux de base (T.N.B.)

3°/ Service de l'intégration des Soins de Santé Primaires divisé en Section Formations Sanitaires des Trois Niveaux de base, Section Formations Sanitaires d'orientation/recours et Section Réorientation du système de Santé nationale.

.../...

4°/ Service de la formation comportant la Section Formation initiale, la Section Recyclage et prefectionnement et la Section de l'audio-visuel, du matériel didactique et de l'information.

5°/ Service de l'Administration et des Finances qui comprend la Section du Personnel et du Budget, la Section du Matériel et de la Dépense et la Section Secrétariat.

Article 5 :Il est organisé en outre un Service régional des Soins de Santé Primaires dans chaque Région. Ces Services Régionaux sont placés sous l'autorité du Responsable du Programme National.

Article 6: Chaque Service Régional comprend les Sections suivants :

- Administration et Finances (A.E.F.)
- Coordination, Contrôle et évaluation (C.C.E.)
- Médicaments, Vaccins et équipements (M.V.E.)
- Santé Maternelle et Infantile (S.M.I.)
- Alimentation; Nutrition, eau potable (A.N.E.P.)
- Activités Sociales et promotionnelles (A.S.E.P.)
- Coordination des Soins Curatifs (C.D.S.C.)
- Médecine Préventive (M.P.)
- Hygiène et Assainissement (H.AS.)

Article 7 : Les Sections des Services Régionaux des Soins de Santé Primaires reçoivent les attributions suivantes :

a) La Section A.E.F. est chargée de la gestion des ressources humaines matérielles et financières de la région ainsi que de leur mobilisation.

b) La Section C.C.E. coordonne, contrôle et évalue l'exécution du programme d'action régional en matière de Soins de Santé Primaires.

c) La Section M.V.E. est chargée de la gestion du Médicament, des vaccins et de l'équipement médical. Elle en assure l'entretien et approvisionne régulièrement les formations sanitaires.

d) La Section S.M.I. supervise les activités liées à :

- La surveillance de la grossesse et la prévention des accidents susceptibles de la ménacer,
- l'éducation des femmes enceintes,
- la prestation des soins aux nouveaux-nés
- la lutte contre la mortalité et la morbidité infantiles par les soins curatifs
  immunisation active,
- la surveillance systématique de l'état de santé de la population juveno-infan-
  (0 à 5 ans)

e) La section Alimentation, Nutrition, Eau Potable a pour rôle de :

- Promouvoir les activités tendant à obtenir pour les populations une alimentation saine et suffisante qualitativement et quantitativement,

- superviser l'éducation nutritionnelle des mères,
- contrôler la qualité de l'eau consommée par les populations

f) La Section A.S.E.P. est chargée de :

- tenir les statistiques des personnes handicapées chroniques au plan physique, moral, mental, environnemental ou de l'âge (vieillards),

- coordonner et contrôler les actions qui sont menées en leur faveur, notamment dans le domaine de la formation, de la rééducation, de la réadaptation professionnelle et de la réinsertion sociale,

- assurer l'assistance matérielle et morale des personnes handicapées.

g) La Section C.D.S.C. coordonne les activités de Soins curatifs tant en médecine classique qu'en médecine traditionnelle (acupuncture et phytothérapie).

h) La Section M.P. est chargée de :

- opérer la surveillance épidémiologique,
- organiser sous la supervision du service régional et des services centraux la lutte contre les épidemies,
- coodonner, contrôler et évaluer les activités d'immunisation active dans le cadre du programme élargi des vaccination,
- organiser sous la direction du service régional et des services centraux les campagnes systématiques de dépistage des maladies sociales (M.T.S.) tuberculose, lèpre, maladies psychiatriques, alcoolisme, etc.)

i) La Section HAS. veille à l'exécution du programme d'hygiène et d'assainissement du milieu, hygiène alimentaire, lutte anti-vectorielle

- supervise l'éducation populaire en hygiène et assainissement
- maintient une collaboration étroite et fructueuse avec les autres secteurs du développement communautaire,
- applique les peines infligées aux auteurs d'infractions en matière d'hygiène et d'assainssement,
- fait des propositions pour l'amélioration des conditions d'hygiène des populations, etc.

.../...

Article 8 : Au niveau de chaque Chef-lieu de Région est constitué un Comité Consultatif Régional pour les Soins de Santé Primaires.

a) Le Comité Consultatif Régional des Soins de Santé Primaires est ainsi composé :

- Président : Le Commissaire Politique
- Vice-Président : Le Directeur Régional de la Santé
- Membres : Le Chef de Service Régional des Soins de Santé Primaires.

  Les Chefs de Section du Service Régional du Programme.

  Un Représentant du Comité Régional du Parti,

  Un Représentant du Conseil Populaire de Région

  Un Représentant de l'UJSC-Jeunesse du Parti

  Des Représentants Régionaux des Administrations suivantes :

  - Agriculture 1
  - Education Nationale 2
  - Energie et Hydraulique 1
  - Industrie 1
  - Petites et Moyennes Entreprises 1
  - Informations 1
  - Traveaux Publics 1
  - Pisciculture 1
  - Administration du Territoire 1
  - Environnement 1

b) Le Comité Consultatif Régional des Soins de Santé Primaires a pour rôle de :

- donner son avis sur les objectifs du Programme Régional, la Planification des activités et leur exécution, le fonctionnement des Comités de Santé.
- apporter sa contribution à l'exécution des Programmes grâce aux appuis logistiques notamment dans les domaines représentés par ses membres,
- Participer à l'animation du Programme Régional notamment dans les campagnes de lutte contre les épidémies, d'hygiène et d'assainissement, de nutrition et d'éducation populaire pour la santé par la mobilisation des masses populaires et des représentants des principaux secteurs de l'économie nationale (Agriculture, Industrie, Energie et Hydraulique, Education

.../...

Nationale, Petites et Moyennes Entreprises, Information, Travaux Publics, Environnement, Administration du Territoire).

c) Le comité Consultatif Régional des Soins de Santé Primaires se réunit deux fois par an sur convocation de son Président. Le quorum est atteint lorsque les deux tiers des membres sont présents. Chaque réunion fait l'objet d'un procès-verbal adressé au Ministre de la Santé et des Affaires Sociales.

Article 9 : Les Soins de Santé Primaires s'appliquent dans toutes les formations sanitaires de la République Populaire du Congo. Toutefois l'accent doit être fortement mis sur le niveau basal.

Article 10 : Les trois niveaux de base (T.N.B.) de l'organisation socio-sanitaire sont ainsi définis :

a) Premier niveau :

- en milieu urbain : zones, unités de production.

b) Deuxième niveau :

- en milieu rural : P.C.A.
- en milieu urbain : Quartiers, entreprises regroupées et assimulées.

c) Troisième niveau :

- Districts et arrondissements des grandes villes.

Article 11 : Les formations socio-sanitaires des trois niveaux de base sont les suivants :

a) au 1er niveau :

- Poste de Santé pour les villages isolés et les unités de production
- Dispensaire pour les villages-centres et les zones des quartiers urbains.

b) au 2è niveau :

- Centres de Santé intégrés urbains -C.S.I.U.) pour les quartiers des villes et ruraux (C.S.I.R.) pour les P.C.A.
- Centres de Santé Intégrés d'Entreprises (C.S.I.E.)

c) au 3è niveau :

- Hôpitaux de base pour les districts et les arrondissements de grandes villes.

.../...

Article 12 : Les unités de production, les villages-centres, les zones et quartiers des grandes villes, les PCA et les districts doivent disposer chacun :
- d'un éco-système sanitaire minimal (E.S.S.M.)
- d'un comité de santé.

Article 13 : Déco-système sanitaire minimal (E.S.S.M.) comprend au moins :
- une latrine au moins par famille, par établissement public et par unité de production.
- un système d'approvisionnement en eau et notamment en eau potable
- une formation socio-sanitaire assurant au moins la prévention des maladies, les soins curatifs, l'éducation pour la Santé et l'assistance sociale.

Article 14 : Les formations socio-sanitaires au niveau basal reçoivent les attributions et les structurations fonctionnelles ci-dessus.

Article 15 : Le poste de santé comprend un agent de santé de village qui le dirige et une matrône, dans le cas des villages : un infirmier diplômé d'état dans le cas des unités de production.
Le poste de santé exécute les tâches suivantes :
- prestation des soins élémentaires et nivaquinisation systématique.
- gestion du médicament pour la santé
- éducation populaire
Le poste de santé reçoit les avis et les directives du comité de santé du village, de l'unité de production ou de la zone et s'y conforme.

Article 16 : Le dispensaire des villages-centres et des zones, des quartiers urbains comprend le personnel suivant ;

- un infirmier Diplômé d'Etat qui en est le responsable
- un aide-soignant
- une matrône
Le dispensaire assume les tâches suivantes :
administration des soins élémentaires et nivaquinisation systématique
- accouchements eutociques
- soins en hospitalisation dont la durée ne doit pas exoéder trois à cinq jours
- évacuation vers le centre plus developpé des cas jugés sérieux
- gestion du médicament

.../...

- éducation populaire pour la santé, éducation des mères et assistance sociale
- contrôle de l'éco-système sanitaire

Le dispensaire reçoit les avis et les directives du comité de village ou de zones de quartier et s'y conforme.

Article 17 : Le Centre de Santé Intégré du P.C.A. ou du quartier des grandes villes ou d'entreprise doit posséder une structure et une organisation lui permettant d'appliquer les composantes essentielles des Soins de Santé Primaires.

Article 18 : Le Centre de Santé Intégré est animé par un personnel comprenant au minimum :

- un directeur qui en est l'administrateur
- un médecin multi-disciplinaire
- un assistant sanitaire généraliste
- une sage-femme
- deux infirmiers diplômés d'Etat généraliste
- une assistante sociale
- deux aides-soignants
- une matrone
- un technicien qualifié de laboratoire
- un infirmier diplômé d'etat option pharmacie
- un infirmier diplômé d'etat option anesthésie
- une monitrice sociale
- un tradi-praticien
- un dentiste.
- un secrétaire, un planton, un commis, un agent d'entretien, un jardinier.

Article 19 : Les activités dévolues au centre de santé intégré sont ainsi arrêtées:

- prestation des mêmes actes assignés au dispensaire des villages-centres
- accouchements dysotociques et petite chirurgie
- vaccinations
- hygiène et assainissement du milieu
- lutte contre les épidémies
- activités liées à la santé maternelle et infantile (surveillance et protection de la grossesse, vaccination, conseils d'hygiène, établissement de pièces règlementaires, etc.)
- assistance sociale

- évacuation des cas graves vers l'hôpital de base
- contrôle des normes de l'éco-système sanitaire et de la règlementation sanitaire en vigueur.

Article 20 : Le centre de santé intégré reçoit les avis et les directives du comité de santé du P.C.A. du quartier urbain ou de l'entreprise en matière socio-sanitaire. Ces avis et directives sont donnés au moins deux fois par an. Leur application ne peut intervenir qu'après agrément du Comité de santé correspondant. Dans l'accomplissement de certaines de ses tâches (lutte contre les épidémies, campagnes d'hygiène, éducation, etc.). Le centre associe les populations, les représentants du parti, les Organisations de Masse et des autres secteurs connexes, notamment l'Agriculture, les Travaux publics, l'Energie et l'Hydraulique, l'Industrie, les P.M.E., la pisciculture, l'Information, l'Administration du Territoire, l'Industrie et l'environnement. Il est tenu pour ce faire de solliciter le concours du bureau du Comité exécutif de la localité.

Article 21 : Dans chaque district, dans chaque arrondissement de grandes villes, doit être organisé un centre de santé intégré principal dit hôpital de base.

Article 22 : La structure, l'organisation et les attributions des hôpitaux de base de districts et arrondissements des grandes villes doivent permettre l'intégration et l'exécution au plus haut niveau des composantes essentielles des Soins de Santé Primaires.

Article 23 : Le personnel minimum de chaque hôpital de base doit comprendre :

a) pour les soins médicaux : (consultations, hospitalisations, gestion et distribution du médicament)

- un médecin multi-disciplinaire
- un pédiatre clinicien
- un gynéco-obstétricien
- un pharmacien
- un chirurgien généraliste
- un dentiste
- un technicien supérieur en anesthésiologie
- un technicien supérieur en radiologie
- un technicien supérieur de laboratoire
- un assistant sanitaire généraliste
- une sage-femme principale
- une sage-femme puéricultrice
- six infirmiers (ères) diplômés d'Etat généralistes
- six aides-soignantes
- deux matrones
- deux agents d'entretien.

b) Pour la Santé Communautaire (S.M.I., médecine préventive, hygiène et assainissement, alimentation en eau potable, nutrition assistance sociale)

- un pédiatre social

- un médecin épidémiologiste
- un médecin spécialiste d'hygiène et assainissement
- un médecin ou un pharmacien micobiologiste
- un docteur en nutrition
- un assistant social principal
- une sage-femme principale option puéricultrice
- deux sages-femmes option puéricultrice
- un technicien supérieur de laboratoire
- trois techniciens supérieurs de santé publique
- trois infirmiers diplômés d'Etat
- un technicien qualifié de laboratoire
- trois aides-soignants
- deux monitrices sociales
- trois agents d'entretien

c) Pour l'Administration :

- un directeur
- un gestionnaire des ressources
- une secrétaire
- un planton
- un commis
- un chauffeur
- un magasinier
- un mécanicien (auto, électricité)
- un plombier
- un jardinier

Article _ : Les activités des hôpitaux de base couvrent l'essentiel des besoins socio-sanitaires des populations et portant dans les domaines suivants :

a) soins médicaux : consultations externes, hospitalisation (médecine, chirurgie, gynécologie, obstétrique, pédiatre), gestion de distribution du médicament

b) santé communautaire : S.M.I., médécine préventive, lutte contre les épidémies, hygiène-assainissement, alimentation en eau potable, nutrition, assistance, sociale,

c) gestion administrative et financière

Article 25 : L'hôpital de base reçoit les avis et directives du comités de santé de district ou d'arrondissement au moins deux fois par an. L'exécution de ces directives requiert l'agrément du Comité Consultatif Régional. Dans l'accomplissement de certaines de leurs tâches (lutte contre les épidémies, campagne d'hygiène et assainissement, éducation), l'hôpital de base et son comité de santé associent les populations, les représentants du Parti, des Organisations de Massos et des autres secteurs connexes. (Agriculture, Industrie, Energie et hydraulique, Pisciculture, P.M.E., Informations, Education national, Administration du Territoire, Environnement, etc.).

Article 26 : Des comités de santé sont constitués au niveau des villages, villages-centres, zones et quartires urbains, unités de production, arrondissement des grandes villes, PCA et districts.

Article 27 : La composition de chaque comité de santé est ainsi fixé :

Président : Le président du Comité de village, zone, unité de production, quartier, PCA, district ou arrondissement

Vice-Président : Responsable sanitaire de la circonscription concernée

Membre :
- un réprésentant du Programme des Soins de Santé Primaires
- des représentants des unités composant la formation sanitaire élus par leurs pairs à raison de :
  - 1 à 3 représentants pour l'unité de soins médicaux
  (1 représentant s'il s'agit du 1er niveau, 2 s'il s'agit du 2è niveau et 3 s'il s'agit du 3è niveau)
  - 1 à 5 représentants pour l'unité de santé communautaire
  (1 représentant s'il s'agit du 1er niveau, 3 s'il s'agit du 2è niveau et 5 s'il s'agit du 3è niveau)
- Le responsable des services généraux
- un représentant du comité de village, zone, unité de production, PCA, district, quartier et arrondissement désigné par les bureaux correspondants
- un représentant du conseil populaire
- un représentant de l'UJSC-jeunesse du parti
- un représentant par Organisation de Masse (C.SC, et U.R.F.C notamment)
- les représentants des secteurs suivants : Agriculture, Industrie, Travaux publics, Energie et hydraulique, Pisciculture, P.M.E, Education, Information, Environnement, Administration du Territoire.

Article 28 : Les Comités de Santé ont pour rôle de :

- veiller à l'application intégrée et coordonnée des composantes essentielles des Soins de Santé Primaires,
- émettre des avis sur la planification des activités annuelles au plan local et sur la qualité de la prestation socio-sanitaire,
- évaluer les activités des formations sanitaires et dresser les procès-verbaux
- aux fins d'exploitation par l'autorité hiérarchique du système de santé,
- participer et faire participer activement les populations aux activités des Soins de Santé Primaires,
- veiller au développement communautaire intégré et coordonné grâce à une collaboration étroite et une concertation permanente des partenaires qui les composent,
- faire au Ministère de la Santé et des Affaires Sociales toutes suggestions susceptibles d'accélérer le développement sanitaire des communautés.

Article 29 : Les Comités de Santé du 1er niveau sont contrôlés et supervisés par ceux du 2è niveau, ces derniers par les Comités de Santé des Districts ou des Arrondissements des grandes Villes.

Les délibérations des Comités de Santé des Districts et Arrondissements, sont examinées par les Comités régionaux consultatifs correspondants qui émettent leurs avis et en saisissent le Ministre de la Santé et des Affaires Sociales par des procès-verbaux.

Article 30 : Les fonctions de membres de Comité de Santé sont bénévoles.

Article 31 : Toutes dispositions antérieures contradictoires sont abrogées.

Article 32 : Un arrêté ministériel régularisera les dispositions de la présente note de Service .

.../...

Article 33 : Le Directeur Général de la Santé Publique, le Directeur Général des Affaires Sociales et le Responsable du Programme des Soins de Santé Primaires veillent chacun en ce qui le concerne, à la stricte application des dispositions de la présente Note.

Brazzaville, le 03 Juin 1985

Le Ministre de la Santé et des Affaires Sociales,

(é) Professeur C. BOURAMOUE.-

AMPLIATIONS /

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- U.R.F.C.....10
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Travail - Démocratie - Paix

SECRETARIAT GENERAL
DU GOUVERNEMENT

DECRET N° 86/392 du 24/03/86
PORTANT INSTITUTION, ATTRIBUTIONS ET ORGANISATION DU PROGRAMME NATIONAL DES SOINS DE SANTE PRIMAIRES.-

LE PRESIDENT DU COMITE CENTRAL DU PARTI CONGOLAIS DU TRAVAIL, PRESIDENT DE LA REPUBLIQUE, CHEF DU GOUVERNEMENT,

Vu la Constitution du 8 Juillet 1979 ;

Vu la loi n° 76/84 du 7 Décembre 1984 portant ratification de l'Ordonnance n° 019/84 du 23 Août 1984 portant modification de certaines dispositions de la Constitution du 8 Juillet 1979 ;

Vu le décret n° 82/228 du 9 Mars 1982 portant réorganisation du Ministère de la Santé et des Affaires Sociales ;

Vu le décret n° 82/595 du 18 Juin 1982, fixant les indemnités de fonctions allouées aux titulaires de certains postes administratifs ;

Vu le décret n° 84/856 du 8 Août 1984 portant nomination du Premier Ministre ;

Vu le décret n° 85/1423 du 7 Décembre 1985 portant nomination des Membres du Gouvernement ;

Vu le décret n° 85/1434 du 17 Décembre 1985 portant organisation des intérims des Membres du Gouvernement ;

Sur proposition du Ministre de la Santé et des Affaires Sociales,

Le Conseil des Ministres entendu :

D E C R E T E :

TITRE 1ER- DISPOSITIONS GENERALES

Article 1er.- Il est institué auprès du Ministère de la Santé et des Affaires Sociales un Programme National des Soins de Santé Primaires rattaché directement au Cabinet du Ministre de la Santé et des Affaires Sociales.

Article 2.- Le Programme National des Soins de Santé Primaires a pour objet de :

1) étudier, mettre au point et coordonner les Soins de Santé Primaires en République Populaire du Congo.

.../...

2)- Organiser l'intégration des activités des Soins de Santé Primaires dans le système de santé national;

3)- étudier et mettre en œuvre les stratégies essentielles au bon fonctionnement des composantes des Soins de Santé Primaires;

4)- susciter la participation des autres secteurs de l'Etat, du Parti, de l'UJSC-J.P et des Organisations de masse ainsi que des Organisations Internationales ;

5)- élaborer, exécuter et évaluer les programmes de formation en Soins de Santé Primaires des encadreurs, des personnels de santé et de ceux des autres secteurs connexes.

TITRE II : ORGANISATION ET FONCTIONNEMENT

ARTICLE 3 .- Les organes du Programme National des Soins de Santé Primaires sont:
- Le Comité de Direction
- La Direction du Programme.

CHAPITRE 1ER : DU COMITE DE DIRECTION

ARTICLE 4 .- Le Comité de Direction du Programme National des Soins de Santé Primaires comprend :

PRESIDENT: Le Ministre de la Santé et des Affaires Sociales

MEMBRES :- Le Directeur du Programme National des Soins de Santé Primaires,
- Un Représentant de chacun des Ministères suivants :

- Ministère du Plan et de l'Economie
- Ministère des Finances et du Budget
- Ministère du Développement Rural
- Ministère de l'Administration du Territoire et du Pouvoir Populaire
- Ministère des Travaux Publics, de la Construction, de l'Urbanisme, de l'Habitat et de l'Environnement
- Ministère du Tourisme, Sport et Loisirs
- Ministère des Enseignements Secondaire et Supérieur
- Ministère de l'Enseignement Fondamental et de l'Alphabétisation
- Ministère de l'Industrie et de la Pêche
- Ministère des Mines et de l'Energie
- Ministère de l'Economie Forestière
- Ministère du Commerce, des Petites et Moyennes Entreprises et de l'Artisanat
- Ministère de la Recherche Scientifique
- Ministère de l'Information, des Postes et Télécommunications
- Ministère de la Culture et des Arts.

...../...

Celle-ci doit intervenir dans un délai de 30 jours francs au delà duquel les délibérations sant exécutoires de plein droit. S'il n'y a ni [illegible] ni [illegible].

CHAPITRE II : DU DIRECTEUR DU PROGRAMME NATIONAL DES SOINS DE SANTE PRIMAIRES.

ARTICLE 8.- Le Programme National des Soins de Santé Primaires est dirigé et animé par un Directeur nommé par décret du Premier Ministre pris en Conseil de Cabinet, sur proposition du Ministre de la Santé et des Affaires Sociales.

ARTICLE 9.- Le Directeur est chargé d'assurer le fonctionnemnt régulier du Programme National des Soins de Santé Primaires.

ARTICLE 10.- La Direction du Programme National des Soins de Santé Primaires comprend les Services suivants :

- service des études et de la planification
- service de la coordination, du contrôle et des évaluations
- service d'intégration des Soins de Santé Primaires
- service de la formation
- service administratif et financier
- services régionaux.

ARTICLE 11.- Les services sont animés par des Chefs de Service nommés par arrêté du Ministre de la Santé et des Affaires Sociales et placés sous l'autorité hiérarchique du Directeur du Programme National.

ARTICLE 12.- Les Services régionaux sont chargés notamment des tâches suivantes :

- programmation, coordination, contrôle, orientation et évaluation des activités en Soins de Santé Primaires au niveau des Districts Arrondissements des grandes villes, communes, PCA, villages-centres, villages et unités de production
- formation et éducation pour la Santé de la population.

../.

- Le Maire de la Ville [illegible]
- Un Député relevant du domaine de la Santé et des Affaires Sociales
- Le Conseiller Médical/Social du Président de la République
- Un Représentant de la Permanence du Parti
- Le Conseiller Socio-Culturel du Premier Ministre
- Le Directeur Général de la Santé Publique
- La Directrice Générale des Affaires Sociales
- Le Président du Comité du Parti du Ministère de la Santé et des Affaires Sociales
- Le Secrétaire Général de la FESYTRASAS
- Le Premier Secrétaire de l'UUSC-JP du Ministère de la Santé et des Affaires Sociales
- Une Représentante du Secrétariat Général de l'URFC
- Un Représentant des Organisations de masse.

A titre consultatif, toute autre personne choisie par le Comité de Direction en raison de sa compétence.

ARTICLE 5 .- Le Comité de Direction se réunit deux fois par an, en Décembre et en Juillet. Il peut être convoqué en séance extra-ordinaire par son Président ou sur la demande écrite des 2/3 de ses Membres.

Le Projet d'ordre du jour est préparé par le Directeur du Programme, arrêté et présenté au Comité de Direction par le Ministre de la Santé et des Affaires Sociales. Le quorum est atteint lorsque les 2/3 des Membres sont présents. Les décisions sont prises à la majorité simple. En cas de partage des voix, celle du Président est prépondérante.

Le Secrétariat du Comité de Direction est assuré par le Directeur du Programme.

ARTICLE 6 .- Le Comité de Direction du Programme National des Soins de Santé Primaires :

- délibère sur le fonctionnement général de la gestion du Programme National des Soins de Santé Primaires
- donne des orientations et des directives pour son développement, son contrôle et son évaluation
- approuve le budget et le programme d'investissement annuels
- de façon générale, contribue à l'exécution du programme et participe à son animation notamment en donnant des avis sur les objectifs annuels et leur exécution

ARTICLE 7 .- Les procès-verbaux du Comité de Direction sont soumis à l'approbation du Conseil des Ministres.

//

- gestion des ressources humaines, matérielles, financières et du médicament
- appui obligatoire aux activités de soin, de prévention, de santé maternelle et infantile, d'hygiène et assainissement, éducation nutritionnelle, etc, menées au niveau des Districts, Arrondissements des grandes Villes, Communes, PCA, Villages-Centres, Villages et Unités de production.

CHAPITRE 3 : DES COMITES CONSULTATIFS REGIONAUX

ARTICLE 13. Au niveau des régions, les responsables des Soins de Santé Primaires sont aidés par les Comités Consultatifs Régionaux présidés par le Commissaire Politique. Ces Comités sont constitués des représentants régionaux du Parti, de l'UJSC-J.P, des Organisations de Masses et des représentants des autres secteurs impliqués dans les Soins de Santé Primaires, notamment ceux de l'Agriculture, l'électricité, l'eau, l'information, l'industrie, les Petites et Moyennes Entreprises, l'éducation et les travaux publics.

Les Comités Consultatifs Régionaux veillent à l'exécution harmonieuse des Programmes de Soins de Santé Primaires, contribuent à l'apport des appuis logistiques indispensables et à l'animation des Centres des Soins de Santé Primaires.

TITRE III : DES DISPOSITIONS DIVERSES

ARTICLE 14. Le Directeur, les Chefs de Services du Programme National des Soins de Santé Primaires perçoivent les indemnités de fonction conformément aux textes en vigueur.

ARTICLE 15. Un arrêté du Ministre de la Santé et des Affaires Sociales fixe les modalités de fonctionnement des Comités Consultatifs Régionaux et, d'une façon générale, du Programme National des Soins de Santé Primaires, sur l'ensemble du territoire national.

ARTICLE 16. Sont abrogées toutes les dispositions antérieures contraires au présent décret.

...../...

ARTICLE 17.- Le présent décret sera enregistré, publié au Journal Officiel de la République Populaire du Congo et communiqué partout où besoin sera./-

Fait à Brazzaville, le 24 MARS 1986

Par le Président du Comité Central du Parti Congolais du Travail, Président de la République, Chef du Gouvernement,

Le Premier Ministre,

Colonel Louis SASSOU-NGUESSO.

Le Ministre de la Santé et des Affaires Sociales,

Pierre Edouard POUNGUI.

Professeur Christophe BOURAMOUE.

Le Ministre des Finances et du Budget,

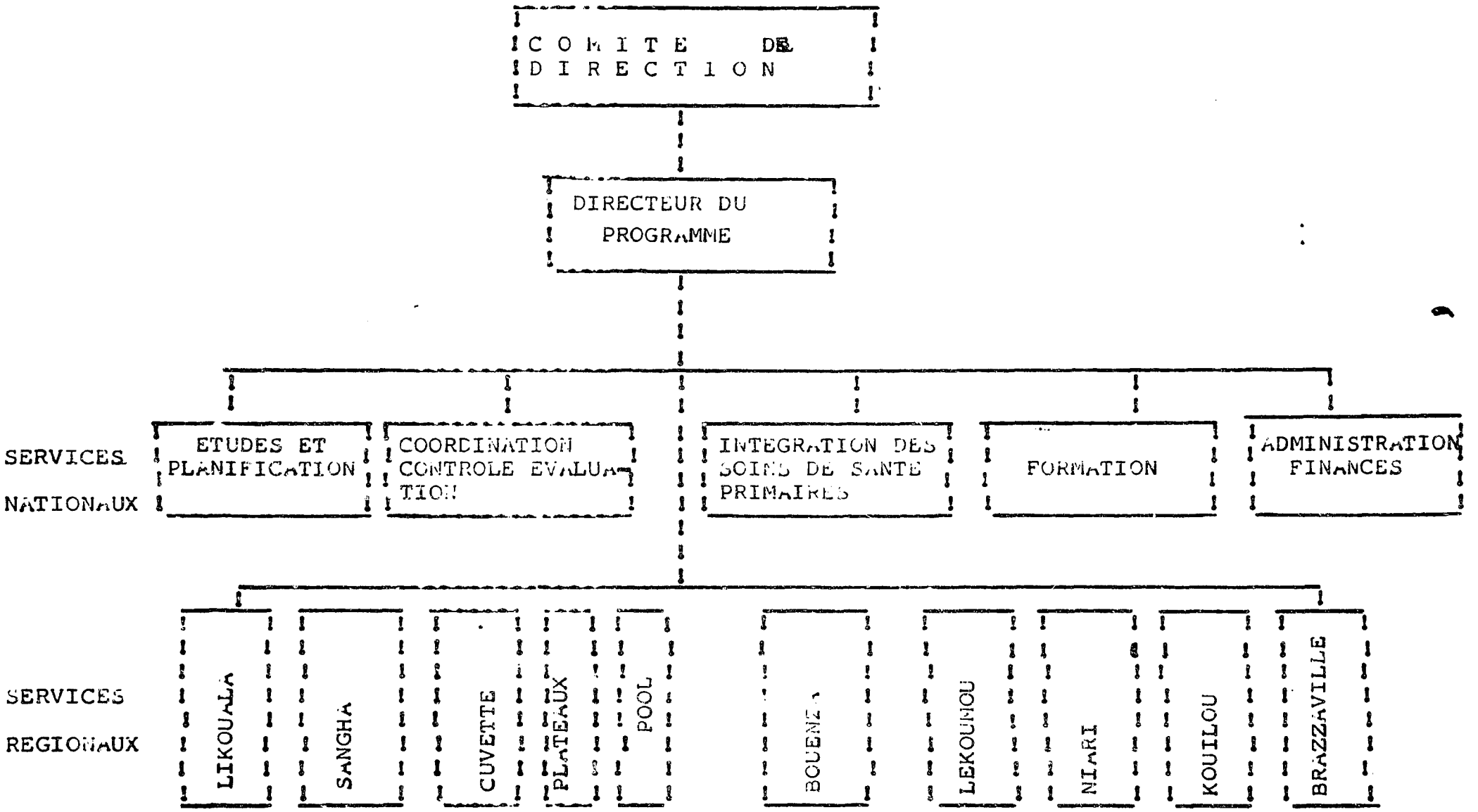
Itihi Ossetoumba LEKOUNDZOU.

Le Ministre du Travail, de l'Emploi, de la Retraite de la Fonction Publique et de la Prévoyance Sociale,

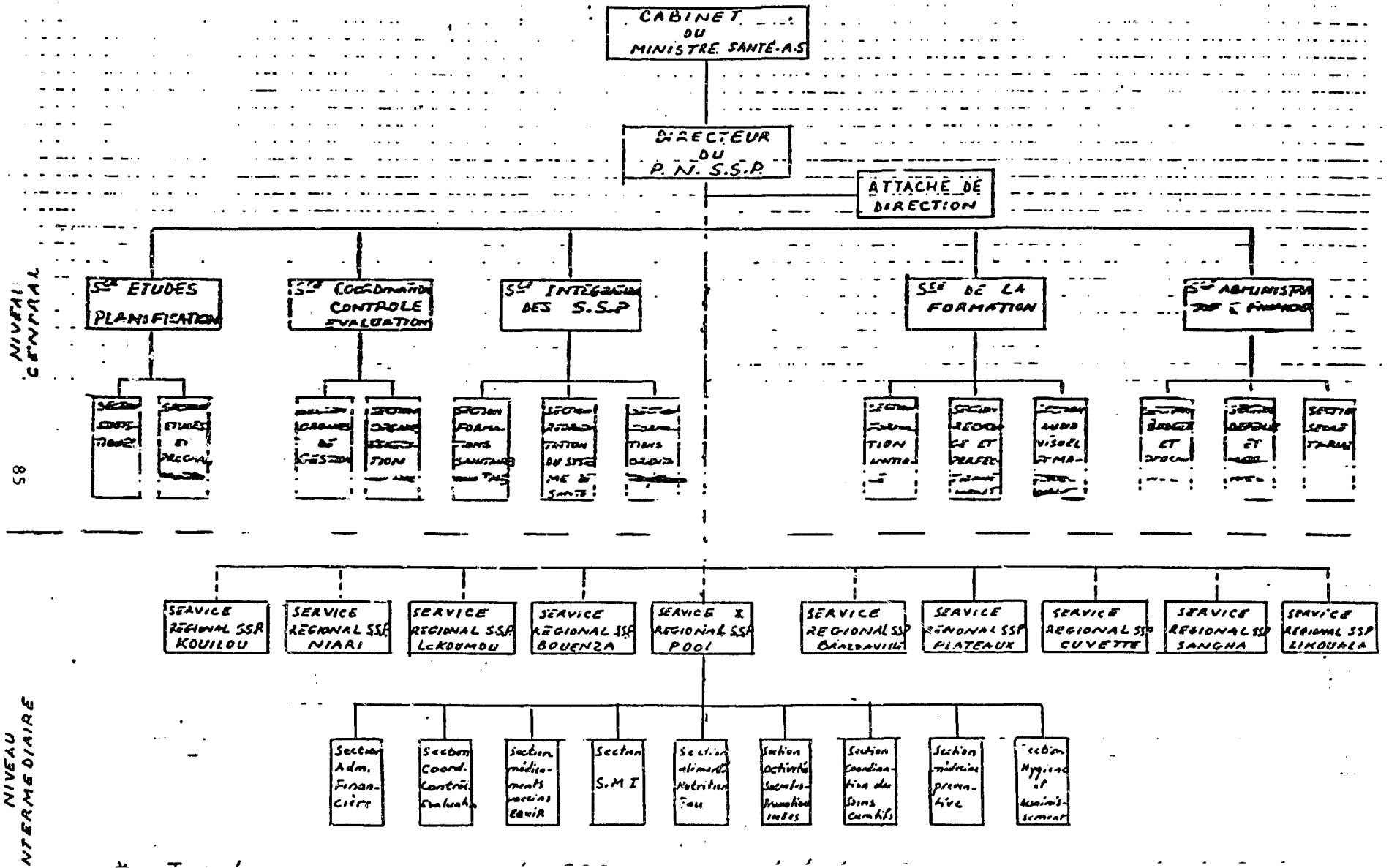
Bernard COMBO MATSIONA.

Le Ministre de l'Administration du Territoire et du Pouvoir Populaire,

Raymond Damase NGOLLO.-


COMITE DE DIRECTION
DIRECTEUR DU PROGRAMME
SERVICES NATIONAUX
ETUDES ET PLANIFICATION
COORDINATION CONTROLE EVALUATION
INTEGRATION DES SOINS DE SANTE PRIMAIRES
FORMATION
ADMINISTRATION FINANCES
SERVICES REGIONAUX
LIKOUALA
SANGHA
CUVETTE
PLATEAUX
POOL
BOUENZA
LEKOUNOU
NIARI
KOUILOU
BRAZZAVILLE

ORGANIGRAMME DE LA DIRECTION DU PROGRAMME NATIONAL DES S.S.P.



A N N E X # 5

4. PROGRAMMES SSP - OBJECTIFS, STRATEGIES, PLAN D'ACTION

4.1 Objectifs

Les objectifs généraux s'énoncent comme suit :

- mettre en place un système national de santé intégré qui permette de garantir à toute la population la santé au sens global;

- réduire les inégalités devant l'accessibilité aux soins de santé;

- organiser un système de santé fondé sur la prévention et l'éducation pour la santé;

- éduquer les populations dans les domaines de la nutrition et de l'hygiène plus particulièrement;

- amener les masses populaires à assumer la responsabilité de leur santé;

- intégrer la médecine traditionnelle à la bio-médecine.

Les objectifs spécifiques à atteindre entre 1985 et 1990 s'énoncent comme suit :

- construire et équiper un dispensaire dans chaque village-centre ou village regroupé dans chaque zone des quartiers urbains;

- aménager ou faire aménager un poste de santé dans tous les villages non regroupés et toutes les unités de production importantes;

- construire et équiper chaque année 10 centres de santé intégrés urbains;

- construire et équiper au moins 10 hôpitaux de base;

- construire et équiper au moins 5 hôpitaux régionaux;

- construire et équiper un centre hospitalier universitaire;

- renforcer les formations sanitaires existant actuellement dans les chefs-lieux de district;

- former un comité de santé dans chaque village, chef-lieu de PCA, chef-lieu de district, zone, unité de production, quartier et arrondissement;

- assurer la formation du personnel approprié à tous les niveaux;

- opérer un redéploiement des ressources humaines, matérielles et financières en fonction de la stratégie des SSP conformément à la Note de Service No 1220/85;

- mettre en oeuvre les programmes sanitaires existants;

- esquisser les descriptions de poste des personnels soignants afin de faciliter le nécessaire réaménagement des programmes de formation;

- organiser une série de séminaires de formation des ASV;

- mettre en place un système de recyclage périodique des personnels;

- renforcer les mécanismes gestionnaires des formations sanitaires.

4.2 Stratégies de SSP

Les stratégies globales retenues pour atteindre les objectifs fixés sont les suivantes :

- auto-responsabilisation des populations avec l'appui des instances politiques;
- participation active des secteurs connexes d'Etat (enseignement, information, agriculture, etc.);
- réorientation du système de santé au plan des structures comme au plan des personnels;
- priorité des soins préventifs et promotionnels sur la médecine curative;
- dotation suffisante en infrastructures sanitaires équipées des villages, zones, PCA, quartiers, districts, arrondissements, région, etc.

Les stratégies spécifiques concernent surtout l'intégration aux programmes nationaux des SSP de tous les programmes de lutte contre les endémies locales. Plusieurs programmes ont été retenus :

- PEV;
- paludisme;
- maladies diarrhéiques;
- maladies sexuellement transmises;
- schistosomiase;
- trypanosomiase;
- onchocercose;

- tuberculose;
- lèpre;
- nutrition;
- tous projets actuels dits "de SSP".

Il s'agira de faire ressortir pour chaque programme : les résultats de l'évaluation en 1985, les modalités nouvelles d'organisation, d'exécution et d'évaluation, s'il y a lieu. L'exécution de ces programmes entre donc dans le cadre des tâches quotidiennes de toutes de nos formations sanitaires existantes et à construire.

Intégration de la médecine traditionnelle à la médecine moderne : La médecine traditionnelle comprend la phytothérapie, l'acupuncture et certains actes rééducatifs de valeur reconnue. Il faudra :

- opérer au préalable un recensement exhaustif des tradipraticiens et des acupuncteurs;
- introduire un dialogue entre les tradipraticiens dûment reconnus par l'Etat et les médecins à travers les séminaires de sensibilisation et de formation;
- poursuivre l'inventaire des plantes médicinales et la mise en place d'un herbier national;
- introduire dans l'arsenal thérapeutique des plantes médicinales qui ont déjà fait leur preuve sur le terrain pratique afin de réduire les coûts des médicaments.

Intégration des structures des trois niveaux de base (TNB) : Les structures de trois niveaux de base (TNB) définies à l'Article 10 de la Note constituent le cadre dans lequel doivent s'appliquer intégralement les composantes des soins de santé primaires (SSP). Par conséquent, elles sont désormais placées sous le contrôle technique du Programme national des soins de santé primaires, leur administration relevant toujours de la Direction générale de la Santé publique.

Éducation pour la Santé (EPS) : Le programme est élaboré par les services techniques du Programme national de SSP en collaboration avec la Direction générale de la Santé publique. Il s'adresse en priorité aux :

- larges masses populaires, notamment paysannes;
- mères enceintes, allaitantes ou non;
- enfants (enseignement en milieu scolaire).

L'éducation pour la santé utilise largement les mass média; elle a recours aux aides audio-visuelles et diverses illustrations facilitant l'assimilation des programmes.

Politique alimentaire et nutritionnelle : Le Parti et l'Etat manifestent une volonté politique ferme et ont adopté l'objectif social de la SPT/2000. En outre, l'autosuffisance alimentaire d'ici à l'an 2000 est devenu le second objectif social pour le Congo. Le Programme des SSP à ce niveau porte autant sur la qualité et la quantité des aliments que sur l'hygiène alimentaire.

Constitution d'un écosystème sanitaire minimal : L'écosystème sanitaire minimal est défini dans la note de service No 1220/85. Tous les niveaux de l'organisation sociale et administrative doivent en disposer. Il comprend :

- une latrine au moins par famille, établissement ou unité de production;
- l'approvisionnement en eau : puits, citernes, sources;
- une formation sanitaire;
- la constitution d'un comité de santé par communauté (villages, quartiers, PCA, districts, etc.).

Hygiène et assainissement : Il sera crée au niveau de chaque chef-lieu de district une équipe d'hygiène et assainissement qui aura pour rôle de :

- encadrer et sensibiliser la population dans la mise en place des structures d'assainissement de base et d'hygiène du milieu;

- mener une lutte anti-vectorielle (chloroquinisation);

- contrôler la qualité de l'eau de consommation et de l'alimentation.

Le nombre total de puits et de latrines à construire ou à aménager ainsi que les coûts correspondants doivent être connus courant 1985. D'une façon générale, le coût global du Programme des SSP doit être connu dans les meilleures délais.

Formation du personnel : L'effort en matière d'infrastructures sanitaires sera nécessairement accompagné du développement des personnels nécessaires et appropriés. Les programmes de formation sont à revoir immédiatement en fonction des nouveaux profils à conférer aux personnels.

4.3 Plan d'action pour les soins de santé primaires

Le plan d'action pour les SSP comportera nécessairement les actions suivantes :

a) Evaluation exacte de la situation socio-sanitaire du pays

- établissements des valeurs en 1985 des principaux indicateurs de santé;

- inventaire des formations sanitaires à réaménager en fonction de la stratégie des SSP;

- inventaire par catégorie des personnels de santé. Définition des besoins minimum des structures (Tableau 1 et Note No 1220/85);

- établissement de la liste nominative et numérique des villages-centres, villages regroupés, unités de production PCA, districts, régions et leurs chefs-lieux ainsi que des blocs, zones, quartiers et arrondissements des villes.

- pour chacune des localités visées, indication de la population des secteurs économiques et sociaux, des structures sanitaires et leurs ressources, des budgets.

b) Rédéploiement des ressources humaines

- attribution des personnels en se conformant à la Note de Service 1220/85 du 3 juin 1985, en commençant par le premier niveau de base;

- utilisation judicieuse des personnels en luttant contre le chômage technique, volontaire ou non, des agents;

- formation et recyclage suivant les nouveaux profils et programmes à définir (agents de santé de villages ou de quartiers, autres personnels).

c) Mise en place des stratégies définies plus haut : Ces stratégies permettent de délimiter les domaines de compétence exclusifs au partage du Programme national des SSP. Elles constituent en même temps pour certaines, des actions spécifiques s'inscrivant dans le cadre même du Programme des SSP. (Exemple : mobilisation et auto-responsabilisation des populations).

d) Construction ou aménagement et équipement des formations sanitaires : La Direction du Programme des SSP évaluera les besoins exacts dans ce domaine et les soumettra à l'attention du Ministre avant fin 1985.

e) Mise en place des écosystèmes sanitaires minimum : La note de service No 1220/85 du 3 juin 1985 définit l'écosystème sanitaire minimal indispensable et prescrit par ailleurs la constitution des comités de santé.

f) Mise en fonctionnement des structures : On veillera à ce que celles-ci disposent du minimum de ressources définies.

g) Réorientation du système sanitaire national - Une commission spécialisée doit être constituée pour élaborer un avant projet à soumettre à l'approbation du Ministère dans un premier temps.

h) Evaluation des coûts du Programme et évaluation régulière des activités.

i) Inventaire des obstacles potentiels et des solutions à leur prévoir.

Tableau 9

CALENDRIER GENERAL DES ACTIVITES GLOBALES A MENER (1985-1990)

Activités	1985	1986		1987		1988		1989		1990	
	2è S.	1èr S.	2è S.	1er S.	2è S.	1er S.	2è S.	1er S.	2è S.	1er S.	2è S.
a) Mobilisation des masses	———	———	———	———	———	———	———	———	———	———	
b) Evaluation situation socio-sanitaire et besoins du Programme SSP	———	———									
c) Redéploiement des ressources humaines		f, g, h,	b, c, d,	d, e, g,	d, e, g,						
d) Mise en place des stratégies spécifiques	——— e, b,f	——— b, c, d	——— e, f, g, h	h,	h,	h	ibid	ibid	ibid	ibid	
e) Réajustement des programmes d'enseignement	—	———	———								
f) Aménagement, équipement des formations sanitaires	———	———	———	———	———	———	———	———	———	———	
g) Mise en place écosystème sanitaire minimal	———	———	———								
h) Mise en fonctionnement des structures SSP	———	———	———	———	———	———	———	———	———	———	
i) Evaluation, coûts	———										
j) Evaluation régulière des activités	———	———	———	———	———	———	———	———	———	———	———
k) Inventaire : obstacles et solutions	———	———	———	———	———	———	———	———	———	———	———

A N N E X # 6

MINISTERE DE LA SANTE ET DES
AFFAIRES SOCIALES
CABINET

REPUBLIQUE POPULAIRE DU CONGO
Travail- Démocratie - Paix

NOTE DE SERVICE N° 0025/MSAS/CAB/KAE.-
portant création d'un Comité de Coordination Technique des Activités des Soins de Santé Primaires (SSP)

ARTICLE 1er: Il est crée au sein du Ministère de la Santé et des Affaires Sociales un Comité de Coordination Technique des Activités des Soins de Santé Primaires.

ARTICLE 2: Le Comité de Coordination Technique des Activités des Soins de Santé Primaires reçoit les attributions suivantes :

- Suivi régulier et contrôle de l'exécution des activités programmatiques annuelles des Soins de Santé Primaires,

- Concertation sur les modalités de mobilisation des ressources et élaboration des recommandations à faire au Programme National des Soins de Santé Primaires pour de réajustements éventuels et surtout pour la budgétisation des Programmes annuels;

- Programmation des activités conjuguées des Directions Centrales devant s'exercer dans le cadre des Soins de Santé Primaires,

- Contribution à l'actualisation régulière de la liste des médicaments essentiels,

- Estimation, programmation, coordination et contrôle des Aides internationales,

- Définition des relations fonctionnelles devant exister entre le Programme national des Soins de Santé Primaires et les Directions Centrales concernées d'une part, les différents services du Programme National des Soins de Santé Primaires et les Services de Santé de base d'autre part,

- Mise en place des appuis informationnels et contrôle régulier de leur fonctionnement et de leur efficience.

ARTICLE 3: La composition du Comité de Coordination Technique est ainsi fixée:

Président : Le Directeur du Programme National des Soins de Santé Primaires

Vice-Président: Le Directeur de la Médecine Curative

Secrétaire : L'Attaché Sanitaire au Cabinet du Ministre de la Santé et des Affaires Sociales

.../...

- **Membres** :
  - Le Directeur de la Santé Maternelle et Infantile/P.F.
  - Le Directeur de l'Hygiène et Assainissement
  - Le Directeur de la Médecine Préventive
  - Le Directeur des Pharmacies et des Laboratoires
  - Le Directeur du Développement Social
  - La Directrice de l'Enfance
  - Le Consultant de l'OMS pour les Soins de Santé Primaires
  - Un Représentant de l'UNICEF
  - Le Consultant de l'OMS pour les statistiques et les évaluations
  - Un Représentant du PNUD
  - Un Représentant de la Présidente de la Croix Rouge Congolaise
  - Les Chefs de Services Régionaux du Programme National des Soins de Santé Primaires
  - Le Chef de Service chargé des Soins de Santé Primaires à la Direction de la Coordination des Programmes de l'OMS
  - Les Chefs de Projets des Soins de Santé Primaires
  - Un représentant du Directeur du Secteur Tertiaire au Ministère du Plan
  - Un Représentant des Organisations Non Gouvernementales

ARTICLE 4: Le Comité peut faire appel à toute autre personne jugée utile pour ses compétences

ARTICLE 5: Le Comité de Coordination Technique des Activités des Soins de Santé Primaires se réunit tous les trois (3) Mois. Il peut toutefois tenir des reéunions extra-ordinaires chaque fois que les nécessités de service l'exigent.

ARTICLE 6: Les réunions du Comité de Coordination Technique des Activités des Soins de Santé Primaires font l'objet des procès-verbaux adressés au Cabinet du Ministre de la Santé et des Affaires Sociales, aux Commissaires Politiques et aux Directeurs Généraux de la Santé et des Affaires Sociales qui en assurent l'exploitation.

ARTICLE 7: Les fonctions de Membres du Comité de Coordination Technique des Activités des Soins de Santé Primaires sont bénévoles.

ARTICLE 8: La présente note de service prend effet à compter de sa date de signature.

LIATIONS:

net Présidentiel
net du P.M.
cteur Régional de l'OMS
ur l'Afrique
net MSAS
S.P.
A.S.
Coordination des
ogrammes de l'OMS/CONGO
ressés
ives

Brazzaville, le 28 Septembre 1985

Le Ministre de la Santé et des Affaires Sociales

Professeur CH. BOURAMOUE

Pour Copie Certifiée Conforme

Brazzaville, le

Dr. NIATY - BENZE.

Directeur du Programme National des Soins de Santé Primaires

A N N E X # 7

CENTRES SANITAIRES ET ESTIMATION DE LA POPULATION CIBLE PAR REGION (RECENSEMENT DE 1984)

Region	Centres médicaux	Population totale	Population âgée de 25 ans	Population des femmes de 15 à 40 ans (18,1%)
Brazzaville	105	592,102	110,094	107,713
Kouilou	65	371,608	68,747	67,261
Niari	51	172,914	31,989	31,297
Lekoumou	27	68,301	12,636	12,367
Bouenza	44	185,147	34,253	33,512
Pool	70	180,051	33,309	32,590
Plateaux	74	108,802	22,128	19,693
Cuvette	59	135,144	25,002	24,461
Sangha	21	46,367	8,577	8,392
Likouala	24	48,993	9,064	8,868
	540	1,912,429	353,799	346,149

Hopitaux, centres médicaux, SMI, dispensaires.

P E R S O N N E L : REPUBLIQUE POPULAIRE DU CONGO

Juin 1984

R E G I O N

Poste	Brazzaville	Kouilou	Niari	Lekoumou	Bouenza	Pool	Plateaux	Cuvette	Sangha	Likouala	Total
Médecins	106	53	17	5	10	9	4	12	5	5	226
Pharmaciens	24	17	1	0	1	0	0	0	1	0	43
Administrateurs de santé	23	4	1	0	0	0	0	0	0	0	28
Assistants sanitaires	122	41	25	5	12	10	6	8	4	4	237
Sages-Femmes principales	30	12	1	0	0	0	0	0	0	0	43
Techniciens	7	7	7	1	0	1	1	6	0	0	30
Secrétaire principale/Comptab.	42	13	4	1	0	2	0	3	0	3	68
Infirmiers (res) diplomés	341	188	93	33	24	41	23	48	18	27	837
Agents Techniques Principaux	33	8	14	0	4	7	2	7	0	2	77
Techniciens de laboratoire	16	3	1	6	2	1	0	4	0	0	33
Secrétaires Admini. Principales	33	1	0	0	0	4	0	0	0	0	38
Sages-Femmes d'Etat	136	26	12	3	5	5	1	8	2	1	199
Secrétaires de la comptabilité	20	23	0	0	3	4	3	6	4	6	69
Agents Techniques de Santé	257	202	105	22	31	54	17	73	22	33	816
Agents Techniques de Laboratoire	102	12	9	8	6	1	0	13	4	6	162
Puericultrices	634	219	56	6	23	28	9	12	6	9	1,002
Secrétaires Administratives	52	2	1	0	1	0	0	13	0	0	69
ATTACHES SAF	7	1	0	0	0	0	0	0	0	0	8
	1,985	832	347	90	122	167	66	213	66	96	3 984

CENTRES DE SOINS PAR REGION

Regions	Hopitaux Généraux	Hopitaux regionaux ou de commune	Hopitaux de district	Centres de soins intégrés	Dispensaires Publics ou Privés	Secteurs opérationnels-Grandes Endémies	Postes de secours
Brazzaville	1	4	2	6	67	1	0
Kouilou	1	1	2	7	54	1	0
Niari	0	2	3	9	49	1	0
Lekoumou	0	0	2	7	26	1	0
Bouenza	0	1	3	8	29	1	0
Pool	0	1	3	32	30	1	16
Plateaux	0	0	3	8	79	1	0
Cuvette	1	0	7	8	80	1	0
Sàngha	0	0	2	4	19	1	0
Likouala	0	0	0	0	0	1	0
	3	9	30	89	433	10	16

A N N E X # 8

CENTRES DE VACCINATION ET DE RELEVES PAR REGIONS

	Centres fixes de vaccinations	Centres S.M.I.	Postes Sentinelles
Brazzaville	25	25	5
Kouilou	8	13	3
Niari	13	13	4
Lekoumou	1	5	0
Bouenza	10	9	4
Pool	8	9	1
Plateaux	3	5	0
Cuvette	7	12	2
Sangha	1	3	0
Likouala	1	3	1
	77	97	20

A N N E X # 9

MINISTERE DE LA SANTE ET DES AFFAIRES SOCIALES

REPUBLIQUE POPULAIRE DU CONGO
TRAVAIL-DEMOCRATIE-PAIX

DIRECTION GENERALE DE LA SANTE PUBLIQUE

DIRECTION DE LA MEDECINE PREVENTIVE

N° ____/MSAS/DGSP/DMP.-

FICHE DE SUPERVISION

CENTRE DE .....

DATE .....

POINT A SUPERVISER	APPRECIATIONS	
A/ ORGANISATION		
- Y a t-il un responsable de TRO ?	oui /__/	non /__/
- Nom _____		
Combien d'agents ont été formé pour le TRO?	nbre /__/	
Combien travaillent pour le TRO ?	/__/	
Nombre de cas des diarrhées enregistrés le mois précédent	/__/	
Nombre de cas des diarrhées traités pour le TRO	/__/	
Nombre de cas des diarrhées traités aux anti-diarrhéiques	/__/	
Nombre des cas au traitement mixte	/__/	
Nombre des cas transferés	/__/	
Nombre d'heures de TRO/jour	/__/	
B/ LOGISTIQUE		
- Existence d'une salle de TRO	oui /__/	non /__/
- Condition de travail	satisfaisant /__/	non satisfaisa /__/
- Matériel de TRO : - gobelets	nbre /__/	

POINTS A SUPERVISER	APPRECIATIONS	
B/ récipients	/__/	
Balances	/__/	
C à c	/__/	
Registres	/__/	
SRO	/__/	
Louches	/__/	
C/ <u>Activités de l'Agent de Santé</u>	bien	mal
- Evaluation de l'Etat de deshydratation	/__/	/__/
- Pesée de l'Enfant	/__/	/__/
- Préparation de SRO	/__/	/__/
- Prescription de SRO	/__/	/__/
- Conseils aux mères sur :		
- L'éfficacité de TRO	/__/	/__/
- Allaitement au sein	/__/	/__/
- Allaitement pendant et après la diarrhée	/__/	/__/
- Surveillance des mères sur l'administration de TRO	/__/	/__/
D/ <u>Tenue de Fiches</u>	correct	incorrect
- Tenue de fiches de statistique	/__/	/__/
- Tenue de fiches de stock	/__/	/__/
E/ <u>Tenue de registre</u>		
<u>Renseignements généraux</u>	Complet	incomplet
	correct	Incorr.
- Age	/__/	/__/
- Poids à l'arrivée	/__/	/__/
- Plan	/__/	/__/
- Quantité prescrite	/__/	/__/
- Quantité administrée	/__/	/__/

	Complet correct	incomplet incorrect	Total	
		5	50	10
Qualité produit				
- Selon le plan	/__/	/__/	/__/	/__/
- Poids à la fin du traitement	/__/	/__/	/__/	/__/
- Poids gagné	/__/	/__/	/__/	/__/
- Durée du traitement	30' /__/	1 h /__/	1h30 /__/	2h /__/
- Etat à la sortie	/__/	/__/	/__/	/__/
	satisfaisant		non satisfaisant	
III/ Compréhension des mères relativement				
- A la préparation de SRO	/__/			/__/
- A l'éfficacité de SRO	/__/			/__/
- A l'administration de SRO	/__/			/__/

II/ Description des éventuels problèmes identifiés.....

.....

.....

.....

IV/ Recommandations .....

.....

.....

Nom du superviseur : _____

Signature

Signature du supervisé

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

FICHE DE SUPERVISION

Centre_____ Date_____

Superviseur_____ Responsable du Centre_____

Vaccins et Matériels

	(5) oui	(0) Non
Existe - il un stock suffisant de vaccins !		
Le stock de seringues et aiguilles est-il suffisant !		
Le stock de vaccins est-il acceptable !		
ya t-il eu rupture de stock de vaccins de - puis 6 mois !		
La fiche de stock est-elle rempli correc - ment !		
La chaine de froid est- elle respectée ! le (le frigo moins de + 8°C, congélateur moins de 0C et suffisance de boites isothermes entretien du réfrigérateur, congélateur)		

Technique de Vaccination

		(10) TB	(5) AB	(0) IS
• Le temps de la stérilisation est-elle respectée				
• La dilution des vaccins selon le type est-elle acceptable !				
• Les injections sont-elles faites correctement !	S/C			
	ID			
• Comment est organisée la séance de vaccination !				
• Les vaccins sont-ils protégés pendant la séance !				

MALADIES DIARRHEIQUE ET PALUDISME

	(5) oui	(0) non
* La tro est- elle pratiquée à l'hôpital! (au moins 80% des cas de diarrhée traités par tro) vérifier les régistres ou feuilles de t°		
* Les sachets de sro sont-ils disponibles a aux centres de santé ! (au moins 90% des C.S organisés doivent les utiliser) vérifier les réquisitions de médicaments.		
* Fait ou la chimioprophylaxie des femmes enceintes! (elles doivent utiliser la chloroquine à 300 mg/semaine pendant au moins 2 mois de grossesse) vérifier le registre et rapport d'utilisation de chloroquine/ médicaments.		
* Fait-on le traitement présomptif chez les enfants de 5 ans ! (ils doivent utiliser la chloroquine à dose unique de 10 mg/kg.) Vérifier les régistres.		

* Thérapeutique de Rehydratation Orale

RAPPORTS ET STATISTIQUES

	(5) oui	(0) non
La fiche de séance est-elle remplie correctement !		
La fiche de vaccination est - elle remise à la mère après la vaccination !		
Le rapport mensuel de vaccinsadministrés est-il rempli correctement et envoyé régulièrement ! (bilan et demande)		
Les rapports mensuels de déclaration de maladies sont-ils envoyés régulièrement ! (au moins 11 sur 12)		

EDUCATION POUR LA SANTE

	(10) TB	(5) AB	(0)
Les conseils sont-ils donnés en groupe !			
Manière individuelle			

Commentaires

Recommandations

Signature du Superviseur

MINISTERE DE LA SANTE ET DES
AFFAIRES SOCIALES

DIRECTION GENERALE DE LA SANTE
PUBLIQUE

DIRECTION DE LA MEDECINE PREVENTIVE

PROJET DE LUTTE CONTRE LES MALADIES
TRANSMISSIBLES DE L'ENFANCE

PROGRAMME ELARGI DE VACCINATION

FICHE DE SUPERVISION

REGION DE.....

CENTRE DE.....

DATE.....

POINTS A SUPERVISER	APPRECIATIONS
A/ ORGANISATION	ANNEE
Date de demarrage des activités vaccinales	! !
1- Y'a t-il un responsable des activités vaccinales	oui ! ! non ! !
2- Nom.....Prenom.....	ANNEE
3- Combien d'agents ont été formés pour les activités vaccinales dans les centres!	Nombre ! !
4- Combien vaccinent !	! !
5- Y'a t'il eu un recyclage des agents !	ANNEE ! ! ! !
6- Quand est ce que a eu lieu le dernier recyclage!	! !
7- Combien de séance par semaine	! !

LOGISTIQUE	APPRECIATIONS	
- Existe t'il un lieu de vaccination	oui	non
- Quelles sont les conditions de travail!	satisfaisant	non satisfaisant
- Ombre	oui	non
- materiel de vaccination existant	nombre	état
- Refrigerateur		
- Glacière		
- Poissonnière		
- seringue 10ml		
- 5ml		
2ml		
1ml		
- aiguilles s/c		
ID		
- Trocard		
- Existe t-il le materiel de sterilisation!	oui	non
- Quelle est la source d'énergie utilisé!	sembuné...	pétrole gaz
- Existe - t'il les fiches uniformes de SMI!	oui	non

......./.....

LOGISTIQUE	APPRECIATIONS	
	oui	non
- si non les mères utilisent elles d'autres documents!		
- Existe t-il de fiche de temperature refrigerateur		
- Existe t-il de thermomètre!		
- Existe t-il des fiches de stock!		
ACTIVITES DE L'AGENT VACCINATEUR		
a) VACCINATION		
- L'enfant a t-il la carte de vaccination		
- La mère a t-elle la carte de vaccination		
STERILISATION		
Méthodes:		
Ebullition		
Autoclave		
A pression vapeur		
- Seringue et aiguilles nettoyées avant la stérilisation	oui	non
autre (préciser)		
- Etat de l'aiguille et de la seringue à l'utilisation	chaud	froid
- Maitrise t-il le temps de sterilisation du materiel de vaccination (20mn d'ébullition)	oui	non
- Maitrise t-il la technique de vaccination		
BCG		
DT coq et antirougeoleux		

LOGISTIQUE	APPRECIATIONS		
Polio			
- Ce materiel est-il utilisé pour d'autres injections			
- Respàne t-il les enfants malades!			
- Vaccine t-il les enfants malades!			
- Respecte t-il les sites d'injection!			
- Comment organise t-il ses seances de vaccination circulation fluide	très bien	bien	assez bien
b/ Contrôle du Réfrigerateur			
- La fiche de temperature de frigo est elle remplie 2 fois par jour	oui	non	
- Les vaccins sont-ils bien disposés!			
- Les vaccins ne sont t-ils pas associés à d'autres denrées alimentaires dans le frigo			
- Le refrigerateurs est-il surchargé en vaccin			
TENUE DE REGISTRE ET FICHE			
- Tenue de la fiche de seance	correct	incorrect	
- Tenue de registre			
- Fiche de rapport mensuel			
- Fiche de stock			
- Y a t-il un système de fichier double au niveau du centre			
INFORMATIONS ET EDUCATION SANITAIRE			
- Les conseils sont-ils donnés en groupe avant la seance de vaccination	oui	non	
- Les conseils sont -ils donnés individuellement pendant la vaccination!			

...../.....

5

LOGISTIQUE	APPRECIATIONS		
	bon	assez bon	mauvais
- Contenu du message éducatif. 1- Utilité de la vaccination! 2- Calendrier de vaccination 3- Conduite à tenir devant les réactions vaccinales.			
OBSERVATIONS:			
RECOMMANDATIONS.			

Fait à.....le.....

Le superviseur.

A N N E X # 10

MINISTERE DE LA SANTE ET DES AFFAIRES SOCIALES

DIRECTION GENERALE DE LA SANTE PUBLIQUE

DIRECTION DE LA MEDECINE PREVENTIVE

PROJET DE LUTTE CONTRE LES MALADIES TRANSMISSIBLES DE L'ENFANCE

REPUBLIQUE POPULAIRE DU CONGO
TRAVAIL * DEMOCRATIE * PAIX

POLITIQUE NATIONALE DU PROGRAMME ELARGI DE VACCINATION

****

BRAZZAVILLE,

MARS 1986.

POLITIQUE NATIONALE
DU PROGRAMME ELARGI DE VACCINATION

****

I - INTRODUCTION :

Pour atteindre l'objectif " Santé Pour Tous en l'an 2000", adopté par les états membres de l'Organisation Mondiale de la Santé (OMS), en 1978 à ALMA-ATA, les autorités politiques congolaises qui n'ont cessé d'exprimer leur préoccupation à cet effet, ont mis en place une politique de santé de masse basée sur la Médecine Préventive et visant la santé des enfants. Ce qui justifie le Programme Elargi de Vaccination dont le démarrage avait eu lieu en 1981 à Brazzaville et dont l'objectif est de protéger l'enfant de 0 à 3 ans contre les six maladies cibles les plus invalidantes et meurtrières (tuberculose, diphtérie, tétanos, poliomyélite, coqueluche et rougeole).

En application de nouvelles orientations politiques en matière de santé dans le cadre des soins de santé primaires dont le Programme Elargi de Vaccination (PEV) est une composante, le Ministère de la Santé et des Affaires Sociales a l'intention de developper et d'étendre les prestations des services de santé en s'appuyant sur les infrastructures de santé déjà existantes et en mettant l'accent sur la réorganisation des services et sur les problèmes de formation des agents de santé, tout en mobilisant au maximum l'énorme potentiel des ressources communautaires.

II - BUT DU PROGRAMME :

Obtenir une réduction de 80 % des taux de mortalité et de morbidité dues aux six maladies cibles du PEV d'ici à la fin de 1990.

III - OBJECTIFS :

Ils consistent à atteindre le plus d'enfants possible dès la naissance et de réaliser une couverture vaccinale étendue autant que possible. Aussi il faut :

- Assurer et maintenir une couverture vaccinale de 80 % des enfants nés au Congo à compter de 1988 contre les six maladies cibles.

- Elargir l'accès aux activités vaccinales de manière à toucher 80 % de la population cible en augmentant le nombre de centres fixes et en appli-

quant les stratégies avancées et mobiles.

En vue d'assurer la couverture complète des populations cibles :

- En milieu rural : les enfants de 0 à 5 ans,
- En milieu urbain : les enfants de 0 à 3 ans,
- Les femmes enceintes.

IV - STRATEGIES :

4 - 1 : APPLICATION DU NOUVEAU CALENDRIER

* B.C.G : dose unique à la naissance,
* Polio - 4 doses : 1ere dose à la naissance,
  2ème dose à partir de 2 mois,
  Intervalle minimum de 1 mois/28 jours.
* DTCOQ : 3 doses à partir de 2 mois.
  Intervalle minimum de 1 mois/28 jours.
* Rougeole : dose unique à partir de 9 mois.
* Tétanos : Femmes enceintes deux doses.
  Intervalle minimum de 1 mois.
  2ème dose au plus tard 15 jours avant la date présumée de l'accouchement.
  Rappel : Tous les 5 ans.

4 - 2 : AMELIORATION DE LA COUVERTURE VACCINALE

4 - 2 - 1 : Vaccination contre la rougeole :

* Dans les Centres Fixes :

- Vacciner contre la rougeole chaque jour et à tout moment (Il est mieux de perdre 9 doses de vaccins qu'un enfant).

- Vacciner les enfants malades (fièvre légère, infection respiratoire, diarrhée bénigne, malnutrition et d'autres infections sans gravité).

* Dans les Centres Hospitaliers :

- Vérifier l'état vaccinal de chaque enfant hospitalisé et lui administrer si nécessaire le vaccin anti-rougeoleux avant sa sortie (ou dans certains cas dès son admission).

* Programme Elargi de Vaccination :

- Prévoir une campagne vaccinale de rattrapage si le contexte épidémiologique l'exige, c'est-à-dire avant le pic du cycle épidémique ou s'il y a une augmentation anormale des cas déclarés.

- Organiser une opération vaccinale de rupture de chaîne de transmission quand on aura constaté un nombre réduit des cas rougeoleux en période d'accalmie épidémique (exemple à partir des cas hospitalisés).

4 - 2 - 2 : Vaccination contre les autres maladies du P.E.V :

- Vacciner les nouveaux-nés avec le B.C.G et la première dose de Polio à la naissance avant la sortie de la maternité.

4 - 2 - 3 : Autres activités :

- Vérifier l'état vaccinal à chaque consultation à l'hôpital, à la SMI (Centre de Santé Maternelle et Infantile) et aux Grandes Endémies. Et vacciner si nécessaire.

- Sensibiliser les mères sur la présentation de la carte vaccinale lors des consultations.

- Désigner chaque année une ou plusieurs journées de vaccination selon le taux de couverture vaccinale obtenue pendant lesquelles tous les vaccins sont disponibles et administrés en fonction des besoins de chaque enfant ; chaque dose est notée sur la carte de vaccination.

- Désigner une semaine de sensibilisation par année pour maintenir le taux de couverture de 80 %.

- Désigner des journées de vaccination au niveau national.

4 - 3 : AUGMENTATION DE L'ACCES AUX SERVICES DE VACCINATION

- Mettre en place un centre fixe de vaccination au chef lieu de région, du district, du Poste de Contrôle Administratif (PCA) pour les régions dont l'accessibilité géographique est satisfaisante au plus tard fin décembre 1987.

- Promouvoir la stratégie avancée des activités vaccinales à partir des centres fixes.

- Maintenir la stratégie mobile autant que cela sera nécessaire pour les régions inaccessibles aux stratégies avancées.

4 - 4 : EDUCATION POUR LA SANTE

- Sensibiliser les mères sur le calendrier de vaccination.

- Mener une causerie éducative pendant chaque séance de vaccination sur l'importance des vaccinations, les réactions possibles, etc ....

- Mener une séance éducative chaque mois sur la vaccination en mettant un accent particulier sur la rougeole, dans les centres de vaccination.

- Mener une campagne éducative contre la rougeole chaque six mois par les mass-média.

4 - 5 : COORDINATION AVEC D'AUTRES COMPOSANTES DES SOINS DE SANTE PRIMAIRES ET D'AUTRES PROJETS.

- Pour tirer tout le parti possible des ressources existantes et pour faciliter l'obtention des ressources supplémentaires, il est nécessaire d'intensifier la coordination entre le PEV et les autres éléments des soins de santé primaires, ainsi qu'avec les autres projets existants dans le pays. Tous les contacts avec les services de santé devraient fournir l'occasion de pratiquer des vaccinations, d'assurer d'autres services nécessaires et de transmettre sous forme aisément compréhensible des messages d'éducation pour la santé. Les messages d'éducation des projets de soins de santé primaires et les services maternelles/infantiles devraient suivre les directives du P.E.V.

- 6 : BON FONCTIONNEMENT DU MATERIEL DE CHAINE DE FROID

- Nommer un responsable de chaîne de froid à chaque niveau chargé de la surveillance et de l'entretien.

- Etablir à tous les niveaux une surveillance écrite et quotidienne de la température des frigidaires en consignant toute panne ou autres anomalies de fonctionnement.

- Etablir une fiche de contrôle de la chaîne de froid (avec l'index de température) qui doit accompagner chaque livraison de vaccins.

- Désigner et former un agent pour la réparation des réfrigérateurs.

4 - 7 : SURVEILLANCE

- Surveiller l'incidence des maladies et collecter les informations adéquates pour la gestion du programme.

Centres Fixes de Vaccination :

- Fournir mensuellement, trimestriellement et annuellement les rapports de surveillance épidémiologique et des activités vaccinales.

Centres Privés :

- Fournir mensuellement les rapports des activités vaccinales et de la surveillance épidémiologique au PEV.

4 - 8 : RESPONSABILITES AU NIVEAU NATIONAL, REGIONAL ET PERIPHERIQUE

* Au Niveau National :

- Planifier le programme national de vaccination.

- Collecter et analyser les informations relatives à l'évaluation.

- Prévoir une surveillance à tous les niveaux de manière à pouvoir identifier les faiblesses d'exécution et les corriger.

- Contrôler l'utilisation du vaccin et des fournitures consommables afin d'assurer la gestion et l'usage convenable avec des pertes réduites au minimum.

- Assurer l'utilisation et l'entretien correct de tout le matériel.

- Evaluer l'accomplissement des objectifs du programme.

- Obtenir un feed-back sur l'évaluation du programme.

- Superviser tout le personnel du PEV et toutes les sections du PEV dans le pays.

- Coordonner les opérations du PEV avec les autres activités et services du Ministère de la Santé.

- Promouvoir la formation et le recyclage des agents d'exécution.

* Au Niveau Régional :

- Planifier le programme régional de vaccination.

- La suite - Idem qu'au niveau national.

* Au Niveau Périphérique :

- Vacciner les enfants selon le calendrier établi.

- Utiliser les vaccins et les fournitures consommables convenablement avec des pertes réduites au minimum.

- Assurer l'entretien correct de tout le matériel.

- Informer et éduquer les populations sur le bien fondé de la vaccination, le calendrier de vaccination, les réactions à la suite d'une vacciantion.

- Collecter des données, faire des rapports et les adresser à la hiérarchie supérieure mensuellement.

4 - 9 : EVALUATION

L'évaluation est une composante essentielle du PEV, qui nous permet à la suite des résultats obtenus de reconnaître les points forts et faibles, afin d'éviter d'apporter s'il y a lieu les ajustements et les modifications nécessaires au bon déroulement du programme. Elle se fera sur la base des données objectives des rapports des postes sentinelles et des enquêtes sur la couverture vaccinale : bisannuellement au niveau national, annuellement à Pointe-Noire et à Brazzaville et dans les autres grandes agglomérations selon les besoins de la programmation.

4 - 10 : SYSTEME D'AUTOFINANCEMENT

Il sera prévu par la vente de carte de vaccination uniforme de SMI un système d'autofinancement dans les centres fixes en privilégiant particulièrement les centres ruraux pour subvenir aux besoins de fonctionnement du matériel de vaccination.

4 -11 : FORMATION

- Prévoir une formation intensive avant l'ouverture d'un centre fixe.

- Prévoir en moyenne un recyclage par an pour chaque vaccinateur.

4 - 12 : RETRO-INFORMATION

Mettre à jour un bulletin épidémiologique couvrant la surveillance épidémiologique, les activités vaccinales, les nouvelles informations sur les vaccinations et les maladies cibles.

4 - 13 : LA PARTICIPATION DES SERVICES :

Affaires Sociales

- Procéder à la sensibilisation des mères sur les activités vaccinales à domicile et dans les centres.

- Récupérer les enfants qui ont échappé à la vaccination.

- Sensibiliser les mères sur la présentation de la carte vaccinale lors des consultations médicales.

- Assurer les séances éducatives sur la vaccination au moins deux fois par mois.

Centres Privés

- Se conformer à la réglémentation en vigueur mise en place par

le PEV en ce qui concerne les activités vaccinales au niveau national.

Crèches et Jardins d'Enfants

- Rendre obligatoire la présentation de la carte vaccinale dans les crèches et les jardins d'enfants avant admission dans l'établissement.

A long terme, cette mesure devra être appliquée aux établissements scolaires, en tenant compte des modifications épidémiologiques.

Caisse Nationale de Prévoyance Sociale (CNPS)

- Rendre obligatoire la présentation annuelle de la carte de vaccination au même titre que le certificat médical de l'enfant avant la perception des allocations familiales pour les enfants. (Ne sont concernés que les enfants de 1 à 3 ans)

Ecoles de Formations

- Promouvoir la formation à la vaccination dans les écoles où sont instruits les personnels de santé, en fournissant des informations sur les schémas de vaccination, sur l'administration des vaccins et sur les besoins en matière de stockage et de transport de vaccins.

Ministère de la Santé et des Affaires Sociales

- Prendre des textes législatifs réglementant l'application des activités vaccinales dans les formations sanitaires, étatiques et privées.

Organisations Internationales

L'Organisation Mondiale de la Santé (OMS), l'UNICEF, le Projet de Lutte contre les Maladies Transmissibles de l'Enfance (LMTE), le FAC et autres projets doivent promouvoir activement au developpement du PEV au Congo en accordant un appui technique et financier plus important.

A N N E X # 11

Politique d'action du programme National de lutte contre les maladies diarrhéiques

Introduction

maladies diarrhéiques, problème majeur de santé publique dans pays en développement, sont une des principales causes de mortalité des ns enfants. La deshydratation facteur principal de gravité et de mor-té est la conséquence de la perte d'eau et d'électrolyte par les selles. En publique populaire du Congo les maladies diarrhéiques occupent la première ce grave à leur taux de mortalité et la seconde place après le paludisme en ce qui est de la morbidité. Conscient de ce fléau, le gouvernement Congolais is en place en 1980, un programme national de lutte contre les maladies diar-que suite aux recommandations de l'organisation mondiale de la santé issues des nées de réflexions sur les ~~problèmes~~ Problèmes ~~points~~ de la santé tenu à Brazzaville la même é.

ns ce présent document nous définissons la politique Nationale du dit programme.

But du Programme

Obtenir une reduction du taux de mortalité dûe aux maladies rrhéiques chez les enfants de moins de 5 ans.

Objectif specifique

Réduire de 50% le taux de mortalité causé par les maladies rrhéiques chez les enfants de moins de 5 ans de 1984 à 1988.

Objectif secondaire

Etendre l'accès au traitement de la diarrhée par les sels de réhydratation par voie orale de manière à toucher 80% de la population ble de 1984 - 1988.

Stratégies

rincipales stratégies retenues par le programme sont les suivantes :

Former les agents de Santé en matière de TRO

Traiter tous les cas de diarrhée par la méthode de réhydratation orale.

Assurer la surveillance epidemiologique des maladies diarrhéiques

Assurer l'education pour la Santé au village

Former les agents de santé en matière de TRO.

Ecoles de formations du personnel de Santé (INSSSA, JJ, ... etc) doivent introduire dans les programmes d'enseignement les notions de la TRO.

Seminaires, Conferences de formation et de ~~Sensibilisation~~ sensibilisation sont organisés au niveau de :

- Hopitaux.
- Centres médicaux
- SMI
- Dispensaires.
- Villages centres pour assurer la formation des agents de santé Communautaire.

Traiter tous les cas de diarrhée par (ORS) recourir au K.O.

- Evaluation et traitement des diarrhées chez les enfants

suivant le degré de déshydratation (présence ou absence des signes suivants sec
cheresse de la bouche, langue, lèvres, plis cutanés, enfoncement des yeux, fon
lle déprimée, etc...) les enfants diarrhéiques sont classés en 3 catégories.

.) La première catégorie regroupe les enfants du plan A n'ayant pas de signes d
shydratations apparents : la perte de poids varie entre 0 et 2,5 %

b) La deuxième catégorie regroupe les enfants du plan B qui présentant a
ins deux signes de déshydratation modérée : la perte de poids à ce stade vari
re 2,5 et 10 %

c) La troisième catégorie regroupe les enfants du plan C qui présentent au
oins deux ou signes de déshydratation sévère. La perte de poids à ce stade est
supérieure à 10 %.

) Centres de traitement des enfants diarrhéiques sont choisis en fonction d
gré de déshydratation.

1) Les Hopitaux et centres hospitaliers. Les hospitaux et centres hospital
gorent les enfants du plan C pour corriger la déshydratation sévère a
oyen de

- Perfusions intraveineuses ou Sonde nasogastrique pour les enfants i
nscients.
- Perfusions IV + SRO pour des enfants conscients capables de boire

La pesée

firmier ne doit pas oublier de peser le malade au début et à la fin du
tement et enregistrer ses poids sur la fiche. La différence entre ces deux
donnera le gain net de liquide administré. L'enfant ne pourra
à la maison qu'il a gagné le poids prévu.

Durée du traitement

irmier ~~devra donner~~ doit noter l'heure du début et de la fin du trai
nt. Ces deux éléments permettront de calculer le nombre d'heures néces-
pour le traitement.

Etat à la sortie :

firmier devra donner une appréciation sur le malade selon les éventua
suivantes :

1| Réhydraté et renvoyé à la maison
2| Transféré à l'hopital
3| Renvoyé à la maison pour le traitement
4| décédé.

Autres médicaments nécessaires au Traitement de la diarrhée

1. Les anti microbiens (y compris les antibiotiques).

Les médicaments antimicrobiens ne sont pas indiqués pour le traitement de routine des diarrhées aiguës. Parmi leurs indications spécifiques figurent :

- Le Choléra
- la dysenterie grave à Shigella
- la dysenterie amibienne
- la Giardiase aiguë

Les médicaments de choix pour le traitement de ~~la dia~~ ces maladies figurent dans le tableau ci après. (voir tableau 7.

La Chimiothérapie spécifique peut également être nécessaire lorsque la diarrhée aiguë est associée à une ~~une~~ autre infection aiguë (pneumonie, otite moyenne etc...)

2 Les Antidiarrhéiques.

Quoique souvent employés, les antidiarrhéiques ne sont pas indiqués pour le traitement de routine des maladies diarrhéiques aiguës.

- Les adsorbants : leur valeur pour le traitement des diarrhées n'a pas été démontrée
- Les inhibiteurs de la motricité intestinale procurent un soulagement passager de la douleur et ont pour certains des propriétés antisécrétoires. Mais ils peuvent ralentir considérablement le péristaltisme intestinal et retarder l'élimination des germes responsables. Mal utilisés chez les enfants ~~de~~ en bas âge, ils peuvent ~~id~~ être dangereux.
- Les Stimulants (adrénaline) ne sont pas indiqués dans le traitement de la maladie diarrhéique. L'état de choc est généralement dû à la déshydratation et à l'hypovolémie et doit être traité rapidement au moyen des liquides intraveineux appropriés
- Les Stéroïdes ne sont pas aussi indiqués, ils peuvent provoquer les effets secondaires graves.

Antimicrobiens utilisés pour le traitement des causes spécifiques des diarrhées aiguës

Cause	Médicaments de choix [a]	Substituts
Choléra [b] [c]	Tétracycline enfts 50 mg/Kg/J en 4 jours Pdt 2 ou 3 jours adultes 500 mg 4 fois/J Pdt 2 ou 3 jours	Furazolidone (Furoxane) enfts 5 mg/Kg/J en 4 doses Pdt 3 jours. Adultes 100 mg 4 fois/J en 3 J Erythromycine : 30 mg/Kg/J en 3 doses Pdt 3 J.
Dysenterie à Shigella	Ampicilline 100 mg/Kg/J en 4 doses pdt 5 jours Trimethropine-sulfamethoxazole 10 mg/Kg/J et 50 mg/Kg/J en 2 doses pdt 5 J.	Acide nalidixique (Negram®) 55 mg/Kg/J en 4 doses pdt 5 jours
Dysenterie amibienne	Métronidazole enfts 30 mg/Kg/J Pdt 5 à 10 J.	Ds les cas très graves. Chlorhydrate de déhydroémétine en IM profonde 1, à 1,5 mg/Kg/J pdt 1 à 5 J selon la réponse (1er âge)
Giardiase aiguë.	Métronidazole enfts 15 mg/Kg/J Pdt 5 J	Quinacrine enfts : 7 mg/Kg/J en dose fractionnée pdt 5 J.

a : Sauf instruction contraire, toutes les doses indiquées sont administrées par voie buccale.

b : l'administration d'antibiotiques n'est pas indispensable à la réussite du TTT mais elle abrège la durée de la maladie et l'excrétion des micro organismes dans les cas graves.

c : L'administration d'antibiotiques est particulièrement nécessaire chez les enfants au bas âge présentant une température élevée persistante.

La surveillance épidémiologique (9)

Elle se basera sur.

1. L'implantation dans les formations sanitaires existantes disposant, sentinelles qui ont pour le rôle.
   - d'Assurer le Traitement des malades.
   - Fournir au programme des données statistiques sur:
     - la morbidité.
     - la mortalité.
     - le nombre de cas traités.

En se basant sur une fiche de surveillance épidémiologique Pré établie.

2. la régularité des données statistiques

3. L'Analyse des données recueillies pour suivre l'evolution des maladies diarrhéiques dans le temps et dans l'espace.

Education pour la Santé.

(10)

L'Education pour la Santé, qui consiste à exercer une action sur les individus pour les amener à modifier leur comportement, jouera un rôle primordiale dans la lutte contre les maladies diarrhéiques. Elle permettra :

- La Conscientisation, la sensibilisation, la motivation, l'action des Collectivités sur les points suivants.

1. Les mesures preventives :

- Hygiene alimentaire bien conduite.
- Hygiene Corporelle.
- Consommation de l'eau potable.
- Salubrité de l'environnement.
- l'Allaitement au sein.

2. Mesures Curatives.

2.1. A Domicile :

- Usage de la Solution Salée Sucrée suivant la recette recommandée.
- Allaitement au Sein
- Poursuite de l'alimentation en Cas de diarrhée.

2.2 Au Centre de Santé :

- Preparation et administration de la SRO.
- Connaissance des signes de deshydratation.

3. Moyens de Communication.

- La Radio.
- La Télévision.
- Les Affiches
- Les discussions de groupe, individuelles.

Supervision

1°) Points à superviser.

a) Organisation logistique

- Salle de la TRO
- Materiel de la TRO (gobelets, cuillerées à café, registre, récipients, balance, eau potable, SRO, ... etc)

b) Activités des agents de santé.

- Evaluation de l'état de déshydratation.
- Prescription de la quantité de SRÔ
- Preparation de la SRÔ
- Administration du traitement.
- Conseils aux mères sur le traitement à domicile.
- Enregistrement du traitement sur le registre.
- Utilisation de fiches de statistique et de stock.
- Durée de la réhydratation.

c) Compréhension.

- Les mères comprennent les causes de la déshydratation.
- Les mères comprennent les signes et symptômes de la déshydratation.
- Les mères comprennent la prevention de la déshydratation à domicile
- Les mères comprennent Comment préparer et administrer la SRÔ
- Les mères comprennent l'alimentation pendant et après une episode diarrhéique.

2) Méthodologie de la supervision :

Elle est fonction des points à superviser, les principales à supervisser sont.

* Observation des agents de santé.
* Parler avec les agents de santé.
* Revoir le registre.
* Parler avec les mères au moment du traitement.

3) Fréquence de supervision :

La fréquence de supervision se fera d'une façon régulière au moins deux fois par semaine voir plus pour les centres en début d'activités.

Principales activités :

1. Standardiser la TRO au niveau national.
2. Planifier les activités de supervision au niveau des centres de TRO.
3. Déterminer les quantités de SRO à distribuer dans les centres de Traitement.
4. Assurer l'Éducation pour la santé aux mères.
5. Coordonner les activités avec les organisations internationales et autres organismes
6. Collecter et analyser les données statistiques
7. Assurer la retro information aux agents des centres de TRO.
8. Evaluer les activités du programme.

Recherche opérationnelle.

Elle doit être basée sur la recherche appliquée :

- Détermination des méthodes les mieux adaptées et les plus efficaces pour promouvoir l'application de la TRO au niveau des ménages et des formations sanitaires, problème qui demeure l'un des plus importants et des plus urgents que doit résoudre la recherche sur le système des soins de santé.

- Enquête CAP sur les maladies diarrhéiques au niveau des collectivités urbaines et rurales

VIII Evaluation (13)

2 types d'evaluations

I) Evaluation des prestations de soins = Evaluation de couverture.

Principaux indicateurs

A. Disponibilité des soins de TRO = Couverture potentielle.

1. Nombre de centres de TRO par region par rapport aux nombres de formations sanitaires
2. Pourcentage de la population ayant accès à la TRO.
3. Nbre d'habitants par unité de TRO.

B. Utilisation effective des services de TRO = Couverture réelle.

1. Taux de consultations par diarrhée (rapport consultation / diarrhée / population < à l'année de service).
2. Nombre d'enfants traités par la TRO.
3. Rapport entre le nombre d'enfant traités par la TRO et l'ensemble des consultations par diarrhée.

II) Evaluation de niveau de santé = Evaluation d'impact

Principaux indicateurs

- Taux de mortalité des enfants de 0 - 5 ans toutes causes réunies.
- Taux de mortalité dû ou associé aux maladies diarrhéiques dans la même tranche d'âge.
- Taux de morbidité dû aux maladies diarrhéiques chez les enfants de moins de 5 ans.

:

A N N E X # 12

ESQUISSE D'UNE POLITIQUE NATIONALE DE LUTTE CONTRE LE PALUDISME EN REPUBLIQUE POPULAIRE DU CONGO.

Direction de la Médecine Préventive

1986

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DDUCTION:

Le paludisme est l'une des cinq causes principales de mortalité
lé, dans de nombreux pays, particulièrement dans notre pays, où il constitue
blème de santé publique.

Si l'on se fonde sur le nombre total des cas, on peut dire que le palu-
demeure encore une endemie dans notre pays, évoluant suivant un mode méso
pu selon les zones géographiques et les saisons.

Le taux de mortalité annuel dû au paludisme est de l'ordre de 0,43‰
0 et 4 ans et de 0,68‰ entre 5 et 9 ans.

Depuis le Congrès Constitutif du Parti Congolais du Travail (P.C.T) de
mbre 1969 jusqu'au 3ème Congrès ordinaire du P.C.T, la priorité sanitaire du
et du gouvernement Congolais est accordée à la lutte contre les maladies trans-
bles.

La recrudescence quasi-générale des maladies endémo-épidémiques en 1975.
situation inquiétante en 1979 ont été dues au relâchement de la surveillance
miologique. Ces situations ont amené l'instance politico-administrative de notre
à décider la création des programmes et projets spécifiques de lutte contre
demies.

te décision se trouve être conforme aux recommandations du Comité
al de l'Organisation Mondiale de la Santé (O.M.S), adoptées lors de sa
inquième session de septembre 1985, dans sa résolution AFR/RC 35/R5 sur
antipaludique. Elles stipulent entre autre.

e seule action antipaludique pratiquable en ce moment est la mise en place
ellations et des services pour réduire la mortalité et la morbidité imputables
ludisme.

'approche nationale pour atteindre cet objectif ancré de la santé pour tous

santé primaires.

L'apparition et la propagation du paludisme pharmaco-résistant esente un danger sérieux de santé-publique dans la region ... Nécessité la mise en œuvre des programmes nationaux antipaludiques, pour l'eva-on des schémas thérapeutiques standards, de la sensibilité des parasites paludisme aux antipaludiques.

Par ailleurs, des quatres variantes pour mener la lutte contre le palu-me, definies par le Comité d'experts sur le paludisme ; le programme nal de lutte contre le paludisme a adopté la variante N°1 et une partie 1°2 :

Variante N°1 Réduction et prévention de la mortalité par le traitement haque cas de paludisme par un médicament efficace.

Variante N°2. Réduction et prévention de la mortalité et de la morbidité préconisant la chimiothérapie et la chimioprophylaxie dans les groupes aut risque.

I/ PROGRAMME ANTIPALUDIQUE AU CONGO.

.1 BUT

Obtenir une réduction de la morbidité et la mortalité causées 1 le paludisme chez les enfants de moins de ~~5 ans~~ cinq ans et les femmes enceintes

2 OBJECTIF.

Reduire de 50% le taux de mortalité dû au paludisme au sein la population cible d'ici 1990.

3 Population Cible.

- Enfants de moins de cinq ans (chimiothérapie)
- Femmes enceintes (chimioprophylaxie)

1.4. STRATEGIES DE LUTTE

Pour atteindre cet objectif et, dans le cadre des soins de santé primaires ; les stratégies suivantes ont été retenues :

1. Intégration des activités du Programme dans les systèmes de soins existants : - Formations sanitaires (Hopitaux, Centre de santé maternelle et infantile, dispensaires ...) - Les secteurs Opérationnels des Grandes Endémies - Les projets de développements Communautaires (MINDOULI et LEKANA) - Les zones pilotes de santé d'Owando et de KINKALA) - Les services régionaux de soins de santé primaires - Les services connexes (Hygiène et assainissement, Municipalité, Agriculture, Hépatologie ...) - Les différents services de recherche (ORSTOM INSSSA, Laboratoire National de Santé Publique ; Direction Générale de la Recherche Scientifique et Technique.).

2 - Le traitement préemptif des cas de fièvre chez les enfants de moins de 5 ans avec un médicament efficace et disponible

3 - La chimioprophylaxie des femmes enceintes

4 - L'éducation pour la santé de la population

1.5 ~~ACTIVITES~~ RESPONSABILITES.

Les activités du programme se situent à 3 niveaux.

1.5.1 Au niveau Central

- Etablir la politique nationale de lutte contre le paludisme
- Coordonner les activités de lutte contre le paludisme
- Faire la surveillance de la resistance du Plasmodium Falciparum aux antipaludiques
- Etablir des schémas thérapeutiques standards sur le paludisme dans notre pays
- Etablir des plans d'éducation pour la santé
- Faire la surveillance épidémiologique du paludisme au plan national (Collecte et analyse des données statistiques sur le paludisme.).
- Promouvoir la recherche opérationnelle sur des thèmes appropriés sur le paludisme.
- Participer aux recherches sur l'espèce vectorielle dominante [illegible]

- Assurer l'utilisation correcte et appropriée des antipaludiques et l'évaluation des activités antipaludiques au plan national.
- Gerer et entretenir le materiel et les médicaments mis à la disposition du programme
- Former ou recycler le personnel de santé national (par rapport aux activités du Programme.)
- Etendre progressivement les activités dans les differentes régions sanitaires du pays.
- Doter les services régionaux des Grandes Endemies en médicaments antipaludiques (Chloroquine).
- Rendre compte aux autorités superieurs du Ministère de la Santé et des Affaires Sociales.
- Créer à long terme un réseau de postes sentinelles dans le pays pour la surveillance de la chimioresistance aux antipaludiques.
- Créer et superviser les activités du laboratoire national de reference sur la Chimioresistance aux antipaludiques.

1.5.2 <u>Au niveau intermediaire ou regional</u>

Les activités du Programme à ce niveau sont organisées par les Secteurs Opérationnels des Grandes Endemies.

- Nomer un responsable des activités de lutte antipaludique
- Promouvoir la politique nationale de lutte contre le paludisme au niveau régional.
- Assurer la surveillance épidémiologique du paludisme (collecte et analyse des données statistiques)
- Faire la surveillance clinique du paludisme pharmacorésistant.
- Collaborer avec les services régionales pour l'E.P.S;
- Etendre les activités du programme dans toute la région
- Doter les Centres de S.M.I et dispensaires régionaux en médicament antipaludiques (Chloroquine)
- Gerer le materiel et médicament du Programme
- Former et recycler le personnel de santé régional.
- Superviser et évaluer les activités du Programme dans la régin
- Faire des rapports mensuels aux autorités sanitaires du niveau Central

RESPONSABILITES (4) (suite)

1.5.4 . ~~ACTIVITES~~ DES SERVICES CONNEXES

La lutte contre le paludisme implique au niveau national, les efforts des autres services ayant un impact direct ou indirect sur l'hôte (l'homme) et le vecteur (moustique). Ainsi dans le cadre des soins de santé primaires sont également intéressés dans cette lutte.

- Le Programme National des S.S.P.: pour l'organisation des services antipaludiques dans les Comités de santé et les Collectivités.
- Les services d'Hygiène et Assainissement de la Municipalité. Pour la santé de lutte antilarvaire, les problèmes d'assainissements
- Les services d'information, les organes de presse: pour la diffusion de l'information sanitaire sur le paludisme
- Les services des programmes éducatifs, scolaires, universitaires et d'alphabétisation: Pour les programmes d'éducation et de formation sur le paludisme
- Les Officines pharmaceutiques: Pour une meilleure distribution des médicaments à travers le pays.

1.5.3 Au niveau périphérique (4)

Les actuités à ce niveau sont assurées par le responsable du Centre de santé, de la formation sanitaire ou par l'agent de santé communautaire au niveau du village. Elles se resument essentiellement à :

- Assurer le traitement présomptif des cas de paludisme confirmé ou de toute fièvre
- Evacuer des cas de paludisme grave dans un centre plus adapté
- Assurer la chimioprophylaxie des femmes enceintes
- Notifier les cas de paludisme ou de fièvre traités
- Notifier le nombre de femmes enceintes sous chimioprophylaxie
- Assurer les actuités d'éducation pour la santé
- Recycler les agents de santé communautaire
- Faire la surveillance clinique du paludisme pharmacorésistant
- Faire des rapports mensuels aux autorités sanitaires régionales

→ (suite page 4)

1.6 RESSOURCES

La mise en place d'un plan national, fait appel à des ressources variables selon l'importance du problème à ressoudre. La réalisation de ce plan tient compte des ressources nationales disponibles

1.6.1 HUMAINES

Il s'agit du personnel de santé évoluant aussi bien dans les centres de santé existant que dans l'administration centrale.

1.6.2 Materielles.

C'est le materiel de l'état existant dans les centres de santé et à tous les niveaux d'exécution du plan (vehicules, tomes, microscopes, bureaux, hopitaux, materiels éducatifs . . .).

1.6.3 Financières

Budget régulier de l'état alloué aux services

Toutes ces ressources peuvent etre renforcées par des subventions des organismes non gouvernementaux dans le cadre de la lutte contre le paludisme dans notre pays.

II PRATIQUE ACTUELLE DE LA LUTTE ANTIPALUDIQUE EN R.P.C.

~~La lutte antipaludique est toujours menée dans notre pays, à tous les niveaux du système de soins, aussi bien par la population~~

elle même (désherbage, usage de moustiquaires ...) que par les pouvoirs publics (installations des services de santé, lutte anti-acide, Campagne d'éducation pour la santé ...)

L'incoordination de toutes ces actions sur le plan national maintient cette maladie à un niveau méso et hyperendémique selon les zones géographiques et selon les ~~climats~~ saisons.

A. TRAITEMENT

Accès palustre simple et paludisme d'invasion.

deux éventualités
- ou le malade a des troubles digestifs ou de signes de gravité
- ou il n'en présente pas

Le malade ne présente pas de troubles digestifs ni de signes de gravité.

Chez l'enfant:

Tout accès fébrile chez l'enfant, doit faire penser d'abord au paludisme et être traité comme tel en faisant un traitement préemptif à la chloroquine.

- Faire une goutte épaisse, mais ne pas attendre les résultats pour commencer le traitement
- Protocole de traitement. 25 mg/kg répartis en 3 jours consécutifs (cf. annexe: N° 3)
  - 1er jour. Le traitement doit être administré sur place à la S.M.I. sous la supervision de l'agent de santé.
  - 2ème et 3ème jour. Le traitement sera continué à domicile par la maman à qui, il sera remis de la chloroquine (reste du traitement à prendre.)

Chez la femme enceinte malade.

- Faire une goutte épaisse si possible.
- Vérifier si la femme est sous chimioprophylaxie avec quel médicament et quelle dose.
- Si elle n'est pas sous chimioprophylaxie ou elle est irrégulière traiter à la chloroquine.

  dose: 1500 mg soit 15 comprimés de chloroquine à 100 mg répartis en 3 jours consécutifs

soit 1er jour : 600 mg ou 6 comprimés de chloroquine à 100 mg
2ème jour : 600 mg ou 6 comprimés de chloroquine à 100 mg
3ème jour : 300 mg ou 3 comprimés de chloroquine à 100 mg.

Le malade présente des troubles digestifs, ou des signes de gravité (accès pernicieux palustre).

Il s'agit habituellement du Plasmodium Falciparum.

Le malade peut présenter :

- Une température corporelle de 39° ou 40°C.
- Une altération de l'état général
- des vomissements, une diarrhée
- Une anémie ; des œdèmes
- Une splénomégalie -- perte de
- des convulsions -- une myocardiaque

Le traitement doit être précoce. L'administration des médicaments par la voie IM ou IV est indispensable.

Le traitement doit associer une thérapeutique spécifique (avec la chloroquine)

- Une thérapeutique symptomatique
  - Réhydratation hydro - électrolytique
  - transfusion de sang.
  - traiter la malnutrition protéinocalorique
  - traiter les anémies
  - traiter les parasitoses associées
- Un traitement pour les éléments de la pernicioste
  - Corticothérapie
  - sédatif
  - Oxygénothérapie
- Un traitement pour maintenir les grandes fonctions de l'organisme ; essentiellement une surveillance du fonctionnement des appareils cardio-vasculaire, respiratoire et rénal.

Ce traitement doit être fait dans un service adapté - la pédiatrie pour les enfants - Le rôle de la SMI ne se limitant plus qu'au traitement symptomatique et à une évacuation à la pédiatrie.

A la pédiatrie : il faut si possible faire une G.E pour confirmation mais ne pas attendre les résultats avant d'instaurer le traitement.

Si la GE est négative. Il faut rechercher une autre cause.

Dès que l'enfant reprend conscience on est même d'avater reprendre la voie per os (Chloroquine ou Amodiaquine) en tenant compte du médicament disponible et déjà administré

(Schéma thérapeutique sur la Chloroquine voir annexe N° 3)

Chez la femme enceinte :

- Les critères de gravité sont les mêmes
- Le traitement est le même avec des doses convenables
- Une orale dès que le malade est sorti du coma.

B/ RESISTANCE A LA CHLOROQUINE

- Si l'enfant est toujours fiévreux après 3 jours de traitement à la Chloroquine.

. Vérifier si le traitement a été suivi à domicile par des petites questions

. Demander si l'enfant a eu des vomissements ou de diarrhée

. Refaire la G.E si possible.

Si la GE est négative : Rechercher une autre cause.

Si la G.E est positive : Changer de médicament. Si l'enfant peut boire, donner 25mg/kg d'amodiaquine

Remarque : Il faut éviter de recourir spontanément à la voie parentérale à cause de nombreux risques qu'elle comporte : - atteinte du nerf sciatique entraînant des paralysies
- abcès médicamenteux. et et.

Chez la femme enceinte suivre le même protocole

C./ CHIMIOPROPHYLAXIE

1/ Enfant de 0 à 5 ans.

La chimioprophylaxie est à déconseiller ~~pour~~ entre autres raisons ~~pour~~ :

- Le phénomène de chimio résistance qu'elle engendre : Du fait d'une part de la pression médicamenteuse qu'elle constitue et d'autre part des infra-doses auxquelles elle est toujours suivie ; ce qui

provoque chez les parasites du paludisme, devenant insensibles au médicament utilisé, une certaine accoutumance vis à vis du produit

- La destruction de l'immunité naturelle ~~acq~~, acquise par des contacts répétés moustique - homme, au profit de l'immunité passive acquise partiellement protectrice et non stérilisante. Source d'agression des signes cliniques du paludisme si chimioprophylaxie mal suivie
- Le coût élevé de cette pratique à long terme

- Femme enceinte.

C'est un groupe vulnérable, compte tenu des conséquences graves du paludisme tant sur le fœtus que sur la femme elle-même entre autres :

- Poids insuffisant de l'enfant à la naissance
- Prématurité,
- mort in utero

Elle se fait avec la chloroquine à raison de 300 mg de chloroquine à 100mg le comprimé soit 3 comprimés de chloroquine par semaine.

D./ PREVENTION

1/- Protection intradomiciliaire

- usage de moustiquaire.
- grillage fin aux fenêtres
- recouvrir les ustensiles contenant de l'eau
- utilisation des insecticides

2/- Mesures d'assainissement simples.

- supprimer tous les récipients susceptibles de contenir un peu d'eau.
- Boucher les trous où les flaques peuvent se former
- enterrer les vieilles boîtes à conserves et les vieux pneus
- Verser du mazout ou du pétrole sur les mares pour empêcher les larves de moustiques de respirer
- Drainer les marais ou canivaux pour les assécher.
- Couper les herbes autour de la parcelle.

3/- mesures Collectives : Consistent en des grands travaux d'assainissement dans le quartier.

Remarques : Vu les contraintes que la lutte antivectorielle implique (Coût très élevé, recherche entomologique, ~~sensibilité~~ étude sur la sensibilité du vecteur au produit ...) Cette stratégie est difficilement applicable dans notre pays. et compte tenu aussi des nombreux cas d'insuccès observés dans plusieurs pays.

Cette disposition est favorable à la politique de l'OMS dans le cadre de la lutte antipaludique. Elle ne pourrait être envisagée qu'en cas d'epidemie, mais cela necessiterait l'assistance des techniciens spécialisés dans cette lutte et un matériel ~~adq~~ adéquat.

E/ SURVEILLANCE.

1/ RESULTATS DE LA CHLOROQUINO-RESISTANCE

La première enquête sur la chimiosensibilité des souches congolaises du Plasmodium Falciparum à la chloroquine, notées dans notre pays, a montré une baisse de sensibilité de ce plasmodium à la chloroquine. Elle est beaucoup marquée dans la zone Sud peuplée que dans la zone Nord moins peuplée.

Sur 120 enfants traités à 10mg/kg, 64,80% ont encore présentés des parasites au 8ème jour (J_7).

Sur 118 enfants traités à 25mg/kg, 28,1% ont été porteurs de parasites au 8ème jour (J_7).

Néanmoins, du fait de sa disponibilité, son administration facile, son prix bas, la chloroquine demeure le médicament de première intention pour le traitement du paludisme dans notre pays.

Le protocole de traitement adopté au plan national est de ~~25~~ 25 mg/kg de poids corporel répartis en 3 jours consécutifs soit :

1er jour : 10mg/kg.
2ème jour : 10 mg/kg.
3ème jour : 5 mg/kg.

Toutefois ce protocole est susceptible de modifications en fonction de l'évaluation de chimiorésistance à la chloroquine.

2/ CONDUITE A TENIR DEVANT L'APPARITION DE LA CHIMIORESISTANCE.

Il s'agit de surveiller : - - 10 (suite)

2.1. L'INCIDENCE du Paludisme par une notification des cas de paludisme traités dans la population cible, mensuellement, ~~ann~~ trimestriellement et annuellement.

2.2. LA Resistance : Le suivi se fera à deux niveaux.

. Au niveau de la formation sanitaire : par le nombre de cas retraités.

. Au niveau Central : par des enquêtes "IN VIVO" simplifiées

Au niveau de formation sanitaire :

La Chimiorésistance sera définie, au niveau périphérique par :

- Une suspicion Clinique

. Persistance de la fièvre 48h après un traitement correctement suivi

. Accès palustre dûment confirmé par le laboratoire chez un patient déclarant suivre une chimioprophylaxie correcte par un antipaludique

- Une suspicion biologique :

. Presence de Plasmodium Falciparum à la goutte épaisse après un traitement normal.

CAT : Signaler le cas chez le Medecin ou le Chef du Centre pour d'autres investigations. Il est chargé, en dernier ressort, d'informer la Direction de la Medecine Preventive (Programme-Paludisme) sur l'ampleur du phénomène dans sa circonscription

Au niveau Central.

Analyser les informations provenant des régions en vue de déterminer l'ampleur du problème et choisir les priorités

- Réaliser sur le terrain, par rapport aux priorités, des enquêtes "in vivo" simplifiées

Former le personnel local aux techniques d'enquête de sensibilité du Plasmodium Falciparum aux antipaludiques.

- Installer un système de surveillance du phénomène de la chimiorésistance des plasmodiums aux antipaludiques au niveau régional.

F/ FORMATION POUR LA SANTE

1/ FORMATION DU PERSONNEL DE SANTÉ

Cette formation qui se veut permanente se fera à travers :

- des cours de recyclage ou de formation
- des séminaires et des stéiers nationaux ou régionaux
- des publications dans les revues médicales et d'information pratiques
- des émissions appropriées à la radio ou à la télévision

Le contenu de ces moyens de formation et d'information varierà en fonction du personnel à former ; comprendra essentiellement les volets suivants :

- Schéma thérapeutique national
- Traitement présomptif de la fièvre ou du paludisme.
- Chimioprophylaxie des femmes enceintes contre le paludisme
- Chimiorésistance et conduite à tenir devant l'apparition du phénomène
- Collecte et utilisation des données statistiques
- Assainissement du milieu
- Education pour la santé de la population.

G/ EDUCATION POUR LA SANTE

EDUCATION POUR LA SANTÉ DE LA POPULATION

Quelques thèmes d'éducation seront abordés tels.

- Mesures simples d'assainissement du milieu.
- Traitement présomptif du paludisme à la dose convenable.
- Mesures simples de protection contre les moustiques.
- Chimioprophylaxie des femmes enceintes.

1/ Moyens de communication.

Tous les moyens capables de véhiculer l'information à la population seront utilisés

- Radio, télévision (Emissions spécialisées)
- journaux locaux (articles ou dossiers sur le paludisme)
- causeries débats. (dans les centres de SMI, les établissements scolaires, les organisations de masse, les organisations religieuses

Toutefois une importante ~~sera~~ accordée aux moyens susceptibles de donner une retro-information pour une évaluation ultérieure

H. RECHERCHE OPERATIONNELLE

Considérant nos insuffisances tant de connaissances que de compréhension en ce qui concerne la dynamique qualitative de la transmission ~~du~~ et de l'épidémiologie du paludisme au Congo l'impact des mesures de lutte antipaludique.... Quelques thèmes de recherche peuvent être étudiés afin d'identifier les inconnues et permettre l'amélioration des services ; Notamment :

- Etablir un système simple de surveillance de la chimio-résistance du Plasmodium Falciparum aux antipaludiques.
- Etablir un système simple pour le suivi de la Chimioprophylaxie des femmes enceintes.
- Etude sur la chimiosensibilité du Plasmodium Falciparum aux autres antipaludiques
- Déterminer la date d'apparition et la cinétique des anticorps antipalustres au sein de la population congolaise pour définir la tranche d'âge ne présentant pas une prémunition, donc justiciable d'une chimioprophylaxie.
- Déterminer l'influence de la chimioprophylaxie sur l'apparition de la prémunition

I. AUTO FINANCEMENT

Il sera prévu, un système d'auto-financement, dans les centres où se mènent les activités du Programme Paludisme en privilégiant les centres ruraux pour subvenir aux besoins, en chloroquine des centres. L'apport du programme ne venant qu'en supplément.

1./ Gestion : La gestion est assurée au niveau central par la Direction de la Médecine Préventive (Programme Paludisme). Au niveau régional, par les acteurs opérationnels des Grandes Endémies.

J/ I / L'EVALUATION.

Pour être sûr qu'un plan d'action national, qui aura coûté beaucoup d'efforts, atteint bien ses objectifs, il faut l'évaluer. L'évaluation aura, dans le cadre de la politique, pour objet, d'améliorer les stratégies, les activités, et l'infrastructure sanitaire utilisée ; de guider la répartition convenable des ressources au cours de l'exécution.

Tous les individus et groupes responsables de l'élaboration, de l'exécution de cette politique aux divers niveaux du système sanitaire assumeront également la responsabilité de son évaluation.

Au niveau central elle sera le meilleur moyen de contrôle des résultats du plan d'action et, de pouvoir décider.

Au niveau régional ou périphérique, elle sera nécessaire pour que le personnel de santé puisse apprécier les résultats de leur travail par le biais de la retro-information. Elle sera aussi un facteur d'encouragement et de motivation ; aussi, participeront-ils à l'évaluation.

Une observation directe pendant et après l'exécution du plan complétera les informations, base de l'évaluation, pour pouvoir comparer les résultats obtenu avec les résultats attendu en rapport avec les objectifs fixés.

Les remarques et suggestions des exécutants et bénéficiaires, seront recueillis par des questions pertinentes sur les différentes étapes du plan d'action, à défaut d'indicateurs chiffrés ; questions telles que :

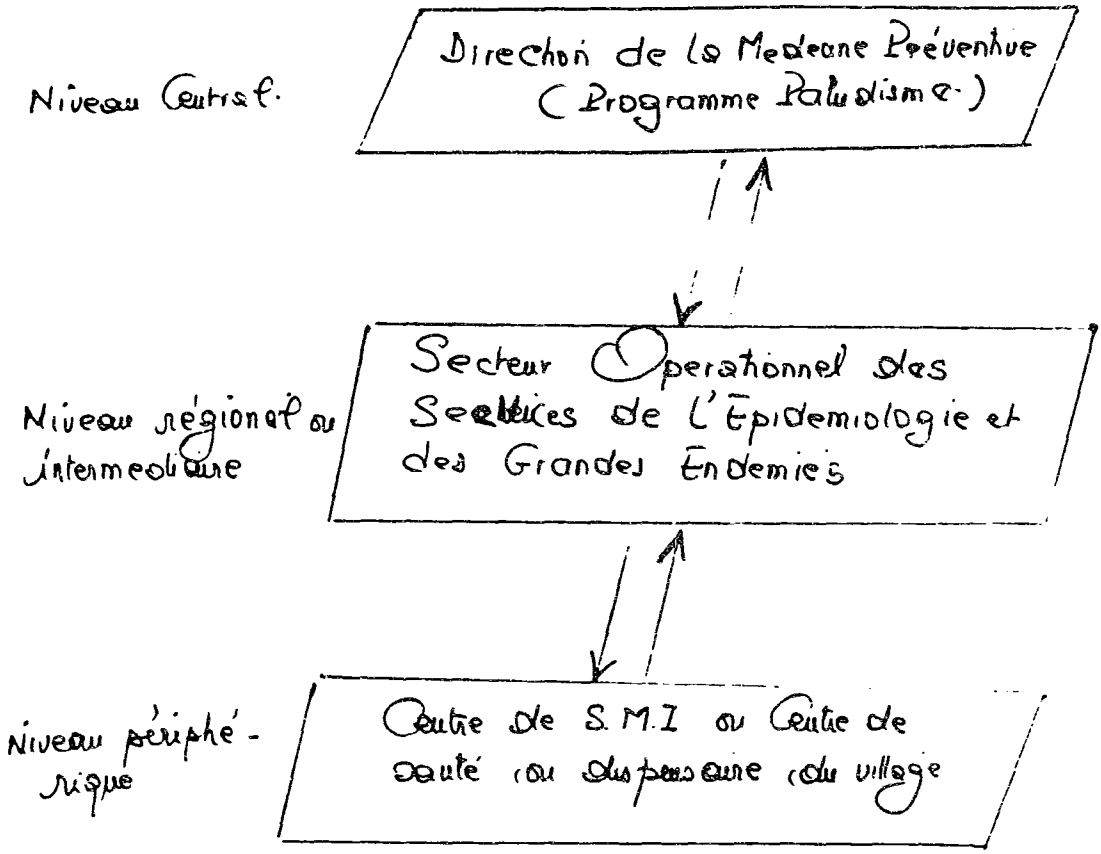
- Quelles sont les points faibles du plan ?
- Quelles difficultés rencontrées dans sa mise en exécution ?
- Quelles corrections ou modifications seront nécessaires ?
- Quelles additions ou suppressions seront nécessaires ?

Ces informations analysées permettront de décider d'un ressyntement ou d'une poursuite normale des activités programmées, des stratégies retenue et des objectifs fixés.

ANNEXES

ANNEXE N° 1

SCHEMA DE FONCTIONNEMENT DU PROGRAMME PALUDISME



ANNEXE N°2

VARIETE ET PRIX DES ANTIPALUDIQUES EN VENTE DANS LES PHARMACIES A BRAZZAVILLE

Varietés	Presentation	Prix en F. CFA.
Chloroquine *	20 Comp à 100mg 100 Comp à 100mg 1000 Comp à 100mg.	250 910 5800
Nivaquine	Sirop.	774
Flavoquine	2 Comp à 200mg 12 Comp à 200mg 60 Comp à 200mg poudre petit grand	146 460 2052 493 1035
Antimoquine (*		
Fansidar.	Comprimé injectable	224 588
Quinimax	1ml. 2ml 4ml. Comprimé Suppo enfant -u adulte.	521 695 1195 1160 701 858
Camoquin	2 Comp à 200mg 24 Comp à 600mg Sirop.	235 825 850
Quinoforme	0,25 } injectable 0,50 }	788 1312
Arsiquinoforme	30 Comprimés	1783
Coplaquine	24 Comprimés	852.

MINISTERE DE LA SANTE ET DES AFFAIRES SOCIALES

REPUBLIQUE POPULAIRE DU CONGO
Travail-Démocratie-Paix

DIRECTION GENERALE DE LA SANTE PUBLIQUE

DIRECTION DE LA MEDECINE PREVENTIVE

LUTTE CONTRE LES MALADIES TRANSMISSIBLES DE L'ENFANCE

LUTTE CONTRE LES MALADIES DIARRHEIQUES.

MOIS DE

ANNEE

CENTRE

REGION SANITAIRE

FICHE DE SURVEILLANCE DES MALADIES DIARRHEIQUES.

AGE / PLAN	(6 mois	6-11 mois	12-23 mois	24 mois et plus	Total	Nbre des cas transférés SRD
A						
B						
C						
TOTAL						

Total des cas traités le mois précédent.

MATERIEL DE TRO

MATERIEL	STOCK AU DEBUT DU MOIS	NOMBRE UTILISE	RESTE	BESOINS
SACHETS				
GOBELETS				
CUILLERES				
BALANCE				

MINISTERE DE LA SANTE ET DES AFFAIRES SOCIALES

DIRECTION GENERALE DE LA SANTE PUBLIQUE

DIRECTION DE LA MEDECINE PREVENTIVE

REPUBLIQUE POPULAIRE DU CONGO
TRAVAIL * DEMOCRATIE * PAIX

PROGRAMME ELARGI DE VACCINATION

RAPPORT DE SURVEILLANCE EPIDEMIOLOGIQUE DES LALADIES CIBLES DU PEV

REGION : ----------
ANNEE :----------

POSTE SENTINELLE ----------
MOIS : ----------
Ou Semaine du ----- au ------
|___|___| |___|___|

C- Cas , D = Décès ; Vac = Vacciné ; Non Vac = Non vacciné.

AGE / MALADIES CIBLES		0-8 mois		9-23 mois		24-35 mois		36-59 mois		5 ans et +		Age inconnu		TOTAL	
		C	D	C	D	C	D	C	D	C	D	C	D	C	D
ROUGEOLE	Vac														
	Non Vac.														
Coqueluche	Vac.														
	Non Vac.														
Poliomyélite	Vac.														
	Non vac.														
Tétanos néonatale															
Tétanos															
Tuberculose															
DIPHTERIE	Vac.														
	Non vac.														

OBSERVATIONS - Origine des cas (Quartier, Arrondissement, District, Village) :

SIGNATURE

[6] MALNUTRITION

circonférence du bras (mètre à ruban ou brassard):_____

dont _____ entre 12 et 13,5 cm (jaune)

dont _____ moins de 12 cm (rouge)

[7] EDUCATION POUR LA SANTE

nombre de séances:_____

citez les thèmes developpés:_____

_____

_____

_____

[8] MORBIDITE

	nombre de nouveaux cas										
	0 à 12 mois		1 à 4 ans		5 à 14 ans		15 à 44 ans		plus de 45 ans		total
	M	F	M	F	M	F	M	F	M	F	
paludisme											
diarrhée											
rougeole											
malnutrition											
blessure, plaie, abscès, morsure											
vers intestinaux											
autres											
TOTAL											

nombre de cas evacués:_____

[8] OBSERVATIONS DE L'ASV

Fait à_____ le_____ Signature:_____

RAPPORT MENSUEL DE L'ASV

DISTRICT:_____ VILLAGE:_____

MOIS:_____19_____ NOM DE L'ASV:_____

[1] DEMOGRAPHIE

population totale:_____ nombre de foyers:_____

enfants de moins de 5 ans:_____

[2] DECES

	nombre de décès	
	M	F
0 à 12 mois		
1 à 4 ans		
5 à 14 ans		
15 à 44 ans		
plus de 45 ans		
TOTAL		

[3] GROSSESSE ET ACCOUCHEMENT

nombre de femmes enceintes:_____dont_____presentant de grossesse à haut risque

nombre de femmes enceintes nivaquinisée:_____

nombre de femmes vaccinées au VAT:_____dont 1er dose

dont 2ème dose

accouchement au village:_____dont vivants:_____

mort-nés:_____

accouchement à la maternité:_____dont vivants:_____

mort-nés:_____

nombre de femmes qui sont mortes au cours ou après l'accouchement:_____

[4] HYGIENE COMMUNAUTAIRE

nombre de latrines:_____dont_____avec couvercle

dont_____sans couvercle

nombre de séances de "retroussons les manches" effectués:_____

[5] VACCINATION

nombre d'enfants vaccinés:_____dont_____BCG, _____rougeole

_____DTCoq-Polio 1 _____DTCoq-Polio 3

_____DTCoq-Polio 2 _____DTCoq-Polio R

MINISTERE DE LA SANTE ET DES
AFFAIRES SOCIALES

DIRECTION GENERALE DE LA SANTE
PUBLIQUE

DIRECTION DE LA SANTE FAMILIALE
ET INFANTILE ET DE L'EDUCATION
POUR LA SANTE

REPUBLIQUE POPULAIRE DU CONGO
Travail - Démocratie - Paix

FICHES DES DONNEES STATISTIQUES MENSUELLES

-:-:-:-:-:-:-

Best Available Document

EMIS :

MOIS :

ANNEE :

FICHES DES DONNEES STATISTIQUES MENSUELS

CONSULTATION DU MEDECIN						CONSULTATION DES ENFANTS SAINS			CONSULTATION PRENATALE				CONSULTATION POST NATALE		PLANNING FAMILIALE		
0 à mois	3 mois	6 mois	12 mois	18 mois	total	Inscrits	Anciennes pesées	total	Inscriptions	nbre	Consultation	nbre	15jrs	45jrs	Méthode locale		total
									1 trim.		6° mois				Pilule		
									2° trim		8mois				Méthode naturel		
									3° trim		9° mois				Stérilet		
									Total		Total		total		Contraceptif injectable		

VACCINATIONS

BCG	Rouvax	DT COQ POLIO					Femmes Enceintes Vaccin Antitetanique			
		1ère dose	2ème dose	3ème dose	Rep.	Total	1ère dose	2ème dose	Rappel	Total

1. [illegible]

AGE / AFFECTIONS	0 - 1 [illegible]	3 mois	6 mois	9 mois	1[illegible] mois	Total des cas
[illegible]						
[illegible]						
[illegible]						
[illegible] HAIRES						
Malnutrition						

2- [illegible]

AGE [illegible] / PATHOLOGIE	1 - 3 mois	4 - 6 mois	7 - 8 mois	9 - 10 mois	TOTAL
SYPHILIS					
GONOCOCIE					
PALUDISME					
TRICHOMONAS VAGINALES					
ALBUMINURIE					
[illegible]					
[illegible]					
DIABETE					

	DÉPISTAGE FONCTIONNEL			CAUSERIES - DÉBATS			
	Nombre séance	participants	thèmes développés	nombres séance	nombre participants	matériel utilisé	thèmes developpés
1ère bouillie							
2ème bouillie							
Malnutrition							

CAUSERIES SUR LA PLANIFICATION FAMILIALE			
Nombre de séance	Nombre de participants	Matériel utilisé	Thèmes developpés

A N N E X # 13

PROGRAMME D'ACTIVITES DU VOLET EDUCATION POUR LA SANTE

1° SEMESTRE 1986

ACTIVITES	SOUS-ACTIVITES	RESSOURCES		PERIODE					
		Humaines	Matérielles	Jan.	Fév.	Mars	Avril	Mai	Juin
Produire du matériel éducatif sur la SSS, les signes de la déshydratation et les mesures d'hygiène collectives et individuelles et le matériel de sensibilisation	- Préparer les messages, dessins, ou photos pour les affiches, dépliants feuilles volantes etc... sur la SSS les signes de la déshydratation et les mesures d'hygiène collectives et individuelles.	- Dessinatrice - Equipe du projet.	- Fourniture de bureau - Appareil de photos - Pellicules en couleurs	↔					
	- Elaborer la fiche tech pour tester le matériel éducatif	- Equipe du projet.	- Fourniture de bureau	↔					
	- Tester le matériel éducatif dans les zones d'action du projet	- Responsable - Personnel des zones d'action - Mères	- Fiches pour le test, - Véhicule.		↔				
	- Assurer la commande et la production du matériel éducation, T.-Shirts et des auto-collants.	- Dessinatrice - Responsable EPS. - Imprimeur	- Emblème - T.Shirts - Véhicules	↔	↔				

ACTIVITES	SOUS-ACTIVITES	RESSOURCES		PERIODE					
		Humaines	Matérielles	Jan.	Fév.	Mars	Avril	Mai	Juin
Organiser des campagnes de mass-média sur la SSS, les signes de la déshydratation et les mesures d'hygiène collectives et individuelles	Concevoir des émissions, spots publicitaires, sketch, documentaires.	Equipe du projet.	Fourniture de bureau. Matériel éducatifs	←	—	—	—	—	→
	Réaliser des émissions, spots, sketch, documentaires à la radio et à la télévision et dans les zones d'action du projet.	Equipe du projet, personnel des zones d'actions, Groupe consultatif, Mères.	Bandes magnétiques, Cassettes vidéo. Appareil de montage Nagra Véhicule		←	—	—	—	→
Former le personnel chargé de la mise en oeuvre des activités EPS	Faciliter la nomination de deux agents responsables de l'EPS dans les zones d'action du Projet.	Equipe des zones d'action Responsable EPS.	Véhicules, Fournitures de bureau.		←	→			
	Elaborer les objectifs et les activités des modules devant servir à la formation et au recyclage en EPS	Responsable EPS	Fournitures de bureau.	←	—	→			

ACTIVITES	SOUS-ACTIVITES	RESSOURCES		PERIODE					
		Humaines	Matérielles	Jan.	Fév.	Mars	Avril	Mai	Juin
idem	Prévoir le matériel technique de formation	Responsable EPS	Matériel technique et éducatif .		↔				
Organiser des séances d'éducation pour la santé sur la SSS, les signes de déshydratation et les mesures d'hygiène collectives et individuelles.	Elaborer les fiches de planification et de préparation de séances d'éducation pour la santé.	Responsable EPS	Fournitures de bureau.	↔					
	Faciliter la distribution et la diffusion du matériel éducatif et des fiches de planification et de préparation pour les séances éducatives.	Responsable EPS	Véhicule Matériel éducatif. Fiches				↔	↔	↔
	Faire démarrer les séances éducatives dans les zones d'action du projet.	Responsable EPS	Véhicule, Matériel éducatif et fiches				↔	↔	↔

ACTIVITES	SOUS-ACTIVITES	RESSOURCES		PERIODE					
		Humaines	Matérielles	Jan.	Fév.	Mars	Avril	Mai	Juin
Coordonner les activités des membres du groupe consultatif et du responsable du volet maladies diarrhéiques	Organiser les séances de travail et rencontre avec les membres du groupe consultatif et le responsable du volet diarrhée.	Equipe du projet. Responsable EPS Groupe consultatif	Fourniture de bureau Véhicule	↔		↔			↔
	Préparer les rapports trimestriels	Responsable E S	Fourniture de bureau Rapport des zones d'action			↔			↔
Réaliser des chansons sur la SSS avec l'UNEAC	Contacter les responsables de l'UNEAC pour les chansons relatives au Projet	Responsable EPS	Véhicule	↔					
	Remettre les instructions sur la SSS à l'UNEAC.	idem	idem	↔					

PROGRAMME D'ACTIVITES DU VOLET EDUCATION POUR LA SANTE

2° SEMESTRE 1986

ACTIVITES	SOUS-ACTIVITES	RESSOURCES		PERIODE					
		Humaines	Matérielles	Juil.	Août	Sept.	Oct.	Nov.	Décembre
Produire du matériel éducatif sur la rougeole et le calendrier de vaccination	Préparer les messages, dessins ou photo sur la rougeole et le calendrier de vaccination	Dessinatrice, Equipe du projet	Fourniture de bureau, Appareil photo, Pélicules en couleurs, véhicule	←	→				
	Tester le matériel éducatif dans les zones d'action	Responsable EPS, Personnel des zones d'action Mères.	Véhicule, Fourniture de bureau, Fiches pour test.		←	→			
	Elaborer la fiche pour le test du matériel éducatif	Equipe du projet.	Fourniture de bureau, et matériel éducatif.	←	→				

ACTIVITES	SOUS-ACTIVITES	RESSOURCES		PERIODE					
		Humaines	Matérielles	Juil.	Août	Sept.	Oct.	Nov.	Déc.
Organiser des campagnes de mass-média sur la rougeole et le calendrier de vaccination à la radio et à la télévision	Concevoir des émissions, spots, documentaires et sketch sur la rougeole et le calendrier de vaccination.	Equipe du Projet.	Fourniture de bureau et matériel éducatif	←	—	—	—	—	→
	Réaliser des émissions, spots publicitaires, sketch et documentaires sur la rougeole et le calendrier de vaccination à la radio et à la télévision.	Equipe du Projet, personnel des zones d'action, groupe consultatif. Mères.	Bandes magnétiques, cassettes, nagra pile, véhicule			←	—	—	→
Publier le calendrier de vaccination dans les journaux de la place (zone d'action).	Faire paraître le calendrier de vaccination dans les journaux des organisations de masses et le quotidien des zones d'action du projet.	Responsable EPS Groupe consultatif.	Fourniture de bureau.		←	—	—	—	→

ACTIVITES	SOUS-ACTIVITES	RESSOURCES		PERIODE					
		Humaines	Matérielles	Juil.	Août	Sept.	Oct.	Nov.	Déc.
	Faciliter la distribution et la diffusion du matériel éducatif et des fiches de planification et de préparation de séances éducatives	Responsable EPS	Matériel éducatif, fiche, véhicule.			←	—	—	→
Continuer à organiser les séances éducatives dans les zones d'action du Projet	Elaborer la fiche de supervision des séances éducatives	Equipe du projet.	Fourniture de bureau.	←	→				
	Effectuer des tournées de supervision dans les zones d'action du projet.	Responsable EPS.	Fourniture de bureau, Fiches de supervision, véhicule.		←	—	—	—	→
Coordonner les activités des responsables du volet diarrhée et PEV et du groupe consultatif.	Organiser les séances de travail avec le groupe consultatif et les responsables des volets diarrhée et PEV.	Equipe du projet, Groupe consultatif et responsable volet	Fourniture de bureau, Véhicule.			←	→		← →

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ACTIVITES	SOUS-ACTIVITES	RESSOURCES		PERIODE					
		Humaines	Matérielles	Juil.	Août	Sept.	Oct.	Nov.	Déc.
	Rediger des rapports trimestriels.	Responsable EPS	Rapports des zones d'action des responsables des deux volets et du groupe consultatif.			↔			↔
Participer à l'évaluation de l'efficacité des stratégies EPS	Préparer la fiche d'évaluation des activités d'EPS	Responsable EPS, Epidémiologiste	Fourniture de bureau					↔	
	Tester la fiche d'évaluation et autres outils devant servir également pour l'évaluation	Responsable EPS, et agent d'évaluation.	Fiche d'évaluation, Véhicule ou autre moyen de locomotion.					↔	
	Evaluer les activités d'EPS.	Agent d'évaluation.	idem.						↔

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CLASSIFICATION

PROJECT EVALUATION SUMMARY (PES) — PART I

Report Symbol U-447

1. PROJECT TITLE	2. PROJECT NUMBER	3. MISSION/AID/W OFFICE
Combatting Childhood Communicable Diseases	698-0421	AFR/TR

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) 86-02

☐ REGULAR EVALUATION ☐ SPECIAL EVALUATION

5. KEY PROJECT IMPLEMENTATION DATES			6. ESTIMATED PROJECT FUNDING	7. PERIOD COVERED BY EVALUATION
A. First PRO-AG or Equivalent FY 85	B. Final Obligation Expected FY 88	C. Final Input Delivery FY 88	A. Total $ ____ B. U.S. $4,000,000	From (month/yr.) Jan. 1985 To (month/yr.) Dec. 1985 Date of Evaluation Review

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., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. AID/W should schedule quarterly implementation reviews of grant agreement performance in Brazzaville.	Davis AFR/TR	June, Sept., Dec. 1986
2. Additional reports and revised proposals for health information systems activities should be provided by WHO/AFRO to AID/W.	Beausoleil WHO/AFRO	April 15, 1986
3. WHO/AFRO should conduct a review of the need for managerial and administrative assistance for the performance of implementation.	Beausoleil WHO/AFRO	April 15, 1986
4. The grant agreement should be extended and additional funds required for the period April 15, 1986 - December 1987.	Davis AFR/TR	April 30, 1986

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

- ☐ Project Paper
- ☐ Financial Plan
- ☐ Logical Framework
- ☒ Project Agreement
- ☐ Implementation Plan e.g., CPI Network
- ☒ PIO/T
- ☐ PIO/C
- ☐ PIO/P
- ☐ Other (Specify) ____
- ☐ Other (Specify) ____

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT

- A. ☐ Continue Project Without Change
- B. ☐ Change Project Design and/or ☐ Change Implementation Plan
- C. ☐ Discontinue Project

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

Joe H. Davis, AFR/TR
Andrew Agle, CDC/Atlanta
Marc LaForce, Evaluator, CCCD Project
Edwin Beausoleil, PM3, WHO/AFRO
Lev Arevshatian, CDI, WHO/AFRO
Dr. Femi-Pearse, PMI, WHO/AFRO
Dr. Dlamini, PHP, WHO/AFRO
David Bassett, CCCD Liaison Officer, Brazzaville

AFR/RA: Walter Sherwin

12. Mission/AID/W Office Director Approval

Signature: Keith W. Sherper

Typed Name: Keith Sherper, Director, AFR/T

Date: 5/14/86

AID 1330-18 (3-78)

EVALUATION OF FIRST YEAR'S PERFORMANCE
UNDER THE CCCD GRANT AGREEMENT

INTRODUCTION:

On March 17 and 18, 1986, a review was conducted of the results of the First Year's Accomplishments under the CCCD Grant Agreement with WHO/AFRO. The evaluation was headed by the Project Manager, Dr. Joe H. DAVIS, AFR/TR; Mr. Andrew AGLE, CDC/Atlanta; Mr. David BASSETT, CCCD Liaison Officer; and Dr. Marc La FORCE, External Evaluator, CCCD Project. WHO/AFRO Staff were headed by Dr. Edwin BEAUSOLEIL, Programme Manager, Disease Prevention and Control for the Regional Director (PM3) with the assistance of various staff members including Drs. AREVSHATIAN, CDI, FEMI-PEARSE, PMI and DLAMINI, PHP.

FINDINGS:

In general, the evaluation team determined that progress in the training portions of the Grant Agreement had been satisfactory. Although some activities had not been completed on the schedule or to the extent specified in the Grant Agreement, this was the result of a shift of priorities of WHO/AFRO in training which AID encouraged and endorsed. The programme during the past year in the health information system project component did not show significant progress and evidenced a need for reconsideration of implementation arrangements.

The results of performance to date are summarized in Attachment A. Modifications to Trainee Support costs funded are described in Attachment B. During discussions further findings were:

1. The three regional training centers supported by AID funds are a part of a larger set of ORT regional training centers (six). Other ORT Training Centers are already operational in Dakar and Addis Ababa and one is planned for Luanda.

2. With reference to activity item 2.1, the evaluation team reviewed three reports of teams which had visited Cameroon, Togo and Zimbabwe on Implementation of Managerial Process for National Health Development. The reviewers were unable to clearly discern the direction of health information systems activities which are expected to emanate from the implementation of such a managerial system. The preparation of the reports did not utilize CCCD funds. This observation is made to

indicate that the evaluation team members were not able to ascertain the value of proceeding with this activity on the basis of information available.

3. The evaluation team was unable to review the report of the short-term consultant listed under Activity 2.2. The consultant had reviewed epidemiological data available to AFRO, OCEAC, OCCGE and the offices for the three WHO/AFRO Regional Epidemiologists. An addendum to this report will be made after adequate review on the consultants report.

4. The evaluation team also discussed with WHO/AFRO the desirability of systematic follow-up of individuals receiving training in WHO/AFRO courses for which funds were provided by AID. It was agreed that a schedule of desired follow-up schedules would be specified and arrangements would be made to ascertain occupational status and programmatic responsibilities of individuals who had been trained. CCCD and WHO field staff would be requested to obtain information if possible -- if not, project funds could be made available to obtain services of STCs for this purpose.

RECOMMENDATIONS:

1. WHO/AFRO should review the level of effort required to plan, implement, evaluate and report on activities carried out under the CCCD Grant Agreement and determine if administrative assistance is warranted to relieve professionals of some routine tests.

2. The health information system component on the CCCD Grant Agreement needs to be reconsidered. Further funds should not be programmed in the area until reasonable concrete proposals and implementation agreements are reviewed. The Epidemiological Bulletin should be published as scheduled.

3. The AID/W project manager should continue to schedule quarterly informal reviews. Attachments A and B should be updated quarterly to facilitate those reviews.

AGREEMENTS REACHED ON ACTIVITIES PROPOSED FOR REMAINDER OF 1986 - 1987 BIENNIUM

1) EPI/CDD Mid-Level Management Courses:
The five courses proposed were agreed to. The project manager agreed that modest additional funds could be provided to evaluate trainees after they returned to normal occupations. WHO/AFRO was advised that it might not be possible to find the course scheduled to take place in Addis Ababa.

2) Refrigerator Repair Technicians' Courses:
The two courses proposed were agreed to. The project manager agreed that modest additional funds could be provided to estimate the probable need for refrigeration repair technicians in all countries of the region and to evaluate trainees at some time after they complete training.

3) EPI Managers' Meeting for Portuguese-Speaking Countries:
The activity was agreed upon but WHO/AFRO was advised that AID might not be able to provide funds at the proposed Luanda site.

4) Senior-Level Courses for Epidemiology and Disease Control:
The activity was agreed upon. The AID project manager agreed that modest additional funds could be provided as necessary for evaluation and follow-up of trainees.

5) Mid-Level Epidemiology Course:
The activity was agreed upon.

6) CDD Programme Managers' Meetings:
The activity was agreed upon.

7) Training of Medical Staff in Diarrhea Case Management Using ORT:
The proposed activity was agreed to subject to favorable evaluation on the training schedules for Addis Ababa in April 1986. ((This course is not receiving AID funds.) Results of the evaluation should be forwarded to CCCD project manager.

8) Publication of WHO/AFRO Epidemiological Bulletin:
The proposed activity was agreed to.

9) WHO/AFRO Support Cost for CCCD Liaison Officer:
The proposed level of support was agreed to.

10) Implementation of Managerial Process for National Health Development:
Consideration of this item was deferred until further information could not be provided. If submitted by April 15 funding could be considered for the next Grant Amendment.

11) Development and Strengthening of Management and Leadership Skills among Operational Level Workers:
There was agreement that this was an activity of priority interest to AID but that further development of the proposal was desired. If a more complete description is submitted to April 15, it can be considered for the next Grant Amendment.

12) Support for Consultants to visit Member States to assist in African Immunization Year:
The proposed activity was agreed to.

13) Support for Printing and Distributing Promotional Material for African Immunization Year:
The proposed activity was agreed to.

14) Training Courses in P. falciparum Sensitivity Testing:
The activity was agreed to as proposed.

15. Training of Managers for Malaria Control Programs.
It was agreed this item would not be considered as a separate proposal but will be considered with item 10.

16) Training Workshop for Development of Nursing Curricula based on PHC:
Agreement was reached that nursing curricula with respect to immunizations, ORT and Malaria treatment is of moderate interest for the CCCD project and that support might be available for a more modest approach which would analyze and document the current content of nursing curricula.

17) Training of Core Group Nurses in Management and Leadership at District Level:
It was agreed that this item would not be considered as a separate proposal but will be considered conjointly with item 10.

18) WHO/AFRO Participation in CCCD Bilateral Project Evaluation:
The funding level proposed should be reduced to 40,000 to 48,000 to reflect participation in 10 evaluations rather than 12. Funding can be used to fund participation by either WHO/AFRO staff or TCDC consultants from a non-CCCD country.

19) Development and Use of Health and Socio-Economic Indicators for Monitoring and Evaluation of Health Programmes:
Consideration of this item will await review of existing consultant report, reviewing existing data sources at AFRO, OCEAC and OCCGE.

20) Development and Use of Health and Socio-Economic Indicators for Monitoring and Evaluation of Health Programs (Nutrition Indicators):
Consideration of this item will await review of consultants report reviewing information available at OCEAC, OCCGE and AFRO.

In summary, all proposals for 1986-87 biennial funding were considered and agreement was reached with the AID project manager on the technical content of proposals totaling US$1,731,000. The venue may have to be changed for two training courses to comply with AID legal constraints. This funding level may be increased slightly as suggestions regarding evaluations are incorporated. A senior-level management study with proposed funding of $30,000 is awaiting additional information. It is expected that positive consideration will be given this activity once additional information is reviewed. Additional proposals were reviewed totaling $943,000. Their funding can be considered when additional information is provided but probable levels of funds available for these activities is not clear at this time. Any funding available is probably substantially less than the total required for all proposals. It is noted that the proposals do not include 13% WHO/AFRO overhead. It is also anticipated that some monies already obligated may be available to partially fund these activities. A quick review of funds remaining from the first year Grant AGreement and not yet reprogrammed indicates that up to $500,000 may remain for reprogramming. WHO/AFRO is requested to provide exact estimates of funds obligated and not yet definitely committed.

This review does not constitute a financial commitment by the United States Governmenmt to fund the activities for which technical agreement was reached. Formal AID/Washington consideration by the Assistant Administrator for the AFircan Bureau is expected to occur in late April.

AFR/TR:JHDavis:rsbe:4/15/86:6434Y

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Evaluation Report

of

Combatting Childhood Communicable Diseases - Liberia

by

Westinghouse Electric Corporation - Public Applied Systems

and

The John Snow Incorporated Project:
Resources for Child Health Project through
The Harvard Institute for International Development

April 9, 1986

AID/W Contract PDC-1406-I-00-4062, Work Order No. 14

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1.0 Evaluation Team

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The team was assisted by the following resource persons:

Russell Charter, MPA	-	Public Health Advisor - CDC
Wendy Roseberry, MPA	-	Assist. Project Officer - AID/W

The team wishes to acknowledge the assistance and support received from the Ministry of Health and Social Welfare (MH&SW) of the Government of Liberia at all levels, AID, and CDC which made the evaluation possible. The team thanks the above and WHO, UNICEF and Peace Corps/ Liberia for their cooperation and patience.

2.0 Evaluation Methodology

The basic team consisted of a public health physician, a public health economist and an epidemiologist with experience in training and health education. This team worked in Liberia from February 24 through March 15th. During a portion of this time the team was joined by a public health physician from WHO and another from UNICEF.

The basic team was oriented for one day at AID/W by Dr. Joe Davis, CCCD Project Officer, who provided them with project documents. Three weeks were subsequently spent in Liberia where the basic team was joined by two representatives of WHO and UNICEF and by two resource persons from AID/W and CDC/Atlanta.

The first week in Liberia was largely devoted to working meetings with officials of the Ministry of Health and Social Welfare (MH&SW), USAID/Monrovia, Peace Corps, UNICEF, and WHO. The whole team met with these officials in general meetings and on an individual basis for detailed discussions on matters in the evaluators field of special interest (Appendix 1). Program documents were obtained, studied and analyzed (Appendix 2). MH&SW facilities, supplies and equipment relevant to CCCD were inspected.

The second week was largely devoted to field visits of clinics and discussions with the EPI/CCCD county level personnel. In Montserrado County visits were made to a MCH clinic, a health clinic operated by catholic nuns with MH&SW staff and a private clinic. The team visited a county hospital, two clinics and an outreach vaccination clinic in Cape Mount County. In Margibi County, the team visited the county health center and a health clinic included in the Liberian Institute for Biomedical Research. The Team visited the County Community Health Center in Bomi County which was established as a separate unit at

the county hospital. The team also visited a remote and simple village clinic doing vaccinations and a well appointed clinic operated by a catholic nun with MH&SW staff.

The third week of the evaluation was spent drafting the report, verifying data and developing a team consensus. The draft report was disseminated to the members of the CCCD Technical Committee for their review. An oral presentation of the major findings and related recommendations was made by the evaluation team's leader. The draft report and recommendations were then discussed. A final report was prepared by the team, which incorporated the results of the discussions with the members of the CCCD Technical Committee. (See Appendix 3 for person's present).

The team was limited in its evaluation by a time constraint of only two working weeks and by a large team from diverse backgrounds, some of whose member came late and left early. Although all MH&SW officials interviewed were forthcoming and helpful and logistic support was given freely, relevant documents and data often had to be requested and searched out rather than being presented in an organized fashion at the outset.

The team was not able to do in-depth research in all aspects of the program, as the scope of work outline might imply, but did obtain enough information and insight on which to base judgments.

3.0 Executive Summary

AID/W requested Westinghouse Electric Corporation and the Harvard Institute for International Development to conduct a mid-project evaluation of the Liberian program for Combatting Childhood Communicable Diseases (CCCD) under an Indefinite Quantity Contract (IQC).

The Liberian program is one of 12 African Bilateral programs funded out of the $47 million programmed by AID/W in 1981 for CCCD in sub-saharan Africa. The bilateral Project Agreement with the MH&SW provides $655,000 of grant funds plus $175,000 of "in-kind" contribution of vaccines. The bilateral grant is monitored by the USAID/Liberia health and population officer. CDC/Atlanta, as part of a PASA with AID/W for technical assistance, supports one Technical Officer in Monrovia with one local assistant plus short term consultants (to date about 300 person days). In addition, the sub-regional CCCD epidemiologist and personnel from the WHO Regional Office for Africa are available to Liberia for the purposes of providing regional training and guidence in the development of health information systems, operations research, health education and management.

The program has also been supported by other donors: UNICEF has provided $370,000 of commodities with some technical assistance; WHO has provided technical assistance, $50,000 of commodity assistance, and some local costs; Peace Corps has provided six health volunteers with three more scheduled (AID funded). Other GOL organizations and private businesses and organizations (Rotary and LRCW) have provided vaccines, publicity, supplies, etc.

The Project Agreement was signed July 19, 1983. The CDC technical officer arrived at post in the Spring of 1984. The Project Completion Assistance Date (PACD) is July 31, 1987. The project is at least one year behind schedule but has begun to gain momentum in the last six months.

The Liberian CCCD program is managed by a CCCD officer located in the MH&SW Preventive Services Bureau which is headed by the Deputy Chief Medical Officer.

The project has three major activities:

(1) To improve the Expanded Program for Immunization (EPI), i.e., immunize children against tuberculosis, measles, polio, tetanus, diphtheria and whooping cough and women of child bearing age against tetanus to prevent neonatal tetanus.

(2) To develop a national diarrhea program emphasizing the use of oral rehydration therapy (ORT).

(3) To develop a national malaria program which will treat presumptive malaria in children under five and give malaria prophylaxis to pregnant women as both the fetus and mother are at high risk.

The goal of the CCCD program is to strengthen the above three activities which are services of a comprehensive Primary Health Care (PHC) program. Thus the CCCD activities will be progressively integrated into the Liberian national PHC program. Since the Technical Committee is a subcommittee of the PHC committee, the eventual integration of CCCD into PHC is assured as is the consistency of the protocol for immunizations, ORT and malaria.

The implementation problems are detailed in the body of the report. They include:

(1) Disruptive political and economic upheavels of 1984-1985;

(2) Lack of GOL funding due to a very low cash flow;

(3) Government hiring freezes and retrenchment of staff resulting in inadequate numbers of personnel available to manage CCCD activities;

(4) Too few vehicles for supervision and logistics;

(5) Wastage of vaccines due to poor management;

(6) Inadequate equipment and poor maintenance of existing equipment;

(7) Deficiencies in health education, health statistics and training;

(8) Lack of uniformity in the programs with the field forging ahead with malaria, ORT and cost recovery activities while the official guidelines are still being developed by the central bureaucracy.

The most urgent actions for the MH&SW and AID include:

(1) Revision of the Project Agreement to reflect present realities as regards financing and scheduling;

(2) Provision of the necessary commodities such as ice-lined refrigerators and four-wheeled drive vehicles by appropriate donor agencies;

(3) Revision and formalization through written memorandums of understanding of the donor contribution plan established in 1983 for the CCCD project. This plan should reflect what goods and services are needed and what donor can best contribute to the project.

(4) Reassignment of available MH&SW staff to enable better management and supervision of project activities;

(5) Formalization and dissemination of a national policy for malaria;

(6) Implementation of cost recovery programs (registration, service and drug fees) for the financing of CCCD activities and PHC programs.

On the basis of their findings, the evaluation team concluded that the Liberian CCCD program should continue to receive AID support for several reasons:

(1) The need is great since Liberia has an infant mortality rate of more than 150 infant deaths for each 1,000 births.

(2) The MH&SW understands the need and has the correct priorities. It is emphasizing low cost preventive medicine through, PHC and CCCD activities rather than high cost, high technology hospitals and research centers.

(3) The MH&SW sees CCCD as one of its few recent successes. Due to the Vaccination Campaign week held in January, 1986, more than 300,000 vaccinations were given in one week. This has encouraged the MH&SW to continue to support CCCD to the best of its limited ability.

(4) The necessary donor support can be mobilized. AID/W has provided major funding. Peace Corps has and will provide vital manpower. CDC and WHO can and will give technical guidance. UNICEF has given major assistance and plans to continue to do so. CCCD has demonstrated that it can obtain other GOL and private resources for this popular program.

(5) The CCCD program is developing procedures, skills and methodologies which are fundamental to the proposed national PHC program.

In spite of the above positive factors, the CCCD program has not progressed as well as expected. The implementation is about a year behind schedule, the GOL has not met some of the preconditions of the Project Agreement and the CCCD Technical Officer arrived late. In general, the implementation of the project has been uneven and slow.

There are serious discrepancies between the Project Agreement and its current implementation which must be regularized to attain project objectives and targets and to avoid auditing problems. The precondition for the MH&SW to establish a formal system of registration fees has not been implemented. The project is behind schedule in coverage of populations and in formally introducing ORT for diarrhea treatment and chloroquine for presumptive treatment for children and prophylactic treatment for pregnant women. The most serious deficiency is the failure of the GOL to maintain its recurrent budget support and to begin to incorporate costs of commodities and operations into its budget. The opposite has happened due to the financial crisis of the GOL, that is salaries have been cut and not paid on time and no new funds have been provided to the program EPI in the 1985-1986 year. In short, the Project Agreement needs to have major amendments or be rewritten to reflect present realities.

While the CDC has provided a technical officer, he needs competent local-hire assistance with his office work. This assistance should enable him to spend more time in the field with the county and community health workers. CDC has also provided more short term consultants than scheduled. Finally, the implementation problems require more field visits by CCCD and AID staff.

4.0 Observations and Findings

4.1 Project planning, administration and management

The country assessment done by the MH&SW, CDC and USAID/Liberia in 1982 was an adequate planning document at that time. Since 1982, conditions have radically changed in Liberia. The current financial crisis has affected the MH&SW's ability to meet the Project Grant Agreement commitments and has necessitated staff freezes, pay reductions, minimal equipment and drug purchases, reduced maintenance, etc. All these factors have adversely affected field operations, services and staff morale.

The plans of operation established for 1986 and the duration of the project were largely drafted by the CCCD Manager and CCCD Technical Officer. They were shared with the relevant staff for comments. The final work plans were officially approved by the CCCD Technical Committee.

The work plans are an adequate but rather optimistic guide to program operations. It is doubted that the implementation of these activities can be kept on schedule. In fact, many of the activities planned for 1986 are already behind schedule. Therefore , a one year extension of the project has been recommended.

The MH&SW is headed by a Minister, a Registered Nurse. A physician is Deputy Minister and Chief Medical Officer (CMO). One of the three bureaus under him is Preventive Services headed a public health physician, the DCMO. The CCCD Office is in this bureau and is headed by an Acting Director who is a physician. This physician expects to start public health training when the permanent director returns from her Stateside training in June of 1986. The current Acting Director of CCCD has only been in office for three months and she replaced another Acting

Director who had been acting for four months. This discontinuity in the office of director of CCCD has been disturbing in spite of the fact that there has been some overlap.

Another, programmatic anomaly is EPI. EPI antedates CCCD having been started in 1978 and CCCD in 1983. The EPI Director has a staff of about 20 but only three or four are professionals with some formal training. This division originally was under a special board, semi-independent of MH&SW, and not in the preventive services bureau. The board is now relatively inactive and EPI is part of preventive services. EPI formerly operated through the use of mobile teams (110 staff) but this was found to be too expensive and it now delivers its services through static health facilities with outreach immunization services to distant villages.

As an independent program, EPI has its own central office operating budget and staff which includes an EPI supervisor in each of the 13 counties. These county EPI supervisors are under the administrative direction of the county Chief Health Officers (CHO's). The EPI budget includes rent, office support, kerosene and gasoline, materials production, training and equipment maintenance. There has been no GOL contribution to the budget during the 1985-86 fiscal year and funds are depleted.

The independent nature of EPI has posed a problem in the integration of staff and activities at the central level with CCCD. The EPI director thinks he reports to the DCMO but the DCMO and CCCD thinks he reports to the CCCD office. The lines of responsibility are about to be regularized with EPI becoming one of the three subdivisions of CCCD (Appendix 4).

At the central and county level logistics is a problem. Vaccines are stored in old refrigerators. Temperatures are not always recorded and record keeping is not always current. City electricity is not constant

and the auxillary generator at the central level is old and not always functioning. Vaccines have been lost and or spoiled at the central and county levels. The two trucks that are assigned to the central level are insufficient for transport of supplies and supervision and the maintainance garage is poorly stocked.

At the county level there is a CHO, who is usually a physician, and has a hospital and a community health office. There may be a dozen clinics serving 100,000 people. Since the population is often scattered in small villages much of it is not within easy reach of a clinic (i.e. 5 kms).

The proposal to train community health workers and establish health posts through a primary health care (PHC) program, may eventually solve the coverage problem. Meanwhile, outreach teams go to unserved villages for vaccination clinics when a vehicle, vaccines and needles are available. The staff at most rural clinics and even the county level are paramedics. A few are physician assistants (PA), but usually a nurse or midwife, and these are often assistants rather than fully trained.

EPI, in spite of their problems had a successful campaign week in January 1986, when over 300,000 vaccinations were done (reports not all in). In general , the staff is enthusiastic and knowledgeable about the program. The problem of coordinating EPI, CCCD and PHC is minimized by having the CMO, DCMO, EPI and CCCD staff serve on the Technical Committee which oversees CCCD and is a subcommittee of the PHC committee. These committees make policy and produce guidelines to ensure technical validity and consistency.

The national policy for ORT was signed by the Health Minister on March 12, 1986. A malaria policy is still in draft and should be approved soon as services are being provided at the clinic level with some variation in protocols.

AID/W supports the CCCD project through regional and bilateral funds and through PASA's with CDC/Atlanta and the Peace Corps. These PASA's provide for the placement of a CCCD Technical Officer and Peace Corps Volunteers to work with host country counterparts.

The $655,000 allocated by A.I.D. for the operational aspects of this bilateral project would be adequate if the GOL was financially able to live up to the terms of the Project Agreement, that is to continue support at its 1983 level and gradually phase in logistic support. However, the GOL has failed to fund the MH&SW as planned. MH&SW staff received their November pay during the team's visit, staff positions are frozen and the EPI budget has not been funded since June 1985. EPI has existed previously on carryover funds but they are now exhausted.

There seems little likelihood that the GOL will be able to provide project funds in the near future. If the project is to carry on, donors (AID, UNICEF and WHO) will have to continue and even increase support. The institution of an official cost recovery program (Pro-AG Registration Fee) may help some, but can not be expected to cover project costs. Any cost recovery money will be needed locally for kerosene, gasoline, "volunteer's" salaries, drugs, paper etc. This money should not be used for vaccines, ORS, chloroquine, or vehicles and refrigerators which entail offshore hard currency procurement best handled by donors.

AID provides two AID/W staff to backstop the project and a third may be required when the present project officer resigns. USAID/Liberia actively monitors the project with two people and seems to keep good track of central planning. If they could get to the field more frequently, it would promote a better understanding of project operational requirements. USAID/Liberia needs to make major changes in the Project Agreement to make it consistent with current realities and prevent auditing problems. The project should be extended one year now without additional funding, except or noted above, and should be

re-evaluated at the end of 1987 to consider further extension of PACD or increased funding. CDC administration and support of the project is generally adequate. The backstop officer in Atlanta is generally abreast of the project. The Technical Officer in Monrovia has been provided, albeit some nine months after the start of the project. CDC has provided more man months of short term consultants than were programmed. There has been little input from African regional CCCD advisors but little has been needed. The resident CCCD Technical Officer has not had to spend 25% of his time on regional affairs as per his job descriptions.

The Technical Officer needs office assistance to enable him to spend more time in the field. The vacant position for a local hire needs to be filled and a second position considered. CDC Atlanta could improve field support by ensuring faster analysis and return of data. The results of the MUHS survey had not been presented to the MH&SW almost a year after the survey's verification studies had been completed.

The CCCD has a full-time director in charge of the project. The Acting Director is the third in the past year. A permanent director is expected to return from training in the U.S. in June 1986. The director has only two or three office staff and needs more staff. There is no way she can supervise activities in eight counties while planning, managing and developing guidelines for a national project. She depends on the CCCD technical officer for advise and assistance.

The CCCD Director reports to the DCMO who directs preventive services. He in turn reports to the CMO who is also Deputy Minister of MH&SW. By implementation letter AID agreed to change the roles of Project Manager and Project Coordinator. The DCMO who was originally the Project Manager is now the Project Coordinator and the CCCD Director, who was formerly Project Coordinator, is now the Project Manager. This change seems reasonable.

The project has three major activities; EPI, diarrheal disease control emphasizing ORT, and malaria control through presumptive treatment of children and prophylactic treatment of pregnant women. The established EPI program has a director and an inadequate number of staff. The CCCD Acting Program Manager is also the person in charge of the ORT and Malaria division. The lack of staff for these specific program areas and the time devoted by existing staff to the Vaccination Campaign has led to a delay in the development of the ORT and malaria components of the CCCD project.

On the whole the mechanisms for coordinating and planning seem well developed. If there is any criticism, it is that the CCCD may be over burdened with planning but underdeveloped in execution, especially in the supervision to field operations.

The established policy in the Project Agreement of maintaining liaison with private voluntary organizations, United Nations Agencies (WHO, UNICEF, UNICEF etc) as well as others concerned with technical cooperation with the Government of Liberia is, by all accounts, being adequately fostered.

The CCCD Technical Committee which meets at least once every three months has, within its membership, representatives from UNICEF, WHO and the Department of Preventive and Social Medicine of the A.M. Dogliotti College of Medicine, University of Liberia. These Agencies and Institutions are actively engaged in CCCD activities and operations research throughout Liberia. Their representation on the Technical Committee of CCCD project affords them and the CCCD project staff an opportunity to share ideas, contribute material, and other resources, harmonize strategies and methodologies and minimize duplication of efforts towards identical or similar goals.

Further coordination is obtained through a weekly CCCD staff meeting which is attended by representatives of CCCD, WHO, UNICEF, Peace Corps etc. This group was very active as an unofficial ad hoc committee formed to coordinate plans for the Vaccination Campaign Week.

The recently concluded National Vaccination Campaign Week (January 1986) is a typical example of such a cooperative effort by CCCD, WHO, UNICEF, Rotary International, CHAL (Christian Health Association of Liberia) and others.

UNICEF, for many years has been a major donor of vaccines, cold chain equipment, needles and syringes as well as vehicles, spareparts and other logistic support for EPI in particular and MH&SW in general. Other significant inputs into the health services from UNICEF have been in the area of basic drugs including ORS and chloroquine, as well as other supporting funds for educational supplies and disgnostic instruments for the training and the practice of Midwives and Traditional Birth Attendants (TBA).

In the support of EPI activities, UNICEF contributed over $250,000 in 1985. A substantial part of this support went towards the National Vaccination Campaign.

Another Donor Agency that has been particularly active in the Phase I CCCD Project Area is Plan International. Its main thrust has been in the area of Community mobilization towards self-help development projects. In this regard it is playing a leading role in the training of Village Health Workers in Bomi and Lower Lofa Counties. Specifically it is providing trainers, food, and gasoline for the training activities. Furthermore Plan International has supplied basic drugs, including chloroquine, to many community clinics in Bomi and Grand Cape Mount Counties. It has also provided funds for the renovation and refurbishing of the Community Health Department of Bomi and Lower Lofa Counties located in the Government Hospital in Tubmanburg.

CHAL has over the years provided technical assistance towards the preparation of handbooks on Immunization and Diarrhea. These handbooks have been used by the In-Service Education Division of the MH&SW for the training and retraining of health workers throughout Liberia. Another notable contribution of CHAL toward CCCD activities has been its health education sessions within several churches throughout the country called "The Church in Health Project".

The World Health Organization (WHO) continues to support the Control of diarrheal diseases (CDD)" activities especially in Montserrado and Bassa Counties. It does this by the funding of workshops and logistic support as well as through the supply of ORS to the MH&SW. Technical assistance has also been provided in the training of various categories of health workers in EPI activities.

4.2 Staffing and Distribution of CCCD Activities

Since August of 1985, the EPI aspect of the CCCD project has been operating in the Phase I counties of Grand Cape Mount and Bomi/Lower Lofa. In December of 1985, the program expanded into Montserrado and Margibi Counties. Maps of the static clinics offering EPI activities in these four counties are found in Appendix 5. The estimated population covered in the Phase I counties is also attached. As can be seen by these maps, the clinics are not evenly disbursed throughout the counties which means outreach activities to reach the surrounding catchment areas are needed. Consequently more vehicles and a redeployment of clinic personnel is needed to ensure adequate coverage. The ORT and malarial components of the CCCD project will be integrated into the ongoing clinic activities in these counties, after training of the clinic staff is completed. To a small extent, the two components have been operationalized in the Phase I Counties. Health Education activities will be included in the outreach services currently handled by the EPI/CCCD county level personnel.

While staffing in many of clinics appears adequate in the terms of number of personnel at each clinic, a closer study has shown that many of the personnel are inadequately trained, disinterested in their job or receive no support from the other members of the clinic staff to carry out their work. In some clinics only one person is assigned the task of vaccinator, resulting in a rupture of services when he or she is not present. This one person, may also be in charge of maintaining the cold chain, training, health education, record keeping etc.. At the county level the EPI/CCCD team consists of two people, one Peace Corps Volunteer and one Host Country National. This two person team currently does outreach activities, supervision, training, material development, record keeping , equipment maintenance, delivery of supplies, planning etc. This small staff needs to be reinforced, as one day the PCV will leave and the Host Country National may be relocated, quit or burnout. Therefore it is recommended that:

1. A third person be assigned to each county level team;

2. Each clinic that is currently offering immunization services have a plan to replace the vaccinator when he or she is not present;

3. A method to acknowledge (i.e. reimburse) the volunteer assistant working in some of the peripheral health posts be established.

4.3 EPI

The Expanded Program of Immunizations has been operational since 1978. The basic method of delivering services was through the use of mobile teams which has since evolved into one of providing services from static health centers, and outreach activities conducted by both the clinic and county level EPI/CCCD personnel.

The CCCD project began its implementation of EPI activities in August of 1985 in the Phase I Counties of Cape Mount and Bomi/Lower Lofa. These two counties account for approximately 9.8% of the total population of Liberia. In December of 1985, 30 months after the date of the project agreement and 18 months after the arrival of the CDC technical officer the implementation of immunization activities began in the Phase II counties of Montserrado, and Margibi. Grand Bassa the third County to be covered in Phase II will begin operations in the near future. Currently the E.P.I. aspect of the CCCD project is now covering 80% of the target populations in Cape Mount and Bomi/Lower Lofa Counties. This is well above the targets established by the 1984 internal evaluation team. The reason for this high coverage is directly attributable to the dedication and energy of the EPI/CCCD personnel at the county level and to the vast success and momentum that was achieved and established through the National Vaccination Week.

It is too early to assess the proposed reductions in mortality as a disease surveillance system is not in place, the baseline MUHS survey data has not been released by CDC/Atlanta, and the program has only been operational in two counties since August of 1985 and two others since December of 1985.

Monthly and quarterly immunization and supervisory schedules have been developed by the EPI/CCCD personnel assigned to the Phase I and Phase II counties. Immunizations are offered on a weekly basis in the Greater Monrovia area and on a quarterly basis in the clinics in the rural counties. Where outreach activities are done, they are conducted by the EPI/CCCD team from the county level as they are the only ones with a means of transport to reach remote areas. The outreach is being conducted as a follow-up to the National Vaccination Week that was conducted in most counties from January 20-25, 1986.

In Bomi/Lower Lofa and Cape Mount Counties, the static clinics that will be holding vaccination sessions during the month, start up their refrigerators one to two days prior to the arrival of the EPI/CCCD county level personnel. The county personnel arrive at the beginning of each month with vaccine, kerosene, needles, syringes and recording supplies that will be needed for the months activities. The clinic personnel then schedule their vaccination sessions and a supervisory visit by the county level team is planned for at least one of the clinic sessions. At this time some outreach sessions are conducted by the county level teams. The immunization policies that are followed are based on WHO guidelines that have been adopted by the Ministry of Health and Social Welfare. In the case of measles, children aged 9-24 months are vaccinated against measles in the urban areas and in the rural counties children up to the age of 36 months are given this vaccine. The frequency of vaccinations in the rural areas appears to be adequate for the target population in these counties.

The vaccination schedule is provided in Appendix 6. Job aides, as to what vaccines should be administered to what age group, were present at two of the four clinics visited. A quick review of the records and a verbal quizing of clinic personnel indicated that they are familiar with and adhering to the vaccination schedule. The only exception being one private clinic which was providing DPT to children up to the age of 10. An assessment by the CCCD Technical Officer of the reports from the National Vaccination Campaign indicate that 100% of all BCG shots were given to children 0-1 year old. No further information was provided to the evaluation team.

A checklist for supervisory visits has been developed by the EPI/CCCD personnel in every county and the supervision that goes on appears to be thorough, although. due to limited personnel, is not done as frequently as the perceived need.

In February and March of 1986, vaccination coverage surveys were conducted on a county wide basis. The results of these coverage surveys for the four EPI target areas are given in Figures 1 - 4. As can be seen by these tables, the coverage rates established for year II of this project have been surpassed in Montserrado, Bomi/Lower Lofa and Cape Mount counties. This is due mostly to the vaccination campaign referred to previously. The graphs also show that the coverage for all target diseases has increased dramatically since 1981.

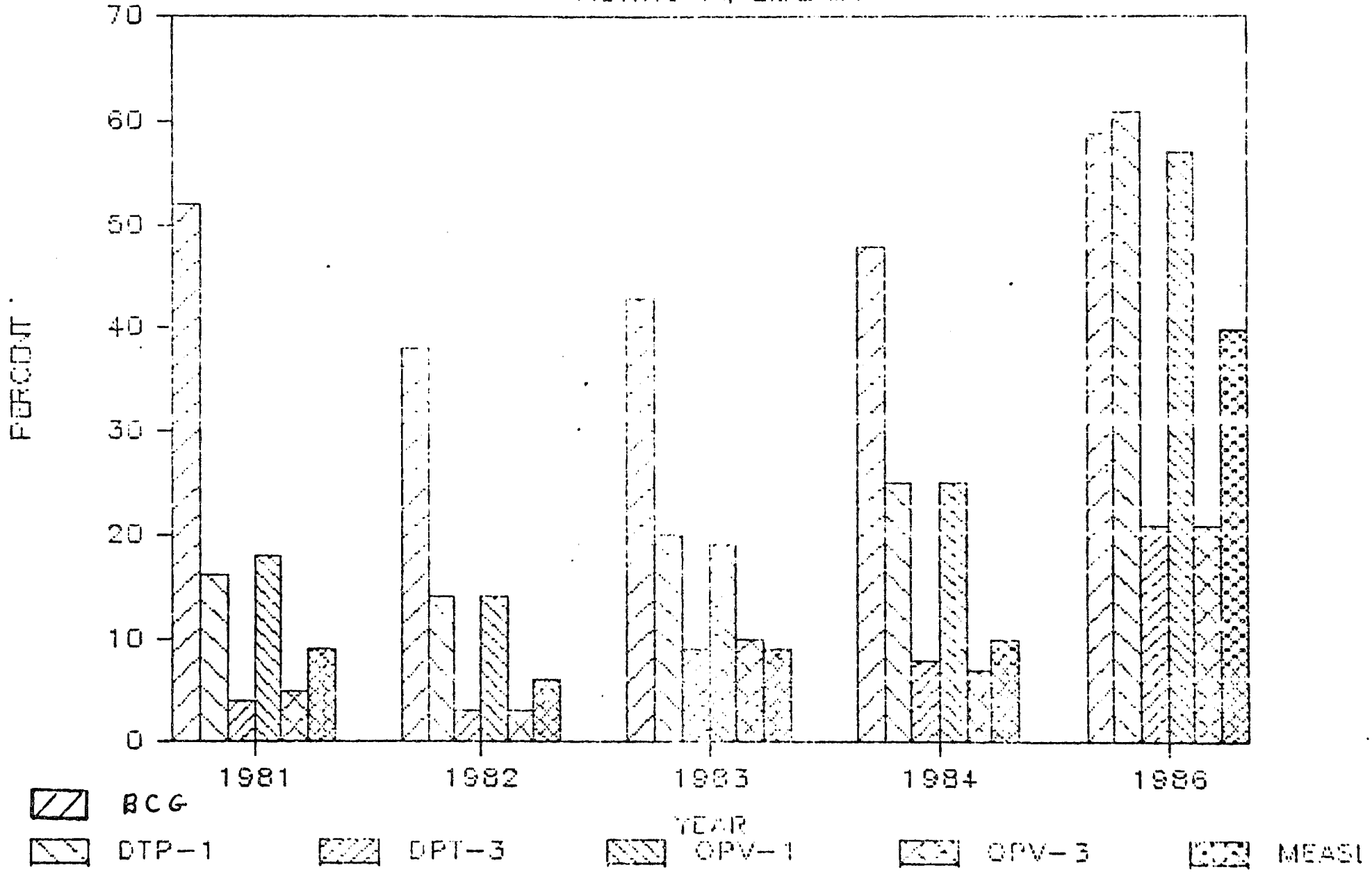
Suffice it to say, the National Vaccination Campaign was a great success and surpassed its targeted objectives. Nevertheless, the impact of this campaign will only be able to be measured in the months to come when the percentage of children returning to the clinic for their second and third does of vaccines can be assessed. Currently, some impact on the number of reported measles cases appears to have been effectuated through this campaign. However, this is based only on verbal reports by a few County Health Officers.

The vaccination techniques, assessed by the physicians on the evaluation team, followed the prescribed country standards. County staff have reported a shortage of all sizes of needles, in particular 24 and 25 gauge needles which they prefer. Disposible needles and syringes are used, therefore, there appears to be no problems with the sterilization of equipment and consequently spread of disease. Proper sterile technique was also observed in the preparation of the vaccination sites. As only two clinics were actively giving immunizations when the evaluation team conducted their field visits, it is not possible to say that all clinics are using the proper sterile techniques.

All clinics, that were visited were well maintained and clean. Be it in a courtyard or regular clinic structure, vaccines were kept in the shade and screening was done at a separate table from that of the vaccination table. The process in two of the three clinics observed was

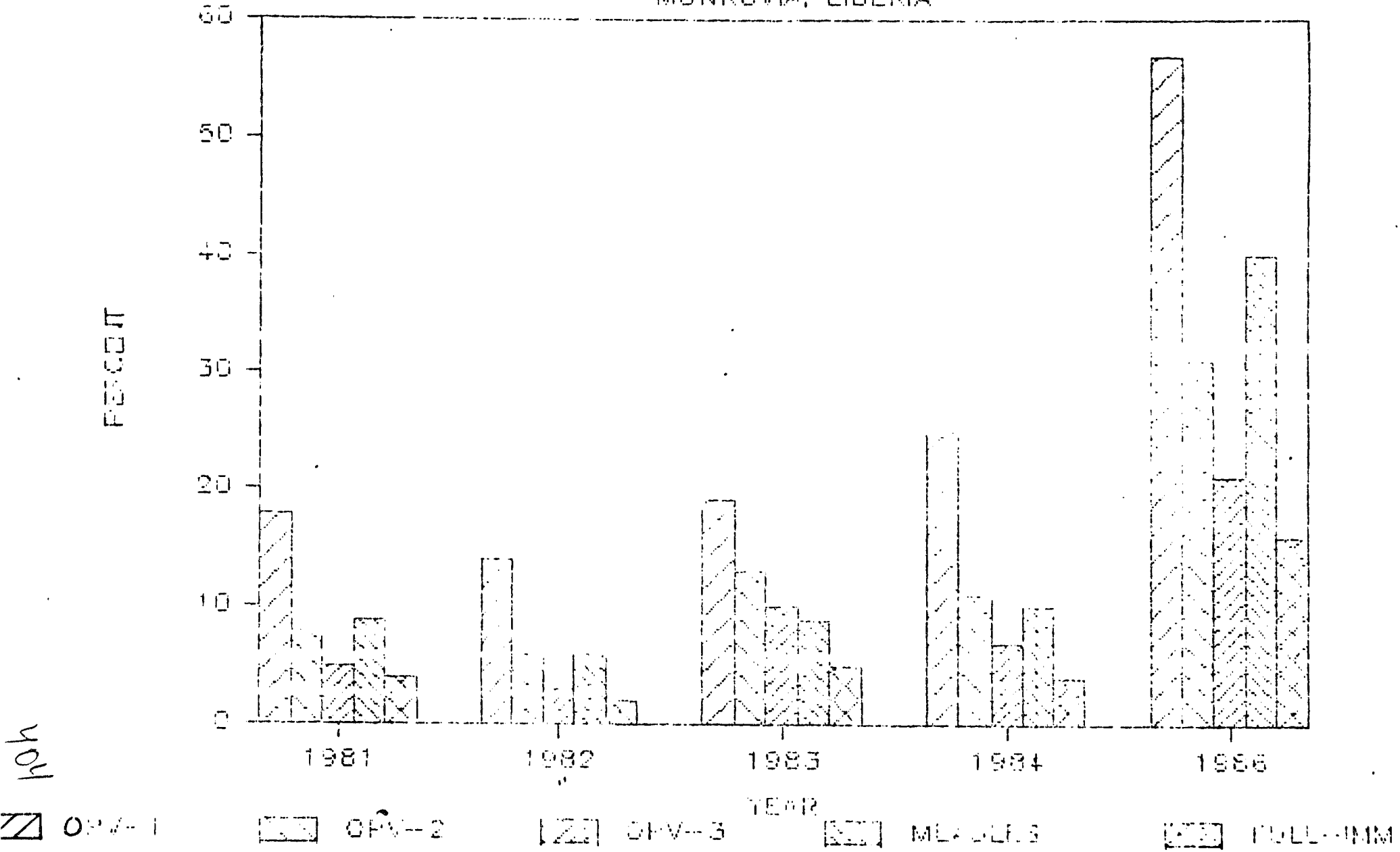
VACCINE COVERAGE FOR

MONROVIA, LIBERIA



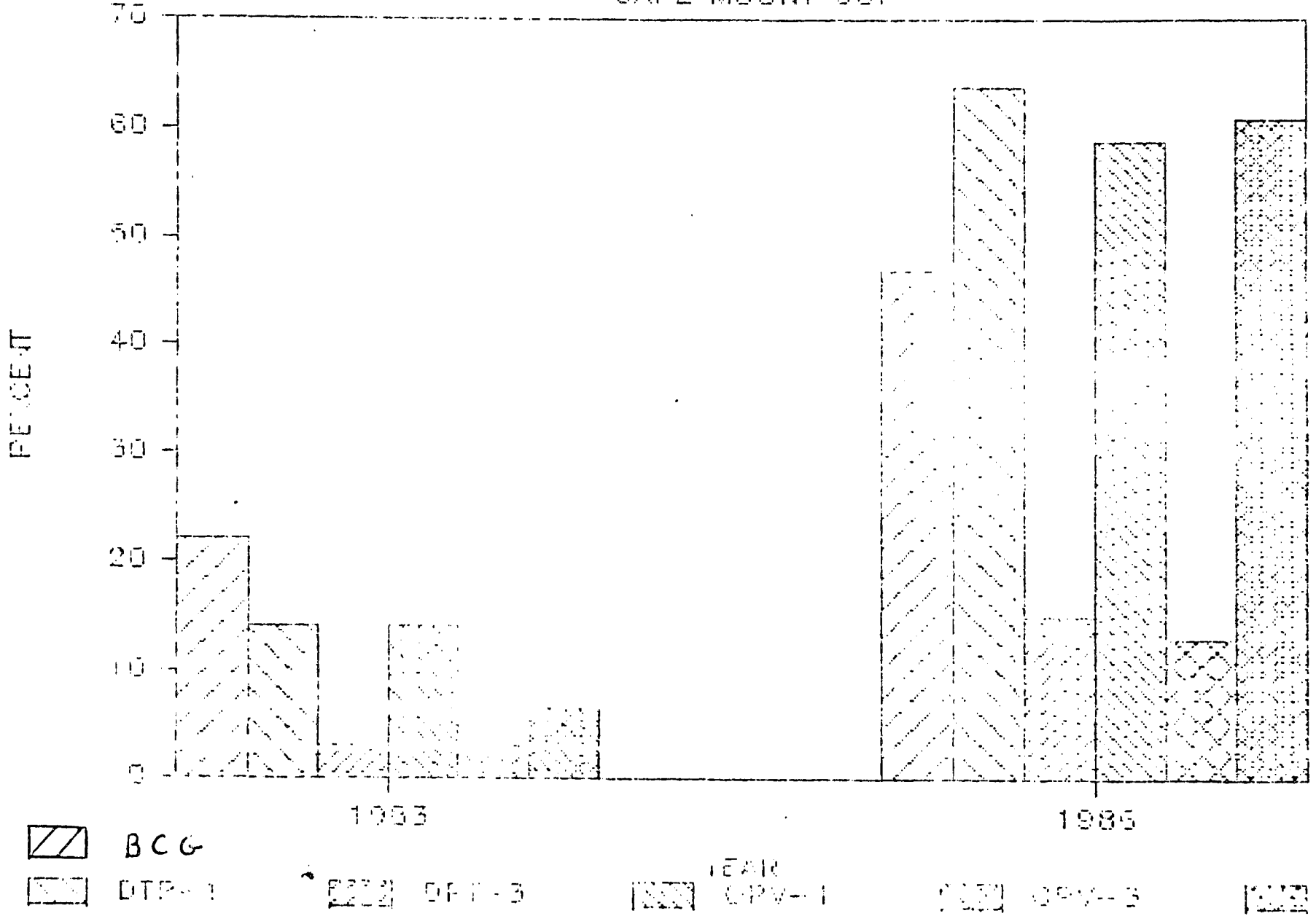
VACCINE COVERAGE FOR

MONROVIA, LIBERIA



VACCINE COVERAGE FOR

CAPE MOUNT CO.



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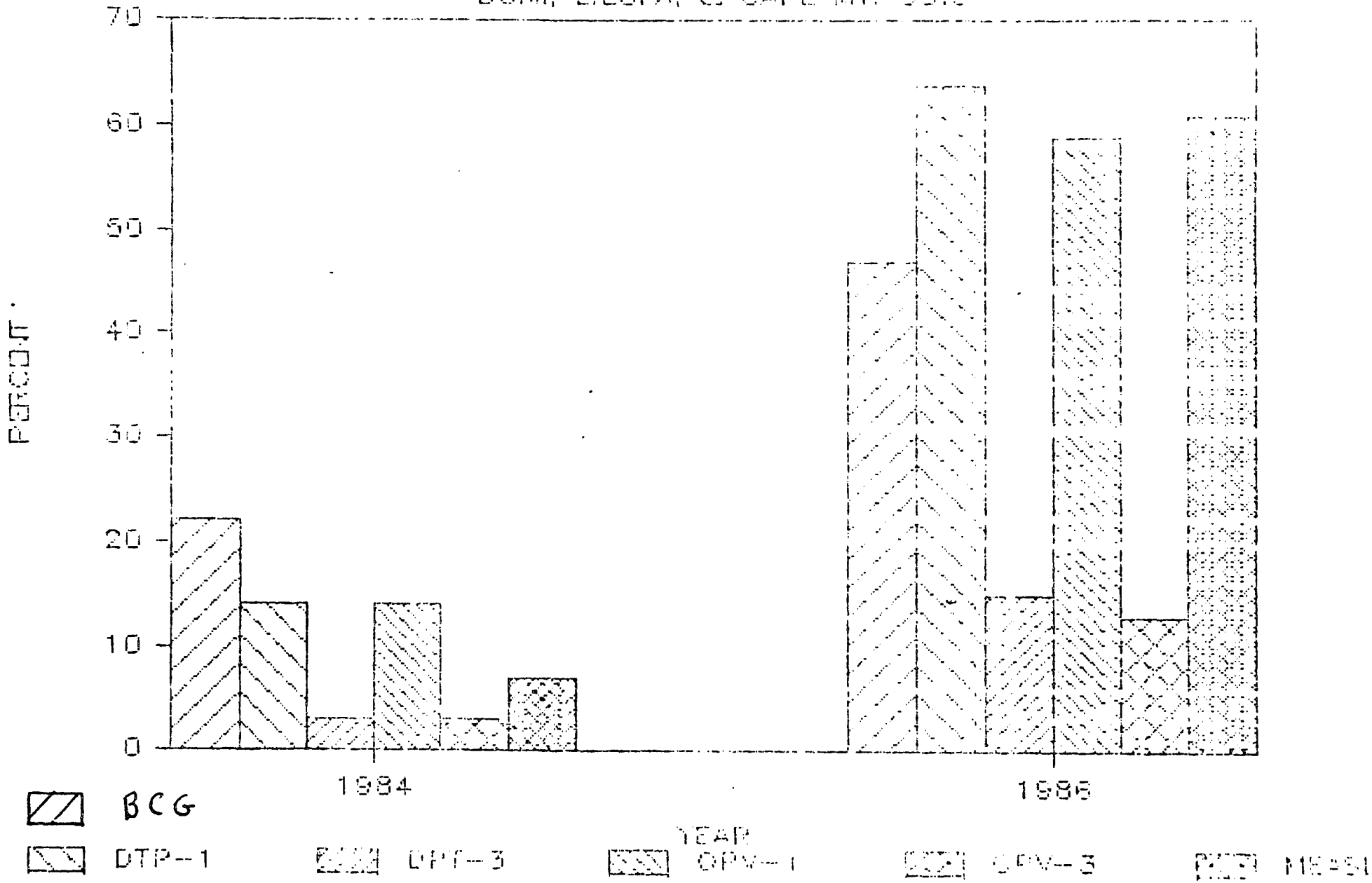
VACCINE COVERAGE FOR

BOMI, LOFA, & CAPE MT. CO.S



quite slow. Women and their children were kept waiting seemingly form several hours before the actual administration of the vaccinations began. During this time, Road to Health (RTH) cards were collected and reviewed for all persons present and the names, ages and immunizations to be given were recorded in a registration booklet. In one Monrovia clinic, a health lecture was also to be given prior to beginning the actual immunization process. In another clinic, it was stated that the clinic personnel were waiting for the arrival of the evaluation team prior to beginning their work. In any case, there is a need to help the clinic personnel streamline their activities in order to immunize the children at a faster rate. One outreach clinic was said to have screened and vaccinated 60 people in one hour. The process used to achieve this rate needs to be followed in the other clinics. Time spent waiting for service, may be one factor accounting for the high drop out rate. Another problem noted is that of completing the tally forms (see Appendix 7). These forms which have been changed several times in the past year, appear to be too complicated for clinic personnel use. Therefore the county EPI/CCCD staff often collect the registration books and complete these forms themselves. These new forms were introduced during the vaccination campaign. Little or no field testing on their appropriateness was done and little time for training field personnel in their use was provided.

Other problems observed during the field visits that hamper the successful implementation of the project were; 1) lack of vehicles and motorcycles that would aid in conducting needed outreach activities; and 2) infrequent supervisory visits from the CCCD central level personnel. It is important to note that the two jeeps that are currently assigned to the CCCD areas in Bomi and Cape Mount Counties, have problems, with their chasis and swerve uncontrollably when driven over 40 miles per hour. This was personally experienced by one evaluator. Additionally, personnel from both the central and the field level report a lack of available U.S. parts for the jeeps.

In Montserrado County, the vehicle that is assigned to EPI/CCCD is often needed and used for other activities. Though the EPI/CCCD staff

submit their request for use of the vehicle in advance, the car often is found without gas. The time to refuel and load the vehicle for their visits creates delays in their getting an early start.

To obtain an adequate coverage of the catchment areas, outreach activities are needed. In spite of the fact that a motorcycle policy has been drafted and accepted, no motorcycles have been distributed. Until the motorcycles that are in Monrovia are distributed, this service will have to depend on the county level personnel who are too few in number to adequately continue this outreach. Furthermore, it appears that two motorcycles per county will not be sufficient to conduct the necessary outreach activities.

4.4 ORT Program

As with other aspects of this project, the ORT component is considerably behind in achieving the coverage objective as stated in the Project Agreement.

There are several reason why these objectives have not been met and probably will not be met by 1987. They are:

1) The delayed arrival of the CDC Technical Officer (June of 1984);

2) The major focus of activities to date being placed on the EPI component to the exclusion of the ORT and malaria components;

3) The delay in developing and having an official (i.e. signed by the Minister) national policy document for the Control of Diarrheal Diseases;

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4) The lack of adequately trained personnel, and availability of health education methods and materials to increase the portion of mothers with knowledge of, access to and utilization of ORT and other appropriate methods (i.e. breastfeeding, proper feeding, good hygiene etc) to prevent dehydration.

With an estimated incidence rate of 4 episodes/child/year and an estimated net mortality rate of 18/1000 for children aged 0-4 per year, it is clear that ORT is a priority problem and an acceleration of activities in this area needs to be done.

The following is a review of what has been accomplished in the ORT component of CCCD.

In December of 1985, the first in series of CCCD training courses on ORT and malaria were held in Bomi/Lower Lofa and Cape Mount Counties (see training section for complete discussion). Since September of 1985, 7,625 (11%) of the 65,000 AID ORS packets received on August 30, 1985 have been distributed. Of those disbursed 1,875 (25%) were distributed in December to Bomi/Lower Lofa and another 1,875 to Cape Mount County. A review of the records in one clinic in Bomi County showed that since the receipt of training and ORS packets, this method of treatment of diarrhea has replaced the method of providing malox and sulfa drugs. I.V.'s and antibiotics are given in the hospitals and some clinics. Although it is difficult to assess the frequency and need for such therapy, the general impression is that this forms the standard method of treatment at the hospital level. This may be due in part to the lack of availability of ORS packets.

While training and retraining of hospital and clinic level personnel in the assessment and appropriate treatment of diarrhea is important, it is highly recommended that the distribution of ORS packets to the Phase I and Phase II counties be implemented. To do this however, the CCCD

Technical Officer and Program Manager need to assist the CCCD county field personnel in estimating their usage rates and therefore the amount of ORS packets they will need to order. It is unclear what criteria the CCCD county personnel use as the basis for their orders.

Prior to CCCD, medical personnel had been taught how to assess and when to treat diarrhea with ORS packets and sugar salt solution. Through discussions with clinic workers in some of the health centers visited it was learned that they have been instructing mothers in the preparation and use of S/S and ORS solution for sometime. No demonstration of actual practices were observed. However , one health worker who prefers giving sugar/salt solution, recited the incorrect receipe. This could be attributed to her being nervous rather than lack of knowledge. The preparation of homemade sugar salt solution is not a simple process. Many variables such as the availability of standardized measures such as coke bottles and sugar cubes, are taken for granted. Technical advise , from the central level, is needed by field personnel as to how to respond to these and other problems they may encounter.

Finally, as stated at the beginning of this section the development and signing of the National Policy for ORT had been delayed. This policy was signed by the Minister on March 12, 1986. While the policy addresses many of the essential strategies recommended by WHO for the control of diarrhea, the lack of including a method to monitor and evaluate the health education strategies that will be developed and used to teach and encourage the public to change their behaviors, is questioned. To decrease the incidence of diarrhea people must not only have access to but utilize the appropriate methods. The role of health education through mass media and direct contact to increase the utilization of ORS or S/S solutions, promote the appropriate hygenic and sanitary practices, and encourage mothers to adopt related health care practices is essential and a stronger focus on this is recommended. However, having said this, the policy for the most part is a good one and it was good to be

informed that this policy is now official. This official document may now encourage those County Health Officers who over rely on I.V.'s and antibiotics, to change their ways and be more amendable to encouraging the use of ORS as the standard method of treatment for diarrhea. The ORT demonstration center, currently under construction in Monrovia, may also provide the needed encouragement to the CHO's to change their method of treatment of cases of diarrhea. Furthermore, if this ORT demonstration and training center is successful, it may be advisable to replicate this center in other counties.

4.5 Malaria

Based on information received from top health professionals of the MH&SW and from CCCD officials a draft National Malaria Control Policy has been written and is awaiting approval by the appropriate MH&SW Committee. It is hoped that the final policy document will soon be signed as this document will form the basis of antimalarial treatment and prophylaxis activities throughout Liberia.

Due to the absence of such a national policy, and considering the hitherto controversial nature of antimalarial chemoprophylaxis in infants and pre-school children activities in the "Malaria Component" of the CCCD Project have lagged far behind program implementation dates.

So far there has been little or no specific inservice training in antimalarial chemoprophylaxis and treatment in the target areas of the project. However evidence obtained from field visits indicated that many health workers had some knowledge about the treatment of presumptive malaria in children with fever. Knowledge of antimalarial chemoprophylaxis in pregnant women was also widespread and fairly adequate among health workers in Phase I and part of Phase II target areas.

To date 30,000 of the 320,000 chloroquine tablets procured by the CCCD Project, have been supplied to Grand Cape Mount and Bomi Counties respectively. UNICEF had also, through the MH&SW, supplied large quantities of chloroquine to most health facilities within the public sector as part of its basic drug supply program.

Additional supplies of chloroquine have been provided by Plan International, as part of their health promotional activities in Bomi and Grand Cape Mount Counties.

Stocks of chloroquine within the CCCD Project (Phase I) areas were therefore considered quite satisfactory during field trips by the Evaluation Team.

4.6 Procurement, Distribution and Quality Control of CCCD Commodities.

GOL expenditure on drugs is very small in comparison with other countries of similar levels of economic development. Other countries typically spend no less than 20 percent and sometimes as much as 50 percent and more of their health recurrent budget on drugs.

The National Medical Supplies Depot which is supposed to procure and manage the distribution of drugs on behalf of GOL has not purchased drugs for the past two years. Normally, such establishments, known in other countries as Central Medical Stores keep records of all imports and carry out quality control tests, and attempt to ensure that a national formulary (where one exists) is adhered to. The national depot in its present state however, would not be able to handle the distribution of drugs and supplies. This situation may be rectified as a major component of AID's PHC project is to strengthen the national drug services ability to procure and distribute drugs. It is anticipated that in two years the drug service will be able to store and distribute vaccines, ORS packets and chloroquine tablets, therefore separate distribution and storage will no longer be needed.

The private sector import of drugs is supposed to be substantially higher than GOL imports. Before the total deterioration of the foreign exchange status of the economy, total imports were estimated to have been between $8 to $10 millions annually.

By recent estimates, major non-private major importers of drugs are:

CHAL	about	$1.3 millions
UNICEF & WHO	about	$0.5 millions

Some of the concessions, missions, and voluntary organizations are also said to be importing. The total volume of this group is hard to estimate.

As far as the coordination of drug imports by donor agencies is concerned, a CCCD donor contribution plan was signed in 1983. This plan however, needs to be reviewed as to its adequacy in light of the GOL's present financial circumstances. Other donors need to be included in this plan and written memorandums of understanding as who will provide, how much of what drugs need to be established.

To date, the CCCD project has provided 37,500 doses of measles vaccine, 65 out of 135,000 planned for packages of ORS packets and 320,000 chloroquine tablets. 7,625 (12%) ORS packets and 30,000 (9%) chloroquine tablets have been distributed. These drugs are sitting in boxes on the floor of a room in the Central EPI/CCCD building. A review of the inventory control sheets and a count of packets indicate that a discrepancy of 1,000 ORS packets exists between the amount of packets recorded as having been distributed and the actual amount on hand. This represents a loss of 13% of the packets that have been distributed. It is unclear how often or whether the Program Manager and Technical Officer review the stocks on hand and compare them with the recorded sheets.

There appears to be no procedure for having the person receiving the supplies sign their name next to the commodities they receive.

From discussions with field personnel who have recently begun implementing the ORT and Malaria components of CCCD, it is evident that they need guidance in determining the amount of drugs they need to order to adequately cover their target populations. As the distribution of supplies and materials in the rural counties is coordinated with the quarterly vaccination sessions, the county personnel must supply a sufficient amount of ORS packets and chloroquine tablets to meet the three month needs of the clinics. Distributing more packets or tablets then can be used may be a danger, as appropriate storage facilities may not be available. This is extremely important as very few clinics are cool enough to ensure a long shelf life.

Improved logistical planning is also needed on the part of the central level. As was previously stated, 12% of 65,000 ORS packets have been distributed in the past six months. Since the packets contain sodium bicarbonate and are not currently being stored in a cool dry place off the floor, the program runs the risk of supplying the clinics with a product that may not be easily dissolved in water. The overstocking and inadequate supervision of drug supplies is especially critical when it comes to vaccines. A check on the amount of vaccines reported to be on hand and actual amount in stock showed large discrepancies (see Table 1). A review of this table shows that with the exception of DPT (which was overrecorded by 13 percent) and BCG, all other vaccines were underreported by 31 to 39 percent.

The discrepancy errors noted in this Table along with the 13 percent discrepancy in ORS records indicate that stronger supervision of stockroom records and actual commodities on hand is needed. Furthermore, from examining the expiration dates, the estimated quarterly distribution reports and the target populations, unless utilization rates increase

TABLE 1

Quantity of Vaccine
Stored at EPI Central Office
On February 25, 1986 and Amount
Distributed Quarterly

Vaccine	Quantity (Doses) observed	Expiration date	Quantity recorded on Feb. 17 1986	Discrepancy (%)	Average Quantity used Quarterly
Polio	20,000	3/27/87			
	118,880	7/87			
	120,000	12/87			
Total	258,880		157,360	39%	35,000
Measles	10,000	8/87			
	64,000	10/87			
	37,500	12/87			
Total	111,500		73,900	44%	25,000
DPT	40,000	11/87			
	14,000	2/88			
Total	54,000		61,740	13%	33,000
BCG	144,000	6/86*	142,200	.01%	32,000
TT	72,000	8/86			32,000
	52,000	11/87			
	163,000	6/88	199,200	31%	

*Date of Expiration soon to be reached

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dramatically, more vaccine is on hand than needs be. Especially critical is the amount of BCG on hand (i.e., 144,000 doses with an expiration date of 6/86). This may indicate that:

1) There is little control over the amount of vaccines the program receives from donors and when they receive it;

2) There is no policy as to when and how much to order (i.e., critical level of need) and amount needed to cover the target population; and

3) There is inadequate supervision of the logistics officer. In fact, there is little agreement between people if indeed there is a logistics officer and not merely a stockroom clerk.

A possible explanation to the current overstocking of vaccine is that the amount that exists at the central level is due to the amounts expected to have been needed for the National Vaccination Week. While, the turnout would have been hard to anticipate, it still appears that the process of estimating supply needs is inadequate, and merits closer attention and supervision.

A review of the cold chain performance was also conducted. At the central level, there are 19 electric refrigerators (G.E.), one kerosene refrigerator, which is under repair, and one freezer, which is also under repair. During the dry season (November - April) electricity is sporadic. This has serious implications for the maintenance of potent vaccine. While there is a generator and an electrician who is in charge of operating the generator, it was noted that this system as described by the EPI/CCCD program personnel does not operate as they state. During the evaluation teams visit, the sporadic flow of electricity allowed the team members to check their system. During an electrical outage, the electrician was visited by a team member who learned that the generator

was leaking water and a replacement part was needed. This part was not bought because the man in charge of petty cash for EPI was not at work and no one had instructed the electrician to contact the CCCD Program Manager and obtain the needed money from her. The following morning the electrician was awaiting the petty cash so as to buy this part. More than 24 hours after the generator problem (which is old and should be replaced) had been discovered, it had not been repaired. It was the impression of this evaluator that this lack of concern about maintaining and starting the generator at any time during the day or night was not an isolated incident.

Another peculiarity with the cold chain process, that was observed at both the central county levels, is the fact that while temperature recording sheets are for the most part being used (exceptions being when they run out of prepared sheets), no temperatures are recorded when the electricity is cut off. The explanation being; 1) instructions have been given not to open the refrigerators when the electricity is off and; 2) it is too dark in the central storage room to do this task. The policy of not opening the refrigerators is a good one, however it results in no recordings of temperatures that might fall below the accepted standards. In one of the county areas where electricity had just been restored after a two day outage the temperature reading was $0^{o}C$ for the freezer and $+10^{o}C$ in the refrigeration section. A closer review and supervision by central and county level personnel of this component of the EPI program is recommended. Outside thermometers should also be provided for all refrigerators used for storing vaccines. Furthermore, owing to the periodicity of electricity at the central level, ice-lined refrigerators should be purchased. The household refrigerators in use are not appropriate and the problem of vaccine efficacy and wastage could turn out to be the downfall of what might otherwise be a successful program.

Another problem with the cold chain that was observed at the county level, was the fact that the RCW-42 refrigerators required constant

attention. To keep the wick buring requires deligency and trained people. It is recommended that training be provided in the care and maintenance of the cold chain to selected people from each county. Also, as the best kerosene that can be bought is in Monrovia, stocking of this at the central level should be done. Much time is wasted by the county EPI/CCCD personnel tracking down kerosene when they come to Monrovia. Their limited time could be better spent in other ways.

In reviewing the quarterly vaccine distribution reports it appears that;

1) More vaccine is requested and distributed than can be used and stored given the conditions of refrigeration at the County levels;

2) No reporting of amount wasted is done;

3) The new reporting forms requesting information on vials taken to and used at the clinics appear to be too difficult for the personnel to complete;

4) The form used at the central level record doses of vaccine distributed, used and on hand while the new forms talk of vials;

5) There is no room for recording expiration dates; and

6) Errors in accounting are prevalent.

Better supervision on the part of the central level is needed, as well as an improved method to assess the quantity of vaccine needed at the county and clinic levels. A monthly inventory of actual vaccine on hand and wasted at the central and county levels needs to be done. Expiration dates should be noted and stock rotated according to those dates. Better accounting from private clinics is also need. A policy

of using vaccines two months after the expiration date was mentioned by the logistics officer in charge of EPI, however with the constant fluctuation in electricity, this policy should be reviewed and abandoned.

The distribution and control of other commodities, (needles, syringes kerosene) needs to be reviewed. According to the distribution spread sheet developed for the National Vaccination Week, more supplies then needed were sent to some counties and less then requested or needed (based on expected coverage estimates) were sent to others. The explanation given was that some counties were so remote that they wanted to provide them with a sufficient supply for the follow-up activities. This policy resulted in shortages in some areas of the county. The major shortage was in needles. This has created problems in the proper administration of vaccine. Again, if a criterion of a critical level was established this might avoid shortages in supplies. This holds true for temperature recording charts, reports forms, etc.

4.7 Training:

Training in EPI, ORT and malaria has been an on-going aspect of the MH&SW In-Service training staff since 1980. Two editions of an EPI manual and one for ORT have been developed and produced. Since the inception of CCCD in 1984, a sub-committee for training was formed and consists of the In-service Education Committee. The basic goals as defined in the September 21, 1984 meeting of this sub-committee were:

1) To assist training needs and evaluate training programs;

2) To develop a training strategy for the CCCD project;

3) To develop a work plan for training material; and

4) To evaluate the result of training materials pertinent to the three CCCD activities and advise the technical committee on training needs. This committee has since been disbanded, but may be reactivated.

The courses that have been given under the auspices of the CCCD project are listed in Table 2. It should be noted that a three day training course was given to 900 health personnel in preparation for the National Vaccination Week.

Training materials used for the first mid-level mangers (MLM) course were taken from the generic CDC/WHO MLM training modules. Some of these materials were adapted by the CDC/Atlanta training officer during her STC in June of 1985. With her expert assistance, a very successful three day workshop was held in Cape Mount in June of 1985. A similar course was given in July of 1985 in Bomi/Lower Lofa County (see Appendix 8 for course agenda). Plans to adapt the MLM materials by the IED and EPI/CCCD personnel in Cape Mount and Bomi/Lower Lofa Counties have been made. This process will begin in March of 1986 and the materials will be field tested during the training of the personnel from the Phase II counties.

In December of 1985, a two day course on malaria, ORT and fee for service was presented in Bomi and Cape Mount. This course was developed by IED and Peace Corps personnel and their counterparts. Support and technical assistance from CCCD central level personnel was noted to be lacking. While it is understood that the technical personnel at the central level were deeply involved in preparing for the National Vaccination Week, it is still regretable that little if any assistance and critiques were offered prior to the presentation of this workshop (see Appendix 8 for program).

With the exception of the courses conducted in Bomi, no records appear to exist of the evaluation of these courses.

Table 2

Courses and Personnel Trained by CCCD

Dates	Place	Course	Materials	Persons	Facilitators
Feb. 12- Mar. 1, 1985	Central Level	TOT/MLM	CCCD/WHO Training manual	3 PCVS 5HCN 3 staff from IED	A. Kroma-IED M. Korkpor CCCD W. Holder -CCCD J. Thornton -TO 2 STC consultants
June 150 17, 1985	Cape Mount	Training of clinic level health personnel	CCCD/WHO training manual	28 clinic staff EPI	P. Boyd Bill Davis D. Massaquoi Laurie Ackerman
July 10 11, 1985	Bomi	Training of clinic personnel	CCCD/ EPI Manual	28 clinic personnel i.e. 5 PAs 1 RN 3 P.Ns 6 NAS 1 TBA 1 Vaccinator 1 Lab. technician 2 health inspectors 8 volunteer worker	James Stevens Mary Momolou Laurie Ackerman David Boyd Norris David
October 1985	Cape Mount	Training Hospital personnel	CCCD/EPI training manual	15 hospital staff	David Boyd Bill Davis
October 1985	Bomi	1 day training health records			Mary-Momolu Laurie Ackerman
December 1985	Cape Mount	ORT/ Malaria Workshop and fee for service	Adapted CCCD training materials	28 personnel from Cape Mount 28 from Bomi	Mary Momolou Laurie Ackerman David Boyd Bill Davis Dr. B. Madut
July- Sept. 85	All counties	3 days training of clinical and hospital in each county	CCCD material	900-1,000 people	IED and EPI/CCCD staff

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With respect to the training plans for the remainder of the project, the "1986 and Life of Project Work Plans" (See Appendix 9) need to be revised to reflect the delays in the program. As it currently reads, many programs are beginning before the staff have been trained. As previously stated, training is an important element of this project and the lack of sufficient personnel to plan, adapt and facilitate these courses may be hindering the projects advancement. Better utilization of the In-service Education Department is encouraged. The Acting Director has attended a TOT course in Lesotho and is extremely interested in this program. He also has much experience in this field. While awaiting the formation of the Information, Education, Communication Divison (IEC) the In-Service Education division should be officially given the responsibility and means to develop and implement this aspect of the CCCD project.

Adaptation of these training materials should also involve the personnel in the Health Education Division. As CCCD is only one aspect of the IED and HED's work, it may be necessary to consider hiring a host country national as a STC to coordinate and supervise the CCCD activities with these two divisions. This may be the only way to accomplish the activities detailed in the project plans. A detailed and precise scope of work delineating the STC's activities should be developed.

One final comment on training. Close attention needs to be paid to the training of CHO'S by the project management. Unless the CHO's have a better understanding of the technical and managerial aspects of the CCCD program, many of the recommendations and technical changes that this program and the government are recommending may not be follwed. It is good to train clinic workers and mid-level staff, but the authority to enforce policy and provide knowledgeable supervision rests with the CHO's. Therefore, a course conducted by the Project Manager and top-level health personnel should be provided to the CHO's in all 13

counties. Any changes in program plans and the medical reasons for these changes should be disseminated to the CHO's when they occur by their supervisors. It is highly recommended that the activities as stated in the "Life of Project" and "1986 Work Plan" concerning this top-level training be carried out as soon as possible. Visits to the field have shown that this is important.

4.8 Health Education

In spite of numerous consultancies, this aspect of the program is also lagging behind. Numerous reports by consultants have attempted to address the process of how to revitalize and strengthen the Health Education Division and how to coordinate its activities with those of other projects. To date, it appears that none of the recommendations have been implemented. Also the recommendations from the 1984 evaluation team have not for the most part been completed. It is apparent much assistance, both financial and personnel, is vitally need. Due to lack of funds and perhaps recognition, the Health Education Department is moribund. Short-term consultancies, while needed and invaluable to the success of the National Vaccination Week will not be sufficient to provide the needed long-term input in this area. If the CCCD project is to reach its goal of decreasing the morbidity and mortality of the target diseases by any percent, it needs to create an awareness on the part of the community that preventive health services exit and to motivate the community to avail themselves of these services. This can only be done through health education at the county and village level and through the use of mass media. The mass education campaign that was mounted during the National Vaccination Week had an effect. However, very few of the posters made, messages broadcast can not be found or heard.

A person to develop and implement a health education strategy for CCCD and to coordinate with HED, IED, UNICEF, and other donor agencies is needed to fill the gap until such time that the division of IEC is

created. One graphic artist assigned to CCCD and virtually working alone is not enough.

The only recommendation that can be made is the same that was made for training. That is, a short term (10 month) host country national with a specific and narrowly defind scope of work be hired to plan and coordinate the CCCD activities with those of IED, HED and relevant donor agencies.

If this is not done this vital aspect of the program will never be fully developed within the time frame of the life of the project.

4.9 Disease Surveillance and HIS Activities

Per the recommendations of the 1984 Evaluation team little has been done in the area of HIS activities. The policy and systems that existed at the time of the 1984 report still exist.

The results of the MUHS survey, which was conducted in the fall of 1984 and verified in January of 1985, have not been transmitted to the GOL by CDC/Atlanta. This, and the fact that the the EPI component has only been operational since August of 1985, does not permit any discussion of the impact this program is having on the targeted diseases. Short-term consultancies are planned and have been conducted by the Regional Epidemiologist in Abidjan, to address this aspect of the program. However progress in this area is well behind the schedule as stated in the 1986 workplan. The evaluation of this system will need to be done by the Internal Evaluation team in 1987.

Comments on the current reporting and report keeping system have been made elsewhere in this report. (section 4.3) The statement made there, as to the need to simplify the tally sheets and field test all forms prior to use can only be reiterated.

In order to determine whether this project should be continued beyond its PACD an evaluation of its impact on the reduction of disease morbidity and mortality will have to be made. In order to do this a surveillance system will have to be in place and operating in sentinal sites in the Phase I areas by the end of 1986 and possibly in the Phase II counties also. Therefore, it is recommended that the MH&SW, CCCD Program Manager, Technical Officer and EPI staff select their sentinal sites in the Phase I counties, develop and field test reporting forms and monitor and revise the system by the end of 1986. In conjunction with this, and through the help of the CCCD Regional Epidemiologist an HIS plan should be developed and approved by the appropriate MH&SW personnel by July 1986.

While it appears that a heavy emphasis has been placed on computer assisted data analysis programs, it is highly recommended that the development of any such data analysis programs be delayed until the sentinal surveillance system is in place and has been monitored by the CCCD central level personnel for at least six months.

5.0 Financing of the CCCD Project

5.1 Recent Trends in the Liberian Economy

In the sixties and early seventies the Liberian economy grew at remarkably high rates of 6% and 4% per annum respectively. In those days, production of its major exports, iron ore and rubber, were increasing and the terms of trade were favorable. Following the sharp rise in the price of oil, its major import, the cost of production of its exports escalated. Concurrently, demand for its exports declined as a result of the recession in the economies of its major trading partners. Thus, during the late seventies its balance of payments deteriorated markedly and its economic growth rate fell to less than 1% per annum (World Bank, 1982). The situation was further exacerbated by two other developments. Expansion of inefficient public sector enterprises in the late seventies over-strained government finances, and the 1980 revolution diminished private sector confidence in the economy. The result was a steady decline in both public and private savings and investments. During the period 1980-84 the Gross Domestic Product (GDP) at current factor cost declined by 1.25% per annum. As the population continued to grow at an estimated 3.3% per annum the decline in nominal per capita income was even more dramatic (Table 3).

The public financial consequences of the above developments have been a steady decline in taxable income. Beginning in FY 81/82, the GOL's tax and non-tax revenues have been declining at a steady rate, though substantial reductions in expenditure have been made the budgetary deficits smaller they still remain high (Table 4).

The large capital expenditures of the late seventies and some imprudent fiscal measures taken immediately after the revolution (e.g., raising the minimum wage of government employees to $200 per month) resulted in huge accumulations of domestic and foreign public debts. By mid-1984 domestic

Table 3
Gross Domestic Product at Current Factor Cost ($ millions)

	1980	1981	1982	1983	1984
Total GDP ($M)	1001	968	977	940	951
Monetary Sector ($M)	801	754	756	714	716
Traditional Sector ($M)	200	214	221	226	235
Population (,000)		1972	2038	2104	2182
GDP per capita ($)		491	479	447	436
Growth Rates					
Total GDP		-3.3	0.9	-3.8	1.2
Monetary Sector		-5.9	0.3	-5.6	0.3
Traditional Sector		7.0	3.3	2.3	4.0
Population		3.3	3.3	3.3	3.3
GDP per capita			-2.4	6.7	-2.5

Sources: Stanley, E. and Mark Gallager, "An Analytical Description of the Liberian Economy", USAID/Liberia, Sept. 1, 1985.
Ministry of Planning and Economic Development, "Statistical Bulletin of Liberia", Jan, 1986.

Table 4
Revenue and Expenditure of the Government of Liberia
(in Current $ Millions)

	1981	1982	1983	1984
Revenues	223	237	232	201
Expenditures	303	318	276	242
Surplus (Deficit)	(80)	(81)	(44)	(41)

Source: MPEA, "Statistical Bulletin of Liberia", January 1986.

public debit was about $353 million and foreign public debit had risen to $928 million. Arrears to domestic vendors now amount to some $60 million, and arrears in external debit payment were about $60 million as of mid-1985. External debt service now constitutes an estimated 30% of export of goods and services and 66% of tax revenue (Stanley and Gallagher, 1985).

Beginning in FY 80/81 the GOL took a series of fiscal measures in order to improve its public finance position. Some of the measures taken were the following:

FY 80/81	Every government employee was required to purchase government bonds worth 2 months of salary.
FY 81/82	A progressive "Reconstruction Tax" of 1% to 8% of salary was imposed on all wage-earners.
FY 82/83	Salaries of government employees were reduced progressively by 16% to 25%.
FY 84/85	Salaries of government employees were cut by 10% across the board. Government employees were required to retire after 25 years of service or 65 years of age, whichever comes first. Those certified as still "productive" were exempted.
FY 85/86	To minimize "redundancy" government employees considered "unproductive" were laid off. This scheme is said to have reduced the wage bill by some $2.5 million per month.

Despite these measures the GOL"S budgetary problems continue to worsen. The result has been further cuts in recurrent expenditures and the virtual elimination of development expenditures (Table 5). In the last year and a half the GOL has been in arrears in its payment of salaries by an average of three months.

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Table 5.
Recurrent and Development Expenditures of the GOL and the MHSW
(in current $,000)

	79/80	80/81	81/82	82/83	83/84	84/85
Total Recurrent						
1. GOL	179700	232800	300600	265300	170182	139906
2. MHSW	21358	24163	27803	24047	20855	12138
2a. MHSW AS % of GOL	12	10	9	9	12	9
Salaries						
3. GOL	92837	141437	157320	136915	117862	118106
4. MHSW	11697	15150	16533	16040	10765	10096
AS % OF RECURRENT						
3a. GOL	52	61	52	52	69	84
4a. MHSW	55	63	59	67	52	83
Development Expenditure from GOL Sources						
5. GOL	151200	36960	56500	53000	35200	37500
6. MHSW	15100	2300	1500	2500	1000	500
6a. MHSW as % of GOL	10	6	3	5	3	1

Source: MOF, Bureau of General Accounting, Expenditure Reports, and MPEA

The MHSW is among the agencies most affected by the budgetary crunch. During the period 1979/80 to 1984/85 MHSW's share of the GOL recurrent budget dropped from 12% to 9% while its share of the development budget fell from 10% in FY 79/80 to 1% in 84/85. No purchase of drugs has been made since FY 83/84.

The deterioration of the budgetary situation is further illustrated by the rapid growth of the share of salaries of the total recurrent budget. Despite its rapid decline in absolute terms, in particular since FY81/82, the share of salaries grew from 55% of the total GOL recurrent budget in FY79/80 to 84% in FY 84/85. WIthin the budget of MHSW the shaRe of salaries also grew from 55% in FY79/80 to 83% in FY84/85.

Recognizing the rapid decline of the GOL's capacity to maintain services and the danger this poses to the sutainability of development project outputs, USAID/Liberia is considering changes in its development assistance strategy. The contemplated change will shift emphasis from institution building and strengthening to maintenance until such a time that the GOL is strong enough to cover costs of service delivery. This would mean selective financing of recurrent costs. Such radical deviation from traditional practices of development assistance may be the only means of ensuring the survival of the very institutions that were targets of strengthening. As child survival is deemed a high priority health service both by USAID and the GOL, recurrent cost financing of the CCCD project activities deserves to be given urgent attention.

5.2 Sources of Funding for Current Project Activity

Sources of funding for the CCCD/Liberia project include:

1. The USAID bilateral grant;
2. The CCCD regional project;

3. The Participatory Agency Support Agreement (PASA) with the Centers for Disease Control (CDC);
4. A grant agreement with WHO/AFRO;
5. A PASA with US Peace Corps;
6. AID/Washington;
7. Other Donors; and
8. The bilateral contributions of GOL.

5.2.1 USAID Bilateral Funds

The USAID bilateral contribution to the project amounts to $655,000 plus an additional $175,000 worth of in-kind contribution of vaccines. Total budgeted GOL contribution was $217,800. The December 1984 internal evaluation of the project amended the budget in order to reflect delays in implementation and the changes it recommended. The revised budget was 67% of the original budget. These budgets and disbursements made up to December 31, 1985 are given in Table 6.

Table 6:
The Original and Revised Budgets and Expenditure Up to Dec 31, 1985

	USAID YEAR I	USAID YEAR II	USAID YEAR III	GOL YEAR III	USAID YEAR IV	GOL YEAR IV
Original Budget*	229300	198100	132000	60500	95600	157300
Revised Budget(1)	78053	190575	99100	36600	74100	112300
Disbursed (2)	20555	129951	63386			
Balance of the Original Budget	208745	68149	68614	60500	95600	157300
Cumm Disbursement	20555	150506	213892			
Cumm Balance	208745	276894	345508	60500	419608	217800

* In-kind contributions of USAID not included
(1) The revised budget of the Evaluation Report, Dec. 1984
(2) USAID/Liberia project financial status reports

Due to delays in project implementation, expenditures to date are behind schedule. Total disbursement as of December 31, 1985 was $213,892. This amount constitutes 33% of the original budget or 49% of the revised budget. At the current rate of expenditure the balance of the original budget will be sufficient to finance project activities well beyond the planned project activities completion date (PACD) of July 1987. Thus, given that the project is not likely to achieve its original objectives in the planned four years of operation, and as resources are available, it is recommended that it be extended for a fifth year without additional USAID bilateral funding. Accordingly, the balance of the original budget should be spread over the next three years as indicated in Table 7 below.

Table 7: Suggested Budget of Five Years of Project Life.

	ACTUAL YEAR I	ACTUAL YEAR II	PLANNED YEAR III	PLANNED YEAR IV	PLANNED YEAR V	TOTAL
USAID	20,555	129,951	241,500	161,000	101,994	655,000
GOL			36,300	72,600	108,900	217,800
GOL AS % PF TOTAL			13	31	52	25

In this suggested budget while the total contributions of both USAID and GOL remain the same, by distributing them over five years the yearly contribution of GOL is reduced to a level that would be affordable. GOL contributions are planned to double yearly starting with $36,300 in Year 3. The projected GOL contribution could be generated by the sale of "Road to Health" vaccination cards, and revenues generated by the recently approved fee-for-service scheme.

5.2.2 The CCCD Regional Project

The Regional Project provides short-term technical assistance in training, health information systems, health education, epidemiology,

operations research and management techniques. The PROAG envisaged that a total of six person-months of short-term consultancy will be made available by the Regional Project at no cost to the CCCD/Liberia project. This estimate has already been exceeded by a large percentage. From January 1984 to February 1986 24 short-term consultancies were used. The total number of person-days of these consultancies amounted to 449 (=19 person months). Some of the consultancies were carried out for the benefit of both the Regional Project and CCCD/Liberia. Nonetheless, the number of short-term consultancies is excessive and demanding on the time of project staff. Thus, as suggested in the 1984 evaluation report, there is a need to limit the number of future consultancies by making them "demand-driven" as opposed to "supply originated".

5.2.3 PASA WITH CDC/ATLANTA

Under a PASA with CDC/Atlanta the project is provided with a resident Technical Officer. This PASA covers the salary and benefits of the Technical Officer and provides a sub-allocation which covers costs associated with his activities in Liberia. Expenditures incurred to date against the CDC suballocation, excluding the salary of the Technical Officer, are itemized in Table 8.

Table 8, Expenditures of the CCCO Technical Officer Suballocation

FY 84	97,000
FY 85	111,896
FY 86 (first quarter only)	20,570
TOTAL	229,466

5.2.4 THE GRANT AGREEMENT WITH WHO/AFRO

This grant provides technical assistance in the development of health information systems, and training courses in epidemiology, EPI, oral rehydration therapy, malaria control, and courses in supervision of disease control. Data on inputs used form this source was not available at the time of the is evaluation.

5.2.5 PEACE CORPS

The PROAG projected that a total of six PCV's would be working in the CCCD project. Four of these were to start in year 2 and two in year 3. The project now has six PCV's; and three more are expected to join the project in year 4. Budgeted and actual PCV inputs in the project are given in the following table.

Table 9: Peace Corps Volunteers in CCCD Project.

	YEAR I	YEAR II	YEAR III	YEAR IV	TOTAL
Person-Years					
Budgeted		4	6	2	12
Actual	1	5	4.5	1.25	
Cost					
Budgeted		62900	101900	36700	201500
Actual	18000	90000	81000	22500	211500

5.2.6 AID/Washington

AID/WASHINGTON provides measles vaccines through a contract with a US manufacturer. The vaccines constitute the in-kind bilateral USAID contribution to the project and have an estimated cost of $175,000.

USAID/Washington also provides funds for specific special studies on cost recovery, alternative financing, cost effectiveness, and applied or operations research in areas related to CCCD activities. Each study or protocol is funded up to $10,000. To date at least one study on Fee-For-Service has been financed from this source.

5.2.7 OTHER DONORS

UNICEF and WHO have made substantial contributions to the support of EPI, oral rehydration, malaria control activities of the MHSW (Table 10). During 1984 and 1985 UNICEF has provided $370,219 for the support of EPI, ORT, and malaria control activities. During the same period WHO has contributed $129,000 in commodities, technical assistance and local cost support. These contributions have significantly augmented the country's ability to combat childhood diseases.

During 1984 and 1985 the assistance obtained from WHO and UNICEF amounted to $498,319. This figure is already 53% higher than the total expected from external donors over the course of the project life.

UNICEF has an understanding with USAID on the coordination of inputs to the CCCD related activities of the MHSW. In a memorandum of understanding dated August 23, 1983, it was agreed that UNICEF would provide all vaccines, except measles, support training activities concerned with EPI and ORT through the In-Service Education Division, and CCCD related local training.

The Rotary Club has pledged to donate polio vaccine until the disease is completely eradicated. Accordingly, it provided the quantities used during the nationwide vaccination campaign held in January of this year and promises to supply the needs for future vaccination activities.

Table 10: Contributions by UNICEF and WHO.

ITEMS	1984		1985		1986 projected	
	UNICEF	WHO	UNICEF	WHO	UNICEF	WHO
EPI RELATED						
Vaccines	57,356		31,395			
Syringes & Needles			134,015			
Equipment & supplies	7,200	24,300	30,073	24,300		18,000
Vehicle			7,200			24,000
Motorcycles & Helmets			7,560			
Local Costs (cash)	3,000	9,750	60,000	9,750	10,850	
ORT RELATED						
Technical Asst		15,000		15,000		
Sachets	2,300		3,450			
Equipment & supplies						4,800
Fellowships						6,000
IEC	6,000		19,000			
Local costs		15,000		15,000		2,500
MALARIA RELATED						
67,000 chloro. tab	835		835		XX	
Equipment & supplies for vector control						12,000
TOTAL	76,761	64,050	293,528	64,050	10,850	67,300

SOURCES: UNICEF/Liberia; and WHO/Liberia

Notes: Estimated freight charges of 15% for vaccines, needles & syringes, ORS, and chloroquine, and 20% for equipment & supplies, vehicles, and motorcycles, have been added to values obtained from UNICEF and WHO.

XX - Estimates not available for UNICEF

The Christian Health Association of Liberia (CHAL) is very active in bulk purchasing of drugs and medical supplies for its member organizations. It also prepares and distributes health education leaflets on immunizations and ORT written in local vernaculars. Given the weaknesses of the government drug procurement and distribution system, CHAL presents a better alternative for the commercial procurement and distribution of ORS and malaria prophylaxis.

5.2.8 GOL CONTRIBUTIONS

According to the CCCD/Liberia PROAG, the GOL is expected to make $5,355,800 worth of in-kind contributions, and $217,800 worth of contributions in commodities. The in-kind portion of the GOL's contribution was computed by taking certain proportions of the budgets of departments and units of the MHSW that were expected to actively participate in the project activities. Furthermore the GOL was expected to absorb 67% of the project cost by the fourth year.

The value of GOL's in-kind contribution to date is very difficult to assess since actual expenditures data disaggregated by the departments and units of the MHSW identified in the PROAG is hard to find. Delays in project implementation further complicate any attempt to compute the actual in-kind contributions of GOL. However, since budgetary cuts were made across the entire spectrum of MHSW activities, the fact that the GOL has not lived up to the terms of th PROAG is incontestable.

The GOL's contribution of commodities was programmed to begin during the third year of the project life. Given past trends and reasonable estimates of future fiscal developments, the required funds are less likely to be available. However, if serious efforts are made to implement the Fee-For-Service scheme and to collect revenue from the sale of "Road to Health" vaccination cards it would be quite possible to generate funds sufficient to cover a significant portion of the GOL's

share of the project cost. Nevertheless, for the reasons presented earlier in the brief discussion of conditions of the national economy and public finance, the GOL will not be able to cover 67% of the project cost by the fourth year. Thus, it would be reasonable to extend the project life by one year without additional funding and spread GOL's share over three years instead of the planned two years.

5.3 THE LIBERIAN FEE-FOR SERVICE SCHEME

The central objective of the CCCD project is to strengthen the institutional capability of the Ministry of Health and Social Welfare, (MHSW), to deliver basic health services for childhood immunization, treatment of acute diarrheal diseases in children, treatment of malaria in children, and malaria prophylaxis of pregnant women. Conditions for disbursement of funds included:

1. MHSW will provide to USAID evidence of adjusted registration fees to be applied at hospitals, health centers, and clinics in the project areas according to the following schedule:

Date	Areas Where Implemented
August 84	Cape Mount, Lower Lofa, Bomi Hills
February 85	Grand Bassa, Montserrado
March 86	Bong, Upper Lofa, Grand Gedeh, Sinoe

   The revenue generated is to be retained in a revolving fund by MHSW for financing of additional project vaccines, needles and syringes , ORS, and chloroquine (or other anti-malarial medications).

2. The plan to implement the adjusted registration fee system was to be provided to USAID by January 1984.

3. During the fourth year of the project, GOL will provide 67% of recurrent costs required to finance vaccines and related supplies, anti-malarials, and diarrhea medications, as well as vehicle operations and maintenance.

4. MHSW will ensure that the adjusted fee system developed under this project will conform to that which will be developed and implemented in other countries by the South Eastern Region Primary Health Care (SER-PHC) project.

Serious efforts to meet the conditions of the PROAG summarized above did not begin until the establishment of the Fee-For-Service Working Group (FFSWG) in November 1984, approximately 11 months past due the date set for MHSW to develop and implement a revised Fee-For-Service ((FFS) system. After at least a dozen meetings, the FFSWG developed a revised FFS schedule that was endorsed by the Primary Health Care Coordinating Committee in March 1985.

The revised FFS schedule and its objectives were communicated to County Health Officers in a workshop held in April 1985. As practically every county had not received its quarterly allotment of the budget from the Ministry of Finance (MOF) in the preceding 6 months, some CHO's started to implement the revised FFS schedule almost immediately with the intention of generating revenues to finance their recurrent expenditures.

Important features of the revised FFS schedule (including an amendment suggested by a World Bank mission that visited Liberia in May 1985) were as follows:

a. Who shall pay? All recipients of curative care.

b. Types of fees: Registration and revisit fees. Inclusive fees for certain services such as normal deliveries.

c. The out-patient FFS schedule:

Type of fees	Age Group	For treatment received at: HC and Clinics	Hospitals
Registration:	Under 5	$0.25	$0.25
	Above 5	$1.00	$2.00
Revisit:	Under 5	$0.25	$0.25
	Above 5	$0.50	$1.00

d. The in-patient FFS schedule was to be developed by the Planning Department of MHSW.

e. Additional charges: Drug Revolving Funds (DRF) may charge per course of treatment with:

Low cost drugs	$0.25
Medium cost drugs	$0.30
High cost drugs	$1.00

Policy includes a listing of drugs by low, medium, and high cost categories. Drugs not found in the list may be treated as low cost if their price is $0.10-$0.30, and high cost if their price is above $0.30.

Injections	$0.25

f.	Exemptions:	Leprosy and tuberculosis cases. No additional charges after the registration fee for preventive services such as immunizations. No additional registration fee for cases referred from lower to higher level facilities.
g.	Financial Management	Until decentralized county level financial management capacities are developed revenues generated by FFS will continue to be deposited in the Treasury, or in a special account established by health projects authorized by the GOL.

MHSW officials indicated that this revised out-patient FFS schedule is now being applied in most parts of the country including CCCD project counties. Facilities with in-patient services apply the old in-patient fee schedule. Some are said to have revised both the new FFS schedule and the old in-patient fee schedule according to their needs and their judgments of what would be acceptable to the population of their catchement areas. This indeed was the observation made during three days of field visits.

Per the recommendations of the December 1984 internal evaluation, the schedule for implementing the FFS was revised as follows:

Date	Areas where project activities would be implemented
April 85	Bomi, Lower Lofa, Cape Mount
December 85	Grand Bassa, Montserrado
August 86	Upper Lofa, Bong, Grand Gedeh, Sinoe

Progress on implementing FFS has been very slow and far behind the revised schedule has been developed. Some four months later, in August 1985, MHSW gave formal notification to USAID of its adoption of the policy. The revised FFS policy and permission for MHSW to retain the revenue generated was approved by the head of state in September 1985. In the Fall of 1985 this policy was communicated to CHO's form all counties. Th MOF gave its approval for MHSW to retain the revenue in December of 1985. Thus, the conditions precedent regarding this issue are now satisfied. But implementation of the policy is yet to be done.

As a result of poor inter-agency communications and lack of effort in implementing the scheme, agents of the MOF in some counties are still collecting revenues generated by health care facilities. MHSW should therefore be urged to clear this confusion with MOF agents and expedite the implementation of the scheme.

5.3.1 EVALUATION OF THE REVISED FEE FOR SERVICE SCHEDULE

There are at least four basic criteria of evaluation of a revenue generating scheme. They are; (a) ease of management and administration of the scheme; (b) economic and financial efficiency; (c) equity; and (d) impact on utilization and provision of health services.

The schedule developed is simple and easy to understand even by the minimally trained but literate health worker. Exemptions, which often complicate administrative aspects and open-up loop-holes which become the source of corrupt activities are kept to a minimum. Thus, other things being equal, it will be easy to administer and manage. Nonetheless, accounting and management principles and guidelines of equal simplicity need to be developed and communicated to the relevant county personnel.

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A manual of financial management for decentralized county administration has been recently developed for the SERPHC. SERPHC should be urged to review the document, revise it as needed, and disseminate it as expeditiously as possible.

One good indicator of financial efficiency is the net revenue (yield = gross revenue less cost of collection). Although the available information on revenue collection is very limited, simplicity of the revised schedule would suggest that collection and administrative costs would be relatively low. Additional labor is not likely to be needed to handle fee collection at any of the levels of the health care facility where it would be implemented. Once again, proper procedures of accounting and management would have to be developed and implemented in order to realize its full potential yield.

The economic efficiency of a financing scheme can be measured by its impact on efficient allocation of resources as well as its impact on the ultimate objective of the health system. One aspect of economic efficiency of FFS would depend on its ability to equate the fee paid by the consumer (marginal private cost) to the economic cost of delivery of the service consumed (marginal social cost). Cost recovery means essentially that. For reasons that are political and socio-cultural as much as they are economic in nature, this level of efficiency is hardly achievable by public health systems. A practical goal would therefore be recovery of portions of the costs of delivery that are less likely to be covered by traditional sources of funds for health care. In the case of Liberia the FFS and DRF's, if properly implemented, have the potential of recovering significant portions of the recurrent cost of health care delivery other than salaries. An important factor in cost recovery is case-load or utilization (demand). Facilities which have low case-loads have very little chance of recovering significant amounts of their recurrent costs. This indeed was confirmed by observations made during field visits of project counties.

There are some exceptions to the above optimistic outlook of recovering significant portions of recurrent costs of delivery. At the present level of fees it would be difficult to recover costs of preventive services for which demand is low and input prices are high. Thus, based on the current FFS schedule it will not be possible to recover more than a small fraction of the recurrent costs of immunization. Some rough estimates of case per dose of vaccine and per fully immunized child based on estimated costs and number immunized during the January 1986 vaccination campaign indicate that except for measles whose cost per case is about $0.48 to $1.06, all other vaccines cost far beyond the $0.25 fee for the "Road to Health" vaccination card of the $1.00 registration fee would cover. Estimated cost per fully immunized child could be as high as $40.65 to $94.84 depending on coverage (Appendix 9). Needless to say, there are clear economies of scale in the delivery of vaccinations. The cost of regular delivery of PHC using low cost VHW's also may not be possible to recover with the current FFS schedule. The study of the "Village Health Worker Program in Nimba County", presented in Appendix 10 indicates that the truly variable cost per case of PHC delivery could be as high as $5.05. Thus, expectations regarding recovery of recurrent costs by means of the current FFS should not be set high.

FFS is almost by definition an inequitable mode of financing. Inequities may be corrected or at least moderated by allowing certain exemptions and some discriminatory pricing. The revised FFS schedule has both. At least two groups of the chronically ill, leprosy and tuberculosis cases, are exempt. Also, children under five pay substantially lower fees.

FFS has a potential negative impact on utilization to the extent that some may be unable and/or unwilling to pay. Among other things, this will depend on the affordability of the fees charged, felt-need, perceived quality of service, and availability of alternative sources of care. Some of these points are discussed below in the section on Ability

and Willingness to Pay. More than likely there will be some positive impact on provision of care since the revenues generated are intended for improvement of health care resources and hence better health care delivery.

Steps taken by the MHSW in establishing the FFS and DRF schemes are positive moves in the right direction towards the search for reliable sources of financing health care. The Ministry should be encouraged and provided assistance to strengthen the management and application of the scheme and to explore other options as well. Other options that merit consideration include:

a. Production-based Payment;
b. Community Labor;
c. Individual Labor;
d. Income Generating Schemes;
e. Personal Pre-payment;
f. Capitation; and
g. Ad hoc schemes such as lotteries, and charities.

5.3.2 ABILITY AND WILLINGNESS TO PAY

Ability and willingness to pay for services provided at government facilities is crucial to the success of both FFS and DRF. A report on an operations research study on community financing in Upper Lofa county indicates that rural populations are more willing to raise funds to purchase seed stocks for DRF than paying FFS. (3) Thus, this relatively strong willingness to pay for drugs (which are essentially measureable commodities) should be exploited to the maximum level possible.

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(3) Cole, A.K., an S. Samuka, "Community Financing in Kolahun District," draft report, Feb 28, 1986, Monrovia, Liberia

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Given that Liberia per capita income is about $450 - 500, the current FFS is well within affordable range. Average per capita private expenditure on health care in countries of similar level of economic development is usually around 3% of income. Accordingly, the average Liberian could afford to spend about $12 - 15 per annum on private health care. Based on the WHO recommended 2 visits per capita, and further assuming that the cost of each visit inclusive of drugs is about $2.50, the resulting annual expenditure of $5 per capita would be affordable by practically every Liberian except the indigent.

Willingness to pay is unfortunately a complex subject. Among other things, it depends on felt need, perceived value of service, and alternative sources of care. A strong health education program would therefore be required to demonstrate the value of the service provided and the need for certain types of care, in particular preventive services, in order to enhanced willingness to pay.

5.4 FIELD OBSERVATIONS

Over a period of three days, three hospitals, three clinics, and one community health department were visited. The facilities are located in three of the CCCD counties Cape Mount, Marghibi, and Bomi Hills. Observations made during these visits are summarized below:

Hospitals Visited		Average Monthly Number of		Average Monthly revenue	
Name	Location	out patients	in-patients	FFS	DRF
St. Timothy	Cape Mount	102	30	58	148
Rennie	Marghibi	436	108	740	NONE
Bomi Hills	Bomi Hill	1500	NA	2776	NA

Utilization, as demonstrated by the number of out-patients and in-patients varies, a great deal. Factors responsible for the wide variation appear to be population of the catchment area, quality of service, and availability of alternative financing. Those located in areas where there are some development projects which are willing to pay for the care of their employees have high attendance rates and generate substantial amounts of revenue.

All of the three facilities have FFS. Their out-patient fees are based on the revised FFS. Their in-patient fees vary, but appear to be based on the old schedule. DRF's are operating in Bomi Hills and St. Timothy.

Management of revenues collected varies. Rennie still remits its revenue to the local agent of the MOF. The other two retain their revenues and apply them to their recurrent expenditure needs.

Utilization of clinic services is invariably low. Here again, size of population and perceived quality of service may be important factors. At the current level of clinic attendance chances of generating revenues to cover recurrent costs are very low. Drug needs, however, will be met by DRF's.

Some rough estimates of the potential revenue collectible from FFS can be made basedon some assumptions. Based on field observations of hospitals and clinics which ranged from very low case-load to relatively high case-load facilities, the following assumptions are made:

a.	Average case-load		
	District Hospital	Out-patients	680
		In-patients	70
	Clinic	Out-patients	50
b.	50% of all patients and children under 5 years of age.		
c.	50% are revisits.		
d.	Average length of in-patient days=		5
e	25% of all patients are indigents.		

Potential Monthly Revenue would then be:

Hospitals	Out-patient	840
	In-patient*	919
	Total monthly	1759
Clinics	Out-patient	19

*In-patient fees are not standardized. It is assumed that adults would be charged on the average $5/day and under-5's $2/day.

If the above assumptions hold neither hospitals nor clinics are likely to generate sufficient revenues to cover more than modest proportions of recurrent costs excluding salaries. It should be noted, however, that the actual revenue currently being collected is about two-thirds of what was expected (i.e. $1,190/month) if you average the FFS revenue collected at the three hospitals listed on page 67. One should keep in mind that district hospitals incur costs of in-patient feeding in addition to the cost of treatment, and some of the clinics have cold chain equipment which has relatively high demands on recurrent cost. The revenues generated and the costs incurred should, therefore, be monitored closely and adjustments be made to the FFS schedule as needed.

Each facility visited, hospital and clinic alike, was deficient in data collection. Not one had a consistent data set on utilization, expenditure, or revenues generated even for the previous six months; each has its own style of data collection.

Lack of facility accountability is a major problem; and fraud and misuse of public funds appear to be common. Audits are rare and take place only when fraud investigation is indicated.

6.0 RECOMMENDATIONS AND CONCLUSIONS

6.1 General Recommendations

Recommendation	ACTION AGENCY	COMPLETION DATE
1) The CCCD Project in Liberia should be extended for a fifth year under current funding levels. After a slow start CCCD is progressing reasonably well considering the unstable political, economical and social cir-circumstances of GOL. The team was particularly impressed by the initiative of the County EPI staff	MHISW CCCD AID/W Other Donors	
2) The PROJECT GRANT Agreement should be revised to conform to the current economic conditions of the GOL. The GOL has not and apparently can not fulfill the terms of the Agreement and continued disbursement of funds contrary to the conditions set forth in the ProAg is in violation of the original ProAg intent. This could lead to serious problems when the project is audited.	GOL MHSW USAID/Liberia	May 1986
3) Given that the GOL is unable to meet its budget commitments it should not be expected to asume 67% of the project	GOL MH&SW AID/W	December 1986

Recommendation	ACTION AGENCY	COMPLETION DATE
cost as planned in the fourth year. Instead, its share of the project cost while not reduced in absolute terms should be spread over a period of five years such that its shares are 13%, 31%, and 52% by the third, fourth and fifth years respectively.	CCCD	
4) The MH&SW staff should be reassigned to meet the managerial and supervisory needs of the CCCD project. In particular one or two staff people should be assigned to manage and supervise the ORT and malarial components of the program.	MHSIW CCCD	May, 1986
5) The 1983 CCCD donor agreement plan should be revised to include all donors that have contributed to the CCCD program. This plan should include who will and can best contribute what commodities and when. This plan should be formalized through recommendations of under study between donors.	MHISW CCCD USAID/w Other Donors	June 1986
6) The CCCD personnel at the Central level should spend more time observing, supervising and monitoring field activities. A	CCCD	May 1986

Recommendation	ACTION AGENCY	COMPLETION DATE
monthly plan of activities by the central level should be developed which includes at least two supervisory visits per month to observe rural clinic operations. Written feedback to the EPI/CCCD staff should be provided after each visit.		
7) A Cost recovery system including registration, service and drug fees should be developed. The funds generated can and should be kept at the county level to finance local operating costs such as gasoline, kerosene, drugs, "volunteers" salaries, etc. These funds should not be used for offshore procurement of vaccines, vehicles etc. which can and should be provided by donor agencies.	MH&SW CCCD USAID/L	June 1986
8) An administrative assistant should be hired for the CCCD Technical Officier and Program Manager	CCCD USAID/L	March 1986
9) The private health sector should be encouraged to participate in the CCCD program and follow the CCCD protocols for immunizations, ORT and malaria. These private clinics should be required to provide monthly reporting on CCCD reporting forms of services given and registration fees collected.	MH&SW CCCD Private Clinics	April 1986

Recommendation	ACTION AGENCY	COMPLETION DATE
10) Decentralization of Health Services management within the MH&SW guidelines should be implemented. This will enhance the responsiveness of county level health officials and encourage community participation.	MH&SW	May 1986
11) The Technical Committee should include Plan International in its meetings. The Technical Committee includes a large group of donor agencies and is to be commended for this. The addition of PLAN will only serve to widen the scope of cooperation between donors engaged in CCCD activities.	CCCD	May 1986
7.2 EPI Recommendations		
12) Close monitoring of the followup activities to the National Vaccination week should be done. Dropout rates should be calculated and the problem addressed.	CCCD/ EPI Central and County level staff.	July 1986
13) Clinic Flow patterns should be reassessed and possibly redesigned. The procedures used to screen, register, vaccinate and deliver health education messages should be streamlined.	CCCD/ EPI Central and County Level Personnel	On-going 1986

Recommendation	ACTION AGENCY	COMPLETION DATE
14) Motorcycles should be distributed to field personnel to enable them to provide outreach services. The need for more motorcycles should also be reviewed and plans developed to provide them if deemed necessary.	CCCD USAID/L	April 1986
15) The impact of the second National Vaccination week should be critically assessed in terms of time, cost, coverage obtained and its effects on the integration and expansion of EPI, ORT and malaria activities at the county and village levels.	MH&SW CCCD	Dec 1986

7.3 Malaria Recommendations

16) The National Policy on Malaria should be finalized and signed by the Minister of Health and Social Welfare and disseminated to all CHO's.	MH&SW	April, 1986

7.4 Procurement, Storage and Distribtuion of Supplies

17) A new generator for the Central EPI Vaccine Storage Room should be purchased	MH&SW CCCD USAID/L Other Donors	May 1986

Recommendation	ACTION AGENCY	COMPLETION DATE
18) The cold chain equipment at the Central and County level should be improved. Ice lined refrigerators opening at the top should be purchased for the EPI central storage Room; thermometers for the outside of refrigerators should be provided for all units needing kerosene should be obtained and stored in the central level for county's needing it.	MH&SW CCCD USAID/L Other Donors	April 1986
19) Monitoring of vaccines temperatures should be supervised and a course in the care and maintenance of the cold chain should be offered to a select number of persons in each county	CCCD/EPI	Ongoing
20) Critical levels for all CCCD supplies should be developed and lag time should be assessed when developing these levels.	CCCD Central and County Level personnel	April 1986
21) A logistics officer at the Central level should be reidentified and trained to reduce the poor accounting of inventory that currently exists.	CCCD	April 1986
22) In connection with the above recommendation, a realistic assessment of the amount of commodities needed to provide CCCD services for 1 year	CCCD Donor Agencies	June 1986

Recommendation	ACTION AGENCY	COMPLETION DATE
should be established by the county level personnel. This assessment should be reviewed by the CCCD program manager and technical officer and communicated to the donors who supply these commodities. Pre-established delivery intervals should be made with the donors to avoid over or under stocking of supplies.		
23) Closer supervision of the expiration dates and commodities on hand at the central level should be done by the CCCD Program Officer, Technical Officer and other appropriate central level personnel. For the next three months this should include a monthly comparison by the CCCD Program Manager and Technical Officer of the Supplies on hand and those recorded to be on hand.	CCCD/EPI	April 1986
24) All inventory control forms and the inventory system should be reevaluated as to their usefulness	CCCD	
25) Kerosene refrigerators should be supplied to all county clinics where electricity outages pose major problems	MH&SW CCCD	May-Dec 1986

Recommendation	ACTION AGENCY	COMPLETION DATE
26) The Inventory of health facilities supplied with cold chain and vaccination equipment should be reviewed and corrected to reflect the realities in the field. Measures should be taken so that each clinic facilities providing immunizationh as a refrigerator in operating condition.	MH&SW	Ongoing
7.5 Training and Health Education		
27) A host country national should be hired as a short term consultant to coordinate with IED & HED in the adaptation and implementation of CCCD training and health education activities. A detailed scope of work should be provided.	MH&SW CCCD USAID/L	June, 1986
28) County health officers should be trained and oriented to CCCD activities by qualified senior level personnel	MH&SW	July, 1986
7.6 Disease Surveillance and HIS		
29) All reporting forms currently used and should be reevaluated as to their usability by clinic level personnel.	CCCD	May, 1986

Recommendation	ACTION AGENCY	COMPLETION DATE
30) The CCCD/HIS development plan should be prepared and approved by the MH&SW	MH&SW CCCD CCCD Regional Epidemiologist	June 1986 1987
31) The sentinal surveillance sets should be selected for the Phase I and II counties. All forms should be field tested and reporting programming implemented and monitored.	MHSIW CCCD	Dec, 1986
32) The development of computer programs by the CCCD Program Manager and T.O. should be delayed until the surveillance system is in place and has been monitored for six months.	MHSIW	No work should be done until mid-1987 if at all.

7.7 Finance

33) GOL should be given further assistance in exploring and implementing suitable financing mechanisms. As the regular GOL sources are getting weaker alternative sources of financing should be sought and implemented. AID/Washington has funds that are available for special studies on financing and cost recovery, should be tapped for this purpose.	USAID/L	December 1986

Recommendation	ACTION AGENCY	COMPLETION DATE
34) MH&SW should expedite implementation of the fee-for-service scheme and decentralization of health service administration. CCCD should take the responsibility to urge the MH&SW to take action expeditiously.	CCCD CMO	June 1986
35) CCCD Technical Committee should review the manual for financial management developed for decentralization county administration of health services, revise it as needed, and make it available to personnel that will be managing revenues generated by fee-for-service and drug revolving funds.	CCCDTC	June 1986
36) The current fee-for-service schedule should be revised after a careful review of experience gained by the end of its first year of application. The review should look into its effectiveness as a means of generating revenue, its impact on utilization of services, and issues related to the management of funds. CCCD should identify a randomly selected set of facilities in its project area and initiate collection of appropriate data.	CCCD	May 1, 1986
37) Drug revolving funds are increasingly becoming popular in Liberia. Since willingness to pay	CCCD	September 1986

Recommendation	ACTION AGENCY	COMPLETION DATE
is often higher for drugs than for services, management problems notwithstanding, drug revolving funds have better chances of success than fee-for-service schemes. Thus, the possibilities of subsidizing services by revenues of drug revolving funds should be looked into.		
38) The lack of standardized health information system (HIS) makes the health care delivery system hard to evaluate. A HIS that is operable by the minimally educated health worker should be instituted. Returns from the field should be analysed and reported on a regular basis to all concerned units of MH&SW. As a complement to the HIS, a simple management information system (MIS) should be developed and implemented. The MIS should include collection and reporting of data on a set of inputs, outputs, and financial aspects of health.	CCCD	June 1986

Appendix I

PERSONS CONTACTED

Ministry of Health and Social Welfare (MH&SW)/Liberia

Martha Belleh, Minister of Health and Social Welfare
Ivan Camanor, Chief Medical Officer/Deputy Minister, MH&SW
Moses Galakpai, Deputy Chief Medical Officer/Preventive Services

Rose Jallah Macauley, Acting CCCD Project Manager
James Thornton, Technical Office, CCCD Project

James Goaneh, EPI Director
George Cooper, EPI Finance Officer
Jack Berrian, EPI Operations Officer
Saye Yanoh, EPI Statistician
Tordell Kpuojohn, EPI Logistics Officer
Joseph Broh, EPI Logistics Officer

Alfred Kromah, Director, In-Service Training Division
Hawa Johnson, In-Service Training Division
Catherine Mucorlor, In-Service Training Division
Marinia Seyon, In-Service Training Division

Francis Blidi, Acting Director, Health Education Division
Alfred Mulbah, Health Education, Health Education Division
William Gibson, Material Production Officer, Health Education Division
Isaih Sacker, Chief Accountant

George Smith, Comptroller
John Bass, Assistant Comptroller

James Kessele, Director, Bureau of General Accounting; (Ministry of Finance)

Mary Dennis, Senior Economist (Ministry of Planning and Economic Affairs)

Moses Wreh, Deputy Budget Officer

Samuel Sasraku, County Health Officer, Montserrado County

Tamba Moseray, EPI Supervisor, Montserrado County

Bouk Madut, County Health Officer, Bomi County

Mary Momolou, Bomi County

Sister Barbara, Klay Clinic, Bomi County

Foley Johnson, Nursing AID, Bomi County
Elizabeth Johnson, Volunteer, Bomi County
Foley Johnson, Jr. Volunteer, Bomi County

Moses Pewu, County Health Officer, Margibi County
Sayeh Freeman, EPI Supervisor, Margibi County

Gabriel Peal, County Health Officer, Grand Cape Mount County
Bill Davis, In-Service Education Department, Grand Cape Mount County
Seyou Kioyolie, Physician Assistant, Grand Cape Mount County
Edward Pendemo, Officer In Charge, Grand Cape Mount County

USAID/Liberia

Mary Kilgour, Mission Director
Betsy Brown, Project Officer
Jenkins Cooper, Assistant Project Officer
Harold Marwitz, Program Officer
Alex Newton, RLA REDSO/WCA
Cynthia Kemner, Financial Analyst
James McCauley, Chief Accountant
Edward Castello, Chief Economist
Mark Gallagher, Economist
Edward Stanley, Economist

UNICEF/Liberia

Ofori Akyea, Resident Representative

W.H.O.

Margaret Korkpor, PHC Officer
Nada Cooper, WHO Administrative Officer

World Bank

John Kendell, Resident Representative

CDC/Atlanta

Russell Charter

Peace Corps/Liberia

Rufus Watkins, Director
Wayne Judkins, Deputy Director
Laurie Ackerman, PCV assigned to Bomi County, CCCD Project
Sarah Morrison, PCV assigned to Montserrado County, CCCD Project
David Boyd, PCV assigned to Cape Mount County, CCCD Project
Darrell McDowell, PCV Graphic Artist, CCCD Project

AID/Washington

Joe Davis, Project Officer
Wendy Roseberry, Assistant Project Officer

Appendix 2

DOCUMENTS REVIEWED

CCCD Monthly Reports - Jim Thornton

CCCD Procurement Plan, Years, I & II

Semi Annual Project Implementation Reports - 9/83 - 9/85

CCCD Financial Status Reports - 12/83 - 12/85

Foreign Trip Report, Stan Becker - 6/85

" , Diana Johnson - 10/85

" , Dennis Olsen - 11/84 and 2/85

" , Melinda Moore - 12/84

" , Stan Foster - 10/85

-CCCD Peace Corps Quarterly Reports, Rusky, Ackerman, Morrison

-Consultancy Report - Joshua Adeniyi, 7/85

-Report on the Reliability Survey of Childhood Mortality in Liberia, Ken Anderson - 7/85

-CCCD Mortality and Use of Health Service Surveys (MUHS), Liberia, Togo, Zaire - CDC 1/9/85

-A Study of the Efficacy of Home Made ORT in prevention of Dehydration in Diarrheal Diseases in Upper Nimba County, Suleman Wai

-CCCD Assessment in Liberia - 1983

-CCCD/Liberia Evaluation Report - 1984

APPENDIX 3

CCCD Special TC Meeting, March 14, 1986

Name	Representing
1. Laurie Ackerman	CCCD Bomi Hills
2. Mary Momolu	EPI/CCCD Bomi Hills
3. Bekpahqbor	EPI
4. Rose Jallah Macauley	CCCD
5. George B. Cooper	EPI
6. Abraham Bekele	HIID/Reach Project
7. Willard Boynton	Westinghouse/PAS
8. Mary L. Harvey	Westinghouse/PAS
9. Alfred J. Kroma	IED, MOH
10. James Goaneh	Dir/EPI
11. Jack Berrian	MAN/EPI
12. F. P. Blidi	HEd.
13. Tamba Moseray	SUP/EPI
14. Raphael h. Kpissay for Dr. Moses K. Galakpai	MH&SW
15. Sue Gerber	CCCD - Bassa
16. Manon Suboh	Family Health - MOH
17. Sarah Morrison	CCCD
18. Jenkins Cooper	USAID
19. Betsy Brown	USAID
20. E. Ofori Akyea	UNICEF
21. J. N. Togba	UL Medical College
22. Russell Charter	CDC
23. Daryl McDowell	CCCD
24. Koh Margaret Korkpor	WHD
25. Wendy Roseberry	AID/W
26. Joseph Broh	EPI Stock Clerk
27. Ivan Camanor	Chief Medical Officer/Deputy Minister MH&SW

RELATION BETWEEN CCCD AND MINISTRY OF HEALTH

CCCD, a USAID funded Project under the Ministry of Health should strengthen the Ministry of Health's capacity to deliver services in the following areas:

Expanded Program on Immunization (EPI)
Oral Rehydration Therapy for Diarrhea (ORT)
Malaria Treatment and Prophylaxis for Pregnant Women

During the life of the Project, the CCCD Project Manager will serve in a temporary position as liaison between the Deputy Chief Medical Officer, Bureau of Preventive Services and the Directors of EPI, ORT, and Malaria Programs. The Project Manager is responsible to monitor and coordinate the operational activities of the three Programs through coordinating work plans, resources, and evaluations. Much of this coordination will be accomplished through a weekly coordinating meeting with the Program Directors. A major portion of the Project Manager's time will be devoted to coordinating training activities among the Programs, In-service Education Division, and the County Medical Directors Staff; coordinating health education activities among the Programs, Health Education Division, and county staff; and coordinating health information systems and epidemiologic evaluational analysis.

The Project Technical Officer will serve as counterpart to the Project Manager, but will also serve as counterpart to the Program Directors to advise on operational matters. Priority on the area of greatest concentration will be decided at the weekly coordinating meeting.

Meaning:

At the beginning of an operational year, the heads of these Ministry of Health Projects should make a plan of work for that year. Such plan should cover the entire operation in the entire country.

I. EPI

(a) EPI should have workplan which includes kerosene needs per county, per month based on a cost saving operational strategy.
(b) Gasoline needs.
(c) Scheduled meetings at central and their cost.
(d) Supervisory visits to counties and cost.

II. ORT

(a) The ORT Program Director should have scheduled supervisory visits to clinics (in operational areas) and cost (gasoline).
(b) Planned workshops for different levels of health workers and cost.
(c) ORS needs for the year based on past operation.
(d) Educational and training materials etc.

III. Malaria Treatment

(a) The Program Director should prepare chloroquine needs for presumptive treatment and prophylaxis for pregnant mothers.
(b) Request for assistance with government vector control program etc.

All Ministry of Health workplan should be approved by the DCMO/BPS. Based on these, CCCD will commit herself to those particular areas of the individual programs that she can support for that year.

In order for this agreement to be reached, there will have to be a justification made of each need and these documented.

When this TASK is completed, the CCCD budget will be prepared, considering all of the above. Every director should have a copy of the budget and will know what activities the dollar figure per line item represent.

The tendency for supervisors of CCCD assisted programs in the counties to confer directly with CCCD Office in Monrovia without first contacting the headquarters office of such program must be discouraged. That is, all health workers should be encouraged by all concerned (respective directors, CCCD P.M. and T.O., and DCMO/BPS etc.) to deal directly with the relevant director for all technical and operational matters. If the director feels comfortable to handle those issues alone, that matter is taken care of there. Otherwise, the Director and the field staff or the Director (but never the field staff alone) should approach CCCD for technical advice from the appropriate person(s).

Resources of CCCD coming into the programs should be delivered through the leadership of these Programs but monitored by CCCD The extension of CCCD assistance to each county must be channeled through the headquarters of the individual programs for which the assistance is meant.

Where money is involved the process should be the same also.

All field request should be documented and brought in duplicate. If same is approved, the director should okay the request by writing:

(a) okay or approved
(b) signature
(c) date before taking appropriate action(s) (filing, paying etc.).

Note: Whatever action(s) are taken should be officially/formally communicated to the appropriate person(s) whether done only in office of the director or after consultation.

(i.e) EPI----------CCCD

ORT----------CCCD

CHOO----------CCCD

Remember:

We are trying to build a sustainable working relationship for the benefit of all concerned and not reporting our personal actions to anyone.

We want to encourage all of us to get deeply involved in our respective programs but strongly warn against personalizing it.

A big advantage in a documented plan of work for Ministry of Health projects along with a budget is that other donors could assist in areas where CCCD cannot fill in. All donors will definitely prefer a clearly written plan of work with such details as the amount of assistance.

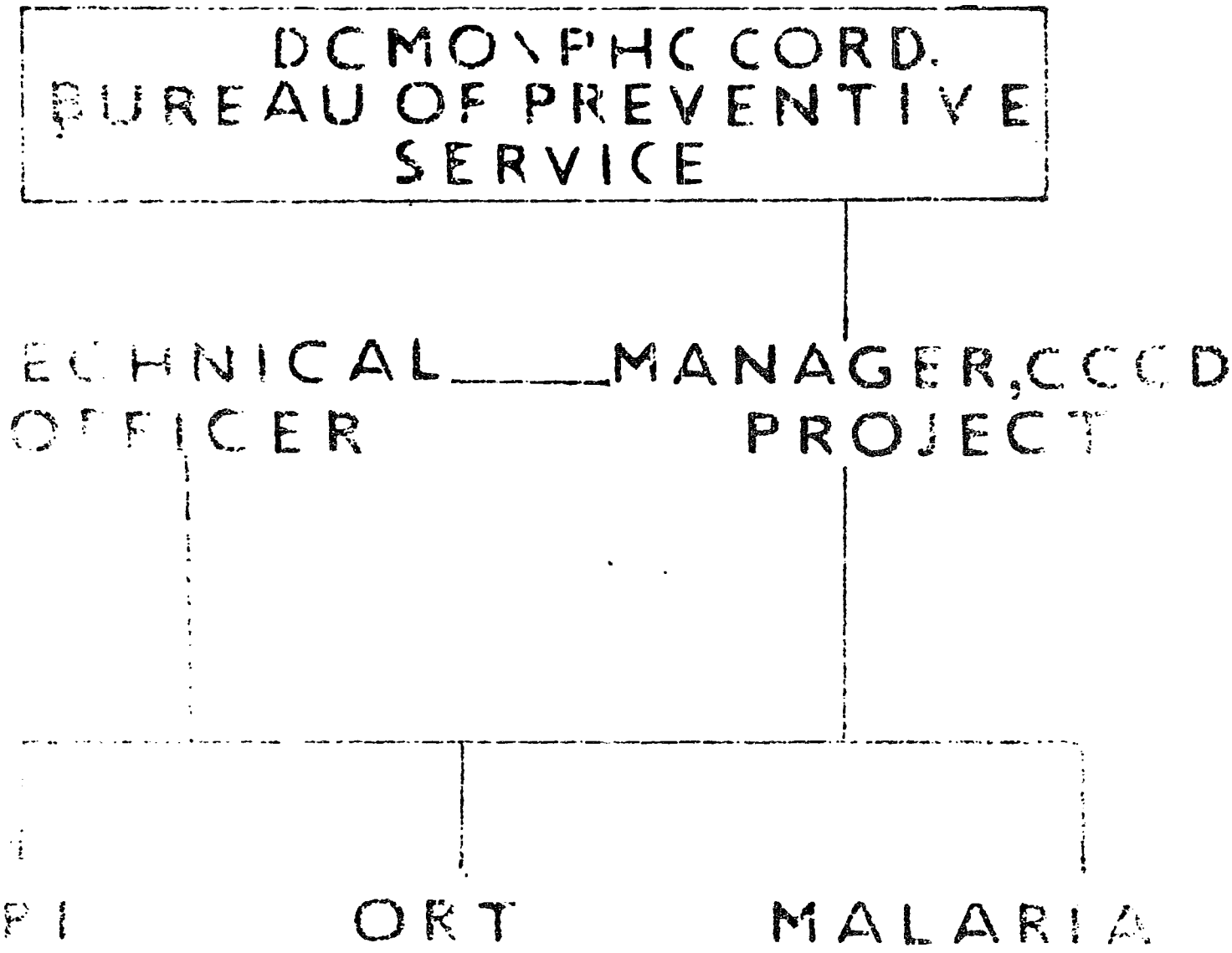
Submitted by: James [illegible]
DIRECTOR, EPI

Rose Jallah-Macauley, M.D.
ACTING MANAGER, CCCD PROJECT

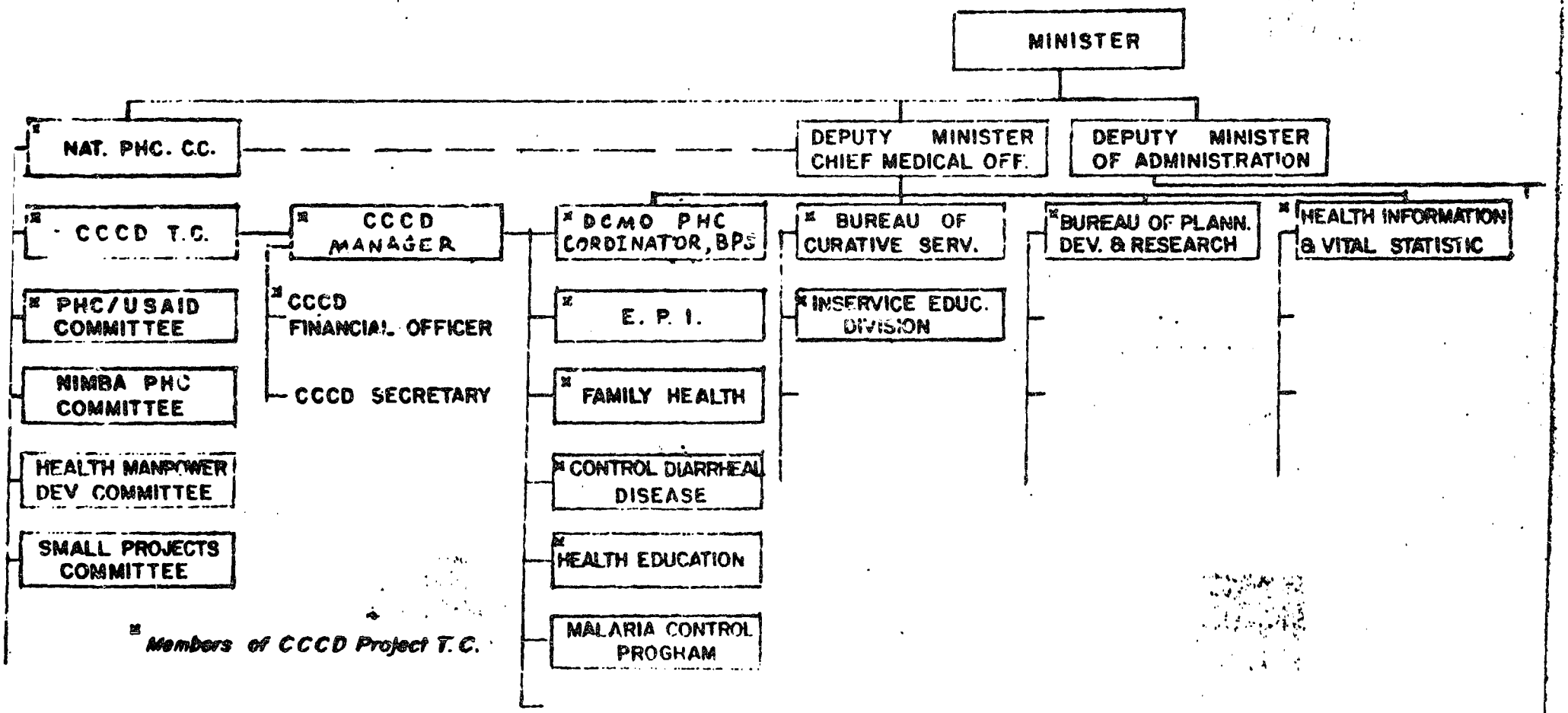
K. Margaret Korkpor
K. Margaret Korkpor
PHC OFFICER, WHO

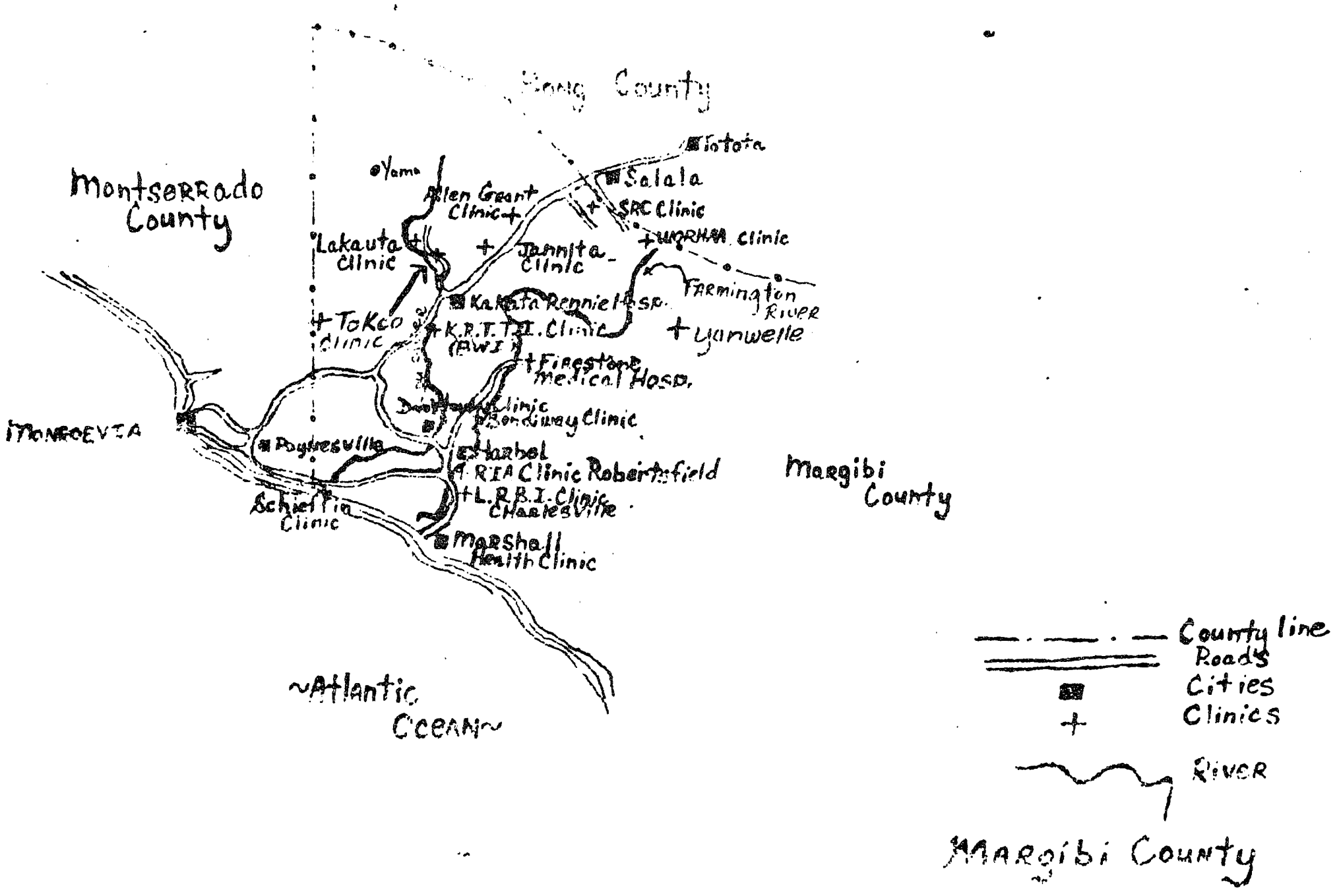
Moses P. Gulakpai, M.D.
DCMO, PHC COORDINATOR, MH&SW

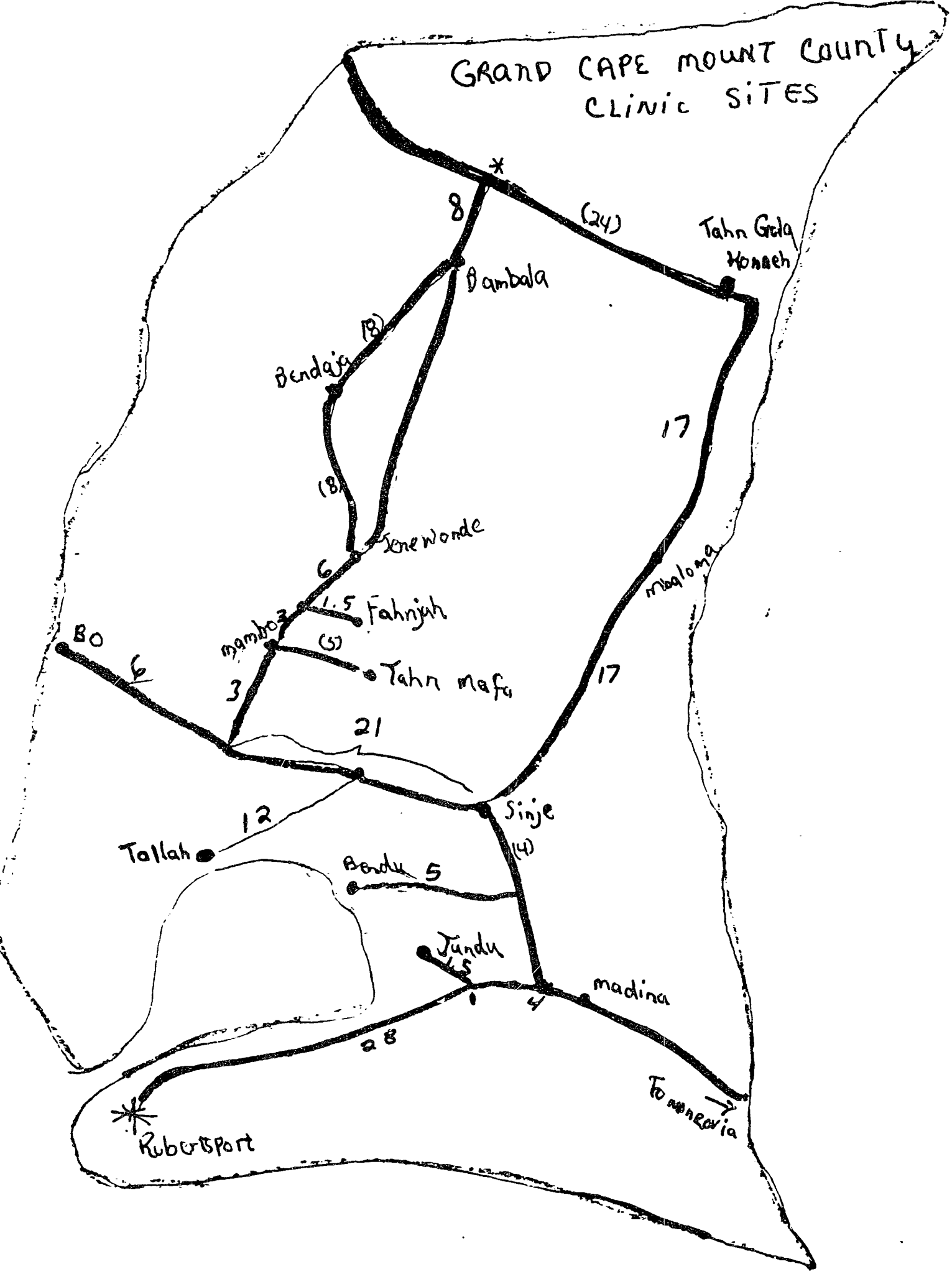
James N. Thornton
TECHNICAL OFFICER

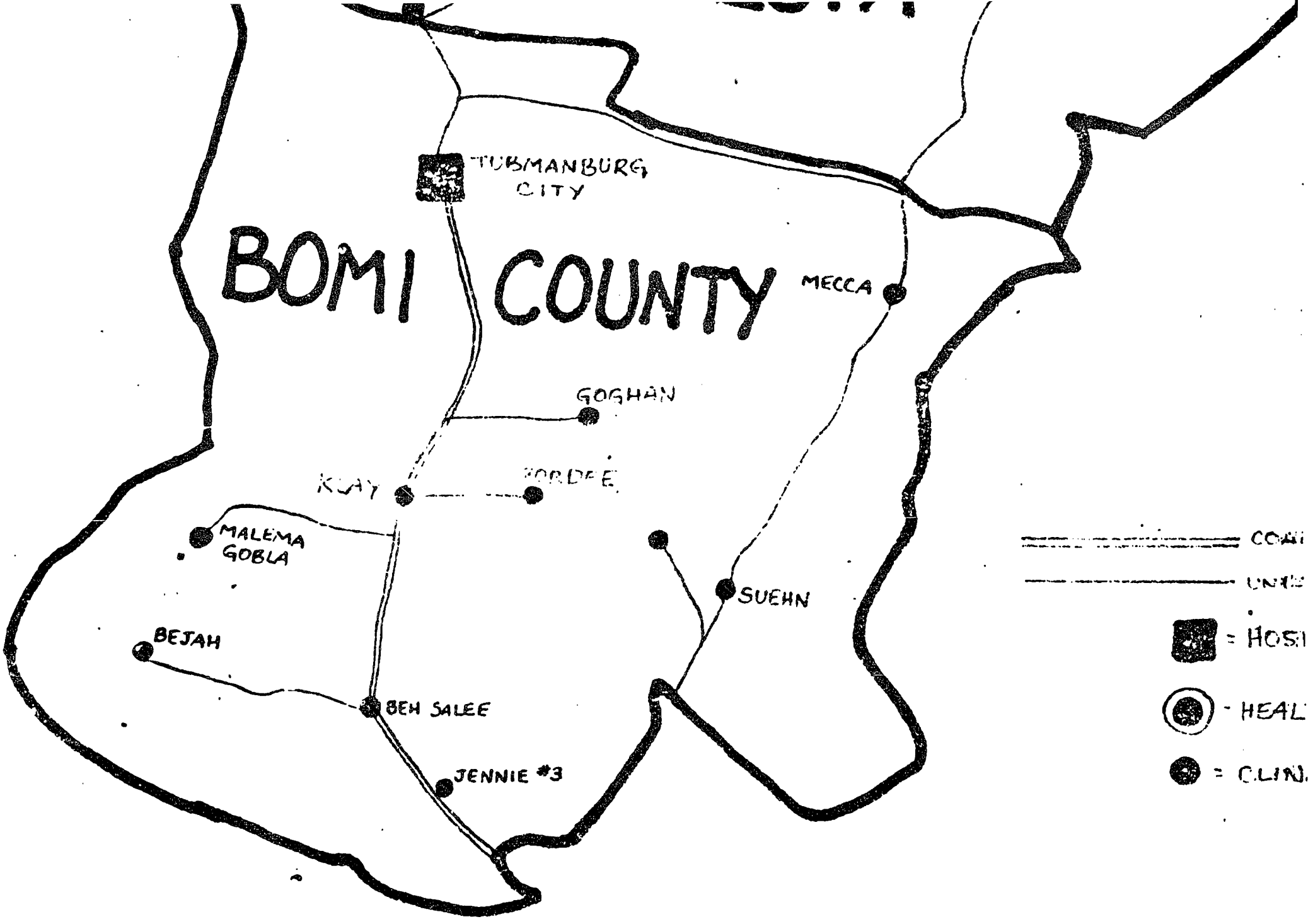

DCMO\PHC CORD.
BUREAU OF PREVENTIVE SERVICE
ECHNICAL OFFICER
MANAGER,CCCD PROJECT
PI
ORT
MALARIA

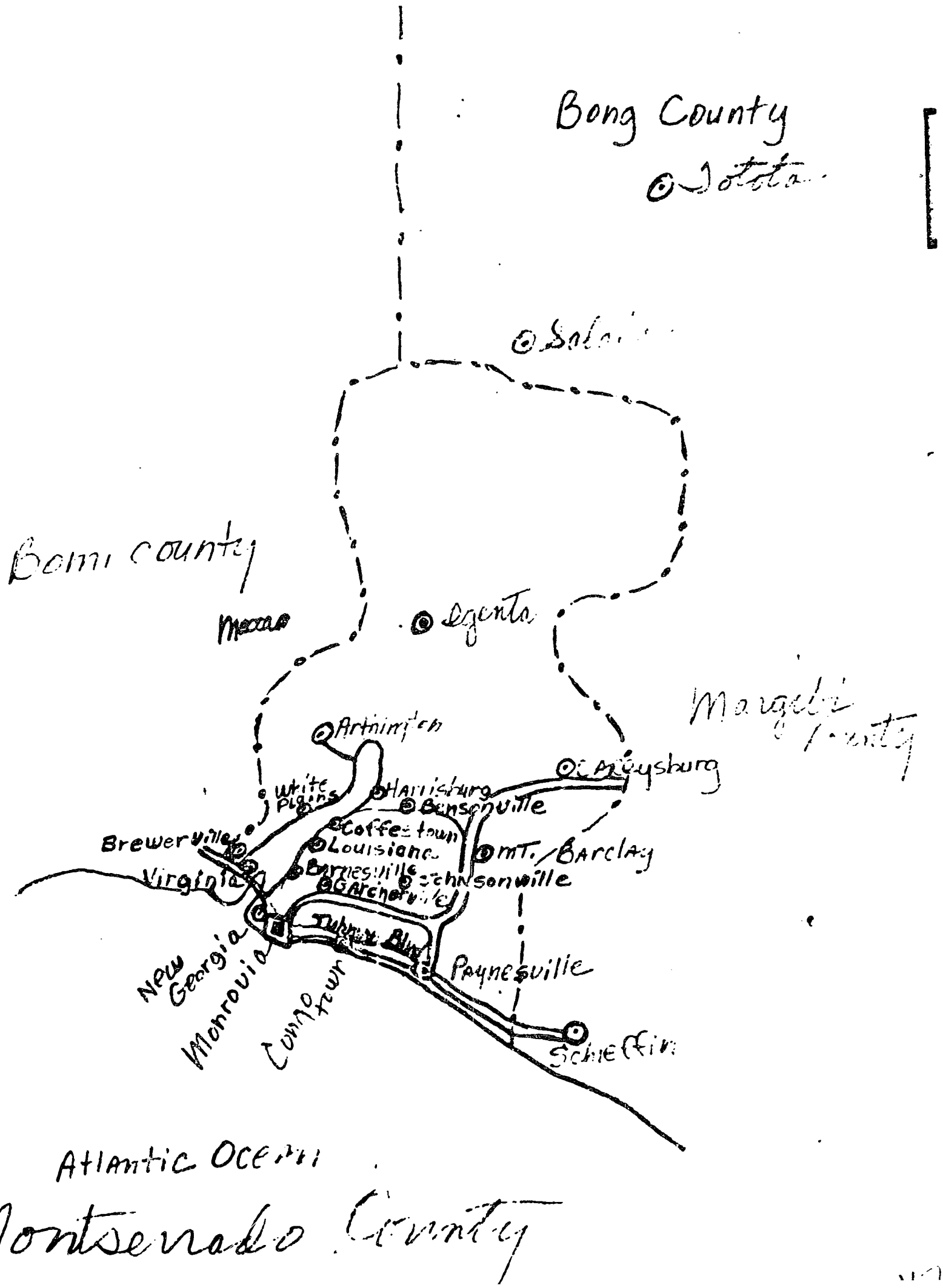
ORGANIZATIONAL CHART ILLUSTRATING THE FUNCTIONAL RELATIONSHIP OF THE CCCD PROJECT AND ITS T.C. WITH OTHER HEALTH PROJECTS AND COMMITTEES OF THE MINISTRY OF HEALTH AND SOCIAL WELFARE

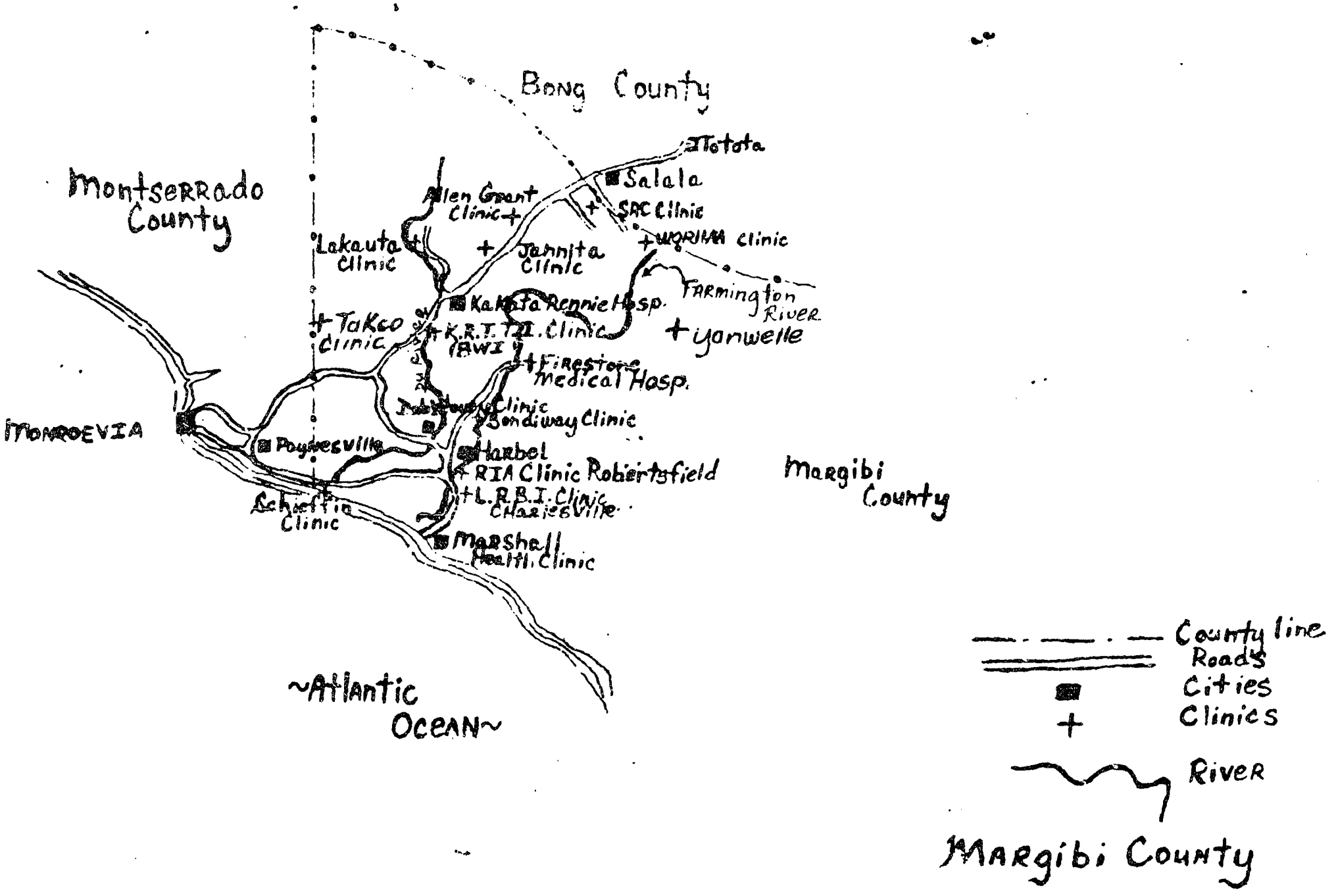



Bong County
Montserrado County
Margibi County
Margibi County
Totota
Salala
Yama
Allen Grant Clinic
SRC Clinic
Lakauta Clinic
Jannita Clinic
Clinic
Farmington River
Kakata Rennie Hosp.
Toko Clinic
K.P.T.T.I. Clinic (PWI)
Yanwelle
Firestone Medical Hosp.
Clinic
Clinic
MONROVIA
Paynesville
Clinic
Robertsfield
L.R.B.I. Clinic
Charlesville
Schiefflin Clinic
Marshall Health Clinic
Atlantic Ocean
County line
Roads
Cities
Clinics
River


GRAND CAPE MOUNT COUNTY
CLINIC SITES
8
(24)
Tahn Gola
Hosseh
Bambala
(8)
Bendaja
17
(8)
Senewonde
6
1.5
Fahnjah
mambo
(5)
Tahn mafa
BO
6
3
17
21
Sinje
12
Tallah
(4)
Bendu 5
Jundu
1.5
1
4
madina
28
To monrovia
Robertsport


BOMI COUNTY
TUBMANBURG CITY
MECCA
GOGHAN
KLAY
MALEMA GOBLA
BEJAH
BEH SALEE
JENNIE #3
SUEHN
= HOSI
- HEAL
= CLIN


Bong County
Salamata
Bomi County
Macca
Sogenta
Margibi County
Arthington
Clayburg
White Plains
Harrisburg
Bensonville
Coffeetown
Louisiana
Brewerville
Mt. Barclay
Virginia
Barnesville
Johnsonville
Archerville
Tubman Blvd
New Georgia
Monrovia
Connoquin
Paynesville
Schiefflin
Atlantic Ocean
Montserrado County


Bong County
Totota
Salala
SAC Clinic
WORHA clinic
Allen Grant Clinic
Lakauta Clinic
Jannita Clinic
Kakata Rennie Hosp.
Farmington River
Yanwelle
Takco Clinic
K.R.T.T.I. Clinic (AWI)
Firestone Medical Hosp.
Clinic
Sondiway Clinic
Monrovia
Paynesville
Harbel
RIA Clinic Robertsfield
L.R.B.I. Clinic Charlesville
Schieffin Clinic
Marshall Health Clinic
Montserrado County
Margibi County
~Atlantic Ocean~
County line
Roads
Cities
Clinics
River
Margibi County

GRAND CAPE MOUNT COUNTY POPULATION ESTIMATED 96,000

CLINIC	CATCHMENT AREA POPULATION	NUMBER UNDER ONE 1%	NUMBER UNDER FIVE (17.5%
JUNDU	4732	190	830
MADINA	2345	95	410
SINJE	3570	145	625
KENDU	3633	145	635
NBALOMA	4774	190	835
TAHN GOLA KONNEH	NEVER SUBMITTED		
BAMBALLA	5941	240	1040
BENDEJA	4284	170	750
JENE-MONDE	3914	155	685
FANEJA	1605	65	280
KAMBO	NEVER SUBMITTED		
TAHN MAFA	1330	55	230
BO	4471	180	780
TALLAH	NEVER SUBMITTED		
		3.876	14.332

CLINICS IN BOMI HILLS / LOWER LOFA
APPROXIMATE DISTANCES FROM TUBMANBURG CITY

BOMI COUNTY (Catchment Pop)	KM	MILES
FLAY CLINIC (2094)	23	13
PEH SALEE CLINIC (1,658)	35	20
JENNIE #2 CLINIC (359)	44	25
GOGHAN CLINIC (1,800)	30	17
ZORDEE CLINIC (1,113)	35	20
MALEMA COPLA CLINIC (1,745)	41	23
BEH TOWN CLINIC (948)	50	28
FEFEH TOWN CLINIC (974)	85	47
SUEHN CLINIC (1,477)	82	46
MECCA CLINIC (1,493)	56	31
LOWER LOFA		
GBARMA CLINIC (2,416)	20	11
YANGAYAF CLINIC (1,498)	35	20
TARPEOIMA CLINIC (2,754)	50	28
TASPA CLINIC (5,000?)	85	48
Bopolu Clinic (4,195)	67	40

	AGES: GIVE ONLY VACCINES FOR THAT AGE GROUP						AMOUNT SITE TECHNIQUE	NUMBER OF DOSES	MINIMUM TIME BETWEEN DOSES	TEMPERATURE OF VACCINE	IF OPENED, DESTROY AT END OF DAY	NORMAL SIDE EFFECTS
	BIRTH-6 WKS.	6 WKS-9 MOS.	9 MOS-1 YR.	1 YR-2 YRS.	2 YRS-5 YRS.	WOMEN 14-49 YEARS						
BCG TUBERCULOSIS	GIVE ONCE ONLY DURING THIS PERIOD						0.05 cc Right Arm Intradermal	1	—	≤0°c FREEZE	✓	Ulcer at site, takes 2-3 months to heal. DON'T PUT ON CREAM/OINTMENT Swollen lymph nodes
POLIO	BEGIN SERIES DURING THESE MONTHS			COMPLETE IF STARTED			2-3 Drops into Mouth	4 IF GIVEN AT BIRTH 3 IF GIVEN WHEN STARTED	4 WEEKS	≤0°c FREEZE	— —	—
DIPTHERIA PERTUSSIS (COUGH) TETANUS		GIVE THREE DOSES DURING THIS PERIOD					0.5 cc Left arm or thigh Intramuscular or Deep Subcutaneous	3 NO BOOSTER	4 WEEKS	2°-8°c	— —	Slight fever, take aspirin Swelling, soreness at site
MEASLES			GIVE ONE DOSE DURING THIS PERIOD *				0.5 cc Left arm or thigh Subcutaneous	1	*	≤0°c FREEZE	✓	Fever or rash 6-10 days later; take aspirin
TETANUS TOXOID						Follow Schedule	0.5 cc Left arm Intramuscular or deep subcutaneous	5 TOTAL	4 WKS. BTWN #1,2 #3,4,5: MONTH SEVEN OR EIGHT OF LATER PREGNANCY	2°c-8°c	— —	Tenderness at site Fever; take aspirin

* If child had measles vaccination at less than nine months of age, he will need a booster at 15 months. In rural counties, maximum age for measles vaccine is three years.

'T SPREAD DISEASE! BURN OR BREAK ALL DISPOSABLE NEEDLES AND SYRINGES!
TELL MOTHERS WHY THEY MUST RETURN, AND WRITE THE DATE ON THE ROAD-TO-HEALTH CARD
EEN THE CHILD FOR OTHER PROBLEMS (such as malnourishment) AND WRITE REFERRALS OR MAKE FOLLOW-UP APPOINTMENTS
KEEP YOUR SITE AND YOUR OWN HANDS CLEAN! SET AN EXAMPLE, USE SOAP
VER FORGET THE COLD CHAIN!

12-85

MINISTRY OF HEALTH AND SOCIAL WELFARE
VACCINATION TALLY SHEET

OPERATIONAL AREA _____ CLINIC _____ DATE _____

TYPE OF VACCINE	AGE GROUPS LESS THAN ONE YEAR OLD	TOTAL GIVEN	AGE GROUPS MORE THAN 1 YEAR OLD	TOTAL GIVEN	TOTAL GIVEN ALL AGES
	CHILDREN 1 DAY THROUGH 11 MONTHS OLD				
BCG	0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40 0 0 0 0 45 0 0 0 0 50 0 0 0 0 55 0 0 0 0 60		// BCG SHOULD NOT BE GIVEN TO CHILDREN OVER 1 YEAR OF AGE DUE TO INCREASE OF SEVERE REACTIONS IF CHILD IS PREVIOUSLY INFECTED		
BIRTH OPV	0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40		// CHILDREN 12 MONTHS OLD AND OLDER SHOULD NOT BE STARTED ON OPV. CHILDREN WHO ARE 12 MONTHS OLD AND OLDER WHO HAVE PREVIOUSLY RECEIVED THE FIRST DOSE SHOULD RECEIVE THE SECOND AND THIRD DOSES TO COMPLETE THE OPV VACCINATION SERIES.		
	CHILDREN 6 WEEKS THRU 11 MONTHS OLD		CHILDREN 12 MONTHS OLD AND ABOVE		
OPV 1	0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40 0 0 0 0 45 0 0 0 0 50 0 0 0 0 55 0 0 0 0 60				
OPV 2	0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40 0 0 0 0 45 0 0 0 0 50 0 0 0 0 55 0 0 0 0 60		0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40 0 0 0 0 45 0 0 0 0 50 0 0 0 0 55 0 0 0 0 60		
OPV 3	0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40 0 0 0 0 45 0 0 0 0 50 0 0 0 0 55 0 0 0 0 60		0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40 0 0 0 0 45 0 0 0 0 50 0 0 0 0 55 0 0 0 0 60		
	CHILDREN 6 WEEKS THRU 11 MONTHS OLD		CHILDREN 12 MONTHS OLD TO 5 YEARS OLD		
DPT 1	0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40 0 0 0 0 45 0 0 0 0 50 0 0 0 0 55 0 0 0 0 60		0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40 0 0 0 0 45 0 0 0 0 50 0 0 0 0 55 0 0 0 0 60		
DPT 2	0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40 0 0 0 0 45 0 0 0 0 50 0 0 0 0 55 0 0 0 0 60		0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40 0 0 0 0 45 0 0 0 0 50 0 0 0 0 55 0 0 0 0 60		
DPT 3	0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40 0 0 0 0 45 0 0 0 0 50 0 0 0 0 55 0 0 0 0 60		0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40 0 0 0 0 45 0 0 0 0 50 0 0 0 0 55 0 0 0 0 60		
	CHILDREN 9 THRU 11 MONTHS OLD		CHILDREN 12 MONTHS OLD AND ABOVE		
MEASLES	0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40 0 0 0 0 45 0 0 0 0 50 0 0 0 0 55 0 0 0 0 60		0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40 0 0 0 0 45 0 0 0 0 50 0 0 0 0 55 0 0 0 0 60		

	BCG	DPT	POLIO	MEASLES
NUMBER OF VIALS OF VACCINE TAKEN TO CLINIC				
NUMBER OF VIALS OPENED FOR USE IN THE CLINIC				
NUMBER OF VIALS NOT OPENED AND RETURNED TO REFRIGERATOR OR COLD BOX				

NAME OF PERSON COMPLETING FORM

SIGNATURE

MINISTRY OF HEALTH AND SOCIAL WELFARE
TETANUS TOXOID TALLY SHEET

OPERATIONAL AREA _____ DATE _____

CLINIC _____ OIC _____

WOMEN OF CHILDBEARING AGE (14-49)		TOTAL GIVEN
TT 1	0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40 0 0 0 0 45 0 0 0 0 50 0 0 0 0 55 0 0 0 0 60 0 0 0 0 65 0 0 0 0 70 0 0 0 0 75 0 0 0 0 80 0 0 0 0 85 0 0 0 0 90 0 0 0 0 91 0 0 0 0100	
TT 2	0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40 0 0 0 0 45 0 0 0 0 50 0 0 0 0 55 0 0 0 0 60 0 0 0 0 65 0 0 0 0 70 0 0 0 0 75 0 0 0 0 80 0 0 0 0 85 0 0 0 0 90 0 0 0 0 91 0 0 0 0100	

PREGNANT WOMEN		TOTAL GIVEN
TT 1	0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40	
TT 2	0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40	
BOOSTER	0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40	

OTHERS AT HIGH RISK		TOTAL GIVEN
TT 1	0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40	
TT 2	0 0 0 0 5 0 0 0 0 10 0 0 0 0 15 0 0 0 0 20 0 0 0 0 25 0 0 0 0 30 0 0 0 0 35 0 0 0 0 40	

NUMBER OF VIALS OF TT VACCINE TAKEN TO CLINIC	
NUMBER OF TT VIALS OPENED FOR USE IN THE CLINIC	
NUMBER OF TT VIALS NOT OPENED AND RETURNED TO REFRIGERATOR OR COLD BOX	

	AGES: GIVE ONLY VACCINES FOR THAT AGE GROUP						AMOUNT SITE TECHNIQUE	NUMBER OF DOSES	MINIMUM TIME BETWEEN DOSES	TEMPERATURE OF VACCINE	IF OPENED, DESTROY AT END OF DAY	NORMAL SIDE EFFECTS
	BIRTH-6 WKS.	6 WKS-9 MOS.	9 MOS.-1 YR.	1 YR-2 YRS	2 YRS-5 YRS.	WOMEN 14-49 YEARS						
BCG TUBERCULOSIS	GIVE ONCE ONLY DURING THIS PERIOD						0.05 cc Right Arm Intradermal	1	—	≤0°c FREEZE	✓	Ulcer at site, takes 2-3 months to heal. DON'T PUT ON CREAM/OINTMENT Swollen lymph nodes
POLIO	BEGIN SERIES DURING THESE MONTHS			COMPLETE IF STARTED			2-3 Drops into Mouth	4 IF GIVEN AT BIRTH 3 IF GIVEN WHEN STARTED	4 WEEKS	≤0°c FREEZE	— —	—
DIPTHERIA PERTUSSIS (COUGH) TETANUS		GIVE THREE DOSES DURING THIS PERIOD					0.5 cc Left arm or thigh Intramuscular or Deep Subcutaneous	3 NO BOOSTER	4 WEEKS	2°-8°c	— —	Slight fever, take aspirin Swelling, soreness at site
MEASLES			GIVE ONE DOSE DURING THIS PERIOD *				0.5 cc Left arm or thigh Subcutaneous	1	*	≤0°c FREEZE	✓	Fever or rash 6-10 days later; take aspirin
TETANUS TOXOID						Follow Schedule	0.5 cc Left arm Intramuscular or deep subcutaneous	5 TOTAL	4 WKS. BTWN #1,2 #3,4,5: MONTH SEVEN OR EIGHT OF LATER PREGNANCY	2°c-8°c	— —	Tenderness at site Fever; take aspirin

* If child had measles vaccination at less than nine months of age, he will need a booster at 15 months. In rural counties, maximum age for measles vaccine is three years.

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KEEP YOUR SITE AND YOUR OWN HANDS CLEAN! SET AN EXAMPLE; USE SOAP

VER FORGET THE COLD CHAIN!

12-85

CCCD WORKSHOP

ORT AND MALARIA CONTROL

LIBERIAN GOVERNMENT HOSPITAL
TUBMANBURG CITY
DECEMBER 11-12.1985

DATE	TIME	TOPIC	TRAINER
Dec 11th	8-9am	Formal Opening and Registration	Mary Momolu
	9-10:30am	Assessment of Dehydration	Laurie Ackerman
	10:30-10:45am	Coffee Break	
	10:45-12:30pm	Treatment of Dehydration	William Davis
	12:30-1:30pm	LUNCH	
	1:30-4pm	Health Education and Dehydration	Mary Momolu
Dec 12th	8-10:30am	Malaria Control	David Boyd
	10:30-10:45am	Coffee Break	
	10:45-12noon	Malaria Control (cont)	David Boyd
	12-1pm	LUNCH	
	1- 2pm	Fee for service	Dr. B. Madut
	2-3pm	Immunization and Miscellaneous Issues	Mary Momolu and Laurie Ackerman
	3-4pm	Post-test, Evaluation and presentation of Certificates	

TENTATIVE AGENDA FOR EPI/CCCD WORKSHOPS

July 10th: TRAINING OF TRAINERS

9am - 12noon -- Review and discuss assigned sessions and various training techniques. Any unresolved issues will be dealt with at this time.
12 - 1pm: LUNCH
1-4pm: Practice teaching the various sessions.

July 15-17: Training of Clinic OICs

Day 1: 8-9am -- Introduction -- Mohammed Bayoh
9-12pm - Refrigerator Maintenance -- James Stevens
Cold Chain/Vaccine Storage -- Mary Momolu
12-1pm - LUNCH
1-3pm -- Sterile Techniques -- Mohammed Bayoh
3-4pm -- Health Education -- David Boyd

Day 2: 8-9am -- Screening Children -- Laurie Ackerman
9-12pm - Prepare and Administer vaccines --Momolu et al
12-1 -- LUNCh
1-4pm -- Records and Reporting -- Laurie Ackerman

Day 3: 8-11am - Planning Vaccination Sessions -- David Boyd
11-12pm Summary and Post Test -- Momolu and Ackerman

July 22-23: Training of other clinic personnel

Day 1: Same as Day 1 for Clinic OICs
Day 2: Morning same as for Clinic OICs
1-3pm -- Records and Reporting --Laurie Ackerman
3-4pm -- Summary and POst Test -- Ackerman and Momolu

NOTE; David Boyd may not be available for the second workshop. It has not yet been determined who will teach Health Education in his absence.

LIBERIA MINISTRY OF HEALTH AND SOCIAL WELFARE
COMBATTING CHILDHOOD COMMUNICABLE DISEASES PROJECT (698-0421.03)

1986 PROJECT WORK PLAN

OBJECTIVE/ACTIVITY	RESPONSIBLE FOR ACTION	TIME TARGET
Assist counties in writing, reviewing, obtaining approval and implementing an adjusted fee-for-service plan	Project Manager Technical Officer	
Second phase counties		March
Third phase counties		October
Assist counties in informing local health workers of the availability of the motorcycles to be purchased under the motorcycle purchase plan.	Project Manager Technical Officer	
Second Phase Counties		March
Third Phase Counties		October
Award motorcycle contracts to local health workers		
Second phase counties	MHSW	As Needed
Third phase counties	PHC Coord. Committee	
CCCD Technical Committee Meeting	Project Manager	Quarterly
Second year external review of project	AID/W; CDC	February
Annual CCCD Consultative Meeting	Project Manager Technical Officer	March
Prepare and submit monthly status of funds report for the local currency budget	Financial Officer Project Manager	Monthly by the 15th
Review local currency budget and expenditures and revise budget as needed according to progress in project implementation	Project Manager Financial Officer Technical Officer	Quarterly
Review procurement plan and revise as needed	Logistics Officer	March
	Technical Officer	September
Set up computerized data systems for analysis of CCCD personnel, inventory control, and budgets	Technical Officer Project Manager	September
Train selected MHSW personnel in use of the micro-computer and data system software	Technical Officer Project Manager	Ongoing from May
Develop and submit annual projection for short term consultant requirements	Project Manager Technical Officer USAID/Liberia	March
Visit sites of the clinics in project counties and review service delivery, cold chain, and fee-for-service accounting	Project Manager Technical Officer	Monthly

Best Available Document

OBJECTIVE-ACTIVITY	RESPONSIBLE FOR ACTION	TIME TARGET
Annual vacation	Project Manager Technical Officer Financial Officer/Secretary	April July-August December

EXPANDED PROGRAM FOR IMMUNIZATIONS

Implementation of enhanced delivery of immunization services, and supervision and follow-up in second phase counties	County Health Officer CCCD County Supervisor Training/Logistics Coord. Project Manager Technical Officer	January
Implementation of enhanced delivery of immunization services, and supervision and follow-up in third phase counties	County Health Officer CCCD County Supervisor Training/Logistics Coord. Project Manager Technical Officer	November
Advise and assist in instituting use of forms for the accountability of resources and supplies.	Technical Officer Project Manager	On-going
EPI supervisors conference	EPI Director EPI Program Manager Technical Officer	Quarterly
Conducting first national vaccination week	EPI Director EPI Program Manager Program Manager County Health Officers Technical Officer	January 20-25
Evaluate the national vaccination week	EPI Director	
Field survey of coverage and KAP	EPI Program Manager	Jan 27-Feb
Analysis of data	Program Manager	Feb 10-14
County level meetings to discuss evaluation	County Health Officers	Feb 17-[illegible]
National meeting to discuss evaluation	Technical Officer	Feb 2[illegible]
Planning for second national vaccination week	EPI Director	
Review of national 3 year plan, revise where necessary and prepare and submit budget	EPI Program Manager Program Manager	April
Update commodity procurement plan, place orders	County Health Officers	April
Health education and mass media planning	Technical Officer	Mar
National level meeting with county organizers	USAID/Liberia	July
County level planning meeting	UNICEF	August
County plans submitted for review and comment and funding	WHO	September
In-service training of staff	Short Term Consultants	Sept-Oct
Distribution of commodities and supplies		Oct-Nov
Second national vaccination week		November

Best Available Document

OBJECTIVE/ACTIVITY	RESPONSIBLE FOR ACTION	TIME TARGET
Evaluate second national vaccination week	EPI Director	
Field Survey of coverage and KAP	EPI Program Manager	December
Analysis of data	Program Manager	December
County level meetings to discuss evaluation	County Health Officers	January
National meeting to discuss evaluation	Technical Officer	January
Advise and assist EPI in improving and monitoring cold chain at the central level and in non-project counties as well as project counties.	Technical Officer Training/Logistics Coord.	On-going

DIARRHEAL DISEASES CONTROL/MALARIA TREATMENT

Establish an oral rehydration therapy center in the greater Monrovia area for training of health workers in ORT	Project Manager Technical Officer USAID/Liberia	January
Internship (two to three days) of Medical Officer and Officers in Charge of clinics of first phase counties at oral rehydration therapy center	Project Manager ORT Center Staff County CCCD Supervisor Technical Officer	February - June
Internship (two to three days) of Medical Officer and Officers in Charge of clinics of second phase counties at oral rehydration therapy center	Project Manager ORT Center Staff County CCCD Supervisor Technical Officer	July-December
Implementation of enhanced delivery of oral rehydration therapy, malaria presumptive treatment for fever in under 5s and malaria prophylaxis of pregnant women in first phase counties	County Health Officer CCCD County Supervisor Training/Logistics Coord. Project Manager Technical Officer	January on-going
Implementation of enhanced delivery of oral rehydration therapy, malaria presumptive treatment for fever in under 5s and malaria prophylaxis of pregnant women in second phase counties	County Health Officer CCCD County Supervisor Training/Logistics Coord. Project Manager Technical Officer	August On-going

TRAINING/TRAINING DEVELOPMENT

Produce the Liberia MLM training materials	Project Manager Technical Officer PCV Graphics Illustrator	January-February
Conduct CCCD MLM course for six county level personnel and four Peace Corps Volunteers for the second phase counties.	Director, In-service Ed. Div. In-service Ed. Div. Staff Project Manager Technical Officer	March

Best Available Document

OBJECTIVE/ACTIVITY	RESPONSIBLE FOR ACTION	TIME TARGET
Evaluate application of training of second phase county level supervisors.	Director, In-service Ed. Div. Project Manager Technical Officer	On-going from April
Conduct CCCD MLM course for eight county level personnel and four Peace Corps Volunteers for the third phase counties.	Director, In-service Ed. Div. In-service Ed. Div. Staff Project Manager Technical Officer Financial Officer	October
Evaluate application of training of third phase county level supervisors	Director, In-service Ed. Div. Project Manager Technical Officer	On-going from October
Train clinic level workers in second phase counties: 1. Delivery of immunization services 2. Diarrheal disease control and oral rehydration therapy 3. Reducing mortality in under 5's and low birth weight due to malaria	County Health Officer CCCD County Supervisor Logistics/Training Coordinator In-service Education Coordinator Project Manager Technical Officer Financial Officer	April-June
Review delivery of immunization services at clinic level, evaluate application of training, provide on-the-job and in-service training to strengthen deficiencies detected.	CCCD Supervisor Logistics/Training Coordinator EPI Program Manager Project Manager Technical Officer	On-going from April
Review delivery of services for oral rehydration and malaria presumptive treatment and prophylaxis, evaluate application of training, provide on-the-job and in-service training to strengthen deficiencies detected	CCCD Supervisor Logistics/Training Coordinator Director, C.D. Division Project Manager Technical Officer	On-going from June
Train clinic level workers in third phase counties 1. Delivery of immunization services 2. Diarrheal disease control and oral rehydration therapy 3. Reducing mortality in under 5's and low birth weight due to malaria	County Health Officer CCCD County Supervisor Logistics/Training Coordinator In-service Ed. Coordinator Project Manager Technical Officer Financial Officer	December to March 87
Train staff of OSU training center	Regional Epidemiologist Project Manager	January
Obtain approval to site training of students of the University of Liberia Medical School, and student P.A.s and nurses of TWIMA in diagnosis and treatment of dehydration at the oral rehydration training center to be added to regular curriculum.	Project Manager Technical Officer	May

Best Available Document

OBJECTIVE/ACTIVITY	RESPONSIBLE FOR ACTION	TIME TARGET
Provide training in diagnosis and treatment of dehydration to medical, physician assistant, and nursing students	Staff at ORT training site Director, C.D. Division Project Manager Technical Officer	On-going from Sept.
Identify intercountry/WHO-AFRO training course to meet senior level training needs	Technical Officer USAID/Liberia	March
Schedule training of senior level staff (A) Project Manager (B) Directors, EPI and Communicable Disease	 MH&SW USAID/Liberia CDC WHO/AFRO	 June- December

HEALTH INFORMATION SYSTEMS

Prepare CCCD/HIS development plan	Technical Officer Regional Epidemiologist Project Manager Asst. Minister, Vital Stats.	January-February
Develop surveillance forms for use at selected sentinel surveillance sites	Technical Officer Regional Epidemiologist Project Manager Asst. Minister, Vital Stats.	January-February
Select sentinel surveillance sites in first phase counties and train health workers in procedures and use of forms	CCCD County Supervisors Logistics/Training Coordinators In-service Ed. Coordinators Technical Officer Project Manager	March
Field test forms and surveillance procedures in sentinel sites of first phase counties	CCCD County Supervisors Logistics/Training Coordinators Technical Officer Project Manager	April
Coordinate supervision of sentinel sites to review procedures, provide in-service training, and evaluate forms	CCCD County Supervisors Logistics/Training Coordinators In-service Ed. Coordinators Technical Officer Project Manager	April-June
Review, revise if necessary, and print surveillance forms and procedures.	Technical Officer Project Manger	July
Prepare and submit monthly project report	Technical Officer	Monthly
Prepare and submit annual MIS report	Technical Officer	March

Best Available Document

OBJECTIVE/ACTIVITY	RESPONSIBLE FOR ACTION	TIME TARGET
Develop microcomputer programs to accept, coalate, compute, and print surveillance data, and coverage and use of health services data	Technical Officer Project Manager Regional Epidemiologist	January-June
Select sentinel surveillance sites in second phase counties and train health workers in procedures and use of forms	CCCD County Supervisors Logistics/Training Coordinators In-service Ed. Coordinators Technical Officer Project Manager	October
On-site inspection of sentinel sites to review procedures, provide on-the-job training, and evaluate forms	CCCD County Supervisors Logistics/Training Coordinators In-service Ed. Coordinators Technical Officer Project Manager	November-January 87

HEALTH EDUCATION/PROMOTION

Analyze KAP data from MOHS Survey	Technical Officer Project Manager Logistics/Training Coordinators	January-March
Select or develop messages and materials for HE/P activities through Mass media Village mobilization Individual counseling	Health Education Division Staff PCV Graphics Illustrator Project Manager Short Term Consultants Technical Officer	March-June
Pre-test messages and materials in selected clinics in the first and second phase counties.	CCCD County Supervisors Health Education Div. Staff PCV Graphics Illustrator Logistics/Training Coordinators	July-September
Evaluate results of pre-test of messages and materials and adapt as needed	Health Education Div. Staff Project Manager Short Term Consultant	August-September
Produce and distribute messages and materials	Health Education Division Graphics Illustrator Technical Officer Ministry of Information LWCN	October
Continue on the job training of Liberian counterpart in materials production for job aids, posters, and	PCV Graphics Illustrator	Ongoing

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OPERATIONS RESEARCH

OBJECTIVE/ACTIVITY	RESPONSIBLE FOR ACTION	TIME TARGETS
Redefine list of suggested OR topics in lines with recommendations developed by Regional Epidemiologist. Disseminate information on OR topics, funding, and proposal development to potential investigators within Liberia	Regional Epidemiologist Project Manager Project Coordinator USAID/Liberia	January-March
Review submitted proposals Reject Return with suggestions for changes Approve protocols (1 to 2)	OR Sub-Committee Regional Epidemiologist Project Manager	As needed
Consultations to research investigators on study design, data collection or analysis	Regional Epidemiologist Technical Officer Project Manager	As needed
Review progress reports and final reports of research projects.	OR Sub-committee Regional Epidemiologist Project Manager USAID/Liberia	As needed
Technical approval for partial and final payments for research projects	Project Manager Regional Epidemiologist USAID/Liberia	As needed

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LIBERIA MINISTRY OF HEALTH AND SOCIAL WELFARE
COMBATTING CHILDHOOD COMMUNICABLE DISEASES PROJECT (698-0421.03)

LIFE OF PROJECT WORK PLAN

OBJECTIVE/ACTIVITY	TIME TARGET	RESPONSIBLE FOR ACTION	STATUS
Develop Life Of Project work plan	Dec, 1985	CCCD : P.M./T.O. USAID: H.O.	COMPLETED
Develop life of project procurement plan	Dec, 1985	CCCD : P.M./T.O. USAID: H.O.	COMPLETED
Develop life of project training plan	Dec, 1985	CCCD : P.M./T.O. USAID: H.O.	COMPLETED
Assist counties in writing, reviewing, obtaining approval and implementing an adjusted fee-for-service plan		CCCD : P.M./T.O. MH&SW: P.C./C.M.O. USAID: H.O.	
First Phase Counties	Nov, 1985		Part. Com
Second Phase Counties	Mar, 1986		
Third Phase Counties	Oct, 1986		
Upon approval of a motorcycle purchase plan, develop forms for applying, and assist counties in informing local health workers of the availability of the motorcycles.		CCCD : P.M./T.O. MH&SW: P.C./PHCCC USAID: H.O.	
First Phase Counties	Nov, 1985		COMPLETED
Second Phase Counties	Mar, 1986		
Third Phase Counties	Oct, 1986		
Award motorcycles contracts to local health workers		MH&SW: P.C./PHCCC CCCD : P.M.	
First phase counties	Feb, 1986		
Second phase counties	Jul 1986		
Third phase counties	Nov, 1986		
Quarterly CCCD Technical Committee Meetings	Quarterly	CCCD : P.M./T.O.	On-going
First and third year internal review of project	Dec, 1984 Dec, 1986	AID/W: CDC : MH&SW: P.C. USAID. H.O.	COMPLETED
Second and fourth year external review of project	Feb, 1986 Jul, 1987	AID/W: CDC : WHO : UNICEF:	
Annual CCCD Consultative Meeting	Mar, 1984 Mar, 1985 Mar, 1986 Mar, 1987	CDC : AID/W:	COMPLETED COMPLETED

OBJECTIVE/ACTIVITY	TIME TARGET	RESPONSIBLE FOR ACTION	STATUS
Set up computerized data systems for analysis of delivery of CCCD interventions, disease reporting, inventory control, and budgets	Jan-Mar 1986	CCCD : T.O./P.M.	
Train selected MH&SW personnel in use of the micro-computer and data system software	Apr-Jun 1986	CCCD : T.O./P.M.	
Develop and submit annual projection for short term consultant requirements	March Annually	CCCD : P.M./T.O. MH&SW: P.C. USAID: H.O.	
Annual vacation			
Project Manager	December		
Technical Officer	July-Aug		
Financial Officer/Secretary	December		
EXPANDED PROGRAM FOR IMMUNIZATION			
Implementation of enhanced delivery of immunization services, and supervision and follow-up in first phase counties: Bomi, lower Lofa, and Grand Cape Mount	Aug, 1985 On-going	MH&SW: C.M.D./C.S./L.T.C. CCCD : P.M./T.O. EPI : DIR/P.M.	IN PROCESS
Implementation of enhanced delivery of immunization services, and supervision and follow-up in second phase counties: Montserrado and Margibi	Mar, 1986 On-going	MH&SW: C.M.D./C.S./L.T.C. CCCD : P.M./T.O. EPI : DIR/P.M.	
Implementation of enhanced delivery of immunization services, and supervision and follow-up in third phase counties: Bong, upper Lofa, Grand Bassa, Grand Gedeh, and Sinoe	Nov, 1986 On-going	MH&SW: C.M.D./C.S./L.T.C. CCCD : P.M./T.O. EPI : DIR/P.M.	
EPI quarterly supervisors conference	Quarterly	EPI :DIR/P.M. CCCD :P.M./T.O.	IN PROCESS
Annual National Vaccination Week	Annually by:	EPI :DIR/P.M.	
Planning activities,national level	April	CCCD :P.M./T.O.	
Commodity ordering and procurement	April	MH&SW:P.C./C.M.D./C.M.D.	
Planning activities, county/local level	July-Aug	C.S./L.T.C.	
Training activities	Aug-Sept	USAID:H.O.	
National vaccination week	November	UNICEF:	
Evaluation	December	WHO/PVO:	
Accountability of resources and supplies.		EPI :DIR/P.M.	
Development of forms	Jul-Dec 85	CCCD :P.M./T.O.	COMPLETED
Training of national and county staff	Jul-Dec 85	MH&SW:P.C./C.M.D./C.S.	
Training of clinic staff	Jan-Jun 86	L.T.C.	
Review of use; retraining; revison if necessary	Jan-Jun 86		
Conduct nationwide inventory and audit of resources and supplies	1986: Each Quarter; Semi-annually thereafter	EPI :DIR/P.M./STAFF CCCD :L.O./P.M./T.O. MH&SW:P.C./C.M.D./C.S. L.T.C.	

OBJECTIVE/ACTIVITY	TIME TARGET	RESPONSIBLE FOR ACTION	STATUS
Advise and assist EPI in improving and monitoring cold chain at the central level and in non-project counties	On-going	CCCD :T.D./L.D./P.M.	

DIARRHEAL DISEASE CONTROL/MALARIA TREATMENT

Develop a national diarrheal disease control policy	Dec, 1985	CCCD : P.M./T.D. CDDiv: DIR MH&SW: D.C.M.D.-P.S.	COMPLETED
Approval of national diarrheal disease control policy	Jan, 1986	MH&SW: MINISTER	
Develop a national malaria treatment and prophylaxis policy	Dec, 1985	CCCD : P.M./T.D CDDiv: DIR MH&SW: D.C.M.D.-P.S.	COMPLETED
Approval of national malaria treatment and prophylaxis policy	Feb, 1986	MH&SW: MINISTER	
Establish an oral rehydration therapy center in the greater Monrovia area for training of health workers in ORT	Mar, 1986	CCCD : P.M./T.D. CDDiv: DIR USAID: H.D./ENGINEER	
Implementation of enhanced delivery of oral rehydration therapy, malaria presumptive treatment for fever in under 5s, and malaria prophylaxis of pregnant women in first phase counties.	Jan, 1986 On-going	MH&SW: C.M.D./C.S./L.T.C. CCCD : P.M./T.D. CCDiv: DIR	
Implementation of enhanced delivery of oral rehydration therapy, malaria presumptive treatment for fever in under 5s, and malaria prophylaxis of pregnant women in second phase counties.	Aug, 1986 On-going	MH&SW: C.M.D./C.S./L.T.C. CCCD : P.M./T.D. CDDiv: DIR	
Implementation of enhanced delivery of oral rehydration therapy, malaria presumptive treatment for fever in under 5s, and malaria prophylaxis of pregnant women in third phase counties.	July- ~~Jan~~, 1987 On-going	MH&SW: C.M.D./C.S./L.T.C. CCCD : P.M./T.D. CCDiv: DIR	

TRAINING/TRAINING DEVELOPMENT

Conduct CCCD Mid-Level Managers course for four county level personnel, two national level trainers, and three Peace Corps Volunteers for the first phase counties. This first training course will also serve as a field test of "generic" CCCD MLM training modules.	Feb, 1985	CCCD : P.M./T.D. IEDiv: DIR/STAFF	COMPLETED
Review results of MLM course and adapt materials as necessary to better meet the needs of Liberia.	Jul-Dec, 1985	CCCD : P.M./T.D. IEDiv: DIR	COMPLETED

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OBJECTIVE/ACTIVITY	TIME TARGET	RESPONSIBLE FOR ACTION	STATUS
Produce the Liberia MLM training materials	Jan-Feb, 1986	CCCD : P.M./T.D. IEDiv: DIR Contractor	
Evaluate application of training of first phase county level supervisors.	Jul-Dec, 1985	CCCD : P.M./T.D. IEDiv: DIR MH&SW: C.M.D.	COMPLETED
Conduct CCCD MLM course for six county level personnel and three Peace Corps Volunteers for the second phase counties.	Mar, 1986	IEDiv: DIR/STAFF HEDiv: STAFF CCCD : P.M./T.D.	
Evaluate application of training of second phase county level supervisors.	Apr-Sept, 1986	CCCD : P.M./T.D. IEDiv: DIR/STAFF HEDiv: STAFF MH&SW: C.M.D.	
Conduct CCCD MLM course for eight county level personnel and four Peace Corps Volunteers for the third phase counties.	Jan, 1987	IEDiv: DIR/STAFF HEDiv: STAFF CCCD : P.M./T.D.	
Evaluate application of training of third phase county level supervisors	Feb-Jul, 1987	CCCD : P.M./T.D. IEDiv: DIR/STAFF HEDiv: STAFF MH&SW: C.M.D.	
Develop and test training materials for clinic level workers for delivery of immunization services	Apr-May, 1985	MH&SW: C.S./L.T.C IEDiv: DIR/STAFF CCCD : P.M./T.D. CDC : STC	COMPLETED
Develop and test training materials for clinic level workers for delivery of services for diarrheal disease control and oral rehydration therapy and malaria presumptive treatment for fever in under 5s, and malaria prophylaxis of pregnant women	Nov-Dec, 1985	MH&SW: C.S./L.T.C IEDiv: DIR/STAFF CCCD : P.M./T.D.	COMPLETED
Train clinic level workers in first phase counties to deliver immunization services	Jun-Jul, 1985	MH&SW: C.M.D./C.S./L.T.C IEDiv: DIR/STAFF CCCD : P.M./T.D.	COMPLETED
Train clinic level workers in first phase counties to deliver services for diarrheal disease control and oral rehydration therapy and malaria presumptive treatment for fever in under 5s and malaria prophylaxis of pregnant women.	Dec, 1985	MH&SW: C.M.D./C.S./L.T.C IEDiv: DIR/STAFF CCCD : P.M./T.D.	COMPLETED
Review delivery of immunization services at clinic level, first phase counties, evaluate application of training, provide on-the-job and in-service training to strengthen deficencies detected.	Aug, 1985 On-going	MH&SW:C.S./L.T.C. IEDiv:DIR/STAFF CCCD :P.M./T.D.	IN PROCESS

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OBJECTIVE/ACTIVITY	TIME TARGET	RESPONSIBLE FOR ACTION	STATUS
Review delivery of services at clinic level, first phase counties, for oral rehydration and malaria presumptive treatment and prophylaxis, evaluate application of training, provide on-the-job and in-service training to strengthen deficiencies detected.	Feb, 1986 On-going	MH&SW:C.S./L.T.C. IEDiv:DIR/STAFF CCCD :P.M./T.O.	
Train clinic level workers in second phase counties to deliver immunization services	Apr-May 1986	MH&SW:C.S./L.T.C. IEDiv:DIR/STAFF CCCD :P.M./T.O.	Done
Train clinic level workers in second phase counties to deliver services for diarrheal disease control and oral rehydration therapy and malaria presumptive treatment for fever in under 5s, and malaria prophylaxis of pregnant women	July-Aug, 1986	MH&SW:C.S./L.T.C. IEDiv:DIR/STAFF CCCD :P.M./T.O.	
Review delivery of immunization services at clinic level, second phase counties, evaluate application of training, provide on-the-job and in-service training to strengthen deficiencies detected.	May, 1986 On-going	MH&SW:C.S./L.T.C. IEDiv:DIR/STAFF CCCD :P.M./T.O.	ongoing evaluation training
Review delivery of services at clinic level, second phase counties, for oral rehydration and malaria presumptive treatment and prophylaxis, evaluate application of training, provide on-the-job and in-service training to strengthen deficiencies detected.	Sept, 1986 On-going	MH&SW:C.S./L.T.C. IEDiv:DIR/STAFF CCCD :P.M./T.O.	
Train clinic level workers in third phase counties to deliver immunization services	Jan-Mar 1987	MH&SW:C.S./L.T.C. IEDiv:DIR/STAFF CCCD :P.M./T.O.	
Train clinic level workers in third phase counties to deliver services for diarrheal disease control and oral rehydration therapy and malaria presumptive treatment for fever in under 5s, and malaria prophylaxis of pregnant women	Jun-Jul 1987	MH&SW:C.S./L.T.C. IEDiv:DIR/STAFF CCCD :P.M./T.O.	
Review delivery of immunization services at clinic level, third phase counties, evaluate application of training, provide on-the-job and in-service training to strengthen deficiencies detected.	April, 1987 On-going	MH&SW:C.S./L.T.C. IEDiv:DIR/STAFF CCCD :P.M./T.O.	
Review delivery of services at clinic level, third phase counties, for oral rehydration and malaria presumptive treatment and prophylaxis, evaluate application of training, provide on-the-job and in-service training to strengthen deficiencies detected.	Jul, 1987 On-going	MH&SW:C.S./L/T/C/ IEDiv:DIR/STAFF CCCD :P.M./T.O.	
Establish training at oral rehydration therapy site as part of the required cirruculua for students of the University of Liberia Medical School, student P.A.s and Nurses of TNIMH, and student nurses from Cuttington College.	Jun, 1986	CCCD :P.M./T.O.	

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OBJECTIVE/ACTIVITY	TIME TARGET	RESPONSIBLE FOR ACTION	STATUS
Define needs for senior level management/administrative training	Feb, 1986	CCCD :P.M./T.O. MH&SW:C.M.O./ USAID:H.O.	
Identify intercountry/WHO-AFRO training course to meet senior level training needs	Apr. 1986	CCCD :P.M./T.O. MH&SW:P.C. USAID:H.O.	
Schedule training of senior level staff (A) Project Manager (B) Directors, EPI and Communicable Disease (C) Directors, Health Education and In-Service Education	May, 1986	MH&SW:P.C./C.M.O. CCCD :P.M./T.O. USAID:H.O.	
HEALTH INFORMATION SYSTEMS			
MCHS baseline survey of first phase counties			
Planning and questionnaire development	Feb-Jul, 84	CCCD : P.M./T.O./R.E.	COMPLETED
Preparation of training materials	Aug-Sept, 84	CDC : CONSULTANT	COMPLETED
Training	Oct-Nov, 84		COMPLETED
Survey	Nov-Dec, 84		COMPLETED
Data entry	Dec-Feb, 85		COMPLETED
Verification survey	May, 1985		COMPLETED
Data entry	Jun, 1985		COMPLETED
Analysis	Jul-Oct, 85		IN PROGRESS
Final report	Nov, 1985		
Prepare a CCCD/HIS development plan	Feb, 1986	CCCD : T.O./R.E./P.M. MH&SW: B.H.I.&V.S.	
Develop surveillance forms for use at selected sentinel surveillance sites	Feb, 1986	MH&SW: B.H.I.&V.S/C.M.O. C.S./L.T.O. CCCD : P.M./T.O.	
Select sentinel surveillance sites in first phase counties and train health workers in procedures and use of forms.	Mar, 1986	MH&SW: B.H.I.&V.S/C.M.O. C.S./L.T.O. IEDiv:DIR/STAFF CCCD :P.M./T.O.	
Field test forms and surveillance procedures in sentinel sites of first phase counties.	Apr, 1986	MH&SW:C.M.O./C.S./L.T.C. CCCD :P.M./T.O.	
On-site inspection of sentinel sites to review procedures, provide on-the-job training, and evaluate forms	Apr, 1986 On-going	MH&SW:C.M.O./C.S./L.T.C. CCCD :P.M./T.O.	
Review, revise if necessary, and print surveillance forms and procedures.	May, 1986	CCCD :P.M./T.O.	
Hospital and health center record reviews for data on measles and dehydration admissions and outcomes.	May, 1986	MH&SW:C.S./L.T.C.	

OBJECTIVE/ACTIVITY	TIME TARGET	RESPONSIBLE FOR ACTION	STATUS
Select sentinel surveillance sites in second phase counties and train health workers in procedures and use of forms	Aug, 1986	MH&SW:C.M.D./C.S./L.T.C. IEDiv:DIR/STAFF CCCD :P.M./T.O.	
On-site inspection of sentinel sites to review procedures, provide on-the-job training, and evaluate forms	Sept, 1986 On-going	MH&SW:C.S./L.T.C. CCCD :P.M./T.O.	
Select sentinel surveillance sites in third phase counties and train health workers in procedures and use of forms	Mar, 1987	MH&SW:C.M.D./C.S./L.T.C. IEDiv:DIR/STAFF CCCD :P.M./T.O.	
On-site inspection of sentinel sites to review procedures, provide on-the-job training, and evaluate forms	Apr, 1987 On-going	MH&SW:C.S./L.T.C. CCCD :P.M./T.O.	
Prepare and submit annual MIS report	March Annually	CCCD :T.O.	
Develop microcomputer programs to accept, collate, compute, and print surveillance data	Jan-Jun, 1986	CCCD :T.O./P.M.	
Train selected MH&SW staff in use of microcomputers for MIS	Mar, 1986 On-going	CCCD :T.O./P.M.	
HEALTH EDUCATION/PROMOTION			
Analyze KAP data from MOHS Survey	Jan-Mar, 1986	CCCD :P.M./T.O. HEDiv:DIR/STAFF	
Assess results of mass media coverage and community mobilization activities used for national vaccination week	Feb-Mar 1986	CCCD :P.M./T.O. HEDiv:DIR/STAFF EPI :DIR/P.M.	
Adapt or develop new messages and materials for HE/P activities through Mass media Village mobilization Individual counseling	Apr-Jun, 1986	HEDiv:DIR/STAFF CCCD :P.M./T.O./B.I. CDC :S.T.E.	
Pre-test messages and materials	Jul-Sept 1986	HEDiv:DIR/STAFF MH&SW:C.S./L.T.C. CCCD :B.I.	
Evaluate results of pre-test of messages and materials and adapt as needed	Aug-Sept, 1986	HEDiv:DIR/STAFF CCCD :P.M./T.O./B.I.	
Produce and distribute messages and materials	Oct, 1986	HEDiv:DIR/STAFF CCCD :T.O./B.I.	
Conduct KAP survey to evaluate impact of HE/P	Feb-Apr, 1987	HEDiv:DIR/STAFF MH&SW:C.M.D./C.S./L.T.C. CCCD :P.M./T.O.	

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OBJECTIVE/ACTIVITY	TIME TARGET	RESPONSIBLE FOR ACTION	STATUS
OPERATIONS RESEARCH			
Redefine list of suggested OR topics in line with recommendations developed by Regional Epidemiologist. Designate information on OR topics, funding, and proposal development to potential investigators with in Liberia	Jan-Mar, 1986	CCCD :R.E./P.M. MH&SW:P.C. USAID:H.O.	
Review submitted proposals Reject Return with suggestions for changes Approve protocols (1 to 2 per year)	As needed	MH&SW:O.R. SUB. COMM. CCCD :R.E./P.M.	
Consultations to research investigators on study design, data collection or analysis	As needed	CCCD :R.E./T.O./P.M.	
Review progress reports and final reports of research projects.	As needed	MH&SW:O.R. SUB. COMM. CCCD :P.M./R.E. USAID:H.O.	
Technical approval for partial and final payments for research projects	As needed	CCCD :P.M./R.E. USAID:H.O.	
Fund 1 to 2 OR proposal per year			

KEY TO ABBREVIATIONS USED IN "RESPONSIBLE TO ACTION"

CCCD — COMBATTING CHILDHOOD COMMUNICABLE DISEASES PROJECT (698-0421.03)
- P.M. — PROJECT MANAGER
- T.O. — TECHNICAL OFFICER
- F.O. — FINANCIAL OFFICER
- R.E. — REGIONAL EPIDEMIOLOGIST

MH&SW — MINISTRY OF HEALTH AND SOCIAL WELFARE
- P.C. — PROJECT COORDINATOR, DEPUTY CHIEF MEDICAL OFFICER, BUREAU OF PREVENTIVE SERVICES
- C.M.D. — COUNTY MEDICAL DIRECTOR
- C.S. — COUNTY CCCD SUPERVISOR
- L.T.C. — LOGISTICS/TRAINING COORDINATOR (PEACE CORPS VOLUNTEER)
- BHI&VS — BUREAU OF HEALTH INFORMATION AND VITAL STATISTICS

EPI — EXPANDED PROGRAM FOR IMMUNIZATION, MH&SW
- DIR — DIRECTOR
- P.M. — PROGRAM MANAGER

HEDiv — HEALTH EDUCATION DIVISION, MH&SW
- DIR — ACTING DIRECTOR

IEDiv — IN-SERVICE EDUCATION DIVISION, MH&SW
- DIR — DIRECTOR

USAID — U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT TO LIBERIA
- H.O. — HEALTH AND POPULATION OFFICER

CDC — INTERNATIONAL HEALTH PROGRAM OFFICE, CENTERS FOR DISEASE CONTROL

AID/W — AGENCY FOR INTRNATIONAL DEVELOPMENT, WASHINGTON D.C.

UNICEF — UNICEF, LIBERIA

WHO — WHO, LIBERIA

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APPENDIX 9

ESTIMATION OF COST PER IMMUNIZED INDIVIDUAL IN THE LIBERIAN EPI/CCCD PROGRAM FOR CALENDAR YEAR 1985

Analysis prepared by Catherine A. Severo, PCV Nimba County Health Team for CCCD Evaluation Team, March 1, 1986.

DESCRIPTION

The cost per immunized individual was calculated for the Liberian EPI/CCCD Program for calendar year 1985. The calculations are based on cost and coverage estimates from a variety of sources. The sources and the weaknesses of the data are identified in Table 1. In general, however, certain qualifiers must be kept in mind. The actual amount of vaccine and supplies provided by the EPI office during 1985 is unknown. While some records exist, the variance between reported figures and subsequent inventories was high by as much as factors of five or ten. While every attempt has been made to correct for this, the resulting cost estimates may be overstated. For certain items, no records exist and estimates, based on personal experience, had to be made.

Since the actual population, of Liberia is unknown. a figure of 1.9 Million is used to estimate coverage. This number is based on trended forward data from the 1974 census figures. Target populations were calculated using the percentages for age groups used throughout West Africa. Although target populations per Liberian county were calculated by regional EPI supervisors in 1985, these data were not available. Coverage estimates are based on the preliminary results of the coverage survey conducted after the January 1986 National Vaccination Campaign by CCCD. Results from three counties and Monrovia are available. The

coverage and cost estimates shown in Table 2 and were calculated using data from two counties which may represent the range of coverage for all counties except Monrovia. These calculations will be corrected in later months as the coverage survey is completed.

Table 1

COST DATA ELEMENT	SOURCE	STRENGTHS/WEAKNESSES
EPI expenditures for 1985	MH&SW budget office Actual FY 1985 expenditures	FY 85 is July 84-June 85. Since salaries equal 88% of the budget and have not changed, actual expenditures in FY85 were accepted as a proxy for calendar 1985.
CCCD total cost Less Malaria related purchases for 1985	USAID cost reports Actual Cal. 85 expenditures	Since immunization represents almost all project activities, all CCCD costs were allocated to it except identifiable expenditures on non-immunization activities.
MH&SW Personnel budget for two weeks in 1985	MH&SW budget office Actual FY 1985 expenditures	The National Vaccine Campaign (NVC) used almost 100% of MH&SW personnel for one week, and large but varying amounts of personnel during the prior 6 month period. A gross estimate of MOHSW's contribution to immunization was set at 2 weeks of time.
Peace Corps Volunteers Doing EPI in 1985	Peace Corps estimate of total support and known PCVs involved	Ten PCVs were involved in various aspects of the program. Percentages of their time were estimated.
Other Health Workers Doing EPI in 1985	MH&SW budget office Actual FY 1985	A small number of workers assigned to MH&SW, Ministry of Education, and Ministry of Agriculture do full-time immunization work. Some very small percentage of double-counting may exist.
Estimated value of vaccine distributed by EPI in 1985	EPI stockroom records for calendar 1985. Cost based on UNICEF price/dose + 15% shipping cost.	Many donors provide vaccine to EPI, including WHO, USAID, UNICEF, Rotarians. Their true costs were not available. Since EPI channels all these donations to the vaccinators, their disbursal records were used to estimate the value of vaccine. An inventory in Feb 1986 showed these records contained serious errors, sometimes as much as 2 million units. These errors have been accounted for. There is a large

COST DATA ELEMENT	SOURCE	STRENGTHS/WEAKNESSES
		discrepancy between doses sent out and coverage estimates. From the expiration dates on doses sent, most non-used doses are no longer viable. This wastage factor must be included in cost estimates. Few records were even made.
Estimated value of supplies sent out by EPI in 1985.	Estimate based on UNIPAC and IDA price lists + 15% shipping, and partial list of items sent out by EPI.	Actual records were not available. Estimates of supplies were that one needle and syringe was needed for every dose sent out. Cold chain equipment estimates were based on personal experience of Nimba County items received, generalized to eleven counties. These estimates may have little validity.

Costs Worksheet

Item			Cost Estimate
EPI Budget			$ 203093
CCCD Cost - Malaria Activities			179165
MH&SW Personnel for 2 Weeks			388308
Peace Corps Volunteer			56769
Other Health Workers			55491
Estimated Value of Vaccine:	TT,	374400 doses	7320
	BCG,	288970 doses	26586
	Measles,	104280 doses	10912
	DPT,	386560 doses	11559
	Polio,	435660 doses	13026
Estimated Value of Supplies:	Syringes		23848
	Needles		22258
	Refrigerators		10856
	Cold Boxes		11284
	Small Thermos Coolers		2745
	Thermos Cold Packs		3896
	TOTAL		$ 1027116

Cost Calculation

Cost per vaccination was calculated for each vaccine separately. This was done in an attempt to capture the differences between partial and fully immunized individuals. The formula used is:

Cost per immunization of one vaccine type:

Support cost common to all vaccines	% of total doses X that are one vaccine type	+	(Additional Support costs injections for one vaccine type	x	% of doses* that are for one vaccine	+ individual vaccine costs

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Estimated Additional Covered Population for Vaccine Type

*Polio vaccine calculations eliminate the second element, support cost for injection, since it is an oral vaccine.

Table 2

Data Elements

Vaccine	Doses	Percentage of Total Doses	Percentage of Total Injectable Doses
BCG	288970	18.2	25.0
Polio	435660	27.4	-
DPT	386560	24.3	33.4
Measles	104280	6.6	9.0
TT	374400	23.5	32.4
	1589870	100.0	100.0

Support cost for all vaccines: $911604
Additional support cost for injectable vaccines: $ 46106

Population estimates:

Total Population:	= 1.9 million
BCG, 0-1 year olds, 3.3% of population, target	= 62700
Polio, 0-2 year olds, 7.5% of population, target	= 142500
Measles, 9 months - 3 years, 11.3% of population, target	= 214700
DPT, 0-5 year olds, 19% of population, target	= 361000
TT, 14-49 year old women, 20% of population, target	= 380000

Coverage Survey Results:

Percentage Vaccinated in County

Vaccine		Monrovia	Margibi	Cape Mount	Bomi/Lower Lofa
BCG		65	36	43	50
Polio	1	58.5	30	58	60
	2	28	25	25	28
	3	21	20	15	10
DPT	1	59.5	41	58	69
	2	26.5	9	26	29
	3	21	4	16	14
Measles		40	33	49	73
Fully Immunized		16	3	12	7
TT	1	21			
	2	7			

Estimated Coverage for Liberia Per Vaccine:

Expected Number Immunized Based On Two Counties' Coverage Data

Vaccine	Using Bomi/LL Coverage	Using Margibi Coverage
BCG	31350	22464
Polio 1	85500	42750
2	39900	35625
3	14250	28500
DPT 1	249090	148010
2	104960	32490
3	50540	14440
Measles	156731	70851
TT 1	79800	79851
2	26600	26600
Fully Immunized	26270	10830

Cost Per Immunization:

Cost Per Vaccine Using Two Coverage Estimates

Vaccine	Using Bomi/LL Coverage	Margibi Estimate
BCG	5.66	7.90
Polio 1	3.07	6.15
2	6.59	7.38
3	18.44	9.22
DPT 1	1.00	1.65
2	2.37	7.65
3	4.92	17.21
Measles	0.48	1.06
TT 1	2.96	2.96
2	8.89	8.89
Fully Immunized	40.65	94.84
*If allocated 75% Support to Measles	4.65	10.29

*The final calculation is made in order to look at value of the program. Some epidomiologists believe measles is the most important vaccine for reducing child mortality. Therefore at least measles vaccine should be delivered by a program. Additional vaccines add variable costs but only marginally affect the total cost.

**The above costs are based on the assumption that before 1985 coverage 0. Therefore, cost per vaccinated child would be considerably higher if these calculations were based on a new cohort of children not the entire number of children in the population.

Appendix 11

Cost Recovery in the Nimba County
Primary Health Care Village Health Worker Program

Brief Summary by Catherine A. Severo, PCV
Nimba County Health Team for CCCD Evaluation
March 6, 1986

Introduction: Fifteen Village Health Workers (VHWs) have been working in three adjacent clans in Nimba County, Liberia since June, 1984. During the first eighteen months of the program they have treated 10,320 cases. A combination of government, private donor, and community funding, supports the VHW's, their supervisory system, and their revolving drug program. This paper describes the issues and successes of the existing program to recover costs through user fees.

Setting: Since 1979, development in Nimba County has been primarily supported since 1979 by the Nimba County Rural Development Program (NCRDP) of the German Technical Assistance Project (Federal Republic of Germany). NCRDP provides limited financial and technical assistance structured to support as few operating costs as possible. The program components include agriculture, fisheries, roads, water, and health. Primary Health Care (PHC) development is divided into ten geographic cycles of two to three clans each (about twenty villages). Within the Cycle I area, St. Mary's Clinic, (a part of the Catholic Mission in Sanniquellie), has been active in health and water development for the last ten years. In 1982, the director of the clinic joined the County Health Team, which is composed of the NCRDP consultant and MH&SW personnel, in its efforts to coordinate all PHC activities in Nimba. The Sanniquellie - Nah/Gbehley-Gen area was chosen for Cycle I because of the readiness of this donor/health care provider to participate.

One MH&SW clinic and two health posts are within the Cycle 2 area. A third health post was constructed during the project period. The clinics

are staffed by a Regional Supervisor (RN), LDNs, a Health Inspector, and other assistants. The health posts are staffed by either a Physician Assistant (PA) or an RN.

In addition, four Peace Corps Volunteers have contributed varying percentages of their time to this project. Due to lack of GOL funds, most of these MH&SW health facilities have received little or no equipment or drugs for the past year or more. Payment for the health staff has a lag time of two to five months.

Goals: The goal of the PHC development in Nimba is to create an integrated multi-level health care system with consistent logistical support at an acceptable cost. There are three main components to this program: 1) mobilization of communities for PHC and for active participation in a VHW program and related development; 2) strengthening the existing health infrastructure, including extending the skills of current MH&SW workers; and 3) creation and implementation of new mechanisms for financing current under supported activities and new activities.

Progress: Pursuit of the three components took place simultaneously. After self-education, consensus building, and planning meetings about PHC, sensitization teams (S-teams) comprised of MH&SW clinic/post staff and St. Mary's staff were formed . The S-teams made a series of visits to 21 communities within Cycle 1. Communities were chosen on the basis of size. Any village with more than 4000 people/50 huts and less than 200 huts could participate in PHC. (This size is considered necessary by NCRDP to muster sufficient human and financial resources but not too large to be a cohesive community.)

During the visits, the concept of PHC was explained and the health status and desires of the community discussed. If a village was interested in PHC, the S-team guided the residents through formation of a Village

Development Committee (VDC), choice of a Chairman, and ultimately, choice of a VHW trainee. The VDCs are envisioned as general development bodies which will make choices among agriculture, construction, water, or other activities, whether self-generated or offered by NCRDP. The VDCs were required to choose a method for supporting their VHWs through ad hoc in-kind and cash contributions both from individual patients and the villages as a whole. The Cycle 1 VDC's chose to support the UHWS through ad hoc in-kind and cash contributions both from individual patients and the villages as a whole. Criteria for selecting the VHW was based on the national MH&SW guidelines. Villages were encouraged to choose by consensus someone who was a settled, permanent, and respected community member. Illiterate or barely literate villagers were preferred. No prior western health experience was allowed because of the likelihood of job dissatisfaction with the limited authority of the VHW role.

Independently, refresher training of MH&SW workers was begun. Cycle 1 health workers were drawn into an integrated system by their new training, their short-team work, and their participation in creating the VHW curriculum. Some of the short-team workers were also trained to become the VHW trainers and supervisors. Three were provided with motorcycles by NCRDP according to the national purchase policy.

The VHWs were to be visited bi-weekly, then monthly, by their VHW Supervisors and encouraged to refer those cases outside their scope, to their nearest health post or clinic. Health posts would refer to either the MH&SW clinic, St. Mary's, or a hospital if necessary. During the supervisory visit, the VHW's monthly records (designed for illiterates) and drug kit would be checked, feedback on referrals given, and the status of community/VHW relations assessed. The Supervisor would try to solve conflicts or if necessary, would refer issues to the County Health Team.

Lastly, the VHW revolving drug scheme was planned. A basic kit of nine items was designed to treat the ten conditions for which the VHWs would be trained. The original plan called for purchase of drugs from Monrovia wholesalers. However, in 1985, monies were channeled through St. Mary's Clinic for the purchase of drugs from the Christian Health Association of Liberia.

Throughout this development process, the emphasis has been on maximizing existing MH&SW and community resources. As much as possible new payments or income from donors were excluded in order to limit dependence on them and to limit increasing the financial burdens of the GOL. For example, MH&SW workers are not given any extra pay or per diem for their VHW supervisory activities, although they are given fuel support. Initially, the villages expected VHWs to go on the GOL payroll, but this was never considered. The VHW was considered as the employee of the village. The village as a whole is the PHC participant with the Health Team.

Implementation: Three S-teams visited 21 villages from November 1983 - February 1984. Fifteen villages formed VDCs and chose VHWs. Th VHWs are trained and installed in their villages by June 1984. Each village rais $109 for the initial purchase of their drug kit.

The VHWs were trained to treat the following conditions:

Condition	Treated With	Amount in Drug Kit
Malaria	Chloroquine	1 Tin/1000 tabs
	Asprine	1 Tin/1000 tabs
Worms	Piperazine	2 liters
Anemia	Iron Syrup	1 liter
Diarrhea	Oral Rehydration Therapy	(Home Made)
Malnutrition	Referred	

Measles	ORT, ASA, Fever control, or referred	
Tetanus	Referred	
Wombs	Cotton, Plaster, Bandages, Genetian Viloet or referred	1 roll, 4 rolls, 6 rolls 5 liter
Aches/Pains	Aspirin	As above
Scabies	Benzyl Benzoate	1 liter

Issue: Several issues emerged during Cycle 2 that required revision of the program before extension to any other project area. During the first six months it became clear that villages were not adequately supporting the VHWs with either in-kind or case contributions. (The Lofa County VHW program has had a similar problem.) The problem appeared to be the low value placed on the VHWs services, the vagueness of the agreement for "support", and perhaps the VHWs inability to make payment demands. At the retraining after the first six months, discussions were held with all involved parties. A per case service fee of $.10 was set. The VHW keeps the fee as full payment. In 1985, the VHWs collected $566.70, an average of $44/VHW/year. Since the average annual income of most small village residents is $100-200/year, this sum can create an incentive to work. However, VHWs do not receive fees for health education or voluntary home visits. Their performance in these areas has been weak. For example, the number of home visits has declined steadily from 76 in January, to 27 in December 1985.

Two villages have been dropped from the program due to poor performance. In both, the community failed to support the VHW financially or psychologically. In one village constant pressures from the town chief to give credit to his friends and relatives seriously affected the VHWs revolving drug program. The town also did not meet its obligations to St. Mary's for water projects. The drug kits were removed from the villages in March 1985. In 1986, one VHW was reinstated after retraining

because his town chief and VDC worked hard with the County Health Team to correct their problems. This town will be on probation until May, 1986.

The need for consistent supervision and training of the VHWs cannot be overemphasized. Their lack of experience and their isolation mean that they need constant reinforcement and motivation by their supervisors. This has a high labor cost.

To some extent, the referral system does not work and referrals are decreasing. The most important factor is the failure of GOL to supply the clinics and health posts. Since the referral facilities hav few or no drugs, many patients refuse to be referred because they cannot receive treatment from the health facility. This is compounded by a second factor: perceived value. The prestige of the VHW is increased by his ability to treat his co-villagers. The villagers value his services more because he has drugs even though he has less training than MH&SW health workers. Therefore, there is a strong social disincentive to refer as well as a serious problem with referral facilities. To solve this problem, a revolving drug program for clinics has been designed and will be implemented in the next two months. Referral will be emphasized at the next annual retraining.

Originally NCRDP and St. Mary's were supposed to provide development costs, but GOL was supposed to cover operating costs. This has been hindered by the decreasing ability of GOL to cover non-personnel costs and by the high operating input of St. Mary's and NCRDP staff. However, one component of the clinic revolving drug program is a new registration fee scheme. Monies generated will be kept within the clinic system. Funding of VHW supervisor transport costs will be second on the list of allowable expenses.

<u>Financial Performance</u>: The VHW program has two separate financial components, the VHW Drug Kits and the non-drug costs. The VHW drug kits

were designed as a stand-alone system. NCRDP provided $1,767 for the purchase of a seed stock. The communities purchased their initial drug kits from NCRDP and then revolved the drugs through drug sales. Drugs were priced per dose at cost plus a small margin for spoilage and wasteage. Drugs are revolved on a cash only basis. VHW supervisors take orders and cash from the VHW during supervision and then deliver the drugs from the depot. The VHW holds all cash in his kit until he chooses to purchase more. VHWs who give credit and whose kits fail will not be refinanced by NCRDP. This forces the VHW and village to keep the money. Unfortunately, within the time constraints, a financial report on the revolving drugs is not possible.

The non-drug costs have been borne by five payers: NCRDP, GOL, St. Mary's, Villages, and Peace Corps. Expenses can be divided into five categories: 1) foreign personnel, including NCRCP, St. Mary's, and Peace Corps, 2) curriculum development, 3) community mobilization, 4) training costs, 5) recurrent activities costs less drugs (see Table 1).

The ability of the program to recover costs from user fees depend on what level of recovery, is desired. Currently, the program recovers 100% of the in-village costs: the VHWs time (valued at $.10/case) and the revolving drug costs. However, no costs are recovered for training, supervision, or development. At a different level, the GOL plus the villages cover 35.7% of recurrent activities and 25% of development, mobilization, and training. These figures do not indicate an ability by the Liberians to support their program in the near future unless additional user fees are imposed.

Cost Breakdown

Total Non-Drug Costs =	$232,768	=	TC_0
Foreign Personnel =	57,443	=	TC_1
TC_1 - Curriculum Development =	53,813	=	TC_2
TC_2 - Curriculum Mobilization =	52,133	=	TC_3
TC_3 - Training Costs	42,103	=	TC_4
Number of VHW's	14		
TC_4/VHW per annum -	3,007		
Number of cases treated (1984/85 =	10,320		
TC_4/Case =	4.08		

This breakdown assumes that the users should pay for recurrent costs and the training of their VHWs, but that outside donors should bear most of the cost of development and outreach. If the donors should also assume the training costs, then TC_4 = $42103 and unrecovered cost per case is $4.08. Thus, to fully recover operating costs, user fees would have to

Table 1

Non-Drug Cost
October 1983 - December 1985

Cost Item	NCRDP	GOL	Source of Support St. Mary's	Villages	Peace Corps	Total	%
1. Foreign Personnel	130000	0	32500	0	12825	175325	75.3
2. Curriculum Development	2835	795	0	0	0	3630	1.6
3. Community Mobilization	1680	0	0	0	0	1680	0.7
4. Training	6850	318	0	0	0	10030	4.3
5. Recurrent Activities	21932	14474	5130	567	0	42103	18.1
TOTAL	163297	18449	37630	567	12825	232768	100
% of Total	70.2	7.9	16.2	2.0	5.5	100	

Sources of Data: See Annex

be $3.98 instead of $.10. There would be an additional administrative burden of collection, monitoring, and disbursal to offset this income as well. Given the perception of Liberian villagers' willingness and ability to pay, even a fee of $.25 or $1.00 may not be collectable.

Change to a higher fee rate to cover non-village costs would entail a change in program philosophy. One of the goals of the program has been to stimulate village participation in PHC. An important component of this has been the VHW as village employee. To require the VHW to collect fees for the larger health system - even though it is the VHW's health system - is likely to be perceived as a shift to VHW as MH&SW employee, with an accompanying drop in community support. Collection of high fees for the county, but only $.10 for the VHW, might be a disincentive for the VHW as well. Therefore, the Nimba County Health Team has preferred to devise other income schemes to cover non-village costs, such as the clinic registration fees. However, as the willingness of NCRDP and other donors to pay for training and other development costs changes, or as villages show more interest in participating, an increase in user fees will be considered. Th results of this analysis will undoubtedly contribute to County Health Team discussion on this issue.

ANNEX

Nimba County VHW Non-Drug Costs

Item	Source of Data	Cost $
Foreign Personnel = $175325		
German Consultant = 50% yr/2yrs/$130000	NCRDP 1983 est.	130000
Peace Corps Volunteers 1 @ 50%/ 3m/$ 18000	Peace Corps est.	
1 @ 5%/ 3m/$ 18000		
1 @ 20%/12m/$ 18000		
1 @ 25%/18m/$ 18000		12500
FMM Sr. B. Brillant, 65%/2Yr/$25000	SBB Prexy	32500
Curriculum Development - $3630		
Curriculum Writing Workshop	NCRDP 1984 budget	350
Training Equipment	NCRDP 1984 budget	1500
Microcomputer, allocated amortized value	estimate based on	435
Graphics for VHW visual aides	actual cost NCRDP	550
MH&SW staff time, 2 wks	budget	
(1RN Supervisor, 2PA, 1RN, 2LPN, 1HI)	1985 MH&SW report	795
Community Mobilization = $ 1680		
Sensitization team	NCRDP 1984 Budget	1500
S-team workshop	NCRDP 1985 budget notes	180
Training Costs = $10000		
Training of trainers	NCRDP 1985 revised budget	
Cycle 1 training	1984 budget	5250
Cycle 1 retraining	1984 budget	1500
MH&SW staff time, 2 months	as above	3180
Recurrent Activities = $42103		
St. Mary's input: transport and maintenance	SBB estimate base	5130
NCRDP input: 9 motorcycles @ $776, depreciated on actual cost 2235		
VHW supervisor fuel 4 X 18m X $10	Actual	720
2 vehicles, allocated, depreciated	est. on actual	16354
fuel and maintenance for vehicles	est. on actual	1584

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Nimba County VHW Non-Drug Costs

Item			Source of Data	Cost $
MH&SW input for supervision, 20% X 18			Salary Report for 1984-85	
1 RN Supervisor	@	$ 4152		
2 PAs	@	3092		
1 RN	@	3327		
2 LDN	@	2600		
1 HI	@	2000		
1 Driver, 50%	@	2000		
1 Public Health, 25%X6m @ Officer, 35% X 12m		13000		14474
Annual Retraining: of Trainers			1986 budget	260
of VHWs				0
Fuel for PCVs @ $10m, amortized			Actual	39
Income for VHWs as proxy for labor			Actual	567
Stationary for Forms			1985 budget	240