Proj. 6250904-
(2)
PD-AAB-727-B1

ACTION MEMORANDUM for the ASSISTANT ADMINISTRATOR, AFRICA

108p.

FROM: AFR/CWR, Fermino J. Spencer

SUBJECT: Interim Approval - Project Proposal, Strengthening of Health Delivery Systems-Project Number 625-11-590-904

Problem: On March 27, 1973, AA/AFR authorized procurement of measles vaccine and related items in the amount of $1.0 million. It is now proposed that the authorization be incorporated in an Interim Approval for the Project Proposal, Strengthening of Public Health Delivery Systems.

Discussion: During FY 1972 A.I.D., although recognizing that its smallpox eradication program had been successful to the extent that no new cases of smallpox had occurred in West and Central Africa since May, 1970, determined to terminate the program as such and to consolidate its gains through a new broader-based effort at strengthening of health delivery systems. It was recognized that in addition to the disease control results achieved, the operation of the earlier program had begun to provide some of the participating countries with knowledge and resources for strengthening their own capacity to control communicable diseases. To a large extent, the countries were and continue capable of maintaining surveillance for smallpox and conducting measles immunization programs although their continuing ability to maintain measles vaccine supply is more subject to question.

The determination to pursue and strengthen the achievements of the smallpox eradication/measles control program, to insure the capacity of the countries to continue basic communicable disease control programs, to support further specific measles control efforts, and to follow a recognized successful health assistance program with further health assistance, led AFR/CWR to undertake responsibility for project design of a follow-up health assistance program. Africa Bureau policy dictated that such a transitional support program should emphasize the strengthening of the health capabilities of the countries concerned, that assistance should be coordinated with that of other donors for maximum effect and should be provided in collaboration with the Ministries of Health and regional organizations serving the area.

Negotiations in late 1971 between A.I.D., WHO/Geneva and WHO/Brazzaville led to an invitation to A.I.D. staff members to visit Brazzaville in November, 1971, to discuss A.I.D.'s future plans for health assistance in Africa. These staff discussions resulted in

plans for an APHA Task Force to explore more specific forms of assistance in collaboration with regional organizations during the period January 23 - March 5, 1972. On the basis of the Task Force Report, a meeting was held in Washington in June of 1972 including A.I.D., WHO/Brazzaville, and Ministry of Health representatives of the Ivory Coast and Sierra Leone. A representative from OCEAC reviewed the documents. During that meeting, a "logical frame matrix" was developed which described the broad outlines of a follow-up program.

Given the nature of the health problems and resources existing within the region, it has been determined that the funds made available through any A.I.D. financed program should be directed toward prevention rather than cure of disease, should be directed to rural rather than urban populations, and should give first priority to the 65 percent of the population composed of mothers and children.

A.I.D. experience, substantiated by the opinions of many knowledgeable Africans and other professionals with long experience in the region, leads us to believe that manpower development and training provide a basic approach for strengthening preventive health services and for achieving important objectives in surveillance and health planning. Within the area of training, priority will be given to training of trainers; to the ultimate training of that group of health auxiliaries who actually provide service, to administrative and supervisory personnel and to the disciplines necessary to conduct surveillance programs - epidemiologists, health statisticians, etc.; to the strengthening of regional training centers and development of prototype field delivery systems for practical on-site demonstration; and to increasing emphasis on teaching methodology, supervision, administration and program management in the curricula. The management of regional training programs should also be supplemented, and increased efforts devoted to involving professional schools in the training of public health workers for governmental health programs.

A.I.D. direct contributions to smallpox/measles supply terminated on December 31, 1972. To provide for interim requirements the Canadian Government agreed to supply 12,000,000 doses of smallpox vaccine during CY 1973. CDC, which had planned to continue three epidemiologists for surveillance and a supply of vaccines, agreed to maintain the technical assistance component. The POP funded

ACTION MEMORANDUM for the ASSISTANT ADMINISTRATOR, AFRICA

Demographic Survey Project in Central/West Africa maintains an A.I.D. input to the overall surveillance activity.

A.I.D. was not successful in terminating the measles component during CY 1972. Rather, the countries of Central and West Africa continue to identify the supply of measles vaccine as their top priority. We plan to allocate $1.0 million under this interim proposal for the CY 1973 vaccine requirements and anticipate a future requirement which will be incorporated in the project now being designed.

A meeting of concerned Governments, regional organizations and donors was held in Brazzavile during the period February 21-22, 1973, to discuss finalization of the program. It was agreed that a permanent Coordinating Committee would be created to serve as the principal liaison among WHO, OCCGE and OCEAC, other donors, the individual countries, and A.I.D. The Committee with A.I.D. and WHO advisors would also serve as a mechanism for completing program design. The Committee will be asked to criticize the program, to meet as a Committee to discuss it and recommend modifications, and particularly to advise on its implementation and evaluation.

Recommendation: That you authorize Interim Approval for the Project Proposal, Strengthening of Health Delivery Systems.

The general purpose of the Project being designed will be the strengthening of the health services delivery capacities of the national governments of West and Central Africa, working in collaboration with WHO and other regional organizations. The primary modalities are expected to be:

(a) strengthening the administration of the WHO training program (initially limited probably to the WHO Centers in Lome and Lagos) in terms of short term consultants, possibility of staff additions and commodity support;

(b) expanding the regional capacity for training, with the emphasis on training of trainers, supervisory and administrative personnel (including participant/scholarship funding);

(c) expanding the training and support for surveillance and epidemiological services (financed primarily with POP funds and through CDC);

(d) assisting in the development and initial operation of selected prototype field delivery systems for practical on-site demonstration;

(e) strengthening the relationships among regional organizations and Ministries of Health on the one hand, and national professional schools (particularly medicine) on the other, in order to enlist academic assistance in training programs and to encourage consideration of practical concepts and problems of community health in academic education and delivery of integrated health services (assistance through short-term consultants and a senior level Project Manager and Assistant Manager available to the Committee); and

(f) procurement of measles vaccine.

Specifically, authorization is requested for the obligation of $1,090,000 in FY 1973 and additionally to continue three direct-hire employees (b below) in FY 1974 to finance:

(a) procurement of measles vaccine and related items in the amount of $1.0 million; for obligation in FY 1973;

(b) direct hire employment of a Public Health Administrator (an M.D., who will also serve as Project Manager), an Assistant Public Health Administrator, and a Secretary, $30,000 for FY 1973 services and approximately $120,000 for FY 1974 services; these people will be responsible for completing project design over the next 6-9 months;

ACTION MEMORANDUM for the ASSISTANT ADMINISTRATOR, AFRICA

(c) short-term consultant contracts to be obligated in FY 1973 for services over the next 6-9 months, $40,000; and

(d) direct participant training, $20,000 to be obligated in FY 1973.

Approved James C Adams Jr

Disapproved _____

Date April 3, 1973

Clearances:
AFR/CWR:HMarshall (draft)
AFR/CWR:CCapoferri (draft)
GC/AFR:JHoskins
AFR/DP:EHogan
SER/FM/FSD:JLarocca (phone)
AFR/DS:JPinder
AA/AFR:DBrown

AFR/CWR:OCylke:bfc:4/3/73

AID 1025-1 (9-71) (FACE SHEET)

NONCAPITAL PROJECT PAPER (PROP)

I. PROJECT IDENTIFICATION

1. PROJECT TITLE: Strengthening Health Delivery Systems in Central and West Africa

APPENDIX ATTACHED: ☐ YES ☐ NO

2. PROJECT NO. (M.O. 1095.2): 625-11-590-904

3. RECIPIENT (specify): ☐ COUNTRY ____ ☒ REGIONAL ____ ☐ INTERREGIONAL ____

4. LIFE OF PROJECT: BEGINS FY 1973; ENDS FY 1976

5. SUBMISSION: ☒ ORIGINAL ____ DATE; ☐ REV. NO. ____ DATE; CONTR./PASA NO. ____

II. FUNDING ($000) AND MAN MONTHS (MM) REQUIREMENTS

A. FUNDING BY FISCAL YEAR	B. TOTAL $	C. PERSONNEL (1) $	C. PERSONNEL (2) MM	D. PARTICIPANTS (1) $	D. PARTICIPANTS (2) MM	E. COMMODITIES $	F. OTHER COSTS $	G. PASA/CONTR. (1) $	G. PASA/CONTR. (2) MM	H. LOCAL EXCHANGE CURRENCY RATE: $ US ____ (U.S. OWNED) (1) U.S. GRANT LOAN	(2) COOP COUNTRY (A) JOINT	(2) COOP COUNTRY (B) BUDGET
1. PRIOR THRU ACTUAL FY	1,011	-	-	-	-	995	16	-	-			
2. OPRN FY 1974	527	107	22	-	-	400	20	64	14			
3. BUDGET FY 1975	955	716	154	74	116	120	a] 45	516	106			
4. BUDGET +1 FY 1976	495	326	74	126	204	-	a] 43	156	34			
5. BUDGET +2 FY												
6. BUDGET +3 FY												
7. ALL SUBQ. FY												
8. GRAND TOTAL	2,988	1,149	250	200	320	1,515	124	736	154			

9. OTHER DONOR CONTRIBUTIONS

(A) NAME OF DONOR	(B) KIND OF GOODS/SERVICES	(C) AMOUNT
World Health Organization (WHO)	Technical	$4,545

III. ORIGINATING OFFICE CLEARANCE

1. DRAFTER: John Pielemeier, H. O. Marshall	TITLE: AFR/DS, AFR/CWR	DATE: April 4, 1974
2. CLEARANCE OFFICER: Fermino J. Spencer	TITLE: AFR/CWR, Director	DATE: April 4, 1974

IV. PROJECT AUTHORIZATION

1. CONDITIONS OF APPROVAL

a] Includes $10 for 24 MM local employee services in FY 1975 and $8 for 20 MM in FY 1976.

b) Evaluation as provided on pages 56-56b of the PROP will be carried out during Phase I of this project as a necessary element of Phase II planning.

2. CLEARANCES

BUR/OFF.	SIGNATURE	DATE	BUR/OFF.	SIGNATURE	DATE
AFR/DP	R. Huesmann	5/24/74	AFR/DS	P. Lyman	5/24/74
GC	A/Z. Gardiner	5-29-74	PPC/DPRE	MWard/FKimball	5/27/74
AA/AFR	D. Brown		PPC	P. Birnbaum	5/29/74

3. APPROVAL AAs OR OFFICE DIRECTORS

SIGNATURE: Samuel C. Adams, Jr. DATE: 5/28/74

TITLE: Assistant Administrator

4. APPROVAL AAID (See M.O. 1025.1 VI C)

SIGNATURE: [illegible] DATE: 5/31/74

ADMINISTRATOR, AGENCY FOR INTERNATIONAL DEVELOPMENT

REVISED APRIL 1975

AID-1 (7-71) (FACE SHEET)

CAPITAL PROJECT PAPER (PROP)

I. PROJECT IDENTIFICATION

PROJECT TITLE: Strengthening Health Delivery Systems in Central and West Africa

APPENDIX ATTACHED: ☐ YES ☐ NO

2. PROJECT NO. (M.O. 1095.2): 625-11-590-904

RECIPIENT (specify): ☐ COUNTRY ☒ REGIONAL ☐ INTERREGIONAL

4. LIFE OF PROJECT: BEGINS FY 1973 ENDS FY 1976

5. SUBMISSION: XX ORIGINAL DATE ☐ REV. NO. DATE

CONTR. PASA NO.

II. FUNDING ($000) AND MAN MONTHS (MM) REQUIREMENTS

A. FUNDING BY FISCAL YEAR	B. TOTAL $	C. PERSONNEL (1) $	C. PERSONNEL (2) MM	D. PARTICIPANTS (1) $	D. PARTICIPANTS (2) MM	E. COMMODITIES $	F. OTHER COSTS $	G. PASA/CONTR. (1) $	G. PASA/CONTR. (2) MM	H. LOCAL EXCHANGE CURRENCY RATE ___ (U.S. OWNED) (1) U.S. GRANT	(2) COOP COUNTRY
PRIOR THRU ACTUAL FY	1,011	-	-	-	-	995	16	-	-		
OPRN. FY 1974	527	107	22	-	-	400	20	64	14		
BUDGET FY 1975	955	716	154	74	116	120	a] 45	516	106		
BUDGET FY 1976	495	326	74	126	204	-	a] 43	156	34		
BUDGET FY											
BUDGET FY											
TOTAL BUDGET FY											
GRAND TOTAL	2,988	1,140	250	200	320	1,515	124	736	154		

G. OTHER DONOR CONTRIBUTIONS

A. NAME OF DONOR	B. KIND OF GOODS/SERVICES	C. AMOUNT
World Health Organization (WHO)	Technical	$4,545

III. ORIGINATING OFFICE CLEARANCE

DRAFTED: John Piglemeier / H. O. Marshall	TITLE: AFR/DS AFR/CWR	DATE: April 4, 1974
CLEARANCE OFFICER: Fermino J. Spencer	TITLE: AFR/CWR, Director	DATE: April 4, 1974

IV. PROJECT AUTHORIZATION

DATE OF APPROVAL

a) Includes $10 for 24 MM local employee services in FY 1975 and $8 for 20 MM in FY 1976.

b) Evaluation as provided on page 52 of the PROP will be carried out during Phase I of this project as a necessary element of Phase II planning.

	SIGNATURE	DATE	BUR/OFF	SIGNATURE	DATE
AFR/DS	R. Huesmann	5/24/74	AFR/DS	P. Lyman	5/3/74
GC	A.Z. Gardiner	5-29-74	PPC/DPRE	MWard/FKimball	5/27/74
AA/PPC	[illegible]		PPC-A	P. Birnbaum	5/29/74

[illegible] 5/31/74 [illegible] 5/31/74

AID Deputy Administrator

P R O P

Strengthening of Health Delivery Systems

in

Central and West Africa

625-11-590-904

3/22/74

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ANNEX I - A Description of Participating Regional Institutions
ANNEX II - Summary of U.S. Inputs
ANNEX III - Logical Framework
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I. Summary description

This project represents a major attempt by A.I.D., other donors, African regional organizations and twenty West and Central African Governments to coordinate and rationalize the use of limited African and donor resources with the goal of extending basic health services to a larger proportion of the population in West and Central Africa.

Extensive A.I.D. pre-project consultation with WHO, FAO, UNICEF, CIDA and other donor organizations, African regional organizations, and health officials from among twenty African countries (Cameroon, Central African Republic, Chad, Congo, Dahomey, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Ivory Coast, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Togo, Upper Volta) has resulted in common agreement that a major collaborative effort is needed in order to attack the problem of relatively inefficient and ineffective health delivery systems in West and Central Africa. At present, national health delivery systems provide basic health services to only 10-40% (varying by country) of their population, primarily to urban groups. Most existing health systems are oriented toward curative rather than preventive medicine and coexist with, but generally do not make use of, an informal health system of midwives and practitioners found in most parts of Africa. In addition to failing to provide effective daily health care, the existing health delivery systems do not have the outreach capability to assist in sustaining progress achieved in the attack phase of endemic disease control programs during their maintenance stage.

In February 1973, the above parties agreed at a special A.I.D./WHO

meeting in Brazzaville to coordinate their resources to improve health delivery systems in West and Central Africa and within this framework to concentrate on alleviating three major problems that limit the effectiveness of health delivery systems: (1) inadequate health planning and management capabilities; (2) health personnel at the local level lack necessary skill for the new approach; (3) weak disease surveillance and control data systems. A project coordinating committee made up of representatives of the African nations, A.I.D., WHO, and FAC was established to coordinate project activities.

Although considerable progress has already been achieved in structuring this project - basic strategy and key problem areas agreed to by all participating organizations - a number of difficult questions still remain to be resolved. The extraordinary potential of the project in rationalizing the use of national and international resources in West and Central Africa requires that the continued development of the project design - selection and detailed planning of additional project activities, further definition of the role of the coordinating committee and the coordination of inputs from donor organizations and African Governments - be carried out with extreme care, after thorough study of alternatives, and after full consultation among all parties involved.

Therefore, the project will be implemented in two phases. This Non-capital Project Paper (PROP) is submitted for project approval and for authorization of funds for the first phase. Funding requested in Phase I (2 years) includes: (1) planning and preparation for Phase II activities in relation to the three problem areas mentioned above; (2) short courses at two established regional training centers and the

proposed African Institute for National Health Planning (AINHP) for a corps of health officials from participating countries on new concepts in health system planning and management; (3) initiation with the assistance of project-funded short-term consultants as requested, of a review of existing national delivery systems and in some cases a redesign of those systems; (4) formulation or updating of national health manpower plans, based upon explicit health objectives, again with short-term consultant assistance; these plans will be the basis for determining the numbers and specializations of health manpower trainers who should receive supplemental training at appropriate regional training centers during Phase II of the project; (5) formulation of detailed plans for expanded planning/management and health manpower training programs at appropriate regional training centers; (6) consultant assistance to regional training centers in order to improve teaching techniques in ongoing training programs; (7) consultant assistance to the Abidjan regional center for activities in data collection and analysis and personnel training; (8) assistance in the form of equipment and supplies to ongoing OCEAC/FAC/CDC programs of disease surveillance training and implementation of data systems; and consultant assistance to a similar program at OCCGE; (9) finally, during Phase I, funding will be provided for the operation of the collaborative project coordinating mechanism, which will direct Phase I project activities and develop the detailed plans for Phase II activities.

In approximately two years, additional project activities in all of these three problem areas will have been identified, funding requirements and implementation schedules will have been detailed, and the breakdown

of inputs from participating organizations will have been determined. This information will then be transcribed by A.I.D. into a PROP for the second phase of the project (five years, estimated $8-10 million.)

In the following section (Logical Framework - narrative), the project goal and purposes are described for life-of-project. These elements of the project have been agreed upon by all participating bodies in earlier planning meetings. Projected End-of-Project Status (EOPS) outputs and inputs for Phase I only are then outlined below by major problem area. One must bear in mind that these projected activities are based on discussions with members of the coordinating committee and recommendations found in recent A.I.D. and WHO documents, but have not been formally adopted by the committee. Thus, it should be expected that some modifications in the items found below may be made by the A.I.D. Project Manager after full consultation with the coordinating committee.

II. Logical framework (narrative)

The goal of this project is the extension of basic health services by increasingly self-sufficient national health systems to a larger proportion of the population in West and Central Africa. At present, it is estimated that only 10-40% of the population (varying by country) in this area receive basic health services. Available services are concentrated in urban areas, and stress curative rather than preventive medicine. Achievement of this goal will be broadly reflected by extension of health services to a greater proportion of the population, especially to related target groups, and a statistically valid decrease

in morbidity and mortality rates.*

The project purpose is to: (a) improve national and regional health planning and management; (b) increase the skills and improve the utilization of health personnel who can provide generalized (polyvalent) health services at the local level; (c) improve the effectiveness of regional and national disease surveillance and health/demographic data systems and integrate these systems into national health delivery system structures. These three objectives relate to the three problem areas in delivery of health services described in section 12 of this document.

Goal and purpose assumptions

The following assumptions, largely self-explanatory, are conditions necessary to the achievement of project purpose. In addition, these same conditions must continue to exist if objectives beyond those of this specific project (the sector goal) are to be achieved in West and Central Africa within an acceptable time-frame.

- Cooperative relationships can be maintained between donor organizations (A.I.D., WHO, FAC, etc.), and between donor organizations and African Ministries of Health (MOH) and regional organizations.
- All parties will retain the development of low cost, effective health delivery systems as a top health priority.
- Donor resources for health sector and health delivery system programs will be maintained at a level sufficient to conduct planned programs.

*Due to inadequacy of baseline data, it is impossible to project specific figures for goal achievement.

- Health budgets in African countries will increase in real monetary terms as African economies and national budgets grow and will increase gradually as a percentage of the national budget.

End-of-project status

Objective #1 - Improved public health planning and management

The project's main thrust in planning and management will be the stimulation of improved national health delivery system planning and management through the strengthening of regional training centers in Lagos (for English-speaking countries) and Lome (for French-speaking countries), and the new African Institute for National Health Planning, consultative services to ministries, and certain complementary activities.

These regional centers have in the past provided courses, upon demand, in health planning and management. With additional donor funding and the new AINHP, these centers can employ teachers (internationals and Africans) full time and provide a more complete series of courses for the training and retraining of African health planners and administrators, especially in areas related to improved health delivery systems. After consultation with participating Governments and organizations, the schools will adopt an improved and expanded curriculum responsive to explicit African health objectives and containing the most current knowledge of health delivery system planning and management in the African context. These institutions will use field training areas made available by national Governments in their training programs in order to help trainees relate their classroom training to the realities of field health activities.

Training will be made available to key planning and management officials from the twenty participating countries and will be directed toward forming in each country a core group of officials who are presently or will in the future be charged with evaluating the effectiveness and efficiency of national health delivery systems, and planning and implementing modifications in the health delivery system within the limited financial and human resources available to their country.

It is anticipated, due to dynamic nature of research on health delivery systems planning and management, that these officials will return periodically to the regional training centers for refresher training.

As a prerequisite to participation in this element of the project, African Governments (MOH's) will prepare a document describing their presently constituted and/or planned national health planning and management units. These documents will be the basis for determining the number of personnel and kinds of training to be provided for a nation's officials at the regional training centers and/or abroad.

In addition to this training function, the project will assist participating Governments in the planning of improved national health delivery systems. It will provide to participating Governments, upon request, the services of short-term consultants with requisite experience in health planning and management to assist in: (1) initially, if necessary, the development of the planning/management manpower plan, described above; (2) developing plans for the improvement of national health delivery systems and training of national health manpower (see

Objective #2 for more details on manpower plans). Also, it is likely that in Phase II of the project limited project-related donor assistance will be available to assist in implementing plans for strengthened health delivery systems in a number of participating countries.

Complementary activities relating to this objective include the strengthening of health and demographic data collection activities in order to improve the data base for planning (described under Objective #3 below), and development of a joint purchasing arrangement through an organization such as the Afro-American Purchasing Center (AAPC) in order that African Governments can save money through bulk purchase of health commodities.

Phase I - During Phase I, plans for expanding the health planning and management training programs at the Lagos and Lome regional centers will be completed.

Meanwhile, teachers presently under contract by WHO, or newly contracted with funding assistance from A.I.D., will provide specialized courses on manpower planning and health delivery system planning to groups of health planners and administrators from participating countries. A.I.D. will provide training materials and equipment necessary for these courses not already available. Training costs for participants will be borne by their respective Governments, WHO, or A.I.D., if necessary. As part of the training program, personnel from WHO- or A.I.D.-supported pilot delivery system projects will participate at the training center programs from time to time. Trips to these pilot system sites might also be arranged as part of the training program. A.I.D. will provide limited participant training in the U.S. for

African personnel selected to eventually staff the regional institutions and to fill top level MOH planning positions.

Upon completion of the regional training courses, participating planners and administrators will be encouraged to review the effectiveness of existing health delivery system in their countries and to initiate planning for strengthening those systems. A.I.D. and WHO will make substantial short-term consultant assistance available to participating countries upon request, to assist in these activities and to assist health officials in preparing preliminary health manpower plans. These plans will be prerequisites for country participation in training programs for trainers of local health personnel (Objective #2), to be established at the Lagos and Lome centers during Phase II of the project.

End-of-project status (EOPS) - Phase I *

(1) Planning completed for establishing during Phase II a major regional capacity for training health planning and management officials from participating countries in subject matters related to improved health delivery systems.

(2) Health officials in most participating countries will have reviewed the efficiency and effectiveness of existing health delivery systems and begun necessary planning for improving these systems.

*EOPS for Phase II within the framework described above will be determined during Phase I of the project by the coordinating committee. Suggested Phase II EOPS which have not yet been discussed in detail with other project participants are found on pages 53-55.

OUTPUTS:

(1) Completed plans for expanded planning/management training programs at Lome and Lagos.

(2) Key health officials from participating countries attend initial short-term planning and management courses at Lagos and Lome.

(3) Short-term consultant assistance provided to several participating countries in order to assist in reviewing existing health systems and in initiating planning of improved systems.

(4) African personnel to staff regional training center facilities and national health planning bodies returning from graduate level training abroad.

Output indicators

(1) One plan per training center.

(2) Numbers to be determined in conjunction with WHO and participating countries.

Estimates:	FY 74	0
	FY 75	5 courses (2-4 weeks); 10-20 participants/course
	FY 76	(3-4 year) 4 courses (2-4 weeks); 10-20 participants/course

(3) Consultant visits to at least ten participating countries.

(4) Five qualified teachers in relevant disciplines. (Lagos, Lome). Five national planning officials.

INPUTS:

(A) A.I.D.:

(1) A.I.D. project personnel (long term)

(2) Short-term specialists for expansion/improvement regional training centers (curriculum, teaching, methodology, health planning and administration) (8 m-m)

(3) Regional training center personnel (A.I.D. contract)

(4) Short-term consultants to assist Governments in preliminary review planning health delivery systems (20 m-m)

(5) Fellowship - trainees at Lagos/Lome ($50,000)

(6) Participant training in U.S. (10 graduate programs)

(7) Travel funds for experts working in A.I.D. pilot health delivery system projects in region ($ 6,000)

(8) Additional training materials and equipment for Lagos/Lome centers ($20,000)

(B) Others: (See "Other Donors" Section, p.

(1) WHO project personnel (long-term) WHO

(2) Short-term specialists for expansion/improvement regional training centers WHO

(3) Base salaries - regional training center personnel (2 Directors, 6 instructors) WHO

(4) Short-term consultants to assist Governments (See #4 A.I.D. above) WHO

(5) Fellowship - trainees at Lagos/Lome WHO

Participating Governments.

(6) Travel funds for experts working on WHO pilot health delivery system projects in region WHO

(7) Physical facilities, logistics support, expendable supplies at existing level at Lagos/Lome centers — WHO, Togo, Nigeria

Objective #2 - Increase the skills and improve the utilization of health personnel providing generalized (polyvalent) health services at the local level

The project's approach to this objective links directly to the health planning and management objectives described above. The health personnel available (both formal and non-formal) can and should be retrained, integrated into functioning health teams and more effectively supervised. Two key elements in this process are: (1) determination by national health officials of skills required in relation to overall health service objectives; and (2) development of regional and national capacities to provide necessary training for local health personnel.

Direct project inputs in assisting in the formation of a cadre of skilled polyvalent health personnel at the local level would be inserted, as in the case of health planning and administration, at the African Institute for National Health Planning and other regional training centers in Lagos and Lome. Based on the manpower and health delivery system plans mentioned below, and a review of courses and course content presently available at Lagos and Lome, the curriculum of these centers would be modified, additional courses would be offered, taught in part by international personnel provided by the project, and the teaching methods used at the centers would be modified in order to be more closely related to the demands of actual field work. Field

training centers would be a key element in these training programs.

Regional training will be provided to trainers who will return to staff and manage national training centers.

During Phase I of the project, national Governments, with the assistance of project personnel and consultants as requested, will determine future local level manpower requirements and the number of trainees by specialization who will be trained at the regional centers. These requirements, described in a Regional Center Utilization Plan, will be based upon an assessment of existing manpower contraposed with a plan for manpower necessary to staff an improved health delivery system. Local level personnel in such an improved system would be trained in the requisite skills necessary to provide polyvalent services. As suggested by WHO, one approach might be the placement of health teams in a specific geographical area with team members selected and training provided in relation to the health needs of that area. Increased emphasis in training for these personnel would be placed on preventive health services, maternal and child care (family health), environmental health, nutrition, data collection, and communicable disease diagnosis and treatment. The regional institution will provide follow-up to assist the teachers in adapting their knowledge to the unique conditions of each African country, and will provide consulting assistance to national Governments as requested, to improve the level of training provided at the national training centers. In addition to the national training plans mentioned above, in order to participate in the program, participating Governments would be required to pledge sufficient financial support to national training centers to

ensure that trainers have the means to pass effectively their skills on to large numbers of local level personnel.

Phase I - During Phase I, plans will be completed for expanding the health manpower training programs at the Lagos and Lome centers. The institutional and educational objectives of these programs and the projected capacity of these centers will be determined following a thorough review of existing trainer training capacity in the region and a review of the projected manpower training needs in the light of the health objectives of the participating countries. These plans for expanded manpower training will include a determination of the facilities, staff and equipment necessary to enable the Lagos and Lome centers to perform their additional tasks and will be coordinated with plans for expansion of the health planning and management training program; see Objective #1, Phase I. WHO training center directors (or their designees), host country (Togo, Nigeria) training center officials, the A.I.D. and WHO H.D.S. project liaison officers and short-term specialists (health manpower, curriculum, teaching methodology) as required will participate in these planning activities. Short-term specialists will be funded by A.I.D. and WHO.

Also during Phase I, participating countries will be required to develop short-term Regional Center Utilization Plans, indicating as clearly as possible, the numbers of trainers, by area of specialization, that will be sent to Lome and Lagos for training during the early part of Phase II. A.I.D. and WHO will require that these plans be based on national manpower training plans, and that the numbers and specializations of trainers to be trained at Lagos and Lome be

linked to the numbers and specializations of local health personnel to be trained or retrained at national training centers by the trainers.

The Regional Center Utilization Plans will also include a description of existing national training center programs, funding necessary to operate these national training centers, and a pledge to provide the facilities and funds necessary to enable trainers to pass on their skills to adequate numbers of local level health manpower. These plans are necessary to ensure that regional training programs will not be isolated events, but will be fully reflected in improved health manpower capacity to provide health services at the local level. At the option of the participating country, these plans may be amended to include a description of educational and institutional improvements proposed for these national training centers during Phase II of the project, and an estimate of funding necessary to upgrade and operate these expanded centers. These plans would be available for donor study and possible partial funding during Phase II of the project.

Participating countries may request WHO/A.I.D. assistance in developing or updating national manpower training plans. Therefore, a limited number of A.I.D.-funded short-term consultants will be required during Phase I.

End-of-project-status (EOPS) - Phase I

(1) Planning completed for establishing during Phase II a major regional capacity for training health planning and management officials from participating countries.

(2) Health officials in most participating countries will have reviewed existing health manpower plans or developed new plans in order to best

utilize regional training facilities and to ensure that appropriate linkages (e.g., national training centers) will be available to enable manpower trainees to train local health personnel.

OUTPUTS:

(1) Completed plans for expanded health manpower (trainer), training programs at Lome and Lagos.

(2) Regional Center Utilization Plans based upon national health manpower plans.

(3) Short-term consultant assistance provided to several participating countries in order to update/establish national health manpower plans and training center utilization plans.

Output indicators

(1) One plan per center (to be integrated with expansion plans) for health planning and management program (see Objective #1).

(2) One plan from most participating countries (15-20 total).

(3) Consultant visits to at least ten participating countries.

INPUTS: (See Summary of U.S. Inputs)

A. A.I.D.:

(1) A.I.D. project personnel (long term)

(2) Short-term specialists for expansion/improvement regional training centers (manpower training, teaching methodology, curriculum) (8 m-m)

(3) Short-term consultants to assist Governments in updating health manpower plans and development of Regional Center Utilization Plans (15 m-m)

B. Others:

(1)	WHO project personnel (long term)	WHO
(2)	Directors (Lagos, Lome centers)	WHO
(3)	Short-term specialists	WHO
(4)	Short-term consultants	FAC

Objective #3 - Improving the regional and national disease surveillance and health/demographic data systems, and integrating these systems into the national health planning and delivery systems

Despite dramatic progress in disease surveillance and control in West and Central Africa, due in part to the A.I.D./WHO-supported measles/smallpox program, a great number of problems must be resolved before surveillance, control programs and data systems can work effectively without further donor assistance.

The American Public Health Association (APHA) Report (March 1972) made a number of recommendations for joint donor/African action in order to improve the national and regional disease surveillance and data collection systems. One major recommendation was increased support for the WHO-supported bilingual epidemiological center in Abidjan. This center will be the focus for WHO-supported data collection, dissemination and related training activities in West Africa. Although plans for the increased functions of the center have not been finalized, it will provide training for national health personnel, provide consultative services to national Governments and will promote and assist in the use of data in planning, programing and evaluation at the request of individual countries.

They also recommended <u>increased donor assistance to the regional surveillance and data collection/utilisation programs</u> carried out by OCCGE (Bobo-Dioulasso) and OCEAC (Yaounde), as well as direct support to national programs. During the first phase of the project, various alternative strategies in the areas of disease surveillance and data collection will be reviewed by these organisations with the assistance of consultants provided by the project. Certain ongoing activities at OCEAC will be supported during the first phase of the project.

One area in which further analysis is necessary is the integration of relatively autonomous specialized disease control structures for the delivery of other health services. This appears to be an area in which considerable savings (efficiency) can be made. Largely mobile disease control unit personnel can be trained to carry out additional functions (other than vaccination and diagnosis) such as health education, data collection and delivery of additional services including environmental health. Alternatively, static local health manpower, with polyvalent skills can be trained to carry out certain activities (e.g., immunization) heretofore performed by mobile disease control units. The project will assist OCCGE, OCEAC, the Abidjan center and national Governments in manpower training and health planning activities that facilitate the integration of these parallel systems.

Finally, the critical link between the discovery and reporting of a particular disease and a response to provide the personnel, vaccines, etc., to prevent its spread must be strengthened. This link, at the national health planning and management level, requires increased communication between the various health structures in a country and

efficient, rapid utilization of the total national resources available (polyvalent health services personnel as well as specialized disease control personnel) to limit the spread of contagious disease.

One possible means of strengthening this link would be the development of a national health status monitoring system responsible for the collection of data necessary for the planning and evaluation of national health policy and health delivery systems. This monitoring system would feed information collected by field staff to a small group of trained officials (statisticians, epidemiologists) located in the planning groups of the Ministry of Health. These professional personnel might be trained at the Abidjan Epidemiological Center and the majority of field cadre trained at national training centers.

Phase I

Phase I activities under Objective #3 will need to strengthen those elements of the surveillance system which currently exist, particularly in communicable disease control, and prepare plans for filling gaps that exist in other target activities, e.g., MCH, nutrition, environmental health.

Phase I activities will be directed predominantly toward strengthening the capabilities of OCCGE and OCEAC to provide technical assistance and training for national Governments in these areas.

The existing OCCGE program specializes in research on endemic diseases of importance in the area, training of technical personnel and the provision of technical assistance and backstopping to member Governments in the planning and execution of disease control programs.

Recognizing the existing capabilities of OCCGE, the principal Phase I activity related to this organization will be to assist in the establishment of meaningful linkages with other participating regional organizations, planning the OCCGE role in Phase II total project activities, and developing curricula for training national personnel in disease surveillance techniques.

OCEAC already has initiated a program for the training of African health workers in the surveillance of selected communicable diseases throughout the member countries. This is in addition to the traditional technical communicable disease research and control program in which OCEAC has engaged for the last decade. During Phase I, it is anticipated that funds from these projects will be used to augment the organization's capabilities for the training of surveillance personnel and to assist personnel after training to begin performance of their assigned duties in the respective national health services by providing certain supplies and equipment.

Expansion of the functions of the WHO-supported Abidjan Epidemiological Center into the areas of manpower training and consultant assistance to national Governments is in the preliminary planning stage. This organization will benefit from short-term technical assistance in development both of data analysis techniques and of curricula for the training of national personnel in data collection and utilization in planning and evaluation.

Lastly, the relative division of labor among these three regional institutions must be clarified prior to the planning of Phase II activities. National health officials in some countries must, during

Phase I, attempt to come to grips with the delicate problems of integrating heretofore parallel disease surveillance and health delivery system structures in a fashion that best suits their particular circumstances.

End-of-project-status (EOPS) - Phase I

(1) Planning completed for strengthening during Phase II regional disease surveillance support programs which provide laboratory backstopping, personnel training and consultant services to national surveillance operations.

(2) Planning completed for establishing during Phase II a major regional capacity for training personnel necessary for national health monitoring systems and for providing consultant assistance for such systems.

(3) Health officials in most participating countries will have reviewed the possibility of integrating disease surveillance and health delivery systems in the context of planning strengthened health delivery systems (see Objective #1).

OUTPUTS:

(1) General planning and coordination:

(a) Institutional linkages and functional specializations clarified among OCEAC, OCCGE, Abidjan Center (as well as Lagos and Lome training centers and the African Institute for National Health Planning) in areas of data collection and manpower training.

(b) National planners in several participating countries, with assistance of short-term planning consultants (see Objective #1) have taken initial steps to integrate health delivery and disease surveillance systems..

(2) Abidjan Epidemiological Center:

Completed plan for manpower training and consultant service programs.

(3) OCCGE:

Improved training curriculum for disease surveillance courses.

(4) OCEAC:

Nucleus of trained, fully equipped personnel for member country disease surveillance activities.

Output indicators

(1) (a) agreement among participating institutions as indicated by institutional plans.

(b) Initial steps taken in 5-10 countries.

(2) 1 plan.

(3) Improved curriculum established in major OCCGE training programs.

(4) Core number of personnel in each country (numbers not specified).

INPUTS: (See Summary of U.S. Inputs)

A. A.I.D.:

(1) A.I.D. project personnel (long term)

(2) Short-term specialists (disease surveillance, health monitoring) (8 m-m)

(3) Short-term consultants (curriculum development statistics) (9 m-m)

(4) Vehicles, equipment, supplies (OCEAC) ($100,000)

B. Others: (See Annex V for more on WHO budget)

(1) WHO project personnel (long term) WHO

(2) Full-time personnel - Abidjan WHO

(3)	Full-time personnel - OCEAC, OCCGE	FAC
(4)	Abidjan center support costs	WHO, Ivory Coast
(5)	OCEAC, OCCGE support costs	FAC, member countries
(6)	OCEAC - trainee costs	Member countries
(7)	OCEAC - laboratory facilities	Pasteur Institute
(8)	OCEAC - epidemiological	CDC ($37,500)

III, Coordinating mechanism

A coordinating mechanism was created at the Brazzaville conference (February 21-22, 1973) to plan and implement specific project activities within the framework of the project objectives agreed upon at Brazzaville. This mechanism, comprised of representatives of donors, regional organizations and participating African countries, was constituted with the objectives of better coordinating and rationalizing the use of limited African and donor resources with the goal of extending the delivery of health services to a larger proportion of the population in West and Central Africa.

The participants at the Brazzaville conference agreed that since this project involved numerous donor organizations and participating African countries, a coordinating mechanism was needed to direct and manage the project. This mechanism for the first time in West and Central Africa provides an opportunity for donors, regional organizations and participating countries to jointly discuss and plan on a periodic basis coordinated actions designed to fund and attack certain major health problems.

The project coordinating mechanism created operates at three levels. First, a project review body composed of all participating countries and organizations will be responsible for general project objectives. The basic objectives of the project were agreed upon by all participants at the Brazzaville conference. A further project document - a Non-capital Project Paper (PROP) - reflecting the Brazzaville decisions has been prepared for A.I.D. approval of the project. Upon A.I.D. approval, this document will be transmitted to the participating organizations and countries for their approval.* Any change in the basic objectives of the project must be approved by the project review body. This body will generally meet on an annual basis at the time of the meetings of the WHO Regional Committee for Africa (usually in September) and will be apprised of project activities and progress toward achievement of objectives at that time and on a periodic basis, as necessary.

Secondly, a project coordination committee has been established, made up of representatives of WHO, A.I.D., FAC and two representatives from the English-speaking and two from the French-speaking nations participating in the project. The Coordination Committee will have the following functions: (1) review and approve annual progress reports submitted by the project managers (A.I.D. and WHO); (2) review and approve proposed project action plans and budgets submitted by the project managers for the next fiscal year; (3) institute and direct evaluations of project activities; (4) within the limits of

*The Coordination Committee has requested that authority for document approval be delegated by the participating African countries to their four elected representatives on the project committee.

stated project objectives, effect changes in project direction which become desirable as a consequence of project evaluations; (5) report the results of Project Coordination Committee meetings to all Governments and organizations participating in the project; (6) initiate and coordinate discussions of all major donor health sector activities in the region and attempt to improve interdonor and donor/host country coordination of health activities so that in the future resources available from all sources can be used in an optimum manner. The Coordination Committee will continue to encourage the participation of donors such as UNICEF, CIDA, FED, UNDP, etc., in its meetings and may recommend to the project review body that they be invited to assume active membership roles in the committee.

The Project Coordination Committee will meet annually, at a minimum, to review annual progress reports, future year action plans and budgets prepared and submitted by the technical arm of the Committee (see below), and may meet at such other times as deemed necessary to ensure proper project direction.

Thirdly, project implementation will be the responsibility of a technical arm of the Committee composed of the WHO project liaison officer and A.I.D. project personnel. This technical group will be responsible for preparation of an annual project implementation plan and an annual budget to be submitted to the Coordination Committee for their approval. They will also prepare annual progress reports describing project activities over the past year. In addition, the technical group will be responsible for development of a multiyear Phase II project document (1 [illegible]) which will describe specific

activities to be carried out during this five-year period, outline implementation schedules for each project activity and detail how participating donor organisations and African Governments will provide funding necessary for each project activity in a coordinated manner. Annual action plans during Phase II will be developed within the framework outlined in the five-year Phase II project document.

Initially, A.I.D. will fund most of the operational costs of the coordinating mechanism. However, during Phase II of the project, it is anticipated that other participants will gradually fund an increasing amount of its operational costs.

By the end of this project, it is expected that the value of close interdonor and donor/recipient country consultation and coordination in attacking this major health problem will be readily apparent.

In addition, it is expected that a certain amount of donor assistance will continue to be necessary beyond the time frame of this project in order that progress toward achieving the stated sector goal can be maintained. Further, it is likely that new projects directed toward additional major health sector problem areas may be recommended by African Governments for similar coordinated multidonor/participant country efforts. Further assistance from A.I.D. will be reviewed at that time in the context of funding availabilities and program considerations.

Thus, it is quite difficult to predict the structure of the coordinating mechanism or mechanisms that will continue to exist beyond the time frame of this project. Such a mechanism(s) may be fully

integrated into the WHO regional structure or may be operated in the same manner as the coordinating structure created for this project.

Phase I

It is anticipated that the Project Coordination Committee will meet approximately four times during Phase I of the project, the first meeting occurring shortly after the arrival of the A.I.D. project manager in the field (the WHO project liaison officer is already appointed and in the field). The project review body may meet twice during Phase I; immediately following the meeting of the WHO Regional Committee for Africa, scheduled for September 1975 in Yaounde, and possibly just prior to submission of the Phase II PROP to A.I.D. and other donor organizations.

A.I.D. project personnel

During Phase I of the project, A.I.D. will provide a project manager (direct hire or contract) to work with WHO and FAC representatives and the Coordination Committee in further development of the project. The project manager will be a health professional with substantial working experience in Africa. He will be accompanied by an assistant project manager (direct hire or contract), a person with extensive project planning and implementation experience in a donor organization, and an administrative assistant. The administrative assistant will be primarily responsible for translating the technical decisions of the health professionals into the program language of the donor organizations, and for the administrative aspects of project implementation. In addition, a bilingual secretary (direct hire) and two clerk-typists (local) will be provided. These personnel will be officed at a location

agreed to by WHO, suitable for best coverage of project areas.

In order to assist in selection of the short-term consultants mentioned earlier, project personnel will compile a roster of expatriate and African consultants with international experience in project-related problem areas. It is expected that the A.I.D.-financed consultants will be funded under an umbrella contract with an organization such as the American Public Health Association (APHA) which has a great deal of experience in international health delivery systems and which has on call a large number of specialists in project-related areas (manpower training, health planning, management, etc.).

The project will explore during Phase I the feasibility of establishing a joint procurement mechanism which, by combining orders, would enable African countries to make cheaper bulk purchases of certain health supplies and equipment from American sources through a central procurement agency such as the Afro-American Purchasing Center (AAPC).

It is anticipated that A.I.D. monies authorized for this project will be obligated by means of a Phase I project agreement to be signed by WHO and by participating African countries or their authorized representatives (the African members of the Coordination Committee). The A.I.D. project manager will obtain the concurrence of the WHO project liaison officer and the recipient entity in the terms of project implementing documents. Similarly, project-designated funds from WHO and other donor organizations will be expended only after consultation with the A.I.D. project manager.

End-of-project-status (EOPS)

(1) Phase II activities agreed upon by participating organization/ Governments.

(2) Functional role of coordinating mechanism during Phase II of project clearly defined.

(3) Coordinating mechanism functioning well enough to assure its ability to coordinate Phase II activities.

OUTPUTS:

(1) Coordination Committee meetings

(2) Review body meetings

(3) Detailed plan for proposed Phase II activities

(4) Consultant roster established

(5) Joint procurement mechanism established

Output indicators

(1) Four meetings (approximately)

(2) Two meetings

(3) Plan will include implementation schedules and financial costs and contributions for Phase II activities

(4) 40-50 consultants

INPUTS: (See Summary of U.S. Inputs)

A. A.I.D.:

(1) A.I.D. Project Manager (direct hire)

Project Assistant Manager

Administrative Assistant

Bilingual secretary

2 Clerk-typists (local hire)

(2) Procurement consultant (2 m-m)

(3) Interpreter, secretary and other support costs for meetings not held at WHO headquarters, Brazzaville A.I.D.

(4) Per diem and travel costs of four African members of Coordination Committee A.I.D.

(5) Per diem (1-2 days for 20 African representatives), interpreter, secretary and other support costs (meeting will follow WHO regional meetings) A.I.D.

B. Others:

(1) Project personnel (long term) WHO

(2) Interpreter, secretary and other support costs for meetings held at WHO headquarters, Brazzaville WHO

IV. Rationale

A. Background

Responding to a call by the World Health Organization (WHO) for concerted action in eradicating smallpox from the earth by 1975, A.I.D. supported a smallpox eradication and measles control program in twenty countries in Central and West Africa from 1966 through FY 1972.

The A.I.D. program, implemented through the Center for Disease Control (CDC), succeeded in reducing the number of smallpox cases in Central/West Africa from over 9,000 reported cases in FY 1967 to zero in FY 1971, and produced substantial gains in the control of measles.

The Smallpox/Measles program was evaluated by an American Public Health Association (APHA) team in early 1971. The team, while recommending a gradual phase-out from the successful project, also

felt strongly that "the valuable experience gained in the accomplishment of what is viewed by many as A.I.D.'s most successful program in Africa must not be lost, but utilized in the further pursuit of international cooperation and goodwill through support of public health programs in West and Central Africa." The team's report further stated that additional donor assistance in the health sector might be used inefficiently if it were not first geared toward improvements in health service delivery systems. Within the general requirements for improvement of health delivery systems, the report suggested three major areas which deserved priority attention: (1) the organization of the health systems; (2) the administration or operation of the system; and (3) the requirements for manpower and training.

A reconnaissance visit to seven West African countries by A.I.D. health specialists in September 1971 revealed that most Ministers of Health had afforded the improvement of their health delivery systems a high priority in national health activities. Bolstered by this support, but also keenly aware of the limitations of what A.I.D. resources alone could accomplish in such a vast geographical area, A.I.D. discussed with WHO, FAC and UNDP officials the concept of a major regional multidonor project in West and Central Africa focusing on the improvement of health delivery systems.

The response was very positive and, subsequently, a second APHA team was contracted to identify "substantive areas in which A.I.D. could appropriately assist in the development of a regional program or programs for improving health service delivery systems including endemic disease control."

The team recommended in March 1972 that the general purpose and more specific objectives of the project support and strengthen the work of regional health organizations. The most effective A.I.D. assistance toward strengthening health service capacity in this region, the team felt, would be provided through manpower development and training in the areas of (1) health planning and management; (2) paramedical personnel; and (3) disease surveillance.

The APHA team recommendations were reviewed by A.I.D./W and A.I.D. field staff and were generally accepted. The objectives of the proposed project were then discussed with WHO officials in New York, Geneva and Brazzaville, with UNICEF, UNDP, FAC and other donor organizations with health programs in West and Central Africa as well as with senior African health and planning officials. It was clear that most parties felt that the proposed project was quite timely in view of increasing African and donor awareness of the need for improving African health delivery systems and could be used as a vehicle for increasing effective donor and African coordination in the planning and implementation of programs designed to improve the delivery of health services in West and Central Africa. The African officials also made it clear that measles vaccine and spare parts for jet injectors were a priority that should be included as part of the donors' assistance.

Formal agreement on the objectives of the project was confirmed at an A.I.D./WHO-sponsored meeting in Brazzaville in February 1973. At that two-day meeting, representatives of Central and West African Governments, subregional organizations, and bilateral and multilateral assistance agencies agreed to, among other things, (1) accept the

principle of the strategy of strengthening public health delivery systems in Central and West Africa... (2) acknowledge the need for permanent cooperation between the receiving countries and the donor agencies... (3) welcome the new trend in external aid, whereby the different agencies are working together to achieve objectives set by the countries themselves, in agreement with the other participating..., and (4) acknowledge the need to establish a mechanism for coordinating the program.

Under such a mechanism, detailed planning and management of the project would not be left merely to a single executing agency or even to one or two organizations, but would be reviewed jointly by the recipient countries and the donor organizations involved in the project.

A coordinating mechanism was, therefore, established, comprised of:

- a program coordination committee which, remaining small in number, would be an effective working instrument, charged with the technical and administrative coordination of the program, evaluation and periodic revisions as would be necessary in the course of its implementation; it would also report on progress directly to the participating countries, subregional organizations and donor agencies;

- a review body which will serve the purpose of confirming the Committee's recommendations and apprising the interested parties of the program's progress.

The composition of the coordination committee eventually agreed to was:

- one representative each of WHO, U.S. A.I.D. and PAC (headquarters senior officials);

- two representatives each of the French- and English-speaking groups of countries involved.

The review body would comprise one representative each of the twenty participating countries, the two subregional organizations (OCEAC and OCCGE) and the donor agencies.

Since the Brazzaville meeting, the Coordination Committee representatives from the English-speaking and French-speaking countries have been selected, and the Committee has met once to review progress in project development and discuss future action steps.

While it is clear from the above that major progress has already been achieved by obtaining common agreement on certain health program objectives in this large region, it is also evident that the details of how to achieve those objectives need further exploration and delineation. Thus, this document requests authorization of those funds necessary to enable A.I.D. to fully participate with other donor agencies, African Governments and regional organizations in the planning of coordinated actions which should, over a reasonable period of time, contribute in a major way to the extension of basic health services to a larger proportion of the population in West and Central Africa. Once these plans have been completed and approved by the Coordination Committee (estimated two years), a second project document containing the elements of Phase II to be financed by A.I.D. in the context of the overall multiorganization program will be submitted for Agency approval.

B. <u>Key problem area - Health delivery systems in West and Central Africa</u>

1. Present health delivery systems in Central-West Africa

The formal health delivery system of Central-West African countries is almost entirely government-supported and generally includes a large general hospital in the capital city, smaller hospitals in provincial capitals, health centers or clinics in major towns and small dispensaries in some of the villages. This network covers from 10-40% of the population. In addition, mobile endemic disease teams provide minimal immunization and disease surveillance services to a much larger percentage of the people, and there are scattered special hospitals for maternity care, tuberculosis, leprosy and mental illness. There are small medical staffs in most hospitals, but the great bulk of in-hospital and almost all out-of-hospital care is given by health assistants, nurses, midwives and auxiliaries, many of whom have had little or no formal training, and lack adequate supervision.

Government services are supplemented in the large cities by a few private professionals and small private clinics and hospitals, and in rural areas by scattered mission hospitals and clinics.

The vast majority of care given in all of these facilities is curative and, in many instances, is provided without charge to the users of the service. Theoretically, there is a care network, with village dispensaries feeding into and receiving supplies and technical support from health centers or provincial hospitals which, in turn, have the same relationship with central referral hospital. In actual fact, it is the rare patient who moves up the care network and even rarer that support extends out to the periphery. In an effort to correct this, some of the countries have recently charged

the mobile endemic disease service with the responsibility of supporting rural out-of-hospital services.

Each country has at least one demonstration health center, many of which are being used as field practice centers for refresher training of rural health service personnel. Frequently, these are assisted by WHO as a part of its program to encourage the development of basic health services.

The informal health care system includes pharmacists and drug sellers, traditional healers and herbalists, and traditional birth attendants. Probably most Africans have access to one or more of these indigenous practitioners.

2. Key problems in the delivery of health services

Among the many problems associated with the effective delivery of basic health services to a larger proportion of the population in West and Central Africa, three key problems have been selected by African and foreign health experts for attention under the proposed project. These problems are: (a) inadequate health planning and management capabilities; (b) inadequately trained and/or insufficient numbers of health personnel at the local level; and (c) weak disease surveillance and control data systems.

(a) Inadequate health planning and management capabilities - National budget allocations for health services in West and Central Africa generally average between 6-9% of the total national budget. Estimates of the proportion of the African population now provided with basic health services vary from only 10-40% on national basis. The level of public resources

spent on health, as a percentage of the national budget or on an expenditure per capita basis, is not likely to rise significantly in the foreseeable future. The dilemma thus posed is how can African Governments attain their expressed goals of extending basic health services to a greater proportion of their citizens without greatly increasing total health program costs. African and foreign health officials agree that the answer is to be found in the reorganization of health service delivery systems in order to increase their efficiency.

Until recently, African Governments have continued to concentrate their resources on endemic disease control through mass campaigns and provision of health services, usually curative, mostly for the urban populations. As new endemic disease campaigns, such as measles/smallpox, have been initiated, the number of semi-autonomous health services providing uni-dimensional services has increased and costs of maintaining these health structures have risen accordingly.

More recently, African Governments, encouraged by WHO, have determined that government health services should no longer continue to grow by minor addition and adaptation, but that their public health systems should be designed and built to reflect the health priorities established by a conscious re-evaluation of national health objectives. While objectives differ by country, it is clear that certain common planning decisions must be made. The various branches

of health services, which have often grown up in isolation from one another, should be integrated. Health services should increasingly be provided to rural areas and to the maternal/child target group. Greater emphasis must now be placed on development of health systems which integrate preventive and curative services, nutrition, family planning, environmental health, and disease surveillance and data systems.

Planners within African Ministries of Health are now faced with the critical questions of how best to structure their health systems to obtain their objectives. These are planning questions which the proposed project hopes to address in conjunction with the combined resources of several donor organizations, African Governments and regional institutions.

Closely associated with the need for increased efficiency through improved health planning is a necessity to improve the management of public health service systems. African health systems often reflect varying degrees of organizational confusion, ambiguities of responsibility and absence of procedures, due in part to a paucity of qualified management personnel. Often one finds the few available doctors in a country spending more of their time on administrative functions than on direct provision of care. In order for health services to be delivered efficiently to the African people, any change in structure of health delivery systems must be complemented by improved systems management at all levels, including the adoption of modern management techniques

and the training of a corps of administrators to share the administrative burden which medical professionals now shoulder.

(b) Inadequately trained health personnel at the local level - Local level health personnel are the agents who must eventually implement any health plan. Thus, no national health plan can fail to place a very high priority on manpower requirements at the local level. This is especially true in Africa, where the grave shortage of trained health workers has been a major stumbling block to practically every major health program. Health manpower shortages in Africa exist at all levels. The physician/population ratio in West Africa is rarely lower than 1/15,000 and as high as 1/85,000 (Upper Volta) compared to 1/500 - 1/1000 in most developed countries. Similarly, other health professionals (nurses, sanitary engineers, midwives, etc.) are in short supply (1 nurse/12,000 population in Africa; 1/300 in Europe), while there is a chronic deficit of trained paramedical health manpower (nurses' aides, midwivery aides, laboratory technicians, sanitary aides, etc.). Moreover, a large portion of the auxiliary manpower presently available is inadequately trained for "generalized" polyvalent health responsibilities. Most were originally trained for specialized jobs such as vaccinations, performing simple laboratory tests, dispensing medicines, or inspecting latrines or markets. While they may (or may not) have

received adequate training in their specialised jobs, many have received no refresher training for many years. Their skills are clearly inadequate for the multidiscipliary tasks which must be carried out by a relatively isolated polyvalent health worker at the village level. They have little concept of preventive health measures and with little or no training in health education would, therefore, probably have little success in effectively teaching health measures to dispensary staff and villagers. They have been taught to treat specific diseases in individual patients, and not to seek basic causes of illness in the family or community environment.

Officials at the next highest (regional) level of the health structure, often professionals, are usually more technically competent but have no special training or skills in planning, management, supervision of local level personnel, or teaching essential to the effective fulfillment of their role.

Although high priority has been given to preparation of health staff (especially professional level staff) in the past, poor planning and administration has led to much waste of limited training resources and often inappropriate training activity. Very little attention has been paid to the development of national training programs, and coordination of training activities to take advantage of the mutually reinforcing and cumulative effects that such coordination could produce. Rather

than resorting to short-cut and stop-gap training measures, national training goals should follow from health program objectives. As national priorities have now turned toward the development of effective low cost delivery systems, health trainees at all levels should learn the skills and proper attitudes toward the organization, management and administration of these systems under the local conditions encountered within their country.

While the specific mix of health personnel which will be necessary to implement these health delivery systems will vary, depending upon the nature of the community's health problems as well as the cultural, economic and political factors found in the area, health manpower experts generally agree that a team approach to health problems should be employed. These teams, made up of professionals and auxiliary health personnel, must be constituted on the basis of national or subnational health objectives. In order to maximize efficiency with the limited human and material resources available, they must offer individually and as a composite group the multidisciplinary skills to provide what are characterized as "minimum health services," ranging from the area of maternal/child health to environmental health, health education, family planning and endemic disease surveillance and control, and health and demographic data collection and analysis.

If such personnel as these are to be produced in West/Central Africa in concert with changing national health priorities, through retraining or the preparation of new personnel (limited due to the already high proportion of health resources allocated for salaries), the curricula and capacities of national and regional health training facilities must be improved. These institutions will be keys to inculcating the multidisciplinary team approach into health personnel at all levels of activity.

In addition, the educational methodology used at most training centers deserves reorientation in order to achieve maximum potential from curriculum reform. Most health training in West/Central Africa, one can generalize, has been formal training, textbook oriented and theoretical rather than being related to practical realities of the job for which the trainee is being prepared.

Finally, there is a lack of training continuity for the trainee. Training institutions typically conduct no trainee follow-up to spot weaknesses in education and thus, their teaching program, nor do they develop long-range training plans for their students.

In summary, while one must recognize that manpower development is a complex field where even the most distinguished institutions and most developed nations demonstrate serious weaknesses, it is clear from the foregoing that manpower development, based upon national health goals

and related to scarce resource availabilities, is certainly a key problem area in West/Central Africa and an area which can benefit from increased donor resources and increased regional cooperation.

(c) Weak disease surveillance and health/demographic data systems - Available data shows a general picture of high prevalence of communicable diseases in West and Central Africa (smallpox, malaria, yellow fever, poliomyelitis, leprosy, onchocerciasis, schistosomiasis) which aside from their direct effect on mortality and morbidity also contribute indirectly to high infant and child mortality rates in the area. Simply administered control technologies have been developed for certain of these diseases - e.g., smallpox, yellow fever, polio - and mass campaigns such as the A.I.D./WHO measles/smallpox program, have been carried out in West and Central Africa with sometimes spectacular reduction in specific disease occurrence. Once the attack phase of an endemic disease control campaign has been completed, disease surveillance and control systems are charged with the maintenance phase of the project, ensuring that outbreaks are quickly spotted, isolated and suppressed. In theory, every country in West and Central Africa has a functioning surveillance system. Hospitals, health centers, dispensaries and clinics in the field recognize the presence of certain diseases, collate data and report their findings to a subnational health unit which tabulates and analyses

data and, in turn, forwards the reports on to the federal Ministry of Health, which reports finally to WHO. National or international response to reported outbreaks might include diagnostic assistance, investigation of outbreaks, initiation of control measures, including educational programs, assistance in therapy including provision of drugs and dissemination of epidemiologic information to adjacent areas. Data collected through this network would normally be used by planners in the health ministry in consideration of long- as well as short-range health programs.

Recent evaluations of the smallpox/measles program by both A.I.D. and WHO have revealed that existing disease surveillance and control operations leave much to be desired and demonstrate serious weaknesses. Field personnel who originate information for the surveillance system are often inadequately trained to diagnose causes of illness and death. Supervision of these personnel is inadequate and usually unsupported by diagnostic aids, such as field laboratories. Reporting is incomplete and frequently handicapped by poor communication and transportation facilities.

One of the great gaps in national health services is the breakdown between data collection and action, and between data collection and planning. Rational planning for and evaluation of progress in health improvement programs cannot be undertaken without efficient

epidemiological services, fed by essential data compiled by health statistical services and supported by a reliable health laboratory service.

Finally, it is evident that attempts must be made to reduce the costs of program maintenance through integration of heretofore parallel health service and communicable disease administrative structures and personnel functions. This structural/functional integration should produce positive synergistic impact, that is, a combined impact greater than the sum of the separate parts, advantageous to the program objectives of both activities.

Traditionally, communicable disease services have been delivered through single-purpose administrative structures characterized by tight vertical links of technical and administrative authority from the central to the peripheral level and have maintained very few, if any, horizontal relationships with other health services. It has become apparent over time, however, that the activities of both the communicable disease services and the normal public health services can benefit from integration.

WHO has pointed out that their malaria campaign has demonstrated that such a program cannot be effective unless there is already in existence a well developed health infrastructure, i.e., an organised network of peripheral health units, able to ensure some basic health services to meet the more urgent needs of the population.

Health education activities as well as continuing surveillance and vaccination for infants and migrants, all vital to the success of communicable disease programs, may be carried out more satisfactorily by an organised static network of health centers than by the mobile teams that are utilised in the attack phase of a campaign. Additional data collection for effective health planning can and should be coordinated with the communicable disease surveillance system. Based on the obvious benefits resulting from decreased administration and personnel costs, integration of communicable disease and health service structures, at least in the maintenance phase, would provide a strong impetus to the development of a unified public health delivery system.

C. The project approach - Strategy

1. Regional and donor coordination

A.I.D.'s strategy in designing this project has been guided by several assumptions. First, it was assumed that A.I.D. should, as a follow-up to the successful measles/smallpox program in West and Central Africa, continue to play a role in health activities in this area in order to (a) preserve the gains achieved in the smallpox/measles program without assuming responsibility for the maintenance of the program, and (b) as recommended in the American Public Health Association (APHA) evaluation of that program, to utilise the "goodwill created, the technical know-how developed, the organisational strengthening provided and the medical advances contributed... to contribute further to the wellbeing of the countries concerned." Secondly, it

was assumed that A.I.D. resources available for health activities in West and Central Africa would have little impact in effecting change in key health problem areas unless they were combined with other donor resources. Finally, it was assumed that the excellent relationships developed among A.I.D., African and other donor health officials during the measles/smallpox program could provide the basis for a genuinely collaborative approach in project conception, design and implementation.

Bypassing the desire for immediate spectacular results, the health community no longer sets its hopes on the creation of autonomous, largely donor-financed structures, established to eliminate at a sweep certain endemic communicable diseases. It has become painfully obvious that the task is infinitely more complex, that programs with support costs that cannot be maintained by national Governments without continuing massive donor resources are not, in the long run, cost-effective answers to the complex, often interrelated series of health calamities that daily befall thousands of Africans. A more mature approach to health is necessary and health resources should be directed toward strengthening and expanding the basic health service systems which already exist in Africa. The task is to work with these existing structures, integrate them as necessary in order to make them more efficient, improve the skills of available health manpower and, finally, to assure that the systems are capable of self-regeneration, to continually reassess and improve the provision of health care based upon the changing realities associated with increased economic development, population mobility, variations in disease type

and incidence, and environmental health conditions.

The task, placed in the foreground of health policy by political and economic as well as humanitarian pressures confronting African countries, is to develop public health systems which, despite severe limitations of human and material resources, can increase the proportion of the population receiving basic health services. While striving to serve an increased percentage of the total population, Governments recognize that within these goals, priority must be given to certain especially vulnerable target groups, such as mothers and young children. These public health systems or delivery systems, once in place, can in theory provide multiple services varying from preventive service (child-spacing, vaccination, etc.) to curative services (timely diagnosis and treatment of disease).

Experience in developing countries has demonstrated that projects designed and carried out by donor organisations, however well motivated, without the active collaboration of host Governments often fail or remain moribund once the donor financial effort flags or terminates. A collaborative approach is especially necessary in a project dealing with health delivery systems, an area in which general models must be adapted to the specific conditions of each African nation, and continually re-adapted to changing economic, political, social and epidemiological conditions. This document, therefore, described the proposed full-scale (Phases I and II) "Strengthening Health Delivery Systems," project in general goal/purpose End-of-project-status (EOPS) terms already agreed upon at the Brazzaville meeting. Over the two years, it is anticipated that the Coordination

Committee will review available data, undertake additional studies, as necessary, and carry on discussions with African health officials in order to determine what project-related inputs (and thereby outputs) are necessary to lead to agreed upon end-of-project objectives.

The collaborative approach to project design is a key element in the total concept of the project's objectives. The collaborative style will be utilized beyond the planning stage throughout the life of the project for project implementation activities and for project evaluation.

The participation of a number of donor organizations in this collaborative approach provides other intangible benefits. Joint review of key problem areas, for example, health planning and management, should lead to concerted donor inputs, each related to that organization's comparative advantage, i.e., each offering what it can best provide (manpower, equipment, etc.). This collaborative approach also should plug critical gaps often overlooked by or beyond the financial means of a single donor organization. Finally, it should also lead to joint donor-recipient decisions on certain complementary national resource investments within an overall scheme. For example, while donor organizations might agree to strengthen regional centers for training trainers and provide increased technical assistance to national training centers, African Governments would agree to invest sufficient resources in national training centers to ensure that returning trainers can effectively pass on their new-learned knowledge to large numbers of field personnel.

V. Course of action

A. A two-phased approach to further project development and project implementation

It should be apparent from the foregoing that considerable progress has already been achieved in structuring this project. The basic strategy of the project has been agreed upon by all participating Governments and organisations. Also, much earlier than originally expected, the project participants have established a Coordination Committee, including selection of representatives from English- and French-speaking countries, to manage the project.

Yet, it is also apparent that a large number of difficult questions still need to be resolved. The extraordinary potential of this project in rationalising use of national and international resources in West and Central Africa requires that the continued development of the project design (selection of additional project activities, further definition of the role of the Coordination Committee, and the coordination of inputs from donor organisations and African Governments) be carried out with extreme care, after thorough study of alternatives, and in full consultation among all parties involved. This can be done only in the field and in close collaboration with the Coordination Committee. Thus, a two-phased approach to the project is proposed, the first phase (24 months) for further project development and implementation of those activities where sufficient planning has been completed, and a second phase (5 years) for expanded project implementation. Phase I activities have been detailed above.

After final approval by all parties of the detailed project implementation plan, expected by mid-FY 1976, the project would extend for five years with an expected A.I.D. input of approximately $8-10 million. A.I.D. funds for the project would be obligated annually based on annual project action plan in concert with the life-of-project implementation plan.

Periodic evaluation of the integrated project, as described in the logical framework, and of its individual components (health training facilities, surveillance and data collection, etc.) is especially important in this project because of the dependence of Phase II design upon the depth and relevance of Phase I activities.

Accordingly, the evaluation process during Phase I will include a project evaluation (Project Appraisal Review - PAR), as described in Supplement I of A.I.D. Manual Order 1026.1, assessing progress toward the outputs, purposes and goals set forth in the logical framework with particular emphasis on satisfaction of conditions specified in the End-of-project-status. The PAR review will be conducted between one year and eighteen months after the arrival on duty of the first member of the project management staff and will be a comprehensive and trenchant review and assessment of Phase I. It will (1) address specifically the rationale contributing to the design of the Phase II PROP; (2) assess the adequacy of Phase I activities to date as a basis for Phase II project design, and (3) recommend further actions required to ensure that a realistic Phase II action plan is developed. This PAR review, supplemented to the maximum extent practicable by expert consultation and collaboration with other donors and participants, will be considered by the A.I.D. project management staff responsible for approving the Phase II PROP.

Phase I activities will include (1) the design of evaluation procedures for Phase II, including specification of benchmarks for periodic assessment of progress in each of the three major problem areas addressed by the project, the methodology so described; and (2) the establishment of baseline data necessary to Phase II evaluation. The Phase II PROP will be considered incomplete in the absence of these elements.

The evaluation process during Phase II will include examination of benchmark achievement in comparison to specifications at each of the periodic intervals designated, as well as a project-wide evaluation during the fourth year of Phase II for the purposes of assessing overall project impact and considering future multidonor and African cooperation in strengthening health service delivery in Central and West Africa. These evaluations will be conducted by the project Coordination Committee designated by the Brazzaville conference or their designees.

B. A.I.D. assistance in Phase II

It is expected that A.I.D. assistance in Phase II of the project will take the form of long- and short-term personnel, participant training, Operation Expatriate (OPEX) salary topping, the provision of limited equipment and commodities, and operational support for the Coordination Committee.

Although specific life-of-project objectives will be determined jointly by the participating organizations/Governments, illustrative life-of-project EOPS follow.

Illustrative life-of-project End-of-project-status (EOPS)

Objective #1: Improved public health planning and management

(1) Most countries have developed plans for improved national health delivery systems;

(2) Implementation of the above plans will have begun in a number of target countries;

(3) Data submitted at regular time intervals, e.g., monthly, from field surveillance personnel will be routinely processed, analyzed and utilized by the central Government Planning Units for purposes of program planning, revision and evaluation;

(4) Consultant services, including increased numbers of Africans, will be available to and called upon regularly by MOH's to assist in planning and managing delivery systems;

(5) Currently available personnel and material resources will have been thoroughly inventoried in the light of the projected plans, deficiencies identified and necessary funds located to fill the gaps in each of the respective countries;

(6) Status of regional health planning and management manpower needs known and updated periodically;

(7) Regional training centers will have modified curriculum content and teaching techniques, and have sufficient staff to provide quality up-to-date training in delivery system planning and management;

(8) Regional field training centers will have been upgraded and utilized for training planners and administrators.

Objective #2: Increase the skills and improve the utilization of health personnel at the local level

(1) Regional training institutions will have adopted improved curriculum content and teaching techniques, and have sufficient staff to provide quality up-to-date training;

(2) Manpower needs for local level personnel and trainers known and updated periodically;

(3) Consultant services, including increased numbers of Africans, will be available and called upon regularly by MOH's to assist in the preparation of manpower plans and in upgrading national training centers;

(4) Key faculty and administrative staff members of national training centers will include personnel trained in polyvalent service teaching techniques at regional training centers;

(5) National training centers will have sufficient financial support, physical plant, equipment and supplies, etc., to assure that trainers can effectively pass on their skills to large numbers of local level personnel;

(6) Systematic training programs for local level health personnel, based upon health delivery system and manpower plans, will be underway at national training centers in a number of target countries.

Objective #3: Improving regional and national disease surveillance and health/demographic data systems and integrating these systems into national health planning and delivery systems

(1) Plans for national health monitoring systems for outstanding communicable and non-communicable disease problems will have been completed and system implementation begun in a representative sample of communities in many participating countries;

(2) Abidjan center functioning as regional epidemiological monitoring center with capacity to train corps groups of personnel for national health monitoring systems, and provide technical assistance to those systems;

(3) National Governments have capacity to train additional personnel necessary for national health monitoring systems;

(4) Specialized disease surveillance personnel retrained at Abidjan and/or elsewhere to carry out a variety of services in concert with national health objectives;

(5) Disease surveillance structures, including personnel, will have been integrated into national health delivery system structures in a manner appropriate to each participating country;

(6) Communicable disease surveillance support systems at OCEAC and OCCGE, increasingly directed by trained African personnel, strengthened and expanded to include the collection of data on a wider variety of significant health problems.

C. Coordinating mechanism

(1) The value of interdonor and donor/recipient consultation and coordination in dealing with this major health problem is readily apparent to participating African Governments, regional and donor organizations.

(2) Agreement will have been reached on an appropriate mechanism for coordinating future collaborative planning and project implementation in the areas of strengthening health delivery systems and possibly other key health problem areas (e.g., nutrition, family planning activities).

(3) Funding for any continuing coordinating mechanism will be shared by all participating Governments and organizations.

D. Relation to other A.I.D.-funded projects

The "Strengthening Health Delivery Systems" provides a useful focal point for transmission of knowledge accumulated through the numerous experimental and operational projects (often, but not always, donor-assisted) being carried out in West and Central Africa in the three basic problem areas addressed by this project.

First, the Coordination Committee provides a useful locus for interdonor and recipient Government discussions of ongoing and proposed donor-assisted health projects for the region, in order that duplication can be avoided and resources can be used most efficiently.

Secondly, the wide access of regional training centers to African health officials from the twenty participating countries provides an excellent vehicle for the transmission of new information/data obtained from this and other pilot/prototype projects. Project managers from a variety of experimental projects could visit the centers from time to time to pass on their project findings to influential officials from all over West and Central Africa. For example, information emanating from A.I.D.-supported projects such as Danfa, DEIDS, MCH Extension could be communicated to students attending planning and management courses at the African Institute for National Health Planning (AINHP), the Lagos and Lome regional training centers. Information from experimental health education and training projects (e.g., OCEAC) could be passed on to trainers of local health personnel from up to twenty countries attending courses at the Lagos and Lome centers.

Data collection and analysis techniques developed by the Center for Disease Control (CDC) as part of the A.I.D.-supported Demographic and Disease Surveillance Survey could be transmitted to health officials attending courses at the Abidjan Epidemiological Center.

C.U.S.S. (University Center for Health Services - Cameroon)

Following closely on similar experiments in South America, A.I.D. (a separate project) is cooperating with France, Canada, Britain, WHO, and the Cameroonian Government in the development of a multi-disciplinary, university-related health training center in Cameroon called C.U.S.S. The first of its kind in Africa, in place of conventional training of various types of health personnel, this center will provide multidisciplinary training aimed at ensuring close coordination of the training and activities of members of the "health team" (professional and paramedical personnel). The training center located at the University of Cameroon in Yaounde will use a curriculum designed especially for African health needs and will attempt to form prospective health team members who are fully aware of the roles of the various members of the health team and the need for increased emphasis upon the provision of service by personnel with minimum requisite skill in order that more limited professional manpower may be more efficiently used.

Although perhaps the most innovative experiment in health manpower training in Africa, C.U.S.S. and similar proposed centers alone cannot hope to train sufficient numbers of African manpower in the near future. While the objectives of C.U.S.S. and other training centers (such as Lagos and Lome) to be assisted by this project/or other A.I.D./donor projects are basically similar, they should not be viewed as

conflicting recipients of scarce donor resources but as only a small number of institutions over half a continent attempting to explore means to resolve the problem of providing health services with scarce manpower resources in concert with professional training at Universities, colleges and other national and regional institutions. It is expected that a great deal of cross-fertilization on training methods, curriculum and objectives will be stimulated between these various African training centers and schools.

OCEAC - Regional Public Health Training project: Cameroon, Central African Republic (CAR), and Chad

This training project for local health personnel has been a pioneer A.I.D. attempt to discover ways to increase the output of local professionals and paramedical health personnel, and thus improve the services provided to low-income Africans in rural areas. The project operates in three pilot areas (one in each country) which theoretically demonstrate a model of delivery of health services for replication on a national basis and are also used as field training centers for national in-service training programs for auxiliary and paramedical personnel.

The field training areas assisted by the OCEAC project (also assisted by WHO in CAR and Chad) should be studied for lessons that can be applied to similar areas which are proposed for the health delivery systems project and could be used by the project, if possible in lieu of developing new field training centers. In addition, A.I.D. must take full advantage of the potential for transferring innovations emanating from the OCEAC project in teacher training and health education techniques to the Lagos and Lome regional training centers.

As described in Section II, the proposed S.H.D.S. project will provide certain assistance to the demographic/disease surveillance activities of OCEAC.

MCH Extension - Dahomey, Gambia, Lesotho*

The purpose of this Title X project is to study and demonstrate in several settings that the role of existing health workers can be expanded to include provision of integrated MCH services, including child spacing. Emphasis is placed on services which can be provided without requiring substantial increases in recurrent costs and on activities which will motivate people to change their health behavior. This is a pilot project and is designed to develop methods which can be replicated on a national scale or adapted by other African countries.

Obviously, the results of this project have direct implications for the H.D.S. project by providing a basis for several of the countries to improve and expand the MCH aspect of their health delivery systems. These pilot demonstrations should be utilized for field observation and training for countries in the H.D.S. project.

Danfa project - Ghana

The Danfa Rural Health and Family Planning project is an operational research project directed toward assisting the Government of Ghana to determine optimal methods (based on an assessment of cost effectiveness) of providing health and family planning services to the rural areas. The project includes assessments of the effectiveness of alternative combinations of health and family planning services,

*Lesotho is not included in the H.D.S. project though a part of the A.I.D.-financed MCH Extension under contract with the University of California, Santa Cruz.

including health and nutrition education, the services of paramedical personnel, family planning advice, as well as preventive and curative health services.

It is anticipated that much of this information will be transferable to other African countries and the Danfa project area could provide an appropriate field observation area for selected trainees from other countries.

DEIDS

An African country is to be selected as the site for the African component of this tri-continental project, administered through a contract with APHA. The project envisages the design and implementation of prototype cost-effective health delivery systems capable of providing services to two-thirds of the women of reproductive age and two-thirds of all children below the age of five years in pilot regions of approximately 500,000 people. The prototype must be applicable (replicable) on a nationwide basis at costs within the bounds of limited national health resources. The delivery system design should incorporate not only innovative health approaches, but also mechanisms which may be outside of traditional health channels, i.e., commerce, industry, education, communication, law, etc. It is assumed that the achievement of wide-coverage delivery will require the training and reorientation of indigenous traditional manpower resources and the linking of these resources to more modern systems of health delivery.

Ideally, one might prefer that the DEIDS (essentially research) project and the H.D.S. project not be initiated simultaneously but that the H.D.S. project, which will encourage African Governments

to adopt more efficient health delivery systems, be funded only after the results of DEIDS are available. However, this ideal time sequence must be modified in relation to African realities. Incremental improvements in health service care through improved delivery systems cannot and should not await completion of the research model. Although DEIDS is a necessary element in Africa, it must be accompanied by donor-funded activities that can lead to improved services in the short-term, and activities that can put to use important though incomplete pragmatic and research-related findings which are now available (small pilot health delivery systems similar to DEIDS but much smaller in scope have been fostered in Africa by WHO). Improvement of health delivery systems is a dynamic process where modifications will always be necessary, an ideal - never reality. The health delivery systems project, through encouraging incremental change in national delivery systems and through exposing African planners and administrators to concepts surrounding the delivery system approach to improved health care (i.e., more stress on preventive health, extension of services to rural areas, the "health team" approach) will help fertilize the ground through better planning and training for the seeds of innovation which, hopefully, will be generated through discoveries of DEIDS and other similar programs.

Demographic and Disease Surveillance Survey - Upper Volta, Nigeria

This project, to be implemented by CDC, is designed to develop and test a simple, practical system (cluster sampling) for the collection and use of data in planning, programing, implementing and

evaluating population and health programs. Units within participating Ministries of Health will be established or strengthened to collect and analyse data with a view to determining priorities for action programs in population and health. In addition, CDC, chosen as a contractor in order to capitalize on its experience gained in administering the smallpox/measles program, will be responsible for collaborating with government authorities in determining and selecting pilot remedial action programs, and for assisting in the preparation of these pilot proposals, which may be submitted to A.I.D. for review and consideration for funding. These proposals, if appropriate, could be keyed into or included in Phase II disease surveillance activities of this project.

Integrated Outreach Health Services program - Liberia

Liberia has requested A.I.D.'s assistance in expanding integrated health services (health, nutrition and family planning) to rural areas of the country. This "outreach" program will provide training and retraining for paramedical and auxiliary personnel who will man the health posts and health units in the countryside. The expanded health system would focus on preventive health activities. Efforts are being made to coordinate design of this project with ongoing and proposed rural development programs such as agricultural development, rural education development and rural water supply programs. The project is expected to be authorized during FY 1974.

Management of Rural Health Services - Ghana

This recently approved project will address the need for improved planning and management within the existing Ghanaian public

health system with a goal of improving the effectiveness of health delivery services in rural areas. Project technicians will work with the Ministry of Health in four areas of concern: (1) long-range planning to establish clearer statements of priorities, including provisions for improved collection and analysis of data and their use in setting priorities; (2) organizational problems within the MOH; (3) information and communication systems; and (4) management of resources (financial, personnel, equipment).

Sahel - Drought-affected countries

Six countries in Central and West Africa Sahelian zones - Chad, Mali, Mauritania, Niger, Senegal and Upper Volta - are suffering from the effects of a severe drought. Over a five-year period the area has experienced below normal rainfall which has resulted in poor or no harvest, dried up water sources, less income from taxes for the Governments, lower foreign exchange earnings, loss of livestock and debilitation of the population of the area. This situation has altered the planned donor assistance. A.I.D. has joined the international donor community in providing assistance for (a) emergency relief requirements, (b) rehabilitation and recovery activities (to help people prepare to better cope with problems of survival over 12-14 months), (c) long-term development aimed at reversing the basic deterioration of the area.

In the health/nutrition area, A.I.D.'s assistance is to ensure that those populations most at risk are supplied with necessary health/medical needs to enable them to endure the effects of the drought. Further, these needs are identified quickly and coordinated action is taken.

The donor assistance to these six countries under the emergency and medium-term affect long-term requirements and should relate to planning, disease surveillance and manpower development to be provided in the multidonor activities on Strengthening of Health Delivery Systems and related A.I.D.-supported population funded family planning/MCH extension projects.

Onchocerciasis Control

The purpose of this program is to support an international program to control onchocerciasis in the Volta River Basin area based mainly on controlling the vector (larvae) by the use of insecticides. A.I.D.'s participation will be in the form of a contribution to an international trust fund, The Onchocerciasis Fund.

The disease occurs in Africa, the Yemen and parts of Central and South America. The medically most important and largest endemic areas are in tropical Africa, and the Volta River Basin is one of the worst. Apart from its generally debilitating effects, onchocerciasis frequently causes eye lesions leading to impairment of vision and total blindness. The latest estimates suggest that around one million people are suffering from onchocerciasis in the zone to be covered by the proposed program and, of these, as many as 60,000 may be blind. Approximate numbers for each country comprising the control zone are as follows: Upper Volta, 410,000; Ghana, Ivory Coast and Mali, 150,000; Dahomey, 120,000; Togo, 50,000; Niger, less than 10,000.

The heaviest costs of onchocerciasis in the Volta River Basin - and the most important benefits that would result from control of the disease - are associated with the retreat of population from heavily infested river valleys which contain some of the most fertile land in

the area. If onchocerciasis can be controlled, there is a reasonable expectation that most of this abandoned land can be brought back into cultivation.

Total costs for the 20-year program are estimated at $120 million, of which $41 million is for the first six years.

Coordination

It is evident that close coordination among A.I.D. health project officials and Missions will be necessary in order that the positive results of these A.I.D. projects can be documented and passed on to key health officials in all countries participating in this proposed project. Some mechanisms for achieving this objective have been mentioned on page 56. In addition, it is strongly suggested that officials from U.S. A.I.D. bilateral Missions and Area Development Offices in West and Central Africa meet periodically with the H.D.S. project manager during Phase I of the project to review the relationships among the activities of the various A.I.D. health/population projects and to suggest ways in which this project can be more relevant to the health needs of their particular constituencies.

E. Relation to other donor activities

This project incorporates a major initiative by A.I.D., WHO, FAC, UNICEF, CIDA and other donor organizations to increase the effectiveness of their individual resource inputs in the health sector in West and Central Africa through increased collaboration and cooperation. All of these organizations have been consulted by A.I.D. during the period of project design and have participated in the selection of key problem areas to be addressed by the project. A.I.D./other donor cooperation on this project has not sprung up anew, but is

largely a result of personal and organisational affinities which have evolved through joint activities such as the A.I.D./WHO measles/smallpox program and the WHO/FAC/CIDA/A.I.D. C.U.S.S. project in Yaounde, Cameroon.

In a major step forward in donor cooperation, A.I.D., WHO and FAC have agreed to participate as members of the project Coordination Committee which will approve and monitor project activities. This Committee should provide an excellent mechanism for interdonor consultation and should result in more efficient use of donor resources.

The effects of cooperation can already be seen in the decision to use this project to bolster several WHO regional institutions through the use of A.I.D. and other donor funds, instead of creating or strengthening additional training centers that would benefit much more limited areas.

The two major donors in West and Central Africa in the health sector, WHO and FAC, have been fully involved in the development of this Strengthening Health Delivery Systems project. A summary of their ongoing health programs in this area follows.

World Health Organisation (WHO) (See Annex V for more details)

The WHO Regional Office for Africa, located in Brazzaville, administered a $20 million program (regular budget) in 1972. The WHO/AFRO Regional Director, Dr. Alfred Quenum, is assisted by a staff of 69 plus 20 WHO country representatives. WHO/AFRO also supports 460 authorized professional personnel (contract) in the field. WHO activities span a large number of health problem areas in Africa but more recently have been concentrated in the areas of basic health service development, national health planning, health manpower development and communicable disease control.

The proposed WHO budget for manpower training for FY 1973 was over two million five hundred dollars for the region (including East Africa), of which $255,000 and $215,000 were budgeted for support of the Lagos and Lome training centers, respectively. The remainder was allocated to Fellowships, stipends, trainee support and medical school-related activities. Emphasis has been placed on the support of existing manpower resources (retraining) and on-the-job oriented training. WHO has expressed a serious interest in an interdisciplinary team approach to training and in the training of multipurpose workers. Although WHO undertook a health manpower census in 1969 and an inventory of current national training resources is maintained, few countries have developed national health training policies or developed truly comprehensive national training plans. The WHO Regional Committee in September 1971 recommended that member States: (1) develop as from 1980 ten-year health plans; (2) improve the collection and analysis of statistical data with a view to rational planning of health personnel needs; (3) establish or develop the necessary training centers for producing qualified professionals and auxiliary staff in sufficient numbers and possessing the requisite qualities; and (4) accord particular attention to the problem of rational utilization of trained staff by evaluating activities in regard to development of human resources every five years.

The same committee asked WHO to accelerate its teacher training programs, develop the teaching of public health, particularly the administration and management of health services, strengthen training programs in the field of national health planning, and intensify applied research in the fields of education methodology and technology for the training of health personnel.

In addition to training health planners and support to the proposed African Institute for National Health Planning, WHO has supported improved national health planning in Africa through the provision of long-term technical assistance to many Ministries of Health and through encouraging the development of health plans.

WHO has demonstrated its concern with the delivery of basic health services through support to small (50,000 population) experimental health delivery and field training areas in several countries. In at least three cases, these areas coincide with A.I.D.-supported activities: the OCEAC project training areas in the CAR and Chad, and the C.U.S.S. field training area in Cameroon.

In the area of communicable disease control, WHO continues to support smallpox, yellow fever and cholera programs, will coordinate a multidonor onchocerciasis eradication program in West Africa and supports certain communicable disease laboratories. WHO also supports regional surveillance centers in Abidjan and Nairobi which collect, tabulate and analyse epidemiological data. A third center, planned for Brazzaville, will house computer facilities for Africa-wide surveillance activities.

In the Central and West Africa countries, WHO inputs in 1974 in three areas specifically related to this project are estimated as follows:

a.	Strengthening Health Services	$2,289,252
b.	Health Manpower Development	1,590,547
c.	Disease Prevention and Control (including surveillance)	665,614
	Total	$4,545,413

(See Annex V for related funding)

FAC (Fonds d'Aide et de Cooperation de la Republique Francaise)

FAC technical assistance in the health and social welfare sphere is concentrated in four sectors: (1) provision of technical staff - approximately 1,000 aid personnel (60% physicians and specialists) are working in the twenty countries of the region (estimated cost of $10 million); (2) logistic support and capital investment: $ 7 million per year in assistance, largely in the areas of preventive and curative medicine and communicable disease control. Equipment has been furnished mainly for mass preventive measures and for mobile medicine. Attempts to modernize health services are undertaken only where possible to do without increasing operating costs; (3) staff training - this form of assistance involves the establishment of training institutions for health staff, often in cooperation with WHO and other external assistance agencies. France provides teachers, supervisors, Fellowships for specialized studies in France and Africa, and teaching materials at an estimated value of $1 million annually; (4) medical research - grants have been awarded for research, largely in the area of mass preventive medicine to OCCGE and OCEAC. Research in vaccine research and productivity has been carried on by various Instituts Pasteur.

France reportedly expects to maintain external aid in the field of health at its present level, but welcomes all new orientations in the use of these funds that might be presented by the recipient nations themselves.

Total funds provided by FAC to the Central and West African French-speaking countries for health and social services amounts to an average of approximately $5.5 million per annum.

F. Summary of other donor inputs

UNICEF

UNICEF has been especially concerned with the needs of children and young people in Africa. Approximately 49% of its 1973 budget ($2.5 million) was allocated for health activities including clinical supplies and equipment, demonstration and teaching materials, means of transport and Fellowships for the basic and/or post-basic training of health staff. UNICEF, which operates in close cooperation with WHO, has concentrated its resources on the areas of health service development, communicable disease control and staff training.

CIDA (Canadian International Development Agency)

The CIDA program in Francophone Africa is focused mainly on education. In CY 1969, 130 African students and trainees in the health area were trained in Canada and 97 Canadian health experts and advisers were stationed in Francophone Africa. One major example of CIDA multi-donor cooperation is their substantial assistance to the C.U.S.S. project in Yaounde, Cameroon, and their providing 12 million doses of smallpox vaccine in CY 1973 to fill the gap left by A.I.D. in Central and West Africa.

C. Budget

	TOTAL		FY 1973		FY 1974		FY 1975		FY 1976	
	Amount	MM	Amount	MM	Amount	MM	Amount	MM	Amount	MM
U.S. Technicians	1,149	(250)			107	(22)	716	(154)	325	(74)
Participant Training	200	(320)					74	(116)	126	(204)
Commodity Procurement	1,515		995		400		120			
Other Costs	124	(44)	16		20		45	(24)	43	(20)
GRAND TOTAL	2,988		1,011		527		955		495	

See Annex II for further dtails.

Annex I

A Description of Participating Regional Institutions

I. WHO Training Center at Lome, Togo

This Center provides training for laboratory technicians and malaria workers. It also provides short-term refresher training for various health personnel. Courses are developed in response to requests from African countries. Each course is designed to the requirements of the trainees and usually limited to 20 persons. The Center has a staff of five full-time trainers who are primarily responsible for the long-term training and for coordination and administration of the short-term courses. The faculty for the short-term courses are generally outside experts. The training emphasizes practical experience and laboratory experience. At least 25 percent of the training is done at a field training center within easy distance of the WHO Center. The budget of the Lome Center is $100,000 per year.

2. The Vogan Health Center

This Center serves as the field training center for the WHO Training Center at Lome. This health center serves 40,000 persons and has several satellite clinics. Its staff of approximately 15 well-prepared and energetic health workers serve as trainers.

3. Lagos Training Center

The Lagos Training Center provides special training courses for various categories of public health workers upon the specific

request of African governments. Short-term refresher courses are administered in the same way as at the Lome Center. It provides laboratory technician training in malariology. The full-time staff of nine inclues; 1 medical officer, a laboratory technician, a health educator, a nurse educator, a sanitarian instructor, an administrative officer, and a secretary. It has a budget of $160,000 per year.

ANNEX II

SUMMARY OF U.S. INPUTS
($000)

	TOTAL		FY 1973		FY 1974		FY 1975		FY 1976	
	Amount	MM	Amount	MM	Amount	MM	Amount	MM	Amount	MM
S. TECHNICIANS - Totals	1,149	(250)			107	(22)	716	(154)	326	(74)
Project Manager (direct hire)	123	(24)			13	(2)	60	(12)	50	(10)
Asst. Project Manager (direct hire)	123	(24)			13	(2)	60	(12)	50	(10)
Administrative Officer (direct hire)	105	(24)			10	(2)	50	(12)	45	(10)
Secretary bilingual (direct hire)	62	(24)			7	(2)	30	(12)	25	(10)
Regional Training Centers Staff (contract: 3 for Lagos, 1 for Lome)	360	(72)			-	-	360	(72)	-	-
Nutrition/Epiedmiology (HASA, short term)	136	(34)			24	(6)	56	(14)	56	(14)
Health Planning/Manpower/Disease Surveillance (contract, short term)	240	(48)			40	(8)	100	(20)	100	(20)
PARTICIPANT TRAINING - Totals	200	(320)					74	(116)	126	(204)
Third country training, short term Two months' training for each of 30 participants in FY 1975 and 60 in FY 1976	90	(180)					30	(60)	60	(120)
U.S. training, long term Two months' language and 12 months academic training for each of 4 participants in FY 1975 and 6 in in FY 1976	110	(140)					44	(56)	66	(84)

ANNEX II (Cont'd)

SUMMARY OF U.S. INPUTS (Cont'd)
($000)

	TOTAL		FY 1973		FY 1974		FY 1975		FY 1976	
	Amount	MM	Amount	MM	Amount	MM	Amount	MM	Amount	MM
COMMODITY PROCUREMENT - Totals	1,515		995		400		120			
Measles vaccines and related items	1,395		995		400		-			
Training materials and equipment	20		-		-		20			
Vehicles and spare parts	100		-		-		100			
OTHER COSTS - Totals	124	(44)	16		20		45	(24)	43	(20)
Local direct hire - 2 clerk typists	18	(44)	-		-		10	(24)	8	(20)
Coordinating Committee and Review Bod. Meetings - travel, per diem, logistic support	64						32		32	
Local support for regional centers	10		-		10		-		-	
Operational travel for technical personnel from other pilot projects	6		-		-		3		3	
Local distribution costs for measles vaccines	26		16		10		-		-	
GRAND TOTALS	2,988		1,011		527		955		495	

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project (Phase I)
From FY 74 to FY 76
Total U.S. Funding
Date Prepared: March 1, 1974

Project Title & Number: Strengthening Health Delivery Systems - Phase I

PAGE 2

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Purpose: (B-1)	Conditions that will indicate purpose has been achieved: End-of-Project status. (B-2)	(B-3)	Assumptions for achieving purpose: (B-4)
	1. Planning completed for establishing regional capacity for training health planners and administrators, and trainers of local health manpower in subject matters related to improved health delivery systems. 2. Existing health delivery systems reviewed and planning for improved systems begun. 3. Existing health manpower plans reviewed and improved; Regional Center Utilization Plans developed. 4. Planning completed for strengthening regional disease surveillance support programs. 5. Planning completed for establishing regional capacity for training personnel for health monitoring systems.		

ANNEX III (Cont'd)

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Strengthening Health Delivery Systems - Phase I

Life of Project: (Phase I)
From FY 74 to FY 76
Total U.S. Funding
Date Prepared: March 1, 19

PAGE

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Purpose: (B-1)	Conditions that will indicate purpose has been achieved: End-of-Project status. (B-2) 6. Integration of disease surveillance and health delivery systems reviewed in context of (2) above. 7. Phase II activities agreed upon by participating organizations/governments. 8. Role of coordinating mechanism clearly defined. 9. Coordinating mechanism capable of coordinating Phase II activities.	(B-3)	Assumptions for achieving purpose. (B-4)

ANNEX III - Cont'd

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: (Phase I) From FY 74 to FY 76
Total U.S. Funding
Date Prepared: March 1, 1974

Project Title & Number: Strengthening Health Delivery Systems -- Phase I

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Outputs: (C-1)	Magnitude of Outputs: (C-2)	(C-3)	Assumptions for achieving outputs: (C-4)
Objective 1 -- Improved Public Health Planning and Management			
1. Completed plans for expanded planning/ management training programs at Lagos and Lome	1. One plan per training center	1. Existence of plans	
2. Key national health officials trained in planning and management courses at Lagos and Lome	2. FY 74 75 76 Courses 0 5 4 Participants 50-100 40-80	2. Lagos/Lome training records	High level national health officials officials can attend two-four week courses
3. Planning for improvement of delivery systems begun	3. Planning underway in at least ten participating countries	3. Government/consultant	
4. Trained African planners	4. Five instructors for Lagos and Lome centers. Five national planning officials	4. Project participant training records	Stimulated by short-term courses at Lagos/Lome and availability consultants. MOHs sufficiently enthused to undertake major planning effort. Suitable candidates available for training.
Objective 2 -- Increase Skills and Improve Utilization of Local Health Personnel			
1. Completed plans for expanded health manpower (trainer) training programs at Lagos and Lome	1. One plan per training center (to be integrated with plans for planning/ management training program, Objective 1)	1. Existence of plans	
2. Regional Center Utilization Plans	2. One plan from most participating countries (15 -20)	2. Existence of plans	Participating countries sufficiently interested in regional training programs to prepare utilization plans

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: (Phase I) From FY 74 to FY 76
Total U.S. Funding
Date Prepared: March 1, 1974

Project Title & Number: Strengthening Health Delivery Systems -- Phase I

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Outputs: (C-1)	Magnitude of Outputs: (C-2)	(C-3)	Assumptions for achieving outputs: (C-4)
Objective 3 -- Improve Regional and National Disease Surveillance and Health Data Systems and Integrate those systems into National Health Planning and Delivery Systems			
1. Institutional linkages and functional specializations of OCEAC, OCCGE, and Abidjan Center clarified	1. Agreement as indicated by institutional plans	1. Review of institution's plans	1. Organizations have complementary rather than competitive objectives
2. Integration of surveillance and delivery systems begun	2. Initial steps taken in five to ten countries		
3. Abidjan Center: Completed plan for manpower training and consultant service programs.	3. 1 plan.		
4. OCCGE: Improved training curriculum	4. Improved training curriculum in major OCCGE training programs	4. Consultant reports	
5. OCEAC: Nucleus of trained personnel for national surveillance activities	5. Corps number of personnel in each OCEAC country (numbers not specified)	5. OCEAC and participating country records	
Coordinating Mechanism			
1. Coordinating Committee Meetings	1. Four (approx.)	1. Project records	
2. Review body meetings	2. Two	2. Project records	
3. Detailed plan for proposed Phase II activities	3. Plan will include implementation schedules, financial costs and	3. Existence of plan	3. Planning activities well coordinated and proceed at adequate pace. Donors and governments

ANNEX III (Cont'd)

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: (Phase I)
From FY 74 to FY 76
Total U.S. Funding
Date Prepared: March 1, 1974

Project Title & Number: Strengthening Health Delivery Systems -- Phase I

PAGE 3 b

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Outputs: (C-1)	Magnitude of Outputs: (C-2)	(C-3)	Assumptions for achieving outputs: (C-4)
Coordinating Mechanism (continued)			
1. (continued)	3. (continued) contributions		3. (continued) willing to pledge contributions for five-year period.
4. Consultant roster	4. Forty--fifty consultants	4. Project records	
5. Joint procurement mechanism established		5. Project records	5. No legal constraints to establishment such a mechanism.

ANNEX III (Cont'd)

AID MANUAL [illegible]
SUPPLEMENT [illegible]

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: (Phase I)
From FY 74 to FY 76
Total U.S. Funding
Date Prepared: [redacted]

Project Title & Number: Strengthening Health Delivery Systems -- Phase I

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Inputs: (D-1)	Implementation Target (Type and Quantity) (D-2)	(D-3)	Assumptions for providing inputs: (D-4)
A.I.D.			
Personnel -- (long-term)			Personnel with appropriate skill available for project assignment
Project Manager (DH)			
Assistant Project Manager (DH)			
Bilingual Secretary (DH)			
Clerk-Typist (LH)			
Administrative Assistant (LH)			
Personnel (short-term)			
APHA Contract (63 mm)			APHA has technical and administrative capability to provide short-term consultants with appropriate skills at appropriate times.
Procurement Specialist (2 mm)			
Training			
Fellowships -- Lagos/Lome Centers (approx. 60)			
Participant training (10 my)			
Commodities, Equipment			
Training materials and equipment -- Lagos/Lome Centers			
OCEAC			
Other			
OPEX -- Directors Lagos/Lome Centers (4 my)			
OPEX -- Instructors Lagos/Lome Centers (20 my)			
Travel -- A.I.D. personnel other projects to Lagos/Lome Center			
Coordinating Committee meeting -- logistic and travel costs			

ANNEX III (Cont'd)

AID 1020-20 (11-72)
SUPPLEMENT 1

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: (Phase I)
From FY 74 to FY 76
Total U.S. Funding
Date Prepared: March 1, 1974

Project Title & Number: Strengthening Health Delivery Systems -- Phase I

PAGE 4

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Inputs: (D-1)	Implementation Target (Type and Quantity) (D-2)	(D-3)	Assumptions for providing inputs: (D-4)
A.I.D. (continued)			
Review Body Meetings -- Logistic and travel costs			
W.H.O.			
Project Director			
Base Salaries -- Directors Lagos/Lome Centerss			
Base Salaries -- Instructors Lagos/Lome Centers			
Short-term Consultants			
Fellowships -- Lagos/Lome Centers			
Continued Support -- Lagos/Lome Centers			
Continued Support -- Abidjan Center			
Interpreting Secretarial and Other Support Costs for Coordinating Committee and Review Body Meetings held at Brazzaville			
Office space for A.I.D. project personnel, Brazzaville			
AI			
Continued Support to OCEAC, UCCGE			
Continued Support to national ministries of health			
Participant Training			

ANNEX IV

OCEAC
Disease Surveillance

Category	Personnel	Training	Technical Assistance	Laboratory Services	Material/ Supplies	Epidemiologist	TOTAL
Financing	Countries	OCEAC	French Co-operation	Institute Pasteur	USAID	AID/CDC	
1972 (CFA)	6,625,000	825,000	12,000,000	2,500,000	9,200,000	3,000,000	34,150,000
(USD)	26,500	3,300	48,000	10,000	36,800	12,000	136,600
1973 (CFA)	12,920,000	585,000	12,500,000	5,000,000	10,000,000	3,125,000	44,130,000
(USD)	51,680	2,340	50,000	20,000	40,000	12,500	176,520
1974 (CFA)	12,920,000	290,000	13,000,000	7,500,000	7,250,000	3,250,000	44,210,000
(USD)	51,680	1,160	52,000	30,000	29,000	13,000	176,840
TOTAL (CFA)	32,465,000	1,700,000	37,500,000	15,000,000	26,450,000	9,375,000	122,490,000
(USD)	129,860	6,800	150,000	60,000	105,800	37,500	489,960

Programme sector/Programme	1974			1975			1976			1977		
	Regular budget	Other sources	Total	Regular budget	Other sources	Total	Regular budget	Other sources	Total	Regular budget	Other sources	Total
	[illegible] $	[illegible] $	[illegible] $	[illegible] $	[illegible] $	[illegible] $	[illegible] $	[illegible] $	[illegible] $	[illegible] $	[illegible] $	[illegible] $
.1 Executive management:												
.1.3 Office of the Regional Director	97 050		97 050	101 260		101 260	102 105		102 405	105 870		[illegible]
.1 Strengthening of health services	4 443 520	1 538 279	5 981 799	5 057 280	1 906 240	6 963 520	5 234 980	1 318 357	6 553 337	5 508 160	682 210	6 190 370
2 Family health:												
2.1 Programme planning and general activities	84 800		84 800	85 720		85 720	88 720		88 720	93 230		93 230
2.2 Maternal and child health	52 900	158 845	211 745	56 060	194 500	250 560	60 980	213 400	274 380	63 410	223 400	286 810
2.4 Nutrition	228 180	17 000	245 180	244 960		244 960	255 050		255 050	265 920		265 920
2.5 Health education	83 200	86 632	169 832	75 460	98 700	174 160	82 260	82 800	165 060	86 370	79 000	165 370
3 Health manpower development	4 960 930	1 669 334	6 630 264	5 359 620	882 683	6 242 303	5 691 705	476 502	6 168 207	6 195 780	213 700	6 409 480
4 Communicable disease prevention and control:												
4.1.1 Programme planning and general activities	264 000		264 000	243 050		243 050	251 550		251 550	264 630		264 630
4.1.2 Epidemiological surveillance of communicable diseases	995 010	305 718	1 300 758	1 067 360	161 300	1 228 360	1 110 340	146 000	1 256 340	1 120 160	87 300	1 207 460
4.1.3 Malaria and other parasitic diseases	493 930	4 594 842	5 088 772	498 040	6 834 700	7 332 740	539 960	9 248 300	9 788 260	558 660	10 400 000	10 958 660
4.1.4 Smallpox eradication	225 400	49 500	274 900	241 380	33 200	274 580	248 340	33 200	281 540	254 480	33 200	287 680
4.1.5 Bacterial diseases	151 000	19 600	170 600	33 400	45 000	78 400	62 400	45 000	107 400	64 400	45 000	109 400
4.1.7 Virus diseases	14 000		14 000	10 200		10 200	10 400		10 400	10 400		10 400
5 Noncommunicable disease prevention and control:												
5.1 Programme planning and general activities	39 500		39 500	40 320		40 320	42 370		42 370	44 980		44 980
5.2 Cancer	6 000		6 000	2 200		2 200	2 400		2 400	7 200		7 200
5.5 Dental health	8 000		8 000	2 200		2 200	2 400		2 400	[illegible]		

Programme sector/Programme	1974			1975			1976			1977		
	Regular budget	Other sources	Total	Regular budget	Other sources	Total	Regular budget	Other sources	Total	Regular budget	Other sources	Total
	US $	US $	US $	US $	US $	US $	US $	US $	US $	US $	US $	US $
2.6 Mental health	4 000		4 000	4 400		4 400	4 800		4 800	4 800		4 800
2.7 Biomedical aspects of radiation	61 400		61 400	59 060		59 060	61 980		61 980	33 320		33 320
3 Prophylactic, diagnostic and therapeutic substances:												
3.1 Programme planning and general activities	48 300		48 300	46 020		46 020	47 120		47 120	49 180		49 180
3.2 Specifications and quality control of pharmaceutical preparations	7 000		7 000	7 600		7 600	8 200		8 200	8 200		8 200
4 Promotion of environmental health:												
4.1 Programme planning and general activities	242 230		242 230	244 810		244 810	252 260		252 260	264 470		264 470
4.2 Provision of basic sanitary measures	43 700	136 184	179 884	40 400	191 300	231 700	54 700	216 900	271 600	56 740	180 000	236 740
4.3 Pre-investment planning for basic sanitary services		2 999 528	2 999 528		921 960	923 960		277 177	277 177		27 925	[illegible]
4.4 Control of environmental pollution and hazards	6 000		6 000	6 600		6 600	45 500		45 500	7 200		[illegible]
4.5 Health of working populations	24 900		24 900	43 080		43 080	45 280		45 280	46 590		46 590
5 Health statistics:												
5.1 Programme planning and general activities	92 800		92 800	91 030		91 030	94 330		94 330	99 180		99 180
5.2 Development of health statistical services	26 770		26 770	37 860		37 860	44 380		44 380	45 640		45 640
6 Health literature services	58 200		58 200	63 200		63 200	68 050		68 050	69 850		[illegible]
8 WHO publications	205 600		205 600	210 650		210 650	221 350		221 350	235 090		235 090
9 Health information of the public	90 300		90 300	91 850		91 850	97 650		97 650	103 670		103 670

AFRICA: SUMMARY BY PROGRAMME SECTOR, PROGRAMME AND SOURCE OF FUNDS (continued)

Programme sector/Programme	1974			1975			1976			1977		
	Regular budget	Other sources	Total	Regular budget	Other sources	Total	Regular budget	Other sources	Total	Regular budget	Other sources	Total
	US $	US $	US $	US $	US $	US $	US $	US $	US $	US $	US $	US $
8.4 Legal services:												
8.4.3 Health legislation	6 000		6 000	4 400		4 400	4 800		4 800	4 800		4 800
9.1 Regional programme planning and general activities:												
9.1.1 Africa	413 500		413 500	416 210		416 210	428 660		428 660	448 530		448 530
9.2 Assistance to country programmes												
9.2.1 Africa	1 198 150		1 198 150	1 256 090		1 256 090	1 322 320		1 322 320	1 390 680		1 390 680
9.3 Regional general support services:												
9.3.1 Africa	1 357 320		1 357 320	1 584 550		1 584 550	1 669 210		1 669 210	1 761 280		1 761 280
9.4 Regional common services:												
9.4.1 Africa	629 500		629 500	707 700		707 700	751 150		751 150	825 500		825 500
Total	16 663 120	11 575 462	28 238 582	18 040 000	11 271 283	29 311 283	19 608 000	12 057 636	31 665 636	20 108 000	11 971 735	32 079 735

REGIONAL OFFICE

	Project No.	Number of posts				Estimated obligations				Regular budget	Other sources
		1974	1975	1976	1977	1974	1975	1976	1977		
						US$	US$	US$	US$		
EXECUTIVE MANAGEMENT											
Office of the Regional Director		4	4	4	4	97 050	101 280	103 405	105 870	[illegible]	
HEALTH MANPOWER DEVELOPMENT		6	6	6	6	65 130	67 700	71 150	74 940	[illegible]	
HEALTH LITERATURE SERVICES		4	4	4	4	36 200	40 000	42 250	44 050	[illegible]	
WHO PUBLICATIONS		11	11	11	11	205 600	210 650	221 350	235 080	[illegible]	
HEALTH INFORMATION OF THE PUBLIC		4	4	4	4	90 300	91 850	97 650	103 670	[illegible]	
REGIONAL PROGRAMME PLANNING AND GENERAL ACTIVITIES		19	19	19	19	413 500	416 210	428 600	448 530	[illegible]	
REGIONAL GENERAL SUPPORT SERVICES		116	116	116	116	1 357 920	1 584 5[illegible]	1 669 210	1 761 280	[illegible]	
REGIONAL COMMON SERVICES						629 500	707 700	751 150	825 500	[illegible]	
Total - REGIONAL OFFICE		164	164	164	164	2 894 600	3 219 920	3 383 825	3 598 930		
Of which: Regular budget		164	164	164	164	2 894 600	3 219 920	3 383 825	3 598 930		
Other sources		-	-	-	-	-	-	-	-		

REGIONAL ADVISERS AND WHO REPRESENTATIVES

	Project No.	Number of posts 1974	1975	1976	1977	Estimated obligations 1974	1975	1976	1977	Regular budget	Other sources
						US$	US$	US$	US$		
REGIONAL ADVISERS											
STRENGTHENING OF HEALTH SERVICES		7	7	7	7	169 130	166 220	172 120	181 040	[illegible]	
FAMILY HEALTH											
Programme planning and general activities		4	4	4	4	84 800	85 720	88 720	93 230	[illegible]	
Nutrition		4	4	4	4	84 800	81 100	87 100	91 510	[illegible]	
Health education		3	3	3	3	75 800	76 760	79 360	83 470	[illegible]	
HEALTH MANPOWER DEVELOPMENT		12	12	12	12	254 140	242 800	252 400	266 200	[illegible]	
COMMUNICABLE DISEASE PREVENTION AND CONTROL											
Programme planning and general activities		11	11	11	11	264 000	213 050	251 550	264 630	[illegible]	
NON-COMMUNICABLE DISEASE PREVENTION AND CONTROL											
Programme planning and general activities		2	2	2	2	39 560	40 320	42 370	44 960	[illegible]	
PROPHYLACTIC, DIAGNOSTIC AND THERAPEUTIC SUBSTANCES											
Programme planning and general activities		2	2	2	2	48 300	46 020	47 120	49 190	[illegible]	
PROMOTION OF ENVIRONMENTAL HEALTH											
Programme planning and general activities		11	11	11	11	242 230	244 810	252 260	264 [illegible]	[illegible]	
HEALTH STATISTICS											
Programme planning and general activities		5	5	5	5	92 800	91 020	94 330	99 180	[illegible]	
Total - REGIONAL ADVISERS		61	61	61	61	1 365 600	1 320 830	1 367 330	1 437 990		
Of which: Regular budget		61	61	61	61	1 365 600	1 320 830	1 367 330	1 437 990		
Other sources		-	-	-	-	-	-	-	-		
WHO REPRESENTATIVES											
ASSISTANCE TO COUNTRY PROGRAMMES		52	52	52	52	1 198 150	1 256 090	1 322 320	1 390 680	[illegible]	
Total - WHO REPRESENTATIVES		52	52	52	52	1 198 150	1 256 090	1 322 320	1 390 680		
Of which: Regular budget		52	52	52	52	1 198 150	1 256 090	1 322 320	1 390 680		
Other sources		-	-	-	-	-	-	-	-		

LIST OF ABBREVIATIONS

AAPC	Afro-American Purchasing Center
AID	Agency for International Development
AINHP	African Institute for National Health Planning
APHA	American Public Health Association
CAR	Central African Republic
CDC	Center for Disease Control
CIDA	Canadian International Development Agency
C.U.S.S.	Centre Universitaire des Sciences de la Sante
DEIDS	Development and Evaluation of Integrated Delivery Systems for Health, Family Planning, Nutrition
DH	Direct hire
EOPS	End of project status
FAC	Fonds d'Aide et de Cooperation
FED	Fonds Europeen de Developpement
H.D.S.	Health delivery systems
MCH	Maternal/child health
MM	Man months
MOH	Ministry of Health
OCCGE	Organisation de Coordination et de Cooperation pour la Lutte Contre les Grandes Endemies
OCEAC	Organisation de Coordination pour la Lutte Contre le Endémies en Afrique Centrale
OPEX	Operation Expatriate (a method for provision by a donor of salary for expatriate assistance, additional to the salary paid by the host Government)
PAR	Project Appraisal Report
PROP	Noncapital Project Paper

LIST OF ABBREVIATIONS (Continued)

SIDA	Swedish International Development Authority
SHDS	Strengthening of Health Delivery Systems
UNDP	United Nations Development Programme
UNICEF	United Nations Childrens' Fund
WHO	World Health Organization

6/15/76

JUN 1 1976

ACTION MEMORANDUM FOR THE ACTING ADMINISTRATOR

THRU: ES

THRU: AA/PPC, Philip Birnbaum

FROM: AA/AFR, Stanley S. Scott

Problem: To amend the Strengthening of Health Delivery Systems in Central and West Africa Project Paper (No. 625-11-590-904) and add $459,000 to the existing project authorization to provide adequate funding for FY 1976. Also, approval is requested to extend Phase I of the project on an expenditure basis for an additional year through FY 1977.

Background: The Acting Administrator approved the PROP for this activity on May. 31, 1974. The project provides a means for effective utilization of health resources (human and financial) available from contributions of donors, regional organizations and participating African countries in order to deliver health services to rural populations.

The requirement for these funds is due to a cost overrun: an increase of $228,000 in participant costs; an $89,000 increase in other costs and a $357,000 increase in commodity procurement, of which $215,000 is offset by a decrease in personnel costs. The increase in commodity procurement is for measles vaccine and/or related items necessary to protect high-risk children and pregnant women against this major health problem in the majority of the participating countries during the past two years. Participant training activities were accelerated in order to make available planning/management, supervisory and other key skilled personnel to ministries of health during early stages of the development of the health systems.

The requested life of project extension will extend Phase I as necessary to permit the project team and consultants to complete the detailed planning required for the Phase II Project Paper which will cover five additional years (FY 1978-82) and be submitted for Agency review during July/August, 1977. The Project Director arrived in Abidjan, Ivory Coast, only in March, 1976, the Deputy Director this May, and the consultants assigned to make an assessment of three key regional training institutions began their work in April 1976.

To meet the requirement specified in the Administrator's May 31, 1974 authorization, a PAR review will now be conducted in the summer of 1977 so as to be available to the A.I.D. project management staff responsible for approving the Phase II Project Paper, as promised in the original PROP (pp 51).

In spite of the delays in recruiting and placing a long-term contract team in the field, much progress has been made in project activities and in expanding the breadth and depth of support for the original objectives. The Development Assistance Paper (DAP) for West and Central Africa, prepared in the spring of 1975, emphasized the value of an extensive interstate regional approach to the area's health problems. It also confirmed the desirability of an integrated area-wide network of national health delivery systems, rationalizing the use of both local and regional institutions. This latter goal is the specific objective of the project's second phase. The World Health Organization's Conference on Health Coordination and Cooperation in Africa held in Yaounde, Cameroon, of 25-26 September, 1975, also confirmed the importance of interstate cooperation as well as the desirability of the regional network and the approach used in this project to reach those objectives.

Most of the organizational components required to systematize a combined regional-national approach to the area's health problems are already in place but they do not yet work as a system. The remaining actions must occur to complete the system, namely to link them together, to establish commonly accepted intermediate objectives, to improve certain of the components with additional manpower and/or skills to make them operationally effective, and to channel resources from a variety of origins so they can be used jointly by the various national and regional organizations to achieve common ends. The first phase of the project is providing the basis for establishment of the regional system. Personnel are being trained; requirements for additional technical, managerial, and operational capabilities are being defined; and material needs are being identified.

The attached Logical Framework links progress to date to the project's Objectively Verifiable Indicators.

The second phase of the project will concentrate on fitting the components together to operate as a system - with national ministries, regional organizations, and donors all working as part of an integrated whole. The Project Paper for the second phase will define

the specific assistance to be provided in this effort. However, some of the more advanced activities, normally regarded as part of the second phase, will begin during the first phase; just as some of the first phase activities were begun by the WHO prior to execution of the project agreement. An example of the former includes systematic manpower training based on clearly identified national manpower needs while an example of the latter involves establishment of revised curriculae for the regional training centers.

The Congressional Submission for African Programs for FY 1976 (at pp 161) shows an intended FY 1976 obligation in the amount of $1,030,000 which is the precise amount of funding proposed for FY 1976.

Attached to this memorandum are a revised Project Paper face sheet, a revised financial schedule, a description of progress to date and current status, and a Project Performance Tracking form.

Recommendation: That you authorize the addition of $459,000 to the existing project authorization and also authorize project implementation activities through FY 1977, as described above.

APPROVED _____

DISAPPROVED _____

DATE 6/15/76

Clearances:

DA/AFR:DBrown _____ Date ____
AFR/DP:RHuesmann (draft) Date 6/10
AFR/DR:PLyman _____ Date 6/11
AFR/RA:DConroy _____ Date 6/11
AFR/GC:EDragon _____ Date 6/11
AFR/SFWA:DShean _____ Date 6/11/76
GC:CCGladson _____ Date 6/16/76
PPC/DPRE:AHandly _____ Date 6/11

AFR/DR:BBahl:6/1/76:X27886
AFR/DP:EParfrey:6/1/76:X29188
AFR/RA:HMarshall:6/1/76:X22476

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT PAPER FACESHEET

TO BE COMPLETED BY ORIGINATING OFFICE

1. TRANSACTION CODE ("X" appropriate box)
[ ] Original [X] Change
[ ] Add [ ] Delete

PP

DOCUMENT CODE 3

2. COUNTRY/ENTITY Sahel and Central West Africa Regional Programs

3. DOCUMENT REVISION NUMBER

4. PROJECT NUMBER 625-11-590-904

5. BUREAU a. Symbol AFR b. Code PH

6. ESTIMATED FY OF PROJECT COMPLETION FY 77

7. PROJECT TITLE - SHORT (stay within brackets) Strengthening of Health Delivery Systems

8. ESTIMATED FY OF AUTHORIZATION/OBLIGATION a. INITIAL mo. 7 yr. 3 b. FINAL FY 77

9. ESTIMATED TOTAL COST ($000 or equivalent, $1 =)

a. FUNDING SOURCE	FIRST YEAR FY 73 b. FX	c. L/C	d. Total	ALL YEARS e. FX	f. L/C	g. Total
AID APPROPRIATED TOTAL						
(Grant)	(995)	(16)	(1011)	(3147)	(300)	(3447)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
HOST GOVERNMENT						
OTHER DONOR(S)						
TOTALS	995	16	1011	3147	300	3447

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

a. Appropriation (Alpha Code)	b. Primary Purpose Code	c. Primary Tech. Code	Thru FY 75 d. Grant	e. Loan	FY 76 f. Grant	g. Loan	FY 77 h. Grant	i. Loan	ALL YEARS j. Grant	k. Loan
FAA/PH	-	-	2417	-	1,030				3447	
TOTALS			2417		1,030				3447	
11. ESTIMATED EXPENDITURES			983		1,013		1,325			

12. PROJECT PURPOSE(S) (stay within brackets) [ ] Check if different from PID/PRP

The purpose of this amendment is to add $459,000 to the project to provide adequate funding for FY 1976. Also, this amendment extends Phase I of the project an additional year through FY 1977.

13. WERE CHANGES MADE IN BLOCKS 12, 13, 14, or 15 OF THE PID FACESHEET? IF YES, ATTACH CHANGED PID FACESHEET
[ ] Yes [ ] No

14. ORIGINATING OFFICE CLEARANCE

Signature

Title E. Dennis Conroy
Director, AFR/RA

Date Signed mo. day yr.

15. Date Received in AID/W, or I AID/W Documen t, Date of Distribution mo. day yr.

AID 1330-4 (7-75)

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY _____ to FY _____
Total U.S. Funding _____
Date Prepared: _____

Project Title & _____

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	STATUS MAY 1976
Project Outputs. (C-1)	Magnitude of Outputs: (C-2)	
Objective 3 - Improve Regional and National Disease Surveillance and Health Data Systems and Integrate these Systems into National Health Planning and Delivery Systems		
1. Institutional linkages and functional specializations of OCEAC, OCCGE, and Abidjan Center clarified	1. Agreement as indicated by institutional plans	- Work to be begun by consultant team 1/77
2. Integration of surveillance and delivery systems begun	2. Initial steps taken in five to ten countries	- To be begun Fall 1977
3. Abidjan Center: Completed plan for manpower training and consultant service	3. 1 plan	- By long-term technicians and committees by 10/76
4. OCCGE: Improved training curriculum	4. Improved training curriculum in major OCCGE training programs	- To be determined
5. OCEAC: Nucleus of trained personnel for national surveillance activities	5. Corps number of personnel in each OCEAC country (numbers not specified)	- To be determined
Coordinating Mechanism		
1. Coordinating Committee Meetings	1. Four (approx.)	- First one Fall 1973
2. Review body meetings	2. Two	- Sept 1976 and Sept 1977
3. Detailed plan for proposed Phase II activities	3. Plan to include implementation schedules, financial costs contributions	- By October 1977
4. Consultant roster	4. Forty-fifty consultants	- By Sept 1976
5. Joint procurement mechanism established	5.	- Proposal received, Finalized by 4/77

LOGICAL FRAMEWORK

From FY _____ to FY _____
Total U.S. Funding _____
Date Prepared: _____

Project Title & Number: _____

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	STATUS MAY 1976
Project Outputs: (C-1)	Magnitude of Outputs: (C-2)	
Objective 1 - Improved Public Health Planning and Management		
1. 1. Completed plans for expanded planning/management training programs at Lagos and Lome.	1. One plan per training center.	- Consultant Team selected - completion plans scheduled for 9/76
1. 2. Key National health officials trained in planning and management courses at Lagos and Lome	2. FY 74 75 76 Courses 0 5 4 Participants 50-100 40-80	- Training being carried out at projected levels, but exactly one year behind
1 3. Planning for improvement of delivery systems begun	3. Planning underway in at least ten participating countries	- Planning already underway in Senegal, Chad, Mali, and CAR under separate projects. Planning for other countries under this project to begin Jan/Feb 1977.
1. 4. Trained African Planners	4. Five instructors for Lagos and Lome centers. Five national planning officials	- Being recruited to begin long term training in Sept 1976
Objective 2 - Increase Skills and Improve Utilization of Local Health Personnel		
2. 1. Completed plans for expanded health manpower (trainer) training programs at Lagos and Lome	1. One plan per training center (to be integrated with plans for planning/management training program Objective 1)	- Same as 1.1 above
2. 2. Regional Center Utilization Plans	2. One plan from most participating countries (15-20)	- Same as 1.1. above

Country: Sahel/C. W. Africa	Project No: 625-11-590-904	Project Title: Strengthening Health Delivery Systems in Central and West Africa	Date:	/ / Original / / Revision #	PPT appr

CPI DESCRIPTION

1. 5/27/74 Project Paper Authorized
2. 4/17/75 ProAg Executed
3. 7/25/75 PIO/T Executed
4. 11/25/75 Institutional Services Contract Executed
5. 10/75 First project funding contribution to regional training courses (both supervisory courses and some technical courses begin spring 1975 with A.I.D. funding contributions on ad hoc as needed basis
6. 1/76 Second cycle of training courses begins at Lome, Dakar, and Lagos
7. 2/76 First long term technician arrives in field (Abidjan)
8. 3/76 Proposal for establishment joint procurement mechanism received from contractor by project coordination committee
9. 5/76 Second long term technician arrives in Abidjan
10. Training and research assessment team arrives in field to review curriculae at three training centers and provide recommendations with respect changes in curriculae, course content, and for A.I.D. assistance to the training programs.
11. 9/76 Coordinating committee and Program Review Committee meet and finalize their roles and procedures.
12. 9/76 Consultant roster presented and confirmed.
13. 9/76 Recommendations of assessment team reviewed and acted upon.
14. 9/76 First six senior personnel sent to U.S. for long term training in planning and management.
15. 1/77 Short term consultant team arrives to determine managerial and logistical requirements of second phase regional delivery system, as well as additional preparations to be made 1st Phase.

1/77

16./ Third round training courses begins with revised curriculum and participants selected in accordance with re-evaluated long term personnel needs of participating countries.
17. 4/77 Arrangements for joint procurement mechanism finalized
18. 4/77 Project Paper for Phase II completed and submitted.
19. 6/77 Authorization for Phase II received.
20. 7/77 Grant Agreement and PIO's for Phase II executed.
21. 9/77 Contract for Phase II executed
22. 10/77 Phase II begins

REVISED FINANCIAL ANALYSIS

1. OBLIGATIONS ($000)

A. Funding by Fiscal Year	Total	Personnel	Participants	Commodities	Other Costs	PASA/Contractor
1. Prior Thru Actual FY 75	2,417	659	230	1,422	106	682
2. OPRN FY 76	1,030	275	198	450	107	182
3. Grand Total	3,447	934	428	1,872	213	864

2. EXPENDITURES ($000)

	FY 73	FY 74	FY 75	FY 76	TQ	FY 77	TOTALS
a. Personnel							
1) Long Term ($)	0	0	0	230	61	292	583
(MM)				(11)	(7)	(24)	
2) Short Term				83	35	233	351
(MM)				(4)	(4)	(21)	
b. Participants							
1) Long Term($)						110	110
(MM)(Trainees)						(84)(6)	
2) Short Term($)						318	318
(MM)(Trainees)						?	
c. Commodities							
Direct/vaccines etc.	647	102	234	594	0	245	1822
Contract				44	2	4	50
d. Other Costs (Direct)				18	3	10	31
Contract				44	25	113	182
TOTALS	647	102	234	1013	126	1325	3447

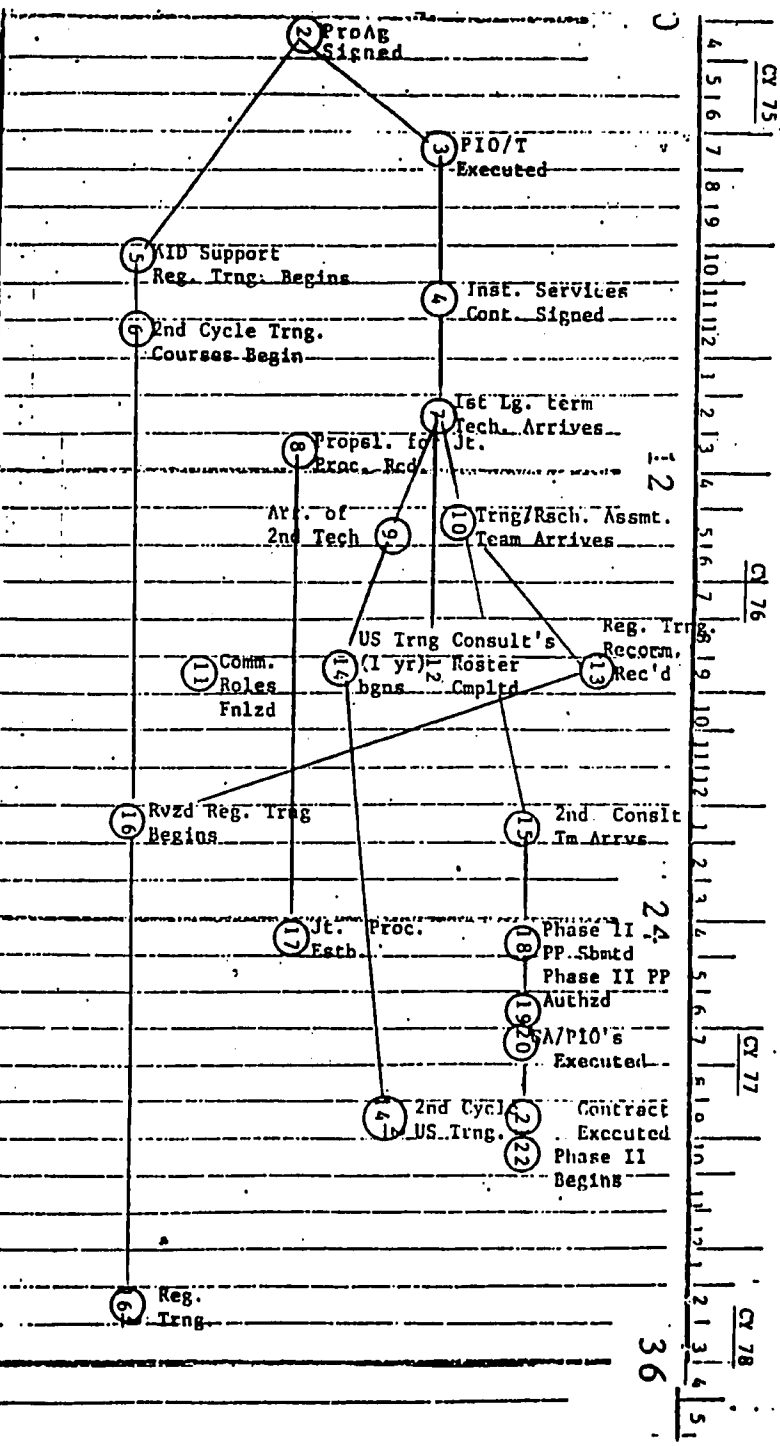
Country: Senegal/C. W. Africa

Project No: 625-11-590-904

Project Title: Strengthening Health Delivery Systems in Central and West Africa

Revision #

CY 75 | CY 76 | CY 77 | CY 78



Initial Plan:

Revision Plan:

Initial F

PROJECT PERFORMANCE NETWORK