

COMBATTING CHILDHOOD COMMUNICABLE DISEASES (CCCD) PROJECT
CONTRACT NO. AFR-0421-C-00-1023-00
PROJECT NO. 698-0421

REPORT ON OUTCOMES OF
AID MEETINGS WITH CDA TECHNICAL
STAFF AND WHO/AFRO AND WHO/GENEVA, APRIL/MAY 1982
AND
RECOMMENDED ADDITIONAL STEPS
TO
ACHIEVE PROJECT OBJECTIVES

Submitted to AFR/RA
Agency for International Development
Washington, D.C. 20523

Submitted by
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Cost of Product 4 Report \$12,819

May 17, 1982

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May 17, 1982

Mr. Donald F. Miller
Director AFR/RA
Agency for International Development
Washington, D.C. 20523

Dear Mr. Miller:

The attached report details the outcomes of a series of activities and meetings held in connection with the Combatting Childhood Communicable Diseases project as well as recommendations for additional steps to be taken by AID and other CDA members so that the project will achieve its desired objectives.

To very briefly summarize, considerable progress has been made in refining the project scope and work plan and in preparing for implementation. Initial negotiations with WHO/AFRO have led to some areas of agreement and have clarified issues and problems which hopefully can be resolved shortly so that a collaborative effort can be undertaken in which all participants benefit, play their desired roles and retain their identity. Although there is general agreement on the great majority of the technical aspects of the project between AID and WHO, there is some difference of opinion concerning the training component of the project and this should be resolved promptly. More frequent and intensified contacts between the health staffs of the CDA members is recommended so as to foster greater cooperation in carrying out all aspects of this project. Finally, every effort should be made to identify specific African countries in which AID will support bilateral communicable disease control activities as soon as possible, so that other CDA members can make similar decisions and coordinate their plans with the AID effort.

This report contains: (1) An executive summary; (2) Introduction and background of meetings; (3) Description and outcome of meetings; (4) Recommendations; and Annexes for reference.

It has been a pleasure working with you and your staff on this extremely important undertaking and I would be very pleased to continue to serve as a consultant to the project.

Yours sincerely,

Paul Zukin

Paul Zukin, M.D.

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PROTECTING HEALTH

MEMORANDUM

TO: Director, Office of Development
Information and Utilization

DATE: May 19, 1982

FROM: Susi Kessler, M.D. *SK*

SUBJECT: Accelerated Delivery Systems Support (ADSS) Project;
Semiannual Report for Period October 1, 1981 - March 30,
1982

A copy of this report was sent to you on May 6. Please substitute the enclosed three pages for pages 5-7 contained in the original document.

I regret the inconvenience.

Enclosure

1. Technical Advisory Services

The Technical Advisory Services Unit arranges short-term rapidly responding consultant services in the fields of primary health care, family planning and population, nutrition, health services delivery, and water supply and sanitation.

Assignments

Contract requirement:

- Provision of 360 person-months of such services to AID regional programs, governments, and non-governmental organizations in developing countries as requested through the Regional Bureaus and Technical Offices of AID.

During this report period, 69.6 person-months were utilized in carrying out the 37 technical advisory assignments received from AID Technical Officers and Regional Bureaus. A total of 60 consultants were involved in these assignments. Table A shows the breakdown of health and population task assignments and the consultant utilization for each of the six-month periods of contract operation during the past two years.

As may be noted, the level of utilization during this report period is similar to that of the previous period. To date, a total of 456.5 person-months have been used or encumbered for ongoing assignments; 427.7 funded by the ADSS contract and 28.8 supported by the UNFPA, WASH and the AID Africa Bureau.

A complete listing of assignments carried out during this period is contained in Appendix A.

Table A
 Number of Task Assignments Made
 And Consultants and Person-Months Used
 10/1/79 - 3/31/82

Period	H E A L T H			P O P U L A T I O N			T O T A L		
	No. of Assign.	No. of Consult.	No. of Per. Mo.	No. of Assign.	No. of Consult.	No. of Per. Mo.	No. of Assign.	No. of Consult.	No. of Per. Mo.
10/1/79 - 3/31/80	26	35	34.2	33	54	55.7	59	89	89.9
4/1/80 - 9/30/80	25	43	56.7	32	59	87.1	57	102	143.8
10/1/80 - 3/31/81	21	30	33.5	30	41	48.8	51	71	82.3
4/1/81 - 9/30/81	10	12	19.0	28	46	51.9	38	58	70.9
10/1/81 - 3/31/82	15	26	31.1	22	34	38.5	37	60	69.6
TOTAL	97	146	174.5	145	234	282.0	242	380	456.5

Consultant services were requested for all regions of the developing world. The number of requests received was fairly uniform among the regions, with the exception of a higher number in Africa. Requests from the African region were almost four times higher during this reporting period than during the previous six-month period. Table B reflects the regional distribution of the 37 task assignments undertaken during this reporting period.

Table B
Number of Assignments by Region
During Six-Month Period*

	<u>Population</u>	<u>Health</u>	<u>Regional Totals</u>
Latin America and the Caribbean	3	3	6
Asia	5	2	7
Africa	4	7	11
Near East	5	2	7
Inter-regional	<u>5</u>	<u>1</u>	<u>6</u>
Total	22	15	37

*Does not include cancelled assignments

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I. EXECUTIVE SUMMARY

This report describes the outcome of a series of meetings carried out by the Consultant, Dr. Paul Zukin, on behalf of the Regional Affairs Office of the African Bureau, with respect to the Combatting Childhood Communicable Diseases (CCCD) project:

- o With technical (health) staff from the development organizations of other member countries in the Cooperation for Development in Africa (CDA);
- o As a member of the AID delegation at the CDA Technical Working Group meeting held in Paris, May 4, 1982.
- o As a member of the AID team negotiating with WHO/African Regional Office (AFRO) in Brazzaville, April 26-28, 1982; and
- o In discussions with the key staffs of the Expanded Programme on Immunization (EPI), the Control of Diarrheal Diseases (CDD) and the Malaria Programme at WHO/Geneva on April 29-30, 1982.

The report next makes five recommendations for additional steps AID should take in order to achieve the objectives of the CCCD Program.

A. Outcomes of Meetings Held

1. Meetings with CDA Country Health Staff

The Consultant met with the health and administrative staff of the Canadian International Development Agency (CIDA) in Ottawa on April 16, 1982, and with the health staffs of the French Ministry of Cooperation in Paris on April 23, 1982 and that of CIDA and the Overseas Development Administration (ODA) of Britain in London, on May 6-7, 1982.

The outcome of the meeting with the Canadians in Ottawa was that they decided to send a member of the CIDA health staff to the CDA Technical Working Group meeting in Paris on May 4, 1982. Substantive discussions were begun concerning potential involvement of Canada in the regional component of the CCCD project and for cooperative arrangements for bilateral in-country programs.

In the meeting with the French Ministry of Cooperation, it was disclosed that because of an internal government political matter, the French had not yet decided whether they would participate in the

CDA Technical meeting of May 4th. The Consultant and other AID representatives present pressed the French to attend the May 4th meeting, even if only as observers. Fortunately, by May 4th, the French had decided to attend the CDA meeting as full participants.

The meetings with the Canadian and British at the offices of ODA in London took place after the May 4th CDA Technical Working Group meeting. This permitted follow up discussions with the Canadians and British regarding their potential participation in the CCCD regional project. Canada likely will provide an epidemiologist to work with the AID/CDC staff and Britain is receptive in principle to play a substantive role in health education/promotion. Both Canada and Britain would like to participate with AID in discussions with African countries concerning bilateral activities. The aim would be to coordinate separate projects in a country rather than collaborating in a single project.

2. WHO/AFRO, Brazzaville

In three days of very formal meetings at the headquarters of WHO/AFRO, in Brazzaville, April 26-28, 1982, the AID/CDC CCCD Project Description was discussed, raising many issues and questions. AFRO is very reticent to allow another organization to play a substantive role in health services development, Africa wide. However, the involvement of donor nations at the individual country level is encouraged since WHO generally does not become involved in field operations.

Despite some acrimony, reason prevailed and a second round of discussions lasting four days, May 7, 8 and 10,11, resulted in considerable agreement on many matters, but leaving several basic problem areas yet to be resolved. These get at roles, relationships and responsibilities in managing the CCCD project generally and several of its component parts. The Director of AFR/RA will meet with the Regional Director of AFRO in June, 1982 at which time a mutually acceptable agreement hopefully can be achieved.

AID, with support from its CDA partners, intends to go forward with the CCCD project, with or without AFRO collaboration. However, proceeding without AFRO would be more costly and would not be a desirable state of affairs. Hopefully this eventuality will not occur.

3. WHO/Geneva

On April 29, 30, 1982, meetings were held with key staff of the EPI, CDD and Malaria Programme divisions of WHO headquarters.

There is broad support for the CCCD project from the WHO EPI and CDD staff. They feel the CCCD project will stimulate the development of primary care and that it is in the interests of AFRO to find a "creative arrangement" which will allow a collaborative program to go forward.

In general, the concepts of CCCD and EPI and CDD are consistent. Some points of disagreement do exist, however. These are primarily in the areas of training and particularly training for diarrheal disease control. CCCD training proposes to have a single curriculum for EPI, CDD and malaria. Some of the methods and materials are yet to be developed and tested.

In the opinion of the Consultant, efforts should be undertaken immediately to resolve any methodological issues with WHO/Geneva or the EPI or CDD program staff at AFRO. At the operational level, all programs should be consistent. This in no way restricts CCCD to develop program improvements and to field test these in pilot projects.

Staff of the Malaria Programme expressed concern at the unrestricted use of anti malarials to treat fevers in children and pregnant women. They feel that reasonable efforts should be made to diagnose the cause of fevers, both clinically and in the laboratory—at least at the health post level and above. At village level they advocate careful control of anti malarial drugs and supervision of their use. Whether a single CCCD training program could adequately prepare country personnel to satisfactorily treat malaria—even presumptive treatment of fevers—was questioned.

4. The CDA Technical Working Group Meeting

Held in the American Embassy in Paris on May 4, 1982, the meeting had participants from all CDA countries except Belgium, and observers from DANIDA and WHO/Geneva EPI/CDD.

There was considerable sharing of bilateral program information among the participants with agreement to expand this in the future and to work toward better integration of field projects.

It was felt that CCCD would provide a mechanism to engage African and CDA countries in strengthened communicable disease control through country assessments, program evaluations and the shared experience of technical staffs. There was unanimous agreement that the CDA CCCD technical meetings should continue on a regular basis, approximately every six months. Interim contacts between CDA technical staff on CCCD matters was also advocated.

5. Recommended Steps to Further CCCD Project Implementation

Five recommendations are made for additional steps that AID should take in order to achieve the objectives of this project.

A. Finalize the CCCD-AFRO Relationship

Every effort should be made to achieve a mutually acceptable accommodation with AFRO for them to play a significant role in the regional aspects of the CCCD project. Neither AFRO nor the CDA countries need lose their identity in such an arrangement. If an agreement cannot be reached, AID should be prepared to go forward in implementing the CCCD project without the involvement of AFRO. Such an action would have the backing of the other CDA countries and the understanding of WHO/Geneva.

B. Resolve Differences Between WHO and CCCD Concepts and Planned Activities

Although in major respects the conceptual design and planned activities of CCCD and WHO are consistent, with respect to training there are significant differences which could prove detrimental to the smooth and orderly conduct of CCCD and WHO programs. These differences should be resolved now.

C. Refine the March 1, 1982 Project Description Document

This document, used as the basis for negotiations with AFRO, had several small but disturbing inconsistencies and other details requiring clarification.

This document should be carefully reviewed and refined jointly by AFR/RA and CDC in light of the meetings recently held in Brazzaville, Paris and Geneva. The document can then be used in further negotiations with AFRO.

D. Implement Bilateral Programs as Soon as Possible

To make use of CCCD funds currently authorized and to provide other CDA countries with definitive information regarding specific African countries in which AID will support bilateral CCCD activities, AID should take decisions and actions to implement CCCD bilateral programs as soon as possible.

E. Strengthen CCCD CDA Technical Staff Relationships

To maintain interest and support of CCCD by other CDA countries, it is imperative that there be ongoing contact between AID health staff and that from other CDA countries.

To nurture and build these relationships, it is recommended that a CDA Technical Working Group meeting be held approximately every six months and that in between these meetings there be one on one contact between AFR/RA technical staff and that of the other CDA countries.

Over the past eighteen months the Consultant has provided the chief linkage on technical matters between the US and other CDA countries as well as with WHO/Geneva. To build relationships and confidences already established, he suggests that he continue to play this role in the future.

II. INTRODUCTION AND BACKGROUND OF MEETINGS

Under contract AFR-0421-C-00-1023-00, Dr. Paul Zukin of Health Management Group, Ltd., has provided continuing technical consultation to AFR/RA in the development and implementation of the Combatting Childhood Communicable Diseases (CCCD) Project (Project 698-0421). The scope of work has called for Dr. Zukin, hereafter called the Consultant, to work closely with AID and CDC personnel to build on design work already completed and produce material to:

- A. Elicit additional ideas and comments from African countries which are potential future participants in the program design.
- B. Inform CDA members, UNICEF, WHO and other potential donors of the status of the AID proposal, in sufficient detail to permit them to form up their own plans and commitments.
- C. Assist AID and other CDA members, in collaboration with participating African countries, in the development of implementation plans.

The scope of work was divided into four phases. The first three phases covered activities undertaken between February and June of 1981 and these have been reported on previously. This report details the fourth phase activities and events. These were carried out from July 1, 1981 through May 7, 1982.

Because of delays in project development the original scope of work of phase four required modification. A contract amendment was made in November, 1981, extending the contract beyond its original completion date of December, 1981. A second modification was made in March, 1982 to clarify a minor inconsistency in the contract terms.

The terms of reference for phase four called for the Consultant to:

- o Participate in negotiations meetings with WHO/AFRO to determine and define their role in the implementation of the CCCD Project and meet with CDA technical representatives to bring them up to date on the status of the project and obtain their views on the next steps to be taken.
- o Compile a report setting forth a summary of the outcome and understandings reached, and recommend to AFR/RA additional steps that should be taken by AID and other CDA members in order to achieve the objectives of the CCCD Program.

In fact, in addition to carrying out the terms of reference as specified, the consultant undertook considerable other work in this phase of the project. He was intimately involved in reviewing and revising the draft project paper leading to its final acceptance in late September, 1981. He critiqued in detail the first draft of the CDC Work Plan and the AID Project Management Plan (December, 1981). In January, 1982, he participated with AFR/RA staff in Washington and CDC staff in Atlanta in discussions which led to significant refinements in the CDC project Work Plan. He also held meetings with WHO/Geneva staff in May, 1982.

A summary of the CCCD project, as presented to the CDA Technical Working Group on May 4, 1982, is contained in Annex I of this report.

III. DESCRIPTION AND OUTCOME OF THE WHO/AFRO, WHO/GENEVA AND CDA MEETINGS

Between April 16 and May 7, 1982, the Consultant participated in a series of meetings with WHO personnel, both in the African Regional Office in Brazzaville and the Headquarters in Geneva and with CDA technical representatives in their own countries and at a CDA Technical Working Group meeting held at the American Embassy in Paris on May 4, 1982.

There was considerable intertwining of these meetings as indicated in the following schedule:

- o April 16, 1982, meeting at the headquarters of the Canadian International Development Agency in Hull, Quebec.
- o April 23, 1982, meeting at the French Ministry of Cooperation, Paris.
- o April 26 - 28, 1982, meetings with WHO/AFRO, Brazzaville, Republic of Congo.
- o April 29-30, 1982, meetings at WHO Headquarters, Geneva.
- o May 4, 1982, CDA Technical Working Group meeting in Paris.
- o May 6-7, 1982, meetings with the CDA technical representatives of Canada and the United Kingdom, at the British Overseas Development Administration, London.

Descriptions and outcomes of the meetings follow:

A. WHO/AFRO Meeting

Between April 26-28, 1982, a meeting on the CCCD project was held at WHO/AFRO in Brazzaville, Congo. The purpose of the meeting was to try to negotiate the role and responsibilities of AFRO in the CCCD project and the terms of an agreement between AID and AFRO.

Dr. Abou Gareeb, Director of Communicable Disease Control for AFRO chaired the meeting. The AFRO delegation consisted of 15 staff members including five of the Region's directors. The Regional Director and his primary deputy, the Director for Program Management, did not attend. On the six member AID team were the CCCD Senior Project Officer for AFR/RA; the AFR/RA Technical Advisor; the Chief of Health and Nutrition for the Africa Bureau; the Chief Health Officer for REDSO/W;

the designated Chief Project Officer for the CCCD Project from CDC and the Consultant. Annex II contains a "Note for Record" of the meeting prepared jointly by the AFRO and AID teams.

In a word, the meetings were very formal and difficult. The AFRO team insisted on going through the Project Description which had been sent them earlier, paragraph by paragraph. There were several clarifications made by the AID team, which resolved some issues. The major concern of AFRO was that it play the dominant role in decision making with respect to all CCCD regional activities. This AFRO said was its "constitutional role" as mandated by all of the African Nations who are members of WHO. The AID team agreed that there should not be competing organizations attempting to coordinate and integrate health services in Africa at the regional level. AID felt, however, that participatory management and collaboration could result in an accommodation that would permit CDA resources and personnel to work with AFRO with some shared responsibilities, to achieve a common goal.

After three days of negotiations, AFRO requested a week's hiatus so that it could review the entire CCCD project internally, in light of the discussions held. It was agreed that negotiations would resume in Brazzaville in approximately seven days and the AID team left the Congo, to attend to other matters.

Negotiations resumed in Brazzaville on May 6th. It had previously been decided that the Consultant would concentrate on discussions with CDA technical personnel and he did not return to the Congo for the second round of negotiations. However, as of this writing, it appears that considerable progress was made in the negotiations, which went on for four days, ending on May 11, 1982. General understandings were reached on many points at issue. Joint AID/AFRO development of the health education component of the CCCD project was suggested. It is anticipated that other remaining areas of contention will be resolved when the Director of AFR/RA meets with the Regional Director of AFRO in Brazzaville in June, 1982.

B. WHO/Geneva Meetings

1. Malaria Program

On April 29, 1982, the Consultant met for ninety minutes with the staff of the Malaria Program. Present were the Program's Director, Dr. J. Najera; its Chief Epidemiologist, Dr. E. Onori; the Chief of Program and Training, Dr. Ivvora; Program Medical

Officer, Dr. P. Beals; a Medical Officer from the Strengthening of Health Services Division, Dr. D. Smith and a member of the Program and Training Department, Dr. S. Litsios.

The Consultant detailed the CCCD project concept, its present status and discussed the rationale for including presumptive treatment of malaria as a program component.

The Malaria Program staff expressed doubt that the CCCD training for the immunization and diarrheal disease control aspects of the project could be expanded to adequately cover malaria interventions as the CCCD training is presently conceived. Dr. Onori summarized the Program's current thoughts regarding malaria control, as follows:

- a. Every effort should be made to diagnose cases of fever before therapy is instituted. At the health post and health center the emphasis should be on developing sufficient clinical skills and laboratory capability. Presumptive treatment for malaria should be given at this level where adequate suspicion for the diagnosis exists.
- b. At the village level they have concern that mass use of chloroquine may lead to increasing resistance. However they have not developed a policy concerning the presumptive treatment of fevers, other than to emphasize review of cases selected for treatment and adequate supervision.
- c. There should be continued efforts at environmental control, particularly in urban areas. This includes the use of insecticides.
- d. Routine prophylaxis is not recommended. They have not reached consensus on whether or not prophylaxis for pregnant women is justified.
- e. It is important to monitor the impact of malaria treatment on resistance of the parasites and on the development of humoral resistance in humans.

In sum, the Malaria Program staff questioned whether the CCCD project could adequately train health workers to undertake rational anti malarial interventions. They had concerns about the mass treatment of fevers, without regard to cause,

because of the threat of the development of resistance to therapy.

2. EPI and CDD

In a two hour meeting on April 30, 1982, the Consultant and the Senior Project Officer, AFR/RA for the CCCD program, met with the core staff of EPI, Mr. Robert Hogan, Programme Management Officer for CDD and Dr. Partow, Chief of Communicable Disease Control, WHO/Eastern Mediterranean Regional Office (EMRO). The EPI staff included Dr. Ralph Henderson, Director, Dr. Jakobus Keja, and Mr. John Copland, Administrative Officer.

Drs. Henderson and Partow both agreed that the CCCD project combines disease control elements very well and should bring together at the country level, EPI, CDD and simple measures to deal with the most serious aspects of malaria. They felt that the problems of bringing AFRO and AID together should be resolvable, that there should be mechanisms to permit a jointly administered program without loss of identity; i.e., a "creative accommodation".

In principle, Dr. Partow felt EMRO would like to be involved in the CCCD project. Main involvement would be at the country level (Sudan, Djibouti and Somalia) and this would be through the WHO country representatives. He suggested that EMRO participation in the Advisory Council would be worthwhile.

Both Dr. Henderson and Mr. Hogan felt that WHO/Geneva, EPI and CDD should not be on the CCCD Advisory Council but that they should serve as a resource for the project.

There was considerable discussion concerning training for CCCD. To integrate the project disease control programs, staff should train together. However, as Dr. Henderson noted, the WHO training for EPI takes two weeks and for CDD, six weeks. How this will be resolved in the CCCD project was not clear.

The question arose regarding the merging of CCCD project concepts with those of WHO. Mr. Hogan thought there was probably a 90% concurrence, although the CCD training approach at WHO and that of CDC differ. This difference must be resolved in order for WHO and AID to collaborate effectively.

The current "CCCD Project Description" as elaborated by CDC (March 1, 1982) calls for a training development component. Mr. Hogan felt that this was "probably wasteful" given existing WHO training material.

Mr. Hogan also pointed out that the CCCD work plan talks about a CDD mid-level course, CDD does not have a mid-level course and he was wondering what CDC had in mind for the CDD component of the CCCD mid-level course. It is evident that there are some differences, probably small, between WHO training and CCCD training which must be resolved in order for AID and AFRO to work together comfortably.

With respect to operational research, Mr. Hogan noted that a Scientific Working Group had been established in AFRO to review research proposals. Although \$93,000 had been made available for CDD studies, to date none of the money had been spent. This pointed up the need for a more vigorous approach to research (and probably other) activities.

Dr. Henderson felt that he was speaking for all those present in stressing the importance of the CCCD project in integrating communicable disease control activities and that it was in WHO's and African countries' interests to see that AID and AFRO worked together. Mr. Hogan emphasized that WHO/Geneva looked to CCCD as a major vehicle to operationalize CDD in Africa and to serve as a model for communicable disease control programs in less developed countries world wide.

C. Meetings with CDA Technical Personnel

1. Canadian International Development Agency (CIDA)

The Consultant spent a full day at CIDA in Hull, Quebec, on April 16, 1982. Participating in the meeting were the following CIDA personnel: Mr. Jean Pierre Buldoc, CIDA representative to CDA, Dr. C. W. L. Jeanes, Director of Health, Dr. Charles R. Nobbe, Deputy Director of Health and Ms. Nancy Gerein, Health Advisor.

Mr. Buldoc was somewhat critical of the "apparent difficulty in getting the CCCD project going." After a "flashy start" it seemed to die. He wondered whether the opposition in the French press or possibly "program problems internal to AID" were to blame. Irrespective, he was pleased that the project was moving and with "an abrupt change in direction, i.e., not to get out of health," CIDA was now actively interested in the CCCD project. He then went on expressing concern that after the November, 1980 CADA Technical Session, there had been no other meeting. This he said, Canada and other CDA countries (unspecified) took as an indication of lack of AID commitment to a multi donor approach. The Consultant noted the

several visits he had made to various CDA countries in the interim. Mr. Buldoc agreed that this was very important but that face to face meetings were also necessary for effective collaboration.

Despite the somewhat negative opinions expressed above, the CIDA meeting had several very positive outcomes.

- a. It was decided that Ms. Nancy Gerein would represent Canada at the Paris Technical Working Group meeting. Prior to the Consultant's visit, only token representation by an embassy staff member had been contemplated.
- b. There was serious consideration given to posting an epidemiologist with the CDC team to support the regional project activities.
- c. Canada was seeking appropriate bilateral programs in Africa and would welcome AID assistance in identifying opportunities. Preferably these would be integrated into an overall CDA plan making most effective use of donor resources.

2. CDA CCCD Technical Working Group Meeting

The meeting, held in the American Embassy in Paris on May 4, 1982, had participants from all CDA countries except Belgium. WHO/Geneva, EPI/CDD and Denmark sent representatives. (See Annex III for agenda for the meeting and Annex IV for the list of participants.) As back ground material, participants were provided with an up-to-date "Summary of the CDA CCCD Initiative" (see Annex I) and an "Overview of AID Supported Health Activities in Sub-Sahara Africa Related to the Combatting of Childhood Communicable Diseases" which the Consultant had preciously prepared (see Annex V).

The meeting was chaired by Mr. Norman Schoonover, AID Development Coordinator in Paris. In his opening remarks he stated the meeting objectives were to inform other CDA countries on the status of the CCCD project and to begin the process of effecting cooperation in communicable disease control activities in sub-Sahara Africa. Initially, this was expected to be at the country-specific level. However, CDA member participation with AID and AFRO in regional support activities was also solicited.

Mr. Noel Marsh, CCCD Project Director for AFR/RA next gave a chronology of events since the November, 1980 Technical Session and restated the CCCD project concepts, and anticipated implementation schedule. He reported on the outcome of the April 26-28, 1982 meeting with AFRO in Brazzaville. Discussion of the Initial Advisory Council meeting which had been scheduled tentatively to be held in early June in Africa was tabled since the meeting was postponed pending a definitive arrangement between AID and AFRO. Following Mr. Marsh's presentation the meeting was turned over to the other country participants to present their country's current and planned CCCD-related activities. The following summarizes these presentations:

- a. Canada. Ms. Gerein reported that Canada presently has no bilateral health programs in Africa. They support activities of WHO and UNICEF. Canada is anxious to cooperate with other CDA countries in bilateral programs and in principle, in the regional support component of CCCD.
- b. Denmark. Altho not a CDA member, Denmark, through DANIDA, has been invited to CDA CCCD meetings because of their involvement in EPI in East Africa.

Dr. Schjerbeck of DANIDA noted that Denmark had allocated \$5 Million over five years for bilateral EPI services in Kenya and Tanzania. Denmark also contributed \$1 Million for cold chain development. He noted that Denmark considers it important to link bilateral aid with multilateral aid hence they are very interested in cooperating with the CCCD project. With respect to CDD, Denmark supports the WHO program but so far has not developed its own diarrheal disease control effort.

The status of EPI in Kenya and Tanzania is:

- o A management program has been established.
- o The cold chain is under development.
- o Maintenance of equipment is being stressed.
- o Logistics (vehicles and supplies) and training are emphasized.

Whereas in Kenya EPI is being implemented step wise in the country's 40 districts, in Tanzania the program is being initiated nation-wide concurrently.

DANIDA assisted start up of EPI in 1980 with steering committees to gain country involvement. Many problems arose as the program got underway, these being primarily administrative and managerial rather than technical. DANIDA field personnel are public health administrators rather than technical staff.

For the sake of efficiency, DANIDA works with UNICEF with respect to purchasing vaccines and commodities.

- c. Federal Republic of Germany. Mrs. Neimann-Jordan, the current head for health in the Federal Ministry of Economic Cooperation summarized Germany's CCCD related activities. Parenthetically, she is the third person to hold this post in the last eighteen months.

Germany allocates 4-6% of its technical cooperation funds for health-related activities. There are no regional programs. All resources go into bilateral programs. Monies are channelled approximately as follows:

- o 40% directly to bilateral projects.
- o 40% through non governmental organizations.
- o 10% to WHO for specific programs, e.g., human reproduction, tropical disease research and onchocerciasis.
- o 10% to the German Volunteer Service, similar to the U.S. Peace Corps.

The main pragmatic priorities are primary care, pharmaceutical research, hospital development and training. Presently, Germany is supporting the following:

- o Primary care in Upper Volta, Togo, Benin, Malawi, Sudan, Gambia and Cameroon, mainly working in small areas.

- o Integrated rural development in Liberia and Sierra Leone.
- o "Adaptive hospital technology" in Kenya.
- o Pharmaceutical development in Tanzania.

There are no specific CCCD activities — these are undertaken as part of primary care, specifically where German field personnel are available for consultation and supervision.

- d. France. Mlle. Dindin indicated that France negotiates a bilateral agreement with each country in which it participates in meeting needs as specified by the country. The main focus is on West Africa's 28 nations. France tries to support and work through national institutions and particularly OCCGE AND OCEAC.*

Currently France is spending 250 million Francs, about \$40 million, for health-related activities, world wide annually. A list of country projects was read and this list will be provided to the CDA countries shortly. There is considerable support for immunization activities but none so far for CDD. No free standing training programs are under way. Rather, French staff are expected to train country nationals as part of their over seas work.

Mlle. Dindin re-confirmed that France has committed 25 million Francs over a five year period, specifically to support CCCD. This came as a welcome reassertion of France's participation in the project.

- e. United Kingdom. Dr. Murray Baker, Principal Medical Advisor for the Overseas Development Administration reported that the UK was committing L.1.3 million over three years for CCCD, L.600 million for East Africa and L.700 million for West Africa. Specific project focus has not been decided on and the UK was hoping to collaborate with other CDA countries in developing cooperative projects. Gambia was suggested as a likely country. In the UK's experience, working through non governmental organizations with

*OCEAC - Organization for coordination and cooperation in the struggle against Endemic Diseases (Central Africa).

OCCGE - Similar organization for West Africa.

regional experience, such as the African Medical and Research Foundation (AMREF), was an effective way to provide assistance and he anticipated that Britain would seek similar organizations through which to channel funds.

- f. WHO/Geneva. Mr. Hogan noted that in the view of WHO/EPI/CDD, the CCCD project was highly supported as a model which would lead to integrated health services development.

A statement summarizing the outcome of the Technical Working Group meeting is being prepared by AID for submission to participants. The main conclusions reached in the meeting were:

- a. A regional project can serve a useful purpose but the primary program engagement is at the bilateral level.
- b. OCCGE and OCEAC and possibly other regional groups should be represented on the Advisory Council.
- c. The regional project should identify common data elements to be collected at country level so that the experience in similar projects could be compared. This should occur automatically if AFRO is involved in the CCCD project but will have to be developed if AFRO elects not to become involved.
- d. Regional Management training does not take the place of in country training. However, where it is not feasible nor cost effective to train at the country level, regional training should be utilized.
- e. CCCD should provide a mechanism to engage African and CDA countries in plans to expand efforts to combat childhood communicable disease through country assessments, program evaluations and technical working groups. Further, such meetings would facilitate coordination of individual projects at the local level.

- f. The CCCD Technical Working Group should continue to meet periodically, probably not less than every six months, to exchange information and to plan for cooperative project development. When the Advisory Council is organized and functioning it is hoped that the Council can provide the forum for CDA and other country dialogue. Whether or not this proves to be the case will require study.

IV. RECOMMENDED STEPS TO FURTHER CCCD PROJECT IMPLEMENTATION

Combatting Childhood Communicable Diseases is a complex project with involvement of many countries and organizations. While great progress has been made in project development, additional effort is required for the project to achieve its goal of reducing childhood morbidity and mortality in sub-Saharan Africa. The following five recommendations are aimed at furthering project implementation.

A. Finalize the CCCD-WHO/AFRO Relationship

After rather difficult negotiations in Brazzaville, progress has been made toward effecting a working relationship between AID and WHO/AFRO. Such an arrangement is to everyone's advantage, particularly the population to be served. Thus it is likely that agreement can be reached in a meeting between the AFRO Regional Director and the Director of AFR/RA scheduled for June, 1982.

However, should resolution not be reached, AID should be prepared to go forward with the project without AFRO participation. AFRO's involvement in regional training would be very useful, but not critical. This component could be undertaken by the U.S. alone, if necessary.

Health education/promotion and operational research, as presently conceived, are primarily to be AID responsibilities under CCCD, with AFRO playing a secondary role. These activities also could be carried out without AFRO participation.

The single component where AFRO's involvement is critical is the health data system. AFRO serves to unify national data systems and to collect data region-wide. This is very important to the efficient and effective functioning of the CCCD project. However, here again, a suitable data system with common elements could be developed to serve the needs of CCCD, without AFRO involvement. This possibility was discussed in the CDA Technical Working Group meeting where it was recommended that CCCD proceed, with or without AFRO involvement.

B. Resolve Differences Between WHO and CCCD Concepts and Planned Activities

Although CCCD's concepts and planned activities are probably 90% coterminous with those of WHO, EPI and CDD, there are differences in training content and approach. These should be resolved now since continued differences can only lead to confusion.

However, this does not mean that under CCCD, innovations in training materials or other programatic elements, cannot be developed and field tested in pilot programs. But, for routine disease control activities WHO and CCCD should be consistent.

C. Refine the CCCD Project Description Document

Over the past eighteen months there have been a series of documents produced by AID and CDC describing and developing the CCCD project. Considerable progress has been achieved in clarifying concepts, developing a suitable work plan, etc. Unfortunately, the latest document, the CDC "Project Description" dated March 1, 1982, still contains certain elements that require clarification or refinement. These proved a problem in the discussions with AFRO in Brazzaville.

Before the next round of talks with AFRO, the CDC Project Description should be carefully reviewed and refined in light of the series of meetings just completed. Such a document could serve as the working paper for further discussions with AFRO, leading to a project description jointly prepared by AID and AFRO. Both AID/RA and CDC should be involved in the refinement of the March 1, 1982 Project Description.

D. Implement Bilateral Programs as Soon as Possible

In order to make use of CCCD funds currently authorized and to provide other CDA countries with definitive information regarding specific African countries in which AID will support bilateral CCCD activities, decisions should be taken and actions instituted to commence implementation of CCCD country programs as soon as possible.

E. Strengthen CCCD CDA Technical Staff Relationships

To maintain interest and support of the CDA countries in CCCD, it is imperative that there be continued contact between AID technical staff and that from other CDA countries. It is clear that such previous meetings held by the Consultant, often accompanied by the AFR/RA Project Director, have resulted in financial and other commitments being made by several CDA countries who prior to the meetings had not evidenced interest in CCCD. To nurture and build these relationships two recommendations are made:

First, approximately every six months there should be a CDA Technical Working Group meeting. This was unanimously advocated at the meeting just held in Paris.

Whether these meetings should continue after the Advisory Council starts to function would require study.

Second, in the intervening six months, i.e., between the CDA technical meeting, there should be one on one contact between AFR/RA technical staff and CDA country technical staff.

This arrangement would provide technical staff contact every three months and should lead to the development of close working relationships and increasing collaboration.

Having served as the primary linkage between AID and the technical staff of the other CDA countries as well as the communicable disease related divisions of WHO/Geneva over the past eighteen months, the Consultant hopes that he can continue to fulfill this role in the future. This would provide continuity and the opportunity to build on relationships and confidences already established.

ANNEX I

SUMMARY OF CDA INITIATIVE ON COMBATTING CHILDHOOD COMMUNICABLE DISEASES

I. Background and Status

The concept of a regional expanded immunization program for Africa has been under consideration by the U.S. and other CDA countries for the past 3 years. The concept has now been expanded to include the control of diarrhealdisease and AID is now proposing to add the presumptive treatment of malaria to the national programs it will support under the bilateral aspects of this program.

There has already been considerable progress made in these areas by WHO, CDA country bilateral programs and the work being done by UNICEF, DANIDA and others. The objective of the CCCD program is to rationalize these efforts and achieve certain economies of scale by approaching some of the problems on a regional level and establishing a CDA framework to enable bilateral activities to be expanded in a more effective and efficient manner.

AID is proposing to fund the regional support project and is seeking a cooperative arrangement between WHO/AFRO, CDC, and AID to implement this aspect of the program.

Establishing a CCCD regional support project is seen as an opportunity to allow CDA members and others to conduct their bilateral activities in whatever manner they wish but having the advantages of drawing on the training and other regional support activities to strengthen their bilateral activities. The project was authorized September, 1981 with planned life-of-project funding of \$47 million over eight years as the U.S. contribution to this effort. The first allocation of \$2.5 million was obligated in Fiscal Year 1981 to fund the technical services being provided by CDC. Four million dollars is to be obligated prior to September 30, 1982 to begin regional activities in Africa and the first two country specific activities.

II. Purpose: Strengthen the Africans' ability to:

- Control six childhood communicable diseases (measles, polio, tuberculosis, diphtheria, pertussis (whooping cough) and tetanus through Expanded Program for Expanded Program for Immunization (EPI).
- Control DiarrhealDisease (CDD) with simple treatment.
- Control disease of local importance such as yellow fever and yaws, and
- Provide presumptive treatment of malaria in selected children and pregnant women.

III. Approach

- Establish a regional project in cooperation with WHO/AFRO to train, provide technical assistance and support to key elements of the individual country EPI, CDD and other disease control activities.
- Build on what already exists in terms of individual country activities and integrate these into primary health care systems whenever feasible.
- Strengthen present bilateral activities to develop effective planning, operations management, cold chain and other logistic support systems and health education programs.

IV. Target Population

EPI: Under one year olds and pregnant women (neonatal tetanus).

CDD: Under five year olds. Malaria: under five year olds and pregnant women.

It is estimated that ten percent of the total EPI target population is now being immunized. Adding the CCCD program to the on-going activities supported by WHO, UNICEF and others should bring the total African-wide coverage up to 50 percent by the mid to late 1980s and close to 90 percent by the year 2000.

V. CDA's Role

The bulk of AID funding will go to finance the regional support part of the program designed to strengthen in-country disease control capability. The balance of AID's funds and the bulk of the other CDA members' contributions will be used to support country programs to improve the delivery of these services to the target population.

AID inputs will consist of CDC personnel (Atlanta and African based) and a grant to WHO/AFRO to help conduct training, develop data and evaluation systems and assist in field operations and epidemiological surveillance, funds to support country health education programs, operations research, and the procurement of vaccines, rehydration salts, cold chain and other delivery equipment.



NOTE FOR RECORD
OF MEETING OF USAID AND WHO/AFRO ON
COMBATING CHILDHOOD COMMUNICABLE DISEASES PROJECT (CCCD)

G2/61/9

Brazzaville, 26-28 April 1982

INTRODUCTION

1. A meeting on Combating Childhood Communicable Diseases Project was held in Brazzaville from 26 to 28 April 1982 under the Chairmanship of Dr Abou Gareeb, DDC/AFRO. Present at this meeting were:

USAID delegation

- Mr Noel Marsh : Senior Project Officer, Office of Regional Affairs, Bureau for Africa, USAID Washington
- Dr James Shepperd : Chief, Health and Nutrition Office, Development Resources, Bureau for Africa, USAID Washington
- Dr Paul Zukin : AID's Senior Consultant for CCCD
- Dr George Jones : AID/Regional Economic Development Services Office, West Africa, Abidjan
- Mr Andrew Agle : CDC/Atlanta
- Dr Joe Davis : Technical Adviser, Office of Regional Affairs, Bureau for Africa, USAID Washington.

AFRO delegation

DDC, DPP, DSD, DEH, DSP, PHD, CDC, HMA, CDI, CDB, FHE, HED, HMP, HMN and HSD.

2. The Chairman extended a warm welcome to the USAID delegation on behalf of the Regional Director. He requested Mr Noel Marsh, head of the USAID delegation, to introduce the Members of his delegation. The AFRO delegation was then introduced. In his opening remarks, the Chairman said that the collaborative relationship between USAID and WHO which started a long time ago was known to everyone. There was, therefore, no need to go into details. However, it would not be out of place to review the latest events.

3. Mr Miller, with his colleagues, visited AFRO from 8 to 12 June 1981.

Apart from discussing the existing collaborative relationship between USAID and WHO/AFRO the team discussed USAID's/CCCD Programme. They left a draft Project Paper on CCCD for WHO/AFRO comments. The draft paper was studied in WHO/AFRO and comments were communicated to Mr Miller, vide RD's letter of 23 June 1981. The main concern of WHO/AFRO was that in the Draft Project paper of USAID/CCCD, no provision had been made to allow WHO/AFRO and Member States to have a say in decision-making, management, monitoring and implementation. The effective role of WHO/AFRO needed further clarification.

4. Mr Miller's letter of 9 October 1981 enclosing a revised version of the Project Paper on CCCD was studied carefully in AFRO. It was observed that some important issues raised in RD's letter of 23 June 1981 were not addressed at all.

5. In fact, there was no fundamental difference between this document and the previous one. The comments to this effect were conveyed in RD's letter of 16 November 1981 to Mr Miller.

6. Dr Stanley Foster and Mr Andrew Agle of CDC/Atlanta visited WHO/AFRO from 12 to 14 October to hold technical discussion with Regional Staff on CCCD. It was also made clear to them that almost all the points raised in the letters of RD remain unanswered.

7. Mr Miller made a proposal that USAID delegation should visit WHO/AFRO from 26 to 28 April 1982 to discuss and reach an agreement on the role and responsibilities of the various parties involved. In particular, AFRO shared his hope that the deliberations would be successful.

8. The USAID delegation thanked WHO/AFRO for their hospitality. They pointed out that the present document was in a draft and had taken into consideration the questions raised by WHO/AFRO. They believed that it would be more profitable to have face-to-face discussion in Brazzaville. They hoped that all parties would come to agreement. They also pointed out that in general, the design of the project followed the concept of WHO/EPI and WHO/CDD programme.

METHOD OF WORK

9. The meeting agreed that initially the USAID delegation will present the CCCD project document, followed by questions of clarification. After this WHO/AFRO would present their comments on the document to be followed by discussions and conclusions. The Notes for Records will be approved by the meeting.

PRESENTATION OF DOCUMENT

10. The essence of the general presentation made by USAID delegation on the document is as follows:

10.1 Dr Mahler, the DG/WHO, visited US in 1977 and requested US contribution for immunization programme on a world-wide basis. US Government decided to focus its effort on the African Region. During planning, the US found out that it was essential to associate other contributors in the framework of CDA. Presently, the US is the sole donor for the CCCD Regional Project. It is however the hope of the US that with the flexibility of the present CCCD Project other donors might join on a bilateral basis.

10.2 USAID hoped to enter into agreement with AFRO to enable it carry out intercountry training and health information system activities.

10.3 USAID had already completed an agreement with CDC/Atlanta to enable them to provide technical guidance to the project and to begin to develop the draft Work Plan.

10.4 USAID will negotiate country specific activities with each country concerned and would hope that other CDA members would do the same.

10.5 Health Education component has not yet been completed in the document hence funds have been set aside for experts to prepare a proposal for that component of the programme.

10.6 Regional Coordinator, who is seen as an essential member of CCCD Project will coordinate regional and bilateral project activities in conjunction with AFRO.

10.7 CCCD Advisory Council will be a prestigious body to guide the countries with membership based on technical expertise rather than on country representation.

In consideration for a manageable size, the Council, nevertheless, will have balanced representation between African experts and CDA. WHO/AFRO will be select associated in the identification of the African Experts.

10.8 The members of the CCCD Technical Working Group will act as the Secretariat dealing with the day-to-day management issues and technical matters.

11. More detailed presentation on various elements was given by the USAID delegation as follows: Introduction, Goals and Objectives (Paul Zukin); Training and Training Development/Adaptation (Andrew Agle); Health Education and Promotion (Noel Marsh); Operations Research (Joe Davis); Health Information System (James Shepperd); Country Specific Activities; CCCD Management (Noel Marsh); Country Programme Support (Andrew Agle).

QUESTIONS FOR CLARIFICATION

12. Several AFRO members posed the following questions:	
<u>Questions</u>	<u>Answers</u>
12.1 Should AFRO now abandon EPI, Malaria and Diarrhoeal Diseases since the CCCD programme is so comprehensive?	No. It is not meant to replace, but rather to make interventions, particularly in the area of PBC. CCCD should be viewed as complementary to AFRO's efforts. It is hoped that AID's contribution would strengthen AFRO's efforts.
12.2 Is there any relationship between CCCD and SHDS and if so what are these relationships?	The mis conception that CCCD would substitute SHDS is not true. Rather attempts are made to include SHDS's geographical area and to begin to strengthen national capabilities. No decision has been made regarding SHDS continuation.
12.3 With regard to paragraph 3.6.2, "AID's principal implementing agent ...", is there any other implementing Agent?	AID regretted the erroneous language in this Section. AID proposed parallel language changes for both the WHO and CDC management sections stating WHO would be the principal implementing agent for intercountry training and health information systems, assuming primary responsibility for these areas; AFRO will work with CDC to develop and implement the workplan. CDC would be the principal implementing agent for operations research and health education, assuming primary responsibility for these areas. CDC will work with AFRO to develop and implement the workplan.

<p>12.4 With regard to point 3.6.3, "AFRO will have responsibilities ...": Where are these responsibilities concerning policy, implementation and administration in the text?</p>	<p>AID viewed the responsibilities under 3.6.3 to be substantive and important. A review followed of all 11 items appearing in this section.</p> <p>Points 4.6.9 and 10 were to be re-written in line with the revised orientation as outlined in the answer to question 11.3 above.</p> <p>A further description of the proposed process of participatory management of the CCCD Regional Project was provided, using a Flow Chart Diagram (see Annex).</p>
<p>12.5 If in fact CCCD document is a draft, why was a decision already made to contract out to CDC?</p>	<p>AID has two methods of selecting contractors viz. tendering and recognition of competence of a person or an institution.</p> <p>The predominant capability of CDC in those areas for which it is the principal implementing agent is recognized world-wide as is the predominant capability of WHO for those activities for which it is chosen to be the principal implementing Agency.</p>
<p>12.6 With reference to 8.2.2, is the aim of CCCD to collect data which already exist?</p>	<p>CCD will focus attention on gathering data where such data are either inadequate and/or incomplete.</p>
<p>12.7 With regard to point 10.3.3, has USAID taken account of efforts being made by WHO and UNICEF in pharmaceuticals?</p>	<p>AID seeks to assist AFRO in further supporting pharmaceutical self-sufficiency in the Region.</p>
<p>12.8 How does the training of CCCD national managers and their counterparts fit in with WHO's EPI national managers?</p>	<p>Provision is made in the CCCD regional programme to train CCCD national managers only when such training is necessary or desirable. There is no intention to duplicate training.</p>
<p>12.9 Why is there no mention of Central Africa only West Africa and East Africa?</p>	<p>AID's subregions in Africa consist of only two: an East African region and a West African region. Central Africa and Southern Africa are incorporated in these two.</p>

<p>12.10 Does AID intend to have a preparatory phase? Specific reference was made to 4.3.1 paragraph 5 having to do with training of epidemiologists in Nairobi.</p>	<p>AID indicated that a preparatory phase is underway currently; certain activities have begun including preparations for training activities scheduled in the work plan for 1982.</p>
<p>12.11 Could paragraph 5, Item 4.3.1 be deleted?</p>	<p>AID hoped that CCCD will work with AFRO in the training of Epidemiologists hence the paragraph was pertinent and should not be deleted.</p>
<p>12.12 Questions were raised on: (a) compatibility of roles proposed for CDC and AFRO; (b) functions of REDSO <u>vis-à-vis</u> WHO; (c) policy and rules as stated in paragraph 3.6.3.</p>	<p>AID stated that these questions had been taken care of in its response to question 12.4.</p>
<p>12.13 As AFRO has country and inter-country projects in each of the three Subregions within the major <u>programmes</u> of Comprehensive Health Services, Research and Manpower Development, Disease Control whose activities are included in CCCD, the question was raised whether this had been considered while designing CCCD.</p>	<p>AID recognized the overlapping of CCCD activities with WHO country and intercountry projects. AID would very much like to follow the geographical division of AFRO which it sees as desirable. AID, however, looks forward to AFRO for answers.</p>

WHO PROCEDURE FOR SIGNING OF AGREEMENTS (as presented by AFRO)

13. When an agreement between WHO/AFRO and any organization has been reached for collaboration, the agreed document is reviewed by the legal section of WHO/AFRO. Thereafter it is sent to WHO/HQ for their legal advice. If the legal unit of WHO/HQ has any observation, it is sent back for amendments. After the legal unit of WHO/HQ has given its agreement that the document is all right from legal point of view, it is ready for the signatures of the Regional Director and the party.

CONSTITUTIONAL ROLE OF WHO (as presented by AFRO)

14. Concerning the question regarding the constitutional role of WHO, it was pointed out that the WHO Basic Documents and the World Health Assembly resolutions including the most recent resolution WHA34.24, are very clear on this subject.

The WHO Basic Documents Chapter II, Article 2 (a) states that the function of the organization shall be to act as the directing and coordinating authority on international health work. Resolution WHA34.24 stresses the responsibility of WHO to fulfil its constitutional leadership role as the directing and coordinating authority in international work. These are binding to WHO as they are binding on the Member States. Therefore, if WHO which is an intergovernmental agency, has to take responsibility in associating itself with any activity in CCCD project, it must ensure that these activities are fully in line with the policy of the organization as defined in various resolutions adopted by its governing bodies.

AFRO'S COMMENTS ON CCCD ~~THIRD~~ PROJECT DESCRIPTION DOCUMENT, DATED MARCH 1, 1982.

General

15. After careful study of the draft project document, we arrived at the conclusion that the authors intend to use WHO as an administrative support structure for activities in which the Organization cannot play its constitutional role as "a directing and coordinating authority on international health work and ensuring technical cooperation between WHO and its Member States... making no distinction between these integral functions carried out at country, regional and global levels whether financed from WHO regular budget or from other sources".¹ WHO is not a support structure, but a specialized technical agency which cannot commit itself to activities that would not be in line with its Constitution and policies as defined collectively by the Member States.

16. We have taken note that 12 countries will be selected to participate in the programme. In our view, the selection of these countries should be jointly made and agreed upon between WHO and USAID.

¹ Resolution WHA34.24.

17. We noted yesterday that you mentioned Kinshasa and Nairobi as assignment places for field epidemiologist of the project. This could have been discussed with WHO in the light of existing AFRO intercountry and Regional Office structures.
18. With respect to selection of project staff and structures, WHO should propose nationals and intercountry structures.
19. Concerning the proposed CCCD information system, we think that it would be a duplication of effort and a confusing issue for the Member States. WHO has its information system for all countries of the Region. The need to strengthen this system, not to build another parallel system for 12 countries, exists.
20. The project document has no cover showing Agency, i.e. fund and sources of fund even though it was our understanding that the purpose of this negotiation was to have WHO as Executing Agency.
21. The second sentence of paragraph 1 of the Introduction states that "CCCD is a specific response of CDA (Cooperation for Development in Africa) to the World Health Organization's request for increased technical cooperation in support of primary health care programme in Africa". Can we have the terms received from WHO spelt out?
22. Normally when we discuss draft project document with partners, the proposed budget is attached to the draft project document with an indication of budget components. No such budget document was attached. We would like to see the budget.
23. Of course, the attached workplan reflects the project description, as it stands now. There are still many questions unanswered about the project document. It is therefore premature for WHO to discuss the present workplan.

<u>Specific</u>	<u>Suggestions</u>
<u>Item 1.5:</u> This does not reflect the activities being undertaken by WHO	Insert activities being undertaken by WHO in collaboration with its Member States.
<u>Item 2.1:</u> The countries and AFRO have already developed national and regional strategies and have set goals, objectives and targets.	To be corrected. Objectives which are within the scope of the national and regional strategies have already been laid down by all the countries in the Region. For specific countries, see MTI. CCCD programme should help to achieve those objectives.
<u>Item 2.2.2:</u> The first sentence is rather vague.	WHO's role must be seen in the framework of "partnership".
<u>Item 3.1:</u> WHO is not a regional health organization. Its "importance" is not reflected in the text. The content seems to follow the usual vertical programme even though AFRO has abandoned this approach in favour of integrated and multidisciplinary approach.	Delete "regional" and "importance"
<u>Item 3.4:</u> The first sentence does not correspond to the sentence 2, paragraph 4 of item 3.1. Also second paragraph does not correspond to the sentence 2, paragraph 4 of item 3.1. According to these, WHO has no role to play.	
<u>Item 3.5:</u> <u>Paragraph 1:</u> It does not take into consideration the existing WHO/AFRO structure for EPI, Diarrhoeal Diseases Control, Malaria, Health Information, Health Education, Research, etc., etc., and also WHO/African Region's intercountry and field staff.	Existing WHO/African Region resources and facilities to be incorporated in this paragraph.

<p><u>Item 3.5.1:</u> The Regional Coordinator will "strengthen" AFRO by bringing the "external resources together" and "drawing upon CCCD personnel", etc. To be able to accomplish all these, he will certainly strain the existing resources of AFRO rather than strengthen them.</p>	<p>If the principle of partnership is accepted, CCCD needs to reinforce the existing structure of AFRO by providing additional facilities to it so that it can undertake additional work of CCCD programme.</p>
<p><u>Item 3.5.2:</u> We do not think CCCD Advisory Council as proposed is the right mechanism for policy-making, guiding, promoting and coordinating the activities of the CCCD programme.</p>	<p>A coordination committee of all 12 participating States with AID, WHO, CDC/Atlanta, UNICEF and concerned CDA members be set up which will make policy (decisions), implementing and a guiding body for the programme. This will be chaired by nationals.</p>
<p><u>Item 3.5.3:</u> In its present form, CCCD Technical Working Group appears to be the secretariat of CCCD programme. It will not be possible for it to function without some permanent mechanisms.</p>	<p>These functions can be taken over by WHO/AFRO strengthened with necessary facilities as outlined in recommendations of paragraphs 2 and 3 of item 3.5.1 above. However, to thrash out matters, CDC/Atlanta and WHO/AFRO can form a Technical Committee where important matters can be discussed and decision taken.</p>
<p><u>Item 3.6.3:</u> The role of WHO/AFRO as presented in this section is not acceptable. In fact, it is no role at all. <u>It is only to provide secretarial assistance and support and act as a post office.</u></p> <p>Point 5 mentions "implement, monitor and evaluate all regional training words which are not substantiated in the text".</p>	<p>AID should be approached to amend this document. WHO/AFRO should be a full fledged partner right from policy-making to implementation and evaluation.</p>

<p><u>Item 4.3.1:</u> WHO/AFRO is following a policy of organizing training programmes within the African Region as recommended by its Regional Committee. Therefore, it would not be in line with decisions of Member States to conduct training programmes outside Africa. Moreover, holding courses outside Africa will not develop national capabilities and self-reliance. Training programme being organized by WHO in Nairobi is not intended to produce epidemiologists for the CCCD Programme.</p>	<p>WHO has developed Training Courses for all levels of personnel for EPI and Diarrhoeal Diseases including Cold Chain. It will be waste of time and money to start afresh. There is need to collaborate with WHO/AFRO and join AFRO in partnership. At present, WHO has built up sufficient national manpower which can be utilized in the spirit of TCDC to undertake all training programmes in African Region. This does not mean that we don't need external help. We surely need help but this should be after tapping national resources.</p>
<p><u>Item 4.3.5:</u> Annual Consultative Meeting but participants do not seem to be mentioned in the text. The relationship of this group to the other structures of CCCD is questionable. One wonders if one of the other CCCD structures cannot handle the functions as set out. Relationship with "Save the Children" not clear.</p>	<p>The Coordination Committee of the CCCD Programme (proposed above) might handle these functions.</p>
<p><u>Item 4.4.1:</u> The statement "WHO/AFRO would be responsible for the planning, management and evaluation of intercountry training activities" is again not correct. Nowhere in the programme can one identify such role precisely.</p> <p><u>Item 4.4.2:</u> All these responsibilities are given to the "Regional Coordinator". In item 4.3.4. point 2, responsibility for EVALUATION rests with "Regional Coordinator".</p>	<p>Either WHO/AFRO is made partner with clear statements in the programmes or it is not mentioned at all.</p>
<p><u>Item 4.5.1:</u> We don't have CCCD Programme Managers as such in the countries. Countries have EPI Managers, Diarrhoeal Diseases Control Managers, etc.</p>	<p>It is perhaps essential to work within the scope, or strategies already developed by the Member States so as to avoid confusing them and wasting both money and energy.</p>
<p><u>Item 5.0:</u> We are unable to separate this section from the Training Programme. WHO has already produced Teaching Modules and other materials for several courses.</p>	<p>Modify where necessary and use available Teaching Modules and materials. New materials can be prepared in those areas where none is available yet.</p>

<p><u>Item 5.3.1:</u> The whole responsibility of development of materials for CCCD lies with Training Coordinator in CDC/Atlanta. (See also page 29, Item 5.4.6). We do not believe that he can coordinate activities being carried out in Africa from Atlanta. To accelerate the process of self-reliance, an African-based institution would reach the standard required in two years with the same amount of funds.</p>	<p>This activity be carried out in Africa in the existing institutions by building up their capabilities.</p>
<p><u>Item 5.4.1:</u> The role of WHO is once more seen as that of a Secretarial Assistant. The complete responsibility lies with "Regional Coordinator" as laid down in item 5.4.4.</p>	
<p><u>Item 6.0:</u> No role for AFRO</p>	<p>WHO/AFRO has this speciality and can be a partner in this activity.</p>
<p><u>Item 7.0:</u> No role of WHO/AFRO except that some WHO staff will be on Research Review Committees in the three countries where Programme Epidemiologist will be posted.</p>	<p>WHO/AFRO has well developed structure and mechanism available and this should be used.</p>
<p><u>Item 8.4.1:</u> For point one, indicators had been developed in consultation with Member States, Regional Committees and Expert Advisory Panel. These were put up to WHO Executive Board and were approved by the Thirty-fourth World Health Assembly in May 1981. WHO/AFRO has developed the substantial health information programme in collaboration with Member States.</p>	<p>The health information programme already developed by Member States in collaboration with WHO/AFRO should be used as basis for this activity and CCCD programme should come in as a partner.</p>
<p>Point 4 was not clear.</p>	
<p><u>Item 9.1:</u> WHO/AFRO has a well developed programme of EPI and diarrhoeal diseases programme is picking up. Anti-malaria activities are being planned. This has not been mentioned at all in the background.</p>	<p>One paragraph about activities going on in the countries with WHO collaboration should be inserted.</p>
<p><u>Item 9.4:</u> US Mission/AID channels, REDSOs, CDC personnel, etc. are used in management but not WHO/AFRO field staff.</p>	<p>WHO/AFRO field staff in the countries can collaborate with AID in implementing bilateral programme. We will be missing an important resource if we omit this. In the spirit of partnership, our field staff can collaborate in the countries' activities.</p>

AID'S REACTIONS TO AFRO COMMENTS

24. AID stated that it was clear that we have not been able to work out details of the CCCD Regional project. AID stated it was committed to working out a partnership relation with AFRO in this area. AID questioned how this partnership could be accomplished and stated they were prepared to begin the necessary work immediately.

25. At the end of the discussion of the above document, AID noted for the record that the matter of "WHO's Constitutional Role" and the Regional Coordinator's role were not reported in the Note for the Record, although this had been discussed in the meeting.

COUNCIL MANAGEMENT STAGES
 CCCD REGIONAL ACTIVITIES

(1)	(2)	(3)	(4)	(5)	(6)	(7)
PREPARE	REVIEW	TECHNICALLY	MODIFY	EXECUTE	POLICY	PREPARE
ANNUAL	ANNUAL	REVIEW	PLAN	REGIONAL	REVIEW	ANNUAL
COMBINED	REGIONAL	ANNUAL	AS	ACTIVITIES	REGIONAL	PROGRESS REPORT
REGIONAL	ACTIVITIES	REGIONAL	INDICATED	PLAN	ACTIVITIES	AND DEVELOP
ACTIVITIES	PLAN	ACTIVITIES				PROPOSED
PLAN		PLAN				ANNUAL PLAN



ANNEX III

AGENDA FOR CDA TECHNICAL WORKING GROUP
FOR THE CCCD PROGRAM

Paris, May 4, 1982

09:30 - Introduction and Statement of Objectives of Meeting

Chronology of Events since last CDA Technical
Working Group Meeting

Restatement of Program Concepts

Status of Design and Implementation of CCCD Program

Advisory Council - Structure and Timing of First
Meeting

Coffee

Presentation of Current and Planned Activities of
CDA Members

12:30 - Lunch

14:30 - How Best to Use Regional Umbrella to Achieve Greater
Efficiency and Coordination of Bilateral Efforts

Coffee

Agreement on the Statement to be Given to the CDA
Policy Group on the Conclusions and Recommendations
Resulting from the Technical Working Group Meeting.

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ANNEX IV

CDA TECHNICAL MEETING ON
COMBATING CHILDHOOD COMMUNICABLE DISEASE PROGRAM

Paris - May 4, 1982

LIST OF PARTICIPANTS

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ANNEX V

OVERVIEW OF AID SUPPORTED HEALTH ACTIVITIES IN SUB-SAHARA AFRICA RELATED TO THE COMBATTING OF CHILDHOOD COMMUNICABLE DISEASES (CCCD)

This paper presents in tabular form and brief narrative summaries an overview of AID supported health projects in sub-Sahara Africa that involve immunization and other activities to control diarrhea and childhood communicable diseases. Also included are primary care and rural health development projects since in most instances these are or will incorporate communicable disease control.

The information provided has been extracted from AID files and from a draft report prepared by the American Public Health Association under contract to AID entitled "Tracking Report on AID Supported Primary Health Care Projects, Volume III-Africa," dated December, 1980. These data have been updated from from a series of cable responses provided by USAID field missions.

The tracking report is expected to be updated periodically and the full report or more complete information on a particular program can be made available upon request by contacting the Office of Regional Affairs, Bureau of Africa, Room 3325, Agency for International Development, Department of State, Washington, D.C. 20523.

USAID ACTIVITIES IN COMBATTING CHILDHOOD COMMUNICABLE DISEASES
AND ASSISTANCE IN RURAL HEALTH SERVICES AND
PRIMARY HEALTH CARE DEVELOPMENT
IN SUB-SAHARA AFRICA

COUNTRY	PROJECT NAME AND NUMBER ¹	PROJECT DATES	FUNDING LEVEL AND SOURCE	LOCATION	REMARKS
Botswana	Health Services Development No. 633-0078	FY 1978-1981 with probable extension to 1983	US \$5.5 Million HG ² \$1.7 Million Other donors	Nation Wide	Basically a project to develop primary health care through training of various category of health workers. No CCCD activi- ties identified.
Burundi	Expanded pro- gram on Immu- nization (EPI)	3/81-3/83	US \$0.5 Million	Nation Wide	Full program support including EPI expert to establish and/or improve various aspects of the program including cold chain logistics, vaccine procurement, distribution and control, immu- nization scheduling, equipment maintenance and repair, data and evaluation. Vehicles, commodi- ties and cold chain equipment are provided.
Congo	EPI	3/81-3/83	US \$0.5 Million	Nation Wide	Full program support as in Burundi
Central African Republic	Ouham Province Rural Health Project No. 676-0002	9/7	US \$2.0 Million	Ouham Province	Project was designed to strengthen management capability and to extend basic health services to a rural area. Project had only limited success. No CCCD activi- ties identified.
Ghana	Management of Rural Health Services No. 590-068	1/75-10/79	US \$1.3 Million	Nation Wide	Project established a national health planning unit and developed a primary care strategy for the country. A follow on project to deliver rural health services including CCCD activities is con- templated.

COUNTRY	PROJECT NAME AND NUMBER	PROJECT DATES	FUNDING LEVEL AND SOURCE	LOCATION	REMARKS
Ghana	Yaws and yellow fever control No. 698-0410.25	1/81-12/82	US \$0.50 Million	Nation Wide	Technical aid and commodities are provided. This project very likely will develop into a national EPI project.
Guinea	Maternal and Child Health	1/81-12/82	US \$0.46 Million	Nation Wide	Project includes EPI activities on a limited basis in the con- text of an MCH project. Con- sultations on EPI and commod- ities are provided.
Kenya	Kitui Primary Care Project No. 615-0185	FY 1979-81	US \$0.413 Million HG \$0.275 Million	Kitui District	Project comprised of four mobile health units serving remote areas with antenatal care, immunization and simple curative care.
	Kibwezi Rural Health Scheme No. 615-0179	FY 1979-81	US \$0.816 Million	Makindu District at Kibwezi	An experimental primary care project emphasizing training of village health workers. Major funding of EPI in Kenya is being provided by Denmark
Lesotho	Rural Health Development Project No. 690-0058	1978-1983	US \$3.254 Million HG \$0.454 Million	Nation Wide	A two phased project, first to improve MOH planning and health manpower development, second to deliver health services. No specific CCCD activities are identified.
Liberia	EPI		US \$0.500 Million	Nation Wide	Full program support as in Burundi.
Mali	Rural Health Services Development No. 688-0208	FY 1979-83	US \$3.890 Million HG \$0.870 Million	Mopti and Kayes Regions	Pilot projects to develop model of rural health care for Mali. No specific CCCD activi- ties identified.

COUNTRY	PROJECT NAME AND NUMBER	PROJECT DATES	FUNDING LEVEL AND SOURCE	LOCATION	REMARKS
Mauritania	Rural Medical Assistance No. 682-0202	FY 1979-83	US \$1.93 Million HG \$0.224 Million	Tarza Region	Project will develop and test a model of rural health outreach by community health workers.
	EPI	3/80-3/82	US \$0.4 Million	Nation Wide	Full program support as in Burundi.
Niger	Public Health Services No. 683-0214	6/78-3/81	US \$1.47 Million	Diffa Department	Project trains health workers, establishes vehicle and medical equipment repair, provides services of sanitary engineers and other health care specialists.
	Rural Health Improvement No. 683-0208	1/78-12/82 extension to 12/84 expected)	US \$14.029 Million	Nation Wide	Provides general support for training all categories of rural health workers, building of rural health facilities, provision of commodities including vaccines and cold chain equipment. Incorporation of CCCD activities is anticipated.
Rwanda	EPI	8/80-8/82	US \$0.5 Million	Nation wide	Full program support as in Burundi.
Senegal	Rural Health Services Development No. 685-0210	7/77-12/83	US \$3.3 Million HG \$1.6 Million	Sine Saloum	Project serves 225,000 rural inhabitants. Recently redesigned, project will focus on infants, children and pregnant women and will emphasize CCCD activities including immunization and diarrhea control.

COUNTRY	PROJECT NAME AND NUMBER	PROJECT DATES	FUNDING LEVEL AND SOURCE	LOCATION	REMARKS
Somalia	EPI	8/79-8/81	US \$0.2 Million	Nation Wide	Provides commodity support, vehicles, etc.
Sudan	Northern Sudan Primary Health Care Project No. 650-0011	FY 1979-82	US \$5.8 Million Af. Dev. Bank \$8.0 Million HG \$0.89 Million	Four provinces in northern Sudan.	Project aims to implement the national primary care programs in four of Sudan's poorest provinces. Specific CCCD activities have not been identified.
	Southern Primary Health Care Project No. 650-0019	FY 1979-83	US \$3.2 Million HG \$1.3 Million	Southern Region	This is related to the above project and extends coverage to the Southern Region. The US is also contemplating a third project, Health Sector Support, for which \$32.0 million has been requested over five years (1980-85) to augment the Government of Sudan's health programs.
Tanzania	Hanang Ujamaa Village Public Health Program No. 621-0138	FY 1977-1979	US \$0.499 Million	Hanang District	This model primary health care project focuses on village organization to support first aid boxes, village leaders (health educators) and village health workers. Communicable disease prevention at the village level is stressed.
	Tanzania School Health Program No. 621-0150	FY 1980-83	US \$5.7 Million	Dodoma and Singida States	In eighty schools, a standardized program of health instruction, health services and nutrition and environmental improvements are being implemented. Health records, including immunization are emphasized.

COUNTRY	PROJECT NAME AND NUMBER	PROJECT DATES	FUNDING LEVEL AND SOURCE	LOCATION	REMARKS
Zaire	Health Systems Development No. 660-1980	1978-1980	US \$0.675 Million HG \$0.44 Million	Kinshasa, Kongolo and Maluku	This project, designed to improve Zaire's capability to plan and implement health programs, had only limited success. However, AID has an endemic disease control project underway which includes an EPI component. Use of oral rehydration salts in diarrheal disease control will be stressed in two projects which are scheduled to be implemented over four or five years. These are the Basic Family Health Services project (No. 660-0067) to begin in 1981 and the Area Nutrition Improvement project (No. 660-0079) to begin in 1982.
20 Central and West African Countries	Strengthening of Health Delivery Systems in Central and West Africa (SHDS)	Phase I 9/77 Phase II 1/78-12/82	US \$20.00 Million WHO		<p>The broad goal of this project is to increase the capability of 20 countries in this region to plan and manage their health delivery systems emphasizing a primary health care strategy.</p> <p>The 20 countries participating are Benin, Cameroon, Central African Republic, Chad, Congo, Guinea, Guinea Bissua, Gabon, Gambia, Ghana, Ivory Coast, Liberia, Mali, Mauritania, Niger, Senegal, Sierra Leone, Togo and Upper Volta.</p> <p>A major objective of the program is to improve regional and national disease surveillance and health information systems. Demonstrations and training with respect to EPI are carried out</p>

COUNTRY	PROJECT NAME AND NUMBER	PROJECT DATES	FUNDING LEVEL AND SOURCE	LOCATION	REMARKS
20 Central and West African Countries					in three countries: Cameroon, the Gambia and Ivory Coast. The US, through Center for disease Control, is providing EPI management training. In 1981, the US will provide approximately 1.3 million doses of measles vaccine, divided among 14 countries: Benin, Cameroon, Central African Republic, Congo, Gambia, Ghana, Guinea, Ivory Coast, Mali, Niger, Senegal, Sierra Leone, Togo and Upper Volta. In 1982, measles vaccine will continue to be supplied these countries and Congo will commence receiving aid to start an EPI program.

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1. Refers to USAID Project Name and Number.
 2. HG refers to Host Government.

COUNTRY	PROJECT NAME AND NUMBER	PROJECT DATES	FUNDING LEVEL AND SOURCE	LOCATION	REMARKS
Swaziland	Rural Water Borne Disease Control 645-0087	FY 79-84	U.S. \$3.2 million	Nation-wide	Emphasis on bilharzia and other water borne disease. Snail control and mass treat- ment campaigns, health educa- tion.
Swaziland	Health Manpower Training 645-0062	FY 77-82	U.S. \$4.3 million	Nation-wide	Institutionalizing nursing and other paramedical programs. Establishing locally-staffed health services support system
Liberia	Primary Health Care	FY 81-85	U.S. \$10.0 million (planned)	Nation-wide	National Primary Health Care project now under design.
Ghana	Primary Health Care Support	FY 82-85	U.S. \$15.6 million	Nation-wide	To be designed.

