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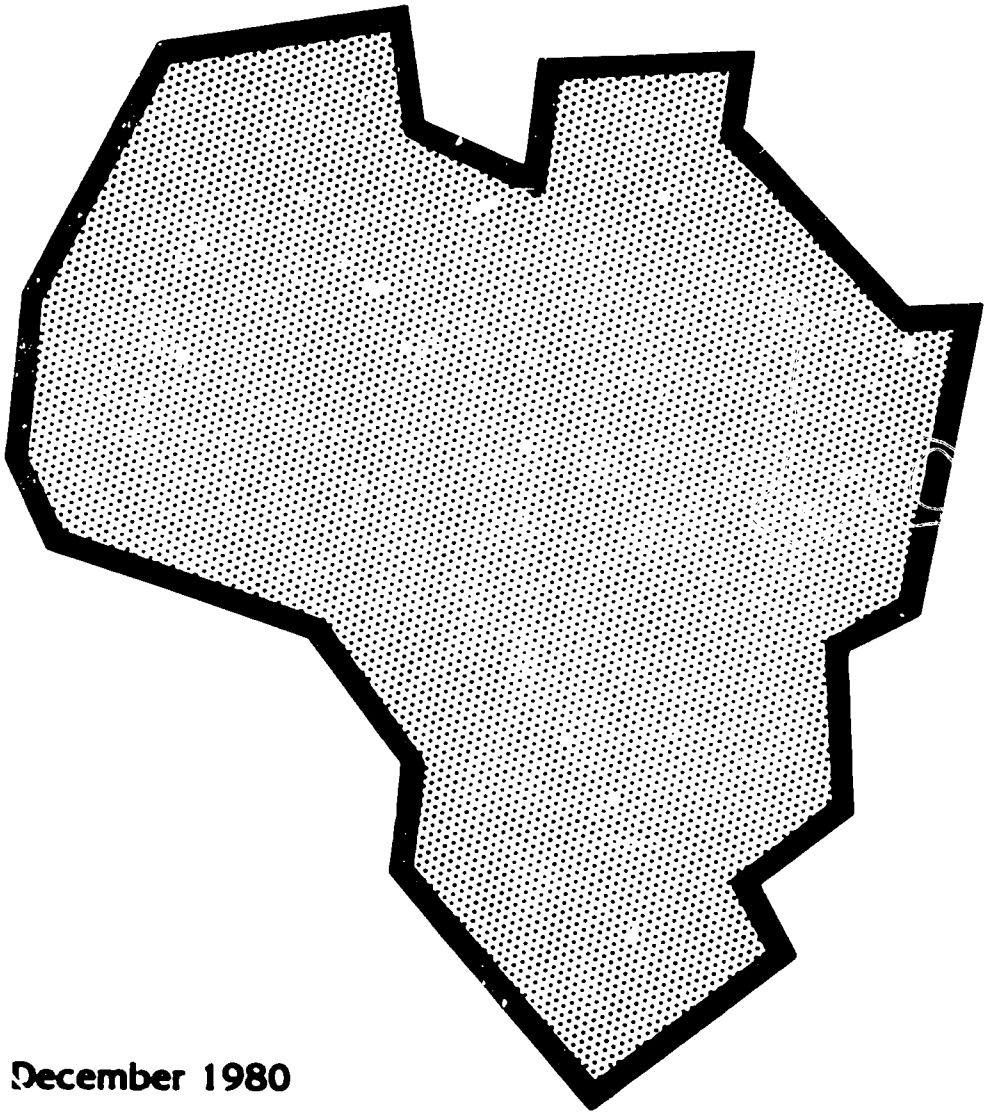

December 1980

Africa Bureau
Agency for International Development

REPORT

A.I.D. AFRICAN HEALTH OFFICERS

CONFERENCE

Abidjan, Ivory Coast

December 8-13, 1980

Hosted by

Regional Economic Development Services Office, West Africa

Sponsered by

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Agency for International Development

TABLE OF CONTENTS

		Page
I.	EXECUTIVE SUMMARY	
	A. Overview	1
	B. Resolutions	1
II.	SUMMARIES OF PRESENTATIONS AND DISCUSSIONS	
	A. Opening	6
	B. Endemic Disease Control	7
	C. Expanded Immunization Program	10
	D. Nutrition	13
	E. Population	20
	F. Primary Health Care	23
	G. Evaluation	27
	H. Administrative Issues	28
III.	CONFERENCE PARTICIPANTS	30
IV.	AGENDA	38

I. EXECUTIVE SUMMARY

A. Overview

The Second A.I.D. African Health Officers' Conference was held in Abidjan December 8-13, 1980. It had 53 attendees; the majority were A.I.D. health officers posted in Africa, the rest AID/W administrators and technical staff, African and U.S. resource persons.

The purpose of the conference was to provide a forum for discussion of technical and administrative issues pertaining to A.I.D. health strategies in Africa and the implementation of health projects. Plenary and small group sessions covered topics in five areas: primary health care, endemic disease control, nutrition, population, and project management (including evaluation and various other technical and administrative subjects.).

The conference was planned by a steering committee composed of health officers posted in Africa and AFR/DR/HN staff. All U.S.A.I.D. Missions in Africa were canvassed for their suggestions on the agenda and all AID/W technical support bureaus were consulted on the conference plan. Through the support of the International Health Society, Inc., the conference was accredited for Continuing Medical Education. Eight participants received CME credits as is required to maintain their licenses to practice.

It was generally agreed that the conference fulfilled its objectives: That A.I.D. health officers did update their knowledge concerning the most recent developments in several areas of public health and did share knowledge and philosophies of health development with their African colleagues and U.S. resource persons present.

The plenary and small group sessions produced many recommendations for action. These were further studied and redrafted for final review by the conferees. Seven resolutions were passed by the conference.

B. Resolutions:

1. Whereas U.S.A.I.D. missions in the field, no matter what the technical composition of their staff, are always in

need of appropriately conceived resources, be it resolved that AID/W provide the field personnel with the following resources:

a. Technical guidelines to reduce mortality and morbidity due to malaria, vaccine preventable disease, diarrheal diseases, malnutrition (PCM, goiter obesity, etc.) and undesired fertility. These guidelines should be applicable at the level of the health center, the dispensary and the community for the inclusion of specific activities in A.I.D. supported PHC programs.

b. Technical guidelines for the development of health information systems that will ensure monitoring of PHC program activities at all levels.

c. Technical guidelines for a systems analysis of drug distribution and utilization at primary and secondary levels of the health care system.

d. Technical guidelines for PHC evaluation methodologies.

e. Guidelines for the use of consultants to include a periodically updated directory of recommended health consultants, with particular emphasis on African professionals.

f. An easily understandable information directory about the nature, coverage and inter-relationship of projects funded by Washington-based-entities such as AFR/RA and DSB.

These guidelines should be prepared in close collaboration with field staff and should be in English and French.

2. Whereas certain AID/W processes have had an extremely negative impact on the field's capacity to identify, design and implement promising interventions in a timely manner, be it resolved that AID/W:

a. Continue to search for and to implement policies that would reduce the time lag between project identification and implementation, especially the AID/W review process.

b. Involve field personnel in the formulation of global strategies, especially for centrally funded projects.

c. Involve field personnel in the contract negotiation process.

d. Involve AFR/DR/HN in the selection of technical consultants for PP design teams.

e. Involve health technicians at an early stage in the formulation of strategies and projects that have implications for the health of populations, e.g. water projects that increase exposure to specific diseases.

3. Whereas, U.S.A.I.D. needs to attract, to develop and to retain qualified health professionals and whereas many health professionals must maintain licensure, certification or registration, be it resolved that AID/W provide for the professional development of health personnel through mechanisms such as:

   a. Funding each health officer to take the WHO/EPI Training Course for National Managers and Mid-Level Managers.

   b. Funding each health officer for the POP seminar on demographic variables and population coordination.

   c. Making available other WHO training courses, e.g. oral rehydration, cold chain, etc.

   d. Developing a formal continuing education program to provide the opportunity for the course work leading to a public health degree as well as for the up-dating of those public health degrees, e.g. self-education modules, correspondence courses, etc.

4. Whereas, the value of existing supplementary feeding programs, e.g. Title II and World Food Program, for improving health and nutritional status is debatable, be it resolved that AID/W:

   a. Give first priority in the distribution of the foodstuffs in MCH programs, to pregnant and lactating women and children between six and thirty-six months of age who are identified as being malnourished. The size and type of food ration should be determined by the degree of malnutrition.

   b. Require that the donated foods be distributed in accordance with host government policies. This is not always the case as exemplified by the reluctance of the Catholic Relief Services program staff to follow directives from the Gambian Ministry of Health.

c. Formulate a strategy for more effective use of U.S. donated foods in MCH programs through Title II and the World Food Program. Senior officials of the Africa Bureau, the Office of Food for Peace, and the Office of Nutrition should be involved in the formulation of this strategy. Data for the strategy should be drawn from a case study of Gambia, the A.I.D. evaluation as of Title II programs in Upper Volta, Cameroon, Morocco, Kenya, etc. and a review of the use of supplemental foods in Africa and the role of PVO's in the distribution of these foods.

5. Whereas, the goal to extend health services to all by the year 2000 will place increasing burdens on LDS budgets and whereas the economic growth may not permit significant increases in allocations for health care, be it resolved that AID/W:

   a. Re-examine the A.I.D. policy for recurrent costs.

   b. Re-examine the life of project maximum of 5 years.

   c. Recognize that health strategies must be implemented by local governments in developing countries.

   d. Initiate a more rigorous analysis of absorptive capacity and project recurrent costs and the impact on LDCs.

6. Whereas, important commodities in support of health programs are not readily and economically available, or are not available in sufficient quantities: be it resolved that AID/W take the following action:

   a. Advise the field on the status of oral rehydration packets. If a U.S. source is not possible, AID/W will facilitate the waiver process in purchasing UNICEF oral rehydration packets with project funds.

   b. Seek to obtain FDA review of the use of methyl progesterone acetate as a contraceptive.

   c. Facilitate the waiver process in purchasing non-U.S. made vehicle with projects funds.

   d. Approve waivers and advance payments to enable U.S.A.I.D.'s to procure vaccines and other commodities from the most economical source, e.g., UNICEF.

7. Whereas, a need exists in most African countries for training relevant to specific disease control components of PHC programs, it is recommended that AID/W support field requests for financial

or human resources to implement such training programs. A seminar for national health personnel on the use of oral rehydration solutions to prevent mortality due to diarrhea is an example of such a training program.

8. Whereas, the Sahel Development team has developed a draft manual for the design of village health worker teams, it is recommended that AID/W:

   a. Send a copy of the manual to all field personnel.

   b. Request all health personnel to review and critique the manual.

   c. Determine whether wider distribution of the manual is appropriate.

II. SUMMARIES OF PRESENTATIONS AND DISCUSSIONS

A. Opening:

Mr. Gordon Evans, Director, REDSO/WA addressed the topic of Health Development in Africa highlighting some lessons learned through the experience of recent years.

Mr. Lawrence Heilman, Deputy Director for Technical Operations, Office of Development Resources, conveyed the greetings of Mrs. Goler T. Butcher, Assistant Administrator for Africa and presented her summing up of progress in health development in Africa since the first Health Officers Conference in 1978. Mr. Heilman also pledged the resources of his office to backstop field officers in their work. Dr. Thomas W. Georges, Principal Health Advisor, Bureau for Africa, greeted the participants.

Dr. Ebrahim M. Samba, Director, WHO Onchocerciasis Program shared his philosophy on rural health development and his views on meeting the goal of Health for All by 2000. He underlined the important role of health professionals in actively promoting rural health services. Drawing from his experiences in the Gambia, he described how he was able to convey his ideas on rural health problems to political leaders in the course of his practice as a surgeon. He pointed out the importance of understanding rural people, their values and pragmatism, in promoting such health interventions as child spacing and varied diets. He told about how the use of radio broadcasts had been effective in promoting participation in immunization services but later resulted in community disappointment because immunization had been presented as one part of the primary health care program which was not fully implemented.

Dr. George Jones oriented the participants to the conference plan.

B. ENDEMIC DISEASE CONTROL

Summary:

Dr. Joe Stockard gave a briefing on three tropical diseases which currently are of considerable interest to the Africa Bureau: Onchocerciasis, schistosomiasis and malaria.

The program for the control of onchocerciasis in the Volta River Basin by means of aerial application of a larvicide, Abate, to the turbulent water breeding sites of the vector fly, Simulium damnosum, has been supported by A.I.D. from the beginning of the project in 1975. This project has succeeded in reducing transmission of new Onchocerca volvulus infections to insignificant levels over most of the program area. Prevalence of the disease is declining and the progression of eye infections to blindness is not occurring in areas where interruption of transmission has been accomplished. It now is clear that the vector fly has a remarkable ability to reinvade the program area from uncontrolled sites. Such sites in Western Mali, Senegal, Guinea and Sierra Leone are a major concern because they are preventing Western Mali from achieving the expected development benefits. Efforts which are needed to solve this problem include the gathering of essential data and, especially in Guinea, the development of infrastructure such as roads without which a control program cannot succeed. The University of Dakar has skilled personnel who can contribute greatly toward the planning of sound health programs in that country. Consideration should be given to supporting such institutions.

Schistosomiasis is widespread throughout Africa. It is a disease of major concern because of the extent to which its prevalence and severity are being increased as a result of major development activities which involve the construction of dams and irrigation systems. Two new drugs, Praziquantel and Amoscanate, are now undergoing safety and efficacy tests. Though neither has as yet been approved by the U.S. Food and Drug Administration (FDA), that agency is closely following the progress of essential tests. AFR/DR/HN will maintain contact with FDA authorities on this important matter.

Anti-malaria activities undertaken during the eradication era (1956-1970) showed that malaria control is possible in Africa even if eradication is not. After 1967, malaria services went into decline and were largely disbanded.

A.I.D. now recognizes that in dealing with the health problems in Africa one cannot ignore malaria, given its widespread prevalence throughout much of the continent and its serious health implications for large numbers of Africans. A Bureau policy statement on malaria will be formulated shortly.

The recommendations of a Strategy Advisory Group on Malaria were reviewed. Field responses to an AFR/DR questionnaire on whether A.I.D. should support efforts to control malaria in Africa were summarized. Subjects which were identified as deserving special attention included monitoring for the development of resistance to anti-malarial drugs, the effects of different treatment schedules on the development of immunity, and clarification of the reasons for large differences between WHO and the Sahel Development Planning Team estimates of the cost of drugs for comparable programs.

The specter of drug resistance in Africa is a continuing concern. The Rieckmann micro laboratory method should be available within a year to monitor possible resistance.

Additional Meeting Notes:

Two Special Group Sessions on malaria strategy and planning were held.

Both groups reacted favorably toward the idea that assistance be provided to African governments to develop and implement effective anti-malaria programs. The first group underlined the need for applied field research, especially on chloroquine resistance, immunity, and treatment protocols. It suggested that operational research concerning these and other issues be undertaken in the field and that A.I.D. supported programs be used for this research. Many other program ideas and suggestions were exchanged including: 1) The responsible use of chloroquine through primary health care systems will insure its effectiveness over the long term; 2) Work needs to be done on production of cheaper anti-malarials along with manuals for their use; 3) The field needs guidance as to the alternative methodologies that are possible for use within existing systems; 4) Recurrent cost implications of A.I.D. projects in this area must be examined closely; 5) WHO has produced a mathematical model for choice of malaria control technologies based on a project in Nigeria; 6) Local production of anti-malarials, especially on a regional basis should be explored; 7) In utilizing present systems for operational research, the issue of countries perceiving themselves as being used as guinea pigs must be addressed; 8) It may be preferable to have in-house A.I.D. malaria expertise, possibly on a regional basis in Africa; 9) A manual setting out options to be considered should be produced for field people; 10) Support for capital development to create capacity of African countries to produce their own anti-malarial tablets from raw materials should be considered.

The second group focused their attention on the extremes in levels of national anti-malaria efforts. The majority considered that the personnel resources available in their countries could support at best only a drug treatment program implemented through an existing health delivery system.

It would be difficult, perhaps impossible, because of the shortage of personnel to staff a separate malaria unit at the central government level. At the other extreme is the plan to support a broadly based anti-malaria effort which encompasses the recommended Tactical Variants 1, 2 and 3, utilizing a malaria control service as well as other government services to attack the problem. This plan has already proceeded to the Project Design stage. This group clearly demonstrated the differences that exist in national capabilities for attacking the problem. It concluded that a logical starting point for malaria control in general would be: 1) Operational field research; and 2) Feasibility studies.

It was concluded that the field missions recognize a need for the malaria problem to be addressed in sub-Sahara and approve of the development of a Bureau position and action plans to begin control efforts where feasible. Also, the recommendation was made that A.I.D. try to attract and train qualified endemic disease control specialists.

C. EXPANDED PROGRAMS OF IMMUNIZATION (EPI)

Summary:

EPI was discussed in several sessions both as a separate program and as part of primary health care. The participants acknowledged EPI's potential for significantly reducing morbidity and mortality due to measles, polio, pertusis, tetanus, tuberculosis and diptheria. Since EPI technology has been proven effective and training and financial resources are becoming available, there was much interest in developing bilateral projects.

While some technical issues of cold chain technology and vaccine effectiveness are still unanswered, the main obstacles to implementation of EPI programs is the lack of the necessary rigorous planning and management. Underlying problems are the lack of trained personnel, national EPI policies and financial resources.

It was noted that a number of new African EPI programs have benefited very much from technical assistance and training offered through WHO, the Permanent Interstate Committee for Drought Control in the Sahel (CLSSS) and the A.I.D. Strengthening of Health Delivery Systems Project (SHDS). The existence of self-monitoring and standardized evaluation formats was noted as useful management and replanning tools. The group concluded that vertical EPI efforts can be integrated in primary health care (PHC).

Much of the discussion related to resources available under SHDS, Combatting Communicable Childhood Diseases Project (CCCD), and Center for Disease Control (CDC) health initiatives project. The special sessions with AFR/RA and SHDS representatives helped to clear up some of the confusion of the field staff concerning the objectives and boundaries of these various programs. There was much concern that large regional projects, especially if planned without field input, could distract recipient countries from their focus on integrated PHC care. Serious questions remain on host country absorptive capacity and recurrent costs in relation to the CCCD Project. Also, concern about the possibility that capital costs might exceed donor resources was voiced. Participants discussed the benefits of the Accelerated Impact Project (AIP) mechanism and UNICEF procurement in the development of EPI programs. Participants noted that although UNICEF is the only source of low cost vaccine and many types of standard medical equipment, A.I.D. policy rarely permits the waiver and the advance payment required by UNICEF.

In summary the recommendations were:

1.) That AID/W seek field (including host country) input in the development of the CCCD and other regional or centrally funded

projects, and that the focus of these projects be on their effectiveness as a resource for discrete bilaterial programs.

2.) That AID/W seek to clarify for the field the distinctions between these various projects and the mechanisms for their use.

3.) That AID/W establish as soon as possible a policy permitting source waivers and advance payment permitting U.S.A.I.D.'s to procure vaccines and medical supplies from UNICEF. As a second step, A.I.D. should encourage the establishment of an EPI revolving fund for vaccine procurement similar to that of PAHO.

4.) That A.I.D. Health officers take the WHO (SHDS sponsored) EPI training course.

Additional Meeting Notes:

Dr. Samuel Ofosu-Amaah stated that WHO considers the immunization of all children under age one and of all pregnant women to be an essential part of health for all by the year 2000. Vaccines included in the basic program are BCG, DPT, oral polio, and measles. Countries must themselves initiate an EPI program, and some may choose to add yellow fever and/or meningococcal meningitis depending on local conditions. WHO can assist with planning and evaluation, training and technical assistance such as cold chain and equipment design and vaccine procurement. Vaccine testing can be done at WHO collaborating laboratories.

Almost all African countries have started an EPI program. Financial support is coming from various donor countries. The possibility is being explored of establishing a revolving fund for the African Region similar to that of the Pan American Health Organization.

Concerns expressed included: Some countries do not seem to be committed at the highest levels; Some countries are not making optimal use of the technical assistance available through WHO (via Brazzaville, please): There is a need for improved data collection and technical exchange between countries and for additional research to improve vaccine stability; The cold chain remains a critical problem in peripheral areas; There is a need for posters and educational materials which are appropriate to Africa; Integration of EPI into PHC and MCH activities is difficult, particularly when converting from the Grandes Endemies approach of most francophone countries.

Other sources of EPI assistance to African countries include: the CDC epidemiologists at Organization for Endemic Disease Control in West Africa (OCCGE) and Organization for Endemic Disease Control in Central Africa

(OCEAC); the Centre International d'Enfance (Paris); and SHDS.

James Cummiskey described the Combatting Communicable Childhood Diseases Project (CCCD) being developed by AFR/RA to deal with diarrheal diseases and selected communicable childhood diseases in sub-Saharan Africa. The project is expected to support regional activities such as demonstration and training programs. Also it will provide some start-up funds for bilateral projects. This latter form of support will probably use the AIP model, be limited to $500,000 per project, and not be available in the Sahel countries where similar resources already exist.

CCCD Project design is proceeding. A final PP is expected in March, 1981. The involvement of other donors is being explored. As the projected costs are well beyond A.I.D.'s means Concerned Action for Development in Africa (CADA) and selected Scandinavian countries are being approached. The CCCD Project is expected to run at least 20 years with A.I.D. support to the first 5 year phase being about $35 million. CDC in Atlanta has been playing a major role in project design and will be the principal implementor. The SHDS Project will continue to be responsible for the regional CCCD activities.

Dr. Mary Harvey joined Mr. Cummiskey in a review of the SHDS, the CCCD, the Family Health Initiatives, and Accelerated Impact Projects (AIP). This session was helpful in clarifying the benefits of these projects and which countries might participate. It was recommended that AID/W distribute to the field a project catalogue for use by project officers as a reference tool.

D. NUTRITION

Summary:

In recognition of the extremely high prevalence of malnutrition in Africa and its relationship to infant mortality and morbidity, nutrition was discussed both as an individual subject and as part of primary health care.

African nutrition problems and their causal factors were reviewed by resource persons. Chronic protein-calorie malnutrition is an underlying cause in the majority of African childhood deaths. Also, vitamin and mineral deficiencies are common. Determining factors are environmental, political and cultural. They include: the decline of per capita food production in Africa; massive refugee movements and urban migration; closely-spaced births; poor weaning habits; and lack of health care.

Because malnutrition is inseparable from this total complex of interrelated factors, vertical solutions are not usually effective. Attempts to alleviate malnutrition through food distribution can easily disrupt the system, aggravating the malnutrition problem. The conclusion was that malnutrition may be alleviated by simultaneous improvements in food production and distribution, health care (including child spacing) and general economic development. To accomplish this, it will be necessary to promote an awareness of nutrition problems among planners and develop integration of nutrition interventions in development efforts. PL480 food distribution problems emerged as a main issue.

Major Points and Recommendations are summarized as follows:

1.) Nutrition problems in Africa are poverty related and associated with declining per capita food production. Recommendation: Nutrition impact should be considered when designing agriculture and rural development projects.

2.) African nutrition surveillance systems are inadequate for national assessment of nutrition status and for monitoring and evaluating impact of nutrition or development programs. Recommendation: Operational research in developing nutrition surveillance should be supported by A.I.D. and guidelines for implementation prepared and circulated.

3.) Health and agriculture personnel in African countries are inadequately trained to effectively deal with nutrition problems or to take advantage of development programs to introduce and improve nutrition training within Africa.

4.) Title II MCH programs have questionable nutritional impact and are often not properly integrated into government health services. Recommendation: The Africa Bureau in collaboration with Food For Peace Office should review Title II programs with a view towards policy formulation.

5.) Most A.I.D. funded PHC projects do not have adequate nutrition components. Recommendation: Develop guidelines for integrating nutrition activities into A.I.D. sponsored projects in Africa. Begin by circulating the preliminary outline of nutrition components of PHC.

6.) Community participation in nutrition program development and implementation is inadequate. Therefore programs are often irrelevant and ineffective. Recommendation: Missions should coordinate nutrition activities with the Peace Corps. Communities must be involved in the design of nutrition education materials if they are to be useful.

7.) The diets of children in the weaning period are often inadequate due to lack of appropriate foods, inadequate information on diets for young children and poor technologies at village level for food preparation. Recommendation: Africa Bureau in collaboration with DS/N should increase efforts to improve weaning foods utilized in both urban and rural communities. Particular attention should be given to introduction of appropriate village level technologies for preparing foods for weaning mixtures, and production of nutrient rich foods to be added to staple cereals or tubers.

Additional Meeting Notes:

Mellen Duffy presented the problem of chronic malnutrition as a pervasive problem throughout Africa with up to 84% of the children between ages 0-5 years being affected. Although malnutrition is presently more prevalent in rural areas, malnutrition is rapidly becoming a serious problem in urban areas. In a recent (1978-79) survey done in Kinshasa, it was found that 42% of the children were malnourished, 11.5% severely.

Other factors exacerbating nutritional status in Africa include: massive refugee movements; decline in per capita food production; and decline in availability of foreign exchange to purchase food for urban customers.

Gladys Carroll described the major form of malnutrition in Africa as protein/calorie malnutrition (PCM), with a small proportion of severe forms; marasmus affecting children 1 to 5 years of age; and kwashiorkor affecting children 1 to 4 years of age. Other nutrition problems include vitamin deficiencies and anemia.

Her suggestions for Improving Nutritional Status in Africa include: assess nutritional status, involve senior government officers and political leaders; coordinate nutrition efforts through various ministries; stress food storage and preservation; combat poverty through activities which raise income of poor and increase food production; and use all avenues for educational activities.

Dr. Nellie Kanno pointed out that knowledge of behavior connected with food preparation, consumption and distribution increases our understanding of people's attitudes and values. Food and drink are often linked to events that have little to do with nutrition. Food can be related to social rank and status. Taboos against certain foods can preclude inclusion of nutritious foods in the diet. Children become accustomed to what a "meal" is through their observation of and instructions by family and others around them. Food consumption patterns are important in many societies for maintaining social relationships. Some societies are capable of changing food consumption patterns more easily than others. She recommended that before introducing new foods we learn the role of food and drink in the society and its cultural significance.

Mary Ann Anderson talked about nutrition resources for U.S.A.I.D. Missions. The Nutrition Office in the Bureau Of Development Support (DS/N) covers all A.I.D. countries and is becoming increasingly involved in Africa. Recently, a Nutrition Advisor was assigned regional responsibility for Africa in AFR/DR.

From the FY80-82 functional review for nutrition activities in the Africa Bureau, DS/N found only a handful of specific nutrition activities and a lack of nutrition components in U.S.A.I.D. integrated health projects. U.S.A.I.D.'s in Africa are not getting their fair share of technical assistance available through DS/N because they do not request it. Since per capita food production is declining in Africa, it is important that U.S.A.I.D.'s take a broad view of food policy. Health and Nutrition Officers should work closely with Agriculture Officers in developing agriculture sector strategies.

Two Special Group Sessions on Nutrition Education were held. One group focussed on three areas:

nutritional assessment tools;
nutritional surveillance; and
appropriate nutrition education for primary health care workers.
The International Nutrition Communication Service (UNES) is a resource for nutrition education materials.

Major points brought out in the discussion included:

1) Illiterates do not always understand two-dimensional audio-visual aids for nutritional education; it was suggested that actual foods be used in demonstration.

2) Nutrition education, particularly in primary schools has been neglected.

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1) Illiterates do not always understand two-dimensional audio-visual aids for nutritional education; it was suggested that actual foods be used in demonstration.

2) Nutrition education, particularly in primary schools has been neglected.

3) Commercial advertising techniques, have been used successfully to promote use of locally available nutritional foods.

4) Changing eating habits in one generation may not be a realistic goal.

5) Simple arm band circumference measures may be a more appropriate tool for PHC workers at village level than weight for height and height for age growth charts.

This group recommended the use of community participation in designing appropriate nutrition education materials; that nutrition education is to be integrated into the cultural, economic, social context of the area; and that INCS's collection of African materials be distributed.

The second group focused on the pros and cons of the CRS Growth Surveillance System in use in Title II programs throughout Africa. The CRS Title II program, was the subject of active debate concerning the efficacy of integrating Title II food distribution into maternal and child health programs.

The group praised CRS's accomplishments in establishing the most extensive system of regular weighing of pre-school children in Title II programs in Africa. The CRS practice of using the child's growth chart to enforce the parents' contractual responsibilities as recipients of Title II food was also commended. However, due to the increasing prevalence of malnutrition in Africa and the steadily rising cost of Title II commodities, the group felt that this resource must be used more effectively to improve nutrition status. Several in the group had seen food aid overwhelm smoothly functioning maternal and child health services as the distribution of Title II foods took precedence.

The group made the following recommendations:

1) Title II food for the MCH category should be used for pregnant and lactating women and children from 6 months to three years old who have been diagnosed by anthropometry as being currently malnourished and at-risk pregnant and lactating women. Only after full coverage of these priority groups has been achieved should the Title II program be expanded to cover other at-risk preschool children, primary school children, and adults.

2) Nutrition education to promote self-reliance and use of local foods should form an essential part of MCH feeding programs. Title II food should be used for recuperation of malnourished children when nutrition education fails.

3) Public education campaigns should be used to explain the rationale for a more closely targeted Title II program and to ease the

political ramifications of eliminating "no longer qualified" beneficiaries.

4) Guidelines for type of commodity used and ration size should be flexible enough to allow for tailoring ration size to the age and severity of malnutrition in the child being treated.

5) Children should be graduated from the feeding program once they have been recuperated and sufficient time has lapsed to assure resumption of their normal growth pattern.

6) The CRS Growth Surveillance System should not be forced on host governments against their will, particularly when their preference is to use an existing MOH endorsed growth chart already in widespread use.

A Special Group on infant weaning foods discussed program interventions. They recommended that the first step be a quick assessment of the area to determine the types of foods available; the existing feeding practices; the existing breast feeding pattern; and the food taboos.

Nutrition education should deal with food taboos, teach food preparation and the addition of local supplemental foods to existing weaning foods. It should be coordinated with the activities of home economics extension workers, social welfare workers, and health workers activities.

The Special Group on nutrition component of primary health care programs discussed the priority tasks for the community health worker (CHW) with respect to nutrition. It was agreed that the CHW must gather information on the nutrition situation of the community before specific priority activities can be decided upon. Based on problems and associated factors identified, the CHW can be trained for nutrition tasks. Among the tasks of a CHW would be monitoring the food and nutrition situation of the community; nutrition education stressing use of local foods and securing collaboration of other community resources as needed (agricultural extension agents, social welfare workers, teachers, etc.). The group stressed that CHW's should be appropriately equipped for their responsiblities and adequately supported by their technical supervisors.

The nutrition activities of other levels in the PHC system were also discussed. It was suggested that African countries should develop national nutrition surveillance systems.

It was recommended that the preliminary outline of the nutrition component of PHC discussed at this session be amplified by the REDSO/WA nutrition officer; that available training materials be more widely circulated.

Two special groups discussed oral rehydration. The analysis of oral rehydration treatments (ORT) has shown that they can significantly reduce infant mortality which often occurs with the dehydration following

diarrheal disease. Based on this WHO has initiated a global oral rehydration campaign with guidelines and specific programs to be announced soon.

While there was consensus that ORT should be a high priority, participants grappled with the technical questions relating to ORT treatments and their delivery within the overall health system. The questions were about: the clinical management of diarrheal diseases (advisability of replacing current drug treatment with ORT); the choice of ORT formulations (composition of salts packaged vs. home preparations); the effective approaches for introduction and delivery of ORT training of planners and medical personnel (integration into PHC, mass media campaigns); and the resources available to field missions, including planned ORT component of the CCCD project.

The participants concluded that:

1.) There should be a synthesis of the available information as guidelines to the field and that the upcoming WHO guidelines might serve.

2.) More information on the outcome of field trials should be made available (including close monitoring of the new Gambia mass media ORT project).

3.) Sensitization of government planners and training of medical personnel is an important initial step. A.I.D. should explore the possibility of in-country seminars for this purpose.

4.) Drug treatments for diarrhea are generally ineffective and sometimes dangerous.

5.) Both packaged oral rehydration salts and home preparations are effective; the choice depends on many local logistical and attitudinal factors. A.I.D. should explore its proposed procurement of U.S. manufactured preparations.

6.) The ORT component of the CCCD project should be developed through field input.

E. POPULATION

Summary

The conference gave special attention to the increasing population problems in Africa. The group acknowledged the seriousness of the situation in Africa. This continent has the highest fertility rate and lowest economic development rate. The increase of the population to 813 million by the year 2000 coupled with the declining rate of per capita agricultural production may produce a catastrophe whose indications are already seen in the current severe famines. Likewise the participants focused on the detrimental impact of high parity and closely spaced births on the health of mothers and children. Globally, Africa has the highest infant mortality rate and also the lowest life expectancy.

A panel made up of population experts from African countries and the U.S. as well as A.I.D. field representatives helped analyze the complex cultural, political and economic factors which have caused this situation. This discussion emphasized the traditional pro-natalist attitudes which continue to be an important cultural value despite the emergence of urbanization and overpopulation. The uncertainty of child survival has encouraged the desire to have many children. The African representatives emphasized that although many African countries do not share this perception, many are beginning to understand the importance of demographic analysis and population planning. They stressed the need for demographic analysis as a way to sensitize planners.

The participants acknowledged the very slow progress in Africa in developing population policies and family planning programs. There was general consensus that the major approach should be an integration of family planning services (especially child-spacing) into basic health services. The African experts cited the success of this approach in a number of African countries. All acknowledged the failure of vertical "family planning only" programs and the ensuing resentment on the part of Africans. However, both Africans and U.S. representatives agreed that careful program development should be undertaken quickly.

Much work remains in development of these programs. Technical questions relating to contraceptive use (especially the availability of injectable depro-provera) needs to be studied. Likewise, the integration of family planning services requires the existence of basic health services. The participants discussed the use of the extensive A.I.D. and other resources in getting these programs off the ground. The field officers found the catalogue of centrally funded population activities very helpful.

Recommendations made included:

1.) That U.S.A.I.D.s work with host countries to develop population strategies and programs.

2.) That PVOs be helped to initiate program development.

3.) That information from successful African family planning projects be circulated.

4.) That population programs be integrated into basic health services and that they be culturally sensitive.

5.) That family planning services be initiated.

6.) That U.S.A.I.D.s make more use of demographic analysis projects to provide the fundamental understanding of population problems.

7.) That A.I.D. health program officers receive population training.

Additional Meeting Notes:

Dr. Carole Tyson gave an historical overview of the use of contraceptives in Africa. She explained that the ancient Egyptians had used a wide variety of contraceptive techniques including extended breast feeding, separation (abstinence) and a day-after drink. Contraceptives are not new to Africa but the more modern methods will require societal adjustments.

Ways family planning should be "packaged" for Africa were proposed including: integration into MCH care; involvement of Africans in all phases; increased use of PVOs where appropriate; awareness of the cultural factors; institutionalization of Family Planning Programs; strong administration/planning; and creativity.

Family planning should be a part of home economics, in the school system and in environmental and agricultural efforts. The strategy should include workable non-clinical distribution systems. Africans should be involved in all phases of program planning, implementation and evaluation.

Dr. Samual Ofosu-Amaah gave an overview of the population/family planning experience in Ghana. He noted that the 4 cell design of the Danfa project did not produce clear cut evidence of the most effective means of meeting the need for family planning services. He did state that the most serious constraint to acceptance was the distance to the facility offering services.

Dr. Amaah stated that one of the biggest problems facing health care professionals was how to involve the community in addressing their own health needs including family planning. One way to do this is to respond to the community's perceived problems. This way means working with traditional midwives, community pro-pharmacies, and village health workers. In summary, the Danfa project had its problems but it did not lead to both a Primary Health Care policy and program in Ghana.

Leonard Robinson noted the early initiation of family planning activities by PVOs in Africa and presented a synopsis of their major activities today. He suggested U.S.A.I.D.s keep in mind several program development points in their work with PVOs: the overall strategy should be multidimensional in scope; the PVOs must take an active role in the coordination of efforts; a mechanism for disseminating program results should be built into the plan; insight into country-specific appropriateness of the project is crucial. He pointed out the unique role of the PVOs as trail blazers and gave many examples of their successes in Africa as well as in other parts of the world.

Dr. Richard Brown shared his experience in a family planning project in Bulape, Zaire where the services were presented as part of the child's nutrition and growth phase. He also shared his observations in the Cameroon, where through the efforts of various donors the Government adopted family planning as part of their formal policy. His experience in Africa has lead him to the following views: A.I.D. should not insist on a population policy from African governments; PVOs have definite possibilities but are sometimes slow to respond; Depro-provera is the contraceptive for Africa (IUDs have more serious side effects; any contraceptive is safer than pregnancy); Family Planning programs should start in cities where population pressure is greatest; we need to look at the vehicles for delivery of Family Planning services: integration is not always the best method; coordination is perhaps not necessary.

William Trayfors made several observations based on this experience in the population sector. He closed the session by saying that family planning is a basic human right. It is an important component of health care. It reduces one of the barriers to economic development.

F. PRIMARY HEALTH CARE

Summary:

Primary health care (PHC) emerged as the single most important topic of the conference, a reflection of A.I.D.'s African health projects portfolio.

The general consensus was that primary health care should remain A.I.D.'s major strategy in Africa, but that A.I.D. should undertake a very rigorous analysis of the experiences of these complex projects and their components to insure that these projects can be successfully implemented with the desired impact. The unanswered technical questions must be answered in a systematic way. Based on the outcome of this analysis, A.I.D. should actively revise its current and future PHC projects.

Several major concerns were expressed. Most PHC projects have not yet demonstrated the hoped-for outcomes. There have been a number of "failures" and in general these projects have not been able to quantify their results in a way that could enable evaluation of their effectiveness.

These unresolved technical issues were identified: How to integrate the levels of primary, secondary and tertiary care; How to integrate the multiplicity of components in PHC (EPI, nutrition, oral rehydration, sanitation, family planning, etc.); How a village health worker can have a significant impact on health; How a manageable training supervision mechanism can be established on a long term basis; How the necessary drug distribution and other supporting logistical elements of PHC can be set up on a long term basis; Whether such projects can continue without exterior technical and financial assistance.

Current design/management problems identified include: Poor, non-rigorous planning of these projects, often with little host country participation; Inappropriate or too many consultants, resulting in ineffective performance, lack of coordination with host country counterparts, inability of host country to replace technical or managerial capability when consultants leave; Lack of built-in monitoring systems which would provide needed management planning and evaluation.

In summary the recommendations were:

1.) That there be rigorous planning with host country nationals to design PHC projects, with emphasis on costs, management capability and project impact;

2.) That PHC evaluation formats be designed with AID/W and field assistance.

3.) That consultants be carefully selected among qualified Africans and other foreigners, as well as Americans; That host country counterpart training be given high priority;

4.) That A.I.D. pursue in depth analysis of the experiences of PHC projects to provide the necessary information for design and management of these projects and that this information be circulated to all field missions.

5.) That AID/W review and circulate "The Village Health Worker Team in Sahel" to all field posts.

Additional Meeting Notes:

Dr. Joseph Foumbi described a primary health care program in a very well-defined pilot zone in Cameroon called "DASP". This DASP zone was initiated by the Government of Cameroon in 1960 and funded jointly by the French, U.S.A.I.D. and WHO. The principle is to adapt community medicine, in addition to agricultural and road development, to local conditions.

The health goals of the project are: Major improvement of provincial hospitals and subdivisional hospitals; Integration of public health activities at all levels; Appropriate training of health personnel; Improvement and augmentation of the manpower pyramid; Adequate laboratory support; Reliable drug distribution and supply system; and Community participation.

Some of the major weaknesses of the project have been: inadequate population coverage; relatively high costs; passive participation of the communities targeted; and absence of coordination between health and other sectors.

There is a village health worker component. Village Health Workers (VHW) are paid based on the small profits from selling drugs. The project identifies and trains traditional birth attendants. It was noted that in the 66 villages having VHW posts, 75% of persons seeking care were treated there. It was Dr. Foumbi's conclusion that the critical element to success in achieving the goals of the project rested with the degree of acceptance and involvement in all aspects of the project on the part of the community.

Dr. James Maneno pointed out that PHC is an overall social-economic development problem. He noted that planning must begin with an identification of community needs, common specific disease conditions and precursors to ill health, e.g., housing, water and sanitation. From this base one can identify the types and levels of interventions needed, with appropriate levels of care by community or local health workers, recognizing that some services may of necessity be at the national level.

The need to develop inter-sectoral relationships at community, district and national levels was stressed. The commitment of the government is a sine qua non of success. It may be necessary to proclaim regulations or change existing laws to effect program goals.

Both speakers noted the importance of government commitment in support of the PHC program. This commitment must be complemented by community involvement from planning through to implementation. Of note was the panelists' observation that donors, often with the best of intentions, may support a project that is so grandiose and expensive that it does not lend itself either to replication, nor to host country support after donor funding expires. Additionally, donors should be careful not to insist on evaluations that the host country is physically incapable of carrying out. The need for data collection from various levels of the delivery system is imperative - both to provide information as to how the program is progressing as well as to identify potential training needs for health.

Dr. B.S.F. Adjou-Moumouni spoke in general terms of the various types of training available through the WHO/SHDS program based in Lome. A variety of courses are offered to all levels of health workers, including nutrition, environmental sanitation, MCH, and EPI.

Dr. Moumouni described the WHO training program at Lome. It is a resource to the 20 West African countries. Priority is given to those countries that have committed themselves to a national PHC effort. Dr. Moumouni indicated that he would like participating governments to identify the role candidates will fill in the government health system after their training at Lome. The hope is that students will return to trainer roles. Alas, so often this is not the case.

The pharmaceutical needs of PHC were discussed. Acute drug shortage at every public health service level seriously affects maintenance and expansion of health services, such as those provided by Village Health Workers (VHW). Effective drugs such as chloroquine and antibiotics are largely unaffordable to the rural poor. Supplies are highly controlled by a handful of pharmaceutical firms that have monopolies or patent and licensing systems. In some countries the drug distribution services of the Ministry of Health are already heavily indebted. Distribution systems for the periphery is seriously hampered by fuel shortages, lack of peripheral warehouses and poor maintenance of vehicles. There is waste, overprescription and generally bad utilization of these scarce resources.

It was recommended that:

1.) The PP for each A.I.D. funded PHC program should include a study of the national drug supply systems.

2.) UNICEF should be used as the major supply source for PHC pharmaceuticals. This might require A.I.D. policy changes with regards to source waivers and advance payment into UNICEF bank accounts for some countries.

3.) Information about drug supply systems should be shared amongst the U.S.A.I.D. Missions. The Sahel Development Program Team (SDPT) Bamako was suggested as a possible resource for this purpose.

G. EVALUATION

Summary:

Evaluation emerged as a hotly debated topic. While there was consensus that evaluation is essential and sorely lacking, the group could not agree precisely on what evaluation should consist of and how it should be done. The group discussed the evaluation framework paper developed in AID/W. The general consensus was that it provided a very useful conceptual framework, but would have to be reinforced by "on-the-ground" practical guidelines which could be used in-country. The group suggested that AID/W assist them in developing practical models and especially in synthesizing and circulating evaluations already done.

Other major points were that evaluation methodology is not very highly developed for African health projects; evaluations are absolutely essential if we are to benefit from experience and answer the many complicated technical questions; and built-in project monitoring is probably more useful than pinpoint evaluations because it provides a good management tool.

The group recommended that:

1.) Evaluations should be based on agreed-upon objectives of host country governments and A.I.D.

2.) Evaluation teams should not be "parachuted" from the U.S. into countries without explicit prior consent.

3.) A.I.D. should be sensitive to the delicate political issues that "evaluation" poses for many countries, especially if objectives have not been defined.

4.) AID/W should assist the field in determining both intermediate and impact indicators that will be useful.

H. ADMINISTRATIVE ISSUES

Summary:

The conference delved into the many A.I.D. administrative problems posing impediments to the health programs. The main points and recommendations are summarized as follows:

1.) Lack of field AID/W communication:

This common complaint underlined the frustration of trying to obtain quick AID/W response to field requests. The participants concluded that the underlying problem is a combination of the lack of support personnel and a number of faulty communication channels. The lack of a mechanism for synthesizing field needs and comments is equally important.

AFR/DR representatives suggested that field officers make better use of the DR/Health office and be careful not to by-pass their assistance, especially for the approval of technical consultants.

The second aspect of this poor communication is the development of regional or central projects without adequate field input, resulting in confusing and poorly adapted projects. This universal complaint focused especially on the preparation of the CCCD Project. AID/W representatives suggest that a recent decision to submit all project proposals to the field for comment prior to approval will help. Finally, field officers congratulated the central bureaus for development of catalogues of resources and stated that regional and central bureaus should attempt to be more responsive to field requests for clarification of the use of these projects.

2.) Lack of information:

The need for technical information guidelines was discussed in several sessions. The participants discussed the lack of a good mechanism to share field experiences. It was agreed that the Health Officers' Conference was a good partial solution. This need reflects the initial stage of many of the health projects in Africa. It was suggested that conferences be developed to study certain problems in-depth, such as primary health care. There was a suggestion that field officers circulate information among themselves and to AID/W on topics of particular interest. The participants did not come up with a mechanism to do this, but suggested the utility of REDSO/WA and the Sahel Development Planning Team as important resources.

3.) Technical Assistance Problems:

Most field officers cited serious problems with consultants. The selection process (AID/W based, not enough field control) and the problem (U.S. consultant overload vs. the small number of trained host country counterparts) raised questions of what A.I.D. policy should be on this.

The field recommended that they be given more control (or at least information) over the contracting process. It was recommended that draft contracts be sent to the Mission before they are signed. AFR/DR representatives reiterated that they can be of more assistance in contractor selection if Missions do not by-pass them in selecting contractors.

It was recommended that, when possible, consultant selection should favor Africans, and that U.S.A.I.D.s should also tap other non-Americans with experience in Africa. Increased emphasis on counterpart training was suggested as a solution to the current imbalance of expatriates vs. host country nationals.

4.) Project Development and Management:

The recurring themes of poor project design and management were discussed in this conference. Participants noted very serious problems resulting from design of projects by U.S. "parachute teams" often with little input from the host country. Participants cited the resulting misunderstandings that have undermined a number of projects. The general recommendation was that project design be longer, more rigorous and based on host country input.

U.S.A.I.D.s noted that the current 2-3 year approval process is extremely detrimental to implementation of projects. Consequently, many field officers have turned to use of the AIP.

AFRICAN HEALTH OFFICERS CONFERENCE
December 8 - 13, 1980
Hotel du Golf, Abidjan

Name	Country/Organization
Dr. B.S.F. Adjou-Moumouni Health Officer World Health Organization GENEVA, Switzerland	WHO
Mr. E. Ofori Akyea Program Officer UNICEF ABIDJAN, Ivory Coast	UNICEF
Mr. Edward E. Anderson, Jr. Deputy Director Agency for International Development American Embassy MONROVIA, Liberia	LIBERIA
Ms. Mary Ann Anderson Nutrition Advisor DS/N Agency for International Development Department of State WASHINGTON, DC 20523	U.S.A.
Mr. Clifford Belcher Health, Population, Development Officer Agency for International Development American Embassy KINSHASA, Zaire	ZAIRE
Mr. Silvio Berthoud Health Expert African Development Bank ABIDJAN, Ivory Coast	AFDB
Ms. Tura Bethune Health Development Officer Agency for International Development American Embassy YAOUNDE, Cameroon	CAMEROON

Name	Country/Organization
Ms. Abby L. Bloom Senior Health Policy Analyst PPC/PDPR/HR, 3869 NS Agency for Interrational Development Department of State WASHINGTON, DC 20523	U.S.A.
Dr. Richard Brown Chief Health Officer Agency for International Development American Embassy YAOUNDE, Cameroon	CAMEROON
Mrs. Gladys Carrol Nutritionist Ministry of Health FREETOWN, Sierra Leone	SIERRA LEONE
Mr. Joseph Carter Health Planner African Development Bank ABIDJAN, Ivory Coast	AFDB
Mr. Arjuma Abayomi Cole Health Development Officer Agency for International Development American Embassy MOGIDISHU, Somalia	SOMALIA
Mr. James R. Cummiskey Health & Population Officer AFR/RA, Room 3325 NS Agency for International Development Department of State WASHINGTON, DC 20523	U.S.A.
Dr. Charles Debose Senior Health Advisor AFR/DR/HN, Room 2497 Agency for International Development Department of State WASHINGTON, DC 20523	U.S.A.

Name	Country/Organization
Mrs. Mary Friedel Diop Program Assistant Agency for International Development American Embassy P.O. Box 49 DAKAR, Senegal	SENEGAL
Ms. Mellen Duffy Nutrition Officer REDSO/WA Agency for International Development American Embassy P.O. Box 1712 ABIDJAN, Ivory Coast	IVORY COAST
Mr. Paul Ehmer Public Health Advisor Agency for International Development American Embassy P.O. Box 9130 DAR ES SALAAM, Tanzania	TANZANIA
Mr. Lawrence Eicher Project Manager Health, Population, Nutrition Office Agency for International Development P.O. Box 1630 ACCRA, Ghana	GHANA
Mr. Gordon W. Evans Director REDSO/WA Agency for International Development American Embassy P.O. Box 1712 ABIDJAN, Ivory Coast	IVORY COAST
Dr. Joseph Foumbi Medical Officer Public Health Department Ministry of Health YAOUNDE, Cameroon	CAMEROON
Dr. Thomas W. Georges Health Advisor AFR/DR/HN, Room 2497 Agency for International Development Department of State WASHINGTON, DC 20523	U.S.A.

Name	Country/Organization
Mr. Harry Godfrey Operations Officer Center for Disease Control c/o Institut d'Hygiene ABIDJAN, Ivory Coast	IVORY COAST
Ms. Mary Harvey Assistant Director Strengthening of Health Development Systems American Embassy P.O. Box 1712 ABIDJAN, Ivory Coast	IVORY COAST
Mr. Lawrence Heilman Deputy Director for Technical Services AFR/DR, Room 2495 Agency for International Development Department of State WASHINGTON, DC 20523	U.S.A.
Mr. Albert E. Henn Director, Health, Nutrition and Population Office Agency for International Development American Embassy P.O. Box 9130 DAR ES SALAAM, Tanzania	TANZANIA
Dr. George Jones Regional Health Officer REDSO/WA Agency for International Development American Embassy P.O. Box 1712 ABIDJAN, Ivory Coast	IVORY COAST
Dr. Nellie Kanno Professor University of Massachusetts Bedford Court Amherst, Massachusetts 01002	UNIVERSITY OF MASSACHUSETTS
Dr. Peter Knebel SDPRO Public Health Advisor for the Sahel Agency for International Development American Embassy P.O. Box 34 BAMAKO, Mali	MALI

Name	Country/Organization
Dr. James Maneno Asst. Director of Medical Services Ministry of Health P.O. Box 30016 NAIROBI, Kenya	**KENYA**
Mr. John P. McEnaney Health Development Officer Agency for International Development American Embassy NIAMEY, Niger	**NIGER**
Dr. Mary Ann Micka Health Officer Agency for International Development American Embassy P.O. Box 699 KHARTOUM, Sudan	**SUDAN**
Mr. Abdul J. Mohamed Chief, Health and Education African Development Bank ABIDJAN, Ivory Coast	**AFDB**
Mr. Thomas Moser AID Representative Agency for International Development American Embassy BANJUL The Gambia	**THE GAMBIA**
Ms. Linda Neuhauser Health Officer Agency for International Development American Embassy P.O. Box 222 NOUAKCHOTT, Mauritania	**MAURITANIA**
Dr. Samuel Ofosu-Amaah Health Officer World Health Organization GENEVA, Switzerland	**WHO**
Mr. Thomas Park Public Health Officer Agency for International Development American Embassy P.O. Box 34 BAMAKO, Mali	**MALI**

Name	Country/Organization
Ms. Joy Riggs-Perla Assistant Regional Health Development Officer Agency for International Development American Embassy P.O. Box 750 MBABANE, Swaziland	SWAZILAND
Mr. Robert R. Robertson Health Development Officer Agency for International Development KIGALI, Rwanda	RWANDA
Mr. Leonard H. Robinson, Jr. Director, International Development Study Center Battelle Memorial Institute (HARC) 2030 M. St., N.W., Suite 700 WASHINGTON, DC 20036	BATTELLE MEMORIAL INSTITUTE
Dr. Stephen Robinson Public Health Physician CARE P.O. Box 246 MONROVIA, Liberia	LIBERIA
Dr. Ebrahim M. Samba Director, WHO Onchocerciasis Programme P.O. Box 549 OUGADOUGOU, Upper Volta	WHO
Mrs. Mary Shea Peace Corps Medical Officer American Embassy P.O. Box 1712 ABIDJAN, Ivory Coast	IVORY COAST
Dr. John B. Slattery Acting Chief, Health, Nutrition & Population Division Agency for International Development Box 30261 NAIROBI, Kenya	KENYA
Mr. Edgar A. Smith Chief, Malaria Division, DS/HEA Agency for International Development Department of State WASHINGTON, DC 20523	U.S.A.

Name	Country/Organization
Mr. Hadley E. Smith Chief, PADS REDSO/WA Agency for International Development American Embassy P.O. Box 1712 ADIBJAN, Ivory Coast	IVORY COAST
Dr. James Sonnemann Health Planner Agency for International Development American Embassy LOME, Togo	TOGO
Dr. Joe L. Stockard Medical Officer AFR/DR/HN Agency for International Development Department of State WASHINGTON, DC 20523	U.S.A.
Dr. B. Teoume-Lessane Health Expert African Development Bank ABIDJAN, Ivory Coast	AFDB
Ms. Donna J. Tesi Health Consultant Peace Corps American Embassy P.O. Box 1712 ABIDJAN, Ivory Coast	IVORY COAST
Mr. Richard L. Thornton Population Officer Agency for International Development American Embassy KINSHASA, Zaire	ZAIRE
Mr. William Trayfors Chief, Population Division AFR/DR/POP Agency for International Development Department of State WASHINGTON, DC 20523	U.S.A.

Name	Country/Organization
Dr. Morris Weiss Health Officer Agency for International Development P.O. Box 1630 ACCRA, Ghana	GHANA
Mr. Michael White Health Advisor CLLSS OUAGADOUGOU, Upper Volta	UPPER VOLTA

AGENDA

SECOND A.I.D. AFRICAN HEALTH OFFICERS CONFERENCE

ABIDJAN, DECEMBER 8-13, 1980

Monday, December 8

a.m.

10:30-12:30 Registration

p.m.

02:30-04:00 Registration

04:00-05:30 Opening Plenary Session

Welcome:

Mr. Gordon W. Evans, Director, REDSO/WA

Mr. Lawrence Heilman, Deputy Director for Technical Services, Office of Development Resources

Dr. Thomas N. Georges, Principal Health Advisor, Bureau for Africa

Opening Address:

Dr. Ebr. .im M. Samba, Director, Onchocerciasis Control Program

Orientation to Conference:

Dr. George Jones, Health Officer, REDSO/WA

Tuesday, December 9

a.m.

08:30-10:30 Plenary Session

Dr. Michael White, Chairperson: Dr. James Sonneman, Rapporteur

Tuesday, December 9

	Onchocerciasis, Schistosomiasis, Trypanosomiasis: Dr. Joe Stockard
	Control of Communicable Diseases: Dr. Samuel Ofosu-Amaah
	Malaria Assistance Strategy: Dr. Joe Stockard
	General Discussion
10:30-10:45	Coffee Break
10:45-12:30	Special Group Sessions
	Room 1: Malaria Strategy and Planning: Mr. Edgar A. Smith and Dr. Joe Stockard
	Room 2: AID/AFR/RA Disease Control Programs, CCCD, etc.: Mr. James R. Cummiskey
	Room 3: Logistics, Management, Cold Chain: Mr. Harry Godfrey, CDC/SHDS
12:30-02:30	Lunch

p.m.

02:30-04:00	Plenary Session
	Status of Nutrition in Africa: Ms. Mellen Duffy, Chairperson; Mr. John B. Slattery, Rapporteur
	The Nutrition Situation: Ms. Gladys Carrol
	Issues of Food Supply and Behavior: Ms. Nellie Kanno, Univ. of Mass.
	Resources for U.S.A.I.D. Missions: Ms. Mary Ann Anderson, DS/N
	General Discussion
04:00-04:15	Coffee Break

Tuesday, December 9

p.m.

04:15-05:30	Special Group Sessions Room 1: Oral Rehydration: Ms. Linda Neuhauser Room 2: Infant Weaning Food: Ms. Gladys Carrol Room 3: Nutrition Education Tools Including Growth Charts: Ms. Mary Ann Anderson
06:30-08:00	Cockcail/Social Chez Mr. & Mrs. Gordon Evans (Transportation to be provided)

Wednesday, December 10

a.m.

08:30-10:30	Plenary Session Population/Family Planning Programs in Africa: Mr. Thomas Parks, Chairperson; Richard L. Thornton, Rapporteur Demography and Health Planning: Dr. Carole Tyson, AFR/DS/POP An Integral Part of Health Services: Dr. Samuel Ofosu-Amaah, Ghana Non-Governmental Organization Programs: Mr. Leonard H. Robinson Jr., Battelle General Discussion
10:30-10:45	Coffee Break
10:45-12:30	Field Views and Experience - Panel Mr. William Trayfors, Chairperson; Dr. Richard Brown, Thomas Park

Wednesday, December 10

p.m.

12:30-02:30	Lunch
02:30-04:00	Special Group Sessions
	Room 1: Malaria Strategy and Planning: Mr. Edgar A. Smith and Dr. Joe Stockard
	Room 2: AID/AFR/RA Disease Control Programs, CCCD, etc.: Mr. James R. Cummiskey, Ms. Mary Harvey.
	Room 3: Logistics, Management Cold Chain: Mr. Harry Godfrey, CDC/SHDS
04:00-04:15	Coffee Break
04:15-05:30	Special Group Sessions
	Room 1: Oral Rehydration: Ms. Linda Neuhauser
	Room 2: Infant Weaning Food: Ms. Gladys Carrol
	Room 3: Nutrition Education Tools Including Growth Charts: Ms. Mary Ann Anderson

Thursday, December 11

a.m.

08:00-10:30	Plenary Session
	Primary Health Care - Integration of Health Services: Ms. Turra Bethune, Mr. John McEnaney
	What, How and Why Integration: Dr. Joseph Foumbi, Cameroon.
	Planning and Administration: Dr. James Maneno, Kenya
	Training: Dr. B.S.F. Adjou-Moumouni, WHO Regional Training Center, Lome

Thursday, December 11

a.m.

10:30-10:45	Coffee Break
10:45-12:30	General Discussion
12:30-02:30	Lunch

p.m.

02:30-04:00	Plenary Session Ms. Mary Diop, Chairperson, Ms. Abby Bloom, Rapporteur Progress Report on Evaluation of Primary Health Care, Dr. Joseph Foumbi, Cameroon; Dr. Charles DeBose, AFR/DR/HN
04:00-04:15	Coffee Break
04:15-05:30	Open Discussion

Friday, December 12

a.m.

08:30	Field Observation Institute of Hygiene, Treichville (Optional), EPI activities, SHDS Activities, In Context of IH Service Special Group Sessions Room 1: Country Health Strategy, CDSS for Health: Mr. Paul Ehmer, Dr. Albert E. Henn Room 2: VHW Manual, Pharmaceuticals: Dr. Peter Knebel; Dr. Michael White Room 3: Nutrition Component of PHC: Detail of Content for Total Systems; Ms. Mellen Duffy
12:30-02:30	Lunch

Friday, December 12

p.m.

02:30-04:00	Self-Directed Activities
	Interviews, Consultation with:
	Resource Persons, REDSO/WA Staff, AID/W Staff
04:00-04:15	Coffee Break
04:15-05:30	Special Group Sessions
	Room 1: Country Health Strategy, CDSS for Health: Mr. Paul Ehmer, Dr. Albert E. Henn
	Room 2: VHW Manual, Pharmaceuticals: Dr. Peter Knebel; Dr. Michael White
	Room 3: Nutrition Component of PHC: Detail of Content for Total Systems; Ms. Mellen Duffy
07:00	Closing Remarks, Dr. Thomas N. Georges
Dinner	Health Officers/Resource Persons
	Expressions of Thanks to Resource Persons
	Evaluation of Conference: Mr. John P. McEnaney

Saturday, December 13

a.m.	African Health Officers Staff Conference
08:30	Recent Developments in AID Organization Affecting Health Development in Africa
	Exchange on Administrative and Management Concerns of Field Staff
	Dr. Thomas W. Georges, AFR/DR/HN
	AID/W and AID/Field Staff
12:30	Lunch