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Family Health Care, Inc.

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**PROGRESS REPORT ON THE  
HEALTH/WATER/NUTRITION COMPONENT  
OF THE SAHEL DEVELOPMENT PROGRAM**

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## I. INTRODUCTION

### A. Background

Since the severe drought of the early 1970's which attracted international attention and brought massive relief assistance to the Sahel region of West Africa, an unusual effort at multilateral planning and coordination of international assistance has been undertaken by the donor community and the Sahelian countries. The mechanism created for this effort is the Club du Sahel, an informal forum which brings together major donor countries and international organizations active in the Sahel, and the eight member countries of the CILSS.\*

Their goal is to avoid a return to the precarious living conditions of pre-drought times, and has been expressed as two-fold: long-term, comprehensive socio-economic development for the region; and in particular, the achievement of regional food self-sufficiency by the year 2000.

In the process of developing a global development strategy for the Sahel, the Club called for sector strategies which would focus on specific areas of economic production and infrastructure. At the same time it was recognized that a special area of major need was usually neglected and yet should be uppermost in the minds of development planners: human health and the related problems of water and nutrition. Because of this concern a separate

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\* French acronym for the Permanent Interstate Committee for Drought Control in the Sahel, whose members are the Cape Verde Islands, Chad, the Gambia, Mali, Mauritania, Niger, Senegal and Upper Volta.

strategy was developed which addressed "health/ water/nutrition in the context of harmonious socio-economic development in the Sahel."

The purpose of this FHC report is to outline the progress made in promoting and implementing the CILSS/Club strategy for health since its adoption in early 1977, and to analyse possible future directions for the CILSS, the Club and AID in the health/water/nutrition sector.

A rather major increase in interest and activity has been taking place in the area of primary health care as witnessed by the large number of new health projects currently underway or under discussion in the Sahel. More importantly, the last several years have seen the beginning of a shift in health policy on the part of most Sahelian governments and donor organizations, toward greater emphasis on primary care. The September, 1978 primary health care conference sponsored by WHO and UNICEF at Alma Ata in the Soviet Union, is a significant example of the current world-wide interest on the subject. It came as the result of several years of public thought and dialogue on health and its relation to development, and involved high level policy and planning officials from participating nations. Some of the Sahel countries have also undergone the WHO country health programming exercise in the last two years (Cape Verde, Gambia, Upper Volta), and all have participated in several regional conferences dealing with primary health care (Niger, January 1977 for the Sahel, and Brazzaville, March 1977, among others), as preparation for Alma Ata.

The role of the CILSS/Club in the health sector will be outlined in Section II of this report. Section III will trace briefly the activities of AID in relation to the CILSS/Club and to other health activities in the Sahel. Section IV will address the likely future developments and their implications for AID programming.

**B. Recommendations**

The CILSS Public Health Advisor and supporting donor organizations such as AID can take advantage of the present increased interest in the problems of health, and play a crucial role in coordinating and promoting efforts in this sector. Three areas of activity are discussed in Section IV of the report, highlighted here:

**1. First Generation Projects**

- o Increased discussions among donors, aimed at stimulating greater interest in multilateral participation in priority health projects.
- o Technical assistance to the CILSS member countries in health sector analyses and in project design activities.
- o Technical assistance to the CILSS member countries in the form of regional conferences on specific technical subjects.

**2. Long-Term Planning**

- o Realistic, step-by-step planning for the implementation of the CILSS/CLUB health strategy
  - Reference to the basic themes of the strategy
  - Reference to the special needs and different stage of development of each country.
- o Information exchange, "mobile seminars"

- o Complementary planning areas: health manpower, evaluation of village based health programs, etc.

3. Coordination with Other Development Sectors

- o Completion and utilization of the CILSS/Health/Ecology health impact guidelines.
- o Active communication with and participation in project design activities in other sectors.

In addition, demographic research activities are starting up at the Sahel Institute and should develop in complementary ways to the needs of the CILSS health unit.

## II. A BRIEF REVIEW OF CILSS/CLUB HEALTH SECTOR ACTIVITIES

### A. Development of a Health/Water/Nutrition Strategy

At its first meeting in Dakar in March, 1976 the Club du Sahel charged a Working Group with preparing a long-term strategy aimed at achieving food self-sufficiency for the Sahelian countries by the year 2000. To address the human element within the overall development program, a Human Resources Team was established as part of this group.

As the team began its work, it became evident that improvement of the health status of the people of the Sahel was one of the major problems to be addressed. Further, it was agreed to target health as an integral part of the development strategy, because the improvement of the quality of life would presumably contribute to an increased capacity for production, and this was another means to facilitate progress toward the ultimate goal of food self-sufficiency.

A subgroup of the Human Resources Team, the Health Commission, was then organized and assumed the responsibility of defining a broad strategy for health/water/nutrition within the framework of socio-economic development in the Sahel. This strategy was prepared during the spring of 1977 through a collaborative process involving consultation with technical people from the Sahel and from the international community (Appendix 1: Summary Health Strategy).

In developing the strategy the Health Commission took cognizance of the fact that health and other social service

investments tend to be much smaller than investments in other sectors. They also tend to reinforce the existing, urban and hospital-based systems of health care which, based largely on Western models, serve only a small segment of the population. The rural masses, which constitute 80% of the Sahelian population, have little or no access to services of any kind.

The strategy therefore focusses on the most basic needs of the rural populations and attempts to make maximum use of the limited financial and personnel resources found in the Sahel. It is a strategy which links health directly to socio-economic development, both in terms of increasing the availability and accessibility of basic health services per se, and of monitoring the potential negative impact on health of the various development programs being mounted through the Club du Sahel. It also seeks to enhance the positive effects on health by promoting the integration of health/water/nutrition components into development projects.

The health-water-nutrition strategy calls for a complete reorientation of current health policies whereby a centrally organized and managed structure would become more decentralized and more dependent upon the active participation of the populations. The government health infrastructure would be strengthened, primarily to provide technical support, supervision and referral capability to the most peripheral services.

Five major program components are put forward in the strategy:

- o development of basic health services at the village level, provided by village health workers and consisting of a range of health promotive, disease preventive and simple curative functions;
- o endemic disease control, enhanced by the fact that village health workers are in place and can participate in expanded programs of immunization and in other special campaigns;
- o environmental sanitation and water, involving simple environmental improvements and organization of the community to assist in the acquisition and maintenance of a safe water supply as part of the health promotive functions of the village health worker.
- o nutrition: An improvement in the nutritional status of the Sahelian population, especially of mothers and children, is dependent upon the local availability of a sufficient quantity of food. Better exploitation of existing foods and better methods of preserving and transporting food are also important. The village health worker can be trained in very basic nutritional surveillance and nutrition education.
- o demographic and health planning: Development of adequate information systems, so essential to planning health and other sector development, can begin with the use of village health workers in the development and collection of health and vital statistics.

In summary, the health-water-nutrition strategy calls for basic health services to extend to the village, with the community taking a primary role in the delivery of these services. It also suggests broad guidelines for the reorientation of present policies and programs.

The CILSS/Club strategy for health stresses the need to integrate planning in the health sector with planning for socio-economic development in other sectors. This

means identifying ways to enhance health benefits as well as ways to prevent or minimize any possibly negative impacts on health of activities in non-health sectors.

B. The Role of CILSS and the Club in the Implementation of the Health/Water/Nutrition Strategy

1. First Generation Program

Meeting in May, 1977 in Ottawa, the Council of Ministers of the Club du Sahel officially adopted the health strategy, along with the global strategy for development of the Sahel.

In addition, the Club reviewed and adopted some 600 sector projects proposed by the CILSS member countries as priority activities for funding. These projects became known as the First Generation Program. The Club recommended the "highest priority should be given to the completion of work of first generation projects..." and charged the CILSS and Club Secretariat with facilitating the funding and implementation of this program.

In order to further the first generation projects in health-water-nutrition, to provide longer-term planning for the implementation of the strategy, and to carry out the task of coordinating the work of the health sector with the other sectors, it was decided to create a health planning unit at the CILSS. Support for a Public Health Advisor to work within the CILSS Division of Projects and Programs, as well as technical assistance for the development of a sector workplan, were requested from AID. The Public Health Advisor was identified and a workplan

prepared in the fall of 1977. In order to accelerate the execution of the sector workplan, an Interim Advisor was also requested and assigned to the Secretariat in early 1978.

The Human Resources Team met in Niamey in March, 1978 to update the human resources portfolios; at this time the health sector workplan was approved. The Interim Health Advisor then began organizing country visits, and during the spring and summer technical teams traveled to each of the CILSS member countries to work with Sahelian officials in the refinement and completion of the first generation project portfolios. (Appendix 2: First Generation Project Visits, and Appendix 3: First Generation Health projects)

In addition to preparing the documents for projects needing funding, the teams were charged with taking an inventory of all national and regional health/water/nutrition projects supported by external assistance. (Appendix 4: Status Report on Donor Activity). They also gathered data for the updating of summary health profiles, and as much information as was available for preparation of the complete country portfolios, and for a beginning reference library for CILSS (Appendix 5: Bibliography). Throughout the missions these technical teams stressed the CILSS/Club health strategy as the principal criterion by which the first generation projects were to be reviewed by the donor community, and initiated a dialogue wherever possible on the implications of that strategy. They encouraged the Sahelian officials to rethink the projects wherever they

were not found to be in keeping with the basic thrust of the strategy or falling under one of its major themes.

These country visits were the first formal contact since early 1977 between a CILSS representative and member country health officials, and often the first ever between CILSS and local donor agency representatives. The contacts revealed a general lack of awareness and understanding of the role and activities of the CILSS/Club and of its strategy for development. They also revealed a certain impatience toward the lack of concrete evidence that CILSS could effectively and quickly acquire funding for first generation projects; CILSS had yet to establish its credibility in the health sector. The establishment of working relationships between the CILSS Health Commission and the member states, as well as between CILSS and other organizations acting in the Sahel was therefore one of the principal tasks of the Interim Health Advisor and the other members of the technical teams.

During August and September of 1978 the project portfolios were prepared at the CILSS Secretariat and transmitted to the Club in Paris for distribution to the donor community. At the end of September the CILSS/Club Human Resources Team met with representatives from the CILSS member states and from the donor community to review the projects and to determine donor interest in supporting them.

Although the consultation with the donors brought about some useful dialogue on the first generation projects,

which were strongly defended by the CILSS country representatives, the attendance of bilateral donor representatives was somewhat disappointing (Appendix 6, list of participants at Niamey). Organization of the meeting had not allowed enough time for proper review of the project portfolios ahead of time by all donors; consequently some of them refused to come. One a more positive note, some non-governmental organizations, which are responsible for extensive work in the area of health-water-nutrition throughout the Sahel, were represented for the first time at these donor consultations. Also the enthusiastic presence of CILSS country representatives should lead to their greater participation in the future in CILSS activities.

## 2. Coordination with other Sectors

During the same period, beginning in the late spring of 1977, a collaborative effort was begun with the CILSS Ecology Unit to develop health impact guidelines for other sector projects and programs. The guidelines will enable project designers in agriculture, livestock, fisheries, forestry, etc. to make early identification of possible negative impacts of development efforts, and to make informed decisions concerning which project design options could reduce the harmful effects on human health. The guidelines will also show how nonhealth projects can be designed to have a maximum beneficial effect on the health of the populations they will serve.

The guidelines were discussed in their most preliminary stages with officials from WHO (Geneva and Ouagadou-

gou), the Onchocerciasis Control Program, and the World Bank. The first drafts were also reviewed in detail with the technicians at CILSS (October 1978), and are currently undergoing revisions and refinement. Appendix 7 provides an outline of the guidelines in their most recent revised form.

### 3. The Sahel Institute

The Sahel Institute, which was created by the CILSS to stimulate research and training for long-term development in the region, has established a program of activities with implications for the implementation of the health strategy.

At a donor meeting held in Ouagadougou in October 1977, a committee charged with reviewing the start-up activities of the Institute approved amended terms of reference for the establishment of a demographic research program within the Socio-Economic Unit. This program is in direct response to one of the five major themes of the health strategy calling for "the study of the impact of demographic phenomena and, in particular, the migratory movements and the growth of populations."

The committee recommended that a program coordinator be recruited to prepare an outline of an overall demographic program for review by a meeting of Sahelian demographers and planners. A coordinator was subsequently identified and began work on May 2, 1977. Following initial assessment missions to the CILSS member countries he convened a meeting in Bamako October 12-14 to discuss

his findings, to recommend program outlines and to solicit the interest of various donors.

For a more detailed chronology of activities in the CILSS/Sahel Institute health sector see Appendix 8.

### III. THE ROLE OF AID IN THE IMPLEMENTATION OF THE CILSS/ CLUB HEALTH STRATEGY

AID's involvement in the implementation of the Sahel health strategy can be categorized in two general ways: assistance to the CILSS/Club and to the Sahel Institute in an effort to strengthen their research, planning and management capabilities, and activities which fall under the rubric of bilateral or regional programming.

#### A. Support to the CILSS/Club and to the Sahel Institute

##### 1. Health/Water/Nutrition Sector Activities

Since the Human Resources Team of the CILSS/Club Working Group decided to develop a health-water-nutrition-strategy for the Sahel in late 1976, AID has provided active leadership and support in this sector. Strengthened status for health within the Club Working Group coincided with priorities already defined by AID. In the late Fall of 1976, a Health/Nutrition/Population Sector had been established within the Sahel Development Program (SDP), reflecting the priority accorded to these areas. SDP played an influential role in the development of the health strategy by submitting to the CILSS/Club Health Commission a background paper entitled "A Strategy for Health as a Component of the Sahel Development Program".\* This document was then synthesized with a paper prepared by a WHO staff member to constitute the CILSS health strategy.

\* Scheyer, S.C. and S.C. Joseph, Family Health Care, Inc., under contract to AID, May 1977.

After the adoption of the strategy by the Club du Sahel in May of 1977, AID continued to support the promotion of the strategy through the CILSS/Club mechanism. In the late summer of 1977 CILSS requested AID to identify and support a Public Health Advisor at the Secretariat in Ouagadougou. A physician was identified and recruited to begin work in mid-1978. In order to move forward with activities in the sector, AID sponsored the development of a sector workplan, prepared in November 1977 by CILSS with the assistance of a team of consultants. AID then provided the Interim Public Health Advisor in February 1978 to begin implementing the workplan.

The support of the SDP to the CILSS for policy and planning activities in health/water/nutrition has clearly generated interest in this sector which was not evident in the early days of the Club Working Group. AID's sustained commitment over the past 2 years to the preparation and promotion of a comprehensive health strategy has made possible an increased dialogue among Sahelian countries and among the donor community. The dialogue has revealed a new awareness of health as a key part of integrated development. It has increased awareness that where health interventions are made in the context of overall development plans, they can enhance other social and economic investments. Discussion has also revealed some significant changes in attitude toward what long-term health policies should be. There seems to be a greater concern for, and

allocation of resources to, the rural populations. In spite of the highly centralized structure of most of these governments, there is evidence of some of the administrative reforms and shift toward decentralization required to provide services at the village levels.

## 2. Ecology Guidelines

Through the same contract for technical assistance to the CILSS, AID/SDP provided support for the preparation of the health impact guidelines which are currently at the final draft stage. This effort complements other AID activities relating to environmental and public health impact assessments in development planning for the major Sahel river basins: the Organization for the Development of the Senegal River Basin (OMVS), the Gambia River Basin and the Lake Chad Basin Commission.

## 3. Demography and Development Planning

The idea of including the "study of demographic phenomena" in the program strategy for the health sector was first introduced by AID at the health subgroup meeting held in Ouagadougou in December 1976. Following this meeting, AID was requested to propose a program designed to assist the Sahelian countries to incorporate demographic considerations into their development planning.

The proposal prepared by AID with the assistance of a contractor included support for the establishment of a demographic unit within the Sahel Institute as well as technical assistance to the Unit and CILSS member countries in the areas of demographic data collection, analysis, and

use. The program was endorsed by the health subgroup at its second meeting in Dakar in March 1977, and was incorporated into the Club health strategy. In addition, the program was included in the CILSS document on the Sahel Institute, prepared in May 1977 for the Council of Ministers' meeting of the Club du Sahel. The CILSS document identified as a short- to medium-term objective a program to encourage the use of demographic data in the design and implementation of development programs.

Since that time AID has continued to support the establishment of the demographic program which has evolved as part of the larger Socio-Economic Unit at the Sahel Institute. Start-up funding for the program, including support for the regional meeting of demographers and planners held in October 1978, was recently made available through the Sahel Regional Aid and Coordination Project (625-0911). In addition, at least a year of technical assistance is being provided by AID to the Institute through a contractor. The contractor will assist the socio-economic/demographic unit coordinator with an inventory of the current status of demographic data and collection capability in the CILSS member countries, and the development of an operational strategy for the promotion and implementation of an appropriate program. These will serve as the basis for a 3-year project of assistance by AID. Assistance is also available from the contractor to USAID Missions for the incorporation of a demographic component into AID projects.

The AID position on population planning is clearly in favor of promoting an understanding and acceptance of the relationship between socioeconomic development and population dynamics. It is hoped that the regional demographic activity will further sensitize Sahelian planners and donors alike to the importance of planning rational population growth and the need to formulate population policies based on reliable data.

B. Bilateral and Regional Programming

In addition to such direct institutional support to CILSS and the Sahel Institute, AID has provided funding for other regional health/water/nutrition activities. These investments are compatible with the regional CILSS/Club strategy and are themselves having a significant impact in focussing attention on the health sector and the changes taking place within it.

The primary thrust of AID assistance in the health sector is towards the establishment of village-based health systems. In Senegal, Mali and Niger important AID-financed projects are underway which aim at the extension of services to the rural poor through the mechanism of the village health team. Pilot projects are planned for Chad, Mauritania and Cape Verde, and a village-based health project is under discussion in Upper Volta.

AID projects are also promoting the integration of the other key components of the strategy into the health services structure: endemic disease control, water supply and environmental sanitation, nutrition, and capabilities

in demographic and health planning.

In addition, AID has encouraged the development of these program components in specific national and regional projects:

o endemic disease control:

- AID/WHO Strengthening Health Delivery Systems (SHDS) project - regional project involving the training of health personnel, provision of vaccines, upgrading of epidemiologic surveillance capability;
- Onchocerciasis Control Program (OCP) - regional project of disease/vector control in the Volta River basin

o environmental sanitation/water:

- Chad (FY 78)
- Upper Volta (FY 79)
- OECD rural water supply survey (FY 78)

o nutrition:

- The development of a strategy for a regional nutrition policy, early 1977, with valuable references on Sahelian food and nutrition systems; and a subsequent multisectoral nutrition planning workshop.
- Nutrition Survey: An ongoing nutritional survey funded by the SDP in Mali (through the OECD Development Center) seeks to increase understanding of caloric and protein requirements and food intake on age and sex-specific bases. A review session was held on this survey in Paris in mid-September, 1978.
- Nutrition research project in Upper Volta - the development and diffusion of weaning food recipes for rural women.

o demography and health planning:

- The SDP regional Demographic Data Collection and Analysis Project (625-09) will provide \$3.5 million beginning in FY '79 for support to the demographic research program which is being developed and coordinated by the Sahel Institute.

Other demographic activities on regional and national levels:

- Institute for Demographic Research and Training in Yaounde - AID-funded study focussing on infant mortality and its relationship to fertility in Ouagadougou and N'Djamena;
- Institute of Development and Economic Planning (IDEP) in Dakar - AID-sponsored study of the relationship between population trends and staple food production in the Sahel.

The CILSS/Club health strategy acknowledges that some Sahelian states are agreeable to small-scale family planning projects. AID continues to advocate family planning as an integral part of maternal and child health services, an approach also endorsed by the World Health Organization and potentially acceptable in the Sahel as a health promotive measure.

- o The Gambia: Maternal and child health project at Santa Cruz.
- o Mali: Family planning demonstration program as part of the 5-year rural health project.
- o Senegal: Bilateral family planning project in the Dakar/Cap Vert Region.

#### IV. FUTURE DIRECTIONS FOR THE CILSS/CLUB HEALTH SECTOR

In contrast to a very few years ago, the health and nutrition needs of the Sahelian populations are beginning to receive concerted attention in terms of long-range development planning, both from Sahelians and from the international donor community. A movement in the direction of health delivery systems which favor village-level services, which are designed to accommodate local resource restraints, and which still meet the basic health needs of most of the people, is now evident in all of the countries of the Sahel.

The preparation of a regional health/water/nutrition strategy added to the growing interest of both donor and Sahelian countries in redefining health policies. The process also resulted in establishing health as a priority sector within the Sahel Development Program. Numerous and sometimes sizeable investments in rural health projects, especially projects of the type recommended in the strategy, have also encouraged interest in non-traditional kinds of health care delivery.

Such trends should be built upon and encouraged since it is most likely to be these innovative, decentralized delivery systems, geared to the local needs and resources, that will begin to truly impact on the health status of the Sahelian populations. CILSS and the Club as the unique regional organizations that they are, can have a key role in this process.

A. The Future Role of the CILSS/Club

Three areas of activity will occupy the CILSS/Club Health Commission and the Public Health Advisor (PHA) over the next 1-2 years: the further promotion of the first generation program, the beginning of long-term planning activities, and the further refinement of the guidelines for determining the health impact of other sector projects, as well as the introduction of these guidelines into the planning process used in other sectors. In addition, the Coordinator of the Socio-Economic/Demographic Unit at the Sahel Institute will continue development of a regional research program.

1. First Generation Projects

The CILSS Public Health Advisor has the task of following through on the discussion and decisions related to the first generation program in health/water/nutrition made at the recent donor consultation in Niamey. In order to successfully mobilize adequate funding for the 29 projects from the eight CILSS countries, the Public Health Advisor might consider the following activities:

- o Further in-depth discussions with donors, to be arranged through the Club Secretariat, concerning their respective priorities for investments which will further the implementation of the strategy and the first generation projects. Several major donors were absent from the Niamey meeting, and it would appear that these contacts would be most useful.
- o Technical assistance to individual CILSS member states in performing health sector analyses, in undertaking project design and in fostering coordinated planning and project development among appropriate national officials and representatives of the donor agencies, especially to better elaborate the first generation projects. This technical

assistance would be carried out by the PHA and/or teams of consultants, in direct collaboration with the national CILSS committees.

- o Technical assistance to the CILSS member countries organized on a regional basis, for the purpose of further defining basic strategies for addressing specific problem areas common to the region as a whole. An example of this type of activity is the meeting of senior Ministry of Health technicians and regional technical organizations (OCCGE, OCEAC) to be held in early 1979 at the request of the CILSS member countries to map out in greater detail the planning and implementation of expanded programs of immunization (EPI).
2. Long-Term Development Planning for Health/Water/Nutrition in the Sahel. 1980-2000

The current focus on development and funding for the first generation program must not divert attention from the need for comprehensive, long-range planning. The strategy for health adopted at Ottawa is only a framework for guiding policy and program development aimed at the improved health of the Sahelian populations. As the dialogue on the strategy continues, thought must be given to the means of implementing it through a step-by-step process to be carefully and realistically programmed over the next twenty years. This implies decision on priorities and definition of specific targets for health improvements within each country and, to the extent possible, in the region as a whole. It is the responsibility of the Public Health Advisor to set this process in motion as soon as possible, especially since it constitutes a necessary prerequisite for the preparation of the second generation program.

One method of approaching this planning process is to organize action around the five major themes of the CILSS/Club strategy: village-based health systems, endemic disease control, nutrition, water and sanitation, and demographic and health planning. The initial objective would be to prepare long-range, regional "sub-plans" in each of these five areas which would subsequently be integrated to form an overall plan for health/water/nutrition in the Sahel. Based on this overall plan, regional and national projects would be identified for development.

At the same time, each CILSS country would be encouraged to begin the preparation of a national health plan for the year 2000, where such a plan does not already exist. National plans would provide the basis for more effective use of resources allocated to health, as well as a coherent local framework for the increasing number of activities of coordination, cooperation and assistance going on in the Sahel region. The Sahelian countries differ considerably in the extent to which their health policies are consistent with the CILSS/Club health strategy. In engaging in the process of stimulating long-term planning, CILSS can also facilitate the exchange of information between health officials and planners with long experience in developing village-based health systems, and those who are just beginning to formulate their policies for change.

One way to do this is by means of "mobile seminars", both within the Sahel region and outside, whereby Sahelian

policy makers have the opportunity to observe and discuss the experiences, both positive and negative, of other health services delivery systems. In any case, there is a clear need for further exchange of ideas and exploration of issues. As evidenced by discussions at the meeting in Niamey, Sahelian officials are more than ever ready to engage in these kinds of discussions.

In discussing and engaging in long-term planning activities, the CILSS Public Health Advisor should also be able to determine what complementary activities might be of most benefit to the planning process. For example, the question of current and future manpower and training needs in the health sector should be looked at on a regional level. If requests such as that of the CUSS for Upper Volta are receiving little response from the donor community, constructive alternatives should perhaps be proposed that address these perceived long-term needs.

Another area of importance (and which has been neglected to date) is the issue of evaluation of the village-based health system as it is being developed in the Sahel region. In a few years there will be a multiplicity of primary health care models, sometimes within the same region of one Sahel country (the Sine Saloum in Senegal, for example) and some will have become an integral part of national plans. It would be useful to find a methodology for evaluating these models.

Some of these activities might well be undertaken at the Sahel Institute, were the Socio-Economic/Demographic Unit will be concerning itself with research in the areas of village-based health systems, maternal and child health and traditional medicine. An advisor in "nutrition, health and development" has been recently recruited as part of the Unit's staff. Research activities at the Institute, and the development of evaluation methodologies, would be directly complementary to the needs of the technical units at the CILSS, including the health unit.

3. Coordination With Other Sectors

The development of guidelines which will assist project designers to integrate health considerations into development planning in other sectors has been discussed in Section II. Once the guidelines are in final form, the Public Health Advisor will be responsible, in collaboration with the Ecology Advisor, for promoting the use of these guidelines on an institutionalized, systematic basis. The draft guidelines will require extensive critique and revisions, and if appropriately and sufficiently utilized, will be the object of frequent modification and refinement in order to produce a tool useful to a wide variety of development planners in the Sahel.

In addition to diffusing and gaining acceptance for the guidelines, the Public Health Advisor may be called upon to provide technical input into activities related to

other sectors and carried out in conformity with the guidelines, for example, new lands development and the implications for health status and health services development, designing a nutrition education component for an agricultural project, participating with the livestock technicians in the design of a village water project to produce water for both human and animal consumption.

In general, increased communications between the PHA and other technicians, and increased participation of the PHA in other sector activities, are to be encouraged.

4. Demographic Research Program at the Sahel Institute

The Coordinator of the Socio-Economic/Demographic Unit of the Sahel Institute has been charged with follow-up to the regional demography meeting held in Bamako. One of his first tasks is to discuss the proposed program with potential funding sources. Over the next few months he will also begin recruitment of an interdisciplinary team of advisors who will provide technical services to the CILSS countries and who will monitor research activities and socio-economic/ demographic policies in all the Sahelian countries.

The Coordinator will direct an inventory of current demographic capability in the Sahel and the development of an operational strategy for the promotion and implementation of an appropriate program of research and training.

B. Implications for AID programming

AID has made an important commitment to participate actively in the support of long-term development in the Sahel through the mechanism of the Club du Sahel. Over the past two years the needs of the region as a whole and each of its eight countries have been further defined, and a consensus on an overall strategy for responding to those needs has been reached through the joint efforts of the CILSS countries and the major donor agencies. With the strategy as a framework, concrete action is now underway throughout the region to implement programs and projects phased over the next 20-30 years. AID, through the USAID representatives in each CILSS country, is fully engaged in this process and is structuring its activity at the level of the missions in a way that is maximally supportive of the overall development strategy of the Club du Sahel as it relates to the particular situation in each Sahelian country. By working within this collaborative structure which is the Club/CILSS, the USAID missions are able to participate with other donors both at the national and regional levels in the mobilization of vast resources to impact on the problems of development, and through that participation, to share information and avoid unnecessary duplication of effort.

In the health sector, AID support for the development of a Club/CILSS health strategy and program and its

bilateral and regional health programming have stimulated important new dialogues among Sahelian and donor health technicians. Without AID's efforts, and those of other donors, it would not now be possible to talk about long-term improvement in the health status of Sahelian populations, which has changed very little over the years in spite of sizeable investments in health services.

A description of AID activity in the sector has been presented in Section III. Given the development over the past year of a work program to be carried out under the guidance of the Public Health Advisor, it is appropriate at this time for AID to assess its current directions in light of what the CILSS/Club health sector has set about to do. As in Section III, AID assistance can be divided into two categories: institutional support to the CILSS/Club and the Sahel Institute, and bilateral and regional programming.

The final pages of this report propose several suggestions related to future AID support of health development in the Sahel. It is up to AID--specifically AFR/SFWA, SDP and the new Sahel Mission Directors Council (SMDC)--to consider these ideas and then determine how they might best be implemented through the field missions, with assistance from the SDP. Successful action on these ideas will depend greatly on the degree to which the Agency can modify its traditional programming processes to enable the missions to work more in concert with the CILSS/Club.

1. Support to CILSS and the Sahel Institute

AID should continue to provide the CILSS Public Health Advisor with the necessary technical assistance resources which will enable CILSS to act as a catalyst in regional health planning efforts. Some of the tasks which might be undertaken by AID or with AID's assistance:

a. First Generation Projects

- increased dialogue with its partners in the Club as a follow-up to the donor consultation in Niamey, to encourage greater participation by other donors in health/water/nutrition activities and to promote the practice of multidonor planning, especially at the national levels;
- provision of consultants to participate in multidonor project appraisal/design missions;
- preparation of background papers for the CILSS on specific technical issues related to project design (manpower, for example);
- preparation and holding of conferences such as the EPI meeting projected for the spring of 1979, which will foster national and regional planning efforts in technical areas related to the first generation program.

b. Long-Term Health Planning

AID should continue to support through the CILSS/Club mechanism the kinds of activities which will promote the development of long-term plans for health:

- study and analysis of basic issues relevant to the formulation of long range plans, i.e., health manpower, health expenditures, current and projected donor activity in the sector, etc.;
- identification of Sahelians and technicians from donor agencies who are available and able to work on long-term plans;
- organization of mobile seminars/exchange visits for host country officials;

- development of a timetable of activities including the identification of specific target dates for completion of tasks;
- organization of special workshops on health planning principles and methodologies using national, regional and international resources, e.g., SHDS project, WHO Institute for Health Planning in Dakar;
- if the Sahel Institute develops an evaluation methodology for primary health care programs, AID should assist as appropriate, incorporating lessons learned from USAID projects.

c. Coordination with Other Sectors

Continuing the same theme of coordination, the support AID provides to the CILSS can go far in promoting ongoing communications between health planners and other sector development planners. Concerning the health impact guidelines, AID should make a concerted effort to encourage their adoption and systematic use, with institutional backing from the CILSS and Club Secretariats. When a final draft of the guidelines is completed by the CILSS, it will be important to plan time on various meeting agendas to discuss their rationale and use in CILSS/ Club development planning.

AID should continue its efforts to integrate health/water/nutrition components when appropriate into nonhealth sector projects, to be carried out either on a bilateral basis or in direct collaboration with other donors. Rather than being perceived as trying to stall design efforts by undertaking environmental impact assessments, innovative approaches by AID to incorporating health

considerations into project design can sensitize other donors to the need for integrated planning.

d. Demographic Research Program at the Sahel Institute

Through a technical assistance contractor, AID is currently initiating the design of a three-year program of support to the Socio-Economic/Demographic Unit of the Sahel Institute for the development of a regional demographic program. It is important for AID to help the Institute establish its credibility as a coordinator/facilitator vis-a-vis the CILSS member countries. The October Bamako meeting of demographers and planners included presentations by country representative of current and planned demographic activities and resources which will be needed to undertake them. The results of this meeting should be widely diffused within AID, especially to the USAID Missions. Efforts should be made to increase the dialogue between the Missions and the country representatives to this conference in order that support for their planned activities can be appropriately incorporated into the 3-year AID regional project.

In addition, AID should be working to sensitize its staff to the importance of integrating demographic considerations into all its development projects. A methodology for doing this is currently being prepared with the assistance of a contractor.

2. Bilateral and Regional Programming

Most of the activities recommended for AID's continued support to the CILSS can also be promoted through the

USAID's bilateral and regional programs. The health officers and those involved in planning and managing AID rural health projects on a national level should be encouraged to evaluate and test those activities in light of the principles of the Sahel health/water/nutrition strategy, and conversely to test the strategy against local experiences. If the strategy is to have any ongoing relation to the realities of the Sahel, it will have to be continually reviewed against village-based health systems as they actually evolve. It will be important therefore to provide for the monitoring of these systems beginning with the design phase, and to assess their impact, initially on attitudes and practice as they relate to health and ultimately on the health status of the population. If these evaluation efforts are carried out by the USAIDs in coordination with SDP, they will contribute to the body of knowledge concerning the concept of village-based health as it applies to the Sahel.

As a leading donor in this sector (by virtue of the types of programs it supports rather than the amount of its assistance) whose several village-level health programs are either already underway (i.e., in Senegal, Mali, and Niger) or planned (Chad, Mauritania, Cape Verde, and Upper Volta), AID has a unique opportunity to design a variety of program initiatives which attempt to test the basic tenet of the health strategy: integration of services at the village level. Several efforts of this kind are in the discussion or planning stages:

- o The Mali rural health project is now exploring ways to incorporate the use of traditional medicine into the scope of its activities. A collaborative effort will be mounted by project staff with the Institute of Traditional Medicine located in Bamako. The project will benefit from the Institute's extensive experience in working with traditional healers, and this could serve as a model for other village-level health programs.
- o AID staff responsible for the Sine Saloum rural health project in Senegal are currently working with the Senegalese Bureau of the Census to incorporate the gathering of important demographic data into the evaluation plan of the project.
- o The health strategy indicates that control of endemic diseases is probably more effective when it is done through services which are already established at the village level. In response to numerous requests from the CILSS countries for assistance to their expanded programs of immunization (EPI), AID is considering the merits of supporting these programs in the context of its efforts to develop village-based health programs. Assistance to an EPI in Niger, for example, in the context of the multi-million dollar rural health project would constitute a highly interesting experiment and would contribute greatly to the technical knowledge related to implementation of the health strategy.
- o In Chad the rural health services project will be designed so that village health workers are working in direct support of activities being undertaken by the rural water supply project. Once again, a chance to see if and how integration occurs at the village level.

Similar programming initiatives by the USAID missions must continue to increase in number. If these interventions are responsive to the first generation project requests from the individual countries, are planned and carried out with explicit reference to the CILSS health strategy and include the involvement of other donors, the USAIDs will contribute greatly to strengthening the credi-

bility of CILSS in each country and to promoting the practice of multisector and multidonor planning. In the final analysis the future existence of CILSS and the Club du Sahel depends on their perceived utility at the national levels of the member states.

In addition to stimulating evaluation and experimentation within bilateral health programs, USAIDs with the coordination of SDP can also play a very helpful role in facilitating communications between each other and the various national services with which they work. For example, health project staff are to be encouraged to organize mobile seminars and exchange visits for host country colleagues to enable them to observe experiences in village-level health services both within and outside the Sahel. During the summer of 1978 a group of Chadian health officials and members of the USAID health planning project team visited Niger to observe its experience in village health services.

The evaluation and information-sharing activities undertaken by AID through its projects of assistance in the health sector can perhaps serve as models for similar efforts to be undertaken by the CILSS and/or by the other donors. For example, a focus on evaluation within AID could stimulate interest in developing a methodology for evaluating all village-based health programs in the Sahel, and activity which could be carried out under the coordination of the Sahel Institute.

It is inevitable that AID will continue to play a leadership role in promoting the implementation of the regional health strategy. Through its many initiatives AID can provide the CILSS Public Health Advisor with vital information and support in identifying and understanding the various successes and failures of the experimental health service delivery systems which will be valuable resources for him in his assistance to the CILSS countries.

**APPENDIX 1**

**Summary of the CILSS/CJ-12  
Health/Water/Nutrition Strategy**

Permanent Interstate Committee  
for Drought Control in the Sahel  
C.I.L.S.S.

Club du Sahel

HUMAN RESOURCES TEAM

Commission on Health-Water-Nutrition

SUMMARY OF THE CILSS/CLUB HEALTH-WATER-NUTRITION STRATEGY

Ouagadougou  
August 31, 1978

## SUMMARY OF CILES/CLUB HEALTH-WATER-NUTRITION STRATEGY

Within the context of human resources development in the Sahel, efforts to improve the health and nutritional status of the population constitute a very high priority. While the argument is often made that good health is the result of economic development, in fact it is an important contributing factor, for an unhealthy population is unable to participate fully in the production activities related to development.

Unfortunately, however, health and other social services are usually given less attention in national development strategies. Or, on the other hand, considerable investments are made, but those investments only reinforce the traditional systems of health care which, based for the most part on Western models, serve only a small segment of the population. The rural masses, which constitute 80% of the Sahelian population, have little or no access to basic services of any kind.

In the face of these realities and given the emphasis on long-term development in the rural areas of the Sahel, the Health Commission of the Human Resources Team developed a strategy for health/water/nutrition which focuses on the most basic needs of the rural populations and which attempts to define the responses to those needs through the maximum utilization of the limited financial and personnel resources found in each of the countries of the Sahel. It is a strategy which links health directly to socio-economic development, both in terms of increasing the availability and accessibility of basic health services per se and of monitoring the potential negative impact on health of the various development programs being mounted through the Club du Sahel. It also seeks to enhance the positive effects on health by promoting the integration of health/water/nutrition components into development projects.

The strategy for health/water/nutrition is based on a number of premises which provide the policy guidelines for future health initiatives in the region

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\*This summary has been prepared from Eléments de Stratégie : Santé-Eau-Nutrition dans le cadre d'un développement socio-économique harmonieux des pays du Sahel, the strategy document adopted by the Club du Sahel at the May 1977 meeting in Ottawa.

aimed at achieving good health for everyone by the year 2000.

- There needs to be a complete reorientation of current policies which currently favor a classical, highly centralized, pyramidal structure and which result in development from the top down, thus benefitting only a small fraction of a dispersed rural population.
- Health development must begin at the village level, with the full active participation of the population in planning and implementing the delivery of basic services. These services must receive the technical support and supervision of a strengthened government health infrastructure which also must be capable of executing an appropriate system of referral, beginning with the village up through the national level of major hospitals.
- An approach to health care delivery which takes into account existing socio-cultural values of the Sahelian populations must attempt to integrate the practices of traditional medicine and pharmacopea which for thousands of years have helped people to survive who had no access to other sources of care.
- The current practice of allocating a disproportionate (in terms of money spent per population served) amount of resources to the improvement of health in the larger urban centers must change. Not only are the recurrent costs unable to be assumed by the countries for the adequate functioning of services, but the cost of extending the services to assure a better coverage of the population cannot be met either by national budgets or with the assistance of foreign donors.
- Planning of health and social services, as well as other sectoral planning, requires reliable data concerning population growth and distribution, combined with an accurate assessment of health and disease patterns.
- Inappropriate planning and implementation of development projects outside the health sector particularly in agriculture, housing and water resources, can have a negative impact on the health of the population.

In summary, improving health services and the health status of the Sahelian population must take place interdependently with improvement of the quality of life in general and with overall socio-economic growth.

From these program premises, five themes have been put forward in a strategy which is to guide the Club du Sahel in the development of health care services in the region. These themes can be summarized briefly as follows :

1. Development of basic health services at the village level

Services would be provided by village health workers who are residents of the village, selected by a village council (or other traditional authority structure) in collaboration with health officials, trained in or near the village and who are able to provide a wide range of health promotive, disease preventive and simple curative functions. These workers refer more complicated disease problems to the next appropriate treatment levels. Normal deliveries occur in the village under the supervision of one of the workers who is generally a traditional midwife who has received supplementary training. The duties of the village health worker are performed in accordance with standard practices worked out on a national basis ; a basic formulary of five or six necessary drugs and dosages is available at the village level. In addition the village worker is responsible for the collection of basic demographic and disease data in the village. The worker may be illiterate or functionally illiterate ; he/she can nevertheless be trained to carry out the above activities competently and efficiently. Remuneration of the workers is decided by the village.

The village health workers will constitute the first level of the delivery system. The other levels of care as they are now organized in most of the Sahelian countries will support the efforts undertaken at the village level :

- arrondissement ("intermediate") level health activities : this level will play a critical role in extending health services out to peripheral village communities. The role of the government health personnel at this level requires that a large proportion of their time is to be spent in liaison with the village health workers, visiting them in their villages, providing administrative and logistic support, supervision, consultation, and continuing education. it is here that initial training of village health workers occurs.
- cercle ("secondary") level health activities : At this level there is most often a large dispensary or health center usually with 10 to 30 beds. The cercle is a major point of reference, support, and more advanced training and recycling for health workers from the arrondissements. Most patients referred for hospitalization from the village and the arrondissement can be accommodated here, including those with complicated problems of delivery. The cercle level, in coordination with the regional level, should also be responsible for the logistics and operation of mobile health activities. Cercle personnel will also participate in village worker training in the arrondissement and the village.
- regional ("tertiary") level health activities : A hospital having the capacity to carry out a wide range of medical and surgical activities is usually found at this level ; it also houses services for endemic disease activities. As described for the other levels, the additional function emphasizing support and supervision of more peripheral health services needs to be strengthened or, in some cases, added. Since the functional liaison for health care between the regional and national levels often has a restricted capacity, the most central responsibility for the delivery of health services and the support of village-based services must rest with the regional level. Here too, the various government organizations concerned with other development sectors can work together with the regional health director to assure appropriate coordination.

The region is where overall coordination of the development, implementation, and evaluation of more peripheral health programs take place, and where the budgetary allocations received from the central government are distributed to more peripheral levels. To the greatest extent possible, there should be budgetary flexibility granted to the regions so that the actual utilization of the budget at village, arrondissement and cercle levels is as relevant as possible to the specific local setting.

- national ("central") level health activities : The national or central level, where the Ministry of Health is located in the capital city, is the locus at which basic health policy and planning, and national management and administration of the health care system should take place. The basic policy and planning reforms which must occur if a village-based strategy is to be put in place are the concern of the central Ministry. Similarly, a reorientation of national health manpower policy, curriculum development for health training institutions, and overall supervision and evaluation of the regional programs should take place at this central level. It is also at this level that interministerial policy and planning for integrated rural development is based.

## 2. Control of Endemic Diseases

In general, disease control efforts are enhanced by having in place a village-based health structure. Indeed, village level workers and government health workers at the most peripheral level have key roles to play in actions which are now being or will be undertaken in the following areas :

- a. Expanded programme of immunization (EPI) of children against :
  - diphtheria
  - whooping cough
  - tetanus (also for pregnant women)
  - polio

measles  
 tuberculosis  
 yellow fever  
 smallpox

- b. Control of treponematoses
- c. Control of trypanosomiasis
- d. Control of schistosomiasis with direct linkage to specific economic development projects
- e. Malaria control, which has been shown in other parts of the world to be more effective when carried out with adequate local surveillance and maintenance
- f. Onchocerciasis control now underway in the Volta River basin should be examined closely before wide-scale application throughout the Sahel, and expansion should be determined on the basis of direct relationship to economic development.

### 3. Environmental Sanitation/Water

Simple environmental improvements and organisation of the community to assist in the acquisition and maintenance of a safe water supply are among the health promotive functions of the village health worker, working in collaboration with the village council and the residents of the village who will benefit from such efforts.

The first priority is to make sufficient water available in every village, then to teach the villagers the importance of safe water and simple means of preventing water wastage and contamination.

To improve general sanitation in the village, there is a great need for simple and effective technologies for the provision of water which the villagers and the village health workers can exploit through the use of available resources.

#### 4. Nutrition

An improvement in the nutritional status of the Sahelian population, especially of mothers and children, is dependent upon the achievement of "nutritional self-sufficiency", i.e., local availability of a sufficient quantity of food. This in turn means better exploitation of existing foods - milk, fish, livestock - as well as better methods of preserving and transporting food. Changes in infant feeding practices can best be brought about through the village-based health system by the efforts of the village health worker who can be trained in very basic nutritional surveillance. Resources for the rehabilitation of malnourished children should be more widely available with emphasis on education of the mothers.

#### 5. Demography and Health Planning

Accurate demographic and health statistics are absolutely essential for planning health as well as non-health sector development programs and projects. Development of information systems in the framework of a national program of village-based health can begin with the use of village health workers in the development and collection of health and vital statistics.

As regards family planning, each government must decide its own policy. Some countries already have small programs, but generally speaking, birth-spacing efforts await the concrete results of maternal and child health programs in terms of increased child survival.

#### CONCLUSION

To achieve minimum adequate coverage of the dispersed rural populations of the Sahel, it is essential that basic health services such as those outlined above begin at the village level, with the community itself taking a primary role in the delivery of these services. The health-water-nutrition strategy adopted by the Club du Sahel suggests broad guidelines for the reorientation of present policies and programs. It is recognized that further studies and more detailed planning are required to define the means by which these guidelines can be adapted to regional, national and local realities.

Ouagadougou August 31, 1978

**APPENDIX 2**

**CILSS First Generation Health Project Visits:  
Schedule and Team Composition**

**CILSS FIRST GENERATION PROJECT VISITS:  
SCHEDULE AND TEAM COMPOSITION**

April 30 - May 4, 1978	Cape Verde	Marshall McBean, M.D. Julia Terry
May 2 - 6	The Gambia	Marshall McBean, M.D. Kathleen Parker, M.P.H.
May 15 - 19	Upper Volta	Michael White, M.D., M.P.H. Kathleen Parker, M.P.H. Julia Terry
May 24 - June 3	Mauritania	John Lucas, M.D., M.P.H. Julia Terry
June 5 - 14	Mali	Pierre Leger, D.S.E. Julia Terry
June 15 - 23	Senegal	Pierre Leger, D.S.E. Julia Terry
June 15 - 25	Chad	Bernard Guyer, M.D. Kathleen Parker, M.P.H.
July 31 - August 11	Upper Volta	Julia Terry
August 3 - 8	The Gambia	Kathleen Parker, M.P.H.
August 14 - 16	Niger	Julia Terry

**APPENDIX 3**

**CILSS First Generation Health Projects**

**CILSS FIRST GENERATION HEALTH PROJECTS**

<u>Country</u>	<u>Project Title</u>	<u>Length of Project</u>	<u>Total Dollars</u>
Cape Verde	CV.C1	Project for Construction and Equipment of Health Facilities, 2 Staff Training Centers and a Regional Depot for Medicines	5 years \$ 4,447,840
	CV.C2	Expanded Programme of Immunization	5 years 225,746
Chad	TCH.C1	Expanded Programme of Immunization	5 years 1,414,246
	TCH.C2	Creation of a National Maternal and Child Health Service	4 years 490,530
	TCH.C3	Reinforcement of Primary Health Services	
	TCH.C4	Health Infrastructure Renovations	1,653,333
	TCH.C5	Reinforcement of Endemic Disease Control Service	1,128,889
	TCH.C6	Personnel Training	
Gambia	GA.C1	Strengthening of Rural Health Services	18 months 1,220,319
	GA.C2	Establishment of a Health Planning Unit in the Ministry of Health	2 years 342,000
	GA.C3	Rural Water Supply	3 years 2,859,000
	GA.C4	Creation of an Endemic Disease Control Unit in the Ministry of Health	4 years 4 years 828,570
	GA.C5	Tuberculosis Control	2 & 4 years 830,000
Mali	MALI C1	Development of Primary Health Care Services	5 years 15,656,666
	MALI C2	Equipment and Development of the National Institute for Research in Pharmacopeia and Traditional Medicine	5 years 1,637,778
	MALI C3	Expanded Programme of Immunization	10 years 3,629,600
	MALI C4	Assistance Project for the Protection of Water and Sanitation in Rural Areas in the Republic of Mali	5 years 2,000,000

(Mali)	MALI C5	Project to Improve the Conditions of Life in Rural Areas	unknown	unknown
Mauritania	MAU.C1	Strengthening of Basic Health Services	5 years	842,418
	MAU.C2	Expanded Programme of Immunization	5 years	593,677
Niger	NIGER C1	Primary Health Care Services	13 years	48,705,955
	NIGER C2	Primary Health Care Services (Alternative)	13 years	33,345,733
	NIGER C3	Basic Environmental Sanitation	5 years	1,206,751
	NIGER C4	Refresher Training and Supervision of Personnel	5 years	1,525,333
Senegal	SEN.C1	Integrated Development of Food and Nutrition in Rural Areas	4 years	4,600,000
	SEN.C2	Strengthening of Basic Dental Health Services in Senegal	5 years	4,747,400
Upper Volta	HV.C1	Creation of the University Center of Health Sciences in Ouagadougou	3 years	7,333,000
	HV.C2	Primary Health Care Services	10 years	65,387,240
	HV.C3	Expanded Programme of Immunization	10 years	5,694,128

APPENDIX 4

Status Report on Donor Activity  
in the Sahelian countries

STATUS REPORT ON DONOR ACTIVITY IN HEALTH/WATER/NUTRITION: CAPE VERDE

Theme of the CILSS/ Club Health Strategy	Project Title	Donor	Description or Na- ture of Assistance	Estimated Level of Funding (G)	Status	Length of Project Begins/Ends
I. VILLAGE-BASED HEALTH SERVICES	Integrated Rural Development: Maio	FRG	Health and Health educa- tional component			
	Rural Health Services	USAID		2,000,000	Under disc.	1979-1981
	Rural Health Pilot Proj. Sta. Catarina	Belg. NGO	Personnel			
	Construction/Renovation of Basic Health Units	Canada/ UNICEF/ WHO		120,000 300,000		Ongoing
II. CONTROL OF ENDEMIC DISEASES/ VACCINATIONS	Expanded Programme of Immunizations	WHO Hungary Algeria	Vaccines Vaccines Vaccines			
III. WATER/ ENVIRONMENTAL SANITATION	Rural Water Supply	UNICEF		1,750,000		1977-1981
	Improvement of Sanitation	WHO	Technical Assistance (Sanitary engineer)			
IV. NUTRITION	Food Assistance	WFP	Foodstuffs	16,000,000		1977-1981
	Food Security	FAO	Foodstuffs, silos, storage	1,000,000		1977-1981
	Nutritional Assessment	School of Public Hlth, Lisbon				
	Food Aid	US, Canada, Belgium, France, China, EC, FRG, Sweden, Norway, Denmark		9,614,000		1977

55

CAPE VERDE - 2

V. DEMOGRAPHY/ HEALTH PLANNING	Demographic statistics	UNFPA	General Census	181,790	Ongoing 1977-1979
	MCH and Family Planning	SIDA (Balda Barnais)			5 years
VI. MISCELLANEOUS	Health Sciences Education	WHO	2 nurse trainers, supplies, materials	218,200	Ongoing 1977-1979
	Scholarships	WHO		70,000	
	Development of Health Services	WHO	Medical personnel, supplies, materials, Lab. technician	366,300	Ongoing
	Pharmaceutical Industry	UNOID	Control laboratory/ pharmaceutical products control Pilot factory for drug production	122,000	Ongoing
				660,000	1977-1981
	Pharmacy	WHO	Technician		Ready to start
	Training/scholarships	UN, Portu- gal, Cuba, Algeria, Roumania, USSR			
	Medical personnel	USSR, FRG, Cuba			
	Infrastructure	Nether- lands	Renovations in the Praia Hospital, X-Ray equipment, Praia & Mindelo, Equipment for health posts		Nearly finished
	Miscellaneous support to health services	Ecumeni- cal Cncl. of Churches	Laboratory, supplies, psychia- tric hospital		

5/10

CAPE VERDE - 3

(Miscellaneous, cont.)	MEXICO (ECO)	Technicians, material, vehicles
	Missouri (ECO)	
	Red Cross	Medications, vehicles
	Algeria	Medications, materials
	Gulben- kian Fdn.	Materials
	ICVS	Medications, materials, equipment
	UNICEF	Equipment
	Sinco (Dalg.)	Technical assistance, equipment
	YBG	Medications, equipment, materials

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Sources: WHO, Profil de Pays  
UNEP, Rapport Annuel sur l'Assistance Extérieure, 1977  
Ministry of Health data

**STATUS REPORT ON DONOR ACTIVITY IN HEALTH-WATER-NUTRITION**

**THE GAMBIA**

Theme of CILUS Health Strategy	Title of Project	Donor	Description or Nature of Assistance	Estimated Level of Funding	Status	Project Begins/Ends
<b>I. VILLAGE-BASED HEALTH SYSTEMS</b>	Strengthening of Health Services	WHO	3 experts : - Public Health Advisor - Laboratory Technician - Nurse Tutor	\$ 794,400	Ongoing	'77-'81
	Maternal/Child Health and Family Planning	USAID	2 nurse technicians + 1/2 time physician project director Training of Community health nurses commodities	\$ 1,000,000	Ongoing ; Second phase ends 12/78	'72 -'78
	Training of Traditional Birth Attendants	UNICEF	Materials			
	Maternal/Child Health Pilot Project - Banjul Kombo St. Mary and Western Division	ODI	Construction/ Renovation ; Equipment ; Vehicles Water Supply	\$ 476,190	Proposal being re- studied for possible revisions	'78 -

- \* SOURCES : (1) UNDP, Annual Report on Development Assistance 1975 The Gambia, April 1976.  
 (2) \_\_\_\_\_, Country Programme for GAMBIA, UNDP assistance requested by the Government of Gambia for period 1977-1981, 12 September 1977.  
 (3) WHO, Gambia Profile, December 1977.  
 (4) Interviews with Gambian officials and donor representatives in Banjul  
 (5) Project documents

U.S. \$ 1 = D 2,10

Theme	Title of Project	Donor	Description or Nature of Assistance	Estimated Level of Funding	Status	Project Begins/Ends
II. CONTROL OF ENDEMIC DISEASES	Short-term consultancies (STC)					
	a) ICP/HSD 003 - assist in creation of Vital & Health Statistics	UNDP/ WHO	Expert	\$ 50,000	Completed	8/76
	b) Vector control- to organize control programme	UNDP/ WHO	3 experts		Completed ; 4-6/76 and small malaria 78-79 (1 year) control pro- gram now underway ; funding for Endemic Disease control Unit being requested through CILSS	
	c) ICP/VDT .001 - assess problem of sexually transmitted diseases	UNDP/ WHO	Expert		Completed, no follow-up at this time	
	Leprosy Control	Nether- lands Leprosy Relief Assoc.	Expert	\$ 250,000	Ongoing	'71-
		Canadian Leprosy Fund	Equipment, Supplies	\$ 500,000	Ongoing	'74-'78

Theme	Title of Project	Donor	Description or Nature of Assistance	Estimated Level of Funding	Status	Project Begins/Ends
	Biomedical research support to Medical Research Council	WHO/ TDR	To be defined	To be determined	Proposed for 5 yrs	
	TB Control-Plans BCG Campaign	UNICEF	Vaccines Equipment	\$ 25,000	Begin 8/78	'78 -
	Strengthening of health delivery systems (regional)	WHO/ USAID	Training Epidemiologic Surveillance	To be determined	Project inputs under discussion	'78 -

Theme	Title of Project	Donor	Description or Nature of Assistance	Page #	Estimated Level of Funding	Status	Project Begins/Ends
<b>II. ENVIRONMENTAL</b>							
<b>SANITATION/WATER</b>							
	GAM/72/003 Study of Sewerage and drainage problems Banjul-Kombo St. Mary	UNDP/ WHO			103,300	Survey recently completed	' 74 - ' 78
		EDF ADB			2,500,000 5,000,000	Implementation to begin soon	' 78 -
	GAM/74/007 Rural Water Supply (pilot)	UNDP/ OTC	Experts, Equipment		314,260	Ongoing ends Dec 78	' 76- '78
		UNICEF Denmark (DANIDA)	Supplies, Equipment, Transport		611,335		' 76- '78
	GAM/78/002 Rural Water Supply (Expansion of pilot program nationwide)	UNDP/OTC	Experts, Training, Equipment, Supplies		5,914,000	Phase II	' 79- '81
		UNICEF/ Denmark Federal Republic of Germany	Hydrogeological Survey			Funding now being sought	
	Rural Water Supply : Kerewan, Hansang, Farafeni, Banau	ODN	Equipment, Supplies		195,850	Recently approved for funding	' 78- '81
	Banjul Water Supply	Federal Republic of Germany			2,350,000		' 75- '81

Theme	Title of Project	Donor	Description or Nature of Assistance	Estimated Level of Funding	Status	Project-Begin/Ends
V. NUTRITION						
	Primary School Feeding Program	World Food Programme		\$ 4,503,000	Ongoing	1970 -
	Preschool Feeding Program	CRS/ USAID OXFAM	Food Stuffs	\$ 400,000 Annually	Ongoing	1975 -
	Supplementary Food Supplier Day Care Centers	CRS/ USAID		\$ 150,000		

Theme	Title of Project	Donor	Description or Nature of Assistance	Estimated Level of Funding	Status	Project Begin/Ends
V. DEMOGRAPHY/ HEALTH PLANNING						
	Family Planning - Assistance to Gambia Family Planning Assoc. (GFPA)	IPPF  USAID	Equipment  Equipment, Building	\$ 400,000 +  \$ 25,000+/yr.	Ongoing  Ongoing	'74-'80
	Communication & Family Planning "hardware experiment"	UNESCO/ UNFPA	Equipment, Expert	\$ 54,000	Ongoing	'75-'78
	GAM/72/PO1 (110) Population Census	UNOTC/ UNFPA		\$ 117,372	Completed	
	Technical assistance - Development of population policy	UNFPA			Completed 11/75	

Theme	Title of Project	Donor	Description or Nature of Assistance	Estimated Level of Funding	Status	Project Begins/Ends
VI. MISCELLANEOUS						
	Medical Supplies transport, equipment	UNICEF		\$ 447,300	Ongoing	'77-'81
	Education Project	IBRD	-Expansion of School of Nursing -Creation of Enrolled Nursing School at Banskang Hospital		Under discussion	'78-'81
	Supply of Medical Stores	Libya	25-50 tons of medicine			1978
	Provision of medical expert-anesthetist	Denmark (DANIDA)				
	Salaries-School of Public Health	UNICEF		\$ 22,000 annually	Ongoing	
	Support to Medical Research Council research activities	ODM		unknown	Ongoing	
	Technical assistance Health personnel (?)	ODM		\$ 555,000	Ongoing	'77-'80

Themo	Title of Project	DONOR	Description Nature of Assistance	Estimated Level of Funding	Status	Project Begin/Ends
	X-ray units at Royal Victoria Hospital & Bansang	ODM		\$ 110.600	Under completion	'76-'78
	Technical Assistance 12 physicans at Bansang Hospital	People's Republic of China (PRC)				'76-
	Construction of a 50 - bed hospital at Kaur Construction of 3 Health Centers : Parafeni Kunang Karantaba	PRC		\$ 2.000.000		
	Blood Transfusion Unit at RGH	Red Cross ODM				
	Construction of Children's Wing - Bannang Hospital	ODM				

STATUS REPORT ON DONOR ACTIVITY IN HEALTH/WATER/NUTRITION

MALI

Theme of the OILSS/ Club Health Strategy	Title of Project	Donor	Description or Na- ture of Assistance	Estimated Level of Funding (\$)	Status	Length of Project Begins/Ends
I. VILLAGE-BASED HEALTH SYSTEMS	Development of Rural Health Health Services	USAID/ Peace Corps	Support to rural health system - Yelemeni, Koro	3,890,000	Begins 7/78	1978-1981
	Primary Health Care	Switzer- land	Support to rural health system - dikasso Region		Begins 7/78	1978-1981
II. CONTROL OF ENDEMIC DISEASES/ VACCINATIONS	Onchocerciasis Control	UNDP/WHO/ IRD/FAO	Regional project (7 co.)	12,885,000 (1978)	Ongoing	1974-
	Assistance to Lepers	Roual Pollereau				
	Strengthening Health Delivery Systems	WHO/USAID	Regional technical assis- tance in health planning, epidemiology, vaccines		Ongoing	
III. WATER/ ENVIRONMENTAL SANITATION	Development of Health Services	WHO	Sanitary engineer, activities and studies related to sanitation;			
	Well construction in rural areas	CARE				
	PLANEAR	WHO/UNDP/ UNICWF	Rural Sanitation Project Design		Funding sought	10 years
	Water system	UNICWF	Equipment, materials			
IV. NUTRITION						
V. DEMOGRAPHY/ HEALTH PLANNING	Family Health Programme	WHO/ UNFPA	MCH and family planning activities, training, evaluation	1,000,000	Ongoing	3 years

## MALI - 2

## VI. MISCELLANEOUS

Development of Health Services	WHO	Personnel, Equipment, Supplies	274,000 (1976)	Ongoing
Development of Health Personnel (Health Sciences School)	WHO	Personnel, Equipment, Scholarships	180,000 (1976)	
Health component - production projects	USAID	Operation Haute Vallée		Under discussion
Health Center Construction	FED, R. Follen- eau			
Urban dispensaries	Saudi Arabia			
MCH Garage	UNICEF	Vehicles, equipment		
Institute for Traditional Medicine (INEMF)	OGA		5,000 (1977)	
Maternities and dispensaries	FED	Construction, Bamako suburbs	2,000,000	Ongoing

Sources: WHO, Profil du Pays, 1976  
 UNDP, Rapport sur l'assistance au Développement, 1976  
 Ministry of Health documents and interviews

STATUS REPORT ON DONOR ACTIVITY IN HEALTH/WATER/NUTRITION

MAURITANIA

Theme of OILSS/ Club Health Strategy	Title of Project	Donor	Description or Na- ture of Assistance	Estimated Level of Funding (\$)	Status	Length of Project Begin/Ends
I. VILLAGE-BASED HEALTH SYSTEMS	Rural medical assistance: Region VI	USAID	Village-based services: personnel, logistical support, training	570,000	design phase	1979-1983
	Health assistance	UNICEF	Village health worker training, materials,	446,000	Ongoing	1977-1978
	Maternal + Child Health	USAID/ Peace Corps	Personnel, logistical support		Ongoing	
II. CONTROL OF ENDEMIC DISEASES/ VACCINATION	Endemic disease control	UNICEF	Participation in control programs for TB, Schistosomiasis, Malaria		Ongoing	1977-1978
	Strengthening Health Services	WHO/USAID	Health planning, epidemio- logy, vaccines			
	Vaccines	World Lu- theran Fdn.				
	Special fund	OOOGE	Material, equipment, medica- tions, - TB survey			
III. WATER/ ENVIRONMENTAL SANITATION	Water and Sanitation -- Nouakchott	FAD	Water supply, sanitation, sewage treatment station			
	Water supply and drainage system - Rosso	FAD			Ongoing	
	Water resources	OTC/UNEP		290,000	Ongoing	
	Under ground water	OTC/UNEP		15,000	Ongoing	

MAURITANIA - 2

	Emergency Water Projects	OTC/UNDP	84,000	Ongoing	
	Water supply projects	UNICEF	Well construction, improvement	150,000	1977-1981
	Studies	USAID	Oasis development, reclamation		
	Equipment for boreholes	UNESCO/ADB		3,500,000	
IV. NUTRITION	School feeding programme	WFP			Ongoing
	Food aid	WFP, FIC, CEE, France, USA, Belgium, UK, Australia, Netherlands			
	Nutrition study	ORAMA	Boutilimit Circonscription		
	Nutritional Rehabilitation Centers	CRS	Ve Arrondissement		
	Food distribution Assistance	Red Crescent			Ongoing
	Technical Assistance	WHO	Nutritionist		1978-
V. DEMOGRAPHY/ HEALTH PLANNING	Population census, needs assessment	UNFPA		200,000	1978
VI. MISCELLANEOUS	Basic health services development	WHO	Technical assistance		1968-present
	Medical personnel, technical assistance to health services	FIC, USSR, Austria, FAC, Spain	Personnel, equipment, material, infrastructure, logistical support		

MAURITANIA - 3

Infrastructure	FED	National hospital + polyclinic, construction and extension		
National School for Nurses and midwives	ADB	Extension of school		
Scholarships, fellowships	WHO			1977-1979
National School for Nurses and Midwives	WHO	Personnel, training programs		1977-1979
Construction and renovation of buildings	FAC	MEH Center - Nouakchott, Regional Hospitals		
Logistical support	Order of Malta			
Training of health personnel	ADB/ADF			15 years
National Institute for Hygiene	FBC			
TB Hospital	Sheik Mazer	Construction		1978-1979
Rural health infrastructure	Kuwait	Regional hospitals, rural dispensaries	1,000,000	Ongoing

Sources: WHO, Profil de la Republique Islamique de Mauritanie, 1976  
 UNDP, Rapport Annual, 1976  
 Ministry of Health documents and interviews

STATUS REPORT ON DONOR ACTIVITY IN HEALTH/WATER/NUTRITION

NIGER

Theme of the CILSS/ Club Health Strategy	Title of Project	Donor	Description or Nature of Assistance	Estimated Level of Funding (\$)	Status	Length of Project Begins/Ends
I. VILLAGE-BASED HEALTH SERVICES	Basic Health Services Delivery	Africare	Personnel, equipment, logistics	2,800,000	Ongoing	1977-1979
	Primary Health Care	Peace Corps	Personnel; health/nutritional education	219,840	"	1974-1979
	Training of Secouristes, Matrones	Oxfam	Training costs	30,000		1976
	Improving Rural Health	USAID	Personnel, training costs, equipment, construction logistics	13,500,000		1978-1982
	Medical assistance - Tahintabaraden	Oxfam	Personnel for training of matrones	36,000		1976
	Assistance to MCH - Niassy Department	Netherlands	Personnel	80,000		1975-1977
	Improvement of Health	France	Personnel, equipment, scholarships	4,709,000		1973-1979
	Rural Health Care - Dosso Department	Belgium	Personnel, medications	1,087,424		1976-1982
	Rural Health Care - Tahoua Department	FRG	Personnel, logistics, equipment, material	7,500,000		1963-1978
II. CONTROL OF ENDEMIC DISEASES/ VACCINATIONS	Onchocerciasis control	WHO/UNDP/ UNDP	Regional project to eliminate onchocerciasis	6,000,000 (Niger only)	Ongoing	1974-1979
	Strengthening of Health Delivery Systems	WHO/USAID	Regional technical assistance in health planning, epidemiology, vaccines	2,477,551 (Niger only)	Ongoing	1973-1980

NIGER - 2

III. WATER/  
ENVIRONMENTAL  
SANITATION

	Improvement of Water Supply	WFP	Loan for improvement of water supply + sanitation facilities - Niamey, Niassali, Kinkar	1,000,000	1973-1977
	Sanitation - Department of Niamey	WED		772,343	Ongoing 1972-1979
	Well construction in rural areas	CARITAS, Swiss Coop., Caritas, CAAT, CIDA, WFP, UNICEF, OXFORD/WFP, WWS		1,501,775 (1976 only)	Ongoing
	Sanitation projects - Niamey, Kinkar	WFP	Loan	5,000,000 (1976)	
	Emergency Water Supply - Sahel Region	UNEP		100,000	1976-1978
	Pumping stations - Basic Department	Switzerland	Repairs, personnel, materials	197,600	1976-1978
	Manual pumps	CARITAS	Material	50,000	1976
IV. NUTRITION	Aid to MHE Centers - rural dispensaries	WFP	Food aid	1,116,800	Ongoing 1976-1980
	Nutrition Education	Peace Corps	Health/nutrition education	(see above)	Ongoing
V. DEMOGRAPHY/ HEALTH PLANNING	Population Census	UNFPA		1,215,400	1976-1978
VI. MISCELLANEOUS	Health facilities construction	WFP	Construction of accommodation + sanitation dispensaries	3,160,000	
	Dispensaries	WFP	Construction of dispensaries, capping of wells	39,600,000	

HICHR - 3

Drugs for dispensaries	UNICEF	Drugs, supplies	24,000	1975-1977
Assistance to Galai Hospital	SIN	Personnel	305,868	
Assistance to Medical Center, Kinder	OSBO	Personnel, commodities	3,999,896	1976-1979
Assistance to Leprosy Hospital, Haradi	SIN	Personnel, equipment	15,570	
Assistance to Gusechene Hospital	SIN	Personnel, equipment	305,868	
Assistance to Hisey Hosp. as	UNR	Personnel, equipment		1975-1979
Assistance to Haradi + Hisey Hospitals	FBO	Personnel	44,000	1976
Health Sciences School - Hisey	ADA'	Expansion of buildings	66,234	1976-1977
Nat. School of Public Health - Hisey	UNEP	Personnel, materials, training supplies	790,636	1972-1976
Hospital assistance - Hisey + Kinder	WFP	Food for hospitalized pts.	1,116,800	1976-1980
Health Sciences School - Hisey	WHO	Midwife instructors	488,300	1975-1979
Scholarships - health sciences	WHO	Scholarships for study abroad	1,555,000	1976-1979

Sources: WHO, Profil du SUD, 1976  
 UNDP, Rapport Annuel sur l'Assistance Extérieure, 1977  
 Ministry of Health documents

**STATE REPORT ON DONOR ACTIVITY IN HEALTH/WATER/SANITATION**

**GENERAL**

<b>Name of GILSP/ Club Health Strategy</b>	<b>Title of Project</b>	<b>Donor</b>	<b>Description or nature of Assistance</b>	<b>Estimated Level of Funding (\$)</b>	<b>Status</b>	<b>Length of Project Begin/Ends</b>
<b>I. VILLAGES-BASED</b>	<b>Technical Assistance- Primary Health Care: Guinea</b>	<b>Canada</b>	<b>Personnel, equipment, supplies</b>	<b>1,000,000</b>	<b>Ongoing</b>	<b>1977-1980</b>
	<b>Primary Health Care</b>	<b>CIDA</b>	<b>Personnel, equipment, supplies</b>	<b>700,000</b>	<b>Ongoing</b>	<b>1976-1979</b>
	<b>Pilot project - Fatick</b>	<b>Netherlands</b>	<b>Personnel, materials</b>	<b>600,000</b>	<b>Ongoing</b>	<b>1977-1980</b>
	<b>Development of Health Services: Sine Saloun</b>	<b>USAID</b>	<b>Primary care services</b>	<b>3,400,000</b>	<b>Ongoing</b>	<b>1976-1980</b>
	<b>Development of Health Services</b>	<b>WHO/UNEP</b>	<b>Training of traditional midwives</b>			<b>1977-1980</b>
	<b>Health/medical assistance in Ntun (Fleuve)</b>	<b>Belgium</b>				<b>1977-1980</b>
<b>II. CONTROL OF INFECTIOUS DISEASES/ VACCINATION</b>	<b>Typhoid/Cholera Control</b>	<b>WHO, UNDP Lab. Santos</b>	<b>Personnel, equipment</b>	<b>56,545</b>		<b>1977-1978</b>
	<b>Assistance to the Epi- demic Disease Control Sector</b>	<b>France</b>	<b>Epidemiologist</b>			<b>1977-</b>
	<b>Assistance to Vaccination Campaigns</b>	<b>WHO</b>	<b>Sine Saloun: cold chain, laboratory equipment</b>			
<b>III. WATER/ ENVIRONMENTAL SANITATION</b>	<b>Environmental Sanitation</b>	<b>WHO</b>	<b>Studies</b>		<b>Ongoing</b>	
	<b>Environmental Sanitation: Nombodoune</b>	<b>WHO</b>		<b>4,000,000</b>		<b>1976-1979</b>

GENERAL - 2

IV. NUTRITION

Food Aid

Belgium, WFP,  
USAID, FIC, UK,  
FIC, France, WHO,  
Switzerland,  
Canada, Saudi  
Arabia, Iran,  
Australia

V. DEMOGRAPHY/ HEALTH PLANNING	National Health Planning	WHO/UNEP	Training of planners, scholarships, health programming, supplies	188,400 (1976)	1975-1979
VI. MISCELLANEOUS	Development of health services	WHO/UNEP	Personnel, equipment, supplies, technical assistance	130,100 (1976)	1966-1979
	Staff development	WHO/ UNICEF	Support to CIBSI: staff, supplies, equipment	23,000 (1976)	1968-1978
	Health staff development	WHO	Personnel: Odontology Institute: training of dental auxiliaries	67,220 (1976)	1970-1979
	Medical assistance: Pikine	Belgium	1 Report, short-term training, equipment, construction	66,500	1975-1979
	Surgical Unit, Hopital Principal	FIC		1,200,000	1976-1979
	Scholarships	FIC, WHO			
	Nursing school	FIC	Technical training	1,600,000	1976-1979
	Assistance with indirect impact on health	FIC, FIC, OCCN UNEP, WFP, USAID	Development projects for agricultural production for local consumption, water projects		

Sources: WHO, Profil de PAYS, 1977

UNEP, Report Annuel sur l'Assistance Exterieur, 1976

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**SITUATION ACTUELLE DES ACTIVITES DES DONATEURS EN  
SANTÉ/EAU/NUTRITION - HAUTE-VOLTA**

THEME DE LA STRATEGIE SANIT. IRE DU CILSS/CLUB	TITRE DU PROJET	DONATEURS	DESCRIPTION OU NATURE DE L'AIDE	NIVEAU DE FINANCEMENT ESTIME (\$)	SITUATION ACTUELLE	DUREE DU PROJET/ DEBUT/FIN
I. SERVICES DE SANTE BASES AU VILLAGE	-Projet d'impact accéléré sur la Santé rurale-Pada N'Gourma	USAID	Assistance au Centre de Santé de nutrition et réhabilitation formation, moyens logistiques	100.000		1976-1978
	-Assistance Technique à la santé	RFA	19 volontaires			1975
	- Assistance Technique à la santé	Corps de la Paix	4 volontaires			1978
	- Maternité villageoise-Sapony	SEL	Construction (financement)	1.200		1976
	- Santé féminine	EAC	Matériel médical, médicaments	400.000		1976..
II. CONTROLE DES ENDEMIES/ VACCINATIONS	- Projet onchocercose	Multi-donateur	Zones de Tenkodogo, Léo, Ouagadougou	5.123.948 (76)		
	-Aide à l'OCCE	FAC	Assistance Technique. Fournitures	940.000 (76)		
III-NUTRITION	-Centre Nutritionnel	OXFAM	Equipement Centre Nutritionnel de Nouna	3.380		1976
	-Centre Nutritionnel	OXFAM	Construction, Centre Nutrition de Kaya	1.920		1976
	-Enquête nutritionnelle - Aide alimentaire	PBE PAM, France FED, Canada, Cathwell		8.099.002		1976
IV. EAU ET ASSAINISSEMENT	-Programme Hydraulique d'urgence	PNUD	Volet National d'un projet Sahel : construction de puits permanents	173.500		1974-77
	-Adduction d'eau	RFA	Bobo Doulouso	206.000		1975-76
	-Etude de Factibilité- (barrages)	Canada, FAC		1.050.000		1975

	Assistance Techni- que	Vol. du Progrès	Forages, barrages		
	Hydraulique villa- geoise.	UNICEF		59.000	1976-77
	-Construction bar- rages	Pays-Bas, FED, Franco OXFAM, BEL		3.167.810	1976-77
	-Construction de barrages	FAD		4.608.000 (pret)	
	-Forage de Puits	OXFAM, Cathwell, RPA, UIC Dori AFRICAR, FOVODES, BEL		123.938	
	-Approvisionnement Eau	RPA	Centres ruraux	206.000	
V. PLANIFICATION DEMOGRAPHIQUE ET SANITAIRE	-Formation sur l'éducation en ma- tière de population	FNUAP	série de séminaires	35.700	1976-77
	-Recensement	FNUAP		323.000	1976
VI. DIVULGATION	-Bourses d'études Supérieures: Méde- cins, Sages-Femmes	RPA, URSS, Canada			1976
	-Bourses: personnel médical,	OMS		30.000	1974
	- Développement de services Santé	OMS PNUD	Personnel, Fournit Personnel, Bourses	154.000 50.200	
	-PMI	Suisse	Personnel	25.000	1976
	-Médecins	FAC	49 techniciens (Médecins + Autres)	1.200.000	"
	-Assistance hopi- tal de Gaoou	RPA	Personnel, équip- ment, Médicaments	550.000	
	- Médecins	BAE	Personnel	45.000	"

DIVERS  
(suite)

-Etude Factibilité d'usine de produits pharmaceutiques	PNUD	CONSULTANT	3	20.000	1975-76
-Garage-Ministère de la Santé	Suisse	Assistance technique		30.000	
-Assistance Hôpital Fada N'Gourma	Frères des hommes	Financement, personnel, matériel			1976
-PMI	Vol. des Pays Bas	Personnel PMI de Ouaga, Bobo Léo, Tiébélé			"
-PMI	Volontaires du Progrès	Personnel			"
- Centre médical de Batié	Volontaires Autrichiens	1 médecin			"
-Centre de rééducation des Polio, Ouaga	"	2 Techniciennes			"
-Artisanat pour polio à Tenkodogo	BEL	Subvention		1.444	"
-Intervention diverses	UNICEF	Médicaments, équipement		571.000	"
-Fonctionnement hospital de Koudougou	Chine	personnel, médicaments		800.000	"
-Impression-Fiches de PMI pour rivaquinisation	OXFAH			7.600	"
-Centre de récupération nut. Hôpital de Ouagadougou	OXFAH	Construction des cases résidentielles		4.392	"
-Adduction d'eau hospital de Djibo	"	matériel		7.000	"
-Centre de rééducation de Tenkodogo	"	Construction, frais opérationnels		3.280	"
-Projet sanitaire de Koumi	"			1.464	"
-Centre médical de Boromo	"	Adduction d'eau		3 680	"
-Maternité de Koumi	BEL	Reconstruction:salle d'accueil		3.200	"
-Biberonnerie de Koudougou	"	Extension, frais de fonctionnement		10.019	"
-PMI de Tenado	"	Budget de fonctionnement		4.964	"
-Centre Médico-Chirurgical de Koudougou	"			1.999	"
- PMI de Safané	"	Construction		12.889	"

DIVERS (Suite)	-Maternité de Wakara	BEL	Construction	15.643	"	1976
	-Dispensaire de Tembaga	"	Equipement aménagement	2.620	"	"
	- PHI de Diabo	"	achat voiture	7.000	"	"
	- PHI de Zabré	"	" "	7.881	"	"
	-Dispensaire et habitation infirmiers - Ouenga	"	construction	20.040	"	"
	-Dispensaire de Rouko	AFRICARE	Achèvement	110.000	"	"
	-Maternité de Markoye	"	Construction		"	"
	-Dispensaire, maternité de Séguénéga	"	Répartition équipement		"	"
	-Aides diverses	Protec.Britannique des enfants		79.078	"	"
	-Aide à la Santé	Franco	médicaments, véhicules	480.000	"	"

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WHO, PROFIL DU PAYS

PNOD, RAPPORT ANNUEL DE L'AIDE EXTERIEURE, 1976

SPOBG, RAPPORT ANNUEL 1977

**APPENDIX 5**

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**APPENDIX 6**

**CILSS/CLUB Human Resources Meeting,**

**Niamey 9/25-27, 1978**

**Participants**

**CILSS/CLUB HUMAN RESOURCES MEETING  
NIAMEY, SEPTEMBER 25-27, 1978**

**PARTICIPANTS**

**CILSS Countries:** Chad  
The Gambia  
Mali  
Mauritania  
Niger  
Senegal  
Upper Volta

**Bilateral Donors:** Canada  
France  
Switzerland  
United States of America

**Organizations:** African Development Bank  
Africare  
Cathwell  
Church World Services  
European Development Fund (FED)  
European Economic Community (CCCE)  
Food and Agriculture Organisation (FAO)  
International Labor Organisation (ILO)  
Onchocerciasis Control Program (OCP)  
Organisation for Economic Cooperation  
and Development (OECD)  
Peace Corps  
Project Concern  
United Nations Development Programme (UNDP)  
UNESCO  
United Nations Fund for Population  
Activities (UNFPA)  
UNICEF  
UNSO  
United Nations Technical Cooperation for  
Development (UNTCO)

CILSS Secretariat Staff  
CILSS Technical Consultants  
Club Secretariat Staff

**APPENDIX 7**

**Sanel Health Impact Guidelines:  
Outline**

**SAHEL HEALTH IMPACT GUIDELINES  
OUTLINE**

**General Format of the Document:**

- Volume I:** PRODUCTION (includes a review of Agriculture, Fisheries and Livestock)
- Volume II:** INFRASTRUCTURE AND ECONOMIC DEVELOPMENT (Includes a review of Ecology and Forestry, Transportation and Technology Transfer)
- Volume III:** REFERENCE MANUAL (includes a review of major tropical diseases, a glossary of scientific terms, an annotated reference list, a case study reference list and an organization directory)

**Structure of Volumes I and II:**

- I. Introduction: Background of document formulation; Sahelian development goals; concepts of total perspective view of development and of complementarity among sectors; identification of users of the document
- II. Health and Development: Levels of health to be considered (individual, community, national, regional); attention to health facilitates development; failure to consider health can compromise results of development projects
- III. Health Problems in the Sahel: Nature of disease organisms; ecology of disease; general review of the diseases in the Sahel (location, prevalence, severity, potential to spread)
- IV. Development Programs and Plans in the Sahel and Their Implications for Health Problems (sector specific discussion): General introduction; goals of the sector; activities of the sector; types of changes associated with sector activities; their impact on health; table - positive and negative effects of the sector; table - approaches to deal with adverse health impacts
- V. Methodology to Review the Potential Impact(s) and Effects on Health from Development Projects: Introduction; checklist; matrix
- VI. Flowchart: Recapitulation of the material and concepts presented

**APPENDIX 8**

**Chronology of Health Sector Activities:  
CILSS/Club and SDP**

**CHRONOLOGY OF HEALTH SECTOR ACTIVITIES:  
CILSS/CLBU DU SAHEL AND SDP**

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**1976**

The Sahel Planning Task Force of AID's Africa Bureau was established to make initial recommendations in the long-term development of the Sahel Region.

- March:** Club du Sahel holds its first meeting, creates international Working Group and calls for the development of a long-term development strategy for the Sahel.
- June:** The Sahel Development Program Team (SDP) was established to lead and coordinate AID efforts in the long-term development of the Sahel.
- October:** Health/Nutrition/Population Sector Chief was appointed to lead SDP activities in this newly created sector.
- November:** G.E. Tempo assisted in the development of a proposal for a regional demographic program. Family Health Care, Inc. (FHC) was engaged to assist in analyzing the health/nutrition/family planning needs of Sahelian countries and developing a long-term strategy to meet those needs.
- December:** At the Ouagadougou meeting of the Human Resources Team, AID presented a draft work plan for the Health/Nutrition/Water Subgroup, to develop a sector strategy paper in preparation for the May-June 1977 meeting of the Club. The work plan was adopted and it was agreed to secure the participation of Sahelian representatives at the next meeting of the Health/Nutrition/Water Subgroup.

**1977**

- January:** Development of the draft strategy for long-term development of the health/nutrition/population sector in the Sahel was undertaken by Dr. Stanley Scheyer of FHC in collaboration with Dr. Steven Joseph of Harvard University. Dr. Martin-Samos, WHO Representative in Upper Volta, pulled together the WHO country profiles to produce: "A Profile of Health, Water, Nutrition in the Sahel."

- March:** Meetings of the Human Resources Team and the Health/Nutrition/Water Subgroup were held in Dakar with five Sahel countries represented in the Subgroup. The FHC Health/Nutrition/Water draft strategy and the Martin-Samos document containing country profiles were presented. It was agreed that Martin-Samos would prepare a synthesis of both documents with Dr. Rasmane Sawadogo (Upper Volta) for presentation at the annual Club meeting. A strategy for a program to assist demographic planning in Sahelian development efforts was also presented at the meeting and endorsed by the Group for further development.
- May - June:** The synthesized health strategy was adopted in Ottawa at the technical meeting of 5/25-28/77 and the Council of Ministers meeting (5/30-6/1/77) with donor representatives including, for AID, Assistant Administrator for Africa, Goler T. Butcher and Deputy Administrator, Robert Nooter.
- July:** CILSS requested AID provide continued assistance to the health sector including the recruitment and support of a Public Health Advisor to the Secretariat for a two-year period.
- August:** AID agreed to continue development of the long-term strategy, assistance to CILSS to implement the strategy, and recruitment, orientation, and support of the CILSS Health Advisor.
- October:** At a meeting of the Sahel Institute held in Ouagadougou, AID presented terms of reference and budget for a Demographic Unit and was requested by the Institute to assist in the recruitment of a Coordinator and to provide initial operating costs.
- November:** The newly recruited Health Advisor to CILSS, Dr. Michael White, attended a meeting in Ouagadougou with the Club/CILSS "Rapporteur," "Co-Rapporteur," and "Animateur" of each sector. The purpose of the meeting was to define the 1978 Working Group plan of action with particular emphasis on screening and funding the first generation of projects proposed by the Sahel countries.
- November:** A Family Health Care team assisted CILSS to define more fully work plans for the health sector for 1978. The plans prepared were agreed to by Rapporteur Sawadogo and CILSS Secretariat

Director of Projects and Programs Yaya Idrissa. It was agreed that an Interim Health Advisor was needed to begin the implementation of these plans as Dr. White would not be available on a full-time basis until July 1978.

1978

- February:** Interim Health Advisor Julia Terry accompanied by Kathy Parker, both of FHC, arrived in Ouagadougou to plan the visits to all eight countries to prepare the dossiers for first generation projects. The review of nonhealth projects for positive and negative impact on health and planning for the development of health impact guidelines for the design of nonhealth projects was also undertaken.
- March:** Interim Public Health Advisor participated in the Human Resources Team meeting in Niamey. The Team reviewed and approved the 1978 health sector work plan.
- April:** Pursuant to the RFP/competitive bidding process, Family Health Care/Population Council were awarded a contract to provide technical assistance to analyze the interrelationship between population and development in the Sahel Region.
- April - August:** Visits were made to CILSS member countries in relation to first generation projects.
- April - July:** Work is begun in collaboration with CILSS Ecology Unit on development of guidelines for incorporating health considerations into the design of nonhealth development projects.
- August-Sept:** Final Preparations at the CILSS of first generation project dossiers for the consultation with donors. Transmittal of the dossiers to the Club du Sahel in Paris.
- Sept:** Meeting of CILSS/Club staff, representatives of member countries, and donor representatives in Niamey to consider Human Resources first generation project dossiers.
- Sept:** Meetings held in Bamako and in Washington between FHC/PC, the Sahel Institute Socio-Economic/Demography Unit Coordinator and USAID to establish a workplan for the demography contract.

October: First draft of health impact guidelines presented to technicians at CILSS for review.

October: Paper on health and new lands development prepared by FHC and presented at Club Conference on New Lands held in Ouagadougou.

**APPENDIX 9**

**The Use of Minorities and Women in the  
Execution of the Contract Activity**

In the execution of this Work Order, two persons were employed on a full-time basis (Project Coordinator and Interim Public Health Advisor); both of these were women. Among the consultants used to carry out the country missions (5 in all) one was a minority. Of staff and consultants used at any time during the work order - 14 in all - 6 women and two minorities were used.