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SUMMARY OF PROCEEDINGS  
1988 CONFERENCE FOR  
HEALTH, POPULATION, AND NUTRITION  
OFFICERS  
BUREAU FOR AFRICA  
A.I.D.

March 20-23, 1988  
Yamoussoukro, Cote d'Ivoire

by

Dorothy B. Wexler, Rapporteur

Produced by

Population Technical Assistance Project  
International Science and Technology Institute, Inc.  
1601 North Kent Street, Suite 1014  
Arlington, Virginia 22209  
Phone: (703) 243-8666  
Telex: 271837 ISTI UR

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MEMORANDUM

TO: Africa Field Missions  
C) 772

FROM: Gary Merritt, Chief, AFR/TR/HPN

RE: 1988 Yamoussoukro HPN Conference  
Summary of Proceedings

Attached are the conference summary and working papers developed during the HPN Officers Conference held in Yamoussoukro, Cote d' Ivoire in March 1988.

It is a very complete record of the presentations and working papers developed during the week, but a written report cannot evoke the satisfaction and sense of purpose which we shared.

While the raison d'etre of the meeting -- technical updates on health issues -- was excellent, I most appreciated the opportunities we had to meet with our HPN colleagues in the field and to exchange ideas and air concerns on a number of issues including personnel, management, sector programming, and new projects. A vast amount of real work occurred both in the working sessions and in the corridors and informal meetings. We continue to profit here in A.I.P./W from the insights gained during these various gatherings.

I stressed several times during the conference that general Agency personnel precepts now strongly favor a "generalist" definition of HPN officer roles in Missions; i.e., "we are all BS-50s." This precept now converges with the "functional account-free, unearmarked" nature of the new Development Fund for Africa (DFA) to provide opportunities, unique within A.I.D. over the past twenty years, to craft country-level sectoral programs that more easily join fertility and mortality goals and objectives. If current DFA levels remain relatively constant over the current ARS period (FY88-90) and HPN activities maintain their current 17-18 percent of DFA (from FY90 ARS), we must expect to program about \$275 million, focused in roughly 25 countries. This is an imposing responsibility in itself, and there is no reason for us to be satisfied with that level. We can successfully compete for more. Exploring the best ways to guide this assistance competently was mainly what the 1988 HPN Africa conference aimed to accomplish, and did.

A host of thank yous are in order to the government of Cote d' Ivoire for permitting us to hold the conference in their beautiful country, to REDSO staff for the enormous amount of time and energy spent preparing for this conference, to ISTI for so beautifully organizing the logistics before, during, and after the meeting, to Inter Management, the local management group, and to the various USAID Missions which provided scarce O.E. funds to the A.I.D. and project officers who attended. The conference provided a fine forum for sharing ideas and experience. We accomplished a lot in an altogether too brief time, and look forward to our next session, perhaps in 1990.

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GLOSSARY

ABS	Annual Budget Submission
ACSI	Africa Child Survival Initiative
AED	Academy for Educational Development
AFR/TR	Bureau for Africa/Office of Technical Resources
AIDS	Acquired Immunodeficiency Syndrome
AIDSCOM	AIDS Technical Support (project), Communication Component
AIDSTECH	AIDS Technical Support (project), Technical Support Component
ARI	Acute respiratory disease
AVSC	Association for Voluntary Surgical Contraception
BRH	Basic rural health
BS-50	Back Stop-50
BuCen	Bureau of the Census
CAFS	Centre for African Family Studies
CBD	Community-based distribution
CEPLANUT	National Nutrition Planning Center (Zaire)
CCCD	Combatting Communicable Childhood Diseases
CDIE	Center for Development Information and Evaluation
CDC	Centers for Disease Control
CDD	Control of Diarrheal Diseases (program)
CPR	Contraceptive prevalence rate
CR	Continuing Resolution
CRPF	Chloroquine-resistant <u>P. falciparum</u>
CS	Child survival
CSM	Contraceptive Social Marketing

DDC	Diarrheal disease control
DFA	Development Fund for Africa
DPT	Diphtheria, pertussis, and tetanus
ELISA	Enzyme-linked immunosorbent assay, a blood screening test
EPI	Expanded Program for Immunization
EPIIS	EPI Information System
ESA	East and Southern Africa
ESAMI	East and Southern African Management Institute
ESF	Economic Support Fund
FDA	Food and Drug Administration
FEWS	Famine Early Warning System
FHI	Family Health International
FHI	Family Health Initiatives (projects I and II)
FPA	Family Planning Association
FPPS	Family Planning Private Sector (programme-Kenya)
FP	Family planning
FVA	Bureau for Food for Peace and Voluntary Assistance
GM	Growth monitoring
GO + initial	Government of + first initial of any country
HAPA	HIV/AIDS Prevention in Africa (project)
HEALTHCOM	Communication for Child Survival (project)
HPN	Health, population and nutrition
HIV	Human Immunodeficiency Virus
IEC	Information, education and communication
IFPRI	International Food Policy Research Institute
IND	Investigation of New Drug

INTRAH	Program for International Training in Health (project)
IPPF	International Planned Parenthood Federation
ISTI	International Science and Technology Institute, Inc.
IUCN	International Union for the Conservation of Nature and Natural Resources
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KAP	Knowledge, attitudes, and practice
LAC	Bureau for Latin America and the Caribbean
LDC	Less developed country
MADIA	Managing Agricultural Development in Africa
MCH	Maternal and child health
MIS	Management information system
MOH	Ministry of Health
NCPD	National Council on Population and Development (Kenya)
NGO	Nongovernmental organization
NHSS	Niger Health Sector Support (grant)
OC	Oral contraceptive
OCCGE	Organization for Coordination and Cooperation in the Fight Against Major Endemic Diseases
OCEAC	Organization for Coordination of the Fight Against Endemic Diseases of Central Africa
OPTIONS	Options for Population Policy (project)
OR	Operations research
ORS	Oral rehydration solution
ORT	Oral rehydration therapy

ORSTOM	Organization for Scientific and Technical Research Overseas
OYB	Operational year budget
PASA	Participating Agency Support Assistance
PDD	Policy Development Division (S&T/POP)
PDPR	Bureau for Program Development and Policy Coordination
PHC	Primary health care
PIO/T	Project Implementation Order/Technical
PPC	Bureau for Program and Policy Coordination
PRICOR	Primary Health Care Operations Research (project)
PRITECH	Primary Health Care Technologies (project)
PSC	Personal Services Contract
PVC	Office of Private and Voluntary Cooperation
PVO	Private voluntary organization
RAPID	Resources for Awareness of Population Impacts on Development (project)
REACH	Resources for Child Health (project)
REDSO	Regional Economic Development Support Office
SIDA	AIDS (French acronym)
SOMARC	Social Marketing for Change (project)
S&T	Bureau for Science and Technology
STD	Sexually transmitted disease
TAC	Technical Advisory Council
TBA	Traditional birth attendant
TFR	Total fertility rate
TIPPS	Technical Information on Population for the Private Sector (project)

UNFPA	United Nations Population Fund
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WASH	Water and Sanitation for Health (project)
WCA	West and Central Africa
WHO	World Health Organization
ZNFPC	Zimbabwe National Family Planning Council

## INTRODUCTION

This conference was the first in nearly four years to be held for Bureau for Africa health, population, and nutrition (HPN) officers and marked the first time in seven years that this conference has been held in Africa.<sup>1</sup> The attendance was the largest ever, with a total of 68 participants--34 from the field and the other 34 evenly divided between representatives from A.I.D./Washington and A.I.D. contractors. The large representation from USAID missions (27 field officers) and from the Regional Economic Development Support Offices (REDSO) (7 staff members) reflects the dynamic growth of HPN activities in the Africa Region over the past few years. In 1982, as best as can be reconstructed, there were only 4 USAID population officers and fewer than 10 health officers stationed in Africa. Today, the Bureau has about 115 technical personnel--Back Stop-50s (BS-50), Foreign Service Nationals (FSN), Participating Agency Support Assistance (PASA) and Personal Services Contracts (PSC)--and these are projected to rise to about 130 over the next three years (based on the 1990 Annual Budget Submission [ABS] exercise in July). (See Appendix F for a complete list of participants and Appendix G for a list of HPN Mission contact persons).

The growth in staff reflects the increased importance of the HPN sector in the Africa Region portfolio. Since 1981, the number of population bilateral projects has grown from 3 to 12 and the number of bilaterally funded health activities has risen from 36 to 54. In 1988 there were five new mission-based, population emphasis projects.

A major concern of this conference was the new \$500 million Development Fund for Africa (DFA), which had been evolving over the last 18 months and became law as part of the A.I.D. Continuing Resolution shortly before the conference. In the Keynote Address, Brian Kline, Deputy Director of the Bureau for Africa/Office of Technical Resources (AFR/TR), set forth the implications of the DFA for field operations. The DFA was the focus of two other presentations: Arthur M. Fell, Director, REDSO/West and Central Africa (WCA) and official conference host, enumerated some changes that would be needed in programming focus; and Katherine Blakeslee, Associate Assistant Administrator, Bureau for Program and Policy Coordination/Office of Policy Development and Program Review/Sector Policy Division (PPC/PDPR/SP), spoke of the relationship of HPN activities to economic development in general.

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<sup>1</sup>The conference immediately preceding this was held in the summer of 1984 in Gettysburg, PA, and prior to that, in 1981, HPN officers met in Lome, Togo.

The conference opened on Sunday, March 20, 1988 with discussion of the DFA, and a good portion of the last day, Wednesday, March 23, also focused on this issue. March 21 was devoted to population and family planning and March 22, to health and nutrition issues. The exploration of population and family planning issues began with an overview by Agency Director for Population Duff Gillespie, followed by five country reports and three panels on topics of critical technical interest in population programming: increasing emphasis on more effective contraceptive methods; developing new ways to deliver services; and achieving a degree of program sustainability. The sessions on health, opened by Charles DeBose, Regional Health Officer, REDSO/WCA, were divided equally between child survival activities in Africa and A.I.D.'s broad-gauged response to the HIV/AIDS emergency on the continent. On the morning of the final day, several presentations covered topics of general interest to both health and population officers (see Appendix B for the conference agenda).

In addition to the formal presentations, every conference participant was assigned to one of six working groups. Three of these were focused on subjects also explicitly addressed during the conference: population/family planning strategy; child survival strategy; and HIV/AIDS. The other three were topics that have increasingly come to the fore in recent years, and have been given more prominence yet with the advent of the DFA: program sustainability; private enterprise and private voluntary organizations; and human resource development. The groups met periodically throughout the conference and presented their conclusions and recommendations at the closing session (see Appendix C for Working Group Reports as cabled to A.I.D./Washington after the conference).

Conference Chairman Gary Merritt, AFR/TR/HPN, requested conference participants to come forward with issues of special concern so that special ad hoc committees might be established to explore these problems and to make recommendations for A.I.D./Washington. There were three such groups, one addressing personnel issues, a second on "orphan projects" (or projects whose funding was in question due to the changes from regional to mission funding), and the third on Sahel projects. (The cabled recommendations of these groups are included in Appendix D. These groups and their recommendations were almost uniformly successful in securing positive follow-up.)

I. DEVELOPMENT FUND FOR AFRICA  
Sunday, March 20 and Wednesday, March 23

I.1 KEYNOTE ADDRESS - "THE DEVELOPMENT FUND FOR AFRICA"

Brian Kline, Deputy Director, Bureau for Africa/Office of Technical Resources (AFR/TR)

Introduction

It may strike you as strange--it certainly does me--that A.I.D. is being asked to testify on its accomplishments under the Development Fund for Africa, a complex piece of legislation that is not yet three months old. But that is the way of Washington. And this fact underlines an important point about the Fund legislation: Congress is sincerely interested in the authorities it has given us and expects us to keep it fully informed about what we are doing and why. A.I.D. asked for the special authorities the fund provides, and a skeptical Congress has given those of us working in Africa a set of more flexible tools than exist in the other regions so that we may exercise more flexible judgment in, to quote the Continuing Resolution (CR), "helping the poor majority in Sub-Sahara Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant...."

This presentation will

- o First, briefly trace the history of this legislation and how we got here;
- o Then, review some of the key features of the Fund--what we can do and what we must do with the authorities provided; and
- o Finally, take a look at some of the steps the Bureau has under way to shift its planning, budgeting and operations to a new mode of working.

Origin of the Development Fund for Africa (DFA)

If there is any starting point for the legislative process that led to the Fund, it is November 1984. Starting with an NBC news broadcast just before Thanksgiving, the American public was confronted with the haunting faces of starving mothers and children in that far-off place, Ethiopia. The response was dramatic:

- o A.I.D. managed a relief and recovery program of over \$1 billion from 1984 to 1986;

- o Congress passed a special supplemental appropriation giving the Office of Foreign Disaster Assistance unusual authorities for longer term "recovery and rehabilitation" assistance--an authority that has been extended in the 1988 CR with a special provision for orphans; and
- o Private voluntary organizations (PVO) raised over \$120 million in donations from American citizens--the largest amount ever collected for an international disaster.

From elementary school food drives to the hype of the rock stars, Africa suddenly received new attention. The American people, PVOs and Congressional staffers began asking, "Why hasn't Africa kept pace with the rest of the world?"

The drought also brought into focus many of the fundamental issues affecting African development. Thus, a large number of African governments began addressing the serious structural problems underlying the lack of economic progress. At the special UN session in May 1986, many Africans clearly expressed heightened concerns about the need for fundamental restructuring of their economies and institutional systems.

This new U.S. public interest in Africa and the Africans' reappraisal of what needs to be done coincided with A.I.D.'s own reappraisal of its role in Africa. Those of you in the field know only too well the statistics and the constraints. But what are the causes of these problems? A.I.D.'s analysis was set forth in last year's Congressional Presentation, which proposed this new African Development Fund:

"The major long-term objective of our assistance is to help African countries initiate and sustain market-led economic growth that allows them to attain food self-reliance and more equitable development progress. The major pieces of the strategy are: economic stabilization and reform, agricultural development, and human resources development.... We will be able to continue agriculture, health, population, child survival, education and environmental activities while stressing private sector and policy reform efforts. The U.S. will be able to offer more flexible support to those countries which are making a significant commitment to policy reform."

The Development Fund for Africa is one major part of the President's End Hunger Initiative. Together with pursuing more effective donor coordination, the Fund aims to deal with Africa's problems by:

- o increasing incomes and employment;

- o expanding agricultural productivity and food security; and
- o improving the capacity of Africans to deal with their own problems.

A.I.D. worked very hard to convince its Congressional overseers that this change was needed. Many were--and remain--skeptical, convinced that the Fund was an abandonment of basic human needs, or a reassertion of the "trickle-down" theory of economic progress. In granting this authorization, Congress demanded more information, more reporting, more rigorous demonstrations that A.I.D. assistance was helping the poor majority.

A.I.D.'s arguments alone were not sufficient to persuade a skeptical Congress. However, the PVO community--energized by the public response to the 1984/5 famine--pressed Congress for a balanced reform package. As a group, PVOs recognized the need to pursue economic growth as part of a strategy for meeting Africa's development needs. And they worked quietly and effectively with key Congressional staffers to press for the Development Fund for Africa.

What emerged in the Continuing Resolution last December was not exactly what A.I.D. proposed, nor did it contain all the earmarkings and micro-management details that many Congressional staffers, lobby groups, and PVOs wanted. But, it does provide a workable framework for A.I.D.'s new emphasis in Africa.

#### What the Fund Will Do

Let's turn now to the key features of the legislation as it passed.

##### 1) A Stable Source of Funding for Africa

The establishment of the fund has isolated and protected the Bureau's budget. Any concerns that we might be pressed to fund activities in Latin America or Asia were put to rest during the first round of budget consultations with the Hill last month. We have our \$500 million, and S&T (Bureau for Science and Technology) and FVA (Bureau for Food for Peace and Voluntary Assistance) are expected to continue supporting African activities above that level with funds from their share of the other functional accounts.

##### 2) Flexibility, Based on Macro-Economic Policy Reform, and Targets for Health/Population

The Fund establishes a flexible authority. In practice, several important advantages should flow from this flexibility.

Perhaps foremost, through the Fund we can support much more vigorous economic policy dialogue and reform in Africa. This will involve macro-economic policy reform--but it will also engage A.I.D. more than ever before in sectoral policy reform. Congress remains skeptical about our ability to really help the poor through policy reform--especially since in the minds of many "macro-economic policy" reform means doing nothing for the poor and hoping for results to trickle down. This is the area where those of us in AFR/TR and technical officers in the field are now challenged to provide a new leadership, to exert ourselves actively to help set agendas at the regional and country levels.

To quote once again--this time from the CR Conference Committee report:

"Assistance...should be provided in the form of direct interventions to enhance human welfare as well as indirectly through sectoral support designed to alleviate specific policy, institutional, or resource constraints in a recipient country's economy. It is expected that these approaches would be integrated into a single country strategy whose different components complement one another and where the potential short-term adverse effects of a change in policy are appropriately taken into account."

The legislation further calls on us to continue working in the same areas as the functional accounts. Funding targets of 10 percent of the DFA have been established for natural resources, for health, and for voluntary family planning. The FY 1989 Bureau Congressional Presentation indicated that about \$40 million of the DFA request will be programmed for health and child survival in 1988 and in 1989, and about \$34 million will go for population and family planning this year and next. When S&T/Health contributions in Africa are added, we expect health investments will reach about \$45 million. If S&T/POP contributions are added to DFA plans, we expect total A.I.D. investment in the population/family planning area will be just under \$60 million in each of the next two years, and that totals of health and population together will be over \$100 million each year.

In short, we have been given a new, more flexible tool for addressing Africa's development problems, a tool which recognizes that these problems call for:

- o Policy reform and technical assistance;
- o Macro-economic growth and participation by the most disadvantaged;
- o Sustained commitment by A.I.D. and sustainable development programs.

3) Emphasis on PVOs

The legislation seeks to emphasize the role of PVOs in the development process. Thus, the Congressional drafters expect A.I.D. to consult on a regular basis with African and American PVOs that have demonstrated their effectiveness in helping address the development problems of Africa at the community level, and to involve those organizations in our programs, projects, and activities to the extent possible. Those of us working in the health and family planning fields have a special opportunity here, since many existing PVO activities involve community-oriented, rural-based health service delivery systems. One of our main challenges, I hope you will agree, is to help Africans foster indigenous PVO organizations and establish much more effective mechanisms for African governments to support their PVOs.

4) Increased Accountability to Congress

The legislation requires an entirely different level and form of consultation with the Hill on what we are doing. For the Agency as a whole, the Congressional notification process has been relaxed. But in Africa we have a new responsibility to meet and talk with Congressional committees about what we are doing and why. In practice this means we are to keep several key Congressional staffers advised of our plans and our progress.

This process has begun. Charles Gladson (Assistant Administrator for Africa) gave the initial set of briefings last month on FY88 budget allocations. At least once each quarter, our Assistant Administrator must--by law--meet with these same Congressional committees to keep them informed and to hear their concerns. This process is to be a dialogue.

Other Resources

Two other major resources are available to us in Africa. The ESF (Economic Support Fund) remains available and is clearly targeted on those special security interest countries in Africa. Only \$90 million has been appropriated this year. PL-480 resources are also lower for Africa, mostly as a result of reduced surpluses in U.S. production in the past few years. While we must incorporate these resources and the local currencies they generate into our "comprehensive country strategies," the real funds--\$500 million--that are available to us can be found in the development assistance account--the Development Fund for Africa.

Changes in Bureau Operations

How is the Bureau changing its operations because of the fund?

1) Targeting Priority Countries

We are targeting OYBs (operating year budgets) more on high priority countries. Certain key factors were included in setting FY88 levels:

- o economic performance;
- o population size;
- o economic policies; and
- o poverty levels.

These criteria were evaluated for all countries and decisions reached on where A.I.D. resources could produce results. In the future, these criteria will be even more important--and the performance question is one where we technical officers need to make our judgments felt to influence budget decisions. It is not just reciting "success stories"--those projects that have met their objectives--although that is important. We also need to look at the impact of government and donor activities on the underlying problems of economic growth and demonstrate clearly how using scarce Fund resources will deal with these fundamental problems.

2) New Management Arrangements for Low Priority Countries

We are trying to reduce our management burden by changing our operations in lower priority countries. Now, this is not a new process. Many details need to be worked out with the Department of State before all changes the Bureau wants can be effected. But an A.I.D./W "Small Country Strategy" exercise this winter has selected six countries where staff will be phased out (bringing the total to 12) and the program focus sharply curtailed.

3) Sectoral Strategies

We are focusing on sectoral strategies across the Africa region. We have already narrowed the sectors we are involved in. We have been identifying within those sectors those things to which A.I.D. should give primary attention; and we are choosing priority countries and priority approaches in each of our key sectors. In child survival, agricultural research, faculties of agriculture, and natural resources, the Bureau has published thoroughly vetted sector strategies. In HIV/AIDS we are working closely with S&T and PPC to create a similar "sector" strategy. The AFR/TR staff have been addressing the need for a similar statement on the Bureau's population/family planning strategy. Further, we in AFR/TR are attempting to look at how these sectors relate to one another--how we identify and clarify from a technical viewpoint the key sectors and subsectors that constitute the Bureau's development strategy. We want to be able to provide better support to the field, which is being asked to

focus its limited resources on key sectors based on need and a proven record of performance.

4) Funds Being Transferred from Bureau's Regional Program to Missions

We are curtailing the role and funding of the Bureau's regional program. For those projects managed by AFR/TR, our FY88 OYB is \$38 million, compared to \$74 million last year. We are closing out 13 projects. Those that are left--and the two new ones being developed (HIV/AIDS and FEWS [Famine Early Warning System])--are clearly aimed at Bureau priorities. Funding is now to come from mission buy-ins. No longer do we have money for country-specific activities. The Bureau in Washington will now primarily provide the vehicle for obligating funds, not a treasury for missions to tap and supplement their resources.

This will make the projects more responsible to mission needs and priorities--what Charles Gladson refers to as letting the "market place" determine what the regional projects do, not remote managers in Washington. The reduction in AFR/TR's management responsibility for these projects is intended to have a second important benefit. Our time will be freed to think about the technical problems that are affecting African development, to look at how our approaches are having an impact--that is, what is the performance? We should be better able to weigh in with technical advice as a result, not just to help the field but to help Bureau top management make better-informed resource allocation decisions.

5) Measurement of Program Accomplishments

We are trying to get a better handle on ways to measure our accomplishments. All of this reporting to the Hill requires us to be able to communicate better what we are doing--where we did what was needed, where we fell short, and why. Equally important, we need to know ourselves how we are doing. At the field level you have to understand how your projects are working. In Washington, AFR/TR has to demonstrate in the intense battle for resources that health, population, education, and agriculture projects are vehicles to improve the quality of life and increase economic productivity. We need honest assessments of impact and achievement to ensure that the problems we are working on really matter and the assistance we provide really makes a difference. If sustainable growth is our objective--and the legislation says it is--then we have to show how what we are doing helps achieve that objective. "Benchmarks" and "evaluation criteria" are more than buzzwords; they are things we really need to address.

Conclusion

A.I.D.'s role centers not only on the size of our assistance resources, but also on the three clear advantages we have:

- o the presence of our professional staff in country;
- o our long experience with designing and implementing development assistance in Africa; and
- o our relationships within the donor community.

Our role is increasingly one of using our local knowledge, our development experience, our influence with other donors, our willingness to innovate and take risks, and the consistency of our vision to serve as a catalyst in the development process.

## I.2 OPENING REMARKS

Arthur M. Fell, Director, Regional Economic Development Support Office/West and Central Africa (REDSO/WCA)

The DFA legislation will require several shifts in the direction of our health and population programs in Africa. Specifically:

1) The focus will move somewhat from the project to the sector level. Health and population officers will need to identify areas of policy reform in their sectors. Specific policy actions that governments are willing to take should be included in the health sector program design. These sector programs (policy reform efforts) will require some conditionalities and more involvement than in the past by other key ministries and the private sector.

2) A performance-based budget allocation system will be developed to target more support for promising reform efforts. Policy changes might include cost recovery schemes, increased allocations to preventive health services, more balanced allocation of government resources to those in greatest need (i.e., to people in rural areas, and to women and children), generic drug formularies, the use of lower level health workers, and incentive performance schemes. The system will also look to increased involvement of the private sector to reduce the financial strain on government budgets.

3) Health and population programs should continue to display sensitivity to the impact of policy reforms on the poor. Health and population officers must be prepared to point out to mission directors the potential of macro-economic policy reforms to have a negative impact on the poor.

4) Health, and especially population, programs will need to exercise leadership in the donor community. Such leadership should arise naturally from the Agency's long history in some

countries, the amount of funding for population activities, and the Agency's perceived technology advantage.

5) Efforts are needed to embark on some long-term institution building in health, for example, by developing one or two universities (Anglophone/Francophone) to be used for training and programs in the economics of health and in public health.

### I.3 ADDITIONAL REMARKS ON THE DFA

Brian Kline, AFR/TR

[This second, unscheduled talk of Mr. Kline took place Wednesday morning and was included to amplify his Keynote address Sunday evening. His follow-up remarks are summarized below.]

#### Background on Need for the DFA

It is clear we cannot do everything, everywhere, and that therefore we need to set sectoral and country priorities. The existence of the Fund does not mean that AFR/TR will be changing its emphasis: Rather, it just allows us to be more flexible.

Our emphasis must be to develop the potential of projects to be self-sustaining. Self-sustainability can occur only in programs that emphasize equitable economic growth and employment generation. Thus, we have to deal with important policy constraints: macro-economic and sectoral. Technical officers are going to have to look at those problems from both top and bottom: the technologies and the policies. We need to look at technologies that will produce results. We also need to develop additional resources to supplement A.I.D.'s limited staffing resources. A.I.D. staffing will never be adequate to provide hands-on management of technical assistance.

#### Results in Terms of Bureau Operations

The main difference the DFA will make in Bureau operations will relate to how programming decisions will be made.

i) The first change is that the missions will have increased ability to determine their own budgets. This is the latest pendulum swing in an age-old debate for A.I.D. on whether this authority should be exercised by country or by function.

ii) The new emphasis on demonstration of results means that the Bureau will be willing to drop activities more quickly if they cannot be proved to work. DP (Office of Development Planning) is looking to increase its deobligation/reobligation

authority. Thus, it will be more important than ever to be able to evaluate results and report achievements.

iii) Although the focus will be on mission needs, the assumption is that economic growth will be the top priority and that everything must be focused and justified in these terms. In this context, a study is being undertaken to explore the effects of economic reform and structural adjustments on the poor [a \$5 million study funded by AFR/DP at Cornell]. Another study, the MADIA study (Managing Agricultural Development in Africa), is suggesting that countries that approach agricultural development from a market point of view appear to be experiencing more equitable growth overall. In Kenya, this study shows that the small farmer has benefited from market-oriented policies, in contrast to Tanzania and Malawi where there were increasing inequities of income distribution.

iv) AFR/TR's funds will be reserved for core activities that must be done centrally (for instance, commodity procurement). Missions will now need to buy into most activities (the CCCD project, for instance).

#### How Buy-ins Will Work

The rapid evolution of this new process represents a major problem for the field's budgeting for FY88 and 89. The CR was passed only three months ago, but missions will be expected to obligate their budgets by the end of September. Furthermore, the field is not being kept abreast of the policy debate in Washington because it is felt that such information could generally be more confusing than helpful.

Within the Africa Bureau, TR has about 75 percent of Regional DFA funds with the rest going to DP/SA/SWA/PRE (Office of Development Planning/Southern Africa Affairs/Sahel and West Africa Affairs/Private Enterprise).

At present, AFR/TR's tentative plans for implementing buy-ins are as follows:

- o A cable will be sent to the field on each of AFR/TR's 17 projects and their disposition under the DFA, i.e., what buy-ins can and cannot do and how they will work. This latter procedural issue has not yet been completely worked out. [Details were sent to missions two weeks after HPN conference.]
- o For TR projects, buy-ins will require an OYB transfer to the TR project; TR will issue the funding citation; and the missions will do the PIO/Ts (Project Implementation Order/Technical). The FHI (Family

Health Initiatives) review procedure has not yet been worked out but will be included in the cable.

- o For S&T projects, funds must be obligated under an AFR project and then a PIO/T issued.

Another new provision is that under the DFA, AFR/TR no longer will be required to request a waiver to buy non-U.S. products.

#### Implications for Health and Population Officers

It will be necessary for health and population officers to make the case for their projects within the mission and to become an effective voice in the decisions on resource allocation. Therefore, they will have to focus on two aspects of their projects: the "macro," or policy issues, and the "micro," or technical implementation issues.

It will be necessary to demonstrate the effect of these projects on overall economic development, not just through "success stories," but through economic analyses. Moreover, it will be important that these data be manipulated and presented in clear and convincing ways.

#### I.4 CROSS-CUTTING POLICY ISSUES

Katherine Blakeslee, Associate Assistant Administrator, Bureau for Program and Policy Coordination/Office of Policy Development and Program Review/Sector Policy Division (PPC/PDP/SP)

[Although this presentation and the discussion that follows took place on Wednesday morning in the context of HPN Sectoral Issues, it is placed here because it relates primarily to the issues associated with the DFA.]

The technical issues addressed in this conference need to be put into the context of A.I.D.'s total mandate. As described by the A.I.D. Administrator in recent Congressional testimony, the Agency's strategy for economic growth has six components: There must be the right political climate; the private sector must be involved; human capital must be developed; the institutional structure must be in place; there needs to be access to technology; and there must be capacity to manage resources.

The issue for us is how HPN can mesh with the other functional sectors in a mutually reinforcing way to implement that strategy. Country models will differ. There are, however, some underlying themes that apply to HPN's role within the whole.

One is that humanitarian aid is still a legitimate part of A.I.D.'s overall mandate. Second, human capital is recognized as essential to economic growth, and our work relates directly to development of human resources. And third, there can be an important role for the private sector in the delivery of social services, as demonstrated, for instance, in Kenya.

The priority that will be accorded to HPN activities in the context of the DFA is still somewhat confused. Although the legislation calls for 10 percent of the funds to be allocated to both health and population, the reality is that these decisions will be made in the missions. It is therefore essential for HPN officers to be involved in the policy dialogue in the missions from the start, and to show how their programs will contribute to economic development. PPC has undertaken four country studies on the socio-economic impact of structural adjustment, in Sri Lanka, Morocco, Cote d'Ivoire, and Costa Rica. The initial findings are that the negative impact on vulnerable groups is not so bad as UNICEF had predicted. Elsewhere, the Harvard International Food Policy Research Institute (IFPRI) study is looking at the effects of commercialization of agriculture on consumption and nutrition.

## DISCUSSION

### Country Priorities

Issue: Equitable economic growth and economic performance are the criteria that will be used to judge whether countries will be ranked as "high priority," but how will A.I.D. measure these criteria? Will the judgment be made on the basis of how the country is performing in comparison with other African countries? Or is the issue how the country is performing with respect to other A.I.D. projects?

Response: The ultimate measure is the country's economic performance in the context of the performance of other countries elsewhere in Africa.

If performance is poor but it is possible to demonstrate that there is potential for policy dialogue or that economic reform would be facilitated by allocation of resources, this would also justify allocation of funds.

### High/Low Priority Countries

Issue: What should be the role of S&T/POP within the new environment of the DFA? Should it be putting its funds into the high priority countries? Or should it be filling the gaps that

will occur now that there are no regional projects to assist the medium and low priority countries?

Response: This issue essentially remained unsettled. One suggestion was that central funds should go to selected low- and medium-level priority countries that appeared to have promise but did not yet merit a bilateral. It was also suggested that specialized technical support should be available for countries with bilaterals.

#### Contributions of Health Programs to Economic Development

Issue: Is it really possible to make a convincing argument that health programs contribute to economic growth? It is difficult to make such arguments even in the U.S. and there is a question whether the limited health interventions being undertaken by A.I.D. in Africa will have sufficient impact to put them in the framework of economic development.

Response: It may be possible to do better in this regard. A.I.D. education technical officers have done studies showing that more schooling leads to better agricultural production, and population programs have been able to discuss the cost-benefit of births averted. By the same token, it may be possible to demonstrate that there are economic gains from infant deaths avoided.

#### Performance Criteria

Issue: Has A.I.D. developed some performance criteria that are particularly pertinent to health and population programs and their relationship to economic growth?

Response: Attempts are being made to develop some guidelines but none have been accepted as yet. It is therefore up to AFR/TR to develop these criteria. This process does not imply that our programs need to change radically. Rather, it is important to continue to ensure technically sound programs, and, most important, to continue documenting successes and finding better ways to do so.

#### HPN Funding Levels

Issue: How binding is the legislation language that health and population will each get 10 percent of the DFA? Isn't there some cause for concern that Agency funding for health is dropping?

Response: There is reason for concern, but our primary mandate remains to save lives and because of this strong mandate from

Congress, these sectors were each targeted for 10 percent of DFA funds.

## I.5 EVALUATION AND REPORTING SUCCESS

Henry Merrill, Chief, Bureau for Africa/Office of Development Planning/Program Analysis and Budget Division

[Gary Merritt delivered these remarks on Evaluation and Reporting based on a prepared text from Henry Merrill. This is an abridged version of that text.]

### Introduction

A recurrent problem in the Africa Region is gathering well-written reports on successful activities in Sub-Saharan Africa for use in the Congressional Presentation as well as for testimony before Congressional committees. This situation is perplexing, as enthusiastic field personnel give very positive oral reports when in A.I.D./W but appear unable to put in writing what they effortlessly convey when speaking.

This situation must change. Given the result-oriented programs associated with population, health, and child survival activities, this conference should be a good place to start working on improved reporting techniques.

### Defining Success

Although many missions forward "success stories" to A.I.D./W, the content often resembles a carefully crafted parody. For example, this contribution was recently received:

"The Country X National Agricultural Program, funded by A.I.D. since 1981, has made several measurable contributions to agricultural development. Seventy participants have been trained, sixteen computers have been purchased and most importantly, an annual planning conference has been institutionalized since 1986.

"The 1986 conference established a listing of priority interest areas which was reconfirmed at the 1987 meeting. We look forward to lengthy discussions on possible implementation plans at the scheduled 1988 meeting.

"In addition, the project funded one hundred vehicles, fourteen of which continue to operate. The project has also set up a working group to recommend publications for the newly created departmental library. To date there are sixty-seven volumes in the library, and the

goal by the end of the project is to have a professional library exceeding one hundred volumes."

But, what happened with regard to agriculture? Success stories are not merely a listing of quantifiable events or actions. "Success" must be linked with developmental change.

Documentation of success must focus on the following questions:

- o Who benefited and how broad is the application of project benefits?
- o What is the change in behavior resulting from project funding?
- o How has the quality of life in the recipient country or project area been improved?
- o Does the project support a host country priority?
- o How will positive change be managed and continued following the withdrawal of project support?

### Reporting Success

Documenting success is often most difficult for those who know the most about the effort that went into the success. Assumptions are made on how much the listener knows, often resulting in the omission of points that the writer believes to be obvious. In addition, numerical detail is often substituted for overall impact as the project manager, knowing of the difficulties involved in getting things done, may believe that reporting on the process is more important than the product.

For example, the number of lives saved by a health effort may be overshadowed by the reporting about the expeditious procurement of pharmaceuticals or pesticides that allowed the health impact to occur. The writer may think the impact of a malaria project is self-evident, but find the spraying of 800,000 homes a logistical miracle.

Rule One: The reader knows nothing.

### Identifying Success

A common failing is to equate project activities with "project success." Reciting a list of activities may omit the context of those activities: i.e., stating that so many health workers have been trained conveys nothing about those persons whose lives are most dramatically affected by the activities--the recipients of services. On the other hand, an explanation of

how services have changed from a villager's point of view, supported with statistical data on clinic visits, makes an appealing, informative, and convincing story.

Rule Two: Look at "success" from a non-A.I.D. point of view.

### Success Revisited

Some of A.I.D.'s most important "success stories" occur long after the application of A.I.D. funding and technical assistance. In Thailand, for example, in the 1960s and early 1970s, A.I.D. funded a large piped water program. By the end of the project, the towns developing piped water had a somewhat spotty record of performance, with less than half of the systems operative. In the late 1970s, A.I.D. conducted a retrospective study of these systems and found that of the 25 surveyed, 24 were operative, supplying treated water in quantity, and the 25th facility was under repair at the time of the field survey. In other words, a project that was classified somewhere between failing and minimally successful upon completion was actually an extraordinary success when measured five years after completion.

Rule Three: Success is not necessarily an instantaneous process, nor does it follow A.I.D. project time limitations.

Rule Four: Success is often found where you least expect to find it.

### Success and Joie de Vivre

Writing "success stories" that then must go through the bureaucratic clearance (a.k.a. the blanding) process is demoralizing. A well-written success story, however, can emerge relatively unscathed. Here is how to write such a presentation:

1) Use non-bureaucratic words and an uncluttered style in describing your activity. This includes action verbs, descriptive nouns and adjectives, as well as short sentences. If you cannot say it clearly, then it is a probable bet that the reader will have similar difficulty in understanding your message.

2) Go to the field in order to get a better understanding of how projects are seen by beneficiaries. Many times the best of intentions are twisted by haughty service providers, outreach workers who do not reach beyond their own homes, or technical assistance teams that spend the bulk of a TDY period getting rather than giving information.

3) Try to convey the excitement of development in your descriptions. A.I.D. is a particularly rewarding place to work and we are all engaged in interesting and stimulating activities. Designing programs to save lives, improve living conditions, and promote a better environment for growth is pretty exciting. Let the message come through to your audience.

Rule Five: Make it fun to read.

I.6           **IMPACT OF RECENT CHANGES IN BUREAU PROGRAMMING AND BUDGETING**

I.6.1        IMPACT ON REDSOS

Charles DeBose, Regional Health Officer, Health/Population, REDSO/WCA

[This presentation took place Wednesday but is included here because of its relevance to the issues raised by the DFA.]

With the withdrawal of funding for regional projects under the DFA, the REDSOs are going to play a considerably reduced role in the areas of health and population. No longer will there be funds, as there were under FHI II, to stimulate new population activities in countries where there are no other means to do so. No longer will technical officers be able to manage programs that are of common value to the region. No longer will REDSO officers have a role in developing guidelines for programming based on regional commonalities or reporting on success stories with a regional flavor. The only role left for REDSOs at this point will be to provide technical assistance to the missions in designing, implementing, and evaluating programs.

The DFA also raises the question of whether REDSOs should focus on "A" missions (those with bilaterals) or "B" missions (those without). To date, it has been the practice to cover the B missions, which have been trying to carry out health and population activities without any health and population staff.

DISCUSSION

The concentration on B missions appears to be in conflict with Washington's priorities. In future, if the smaller countries are to receive no programming funds, then the question arises as to whether REDSO technical staff should give any time to them. Guidance is needed from Washington on this issue.

I.6.2 IMPACT ON REGIONAL PROGRAMS - CAFS

Rosalind Waithaka, Population Assistant, REDSO/ESA

[Ms. Waithaka made this presentation in place of Art Danart, REDSO/ESA, who was unable to attend the conference. Mr. Danart had been scheduled with Mr. DeBose to discuss "Impact of Recent Changes in Bureau Programming and Budgeting."]

REDSO/ESA manages two regional projects: CAFS (Centre for African Family Studies) and ESAMI (East and Southern African Management Institute). The CAFS program, in particular, is in danger of becoming a casualty of the phasing out of regional management responsibilities. The project is an effective regional training program which has provided training to personnel from many African countries in four areas: training of trainers, management, contraceptive technology update, and family planning communication.

DISCUSSION

Comments: Although CAFS is weak in the area of clinical training, it has made significant progress in IEC and management training and fills a need for regional training.

The kind of regional capability represented by CAFS makes a lot of sense and is certainly a better way of providing training to Africans than sending them to the U.S.

Issue: If CAFS is an example of a project meeting Washington criteria for institution building and for developing African capabilities, should not some means be found to continue this project?

Response: A.I.D./W has been concerned that REDSO officers have been diverted from their original and prime function of providing technical assistance by the management responsibilities that they have assumed. It is very clear now that A.I.D./W will no longer allow REDSOs to undertake a management role.

Issue: A.I.D./W's view is that management of valuable regional projects should be transferred to the missions. In the case of CAFS, however, the Kenya mission does not have the time or staff to take on this management responsibility. Will the next step be to downgrade the REDSOs to be a department of the missions?

[As a result of the interest in this issue expressed at the conference, a cable was sent to A.I.D./W recommending that responsibility for the management of the follow-on regional family planning training project with CAFS remain with REDSO/ESA (see Appendix E).]

## II. POPULATION AND FAMILY PLANNING Monday, March 21

### II.1 WORLDWIDE A.I.D. POPULATION/FAMILY PLANNING ISSUES

Duff Gillespie, Agency Director for Population, Bureau for Science and Technology/Office of Population (S&T/POP)

S&T/POP's efforts in Africa are in a period of transition. As the field, through a growing number of bilaterals, shoulders an increasing responsibility for the financing and implementation of population programs it is necessary to reexamine the part the Office of Population plays in Africa. This shift from centrally funded to bilaterally funded activities comes at a time of expected steep declines in centrally funded allocations to S&T/POP's budget. Although figures are not final, the current prospect is that S&T/POP's FY88 budget will have dropped to \$89 million, the lowest since 1982, and well below the \$160 million processed by S&T/POP during FY87 (of which \$115 million were central funds and the other \$45 million were field buy-ins).

Now that S&T/POP may no longer be the largest presence in the area of population activities in Africa, its role needs to be reassessed. Two issues need careful review: 1) What level of funding should the Office provide to countries with bilaterals? and 2) Will the growing role of bilaterals result in a shift in the functional areas the central program funds?

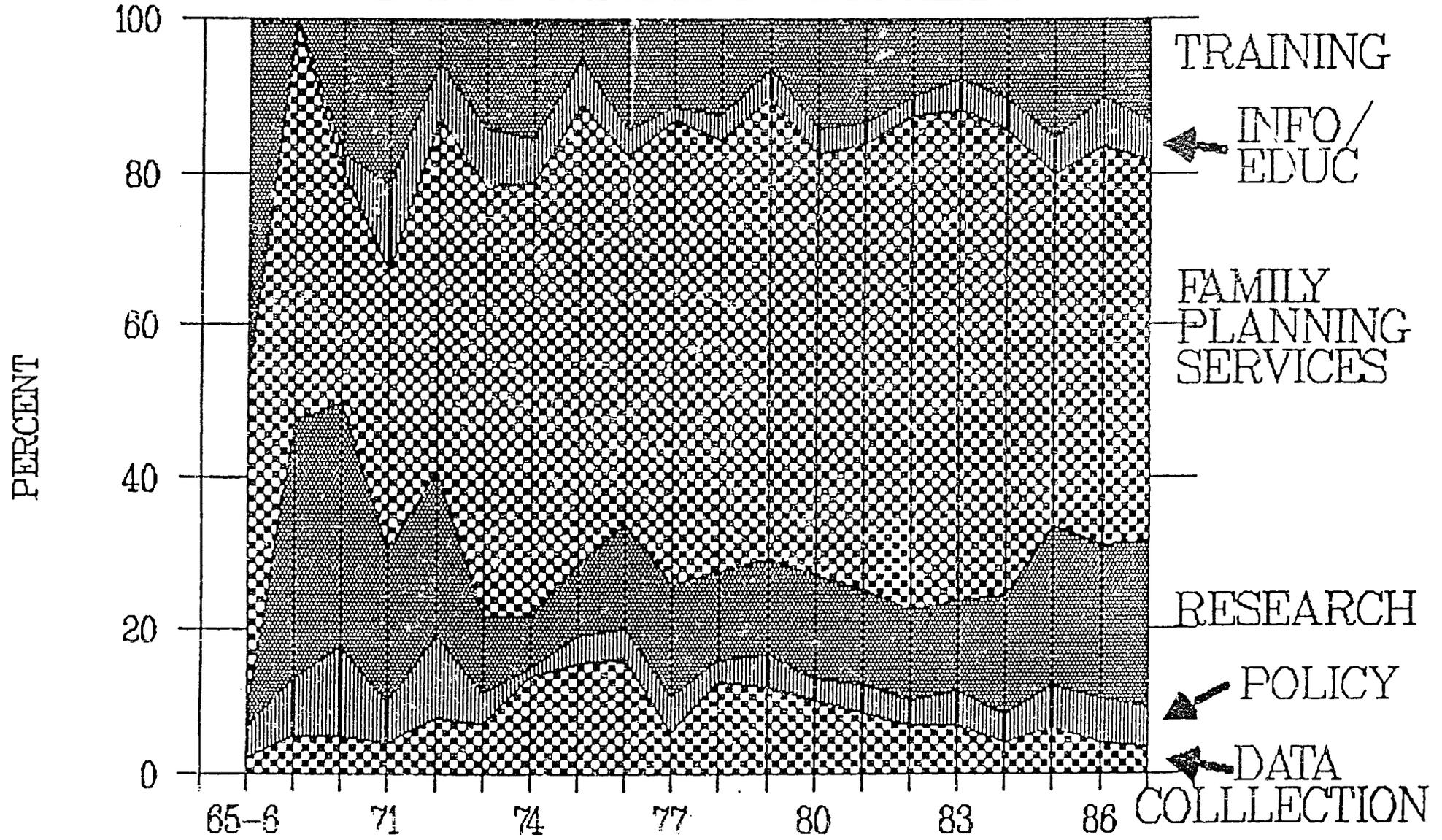
With respect to the first, in FY87, Agency-wide, 45 percent of S&T/POP funds went to countries with bilaterals, whereas in Africa the proportion was 37 percent. With the number of bilaterals increasing, the question is whether there should be a commensurate increase in the percentage of central funds allocated to countries with bilaterals.

With respect to the increase in bilateral funds, S&T/POP has its own priorities, which are of less immediate concern to the field, e.g., biomedical research. If our budget shrinks and the bilaterals' increases, a greater percentage of our budget may have to go to these S&T priority areas, although the absolute amounts would not increase. S&T/POP functional allocations since 1965/6 are shown in Table 1.

Traditionally, S&T/POP has placed a high priority on family planning service delivery, although recently the protected operations research budget, together with increased allocations for contraceptive development, has begun encroaching on funding for service delivery. S&T/POP is also moving out of basic demographic research, with the exception of the Demographic and Health Surveys (DHS) project, which is the largest effort of

Table 1

# S&T/POP FUNDING BY PROGRAM AREA



its kind in the world. The field has looked to S&T/POP primarily for assistance in policy development, with the largest portion of buy-ins having gone to the Policy Development Division (PDD). S&T/POP's response has been to fund RAPID III and the new OPTIONS project.

The real issue is not how much is in the central account or how much is in bilateral accounts. The real issue is the adequacy of resources for population activities. Table 2 shows that between 1975 and 1985, the number of women worldwide identified as wanting no more children increased dramatically, from 110 million in 1975 to 170 million in 1987. Wanting no more children is, of course, a very conservative definition of demand since it excludes spacing and timing. At the same time, the donor funds available to meet that demand have increased only slightly, and the cost per couple to provide family planning has risen from \$9.14 to \$20. In short, the demand for population funds at present far outstrips their supply.

## II.2 FIELD PERSPECTIVES ON FAMILY PLANNING PROGRAM DEVELOPMENT

Moderator: Jack Thomas, AFR/TR/HPN

### II.2.1 PHASE I -- SUDAN

Paula Bryan, HPN Officer, USAID/Khartoum

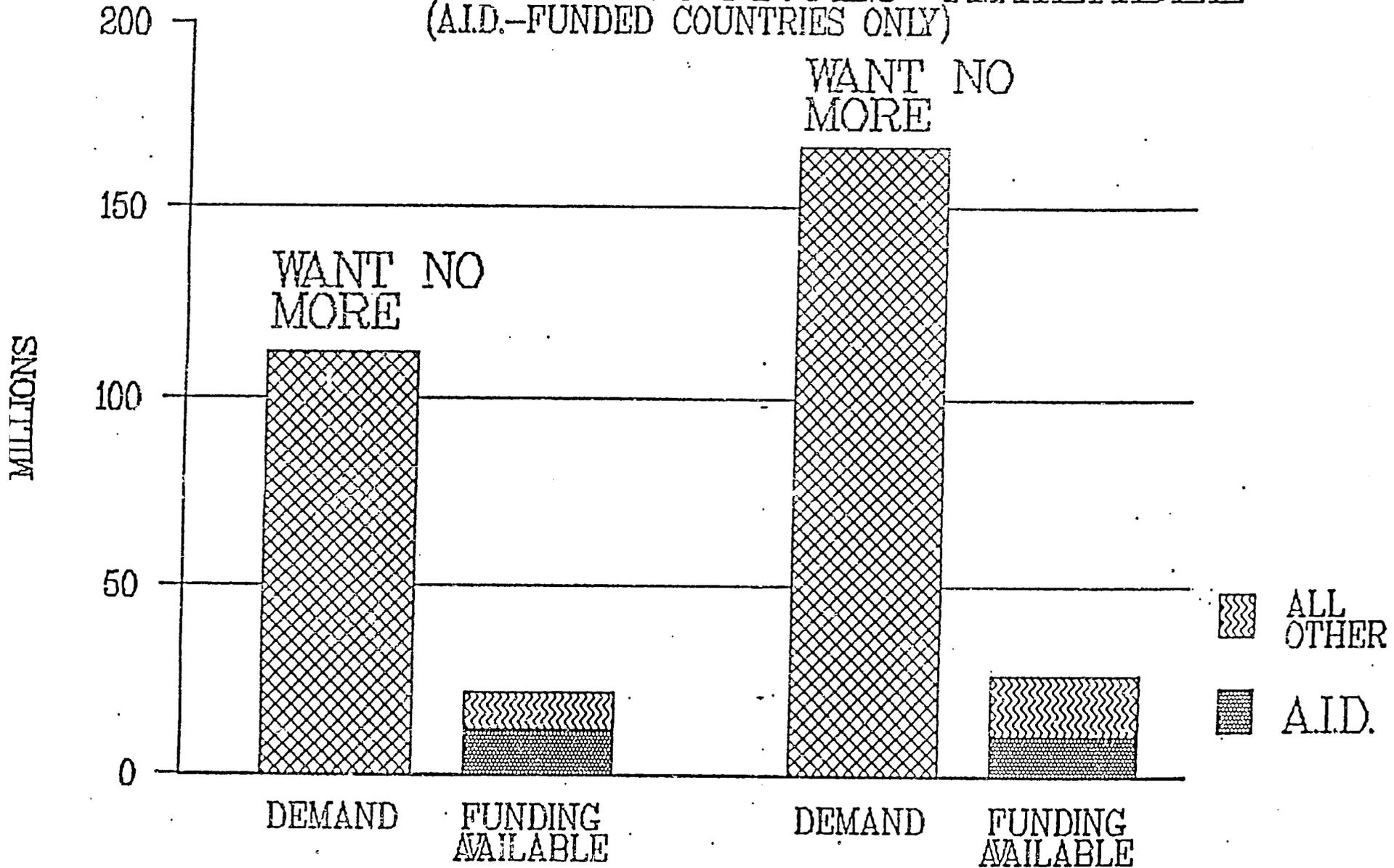
Although family planning efforts have been supported for two decades by private sector groups in Sudan, only recently has there been a significant broadening of the constituency base to include high-level government support. Sudan is ranked by A.I.D. as a Phase I country, i.e., a country "with an emerging interest and increasingly favorable policy climate" with respect to family planning programs. The pivotal event in the process toward an improved climate was the third National Population Conference, which took place in October 1987. Two earlier conferences had been primarily academic efforts to develop positions vis-a-vis the World Population Conferences of 1974 and 1984 and consisted of internal dialogues within the population community. In contrast, the 1987 conference was tied to efforts to end female circumcision (which affects 95 percent of Sudanese women) and was held in response to the Prime Minister's expressed interest in developing a national population policy. This conference has served to encourage a broader awareness of population issues, as it received very substantial coverage in the media.

Until the conference, the main support for family planning had come primarily from the medical community and secondarily from social science and economic researchers. Family

Table 2

# DEMAND FOR FAMILY PLANNING AND DONOR RESOURCES AVAILABLE

(A.I.D.-FUNDED COUNTRIES ONLY)



planning activities, however, have also been implicitly supported by the government for more than a decade: Sudan's IPPF affiliate, the Family Planning Association (FPA), has been operating in approximately 50 government clinics and UNFPA-supported services have also been carried out in the context of the national MCH/FP program.

The effectiveness of these efforts has been limited, however. The population of 25 million is growing at 3.1 percent, the total fertility rate shows that Sudanese women still have an average of seven children, and the contraceptive prevalence rate is only 9 percent (1984), up from 5 percent in 1979.

What has brought population to the fore is not the rate of growth per se, but rather the following four factors: the relationship between population growth and its impact on government services (e.g., the need for additional schools); the drought of the 1980s, which emphasized the interrelationship of population and resources; rapid urbanization, which drew attention to the need for housing and services; and most important, the refugee migration problems in the country, which, in turn, have been largely to blame for the rapid rate of urbanization.

USAID has been supporting population activities in Sudan since the 1970s, including policy development efforts, family planning service delivery, operations research, IEC, and training. USAID supported the third National Population Conference in several ways. Through OPTIONS, observational travel has enabled high-level government officials to learn about family planning projects elsewhere. A.I.D./W personnel have visited Sudan and encouraged Council members to widen their contacts to reach other ministries to ensure that the conference might be the forerunner of policy implementation. Plans for the future include continuing support for policy development, support for efforts to gather demographic and related information, and attention to the current acute shortage of contraceptive supplies. Efforts to support the private sector will also be important. Expenditures for health by the private sector are 10-20 times higher than those by government.

In summary, the most noteworthy characteristic of USAID's efforts in the Sudan is that it has supported the process of policy development, rather than imposing any policy priorities. The process is as important as the policy that will emerge in the next 18 months, because it is raising awareness, developing skills, and most important, cultivating a national consensus with respect to the priorities to which donors will be asked to respond. Together, these conditions should provide a climate for successful family planning programs in the future.

USAID in Sudan is presently at the crossroads. Although the conditions are ripe to start developing a bilateral program, there are not enough direct hire staff at the mission either to develop or to implement such a program. Staff are needed to work with new groups and to explore the western provinces to identify the possibilities there. The mission could have a project by next year, but four direct hire staff are needed. There will have to be commitment from A.I.D./W for additional personnel if a bilateral is to be developed.

## II.2.2 PHASE II

### II.2.2.1 Nigeria

Joyce Holfeld, Regional Population Officer, REDSO/WCA

[This presentation was scheduled to have been given by Keys MacManus, A.I.D. Affairs Officer in Nigeria and primary architect of that country's new \$67 million Family Health Initiatives Project. Because Ms. MacManus could not attend the conference, Joyce Holfeld, who spends about 30 percent of her time as REDSO regional backstop to the Nigeria program, described the program in her stead.]

The sheer magnitude of the population problem and the programs needed to address it give a unique perspective to the Nigeria program. With 105 million people, Nigeria has the eighth largest population in the world and the largest in Africa.

Just five years ago, it was impossible to discuss family planning with government officials. The total fertility rate was 6.8; on average women desired 8.5 children; and the annual population growth rate was 3.3 percent. Progress over the past five years has been remarkable. Based on a coordinated strategy developed with S&T/POP's Cooperating Agencies, efforts have been directed to policy development, innovative approaches to service delivery, IEC, and training. These initiatives utilize the existing infrastructure, which includes a vigorous and enterprising private sector that is already selling contraceptives; strong health facilities providing integrated services; multiple, lively, and open channels for IEC; and informed and interested policymakers. Building on these strengths, over the past five years Nigeria has moved from a Phase I to a Phase II country, with family planning activities having taken hold and with the need now to strengthen and expand the existing program.

The population project, although A.I.D.'s largest in Africa, represents one of the lowest from the perspective of per capita expenditures. The goal by 1992 is to increase the practice of family planning fourfold, to 2.5 million users of

modern contraception. The tremendous effort this implies---i.e., 2.5 million users is more than the entire population of more than 20 African countries--contrasts with the small dent it will make on the problem of population growth in Nigeria, where 2.5 million users represent only 12 percent of the population.

The strategy for the future continues to be four-pronged, with efforts directed toward the private and public sectors, toward IEC, and toward policy development.

### Private Sector

Contraceptives will be distributed largely through the existing private sector networks--large-scale commercial distributors, like Sterling Products Ltd. and W.C. Clark; through nurses, midwives, doctors, mission and other hospitals, and clinics; and through the factories and the many types of associations that are a common feature of Nigerian life. The five-year goal is to develop 12,000 outlets serving 1.2 million clients, focusing primarily in urban areas where low-cost distribution systems are already in place. Progress has been slower than expected for two reasons: devaluation has turned the Nigerian economy from a sellers' to a buyers' market; and the institutions involved have not exhibited the marketing skills that had been expected.

### Public Sector

In the public sector, the goal is to develop 3,600 service delivery points that will serve 800,000 clients, 200,000 of them new. Because the infrastructure is largely in place, efforts are being directed to providing pre-service training to nurses.

### IEC

The goal of the IEC component is to encourage acceptance and continued use of contraceptives by increasing the awareness of family planning concepts and options to 80 percent of the population.

### Policy

The policy initiatives are tailored to Nigeria's federal system, working with state and local level leadership of both the government and such private sector groups as women and private practitioners. Workshops are being planned with various ministries and local groups to provide opportunities to discuss problems, issues, policy, and strategic plans. Emphasis will be on developing the fiscal planning and management skills that will be needed to carry out policies.

Other special efforts will include operations research, to see what works and what does not, and exploration of how to increase the use of more effective contraceptive methods through AVSC.

Overall, there is good cooperation between the public and private sectors, with the public sector according tax relief for imports of contraceptives and licensing chemical sellers to sell ethical contraceptives. With respect to institutionalization, there is a good effort toward cost-recovery and toward transfer of skills.

#### II.2.2.2 Ghana

Ray Kirkland, HPN Officer, USAID/Accra

The experience in Ghana, with respect to family planning, sounds very much like Nigeria's, "writ small." According to the most recent data, which are quite dated, the total fertility rate in Ghana is 6.5, the growth rate is 3.2 percent, and prevalence is 10 percent, with 5.6 percent using modern methods. Although Ghana was the second country in Africa publicly to adopt a population policy, relatively little has been accomplished either by way of increasing the level of demand for services or of making contraceptives widely available.

The \$7 million Contraceptive Supplies Project, which began in 1985, has also made little headway, in part because it was based on a number of assumptions that proved to be overly optimistic. Project strategy, like that of the Nigeria project, combines public and private sector initiatives. The public sector component emphasizes improving the MOH contraceptive supply and reporting system, and thanks to recent technical assistance from the Centers for Disease Control (CDC) and John Snow, Inc., under the Family Planning Logistics Management Project, progress has begun. Principally because of the very limited potential of the public sector, the private sector is seen as the principal means to expand the program. The goal here is to develop as many private sector outlets as possible. Retailers, private midwives, market women, and department stores are all seen as target outlets. During the first 1-1/2 years, sales were very limited, but now about one-half of all contraceptives are being sold through the private sector, and it is estimated that by 1990, 90 percent of family planning services will be provided through the private sector.

Among the incorrect assumptions on which the project was based are the following: 1) that there was a positive policy climate for family planning program development in the country; 2) that there was considerable unmet demand for services; 3) that the existing MCH/FP system could absorb and distribute large

numbers of contraceptives; and 4) that the existing training program was producing a substantial number of family planning service providers, so that the need would be only for refresher courses. In part because of the economic deterioration in Ghana between 1983 and 1985, none of these assumptions proved to be true when the project got under way. The media carried no positive government messages to support family planning; the MOH distribution and reporting system had become very undependable; there was no family planning in-service and little pre-service training; and generally, the population appeared neither approving of nor eager for family planning services. Some \$3 million worth of centrally funded projects have been used since 1985 to address the problems that have arisen during project implementation. Progress made by the project to date owes a great deal to the flexibility and the skills made available through these sources.

#### DISCUSSION

Issues: With respect to the private sector: How is the government reacting to the heavy emphasis on the private sector? Does it evidence any hostility? Are there any opportunities to program through multinational corporations? What are government regulations vis-a-vis private sale of oral contraceptives (OC)?

Response: The Ghana government stresses the use of the private sector because it is aware of its own great limitations. Programming opportunities through the multinationals are not promising at present, as the economy is still very fragile. An assessment by the Enterprise project shows that the companies are not very enthusiastic. OCs can only be sold by prescription at present, except through demonstration projects.

Comment: Recent developments in family planning in Africa are really amazing. In Southeast Asia, family planning has been developing slowly since the 1950s, starting with doctors, the private sector, and moving gradually to clinics and outreach clinics. In Africa, the pattern is to leapfrog the steps taken in Southeast Asia and show a willingness to experiment, which is really exciting. Whereas there has been slow percolation over 20 years in Ghana and Nigeria, progress is accelerating in Francophone Africa, Zimbabwe, and Zaire. Overall, in Africa the situation is now moving faster than in Latin America or South Asia.

## II.2.3 PHASE III

### II.2.3.1 Kenya

David Oot, Chief HPN Officer, USAID/Nairobi

Kenya is ranked by A.I.D. as one of two Phase III countries, i.e., one with "a maturing program including a wide range of services available through a variety of channels, a supportive policy climate, and funding at least at some level from the host country."

Compared with Asia, however, where the most advanced countries (e.g., Thailand) have prevalence rates of up to 70 percent, Kenya does not seem very advanced. It has the most rapidly growing population of any country in the world, it is pronatalist, and people want large families. Nevertheless, there have recently been several encouraging developments with respect to population and family planning: demand is growing for family planning services; between 1978 and 1984, there was a doubling of the number of people who did not want a second child; also between these years, contraceptive use rose from 7 to 17 percent; and in areas well served by health/family planning services (e.g., Chogoria), prevalence has reached 40 percent.

With respect to the criteria that define Phase III countries, Kenya has an inconsistent record:

1) The government has made a commitment to family planning; an official population policy has been in existence since 1984; and there is a National Council on Population and Development (NCPD), which plays a major role in coordinating NGO and donor agency activities. The Council represents both a plus and minus, a plus because it reflects the high political and media attention given to family planning and a minus because there have been some bureaucratic issues that have slowed implementation of policies enunciated.

2) The integration of population issues into other development activities has been somewhat problematic, and there is little prospect that family planning will be incorporated into the upcoming five-year plan.

3) The GOK has contributed very little in the way of financial resources to the family planning program. Nonetheless, the encouraging news is that the bilateral program is mentioned in the GOK budget and that plans are being discussed to use some counterpart funds to support the USAID program.

4) The government does not routinely make all types of family planning services available; in fact, fewer than half of the existing health facilities routinely offer such services.

The private sector, however, plays a major role in service provision, particularly through the FPA and mission hospitals. The major USAID effort, the Family Planning Private Sector (FPPS) Programme of Kenya, is designed to help Kenya's private sector companies add family planning services to the health services they already provide to workers and dependents. The U.S. is also exploring other programming options. An early attempt to carry out a CSM program failed, but efforts continue to revive the program. There is a recent commitment to expanding CBD programs, an important move since only 10-12 percent of the population has access to services at the community level. AVSC has had great success in its efforts to increase the use of voluntary surgical contraception.

An unexpected problem has occurred because of the high demand for contraceptives: Frequent shortages have necessitated rationing in some situations. Nonetheless, additional demand-creation efforts are justified to provide information about the availability of contraceptives and to target special groups with messages geared to their special needs.

In summary, Kenya seems to be undergoing a major transition that is very encouraging. FPA figures show a doubling of contraceptive use over the past two years, especially through injections, although limited supplies are a major constraint. Long waiting lines at the clinics provide further evidence that demand exists for family planning. Although Kenya is not yet a Phase III country, it could become one by 1992, if present upward trends continue with respect to availability and use.

#### II.2.3.2 Zimbabwe

Lucretia Taylor, Program Officer, USAID/Harare

If Zimbabwe is a Phase III country from the viewpoint of contraceptive availability and use (its 37 percent CPR is the highest in sub-Saharan Africa), it is also experiencing a high 3.2 growth rate and a total fertility rate of 6. The demographic implications of these statistics have been recognized at the highest level, with the Prime Minister having stated publicly that resources cannot indefinitely accommodate a population growth rate of this magnitude.

Although U.S. bilateral assistance to Zimbabwe's population program has terminated, the Child Spacing and Fertility Project (1982-1987) should be considered a great success. It built on one of Africa's longest traditions of family planning service provision (including 620 outlets providing Depo-Provera, orals, and condoms) and has considerably strengthened the parastatal organization that supervises the provision of these services. This organization, now called the

Zimbabwe National Family Planning Council (ZNFPC), was judged in the final project evaluation to have made important strides as a result of USAID inputs. Specifically, its management capacity, including that for program planning, had been improved, and its Evaluation and Research unit had developed computer capability to manage contraceptive inventories and distribution and to track service statistics. These systems now provide program management with a solid understanding of how the program is working.

Since the suspension of bilateral assistance in 1987, A.I.D. has continued to support ZNFPC's work in family planning through 17 separate activities carried out through centrally funded S&T/POP projects. Several of these efforts are designed to supplement the existing program, which rests primarily on the efforts of 600 CBD-educated distributors who go house-to-house distributing contraceptives, plus rural clinics and youth advisors. Through the TIPPS (Technical Information on Population for the Private Sector) project, the country's largest insurer has agreed to include family planning as one of the health benefits provided to its employees. In another private sector initiative, condoms will soon be available commercially through a new SOMARC CSM project. To increase the availability of more effective methods in ZNFPC clinics, AVSC is providing assistance to the ZNFPC for counseling on and provision of voluntary surgical contraception (VSC).

#### DISCUSSION

Comments: Zimbabwe is an interesting case. Although its family planning program is very successful, to date it has done very little to increase birth intervals and thus reduce the overall TFR. Indeed, the data suggest that birth intervals with modern methods are the same as with traditional methods, including breastfeeding. Parenthetically, the use of progestin-only orals is unusually high in Zimbabwe. One reason for the failure to reduce fertility may have been that the IEC program for field workers was emphasizing only a partial message for birth spacing: that is, they were encouraging birth spacing of two years, not two or more years. Thus, they were only teaching what would be happening anyway. Emphasis still must be placed on the need to avoid the four common problem areas with respect to births: too young, too old, too frequent, and too many.

Until independence in 1980, the Zimbabwe program had relied most heavily on Depo-Provera. Because the FDA had not approved use of this method for U.S. clients, however, opposition grew to its use. Now, users have switched to OCs and condoms, with IUDs the third most frequently used method. Depo-Provera is still available, but only for high-risk cases.

II.3           **PANELS: TECHNICAL UPDATE ON PROGRAM ISSUES**

II.3.1        **PANEL 1: IMPROVING METHOD MIX--MORE EMPHASIS ON MOST RELIABLE METHODS**

II.3.1.1     Introductory Remarks

Gary Merritt, Chief, AFR/TR/HPN

Three handouts [Tables 3, 4, and 5] provide a backdrop to the following presentation on the need to improve the method mix. Table 3 dramatically illustrates an important fact that must be understood by HPN officers in advising Bureau leadership: namely, increasing contraceptive prevalence in the early years of a program is not likely to be accompanied by declining crude birth rates. As demonstrated here, the relationship between the two is not linear. The thick S-shaped curve line shows that early rises in prevalence generally do not result in declines in fertility until prevalence levels of 25 to 30 percent are reached. This phenomenon will continue to be true in Africa into the 1990s for several reasons: 1) many countries will have increasing numbers of women in the youngest fertile age cohorts; 2) there continues to be a high reliance on the least effective methods; and 3) use-effectiveness is also poor in Africa. The other two handouts illustrate the low level of contraceptive prevalence in Africa [see Table 4] and the failure rates of the major contraceptive methods worldwide [see Table 5]. Together, the three tables make a compelling case for increasing the emphasis on the more reliable methods.

II.3.1.2     Voluntary Surgical Contraception

Joseph Dwyer, Director, Africa Regional Office, Association for Voluntary Surgical Contraception (AVSC), Nairobi

Recent studies by noted authorities have painted a very pessimistic picture with respect to the prospects for fertility control in sub-Saharan Africa. Both Odile Frank and John and Pat Caldwell, in two separate articles, have identified lack of demand for fertility control as the main cause for the high fertility rate in Africa.

AVSC's experience, particularly in Kenya but also to a lesser extent elsewhere, suggests that demand for voluntary surgical contraception does exist if the procedure can be done simply, safely, and voluntarily.

The key variable appears to be the acceptability of the services. Traditionally, in Kenya, a tubal ligation was performed as major surgery, requiring an entire operating room and a full complement of doctors, with the patient under a

Table 3

CRUDE BIRTH RATES, 1980, AND PREVALENCE OF CONTRACEPTIVE USE, 1977-1983

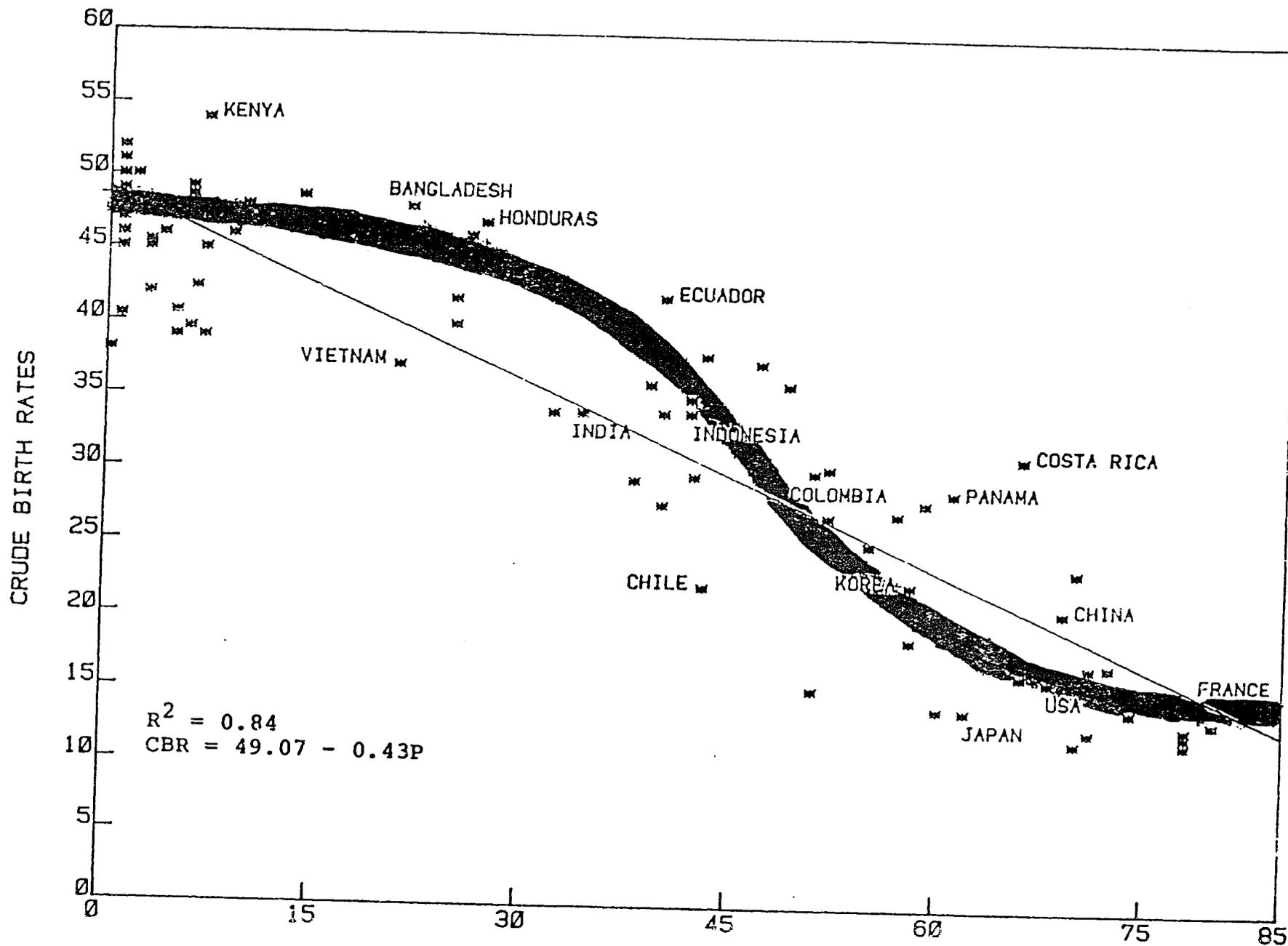


Table 4

CONTRACEPTIVE PREVALENCE IN SUB-SAHARAN AFRICA  
Percent of Currently Married Women 15-44 Using Contraception

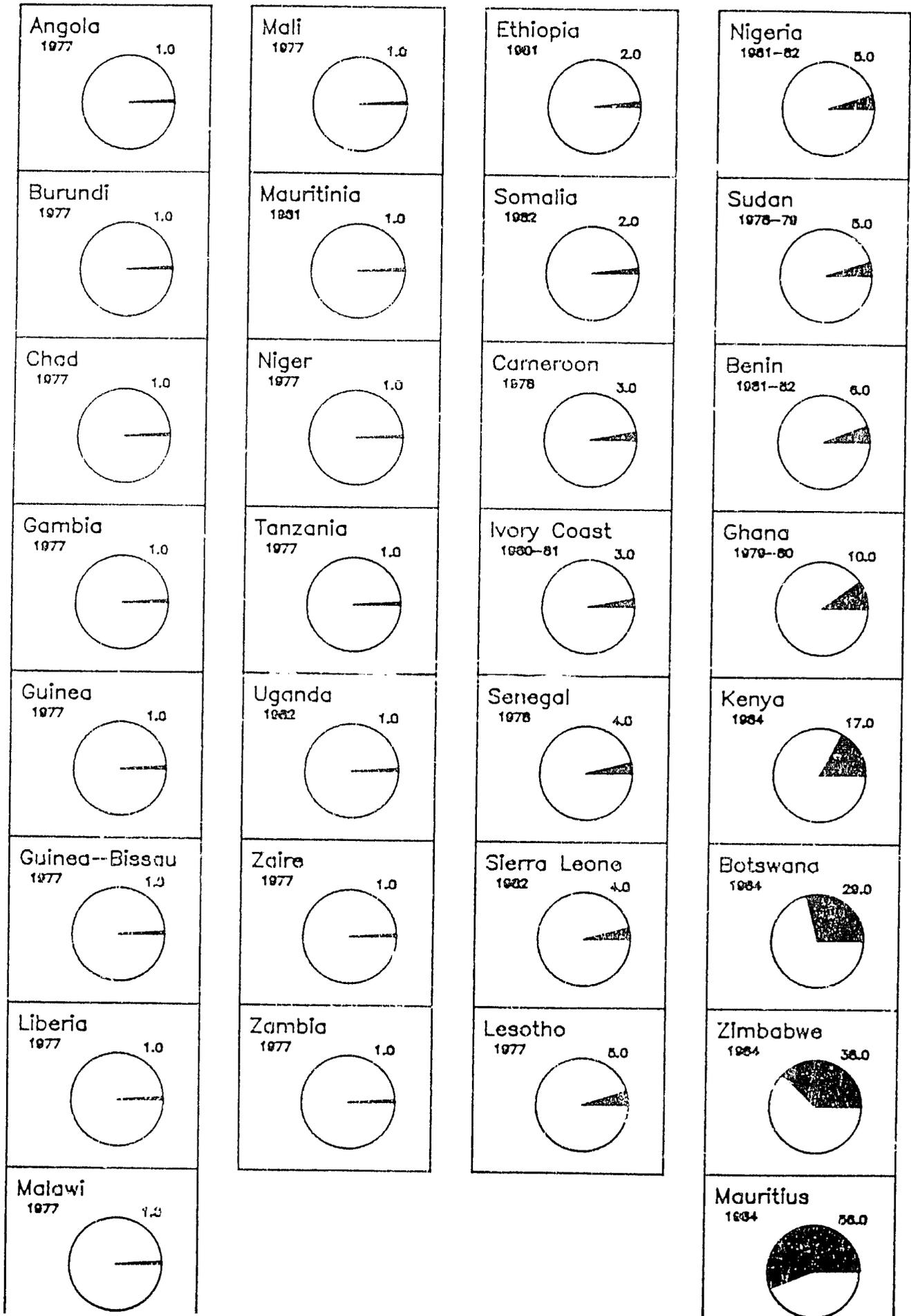
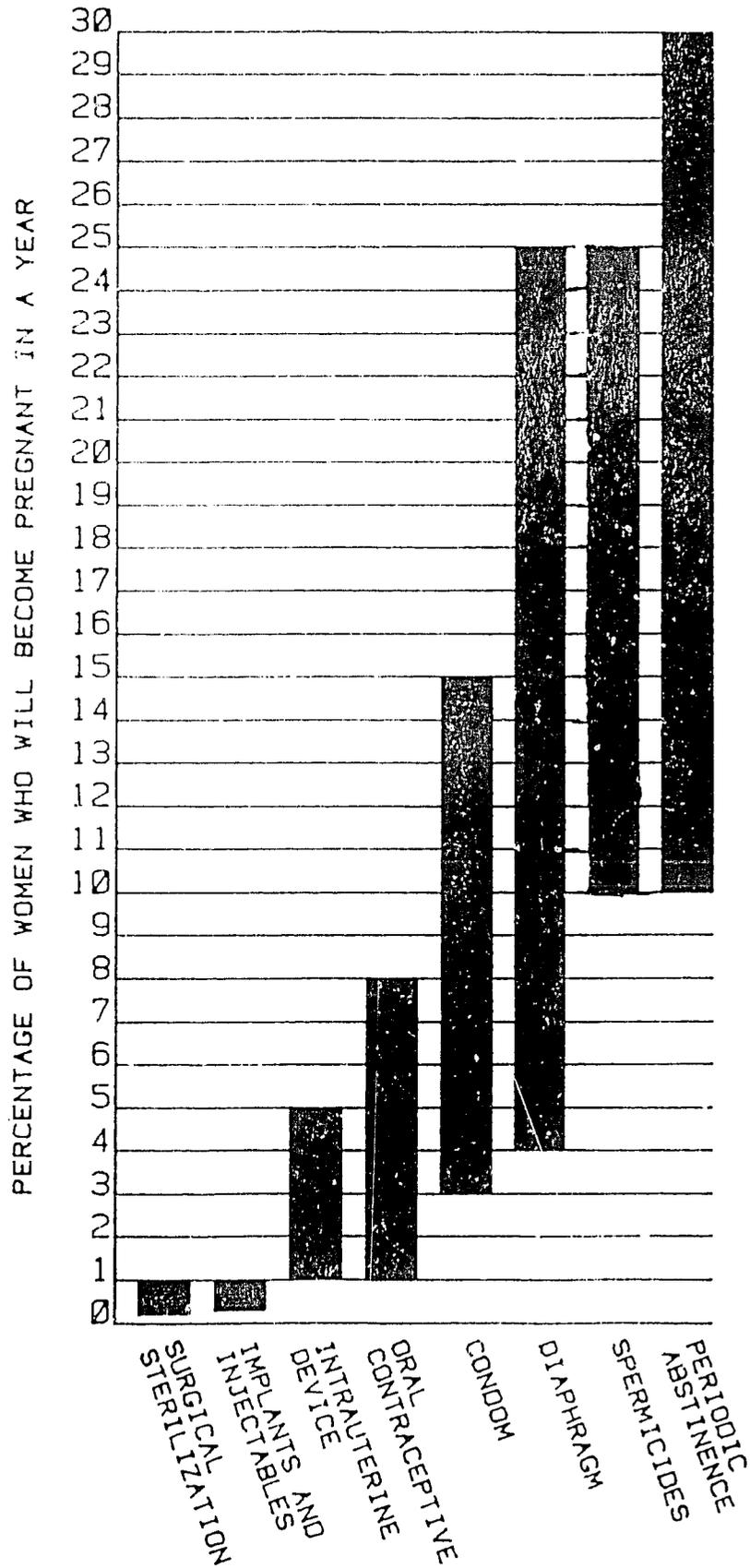


Table 5

ESTIMATED RANGE OF FAILURE RATES FOR MAJOR CONTRACEPTIVE METHODS UNDER USE CONDITIONS WORLDWIDE



general anaesthetic. A woman could remain in the hospital five to seven days after the procedure, occupying a bed that might already have one or two persons in it.

The AVSC method of delivery, providing VSCs by using minilaparotomy with a local anaesthetic, has been extremely acceptable to both clients and providers, with the total number of VSC procedures in Kenya increasing from 200 in 1982 to over 8,000 in 1987. With minilap, the entire routine is simplified: All that is needed is a clean basic facility and three medical staff (a doctor, a scrub nurse, and a runner); the procedure is performed with a local anaesthetic; and it does not require an overnight stay in the hospital. Furthermore, any doctor with experience in female abdominal surgery can learn to do a minilap and any nurse can be trained to assist.

Although Kenya has led the way in sub-Saharan Africa within all sectors, including the MOH private hospitals and FPA clinics, in providing VSC services, initial efforts elsewhere are also very promising. Total numbers are small, but there have been quantum leaps in the percentages of patients served in the Jos University Teaching Hospital in Nigeria, in Kumasi, Ghana, and in Jinja, Uganda. Doctor and nurse teams have been trained in Kenya for seven other countries (Ethiopia, Tanzania, Zimbabwe, Mauritius, Liberia, Zaire, and Burundi), and each country is experiencing an increasing demand and satisfied clients. AVSC is supporting a training of trainers session in Kenya and may start to provide some training in Mauritius for the French-speaking countries.

An important aspect of AVSC's program is counseling. The training on counseling provided to nurses and other health persons enables them to assist clients to decide whether voluntary sterilization is the right method for them. It deals with common fears and misconceptions about permanent sterilization and is an important ingredient in the acceptability of AVSC's efforts.

Because there are many thousands of couples and women in Africa who do not want more children but who are not ready for a permanent method, AVSC is expanding its mission from VSC to assisting with specialized aspects of two other methods: introduction of NORPLANT<sup>R</sup> and quality assurance for IUDs.

### II.3.1.3 Implants, Injectables, and IUDS

Malcolm Potts, President, Family Health International

In Africa, family planning efforts must be based on two overriding goals:

- o preserving the all-important natural method of breastfeeding; and
- o increasing the use of effective artificial methods that provide prolonged protection with good user compliance and correspondingly low failure rates.

Achieving these goals will be difficult. A variety of factors (falling age of puberty and marriage and some instances of decreased breastfeeding) are resulting in unnaturally high levels of fertility in Africa. The 8.5 TFR found in some areas in Nigeria for instance, is twice as high as in preliterate societies in the Kalahari and New Guinea.

In this environment, the importance of breastfeeding cannot be underestimated. In Africa anovulation associated with breastfeeding is the single most important variable determining the interval between two pregnancies. If the African pattern of breastfeeding were to decline as it has in Latin America, the contraceptive prevalence rates would need to increase to one-quarter to one-third of married women merely to hold fertility constant. Thus, any effort to launch a large-scale family planning campaign without taking breastfeeding into account would be folly.

Without some form of protection, the typical fertile woman who is ovulating and having regular intercourse will become pregnant within three months. Even women using conventional reversible methods are at considerable risk, particularly in LDCs, where failure rates for condoms and pills are even higher than in the developed world. In the Philippines one-fifth of the women become pregnant in the first year of pill use, as do almost one-half of those who rely on condoms. This pattern may be repeated in Kenya. Wherever achieved fertility has fallen significantly in A.I.D.-supported programs, VSC and IUDs have been important supplements to pills and condoms.

From the technological standpoint, prospects are good that by the early 1990s one or more effective new methods will become available in Africa that will offer new options for ovulating women, even those who are breastfeeding but also ovulating. The latter is an extremely important group: In Africa, more women needing contraception are lactating than menstruating.

The most promising technologies are four new formulations of FDA-approved steroids, including two injectables--(norethindrone microspheres or NET 90-day injectables and 30-day NET injectables with added estrogen)--and two implants--(NORPLANT<sup>R</sup> and NET pellets).

Unless something totally unforeseen happens, one or more of these new methods will have received FDA approval within the next four to five years. It is time, therefore, for missions to think about planning acceptability trials and for S&T/POP to begin to budget for these new methods.

This is where matters stand with respect to the four methods.

o Norethindrone (NET) microspheres: 90-day injectables. These injectables release the progestin NET hormone at different rates depending on size of the microcapsule. FHI, which holds the Investigation of New Drug (IND) license on this technology, is testing a 90-day delivery system and plans FDA-approved trials with 1,200 volunteers in 12 U.S. centers and 5 in Latin America and Thailand. If there are no unforeseen events, the drug will be submitted for FDA marketing approval in 1992. NET microspheres involve a sophisticated technology and are likely to be relatively expensive, requiring a subsidy in many African countries.

o 30-day NET injectables with added estrogen. This is the only injectable that does not result in irregular menstrual cycles. In 1987, FHI and WHO successfully completed trials of this method, which is popular in Latin America and might be useful as well as in Africa. This method will, however, never be submitted to the USFDA, so it cannot be supplied by A.I.D.

o NORPLANT<sup>R</sup>. This widely known injectable uses the FDA-approved progestin--levonorgestrel. The six-rod system has been used by thousands of women and is approved for use in Finland, the Dominican Republic, and Thailand, and introductory trials are being conducted in several countries with A.I.D. funding. The use of NORPLANT<sup>R</sup> is likely to be limited by expense and the need for careful training for insertion and removal.

o NET pellets. This is the dark horse in the long-acting steroids race. These small pellets are made of fused NET and pure cholesterol and are implanted under the skin of the upper forearm. Expected efficacy is 12-24 months. Phase II clinical trials are starting, and if there are no unexpected findings, Phase III trials will take place in four centers in the U.S. and five in Latin America and Thailand. These should be completed by 1991. NET pellets could be ideal for Africa. Unlike NORPLANT<sup>R</sup>, they are biodegradable, and therefore there is no need for removal--the Achilles heel of NORPLANT<sup>R</sup>. They should be cheap and easy to use, and use could be partly driven by market forces. They may even be appropriate for Third World manufacture. Indeed, an exciting vision would be a total package of local manufacture, registration, introduction, and distribution financed by the DFA, perhaps in Zimbabwe.

In addition, two established technologies will continue to be important in providing effective methods:

o The CUT380A IUD. This well-tested device outperforms all other IUDs, has few failure rates, and relatively few side effects. It is available as an A.I.D. commodity and is expected to be reintroduced to the U.S. market later this year following resolution of liability problems.

o Depo-Provera. This three-month injectable has been in use since the 1960s and approved as a contraceptive in many developed and developing countries. Although it is popular wherever it has been available, it is not, nor will it ever be, available through A.I.D. It is available in U.S. pharmacies, but for uses like cancer therapy, not for contraception. Nonetheless, thousands of American women do use it as a contraceptive.

For breastfeeding women, three methods may be appropriate. A.I.D. provides progesterone-only pills, which are probably the best existing method for this group. Among the steroids, NORPLANT<sup>R</sup>, NET 90-day, and NET implants are likely to be satisfactory. None of these methods should be used too soon after delivery. IUDs, on the other hand, can be administered a few hours after a birth. Although expulsion rates are higher for postpartum than for interval insertions, if providers are properly trained, postpartum IUD insertion is a worthwhile practice.

If all babies born into the world could be at least 2 years apart, there would be 800,000 fewer infant deaths and tens of thousands fewer maternal deaths each year. Breastfeeding and reversible methods of contraception are central to child survival and nutrition, as well as to population growth. Appropriately united, they could well be the central focus of this conference.

#### DISCUSSION

Other Methods: There is little expectation that a new male contraceptive will be developed in the near future. All barrier methods need further research. Today's sponge is too large and cumbersome. Spermicides have been neglected but could be useful. Work is under way on plastic condoms, which might be cheaper, have a longer shelf life than the standard rubber condom, and possibly could be manufactured in Africa. Spermicidal lubricated condoms have been investigated by S&T/POP. Although studies in five countries have shown that they were at least as acceptable as regular condoms, there is no clinical information that they are any safer. The initial research on cost suggests that they will also be much more expensive for A.I.D. to purchase.

Traditional Methods: In Matlab in Bangladesh, an operations research (OR) study in 1974 showed that using oral contraceptives alone, the program was able to increase contraceptive prevalence from 1-4 percent to 18 percent. At the same time, however, the program had a negative effect on the existing 22-month breastfeeding interval. Only when other methods were added was a decline in fertility achieved.

Initial steps are being taken to enable missions to arrange to have condoms tested in-country. Though the possibility for human error is great with such testing, funds have been set aside this fiscal year to help missions acquire the information they need to conduct these tests with minimum errors.

## II.3.2 PANEL 2: EXPANDING SERVICE MODALITIES

### II.3.2.1 Marketing Approaches

Ray Kirkland, HPN Officer, USAID/Accra

The Contraceptive Social Marketing (CSM) program in Ghana, now in its second year, is considered a model for Africa. Building on two previous attempts to market contraceptives through the private sector, the CSM program has operated through DANAFCO, a private distribution company that had been involved in one of the earlier efforts. Thus, start-up costs for this program were low. DANAFCO has overall responsibility for the program, subcontracting training, research, and advertising to other local firms.

USAID supplies contraceptives to DANAFCO, which has arranged training for 2,700 retail pharmacists and chemical sellers who sell the products. A distribution network has been established in the 10 regional capitals and the network is currently being expanded to the 22 major towns. The program is now exploring using market women to sell products and expanding the network to include large commercial companies.

Products sold include condoms, foaming tablets, and oral contraceptives. The price structure is based on a government formula that is designed to enable sales to cover operating costs, excluding costs of contraceptives, which are donated. It is not clear at this point whether this goal can be met.

Considerable efforts have been made to conduct research, including market research, to test initial advertising messages and retail audits to track product distribution. Panel studies are now being planned to assess the health risks of over-the-counter sales of OCs.

## DISCUSSION

Additional Comments: The plan is to add ORS products to the CSM program. The reason is twofold--primarily to increase the availability of ORS and secondarily to increase the potential of the CSM program to be self-sustaining. As the economy improves, there is some question whether retailers will want to continue to distribute contraceptives. The hope is that ORS sales will involve profit, which will motivate retailers to continue also to distribute contraceptives.

While no CSM program in Africa has begun with the simultaneous sale of ORS and contraceptives, the two products are being distributed together in Bangladesh and Nepal. One lesson learned in those countries was the importance of training retailers in how to mix ORS. If purchasers are instructed how to use them properly, there will be continuing demand for the product and growing repeat sales, which is the life blood of any retailer.

Columbia University's operations research study to learn whether market women can sell ORS products is showing very promising initial results.

### II.3.2.2 Industrial and Plantation Efforts

David Oot, Chief HPN Officer, USAID/Nairobi

The FPPS Program in Kenya is designed to see whether private firms that already had health plans in place will agree also to provide family planning programs for their workers. The idea is that after two years, there would be no further need for external financing. By then, companies would be convinced of the economic benefits of offering family planning services to their work forces and would therefore be prepared to support such services with their own resources.

Kenya has a well-organized agricultural sector with large numbers of workers congregated on estates that produce tea, coffee, sugar, sisal, pineapple, and flowers. To qualify for inclusion in the FPPS program, a company must have a registered service delivery point or health facility, be prepared to provide family planning services over the long term, and have the potential of reaching a sizeable population, including dependents.

USAID support is provided through John Snow Inc.'s Enterprise project, which has provided training for clinic staff and some staffing, and facilitated transport of MOH-supplied contraceptives. The government of Kenya coordinates the program through the NCPD. A Technical Advisory Council (TAC), whose

membership includes the chairman of the NCPD and the president of the University of Nairobi, reviews workplans submitted annually by all subprojects, but provides little day-to-day supervision.

In addition to commercial enterprises, FPPS has begun to work with mission hospitals and educational institutions. To date, services have been established at 120 service delivery points, 35,000 people have received services, and several employers have continued to provide these services after program support has been terminated. Two-thirds of the condoms distributed in Kenya are provided through the FPPS.

#### DISCUSSION

Comments: Some effort is being made to include some child survival interventions in the company health centers, but this is proceeding very slowly so as not to overload center staff.

#### II.3.2.3 Community-Based Distribution

Don Lauro, Program Director, Population/Health, Columbia University, Cote d'Ivoire

CBD is another private sector approach to providing family planning services. Like the other two private sector approaches just discussed, it is seen as a way to supplement the limited services now available through ministries of health. Conveniently located MOH service points that provide primary health care are typically overwhelmed. At the other extreme, modern health facilities constructed in sparsely populated areas may remain underutilized.

CBD is designed to bring services to where the underserved people actually are--the community level. The most revolutionary aspect of the approach is the dependence on community members to provide services. Service providers may include traditional birth attendants (TBA), community health agents, retail sellers, and community leaders. Under a CBD project, members of one of these groups will be trained to provide IEC and one or more of the following services: family planning, vaccinations, ORT, sanitation, and pre- or post-natal care.

Whereas CBD agents are all private sector people, the success of any CBD effort depends on the public sector or other larger entity to provide for referral, supervision, and supplies. Such supervision is essential to CBD worker commitment, and many CBD efforts have foundered due to lack of support from a larger system.

A.I.D. is making a major commitment to establishing CBD programs. It has supported efforts in 18 African countries: 4 in East Africa, 12 in West Africa, and 2 in Southern Africa. Yet CBD continues to be perceived as a departure from the traditional clinic- and hospital-based services in Africa. In fact, CBD can either draw from traditional systems, like TBAs, village-level support mechanisms, and traditional marketing practices, or it can adopt a modern structure by utilizing urban social workers, pharmacists, and market vendors to sell or distribute contraceptives.

In Africa, operations research has played an important role in helping to demonstrate that CBD can work on a small scale, paving the way for larger efforts. Once a new model has proven workable, further OR study can address key issues, such as how to improve linkages with the broader system--particularly how to provide better supervision or resupply--and can also test models to learn how to achieve better cost-effectiveness. The majority of OR projects have been undertaken to test village-level CBD, including examples in Sudan, Kenya, Ghana, Rwanda, Cote d'Ivoire, Nigeria, Senegal, and Zaire.

OR efforts are taking new directions. These include how to provide services in urban areas, through market approaches, and through factory or union-based activities. A short video [shown during this presentation] demonstrates that the market approach is working well in Ibadan, Nigeria. This project trains market women to sell contraceptives, ORS, and malaria treatment to village women. Political opposition to this approach was diffused because the prestigious University of Ibadan has been involved in implementing the study. It is not known whether the sales in the market are to women who would otherwise be buying contraceptives from the pharmacies, although this is an important consideration.

## DISCUSSION

Comments: CBD is sometimes thought of as a public sector approach, but this is an erroneous notion. Utilizing TBAs, commercial outlets, and other private groups, CBD was conceived as an approach designed to fall outside the existing public sector clinic network. The importance of the government health system as a back-up, however, cannot be overestimated. In Africa, there are few of the IPPF affiliates that elsewhere have provided support systems for CBD workers. Therefore, the collapse of government support can mean serious problems for the CBD undertaking.

An unresolved issue in CBD programs is the extent to which primary health care interventions should be included in CBD programs that are primarily geared to providing family planning

services. In the early days, programs were used as entrees, with CBD workers adding contraceptives to the PHC interventions they were distributing. Because CBD workers are often illiterate and work only part-time, there is a danger in overloading them with too many tasks. Indeed, OR studies have shown that in many integrated efforts, the results have not been synergistic. Rather, the system has been overloaded and both efforts have foundered.

### II.3.3 PANEL 3: PROGRAM SUSTAINABILITY

#### II.3.3.1 Sustainability of CCCD Programs

Wendy Roseberry, ACSI-CCCD Project Manager, AFR/TR/HPM

At this juncture, CCCD programs in many countries have reached operational levels, and the time has come to work actively on long-term goals of program self-sufficiency. This was a major conclusion of two recent evaluations of the ACSI-CCCD program--the 1987 Fifth Year Evaluation and the 1986 Regional Inspector General's audit. Specifically, both studies recommended that a project sustainability strategy be developed.

Project management is working closely with CDC, S&T/H, PPC/CDIE and other A.I.D. offices to develop a strategy that reflects lessons learned about sustainability elsewhere and the best thinking now available at A.I.D. about how sustainability might be achieved. Design of follow-up projects, for instance, will reflect the findings of evaluations undertaken by PPC/CDIE [see Lois Godiksen's presentation immediately following]. These evaluations found that six program factors were significantly related to program sustainability. Upcoming programming will attempt to incorporate these conditions insofar as possible into project design. [The draft strategy was distributed to conference participants--see Appendix E.]

Although sustainability and auto-financing are not the same, auto-financing is certainly an essential component of sustainability. Considerable work has been performed in CCCD project countries in implementing alternative financing mechanisms and in determining project costs. Last year, REACH had been asked to summarize CCCD health financing experience and to recommend future actions. Two major recommendations from the REACH report were 1) to perform more cost studies to determine project costs, and 2) to develop a system to monitor country progress in financing CCCD costs.

Missions are beginning to monitor host-country contributions, but considerably more monitoring is necessary to identify both costs and revenues of health projects over time. In addition, the next program agreements must address the need

for alternative financing strategies and identify the types of studies and research activities that are needed to increase understanding of possible approaches.

#### DISCUSSION

Comments: Efforts to increase sustainability of projects must take into account what other donors are doing that might affect the process.

Response: Although in Guinea, for example, the CCCD program is working hand-in-hand with UNICEF, elsewhere, other donors are looking for quick schemes that do not conform to A.I.D.'s programming criteria.

#### II.3.3.2 Sustainability of U.S.-Sponsored Health Programs

Lois Godiksen, Sociologist, Bureau for Program and Policy Coordination/Center for Development Information and Evaluation (PPC/CDIE)

In 1986, the Center for Development Information and Evaluation (CDIE) initiated a group of studies to assess the sustainability of health project activities after A.I.D. funding had ended. Evaluations of two programs in Africa, one that was continuing, the other that was not, revealed some clear differences. Perhaps the most important was this: that one had sustainability built in as a project goal and the other did not.

The project that was being sustained, the Lesotho Rural Health Development Project, had been designed with sustainability as a prime objective. The other, the Gambia Mass Media and Health Practices project, instead had focused primarily on the more near-term goal of demonstrating that health behavior could be dramatically changed in rural areas by a combination of radio, print, and face-to-face contacts.

The Gambia project was successful and cost effective in achieving its objective, but host country staff had not been well enough trained to enable them to manage project activities alone and no plans existed for the government to assume the burden of project financing when A.I.D. project funding ended. By contrast, the Lesotho program was designed specifically to strengthen central and local management and administrative capabilities to carry out program activities. The design also included a planned annual phase-in of government financial contributions. Two years after A.I.D. funding ended, the project was still operating effectively, although a shortage of national financial resources was looming as a problem.

CDIE has undertaken two other field studies, broad historical and comparative research efforts in Honduras and Guatemala. Each looked at the relationship between a broad range of factors that affected project implementation and the degree to which specific project activities were sustained. For example, in both Honduras and Guatemala, it was found that project activities that were considered high priority by the government were more likely to be sustained. Likewise, in both countries, projects that were perceived to be effective while in progress were more likely to be sustained after termination of A.I.D. funding. Also, integrated projects were more likely to be sustained than vertically implemented ones.

Findings were not always the same in both countries. Whereas in Guatemala, projects that provided significant training and enduring technical assistance were likely to be sustained, in Honduras no relationship was found between sustainability and size and duration of technical assistance and training components. Also, unexpected was the finding, again in Honduras, that no relationship appeared to exist between sustainability and national assumption of recurrent salary costs or cost recovery. (In Guatemala, as expected, projects that provided for progressive absorption of recurrent projects by the national budget were more likely to be sustained.) Just because these relationships were not found in Honduras, however, does not mean that they did not exist.

In both Honduras and Guatemala, family planning and nutrition projects were found to have a low degree of sustainability. Malaria projects were also found to have a low degree of sustainability in Honduras, but a medium degree in Guatemala. In both countries, water supply projects were found to have a high degree of sustainability (in Honduras, these included rural water supplies and latrine and pump projects). In Honduras, auxiliary nurse training had high sustainability and in Guatemala health service projects were found to have a high degree of sustainability.

In Guatemala, where the methodology had evolved from the initial work in Honduras, sustainability factors identified were divided into two sets: 1) nine factors over which project officers have relatively little control--"contextual factors"--(including natural disasters, political factors, U.S.-national bilateral relations, sociocultural factors, economic factors, private sector, implementing institution, donor coordination, and national commitment); and 2) six factors that are more within project management control--"project characteristics"--(including the project negotiation process, institutional and managerial aspects, financing, project content, community participation, and project effectiveness).

At present, CDIE is planning to conduct similar studies in five countries in Africa--Botswana, Ghana, Senegal, Tanzania, and Zaire. The hope is that these studies will assist project managers to frame useful questions about the issue of project implementation in order to judge whether activities will be sustainable over the long run.

### III. HEALTH AND CHILD SURVIVAL

Tuesday, March 22, 1988

#### III.1 HEALTH AND CHILD SURVIVAL

Moderator: Charles DeBose, Regional Health Officer, REDSO/WCA

##### III.1.1 INTRODUCTION

Charles DeBose, REDSO/WCA

The past 15 years have seen three major shifts in health programming in Africa, from large rural-based health service projects to primary health care projects, and now to a focus on child survival.

The focus in the early seventies was on hospitals and urban health service projects, medical schools, and commodity procurement. By the late seventies, the focus had shifted to primary health care (PHC). The shift coincided with an economic collapse in many countries. It also reflected the belief that it was important to emphasize basic human needs and that PHC was the most effective and efficient means to achieve reductions in mortality and morbidity. Although elements of self-financing and private sector initiatives were incorporated in second generation versions of the PHC projects, on the whole USAID missions did not respond positively. Later evaluations have proved that most comprehensive PHC systems that were launched were too ambitious or complex and were neither sustainable nor effective in reducing mortality and morbidity.

Today, child survival has taken center stage among the Agency's health programs and has generated considerable activity. The companion conference to ours--the A.I.D. Africa Child Survival-CCCD conference--marks the fourth such meeting since 1981, when the project was launched.

Africa's CCCD project represents a new beginning for health programming. It is the Agency's first attempt to focus on specific cost-effective measures that are readily implemented and that target specific childhood diseases with appropriate technologies. The main theme of this session is the important and challenging aspects of our experiences to date in child survival, including progress made in self-sufficiency in the area of health services.

### III.1.2 AFRICA BUREAU STRATEGY

James Shepperd, Senior Medical Officer, AFR/TR/HPN

The Africa Bureau health, nutrition and child survival strategy is primarily focused on selected cost-effective measures that target specific childhood diseases with appropriate technologies: immunizations, oral rehydration therapy, the prevention and treatment of malaria, birth spacing, and nutrition interventions.<sup>2</sup>

Funding for child survival in the Africa Region increased from less than \$25 million in FY85 to nearly \$37 million in FY87. Table 6 shows that, together, ORT and immunizations account for over 50 percent of the funding and thus are often called the "twin engines" of child survival. Today, the Africa Child Survival Initiative (ACSI)-CCCD project, operating in 13 countries, is not only the Agency's first, but now is its largest, child survival project.

Child survival activities are beginning to demonstrate progress: 29 of the 40 A.I.D.-assisted countries in Africa have child survival activities funded by the Africa Bureau; immunization coverage has increased--8 of the 13 ACSI-CCCD countries have achieved at least 50 percent coverage with measles vaccine; and there are ORT programs in all CS emphasis and ACSI-CCCD countries, some with extensive networks of ORT treatment centers. On the other hand, there are some gaps; funding for nutrition interventions hardly increased between FY85 and FY87, and support for malaria activities is modest.

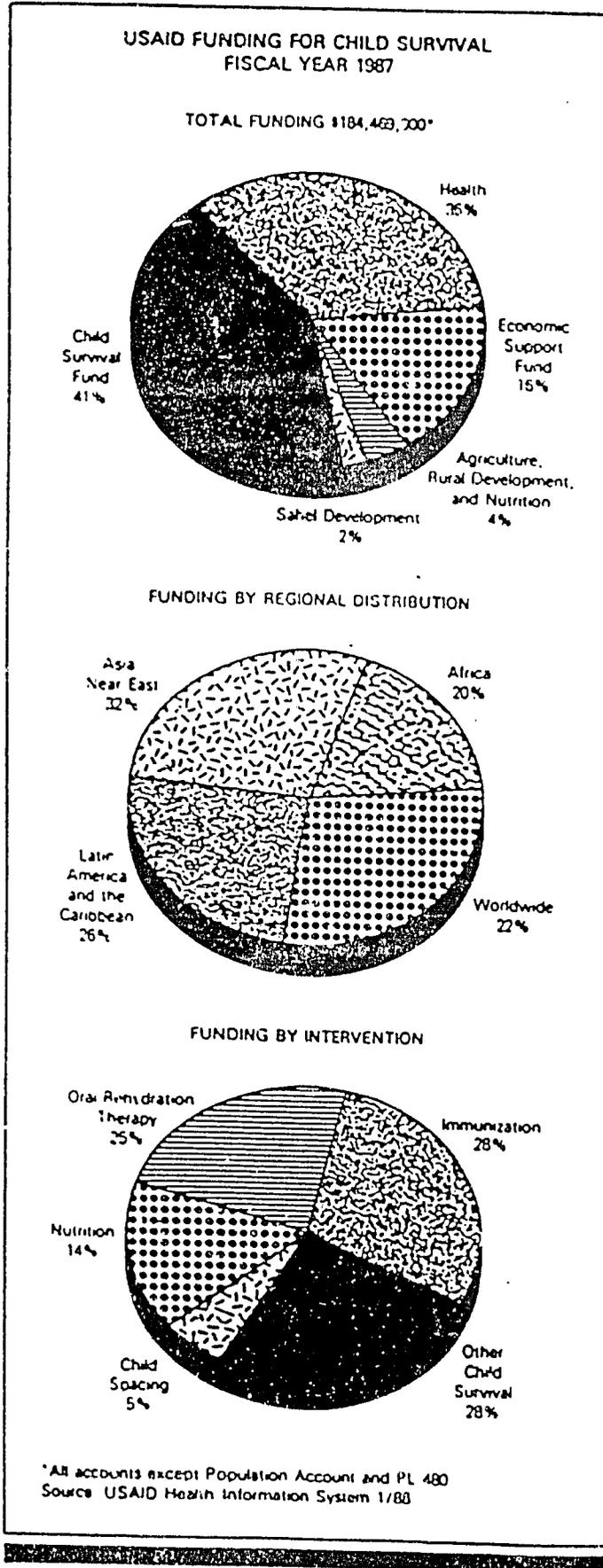
The issue of sustainability is critical. To help ensure the institutionalization of AID-funded activities, priority has been given to the development of human resources and health care financing. Training needs in the Africa Region are staggering: On the basis of a model showing required health worker to population ratios, existing staff and attrition rates, it is estimated that approximately 200,000 new health workers will have to be trained over the next five years. There is also an imperative to develop centers of excellence, to provide specialized training within the region.

Alternative schemes for health care financing will have to be explored. Private enterprise development will have to be a part of the plans for increasing the availability of services. Social marketing of ORS and contraceptives is just beginning; the potential for expansion of these types of programs should be studied.

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<sup>2</sup>Agency-wide, four of these interventions are identified as comprising the child survival strategy. The addition of malaria is specific to Africa.

Table 6



### III.1.3 S&T RESOURCES FOR HEALTH AND CHILD SURVIVAL

Pamela Johnson, Child Survival Coordinator, S&T/H

In FY87, the total Agency obligation to health of more than \$300 million was the largest to date. Child survival had more support than ever from the administration and Congress (61 percent of the total commitment in health). There has, however, been a corresponding decline in support to water and sanitation and vector-borne disease control. The Africa Bureau followed suit, steadily increasing levels for child survival. In FY88 and FY89, however, there was a substantial decline in the overall health budget, with funding for child survival activities also declining. FY88 funding for child survival in Africa is \$25.5 million, with \$29.4 million anticipated for FY89.

The Office of Health budget grew to approximately \$50 million in FY87, roughly 16 percent of the Agency's total for health and CS; 75 percent of its service projects and almost all research are directed toward CS. The budget is still small, however, and does not permit the extensive in-country programming that the Office of Population has been able to carry out. The Office of Health is dependent upon buy-ins to extend resources to as many countries as possible.

During FY87, with the exception of the Congo, S&T/H service projects reported some activity in every country in Africa with a health/CS program. PRITECH (Primary Health Care Technologies), REACH (Resources for Child Health), and WASH (Water and Sanitation for Health) were the most active projects and received the greatest volume of buy-ins.

The larger service projects are well known. Some of the less known projects include

- o Malaria vaccine development -- The Office of Health has a long-standing commitment to the development of a malaria vaccine. AID-funded researchers have developed candidate vaccines directed both at the sporozoite and the blood stages of the parasite. This past year preliminary testing was carried out on a sporozoite vaccine, and plans are being made for field trials;
- o Improvement and testing of other vaccines--a cholera vaccine, a two-dose pertussis vaccine, and a measles vaccine that may be effective as early as six months of age;
- o Health technologies development--of improved diagnostic tools (for malaria, acute respiratory infection, and blood testing) and of non-reusable injection devices;

- o Diarrheal disease control--vaccine development, improvement of oral rehydration solutions;
- o Operations research--PRICOR (Primary Health Care Operations Research project) studies of growth monitoring and PRICOR country programs in Zaire and Senegal;
- o Office of the Science Advisor research grants--\$9 million annually to carry out all kinds of research. The hope is at least to double the level of funding for African proposals (from 10-20 percent to 40 percent).
- o Child Survival Fellows Program--based on buy-ins;
- o Technical Advisors for Child Survival--Public Health Service officers can be recruited, using program funds, and can function as A.I.D. direct hires.

New areas that are receiving support include

- o Maternal and neonatal health -- focusing on tetanus toxoid;
- o Acute respiratory infection.

#### III.1.4 COUNTRY PROGRAM REVIEWS

##### III.1.4.1 Zaire Child Survival Program

Glenn Post, Chief HPN Officer, USAID/Kinshasa

#### 1) Introduction

Several distinguishing features characterize the USAID/Zaire program and provide the setting for child survival activities.

Most striking are the strong private sector focus of USAID's efforts to establish a primary health care system; the existence of central Africa's only school of public health, which can assist in meeting the country's health manpower needs; the AIDS problem, which is affecting many other health activities; and the close ties between USAID's efforts and the government's, most dramatically demonstrated in the structure of the GOZ Five-Year Plan, which was based on USAID's experience in Zaire. Overall, the USAID HPN efforts include two bilaterals--the Basic Rural Health (BRH) project and the Family Planning Services Project. Many S&T/POP and S&T/H service projects are also active in Zaire.

2) Features of the USAID Program

o Primary health care infrastructure

The Basic Rural Health (BRH) Project is the foundation of the program, aiming to establish a sustainable community-supported PHC system in 100 of Zaire's 306 health zones. In addition, the Shaba Health Project covers one poor area of the country. Emphasizing preventive health care, BRH is designed to strengthen the health infrastructure already in place in rural Zaire in order to institutionalize the delivery of CS interventions. The project provides an initial supply of medicines as well as basic equipment, staff training, operations research, rehabilitation of health facilities, logistics support, and the development of management systems. Currently BRH is active in 80 health zones.

o Water and sanitation

A major water component of the BRH and Shaba projects reinforces the USAID ORT child survival intervention. Support is provided to spring capping, drilled wells, and gravity-fed adduction systems. Water activities are undertaken only if there is strong community support. They are closely tied to the health zone structure, fostering health education.

o Institutionalized training

The University of Kinshasa School of Public Health, the first institution of its kind in central Africa, provides MPH-level training for key project staff, as well as short-term courses designed specifically to meet training needs of USAID-funded projects. JHPIEGO (John Hopkins Program for International Education in Gynecology and Obstetrics) is helping to integrate child spacing and reproductive health into the medical school and university level nursing curricula; INTRAH (Program for International Training in Health) is doing the same with practical and professional level nursing institutions. Negotiations are under way with the MEDEX Group (at the University of Hawaii) to work with training schools on improving their training for the other CS interventions.

o Health care financing

User fees are well accepted in Zaire; a variety of cost-recovery systems are being tried in different health zones. In 1986, a REACH-assisted study of 10 of the better run health zones showed that the zones were financing 79 percent of all operating costs from user fees. At the health center level, 90 percent of operating costs were recovered. During the past two years, local economic conditions have worked against effective cost recovery. REACH is continuing to assist zones with the

improvement of their financial management and information and to institute better cost-recovery mechanisms, based not only on a zone's financial data but also on consumer-demand information.

o Private sector

Zaire has a thriving private sector and a strong network of PVOs. The BRH and the Shaba Health and Shaba Water projects are managed by PVOs. Many of the health zones are PVO supported, an arrangement that accords with GOZ policy. The Food for Peace program, which is also PVO managed, includes a private-sector component designed to lower the price and promote the commercial manufacture and distribution of a nutritious, low-cost weaning food. The Zaire CCCD project purchases ORS from a local producer and BRH is procuring WHO-approved solar refrigerators that are produced and maintained by a local private manufacturer. A CSM project recently began in Kinshasa.

Private companies are legally responsible for the health care of their employees and their families. The TIPPS project is active in demonstrating to these firms that including family planning services in their health care package will save them money; TIPPS is about to begin promoting the cost benefits of an entire range of CS interventions.

o Operations research

The School of Public Health is building a strong institutional capacity for child survival research. Both the Tulane University Family Planning OR Project and CCCD carry out a broad range of CS-related studies, with assistance from long-term technical advisors. PRICOR also has a resident long-term advisor working with the MOH to coordinate about 30 practical, small-scale, CS-intervention research activities, which are being carried out through the School of Public Health, CCCD, BRH, and others.

o AIDS

USAID recognized early the child survival implications of AIDS. The School of Public Health incorporated AIDS into its research program, as well as into training. The Family Planning Services and CCCD projects are adding appropriate components to combat AIDS and are planning an AIDS training module for BRH. In 1987 USAID began support to HIV rapid test blood screening in Kinshasa, which is estimated to prevent 1,500 pediatric AIDS cases a year.

o Communications

The Zaire HEALTHCOM (Communications for Child Health) project will establish a regional model for modern CS

communications, emphasizing immunizations, ORT, malaria control, and AIDS, and will strengthen the national capacity to develop IEC programs for these and other CS problem areas. A major IEC component has been added to the Family Planning Services project.

- o Policy framework

The USAID program fully supports the GOZ Five-Year Plan, which was formulated based on USAID's experience. Current discussions with the MOH focus on enhancing prospects for financial sustainability. Through WASH, USAID had a major input into the National Water and Sanitation Plan, and, through CCCD, significantly influenced national plans for immunizations, malaria, and controlling diarrheal diseases. Through the Family Planning Services project, USAID supported the development of a national population policy, which, though not yet formally approved by the President, is in fact being implemented. Through the OPTIONS project, USAID is working with various GOZ ministries to improve and coordinate planning and budgeting to achieve the policy's objectives. USAID helped to elaborate the national family planning IEC strategy.

- o Donor collaboration

USAID participates in multi-donor GOZ coordination mechanisms established for CCCD activities, for AIDS, and for the national water and sanitation program. USAID assisted in establishing a national PHC coordinating body.

- 3) Child Survival

- o Immunizations, ORT, malaria control

CCCD supports the delivery of immunizations, ORT, and malaria control services, operating through the national PHC system. CCCD has 20 regional branches, supporting almost 200 health zones (encompassing 76 percent of the population). CCCD provides vaccines, ORS, chloroquine, equipment and supplies, as well as training and technical supervision.

The vaccination strategy is implemented through fixed centers with outreach activities. In CCCD zones, 1986 vaccine coverage among children was 48 percent for measles, 51 percent for DPT 3, and 65 percent for BCG. Among pregnant women, 48 percent received their full dose of tetanus toxoid. While these coverage rates are commendable for a country as vast as Zaire, they are not accelerating as quickly as anticipated. To remedy this, USAID is working to expedite delayed cold-chain and logistics procurements. Furthermore, eight physician regional field coordinators are being assigned to stimulate vaccination activities, particularly through urban campaigns.

CCCD procures ORS for the PHC system, although the private sector also supplies a variety of ORS products. CCCD has established a revolving fund to ensure a continuing supply of ORS as well as chloroquine to health zones. CCCD has established an international ORT training center at Mama Yemo Hospital in Kinshasa, as well as two regional centers; four other regional centers are expected to begin training during the next 18 months.

In 1986, ORS was available in 73 percent of health facilities. KAP surveys have shown that ORT is widely known throughout Zaire, although often incorrectly practiced. Community-supported PHC activities are helping to improve this situation.

Malaria services focus on presumptive chloroquine treatment of fevers compatible with malaria in children under five and prophylaxis for pregnant women. Preliminary 1987 CCCD data indicate that presumptive antimalarial therapy is being practiced in at least 71 percent of project zones. CCCD OR is currently investigating new regimens to improve malaria control in pregnant women, such as a monthly curative dose. Chloroquine resistance is widespread and is being monitored through six regional surveillance sites.

o Child spacing

The BRH is responsible for developing family planning activities in the rural health zones. Progress has been slow; current plans are to incorporate a family planning module into the refresher training for health zone medical chiefs, to improve the contraceptive distribution network, and to disseminate recently developed educational materials. The Family Planning Services project supports activities in 52 urban health zones.

Much groundwork has been done in training and supplying providers, but contraceptive prevalence remains distressingly low. One reason appears to be that project staff have not adequately considered the needs of the users; a series of workshops is under way to provide a more appropriate perspective. The Tulane OR project has shown that CBD can be effective, and it has identified deficient client information as hindering success. A major new IEC component is being introduced, and increased CBD activities are being supported. The CSM program in Kinshasa grew to almost 300 distribution points in four months and will be expanding to other cities this year.

o Nutrition services

Nutrition services, such as growth monitoring, are widely available; however, PRICOR-assisted OR indicates they are less than optimally effective. USAID is working to ameliorate this situation. Although A.I.D.'s only bilateral nutrition

project in Africa will end shortly, the National Nutrition Planning Center (CEPLANUT) it developed will continue to support the CS program. The project developed an appropriate growth chart and accompanying manual, a nutrition curriculum for nurses and one for primary school students, and is currently finalizing a module to be incorporated into the refresher training for key health zone staff. The School of Public Health, which offers special courses in nutrition surveillance, is about to begin a major research activity in collaboration with CEPLANUT. The study will examine current growth monitoring and promotion strategies in Zaire, analyze their contribution to nutritional status, and develop and test a feasible, effective, sustainable program for Zaire.

The Food for Peace Title II program supports targeted supplementary feeding in Kinshasa PHC centers and the production and distribution of a commercial low-cost weaning food. Following up on a study of weaning practices, the program is about to embark on a multi-media campaign. Supplementary feeding is not free and is only supported in centers that had previously begun feeding on their own.

#### III.1.4.2 Niger Child Survival Strategy and Program

Margaret Neuse, HPN Officer, USAID/Niamey

##### 1) Nature and Scope of the Problem

An effective child survival program is a high priority in Niger. The infant mortality rate of 135 per 1,000 children born is one of the highest in the world; almost one-third of the children die before their fifth birthday; as many as one in four children is clinically malnourished, and this figure rises during periods of drought; fertility rates are also very high and contribute to high rates of maternal and child mortality.

Niger has virtually no private health care sector (e.g., PVOs, religious missions); it is basically a governmental system. Constraints faced by the public sector in delivering basic health services include 1) poor access to health facilities for at least half of the population, with a large proportion of the rest served by village health teams that do not provide many of the essential services; 2) lack of operating funds; 3) inadequacy of pharmaceutical supplies; and 4) ineffectiveness of village health teams. (Although over 8,000 community health workers have been trained over the last eight years, they have had no noticeable effect on the health status of the population.)

##### 2) Overall USAID Strategy

In Niger, A.I.D. is introducing a new approach to health programming.

With the termination of the Rural Health Improvement Project on December 31, 1987 (a project that had supported the rural health delivery system for more than nine years), and the signing of the Niger Health Sector Support (NHSS) Grant in August 1986, USAID/Niger shifted its approach from infrastructure and direct project support to policy reform. The NHSS creates the framework for addressing the key constraints in the health delivery system as well as for developing and delivering the key child survival interventions. The idea behind these dual goals is that the "twin engines" of child survival (ORT and EPI [Expanded Program for Immunization]) will not work unless they have an airplane (that is, a health infrastructure).

The NHSS consists of two major components: a dollar component (\$4.5 million) and a local currency component (\$10.5 million). The dollar component provides resources for long- and short-term technical assistance and training. Although the emphasis of these inputs will be on policy reforms, technical assistance and training can be provided for a wide variety of child survival interventions.

The local currency component is tied to the establishment of flexible benchmarks. It is divided into five increments; for each increment there is a set of conditions precedent that must be met by the Government of Niger before the transfer of the funds is made. These conditions are linked to the following policy reform areas: 1) improvement of cost recovery and management of hospital services; 2) cost recovery for basic health services; 3) increased efficiency and cost recovery in drug procurement and distribution; 4) improved health planning and allocation of health resources, particularly financial and personnel; 5) improved delivery of health services, specifically by the village health teams and in training and supervision; and 6) the development and implementation of demographic policies and policies to encourage the delivery of family planning services. After the conditions are met and the transfer of funds has taken place, the Ministry of Plan oversees the use of the funds for local costs of health activities. Within certain guidelines the Ministry of Public Health and Social Affairs has a great deal of flexibility in selecting the specific needs for which they can use these funds.

This approach has several advantages. It focuses directly on the major constraints in the Niger health system. It establishes a policy reform framework that is internally flexible. It reinforces the need for policy and institutional reforms. It puts the burden on the CON to allocate resources. It allows for a flexible response to needs as they arise. And, perhaps most important, it carries the message that the U.S. is seriously committed to policy reform.

This approach is not proving easy to implement. It is very new and the MOH has never been asked to plan this way before. There have been difficulties in establishing operating procedures and in explaining this new approach to other donors. A structure within the MOH is required to manage the policy reform process, including studies. Since the MOH has a monopoly in providing services, there is only one entity with which to work. It is not possible to set clear targets for project achievement. In fact, the project is already a year behind schedule. With a long-term technical assistance team now in place, however, the project should start progressing more rapidly.

To complement the NHSS and respond to the GON request for special assistance to its family planning and demographic research programs, USAID/Niger is developing a bilateral population project. This project builds on the experience gained to date with the implementation of central and regional resources. In 1983 there were virtually no family planning services in Niger; today family planning services are being delivered in the capital of Niamey, and in selected facilities in Niamey and Zinder Departments, and elsewhere. Assistance has been given to the Ministry of Plan in its preparation for a second national census scheduled for May 1988.

### 3) Child Survival Strategy

USAID's child survival strategy contains two major components: institutional and management support and specific child survival interventions. The management support efforts include OR efforts to support village health teams; studies and policy reforms geared to improving self-financing; and efforts to improve pharmaceutical supplies. Six child survival interventions are planned: immunizations, control of diarrheal diseases; nutrition programming and education; family planning; strengthening of the malaria control program; and assessing the need for programming for acute respiratory infections.

## III.2 NUTRITION

Moderator: Linda Lankenau, Nutritionist, HPN Officer, USAID/Nairobi

### III.2.1 AN OVERVIEW

Neen Alrutz, Nutritionist, AFR/TR/HPN

The decreasing emphasis on nutrition was recently expressed cogently by a USAID mission director who said: "We won't be doing any more nutrition activities in the future. We intend to focus on child survival instead."

While people in the HPN field are aware of the well-documented and accepted link between adequate nutrition, growth, and health of young children, fewer and fewer resources are being allocated to nutrition activities. In Africa, Agency support for nutrition through health and child survival programs has dropped precipitously, from \$6.2 million in 1985 to only \$2.5 million in FY88 [see Table 7].

Table 7  
Nutrition Assistance Through  
Health and Child Survival Program  
(in \$000's)

Region	1985	1986	1987	1988
Africa	6,207	3,247	3,131	2,538
Asia and the Near East	9,882	6,070	4,112	1,996
Latin America and the Caribbean	9,492	4,780	5,115	1,896
Worldwide Projects	13,671	11,026	13,762	7,625

Source: ISTI Health Information System

Why this drop? Variously, the blame has been placed at the doorstep of three different groups in A.I.D. People point to a bureaucratic rivalry between central and regional bureaus; to a lack of nutrition expertise and interest among HPN officers; and to the Agency's own inability to decide who "owns" nutrition--agriculture or HPN officers. The recent PPC review of nutrition/agriculture/policy reform interactions being funded through IFPRI and Harvard may yield interesting insights on the interrelationships among these programs. Regardless of the findings, however, it is clear that the real owners of nutrition activities in the field are the HPN officers and increasingly the PVOs whose projects contain nutrition components.

Much of the blame for ineffective nutrition activities must be ascribed to the nutrition promoters themselves. Only in

the past five years have nutritionists begun to agree on what nutrition programs should involve, and only in the past two have success stories begun to emerge. Specifically, on the evidence of an applied nutrition/education project implemented by Caritas/Catholic Relief Services in the Dominican Republic, it appears that a viable strategy would include a combination of education and growth monitoring/promotion within a community development framework. No food supplements or medical interventions were included in the DR program.

The conclusion is that it is time to choose and promote a few unequivocal, workable, and effective nutrition interventions that would comprise a new nutrition strategy. Interventions might include the following:

1) Breastfeeding/ORT

Breastfeeding improves nutritional status and is crucial in diarrheal control. We must get on board the breastfeeding bandwagon. At the same time, the nutritional aspects of ORT need to be brought to the fore. ORT should be renamed "Diarrheal Disease Control" (DDC) and should include promotion of breastfeeding, appropriate feeding practices in infancy, including weaning to prevent insofar as possible the onset of diarrhea, and refeeding after diarrheal intervals to promote catch-up in growth. Once the new definition is accepted, every effort in implementing ORT programs must be pressed to expand their activities to include the full spectrum of anti-diarrheal activities.

2) Growth monitoring and promotion

Weight faltering in infants is the first signal of possible malnutrition. We need to find innovative ways to measure growth, to train health workers to recognize lack of growth, and to educate mothers how to assess and foster growth in their own children.

3) Continued vitamin A activity, including research on the relationship between vitamin A and diarrhea

It is important to continue to move from the short-term intervention of vitamin A capsules to long-term interventions of improving vitamin A consumption through gardening projects. A promising initiative in this area is a project promoting vitamin A gardens in the Sahel.

In addition to selecting a limited number of key interventions, we need to develop a new strategy that includes better promotion of nutrition activities, more creative financing, and closer collaboration with agricultural projects, as follows:

1) Promotion

We need to find better ways to present the successes of nutrition interventions. Nutrition advocates should develop a nutrition version of the RAPID presentation to give policymakers, doctors, health workers, mission directors, program and agricultural officers, and even themselves, a compelling message about the need for specific nutrition interventions and the results that can be expected from them.

2) Financing

Financing is another area where we must become more creative, particularly in these times of tighter and tighter budgets. There are some interesting initiatives now under way in Africa. In Guinea, USAID is undertaking an urban nutrition impact study using money set aside for studies in the African Economic Policy Readjustment Reform. Other funding sources are being tapped in Mali and Mauritania.

3) Integration of nutrition into agricultural projects

Finally, we need to ensure that nutrition and consumption considerations are fully integrated into agriculture projects and policies.

S&T/N has start-up resources that should be taken advantage of where possible. The WELLSTART lactation management program is offering training courses for hospital-based medical personnel on the technical aspects of breastfeeding promotion. Another new initiative, one that is very exciting, is a new education and social marketing project with AED (The Academy for Educational Development), designed to work in the emphasis areas outlined earlier. The response in Latin America was immediate; almost every country agreed to pay for long-term technical assistance. In Africa, to the contrary, few countries responded and many countries were not even interested in permitting an assessment visit.

Thus, both in the field and in Washington, our work is cut out for us. We need to assess our current needs, tighten our focus to fewer interventions, collaborate with the agriculture sector, be creative with finances, and become better advocates for nutrition activities.

III.2.2 REDSO/WCA NUTRITION PROGRAMS

Ming Hung, MCH/FP and Nutrition Advisor, REDSO/WCA

Two types of nutrition activities, one related to growth monitoring (GM) and the other to weaning practices, are

being funded by REDSO/WCA and may be of interest elsewhere. Each has potential high impact, involves minimal mission management burden, and has a relatively modest budget.

An OR study on GM in Togo is seeking to identify the main problems in GM programs and to find ways to address them. The problems are familiar to all. First, weighing and charting growth has turned out to be a far more difficult task than first envisioned. Second, most health workers do a poor job in counseling mothers. This point was dramatically highlighted in another OR study in Zaire carried out by PRICOR, showing that although most health workers did weighing and charting correctly, they failed almost unanimously when it came to counseling the mothers. Despite the difficulties, GM activities can be very useful tools in promoting child health. They help to identify the at-risk child and to prevent his/her condition from deteriorating. Furthermore, GM can be an entry point for other health and nutrition services.

The REDSO/WCA weaning practices project in Ghana is similar to other weaning practices projects in Cameroon, Zaire, and Swaziland. It was funded through a buy-in to the S&T/N Weaning Practices project, with Manoff International as the contractor. The project will research current weaning practices in selected geographic areas, identify those that are beneficial and those that are harmful, and develop appropriate educational and communication strategies, including media programs, to promote the helpful practices and discourage the rest.

## DISCUSSION

New methods to counsel mothers on infant and child nutrition are badly needed. Population programs have made important strides in the area of counseling, but although the nutrition community is catching up, additional progress is needed.

Nutrition will continue to be an orphan within the HPN community if strategic concerns are not addressed. There are too few resources to focus on all three proposed interventions: breastfeeding/ORT, growth monitoring, and vitamin A. For the next five years, the focus should be narrowed to one. Which one that might be is not easy to decide, but conference participants may want to make some suggestions. [Suggestions were forthcoming, including one to support vitamin A supplementation, particularly for children with measles; one to focus on breastfeeding; one for growth monitoring; and one urging a focus on weaning.]

The WELLSTART program is important and has worked well. Overall, it is very important for nutrition programs to document their successes.

### III.3 TECHNICAL UPDATES

Moderator: Richard Greene, HPN Officer, USAID/Ouagadougou

#### III.3.1 TECHNICAL UPDATE ON EXPANDED PROGRAM FOR IMMUNIZATION (EPI)<sup>3</sup>

Pierre Claquin, Associate Director for EPI, REACH

##### 1) The Status of EPI Worldwide

Immunization services, which reached less than 5 percent of the children of the developing world in 1974, are now protecting some 50 percent with three doses of DPT (diphtheria, pertussis, and tetanus) or polio vaccines. EPI in developing countries is preventing 200,000 childhood cases of paralysis from polio each year and over a million deaths from measles, neonatal tetanus, and whooping cough.

International support has been essential for national progress, including that from bilateral sources, United Nations agencies (e.g., UNICEF and WHO), and private and voluntary groups. A.I.D. is playing a major role in Africa, providing financial and technical support through the CCCD program and through centrally funded and bilateral projects.

1990 is the first target date for EPI, but the program must continue forever. Priorities for the coming decade will be to

- o accelerate progress in countries that have not attained the 1990 goal;
- o sustain high immunization coverage in the remaining countries for the foreseeable future;
- o eliminate target diseases as public health problems, shifting program focus from immunization coverage to disease control. (Smallpox was not eradicated by high vaccination coverage rates but by active case detection and systematic containment);
- o introduce new vaccines as soon as they become available for public health use; and
- o use the full potential of EPI as a springboard to promote and deliver other primary health care

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<sup>3</sup>EPI programs may include DPT, BCG [a tuberculosis vaccine], polio, measles for children, and tetanus toxoid for pregnant women.

interventions, and pursue research and development in support of all these actions.

2) The Status of EPI in Africa

With respect to the EPI campaign, Africa is lagging behind other regions of the world. Table 8 shows, by country, 1986 vaccination coverage for the third dose of DPT. Both CCCD countries and countries in which A.I.D. is providing EPI assistance through other mechanisms are marked. In 1986 estimated deaths from vaccine-preventable diseases were as follows: 520,000 from measles, 311,000 from neonatal tetanus, 179,000 from pertussis and 86,000 from polio.

Over the last three years, political leaders and ministers of health have shown an increased awareness of the seriousness of the situation. Initiatives, like the African Immunization Year, have contributed to the mobilization of populations; an accelerated strategy for EPI has been launched in 31 countries; national EPI committees have been established in 24 countries; and more than 20,000 health personnel were retrained in EPI techniques.

3) A.I.D.-Funded Interventions

Management Information

o In response to implementation problems arising primarily from lack of logistics and management expertise, a five-day workshop will be held in September for national EPI staff of Mali, Senegal, Niger, Chad, Mauritania, Madagascar, Togo and Cote d'Ivoire.

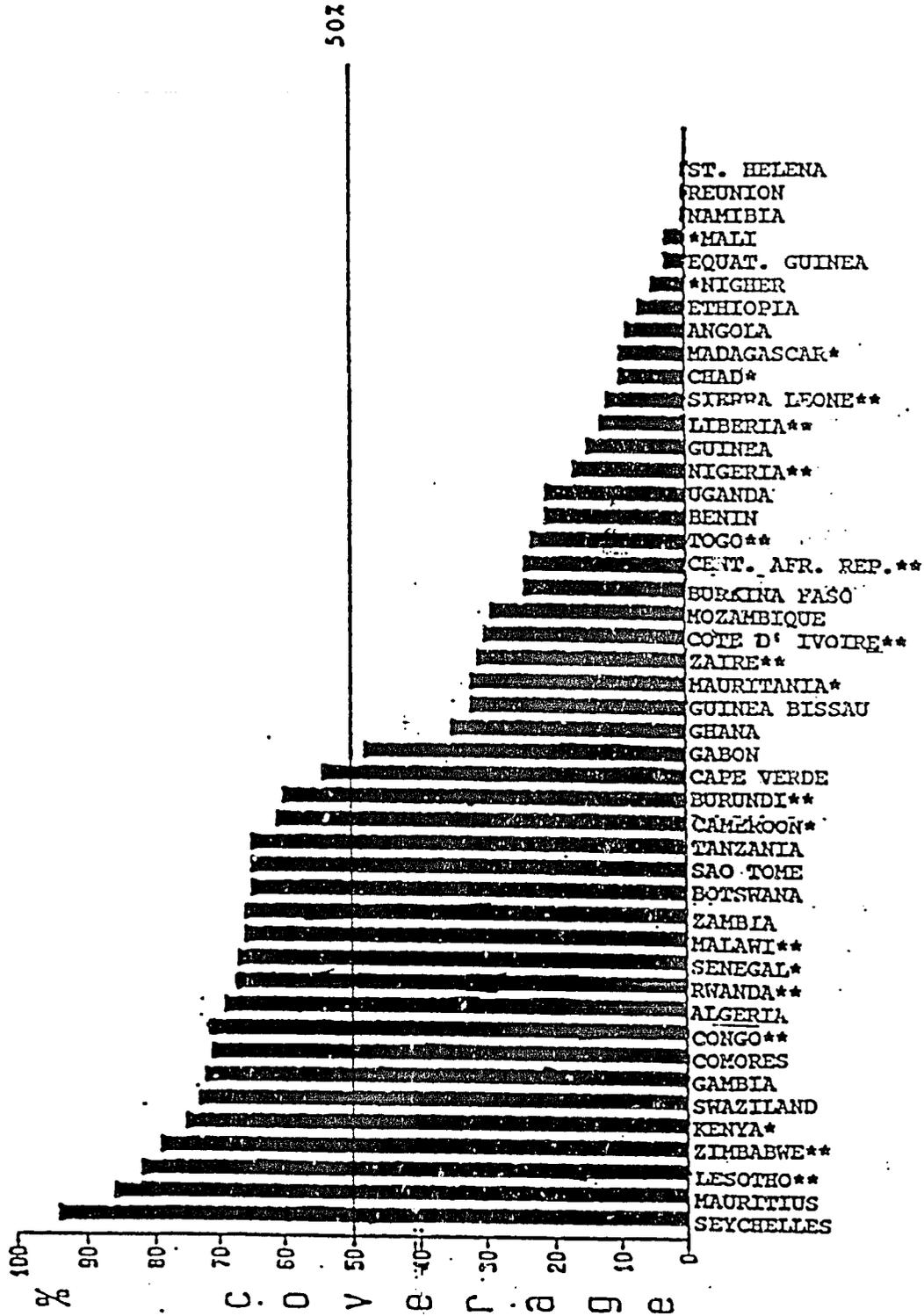
Research

o In order to facilitate monitoring of immunization activities, a new MIS software program known as EPIIS (EPI Information System) has been successfully installed in several countries in Asia and will be introduced in Africa this summer.

o Vaccination coverage surveys using the WHO 30-cluster method are simple but useful for collecting information on coverage and other programmatic indicators. In collaboration with WHO, an improved software program, COSAS, has been successfully tested.

o In close collaboration with WHO, field testing will begin in June for a new single-use injection device.

TABLE 8  
Reported immunization coverage of 3 doses of DPT in children less than 12 months of age, Africa Region, 1986



\*\*Countries in which A.I.D. is providing EPI assistance through the CCCD program.

\*Countries in which A.I.D. is providing EPI assistance through other mechanisms.

o Costing and cost-effectiveness studies of EPI have been undertaken in Mauritania, Senegal, and Cameroon. These studies are valuable for understanding the requirements for financial sustainability of program activities. Matrixes are being developed for missions to document costs.

o Two special initiatives have been taken to combat measles and neonatal tetanus in Africa: 1) studies of measles control strategies will be undertaken in Kenya and Cote d'Ivoire; and 2) Anglophone and Francophone workshops on the control of neonatal tetanus will be held for EPI managers.

#### Interagency Collaboration

o Collaboration has improved between donor agencies. A.I.D./W is meeting with UNICEF at regular intervals to share concerns and to improve collaboration in field projects. Collaboration between A.I.D., the EPI unit of OCCGE (Organization for Coordination and Cooperation in the Fight Against Major Endemic Diseases), and ORSTOM (Organization for Scientific and Technical Research Overseas) is excellent. It is envisioned that dialogue will soon start with OCEAC (Organization for Coordination of the Fight Against Endemic Diseases of Central Africa).

o At the request of UNICEF, the A.I.D.-funded REACH project evaluated the UNICEF acceleration strategy (campaign approach to strengthen routine immunization services) in Cameroon and Senegal. This led UNICEF to a better understanding of the limitations of this approach.

o A.I.D. has funded a full-time position to support and strengthen the immunization activities of PVOs and NGOs in Africa.

o As a contribution to better documentation of EPI in CS countries, a directory of EPI partners has been prepared for each country.

#### III.3.2 TECHNICAL UPDATE ON ORAL REHYDRATION THERAPY (ORT)

Suzanne Prysor-Jones, Health Planner, ORT Programs, PRITECH, Senegal

Current issues in ORT fall into three major categories: issues arising from updates of the technology; those arising from monitoring and evaluation; and those that relate to the need to consolidate program achievements. This presentation sets forth the major issues in each category and lists a number of strategies planned to respond to each issue. [Rather than the narrative form adopted elsewhere in this summary, the

presentation of this section is in the outline form used by Ms. Prysor-Jones at the conference.]

1) Issues Arising from the ORT Technical Update

Issue: Feeding is important for diarrhea patients, both during and after an episode: it reduces the length of the episode and the stool output, and prevents nutritional ill-effects (chronic diarrhea malnutrition syndrome, responsible for 50 percent of deaths).

Strategies:

- o search for special foods during episode;
- o focus on dietary advice given to mother;
- o use patient contact to assess and record nutrition status.

Issue: In the treatment of dysentery, it is important to take into account that 30-40 percent of bloody diarrhea is due to *Shigella* (which requires treatment with antibiotics).

Strategies:

- o identification of bloody diarrhea and recording of it;
- o clear norms on presumption and treatment of *Shigella*, and procedures if no response;
- o research to establish etiologies in countries/regions (importance of *Shigella*).

Issues: With respect to ORS, the search for marketable SUPER-ORS continues. Acceptance improves with coloring and flavoring, but difficulties remain in correct mixing of sugar-salt solution.

Strategies:

- o search for alternative home fluids, especially cereal-based;
- o research on increasing ORS acceptability.

Issues: Although a threshold of good diarrhea treatment has been attained, research on cost-effectiveness of alternative strategies to prevent diarrhea is still needed. New WHO materials are available on this problem.

Strategies

- o identification of country-specific priority;

- o interventions to avoid the danger of dispersed efforts, including: breastfeeding, improved weaning practices, handwashing, use of plenty of clean water, hygienic disposal of babies' stools, use of latrines, and measles immunization.

## 2) Issues Arising from Monitoring and Evaluation

Plans: In 1988, a number of activities are planned including a greater focus on supervision; testing of WHO-developed health facility surveys; and implementation of household surveys.

Issues: One training course does not provide sufficient time to teach all aspects of diarrhea treatment practices: i.e., fluids, feeding, education, referral, and appropriate use of drugs.

### Strategies:

- o focus on pre-service training;
- o search for low-cost methods for re-training and continuing education.

Issues: Mothers' knowledge and practice will fall off if they are not reinforced. It is important that mixing and administration of sugar-salt solution be done correctly.

### Strategies:

- o study and monitor extent and causes of difficulties;
- o reinforce and vary messages (to avoid confusion);
- o focus on improving face-to-face education.

Issue: Health staff are often poor educators.

### Strategies:

- o clarification of messages (rehydration and feeding);
- o continuing education on techniques;
- o task/time analysis to specify realistic activities;
- o focus on individual patient contact improvement.

Issue: Sustained community involvement is the weak link in ORT.

Strategies:

- o clarify tasks required of different actors;
- o intensify work with existing groups and networks (often non-health);
- o promote decentralized decision-making.

Issues: Monitoring itself is weak. Little supervision is provided to those who are teaching activities, and that which is provided is poor. Information systems are also weak.

Strategies:

- o use technical aides for supervision;
- o small surveys to compensate for poor information systems;
- o inexpensive evaluation techniques: e.g., intercept groups.

Issue: ORS distribution can be an example for the distribution of other essential drugs.

Strategies:

- o use ORS example to push for overall reform;
- o use information on current management practices for ORS, stockouts, etc., to pressure decisionmakers.

3) Issues Arising from the Need to Consolidate Program

Update: Some progress has been made in three areas: better treatment practices by health staff; more appropriate home treatment by mothers; improved access to ORS.

Issue: Regional and district teams must take responsibility for decentralized implementation and follow-up.

Strategies:

- o improve district/regional planning capacities;
- o clarify roles and responsibilities of regional/district staff.

Issues: ORT activities must be integrated into general PHC functions without losing the selective intervention focus. This will involve making ORS widely available through commercial channels and focusing on cost containment and recovery.

Strategies:

- o include ORT in general information system;
- o add ORT component to other training efforts;
- o experiment with integrated supervision visits;
- o integrate ORS into improved drug supply systems;
- o add ORT to other patient contact points (EPI, growth monitoring).

Issue: Political commitment should be sustained beyond initial eye-catching activities.

Strategies:

- o adopt realistic intermediate goals;
- o diversify sources of funding and support;
- o state clearly activities required to sustain achievements.

III.3.3 TECHNICAL UPDATE ON MALARIA

Joel Breman, Chief, Malaria Control Activity, Malaria Branch, Division of Parasitic Diseases, CDC

Malaria is endemic in 12 of the 13 ACSI-CCCD countries, and the prevalence of Plasmodium falciparum infection in endemic areas is frequently over 50 percent, with the highest rates occurring in children.

The ACSI-CCCD malaria control strategy is based on the WHO policy, which has evolved from eradication to prophylaxis and treatment. The strategy is designed to 1) ensure prompt and effective treatment to high-risk groups with malaria (e.g., children less than 5 years of age and pregnant women); 2) control malarial infection in pregnant women by prophylactic drug use, principally to reduce the risk of low birth weight of infants and, thereby, improve child survival; 3) maintain surveillance on malaria treatment and prevention practices by monitoring the clinical and parasitologic response to therapy and the patterns of severe illness and death; and 4) develop national malaria control plans with detailed guidelines for their implementation and evaluation.

Since the late 1970s, chloroquine resistant P.

falciparum (CRPF) has become an increasingly prominent epidemiologic feature in Africa. Were it not for this decreased sensitivity, Chloroquine would be the ideal drug for treating malaria: It is relatively inexpensive, acts rapidly to decrease the parasite density and symptoms, and is well tolerated. Traditionally, the goal of malaria therapy has been complete elimination of the parasitic infection; however desirable this may be, the primary treatment objective is to reduce the frequency of severe illness and death by prompt therapy. Where malaria reinfection is likely soon after treatment, as in most areas of CCCD countries, it has been demonstrated that it is not necessary to eliminate parasitemia completely to achieve a reduction in malaria morbidity (decreased temperature) and mortality.

Studies in 9 of the 13 ASCI-CCCD countries indicate that in areas with chloroquine resistant P. falciparum, treatment with chloroquine resulted in decreased temperature of febrile children and a great reduction in parasite density, preventing severe illness and possible death. Consequently, the priority must be to continue the use of 4-aminoquinolines as long as they retain clinical and parasitologic efficacy. There is no equally safe and cheap alternative. At the same time, unnecessary drug-use practices that could promote resistance should be restricted. These practices include use of antimalarials for non-febrile illnesses, underdosing, wide-scale chemoprophylaxis, and excessive use of antibacterial compounds.

Baseline surveys have shown a wide range of treatment practices; chloroquine is being used in varying doses without standard guidelines, and excessive numbers of quinine and chloroquine injections are being given at health units. Few pregnant women are taking chemoprophylaxis during pregnancy. Research has begun to look at alternative drug treatment approaches to prevent the adverse effects of malaria on the fetus.

WHO recommends a dose of 25 mg/kg over three days (10 mg - 10 mg - 5 mg). There will be some clinical and parasitologic treatment failures, requiring a well-defined referral plan for evaluating and treating therapy failures. In addition, a small percentage of children will be seen who are too seriously ill to be treated at the community level and will require parenteral therapy. Communities should have clearly established links with health facilities where effective parenteral antimalarial drugs and resources for clinical and laboratory diagnosis and treatment are available.

All CCCD countries have now integrated malaria control into primary health care and all have begun to implement standardized treatment and prevention practices that are described in national CCCD malaria plans. National malaria control units are responsible for the following: disseminating

information on malaria; training peripheral and intermediate-level health workers in the diagnosis, treatment and prevention of malaria; providing drug-use schedules for clinics and hospitals; and performing operational research.

### III.3.4 TECHNICAL UPDATE ON ACUTE RESPIRATORY DISEASE (ARI)

Robert Clay, Public Health Advisor, Diarrheal Diseases, S&T/H

Acute respiratory disease has only recently been recognized as a major problem; WHO did not establish a global program until 1982. The average incidence of ARI is 4-8 episodes per year, inversely related to age. ARI is the leading cause of the use of health services throughout the world; 30-60 percent of sick children visit treatment facilities because of ARI, and 30-40 percent of those are hospitalized. Although most acute respiratory infections are not fatal, 1 in 50 episodes of cough will develop into pneumonia, and without treatment 15-25 percent of children with pneumonia will die. There are approximately 2.5 million deaths per year from ARI, of which 90 percent are in developing countries.

ARI has been classified into three types--mild, moderate and severe--with the following criteria and case management recommendations for each category.

#### 1) Mild

##### Criteria:

- o cough, hoarseness, wheeze or fever with respiration <50 per minute;
- o stridor relieved when at rest;
- o red throat;
- o blocked or runny nose;
- o ear ache or ear drainage.

##### Management:

- o support measures only--no antimicrobials;
- o fluids;
- o breastfeeding;
- o treatment of fever.

2) Moderate

Criteria:

- o respiration 50-70 per minute;
- o wheeze or fever but no chest indrawing.

Management:

- o antimicrobial at home--plus support measures.

3) Severe

Criteria:

- o cough or wheeze and unable to drink;
- o cough without wheeze and chest indrawing;
- o cough with wheeze and respiration >70 per minute or complicated by cyanosis, seizures, apnea, change in consciousness, severe dehydration or stridor when at rest.

Management:

- o referral and antimicrobials--plus support measures.

Preventive measures for ARI include immunization (four respiratory diseases are included in EPI--measles, pertussis, diphtheria, and TB); chemoprophylaxis; improved nutrition; health education; and the reduction of indoor air pollution.

A number of activities are recommended for the future, including clinical research, epidemiologic research, diagnostic technologies development, ARI control programs, EPI coverage, and vaccine development and testing.

There is a growing interest in ARI among international donors, particularly WHO. Currently, the Control of Diarrhoeal Diseases (CDD) program at WHO has assumed management responsibility for the ARI unit and the issue as to whether ARI and CDL should be combined is under review. There are a number of interrelationships between CDD and ARI. For example, they have the same target population--children under five; diarrhea and ARI are often the first or second leading causes of infant and child mortality; both emphasize case management; nutrition management is key during illness and as a preventive intervention; communication activities are important to both; and both are part of the primary health care program.

A.I.D. is considering two programming options. One possibility is to use existing central resources, (e.g., PRITECH, REACH, PRICOR, and others), to create a coordinated approach, implemented by single contractor. The other option is to develop a new ARI project.

### III.4 HIV/AIDS ISSUES

Moderator: William Lyerly, Africa Bureau AIDS Coordinator, AFR/TR/HPN

#### III.4.1 TECHNICAL AND PROGRAMMATIC UPDATE ON HIV/AIDS

Jeff Harris, A.I.D./W AIDS Program Coordinator, S&T/H

##### The Epidemiology

"Sutton's Law" (named for a bank robber whose law was to go where the money was) is a good way to think about developing a strategy to combat HIV/AIDS. The lesson for A.I.D. is to go where the virus is, letting the epidemiology of the disease be our guide.

In Africa as of October 1987, the majority of the reported cases of AIDS were in central Africa, although almost all countries have reported some cases. Reporting, however, is not very good; in Zambia, for example, almost no AIDS has been reported, but the prevalence of HIV is very high.

As determined earlier, transmission is primarily through sexual intercourse, which worldwide accounts for 80-90 percent of all transmission; through blood transfusions, which may account for 5-15 percent of the cases in Africa; and finally, via mother-to-child.

Heterosexual transmission is the most important mode of transmission in Africa, and infection is far more common among prostitutes than among other women. An explosive spread has taken place in the incidence of HIV among Nairobi prostitutes: infection has increased from only 4 percent in 1981 to 60 percent in 1985 to 95 percent in 1987. Overall in Africa, those persons at highest risk are those with the largest number of sexual partners (i.e., prostitutes, truckers, and the military).

New studies suggest that genital ulcers may make women more susceptible to infection with the HIV virus. Nairobi prostitutes with genital ulcers were found to be twice as likely to be HIV-positive as those without. Other STDs that cause breaks in the skin may also be factors in the transmission of the virus. The implication is that a strategy that includes treatment of STDs that cause skin breaks might help prevent the spread of the HIV virus.

Blood transfusion, while far less important than sexual transmission in the overall picture of AIDS epidemiology in Africa, represents a risk for those who need blood. Virtually all infected blood used for transfusions will transmit the disease. Because AIDS is far more common in urban than in rural areas in Africa, the conclusion from a strategic viewpoint is that blood screening efforts should be concentrated in urban areas.

With respect to transmission through needles, it appears that intravenous injections are far more likely to transmit the virus than intramuscular injections. Intravenous drug use in the U.S. carries a 17-25 percent risk of transmission compared with 0.5 percent risk for intramuscular injections. Thus, there seems to be little danger associated with shots for Depo-Provera or malaria. Nevertheless, it is important that extreme care be taken so that programs involving injections (EPI, family planning) in no way contribute to the spread of the HIV virus.

Information is incomplete with respect to perinatal transmission but it appears that roughly half of all infected women will have passed on the infection to the child before its birth, and half of those born with the virus will die within the first year of life. The best way to prevent this form of transmission is to prevent the infection in the mother.

Evidence continues to be overwhelming that AIDS is not transmitted through household contact: i.e., through sharing of utensils, etc. In addition, there is no evidence that mosquitoes transmit the disease.

In summary, four strategic issues and conclusions arise from what is now known about the epidemiology of AIDS:

Emphasis Countries: It is appropriate to concentrate resources in the countries where the problem is greatest, but not to exclude others.

Targeted Education: It is appropriate to target groups practicing high-risk behavior.

Targeted Blood Transfusions: It makes sense to concentrate first on blood transfusions in urban areas.

Injection providers: The risk from intramuscular injections is sufficiently low that private-sector providers of injections do not warrant targeting.

### Effective Strategies

The technical means at our disposal to prevent AIDS are

imperfect. Mass media, for example, as a mechanism to bring about behavior change, turned out to be notably ineffective in Britain, where the much publicized AIDS awareness campaign, costing 20 million pounds, brought about no behavior change among high risk groups. This contrasts with the focused education campaign directed at Nairobi prostitutes, which produced a major behavior change within this group: In a few months, condom use, at least part of the time, increased from 0-90 percent. Condom efficacy is also not perfect. Again in Nairobi, 30 percent of the prostitutes who used condoms became HIV positive. This compares with 22 percent who did not use condoms and became HIV positive. The greatest problem with condoms appears to be failure to use them, not breakage.

Blood transfusion screening also is hampered by current technology. The ELISA test, which works well, is designed for large numbers of people and requires refrigeration and electricity. Rapid tests, which will be more appropriate in Africa, are being developed but are not yet ready [see "Additional Comment" by William Lyerly in the section "A.I.D./Resources for Prevention and Control of HIV/AIDS" for further discussion of Rapid tests].

#### Available Funding

FY88 funding for AIDS activities totals \$30 million, including \$15 million in cash to governments and another \$15 million in goods and services. The \$15 million in cash is to be channeled through WHO, with \$10 million unearmarked and \$5 million earmarked to be allocated through WHO donors meetings. These meetings are an extremely effective means to mobilize funds from other donors. The other \$15 million for goods and services is divided among the following: the AFR and LAC regions; S&T/POP for condoms; and S&T/H for a number of projects, the largest of which are AIDSTECH and AIDSCOM (the Technical Support and Communication components respectively of the AIDS Technical Support project). The allocation among the various health projects is still under study.

#### DISCUSSION

Concern was expressed that it would be difficult to distinguish emphasis countries from non-emphasis countries because of the lack of good epidemiological data. To access the epidemiological expertise of CDC, a PASA has been set up in the Office of Health budget.

Concern was also expressed that, although many countries preferred multilateral assistance (for instance, Swaziland), in those countries where several donors are active (like Uganda and Tanzania), programs were not being implemented as fast as might seem desirable.

### III.4.2 AFRICA BUREAU REGIONAL STRATEGY AND PROJECT

William Trayfors, Assistant Director, AFR/TR

Over the past two years, Agency policy has evolved from a view that AIDS was a problem largely for WHO to manage to a decision that steps must be taken immediately to enable the Agency to provide direct programmatic assistance, in addition to continued support through WHO. Part of the reason for the change is the new knowledge that AIDS is not confined only to urban concentrations, but that it also appears to be spreading rapidly in rural areas (e.g., in Zambia, Tanzania, and Uganda).

How should we think about the problem of AIDS? Should our attitude be one of great alarm? Or is a more measured response justified, given that the incubation period (from infection to manifestation) appears longer than first believed--on the order of nine years--and that the epidemic appears to remain largely confined to high-risk groups?

For the Africa Region, the immediate problem is that there is very little money available for direct country assistance in relation to the volume of requests. In FY88, a total of \$3 million from AFR/TR and less than \$1 million out of the Agency budget of \$30 million compares with \$10.5 million worth of requests for country programs. AFR/TR's most recent response has been the new HAPA project (HIV/AIDS Prevention in Africa project), which is authorized to provide \$10 million over a three-four year period and includes another \$10 million for mission buy-ins. The purpose is to provide immediate Africa Bureau support for national AIDS control and prevention activities in African countries.

The implementation mechanism and the origin of some of the funding remain to be decided. Mission responses to this initiative will help determine which should be emphasis countries. [Note: The HAPA project paper was approved, with input for the HIV/AIDS Working Group of the HPN Conference; and the project was authorized June 21, 1988.]

### III.4.3 POLICY ISSUES

Katherine Blakeslee, Associate Assistant Administrator, PPC/PDPR

In the face of a lack of information, the Agency is moving very cautiously with respect to predicting the impact of AIDS on other development projects. Some modeling is now being done to get an idea of the implications of AIDS on foreign policy and development activities: i.e., on health budgets, status, and programming; on travel, tourism, and international mobility; and on overall national development (urbanization, family structure, political stability).

Policy issues at the operational level are many and difficult:

- o How can limited funds be targeted to be most effective in the prevention and control of AIDS?

- o How do we choose between emphasizing control and emphasizing prevention? How appropriate is our list of high-priority countries: Kenya, Zaire, Zambia, Zimbabwe, Congo? What emphasis should be accorded to medium priority countries: South Africa, Botswana, Central African Republic, Nigeria, Cote d'Ivoire, and Senegal? How do we make choices within the continuum of high-risk groups? Especially in high-prevalence areas, what are the implications of the interface of family planning and AIDS? For example, what is the role of family planning workers? How do we reconcile promoting condoms as prophylactics against AIDS with our cafeteria approach and our emphasis on more effective methods? Do family planning workers have an ethical obligation to discuss AIDS?

- o From the standpoint of mortality, how do we resolve the trade-off between the effectiveness of methods against AIDS and their effectiveness against pregnancy? If one out of every 200 deliveries in Africa results in maternal death and if there is 1 percent prevalence of AIDS and a 50 percent mortality rate overall, the mortality rate is the same. If there must be trade-offs between funding for child survival, for family planning, and for health, what should these be?

We don't know the answers. We may not be able to issue specific policy guidelines now on these issues that would be appropriate in all situations in all countries, but we must consider these questions in our family planning and AIDS programming at the country level.

## DISCUSSION

There are dramatic differences in types of policies that are feasible in different countries. For example, AIDS can be discussed openly in some places, whereas elsewhere the whole range of STDs is an extremely sensitive subject.

### III.4.4 COUNTRY PERSPECTIVE: UGANDA

Paul Cohn, Health and Population Officer, USAID/Kampala

The AIDS situation in Uganda, with 2,752 officially identified cases and double that number expected soon, has

received considerable international attention. Between 1982 and 1986, the official stance was denial, but then with the number of deaths growing, the existence of the disease was publicly recognized. A flurry of activity ensued, including a WHO-sponsored donor conference, considerable blood testing, distribution of 2.4 million condoms, and an educational campaign, targeting both the public at large and the MOH. By 1987, an organized strategy had been drawn up: With WHO stationing staff in-country, the MOH increased its AIDS staff from 50 to about 90 people, efforts began to revitalize the national STD programs, and a full-fledged educational program was mounted--including films, songs, and participation of popular music groups.

The AIDS control and prevention program now includes four components: 1) development of a management and administration staff; 2) an IEC program, whose capability the MOH intends to increase in order to continue this work over the long term; 3) surveillance and control, which is being carried out primarily by WHO; and 4) support for laboratories doing blood screening.

The overall AIDS budget in Uganda for next year is \$10 million. This may be more than can be absorbed. The MOH is contributing 25 percent of its total budget, or some \$4.5 million. Mission funds are also important. WHO is contributing \$1.4 million over four years.

The data that have been accumulated on AIDS show that the male:female ratio among those infected is 1:1, with 70 percent of cases aged 20 to 40. No significant correlation has been found between AIDS and injections. The relationship suggested elsewhere between AIDS and lesions caused by STDs may not be borne out in Uganda. Rather, HIV seropositivity seems to be correlated with a decreased number of T-4 lymphocytes (white blood cells) and the high level of exposure to AIDS that comes with multiple sex partners. Studies have shown a high level of incidence among barmaids (68 percent), TB patients (45 percent), hospital patients (38 percent), truck drivers (30 percent), and pregnant women, urban and rural, (10 to 24 percent). Incidence was found to be low among really rural people (1/2 to 2 percent), and among those who had casual social contacts with AIDS patients (2 percent). Doctors are particularly concerned about AIDS within their ranks. There have been six physician deaths from AIDS between 1983 and 1986, making it now the biggest single cause of death among doctors.

An ethical issue in Uganda is that people who have participated in AIDS studies are not being told their sero-status.

### III.4.5 COUNTRY PERSPECTIVE: ZAIRE

Glenn Post, Chief HPN Officer, USAID/Kinshasa

That Zaire ranks as one of A.I.D.'s five top-priority countries for AIDS funding is highly appropriate, not only in view of the epidemiological situation, but also because of the government's high level of commitment to combatting the disease and the country's unique research capabilities.

The Government of Zaire officially recognized AIDS as an area of concern in 1983 when it authorized Project SIDA, a research institute operating with U.S. and Belgian assistance. Although AIDS remained a sensitive issue for several years more, by 1987 a National AIDS Prevention and Control program had been launched and a comprehensive, medium-term plan drawn up for consideration by external donors. At a WHO-sponsored donor meeting last month, a total of almost \$4.7 million was pledged to implement first-year activities, including \$1 million from USAID. In a very positive move, the MOH has called for on-going evaluation of program initiatives.

Estimates of adult seropositivity in Kinshasa range from 3 to 8 percent, with estimates for other major cities at 5 to 6 percent. These figures may be high. Groups at highest risk are prostitutes, tuberculosis patients, children with malaria or sickle-cell anemia who need blood transfusions, young women aged 15 to 25, and individuals who have multiple sex partners, especially clients of prostitutes. Thus far, AIDS seems to be confined primarily to urban areas. There is also evidence that individuals of higher socioeconomic status have relatively higher HIV infection rates.

In the summer of 1987, USAID/Kinshasa became the first bilateral mission to develop its own AIDS strategy. In the project, all assistance is channeled through one of two mechanisms: 1) the WHO-supported National AIDS Prevention and Control Program or 2) established institutions, including Project SIDA and A.I.D.-supported bilateral projects.

The strategy is to assist implementation of GOZ activities in three principal areas: prevention of transmission, training, and research.

#### Prevention

The first task has been to demonstrate the feasibility of establishing a machine-independent, rapid HIV-screening program. This Project SIDA experiment suggests that all but the poorest segments of the population would be willing to pay for such a service. The safe blood supply that has been ensured in two hospitals will, it is estimated, prevent 2,000 AIDS cases a year. The system is expected to be established elsewhere in

Zaire and information about it disseminated to other African countries. Efforts are also being made to prevent transmission through injections by increasing supplies of needles, syringes, and sterilizers and by reinforcing training for their proper use.

The harder task will be to develop approaches to prevent transmission through sexual activity, which accounts for 80 to 85 percent of the infections. As a first venture, USAID funded publication of a comic book "Le SIDA," (SIDA is the French acronym for AIDS), a joint SIDA/National AIDS Committee project. USAID is also funding an AIDS mass media campaign, to be implemented with assistance from Population Services International. A three-year research effort is under way focusing on convincing couples, of which one partner is HIV-positive, to use condoms. This should help identify the level of effort needed to promote condom use, while testing the efficacy of condoms in preventing transmission. It is also planned to support distribution of condoms to high-risk-behavior groups.

### Training

The effort is to incorporate, wherever possible, a segment on AIDS into training for all types of health care personnel involved in USAID HPN projects. The University of Kinshasa School of Public Health has already incorporated AIDS information into the MPH curriculum and plans to extend the training to doctors, nurses, and other health personnel. Other activities will include a seminar to be held this summer by the School of Public Health on public health interventions in AIDS and long- and short-term training.

### Research

USAID has a unique opportunity to draw on local research expertise in Kinshasa, where AIDS-related epidemiological and behavioral research are under way at the University of Kinshasa School of Public Health and through Project SIDA. The School of Public Health, for instance, is developing an AIDS mathematical model, which should be extremely useful for determining resources and identifying strategies most appropriate for controlling AIDS in urban Africa. The Family Planning Services Project Operations Research Unit is studying the feasibility of incorporating AIDS education and prevention activities into a CBD program. In a KAP survey, also carried out by the OR unit, it was learned that throughout Kinshasa, the knowledge level is extremely high regarding modes of transmission of AIDS, especially sexual or unsterilized-needle transmission.

### III.5 A.I.D./W RESOURCES FOR PREVENTION AND CONTROL OF HIV/AIDS

Moderator: William Trayfors, AFR/TR

#### III.5.1 TECHNICAL ASSISTANCE IN DIAGNOSTICS, BLOOD BANKING, OPERATIONS RESEARCH, AND DELIVERY SYSTEMS

Peter Lamptey, Director, AIDSTECH, Family Health International

[Peter Lamptey delivered this talk in place of Malcolm Potts, who had originally been scheduled.]

The AIDSTECH project works with USAID missions worldwide to support activities aimed at preventing HIV infection and controlling the spread of AIDS in the developing world. AIDSTECH, staffed by a core of technical experts located at Family Health International, has identified seven types of activities it will support. All are seen as complementary to the leadership efforts of WHO.

First, AIDSTECH will support initiatives to prevent HIV infection through sexual and perinatal transmission. Second, the project will assist efforts to prevent HIV transmission through blood transfusion and skin-piercing procedures. Third, AIDSTECH will support the development of surveillance systems to track the spread of HIV infection. AIDSTECH will also support four additional efforts: 1) to assist governments in developing health care financing strategies; 2) to alert policymakers to the implications of the AIDS epidemic through development of computerized and graphic interactive presentations of expected trends in the spread of the disease; 3) to disseminate information on what is being learned through specific projects to other groups involved in efforts to control AIDS; and--closely linked to this--4) to support attendance at AIDS-related conferences, notably a major upcoming International Conference on AIDS to be held in Stockholm in June 1988.

With respect to supporting interventions to prevent HIV infection through sexual transmission, the epidemiology points to three high-risk groups: commercial sex workers, the military, and truckers and bus drivers. An initiative funded by the American Foundation on AIDS Research suggests that training prostitutes to distribute condoms and promote condom use within the prostitute community is a very effective strategy. AIDSTECH is currently working with programs to prevent sexual transmission in Ghana, Mali, and Cameroon and has been invited to develop similar programs in Zaire, Kenya, and Burkina Faso.

With respect to preventing transmission through blood transfusions, AIDSTECH has a comprehensive strategy, including providing assistance for needs assessment, program planning,

procurement of equipment and supplies, and training, particularly of laboratory technicians. AIDSTECH has provided technical assistance to Malawi, Senegal, Cote d'Ivoire, Ghana, and Burkina Faso to help ensure the safety of the blood supply in selected institutions in these countries. An important issue is the technology of blood testing. The most commonly used test to detect the AIDS virus is the ELISA test, but this is not very appropriate for use in small institutions in Africa, in particular because it requires testing in batches of 90 lots or more. A promising alternative, Rapid kits, can test individual samples easily and quickly. This technique has not yet been licensed by the USFDA, however, and so cannot be provided through A.I.D.

#### ADDITIONAL COMMENTS

William Lyerly, AFR/TR/HPN

Several versions of the five Rapid tests now being evaluated may be technologically appropriate for use in small hospitals in the developing world. These assays take only 10 to 15 minutes and require no equipment and very little technical skill to administer. One assay protocol involves use of an eye-dropper and the results are easily read visually. The test is believed to be extremely sensitive and could cost under \$1 per test. These assays are being marketed in Europe and are also commercially available in Africa.

#### DISCUSSION

A cost of \$1 per test may be expensive for most African countries. The issue also remains as to who would fund an Africa-wide program of blood screening for blood transfusions. The cost is estimated at about \$2 million over the next year, or enough for an expected 1 million transfusions. WHO, UNDP, and A.I.D. are planning to discuss whether A.I.D. or WHO should be responsible for providing this funding. [The comments in this paragraph were made at the end of the entire discussion on AIDS.]

#### III.5.2 COMMUNICATIONS AND EDUCATION

Glen Margo, Project Director, AIDSCOM, Academy for Educational Development

Among the four elements of any AIDS control program--epidemiology, management, IEC, and testing--it is apparent that what is needed most is an effective IEC strategy aimed at slowing transmission of the HIV virus. The AIDS emergency is currently threatening to draw on resources desperately needed for other

public health efforts. At the same time AIDS is inextricably linked with many other endemic diseases. HIV may be only a catalyst for a disease process that may actually begin prior to infection and entail genetic predispositions, environmental factors in nutrition, infectious agents, toxins and allergies, and behavioral factors in psychosocial and emotional tendencies. These interactions have obvious implications for an IEC strategy. First, there is neither time nor resources with which to build a new infrastructure. Instead, what is needed is to study the techniques learned over the years through interventions in other areas of health (malaria eradication, child survival, maternal and child care, family planning, and nutrition) and to apply them in mounting campaigns to prevent HIV transmission. Second, the AIDS message should not be purveyed only by MOHs. It should also be disseminated through other programs, such as population and agriculture. Finally, the message should not be narrowly confined to AIDS, but should be pitched to the broader framework of health promotion for AIDS prevention.

AIDSCOM is a project created to provide assistance in IEC to USAID missions and national AIDS programs. The AIDSCOM approach is an integrated four-pronged strategy including 1) developing national AIDS information campaigns; 2) developing interpersonal, community, and institutional networks; 3) providing AIDS counseling and behavior support programs; and 4) condom marketing programs. If all four activities are not in place, the program will lose much of its effectiveness and might even fail.

Information campaigns should be highly visible mass media educational efforts, integrated with interpersonal channels, to increase awareness about AIDS. These campaigns should emphasize high risk behaviors, not high-risk groups, and should include not only those engaging in high-risk behavior but also their partners. The end goal is to bring about a change in this high-risk behavior. Experience has shown that bringing about change requires a cumulative effort, involving repetition, reinforcement, and consistency of objectives and strategies. The techniques and approaches used successfully in other health programs should be drawn on in developing the right message. It is important that these campaigns be well designed. A poorly implemented campaign can spread misconceptions and fears, stigmatize certain groups within the population, and raise expectations for services or products that are not available in the community.

Information campaigns cannot be purveyed by the media alone. They must have support from the community at large. A wide range of existing community or national networks--the health system and other ministries, the military, the commercial sector--can all bring skills and special capabilities to the campaign and may reach specific audiences in a more effective way

than could a mass media campaign. The military, for instance, might distribute condoms and brochures among its members. Traditional healers would be effective spokesmen because they have considerable credibility among many segments of the population. In East Africa, the Red Cross has developed an excellent program in AIDS prevention.

At the personal level, counseling, and training for counseling, have been identified as priority needs. Counselors in Africa include a broader spectrum of people than in the U.S., including, for example, lab workers, traditional birth attendants, school teachers, and others. An important issue in counseling is the need to develop more sympathetic attitudes toward AIDS victims.

Finally, marketing of condoms is needed, with the emphasis on applying commercial marketing strategies to condom marketing. These efforts should emphasize the role of the condom as a prophylactic against AIDS and should look, from a marketing perspective, at product design, packaging, pricing, and distribution.

The AIDSCOM project is most heavily involved in Latin America, the Caribbean, and the Philippines. Its deliverables include resident advisors, short-term technical assistance, local health promotion costs, and linkages to other AIDS education programs worldwide.

## DISCUSSION

[This includes comments that were made at the conclusion of earlier presentations on AIDS.]

Central funding for AIDSCOM and AIDSTECH is less than originally anticipated, and African missions in particular have been slow in accessing the services offered by these projects. At present, each project is funded only at 50 percent. Considerable opportunity exists, therefore, for additional mission buy-ins. Funds for such buy-ins can be accessed through mission buy-ins to the HAPA project. The original concept was that 50 percent of AIDSCOM and AIDSTECH resources would be allocated to Africa, but it is difficult to predict if this will occur.

There is considerable doubt whether mass campaigns will be effective in bringing about the behavioral change that is needed. Instead, small group discussions may be a more appropriate educational approach.

It is essential that an effort be made in Africa to target resources so that they will reach groups most likely to

spread or become infected with the HIV virus. To provide condoms to every sexually active person in Africa would be impossible: It would cost \$2 billion to supply all Africans with condoms for one year. It would take 130 million condoms to reach 20 percent of the married women of reproductive age in Zaire alone; this represents 23 percent of A.I.D.'s entire condom purchase last year.

A.I.D. funding for condoms is negligible in the context of the worldwide potential demand. The \$3 million set aside by A.I.D. for condom purchases this fiscal year compares with a conservative estimate that \$500 million would be needed annually for a highly targeted worldwide condom program. A.I.D. is attempting to encourage WHO and Japan to provide some funds to purchase condoms for LDCs.

Condoms may not be accepted in the near future in Africa. For example, there is some question as to whether the 2.4 million condoms distributed in Uganda as part of the AIDS campaign were properly distributed and used.

Although A.I.D. is beginning to fund some AIDS programs of its own, it will continue to look to WHO for leadership in the overall effort to control the spread of AIDS. Because A.I.D.'s \$15 million pledge represents one-third of WHO's total budget for AIDS, the U.S. should be able to play a role in the formulation of international policies and programs implemented by WHO. A.I.D. has participated in all eight of the pledging conferences held by WHO in Africa, and has made pledges to six country campaigns.

IV. HPN SECTORAL ISSUES<sup>4</sup>  
Wednesday, March 23, 1988

IV.1 RAPID ENVIRONMENTAL MODEL PRESENTATION

Don Dickerson, Economist, The Futures Group

[The bulk of this session was devoted to a presentation of the RAPID environmental model entitled "The Effects of Population on Environment and Natural Resources." Originally developed for the triennial meeting of the IUCN (the International Union for the Conservation of Nature and Natural Resources) in Costa Rica, this presentation was also used for the National Audubon Society. The following is a summary of the commentary that accompanied the visual presentation.]

This presentation provides graphic evidence of the erosion of the environmental systems in African countries where population pressures are reducing the recovery time these systems need to replenish themselves. Overall, it is estimated that 20 to 39 percent of all arable land has been lost in Africa because of the reduction of recovery time for topsoil. In Africa, too, forests are changing to wasteland and eventually to desert. In Egypt, the problem shown is the effect of population pressures on available arable land in the delta. In Botswana, the pressure is on grazing lands: Here, if the current ratio of head of cattle to population remains constant, all available land will be in use for grazing by 2010 and each hectare will need to support 6 and 1/2 head of cattle instead of the current density of 2 and 1/2 head per hectare. In Burkina Faso, the ecological system at risk is forest land, with the acute fuelwood shortage spreading rapidly, both within that country and throughout the Sahel.

The conclusion of the presentation suggests a programmatic approach to restructuring the environment to population equation. Specifically, the recommendation is for a combination of three initiatives: wise use of resources, policies to control population growth, and efforts to ensure equitable development. Together, these initiatives should add up to greater sustainability of the ecological systems.

Comments: The presentation has had a very dramatic influence on environmental groups, which are becoming increasingly aware of the interrelationship of population growth and the environment. These groups, many of them active lobbyists, have been very helpful in supporting population legislation in Congress. RAPID is one of S&T/POP's most successful programs.

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<sup>4</sup>Several presentations that took place under this general heading have been moved to Chapter I.

#### IV.2 PVO PROGRAMS

Mary Harvey, PVO Technical Advisor for EPI, REACH, for Bureau for Food for Peace and Voluntary Assistance/Office of Private and Voluntary Cooperation (FVA/PVC)

In Africa, and indeed worldwide, PVOs are important contributors to the Agency's child survival activities. In Africa, 12 PVOs are carrying out 24 child survival activities in 11 countries (see Table 9). Worldwide, a total of 22 PVOs are involved in child survival activities, having provided assistance through 61 activities in 21 countries since 1985.

Incorporating PVOs into its child survival strategy was a natural step for A.I.D. When the child survival program got under way in 1985, PVOs already had a long history of experience and success working at the periphery in a variety of development projects worldwide.

FVA/PVC, which funds PVO child survival activities, has developed guidelines and arranged workshops through Johns Hopkins University Institute for International Programs to assist PVOs to implement and evaluate their child survival activities. The guidelines are quite stringent, involving both an internal and an external review of PVO proposals, extensive documentation of plans, and regular monitoring and evaluation.

Child survival in FY87 was the single most important item in the worldwide PVO portfolio, representing 22 percent of the \$44.6 million total. Together, child survival and other health activities (14 percent) comprise over one-third of all PVO expenditures (see Table 10). In Africa, the child survival funded programs are focusing on EPI and diarrheal diseases. Vitamin A and nutrition are also included, and the plan is to increase the level of child-spacing activities.

The outlook for funding of PVO activities has changed in recent years. One change is the decline in the proportion of funding for PVOs as part of the combined accounts that fund child survival activities. From FY85 to FY87, PVO funding fell from 27 percent to 17.5 percent of the total combined account. A second change is the relative importance of U.S. government support compared with private support for all registered PVOs. Between 1980 and 1985, while funding from all sources was rising steadily, the proportion of the U.S. government contribution to that total was declining (see Table 11).

Table 9

FVA/PVC CHILD SURVIVAL PVO PROJECTS IN AFRICA  
1985 - 1988

COUNTRY	PRIVATE AND VOLUNTARY ORGANIZATIONS*											
	ADRA	AFRICARE	AHREF	CARE	FP PLAN	HKI	IEF	MIHV	SAWSO	SCF	WVRO	ROTARY
CAMEROON										FY86-89 \$532,061		
KENYA			FY86-89 \$750,000						FY85-88 \$275,177		FY87-91 \$809,470	
MALAWI	FY85-88 \$354,650						FY85-88 \$442,000			FY85-88 \$306,666		
MALI				FY86-89 \$951,000	FY86-89 \$451,295						FY87-91 \$1,053,507	
NIGER				FY87-91 \$902,397		FY86-89 \$654,062						
NIGERIA	FY87-91 \$222,202	FY86-89 \$659,485										FY87-91** \$2,000,000
RWANDA	FY85-88 \$309,700											
SENEGAL											FY86-89 \$434,509	
SUDAN	FY87-91 \$424,723			FY86-89 \$958,778						FY86-89 \$1,470,374		
UGANDA				FY85-88				FY85-88 \$418,830				
ZIMBABWE										FY85-88 \$354,650	FY85-88 \$690,000	

\*Funding dates  
AID & Cashmatch

FVA/PVC 3/17/88

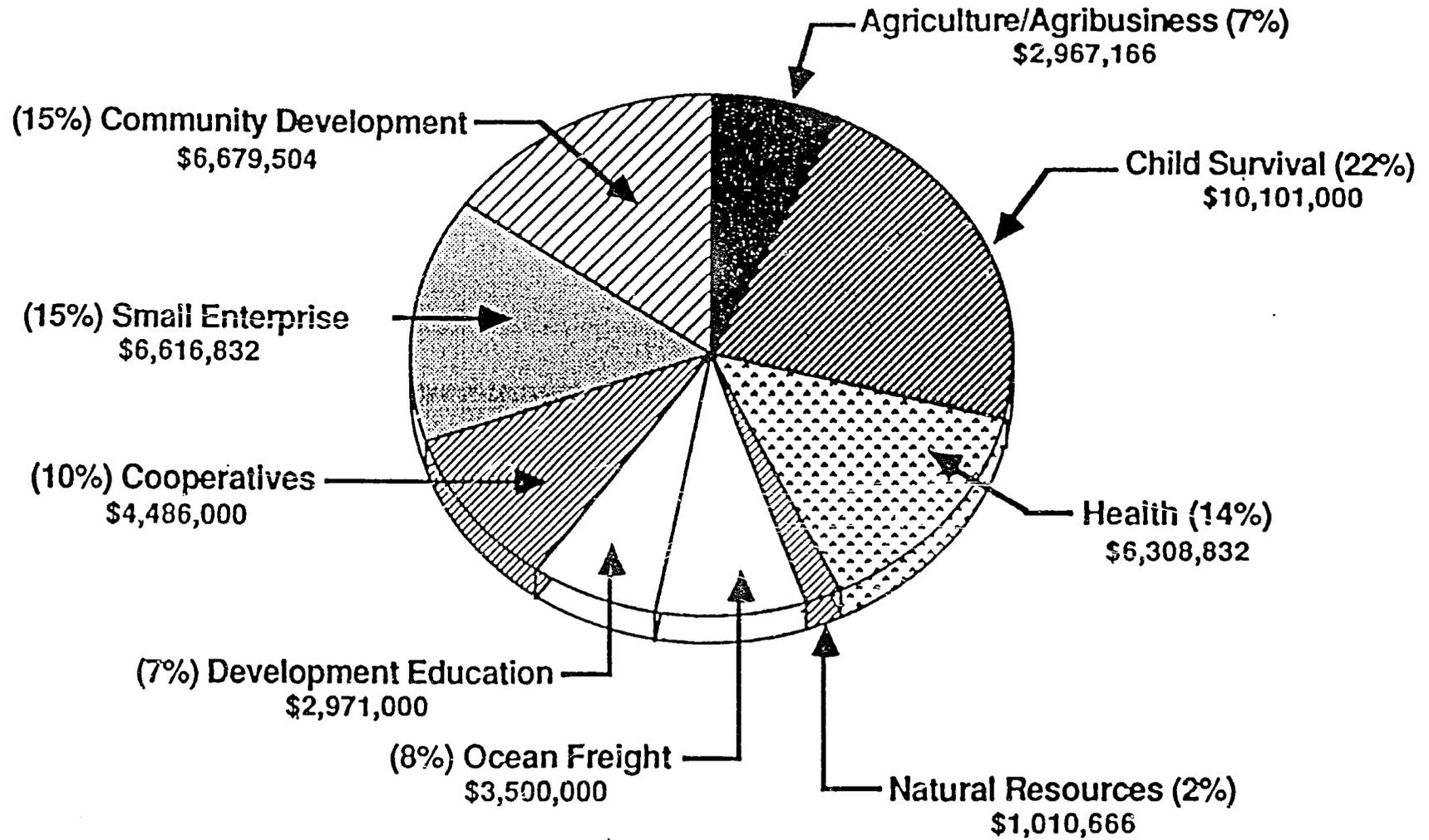
\*\*Although Rotary is attributing \$2.0 million of USAID support to Nigeria  
USAID is working in a technical capacity with Rotary in many African countries.

ADRA	Adventist Development and Relief Agency	MIHV	Minnesota International Health Volunteers
AHREF	African Medical and Research Foundation	SAWSO	Salvation Army World Service Organization
FP Plan	Foster Parents Plan	SCF	Save the Children
HKI	Helen Keller International	WVR	World Vision Relief Organization
IEF	International Eye Foundation		

Table 10

# PVC PROJECT PORTFOLIO

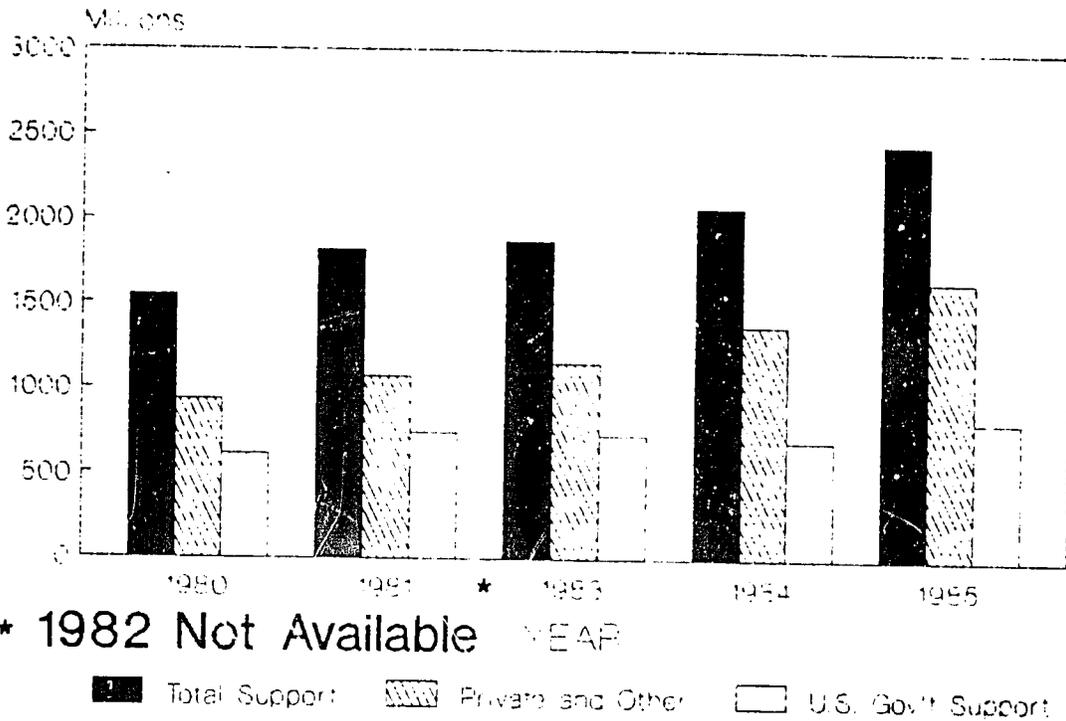
## SUMMARY BY SECTOR



FY 87 OBLIGATIONS = \$44,641,000

Table 11

## ALL REGISTERED PVOs Support and Revenue Summary



Data taken from A.I.D. publication "Report of American Voluntary Agencies Engaged in Overseas Relief and Development Registered with the Agency for International Development" and the A.I.D. form computation of 10 percent of private funding for PVOs' international activities.

One reason for the fall in the proportion of government support was that missions were being encouraged to fill the gap by providing additional support to PVOs through new child survival bilateral projects. Mission support has not increased, however. Rather, it has remained constant since FY83 at about \$4 million or less each year.

The attempted transition to mission support raises two questions: 1) What can the Agency do to accelerate the process? and 2) If funds from missions do materialize, can they be applied to PVO headquarters operations? This second issue has arisen in part because A.I.D./W earlier had put a portion of its funds into strengthening the management capabilities of PVO staffing at the headquarters level, and there is considerable interest in ensuring that these improvements be sustained.

Other issues relate to how PVOs can better collaborate among themselves as well as with MOHs, USAIDs, and other donors; how projects can be sustained; the development of appropriate tools for monitoring and evaluation; and the requirement for waivers for purchases of non-American equipment and supplies.

#### DISCUSSION

Comments: Missions may be using indigenous PVOs instead of U.S.-based PVOs to implement child survival activities. A.I.D.'s General Counsel is currently reviewing legislation that would require that all PVOs worldwide be registered in order to qualify for funding. The intent of the legislation is to ensure that funds from missions to indigenous PVOs are well managed. Worldwide, A.I.D. is working with 800 PVOs, mostly host country PVOs, and the need to register them all is a daunting prospect. The NGOs would find such a move intrusive, and furthermore, missions are probably much better positioned to judge the competence of indigenous PVOs than is A.I.D./Washington.

The DFA legislation includes a memorandum of understanding that explicitly includes PVOs in the implementation of the strategy for child survival and envisions indigenous and U.S.-based PVOs playing an equal role. The targeted \$25 million to be allocated to PVOs would include \$12 million through the central office and the rest through bilaterals.

#### IV.3 COMMENTS ON MICROCOMPUTER DATABASES AND SOFTWARE AVAILABLE FOR MISSION HPN OFFICERS

William Trayfors, AFR/TR

[This presentation was given Monday, but has been placed here because it relates to an "HPN Sectoral Issue."]

AFT/TR currently has access to a tremendous amount of data from a wide variety of sources. With microcomputer technology, it can interact with these various databases to demonstrate the qualitative and quantitative effects of the programs it supports. AFR/TR itself is required to update only a few essential databases: on its field staff, its obligations for AIDS, a special purpose PL 480 database, etc. In addition, it receives regular updates from a number of sources including the Department of Defense's database on morbidity; the Population Projects Database, which provides a continuously updated inventory of all A.I.D. population projects and subprojects worldwide; UNFPA and IPPF on population and family planning; PPC/CDIE for various economic and social databases; the Population Reference Bureau, for basic demographic data worldwide, etc. Much of the data manipulation required by AFR/TR is carried out under contract by other organizations. The Bureau of the Census (BuCen) pulls together data for Congressional presentations, for example, and the International Science and Technology Institute's Health Information System project develops analyses of all health and child survival activities.

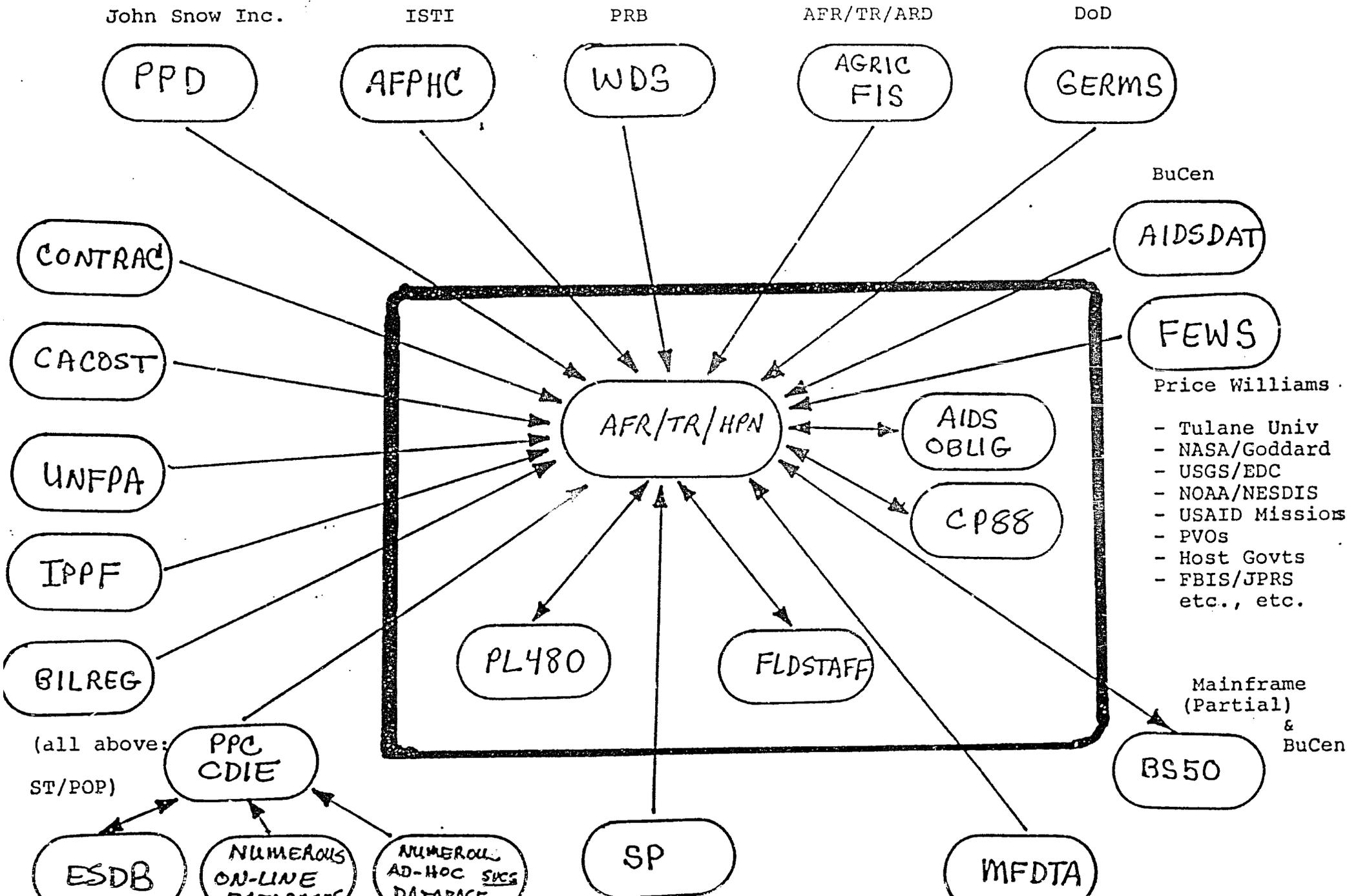
These databases are available for use in the field and can be ordered through AFR/TR/HPN, which uses BuCen for back-up if necessary (see Figure 1).

AFR/TR has found many special uses for these databases. A good example is a presentation for the White House that showed the link between worldwide food production and population. A graph tracing trends in both food production and population growth between 1961 and 1986 demonstrated dramatically that over this period the average per capita production of cereals in Africa was dropping because the population was increasing faster than was cereal production.

Recommendations for software for word processing, spreadsheets, and databases are as follows: Word Perfect is currently the recommended word processing program, and for A.I.D., which uses Wang computers, PerfLink will convert Word Perfect to/from Wang. Lotus 1-2-3 is still the best known spreadsheet program. Although dBaseIII, the most commonly used database, is adequate and well known, Condor 3 is preferable for much of AFR/TR's need, and high marks should go to ENABLE, which is an integrated system that can read other databases, spreadsheets, and word processing files, and interface with other software packages such as Lotus 1-2-3.

Figure 1

A PARTIAL DIAGRAMMATIC REPRESENTATION OF ELECTRONIC DATABASES AVAILABLE IN TR/HPN



Follow-up

Jack Lawson of the International Science and Technology Institute, Inc. (ISTI) showed a number of graphs produced through the ISTI Health Information System project that demonstrate visually the progress of A.I.D.'s child survival activities.

DISCUSSION

Comments: In the new competitive environment for funds, it is more important than ever for HPN staff to analyze data in ways that will present convincing evidence of program successes and their contribution to overall economic growth. The missions must generate the basic data and keep them updated. Washington's stringent procurement guidelines make it difficult for both missions and A.I.D./W to purchase the equipment needed to develop convincing presentations of program accomplishments, but ways to overcome this problem can be found.

APPENDICES

CP

Appendix A  
LIST OF PARTICIPANTS

LIST OF PARTICIPANTS  
FOR THE  
HEALTH, POPULATION, AND NUTRITION OFFICERS CONFERENCE  
BUREAU FOR AFRICA

HOTEL PRESIDENT  
Yamoussoukro, Côte d'Ivoire  
March 20-23, 1988

Neen ALRUTZ, Nutritionist, AFR/TR/HPN, A.I.D., UNITED STATES

Felix AWANTANG, Technical Advisor, Child Survival,  
AFR/TR/HPN, A.I.D., UNITED STATES

Victor BARBIERO, Health/Population/Nutrition Officer,  
REDSO/ESA, KENYA

Dr. Ali BIELY, Community Medicine (PHC), USAID, SUDAN

Katherine BLAKESLEE, Associate Assistant Administrator  
PPC/PDPR/SP, A.I.D., UNITED STATES

Leslie BRANDON, Population/Family Planning Advisor, USAID,  
CHAD

Dr. Joel BREMAN, Epidemiologist, Infectious Diseases,  
Malaria, CDC-ATLANTA, UNITED STATES

S. Modupe BRODERICK, Health Management, REDSO/WCA, COTE  
D'IVOIRE

Paula J. BRYAN, HPN Officer, USAID, SUDAN

Dr. Pierre CLAQUIN, Associate Director for EPI, REACH, UNITED  
STATES

Robert CLAY, Public Health Advisor, Diarrheal Diseases,  
S&T/H, A.I.D., UNITED STATES

Paul COHN, Health/Population Officer, USAID, UGANDA

Alice B. COLE, Project Mgr., Family Health/Family Planning  
Project, USAID, LESOTHO

Perle COMBARY, Sociologist/Population, USAID, BURKINA FASO

Dr. Charles DEBOSE, Regional Health Officer, REDSO/WCA, COTE  
D'IVOIRE

Donald DICKERSON, Economist, FUTURES GROUP, UNITED STATES

Joseph DWYER, Regional Director, Association for Voluntary  
Sterilization (AVSC), KENYA

Dr. Alexandra FAIRFIELD, Epidemiologist, ST/H, A.I.D., UNITED  
STATES

Arthur M. FELL, Director, REDSO/WCA, COTE D'IVOIRE

Alan C. FOOSE, Regional Health & Population Development  
Officer, USAID, SWAZILAND

Pape GAYE, Regional Director, International Training in  
Health (INTRAH), COTE D'IVOIRE

Gladys GILBERT, Special Projects Officer, USAID, SOMALIA

Duff GILLESPIE, Agency Director Office of Population, ST/POP,  
A.I.D., UNITED STATES

Lois GODIKSEN, Sociologist, PPC/CDIE, A.I.D., UNITED STATES

Richard GREENE, Technical Advisor, Public Health, USAID,  
BURKINA FASO

Hanan HADDAD, Population Program Assistant, REDSO/WCA, COTE  
D'IVOIRE

Dr. Jeff HARRIS, ST/H and AID/W AIDS Program Coordinator,  
A.I.D., UNITED STATES

Mary HARVEY, REACH, UNITED STATES

Shirley HILL, Program Assistant, FHS-II Project, USAID,  
LESOTHO

Joyce HOLFELD, Regional Population Officer, REDSO/WCA, COTE  
D'IVOIRE

John HOWARD, Demographer, USAID, LIBERIA

Ming HUNG, MCH/FP and Nutrition Advisor, REDSO/WCA, COTE  
D'IVOIRE

Pamela JOHNSON, Child Survival Coordinator, ST/H, A.I.D.,  
UNITED STATES

James R. KIRKLAND, HPN Officer, USAID, GHANA

Brian KLINE, Deputy Director, AFR/TR, A.I.D., UNITED STATES

Caroline KOROMA, Project Coordinator, Family Planning, USAID,  
TOGO

Dr. Peter LAMPTEY, AIDSTECH Project Director, Family Health  
International (FHI), UNITED STATES

Linda LANKENAU, HPN Officer, USAID, KENYA

Don LAURO, Program Director, Population/Health, Columbia  
University, COTE D'IVOIRE

Dr. John LAWSON Jr., Health Information Services Project,  
International Science & Technology Institute (ISTI), UNITED  
STATES

Mark LEDIARD, Vice President, Academy for Educational  
Development (AED), UNITED STATES

Gary LEINEN, Health Officer, USAID, CAMEROON

Joann LEWIS, Public Health Research, Family Health  
International (FHI), UNITED STATES

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William LYERLY, Africa Bureau AIDS Coordinator, AFR/TR/HPN,  
A. I. D., UNITED STATES

Pamela MANDEL, HPN Officer, USAID, MAURITANIA

Dr. Glen MARGO, AIDSCOM Project Director, Academy for  
Educational Development (AED), UNITED STATES

Gary MERRITT, Chief, AFR/TR/HPN, A. I. D., UNITED STATES

Margaret NEUSE, HPN Officer, USAID, NIGER

David GGT, Chief HPN Officer, USAID, KENYA

Dr. Glenn POST, Chief HPN Officer, USAID, ZAIRE

Dr. Malcolm POTTS, President, Family Health International  
(FHI), UNITED STATES

Agma PRINS, Senior Program Manager, PRITECH, UNITED STATES

Dr. Suzanne PRYSOR-JONES, Health Planner, ORT Programs,  
PRITECH, SENEGAL

Gerard RAKTONDRAINIBE, Projects Officer, USAID, MADAGASCAR

Wendy ROSEBERRY, ACSI-CCCD Project Manager, AFR/TR/HPN,  
A. I. D., UNITED STATES

Dr. James SHEPPERD, Senior Medical Officer, AFR/TR/HPN,  
A. I. D., UNITED STATES

Asina SIBETTA, Training Specialist, USAID, ZAMBIA

Betsy STEPHENS, POPTech Project, International Science &  
Technology Institute (ISTI), UNITED STATES

Carina STOVER, Population/Health Officer, USAID, RWANDA

Paula TAVROW, Program Officer, USAID, TANZANIA

Lucretia TAYLOR, Program Officer, USAID, ZIMBABWE

Jack THOMAS, Deputy Chief, AFR/TR/HPN, A.I.D., UNITED STATES

William TRAYFORS, Assistant Director, AFR/TR, A.I.D., UNITED STATES

Myra TUCKER, ACSI-CCCD, Assistant Project Manager, AFR/TR/HPN, A.I.D., UNITED STATES

Rosalind WAITHAKA, Population Assistant, REDSO/ESA, KENYA

Dorothy WEXLER, POPTECH Project, International Science & Technology Institute (ISTI), UNITED STATES

Neil WOODRUFF, Public Health/Population Officer, USAID, MALI

Francisco ZAMORA, Health Development Officer, USAID, LIBERIA

10/8

Appendix B  
CONFERENCE AGENDA

Appendix B  
Conference Agenda

CONFERENCE FOR HPN OFFICERS  
BUREAU FOR AFRICA

Yamoussoukro, Côte d'Ivoire  
March 20 - 23, 1988

SUNDAY, March 20

15:00 : 18:00 Registration

18:00 Welcome Ceremonies

Introduction : Gary Merritt, AFR/TR/HPN

Arthur Fell, Director, REDSO/WCA

18:40 Open Floor - Conference Participants' Concerns

19:00 Keynote Address - "The Development Fund for Africa"  
Brian Kline, D Dir/AFR/TR

19:30 Buffet Dinner : Seating by Working Groups

I. Working Groups (Facilitators/Rapporteurs) :

1. Population/Family Planning Strategy (Joyce Holfeld/Leslie Brandon)
2. Child Survival Strategy (Victor Barbiero/Richard Greene)
3. HIV/AIDS (Bill Lyerly/Carina Stover)
4. Program Sustainability (David Oot/Margaret Neuse)
5. Private Enterprise & PVOs (Chuck De Bose/Ray Kirkland)
6. Human Resource Development (James Shepperd/Pamela Mandel)

All participants will be appointed to a Working Group for the duration of the conference (1). Working groups reports and recommendations will be reviewed in Plenary Session on Wednesday.

II. Committee to coordinate Working Groups, preparations for publication of proceedings, social events, and ombudsmen for special concerns :

David Oot  
James Shepperd

Gladys Gilbert (lead)  
Francisco Zamora  
Dotty Wexler (ISTI)

IMPORTANT

Sessions that qualify for CME credits are marked with an asterisk.  
Please see CME table for details and forms.

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(1) see P. 6 for list of working group members.

MONDAY, March 21 \*

Population & Family Planning : (Organizer : Jack Thomas)

- 08:00 \*Worldwide A.I.D. Population/Family Planning Issues\*  
Duff Gillespie, Agency Director for Population  
-- Discussion
- 08:45 Field Perspectives on FP Program Development  
Moderator : Jack Thomas, AFR/TR/HPN  
Phase I - Sudan : Paula Bryan, HPN officer, Khartoum  
-- Discussion
- 09:30 Phase II - Nigeria : Joyce Holfeld, REDSO/WCA  
- Ghana : Ray Kirkland, HPN Officer, Accra  
-- Discussion
- 10:15 Break
- 10:30 Phase III - Kenya : David Oot, Chief HPN Officer, Nairobi  
- Zimbabwe : Lucretia Taylor, Program Officer, Harare  
-- Discussion
- 11:15 Panels : Technical Update on Program Issues
- Panel 1 : Improving Method Mix - More Emphasis on Most Reliable  
Methods  
Voluntary Surgical Contraception - Joe Dwyer, AVSC/  
Nairobi  
Implants, Injectables, IUDs - Malcolm Potts, Pres. FHI  
-- Discussion
- 12:30 Lunch (and Working Group caucuses)
- 14:00 Panel 2 : Expanding Service Modalities  
Marketing Approaches - Ray Kirkland  
Industrial and Plantation Efforts - David Oot  
Community-Based Distribution - Don Lauro,  
Columbia University  
-- Discussion
- 15:15 Break
- 15:30 Panel 3 : Program Sustainability  
To be determined  
Wendy Roseberry, AFR/TR/HPN-CCCD  
-- Discussion
- 16:30 Special session on microcomputer data bases and software available  
for Mission Health, Population and Nutrition Officers - Bill  
Trayfors, AFR/TR
- 17:00 Free Evening/Maquis Night in Yamoussoukro

TUESDAY, March 22 \*

Health and Child Survival : (Organizer : James Shepperd, AFR/TR/HPN)

- 08:00 Health/Child Survival -- Moderator : Chuck DeBose, REDSO/WCA
- Africa Bureau Strategy - James Shepperd
  - S&T Resources for Health and Child Survival - Pamela Johnson, S&T/H
  - Country Program Reviews
    - Zaire - Glen Post, Chief HPN Officer, Kinshasa
    - Niger - Margaret Neuse, HPN Officer, Niamey
  - Discussion
- 09:30 Break
- 09:45 Nutrition - Moderator : Linda Lankenau, HPN Officer, Nairobi
- Neen Alrutz, AFR/TR/HPN
  - Ming Hung, REDSO/WCA
  - Discussion - S&T/N Resources
- 11:00 Technical Updates - Moderator : Richard Greene, HPN Officer, Ouagadougou
- EPI - Pierre Clauquin, REACH
  - ORT - Suzanne Pryson-Jones, PRITECH
  - Malaria - Joel Breman, CDC/Atlanta
  - ARI - Robert Clay, S&T/H
- 13:00 Lunch
- 14:00 HIV/AIDS Issues - Moderator : Bill Lyerly, AFR/TR/HPN
- Technical and Programmatic Update on HIV/AIDS : Jeff Harris, S&T/H
  - Africa Bureau Regional Strategy and project : Bill Trayfors
  - Policy Issues : Kathy Blakeslee, PPC/PDPR
  - Country Perspective : Paul Cohen, USAID/Kampala
  - Country Perspective : Glen Post, USAID/Kinshasa
  - Discussion
- 15:45 Break
- 16:00 A.I.D./W Resources for Prevention and Control of HIV/AIDS
- Moderator : Bill Trayfors
  - Technical Assistance in Diagnostics, Blood Banking, Operations Research, and Delivery Systems - Malcolm Potts, President, FHI (AIDSTECH)
  - Discussion
  - Communications and Education - Glen Margo, AED, Project Director/AIDSCOM
  - Discussion
- 17:30 Working Groups
- 18:30 Open

WEDNESDAY, March 23

HPN Sectoral Issues

- 08:00 Introduction (Moderator : Gary Merritt)
- Cross Cutting Sectoral Issues - Kathy Blakeslee  
Evaluation and Reporting Success - Hank Merrill, AFR/DP  
PVO Programs - Mary Harvey, REACH, for Office of FVA/PVC  
-- Discussion
- 09:30 Impact of Recent Changes in Bureau Programming and Budgeting  
Charles Debose  
Art Danart, REDSO/ESA  
--Discussion
- 10:30 Break
- 10:45 RAPID Environmental Model Presentation - Don Dickerson,  
The Futures Group
- 11:30 Working Group Wrap-Ups
- 12:30 Lunch
- 14:00 Reports from Working Groups (1-4) - Open Floor
- 15:30 Break
- 15:45 Reports from Working groups (5-6) - Open Floor
- 16:30 Summary of Meeting and Recommendations (key opportunity for  
collective messages to A.I.D./W and REDSOs)
- 17:00 Adjournment

Other than Sunday and Monday evenings, ad hoc sessions can be arranged at participants' request on various subjects. Arrangements can be made through any representative of AFR/TR/HPN.

A video resource center will be set up throughout the conference in Room 651 so that participants may view selected tapes at their convenience. Also, there will be RAPID and REACH presentations on microcomputer, as well as useful HPN data bases accessible on portable computers. Copies of these can be made or ordered. See Jack Thomas.

## LIST OF WORKING GROUP MEMBERS

### 1. Population/Family Planning Strategy

- Ali Biely
- (R) Leslie Brandon
- Perle Combarry
- Joe Dwyer
- Duff Gillespie
- (F) Joyce Holfeld
- Ming Hung
- Malcolm Potts
- Gerard Rakotoundrainibe
- Lucretia Taylor
- Jack Thomas
- Rosalind Waitthaka

### 2. Child Survival Strategy

- Neen Alrutz
- (F) Vic Barbiero
- Modupe Broderick
- Pierre Claquin
- Robert Clay
- (R) Richard Greene
- Hannan Haddad
- Shirley Hill
- Pamela Johnson
- Gary Leinen
- Jack Lawson
- Susan Pryor-Jones

### 3. HIV/AIDS

- Paul Conn
- Jeff Harris
- Peter Lamprey
- (F) Bill Lyerly
- Glen Margo
- Glenn Post
- (R) Carina Stover
- Paula Tavrow
- William Trayfors

4. Sustainability

Hanaye Bisson  
Katherine Blakeslee  
Alice Cole  
Alan Foose  
Gladys Gilbert  
Levis Godikson  
Joanne Lewis  
(R) Margaret Neuse  
(F) David Oot  
Neil Woodruff

5. Private Enterprise and PVOs

(F) Chuck DeBose  
Don Dickerson  
Pape Gaye  
Mary Harvey  
John Howard  
(R) Ray Kirkland  
Brian Kline  
Don Lauro  
Asina Sibetta

6. Human Resource Development

Paula Bryan  
Alexandra Fairfield  
Art Fell  
Caroline Koroma  
Linda Lankenau  
Mark Lediard  
(R) Pamela Mandel  
Agma Prins  
(F) Jim Shepperd  
Francisco Zamora

Appendix C  
WORKING GROUP REPORTS

Appendix C

Working Group Reports

INCOMING  
TELEGRAM

PAGE 01 ABIDJA 07616 01 OF 03 141350Z 5186 042317 AID027

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ACTION AID-00

CONFERENCE WERE POPULATION AND FAMILY PLANNING, HEALTH AND CHILD SURVIVAL, HIV/AIDS, AND NUTRITION. TECHNICAL UPDATES WERE PROVIDED IN KEY AREAS.

INFO RF0-01 LH-00 /001 46 LH19

ISSUES DISCUSSED FOCUSED AROUND

ACTION OFFICE POP-04

INFO AFER-03 AFDA-03 AFRW-04 AFOW-03 AFDF-06 FPA-02 ANDP-03  
AFTR-05 PPCE-01 AMPF-01 PHDC-01 ANTR-06 STHE-03 STM-03  
SAST-01 EC-01 CDC-06 RELO-01 /B57 A1 W114

- TECHNICAL STRATEGIES FOR IMPROVING PROGRAM EFFECTIVENESS AND EFFICIENCY IN HPM AND AIDC SECTORS;

INFO LOG-00 AFEB-01 CIAE-00 EB-00 DODE-00 OES-03 /009 W  
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- PROGRAM FORMULATION AND FUNDING MECHANISMS UNDER THE DEVELOPMENT FUND FOR AFRICA (DFA) AND NEW AFRICA BUREAU MANAGEMENT AND OPERATIONS; AND

- SUSTAINABILITY OF THE RAPID ADVANCES MADE IN HPM PROGRAMS, ESPECIALLY IN PRIVATE SECTOR, SELF-SUSTAINING INITIATIVES AND LONG-TERM HPM HUMAN RESOURCE DEVELOPMENT IN AFRICA.

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AMEMBASSY DAR ES SALAMU  
AMEMBASSY DUBOULTI  
AMEMBASSY FREE TOWN  
AMEMBASSY GABORONE  
AMEMBASSY HARARE  
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AMEMBASSY MBABANE  
AMEMBASSY MOGADISHU  
AMEMBASSY MONROVIA  
AMEMBASSY NAIROBI  
AMEMBASSY N'DJAMENA  
AMEMBASSY NIAMEY  
AMEMBASSY NOUAKCHOTT  
AMEMBASSY OUAGADOUGOU  
AMEMBASSY PRNIA  
AMEMBASSY YAOUNDE  
SECSTATE WASHDC PRIORITY 6610

THIS CONFERENCE FOR A.I.D. HPM OFFICERS WAS HELD CONCURRENTLY WITH THE CENTERS FOR DISEASE CONTROL (CDC) STAFF WORKING IN THE REGIONAL AFRICAN CHILD SURVIVAL INITIATIVE-COMBATTING CHILDHOOD COMMUNICABLE DISEASES (ACSI-COCD) PROJECT. THIS PERMITTED BROAD INTERACTIONS BETWEEN THE HPM AND CDC PROJECT STAFF OUTSIDE THE FORMAL MEETINGS. THESE A.I.D. AND CDC IN-HOUSE MEETINGS WERE FOLLOWED BY LARGE TECHNICAL MEETINGS INVOLVING WELL OVER TWO HUNDRED PEOPLE FROM AFRICAN, AFRICAN ACSI-COCD COUNTRIES, UNITED NATIONS AGENCIES, REGIONAL ORGANIZATIONS (O.C.O.G.E.), AND OTHER BILATERAL DONORS. HPM OFFICERS FROM COUNTRIES WITH MAJOR CHILD SURVIVAL ACTIVITIES STAYED ON FOR THE HEALTH CARE FINANCING TRAINING AND THE ACSI-COCD CONSULTATIVE MEETING. THE LARGER FRAMEWORK PERMITTED AN EFFICIENT USE OF A.I.D. FUNDS FOR THE GREATER BENEFIT OF THE PARTICIPANTS AND FOR PROGRAM DEVELOPMENT.

END INTRODUCTION.

2. THIS CABLE (ONE OF SEVEN SEPTELS ISSUING FROM THE

UNCLAS SECTION 01 OF 08 ABIDJAN 07616

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NAIROBI FOR REDSO/ESA

E.O. 12356 N/A

SUBJECT: ALL-AFRICA CONFERENCE FOR HPM OFFICERS, MARCH 20-23, 1988, YAMOUSSOUKRO, COTE D'IVOIRE

1. INTRODUCTION: THE FIRST MEETING SINCE 1981 OF A.I.D. HEALTH, POPULATION AND NUTRITION OFFICERS IN SUB-SAHARAN AFRICA WAS HELD IN YAMOUSSOUKRO, COTE D'IVOIRE, FROM MARCH 20TH TO 23RD. TWENTY-SIX MISSIONS WERE REPRESENTED. TWENTY-FIVE USCDH OFFICERS AND EIGHTEEN OTHER MISSION HPM PERSONNEL JOINED. REPRESENTATIVES OF AFH/TR, PPC, S&T/POPULATION, S&T/HEALTH AND INVITED SPEAKERS FOR A TOTAL OF 63 PARTICIPANTS. THE MAIN FOCI OF DISCUSSION AT THE

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INFO AFCA-03 AFCA-03 AFM-04 AFGW-03 AFDP-06 FFA-02 ANDP-03  
AFTR-05 PPOE-01 AAPF-01 PPDC-01 ANTR-06 STHE-03 STN-03  
CAST-01 ES-01 CDC-06 RELO-01 /057 A1 WF18

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AMEMBASSY FREETOWN  
AMEMBASSY GABON  
AMEMBASSY GENEVA  
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AMEMBASSY MAPUTO  
AMEMBASSY NAGERN  
AMEMBASSY NAIROBI  
AMEMBASSY NIAMEY  
AMEMBASSY NOUAKHOTT  
AMEMBASSY OUAGADOUGOU  
AMEMBASSY PRATA  
AMEMBASSY YAOUNDE  
SECSTATE WASHDC PRIORITY 6611

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CONFERENCE TO SELECTED GROUPS OF ADDRESSEES) REPORTS ON SOME OF THE KEY ISSUES DISCUSSED AND CONVEYS HPM OFFICERS' CONCERNS AND RECOMMENDATIONS TO AID/W AND AFRICA MISSIONS. CONFEREES MET IN SEVEN PLENARY AND SOME 18 WORKING GROUP SESSIONS, AND THREE SESSIONS ON SPECIAL TOPICS.

THE CONFERENCE ORGANIZERS FROM AFR/TR AND REDSO AND THE PARTICIPANTS UNANIMOUSLY CONCLUDED THAT THIS MEETING MET ITS OBJECTIVES. IT SHOULD BE HIGHLIGHTED THAT CONFEREES FELT THAT TOO MUCH TIME HAD ELAPSED SINCE THE LAST MEETING. HPM FIELD OFFICERS HAVE NOT HAD THIS OPPORTUNITY FOR THE LAST SEVEN YEARS TO OBTAIN UP-DATED

INFORMATION ON TECHNICAL ISSUES AND FUNDING MECHANISMS, ESPECIALLY CONCERNING HIV/AIDS, BUREAU OPERATIONS AND MANAGEMENT. ALSO, ALLOCATING ONLY THREE AND A HALF DAYS TO THE CONFERENCE DID NOT LEAVE ENOUGH TIME FOR DISCUSSIONS AND INFORMAL MEETINGS, AND LIMITED THE VALUE OF THE CONFERENCE IN STIMULATING INFORMAL INTERACTION. FUTURE MEETINGS SHOULD ALLOW FIVE FULL DAYS.

THE FOLLOWING PARAGRAPHS SUMMARIZE THE CONFERENCE PARTICIPANTS' AND WORKING GROUPS' OBSERVATIONS, FINDINGS AND RECOMMENDATIONS.

3. ON HIV/AIDS.

- FIELD OFFICERS ENDORSED THE CONCEPT OF THE HIV/AIDS PREVENTION IN AFRICA (HPA) PROJECT. THEY EXPRESSED THE NEED FOR MORE INFORMATION FROM AID/W ON FUNDING LEVELS, COUNTRY ALLOCATION, REGIONAL AND OTHER PROJECTS (MAPA, AIDSTECH, AND AIDSCOM), AND HOW TO ACCESS THE RESOURCES AVAILABLE, GUIDANCE ON LESSONS LEARNED, AND GUIDANCE ON REPORTING RECOMMENDATIONS (NOT IN ORDER OF PRIORITY).

A. AFRICA BUREAU SHOULD ENSURE ALL NEEDED TRAVEL FOR THE BUREAU AIDS COORDINATOR RATHER THAN RELY ON MISSIONS DE FUNDS.

B. FIELD SHOULD PLAN HIV/AIDS ACTIVITIES, ENSURE THEIR INCLUSION IN ANNUAL OYBS, AND COMMUNICATE PLANS AND ACTIVITIES TO AID/W.

C. THE IMPACT OF HIV/AIDS ON POPULATION GROWTH SHOULD BE INCLUDED IN RAPID MODELS TO INFORM LDC AND WASHINGTON DECISION MAKERS OF IMPLICATIONS OF AIDS IN RELATION TO FAMILY PLANNING AND CHILD SURVIVAL.

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HARD ON AFRICA (AND SHOULD BE TREATED AGAIN TO A I.D. POLICIES RE LOCUSTS AND FAMINE).

INFO RED-01 LM-00 /001 A6 LM19

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INFO AFPA-03 AFSA-03 AFFW-04 AFCW-03 AFDP-06 FPA-02 ANCP-03  
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SAST-01 ES-01 CDC-06 RELO-01 /057 A1 WTR

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D. AID/W SHOULD SUPPORT MISSION EFFORTS TO FACILITATE DONOR COORDINATION IN THE FIELD, ESPECIALLY WITH WHO AND UNDP

E. AID/W SHOULD MAKE EVERY EFFORT TO SEEK AND CHANNEL FUNDS FOR HIV/AIDS PREVENTION BUT NOT AT THE EXPENSE OF REDUCING CHILD SURVIVAL AND POPULATION PROGRAMS, AS THIS COULD OCCUR IF DEMANDS FOR HIV/AIDS CONTROL FUNDING INCREASE

F. HIV/AIDS PREVENTION ACTIVITIES SHOULD BE EXEMPTED FROM BROOME AMENDMENT RESTRICTIONS SINCE IT IS A GLOBAL PANDEMIC OF AN EMERGENCY NATURE IMPACTING ESPECIALLY

G. LESS EXPENSIVE BLOOD SCREENING TECHNIQUES SHOULD BE MADE AVAILABLE TO THE FIELD ASAP, ESPECIALLY FOR SMALLER HOSPITALS AND RURAL AREAS

H. LOCAL CURRENCY SHOULD BE INCLUDED IN THE AFPA HAPA PROJECT DESIGN AND MADE AVAILABLE, AS APPROPRIATE.

4. ON CHILD SURVIVAL:

- THE CONFERENCE PARTICIPANTS ENDORSED THE DRAFT AFRICA BUREAU HEALTH, NUTRITION AND CHILD SURVIVAL STRATEGY STATEMENT
- MANY PARTICIPANTS EXPRESSED THE VIEW THAT THE OF... ACCOUNT OF NEW OPERATIONAL PROCEDURES MAY REDUCE CC ACTIVITIES IN BILATERAL BUDGETS, AND THAT PLANNED FUNDING LEVELS FOR CC IN AFRICA APPEAR TO BE DECREASING. SOME FELT THAT CC PROGRAMS WOULD BE DIFFICULT TO JUSTIFY IF THE BUREAU WISHED ONLY TO STRENGTHEN ECONOMIC GROWTH RATHER THAN SOCIAL DEVELOPMENT. AFRICA BUREAU'S OPERATIONAL APPROACH OF SEVERELY RESTRICTING THE FOCUS IN FOOD AND NUTRITION MAY MEAN THE END OF HEALTH/CS AND POPULATION PROGRAMS IN MANY COUNTRIES.

RECOMMENDATIONS:

A. AFRICA BUREAU IS REQUESTED TO CABLE ALL MISSION DIRECTORS REGARDING THE PRIORITY OF CC, INCORPORATING CC INTO THE CDS, ABO AND OYB SUBMISSIONS, AND THE NEED TO APPROACH CONGRESSIONALLY MANDATED TARGETS.

B. MISSIONS SHOULD IDENTIFY AND QUANTIFY ALL POTENTIAL OPPORTUNITIES FOR CC ACTIVITIES. REDSO/ESA SHOULD BE USED

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ACTION AID-00

SHOULD INCLUDE SUPPORT FOR INSTITUTIONAL DEVELOPMENT AND COMPLEMENTARY INPUTS, I.E., BASIC DRUGS, HEALTH PLANNING, WATER AND SANITATION, ETC.

INFO RED-01 LH-00 /001 XG LH19

F. CS PROJECTS SHOULD RUN FOR 6-10 YEARS TO ALLOW THE DEVELOPMENT OF SUSTAINABLE SYSTEMS

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G. THE FINANCING OF PROJECTS FOR THEIR LONG-TERM SUSTAINABILITY, INCLUDING UNIT AND RECURRENT COSTS, SHOULD BE CALCULATED AT THE BEGINNING OF CS PROJECTS AND RE EXAMINED ON A ROUTINE BASIS AS LONG AS A I.D. SUPPORT IS CONTINUED.

INFO AFEA-03 AFCA-03 AFFW-04 AFCW-03 AFDP-06 FPA-02 ANDP-03  
AFTR-05 PFCE-01 AAFP-01 PPOC-01 ANTR-06 STHE-03 STM-03  
SAST-01 ES-01 CDC-06 KELG-01 /057 A1 WF18

H. A.I.D. SHOULD CONTINUE TO USE PVOS, AS APPROPRIATE, BUT PROVIDE ADDITIONAL TECHNICAL AND MANAGERIAL SUPPORT, AS NECESSARY.

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5. ON HUMAN RESOURCES DEVELOPMENT:

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- FM AMEMBASSY ABIDJAN
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- AMEMBASSY DAKAR ES SALAM
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- AMEMBASSY NOUAKCHOTT
- AMEMBASSY OUAGADOUGOU
- AMEMBASSY PRAIA
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- SECSTATE WASHDC PRIORITY 6113

RECOMMENDATIONS:

THE AFRICA BUREAU HEALTH AND CHILD SURVIVAL PROGRAM SHOULD ADDRESS THE LACK OF HUMAN RESOURCES IN AFRICA BY GIVING ATTENTION TO:

A. MAKING AN HPN HUMAN RESOURCES DEVELOPMENT PLAN FOR EACH COUNTRY IN 1988 USING HRDA PROJECT RESOURCES.

B. ORGANIZING BILATERAL AND MULTI-LATERAL DONOR AND FOUNDATION INVESTMENT IN NATIONAL AND REGIONAL EDUCATIONAL INSTITUTIONS WITH A.I.D. PLAYING A LEADERSHIP ROLE. ALSO, WE SHOULD SEEK OTHER FINANCING, INCLUDING THE PRIVATE SECTOR.

C. ENCOURAGING THE DEVELOPMENT OF AFRICAN CENTERS OF EDUCATIONAL EXCELLENCE IN HPN TO SUPPORT U.S. EFFORTS IN THE CONTROL OF HIV/AIDS, RAPID POPULATION GROWTH,

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TO GATHER THIS INFORMATION.

D. CS PROJECT REPORTS SHOULD INCLUDE ANALYSES SHOWING POSITIVE ECONOMIC EFFECTS AND IMPACT OF THE PROJECT, AND AID/W SHOULD PULL TOGETHER PAST AND PRESENT A.I.D. EXPERIENCES IN THIS REGARD.

D. HPN OFFICERS SHOULD EMPHASIZE POLICY DIALOGUE, INVOLVEMENT OF THE PRIVATE SECTOR, COST RECOVERY AND SUSTAINABILITY IN THEIR CS ACTIVITIES.

E. SINCE THE "TWIN ENGINES" OF CHILD SURVIVAL MUST BE ATTACHED TO A VEHICLE FOR THEM TO FUNCTION, CS PROGRAMS

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ACTION AID-00

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PRIVATE ENTERPRISE RELATED ACTIVITIES, IN SUPPORT OF  
HPN, EDUCATION, AGRICULTURE, AND OTHER SECTORS:

INFO RED-01 UN-01 7001 A6 1419

ACTION OFFICE POP-04

INFO AFEA-03 AFCA-03 AFFW-04 AFCW-03 AFDP-06 FPA-02 ANDP-03  
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SAST-01 ES-01 CDC-06 RELO-01 /057 A1 WF18

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SECSTATE WASHDC PRIORITY 6614

UNCLAS SECTION 05 OF 08 ABIOJAM 07616

AIDAC

NAIROBI FOR HEDSO/ESA

CHILD SURVIVAL PROBLEMS, AND NUTRITIONAL AND TROPICAL  
DISEASES, THROUGH:

- C.1. DEVELOPING SPECIALIZED PROGRAMS IN HEALTH  
MANAGEMENT AND ADMINISTRATION TRAINING;
- C.2. INSTITUTIONALIZING NATIONAL AND REGIONAL  
SHORT-TERM TRAINING IN SELECTED INSTITUTIONS AND  
STRENGTHENING LINKAGES BETWEEN U.S. AND HOST COUNTRY  
INSTITUTIONS;
- C.3. DEVELOPING TRAINING PROGRAMS IN DEVELOPMENT  
COMMUNICATIONS AND IN SOCIAL MARKETING, AND OTHER

- C.4. REVISING CURRICULA IN HEALTH RELATED TRAINING  
CENTERS TO REFLECT ALL CHILD SURVIVAL INTERVENTIONS;

D. REFOCUSING A SIGNIFICANT PROPORTION OF PARTICIPANT  
TRAINING IN MISSION PLANS TO DEVELOP THE LEADERSHIP FOR  
NATIONAL AND REGIONAL HPN INSTITUTIONS RATHER THAN  
FOCUSING ON PROJECT REQUIREMENTS ONLY

E. TYING RESEARCH ON HPN PROBLEMS TO THE DEVELOPMENT  
OF TRAINING INSTITUTIONS

F. PROMOTING THE USE OF AFRICAN CONSULTANTS AND STAFF  
IN A.I.D. PROGRAMS.

6. ON PRIVATE ENTERPRISE AND PVOS:

RECOMMENDATIONS:

A. AFRTR SHOULD DEVELOP A PRIVATE SECTOR STRATEGY  
STATEMENT BASED ON AN ASSESSMENT OF THE AFRICAN CONTEXT  
AND ON PAST AND PRESENT EXPERIENCE WITH THE PRIVATE  
SECTOR.

B. HPN OFFICERS SHOULD SEEK OUT INNOVATIVE WAYS TO  
UTILIZE THE PRIVATE SECTOR

C. WHEN PRIVATE SECTOR CHANNELS ARE ALREADY DEVELOPED,  
HPN OFFICERS SHOULD EXPLORE WAYS OF BUILDING ON OR  
INCORPORATING OTHER SERVICES, E.G., ORAL CONTRACEPTIVES  
AND ORAL REHYDRATION SALTS.

D. DURING DIALOGUE OR DISCUSSIONS WITH HOST  
GOVERNMENTS CONCERNING PROGRAM SUSTAINABILITY, HPN

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PAGE 01 ABIDJA 07616 06 OF 08 141359Z 7011 042333 AID1620  
ACTION AID-00

ABIDJA 07616 06 OF 08 141359Z 7011 042333 AID  
PUBLIC FUNDS FOR PHC, AND CONSIDER THE "BAMAKO  
INITIATIVE."

INFO RED-G1 LH-00 /001 A6 LK19

ACTION OFFICE PCP-04  
INFO AFER-03 AFCA-03 AFFW-04 AFCW-03 AFOP-06 FPA-03 ANDP-03  
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SAST-01 ES-01 CDC-06 RELO-01 /057 A1 WY10

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AMEMBASSY N'DJAMENA  
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AMEMBASSY NOUAKHOTT  
AMEMBASSY OUAGADOUGOU  
AMEMBASSY PRAIA  
AMEMBASSY YAOUNDE  
SECSTATE WASHDC PRIORITY 6615

UNCLAS SECTION 06 OF 08 ABIDJAN 07616

AIDAC  
NAIRCB1 FOR REDSO/ESA

E.O. 12356 W/A  
SUBJECT: ALL-AFRICA CONFERENCE FOR MPH OFFICERS, MARCH

OFFICERS SHOULD SEEK GOVERNMENT SUPPORT FOR PRIVATE  
SECTOR ACTIVITIES.

E. USAID'S SHOULD BE PREPARED TO PROVIDE RELEVANT  
SKILLS TO THE PRIVATE SECTOR AND TO USE THE ENTERPRISE  
AND TIPPS PROJECTS TO DEMONSTRATE TO PRIVATE  
ENTERPRISES THE COST-BENEFIT OF PROVIDING CHILD  
SURVIVAL AND FAMILY PLANNING SERVICES TO EMPLOYEES.

F. USAID'S SHOULD CONSIDER PROMOTING PRIVATIZATION IN  
THE AREAS OF CURATIVE OR TERTIARY CARE THUS RELEASING

G. USAID'S SHOULD REALISTICALLY APPROACH THE "FOR  
PROFIT SECTOR", RESPECTING THEIR PROFIT MOTIVE AND  
ALLOWING THEM SUFFICIENT INCENTIVES TO PARTICIPATE IN  
APPROPRIATE MPH ACTIVITIES SUCH AS SERVICE DELIVERY,  
MANUFACTURE AND DISTRIBUTION OF MEDICATIONS, SUPPLIES,  
EQUIPMENT, ETC

7. ON SUSTAINABILITY:

THE WORKING GROUP BELIEVES THAT THE FOLLOWING FACTORS  
SHOULD BE CONSIDERED WHEN PLANNING AND DESIGNING MPH  
PROJECTS:

A. HUMAN RESOURCES - WITHOUT TRAINED AND MOTIVATED  
STAFF, NEITHER ACTIVITIES NOR OBJECTIVES WILL BE  
SUSTAINED

B. FINANCIAL RESOURCES - THESE WOULD BE TRANSLATED  
INTO SALARIES, GOODS AND SERVICES, ETC. PROGRAMS THAT  
HAVE THE MEANS TO CONTINUE AT SOME LEVEL AND THEREFORE  
HEALTH CARE FINANCING PLANS MUST BE INCORPORATED INTO  
NEW AND OLD PROJECTS

C. COMMITMENT - BY THE GOVERNMENT AND OTHER RELEVANT  
PARTIES IS VITAL TO SUSTAINED ACTION. POLICY DIALOGUE,  
JOINT PLANNING AND PRIORITY SETTING WITH THE GOVERNMENT  
ARE VITAL ELEMENTS OF THE SUSTAINABILITY EQUATION.

D. WHAT/HOW PROJECTS WERE DEVELOPED - THIS RELATED TO  
COMMITMENT. IF ACTIVITIES ARE DEVELOPED IN CLOSE  
COLLABORATION AND THEY MEET A FLOW NEEDS THEY ARE  
MORE LIKELY TO BE SUSTAINED. THE MORE COMPLEX THE  
PROJECT, THE MORE DIFFICULT TO SUSTAIN

E. INTEGRATION - ACTIVITIES/OBJECTIVES ARE MORE LIKELY

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PAGE 01 ABIDJA 07616 07 OF 08 141403Z 5200 042327 A101283  
ACTION AID-00

ABIDJA 07616 07 OF 08 141403Z 5200 042327 A101283

INFO RED-01 LH-00 /001 A6 LM19

STRATEGY IS WITHIN THE CONTEXT OF THE OVERALL AGENCY STRATEGY WHICH INCLUDED THE POPULATION POLICY (1982), THE BLUEPRINT FOR DEVELOPMENT (1986), CHILD SPACING FOR CHILD SURVIVAL (1987) AND THE ST/POP STRATEGY (1987)

ACTION OFFICE POP-04

B. CHANGE LAST SENTENCE OF LAST PARAGRAPH IN PROGRAM EMPHASIS SECTION TO READ:

INFO AFEA-03 AFSA-03 AFFW-04 AFCM-03 AFDP-05 FPR-02 ANDP-03  
AFTR-05 PPCE-01 ANPF-01 PPDC-01 ANTR-06 STHE-03 STM-03  
SACT-01 ES-01 CDC-06 RELO-01 /057 A1 W518

\*FOR COUNTRIES IN AFRICA, A.I.D. IS PLACING NEW EMPHASIS ON PROMOTING A MORE APPROPRIATE MIX BY:

INFO LOG-00 AF-00 CIAE-00 EB-00 DODE-00 OES-00 /000 W  
-----137926 142229Z /53 38

- 1) MAKING ALL METHODS OF CONTRACEPTION AVAILABLE AND ACCESSIBLE BY ELIMINATING LOGISTICAL AND ADMINISTRATIVE BARRIERS;

- 2) PROMOTING MORE EFFECTIVE METHODS INCLUDING ORAL CONTRACEPTIVES, IUD'S AND VOLUNTARY SURGICAL CONTRACEPTION, AND

- 3) UTILIZING THE PRIVATE SECTOR TO DEVELOP AND EXPAND CONTRACEPTIVE USE IN COMMERCIAL, INDUSTRIAL AND VOLUNTARY ORGANIZATIONAL SETTING."

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AMEMBASSY BUJUMBURA  
AMEMBASSY COLONIA  
AMEMBASSY DAKAR  
AMEMBASSY DAR ES SALAAM  
AMEMBASSY DJIBOUTI  
AMEMBASSY FREETOWN  
AMEMBASSY GABORONE  
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AMEMBASSY KHARTOUM  
AMEMBASSY NIAGNI  
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AMEMBASSY LAGOS  
AMEMBASSY LIBREVILLE  
AMEMBASSY LINDGREN  
AMEMBASSY LOME  
AMEMBASSY LUSAKA  
AMEMBASSY MALABO  
AMEMBASSY MAPUTO  
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SECSTATE WASHDC PRIORITY 6616

C. ADD ADDITIONAL NARRATIVE SECTIONS AS FOLLOWS.

- 1) DEFINITION OF PROGRAM CONTENT INCLUDING BRIEF DESCRIPTION OF POLICY DEVELOPMENT AND IMPLEMENTATION; INFORMATION, EDUCATION AND COMMUNICATION, SERVICE MODALITIES; TRAINING, RESEARCH, AND INSTITUTIONAL DEVELOPMENT.

- 2) IMPLICATIONS FOR INTRA-SECTORAL DEVELOPMENT INCLUDING BRIEF DESCRIPTION OF WAYS TO INTERRELATE FAMILY PLANNING ACTIVITIES WITH BREASTFEEDING, CHILD SURVIVAL ACTIVITIES, AND MANAGEMENT OF SEXUALLY TRANSMITTED DISEASES INCLUDING AIDS.

UNCLAS SECTION 07 OF 08 ABIDJAN 07616

AIDAC

NAIROBI FOR REOSG/ESA

TO BE CONTINUED IF INTEGRATED INTO THE STRUCTURES ALREADY IN EXISTENCE.

B. ON AFRICA BUREAU POPULATION AND FAMILY PLANNING STRATEGY:

THE HPK OFFICERS ENDORSED THE BUREAU FOR AFRICA, POPULATION AND FAMILY PLANNING STRATEGY.

THE WORKING GROUP REVIEWED THE STRATEGY AND RECOMMENDED THE FOLLOWING CHANGES:

A. MENTION IN LEAD PARAGRAPH THAT THE AFRICA BUREAU

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PAGE 01 ABIDJA 07616 08 OF 08 141403Z 5204 042330 AID1285  
ACTION AID-00

INFO RED-01 LH-00 0001 A6 L116

ACTION OFFICE POP-04  
INFO AFEA-03 AFSA-03 AFFW-04 AFCW-03 AFDP-06 FPA-02 ANDP-03  
AFTR-05 PCE-01 AAPF-01 PPDC-01 ANTR-06 STHE-03 STN-03  
SAST-01 ES-01 CDC-06 RELO-01 /057 A1 WF16

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SECSTATE WASHDC PRIORITY 6617

UNCLAS SECTION 08 OF 08 ABIDJAN 07616

AIDAC

NAIROBI FOR REDSO/ESA

- 3) PRIORITIES AND MECHANISMS FOR FUNDING INCLUDING  
A BRIEF DESCRIPTION OF THE CRITERIA FOR DETERMINING  
FUNDING PRIORITIES AND THE VARIOUS BILATERAL, REGIONAL  
AND CENTRAL FUNDING MECHANISMS AND WHAT EACH IS  
SUPPOSED TO FUND.

D. ADDITIONAL EDITORIAL CHANGES AND SPECIFIC COMMITTEE  
MEMBER COMMENTS ON THE STRATEGY WERE POUCHED TO  
AFR/TR/HPN G. MERRITT, ON APRIL 7, 1988. KUX

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PAGE 01 ABIOJA 08763 260926Z 4264 047433 AID1701  
ACTION AID-00

ACTION OFFICE AFTR-05  
INFO AAAP-03 AFOW-03 SEOP-01 AFEO-02 AFPO-04 SERP-01 SECS-02  
AMAD-01 SEOS-02 STHE-03 SAST-01 ES-01 AAID-01 RELO-01  
/031 A0

INFO LOG-00 AF-00 CIAE-00 EB-00 DODE-00 /000 W  
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R 260923Z APR 88  
FM AMEMBASSY ABIOJAN  
TO SECSTATE WASHDC 6899

UNCLAS ABIOJAN 08763

AIDAC

FOR AFTR/HPN

E. O. 12356: N/A  
SUBJECT: HIV/AIDS PREVENTION IN AFRICA PROJECT (HAPA)  
698-0474

REFS: (A) STATE 77291; (B) ABIOJAN 7616

1. AS DISCUSSED AT AFRICA HPN CONFERENCE IN YAMOUSSOUKRO WHEN REDSO/WCA REGIONAL HEALTH OFFICER PROVIDED COMMENTS TO AFTR/HPN, WE ENDORSE SUBJECT PROJECT STRONGLY AND ESPECIALLY WELCOME THE FLEXIBLE AND RAPID FUNDING MECHANISM THAT WILL BE PROVIDED BY THE PROJECT WHICH HAS MET WITH MUCH SUCCESS IN THE FHI PROJECTS.
2. IN ADDITION TO COMMENTS PROVIDED IN REF B, REDSO/WCA REQUESTS CLARIFICATION ON QUOTE BUY-INS UNQUOTE. PER REF A PARA 2, THE HAPA PROJECT WILL PROVIDE \$10 MILLION IN GRANT FUNDS OVER A THREE YEAR LOP, WITH AN AUTHORIZATION FOR AN ADDITIONAL \$10 MILLION IN MISSION BUY-INS. IT IS NOT CLEAR WHAT THE MISSIONS CAN BUY-INTO. IF MISSIONS HAD BILATERAL FUNDS TO BE USED ON AIDS PROGRAMS, THEY CAN BUY INTO THE S&T AIDSTECH AND AIDSCOM PROJECTS FOR TECHNICAL ASSISTANCE, EQUIPMENT AND SUPPLIES, ETC. FROM THE DESCRIPTION PROVIDED, THE HAPA PROJECT DOES NOT PROVIDE TECHNICAL SERVICES NOR COMMODITY PROCUREMENT AS DO THE S&T PROJECTS. IT IS MAINLY A FUNDING MECHANISM.
3. REDSO/WCA SUBMITTED A PVO PROJECT (THE USE OF HIV ANTIBODY AND HBV ANTIGEN TESTING FOR PREVENTION AND CONTROL OF TRANSMISSION IN THE NORTHERN IVORY COAST, SUBMITTED BY BAPTIST MISSION HOSPITAL AT FERKESSEDOUGOU) FOR CONSIDERATION FOR FUNDING WHICH IS STILL PENDING. REDSO HOPES THAT THIS PROJECT WILL BE GIVEN CONSIDERATION FOR FUNDING UNDER THE HAPA PROJECT.
4. THERE IS ALSO A NEED FOR AN AIDS COORDINATOR TO BE BASED IN REDSO/WCA, TO COORDINATE AND MONITOR AIDS PREVENTION AND CONTROL PROGRAMS IN THE REGION, AND PROVIDE TECHNICAL ADVISORY SERVICES TO THE WCA MISSIONS. THIS POSITION CAN IDEALLY BE FUNDED THROUGH THE HAPA PROJECT.
5. PLEASE ADVISE. KUX

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Appendix D  
RECOMMENDATIONS OF AD HOC COMMITTEES

## Recommendations of Ad Hoc committees

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TELEGRAMPAGE 01 ABIDJA 07003 00 OF 02 070421Z 1700 033654 A109864  
ACTION AID-09

ABIDJA 07003 00 OF 02 070421Z 1700 033654 A109864

## SUMMARY.

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 PPPB-02 ANTR-06 STHE-03 STM-03 SAST-01 POP-04 ES-01  
 RELO-01 /044 A1 WFO3

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SECSTATE FOR DEPUTY ADMINISTRATOR JAY MORRIS;  
 IAC/OR/HLP AND AKE/TR/HPM FOR INFO; NAIROBI FOR USAID  
 AND REDSO/ESA

E.O. 12356 M/A

SUBJECT: AGENCY POLICY ON BREASTFEEDING; US PERSONNEL

REF: AFRICA HPM OFFICERS' CONFERENCE, COTE D'IVOIRE,  
 28-23 MARCH 1984

1. SUMMARY: THE AFRICA BUREAU HPM OFFICERS RECOMMEND THAT WE BRING OUR AGENCY PERSONNEL POLICIES MORE INTO AGREEMENT WITH STATED PROGRAMMATIC POLICY ON BREASTFEEDING URGED WITHIN BOTH OF THE AGENCY'S POLICIES ON POPULATION AND HEALTH FOR OVERSEAS DEVELOPMENT ASSISTANCE. AT PRESENT, THERE IS NO CLEAR POLICY FOR EMPLOYEES OR FOR MISSIONS THAT FACILITATES BREASTFEEDING FOR HEALTH, FAMILY PLANNING AND FAMILY CONSIDERATIONS AT U.S.G. WORK PLACES ABROAD. END

2. DURING THE REF AFRICA BUREAU HPM CONFERENCE, OH OFFICERS DISCUSSED THE GAP BETWEEN THE A.I.D. PROGRAMMATIC STANCE ON BREASTFEEDING AND THE BREASTFEEDING SUPPORT SITUATION THAT EXISTS IN USAID MISSIONS AROUND THE WORLD. HPM OFFICERS ACTIVELY PROMOTE BREASTFEEDING IN OUR HOST COUNTRIES, IT BEING WELL ESTABLISHED THAT CONTINUED BREASTFEEDING DECREASES MORBIDITY AND MORTALITY IN YOUNG CHILDREN WHILE AT THE SAME TIME PROVIDING PROTECTION FROM AN ADDITIONAL PREGNANCY; THIS IS ONE OF THE AGENCY'S KEY CHILD SURVIVAL AND CHILD SPACING INTERVENTIONS. WE WORK WITH OUR HOST COUNTRY COLLEAGUES TO DESIGN AND IMPLEMENT BREASTFEEDING PROJECTS, TRAIN HOST COUNTRY NATIONALS IN LACTATION MANAGEMENT, FINANCE BREASTFEEDING PROJECTS THROUGH BOTH CENTRAL AND BILATERAL RESOURCES, AND WORK TO CHANGE POLICY IN ORDER TO PROMOTE BREASTFEEDING IN THE WORKPLACE (BOTH IN THE PRIVATE AND PUBLIC SECTORS).

3. WITHIN A.I.D. ITSELF THERE ARE NO PROVISIONS MADE TO ALLOW OUR OWN STAFF, BOTH U.S. AND HOST COUNTRY NATIONAL, TO DO THIS. IN GENERAL, NO POLICY OR REGULATION HAS BEEN ESTABLISHED TO PROMOTE BREASTFEEDING. IN MANY CASES AID OFFICERS MUST RESIDE AT A FAR DISTANCE FROM THE WORK PLACE. FORTY-FIVE MINUTE LUNCH BREAKS ARE INSUFFICIENT TO RETURN HOME TO NURSE; HOWEVER, FLEX TIME IS NOT PROVIDED IN ORDER TO ACCOMMODATE TRAVEL TO/FROM THE OFFICE. IN SOME MISSIONS, WOMEN ARE FORBIDDEN TO NURSE IN A.I.D. OFFICES (EVEN IF THE CHILD COULD BE BROUGHT TO THE MOTHER), AND SUPPORT FOR CRECHES HAS BEEN REFUSED.

4. AS HPM OFFICERS, WE FEEL THAT A I.D. SHOULD NOT ONLY TALK ABOUT SUPPORT FOR BREASTFEEDING TO OTHERS BUT SHOULD ALSO BE IN THE FOREFRONT BY PROVIDING A BEST EXAMPLE.

5. WE ASK YOUR GUIDANCE AND SUPPORT TO PUT OUR PROFESSIONAL CONCERN, AS WELL AS AGENCY POLICY, INTO ACTION. WE MAKE THE FOLLOWING REQUESTS:

A. THAT YOU REVIEW THE SITUATION IN BOTH AID/W AND THE MISSIONS REGARDING ACTUAL PRACTICES IN SUPPORT OF BREASTFEEDING.

B. THAT AID/W CABLE MISSIONS TO ENCOURAGE THEM TO PUT INTO PLACE A SYSTEM TO SUPPORT BREASTFEEDING BY EMPLOYEES.

C. THAT PARAMETERS OF A.I.D. SUPPORT FOR BREASTFEEDING BE SENT TO THE MISSIONS (BASED ON A ABOVE). EXAMPLES COULD INCLUDE FLEX TIME, CRECHE FACILITIES AND SUFFICIENT MATERNITY LEAVE TO ASSURE SUCCESSFUL ESTABLISHMENT OF LACTATION DURING THE FIRST CRITICAL WEEKS.

D. WHILE WE UNDERSTAND THAT THERE ARE COST AND PERHAPS LEGAL CONSIDERATIONS, AS WELL AS MANAGEMENT CONCERNS, HPM OFFICERS LOOK TO YOU FOR SUPPORT AND GUIDANCE ON SUCH AN IMPORTANT ISSUE. KUX

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INFO AAAP-03 AFCD-02 AFEA-03 AFFV-04 AFCW-03 AFDP-06 FPA-02  
AMAD-01 STFN-02 IT-06 RELO-01 /038 AG

INDIVIDUAL INSTANCES OF THE PROJECTS LISTED BELOW, HOWEVER, EITHER THE CENTRAL FUNDING MECHANISM IS WITHOUT SUFFICIENT BUDGET THIS FISCAL YEAR OR THE S&T OFFICES ALREADY HAVE OBLIGATED FUNDS AND THESE CANNOT BE REALLOCATED TO ADJUST FOR THE NEEDS LISTED BELOW.

INFO LOG-08 AF-00 DES-09 /009 W

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R 011054Z APR 88  
FM AMEMBASSY ABIDJAN  
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AMEMBASSY NOUAKHOTT PRIORITY  
AMEMBASSY OUGADOUGOU PRIORITY  
AMEMBASSY YAOUNDE PRIORITY

3. THE MAIN EXAMPLE IS THE SAHEL REGIONAL PRITECH OFFICE IN DAKAR, SENEGAL, WHICH PROVIDES TECHNICAL ASSISTANCE TO ALL OF THE SAHEL COUNTRIES PROMOTING ORAL REHYDRATION THERAPY AND DIETARY MANAGEMENT OF DIARRHEAL DISEASE. ONE OF THE TWIN ENGINES OF CHILD SURVIVAL, DIARRHEAL DISEASE CONTROL IS OF PARTICULAR IMPORTANCE IN THE SAHEL COUNTRIES. AS A RESULT OF THE ADVENT OF DFA AND TERMINATION OF THE SAHEL ACCOUNT, SAHEL MISSIONS RECENTLY (AND UNANIMOUSLY) CABLED TO EXPRESS THEIR STRONG SUPPORT FOR CONTINUATION OF THE PRITECH REGIONAL OFFICE, CITING THE NUMEROUS EXAMPLES OF PROGRESS IN DIARRHEAL DISEASE CONTROL IN THEIR COUNTRIES (SEE REF C - F).

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SECSTATE FOR AFR/TR/HPN, AFR/DP; NAIROBI FOR REDSO/ESA;  
ALL MISSIONS FOR HPN OFFICERS

SEVERAL HPN OFFICERS NOTED THAT WHEN DFA PROCEDURES WERE ANNOUNCED, THEY WERE NOT FOREWARNED THAT MISSIONS ALSO WOULD BE EXPECTED TO PICK UP A SHARE OF THE COSTS OF THE REGIONAL OFFICE IN THEIR OYB ALLOCATIONS. THE MISSIONS ALSO POINTED OUT THAT A COST-SHARING ARRANGEMENT THROUGH MISSION BUY-INS FOR THE REGIONAL OFFICE IS IMPRACTICAL AND UNRELIABLE. SINCE 1988 OYB'S ARE NOW SET AND IN SOME INSTANCES, CANNOT BE INCREASED, THE PRITECH REGIONAL OFFICE HAS BEEN ORPHANED.

E.O. 12958 N/A  
SUBJECT: ORPHAN PROJECTS IN POPULATION AND HEALTH

REF: (A) AFRICA HPN OFFICERS' CONFERENCE, MARCH 20-23, 1988 YAMOUSSOUKRO, COTE D'IVOIRE; (B) STATE 42051 (C) LIAISON 2276; (D) NOUAKHOTT 1149; (E) NIAMEY 1845; (F) BAMAKO 1396

ST/H STATES EMPHATICALLY THAT THEY HAVE INSUFFICIENT FUNDS TO CARRY THIS REGIONAL OFFICE UNTIL NEXT FISCAL YEAR, WHEN MISSIONS WOULD BE EXPECTED TO BE ABLE TO PLAN FOR A SHARE OF THE REGIONAL OFFICE IN THEIR ABS. A SPECIAL SESSION OF THE HPN CONFERENCE STRONGLY ENDORSED ANY MEANS OF CONTINUING THE PRITECH OFFICE IN ALL MISSIONS FOR HPN OFFICERS

DAKAR FOR SEVERAL YEARS.

1. PORTFOLIO REVIEWS AT THE CONFERENCE REVEALED A FEW ACTIVITIES IN HEALTH AND POPULATION THAT WERE QUOTE ORPHANED UNQUOTE AS A RESULT OF CHANGED FROM REGIONAL TO MISSION FUNDING OF THE SAHEL POPULATION INITIATIVES (SPI) PROJECT AND THE FAMILY HEALTH INITIATIVES II PROJECT (FHI II), AT THE SAME TIME FUNDING LEVELS TO S&T/H AND S&T/POP WERE BEING REDUCED. AT THIS POINT IN THE YEAR ANOTHER EFFORT SHOULD BE MADE TO IDENTIFY ORPHANS AND BE SURE THAT APPROPRIATE ACTIONS ARE TAKEN TO EITHER FUND THESE ACTIVITIES OR NOTIFY TO THE CONTRARY.

4. DUE TO MAURITANIA'S LOW OYB ALLOCATION AND ITS DESIGNATION UNDER THE SMALL COUNTRY STRATEGY, IT STANDS AS ONE OF THE COUNTRIES MAKING SIGNIFICANT PROGRESS IN THE CONTROL OF DIARRHEAL DISEASES (CDD) THROUGH THE REGIONAL PRITECH EFFORT, CDD ACTIVITIES WILL CONSIDERABLY DIMINISH, COMPOUNDED BY THE REDUCTION OF UNICEF'S CDD BUDGET AT THE SAME TIME (SEE REF D).

2. WHILE MOST IMPORTANT ACTIVITIES PLANNED FOR FY 88 UNDER THE REGIONAL PROJECTS WERE READILY PICKED UP BY MISSIONS AS PART OF THEIR OYB'S UNDER THE DEVELOPMENT FUND FOR AFRICA (DFA), A FEW IMPORTANT REGIONAL AND COUNTRY-SPECIFIC ACTIVITIES ARE AT THE MOMENT INADVERTENTLY ABANDONED SINCE NO MISSION HAD PLANNED FOR THESE ACTIVITIES UNDER COUNTRY-SPECIFIC ABS REQUESTS, MISSIONS HAVING MISTAKENLY UNDERSTOOD THAT REGIONAL ACTIVITIES, PER SE WOULD CONTINUE TO BE FUNDED REGIONALLY. IN A CASE OR TWO, MISSIONS WERE NOT GIVEN SUFFICIENT OYB'S TO BE ABLE TO CONTINUE TO SUPPORT THESE ACTIVITIES. RAPID OPERATIONAL CHANGES ACCOMPANYING THE DFA THIS YEAR GAVE TOO LITTLE TIME TO PLAN FOR ALL CHANGE-OVERS WITH RESPECT TO REGIONAL PROJECTS.

IN ADDITION, MAURITANIA HAS MADE SIGNIFICANT PROGRESS TOWARDS A FAVORABLE POPULATION POLICY CLIMATE. USAID/NOUAKHOTT HAS USED SPI FUNDS FOR POLICY DEVELOPMENT ACTIVITIES, TRAINING AND SUPPORT FOR SERVICE DELIVERY. IN ORDER TO ASSIST THE GIRM IN PROMOTING AND EXPANDING FAMILY PLANNING SERVICES, THE MISSION HAD REQUESTED \$300,000 FOR POPULATION ACTIVITIES IN ITS FY 88 OYB REQUEST UNDER SPI, AN AMOUNT THAT THE OFFICE OF POPULATION SAYS IT IS UNABLE TO FINANCE WITH ITS DECREASING BUDGET.

MISSIONS AND AFR/TP HAVE SOLICITED CENTRAL FUNDING FROM OFFICES OF THE SCIENCE AND TECHNOLOGY BUREAU, AND THEY HAVE BEEN FORTHCOMING WHERE POSSIBLE. IN THE

5. MISSION ACTION: MISSIONS SHOULD REVIEW AGAIN AND NOTIFY AFR/TR/HPN AND AFR/DP OF ORPHAN HPN PROJECTS WHICH HAVE NOT BEEN CITED ABOVE. NOTICE SHOULD INCLUDE PROJECT ACTIVITY, BRIEF RATIONALE/JUSTIFICATION FOR MAINTAINING ACTIVITY, AND ESTIMATED FY88 AND 89 COSTS.

6. AFR/TR/HPN AND AFR/DP SHOULD THEN DETERMINE IF ALL PLANNED HPN ACTIVITIES ARE COVERED UNDER THE DFA, AND OBTAIN FUNDING FOR EACH ORPHAN ACTIVITY. IF FUNDING IS NOT AVAILABLE, THEN AID/W SHOULD NOTIFY INVOLVED

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MISSIONS AND/OR CONTRACTORS; SO THAT THEY CAN PLAN  
ACCORDINGLY.

7. FYI: THE CONFERENCE STRONGLY ENDORSED THE CONCEPT THAT THE BUREAU FOR AFRICA SHOULD MAINTAIN FLEXIBLE RESOURCES WITHIN THE FHI II PROJECT FOR POPULATION ACTIVITIES IN THE REGION TO MEET THE MANY TARGETS OF OPPORTUNITY. ALL ALLOCATIONS IN THE PAST HAVE BEEN FULLY OBLIGATED. BOTH REDSOS AND NUMEROUS ASSESSMENTS BY AFR HAVE INDICATED STRONGLY THAT AFR'S FHI AND SPI PROJECTS WERE THE MAIN UNDERLYING MECHANISMS THAT ENABLED AFR TO GENERATE THE STRONG MOMENTUM OF THE PAST FEW YEARS IN WHICH MANY AFRICAN GOVERNMENTS HAVE PROMULGATED NATIONAL POPULATION POLICIES AND/OR HAVE INSTITUTED PROJECTS AND PROGRAMS TO MAKE FAMILY PLANNING INFORMATION AND SERVICES AVAILABLE. MUCH WORK REMAINS TO BE DONE IN THE NEXT FEW YEARS. TO REMOVE OUR FLEXIBLE TOOLS WILL DIMINISH OUR CAPACITY TO MAKE GOOD ON THE INVESTMENTS THUS FAR.

AS THE S&T BUDGET SHRINKS, THE OFA SHOULD PICK UP MORE CENTRALLY-FUNDED ACTIVITIES THROUGH BUY-ING TO ENSURE THAT AS MANY AS POSSIBLE OF THE GOOD QUALITY PROPOSALS CAN RECEIVE SUPPORT. KUX

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CABLE ON CAFS

Appendix E  
Cable on CAFS

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ACTION AID-00

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ACTION OFFICE AF14-02  
INFO AAF-03 AFEA-03 AFSA-03 AFFW-04 AFCW-03 AFDP-06 AFPO-04  
PDPF-01 PPPB-02 GC-01 GCAF-01 PPDC-01 GCMH-02 GTHE-03  
SAST-01 POP-04 ES-01 RELG-01 /049 A4 KL04

INFO LOG-08 AF-WW CIAE-06 EE-00 OOOE-00 SVC-00 /000 W  
-----061357 011511Z /48 49

- R 011642Z APR 86
- FM AMEMBASSY ABIDJAH
- TO SECSTATE WASHDC 5174
- INFO AMEMBASSY ACCRA
- AMEMBASSY ADDIS ABABA
- AMEMBASSY ANTANANARIVO
- AMEMBASSY BAHAKO
- AMEMBASSY BANJUL
- AMEMBASSY BISSAU
- AMEMBASSY BRAZZAVILLE
- AMEMBASSY BUJUMBURA
- AMEMBASSY CONAKRY
- AMEMBASSY DAKAR
- AMEMBASSY DAR ES SALAAM
- AMEMBASSY DJIBOUTI
- AMEMBASSY FREETOWN
- AMEMBASSY GABORONE
- AMEMBASSY HARARE
- AMEMBASSY KHARTOUM
- AMEMBASSY KIGALI
- AMEMBASSY KINSHASA
- AMEMBASSY LAGOS
- AMEMBASSY LIBREVILLE
- AMEMBASSY LILONGWE
- AMEMBASSY LOME
- AMEMBASSY LUSAKA
- AMEMBASSY MALABO
- AMEMBASSY MAPUTO
- AMEMBASSY MASERU
- AMEMBASSY MBABAHE
- AMEMBASSY MOGADISHU
- AMEMBASSY MONROVIA
- AMEMBASSY NAIROBI
- AMEMBASSY NDJAMENA
- AMEMBASSY NIAMEY
- AMEMBASSY NOUAKHOTT
- AMEMBASSY OUAGADOUGOU
- AMEMBASSY PRAIA
- AMEMBASSY YAOUNDE

UNCLAS ABIDJAH 07004

AIDAC

NAIROBI FOR USAID AND REDSO/ESA

E. O. 12356 N/A

SUBJECT: REDSO MANAGEMENT OF THE CAFS PROJECT

REF: (A) REDSO/WCA AND REDSO/ESA ASSESSMENT REPORT, 9 OCTOBER 1987; (B) AFRICA HPN OFFICERS' CONFERENCE, COTE D'IVOIRE, 20-23 MARCH 1988

1. BACKGROUND: THE CENTER FOR AFRICAN FAMILY STUDIES (CAFS) FAMILY PLANNING TRAINING SUPPORT PROJECT WAS FUNDED UNDER A THREE-YEAR GRANT FROM REDSO/ESA IN SEPTEMBER OF 1985, USING \$2.3 MILLION FROM THE FAMILY HEALTH INITIATIVES (FHI) I PROJECT. IN SEPTEMBER OF 1987, REDSO/WCA PROVIDED AN ADDITIONAL GRANT OF \$271,000 UNDER FHI II. THE PACD OF THE CAFS PROJECT IS SEPTEMBER OF THIS YEAR, BUT IS EXPECTED TO BE EXTENDED

FOR SIX MONTHS AT NO COST IN ORDER FOR CAFS TO COMPLETE ITS WORK PLAN. CAFS, ESTABLISHED IN 1975 IN EASTERN AFRICA, IS AN UNIQUE AFRICAN INSTITUTION THAT PROVIDES A REGIONAL RESOURCE FOR THE TRAINING OF FAMILY PLANNING WORKERS. THE PROJECT AIMS TO INCREASE CAFS' CAPABILITIES IN PROVIDING TRAINING IN MANAGEMENT, INFORMATION, EDUCATION AND COMMUNICATION (IEC) AND CONTRACEPTIVE TECHNOLOGY.

2. A MID-TERM EVALUATION CONDUCTED IN AUGUST/SEPTEMBER 1987 FOUND THAT THE CAFS PROJECT IS HIGHLY SUCCESSFUL IN PROJECT IMPLEMENTATION AND IN ACHIEVING THE PROJECT'S GOALS AND OBJECTIVES. BOTH REDSO/ESA AND REDSO/WCA CONSIDER CAFS' ROLE AS A CRITICAL ONE IN MEETING THE TRAINING NEEDS FOR FAMILY PLANNING PROGRAMS IN SUB-SAHARAN AFRICA. IT ALSO MEETS AGENCY PRECEPTS FOR INSTITUTION BUILDING, CREATING A CRITICAL MASS OF INDIGENOUS TECHNICAL EXPERTISE, AND COST EFFECTIVENESS THROUGH ECONOMIES OF SCALE. ALTHOUGH THE PROJECT IS AIMED AT INCREASING THE FINANCIAL SELF-RELIANCE OF CAFS, THE EVALUATION OBSERVED THAT THREE YEARS IS TOO SHORT A PERIOD FOR AN INSTITUTION TO DEVELOP ITS ABILITY TO GENERATE OTHER FUNDING AND REDUCE RELIANCE ON DONORS.

BOTH REDSO'S THEREFORE WISH TO CONTINUE AID'S ASSISTANCE TO CAFS IN A FOLLOW-ON PROJECT TO BE FUNDED IN FY 89 UNDER THE FHI II PROJECT AS ONE OF THE DESIGNATED REGIONAL ACTIVITIES. THE MANAGEMENT BURDEN ON REDSO/ESA HAS NOT BEEN HEAVY, ESPECIALLY GIVEN CAFS HEADQUARTERS OFFICE IN NAIROBI. HPN OFFICERS HAVE FOUND THE PROJECT MANAGEMENT OF REDSO/ESA TO BE HIGHLY SATISFACTORY AND THE TECHNICAL ASSISTANCE PROVIDED BY REDSO/ESA TO BE HIGHLY EFFECTIVE IN DEVELOPING BOTH THE EXPERTISE AND REGIONAL PERSPECTIVE OF THIS INSTITUTION.

3. PROBLEM: IN ACCORDANCE WITH THE FINDINGS OF THE (B) OF 87 AND PRECEPTS OF THE DFA, REDSO MANAGEMENT OF REGIONAL PROJECTS SHOULD BE MINIMIZED, FROM WHICH IT FOLLOWS THAT MANAGEMENT OF THE CAFS FOLLOW-ON PROJECT SHOULD BE ASSUMED BY AFR/TR OR A BILATERAL MISSION -- USAID/KENYA BEING THE MOST LIKELY CANDIDATE. THE USAID/KENYA HPN OFFICER STRESSED THAT IT WOULD BE ALTOGETHER INAPPROPRIATE FOR USAID/KENYA TO ASSUME RESPONSIBILITY, WITHOUT RESTRUCTURING THAT OFFICE TOWARDS OVERALL REGIONAL ORIENTATIONS; THEIR DUTIES ARE FOCUSED ON KENYA (AND NOT, E.G., ON ZAMBIA OR TOGO).

PARTICIPANTS AT THE HPN CONFERENCE DISCUSSED THIS ISSUE AT LENGTH AND AGREED UNANIMOUSLY THAT, GIVEN THE NATURE OF THIS PROJECT WHICH INVOLVES AN UNDERSTANDING OF THE NEEDS OF ALL THE COUNTRIES IN THE TWO REGIONS, A REGIONAL OFFICE IS UNIQUELY SUITED TO OVERSEE THE MANAGEMENT OF THIS PROJECT. A BILATERAL MISSION DOES NOT HAVE THE REGIONAL PERSPECTIVE NEEDED, NOR THE OPPORTUNITY TO MAKE TECHNICAL ASSISTANCE VISITS TO COUNTRIES OF THE REGION TO OBTAIN FIRST HAND FEEDBACK AND TO MONITOR PROJECT ACTIVITIES, AS WELL AS TO PROVIDE APPROPRIATE MANAGERIAL GUIDANCE/SUPPORT TO CAFS. AFR/TR/HPN IS THOUSANDS OF MILES AWAY FROM THE CAFS HQRTS IN NAIROBI, CLEARLY AN INAPPROPRIATE SITUATION FOR GOOD MANAGEMENT.

4. RECOMMENDATION. THE HPN CONFERENCE PARTICIPANTS STRONGLY RECOMMEND THAT THE RESPONSIBILITY FOR THE MANAGEMENT OF THE FOLLOW-ON REGIONAL FAMILY PLANNING TRAINING PROJECT WITH CAFS SHOULD REMAIN IN REDSO/ESA.

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IT SHOULD NOT BE TRANSFERRED TO A BILATERAL MISSION NOR  
TO AFR/TR.

5. PLEASE ADVISE REOSO'S. KUX

NOTE BY GC/T: (0) IN PARA 1 CORRECTION TO FOLLOW.

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APPENDIX F  
DRAFT ACSI-CCCD SUSTAINABILITY STRATEGY

## Appendix F

### DRAFT ACSI-CCCD SUSTAINABILITY STRATEGY

#### Sustainability Strategy

Objective: Strengthen national capability to continue ACSI-CCCD project benefits and activities after AID assistance is ended.

(Benefits = outcome = "improved child health")  
(Activities = outputs = trained staff, functioning institutions, etc.)

Strategy: Promote and follow AID policies, procedures and assumptions that certain project characteristics generate sustainable programs.\*

Provide program support in:

Designing projects: with at least 8 years of life  
: with low-cost interventions  
: that promote PHC integration  
: with an implementation pace compatible with each country's absorptive capacity

Implementing activities in:

Training: .curriculum development  
.training of trainers  
.development of decentralized training programs

Operational Research: .review committee development  
.training in conducting research

Health Information Systems: .micro-computer use  
.use of data for decision-making  
.development of Epidemiological Reports

Health Education: .training in behavioral analysis  
.training in materials development and use of mass media

Health Financing: .development of plans to meet project costs  
.piloting alternative financing studies  
.establishing ACSI-CCCD budget line items

Program Management: . in-service training  
.collaboration with institutions/universities

Evaluating project efforts with a sustainability process indicator questionnaire and checklist.

\*Assumptions that certain contextual factors and project characteristics are related to project sustainability.

## PROCESS INDICATORS IN ACSI-CCCD OPERATIONAL AREAS

### National Commitment to Project Goals

- .Existence of national policies on EPI, CDD, malaria, and PHC
- .Designation of Directors for each intervention (EPI, Malaria, Diarrhea Disease) program
- .Inter-ministry involvement (ministries of plan, finance, information and etc.) in child survival programs

### Project Negotiation between AID and National Authorities

- .National involvement in the project extension design (in developing objectives, workplans, and etc.)

### Institutional Organization of the Project

- .Integration of EPI, CDD, malaria and support activities into the established authority structure from central to local levels
- .Existence of functional units for the following:
  - Health Education Units
  - Operational Research Review Committee
  - Training Units
- .Existence within the MOH of a functional planning unit
- .Existence within the MOH, the ability to supervise and manage its employees
- .Existence within the MOH, recognition (remuneration) and access to career advancement to employees

### Financing

- .Existence of a government plan to cover project costs
- .Increase in government assumption of project costs
- .Existence of a national policy on community co-financing of public health services
- .Increase in the preventive health budget from the previous year

### Training

- .Existence of a viable in-service training capability in the MOH
- .Existence of a decentralized in-service training structure
- .Existence of an evaluation/monitoring system within the training program
- .Existence of pre-service training in child survival strategies in the medical training institutions

Appendix G

MISSION CONTACT LIST FOR  
HEALTH, POPULATION, AND NUTRITION ISSUES

Appendix G

Mission Contact List for  
Health, Population, and Nutrition: Bureau for Africa

Unless otherwise noted, the address is written:

[Name]

[Title]

USAID/[Mission Name]

Washington, D.C. 20520

REDSO/West and Central Africa

Charles Debose, Health Dev. Officer;  
Joyce Holfeld, Pos. Dev. Officer  
REDSO/WCA, Abidjan

Botswana

Ann Domidion  
Human Resources Dev. Officer  
USAID/Gaborone

Burundi

John Ford, Project Officer  
USAID/Bujumbura

Cape Verde

August Hartman  
USAID/Praia

Central African Republic

Hugh Smith  
USAID/Bangui

Djibouti

John Lundgren  
A.I.D. Representative  
USAID/Djibouti

Gambia

Thomas Mahoney  
Program Officer  
USAID/Banjul

Guinea

Theodora Woods-Stervinou  
Program Officer  
USAID/Conakry

Kenya

David Oot, Sup.Hlth, Pop.Dev.Off.;  
Laura Slobey, Pop. Dev. Off.;  
Linda Lankenau, Health Dev. Off.  
USAID/Nairobi

REDSO/East and  
Southern Africa

Arthur Danart, Pop.Dev. Off.  
Vic Barbiero, Hlth.Dev. Off.  
REDSO/ESA/Nairobi

Burkina Faso

Richard Greene  
Health/Pop. Dev. Officer  
USAID/Ouagadougou

Cameroon

Gary Leinen  
Health/Pop. Dev. Officer  
USAID/Yaounde

Chad

Diane Blane, Gen.Dev.Off.;  
Leslie Brandon, Pop. Advisor  
USAID/N'Djamena

Ethiopia

Frederick Mochmer, Jr.  
A.I.D. Representative  
USAID/Addis Ababa

Ghana

Ray Kirkland  
Pop. Dev. Officer  
USAID/Accra

Guinea Bissau

A.I.D. Representative  
USAID/Bissau

Lesotho

Patsy Layne  
Hum. Res. Dev. Off.  
USAID/Maseru

Liberia  
Francisco Zamora  
Health Dev. Officer  
USAID/Monrovia

Malawi  
Charles Gurney, Hlth/Pop. Dev. Off.  
Gary Newton, Hlth/Pop. Dev. Off.  
USAID/Lilongwi

Mauritania  
Pamela Mandel  
Health Dev. Officer  
USAID/Nouakchott

Niger  
Margaret Neuse, Hlth. Dev. Off.;  
Carina Stover, Hlth./Pop.Dev. Off.  
USAID/Niamey

Rwanda  
Joan LaRosa  
Health/Pop./Nutr. Officer  
USAID/Kigali

Sierra Leone  
James Habron  
A.I.D. Affairs Officer  
USAID/Freetown

South Africa  
Timothy Bork  
A.I.D. Director  
USAID/Pretoria

Swaziland  
Alan Foose, Hlth./Pop. Dev. Off.;  
Mary Pat Selvaggio, Pop. Dev. Off.  
USAID/Mbabane

Togo and Benin  
Caroline Koroma  
Pop.Prog.Coordinator, FHI II  
USAID/Lome

Zaire  
Glenn Post, Sup, Hlth/Pop. Dev. Off.;  
Lois Bradshaw, Pop. Dev. Off.;  
Chris McDermott, Hlth. Dev. Off.;  
USAID/Kinshasa  
APO NY 09662-0006

Zambia  
Fred Perry  
General Development Officer  
USAID/Lusaka

Madagascar  
Sam Rea  
Program Officer  
USAID/Atananarivo

Mali  
Neil Woodruff  
Health Development Officer  
USAID/Bamako

Mozambique  
Alan Silva  
A.I.D. Affairs Officer  
USAID/Maputo

Nigeria  
Hank Merrill, AAO  
Gerry Cashion, Prog.Off.  
USAID/Lagos

Senegal  
Dennis Baker, Actg. Hlth. Off.;  
Fatimata Hane, C.S. Advisor  
USAID/Dakar

Somalia  
Gladys Gilbert  
Special Projects Officer  
USAID/Mogadishu

Sudan  
Paula Bryan  
Pop. Dev. Off.  
USAID/Khartoum

Tanzania  
Paula Tavrow  
Program Officer  
USAID/Dar es Salaam

Uganda  
Paul Cohn  
Hlth./Pop. Dev. Officer  
USAID/Kampala

Zimbabwe  
Lucretia Taylor  
Program Officer  
USAID/Harare