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**RECOMMENDATIONS FOR IMPROVED HPN PROGRAM IMPLEMENTATION WITHIN THE
BUREAU FOR ASIA**

**Report Prepared at the Asia Bureau Health, Population
and Nutrition Officers Conference**

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Singapore**

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EXECUTIVE SUMMARY

USAID ASIA BUREAU HEALTH, POPULATION AND NUTRITION OFFICERS CONFERENCE

Conference Description

The Bureau for Asia Health, Population and Nutrition Officers Conference was held at the York Hotel, Singapore, on May 20-25, 1984. In attendance were twenty-eight HPN field officers, thirteen AID/Washington officials and eight outside consultants serving as technical experts. The conference was organized and managed by Jeffalyn Johnson and Associates, Inc.

Objectives

The conference was designed to meet three objectives:

1. To upgrade Asia HPN officers' knowledge of key technical areas, including population/family planning, oral rehydration therapy (ORT), nutrition, immunization, malaria and water and sanitation.
2. To review the status of Bureau efforts to implement policies and strategies in these areas by identifying constraints to implementation and recommending approaches for overcoming constraints.
3. To identify and discuss internal bureaucratic issues of concern to HPN field officers.

Design Considerations

The conference was designed to maximize field officer participation while meeting their expressed need for information on state-of-the-art

technology and issues in the six health care interventions. In addition, the Asia Bureau HPN staff in Washington had identified two specific products that participants were to develop during the conference; this too was a principal design consideration.

To meet these criteria, the conference format incorporated the following activities.

1. Technical Presentations on Each Health Care Intervention

Careful attention was given to ensure the selection of presenters who were recognized experts, had extensive field experience (region specific whenever possible), and were known to have good presentation skills. The number of speakers for each session was limited; detailed scopes of work, outlining their roles and responsibilities, were distributed to the presenters prior to the conference. This resulted in well-organized, detailed presentations that addressed the audience's needs. In addition to technical experts, several of the plenary sessions included related case study presentations by HPN field officers. All technical presentations were followed by discussion and questions and answers.

2. Presentations by Central and Regional Bureau Representatives

These presentations addressed areas of special concern to the field officers and included contracting, staffing/training, and centrally-funded population, health and nutrition activities.

3. Working Groups. Time was divided equally between plenary session presentations and small working groups. Groups were convened for each of the six subject areas (population/family planning, QRT, nutrition, immunization, malaria and water and sanitation) as well as for USAID special concerns. The tasks and desired outcomes of the working groups on malaria and water and sanitation differed from those addressing elements of the Bureau's selective care strategy (population/family planning, QRT, nutrition and immunization).

A. Selective Care Strategy

On the first day, conference participants were divided into four small groups corresponding to each of the four health care interventions. Conference and Asia/TR staff served as group facilitators. Each group was asked to identify and prioritize issues, constraints and problems (within and outside AID) related to program implementation for one of the technical areas. The top five priority issues for each intervention were used as the basis for the working groups that met throughout the week.

Participation in the working groups was self-selected. Each group met at least twice for a minimum of eight hours to complete the assigned tasks. Using the priority issues/constraints lists, each group was instructed to: (a) expand or clarify the constraints to implementation; (b) identify the entities (e.g., host countries, other donors, AID) best suited or responsible for addressing the constraints; (c) specify the types and amounts of AID resources required; and (d) recommend action strategies that missions, S&T and/or other bureaus could initiate to overcome the constraints to implementation.

At the close of the conference, each working group had accomplished the work session objectives and had prepared a written summary of their conclusions. The four working group reports have been compiled into this report and will serve as an action plan for the missions and Asia Bureau.

B. Malaria and Water and Sanitation

The two working groups on malaria and water and sanitation were charged with examining the Bureau's role with respect to these areas and developing recommendations for refining the scope and nature of the malaria and W/S strategies within the Asia Bureau Health Strategy. The working groups' recommendations, "The Role of Malaria Control and Water and Sanitation in the Asia Bureau Health Strategy", are included in the body of this report.

Working Group Recommendations

Oral Rehydration Therapy

The major constraints to implementation include lack of training in program management and logistics (e.g., formulation, packaging, and distribution), inadequate use of the resources/skills of the commercial sector to both distribute and promote ORT, lack of acceptance by the medical community, poor donor coordination, the fact that diarrhea is not perceived by providers and potential users to be a problem, and the lack of knowledge and demand for ORT by mothers.

Recommended Actions

- Carry out country-specific needs assessments. Where indicated,
 - a. provide technical assistance to improve presentation, packaging, marketing;
 - b. support operational research to determine most acceptable product, mode of delivery, etc.; and
 - c. support the establishment of a national training capacity in ORT.
- Conduct regional ORT meeting for policy makers and national/sub-national seminars for the medical profession.

Immunizations

Between 15 and 30 percent of deaths under age five are preventable with immunizations. Neonatal tetanus and measles are the most important of these, yet coverage in Asia is only ten percent and one percent respectively. Constraints include a lack of government commitment, inappropriate immunization policies, weak program management, low revaccination rates, problems of vaccine potency and inadequate planning for recurrent costs.

Recommended Actions

- Conduct needs assessments and provide support for surveys to quantify the problems and, where appropriate, assist in preparing national immunization plans, focusing on measles and neonatal tetanus (current coverage is low and potential health impact is high).
- Develop/test improved vaccines (especially measles), temperature markers and cold chain equipment.
- Improve revaccination rates through more effective communication strategies.
- Help estimate recurrent cost requirements and design/test cost recovery schemes.
- Support creative ways to deliver tetanus toxoid to fertile women, e.g., through family planning programs or public secondary schools.

Population/Family Planning

Constraints to population program implementation include host country policies limiting contraceptive choices, inadequate government commitment to population, lack of trained managers, insufficient recurrent cost financing, and reluctance to use needed external technical assistance. Constraints internal to AID include lack of AID population staff, lack of grant funds, complicated AID contracting and procurement procedures, and lack of centrally-funded population resources.

Recommended Actions

- Support operations research to resolve program design issues and clinical field trials of contraceptive technology not yet accepted in the program.

- Provide grant funds and use host country technical experts to facilitate acceptance of technical assistance.
- AID should carefully consider recurrent cost implications of projects and plan for phased introduction of local financing and/or cost recovery.
- Support major multi-donor efforts to increase in-country management skills and finance academic training in population.
- PPC should allocate more funds to the Office of Population and/or the Asia Bureau to establish a line item account for S&T/POP activities in Asia.

Nutrition

Internal AID constraints include lack of trained staff, underutilization of PL 480 food for nutrition objectives, and a lack of organizational focus on nutrition. Within the host country, nutrition planning/programming efforts are often disjointed. Growth monitoring programs, while accepted in much of Asia, are not properly designed and implemented. Food supplementation programs often fail to reach the target population and are not cost-effective. Health status monitoring systems give inadequate attention to nutritional deficiencies.

Recommended Actions

- Increase use of PL 480 commodities to influence nutrition policies and target food distribution to improve nutrition impact.
- Give increased attention to nutrition implications in the design of projects, especially in agriculture.
- Support training of host country staff responsible for planning and implementing growth monitoring programs.

- Efforts to monitor health status should include key micro-nutrient deficiencies, protein-energy malnutrition and low birth weight.

Water/Sanitation and Malaria

Conferees also reviewed Bureau strategies for water and sanitation and malaria. The report contains the findings and recommendations of these working groups. Further analysis of these areas of activity is planned over the next few months, with any necessary revisions to be made by the end of 1984.

Special Concerns

Training

As the number of technical officers has declined, many officers have found that they must assume responsibility for designing/managing activities for which they have little background. Short-term training, focused on the elements of the selective care strategy, was strongly recommended by each of the working groups.

AID Policies and Procedures

Many participants felt that the burden of AID imposed policies and procedures is making it increasingly difficult for technical officers to function effectively. During the coming year, an effort will be made by field missions and ASIA/TR to document examples of such impediments in the form of case histories.

DETAILED WORKING GROUP RECOMMENDATIONS

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RECOMMENDATIONS FROM ORAL REHYDRATION WORKING GROUP

I. Constraints and Recommendations for Improved ORT Implementation

A. Policy and Planning

Limited perception of diarrhea as a problem in effectiveness of ORT programs; uncertainty over numerous technical details related to ORT implementation; tendency to a limited approach to ORT excluding use of private sector, commercial activities, traditional practitioners and home ORT strategies; and general program inflexibility all hamper ORT program development. Lack of donor coordination results in conflicting advice and pressures on government. Many governments lack the organizational structure needed to assure ORT planning, implementation and integration into the national health system. Finally, medical professionals remain the single largest impediment to implementation of national ORT programs through ignorance, misinformation and financial considerations.

Recommended AID Response

1. AID missions are encouraged to participate actively in donor coordination groups at the national level to ensure a consistent donor strategy in issues ranging from the role of ORT in host country health plans to specific implementation issues such as recommended packet volumes, home rehydration approaches, commercial sector marketing, training strategies, monitoring and the like. If such a donor group does not already exist, AID should make particular efforts to establish one and support its regular functioning. This is a prime activity to insure that donors do not appear to be in competition and that a single, consistent array of messages is transmitted to the host country officials.
2. In countries where appreciation of the diarrhea problem and/or understanding of the potential of an ORT program to strengthen PHC

services are lacking, AID should provide expert advisors to the government to assist in the analysis of the problem and to identify the potential for an ORT program with estimates not only of its health impact, but also of the financial savings that can be expected to be realized by the host country. This type of assistance is available through centrally funded projects such as Pritech.

3. In many countries, in spite of apparent recognition of the diarrhea problem and acceptance of the need for a specific ORT program, the organizational structure in host country ministries is lacking. Where this is the case, AID should offer support for the establishment of a central organization capable of analyzing, directing and assisting in the implementation of a national ORT program. Although this organization may be within the Ministry of Health, an alternative might be a semi-autonomous inter-ministerial organization incorporating representatives from ministries of health, education (Medical Schools), information (T.V., radio mass-media) and social services, as well as appropriate donors (AID, WHO, UNICEF), PVOs and pharmaceutical manufacturers. While this does not advocate the establishment of a vertical program, it does follow WHO recommendations for a national country diarrhea program manager and the necessary staff and authority to see that ORT is reflected in the planning, budgeting, training, supervision and reporting system of the host country health system. The task of the steering committee and its secretariat should be the coordination and facilitation of existing programs and the provision of supportive services such as mass-communications, training, research, information dissemination and product availability.
4. ORT programs are presently in place in more than 50 countries throughout the world. Many of them experience similar problems, both of a technical as well as a managerial nature. AID, through regional and central offices, should make increased efforts to provide host countries with access to information on program experience from other countries. A standard evaluation methodology

should be evolved in coordination with WHO and UNICEF. Careful documentation of experiences in such wide areas as home made solutions; teaching methodology at the village level; mass communication strategies; monitoring and reporting systems; training and convincing of doctors and other health professionals; packet production, distribution, promotion and commercialization; operational research results; and a host of management issues in the planning, budgeting, implementation and evaluation cycles should be made available to all missions and be updated regularly.

5. AID should sponsor a regional conference for high level officials from the Ministry of Health, Finance and other relevant ministries from countries throughout the Asia region. Such a conference would focus on careful, analytical presentations from the host countries in an effort to share experiences and provide mutual stimulation to further activities in the field of ORT. The conference would focus on operational issues and solving constraints with recognition of the potential of ORT to improve national PHC systems and to meet national goals of equitable and self-reliant health care systems. This conference would emphasize presentations by Asian countries, with participating agencies and guests facilitating rather than directing or lecturing.

6. Provide high quality, internationally recognized promotion of ORT among health professionals in host countries. This could take the form of short term consultants to make presentations at national pediatric meetings, or other such local fora, during which important opportunities should be found to recruit the support of health professionals, particularly doctors. Similar efforts at professional promotion through meetings, publications and dissemination of information about successful programs throughout the world should be encouraged by the mission. Pritech should be asked to provide regular updates as well as to respond to specific national needs in technical and managerial areas relating to promotion among health professionals.

7. AID missions in concert with other donors, specifically WHO and UNICEF, can offer a comprehensive assessment of the diarrhea situation and the development of a detailed plan for a national ORT program to host countries. AID should support in-depth country assessments, including: epidemiologic evaluations of the diarrhea problem and its contribution to mortality, morbidity and health sector costs; management issues in planning, budgeting, personnel and finance; logistics issues such as production, distribution, promotion and commercialization, including both package and home made formulas; training with consistent strategies ranging from high level health specialists through paramedic levels to the lay public; communication strategies linked to health training and mobilizing appropriate media such as radio, print and other marketing approaches; supervisory and monitoring systems, including epidemiologic surveys, routine diarrheal disease monitoring, establishment of sentinel areas and supervisory systems aimed at assessing implementation of ORT programs at each level; evaluation of ORT programs including baseline surveys, process and impact evaluations and the use of micro-computer technologies with monitoring, evaluation and rapid feedback of program results. Such comprehensive assessments can provide not only an important stimulus for the development of ORT programs in host countries but also represent important steps in obtaining the support of other donors such as World Bank, regional banks and bilateral funds from other countries that might not be otherwise forthcoming.

8. AID should give careful consideration to the advantages and disadvantages of linking ORT to other specific activities, particularly family planning. Where research and experience demonstrates that they can be mutually supportive, they can be successfully combined. Where ORT is not widely understood and valued, or where there is strong resistance to family planning by certain segments of the population, they might best be kept separate during initial introduction.

B. Management Issues

Constraints in management include lack of government understanding or appreciation for the diarrhea problem and the role of ORT in solving the problem, as well as limited management capabilities related to planning, implementing, supervising and monitoring public health programs.

Recommended AID Response (in addition to those activities cited in Section A)

1. Assist the host government in a management assessment of the central ministry with particular reference to ORT programming, and provide necessary TA and training opportunities to reinforce management of public health programs in ORT. Flexible money should be available to carry out reviews and surveys of an operational nature enabling flexible research evaluation activities to diagnose management constraints and initiate corrective action within the government machinery. This may also include inter-country travel to see successful neighboring programs, training at ICDDRB or in the US, or in-country training programs arranged with appropriate TA.
2. Recognizing the limited capability of governments to provide services and education to all segments of the population, AID should support expanded activities by PVOs in ORT provision.
3. Other management suggestions are found in Section A under policy.

C. Communication Issues

Perception of the professional medical community of ORT as a second class remedy, a lack of public appreciation for the importance of diarrhea and the necessity for action, a lack of perception of the difference between diarrhea and dehydration (the actual cause of death) a lack of understanding of the central role of feeding to effective

diarrhea therapy, and a lack of appreciation by governments for the effective use of media and communications strategy in mobilizing public action. Also lacking is knowledge of current practices by mothers with regard to diarrhea/dehydration diagnosis, treatment, management and help-seeking activities. Successful communications must have this information.

B. Recommended AID Response

1. Provide technical assistance to the host country either from the US or host country expert resource to assess the capacity of both public and private institutions to carry out widespread effective communications campaigns. Where extensive experience in social marketing or even commercial marketing is found, outside TA may be appropriate to assist in identifying specific, unique elements of ORT that must be included as an integral part of a communication effort.
2. Provide assistance in the development of a detailed communication strategy to promote ORT. Extensive experience has shown the fallacy of simply mobilizing mass media behind a public and social concept resulting all too often in limited impact. Precise definition of product, target audience, and goals of a mass communication campaign are a critical first step to a successful promotion strategy. AID has a number of central as well as bilateral funded projects and has unique experience in this area which should be offered to host country governments and participating marketing agencies.
3. In many countries, both long and short term technical assistance in the development of products and promotional and mass communication materials will be needed. In addition, capital inputs to provide development of audio-visuals and print materials may be required. Air time in some countries must be purchased. In most countries this work can best be done through a contract with the private

sector who will be expected not only to develop materials but to coordinate and oversee the implementation of a mass communication strategy.

4. AID may support research to identify current diarrheal dehydration knowledge, attitudes, and practice (KAP) among health professionals, families and lay practitioners to provide a basis for program/communications strategies.

D. Logistics, Production and Distribution

Problems occur in the formulation, packaging and distribution of packaged ORS through government systems, lack of stimulation to commercial production and marketing and, in the case of home made solution, considerable variations in directions often confuse and confound the user.

Recommended AID Response

1. AID should be involved in the initial development stage for new presentation, packaging and marketing of ORS. This would involve particular attention to improvements in composition, such as substituting citrate for bicarbonate, changing of packaging materials and labeling, and new presentations such as tablets, premixed solutions, etc. The Private Enterprise Group could be the vehicle for providing private sector loans to promote production, distribution and marketing of ORS; particular attention should be given to ensuring strategies that do not discourage such commercial production and promotion.
2. Social marketing approaches to ORT should be stimulated and supported. Where feasible, government production should be shifted towards a cost recovery strategy either through government mechanisms or through contracting to the commercial sector.
3. AID should support adequate operational research to define such important issues as optimal volume for ORS packets and appropriate,

culturally acceptable home-made solutions to be promoted by the program. In this regard, access to experience from other countries would be most useful and could assist the host country in making important standardization decisions which must necessarily precede production, promotion and outreach efforts.

4. Although an acceptable product is of important concern, it is felt that AID should avoid over-emphasis on the development and distribution of "the best-possible-product," and give priority to the critical areas of training, information, management and provision of services.

E. Training

There is a considerable underestimation of the difficulty of teaching ORT at rural levels. The training is often focused on health workers who are frequently not capable of transferring their knowledge and skills to mothers. The resistance of the medical community to the use of ORT can often be traced to professional training both during formal schooling as well as continuing education which often occurs through such non-formal routes as medical journals, detail men from pharmaceutical companies, etc.

Recommended AID Response

1. In depth country assessment of present training in diarrheal disease management at all levels. This training should start with professional schools and should include an analysis of training content and pedagogic methodology. Particular attention should be paid to consistency of messages from the highest to the lowest levels of the training pyramid. This could result in a unified training strategy extending from professional schools all the way to laymen, public schools and various extension workers from other sectors.

2. Assist in the establishment of national training capacity in ORT. Through utilization of ICDDRDB training courses, train a cadre of national trainers who would return to the host country and establish one or more clinical training centers in existing respected health care facilities.
3. Provide resources necessary to establish national training centers and for a programmed expansion of ORT units throughout the health system of the country.
4. Provide assistance in the development of training modules and training programs that emphasize demonstration, practical experience and repetitive reinforcement of ORT tasks. This is particularly important in the approach to lay workers which has largely focused on didactic training materials to the exclusion of demonstration and experiential activities.
5. Support national efforts for widescale training activities of lay workers and mothers and assure that materials and supplies are available to apply training skills after training is completed. Diarrheal seasonality also raises the issue of when to schedule widespread lay worker training. Whenever possible, this training should be timed to precede the diarrheal season by as little time as possible to ensure that trainees practice the newly learned skills as quickly after training as possible.

F. Research

Lack of operations and marketing research in host countries to define both the demand and the potential market for ORS. Lack of knowledge of the determinants of utilization of ORT by health professionals and mothers, including knowledge on repeat users of ORS. Inability to measure impact of ORT activities.

Recommended AID Response

1. AID should provide flexible funding for practical in-country operational research addressing various issues, ranging from anthropologic determinants of response to diarrheal disease to appropriate home made solutions, feeding practices, mixing of ORS solutions and the like. Research could also facilitate management and policy decisions through the development of management information systems to assess progress of training, logistics supervision and communication strategies.
2. Funds are needed to establish baseline studies and gather information on diarrhea problems and the development of impact indicators with which to monitor awareness, acceptance, use, repeat users; making this available as a continuing motivation tool for the expansion of ORT programs and modification of program design.
3. Support of local professional interest in practical research questions, both as a means to answer technical problems as well as to motivate health professionals to the use of ORT. This may take the form of multi-center trials, national meetings to present ORT experiences, publication of journals and newsletters, etc.

G. Donor Coordination

Perceived monopoly of other international donors (particularly UNICEF and WHO) in the ORT field; conflicting donor emphasis and approaches that confuse and retard government implementation programs; and a lack of adequate funds.

Recommended AID Response

1. As indicated in Section A on policy, AID should participate actively in existing donor coordination groups and, where absent, should attempt to convene such a group to ensure inter-donor consistency

in strategy and optimal allocation of available donor funds to be applied to the national program. AID funds may be used to best advantage in the commercial sector, marketing, cost recovery strategies, managerial training, ORS production and evaluation approaches to complement other donor activities. The emphasis among donors should be on ensuring a unified strategy mobilizing all possible resources in a single national program.

II. Conclusions

Conference participants believe that ORT is an integral part of national primary health care activities and that the planning and widescale implementation of ORT is a critical step in the development of effective high coverage PHC programs reaching the poor and particularly children. Our support of ORT is not recommended as a vertical program approach; it should be seen as a means of supporting national health systems and demonstrating the effectiveness of comprehensive planning, management strategies, training, communication, supervision, monitoring, appropriate research and evaluation as a step towards providing health for all. By participating in national ORT program development, AID will further their national goals for comprehensive primary health care and a self-reliant health care system.

RECOMMENDATIONS FROM IMMUNIZATION WORKING GROUP

I. Immunization and AID Health Strategy

Immunization is one of four selected health interventions, along with family planning, ORT and nutrition, identified as a priority in improving the health of infants and children in Asia.

Diseases Preventable by Immunization

Fifteen to thirty percent of under-five deaths in Asia are preventable by immunization. Epidemiologic data documents two EPI diseases, neonatal tetanus and measles, as major causes of this mortality. Neonatal tetanus kills 2-3% (range 0.5-6%) of all newborns in Asia (see Appendix I). Measles infects almost all children and is responsible for deaths directly or through complications in 1-5 percent of children.

Current EPI Strategies in Asia

Asian countries in co-operation with WHO and UNICEF have initiated Expanded Immunization Programs (EPI). Although reported coverage is low, countries are making progress in delivering BCG and DPT and, in most countries, poliomyelitis. Immunization of the two diseases with highest mortality, neonatal tetanus and measles, is low--10% and 1% respectively. This represents an unacceptable loss of life.

Opportunities for Aid Support

Within the context of the AID Health Strategy, epidemiologic data, available technology and current progress of national immunizations programs, AID has a unique opportunity to strengthen the two weakest and most important immunizations--tetanus immunization of pregnant or potentially pregnant woman and measles immunization of infants 9-15 months of age.

Specifically, AID can utilize current health and family planning activities to demonstrate that these two vaccines can be incorporated into

on-going activities to reduce neonatal tetanus and measles mortality. Implementation opportunities exist in three areas:

1. Include or expand measles immunization in ongoing and planned PHC projects--India (Maharashtra and Gujarat); Indonesia (CHIPS, VFP-MCW); and Pakistan (PHC).
2. Include tetanus toxoid immunization of fertile aged women on an experimental basis in family planning programs (target populations are the same).
3. Expand bilateral EPI program in Indonesia to include measles vaccine.

Within these programs, immunization would be strengthened through:

- identification of at risk populations;
- staff training;
- development of logistics, including cold chain;
- supervision and continuing education; and
- evaluation of coverage, impact on mortality and cost effectiveness

Development of a centrally funded project to initiate or expand delivery of tetanus toxoid and measles vaccines in ongoing bilateral health and family planning projects is recommended. This should include provision of measles vaccine to demonstrate its feasibility and effectiveness in improving nutrition, decreasing diarrheal mortality, and improving child survival.

II. Deliberations of Working Group

AID Health Officers meeting in Singapore, May 21-25, identified seven priority constraints limiting immunization in Asia:

A. AID and Host Country Commitment

Lack of commitment is a constraint to current immunization.

Recommendations for AID

1. AID/Washington needs to affirm the importance of immunization as an integral part of its Health and Population Strategy.
2. AID missions need to review current project portfolios to identify areas for increased support to national immunization programs.
3. AID missions should meet with national EPI authorities to review the current status of programs, including workplans, annual reports and evaluations.
4. In areas where commitment needs strengthening, consider assistance in the following areas:
 - a. Review available data on epidemiology of EPI diseases.
 - b. When necessary, support surveys to identify populations at risk and quantitate current mortality.
 - c. Review/revise/develop national EPI Plan to strengthen the neonatal tetanus and measles components.
 - d. Work with planners to develop a fundable project document emphasizing inclusion of high priority diseases.

B. Coordination of EPI Donors

Support to national EPI programs is currently being provided by numerous donors (WHO, UNICEF, World Bank and bilateral countries). AID should maintain a dialogue with WHO and UNICEF at the global level.

Donor coordination to ensure consistency in policy and to avoid duplication of inputs is necessary. In most countries, AID will provide only a small part of the external assistance.

Recommendations for AID Missions

1. Encourage national governments to take the lead role in coordinating donor activities.
2. Encourage formation of an EPI advisory body under national auspices.
3. Evaluations, where possible, should involve all donors.
4. Where national coordination functions poorly, informal donor coordination should be developed on an interim basis.
5. With assistance of other donors, identify resource gaps where AID resources, experience and expertise will significantly effect outcomes.

C. Development of EPI Policy

National governments are currently implementing PHC strategies. Policies do not always adequately reflect need and available resources.

Recommendations for AID Missions

1. Review national PHC plans, annual reports, and evaluations.
2. Encourage the selection of interventions, e.g., measles and tetanus immunization, which meet identified epidemiologic needs in the appropriate target populations in the most cost effective manner.
3. Emphasize the priority of providing services to populations with current access to health facilities. Expansion to unserved areas should be a second priority.

4. Work to change the "mind set" of special immunization clinics to the screening and immunization of all target populations attending health facilities, sick and well, as recommended by WHO. Such policy will require that multiple categories of health workers be involved in giving immunization.
5. In selecting areas for AID assistance, focus on specific activity gaps not well covered by host countries or other donors.
6. Recognizing the expertise of UNICEF in procurement, limit AID procurement to those items required to ensure priority immunization in ongoing bilateral projects.
7. Where AID procurement is required, limit purchase to WHO/UNICEF tested and approved commodities. Use central procurement with blanket waivers as appropriate for vaccines and refrigerators.
8. AID should pursue an agreement with HHS so that AID can call on long and short term technical assistance from CDC without ceiling restrictions.
9. While recognizing the importance of regional/national self sufficiency in vaccine production, feasibility studies and support for live vaccine production should take into account expected major changes in technology.

D. Program Management in EPI

Effective program management (planning, training, supervision, problem identification and solution, and evaluation) is the major constraint to effective immunization.

Potential Areas for AID Support to National EPI Programs

1. Combine EPI/epidemiology training to better define populations at risk and to measure impact of services.

2. Encourage central technical management of EPI.
3. At the delivery level, management should be integrated as part of PHC.
4. Establish a cold chain system with appropriate equipment, training, monitoring and maintenance; include funds for fuel and spare parts.
5. Through an ongoing system of temperature monitoring, ensure the potency of vaccine from manufacturer to administration.
6. Encourage national participation in WHO approved system of vaccine procurement and testing.
7. Develop at each level reasonable targets for coverage and objectives for disease reduction.
8. Develop simple monitoring of process and outcome indicators with analysis and use at level of collection.
9. Strengthen training and retraining with emphasis on continuity of program leadership and mid-level management.
10. Develop national commitment to problem identification and an operational research approach to finding solutions.

E. Public Involvement in EPI

Effective immunization requires the active participation of target populations.

Potential Areas for AID Support to National EPI Programs

1. Develop a communications strategy with the assistance of consultants, e.g., Pritech, to convey importance of and plan for immunization to:

- policy makers
 - health workers
 - local leaders
 - target population
2. Pretest, monitor and constantly revise the communications strategy.
 3. Utilize local social science expertise to identify social and cultural beliefs toward neonatal tetanus and measles and their prevention by immunization.
 4. As part of routine supervision, determine patient perceptions of services provided and need for follow-up through exit interviews.
 5. As part of coverage surveys, identify reasons for and constraints to public participation in immunization.
 6. Coopt, where possible, existing organizations to support on-going immunization programs e.g., political parties, schools, Rotary Clubs, etc.

F. Recurrent Costs of EPI

Immunizations, once started, require long term funding.

Potential Areas for AID Assistance

1. Assist national governments in accurately estimating costs of immunization.
2. Develop and test approaches to cost sharing (user fees) and auto-financing.
3. Document cost effectiveness of immunization.
4. Develop long term budgetary plan for immunization.

5. Develop, where appropriate, private physician participation in immunization.

6. Improved Vaccines

Maintenance of vaccine potency in the field is still a serious problem. Current measles vaccines do not protect children under 9 months, a group in which up to 30% of cases occur.

Recommendations for AID

1. Develop, test and make available measles vaccine which will effectively immunize children at an age early enough to block disease transmission.
2. Continue to support development of an affordable solar refrigerator.
3. Support testing and introduction of time temperature markers.
4. Support, where reasonable opportunities for success exist, the development of heat stable vaccines.

NEONATAL TETANUS - CAUSE, RISK FACTORS, AND PREVENTION

MORTALITY: ONE NEONATAL TETANUS DEATH PER 100 LIVE BIRTHS (RANGE 0.1-6.6)

CAUSE: INFECTION OF UMBILICAL CORD AND OR CIRCUMCISION SITE WITH TETANUS SPORES AT TIME OF CUTTING OR THROUGH ENVIRONMENTAL OR DRESSING CONTAMINATION

RISK FACTORS:

UNIMMUNIZED MOTHER
HOME DELIVERY
ATTENDANT UNTRAINED IN ASEPTIC CORD CARE
ANIMAL EXPOSURE
MALE
PREVIOUS TETANUS DEATH IN FAMILY

PREVENTION:

TWO DOSES TETANUS TOXOID FOUR WEEKS APART
BOOSTERS AT THREE AND FIVE YEARS

STRATEGY:

IMMUNIZATION OF PREGNANT WOMEN

INDONESIA

ONLY 143 OF 2261 WOMEN WITH 2 OR MORE CONTACTS WITH HEALTH FACILITY DURING PREGNANCY RECEIVED 2 DOSES OF TT - - 47 NEONATAL TETANUS DEATHS (20.8/1000)

2047 WITH NO CONTACT; 74 NEONATAL TETANUS DEATHS 36.1/1000

IMMUNIZATION OF FERTILE AGE WOMEN

M.

NEONATAL TETANUS DEATHS PER 1000 LIVE BIRTHS

COUNTRY	AREA	NEONATAL TETANUS DEATHS PER 1000 BIRTHS		REFERENCE
		URBAN	RURAL	
BANGLADESH	NATIONAL		37	WER 1982; 57:138 WER 1982; 57:138
			27	
INDIA	ANDRA PRADESH	2.7	6.8	BHARGAVA AND SOKEY <u>THE CONTROL OF NEONATAL TETANUS IN INDIA</u> DELHI 1983
	BIHAR	5.3	11.3	
	DELHI	1.0		
	GUJARAT	1.9	5.8	
	HARYANA, PUNJAB			
	CHANDIGARH	3.1	8.4	
	KARNATAKA, GOA	1.5	5.1	
	KERALA	1.9	1.9	
	MADHYA PRADESH	1.4	20.4	
	MAHARASTRA	4.9	4.7	
	ORISSA	2.0	8.6	
	RAJASTAN	3.4	13.5	
	TAMIL NADU	0.0	4.9	
	UTTAR PRADESH	15.3	66.6	
WEST BENGAL	5.0	11.9		
INDONESIA	JAKARTA	6.9		WER 1982; 57:392 WER 1983; 58:56
	NATIONAL		10.7	
	NTB		17.6	
PAKISTAN			15	ISLAM PAK PED J 1982; VI:228-233
PAKISTAN		21	33.7 (AGRICULTURAL) 42.5 (CATTLE)	SULEMAN PAK PED J 1982; VI: 152-183
PHILIPPINES				
CEYLON				
SIERRA LEONE			5	NADDA SRIYABHAYA PAK PED J VI:246-249

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RECOMMENDATIONS FROM NUTRITION WORKING GROUP

I. AID Constraints to Implementation

A. Staffing

1. AID has very few nutrition foreign service positions and, with limits placed on adding more positions, missions must acquire the expertise needed to implement Agency policies and strategies from other sources. AID officers who manage nutrition-related projects need specialized training in nutrition topics such as breastfeeding, weaning foods and practices, growth monitoring, common international nutrition problems and solutions, and some nutrition economic and policy options. In addition, AID technical officers need to know how to integrate nutrition into the design and implementation of health and agricultural projects. Nutrition officers also need training in health and population technical matters, ORT and immunization in particular.
2. AID personnel policies with respect to maternity leave have not kept pace with changing characteristics of the technical staff. This is particularly true in nutrition because of the high proportion of nutrition officers who are females. AID supports breastfeeding for LDC mothers but does not exercise sufficient flexibility to enable staff to breastfeed.

Recommended AID Actions

1. The S&T Bureau should develop a program of technical training for in-service training of health, nutrition and population officers. The scope of this training should be designed to encompass topics important to the implementation of nutrition projects as well as policy and strategy formulation. The training should be organized into packages of material of varying depth that can be taken sequentially as short-term units or put into a long-term training format.

2. The Asia Bureau should support a training program to upgrade PHN officers in nutrition at the rate of one mission per year, or faster if a mission feels the need.
3. The Personnel Division should review policies, such as maternity leave, and bring them into line with good nutrition practices.

B. Food AID Programming

AID's major nutrition resource is PL 480 food. Utilizing this food to affect nutrition requires imaginative program design. This is important given the lack of a guaranteed, long-term supply of Title II food and the disruption of growth monitoring programs when food is withdrawn.

Recommended AID Actions

1. The Nutrition Working Group recommends that nutrition/food supplements (including PL 480, Title II and WFP) not be given in a long term, saturation manner but be targeted to children under 3 years recovering from serious illness, especially measles, malaria or diarrhoeal disease, or any child with PEM and growth faltering.
2. Title III food and/or proceeds should be used for the development of nutrition policies and for the support of action programs to implement the policies.

C. Nutrition Focus

AID has no organizational focus on nutrition activities to back up host country or AID nutrition policies. Mission strategies and project portfolios often fail to assess and/or address nutrition problems of the host country.

Related to this, the AID health strategy has been too preoccupied with mortality reduction with little concern for nutrition-related morbidity. Improved nutritional status is basic to improving the quality of life.

Recommended AID Actions

1. CDSS documents should provide assessments of the local nutrition and food situations. This will enable missions to plan actions in relation to the nature and magnitude of the food and nutrition problems.
2. We recommend that nutrition efforts focus on improving the nutritional status of the 0-3 age group and pregnant and lactating women. Even if ORT and immunization programs are effective in reducing mortality, the risk of malnutrition will still be as important as ever.

II. Technical Needs

A. Growth Monitoring Activities

Growth monitoring (GM) is widely accepted (in principle) as an element of basic Primary Health Care (PHC). Six of nine USAID-assisted Asian countries are involved in such programs, although most are poorly designed and implemented.

Recommended AID Action

Of all PHC activities, GM at the village level provides regularly recurring contact between mothers and the health system within which other PHC activities can be delivered (ORT, EPI, FP, malaria, Vit. A, Fe/FA, etc.). GM is an essential PHC activity and efforts should be used to introduce and/or strengthen such programs in all AID-assisted programs in Asia. Technical aspects of growth monitoring are discussed on page 11.

B. Community Nutrition Programs Supported by AID in LDCs

The working group believes that lasting and self-reliant nutrition improvement programs are most likely to exist if organized and implemented by the community. Such programs however, have special design and follow-up requirements.

Recommended AID Actions

1. Program messages should be based on village-level information on current beliefs and practices of mothers.
2. Program messages, educational and training materials and methodologies should be field tested prior to use in a large scale program.
3. AID should encourage tailoring nutrition programs to accommodate regional diversity within countries.
4. Components of an integrated program should be included based on the epidemiology of the target population.
5. Consideration should be given to the sustainability of a program following withdrawal of donor resources. Income generating schemes may be a means for providing a village with a mechanism for sustaining their program.
6. Community nutrition groups should include no more than 25 participants with a sufficient number of village health/nutrition workers (VHW) to conduct one-to-one health education. The number of posts per village should be calculated based on this ratio. Where growth monitoring is included, VHWs must be trained to interpret growth charts and provide appropriate messages to the mothers. Growth monitoring without nutrition and health education is not an effective nutrition intervention. Training programs should provide VHWs with skills to communicate effectively with mothers on this subject.
7. Supervisory systems must be planned based on the number of posts/ meetings per village at the ideal ratio as per point 6.

8. Where resources are scarce, growth monitoring programs should focus on under 3 year olds rather than under fives. Mothers should be encouraged to enroll their children in growth monitoring programs between four and six months of age.
9. Follow-up and referral health services must be provided.
10. The health system evaluation of growth retarded children should include examination of the ears, skin and mucous membranes, lungs, abdomen, and stool and urine as equipment is available. Diseases commonly causing growth retardation include otitis media (ear); eye and skin infections (boils, scabies, etc); pneumonia, including tuberculosis; living parasites and pathogens (intestine); and urinary tract infections (kidney and bladder).

C. Nutritional Activities in the Health System

Health systems often do not monitor as broad a range of nutrition status indicators as they should.

Recommended AID Actions

The Nutrition Working Group recommends that the following nutritional deficiencies be monitored primarily by the health system as nutrition/health problems requiring intervention through health centers and health workers.

1. Iron deficiency anemia/folic acid deficiency, especially in pregnant women and in children under three years.
2. Vitamin A deficiency, especially in children under five years.
3. Iodine deficiency (cretinism, deaf mutism, and goitre).
4. PEM (Protein/Energy Malnutrition).

Monitoring should include disease epidemiology and targeting as well as operations research (where needed).

As low birth weight (BW) is one of the most sensitive indicators of community health, the health system should monitor BW as a key epidemiological tool to detect subpopulations where formal nutrition and health interventions are needed. In addition, the importance of monitoring maternal nutrition status and infections during the peri- and postnatal periods and intervening, where necessary, is essential and needs increased attention in AID's Asia projects.

D. Food Supplements as Part of Community Nutrition Programs

Food supplementation programs are often too poorly designed to achieve nutrition and/or development objectives.

Recommended AID Actions:

1. It is recommended that experimentation be done with distributing food supplements in a similar manner as medicines, i.e., for 5-10 days after illness in addition to the normal diet. Preferably, these supplements should be given at separate sites and by separate organizations than those involved in delivering health services and doing growth monitoring. However, food may be given at the village level.
2. Further research is needed to determine the optimal length of time and quantity of food supplements that should be given to ensure maximum catch up growth.
3. The Nutrition Working Group recommends that special attention be paid to the health and nutrition status of adolescent females. Distribution of food supplements to these malnourished women should be tested to see if catch up growth occurs. Such a project could also include education in literacy, health, nutrition, childcare, family planning and training in activities leading to income generation. Besides directly improving the mother's nutrition status and knowledge, such an intervention has potential for delaying age

at marriage and first pregnancy with subsequent improvement in health of both the mother and her future children.

E. Weaning Foods

Appropriate and affordable weaning food is seldom available in villages

Recommended AID Actions

1. Further study and attention to weaning foods, with special focus on locally produced foods of high nutritional value is needed.
2. Easy, low-cost food processing techniques such as roasting, malting extrusion and fermentation of staples that increase flavor, preservation, energy density and perhaps quality of food deserve special attention.
3. Social marketing strategies for weaning food should stress the newness and modernness of the foods, despite the local origin or traditional ingredients used in the weaning food.

F. Other Research Priorities

The Nutrition Working Group feels that there are special nutritional problems associated with rapid, uncontrolled urbanization. These problems include, but are not limited to, breastfeeding decline, inadequate water supply and sanitation facilities, lack of creches for children of working mothers, and inadequate health/nutrition delivery systems.

Recommended AID Actions

We recommend a central operations research project be established which can make funds available for nutrition studies (many referred to herein). This fund should be accessed by missions and contractors to acquire facts needed for project design.

III. Policy and Planning Constraints at Country Level

The multi-sectoral nature of nutrition problems and division of responsibility among a number of ministries frequently results in nutrition not receiving the concerted attention, coordination and continuity needed. Diverse approaches by various donors also lead to coordination problems and conflicts. There is no "quick fix" for malnutrition, and a long-term commitment of resources to programs is essential. The lack of impact in the short-term is a characteristic of nutrition interventions which may lead to discouragement and premature abandonment of programs by governments and donors. The long-term nature of these programs also can lead to a heavy recurrent cost burden on governments for staff and food, particularly after donors withdraw and Title II food aid declines.

Some countries also have been using growth monitoring incorrectly as an end in itself with no link to an action response to promote growth in children who are found to be faltering.

Scaling up from pilot projects to large scale, national projects has sometimes been done too fast with inadequate attention to quality of services delivered and need for modifications.

Recommended AID Actions

1. Countries should assign one ministry or planning body the lead role for nutrition or form an active coordination and planning committee with key ministries represented. This responsible body should coordinate and orchestrate the work of various programs and donors.
2. In choosing to tackle the undernutrition problem, countries should be made aware by AID and others donors of the level and duration of commitment required to see results.

3. With reference to the recurring cost burden imposed by these programs, AID can help host countries by thorough economic and financial analyses of nutrition interventions.
4. Costs of community nutrition programs should be minimized by asking participating families to contribute financially to pay the worker. Supplementary feeding should be short-term and targeted on malnourished children, thereby minimizing Title II or local food requirements. This lends itself to a policy dialogue between AID and host governments and to better guidance from FYA/FFP and AID/W on targeting of MCH feeding programs.
5. Scaling up pilot projects to national coverage should be done in a phased manner with a built-in feedback mechanism for making necessary modifications and improvements.
6. AID, other donors and host countries should consider working in those villages where community nutrition programs already are in place. Such programs should also support income-generating activities, particularly for women, to get at the root causes of poverty-based undernutrition.

IV. Growth Monitoring

Recommendations

It is essential that AID HPN staff and host country counterparts:

1. Better understand the difference between growth monitoring (GM) and nutritional status assessment as follows:

<u>Growth Monitoring</u>	<u>Nutritional Status Assessment</u>
Dynamic	Static
Immediate situation	Cummulative over years
Frequent monitoring	Periodic measure
Early warning	Late results
Brief reaction/response	Long response needed
Small group activity	Large group
Active interaction with mother	Mother passsive
Mother is best measurer	Professional measurer best
Other PHC inputs indicated	Nutrition rehabilitation needed

2. Better understand the key elements of GM success as follows:

- Mother based - responsible and active
- Age of enrollment - less than 6 months
- Normal nutrition at enrollment - focus on promoting this.
If rehabilitation is needed, send outside of GM program.
- Small group--20-25 mothers or less
- Action response to faltering-growth:
 - Home action - possible and realistic
 - Mother pairing - successful neighbor as teacher
 - Credible referral - health center takes some action

- Growth Chart Design and Use
 - Mother retained, and as indestructible as possible
 - Designed for mothers not nutritionists
 - Individualized growth channel - expected trend
 - (Avoid linear and nutri-status)
 - Scales--easy to use, durable, new digital, solar powered
 - Teaching of mothers should have phased introduction of messages and activities over months or years; mothers' understanding and competence should be tested prior to introducing new ideas/actions
3. Avoid the following program features which guarantee failure of GM programs (or any health, nutrition or population program):

- Make mothers passive participants
- Admit older children
- Have large group (more than 30)
- Emphasize group (not individual) results
- Keep cards at the Health Center
- Do not encourage mother-to-mother interaction
- Have no back-up for kids who fail to grow
- Have referrals greeted with refusal at Health Center
- Have no other PHC services provided along with GM

While GM comprises an important individual health monitoring activity, it is, by itself (weighing) of no value. Thus, half measures are often not productive or even counter productive. GM can form the basis of village operated PHC activities leading to a sustained PHC program that provides useful data on the nutritional health of a population as well as for individualized health and nutrition cases.

RECOMMENDATIONS FROM POPULATION WORKING GROUPS

WORKING GROUP A

I. Host Country Management and Implementation

Many of the constraints to improved program management are the same that have troubled Asian programs for the past five to ten years. In some areas there has been significant progress; however, fundamental problems remain.

The sense is that the private sector can do much more to assist Asian countries overcome many implementation constraints. As a general recommendation, the Working Group feels strongly that program managers should use more private sector talent in MIS development, IEC and training. Governments should turn increasingly to the private sector for assistance in these areas and AID should assist.

The third general point is that only those constraints for which the Group was able to develop specific actionable recommendations are included in this report. There was not nearly enough time to cover all constraints to improved program management.

Donors, especially AID, should not always focus assistance on areas that need improvements. Rather, they should provide assistance for activities that governments have demonstrated they can implement. This will help to accelerate program implementation in some areas.

II. Constraints and Recommendations for Improved Host Country Management and Implementation

A. Management Information Systems

In many countries, program managers still do not have accurate and timely program information upon which to make decisions. Often times, inappropriate technology has been used to develop MIS.

Recommendations

AID needs to devote increased resources to both informal and more structured systems of gathering and assessing large amounts of program information. Informal systems should be encouraged in countries where other types of MIS have not been implemented well.

B. Lack of Trained Program Managers and Supervisors at All Levels

This seems to be a major constraint in almost all countries and an area of concern that has become more serious in the past five years.

Recommendations

A major new effort should be undertaken with multi-donor support to increase assistance for in-country as well as U.S. training in management and in academic studies such as demography. Missions should undertake a review of training needs and incorporate short and long term training assistance in projects. Asia/TR and S&T/POP should review this area with other donors and decide on a division of labor for assistance.

C. Recurrent Cost Financing

Increasing evidence suggests that governments can no longer afford the recurrent costs of monitoring large delivery programs.

Recommendations

Missions should assist countries to improve the cost effectiveness of programs by funding operations research which looks into alternate ways of organizing and managing service delivery. Community financing schemes should be tried. AID should assist the countries in ASEAN to determine the feasibility of procuring oral contraceptives from Indonesia as a way to lower their dependency on AID procurement.

D. Technology

Present contraceptive technology is limited. Some countries have not introduced all existing appropriate contraceptive technology into their programs.

Recommendations

S&T/POP should continue to finance the development and improvement of contraceptive technology. Missions, in concert with S&T/POP, should assist programs to introduce existing technology by financing field trials and by systematically providing research results to program managers.

E. AID Regulations and Procedures

AID regulations and procedures are a serious constraint to improved program implementation and they are getting worse.

Recommendations

Missions and Asia/TR should document for senior Agency management, case histories of how AID procedures and regulations impede our work so that this information can be used in Congressional testimony and other ways to argue for sanity in our assistance programs.

F. Logistics

Great improvements have been made in family planning logistics systems during the past five years. However, much more needs to be done.

Recommendations

Logistics is a component of the program where the private sector can play a much greater role than it has in the past. Program managers and mission population officers need to figure out how the private sector can play a greater role.

G. Program Promotion

Many programs have lost their IEC creativity and there is a tremendous need for innovation in this area.

Recommendations

Again, the private sector should be used far more extensively than it has been in the past. The health benefits of family planning need to be emphasized. There is a need for inter-country sharing of ideas. ST/POP needs to focus more of its central resources on Asia in this area.

WORKING GROUP B

I. Constraints and Recommendations for Improved Host Country Policy

A. Government Policy Against Family Planning Services

1. Where a host country government's policy is not supportive of offering family planning services, e.g., Burma, AID should assist in reviews of the health, economic, social and human rights benefits of family planning services, and pursue existing interests rather than confront existing policies.
2. Where selected family planning services, i.e., methods, are not available, AID should be sensitive to the reasons for their exclusion. Substantive reasons should be addressed with O.R., clinical trials or training; socio-cultural and political reasons, e.g., VSC in Indonesia, should be accommodated by looking for acceptable alternatives such as the use of the private sector or a proper euphemism to describe the procedure.
3. AID should encourage host country family planning program development with broad-based donor and local support so that institutionalization will not be excessively threatened by vagaries in donor/recipient and local political relationships.

B. Recurrent Costs

From the outset, AID should encourage careful consideration of costs, benefits and ultimate sources of financing for long-term recurrent costs with phased introduction of some method(s)--e.g., host country financing, user fees, prepaid subscription, commercial sector--of local financing of recurrent costs.

C. Government Acceptance of Technical Assistance

1. All non-commodity inputs in social sector programs should be grant financed to enhance acceptability to host country and facilitate

implementation of most critical project inputs, e.g., TA, training, local costs.

2. AID should encourage maximum use of locally available technical skills for project design, implementation and evaluation for both economic and institutional reasons. In addition, AID should find ways to make use of local consultants that are easier to access.
3. Since host countries are often sensitive or resistant to receiving technical assistance which we perceive to be required, the need for adequate AID technical staff takes on greater importance (either expatriate or local national). The shortage of AID technical staff requires that AID "technical advisors" become increasingly involved in AID implementation activities which lowers their perceived value to the host country government.

D. Government Policy vs. Implementation Gap

AID should examine and encourage host country programs to examine evidence of stated policy (budgets, leadership, etc) as one measure of likelihood of success and, to the extent possible, should try to encourage host countries to manage their inputs to achieve the highest expected value from program inputs.

E. Government Use of and Commitment to Research

1. AID should encourage host country use of operations research to gain rapid acceptance or rejection of new concepts, resolve uncertainty in program implementation issues, accelerate the process of implementation and modify program design.
2. Where family planning services are part of general health services, a discrete management unit capable of management by objectives for family planning only is essential. AID should encourage the emergence of strong program management irrespective of ideology regarding integration.

WORKING GROUP C

I. Constraints and Recommendations for Improved Population Program Implementation

A. AID Policy

Certain AID policies regarding birth control constrain AID's ability to be an effective donor in many countries. Examples include the restrictions of supplying certain methods, e.g., Depo Provera, and policies regarding provision of services, e.g., voluntary sterilization, injectables. These restrictive policies can lead to strained host country relations where the host country desires assistance in these areas, and ultimately, impaired program performance.

Recommendations

While AID/W has the ultimate authority to determine whether or not specific project activities are in compliance with policies and guidelines, in general AID/W should delegate to missions the authority to determine compliance with the substance and, more importantly, the spirit of policies and guidelines. This approach is required by the great variability in local context. Where AID/W and a mission disagree on the question of compliance, it may be desirable to consult outside experts on the issue and to examine carefully the local context.

B. Staffing

Some missions do not have enough professional population staff to perform effectively. Also, existing staff need continuing training to upgrade skills and keep current with developments in the field (both health and population).

Recommendations

1. Additional population staff should be recruited and placed in missions which are understaffed.

2. HPN officers should receive mandatory refresher training during the course of home leave which should be financed with AID/W training funds. This mandatory training should be required every four or five years.
3. Generalists--program officers, project development officers--can be assigned to technical officers to assist with the day-to-day project management, e.g., contracting, finance management.
4. Ability to hire capable FSNs to assume many of the duties of direct hires.

C. Central/Bilateral Funding

There are not enough central funds for population programs in Asia, especially in the face of declining bilateral programs in some areas and a shift to a larger loan portfolio which makes it more difficult to develop and implement population programs.

Recommendations

1. PPC should allocate more population funds to the Office of Population and/or more funds should be given to the Asia Bureau to establish a line item account to support central population activities in Asia missions.
2. Missions should be required to develop comprehensive long-range strategic plans for achieving country population objectives which would take into account all possible sources of funding support and which could be used as a basis for AID/W planning and resource allocation.

e. Grant/Loan

There are not enough grant funds. Given seriousness of population problem, population programs should be given priority in allocation of grant funds as it is very difficult to fund population programs with loan funds in most instances.

Recommendations

Missions should be allocated sufficient grant money to supplement loan financed activities, e.g., purchase of contraceptives, where such grant funds are essential to carry out activities necessary for project achievement, e.g., technical assistance.

E. Contracting

AID contracting procedures undermine efficient implementation. These procedures:

- are time consuming, resulting in project delays;
- have unrealistic competitive requirements, even for small procurements;
- impede selection of qualified, experienced contractors;
- can cause strains with host country;
- are very staff intensive and take technical officers away from technical jobs; and
- force USAID into host country contracting mode (which may be fraught with its own problems.

Recommendations

1. The Contracts Office should adopt the IQC concept or "options" approach, as used in the central procurement of contraceptives, in setting ceilings for central technical assistance contracts.

2. The Contracts Office should shorten/streamline the direct procurement process for PSCs, other TA and commodity purchases.
3. No formal competition for PSAs should be required.
4. IQCs should be negotiated at a lower rate so that more missions can take advantage of this less time-consuming mechanism of contracting. Now IQCs are seen as too expensive.
5. ST/POP should make provision in its new technical assistance contract for the contractor to establish rosters of developing country consultants for each region.

WATER AND SANITATION IN ASIA BUREAU HEALTH STRATEGY

I. Introduction

Water supply and sanitation (WS/S) was included in the conference agenda to encourage further consideration of the Asia Bureau strategy in the sub-sector. A role for the Agency in Asia recognizes:

1. WS/S is a multisectorial issue and should not be considered a health sub-sector only.
2. Significant amounts of funding for WS/S projects are likely to be provided from other AID accounts as part of large water resource development programs or from other donors.
3. Primacy of development banks as major donors in the WS/S sub-sector.
4. Important technical coordination role of international agencies such as WHO and UNICEF.

The Asia Bureau HPN office, therefore, should identify specific components of comprehensive WS/S programs which:

1. match Bureau HPN interests and program backstopping capabilities of HPN;
2. are not being met adequately by other donors; and
3. are realistic given the overall financial and administrative limits.

In general, the strategic approach should be to join with other donors in the sub-sector so the specific concerns of the health sector could be incorporated into large WS/S projects funded primarily by development banks, international development organizations (UNDP or UNICEF) or other AID programs (HIG, irrigation projects). The following table identifies those parts of the spectrum of WS/S activities which are appropriate areas for AID support. These areas may range from a "possible" to a "major" role depending on the situation in the country involved.

WATER AND SANITATION IN THE ASIA BUREAU HEALTH STRATEGY

<u>Problem</u>	<u>Situation Satisfactory</u>	<u>Assistance Available From:</u>	<u>Role for AID</u>
1. <u>Policy Dialogue</u>	No	Development Banks Other Bilaterals	Yes
2. <u>Planning and Design Capability</u>			
Project Preparation	No	World Bank	Yes
Technology Development:			
Water	Yes	--	No
Sanitation	No	UNDP/World Bank Technology Advisory Group	No
Tariff Structures	No	Development Banks	No
Information on Health Impact of Different Levels of Service	No	Some from WHO	Yes
Incorporating Health Considerations into Design Practices	No	None	Yes
3. <u>Management Tools</u>			
Performance, Utilization and Health Impact Evaluation Methods	No	WHO	No
Financial Management	No	Development Banks	Yes
4. <u>Management Practice</u>			
Monitoring and Evaluation	No	Little Available	Yes
Financial	No	Little Available	Yes
Manpower Development	No	Some Bilaterals	Yes

II. Summary of Possible Role for Asia Bureau

A. Strategic

Consideration should be given to increasing the priority given to low-income urban areas both for projects and for technical assistance through the WASH project.

B. Applied Research

1. The conduct of evaluations of performance, utilization and impact, with particular emphasis on the vital area of the health impact of different levels of water and sanitation service.
2. Developing techniques/methods for incorporating health considerations into water and sanitation project design.

C. Institution Building

1. Management support and manpower development for host country water and sanitation implementing agencies.
2. Short-term training for Asia Bureau Health Officers in water supply and sanitation.

D. Policy

1. AID should use AID/W resources to address health issues in water resource development projects, including social soundness analysis of all projects.
2. AID should promote the recovery of recurrent costs through subsidized financing or user fees in policy dialogue.
3. Central resources such as the WASH project should be used to identify potential roles for AID in WS/S projects. In many instances, appropriately timed TA from AID/W can achieve WS/S subsector goals by promoting health concerns in large water resource development projects funded by other donors or from other accounts within AID.

MALARIA CONTROL IN ASIA BUREAU HEALTH STRATEGY

I. Introduction

Malaria continues to be a serious problem in many parts of Asia. In spite of major achievements made in controlling this disease over the last two decades, there is still a reservoir of malaria which impedes economic and social progress in Asia. AID has been a major donor to malaria control programs in Asia and can take satisfaction in the accomplishments made by many countries in developing effective institutions to combat this disease. AID has supported training and research, provided commodities and technical assistance, and has influenced malaria policy and programs not only in Asia, but world-wide. AID support of the international training center in Manila from 1963-1973 helped train over 1,200 professionals for world-wide efforts in malaria. In addition to direct program support, AID has helped finance research connected with the development of a malaria vaccine.

Malaria control will be a part of every Asian country's health program for the foreseeable future and it is imperative that the Asia Bureau Health Strategy include support for anti-malaria efforts, both to reduce the incidence where malaria levels remain high and to maintain control levels where incidence has been lowered. Special priority will be given to areas having high infant mortality.

The Asia Bureau should consider in its policy that country commitment, tactical flexibility, use of the primary health care (PHC) systems and research form major elements in a malaria control strategy. Inter-sectoral coordination between malaria control and other country development activities is essential. AID should continue its cooperation with the World Health Organization, other UN agencies, and bi-lateral and private donors in the field of malaria control.

II. Strategy

The objectives of the strategy include:

1. Maintain the gains made to date and improve on these gains where possible.

2. Consider increased malaria control assistance to those areas in need which are not now receiving assistance either through the PHC and/or selective care delivery systems.
3. Apply the Tactical Variants (I, II, III, IV) as appropriate within the country. (See proceedings of AID Malaria Strategy Workshop for detailed description of these.)
4. Increase effectiveness of the malaria control efforts through improved program design, management and implementation.
5. Increase participation of the community and other development sectors (e.g., irrigation programs) in the field of malaria control.

In order to respond to epidemics, focal outbreaks, and unusual occurrences of the disease which affect the economic and social well-being of the country, the Asia Bureau may still have to provide issues and transfers (e.g., for commodities) on a highly selective basis. Such resource transfers could be made using loan funds and may be viewed as shelf-projects should "fall-out" money materialize.

III. Emphasis of the Malaria Control Strategy

The emphasis of the Malaria Control Strategy should be on research, training, technical assistance, program design and evaluation.

The research should include both operational research, focused on the development, adaptation and transfer of cost-effective malaria control technologies, as well as in-country support of laboratory research activities in malaria control. All research should be aimed at solving problems related to program implementation. AID should consider the use of Asian research institutions and individual researchers to promote country interchange of scientists. Special research emphasis should be on alternative control methodologies, insecticide resistance, parasite resistance and changes in vector behavior.

Training assistance should be aimed primarily at strengthening national training capabilities through support of regional training facilities and possibly through bilateral project support. In addition, short-term training of AID field staff in techniques and methodologies of malaria control should be carried out. Specific participant training may be short or long term in nature and carried out in the U.S. or at the regional level; emphasis should be on regional training with special attention to developing epidemiological skills, vector biology, parasitology and management. Training should be provided to public health personnel as well as those assigned specifically to the malaria control program.

Program design and evaluation activities, such as epidemiological surveys, economic analyses, field evaluations and preparation of plans of operation and research protocols, should also be supported.

Technical assistance (TA) for operational, technical and administrative tasks are to be provided. TA can be provided for malaria control activities within a primary health care system or a specialized anti-malaria activity.

IV. Recommendations for Malaria Control Strategy

The Asia Bureau should support the following actions on a prioritized basis in the development of a malaria control strategy:

1. Pending a further review of Secretariat activities, consider (in cooperation with WHO and other donors) increased attention to the Regional Malaria Training Secretariat in Kuala Lumpur, Malaysia.
2. Establish a regional Bureau funded project to provide technical assistance to individual countries on a selective basis and to assist, where appropriate, in the orderly phase-out of bilateral funded program activities. The project should include funding for resident staff and their travel and should allow for buy-ins from bilateral programs when available. Examples of specific TA activities are:

- a. Assistance in the development of country strategy, training, and research programs.
 - b. Participation in external assessment teams.
 - c. Development of project assistance documents.
 - d. Assistance in inclusion of malaria control activity in country PHC programs.
 - e. Assistance to help address technical and management problems related to program implementation.
3. Individual bilateral malaria control and/or health projects should consider applying the following Tactical Variants as guides to levels of activity:

TV-1 = Reduction and Prevention of Mortality.

TV-2 = Reduction and Prevention of Mortality and Morbidity.

TV-3 = Reduction of Prevalence and Endemicity of Malaria.

TV-4 = Country-wide Malaria Control.

These Tactical Variants are further described in the recommendations of the report of the June 1983 AID Malaria Strategy Workshop. Within these Tactical Variants, funding support and program emphasis should focus on policy/strategy dialogue, research, training, technical assistance, project design/evaluation and institutional development.

4. The Asia Bureau malaria control strategy should take into account the individual country variations and rapidly changing malaria conditions in the Region.
5. The Asia Bureau should encourage Centers for Disease Control (CDC) scientists to make use of the on-going research programs of the Office of the Science Advisor and the National Academy of Science (BOSTID).

V. Summary

The Asia Bureau should continue to support malaria control activities in Asia. A revised malaria control strategy for the Asia region should include an emphasis on training, research, program design/evaluation and technical assistance. This represents a major shift from earlier malaria program support which often included major investments in insecticides.

Asia Bureau support of a regional training/research project is considered essential as a bridge between the bilateral malaria control projects, other mission health activities and Asia Bureau health interests. In special cases, the use of resource transfers may be appropriate.

RECOMMENDATIONS FROM SPECIAL CONCERNS WORKING GROUPS

A. Communication Review Board

AID's Communication Review Board appears to be able to turn down requests for clearance of proposals for communication tools which come under its purview without having to explain formally why the proposal was turned down.

Recommendation

It is the unanimous sense of the HPN Conference attendees that the AID Administrator direct the Communication Review Board to provide a formal reply to the submitting officer documenting the reason(s) why a request for approval has been turned down at the same time the disapproval notification is sent.

B. Staffing

1. Demands of project management in social sectors, especially HPN, allow inadequate time for fulfilling other essential roles.
2. The shortage of HPN staff is compromising the quality of implementation.
3. Decentralization from AID/W to field and within missions may compound the problem; increasing generalist personnel in missions will offer little or no relief.

Background

The greatest constraint to better utilization of existing HPN skills is a multi-dimensional staffing problem:

1. Since 1968, AID staff has been reduced by 70%; a shortage of technical and project staff compared to management, program, P.D. and support staff has emerged.

2. AID's outmoded, cumbersome project design and implementation system forces us to focus most of our time on eliminating bureaucratic roadblocks to input achievement rather than focusing on improving linkages between output and purpose. (Our production/assembly line is inefficient and requires retooling if we are to reach our objectives with reduced staff.)
3. Because the system demands most HPN time for project implementation hurdles, other HPN officer roles get neglected, including:
 - a. Sector managers of HPN resources;
 - b. Development managers in context of CSSS; and
 - c. Outreach workers for 4 pillars (institution building, policy dialogue, technology transfer and increased use of the private sector.)

Recommendations

1. Increase HPN technical/project officer staff as a percent of total AID staff (transferring PD officers to field will not alone offer the relief required).
- B. Begin dialogue with AID and with Congress regarding the need to scrap the existing programming system for HPN in favor of programming and financing based on outputs or purpose (e.g., reduction in IMR, increase in contraceptive prevalence, increased EPI coverage).

C. AID/W Funding for Asian Population Programs

There is a problem of a shortage of funds for ST/POP to meet the demand for centrally financed population projects in Asia. The working group recognized that although important and legitimate needs exist for

central population support for Africa and certain Latin America countries, this support should not be given at the expense of the Asia region, which contains almost 1/2 of the lesser-developed world's population and where absorptive capacity is generally high.

Recommendations

1. AID/W should allocate a greater percentage of Agency population funds to S&T/POP to meet the worldwide demand for centrally-financed and managed population project support; Asia should be given a higher priority for funding than now exists.
2. In the absence of the above, the Asia Bureau should establish a budget line item to supplement and expand S&T/POP activities in Asia. However, this should not be done at the expense of Mission OYBs.
3. PPC should reallocate under-utilized population funds in other AID/W Bureaus to the Asia Bureau for establishing the line item described above for transfer of POP funds to S&T/POP for use in Asia.
4. S&T/POP should allocate a relatively higher percentage of its current budget for central project support for Asia.
5. S&T/POP should immediately advise population intermediaries or cooperating agencies such as FPIA and IPAVS to increase their program effort in Asia in consultation with Asia missions.