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**Presidential Mission to Africa
January 4-18, 1991**

EXECUTIVE SUMMARY

In his remarks at the World Summit for Children at the United Nations on September 30, 1990, President Bush called upon Secretary of the Department of Health and Human Services (DHHS) Louis W. Sullivan, M.D., and Administrator of the U.S. Agency for International Development (USAID) Ronald W. Roskens, Ph.D., to go to Africa *"to see what else America and the world can do to advance child survival across that continent and the world."* In response to the President's challenge, Secretary Sullivan and Administrator Roskens led a delegation of officials from their respective organizations to seven African countries (Côte d'Ivoire, Malawi, Nigeria, Senegal, South Africa, Uganda and Zimbabwe) to review ongoing activities in child survival and pediatric AIDS prevention and to discuss possible areas of collaboration to further these efforts. A brief stop also was made in Namibia to meet with host country and U.S. officials.

International health statistics indicate that Africa--particularly sub-Saharan Africa--lags behind the rest of the world in the health status of its people. Despite major reductions in infant and child mortality over the past three decades, levels in sub-Saharan Africa remain the highest in the world. Of the 30 countries with an infant mortality rate greater than 100/1000 live births, 23 are in sub-Saharan Africa. This compares with the U.S. infant mortality rate of 10/1000 live births.

The reasons for poor child survival are complex and involve social, economic and political factors which exacerbate common diseases leading to illness and death. The specific conditions that contribute the most to poor child survival in Africa include diarrheal diseases, malaria, acute respiratory diseases, malnutrition, measles and other vaccine-preventable diseases, high fertility, and now, increasingly, AIDS.

In the countries visited, the delegation met a wide range of Africans and Americans concerned with health and development in Africa and saw a variety of child survival and AIDS programs and activities.

Through these discussions and visits the delegation gained further understanding of the progress attained and challenges remaining for improved survival of African children. The following conclusions and recommendations resulted from the Presidential Mission:

- o **Healthy economies provide the resources for healthy children.** U.S. policy should continue to emphasize broad-based economic growth to help create an environment in which health programs will be sustainable and effective.
- o **Strong primary health care policies and systems must undergird health interventions.** U.S. assistance should continue to support targeted child survival activities while promoting policies to advance primary health care and integrated approaches to prevention.
- o **Malaria, the forgotten killer, must be remembered.** U.S. assistance should be intensified toward combating malaria in Africa, helping to develop more integrated approaches to applied and basic research and malaria control programs.
- o **Behavior change is the key to breaking the AIDS transmission chain.** U.S. programs should support additional interventions to promote behavior change, encourage social marketing of condoms and the control of sexually transmitted diseases and support research on other means to reduce HIV transmission, including vaccines.
- o **Rapid population growth can overwhelm health care efforts.** The United States should intensify assistance for improved reproductive health and family planning in Africa and should include efforts to increase the range of choice of contraceptive methods.

- o **Information technology can be more effectively harnessed in the battle to save children's lives.** The United States should explore additional means to ensure that African professionals have access to public health information, technical assistance and training in epidemiology, disease surveillance, computer science and data use.
- o **Stronger institutional linkages can improve the health of Africans and Americans.** DHHS and USAID should disseminate widely the findings of this mission to American academic, philanthropic, health and civic institutions that may be of assistance to health programs in Africa.
- o **U.S. technical assistance has made a difference.** DHHS and USAID should review existing program portfolios to ensure that all appropriate technical assistance consistent with the recommendations of this report is implemented.

I. Purpose and Scope of the Presidential Mission to Africa

The September 1990 World Summit for Children held at the United Nations in New York highlighted the challenges and opportunities for child survival as we enter the final decade of this century. In 1991, some 14 million children will die, approximately one-third of them in Africa alone--most of them from preventable causes. A very high percentage of these deaths will occur in sub-Saharan Africa due to prevalent childhood communicable diseases, malnutrition and high fertility. A major recent threat to the survival of children in Africa is the AIDS epidemic, with an estimated 500,000 infants and children under 5 years of age infected in the last decade and at least twice as many orphaned as a result of one or more parent dying from AIDS.

In light of the tragic health picture in many parts of Africa and to underscore the deep commitment of the United States to saving the lives of the world's children, you challenged us to *"...go to Africa to see what else America and the world can do to advance child survival across that continent and across the world...."*

We defined our mission to include assessment of the following:

- o Progress to date in improving infant and child survival in Africa;
- o Impact of the AIDS epidemic on children and their families;
- o Opportunities for expanding relationships between African and American health institutions; and,
- o Identification of ways we can strengthen the impact of U.S. health, population and nutrition assistance to Africa.

In this context, we visited a range of public and private health projects that have received assistance from both the U.S. public and private sectors. We met with many people: heads of state; ministers of health, finance and planning; representatives of private voluntary organizations; community health workers; university researchers; business leaders working with projects

that link the public and private sectors; U.S. Ambassadors; representatives of U.S. government health and development agencies working in Africa, including USAID, DHHS and the Peace Corps; as well as representatives of the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF).

We also considered some of the complex economic, social and political issues related to improving the health status of African children. Although we focused on ways that the United States could better assist in improving the health of the children of Africa and the rest of the developing world, we believe that the policy recommendations in this document are relevant to all concerned nations.

To develop an appreciation for the wide range of issues and activities related to our charge, we visited Côte d'Ivoire, Malawi, Namibia, Nigeria, Senegal, South Africa, Uganda and Zimbabwe. These countries represent a spectrum of the wide economic, political and cultural diversity of the African continent. Unfortunately, time constraints and political and logistical considerations did not allow us to visit other countries that may have provided us with additional insights. The countries visited, however, did offer us a reasonably comprehensive and representative view of the health problems currently facing this region.

In our discussions with African leaders and others, we stressed our country's commitment to help Africa solve its problems in concert with the public and private sectors of the United States and the world community. We were mindful of your statement at the World Summit for Children: *"Programs can best enhance the welfare of the children by strengthening the mutual responsibilities of public institutions and individual families. We should also look to the private sector as an essential partner. Public efforts on behalf of children should encourage experimentation among neighborhoods and local governments--not stifle it."* These words helped provide the framework within which we viewed the African health picture and the role of the United States.

We studied a variety of child survival and AIDS programs and activities offered through hospitals, clinics and public health programs. In addition to

AIDS, these programs included interventions aimed at diarrheal disease, malaria, acute respiratory infections, measles and other vaccine-preventable diseases and malnutrition. We also visited programs that promote other measures vital to the health of children in these countries such as breast-feeding, family planning and child spacing, and the use of safe drinking water.

We can take great pride in these ongoing activities, which are being supported by the U.S. government both bilaterally and multilaterally, including support through WHO and UNICEF. We, in partnership with other public and private organizations, have helped African nations make significant advances in child survival during the past decade using strategies aimed at primary care service delivery and long-term capacity-building. As you will see from this report, however, a great deal remains to be done, and there are formidable obstacles for African countries to overcome. The United States, therefore, can strengthen and improve its support of African child survival and AIDS-related efforts.

ITINERARY

Nigeria	Jan. 5
Côte d'Ivoire	Jan. 6 - 7
Uganda	Jan. 8 - 10
Malawi	Jan. 10 - 12
South Africa	Jan. 13 - 15
Zimbabwe	Jan. 16 - 17
Senegal	Jan. 18

Brief stops in Namibia and Senegal included meetings with Ministers of Health and other leaders. Much to our regret, Mali could not be included as planned--due to unavoidable schedule changes.

ACKNOWLEDGMENTS

African leaders and the people in each country we visited greeted the U.S. delegation with genuine warmth, enthusiasm and candor. U.S. Missions without exception provided outstanding leadership and support to the delegation. U.S. private voluntary organizations and international donor groups contributed greatly to our fact-finding efforts.

The delegation wishes to extend its deepest appreciation for the information and hospitality shown us by all the Africans and Americans, far too numerous to mention by name, whose active participation in child survival efforts and AIDS prevention are saving lives and making invaluable contributions to human development in their countries.

II. Overview of the Child Health and AIDS Situation in Africa

Of 176 independent nations in the world, 56 are in Africa. Of an estimated 4.1 billion people living in developing countries, 640 million live in Africa. However, it is predicted that the population of Africa will increase by 1 billion people by the year 2025, making the continent the fastest growing region in the world. International health statistics indicate that Africa--particularly sub-Saharan Africa--lags behind the rest of the world in the health status of its people. U.N. statistics for the countries we visited reveal infant (under 1 year) and under-5 mortality rates among the highest in the world.

1988	Infant Mortality (Deaths/1000 Live Births)	Under-5 Mortality (Deaths/1000 Live Births)
Côte d'Ivoire	95	142
Malawi	149	262
Namibia	105	176
Nigeria	104	174
Senegal	80	136
South Africa	71	95
Uganda	102	169
Zimbabwe	71	113
United States	10	13

SOURCE: UNICEF, *The State of the World's Children*, 1990.

Additionally, worldwide:

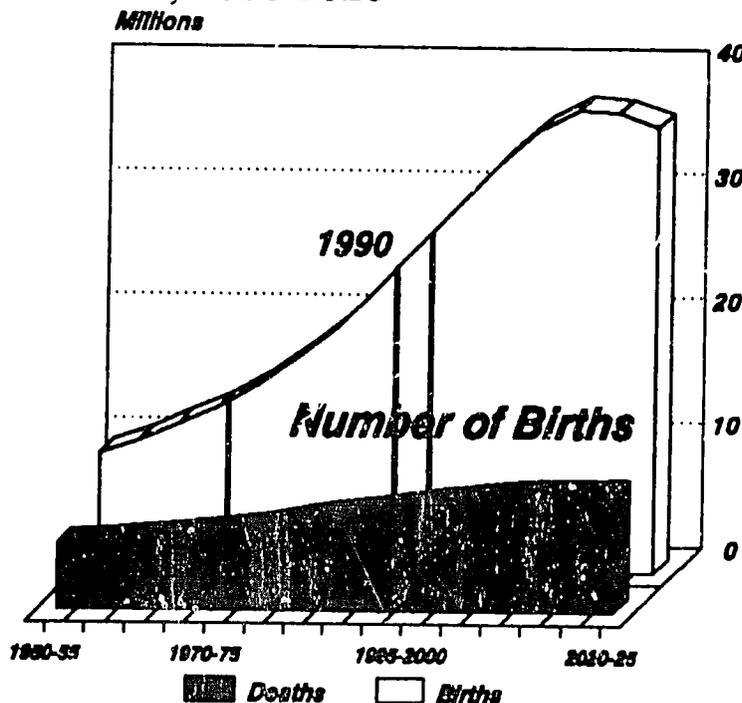
- o Of 30 countries with an infant mortality rate greater than 100/1000 live births, 23 are in sub-Saharan Africa;
- o Of 50 countries with an under-5 mortality rate greater than 100/1000 live births, 33 are in sub-Saharan Africa;
- o Of 40 countries with daily per capita calorie supply less than 100% of the requirement, 26 are in sub-Saharan Africa; and,
- o Sub-Saharan Africa has the highest maternal mortality rate in the world--twice that of North Africa and the Middle East, three times the rate of Asia and 42 times the rate of industrialized nations of the world.

Sub-Saharan Africa Births and Deaths, 1950-2025

African women now average six to eight live births, the highest levels in recorded history at national levels. Births far exceed deaths.

Despite increased deaths in Africa from malaria and AIDS, populations will continue to grow rapidly.

In 1950, about 5 million people were added to the population each year. By 2025, the number will increase to about 30 million people added annually.



SOURCE: World Population Prospects, 1990, United Nations, Medium Variant Projections

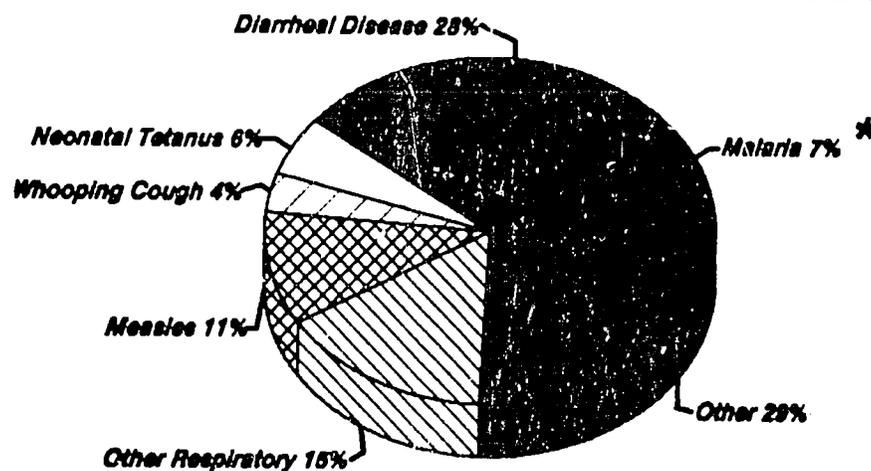
The toll from infectious diseases and malnutrition remains high. The following are particularly acute:

- o Diarrheal diseases and dehydration are the leading causes of infant and child deaths throughout Africa and the developing world. An estimated 4.6 million children die worldwide each year of diarrhea that results from drinking water that contains bacteria, viruses and parasites.
- o Malaria is considered to be the foremost health challenge in Africa. Of the 110 million cases of malaria reported annually, 90 million occur in Africa. One million African children die each year of malaria. The lack of a simple, effective treatment for malaria makes it an ever-increasing threat to child survival. Other parasitic diseases that cause substantial debilitation of children in Africa are guinea worm and onchocerciasis.
- o Acute respiratory infections are a recognized major threat to child survival in the developing world, including Africa. Pneumonia and other respiratory infections are thought to contribute to approximately 1 million childhood deaths in Africa annually.
- o Measles is the leading single killer among vaccine-preventable diseases in the world and is responsible for 1.5 million infant and child deaths annually in the developing world, up to one-half of them occurring in sub-Saharan Africa. Other vaccine-preventable diseases that cause substantial sickness and death in African children include neonatal tetanus, whooping cough, polio and diphtheria.
- o Malnutrition is present in an estimated 30% of African children between 12-23 months. Throughout the developing world, more than 150 million children are malnourished, making them vulnerable to many life-threatening illnesses and diseases as well as decreasing overall physical and mental capacity. In all of the countries we visited, malnutrition was cited as the most important contributor to childhood mortality.

- o AIDS is rapidly becoming a major killer of African children. During the last decade, approximately 500,000 infants in Africa were born with HIV infection. It is expected that by the end of the 1990s there will be an additional 10 million HIV-infected children in Africa. In addition, 5 million to 10 million children less than 10 years old are expected to become orphans in Africa during the 1990s because of the death of one or both parents from AIDS. During this decade, it is estimated that infant and child mortality rates in some African countries will increase by 50% due to AIDS. The AIDS epidemic promises to sap African nations of not only many of their productive adults and leaders but their hope for the future--their children.

Although there are many severe health problems facing African countries, the leaders and people of these nations are strongly committed to addressing these issues. Attendance at the World Summit for Children by high-level representatives from 49 African countries, including 18 African heads of state, underscored their commitment to solving health problems facing their nations' children. President Museveni of Uganda captured the views of Africans and non-Africans alike when he stated at the summit, *"We have realized that meaningful development must begin with the human being, especially the child."*

Causes of Child Deaths Worldwide



* *In Africa, malaria accounts for 20-30% of deaths of children < 5 years old.*

SOURCE: WHO and UNICEF estimates

III. Observations and Findings

Your dispatch of a high-level delegation concerned with the future of Africa and its children, at a time of urgent events elsewhere, was deeply appreciated by the African leaders and citizens with whom we met. Many in Africa continue to seek assurance that Africa will remain a priority for the U.S. government. We attempted to provide that assurance, noting as one example that for FY 1991 the United States had increased the Development Fund for Africa from \$560 million to \$800 million. For most of the countries on our mission, this was the highest level U.S. delegation they had ever received. We were met everywhere with warmth and enthusiasm.

The major observations we made and conclusions we drew based on the visit are summarized below. We have organized our findings, conclusions and recommendations as a composite picture of our visit to multiple countries but also have included references to specific countries when applicable. There is often a tendency to refer to conditions in sub-Saharan African countries as being similar. This mission reinforced our understanding of distinct national and cultural differences in each African country. Although there was similarity between certain problems related to child survival and AIDS across the continent, tremendous variety exists in the nature and magnitude of the responses to these problems and in their successes. Recognition of these national differences is an important component in developing successful strategies for U.S. involvement.

Although observations are based on our experiences in Africa, we believe the conclusions drawn from them are applicable in other developing countries as well.

A. **Health needs must be viewed in their economic and development context.**

Despite progress that has been made in Africa, it is apparent that basic survival is a daily struggle for many families. Most African families have yet to see the benefits of development. Although the focus of our mission emphasized child survival and the impact of AIDS, we did not lose sight of the other enormous problems gripping sub-Saharan Africa:

famine in many countries due either to drought or civil strife; the inability of many countries to produce sufficient food; rapid environmental degradation; a deteriorating economic climate that has seen a 15% drop in per capita income in 65% of the sub-Saharan African countries in the last decade; widespread illiteracy, especially for women; the evacuations of tens of thousands of refugees because of political strife and famine; and the emergence of thousands of orphaned children because of AIDS. All of these problems must be addressed by the African people and world community in the months and years ahead. They are problems that are inextricably linked to improving health status.

The consequence of the economic decline in Africa in the 1980s was visible in the significantly deteriorating infrastructure and shortages of essential supplies. It is clear that development assistance needs are great, and the United States and other donors must continue to support such efforts outside of the health sector. Working with African nations to adopt policies which foster strong economic growth and helping to sustain those efforts are essential priorities. Many of the leaders we met shared this view. Many are already implementing strenuous stabilization programs and are committed to their success. While development progress can be measurably helped by donors and other concerned groups, its pace and beneficiaries will be determined by the will of the people and their leaders. We returned hopeful that many leaders now in charge of the future of African countries are genuinely committed to sound economic development and improvement in their countries' health status.

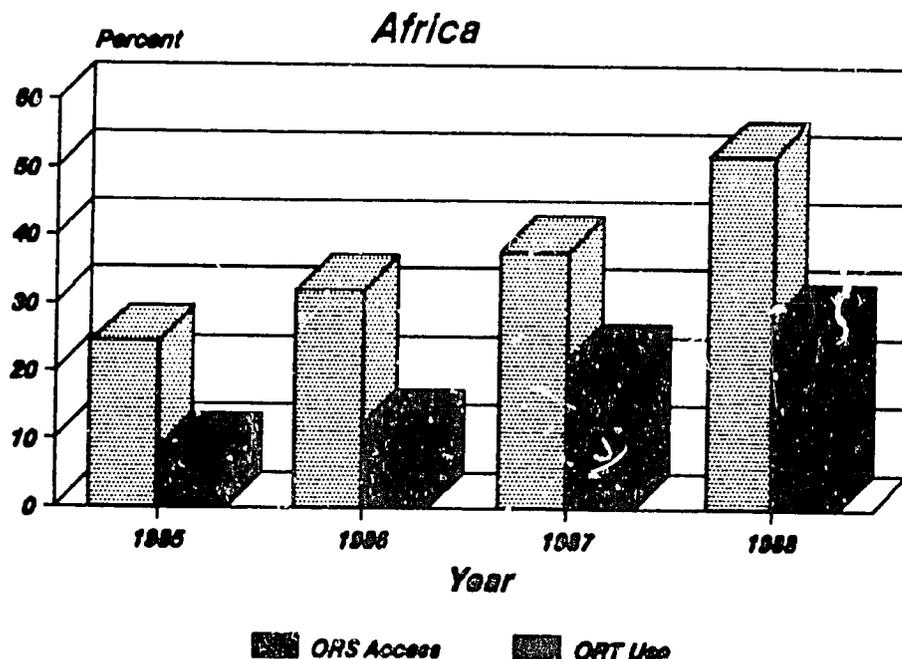
Within that broader context, we also wish to note that good health is a critical element in advancing a nation's economic stability and growth. Health assistance is a key adjunct to broader assistance programs. Healthy people produce healthy, stable and productive nations. Programs to improve the health of the African people should, therefore, be undertaken simultaneously with broader assistance initiatives.

Likewise, as in the case of economic growth, effective assistance in the health sector requires attention to an overall policy framework upon which to build health interventions and activities. In several countries, we observed that significant progress has been made in improving child survival by placing priority on health promotion and preventive services over treatment care and by making appropriate low-cost technology available through delivery of services at a village level.

B. African countries are making real progress in child survival.

Consistent with the philosophy of the international public health community, African nations have increasingly focused on developing primary health care systems. As a result, in the last decade remarkable progress has been achieved in increasing access to oral rehydration therapy, expanding immunization coverage and providing family planning services.

ORS Access & ORT Use Rates 1985 - 1988

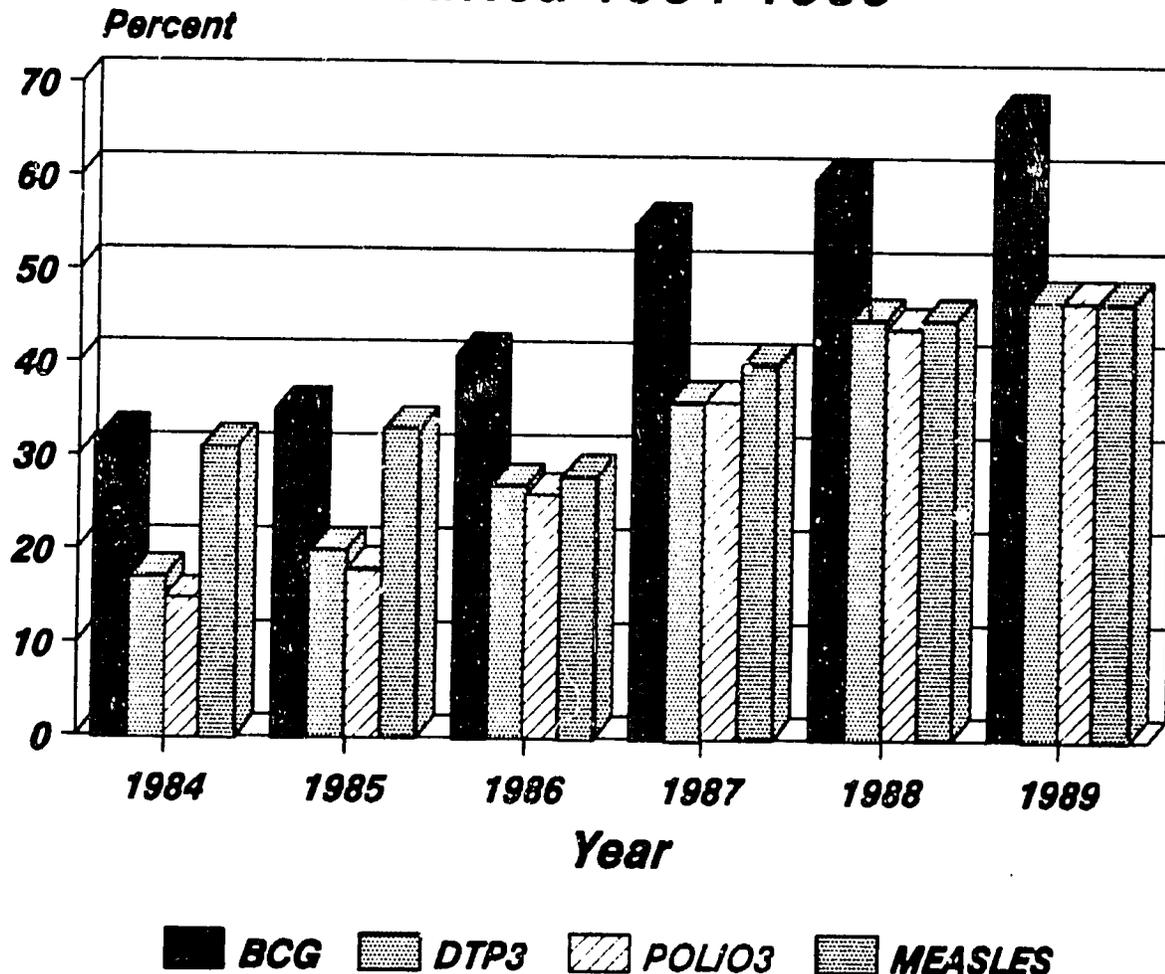


SOURCE: WHO Data

Collaboration with African countries on child survival has been based on financial support coupled with technical assistance. The United States has contributed over \$1 billion for child survival (\$200 million in Africa) since 1985. The results of these and other investments by the international community were notable.

Vaccination Coverage Rates

Africa 1984-1989



SOURCE: WHO Data

We observed that hospital admissions due to diarrhea have been dramatically reduced due to management of diarrhea and dehydration with oral rehydration therapy. In several countries, measles no longer topped the list of causes of hospitalization and death because of successful immunization programs. A striking demonstration of what can be accomplished with greater immunization was provided by data from Côte d'Ivoire where, after a major nationwide effort to increase immunization in 1987, childhood deaths (primarily due to measles) markedly declined in 1988. Unfortunately, these preventable deaths rose again in 1989 because the immunization levels were not maintained. This experience and other similar examples demonstrated the importance of sustained efforts to ensure the benefits of child survival for each new generation.

Popular demand for primary health care services was obvious in the long lines we saw at every health facility we visited. In the countries where priority had not been placed on the provision of basic care and preventive services, health status and service coverage indicators have clearly not kept pace with those in the rest of the continent.

C. Malaria remains a widespread and devastating problem.

Malaria was cited as the leading cause of childhood morbidity and mortality in most of the countries we visited. Resistance to chloroquine treatment has developed in all areas of Africa during the last decade. However, due to the cost of alternative drugs and continued effectiveness in some countries, chloroquine remains the most widely used treatment for malaria. In distinction to the advances in child survival due to increased immunization levels and use of oral rehydration therapy, less progress has been made in programs to control malaria in children. While the United States has invested over \$200 million worldwide in both malaria control and vaccine research, few of those funds have been specifically directed to improving malaria control in Africa.

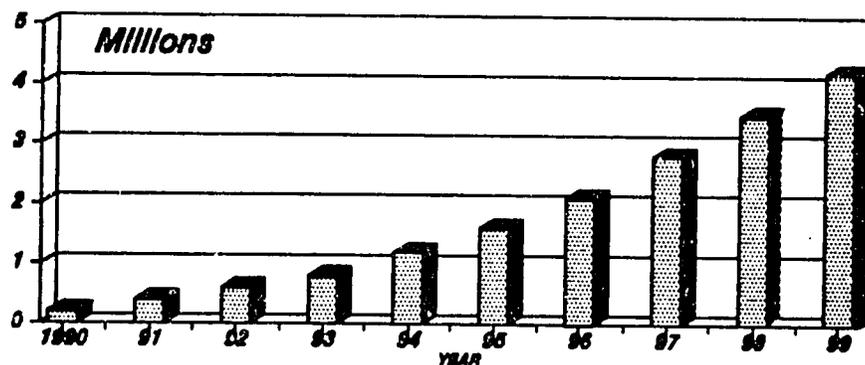
Encouraging results were presented from a research project in Malawi supported by DHHS and USAID demonstrating improved pregnancy

outcome among pregnant women with malaria treated with the drug mefloquine. These results have important implications for decreasing problems of low birthweight and infant mortality due to malaria. We were impressed that more needs to be done in the area of research on malaria prevention and treatment so that more effective malaria control programs can be developed.

D. The AIDS epidemic presents a rapidly increasing public health and social challenge.

HIV infection is rapidly becoming one of the major causes of death for children in most of the countries we visited. Half of the countries reported that in urban areas the rate of HIV infection in pregnant women attending health care facilities was 20-30%. In approximately one-third of their pregnancies, these women will pass the infection on to their children. In Zimbabwe, it was reported that approximately half of the pediatric hospital admissions in the capital city were for HIV-associated illness. Other countries recognized that they most likely underestimated the extent of illness in hospitals due to HIV infection and AIDS in children because of the difficulty in making the diagnosis in young children. AIDS is also a secondary factor in childhood death. The uninfected children of an HIV-infected mother are far more likely to die than those born to an uninfected mother, presumably due to inadequate care from an ill mother or from the child becoming an orphan.

*Estimated Number of AIDS Orphans
0-15 Years of Age: Africa 10 Countries*

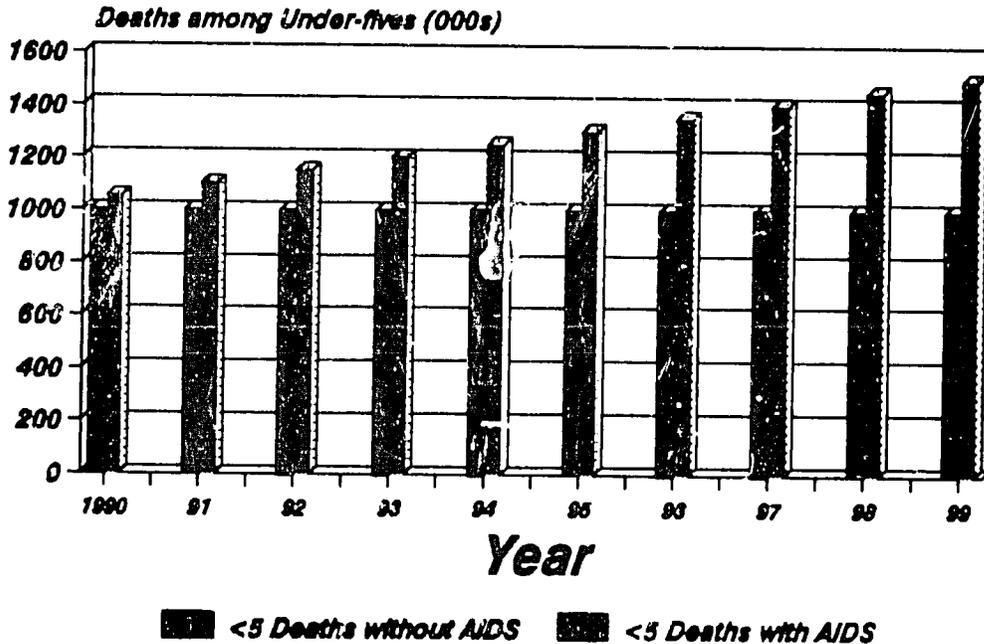


SOURCE: UNICEF, Preble, E., 1990

The countries we visited represented the full spectrum of the AIDS epidemic in Africa. In some countries, such as Uganda where the epidemic is advanced and HIV-infection rates are greater than 25% among adults in hardest-hit areas, AIDS-related deaths have occurred in most families. Because of the large number of young adults who have already died, the problem of AIDS orphans was very evident and a major concern within the country. Côte d'Ivoire provided an example of an epidemic that may have begun more recently but has spread very rapidly due to an extremely mobile population and is complicated by the co-existence of both recognized AIDS viruses, HIV-1 and HIV-2. In South Africa, the infection rates are still low relative to neighboring countries. However, the potential exists for very rapid spread there, given a labor system that necessitates extensive migration and the current political and social turmoil.

Estimated Impact of AIDS on Deaths

Children <5: Africa 10 Countries



SOURCE: Preble, E., Soc. Sci. Med Vol 31 No. 6, Medium Projections

In general, in all of the countries, the trends toward greater population mobility and urbanization, high levels of other sexually transmitted diseases and the doubling of infection rates in less than one year give them a very limited time within which to curb the spread of HIV infection. Clearly, AIDS has the potential of undoing many of the current and future health, social, developmental and political gains in Africa.

In all of the countries, some level of AIDS prevention activities and community education had begun. We saw a number of effective education and counseling programs undertaken by community and voluntary organizations, schoolteachers and health care workers. We also observed programs to improve the safety of the blood supply. However, with no available vaccine or cure, substantial reduction in the spread of HIV infection will only occur when millions of individuals change behaviors that are often deep-rooted.

We observed the importance of discussions of these issues by the highest level of political leadership. This gives societal legitimacy and support for individual behavioral change and paves the way for creating a societal norm that will reinforce such change. Strong, visible political leadership such as that provided by President Museveni of Uganda is critical to begin this process. Some of the other leaders with whom we met viewed AIDS with concern but did not give it the urgency we believe the situation warrants. In South Africa, long-standing mistrust of the government on the part of the black majority limits the credibility of government-initiated activities. The grass-roots, community-based health network that exists there will need to play a major role in reaching the population on AIDS prevention.

In 1990, the United States provided \$14 million to AIDS prevention activities in Africa, in addition to its support of the WHO Global Programme on AIDS. We observed many examples of U.S.-funded AIDS programs, including testing and counseling; AIDS prevention in the workplace in Uganda; AIDS education activities in the schools and churches in Malawi; grass-roots, community-based AIDS prevention in

South Africa; and targeted programs for prevention of AIDS in high-risk groups in Zimbabwe.

The U.S.-funded AIDS prevention programs that we saw were well-targeted, well-managed and deeply appreciated. Their focus on partnerships between private voluntary organizations and government activities is appropriate, but the effort is modest in relation to the need. The U.S.-sponsored research collaboration under way in Africa is yielding important findings about the transmission and natural history of HIV infection that benefit Africa as well as the United States.

These projects also provide important health services to the government and peoples of the countries in which they operate. More should be done, however, to increase the ability of these sites to train Africans and strengthen the research capacity of African institutions.

E. Rapid population growth is an underlying cause of poor child survival in Africa.

Among the greatest threats to child survival in Africa and to Africa's future are high fertility and rapid population growth. In most of the countries visited, women had on average seven or eight children, leading to population doubling in about 20 years and a population pyramid with more than half of the population under 17 years old. Despite valiant attempts to raise the standard of living and achieve economic growth, per capita income and per capita GDP have decreased in the last 10 years due in part to inability to keep up with the rapid growth of the population.

Everywhere we went, countries' attempts to provide primary health and prenatal care to women and children were outstripped and overwhelmed by the sheer volume of pregnant women and children needing care. The impact of high fertility rates on child survival is manifest primarily by malnutrition, which is a major contributor to death in most countries we visited. Secondary effects of the rapid population growth are reduction in resources available for prevention and primary health care services for children due to the inability of services to keep pace with the population growth.

Although there is a recognition of the need for child spacing to improve child survival, we observed only limited and mostly recent acceptance of the importance of limiting the number of children per family. Since 1965, the United States has spent more than \$4 billion for population activities worldwide. Efforts in Africa are the most recent and least developed, yet impressive progress is being made. In Zimbabwe, for example, contraceptive prevalence that rose from less than 5% to 43% within five years is a result of intensive cooperative efforts by that country together with the United States and other donors. However, in other African countries we visited, use of modern contraceptives is still less than 5%. While evidence shows growing progress in access to family planning services, continued attention and assistance for voluntary family planning will be required.

F. Poor child health and high birth rates are impeding the social progress of African women.

The effect of poor child health on women in Africa was acutely visible at every health facility we visited. Many women spend inordinate amounts of time overcoming the difficulties they face in seeking health care for their children and nursing them back to health. This is now increasingly complicated by the care for terminally ill children and other family members with AIDS. Attempts to fully involve women in the nations' development process will not be successful as long as inadequate health care systems place disproportionate burdens on women and as long as motherhood itself remains unsafe due to lack of prenatal and obstetrical care. Development progress in Africa will be greatly enhanced as more women are able to participate more fully and equitably in their societies.

G. Private sector initiatives are improving sustainability of health programs.

An important feature of creating viable health systems in Africa is the ability to sustain service delivery. This requires appropriate design of the system, emphasizing cost-effective and affordable interventions, as well as attention to financial viability in implementation. We observed

many innovative ways in which the base of financial support for primary health care is being broadened in Africa, including private sector initiatives. In Uganda, we participated in the dedication of a USAID-supported oral rehydration salts production facility which will manufacture and distribute this essential, lifesaving product at an affordable price. In Zimbabwe, we observed the initial production of simple, affordable diagnostic tools which will be distributed throughout Africa and the developing world. User fees and cost recovery are other important components of sustainable primary health systems which we observed in Nigeria. Finally, involvement of non-governmental organizations in health is becoming increasingly important in prevention of HIV infection and care of people with AIDS. In Uganda, we saw outstanding examples of involvement by local and international private voluntary organizations as well as by local business, industry and labor organizations in AIDS prevention and care.

H. Health data and information systems underlie sound health policy decisions.

Health information gaps were noticeable in all of the countries we visited. Data for appropriately targeting health programs were viewed as a critical component by public health officials. A major challenge facing decision-makers in the health sector is the allocation of scarce resources among a wide range of competing, high-priority needs. Compounding the severe resource shortages, increasing and shifting demand for health services requires review and reformulation of policies. Accurate health data is an important component in enabling health policy-makers to make the best decisions. However, a shortage of trained personnel to collect, analyze and disseminate these data was cited as a major limitation to public health efforts. Often even rudimentary systems for estimating population size, registration of vital statistics and tracking the spread of disease were lacking. The United States has provided technical assistance in surveillance and epidemiology by advisors in the field working along with African professional counterparts. We also met several public health professionals who had received training in American schools of public

health, supported by U.S. scholarships. The technical assistance in surveillance and epidemiology that the United States has provided was highly regarded, greatly appreciated and repeatedly sought.

I. Primary health care has been a stimulus for democratization.

Many of the countries we visited are currently undergoing democratization, the decentralization of development activities and the empowerment of local communities and institutions. While this is not an easy process, we saw leadership, skill, dedication and the growing awareness that democratic processes are needed to mobilize a nation's human resources.

In those countries in which primary health care is being aggressively implemented, we observed the health sector serving as an important introduction to self-governance and grass-roots democracy. Decisions were being made at the local level, and village health workers were chosen democratically by the village. In areas where little else is under the control of the community, the right to make health decisions was highly valued and well exercised.

We also observed the importance of investments in people to achieve political stability. In Zimbabwe, the decision to invest in health and education appears to have been a critical factor in the political healing process that occurred during the decade after the country's turbulent struggle for majority rule. Likewise, we were told by South African leaders that concrete programs that benefit people will be necessary to address rising expectations of the black majority for their new government. This will include direct investment in the health and education of all citizens of that nation.

IV. Conclusions and Recommendations for Future U.S. Involvement

A. Healthy economies provide the resources for healthy children.

Efforts to improve child survival and overall health in Africa must be coupled with continued assistance for economic development. In achieving goals in these areas, it is clear that the countries we visited look to the United States for leadership, that our assistance is valued and sought, and that the United States has unique contributions to make in the field of public health as well as economic development. We have an excellent opportunity to use the base provided by our collaboration in health to engage in policy dialogue on broader economic and social issues that impact beyond health.

Recommendation: That U.S. policy should continue to emphasize broad-based economic growth in Africa to help create an environment in which health assistance programs will be sustainable and most effective. Simultaneous investment in human capital through improved health policy and targeted child survival and AIDS prevention programs is essential. Africa should continue to receive a priority in the allocation of assistance funds to support these objectives.

B. Strong primary health care policies and systems must undergird health interventions.

Improved child survival will be most effectively accomplished by assistance for targeted child survival interventions while continuing to advance self-sustaining primary health care and integrated approaches to prevention. This requires a health policy framework that favors primary health care, allocates resources fairly between rural and urban populations, selects appropriate technologies and gives attention to improved means of health financing and public-private partnerships.

The United States can help encourage African nations to adopt a policy framework that ensures that the limited public and private resources for health are used efficiently and that initiated health programs are sustainable. As well, a continued emphasis on increasing immunization coverage and access and utilization of oral rehydration therapy is essential in order to maintain the advances in child survival made in the last decade. The USAID Measles Initiative to reduce deaths from measles by 95% by 1995 should be focused in Africa where one-third to one-half of measles deaths now occur.

Increased attention must be focused on other major diseases affecting children for which the prevention and treatment are not as well established, such as malaria, acute respiratory infections and AIDS. Continuing to build the primary care infrastructure will provide for the appropriate response to these and other potential new threats, as well as for the delivery of new interventions as they become available.

Recommendation: That U.S. assistance efforts should focus on sustaining efforts in targeted child survival activities in ways that develop indigenous primary health care systems. Efforts to strengthen these systems--undertaken in collaboration with UNICEF, WHO and other donor and private organizations--should include training in health management, assistance in designing cost-recovery systems and coordination of private and public sector efforts.

C. Malaria, Africa's forgotten killer, must be remembered.

Malaria is now the leading cause of death for children in much of Africa. Methods exist for treating and preventing malarial illness, and programs have made important advances in the past decade to make services available in parts of Africa most severely affected by malaria. The most widely available drug treatment is increasingly ineffective due to growing drug resistance to chloroquine by the malarial parasite. Operations research and program evaluation are critical components of malaria control programs, whereby prevention and treatment strategies can be monitored and their effectiveness enhanced. At the request of

USAID, DHHS and the Department of Defense, the Institute of Medicine of the National Academy of Sciences is currently completing a study entitled "Malaria Prevention and Control: Status Review and Alternative Strategies." The recommendations of this and other studies, as well as the experience gained in child survival programs, will contribute to the understanding of the priorities for future U.S. investments in malaria prevention and control.

Recommendation: That U.S. assistance efforts be intensified toward combating malaria in Africa, developing an integrated approach of applied and basic research and malaria control program support.

D. Behavior change is the key to breaking the AIDS transmission chain.

AIDS is a devastating social problem that has already had consequences beyond the health sector in many African countries. An urgent response is critical in order to halt the spread of this epidemic. A continued intensive campaign on multiple fronts is necessary. While there are still gaps in knowledge of how to decrease high-risk behavior in different cultural contexts and of what medical interventions may reduce HIV transmission, much has been learned from global efforts in AIDS prevention over the last decade.

Certain interventions such as increased access to condoms, particularly through social marketing, community-based prevention programs and programs targeted to youth, have had encouraging results and need increased support. Although a vaccine when developed will be an important component of HIV prevention, decreasing the behaviors that place individuals at risk for acquiring HIV infection remains the foundation for prevention activities now and in the future. Prevention of HIV infection in children will require more attention to prevention of HIV infection in women, since most pediatric HIV infection occurs by perinatal transmission.

Additional research is needed on behavioral interventions to improve understanding of how to promote behavior change and on biomedical interventions including vaginal virucides, female condoms, treatment regimens for HIV-associated infections found in Africa, vaccines and anti-retroviral therapy.

More support must be given to improving the prevention and control of other sexually transmitted diseases because of their role in facilitating transmission of HIV and their link with the same behaviors that increase the risk of acquiring HIV infection.

Humane, cost-effective ways of caring for HIV-infected people, who are beginning to overwhelm already inadequate health care facilities, must be found. More attention must be focused on the growing problem of AIDS orphans. The United States can provide assistance in formulating policies which encourage culturally appropriate and affordable approaches to community-based care for people with AIDS and foster care of AIDS orphans.

Recommendation: That the United States support additional interventions to promote behavior change, encourage social marketing of condoms, control the spread of other sexually transmitted diseases and support research on other means to reduce HIV transmission, including vaccines. The United States should also focus more attention on prevention of HIV infection in children by reducing HIV transmission among women of childbearing age. The program budgets in these areas need to continue to increase.

E. Rapid population growth can overwhelm health care efforts.

Rapid population growth poses a major threat to child survival and a barrier to economic growth in Africa. The United States, through USAID funding, is the leader among international donors in voluntary family planning, and this assistance has been effective in increasing contraceptive use necessary for improved reproductive health and family planning. The United States can continue to assist through

provision of funds and technical assistance to help improve access to contraceptive counseling, encourage the integration of family planning into primary care activities, help conduct behavioral research on contraceptive attitudes and impediments to use, and support research to expand the range of contraceptive methods from which to choose. The United States can also play a role in encouraging national leadership to demonstrate the necessary political commitment.

Recommendation: That the United States should intensify assistance for improved reproductive health and family planning in Africa, including efforts to increase the range of choice of contraceptive methods and use of the most effective methods.

F. Information technology can be more effectively harnessed in the battle to save children's lives.

Building capacity for health information systems and epidemiologic data will be most effective by providing in-country field training as well as providing support for formal training in epidemiology, statistics and computer science. While these activities exist currently, they are not adequate to meet the existing needs. More assistance is also needed to increase the use of existing data for making sound health policy decisions.

Recommendation: That the United States explore additional means to ensure that African health professionals have access to needed public health information resources and the necessary technical assistance and training in epidemiology, disease surveillance, computer science and data use from U.S. universities, foundations and other private and public sector sources.

G. Stronger institutional linkages can improve the health of Africans and Americans.

Stronger links between U.S. and African institutions should be made, including medical, nursing and public health schools, universities and private organizations. These U.S. institutions and organizations can fill gaps left by U.S. public sector assistance, provide useful technical expertise and also gain experience and knowledge from African counterparts.

Recommendation: That DHHS and USAID widely disseminate the findings of this mission to American academic, philanthropic, health and civic institutions that may be of assistance to health programs in the nations of Africa, with information on how institutional linkages can be established.

H. U.S. technical assistance has made a difference.

U.S. technical assistance was highly valued in all of the countries we visited. Efforts should be made to enhance and facilitate the provision of technical assistance by both DHHS and USAID.

Recommendation: That DHHS and USAID review existing programs to ensure that all appropriate technical assistance consistent with the recommendations of this report is implemented.

Country	Main Sites Visited During The Presidential Mission to Africa	Principal Contacts
Nigeria	<p><u>Lagos</u> Lagos University Teaching Hospital Lagos University Hospital Primary Health Care Station, Pakota</p> <p><u>Minna, Niger State</u> Minna, Niger State - Primary Health Care Center</p>	<p>The Honorable Ibrahim Babangida President</p> <p>The Honorable Olikoye Ransome-Kuti Minister of Health Lagos, Nigeria</p> <p>The Honorable Lannon Walker U.S. Ambassador Lagos, Nigeria</p> <p>Mr. Eugene R. Chiavaroli USAID Affairs Officer Lagos, Nigeria</p>
Côte d'Ivoire	<p><u>Abidjan</u> Koumassi Maternal and Child Care Center Treichville University Hospital Center in Treichville Retro-CI Project, HIV/AIDS Research Project</p>	<p>His Excellency Felix Houphouet Boigny President</p> <p>His Excellency Alain Ekra Minister of Health Abidjan, Côte d'Ivoire</p> <p>The Honorable Kenneth Lee Brown U.S. Ambassador Abidjan, Côte d'Ivoire</p> <p>Mr. Frederick E. Gilbert USAID/REDSO Director Abidjan, Côte d'Ivoire</p>
Uganda	<p><u>Kampala</u> Oral Rehydration Salts (ORS) Production Facility, Medi-Pharm Nakasero Blood Bank New Mulago Hospital, Makerere University Medical School Namulonge Agricultural Research Center Orthopaedic Facilities at Old Mulago Hospital AIDS Care and Counselling Center - TASO AIDS Information Center</p>	<p>His Excellency Yoweri Museveni President</p> <p>His Excellency Zak Kaheru Minister of Health Kampala, Uganda</p> <p>The Honorable John A. Burroughs, Jr. U.S. Ambassador Kampala, Uganda</p> <p>Mr. Keith Sherper USAID Mission Director Kampala, Uganda</p>

Country	Main Sites Visited During The Presidential Mission to Africa	Principal Contacts
<p>Uganda</p>	<p><u>Kampala</u> (cont'd.) Experiment in International Living Grant, AIDS Control, Uganda Women's Effort to Save Orphans (OWESO) Uganda Cancer Institute</p> <p><u>Rakai District</u> Rakai District Hospital World Vision Orphans Project Community AIDS Prevention Project</p>	
<p>Malawi</p>	<p><u>Blantyre</u> Queen Elizabeth Central Hospital St. Michael's Church of Central Africa Presbyterian Zomba Rural Piped Water Project</p> <p><u>Mangochi District</u> Koche Primary School Mangochi District Hospital Mpima Village - Self-Help Clinic Chipalamawamba Village Domasi Water Project Mozambique Refugee Camp</p>	<p>The Honorable Dr. H. Kamuzu Banda Life President</p> <p>The Honorable Dr. H.M. Ntaba, M.P. Minister of Health</p> <p>The Honorable George Trail U.S. Ambassador</p> <p>Ms. Carol Peasley USAID Mission Director</p>
<p>South Africa</p>	<p><u>Johannesburg/Soweto</u> Regina Mundi Catholic Church Baragwanath Hospital Ipelegeng Center/USIS Library African National Congress Health Secretariat, and affiliated health organizations</p> <p><u>Capetown/Crossroads</u> Kayelitsha Day Hospital Red Cross Children's War Memorial Hospital</p>	<p>His Excellency Frederik Willem de Klerk, State President</p> <p>Mr. Nelson Mandela Deputy President African National Congress</p> <p>Chief Minister Mangasuthu Buthelezi Inkatha Freedom Party</p> <p>Her Excellency E. H. Venter Minister of National Health and Population Development</p> <p>The Honorable William Swing U.S. Ambassador</p> <p>Mr. Dennis Barrett USAID Mission Director</p>

Presidential Mission to Africa

Country	Main Sites Visited During The Presidential Mission to Africa	Principal Contacts
Zimbabwe	<p><u>Harare</u> Zimbabwe National Family Planning Council Spilhaus Clinic Blood Transfusion Center Central African Pharmaceutical Suppliers (CAPS) Facility</p>	<p>The Honorable Robert Mugabe President</p> <p>The Honorable Timothy Stamps Minister of Health Harare, Zimbabwe</p> <p>The Honorable Donald Petterson Charge d'Affaires U.S. Embassy Harare, Zimbabwe</p> <p>Mr. Ted Morse USAID Mission Director Harare, Zimbabwe</p>
Senegal		<p>His Excellency Assane Diop Minister of Health and Social Development Dakar, Senegal</p> <p>The Honorable George Moose U.S. Ambassador Dakar, Senegal</p> <p>Mr. Julius Coles USAID Mission Director Dakar, Senegal</p>
Namibia		<p>His Excellency Nicky Iyambo, M.D. Minister of Health and Social Services Windhoek, Namibia</p> <p>The Honorable Genta Hawkins Holmes U.S. Ambassador Windhoek, Namibia</p> <p>Mr. Richard Shortlidge USAID Representative Windhoek, Namibia</p>