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AFRICA CHILD SURVIVAL INITIATIVE
COMBATting CHILDHOOD COMMUNICABLE DISEASES
(ACSI-CCCD)

**BUILDING ON THE ACSI-CCCD
EXPERIENCE FOR THE FUTURE**

MANAGEMENT



UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
Africa Regional Project (698-0421)



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
and Prevention
International Health Program Office



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BUILDING ON THE ACSI-CCCD EXPERIENCE FOR THE FUTURE

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Introduction

Public health programs in developing countries are facing new challenges in the 1990s. The pool of global resources for health is shrinking in proportion to expanding needs. Reinvigorated efforts are underway to strengthen the management of public health programs and to improve the quality of the services they provide. Experiences of public health personnel in developing countries and international assistance agencies can help ensure that hard-won gains are used as the foundation for new initiatives.

From 1982-1993, the Agency for International Development (A.I.D.) worked with 13 African countries to strengthen public health programs. The goal of the Africa Child Survival Initiative-Combating Childhood Communicable Diseases Project (ACSI-CCCD) was to reduce morbidity and mortality in children younger than 5 years of age¹. CCCD provided assistance to 13 countries in four program areas (immunization, diarrheal diseases, malaria, and acute respiratory infections) and six support strategies (health information systems, training and supervision, health education, operations research, health financing, and sustainability)¹. CCCD originally focused on target diseases and selected technologies. In the later years of the project, the focus shifted to improving the quality and effectiveness of health services for children under 5. Now, in response to progress made in discrete technical and support program areas and the stated priorities of program managers, the emphasis has broadened to a more management-oriented public health approach.

The purpose of this paper is to review selected aspects of CCCD experience from a management perspective. We have used a management model of public health programming as an organizational framework for the review (Figure 1). The model incorporates 1) policy development, 2) program planning, 3) program implementation, and 4) evaluation. Although this model was not explicit in the original design of the CCCD project, several country programs used the model implicitly as their programs evolved. Appropriate implementation of the four components is assumed to lead to effective delivery of preventive services and case management of disease and subsequent reductions in morbidity and mortality. For each program component, we summarize briefly its importance, describe selected CCCD experiences, report on current status, refer the reader to appropriate sources of additional information,^a and point to issues that will need to be addressed in the future.

^a In 1992, at the request of the United States Agency for International Development (A.I.D.), the Centers for Disease Control and Prevention (CDC) undertook a large-scale review of activities and accomplishments under the CCCD project. The more than 40 products of this review include journal articles, handbooks, computer software systems, and compendia of abstracts and research reports. Most concentrate on a specific strategy (e.g., health information systems, training, or operational research) or disease program (e.g., immunization, diarrheal diseases, or malaria control).

Elements of a Public Health Program From A Management Perspective

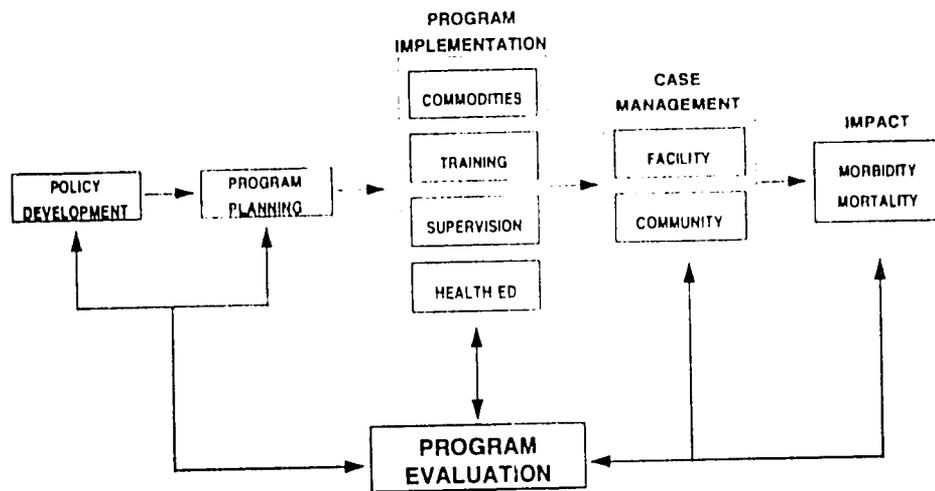


FIGURE 1

The Role of “Functional” Public Health Policy

Public health programs need functional as well as rhetorical policies. A functional policy focuses on specific diseases (such as diarrheal disease or malaria) or attributes of the health care system (such as logistics or training) and provides a set of guidelines or “marching orders” for those responsible for planning, implementing and evaluating health services programs. “Rhetorical policy,” on the other hand, refers to national or international statements of goals that contain limited, if any, operational guidance. An example of a rhetorical policy is the goal of “Health for All by the year 2000”, which most countries adopted at Alma Ata in 1978². Rhetorical policy can serve an important advocacy purpose, but cannot replace functional policy as a critical operational component in public health programs. A comparison of the characteristics of functional and rhetorical policy is presented in Table 1.

Table 1. Characteristics of Functional and Rhetorical Policy

	Functional Policy	Rhetorical Policy
Purpose	Operational Guidance	Advocacy
Audience or focus	Internal	External
Complexity	User friendly	Requires explanation
Specificity	High	Low
Foundation	Empirical data	Values, Philosophy
Relationship to program development process	Linked	Usually not linked
Program Ownership	High	Low

Functional policy as the basis for program development was recognized early in CCCD, and significant progress has been made in the number of countries that adopted policies for child survival interventions^{1,3}. These improvements were often the result of operational research that demonstrated the inadequacy of existing policies given current epidemiologic patterns¹. For example, CCCD countries that have adopted malaria policies since 1984 are presented by year of MOH approval in Figure 2. Although CCCD cannot claim full credit for these policies, malaria provides a particularly useful example of policy development because the role of the World Health Organization (WHO) in promoting malaria policy has been limited compared with their efforts to promote policies for immunization or diarrheal disease.

**Malaria Policies in CCCD Countries
By Year of Approval by MOH**

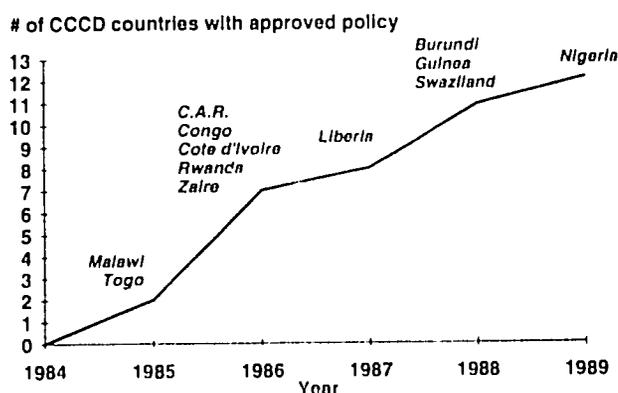
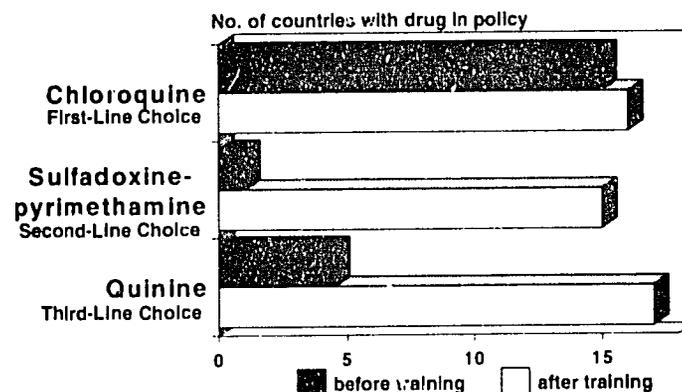


FIGURE 2

Other contributions of CCCD in the policy arena include an increased recognition of the need to base policies on locally-relevant and technically correct data¹, the development or refinement of methods to support the effective use of data in policy development^{4,5}, and the importance of using a comprehensive, multidisciplinary approach to policy formulation and modification illustrated by the experience of developing a policy on acute respiratory illness (ARI) in Lesotho⁶.

Most recently, innovative approaches for building functional policy-making skills in malaria control have been developed and demonstrated through CCCD-supported activities in francophone Africa^{7,8}. Program managers from 17 countries collaborated with CDC and WHO in a regional workshop designed and implemented by their peers. Participants systematically reviewed data collected in African countries and developed or refined functional policies for malaria control on the basis of these data. This workshop and subsequent technical assistance resulted in improvements in both the technical quality and the usefulness of national malaria control policies. For example, following the workshop the number of countries whose policies included the designation of WHO-recommended second- and third-line antimalarial drugs dramatically increased (Figure 3). This same approach to strengthening skills in policy development can be applied to integrated case management programs or to new threats to child survival such as HIV.

First, Second, and Third-Line Drug Choice Before and After Training Intervention



Source: Bobo-Dioulasso, 1991
N = 17 Participating African Countries

FIGURE 3

Functional policy should be derived from the best technical data available, informed by practical experience in the health delivery system, and crafted by program managers and members of their front-line staff who have contact with families and communities. Functional policy should match the level of available or anticipated program resources and should take into consideration the program's sphere of responsibility and authority to formulate, advocate for, and implement policy. Challenges for the future include helping program managers develop functional policies that meet their needs and further building managers' skills in the appropriate use of data for policy development and refinement.

Management-Driven Planning for Public Health Programs

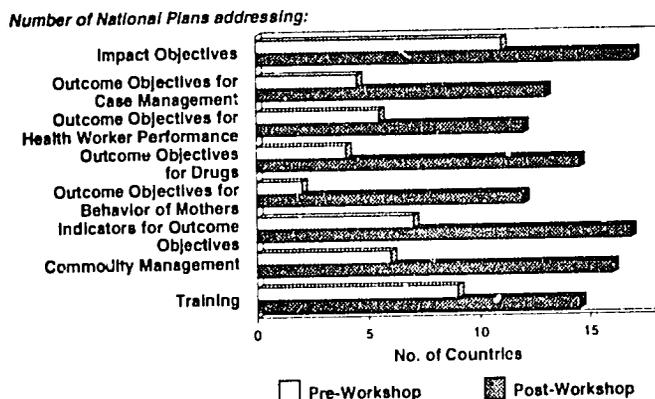
Program plans are the link between functional policy and public health action. Among the essential elements of a plan are 1) objectives and indicators related to the anticipated health impact of program activities; 2) objectives and indicators specifying the intermediate outcomes of program activities, including quantified changes in the care received by the target population and in the performance of those charged with its care; 3) a plan for program implementation that includes what will be done, by whom, when, and how; 4) a plan for monitoring the implementation of program activities; and 5) a plan for evaluating program outcomes and impact.

In many African countries, multiple and conflicting planning documents currently exist for child survival programs. The needs of donor agencies often drive the planning process, rather than the needs of programs and their managers. Frequently, program managers are asked to complete standard planning templates that vary from one donor agency to another. Once plans are written, the critical process of “replanning”, carried out in response to lessons learned through implementation and evaluation, is rare.

During program evaluations, CCCD managers often cited the development of workplans as a positive example of knowledge and skill transfer in planning⁹. Improvements in health information systems^{10,11} and a considerable body of applied research¹² have increased the quality and quantity of data available for program planning efforts¹ and have resulted in a heightened awareness of the importance of data to planning¹³. A systematic planning process for the continuing education of health workers which is based on relevant data from the periodic review of health worker performance has been developed and implemented at state and district levels in Nigeria¹⁴.

Recent malaria control-related activities in francophone Africa are, again, illustrative of CCCD supported efforts to improve planning. A second regional workshop for malaria control program managers and related technical assistance efforts^{7,15} resulted in increases in both the completeness and quality of malaria control program plans (Figure 4).

Completeness of Malaria Control Plans: Pre- and Post-Workshop



May 1992; N = 17 African countries

FIGURE 4

In the future, donors must help program managers assume greater ownership of the planning process. Considerable progress toward strategic planning led by program managers has been made through the WHO-defined review and replanning process for CDD, EPI, and HIV prevention programs¹⁰. This approach promotes ministry involvement in planning through a two-step process in which country staff review available data, identify problems, and specify priorities and only then meet with potential donors to determine resource availability. Further effort will be needed to develop strategies for strengthening planning skills and to promote dynamic, data-based replanning.

Support for Program Implementation

Program implementation requires systematic, comprehensive action as specified in the planning phase. Full program implementation addresses at least the procurement and distribution of essential drugs, health worker training and supervision, and health education. CCCD has demonstrated success in implementing some strategies in various countries but has not had the opportunity to assist any one country in implementing all strategies. Experience has demonstrated repeatedly that comprehensive programs are needed if the goal of mortality reduction is to be achieved^{1,17}.

In addition to comprehensiveness, a second finding in CCCD countries is the importance of implementing program activities in a logical sequence. As presented in Figure 5, the impact of a 2-year health worker training program in appropriate case management of febrile children in Côte d'Ivoire was limited because at the close of the training, 74% of health facilities were found to have no stocks of antimalarial drugs¹⁸.

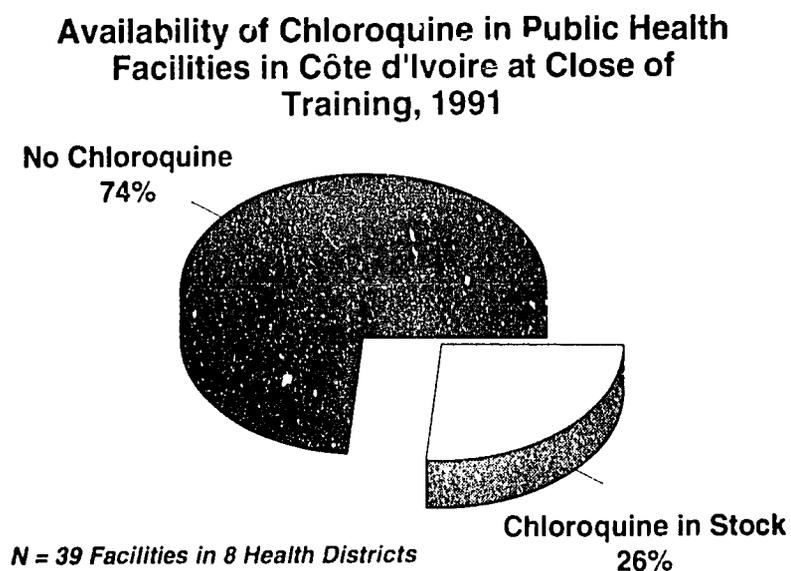


FIGURE 5

Training to prescribe drugs appropriately and to forecast drug needs presumes the availability of drugs. Similarly, calls for community-based health education are premature in most CCCD countries, where facility-based assessments of service quality have found not only that essential commodities are lacking but also that existing opportunities for health workers to educate child caregivers are repeatedly missed or underused, even after health workers are trained¹⁹ (Figure 6). Despite CCCD's focus on local capacity-building, various constraints have impeded the full-scale implementation of existing interventions of demonstrated effectiveness on a country-wide basis. Even minimum program needs for commodities or transportation to ensure program sustainability have not been met.

Assessment of Messages Given to Mothers Before and After Training in Côte and Nigeria

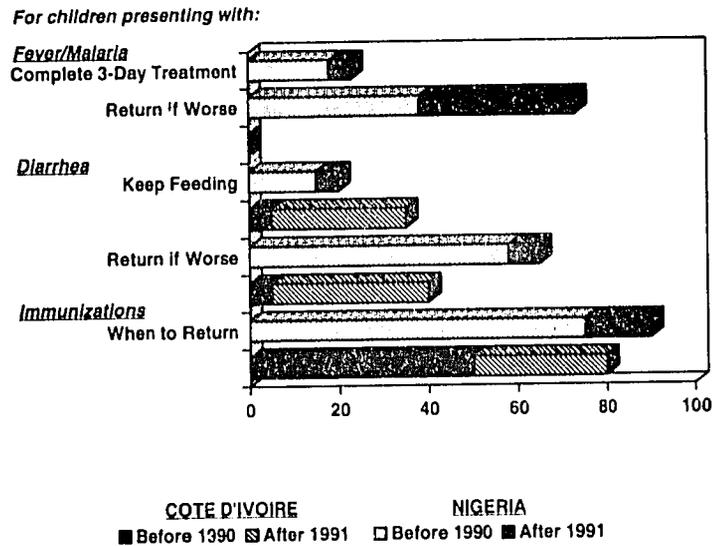


FIGURE 6

Future assistance efforts must ensure that the resources available for full implementation of disease control programs are appropriately distributed among the different support strategies and that these activities are appropriately sequenced in time and place. Ministry of health decision makers and those in the donor community must become better informed about the complexities of program implementation and ensure that it is adequately supported. The development of skills in program implementation skills that occurs when a program manager and an expatriate resident advisor work together to achieve specific objectives was an important development strategy of CCCD that merits further consideration⁸.

Evaluation as Program Management

The goal of program evaluation in public health is to improve health programs and guide the allocation of program resources through the systematic collection and use of data^{20,21}. Responsibility for program evaluation therefore should rest with national program managers²². Program managers need epidemiologic and behavioral data to develop and refine program policies and plans, and they must be able to obtain these data at a reasonable cost. Routinely collected data from ongoing management or health information systems, supervisory activity reports, or operational research can provide the necessary information for program monitoring if the data are of adequate quality. These data must then be translated into information appropriate for program decision making, communicated effectively, and used to improve program operations and revise program objectives and plans.

Although CCCD country level projects have been subjected to repeated external evaluation^{23,24}, recognition of the importance of evaluation as a part of a program manager's repertoire of essential skills is relatively recent. CCCD has promoted the development of useful methods and tools for program evaluation^{25,26,27,28} and has carried out impressive, highly technical evaluations of particular interventions in collaboration with national counterparts^{29,30}. Efforts to build capacity in the design and management of program evaluation for malaria control have been initiated³¹ but will need to be continued.

One example of a useful evaluation tool is the facility-based assessment (FBA) method used in CCCD countries. As presented in Table 2, most countries have used at least some FBA components to assess training needs or assess service quality²⁶.

Chronological list of facility-based assessments conducted in collaboration with the ACSI-CCCD Programme

Country	Year	No. of Facilities	ASSESSMENT COMPONENTS UTILIZED				
			Observation	Exit Interview	Health worker/ supporter Interview	Record Review	Equipment Inventory
Malawi	1986	23	X	X	X		X
Burundi	1987	8	X	X	X		X
(Ngozi region)	1987	11	X				X
Nigeria	1988	30	X	X	X	X	X
Togo	1988	25	X	X		X	X
Guinea	1988	11	X	X			X
Swaziland	1989	15	X	X	X		X
C.A.R.	1988	79	X	X	X		X
Nigeria	1989	30	X	X	X		X
Zaire	1989	12	X	X			
Cote d'Ivoire	1990	41	X	X	X		X

TABLE 2

FBA data can provide a useful snapshot of operational strengths or weaknesses, which can guide program planning or replanning efforts, as well as program implementation. Figure 7 presents selected results from an FBA conducted by Côte d'Ivoire in 1991; the Ministry of Health has since rectified the problem of chloroquine shortages in public health facilities. These data were collected through a special survey and CCCD-supported efforts are underway to strengthen supervisory systems as a source of routine data on service quality³².

Management of Febrile Children in Côte d'Ivoire, 1990

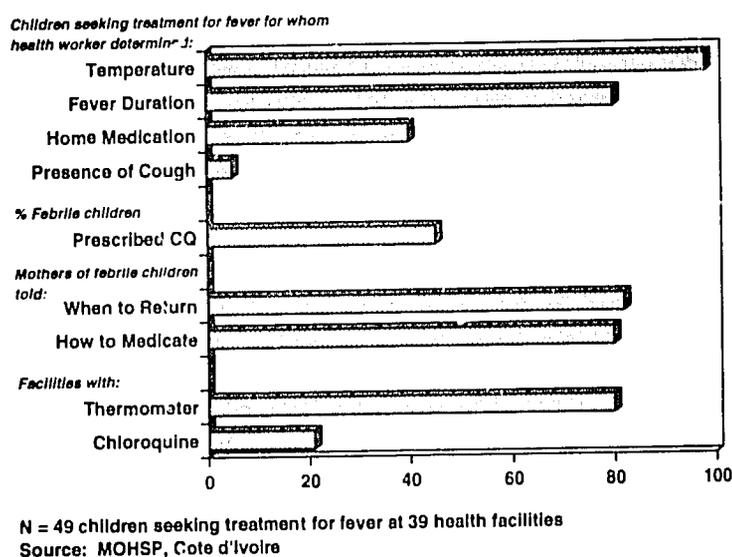


FIGURE 7

Future assistance efforts must help program managers design and use evaluation to improve program operations. In addition, management aspects of evaluation (such as the identification, training and support of staff with evaluation responsibilities) need to be addressed^{21,33}.



Conclusions

Building comprehensive public health programs in Africa requires not only political will and adequate resources, but also strong managers and functioning data systems. The products of the review of activities and accomplishments of the CCCD Project represent a valuable technical resource for future, management-oriented efforts that will strengthen both managers and data systems. Effective use of these products can ensure that past successes, as well as past mistakes, serve as a foundation for continuing innovation.

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