WORKSHOP REPORT

Malaria Control in PHC in Africa

Washington, D.C.

June 28–July 2, 1982

Submitted by: American Public Health Association
1015 15th Street, N.W.
Washington, D.C. 20005

ADSS Contract AID/DSPE-C-0053
MALARIA CONTROL IN PRIMARY HEALTH CARE

IN AFRICA

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WORKSHOP REPORT

Malaria Control in PHC in Africa

A. ACTIVITY

During the week of June 28 to July 2, a meeting of malaria and primary health care experts was held at the Shoreham Hotel in Washington, D.C. This workshop, organized in collaboration with the Africa Bureau and the Office of Health of the Agency for International Development and the Malaria Branch of the United States Public Health Service Centers for Disease Control, was managed by the American Public Health Association under the Accelerated Development Systems Support (ADSS) project.

The purposes of this workshop were to:

- Review recent information regarding malaria in Africa;
- Study the status of malaria control and PHC in Africa;
- Consider current technical information concerning methods of controlling malaria in Africa;
- Generate conclusions and recommendations concerning malaria control which would be incorporated into a malaria control field manual, and;
- Obtain feedback from AID field officials and their counterparts about the contents and format for such a manual.

The overall rationale for this meeting is the growing awareness that, while the eradication of malaria in Africa is not feasible in the immediate future, much can be done to reduce mortality and morbidity, particularly among highly vulnerable groups such as young children and pregnant women. Furthermore, Africa's growing primary health care movement offers new opportunities to protect rural people and others from the physical, economic and social harm caused by malaria. Although accurate statistics are not available, it is clear that malaria constitutes one of Africa's major causes of illness and death.

B. PLANNING

APHA's planning of this activity began early in 1982 with a series of meetings with AID officials. An APHA planning committee was soon organized (see Attachment A) which
assisted in guiding the development of a detailed working paper for workshop review and in preparing plans for the workshop itself. The working paper provided detailed information concerning malaria control in PHC and raised substantive issues which workshop participants would have to address prior to reaching conclusions and making recommendations to AID.

C. PARTICIPATION & ORGANIZATION

APHA's preparatory activities also included the identification of appropriate workshop participants drawn from bilateral and multilateral donor agencies, African PHC and malaria control officials, researchers, academicians and selected independent consultants. An agenda was formulated which was designed to maximize individual participation as well as lead to authoritative recommendations. (See Attachment B.)

Fifty-three specialists met for four and one-half days and had the following affiliations:

- a. AID/Mission officials ..................... 4
- b. AID/Washington officials .................. 8
- c. Other US Government officials from
   CDC, NIH, HHS, the Peace Corps,
   and USPHS .................................. 12
- d. PHC and malaria control officials
   from Africa .................................. 8
- e. WHO/Geneva, /Brazzaville and PAHO ...... 5
- f. Research & academic institutions .......... 7
- g. The World Bank .............................. 2
- h. Expert consultants .......................... 7

These participants included nationals from five African nations: Ghana, Tanzania, Zambia, Kenya and the Sudan, as well as other professional health care experts and malariologists working in Mali, the Sudan, Tanzania, The Congo, The Gambia, Zaire and elsewhere. (See Attachment C.) Participants were organized into four task forces which met simultaneously on June 29 and 30 to address clinical and administrative aspects of malaria mortality and morbidity reduction. Following plenary sessions, four differing sets of small groups met on July 1 to discuss the role of vector control in malaria programs within PHC or unresolved questions raised earlier. On July 2, meeting in plenary session, the workshop participants reviewed a summary report of conclusions reached and recommendations for action.

D. WORKSHOP OUTPUTS & EVALUATION RESULTS

The major product which will result from these efforts will
be a draft of malaria control guidelines, to be submitted to AID for review on or about August 15, 1982. APHA feels that these guidelines will represent the current "state of the art" with respect to malaria control within the context of primary health care, and will serve as an important source of direction in program design and development for AID officials and their counterparts. Major conclusions and recommendations which came out of the workshop are presented in Attachment D.

Both informal and formal evaluations suggest that the goals of this meeting have been achieved. (See Attachment E for evaluation results.) A number of useful suggestions were offered by participants for strengthening of future workshops, mainly emphasizing the need for more advanced distribution of background documents, and the devoting of a larger proportion of time to small group discussions in contrast to plenary sessions.
Malaria Control in Primary Health Care

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AID/Africa Bureau
Malaria Control in Primary Health Care
The Shoreham Hotel
Washington, D.C.
June 27 - July 2, 1982

AGENDA

Sunday, 6/27

6:00 PM  Reception in the Executive Room
   (Lower lobby — Cash Bar)

8:00 PM  Meeting of Workshop Coordinating Committee
   (Caucus Room)

Monday, 6/28

9:00 AM  Welcome & Introduction to Workshop Objectives & Plans
   (The Board Room)
   Dr. James D. Shepperd, Director, AID/Africa Bureau/Health & Nutrition
   Dr. Joe Stockard, Workshop Chairperson, AID/Africa Bureau/Health & Nutrition
   Dr. A. M. Haridi, MOH, Sudan

9:30 AM  Adoption of Agenda & Introduction to Working Paper
   Dr. Susi Kessler, Director, International Health Programs, American Public Health Association

9:40 AM  Review of AID Malaria & PHC Policies & Programs
   Dr. James D. Shepperd, AID/Africa Bureau/Health & Nutrition
   Dr. Al Henn, AID/Science & Tech./Office of Health

10:30 AM  Coffee Break

10:50 AM  Malaria Control in Africa
   Dr. Anatole Kassatsky, Regional Malaria Advisor, WHO/Brazzaville

11:15 AM  WHO Malaria Action Programme
   Dr. Jose A. Najera, Director of Malaria Action Programme, Geneva

11:40 AM  PHC in Africa
   Dr. Duane Smith, Office of Strengthening of Health Services, WHO/Geneva
   Dr. Daniel Kaseje, Univ. of Nairobi, Kenya
Monday, 6/28 (cont'd)

Noon
Lunch & Study of Working Paper

3:00-5:30 PM
Plenary Discussion of Malaria Control Options
(The Board Room)

Moderator: Dr. Joe Stockard, AID
Reporter: Dr. Petra Reyes, APHA Consultant

Selected Key Issues:

a. Role of PHC worker in malaria control
b. Manpower requirements for mortality and morbidity reduction in PHC settings
c. Presumptive vs. confirmed case treatment
d. Drug resistance resulting from chemoprophylaxis
e. Minimum levels of surveillance and evaluation for mortality and morbidity reduction
f. Elements essential for the support of malaria control activities in PHC programs

5:45-6:15 PM
Meeting of Workshop Coordinating Committee
(Caucus Room)

Tuesday, 6/29

9:00 AM
Plenary Orientation to Task Force Assignments
(The Board Room)

Chairperson: Dr. Susi Kessler, APHA

9:15 AM-5:30 PM
Task Force “A”: Technical Consideration of Mortality Reduction
(with coffee & lunch)
(The Board Room)

Facilitator: Dr. Al Henn, AID
Reporter: Dr. Bettie Graham, NIH

Topics:

a. Diagnostic procedures
b. Treatment drugs & regimens
c. Emergence of drug resistance
d. Drug side-effects and immunity
e. Manpower requirements
f. Evaluation of clinical services

9:15 AM-5:30 PM
Task Force “B”: Administration of Services to Reduce Mortality
(The Cabinet Room)

Facilitator: Dr. F. K. Wurapa, Zambia
Reporter: Dr. J. “Bud” Prince, Consultant

Topics:

a. Logistic requirements
b. Target population
c. Community organization & health education
d. Surveillance & evaluation
e. Manpower & training
Tuesday, 6/29 (cont’d)

9:15 AM-5:30 PM  Task Force “C”: Technical Aspects of Morbidity Reduction
(The Council Room)

   Facilitator:  Dr. Carlos Kent Campbell, CDC
   Reporter:  Dr. Victor Barbiero, APHA Consultant

   Topics:
   
a. Drug resistance  
b. Chemoprophylaxis  
c. Side-effects  
d. Immunity modifications  
e. Surveillance & evaluation

9:15 AM-5:30 PM  Task Force “D”: Administrative Aspects of Morbidity Reduction
(The Caucus Room)

   Facilitator:  Dr. Merrill “Bud” Shutt, Univ. of North Dakota
   Reporter:  Dr. William Chin, CDC

   Topics:
   
a. Manpower & training requirements  
b. The private sector  
c. Logistics  
d. Organizational relationships & patterns

Wednesday, 6/30

9:00 AM  Task Forces “A” through “D” continue meeting
(See Tuesday, 6/29, for room assignments)

Noon  Lunch

1:30 PM  Reports of Task Forces “A” & “B” followed by discussion
(The Board Room)

   Chairperson:  Dr. Al Henn

3:15 PM  Coffee Break

3:45-5:30 PM  Reports of Task Forces “C” & “D” followed by discussion
(The Board Room)

   Chairperson:  Dr. Joel G. Breman, CDC

Thursday, 7/1

9:00 AM  Task Force “E”: Aspects of Vector Control
(The Board Room)

   Facilitator:  Dr. W. L. Kilama, Univ. of Dar es Salaam
   Reporter:  Dr. Eugere Gerberg, Consultant

   Topics:
   
a. Vector control methodologies & effectiveness
      
(1) Chemical methods  
(2) Biological  
(3) Source reduction  
(4) Avoidance  

b. Community acceptance & participation
Thursday, 7/1 (cont’d)

9:00 AM
Task Force “F”: Aspects of Vector Control
(The Cabinet Room)

Facilitator: Dr. Lawrence Cowper, AID/Health
Reporter: Dr. Augusto Noguer, WHO/Geneva

Topics:

a. Planning vector control activities
b. Assessment, surveillance & evaluation
c. Vector control & PHC relationships

9:00 AM
Task Force “G”: Assessment & Evaluation of Malaria Control
(The Council Room)

Facilitator: Dr. Victor Barbiero, APHA Consultant
Reporter: Dr. Joel G. Breman, CDC

Topics:

a. Planning overall malaria control evaluation activities, including baseline data collection
b. Resource requirements for evaluation
c. Malaria control indicators and measures

9:00 AM
Task Force “H”: Special Issues in Malaria Control
(The Caucus Room)

Facilitator: Dr. John Karefa-Smart, Consultant
Reporter: Dr. Andre Prost, World Bank

Topics:

a. Issues and resources to be included in AID/Africa Guidelines
b. Topics of major concern requiring additional deliberation

Noon
Lunch

1:30 PM
Task Force Reports “E” & “F” followed by discussion
(The Board Room)

Chairperson: Dr. Eugene J. Gerberg, Consultant

3:15 PM
Coffee Break

3:35 PM
Task Force Reports “G” & “H” followed by discussion
(The Board Room)

Chairperson: Dr. Omar Juma Khatib, Tanzania

6:00-7:00 PM
Meeting of Steering Committee & AID Field Officers
(Caucus Room)

7:00 PM
Workshop Dinner

Friday, 7/2

10:00 AM
Wrap-Up Session: Summary and Conclusions
(The Board Room)

Chairperson: Dr. Joe Stockard
Rapporteur: Mr. Albert Farwell
Closing Remarks: Dr. James D. Shepperd

Noon
Adjournment
Malaria Control in Primary Health Care
The Shoreham Hotel
Washington, D.C.
June 27 - July 2, 1982

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SUMMARY CONCLUSIONS AND RECOMMENDATIONS

At the request of the Bureau for Africa, Agency for International Development, an advisory group of malariologists, medical officers, public health specialists, social scientists and medical economists was convened in Washington, D.C., between June 28 and July 2, 1982. Fifty-three in number, and coming from 10 countries and a wide range of international agencies, U.S. government agencies and private organizations, the group members gathered to advise the Bureau for Africa on:

- the possibility of conducting, within the framework of national primary health care efforts, successful programs to control the ravages of malaria in the countries of sub-Saharan Africa;
- the kinds of malaria control programs appropriate to implementation within a PHC framework;
- the goals of such programs;
- the constraints to the success of such malaria control programs;
- areas of program implementation in which the "conventional wisdom" derived from prior anti-malaria efforts provided inadequate guidance;
- the risks and dangers inherent in a program which, for reasons however persuasive, operates without the safeguards hitherto deemed essential; and
- the desirability of providing external support for national malaria control efforts within a PHC framework, and the essential preconditions for such support.

As was to be expected, a group so diverse in geographic, institutional and disciplinary origins sometimes found more than one answer to these challenges. Yet the extent to which the group reached consensus was both remarkable and encouraging; conclusions reached and recommendations advanced were, in some instances, sharply different from established practice.

The Advisory Group concludes:

A. Primary Health Care: An Appropriate Vehicle for Malaria Control?

1. PHC is considered an appropriate vehicle for malaria control in sub-Saharan Africa, and often in fact is the only vehicle for control that exists.
2. The state of the art is such that it is possible to mount a variety of selected anti-malaria efforts within a PHC framework -- depending on the goals of such efforts.

B. Kinds of Malaria Control Programs Suitable for Implementation Within A PHC Framework

1. Of the four WHO-defined "tactical variants" -- selections of control techniques that relate malaria control tactics to the severity of the problem, the level of control sought and the indigenous capacity to achieve that level -- mortality control (through chemotherapy) and morbidity control (through chemoprophylaxis and possibly limited vector control) appear suitable for implementation within PHC at this time.

2. Where vector control activities are restricted to minor environmental modification measures, water control and mosquito avoidance techniques such as the use of bed nets, screens and repellants, they can be encouraged through appropriate extension of health education and sanitation activities within PHC. Vector control which includes wide-spread chemical control will in Africa be appropriate only in localized areas, for protection of urban and periurban populations; in some of the coastal islands; or under specialized circumstances such as the need to protect strategic areas or groups for economic, social or political reasons. In such circumstances, operational responsibility of vector control should wherever possible be decentralized to such administrative units as municipalities or productive enterprises. Such activity as chemical control or large-scale environmental management will usually require planning at a higher level, with technical inputs and support from a specialized vector control unit.

3. Whatever the goal and the selection of malaria control techniques, there is need for a central core of technical and managerial expertise that can plan, train, direct, supervise, support and evaluate malaria control efforts at the periphery. Vector control programs would increase such needs.

4. Peripheral elements in the PHC system require guidance and support from higher levels in the system. To perform effectively, the PHC worker needs training and supplies, supervision and a referral system to treat complicated cases of malaria.
C. Program Goals

1. Individual countries must establish their own goals and priorities with respect to malaria control. The most pressing need is to reduce malaria-related mortality in rural areas.

2. Limitations on resources (in money, manpower and material) are such that any activity undertaken to reduce the impact of malaria must be so implemented as to produce maximum results for minimum expenditure of resources. In practice, this means that one form of malaria control within the parameters of technical feasibility -- chemoprophylactic morbidity control -- will probably not be widely employed because the same amount of resources devoted to chemotherapy can provide mortality control to far more people. Chemoprophylaxis and limited vector control to reduce morbidity should be restricted to high risk populations and only be considered where appropriate infrastructure and economic conditions permit.

3. The level of control envisioned under Tactical Variant I, reduction of malaria-caused mortality, can be implemented within PHC systems, and would constitute an enormous advance toward the goals of "Health for All by the Year 2000" if it could be achieved continent-wide throughout Africa.

D. Drug Selection

1. Six criteria should govern the selection of either a therapeutic or a prophylactic anti-malarial drug: (1) safety and freedom from serious side-effects; (2) simplicity in administration; (3) effectiveness; (4) acceptability to patients; (5) availability; and (6) low cost.

Recommendations:

a. These criteria should be applied to drug selection before a malaria control program starts and should continue to be applied during program implementation to permit appropriate drug choice changes in response to local situations (e.g., lowered acceptability, lessened effectiveness, cost changes, etc.)

b. Although limited chloroquine resistance (R 1 level) has been found in some parts of East Africa, chloroquine continues to be the anti-malarial drug of choice in Africa.
c. Amodiaquine, although more expensive, is also satisfactory. It should not be considered as a simple substitute for chloroquine. It should be reserved for special situations (emergence of serious resistance or drug rejection by patients because of side effects) in which chloroquine would no longer be fully acceptable.

E. Constraints to Program Success

1. Among identified constraints to successful malaria control, the following ranked high.

a. Failure to establish baseline data; to know the levels of malaria endemicity and the patterns of excessive mortality throughout the area to be served; to anticipate logistic, manpower and financial requirements; to provide for regular evaluation of results attained; and to replan the program on the basis of evaluation results.

b. Inadequate knowledge of cost-effectiveness of control measures.

c. Assignment of anti-malaria responsibilities to a health infrastructure inadequately prepared to assume the burden.

d. Shortages of both trained manpower and essential training capacity; inadequate training facilities at all levels.

e. Poor administrative and general services support.

f. Structural inadequacy of the anti-malaria effort at the center. (Seven of the eight Task Forces into which the Advisory Group was subdivided identified a central malaria service within the Ministry of Health as an absolute need to support the "front line" elements of the PHC system.)

g. Difficulty of access to malarious areas.

h. Limited resources to cope with the many problems faced (of which malaria is only one).

i. Inflation of all costs in the face of declining per capita resource availability throughout much of Africa.

Of these nine key constraints to program success (others were also cited), the first three can be averted or contained by proper initial preparation and planning; the second three
are in fact part of the problem to be overcome; and the final three are the hard facts of life that must be recognized and taken into account in setting program goals -- including such goals as the assumption by the host government of all costs beyond the period of external support.

F. Diagnosis and Treatment

1. Current practice in many malaria control programs often requires a time-consuming, equipment-intensive and skill-demanding series of steps prior to radical (i.e., parasite-killing as opposed to parasite suppression) treatment of confirmed malaria: blood slide preparation and microscopic examination for all suspected malaria cases; and preliminary suppressive treatment pending laboratory confirmation of malaria. Only then is chemotherapy administered at the "radical cure" level -- over a period of three or more days.

2. In a program conducted within the framework of PHC, (but, more particularly, in a situation where 80 percent of the population may have parasites in their blood):

   a. The PHC worker should have sufficient training to provide chemotherapeutic treatment, at a prescribed dosage for radical cure of malaria, to an individual who has fever, even if the worker has not been trained to confirm the diagnosis.

   b. Radical single-dose chloroquine treatment of clinically diagnosed malaria has been demonstrated in Africa to be both safe and effective; additionally, the PHC worker can supervise the actual use of the drug.

   c. The only required verification of a clinical diagnosis of malaria normally is a successful patient response to treatment. Failure of the patient to respond to chemotherapy indicates the need to reconsider the diagnosis following the local fever protocol; this may lead to prompt referral to the next level of supporting health service.

Recommendations:

a. PHC worker training should establish as mandatory the radical single-dose treatment of all fever cases by administration of a prescribed level of chloroquine (or other drug of choice). It is entirely appropriate to waive laboratory confirmation of acute malaria prior to
radical treatment, in view of constraints imposed by shortages of time, laboratory facilities and skills.

b. Supervision from higher levels in the system is an essential element of support to the PHC worker.

c. Education of the population regarding malaria control should be stressed.

G. Training

1. It is essential to revise training curricula for PHC workers to incorporate the required level of knowledge of their role in the anti-malaria effort.

2. There are at present no comprehensive training facilities in Africa that provide for the range of skills required for the leadership of a successful anti-malaria program. WHO's demonstration activities, seminars, study tours, support of a post-graduate course in public health and a training center for health personnel have been useful but do not meet the anticipated requirement for trained leadership.

3. Development and strengthening of national training centers constitute a critical need for most of Africa.

Recommendation: While such centers should have African direction at the earliest possible time, they may require initially (and as long as is needed) the stimulus of external technical inputs.

4. Training programs for administrative and operational personnel must be available to each country undertaking an anti-malaria effort. Training must be keyed to the level of control sought.

5. The success of malaria control efforts depends on the availability of trained personnel at all grades. The investment of funds of the external donor and the host government is endangered if technical personnel are improperly or inadequately trained to carry out the program.

Recommendation: National institutions that provide training in control of malaria in countries that receive external support for anti-malaria programs should also receive external technical and financial assistance whenever improved training is regarded as critical to the success of the relevant programs. The level of assistance will depend on the extent to which the countries themselves are unable to provide training appropriate to the demands of the program.
6. The importance of training cannot be allowed to obscure the fact that investment in training facilities will prove unproductive unless there is a will to utilize the facilities. WHO regional malaria training centers in Lomé and Lagos were reported to have discontinued their programs because of lack of interest on the part of the nations of Africa in providing candidates for training.

H. Program Continuation Beyond External Assistance

1. Malaria control programs are not time-limited; they have costs that (especially for programs with the limited objective of reducing morbidity and mortality) will not decline over time. Yet external assistance is normally time-limited, and the impact of continuing costs on Ministry of Health budgets after the termination of external inputs may be such as to cause retrenchment or even termination of the malaria control activity.

2. The continued private-channel sale of anti-malarial drugs throughout most of tropical Africa, even at high prices, demonstrates both the awareness of the ability of such drugs to cure malaria and the willingness of Africans to pay for chemotherapy.

Recommendations:

a. To minimize the strain of malaria control on national health budgets, and to make possible the continuation of control efforts beyond the conclusion of external assistance, most if not all countries of sub-Saharan Africa should consider the adoption of a policy under which chemotherapeutic drugs would be provided at cost to the users.

b. Such a policy, if adopted, should be embodied in the plan for controlling malaria, and should constitute a significant element in the host government support commitment which could be used as one element in the basis for any external assistance.

Note: The Advisory Group was unanimous in its conclusions that: (1) administering a dosage lower than that required to clear the blood of parasites would encourage parasite selection for drug resistance, (2) single-dose radical treatment should replace multiple-dose treatment, (3) the drug of choice should be administered by an individual trained to prescribe the proper radical dosage for the body weight of the victim.
A vigorous minority held that the trained individual who administers drug treatment of malaria should for the time being be a member of the PHC system, but that ultimately it will prove desirable and even necessary to have trained individuals in every home, to permit immediate self-medication or home medication of malaria. Such a policy should be geared to the continuous availability of the drug of choice in every home, the ready availability of resupply, the availability of back-up services to take care of cases that do not respond to home drug medication, and the adoption of a policy of unrestricted sale of the drug of choice (versus a policy of free drug distribution).

Adherents of this position recognized the high initial drug cost, but believed that the combination of (1) reduced requirements per location for PHC workers to administer drugs, and (2) revenue generation through sale of anti-malarial drugs would enable maximum extension of mortality reduction through chemotherapy within the confines of an inevitably limited Ministry of Health budget.

The ultimate success of such a home-based program of malaria control through self-financed chemotherapy would depend substantially upon the extent to which community leaders and organizations are able to develop their support for the program among community residents, and understanding of its details.

I. Preconditions for External Support

1. External support is not warranted in the absence of a long-term national commitment to a goal-oriented, well-planned, organizationally sound, technically and administratively feasible and costed plan of malaria control activity that takes full account of the country's physical and human resources down to the community level. (See, however, Section I-4, below)

Recommendations:

The prerequisites for assistance include:

1. Request

A request from the host government for assistance in malaria control, whatever the level of control sought, must be supported by evidence of national will to carry out the proposed program and of the priority assigned to the problem of malaria.
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1. Request

A request from the host government for assistance in malaria control, whatever the level of control sought, must be supported by evidence of national will to carry out the proposed program and of the priority assigned to the problem of malaria.
2. **Plan**

The request should be keyed to a plan describing the malaria problem, the proposed course of action and the anticipated results. The plan should provide:

a. **The area in which the program will be conducted, population affected, specific population groups and age groups targeted for attention.**

b. **A baseline of epidemiological data that describes the existing problem in quantitative terms; this will enable subsequent evaluation of accomplishment under the program.**

c. **A life-of-project projection of requirements in terms of manpower, money (local currency and foreign exchange) and equipment or supplies, specifying the quantity and quality of the resources to be provided by the host government and those expected from external sources -- AID, WHO or other agencies.**

d. **Logistic and transportation requirements of the plan, including a description of methods of procurement, warehousing, distribution, stock control, reorder points, etc.**

e. **Training requirements and a plan of who requires training; where, when, and by whom.**

f. **The relationship of the malaria control project to other PHC activities.**

g. **Methods of assuring coordination with and the full support of other elements in the Ministry of Health with other health agencies in the country, and with other ministries or agencies concerned with activities affecting malaria in the country.**

h. **A plan for continuing the project beyond the period of external assistance.**

3. **Counterpart Relationship**

From the outset of the project, there should be an identified, qualified officer to whom the host government assigns responsibility for project management and evaluation. This officer may be the counterpart of the USAID H/N officer.
4. **Assistance in Plan Preparation**

The preparation of such a plan may be beyond the immediate capacity of a number of African countries. International and bilateral assistance in plan preparation, including feasibility studies as embodied in small-scale projects to test the applicability of an intervention technique, or assistance in training, warrant support by international and bilateral sources of external assistance.
AID/APHA MALARIA CONTROL IN PHC IN AFRICA WORKSHOP

Evaluation Form

A. Content

1. Appropriate selection of participants, range of expertise, African & organizational representation

B. Support Services

1. Adequacy of meeting rooms

2. Availability of secretarial services

3. Travel & financial arrangements

C. Suggestions for Improvement of Guidelines

(A comparison of responses of field workers vs. administrators and others not in the field showed no significant differences.)

D. Suggestions for Improvement of Future Meetings

--- OVER ---
E. Which category best describes you?  (check 1 only)

<table>
<thead>
<tr>
<th>#</th>
<th>%</th>
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<tbody>
<tr>
<td>1</td>
<td>3</td>
<td>Malaria specialist working in Africa.</td>
</tr>
<tr>
<td>5</td>
<td>15</td>
<td>PHC specialist working in Africa.</td>
</tr>
<tr>
<td>9</td>
<td>26</td>
<td>Malaria specialist working outside of Africa.</td>
</tr>
<tr>
<td>6</td>
<td>18</td>
<td>PHC specialist working outside of Africa.</td>
</tr>
<tr>
<td>11</td>
<td>32</td>
<td>Other (specify)</td>
</tr>
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**2** 6**

**Not applicable.**
Comments from Malaria Evaluation Forms

<table>
<thead>
<tr>
<th>Classification(a)</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>n.a.</td>
<td><strong>C.</strong> Revision after 2-3 years if the conditions and the development of malaria programme will be successful.</td>
</tr>
<tr>
<td>5</td>
<td>The document needs supporting technical documents which review scientific papers related to subject.</td>
</tr>
<tr>
<td>5</td>
<td><strong>D.</strong> (Sociologist with some specialization on development issues in Africa.) Extend invitation to social scientists with field experience in PHC programs.</td>
</tr>
<tr>
<td>2</td>
<td><strong>C.</strong> Details of addresses for training institutions, sources of additional information.</td>
</tr>
<tr>
<td>5</td>
<td><strong>D.</strong> Disseminate information well before meeting.</td>
</tr>
<tr>
<td>5</td>
<td><strong>C.</strong> Improve environmental mgmt. and vector control sections.</td>
</tr>
<tr>
<td>5</td>
<td><strong>D.</strong> Distribute papers in advance. Pay part of per diem upon arrival.</td>
</tr>
<tr>
<td>3</td>
<td><strong>C.</strong> Task force groups too large for meaningful contributions. Fewer plenary sessions.</td>
</tr>
<tr>
<td>2</td>
<td>More field workers with practical experience.</td>
</tr>
<tr>
<td>3</td>
<td>Hold the meetings on the African Continent.</td>
</tr>
<tr>
<td>4</td>
<td><strong>C.</strong> Barry Karlin is greatly appreciated! The time allotted Task A-D was excellent. However, the tasks E-F were not covered in depth and in general of average rating.</td>
</tr>
<tr>
<td>5</td>
<td><strong>D.</strong> Include financial/economics advisors from World Bank, PVO, etc.</td>
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</table>

(a) Classification

1. Malaria specialist working in Africa.
2. PHC specialist working in Africa.
3. Malaria specialist working outside Africa.
4. PHC specialist working outside Africa.
5. Other

*C. Suggestions for Improvement of Guidelines

**D. Suggestions for Improvement of Future Meetings
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>5</td>
<td>C. Make much more specific, illustrative with case-studies and the range of ecological-demographic situations that would determine control strategies.</td>
</tr>
<tr>
<td>3</td>
<td>C. The introduction and background are boring and redundant, and need a great deal of thought and editing to make them concise, interesting and useful. Epidemiologic stratification and the concept of control must be presented with same general guidelines. Even presumptive treatment of fever depends on it.</td>
</tr>
<tr>
<td>1</td>
<td>D. Reduce number of participants by 1/4. Poll the field people prior to the meeting to better define local AID and country concerns.</td>
</tr>
<tr>
<td>5</td>
<td>D. Information concerning the meeting should be sent out much earlier.</td>
</tr>
<tr>
<td></td>
<td>C. (Malaria specialist formerly working in Africa; member of WHO expert Committee on Malaria.) Reports of the WHO Expert Committee on Malaria to be available for consultation at the meeting.</td>
</tr>
<tr>
<td></td>
<td>D. Background documentation to be available to participants at least one week before meeting.</td>
</tr>
<tr>
<td>5</td>
<td>C. (AID staff) Add bibliography.</td>
</tr>
<tr>
<td>2</td>
<td>D. Keep working groups a bit smaller; better distributions of microphones.</td>
</tr>
<tr>
<td>5</td>
<td>D. Make the Task Groups smaller for more in-depth considerations.</td>
</tr>
<tr>
<td></td>
<td>C. (AID Field Officer) Put in introduction on economic outlook for the African Region; put in caveat that whatever strategy considered needs to be continued by host government. Emphasize that exploration of non-government systems is permitted and encouraged.</td>
</tr>
<tr>
<td></td>
<td>D. Smaller, equal representation of specialists and planners/administrators; perhaps next meeting would have health officers and small number of specialists.</td>
</tr>
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Other comments:
Major policy issues were raised only at the end of the conference and only with great difficulty because of makeup of group. (40 physicians, 5 other technical experts and 5 administrators/planners out of 50).

Too much time allotted for plenary non-directed discussions (lectures) by a few senior technical specialists; not enough time for in-depth discussions of issues in task force sections.

Suggest that future meetings get detailed input from field prior to setting up agenda. (Perhaps this was done.)

Most of time was devoted to presentations by specialists on how to implement programs with financial considerations left out.

C. More direct presentation of costs, expected benefits, effectiveness, possible risks of various possible activities in a variety of epidemiologic, social, etc. circumstances.

D. Materials available in advance of arrival.

C. Try to avoid much overlap by the groups of issues; otherwise you did a splendid job.

D. More time is important for group discussion, drafting and typing the report to enable group members to read and comment.

D. (Consultant, international public health practice) Follow-up with African meeting for HPN Officers.

C. Insert definitions of malaria cases and deaths for planners, service providers and evaluators. A glossary.

C. Focus on areas of consensus (majority only) and present only important areas of controversy in a separate "Issues" section. More detailed treatment of training programs.

D. Recommend that final manual not be mailed out, but be presented in a health officers training program.
<table>
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<tr>
<td>3</td>
<td>C. Correct guideline statements with both group reports and plenary comments.</td>
</tr>
<tr>
<td></td>
<td>D. Send working documents, meeting objectives and agenda to participants well in advance.</td>
</tr>
<tr>
<td>3</td>
<td>C. More precision in objectives and rationale of the activities. Presentation of baseline information and brief description of the social structure of the countries involved.</td>
</tr>
<tr>
<td></td>
<td>D. Try to meet facilitators, reporters and moderators before the meeting. Send the documents well in advance for participants to study.</td>
</tr>
</tbody>
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