

Occasional Paper No. 3

PUTTING CHILDREN FIRST

**A Report on the
Effectiveness of U.S. Agency for
International Development
Child Survival Programs
in Fiscal Year 1991**

January 1995



**RESULTS
EDUCATIONAL FUND**

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International Development
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CAUTIONARY NOTE

RESULTS Educational Fund and Bread for the World Institute have a long history of support for, and commitment to, child survival activities in the developing world. This study should be read in the spirit of that commitment, as constructive criticism to make the child survival program even more effective. Any use of these findings as a case for cutting or eliminating U.S. government support for primary health care in the developing world is a misinterpretation of the report's intent. One of our conclusions is that funding for the program should be increased.

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The report was edited by Sam Harris and Alan Gold of RESULTS Educational Fund and Marc J. Cohen of Bread for the World Institute. Jashinta D'Costa and Susan Park of Bread for the World Institute provided assistance to the editors. Cohen also served on the Advisory Committee for *Putting Children First*.

The Advisory Committee consisted of development and child survival professionals, and was formed to provide input and counsel. It met three times during 1993. Members included Robert Berg, President, International Development Conference; Peter Bourne, President, Global Water; Anthony Gambino, Director of Public Policy, InterAction; Gerald Mills, Director, Baltimore/Washington Field Office, Save the Children; Dory Storms, Director, PVO Child Survival Support Project, School of Hygiene and Public Health, Johns Hopkins University; Charlene Dale, Executive Vice President, International Child Health Foundation; and Kenneth Flemmer, Vice President for Programs, Adventist Development and Relief Agency.

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EXECUTIVE SUMMARY

It is tragic enough that one and a half million children died as a result of wars over the past decade. But it is far more unforgivable that during that same period, 40 million children died from diseases completely preventable with simple vaccines or medicines. Every day – this day, as we meet here – over [35,000] of the world's children will die of malnutrition and disease.

Our UNICEF director, Jim Grant, has reminded me that each of those children had a name and a nationality, a family, a personality, and a potential. We are compelled to do better by the world's children. Just as our own nation has launched new reforms to ensure that every child has adequate health care, we must do more to get basic vaccines and other treatments for curable diseases to children all over the world. It's the best investment we'll ever make. We can find new ways to ensure that every child grows up with clean, drinkable water, that most precious commodity of life itself

– President Bill Clinton, September 27, 1993
Address at the United Nations

It is tragic to note that just months after President Clinton's remarks at the United Nations, the United States cut funding for child survival activities within the foreign assistance program by \$40 million, the first cut in a decade.

According to the United Nations Children's Fund (UNICEF), 35,000 children die each day worldwide from malnutrition and preventable disease. Yet low-cost approaches to child health such as growth monitoring, oral rehydration therapy (ORT), promotion of breast feeding, immunizations, and appropriate spacing of births have brought that grim number down from 40,000 children a day a decade ago.

These approaches could reduce child death rates by at least one-third by the year 2000. UNICEF states that over the next decade, 25 million child deaths resulting from diarrhea alone could be prevented with the use of ORT. In addition, a reduction in child death rates would impact spiralling population growth rates

According to UNICEF, “[T]here has never been a steep and sustained fall in child births which has not been preceded by a steep and sustained fall in child deaths.”¹

The September 1994 U.N. Conference on Population and Development in Cairo reaffirmed the importance of child survival activities in reducing population growth.

Beginning in 1984, organizations committed to the elimination of hunger and poverty in developing countries – including RESULTS and Bread for the World – intensified their efforts to ensure a powerful U.S. response to the opportunities presented by the availability of low-cost primary health care measures. On October 1, 1984, the U.S. Agency for International Development (USAID) launched a congressionally mandated child survival initiative to improve the health of children in developing countries. Shortly afterwards, Congressman Christopher Smith, a Republican from New Jersey, remarked, “There can be no doubt that the work financed through the Child Survival Fund is today helping to advance the so-called ‘child survival revolution.’”² Congressional earmarks for child survival programs grew from \$0 in fiscal year (FY) 1984 to \$275 million in FY 1993.³ The increase for vitamin A and micronutrients such as iodine was from \$0 in FY 1985 to \$25 million in FY 1993.

The steady increases in U.S. funding of child survival activities contributed to substantial reductions in deaths of children under five in countries receiving USAID child survival money. This report notes that in Egypt and India, for example, USAID child survival assistance played an essential role in saving the lives of hundreds of thousands of children.

Still, there was no high-level government commitment to measurable goals regarding child survival until the 1990 World Summit for Children, where leaders from 159 nations met and agreed to a compelling vision and to a set of specific goals to be achieved by the year 2000. The goals include: reducing the mortality rate of children under age five (the under-five mortality rate) by at least one-third, halving of maternal mortality and child malnutrition rates, and providing universal access to clean water, safe sanitation, and basic education. The fulfillment of the Summit's vision could mean the end of widespread hunger and poverty as we know it today. The child survival programs funded by USAID could play a crucial role in meeting these objectives if sufficient resources are committed and those resources are used effectively.

This report focuses on \$225 million in child survival activities funds which the Congress appropriated for FY 1991. Our research sought to determine whether the programs met the intent of the authorizing legislation for child survival programs, which directed USAID to deal "directly with the special health needs of children and mothers" and use

simple available technologies. . . such as improved and expanded immunization programs, oral rehydration to combat diarrheal diseases, and education programs aimed at improving nutrition and sanitation and at promoting child spacing

We also intended to determine whether the programs were carried out in the most cost-effective manner and if each program included community participation as an integral component.

To this end, we conducted a desk study of the ten largest recipient countries of child survival money in FY 1991: Afghanistan, Bolivia, Egypt, El Salvador, Haiti, India, Mali, Mozambique, Nicaragua, and the Philippines. We reviewed all available USAID documents on child survival programs for that year, and interviewed people involved in child survival policies and programs, both within USAID's Washington office and its field missions, and a range of people working in the health sector in each country. In addition, we commissioned on-site research and interviews in Egypt, El Salvador, and the Philippines.

Conclusions

- 1. The best and most cost-effective work in the U.S. bilateral child survival program is done by governmental and non-governmental organizations that have learned how to develop community participation and involvement.*** The leader of one such group profiled in this report, Vicky Guzman de Luna, MD, founder of ASAPROSAR in El Salvador, expressed the commitment to community participation this way:

Now, since the war is over, we're seeing there is lots of money coming into the country. People from the outside now want to give us money, but they want to tell us how we should do our work. For instance, right now there is a group coming to San Salvador that doesn't want the people to build their own latrines, they want them to contract it out and let someone else

build their latrines. This is against our philosophy because we really want people to participate. The people need to change because they want to change, not because it's imposed on them. The people can come in and bring the latrines for them and they might see changes in their homes or in their schools, but the campesinos won't have changed within, and most likely they won't be using latrines. . . .

2. ***USAID spent too much of its resources on expensive U.S. consultants and for-profit consulting firms.*** A ten-year child survival program in Egypt called for 240 months of long-term U.S. consultants at \$17,400 per month, an annual rate of \$208,000. In contrast, medical doctors who work in the Egyptian Ministry of Health are paid about \$500 per month. Many grassroots groups are able to serve children effectively at a cost of \$5-\$10 per child per year. One of these grassroots groups could reach 20,000-40,000 children in one year with the amount paid to just one consultant in one year. While it is true that U.S. consultants can contribute skills and attitudes that might not be available locally, USAID's child survival program leans too heavily in that direction.
3. ***Buy American rules took money away from service delivery.*** In several instances, USAID policy required imported supplies from the United States, even though the equivalent supplies were available locally at much lower cost, e.g., antibiotics in Egypt, or the U.S. goods were not appropriate to the program, e.g., leisure vehicles to be used on very difficult rural terrain in El Salvador. The high cost of these supplies and vehicle repairs meant that less money was available to deliver child and maternal health services.
4. ***A significant number of programs did not match the congressional child survival mandate.*** For instance, child survival resources were used to fund family planning activities and improvement of math skills in Bolivia and microenterprise development in Nicaragua. While these programs can be valuable, money spent on them should not be counted as child survival spending.
5. ***More attention was placed on inputs and strict adherence to regulations than on "outcomes."*** Frequently, agencies

were unable to provide statistics for how their work contributed to any change in child mortality rates or other indicators of improved well-being. They could tell us on what some of the money was spent, but not the end results of those expenditures. There is need to change the focus from a heavy emphasis on financial accountability to greater emphasis on measurable progress toward improved child well-being.

6. ***There was too much emphasis on privatization and policy dialogue at the expense of direct child survival interventions.*** For example, the largest project in the Philippines (\$13 million in 1991) called for reaching benchmarks such as privatization of hospitals before the funds were released. Benchmarks such as availability of basic drugs in rural areas would have been more appropriate to the child survival mandate.
7. ***Country choice was not based on need.*** The countries which received the most funding for child survival activities were not necessarily the countries where the need was greatest. Child survival money was often used to pursue current U.S. foreign policy goals. For example, India has over 3 million child deaths per year. The Philippines, with a child mortality rate one-half the rate in India, and about 120,000 child deaths per year, received three times as much child survival assistance. In FY 1991, the Philippines hosted major U.S. military facilities.

Recommendations

1. ***Set and use measurable outcomes for the child survival program.*** The USAID child survival program should state, in measurable terms, what its desired results are, using child mortality and morbidity and related indicators. Specifically, programs in the field should contribute in measurable ways toward fulfilling the year-2000 goals agreed to at the World Summit for Children (e.g., reducing child mortality by at least one-third, virtual elimination of iodine deficiency disorders and vitamin A deficiency and its consequences, global eradication of poliomyelitis by the year 2000 and neonatal tetanus by 1995, reduction by one-third in the deaths due to acute respiratory

infections in children under five years, and cutting child malnutrition by one-half).

This approach would be consistent with the Clinton Administration's goal of a "results orientation" for USAID programs.

2. ***Provide increased resources to grassroots groups that have learned to mobilize community participation.*** The USAID child survival program should support, assist, and expand (without smothering with red tape) those grassroots groups that nurture community participation and involvement. This involvement and community ownership bring not only services, but also transformation (a sense among people that they have control over their lives) and make it more likely that programs will be sustained beyond the availability of external resources.
3. ***Focus on countries based on need, not politics.*** The median under-five mortality rate in sub-Saharan Africa is 180 per thousand live births, yet only Mozambique and Mali were among the top 10 recipients of FY 1991 child survival funding. More children die in South Asia than in any other region, yet India was the only South Asian country among the ten largest recipients of child survival funds in 1991 (see table, p. 57).

Activities should focus on fewer countries, especially those with the highest under-five mortality rates and strong national commitments to child survival, and concentrate on a limited number of projects most likely to benefit the greatest number of children and women. USAID tends to withdraw from countries which have a relatively lower priority for U.S. foreign policy, focusing instead on nations which are of strategic concern to the U.S. government. Of course, it has been customary to use assistance to further diplomatic aims, but child survival funds should be allocated, as much as possible, based on need.

4. ***Reduce administrative requirements.*** USAID's paperwork and administrative requirements must be reduced so that those groups that are most able to make a difference with people are not constrained or eliminated just because they are less able to interact with an aid bureaucracy. This can and must be done without losing the ability to measure results and ensure accountability.

Some progress has been made in this area as the result of work in 1993 and 1994 by a joint task force established by USAID and InterAction, the association of U.S. non-governmental international development organizations. It has called for simplified accountability and reporting requirements and an end to USAID's micro-management of non-governmental organization projects.

Nevertheless, there is need for broader reform and concern as to whether reforms will truly filter down to the USAID field mission level.

5. ***Increase U.S. funding for child survival activities.*** In addition to these qualitative improvements in USAID's child survival programs, the United States should increase its spending on child survival activities in developing countries, including U.S. contributions to UNICEF. In FY 1994, such spending accounted for less than 5 percent of all non-military foreign aid. Enlarging the budget for child survival activities would demonstrate a strong U.S. commitment to maintaining progress in reducing preventable deaths of the world's children. Even at a time of fiscal restraint, that is an important investment with a high social payoff.

NOTES

1. United Nations Children's Fund, *The State of the World's Children 1988* (New York: Oxford University Press, 1988), p. 23

2. *Foreign Assistance and Related Programs Appropriations for 1986, Hearings Before a Subcommittee of the Committee on Appropriations, House of Representatives, Ninety-Fifth Congress, First Session, Part 6* (Washington: U.S. Government Printing Office, 1985), p. 401.

3. The U.S. government's fiscal year runs from October 1 through the following September 30

INTRODUCTION

For the baby boy, I tried to get help. But as I was carrying him for help, he just died in my arms. My daughter was older, I had got used to playing with her, being with her. It's difficult. . . . It's sad to remember those times with my children. She was alright when she went to bed. By midnight she was sick. She died just as day broke. I am not alone. It's happened to a lot of women.

– Maria Auxilia Paja

A mother from a rural area in South America whose children died of a respiratory infection and measles.

Despite substantial reductions worldwide in childhood deaths and lower incidence of childhood diseases, some 13 million children under the age of five still die each year as a result of malnutrition and preventable disease. Yet it is now clear that virtually all of the major childhood diseases could be prevented or treated with new and affordable approaches. Moreover, as the United Nations Children's Fund (UNICEF) points out,

Ninety percent of the growth of the human body and brain occurs in the first few years of life. The intricate process of that growth cannot be postponed. That is why action to protect the normal health and growth of children should be at the forefront of development strategies.¹

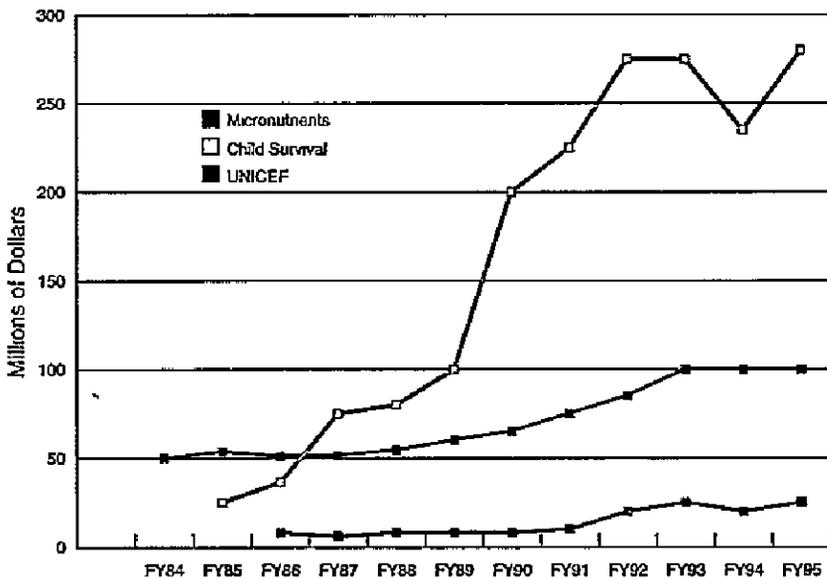
The commitment to improve the lives of children must be maintained and should not be at the mercy of shifting priorities due to political or economic changes. What is needed is the support and commitment of opinion leaders and the media, of educators and religious leaders, of professional bodies, of governments, and of citizens at large.

The U.S. Congress has shown consistent leadership in highlighting these priorities since the creation, in 1984, of the Child Survival Fund and the earmarking of additional primary health resources for poor mothers and children within the health account of the U.S. Agency for International Development (USAID). The legislation authorizing child survival programs has been clear and specific, stating that

the President shall promote, encourage, and undertake activities designed to deal directly with the special health needs of children and mothers. Such activities should utilize simple, available technologies which can significantly reduce childhood mortality, such as improved and expanded immunization programs, oral rehydration to combat diarrheal diseases, and education programs aimed at improving nutrition and sanitation and at promoting child spacing.

To implement this mandate, USAID launched its child survival program on October 1, 1984, seeking to improve the health of children and women in the developing countries, committing itself to reducing child deaths through affordable, proven technologies. As Figure 1 indicates, Congressional earmarks for child survival programs (i.e., Congressional directives concerning USAID spending on these programs) grew from \$0 in fiscal year (FY) 1984 to \$275 million in FY 1993.² The increase for vitamin A and micronutrients such as iodine was from \$0 in FY 1985 to \$25 million in FY 1993. Funding declined by \$40 million for child survival and \$5 million for micronutrients in FY 1994, but is expected to increase again in FY

Figure 1: Funding of Child Survival, UNICEF, and Micronutrients, Fiscal 1984-1995



Source: Congressional Appropriations Committee; USAID; FY1995 numbers represent Congressional recommendations.

1995. U.S. contributions to UNICEF also grew during the late 1980s and early 1990s.

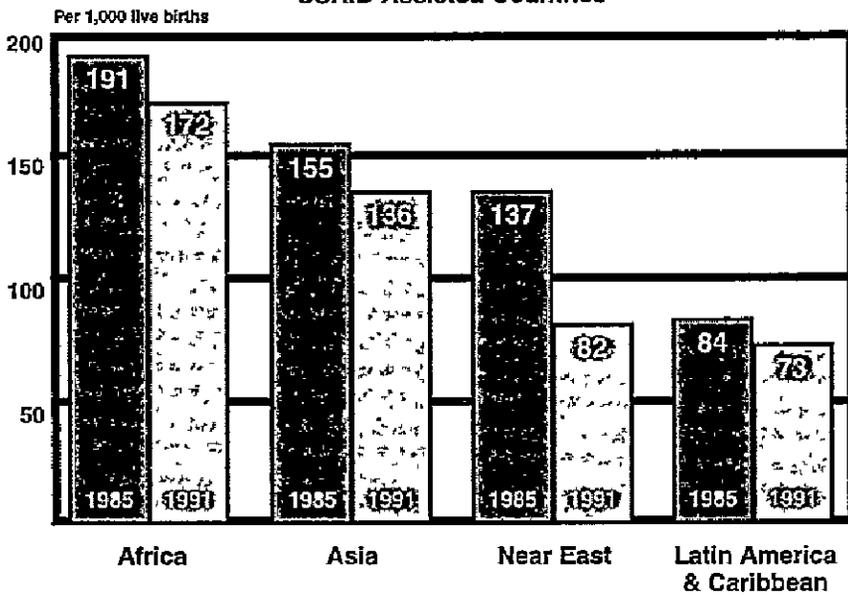
Bread for the World and RESULTS, grassroots anti-hunger lobbies, mobilized their members around the United States to encourage Congress to create the Child Survival Fund. Since that time, members and staff of the two organizations have continued to press for increased funding for child survival activities. In 1995, Bread for the World will continue to advocate enhanced contributions to child survival in the context of efforts to enlarge U.S. support for sustainable development in Africa. RESULTS will continue to focus on assuring that the U.S. government makes the basic needs of the world's children a priority, through fulfilling the year-2000 goals of the World Summit for Children.

Both organizations recognize that the latter half of the 1990s will be a period of leaner federal government programs. But they will insist that spending on child survival remains highly cost-effective and beneficial to the entire world community, since it increases the chances that children will grow into healthy, productive, and creative adults. We must remember that when 1 billion people around the world are unable to provide basic necessities for themselves, this creates political and economic insecurity, which has repercussions for the environment, population growth, migration, and countless other areas of global stability.

The steady increases in U.S. funding of child survival activities contributed to substantial reductions in deaths of children under five in countries receiving USAID-child survival money (see Figure 2). While it is not possible to assess here the exact extent to which this spending contributed to these gains for the world's children, U.S. aid clearly played a crucial role in the "child survival revolution." Congressman Chris Smith, a Republican from New Jersey, has said that USAID's "Child Survival Fund has been one of the most remarkable foreign aid usages of our dollars in terms of saving lives and enhancing the lives of those children who are saved."³

Despite the increased funding for child survival activities, less than 10 percent of total U.S. development assistance is allocated directly to primary health care, clean water, safe sanitation, and other programs aimed at meeting the basic needs of the world's poorest people. Aid for health is too often directed toward hospitals and costly medical equipment which serve the needs of an urban minority, rather than primary health care for the majority.

FIGURE 2: Under-Five Mortality in USAID-Assisted Countries



This study asks the following questions:

1. Have USAID Child Survival programs been designed and carried out in ways that deal directly with the specific health needs of poor children and mothers?
2. Have the programs used simple, available techniques?
3. Have the programs been carried out in the most cost-effective manner?
4. Have the programs encouraged community participation in design, implementation, and evaluation?

The findings and recommendations presented in this report are intended to provide information which we believe is needed by USAID, Congress, and committed citizens, to help them improve the child survival program.

This study comes at a time when USAID needs to renew its commitment to child survival programs, clarify its objectives, accelerate efforts to simplify procedures, and establish priorities among interventions and countries of emphasis.

METHODOLOGY

In 1993, RESULTS Educational Fund undertook a desk study of ten countries receiving the highest level of child survival funding in fiscal year 1991: Afghanistan, Bolivia, Egypt, El Salvador, Haiti, India, Mali, Mozambique, Nicaragua, and the Philippines. These ten countries accounted for approximately 50 percent of total USAID child survival funding that year. RESULTS Educational Fund commissioned field research in three of the countries: Egypt, El Salvador, and the Philippines.

The main methods for the desk study included:

1. Collection, review, and analysis of all available USAID documents and reports on child survival activities funded in FY 1991
2. In-person and telephone interviews with USAID staff, both in Washington and in the field, and with grassroots groups and others involved in child survival programs (including those not funded by USAID).

The field research sought to verify information presented by USAID in project documents, grant agreements, and its annual report to Congress.

LIST OF ABBREVIATIONS USED

ADRA	Adventist Development and Relief Agency
ASAPROSAR	Salvadoran Association for Rural Health
FY	Fiscal year
NGO	Non-governmental organization
OMB	Office of Management and Budget (U.S. government)
ORT	Oral rehydration therapy
PVO	Private voluntary organization
PVC	Office of Private and Voluntary Cooperation (USAID)
U5MR	Under-five mortality rate (per 1,000 live births)
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development

A CASE STUDY – ASAPROSAR: CHILD SURVIVAL AT ITS BEST

Dr. Vicky Guzman de Luna is Director General of the Salvadoran Association for Rural Health (ASAPROSAR), a community-based health organization headquartered in Santa Ana, El Salvador. Although Guzman is Salvadoran, she received her medical training in Mexico because, as a woman, she could not enter medical school at that time in El Salvador. Guzman, whose program began receiving USAID child survival funds in 1991, was interviewed in El Salvador and during a visit to the United States.

ASAPROSAR works with rural families to better their living conditions by the advancement of women and the empowerment of people. In 1993, the organization had 37 staff and 1,000 volunteers serving 120,000 individuals.

Guzman did her medical training in Mexico, and worked there for eight years as a “barefoot doctor,” serving rural poor people from 1964 to 1971. She then returned to El Salvador, where she wanted to learn what it was like in the rural areas. When she traveled in the countryside outside of Santa Ana, which is where she grew up, she was surprised to find that there were absolutely no health services. She decided to provide health services to people in that area.

Initially, her only focus was on treating disease. Overwhelmed by the problems she encountered, she felt there was no time to provide health education. She lived with the people, shared their poverty, rode horseback and walked to where her patients were. She spent most of each week at work in the rural villages. Guzman often felt helpless, expressing her frustration over tragedies such as seeing a baby die for lack of intravenous fluids. The people, however, felt it was a miracle that she was there because many had never seen a doctor before.

The first few years were very hard, visiting patients from 8:00 in the morning until 1:00 the following morning, but they were relatively uncomplicated. Then the harassment started. ASAPROSAR had been covering only about 1,000 people, but within several months, it had grown to the point where it was covering about 60,000 people and 20 villages. The late 1970s and the 1980s were a time of extreme political polarization in El Salvador, and the country’s military-dominated government often regarded non-government organizations which worked with rural poor people as “subversive.”

The military began to ask why ASAPROSAR was growing so rapidly and assigned four *hacienda* (village) police to observe what

Guzman was doing. The police would keep watch inside her examining room where she was seeing patients. After a while, the police officers became bored with just doing nothing. They had a meeting with all the people and asked what their greatest problem was. The people said it was alcoholism. One of the officers was a member of Alcoholics Anonymous. He started an AA group which met every night while Guzman did her consultations. The group is still in existence 20 years later.

At one point, there were so many people to be seen that those who were helping urged Guzman to think of a way to prevent the people from getting sick. She decided to do an evaluation to see what the situation was. She saw that there was no clean water, there were no latrines, and the communication between the rural area and the cities was difficult because there were no roads. That is when she realized that the isolation of the region made it easy for persecution to occur.

Guzman was imprisoned for three months. She cites her imprisonment as providing time to think about what she was doing. She realized she needed to change the way she was working. After leaving prison, Guzman suspended her regular work of treating patients for about a year to concentrate on long-term solutions. She was particularly interested in involving the people in solving their own problems. She says that she asked the people questions such as, "How can we build a latrine and work together so there's less contamination? How can you live not so close to the animals and have drinkable water?" There was so much malnutrition, and the people began to look at what was in their environment that they could use for food for the children.

While Guzman was working in areas where there were many cases of malaria, the people told her there was a type of tree that gave off a terrible odor. There were no mosquitos around those trees, so they began to plant that kind of tree around the village. People also put a certain kind of fish in the water that would eat the larvae of the mosquitoes. These are only a couple of examples of the kinds of things that she began to learn from the people.

People always participate in the decision making at ASAPROSAR. One example is the education of couples. When ASAPROSAR had been working with women for a while, the women said, "Now it's time that you talk to the men also." It was only as the couples began to talk about the problems in the community that they began to change their behavior. The couples

themselves have decided that two or three children are really best. It was not because ASAPROSAR gave them contraceptive supplies. As the couples analyzed and reflected on their own problems, it gave them a realization of the problems of overpopulation. All ASAPROSAR did was teach them the alternatives of family planning. It was the couples who decided what they would do.

Guzman stresses that with El Salvador's civil war over, there is a great deal of money coming into the country, but that people from the outside want to tell ASAPROSAR how it should do its work. She explained that

there is a group coming to San Salvador who doesn't want the people to build their own latrines, they want them to contract it out and let someone else build their latrines. This is against our philosophy because we really want people to participate. The people need to change because they want to change, not because it's imposed on them. The people can come in and build the latrines for them and they might see changes in their homes or in their schools, but the campesinos [villagers] won't have changed within, and most likely they won't be using latrines because they won't be useful to them. There's much technology coming into the country now that's really not appropriate to the culture.

ASAPROSAR has seen dramatic improvements in health in areas it serves. When the organization first arrived in one typical area, 60 out of 100 children had diarrhea. Recently, in a survey in that same area, ASAPROSAR found two children that had diarrhea. Before the group's arrival, if 100 children had respiratory diseases, 20 of them would typically die. Now in those areas, although respiratory diseases still occur, Guzman says that there has not been an infant death in the last few years from this cause.

In an interview in March 1993, Guzman commented:

Now none of the children are dying from dehydration. In all of the communities that we go in, one of our goals is that there is at least one person in each family who knows what to do if the child has diarrhea. A lot of the women can't read and write, so we teach them how to make the oral rehydration fluid to the tune of a popular song.

When ASAPROSAR first arrived, only 25 percent of the children were vaccinated. Now 98 percent of the children are vaccinated, because the women understand how important it is. The remaining 2 percent are not yet of the age to be fully vaccinated. The results are clear. When there was a cholera epidemic recently, there was not one case of cholera in ASAPROSAR's area. About three years ago, there was a terrible outbreak of German measles, and ASAPROSAR only had one case in all of the communities they served. The people themselves were so proud, they told the other communities.

It was not only medical technology that saved lives and improved health care. Guzman said that indigenous folk wisdom also can play an important role:

I was amazed at the amount of self-knowledge they had to solve problems. I was so reliant on technology and laboratories, and I realized that when I'm in the country, I don't need all those things.

One time I was taking care of a woman who was unconscious. She was also pregnant and almost ready to have her delivery. We were very far from the city and it was late at night. I didn't know she had diabetes, but I suspected. I was trying to figure out how I would know if there was sugar in the blood. I was explaining to the people what diabetes was and if they could figure out if she had sugar in her blood. One of the men said, "Let's clean this little area right now," and he urinated on a certain spot. Then nearby, they put the urine of the woman. I said, "OK, what's going to happen?" and the man said, "Well, if she's got sugar in her urine, the ants are going to come to her urine." Within ten minutes, there were the ants coming to her urine. For me it was discovering a new world, the knowledge these people had, because I was really impotent with[out] all of my technology. This is what inspired me and I really think that I have learned more than they have.

TOO MUCH PAPERWORK: TOO FEW "RESULTS"

Several of the points stressed in this report are profoundly affected by, and dependent on, changes in the administrative and paperwork requirements within USAID generally and the child survival program specifically. Those points include: 1) the best and most cost-effective work in child survival is done by U.S.-based private voluntary organizations (PVOs) and indigenous grassroots groups that have learned the lessons of community participation and involvement, but these groups have difficulty fulfilling USAID's complex administrative regulations; 2) USAID spent too much of its resources on expensive U.S. consultants and for-profit consulting firms; and 3) more attention was placed on inputs and strict adherence to regulations than on "results."

The system of paperwork involved in applying for, qualifying for, negotiating, receiving, evaluating, and auditing child survival funds is mired in repetitive and sometimes conflicting rules and regulations from USAID, the Office of Management and Budget (OMB), and other government agencies. A 1993 paper, "Streamlining the Procurement Process and Reducing Administrative Requirements," prepared by a joint USAID-PVO taskforce reported that

the process is rife with redundancies, probably costing more than it saves, does an imperfect job of protecting the government, stifles risk taking and program impact, and generally makes everyone unbappy.⁴

The following example provides an idea of the administrative requirements of USAID's Office of Private and Voluntary Cooperation (PVC), which administered a program of grants to PVOs that accounted for approximately \$18 million of the \$225 million Child Survival Fund in FY 1991. Kenneth Flemmer, Vice-President for Programs at Adventist Development and Relief Agency (ADRA), estimates that it takes 244 days over a three-year period and costs ADRA \$64,264 in staff time, travel, and other charges to fulfill all requirements on just one three-year child survival grant:

ACTIVITY	NUMBER OF DAYS
Pre-Approval Activities	
Proposal preparation and budget	21
Revised proposal budget	7
Information for contracts office	14
Post-Approval Activities	
Preparation and approval of detailed implementation plan	30
Approval of annual workplans and budget (times three years)	21
Prepare first annual report	9
Prepare the final report	10
Conduct and get approval on mid-term evaluation	30
Conduct and get approval on the final evaluation	30
Obtain USAID approvals for travel, consultants, training, evaluations, procurement, etc.	21
Accounting support	30
Mid-term and final audit	21
Estimated headquarters time for child survival implementation	244 days
Estimated headquarters cost: \$64,264	
Staff Time	\$45,264
Travel	12,000
Other	<u>7,000</u>
TOTAL	\$64,264

Flemmer reports that before 1994, the process was even more cumbersome, with another 71 days of staff time costing \$13,064

required to prepare quarterly financial and activity reports, trip reports, and training reports. He also argues that:

1. It is not uncommon to find requirements changed in the middle of a project cycle, often at the last minute
2. Requests for proposals are often made with insufficient preparation time provided to implementing agencies for quality planning and without a correlating extension of the due date.
3. Guidelines call for proposals with increased complexity in shorter time frames which, in the end, cost PVOs more time and resources to prepare. Once the proposal is approved by USAID, PVOs are required to submit additional documentation on implementation plans, along with annual work plans and annual reports for the procurement office.

Other PVO representatives complain of burdensome and often arbitrary micro-management of PVOs' implementation of projects by USAID field officials.

One former USAID mission health director argues that basic contracting procedures are designed for large for-profit firms, which usually have big offices, highly paid consultants, large support staffs, and enormous overhead costs. USAID, he says, is more interested in "process" (and the processing of the right forms) than in seeing that the process serves the intended beneficiaries. As a result, the manner in which requests for proposals are designed and announced inhibits the involvement and competitiveness of PVOs, and the lion's share of the contracts go to these large, high-cost firms.

A PVO contract with USAID might come to \$500,000 over three years, while a for-profit firm or for-profit consortium project could total \$50,000,000 or more. Yet the paperwork requirements are the same. This is true even in the case of PVC's grants, but the office deals exclusively with PVOs, and does not contract with for-profit entities.

Despite the Paperwork Reduction Act passed by Congress 13 years ago, Vice President Albert Gore says that Washington is drowning in paper. The government's bureaucratic procedures, which include financial, management, personnel, procurement, budgeting, and information systems, are structured in a way that compels federal employees to "follow every rule, document every decision, and fill out every form." Gore notes that the government is more concerned with what it spends than with what it is trying to accomplish. Complex and redundant implementation, reporting, and

audit requirements are heavily focused toward "input monitoring" because of the fear of fraud, waste, abuse, negative congressional reaction, and bad press. Gore estimates that the U.S. government could save \$40.4 billion annually by streamlining the bureaucracy and \$3.3 billion by eliminating duplications among the intergovernmental agencies.⁵ Congress and OMB must find ways to reduce the paperwork burden to increase the efficiency of child survival programs.

Merely eliminating unnecessary and duplicative paperwork is insufficient, however. The U.S. Government should state, in measurable terms, the goals of its child survival programs and require the same of the specific projects it funds. What kind of reduction in child mortality and child malnutrition rates are we trying to achieve? The establishment of specific goals will permit USAID to choose the best and most cost-effective strategies for child survival, and will also be consistent with the agency's new "results orientation."

Work done by U.S.-based PVOs, indigenous grassroots groups, and government agencies that have learned the lessons of community participation and involvement will stand out as some of the best and most cost-effective. In addition, PVOs are required to match their USAID child survival grants by 25 percent with funds from private contributions.

Despite these comparative advantages, between FY 1985 and FY 1991, USAID only provided an average of \$15 million a year to PVOs for child survival activities via PVC (PVOs do receive some child survival contracts through other channels, such as directly from USAID field missions).

FINDINGS

Unless otherwise noted, all project descriptions below are taken from *Child Survival. A Seventh Report to Congress on the USAID Program* (Washington: USAID, 1992) and official USAID project documents. Most of the projects studied are intended to be carried out over several years, but budget figures are for FY 1991 only. Countries' status for reaching World Summit for Children year-2000 mortality goals are taken from UNICEF's *Progress of Nations 1993*. Our praise, questions, and concerns are presented *in italics*.

Field Research Countries

EGYPT

1991 Population (millions)	53.6
1960 Under-Five Mortality Rate (U5MR)	260
1991 U5MR	85
Global Rank of Severity of U5MR	56
FY 1991 USAID Child Survival Program	\$8 million

Status on Reaching World Summit for Children Year-2000 Mortality Goal

"On target" to reach the U5MR goal of 51 per 1,000 live births. During the 1980s, Egypt's U5MR dropped from 180 to 76 per 1,000 live births. USAID's evaluation of the Child Survival Program corroborates the substantial improvement in infant mortality in Egypt from 1984 to 1987, paralleling an improvement in immunization coverage from 64 percent in 1984 to over 87 percent in 1987.⁶

Child Survival Project: \$8 million (FY 1991)

As part of a ten-year (1985-1995) project, supports a nation-wide child health program, including services and research related to immunization, breastfeeding, growth monitoring, maternal health and nutrition, birth spacing, and acute respiratory

infections. Assists in upgrading the Ministry of Health's immunization, acute respiratory infections, child nutrition, and child spacing programs.

- The \$8 million includes \$2.8 million for immunization, \$800,000 each for acute respiratory infections and child nutrition, and \$1.2 million for child spacing.

According to a 1991 project document, some of the accomplishments include. reduction in the infant mortality rate from 87 to 44 per 1,000 live births; an increase in immunization coverage for measles of children under one from 41 percent to 86 percent; and coverage levels of 88 percent for tuberculosis, 87 percent for polio, and 86 percent for DPT. Key supporting programs have been the training of 3,000 health workers, cold chain equipment in 3,600 sites, and the initiation of a polio education program.

The acute respiratory infection component is operational in five provinces that are home to 40 percent of the population. It has trained more than 2,000 health workers. Egypt has developed a national plan to combat acute respiratory infections, one of the first in the developing world

The Egyptian public health community gave the Child Survival Project extremely favorable evaluations overall, and felt that USAID's support had played an essential role in allowing the country to reduce child mortality, exceed the goal of fully immunizing 80 percent of children under one against six diseases, and meet the target of immunizing 60 percent of women of childbearing age against tetanus.

Factors behind this success include a long history of vaccination activity in the country, effective public education through the mass media, training of health teams, and the establishment of an unswerving cold chain. In addition, according to a former USAID health official, concentrating efforts on limited issues and close collaboration with UNICEF helped in achieving good results.

The project also resulted in the establishment of 360 units around the country for the care of newborn and premature

babies, and the prevention of 3.5 million child deaths from acute respiratory infections between 1988 and 1994. Child spacing activity has trained 11,000 birth attendants. A large percentage of births take place at home with help from these attendants. Maternal mortality is reported to be declining.

Independent evaluations conducted for USAID found that the project contributed to reduced incidence of disease and reduced fertility among women of childbearing age.

The Egyptian government remains strongly committed to child survival. It has allocated substantial budgetary resources of its own to assure the continuation of the project, despite harsh overall fiscal stringency.

There were a number of shortcomings in the project, however. There was widespread dissatisfaction in Egypt with Buy American rules and the use of U.S. consultants.

Buy American rules raised the costs of some equipment and supplies, leaving less money for service delivery. For example, the antibiotic amoxicillin was important in treating children with acute respiratory infections. One Egyptian doctor stated that at the beginning of the project, it was against the rules for USAID to pay for medication. After negotiations, USAID agreed to supply the medication, provided that it be supplied from the United States. This Egyptian doctor asserted that equivalent local brands could have been purchased for less money, allowing treatment of more children. Part of the additional cost was for shipping, handling, customs paperwork, and distribution from port of entry. Project staff also had to use valuable resources re-labeling the medication in Arabic.

Similarly, project staff felt that Chinese-made oxygen concentrators and timers for use in the acute respiratory infections component were less expensive and delivered on a more timely basis than U.S.-made equipment. Other project donors, such as UNICEF, permitted the purchase of goods and services from worldwide sources, while equipment ordered by USAID from U.S. sources was higher-priced and did not arrive on schedule.

The project is perhaps the most egregious case of using expensive U.S. consultants. Project documents called for the equivalent of 20 years of U.S. consultants at \$17,400 per month (\$208,000 annually). U.S. consulting firms charge USAID an average of 130 percent of actual operating costs of the projects for "overhead," e.g., maintaining headquarters offices. One former USAID/Egypt health official said that Egyptian doctors worked in the salary range of \$150-200 per month and the salary of the Minister of Health is \$400 per month. In Egypt, this official said, there are enough committed people and an effective public health system. When U.S. contractors are used in developing countries, nothing really is left when they leave except that some people get astronomical wages

Other informants reported that many of the U.S. consultants had little experience in developing countries and poor communication abilities, and their presence added nothing for Egyptian children. Indeed, engaging their services may have had a negative effect due to loss of precious time and money that could have been used to save the lives and improve the health of many children.

In addition, there were many qualified local consultants available, and U.S. contracting firms could have employed them through subcontracts, though this seldom happened. The project could have hired 10 top level consultants from Egyptian universities and research institutes for each U.S. consultant. Local experts remain available on a long-term basis to assure the sustainability of child survival gains

Another concern focused on lack of coordination among the project's components (immunization, acute respiratory infections, child nutrition, and child spacing) and between the Child Survival Project and the separate National Control of Diarrheal Disease Project. It is not enough to save a child from acute respiratory infections and allow him or her to die of an accident, diarrhea, or malnutrition.

There was strong sentiment in Egypt that the child nutrition component of the project was not successful. There was no surveillance system to measure the degree of malnutrition and

therefore no way to measure improvement through 1991. The project evaluation for USAID found that the distribution of nutrition education materials was not monitored, and may not have been targeted to the neediest people. The nutrition component is reported to have trained more than 3,000 health practitioners in improved nutrition techniques and education, but it is unclear what they then did and how many people benefitted. The separate nutrition component was eventually canceled, although nutrition education was added to the child spacing component.

The acute respiratory infection component was the second largest element of the Child Survival Project. Emphasis was given to training doctors and other health workers in standard case management methods. The mid-term evaluation indicated that a community information campaign for mothers was needed. It is unclear whether any such community media campaign occurred before the end of 1991. We have not been able to find data on treatment usage as opposed to availability

The former USAID health official whom we interviewed complains that USAID is getting rid of more and more technical staff who are concerned about delivering services to the people. Instead, the agency is filled with people who are good at following bureaucratic procedures and devising policy processes.

It should be noted that in FY 1991, the United States provided Egypt \$815 million in aid from the Economic Support Fund. This included funding for the Child Survival Project, but child survival money represents less than one percent of total U.S. assistance.

EL SALVADOR

1991 Population (millions)	53
1960 U5MR	210
1991 U5MR	67
Global Rank of Severity of U5MR	66
FY 1991 USAID Child Survival Program	\$11.311 million

Status on Reaching World Summit for Children Year-2000 Mortality Goal

"On target" for reaching the U5MR goal of 47 per 1,000 live births.

General Concern:

One medical doctor who previously worked in Nicaragua and now works in the Philippines asked the following question: El Salvador got \$106 million in 1992 for 800,000 children under five (\$13.25 per child), while the Philippines got the same amount of money for 9.2 million children (\$1.15 per child) Why the greater than 11-fold difference? If child survival funding is driven by geopolitical concerns, how does that distort our priorities and the spending of resources?

Projects:

1. Maternal Health and Child Survival Services: **\$5.385 million**

Promotes preventive health and child survival services through Salvadoran PVOs in rural areas where such services are weak or nonexistent. Between 1990 and 1997, the project is expected to extend access to quality maternal health and child survival services, including immunization and prenatal care, to an estimated 350,000 individuals living in 350 of the country's poorest communities. The project also seeks to strengthen the capacity of Salvadoran PVOs to carry out projects. Medical Services Corporation International, a U.S.-based consulting firm, is receiving \$25 million over the life of the project.

With its focus on indigenous grassroots groups, this was perhaps the best project we studied. The empowerment of people through groups such as ASAPROSAR (see case study above), which encourage community participation and greater community awareness of healthful behavior, is something that should happen throughout USAID's child survival program.

On the other hand, the burden of paperwork and regulations is cumbersome and/or harmful to the work of the grassroots groups. ASAPROSAR Director Dr Vicky Guzman complained that she has to fill out reports every month, which eats up substantial staff time. She recommended quarterly grant disbursements and reports. She also said that USAID is interested in knowing who has attended community meetings. Given the conflict and political polarization which the country has experienced, this makes many people uneasy.

Other local PVOs complained of restrictions and conditions on USAID monies, and of "destructive criticism" from USAID auditors. However, some PVOs felt that the requirements facilitated the development of indigenous capacity to carry out projects. Several PVOs criticized USAID for a "top-down" approach, designing projects without much reference to the views and desires of the communities served.

Guzman said that Buy American requirements have created problems. USAID insisted on providing ASAPROSAR with Jeep Cherokees, even though these are not appropriate for rural El Salvador. And in any event, USAID does not provide maintenance money for the vehicles.

Guzman reported that there were pressures on ASAPROSAR to rely more on paid staff and less on volunteers, despite the organization's great successes in getting communities to take ownership of programs

Salvadoran child survival PVOs generally view USAID funds favorably, because it is a stable source of funding and allows the groups to extend their reach among poor rural families. There is concern, though, that communities become able to sustain health gains once USAID funding ends.

2. Health and Jobs for Displaced Families:
\$2.071 million

Supports the Ministry of Health's program to provide health and nutrition services for displaced and relocated families. The project was initiated in 1982 to serve more than 500,000 people displaced by the country's civil war. Three U.S. PVOs carry out this project – the International Rescue Committee, World Relief, and Project HOPE. An additional grant of \$.4 million was given in 1990 to Creative Associates International to help an estimated 1,000 Salvadoran war-displaced families to permanently relocate or return to their place of origin and become economically self-sufficient.

The project has a number of child survival components, including supplemental feeding, nutrition education, immunization, training of community health promoters, and training related to sanitation and clean water. However, the project also includes non-child survival components such as agriculture and housing construction. These are also important to improving the well-being of displaced people, but only those activities which are clearly child survival should be counted as such.

A former project staffer complained that there is some competition among foreign and local PVOs and the Ministry of Health to carry out child survival activities. "Everything in this country is political," she commented. She felt that the project did not include community participation from the beginning, although in its later stages it became less top-down.

3. Community Based Integrated Rural Development:
\$1.380 million

In cooperation with the Ministry of Health, Save the Children Federation, a U.S.-based PVO, provides families in eastern and northern regions of the country with immunization, ORT, nutrition education, and potable water. USAID granted Save the Children \$2.48 million over five years (1989-1994) to improve the social and economic conditions of 1,500 low-income families, especially women and children in two areas of La

Union, and to reinforce the organizational and management capacity of community groups and programs in four other areas.

Community participation was an important element in this project. Beneficiary communities are involved in planning and implementing activities, and there is an effort to make these activities self-sustaining

The project involves some agricultural and youth group development activities as well as child survival. These are funded with child survival money, but should be counted as agriculture and rural development.

Project personnel complained about Buy American requirements which forced them to purchase high-maintenance, inefficient vehicles, and cumbersome bureaucratic procedures which further drained project resources

4. Health Systems Support: \$1.040 million

Assists the Ministry of Health with its efforts to increase child survival and related activities in local health systems nationwide, including the recruitment and training of community health promoters. Strengthens the capability of the ministry to deliver logistical systems support and basic health services and to strengthen policy, program planning, and management support.

The project supports primary and preventive health care services provided to poor rural communities through the Ministry of Health. Like some of the other projects, it works through community health promoters. Although the project does focus on child survival activities, including immunizations, ORT, and treatment of acute respiratory infections, it also provides more generalized health care services. Only the actual child survival portion should be counted as such, although the general expansion of access to public health services is an important activity.

Project personnel noted that the Ministry has "massive and comprehensive infrastructure," but its employees are less

committed and creative than those of non-governmental organizations.

A mid-term evaluation of the project called for greater emphasis on service delivery, but made no mention of progress on measurable indicators of improved child health.

5. Rehabilitation Services: \$.750 million

Supports rehabilitation activities through a local PVO, the Teleton Foundation, which provides technical assistance, training programs, development of prosthetic devices, and services to disabled people. The project's major purposes were enabling the Foundation to establish a privately operated prosthetic manufacturing workshop and strengthening its training programs.

This is not a child survival project. It provides prosthetic devices, crutches, and rehabilitation services to war victims. This is an important activity for overcoming the legacies of conflict, but it should be charged to USAID's general health account.

6. Family Health Services/Maternal and Child Health: \$.705 million

Expands the activities of the non-governmental family planning service system and provides family planning and maternal/child health services to rural communities through the Salvadoran Demographic Association. The project seeks to increase the number of families using modern family planning methods from 120,000 to 200,000. An additional 1,550 rural communities will have access to family planning.

There is a strong family planning emphasis in the project, but it seems well-integrated with child survival activities. The project provides preventive and primary health care through clinics and community promoters. Health education includes promotion of ORT, breastfeeding, birth spacing, and growth monitoring, as well as advice on avoiding acute respiratory infections. Promoters distribute ORT packets, vitamins, and anti-parasitic medicine, as well as contraceptives.

PHILIPPINES

1991 Population (millions)	63.8
1960 U5MR	128
1991 U5MR	46
Global rank of seventy of U5MR	75
FY 1991 USAID Child Survival Program	\$16.655 million

Status on Reaching World Summit for Children Year-2000 Mortality Goal

The Philippines is ranked fifth among the countries of East Asia and the Pacific with a 1990 U5MR of 62 per 1,000 live births, 29 points better than might be expected given its per capita income of \$740. However, U5MR declined by only 1.2 percent per year during the 1980s, or 2.9 percent below the average annual rate reduction needed in the 1990s to reach the goal of 41 per 1,000 live births.

General Concern:

Most of USAID's child survival projects in the Philippines lacked clear targets for measurable progress in child survival. All relied heavily on expensive U.S. consultants.

Projects:

1. Child Survival Program: \$13 million

Supports improved access to child survival services such as oral rehydration, immunization, and maternal and child health. The project is to receive \$50 million in grant assistance over a period of five years (1989-1994). Of this total, \$5 million is paid directly to U.S. contractors for technical assistance, monitoring and evaluation, and audit requirements. The remaining \$45 million is "performance-based disbursements," which require the Government of the Philippines to meet USAID's performance benchmarks, such as privatization of health services, long-term financial sustainability, and area-based program planning before the child survival money is released. It is then deposited into a

U.S. Federal Reserve Bank account to be used to service the debt of the Philippine government. In FY 1991, debt payment of \$13 million was scheduled, after which the Philippine government transferred \$13 million in pesos to its Department of Health for child survival-related services such as immunizations of children and pregnant women.

This project is widely viewed as a great success in the Philippines. It exceeded the 1993 target of immunizing 85 percent of the children under age one by 1991, and made progress on immunizing women of childbearing age against tetanus.

However, it is difficult to say how much of the project's success should be attributed to USAID support, since other donors (especially the World Bank) have also contributed funds, and the Philippine government began efforts to expand immunization long before USAID began to fund this activity.

The Philippine public health community acknowledges that the USAID project performance benchmarks relating to hospital privatization "seem to detract from the underlying purpose" of the project. But since the Department of Health spends 65 percent of its budget on operating hospitals, there was some sentiment that privatization would free up resources for primary health care activities. And the benchmarks were regarded as an effective management tool. However, they should be tied more closely to child survival (e.g., increased availability of basic drugs in rural areas).

In addition, Filipino health professionals liked the benchmark approach to paying out project funds, because once the benchmarks were met, the Department of Health had the full prerogative as to how the money was spent without all the USAID red tape. Strong local monitoring systems prevented corruption and diversion of the funds

Weaknesses in the project included:

- No guarantee that the Philippine government will keep it going in the absence of external funding.*

- *No baseline study to assess the project's impact on child mortality and malnutrition.*
- *Different units within the Department of Health used different definitions of some child survival indicators, such as births attended by trained personnel. This made it hard to measure progress*
- *About 33 percent of the funds went to augment budgets for the field units implementing the program. This money could have been used more effectively. For example, most went into buying drugs for hospitalized patients, when it could have been used to provide basic drugs for community health facilities.*
- *Communication funds were spent on television, even though less than 30 percent of rural Filipinos own television sets. Use of Red Cross posters and comic books on health issues would have been more appropriate communication devices in poor rural communities*

**2. National Health Finance Development Project:
\$1.34 million**

Assists the Philippine Department of Health in the reform of its medicare program and in the development of the legal and regulatory basis for health maintenance organizations toward developing alternative delivery systems. Seeks to increase utilization of health services in the five lowest income earning areas. Will establish mechanisms which include private sector health care providers in the policy reform process; improve the efficiency and expanded coverage of the health care financing programs via reforms such as private risk-sharing, employer-provided health benefits, and community financing schemes; and improve the efficiency of hospital-based care provided through public and private hospitals.

Implementation did not actually begin by the end of FY 1991, so there really is nothing to evaluate. Moreover, there is no connection to improvement of maternal and child health whatsoever. The project should not be counted as a child survival activity, although Department of Health officials felt that given the lack of ongoing financing for the Child Survival Program, making hospitals self-financing might free up resources for child survival activities. Interviews suggested that this project is bogged down with heavy USAID bureaucratic requirements.

**3. Enterprise in Community Development:
\$1.200 million**

Focuses on primary health care, including child survival programs implemented by local communities. Fosters business and community participatory development activities in areas outside the Manila Metropolitan area. Provides co-financing, technical assistance, and training. Over five years, the project is to directly benefit rural poor people and indirectly benefit the private sector in rural areas.

4. PVO Co-Financing III: \$.610 million

Strengthens indigenous private voluntary organizations in health promotion and child survival activities. Seeks to increase productivity, raise incomes, and generate employment among target beneficiaries, as well as to increase the capacity of PVOs and cooperatives to plan, manage, and execute development activities.

USAID/Philippines gave a \$.3 million grant under the project for a period of three years (1989-1992) to Medical Ambassadors Philippines, a local PVO, to support community-based primary health care in 14 ethnic minority communities, with a combined target population of 30,000 people, on the islands of Luzon and Mindanao.

Raising incomes and generating employment among poor people are important parts of sustainable development, but should not be counted as child survival.

5. Urban and Industrial Environment Management
Project: \$.500 million

Over five years, the project will receive \$20 million to promote improved pollution reduction with sustained economic growth in the industrial sector.

Clearly, this is an environmental project, which is not directly connected to the child survival mandate. It also lacks measurable goals for health outcomes.

Desk Study Countries

AFGHANISTAN

1991 Population (millions)	17.9
1960 U5MR	360
1991 U5MR	257
Global Rank of Severity of U5MR	3
FY 1991 USAID Child Survival Program	\$9.012 million

Status on Reaching World Summit for Children Year-2000 Mortality Goal

Not available

Projects:

1. Health Sector Support: \$6.678 million

Provides training and medical supplies cross-border to health care units which support immunization and diarrheal disease control through primary care services to mothers and children. Specific objectives include:

1. Improve first aid and emergency services, including medical and surgical care for war casualties, phasing down as need subsides;
2. Expand general health care services for civilians, including women and children, as well as Mujahideen (Afghan "freedom fighters"); and
3. Enhance capability of organized Afghan entities (private or public) and/or organized areas to plan, organize, and manage expanded health care activities.

By April 1992, the project was supporting 1,587 health facilities and 2,959 health and support staff inside Afghanistan; it had trained 2,178 basic health workers for deployment inside Afghanistan, and had established ten central supply depots and

six training facilities inside Afghanistan.

This is a first aid, emergency service, and general health program. Based on the purposes stated in project documents, only a small portion can be considered child survival.

2. PVO Support Project: \$1.756 million

Expands child survival and health program activities through grants to U.S. and local PVOs for services within Afghanistan. Supports establishing an umbrella mechanism to coordinate PVO activities financed by the U.S. government; assists U.S.-supported indigenous, European, and U.S. PVOs in undertaking activities beneficial to war-affected Afghans in free areas of Afghanistan; and supports a limited number of PVOs whose activities come within the priority areas of health, education, and food and agricultural production.

This project includes health, education, and food and agricultural production. Here again, only a small portion of the project appears to involve child survival activities, although in both projects, the activities funded appear valuable.

3. Commodity Support Program: \$.546 million

Makes humanitarian assistance available for distribution in rural Afghanistan.

Project documents show that it supports mine detection and clearing, and supplies food, clothing, breeding stock, trucks, and pack animals. These activities and supplies may contribute to the general well-being of beneficiaries, but they should not be counted as child survival activities.

4. Technical Services and Support: \$.032 million

Provides support for health and child survival activities by enabling the USAID field mission to obtain technical and logistical services necessary to support a range of assistance activities, including policy planning; the design and evaluation of program activities; and project implementation.

BOLIVIA

1991 Population (millions)	7.4
1960 U5MR	282
1991 U5MR	126
Global Rank of Severity of U5MR	44
FY 1991 USAID Child Survival Program	\$7.471 million

Status on Reaching World Summit for Children Year-2000 Mortality Goal

Behind schedule on progress toward meeting the goal of a U5MR of 70 per 1,000 live births. Bolivia reduced child mortality by 3 percent per year during the 1980s, but would have to reduce it by 5.8 percent per year during the 1990s to reach the goal.

General Comment:

The USAID/Bolivia mission set a broad range of performance indicators and targets.⁷ This was an important step, but we would argue that the targets should be linked to the goals agreed to at the World Summit for Children.

Projects:

1. PVO Child Survival II: \$3.165 million

Provides technical assistance and training to a network of organizations seeking to reduce infant and maternal mortality. Strengthens technical, managerial, and service delivery capacities of Bolivia's PVOs and enhances the coordinating capability of the Bolivian PVO umbrella organization.

The stated goals are valid, but they are not put in quantifiable terms. 1991 was the first year of the project, meaning that it might not have an easily measurable impact on mortality and morbidity, but goals could be established for the

life of the project. It appears that any specific goals were left up to USAID/Bolivia, and were not included in project documents.

2. Water and Health II: \$2 million

Works with the community, through CARE, to expand potable water and sanitation systems in La Paz and Cochabamba using educational campaigns to promote the use of ORT, immunization, and improved nutrition.

Again, the stated goals are valid, but not quantifiable.

3. FY 1991 Child Survival and Vitamin A Grants to Project Concern International: \$.700 million

Extends primary health care and child survival services, including vitamin A supplementation, in rural and peri-urban highland communities, targeting over 35,000 women and children and using local health teams to mobilize community participation.

According to a Project Concern proposal for extension of the project, it seeks to reduce morbidity and mortality in children under five due to diarrheal, respiratory, and vaccine-preventable disease and in women of child bearing age due to childbirth complications. The major objectives are to increase the capacity of local service providers and the government to deliver child survival services, to increase the acceptance and use of these services by the community, and to increase the ability of the community to support them.

We learned from Project Concern International that project goals included immunization of 90 percent of 12-23 month olds in rural areas of Potosi and Cochabamba and 80 percent immunization in urban areas; immunization of 60 percent of the women of childbearing age against tetanus; and instructing 85 percent of mothers about weaning and vitamin A-rich foods. But it was troubling to learn that USAID's mid-term evaluation of the project was a process evaluation and that there would not be a measure of health outcomes until the final evaluation.

4. Reproductive Health: \$.584 million

Supports the Ministry of Health and local organizations to extend voluntary family planning services to prevent high risk births.

When family planning activities are part of a comprehensive system of primary health care, they can logically be considered child survival activities. However, this appears to be a free standing family planning program which should be charged to the population account rather than child survival.

5. Self-Financing Primary Health Care II: \$.562 million

Works through a Bolivian PVO to improve the health status of agricultural workers and their families through a network of private clinics operating within the existing agricultural cooperatives to improve access, quality, coverage, and sustainability of health care services to under-served populations. Over five years, the project is expected to provide services to 340,000 people.

6. Alternative Development: \$.144 million

Support for development of potable water supplies in the Cochabamba region to improve family health; part of a larger program to divert farmers from cultivation of coca leaf.

7. Central Contraceptive Procurement: \$.120 million

Promotes birth spacing.

Again, this is a population project, not a child survival activity

8. Interactive Radio Learning: \$.090 million

Develops radio health programs directed toward primary school children to communicate health education messages which have proven effective in improving and changing family health behavior. Over five years, the project seeks to improve the

health status of children in primary grades three through five and the mathematics skills of children in grades two through five using interactive radio instruction. The curricula developed are expected to become an institutionalized part of the Ministry of Education and Culture. The health curricula will be extended to out-of-school children and adults.

Only a portion of this project should be counted as child survival. Improving mathematics skills – an important objective for development – should be charged to education.

9. Program Development and Support: \$.088 million

Provides support for health care financing studies.

10. Special Development Activities: \$.018 million

Supports health and child survival development activities through local organizations. Specific activities include assisting small rural communities and local organizations to develop community-sponsored industries, rural infrastructure, selected social services, water supply systems, school remodelling, and construction of health posts. Encourages increased participation of local governments and community organizations in development. Accelerates the decentralization process and enhances local decision making capabilities.

The project is very small and most of the supported activities seem unrelated to child survival.

HAITI

1991 Population (millions)	6.6
1960 U5MR	270
1991 U5MR	137
Global Rank of Severity of U5MR	37
FY 1991 USAID Child Survival Program	\$7.323 million

Status on Reaching World Summit for Children Year-2000 Mortality Goal

Behind schedule to meet the U5MR goal of 70 per 1,000 live births. The rate fell by an average of 3.3 percent per year during the 1980s, and to reach the goal, it would have to fall an average of 6.9 percent per year during the 1990s.

Projects:

1. Voluntary Agencies for Child Survival: \$4.785 million

Provides technical assistance to local and U.S. PVOs to strengthen their child survival activities, including training health workers and physicians. PVO community outreach programs offering oral rehydration therapy, immunization, growth monitoring, and family planning were to reach one million children and women of childbearing age over a five year period. The project also provides long-term technical assistance to private sector organizations to develop the management systems of three Haitian health organizations.

This project included specific measurable targets, but although it was in its fourth year (of five) in FY 1991, no information was available on how actual outcomes compared to the goals. Also, it is unclear whether the technical assistance to private sector organizations was cost-effective.

2. Expanded Urban Health Services: \$2.127 million

Supports the Center for Development and Health, a local PVO, to provide a wide range of child survival and other health services, especially the expansion of vaccination coverage to mothers and children in low-income urban areas. Assists the private sector in continuing to deliver primary health care and child survival health services in low-income urban areas.

Similar to the above project, this one included measurable targets, but no information was available as to how well it was succeeding in FY 1991 (the second of five project years).

3. FY 1991 Child Survival and Vitamin A Grants to World Vision Relief and Development: \$.410 million

Provides assistance to improve the health services available, especially to women and children, on the island of La Gonave, including activities to reduce vitamin A deficiency through nutrition education and supplementation. The target population includes about 2,600 infants 0-11 months; 2,600 children 12-23 months; 9,600 children 24-59 months; and 17,000 women of childbearing age.

This project was among the best targeted (in terms of measurability) of all those studied. A survey in September 1991 indicated 74 percent of children 12-23 months were fully immunized, compared to the project objective of 75 percent, according to the Final Evaluation Report dated December 27, 1991. Seventy percent of mothers with children under two used ORT, compared to the goal of 80 percent. The evaluation notes, "Only maternal care fell short of project's objective – 42 percent of mothers had received tetanus immunizations, whereas the project objective was 70 percent. . . ."

4. Special Development Activities: \$.001 million

Assists local organizations to develop small, self-help community health and potable water activities, including digging latrines and constructing schools.

INDIA

1991 Population (millions)	863:2
1960 U5MR	236
1991 U5MR	126
Global rank of severity of U5MR	42

FY 1991 USAID Child Survival Program \$5.83 million

Status on Reaching World Summit for Children Year-2000 Mortality Goal

India is behind schedule to meet the U5MR goal of 70 per 1,000 live births. In the 1980s, India reduced the rate by 3 percent per year, and would need to reduce it by another 6.2 percent annually during the 1990s in order to reach the goal.

Projects:

1. Child Survival Health Support: \$4.83 million

Assists the Ministry of Health, through UNICEF and local non-governmental organizations, in a major expansion of child survival initiatives by promoting ORT, immunization, control of acute respiratory infections, and high risk birth management. By the end of 1991, the expected outcomes were: extension of the universal immunization program to all of India's 412 districts; immunization coverage of 85 percent in the four target states of Gujarat, Maharashtra, Himachal Pradesh, and Haryana; a national network of clinical rehydration training centers established and fully functioning in every district in the four target states; and reduction in infant deaths of 1.9 million per year.

This project was part of a five year, \$288 million effort by USAID, UNICEF, the Government of India, and others to expand immunizations and ORT. USAID was wise to give its funds to UNICEF for a national effort focused on measurable reductions in mortality. The project, in turn, is one component in India's national child survival program, which is the largest in the world, and which has played a major role in reducing child mortality in the country. It has consistently received firm support from the highest levels of the national government.

Several of the project's 1991 goals were reached Nationwide, for example, immunization against measles jumped from 1 percent in 1985 to 86 percent in 1991 (slightly higher than the 85 percent target). But while India's U5MR fell from 154 per 1,000 live births in 1986 to 126 in 1991, saving about 700,000 children per year, that was short of the stated goal of 1.9 million fewer deaths per year.

India had a total population of 863 million in 1991. There were about three million deaths of children under five that year. Given this level of need, the modest size of the USAID child survival program evidently reflects the relatively low importance of India in U.S. foreign policy

**2. Quality Control for Health Technologies:
\$1.00 million**

Supports creation of an independent biological testing laboratory to improve the quality of preventive health care by ensuring that safe and effective vaccines are delivered to children and mothers.

MALI

1991 Population (millions)	9.5
1960 U5MR	400
1991 U5MR	225
Global rank of severity of U5MR	8
FY 1991 USAID Child Survival Program	\$6.879 million

Status on Reaching World Summit for Children Year-2000 Mortality Goal

Behind schedule to meet the goal of 70 deaths per 1,000 live births. Mali reduced its U5MR by 3 percent per year during the 1980s, but would have to reduce mortality by 11.9 percent per year during the 1990s to achieve the objective.

Projects:

**1. Community Health and Population Services:
\$3.849 million**

Targets women and children facing potential health risks by providing health and family planning services at district and community health centers, private clinics, and pharmacies

2. PVO Co-Financing: \$2.655 million

Supports indigenous and U.S. non-governmental organizations (NGOs) to implement village-level outreach activities, including child survival, microenterprise development, and natural resource management. Strengthens Malian NGOs. Child survival activities focus on child spacing, family planning, immunizations of mothers and children, nutrition, growth monitoring, promotion of ORT, village training, and health education and hygiene.

Project documents show that in FY 1990, child survival activities accounted for about 27 percent of total project grants. Up to December 30, 1990, three months into FY 1991, there were only two child survival grants, totalling \$1,180,364, or less than

50 percent of the funds available. This raises the question of whether all of the \$2,655,000 reported as obligated in FY 1991 should have been counted as child survival

3. FY 1991 Child Survival and Vitamin A Grants to World Vision Relief and Development: \$.375 million

Helps the Ministry of Health work with mothers in the Sikasso Region to reduce the high rate of child vaccination drop-outs and to reduce vitamin A deficiency through increased production and consumption of vitamin A-rich foods. Project components include nutrition, diarrheal disease control, growth monitoring, maternal health activities, and immunization for children and women of childbearing age. The immunization component will be implemented throughout the district

MOZAMBIQUE

1991 Population (millions)	14.6
1960 U5MR	331
1991 U5MR	292
Global rank of severity of U5MR	2
FY 1991 USAID Child Survival Program	\$13.018 million

Status on Reaching World Summit for Children Year-2000 Mortality Goal

Behind schedule to meet the U5MR goal of 70 per 1,000 live births. During the 1980s, the rate increased from 269 to 297 deaths per 1,000 live births, partly as a result of civil strife. In order to reach the goal, child deaths would have to be reduced 14.5 percent per year during the 1990s.

General Concerns:

Neither USAID child survival project in Mozambique in FY 1991 appears to have any measurable targeted outcomes. Moreover, an official of the Health Division of USAID's Mozambique field mission told us that child survival programs are wrapped up in tedious bureaucratic procedures. These make it very difficult to get small grants approved for small local PVOs. The official suggested that grants in the range of \$25,000 should involve less red tape.

Projects:

1. Primary Health Care Support Project: \$9.340 million

Provides technical assistance to the Ministry of Health to develop policy reform in the health sector, including budget allocations to primary health care, and to promote private sector involvement in the pharmaceutical industry and in the provision of health care services. Provides essential drug supplies and contraceptives.

2. PVO Support Program: \$3.678 million

Involves PVOs in emergency activities including health and child survival services. Seeks to reduce vulnerability to absolute poverty within targeted groups of the population by sustaining an effective food safety net for urban poor people; reducing dependence on external food; establishing a policy for private agricultural production; and increasing the role of the market in allocating resources to private producers

There is a seeming lack of focus on simple available technologies such as immunization and ORT.

NICARAGUA

1991 Population (millions)	3.8
1960 U5MR	209
1991 U5MR	81
Global rank of severity of U5MR	59
FY 1991 USAID Child Survival Program	\$7.125 million

Status on Reaching World Summit for Children Year-2000 Mortality Goal

On target for reaching the U5MR goal of 58 per 1,000 live births.

Projects:

1. PVO Co-Financing: \$4.281 million

Supports PVOs working in community health, child survival, orphan assistance, emergency medicine, employment generation and microenterprise development for lower income families, and sustainable natural resource management. Over the five year life of the project, about 20 percent of the funds will go to the health sector.

Project documents show that 80 percent of the funds to be granted to PVOs over five years are for employment generation, microenterprise, natural resource management, and project administration. These activities are meritorious but should not be counted as child survival. Also, the project lacks measurable goals for improving children's health.

2. Expanded Program of Immunization: \$1.219 million

Provides support for the national immunization program targeting women and children. Over two years, the project will provide \$2.5 million to the Pan American Health Organization for equipment and supplies, logistical resources, training, and evaluation to intensify Nicaragua's immunization efforts, to cover previously lost opportunities for vaccination, and to strengthen national epidemiological research and surveillance. It

was anticipated that the project would extend present field coverage of children less than one year old in all municipalities of Nicaragua.

This project also lacks measurable goals.

3. FY 1991 Child Survival Grant to Adventist Development and Relief Agency (ADRA): \$.800 million

Works in three districts of north-central Nicaragua to provide mothers and children with basic health services, including increased vaccination coverage, promoting dietary management of diarrhea at the household level, growth monitoring, and nutrition education. The project operates in one of the poorest and most disadvantaged areas of the country.

Specific numerical immunization coverage and ORT usage goals are included in project documents.

4. FY 1991 Child Survival and Vitamin A Grants to Project HOPE: \$.550 million

Extends hospital-based activities in Boaco into the surrounding community, focusing on a mix of child survival interventions, including immunizations, vitamin A supplementation, diarrheal disease control, control of pneumonia, and promotion of good nutritional practices. Focuses on children under two years of age and women of childbearing age in rural and peri-urban areas. The project will bring medical care to children and mothers by providing urgently needed medical supplies, equipment, and technical assistance to community hospitals. This region was selected because of its urgent needs and because it is a major settlement area for former "contra" fighters and their families.

Like the ADRA project, this one includes specific numerical immunization coverage and ORT usage goals. However, it is troubling that beneficiaries are targeted in part based on their political affiliation.

5. **FY 1991 Child Survival Grant to Project Concern International: \$.275 million**

Establishes a support system for delivering child survival interventions to mothers and children in the peri-urban barrio of Acabualinca in the city of Managua.

The project lacks measurable goals for improving children's health.

CONCLUSIONS

1. ***The best and most cost-effective work in the U.S. bilateral child survival program is done by governmental and non-governmental organizations that have learned how to develop community participation and involvement.*** The leader of one such group profiled in this report, Vicky Guzman de Luna, MD, founder of ASAPROSAR in El Salvador, expressed the commitment to community participation this way:

Now, since the war is over, we're seeing there is lots of money coming into the country. People from the outside now want to give us money, but they want to tell us how we should do our work. For instance, right now there is a group coming to San Salvador that doesn't want the people to build their own latrines, they want them to contract it out and let someone else build their latrines. This is against our philosophy because we really want people to participate. The people need to change because they want to change, not because it's imposed on them. The people can come in and bring the latrines for them and they might see changes in their homes or in their schools, but the campesinos won't have changed within, and most likely they won't be using latrines.

2. ***USAID spent too much of its resources on expensive U.S. consultants and for-profit consulting firms.*** A ten-year child survival program in Egypt called for 240 months of long-term U.S. consultants at \$17,400 per month, an annual rate of \$208,000. In contrast, medical doctors who work in the Egyptian Ministry of Health are paid about \$500 per month. Many grassroots groups are able to serve children effectively at a cost of \$5-\$10 per child per year. One of these grassroots groups could reach 20,000-40,000 children in one year with the amount paid to just one consultant in one year. While it is true that U.S. consultants can contribute skills and attitudes that might not be available locally, USAID's child survival program leans too heavily in that direction.

3. ***Buy American rules took money away from service delivery.*** In several instances, USAID policy required imported supplies from the United States, even though the equivalent supplies were available locally at much lower cost, e.g., antibiotics in Egypt, or the U.S. goods were not appropriate to the program, e.g., leisure vehicles to be used on very difficult rural terrain in El Salvador. The high cost of these supplies and vehicle repairs meant that less money was available to deliver child and maternal health services.
4. ***A significant number of programs did not match the congressional child survival mandate.*** For instance, child survival resources were used to fund family planning activities and improvement of math skills in Bolivia and microenterprise development in Nicaragua. While these programs can be valuable, money spent on them should not be counted as child survival spending.
5. ***More attention was placed on inputs and strict adherence to regulations than on "outcomes."*** Frequently, agencies were unable to provide statistics for how their work contributed to any change in child mortality rates or other indicators of improved well-being. They could tell us on what some of the money was spent, but not the end results of those expenditures. There is need to change the focus from a heavy emphasis on financial accountability to greater emphasis on measurable progress toward improved child well-being.
6. ***There was too much emphasis on privatization and policy dialogue at the expense of direct child survival interventions.*** For example, the largest project in the Philippines (\$13 million in 1991) called for reaching benchmarks such as privatization of hospitals before the funds were released. Benchmarks such as availability of basic drugs in rural areas would have been more appropriate to the child survival mandate.
7. ***Country choice was not based on need.*** The countries which received the most funding for child survival activities

were not necessarily the countries where the need was greatest. Child survival money was often used to pursue current U.S. foreign policy goals. For example, India has over 3 million child deaths per year. The Philippines, with a child mortality rate one-half the rate in India, and about 120,000 child deaths per year, received three times as much child survival assistance. In FY 1991, the Philippines hosted major U.S. military facilities.

RECOMMENDATIONS

1. ***Set and use measurable outcomes for the child survival program.*** The USAID child survival program should state, in measurable terms, what its desired results are, using child mortality and morbidity and related indicators. Specifically, programs in the field should contribute in measurable ways toward fulfilling the year-2000 goals agreed to at the World Summit for Children (e.g., reducing child mortality by at least one-third, virtual elimination of iodine deficiency disorders and vitamin A deficiency and its consequences, global eradication of poliomyelitis by the year 2000 and neonatal tetanus by 1995, reduction by one-third in the deaths due to acute respiratory infections in children under five years, and cutting child malnutrition by one-half).

This approach would be consistent with the Clinton Administration's goal of a "results orientation" for USAID programs.

2. ***Provide increased resources to grassroots groups that have learned to mobilize community participation.*** The USAID child survival program should support, assist, and expand (without smothering with red tape) those grassroots groups that nurture community participation and involvement. This involvement and community ownership bring not only services, but also transformation (a sense among people that they have control over their lives) and make it more likely that programs will be sustained beyond the availability of external resources.
3. ***Focus on countries based on need, not politics.*** According to UNICEF, two-thirds of the world's child deaths occur in just ten nations, which contain 58 percent of the world's population (see table, p. 57).⁸ Only one of these countries, India, was among the 10 leading recipients of USAID child survival funds in FY 1991.

The median under-five mortality rate in sub-Saharan Africa is 180 per thousand live births, yet only Mozambique and Mali were among the top 10 recipients of FY 1991 child survival funding. More children die in South Asia than in any other region, yet India was the only South Asian country among the ten largest recipients of child survival funds in 1991.

COUNTRIES WITH HIGH CHILD SURVIVAL NEEDS

Country	Population (Millions)	% of World Population	Annual Child Deaths (Millions)	Annual Child Deaths as % of World Population	Annual Child Deaths as % of National Population	Under 5 Mortality Rate Rank, 1992
India	879.5	17.6	3.224	0.065	0.37	42
China	1,188.0	23.8	1.071	0.021	0.09	79
Nigeria	115.7	2.3	1.012	0.020	0.87	19
Pakistan	124.8	2.5	0.695	0.014	0.65	36
Bangladesh	119.3	2.4	0.583	0.012	0.49	40
Indonesia	191.2	3.8	0.572	0.011	0.30	46
Ethiopia	53.0	1.1	0.542	0.011	1.02	15
Zaire	39.9	0.8	0.353	0.007	0.88	20
Brazil	154.1	3.1	0.247	0.005	0.16	63
Tanzania	27.8	0.6	0.231	0.005	0.83	26

Source: UNICEF, *Progress of Nations 1993* (New York: UNICEF, 1993).

Activities should focus on fewer countries, especially those with the highest under-five mortality rates and strong national commitments to child survival, and concentrate on a limited number of projects most likely to benefit the greatest number of children and women. USAID tends to withdraw from countries which have a relatively lower priority for U.S. foreign policy, focusing instead on nations which are of strategic concern to the U.S. government. Of course, it has been customary to use assistance to further diplomatic aims, but child survival funds should be allocated, as much as possible, based on need.

4. **Reduce administrative requirements.** USAID's paperwork and administrative requirements must be reduced so that those groups that are most able to make a difference with people are not constrained or eliminated just because they are less able to interact with an aid bureaucracy. This can and must be done without losing the ability to measure results and ensure accountability.

Some progress has been made in this area as the result of work in 1993 and 1994 by a joint task force established by USAID and InterAction, the association of U.S. non-governmental international development organizations. It has

called for simplified accountability and reporting requirements and an end to USAID's micro-management of non-governmental organization projects.

Nevertheless, there is need for broader reform and concern as to whether reforms will truly filter down to the USAID field mission level.

5. ***Increase U.S. funding for child survival activities.*** In addition to these qualitative improvements in USAID's child survival programs, the United States should increase its spending on child survival activities in developing countries, including U.S. contributions to UNICEF. In FY 1994, such spending accounted for less than 5 percent of all non-military foreign aid. Enlarging the budget for child survival activities would demonstrate a strong U.S. commitment to maintaining progress in reducing preventable deaths of the world's children. Even at a time of fiscal restraint, that is an important investment with a high social payoff.

NOTES

1. United Nations Children's Fund, *The Progress of Nations 1993* (New York: UNICEF, 1993), p. 5; see also p. 4.
2. The U.S. government's fiscal year runs from October 1 through the following September 30.
3. *Rewrite of the Foreign Assistance Act of 1961 and Fiscal Year 1995 Foreign Assistance Request (Part 1), Hearings Before the Committee on Foreign Affairs, House of Representatives, One Hundred Third Congress, Second Session, on H.R. 3765, February 3, 9, 23, 24, and March 15, 1994* (Washington: U.S. Government Printing Office, 1994), p. 29.
4. "Streamlining the Procurement Process and Reducing Administrative Requirements," September 20, 1993, available from the American Council for Voluntary International Action (InterAction), 1717 Massachusetts Avenue, N.W., Suite 801, Washington, DC 20036.
5. Vice President Albert Gore, *From Red Tape to Results: Creating a Government that Works Better and Costs Less – Report of the National Performance Review* (Washington: U.S. Government Printing Office, 1993), pp iii, 1-5.
6. "Child Survival Programs in Egypt," *AID Impact Evaluation Report* No 73.
7. *A.I.D. Technical Report* No. 5, Center for Development Information and Evaluation, November 1992, pp. 21-22.
8. For the purposes of comparison, in the United States, 42,000 children die each year and account for 0.016 percent of the population

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