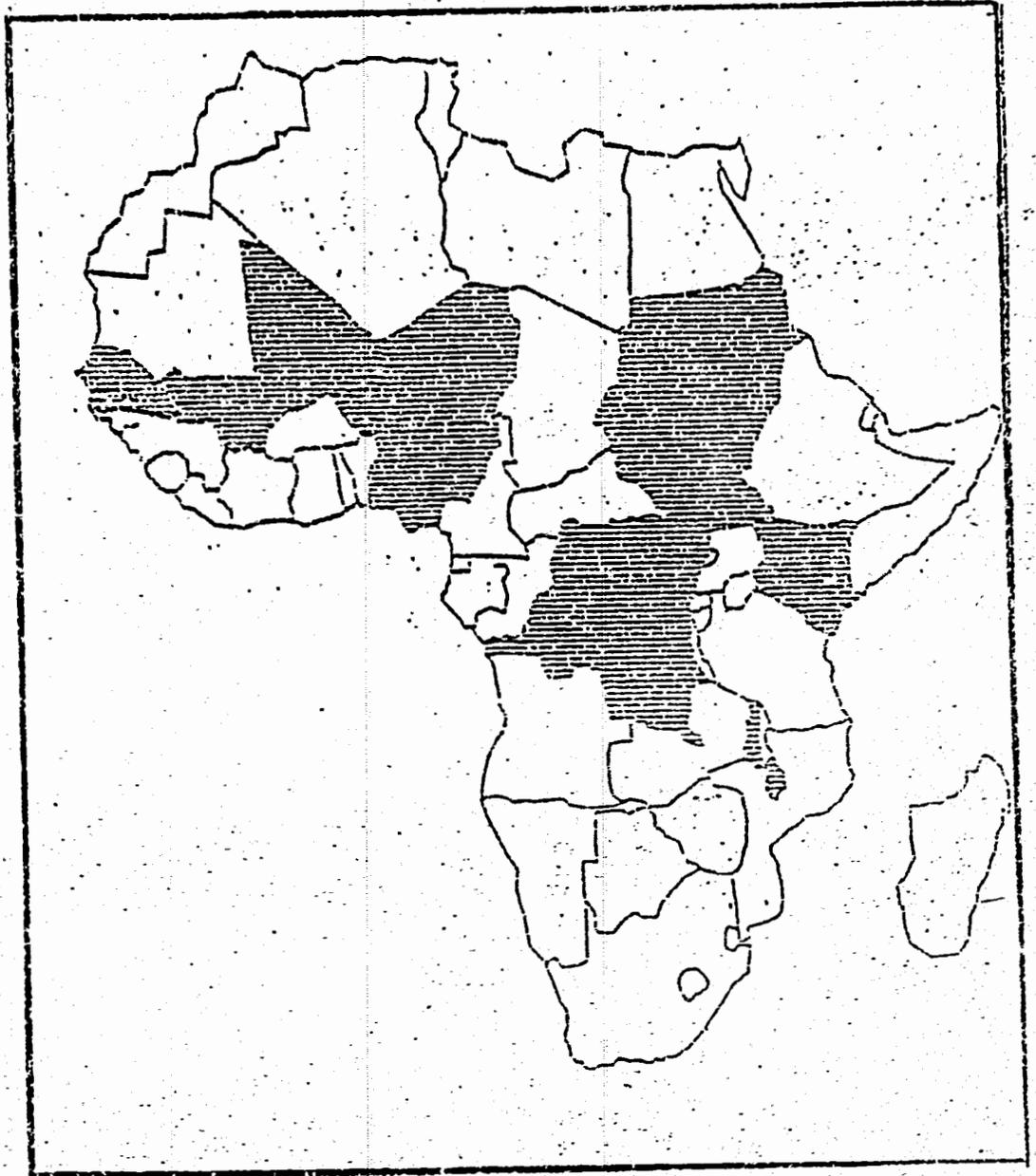


Africa Bureau
Sector Strategy

Child Survival Action Plan

CSAP



Office of Technical Resources
Bureau for Africa
Agency for International Development
February, 1987

CHILD SURVIVAL STRATEGY
1987 - 1990
BUREAU FOR AFRICA
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

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EXECUTIVE SUMMARY

The purpose of this document is to articulate A.I.D.'s strategy for child survival activities in Africa over the next four-year period (FY 1987 - 1990). This strategy stresses two key technologies, oral rehydration therapy (ORT) and immunization, as the "twin engines" to break the cycle of disease, malnutrition and death among children in many developing country environments. In addition, both child spacing and nutrition are cited as being critical to child survival.

While these activities follow closely the Agency's worldwide strategy for child survival programs (see Annex 1), the special conditions found in Africa necessitate certain departures from the Agency strategy, particularly in terms of emphasis.

Africa-specific differences include:

- o Emphasis on child spacing due to very high fertility and closely spaced births and the associated morbidity and mortality.
- o Some emphasis on other major diseases such as malaria and AIDS
- o Famine relief, nutrition, and early warning links to child survival
- o Emphasis on training of management, program planning, and service delivery personnel.

This document provides guidelines for the development of activities in each of these additional areas, as well as in the core activities (ORT and immunization), in the eight selected "emphasis" countries: Kenya, Malawi, Mali, Niger, Nigeria, Senegal, Sudan, and Zaire.

The responsibility for specific country-level child survival programs, of course, lies with the missions. They have the responsibility to ensure that key child-survival interventions are supported, either by A.I.D. or other donors, in the eight emphasis countries. In non-emphasis countries, USAIDs are encouraged to identify gaps and to propose appropriate activities (A.I.D. or other donor) consistent with their management capacities. Support of child survival activities in nonemphasis countries will be provided on a case-by-case basis.

As part of future child survival efforts, new projects and programs in Africa must include plans for both financial and institutional sustainability during the design stage. Additionally, the Africa Bureau currently is reviewing its strategy for training in both health and population in order to better concentrate resources on child survival activities. These Africa-specific modifications are highlighted in this paper, along with the rationale for them.

I. INTRODUCTION

Prior to this decade, the Agency's health strategy was focused on attempts to establish broad-scale primary health care systems in the developing nations. In the African context, seven major country projects were launched. While there were a number of positive gains attributable to these projects, it was clear that due to their high cost and design, and insufficient attention paid to financial sustainability, they were unlikely to have the desired impact on morbidity and mortality, at least in the near term. Fiscal 1981 marked the beginning of the Africa Bureau's Combatting Communicable Childhood Diseases (CCCD) project, which began to focus on specific, cost-effective measures which were more readily implemented and targeted specific childhood diseases with appropriate technologies.

Recognizing the emotional and financial costs of extremely high infant and child mortality in the developing world, the U.S. Congress created a new appropriation account in fiscal 1985 entitled Child Survival, in concert with a UNICEF global initiative.

In April of 1986, the Administrator approved the Agency's Child-Survival Strategy "as a basis for sharpening the focus of our health and related programs and as a basis for accomplishing the goals that the Agency has set to reduce the preventable deaths of children" in the developing world.

A.I.D.'s Child-Survival Strategy seeks to reduce significantly the number of child deaths in developing countries by the end of the decade. ORT and immunization are the principal instruments for achieving this goal. These two interventions will be used as the base upon which to build effective health care systems. All designated emphasis countries should have nationwide ORT and immunization programs, drawing on either A.I.D. or other donor support.

Although ORT and immunization are the primary interventions, birth spacing and a focused nutrition package emphasizing breastfeeding, improved weaning practices, and growth monitoring and promotion are also critical to child survival. They are an integral part of the child survival strategy.

Within the Agency's health program, child survival activities clearly will have priority. However, it is recognized that in some circumstances, other health interventions could be critical to achieving child survival goals or to addressing

other important health needs. The case will have to be made on an individual basis that, within a particular country context or setting, these other activities are more appropriate than the child-survival activities described above.

Implementation of A.I.D.'s Strategy for Child Survival

The Agency strategy includes the following elements:

- o Focus on ORT and immunization as the "twin engines;"
- o Support for (and coordination with) other important child-survival interventions such as nutrition and birth spacing;
- o Support for results-oriented research programs related to child survival;
- o Special efforts focused on a limited number of "emphasis" countries; and,
- o Involvement of the private sector.

In addition, the Africa Bureau will focus on malaria treatment, nutrition surveillance, AIDS, and enhanced training aimed at supporting child survival project activities. The Africa Bureau's child-survival program, per se, will not include support for parasitic diseases (other than malaria), large-scale capital-intensive water projects, or comprehensive primary health care projects.

II. PROBLEM

Infant mortality in Africa is the highest of any region of the world. Infant mortality (deaths in the first year of life) varies from 4 percent to 20 percent of all live births in Africa each year. With an average of 121 infant deaths per 1,000 live births, sub-Saharan Africa compares poorly with the rest of the developing world, including India and China, where the average Infant Mortality Rate (IMR) is 87 deaths per thousand live births.

The IMR's in Africa range from 180 in Mali and Sierra Leone, 155 in Somalia and 142 in Chad to 127 in Nigeria, 80 in Zimbabwe, 72 in Kenya and 25 in Mauritius. In general, west Africa and the Sahelian countries have higher IMR's than east and central Africa. By comparison, the United States has an IMR of 10.5 and northern and western Europe are at nine per thousand live births.

Table 1 on the following page contains a summary of mortality conditions in Africa. Countries are ranked according to their 1986 estimated Infant Mortality Rates (IMR).

SUBSAHARAN AFRICA MORTALITY DATA (SORTED BY IMR) - 1986 Table 1

COUNTRY	POPULATION (MILLIONS)	POP AS % AFRICA	1986 IMR	1986 CBR	1986 BIRTHS	# INFANT DEATHS/YR	% OF ALL INFANT DEATHS	1986 CDR	TOTAL DEATHS/YR	DEATHS/DAY 10000 POP	TOTAL DEATHS/D
MALI	7.9	1.7%	180	50	395000	71100	2.7%	23	181700	6.3	496
SIERRA L	3.7	0.8%	180	47	173900	31302	1.2%	30	111000	8.2	304
GAMBIA	0.8	0.2%	174	49	39200	6821	0.3%	29	23200	7.9	64
ETHIOPIA	43.9	9.2%	168	44	1931600	324509	12.2%	23	1009700	6.3	2766
GUINEA	6.2	1.3%	159	47	291400	46333	1.7%	24	148800	6.6	408
MALAWI	7.3	1.5%	158	53	386900	61130	2.3%	21	153300	5.8	420
SOMALIA	7.8	1.6%	155	48	374400	58032	2.2%	23	179400	6.3	492
MOZAMBIQUE	14.0	2.9%	153	45	630000	96390	3.6%	20	280000	5.5	767
BURKINA	7.1	1.5%	149	48	340800	50779	1.9%	22	156200	6.0	428
ANGOLA	8.2	1.7%	143	47	385400	55112	2.1%	22	180400	6.0	494
GUINEA-B	0.9	0.2%	143	41	36900	5277	0.2%	22	19800	6.0	54
CAR	2.7	0.6%	142	47	126900	18020	0.7%	19	51300	5.2	141
CHAD	5.2	1.1%	142	45	234000	33228	1.2%	25	130000	6.8	356
NIGER	6.7	1.4%	140	51	341700	47838	1.8%	23	154100	6.3	422
MAURITANIA	1.9	0.4%	137	50	95000	13015	0.5%	21	39900	5.8	109
DJIBOUTI	0.3	0.1%	132	43	12900	1703	0.1%	18	5400	4.9	15
EQ GUINEA	0.4	0.1%	132	42	16800	2218	0.1%	19	7600	5.2	21
LIBERIA	2.3	0.5%	132	48	110400	14573	0.5%	17	39100	4.7	107
SWAZILAND	0.7	0.1%	129	47	32900	4244	0.2%	17	11900	4.7	33
NIGERIA	105.4	22.2%	127	48	5059200	642518	24.1%	18	1897200	4.9	5198
BURUNDI	4.9	1.0%	124	47	230300	28557	1.1%	17	83300	4.7	228
RWANDA	6.5	1.4%	124	54	351000	43524	1.6%	16	104000	4.4	285
BENIN	4.1	0.9%	120	51	209100	25092	0.9%	21	86100	5.8	236
SUDAN	22.9	4.8%	118	46	1053400	124301	4.7%	17	389300	4.7	1067
TANZANIA	22.4	4.7%	115	50	1120000	128800	4.8%	15	336000	4.1	921
GABON	1.2	0.3%	112	34	40800	4570	0.2%	18	21600	4.9	59
SENEGAL	6.9	1.5%	112	48	331200	37094	1.4%	19	131100	5.2	359
UGANDA	15.2	3.2%	112	50	760000	85120	3.2%	17	258400	4.7	708
LESOTHO	1.6	0.3%	111	42	67200	7459	0.3%	17	27200	4.7	75
IVORY COAS	10.5	2.2%	110	46	483000	53130	2.0%	16	168000	4.4	460
NAMIBIA	1.1	0.2%	110	43	47300	5203	0.2%	14	15400	3.8	42
TOSO	3.0	0.6%	107	48	144000	15408	0.6%	17	51000	4.7	140
ZAIRE	31.3	6.6%	106	42	1314600	139348	5.2%	14	438200	3.8	1201
CAMEROON	10.0	2.1%	103	44	440000	45320	1.7%	17	170000	4.7	466
GHANA	13.6	2.9%	90	47	639200	57528	2.2%	13	176800	3.6	484
COMOROS	0.5	0.1%	88	46	23000	2024	0.1%	15	7500	4.1	21
ZAMBIA	7.1	1.5%	88	48	340800	29990	1.1%	15	106500	4.1	292
S. AFRICA	33.2	7.0%	86	33	1095600	94222	3.5%	10	332000	2.7	910
CONGO	1.8	0.4%	81	44	79200	6415	0.2%	19	34200	5.2	94
ZIMBABWE	9.0	1.9%	80	47	423000	33840	1.3%	12	108000	3.3	296
BOTSWANA	1.1	0.2%	76	45	49500	3762	0.1%	12	13200	3.3	36
CAPE VERDE	0.3	0.1%	75	35	10500	788	0.0%	11	3300	3.0	9
KENYA	21.0	4.4%	72	54	1134000	81648	3.1%	12	252000	3.3	690
SAD T/PRCP	0.1	0.0%	69	39	3900	270	0.0%	10	1000	2.7	3
MADAGASCAR	10.3	2.2%	67	45	463500	31055	1.2%	17	175100	4.7	480
MAURITIUS	1.0	0.2%	25	21	21000	519	0.0%	7	7000	1.9	19
SEYCHELLES	0.1	0.0%	14	27	2700	37	0.0%	8	800	2.2	2
REUNION	0.5	0.1%	13	24	12000	156	0.0%	6	3000	1.6	8
TOTALS-->	475	100%			21905100	2669320	100%		8280000	4.8	22685

Annual childhood mortality rates, for those aged one through four, range from 50 per 1,000 in Guinea and Sierra Leone to 20 in Nigeria, 13 in Kenya and 3 in Mauritius. Hence, of all children born in sub-Saharan Africa, one in five will not live until the fifth birthday. Child mortality, or deaths of children aged one through four, ranges between one and five percent. Thus, from five to 25 percent of all children born in Africa die before their fifth birthday. Of all mortality each year in Africa, over one-half is attributable to infants and children under age five.

The factors behind these high rates of mortality are a combination of negative forces, including high fertility and closely spaced births, a plethora of endemic diseases, malnutrition, dehydration due to diarrheal diseases, inadequate water supplies and low investments in the health sector by African governments.

Contributing significantly to high infant and child mortality in Africa are universally high birth rates. One analysis (Trussell and Pebley: 1984) which took into account other socio-economic variables related to child survival estimated the impact on infant and child mortality of changes in conditions of childbearing as follows:

If all births were spaced two years apart, infant mortality would decrease by 10% and child mortality by 21%.

If childbearing were confined to the prime reproductive ages (20-34), infant and child mortality rates would fall about 5%.

If fourth and higher order births were eliminated, infant and child mortality would fall 4%.

The major factors in infant and child deaths in Africa are dehydration due to diarrhea, communicable diseases, malnutrition and vector-borne malaria. Often, several of the foregoing health problems combine and lead to death. Communicable diseases include diphtheria, whooping cough (or other upper respiratory infection), polio, measles, tuberculosis and tetanus, all of which can be prevented through vaccination.

Approximately 50% of these deaths in children under five years of age are caused by conditions for which effective and inexpensive interventions are available. Measles, DPT, and polio immunizations, oral rehydration therapy (ORT), child-spacing, and the provision of adequate prenatal care, including tetanus vaccination, are examples of proven technologies that could prevent up to one half of the childhood deaths in Africa.

Often, a combination of malnutrition with an endemic disease or acute diarrhea is the ultimate cause of mortality, rather than any single health factor. Endemic diseases include malaria (which is increasingly resistant to chloroquine in some areas), immunizable diseases such as polio, diphtheria, tetanus, tuberculosis, measles and pertussis (whooping cough). Other tropical diseases such as onchocerciasis (river blindness), schistosomiasis (bilharzia) and dracunculiasis (guinea worm) also contribute to child mortality.

Only an estimated 27 per cent of sub-Saharan Africans have access to safe water supplies. Per capita annual health expenditures by African governments range from \$1 to \$10. Most expenditures are used for salaries and operating expenses, and few governments have recognized the importance of enlisting the private sector in public health efforts.

It must be stressed that aggregate mortality data for Africa do not paint a complete picture. These figures mask urban-rural differences and most often are estimates based on old censuses and surveys and in which mortality rates are uniformly assumed to have declined. Also, the health effects of the recent drought in the Sahel have not been included in the calculations.

Tables, graphs and charts with more specific detail can be found in Annex 3.

III. CONSTRAINTS TO SOLVING THE PROBLEM IN AFRICA

While there are manifold similarities among conditions found in LDC's worldwide, including in Africa, the countries of Africa south of the Sahara encompass a set of development problems which seem in fact different from those of other regions, at least in degree if not in their essential character. Among these special conditions are the following seven which are particularly striking:

- o Severe economic problems and prospects -- the 48 nations of sub-Saharan Africa include many for which the economic outlook is bleak, even under favorable circumstances. Low incomes and poor nutrition are interrelated, fundamental causes of infant and child morbidity and mortality in Africa.;
- o Many sub-Saharan states are drought- and famine-prone, with millions of people living at the survival margin; cataclysmic natural and political events occur with startling frequency and regularity--children are very often the first victims;

- o An unusually incomplete human resource and institutional base* characterizes most African nations, as compared to other major regions of the world; coupled with the very fragile economic base, this presents special problems for program planning and for management and institutionalization of child survival programs;
- o Very High Fertility -- Kenya's well-documented population is growing at over 4% per annum; other African states are similarly situated for such exceptionally high demographic growth rates, particularly as infant and child mortality falls in response to child-survival initiatives;
- o Parasitic and other lethal contagious and debilitating diseases are more prevalent in Africa, and take a relatively higher toll in the lives of infants and children than elsewhere, often when an infant or child has more than one affliction at one time.
- o A recent epidemic in Africa is causing widespread concern -- acquired immunodeficiency syndrome or AIDS. While data on the epidemiology of this fatal disease are incomplete, what is known is horrifying: AIDS threatens to become the most devastating public health problem of our time. The course of its occurrence and transmission in sub-Saharan Africa is of vital concern to the public health community as well as to economists and planners who are just beginning to examine the macro-economic implications of this disease. Transmission of AIDS from mother to child, and to children through use of unsterile syringes or contaminated blood is of immediate concern in Africa, as elsewhere.
- o Poor government capacity and performance in providing preventive health services, including: (1) inadequate resource allocation to the problem; (2) serious distortions in the previous pattern of preventive health care including an overemphasis on curative as opposed to preventive services, care skewed to urban, elite and high tech solutions, overreliance on free government care; and (3) a tendency to overlook and undersupport non-governmental service delivery.

* There are several notable exceptions, but the general condition is as stated

Each of the above sets of conditions are addressed by the Africa Bureau as outlined in the U.S. Assistance Strategy for Africa 1987 - 1990. The Strategy recognizes the interrelated nature of Africa's fundamental problems, and puts forth an integrated set of priority interventions designed to address them. Child survival is one component of that comprehensive strategy as will be described below. The priority elements of the Bureau Strategy include a focus on:

- o economic restructuring to promote economic growth leading to increased employment and income generation;
- o agricultural development, including food production and marketing, natural resource management and development of famine early warning systems to alleviate hunger;
- o human resources development, including family planning, child survival, training and institutional development to build human and institutional capacity.

IV. AFRICA CHILD SURVIVAL OBJECTIVES AND GOALS

The objectives of the Africa Bureau Child Survival Action Program are designed to implement the Agency strategy for Child Survival, and to fit with the other elements of the Bureau Strategy to make the best use of very scarce resources. The specific objectives of the strategy are as follows:

1. To reduce morbidity and mortality in the under five population particularly in selected "emphasis" countries in Africa.
2. To strengthen the financial and policy commitment of African governments to child survival, as well as the capability of African governments and private institutions to plan, implement, sustain and evaluate programs to improve child health and survival.

Goals By 1990

The goals of the Child Survival Action Program, to be achieved in the emphasis countries by the end of 1990, are:

1. To reduce the Infant Mortality Rate (IMR) to less than 75 per 1000 per annum.
2. To immunize 80% of children under 5 years of age.
3. To assure wide access to appropriate and correct case management of diarrheal disease episodes for children under 5 years of age.

4. To provide access to voluntary family planning information and birth spacing methods for 50% of couples.
5. To reduce the percentage of children under 80% weight for height to less than 10%.
6. To provide access to an appropriate anti-malarial treatment for at least 80% of children under 5 years of age consulting for fever/malaria.

Admittedly, these goals are ambitious. In some emphasis countries, they may be extremely difficult or impossible to achieve by the end of 1990. Each emphasis country will need to set country-specific targets in accordance with realities of the country situation. These should be realistic, but as close to the above-listed targets as is judged to be practicable.

V. AFRICA CHILD SURVIVAL INTERVENTIONS

A. Immunizations

Widespread access to immunization would substantially reduce childhood deaths and disease (particularly those caused by measles and neonatal tetanus). The six targeted diseases, which coincide with those identified by WHO's Expanded Programme of Immunization (EPI) are: measles, diphtheria, pertussis (whooping cough), polio, tuberculosis and tetanus. In Africa, the 80% vaccination coverage target among children under five years of age is highly desirable; in fact, several countries have reached levels near the target.

The strategy objectives for immunization are:

1. The primary target group for immunizations are children under one year of age and women of fertile age.
2. The vaccines to be emphasized are measles among infants and tetanus toxoid for fertile women.
3. A primary objective of A.I.D. support is to help develop a service infrastructure able to deliver immunizations in a sustained manner for the foreseeable future. Specifically, immunizations should be made available on a regular basis from as many of the existing health facilities as appropriate. As a national immunization capability is established, other child-survival health interventions can be added to the system.

4. In addition, national immunization campaigns will be used as appropriate to increase demand for immunization services. A.I.D. efforts will be coordinated with other donors (particularly UNICEF, Rotary International and bilateral donors) to assure the most effective assistance to national immunization programs.
5. Attaining high immunization coverage levels and reduction of cases and deaths caused by the target diseases will require widespread social mobilization with the maximum possible involvement of private agencies and groups.
6. Continued research on vaccine development, sterilization of injection equipment, and health education are essential. One pressing priority is the development of a safe measles vaccine effective before the age of nine months, and continued commitment to the development of a malaria vaccine.

V. B. Control of Diarrheal Disease (CDD)

The guiding principle of A.I.D.'s diarrheal disease control strategy is the reduction of childhood deaths due to dehydration caused by diarrhea through appropriate case management which can be provided by professional health care providers or by mothers, in health facilities or in the home.

National programs should be comprehensive in nature, but realistic and feasible. Different components should be implemented in a step-wise fashion. The phasing of the introduction of oral rehydration therapy may involve health facility strengthening, private sector initiatives or home base preparation depending on the host country situation. The principles of oral rehydration therapy should be established which include:

- 1) fluid and electrolyte replacement,
- 2) continued feeding, and
- 3) referral to a better equipped facility if indicated
- 4) education of mothers as primary care givers

In order to assure that these principles are understood and implemented, each A.I.D.-supported CDD program should seek to establish one or more training sites for health professionals and/or private sector workers such as pharmacists where hands-on experience in the management of acute diarrhea in children can be learned.

A.I.D. should seek to increase the availability of ORS through all distribution channels, including the private sector through social marketing and social advertising. This entails ensuring that supplies, particularly of ORS are regular and ample and that distribution systems are properly designed and effective. To accomplish this, cooperation with other agencies and indigenous organizations should be pursued. Where it is deemed both feasible and necessary, anthropological studies should be undertaken to better understand consumer beliefs and practices.

Access is also part of availability and needs to be expanded at two levels: health facilities and communities. Health workers, and providers of ORS (pharmacists, merchants, CHWs, mothers) should be trained and enlisted into the program. Health education through the best use of available communication channels (mass media) should be used to encourage mothers and caretakers to seek treatment for diarrhea from trained health providers or to provide treatment through home based ORT.

Ideally, prior research will have gone into the identification of the best available home fluid. The end result should be widespread effective use of the best available means of reducing mortality due to diarrheal diseases, including: the administration of adequate quantities of effective oral rehydration solutions; continuation of breastfeeding and appropriate foods to children with diarrhea; and appropriate referral of more severe cases to facilities where adequately trained health personnel are competent to manage them.

On a case-by-case basis, ORT and diarrheal disease control efforts will be strengthened in the Africa region by exploring low-cost water and sanitation interventions oriented towards the prevention of diarrheal diseases. The water component of the Africa Bureau diarrheal disease control strategy will not promote capital-intensive water supply programs. Rather, the emphasis will be put on inexpensive water and sanitation interventions carried out in the public and private sector which can have maximum impact on diarrheal diseases.

Attention will be given to strengthening and expanding the outreach aspects of existing PVO and Peace Corps water and sanitation programs in child survival emphasis countries.

V. C. Nutrition and Famine Relief

The synergism between malnutrition and major infectious diseases (especially diarrheal diseases, measles, whooping cough, and maternal malaria infection during pregnancy) are well known. Improving nutritional status during the first five years of life will make a substantial contribution to improved child survival.

Specific goals of the Africa Bureau nutrition strategy are:

1. to promote breastfeeding and to reverse its decline where appropriate;
2. to improve density, quality, frequency, and amount of food given;
3. to promote dietary approaches for the case management of diarrhea and other infectious diseases;
4. to increase the coverage and improve the effectiveness of growth monitoring activities in identifying children at-risk; and
5. to target supplementary feeding programs toward mothers and young children identified as being at high risk of nutritional deficiencies.

Additional objectives likely to be directly supportive of the nutrition strategy for child survival are prevention, treatment, and research on:

1. vitamin A deficiency;
2. iron deficiency anemia; and
3. improved nutritional status of pregnant and lactating mothers.

To be effective, especially in a resource-constrained environment, nutritional programs need to be targeted toward populations most at-risk. With few exceptions, however, such populations tend not to be geographically grouped so as to minimize logistical problems; thus there is a need for accurate targeting of at-risk populations. Identification of at-risk groups implies some sort of nutritional surveillance system capable of detecting food emergencies before they become severe, such as famine early warning systems (FEWS) attempt to do.

Certain problems particular to nutritional surveillance tend to be important in impacting child nutrition:

- o endemic malnutrition
- o periodic, catastrophic famine which has major impacts on child survival in parts of Africa
- o documented seasonal food shortages, a major problem in Sahelian countries, which leads to nutritional stress and mortality at certain times during the year

- o yearly variability in food production at local or regional levels, independent of overall national-level production, which results in marginal areas repeatedly exposed to food shortages, threatening child survival on the local level
- o feeding practices, not well documented in much of Africa, have obvious relation to child survival; nutritional surveillance information can be helpful in identifying feeding practices which are in need of modification to improve child survivorship.

Early warning systems, such as the Africa Bureau's FEWS project, can help to target populations at-risk, both for program planning and for crisis management purposes.

In Africa, where nutritional deficiencies tend to be linked primarily to inadequate food production and availability, famine early warning systems and low-cost, sustainable nutritional surveillance systems will serve as essential linkages to Africa Bureau food production initiatives and P.L. 480 assistance to enable A.I.D.'s agricultural portfolio to be integrated with child survival needs.

Information from these nutrition surveillance systems also will be used as a basis to monitor the impact on child survival from structural readjustment programs which are becoming a growing concern in the region. This will enable further linkages to be made between food aid programs and nutritional needs. In some cases, it is envisioned that P.L. 480 proceeds will be used for local-cost financing of child survival activities.

Over the next four years the Africa Bureau will emphasize improved infant and child feeding, dietary management of diarrhea, and growth monitoring as primary nutrition interventions for child survival within the region. These activities will be underscored by concerted efforts to develop famine early warning systems and sustainable nutritional surveillance systems at the regional and country level.

V. D. Child Spacing

In Africa, emphasis will be placed on the following guiding principles of A.I.D.'s Family Planning Strategy: (1) to provide individuals with the freedom to choose the number and spacing of their children; and (2) to do so while bringing national and regional growth rates to a level which is consistent with, and can be supported by, economic growth and productivity. The key elements include:

- o inclusion of child spacing in all child survival programs to the extent possible;

- o focus of program efforts and resources on women and children at most risk (women who: have children 14 months or younger, are under 18 years of age or over 35 years, or have already borne four or more children)
- o ensure appropriate information and means for child spacing for target groups and other clients; and
- o suggest research to help identify, reach, and service those most at-risk.

Goals need to be tailored to individual countries, and can best be achieved through a balanced program of research, program implementation, and periodic monitoring and evaluation.

A program of social sciences and operations research should be planned for those countries which are just beginning to provide voluntary family planning information and services. A program of this type is needed to provide accurate information to program administrators concerning local determinants of contraceptive use, to involve local research institutions and policymakers in the implementation process, and to solve identified problems of supply, demand, logistics, and program management.

Policy discussions should be held with national planners and opinion leaders to discuss links between high birth rates and high infant mortality, low socio-economic and educational status of women, and cultural and legal barriers to limiting births. A high level of government commitment needs to be obtained in order for family planning programs to be successful and sustainable.

Elements of a program need to include the development of effective information and service delivery systems through both the public and private sectors (social marketing, community-based distribution, and other techniques), and encouraging the increased use of newly available services. Cooperation with other donors and the private sector should be stressed.

Finally, a successful program as it matures will have pursued a course of decreasing dependence on external support. The transfer of contraceptive technology, data collection and analysis techniques, distribution systems and, perhaps most important of all, improved management practices -- combined with cost-recovery schemes and continued political support -- should all be clear end-points of AID child-spacing strategy.

V. E. Malaria

Malaria is a more serious threat to child survival in Africa than in other parts of the world because of the parasitic species and the highly efficient vector found there. It is estimated that as many as one million African children die from malaria infection each year. Hence child survival efforts in Africa must include a malaria control component. The rapid spread of chloroquine resistance to southern and central Africa has made malaria control more difficult. This strategy emphasizes the reduction of malaria-induced mortality in infants and children and the contribution of malaria to low birthweights and fetal wastage. The most appropriate malaria control strategy for eastern and central Africa is presumptive treatment of acute attacks of fever-inducing illness compatible with malaria symptoms with appropriate antimalarial drugs (principally chloroquine). There is preliminary evidence suggesting that low dose (5 mg/kg) weekly administration of chloroquine for chemoprophylaxis is not effective. The specific strategy objectives for malaria include:

1. promotion of prompt treatment with appropriate antimalarial drugs for children having fevers compatible with those produced by malaria;
2. operations research to define the most appropriate program interventions to reduce the risks of maternal malaria infection which results in low birthweights and decreased child survival -- these investigations should focus on the practical problems of supply of antimalarial drugs and compliance of pregnant women, as well as to the response of malaria infections in pregnant women to various antimalarial drugs, especially chloroquine;
3. development of surveillance systems to monitor the in vivo response of malaria infections to anti-malarial drugs, especially chloroquine; and
4. development and implementation of national malaria control plans based on monitoring of response to antimalarial drugs and prompt treatment of children with appropriate antimalarial drugs.

V. F. Acquired Immunodeficiency Syndrome (AIDS)

The magnitude of the AIDS problem as a matter of public health -- and its ultimate effect on child survival -- is as yet uncertain. AIDS has become a major cause of death in some African nations. It is estimated that there are two million persons in the region who are now carriers of the HIV virus. Medical research indicates that the HIV virus is spread primarily through sexual contacts, blood transfusion, or use of contaminated syringes. Additionally, HIV virus may be transmitted from mother to fetus during pregnancy or childbirth.

Estimates by the U.S. Public Health Service indicate that after a gestation period of 6 years, 20% to 40% of the people who carry the HIV virus will develop AIDS. Currently, it appears that infants of HIV-infected mothers are becoming infected with HIV virus during pregnancy or childbirth at the rate of 50%. Further, it appears certain that the rate of conversion from HIV infection to frank AIDS is much faster in infants than in adults.

Although this strategy recognizes AIDS as an important component of child survival in Africa, its degree of impact is as yet uncertain. Therefore, the Africa Bureau will closely monitor the implications of AIDS for child survival in the region, and will respond appropriately in accordance with the newly approved A.I.D. policy statement on AIDS.

VI. IMPLEMENTATION OF THE CHILD SURVIVAL PROGRAM

An effective child-survival strategy in Africa must address a complexity of issues broader than EPI, oral rehydration, birth spacing and nutrition. Training directed at child survival activities and projects must be rationalized with a view towards supporting projects and long-term institutionalization. The private sector must be enlisted as an alternative delivery system which most often can be more cost effective than public sector institutions. Sound management must be a keystone of all our activities in these endeavors, a factor that has been identified as a serious constraint in past efforts.

VI. A. Management and Training

Experience with child survival, health, population, and nutrition programs in Africa had shown the urgent need to develop a broader base of personnel trained to manage such efforts. Thus it will be important for each emphasis country to consider carefully the human resource base and needs for program implementation. Attention should be given to the development of host country training capacity to meet program needs, both nationally and regionally, through in-service training and continuing education programs. Technical cooperation between countries in the region should be promoted to facilitate the transfer of management skills. This can be achieved by linking child survival training and consultation services with formal and informal networks to share training, information, and research resources. Regional training institutions need also to be strengthened to increase their output and, where possible, the scope of their programs. A recently commissioned study by the Africa Bureau concluded that there were several opportunities to strengthen national institutions which could serve regional needs, as well as already existant regional institutions.

In the management and training area primary emphasis should be put on in-country training wherever feasible, due to its lower cost and to the increased likelihood of its relevancy to meet specific needs in each country. A particular effort should be made to identify innovative training approaches which have the potential to strengthen planning and management capability at several hierarchical levels in accordance with identified needs and conditions in each emphasis country.

VI. B. Private Sector

Private sector involvement in child survival is considered to be central to achieving Bureau objectives. The following areas should be considered in all country-specific planning:

o Private Voluntary Organizations -- Compared to other regions, a large part of Africa's health services are provided by church-affiliated missions and private voluntary organizations (PVO's). They are particularly good at reaching people in underserved rural areas. Collectively, it is estimated that A.I.D.'s 1986 grant awards to PVO's will benefit more than 750,000 African children under five, and a like number of children of childbearing age. Although most PVO activities are financed from private contributions, A.I.D. is providing support through its central FVA/PVC Office and through local USAID missions to indigenous PVO's.

The Bureau's primary thrust is to encourage PVO's to become more actively involved in underserved areas of the child survival emphasis countries. PVO's will be encouraged to increase their collaboration with other PVO's and with host country government health services, particularly in the priority child survival interventions of immunizations and ORT, and to develop effective strategies to promote long-term sustainability of their programs.

In the strategy statement for each A.I.D. child survival emphasis country, the role of PVO's and appropriate use of FVA/PVC centrally-funded programs, USAID mission-funded indigenous or U.S. PVO's will be described.

To assist PVO's wishing to work in the emphasis countries, FVA/PVC will collaborate with the Africa Bureau to promote a series of PVO regional training workshops.

In non-emphasis countries, PVO child survival activities will be supported on a case-by-case basis, particularly in cases where A.I.D. bilateral programs and staffing are a major constraint.

o Social Marketing -- There are currently two active contraceptive social marketing projects in Africa: Ghana and Nigeria. Using all the principles of modern marketing, including market research, incentives for distributors, wholesalers, and retailers, mass media advertising and an aggressive, subsidized pricing policy, social marketing projects seek to use existing distribution networks to increase the availability of contraceptives in nationwide projects. This approach may also be used for oral rehydration products, as will be tested in Ghana in conjunction with the contraceptive marketing project. New contraceptive marketing projects are planned for Zimbabwe, Kenya, Mali, Somalia, and Niger. It is planned to expand to other countries as well, and to add ORS to at least several of the projects. In Nigeria, UNICEF (under the ACSI-CCCD project) will use mass media advertising to increase demand for ORS.

o Social Advertising -- In the Gambia, mass media advertising was used to both teach proper oral rehydration mixture and how it is administered. Mass media is used in numerous countries to announce vaccination campaign days and where and when to take children for immunizations. Other child survival messages should be developed, after consumer research, for promotion through the mass media.

o Private Enterprise -- The Enterprise Project, funded by the Office of Population, already is demonstrating that private business can be enlisted in the child survival effort. In Nigeria, 20 companies with more than 5,000 employees were approached with regard to the provision of family planning services in their employee health clinics. Nineteen of these companies requested participation in the project, although funding was available for only one of them. The company selected will purchase contraceptives from the social marketing project, at wholesale, and sell them to employees. The company's health clinic employees will then receive training in family planning service delivery. The above approach is designed to make the project self-sustaining. This effort can easily be expanded to other companies, and other child survival technologies could be added once the initial intervention is institutionalized.

o Local Production -- In larger population countries, local production of oral rehydration salts is both cost effective and culturally more acceptable. In Ghana, for example, the centrally-funded SUPPORT project is providing technical assistance in quality control to ensure that proper mixtures are derived in each batch of salts, which will be sold by the social marketing project. It is planned that UNICEF will provide quality control technical assistance for local production of ORS in Ghana. This effort will be expanded to at least four other countries during the next four years.

VI. C. Building Sustained Capacity

Special efforts will be made to assure financial viability and sustainability of child survival activities. Full cost recovery in health in Africa is a particular problem in that free popular medical care has been a policy of many governments. Increasingly, however, African governments are acknowledging that these policies are not sustainable over the long run.

Kenya, for example, has expressed an interest in developing health financing projects as a major element of A.I.D.'s health sector assistance. In Zaire, a fee for service system in government hospitals was introduced in 1985. The Sudan A.I.D. mission reports (August 1986) that the Minister of Health has initiated fee-for-service mechanisms in GOS hospitals and has received the support of the national legislature. The governments of Nigeria, Rwanda, and Liberia also are beginning to implement fee-for-service charges at their health facilities. A recent high-level Malawian health delegation emphasized that country's keen interest in cost recovery schemes and other cost reduction measures.

The Africa Bureau fully supports the guidelines established by the Agency as described in the July 1986 Memorandum for the Executive Staff.

VII. COORDINATION WITH OTHER DONORS

The Africa Bureau, both in multilateral meetings and in individual countries, works closely with other donors in child survival activities. A principal aim of this collaboration is to attempt to obtain consensus among the major donors regarding priority countries and priority program interventions needed to impact child survival. This is done through formal and informal meetings and through the sharing of information concerning topics of interest in child survival, as well as strategy documents such as this one, and detailed information concerning A.I.D. policies and programs in each country. A.I.D. also provides funding for child survival activities through other donor organizations such as UNICEF, UNDP, and WHO.

Some of the principal mechanisms for collaboration are as follows.

- o Cooperation for Development in Africa (CDA) -- The Health Technical Committee of CDA meets semi-annually, chaired by a representative of AFR/TR, to exchange information on technical matters, projects and funding. The CDA membership includes the United Kingdom, Canada, France, Italy, West Germany and the United States. At present, AFR/TR is coordinating an effort to exchange microcomputer data files on child survival and health-related activities so that all donors will have a complete picture of donor activity in a country.

o UNICEF - The major donor in Africa child survival activities, UNICEF also has a regional grant from A.I.D. to supplement their efforts. The Italian Government has pledged \$100 million over five years for immunization activities and A.I.D. has granted the organization \$6 million for child survival efforts in Nigeria, to be conducted in collaboration with the ACSI-CCCD project (\$8 million). There is close collaboration with UNICEF in virtually all African countries in child survival in which A.I.D. also is working.

o United Nations Development Programme (UNDP) -- A.I.D. granted UNDP \$3.5 million in fiscal 1985 for child survival projects in seven African countries. Presently under consideration is an amendment to this grant to add nutrition projects in several more African countries.

o World Health Organization (WHO) -- USAID missions, the A.I.D. regional offices, and AFR/TR work closely with WHO in Geneva and in its Africa regional office in Brazzaville. WHO plans to incorporate more birth spacing in its Africa programs and has worked closely with REDSO/WCA on health manpower training in West Africa for the past 10 years.

A.I.D. development assistance is not now being given to five countries (population = 115 million or 23 percent of the African total). Most of these countries receive assistance from UNICEF, WHO, or other donors. For example, in Angola, Ethiopia, Mozambique, and Tanzania, the UNICEF Universal Child Immunization Program has made major commitments out of a \$100 million donation from the Government of Italy. Other major bilateral donors include France (mainly in west Africa), Sweden, the Netherlands, and the United Kingdom. Other multilateral donors include the European Economic Community, the African Development Bank and the World Bank.

In virtually all countries with A.I.D. missions, close collaborative arrangements are maintained with other donors in order to avoid duplication and to promote mutually supportive child survival activities.

VIII. PRIORITIZING COUNTRY CHILD SURVIVAL PROGRAMS

Mission Responsibility -- One of the least understood aspects of the Child Survival Strategy is its implications for USAID mission responsibility. In emphasis countries, the Agency strategy levies the responsibility on USAID missions for the accomplishment of the Agency's goals whether or not the mission has, under its own management, bilateral programs involving child survival interventions. If other donors are handling a particular aspect of the Strategy, it is not necessary that A.I.D. have a program of its own.

However, missions should ensure that the essential CSAP interventions are covered either by A.I.D. or by other donors, and should recommend programs where there are identified deficiencies. The Agency strategy assigns responsibility to the Mission Director to decide whether child survival strategy goals need be accomplished through bilateral U.S. assistance or through the efforts of others.

Focus Countries -- At present, A.I.D. is targeting its child survival assistance to eight African countries, designated as "emphasis countries", together comprising a population of 210 million, or 44 percent of the total sub-Saharan population. The 35 non-emphasis countries have a population totaling 150 million, or 33 percent of the African total. During the next four years, the following eight countries in Africa will be emphasized for child survival activities:

Kenya	Nigeria
Malawi	Senegal
Mali	Sudan
Niger	Zaire

These countries were selected as emphasis countries based on the following criteria:

- o population size
- o infant and child mortality rates
- o government commitment to child survival activities
- o immunization and ORT coverage
- o mobilization and absorptive capacity
- o A.I.D. presence and availability of funds
- o opportunities for donor collaboration.

Non-emphasis Countries -- It is expected that USAID's in non-emphasis countries will wish to:

examine opportunities for important child-survival initiatives

recommend bilateral, regional, or centrally-funded activities consistent with their CDSS and management capabilities

make recommendations for other donor activities where significant gaps are identified.

Non-focus African countries will remain eligible for A.I.D. child survival funding so long as funds are available after projects and programs for the emphasis countries have been allocated. Non-emphasis countries with specific, critical health problems (such as high incidence of malaria or AIDS), will be addressed on a case-by-case basis.

IX. IMPLEMENTATION PLAN FOR 1987 - 1990

Because of the wide variation in country situations which will affect the achievement of child-survival targets by 1990, it is important that implementation plans be developed on a country-specific basis. Each of the eight emphasis countries is expected to develop within 90 days from the date of this document an implementation plan for child survival activities to be carried out over the next four years. This plan should include a brief overview of the country situation with respect to infant and child survival, identification of the key gaps in present program activities, and a summary plan for actions to be taken by A.I.D. and by other donors to fill the gaps. While these individual country plans should be realistic in terms of assistance levels, they should also identify program opportunities which could be developed if sufficient funding were to be made available. USAID's needing technical assistance in the preparation of this plan should request AID/W assistance immediately.

In collaboration with the Science and Technology Bureau the Africa Bureau will, within the next 90 days, complete its action plan concerning the use of regional and centrally-funded mechanisms to address key child survival goals described in this strategy. This plan should dovetail with individual country plans. It is therefore important that USAID's in the emphasis countries cable in outline form at the earliest possible date a rough description of their action plans for child survival activities over the next four years.

AFR/TR:WTrayfors/JThomas/RBritanak/JShepperd
AFR/DP:NGreeley

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ANNEXES

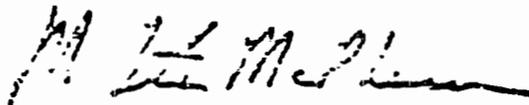
- Annex 1 - A.I.D. Worldwide Child Survival Strategy
- Annex 2 - Mandate for Increased Emphasis on Child Survival
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- Annex 6 - Health and Population Personnel

April 1, 1986

THE A.I.D. CHILD SURVIVAL STRATEGY

TO THE STAFF OF THE AGENCY FOR INTERNATIONAL DEVELOPMENT:

I have, several times in the last year, underlined the importance I attach to the Agency's Child Survival Programs. At my request, The Child Survival Task Force has developed and I have approved the following strategy as guidance to field missions. I call upon each mission to use this strategy as a basis for sharpening the focus of our health and related programs and as a basis for accomplishing the goals that the Agency has set to reduce the preventable deaths of children.



M. Peter McPherson
Administrator
Agency for International Development

A.I.D. CHILD SURVIVAL STRATEGY

INTRODUCTION

Fifteen million children under age 5 die each year in developing countries. The deaths of these children account for more than half of all deaths in developing countries. In this environment, malnutrition, disease, unsanitary conditions, closely spaced births and lack of maternal education all interact in a vicious circle. Two key technologies, oral rehydration therapy (ORT) and immunization, can break into the circle and significantly reduce infant and child death and disability associated with these factors and help build a sustainable health delivery system. Up to half of the deaths in children, or one quarter of all deaths in the developing world, could be prevented by these interventions. They are the "twin engines" of this strategy.

The magnitude of child mortality and the fact that we have proven, effective interventions--ORT and immunization--which can help save half of these children are the bases for making child survival the focus of A.I.D.'s health program.

A.I.D. has joined other donors in a worldwide effort to achieve certain targets in child survival by the end of the decade. The aim is to prevent two million deaths through the use of ORT, and to collaborate in all international efforts to provide continuing immunizations for all the world's children. The Agency's Blueprint for Development also includes among its goals the reduction of infant mortality to less than 75/1000 and the reduction of mortality in children under five to less than 10/1000.

A.I.D.'s focus will be on developing a sustained capacity in each country to effectively provide ORT, immunizations and other important child survival interventions in nutrition and birth spacing to their vulnerable populations.

A.I.D. has been funding activities aimed at child survival for a number of years. In FY 1985, additional funds appropriated by Congress for child survival and related health programs allowed A.I.D. to accelerate its efforts to improve the health of children in A.I.D.-assisted countries. In FY 1986 Congress again appropriated additional funds for child survival. For FY 1987 A.I.D. is requesting a separate Child Survival Account. Funding for child survival will also come from many other accounts including Health, Population, ESF, Agriculture, Sahel, and PL 480. In future years funding will continue to come from a variety of agency accounts reflecting the multi-disciplinary requirements of this strategy.

This strategy establishes the improvement in the health and survival of children and mothers as the priority goal of the Agency's health program.

A.I.D.'S FIVE YEAR CHILD SURVIVAL STRATEGY

A.I.D.'s Child Survival Strategy seems to reduce significantly the number of child deaths in LDC'S by the end of the decade. ORT and immunization are the twin instruments for achieving this goal. These two interventions will be used as the base upon which to build effective health care systems. All designated emphasis countries should have nationwide ORT and immunization programs (drawing on A.I.D. and/or other support as appropriate).

Although ORT and immunization are the primary interventions upon which we plan to focus, birth spacing and a focused nutrition package emphasizing breastfeeding, improved weaning practices, and growth monitoring are also critical to child survival. They are an integral part of our child survival strategy.

The two above paragraphs describe the focus of A.I.D.'s Child Survival Strategy. Within the Agency's health program, child survival will have priority. However, it is recognized that in some circumstances, other health interventions could be critical to achieving child survival goals or to address other important health needs. The case will have to be made on an individual basis that, within a particular country context or setting, they are more appropriate than the child survival activities described above.

THE IMPLEMENTATION OF A.I.D.'S STRATEGY FOR CHILD SURVIVAL INCLUDES THE FOLLOWING ELEMENTS

- o Focus on ORT and immunization as "Twin Engines;"
- o Support for (and coordination with) other important child survival interventions such as nutrition and birth spacing;
- o Support for a results-oriented research program related to child survival;
- o Special efforts focused on a limited number of "emphasis countries;" and,
- o Involvement of the private sector.

SELECTIVE INTERVENTION APPROACH

The decision to focus on ORT and immunizations is based on the direct impact that these interventions can have on child survival and the capacity of these two "engines" to drive the development of a sustainable health system capable of meeting the health needs of the vulnerable populations.

IMMUNIZATION

Detailed guidance on the design of immunization activities is incorporated in the Agency's Immunization Strategy (January 1986).

The Immunization Strategy has six principal elements:

1. A primary target group of children under one year of age;
2. Emphasis on vaccines, to meet the needs of children and fertile-aged women, especially measles and tetanus-toxoid;
3. Development of county-specific plans, coordinated with other donors;
4. Major focus on target countries so as to maximize health benefits that can be obtained with available resources;
5. Emphasis on institutional capacity development to sustain host country immunization service delivery;
6. Continued research on vaccine development, immunization technology improvements, and health service delivery.

CONTROL OF DIARRHEAL DISEASE - ORAL REHYDRATION THERAPY:

Oral rehydration therapy (ORT) programs within the context of overall diarrheal disease control have eight principal elements:

1. Emphasis on support for coherent and comprehensive national ORT programs in coordination with other donors.
2. Appropriate nutrition interventions in addition to fluid therapy, especially dietary management of diarrhea (breastfeeding, feeding during episodes, refeeding) and appropriate hygiene interventions, especially sanitation education.

3. In concert with expanded services, use of comprehensive approaches to communication, including mass media, to promote and sustain the correct use of ORT and improved feeding and hygiene practices.
4. Provision for appropriate training, including physician training, as well as adequate supplies of salts within the overall national program.
5. Support for the World Health Organization formula for oral rehydration salts and for an appropriate combination of home-mix and packet-based programs, recognizing that there are community-specific factors that require adaptation to local conditions and resources.
6. Involvement of the private sector to prescribe, distribute, and promote ORT and to produce the packets..
7. Efforts to build and finance a sustained capacity to deliver ORT and other child survival services.
8. Research on improved formulae, vaccine development, communication techniques and service delivery.

NUTRITION

In the nutrition area, the interventions most closely related to child survival include:

1. Promotion of exclusive breastfeeding to 4-6 months to reduce the probability of infectious diseases, diarrheas and associated weight loss.
2. Promotion of proper weaning practices including the introduction of solid foods between 4 to 6 months, with continuation of breastfeeding.
3. Feeding during diarrhea to prevent serious weight loss and increased feeding after episodes of diarrhea and other infectious diseases.
4. Growth monitoring to detect growth faltering and to serve as a catalyst for prescribing appropriate followup interventions, i.e. ORT, feeding, etc., in a timely fashion.
5. Vitamin A supplementation where appropriate.
6. Targeted supplementary feeding programs to children under three years old and pregnant women under PT 480

BIRTH SPACING

In the area of birth spacing, the interventions most closely related to child survival include:

1. Promotion of appropriate breastfeeding.
2. Provision of a full range of voluntary family planning services and supportive activities as articulated in the Agency's Family Planning Strategy.

ACHIEVING MAXIMUM IMPACT AND SUSTAINABLE PROGRAMS

There are three important aspects of A.I.D.'s Child Survival Strategy which are critical to achieving maximum impact and long term sustainability. They are: institutionalization of services, use of modern communication strategies, and collaboration among donors.

INSTITUTIONALIZATION OF SERVICES: Sustained host government commitment is perhaps the most important part of a successful child survival program. The institutionalization of ORT and immunization services within developing countries depends upon their technical, financial and institutional viability. All three are critical to the sustained impact and effectiveness of these interventions. The importance of child survival activities and the need for institutionalization of these efforts should be part of all A.I.D. policy dialogue. All A.I.D. child survival programs must seek to develop local capacity to sustain the provision of services. This may require discussions with host countries on the reallocation and mobilization of health care resources. In all new child survival initiatives, careful analysis and planning for recurrent costs should be incorporated in the project design. Where the institutional and financial capacity to sustain these programs is weak, time-limited donor assistance for recurrent costs may be considered.

Although one-time mobilization campaigns may be critical to create public awareness and stimulate a demand for these services, the existence of an indigenous capacity to manage and deliver such services is essential to ensure that new cohorts of children will receive similar care. In countries where a health infrastructure already exists, A.I.D. will focus assistance on introducing or strengthening the ORT and immunization components of these systems and developing retail sales activities. In countries where it is lacking, A.I.D. will incorporate plans for developing the public and private infrastructure to undertake these child survival service programs.

UTILIZING THE PRIVATE SECTOR: Every effort should be made to explore opportunities for involvement of the private sector, to complement or supplement public sector programs. To the extent practicable, the private sector should be utilized to prescribe, distribute, and promote ORT and to produce the packets as well as to distribute vaccines. PVO's also should be used to implement programs where appropriate.

MODERN COMMUNICATION STRATEGIES: Although ORT and immunization programs already exist in many A.I.D.-assisted countries, lack of knowledge and low use levels persist. It is likely, therefore, that demand creation will be a key element of child survival activities. Experience has shown that modern marketing and communication techniques can be successfully applied to programs which have a social objective. Although mass media is apt to be part of most strategies, this must often be combined with person-to-person communication strategies. It is essential that demand creation efforts be carefully coordinated with adequate supplies and trained personnel. For ORS (oral rehydration salts, used in ORT), as for family planning, a social marketing approach should be considered.

SELECTED COUNTRY FOCUS

Currently, A.I.D. supports ORT and immunization activities in more than 50 countries. A.I.D.'s resources need to be concentrated to achieve maximum impact. During the next five years, A.I.D. will place special emphasis on programs in a selected number of countries where child survival problems are especially severe in order to maximize the effectiveness of the services and their impact on infant and child mortality. A.I.D.'s child survival effort for the remainder of the decade will be concentrated in the following countries:

Bangladesh	Mali
Bolivia	Morocco
Ecuador	Nepal
Egypt	Niger
Guatemala	Nigeria
Haiti	Pakistan
Honduras	Peru
India	Senegal
Indonesia	Sudan
Kenya	Yemen
Malawi	Zaire

THE PROCESS OF SELECTING THESE COUNTRIES INVOLVED
CONSIDERATION OF THE FOLLOWING FACTORS:

- o Total number of infant and child deaths;
- o Infant mortality rates;
- o Immunization and ORT coverage levels;
- o Mobilization and absorptive capacity (including accessibility of population and availability of mass media and infrastructure);
- o Degree of government commitment to child survival, measured in terms of allocation of local resources and in terms of strong identification of local leadership (political, religious and other) with these efforts;
- o Availability of funds from development assistance, ESF, Sahel and PL 480 and opportunities for programming these funds;
- o Opportunities for effective donor collaboration aimed at achievement of common goals for improving child survival;
- o Expectation that A.I.D. will continue to maintain a large program and sizable presence over the next three to five years.

IN THESE "EMPHASIS COUNTRIES," THE PLANNED A.I.D. COMMITMENT INCLUDES:

- o Sustained bilateral funding for child survival activities for at least the next 3-5 years;
- o A coordinated approach involving support for U.S. and indigenous PVO's, international organizations and other U.S. agencies such as the Peace Corps;
- o Priority A.I.D./W support for the management and technical staff required to conduct child survival activities and for training to upgrade the skills of A.I.D. and host country staff.

This strategy is equally applicable to non-emphasis countries; however, the A.I.D. personnel and program resources for child survival activities in non-emphasis countries will be limited. Consequently, our efforts will have to emphasize policy dialogue and the influence obtainable through coordinated efforts with the donors. PVO's and the Peace Corps are also options for achieving child survival objectives in "non-emphasis" countries where A.I.D. bilateral programs and staffing are a major constraint. Even where there are no A.I.D. bilateral resources, we would expect child survival to be part of our policy dialogue in support of effective action by other donors and the host country to save children's lives.

COLLABORATION WITH OTHER DONORS

A.I.D. and other donors (UNICEF, WHO, UNDP, PAHO, etc.) have joined together in the worldwide effort to achieve goals for both ORT and immunization by the end of the decade. By 1990, the infrastructure and programs should be in place to avert the deaths of two million children who will otherwise die from diarrhea and related dehydration. A.I.D. has also pledged to collaborate in an international effort to provide immunizations for all the world's children, with specific coverage goals defined at the country level. The challenge of meeting the internationally agreed goals and the inevitable limits on available funding means that we must strive to achieve maximum impact. Multi-donor collaboration at the country and sub-regional level is an important part of this international child survival effort.

Missions in the design of their country strategy and accomplishment of their program objectives should take fully into account the capacities of these other institutions. In this regard, a close program relationship has developed with UNICEF which has programs in many countries directly supportive of the A.I.D. strategy. The closest field coordination in support of country program goals is encouraged.

FUNDING

Funding for the Agency's child survival effort will come from funds earmarked specifically for child survival and the regular Health account. Population, Agriculture, Sahel, ESF and PL 480 accounts will also be used for child survival activities wherever appropriate.

PL 480 Title II and Section 416 programs can provide essential support for country child survival initiatives. Title II programs provide an excellent logistics system for transportation and distribution of supplies, particularly to and within hard-to-reach areas. It also provides established contacts with communities and vulnerable groups. Title II food resources can be used to prevent serious malnutrition and may be used in combination with ORT to manage diarrhea episodes and reduce rapid weight loss. The food may also serve as an incentive to bring mothers for other child survival interventions.

MONITORING AND EVALUATION

Very specific Agency objectives have been set for our child survival efforts. Monitoring and evaluation are an essential component of child survival activities. A.I.D.'s field missions are responsible for project management and program monitoring of their country programs. In addition, in collaboration with other concerned donors as appropriate, they will need to

The Regional Bureaus will oversee and coordinate country performance. The Child Survival Task Force will monitor Agency performance and, in collaboration with other donors, track progress towards the world community's goals of universal immunization, access to ORT and reduced infant and child mortality.

Annex 2

MANDATE FOR INCREASED COMMITMENT TO CHILD SURVIVAL

Recent enhanced interest in child survival as the top priority for health sector interventions has been manifested in several ways. Within A.I.D., recognition of the potential impact of ORT has led to the Agency's sponsorship of two international conferences on oral rehydration therapy, as well as regional ORT conferences in Asia and Africa. More recently, immunization has been added to A.I.D.'s priority list, becoming the second of the twin engines for the A.I.D. Child Survival Strategy. The Bellagio Conference and the follow-up meeting in Cartagena provided opportunity for all the leading international and bilateral agencies to focus on developing common strategies for the implementation of child survival programs in the developing world.

In Africa, the Africa Bureau's Combatting Childhood Communicable Disease Project has led the way as the Agency's first and largest child survival project. UNICEF and WHO are working in concert with A.I.D. and other donors in strengthening child-survival programs around the world. Special emphasis has been given to Africa because of the special needs there. Recently, Italy pledged \$100 million to UNICEF for expanded immunization programs in Africa. UNICEF has shifted 100 of its overseas staff positions to posts in Africa, in part to help expand activities in the child survival.

In FY 1985, additional funds appropriated by Congress for child survival allowed A.I.D. to accelerate its efforts to improve the health of children in A.I.D.-assisted countries and passed a resolution (S. CON. RES. 78) "In support of universal access to immunization by 1990 and accelerated efforts to eradicate childhood diseases". In FY 1986 Congress again appropriated additional funds for child survival. For FY 1987 A.I.D. requested a separate child survival account. Funding for child survival activities and projects will also be derived from other accounts, including health, population, ESF, Sahel, and PL480. In future years funding will continue to come from a variety of Agency accounts, reflecting the multi-disciplinary requirements of this strategy.

Sources of Data

There are three readily available sources of national level infant (ages 0-1) and child (ages 1-4) mortality data for Africa: The United Nations (UN), the World Bank (WB) and the Population Reference Bureau (PRB). Although UN data underlie the WB and PRB estimates, the figures do differ slightly. Variations arise because all the figures are basically extrapolations from inadequate data sources--poor or out-of-date censuses and sample surveys, and the three groups make slightly different educated guesses about the parameters. In general, however, infant and child mortality rates from all sources lie within the same range for any given country. In following sections of this memo, data will be drawn from the World Bank, 1984 World Development Report.

The effects of drought

Unfortunately, the kinds of aggregate statistics available from the UN, WB and PRB are not useful for tracking the effects of severe drought on infant and child mortality, and in fact over time, show a continuous downward trend in both infant (IMR) and child (Ch.MR) rates. ("Normal" mortality levels will be discussed below.) Further, assuming the underlying data were adequate enough to be sensitive to drought effects, statistics usually take 2 or 3 years to update and thus increases in the IMR would show up only after a time lag. For example, 1984 PRB estimates for the drought stricken countries compared to 1982 WB estimates indicated slightly increased infant mortality levels in Ethiopia, Niger, and Mali, constant levels in the Sudan, Mauritania, and the Ivory Coast, and decreased levels in Somalia, Chad, and Senegal. Small scale village studies of the 1970s drought in the Sahel indicated that infant mortality does not necessarily rise. Because fertility declines during drought, those babies who would have been at highest risk of dying are never born. At least one study found that the downward (i.e., improving) trend in infant mortality rates actually continued, but at a slower rate. The fertility effects of drought would not protect children age 1-4 and one might expect to see a rise in the child death rate. Unfortunately, available data are insufficient to demonstrate this effect.

"Normal" Infant and Child Mortality

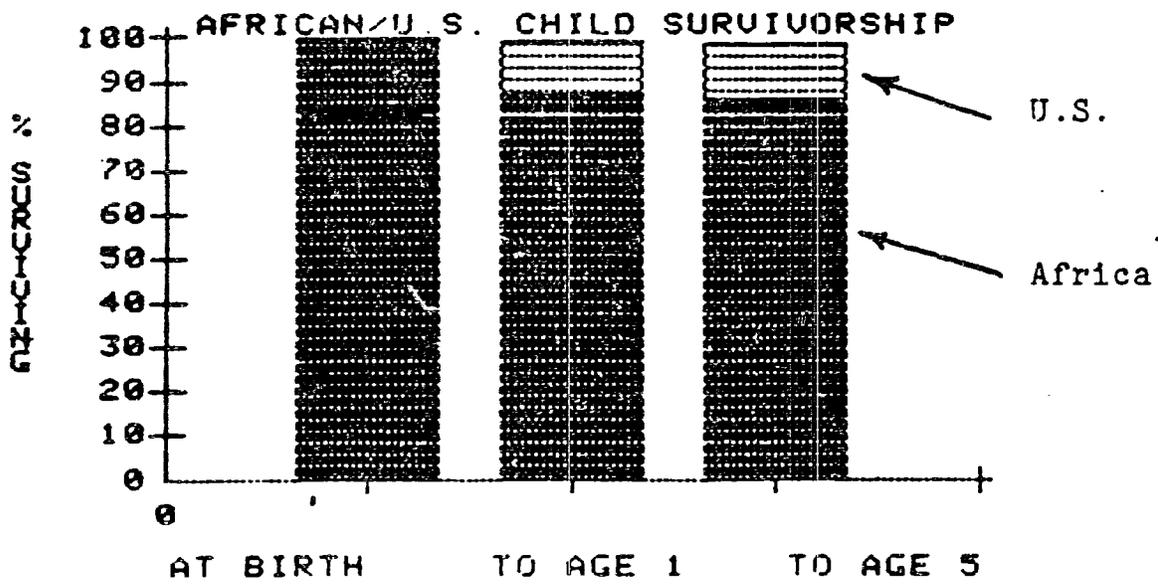
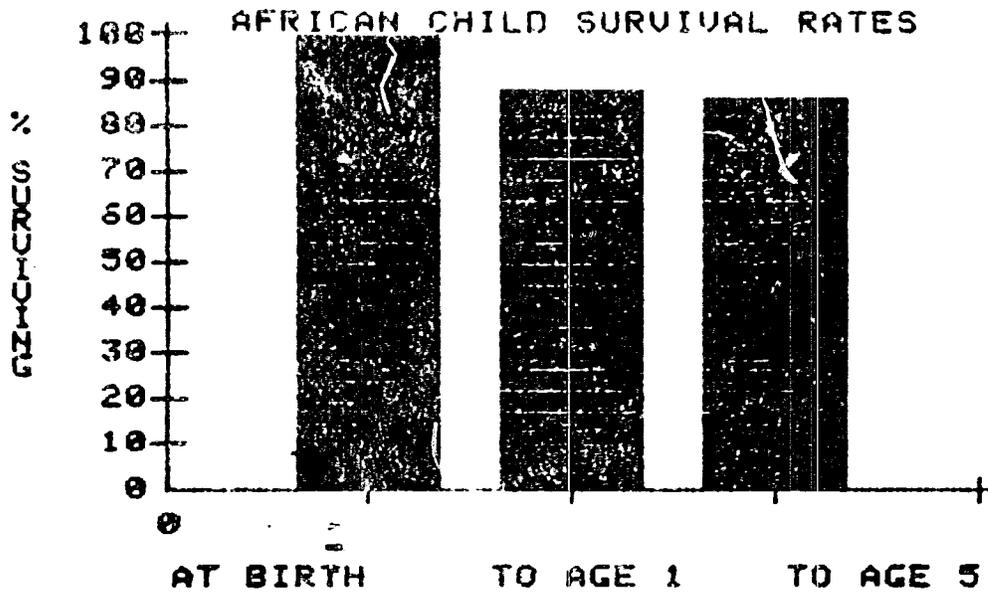
In 1982, the IMR range was from 190 deaths per 1000 births in Guinea and Sierra Leone, 184 in Somalia and 161 in Chad to 109

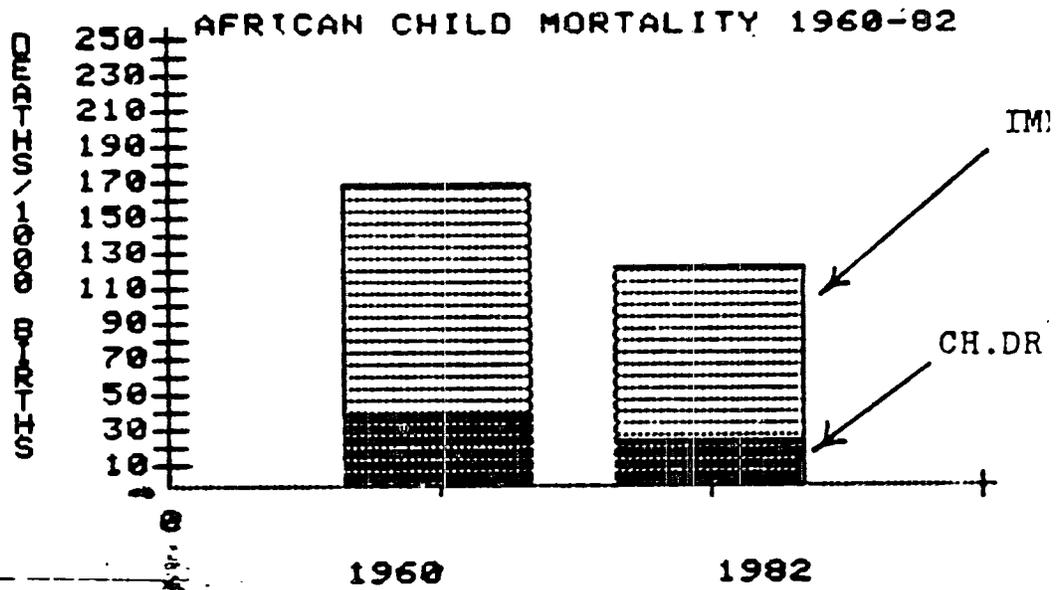
in Nigeria, 83 in Zimbabwe, 77 in Kenya, and 34 in Mauritius, with the overall average for Sub-Saharan countries being 121. In 1962 the overall average was 168, and the range was from 235 in Sierra Leone to 70 in Mauritius. In 1962, eight countries recorded levels over 200--meaning that at least 20% of all babies born died during their first year, and only one country was below 100. In 1982, the World Bank estimated that no African country had an IMR over 200 and nine had levels under 100. In general, the 1982 IMRs are about 3/4 the 1960 rates. Despite these improvements, the levels in Africa are still the highest in the world. The overall average for low income countries, including China and India, is 87 deaths per 1000 births, for middle income countries 76 per 1000, and for industrial market economies 10 per 1000. In general, West Africa and the Sahelian countries have higher IMRs than east and central Africa. Some exceptions are Malawi and Somalia which have high "West African" levels, 134 and 187 respectively, and Ghana (86), Liberia (91) and the Cameroons (92) which have "East African" levels.

Child death rates appear to have fallen slightly more than IMRs with the average 1982 rate of 24 being 3/5 the 1960 level of 41. The rank order is essentially the same as for IMR with the range being from 50 deaths per 1000 1-4 year olds in Guinea and Sierra Leone to 20 for Nigeria, 13 for Kenya and 3 for Mauritius.

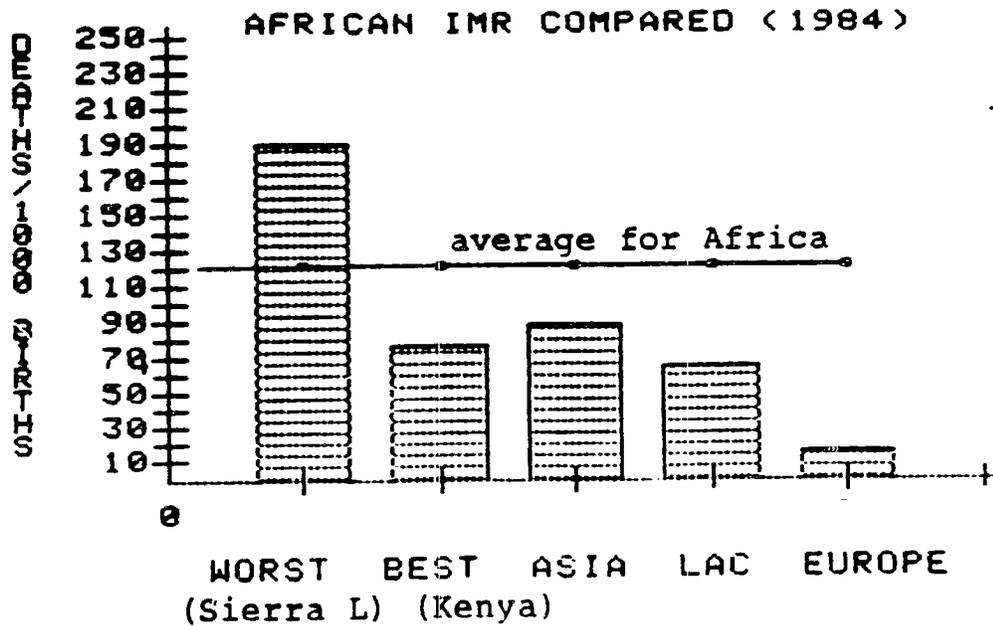
The high levels of infant and child mortality in Africa mean that of all the babies born, on average only 86% will survive to age 5, in Guinea and Somalia only 79%, in Senegal 81%, Ethiopia and the Ivory Coast 86%, Nigeria 87%, Kenya 91%, and 96% in Mauritius. The overall average for low income countries is a 90% survival rate and for the industrial market economies, 99%.

As a closing note, it must be stressed that aggregate mortality data for most African countries do not necessarily paint the complete picture. Not only do the aggregate figures mask urban-rural differences, but also mortality levels projected from old censuses and surveys are uniformly assumed to include declines. It would, therefore, be imprudent to consider them sufficiently reliable at the country level to influence many program decisions.





* IMR=Infant Mortality Rate (age 0-1)
 ** CH.DR=Child Death Rate (age 1-4)



AFRICA: Infant Mortality and Child Death Rates

1960 and 1982

COUNTRY	IMR82	IMR60	CH. DR82	CH. DR60
SIERRA L	190	235	50	72
GUINEA	190	222	50	65
SOMALIA	184	213	47	61
ANGOLA	165	216	29	60
CHAD	161	210	37	60
BURKINA F	157	234	36	71
SENEGAL	155	178	34	45
GUINEA-B	150	190	31	44
MALAWI	137	206	29	58
NIGER	132	178	27	45
MAURITANIA	132	178	27	45
MALI	132	179	27	45
RWANDA	122	167	25	40
BURUNDI	123	143	24	31
TOGO	122	201	25	55
ETHIOPIA	122	172	25	42
UGANDA	120	139	22	28
SUDAN	119	168	23	40
IVORY COAS	119	167	23	40
CAR	119	170	23	41
BENIN	117	173	23	42
MADAGASCAR	116	177	23	45
NIGERIA	109	190	20	50
ZAIRE	106	150	20	32
ZAMBIA	105	164	20	38
MOZAMBIQUE	105	154	20	34
TANZANIA	98	144	18	31
LESOTHO	94	137	17	29
CAMEROON	92	134	16	28
LIBERIA	91	173	16	42
GHANA	86	132	15	27
ZIMBABWE	83	100	14	19
KENYA	77	112	13	21
CONGO*	68	118	10	23
MAURITIUS	34	70	3	11

*Figures for the Congo seem implausibly low (CF PRB Figure of 128 IMR for 1982)

EXAMPLES OF ESTIMATED ACCESS AND USE RATES FOR ORAL REHYDRATION THERAPY
for countries with active CDD programmes and from which the most
data were available, 1983

Country	ORS access rate (%) ^a	ORS use rate (%) ^b	ORT knowledge rate (%) ^c	ORT ever used (%) ^d
Bangladesh	20	8	25	6
Bolivia	35			
✓ Botswana	85			
Colombia	35	15		
Cuba	80			
Egypt	50	16		
✓ Gambia			80	47-66
Haiti	60	35		
Honduras	60	26		
Indonesia	33	17		
Jamaica	40	15		
Jordan	32	6		
✓ Lesotho	21		80	50
Maldives	100	25		
Nepal	14			
Nicaragua	80	45		
Pakistan	33	6		
Philippines	70	25		
Sri Lanka	20	4		
✓ Sudan	23	3		
Suriname	40	5		
Thailand	60	35		
Viet Nam	35	5		
Zimbabwe			80	50

^aEstimated proportion of diarrhoea episodes with reasonable access to oral rehydration salts (ORS). In 6 countries estimates were based on reported ORS distribution or supply figures assuming 10% of episodes require ORS and that 50% of packets remain undistributed, spoil, or for other reasons are not available to diarrhoea cases in the 0-4 years ago group.

^bEstimated proportion of diarrhoea episodes actually treated with ORS.

^cProportion of mothers who indicated they knew about oral rehydration therapy (ORS or household fluids).

^dBangladesh - proportion of diarrhoea episodes treated with household fluids; other countries - proportion of mothers who have ever used ORS or household fluids to treat diarrhoea.

AFRICAN REGION: ESTIMATED IMMUNIZATION COVERAGE
AND DELIVERY (1985 UPDATE)

COUNTRY	GEOGRAPHIC COVERAGE	FULLY IMMUNIZED UNDER ONE	IMMUNIZATION DELIVERY		
			H/FACILITY	OUTREACH	MOBILE TEAMS
	%	%	%	%	%
ALGERIA	95	30	50	30	20
ANGOLA	35	46	75	0	25
BENIN	85	-	-	-	-
BOTSWANA	100	62	85	15	0
BURKINA FASO	10	5	5	0	95
BURUNDI	94	55	100	0	0
CAPE VERDE	100
CENTRAL AFRICAN REP.	-	-	-	-	-
CHAD	40	40	-	-	-
COMOROS	...	-	-	-	-
CONGO	65	30	65	0	35
EQUATORIAL GUINEA	60	20	70	30	0
ETHIOPIA	16	-	92	8	-
GABON	80	30	-	-	-
GAMBIA	100	55	75	25	0
GHANA	...	-	-	-	-
GUINEA	...	-	-	-	-
GUINEA BISSAU	70	15	50	30	20
IVORY COAST	...	-	-	-	-
KENYA	43	30	80	20	-
LESOTHO	100	58	-	-	-
LIBERIA	-	-	80	20	0
MADAGASCAR	60	40	70	10	20
MALAWI	85	55	-	-	-
MALI	21	-	-	-	-
MAURITANIA	100	13	20	10	70
MAURITIUS	100	50	10	90	0
MOZAMBIQUE	-	-	-	-	-
NAMIBIA	100	70	75	25	0
NIGER	100	-	-	-	-
NIGERIA	60	15-25	60	20	20
REUNION	...	-	-	-	-
RWANDA	100	50	75	25	0
SAO TOME AND PRINCIPE	100	65	100	0	0
SENEGAL	100	20	...	-	-
SEYCHELLES	-	-
SIERRA LEONE	92	27	-	-	-
ST HELENA	...	-	-	-	-
SWAZILAND	-	24	-	-	-
TOGO	70	6	-	-	-
UGANDA	25	-	-	-	-
UNITED REP. OF CAMEROON	24	14	70	30	0
UNITED REP. OF TANZANIA	100	18-30	90	5	5
ZAIRE	50	24	60	30	10
ZAMBIA	100	80	75	25	0
ZIMBABWE	100	45	55	35	10

... Data not available

- Estimate not given

Table 6

HEALTH, POPULATION, NUTRITION AND ECONOMIC INDICATORS IN AID ASSISTED AFRICAN COUNTRIES

HPN INDICATORS	INDIAN OCEAN				EAST AND SOUTHERN AFRICA												
	MAUR- ITIUS	MAD- AGAS- CAR	SEY- CHEL- LES	COM- OROS	ZIM- BA- BWE	KEN- YA	BOT- SWANA	LES- OTHO	SU- DAN	SOMA- LIA	TAN- ZA- NIA	UGAN- DA	MAIA- WI	MO- ZAM- BIQUE	SWA- ZI- LAND	ZAM- BIA	ASIA* THAI- LAND
Family Planning - 1985																	
% Contraceptive Women (15-49)	50	1	NA	NA	14	8	8	7	5	1	NA	NA	NA	NA	NA	NA	56
% Population Under 15 Years	33	44	37	46	48	52	50	50	46	45	46	48	48	46	47	47	38
Crude Birth Rate	21	45	26	46	47	54	50	42	47	47	50	50	52	45	48	48	25
Total Fertility Rate	2.7	6.4	4.1	6.3	6.6	8.0	6.6	5.8	6.6	6.6	7.1	6.9	6.9	6.1	6.5	6.5	3.5
% Women Using Modern Contraceptives	32	NA	NA	NA	7	4	NA	2	4	NA	NA	NA	NA	NA	NA	NA	54
Health - 1985																	
Crude Death Rate	7	17	7	16	12	13	13	16	17	21	15	15	20	17	17	15	6
Infant Mortality	27	67	14	88	70	82	79	110	118	142	98	94	145	110	113	109	51
Life Expectancy At Birth (Years) - Total (M & F)	67	50	68	50	56	53	54	49	48	43	50	52	47	49	52	51	63
ECONOMIC - 1985																	
PER CAPITA GNP (In Dollars)	1,150	290	2,400	NA	740	340	920	470	400	250	240	220	210	NA	890	580	810
Population Growth - Mid 1985																	
Total, M & F (Millions)	1.0	10.0	0.1	0.5	8.6	20.2	1.1	1.5	21.8	6.5	21.7	14.7	7.1	11.9	0.7	6.8	57.2
Women (15-49) Millions	0.3	2.3	.02	0.1	1.9	4.2	0.2	0.4	4.9	1.6	4.7	3.2	1.6	3.1	0.1	1.5	25.2
Women (15-49) Year 2020	0.4	6.5	.02	0.3	6.8	17.2	0.9	0.9	13.5	3.5	17.3	11.2	5.1	9.2	0.5	5.0	22.2
Natural Rate of Increase	1.5	2.8	1.9	3.0	3.5	4.1	3.7	2.6	2.9	2.6	3.5	3.5	3.2	2.8	3.4	3.3	1.9
Years to Double Total Population	47	25	37	24	20	17	19	27	24	27	20	20	22	25	22	21	36
Projected Total Pop. Year 2020	1.6	26.8	0.1	1.0	28.1	68.0	3.5	3.7	33.2	14.1	70.7	43.7	20.5	36.0	1.8	20.7	67.6

Sources: Population Reference Bureau's Population Data Sheet and the World's Women (1985)
 U.N. World Population Prospects, Population Studies #86 (1985)
 Gross National Product Per Capita Figures, World Bank Atlas (1985)

Explanatory Note: * As a point of reference and comparison, of the AID assisted countries in Asia, Thailand has the highest percentage of contracepting women (15-49) while in all of Africa, Mauritius has the highest, and which is a key factor in favorably influencing other HPN and Economic indicators

COUNTRY	TITLE	PROJ#	FY85	FY86	FY87	FY88	APPR
Kenya	Const/Community Based Child Survival	6150241	0	0	1200	0	CS
Mali	Integrated Family Health Services	6880227	0	0	0	750	CS
Niger	Health Sector Support	6830254	0	0	1500	0	CS
Regional	Combating Childhood Communicable Diseases	6980421	0	4000	7710	7300	CS
Regional	Program Development Support II	6980510	0	0	70	200	CS
Regional	African Child Survival (UNDP)	6980513	3500	0	0	0	CS
Regional	Regional Child Survival Support	6980469	0	0	1600	2000	CS
Sudan	Child Survival Project	6500084	0	0	2000	3000	CS
Uganda	Child Survival Project	6170116	0	0	200	1000	CS
Subtotal			3500	4000	14500	14250	
Cameroon	Program Development and Support	6310510	0	400	0	0	HE
Cameroon	Maternal Child Health	6310054	0	0	3010	2000	HE
Congo	Nutrition Education II	6790006	188	0	0	0	HE
Kenya	Family Planning Support and Services	6150232	250	2479	1394	0	HE
Kenya	Training for Development	6150234	0	0	941	0	HE
Kenya	PVO Co-Financing	6150236	2000	0	0	0	HE
Kenya	Program Development and Support	6150510	65	20	165	102	HE
Kenya	Kenya Health Planning and Information	6150187	100	0	0	0	HE
Lesotho	Rural Water and Sanitation	6320086	1294	0	0	0	HE
Liberia	Primary Health Care Project	6690165	3021	3610	3227	0	HE
Liberia	PVO and NGO Support	6690211	0	0	280	800	HE
Liberia	Program Development & Support	6690510	30	30	53	30	HE
Malawi	Human Resources/Institution Devel.	6120230	0	0	1309	500	HE
Malawi	Health Institutions Development	6120211	2000	1920	0	0	HE
Malawi	Family Planning	6120224	0	0	0	3500	HE
Regional	Israeli African Support	6980465	0	380	0	0	HE
Regional	Health Constraints to Rural Production	6980406	3853	0	0	0	HE
Regional	Program Development Support II	6980510	1160	1383	1151	1100	HE
Regional	African Manpower Development II	6980433	0	880	0	0	HE
Regional	African Development Support (TR)	6980464	0	0	300	300	HE
Regional	Health Institutions Improvement (I220)	6980412	375	0	0	0	HE
Regional	AIDS Control for WHO/AFRO Region	6980468	0	1000	0	0	HE
Regional	Health Training and Management Initiative	6980476	0	0	2000	2000	HE
Regional	Combating Childhood Communicable Diseases	6980421	6840	11491	4781	9500	HE
Regional	Strengthening Health Delivery Systems II	6980398	3100	500	0	0	HE
Regional	Onchocerciasis Control Phase II	6980399	1982	0	0	0	HE
Rwanda	MCH/Family Planning II	6960126	0	0	0	1000	HE
Somalia	PVO Development Partners Project	6490126	2000	4660	1000	250	HE
Somalia	Program Development & Support	6490510	200	0	100	50	HE
Sudan	Health Constraints to Rural Production	6500073	2122	0	0	0	HE
Sudan	Rural Health Support-OPG	6500030	1682	0	0	0	HE
Sudan	Program Development and Support	6500510	58	0	70	70	HE
Swaziland	Rural Health Development	6450220	2000	983	1000	1000	HE
Swaziland	Health Planning and Management-OPG	6450215	1130	0	0	0	HE
Swaziland	Rural Water-Borne Disease Control	6450087	0	1000	1000	0	HE
Togo	Rural Water and Sanitation	6930210	1608	0	0	0	HE
Togo	Health Sector Planning and Support	6930228	0	0	911	1500	HE
Uganda	Oral Rehydration Therapy	6170107	2050	550	0	0	HE
Zaire	Basic Rural Health II	6400107	4250	2500	4040	3000	HE
Zaire	Kimbanguist Hospital Assistance	6400122	0	750	0	0	HE
Zaire	Shaba Refugee Health	6400114	2500	0	0	0	HE
Zaire	Program Development and Support	6400510	160	85	0	50	HE
Zaire	Basic Rural Health	6400086	110	0	0	0	HE
Zaire	Shaba Refugee Water Supply	6400116	2250	0	0	0	HE
Zaire	School of Public Health	6400101	2000	2235	0	0	HE
Subtotal			48718	36796	26652	26752	
Burkina Faso	Strengthening Health Planning Capacity	6860251	0	1750	0	0	SH
Burkina Faso	Seguenga Integrated Rural Devel.-OPG	6860231	550	0	0	0	SH
Burkina Faso	Rural Water Supply	6860228	1200	0	0	0	SH
Chad	Oral Rehydration Therapy	6770934	350	0	0	0	SH
Mali	Integrated Family Health Services	6880227	0	1200	1650	960	SH
Niger	Rural Health Improvement	6830208	1400	900	0	0	SH
Niger	Niger Health Sector Support	6830254	0	3507	3500	0	SH
Sahel Regional	Oral Rehydration Therapy-PRITECH	6250963	1300	0	0	0	SH
Sahel Regional	Onchocerciasis Control Program	6250966	0	2500	2500	2500	SH
Senegal	Rural Health Services II	6850242	3514	0	960	0	SH
Subtotal			8314	9857	8550	3460	
Total			60532	50653	49702	44462	

COUNTRY	TITLE	PROJ#	IMPLAGT	APPR	FY86	NON86
Burkina Faso	Seguena Integrated Rural Devel.-DPG	6860231	AFRICARE	SH	0	0
Cameroon	Northern Wells Phase II	6310051	CARE	HE	0	0
Cameroon	SCF:86 CS Grant	9380524	SCF	CS	0	370
Chad	Oral Rehydration Therapy	6770934	AFRICARE	SH	0	0
Comoros	Care(PVD)	6020001	CARE	FN	750	0
Congo	Nutrition Education II	6790006		HE	0	0
Kenya	Family Planning Management Program-OPG	6150216	AMREF	HE	0	0
Kenya	Kitui Primary Health Care II	6150219	CRS	HE	0	0
Kenya	PVD Co-Financing	6150236	Multiple	HE	0	0
Kenya	PVD:Matching Grant:MFM	9380261	MFM	FN	0	0
Kenya	Improving CS through Home Leagues	9380509	SAMSO	HE	0	0
Kenya	AMREF:86 CS Grant	9380519	AMREF	CS	0	750
Malawi	Lower Shire Valley Intervention	9380501	IEF	CS	0	0
Malawi	Reduce IMR/CDR Thru ORT/EPI	9380508	ADRA	HE	0	0
Malawi	SCF:86 CS Grant	9380524	SCF	CS	0	280
Mali	CARE:86 CS Grant	9380516	CARE	CS	0	550
Mali	PLAN:86 CS Grant	9380522	PLAN	CS	0	200
Nigeria	Africare:86 CS Grant	9380517	Africare	CS	0	440
Regional	Child Survival Tech.Assistance for Africa	938000X		CS	0	200
Rwanda	Reduce IMR/CDR Thru ORT/EPI (ADRA)	9380508	ADRA	HE	0	0
Senegal	WJRO:86 CS Grant	9380518	WJRO	CS	0	270
Senegal	CRS:86 CS Grant	9380523	CRS	CS	0	440
Sierra Leone	PVD:Matching Grants:MFM	9380261	MFM	FN	0	0
Somalia	PVD Development Partners Project	6490138	Multiple	HE	4600	0
Sudan	Internal Food Aid Transport	6500080	ADRA	HE	0	515
Sudan	CARE:86 CS Grant	9380516	CARE	CS	0	750
Sudan	WJRO:86 CS Grant	9380518	WJRO	CS	0	370
Sudan	SCF:86 CS Grant	9380524	SCF	CS	0	580
Swaziland	Health Planning and Management-OPG	6450215	JHAP	HE	0	0
Uganda	Community Health Services Everywhere	9380503	CARE	HE	0	0
Uganda	Rural Hlth.Center Proj.of Makerere U.	9380513	NIHV	HE	0	0
Zaire	Food for Peace	6600079	Org.For Rehab.	P2	0	0
Zaire	Basic Rural Health	6600086	ECZ	HE	0	0
Zaire	PVD Economic Support Project	6600097		ES	0	0
Zaire	Basic Rural Health II	6600107	ECZ	HE	2500	0
Zaire	Shaba Refugee Health	6600114	Un.Hedth.Ctrch	HE	0	0
Zaire	Shaba Refugee Water Supply	6600116	AIDR	HE	0	0
Zaire	Kimbanguist Hospital Assistance	6600122	Hadassah/USA	HE	750	0
Zimbabwe	Protecting the Life & Hlth. of Children	9380502	SCF	CS	0	0
Zimbabwe	Zimbabwe Supported Primary Health Care	9380505	WJRO	HE	0	0
Total					8600	5715

Table 7

FUNDING FOR HEALTH AND CHILD SURVIVAL
IN AFRICA COMPARED WITH OTHER REGIONS

	<u>FY 85</u>	<u>FY 86</u>	<u>FY 87*</u>	<u>FY 88*</u>
Health	48,718	36,796	26,652	26,752
CSF	3,500	4,000	14,500	14,250
Sahel	<u>8,314</u>	<u>9,857</u>	<u>8,550</u>	<u>7,410</u>
<u>Total for Health and CS/Africa</u>	60,532	50,653	49,702	48,412
ANE	76,300	107,121	76,300	81,283
LAC	91,508	72,132	62,148	61,959
<u>Total for Child Survival</u>				
AFRICA	31,415	32,216	25,684**	27,771**
ANE	25,123	48,640	33,670**	22,884**
LAC	32,310	38,590	35,966**	32,211**

*Africa fund

**Incomplete reporting. Attributions from ^anumber of new projects are not yet available. _^

Wang #:4592u

A.I.D.

ST/HEALTH PROJECTS WHICH INCLUDE CHILD SURVIVAL SUB-PROJECTS
ACTIVITIES IN AFRICA

<u>Project No. & Title</u>	<u>OBL 86</u> <u>(\$000)</u>	<u>OYB 87</u> <u>(\$000)</u>
<u>Program - Centrally funded - Nutrition</u>		
931-1010 Nutrition: Imprv of Maternal/ Infant	950	1,575
931-1064 Nutrition: Surveys and Surveillance	525	175
931-1065 Nutrition: Education Field Support	0	500
931-1198 Nutrition: Health Systems RSSA	325	325
<u>Program: Centrally Funded - Health</u>		
931-1018 Communication for Child Survival	200	0
936-3023 Demographic & Family Health Surveys	500	500
936-5920 Primary Health Care-operations research	1,600	2,000
936-5927 Technology for PHC	4,200	0
936-5929 HHS Resource Support	200	200
936-5932 Medex Support	500	1,000
936-5939 ORT-Help	1,100	750
936-5942 Water & Sanitation for Health II	2,734	2,500
936-5948 Vector Biology & Control	600	1,500
936-5951 Child Survival Action Program Support	1,017	1,250
936-5952 Applied Diarrheal Disease Research	550	1,500

PROGRAM: CENTRALLY FUNDED - CHILD SURVIVAL FUNDOffice of Nutrition

931-1010 Nutrition: Imprv of Maternal/ Infant diet	0	800
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Office of Health

931-1018 Communication for Child Survival	1,500	2,000
936-5927 Technology for PHC	2,700	4,500
936-5928 Diarrheal Disease Research	1,050	0
936-5935 Diagnostic Technology Development	875	0
936-5952 Applied Diarrheal Disease Research	950	0
936-5953 Supply Promotion and Production of ORT	0	500
936-5966 Perinatal Health	0	1,000
936-5969 Technology for PHC II	0	2,500

Office of Population

936-3023 Demographic & Family Health Surveys	0	500
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TOTAL	22,076	255,75
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SOURCE: FY1988 CP
DATE: 02/17/87

A.I.D.

FVA/PVC PROJECTS WHICH INCLUDE CHILD SURVIVAL SUB-PROJECT/
ACTIVITIES IN AFRICA

Project No. & Title	OBL 86 (\$000)	OYB 87 (\$000)
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PROGRAM: CENTRALLY FUNDED - HEALTH

Program Grants (MATCHING)

938-xx23 Salvation Army World svc office (SAWSO)	0	472
938-0135 Catholic Relief Service (CRS)	425	0
938-0249 Salvation Army World SRVC Office (SAWSO)	500	0
938-0267 Coop for Amer Relief Everywhere	1,485	1,000
938-0269 Helen Keller Inter (HKI)	600	600
938-0270 International Eye Foundation (IEF)	275	275
938-0273 Adventist Development and Relief Agency	400	400
938-0276 African Med/Res Found (AMREF)	200	213

Program Grants (COST-SHARING)

938-xx64 World Vision Relief Agency (WVRO)	0	650
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PROGRAM: CENTRALLY FUNDED - CHILD SURVIVAL FUND

938-0500 Technical Support/Child Survival	40	10,000
938-0508 Adventist Dev Relief Agency	40	0
938-0516 Coop American Relief Everywhere (CARE)	1,300	0
938-0517 Africare	440	0
938-0518 World Vision Relief Organization (WVRO)	580	0
938-0519 African Medical and Research Foundation	750	0

PROGRAM: CENTRALLY FUNDED - CHILD SURVIVAL FUND

938-0521	Project Concern International	900	0
938-0522	Foster Parents Plan	700	0
938-0523	Catholic Relief Services	440	0
938-0524	Save the Children (SAVE)	1,270	0
938-0526	PVO Child Survival Operations Program	190	0

PROGRAM: CENTRALLY FUNDED - AGRICULTURE, RURAL, DEV, & NUTRITIONVitamin A

938-0284	Helen Keller	1,741	0
938-0516	Coop American Relief Everywhere (CARE)	25	0
	TOTAL	12,401	13,610

SOURCE: FY1988 CP
DATE: 02/17/87

A.I.D.

S&T BUREAU PROJECTS WHICH INCLUDE POPULATION
ACTIVITIES IN AFRICA

<u>Project No. & Title</u>	<u>Obl 86</u> <u>(\$000)</u>	<u>OYB 87</u> <u>(\$000)</u>
<u>Policy</u>		
932-0643 Population Policy Research	320	0
936-3000 Demog Data for Development	1,782	1,425
936-3017 Rapid II	2,000	1,300
936-3023 Fam Health & Demog Surveys	4,000	3,000
Funding from: population	0	2,500
Funding from: child survival		500
936-3027 Integ Pop/Dev Planning II (INPLAN)	2,100	750
936-3035 Pop Policy Initiatives	3,750	3,326
<u>Research</u>		
936-3005 Population Council Program	4,700	4,100
936-3030 Strategies for Improv Serv Delivery	7,837	7,195
936-3040 Natural FP Initiatives	3,000	1,405
936-3041 Family Health Int'l	7,680	7,000
936-3044 Contraceptive Research and Development	4,750	3,000
<u>Family Planning Services</u>		
932-0955 Planned Parenthood Fed. of Amer.	16,000	6,400
932-0968 Assoc for Vol Surgical Contraception	10,200	10,000
936-3024 Population Technical Assistance	0	500
936-3028 Contraceptive Social Marketing	3,500	4,174
936-3034 FP Enterprise	2,500	5,000
936-3037 Expanding FPS-Women Mgrs	600	572
936-3042 Family Planning Services	9,750	7,597
<u>Commodity/Program Support</u>		
932-0502 Program Development & Support	2,599	2,314
936-3018 Contraceptive Procurement	15,400	10,000
936-3038 FP Logistics Management	2,086	1,349

Information/Training

932-0604	Training in Reprod. Health	5,069	0
932-0551	Worldwide Training	315	0
936-3004	Pop Comm. Service	5,100	3,300
936-3031	PAC Training II	6,000	5,077
936-3032	Pop Informatin Program III	2,200	1,505
936-3033	Pop Service Intern Training	419	700
936-3039	FP Management Training	1,765	2,000
936-3045	Training in Reproductive Health	1,093	4,500

Population Planning

932-0662	UNFPA	0	25,390
	TOTAL	126,515	125,879

SOURCE: FY1988 CP
DATE: 02/17/87

 POPULATION AND HEALTH PERSONNEL
 AFRICA BUREAU
 FY 83 - FY 86

	FY 83 ACTUAL	FY 84 ACTUAL	FY 85 ACTUAL	FY 86 OYB	FY 87 ABS
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HEALTH

DIRECT HIRE	14	14	13	13	14
PSC	1	1	1	1	1
CCCD (CDC)	4	8	14	19	23
SUBTOTAL	<u>19</u>	<u>23</u>	<u>28</u>	<u>33</u>	<u>38</u>

POPULATION and HEALTH

DIRECT HIRE			13	13	15
PSC			1	1	1
SUBTOTAL	<u>0</u>	<u>0</u>	<u>14</u>	<u>14</u>	<u>16</u>

POPULATION

DIRECT HIRE	9	10	11	11	13
PSC	1	3	5	5	6
IDI	2	3	6	4	0
SUBTOTAL	<u>12</u>	<u>16</u>	<u>22</u>	<u>20</u>	<u>19</u>
PERSONNEL	31	39	64	67	73

SOURCES:

AFR/RA (CCCD)

S&T/POP (POPULATION)

WORLDWIDE STAFFING PATTERN (1/30/86)

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