CHILD SURVIVAL IMPLEMENTATION REPORT
BUREAU FOR AFRICA

August 1988

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON D C 20523

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ASSISTANT
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AUG 5 1988

INFORMATION MEMORANDUM FOR THE ADMINISTRATOR

THROUGH: ES

FROM: AA/AFR, Charles L. Gladson

SUBJECT: Child Survival Implementation Report

We are pleased to forward the Bureau for Africa's 1988 Child Survival Implementation Report. The report details progress and identifies constraints in our regional Child Survival program. This high priority area is under regular review within the Bureau. The Africa Child Survival strategy is being followed, and significant results are emerging.

The Bureau will achieve its target of approximately 10 percent of the DFA account for child survival and other health activities throughout the period FY 1988 to FY 1990.

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THE BUREAU FOR AFRICA
CHILD SURVIVAL IMPLEMENTATION REPORT, FY 1988

EXECUTIVE SUMMARY

A reappraisal of objectives and approach to Child Survival in sub-Saharan Africa is underway, prompted by cumulating data on program implementation and recent extensive FY 1990 ABS reviews. This Implementation Report reflects those data and reviews. It notes progress, identifies problems, shows planned funding levels and suggests some programmatic changes. It reaffirms earlier Agency and Bureau strategy of emphasizing immunization and oral rehydration to most cost effectively reduce infant and child mortality -- they are working.

However, most of Africa presents profiles of higher early mortality and much more rural and more rudimentary public health infrastructures than all but a few countries elsewhere. We've learned that emphases need to be broader than the "twin engines" if the target of an infant mortality rate of 75/1000 is to be reached in most A.I.D. Child Survival (CS) Emphasis Countries in Africa by 1995, let alone the target date of 1990. We've learned clearly that substantial resources beyond those likely to be available through A.I.D. will be required, including better host country budgetary commitment, more cost recovery, and broader donor participation. And we've learned that changes will not be as rapid as earlier thought possible.

The Bureau has major investments in child survival in seventeen countries, in two categories. There are eight CS Emphasis Countries (see Table 1). The Africa Child Survival Initiative - Combatting Childhood Communicable Diseases (ACSI-CCCD) Project which began in 1981 was the Agency's first CS oriented project and it continues as the largest, operating in twelve countries (see Table 2). Malawi, Nigeria and Zaire are common to both categories. The ABS shows that between 1986 and 1990 the Bureau's investment in Child Survival activities will steadily rise from $27 million to $39 million. Technical personnel (BS-50s, FSNs, PASAs and PSCs) will rise from about 115 to 135 over the period, unless restrictions on Operating Expenses diminish that number. In the latter case, there will be great shortfalls in acheiving CS objectives.

In general, immunization programs are working well. Six of the 17 countries may reach the target of 80% coverage by 1995 and another four may do so under optimal circumstances. Oral rehydration therapy presents greater challenges. At best, five of the 17 countries may reach the target of 100% access to oral rehydration salts by 1995 and no more than six will meet the target of 45% use levels by 1995.

In the following report the status of programming for immunizations, oral rehydration therapy, dietary management of diarrhea, malaria and high risk births is reviewed. An approach to improving program sustainability is outlined. Implementation problems and approaches to them are presented.

Table 1 Africa - Child Survival Emphasis Countries:
Comparison of Vaccine Coverage Data Over Time

Country	Coverage Rates by Antigen 1983 Measles	DPT3	1985 Measles	DPT3	1986 Measles	DPT3	1987 Measles	DPT3
Kenya	55%	58%	63%	70%	65%	72%	60%*	70%*
Malawi**	70% (82)	69% (82)	53%	55%	66%	66%	66%*	66%*
Mali	NA	NA	NA	NA	NA	3%		
Niger	19% (81)	6% (81)	NA	NA	NA	5%		
Nigeria**	17% (84)	5% (84)	14%	10%	32%	21%	20%*	18%*
Senegal	NA	NA	39%	53%	60%	NA	63%*	47%*
Sudan	2%	3%	6%	8%	11%	14%	22%*	29%*
Zaire**	29%	16%	40%	37%	40%*	37%*	39%*	36%*

Source: WHO reports for the age groups 12-23 months
*USAID/Host Country reports
**Also an Africa CS Initiative-CCCD Country.

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Table 2. Africa Child Survival Initiative - CCCD Project Countries: Comparison of Vaccine Coverage Data Over Time

Country	Coverage Rates by Antigen 1983 Measles	DPT3	1985 Measles	DPT3	1986 Measles	DPT3	1987 Measles	DPT3
Burundi	45%	27%	30%*		42%	65%	54%	68%
CAR	16%	14% (82)	30%	24%	35%*	20%*	18%*	18%*
Cote d'Ivoire	--	--	30%	24%	25%	30%	88%*	71%*
Guinea	--	--	1%	--	2%	15%	10%*	10%*
Lesotho	73%	55%			73%	82%	67%*	66%
Liberia		23%	23%*	4%*	50%*	23%*	40%*	22%*
Rwanda	42% (81)	59%	52%	50%	50%*	87%	61%*	75%*
Swaziland	47%	57%	49%	61%	66%	73%	74%*	74%*
Togo	47% (81)	18% (81)	21%*	18%*	30%*	23%	32%*	32%*

Source: WHO Reports for the age group 12-23 months, unless otherwise indicated.
*ACSI-CCCD reports for children under one.

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IMMUNIZATIONS

The Bureau has reviewed the progress of immunization programs over several years among the eight CS Emphasis Countries and the additional nine countries participating in the ACSI-CCCD Project. Measles and DPT 3 coverage were picked as markers to estimate access to immunizations and achieved fully immunized levels, respectively. Tables 1 & 2 present a comparison of the data reported by WHO on these 17 countries.

From these tables certain conclusions may be drawn. The majority of these 17 countries have made progress in immunization coverage as shown by the increase in measles and DPT-3 coverage in six of the eight emphasis countries and seven of the nine ACSI-CCCD countries. Seven of the 17 countries have a measles coverage rate of 60% or more and one other has a rate of 54%. The DPT-3 coverage rates for these eight countries range from 47 to 75%.

Despite these signs of progress only Kenya, among the CS Emphasis Countries and Swaziland, among the ACSI-CCCD Countries, have a probable chance of reaching and maintaining 80% coverage by 1990. (See Table 3.) The excellent rates for Cote d'Ivoire were obtained by a survey conducted after the immunization campaign. Because of weak health infrastructure, it is unlikely that these rates can be sustained in the long term. By 1995 Lesotho, Malawi and Senegal enter the probable category.

The reasons for not reaching the Agency's goal are many. The most important is that strengthening the infrastructure of a national immunization program takes time. Time is required for host country structures to efficiently begin to use donor aid and to find ways to sustain activities without infusion of massive amounts of donor assistance. More detail about individual country programs follows.

In Kenya, DANIDA (Danish aid) is the major actor supporting the Ministry of Health (MOH) in the Expanded Program of Immunization (EPI) with additional support being provided by UNICEF and USAID. From Table 1, it is evident that the immunization rates for measles and DPT 3 have reached a plateau in recent years. USAID/Kenya has noted that there are certain districts in which high infant mortality rates (IMR) (on the order of 200/1000 live births) persist. USAID is proposing to assist the MOH to conduct special studies of these areas in order to target CS activities there. This initiative is expected to improve overall immunization coverage rates and it is probable that 80% coverage will be achieved by 1990.

In Senegal UNICEF is the major donor for the EPI of the MOH. Steady progress is being made in access rates (measles) but problems of community motivation continue impeding completion of immunization schedules. More attention is being devoted to a mass media campaign in an effort to decrease the drop-out rate and increase the fully immunized rate. It may be possible to achieve the target coverage goals by 1990 but hopefully not at the expense of all other preventive health care programs as happened in 1986-87 when a campaign strategy displaced routine health facility activities.

Table 3. Infant Mortality, Immunization and ORT Rates in Child Survival Emphasis and ACSI/CCCD Countries, Probability of Attaining Agency Targets

Country	Immunization Coverage Rates					Oral Rehydration Therapy					
	IMR**	DPT3	Measles	80% Coverage 1990*	1995*	ORS access	100% access 1990*	1995*	ORT use rate	45% use 1990*	1995*
Kenya	72	75	60	prob	Y	40	U	pos	23	pos	prob
Malawi	150	66	55	pos	prob	23	N	pos	10	U	pos
Mali	169	3	NA	N	U	20	N	U	2	N	U
Niger	135	5	19	N	U	4	N	U	1	N	U
Nigeria	105	21	32	U	pos	25	N	pos	18	U	pos
Senegal	131	53	70	pos	prob	26	N	pos	3	N	pos
Sudan	106	14	11	N	U	38	N	U	8	N	pos
Zaire	98	32	39	N	pos	48	N	U	18	U	pos
Burundi	114	42	65	U	pos	30	U	U	9	N	U
CAR	132	35	20	N	U	10	N	U	6	N	U
Cote d'Iv.	112	88	71	prob	Y	10	N	U	4	N	U
Guinea	147	--	15	N	U	10	N	U	1	N	U
Lesotho	100	73	82	pos	prob	100	Y	Y	6	N	U
Liberia	122	50	23	U	U	13	N	U	6	N	U
Rwanda	122	50	87	U	pos	21	N	U	8	N	U
Swaziland	118	66	73	prob	Y	--	N	U	--	N	U
Togo	93	30	23	N	U	56	pos	prob	9	N	U

*Bureau assessment of likelihood that sustained levels indicated will be achieved.(No, Unlikely, Possible, Probable, Yes).
**Infant mortality rate = # of infant deaths/1,000 live births from U.N. 1986, World Pop. Prospects.
Source of Data: WHO Programme Reports and ACSI-CCCD/USAID reports.
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Malawi, according to WHO data, continues to make gains in immunization coverage. However, ACSI-CCCD coverage surveys have revealed areas where coverage rates are much lower. Solutions to program constraints are being explored. The mission feels that while UNICEF should be the lead donor for the EPI, USAID will continue to support EPI, as appropriate. In a new project authorized in FY 1988, the Mission plans to assist EPI by continuing to support the health information system developed under the ACSI-CCCD project and by developing a new health education program to motivate communities to greater participation in preventive health care measures. It remains to be seen whether this approach will enable the achievement of the coverage targets by 1990.

Of the eight CS Emphasis Countries in sub-Saharan Africa, the remaining five (Mali, Niger, Nigeria, Sudan and Zaire) face tremendous logistical and cold chain problems because of geographic and climatic conditions. Mali and Niger are strengthening a primary health care infrastructure upon which to build an immunization program. The major donor for the EPI in both countries is UNICEF and progress continues to be slow because of limited absorptive capacity. It is unlikely that either country will achieve the coverage goals by 1995 because of the weak infrastructure.

Nigeria and Sudan, where UNICEF is the lead donor through which USAID is channeling funds to assist the EPI of the MOH, are making slow but steady and significant progress building toward a possible 1995 achievement of target coverage, although Sudan must resolve its civil war to do so. Zaire has plateaued in recent years but with implementation in 1987 of EPI services in 63% of her health zones, serving 73% of the population, coverage rates are expected to improve. In addition, USAID/Zaire has initiated systems analysis to identify CS service delivery problems and operations research to find and implement solutions to these problems. Thus, it may be possible to achieve the coverage targets by 1995.

Overall trends in vaccination coverage in ten ACSI-CCCD countries for the years 1985-87 have increased and are shown in Figure 1 (excludes Nigeria and Swaziland coverage data). Of the nine ACSI-CCCD countries (other than Malawi, Nigeria and Zaire), Cote d'Ivoire, Lesotho, Rwanda and Swaziland show high measles coverage rates of over 60% for children under one year of age, and a range of 55-74% for DPT-3. For example, in Swaziland, national coverage surveys in 1982, 1985 and 1987 have documented increasing rates of vaccination coverage as shown in Figure 2.

In summary both the CS Emphasis Countries and the ACSI-CCCD Countries have shown progress in immunization coverage. Based on their current status it appears that six of 17 will probably meet the 80% coverage target by 1995. An additional four could possibly meet that target by 1995 should all factors operate favorably. The likelihood of these countries achieving this objective can be increased through continued long-term assistance which is sensitive to the absorptive capacity and emphasizes continued monitoring of achievement and concerted donor coordination.

FIGURE 1.

Vaccination Coverage for DPT 1, DPT 3, and Measles As Estimated by Comparing Doses Administered to Children Under One with Population Under One, 10 CCCD Countries, 1982-1987

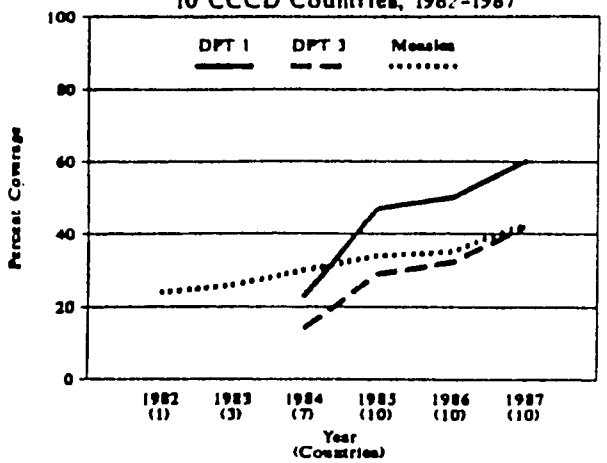
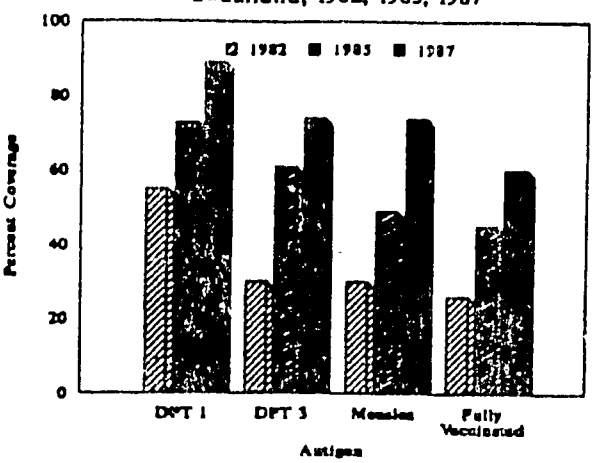


FIGURE 2.

Vaccination Coverage Determined by Cluster Sample Survey, Children 12-23 Months of Age, Swaziland, 1982, 1985, 1987



ORAL REHYDRATION THERAPY (ORT)

From Table 4, it appears that only Sudan has made significant progress at improving access to oral rehydration salts (ORS) although reports from only two years make any conclusions tenuous. Improvements in the use of ORS can be noted in four of the eight CS Emphasis Countries and in three of the remaining nine ACSI-CCCD Countries. Lesotho has the distinction of having already achieved 100% access to ORS and Kenya has the possibility of achieving 45% use of ORT by 1990. The ACSI-CCCD Project reports that in Malawi, Swaziland and Togo, 100% of health facilities are using ORS. In Burundi, Cote d'Ivoire, Liberia, Rwanda and Zaire the proportion of facilities using ORS ranges from 54% to 77%.

In Lesotho, ORT Units have been established in 16 of 18 hospitals (89%) as shown in Figure 3 and local production of ORS has doubled. Another type of accomplishment is shown for Malawi in Figure 4. Record reviews at Kamuzu Central Hospital in Lilongue, Malawi have documented that moderate and severe cases are being appropriately treated with ORT. In addition, the use of intravenous fluids and antibiotics has decreased substantially.

In Senegal a recent mid-term evaluation of the national Control of Diarrheal Disease Program conducted a survey of health workers and mothers. All cases of diarrhea obvserved during the survey were evaluated for the state of dehydration and 88% were correctly diagnosed. Most health workers agreed that ORS was effective in reducing dehydration and most knew that they should be counselling mothers how to use it and to feed their children during diarrheal episodes. Most facilities surveyed (63%) displayed posters promoting the use of ORT, 43% had treatment guides available and 60% had ORS in stock. Some facilities had even reduced the use of anti-diarrheals and intravenous fluids.

Table 4. Africa Child Survival Activities:
Comparison of ORS Access and ORT Use Rates

Source: WHO Program Reports for Control of Diarrheal Diseases

CS Emphasis Countries	1987 Report ORS Access	1987 Report ORT Use	1988 Report ORS Access	1988 Report ORT Use	ASCI-CCCD Countries	1987 Report ORS Access	1987 Report ORT Use	1988 Report ORS Access	1988 Report ORT Use
Kenya	40%	3%	40%	26%*	Burundi	N/A	6.6%	30%	9.3%
Malawi*	23%	2%	23%	28%*	CAR	56.%	5.6%	10%	5.6%
					Cote d'Ivoire	N/A	N/A	10%	4.3%
Mali	20%	2%	20%	2%	Guinea	6%	.6%	10%	1%
					Lesotho	100%	10%	100%	6%
Niger	4%	1%	4%	1%	Liberia	13%	1%	13%	6%
Nigeria	N/A	5%	25%	18%					
Senegal	26%	3%	***	***	Rwanda	21%	6%	21%	8%
					Swaziland	N/A	4%	N/A	N/A
Sudan	8%	5%	38%	8%	Togo	52%	5%	56%	9%
Zaire	45%	13%*	48%	18%					

* ACSI-CCCD or USAID Reports
** Also ACSI-CCCD Countries
*** 60% of health facilities surveyed had ORS;
5% of mothers used SSS.

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FIGURE 3.

Percent of Hospitals with ORT Units, Lesotho, 1986-1987

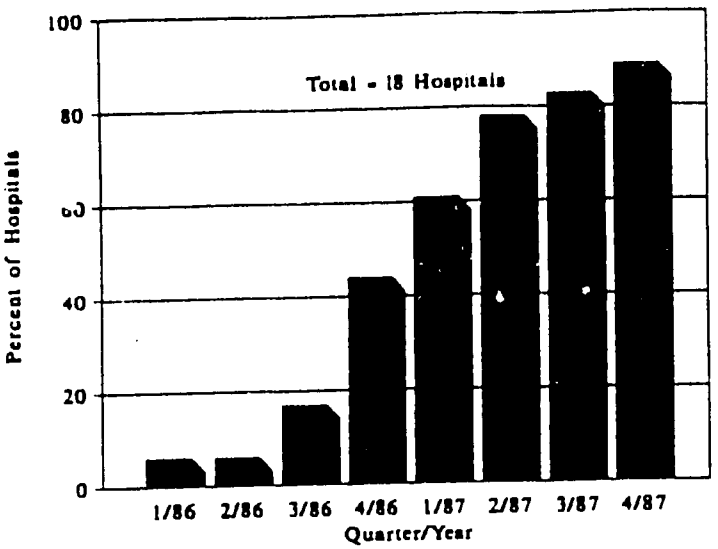
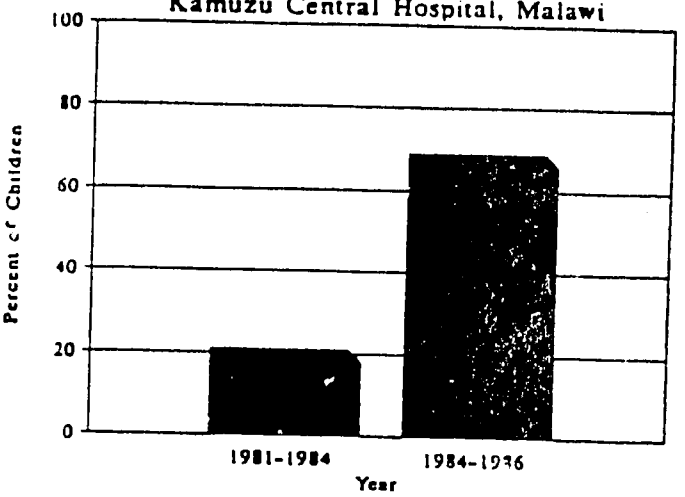


FIGURE 4.

Percent of Diarrhea Patients with Mild/Moderate Dehydration Treated Exclusively with ORS, Kamuzu Central Hospital, Malawi



Given these examples, it is conceivable that by 1995 four of eight CS Emphasis Countries could achieve 100% access to ORS plus one additional ACSI-CCCD Country. However, 100% access is unrealistic for countries like Mali, Niger, Sudan and Zaire where the transportation infrastructure is extremely limited. It is also possible that five of eight CS Emphasis Countries could achieve 45% ORT use by 1995. The likelihood of greater achievement in ORT use depends on continued training of health care workers and mothers in effective case management and prevention, supervision, monitoring of progress and knowledge, attitude and practice studies to determine the constraints to greater use of ORT. With more countries making greater political commitment to child survival in general and to Control of Diarrheal Disease programs in specific, countries will be more likely to achieve national goals. In addition, progress in ORT will be promoted by applied research to develop more effective home fluid strategies and more effective methods to increase utilization of rehydrating fluids.

Despite these gains significant problems remain. For example, a health facility needs assessment in Nigeria determined the knowledge and capability of mothers trained in the preparation of a salt/sugar solution (SSS) at home. As Figure 5 shows, only a small percentage of mothers who had heard of SSS were able to mix it correctly under observation.

Operations research in Zaire in the best health zones determined that over 90% of mothers knew of the SSS but only 28% knew the correct recipe. All of the mothers had been instructed by health workers to give ORS or SSS but only 26% of them were taught how to prepare the solution. The mid-term evaluation in Senegal revealed similar problems in the training of mothers by health workers.

FIGURE 5.

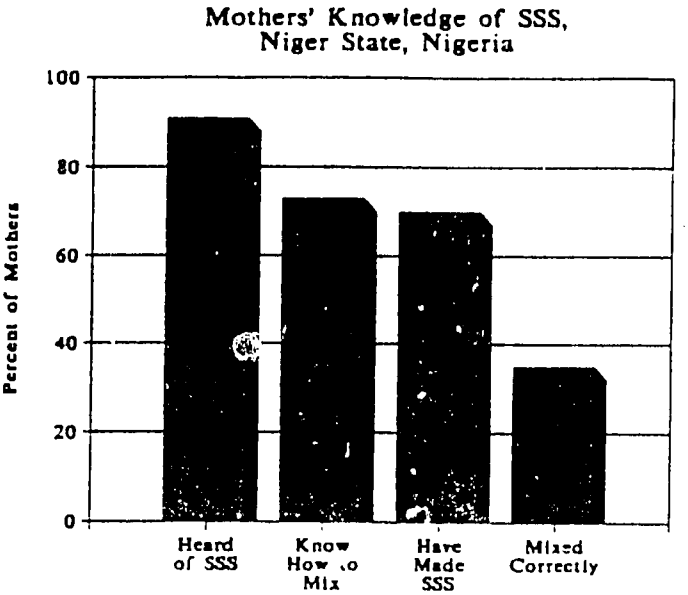


FIGURE 6.

Health Financing Studies

Country	Needs Assessment	Cost	HCF Strategies
Burundi	X *R*	X *R*	
C.A.R.	X *R*	O *R*	O *R*
Lesotho	O		
Liberia		X *R*	X
Malawi		X	
Nigeria	O	O	O
Rwanda	X *R*		X *R*
Swaziland		X	
Togo	X	X	
Zaire	X *R*		O *R*

X - Activities completed
O - Ongoing activities
R - Studies conducted in collaboration with REACH

To assist Missions to improve performance in ORT the Bureau for Africa plans to emphasize dietary management of diarrheal disease and promotion of appropriate hygiene, sanitation and weaning practices. In addition prolonged breastfeeding and appropriate feeding practices throughout infancy and particularly during and after diarrhea can decrease diarrheal episodes and promote child growth. Inputs to program evaluations and scopes of work are another means to assist Missions. It is, however, important to assure feedback from the evaluations to project implementation.

Missions demonstrated the importance placed on activities in ORT during FY 88 through buy-ins to PRITECH, a S&T/H project funded to provide technical assistance in diarrheal disease control. The Bureau funded support to the PRITECH Regional Office in the Sahel. However, continued funding for this regional office is problematic and will depend on Missions supporting that office through buy-ins. To facilitate this type of collaboration with S&T/H, the Bureau will actively participate in monitoring new project designs, developing scopes of work and annual workplans, as well as selecting technical assistance teams for evaluations.

The ACSI-CCCD project plans to continue to test effective strategies in training mothers in the correct preparation and use of SSS. Operations research activities will explore the availability and use of locally available fluids including traditional porridges for home treatment.

NUTRITION

The Bureau's CS Strategy emphasizes breastfeeding, growth monitoring, improved feeding practices, dietary management of diarrhea, targeted feeding programs and Vitamin A interventions where appropriate. These nutrititon goals have been inadequately addressed in both Emphasis and ACSI-CCCD Countries. Because malnourished children are twenty times more likely to die than normal children and malnutrition underlies more than half of the child deaths, the Africa Bureau needs an effective nutrition program. Without it, the CS initiatives will fall short of the targets.

Nutrition is an appropriate component of an integrated health or agriculture project. However, it is typically underemphasized because USAID officers and host country officials are uncertain about the impact of nutrition interventions or about how to implement them.

African countries represent 20 of the 39 countries classified by WHO (1987) as having significant or probably significant Vitamin A problems. Yet, in 1989 and 1990, there is only one country reporting bilateral health projects with Vitamin A activities. FVA-funded Vitamin A programs exist in Malawi, Mauritania and Niger plus S&T/N-funded activities exist in Niger and Sudan. USAID missions in Africa need to use the new Vitamin A project to begin assessments of Vitamin A problems in the countries thought to be most critically affected and to design integrated projects if a problem is found.

The Africa Bureau plans to be a better advocate in promoting the link between improved nutrition and child survival activities to encourage host country decision makers and USAID's to actively incorporate nutrition components into their country projects. In order to better focus on key concerns and track progress in nutrition. The Bureau has initiated a nutrition monitoring system which will become a part of the CS data system. The system will track A.I.D.'s nutrition activities that are scattered across the health, child survival, agriculture, rural development and PL 480 sectors on a country by country basis. Based on findings, a nutrition action plan for Africa will be developed.

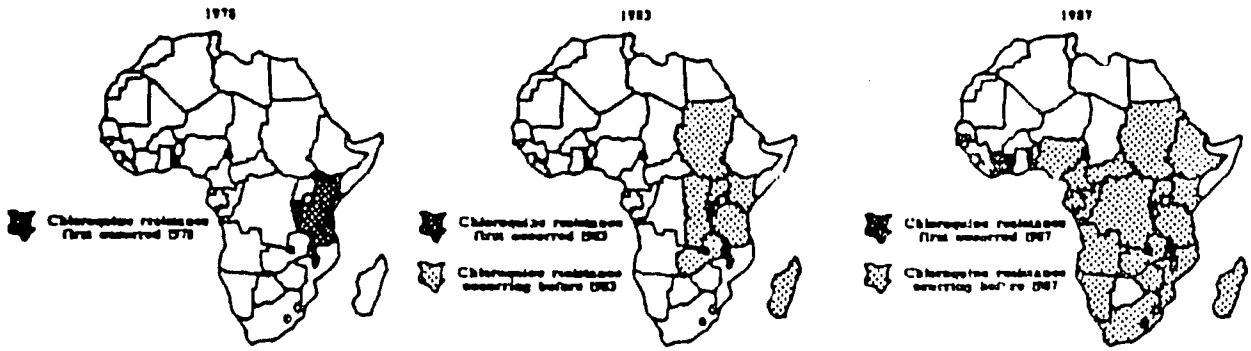
REDSO/WCA has funded the development of a nutrition program strategy for West Africa in order to assist missions in the region in planning and designing nutrition activities under health bilateral projects. The Bureau's Nutrition Advisor will assist in this project which will begin in October 1988.

To date, Africa's regional child survival project ACSI/CCCD addresses nutrition only as it relates to dietary management of diarrheal disease, including appropriate feeding during and after diarrhea and appropriate weaning practices. The follow-on project will contain strong nutrition components related to prevention and treatment of diarrhea.

MALARIA

Fourteen of the 17 CS Emphasis and ACSI-CCCD Countries have malaria activities focusing on chemoprophylaxis of high risk groups, presumptive treatment of fever, drug sensitivity surveillance systems and operations research. Because chloroquine resistant malaria continues to spread westward in Africa as shown in Figure 7,

FIGURE 7. Spread of Chloroquine Resistant *Plasmodium falciparum* Malaria in Africa, 1978, 1983, 1987



drug sensitivity studies have been carried out in ten of the 12 malarious ACSI-CCCD Countries. Training and continued surveillance (Figure 8) are fundamental in monitoring this problem.

In addition to training and surveillance, national malaria policies are reviewed annually in ACSI-CCCD Countries and adjusted in response to the surveillance data. Increased attention is also being directed at methods of personal protection, e.g. insecticide -impregnated bed nets and curtains.

FIGURE 8.

Antimalarial Drug Sensitivity Training and Surveillance, 1983-1987

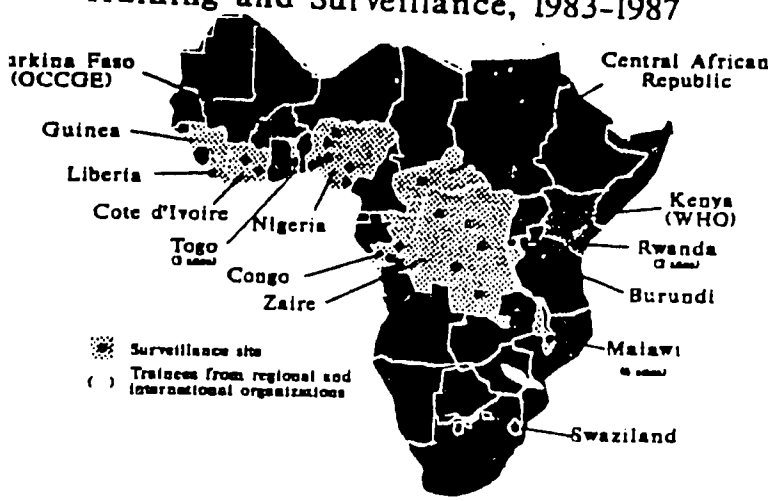
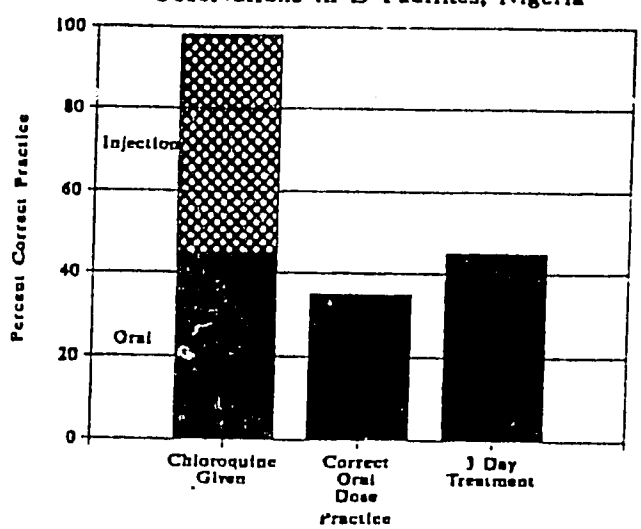


FIGURE 9.

Treatment of Fever by Health Workers: Observations in 19 Facilites, Nigeria



Supervisory checklists and health facility needs assessments document program performance and effectiveness as shown by a survey in Nigeria, Figure 9. Malaria treatment guidelines are being followed in 70-100% of health facilities in CAR, Liberia, Malawi Togo and Zaire. In Togo, a national sample survey of community practices documented antimalarial drug treatment in 65% of fever cases, Figure 10.

Operations research in Malawi has shown that infants born to mothers with placental parasetemia have an average of a 125 gram lower birth weight than infants born to nonparasetemic mothers, Figure 11. Also in Malawi, as well as in Zaire, ongoing studies are testing alternative regimens of malaria treatment/prophylaxis in pregnant women.

FIGURE 10.

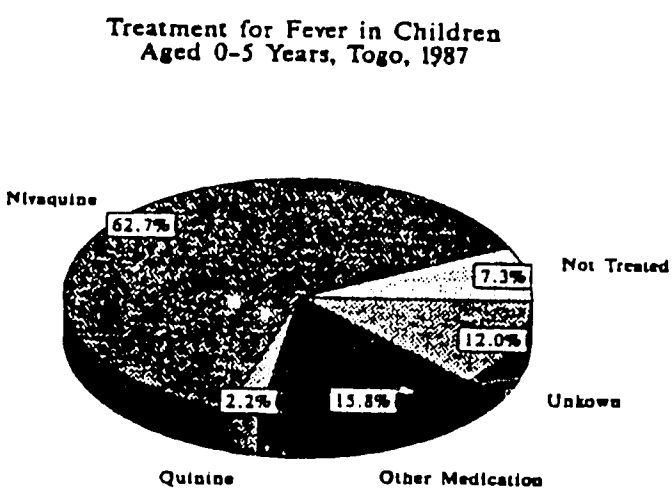
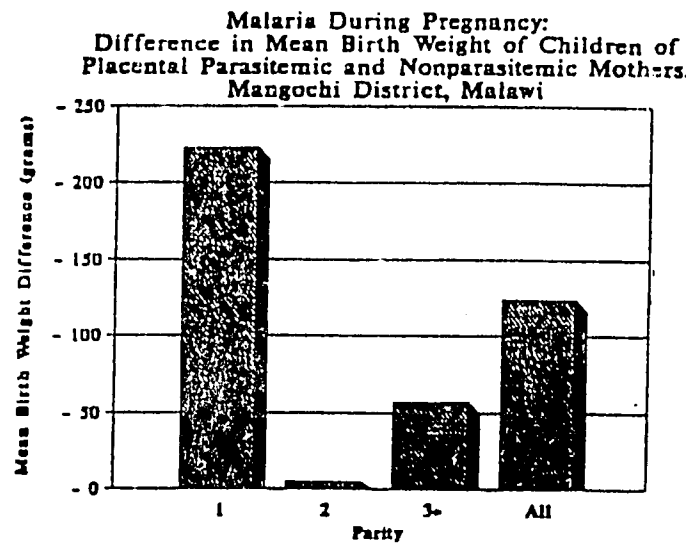


FIGURE 11.



HIGH RISK BIRTHS

Births to women with certain high risk characteristics result in a greater risk of death before one year of age. These "high risk births" occur to pregnant women who are over age 35 or under age 20, who are delivering their fourth child or whose last pregnancy terminated less than 24 months previously. Health education, service delivery or outreach programs that focus on these charachteristics may appropriately be categorized as CS programs since special attention to these births may have a measurable impact on the IMR. Recognizing this, Kenya, Malawi, Mali, Niger, Nigeria and Zaire have directed selected project efforts toward this intervention. In addition, USAID projects in Swaziland and Togo also have high risk birth components, though not as part of the ACSI-CCCD Project.

SUSTAINABILITY

Sustainability of CS programs continues to be a top priority in the Bureau. In most African countries economic conditions have deteriorated over the decade of the 1980's placing severe strain on government budgets and the health sector budget. Faced with this economic reality and the desire to address basic health needs, governments must consider ways not only to increase revenues, but also to reallocate existing revenues to health services that are the most effective in reducing premature mortality and unnecessary morbidity. Health financing is a key element in an integrated strategy to sustain the outcomes and benefits of such services. Completion of on-going health care financing (HCF) studies in 14 of the 17 countries is leading to important policy dialogue on the allocation of scarce health resources.

A study of costs in Kenyatta National Hospital in Nairobi, Kenya has led to policy reform and privatization of the hospital. These actions will provide the opportunity to the government to channel more funds into CS activities. A study of ten of the best health zones in Zaire found that they were able to finance from 67% to 90% of their operating expenses through user fees. Revolving drug funds in Liberia have generated the revenues necessary to maintain a steady supply of essential drugs to communities. CAR has begun efforts to engage policymakers in considering potential cost recovery activities.

The Bureau plans to continue to emphasize HCF by actively promoting field activities and close collaboration with the S&T/H project REACH (Resources for Child Health). Half of the ACSI-CCCD Countries have adopted plans for cost recovery and the Project plans to develop country-specific health financing objectives as part of an overall sustainability strategy. Standard cost information is necessary if realistic cost recovery targets are to be set. Thus, the project will conduct baseline cost analyses using standardized costing guidelines. Health financing data will be incorporated as a component of health information systems or management information systems to ensure timely and accurate data for use in project management and evaluation.

HCF is not the only factor contributing to the sustainability of CS programs. Often, technically sound, sustainable child survival strategies have not been integrated and institutionalized into national organizational structures and budgets. Adequate staff and resources to assure program sustainability are not available in all of the 17 emphasis and ACSI-CCCD countries.

CS priorities and objectives should be established in all countries and national level dialogue should be carried out at least annually emphasizing program implementation. This is being done with the finalization of CS Strategies in five of the eight emphasis countries: Kenya, Niger, Senegal, Sudan and Zaire. The status of ACSI-CCCD development and implementation plans for individual

interventions is depicted in Figure 12. In most ACSI-CCCD countries, national plans for EPI, CDD, malaria and health information systems have been adopted and the majority have adopted health education and training plans. In addition to the three CS Emphasis Countries shown in Figure 12, Kenya, Niger, Senegal and Sudan have adopted national plans for EPI and CDD. Mali has a national CDD plan; Niger has a national malaria plan. Kenya and Zaire have strategies for child spacing; Niger, Senegal and Sudan are drafting them.

FIGURE 12.

	Strategies Adopted				Plans Adopted			Selected Activities	
	EPI	CDD	Malaria	HIS	Health Education	Training	Cost Recovery	ORT Demo Unit	Operational Research
Burundi	+	+	+	+		+	+	+	
CAR	+	+	+	+	+	+	+	+	
Cote d'Ivoire	+	+	+		+	+		+	+
Guinea	+	+	+					+	
Lesotho	+	+	NA	+	+	+		+	
Liberia	+	+	+	+		+	+	+	
Malawi	+	+	+	+	+	+		+	+
Nigeria	+	+			+	+	+		+
Rwanda	+	+	+	+	+	+		+	
Swaziland	+	+	+						
Togo	+		+	+	+		+		+
Zaire	+	+	+	+	+		+	+	+

FIGURE 13.

Country	Computers, Software	Training	HIS Bulletin
Burundi	X	X	
C.A.R.	X	X	
Cote d'Ivoire	X		
Guinea	X		
Lesotho	X	X	X
Liberia	X	X	X
Malawi	X	X	X
Niger	X	X	
Nigeria	X	X	X
Rwanda	X	X	X
Senegal	X		
Swaziland	X		
Togo	X	X	
Zaire	X	X	X

The development of national systems of data collection, collation and analysis will enable decision makers to quantify health problems and health risks, establish priorities, focus interventions on target groups and monitor the effectiveness of interventions. Figure 13 reveals that assistance in developing health information systems has been provided in 14 of the 17 countries.

The development of simple but dependable national health information systems (HIS), needs increased attention even for those countries performing poorly. A reliable HIS provides an accurate description of problems and can encourage even wary donors to consider investing in what they may consider marginal activities. In some countries like Malawi, Rwanda and Togo with relatively successful HIS's, national directors have come to appreciate the value of simple and responsive systems in keeping them adequately informed on how best to allocate limited resources. In other countries, national health leaders have yet to develop this appreciation for good data for internal management and for effective negotiating for needed assistance from donors. USAID's need to work more intensely with national leaders to familarize them with the usefulness of such data.

DONOR COORDINATION

A.I.D. and other donors have worked very closely during FY 88 to maximize the resources available to them. Several special meetings have been held between A.I.D. and UNICEF to facilitate the working relationship between the two agencies as they collaborate to expand the availability of immunizations and oral rehydration therapy. A joint A.I.D.-UNICEF cable was sent out recently recommending ways to coordinate implementation at the national level and asking for mission expressions of experience and recommendations. Our best estimate is that we are working with UNICEF in not less than 14 African countries. There are direct grants to UNICEF for child survival work in two of the largest countries -- Nigeria and Sudan. USAID's are reporting improved donor coordination in other countries through the operation of Interagency Coordinating Committees (ICC). These national committees involve USAID as well as bilateral and multilateral donors.

Through the ASCI-CCCD project we are funding several major support activities through the Regional Office the World Health Organization for Africa (AFRO). For the first time there was a sponsored Year of Immunization (1987) in Africa. A newsletter reports on the results of the immunization program in a way similar to those reported for other regions of the world. The regional office with A.I.D. support also focuses on training, diarrheal disease control and health information systems throughout the continent.

Some of the intercountry coordination that had been attempted under the Cooperation for Development of Africa (C.D.A.) coalition has been largely superceded by the series of "Bellagio Meetings".

INFANT MORTALITY RATES

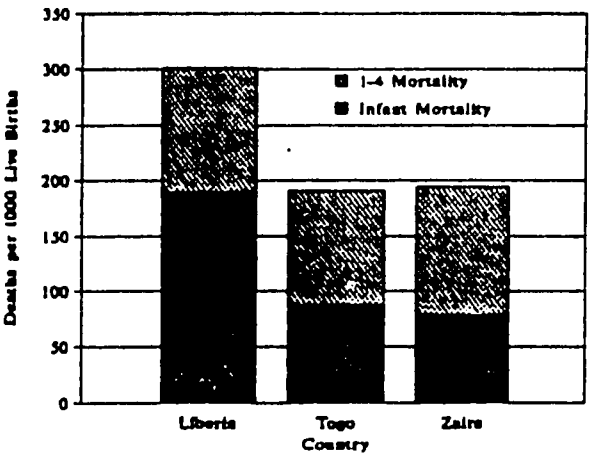
Having discussed the Bureau's CS activities, it is appropriate to address the Agency's ultimate goal - achieving Infant Mortality Rates (IMR) of 75/1,000 live births by 1990 through the effective implementation of CS interventions. The IMR is used as a proxy indicator of the overall status of health care and over the years the IMR's have tended to decrease worldwide. But, whether we will be able to effectively change the slope of that downward trend by the Agency's CS porgram is a point that remains to be proven. Economic development and other donor imputs must also be factored in.

Table 3 reveals that Kenya has an IMR less than 75/1,000 live births according the the UN estimates in 1986. If the estimated decreases in IMR's remain steady, it is possible that the estimates for Togo and Zaire for 1990 could approach the Agency's target. It is also conceivable that the estimates of IMR for 1995 for Burundi, Cote d'Ivoire, Lesotho, Nigeria, Senegal, Sudan and Swaziland could approach the target.

Aside from such estimates, the actual measurement of infant and child mortality in countries where selected preventive and

curative child survival services have been provided remains a challenge. In Liberia, Togo and Zaire among the ACSI-CCCD countries in 1985, baseline mortality was determined using cluster sample methodology and retrospective maternity histories. The results are shown in Figure 14. Follow-up surveys in Liberia and Zaire are scheduled in 1988.

FIGURE 14. Infant, Child and Under Five Mortality: Deaths per 1000 Live Births, Three Countries



The Demographic and Health Survey (DHS) conducted in Senegal in 1986, showed a 28% decrease in the IMR during the past decade, from 120 in 1971-76 to 86 in 1981-85. DHS's will provide data on IMR's for Kenya, Mali, Niger, Nigeria and Sudan among the CS Emphasis Countries and for Burundi, Liberia and Togo among the ACSI-CCCD Countries. It is through the results of these indepth surveys that we will obtain more detailed information on the progress being made in the Tier II indicators listed in Table 5.

PLANS FOR NEW PROJECTS

CS Emphasis and ACSI-CCCD Countries:

During FY 1988 three new projects with sizable CS components are planned in Malawi, Mali and Niger as shown in Table 6. Niger, Rwanda and Swaziland intend to target child spacing services on high risk births in new projects. The ACSI-CCCD Project will be amended to enable the extension of country-specific programs through 1991.

Following the lead of Kenya in 1988, Senegal and Sudan plan to design in FY 1989 specific immunization and ORT components to complement child spacing services in the private sector. In FY 1990 Liberia, Malawi, Senegal and Sudan also plan follow-on projects emphasizing CS interventions. The Senegal project and the Economic Stabilization and Sectoral Adjustment Project in Kenya both plan significant policy dialogue and policy reform components which will have direct implications for child survival. The Bureau plans an FY 1990 follow-on design of the ACSI-CCCD Project.

TABLE 5. CHILD SURVIVAL ACTION PROGRAM

CORE INDICATORS FOR TIER II MONITORING AND EVALUATION

1) Percent of infants/children (12-23 months) who have a weight for age greater than that which is two standard deviations below the mean.

2) Percent of infants/children (0-59 months) with diarrhea in the last two weeks who were treated with ORT.

3) Percent of children (12-23 months) who were vaccinated by age 12 months with:
   a) BCG
   b) DPT 3
   c) polio 3
   d) measles vaccine

4) Percent of women 15-49 years delivered in the last 12 months who have received two doses of tetanus toxoid.

5) Percent of infants (0-11 months) who are being breastfed and are receiving other foods at an appropriate age.

6) Percent of women (15-49 years) in union who are currently using modern contraception.

Table 6. CHILD SURVIVAL ATTRIBUTIONS OF NEW PROJECTS

Country	Project Number and Name	AKDN	LOP Fund (000)	ORT %	IMM %	NUT	HRB %	OTH/CS	TOTAL CS	TYPE OF NEW CS and % Health	Pop	Oth
FY 88												
Malawi	612-0231 PRM Hlth Init/CS	DFA	12000	5%	5%	5%	5%	20%	40%	45%	15%	
Mali	688-0252 Dioro/CS Africare	DFA	890	40%	0	45%	5%	10%	100%	0		
Mozambique	656-0207 CS Pilot	DFA	500	20%	20%	40%	0	0	80%	20%		
Niger	683-0258 Family Hlth & Dev.	DFA	11000	0	0	0	30%	5%	35%	4%	61%	
	683-0259	DFA	770	50%		50%			100%			
	FP II	DFA	9000		0	0	0	20%	20%	1%	79%	
Swaziland	645-0228	DFA	2400	0	0	0	20%	0	20%	2%	78%	
FY 89												
Sudan	650-0085 Pop Pol Prog Sup (CS Imp plan proposes 10000 LOP with 4000 for CS)	DFA	10000	15%	5%	0	20%	0	40%		60%	
FY 90												
Ghana	641-0118 Family Hlth & CS	DFA	10000	20%	0	0	60%	20%	100%	0		
Liberia	669-0219 PHC-II	DFA	6000	10%	20%	10%	30%	30%	100%	0		
Malawi	612-0230 Sve;Hlth/AG/RE	DFA	10000	5%	5%	0	0	15%	25%	64%		11%
Mozambique	656-0209 Zambeya CS	DFA	4000	20%	20%	40%	0	0	80%	20%		
Senegal	685-0286	DFA	20000	15%	20%	15%	15%	25%	90%	10%		
Sudan	650-0084 CS Project	DFA	10000	30%	30%	10%	10%	20%	90%	10%		
Uganda	617-0114 Fam. Hlth Proj.	DFA	4000	13.7%	0	0	25%	0	38.7%	21.3%	40%	

(53110)

Other Countries:

In FY 1988 USAID/Mozambique intends to begin testing mechanisms of working with the government and PVO's to provide effective services to displaced children. These activities will be preparatory to a larger CS effort planned for 1990. In addition Ghana and Uganda are planning projects which will combine a focus on immunizations and high risk births with child spacing services.

PERSONNEL

The plans for new projects as noted in the previous section are ambitious even for present staffing levels. However, the potential shortfall in the Bureau's OE budget may impose the loss of health officers as well as supporting staff, e.g. project design and program officers. Such a loss would curtail new CS starts in Chad, Malawi, Mali, Mozambique, Senegal and Togo. The implementation of a key health/CS sector policy reform program in Niger will be seriously impaired. We would find it difficult to achieve the 10% Congressional target levels in health and CS.

Presently there are 36 BS-50, HPN officers in the Bureau, of which 24 are in Missions, 5 in REDSOs and 7 in AFR/TR. There are 16 FSNs, 21 PSCs and 20 PASA (CDC) employees in the field, about 15 PASAs for the ACSI-CCCD program in Atlanta, and 8 PASA and PSC employees in REDSOs and AFR/TR. These 122 people form the technical personnel core for the Bureau's CS implementation. In late FY 1988 technical staff will be augmented by two Technical Advisors for CS (TACS, Sudan and Uganda) and by three CS Fellows (Nigeria and two in Kenya). Three TACS are planned for FY 1989 (Mali, Niger and Senegal) plus an additional five CS Fellows (Malawi, Mozambique, Nigeria, Sudan and Uganda), bringing the regional total to 135 HPN personnel.

BUDGET ANALYSIS

Table 7 summarizes the projected funding levels for the Development Fund for Africa (DFA) in the health and child survival sectors of the Bureau as they have evolved during the FY 1990 ABS process. Greater detail may be found in the appended Annexes A - C.

TABLE 7. DEVELOPMENT FUND FOR AFRICA, PROJECTED FUNDING LEVELS FOR HEALTH AND CHILD SURVIVAL: FY 1990 ABS RESULTS

Category	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990
Health	$18,154	$12,880	$12,291	$12,883	$14,488
AIDS			911	2,000	2,132
Child Survival	27,453	31,883	32,436	33,045	39,439
Totals Hlth/ CS	$45,607	$44,763	$45,637	$47,928	$56,059

The overall levels for health and CS activities within the DFA are projected to increase over the next two years as are project activities or Mission buyins for AIDS. The increase in CS obligations from FY 1986 to FY 1987 was made at the expense of traditional health activities. However, by FY 1990 health activities will increase.

The distribution of the projected obligations for the CS interventions, Table 8, reveals in the funding levels the same lack of emphasis on nutrition that was described previously. We will actively solicit Mission interest in nutrition interventions for FY 1989 - 90. Since FY 1986, there has been a steady increase in the proportion of funding focusing on high risk births. In the Other CS category, the majority of the programs emphasize malaria interventions or water and sanitation.

TABLE 8. DISTRIBUTION OF OBLIGATIONS AMONG THE CHILD SURVIVAL INTERVENTIONS

YEAR	PER CENT CHILD SURVIVAL INTERVENTIONS				
	ORT	EPI	NUTR	HRB	OCS
1986	28	40	6	4	22
1987	23	26	9	11	31
1988	29	28	9	15	19
1989	30	34	4	19	13
1990	25	25	6	23	21

HRB = High Risk Births; OCS = Other CS Activities

ANNEX A

: 08/01/88 AFR/TR PLANNING LEVELS: FY88 ATTRIBUTIONS FOR HEALTH CHILD SURVIVAL POPULATION AND AIDS PAGE: 1

COUNTRY	PROJECT NUMBER	TITLE	FY	PLANNED OBL	HEALTH	CS-HRB	HRB/CS	HRB/PN	PN-HRB	AIDS	PROJECT TOTALS	COMMENT
REDSO/WCA	698-0421.24	ACSI-CCCD	88	40.0	.0	40.0	.0	.0	.0	.0	40.0	PSC/CS
AFR REGIONAL	625-0966	ONCHO CONTROL	88	2500.0	2500.0	.0	.0	.0	.0	.0	2500.0	
AFR REGIONAL	625-0978	CERPOD-FromPopPoli	88	1000.0	.0	.0	.0	.0	1000.0	.0	1000.0	
AFR REGIONAL	698-0421	ACSI-CCCD	88	10120.0	1500.0	8620.0	.0	.0	.0	.0	10120.0	
AFR REGIONAL	698-0462	FHI-II	88	2300.0	.0	.0	.0	.0	2300.0	.0	2300.0	
AFR REGIONAL	698-0471	MEDEX	88	1500.0	1350.0	150.0	.0	.0	.0	.0	1500.0	
Botswana	633-0249	PopSector	88	1500.0	.0	.0	.0	.0	1500.0	.0	1500.0	
Burkina	686-0251	Stghn Hlth Plng	88	200.0	200.0	.0	.0	.0	.0	.0	200.0	
Burkina	698-0421.86	ACSI-CCCD	88	110.0	.0	110.0	.0	.0	.0	.0	110.0	
Burkina	698-0462.86	FHI-II	88	25.0	.0	.0	.0	.0	25.0	.0	25.0	
Burkina	698-0474.86	HAPA	88	68.0	.0	.0	.0	.0	.0	68.0	68.0	
Burundi	695-0123	Population	88	1500.0	.0	.0	.0	.0	1500.0	.0	1500.0	
Burundi	698-0421.95	ACSI-CCCD	88	300.0	60.0	240.0	.0	.0	.0	.0	300.0	
Cameroon	631-0056	MCH/CS	88	1500.0	225.0	1125.0	150.0	.0	.0	.0	1500.0	
Cameroon	631-0067	Hlth Constraints	88	130.0	130.0	.0	.0	.0	.0	.0	130.0	
Cameroon	698-0421.31	ACSI-CCCD	88	140.0	.0	140.0	.0	.0	.0	.0	140.0	Vaccine
Cameroon	698-0462.31	FHI-II	88	400.0	.0	.0	.0	40.0	360.0	.0	400.0	
CAR	698-0421.76	ACSI-CCCD	88	350.0	35.0	315.0	.0	.0	.0	.0	350.0	
Chad	698-0462.77	FHI-II	88	354.0	.0	.0	.0	.0	354.0	.0	354.0	
Gambia	635-0221	Sm Proj Asst	88	40.0	10.0	.0	.0	.0	.0	.0	10.0	30 Oth Act
Gambia	698-0421.35	ACSI-CCCD	88	100.0	.0	100.0	.0	.0	.0	.0	100.0	
Ivory Coast	698-0462.81	FHI-II	88	240.0	.0	.0	.0	.0	240.0	.0	240.0	
Kenya	615-0223	Pvt Sec FP	88	1900.0	.0	.0	.0	.0	1900.0	.0	1900.0	
Kenya	615-0232	FP Sup Svcs	88	5900.0	.0	400.0	.0	2090.0	3410.0	.0	5900.0	
Kenya	615-0241	CORAT CS	88	300.0	.0	210.0	90.0	.0	.0	.0	300.0	
Kenya	698-0462.15	FHI-II	88	315.0	.0	.0	.0	.0	315.0	.0	315.0	
Lesotho	698-0421.32	ACSI-CCCD	88	325.0	16.2	308.8	.0	.0	.0	.0	325.0	
Liberia	669-0211	PVO-NGO Sup	88	3381.0	600.0	.0	.0	.0	.0	.0	600.0	2781=Ed,et
Liberia	698-0421.69	ACSI-CCCD	88	850.0	127.5	722.5	.0	.0	.0	.0	850.0	
Malawi	612-0231	Prom Hlth Init/ CS	88	3750.0	1500.0	1312.5	187.5	0	562.5	187.5	3750.0	
Mali	688-0252	Dioro CS/Africare	88	890.0	.0	845.5	44.5	.0	.0	.0	890.0	
Mali	698-0421.88	ACSI-CCCD	88	375.0	.0	375.0	.0	.0	.0	.0	375.0	
Mauritania	698-0462.25	FHI-II	88	350.0	.0	.0	.0	.0	350.0	.0	350.0	
Mauritania	698-0463.25	HRDA-C S TNG	88	420.0	.0	420.0	.0	.0	.0	.0	420.0	
Mozambique	656-0207	CS PILOT	88	250.0	50.0	200.0	.0	.0	.0	.0	250.0	
Niger	683-0254	Hlth Sect Sup	88	3510.0	1404.0	1755.0	351.0	.0	.0	.0	3510.0	
Niger	683-0258	Fam Hlth & Dem	88	2400.0	.0	120.0	.0	720.0	1467.0	93.0	2400.0	
Niger	683-0PVO	Africare/CS	88	770.0	.0	770.0	.0	.0	.0	.0	770.0	
Niger	698-0421.83	ACSI-CCCD	88	300.0	.0	300.0	.0	.0	.0	.0	300.0	
Niger	698-0462.83	FHI-II	88	405.0	.0	.0	.0	121.5	283.5	.0	405.0	
Nigeria	620-0001	Fam Hlth Svcs	88	10000.0	.0	.0	.0	.0	10000.0	.0	10000.0	
Nigeria	698-0421.20	ACSI-CCCD	88	1430.0	100.1	1315.6	14.3	.0	.0	.0	1430.0	
Rwanda	696-0128	FP II	88	3250.0	.0	.0	.0	617.5	2600.0	32.5	3250.0	
Sudan	650-0030	Rural Hlth Support	88	700.0	105.0	490.0	105.0	.0	.0	.0	700.0	
Sudan	650-0513	UNICEF Grant	88	3000.0	.0	3000.0	.0	.0	.0	.0	3000.0	
Sudan	698-0421.50	ACSI-CCCD	88	175.0	.0	175.0	.0	.0	.0	.0	175.0	
Sudan	698-0421.50	ACSI-CCCD	88	150.0	.0	150.0	.0	.0	.0	.0	150.0	
Sudan	698-0421.50	ACSI-CCCD	88	175.0	.0	175.0	.0	.0	.0	.0	175.0	
Sudan	698-0421.50	ACSI-CCCD	88	500.0	.0	450.0	50.0	.0	.0	.0	500.0	
Sudan	698-0462.50	FHI-II	88	100.0	.0	.0	.0	.0	100.0	.0	100.0	
Swaziland	645-0220	Prim Hlth Care	88	882.0	396.9	396.9	88.2	.0	.0	.0	882.0	

COUNTRY	PROJECT NUMBER	TITLE	FY	PLANNED OBL	HEALTH	CS-HRB	HRB/CS	HRB/PN	PN-HRB	AIDS	PROJECT TOTALS	COMMENT
Swaziland	645-0228	Fam Hlth Svcs	88	1400.0	.0	.0	.0	280.0	1090.0	30.0	1400.0	
Tanzania	698-0462.21	FHI-II	88	400.0	.0	.0	.0	.0	400.0	.0	400.0	
Togo	693-0228	Hlth Sect Sup	88	1535.0	.0	1535.0	.0	.0	.0	.0	1535.0	
Togo	698-0421.93	ACSI-CCCD	88	200.0	.0	200.0	.0	.0	.0	.0	200.0	
Zaire	660-0094	FP Svcs	88	1000.0	.0	.0	.0	.0	1000.0	355.0	1000.0	AIDS$ Requ
Zaire	660-0107	Basic Rural Hlt	88	3000.0	1980.3	960.0	60.0	.0	.0	145.3	3000.0	AIDS$ Requ
Malawi	698-0474	HAPA	88	200.0	.0	.0	.0	.0	.0	200.0	200.0	
Senegal	698-0474	HAPA	88	118.0	.0	.0	.0	.0	.0	118.0	118.0	
Tanzania	698-0474	HAPA	88	114.0	.0	.0	.0	.0	.0	114.0	114.0	
Zambia	698-0474	HAPA	88	68.0	.0	.0	.0	.0	.0	68.0	68.0	RSSA HAPA
		TOTALS--->		79205.0	12290.0	27426.8	1140.5	3869.0	30757.0	1411.0	76394.0	

HEALTH: $12,290 + 1,411 ÷ 500 = $13,201

CHILD SURVIVAL: $27,427 + 1,140 + 3,869 =$32,436

POPULATION: $30,757 + 1,140 + 3,869 =$35,766

COUNTRY	PROJECT NUMBER	TITLE	FY	PLANNED OBL	HEALTH	CS-HRB	HRB/CS	HRB/PN	PN-HRB	AIDS	PROJECT TOTALS	COMMENT
REDSO/WCA	624-0510	PD&S	89	400.0	.0	300.0	.0	.0	.0	100.0	400.0	
REDSO/WCA	698-0421.24	ACSI-CCCD	89	40.0	.0	40.0	.0	.0	.0	.0	40.0	
AFR REGIONAL	625-0966	Oncho	89	2500.0	2500.0	.0	.0	.0	.0	.0	2500.0	
AFR REGIONAL	625-0978	CERPOD-PromPopPoli	89	1000.0	.0	.0	.0	.0	1000.0	.0	1000.0	
AFR REGIONAL	698-0421	ACSI-CCCD	89	10000.0	1500.0	8500.0	.0	.0	.0	.0	10000.0	
AFR REGIONAL	698-0462	FHI-II	89	3500.0	.0	.0	.0	.0	3500.0	.0	3500.0	
AFR REGIONAL	698-0471	MEDEX	89	1500.0	1350.0	150.0	.0	.0	.0	.0	1500.0	
Botswana	633-0249	PopSector	89	1200.0	.0	.0	.0	.0	1200.0	.0	1200.0	
Burkina	698-0421.86	ACSI-CCCD	89	100.0	.0	140.0	.0	.0	.0	.0	100.0	40 reqtd
Burkina	698-0474.86	HAPA	89	50.0	.0	.0	.0	.0	.0	50.0	50.0	
Burundi	695-0123	Population	89	900.0	.0	.0	.0	.0	1250.0	.0	900.0	350 Reqt/B
Burundi	698-0421.95	ACSI-CCCD	89	325.0	65.0	260.0	.0	.0	.0	.0	325.0	
Cameroon	631-0510	PD&S	89	75.0	.0	.0	.0	.0	75.0	.0	75.0	
Cameroon	698-0421.31	ACSI-CCCD	89	100.0	.0	100.0	.0	.0	.0	.0	100.0	
Cape Verde	698-0462.55	FHI-II	89	100.0	.0	.0	.0	.0	100.0	.0	100.0	
CAR	698-0421.76	ACSI-CCCD	89	400.0	40.0	360.0	.0	.0	.0	.0	400.0	
Chad	698-0421.77	ACSI-CCCD	89	125.0	.0	125.0	.0	.0	.0	.0	125.0	
Gambia	698-0421.35	ACSI-CCCD	89	100.0	.0	125.0	.0	.0	.0	.0	100.0	25 reqtd
Ghana	641-0510	PD&S	89	65.0	.0	26.0	39.0	.0	.0	.0	65.0	
Ghana	698-0474.41	HAPA	89	500.0	.0	.0	.0	.0	.0	500.0	500.0	AIDSTECH B
Guinea	698-0421.75	ACSI-CCCD	89	615.0	31.0	584.0	.0	.0	.0	.0	615.0	
Ivory Coast	698-0462.81	FHI-II	89	240.0	.0	.0	.0	.0	240.0	.0	240.0	
Kenya	615-0232	FP Sup Svcs	89	7600.0	.0	.0	.0	2888.0	4712.0	.0	7600.0	
Kenya	615-0236	PVO Co-Financg	89	1975.0	300.0	.0	.0	.0	300.0	.0	600.0	1375=PVO
Kenya	615-0243	EconStb&SectAdj	89	7000.0	2000.0	.0	.0	.0	.0	.0	2000.0	*5000=Econ
Kenya	615-0510	PD&S	89	110.0	.0	.0	.0	.0	110.0	.0	110.0	
Kenya	698-0462.15	FHI-II	89	400.0	.0	.0	.0	.0	400.0	.0	400.0	
Liberia	669-0211	PVO-NGO Sup	89	2500.0	500.0	.0	.0	.0	.0	.0	500.0	2500=PVO's
Liberia	669-0510	PD&S	89	150.0	150.0	.0	.0	.0	.0	.0	150.0	
Madagascar	687-0510	PD&S	89	50.0	.0	50.0	.0	.0	.0	.0	50.0	
Madagascar	698-0462.87	FHI-II	89	50.0	.0	.0	.0	.0	50.0	.0	50.0	
Madagascar	698-0462.87	FHI-II	89	400.0	.0	.0	.0	.0	400.0	.0	400.0	FPMGTTNG
Madagascar	698-0462.87	FHI-II	89	270.0	.0	.0	.0	.0	270.0	.0	270.0	BUCEN
Mali	688-0227	Intg Fam Hlth Svcs	89	900.0	.0	360.0	315.0	.0	225.0	.0	900.0	
Mali	698-0421.88	ACSI-CCCD	89	200.0	.0	400.0	100.0	.0	.0	.0	200.0	Reqtd 300
Mali	698-0421.88	ACSI-CCCD	89	300.0	.0	350.0	.0	.0	.0	.0	300.0	50 reqtd
Mali	698-0462.88	FHI-II	89	700.0	.0	35.0	.0	245.0	420.0	.0	700.0	
Mauritania	698-0421.25	ACSI-CCCD	89	100.0	.0	100.0	.0	.0	.0	.0	100.0	From PD&S
Mozambique	656-0207	CS Pilot	89	250.0	.0	500.0	.0	.0	.0	.0	250.0	[illegible] reqst
Niger	683-0254	Hlth Sect Sup	89	1500.0	600.0	750.0	150.0	.0	.0	.0	1500.0	
Niger	683-0258	Fam Hlth & Dem	89	3100.0	.0	155.0	.0	930.0	1880.0	135.0	3100.0	
Niger	698-0421.83	ACSI-CCCD	89	310.0	.0	435.0	.0	.0	.0	.0	310.0	125 reqtd
Nigeria	620-0001	Fam Hlth Svcs	89	10000.0	.0	.0	.0	.0	10000.0	.0	10000.0	
Nigeria	698-0421.20	ACSI-CCCD	89	1500.0	170.0	2231.0	24.0	.0	.0	.0	1500.0	925 reqt
Rwanda	696-0126	FP II	89	2000.0	.0	.0	.0	380.0	1600.0	20.0	2000.0	
Rwanda	696-5010	PD&S	89	60.0	60.0	.0	.0	.0	.0	.0	60.0	
Senegal	685-0248	Fam Hlth & Pop	89	425.0	.0	382.5	.0	42.5	.0	.0	425.0	
Senegal	685-0510	PD&S	89	140.0	.0	140.0	.0	.0	.0	.0	140.0	CS Design
Senegal	698-0421.85	ACSI-CCCD	89	75.0	.0	75.0	.0	.0	.0	.0	75.0	PRITECH
Senegal	698-0421.85	ACSI-CCCD	89	200.0	80.0	120.0	.0	.0	.0	.0	200.0	PRICOR
Senegal	698-0421.85	ACSI-CCCD	89	500.0	100.0	300.0	100.0	.0	.0	.0	500.0	TACS

COUNTRY	PROJECT NUMBER	TITLE	FY	PLANNED OBL	HEALTH	CS-HRB	HRB/CS	HRB/PH	PH-HRB	AIDS	PROJECT TOTALS	COMMENT
Senegal	938-0518	WVRO/CS	89	300.0	27.0	228.0	45.0	.0	.0	.0	300.0	
Sudan	650-0085	PopPolProgSup	89	3425.0	.0	675.0	675.0	.0	2075.0	.0	3425.0	
Sudan	650-0510	PD&S	89	85.0	.0	45.0	.0	.0	40.0	.0	85.0	
Sudan	650-0513	UNICEF Grant	89	6525.0	.0	6525.0	.0	.0	.0	.0	6525.0	
Sudan	698-0421.50	ACSI-CCCD	89	300.0	.0	270.0	30.0	.0	.0	.0	300.0	CS Fellow
Sudan	698-0421.50	ACSI-CCCD	89	700.0	500.0	200.0	.0	.0	.0	.0	700.0	BI's
Swaziland	645-0220	Prim Hlth Care	89	800.0	360.0	360.0	80.0	.0	.0	.0	800.0	
Tanzania	621-0510	PD&S	89	20.0	.0	.0	.0	.0	.0	20.0	20.0	
Tanzania	698-0462.21	FHI-II	89	800.0	.0	.0	.0	.0	800.0	.0	800.0	
Tanzania	698-0474.21	HAPA	89	500.0	.0	.0	.0	.0	.0	500.0	500.0	
Togo	693-0228	Hlth Sect Sup	89	650.0	.0	650.0	.0	.0	.0	.0	650.0	
Togo	698-0421.93	ACSI-CCCD	89	400.0	.0	400.0	.0	.0	.0	.0	400.0	
Zaire	660-0094	FP Svcs	89	2000.0	.0	.0	.0	.0	2000.0	589.0	2000.0	AIDS$ Requ
Zaire	660-0101	Sch Pub Hlth	89	1500.0	1050.0	375.0	75.0	.0	.0	100.0	1500.0	AIDS$ Requ
Zaire	660-0107	Basic Rural Hlt	89	2000.0	1320.0	640.0	40.0	.0	.0	148.0	2000.0	AIDS$ Requ
Zaire	660-0510	PD&S	89	160.0	.0	90.0	10.0	.0	.0	60.0	160.0	
Zaire	698-0421.60	ACSI-CCCD	89	1200.0	180.0	1020.0	.0	.0	.0	.0	1200.0	
Zambia	611-0510	PD&S	89	20.0	.0	.0	.0	.0	20.0	.0	20.0	
Zambia	698-0462.11	FHI-II	89	100.0	.0	.0	.0	.0	100.0	.0	100.0	
Zambia	698-0474.11	HAPA	89	115.0	.0	.0	.0	.0	.0	115.0	115.0	
Zimbabwe	698-0462.13	FHI-II	89	500.0	.0	.0	.0	.0	500.0	.0	500.0	Contracept
Zimbabwe	698-0462.13	FHI-II	89	500.0	.0	.0	.0	.0	500.0	.0	500.0	
Zimbabwe	698-0474.13	HAPA	89	500.0	.0	.0	.0	.0	.0	500.0	500.0	
		TOTALS--->		89700.0	12883.0	28571.5	1683.0	4485.5	33767.0	2837.0	81325.0	

HEALTH: $12,883 + 2,837 - 837 = $14,883

CHILD SURVIVAL: $28,591 + 1,683 + 4,486 - 1,715 = $33,045

POPULATION: $33,767 + 1,683 + 4,486 - 350 = $39,586

COUNTRY	PROJECT NUMBER	TITLE	FY	PLANNED OBL	HEALTH	CS-HRB	HRB/CS	HRB/PN	PN-HRB	AIDS	PROJECT TOTALS	COMMENT
REDSO/WCA	624-0510	PD&S	90	400.0	.0	300.0	.0	.0	.0	100.0	400.0	
AFR REGIONAL	'625-0978	CERPOD-PromPopPoli	90	1000.0	.0	.0	.0	.0	1000.0	.0	1000.0	
AFR REGIONAL	625-0966	ONCHO CONTROL	90	2500.0	2500.0	.0	.0	.0	.0	.0	2500.0	
AFR REGIONAL	698-0421	ACSI-CCCD	90	10000.0	1500.0	8500.0	.0	.0	.0	.0	10000.0	
AFR REGIONAL	698-0462	FHI-II	90	3300.0	.0	.0	.0	.0	3300.0	.0	3300.0	
AFR REGIONAL	698-0471	MEDEX	90	1500.0	1350.0	150.0	.0	.0	.0	.0	1500.0	
Botswana	633-0249	Pop Sector	90	1000.0	.0	.0	.0	.0	1000.0	.0	1000.0	
Burkina	698-0462.86	FHI-II	90	100.0	.0	.0	.0	.0	100.0	.0	100.0	
Burkina	698-0474.86	HAPA	90	100.0	.0	.0	.0	.0	.0	100.0	100.0	
Burundi	695-0123	Population	90	1500.0	.0	.0	.0	.0	1500.0	.0	1500.0	
Cameroon	631-0056	MCH/CS	90	2000.0	300.0	1500.0	200.0	.0	.0	.0	2000.0	
Cameroon	698-0421.31	ACSI-CCCD	90	100.0	.0	100.0	.0	.0	.0	.0	100.0	
Cape Verde	698-0462.55	FHI-II	90	100.0	.0	.0	.0	.0	100.0	.0	100.0	
CAR	698-0421.76	ACSI-CCCD	90	150.0	15.0	135.0	.0	.0	.0	.0	150.0	
Gambia	698-0421.35	ACSI-CCCD	90	100.0	.0	100.0	.0	.0	.0	.0	100.0	
Ghana	641-0118	Fam Hlth & CS	90	3000.0	.0	1200.0	1800.0	.0	.0	.0	3000.0	
Ghana	641-0510	PD&S	90	120.0	.0	120.0	.0	.0	.0	.0	120.0	
Ivory Coast	698-0462.81	FHI-II	90	250.0	.0	.0	.0	.0	250.0	.0	250.0	
Kenya	615-0232	FP Sup Svcs	90	7744.0	.0	.0	.0	2942.7	4801.3	.0	7744.0	
Kenya	615-0236	PVO Co-Financg	90	2094.0	300.0	.0	.0	.0	300.0	.0	600.0	*1494=PVO
Kenya	689-0463.15	HRDA/Pop tng	90	250.0	.0	.0	.0	.0	24.0	.0	24.0	*226=HRDA
Kenya	698-0243	EconStbl&SecAdj	90	8000.0	.0	2000.0	.0	.0	.0	.0	2000.0	*6000=Econ
Kenya	698-0462.15	FHI-II	90	400.0	.0	.0	.0	.0	400.0	.0	400.0	
Liberia	669-0211	PVO-NGO Sup	90	1760.0	200.0	.0	.0	.0	.0	.0	200.0	1560=PVO's
Liberia	669-0215	PHC II	90	1000.0	.0	700.0	300.0	.0	.0	.0	1000.0	
Madagascar	698-0462.87	FHI-II	90	50.0	.0	.0	.0	.0	50.0	.0	50.0	
Malawi	612-0231	Prom Hlth In/CS	90	3250.0	1300.0	1137.5	162.5	.0	487.5	162.5	3250.0	
Malawi	612-0232	Svcs:Hlth/Ag/RE	90	5000.0	3200.0	1250.0	.0	.0	.0	.0	4450.0	550=ARDN &
Mali	688-0227	Intg Fam Hlth Svcs	90	1920.0	.0	768.0	672.0	.0	480.0	.0	1920.0	
Mali	698-0421.88	ACSI-CCCD	90	300.0	.0	300.0	.0	.0	.0	.0	300.0	
Mali	698-0462.88	FHI-II	90	700.0	.0	35.0	.0	245.0	420.0	.0	700.0	
Mauritania	698-0462.25	FHI-II	90	350.0	.0	.0	.0	.0	350.0	.0	350.0	
Mozambique	656-0209	Zambezia CS	90	1000.0	200.0	800.0	.0	.0	.0	.0	1000.0	
Niger	683-0254	Hlth Sec Sup	90	1483.0	593.2	741.5	148.3	.0	.0	.0	1483.0	
Niger	683-0258	Fam Hlth & Dem	90	2700.0	.0	135.0	.0	810.0	1596.0	159.0	2700.0	
Niger	698-0462.83	FHI-II	90	200.0	.0	.0	60.0	.0	140.0	.0	200.0	
Nigeria	620-0001	Fam Hlth Svcs	90	10000.0	.0	.0	.0	.0	10000.0	.0	10000.0	
Nigeria	698-0421.20	ACSI-CCCD	90	1500.0	105.0	1380.0	15.0	.0	.0	.0	1500.0	
Senegal	685-0286	CS Program	90	2000.0	200.0	1500.0	300.0	.0	.0	.0	2000.0	
Sudan	650-0084	CS Project	90	3500.0	350.0	2800.0	350.0	.0	.0	.0	3500.0	
Sudan	650-0085	PopPolProgSup	90	2000.0	.0	400.0	400.0	.0	1200.0	.0	2000.0	
Swaziland	645-0228	Fam Hlth Svcs	90	500.0	.0	.0	.0	100.0	390.0	10.0	500.0	
Tanzania	698-0462.21	FHI-II	90	800.0	.0	.0	.0	.0	800.0	.0	800.0	
Tanzania	698-0474.21	HAPA	90	500.0	.0	.0	.0	.0	.0	500.0	500.0	
Togo	693-0228	Hlth Sec Sup	90	654.0	.0	654.0	.0	.0	.0	.0	654.0	
Togo	698-0421.93	ACSI-CCCD	90	592.0	.0	592.0	.0	.0	.0	.0	592.0	
Uganda	617-0114	Fam Hlth Proj	90	2350.0	.0	322.5	.0	587.5	940.0	500.0	2350.0	
Zaire	660-0101	Sch Pub Hlth	90	1400.0	980.0	350.0	70.0	.0	.0	100.0	1400.0	AIDS$ Requ
Zaire	660-0107	Basic Rural Hlt	90	1750.0	1155.0	560.0	35.0	.0	.0	200.0	1750.0	AIDS$ Requ
Zaire	698-0421.60	ACSI-CCCD	90	350.0	.0	350.0	.0	.0	.0	.0	350.0	HlthCom
Zaire	698-0421.60	ACSI-CCCD	90	1600.0	240.0	1360.0	.0	.0	.0	100.0	1600.0	AIDS$ Requ

DEFINITIONS FOR AFR/TR ATTRIBUTIONS TABLES
HEALTH/CHILD SURVIVAL/POPULATIONS/AIDS

HRB = High Risk Births, i.e. high parity, mothers over 35 or under 20, last delivery less than 24 months, obstetric or medical problems. FP services targeted on these births should be counted as both Child Survival and Population services.

CS-HRB = Child Survival interventions excluding high risk births, i.e. immunizations, oral rehydration therapy, nutrition education, growth monitoring, malaria, etc.

HRB/CS = High Risk Births attributed from a Child Survival or Health project.

HRB/PN = High Risk Births attributed from a Family Planning project.

PN-HRB = Population or fp projects excluding attributions for high risk births.

Sources of data: FY 90 ABS; 1987 CS Questionnaires; Consultation with BS-50 Field Officers to clarify ABS data.

COUNTRY	PROJECT NUMBER	TITLE	FY	PLANNED OBL	HEALTH	CS-HRB	HRB/CS	HRB/PN	PN-HRB	AIDS	PROJECT TOTALS	COMMENT
Zambia	611-0510	PD&S	90	20.0	.0	.0	.0	.0	20.0	.0	20.0	
Zambia	698-0462.11	FHI-II	90	100.0	.0	.0	.0	.0	100.0	.0	100.0	
Zambia	698-0474.11	HAPA	90	100.0	.0	.0	.0	.0	.0	100.0	100.0	
Zimbabwe	698-0462.13	FHI-II	90	500.0	.0	.0	.0	.0	500.0	.0	500.0	
Zimbabwe	698-0462.13	FHI-II	90	500.0	.0	.0	.0	.0	500.0	.0	500.0	
Zimbabwe	698-0474.13	HAPA	90	500.0	.0	.0	.0	.0	.0	500.0	500.0	
		TOTALS--->		96637.0	14488.2	30241.1	4512.8	4685.2	30748.8	2531.5	86807.0	

HEALTH: $14,488 = 2,532 - 400 = $16,620

CHILD SURVIVAL: $30,241 +4,513 + 4,685= $39,439

POPULATION : $30,749 + 4,513 + 4,685=$39,947