

PROTECT DATA SHEET

1. TRANSACTION CODE

A = Add
 C = Change
 D = Delete

Amendment Number

6

DOCUMENT CODE

3

2. COUNTRY/ENTITY

AFRICA REGIONAL

3. BUREAU/OFFICE

AFR

06

4. PROJECT NUMBER

698-0421 & 625-0967

5. PROJECT TITLE (maximum 40 characters)

Africa Child Survival Initiative

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY
 09 30 91

7. ESTIMATED DATE OF OBLIGATION
 (Under "A" below, enter 1, 2, 3, or 4)

A. Initial FY [79] B. Quarter [3] C. Final FY [91]

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FIRST FY 79			LIFE OF PROJECT		
	F. FX	G. L/C	D. Total	E. FX	F. L/C	G. Total
AIC Appropriated Total	475	475	475	105,661		105,661
(Grant)	(475)	(475)	(475)	(105,661)	()	(105,661)
(Loan)	()	()	()	()	()	()
Other U.S. I-PW-ins				17,907		17,907
U.S. 2						
Ext Country						
Other Donor(s)						
TOTALS	475	475	475	123,568		123,568

9. SCHEDULE OF AID FUNDING (\$000)

A. AFRID PRIMARY PURPOSE CODE	B. PRIMARY TECH. CODE	D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
11EFA		48,936				48,936	
11Gnp		527				527	
11GCS		11,695				11,695	
11GSS		6,341		30,568		62,410	
TOTALS		67,499		30,568		123,568	

10. SECONDARY TECHNICAL CODES (maximum 3 codes of 3 positions each)

514 589

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 6 positions each)

A. Code R/H
 B. Amount 123,568

13. PROJECT PURPOSE (maximum 400 characters)

Strengthen Africans' ability to control 6 childhood communicable diseases (measles, polio, tuberculosis, diphtheria, pertussis and tetanus) through the Expanded Program for Immunization (EPI); provide treatment for diarrhea through the Control of Diarrhea Disease program and provide anti-malarial treatment for fevers in children ages 0-5.

14. SCHEDULED EVALUATIONS

MM YY MM YY MM YY
 Initial 01 90 Final 06 91

15. SOURCE/ORIGIN OF GOODS AND SERVICES

908 901 Local Other (Specify)

16. AMPLIFICATION/NATURE OF CHANGE PROPOSED (This is page 1 of a page FF Amendment)

This amendment provides additional funds necessary to allow the extension of country subprojects to coincide with the PACD or the core project and to expand child survival technical assistance activities.

*These amounts refer to new authorization levels for this amendment.

17. APPROVED BY

Signature: Keith W. Sherper
 Title: Director, AFR/CR
 Date Signed: 09 25 88

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DATE MEETS, DATE OF DISTRIBUTION

MM DD YY

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON DC 20523

ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR FOR AFRICA

FROM: AFR/PD, Timothy J. Bork

SUBJECT: Amendment to the Africa Child Survival Initiative -
Combatting Childhood Communicable Diseases Project (ACSI-CCCD)
No. 698-0421

I. Problem: Your approval is requested to amend the ACSI/CCCD Project to increase the authorized LOP funding level from \$93,000,000 to \$123,568,000 for a net increase of \$30,568,000.

II. Discussion:A. Background:

The ACSI/CCCD Project is the Agency's primary child survival project for Africa. The project has been designed to 1) strengthen the ability of African countries to control preventable childhood diseases through immunizations, 2) to treat dehydrating diarrheas with oral rehydration therapy and 3) to treat and prevent malaria with appropriate antimalarials. When completed, the project hopes to achieve a 25 percent reduction in infant mortality rates.

Since its initial authorization in 1981, the ACSI/CCCD Project has been amended five times as follows:

- Amendment no. 1 (12/83) - Extended mandatory evaluation clause by one year
- Amendment no. 2 (7/84) - Authorized the use of Sahel Development Program funds
- Amendment no. 3 (7/86) - Extended the PACD to 9/91, increased LOP costs to \$89,000,000 and changed the project name to include "Africa Child Survival Initiative"
- Amendment nos. 4 and 5 (5/87 and 8/87) - Increased LOP costs by \$4,000,000 to a total of \$93,000,000 to meet urgent agency requirements related to AIDS.

B. Amendment Description:

The basic goals and objectives of the ACSI/CCCD Project remain unchanged by this amendment. The purpose of this amendment is to add sufficient funding to accomplish the following:

- Extend all country subprojects* - The project's original design allowed country-specific project funding for 4-5 years. Thus some country-specific projects are scheduled to terminate in 1988 just as operational levels have been achieved, yet before targets have been reached. Several evaluations performed within the agency in recent years have recommended health projects have a life of 8-10 years in order to implement activities that can be sustained. Providing additional project time and resources will allow national governments the opportunity to reach child survival targets and devote adequate time to sustainability issues. The amendment will allow ten of the thirteen country subprojects to be extended until the 1991 PACD of the core project. Extensions for the other three subprojects are not needed.

- Provide additional funds to the core project - Some of the country subproject costs such as the technical officers and related support costs do not appear in the country subproject budgets but are included in the main PASA with CDC. Extensions of the country subprojects will, therefore, also increase core project costs. Funds have been included in the amendment to cover these increased costs.

- Expand technical assistance activities - This amendment will expand the technical assistance component to allow missions that currently do not have bilateral health programs to utilize the ACSI/CCCD regional project mechanism to access, through buy-ins, certain centrally managed projects such as REACH, HEALTHCOM AND PRITECH.

C. Follow-on ACSI II Project

In view of the success of the current ACSI/CCCD Project and the continuing need for child survival assistance in the region, the Africa Bureau intends to develop a follow-on ACSI II Project which will continue many of the activities begun under the current project but also will include new project elements which respond to other child survival needs not included in the present ACSI/CCCD Project. A PID-like document for the ACSI II

* Provided the recipient country is not in violation of FAA Section 620(q) or Section 518 of the Continuing Resolution (Brooke-Alexander).

- b -

Project will be completed in FY89 and a Project Paper will be completed in early FY90 to enable an FY90 start for the new project. This schedule will assure that there is a sufficient overlap with the current project so that there is no loss of project continuity.

D. Financial Summary

The amendment will add \$30,568,000 to the ACSI/CCCD Project for a new LOP of \$123,568,000. The cost breakdown (in \$000) is as follows:

	<u>Amendment</u>	<u>New LOP</u>
Country Subproject Extensions (BUY-INS)	\$8,366	\$25,492
Core CDC PASA	\$8,020	\$60,470
Other Regional Costs	\$4,641	\$28,065
Other Technical Assistance (BUY-INS to Central Projects)	\$9,541	\$9,541
Total	\$30,568	\$123,568

Of the total estimated amendment cost of \$30,568,000, \$17,907,000 is anticipated as buy-ins from missions. The remaining amount of \$12,661,000 will be added to the core regional project from AFR regional funds.

E. Committee Action and Findings

The ECPR was held on July 19, 1988 and the amendment was approved. Based upon ECPR discussions, the Project Committee concluded the following:

1. Requirements of FAA Section 611(a) continue to be satisfactorily met.
2. An environmental exclusion statement signed by the Bureau Environmental Officer is included in the amendment document.
3. No human rights clearance for this project is required.
4. Appropriate payment verification measures continue to be included in this project.
5. The implementation plan for the amendment is realistic and establishes a reasonable timeframe for carrying out planned activities.

C

6. Mission buy-ins to the ACSI/CCCD Project for technical assistance from other centrally-managed projects will be limited to those missions which do not have a bilateral child survival health program.

F. Other Considerations

1. Gray Amendment Entities - The maximum participation of Gray Amendment organizations in ACSI/CCCD Project activities has been and will continue to be encouraged.

2. Brooke Amendment - Currently Liberia is under Brooke Amendment sanctions. No new subproject obligations may occur for this country until the sanctions are lifted.

3. Designated Officer: The AID/W project officer is Dr. James Shepperd, AFR/TR/HPN.

III. Waivers: This amendment will be DFA funded and therefore liberal procurement regulations will be in effect. No additional waivers are anticipated at the present time.

IV. Congressional Notification: A Congressional Notification was submitted on September 13, 1988 increasing the LOP to \$123 million. The waiting period expired on September 28, 1988. If there is any significant change in the planned FY 89 obligation as shown in the FY 89 CP (\$10 million), an additional notification will be submitted.

V. Recommendation: That you sign the attached authorization amendment to increase life-of-project funding from \$93 million to \$123.6 million which represents an increase of \$30.6 million. Under Delegation of Authority 400, Section 4, you have the authority to approve this amendment.

Attachments
Project Paper Amendment
Authorization Amendment

Clearances:

<u>DAA/AFR:WBollinger</u>	Date <u>10/14/88</u>
<u>GC/AFR:GBisson (Draft)</u>	Date <u>10/6/88</u>
<u>AFR/TR:KSherber (Draft)</u>	Date <u>9/26/88</u>
<u>AFR/TR:WTrayfors (Draft)</u>	Date <u>9/26/88</u>
<u>AFR/TR/HPN:GMerritt (Draft)</u>	Date <u>9/26/88</u>
<u>AFR/PD/CCWAP:MJJune (Draft)</u>	Date <u>7/20/88</u>
<u>AFR/DP:JGovan (Draft)</u>	Date <u>9/26/88</u>
<u>PPC/PB/C:RMaushammer (Draft)</u>	Date <u>10/4/88</u>
<u>AFR/CONT:RKing (Draft)</u>	Date <u>9/28/88</u>
<u>M/SE/OP/OS/AFR:SDean (Draft)</u>	Date <u>9/26/88</u>

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AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON DC 20523

PROJECT AUTHORIZATION
(Amendment No. 6)

Country: Africa Regional
Sahel Regional

Project Name: Africa Child Survival Initiative -
Combatting Childhood Communicable
Diseases

Project Numbers: 698-0421
625-0967

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended ("the FAA"), the Africa Child Survival Initiative - Combatting Childhood Communicable Diseases Project for Africa was authorized on September 28, 1981 and was amended on August 2, 1982, July 16, 1984, August 13, 1986, May 1, 1987 and August 24, 1987. I hereby further amend the project authorization as follows:

"Section 1 is amended by substituting '\$123,568,000' for '\$93,000,000' both times the latter appears."

2. None of the funding added by this amendment shall be used to finance activities in countries in violation at the time the amendment is executed of Section 620(q) of the FAA, or Section 518 of the FY 89 Foreign Operations, Export Financing, and Related Programs Appropriations Act, unless and until such violations have been cured.

3. The authorization cited above remains in force except as hereby amended.



Charles L. Gladson
Assistant Administrator
for Africa Bureau

10/20/88

Date

Clearances: As shown on the Action Memorandum

GC/AFR:GBisson/gw 2718H/10/4/88/X79218

2'

AFRICA CHILD SURVIVAL INITIATIVE
COMBATTING CHILDHOOD COMMUNICABLE DISEASES

AMENDMENT

SEPTEMBER 1988

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TABLE OF CONTENTS

	PAGE
I. Executive Summary.....	3
II. Project Overview	
A. Project Description.....	5
B. ACSI II Follow-on Project.....	6
C. Project Implementation.....	6
D. Project Progress.....	7
III. Proposed Amendment	
A. Amended Project Description.....	9
B. Project Implementation.....	10
C. Project Management.....	11
D. Project Evaluation.....	12
IV. Project Financing	
A. Proposed Budget.....	13
B. Budget Justification.....	13
Graphs	
I. Current and Proposed Project Time Line.....	15
II. Project Implementation Plan.....	16
Tables	
I. Summary Financial Table.....	17/18
II. Annual Budget Submission.....	18
III. Summary of Authorizations.....	19
Annexes	
A. Project Progress Summary.....	20
B. Project Targets.....	23
C. Project Design Extensions.....	24
D. Amendment Strategies	
1. Impact Monitoring.....	27
2. Program Management.....	31
3. Sustaining Project Efforts.....	35
4. Health Financing.....	45
E. Revised Log Frame.....	51
F. Environmental Examination.....	53
G. Project Checklist.....	54
H. 1986 Annual Report.....	58

I. EXECUTIVE SUMMARY

The Africa Child Survival Initiative - Combatting Childhood Communicable Diseases (ACSI-CCCD) project is the Agency's largest effort to enhance the chances of children surviving past the age of four in the African nations. The project's goal and objectives are ambitious. By strengthening African capability to control diseases preventable by immunizations, to treat dehydrating diarrheas with oral rehydration therapy, and to treat and prevent malaria with appropriate antimalarials, the project proposes to reduce infant mortality rates by 25%. The intermediate process indicators illustrated in the ACSI-CCCD 1986 Annual Report (Annex H) suggest such goals and objectives are not unrealistic.

The primary purpose of this project amendment is to better assure that national child survival policies and programs initiated with ACSI-CCCD project support are sustained. This amendment will allow existing country-specific project activities to continue full implementation for an additional 3 years and will provide additional funding for short term technical assistance in specialized child survival areas. While the PACD of the regional project is 1991, the majority of country-specific projects are scheduled to end this year. These 3 years will provide host-countries additional time to not only demonstrate greater project impact but also to develop the necessary institutional capability to sustain these activities once AID assistance is completed.

At the present, ACSI-CCCD is cooperating with 13 national governments in sub-Sahara Africa. Project agreements provide one to two long-term resident advisors assigned to Ministries of Health, substantial short-term technical assistance, various commodities, and limited funding for local expenses. Health education, training, operational research, and development of health information systems are the main project activities performed in the country programs to control immunizable, diarrheal and malarial diseases.

As one would expect, progress to date can be seen most readily in the three country projects of longest life. Zaire's measles vaccination coverage rates have increased during project life from 23% to 39%. Rates in Togo for measles vaccination coverage have increased from 3% to 43% and in Liberia from 7% to 39%. The percentage of health facilities using ORT for dehydrating diarrhea has increased from 26% to 77% in Zaire and 36% to 83% in Togo. In Liberia 64% of the health facilities are using ORT. Over 80% of facilities in Zaire, Togo and Liberia are now following appropriate malaria treatment guidelines.

Experience to date has shown at least a two year start-up phase is necessary before reaching project operational levels in service delivery. Efforts in the third and fourth years of project life begin to focus on improved application of management techniques, decentralized training programs, accelerated service delivery and intensified communication efforts.

In order to accomplish the project's objectives, more attention including increased technical assistance will be focused on 1) improving quality of service delivery, access, coverage and demand, and 2) strengthening national capability to sustain project operational levels once achieved. Project management staff have developed and refined several strategies and plans to assist project efforts during these next three years. A sustainability strategy including a plan to help project countries meet project costs, a program management strategy and a plan to measure impact are introduced and discussed in the Annex of this paper.

Increasing 11 project countries by three years, continuing the level of support under the PASA with the Centers for Disease Control and expanding technical assistance activities will require an addition of approximately \$31 million dollars to the current authorized level of \$93 million.

It should be noted that in view of the success of the current project, AFR/TR/HPN will be developing a new project, ACSI II, which will continue many of the activities which have proven successful under the current project and may add other child survival components that address health needs not presently being met by the current project. The new ACSI II project will be a ten year project which will begin in late 1990 or early 1991 to allow a period of overlap with the existing project.

In summary, this amendment will provide country-specific projects six years minimum (nine years maximum) duration not only to achieve their mortality/morbidity reduction objectives, but also to benefit from additional inputs over a long enough period of time to strengthen capability to sustain these achievements.

II. PROJECT OVERVIEW

A. Project Description

The purpose of the ACSI-CCCD project is to strengthen three primary health care components: immunization of infants, pregnant and fertile aged women; treatment of acute dehydrating diarrheas with oral rehydration therapy (ORT); and presumptive treatment of fever with antimalarial drugs. A 25% reduction in under five mortality by 1991 is the project's objective.

The 13 African country projects contain a life of 4-5 years with the exception of Zaire (8 year LOP). Each project agreement sets forth targets for coverage and disease reduction and a project implementation plan for accomplishing these objectives.* Funding for commodity procurement and local program costs are provided in the grant by AID with host country contributions increasing as project life matures. Regional activities under the PASA with the Centers for Disease Control (CDC) support the long-term assignment of one or two field officers to Ministries of Health and substantial short-term technical assistance.

Disease intervention strategies are promoted through strengthening of four major program activities; training, health education, operational research and health information systems. Attention has also been placed on other activities such as health financing, local production of ORS, improved management practices and systems, and intensified community mobilization and use of mass media.

The project has not performed in isolation. A grant to the World Health Organization Africa Regional Office (WHO/AFRO) supports intercountry and national training in management and delivery of the three interventions, the development of an epidemiological bulletin and WHO participation in ACSI-CCCD country evaluations. Training and assignment of Peace Corps Volunteers to strengthen health education activities and service delivery is available under a PASA with Peace Corps. A cooperative agreement between CDC and the University of North Carolina supports collaboration with the Nigeria Africa Regional Health Education Center in strengthening national health education activities. Additionally, HEALTHCOM has initiated health communication projects with ACSI-CCCD in five countries; Swaziland, Lesotho, Malawi, Zaire and Nigeria. REACH, PRITECH and the Bureau of Census have contributed valuable technical assistance to many ACSI-CCCD project countries as well. The Nigeria country project contains a grant agreement with UNICEF to procure commodities and health communication materials. In most instances, ACSI-CCCD project monies have funded this assistance from the other AID projects.

This project's collaboration with UNICEF originated at the country level during each country's CCCD project assessment and continued through "technical coordination committees" stipulated in the grant agreements. In Zaire, CAR and Togo, these meetings have become what the designers had envisioned; formal mechanisms chaired by the ministries to coordinate resources and activities.

* See project targets in 1986 Annual Report (Annex H)

While in other countries, Guinea and Rwanda for example, meetings are held at a more informal level, albeit still effective. UNICEF's expertise in mobilizing political and social support for child survival activities has definitely aided CCCD country efforts.

In a few countries, collaboration between UNICEF and AID has proved challenging. UNICEF promotion of immunization campaigns in the Congo, Cote d'Ivoire and Nigeria had delayed many CCCD implementation plans previously agreed to by Ministries of Health. Both agencies are evaluating the merits of such campaigns, (both financially and epidemiologically) and have agreed to continue frequent Washington/New York discussions on this topic.

The project has a funding level of \$93 million (including \$4 million for a separate Acquired Immune Deficiency Syndrome component) and a regional PACD of 1991. Regional management is located in AFR/TR/HPN and technical management in the International Health Program Office of CDC in Atlanta, Georgia. Initiated in 1981, the project is completing its seventh year.

B. ACSI II Follow-on Project

As mentioned earlier, the Africa Bureau plans to develop a new 10 year project, ACSI II, which will be a follow-on project to ACSI-CCCD. Plans are currently underway to prepare a PID-like document during early CY 89 with the development of the project paper taking place in late CY 89. The new project is expected to be approved in CY 90 for implementation in late CY 90 or early CY 91 before the current project terminates. The new project will continue the successful elements of the current project i.e., immunization, ORT, etc and may also include an increased emphasis on other health/child survival components such as sustainability, privatization, health financing, other donor support and institutionalization.

C. Project implementation

With over 6 years experience, one can identify a few generalities regarding the implementation and operation of African child survival country projects. Start-up phase on the average requires 2-3 years. Long-term advisor placement, national policy development, designation of national program directors, commodity delivery, and training of future trainers consume on the average, the first 24 months of project life.

Four country projects have just completed this start-up phase (Cote d'Ivoire, Guinea, Burundi and Nigeria) and six have only been "operational" for a few years, (see Graph #1, page 15 for an illustration of the project time line of the 13 countries).

In the most mature projects with over 5 years of life (Zaire, Togo and Liberia) service delivery coverage has increased, training has reached peripheral health personnel, special studies in health financing, epidemiology, and local ORS production have been performed, and upgraded information systems are being relied upon to demonstrate strengths and weaknesses. These 3 countries are now concentrating on completion of national access to service delivery, perfection of health messages, improved supervisory techniques and management systems, and increased community co-financing.

D. Project Progress

In the 9 countries where project activities have been operating for 3 years or more, progress is evident in vaccination coverage and in facility use of oral rehydration therapy (ORT) and antimalarials. This progress is most apparent in those countries with longest project life. Measles vaccination coverage rates in Zaire have increased during project life from 23% to 39%, in Togo from 3% to 43% and in Liberia from 7% to 39%. The percentage of health facilities using ORT for dehydrating diarrhea cases has increased from 26% to 77% in Zaire, from 36% to 83% in Togo, and to 64% in Liberia. In malaria, over 50% of health facilities in Zaire, Togo and Liberia are following appropriate malaria treatment guidelines.

A few country projects are beginning to demonstrate impact on disease specific mortality. A diarrhea mortality study at Queen Elizabeth II hospital in Maseru, Lesotho showed a decrease in diarrhea deaths per 100,000 from 15 in 1984 to 9 in 1985. Reported measles cases in the Congo have declined from over 10 thousand cases in 1984 to an estimated 6 thousand cases in 1986.

Project-wide progress is illustrated by the following accomplishments. Seven of the 13 CCCD countries have achieved measles vaccination coverage of 50% or more in their operational areas. Twelve countries have 1 or more ORT demonstration and training centers, and 6 countries have carried out in vivo chloroquine sensitivity studies. The majority of countries have adopted national policies for each intervention, developed sterilization guidelines, and have established supervisory mechanisms.

Immunization: ACSI-CCCD project progress to date is most visible in the immunization program. All countries have EPI units. Many can now perform vaccination coverage surveys, have information systems to support routine reporting and analysis and have obtained political and public commitment.

Areas requiring attention in the next few years include increased vaccination coverage, research in providing measles vaccines to younger age groups, improved sterilization practices and improved compliance in completing vaccination schedules.

Control of Diarrheal Disease: For the most part, implementation efforts in this component have focused on developing national diarrheal disease program strategies, establishing ORT demonstration units and training personnel. Preliminary data regarding the use of ORT is impressive for such a relatively new intervention. Enhanced political commitment, increased involvement in prevention, (ie hygienic and weaning practices) and more behavioral research is needed for countries to develop effective diarrheal disease programs.

MALARIA CONTROL: Malaria activities have been at the operational level long enough in Liberia, Togo and Zaire to reflect high utilization of appropriate treatment. The remaining countries are just completing their malaria program strategies and only now beginning to concentrate on quality of service delivery.

For a summary of existing levels of use and coverage, please see the 1986 Annual Report (Annex H), page 58.

Other Project Activities: In addition to the 3 major intervention areas, project personnel have improved the health sector's quality of service delivery and financial viability by training health professionals, conducting operational research, developing information and management systems, and establishing alternative financing mechanisms.

. Training - In 1985, the project provided 27,500 person days of training, and in 1986, 50,000 days.

. Research - In 1986, 84 operational research projects were active and 48 were completed.

. Management - Twelve countries have established micro computer capability to manage the project and to monitor impact.

Financing: Nine countries have performed health financing studies. Togo, Zaire and Liberia have established drug revolving funds and/or fee-for-service mechanisms. Guinea, Togo and Liberia with CCCD assistance, have at the national level disregarded previous "health for free" policies and institutionalized beneficiary financing policies.

III. PROPOSED AMENDMENT

A. Amendment Project Description

This amendment will neither alter ACSI-CCCD's purpose nor its objective. The project will continue to strengthen the three primary health care components with an overall objective to reduce under five mortality by 25%. What this amendment will do is provide sufficient time for project inputs to make their expected impact on mortality reduction and allow the implementation of activities in a manner that is more likely to be sustained once direct project assistance is ended. Graph #1 (page 15) illustrates the current and amended time line for country-specific projects. The 4 to 5 year LOP for country projects will not be sufficient to enable programs to reach operational levels long enough to affect mortality rates or allow project management the time and resources to concentrate on conditions that generate sustainability. As mentioned previously, attainment of operational levels in all 3 interventions requires at least two years for most countries and as long as three years for some, (Liberia, Guinea, Cote d'Ivoire).

In summary, amendment to the project is justified for the following reasons:

- for most projects, the existing 4-5 year LOP provides inadequate time to assure sustainable large scale national efforts,
- additional work is necessary to put into place those conditions that generate sustainable programs, and
- the Africa Bureau has expressed its intent to concentrate its limited resources on programs that have already started.

Extension Design

The project description authorized by this amendment will contain the same regional PACD of 9/31/91 with a new funding authorization of \$123 million. The \$31 million increase in funding will allow country-specific projects (if progressing satisfactorily) to extend individual PACDs to 9/31/91. If all projects extend to 9/31/91, one country will have a 9 year life, 2 will have 8 years life, 5 with 7 years life, and 3 with 6 years life. Congo will be terminated in 1988 and Nigeria initiated in 1986, is already scheduled to last until 1991, (5 year life).

Project Targets

Proposed targets for the amendment have been altered to provide more accurate means of measuring project accomplishment. In most instances the new targets do not imply any reduction from previous levels and in some instances, propose higher levels of achievement.

Page of the annexed Annual Report illustrate the proposed target levels with a comparison to the previous project levels. Disease reduction targets have been added for Poliomyelitis, inpatient diarrhea deaths, inpatient and admission malaria deaths.

The measles target has been changed from mortality to morbidity to reflect the main objective of the intervention, the prevention of disease. Reliable methods to monitor trends in measles mortality primarily due to secondary complications have not as yet been identified. However, trends in measles morbidity can be used to estimate trends in measles mortality.

Experience in use of ORT at health facilities allows for an increase in target for effective case management from 50% to 90% for cases of diarrhea attending health facilities. Methodologies are available to measure the achievement of these targets. The target for appropriate community treatment for diarrhea has been increased from 20% to 50%. Major constraints lie in the assessment of community practices, a major priority for operational research.

B. Project Implementation

Examination of project data summarized in Annex A (page 20) finds the nine projects beginning prior to 1985, having an average measles vaccination coverage rate of 53% (ranging from 24% to 78%) and an average fully immunized coverage rate of 40% (ranging from 9% to 74%). It is highly unlikely that these countries will achieve the 80% fully immunized coverage target by the end of 1990 (in 3 years time) with the exception of Lesotho and possibly Rwanda. It is probable that by 1995 most countries will reach or exceed the end-of-project targets (including ORT and Malaria targets) if efforts are focused on both day-to-day program strengthening to improve service delivery quality and periodic intensified activities to increase coverage rapidly. Implementation under the amendment will continue to rely on the four support strategies:

- .training
- .health education/communication
- .operational research, and
- .health information systems,

plus three others,

- .program management
- .sustaining program activities and benefits
- .impact monitoring.

The Project Implementation Plan (graph #2, page 16) illustrates the progression of strategies and activities followed during project life. The amendment will allow activities under these strategies to include concentration on 1) improved quality of services, 2) activities that generate self-sufficiency, and 3) increased opportunity to measure and document impact (discussed in Annex D Section 1. Impact Monitoring).

In summary, ACSI-CCCD project countries have begun an implementation phase of activities beyond the operational phase. These efforts and those of other projects have been formulated into new project strategies. These strategies, discussed in Annex D are still very much in the developmental stage and will continue to be refined with additional experience and consultation from other AID projects and donors.

C. Project Management

Regional and Mission Project Management

To date, AID and CDC have shared responsibility for implementing ACSI-CCCD project activities. This amendment will continue this arrangement where AFR/TR with USAIDS oversee project management, funding and evaluation and CDC manages technical implementation and impact monitoring. The specific responsibilities of the various parties are listed below.

AFR/TR is responsible for the overall implementation and coordination of the ACSI-CCCD project in Africa. AFR/TR has a staff of 3 1/2 individuals responsible for 1) management of CDC/PASA; 2) management of the Peace Corps/PASA; 3) management of the WHO/AFRO Grant Agreement; 5) management of centralized procurement and all evaluations; 6) coordination of all CDC and Peace Corps activities with USAID's and other components of AID; and 7) coordination with other donors.

CDC is delegated authority to provide and coordinate all technical assistance to country-specific programs and to implement intercountry project components of epidemiological support, operational research, training and health education. AID funds are provided for this purpose through a PASA. To date, approximately 23 million dollars have been expended by CDC in performance of the technical assistance role in Africa. CDC carries out these responsibilities by means of a 13 person professional staff (and 9 support staff) in Atlanta and 17 field officers. CDC field staff are not assigned any management responsibility for field CCCD projects. They are expected to devote all their effort to provision and coordination of technical assistance required by field programs.

USAID's are delegated all project management responsibilities for country-specific projects with some important exceptions which ease their management burden extensively. Exceptions are mobilization and management of technical assistance (performed by CDC), project approval, development of ProAgs and project evaluation (done by AFR/TR) and management of procurement services agents (done by AFR/TR).

The USAID's are solely responsible for all other executive management and administrative support requirements of the country-specific projects.

Peace Corps is responsible for placement of health education generalist and specialist volunteers for provision of technical assistance to country-specific CCCD projects. Their volunteers coordinate with USAID and CDC field staff but are not supervised by them. The PASA is managed by AFR/TR.

WHO/AFRO is exclusively responsible for carrying out intercountry training in senior epidemiology, CDD and EPI management. The Grant Agreement is directly managed by AFR/TR. The grant is in its fourth year and will be evaluated this August by an external evaluation team.

D. PROJECT EVALUATION

CCCD has followed a strict monitoring and evaluation schedule. Over 30 evaluations will have been performed by the end of 1988. The regional project has been reviewed four times since project initiation, twice by outside consultants and twice by internal management. Each country-specific project has been reviewed at least twice, one internal and one external evaluation, (except for Nigeria) and many projects three times. Project Evaluation Summary (PES) facesheets have been completed on all evaluations, with recommendations accepted and action dates designated, and signed by mission directors or the AFR/TR Director. Other monitoring exercises have included a RIG audit and WHO-AFRO grant evaluation in 1986 and a financial analysis in 1987. A review of the findings from these evaluations can be found in the 1987 Amendment Paper.

IV. PROJECT FINANCING

A. Proposed Budget

It is proposed that current funding for the ACSI-CCCD project be increased \$30,568,000 from the current level of \$93 million. Tables I through III (pages 17-19) present a summary of past and proposed project obligations. The increased funding is based on continuing country-specific activities in 12 of the current 13 countries, (the Congo project will be closed at the end of 1988) and regional activities (including those under the PASA with CDC and those with other implementing agents.)

Projections of the two major cost line items were done in the following manner based on certain assumptions:

1. Country-Specific Activities - (Table I) Projections were developed principally by CDC/Atlanta country backstop officers. They were refined or adjusted based on a review of current performance and financial status, a review of recent evaluations or other correspondence, discussions with AID/W, CDC, and missions.

2. Regional activities - (Table I) The CDC/PASA included full time Technical Officers in all countries and field epidemiologists in each of the child survival positions. These costs will be quite similar to those PASA costs of 1987, since support levels are the same.

The more significant operational changes in the regional activities which have increased costs are:

- Provision of local hire PSCs in all countries in order to improve project monitoring and management.

- Provision of funds for contracts with measles vaccine manufacturers and health education and program management contractors.

B. Budget Justification

Since obligations are effected under a number of different documents, the proposed budget line items are only suggestive. Variations, especially between country totals, are due to: exchange rate/foreign exchange fluctuations, host country contribution shortfalls, development of alternative financing mechanisms, country buy-ins and changes in donor participation.

Mission Buy-ins

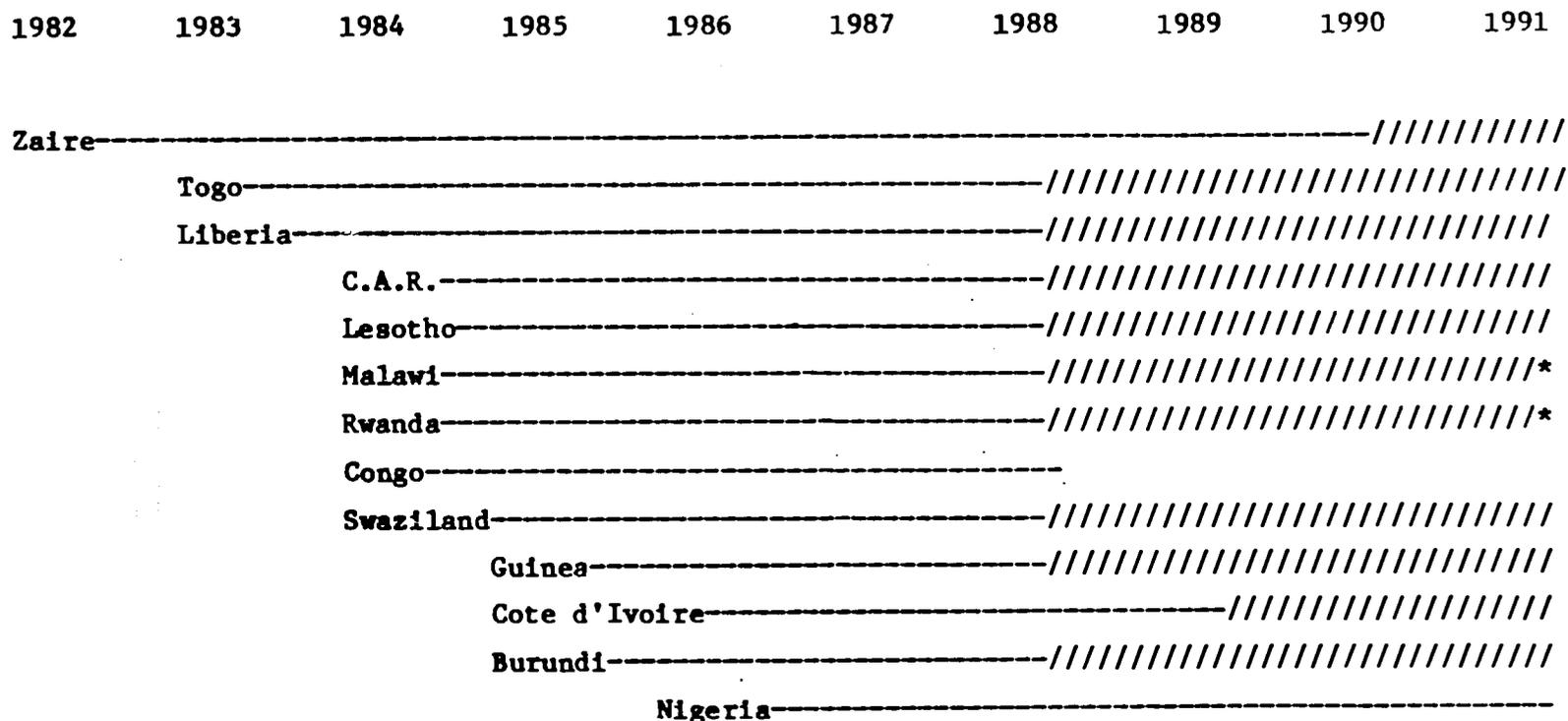
The management of the Development Fund for Africa requires that missions buy-in to the core portion of regional projects. The only regional project in the major bureau program in child survival is the ACSI-CCCD project. This project amendment will raise the existing project authorization level from \$93,000,000 to \$113,428,000 [Table II, approximately \$12.6 million core and \$8.3 million bilateral], to cover country-specific and regional ACSI-CCCD needs discussed in this paper. There is also an additional \$9,541,000 to be authorized in order to accommodate additional bureau child survival buy-ins into centrally funded projects. This will bring the total increased authorization to \$30,568,000 [Table III].

This amendment will also authorize the use of the project core operation to serve as the envelope into which missions may buy into for various S&T HPN projects. CDC will not be responsible for the buy-ins generated outside the ASCI-CCCD project.

Since the 1988 change in Africa Bureau funding allocations, missions have proceeded to buy into CCCD regional activities at levels very similar to those previously projected by AFR/TR. It is expected that missions will continue to buy-in in 1989 and 1990, however, the future status of two country-specific projects, Rwanda and Malawi is unknown at this time. Budgets have included Rwanda and Malawi mission buy-in estimates in case these projects continue or restart in 1989.

CURRENT AND PROPOSED COUNTRY PROJECT TIME LINE

GRAPH I



----- = original LOP
 ////////// = extended LOP
 //////////* = future status unknown

The proposed number of years illustrated here as extension is only for budgeting purposes. The planned reassessments and redesigns will determine exact lop time.

ACSI-CCCD PROJECT IMPLEMENTATION PLAN
Graph II

	1981 "START-UP"	through 1988 "OPERATIONAL"	through 1991 "QUALITY & INSTITUTIONALIZATION"
GOAL	Strengthen capability to Reduce Mortality	Strengthen capability to Reduce Mortality	"in a sustainable manner"
STRATEGIES	Health Education Health Information Systems Training Operational Research Technical Assistance	Impact Monitoring Health Education Training Operational Research	Health Information Systems Program management Sustainability Health financing
ACTIVITIES	Pro Ag signing AFR. Director assigned advisors posted commodities ordered internal review local \$ account est. implementation plans ORT centers functional supervision/continuing education health care financing pilots begun internal and external evaluations	policy development training of trainers surveys performed HIS begun OR priorities established community mobilization coverage increase/with access health education units functioning oper. research review committees effective internal and external evaluations impact surveys performed	community mobilization increased demand increased coverage/with access Nat. \$ committed co-financing functioning training units functioning decentralized training
GUIDANCE: 4th Year External Eval, 5th Year Internal Eval, RIG Audit, AID Health Care Financing strategy, AID Child Survival Strategy, Africa Bureau Child Survival Action Plan, PPC/CDIE Sustainability Evaluations			

TABLE I

Country/Category	Start Date	Current \$000 LOP	Funds Required	Revised \$000 LOP	Obligations by Year			
					88	89	90	91
Burundi	8-85/9-91	834	625	1,459	300	325	0	0
CAR	5-84/9-91	691	1,445	2,136	1,445	0	0	0
Guinea	6-85/9-91	885	804	1,689	804	0	0	0
Cote d'Ivoire	6-85/9-91	1,691	500	2,191	0	500	0	0
Lesotho	5-84/9-91	563	525	1,088	325	0	200	0
Liberia	7-83/9-91	655	850	1,505	500	350	0	0
Swaziland	8-85/9-91	686	0	687	0	0	0	0
Togo	4/83/9-91	1,140	1,192	2,332	200	792	200	0
Zaire	8-82/9-91	6,841	700	7,541	0	700	0	0
Congo	5-84/12/88	647	0	647	0	0	0	0
Rwanda	6-84/9-91	1,072	790	1,862	0	790	0	0
Malawi	6-84/9-91	1,421	935	2,356	0	935	0	0
Nigeria**	12-86-9-91	(14,450)	0	14,450	0	0	0	0
<u>Sub-Total Country Buy-Ins</u>		<u>17,126</u>	<u>8,366</u>	<u>39,942</u>	<u>3,574</u>	<u>4,392</u>	<u>400</u>	<u>0</u>
Regional								
CDC PASA:								
Field T.O.s		27,260	6,100	33,360	3,740	3,740	3,740	3,740
CDC Core Costs		20,590	1,920	22,510	3,000	3,600	3,000	3,000
Nigeria - PASA		4,600	0	4,600	920	920	920	920
<u>Sub-Total CDC PASA</u>		<u>52,450</u>	<u>8,020</u>	<u>60,470</u>	<u>7,660</u>	<u>8,260</u>	<u>7,660</u>	<u>7,660</u>

TABLE I (continued)

Country/Category	Start Date	Current \$000 LOP	Funds Required	Revised \$000 LOP	Obligations by Year			
					88	89	90	91
Other Regional Costs								
Field PSC/APOs		0	2,240	2,240	560	560	560	560
UNICEF Grant (Nigeria)		6,000	0*	6,000	0	2,500	0	0
WHO/AFRO		6,399	(599)	4,800	325	600	600	600
Measles Vaccine		1,592	880	2,472	1,412	0	700	0
RSSA		1,134	0	1,134	150	150	150	150
HEALTHCOM/Nigeria		970	250	1,220	215	650	0	0
PRITECH/Nigeria		469	471	940	213	415	300	225
H. Education		960	240	1,200	0	600	300	300
OQCs (Evaluation)		1,900	560	2,460	300	300	300	300
AIDS Activities		4,000	0	4,000	0	0	0	0
Subtotal		23,424	4,641	27,466	3,175	5,775	2,910	2,335
TOTAL		93,000	21,027	113,428	14,409	18,427	10,970	9,570

*Current Funding of 6,399 reduced by 1,599

**Non add since Nigeria funding is included under regional/other regional costs.

TABLE III. SUMMARY TABLE OF AUTHORIZATION
 CCCD ACSI Project Amendment July 1988

(000)

Activity	Current LOP	New Funds	Revised LOP	Actual/Proposed Obligations thru 7/88
Core CDC PASA	52,450	8,020	60,470	
other regional (from table I)	23,424	4,541	28,065	
Total Core	75,874	12,661	88,536	42,797*
Total Country Buy-ins	31,576	8,366+	39,942	
Subtract Nigerian (from table I)	-14,450	Buy in	14,450	
	17,126	8,366	25,492	18,322
Total ACSI-CCCD Project	93,000#	21,027	114,027	61,119*
EST. FY'88 obligations				16,800
Total other buy-ins to centrally funded projects (from table II)		9,541	9,541	77,919
Grand Total	93,000#	30,568	123,568	80,419

+Funds to be included in mission OYB. \$8,366

*From P.A.I.S. report of 3/88

#From previous amendment

ANNEXES

Immunizations:

Listed below are coverage surveys carried out in 1986 project operational areas. Starred surveys *** represent national coverage.

<u>COUNTRY</u>	<u>VACCINATION COVERAGE-1986</u>		<u>AGE GROUP</u>
	Measles	Fully Immunized	
Zaire:	39%	35%	12-23 mos.
Liberia:	39%	9%	12-23 mos.
Togo:***	43%	27%	12-23 mos.
Burundi:***	57%		12-23 mos.
CAR:	24%	14%	12-23 mos.
Lesotho:***	73%	65%	12-23 mos.
Malawi:***	52%	35%	12-23 mos.
Rwanda:***	78%	58%	12-23 mos.
Congo:***	77%	74%	12-23 mos.
Swaziland:***	74%	38%	12-23 mos. (1987)
Cd'Ivoire:***	87%		12-23 mos (1988)

Projects which began in 1985 and after are beginning to develop national data on fully immunized children.

<u>COUNTRY</u>	<u>VACCINATION COVERAGE -1986</u>		<u>AGE GROUP</u>
	Measles	Fully Immunized	
Guinea:	16%	4	12-23 mos. (Conakry)
C'Ivoire:	56%	-	12-23 mos. (Yamoussoukro)
Burundi:	57%	46%	12-23 mos. (Burundi)
Nigeria:	16%	-	12-23 mos. (national)

Diarrheal Disease Control:

Numbers below represent availability and may not represent effective use. Methods to assess quality of use are being developed and tested.

<u>COUNTRY</u>	<u>CDD PROCESS INDICATORS</u>
Zaire:	77% of health facilities using ORS compared to 26% in 1984
Liberia:	64% of health facilities using ORS (previous use unknown)
Togo	100% of health facilities using ORS compared to 36% in 1983
CAR:	6% of health facilities using ORS (previous use unknown) and 1 ORT unit established
Lesotho:	100% of health facilities using ORS in 1985 and 1986 (previous use unknown), 14 ORT units outside capital and local ORS production doubled
Malawi:	100% of health facilities using ORS compared to 0% use in 1980, ORT units established in 44 hospitals
Rwanda:	60% use of ORS in health facilities
Congo:	8% use of ORS in health facilities compared to 4% in 1982 and 3 ORT units in Brazzaville and environ
Swaziland:	100% of hospitals and facilities using ORS
Guinea:	3 ORT units (1 demonstration center)
C'Ivoire:	54% of health facilities using ORS (previous use unknown) and 1 pilot ORT demonstration center
Burundi:	1 ORT demonstration center, 100% hospitals and 75% health facilities using ORT.
Nigeria:	5 ORT demonstration centers

Malaria Control:

Data below originate from surveys performed in project operational areas.

<u>COUNTRY</u>	<u>MALARIA PROCESS INDICATORS</u>
Zaire:	-70% of health facilities are following malaria treatment guidelines compared to 99% in 1985
Liberia:	-82% of health facilities sampled are following malaria treatment guidelines (previous practices are unknown)
Togo	100% of health facilities are following malaria treatment guidelines compared to 43% in 1983
CAR:	100% of health facilities are following malaria treatment guidelines (previous practices unknown), National Malaria policy adopted & sensitivity testing performed
Lesotho:	N/A
Malawi:	100% of health facilities are following malaria treatment guidelines compared to 49% in 1980 and numerous malaria operational research projects performed
Rwanda:	49% of health facilities are following malaria treatment guidelines compared to 47% in 1985, National Malaria Coordinator appointed and 4 year plan completed
Congo:	100% of health facilities are following malaria treatment guidelines in 1985 and 1986 (previous practices unknown) and National Malaria plan developed
Swaziland:	Development of Malaria Communication materials and messages
Guinea:	National malaria plan drafted
C.'Ivoire:	National Malaria plan developed and sensitivity testing performed
Burundi:	National Malaria policy drafted
Nigeria:	Sensitivity testing performed

ANNEX B

PROJECT TARGETS

	TARGET PREVIOUS LEVEL	TARGET REVISED LEVEL	METHODS OF MEASUREMENT
0-4 Mortality	-25%*	-25%	Demographic Sample Survey
Neonatal Tetanus	-25%	-25%	Major Hospital Surveillance Coverage and Vaccine Efficacy
Poliomyelitis	--	-75%	Sentinel Surveillance Routine Reporting
Measles Mortality	-50%	--	Sentinel Surveillance
Measles Morbidity	--	-50%	Routine Reporting Coverage and Vaccine Efficacy
Inpatient Diarrhea Deaths	--	-50%	Major Hospital Surveillance
Inpatient Malaria Deaths	--	-50%	Major Hospital Surveillance
Immunization Coverage 12 months	80%	80%	Estimated Coverage Coverage Survey
Tetanus Toxoid Coverage Pregnant Women at Term Coverage Survey		--	60%
Effective Case Management of Diarrhea at Health Facilities	50%	90%	Supervisory Check List Facility Survey Training Needs Assessment
Effective Case Management Fever/Malaria at Health Facilities	90%	90%	Supervisory Check List Facility Survey Training Needs Assessment
Appropriate Rx Diarrhea in the Community	20%	50%	Practice Survey
Appropriate RX Fever/ Malaria in the Community Practice Survey		80%	70%

*% reduction will represent changes from nationally established baseline data.

ANNEX C

PROJECT DESIGN EXTENSIONS

Country-specific project extension will not occur automatically. The project's strict monitoring schedule (internal or external evaluations, performed alternative years) and a planned "extension design" exercise will determine project viability and extension feasibility. The extension design will require MOH and U.S. project staff to assess current project implementation workplans and strategies, identify areas requiring revision, and propose modifications reflecting new targets, indicators and/or methodologies. It is anticipated that many amended project agreements will include conditions precedent for host-country monetary contributions and/or program-specific personnel. Missions and MOH's will incorporate the sustainability strategy recommended in the Fifth Year Evaluation (and included in this amendment Annex) and the system to monitor host-country contributions recommended by the RIG audit.

The country project agreement amendment and monitoring schedules for 1988 and 1989 are shown below.

1988 PROJECT EXTENSION DESIGN AND EVALUATION SCHEDULE

DATE	ACTIVITY	PARTICIPANTS
1/88	Extension Design: Guinea	TACS/CDC/PM
2/88	Extension Design: CAR	TACS/CDC
2/88	Extension Design: Togo	TACS/CDC
2/88	Extension Design: Swaziland	PM/CDC
5/88	Extension Design: Liberia	TACS/CDC/PM
5/88	External Evaluation: Rwanda	PM/CDC/STC
5/88	Internal Review: Cote d'Ivoire	PM/CDC/STC
6/88	Extension Design: Burundi	CDC/TACS
8/88	External Evaluation: Lesotho	PM/CDC/STC
8/88	External Evaluation: WHO/AFRO	PM/CDC/STC
8/88	External Evaluation: Zaire	PM/CDC/STC
9/88	Extension Design: C. d'Ivoire	TACS/CDC
10/88	External evaluation: Malawi	PM/CDC/STC

1989 PROPOSED EXTENSION DESIGN AMENDMENT SCHEDULE

01/89	Internal Review: Nigeria	PM/CDC
10/89	Extension Design: Zaire	TACS/CDC
10/89	Extension Design: Nigeria	TACS/CDC

 PM = AID/W Project Manager or Assistant PM
 CDC = CDC/Atlanta or field personnel
 TACS = Technical Advisor for Child Survival
 STC = Short Term Consultant

As has been the practice to date, individual country projects will determine their specific priorities among the child survival interventions and support strategies. For example, the Cote d'Ivoire project design included the control of yaws within its project mandate and in Nigeria, yellow fever control and child spacing were added. Such flexibility among project interventions will continue under this amendment.

Extension designs will apply the same criteria in selecting priority interventions as was used for selecting the first three interventions, (immunization, ORT and anti-malarial treatment):

- .epidemiologic need - a documented cause of mortality in infants and children 1-4,
- .technical feasibility - availability of an intervention proven to be effective in disease prevention or treatment,
- .logistic feasibility - intervention can be delivered effectively in the African environment,
- .cost - intervention is affordable,
- .acceptability - both the government and the public recognize the health problem as significant and are willing to allocate resources,
- .measureability - system exists or can be developed to measure intervention effectiveness in achieving objectives and targets

Project management foresee a few extension designs including operational research plans in acute respiratory infections (ARI), child spacing, Vitamin A deficiency, or Acquired Immune Deficiency Syndrome (AIDS), since these diseases are often major causes of mortality among children in African countries.

ARI: Acute Respiratory Infection is becoming increasingly recognized as a major cause of under five mortality, accounting in some studies for as much as 20% of under five mortality. Part of this mortality overlaps with two diseases preventable by immunization, measles and pertussis.

Algorithms for the clinical diagnosis and treatment of ARI have been developed by WHO and are being tested widely in the developing world including Africa. Two major obstacles have been identified, choice of drug and cost.

In view of ACSI-CCCD success in upgrading the quality of clinical care for diarrhea and malaria at health facilities, ACSI-CCCD has the potential to introduce a rational approach to ARI treatment at the health facility level.

Vitamin A Deficiency: Data from Indonesia has documented an association between Vitamin A deficiency and mortality. While there are still many questions as to the nature of the association, use of Vitamin A in areas of recognized deficiency makes good public health sense.

Different strategies for the distribution of Vitamin A have been tested in Africa. Ranging from kitchen gardens to capsule distribution, introduction of operational research into Vitamin A issues is a viable option of ACSI-CCCD projects which have achieved good levels of coverage with current interventions and which are operating in areas of Vitamin A deficiency.

AIDs: AIDS is increasingly being recognized as a potential major contributor to child mortality in Africa. In Kinshasa where as many as 15% of pregnant women are infected with AIDS, 4-8% of their children can be expected to be infected by the time of birth. While current AIDS mortality is less than 5% of that due to current ACSI-CCCD interventions, epidemiologic projections indicate major AIDS problems in the 1990's.

Although most ACSI-CCCD programs do not have the resources or the capability to take on national AIDS control, ACSI-CCCD has a number of areas of comparative advantage which could contribute to national programs of AIDS control:

- .Health Information - the collection, analysis, and dissemination of data,
- .Management of needle use - (logistics, training, supervision)
- .Health worker education.

Child Spacing: Short interbirth intervals have an adverse effect on both the preceding and the following child. World Fertility Survey Data indicate that short interbirth intervals may double mortality risk due to the cessation of breast feeding and the introduction of less nutritious more contaminated food for the preceding child and through maternal depletion on the following child.

ACSI-CCCD has the advantage of increasing rates of contact with new mothers as they bring their children to facilities for immunizations.

While contraceptive education and distribution may be beyond the capability of some ACSI-CCCD programs, opportunities for closer liaison and cooperation with national family planning programs will be explored.

ANNEX D Amendment Project Strategies

1. Impact Monitoring

The strategy and methodologies used to measure impact have evolved since project initiation in 1981 and will continue to evolve as information systems become more complete and as experience provides more lessons learned.

Due to the inherent differences within and between ACSI-CCCD participating countries, no single set of targets is appropriate for all countries or for all areas within countries. In accordance with sound management principles, targets need to be set by those responsible for implementation. ACSI-CCCD targets are thus generic and require adaptation at the local and country level. This process will be performed formally during the assessment activity for new project countries and targets will be reassessed for existing countries during design extension. Targets to be achieved during the project extension 1988-1991 are summarized on the following page.

<u>INDICATOR</u>	<u>TARGET</u>	<u>BASELINE/REFERENCE LEVEL</u>
0-4 Mortality	-25%	Demographic Survey in Liberia, Togo, Zaire. Demographic and Health Survey Census. Hill/Brass/McCrae Vital Registration
Neonatal Tetanus Mortality	-25%	Neonatal Tetanus Incidence Estimated by Survey
Poliomyelitis Morbidity	-75%	Poliomyelitis Incidence as Estimated by Lameness Survey
Measles Morbidity	-50%	Births times 90%
Inpatient Diarrhea Deaths	-50%	Preprogram Diarrhea Deaths at Major Hospitals
Inpatient Malaria Admissions	-50%	Preprogram Malaria Admissions at Major Hospitals
Inpatient Malaria Deaths	-50%	Preprogram Malaria Deaths at Major Hospitals
Immunization Coverage at 12 months	80%	Coverage at Start of Program

Tetanus Toxoid Coverage at Term	60%	Coverage at Start of Program
Effective Case Management of Diarrhea at Health Facilities	90%	Data on Facility Practices Available or Year 1 of Extension
Effective Case Management of Malaria at Health Facilities	90%	Data on Facility Practices Available or Year 1 of Extension
Appropriate Community Treatment of Diarrhea	50%	Community Practice Data Available or Year 1 of Extension
Appropriate Community Treatment of Malaria	50%	Community Practice Data available or Year 1 of Extension

Impact evaluation has been divided into eight areas. Each area subsection lists a key question, methods to be used, and frequency measurement will take place.

1. POLICY/STRATEGY/TECHNICAL GUIDELINES

QUESTION: For each selected child survival strategy, are there written documents outlining policy, strategy, and procedures (job aids)? Have these been reviewed/ revised on an annual basis?

METHOD: Internal and/or external review

TIMING: Annually

2. PROGRAM COVERAGE

QUESTIONS: What percentage of population lives in areas in which program is operational? (Operational Area).

METHOD: Internal review to determine percent of population living in operational areas (Sectors, Districts, Local Government Area).

TIMING: Annually

3. ACCESS TO IMMUNIZATION

QUESTION: What percentage of target populations have access to immunization?

METHOD: Access will be estimated in percent by dividing DPT1 reported administered to children under one by the under one population and multiplying by 100.

TIMING: Annually

4. IMMUNIZATION COVERAGE

QUESTION: What is the vaccination coverage of infants at 12 months?

METHODS: Two methods will be used;

- a). Reported vaccinations under one divided by under one population x 100.
- b). Vaccination coverage surveys.

TIMING: Two methods will be used;

- a). Estimated coverage from reported vaccinations on an annual basis.
- b). National coverage surveys every 3 years.

5. COMMUNITY COVERAGE WITH KEY CHILD SURVIVAL INTERVENTIONS

QUESTION: What percentage of at risk populations (infants, 1-4 and pregnant women) are receiving appropriate preventive/curative care.

METHOD: sample population-based surveys to measure community practices (immunization, ORT for diarrhea, and treatment/referral for malaria).

TIMING: First and last years of extension.

6. FACILITY PRACTICES

QUESTION: Three methods will be used to assess health worker performance .

- a). Supervisory Check Lists
- b). Facility Surveys
- c). Training Needs Assessments

TIMING: Data on practices will be collected to monitor staff capability to provide appropriate prevention/treatment annually.

7. FACILITY EFFECTIVENESS IN PREVENTING DIARRHEA AND MALARIA DEATHS

QUESTION: How effective are facilities in preventing diarrhea and malaria deaths?

METHODS: Sentinel surveillance for outpatient contacts, admissions, and deaths at major hospitals.

TIMING: Annually.

8. DISEASE REDUCTION

QUESTION: How effective has the national program been in preventing morbidity and mortality?

METHODS:

Measles Morbidity
National reported cases
Sentinel facility reported cases
Vaccine coverage times vaccine efficacy

Neonatal Tetanus
Sentinel facility reported cases

Poliomyelitis
National reported cases
Sentinel facility reported cases

Severe Dehydration
Sentinel facility reported cases

Malaria Admissions
Sentinel facility reported admissions

TIMING: Annually

9. UNDER FIVE MORTALITY

QUESTION: How effective are the ACSI-CCCD interventions in reducing under 5 mortality and in increasing child survival?

METHODS: Retrospective demographic survey of pregnancies and use of health services (MUHS) in three countries (Liberia, Togo, and Zaire). Alternative methods of assessing trends in mortality are being explored.

TIMING: MUHS Surveys will be carried out in years 1 and 4. If projects are extended, a third survey will be carried out in year seven.

2. Program Management Strategy

The issue of program management is of particular concern to ACSI-CCCD. The project's original design emphasized the importance of developing effective national program management for successful project implementation and for sustainability of country programs.

ACSI-CCCD's strategy for Program Management is one that will develop host country capabilities over time to routinely deliver primary health care services. This is contingent on a comprehensive program strategy which balances demand creation with the ability to develop, coordinate, and to deliver health services effectively. Each individual country project strategy is to represent host country and donor consensus on the timing, scope, and magnitude of complimentary inputs to achieve targeted reductions in morbidity and mortality.

The ACSI-CCCD approach for improving program management aims at identifying management problems that are programmatic in nature. Considerable emphasis is placed on improving performance of program components, (logistics, cold chain, training) by promoting the use of management tools and techniques, i.e. work plans and supervisory checklists. Improving program performance is best done through a combination of on-the-job training provided by the ACSI-CCCD Technical Officer (T.O.) and appropriate formal and informal training exercises. The interaction of T.O.'s and their counterparts is the most significant type of program management training (or transfer of knowledge) that occurs within the project.

ACSI-CCCD Program Management focus includes:

- .the development and implementation of specific program interventions
- .the organization and supervision of personnel
- .promotion of donor coordination of resources
- .the collection, interpretation, and meaningful presentation of data
- .decision making based on data analysis

ACSI-CCCD concentrates on strengthening project management through the use of:

- .transferring of management skills provided by Technical Officers
- .short-term training courses in management techniques
- .microcomputer applications for data analysis
- .national and international workshops on updates on the state-of-the-art in managing preventive health programs
- .short-term technical consultancies in management
- .participation of national coordinators in evaluating other country programs
- .operational research to find solutions to management problems

CDC has begun to select Technical Officers with stronger program management skills in addition to the required technical skills. It is planned that prospective T.O.'s will be provided with pre-assignment apprenticeships in projects with demonstrated program management capabilities. Specific guidelines on program management and intensified supervision will be provided throughout the T.O.'s assignment.

Country workplans address program management issues such as: assignment of national staff charged with program management, monitoring/supervision, and training responsibilities; assessments to identify competencies and deficiencies in program management and delivery systems; inventory of incountry resources for preservice and inservice training capabilities; provision of training; evaluation of training; on-the-job training; use of microcomputers and a data information system for ongoing evaluation and monitoring of program management; a program of regular field supervision; donor coordination; and a plan for the government's gradual assumption of donor contributions and for cost recovery.

National and international ACSI-CCCD meetings and conferences are used as opportunities to provide workshops on a variety of program management issues. Emphasis is placed on: health financing; donor coordination; and infrastructure building. Participation in WHO's EPI and CDD manager's meetings also serves to meet training needs of ACSI-CCCD managers.

In order to foster inter-country exchange, national ACSI-CCCD managers/coordinators participate in future ACSI-CCCD country evaluation teams. When appropriate, ACSI-CCCD promotes the exchange of coordinators between countries for short periods of time.

Within the framework of ACSI-CCCD support for operational research, both individuals and institutions are encouraged to develop and to submit proposals on different aspects of management. Results of these studies may be incorporated into training programs.

Future bilateral project designs or design extensions will examine program management issues and propose specific recommendations as conditions for extension or expansion of projects. Some of the issues to be examined will include: appropriate project framework within the Ministry of Health; ability of infrastructure to coordinate and deliver services in a changing epidemiologic, technical, and political environment; donor collaboration; political and financial commitments; cost recovery; and participation of both the public and private sectors.

The CCCD Project with its multiple interventions and support strategies is essentially an exercise in health program management. The managerial character of the project has a direct impact on its technical components. The introduction of efforts in the early and mid-phases of the project to develop a comprehensive management program represents a start and a unique opportunity to develop its managerial requirements. The contribution that the project can make to improving the managerial capability in the health sector of host countries will be enhanced if the various efforts are conducted in a coherent and coordinated manner which mesh with the long term primary health care plan. The following outline summarizes project intent and past achievements in Program Management.

PROGRAM MANAGEMENT

- OBJECTIVES
- .Strengthen program managers' skills
 - .Improve planning and problem solving
 - .Ensure program development and continuity
- INDICATORS
- .Number of countries with:
 - Program management training
 - Management information system
 - .Number of program managers trained
 - .Number of countries with work plans
 - .Number of countries with effective donor coordination groups
- ACHIEVEMENTS
- .Technical Officers provided on-the-job management training to counterparts
 - .Management training modules developed in 3 countries
 - .Over 300 health workers trained in program management in 3 countries
 - .National CCCD Symposium conducted for 350 health professionals in Zaire
 - .Inventories of management training resources completed in 12 countries.
 - .EPI, CDD, and Malaria work plans approved or pending approval in 12 CCCD countries
 - .Computerized Management Information System (MIS) established in 10 of 12 countries
 - .Donor coordination groups functioning in 12 countries
- INSTITUTIONALIZATION
- .Cadre of trained computer users in 10 countries
 - .Training collaboration established with universities or other institutions in 3 countries
 - .MOH commitments to inservice training in 5 countries
 - .Cost recovery systems established in 6 countries
- PROBLEMS
- .Inadequate inservice training for program managers
 - .Ineffective coordination of donor activities in some countries

3. Sustaining Project Efforts

The project proposes to concentrate its efforts on reducing under five mortality in a way that will strengthen African capability to continue these efforts after the project PACD.

Sustainability is defined as:

the ability of a program to deliver a high level of benefits after a donor ends major financial, managerial and technical support.*

Preliminary work performed by PPC/CDIE has identified four categories of factors or conditions that generate project sustainability; economic, project design, institutional and socio-political. ACSI-CCCD characteristics and process indicators for these factors were noted during the Fifth Year Evaluation under each category and overall project progress was summarized based on project design and performance.

Category 1. Economic and Financial

Factor Description: Project benefits are perceived by the host government and project beneficiaries to the extent that they are willing to provide the required resources. Thus quality services will be provided at a cost that beneficiaries and the government can afford.

ACSI-CCCD Project Characteristics:

-The ACSI-CCCD project design supports "selective" primary health care programs, requires no additional personnel be hired for implementation, and relies on low cost interventions.

-All ACSI-CCCD project countries must assume a growing percentage of project recurrent costs as the project matures.

-All missions have been requested to monitor host-country contributions.

-All project-country USAID's have been requested to develop a strategy to help host-countries meet their project recurrent costs.

-Seven person months of technical assistance have been reserved from the S&T/H REACH project to assist countries in developing health financing mechanisms and strategies.

* Definition and categories based on health project sustainability evaluations performed and internal working papers developed by PPC/CDIE. (These categories have since been revised by PPC/CDIE into two categories of factors, contextual factors and project characteristics.)

-REACH has developed a summary of AID health financing experience in Africa, to serve as a guide for mission and ACSI-CCCD staff.

-Almost all project countries have supported health financing or cost studies.

ACSI-CCCD Progress To Date:

Overall, national governments have not contributed the full share of the project costs as stipulated in their grant agreements (see next section on Child Survival Costs. Some countries are at least two years behind the grant's host country contribution schedule. There are, however, countries whose efforts are noteworthy: Zaire, Togo and Liberia have successfully generated enough revenue from fee-for-service and drug revolving fund mechanisms to cover a portion of health facility operating costs; CAR, Guinea and Liberia have been able to incorporate specific ACSI-CCCD line items into their national budgets, and Malawi and Guinea have exceeded their share of contributions stipulated in their grant agreement budgets.

Missions are only now beginning to monitor host-country contributions and have yet to request technical assistance using the 7 person months allotted from the REACH "buy-in." Strategies to assist host countries to meet their project costs will be formally developed during the extension design process.

Category 2: Project Design

Factor Description: After the start-up phase of the project, the project must continue to deliver benefits efficiently that are appropriate to the needs of those it serves. Interventions should be simple, low cost, and cost effective; activities should involve the private sector when appropriate, and be supported by the donor long enough to firmly establish maintenance.

ACSI-CCCD Characteristics:

As mentioned above, the ACSI-CCCD project design supports "selective" Primary Health Care programs, requires no additional personnel to be hired for implementation, and relies on low cost interventions.

-ACSI-CCCD supports integration of its activities into the country's existing PHC structure and external evaluators are requested to assess the integration of program and service delivery.

-ACSI-CCCD design permits flexibility in adding or subtracting interventions to conform to specific country needs.

-ACSI-CCCD project implementation for each country is based on the ability of the host-country to support these activities. Some projects are national while others are regional and many have scaled back implementation pace to fit the country's absorptive capacity.

-Most LOPs have been extended to five years and one (Zaire) to eight years.

-Private sector involvement in local production of ORS is beginning in Nigeria and Zaire, and is being explored in Cote d'Ivoire.

-Many countries have enlisted private sector involvement in intensified vaccination and ORT efforts.

ACSI-CCCD Progress To Date:

The interventions included in the project design tend to require two years start-up time and questions of PHC integration and private sector involvement only now are beginning to be addressed. The low cost of interventions and flexibility of the project design should help to insure sustainability.

Category 3: Institutional and Management

Factor Description: A viable institution(s) that has a structure and momentum of its own must exist to continue providing benefits after the end of the project. The institution will provide a framework for managing and organizing activities that are part of a larger effort. The institution will provide on-going training and coordination among ministries, reflect management and leadership capacity and promote decentralization, use of management information systems and supervision of performance.

ACSI-CCCD Characteristics:

-A program management strategy has been developed to strengthen management skills in planning, budgeting, problem solving, etc.

-All projects have begun training mid-level managers and service delivery personnel.

-A few countries have established training of trainers courses and decentralized training schedules.

-Supervisory schedules to strengthen service delivery performance and feedback are being developed.

-Some projects have worked with other ministries in implementing activities, (particularly in intensive vaccination efforts).

-Most projects have established donor coordination committees to insure cooperation and planning.

-Management information systems have been developed in all countries providing intermediate process indicators on program progress annually.

ACSI-CCCD Progress To Date:

Decentralized training programs have delegated to regional health personnel the responsibility and independence to perform their own training in continuing education programs. Formal course and on-the-job training in health education planning and application under the ARHEC and UNC* agreement will strengthen national health education units. The annual consultative meetings renew enthusiasm, allow nationals to share lessons learned and provide decision makers the most recent "state of the art" in disease control. Lastly, supervisory teams and management systems have produced on-going monitoring and upgrading of service delivery. Many countries that have supported intensified vaccination efforts have learned the benefits of enlisting other ministries in communication and mobilization activities and of using donor coordination committees.

Strengthening institutional and management capabilities will be one of the most important goals for the project as operational levels and disease targets are reached.

Category 4: Political, Policy and Socio-Cultural Context

Factor Description: An ability to deal with external factors, the inclusion of interest groups, a value for the services provided, local participation and an agreed upon direction for goals all must be characteristic of the project scope.

ACSI-CCCD Characteristics:

-The Congo project is, at the time of this evaluation, near termination because of lack of commitment on the part of the government.

-In the Cote d'Ivoire, the recent second year evaluation identified lack of commitment as a problem, which was resolved by the third year.

-Liberia and Togo have received national policy endorsement to implement health financing mechanisms and to allow revenue generated from health services to remain at the local level.

*Africa Regional Health Education Center and University of North Carolina

-CAR, Liberia and Guinea projects have received funding under specific ASCI-CCCD budget line items in the governments' national budgets.

-Almost all MOH's have approved intervention-specific national strategies and those involved in intensive vaccination efforts have obtained presidential level endorsement, both in participation and funding.

ACSI-CCCD Progress To Date:

Congo child survival activities have failed to receive sufficient support, (both monetarily and in human resources) to enable implementation of basic project activities. The Cote d'Ivoire MOH has also, to date, provided little support to ACSI-CCCD activities. AID project management has decided to terminate such projects after probation periods and deadlines, rather than support activities that are questionable in long term effectiveness.

Community co-financing of health services are good indicators of socio-political support. Studies of beneficiaries' willingness to pay for services and cost savings from preventive health activities are needed as soon as possible to foster continued socio-political support. The effect of intensive vaccination efforts, with their political and media support, on the development of sustainable programs is an unanswered question.

The project's efforts to date in management and decentralized training, health financing and cost studies, in HIS development and in adhering to its original design parameters is evidence that attempts have been made to insure sustainable programs.

In summary, it was recognized that projects have reached operational levels and can now begin to work actively on long-term goals of program self-sufficiency, and over-all PHC integration of intervention components at the service delivery level. Addressing questions of program sustainability and financial viability can not be postponed until after the PACD, but rather addressed and implemented concurrently with ongoing efforts to strengthen quality of service delivery.

The Evaluation report recommended the project develop a strategy for sustaining program efforts, also a recommendation made by the 1986 RIG audit. This strategy will take advantage of the work performed by PPC/CDIE, the suggestions from the 1986 RIG audit and 1987 Fifth Year Evaluation reports and experience from other child survival projects (HEALTHCOM, REACH, etc.). For example, the following significant relationships were found in the Honduras and Guatemala evaluations:

1. National commitment to project goals was essential to the sustainability of project outputs and benefits. Projects which pursued goals which were priority goals of the national government and for which there was general consensus among significant groups in the health sector were likely to be sustained.

2. Cooperative negotiations between AID and the ministry with regard to project objectives, design, and implementation contributed to sustainability. Projects which were negotiated in a mutually respectful process in which a consensus over goals, activities and implementing plans is established are more likely to be sustained than those which appear to be imposed by AID.
3. Vertically organized projects in several cases generated institutional resentment which jeopardized project sustainability. Integrated projects tended to be more sustained but at lower levels of effectiveness. Projects with stable qualified management both within the implementing agency and from AID are more likely to be sustained.
4. Projects that were perceived to be effective during the life of the project were more likely to be sustained than projects which were unable to achieve anticipated output.
5. Projects which provide for progressive absorption of recurrent project costs by the national budget are more likely to be sustained. (finding for Guatemala only)
6. Projects which provide significant training at either the professional or para-professional levels are likely to be sustained...Projects with enduring technical assistance are also more likely to be sustained.*

These known relationships will guide the participants in their extension design of the country projects in: 1.) stipulating national monetary and human resource commitment in the revised project agreements, 2) requesting MOH participation full time on extension design activities in determining project plans and objectives. 3) encouraging integration of project activities within existing MOH programs, and 3) planning and designing activities that will generate support and visibility for project progress.

Below is the draft sustainability strategy for the project. At the present project management is working closely with CDC, S&T/H, PPC/CDIE and other AID offices to fine-tune the strategy to reflect lessons learned and current state-of-the-art. The strategy includes a set of indicators and questions for project staff in designing new projects, in designing the existing projects for extension and in monitoring project progress towards a sustained status.

*Sustainability of U.S. Supported Health Programs in Honduras, Draft February 1987 and in Guatemala, Draft September 1987, PPC/CDIE

Sustainability Strategy

Objective: Strengthen national capability to continue ACSI-CCCD project benefits and activities after AID assistance is ended.

(Benefits = outcome = "improved child health")
(Activities = outputs = trained staff, functioning institutions, etc.)

Strategy: Promote and follow AID policies, procedures and assumptions that certain project characteristics generate sustainable programs.*

Provide program support in:

Designing projects: with at least 8 years of life
: with low-cost interventions
: that promote PHC integration
: with an implementation pace compatible with each country's absorptive capacity

Implementing activities in:

Training: .curriculum development
.training of trainers
.development of decentralized training programs

Operational Research: .review committee development
.training in conducting research

Health Information Systems: .micro-computer use
.use of data for decision-making
.development of Epidemiological Reports

Health Education: .training in behavioral analysis
.training in material development and use of mass media

Health Financing: .development of plans to meet project costs
.piloting alternative financing studies
.establishing ACSI-CCCD budget line items

Program Management: .inservice training
.collaboration with institutions/universities

Evaluating project efforts with a sustainability process indicator questionnaire and checklist.

*Assumptions that certain contextual factors and project characteristics are related to project sustainability.

PROCESS INDICATORS IN ACSI-CCCD OPERATIONAL AREAS

National Commitment to Project Goals

- .Existence of national policies on EPI, CDD, malaria, and PHC
- .Designation of Directors for each intervention (EPI, Malaria, Diarrhea Disease) program
- .Inter-ministry involvement (ministries of plan, finance, information and etc.) in child survival programs

Project Negotiation between AID and National Authorities

- .National involvement in the project extension design (in developing objectives, workplans, and etc.)

Institutional Organization of the Project

- .Integration of EPI, CDD, malaria and support activities into the established authority structure from central to local levels
- .Existence of functional units for the following:
 - Health Education Units
 - Operational Research Review Committee
 - Training Units
- .Existence within the MOH of a functional planning unit
- .Existence within the MOH, the ability to supervise and manage its employees
- .Existence within the MOH, recognition (remuneration) and access to career advancement to employees

Financing

- .Existence of a government plan to cover project costs
- .Increase in government assumption of project costs
- .Existence of a national policy on community co-financing of public health services
- .Increase in the preventive health budget from the previous year

Training

- .Existence of a viable in-service training capability in the MOH
- .Existence of a decentralized in-service training structure
- .Existence of an evaluation/monitoring system within the training program
- .Existence of pre-service training in child survival strategies in the medical training institutions

The following questions* are posed to help prepare initial plans for building the conditions of sustainability into a new program, to test progress and to determine its achievement when external assistance is terminated. These questions should be applied to a program at all levels of operations - national, regional and village.

1. Is there agreement among the principal participants on the objectives of the program or, at least, a comparability of objectives and motivations?

Comment: Lack of agreement is often cited as a cause for program failures both before and after assistance is terminated.

2. Is there commitment to the program at policy, operations and beneficiary levels as evident in allocations of time and money? Are these resources increasing? Is there a demand for the program's services particularly from the beneficiaries?

Comment: Sustainability and auto-financing are not the same. In most countries, auto-financing is, of course, essential to sustain operations. It is also a reflection of commitment to the program and the demand for its services. There is the danger that external assistance obscures differences of commitment to program objectives. The donors' interest, enthusiasm and funding can not substitute for local involvement and commitment. Also there is a tendency for programs supported by external assistance to be supply driven and fail to promote and build local demand. Demand for services is a key test for sustainability.

3. Is there an understanding of roles and responsibilities among the principal participants and complementary organizations within the program and outside of the program structure itself?

Comment: Lack of clarity on this point is among the most frequently cited problems affecting program operations and sustained support. One of the tests of effective managerial leadership is the ability to promote the cooperation of a wide range of constituencies and support groups.

4. Is there a professional, managerial and operational capacity to maintain and develop each component of the program, individually and collectively?

Comment: The development of local competence and organizational systems to carry out development programs is a primary objective of external assistance. Often this assistance focuses on the technical and funding aspects of the program and does not give adequate attention to management and supervision or to logistics and maintenance - both vital parts of a sustained program.

*Checklist provided by Fifth Year Evaluation Panel Member Mr. Haven North, AAA/PPC/CDIE.

5. Is the project-supported technology appropriate to local conditions and capabilities?

Comment: Sometimes the "best" is not the wisest choice for sustainability. The choice must be weighed against practical questions of sustainable costs, administrative and organizational capacities and beneficiary acceptance i.e., sustained demand.

6. Does the program have the capacity to adapt to changing circumstances in time of adversity as well as opportunities for innovation, growth and change in focus or technology?

Comment: A well established program through demand for services and constituency building should be able to withstand adversity whether economic or political and make skillful adaptations to cope with changing environments. Similarly its leadership should be knowledgeable about new developments and opportunities to avoid being by-passed when these opportunities arise.

7. Is there a capacity for regeneration and for maintenance of professional and managerial skills?

Comment: It is not sufficient for a sustainable program to have only a competent staff in place; there also must be mechanisms for continuous regeneration and replacement of staff capabilities.

8. Are the financial, personnel and information resources in balance and consistent with the objectives?

Comment: Frequently, either the staff and/or funding for a program are out of balance with each other and both with the objectives. Objectives are often too ambitious for the time frame set for the program as well as the resources available from the support groups. Effective information systems built on empirical data are essential for sound management of a program to enable it to adjust to changing situations and maintain credibility and support.

9. Have the dynamics of the program moved from the demonstration stage (establishing credibility and participation) to an established capacity to meet objectives?

Comment: The pressure to achieve operational objectives rapidly works against longer term efforts to build institutional and managerial capacities. (The exception would be in cases where a substantial institutional capacity already

exists to support the new program.) Yet evidence that a program can provide useful services promptly is important to its acceptance. Given an adequate time frame, say ten years, the development program should evolve from an early period of demonstration to institutionalization. Too frequently external assistance is terminated before the institutionalization phase has been completed. Donor/technical assistance roles may shift during this continuum from operational responsibilities to advisory assistance.

The project is encouraged to actively address this issue of sustainability now, rather than after the project is over. In the development of this sustainability strategy, the following questions still need to be answered:

.What continuing resources (monetary and human) are necessary for sustaining this project's activities and benefits?

.Should the project be responsible for insuring sustained program activities and benefits, as well as behavioral change, ("sustainability of the health related behavior impact"*)?

.What kind of information should be collected to provide an indication of the host-country's ability to sustain these benefits, (indicators or factors of sustainability) while the project is operating?

.Should sustainability be synonymous with "self-sustaining" or "self-financing"?

.If the target of our efforts is continuation of project benefits after 1995, should project management plan to measure attainment of this target, years later? Should we develop measureable targets for sustainable programs or institutionalization?

4. Health Financing Under New Amendment

Under the new amendment, assistance to ACSI-CCCD project countries in health financing will be emphasized to a greater extent simply because of the obvious role health financing plays in sustaining project activities. The Agency has recognized the important role financing plays in health care and has demonstrated this recognition in its Agency Health Financing Strategy Guidelines and the provision of technical assistance in the Resources for Child Survival (REACH) project.

* Success Criteria For ORT Programs and An appeal to Consumers (Distinguished Planners) Preferences, August 1987 Carl Stevens

Both ACSI-CCCD and REACH projects plan to collaborate in developing an ACSI-CCCD health financing guide that will assist project staff in strengthening host-country ability to finance its health activities. This guide will be based on the accumulative experience of all 10 ACSI-CCCD countries in cost-recovery and cost-analysis as well as the experience of other countries around the world.

Host-country progress in establishing mechanisms for cost-recovery has been varied. Zaire, Togo, Liberia and Guinea, have all nationally endorsed community co-financing and have taken advantage of ACSI-CCCD technical assistance in improving existing or in initiating new cost-recovery programs. The first three countries above have successfully generated enough revenue from fee-for-service and drug revolving fund mechanisms to cover a portion of health facility operating costs. CAR, Burundi and Rwanda have just recently developed their plans and begun pilot studies. With the exception of Nigeria, other project countries have been quite reluctant to alter their "Health is Free" policy. Nigeria has proved to be one of the more progressive in applying alternative health financing schemes. Johns Hopkins under the Pritech component of the Nigeria ACSI-CCCD project is analyzing financial planning and budgeting processes with the use of workshops and situation analysis to improve practices in 2 pilot states.

Much work remains to be done in ACSI-CCCD countries in this area. In general this work with host-countries will be focused on:

1. increasing beneficiary payments for services
2. increasing efficiency in the system to reduce costs
3. re-allocation of resources within the health system

Increasing beneficiary payments will probably continue to receive the most attention because it appears the most-promising in Africa. The percentage of recurrent costs recovered from user fee programs varies in African countries, from 2.2% in Swaziland (1985) to 80% in Zaire (1986).*

The following is a summary of activities suggested by REACH to be performed in ACSI-CCCD countries in the area of health financing:

Zaire

- o Systems development
 - develop options for financing central offices
 - develop models of improved cost recovery systems
 - develop a model financial MIS

*Dunlop, David 1987

- o Assist MOH in studying policy questions including:
 - self-financing issues of cross-subsidization and GOZ subsidy of zones
 - analysis of financing and impact of parallel health care delivery systems
 - need for TA in pricing and demand studies
 - cost recovery of investment costs in third-party payment systems
- o Support for training
 - develop training material, train, monitor and evaluate
 - train local management committees
 - finance training at local levels

Liberia:

- improve the provision of needed commodities and human resources
- assess current cost recovery programs in effect and make recommendations for improved implementation and expanded efforts

Rwanda:

- Begin charging patients for drugs with the objective of covering cost by purchasing and distributing an adequate supply of drugs. (use demonstration communes to phase-in resolving drug fund beginning with chloroquine and ORS in the one province)
- Perform a feasibility study to explore opportunity for locally controlled system of health cards after a drug fund has been put into operation

Togo:

- Development of materials on "Why and How" villages should undertake self-financing
- Organize a seminar for mid-level MOH staff
- Develop promotion programs
- Coordinate acquisition of health cards

Guinea:

- Additional consultancies to assist MOH in developing payment structural options
- Assist in preparing and implementing test cost recovery system
- evaluation of project progress in cost recovery

CAR:

- Develop 2 forms of payment to improve equity and efficiency (fee-for-service and prepayment)
- evaluate above forms of payment

Cote d'Ivoire,
Swaziland,
Malawi,
Lesotho,
Burundi:

Consultancy on assessing existing health financing practices and to recommend additional assistance if needed.

Nigeria:

Continue as planned ACSI-CCCD funded Health Financing Planning and Management Project Component under direction of Pritch/Johns Hopkins direction.

Child Survival Costs and Plans for Host-Countries to Meet CCCD Project Costs:

Although Primary Health Care is relatively less expensive than other health strategies, its benefits still rely on extensive coverage. The original CCCD Project Paper (PP) openly doubted whether African countries could assume total program costs for immunizations and Diarrhea Disease and Malaria Control. The following paragraphs are quoted from the 1981 PP:

"The costs of continuing the immunization program once the donor input terminates have not been estimated. PHC costs are high and population pressures will exacerbate the problem; and foreign exchange is a major constraint for most of the African countries. Hence, program continuation may well hinge on long term donor assistance, for even the marginal cost of adding immunizations to existing systems may be unaffordable for the low income countries of sub-Saharan African.

Since project initiation, there have been several attempts to estimate costs of national "CCCD" programs. For the first nine-months of CCCD project implementation, national child survival program totals constituted approximately \$3,310,000 and \$950,000 U.S. dollars for Malawi and Swaziland, respectively.* Since these totals illustrate recurrent and capital inputs in the start-up phase of these child survival programs, costs should decrease as the programs mature. It should be noted that Swaziland,

"with about one-tenth the population of Malawi, had greater total costs per person (\$1.38 versus \$0.50), which could have been related to considerably higher per capita income of Swaziland (approximately four times as large as Malawi's \$210 in 1983) as well as to other factors."*

The majority of all country-specific projects have received an economic assessment as part of their second year external evaluations. Most consultants found evidence that host-countries could eventually assume local project costs by charging fees for services and for drugs (chloroquine and ORS), but not in the near future the costs for vaccines and vehicles which require foreign exchange.

*Uses of Cost Analyses in Child Survival Programs: Evidence from Africa, Qualls and Robertson. Draft October 1987

The primary element of the ACSI-CCCD project's involvement with health financing has been in its assistance to countries to meet their "CCCD-specific" project costs. Although the 1986 RIG audit had concluded that host-countries were not contributing their increased percentages of project costs as stipulated in the project agreements, the 1987 financial analysis performed found contributions to have improved:

000's

Country	Pro Ag Requirement	Actual Contribution	%
Burundi	233	76	33%
C.A.R.	217	87	40%
Congo	500	72	14%
Guinea	190	354	186%
Cote d'Ivoire	UnKnown	UnKnown	UnKnown
Lesotho	236	166	60%
Liberia	126	72	57%
Malawi	1,331	772	58%
Rwanda	810	574	71%
Swaziland	988	600	61%
Togo	373	230	62%
Zaire	4,849	1,395	29%

The extension design activities scheduled for this upcoming year will work with ministry of health personnel in developing a plan to meet ACSI-CCCD costs. Most plans will include the grant's schedule of contributions with an explanation of how the ministry will increase its contribution, (increase in user fees, reallocation of resources, etc.). As recommended by the 1986 RIG Audit, implementation pace will be adjusted to a country's absorptive capacity and contribution capability.

REACH technical assistance will be of major importance to mission and ministry officials in determining ways for governments to assume costs in a phased approach.

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title: AFRICA CHILD SURVIVAL INITIATIVE - COMBATTING CHILDHOOD COMMUNICABLE DISEASES

NARRATIVE SUMMARY	OBJECTIVES/VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Goal: To improve the health of the pediatric population of sub-Saharan Africa.</p>	<p>50% reduction in disease specific mortality rates for diseases preventable by immunizations, diarrhea disease and malaria in the age groups 0-5, reduction by 75% of disability from polio and an overall reduction in infant and childhood mortality by 25%.</p>	<p>Serial mortality studies in a sample of countries and lameness surveys.</p>	<p>Adequate baseline data will be available or will be collected by special surveys.</p> <p>Participating gov'ts will support the development and maintenance of data collection systems.</p>
<p>Purpose: Strengthen the Africans' ability to control:</p> <ul style="list-style-type: none"> -Six childhood communicable diseases (measles, polio, tuberculosis, diphtheria, pertussis and tetanus through the Expanded Program for Immunization (EPI). -Diseases of local importance such as yellow fever and yaws. -Provide simple treatment for the Control of Diarrheal Diseases (CDD), and malaria. 	<p>Conditions that will indicate purpose has been achieved: End of project status:</p> <p>80% of target population in AID supported countries fully immunized against the six EPI diseases.</p> <p>90% of cases of acute diarrhea and fevers effectively treated in facilities.</p>	<p>Immunization coverage surveys, diarrhea and malaria treatment practice surveys and facility case treatment reports.</p>	<p>Participating countries will continue to place a high priority on CDD and developing PHC programs and will provide adequate resources to support these activities. WHO and other regional organizations will continue to provide support and training in developing country-specific health care programs. Participating countries will actively seek participation in CDD programs.</p>

Outputs:

1. No. of countries with CCD projects	1. 30 countries with CDA supported CCD projects, 14 with AID support	1. CCD management information system	Participating countries will make adequate & appropriate personnel available for participant training, health information systems. Alternative financing systems will be piloted.
2. Trained Personnel	2. 20,000 upper, mid and peripheral health personnel trained	2. Evaluations	
3. Health Education Programs	3. health education campaigns completed in 14 countries		
4. Health Information Systems	4. CCD health information systems operational in 14 countries		
5. Operational Research Projects	5. operational research projects completed in 15 countries		
6. Sustained programs			

Inputs:

(000's)			
1. Technical Assistance	\$45,700	2,038 P.M.	1. CCD management information systems
2. Training	\$12,700	11,800 P.M.	2. Evaluations
3. Health Info. Systems	\$ 3,100		3. Quarterly implementation
4. Health Education	\$ 4,000		
5. Operational Research	\$ 2,700		
6. Commodities	\$36,750	vehicles, vaccine, cold chain equip.	MOH's develop ways and means of distributing and utilizing: a. Oral rehydration salts b. CCD health promotion materials.
7. Special AIDS Fund	\$ 4,000		Participating country has ability to provide personnel, building space and other support. T/A personnel can be recruited and assigned to project as needed.

52

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only: B(1) applies to all projects funded with Development Assistance; B(2) applies to projects funded with Development Assistance loans; and B(3) applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 1988 Continuing Resolution Sec. 523; FAA Sec. 634A. If money is sought to obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified?
2. FAA Sec. 611(a)(1). Prior to an obligation in excess of \$500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?
3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

Yes. CN submitted 9/13/88. If there are significant changes in planned FY 89 obligations, another notification will be submitted.

Yes.

N.A.

4. FAA Sec. 611(b); FY 1988 Continuing Resolution Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) N.A.
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? N.A.
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. ACSI-CCCD is a regional project.
7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to:
 (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.
 a. No
 b. Yes
 c. No
 d. Yes
 e. No
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).. N.A.
9. FAA Secs. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars. Project agreements require host country assumption of local currency costs. U.S. dollar is used primarily for foreign exchange costs.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No
11. FY 1988 Continuing Resolution Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N.A.
12. FY 1988 Continuing Resolution Sec. 553. Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel? No
13. FAA Sec. 119(g)(4)-(6). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas? N.A.

14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? N.A.
15. FY 1988 Continuing Resolution. If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? N.A.
16. FY Continuing Resolution Sec. 541. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.? N.A.
17. FY 1988 Continuing Resolution Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has prior approval of the Appropriations Committees of Congress been obtained? N.A.
18. FY Continuing Resolution Sec. 515. If deob/reob authority is sought to be exercised in the provision of assistance, are the funds being obligated for the same general purpose, and for countries within the same general region as originally obligated, and have the Appropriations Committees of both Houses of Congress been properly notified? N.A.
19. State Authorization Sec. 139 (as interpreted by conference report). Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision). Yes

1986 ANNUAL REPORT

AFRICA
CHILD
SURVIVAL
INITIATIVE



COMBATTING
CHILDHOOD
COMMUNICABLE
DISEASES

AFRICA REGIONAL PROJECT
(698-0421)

AGENCY FOR INTERNATIONAL DEVELOPMENT
In Cooperation With

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL
INTERNATIONAL HEALTH PROGRAM OFFICE
ATLANTA, GEORGIA 30333

Participating Agency Service Agreement
PASA No. BAF 0421 PHC 2233

- 58 -

INTRODUCTION

"The A.I.D. Combatting Childhood Communicable Diseases (CCCD) project, authorized in September 1981, is maturing nicely and has been well received in Africa. Twelve countries have signed bilateral agreements and interest in the program is still growing. A.I.D. has a unique opportunity to contribute to an important international African health program. Continuation of the program over the next 5-10 years can make a major contribution to the reduction of African childhood morbidity and mortality."

— REPORT OF THE FOURTH YEAR EXTERNAL EVALUATION OF THE CCCD PROJECT, 1986

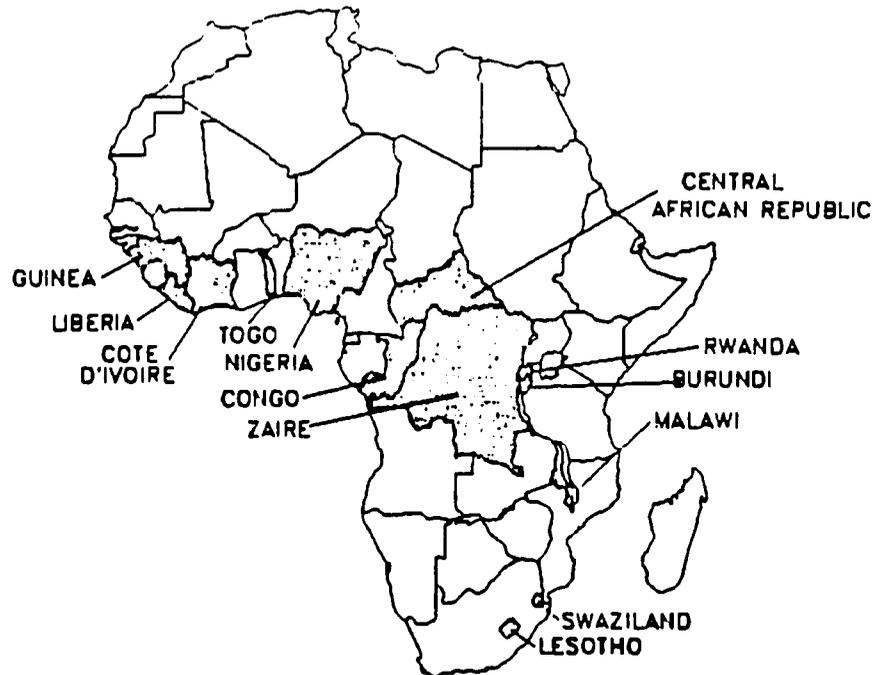
A.I.D. implemented a recommendation of the evaluation with a project amendment increasing the authorized ceiling of bilateral projects from 12 to 14; authorizing a 2-year extension (through Fiscal Year 1991); and increasing life of project funding from \$47 million to \$89 million. Late in the year, the 13th — and largest — bilateral project was initiated in Nigeria. The amendment also renamed CCCD as the AFRICA CHILD SURVIVAL INITIATIVE—COMBATTING CHILDHOOD COMMUNICABLE DISEASES (ACSI—CCCD). For brevity, the traditional "CCCD" will be used throughout this report.

The Third CCCD Consultative Meeting was held in Brazzaville in March. In recognition of WHO's designation of 1986 as AFRICA IMMUNIZATION YEAR, the meeting emphasized immunization activities and was jointly sponsored by CCCD and WHO. This year's meeting was the largest yet, with nearly 200 participants. The presentations were of great interest and high quality, stimulating animated discussion and demonstrating both the impressive progress the national child survival programs are achieving and the challenges which must be met if further gains are to be made.

Some of these challenges were presented in the CCCD 1985 Annual Report in the pages devoted to "MAJOR CONSTRAINTS AND REMEDIAL ACTIONS." New and continuing challenges as well as examples of how project countries are facing these challenges will be found throughout the 1986 report. Because of the fundamental importance to successful project implementation which some of these challenges represent, this year's report includes sections specifically devoted to SUSTAINABILITY, PROGRAM MANAGEMENT, and IMPACT MONITORING. The growing threat of Acquired Immunodeficiency Syndrome (AIDS), though not directly a CCCD challenge, is of particular importance in Africa and a special section is included to describe how CCCD is dealing with the AIDS problem.

As the premier, pioneering, and largest A.I.D. Child Survival project, CCCD has a special responsibility to seek solutions to problems faced by health workers and others engaged in Child Survival programs everywhere. We hope the reader will find information and experiences in the following pages which will be useful in addressing similar challenges. Comments and suggestions which could make future reports more useful will be welcome.

USAID BILATERAL CCCD PROJECTS



COUNTRY	TOTAL POPULATION (000)	START	FINISH	USAID BUDGET \$ (000)	LOCAL BUDGET \$ (000)
ZAIRE	35 300	8/82	12/91	6 849	4 167
TOGO	3 100	4/83	*7/88	1 140	373
LIBERIA	2 390	8/83	8/88	830	217
C A R	2 630	5/84	5/89	691	217
LESOTHO	1 522	5/84	5/88	664	375
MALAWI	7 279	6/84	3/88	1 423	1 331
RWANDA	6 040	6/84	5/88	1 072	956
CONGO	1 920	6/84	6/88	667	500
SWAZILAND	700	6/84	6/88	703	285
GUINEA	6 100	6/85	12/87	885	650
COTE D'IVOIRE	11 000	6/85	4/89	1 691	5 014
BURUNDI	4 800	9/85	3/88	834	233
NIGERIA	99 000	12/86	9/91	14 450	28 957
TOTAL	181 781				

* Proposed

60

THE CCCD PROGRAM

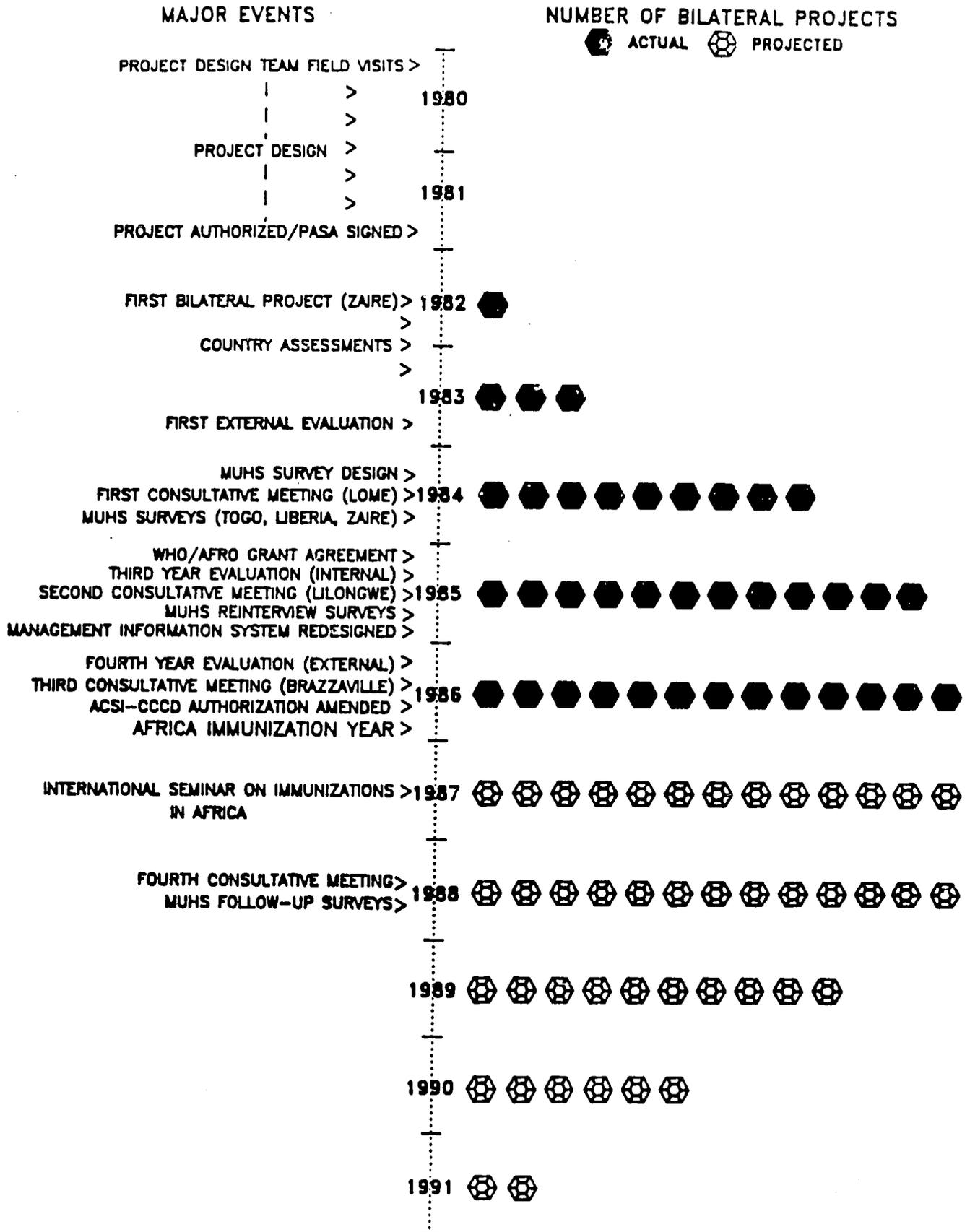
- OBJECTIVE** Reduce morbidity and mortality of African children by strengthening national capacity to:
- Immunize infants and women of childbearing age
 - Provide appropriate case management, including Oral Rehydration Therapy, for children with diarrhea
 - Provide appropriate treatment of children with fever/malaria
 - Provide malaria chemoprophylaxis to pregnant women

- STRATEGY** Promote and follow World Health Organization (WHO) policies and procedures and provide program support through the following intercountry and bilateral services:
- Training
 - Operational Research
 - Health Information Systems
 - Health Education
 - Technical Cooperation

INDICATORS AND SPECIFIC TARGETS IN CCCD OPERATIONAL AREAS:

<u>Indicator</u>	<u>Baseline Levels</u>	<u>End of Project Targets</u>
Infant Mortality	100-200/1000	25% Decrease
1-4 Mortality	10-20/1000/Year	25% Decrease
Neonatal Tetanus Mortality	5-20/1000	25% Decrease
Measles Mortality	2-8/1000	50% Decrease
Vaccination Coverage (<1 year age group)	10%	80%
Newborn Tetanus Protection	5%	50%
Health Facility Use of ORT	1%	50%
Community Use of ORT	1%	20%
Appropriate malarial treatment in health facilities	50%	90%
Appropriate malaria treatment ^o in communities	30%	80%

CCCD TIMELINE

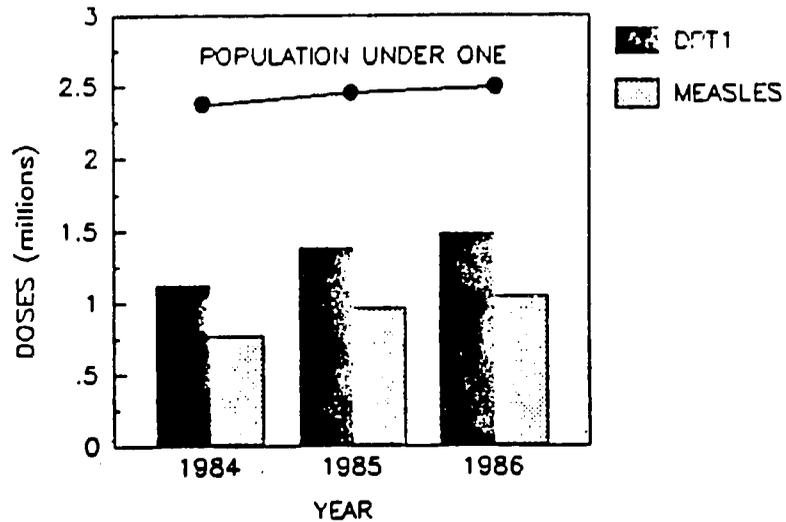


62'

IMMUNIZATION

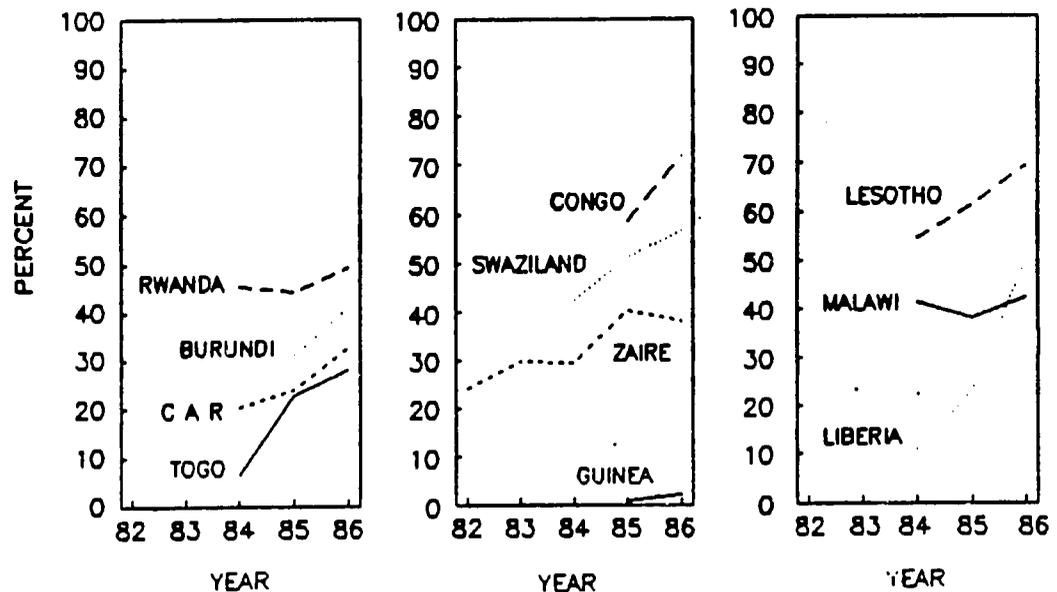
- OBJECTIVES**
- o Reduce morbidity and mortality of childhood diseases preventable by immunization
 - o Administer each injection with a sterile needle and sterile syringe
 - o Achieve 80% vaccine coverage with BCG, measles, 3 doses of DPT and 4 doses of OPV by 1 year of age
 - o Achieve 80% coverage with 2 doses of tetanus toxoid in pregnant women by the time of delivery
- INDICATORS**
- o Percent of injections administered with a sterile needle and sterile syringe
 - o Number of vaccinations administered
 - o Percent of children fully vaccinated by 1 year of age
 - o Number of reported cases and deaths from target diseases
 - o Polio and measles vaccine efficacy
- ACHIEVEMENTS**
- o National sterilization guidelines developed
 - o Training conducted in correct equipment sterilization procedures
 - o 1.7 million children under 1 year of age vaccinated with DPT1 and 1.2 million children with measles vaccine
 - o Increased vaccination coverage in 8 of 12 countries
 - o Major polio vaccine efficacy study of killed and live poliomyelitis vaccines
- INSTITUTIONALIZATION**
- o Expanded Program on Immunization units functioning in the Ministry of Health of all bilateral countries
 - o Capability at the national level of most CCCD countries to conduct vaccination coverage surveys
 - o Faster routine reporting and analysis of cases of vaccine-preventable disease and the number of immunizations given in 5 countries
 - o Public recognition and support of immunization programs by heads of state
- PROBLEMS**
- o Limited access and coverage in rural areas
 - o Potential for community participation not fully realized
 - o Measles occurring in children less than 9 months of age
 - o Inadequate sterilization of injection equipment
 - o Epidemic poliomyelitis in vaccinated populations
 - o High percentage of children fail to complete the vaccination series
 - o Difficulty documenting the impact of immunizations on disease

TOTAL DOSES OF DPT1 AND MEASLES VACCINE GIVEN TO CHILDREN < 1 IN EIGHT COUNTRIES WITH CCCD PROJECTS (BY YEAR) SINCE 1984*



* C A R, CONGO, LESOTHO, LIBERIA, MALAWI, RWANDA, TOGO, ZAIRE

APPROXIMATE PERCENTAGE** OF CHILDREN RECEIVING MEASLES VACCINE BEFORE THEIR FIRST BIRTHDAY IN CCCD COUNTRIES SINCE THE PROJECT AGREEMENT DATE THROUGH 1986

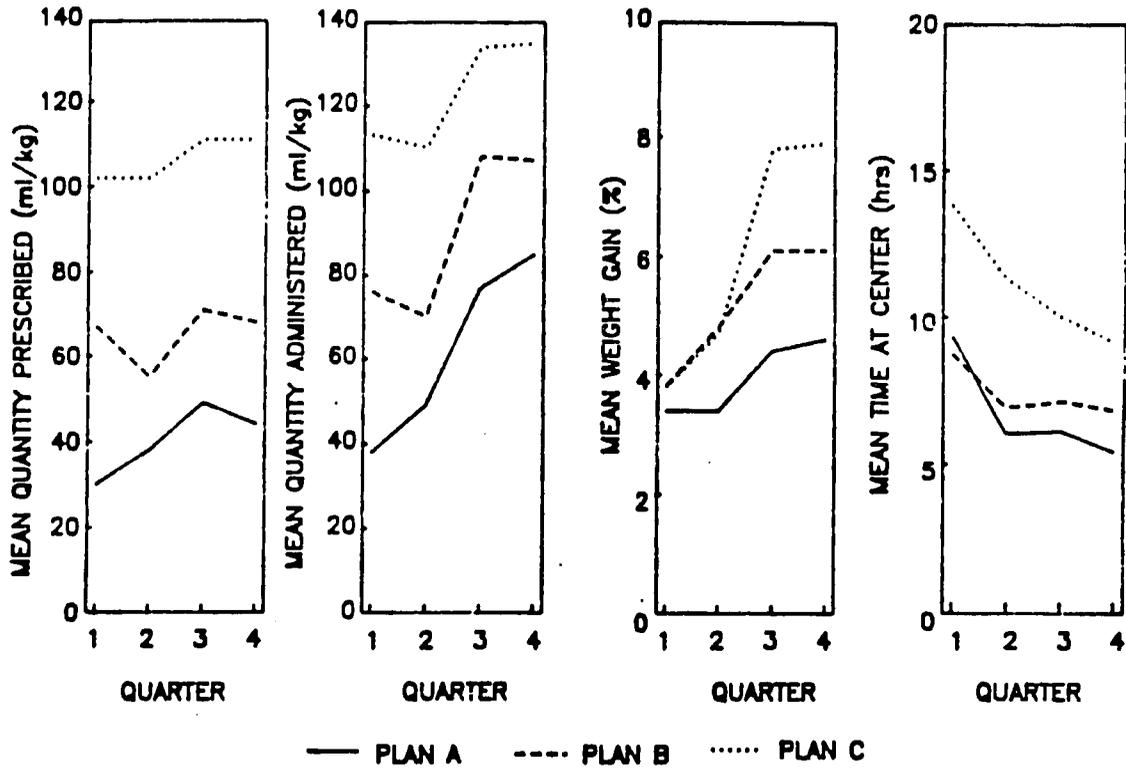


**Doses administered to children under one divided by estimated number of births

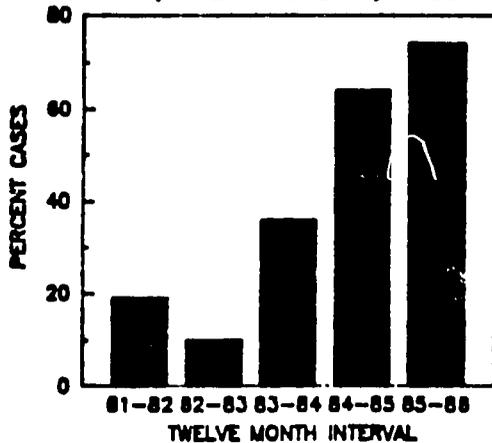
DIARRHEAL DISEASE CONTROL

- OBJECTIVES**
- o Reduce mortality due to dehydration secondary to acute watery diarrhea
 - o Improve clinical management of diarrheal disease at health facilities
 - o Prevent dehydration through the promotion of appropriate home management of acute diarrhea
- INDICATORS**
- o Proportion of diarrhea cases appropriately managed in health facilities
 - o Hospital case fatality rates for acute diarrhea
 - o Proportion of cases of diarrhea appropriately managed at home
 - o Diarrhea-associated mortality in children < 5 years of age
- ACHIEVEMENTS**
- o Surveys of diarrhea case management practices at home and in facilities conducted in 5 countries
 - o Analyses of sugar-salt solutions identified problems in current strategy and the need to develop alternate approaches
 - o At Mama Yemo, the mean quantity of fluid administered for each treatment plan increased, and the time required for rehydration decreased
- INSTITUTIONALIZATION**
- o National CDD policies adopted or drafted in 11 countries
 - o ORT demonstration and training units functioning in 8 countries (as compared to 5 in 1985)
- PROBLEMS**
- o Full-time program coordinators not designated in 7 countries
 - o Insufficient emphasis on hands-on training of health personnel at peripheral levels
 - o Inadequate application of appropriate case management techniques in the home
 - o Greater emphasis needed on nutritional aspects of diarrheal disease prevention and treatment
 - o Strategies not developed for the management of specific causes of high mortality, such as chronic diarrhea and dysentery

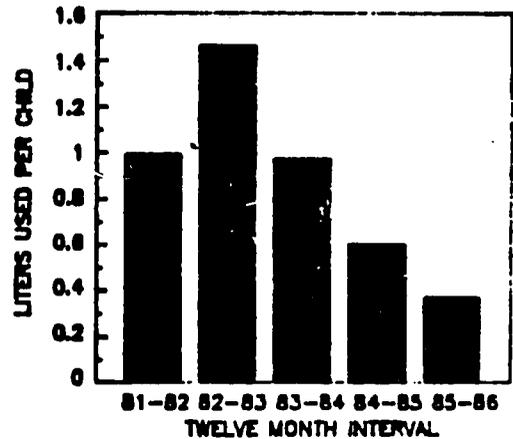
**SUMMARY OF ORT OPERATIONAL INDICATORS
MEAN VALUES, BY QUARTER AND BY TREATMENT PLAN
MAMA YEMO HOSPITAL, KINSHASA, ZAIRE, 1986**



**PERCENT OF CHILDREN HOSPITALIZED WITH MILD/MODERATE DEHYDRATION TREATED WITH ORS AND NO IV FLUIDS OR ANTIBIOTICS
KAMUZU CENTRAL HOSPITAL, LILONGWE, MALAWI
JULY 1, 1981 - JULY 1, 1986**



**MEAN IV FLUID VOLUME, HOSPITALIZED CHILDREN WITH DIARRHEA
KAMUZU CENTRAL HOSPITAL, LILONGWE, MALAWI,
JULY 1, 1981 - JULY 1, 1986**

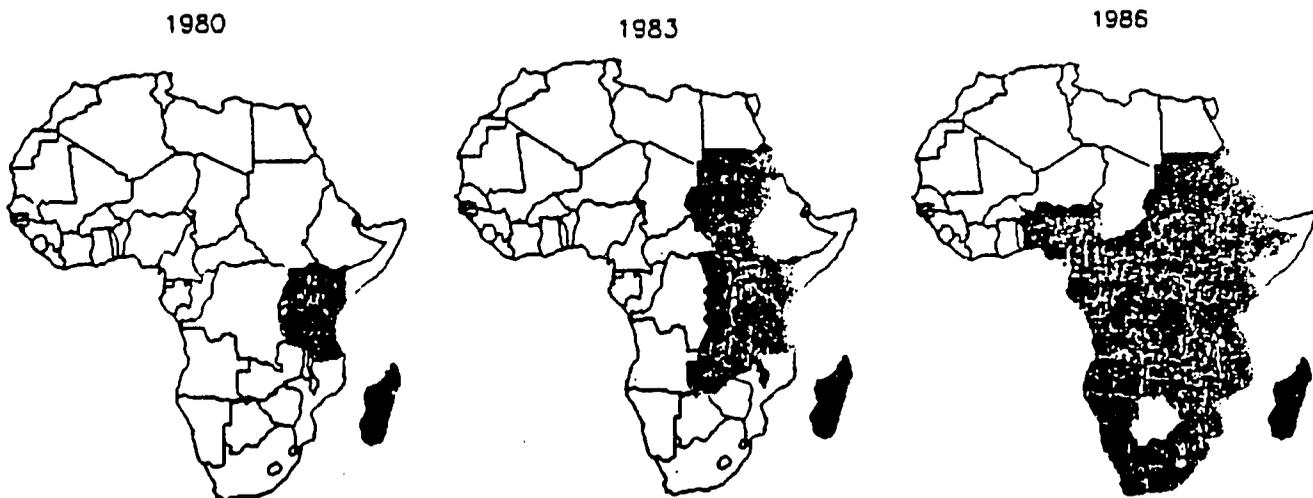


66

MALARIA

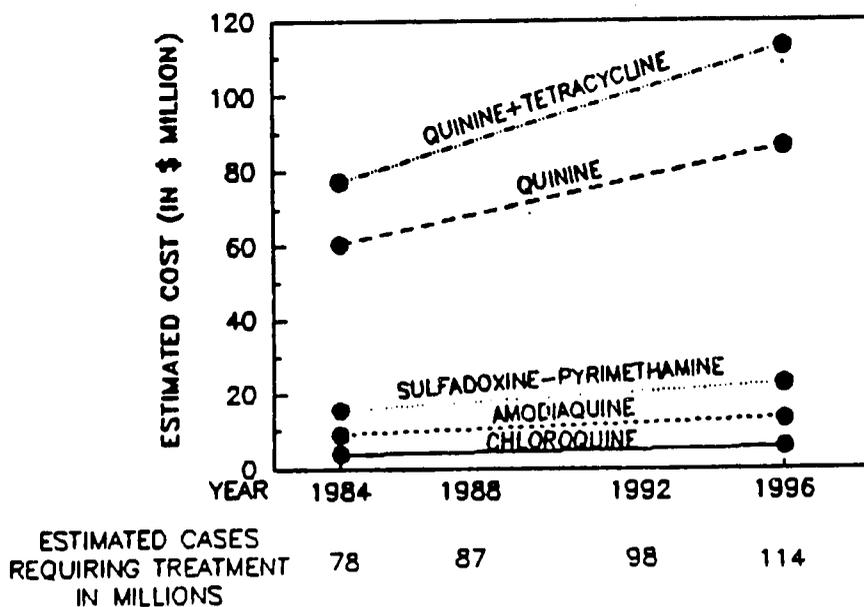
- OBJECTIVES**
- o Reduce deaths due to malaria in children < 5 years old
 - o Reduce maternal and infant morbidity and mortality due to malaria during pregnancy
 - o Develop effective national strategies for clinical management of malaria at health facilities and for presumptive treatment in communities
 - o Develop sentinel surveillance for malaria parasite drug sensitivity
- INDICATORS**
- o Number of countries with national malaria policies
 - o Number of countries with sentinel surveillance for drug sensitivity
 - o Number of severe malaria cases and deaths reported from sentinel facilities
 - o Percentage of health facilities using recommended treatment procedures for malaria
 - o Percentage of fever cases in the community treated appropriately
- ACHIEVEMENTS**
- o Studies measuring in vivo response to chloroquine carried out in 6 countries
 - o Treatment recommendation of 25 mg/kg of chloroquine adopted in most CCCD countries
 - o Studies of response to chloroquine and other drugs among pregnant women and of use of chloroquine during pregnancy carried out in 2 countries
 - o Feasibility of investigating the effect of antimalarial drugs during pregnancy on birthweight and infant survival demonstrated during preliminary studies in Malawi
 - o Practices in the treatment of children with fever/malaria in health facilities and at home assessed in 3 countries
 - o Health staff from Burundi, Guinea, and OCCGE trained during Cote d'Ivoire study and training exercise
- INSTITUTIONALIZATION**
- o National malaria control plans developed in 11 of 12 malaria endemic countries
 - o Previously trained malaria staff carried out drug response studies in 4 countries
- PROBLEMS**
- o Impact of CCCD interventions on severe disease and death not documented
 - o Limited effectiveness of recommended chloroquine prophylaxis during pregnancy because of drug resistance and poor compliance
 - o Decreased chloroquine sensitivity detected in West Africa
 - o Higher cost of second line drugs

SPREAD OF CHLOROQUINE RESISTANT PLASMODIUM FALCIPARUM IN AFRICA



IMPLICATIONS OF INCREASING RESISTANCE OF PLASMODIUM FALCIPARUM ON COST OF ANTIMALARIAL DRUGS IN AFRICA

ESTIMATED COSTS OF MALARIA DRUG TREATMENT BY YEAR, 1984-1996, AND BY DRUG



Adapted from D. Clyde

68

TRAINING

OBJECTIVES

- Improve skills of health workers in delivering curative and preventive services
- Strengthen countries' capabilities to plan, conduct, and evaluate training
- Assist countries in assessing training needs and identifying training resources
- Integrate appropriate technical information into curricula of health training institutions

INDICATORS

- Number of countries with:
 - national training plans
 - decentralized training
 - continuing education plans
- Number of countries conducting training needs assessments to measure both the need for and the effectiveness of training
- Number of health workers trained

ACHIEVEMENTS

- Developed training plans in 3 countries
- Completed local adaptation of peripheral level training materials in 4 countries
- Carried out training needs assessments in 3 countries
- Initiated decentralized training in 9 countries

INSTITUTIONALIZATION

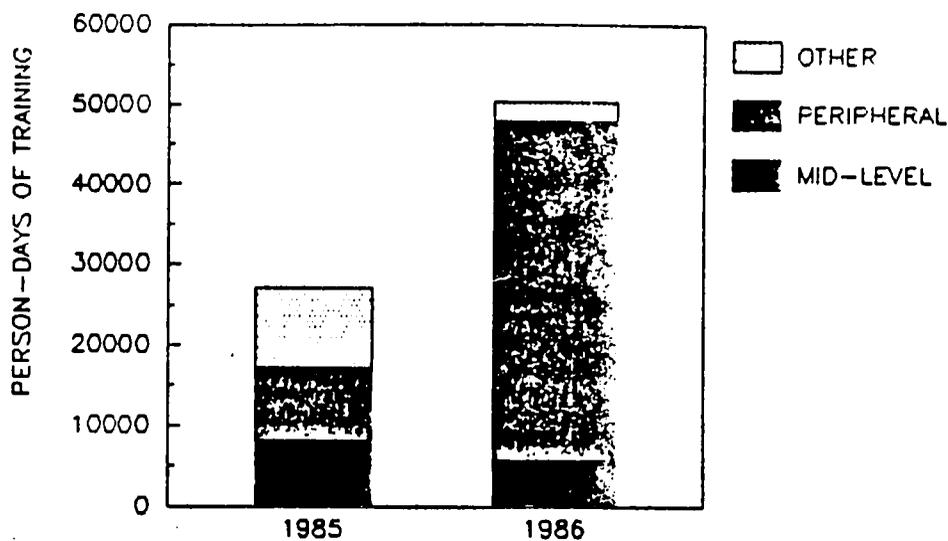
- Allocation of core group of trainers to provide peripheral training in 4 countries
- Decentralized training instituted in 1 country

PROBLEMS

- Inadequate plans and/or implementation of regular continuing education for peripheral personnel (12 countries)
- Slow or no integration of national technical guidelines into curricula of training institutions
- Lack of coordination of training with the availability of equipment, supplies, and drugs needed to utilize the training
- Lack of supervisory system to evaluate performance, assess effectiveness of current training, and identify training needs for facilities

GA

PERSON-DAYS OF TRAINING
1985-1986



STATUS OF CCCD TRAINING ACTIVITIES, BY COUNTRY

ACTIVITY	BURUNDI	C A R	CONGO	COTE D'IVOIRE	GUINEA	LESOTHO	LIBERIA	MALAWI	RWANDA	SWAZILAND	TOGO	ZAIRE
IDENTIFY TRAINING COORDINATOR	●			●		●	●	◐	●			●
DEVELOP 1 YEAR TRAINING PLAN (1987) WITH SPECIFIC CONSULTANT NEEDS AND COORDINATION WITH OTHER AGENCIES INVOLVED IN TRAINING	●	●		●		●	●		●	◐		●
ADAPTATION OF TRAINING MATERIALS FOR PERIPHERAL-LEVEL WORKERS	◐	◐	◐	●		●	●	●	●	◐	◐	◐
TRAINING OF TRAINERS (CORE TRAINERS)				◐		●	◐			◐	●	
DECENTRALIZATION OF TRAINING	◐	◐		◐		●	◐	◐	◐	◐		
NEEDS ASSESSMENT CONDUCTED PRIOR TO PERIPHERAL LEVEL TRAINING	●			◐		●		◐	◐			
CONTINUING EDUCATION PLAN						●				◐		
REVIEW OF SCHOOLS OF HEALTH SCIENCE CURRICULA IN CCCD CONTEXT	◐		◐	◐		●						
EVALUATION OF PERIPHERAL LEVEL TRAINING	◐			◐			◐	●	◐		●	
REPORTS SUBMITTED ON NUMBER OF PERSON-DAYS OF TRAINING	●	●	●	●	●	●	●	●	●	●	●	●

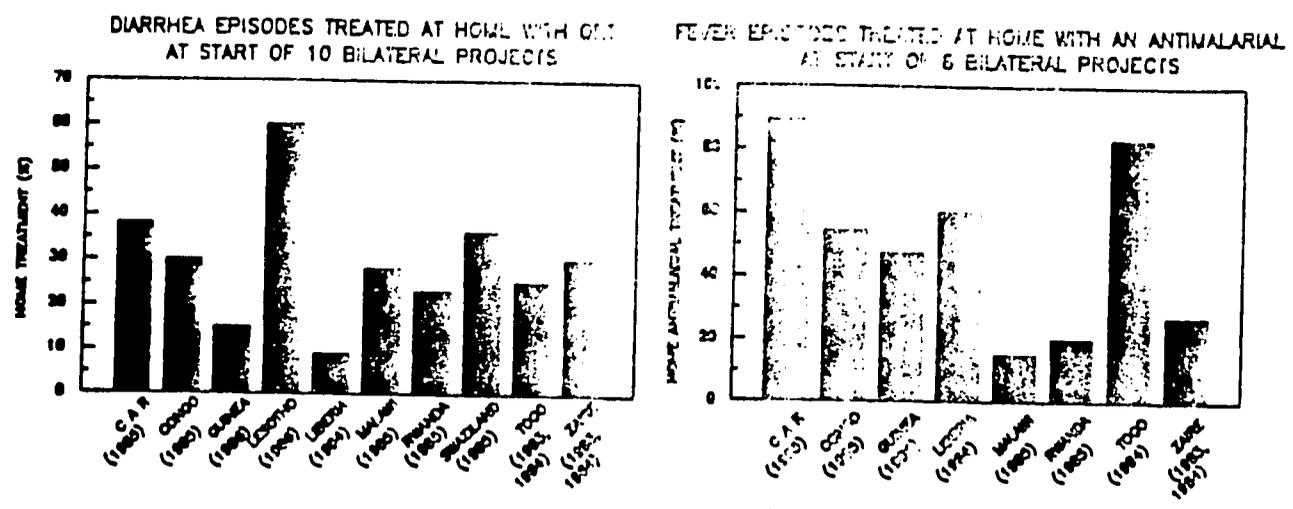
● FULLY COMPLETED ◐ PLANNED/STARTED

10

HEALTH EDUCATION/PROMOTION

- OBJECTIVES**
- Maximize utilization of EPI, CDD, and malaria treatment services at health facilities
 - Facilitate adoption of specific behaviors in the home/community
 - during episodes of diarrhea and fever
 - before and after the use of vaccination services
- INDICATORS**
- Number of countries conducting formative research for health education planning
 - Number of countries with organized health education activities
 - Vaccination coverage rates
 - Percent of diarrhea and fever episodes appropriately treated at home with some form of ORT and antimalarial drugs
- ACHIEVEMENTS**
- Formative research conducted in 7 countries
 - Special EPI promotional campaigns carried out in 6 countries
 - Educational materials produced in 8 countries
 - Practical training in patient education integrated into Mama Yemo ORT Center curriculum
 - Cooperative Agreements signed with University of North Carolina for intercountry training in health education planning and management and with University of South Carolina to develop and refine guidelines for educational diagnosis
- INSTITUTIONALIZATION**
- Health Education Unit staff person recognized as member of CCCD central team
 - Educational materials pretested prior to mass production and distribution
 - Formative research for health education planning and monitoring considered important although not systematically implemented
- PROBLEMS**
- Insufficient resources in relation to individual country needs
 - Lack of public education programs about malaria treatment and chemoprophylaxis during pregnancy
 - Lack of routine reporting of health education activities or home-based treatment practices for evaluation

HOME TREATMENT OF DIARRHEA AND MALARIA BY COUNTRY



STATUS OF HEALTH EDUCATION/PROMOTION CCCD BILATERAL PROJECTS 1982 - 1986

ACTIVITY	BURUNDI	C A R	CONGO	COTE D'IVOIRE	GUINEA	LESOTHO	LIBERIA	MALAWI	RWANDA	SWAZILAND	TOGO	ZAIRE
PRE-PROGRAMMING VISIT BY IHPO HEALTH EDUCATION SPECIALIST	●	●	●	●	●	●	●	●	●	●	●	●
NATIONAL H.E. COORDINATOR/LIAISON DESIGNATED		●	●	●	●	●		●	●	●	●	●
BASELINE/FORMATIVE DATA COLLECTED	●	●	●	●	●	●	●	●	●	●	●	●
ASSESSMENT/STRATEGY/WORKPLAN DEVELOPED	●	●	●	●		●		●	●		●	●
PEACE CORPS JOB DESCRIPTIONS READY/PCV'S REQUESTED		●	NA	NA	NA	●	●	●	NA		●	●
EDUCATIONAL MATERIALS DEVELOPED	●	●	●	●		●	●	●	●	●	●	●
HEALTH WORKER TRAINING WITH PUBLIC EDUC. MATERIAL DIFFUSION	●	●	●	●	●	●		●	●		●	●
MESSAGE DIFFUSION VIA PRINT/MEDIA/SCHOOLS/ETC.	●	●	●	●	●	●	●	●	●	●	●	●
REPORTING/MONITORING OF H.E. ACTIVITY COVERAGE AND CHANGES IN PRACTICES								●				●

● FULLY COMPLETED

◐ PARTIALLY COMPLETED

NA NOT APPLICABLE

72

HEALTH INFORMATION SYSTEMS

OBJECTIVES

- o Strengthen local, regional, and national systems of data collection, collation, analysis, use, and feedback
- o Develop, test, and use selected indicators to monitor performance
- o Measure disease-specific morbidity and mortality
- o Measure effectiveness of interventions in reducing disease specific morbidity and mortality
- o Measure impact of interventions on increasing child survival

INDICATORS

- o Number of countries with systems to:
 - inventory and maintain adequate supplies of vaccines, ORS, chloroquine, supplies, and equipment
 - assess community health practices
 - measure number of services delivered by health system
 - monitor coverage of at-risk populations
 - measure disease morbidity and mortality
 - monitor quality, completeness, and timeliness of disease surveillance
- o Number of countries with regular feedback of data to reporting units

ACHIEVEMENTS

- o Microcomputer capability established in 12 of 13 countries
- o Local staff trained in use of microcomputers in 10 countries
- o Software developed and used for reporting annual project data
- o Health practices survey methodology developed and field tested in Guinea
- o Health practices survey training materials and software developed by US Bureau of the Census
- o Facility survey methodology developed in 3 countries

INSTITUTIONALIZATION

- o Microcomputer capability established with national staffs in 10 countries
- o Lag time between collection and analysis of data reduced in 5 countries
- o Graphics capability being used to monitor EPI activities in 12 countries

PROBLEMS

- o MIS software not currently available in French
- o Lack of feedback at country and intercountry level

IMPACT MONITORING

STRATEGY:

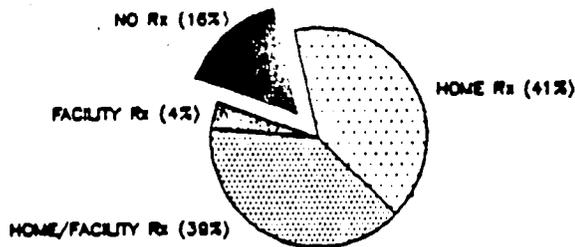
In partnership with CCCD national programs, Health Information Systems have been developed to provide essential management data to answer 5 programmatic questions. These 5 questions, methods used to answer the questions, and examples of data are presented below.

Question 1: What are the maternal, family, and community knowledge, attitudes and practices about immunization, treatment of diarrhea, and treatment of malaria?

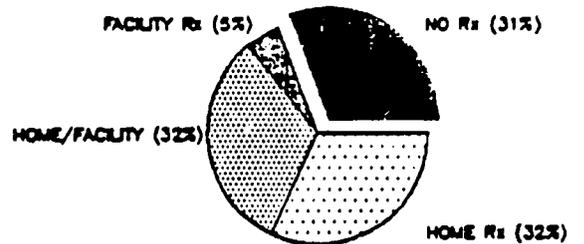
Methods: Health Practices Survey (e.g. Guinea)
 100 Household Survey (e.g., Zaire)
 Sentinel Surveillance (e.g., Malawi)
 Focus Group Interviews (e.g., Rwanda)
 Add-on questions to cluster survey (e.g., Zaire)

Example: In Conakry, Guinea, a cluster survey was carried out in 1986 to assess current community health practices. Findings on current sources of treatment for fever and diarrhea are summarized below.

TREATMENT PRACTICES FOR FEVER
 CONAKRY, GUINEA, JUNE 1986



TREATMENT PRACTICES FOR DIARRHEA
 CONAKRY, GUINEA, JUNE 1986

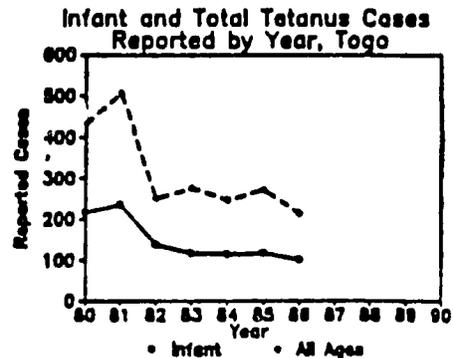
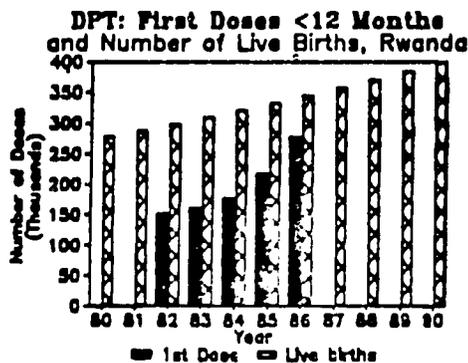


Question 2: How many at-risk populations are being reached by the health system?

Methods: Annual reporting of:

- total vaccinations given
- total vaccinations given to children < 1 by antigen
- percentage of children < 1 receiving each antigen
- cases and deaths of target diseases seen by sentinel health facilities, or where available, from all facilities

Example: Annually CCCD countries provide data on vaccinations given and target disease morbidity and mortality in tabular format and in graphic presentation. Two examples are reproduced:



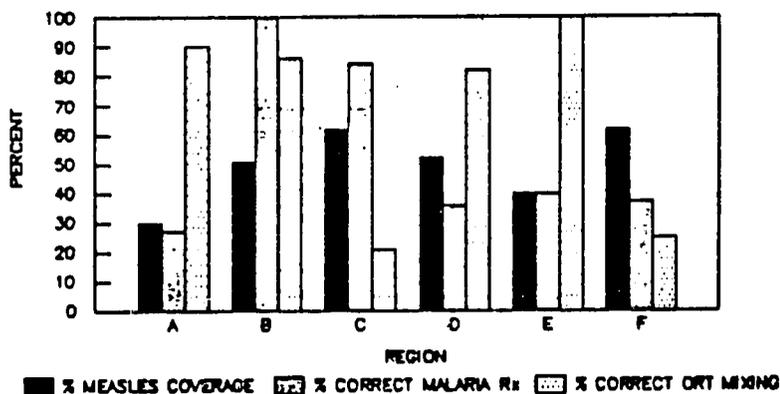
74

Question 3: What is the quality of health services being provided at health facilities?

- Methods: Facility Surveys (e.g., Rwanda)
 Training needs assessment (e.g., Liberia)
 Health Facility Survey (e.g., Cote d'Ivoire)
 Supervisory checklists (e.g., Zaire)

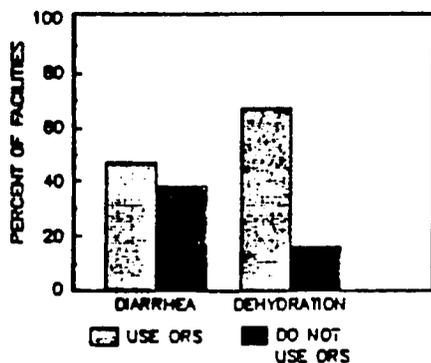
Example: Rwanda has developed a supervisory system in which central teams visit the regions two times per year. Visits collect data on quality of services being provided; assess training effectiveness and the need for further training; and instruct regional teams on methods of supervision. Data collected from 6 regions on measles coverage, appropriate malaria treatment, and correct ORS preparation are presented below.

**SUPERVISORY ASSESSMENT OF CCCD SERVICES
 MEASLES COVERAGE, MALARIA/DIARRHEA Rx, RWANDA**

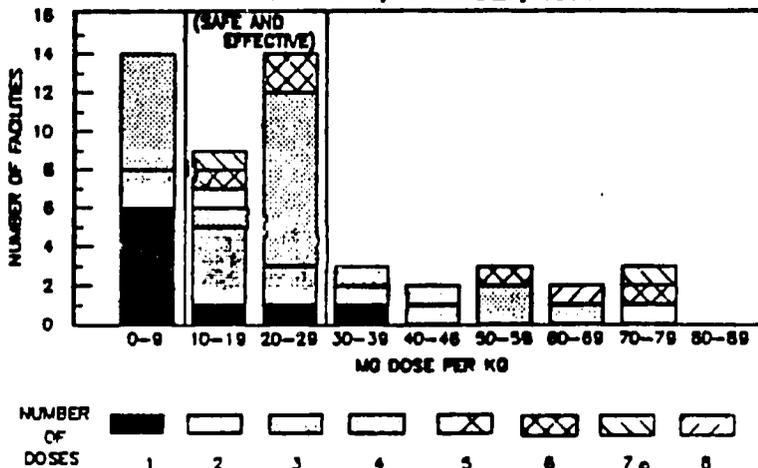


Example: In Cote d'Ivoire 140 facilities were visited to obtain similar information. Two examples of data obtained are summarized below.

FACILITIES USING ORS FOR DIARRHEA AND DEHYDRATION, COTE D'IVOIRE, 1986



**CHLOROQUINE TREATMENT PRACTICES
 AMOUNT PRESCRIBED FOR A 2-YEAR-OLD, 12 KG CHILD
 COTE D'IVOIRE, DECEMBER, 1986**



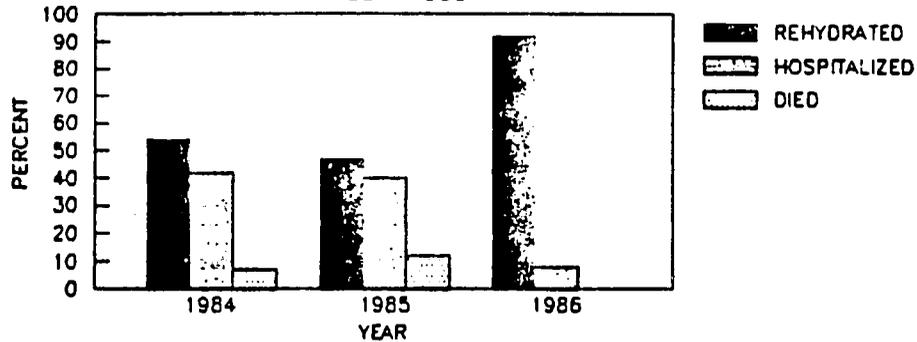
17

Question 4: How effective are interventions in reducing disease specific morbidity and/or mortality?

Methods: Vaccine efficacy studies (e.g., Measles-Congo, Polio-The Gambia)
 Inpatient diarrhea case fatality (e.g., Zaire, Lesotho)
 Malaria case fatality at sentinel facilities

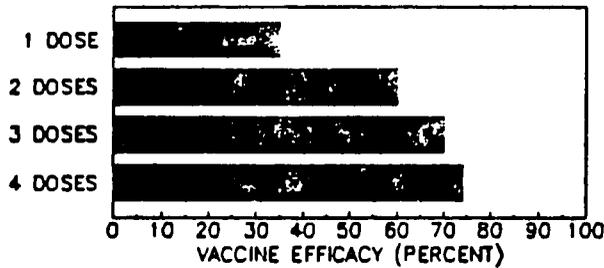
Example: At the Mama Yemo Hospital in Kinshasa, Zaire, monitoring of severe dehydration cases, cases requiring admission, and deaths provides a measure of impact.

OUTCOME OF SEVERE DEHYDRATION CASES
 ADMITTED TO MAMA YEMO, KINSHASA ORT UNIT
 1984-1986



Example: During the poliomyelitis investigation in The Gambia, vaccine efficacy by number of doses administered was determined.

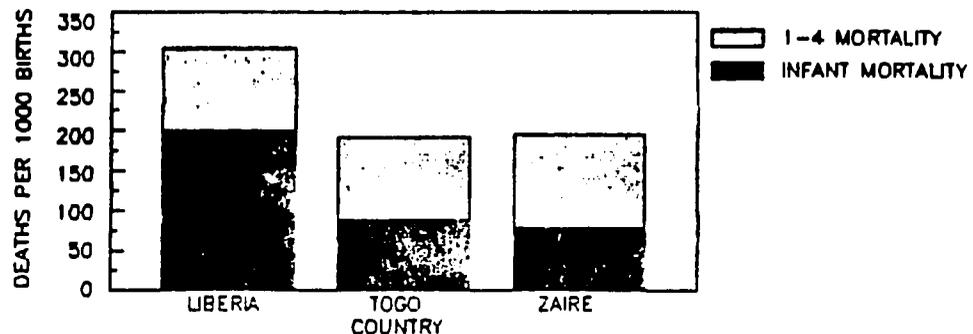
ORAL POLIO VACCINE EFFICACY BY DOSE
 THE GAMBIA, 1986



Question 5: What is the impact of disease specific mortality reductions on overall child survival?

Method: Baseline levels of mortality and use of health services have been measured in 3 countries: Liberia, Togo, Zaire. Follow-up mortality surveys will be carried out in 1988. Mortality data obtained in the baseline surveys are shown below.

INFANT, CHILD, AND UNDER FIVE MORTALITY
 DEATHS PER 1000 BIRTHS, THREE COUNTRIES



76

OPERATIONAL RESEARCH (*)

OBJECTIVES	<ul style="list-style-type: none"> o Identify and solve operational problems limiting the achievement of CCCD targets and objectives o Develop African capability to conduct operational research
INDICATORS	<ul style="list-style-type: none"> o Number of projects designed, started, and completed o Impact of research projects on program operations and child health
ACHIEVEMENTS	<ul style="list-style-type: none"> o Active projects in 1986 109 o Projects completed 66 (see country summaries of projects completed, pp. 44-45)
INSTITUTIONALIZATION	<ul style="list-style-type: none"> o Research review committees established in 5 countries
PROBLEMS	<ul style="list-style-type: none"> o Lack of operational research activities in CCCD countries with small populations o Need clearer definition of operational research priorities to guide operational research activities

(*) Redefined to include both regionally funded operational research and special studies dealing with operationally important issues

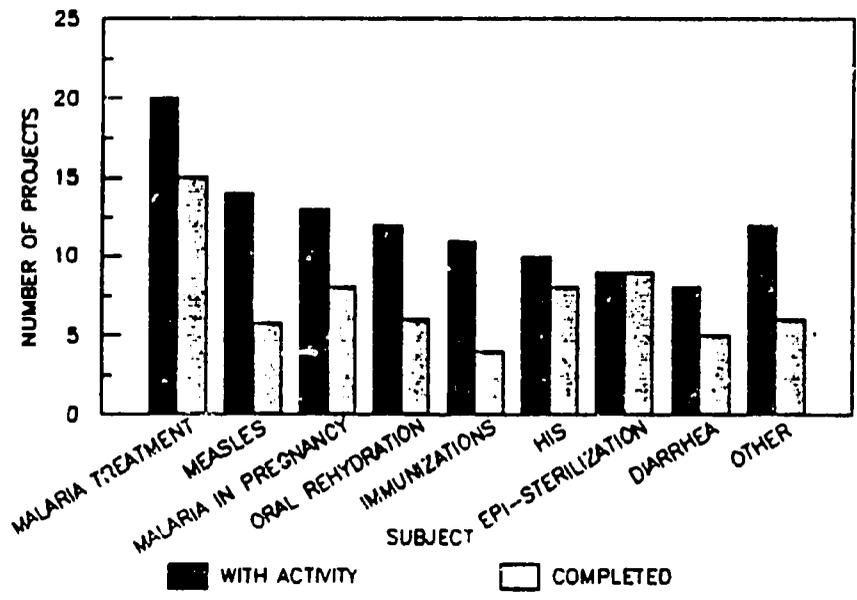
COUNTRIES WITH CCCD SPONSORED OPERATIONAL RESEARCH ACTIVITY, 1986

NUMBER OF PROJECTS PER COUNTRY

BURKINA FASO	2
BURUNDI	6
C A R	5
CONGO	3
COTE D'IVOIRE	11
GAMBIA	1
GUINEA	9
KENYA	5
LESOTHO	4
LIBERIA	3
MALAWI	25
NIGER	2
RWANDA	8
SENEGAL	1
SUDAN	1
SWAZILAND	2
TOGO	4
ZAIRE	14
ZAMBIA	1
ZIMBABWE	2



OPERATIONAL RESEARCH PROJECTS SUPPORTED BY CCCD IN 1986, BY SUBJECT AND ACTIVITY STATUS



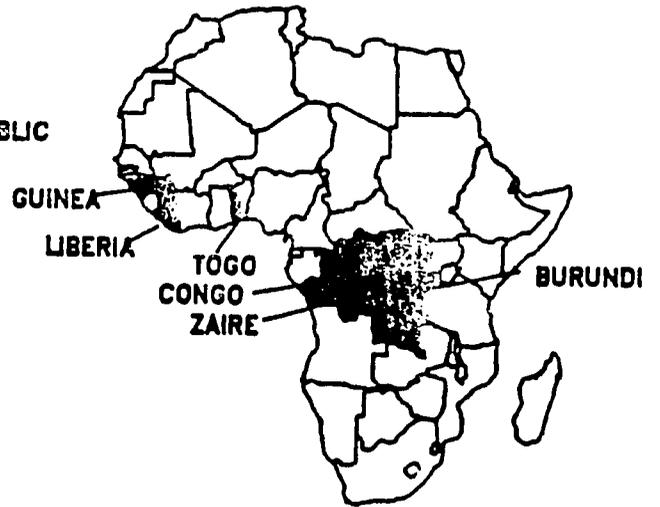
SUSTAINABILITY

- | | |
|---------------------|---|
| OBJECTIVES | <ul style="list-style-type: none"> o Ensure political commitment and social demand for Child Survival programs o Strengthen management capabilities o Ensure adequate financing of program activities |
| INDICATORS | <ul style="list-style-type: none"> o Official government endorsement of child survival policies o Number of countries with management training o Number of cost recovery studies o Number of countries with national cost recovery policies o Percentage of recurrent costs assumed by countries as compared to scheduled assumption of costs |
| ACHIEVEMENTS | <ul style="list-style-type: none"> o Cost recovery studies done in 9 countries o Cost recovery systems established in 6 countries o Long term cost recovery projects proposed for 2 countries o Government contributions exceeded project targets by more than 30% in 3 countries o Financial management modules developed and used in 3 countries o Presidential support demonstrated in 5 countries o Active community participation in health activities in 7 countries |
| PROBLEMS | <ul style="list-style-type: none"> o Inflation, foreign exchange, and budget constraints make it increasingly difficult for countries to meet target financial contributions o Reluctance of some countries to consider cost recovery systems o Life of project too short to allow for adequate development of sustainable systems o Lack of integration of curative and preventive services in some countries |

COST STUDIES COMPLETED, 1983-1986



COST RECOVERY MECHANISMS ESTABLISHED



COST RECOVERY MECHANISMS ESTABLISHED IN CCCD COUNTRIES

	BURUNDI	C A R	CONGO	COTE D'IVOIRE	GUINEA	LESOTHO	LIBERIA	MALAWI	RWANDA	SWAZILAND	TOGO	ZAIRE
DRUG REVOLVING FUND							●					●
USER FEES	●						●				●	●
VACCINATION CARD FEE			●		●						●	●
OTHER							●					

80.

PROGRAM MANAGEMENT

- OBJECTIVES**
- o Strengthen program managers' skills
 - o Improve planning and problem solving
 - o Ensure program development and continuity
- INDICATORS**
- o Number of countries with:
 - Program management training
 - Management information system
 - o Number of program managers trained
 - o Number of countries with work plans
 - o Number of countries with effective donor coordination groups
- ACHIEVEMENTS**
- o Strategy and position paper on training program managers submitted to A.I.D./W
 - o Technical Officers provided on-the-job management training to counterparts
 - o Management training modules developed in 3 countries
 - o Over 300 health workers trained in program management in 3 countries
 - o National CCCD Symposium conducted for 350 health professionals in Zaire
 - o Inventories of management training resources completed in 12 countries
 - o EPI, CDD, and Malaria work plans approved or pending approval in 12 CCCD countries
 - o Computerized Management Information System (MIS) established in 10 of 12 countries
 - o Donor coordination groups functioning in 12 countries
- INSTITUTIONALIZATION**
- o Cadre of trained computer users in 10 countries
 - o Training collaboration established with universities and other institutions in 3 countries
 - o MOH commitments to inservice training in 5 countries
 - o Cost recovery systems established in 6 countries
- PROBLEMS**
- o Inadequate inservice training for program managers
 - o Ineffective coordination of donor activities in some countries

CCCD PARTNERS

<u>Collaborating Body</u>	<u>Specialty</u>	<u>CCCD Countries</u>
WORLD HEALTH ORGANIZATION		All
UNICEF		All
COOPERATION FOR DEVELOPMENT IN AFRICA (CDA) Belgium, UK, Canada, France, Italy, FRG, USA		Congo (France) The Gambia (UK)
PEACE CORPS	Training, Health Education (72 Volunteers working in CCCD projects)	C A R Lesotho Liberia Malawi Togo Zaire
PRITECH Technologies for Primary Health Care	Planning and Implementation of ORT Programs	Congo Cote d'Ivoire Guinea Nigeria Rwanda
HEALTHCOM Communications for Child Survival	Communications, Social Marketing, Behavior Analysis	Burundi Cote d'Ivoire Lesotho Liberia Malawi Nigeria Rwanda Swaziland Zaire
REACH Resources for Child Health	Immunization Programs, Health Care Financing	C A R Guinea Liberia Rwanda Zaire
BUREAU OF THE CENSUS	Health Information Systems	Cote d'Ivoire Liberia

BT

WHO REGIONAL OFFICE FOR AFRICA (AFRO)



The initial 1985 grant from A.I.D. authorized \$4 million to AFRO. A 1986 grant amendment provided \$1 million for Africa Immunization Year and for additional resources to strengthen regional activities in training, HIS, and malaria.

ACHIEVEMENTS

CCCD funds supported 7 training courses and 3 program managers' meetings for 191 nationals from 20 countries.

The Regional Director approved the proposed development of a new intermediate-level epidemiology training course.

Renovation of Zaire's intercountry ORT Training Center at Mama Yemo Hospital was funded.

WHO/AFRO supported accelerated Africa Immunization Year activities in member countries.

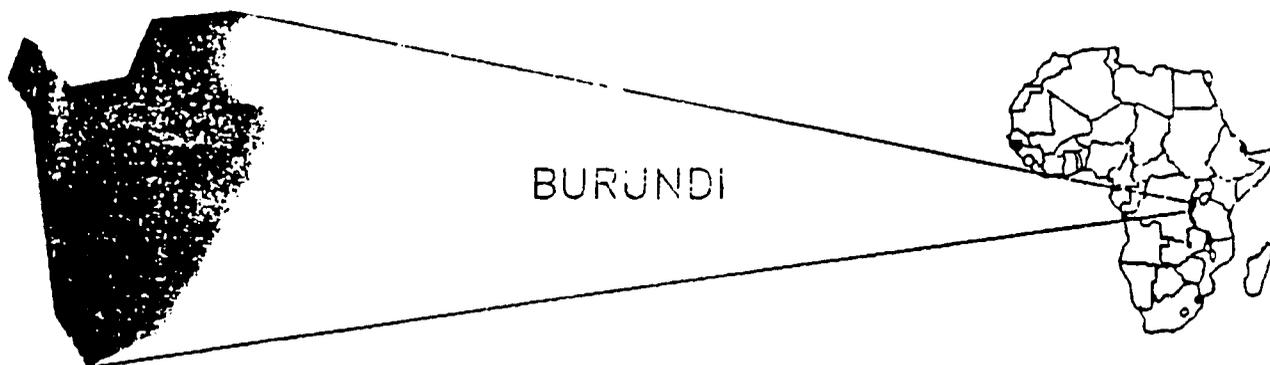
Evaluation of the effectiveness of WHO/AFRO training courses was started.

WHO/AFRO participated in the CCCD program evaluations in Liberia and Rwanda.

An external evaluation of AFRO's CCCD activities was conducted.

PROBLEMS

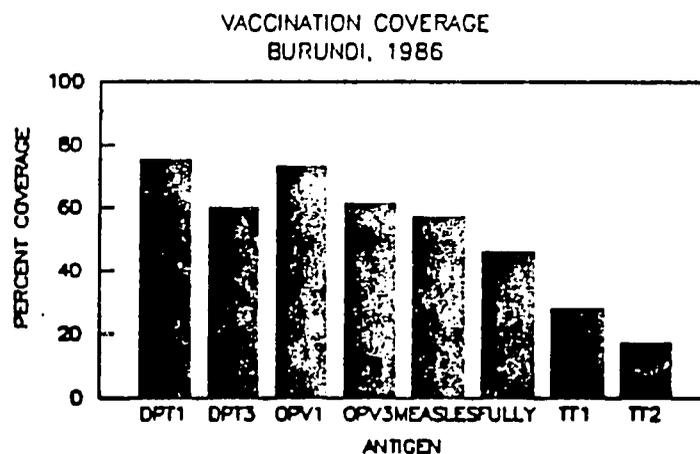
- Slow progress toward an agreement on improving the regional HIS.
- Delays in publishing AFRO's Epidemiology Bulletin.



The Technical Officer arrived at post in April 1986.

The MOH approved national plans of operation for EPI, CDD, Malaria, and HIS.

Results of the 1986 national EPI vaccination coverage survey showed the following:



The MOH adopted a National Policy on Sterilization and Injection Practices.

An ORT demonstration and training unit was established.

The MOH completed a training needs assessment and 1986-87 training plan and calendar.

Forty-five MOH personnel participated in the first MLM course concentrating on EPI.

An in-depth review of the disease surveillance system was completed.

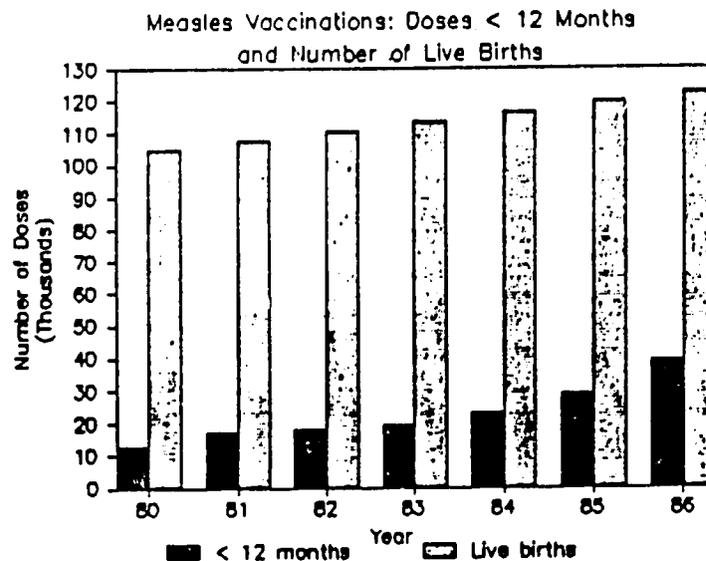
An Operational Research Review Committee was established.

The First Year Internal Review, conducted in early October, found the project to be off to a good start.

194



A full-time Technical Officer was assigned in January 1986. The MOH adopted national five-year plans for malaria and CDD. The MOH planned and conducted a national measles vaccination campaign.

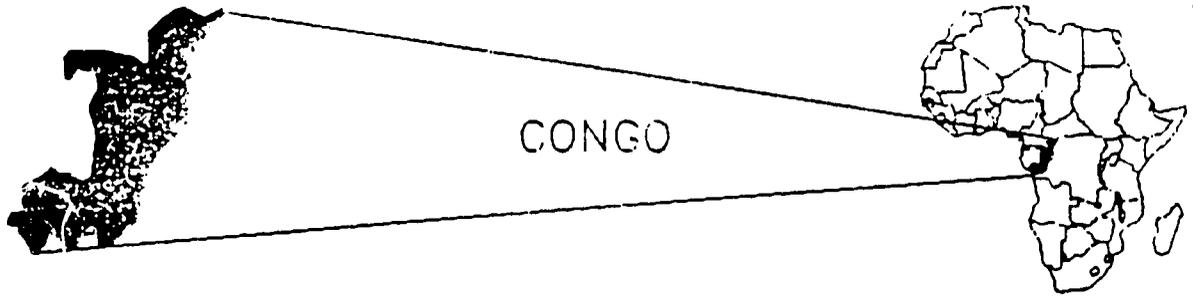


An ORT demonstration and training center was opened in Bangui. The first ORT training course was conducted using a nationally-prepared training guide.

An in vivo chloroquine sensitivity study conducted in Bambari showed low levels of resistance of P. falciparum parasites.

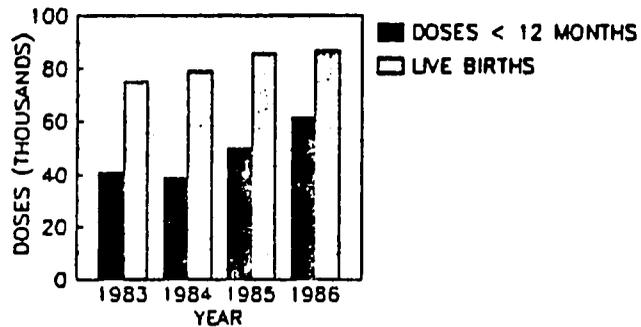
The Midterm Evaluation team recommended project extension and increased funding levels.

95



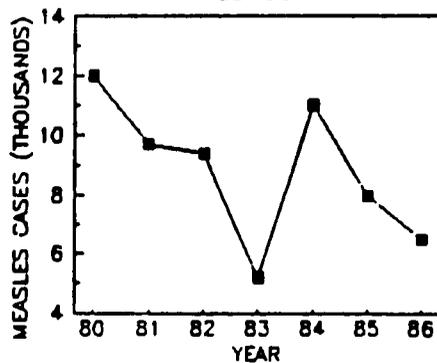
The Government hosted the Third CCCD Consultative Meeting. The MOH adopted national plans for malaria and CDD. The President launched the national vaccination program in December. Public participation exceeded expectations as did vaccination coverage.

MEASLES VACCINATIONS: DOSES < 12 MONTHS AND NUMBER OF LIVE BIRTHS



Reported measles cases continued to decline in 1986.

MEASLES CASES REPORTED BY YEAR CONGO

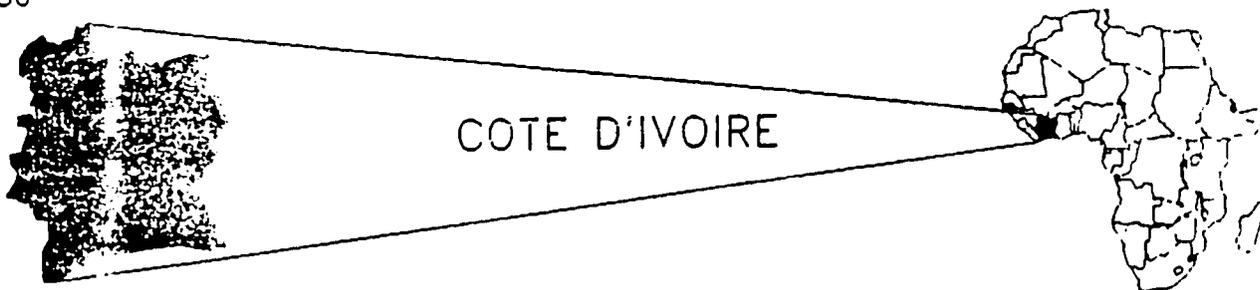


An EPI sterilization practices survey was carried out.

A study on the persistence of maternal antibodies for measles in children < 1 year of age was completed.

Expenditures of bilateral funds were suspended temporarily pending the Government of Congo's budgetary contribution.

96



The MOH drafted national plans for CDD, malaria, and health education.

The EPI program became operational in all health sectors.

An ORT demonstration and training unit was established at the Port Bouet MCH Center.

An intercountry malaria in vivo training course was completed.

The MOH developed a strategy, work plan, and job aids for training.

Four trainers participated in an intercountry TOI course in Togo.

Fifty-five peripheral health staff and 18 mid-level managers were trained.

The US Bureau of the Census conducted an initial evaluation and formulated plans for improving the national HIS.

The MOH established an Operational Research Review Board.

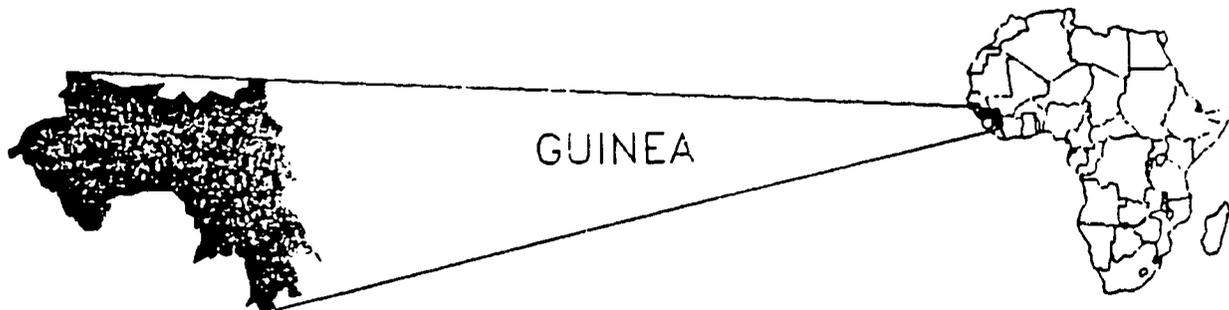
Formative research on EPI, CDD, and malaria was completed.

A measles antibody study in children ages 4 to 9 months was carried out.

A health facilities survey of 140 facilities (49 in Abidjan and 91 in rural areas) was conducted.

Survey data from the 140 health facilities surveyed in 1986 indicated:

- 30% provide immunization services
- 16% immunize sick children
- 8% use a sterile needle and a sterile syringe for each vaccination injection
- 68% recommend chemoprophylaxis to pregnant women



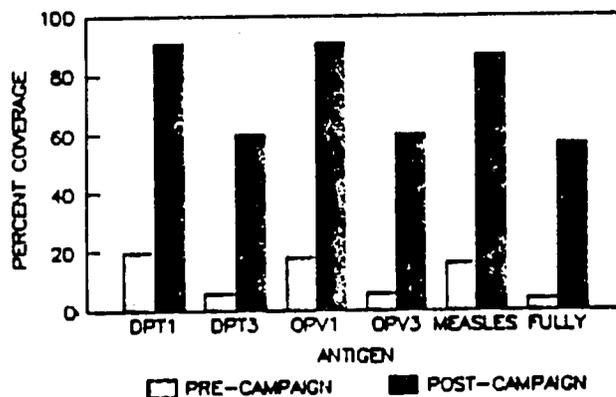
The MOH, CCCD, UNICEF, and WHO collaborated in a national EPI review which resulted in a revised national plan.

The Malaria Program Director drafted a national malaria strategy.

An accelerated vaccination campaign was completed in Conakry.

A vaccination coverage survey in Conakry showed the following:

PRE- AND POST-VACCINATION CAMPAIGN COVERAGE
CHILDREN 12-23 MONTHS, CONAKRY, GUINEA



Donka Hospital, Conakry, established ORT demonstration centers in its outpatient clinic and pediatric ward.

The first TOT course in EPI trained 15 health personnel.

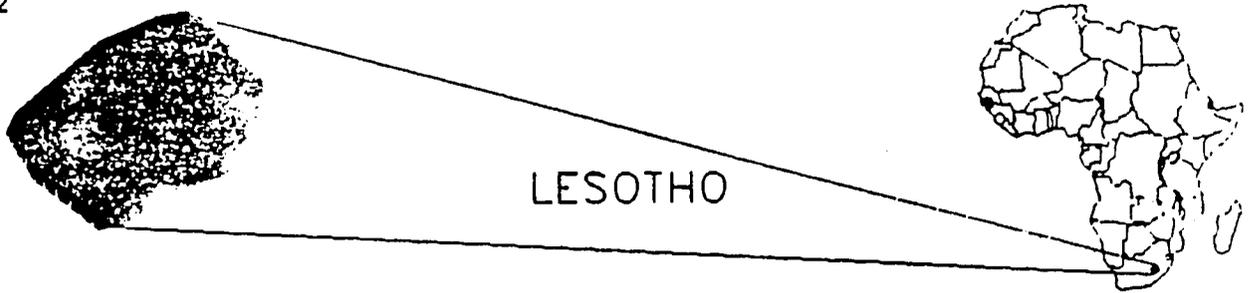
The first field test of the CCCD Health Practices Survey was conducted to assess community practices relating to CCCD interventions.

Studies were completed on:

- neonatal tetanus
- a cholera outbreak
- EPI sterilization practices

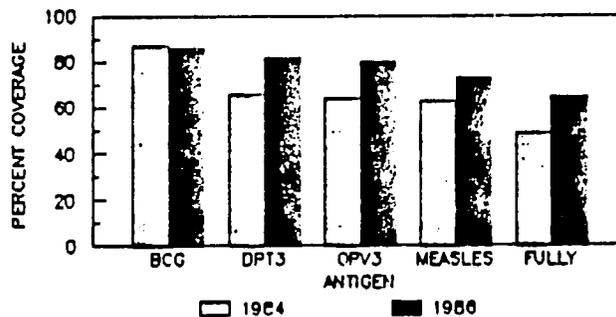
A consultant developed a model for analysis of cost recovery options for the MOH.

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The 1986 Immunization survey showed increases in coverage:

VACCINATION COVERAGE SURVEYS, CHILDREN 12-23 MONTHS
LESOTHO, 1984, 1986



An EPI sterilization practices survey was carried out.

A plan was developed to ensure the use of a sterile needle and a sterile syringe for each injection.

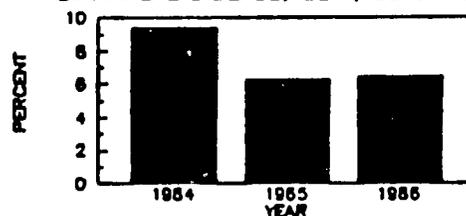
A measles epidemiology study was carried out.

An ORT demonstration and training center was established at the Queen Elizabeth II Hospital (QE II) in Maseru.

A diarrhea mortality study at QE II showed a decrease in the CFR from 9.4 to 6.3 in 1984 and 1985, respectively.

Preliminary data (QE II) for 1986 shows a CFR of 6.5 with a 41% decrease in diarrhea-related pediatric ward admissions.

CASE FATALITY RATES
DIARRHEAL DISEASE, QE II, LESOTHO



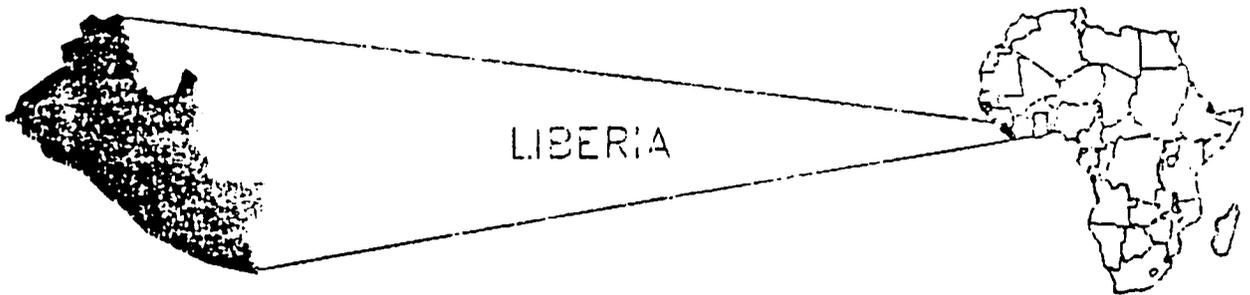
ORT units were established in 10 of the 18 Health Service Area hospitals.

The MOH assumed responsibility for decentralized training.

More than 2,000 peripheral health workers were trained in EPI and CDD through CCCD-sponsored courses.

The 1986 External Evaluation team concluded: "The CCCD Project is basically well run and making good progress in achieving its stated goals."

94



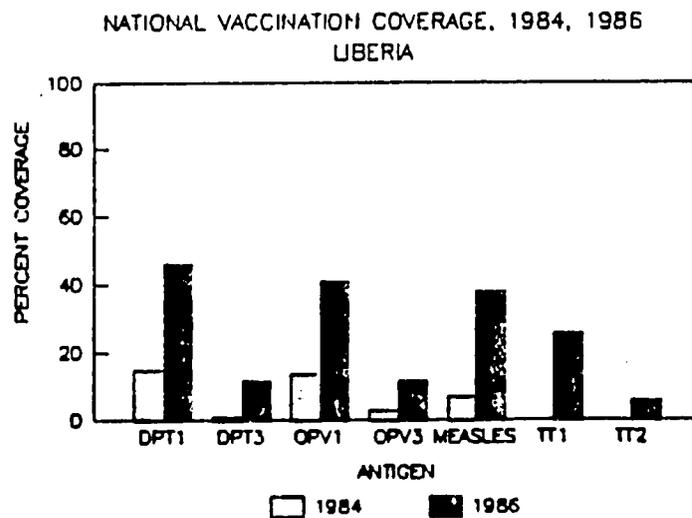
The project expanded to 5 additional counties; 55% of the total population now has access to CCCD services.

The CCCD Project Manager successfully lobbied for annual operating funds from the Development Budget Fund (PL-480).

A unique motorcycle distribution plan was implemented allowing health workers to purchase motorcycles at reduced cost for outreach work.

The MOH approved a national malaria control policy.

The National Vaccination Weeks media campaign and increased availability of vaccinations at fixed facilities combined to result in the following coverage:

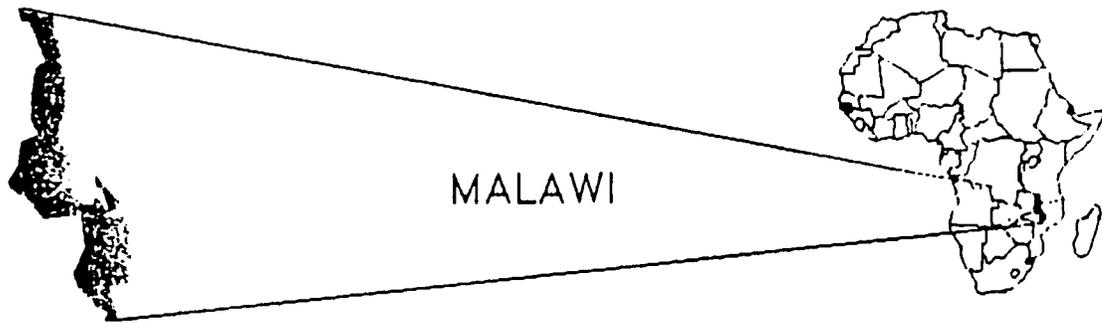


An ORT demonstration and training center was established at Redemption Clinic; another center for treating severely dehydrated children was created at JFK Hospital.

A CCCD consultant completed a training needs assessment in the project area.

Revolving drug funding systems were implemented in 3 counties.

Training workshops on implementing fee-for-service procedures were conducted.



National five year plans (1986-1990) for EPI, CDD, and malaria were developed.

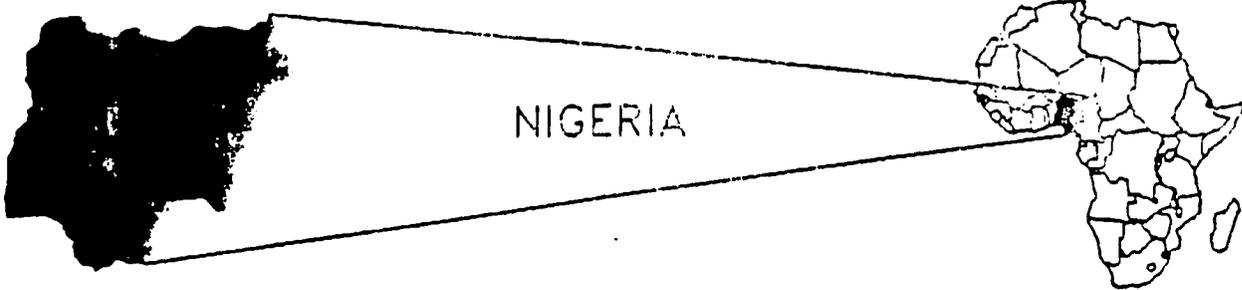
The MOH developed a plan for Improving EPI sterilization practices.

Success in making the transition from I.V. use to ORS was demonstrated at the Kamuzu Central Hospital with a seven-fold decrease in I.V. usage from 1982 to 1986.

ORT treatment centers were operational in all 44 hospitals in the country and in 95% of the 600 static health facilities.

Operational research studies showed limited effectiveness of chloroquine against P. falciparum malaria among pregnant women and limited use of chemoprophylaxis during pregnancy.

A mass communications project with HEALTHCOM was implemented to improve community participation in health services delivery.



A.I.D. reviewed and approved the project proposal.

The 5-year project provides for a collaborative technical assistance effort among the MOH, CDC, UNICEF, PRITECH, and HEALTHCOM.

A.I.D. granted funds to UNICEF for commodities, training, communications, and program monitoring and evaluation.

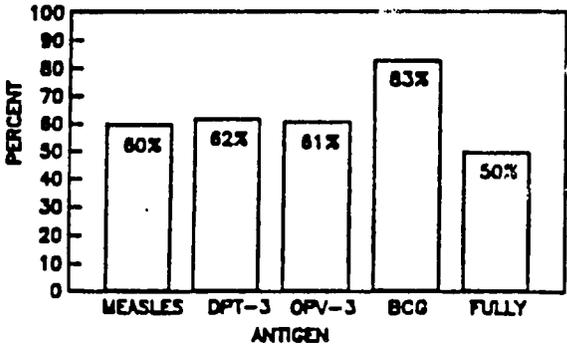
Technical assistance is being provided in:

- health information systems
- operational research
- pharmaceutical supply and distribution
- financial planning and management
- health communications and mobilization

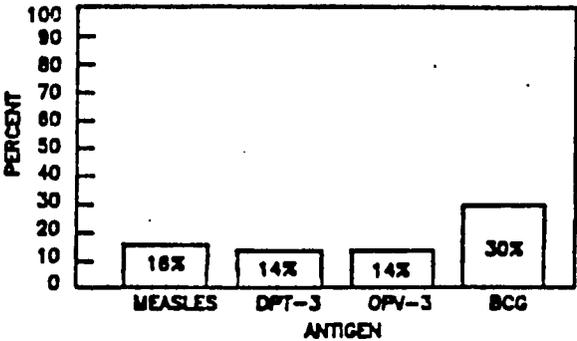
The MOH and its collaborating partners established the implementation plan for 1987.

VACCINATION COVERAGE in children 12-23 months of age

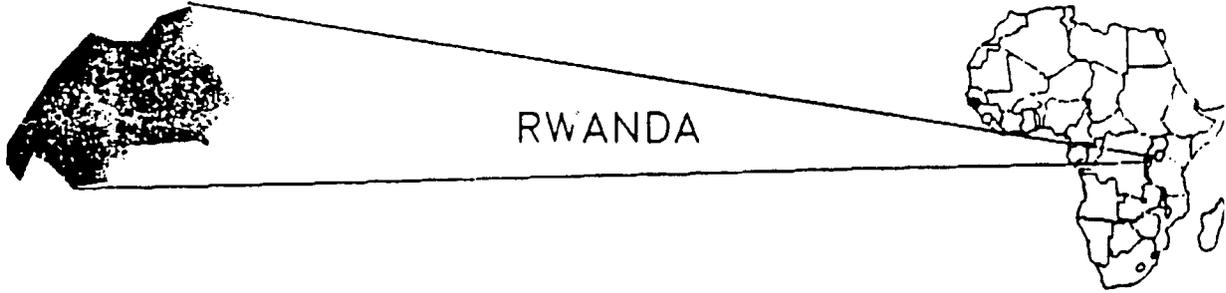
VACCINATION COVERAGE SURVEY RESULTS
FROM LOCAL GOVERNMENT AREA CAPITALS,
NIGERIA, SEPTEMBER, 1986



COUNTRY-WIDE VACCINATIONS REPORTED
COMPARED TO ESTIMATED TARGET POPULATION
OCTOBER, 1985-NOVEMBER, 1986



92

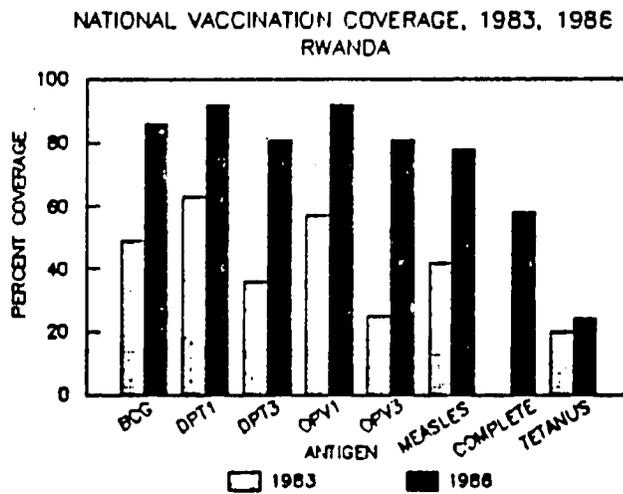


The MOH strengthened project management by assigning three medical assistants and one physician to the CCCD program.

The MOH drafted national CDD and malaria plans.

An intensified program of supervision, ensuring frequent visits by central level staff, has identified and solved training problems.

National vaccination coverage increased in 1986.



ORT demonstration and training centers were established at the Central Hospital, Kigali, and in 4 regions.

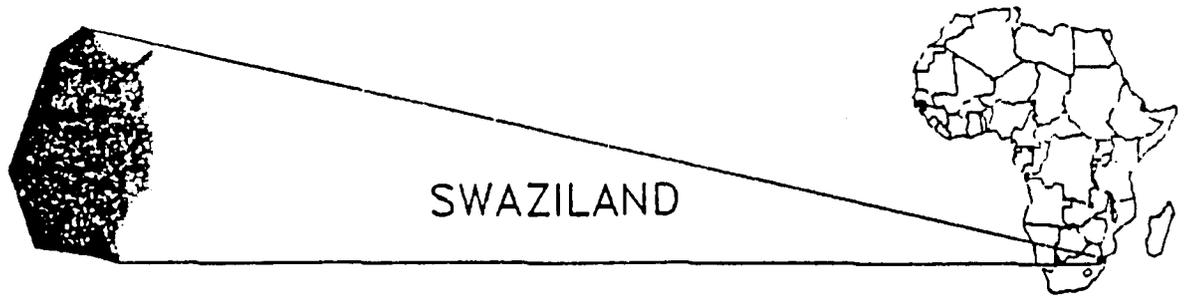
Two protocols were prepared for long-term chloroquine and amodiaquine sensitivity studies.

CCCD in collaboration with UNICEF funded an EPI national training course for 40 EPI supervisors and hospital directors.

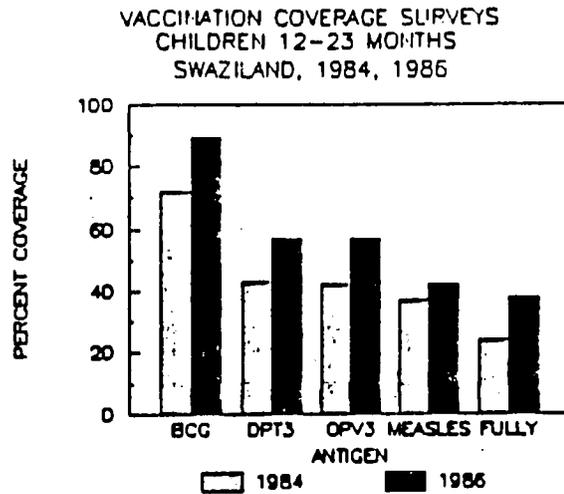
Formative research provided planning information for an EPI promotion campaign.

A 3-month EPI promotion campaign was conducted using person-to-person contact, radio messages, flyers, posters, and newspaper articles.

A cost recovery study was completed.

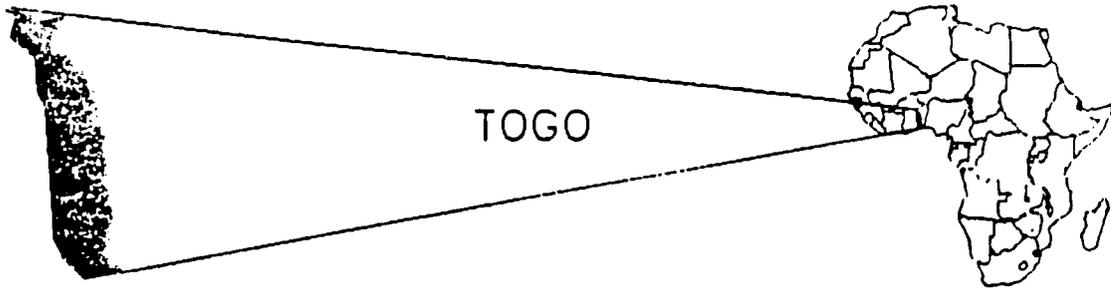


The 1986 vaccination coverage survey demonstrated increases in coverage.



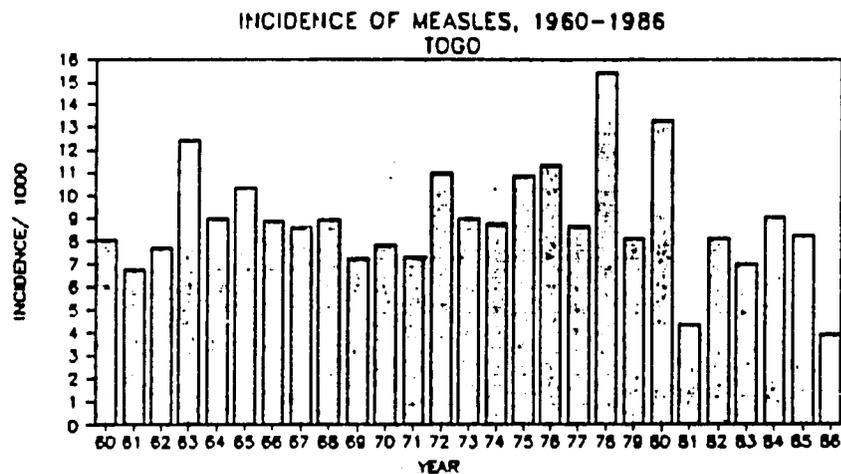
- The MOH adopted a strategy of providing daily vaccination services.
- The vaccine distribution system was decentralized to regions.
- An EPI sterilization practices survey was conducted.
- An ORT demonstration and training center began operations in the capital city of Mbabane.
- An increase in malaria deaths was investigated.
- CCCD and WHO co-sponsored a PHC workshop for 65 physicians and nurses.
- An External Evaluation team recommended extension of the project.

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The President launched the accelerated immunization activities which will continue throughout 1987.

Reported incidence of vaccine-preventable diseases declined to the lowest levels ever.

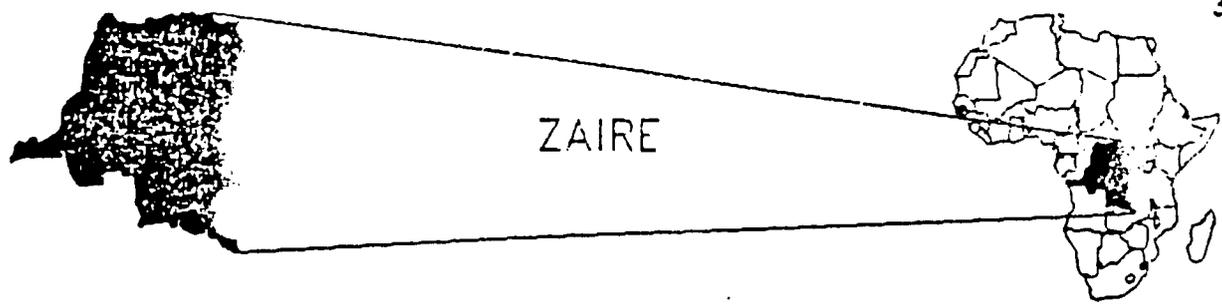


An EPI sterilization survey was completed.

In vivo studies showed no decreased sensitivity of P. falciparum to chloroquine.

Plans were completed for the computerization of the National Health Statistics Office, and computers were ordered.

The Technical Officer was reassigned to CCCD/Atlanta.



The Technical Officer was reassigned to CCCD/Atlanta In June and a replacement was posted In November.

Over 350 health professionals attended Zaire's first national CCCD Symposium, which was financed through private and public funds.

A senior staff epidemiologist returned after completing CCCD-funded studies at Johns Hopkins University.

The MOH Inaugurated the national ORT demonstration and training center at Kinshasa's Mama Yemo Hospital.

One WHO Intercountry and 2 national ORT training courses were conducted.

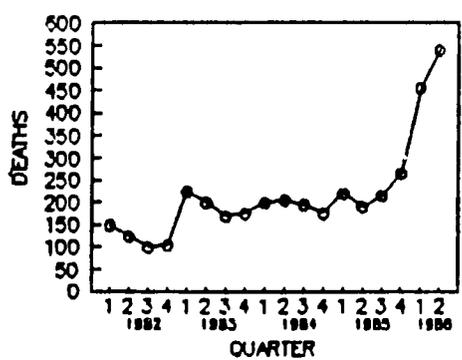
A training videotape on diarrhea case management with ORT was produced.

Three regional ORT training centers were established with core staff trained at the Mama Yemo Center.

Data on clinical outcome of cases treated with ORT from 1984 to 1986 indicated decreases in hospitalizations and deaths.

Pediatric deaths attributed to malaria increased significantly during the first and second quarters at Mama Yemo Hospital.

PEDIATRIC DEATHS ATTRIBUTED TO MALARIA AT MAMA YEMO HOSPITAL, KINSHASA, ZAIRE, 1982-1986



Two In vivo chloroquine sensitivity courses were conducted.

The antimalarial drug sensitivity monitoring network was expanded.

University personnel collaborated with CCCD staff to study:

- response of P. falciparum parasites to antimalarial drugs in pregnant women
- women's attitudes and practices toward malaria chemoprophylaxis.

The first Issue of the quarterly CCCD publication "Sauvons Les Enfants" was published.

ab

AIDS IN AFRICA

EPIDEMIOLOGY

Human Immunodeficiency Virus (HIV) infection is endemic in central and eastern Africa. The World Health Organization estimates that 5 million individuals may already be infected.

Acquired Immunodeficiency Syndrome (AIDS), the uniformly fatal sequela of HIV infection, is estimated to occur at a rate of 1.3 cases per 100 person-years of HIV infection. 30,000-50,000 new AIDS cases will develop in 1987.

Epidemiologic studies have identified four high risk groups for HIV infection:

- Heterosexuals with multiple sexual partners
- Recipients of blood transfusions
- Infants of HIV infected mothers
- Recipients of injections/scarifications with nonsterile instruments

ACTIONS BEING TAKEN BY AFRICAN COUNTRIES

With leadership from WHO, countries are establishing multisectoral AIDS committees to establish priorities, policies, and practices including:

- Development of HIV screening capability
- Upgrading of blood bank operations to include HIV screening
- Screening of high risk groups
- Development of counseling capability and policies
- Promotion of standard policy of sterile needle and sterile syringe for each injection
- Education on safe sexual practices

ACTIONS BEING TAKEN BY CCCD

CCCD has established as a priority the implementation of the WHO policy of a single sterile syringe and a single sterile needle for each injection.

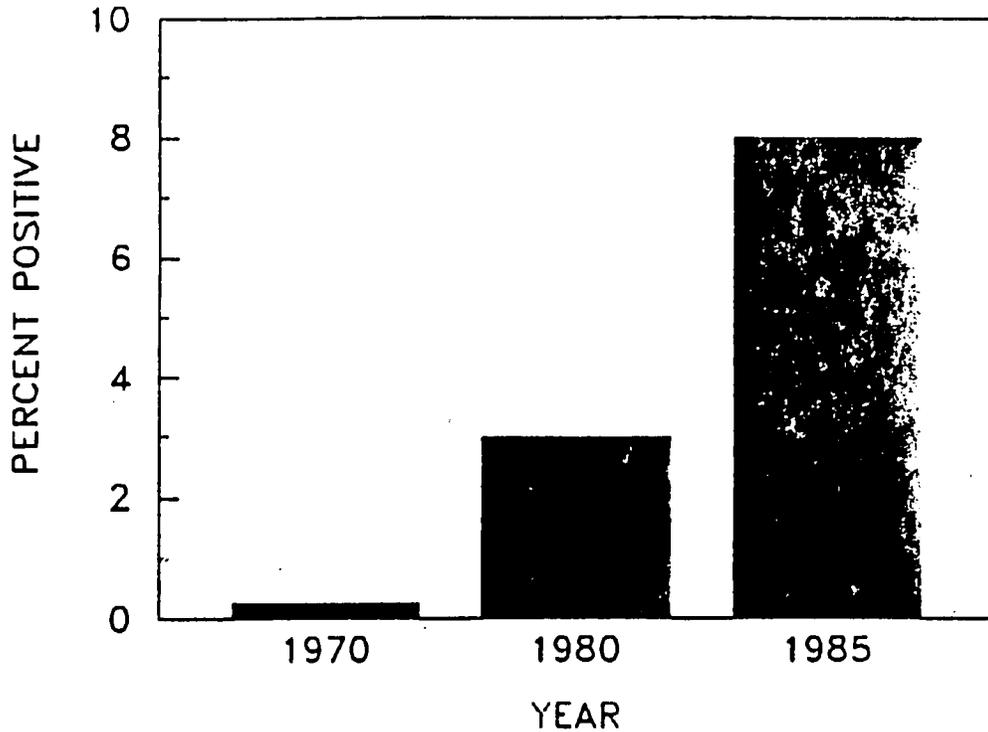
Health practice surveys in 12 CCCD countries documented deficiencies due to problems in supply, training, sterilization, and supervision.

Supplies of needles and syringes have been increased (reusable plastic syringes and stainless steel needles as recommended by WHO in 11 countries and disposable syringes and needles in 1 country).

Pressure cooker sterilizers are being procured for each vaccination unit. Increased priority has been given to training/retraining.

Supervisory assessment of sterilization practices is being increased.

HIV POSITIVITY IN PREGNANT WOMEN IN KINSHASA ZAIRE



Source: Science. 1986; 234:956-963

USE OF STERILE INJECTION EQUIPMENT RESULTS OF IMMUNIZATION PRACTICE SURVEYS IN 9 CCCD COUNTRIES



98

CCCD STAFF AFRICA

USAID BILATERAL PROJECTS

<u>COUNTRY</u>	<u>NATIONAL COORDINATOR</u>	<u>TECHNICAL OFFICER</u>	<u>USAID PROJECT OFFICER</u>
ZAIRE	MAMBU MA-DISU	JOHN PAUL BRENNAN	GLEN POST FELIX AWANTANG
TOGO	KARSA TCHASSEU	(VACANT)	ERNIE POPP
LIBERIA	EUGENIA KROMAH	JIM THORNTON	BETSY BROWN
MALAWI	JEAN KALILANI	REGGIE HAWKINS	CHARLES GURNEY
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OPERATIONAL RESEARCH PROJECTS COMPLETED IN 1986

BURUNDI

Epidemiology of diarrhea among children hospitalized with diarrhea – Bujumbura
One year follow-up of hospitalized and OPD measles cases
Health information systems review

C A R

EPI sterilization practices survey
Review of birthweights by health region
In vivo response to chloroquine – Bambari
Household contributions to health financing

CONGO

Response to chloroquine of P. falciparum malaria in children – Brazzaville
Measles antibodies (maternal) in children 4–10 months old – Brazzaville
EPI sterilization practices survey

COTE D'IVOIRE

Evaluation of home prepared oral rehydration solutions
Measles antibodies (maternal) in children 4–9 months old
Oral rehydration demonstration unit Port Bouet – Abidjan
Survey of health facility practices in treatment of fever and malaria prophylaxis in pregnancy
In vivo response P. falciparum malaria to chloroquine (10 mg/kg)
Health facility survey

GUINEA

Health practices survey – Conakry
Health facility survey – Conakry
Treatment of fever among pregnant women – Conakry
Investigation of cholera outbreak – Conakry and rural areas
Diarrheal disease demonstration unit Donka Hospital – Conakry
EPI sterilization practices survey
Study of cost recovery in primary health care

KENYA

Comparison of two survey methods to estimate neonatal tetanus mortality
Evaluation of photovoltaic vaccine refrigerator/freezer
Effect of malaria prophylaxis in pregnancy on birthweight and infant growth
Retrospective study of measles cases and measles vaccine efficacy

LESOTHO

Case-control study of fatal cases of children hospitalized with diarrhea
Epidemiology of measles
EPI sterilization practices survey

LIBERIA

Health information system review
Health financing study
EPI sterilization practices survey

OPERATIONAL RESEARCH PROJECTS COMPLETED IN 1986

MALAWI

Kamuzu hospital epidemiologic study of children hospitalized for diarrhea
 Accuracy of mixing sugar salt solutions by mothers at health facilities
 Efficacy of Fansidar in childhood malaria
 Quinine treatment of children hospitalized with malaria
 Survey of treatment of fever and parasitemia
 Job performance survey of treatment of fever and diarrhea in health facilities
 Repeat in vivo response to chloroquine of P. falciparum infection in children
 Clinical response of P. falciparum malaria to chloroquine and Fansidar
 Malaria parasitemia in children with clinically diagnosed malaria
 Compliance to malaria prophylaxis in antenatal clinics
 Response to antimalarial drugs of P. falciparum in pregnant women
 Chloroquine prophylaxis in pregnancy: effect on parasitemia and placental infection
 KAP study on childhood diarrhea and dehydration – Mulanje District
 EPI sterilization practices survey

NIGER

Measles outbreak in 1985 – Niamey
 EPI coverage survey

RWANDA

Seroconversion to measles vaccine administered to sick children
in vivo response to chloroquine (25 and 50 mg/kg) of P. falciparum in children
 Study of autofinancing of CCCD program
 Formative research on diarrhea/malaria/immunizations

SENEGAL

Epidemiology of polio and efficacy of inactivated polio vaccine

SWAZILAND

Epidemiologic study of malaria deaths
 EPI sterilization practices survey

TOGO

EPI sterilization practices survey
In vivo response to chloroquine in children with P. falciparum malaria – Sovanes Region

ZAIRE

Development of sugar-salt solution recipe – Kinshasa
 Diarrheal disease treatment center – Mama Yemo Hospital
In vivo response to chloroquine of P. falciparum in pregnant women
 Study of pregnant women and health workers: KAP on malaria in pregnant women
 Investigation of malaria mortality among hospitalized children
 EPI sterilization practices survey
 Health zone financing study

ZIMBABWE

Survey of antimalarial drug availability and use

REFERENCE DOCUMENTS

General	CCCD Project Paper and 1986 Amendment CCCD Project Description CCCD Workplan 1982-1983 CCCD Workplan 1983-1984 CCCD Workplan 1984-1985 CCCD Workplan 1985-1986 CCCD Workplan 1986-1987
Bilateral	Country Assessment Reports -- 14 Bilateral Project Grant Agreements (ProAgs) -- 12 Nigeria Memo of Understanding
Periodic Reports	Monthly reports from CCCD field staff Quarterly reports from field staff (through 1984) Annual reports from each bilateral project, 1985, 1986 Quarterly reports (project-wide MIS) Annual reports (project-wide MIS), 1983, 1984, 1985
Evaluations	Bilateral project review reports Bilateral project evaluation reports First External Evaluation, September 1983, report Internal Evaluation, January 1985, report Second External Evaluation, May 1986, report
Special Reports	Consultant Reports Cost Studies Mortality and Use of Health Services (MUHS)

THESE DOCUMENTS ARE AVAILABLE AT CDC. FOR SPECIFIC REFERENCES, WRITE:

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103-