

**PAN-AFRICAN EPIDEMIC
PREPAREDNESS PROJECT**

ADDIS ABABA, ETHIOPIA

INTERIM ASSESSMENT REPORT

CONDUCTED APRIL 1992

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for

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EXECUTIVE SUMMARY

BACKGROUND

The purpose of the Pan-African Epidemic Preparedness (PEP) project is to save lives by preventing epidemics of Cerebrospinal Meningitis and Yellow Fever in Africa. The PEP project is a World Health Organization (WHO) project with multiple donor support, of which the Agency for International Development's (AID) Office of U.S. Foreign Disaster Assistance (OFDA) is one donor. The project has faced significant management and administrative problems, which affect implementation.

In summary, the problems are as follows:

- a) mission too broadly defined;
- b) lack of resources necessary to have programmatic impact;
- c) management responsibility not well defined with WHO; and
- d) administrative support is inadequate and not geared toward rapid response.

OVERALL RECOMMENDATION REGARDING CONTINUATION OF FUNDING BY OFDA

Of the four options outlined in this report for OFDA action, this assessment recommends Option 2.

Option 2: OFDA re-locates the project, while maintaining the option of re-joining the Center after one year.

Optional sites for re-locating the project include: (1) the U.S. Agency for International Development (USAID) office in Addis Ababa which currently houses the OFDA Regional Advisor; and (2) the REDSO office in Nairobi, which serves as a regional center.

SUMMARY OF PROBLEMS AND RECOMMENDATIONS

Technical Problem #1: Project resources are not adequate to achieve the project's overly ambitious objectives.

Recommendation: A revised Plan of Action is advised for the project, and for the Center, if the project is to remain there. A mandate should be provided for recommending a re-design of the project Center (and program) given the experience to date regarding achievements made and constraints faced. An

expert from Pan American Health Organization (PAHO), in particular, should be included, because of its experience in developing a regional preparedness program in an incremental fashion.

Technical problem #2: A decision is required whether the program should now plan to expand, and if so, to which of the four identified possibilities.

Recommendation: Prior to expanding the program to three additional countries, funds must first be adequate for the three current country programs. At the current resource level, it is only barely possible to have an effective program in the first two countries, Ethiopia and Uganda. Any expansion beyond these two countries should be conducted in a localized, targeted fashion, until the PEP project commands resources commensurate with requirements for implementation. Including Nigeria as the third country-level program should thus be reconsidered.

Management Problem #1: WHO supervision and support to the Center is not rapid, responsive, and flexible as is required for its mission of disaster preparedness and response.

Recommendation: Management responsibility from Headquarters should be vested in one person to ensure follow-up and accountability for rapid action as required to achieve its mandate.

Management Problem #2: Expansion of the PEP Coordinator's Scope of Work beyond the Grant Scope of Work.

Recommendation: Agreement should be secured and documented between WHO and USAID regarding the change in responsibilities of the Project Coordinator, who now only provides 80% of her time to the PEP project.

Management Problem #3: Discrepancies exist between OFDA and WHO project budgets.

Recommendation: OFDA should request a clarification from WHO regarding utilization of grant funds. In particular, OFDA and WHO should resolve discrepancies regarding the changes in salary and benefits, and project start and completion dates.

I. BACKGROUND

A. History and Scope of the Project

The World Health Organization (WHO) Pan-African Epidemic Preparedness (PEP) project was initiated in August 1990 in response to the series of meningococcal meningitis epidemics that swept the countries of the meningitis belt in Africa in 1988 and 1989. In Ethiopia alone, 1,685 deaths and 45,803 cases resulted; donor agencies spent more than \$6 million US dollars to combat the epidemic.

According to data from the Disaster Events Database at the Centre for Research on Epidemiology of Disasters (CRED), Ethiopia endured four Meningitis outbreaks out of 32 outbreaks that occurred in Africa between 1982 and 1991. In addition, 23 percent of all Africans affected by epidemics were Ethiopian.

The Agency for International Development (A.I.D.) Office for U.S. Foreign Disaster Assistance (OFDA) supports the PEP project by providing an epidemiologist to serve as the Project Coordinator. The PEP project is based at the WHO Pan-African Center for Emergency Preparedness and Response in Addis Ababa, Ethiopia. WHO, through contributions from other donors, provides the funds for the operational and field activities of the epidemiologist, including supplies and equipment.

The aim of the project is to improve the epidemic preparedness capabilities of targeted countries in sub-Sahel Africa. An implicit objective is to strengthen district health services to be better prepared to cope with health emergencies of any kind.

The current PEP Plan of Action comprises the following three objectives (see Appendix 1 for complete Plan of Action):

1. To strengthen the state of preparedness to respond to epidemic emergencies, in particular, meningitis and yellow fever.
2. To strengthen active and passive health surveillance systems by developing early warning systems, and enhancing laboratory support.
3. To strengthen health personnel's performance on individual case management and laboratory diagnosis through appropriate training.

B. Project Status

Phase I of the project, 1990-1991, is complete, and an evaluation was conducted. Phase II of the project, 1991-1993, for which a second proposal document was

developed, has reached the mid-term mark. OFDA has requested an interim assessment of the current project performance at this juncture, prior to approval for further funding. Continued funding of the PEP project by OFDA, which must commit the funds by June 1992, is dependent on the findings of this interim assessment.

C. Objectives of the Present Interim Assessment

1. Assess the performance-to-date of the PEP project.
2. Make a recommendation on whether OFDA should continue funding Phase II of the PEP project.
3. If continued OFDA funding of PEP is recommended, propose modifications, as appropriate, to strengthen project design, including whether the project should shift from a preparedness to a mitigation strategy.

II. PROBLEMS AND RECOMMENDATIONS

A. Technical Matters

1. Project Scope and Plan of Action

The current Plan of Action of the Center, including the section on Preparedness activities, is long-term and ambitious. In particular, the Center's mission of providing preparedness and response assistance throughout the Africa region must be reconciled with the constraints faced by the program: limited financial resources, plus poor communications and difficult travel linkages impede implementation, particularly when rapid response is required.

Also, the responsibilities and activities of the Response Unit and the Training Unit (which still is not in place) must be coordinated to ensure that all units target regional priorities in a coordinated manner and optimally utilize the limited resources available.

Technical Problem #1: Project resources are not adequate to achieve the project's overly ambitious objectives.

Recommendation: A revised Plan of Action is advised for the project, and for the Center, if the Project is to remain there. A mandate should be provided for recommending a re-design of the project Center (and program) given the experience to date regarding achievements made and constraints faced. An expert from Pan American Health Organization (PAHO), in particular, should be included, because of its experience in developing a regional preparedness program in an incremental fashion.

2. Status of Country Programs

Significant work has been achieved to date in two of the three target countries (Ethiopia, Uganda, and Nigeria):

The Ministries of Health (MOH) of Ethiopia and Uganda have developed guidelines for control of Cerebrospinal Meningitis (CSM). Development of early warning systems, and training of local health workers in epidemic surveillance, preparedness and response has begun.

The Nigerian MOH has now approved the project, but has stated that it is able to contribute only minimal local funds, placing the project implementation in question.

The original scope of work requires expanding the program to three more countries in 1993 (in addition to the current programs in Ethiopia, Uganda and Nigeria). Four additional priority countries have been recommended for inclusion into the program: Niger; Sudan; Kenya; and Tanzania, while outside the meningitis zone, have been experiencing a significant number of cases.

Technical Problem #2: A decision is required whether the program should now plan to expand, and if so, to which of the four identified possibilities.

Recommendation: Prior to expanding the program to three additional countries, funds must first be adequate for the current country programs. At the current resource level, it is only barely possible to have an effective program in the first two countries, Ethiopia and Uganda. Any expansion beyond these two countries should be conducted in a localized, targeted fashion, until the PEP project commands resources commensurate with requirements for implementation. Including Nigeria as a country-level program should thus be reconsidered.

B. Program Management Matters

1. Supervision by WHO

All Center functions have been reorganized following an evaluation of the Center conducted by the Italian Government and WHO. The purpose of the re-organization was to provide the Center professional staff with greater autonomy and ability to take more rapid action, and to ensure all regions of Africa were served equitably. Under re-organization, the following key actions were taken:

1. Supervision of the Center was moved from WHO Africa Region (Brazzaville) to Headquarters (Geneva).
2. Positions of Unit Chief were established for three divisions: Preparedness, Response, and Training. (The fact that there is now a Unit Chief for Response activities should take the onus off the PEP Coordinator for providing both Preparedness and Response functions. However, the Response Unit Chief is also the WHO representative to Eritria; therefore perhaps less than 50 percent of her time is devoted to regional response activities.)

3. An annual Plan of Action is now required from each Unit Chief, and must be approved by the Center Coordinator and WHO/Headquarters. The Unit Chiefs can then independently take action on all pre-approved activities. (However, funding was withheld until Action Plans were completed and approved, which is cause for future concern.)

Furthermore, supervisory responsibility by WHO has changed many times over the PEP project's short one and one-half year life:

- As stated above, supervisory responsibility at WHO shifted from Brazzaville to Headquarters. At Headquarters, responsibility shifted from Control of Communicable Diseases Division (which still has technical supervision), to Emergency Relief Operations.
- Directorship of Emergency Relief Operations has changed 3 times.
- The Center Coordinator has changed twice.

2. Project Support from WHO

Although WHO has made major changes regarding supervisory responsibility at both the Center in Addis and from Headquarters, the PEP project is still unable to achieve its mission in an optimal manner due to a lack of rapid responsiveness from WHO regarding project administration, particularly for travel authority and procurement. The Administrative Officer for the Center is currently in Geneva, which further delays action. The PEP project has been without a dedicated secretary, vehicle and driver for many months. (However, it is notable that following the visit of this consultant, the Center Coordinator decided to make the OFDA-donated vehicle available specifically for the project, and WHO/Geneva has exerted authority to ensure that the PEP Coordinator has a dedicated secretary.)

Management Problem #1: WHO supervision and support to the Center is not rapid, responsive, and flexible as is required for its mission of disaster preparedness and response.

Recommendation: Management responsibility from Headquarters should be vested in one person to ensure follow-up and accountability for rapid action, as required to achieve its mandate.

3. The PEP Coordinator's Scope of Work

Technical responsibilities of the Coordinator have been expanded by WHO beyond the original Scope of Work agreed upon with USAID for epidemic preparedness. The PEP Coordinator has been promoted to Chief, Emergency Preparedness Unit, and now devotes 80 percent of her time to the PEP project and 20 percent to her other responsibilities. Her duties now include: technical responsibilities for development of health emergency plans and refugee health activities; and supervision of two staff members for two other projects, technical disasters and risk mapping.

Management Problem #2: Expansion of the PEP Coordinator's Scope of Work beyond the Grant Scope of Work.

Recommendation: Agreement should be secured and documented between WHO and USAID regarding the change in responsibilities of the Project Coordinator, who now provides only 80 percent of her time to the PEP project.

4. The Grant Budget

Inconsistencies exist between the budget line items of the OFDA grant and the WHO project operational budget. In addition, the Coordinator's salary and benefits have increased markedly (in part because Addis Ababa is now a hardship post), and are not provided for under the current grant agreement. Clarification is also required regarding the start and completion dates of the consecutive OFDA grants to the project.

Management Problem #3: Discrepancies exist between OFDA and WHO project budgets.

Recommendation: OFDA should request a clarification from WHO regarding utilization of grant funds. In particular, OFDA and WHO should resolve discrepancies regarding the changes in salary and benefits, and project start and completion dates.

III. FUNDING OPTIONS

Prior to detailing the options for OFDA, it must be recognized that alternatives are circumscribed by:

- (a) the current project completion date (PACD) of July 31, 1992.
- (b) the realistic assumption that WHO will not, before the PACD (and perhaps before 1993), make the structural changes recommended under the options below.

The following options are also presented under the assumption that OFDA will allow the current project funding to complete prior to initiating any of these options.

A. Option 1

OFDA extends the PEP project through December 1992 and makes funding of the PEP project, beyond 1992, contingent upon resolution by WHO (to OFDA's satisfaction) of the management and technical problems detailed in this report.

Pros: This will allow a smooth transition given the short time before the PACD by:

- (a) ensuring OFDA and project commitments are met.
- (b) providing WHO with ample time to make changes deemed requisite by OFDA for continuation of the PEP project.
- (c) providing OFDA with adequate time to determine if WHO has made the requisite changes, and to develop contingency plans for the options described here.

Cons: This will delay real action, and will not send a strong enough message to WHO to ensure that OFDA conditions for project continuation are met.

B. Option 2

OFDA re-locates the project, while maintaining the option of re-joining the Center after one year.

Optional sites for re-locating the project include: (1) the USAID office in Addis Ababa which currently houses the OFDA Regional Advisor; and (2) the REDSO office in Nairobi, which serves as a regional center.

Pros: The project would have greater autonomy for making decisions and taking actions, plus better administrative support. Re-location to Nairobi would also improve upon the current constraints faced in communications and travel.

Cons: Many reasons exist for maintaining the PEP project at the Center:

(1) The project would lose the leveraging provided by other donor support which is the source of all administrative and country-level operational funds. OFDA would have to significantly increase its financial support to provide operational funds, plus costs associated with re-location.

In addition to the more than \$750,000 provided by the Italian Government, part of which funds the Center administration, the Governments of Canada and Finland also provide greater than \$100,000 each, dedicated to preparedness activities. Significant other potential resources exist: \$5 million has been set aside for WHO activities in Africa under the multi-donor SEPHA appeal; United Nations Development Program (UNDP) has targeted \$200,000 for activities in Ethiopia, and the World Bank has indicated interest in assisting the PEP project.

(2) For a relatively small contribution of approximately \$133,000, the PEP project provides a highly visible U.S. presence on disasters in the Africa region. (OFDA's PEP Coordinator is now Chief, Preparedness Unit, and is the pre-eminent expert at the Center). OFDA's continuation of funding would provide the opportunity to continue to influence disaster preparedness activities for the Africa region. Furthermore, the Center is now established. It will be much easier to try to effect change by working cooperatively with the other donors (and who are interested in exerting influence jointly) than to develop a new regional center or program.

(3) The Center focus on Africa provides OFDA with a means of reaching its objective to concentrate greater resources on PMP activities in Africa. The Center can also be seen as a potential vantage point from which to effect other activities in Africa, provided the current problems are resolved.

(4) The Center program and priorities match well with those of OFDA/PMP: the lion's share of the resources are devoted to preparedness activities, which include risk mapping and technological disasters.

C. Option 3

OFDA re-locates the project and re-assigns the duties of the PEP Coordinator (Dr. Davis) to other OFDA regional activities.

Pros: Dr. Davis can provide assistance on other OFDA regional priorities, which are extremely demanding and increasing. In particular, the health needs assessments of the conflicts in the Horn, and Southern Africa drought appear preeminent. In addition, OFDA priorities can be re-assessed to determine if OFDA's limited resources are best focused on control of yellow fever and meningitis.

Cons: The OFDA-funded Coordinator has made commitments regarding country-level programs for disease control, and thus raised MOH expectations. It must be considered whether those expectations for "delivering the goods" are WHO's alone, or are locally perceived to be also OFDA's responsibility to follow through.

D. Option 4

OFDA terminates the project.

Pros: OFDA can shift its time and resources to other priorities, and risk no future resources on efforts to strengthen the project.

Cons: OFDA stands to lose: the preeminent American presence at the Center; the proven capabilities and effectiveness of Dr. Davis, plus the resources associated with having her on site in Africa; and all other project investments to date.

IV. CONCLUSION

Based on the pros and cons outlined above, this assessment recommends OFDA enact Option 2. This option will allow a smooth transition, given the short amount of time before the PACD, and ensure that OFDA and project commitments are met, and provide the option of rejoining the Center and leveraging resources, if OFDA concerns are resolved.

ANNEX A

List of Persons Met

WHO/Geneva

Dr. A. Tekle, Director, Emergency Relief Operations
Dr. G. Torrigiani, Dir. of Control of Communicable Diseases Div.
Ms. K. Esteves, Technical Officer, Control of Communicable Diseases Div.

WHO Pan-African Center/Addis Ababa

Dr. A. Salama, Director
Dr. C. Davis, Coordinator, PEP project
Dr. C. Djeddah, Chief, Response Unit
Ms. Paivi Kurttio, APO, Technological Disasters
Mr. Georgio Sartori, GIS Consultant

A.I.D./Ethiopia

Ms. Wendy Fenton, Program Assistant, AID/Ethiopia

Ethiopia Ministry of Health

Dr. Mahdi, Head Epidemiological Division, MOH, Ethiopia

ANNEX B



**PANAFRICAN CENTRE FOR
EMERGENCY PREPAREDNESS AND RESPONSE**

ADDIS ABABA

PLAN OF ACTION

1992

**EMERGENCY RELIEF OPERATIONS DIVISION
EMERGENCY PREPAREDNESS AND PLANNING PROGRAMME**

January 1992

OBJECTIVES AND IMPLEMENTATION STRATEGIES/EMERGENCY PREPAREDNESS UNIT (EPU)

OBJECTIVES	IMPLEMENTATION STRATEGIES	OUTPUT	TIME FRAME	EVALUATION CRITERIA	BUDGET - US\$
<p>1. To develop and implement health emergency preparedness plans and activities in African Member States</p>	<p>1. Coordinated regional approach to EPR activities.</p>	<p>i)- Coordinated regional approach to EPR activities - Coordinated agency response to EPR</p>	<p>1st Quarter 1992</p>	<p>i) Approved work plan by EMRO/AFRO/HQ</p>	<p><u>US\$13 560</u> Duty travels Harare - 6 days Maputo - 5 days Luanda - 10 days Niamey - 10 days Lagos - 14 days Ethiopia - 40 days</p>
	<p>2. Determine the state of Emergency Preparedness in African Member States by use of a questionnaire and assessment missions.</p>	<p>ii) A report outlining the status of the state of EPR</p>	<p>2nd Quarter 1992</p>	<p>ii) Report completed by September 1992</p>	
	<p>3. Conduct 1 country assessment of the state of emergency preparedness.</p>	<p>iii) Country assessment report on state of preparedness.</p>	<p>3rd Quarter 1992</p>	<p>One country assessment report by Nov 1992</p>	<p><u>2 350</u> Abidjan - 7 days duty travel</p>
	<p>4. To assist 1 selected hazard prone country to develop and implement health preparedness plans at the national level.</p>	<p>iv) National EPR legislation and contingency plan including Health Sectorial Plan.</p>	<p>4th Quarter 1992</p>	<p>One national EPR plan by November 1993</p>	

OBJECTIVES AND IMPLEMENTATION STRATEGIES/EMERGENCY PREPAREDNESS UNIT (EPU)

OBJECTIVES	IMPLEMENTATION STRATEGIES	OUTPUT	TIME FRAME	EVALUATION CRITERIA	BUDGET - US\$
<p>2. To strengthen the state of preparedness to respond to epidemic emergencies in particular meningococcal meningitis and yellow fever.</p>	<p>1. To improve management planning</p> <p>2. Identify communicable diseases for which epidemic preparedness constitutes a priority</p> <p>3. Develop clear epidemic preparedness goals</p> <p>4. Develop prevention and control measures for meningitis and/or YF that can be implemented at national, regional and district levels.</p>	<p>i) Clearly formulated national and regional strategies for epidemic preparedness in Ethiopia, Uganda.</p> <p>ii) Resource Person, Harare Workshop, Cholera</p> <p>iii) Epidemic Preparedness Angola Workshop</p>	<p>End, 2nd quarter 1992</p> <p>2nd Quarter 1992</p> <p>3rd Quarter 1992</p>	<p>National Plans Action by Sept 1992</p> <p>Report & Recommendations, Harare meeting</p> <p>Contingency Plans of Action</p>	<p><u>8 000</u> 3 660 - 2 duty travels, Uganda 1 345 - workshops 2 000 - national workshops 400 - secretarial support 595 - printing, duplication, etc</p> <p><u>82 330</u> 6 800 - driver 75 530 - supplies</p> <p>Driver for in-country travels in Ethiopia</p>
<p>3. To strengthen active and passive health surveillance systems, developing early warning systems, enhancing laboratory support.</p>	<p>1. Design, field test disease reporting forms.</p> <p>2. Develop epidemic reporting system from district to national level</p>	<p>i) An operational epidemic early warning surveillance system in 1 pilot country (Ethiopia)</p> <p>ii) Supervision and monitoring system in place.</p>	<p>4th Quarter 1992</p> <p>4th Quarter 1992</p>	<p>Arrival Equipment by August 1992</p> <p>Early warning system in place by November 1992</p>	