PD-ABP-476 94953

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number: ____

DOCUMENT CODE: 3

COUNTRY/ENTITY: Central African Republic

3. PROJECT NUMBER: 676-0024

BUREAU/OFFICE: Africa — 06

5. PROJECT TITLE (maximum 40 characters): Sustainable Child Survival

PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 06 DD 30 YY 97

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

A. Initial FY 92 B. Quarter 4 C. Final FY 97

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

A. FUNDING SOURCE	FIRST FY B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	2,500	--	2,500	12,543	--	12,543
(Grant)	(2,500)	(--)	(2,500)	(12,543)	(--)	(12,543)
(Loan)	( )	( )	( )	( )	( )	( )
Other 1.						
2.						
Host Country		783	783		3,915	3,915
Other Donor(s)						
TOTALS	2,500	783	3,283	12,543	3,915	16,458

9. SCHEDULE OF AID FUNDING ($000)

APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
SS				-0-	-0-	12,543	-0-	12,543	-0-
TOTALS				-0-		12,543	-0-	12,543	-0-

SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each) — 11. SECONDARY PURPOSE CODE

SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code

B. Amount

PROJECT PURPOSE (maximum 480 characters)

To reduce infant mortality and HIV transmission in all five health regions, while increasing accessibility to health services.

SCHEDULED EVALUATIONS

Interim MM 06 YY 94 MM 06 YY 95 Final MM 06 YY 97

15. SOURCE/ORIGIN OF GOODS AND SERVICES: ☐ 000 ☐ 941 ☐ Local ☐ Other (Specify) 935

AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ____ page PP Amendment.)

Concurrence on methods of financing and implementation.

Willard L. Grizzard, CON

17. APPROVED BY

Signature: Myron Golden

Title: Director, AFR/CCWA

Date Signed: MM 08 DD 06 YY 92

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

AID 1330-4 (8-79)

SUSTAINABLE CHILD SURVIVAL PROJECT

Central African Republic

Agency for International Development
Bureau for Africa
Office of Central and Coastal West Africa
Washington, D.C. 20523

August 1992

SUSTAINABLE CHILD SURVIVAL PROJECT
TABLE OF CONTENTS

Map of Central African Republic (C.A.R.) i
Abbreviations and Acronyms ii

Executive Summary ES-1

I. BACKGROUND AND SETTING 10

A. Setting 10
B. Recent Economic Developments 10
C. Health Situation in C.A.R. 11
D. Health Policies, Strategies and Programs 12
C. A.I.D. Strategy in C.A.R. 15
E. Donor Assistance in Health 17

II. PROJECT RATIONALE AND DESCRIPTION 18

A. Relation to PID 18
B. Project Goal, Purpose, and Strategy 19
C. Principal Project Components 22

III. IMPLEMENTATION PLAN 35

A. Implementation Arrangements and Responsibilities 35
B. Training Plan 41
C. Implementation Schedule 41

IV. FINANCIAL PLAN 42

A. A.I.D. Budget 43
B. CARG Contribution 44

V. EVALUATION PLAN 46

A. Yearly In-Country Review 46
B. Mid-term Evaluation 46
C. Final Evaluation 47
D. Inputs to the Evaluation Process 47

B

VI. SUMMARY OF ANALYSES 53

A. Summary of Technical Annex 53
B. Summary of Economic Analysis 56
C. Summary of Social Soundness Analysis 59
D. Summary of Administrative/Institutional Analysis 64

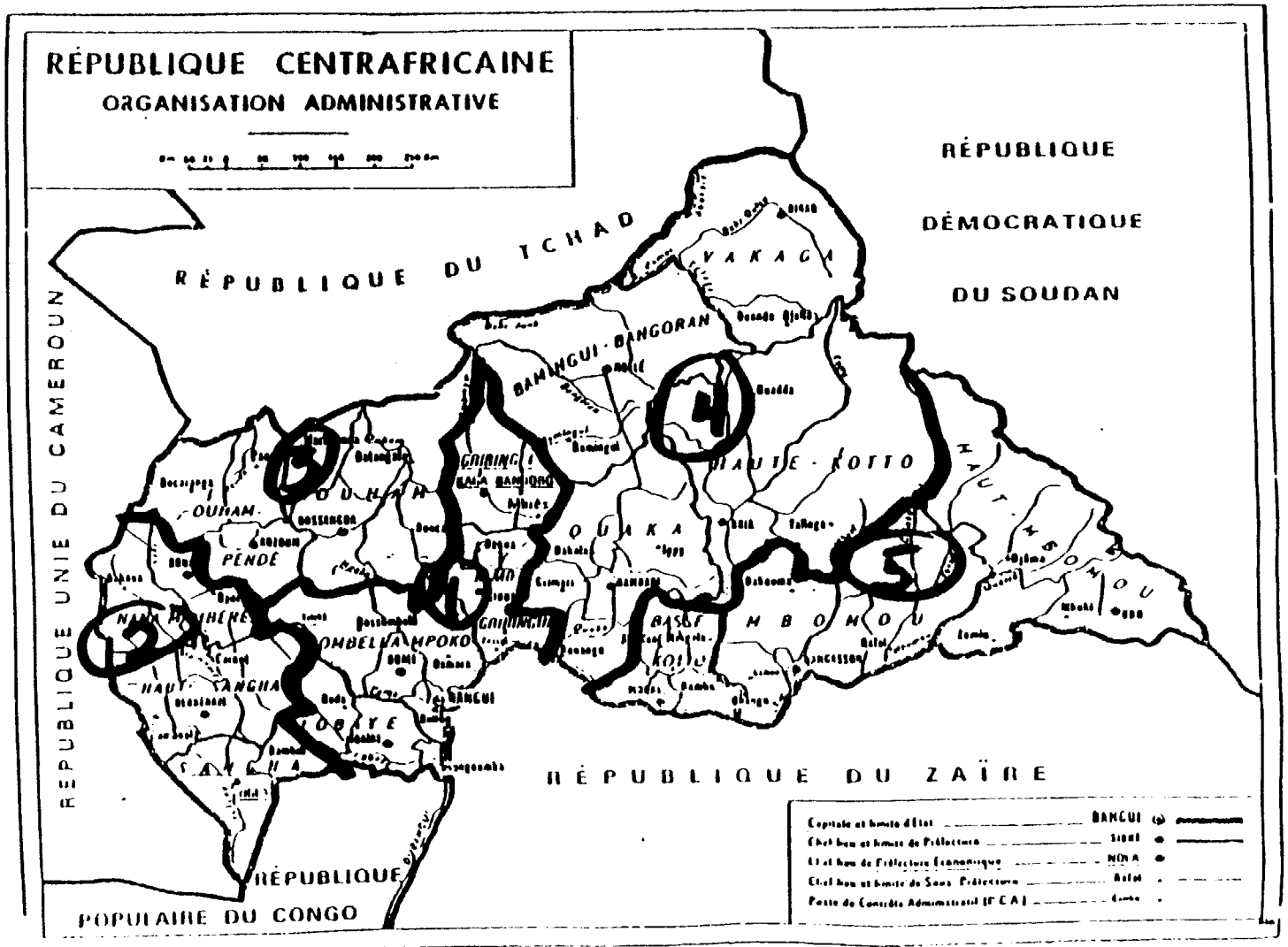
VII. CONDITIONS AND COVENANTS AND WAIVERS 68

ANNEXES

A. PID Approval Message/Memo
B. Logical Framework Matrix
C. CARG Request for Assistance
D. Initial Environmental Examination
E. Statutory Checklist

F-1. Technical Analysis - Child Survival
F-2. Technical Analysis - HIV/AIDS and STDs
G. Economic and Financial Analysis
H. Social Soundness Analysis
I. Administrative/Institutional Analysis

J. Cost Recovery in C.A.R.
K. Implementation Schedules
L. Bibliography
M. Small Country Program Strategy


RÉPUBLIQUE CENTRAFRICAINE
ORGANISATION ADMINISTRATIVE
RÉPUBLIQUE DU TCHAD
RÉPUBLIQUE DÉMOCRATIQUE DU SOUDAN
RÉPUBLIQUE UNIE DU CAMEROUN
RÉPUBLIQUE DU ZAÏRE
RÉPUBLIQUE POPULAIRE DU CONGO
VAKAGA
BAMINGUI-BANGORAN
HAUTE-KOTTO
HAUT-MBOMOU
OUHAM
OUHAM-PENDE
NANA-GRIBINGUI
OMBELLA-MPOKO
HAUT-SANGHA
SANGHA
LOBAYE
OUAKA
BASSE-KOTTO
MBOMOU
BANGUI
Capitale et limite d'Etat — BANGUI
Chef-lieu et limite de Préfecture — SIBUT
Chef-lieu de Préfecture Economique — NOLA
Chef-lieu et limite de Sous-Préfecture — Bafaï
Poste de Contrôle Administratif (P.C.A.) — Gamba

ACRONYMS AND ABBREVIATIONS

ADB or AFDB	African Development Bank
ADS	Africa Development Support (an AFR regional project)
AFR	Bureau for Africa, A.I.D./Washington
AFR/CCWA	Office of Central and Coastal West African Affairs, Africa Bureau
AFR/PD	Office of Project Development, Africa Bureau
A.I.D. or AID	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
AIDSTECH	Technical Support and Training for the Prevention and Control of AIDS (a centrally-funded A.I.D. project)
AID/W	Agency for International Development/Washington
ALO	A.I.D. Liaison Officer, Bangui
API	Assessment of Program Impact
ARI	Acute Respiratory Infection(s)
ACSI-CCCD	African Child Survival Initiative-Combatting Childhood Communicable Diseases (an AFR regional project)
BAD	African Development Bank (French acronym)
BCG	Anti-tuberculosis vaccination
C.A.R. or CAR	Central African Republic
CARG	Government of the Central African Republic
CCCD	See ACSI-CCCD
CCWA	See AFR/CCWA
CDC	Centers for Disease Control
CDD	Control of Diarrheal Diseases
CNHU or CNHUB	National University Hospital Center, Bangui
CREDES	A French consulting firm contracted by ADB to do a pharmaceutical study in C.A.R.
CRPF	Chloroquine Resistant Plasmodium Falciparum
CSM	Condom Social Marketing
CYP	Couple Year of Protection
DEPS	Directorate of Planning, Studies, and Statistics, CARG
DFA	Development Fund for Africa
DHS	Demographic and Household Survey(s) (an AID/W project)
DMPGE	Directorate of Preventive Medicine and Infectious Diseases, CARG
DPT	Diptheria, Polio, and Tetanus (immunization)
DSMI	Directorate of Maternal and Child Health, CARG
EEC	European Economic Community
EPI	Expanded Program on Immunization
ESAF	Enhanced Structural Adjustment Facility

FAAS	Foreign Affairs Administrative Support
FCFA	CFA Franc--currency used in C.A.R., valued at 50 per French Franc
FF	French Franc
FNUAP	United Nations Fund for Family Planning Assistance
FSN	Foreign Service National
FY	Fiscal Year
GDP	Gross Domestic Product
GNP	Gross National Product
HE	Health Education
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS or H/MIS	Health Management Information System
HRDA	Human Resources Development Assistance (a regional AFR training project)
IBRD	International Bank for Reconstruction and Development (also known as World Bank)
IEC	Information, Education, and Communication
IMF	International Monetary Fund
KAP	Knowledge, Attitudes, and Practices
MCH	Maternal and Child Health
MOH	Ministry of Health (see also MSPAS)
MSH	Management Sciences for Health (a U.S. firm)
MSPAS	CARG Ministry of Public Health and Social Affairs
NACS	National AIDS Control Service, CARG
O&M	Operations and Maintenance
OMS	World Health Organization (French acronym)
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PASA	Participating Agency Service Agreement
PEV	CARG expanded program of vaccination (French acronym)
PHC	Primary Health Care
PID	Project Identification Document
PNDS	CARG National Health Plan (French acronym)
PSI	Population Services, International (a U.S. PVO)
PVO	Private Voluntary Organization
REACH	Resources for Child Health (an AID/W-funded project)

SAP	Structural Adjustment Program
S&T	Science and Technology Bureau, AID/W
SCSP	Sustainable Child Survival Project, the proposed new name for this project
SDAP	Social Dimensions of Adjustment and Development, an IBRD project
SMI/SP	CARG Directorate of Maternal and Child Health/Family Planning (French acronym)
SNIEC	National Service for Information, Education, and Communications (proposed new CARG office)
STD	Sexually Transmissible Disease(s)
TA	Technical Assistant/Technical Assistance/Technical Advisor
TAACS	Technical Advisor for AIDS and Child Survival
TT	tetanus toxoid
UNDP	United Nations Development Fund
UNICEF	United Nations Children's Fund
UNIPAC	United Nations Procurement Agency
USAID	United States Agency for International Development overseas mission
VITA	Volunteers in Technical Assistance (a U.S. PVO)
WB	World Bank
WHO	World Health Organization
WHO/GPA	World Health Organization's Global Program on AIDS

Acronyms:4707y

SUMMARY AND RECOMMENDATION

Setting

With a per capita gross national product (GNP) of $380 (1988), the C.A.R. is classified as a least developed country. Its economic development is constrained by the C.A.R.'s remote location, dependence on a limited range of primary commodity exports, poor transport and communications infrastructure, a relatively non-monetized economy, a limited internal market and widely dispersed population, and low levels of domestic savings, investment and productivity.

As in many other parts of Africa, the population of the C.A.R. is predominately young with 45 percent under 15, of which 18 percent are under 5, and 5 percent are under one year of age. The estimated average life span is 47 for men and 49 for women. C.A.R.'s population has a poor health status even by African standards, with an infant mortality rate of 143 per thousand and a low life expectancy. Children are the most vulnerable. One out of seven children dies before his/her first birthday and mortality rates for children under 5 are 226 per 1000 (UNICEF 1990).

For the general population the major causes of death are respiratory infections, meningitis, diarrhea and malaria. Principal causes of morbidity for children under 15 are diarrheal diseases, malaria, parasites, and acute respiratory infections (DEPS 1988). Childhood illness, however, is complex and inter-related; for example, a malnourished child is more susceptible to diarrhea or upper respiratory disease.

Women are the second most vulnerable group. Not only are they susceptible to the same health risks as the rest of the population, but early marriage, inadequate pre-natal counselling, frequent pregnancies, and difficult birthing conditions have resulted in one of the highest maternal mortality rates in Africa (PNDS 1991). The increased incidence of AIDS among women is especially disturbing because of the high rate of HIV transference to newborns.

Recent Economic Developments

The government of C.A.R. (CARG) began an economic reform program in 1986 designed to encourage agricultural production, reduce government control of the economy and correct major macroeconomic imbalances (unsustainable current account and fiscal deficits). The third Structural Adjustment Program (SAP), approved in June 1990, focuses special attention on strengthening institutional capacity, developing coherent human resource development policies and programs in health and education and alleviating the social costs of adjustment.

The economic reform program has thus far failed to promote satisfactory growth (less than one percent annual growth in gross

domestic product (GDP) 1987-90) and efforts to reduce fiscal and current account deficits have fallen short of targets. At the same time, there has been progress in dismantling state controls on the economy and in reducing the number of civil servants. After showing mixed results in the period 1986-89, the reform program stumbled badly in 1990 with extra budgetary expenditures and transparency issues emerging as major concerns for the donors. Recently the reform program and government administration in general has fallen victim to the political, financial and labor crises which have hit the country over the past year. From May 1991 through January 1992, the country was paralyzed due to a nation-wide strike by the public sector demanding the back payment of salaries and better social and political conditions.

CARG Health Policies, Strategies and Programs

C.A.R. shares with many other African countries a French colonial history that emphasized high cost, urban-based curative medicine with free health care and medicines. Beginning in 1978, the C.A.R. began to move towards the creation of a national primary health care system that would provide low cost, preventative services to the entire population.

In August 1989, the new "National Committee for the Coordination of Primary Health Care" began development of the National Health Plan for 1992-1996, which emphasized the decentralization of the health care system. The Plan, which was completed in May 1991, outlines 10 priority programs for the next five years -- five health programs and five support programs. A.I.D.'s Sustainable Child Survival Project will provide assistance to three of the five health programs: Maternal and Child Health, Endemic Diseases, and AIDS. The project will also provide assistance through three support programs: Essential Drugs and Vaccines, Health Information and Education, and Institutional Services.

A.I.D. Strategy in C.A.R.

A.I.D. has provided approximately $50 million of development assistance to C.A.R. since its independence in 1961. Because of human rights abuses under former President Boukassa, U.S. assistance to C.A.R. was restricted during the 1970's. Following the resumption of assistance in 1981, A.I.D. focused its assistance on rural development, vocational education and health. However, the rural development activities implemented during the 1980's performed poorly due to weak government commitment and institutional capabilities. Given the poor prospects for future interventions, A.I.D. ended these activities in September 1991.

The regional Combatting Childhood Communicable Diseases (CCCD) project has been active in C.A.R. since 1984. The Centers for Disease Control (CDC) has provided an on-site technical officer to

implement the project, which has been considered very successful. In 1990, C.A.R. health activities were expanded to support the National AIDS Prevention Committee with the assignment of a second CDC officer to C.A.R. to manage this effort. In 1991, A.I.D. provided additional funding to support a health finance economist. Because of the continuing success of these activities and an active and progressive Ministry of Health committed to primary health care, A.I.D. approved a program focus in mid-1991 which will concentrate A.I.D. activities in C.A.R. in the health sector. Under this approach, the proposed five-year Sustainable Child Survival project was designed to build on the successful child survival, AIDS and health cost recovery work.

Until March, 1992, USAID/Yaounde served as the mission for C.A.R. Since 1984, in country, day-to-day relations has been handled by a Embassy Officer. The C.A.R. program is now managed as part of AFR/CCWA's Small Country Program Strategy (see Annex M). Approved in March, 1992, this approach was designed to improve A.I.D. oversight in those countries which have no resident A.I.D. direct hire employees. AFR/CCWA has now assumed responsibility as the cognizant mission for the C.A.R. program.

The proposed project, with its emphasis on primary health care, child survival, cost recovery, and condom social marketing and treatment of sexually transmitted diseases to combat AIDS, conforms to the Development Fund for Africa Action Plan for FY 1989-1991. The project is focused on those areas: a) where A.I.D. has had proven success in the country, and has comparative strength; b) where A.I.D. project components complement other donors' activities in the sector; and c) which follow the guidance in the DFA Action Plan.

Project Rationale and Description

The Sustainable Child Survival (SCS) Project is an extension and expansion of the child survival interventions that have been supported by A.I.D. through the regional ACSI-CCCD project since 1984. In collaboration with UNICEF, this project has been implemented in C.A.R. with remarkable success. Nevertheless, on-going and future child survival interventions can be sustained only if the Ministry of Health (MOH) more effectively integrates its activities in primary health care, strengthens its institutional capacity, and institutes cost recovery and cost reduction mechanisms.

The SCS project will thus support the CARG's implementation of an integrated primary health care program (PHC) by providing technical training and related commodities to the Ministry of Health for child survival interventions; technical assistance for institutional development and the elaboration of strategies for integrating the various interventions currently carried out by separate directorates within the Health Ministry; and financing for

studies that will help design cost recovery and cost reduction activities nation-wide.

The project goal is: **"to provide adequate, affordable health care to the C.A.R. population."**

The project purpose is: **"to reduce infant mortality and HIV transmission in all five health regions, while increasing accessibility to health services."**

The project has two major components: Child Survival Interventions and Sustainability Interventions. The Child Survival component provides technical assistance in six areas: 1) an Expanded Program of Immunization (EPI); 2) Control of Diarrheal Diseases (CDD); 3) Malaria; 4) Acute Respiratory Illnesses (ARI); 5) HIV/AIDS (including the treatment of sexually transmitted diseases, and condom social marketing); and 6) birth spacing. The first three are continuations of the work initiated under the CCCD project; the last three comprise a logical expansion of these earlier efforts.

The Sustainability component includes Institutional Strengthening activities, and assistance in developing strategies and policies for cost recovery in the health sector. The three Institutional Strengthening activities are: 1) training in management, planning, training methodologies, and technical fields 2) the development and installation of an integrated development of health/management information systems (H/MIS) (to be provided in conjunction with the African Development Bank); and 3) assistance to help the CARG develop a national cost recovery system. With regard to the cost recovery interventions, the project will support the work of the Ministry's Health Economics Unit to diversify and increase sources of revenue in the health sector and to develop, test, and implement alternative health financing systems.

A summary of the A.I.D. funding for the project is provided on the following page.

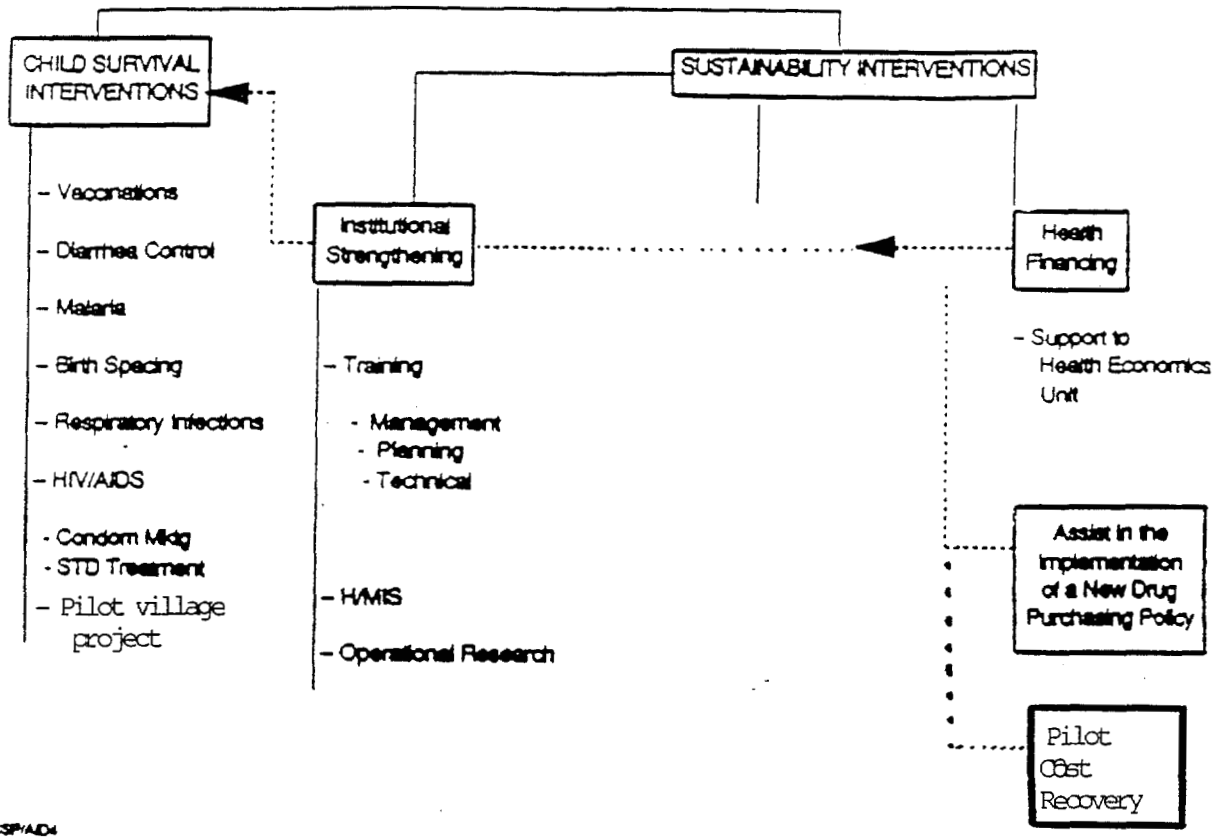
A.I.D. BUDGET
(1,000)

	FY 1993	FY1994	FY1995	FY1996	FY1997	TOTAL
-Child Survival	1,438	1,438	1,008	988	936	5,808
-HIV/AIDS & STDs	913	913	863	806	100	3,595
-Institutional Strengthening	490	85				575
-Health Financing & Sustainability	505	390	155			1050
-Evaluation & Data Collection	335	90	90	10	90	615
-PVO Support	300	300	300			900
TOTAL PROJECT	3,981	3,216	2,416	1,804	1,126	12,543

The host country contribution, which is a combination of direct capitol CARG cost (primarily salaries) and the reduction of expenditures from the health cost recovery programs, is estimated at $3,915,200 over the five years.

The general structure of the proposed project is provided on the following page.

SUSTAINABLE CHILD SURVIVAL PROJECT



Implementation Arrangements and Responsibilities

Pursuant to the C.A.R. Small Country Strategy, (see Annex M) one organization will have primary responsibility for the implementation of the Sustainable Child Survival project: the Centers for Disease Control (CDC). The role of CDC and the contracting mechanism anticipated is discussed below.

A.I.D. will negotiate an Inter-agency Agreement (IAA) with the CDC to carry out the project. CDC is uniquely qualified to implement the child survival interventions component of the project. It has been responsible for the A.I.D. contributions to child survival in C.A.R. since 1985 under the regional ACSI-CCCD project. The methodology developed by CDC for implementing the child survival interventions has been accepted by the CARG. Indeed, the CARG has strongly expressed their desire (see Annex C) that CDC continue to provide technical support to the activities. In addition, CDC is known worldwide for its expertise in AIDS and this will be invaluable as the CARG intensifies its effort to combat AIDS.

The project will: (1) provide institutional interventions directed at technical, management, and planning programs to strengthen infrastructure responsible for inservice training/supervision of health personnel at the central, regional and prefectoral levels, (2) assess and prioritize health education needs and develop and implement culturally appropriate interventions, and (3) develop and coordinate a research agenda to address operational issues.

Child Survival Interventions

The Sustainable Child Survival project will provide assistance for the technical interventions and support strategies of the current Combatting Childhood Communicable Diseases (CCCD) Project. It will further assist the MSPAS in addressing three additional threats to child survival: Acute Respiratory Illnesses (ARI), the human immunodeficiency virus (AIDS), and high risk births. The project will place greater emphasis than its predecessor on activities to strengthen training and supervision, to reach communities and influence health behaviors, to improve health workers' abilities to both solve operational problems, and to collect, analyze and use health data. A long-term (60-month) technical advisor will be provided to supervise the child survival interventions.

A.I.D. will finance a long-term (48-month) technical advisor from the CDC to help control the AIDS epidemic through program management, training, STD control, and monitoring and evaluation. The Sustainable Child Survival project will give priority to four of the seven major program emphases of the National AIDS Control Service (NACS): 1) evaluating the progress of the disease; 2)

improving access to condoms; 3) diminishing sexual transmission through the control of STDs; and 4) promoting behavioral change through health education and social mobilization.

CDC will call on the private sector (Population Services International) to implement the condom social marketing component of the project. The condom social marketing advisor will: 1) augment demand for condoms, 2) distribute condoms throughout C.A.R., 3) monitor distribution and sales, and 4) evaluate the use of condoms in the general population. It is expected that these efforts will be strongly supported by the MSPAS through health education for the general public and for high risk groups.

CDC will utilize Africare to implement a village-level outreach activity that will extend CDC child survival and sustainable interventions to selected rural communities. The village-level outreach advisor (36 months) will oversee activities to demonstrate successful approaches for the delivery and supervision of community based interventions that can be replicated throughout the Central African Republic.

Sustainability Interventions

The project will provide technical assistance to the MSPAS to assist with the development of training methods and materials. Technical, management, and planning training programs will be developed and implemented. Short-term experts will develop a plan for integrating current child survival surveillance systems into the national H/MIS. The SCSP will provide computers as commodity support and technical assistance to help the development of these systems.

The Sustainable Child Health project will assist the CARG to promote policy dialogue on health care financing issues among the government and donors, and to develop, test, and implement alternative health financing systems. A long-term (42-month) health economist will be provided to identify measures to increase the efficient use of financial resources and to promote hospital financial autonomy. Hospital fees have already been enacted so the emphasis will be on strengthening the accounting infrastructure, reducing hospital costs, and reforming hospital fees.

A.I.D. Monitoring and Oversight

The responsibility for monitoring and oversight of the C.A.R. program has recently been shifted from USAID/Cameroon to AFR/CCWA. A responsible officer from that office will visit C.A.R. once or twice every calendar year. On-site supervision will be provided by an A.I.D. Liaison Officer (ALO) and his two FSN assistants at the U.S. Embassy in Bangui. The Embassy has agreed to finance these positions for an additional two years.

The ALO and his assistants are capable of providing a higher level of monitoring and oversight than has been requested of them to date. The ALO should thus be given responsibility for the day-to-day administrative oversight of the project and for the supervision of the personnel funded under the project. The latter would nevertheless report to CDC and would look to CDC for technical backstopping.

RECOMMENDATION: That the Sustainable Child Survival project be approved for a five year life of project funding of $12,543,000.

I. BACKGROUND AND SETTING

A. Setting

The Central African Republic (C.A.R.), a landlocked country in the heart of Africa, is slightly smaller than Texas. An estimated 2.8 million inhabitants, including half a million in the capital city of Bangui, are concentrated along the rivers and roads in the southwestern half of the country. National infrastructures are underdeveloped. There are only 452 kms (280 miles) of paved roads and the rest are barely passable during the 4 to 6 months of the rainy season.

With a per capita gross national product (GNP) of $380 (1988), the C.A.R. is classified as a least developed country. The primary sectors of agriculture, forestry and fisheries occupy three quarters of the population; in 1989 they accounted for 42 percent of GNP and 49 percent of exports. Diamonds bring in 40 percent of export earnings, coffee and timber account for 20 percent each, and cotton, the most widely cultivated export crop, brings in only six percent of export earnings.

Economic development is constrained by the C.A.R.'s remote location, dependence on a limited range of primary commodity exports, poor transport and communications infrastructure, a relatively non-monetized economy, a limited internal market and widely dispersed population, and low levels of domestic savings, investment and productivity.

Education has not been a high government priority, utilizing only 21.1 percent of the national budget (SPA 92). The rate of scolarisation for children from 6-14 is 60 percent and the average student/teacher ratio is 70. Illiteracy remains high -- 66 percent in 1989, with 60 percent for men and 71 percent for women.

As in many other parts of Africa, the population of the C.A.R. is predominately young with 45 percent under 15, of which 18 percent are under 5, and 5 percent are under one year of age. The estimated average life span is 47 for men and 49 for women. In 1990, 45 percent of the population were in urban areas with 25 percent concentrated in Bangui.

B. Recent Economic Developments

The government of C.A.R. (CARG) began an economic reform program in 1986 designed to encourage agricultural production, reduce government control of the economy and correct major macroeconomic imbalances (unsustainable current account and fiscal deficits). The reform program has been supported by three consecutive IBRD structural adjustment credits and three credits under the IMF Structural Adjustment Facility. Combined multilateral and bilateral assistance was $143 million in 1988.

Under debt rescheduling and relief arrangements, total external debt has declined from $643 million in 1988 to $514 million (40% of GNP). Scheduled debt service as a percent of exports of goods and services stood at 22.7 percent in 1989.

Under the third Structural Adjustment Program (SAP) approved in June 1990, the CARG agreed to continue efforts to reduce the fiscal deficit, strengthen investment planning, reform the civil service and implement reform measures in agriculture and transport. The third SAP focuses special attention on strengthening institutional capacity, developing coherent human resource development policies and programs in health and education and alleviating the social costs of adjustment. A Social Dimensions of Adjustment and Development Project (SDAD), which will focus on the development of survey measures to assess the impact of adjustment on the poor and finance a program of training for rural youth, is being developed with support from the World Bank, African Development Bank and the UNDP.

The economic reform program has thus far failed to promote satisfactory growth (less than one percent annual growth in gross domestic product (GDP) 1987-90) and efforts to reduce fiscal and current account deficits have fallen short of targets. At the same time, there has been marginal progress in dismantling state controls on the economy and in reducing the number of civil servants. After showing mixed results in the period 1986-89, the reform program stumbled badly in 1990, with extra budgetary expenditures and transparency issues emerging as major concerns for the donors. The reform program and government administration in general has fallen victim to the political, financial and labor crises which have hit the country over the past six months. From May - December 1991, the public sector was on strike demanding the back payment of salaries; these strikes extended to the private sector from June 1991.

At a UNDP Round Table in April 1991, donors told the CARG that it would have to implement promised political reforms and strengthen economic management before they could pledge significant new non-project aid in support of the government's program. An IMF mission in April 1991, concluded that the C.A.R.'s current macroeconomic situation and policies do not meet the standards for support under an ESAF (Enhanced Structural Adjustment Facility). Nevertheless, the IMF, the World Bank and the CARG are continuing consultations on the country's macroeconomic policies so that the second tranche of the World Bank's structural adjustment credit can be disbursed later this year.

C. Health Situation in C.A.R.

C.A.R.'s population has a poor health status even by African standards, with an infant mortality rate of 143 per thousand and

a low life expectancy. Children are the most vulnerable. One out of seven children dies before his/her first birthday and mortality rates for children under 5 are 226 per 1000 (UNICEF 1990).

In the general population the major causes of death are respiratory infections, meningitis, diarrhea and malaria. Principal causes of morbidity for children under 15 are diarrheal diseases, malaria, parasites, and acute respiratory infections (DEPS 1988). Childhood illness, however, is complex and inter-related. A malnourished child is more susceptible to diarrhea or upper respiratory disease. Often this malnutrition is due to improper weaning foods, early weaning as the result of another pregnancy or poor nutritional knowledge (PNDS 1991).

Women are the second most vulnerable group. Not only are they susceptible to the same health risks as the rest of the population, but early marriage, inadequate pre-natal counselling, frequent pregnancies, and difficult birthing conditions have resulted in a maternal mortality rate of up to 8 percent, one of the highest in Africa (PNDS 1991). The increased incidence of AIDS among women is especially disturbing because of the high rate of HIV transference to newborns.

The government budget available for health ($12.4 million out of a total government budget of $193 million in 1988) is insufficient to address these problems. Most of the health budget is spent for salaries (approximately 70% of the total for 1988) or for curative services in Bangui (approximately 65% of the remaining health funds for 1988), leaving little for preventive or curative care in facilities outside of Bangui.

D. Health Policies, Strategies and Programs

C.A.R. shares with many other African countries a French colonial history that emphasized urban based curative medicine with free health care and medicines. Beginning in 1978 with the Alma-Ata Declaration, and again by the Bamako Initiative of September 1987, the C.A.R. began to reorient its national health system towards primary health care, particularly through services at community health centers targeting women and children.

The Bamako Initiative is a strategy that was developed by African Health Ministers at the 37th regional meeting of the World Health Organization (WHO) in Bamako, Mali in September 1987. The Ministers agreed to give higher priority to investments in lower cost primary health care (PHC) programs (rather than the higher cost curative health care programs of the past). The strategy also aims to develop community financing (cost-recovery) mechanisms that would allow local communities to take charge of their health needs.

In August, 1989, the newly formed "National Committee for the Coordination of Primary Health Care" launched a project to develop the National Health Plan for 1992-1996. This ambitious project, funded and assisted largely by the World Health Organization (WHO), had three main steps: a decentralized strategy to assess national needs and analyze problems in the existing health care system; the articulation of a national health policy; and the delineation of priority health programs for 1992-1996.

Regional and prefectural teams were trained by a Cellule d'Execution des Soins de Sante Primaire (Primary Health Care (PHC)) to discuss with village health committees the major health issues facing the rural population. This information was then gathered into prefectural micro-plans, which, in turn, were synthesized into primary health care plans for each of the five regions and for Bangui. These six plans were then pulled together and analyzed at the central ministry level.

1. Issues and Constraints

During this process, six major health problems were identified:

- infectious and parasitic illnesses
- poor health of women and children
- nutritional deficiencies
- lack of essential medicines
- inadequate geographic health coverage
- lack of clean water and poor sanitation

The principal constraints and weaknesses identified in the health sector were:

- Structural constraints
  - the over-centralization of authority and resources, and the persisting unwillingness of the central government to delegate responsibilities to the regions
  - the need for a national policy of decentralization
- Organizational constraints
  - lack of differentiated tasks and roles at the national, regional and prefectural levels
  - the need for clearer hierarchial communication structures and descriptions of different personnel categories
  - an inadequate regulatory framework

- the lack of a clear and organized management system for the stocking, distribution and replacement of supplies and equipment
- an inappropriate/inadequate organizational structure at the ministry, regional and local levels, resulting poor coordination among directorates and a lack of horizontal integration, rapid staff turnover, wasteful duplication of efforts, and top down planning and implementation
- weak planning, evaluation and supervisory systems
- inadequate information systems
- insufficient emphasis on community participation in health care

- Physical/human constraints

  - poor distribution of health facilities (64% of the population live farther than 10 kms from a health facility)
  - inequitable distribution of equipment and supplies (including medicines)
  - poor quality of existing facilities
  - insufficient staff to meet technical and managerial needs of the health sector
  - lack of a national policy governing essential drugs and of an effective distribution system
  - negative impact of the national economic crisis on the health sector (PNDS 1991).

2. Policies and Programs

Following this needs assessment, the Ministry of Public Health and Social Affairs (MSPAS) held a workshop to develop a national health policy and five year plan. Multinational and bilateral donors were invited to a one-day meeting to review and provide feedback and advice on the Ministry's work to date, including proposed sectoral objectives and institutional strategies. The document, the National Plan for Health Development (PNDS), was completed in May 1991, and outlines ten priority programs for the next five years: five health programs and five support programs. The five health programs are:

- National Program for the Control of the Quality of Water and Environmental Health

- National Program for Nutrition

- National Program for Maternal and Child Health

- National Program to Combat Endemic Diseases (i.e., diarrhea, malaria, leprosy, iodine deficiency, acute respiratory infections, trypanosomiasis,

onchercerosis, sexually transmitted diseases, and immunizable diseases)

- National Program to Combat AIDS

The five support programs are:

- National Program for the Training of Health Personnel
- National Program for the Rehabilitation, Construction and Equipping of Health Facilities
- National Program for the Provision of Essential Drugs and Vaccines
- National Program for Health Information and Education
- National Program for the Strengthening of Institutional Services at the Central, Intermediary and Peripheral Levels

The workshop also recommended a restructuring of the ministry, including the creation of two new departments (Infrastructure and Pharmaceuticals), the elimination of the Curative Health Department, and the creation of a new National Service for Information, Education and Communication. No consensus was reached on this proposal, however, and a decision is still pending.

E. A.I.D. Strategy in C.A.R.

1. Background

A.I.D. has provided approximately $50 million of development assistance to C.A.R. since the country's independence in 1961. U.S. assistance to C.A.R. was restricted during the 1970's because of the human rights record of then-President Boukassa. Following the resumption of assistance in 1981, A.I.D. has focused its assistance on rural development and health.

In the rural sector, Africare and Volunteers in Technical Assistance (VITA) implemented A.I.D. projects during the period 1981-1991. However, as a result of evaluations indicating the poor performance of these projects, weak government commitment and institutional capabilities, and poor prospects for future interventions, A.I.D. ended these activities in September 1991. However, Opportunities Industrialization Centers International (OICI) received A.I.D. funding in late 1990 to begin a three-year farmer vocational training activity, which will provide "hands-on" practical training for 1,350 young and adult farmers by 1993.

In the health sector, the regional project Combatting Childhood Communicable Diseases (CCCD) has been active in the C.A.R. since 1984. The Centers for Disease Control (CDC) has provided an on-site technical officer to implement the project, which is regarded as highly successful. In fact, in recognition of its accomplishments, C.A.R. won the child survival award from the National Council for International Health child survival award in 1990.

In 1990, A.I.D's activities in C.A.R.'s health sector were expanded to support the National AIDS Prevention Committee. The CDC assigned another officer to the country to manage this effort. Then in 1991, the Research and Development Bureau's Health Financing and Sustainability project provided funding for a health finance economist, who was assigned to work with the Director General of the Health Ministry. This economist is supervising background studies to be used in the preparation of new legislation on health finance. The legislation will be a product of a series of A.I.D.-funded activities in sustainable health care financing.

In light of the considerable success of A.I.D's activities in the health sector and the sincere and solid commitment of C.A.R.'s Ministry of Health to improving primary health care, A.I.D. approved in mid-1991 a program strategy to concentrate its resources for the C.A.R. in the health sector. The proposed five-year Sustainable Child Survival project was designed to build on the successes in child survival, AIDS and health cost recovery.

2. Conformity to A.I.D. Policy

With its emphasis on primary health care, child survival, cost recovery, and condom social marketing and treatment of sexually transmitted diseases to combat AIDS, the proposed project conforms to the FY 1989-1991 Development Fund for Africa Action Plan. Target 1.3 of that Action Plan supports greater equity and efficiency in health care and child survival. The Africa Bureau has also agreed to include cost recovery mechanisms in its overall strategy to improve the sustainability of health and child survival activities. The Sustainable Child Survival project thus focuses on those areas: a) in which A.I.D. has had proven success and has a comparative advantage; b) which complement other donors' activities in the health sector; and c) which conform to the guidance in the DFA Action Plan.

3. A.I.D. Management Systems

Since 1984, a designated Officer of the U.S. Embassy/Bangui and two FSNs (all three funded by the Embassy) have handled the day-to-day relations with the C.A.R., other donors, PVOs and A.I.D. project contractors. Until March, 1992, USAID/Yaounde was

responsible for programming, technical project management and backstopping, accounting, contracting and procurement for activities in the C.A.R. The program is now managed by A.I.D./Washington, under AFR/CCWA's Small Country Program Strategy. Approved in March, 1992, (see Annex M) this approach was designed to improve A.I.D. oversight in countries which have no resident direct hire A.I.D. employees. Thus AFR/CCWA now has responsibility as the cognizant mission for the C.A.R. program.

F. Other Donor Assistance in Health

According to the July 1990 UN Report on Cooperation and Development, total external assistance to the health sector in C.A.R. for 1989 totalled just over $7 million. The largest donors were the African Development Bank, France, and the People's Republic of China. UN agencies (UNICEF, OMS, FNUAP) accounted for nearly a third of total assistance. The U.S. is the next largest bilateral donor in this sector, while Germany and Japan have smaller programs. The EEC and Germany also provide some health interventions under their integrated regional development projects.

In the future, the EEC is expected to provide more support to the Ministry at the central level (i.e., to the National Sexually Transmitted Diseases Laboratory in support of treatment for sexually transmitted diseases (STDs) and Acute Respiratory Infections) while continuing its health programs in selected regions. Over the past 18 months, the World Bank has been discussing a health project with the government, but the specific form of intervention (possibly infrastructure rehabilitation or support to primary health care in one region) has yet to emerge. Current World Bank plans call for a health project to be launched in 1992.

French assistance is concentrated in the curative sector (including the provision of medicines to the hospitals) as well as scholarships for physician and pharmacist training. France also has smaller interventions in support of the national AIDS program and a tuberculosis program. In recent years, both the African Development Bank and China have financed the building and some operational expenses for two new hospitals in Bangui. WHO provides technical assistance to the ministry, some training funds, and support to the national AIDS program. UNICEF has financed water well projects, childhood vaccination, and some in-country training programs. This year, UNICEF hopes to launch a pilot primary health care project following the guidelines of the Bamako Initiative in three prefectures. UNDP also provides assistance for the wells project and supports family planning through the FNUAP.

There is currently no regular donor coordination in the health sector. While the CARG has not encouraged donor coordination in the past, the government and the ministry of health have been more receptive to coordination efforts over the past year. Last fall, donors participated in a series of meetings contributing to the formulation of the five year health plan. In addition, donors have made efforts recently to improve coordination in specific programs, such as in the implementation of nationwide vaccination programs (UNICEF and USAID), and in the elaboration of a primary health program and cost recovery system (UNICEF, AFDB and USAID). Because in the past some donors failed to follow through on their commitments, the MSPAS now seeks to engage a number of donors in the same program or project, what Central Africans call "multipartnerships."

II. PROJECT RATIONALE AND DESCRIPTION

A. Relation to PID

The design team for this Project Paper recommended that two of the three components proposed in the original Project Identification Document (PID) be pursued:

1) A continuation of the child survival interventions currently being provided by the Centers for Disease Control (CDC) in collaboration with the Directorate of Preventive Medicine and Endemic Diseases (DMPGE) of the C.A.R. Ministry of Health. This project is now financed through A.I.D.'s regional project, the Africa Child Survival Initiative-Combatting Communicable Childhood Diseases (ACSI-CCCD);

2) A cooperative grant with an NGO to carry out a program of condom social marketing.

The third activity proposed in the PID, a grant to UNICEF to permit it to extend to three additional prefectures its Primary Health Care (PHC) program, is not warranted at this time as the plans for expansion are still being elaborated.

The child survival activities will be the core of the project, and will be expanded to include interventions in acute respiratory infections (ARI), birth spacing, and combatting HIV/AIDS and sexually transmitted diseases (STDs). The project will also encourage the CARG's implementation of the Bamako Initiative in its movement toward a more integrated primary health care system and the search for a grass roots approach to health care provision.

In addition, project resources will: a) support the technical training to geographically-oriented PHC programs, to ensure that the child survival interventions included in these programs are technically sound and adequately supported; and b) finance studies to help design cost recovery and cost reduction activities in peripheral areas.

The on-going and planned child survival interventions can be sustained only if these activities are better integrated within the Ministry of Health (MOH) structure, the institutional capacity of the MOH is strengthened, and cost recovery/cost reductions are instituted. Thus, sustainability involves institutional strengthening of the MOH as well as improved public health financing.

The project will include five long-term technical advisors (TAs), specializing, respectively in: child survival; HIV/STD control; village-level outreach advisor; health economics and finance; and condom social marketing. Additional short-term technical advisors will be provided as necessary.

B. Project Goal, Purpose and Strategy

The project goal set forth in the Project Identification Document (PID) was "to improve the health status of the people of C.A.R." A more precise formulation of the goal is:

> **"to provide adequate, affordable health care to the C.A.R. population."**

This Project Paper proposes a re-structuring of the project outlined in the PID, to create a more integrated project that should be able to make a significant contribution to a single project purpose:

> **"to reduce infant mortality and HIV transmission in all five health regions, while increasing accessibility to health services."**

Child Survival Interventions: A.I.D. will continue to support CCCD activities, which, with UNICEF's help, have been successfully implemented in C.A.R., and pursue a logical expansion of those activities by adding technical interventions that address three other major threats to child survival: acute respiratory infections (ARI), HIV/AIDS, and inadequate birth spacing. In light of the severity of the problem of AIDS in the C.A.R., this project will include activities in monitoring, education, prevention and treatment, including adjunct programs in the social marketing of condoms and the control of Sexually Transmitted Diseases (STDs).

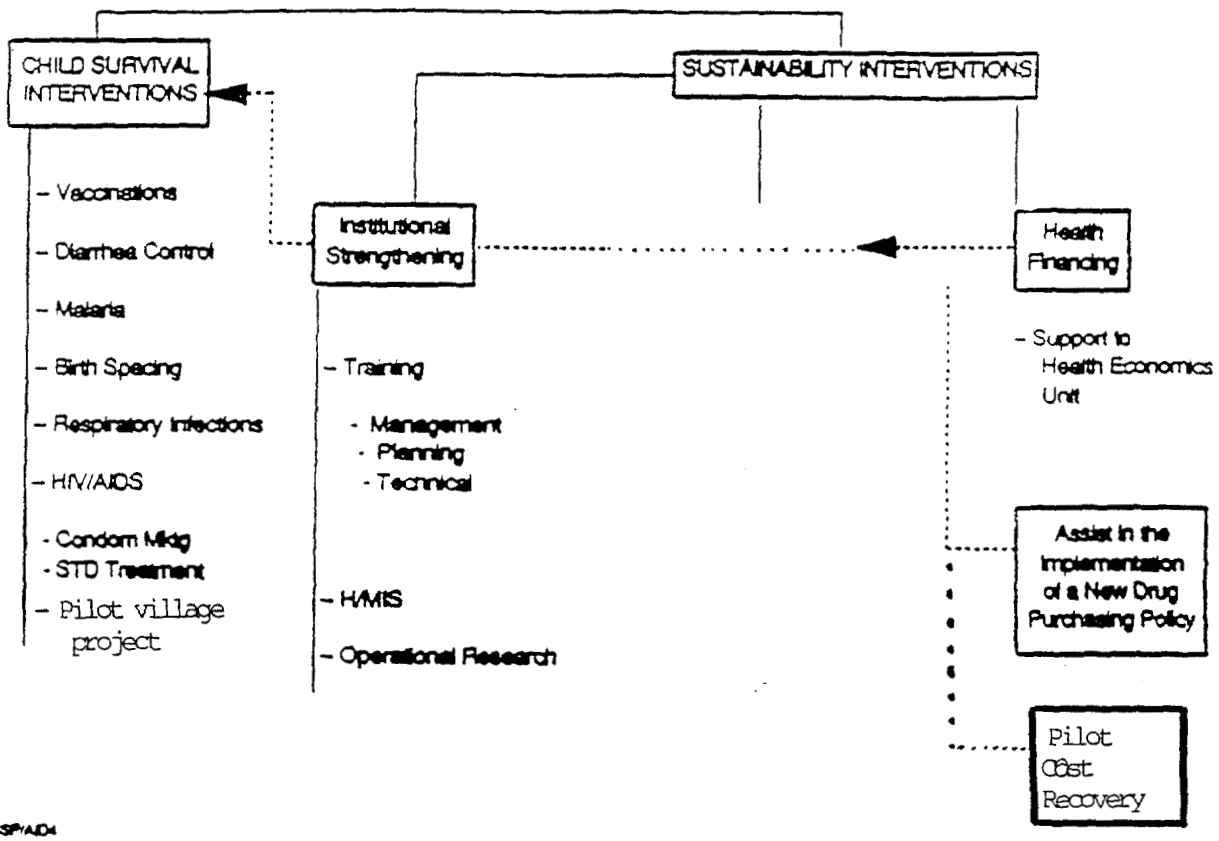
Sustainability Interventions: A review of the Ministry's five-year plan, proposed donor activities, and the institutional capacity of the Ministry, suggests that there is an urgent need for reinforcement of the Ministry's implementation capacity. Thus, the project includes training for key Ministry staff and support for the development of a health/management information system (H/MIS). This institutional support will not only increase the CARG's capacity to plan and carry out activities effectively and efficiently, but it is an essential ingredient to achieving sustainable programs.

To support the CARG's efforts to develop cost recovery mechanisms for the health care system, the project will finance a Health Finance Advisor (an advisor is already in place, and financed by A.I.D.'s R&D bureau through October 1992). In addition, the project will provide more general support to the Health Economics Unit with which this Health Finance Advisor is working.

According to studies underway, it appears that the best opportunity for an early cost recovery intervention will be in the hospitals, health centers, and maternity clinics in Bangui, and, subsequently, in the regional and prefectural hospitals. The project will finance training, short-term technical assistance as needed, and workshops for planning cost recovery interventions for hospitals.

The general structure of the proposed project is illustrated in Figure II-1 below. Additional detail on specific components follows on subsequent pages.

SUSTAINABLE CHILD SURVIVAL PROJECT



C. Principal Project Components

Child Survival Interventions

A.I.D. and CDC will provide assistance in the technical interventions and support strategies of those previously developed by the Combatting Childhood Communicable Diseases (CCCD) project. The CCCD project is comprised of 3 technical interventions and 4 support strategies. The technical components include support to: the Expanded Program for Immunization (EPI); Control of Diarrheal Diseases (CDD); and Malaria Control. The support strategies include training, health education, operational research and health information systems. The successful models used to define and implement technical interventions under CCCD will be applied in the Sustainable Child Survival project to assist the MSPAS in addressing three additional threats to child survival: acute respiratory infections (ARI); human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS); and high risk births.

The new project will also increase emphasis on the support strategies, in order to: strengthen training and supervision; reach communities and influence health behaviors; improve health workers' abilities to solve operational problems; and to collect, analyze and use health data. It will promote the application of these strategies across departments with the goal of enhancing the integration of the ministry. The project will also develop integrated training programs and supervisory systems, transfer effective methodologies from one intervention area to others, and develop integrated management and health information systems.

The objectives under each child survival component of the project were elaborated in consultation with the MOH and the CDC Child Survival Advisor. The authors of the objectives affirm they are realistic and achievable, but that they should be considered illustrative for now. More clearly defined objectives will be compiled after the DHS survey has been completed (during first 12 months of project). The baseline data for most of the targets will also be provided by the DHS survey.

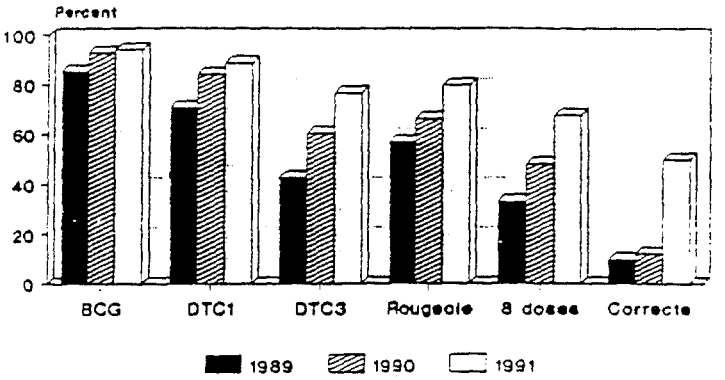
1. Expanded Program of Immunization (EPI)

Status:

C.A.R. has achieved excellent vaccination coverage. The January 1991 coverage survey showed record coverage levels for all antigens. Sixty-seven percent of mothers with infants received 2 doses of anti-tetanus vaccine. Measles vaccination for children under one year old have increased from less than 20% before EPI to 80%. Vaccination coverage has improved equally well for BCG, DPT and polio.

The MSPAS has improved access to and the quality of immunization services. The number of vaccination centers has increased from 108 in 1987 to 233 in 1990 (57 new centers were added in 1990). In 1990, there were no ruptures in vaccine stocks, and children were immunized at younger ages.

Vaccination Coverage (by Card)
Central African Republic 1989-1991
Nationwide Results



BCG verified by card or scar

Reported measles cases declined from greater than 6000 per 100,000 population in 1984 to less than 500 in 1989. Reported polio cases dropped from less than 6 per 100,000 in 1981 to less than 1 per 100,000 in 1989.

EPI's success is largely attributable to a reliable logistics system, an effective system of supervision, appropriate training and use of information, education and communication (IEC), and the establishment of a management and health information system.

Objectives:

Baseline data: 1991 and 1992 immunization coverage survey data.

By 1997, the EPI program will have met the following targets:

-- Reduce measles morbidity by 50%
-- Reduce poliomyelitis disability by 50%
-- Decrease neonatal tetanus mortality by 50%
-- Increase BCG coverage to 95% of infants under one year of age

-- Increase measles immunization coverage to 90% of infants under one year of age
-- Increase DPT3 and OPV3 to 90% of infants under one year of age
-- Increase TT coverage of women of childbearing age from 67% to 80%

Strategies:

The strategies to be used are to provide an uninterrupted supply of vaccines to all health centers, increase coverage in rural areas, improve quality of vaccination services, evaluation, and develop strategies to increase vaccination coverage (comprehensive program objectives are set forth in Annex F-1.)

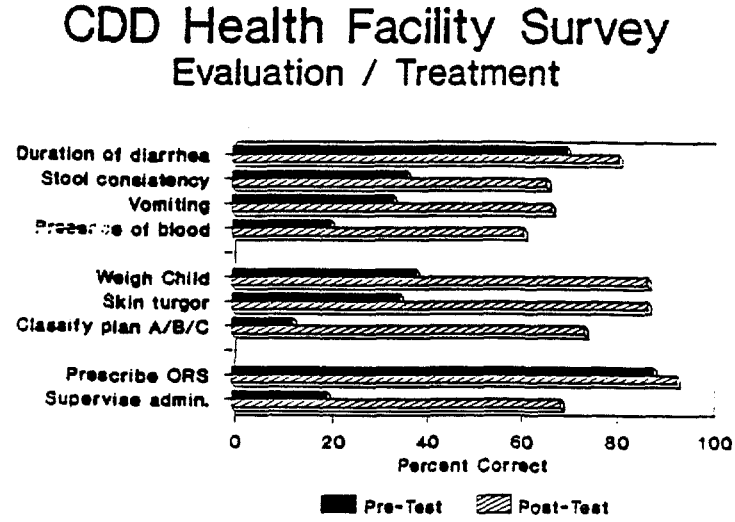
A.I.D.'s contribution will include long and short-term technical assistance, a vehicle for use by regional teams, and some commodities (e.g., syringes and cold chain equipment). UNICEF is expected to continue to provide vaccines. Further details are provided under Section III, the Implementation Plan.

2. Control of Diarrheal Diseases (CDD)

Status:

The case fatality rate for children under five hospitalized with diarrhea in three regional hospitals declined from 8.7% in 1987 to 4.9% in 1989.

During 1989 and 1990, the methodology used by the EPI program to strengthen service delivery was applied successfully to CDD. In 1989, standards were established for evaluating health worker performance, and assessments of training needs were conducted throughout the country. In 1990, over 300 health workers from 175 treatment sites were trained, and a national symposium was held for the case management of diarrhea. Evaluation of health worker performance after training showed measurable improvement in proper treatment of diarrhea.



CDD Health Facility Surveys CAR 1989-90
n = 144 pre-test / 138 post-test

Objectives (by 1997):

Baseline data: Mortality information will come from the results of the 1992 Preceding Births Technique surveys, health facility survey data and the planned DHS Survey.

- -- Reduce diarrhea mortality by 30%
- -- Provide effective case management including patient education to 90% of diarrhea cases treated at health facilities
- -- Provide effective community case management to 50% of diarrhea cases

Strategies:

The strategies for achieving the above objectives are to make ORS available in hospitals and health centers, maintain measles immunization coverage, train and supervise health care workers, to develop and implement IEC plan, to develop training and educational materials for CDD mobilization activities and train community mobilizers (a comprehensive set of objectives are set forth in Annex F-1.)

A.I.D. assistance will be in the form of long and short-term technical assistance, commodities (primarily ORS packets during the first two years of the project), and some equipment.

3. Malaria

Status:

Malaria is one of the primary causes of death in infants and children, and is the third most frequent reason for persons of all ages to seek medical consultations. Case fatality rates at three regional hospitals increased from 3.0% in 1987 to 4.1% in 1988 and to 7.0% in 1989, largely due to increasing resistance to standard therapy and the absence of an effective control program.

Malaria is a known contributor to prematurity, low birth weight and neonatal mortality. In 1988, 36% of women receiving prenatal care in Bangui were reported to have malaria. Severe or recurrent malaria also contributes to the development of anemia, which further increases the risk of both maternal and child mortality.

Efforts to reduce the incidence of malaria have been made more difficult by the emergence of chloroquine resistant plasmodium falciparum (CRPF). Resistance has been documented in C.A.R. since 1985. In-vivo CRPF studies are carried out annually with school children. The most recent study showed about 10% of R1 resistance (parasitemia disappears and recrudesces) and R2

resistance (parasitemia decreases and then increases) among 204 school children treated with the current standard 3 day dose of 25mg/kg of chloroquine. No R3 resistance (parasitemia never decreases) has been documented to date.

Current national malaria policy recommends presumptive treatment of fever for children under five years of age with 25 mg/kg of chloroquine given over 3 days. Fansidar is the second line drug for chloroquine treatment failures.

The development of an effective malaria prevention and treatment program has been slow, but is now underway. The program development was delayed because training for the three major program interventions was undertaken separately, and malaria training was undertaken last. However, national training for malaria prevention and treatment is scheduled to occur this year. In 1990, malaria treatment practices were evaluated and a training manual was developed based on identified training needs. The training of trainers has been completed and the actual training should begin shortly.

Objectives (by 1997):

Baseline data: Mortality information will come from the results of the 1992 Preceding Births Technique surveys, health facility survey data and the planned DHS Survey.

- -- Reduce inpatient malaria mortality by 25%
- -- Provide effective case management, including patient education, in 95% of fever cases treated at health facilities
- -- Achieve early and appropriate home treatment with appropriate anti-malarial therapy in 60% of fever cases (at home or health facilities)
- -- Promote appropriate measures in 50% of villages to reduce malaria transmission

Strategies:

The strategies for achieving the foregoing objectives are to promote the availability of chloroquine and second line drugs at all fixed health facilities, continue to monitor chloroquine resistance, provide training and supervision of health workers, accelerate IEC, promote use of mosquito nets, to correctly treat febrile pregnant women (additional comprehensive strategies are set forth in Annex F-1.)

The availability of antimalarials in C.A.R. must be increased. Malaria control efforts have been hampered by insufficient supplies of chloroquine and fansidar. The MSPAS plans to couple training with increased provision of drugs, but

the projected supply of drugs is still not expected to be sufficient to meet demand.

The quantities of malaria drugs provided in the past have been based on the estimated needs of children under five and pregnant women. It is unrealistic to expect drug supplies in health centers to be used solely for these two high risk groups. It is essential that drugs be made available to the general population, and that a system of cost recovery be instituted as soon as possible to defray the cost of drugs and make the system sustainable.

The primary A.I.D. input will be long and short-term technical assistance and malaria drugs (primarily chloroquine) during the first two years of the project.

4. Acute Respiratory Illnesses (ARI)

Status:

ARI is one of the four major causes of death in children in C.A.R. The majority of ARI deaths are due to pneumonia. Fifteen to 20% of deaths from respiratory infections are from pertussis and measles, and are preventable by immunization.

Studies have isolated two principal bacteria, Streptococcus pneumonia and Hemophilus influenza, from cases of severe pneumonia in children above two months of age. Both are susceptible to inexpensive antimicrobial drugs. In addition, the first strain is preventable through a polyvalent vaccine and the latter is preventable through a licensed effective monovalent vaccine. Additional studies have determined that a small number of clinical signs can be used to identify children with pneumonia.

Given the gravity of the ARI problem in C.A.R. and the availability of appropriate treatment measures, diagnostic tools and vaccine prevention, the MSPAS strongly supports the inclusion of ARI as component of this project. Further research is required on the causes of ARI in C.A.R., current treatment practices, and to develop more effective treatment protocols. The training, health education, management and evaluation methodology that have proven effective in combatting the other major causes of child mortality will be applied to ARI.

Objectives (by 1997):

Baseline data: The Sustainable Child Survival project will collect baseline information on ARI case management in health facilities as part of its first-year workplan. The 1992 Preceding Births Technique surveys and the planned DHS should provide mortality data.

-- Reduce ARI mortality by 25% in children under five years of age
-- Provide correct treatment for 50% of lower respiratory tract illnesses treated at health facilities

Strategies:

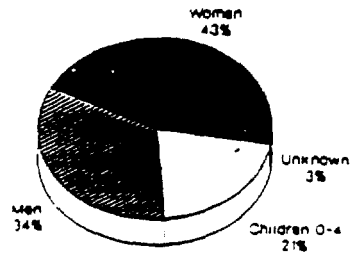
The strategies are to establish a national ARI program, to insure an adequate supply of appropriate drugs in health facilities, to provide training and supervision in case management for health workers, and to provide health education for caretakers. (additional and comprehensive strategies are set forth in Annex F-1.)

5. HIV/AIDS

Status:

The HIV/AIDS epidemic is a major threat to progress in child survival. HIV/AIDS rates in Africa are the highest in the world, and C.A.R. is among the 10 countries in Africa with the highest estimated levels of HIV infection. Pregnant women are often used as a sentinel group to estimate the level of HIV infection in the general population. In Bangui, at least 9% of women attending prenatal clinics test HIV-positive. Of the total reported AIDS cases in C.A.R., 21% are in children under 5 years of age, and 34% and 43% are among adult males and females respectively.

Distribution of AIDS Cases
Men / Women / Children



PNLS Central African Republic 1998

The MSPAS's primary strategies for the control of AIDS in C.A.R. are to increase the use of condoms, reduce the prevalence of STDs, and reduce the number of casual sexual contacts in the population. A more thorough discussion of this strategy, as well as the objectives and strategies for the Sustainable Child

Survival project, is provided in Annex F-2. Five additional relevant documents are available from AFR/CCWA: (1) the HIV/AIDS Project USAID/CDC 1990 annual report, (2) a proposal from PSI for condom social marketing, (3) a memorandum about STD operational research under the current HIV/AIDS PASA agreement, (4) a proposal for HIV/STD support at the regional and prefectural levels, and (5) a proposal for evaluating STD programs.

Objective (by 1997):

Baseline data: Baseline information on incidence and prevalence will be drawn from a 1991 USAID supported STD prevention and control project. 1992 surveys on HIV and STD will provide baseline information of health worker interventions and public health education efforts.

-- Reduce both the incidence of HIV/AIDS and the incidence and prevalence of STDs through monitoring, surveillance, and impact assessment;

-- increase public knowledge of the disease and its transmission;

-- increase interventions to prevent HIV transmission, and to diagnosis, treat, and prevent transmission of STDs.

Strategies:

To evaluate the progress of the HIV/AIDS epidemic, to increase access to condoms, to develop a pilot project for STD control, to develop and provide health education, and to improve early detection (additional and comprehensive objectives are set forth in Annex F-2.)

6. Birth spacing

Status:

Infant survival is significantly higher among those infants born more than two years after the end of the mother's last pregnancy. Infants' chances of survival are also greater if their mothers are above 18 years of age and have not already had many births. The number of births to women in C.A.R. who are older than 18 years or older than 35 is not yet known. It is estimated that only 4% of women in urban areas and 1% of women in rural areas use a modern method of birth spacing.

The total percentage of high risk deliveries in C.A.R. is also unknown. However, 18.7% of infants are classified as low birthweight (less than 2500 grams), and maternal mortality is estimated at 8 per 1000 births. Approximately 48% of pregnant

women seek prenatal services; and, of registered births, 67.6% of women seek postnatal services.

By reducing high risk births, providing birth spacing services to women will make a significant contribution to reducing infant mortality and to improving maternal health. The use of condoms for birth control will have the added benefit of reducing the transmission of STDs and HIV/AIDS.

Objectives (by 1997):

Baseline data: The baseline data will be drawn from the 1991 and 1992 vaccination coverage surveys and the planned DHS Survey.

- -- Increase the % of women obtaining prenatal services from 48% to 60%
- -- Increase by 10% the proportion of women utilizing a modern method of birth spacing

Strategies:

The strategies for achieving these objectives are to conduct applied research to define the level of knowledge and demand for contraceptive services, use IEC to promote utilization of birth spacing, target young women in schools for birth spacing messages, conduct O.R. to define the best sites for services to be delivered. (additional and comprehensive strategies are set forth in Annex F-1.)

The Sustainable Child Survival project will provide long and short-term technical assistance and support to health education activities. The long term A.I.D.-funded Child Survival Advisor will work more closely with the Maternal and Child Health (MCH) Directorate, fostering improved coordination between this Directorate and the Directorate of Preventive Medicine and Endemic Diseases. The project will also furnish a vehicle and computers to the MCH Directorate.

Sustainability Interventions: Institutional Strengthening

1. Training

Status:

The C.A.R.'s success in EPI has been achieved through strengthening service delivery, training health workers, providing health education, and monitoring and evaluating performance. The most prominent achievement of the program has been health worker training. The training emphasizes developing skills to enable health workers to improve the quality of

services and improve their own performance. The MSPAS has created a permanent structure which integrates training in management and supervision with the development of technical skills.

The Ministry's training strategy includes the following elements:

(1) the creation of a training unit within the Department of Preventive Medicine and Endemic Diseases (DMPGE) for the development of in-service training programs;
(2) the development of an annual training plan;
(3) the development of a standard instrument for assessing training needs and the impact of training on health worker performance;
(4) the training of trainers at central and regional levels,
(5) the establishment of a data management system for monitoring health personnel trained by the central and regional teams;
(6) the development of the expertise to produce appropriate training materials and to revise them as necessary; and
(7) the institutionalization of an in-service program based on assessment of health worker performance.

This strategy has been used within the EPI and the CDD programs and is being applied to malaria control this year. The Sustainable Child Survival Project will assist the MSPAS in applying this methodology within the programs designed to combat ARI, HIV/AIDS, and high risk births.

The Division of Maternal and Child Health (DSMI) is responsible for prenatal care, and will therefore be responsible for applying the training strategy to the prevention of high risk births and for replicating the training methodology currently used within the DMPGE. The technical advisors funded by this project will assist with this effort.

Objective (by 1997):

-- Upgrade health facility and health worker capacity to meet WHO standards in clinical assessment, treatment, patient education, supplies and equipment, and reporting

Strategies:

The strategies for achieving this objective are to strengthen and improve structure of training programs, establish national quality standards for health care workers, develop and institutionalize more effective evaluation methods, and to encourage certain administrative programs to improve management (additional comprehensive strategies are set forth in Annex F-1.)

2. Health and Management Information Systems (H/MIS)

Status:

Data collection and reporting in the C.A.R. follows the organizational structure of the health care system. Management and health data are collected at public and private health facilities and are forwarded to the regions. The regions then compile the data and submit them to the appropriate departments of the Ministry in Bangui. Reports are prepared by the various departments in the central MSPAS, and an annual summary is prepared by the planning and statistics unit (DEPS).

In addition to H/MIS reporting, the MSPAS has conducted several special studies and surveys to obtain health information data. In 1989, a 0-2 mortality survey was carried out in Bangui using the Brass-MacRae preceding birth method. The survey was repeated in 1992. National vaccination coverage surveys are carried out periodically. The most recent survey was completed in January 1991. Facility needs assessments are carried out to determine health worker practices before and after training. Knowledge, attitudes and practices surveys are conducted for developing public health interventions for target diseases. These capacities need to be strengthened to complement routine reporting systems.

The departments of preventive medicine (DMPGE) and maternal and child health and family planning (SMI/FP) maintain the most current data on services and key disease indicators. Unfortunately, the analysis and publication of national summary data is very slow. The most recent national annual report of health information was published in 1988.

Despite the delay in publishing national data, the MSPAS has made progress in a number of areas of HIS development. Computer hardware and software are now being used to compile and analyze data at the DMPGE and SMI/FP. A statistics unit has been established at the DMPGE, and systems are in operation to report both routine service data and surveillance data for EPI target diseases, diarrhea and malaria. The MSPAS has published 3 issues of an epidemiologic newsletter to provide information to decision-makers and feedback to reporting sites.

The progress made within specific MSPAS departments must now be generalized to the entire Ministry. To this end, the MSPAS, with assistance from the African Development Bank (BAD), is developing a plan for improving its overall health and management information systems over the next 3 years. This major initiative aims to strengthen and simplify the management and health information systems. It is a complex undertaking and warrants supplementary assistance from A.I.D. The Sustainable Child Survival Project will thus provide support to those activities

related to compiling information systems in cost recovery and cost reductions.

Objectives (by 1997):

-- Develop national capacity to collect, analyze, and use primary health care data for cost recovery and reduction in a timely, effective, and efficient manner at the district, regional, and national levels
-- Increase sentinel site reporting to 100% of all sites monthly

Strategies:

Both long and short-term CDC experts/advisors will develop a plan for integrating current child survival surveillance systems into the HMIS. Computers provided as commodity support to the regional health offices will also support the development of this system.

3. Health Care Financing

Status

As a result of the severe economic problems facing the C.A.R. and their impact on the CARG's ability to finance the delivery of health services, the MSPAS began some years ago to explore alternative means of generating resources for the sector.

Preliminary studies were carried out by Levin and Weaver in 1987, financed by the REACH project of the A.I.D.'s Science and Technology Bureau to determine the willingness of patients to pay for services. The authors of these studies recommended that the MOH organize a cost-recovery workshop for policy makers and create a working group within the MSPAS to develop a pilot project to test cost-recovery methods in the health sector.

The workshop was held in April 1989. One month before the workshop, a progressive health financing law was promulgated, providing norms for the payment for medical services and allowing health facilities to retain and use their revenues for operating expenses. The workshop helped establish a consensus on how to implement the health financing law. Several further studies were recommended, as well as the creation of a working group within the Ministry to undertake these studies and their follow-up.

Following a request from the MSPAS, A.I.D. placed a long-term technical advisor in C.A.R. in April 1991. This advisor has been working within the Health Economics Unit of the Director General of Public Health to help this unit carry out the studies proposed by the workshop and to develop a cost-recovery system

for the health sector. A.I.D. also subsequently sent the Central African members of this unit to the U.S. for short-term training. For a more complete background on cost recovery developments in C.A.R., see Annex J.

Objective (by 1997) :

-- Develop a national cost recovery system for health care services

Strategies:

The Sustainable Child Survival Project will provide long and short-term technical assistance. In FY 1993, the project will assume responsibility for funding the Health Economics Advisor position in C.A.R. (presently financed by A.I.D.'s Africa regional ADS project). The advisor will continue to assist the MSPAS in developing mechanisms for cost-recovery. The project will also provide further financial, commodity and short-term technical assistance to the Health Economics Unit of the MSPAS, to allow it to undertake studies in financial management and drug procurement. Research topics will include: the cost of health care; potential fees to be charged at rural and urban health centers and hospitals; hospital fee reforms; hospital accounting systems; and hospital efficiency. Funding will also be provided for the organization of workshops to review the results of the various studies and to build consensus on health financing issues.

Funds will be set aside to initiate a pilot phase for cost recovery programs. Specific activities during this pilot phase may include a cost recovery workshop to review past research and possible options; identification of several pilot health facilities and selection of cost recovery procedures to test; training workshops to orient staff to the new program; monitoring of program implementation; and evaluation of program achievement and impact. Pharmaceuticals will be purchased for approximately 10 sites, to initiate cost recovery programs.

For more discussion of the issues relating to cost recovery and cost reduction in C.A.R., see Sections III, IV and V of the Economic Analysis in Annex G. For a more complete background on cost recovery developments in C.A.R. and the proposed A.I.D. support to CARG's financing efforts in the health sector, see Annex J.

III. IMPLEMENTATION PLAN

A. Implementation Arrangements and Responsibilities

1. A.I.D.-funded Implementation Agents

The Centers for Disease Control (CDC) will be the lead agency and will contract portions of the project's implementation to U.S. and local PVO and NGOs such as Africare and Population Services International (PSI).

CDC brings seven successful years of experience in implementing the Africa Child Survival Initiative-Combatting Childhood Communicable Disease (ACSI-CCCD) Project in the C.A.R. and in twelve other African countries, and three years of implementing Technical Assistance in AIDS and Child Survival (TAACS) in 11 countries. CDC has served as the major U.S. public health agency for STD control since the 1940's, and for HIV/AIDS prevention and control since the problem was first identified. With CDC administrative and technical support structures already in place for the CCCD and HIV/AIDS projects in the C.A.R., USAID and the CARG concur that CDC is best suited to carry out the Sustainable Child Survival project.

Using expanded health information systems to identify health priorities, CDC's expertise includes: the creation of systems to train, monitor and evaluate multivalent health workers; the integration of ARI into existing PHC structures; and health facility assessment, supervision and evaluation. The CARG has approved the methodology developed by CDC for implementing the current child survival interventions, as well as the strategies promoted by CDC to address other intervention areas. For these reasons, the CARG has expressed a strong preference for CDC to continue to provide technical support to these activities. CDC is both capable and willing to apply its proven support strategies to the integration of the new health interventions into the C.A.R.'s PHC program.

Although other private entities, including U.S. NGOs, may have demonstrated the capacity to implement one or several activities of the project, none of these are capable of executing as many sections of the project as is CDC. As the lead agency, CDC will have the authority to enter into agreements with U.S. and local NGOs to undertake specific activities as described in the project paper. For example, the budget authorizes $900,000 specifically for extending child survival activities to the village level through a U.S. PVO (Africare). CDC will seek to augment its own capabilities by inviting NGOs to participate in other sectors of the project as well. CDC will utilize Gray Amendment criteria in their selection of participating NGOs.

Project managers will work closely with the CARG and other donors to ensure that U.S. assistance promotes an integrated and more comprehensive system of primary health care (PHC). The

implementation of the two components of the project are discussed below.

A. Child Survival Interventions

The Sustainable Child Survival Project will continue to provide assistance through CDC for the technical interventions and support strategies as developed in the Combatting Childhood Communicable Diseases (CCCD) Project in CAR. It will further assist the MSPAS in addressing three additional threats to child survival: Acute Respiratory Illnesses (ARI), the human immunodeficiency virus (AIDS), and high risk births. The project will place greater emphasis than its predecessor on activities to strengthen training and supervision, to reach communities and influence health behaviors, to improve health workers' abilities both to solve operational problems, and to collect, analyze and use health data. A long-term technical advisor will be provided to supervise the child survival interventions.

The Ministry of Public Health and Social Affairs (MSPAS) has been working with a number of international partners to control the AIDS epidemic in the C.A.R. A.I.D. has financed a long-term technical advisor from the CDC to assist with this effort including program management, training, STD control, and monitoring and evaluation. The Sustainable Child Survival Project will give priority to four of the seven major program emphases of the National AIDS Control Service (NACS): 1) evaluating the progress of the disease; 2) improving access to condoms; 3) diminishing sexual transmission through the control of STDs; and 4) promoting behavioral change through health education and social mobilization.

CDC's child survival interventions will be complemented by the following condom social marketing and village-level outreach activities.

1. Condom Social Marketing: Between 1988 and 1990, NACS mounted a health education and condom awareness campaign which included the free distribution of approximately 3.5 million condoms around the country. Later, these condoms began to appear for sale in Bangui markets. This receptivity to purchasing condoms is encouraging for future activities. Through an AID/W buy-in, CDC will call on the services of PSI to carry out discreet activities in condom marketing. Specifically, the project will implement the following activities: 1) augment demand, 2) distribute condoms throughout C.A.R., 3) monitor distribution and sales, and 4) evaluate the use of condoms in the general population. It is expected that these efforts will be strongly supported by the MSPAS through health education for the general public and for high risk groups.

2. Child Survival Activities at the Village Level: While CDC will be primarily involved with project activities at

the national level, it is anticipated that village level outreach activities will be channeled out through Africare. Specifically, Africare will be responsible for:

a. Extending CDC child survival and sustainable interventions to selected rural communities;

b. Demonstrating on a pilot basis successful approaches for the delivery and supervision of community based child survival and sustainable interventions that can be replicated throughout the Central African Republic. Specific interventions include: diarrheal disease control, immunization, malaria, birth spacing, acute respiratory infection, HIV/AIDS education, and cost recovery.

B. Sustainability Interventions

The Sustainable Child Survival Project will continue to provide assistance through an AID/W buy-in to Abt Associates for the technical interventions and support strategies as developed in the Combatting Childhood Communicable Diseases (CCCD) Project in CAR. The project will provide technical assistance to the MSPAS to assist with the development of training methods and materials. Technical, management, and planning training programs will be developed and implemented.

Short-term advisors will develop a plan for integrating current child survival surveillance systems into the national H/MIS. The SCSP will provide computers as commodity support and technical assistance to help the development of these systems.

In 1989, the C.A.R. National Assembly passed a law authorizing the recovery of costs for certain health services. A national workshop on health care financing was conducted to build a consensus for cost recovery. In 1991, an A.I.D.-funded health economist was assigned as resident advisor to work with the Health Economics Unit in the office of the Director General of MSPAS. The Sustainable Child Survival Project will continue to support the resident long-term technical advisor as well as short-term advisor and commodities and training. The economist will continue to work with the CARG to diversify and increase sources of revenue in the health sector, to identify measures to increase the efficient use of financial resources, to improve the ability of the CARG to assess health care costs, and to use this information to develop sustainable health care strategies. In pursuit of these objectives, the Sustainable Child Health Project will assist the CARG to promote policy dialogue on health care financing issues among the government and donors, and to develop, test, and implement alternative health financing systems.

The success of a cost recovery program depends upon the quality of the health care which the population is expected to help pay for. The majority of the necessary improvements can occur as a result of the child survival interventions. Hospital fees have already been enacted so the emphasis will be on strengthening the accounting infrastructure, reducing hospital costs, and reforming hospital fees.

2. Monitoring and Oversight

In response to limited field staff and resources and Congressional interest in limiting the number of African countries with bilateral programs, the Africa Bureau developed a strategy for small country programs (SCP). (See Annex M.) This strategy called for limiting U.S. assistance to a core[1] or a core-plus-one program[2]. The C.A.R. has been chosen for a core-plus-one program. A.I.D has determined that health will be the single sector for its resources for the C.A.R.

Pursuant to the SCP policy enacted March 10, 1992, the management responsibility was shifted to the A.I.D./Washington geographic office, AFR/CCWA. Thus, the responsibility for monitoring and provision of oversight of the C.A.R. program now lies with AFR/CCWA. The country desk officer (CDO) has been designated as the country representative and will serve as the Mission. A representative of AFR/CCWA will visit C.A.R. once every six months, beginning in September 1992.

AFR/CCWA is assisted by an officer of the U.S. Embassy/Bangui who had been assigned to serve as A.I.D. Liaison Officer (ALO). The ALO is assisted by two Embassy-funded foreign service nationals (FSNs). The Embassy has agreed to continue the assignment of a U.S. direct-hire State Department employee to the ALO position for the duration of the project as well as the two FSN assistants.

The ALO and his assistant are capable of providing a higher level of monitoring and oversight than had been requested of them in the past. The ALO will be given responsibility for the day-to-day administrative oversight of the project. The ALO will have administrative supervisory responsibility for the A.I.D.-funded personnel located in C.A.R. These project personnel will be technically supervised by CDC.

The ALO will serve as Project Coordinator, and will be expected to call representatives of the project components to regular coordination meetings (bi-weekly as suggested by the design team). Project progress, general policies, project impediments, the nature and number of anticipated visiting consultants, relations with the Ministry, and donor coordination are examples of topics to be discussed at the meetings.

---

[1]A core program includes five program options: Peace Corps; Small Project Assistance; the Ambassador's Special Self-Help Fund; democracy, governance and human rights activities; the ATLAS project; and P.L. 480 emergency/humanitarian food aid.

[2]Core-plus-one program consists of a single grant in a single sector which will be added to the core program.

The CDC project advisors will submit to the ALO quarterly implementation reports on project progress, including information on project finances. The format for this report will be established by the AFR/CCWA CDO in consultation with the ALO and the Field Support Officers at CDC. The ALO will attach the individual reports to his/her own oversight report and will transmit to the AFR/CCWA and CDC, Atlanta. The ALO's report will summarize the highlights of the CDC report, discuss relationships with the Ministry, describe any changes in the CARG health policy environment, and report on donor coordination.

The ALO's assistant will require some short-term training in A.I.D. operations, such as the Project Implementation Course, which will be funded through this project.

CDC staff working with the project components of child survival and HIV/AIDS control will have access to project funds for local expenditures through a sub-allocation fund. Under this mechanism, local support costs will be estimated by field staff one year in advance and monies will be reserved in the IAA for these purposes. Quarterly allowances will be forwarded from CDC at the beginning of each quarter. Field staff will process obligating documents/vouchers to the Embassy Certifying Officer who must approve for payment. Vouchers will be processed through the Department of State Regional Finance Center to CDC.

CDC will buy into the FAAS agreement with project funding (to be negotiated on an annual basis between CDC and the Embassy). The following services are anticipated: pouch privileges, budget and fiscal services (e.g., issuance of purchase orders, accommodation exchange), access to the Peace Corps medical unit (subject to payment of an annual fee to the Peace Corps), and cable communications privileges.

3. Relations with the CARG

There will be no bilateral obligating agreement between A.I.D. and the C.A.R. A.I.D. will sign an Inter-agency Agreement with CDC specifying CDC's responsibilities for implementing the project, including CDC's responsibility for negotiating a Memorandum of Understanding with the CARG. The Memorandum of Understanding will provide for the rights, privileges, and exonerations for contractor and personnel, other tax exemptions normally found in a bilateral umbrella agreement, as well as government contributions.

The project will finance five long-term technical advisors (TA): (1) a child survival advisor; (2) a HIV/STD control specialist; (3) a health economist; (4) a village-level outreach advisor; and (5) a condom social marketing advisor. The TA personnel will work with their counterparts as described below. The ALO will be responsible for assisting TA personnel in

establishing and maintaining relationships, as appropriate, and in taking issues to higher levels of the CARG when deemed necessary for the implementation of the project. In addition, the ALO will have primary responsibility for orchestrating the Embassy and A.I.D. activity to foster reform of the pharmaceutical purchasing policies of the CARG.

A long-term (60 months) Child Survival Advisor will work as counterpart to the Director General, collaborating daily on a technical level with the Director of Preventive Medicine and Endemic Diseases (DMPGE--French acronym) and the Director of Maternal and Child Health. S/he will also serve on the technical task force reviewing the primary health care proposal put forward by UNICEF. It is hoped that this service will lead the Director General, who has been chairing the task force, to look to her/him more for advice on technical and organizational matters.

A long-term (48 months) HIV/AIDS Advisor will work as counterpart to the head of the HIV/AIDS service and to the director of the STD (sexually transmitted diseases) program, constituent parts of the DMPGE under the present organization.

The long-term (42 months) Health Economics Advisor will work with counterparts in the Health Economics Unit and with the Director General, when appropriate.

A long-term (36 months) village-level outreach coordinator will be funded to provide oversight to extending, on a pilot basis, approaches for the delivery and supervision of community-based child survival activities.

The long-term (60 months) Social Marketing Advisor will work with appropriate counterparts in the national HIV/AIDS service and the STD control program. As mentioned in 1-a above, this advisor will assist public and private sector staff to increase demand for condoms, assure wide distribution, monitor distribution and sales, and evaluate use of condoms in the general population.

The long-term resident advisors and short-term consultants will support Ministry of Health efforts to develop training methods and materials for technical, management and planning programs. The efforts will focus on strengthening in-service training supervision of health staff at all levels, by decentralizing the planning and implementation of these activities to the regional and prefectoral levels. Specific activities to reinforce the actual training courses will include: designing improved methods to assess training effectiveness, developing an integrated supervisory system; and monitoring checklists, improving supervisory skills, creating a training data base for health workers, coordinating training programs

among different Ministry departments, and developing a management information system to monitor health worker performance.

B. Training Plan

The on-the-job technical training needed to implement the child survival interventions will be carried out as a regular activity in the implementation of the interventions. Ministry officials will carry out training of trainers (field supervisors) who in turn will train at the regional, prefectural, and peripheral levels.

The Health Economics advisor will call in short-term expert/advisors to assist in the training activities related to establishing systems of cost recovery in health facilities. The training will be planned by the Health Economics Unit with assistance as needed from the advisor.

Training will strengthen infrastructure responsible for inservice training/supervision of health personnel at the central, regional and prefectoral levels, increase decentralization of training, reinforce regional capabilities, promote improved methods to assess training effectiveness, develop a standardized supervisory checklist/guidelines, develop a management information system to monitor performance, develop a data base which records training and certification of all health agents, identify skills requisite to the successful implementation of PHC and develop training program to strengthen those skills, and incorporate principles of prevention, etc., into curricula at universities and technical schools (see annex K-1 for additional descriptions of major actions.)

C. Implementation Schedule

Following the project authorization in July 1992, an Inter-agency Agreement will be negotiated and signed with CDC. A memorandum of understanding will be signed between the CARG and CDC in August, 1992. Project funded activity will commence in August or September 1992.

Gantt-type charts showing implementation plans for the principal project activities are provided in Annex K.

IV. FINANCIAL PLAN

A. A.I.D. Budget

The annual technical assistance costs under the Child Survival component include the cost of the long term advisor plus six months of short term visits by expert/advisors as needed. It is anticipated that these six months of short term technical assistance will also cover short term visits for the HIV/AIDS and Institutional Strengthening components. The Technical Assistance element under the HIV/AIDS and Institutional Strengthening components is for long term expert/advisors only, for four and two years respectively. The Technical Assistance element under the Health Financing and Sustainability component is for one long-term advisor for two years and a follow-on advisor for 18 months. The costs of short term expert/advisors has been incorporated in the Studies element. The technical assistance element for the condom social marketing advisor is for 60 months.

Commodity procurement (motor vehicles, syringes, cold chain equipment, pharmaceuticals, etc.) is heavy during the first two years. This reflects both special needs, e.g., to sustain some activities while initiating some new ones, and the special circumstances in C.A.R. at this time. There are donors discussing significant new projects in the health field (e.g., World Bank and the EEC), but these projects are not expected to be disbursing before 1993. In addition, the CARG is committed to a program of cost recovery, but that also is expected to take two years to put into place and make effective on a large enough scale to impact significantly on the health budget.

The majority of the child survival and HIV/AIDS commodity procurement will be done through CDC and some by the CDC technical office in-country with the support of the A.I.D. Liaison Office. CDC is also expected to provide procurement support to the Health Economics Advisor to the extent it may be needed. No break out of commodities or other elements have been made for the Condom Social Marketing component since that will be managed by the PVO entity which will implement this component.

A financial budgeting summary by year, for the A.I.D. funding of the five-year Sustainable Child Survival project is on the following page.

AID ILLUSRATIVE BUDGET
($ '000)

	FY1993	FY1994	FY1995	FY1996	FY1997	TOTAL
Child Survival	**1438**	**1438**	**1008**	**988**	**936**	**5808**
Technical Assistance	420	420	420	420	420	2100
Long Term	250	250	250	250	250	1250
Short Term	170	170	170	170	170	850
Commodities	600	600	170	150	98	1618
Vehicles	100	200	20	20	20	360
Pharmaceuticals	500	400	150	130	78	1258
Training	58	58	58	58	58	290
Intra Country In-service	28	28	28	28	28	140
Inter-Country In-service	30	30	30	30	30	150
Health Education	70	70	70	70	70	350
Community/Patient Education	35	35	35	35	35	175
Mass Media	35	35	35	35	35	175
Other Direct Costs	50	50	50	50	50	250
Office Supplies	10	10	10	10	10	50
In-country Travel	40	40	40	40	40	200
CDC Support & Overhead	240	240	240	240	240	1200
HIV/AIDS & STDS	**913**	**913**	**863**	**806**	**100**	**3595**
Technical Assistance	250	250	250	250	0	1000
Long Term	200	200	200	200		800
Short Term	50	50	50	50		200
Commodities	40	40	20	0	0	100
Vehicles	40	5	5			50
Pharmaceuticals		35	15			50
Training	15	15	15	15	0	60
External In-service	10	10	10	10		40
Internal In-service	5	5	5	5		20
Health Education	40	40	40	20	0	140
Workshops	30	30	30	15		105
Supplies	10	10	10	5		35
Other Direct Costs	15	15	10	10	0	50
Office Supplies	5	5	3	2		15
In-country Travel	10	10	7	8		35
CDC Support & Overhead	78	78	78	61		295
Condom Social Marketing	475	475	450	450	100	1950
Condom Packaging/Publicity	150	150	125	125	50	600
Office Operating Costs	125	125	125	125	50	550
Technical Assistance	200	200	200	200		800

	FY1993	FY1994	FY1995	FY1996	FY1997	TOTAL
Institutional Strengthening	**490**	**85**	**0**	**0**	**0**	**575**
Commodities	360	10	0	0	0	370
Vehicles and Computers	300	9				309
Radios	60	1				61
Training	15	15	0	0	0	30
Intra-country Travel	15	15				30
Other Direct Costs	15	15	0	0	0	30
Office Supplies	5	5				10
In-country Travel	10	10				20
CDC Support & Overhead	100	45				145
Health Financing & Sustainability	**505**	**390**	**155**	**0**	**0**	**1050**
Technical Assistance	215	265	110	0	0	590
Long Term	200	200	90			490
Short Term	15	65	20			100
Commodities	150	0	0	0	0	150
Computer Equipment	30					30
Vehicles	40					40
Pharmaceuticals	80					
Training Workshops	50	60	40	0	0	150
In-country Travel/Perdiem	40	45	30			115
Supplies	10	15	10			35
Studies & Pilot	75	50	5	0	0	130
Local Consultants	50	40				90
In-country Travel/Perdiem	25	10	5			40
Other Direct Costs	15	15	0	0	0	30
CES Operating Costs	10	10				20
Fuel and Supplies	5	5				10
Evaluation & Data Collection	**335**	**90**	**90**	**10**	**90**	**615**
Demographic & Health Survey	200					200
Internal Reviews & Impact Studies	135	90	10	10	10	255
Child Survival	85	65	8	8	10	176
HIV/AIDS and STDs	50	25	2	2		79
External Evaluations			80		80	160
PVO-Supported Community PHC Pilot	**300**	**300**	**300**			**900**
Long Term Technical Assistance	150	150	150			450
Training, Supplies, Equipment	150	150	150			450
Total Project	**3981**	**3216**	**2416**	**1804**	**1126**	**12543**

The costs shown for training are for in-country training, mostly related to the technical aspects of the trainee's job. Long-term training out of country will be funded under the regional Atlas Project.

The budget for Health Financing and Sustainability does not include funding for public information campaigns. It is possible that the CARG will be in a position to fund these when the time comes. In addition, it is unclear at this time whether the Ministry will feel the need for a long-term advisor after the initial 24 month tour. 18 months additional would have been planned, however, it may be decided that it would be a better use of the funds to finance some short term trips and the public relations campaigns.

The Evaluation and Data Collection component includes $200,000 for a Demographic and Health Survey; it is anticipated that the R&D Bureau's DHS project can help fund the survey in C.A.R. if the costs will exceed the budgeted amount. The bulk of the Internal Reviews and Impact Studies element is for impact studies related to HIV/AIDS and STDs. The details on these studies are in Section V, Evaluation Plan.

B. CARG Contribution

The CAR government's $3,915,200 contribution to the Sustainable Child Survival Project is approximately 24% of the total LOP funding. The CARG's contribution will be targeted to five main categories: 1) the salaries of counterparts who work with the technical advisors, 2) office space for technical advisors, 3) counterpart funds for operating expenses of the programs that the project will support (EPI, diarrhea, malaria, birth spacing, ARI, and HIV/AIDS activities, 4) salaries of MSPAS staff who work on the programs, and 5) building costs for program activities.

The CARG contributions to the SCS project over the five year project are listed by categories as follows:

1)	Counterpart Salaries	89,700
2)	Office space for technical advisors	23,000
3)	Counterpart Funds	192,500
4)	Salaries of health staff for programs	3,150,000
5)	Building space for programs	460,000
	Total	3,915,200

1. Salaries of counterparts. The CARG proposed contribution of $89,700 for counterpart salaries will support an estimated 13 person years of technical advisors. This calculation assumes a

monthly salary of 150,000 FCFA at an exchange rate of 260 FCFA/$US.

2. Office space for technical advisors. The proposed $23,000 allocation for office space will be sufficient for a total of 13 person years of technical advisors. This calculation is based on an office of 216 square feet, a construction cost of $150 per square foot, a building life of 30 years, an interest rate of 6 percent, an inflation rate of 5 percent, and an exchange rate of 260 FCFA/$US.

3. Counterpart funds. The CARG will provide $192,500 in counterpart funds over the five year project. This annual contribution of $38,500 is at the same level as was contributed during the CCCD project.

4. Salaries of civil servants. The CARG life of project contribution for the salaries of MSPAS health staff is $3,150,000. This annual level of $630,000 is consistent with the CARG annual contribution during the Expanded Program of Immunization under the CCCD project (See "Revue des Programmes PEV/SMI en Republique Centrafricaine," (April-May 1991). p. 47 and 48.).

5. Building space of program activities. The $460,000 contribution for building space over the five years of the project is based on estimates of the building costs for EPI of $92,000 per year.

In addition to these standard contributions, it may be possible to use the project to leverage additional contributions specific to each of the programs or to each of the offices in which the technical advisors will be located. Discussion of such contributions would be more appropriate in the context of the negotiations with the government than in the context of the project paper approval process.

V. EVALUATION PLAN

The evaluation process of the Sustainable Child Survival Project (SCSP) should have three elements: yearly in-country review, a mid-term evaluation, and a final evaluation. These are discussed below, followed by sections on special inputs that will be needed to facilitate the evaluation process.

A. Yearly In-Country Review

Each year the in-country program components will conduct a review of progress. These reviews will include one or more individuals from the MOH plus a representative from AID/W and/or CDC. The review will focus on each program's work plan for the previous year and measure progress against the work plan. The review will identify what inputs (e.g., materials, personnel, consultants) were available and used as planned. The review will also determine what planned activities (e.g., training, operations research, treatment of patients) occurred during the period. When inputs were not available or activities did not occur as planned, the review will determine why this occurred, what should be done to overcome the lack of progress, what changes in the program are necessary, and how to avoid similar problems in the future. The logical framework should also be reviewed to determine if the basic design is still valid: whether the goals, purposes, and outputs of each program still attainable. Particular attention should be paid to the assumptions in the logical framework. If the assumptions are no longer valid, changes in the logical framework may be necessary. A work plan for the following year should also be developed at this time.

B. Mid-term Evaluation

A mid-term evaluation will occur approximately halfway through the five-year project, i.e., during the project's third year. While the yearly In-Country Reviews will be conducted primarily by project staff, the mid-term evaluation will be conducted by individuals not directly connected with the project. The reviewers may include a representative of the MOH, USAID/W, and CDC plus outside consultants with expertise in the various program components. This review will focus on the program outputs as specified in the logical framework and will address three issues: Have the programs been implemented according to plan? How can implementation problems be overcome? What mid-program decisions and changes need to be made?

The evaluation will also address the issue of continuing to fund primarily vertical interventions on a national basis versus integrated primary health care on a limited geographic basis. The review could recommend supporting, either through a new

project or an amendment to this one, the expansion of the geographically-oriented PHC initiative into one or more additional prefectures once: (1) the approach has been adopted by the CARG; (2) the approach has been initiated in at least one prefecture; (3) the initial experience has been evaluated for lessons learned; and (4) the MOH has determined that further expansion of the initiative in the time frame proposed is justified.

C. Final Evaluation

The group conducting the final review will be similar to the group conducting the mid-term evaluation. The final evaluation will focus on the program goal and purpose as specified in the Logical Framework and address the following issues: What components of the program were successful and what components were not? What components should be continued? What components should be added? What components are worthy of transfer to other countries? The final evaluation will be facilitated by the yearly In-Country Reviews, the final Assessment of Program Impact (API), and the two HIV Impact Evaluations (see below).

D. Inputs to the Evaluation Process

The evaluation process will be facilitated by three types of inputs: the yearly In-Country Reviews, an Assessment of Program Impact (API), and HIV Impact Evaluations of the effectiveness of the STD and condom social marketing programs. The In-Country Reviews are described in A. above. The API and HIV Impact Evaluations are described below.

1. Assessment of Program Impact (API)

Each of the project components has a set of objectives, outputs, and inputs. Prior to the mid-term evaluation, an API will be completed by each project component. Although the API contains information about objectives and outputs, the primary focus during the interim review will be on outputs.

The following studies will be conducted in order to obtain the needed data: survey of health facilities, sample survey of mothers, HIV/AIDS survey and an examination of condom social marketing records. Each of these studies, which are described below, will be conducted at baseline, after 2.5 years (just prior to the mid-term evaluation, and after 5 years (just prior to the final evaluation). These studies need to be conducted using similar methods at each point in time so that the data will be comparable across time periods.

Survey of Health Facilities

Most of the Objectively Verifiable Indicators are reflections of how well health care facilities are functioning: approximately 19 hospitals, 81 health centers, and 91 health sub-centers. This survey will obtain data which can be categorized into the following groups: staffing pattern, equipment, availability of supplies and drugs, diagnoses and services provided, data on morbidity and mortality, knowledge and adherence to treatment protocols (needs assessment), staff knowledge, implementation of cost recovery. This survey will be conducted by a team that visits each center to examine records and interview staff. In time, much of these data should become available regularly as a part of the health management information system.

Sample Survey of Mothers

This will be a stratified cluster sample of mothers in the country to determine health care utilization, vaccination coverage, and infant mortality rates. The sample will be stratified by region, proximity to a health facility, and village size. Although not explicitly part of the Logical Framework, this survey could also obtain traditional child survival information such as anthropometric measurements of children, mothers KAP regarding ORT and breast feeding and HIV/AIDs and STD issues, and information on health care expenditures.

HIV/AIDS Survey

This will be a stratified cluster sample to determine male and female KAP regarding HIV/AIDS-relevant high risk behaviors in the general population and in specific high risk groups: STD patients, prostitutes, "filles libres," youths, truck drivers, and workers. High risk groups would be over sampled in this survey. This would also provide an estimate of actual condom purchases and use nationwide.

Examination of Condom Social Marketing Records

The records of the condom social marketing component in C.A.R. will be examined at 2.5 and 5 years to determine the number of condoms distributed.

Health and Management Information Systems

Sentinel surveillance and routine health and management information systems will provide data on disease incidence and service statistics.

2. HIV Impact Evaluations

The project design assumes that both the STD and condom social marketing programs are effective in reducing the transmission of HIV. Impact evaluations of both the STD and the condom social marketing programs need to be conducted because these programs are expensive and there is little or no available evidence from either C.A.R. or other countries on the effects of these programs on the incidence and prevalence of HIV/AIDS. Once the effectiveness of the two programs has been assessed, the cost and cost-effectiveness of the programs should be determined. These studies are described briefly below; a more complete discussion is included in documents available in Bangui and from AFR/CCWA.

STD Program

There is considerable data worldwide and some from C.A.R. that demonstrates a correlation between STDs and HIV in individuals. From these data it has been theorized that STDs promote the transmission of HIV and therefore that reducing STDs will reduce the transmission of HIV. However, the effectiveness of STD treatment on the incidence of HIV has not been demonstrated (Mertens et al., 1990). To demonstrate the effectiveness of an intensive STD program, at least 20 villages will be randomized to one of the following two STD programs:

(1) a standard STD program in which diagnosis and treatment would be available at health centers for those individuals who self-refer; and

(2) an intensive STD program which would include aggressive screening, counseling, partner notification, and patient follow-up in addition to standard diagnosis and treatment.

These two groups will be followed for one year to determine the differences in STDs, relevant KAP, and the rates of STDs and HIV. If the more intensive program were found to be cost-effective, it would be implemented in all health facilities.

Condom Social Marketing

There is good evidence the condoms when properly used will reduce the risk of HIV infection (Conant et al., 1986). However, the condom social marketing program will be primarily a distribution program and will not ensure that the condoms are used appropriately by high risk individuals. To demonstrate the effectiveness of the social marketing of condoms a group of at least ten villages will be randomly assigned to receive the program and compared to at least ten villages randomly assigned to not receiving the program. These two groups will be followed for one year to determine the differences in condom KAP, plus STD, HIV, and birth rates (birth spacing and unwanted pregnancy). If no differences have been observed after one year, the villages will be followed for an additional year.

REFERENCES: Conant, M.A. et al. Condoms prevent transmission of AIDS-associated retrovirus. JAMA 1986; 255:1706.

Mertens, T.E., Hayes, R.J., Smith, P.G. (1990). Epidemiological methods to study the interaction between HIV infection and other sexually transmitted diseases. AIDS 4:57-65.

VI. SUMMARY OF ANALYSES

A. Summary of Technical Annex

1. Background -- Child Survival

The Ministry of Public Health and Social Affairs (MSPAS) has demonstrated leadership in and commitment to the health of children in C.A.R. Despite severe economic problems, C.A.R. has made substantial gains in child health particularly in vaccine preventable diseases. Since 1985, immunization coverage has more than doubled and reported measles cases have declined by 85%. In 1990, C.A.R.'s achievements in child survival were recognized internationally when it received the National Council for International Health's award for outstanding progress in child survival.

As elsewhere in Africa, C.A.R.'s advances in child survival can be largely attributed to its vigorous implementation of programs targeting specific causes of death in children. Although this approach has been successful, it has promoted the vertical structure of health services. The challenge now before C.A.R. and its health partners is to maintain gains in child health, address additional threats to child survival, and bridge to a system of integrated health services.

The MSPAS' concern with the development of a fully functional, integrated system of primary health care (PHC) is reflected in its national plan for health development for 1992-1996. The plan is composed of both technical and capacity building elements. Five of the 10 components of the plan are specific health programs: (1) endemic diseases, (2) HIV/AIDS, (3) nutrition, (4) water and sanitation, and (5) maternal and child health and family planning. The other five address the development of the health system and include: personnel development; buildings and equipment; essential drugs and vaccines; information, education and communication; and institutional development and decentralization. The government plans a meeting with donors within the next six months to determine their support to the various program elements.

2. A.I.D. assistance

A.I.D. and CDC assistance over the next five years will support efforts of the government of C.A.R. to strengthen the system of primary health care. Technical and financial resources will be directed at (1) linking priority health interventions to an integrated PHC program, (2) improving

the quality and utilization of health services, (3) supporting additional health interventions of major importance, (4) developing better methods to influence health behaviors in the population, (5) strengthening the efficiency and effectiveness of health care delivery and (6) establishing cost recovery mechanisms. In this process, A.I.D. will work closely with the C.A.R. government and other donors to ensure that U.S. assistance promotes an integrated and more comprehensive system of PHC.

The expanded and more integrated A.I.D./CDC assistance includes the provision of a child survival advisor who will work at the Director General level. The advisor will work on integrating child survival interventions and PHC, and with the departments of pharmacy, preventive and curative medicine, maternal and child health and family planning, and health planning and statistics. Primary aspects of the specialist's role will be to provide support in implementing PHC within the MSPAS, to coordinate A.I.D./CDC assistance for PHC, and to promote cooperation among the many partners supporting various aspects of PHC.

A.I.D. and CDC will continue to provide assistance in the technical interventions and support strategies of the current Combatting Childhood Communicable Diseases (CCCD) project. CCCD is comprised of three technical interventions and four cross-cutting support strategies. The technical components include support to the (1) Expanded Program on Immunization (EPI); (2) Control of Diarrheal Diseases (CDD); and (3) malaria prevention and control. The support strategies include: (1) training and supervision; (2) health education; (3) operational research; and (4) health information systems. The successful models used to define and implement technical interventions under CCCD will be used to assist the MSPAS in addressing three additional threats to child survival: (1) acute respiratory infections (ARI); (2) human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS); and (3) high risk births. (See the Africa Child Survival Initiative CCCD Project 1990 annual report for more information about the current CCCD project -- copies available from AFR/CCWA.)

The new project will increase emphasis on the support strategies to strengthen training and supervision, to reach communities and influence health behaviors, to improve health workers' abilities to both solve operational problems, and to collect, analyze and use health data. It will promote the application of these strategies across departments, merging them into the overall ministry system. The project will also assist in developing integrated training programs and supervisory systems by transferring effective methodologies developed in one intervention area

to others, and by helping develop integrated management and health information systems.

3. Integration of services

With support from A.I.D. and other donors, the Directorate of Preventive Medicine and Endemic Diseases (DMPGE) has developed model logistic, supervision, management and health information systems to support its child survival interventions. Support from A.I.D. under this new project will assist the MSPAS to develop and test strategies to apply these systems to the MSPAS as a whole. The project will provide assistance in establishing recurrent cost financing programs, in increasing the cadre of trained health providers, and in developing consolidated logistic, supervision, management and health information systems.

Health care is integrated at the delivery level in that a single health agent provides a broad spectrum of health services. However, central and regional level management is most often provided through vertical programs identified with particular interventions. This project will emphasize common aspects of the various programs (especially the support strategies) and support integration and coordination among programs and divisions within the MSPAS.

Project activities will promote the concept of the health worker as a health care provider capable of assessing each individual presenting for care, rather than the health worker as an EPI or CDD agent. Programs will be developed for mortality reduction by providing multiple services through health care programs which address age-specific risks of mortality. The proposed project interventions and support strategies lend themselves to addressing mortality reduction at specific ages. The perinatal-neonatal period is addressed by the MCH program, and the post-neonatal infant and childhood period is addressed in out-patient pediatric settings.

A more thorough discussion of integrated health services is included in Section E. of Annex F-1.

4. Technical interventions and support strategies

Detailed descriptions of the technical interventions and support strategies for child survival are included in Annex F-1. The following table identifies the location of these sections in the annex:

Technical Interventions:

Expanded Program of Immunization.....3
Control of Diarrheal Diseases.....4
Malaria.....6
Acute Respiratory Infections.....7
HIV/AIDS (summary).....8
Birth Spacing.....8

Support Strategies:

Training and supervision.....9
Health Education.....10
Management and Health Information Systems.....12
Health Care Financing (summary).....13

A more detailed presentation on HIV/AIDS and STDs is included in Annex F-2. A more complete discussion of health care financing, particularly cost recovery in the C.A.R., is presented in Annex J.

B. Summary of Economic Analysis

The Economic Analysis in Annex G presents a cost-effectiveness analysis of the project, comparing the costs of different project interventions. It is followed by four other economic analyses. Section II (beginning on page G-10) analyzes the C.A.R. health budgets from 1985-1991 and discusses more equitable and efficient distribution of resources. Section III (page G-25) discusses areas in which the efficiency of the government health system can be improved. Section IV (page G-32) analyzes the potential savings from using generics for four drugs. Section V (page G-37) on cost recovery compares the potential revenues to be generated at different levels of the health systems and in different geographic areas.

Table I-1 of Annex G (page G-9) summarizes the cost-effectiveness estimates of the different project components. In each case the project has chosen proven, least-cost approaches to reducing morbidity and mortality, e.g., ORT against diarrheal disease, and vaccinations against immunizable diseases. In some cases the cost-effectiveness data of certain approaches are limited, such as for ARI, social marketing of condoms against HIV and AIDS, and the treatment of STDs against AIDS. In such cases the project has selected the most promising methodologies and has built in operational research, monitoring, and evaluation so that assessments of cost-effectiveness can be made regularly and project strategies modified to improve cost-effectiveness.

C.A.R. Health Budgets

The Ministry of Public Health and Social Affairs (French acronym: MSPAS) receives approximately three percent of the C.A.R. government (CARG) budget. It amounted to 3.16 billion FCFA in 1990, which in per capita terms is 1098 FCFA (US $4.39), over 90 percent of which was devoted to recurrent expenditures, less than 10 percent was for investment expenditures. Donor assistance to the health sector is responsible for most of the investment and some of the operating expenses of the health sector. It amounted to 3.3 billion FCFA in 1990, doubling the budget for health from 3.16 billion to 6.4 billion FCFA, or 2236 FCFA per capita (US $8.95). Almost 70 percent of donor assistance is directed at constructing, rehabilitating, equipping, and supplying hospital facilities.

As a percentage of the CARG budget, the amount allocated to health experienced a drop from approximately six percent for the years 1986-1988 to three percent for the years 1989-1991. This is less than half the 10 percent recommended by the World Health Organization for developing country health budgets as a percentage of the government budget.

Imbalances exist between the expenditures on personnel and other operating costs, and between expenditures in Bangui and other regions. Salaries account for approximately 80 percent of the recurrent health budget, while all other operating costs (e.g. drugs, supplies, maintenance, gasoline, etc.) account for the remaining 20 percent. The geographic distribution of resources is also skewed: the annual per capita expenditure on health in Bangui is approximately 3803 FCFA as compared to 588 FCFA outside Bangui.

The private sector plays a relatively small role in the provision of facility based services, but an important role in the provision of pharmaceutical products. In 1990 the population purchased over 3 billion FCFA (1050 FCFA per capita) worth of drugs, primarily from private pharmacies. This amount is roughly equivalent to the MSPAS 1990 health budget. Significant savings are possible for the government and the population if brand name drugs are replaced by generics, and large orders made using an international competitive bidding process.

There are some encouraging signs in the pattern of health expenditures over the past five years. The percentage of recurrent expenditure on personnel, though high, has shown a steady decline from 87 percent in 1985 to 77 percent in 1990.

Six statistical tables related to the MSPAS budget begin on page 19 of Annex G.

Cost Reductions and/or Efficiencies

Section III of Annex G examines the potential for improving efficiency of health care delivery in C.A.R. in three areas of the health sector: personnel, pharmaceuticals, and hospitals. The inefficiencies in the C.A.R. health care system are described. Some are well documented, such as the problems in the pharmaceutical sector; others require further study, such as the most efficient use of the three Bangui hospitals. The principal recommendations and areas for further study are summarized below.

Personnel

Continue to provide training to health workers in appropriate treatments for diarrheal disease, respiratory infections, and malaria. Study and discuss with the MSPAS the distribution of personnel in the health regions; more information is needed on how many people regional (and prefectural) personnel are treating and whether there are suitably equipped health facilities to accommodate more health personnel if they were to be sent to the regions. Continue working with the CARG and MSPAS on increasing the portion of the recurrent health budget allocated to O&M, especially drugs and supplies.

Drugs

The problems and potential solutions have been clearly laid out in the ADB/CREDES report. MSPAS and donors must collaborate on how to implement the recommendations. A concerted training effort will have to be undertaken to retrain prescribers, pharmacists, and the population in the use and acceptance of fewer drugs per illness and an increasing reliance on less expensive generics.

Hospitals

The issue of primary care being provided at hospitals requires further study. Some of the questions to be answered are the following: What percent of the outpatients can be safely treated in primary health care facilities? Can these patients be treated more cost-effectively at health centers? What systems and incentives can be put in place to encourage care at the appropriate level?

Benefits from a Generic Drug Policy

According to the CREDES report, drugs sold in both the private sector and the public sector are expensive because the majority are brand name drugs and often no competitive bidding process is used to select the supplier. In Section IV of Annex G-1, an estimate is made of potential benefits to be gained if

more generic drugs were purchased, and if an international competitive bidding process were implemented. There is also some discussion of the possible use of the savings, e.g., reduced prices, bonuses to health workers, retain at collecting hospitals, return to the health system, or remit to the national treasury.

Cost Recovery

Section V of Annex G looks at the potential revenues that might be generated at different levels of the health system and in different parts of the country. There is also some analysis of the feasibility and economic costs of recovering costs. The section concludes with some general principles of cost recovery.

The cost recovery potential achieved depends on what services facilities charge for, how much, and how well prepared they are to collect fees. Under a strenuous set of assumptions, if there are fees for consultations, the regions would generate the most revenue; if fees are collected for hospitalizations, then Bangui would recover the most amount of money. If both hospitalizations and consultations must be paid for, it is a close call as to whether Bangui facilities or regional facilities will generate more revenue. Finally, comparing cost recovery for consultations across different health facility levels it is hospitals which would generate the most revenue.

These revenue calculations aside, given the current health infrastructure in C.A.R., it is probably most feasible to consider cost recovery in cities and towns rather than villages; delivery of quality services is easier, there are more trained personnel, financial institutions exist, and incomes are higher.

If, on the other hand, a high priority is providing basic health services to the rural 47 percent (World Bank, 1989) of the population, including attempting to reduce high infant and maternal death rates, it is important to invest in cost recovery at the periphery levels. The government does not have the financial resources, nor is donor assistance sufficient, to provide good quality, basic health care to this population. A partial solution is for the population to assume more responsibility for its own health care.

C. Summary of Social Soundness Analysis

The Social Soundness Analysis was prepared by a Central African consultant in French. A copy of the full document was made available in Bangui to the A.I.D. Liaison Office and A.I.D.-funded technical officers. Reference copies are also available in AFR/CCWA. Annex H provides, in English, the table of contents for the full report plus a synopsis of certain sections. There

follows here excerpts of the section of the synopsis on AIDS, the part that is most relevant to the design of the project.

Socio-cultural Values that Determine Sexual Practices in C.A.R.

C.A.R. is a patriarchal society. In rural areas, where control is very rigid, a young girl is supposed to conserve her virginity until marriage, even if she is married very late. Men, on the other hand, are not held to this rule. Upon attaining puberty, young circumcised men are even discretely encouraged to test their masculinity and virility. Fertility is considered the realization of self and of one's family.

In a society where children are valued above all, health professionals struggle to relay the message that individuals suffering from AIDS or sexually transmitted diseases (STDs) should take precautions not to have children. This type of mentality also explains why in urban areas certain women do not hesitate to become pregnant to secure a man. Often they think that the more children they have, the better their chance of keeping him.

From the Central African woman, fidelity and devotion to one man is expected. A man, however can have relations with several women. As imposed by society, polygamy is limited to between four and six women. Officially, there is no fixed limit.

Central African Attitudes Regarding AIDS

Central Africans are beginning to take AIDS (SIDA in French) seriously. For a period of time, expressions such as "Syndrome Invente pour Decourager les Amoureux" (Syndrome Invented to Discourage Lovers) were the norm. Today numbers of Central Africans, especially in Bangui, know a person with AIDS among their family members, friends or acquaintances.

In urban areas, people have greater access to information on AIDS. And in certain places, condoms have been introduced. Prostitutes who frequent expatriates have begun to adopt a more prudent approach to sexual relations by having their customers wear condoms. On the other hand, in rural areas, people remain convinced that AIDS is an urban phenomena. Individuals who come from cities are immediate suspects. Studies conducted in Bambari, Bossangoa and Bozoum demonstrate a rapid progression of AIDS in these regions. Heavily implicated in the spread of AIDS are sites where individuals from provincial cities and rural sectors can co-mingle.

Many people infected with AIDS return to their villages to die. Those that are ill are generally well assisted by their families and receive social support. Others develop a desire for vengeance. They do not want to die alone and thus engage in

sexually promiscuous behavior in a premeditated manner. In Bangui, there are numerous examples of people who have died from AIDS and left long lists of their victims.

Sexual practices and AIDS propagation

Certain sexual customs which support the propagation of the disease are discussed below.

The Proliferation of Sexual Relations

Sex with the objective of procreation is little respected, especially in urban areas. The average Central African male maintains at least one secondary relationship in addition to his principal relationship. In addition to legal polygamous relationships, there exists numerous cases of concubines and/or peripheral relationships, especially in urban areas where societal control is weak. The male dominance of the society supports this behavior which is condemned by women but tolerated by men.

Sexually Transmitted Diseases (STDs)

STDs are relatively widespread in urban areas. The most prevalent are gonorrhea, syphilis, genital herpes and chlamydia. These diseases are readily observed in men, whereas women are slow to discern the problem.

Treatment is also problematic. In general, men prefer to self-treat with questionable antibiotics (or traditional cures) which can be purchased directly from the pharmacy without a prescription. This serves only to perpetuate the illness. Within the confines of a couple, the man and woman are rarely treated together. A contaminated man prefers to hide the illness from his wife and vice versa to avoid domestic disputes. Taboos which surround STDs are at the root of this problem. One does not dare to speak about it and only with difficulty to one's physician. This taboo exerts itself to an even greater extent for women. In hospitals and dispensaries, they are often mistreated, injured and ridiculed by nurses. In other cases, health professionals divulge the names of persons with STDs or AIDS in the cities where they live. The spread of STDs parallels that of AIDS.

The Use of Condoms

Condoms are not very widely used in C.A.R. This use is beginning to be undertaken by the educated class, but in general it is still considered taboo. The marketers of condoms (pharmacies, health workers, etc.) feel the population is not yet prepared to face the problem sufficiently for them to be able to assist the population in overcoming their handicap and reticence.

Reticence is caused by two major beliefs. Public rumor has given rise to the belief that sexual practices with a condom do not allow for the fullness of pleasure desired. In addition, men have a tendency to believe that the use of a condom will have a negative effect on virility. All C.A.R. males are prepared to take any risk, even that of AIDS contamination to maintain this virility. These beliefs have not been addressed by health agents.

AIDS Impact on C.A.R. Beliefs

It is perhaps too early to evaluate the impact of AIDS on behavior, but the phenomena, as evidenced by disruptions caused within society, has begun to permeate the minds of the people. The intensity of the AIDS awareness campaigns have brought about the realization that even traditional healers cannot provide cures. Resignation to the situation has promoted a new discovery of the virtues of fidelity among many couples.

AIDS Awareness Campaigns

A program targeting the reduction of AIDS was started in 1987. This program followed the WHO guidelines and focused on posters and the distribution of T-shirts. Unfortunately, the cultural differences of the C.A.R. people were not taken into account.

The poster most widely known presents three couples: one kissing on the mouth, one holding hands and one eating from the same plate. The text, literally translated from Sango (the national language), reads "AIDS cannot be caught from this". The message meant to imply that one could not catch AIDS from kissing on the mouth, holding hands or eating from the same plate. However, the public's reaction to this poster was, "AIDS is not a dangerous illness." AIDS has become known as an inoffensive, insignificant disease, instead of being known as a dangerous illness. What the campaign failed to take into account was that the majority of the population is illiterate and has a very limited ability to synthesize information.

Campaigns which are based on the distribution of T-shirts have very limited effect. In a country where clothes are a luxury, T-shirts are not worn to consciously promote a cause, but by necessity because it is necessary to be clothed.

Health Mobilization and AIDS Awareness Campaigns

The poor conditions of health and the absence of appropriate resources do not permit health agents to effectively combat this disease. In short, they were not trained to communicate with patients and the population, but to deliver instructions.

Training in the technique of communication between the group and the group leader must exist in order to effectively fight this plague. People must be convinced via the instillation of fundamental values in targeted groups. These groups will in turn disseminate the message strengthened by their belief in the message. In-depth research is necessary to define the correct mode of communication needed and to identify the determining factors for good communication.

D. Summary of Administrative/Institutional Analysis

The administrative/institutional analysis in Annex I deals with three areas:

1) the overall Ministry of Health structure and capabilities;

2) the organizational arrangements for implementing the specific elements of the A.I.D. - funded interventions; and

3) the plans for A.I.D.'s project management and monitoring.

The conclusions of the analysis of 2) and 3) are reflected in Section III, Implementation Plan. In Section I. E., there is a summary description of the Ministry of Health and a listing of the issues and constraints and principal programs proposed in the Five Year Health Plan. There follows the Ministry's response to the issues and constraints and how the project proposes to help strengthen the Ministry's capabilities.

Ministry Response to Issues and Constraints

Centralization/Decentralization

Ministry officials are committed to further decentralization and have requested that donors provide assistance to help bring this about. In the past, donors have provided vehicles for supporting field operations, but only for those interventions supported by the donor. Thus, the responsible regional and prefectural officials could only use the vehicles for one type of health activity. Similarly, malaria suppressives might be provided only for women and children. The reality is that the local health official must help whoever needs it; thus, the restrictive donor policy could end up hamstringing its own program by its narrow approach.

In response to the Ministry's request, the design team has included funds in the project budget to purchase for each region one all-terrain vehicle, a computer for use in developing a

management information system and supporting the anticipated cost recovery activities, and reproduction equipment. Also included are radios for each of the prefectural hospitals (radios are only at the regional level at this time).

A.I.D.-financed advisors (child survival and health financing) are members of the Director General's task force to plan and coordinate the implementation of a geographically-oriented primary health care program to be initiated with UNICEF assistance in three prefectures. This effort should contribute to defining a CARG decentralization policy.

Organizational Restructuring and Personnel Use

One recommendation of the new national five year plan (PNDS) is the re-structuring of the Ministry to accord better with the programs outlined in the PNDS. The two support departments of DEPS (planning, studies and statistics) and DAF (administration and finance) remain, but the number of technical departments would go from four to five. Preventive Medicine and Endemic Diseases (DMPGE), Maternal and Child Health/Family Planning (SMI/PF) and Environmental Health (Assainissement) remain, but Curative Medicine is reduced to a section in the new department of Infrastructures. The other new department is Pharmacies, which was previously in the Inspectorate General. It has not yet been decided whether the vaccination program will be moved to SMI/PF or remain in DMPGE. A training section is to be placed in DEPS.

In addition to the above departments, there are three special units at the level of the Director General. One is a Health Financing Unit to which a U.S. technical advisor is assigned. A new unit yet to be formed is the Service National pour Information, Education et Communication (SNIEC), which would coordinate and advise the individual departmental training units on health education. The third is the Primary Health Care Coordination unit.

Two of the ten priority programs for the five-year national health plan concern training and health education respectively. The design team supported this important emphasis, but suggested that separating the two pedagogical/educational components and placing them in different departments would cause confusion and duplication, <u>not</u> the coordination of programming that the five-year plan calls for.

The team recommended creation of a separate Directorate of Training and Health Education. This Directorate would be the third <u>support</u> department like DEPS and DAF, serving the other <u>technical</u> departments. Not only would one department facilitate cross-Ministry training coordination and planning, but it would facilitate the coordination of donor training assistance and

provide the vehicle for decentralizing training. The Directorate, like the technical departments, would have a Chef de service at the regional level who could plan, coordinate and monitor all training and health education interventions in the region. This task now falls on the regional Medicin Chef (chief medical officer) who already has too many administrative responsibilities.

The CARG civil service was on strike during the design team's visit and had been for three months. This explained why some of the organizational decisions had not been taken. The team offered some process suggestions for helping to arrive at decisions once the government was again in operations.

Some of the organizational changes are designed to deal with the lack of a management system for the distribution of supplies and equipment. The African Development Bank (AFDB) has financed a study of pharmaceuticals distribution, and its contractor (CREDES) has recommended significant changes in their purchase and distribution, e.g., greater purchase of generics, open international bidding, contracting for delivery of drugs to regional depots.

A dependable supply of reasonably priced pharmaceuticals is crucial to the delivery of good health services in the C.A.R. and to the success of any attempt to introduce cost recovery in the regional and peripheral health facilities. The design team recommended, therefore, that A.I.D. should review possibility of supporting a pharmaceutical purchasing and distribution reform through the Sustainable Child Survival Project if the CARG adopts the CREDES recommendations.

The AFDB is also supporting the development of a management information system throughout the Ministry and providing studies to help in personnel reform. The project will provide short-term technical assistance as needed to help with the planning of the health information system.

The design team found that Ministry officials were aware of the problems of horizontal coordination within the Ministry and were seeking help in overcoming them. In response, the project includes some support for other parts of the Ministry as well as planned support for cross-directorate training.

Some commodity support is planned for the Maternal Child Health/Family Planning Directorate and it was agreed that the A.I.D.-funded Child Survival Advisor would work with that directorate as well as with the DMPGE with the current CCCD Advisor which now works. She will also work with the planning directorate in relation to the information system. A vehicle and some equipment has been budgeted for the Director General to assist him in improving coordination.

The provision of additional resources and improving the management thereof, in conjunction with technical and motivational training, should result in improved attitudes and morale among health personnel in the field. All of these working together will provide a more fertile environment for cost recovery, and the latter may permit additional funding for salaries. This would improve morale still further and facilitate improved personnel management, including greater assignment to peripheral areas.

VII. CONDITIONS AND COVENANTS AND WAIVERS

A. Conditions and Covenants

It is proposed that a covenant be included in the CDC-CARG Memorandum of Understanding to the effect that the CARG will seek continued support from UNICEF for vaccines for the immunization program, seek expanded support from other donors (particularly for PHC), and will move as quickly as possible to initiate cost reductions and cost recovery in the public health sector.

B. Waivers

Since Code 935 is authorized for procurement under the DFA, no source/origin waivers are anticipated. However the buy-America policy will apply unless circumstances can be documented which will allow for non-American procurement.

PP-TEXT.C.A.R.

Central African Republic

SUSTAINABLE CHILD SURVIVAL

PROJECT PAPER (676-0024)

- ANNEXES -

ANNEX A

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR FOR AFRICA

FROM: AFR/PD, Timothy J. Bork

SUBJECT: Central African Republic; Sustainable Child Survival and Applied Cost Recovery Project.

I. Problem

Your approval is requested for the PID and related field guidance cable for the Central African Republic Sustainable Child Survival and Applied Cost Recovery Project. The PID indicates a planned life-of-project funding level of $7,500,000 and an FY 91 obligation of $2,850,000. AID/W will maintain authority to authorize the project.

II. Discussion

A. Project Description

The overall goal of this three-year project is to enhance the sustainability of the CAR's health sector, including: (1) child survival interventions through immunization, control diarrheal disease (CDD) and malaria control, (2) primary health care (PHC) program based on cost recovery in one region, and (3) a national condom social marketing program to combat AIDS and sexually transmitted diseases (STDS).

The objective of the child survival component is to reinforce, integrate, decentralize, and render sustainable the three priority child survival interventions (immunizations, CDD, and malaria control) which were effectively launched under the Africa Child Survival Initiative/Combatting Childhood Communicable Diseases (ACSI/CCCD) Project which began in the early 1980's. Activities will include strengthening of immunization, CDD, and malaria control service delivery; in-service training, pre-service curriculum development; design of integrated supervision, management, and logistics systems; development of a health management information system; integrated information education, and communication (IEC); and operations research.

The objective of the integrated PHC and applied cost recovery component is to support implementation of the national PHC

program. In early 1991, the CAR adopted a National Health Development Plan which is based on the principles of decentralized health planning, provision of essential drugs, integration of services, and community participation in the financing and management of health care. The interventions proposed in this component will support the national PHC program and the specific cost recovery strategy developed by the MOHSA's health training working group in one of the five regions of the country. This component will be implemented under the direct supervision of the MOHSA's PHC Directorate which is responsible of overseeing the execution of the CAR's integrated PHC program.

The objective of the HIV/AIDS prevention and control program will be to assist the National AIDS Committee and the MOHSA to develop and implement a nationwide social marketing program to sell condoms through commercial outlets, health centers, and the workplace. The sub-objectives of the program will be to (1) increase the awareness and acceptability of condoms in the CAR, (2) increase the availability of condoms through mainly commercial channels, and (3) increase the use of condoms by Central Africans, particularly high risk groups for AIDS and STD's. This last sub-objective will be implemented by a U.S. PVO with prior social marketing experience in Africa.

B. Financial Summary ($000)

1. Child Survival Component	$2,400
2. Integrated PHC and Applied Cost Recovery Component	$2,600
3. Condom Social Marketing Component	$2,000
4. Other	$200
5. Contingency	$300
Grand Total	**$7,500**

C. Committee Action and Findings

1. Project Design: USAID/Cameroon originally proposed that a more definitive project design (i.e., Project Paper) would not be necessary and that the activities could be developed and implemented through a series of buy-ins to regional projects. The PC felt that such an approach would be too narrow (since the regional projects end in FY 93) and too fragmented. In addition, the PC found that a more

comprehensive understanding and sectoral strategy for health interventions is required given the increased OYB levels, transition of management oversight (with changes in key individuals both in Bangui and in AID/W) and, the anticipated involvement of other multilateral agencies in the health sector. The PC recommended that a PP be prepared in accordance with HB 3 to provide the programmatic documentation needed to authorize and provide funding, and the guidance needed to implement activities through 1996.

2. Design Issues: The PC identified several areas which needed to be addressed during project design. During the preparation of the project paper, the design team will need to provide more details on the following:

(a) Management Oversight: The PC was concerned about in-country management oversight in the face of expanded activities in the health sector. The PC felt that adequate coordination and collaboration must be assured for the proposed three implementing agencies designated under the three health components (as well as the present health buy-in activities). The PC recommended that the design team propose a reasonable management plan. This plan should be cognizant that DOS personnel ceilings for CAR will not permit placement of additional long-term USG direct hire. Therefore, the management plan should explore the use of both short and long term advisors. A long-term management advisor might be provided through the use of a TAACS or PSC position under the new position or changing the scope of work of the existing PASA/CDC advisor (who is currently working on HIV/AIDS).

(b) Family Planning: The PC raised the issue of including a family planning component in the new project. The USAID/Cameroon representative noted that family planning is part of the integrated primary health care component. In addition, the condom social marketing component would also play an important role in the overall family planning effort. The PC noted the importance of family planning in the CAR and recommended that PP design provide more detail on the family planning element of the project.

(c) Malaria: The design team should review drug treatment protocols for malaria to insure that the project will support effective, appropriate malaria treatment while minimizing potential adverse reactions.

(d) Host country 25 percent contribution: The PC noted that a waiver will be required in the event that the host country contribution to the project does not equal 25 percent or greater of total project.

III. Recommendation

That you (1) sign the PID face sheet thereby approving the PID and (2) sign the attached guidance cable.

Attachments: 1. PID-like Document
2. Field Guidance Cable

Clearances: As shown on the guidance cable

DAA/AFR:ELSaiers _____ DATE: 4/15/91

10

ANNEX B

Logical Framework

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
GOAL: To provide adequate and affordable health care to the C.A.R. population.	1) Coverage: The number of people receiving services related to the project's priority interventions will increase by 50 percent during the life of the project. For some existing interventions, the increase will occur primarily in peripheral facilities. For new interventions, the increase will occur in facilities serving population centers throughout the country. 2) Adequacy and appropriateness of health care: (a) The types of medical and health education services available at prefectural and peripheral facilities will have increased, e.g., for diarrhea control, malaria, acute respiratory infections (ARIs); low birth spacing. (b) the quality of the care provided at the foregoing facilities will have improved in comparison with that being provided in CY 1990, i.e., case management of diseases will be according to national policy, e.g., i) proper drugs will be used for malaria (presently it should be chloroquine as the front line drug and fansidar as the second line drug); ii) there will be a reduction in the use of quinimax and other injectibles; iii) vaccination cards of young children and adult women will be checked to catch missed vaccinations; and	1) Base-line: 5-year health plan and prefectural micro-plans; HMIS data; various studies; Demographic and Health Survey (DHS); community-based surveys. Subsequent: Vaccination coverage surveys; special surveys (KAP, exit, focus groups); health/management information system (HMIS); community-based surveys. 2) Base-line: DHS; special studies of facilities; analyses of micro-plans; health facility assessment (pre-training); community-based surveys. Subsequent: Health facility assessments (pre and post-training); HMIS; supervisory reports; special studies.	1) The CARG policies of de-centralization and promotion of primary health care will be supported by external donors and will be effective in reaching more people and providing a higher quality of health care. 2) The CARG will adopt a policy along the lines of the recommendations of the CREDES report with regard to the purchase of generic drugs and the establishment of an improved system of pharmaceutical purchase for, and distribution within the public health system.

BEST AVAILABLE COPY

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
	iv) there will be a reduction in the use of anti-diarrheals and antibiotics in the front line treatment of diarrheal diseases.		
	(c) the management and delivery of primary health care services will have improved dramatically. This will be evidenced by:		
	i) adequate supplies of vaccines, ORS, chloroquine, contraceptives, and antibiotics for the treatment of ARIs and STDs as well as medical devices and equipment will be on hand and usable and personnel will know how to use them;		
	ii) the delivery of services at health facilities will be better managed and patients will be sensitively dealt with;		
	iii) cost recovery will be operational in regional and prefectural hospitals and helping to ensure supplies of drugs;		
	iv) health trends information will be tracked through sentinal surveillance and H/MIS to monitor program efficacy and to allocate resources;		
	v) vaccination coverage surveys will be used as management tools to target and schedule outreach activities, as well as evaluate the success of the immunization program; and		
	vi) supervision systems will be in place, using positive		

BEST AVAILABLE COPY

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
	reinforcement and including regular monitoring visits with staff		
PURPOSE: Reduce infant mortality and HIV transmission in all five health regions, while increasing accessibility to health services.	1) The overall infant mortality rate, other than from AIDS, will have fallen by 50 percent during the life of the project, and by at least 25 percent in the remotest health region. 2) HIV/AIDS transmission rates will have stabilized (if currently increasing) or will have been reduced by 25 percent in areas where saturation levels have already been reached. 3) Cost recovery will be functioning effectively in national, regional, and prefectural hospitals and will be in the process of being introduced in at least 25 percent of the sub-prefectural health centers.	1) Base-line: DHS; special surveys and studies. Subsequent: Infant mortality survey using preceding birth technique; HMIS; special surveys. 2) Base-line: DHS; special surveys and studies. Subsequent: Special surveys and studies (see Evaluation Plan). 3) Base line: CREDES report; economic analyses of PP. Subsequent: Reports of drug distribution organization; special studies if needed; HMIS; budget analyses.	1) The CARG policies of de-centralization and promotion of primary health care will be supported by external donors and will be effective in reaching more people and providing a higher quality of health care. 2) The CARG will adopt a policy along the lines of the recommendations of the CREDES report with regard to the purchase of generic drugs and the establishment of an improved system of distribution of pharmaceuticals within the public health system. 3) A more adequate and appropriate level of health care is a pre-condition to the effective functioning of a cost recovery system; the effective functioning of a system of cost recovery and the reduction of health costs, e.g., through the use of generic drugs, is a pre-condition to a sustainable health system. 4) The introduction of treatment services will reduce the prevalence of sexually transmitted diseases (STDs) contributing to HIV transmissions, and related counseling (i.e., behavior change interventions), partner notification, and contact tracing will have a synergistic effect on the reduction of HIV transmission.
OUTPUTS: A) Child Survival and AIDS Control Interventions 1) Vaccination coverage will be achieved and maintained at 90 percent. 2) All functioning health centers will be able to prescribe properly and to provide the appropriate drugs to treat acute respiratory infections, diarrheas, malaria, and where	A) Child Survival and AIDS Control Interventions 1) Base-line: Vaccination coverage survey (every 2 years); DHS. Subsequent: HMIS; vaccination coverage surveys. 2) Base-line: Health facility assessment (pre-training); special studies and/or analyses. Subsequent: HMIS; health agent performance assessments; health		

BEST AVAILABLE COPY

73

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
appropriate, STDs. 3) New acceptors of birth spacing will have increased from 4 to 10 percent. 4) HIV/AIDS program activities initiated in the principal population centers will have resulted in modification of high risk behaviors among target populations and in the distribution of over four million condoms through a social marketing program. 5) An expansion in the routine treatment and follow-up of STDs in the population centers with the highest prevalence of STDs will have been achieved and prevalence will have been reduced, particularly among high risk individuals and target populations. B) <u>Sustainability Interventions</u> 1) Training programs will have been developed and strengthened to improve health worker and manager performance. 2) Health education programs will be developed and expanded to increase behaviors that reduce the occurrence of and/or mortality due to ARI, diarrhea, malaria, HIV/AIDS, and unplanned pregnancies. 3) The health and management information systems will be developed. a) Data collection will be expanded and standardized. b) MSPAS' efficiency and ability to handle health and management information will be increased. c) Use of information will be increased. 4) Based on appropriate studies and analysis, the MSPAS will have established cost recovery policies and strategies that improve the quality of the health care	facility assessments (pre and post-training). 3) Base-line: DHS; survey of mothers. Subsequent: Survey of mothers; HMIS. 4) & 5) Base-line: KAP surveys; DHS. Subsequent: KAP surveys; PSI records; HMIS. B) <u>Sustainability Interventions</u> Base-line: CREDES report; report in this PP. Subsequent: HMIS; special studies and analyses.		

BEST AVAILABLE COPY

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
and promote hospital financial autonomy.			
A) Child Survival and AIDS Control Interventions			
1) 90% of infants (under 1 year) are completely and correctly vaccinated.			
2) 90% of all patients seen in regional and prefectural hospitals are correctly treated and managed for target interventions; 60% in peripheral areas.			
3) Women practicing birth spacing techniques will have increased from 4% to 10% of childbearing women (ages: 15-44).			
4) a) Target groups will have reduced the number of casual sexual partners; b) Target groups will have reduced the rate of unprotected intercourse; and c) 4 million condoms will have been distributed through a social marketing program.			
5) Correct treatment of STDs in targeted population centers will have increased to 60%.			
6) MSPAS will have finalized its re-organization and put it into operation by the end of CY 1992 and the Ministry will have resumed normal operations before that date.			
B) Sustainability Interventions			
1) a) Legislation and implementing regulations for cost recovery, if necessary, will have been issued by June 1993.			
b) Cost recovery will be			

BEST AVAILABLE COPY

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
implemented in regional and prefectural hospitals by the end of CY 1993.			
INPUTS: Child Survival and AIDS Control Interventions 1) Long-Term Technical Assistants: a) Child Survival Specialist (5 years) b) HIV/AIDS/STDs Specialist (4 years) c) Village-level Outreach Advisor (2 years) 2) Short-Term Technical Assistance--up to 6 months annually arranged by CDC. 3) Commodities: malaria suppressives and ORS packets (first 2 years of project), vehicles, radios, cold chain equipment, computers, etc. 4) Local Support Costs: local training, transportation, studies, supplies, social mobilization/health education. Sustainability Interventions 1) Long-Term Technical Assistant: Health Economist (2 years); possible follow-on for 18 months. 2) Short-Term Technical Assistance--up to 40 weeks over 2 years. 3) Commodities: Vehicles, computers, office equipment. 4) Local Support Costs: local training, transportation for studies and training, workshops. logframe.aid/aid5	AID BUDGET in ($000s) Child Survival 5,805 Technical Assistance 2,100 Commodities 1,618 Local Support Costs (incl. training, health education) 890 CDC Overhead 1,200 HIV/AIDS and STDs 3,595 Technical Assistance 1000 Commodities 100 Local Support Costs (incl. training, health education) 250 CDC Support/Overhead 295 Condom Social Marketing 1,950 Health Financing & Sustainability 1050 Technical Assistance 590 Commodities 150 Local Support Costs (training, studies) 310 Institutional Str. 575 Commodities 370 Training 30 Other Direct Costs 30 COC Support/Overhead 145 Evaluation/Data Collection 615 PVO Support 900 Project Total 12,543	Financial Reports Progress Reports Internal Reviews Evaluations	1) UNICEF will continue to provide vaccines. 2) Beginning in 1994, malarial suppressives, ORS packets and other essential drugs will be supplied by other donors or funded through a revolving fund financed by donors and cost recovery receipts.

BEST AVAILABLE COPY

76

ANNEX C - CARG Request for Assistance

/)/)INISTERE DE LA SANTE PUBLIQUE
ET DES AFFAIRES SOCIALES

C A B I N E T

SECRETARIAT GENERAL

DIRECTION GENERALE DE LA
SANTE PUBLIQUE

REPUBLIQUE CENTRAFRICAINE
Unité - Dignité - Travail

BANGUI, LE 22 JUIL. 1991

LE MINISTRE DE LA SANTE
ET DES AFFAIRES SOCIALES

N° 1472/MSPAS/CAB/SGSPAS/DGSP.-

A

SON EXCELLENCE MONSIEUR
L'AMBASSADEUR DES U.S.A.

BANGUI

OBJET : Demande d'Assistance
dans la pérénnisation.

Excellence,

Dans le cadre de l'exécution du Plan National de Développement Sanitaire (1992-1996) de la République Centrafricaine et suite aux discussions menées par l'importante équipe de planification avec les cadres de mon Département,

J'ai l'honneur de solliciter l'assistance de l'USAID dans les domaines suivants aux fins d'améliorer et de promouvoir la santé de la population centrafricaine.

1) Survie de l'Enfance : Renforcement et poursuite des activités développées dans le cadre du Projet de Lutte des Maladies Infantiles Transmissibles (CCCD : Programme Elargi de Vaccination, Lutte contre les Maladies Diarréhiques, Paludisme), ainsi que les Infections Respiratoires aigûes.

Dans le cadre de la Lutte contre le SIDA, la commercialisation sociale des condoms et le

.../

traitement des Maladies Sexuellement Transmissibles seront les principaux volets.

2) Renforcement Institutionnel : L'appui demandé consistera en Assistance technique dans les domaines de la formation, de l'Information, Education et Communication et de la mise en place d'un système d'Information Sanitaire.

3) Interventions de pérénnisation : Il s'agit d'un soutien à l'Initiative de Bamako par la mise à disposition d'une assistance technique en matière de recouvrements de coûts et à la mise en place d'un fonds destiné à la fourniture de médicaments essentiels.

Par ailleurs, compte tenu du succès de la collaboration et des bonnes relations développées entre le Ministère de la Santé Publique et des Affaires Sociales et le Centre de Contrôle des Maladies (CDC) d'Atlanta, je voudrais ici exprimer le voeu de continuer à travailler avec cette institution qui a déjà fait ses preuves en République Centrafricaine depuis 1984 dans le domaine des activités techniques pour la survie de l'enfance.

Je saisis cette occasion pour renouveler les sincères remerciements du Gouvernement à l'Agence Américaine pour le Développement International (USAID) pour son appui technique et financier qui a permis le lancement avec succès du Projet CCCD au profit de la couche infantile de la République Centrafricaine et ainsi que pour la réalisation de l'importante mission de planification qui vient de séjourner dans mon pays.

Dans l'espoir du renforcement de notre coopération déjà fructueuse, je vous prie d'agréer, Excellence Monsieur l'Ambassadeur, l'expression de ma profonde gratitude et de ma haute considération.-

Mme Geneviève LOMBILO.-

78

ANNEX D

Initial Environmental Examination
or
Categorical Exclusion

Country: Central African Republic

Project Title: Sustainable Child Survival Project

Funding: $15,043,000

IEE Prepared by: Robert Hellyer
Project Development Officer
AFR/PD/CCWAP

Environmental Action Recommended:

Positive Determination _____
Negative Determination _____
Categorical Exclusion ✓
Deferral _____

Summary of Findings

The project activities meet the criteria for categorical exclusion in accordance with Reg. 16: training and technical assistance under 216.2 (c) (2) (i), research under 216.2 (c) (2) (iii), institutional building under 216.2 (c) (2) (xiv), child survival, family planning and primary health care under 216.2 (c) (2) (viii). Therefore the project activities are recommended for categorical exclusion.

Clearance: _____ Date: Sept. 5, 1991
Al Ford
CAR Desk Officer
AFR/CCWA

Concurrence: _____ Approved X
Bureau Environmental Officer
AFR/TR/PRO
Disapproved _____
Date 9/6/91

Clearance: _____ Date: 10 Sept 91
GC/Africa Bureau

ANNEX E

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to the eligibility of countries to receive the following categories of assistance: (A) both Development Assistance and Economic Support Funds; (B) Development Assistance funds only; or (C) Economic Support Funds only.

A. COUNTRY ELIGIBILITY CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUND ASSISTANCE

1. Narcotics

a. Negative certification (FY 1991 Appropriations Act Sec. 559(b)): Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully? NO

b. Positive certification (FAA Sec. 481(h)). (This provision applies to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics control, disaster and refugee relief, narcotics education and awareness, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly N/A

affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government):

(1) does the country have in place a bilateral narcotics agreement with the United States, or a multilateral narcotics agreement? N/A

(2) has the President in the March 1 International Narcotics Control Strategy Report (INSCR) determined and certified to the Congress (without Congressional enactment, within 45 days of continuous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (a) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals agreed to in a bilateral narcotics agreement with the United States or in a multilateral agreement, to prevent illicit drugs produced or processed in or transported through such country from being transported into the United States, to prevent and punish drug profit laundering in the country, and to prevent and punish bribery and other forms of public corruption which facilitate production or shipment of illicit drugs or discourage prosecution of such acts, or that (b) the vital national interests of the United States require the provision of such assistance? N/A

c. Government Policy (1986 Anti-Drug Abuse Act of 1986 Sec. 2013(b)). (This section applies to the same categories of assistance subject to the restrictions in FAA Sec. 481(h), above.) NO

If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec 481(h)), has the President submitted a report to Congress listing such country as one: (a) which, as a matter of government policy, encourages or facilitates the production N/A

or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S. Government agency has suffered or been threatened with violence inflicted by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the President has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country?

2. **Indebtedness to U.S. citizens** (FAA Sec. 620(c): If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity? NO

3. **Seizure of U.S. Property** (FAA Sec. 620(e)(1)): If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? No

4. **Communist countries** (FAA Secs. 620(a), 620(f), 620D; FY 1991 Appropriations Act Secs. 512, 545): Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism, or (b) removed a country from applicable NO

restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided either directly or indirectly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, Iran or Syria? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside Afghanistan through the Soviet-controlled government of Afghanistan?

5. **Mob Action (FAA Sec. 620(j)):** Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property? NO

6. **OPIC Investment Guaranty (FAA Sec. 620(l)):** Has the country failed to enter into an investment guaranty agreement with OPIC? NO

7. **Seizure of U.S. Fishing Vessels** (FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5): (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made? NO

8. **Loan Default (FAA Sec. 620(q);** FY 1991 Appropriations Act Sec. 518 (Brooke Amendment)): (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1990 Appropriations Act appropriates funds? NO

9. **Military Equipment (FAA Sec. 620(s)):** If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? N/A

(Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

10. **Diplomatic Relations with U.S.** (FAA Sec. 620(t)): Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption? NO

11. **U.N. Obligations** (FAA Sec. 620(u)): What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.) NO

12. **International Terrorism**

a. **Sanctuary and support** (FY 1991 Appropriations Act Sec. 556; FAA Sec. 620A): Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons? NO

b. **Airport Security** (ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures? NO

13. Discrimination (FAA Sec. 666(b)): Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?	NO
14. Nuclear Technology (FAA Secs. 669, 670): Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)	NO
15. Algiers Meeting (ISDCA of 1981, Sec. 720): Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.)	See FY91 Taking into Consideration Memo.
16. Military Coup (FY 1991 Appropriations Act Sec. 513): Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance?	N/A

85

17. **Refugee Cooperation** (FY 1991 Appropriations Act Sec. 539): Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin? YES

18. **Exploitation of Children** (FY 1991 Appropriations Act Sec. 599D, amending FAA Sec. 116): Does the recipient government fail to take appropriate and adequate measures, within its means, to protect children from exploitation, abuse or forced conscription into military or paramilitary services? NO

B. COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO DEVELOPMENT ASSISTANCE ("DA")

1. **Human Rights Violations** (FAA Sec. 116): Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy? NO

2. **Abortions** (FY 1991 Appropriations Act Sec. 535): Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performance of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance of involuntary sterilization as a method of family planning, to coerce or provide any financial incentive to any person to undergo sterilizations, to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? NO

C. COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO ECONOMIC SUPPORT FUNDS ("ESF")

Human Rights Violations (FAA Sec. 502B): Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest?	N/A

5C(2) - ASSISTANCE CHECKLIST

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

A. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS

1. Host Country Development Efforts (FAA Sec. 601(a)): Information and conclusions on whether assistance 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) N/A b) Yes c) N/A d) Yes, Pharma Reform e) N/A f) N/A
2. U.S. Private Trade and Investment (FAA Sec. 601(b)): Information and conclusions on how assistance 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

3. Congressional Notification

a. General requirement (FY 1991 Appropriations Act Secs. 523 and 591; FAA Sec. 634A): If money is to be 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 (unless the notification requirement has been waived because of substantial risk to human health or welfare)?	YES
b. Notice of new account obligation (FY 1991 Appropriations Act Sec. 514): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?	N/A
c. Cash transfers and nonproject sector assistance (FY 1991 Appropriations Act Sec. 575(b)(3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic poolicy reforms to be promoted?	N/A
4. Engineering and Financial Plans (FAA Sec. 611(a)): 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?	a) Yes, see Project Paper b) Yes, see Project Paper
5. Legislative Action (FAA Sec. 611(a)(2)): If legislative action is required within recipient country with respect to an obligation in excess of $500,000, 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?	CAR 5 Year Health Plan 1992-96

6. Water Resources (FAA Sec. 611(b); FY 1991 Appropriations Act 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
7. Cash Transfer and Sector Assistance (FY 1991 Appropriations Act Sec. 575(b)): Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)?	N/A
8. Capital Assistance (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
9. Multiple Country Objectives (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) N/A b) Yes, c) N/A d) Yes, dissolve State Pharmaceutical Company e) N/A f) N/A
10. U.S. Private Trade (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).	Establishment of Generic Pharmeceutical Policy may encourage U.S. Private Trade.

11. Local Currencies

a. Recipient Contributions (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.	CAR will contribute land, salaries of personnel and facilities however CAR is an RLDC so 25% requirement in not appliable.
b. U.S.-Owned Currency (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
c. Separate Account (FY 1991 Appropriations Act Sec. 575). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:	N/A
(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?	N/A
(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?	N/A
(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?	N/A

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government? N/A

12. **Trade Restrictions**

a. **Surplus Commodities** (FY 1991 Appropriations Act Sec. 521(a)): 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

b. **Textiles (Lautenberg Amendment)** (FY 1991 Appropriations Act Sec. 521(c)): 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? N/A

13. **Tropical Forests** (FY 1991 Appropriations Act Sec. 533(c)(3)): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas? N/A

92

14. **Sahel Accounting (FAA Sec. 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. **PVO Assistance**

a. **Auditing and registration** (FY 1991 Appropriations Act Sec. 537): 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.? YES

b. **Funding sources** (FY 1991 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): 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? YES

16. **Project Agreement Documentation** (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). N/A

17. **Metric System** (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the YES

extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

18. Women in Development (FY 1991 Appropriations Act, Title II, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased? N/A

19. Regional and Multilateral Assistance (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs. NO N/A

20. Abortions (FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 525): NO

a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? NO

b. Will any funds be used to lobby for abortion? NO

21. Cooperatives (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life? N/A

22. **U.S.-Owned Foreign Currencies**

a. Use of currencies (FAA Secs. 612(b), 636(h); FY 1991 Appropriations Act Secs. 507, 509): Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services.	N/A
b. Release of currencies (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

23. **Procurement**

a. Small business (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?	To the extent possible.
b. U.S. procurement (FAA Sec. 604(a)): Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him?	YES
c. Marine insurance (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?	N/A
d. Non-U.S. agricultural procurement (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)	N/A
e. Construction or engineering services (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible	N/A

under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

f. Cargo preference shipping (FAA Sec. 603)): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates?

No

g. Technical assistance (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

a) Yes
b) Yes, (CDC/PASA)

h. U.S. air carriers (International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

Yes

i. Termination for convenience of U.S. Government (FY 1991 Appropriations Act Sec. 504): If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States?

Yes

j. Consulting services (FY 1991 Appropriations Act Sec. 524): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?	Yes	
k. Metric conversion (Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?	Yes	
l. Competitive Selection Procedures (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	Yes	CDC/PASA
24. Construction		
a. Capital project (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used?	N/A	
b. Construction contract (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?	N/A	

c. Large projects, Congressional approval (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress? N/A

25. U.S. Audit Rights (FAA Sec. 301(d)): If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A

26. Communist Assistance (FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? N/A

27. Narcotics

a. Cash reimbursements (FAA Sec. 483): Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? N/A

b. Assistance to narcotics traffickers (FAA Sec. 487): Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance? N/A

28. **Expropriation and Land Reform** (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President?	N/A
29. **Police and Prisons** (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?	N/A
30. **CIA Activities** (FAA Sec. 662): Will assistance preclude use of financing for CIA activities?	N/A
31. **Motor Vehicles** (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained?	N/A
32. **Military Personnel** (FY 1991 Appropriations Act Sec. 503): Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel?	N/A
33. **Payment of U.N. Assessments** (FY 1991 Appropriations Act Sec. 505): Will assistance preclude use of financing to pay U.N. assessments, arrearages or dues?	N/A
34. **Multilateral Organization Lending** (FY 1991 Appropriations Act Sec. 506): Will assistance preclude use of financing to carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)?	N/A
35. **Export of Nuclear Resources** (FY 1991 Appropriations Act Sec. 510): Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology?	N/A

36. **Repression of Population** (FY 1991 Appropriations Act Sec. 511): Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights? N/A

37. **Publicity or Propoganda** (FY 1991 Appropriations Act Sec. 516): Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? N/A

38. **Marine Insurance** (FY 1991 Appropriations Act Sec. 563): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate? N/A

39. **Exchange for Prohibited Act** (FY 1991 Appropriations Act Sec. 569): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law? N/A

B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

1. **Agricultural Exports (Bumpers Amendment)** (FY 1991 Appropriations Act Sec. 521(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?	NO
2. **Tied Aid Credits** (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?	NO
3. **Appropriate Technology** (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	N/A
4. **Indigenous Needs and Resources** (FAA Sec. 281(b)): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.	Activity follows priorities laid out in CAR five year Health Plan

5. Economic Development (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?	N/A
6. Special Development Emphases (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.	a) N/A b) N/A c) N/A d) N/A e) N/A
7. Recipient Country Contribution (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	YES
8. Benefit to Poor Majority (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?	YES

p2

9. Abortions (FAA Sec. 104(f); FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 535):

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?	NO
b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?	NO
c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?	NO
d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services?	YES
e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning?	NO
f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?	NO
g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization?	NO

103

10. Contract Awards (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes

11. Disadvantaged Enterprises (FY 1991 Appropriations Act Sec. 567): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)? N/A

12. Biological Diversity (FAA Sec. 119(g): 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?

a) N/A
b) N/A
c) N/A
d) N/A

13. Tropical Forests (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c)-(e) & (g)):

a. A.I.D. Regulation 16: Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? N/A

b. Conservation: Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent N/A

feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

N/A

105

c. Forest degradation: Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development? N/A

d. Sustainable forestry: If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry? N/A

e. Environmental impact statements: Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment? N/A

14. **Energy (FY 1991 Appropriations Act Sec. 533(c)):** If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?	N/A
15. **Sub-Saharan Africa Assistance (FY 1991 Appropriations Act Sec. 562, adding a new FAA chapter 10 (FAA Sec. 496)):** If assistance will come from the Sub-Saharan Africa DA account, is it: (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) to be used to promote sustained economic growth, encourage private sector development, promote individual initiatives, and help to reduce the role of central governments in areas more appropriate for the private sector; (c) being provided in accordance with the policies contained in FAA section 102; (d) being provided in close consultation with African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (e) being used to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups; (f) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks,	a) Yes b) Yes c) d) N/A e) Health f) Meets needs of mother and children

to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

16. **Debt-for-Nature Exchange (FAA Sec. 463):** If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management. N/A

17. **Deobligation/Reobligation (FY 1991 Appropriations Act Sec. 515):** If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified? N/A

18. **Loans**

a. **Repayment capacity (FAA Sec. 122(b)):** Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest. N/A

b. Long-range plans (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?	N/A
c. Interest rate (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?	N/A
d. Exports to United States (FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?	N/A
19. Development Objectives (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?	1) N/A 2) N/A 3) N/A 4) N/A 5) N/A

20. Agriculture, Rural Development and Nutrition, and Agricultural Research (FAA Secs. 103 and 103A):

a. Rural poor and small farmers: If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

N/A

b. Nutrition: Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

N/A

c. Food security: Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

N/A

21. Population and Health (FAA Secs. 104(b) and (c)): If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of

Activity is in support of CAR 6 5year Primary Health Care Plan

mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

22. **Education and Human Resources Development (FAA Sec. 105):** If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities. N/A

23. **Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106):** If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is: N/A

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment; N/A

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations; N/A

c. research into, and evaluation of, economic development processes and techniques; N/A

d. reconstruction after natural or manmade disaster and programs of disaster preparedness; N/A

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance; N/A

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development. N/A

24. Sahel Development (FAA Secs. 120-21). If assistance is being made available for the Sahelian region, describe: (a) extent to which there is international coordination in planning and implementation; participation and support by African countries and organizations in determining development priorities; and a long-term, multidonor development plan which calls for equitable burden-sharing with other donors; (b) whether a determination has been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of projects funds (dollars or local currency generated therefrom). N/A

ANNEX F-1

TECHNICAL ANALYSIS CHILD SURVIVAL

A. Background

The Ministry of Public Health and Social Affairs (MSPAS) has demonstrated leadership and a commitment to the health of children in C.A.R.. Despite severe economic problems, C.A.R. has made substantial gains in child health, particularly in increasing vaccinations against preventable diseases. Since 1985, immunization coverage has more than doubled, and reported measles cases have declined by 85%. In 1990, the government received the award of the National Council for International Health in recognition of this outstanding progress in child survival.

As elsewhere in Africa, C.A.R.'s advances in child survival can be largely attributed to its vigorous implementation of programs targeting specific causes of death in children. Although this approach has been successful, it has promoted the vertical structure of health services. The challenge now before C.A.R. and its health partners is to maintain gains in child health, address additional threats to child survival, and bridge to a more integrated health service system.

The MSPAS' commitment to the development of a fully functional, integrated system of primary health care (PHC) is reflected in its national plan for health development for 1992-1996. The plan is composed of both technical and capacity-building elements. Five of the 10 components of the plan are specific health programs: (1) endemic diseases, (2) HIV/AIDS, (3) nutrition, (4) water and sanitation, and (5) maternal and child health and family planning. The other five components include development strategies for personnel, buildings and equipment, essential drugs and vaccines, information, education and communication, and institutions with an emphasis on decentralization. The government plans to solicit donors' support for the various program elements.

B. A.I.D. assistance

A.I.D. and CDC assistance over the next five years will support efforts of the government of C.A.R. (CARG) to strengthen its system of primary health care and to promote an integrated and comprehensive PHC system. Technical and financial resources will be directed at: (1) linking priority health interventions to an integrated PHC program; (2) improving the quality and utilization of health services; (3) supporting additional health interventions of major importance; (4) developing better methods for influencing health behaviors in the population; (5) strengthening the efficiency and effectiveness of health care

delivery; and (6) establishing cost-recovery mechanisms. A.I.D. will work closely with the CARG and with other donors in these efforts.

In order to enhance its contribution to the establishment of primary health care, A.I.D./CDC assistance will be expanded and made more flexible and interdepartmental. The senior CDC project coordinator will work at the Director General level on integrating child survival interventions and PHC, and will work to stregthen coordination among the departments of pharmacy, preventive and curative medicine, maternal and child health and family planning, and health planning and statistics. The project coordinator will provide support to the MSPAS in the implementation of PHC, oversee A.I.D./CDC assistance in PHC, and promote cooperation among the many partners supporting various aspects of PHC.

A.I.D. and CDC will continue to provide assistance in the technical interventions and support strategies of the current Combatting Childhood Communicable Diseases (CCCD) project. CCCD is comprised of three technical interventions and four cross-cutting support strategies. The technical components include support to the expanded program on immunization (EPI), control of diarrheal diseases (CDD), and malaria prevention and control. The support strategies include training and supervision, health education, operational research and health information systems. The successful models used to define and implement technical interventions under the current CCCD will be used to assist the MSPAS in addressing three additional threats to child survival: acute respiratory infections (ARI); human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS); and high risk births. (See the Africa Child Survival Initiative CCCD Project 1990 annual report for more information about the current CCCD project -- copies available from AFR/PD and CCWA.)

The Sustainable Child Survival project will increase emphasis on the support strategies with the goals of: strengthening training and supervision; reaching communities and influencing health behaviors; and to improve the abilities of health workers to solve operational problems, and to collect, analyze and use health data.

With support from A.I.D. and other donors, the Directorate of Preventive Medicine and Endemic Diseases (DMPGE) has developed model logistic, supervision, management and health information systems to support its child survival interventions. Support from A.I.D. under the Sustainable Child Survival project will assist the MSPAS to develop and test strategies to apply these systems to the MSPAS as a whole. The project will provide assistance for establishing programs for essential drugs and recurrent cost financing, increasing the cadre of trained health providers, and developing consolidated logistic, supervision, management and health information systems.

Health care is integrated at the delivery level in that a single health agent provides a broad spectrum of health services. However, central and regional level management is most often provided through vertical programs identified with particular interventions. The Sustainable Child Survival project will emphasize common aspects of the various programs (especially the support strategies) and support integration and coordination among programs and divisions within the MSPAS.

Project activities will also promote the concept of the health worker as a health care provider capable of assessing each individual presented for care, rather than the health worker as an EPI or CDD agent. Programs will be developed which provide multiple services and address age-specific risks of mortality. The MCH program focuses on intervations during the perinatal-neonatal period, while services for post-neonatal infants and children are provided in out-patient pediatric settings. Integrated services are discussed more thoroughly in Section E. of this annex.

C. Technical Interventions - Strategy

The DMPGE has developed a successful strategy for strengthening its child survival interventions which it has implemented sequentially in 3 programs areas, EPI, CDD and malaria. This strategy employs the following steps: (1) establish national policy including case management protocol and measurable objectives, (2) develop a set of standards for evaluating health worker performance, (3) evaluate performance, (4) develop training manuals, (5) train trainers at the national and regional levels, (6) train and supervise health workers, and (7) evaluate health worker performance at the health facilities.

The current status of programs and the objectives the Sustainable Child Survival project aims to achieve in the following six technical areas are described in the body of the PP, in Section II.C. This annex describes the strategy that will be followed in order to achieve the project objectives. The Child Survival advisor will be responsible for implementing these strategies.

1. Expanded Program of Immunization

The following strategies will be used to attain project objectives for the EPI:

- -- Provide an uninterrupted supply of vaccines to all vaccination centers
- -- Increase coverage in rural areas by:
  - -monitoring coverage by district
  - -utilizing strategie avancee (outreach from fixed centers)
- -- Add VAT vaccination programs for females in schools and other areas where women gather
- -- Improve quality of vaccination services

through follow-up and supervision of 350 health workers previously trained, through the training of 2340 additional health workers, and through the provision of supplies

-- Develop strategies to increase vaccination coverage in the first year of life such as:
  -building missed opportunities strategies into all appropriate clinics serving children under five and prenatal clinics
  -tracing defaulters
  -vaccinating at all contacts
-- Support polio pre-eradication and neonatal tetanus elimination strategies
-- Evaluate programs in conjunction with HIS program using disease reporting, sentinel sites, and surveys

It is worth footnoting that even with well-functioning systems, the MSPAS will be challenged to maintain the country's high immunization coverage levels. In order to sustain vaccination coverage without substantial outreach efforts, vaccination centers and regional vaccine depots must be added. The ministry hopes to add 125 vaccination centers and 5 regional depots over the next five years. (Assistance through this project will not directly address this critical need.)

2. Control of Diarrheal Diseases (CDD)

The following strategies will be employed to achieve the project objectives in CDD:

-- Make ORS available in 95% of hospitals and health centers and sub-centers
-- Increase the use of ORS to 95% of hospitals and urban health centers, and 60% rural health facilities
-- Maintain measles immunization coverage at a level of at least 80%
-- Train and supervise health care workers to increase the level of correct case management, including patient education, in all health facilities to at least 60%
-- Improve follow-up supervision of 350 health workers previously trained in CDD case management
-- Develop and implement an IEC plan using measurable objectives and the triad approach, i.e., health facility, mass media and social mobilization
-- Develop training and educational materials for CDD social mobilization activities and train community mobilizers
-- Provide IEC to caretakers and community leaders to ensure that:

- 50% of caretakers continue to give liquids and to correctly feed their children during diarrheal episodes
- 50% of caretakers know when to take a child with diarrhea to a health facility
- 80% of caretakers in Bangui and 50% of caretakers in the rest of the country wash the buttocks of their infants after each stool and wash their (caretakers) hands before handling food
- 70% of caretakers in Bangui and 60% of caretakers in the rest of the country dispose of diarrheal stools correctly

-- Include CDD health education in primary and secondary school curricula
-- Promote breastfeeding
-- Conduct operational research to improve strategies for effective home case management
-- Apply the results of home fluids research once the current study is completed
-- Evaluate programs in conjunction with HIS program using disease reporting, sentinel sites, and surveys
-- Evaluate health education practices at the health facility and community level using post-training assessments several months after training
-- Develop a data base of KAP survey results and the results of facility needs assessments

Breastfeeding reduces the risk of a child developing diarrhea and continued breastfeeding during diarrhea reduces the child's chances of becoming dehydrated. In addition to playing a critical role in preventing and managing diarrhea, breastfeeding improves resistance to infections and provides essential nutrition. At present, 77% of mothers in Bangui are reported to exclusively breastfeed their infants until 4 months of age. The project will thus develop IEC interventions to promote breastfeeding.

Oral rehydration solution use in homes also needs special attention. A 1989 survey of 3763 children treated at four regional oral rehydration treatment units and four outpatient departments documented home use of ORT in only 5% of patients. Since 1990, caretakers have had increased access to ORS, and training and IEC have been used to promote its use. This project will continue monitoring and promoting the use of ORS and home fluids.

Operational research studies have been conducted to identify appropriate cereal-based solutions to use for rehydration in the home. The ministry is completing analysis of the most recent study and expects to be ready soon to communicate recommendations to caretakers for use in the community. Additional operational research must be carried out so that more effective strategies

for promoting prevention activities and appropriate case management practices in the home can be developed.

As in the case of immunization, the ministry needs additional facilities, equipment, supplies, and trained professionals to meet its objectives in CDD. The ministry plans to maintain ORT units for training and to expand the number of treatment sites from 175 to 448 over the next five years. As with immunization, the Sustainable Child Survival project will not directly support the construction of ORT facilities. The project will, however, provide limited support to furnish ORT units, and significant assistance in IEC and in training health care workers in case management.

3. Malaria

The following strategies will be employed to achieve the project objectives in combatting Malaria:

- -- Promote the availability of chloroquine and second line drugs at all fixed health facilities
- -- Continue monitoring chloroquine resistance
- -- Raise to 80% the percent of homes with immediate access to chloroquine (or an appropriate antimalarial kept at home or within the same neighborhood or village)
- -- Provide training and supervision of health workers to ensure correct treatment of fever cases at health centers
- -- Correctly treat 95% of febrile pregnant women at health facilities
- -- Accelerate IEC to inform the public of correct malaria treatment for children less than 5 years of age and to encourage families to have chloroquine at home
- -- Use community mobilizers to increase by 25% the number of caretakers who obtain early and correct treatment of fevers in their children
- -- Promote the use of mosquito nets impregnated with insecticide
- -- Promote the elimination of mosquito breeding sites by training villagers through health committees and by using community mobilizers

4. Acute Respiratory Infection

The following strategies will be employed to achieve the project objectives in reducing ARI:

- -- Establish a national ARI program
  - define national policy
  - determine current treatment practices
  - determine current levels of inpatient mortality

- develop diagnosis and treatment protocols
- provide training in appropriate diagnosis and treatment for health professionals including, assessment and treatment of children with cough or difficulty breathing, common cold and pneumonia, and health education messages for caretakers with children with respiratory infections

-- Insure an adequate supply of appropriate drugs in health facilities
-- Provide training and supervision in ARI case management for health care workers
-- Develop and implement IEC programs for ARI
-- Conduct a KAP study to determine the criteria used by caretakers to assess the severity of respiratory illness
-- Provide health education for caretakers regarding assessment of and appropriate treatment for ARI both prior to and following clinic visits including:
  - recognition of rapid respiration and difficulty of breathing as symptoms of pneumonia
  - recognition of the difference between symptoms of the common cold and those of pneumonia
  - treatment of cough or common cold at home
  - recognition of the need to seek care for ARI from a trained person
-- Utilize social mobilizers to identify and refer infants in need of treatment for ARI
-- Examine the role of vaccines in preventing ARIs

5. HIV/AIDS

The following strategies will be pursued to achieve the project objectives in reducing the incidence of HIV/AIDS and STDs. Coordinated donor support will enable the Ministry of Public Health and Social Affairs programs to:

-- Evaluate the progress of the AIDS epidemic, including the estimation of the prevalence of STDs
-- Increase access to condoms for the population of C.A.R.
-- Diminish sexual transmission of HIV by providing appropriate treatment of STDs
-- Develop a pilot project for STD control in one region
-- Apply lessons learned in the pilot project to national STD control activities
-- Develop and provide appropriate health education to change risk-taking behaviors
-- Diminish transmission of HIV/AIDS by invasive procedures
-- Reduce HIV/AIDS transmission through early detection and counseling of infected persons
-- Diminish transmission by blood transfusions

6. Birth spacing

The following strategies will be employed to increase the practice of birth spacing:

- -- Conduct applied research to define the level of knowledge about and demand for contraceptive services, including a community baseline survey if possible
- -- Conduct operational research to define the best sites at which birth spacing services or supplies should be offered, including private sector outlets and immunization clinics
- -- Conduct operational research about integration of birth spacing into immunization programs
- -- Establish birth spacing services in 50% of health facilities
- -- Use IEC to promote utilization of birth spacing services
- -- Use IEC to promote breast feeding
- -- Target young women in schools and other gathering places for birth spacing messages to reduce early teenage pregnancies

Both access to birth spacing services and the quality of these services must be improved. These services can be provided in conjunction with other services such as infant and child immunization. Operational research must be conducted on the feasibility and acceptability of offering contraceptive services to women at the time her child receives DPT1. Once available, these services must be publicized and made widely accessible.

D. Sustainability Interventions: Institutional Strengthening

1. Training

The project will provide short-term technical advisors to the MSPAS as required to assist with the development of training methods and materials. Strategies for improving training and supervision include:

Strengthen and improve structure of training program.

- -- Increase decentralization of training to regional teams
- -- Improve coordination among MSPAS' departments
- -- Provide consultant support to ensure that the effective training strategy currently used by the DMPGE is transferred across departments

Establish national quality standards for health care workers.

- -- Institutionalize the use of professional certification (i.e. certified vaccinator, certified CDD therapist, expert social mobilizer)
- -- Develop a standardized supervisory checklist and supervisory guidelines that integrate all MSPAS programs and policies

Develop and institutionalize more effective evaluation methods.

- -- Identify skills requisite to the successful implementation of PHC and develop training programs to strengthen those skills
- -- Promote improved methods to assess training effectiveness in improving health worker skills
- -- Develop a management information system to monitor performance of health care workers
- -- Develop a data base which records training and certification of all health agents
- -- Conduct monthly supervisory visits at the regional level
- -- Institutionalize measures to reward superior performance

Encourage certain administrative programs to improve management.

- -- Incorporate principles of prevention, early intervention, and appropriate case management into curricula at universities and technical schools
- -- Establish training programs to improve supervisor's skills in planning supervision, utilizing positive supervisory techniques, providing feedback to personnel, and in conducting on-site refresher training
- -- Provide training for leadership in administration, policy formation, and resource planning and management
- -- Increase access to professional literature
- -- Increase opportunities for exchanges with African colleagues from other countries by
  - increasing use of African consultants and
  - ensuring participation at international conferences

This training strategy will be used both for the specific technical interventions and for the institutional strengthening activities. Training for integrated service delivery and management systems will be tested, refined, implemented and evaluated during the project.

To ensure that the improved performance of health workers achieved through training is sustained, training must be reinforced by closer and more regular supervision. Supervisors must assess training needs and provide on-the-job training as part of routine supervision. The CARG recognizes this need, and the project will provide additional training in the supervisory skills and techniques that reinforce positive performance and promote improved performance.

2. Health and Management Information Systems (H/MIS)

Both long and short-term CDC experts will develop a plan for integrating current child survival surveillance systems in to the national H/MIS. The SCSP will provide computers as commodity support and technical assistance to help the development of these systems. The project will use the following strategies to assist the MSPAS create H/MIS:

Strengthen MSPAS structures' efficiency and ability to handle health and management information

- -- Assess national H/MIS needs in terms of data, staffing, equipment, and use of data
- -- Develop with country staff a plan for system improvement
- -- Strengthen capacities to conduct outbreak investigations, surveys and special studies
- -- Provide training at the service delivery level in data collection, record keeping, data analysis and application
- -- Computerize regional and central reporting systems
- -- Provide central and regional training in computer programming and maintenance
- -- Provide technical assistance in computer programming, disease surveillance, and epidemiology relevant to development and use of H/MIS
- -- Link supervisory data to H/MIS
- -- Assist the DEPS in integrating data systems for service delivery, program implementation, training, health education and promotion
- -- Strengthen behavioral science contributions to the evaluation H/MIS process, including training for the use of appropriate qualitative methods as needed

Standardize and increase collection of data

- -- Simplify data collection at the service delivery level
- -- Establish standardized case definitions for EPI diseases, diarrhea, malaria, ARI, STDs, and HIV/AIDS
- -- Improve sentinel surveillance data collection and reporting for both the target childhood diseases and HIV/AIDS

Increase the utility and availability of processed data

- -- Increase use of routine service data
- -- Improve utility of information systems for health workers at all levels
- -- Develop workplans that concentrate on priority monthly and annual analyses
- -- Provide quarterly feedback reports to sentinel sites
- -- Provide data regularly to policy makers and managers

- -- Promote the publication of annual reports during the first half of the following year to assess yearly disease trends and progress toward targets
- -- Expand the distribution and develop the content of the DMPGE Echo
- -- Develop other professional communications such as an epidemiologic bulletin

3. Health Financing

In 1989 the C.A.R. National Assembly passed a law authorizing the recovery of costs for certain health services. A national workshop on health care financing was conducted to build a consensus for cost recovery. In 1991, a health economist, working with A.I.D.'s Health Financing and Sustainablity Project, was assigned as resident advisor to work with the Health Economics Unit in the office of the Director General of MSPAS. The advisor is working with the CARG to diversify and increase sources of revenue in the health sector, to identify measures to increase the efficient use of financial resources, and to improve the ability of the CARG to assess health care costs and to use this information to develop sustainable health care strategies. The current ASCI-CCCD project is assisting the government to promote policy dialogue on health care financing issues among the government and donors, and to develop, test, and implement alternative health financing systems.

The Sustainable Child Survival Project will continue to support short-term and long-term technical assistance as well as commodity and training support. The success of a cost recovery program depends upon the quality of the health care which the population is expected to help pay for. The majority of the necessary improvements can occur as a result of the child survival interventions. Hospital fees have already been enacted so the emphasis will be on strengthening the accounting infrastructure, reducing hospital costs, and reforming hospital fees.
The following strategies will be used:

<u>Improve the quality of the health care</u>
- -- Conduct studies of health facilities
- -- Survey patient needs
- -- Improve personnel training

<u>Promote hospital financial autonomy</u>
- -- Strengthen the accounting infrastructure
- -- Reduce hospital costs
- -- Reform hospital fees

For a more detailed description of the strategies to be utilized, see Annex J.

ANNEX F-2

HIV/AIDS AND STDs

A. Background

AIDS prevalence rates in the CAR are among the highest in Africa. In December 1988, when national data were last collected, CAR ranked ninth in prevalence among all African nations. In 1990 it ranked eighth among countries receiving A.I.D. assistance. (WHO 1990, A.I.D. 1990)

Between 1985 and 1987 national serosurveys were conducted to determine AIDS prevalence in the general population. The rate of infection increased from 2.1% in 1985 to 7.8% in 1987. Since 1989, the MSPAS has tracked seroprevalence among sentinel groups in the population. Surveillance indicates that at least 9% of women attending prenatal clinics in Bangui are seropositive, and 6-9% of women attending clinics in other large towns are also positive. 8.5% of blood donors are HIV positive. (U.S.A.I.D. 1990)

Sexually Transmitted Diseases (STDs), a probable cofactor in the transmission of HIV infection, are also common in the CAR. (Mertens et. al. 1990, Simonsen et. al. 1988, WHO 1989) Among male students in their last year of "Lycee", 60% have had an STD. (Institute Pasteur) In a survey of women attending maternal and child health clinics, 10% tested positive for syphilis. Other STDs like gonorrhea and chlamydia infect large numbers of people and are likely responsible for a high level of sterility among women. (U.S.A.I.D. 1990, PSI 1991)

In Bambari, a crossroads for trade with Zaire, Chad, and Sudan, 33% of women ages 15-19 seeking treatment for STDs have tested HIV positive. (PSI 1991) In Bangui, the nation's capital, 16% of STD patients tested HIV positive. (U.S.A.I.D. 1990)

It is estimated that heterosexual transmission accounts for over 80% of all reported AIDS cases in the region. Thus, reducing the rate of heterosexual transmission of HIV infection by STD control, condom use, and a reduction in the number of casual sexual partners, will have a much greater impact on reducing the magnitude of the epidemic than providing clean needles or screening the blood supply. (Rowley et. al. 1990, Schopper 1990)

B. A.I.D. assistance

The Ministry of Public Health and Social Affairs (MSPAS) is working with a number of partners to control the CAR AIDS epidemic. The World Health Organization's Global Program on AIDS (WHO/GPA) in collaboration with the United Nations Development Program (UNDP) has led donor support to AIDS control in CAR. A.I.D. has provided a long term advisor from the Centers for

Disease Control to assist with program management, training, STD control, and monitoring and evaluation. (See Attachment B, HIV/AIDS Project U.S.A.I.D./CDC 1990 Annual Report.)

Recognizing the severity of the AIDS problem in CAR and the opportunity to institute measures to help control its spread, A.I.D. is increasing its support to the National AIDS Control Service (NACS). The major program emphases of NACS are (1) evaluating the progress of the disease, (2) improving access to condoms, (3) diminishing sexual transmission through the control of STDs, (4) providing health education, (5) diminishing transmission via invasive procedures, (6) providing early detection and counseling, (7) and diminishing transmission by blood transfusion.

A.I.D. will provide technical and fiscal resources in support of AIDS prevention and control initiatives, including the social marketing of condoms, prevention and treatment of STDs, and targeted health education measures.

1. Evaluating the disease progress

Status:

Evaluating the progress of the disease is fundamental to determining control measures. The last HIV seroprevalence study was conducted in 1987. 7.8% of persons screened were seropositive, reflecting a doubling of the cases since the last survey in 1986. Since 1989, the National AIDS Control Service (NACS) has tracked seroprevalence among 4 sentinel groups in the population: pregnant women, patients with STDs, blood donors and tuberculosis patients. These groups are followed in 10 locations; 6 in the capital city of Bangui and 4 in the prefectoral capitals of the country. According to this surveillance system, the number of cases has doubled since 1988 and currently lies well above 2,000. However, because of the incompleteness of reporting the number of cases is likely to be severely underestimated.

Interventions:

More complete and accurate information will be attained by: (1) improving the monitoring system (sentinel surveillance and health information systems related to HIV, AIDS, and selected STDs), and by (2) developing, conducting and evaluating operational research related to monitoring and evaluation methods.

2. Improving access to condoms

Status:

Improving access to condoms is essential to the prevention of both HIV/AIDS and STDs. Social marketing has proven to be an extremely effective and cost efficient means of dramatically increasing access to condoms and consequent use in a number of African countries. Furthermore, the participation of private sector entities, from large wholesalers to street vendors, who earn reasonable profits, can make a significant contribution to HIV/AIDS information campaigns.

Between 1988 and 1990, NACS mounted a condom awareness campaign which included the free distribution of approximately 3.5 million condoms around the country. Because of the health education efforts occurring simultaneously, not only were the condoms absorbed, but they later began to appear in the markets of Bangui at prices ranging from 25 to 200F CFA ($.10 to .90) per condom. (PSI 1991) The apparent receptivity of Central Africans to purchasing condoms is encouraging. The social marketing of condoms could make an important contribution the reduction of HIV/AIDS and STDs in CAR.

Interventions:

To implement the social marketing of condoms, an agreement will be developed with a non-goverment organization firm to undertake the following activities: (1) augment demand, (2) distribute condoms throughout CAR, (3) monitor distribution and sales, and (4) evaluate the use of condoms in the general population.

The social marketing efforts will be supported by the MSPAS through health education for the general public and for high risk groups. The MSPAS will augment condom distribution by proving condoms in STD treatment settings, in maternal and child health service settings particularly in post-natal, immunization and birth spacing services. Health education about HIV/AIDS and STDs, and promotion of the use of condoms will also be integrated into the regular provision of health services by the MSPAS.

3. Diminishing sexual transmission through STD control

Status:

Diminishing sexual transmission through STD control is key to decreasing the incidence of AIDS. STDs are associated with increased incidence of HIV/AIDS, and the use of condoms decreases both STDs and the sexual transmission of HIV/AIDS. In a recent survey by the Pasteur Institute, results suggest that young Central African males have a mean of 7 sexual encounters per week, half of which are with individuals who are not their regular sexual partners. (Gresenguet et. al. 1990)

Interventions:

The project will use the following strategies to reach these individuals:

- -- develop diagnosis and treatment protocols for the treatment of STDs
- -- provide health worker training in STD diagnosis and treatment
- -- evaluate health worker performance after training
- -- provide correct diagnosis and appropriate treatment for all STD cases presenting at operational health facilities
- -- provide condoms to all STD patients
- -- provide counseling about STDs and HIV/AIDS prevention for all persons and their partners presenting with STDs at health facilities
- -- provide partner notification and treatment for persons with STDs
- -- use social mobilizers to inform the general public about HIV/AIDS and STDs

A pilot STD control project in Region 4, which has some of the highest STD rates in the country, will be supported by the project. The purpose of this initiative is to reduce STD transmission in a high prevalence area with minimal resources. The project will start small, concentrating on one or two health facilities, then gradually expand to encompass the entire Region over the course of a year. The lessons learned will used to strengthen STD control programs in other areas of the country.

Also, support under this pilot will provide for the seroepidemiological study of the interactions between ulcerative STDs and HIV in CAR. Although not conclusive, there has been a link drawn between the presence of STD genital ulcers and an increased incidence of HIV seroconversion (Simonsen, et. al. 1988, Cameron et. al. 1989). Clarifying this linkage will enable the MSPAS to better target its limited resources.

See Attachments D, E and F for more detailed information about STD control activities.

4. Behavior change interventions

Status:

Developing and providing appropriate health education is necessary to affect high risk behaviors. In addition to programs

for the general public, the National AIDS Control Service (NACS) is targeting three categories of high risk persons for specific health education interventions: young, unmarried women "filles libres", migrant workers, and truck drivers.

Interventions:

For each of the high risk groups, the project will assist NACS in (1) determining the scope of the problem among the targeted high risk groups and their contribution to the AIDS epidemic, (2) conducting KAP surveys, (3) developing, testing and refining health education messages, (4) implementing and evaluating the effectiveness of health education strategies, and (5) in institutionalizing these efforts if they are found to be beneficial in preventing the spread of AIDS.

Filles Libres

Filles libres are women who live alone or with other filles libres and who oftentimes engage in high risk sexual behavior or prostitution to earn their livelihood. (MSPAS 1990) The strategy employed by the NACS has been to engage filles leaders, women who are respected by the other women with whom they live, in intense anti-HIV/AIDS health education efforts. To date, more than 60 filles libres have been educated by filles leaders in anti-HIV/AIDS and STD health education messages. (MSPAS 1990)

NACS implementation strategies are to: recruit filles leaders as health educators, inform and educate filles libres in Bangui and in other population centers, and to establish an organization to serve the needs of the filles libres and others diagnosed with AIDS.

Truck Drivers

Bambari stands out as a special problem area with high STD and HIV rates. The town, and to some extent the region, is a cross-roads for trade and commerce moving between Bangui and those regions of the country that border Zaire, Sudan and Chad. Among STD patients in Bambari, the rate of infection with HIV is 22%, higher than that of Bangui (U.S.A.I.D. 1990), and truck drivers have been implicated in the spread of the disease. This project will assist NACS to establish and continue an outreach and health education program targeting truck drivers.

NACS strategies include collecting information about the routes of truck drivers in relation to the spread of HIV, targeting truck drivers along these routes, and developing and implementing a health education program for the target group.

Migrant Workers

Agriculture, forestry and fisheries occupy four-fifths of the population in CAR. (Green 1991) Many agricultural areas are dependent on seasonal workers who come in from outside of that region to assist in harvesting crops. These individuals, who are predominantly male, oftentimes engage in high risk behaviors and may harbor STDs. Like truck drivers, they have been targeted by the NACS for specific health education interventions.

5. Invasive procedures

Status:

Diminishing transmission of HIV/AIDS caused by invasive procedures is another of the objectives of the National AIDS Control Service. Practices such as circumcision, cutting the umbilical cord at delivery, and providing injections for illness, often entail the use of a single instrument (razor, knife, needle) for multiple procedures. The use of unsterilized instruments leads not only to a greater risk of infection, but to increased risk of exposure to HIV.

NACS strategies include: increasing access to sterilization equipment in health facilities, training all health personnel in sterile procedures, training traditional birth attendants in sterile techniques and providing birth attendant kits, and encouraging the use of sterile equipment for invasive procedures.

6. Early detection

Status:

Reducing HIV/AIDS transmission through early detection and counseling is the first line of secondary prevention to be targeted by NACS for intervention. It also presents an excellent opportunity for primary prevention among sex partners of persons who are HIV positive. Currently, health personnel in the interior of the country lack the diagnostic tools necessary to be able to readily identify a patient with HIV/AIDS. Also, a need exists for HIV counseling of patients and family members once an individual tests positive. Lastly, condoms need to be provided to HIV positive individuals.

Interventions:

Although not a major area of emphasis, this project will provide support to the NACS in: (1) training health workers in HIV/AIDS counseling techniques, and in (2) monitoring and evaluating post-training performance.

7. Blood transfusion

Status:

Diminishing transmission by blood transfusion has been undertaken by the Pasteur Institute and is therefore not a component of the project. Although transmission by blood transfusion plays only a small role in HIV transmission in the CAR, the importance of blood screening cannot be overlooked. Currently, only individuals living in and close to Bambari, Bangassou, Bouar, Berberati and Bossangoa are tested, leaving a great part of the population at risk. (MSPAS 1990) People in need of transfusion rely on relatives to provide blood. Under the auspices of the Pasteur Institute, a program has been initiated to widen the range of sites where blood testing occurs, with the ultimate goal of providing access for the nation to blood testing facilities before transfusions take place. (Institute Pasteur 1990)

In conclusion, given the prevalence of AIDS in the CAR, more intense AIDS control efforts are vital to protecting the health of the population.

C. Project Objective and Strategies for HIV/AIDS and STDs

The objective of this project is to reduce both the incidence of HIV/AIDS and the incidence and prevalence of STDs through monitoring, surveillance, and impact assessment; increasing public knowledge of the disease and its transmission; and interventions to prevent HIV transmission, and to diagnose treat, and prevent transmission of STDs. The objective will be accomplished through coordinated donor support of the Ministry of Health and Social Affairs programs to:

Strategies:

- -- Evaluate the progress of the HIV/AIDS epidemic, including the estimation of the prevalence of specific STDs
- -- Increase access to condoms for the population of CAR
- -- Diminish sexual transmission of HIV by providing appropriate treatment of STDs
- -- Develop a pilot project for STD control in one Region
- -- Apply lessons learned in the pilot project to national STD control activities
- -- Develop and provide appropriate health education to change risk taking behaviors
- -- Diminish transmission of HIV/AIDS by invasive procedures
- -- Reduce HIV/AIDS transmission through early detection and counseling of infected persons
- -- Diminish transmission by blood transfusions

The project will give priority support to four of the seven areas targeted by NACS: (1) evaluate the progress of the disease, (2) improve access to condoms, (3) diminish sexual transmission through STD control, and (4) to promote behavioral change through health education and social mobilization. Less emphasis will be given to interventions to diminish transmission by invasive procedures and blood transfusion, and to screening and counselling activities.

References for HIV/AIDS and STDs

Cameron DW, Simonsen JN, D'Costa LLJ, et. al. Female to male transmission of HIV type 1: risk factors for seroconversion in men. Lancet, 1989; ii:403-407.

Hawkins RV and Somse P. Proposed U.S.A.I.D. HIV/STD Support at the Regional and Prefectoral Level in CAR. 1991.

Hawkins RV and Steen R. Central African Republic: HIV/AIDS Project U.S.A.I.D./CDC 1990 Annual Report. 1990.

Institute Pasteur Bangui Centrafrique. Rapport Annuel 1990.

Mertens TE, Hayes RJ, Smith PG. Epidemiological methods to study the interaction between HIV infection and other sexually transmitted diseases. AIDS, 1990; 4:57-65.

Ministere de la Sante Publique et des Affaires Sociales, Programme National de Lutte contre le SIDA. Reprogrammation du Plan a Moyen Terme de Lutte contre le SIDA pour la Periode 1991-1992, 2eme version. 12/90.

Population Services International. Unsolicited Proposal to the Agency for Internation Development: Central African Republic. Condom Social Marketing for AIDS-Prevention. 5/91.

Rowley JT, Anderson RM and Ng TW. Reducing the spread of HIV infection in sub-Saharan Africa: some demographic and economic implications. AIDS, 1990; 4:47-56.

Schopper D. Research on AIDS interventions in developing countries: State of the art. Social Science Medicine, 1990; 30(12):1265-1272.

Simonsen JN, Cameron BW, Gakinya MN, et. al. Human immunodeficiency virus infection among men with sexually transmitted diseases. Experience from a center in Africa. New England Journal of Medicine, 1988; 319:275-278.

Somse P and Hawkins RV. Project de plan d'action de lutte contre le SIDA en milieu des filles libres. Ministre de Sante Publique et Affaires Socials. 1991(a).

Somse P and Hawkins RV. Project de document du plan d'action de lutte contre le SIDA parmi les camionneurs. Ministre de Sante Pubique et Affaires Socials. 1991(b).

US Agency for International Development. Project Identification Document Facesheet (PID) for the Central African Republic. 1/91

US Agency for International Development. HIV Infection and AIDS: A Report to Congress on the U.S.A.I.D. Program for Prevention and Control. 7/90.

World Bank, Division of Population et Resources Humanes, Departement de l'Afrique Occidentale et Centrale, Region Afrique, Rapport No. 7492, "Analyse de Constraintes Sectorielles et des Sources de Financement du Secteur Sante en Republique Centrafricaine". 9 fevrier 1989.

World Health Organization. World Health Organization global AIDS statistics. AIDS Care, 1990; 2(4):437-440.

World Health Organization. Report of the consultation on sexually transmitted diseases as a risk factor for HIV transmission. Geneva, 4-66 January, 1989. WHO/GPA/ESR

ANNEX G

ECONOMIC ANALYSIS

The purpose of the economic analysis is to determine the social profitability of the project, i.e. is the project going to produce benefits for society as a whole that are higher than the project costs? This allows project designers to determine if the project is a worthwhile investment for the country.

In the social sectors, such as health, it is difficult to perform this type of economic analysis, which entails assigning dollar values to the costs and benefits of a project. Such analysis is difficult because it is often impossible to reduce health outputs to monetary values, and sometimes even to quantify them (such as the improved quality of life resulting from improved health status).

As a result, in social sector projects USAID does not require cost-benefit analysis, but advocates the use of least-cost analysis of competing project designs. In other words, the economic analysis must show that the project has chosen a design which minimizes costs to the greatest degree possible, while achieving the same outputs.

This section presents a cost-effectiveness analysis of the project, comparing the costs of different project interventions. It is followed by four other economic analyses. Section II analyzes the CAR health budgets from 1985-1991 and discusses more equitable and efficient distribution of resources. Section III discusses areas in which the efficiency of the government health system can be improved. Section IV analyzes the potential savings from using generics for four drugs. Section V on cost recovery compares the potential revenues to be generated at different levels of the health systems and in different geographic areas.

I. ANALYSIS OF PROJECT INTERVENTIONS

A. Cost-Effectiveness of Project Interventions

1. Expanded Program on Immunization (EPI)

Child immunizations are recognized as one of the most effective means of preventing child mortality and morbidity. It is estimated that worldwide approximately two million children a year are saved by immunization against measles, whooping cough, and tetanus.

C.A.R. has achieved excellent vaccination coverage. According to a January 1991 coverage survey, 67 percent of mothers with infants received two doses of anti-tetanus vaccine. Measles vaccinations for children under one year old have increased from less than 20 percent before the EPI to 80 percent today. Important gains have also been made in vaccinations against tuberculosis, diphtheria, pertussis, and polio.

A recent cost study of the C.A.R. EPI program estimates that the cost per fully immunized child was $25.70. Studies conducted in other countries under the USAID-funded REACH project have found the cost per fully immunized child to be between $15 and $18. Two explanations for the relatively high cost in the C.A.R. are: 1) the low population density which requires significant travel and logistic expenses; and 2) the relatively high coverage already attained - to reach higher and higher coverage rates the furthest, least accessible children must be vaccinated, which raises the cost of the whole program.

2. Combatting Diarrheal Disease (CDD)

In much of sub-Saharan Africa diarrheal diseases are responsible for 22 percent of all illness in children under five. Oral Rehydration Therapy (ORT) is the most effective treatment for dehydration. A packet of oral rehydration salts (ORS) costs only a few cents and can be prepared and administered to a child by a health worker or the mother if they have been trained in its use.

The CCCD strategy in C.A.R. has been to focus resources on one intervention at a time, starting with EPI. ORT is now receiving more attention in terms of training and distribution of ORS packets. The fatality rate for children under five hospitalized with diarrhea in three CAR regional hospitals declined from 8.7 percent in 1987 to 4.9 percent in 1989. In addition, the evaluation of health worker performance after training showed measurable improvement in proper treatment of diarrhea.

In some areas of the developing world, where consumers have accepted ORS without costly promotion, the cost per death averted has been in the range of $200 to $400. Viewed in other terms, the cost to treat a child with ORS per year is approximately $1.30, assuming approximately 10 episodes of diarrheal disease per year, and a cost per UNICEF packet of ORS of $0.06 (2 packets are required to treat one case of non-severe diarrhea).

3. Malaria

Malaria is the primary cause of death in infants and is the third most frequent reason for medical consultations for persons of all ages. Case fatality rates at three regional hospitals in C.A.R. increased from three percent in 1987 to seven percent in 1989.

Current national malaria policy recommends presumptive treatment of fever for children under five years of age. Fansidar is the second line drug for chloroquine treatment failures, which are estimated to occur in ten percent of episodes.

Estimates of the cost per malaria death averted by presumptive treatment of fevers range from $200 to $400.

4. Acute Respiratory Infection (ARI)

ARI is one of the four major causes of death in children in CAR. The majority of ARI deaths are due to pneumonia. Studies of pneumonia in children reveal that the two principal bacteria which cause the disease are susceptible to inexpensive antimicrobial drugs. Additional studies have determined that a small number of clinical signs can be used to identify children with pneumonia. This information suggests that inexpensive ARI intervention is possible, given a moderate amount of health worker training, and the availability of the appropriate drugs.

A recent World Bank report (Stansfield, Shepard, and Gwatkin, 1990) describes a variety of approaches to combatting ARI including case management, promotion of breastfeeding, EPI vaccines, pneumococcal vaccine and the reduction of malnutrition. The World Health Organization promotes case management for reducing ARI deaths.

UNICEF, in its State of the World's Children (1990), reports that early diagnosis and prompt treatment with antibiotics can prevent most child deaths due to ARI. For approximately $1.00, a child can be effectively treated with antibiotics such as cotrimoxazole.

The World Bank report (Stansfield et al.) calculate an average cost of case management of between $177 and $421 per ARI death averted. This is roughly the same range, per death averted, as ORT, presumptive treatment for malaria, and condom social marketing (to be discussed below).

5. HIV/AIDS

The AIDS epidemic is a major threat to progress made in child survival. AIDS rates in Africa are among the highest in the world, and CAR has one of the highest estimated levels of HIV (the virus which causes AIDS) infection. In Bangui, at least nine percent of women attending prenatal clinics are HIV positive. Of the total reported AIDS cases in CAR, 21 percent are in children under five years of age.

The project is taking a two-pronged approach to combatting AIDS. First it will support a condom social marketing campaign designed to prevent the transmission of HIV. In addition the project will support the government's AIDS program, especially in the treatment and prevention of sexually transmitted diseases (STDs).

a) Preventing HIV Transmission through Condom Social Marketing

The condom social marketing campaign will be conducted by Population Services International (PSI), a non-profit organization which develops, operates and provides technical assistance to health, family planning, and AIDS prevention programs in developing countries. PSI has already conducted successful condom social marketing campaigns in Zaire and Cameroon.

PSI states in an appendix to its proposal that research being conducted by the AIDSTECH project (a centrally-funded A.I.D. project) in Zaire suggests that the sale of 1000 condoms prevents a single transmission of HIV (higher prevalence rates would probably lead to a greater number of HIV transmissions prevented per 1000 condoms sold). Given this rough estimate, and using PSI's marketing projections for CAR, over the five-year period one would expect 3800 HIV transmissions to be prevented. This at a cost of $1.6 million (PSI proposed budget including commodities and transport). Dividing the total cost by the 3800 HIV transmissions averted gives a cost per HIV transmission averted of $421.

With additional epidemiologic information, such as percent of those with HIV who develop AIDS, and case fatality rate for AIDS, one could calculate a cost per death averted. Since both of the missing pieces of information are probably close to 100% the cost per death averted is probably not much greater than the $421 cited above.

Family planning programs often use the term "couple year of protection" (CYP) to describe the cost-

effectiveness of their services. CYP indicates the cost per year, per couple, of contraceptive protection. PSI reports a CYP cost of $12.17 for their condom social marketing campaign in Zaire.[1] In C.A.R., however, due to the low population density and poor transport and communication systems (and possibly other factors such as low demand for contraceptives), PSI estimates a CYP of $34 to $40 (the cost of CYP decreases with greater sales volume).

b) Treating and Preventing the Spread of STDs

Besides the substantial morbidity and mortality which they cause, STDs are thought to increase the rate of transmission of HIV. The seemingly high rate of transmission of HIV in Africa, as compared to other continents, may be due largely to the high prevalence of un-treated STDs. This line of reasoning is behind the strong interest in the treatment and prevention of STDs.

Cost data from CDC in Atlanta and field data from Niger suggest that the treatment of STDs costs $8 to $20 per case (this does not include personnel salary, diagnostic expenses, nor educationcampaigns to attract STD patients).[2] To compare the cost effectiveness of STD treatment to condom social marketing for the prevention of HIV transmission, more epidemiologic data are needed. This includes the prevalence of STDs in CAR, and the increased incidence of HIV transmission among partners who have an STD. At $20 per treatment as long as fewer than 21 ($421 from condom social marketing/$20 per STD treatment = 21) treatments of STD are needed to prevent a single transmission of HIV, then treating STDs is more cost effective than social marketing of condoms. If STD treatment is closer to $8.00, then the point at which condoms are more cost effective is after 52 STD treatments (421/8 = 52).

6. **Birth Spacing**

---

[1] Based on 100 condoms per couple per year. Duncan Earle, PSI Cameroon Director, July 7, 1991.

[2] According to a CDC internal memorandum: A course of Benzathine penicillin (2.4mU) costs $9.71, transport to the C.A.R. roughly doubles the cost to $20; for Niger the RESSFOP project, Tibiri, Republic of Niger 1990: a health center which was experimenting with cost recovery charged for STD treatment injections almost at cost of 2000 FCFA. At the time (early 1990) the exchange rate was approximately 250 FCFA per $1.00 U.S. making the treatment cost 2000/250 = $8.00.

According to recent research, birth spacing may have a greater impact on reducing infant motality than either the age of the mother or the number of children borne by her.[1] World Fertility and Demographic and Health Survey data show that children born less than two years after an older sibling are twice as likely to die as infants born more than two years apart. The range of problems from inadequately spaced babies include low birth weight, nutritional problems, lack of maternal care, and greater susceptibility to infectious diseases.[2]

A birth spacing program, including the promotion of family planning methods to increase the interval between births and to reduce the size of families, enhances the prospects for child health. A side benefit is a reduction in maternal mortality.[3]

While few data are available on the unit cost and cost-effectiveness of birth spacing programs, there are numerous estimates of the cost-effectiveness of family planning programs. Since birth spacing programs are closely related, and promote many of the same contraceptive practices, their cost-effectiveness estimates are used as a proxy. A frequent cost estimate for family planning and birth spacing programs is the Couple-Year-of-Protection (CYP) which is the cost of providing a couple with a year's worth of contraceptive protection. Some estimates of CYP are provided below (Table 1) from a recent project paper in Cote d'Ivoire. The costs include technical assistance, program evaluation, training, IEC, contraceptive logistic support, AIBEF headquarter's support, and general MOHSP support.

Table 1. Cost Per Couple Year of Protection ($)
(Total Direct and Indirect Costs Net of Revenue)

YEAR	AIBEF Clinics	AIBEF CBD (a)	MOHSP Clinics	CSM Program
1992	159	156	67	27

Notes:
AIBEF = Association Ivorien pour le Bien Etre Familial
MOHSP = Ministry of Health and Social Programs
CBD = Community Based Distribution
CSM = Condom Social Marketing

This table is reproduced from Bitran, Smith, and Yinger, 1991.

[1] Royston, Erica, and Sue Armstrong, editors, Preventing Maternal Deaths, World Health Organization, Geneva, 1989. pp. 214-215.

[2] Bitran, Ricardo, Rhonda Smith, and Nancy Yinger, Economic Analysis for the Cote d'Ivoire Family Planning Health Project Paper, July 20, 1991, p. 5.

[3] Royston and Armstrong, p. 215.

Of the above figures, the one for MOHSP clinics, $67 per CYP, is most comparable to the planned birth spacing intervention of this project. Compared to the other interventions (e.g. EPI, CDD, etc.) birth spacing has a relatively high unit cost.

Further analysis will be needed to estimate a cost per death averted as has been cited for many of the other project interventions. A condom social marketing program, which is not specifically designed for birth spacing, but which has some of the same effects, has been included for comparison.

B. Other Project Activities Which Will Enhance Cost Effectiveness

The project's health interventions will be supported by a variety of activities which are largely responsible for the success of the CCCD program. They include training and supervision of all levels of health workers, health education for the general population as well as target groups, developing management and health information systems, and operational research. A new initiative, health care financing, will promote the long term sustainability of the project activities. A separate section of this project paper will discuss cost recovery in more detail.

1. Training and Supervision

The C.A.R. training methodology emphasizes the quality of services and health worker performance. Training can improve the cost effectiveness of health interventions by increasing the efficiency with which health care providers treat patients and the efficacy of the treatment given. Well trained personnel can reduce drug costs by more rational use of drugs (e.g. fewer drugs and reliance on generics). For example health workers can reduce the cost of treating diarrhea by promoting inexpensive ORS instead of anti-diarrheal drugs.

2. Health Education

The purpose of health education is to change attitudes and practices in order to improve the health of the population. Health education improves cost effectiveness of programs such as EPI and CDD by increasing demand. Social mobilizers and volunteers who have trained in delivering public health messages, can increase the population's demand for child vaccinations and ORS. Mothers who bring their children to health centers reduce the need for relatively expensive mobile vaccination

teams. Another example is in condom use. As condom use becomes more widespread, the number of cases of STDs will decline, reducing total STD treatment costs.

3. **Health Management Information Systems (HMIS)**

Health management information systems provide important epidemiological, financial and other management information to health planners at all levels. This information helps to get drugs to communities in need and can check the spread of diseases before they reach epidemic proportions. A well-functioning MHIS is an important component in the efficient distribution of drugs and supplies, avoiding waste, and providing appropriate medical supplies to meet the needs of health facilities.

4. **Operational Research**

ARI and STD programs are in their infancy in much of Africa. While treatment protocols have been devised in the developed world, there has been little research on the most effective means of treating these and other illnesses in the developing world. The project has selected interventions based on what limited cost effectiveness data are available. However it is probable that with time operational research will indicate more cost effective means both of identifying and treating patients. The project intends to support operational research in the project interventions and thus stands to enhance cost-effectiveness as a result of studies conducted.

C. **Conclusion on Cost-Effectiveness**

Table 1 summarizes the cost-effectiveness estimates of the different project components. In each case the project has chosen proven, least-cost approaches to reducing morbidity and mortality, e.g., ORT against diarrheal disease, and vaccinations against immunizable diseases. In some cases the cost-effectiveness data of certain approaches are limited, such as for ARI, social marketing of condoms against HIV and AIDS, and the treatment of STDs against AIDS. In such cases the project has selected the most promising methodologies and has built in operational research, monitoring, and evaluation so that assessments of cost-effectiveness can be made regularly, and project strategies modified to improve cost-effectiveness.

TABLE I-1

COST EFFECTIVENESS OF PROJECT INTERVENTIONS

STRATEGY/DISEASE	UNIT COST	COST/DEATH AVERTED
EPI	$25 per FIC [a]	$500[b]
CDD (ORT)	$1.30 per child/yr[c]	$200 to $400[d]
Malaria	$0.78/child/yr[e]	$200 to $400[f]
ARI	$1.00 / treatment[g]	$171 to $421[h]
Condom Social Mktg.	$34-$40 /couple/yr[i]	>$421
STD Treatment	$8-$20/treatment[j]	NA
Birth Spacing	$67 per CYP	NA

Notes:

a) Revue des programmes PEV/SMI en Republique Centrafricaine 1991.
b) Cameroon Child Survival Project Paper, USAID, 1987.
c) Chad MCH Project Paper, USAID, 1989.
d) Chad MCH Project Paper, USAID, 1989.
e) Based on $0.12 per episode (chloroquine) plus $0.01 per episode (fansidar - based on 10% chloroquine failure rate) = $0.13 per episode. Assuming 6 episodes/child/yr total is $0.13 x 6 = $0.78.
f) Cameroon Child Survival Project Paper, USAID, 1987.
g) UNICEF, State of the World's Children, 1990.
h) Stansfield, S., Shepard, D., and Gwatkin, D., 1990. "Acute Respiratory Infection," in Health Sector Priorities Review, World Bank.
i) Refer to the discussion above on condom social marketing.
j) Refer to the discussion above on STD treatment.

econ.doc/aid4

II. HEALTH BUDGETS FOR THE C.A.R. (1985-1991)

A. Summary

The Ministry of Public Health and Social Affairs (French acronym: MSPAS) receives approximately three percent of the C.A.R. government (CARG) budget. It amounted to 3.16 billion FCFA in 1990, which in per capita terms is 1098 FCFA (US $4.39), over 90 percent of which was devoted to recurrent expenditures, less than 10 percent was for investment expenditures. Donor assistance to the health sector is responsible for most of the investment and some of the operating expenses of the health sector. It amounted to 3.3 billion FCFA in 1990, doubling the budget for health from 3.16 billion to 6.4 billion FCFA, or 2236 FCFA per capita (US $8.95). Almost 70 percent of donor assistance is directed at constructing, rehabilitating, equipping, and supplying hospital facilities.

As a percentage of the CARG budget, the amount allocated to health experienced a drop from approximately six percent for the years 1986-1988 to three percent for the years 1989-1991. This is less than half the 10 percent recommended by the World Health Organization for developing country health budgets as a percentage of the government budget.

Imbalances exist between the expenditures on personnel and other operating costs, and between expenditures in Bangui and other regions. Salaries account for approximately 80 percent of the recurrent health budget, while all other operating costs (e.g. drugs, supplies, maintenance, gasoline, etc.) account for the remaining 20 percent. The geographic distribution of resources is also skewed: the annual per capita expenditure on health in Bangui is approximately 3803 FCFA as compared to 512 FCFA outside Bangui.

The private sector plays a relatively small role in the provision of facility based services, but an important role in the provision of pharmaceutical products. In 1990 the population purchased over 3 billion FCFA (1050 FCFA per capita) worth of drugs, primarily from private pharmacies. This amount is roughly equivalent to the MSPAS 1990 health budget. Significant savings are possible for the government and the population if brand name drugs are replaced by generics, and large orders made using an international competitive bidding process.

There are some encouraging signs in the pattern of health expenditures over the past five years. The percentage of recurrent expenditure on personnel, though high, has shown a steady decline from 87 percent in 1985 to 77 percent in 1990. Health statistics indicate that the population in CAR suffers from high morbidity and mortality rates (infant mortality rate of 129 per thousand live births and life expectancy of 49 years in

1989[4]); however an impressive increase in infant vaccination coverage in the last three years should help lower the infant and child mortality rate. Efforts are underway to match the vaccination progress with an initiatives to prevent the transmission of HIV (the virus which causes AIDS) and to prevent and treat diarrheal disease and malaria.

Technical Note

The following discussion refers to the attached Tables II-1 to II-6. In Table II-1 the rows have been given letters for easier reference. An exchange rate of 250 FCFA per US $1.00 has been used throughout the discussion. All FCFA amounts are in current FCFA, unless otherwise indicated. "Foreign assistance" or "donor assistance" refers to both grants and loans; "budget" and "budgeted amounts" will be used interchangeably with "expenditure", unless stated otherwise. Also "health budget" refers to the budget for health and social affairs, since the two sectors are combined in one ministry (Ministry of Public Health and Social Affairs) with a single budget.

B. MSPAS Health Budget

The Ministry of Public Health and Social Affairs (French initials: MSPAS) budget (recurrent and investment) was 3.16 billion FCFA in 1990 or approximately US $12.6 million. Over the last seven years the budget has ranged from 3.0 billion to 3.8 billion FCFA, with the exception of 1985 when it was 2.7 billion FCFA.

As a percentage of the C.A.R. government budget (including debt service) the MSPAS budget represented five to six percent until 1989 when it dropped to approximately 3 percent (refer to Row N). The budget has generally experienced a positive growth rate in current FCFA, except for 1989 when it contracted by 19.5% (refer to Row G). The MSPAS has the third largest share of the CARG budget, behind education and national defense.

It should be noted that the data discussed here are derived from government budgets developed by the Ministry of Finance (MOF). Actual expenditure data, as opposed to budgeted amounts, were not readily available. The Secretary General for health and social affairs reports that approximately 90 percent of budgeted amounts are expended in any given fiscal year. He indicated that in recent years the percentage has been dropping due to severe liquidity problems within the treasury. Foreign and local suppliers of drugs and other medical supplies are increasingly hesitant to deliver goods ordered by the CARG because of unpaid invoices.

1. Recurrent Budget

---

[4] UNICEF, State of the World's Children, 1991.

Generally over 90% of the MSPAS budget is devoted to recurrent expenditures (salaries and operations and maintenance: O & M) (refer to Table II-1 Row D). The relatively small CARG health investment expenditure (Row E) is augmented by donor assistance in terms of construction, rehabilitation and equipment (to be discussed later). Of the recurrent budget, approximately 80 percent is devoted to personnel salaries, leaving only 20 percent for all other operating expenses including drugs, supplies, maintenance of vehicles and buildings, gas and others (see Row L).

While there is no standard formula for the ratio of personnel expenditures to O&M expenditures in developing country health systems, there is internal and external pressure to achieve a better balance. Health personnel and health consultants alike describe facilities in CAR lacking in the most basic drugs, supplies and equipment, a situation which severely limits the effectiveness of health personnel in treating the population.

Over the last few years the donor community and international lending agencies have been encouraging the CARG to reduce their personnel expenditure. The Voluntary Assisted Departure (VAD) program provides financial incentives for civil servants, including those in the health sector, to retire early from government service. Under the first structural adjustment program the government agreed to hire only one new recruit for every three departures from the civil service (referred to as the "1 for 3 franc" rule). Interestingly the Ministry of Public Health has been permitted to adhere to a more lenient policy of one to one replacement of departing health civil servants.

The above programs appear to have been effective. Health budget data show encouraging signs of an improving balance between salaries and O&M. From 1985 to 1991 the percentage devoted to salaries decreased from 87 percent to 77 percent (see Row L), meaning that an increasing percentage is going to O&M. There is, however, still room for improvement. In Niger, for instance, the allocation to salaries and O&M was approximately 60 percent and 40 percent respectively in 1990, and still the GON was trying to reduce this imbalance with the assistance of a USAID health sector grant.

2. Investment Budget

The health investment budget is a relatively small part of the total CARG budget devoted to health, averaging 6 percent of the health budget. Most government health investment consists of "counterpart funds" which is the government's small contribution to donor-funded projects. Total CARG health investment, 299 million FCFA in 1991 (see Row E), is dwarfed by donor assistance, which for example, provided for the construction of two new hospitals in Bangui in the last decade (refer to section C below for a discussion of the external assistance to CAR).

3. Per Capita Expenditures

For the last three years the per capita CARG expenditure on health has been relatively stable at just above 1000 FCFA ($4.00) (see Row O).[5] Considering that 77 percent of this pays civil servant salaries, only 230 FCFA per capita are devoted to the operating costs required in the provision of care: drugs and other medical supplies, gasoline for supervision of personnel, electricity and water, etc.

This figure cited of 1000 FCFA per capita, however, conceals very uneven distribution of health resources throughout the country. Examination of O&M expenditures and donor assistance indicate that between 65 and 80 percent of health expenditures (CARG and Foreign Aid) are made in Bangui, where only 20 percent of the population lives. A rough calculation, using the lower figure of 65 percent of resources devoted to Bangui, shows that 1991 government budgeted per capita expenditure on health in Bangui is approximately 3803 FCFA, compared to 512 FCFA outside Bangui.[6] Later sections will discuss this disparity in more detail.

---

[5] Some donors suggest that published government population figures for C.A.R. are inflated. These donors estimate the 1991 population at 2.57 million as opposed to 2.94 million as reported by the government. Based on the lower figure, and extrapolating back in time, the 1990 per capita MSPAS health budget would be 1260 FCFA instead of 1097 as is shown in Table 1. The higher population figure results in an average underestimation of per capita health expenditure of about 13 to 14 percent.

[6] 1991 CARG health budget of 3440 million FCFA; Bangui population of 588,000 and a non-Bangui population of 2,352,000. (.65*3440 M FCFA)/588,000 = 3803 FCFA per capita in Bangui. (.35*3440 M FCFA)/2,352,000 = 512 FCFA per capita outside Bangui.

C. External Assistance to the Health Sector

1. Investment and Recurrent Expenditure

Ministry of Plan (MOP) records indicate substantial, if fluctuating, donor assistance to the health sector. The Minister of Plan suggested that the accuracy of data improves in 1990; prior to that year the figures probably underestimate the amount of foreign assistance. Table II-2 shows that for the years 1986 to 1990 donor assistance is equal to 50 to 100 percent of the MSPAS budget depending on the year. In 1990, for example, foreign assistance roughly doubles the expenditure on health from 3.2 billion FCFA to 6.4 billion FCFA.

Although the Ministry of Plan categorically calls donor projects "investment", a substantial portion of project funds are in fact contributing to the operating costs of the health sector. The EPI (vaccination) program is a good example. AID and UNICEF assistance to EPI not only provides for traditional investment, such as vehicles and equipment, but also pays for operating costs such as vaccines, syringes, and gasoline.

2. Per Capita Expenditures

The 1990 per capita foreign aid assistance to the health sector was 1139 FCFA (3.28 billion FCFA/2.88 million people).

D. Total Expenditures on Health (CARG and Donors)

The total expenditure for health, which includes CARG and donor recurrent and investment expenditures, is shown in Table II-2. For 1990 the combined CARG and donor budget was 6.4 billion FCFA (U.S. $25.8 million) or 2236 FCFA per capita (U.S. $8.95). The fluctuations in the total are probably partially due to inaccuracies in MOP reporting before 1990. Prior to 1990, according to the Minister of Plan, "uncommitted funds" (proposed donor projects which were not yet formally agreed upon) were included in the investment budget as well as committed funds.

E. Disparities in Health Budget Allocations: By Regions and by Levels of Care

Expenditures on health in CAR are unevenly distributed, favoring Bangui to the rest of the country and hospital care to lower level care. This is true for CARG funds as well as for external assistance.

1. Hospital Care versus Primary Health Care

Tables II-3 and II-4 show the distribution of health sector funds to hospital and primary health care.[7] In this section the term "primary health care" refers to services and programs run out of health centers and sub-centers and directed principally by the Ministry's Direction of Preventive Medicine, but also by the Direction of Maternal and Child Health. These programs include, among others, vaccination, control of diarrheal disease, and malaria, in addition to the routine curative care provided at health facilities below the hospital level. Table II-3 shows the recurrent health budget while Table II-4 shows external assistance to the health sector.

From 1985 to 1988 hospital facilities received on average 64 percent of the health O&M budget, while primary health care programs and facilities received only four percent on average, according to World Bank figures (1989, p. 42) (see Table II-3). The remaining 32 percent was distributed among pharmaceuticals (25 percent), general administration, and social affairs. The 60 percent increase in hospital sub-sector recurrent budget in 1988 (Table 3) is explained in part by the partial opening (for outpatient care only) of the Hopital l'Amitie.

The four percent statistic for primary health care is somewhat misleading since a portion of pharmaceuticals is directed at primary care. In addition, a certain amount of care provided at hospitals should be classified as primary care. Since hospitals are often given priority in the distribution of health resources, including personnel and supplies, they attract patients needing primary health care who could be treated just as effectively in a health center if the appropriate supplies were available. One indication that C.A.R. hospitals provide more than just tertiary or secondary care is that almost eight times as many outpatients are treated as inpatients[8].

Information from the Ministry of Finance reveals that Bangui hospitals are favored over all other facilities. On average 50 percent of the MSPAS O&M budget is devoted to the three Bangui hospitals (bottom half of Table II-5)

---

[7] These tables are based on World Bank data from 1984 to 1988. In its report, the Bank refers to two subsectors in health, the "secteur curatif" and the "secteur preventif". Accompanying text in the report indicates that these two sectors correspond roughly to what is referred to in this paper as "hospital" and "primary health care". Refer to pages 47-50 in the report, "ANALYSE DES CONTRAINTES SECTORIELLES ET DES SOURCES DE FINANCEMENT DU SECTEUR SANTE EN REPUBLIQUE CENTRAFRICAINE," 1989.

[8] Based on 1988 DEPS statistics.

which have 37 percent of the country's inpatient beds (DEPS, 1988). The remaining 368 facilities receive the other 50 percent of the O&M budget. This skewed distribution of resources points out a government emphasis on hospital care as opposed to primary health care (in addition to being another piece of evidence of the unequal distribution of resources between Bangui and the rest of the country).

In some countries the international donor community helps to correct such imbalances by concentrating its resources on preventive and primary health care services. This is the case in Niger (World Bank, 1991, forthcoming). In C.A.R., however, the preponderance of external aid is directed at the hospital subsector, though the imbalance is not as dramatic as with government funds. Table II-4 shows the allocation of donor assistance to hospitals and primary health care for the years 1984 to 1988. Nearly 70 percent of donor aid went to hospitals: 67 percent of which went to the construction of the two new Bangui hospitals, Hopital de l'Amitie and Hopital Communautaire. Other investment provided for the construction of the Centre Pediatrique at the CNHU, the equipping of the National Laboratory to conduct AIDS-related tests, and the construction of pediatric pavilions in five regional hospitals.

Donor assistance to the non-hospital subsector for the period 1984-88, which comprised just 31 percent of donor aid, supported projects and programs under the auspices of the MSPAS Directorate of Preventive Medicine and the Directorate of Maternal and Child Health. They included maternal and child health programs, nutrition, and disease control (e.g. EPI and the diarrheal disease program).

2. Distribution of Expenditures to Bangui and Health Regions

MSPAS officials and donor representatives are nearly unanimous in decrying the inequitable distribution of health resources between Bangui and the health regions. The largest city in C.A.R., with 20 percent of the country's population (588,000; 1991 CARG estimate), Bangui receives on average 66 percent of the health O&M budget (see Table II-5). That leaves on average 34 percent of the O&M budget for the 80 percent of the population that live outside Bangui. In per capita terms Bangui citizens receive 824 FCFA of O&M budget, while the regional population receives 109 FCFA per capita.

The maldistribution of resources is also evident in donor funds. Table II-6 shows the allocation of donor assistance to the hospital sector from 1984 to 1988. Bangui received 83 percent of the funds while the rest of the country received only 17 percent. Part, though

certainly not all, of this imbalance in donor assistance to Bangui is related to the substantial French support for the facilities in which the French technical assistants work. Most of the "cooperants" (technical assistants) work in facilities located in Bangui. Of the 46 foreign doctors working in C.A.R. in 1988, 41 were practicing in Bangui. For comparison purposes, of the 82 Central African physicians (excluding 26 interns) 60 were in Bangui (DEPS, 1988).

F. Private Sector Expenditures

Data available in the C.A.R. provide little information on private sector expenditures, with the exception of expenditures on pharmaceuticals. An assessment trip by the A.I.D. Health Financing and Sustainability (HFS) project found that less than four percent of hospital admissions and outpatient consultations occurred in private sector facilities (Setzer and Weaver, 1991). This percentage seems small in relation to estimates of private health resources: private sector facilities account for 14 percent of the 4202 hospital beds and nine percent of C.A.R. health personnel. The HFS report concludes that the disparity between utilization and resources (facilities and personnel) may be due to either low utilization or under-reporting.

A recent pharmaceutical sector study (ADB-CREDES, 1991) sheds light on the extent of private sector expenditures on health care. The study document reports that the population of C.A.R. purchased, out-of-pocket, roughly 3 billion FCFA worth of drugs in 1990, or 1050 FCFA per capita. This is equivalent to the MSPAS 1990 expenditure on health.

Private pharmacies and private sector imports dominate the pharmaceutical sector. Of the 27 pharmacists in C.A.R., 22 are in the private sector. In 1990 the private sector accounted for 60 percent of drug imports, while the state agencies of Pharmapro and the Pharmacie d'Etat combined accounted for less than one percent of imports. The remaining 39 percent is attributed to the FAC (French Cooperation), other donors, NGOs, private companies, and the armed forces, among others.

Table II-1

CARG AND MSPAS BUDGETS (source: CREDES 1991, MOP)
(Millions of FCFA)

	1985	1986	1987	1988	1989	1990	1991
A) CARG recurrent budget	33,682	35,828	36,500	54,023	62,514	57,589	55,237
B) CARG investment budget	17,530	15,076	18,110	4,131	37,972	45,755	50,155
C) CARG Budget TOTAL	51,212	50,904	54,610	58,154	100,486	103,344	105,392
D) MSPAS recurrent budget	2,563	3,113	3,223	3,454	2,926	2,900	3,141
E) MSPAS investment budget	130	122	193	309	102	260	299
F) MSPAS Budget TOTAL	2,693	3,235	3,416	3,763	3,028	3,160	3,440
G) growth rate		20.1%	5.6%	10.2%	-19.5%	4.4%	8.9%
H) MSPAS salaries	2,225	2,690	2,780	2,799	2,335	2,249	2,420
I) growth rate		20.9%	3.3%	0.7%	-16.6%	-3.7%	7.6%
J) MSPAS O & M	401	423	460	655	591	651	720
K) growth rate		5.5%	8.7%	42.4%	-9.8%	10.2%	10.6%
L) MSPAS salaries as % recurrent budget	87%	86%	86%	81%	80%	78%	77%
M) MSPAS recurrent as % of CARG recurrent	7.6%	8.7%	8.8%	6.4%	4.7%	5.0%	5.7%
N) MSPAS total as % of CARG total	5.3%	6.4%	6.3%	6.5%	3.0%	3.1%	3.3%
O) MSPAS Budget per capita	1,040	1,225	1,265	1,363	1,074	1,097	1,170
P) Population	2.59	2.64	2.7	2.76	2.82	2.88	2.94

Table II-2

Foreign Assistance to the Health Sector
and Global Health Budget
(Millions of FCFA)

	1986	1987	1988	1989	1990	1991
Total Aid to Health Sector	1,833	1,644	2,510	1,959	3,281	NA
MSPAS Budget	3,235	3,416	3,763	3,028	3,160	3,440
Global Health Budget (a)	5,068	5,060	6,273	4,987	6,441	NA
Per Capita Global Health Budget	1,920	1,874	2,273	1,768	2,236	NA
Population	2.64	2.7	2.76	2.82	2.88	2.94

Notes:
(a) "Global Health Budget" is the sum of the CARG health budget plus donor assistance (grants and loans) to the health sector.

Sources: Ministry of Plan, and Ministry of Finance;
Population data from African Development Bank-CREDES report 1991

10-Jul-91

Table II-3

MSPAS RECURRENT HEALTH BUDGET
(000 000 FCFA)

	1985	1986	1987	1988
Hospitals	238.3	248.7	284.4	468.5
%	61%	59%	62%	72%
Primary Care	14.6	18.9	22	22.8
%	4%	4%	5%	3%
Drugs	110.8	116.3	121.4	126.6
%	28%	27%	26%	19%
Other (a)	27	39.1	32.1	37.2
%	7%	9%	7%	6%
TOTAL	390.7	423	459.9	655.1
%	100%	100%	100%	100%

(a) General administration and social affairs.
Source: World Bank, 1989, p. 42.
See footnote in the text concerning "hospital" and primary health care" nomenclature.

Table II-4

External Aid to the Health Sector 1984-198
(000 000 FCFA)

	Million FCFA	Percent
Hospitals	10,647	69%
Primary Care	3,857	31%
TOTAL	14,504	100%

Source: World Bank 1989, p. 46.
See footnote in the text concerning "hospital" and primary health care" nomenclature.

10-Jul-91

Table II-5

MSPAS O&M Budget
by geographic region and by level of care, 1988-1991

(000 FCFA)

	1988	%	1989	%	1990	%	1991	%	O&M Per Capit 1991
O&M Budget	655,100		591,080		650,600		721,200		
% change			-9.8%		10.1%		10.9%		
Bangui	471,672	72	384,202	65	409,878	63	461,568	64	0.824
Regions	183,428	28	206,878	35	240,722	37	259,632	36	0.109
Bangui Hospitals	353,754	54	289,629	49	305,782	47	360,600	50%	
All Other	301,346	46	301,451	51	344,818	53	360,600	50%	

Source: Ministry of Finance;
Population data for per capita calculation from African Development Bank - CREDES 1991

Table II-6

Distribution of hospital aid to the health sector 1984-1988
(000 000 FCFA)

	BANGUI		REGIONS		TOTAL	
INVESTMENT	7,643	89	938	11	8,581	81%
RECURRENT	1,239	60	827	40	2,066	19%
TOTAL	8,882	83	1,765	17	10,647	100%

Source: World Bank 1989, p. 48
See footnote in the text concerning "hospital" and primary health care" nomenclature.

III. IMPROVING EFFICIENCY IN THE C.A.R. PUBLIC HEALTH SYSTEM

In recent years governments and donors in developing countries have begun to consider cost recovery as a solution to inadequate health care coverage for the population. While there is promising evidence (Vogel, 1988; Knippenberg, 1990) that cost recovery can improve health care services in some countries, improvements in health care delivery can and should be made regardless of the existence of cost recovery. By improving the efficiency with which health care services are provided, governments can furnish more and/or better quality services for the same expenditure or can produce the same amount of services for less money. This section examines the potential for improving efficiency of health care delivery in C.A.R. in three different areas of the health sector: personnel, pharmaceuticals, and hospitals.

A. Personnel

1. Distribution

Numerous C.A.R. health officials point to the maldistribution of health personnel between Bangui and the health regions as a major inefficiency of the public health system. Of the 3005 employees of MSPAS (DSAF, 1990) 43 percent (1301) work and reside in Bangui; the remaining 57 percent (1704) work in the five health regions (refer to Table III-1). Given that only 20 percent of the population lives in Bangui, the health personnel to population ratio in Bangui is three times what it is in the regions (1/452 for Bangui, as compared to 1/1380 for the rest of the country).

Some of this imbalance may be justified on the grounds that there are more hospitalizations in Bangui than in all the other regions (196,000 hospital days in Bangui as compared to 162,000 hospital days for the regions), and that relatively large numbers of administrators are required in Bangui until more decentralization occurs. On the other hand, the number of outpatient consultations is greater in the regions than in Bangui (709,000 in the regions as opposed to 361,000 in Bangui), somewhat counteracting the argument for more personnel because of the greater number of hospitalizations.

As with other indicators of the efficiency of health systems in developing countries, there are no clear guidelines for the most efficient distribution of health personnel. The per capita health personnel in Bangui versus the other regions seems to be strong evidence that an imbalance exists, which, if corrected, could result in more people being served with the same number of personnel.

2. Personnel to Supplies Ratio

Analysis of the government health budget reveals that 77 percent of the recurrent budget is devoted to salaries and only 23 percent to supplies. Anecdotal evidence suggests that health facilities are often without the most basic drugs and medical supplies. A technical assistant visiting a Bangui health center in 1987 observed a nurse, lacking disinfectant, bandages and aspirin, administering chloroquine to a patient presenting with a lacerated foot. The nurse explained that he felt compelled to give the patient something, even if it was not the appropriate treatment for the injury.

The lack of appropriate supplies and drugs limits the effectiveness of health personnel, as the above example illustrates. A better balance between personnel and supplies would allow personnel to treat more cases effectively. Data from recent CAR health budgets indicate that over the past few years supplies have been steadily receiving more of the recurrent budget. This trend should be monitored and encouraged.

3. Training

Training and supervision improves the chances that health personnel will provide appropriate care, minimizing waste and over-prescription of drugs. As an example, until recently many cases of child diarrhea were treated with expensive antibiotics or intravenous fluid. The arrival of ORT has greatly reduced the cost of treating a case of diarrhea; at 10 to 12 US cents per packet of ORS, a child can be treated for numerous episodes of diarrhea for less than $2.00 per year. Still a great effort must be made before most health workers are trained and regularly use ORS for the treatment of infant and child diarrhea. This training effort is part of the ongoing CCCD project.

Training is also needed in treatment practices for malaria, acute respiratory infections, and other common childhood illnesses. Without proper training the tendency to use and prescribe large numbers of drugs, with limited effectiveness, will continue. The following section addresses prescription practices in more detail.

B. Pharmaceuticals[9]

The population of C.A.R. purchased, out-of-pocket, over 3 billion FCFA worth of drugs in 1990, or 1050 per capita. In addition, the state agency responsible for purchasing and

---

[9] This section draws heavily on "ETUDE DU SOUS SECTEUR PHARMACEUTIQUE", CREDES, March 1991.

distributing drugs to government health facilities, PHARMAPRO, purchased an additional 167 million FCFA worth of drugs. What is the population getting for this money?

Unfortunately the answer to the above question is a lot less than could be purchased given a few fundamental changes. In terms of the 167 million expenditure by PHARMAPRO, 89 percent of this is spent locally on purchases of drugs at two private distributors, without competitive bidding, at top prices. Only 11 percent of PHARMAPRO's orders are made on the international market at better prices.

1. **State-Run Pharmaceutical Institutions**

PHARMAPRO has no functioning vehicles to deliver drugs to hospitals and health centers outside Bangui, requiring health regions to send someone to Bangui for their drugs. This results in facilities, especially at lower levels, chronically short of or without drugs.

The other state institution involved in pharmaceuticals, la Pharmacie d'Etat (State Pharmacy), was created to provide affordable drugs to populations far from private pharmacies. With decreasing credibility with foreign suppliers, the State Pharmacy, like PHARMAPRO, buys almost all its supplies on the local market. After a 30 to 50 percent markup plus transportation costs to the regions, State Pharmacy prices for drugs are equivalent to the prices in private pharmacies.

2. **Overuse of Brand Name Drugs**

The two state pharmaceutical institutions and the private sector pharmacies stock primarily brand name drugs, which are much more expensive than the chemically identical generics. The CREDES pharmaceutical study (p. 53) found that in Bangui the average cost per prescription purchased was 3,219 FCFA (US $12.90)[10] and the average number of drugs per prescription was 1.9. In Health Region number three, the equivalent expenditure per prescription was 1,034 FCFA (US $4.10) and the average number of drugs per prescription was 1.0.

3. **Necessary Pharmaceutical Sector Reforms**

As is outlined in the CREDES report, significant savings are possible for the state and for the population. International competitive bidding for drug orders, replacing brand name drugs with generics, and improving prescription practices would have a significant effect on reducing drug expenditures. (For a more complete analysis

[10] At an exchange rate of 250 FCFA = US $1.00

of the savings from generics, see IV below.) These initiatives must be accompanied by a large education campaign. Health personnel will require training in how to prescribe fewer total drugs and to use more generics; the population must also be sensitized to the fact that they can be treated just as effectively with fewer drugs.

A final efficiency gain to be made is related to cost recovery. As the pharmaceutical supply system improves, a more efficient use of drugs can be promoted at government health facilities if there is a fee for the drugs. Even if it only recovers a fraction of the cost of the drug, the fee will prevent a certain amount of overconsumption, saving more drugs for the serious cases of illness.

C. Hospitals

1. Government Hospital Budget

The three Bangui hospitals consume approximately 50 percent of the health sector's non-salary operating budget (361 million FCFA of the 721 million FCFA 1991 O&M budget). Efficiency gains made at this level have the potential for large savings. In the 1980s two new hospitals were constructed in Bangui (Hopital Communautaire and Hopital de l'Amitie). Only partially functional today, these two hospitals, according to World Bank estimates (1989, p. 11), would consume 85 percent (558 million FCFA) of the 1988 O&M health budget.

2. Hospital Mission: Tertiary or Primary Care?

C.A.R. health policy makers must ask themselves if an 85 percent O&M expenditure on hospitals is the most efficient way to improve the population's health. In the developing world it is estimated that 70 percent of child deaths are attributable to five causes: diarrhea, respiratory infections, measles, malaria, and neo-natal tetanus.[11] With preventive practices (e.g. vaccinations) and early treatment, most of these deaths can be prevented inexpensively at health centers.

The principal functions of hospitals is to serve as reference centers for the most serious health problems encountered at lower levels of care. Often however hospitals become the first point of contact since lower level health centers are often lacking in the most basic supplies and drugs. The Bangui hospitals treat approximately eight times as many outpatients as inpatients; regional hospitals experience a similar outpatient to inpatient ratio.[12] This situation is not unique to C.A.R. According to Weaver et al. (1990, p.14) Niamey National Hospital in Niger sees four times as many outpatients as inpatients.

This is not to say that hospitals should have absolutely nothing to do with primary care. Other countries have taken advantage of the resources of hospitals to reinforce primary health care. Hospitals in Delhi, India provide administrative support, nurse training, and health education in support of primary health care. In the Philippines, mothers who have just delivered are counseled on breastfeeding; and in Niger the diarrheal disease control program intends to establish ORT units in two hospitals. These units, in addition to providing ORS to acute cases of child dehydration, will serve as training sites for mothers and health workers in the proper use of ORS.

---

[11] UNICEF, State of the World's Children, 1990, p. 17.

[12] Bangui Hospitals: 196,000 hospital days/7 days per stay average = 28,000 inpatients compared to 212,000 outpatients; 212,000/28,000 = 7.6 times as many outpatients as inpatients. Regional and Prefectoral Hospitals: 162,000 hospital days/7 days per stay average = 23,000 inpatients compared to 176,000 outpatients; 176,000/23,000 = 7.7 times as many outpatients as inpatients. Consultations are first time visits. Hospital days are based on DEPS 1988 data.

Well designed and targetted support for primary health care support can be an efficient use of hospital resources. Unplanned reliance on hospitals for primary health care services, however, deprives the secondary and tertiary care units of their limited human and material resources. Some recommendations for improving hospital efficiency are provided below.

3. Addressing Efficiency Problems

The problems cited above raise a number of issues which should be examined to increase the efficiency of C.A.R hospitals. The MSPAS and the CARG should consider the necessity of having three Bangui hospitals. Given the intensive use of resources at hospitals and the pressing needs for primary health care in the regions, policy makers must ask whether this use of hospitals is the most efficient means of providing health care to the population. If the decision is made to maintain three operating hospitals then the MSPAS should at least consider closing down some sections of certain hospitals to reduce redundancy of services. There may be a certain degree of specialization possible for each of the three hospitals.

Fee schedules at the hospitals should be reviewed with the intention of encouraging the use of outpatient facilities such as health centers and sub-centers. Given that there are sixteen health centers in Bangui providing primary health care services, incentives should be put in place to encourage their use instead of the hospitals. In conjunction with a revision of fees, policy makers should also examine the existing referral system. According to the director of the CNHU, anyone who is willing to pay the hospital fee can come for outpatient care. To encourage primary health care at the health centers rather than the hospitals, referral slips can be instituted. In cases where the health center nurse or physician feels that the specialized services of the hospital are necessary, he or she gives a referral slip to the patient. The patient presents the slip on arrival at the hospital and is not charged or is charged a smaller fee than a person who arrives without a referral slip.

D. Conclusion

The preceding section has attempted to describe inefficiencies in the C.A.R. public health care system. Some are well documented such as the problems in the pharmaceutical sector; others require further study, such as the most efficient use of the three Bangui hospitals. The principal recommendations and areas for further study are summarized below.

Personnel

Continue to provide training to health workers in appropriate treatments for diarrheal disease, respiratory infections, and malaria. Study and discuss with the MSPAS the distribution of personnel in the health regions; more information is needed on how many people regional (and prefectoral) personnel are treating and whether there are suitably equipped health facilities to accommodate more health personnel if they were to be sent to the regions. Continue working with the CARG and MSPAS on increasing the portion of the recurrent health budget allocated to O&M, especially drugs and supplies.

Drugs

The problems and potential solutions have been clearly laid out in the ADB/CREDES report. MSPAS and donors must collaborate on how to implement the recommendations. A concerted training effort will have to be undertaken to retrain prescribers, pharmacists, and the population in the use and acceptance of fewer drugs per illness and an increasing reliance on less expensive generics.

Hospitals

The issue of primary care being provided at hospitals requires further study. Some of the questions to be answered are the following: What percent of the outpatients can be safely treated in primary health care facilities? Can these patients be treated more cost-effectively at health centers? What systems and incentives can be put in place to encourage care at the appropriate level?

effic.doc/aid4

IV. POTENTIAL ECONOMIC BENEFITS FROM IMPLEMENTING A GENERIC DRUG POLICY IN C.A.R.

A. Introduction

According to the CREDES report, drugs sold in both the private sector and the public sector are expensive because the majority are brand name drugs and often no competitive bidding process is used to select the supplier. What follows is an estimate of potential benefits to be gained if more generic drugs were purchased, and if an international competitive bidding process were implemented.

The discussion is based upon the calculations made in the accompanying Table IV-1. The prices are quoted from the 1991 CREDES report on the CAR pharmaceutical sector. Hospital drug consumption data is based upon discussions with the directors and administrators of the Centre Pediatrique and the Centre National Hospitalier Universitaire de Bangui (CNHUB).

B. Current Drug Prices Versus Generic Drug Prices

At the top of Table IV-1 four representative drugs are listed with the range of prices encountered by the CREDES investigators. There was little difference between the private sector prices and the public sector prices (e.g., Pharmacie d'Etat). The "low" and "high" prices indicate the approximate range of prices found. For example an aspirin tablet ranged from 22 to 31 FCFA.

Column C gives generic prices, as quoted by Management Sciences for Health (MSH); column D 200 percent margin (column C x 3) on the generic. Current CAR prices (columns A and B) are on average five to ten times more expensive than generics, even with the 200 percent margin on the generics (refer to the percentages in columns E and F).

C. Potential Savings of the Generic Drug Policy

The middle of table IV-1 (columns G-P) indicates the sizable savings which could be realized by the population, and a cost recovery "profit" which hospitals could generate, assuming that generic drugs were purchased on the international market instead of brand names. The savings and profit depend on the prices currently charged for brand name drugs. Calculations have been made for a "low" price scenario and a "high" price scenario. The discussion, however, will concentrate on the "low" price scenario.

Based on the practices of the Centre Pediatrique, it has been assumed that hospitals currently use 66 percent brand

name drugs and 34 percent generics. The cost savings discussed here are calculated solely on the basis of the brand name drugs. In column H the annual expenditure on drugs at CHNUB is shown as 310 million FCFA, of which 205 million is on brand names. The drug bill for all regional and prefectoral hospitals combined is estimated at 451 million FCFA.[13] Total hospital drug expenditure is estimated at 761 million FCFA (310 million + 451 million, see column H). The brand name drugs are 66 percent of this amount, or 502 million FCFA. The savings and profit calculations which follow are based on this figure of 502 million FCFA currently spent in C.A.R. on brand name drugs for use in hospitals.[14]

Assuming that current brand name prices paid by CARG are 5.7 times as expensive as generics (column E, 573%), by replacing brand names with generics the CARG would pay only 88 million FCFA, as shown in column K, instead of 502 million (502 million FCFA/5.7). By charging patients 50% of the brand name price now charged in C.A.R., the hospital (or whomever receives the money in the end) would earn a 164 million FCFA profit per year (251.2 - 87.6 = 164; column L minus K), once cost recovery is implemented for drugs.

The economic benefit to C.A.R. society is shown in columns Q, R and S. The society saves 415 million FCFA (502.4 million - 87.6 million = 414.8 million FCFA; column I minus K) which can be put to other productive or beneficial uses. Of the 415 million FCFA, the population benefits directly from 251 million FCFA (column R), while the hospital benefits from 164 million FCFA (column S).

D. Potential Uses of the Drug Savings

A quick analysis of potential uses for the 164 million FCFA "profit" indicates five uses of the funds:

1) return to the **population** by means of lower prices, e.g., set prices at cost.

---

[13]The estimate is made by assuming that drug use is proportional to the number of beds, thus the regional and prefectoral hospitals would require approximately three times (1511 beds/519 beds = 2.9) as may drugs as CNHUB (column G). However it has also been assumed that the regional and prefectoral hospitals provide care which is only 50 percent as resource intensive as CNHUB, given that CNHUB is the highest level referral hospital. Thus regional and prefectoral hospital drug expenditure is calculated as 310 million x 2.9 x 50% = 451 million FCFA.

[14]Hospital de l'Amitie and Hopital Communautaire, both in Bangui, are excluded as they are only partially functional, providing outpatient consultations only. Private sector hospitals have also been excluded.

2) give to **practitioners** and other health support workers as a bonus/incentive to collect fees.

3) retain at the **hospital** to increase the number or type of services offered or to improve the quality of services.

4) return to the **health system** in general, increasing the number of lower level health centers or improving the quality of their service.

5) remit to the **national treasury** which would presumably benefit all sectors.

Advantages and disadvantages of the use of funds (uses are not mutually exclusive):

1) Return to the population: Administratively easy; simply charge prices at cost; benefits those who use services; does not help to improve coverage to areas not served by a hospital, e.g., health centers, sub-centers, and posts.

2) Give to practitioners: This provides an incentive to collect fees, thus is important for making the system work in terms of recovering costs; in terms of equity, practitioners are often much better off than most of the patients they treat. They are salaried civil servants, receiving health and other benefits.

3) Retain at the hospital level: Allows the hospital to improve the service it provides to the population, or to subsidize the cost of drugs for the poor or for those who require expensive drugs. In so far as hospital personnel gain satisfaction from providing quality care, this use provides an incentive to collect fees.

4) Retain in the health sector: People who live far from hospitals can benefit if some of the profits are used to strengthen the periphery. Funds can be used to rehabilitate health centers, sub-centers, and posts, extend the drug supply system to that level, and, in general improve the quality and quantity of care they provide.

5) Remit to the national treasury: The profit becomes in effect a tax on the sick; the money they pay is used as general revenue by the government. Equity issues of such a tax must be considered. In theory it allows the government to use the funds where, in the opinion of decision makers, they are most needed, and where the greatest number of people will benefit.

A combination of the uses of funds is possible, and probably desirable. For example it may be decided that the most important need is to improve the service at periphery facilities. However, rather than putting all the profit there, a portion might be distributed to hospital personnel as an incentive to collect fees.

TABLE IV-1

Row	A	B	C	D	E	F
	CREDES reported public & private drug prices in CAR			Generic Prices (World market)	public & priv. prices as a percentage of generic prices (c)	
	Low	high	MSH Price	(a) MSH Price + 200% (b)	Low	high
Aspirin	22	31	1.5	4.5	489%	634%
Paracetamol	43	57	2.36	7.08	607%	939%
Mebandazole	95	115	3.46	10.38	915%	1257%
Chloroquine	16	43	1.89	5.67	282%	1524%
				Average	573%	1088%

Row	G	H	I	J	K	L	M	N	O	P
		(000 000 FCFA)								
		"Low" Price Scenario				"High Price Scenario				
	# beds	annual drug exp.	brand name 66%	generic 34%	expendit. on 66% if generic	sell at 50% brand price (a)	Hospital "profit"	expend. on 66% if generic	sell at 50% brand price (e)	Hospital "profit"
CNHUB	519	310.0	204.6	105.4	33.7	102.3	66.6	18.8	102.3	83.5
REG/Pref Hosp (d)	1511	451.32	97.8	153.4	51.9	148.9	97.0	27.4	148.9	121.5
	2,030	761.3	(e) 502.4	258.8	87.6	251.2	163.6	46.2	251.2	205.0

Row	Q	R	S	T	U	V
	(000 000 FCFA) ECONOMIC BENEFIT TO SOCIETY OF GENERIC DRUG POLICY					
	"low" brand name price scenario			"high" brand name scenario		
	Society savings	of which populat.	of which hospital	Society savings	of which populat.	of which hospital
CNHUB	168.9	102.3	66.6	185.8	102.3	83.5
Reg. Pref Hosp (d)	245.9	148.9	97.0	270.5	148.9	121.5
Total	414.8	251.2	163.6	456.3	251.2	205.0

Notes:

(a) Includes 40% for shipping and insurance, as reported by Management Sciences for Health (MSH), Boston, MA USA.
(b) 200% margin presumably to cover importer, wholesaler and retailer profit.
(c) As a percentage of MSH price with 200% margin.
(d) Assumes 50% intensity of drug use (compared to CHNU) at regional and prefectoral hospitals.
(e) "The hospital expenditures on drugs are believed to be much higher than the total MOH budget for drugs (126 million FCFA in 1988) because of substantial French assistance to hospitals, particularly for pharmaceuticals and supplies."

Table IV-A104

BEST AVAILABLE COPY

V. COST RECOVERY

A. Introduction

In recent years governments of developing countries have increasingly become aware that government financing of health care is not sufficient to achieve desired health care objectives. As their ability to provide quality health care services is hampered by poor economic performance, many governments realize that alternative means of financing health care are needed.

One of the principal alternatives to completely government financed health care requires the population to contribute more directly to its own health care. A variety of methods are possible including earmarked taxes for health, user fees, drug revolving funds, and prepayment schemes. These different approaches are called cost recovery.

C.A.R. has been moving toward cost recovery over the past few years. In 1989 a national workshop was conducted to consider instituting cost recovery in the country. That same year legislation was passed which paves the way for health facilities to collect fees and to retain a portion of their receipts. In 1991 the president signed a law which sets and institutes fees for inpatient and outpatient care at government health facilities. On an experimental basis the Centre Pediatrique in Bangui has been collecting fees in what is called "autonomie partielle de gestion" (partial management autonomy).

The Ministry of Public Health (MSPAS) has created an internal advisory body, the "Cellule de l'economie de la sante", to advise the Director General and the Ministry on health economics and health financing matters. Staffed by two nationals and an expatriate economist, the cellule is responsible for charting the government's course on cost recovery. This will be accomplished through studies of population willingness to pay for health services, costs of providing care at different levels of the health system, and the development of a strategy for implementing an appropriate cost recovery system nationwide.

Implementing a comprehensive change in the way health is financed, especially if it requires the participation of the population, is a complicated undertaking. One of the cellule's first tasks will be to recommend where and how to begin. Probably cost recovery will be instituted in phases, either in one region at a time, or at one level of the health system at a time (e.g. hospitals, health centers, or

sub-centers). The following sections examine the potential for cost recovery in Bangui versus the health regions, and at hospitals versus at health centers. Theoretical revenue generation is estimated, which is followed by a discussion of the economic costs and constraints involved in instituting cost recovery.

B. Potential REvenues at Different Levels and in Different Regions

1. Assumptions and Scenarios Investigated

Given the limited time in country and limited data available, a relatively narrow definition of cost recovery was considered. The following calculations are based on the charging of a single, all inclusive fee for an episode of illness (drugs, medical interventions, and medical tests are included). Repeat visits for the same episode of illness are free. Despite this limited definition, used here for convenience, there are numerous other options, which have been mentioned previously, and which will be considered by the Ministry's CES. They include earmarked taxes, prepaid HMO-type schemes, insurance, fees for each visit, etc.

The calculations have been simplified through several assumptions such as no exemptions (e.g. for indigent and students) and 100 percent fee collection. While there are few facilities that can reasonably be expected to meet these criteria, it is likely that all facilities will face roughly the same exemption and collection rates making comparisons among facilities possible.

Scenario 1: The first situation (Table V-1[1]) compares outpatient consultation only (both in hospitals and health centers) in Bangui versus the other health regions. A flat fee of 500 FCFA is assumed.

Scenario 2: The second scenario (Table V-2) compares hospitalizations only, again in Bangui versus the other regions. An average daily rate was used based upon the number of 1988 hospital days and the new fee schedule signed in 1991.

Scenario 3: The third scenario (Table V-3) is simply a combination of the first two, hypothesizing fees for

---

[1] "1st Visits" refers to the first contact with a health facility during an episode of illness. All subsequent follow up visits for the same illness are not counted.

hospitalizations and consultations, and comparing revenues in Bangui versus the regions.

Scenario 4: the fourth situation (Table V-4) compares revenues at different levels (e.g., hospital, health center, sub-center) based upon a fee scale which has higher fees at hospitals and lower fees at centers and sub-centers. Only consultations are considered.

2. **Bangui versus the Regions (Situations 1, 2, and 3)**

a) Consultations Only

Given that the total number of outpatient first visits in the regions is nearly double the number in Bangui (708 thousand versus 361 thousand) the potential revenue generated is much higher in the regions. Assuming 500 FCFA per episode (paid at the first consultation) the regions would recover 354 million FCFA compared to 180.5 million FCFA in Bangui. To put these amounts in perspective, 354 million FCFA is equal to 54 percent of the 1990 MSPAS O&M budget.

b) Hospitalizations Only

Although the annual number of hospital days (1988) is 20 percent greater in the regions than in Bangui (296,164 days versus 243,470 days) the revenue generating capability of Bangui is probably greater than the regions. Decret no. 91.065 sets fees higher in Bangui hospitals than in regional and prefectoral ones. Average rates of 818 FCFA per day in Bangui and 158 FCFA per day in the regions are used. Health centers, many of which have inpatient beds, would charge 100 FCFA per day. Based on these fees Bangui facilities would generate 165 million FCFA compared to 39 million FCFA in the regions.

c) Outpatient Visits and Hospitalizations

Table V-3 combines Tables V-1 and V-2 to compare revenue generation in Bangui and the health regions on the basis of fees for both hospitalizations and outpatient consultations. Potential revenue for the regions would be slightly higher than for Bangui: 393 million FCFA versus 345 million FCFA. This is due largely to the much greater potential revenue generated by consultations in the regions (354 million FCFA).

3. **Cost Recovery at Different Levels**

Table V-4 compares potential cost recovery at different levels of the health pyramid. Higher fees are assumed at higher level facilities: 500 FCFA for a hospital consultation, 300 FCFA for a health center, and 200 FCFA for a sub-center. Only outpatient consultations are considered.

Comparing the three different levels, hospitals and health centers earn approximately the same amount of revenue, while sub-centers only earn a small portion. Hospitals earn approximately 194 (106 plus 88) million FCFA, centers 170 (125 plus 45) million FCFA, and sub-centers only 23 million FCFA.

4. Feasibility of Recovering Costs

Before recommendations can be made to the government about where cost recovery should be implemented (Bangui versus regions, hospitals versus health centers) and in what form, feasibility and economic costs must be examined. This includes:

- Cost of providing services at different levels;
- Administrative feasibility;
- Training requirements;
- Transportation and logistics; and
- Economic feasibility;

Cost of Providing Services

The cost of services provided at the health facilities where the cost recovery is in place is important information for designing and implementing a system of cost recovery. To make the system work the managers must know to what degree revenues will cover their costs and to what degree they will still be dependent on government or donor funding. Knowing the cost of specific services is useful for variable pricing; a facility may decide, for example, to subsidize an expensive drug by marking up the price of less expensive drugs.

Administrative Feasibility

Cost recovery systems require fee collection, management of funds, accounting and safekeeping of funds, and management of supplies. If systems are not in place there may be considerable investment required. Fee collection systems (tickets, receipts, reception

desk) must be in place, financial managers may have to be hired to control the collection of funds, safes or other means of safeguarding money must be provided for.

Often administrative systems and capabilities are more concentrated in urban areas; hospitals may already have managers who have financial skills and training. In smaller towns or villages where health facilities may be staffed by one to two people the expertise to collect and manage funds may not exist, and there may be no banks nearby to safely keep money collected. Safes may be the only viable alternative. Also personnel may have to be hired and or trained to perform the financial management and fee collection.

Training and Supervision

Where the financial and managerial skills are not in place, it may be necessary to train people in these skills. Where there are large facilities serving lots of people it may be possible to train a few who will run the financial management. At more dispersed facilities (centers and sub-centers) at least one person at each facility will require training.

Supervision is also necessary to ensure that there is proper accounting, fee collection and safe-keeping of funds. The costs per person treated rise the more secluded the health facility is.

Logistics and Communication

A premise of cost recovery is that there are dependable services of good quality being offered at facilities. In the past this has been difficult to achieve in the C.A.R. due to the size of the country, impassable roads during the rainy season, and lack of funds. Until these issues are addressed in some fashion cost recovery will probably be most successful in larger towns with better access to the capital from which supplies and personnel come -- key ingredients for quality services.

Improved delivery of supplies and drugs is possible, and a system has been proposed in an ADB-funded study carried out by CREDES. It is not inexpensive, however. The 1991 report estimates that 39 million French francs (US $7.1 million at an exchange rate of 5.5 FF per US $1.00) are required to reform the pharmaceutical sector. The supply system alone is estimated at approximately 30 million FF (US $5.5 million).

Economic Feasibility

The purpose of cost recovery systems is to generate revenues for the facility or the health system. These revenues can be used to improve the quality or expand health services. As the preceding paragraphs have shown, there can be significant costs involved in establishing and managing a cost recovery system. Administration, training and supervision, and drug supply systems can be expensive. The costs of implementing and supervising cost recovery at small posts with low utilization, may be greater than the small revenue generated by the sale of drugs, making such a venture unjustifiable on economic grounds.

In other settings, such as busy health centers or hospitals, the investment in the cost recovery system is small in relation to the potential revenue from drugs and other services. Hospitals throughout Africa, and increasingly health centers, are proving that it makes economic sense to pursue a policy of cost recovery (Vogel, 1988).

Before launching a cost recovery system, careful analyses should be made. For example, health planners must know, among other things, facility utilization levels, availability of personnel with financial skills, income levels or willingness of the population to pay for services. These and other pieces of information will indicate to planners the economic viability of a cost recovery system.

Conclusion

The potential cost recovery achieved depends on what services facilities charge for, how much, and how well prepared they are to collect fees. Under a strenuous set of assumptions, if there are fees for consultations, the regions would generate the most revenue; if fees are collected for hospitalizations, then Bangui would recover the most amount of money. If both hospitalizations and consultations must be paid for, it is a close call as to whether Bangui facilities or regional facilities will generate more revenue. Finally, comparing cost recovery for consultations across different health facility levels it is hospitals which would generate the most revenue.

These revenue calculations aside, given the current health infrastructure in C.A.R., it is probably most feasible to consider cost recovery in cities and towns rather than villages; delivery of quality services is easier, there are more trained personnel, financial institutions exist, and incomes are higher.

If, on the other hand, a high priority is providing basic health services to the rural 47 percent (World Bank, 1989) of the population, including attempting to reduce high infant and maternal death rates, it is important to invest in cost recovery at the periphery levels. The government does not have the financial resources, nor is donor assistance sufficient, to provide good quality, basic health care to this population. A partial solution is for the population to assume more responsibility for its own health care.

Some General Principles of Cost Recovery

1. Cost of providing a given type of care is generally higher at higher level facilities because of the more intensive use of resources.

2. If fees are not instituted at all levels of facilities, there will be a tendency for patients to seek care where there are no fees.

3. Given number 2, fees can be used to encourage appropriate care seeking behavior. Higher hospital fees for outpatient care (as compared to the fees at health centers) will encourage people to seek care at lower levels where it is generally less expensive to provide care. This frees up hospitals to carry out their tertiary care functions.

TABLE V-1
FEES FOR OUTPATIENT CONSULTATIONS ONLY

	BANGUI				REGIONS		
	Annual Number of 1st visits	Fee	Potential Revenue (FCFA)		Annual Number 1st visits	Fee	Potential Revenue
Hospital	212000	500	106,000,000	Hospital	176000	500	88,000,000
Centres	149000	500	74,500,000	Centres	418000	500	209,000,000
S.Centres	0	500	0	S.Centres	114000	500	57,000,000
TOTAL	361000		180,500,000	TOTAL	708000		354,000,000

Assumptions:
a) 500 FCFA fee for all types of consultations
b) Single payment per episode of illness
c) No exemptions (e.g. for indigent, civil servants, students)
d) 100% fee collection rate
No change in demand in response to the new fee system

Data Source: DEPS Bulletin Annuel d'Information Sanitaire 1988

TABLE V-2
FEES FOR HOSPITALIZATIONS ONLY

	BANGUI				REGIONS		
	Annual # Hospital Days	Average Daily Fee	Potential Revenue (FCFA)		Annual # Hospital Days	Average Daily Fee	Potential Revenue (FCFA
Hospitals	195786	818	160,152,948	Hospitals	162045	158	25,603,110
Centres	47684	100	4,768,400	Centres	134119	100	13,411,900
S.Centres	0	0	0	S.Centres	0	0	0
TOTAL	243470		164,921,348	TOTAL	296164		39,015,010

Assumptions:
a) Average fees are based on fees proposed in Presidential Decret No. 90 and the occupancy rates reported by DEPS, 1988.
b) Distribution of patients among bed categories: I(3%), II (7%), and III (90%).
c) No exemptions (e.g. for indigent, civil servants, students)
d) 100% fee collection rate
e) Pediatrique bed fees equivalent to general medicine bed fees.
f) No change in demand in response to new fee system

Data Sources: DEPS Bulletin Annuel d'Information Sanitaire 1988

Presidential Decret No. 90.

TABLE V-3
FEES FOR HOSPITALIZATIONS AND OUTPATIENT CONSULTATIONS

	BANGUI	REGIONS
	Potential Revenue	Potential Revenue
Hospitalizations		
Hospitals	160,152,948	25,603,110
Centres	4,768,400	13,411,900
Total	164,921,348	39,015,010
Consultations		
Hospitals	106,000,000	88,000,000
Centres	74,500,000	209,000,000
S. Centres	0	57,000,000
Total	180,500,000	354,000,000
TOTAL	345,421,348	393,015,010

Assumptions:
a) 500 FCFA fee for all types of consultations
b) Single payment per episode of illness
c) No exemptions (e.g. for indigent, civil servants, students)
d) 100% fee collection rate
e) Average hospital fees are based on fees proposed in Presidential Decret No. 9 and the occupancy rates reported by DEPS, 1988.
f) Distribution of patients among bed categories: I(3%), II (7%), and III (90%).
g) Pediatrique bed fees equivalent to general medicine bed fees.
h) No change in demand in response to new fee system

Data Sources: DEPS Bulletin Annuel d'Information Sanitaire 1988
Presidential Decret No. 90

TABLE V-4
OUTPATIENT CONSULTATION FEE COLLECTION AT DIFFERENT LEVELS

	Number 1st visits	Visits Percent	Tarif	Potential Revenue	Revenue Percent
Hopitaux Centraux	212,361	20%	500	106,180,681	27%
Hopitaux reg./pref.	175,829	16%	500	87,914,537	23%
Centre de Sante					
Bangui	148,739	14%	300	44,621,823	12%
Other	418,330	39%	300	125,498,877	32%
Sous centres	114,465	11%	200	22,893,000	6%
Total	1,069,724	100%		387,108,918	100%

Assumptions:
a) Sliding fees by facility level
b) Single payment per episode of illness
c) No exemptions (e.g. for indigent, civil servants, students)
d) 100% fee collection rate
e) No change in demand in response to the new fee system

Data Source: DEPS Bulletin Annuel d'Information Sanitaire 1988

ANNEX H

SYNOPSIS OF THE SOCIAL SOUNDNESS ANALYSIS

The Social Soundness Analysis was prepared by a Central African consultant in French. A copy of the full document was made available to the A.I.D. Liaison Office and the A.I.D.-funded technical officers in Bangui. Reference copies are also available in AFR/PD and CCWA. There follows the table of contents of the full report and a synopsis in English of the sectionsin bold type in the table of contents.

I. Socio-cultural Environment
- A. Generalities
- B. Demographic Characteristics
- C. Social Organization of the Population
  - **1. Village Organization**
  - **2. Women in C.A.R. Society**
    - **a. Single Women**
    - **b. Married Women**
    - c. Marriage, Fecundity, and Dowry

II. C.A.R. Health System
- **A. Health Politics**
- **B. Health Structure**
  - 1. Administrative Structure
  - 2. Technical Structure
  - 3. Private Health Structures
  - 4. Traditional Health System
    - **a. Traditional Matrons**
    - **b. Traditional Healers**
- C. Beneficiaries and the Health System
  - 1. Public System
  - 2. Private System

III. Experiences in Cost Recovery other than in the Health Sector
- A. Agriculture Society (SOCADA)
- B. Coffee Society
- C. Village Hydraulic
- D. Agency for the National Development of Elevage
- E. Experiences in Community Participation

IV. AIDS
- **A. Socio-cultural Values that Determine Sexual Practices in C.A.R.**
- **B. C.A.R. Attitudes Regarding AIDS**
- **C. Sexual Practices and AIDS Propagation**
- **D. AIDS Impact on C.A.R. Ideas**
- **E. AIDS Campaigns**
- **F. Health Mobilization and AIDS Campaigns**
- **G. Information, Education and Communication**

Socio-cultural Environment

Village Organization

There are approximately 8000 villages in C.A.R. The village is the focal point for approximately 60 percent of the population. It is the societal anchor for the entire population: All Central Africans possess a village of origin, even if they have lived in urban areas for multiple generations. This village provides support in their daily life.

The village structure serves two purposes, administration and traditional. The former is a product of modern society and the latter is based on lineages. The latter determines the status of an individual within the village. Within a village, the village chief, known as the Makonkji, has supreme authority. However, this is exercised in a collegial system in conjunction with others of importance.

Women in C.A.R. Society

The society of C.A.R. is principally a patriarchal one. In this context, women are valued strictly as wives and mothers. In waiting for marriage, a young woman is viewed as one who will one day marry and leave the village. Thus, certain village secrets are withheld from her as is her inheritance.

The primary function of a C.A.R. woman is to bear children. From this function, she derives self-esteem. Young single women help their mothers in heavy household chores. This places a single woman in an ambiguous situation by raising her value vis-a-vis her future dowry and diminishing her worth by displaying the contrast between her rights and privileges and those of her brothers. In general, a woman is obliged to leave her village and/or her lineage to go and live with her husband. Within C.A.R. this practice varies from region to region, depending on whether the village population is heterogenous or homogenous.

Older unmarried women are considered deviant because they have aged without marrying. To a small degree, they are often ostracized by their families, lineages, or villages. To survive, they must "fight like men" to better their conditions, to free themselves from their families and to impose a certain respectability on their environment. The route most open to them is that of commerce. Those that do not succeed in transcending their difficulties usually leave the village for city life. The socio-psychological conditions under which single women must live explain why there are relatively few living in villages.

C.A.R. Health System

Health Politics

Under the African Regional Health Development charter of 1974, the African regional member states of WHO united to put forth a hierarchial health system. This was later defined by a number of decrees which gave rise to the Ministry of Public Health and Social Affairs (MSPAS) and its constituent departments.

Health Structure

Traditional Matrons

Traditionally, each village or clan recognizes a woman of 40 to 60 years of age, known by the community to possess the skills necessary to assist village women in times of child birth. Their social status permits them to influence the course of life in the village. The fact that the life of a neonate depends in part on them confers upon them a quasi-magical or even supernatural power.

In the early eighties, a project to train traditional matrons was initiated by the Peace Corps. These matrons received training in the regional hospitals before returning to their villages. This project enabled the matrons to better their skills; however, it destroyed the traditional basis under which they had previously functioned. Because of this training, the matrons were no longer viewed as "traditional." They became "simply matrons." In the perception of the villagers, they had entered the modern system to stand with doctors, nurses and "sage-femmes." They were no longer approached nor listened to as before. Nevertheless, traditional matrons and simply matrons continue to play an important role in the birth of a child in rural areas.

Traditional Healers

The average Central African believes that where modern medicine cannot succeed, traditional medicine can work miracles. In addition, the belief in supernatural forces, evils that modern medicine cannot cure and/or malefactions is relatively strong among Central Africans. This lends a certain status to traditional healers.

There is often confusion regarding the role of the traditional healer. Certain groups, Christians in particular, tend to confuse the work of the healer with a practice of fetichism oriented toward evil and crime. More and more, healers are being seen as exceptional individuals capable of predicting the future, explaining supernatural or magical causes of an illness, and to be able to cure using magical incantations rather than natural ingredients. In a word, traditional healers have become a "power."

In spite of the emergence of modern medicine, traditional healers remain plentiful in C.A.R. They, like their private physician

counterparts, have increasingly demanded remuneration for their interventions. Still, given the cost differentiation between modern and traditional medicine, demand for traditional healers has increased. This demand has been accompanied by charlatans placing the reputation of skilled traditional healers in danger. However, many Central Africans continue to believe in the merits of traditional healers and spend significant quantities of money to benefit from their services.

AIDS

Socio-cultural Values that Determine Sexual Practices in C.A.R.
By way of introduction, it is necessary to recall that C.A.R. is based on a patriarchal society and that women are enjoined outside of their clan of origin in order to marry. Inherent in this structure are the following rules: (1) Sexual relations are not permitted with anyone from the father's or the mother's clan, even if the clan is composed of several thousand people; and (2) for the majority of Central Africans, sexual relations are not permitted with a person belonging to the clans of the grandparents.

In rural areas, where control is very rigid, a young girl is supposed to conserve her virginity until marriage, even if she is married very late. Thus, it is not rare to find young girls of 25 to 30 years old still virgins in rural areas. The virginity of a young girl is a source of pride to her parents and her husband's parents, even in urban areas. This principal holds true especially in Muslim communities. Men, on the other hand, are not held to this rule. Upon attaining puberty, young circumcised men are even discretely encouraged to test their masculinity and virility.

In that Central Africans consider their existence as a dimension of a group rather than as an individual, fertility is considered the realization of self and of one's family. In general, material riches are valued less than the number of children one has. However, in urban areas, a modification of the system can be noted. In rural areas, a child is valued for participation in agricultural production. This is contrasted in the urban areas where parents' aspirations for the future of their children compel them to provide resources over long periods of time for the education of their children. These conditions of life impose a revision of the attitude of parents vis-a-vis their children.

In a society where children are valued above all, health professionals struggle to relay the message that individuals suffering from AIDS or sexually transmitted diseases (STDs) should take precautions not to have children. This type of mentality also explains why in urban areas certain women do not hesitate to become pregnant to secure a man. Often they think that the more children they have, the better their chance of keeping him.

From the C.A.R. woman, fidelity and devotion to one man is expected. A man, however can have relations with several women. As imposed by society, polygamy is limited to between four and six women. Officially, there is no fixed limit.

Pregnancy and birth also influence the sexual relations of a couple. During the months preceding birth, sex is usually less frequent. After their birth, sexual relations are traditionally forbidden for a period of time. Within certain ethnic groups, this can extend until the child begins to walk. However, increasingly urban couples refrain for a period of 40 days, as advised by the "sage-femme". During this period of abstinence, the man usually has relations (which are more or less open) with one or more women.

C.A.R. Attitudes Regarding AIDS

Central Africans are beginning to take AIDS (SIDA in French) seriously. For a period of time, expressions such as "Syndrome Invente pour Decourager les Amoureux" (Syndrome Invented to Discourage Lovers) or "Salaire Impaye Difficilement Acquis" (Unpaid Salary Difficulty Acquired) were the norm. Today numbers of Central Africans, especially in Bangui, know a person with AIDS among their family members, friends or acquaintances.

In urban areas, people have greater access to information on AIDS. And in certain places, condoms have been introduced. Prostitutes who frequent expatriates have begun to adopt a more prudent approach to sexual relations by having their customers wear condoms. On the other hand, in rural areas, people remain convinced that AIDS is an urban phenomena. Individuals who come from cities are immediate suspects. Studies conducted in Bambari, Bossangoa and Bozoum demonstrate a rapid progression of AIDS in these regions. Heavily implicated in the spread of AIDS are sites where individuals from provincial cities and rural sectors can co-mingle.

Many people infected with AIDS return to their villages to die. Those that are ill are generally well assisted by their families and receive social support. Others develop a desire for vengeance. They do not want to die alone and thus engage in sexually promiscuous behavior in a premeditated manner. In Bangui, people that have died from AIDS and left long lists of their victims are well known.

Sexual practices and AIDS propagation

Certain sexual customs which support the propagation of the disease are discussed below:

The Proliferation of Sexual Relations

Sex with the objective of procreation is little respected, especially in urban areas. The average Central African male maintains at least one secondary relationship in addition to his principal relationship. In addition to legal polygamous relationships, there exists numerous cases of concubines and/or peripheral relationships, especially in urban areas where societal control is weak. The male dominance of the society supports this behavior which is condemned by women but tolerated by men.

Sexually Transmitted Diseases (STDs)

STDs are relatively widespread in urban areas. The most prevalent are gonorrhea, syphilis, genital herpes and chlamydia. These diseases are readily observed in men, whereas women are slow to discern the problem.

Treatment is also problematic. In general, men prefer to self-treat with questionable antibiotics (or traditional cures) which can be purchased directly from the pharmacy without a prescription. This serves only to perpetuate the illness. Within the confines of a couple, the man and woman are rarely treated together. A contaminated man prefers to hide the illness from his wife and vice versa to avoid domestic disputes. Taboos which surround STDs are at the root of this problem. One does not dare to speak about it and only with difficulty to one's physician. This taboo exerts itself to an even greater extent for women. In hospitals and dispensaries, they are often mistreated, injured and ridiculed by nurses. In other cases, health professionals divulge the names of persons with STDs or AIDS in the cities where they live. The spread of STDs parallels that of AIDS.

The Use of Condoms

Condoms are not very widely used in C.A.R. This use is beginning to be undertaken by the educated class, but in general it is still considered taboo. The marketers of condoms (pharmacies, health workers, etc.) feel the population is not yet prepared to face the problem sufficiently for them to be able to assist the population in overcoming their handicap and reticence.

Reticence is caused by two major beliefs. Public rumor has given rise to the belief that sexual practices with a condom do not allow for the fullness of pleasure desired. In addition, men have a tendency to believe that the use of a condom will have a negative effect on virility. All C.A.R. males are prepared to take any risk, even that of AIDS contamination, to maintain this virility. These beliefs have not been addressed by health agents.

<u>AIDS Impact on C.A.R. Beliefs</u>

It is perhaps too early to evaluate the impact of AIDS on behavior, but the phenomena, as evidenced by disruptions caused within society, has begun to permeate the minds of the people. The intensity of the AIDS awareness campaigns have brought about the realization that even traditional healers cannot provide cures. Resignation to the situation has promoted a new discovery of the virtues of fidelity among many couples.

AIDS Awareness Campaigns

A program targeting the reduction of AIDS was started in 1987. This program followed the WHO guidelines and focused on posters and the distribution of T-shirts. Unfortunately, the cultural differences of the C.A.R. people were not taken into account.

The poster most widely known presents three couples: one kissing on the mouth, one holding hands and one eating from the same plate. The text, literally translated from Sango (the national language), reads "AIDS cannot be caught from this". The message meant to imply that one could not catch AIDS from kissing on the mouth, holding hands or eating from the same plate. However, the public's reaction to this poster was, "AIDS is not a dangerous illness." AIDS has become known as an inoffensive, insignificant disease, instead of being known as a dangerous illness. What the campaign failed to take into account was that the majority of the population is illiterate and has a very limited ability to synthesize information.

Campaigns which are based on the distribution of T-shirts have very limited effect. In a country where clothes are a luxury, T-shirts are not worn to consciously promote a cause, but by necessity because it is necessary to be clothed.

Health Mobilization and AIDS Awareness Campaigns

The poor conditions of health and the absence of appropriate resources do not permit health agents to effectively combat this disease. In short, they were not trained to communicate with patients and the population, but to deliver instructions.

Training in the technique of communication between the group and the group leader must exist in order to effectively fight this plague. People must be convinced via the instillation of fundamental values in targeted groups. These groups will in turn disseminate the message strengthened by their belief in the message. In depth research is necessary to define the correct mode of communication needed and to identify the determining factors for good communication.

Information, Education and Communication (IEC)

Currently, the average length of an IEC project administered in C.A.R. is two and one-half years. During this period, often the first three to six months have been dedicated to raising the

level of AIDS awareness in the population. Providing information and training to individuals responsible for the programs is generally neglected. The accent is placed only on the beneficiaries and not on the distributors of the message.

Training the responsible parties should be the priority and contain:

- a seminar which contains adequate time for analysis and reflection on the project's objectives and adequate resources to put the project in place. This would permit everyone connected with the project to understand exactly what is expected from them, to reach consensus among themselves about what the project entails and to anticipate problems and propose solutions for overcoming them.

- training for the responsible parties in the sociology of target groups (i.e., how to identify a target group, being sensitive to their social-cultural values, their conditions and ways of life, methods on ways to approach them, ways in which to impart the message, etc.).

The responsible parties must comprehend that an effective approach strategy is based on a thorough understanding of the socio-cultural context of the target group. Upon receipt of the information, the target group should be able to analyze their behavior and routines. This will enable them to focus on their problems which could pose potential dangers.

The AIDS awareness campaign addresses the entire population which is not homogenous. The strategy chosen should take into account the behavioral differences of each social group. For example, students do not always act the same as people in the military or people who live in rural areas. Thus, it is necessary to take into account their cultural differences which should be determined via in-depth studies.

In any case, an AIDS awareness campaign which includes information dissemination and/or training, should not occur only in the first three or four months of the project. It should be repeated periodically throughout the life of the project. This will insure the dissemination of the message from the responsible parties to the target groups and allow for feedback from the target groups as to which messages work and which do not work.

PPANNEXH.CAR/aid4

ANNEX I

ADMINISTRATIVE/INSTITUTIONAL ANALYSIS

The administrative/institutional analysis deals with three areas:

1) the overall Ministry of Health structure and capabilities;

2) the organizational arrangements for implementing the specific elements of the A.I.D. - funded interventions; and

3) the plans for A.I.D.'s project management and monitoring.

A. Overall Structure and Capability of the Ministry of Health

1. Institutional Structure

The Ministry of Public Health and Social Affairs (MSPAS--French acronym) is composed of two separate divisions: Public Health and Social Affairs. What follows is related to Public Health. There are three operational levels: central, regional and peripheral. The central level in Bangui is responsible for the creation of national health policy and the design of national programs that will implement that policy. It is composed of technical and support departments.

The regional level was created in 1962 in an effort to strengthen the administration of programs outside of Bangui. There are five health regions which generally have no political/administrative counterpart. Each is administered by a Chief Medical Officer (Medicin Chef). Each of the four central technical departments has a representative at this level, and with the Medicin Chef, they are responsible for coordinating the implementation of health programs throughout their geographic area. Each region has a 100-120 bed hospital and a drug depot. Unfortunately, the system has not been very effective. First, Bangui has not delegated sufficient decision making authority or material and human resources to the regions to make decentralization effective. Second, the administrators in the regions are doctors by training with few skills in planning, supervision or evaluation.

The periphery is defined as everything under the region. However there are four levels within this. The first level is the prefecture. There are 16 prefectures in the country, two to four per region. Each is directed by a Medicin Chef who is also

director of the prefectural hospital. He/she is responsible for coordinating and supervising program activity and resource distribution throughout the prefecture.

Next there are 64 sub-prefectures, each of which has either a Centre de Sante or a Sous Centre Sante. The Centre de Sante may be headed by a doctor in a larger town or by a "technicien superieure" or by a nurse, depending upon the size and isolation of the facility. Next are the 171 communes, the lowest political/administrative unit. These have either a Sous Centre Sante or more commonly a Poste de Sante, which will be managed by an assistant nurse. Finally at the lowest level, the village, there may be a Case de Sante or birthing hut staffed by a volunteer traditional birthing attendant. In principle, health committees exist at all levels. Few are believed to be playing a significant role. The diagram below illustrates this organization.

2. Issues and Constraints

During the recent planning process that produced the National Five Year Health Plan, the following structural, organizational and personnel constraints were identified:

Structural constraints

* the over centralization and unwillingness at the level of Bangui to delegate authority and resources to the regions

* the need to develop a national policy for decentralization

Organizational constraints

* undefined tasks and roles at the national, regional and prefectural levels

* the need to clarify hierarchial communication structures and the descriptions of the different personnel categories

* an insufficient regulatory framework

* no clear and organized management system for the stocking, distribution and replacement of supplies and equipment

* an inappropriate/inadequate organizational structure at the ministry, regional and local levels resulting in vertical programming, poor coordination or lack of horizontal integration, rapid staff turnover, wasteful duplication of efforts and top down planning and implementation

* weak planning, evaluation and supervision systems

* inadequate information systems

* little emphasis on community participation in health care

Personnel

* insufficient numbers of staff (one doctor per/16,600 inhabitants; one "technicien superieure" per/22,000 inhabitants.

* the poor use and assignment of human resources, particularly in placement, with 85 percent of health personnel located in the hospitals and urban health centers and not providing primary health care sector to rural areas

* poor staff attitudes and motivation due to poor working and living conditions, and the subsequent result of poor service delivery

* low skill levels of staff resulting from inadequate and/or inappropriate training vis-a-vis the reality of the field.

3. Ministry Response to Issues and Constraints

a. Centralization/Decentralization

Ministry officials are committed to further decentralization and have requested that donors provide assistance to help bring this about. In the past, donors have provided vehicles for supporting field operations, but only for those interventions supported by the donor. Thus, the responsible regional and prefectural officials could only use the vehicles for one type of health activity. Similarly, malaria suppressives might be provided only for women and children. The reality is that the local health official must help whoever needs it; thus, the restrictive donor policy could end up hamstringing its own program by its narrow approach.

In response to the Ministry's request, the design team has included funds in the project budget to purchase for each region one all-terrain vehicle, a computer for use in developing a management information system and supporting the anticipated cost recovery activities, and reproduction equipment. Also included are radios for each of the prefectural hospitals (radios are only at the regional level at this time).

A.I.D.-financed experts (child survival and health financing) are members of the Director General's task force to plan and coordinate the implementation of a geographically-oriented primary health care program to be initiated with UNICEF assistance in three prefectures. This effort should contribute to defining a CARG decentralization policy.

b. Organizational Restructuring and Personnel Use

One recommendation of the new national five year plan (PNDS) is the re-structuring of the Ministry to accord better with the programs outlined in the PNDS. The two support departments of DEPS (planning, studies and statistics) and DAF (administration and finance) remain, but the number of technical departments would go from four to five. Preventive Medicine and Endemic Diseases (DMPGE), Maternal and Child Health/Family Planning (SMI/PF) and Environmental Health (Assainissment) remain, but Curative Medicine is reduced to a section in the new department of Infrastructures. The other new department is Pharmacies, which was previously in the Inspectorate General. It has not yet been decided whether the vaccination program will be moved to SMI/PF or remain in DMPGE. A training section is to be placed in DEPS.

In addition to the above departments, there are three special units at the level of the Director General. One is a Health Financing Unit to which a U.S. technical advisor is assigned. A new unit yet to be formed is the Service National pour Information, Education et Communication (SNIEC), which would coordinate and advise the individual departmental training units on health education. The third is the Primary Health Care Coordination unit.

Two of the ten priority programs for the five-year national health plan concern training and health education respectively. The design team supported this important emphasis, but suggested that separating the two pedagogical/educational components and placing them in different departments would cause confusion and duplication, <u>not</u> the coordination of programming that the five-year plan calls for.

The team recommended creation of a separate Directorate of Training and Health Education. This Directorate would be the third <u>support</u> department like DEPS and DAF, serving the other <u>technical</u> departments. Not only would one department facilitate cross-Ministry training coordination and planning, but it would facilitate the coordination of donor training assistance and provide the vehicle for decentralizing training. The Directorate, like the technical departments, would have a <u>Chef de service</u> at the regional level who could plan, coordinate and monitor all training and health education interventions in the region. This task now falls on the regional Medicin Chef (chief medical officer) who already has too many administrative responsibilities.

The CARG civil service was on strike during the design team's visit and had been for three months. This explained why some of the organizational decisions had not been taken. The team offered some process suggestions for helping to arrive at decisions once the government was again in operations.

Some of the organizational changes are designed to deal with the lack of a management system for the distribution of supplies

and equipment. The African Development Bank (AFDB) has financed a study of pharmaceuticals distribution, and its contractor (CREDES) has recommended significant changes in their purchase and distribution, e.g., greater purchase of generics, open international bidding, contracting for delivery of drugs to regional depots.

A dependable supply of reasonably priced pharmaceuticals is crucial to the delivery of good health services in the C.A.R. and to the success of any attempt to introduce cost recovery in the regional and peripheral health facilities. The design team recommended, therefore, that the project should be prepared to support a pharmaceutical purchasing and distribution reform if the CARG adopts the CREDES recommendations.

The AFDB is also supporting the development of a management information system throughout the Ministry and providing studies to help in personnel reform. The project will provide short-term technical assistance as needed to help with the planning of the health information system.

The design team found that Ministry officials were aware of the problems of horizontal coordination within the Ministry and were seeking help in overcoming them. In response, the project includes some support for other parts of the Ministry as well as planned support for cross-directorate training.

Some commodity support is planned for the Maternal Child Health/Family Planning Directorate and it was agreed that the A.I.D.-funded Child Survival specialist would work with that directorate as well as with the DMPGE with which she now works. She will also work with the planning directorate in relation to the information system. A vehicle and some equipment has been budgeted for the Director General to assist him in improving coordination.

It is proposed to finance a training/health education expert for two years to help strengthen these activities. It is anticipated that the methodologies used for carrying out a number of training activities could foster team-building and facilitate horizontal coordination. The assistance to training should also help overcome some of the personnel constraints mentioned in 2. above.

The provision of additional resources and improving the management thereof, in conjunction with technical and motivational training, should result in improved attitudes and morale among health personnel in the field. All of these working together will provide a more fertile environment for cost recovery, and the latter may permit additional funding for salaries. This would improve morale still further and facilitate improved personnel management, including greater assignment to peripheral areas.

ANNEX J

COST RECOVERY IN THE CENTRAL AFRICAN REPUBLIC

A. History of Cost Recovery in the Central African Republic

There are basically three phases of cost recovery activity in the Central African Republic (C.A.R.). The earliest phase (pre-1988) is characterized by limited cost recovery in public hospitals, several village pharmacies, and extensive cost recovery in missionary facilities. There is little information available on cost recovery in hospitals, although Pasnik (1986) reports the fee schedule and recent data on revenue are now available (see below).

Preliminary surveys of health facilities and pharmacies by Levin and Weaver (1987) provide a description of cost recovery at a missionary hospital and the Peace Corps and UNDP village pharmacy projects. They also describe the government's first experiment with semi-autonomous financing in which Castors Maternity was allowed to charge for deliveries and retain the revenue for operating expenses. More recently, cost recovery activities in missionary facilities and at the village level have expanded. Langley et. al. (1989) provide an inventory of these activities.

Another phase concerns primary health care (PHC) and community financing. The origins of this phase can be traced to 1988 when Wilyboro Sako, the Minister of Public Health and Social Affairs at the time, attended the annual World Health Organization meeting in Geneva where PHC and cost recovery as embodied in the Bamako Initiative were the main topic of discussion. The Minister thought that the Bamako Initiative, to which the C.A.R. was a signatory, provided the legal basis to expand cost recovery in government facilities. In addition, community level financing of PHC seemed like the path of least resistance for introducing cost recovery because it involved initiating new services and financial systems rather than reforming existing ones associated with vested interests.

Upon his return from Geneva, the Minister organized the first PHC workshop in autumn of 1988 and drafted legislation to allow facilities to retain and use their revenue for operating expenses, either by working within the context of normal public finance procedures or by establishing partial financial autonomy.

Minister Sako also organized the nation's first consensus building workshop on cost-recovery--sponsored by USAID (see Makinen et. al. 1989). The workshop participants recommended several activities in health finance and management and proposed that a working group be established within the Ministry to coordinate the analyses. Following the workshop, the Minister asked USAID to fund

a long-term technical advisor (TA) in health finance for the Ministry. Although considerable PHC activities continued, culminating in the development of a national health plan in 1991 with a focus on PHC, most of the discussion of cost recovery was postponed until the arrival of the technical advisor.

The most recent phase concerns a 1991 law, drafted by Mr. Jean Lombassa when he was Minister in 1989, that fixes the prices at public hospitals and health centers. This phase marks attempts to address the issues in existing, albeit limited, cost recovery activities in public hospitals. Fees for hospitalizations are set on an all inclusive, daily basis. The cost of drugs is not included except in the case of the Complex Pédiatrique (see discussion of the complex below).

The law also sets fixed fees for outpatient consultations based upon the qualifications of the medical personnel performing the consultation. Fees to be charged for certain medical acts are also included. The legislation does not address whether the funds can be retained by the facilities, except that 30 percent (as opposed to 40 or 50 percent in the previous hospital legislation) can be distributed to medical personnel at the facilities as part of a bonus system for health personnel.

Despite these important legislative initiatives, cost recovery performance in public health facilities in C.A.R. remains weak, largely due to a lack of management infrastructure. When the successful semi-autonomous cost recovery experiment at Castors maternity was extended to the other four maternities in Bangui, revenues in 1989 were five to 12 times greater at Castors Maternity than at the others. It is likely that these differences are due to management abilities; Castors Maternity is run by an expatriate nurse, while the others are run by Central Africans who were given no management training or assistance. (Levin and Weaver found that public sector health professionals lacked the management training and ability found in comparable professionals at missionary facilities.)

Considering cost recovery at the Centre National Hospitalier Universitaire à Bangui (CNHUB), the amount of fees collected are similar or below comparable hospitals that have insufficient management infrastructure. For example, revenue in 1990 was 61,666,666 FCFA ($246,666 at 250 FCFA/US$) or 105,263 per hospital bed (the denominator adjusts for the size of the hospital, although it is an imperfect adjustment when outpatients outnumber inpatients). In comparison, Niamey National Hospital in Niger whose revenue in 1989 was 162,334 FCFA per hospital bed undertook a major effort to increase revenues through reform of the hospital prices and accounting system.

The low receipts at CNHUB may be attributable to: 1) extensive exemptions for civil servants and other patients, 2) lack of billing procedures and resources for collecting outstanding bills from local companies, 3) lack of financial autonomy; funds

are turned over to the treasury rather than retained for operating expenses to improve the quality of hospital care, and 4) an inappropriate fee structure.

Interestingly enough, revenue at the Complex Pédiatrique is not appreciably higher than at the rest of the CNHUB. Revenue in 1990 was 19,026,980 FCFA ($76,108) or 126,006 FCFA per hospital bed. Although the complex has made considerable progress in providing the necessary pharmaceuticals and improving the quality of care, it is a long way from recovering its operating costs exclusive of salaries.

In summary, initial interest in community financing has broadened to include cost recovery in public hospitals and health centers. C.A.R. has made impressive progress in creating a favorable legal environment for cost recovery, but much remains to be done in establishing administrative procedures and in implementation.

B. A.I.D. Support for Health Finance

A.I.D. has had a growing involvement in health finance in C.A.R. for five years, beginning with short-term TA and the national cost recovery workshop, leading to the current funding for a long term TA in health economics in the newly created Health Economics Unit in the office of the Director General of the MSPAS. The A.I.D. funding is in response to the Minister's request mentioned above. He requested an experienced expert with a background in economics and management to advise him on the design and implementation of a national cost recovery program. Due to the difficulty of finding a person with such broad qualifications, it was decided that if the long-term TA were an economist, his/her skills would be complemented with short-term technical assistance in management (or vice-versa if the long-term TA was a management expert).

The funding mechanism for technical assistance in health finance has been problematic due to the lack of a bilateral agreement, causing considerable delays in fielding the long-term TA. For FY 1991, the long term TA has been funded by the regional African Development Support project (ADS)--which does not allow funding for short-term TA or local research expenses. The short-term TA has been funded through ASCI-CCCD, another regional project. For FY 1992, funding for the long-term TA through the ADS grant will continue--for a total of 18 months. An alternative source of funding must be found for the short-term TA and local research expenses.

C. Proposed Health Finance Activities in C.A.R.

AID will continue support (long-term and short-term TA, commodity support, and training) to the Health Economics Unit for the development and implementation of a national cost recovery program in close collaboration with the child survival programs. The success of a cost recovery program rests on the quality of the health care for which the population is asked to contribute. The child survival interventions can provide the majority of the necessary quality improvements for successful cost recovery. For example, in Niger, 90 percent of the consultations for children and 50 to 60 percent of the consultations for adults were for diarrhea, malaria, and respiratory infections.

Cost recovery will in most cases follow chronologically the child survival interventions and support the sustainability of the interventions by providing funds for pharmaceuticals and other operating costs. Consequently, the implementation strategy of the national cost recovery program will be in the image of the child survival interventions, beginning in urban health facilities that serve a large proportion of the population and extending over time to peripheral health facilities. It is expected, therefore, that cost recovery activities will begin in Bangui and other urban areas within the first two years of the project.

There are, however, two exceptions to this strategy. The first concerns implementation of the newly enacted hospital fee legislation and promoting financial autonomy. It is proposed that the project address these concerns by supporting activities that strengthen the accounting infrastructure and reduce the costs of providing services. Later activities will investigate potential reforms of hospital fees such as introducing cost recovery for pharmaceuticals (if they cannot be financed from the revenues of the existing fees) and social insurance for financing hospital fees for patients with catastrophic illnesses.

Support, in the form of technical assistance and studies, will also be provided to the Bamako Initiative activities in support of the national primary health care program. Although these activities are scheduled to begin in peripheral health centers rather than urban health facilities, they are supported because these initial experiences will provide important lessons for use in planning the eventual implementation of cost recovery in peripheral health facilities. In addition, it is important to give these initial activities every opportunity to succeed, because their success or failure will weigh heavily in the decision to adopt a national cost recovery program.

The following provides brief descriptions of the proposed activities.

1. Cost Recovery in Support of Child Survival Interventions

The strategy for developing a national cost recovery program will follow the child survival strategy, with some revisions dictated by the financial rather than medical nature of the

program. Briefly, that strategy involves the following steps: a) study of health facilities to assess needs, b) survey of patients to estimate their knowledge, attitudes and practices related to the intervention, c) development of training materials and training of health facility personnel, d) evaluation of facilities after the training, and e) social mobilization to inform the population about the intervention and promote their participation.

USAID will support the first three steps as distinct cost recovery activities, and the final steps will be supported in ongoing child survival activities. Activities in the first three steps are described below:

a. Health Facility Study

Analyses of the cost of services can provide information on the cost of current services as well as on the cost of the potentially higher quality services that will be available when the child survival interventions are completed and cost-recovery is introduced. The Health Economics Unit will prepare estimates of the cost of the current services to provide baseline data. The study will also gather information on ways to provide high quality services at the lowest possible cost. This analysis will be conducted in collaboration with medical personnel who will establish the standard child survival interventions with essential drugs. It will include analyses of the costs of transporting and distributing pharmaceutical products to insure a continuous supply of essential drugs to health facilities.

The project will also support studies that address whether public health facilities or private suppliers are the most cost-effective suppliers of pharmaceuticals. The relative cost-effectiveness of the public and private sectors is likely to vary across villages because some already have successful village pharmacies or depots while others do not have an accessible private source of pharmaceuticals. Thus the study will provide guidance to villages to help them assess the relative advantages of the two sectors and select which one to support. The results of their selection will have important implications for the management training, because in some cases the private sector suppliers may receive training to complement the training of health personnel.

b. Population Survey

The type of survey recommended would be a variation of traditional demand studies that would seek to directly address the concerns of policymakers in C.A.R. Policymakers need to know what health services the population would like, and how much the population is willing to pay for these services. They are interested in whether the amount that

the population is willing to pay is more or less than what it is already paying for care and what it will cost to deliver those same services.

Therefore, the study will use marketing techniques to determine which services the population wants, experimental economic techniques to estimate how much the population is willing to pay for those services, and traditional methods to estimate how much the population currently spends for health care. These data will be supplemented with information on household income in order to assess the population's capacity or ability to pay for health care; capacity will be measured as the percent of income devoted to health care expenditures.

c. Management Training

Support for management training will occur in three phases:

i) studies of accounting and financial management to identify the appropriate management practices for public facilities--and possibly private suppliers;

ii) development of training materials; and

iii) training.

2. Hospital Finance

Hospital fees have already been enacted, so many of the issues for hospital finance concern the promotion of hospital financial autonomy, or in the case of C.A.R., partial financial autonomy. The hospital finance activities seek to promote financial autonomy by strengthening the accounting infrastructure, reducing hospital costs, and reforming hospital fees.

Strengthening the accounting infrastructure will improve capacity for collecting fees as well as for allocating revenue. Reducing costs will allow the hospital to make the most of its resources and reduce dependence on external financing. Reform of hospital fees promotes efficiency by providing appropriate price signals. These activities are briefly described below.

a. Hospital Accounting

Support for hospital accounting will include studies of the accounting system, with recommendations for a system that will improve the capacity for collecting fees and allocating revenue. Training will also be provided to all hospital personnel with financial responsibilities. The activities

will occur in two phases: the first for Bangui hospitals; the second for regional and prefectural hospitals.

b. Hospital Cost Containment

A study of hospital cost containment will complement drug cost containment activities by addressing issues specific to more sophisticated hospital equipment and practices. This activity will occur primarily in Bangui, because the Bangui hospitals have the most sophisticated equipment. The study will devote particular attention to managing the recurrent costs of the new hospital facilities. Lessons learned for the Bangui hospitals can be applied to other hospitals as they acquire the relevant equipment.

c. Hospital Fees

After working with the newly-enacted fee structure for a couple of years, it will be time to evaluate its performance with an eye to improving price signals and ensuring that revenue from all sources is sufficient for all necessary services (especially pharmaceuticals). A.I.D. will provide TA and funding for three related studies:

i) a cost study will compare the fees received to the costs of providing services and provide an analysis of which services are subsidized under the new fee structure;

ii) a patient survey will identify which patients are paying for care, which patients have exemptions, and which patients have an ability to pay for care; and

iii) a social insurance feasibility study will explore alternative payment methods for public servants, private sector employees, and patients with catastrophic illnesses.

3. Cost recovery in support of PHC

The activities in support of PHC are basically the same as those foreseen in support of child survival interventions, i.e. facility studies, population surveys, and management training. These activities for peripheral areas, however, will be conducted earlier than would occur under the child survival strategy to accommodate the schedule for implementing the Bamako Initiative in the initial three prefectures.

1=DMPGE 3= MOE
2=SMI

ANNEX K

AID 1020-10(5-87)

JOINT PROJECT IMPLEMENTATION PLAN PART I – WORK SCHEDULE	1. COOPERATING COUNTRY: Central African Republic	2. PROJECT TITLE: Sustainable Child Survival	3. PROJECT NUMBER	4. DATE (Month, Day, Year): FY 93
5. RESPONSIBLE PROJECT COORDINATOR: AFR/CCWA	6. RESPONSIBLE COOPERATING COUNTRY AGENCY: Ministry of Public Health and Social Affairs	7. COOPERATING SPONSOR: Centers for Disease Control		☐ DRAFT ☒ ORIGINAL ☐ REVISION NO.

8. NO.	9. DESCRIPTION OF MAJOR ACTIONS OR STEPS	10. PRIMARY ACTION AGENT	11. TARGET DATES: PREPARATORY ACTION	PHYSICAL START	PHYSICAL COMPLETION	12. TIME SPAN (Optional): FY-93	FY-94	FY-95	FY-96	FY-97	FY-
	EPI										
	- Provide an uninterrupted supply of vaccines to all vaccination centers	1/2									
	- Increase coverage in rural areas	1/2									
	- Add VAT vaccination programs for females	1/2									
	- Improve quality of vaccination services	1/2									
	- Develop strategies to increase vaccination coverage in the first year of life	1/2									
	- Support polio pre-eradication and neonatal tetanus elimination strategies	1/2									
	- Evaluate programs in conjunction with HIS program	1/2									
	CDD										
	- Make ORS available in 95% of hospitals, health centers, and sub-centers	1/2									
	- Increase use of ORS to 95% of hospitals and urban health centers, and 60% rural health facilities	1/2									
	- Maintain measles immunization coverage at level of at least 80%	1/2									
	- Train and supervise health care workers to increase level of correct case management	1/2									
	- Improve follow-up supervision of previously trained CDD health workers	1/2									
	- Develop and implement an IEC plan	1/2									
	- Develop training and educational materials for CDD social mobilization activities and train community moblizers	1/2									
	- Provide IEC to caretakers and community leaders	1/2									
	- Include CDD HE in primary and secondary school curricula	1/3									
	- Promote breastfeeding	1/2									
	- Conduct operational research on effective home case management	1/2									
	- Evaluate programs in conjunction with HIS program	1/2									

200

1=DMPGE
2=SMI 3=MOE

AID 1000-1(8)-671

JOINT PROJECT IMPLEMENTATION PLAN
PART I – WORK SCHEDULE

1. COOPERATING COUNTRY: Central African Republic
2. PROJECT TITLE: Sustainable Child Survival
3. PROJECT NUMBER:
4. DATE (Month, Day, Year): FY 93

5. RESPONSIBLE PROJECT COORDINATOR: AFR/CCWA
6. RESPONSIBLE COOPERATING COUNTRY AGENCY: Ministry of Public Health and Social Affairs
7. COOPERATING SPONSOR: Centers for Disease Control

☐ DRAFT
☒ ORIGINAL
☐ REVISION NO.

8. NO.	9. DESCRIPTION OF MAJOR ACTIONS OR STEPS	10. PRIMARY ACTION AGENT	11. TARGET DATES: PREPARATORY ACTION	PHYSICAL START	PHYSICAL COMPLETION	12. TIME SPAN (Optional): FY-93	FY-94	FY-95	FY-96	FY-97	FY-
	CDD (cont.)										
	- Evaluate health education practices at the health facility and community level	1/2									
	- Develop a data base of KAP survey results and results of facility needs assessments	1/2									
	Malaria										
	- Promote the availability of chloroquine/second line drugs at all fixed health facilities	1/2									
	- Continue monitoring chloroquine resistance	1/2									
	- Raise to 80% the percent of homes with immediate access to chloroquine/appropriate antimalarial	1/2									
	- Provide training and supervision of health workers	1/2									
	- Correctly treat 95% of febrile pregnant women at health facilities and provide chemoprophylaxis	1/2									
	- Accelerate IEC	1/2									
	- Promote the use of mosquito nets impregnated with insecticide	1/2									
	- Promote the elimination of mosquito breeding sites	1/2									
	ARI										
	- Establish a national ARI program	1/2									
	- Ensure an adequate supply of appropriate drugs in health facilities	1/2									
	- Provide training and supervision in ARI case management for health care workers	1/2									
	- Develop and implement IEC programs for ARI	1/2									
	- Conduct a KAP study	1/2									
	- Provide HE for caretakers re: assessment of/ appropriate treatment for ARI	1/2									
	- Utilize social mobilizers	1/2									
	- Examine the role of vaccines in preventing ARIs	1/2									

1=DMPGE
2=SMI 3=MOE 4=American NGO/ C.A.R. private sector

AID 1020-10(5-67)

JOINT PROJECT IMPLEMENTATION PLAN PART I – WORK SCHEDULE	1. COOPERATING COUNTRY: Central African Republic	2. PROJECT TITLE: Sustainable Child Survival	3. PROJECT NUMBER	4. DATE (Month, Day, Year): FY 93
5. RESPONSIBLE PROJECT COORDINATOR: AFR/CCWA	6. RESPONSIBLE COOPERATING COUNTRY AGENCY: Ministry of Public Health and Social Affairs	7. COOPERATING SPONSOR: Centers for Disease Control		☐ DRAFT ☒ ORIGINAL ☐ REVISION NO.

8. NO.	9. DESCRIPTION OF MAJOR ACTIONS OR STEPS	10. PRIMARY ACTION AGENT	11. TARGET DATES: PREPARATORY ACTION	PHYSICAL START	PHYSICAL COMPLETION	12. TIME SPAN (Optional): FY-93	FY-94	FY-95	FY-96	FY-97	FY-
	HIV/AIDS										
	- Evaluate the progress of the AIDS epidemic	1									
	- Increase access to condoms for the CAR population	1									
	- Provide appropriate treatment of STDs	1									
	- Develop a pilot project for STD control in one Region	1									
	- Develop/provide appropriate HE to change risk taking behaviors	1									
	- Diminish transmission of HIV/AIDS by invasive procedures	1									
	- Provide early detection and counseling of infected persons	1									
	- Diminish transmission by blood transfusions	1									
	- Implement condom social marketing program	4									
	Birth spacing										
	- Conduct applied research to define level of, knowledge about and demand for contraceptive services	2/1									
	- Conduct operational research to define best sites at which birth spacing services/supplies should be offered	2/1									
	- Conduct operational research about integration of birth spacing into immunization programs	2/1									
	- Establish birth spacing services in 50% of health facilities	2/1									
	- Use IEC to promote utilization of birth spacing services	2/1									
	- Use IEC to promote breast feeding	2/1									
	- Target young women in school for birth spacing messages	2/1									
	Training and Supervision										
	- Strengthen infrastructure responsible for inservice training/supervision of health personnel at the central, regional and prefectoral levels	1									
	- Increase decentralization of training	1									
	- Reinforce regional capabilities	1									

1=DMPGE
2=SMI 3=MOE 4=American NGO/ C.A.R. private sector

AID 1020-18(5-67)

JOINT PROJECT IMPLEMENTATION PLAN PART I – WORK SCHEDULE	1. COOPERATING COUNTRY: Central African Republic	2. PROJECT TITLE: Sustainable Child Survival	3. PROJECT NUMBER	4. DATE (Month, Day, Year): FY 93
5. RESPONSIBLE PROJECT COORDINATOR: AFR/CCWA	6. RESPONSIBLE COOPERATING COUNTRY AGENCY: Ministry of Public Health and Social Affairs	7. COOPERATING SPONSOR: Centers for Disease Control		☐ DRAFT ☒ ORIGINAL ☐ REVISION NO.

8. NO.	9. DESCRIPTION OF MAJOR ACTIONS OR STEPS	10. PRIMARY ACTION AGENT	11. TARGET DATES: PREPARATORY ACTION	PHYSICAL START	PHYSICAL COMPLETION	12. TIME SPAN (Optional): FY-93	FY-94	FY-95	FY-96	FY-97	FY-
	Training and Supervision (cont.)										
	- Promote improved methods to assess training effectiveness	1									
	- Develop a standardized supervisory checklist/ guidelenes	1									
	- Develop a management information system to monitor performance	1									
	- Develop a data base which records training and certification of all health agents	1									
	- Conduct monthly supervisory visits at the regional level	1									
	- Establish an integrated system of supervision	1									
	- Improve supervisor's skills	1									
	- Provide training for leadership	1									
	- Identify skills requisite to the successful implementation of PHC and develop training programs to strengthen those skills	1									
	- Incorporate principles of prevention, etc., into curricula at universities and technical schools.	1/3									
	- Coordinate training among MSPAS' departments	1									
	- Provide consultant support	1									
	- Institutionalize the use of professional certification	1									
	- Institutionalize measures to reward superior performance	1									
	- Increase access to professional literature	1									
	- Increase opportunities for exchanges with African colleagues from other countries	1									
	MIS/HIS										
	- Assess national HIS/MIS needs	1									
	- Develop with country staff a plan for system improvement	1									
	- Simplify data collection at the service delivery level	1									
	- Establish standardized case definitions for EPI diseases, diarrhea, malaria, ARI, STDs, and HIV/AIDS	1									
	- Provide training at the service delivery level	1									
	- Computerize regional and central reporting systems	1									
	- Provide central and regional training in computer programming and maintenance	1									
	- Provide technical assistance	1									
	- Improve sentinel surveillance data collection and reporting for target childhood diseases and HIV/AIDS	1									
	- Increase use of routine service data	1									

1=DMPGE
2=SMI 3=MOE 4=American NGO/ C.A.R. private sector

AID 1020-18(5-67)

JOINT PROJECT IMPLEMENTATION PLAN PART I – WORK SCHEDULE	1. COOPERATING COUNTRY: Central African Republic	2. PROJECT TITLE: Sustainable Child Survival	3. PROJECT NUMBER	4. DATE (Month, Day, Year): FY 93
5. RESPONSIBLE PROJECT COORDINATOR: AFR/CCWA	6. RESPONSIBLE COOPERATING COUNTRY AGENCY: Ministry of Public Health and Social Affairs	7. COOPERATING SPONSOR: Centers for Disease Control		☐ DRAFT ☒ ORIGINAL ☐ REVISION NO.

8. NO.	9. DESCRIPTION OF MAJOR ACTIONS OR STEPS	10. PRIMARY ACTION AGENT	11. TARGET DATES: PREPARATORY ACTION	PHYSICAL START	PHYSICAL COMPLETION	12. TIME SPAN (Optional): FY-93	FY-94	FY-95	FY-96	FY-97	FY-
	MIS/HIS (cont.)										
	- Link supervisory data to MIS/HIS	1									
	- Assist the DEPS in integrating data systems	1									
	- Improve utility of information systems for health workers at all levels	1									
	- Develop workplans that concentrate on priority monthly and annual analyses	1									
	- Provide quarterly feedback reports to sentinel sites	1									
	- Provide data regularly to policy makers and managers	1									
	- Promote publication of annual reports	1									
	- Expand the distribution and develop the content of the DMPGE "Echo"	1									
	- Develop other professional communications	1									
	- Strengthen capacities to conduct outbreak investigations	1									
	- Strengthen behavioral science contributions to the evaluation MIS/HIS process	1									
	Applied Research										
	- Assist in developing a research agenda	1									
	- Coordinate applied research activities	1									
	- Assist national researchers	1									
	- Provide training to CAR investigators in conducting, applying, and publishing research	1									
	- Promote opportunities to increase intercountry exchanges of program experience/research findings	1									
	- Support participation in CDC's International Epidemic Intelligence Course	1									
	- Train health care workers in conducting disease outbreak investigations	1									
	- Assist in conducting research to improve management and identify strategies for facilitating decentralization	1									

1=DMPGE
2=SMI 3=MOE 4=American NGO/ C.A.R. private sector 5=Cellule d'economie de la sante

AID 1020-1(15-67)

JOINT PROJECT IMPLEMENTATION PLAN PART I – WORK SCHEDULE	1. COOPERATING COUNTRY: Central African Republic	2. PROJECT TITLE: Sustainable Child Survival	3. PROJECT NUMBER	4. DATE (Month, Day, Year): FY 93
5. RESPONSIBLE PROJECT COORDINATOR: AFR/CCWA	6. RESPONSIBLE COOPERATING COUNTRY AGENCY: Ministry of Public Health and Social Affairs	7. COOPERATING SPONSOR: Centers for Disease Control		☐ DRAFT ☒ ORIGINAL ☐ REVISION NO.

8. NO.	9. DESCRIPTION OF MAJOR ACTIONS OR STEPS	10. PRIMARY ACTION AGENT	11. TARGET DATES: PREPARATORY ACTION	PHYSICAL START	PHYSICAL COMPLETION	12. TIME SPAN (Optional): FY- 93	FY- 94	FY- 95	FY- 96	FY- 97	FY-
	Applied Research (cont.)										
	- Assist in conducting formative research for new intervention programs	1									
	- Increase linkages with local academic institutions	1									
	Cost Recovery										
	- Support for Health Economics Unit										
	- Vehicles and equipment	5									
	- Supplies and local travel	5									
	-A. Cost Recovery activities in Bangui Hospitals										
	- Studies										
	- Hospital accounting system	5									
	- Hospital efficiency study	5									
	- Hospital patient survey	5									
	- Hospital cost study	5									
	- Social Insurance feasibility	5									
	- Workshop on hospital financial autonomy and improving hospital efficiency	5									
	- Accounting Training	5									
	-B. Urban Finance- urban health centers in Bangui, regional and prefectural hospitals										
	- Studies										
	- Cost studies	5									
	- Marketing study	5									
	- Accounting and financial information study for urban health centers	5									
	- Hospital accounting systems at regional and prefectural level hospitals	5									
	- Comparison of prospects for private vs. public local pharmaceutical supply	5									
	- Workshop- Consensus building on national cost recovery program	5									
	- Training										
	- Management training for urban health centers in Bangui	5									

295

1=DMPGE
2=SMI 3=MOE 4=American NGO/C.A.R. private sector 5=Cellule d'economie de la sante

AID 1020-18(5-67)

JOINT PROJECT IMPLEMENTATION PLAN PART I - WORK SCHEDULE	1. COOPERATING COUNTRY: Central African Republic	2. PROJECT TITLE: Sustainable Child Survival	3. PROJECT NUMBER	4. DATE (Month, Day, Year): FY 93
5. RESPONSIBLE PROJECT COORDINATOR: AFR/CCWA	6. RESPONSIBLE COOPERATING COUNTRY AGENCY: Ministry of Public Health and Social Affairs	7. COOPERATING SPONSOR: Centers for Disease Control		☐ DRAFT ☒ ORIGINAL ☐ REVISION NO.

8. NO.	9. DESCRIPTION OF MAJOR ACTIONS OR STEPS	10. PRIMARY ACTION AGENT	11. TARGET DATES: PREPARATORY ACTION	PHYSICAL START	PHYSICAL COMPLETION	12. TIME SPAN (Optional): FY-93	FY-94	FY-95	FY-96	FY-97	FY-
	Cost Recovery (cont.)										
	- Urban Finance (cont.)										
	- Training (cont.)										
	- Accounting training for regional and perfectural hospital	5									
	- Implementation										
	- Implementation of cost recovery in Bangui facilities	5									
	- Drug revolving funds from NPA-like money	5									
	- Expansion of cost recovery to regional and prefectural hospitals	5									
	- C. Community Finance, i.e., in peripheral health centers, sub-centers, and posts										
	- Studies										
	- Cost Studies	5									
	- Marketing Study	5									
	- Village-level structure study	5									
	- Comparison of prospects for private vs. public local pharmaceutical supply	5									
	- Accounting and financial information study (including monitoring)	5									
	- Training										
	- Support to Bamako Initiative- management training in three prefectures	5									
	- Management training for community financing in national program	5									
	- Implementation										
	- Evaluation of Bamako Initiative in 3 prefectures	5									
	- Implementation of national cost recovery program	5									

AID 1020-18(5-67)

JOINT PROJECT IMPLEMENTATION PLAN PART I - WORK SCHEDULE	1. COOPERATING COUNTRY Central African Republic	2. PROJECT TITLE Pilot Demonstration PHC/CS Project	3. PROJECT NUMBER	4. DATE (Month, Day, Year) FY 93
5. RESPONSIBLE PROJECT COORDINATOR AFR/CCWA	6. RESPONSIBLE COOPERATING COUNTRY AGENCY Ministry of Public Health and Social Affairs	7. COOPERATING SPONSOR Africare Inc.		☐ DRAFT ☒ ORIGINAL ☐ REVISION NO.

8. NO.	9. DESCRIPTION OF MAJOR ACTIONS OR STEPS	10. PRIMARY ACTION AGENT	11. TARGET DATES: PREPARATORY ACTION	PHYSICAL START	PHYSICAL COMPLETION	12. TIME SPAN (Optional): FY. 93	FY. 94	FY. 95	FY. 96	FY. 97	FY.
IV	Training										
	Design & Preparation	1/2									
	Training of Personnel/Support Staff	1/2									
	Training of VHW										
V	Procurement of Supplies	1/2									
VI	Service Delivery Initation	1/2									
	Cost Recovery	1/2									
	ORT	1/2									
	E.P.I.	1/2									
	A.R.I.	1/2									
	Malaria	1/2									
	Family Planning/HIV AIDS	1/2									
VII	Technical Assistance										
	HQ/Regional Office	1/2									
	External	1/2									
VIII	Progress	1/2									
	Annual review, reports	1/2									
	Midterm Evaluation	1/2									
	Final Evaluation	1/2									

207

AID 1020-1015 471

JOINT PROJECT IMPLEMENTATION PLAN PART I - WORK SCHEDULE	2. COOPERATING COUNTRY Central African Republic	3. PROJECT TITLE Pilot Demonstration PHC/CS Project	3. PROJECT NUMBER	4. DATE (Month, Day, Year) FY 93
5. RESPONSIBLE PROJECT COORDINATOR AFR/CCWA	6. RESPONSIBLE COOPERATING COUNTRY AGENCY Ministry of Public Health and Social Affairs	7. COOPERATING SPONSOR Africare, Inc.		☐ DRAFT ☒ ORIGINAL ☐ REVISION NO.

8. NO.	9. DESCRIPTION OF MAJOR ACTIONS OR STEPS	10. PRIMARY ACTION AGENT	11. TARGET DATES: PREPARATORY ACTION	PHYSICAL START	PHYSICAL COMPLETION	12. TIME SPAN (Optional): FY. 93	FY. 94	FY. 95	FY. 96	FY. 97	FY.
	Africare Pilot Demonstration - Child Survival	1/2									
I	Personnel in Position	1/2									
	Project Coordinator										
	Co-coordinator										
	Community/Village Health Workers	1/2									
	Support	1/2									
	Other	1/2									
		1/2									
II	Detailed Implementation Plan										
	Design/Planning	1/2									
	Preparation	1/2									
		1/2									
III	A. Health Information System	1/2									
	Assess rural HIS/MIS needs										
	Develop with country staff a plan	1/2									
	Baseline survey of target population	1/2									
	Design preparation										
	Data collection	1/2									
	Data analysis	1/2									
	Dissemination and feedback to community	1/2									
		1/2									
	B. Registration Record System	1/2									
	Design/Preparation	1/2									
	Training of support staff & VHW										
	On going implementation of record system										
	C. Drug Management and Cost Recovery (training, record system...)										

ANNEX L

BIBLIOGRAPHY

A.I.D.: Toward Strategic Management December 1990.

Agence des Etats Unis pour le Developpement International: Repertoire des Institutions de Formation en Afrique Francophone (1985)

Agency for International Development: The Development Fund for Africa Report, 1991

Armstrong, Paul E.: Audit of A.I.D. Assistance to the C.A.R. and Equatorial Guinea (March 6, 1990).

Anderson, James M., U.S.A.I.D.: "Entrepreneurs International reflects the administration's belief that foreign aid focusing on private sector development leads to sustainable economic growth".

Annex A Municipal Development Support Project Logical Franmework.

Annex E Description of the HPN Portfolio of the Bureau for Science and Technology.

Assessment of Program Impact: Review of Health Indicators.

Assessment of Program Impact: Analysis Table.

Assessment of program impact: Objectives, targets, indicators and sources from some african countries.

Bamako Initiative: Progress Report (February 12, 1991).

Banque Mondiale, R.C.A.: Aide-Memoire de la mission d'identification de Projet dans le secteur de la sante (29 Juillet -10 Aout 1989).

Banque Mondiale, R.C.A.: Analyse des contraintes sectorielles et des sources de financement du secteur sante (9 Fevrier, 1989).

Banque Mondiale, R.C.A.: Mission de Preparation d'un projet de reforme du secteur socio-sanitaire (21 Decembre 1989).

Benoit, Ato; Kouagou, Bangassi; Roudouane-Djaras, Ndjikara, et Chachir, Walidou: Rapport d'Evaluation du Projet de Pisciculture Familiale (Bangui/R.C.A., Mai 1991).

Bork, Timothy J.: Early-warning checklist for monitoring project design and implementation (Oct 19, 1990).

Bossert, Thomas J.: Can they get along without us? Sustainability of donor-supported health projects in Central America and Africa.

Bollinger, Walter G.: African training for leadership and advanced skills (July 1990).

Bollinger, Walter G.: The Administrator's Evaluation Initiative (Oct 11, 1990).

Brenzel, Logan: The Costs of EPI: Lessons Learned from Cost and Cost-effectiveness Studies of Immunization Programs, Revised September 1990.

Buy America Initiative Final Implementation Guidance (Dec 1990).

C.A.R.: Sustainable Child Survival and Applied Cost Recovery. Methods for Evaluating STD Programs in the C.A.R.

Centre Inter-Etats d'Enseignement Superieur de Sante Publique d'Afrique Centrale: Enseignement Post-Universitaire en Sante Publique.

Dailly, J.P.: The World Bank/International Finance Corporation, Office Memorandum (March 23, 1991).

David, Joe, Gary, Leinen and Harry, Godfrey, CCCD/RCA et le Personnel du Ministere de la Sante: Examen du Programme CCCD/RCA (27-31 Mai 1985).

Demographic and Health Surveys: Data Quality in DHS-I Surveys (summer 1990).

Direction de la Medecine Preventive: Mise au Point sur l'Etat d'Avancement du PEV a la Deuxieme Reunion du Comite de Coordination (Bangui/R.C.A., 2 Octobre 1990).

Direction des Etudes de Planification et des Statistiques SSIS: Bulletin Annuel d'Information Sanitaire (Annee 1988).

Direction de la Medecine Preventive, R.C.A.: Manuel de Formation en Matiere du Programme Elargi de Vaccination.

Dunlop, David W., U.S.A.I.D. Evaluation Special Study No.8: Toward a Health Project Evaluation Framework (June 1982).

Endsley, Scott, Direction de la Medecine Preventive: Dietary Practices during Diarrhea: A Community Case Control Study (November 1990).

Evaluating U.S.A.I.D. Projects.

Feasibility Study for the Implementation of a System of Household Contribution to Health Financing C.A.R. (Sept 8 - Sept 29, 1986).

Fleming, Harold S.: C.A.R Bamako Initiative (May 9, 1991).

Flipcharts, Atelier sur le Financement des Soins de Sante en Republique Centrafricaine (24-28 Avril, 1989 Bangui R.C.A).

Foltz, Anne-Marie; Harvet, Gutman; Sif, Ericsson and John P., Raleigh, A.I.D.: Final Report: External Evaluation of the Regional core Support Components: ACSI/CCCD-Project No. 698-0421

Forgy, Larry; Keith, McInnes; Steve, Heinig and Brad, Michaels: Costing of the Talloires Child Survival Goals (Septembre 1990).

Grant, James P., UNICEF: La Situation des Enfants dans le Monde 1990.

Gestion des Services de Sante et des Programmes de Population, Centre Africain d'Etudes Superieures en Gestion Dakar.

Health/Population Office: ACSI-CCCD PROJECT C.A.R.: Oyb Transfer for fy 1992 Funding of CDC Field Staff and Technical Assistance (May 13, 1991).

Honnold, Ed.: Statutory Checklists for FY 1991.

Howard, Lee M. MD; Dr PH: An Assessment of Donor Coordination and External Financial Mobilization for Health, Population and Nutrition in Sub-Saharan Africa (Africa Regional IQC PDC--1406-I-7152-00 Delivery Order No.10.

International Applied Health Economics and Finance (July 1 to August 10, 1991) Tulane University.

International Health Programs 1991 Family Health Workshops Santa Cruz, California.

Institution Building as a Guide to Action.

Issues Raised at S&T/Health Program Review (April 10, 1990).

Johnson, Ethna; AF1PH: Central African Republic: Health Sector Mission Back-to-Office Report (January 10, 1991).

Johnson, Ethna: Central African Republic : Health Sector Project-Revised Executive Project Summary (January 30, 1991).

Johnson, Ethna: The World Bank/IFC/M.I.G.A Washington (March 14, 1990).

Jones, Andrea L. : Using a Team Planning Approach to Strengthen the Implementation and Sustainability of Development Efforts. (October 1988 revised)

Langley, Philip; Boniface, Tiotsop et Jean, Gbedo UNICEF Bangui R.C.A.: La Sante a la Portee de la Femme et de l'Enfant: Experience en Soins de Sante Primaires et Propositions pour l'Initiative de Bamako en R.C.A. (Revision Nov.1989).

Langley, Philip; Boniface, Tiotsope et Gbedo Jean, UNICEF Bangui R.C.A.: La Sante a la Portee de la Femme et de l'Enfant: Experience en SSP et Propositions pour l'Initiative de Bamako en R.C.A. (Juin 1989).

Leighthon, Charlotte; Trip Report: Plan for Health Financing Workshop Central African Republic (August 20-27, 1988 Anglais/Francais).

Leighton, Charlotte: Rapport Interimaire sur les Analyses du Financement des Soins de Sante et Recouvrement des Couts (1er Mars 1990) Ministere de la Sante Publique R.C.A.

Leighton, Charlotte: Scope of Work for a Health Financing Advisor in the C.A.R. (March 7, 1990).

Lentz, Benjamine; Joseph Danga (Africare): Preliminary Agricultural Production Study 14 May to 8 June, 1989 for the Four Sous-Prefectures : Bossangoa, Bouca, Bozoum, and Paoua of Ouham and Ouham-Pende Economic Region, R.C.A. December 1989.

Lombilo, Genevieve; Ministere de la Sante Publique: Briefing des Partenaires du MSPAS sur l'Elaboration du Projet du Plan National de Developpement Sanitaire (1991-1995).

Lombilo, Genevieve; Ministere de la Sante Publique: Plan d'Eradication de la Poliomyelite Phase Preliminaire (Document Provisoire Janvier 1991).

Makinen, Marty; Donald, Grayhill and Allison, Percy: Compte Rendu de l'Atelier Portant sur le Financement du Secteur Sante en R.C.A. du 24 au 28 Avril 1989.

Makinen, Marty; Donald, Graybill and Allison, Percy: Proceedings from the Workshop on Health Care Financing in the Central African Republic (April 24-28, 1989).

Marsden, Keith: African Entrepreneurs, Pioneers of Development (Sept 1990).

Martin, Ray: Report on International Workshop on Public Health Training in the Africa Region, Brazzaville, June 18-21, 1990.

McDavid, Bess: Training News Update.

McFarland, Deborah A.: Status Report on Health Financing Activities in CCCD (Dec 12, 1989).

Ministere de l'Economie des Finances du Plan et de la Cooperation Internationale R.C.A.: Rapport de Presentation du Programme triennal d'Investissement 1990-1992 (Mars 1990).

Ministere de la Sante Publique R.C.A.: Micro-Plan de Developpement Socio-Sanitaire de la Prefecture de Kemo.

Ministere de la Sante Publique, R.C.A.: Extrait Document Projet Renforcement Institutionnel du MSPAS et Etude du Sous-Secteur Pharmaceutique.

Ministere de la Sante Publique, R.C.A.: Politique Sanitaire de la Republique Centrafricaine 1992-1996 (Janvier 1991).

Ministere de la Sante Publique, R.C.A.: Micro-Plan-Regional des Soins de Sante Primaires de la Region Sanitaire No.3 (Sept 1990).

Ministere de la Sante Publique, R.C.A.: Micro-Plan Prefectoral des Soins de Sante Primaires de l'Ouham (Aout 1990).

Ministere de la Sante Publique: Renforcement Institutionnel du MSPAS et Etude du Secteur Pharmaceutique.

Ministere de la Sante Publique: Programme Cadre pour l'Acceleration de la mise en Oeuvre des Soins de Sante Primaires en Republique Centrafricaine.

Ministere de la Sante Publique, R.C.A.: Plan Regional de Developpement de Soins de Sante Primaires dans la Region Sanitaire No.3 (sept 1990).

Ministere de la Sante Publique, R.C.A.: Plan de Developpement des Soins de Sante Primaires dans la Region Sanitaire No.5 (Sept 1990).

Ministere de la Sante Publique, R.C.A.: Plan de Developpement des Soins de Sante Primaires dans la Region Sanitaire No.1 (Sept 1990).

Ministere de la Sante Publique, R.C.A.: Plan de Developpement des Soins de Sante Primaires dans la Region Sanitaire No.4 (Septembre 1990).

Ministere de la Sante Publique, R.C.A.: DMPGE-ECHO Bulletin Trimestriel d'Information Sanitaire No.1 (Decembre 1989).

Ministere de la Sante Publique, R.C.A.: Enquete sur l'Etat Nutritionnel des Enfants de 0 a 5 ans a Bangui en 1990 (Oct 1990).

Ministere de la Sante Publique: L'Experience de la R.C.A. en Planification et Management des Soins de Sante Primaires.

Ministere de la Sante Publique: Document de Travail Politique Sanitaire de la R.C.A., 1992-1996 (Novembre 1990).

Ministere de la Sante Publique: Objectifs, Indicateurs et Strategies Operationnelles des Programmes Socio-Sanitaires Prioritaires, 1992-1996 (Novembre 1990).

Ministere de la Sante Publique: Fiches des Programmes Prioritaires du Plan de Developpement Sanitaire de la RCA 1992-1996 (Decembre 1990).

Ministere de la Sante Publique: L'Experience de la R.C.A. en Planification et Management des Soins de Sante Primaires (Aout 1990).

Ministere de la Sante Publique: Projet de Politique Sanitaire de la R.C.A. 1992-1996 (1er Fevrier 1991).

Ministere de la Sante Publique/Direction de la Medecine Preventive et de Lutte contre les Grandes Endemies: Seminaires de Formation des Agents de Sante en matiere de P.E.V. en Regions Sanitaires (R.C.A.).

Ministere de la Sante Publique, R.C.A.: Reprogrammation du Plan a moyen terme de Lutte contre le SIDA pour la periode 1991-1992 (Document provisoire 2eme version Dec 1990).

Ministere de la Sante Publique/DMPGE R.C.A.: DMPGE-ECHO Bulletin Trimestriel d'Information Sanitaire (No.3 Nov 1990).

Ministere de la Sante Publique/DMPGE R.C.A.: Enquete Nationale de Couverture Vaccinale (Janvier-Fevrier 1989).

Ministere de la Sante Publique, R.C.A.: Symposium National des Medecins sur la Therapie de Rehydratation Orale (31 Aout 1989).

Ministere de la Sante Publique, R.C.A.: Micro-Plan Prefectoral des Soins de Sante Primaires de la Nana-Grebizi (Sept 1990).

Ministere de la Sante Publique, R.C.A.: Plan Regional des Soins de Sante Primaires de la Region Sanitaire No.2 Berberati (Sept 1990).

Ministere de la Sante Publique, R.C.A.: Micro-Plan Prefectoral des Soins de Sante Primaires de la Nana-Mambere (Sept 1990).

Ministere de la Sante Publique, R.C.A.: Micro-Plan de Developpement Socio-Sanitaire de la Prefecture de la Lobaye.

Ministere de la Sante Publique, R.C.A.: Plan National de Developpement Sanitaire 1992-1996 (Mai 1991).

Montgomery, Katherine: Annual Report C.A.R, CCCD-Project/USAID 1986.

Montgomery, Katherine: Monthly Report March/April- CCCD-Project (May 6, 1987).

Montgomery, Katherine: Quarterly Financial Report of Local Currency Account (May 5, 1987).

Montgomery, Katherine: CCCD-Project Budget (May 7, 1987).

Naimoli, Joseph F.: Annual Report 1989, ACSI-CCCD Project C.A.R.

Naimoli, Joseph F.: 1988 Annual Report, Appendix:Support Strategies, ACSI-CCCD Project C.A.R.

Naimoli, Joseph F. and Montgomery Katherine: Annual Report 1987, African Child Survival Initiative To CCCD C.A.R.

NASPAA: Country Training Plan, C.A.R. (March 1988).

Palein, Michel: Suivi de la Preparation d'un Projet de Sante en vue d'un Financement eventuel de l'IDA.

Politique Sectorielle: Proposition de Presentation du Document.

Ponto, Matilde and Dr. Gerald Rosenthal: Guidelines for Identifying and Implementing Health Care Financing Activities (November 1989).

Processus de Formulation du Plan National, des Programmes Prioritaires et des Mesures d'accompagnement.

Pragma Corporation: Family Health Initiatives II Management Assessment, conducted for: AID/AFR/TR/HPN (March 1990).

Programme de Renforcement Institutionnel et de Restructuration des Services Centraux, Intermediaires et Peripheriques.

Presidence of the Republic: To fix General Principles Related to Public Health in the C.A.R.

Presidence de la Republique Centrafricaine: Loi No. fixant les Principes Generaux Relatifs a la Sante Publique en R.C.A.

Proposed USAID HIV/STD Support at the Regional and Prefectoral Level in C.A.R.

PSI: Unsolicited Proposal to the U.S.A.I.D./C.A.R. Condom Social Marketing for AIDS-Prevention (April 17, 1991).

R.C.A.: Problemes Socio-Sanitaires Prioritaires et Contraintes du Secteur Sante.

R.C.A.: Propositions pour le Financement des Activites Preparatoires de la mise en Oeuvre de l'Initiative de Bamako (Octobre 1990).

R.C.A.: Politique de Financement et Prestations des Soins en R.C.A.

R.C.A.: Manuel de Formation en Matiere du Programme Elargi de Vaccination (DMPGE, Fevrier 1989).

R.C.A.: Programme de Cooperation Gouvernement RCA/UNICEF, Plan d'Action 1991 (Janvier 1991).

R.C.A.: Plan d'Action 1989 Securite Alimentaire/Nutrition Conseil d'Administration 1988 (Bangui, Novembre 1987).

Revue des Programmes PEV/SMI en R.C.A. (Avril-May 1991).

Second External Evaluation of the ACSI-CCCD Project, the C.A.R.

Sencer, Dave: 2nd Meeting on Child Survival in Africa (March 27, 1989).

Setzer, James C., MarciaR., Weaver: Trip Report the Central African Republic (5-18 November 1990).

Setzer, James C., and Marcia R., Weaver: Assessment Report the Central African Republic (January 15, 1991)

Sobela, Francois Directeur General de la Sante Publique: Documents de Travail de la Reunion de Briefing/Atelier sur le Projet de Politique de Developpement Sanitaire de la Republque Centrafricaine (1992-1996).

Solloway & Associates: Lessons Learned from Review of Africa Bureau Evaluations 1987-1989.

Steen, Richard and Karen Hawkins-Reed: Africa Child Survival Initiative CCCD Project, 1990 Annual Report C.A.R.

S&T/Health: Directory 1990.

Stephens, Dorothy : Comments on PSI 5/13/91

Sullivan, Louis W. and Ronald W., Roskens: A Report to the President Child Survival and AIDS in Sub-Saharan Africa : Findings and Recommendations of the Presidential Mission to Africa (January 4-18, 1991).

Trebucq A.; Barriere L.; Zitsamele-Cody R.; Wayawo, Etard J.F.; Salah; Kiteze; Louis, J.P.; et Roungou: Rapport sur l'Enquete de Couverture Vaccinale Realisee en Fevrier 1991 en R.C.A. (Mars 1991) OCEAC.

UNICEF: Bamako Initiative Introduction.

UNICEF, R.C.A.: Programme de Cooperation R.C.A. - UNICEF (1989-1993) Revue a mi-Parcours. Programme Hydraulique Villageoise et Assainissement (Y W 908) Avril 1991.

University of Connecticut: 1991 Management Workshops in French, the Division of International Affairs and Center for International Community Health Studies.

United States Agency for International Development (U.S.A.I.D.): Africa Child Survival Initiative, Combatting Childhood Communicable Diseases 1988-1989 Bilingual Annual Report.

U.S.A.I.D.: Child Survival A Fifth Report to Congress on the USAID Program.

U.S.A.I.D.: Handbook 3; September 30, 1982.

U.S.A.I.D.: African Manpower Development - Phase II.

U.S.A.I.D.: Programming Options and Management Plan.

U.S.A.I.D.: Policy Guidance on AIDS.

U.S.A.I.D.: Programming Options and Management Plan.

U.S.A.I.D./C.A.R.: Sustainable Child Survival and Applied Cost Recovery Project (4-12-91).

U.S.A.I.D.: Office of International Training 1989

Vogel, Ronald J.: Cost Recovery in the Health Care Sector, Selected Country Studies in West Africa.

Walter G., Bollinger A.I.D.: Guidance for Country Program Strategy Design.

Waty, Marie Odile: Analyse du Systeme de Recouvrement des Couts, Programme National PEV/SSP/ME Republique de Guinee (Rapport d'une Mission OMS, Mars 1989).

Way, Peter O. and Karen, Stanecki: How Bad Will It Be? Modelling the AIDS Epidemic in Eastern Africa (February 14-19, 1991).

Wazoua, D. Ministere de l'Economie, des Finances, du Plan et de la Cooperation Internationale: Rapport de Presentation de la Loi de Finances pour 1990, R.C.A.

Weaver, Maria; Holly, Wong; Amadou, Sekou; Robert, Simon and Felix, Lee: Reform of Hospital Fees in Developing Countries (August 17, 1990).

Westinghouse: External Evaluation Report of African Child Survival/CCCD Project in C.A.R. (Nov 7, 1986).

ANNEX M

U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

MAR 10 1992

ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR FOR AFRICA

FROM: AAA/AFR/DP, Margaret P. Bonner

SUBJECT: Africa Bureau Small Country Program Strategy

Problem: You are asked to approve the attached Africa Bureau Small Country Program Strategy, as well as a series of recommendations concerning individual small country programs.

Background: The Africa Bureau Small Country Program Strategy presents a framework for accommodating U.S. interest in maintaining a development presence in countries which are of lower A.I.D. priority. It does not affect all small country programs, but only those where the Africa Bureau cannot sustain a minimum commitment of staff and resources. It explicitly recognizes that A.I.D. has limited staff resources to maintain a physical presence, yet addresses A.I.D.'s need to preserve an acceptable level of accountability without resident direct hire staff.

The strategy is based on the Africa Bureau's goal under the Development Fund for Africa of achieving development impact by concentrating resources in a limited number of priority countries. It is also meant to reduce A.I.D. vulnerability to management and accountability weaknesses in small country programs by creating a uniform, well-focused and efficient program and management framework. In addition, it responds to Congressional interest, reflected in the FY 1992 House Appropriations Committee report, in limiting the number of African countries with bilateral programs.

After holding a series of meetings and reviewing several papers in which Bureau-wide and country-specific concerns were fully vetted, Africa Bureau staff developed the attached Small Country Program Strategy and other specific recommendations concerning the A.I.D. programs in fourteen small countries.

Discussion:

Under the proposed Africa Bureau Small Country Program Strategy, U.S. assistance to indicated countries will be limited to two program types: (1) a core program and (2) a core-plus-one program, both of which entail minimal or no resident direct hire field staff.

320 TWENTY-FIRST STREET, N.W., WASHINGTON, D.C. 20523

218

As discussed in greater detail in the attached strategy paper, the core program includes five program options: Peace Corps Small Project Assistance (SPA), the Ambassador's Special Self-Help Fund, centrally funded/contracted short-term democracy, governance and human rights activities (Sec. 116e), training through the regional African Training for Leadership and Skills (ATLAS) project, and P.L. 480 emergency/humanitarian food aid (with no monetization). Countries with core programs will have no other regionally or centrally-funded activities. Core program options will be available for all small countries, including those with on-going A.I.D. programs and those where an A.I.D. program is being re-established after a hiatus. The number of these activities in any one country will be kept to a minimum and kept constant or reduced over time.

The core-plus-one program consists of a single grant in a single sector which will be added to the core program where additional assistance is deemed appropriate. Priority will be given to that sector for any training carried out under the core program. Any regional or centrally-funded project activities will be subject to review and approval of the management units indicated below and must be in the main sector of focus. Exceptions will be considered only on a case-by-case basis.

For each program, clear management and implementation responsibility lines will be drawn and agreed upon by the appropriate parties in advance. Decisions on program activities are the responsibility of the appropriate Africa Bureau geographic office directors. In most instances, primary management responsibility for these activities will be housed in the A.I.D./Washington geographic office, unless specifically delegated to a REDSO. Supplementary management/implementation responsibility may be housed in other A.I.D./Washington offices as appropriate (e.g., AFR/ONI, FHA/FFP). Responsibility for controller and financial management functions will be housed in A.I.D./W or in a REDSO, as agreed upon in advance. In the field, the Embassy, the Peace Corps and other non-A.I.D. entities will be responsible for implementing the activities.

The following are country-specific recommendations and their associated management units based on current plans. Programs could change slightly if circumstances warrant, such as the inclusion of short-term democracy/governance and human rights (Sec. 116e) activities as appropriate.

A. Core Programs

1. **Comoros:** U.S. assistance to Comoros will be conducted as a core program consisting of Special Self-Help and training under the ATLAS project, with management responsibility delegated from AFR/EA to REDSO/ESA. The transition to a core program will be completed when the ongoing bilateral project ends in 8/94.

2. **Equatorial Guinea:** By February 1992, U.S. assistance to Equatorial Guinea will consist of a core program, with program authority and management by AFR/CCWA. Core activities will be limited to Special Self-Help, ATLAS training and Peace Corps SPA support.

B. **Core-Plus-One Programs**

1. **Central African Republic:** By October 1992, the A.I.D. program in Central African Republic will consist of a core program plus one grant activity authorized and managed by AFR/CCWA and focused on health. Core program activities will include Peace Corps SPA support, ATLAS training, Special Self-Help, and short-term democracy, governance and human rights activities.

2. **Congo:** By October 1992, the A.I.D. program in the Congo will consist of a core program plus one ongoing grant activity focused on forest conservation and natural resources management. Program authority and management will be the responsibility of AFR/CCWA. Core program activities will include Peace Corps SPA support, ATLAS training, Special Self-Help, and short-term democracy, governance and human rights activities.

3. **Mauritius:** The current A.I.D. program in Mauritius, management of which is delegated to REDSO/ESA by AFR/EA, falls within the scope of the core-plus-one program, with Special Self-Help and human rights assistance and a project focused on training for industrial diversification which will end in 1996. ATLAS training will complement the bilateral project.

4. **Sao Tome and Principe:** By July 1992, A.I.D. assistance to Sao Tome and Principe will consist of a core program plus one grant activity authorized and managed by AFR/CCWA. All activities will focus on agriculture. The core program will include training under ATLAS and Special Self-Help assistance.

5. **Sierra Leone:** By July 1992, A.I.D. assistance to Sierra Leone will consist of a core program plus one grant activity focused on enterprise development. The program will be authorized and managed by AFR/CCWA. The core program will include ATLAS training, Special Self-Help and a PVO-implemented Title II humanitarian assistance program.

C. **Other Small Programs**

1. **Seychelles and Djibouti:** A.I.D. assistance in these two countries is limited to ESF-funded budget support, with management delegated to REDSO/ESA by AFR/EA. As these programs are essentially political rather than

developmental in nature, they are not appropriate candidates for DFA funding and assistance under the Small Country Program Strategy, with the possible exception of future human rights (Sec. 116e) assistance. They may, however, participate in the ATLAS project, which will need to be amended so that these countries can buy into the project within their ESF budgets.

2. **Botswana, Lesotho and Swaziland:** While the Small Country Program Strategy is not an appropriate framework for assistance to these countries, it has become clear that their very different circumstances require a new and innovative assistance strategy for the future. Over the next two years, transition plans will be developed for these three countries to describe a transition from the current A.I.D. program to a new type of assistance relationship which is less management-intensive. A timetable for these transitions will also be included.

3. **Gabon and Mauritania:** A.I.D. assistance to these countries, either bilateral or centrally-funded, is limited to Special Self-Help programs, managed by the Embassies with accounting support from REDSO/WCA.

Recommendation One: That you approve the attached Small Country Program Strategy.

Approved SMS

Disapproved _____

Date 3-10-92

Recommendation Two: That you approve the country-specific recommendations, including (1) a core program only for Equatorial Guinea and Comoros, the former to be managed by AFR/CCWA and the latter by REDSO/ESA; (2) sector-focused core-plus-one programs for Congo, Central African Republic, Sierra Leone, Sao Tome and Principe to be managed by AFR/CCWA, and for Mauritius, to be managed by REDSO/ESA; (3) ESF-funded training for Seychelles and Djibouti; (4) programs limited to Special Self-Help for Gabon and Mauritania; and (5) the development of appropriate transition

plans and timetables for Botswana, Lesotho and Swaziland. The number of activities in each of these programs will be kept to a minimum and kept constant or reduced over time.

Approved 8M8

Disapproved _____

Date 3-10-92

SGrossman:AFR/DP/PAB:3/6/92:SMCNTRY
with input from RHellyer:AFR/CCWA

Clearances:

LStamberg, AFR/DP (draft)
JGovan, AFR/DP
Keith Brown, AFR/SA (draft)
WWeinstein, AFR/ONI (draft)
BKline, AFR/MRP (draft)
RCobb, DAA/AFR 3/10/92
JHicks, DAA/AFR (draft)
LRogers, OPS (draft)
RMaushammer, POL (draft)
ESpriggs, GC/AFR (draft)
✓ ARosenberg, AF/EPS

TBork, AFR/SWA (draft)
JWolgin,AFR/ARTS (draft)
CRozell, AFR/CCWA
MGolden, AFR/CCWA
DLundberg, AFR/EA
LDean, AFR/SA (draft)
FFischer, REDSO/ESA (draft)
FGilbert, REDSO, WCA (draft)

AFRICA BUREAU SMALL COUNTRY STRATEGY

BACKGROUND

Over the past several years, the Africa Bureau has been attempting to accommodate two paradoxical trends in the foreign assistance program. On the one hand are pressures to condense our programs due to dwindling management resources, Congressional and Agency exhortations to concentrate funds in a smaller number of countries, accountability concerns and external challenges to the efficacy of our programs. On the other hand are the pressures to expand our efforts in response to an increase in program resources for Africa, the great needs of the people of Africa, interest in maintaining a U.S. presence in as many countries as possible and the numerous special interests we have had to accommodate.

In part, the Africa Bureau has responded to these trends by devising a new way of doing business under the Development Fund for Africa (DFA). To use our resources more efficiently, we enumerated four strategic objectives to which our country program activities are geared. We plan to achieve and demonstrate results by concentrating resources in a limited number of priority countries that are most likely to use them effectively. Further, within each country, we are focusing on achieving a limited set of objectives which support the overall strategic objectives. In addition, to enhance accountability and better focus our programs, we have initiated new monitoring, evaluation and reporting systems which are beginning to bear fruit.

Despite this, the results of our efforts to concentrate resources have been inadequate. A recent Congressional staff report reveals that since the creation of the DFA, the number of African countries receiving some form of development aid from the United States has increased, and the degree to which A.I.D. concentrates development funds in Africa has declined. This is not surprising in view of the pressures to respond to important new priorities, such as the emerging democracies in Benin, Namibia, Ethiopia and Angola. However, if we are to be able to meet priority ongoing and new program requirements, we must find a way to use our management resources even more efficiently.

After holding a series of meetings and reviewing several papers in which Bureau-wide and country-specific concerns were fully vetted, the Africa Bureau has approved a strategy for small country programs which will enable us to further concentrate resources in priority countries, yet satisfy overall foreign policy requirements.

PRINCIPLES OF THE SMALL COUNTRY PROGRAM STRATEGY

The Africa Bureau's Small Country Program Strategy was designed for countries of lower A.I.D. priority. It does not affect all small country programs, but only those where the Africa Bureau cannot sustain a minimum commitment of staff and resources. It can be used for countries with ongoing A.I.D. programs where the Bureau has made a conscious decision to restrict assistance, as well as for countries where renewed assistance is proposed after a hiatus in the A.I.D. program.

Under the Africa Bureau's Small Country Strategy, the overall management of U.S. assistance activities is the responsibility of the appropriate geographic office in A.I.D./Washington, unless specifically delegated to REDSO, with other A.I.D/Washington, U.S. government and private entities having implementation responsibility as agreed. Unless specifically delegated to REDSO, there is no field management of programs beyond possible REDSO responsibility for controller and financial management functions, as appropriate. To the extent possible, programs are be implemented by a PVO, NGO or other non-A.I.D. entity, with assistance preferably provided on a grant (OPG) basis, rather than a contract.

PROGRAM ELEMENTS UNDER THE SMALL COUNTRY PROGRAM STRATEGY

Core Program

All country programs governed by this strategy have the option of including one or more of the following core program elements: Peace Corps Small Project Assistance (SPA), the Ambassador's Special Self-Help Fund, centrally-funded/contracted short-term democracy, governance and human rights activities, training and P.L. 480 Title II emergency/humanitarian program (with no monetization) as necessary. The number of activities will be kept to a minimum and kept constant or reduced over time. **In each case, clear management and implementation responsibility lines are drawn and agreed upon by the appropriate parties in advance.** For example, a P.L. 480 emergency/humanitarian program is likely to be implemented by a PVO and managed by the Food and Humanitarian Assistance Bureau in A.I.D./W, with concomitant responsibilities housed in the A.I.D./W geographic and financial management offices and/or the Regional Economic Development Services Offices (REDSO). A short-term democracy activity is likely to be implemented by an NGO and managed by the Embassy, with concomitant responsibilities housed in the A.I.D./W geographic office and the financial management office (FA/FM) and/or REDSO. Training will be conducted through the regional Africa Training for Leadership and Skills (ATLAS) project, which is implemented by a contractor and managed by the Africa Bureau Office of Operations and New Initiatives. Mission program authorities rest with the delegated geographic office or REDSO.

Core-Plus-One Program

The core-plus-one program provides the option to add one more program element to certain core programs - a **single** bilateral activity, preferably a grant, in a **single** sector. Training conducted under the core program can either be an integral part of this activity or done through the ATLAS project. Priority will be given to the focus sector for any training carried out. Centrally-funded activities (through A.I.D. central bureaus and Africa Regional projects) will be limited to the focus sector and must be explicitly approved by the responsible Bureau management unit. Other activities will be considered only on an exceptional basis.

Re-entry Program

Normally, where an A.I.D. program is being re-established after a hiatus in a country of lesser development priority where there is U.S. interest, the first option is a core program. A core-plus-one program will be considered as a second option only where justified and where the Bureau has the management capacity to undertake this increased responsibility.

IMPLICATIONS FOR A.I.D.

Implementation of this small country strategy is expected to result in reduced field management time associated with these programs over the long term, thus permitting the Africa Bureau to further concentrate its management resources on higher priority activities. For example, in FY 90, the missions in Zaire and Cameroon and REDSO/WCA dedicated about 5.53 FTEs to the implementation of the programs in Equatorial Guinea, Central African Republic, Congo, Sao Tome and Principe and Sierra Leone. These field staff resources will be able to be redirected once the transition period is over. In contrast, the management of these programs from A.I.D./W is expected to take approximately 2.5 FTEs, resulting in an overall savings of over 3.0 FTEs.

This strategy is also meant to reduce A.I.D. vulnerability to management and accountability weaknesses in small country programs as illustrated in a March 1990 RIG/A/Dakar audit report concerning Central African Republic and Equatorial Guinea by creating a uniform, well-focused and efficient program and management framework. The small country strategy also responds to Congressional interest, reflected in the FY 1992 House Appropriations Committee report, in limiting the number of African countries with bilateral programs.

The Small Country Program strategy is based on the premise that a minimum set of field activities will be responsibly managed and overseen from A.I.D./Washington or from REDSO if specifically delegated. It assumes that the Africa Bureau and the Research and Development Bureau will cooperate in limiting and eliminating centrally-funded activities in these countries.

It also assumes the full cooperation of the A.I.D. financial management office and the REDSO accounting stations, both of which have been assured. Another important requirement to the success of this stragegy is sufficient operating expenses to fund travel so that project managers are able to monitor these activities.

For the near term, it is not likely that there will be a decrease in overall staff time allotted to managing these programs. Rather, there is likely to be an increase in controller and project management time as funds are deobligated and projects and accounts are closed. In the long term, however, this strategy presents the best opportunity for the Africa Bureau to reconcile the conflicting trends in the foreign assistance program and to fulfill the objectives of the DFA.

SGrossman:AFR/DP/PAB:3/6/92:SMCNTRY
with input from RHellyer, AFR/CCWA

Clearances:

LStamberg, AFR/DP (draft)
JGovan, AFR/DP
MBonner, AFR/DP
CRozell, AFR/CCWA
MGolden, AFR/CCWA
DLundberg, AFR/EA
LDean, AFR/SA (draft)
FFischer, REDSO/ESA (draft)
LRogers, OPS (draft)
RMaushammer, POL (draft)
ESpriggs, GC/AFR (draft)
ARosenberg, AF/EPS

TBork, AFR/SWA (draft)
JWolgin,AFR/ARTS (draft)
Keith Brown, AFR/SA (draft)
WWeinstein, AFR/ONI (draft)
BKline, AFR/MRP (draft)
RCobb, DAA/AFR, 3/10/92
JHicks, DAA/AFR (draft)
FGilbert, REDSO, WCA (draft)