

PROJECT DATA SHEET

1. TRANSACTION CODE

C A = Add
C = Change
D = Delete

Amendment Number
3

DOCUMENT CODE
3

2. COUNTRY/ENTITY
Africa Regional

3. PROJECT NUMBER
698-0421 & 625-0963

4. BUREAU/OFFICE
AFR 06

5. PROJECT TITLE (maximum 40 characters)
Africa Child Survival Initiative -
Combatting Childhood Comm. Diseases

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)
MM DD YY
09 30 91

7. ESTIMATED DATE OF OBLIGATION
(Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY 79 B. Quarter 3 C. Final FY 91

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

A. FUNDING SOURCE	FIRST FY 86			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	500	-	500	89,000	-	89,000
(Grant)	(500)	(-)	(500)	(89,000)	(-)	(89,000)
(Loan)	()	()	()	()	()	()
Other U.S.						
1. Host Country				40,000	150,000	190,000
2. Other Donor(s)				225,000	45,000	270,000
TOTALS	500	-	500	354,000	195,000	549,000

9. SCHEDULE OF AID FUNDING (\$000)

A. APPRO. PRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) HEA	539	500		30,455	-	28,000	-	74,473	
(2) SDA	539	500		527				527	
(3) CSP						14,000		14,000	
(4)									
TOTALS				30,982		42,000		89,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)
514 589

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)
A. Code R/H B. Amount 89,000

13. PROJECT PURPOSE (maximum 480 characters)
Strengthen the African's ability to control: six childhood communicable diseases (measles, polio, tuberculosis, diphtheria, pertusis (whooping cough) and tetanus through the Expanded Program for Immunization (EPI)); provide simple treatment for diarrhea through the Control of Diarrhea Disease program and provide anti-malarial treatment for fevers in children ages 0-5.
APP/CONT: T Rattan *TR*

14. SCHEDULED EVALUATIONS
Interim MM YY MM YY Final MM YY
0 1 3 8 0 1 9 0 0 6 9 1

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

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ___ page PP Amendment.)
The amendment extends the project by two years and provides additional funds required to finance the extension and expand the number of countries to be assisted by up to 14. Also, the Child Survival Fund account is being authorized at \$14,000.00.

17. APPROVED BY
Signature: Keith W. Sherper
Title: Director, AFR/TR
Date Signed: MM DD YY 07 30 86

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM DD YY 07 30 86

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

8/14/86

THIRD AMENDMENT
TO PROJECT AUTHORIZATION

Entities: Africa Regional
Sahel Regional

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

Project Numbers: 698-0421
625-0967

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, the Combatting Childhood Communicable Diseases Project for Africa was authorized on September 28, 1981 and was amended on August 2, 1982 and July 16, 1984. I hereby further amend the project authorization as follows:

a. The name of the project is changed to "Africa Child Survival Initiative - Combatting Childhood Communicable Diseases."

b. Paragraph 1 is amended by deleting "Sections 104 and 121" and substituting "Sections 104, 104(c)(2)B and 121" and by substituting "\$89,000,000" for "\$47,000,000" both times the latter appears. Funding authorized under the project will be charged to the cited appropriation accounts as follows:

Section 104:	\$74,473,000
Section 121:	\$ 527,000
Section 104(c)(2)B:	\$14,000,000

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

Date: Aug 13, 1986

Samuel Brown
Administrator

Clearances: As shown on the action memorandum

1757H

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

AUG 4 1986

ASSISTANT
ADMINISTRATOR

AUG 12 4 23 PM '86
ACTION MEMORANDUM FOR THE ADMINISTRATOR

THRU: A-AA/PPC, Martin V. Dagata *M. V. Dagata*
FROM: A-AA/AFR, Alexander R. Love *Alexander R. Love*

SUBJECT: Africa Child Survival Initiative - Combatting
Childhood Communicable Diseases (CCCD) project (698-0421)
Project Authorization Amendment

Problem:

You are requested to authorize an amendment to the CCCD Child Survival project to:

(A) increase the funding level from 47 million dollars to 89 million dollars for a net increase of 42 million dollars, of which 28 million dollars will be provided from the FAA Section 104 health account and 14 million dollars from the child survival account, and

(B) extend the PACD of the project by 2 years from September 30, 1989 to September 30, 1991 for a total term of 12 years, 5 months. An extension of the term beyond ten years requires the Administrator's approval.

Background:

The planning phase of the project was initiated on May 3, 1979. On Sept. 28, 1981, you approved the Combatting Childhood Communicable Diseases Child Survival project with a life of project funding of \$47,000,000. The project authorization has been amended twice since that time. The first amendment was on Dec. 19, 1983 in order to extend by one year the mandatory evaluation clause contained in paragraph 7 of the project authorization. The second amendment was on July 16, 1984 for the purpose of authorizing the use of Sahel Development Program funds by the CCCD project.

The CCCD Child Survival project is entirely a child survival activity. Implementation has been highly successful during the first 56 months of the project. After some initial delays in reaching agreement with WHO/AFRO, regional components of the project are now underway. Country specific activities are operational in 12 African countries. The country-specific activities have resulted in an average annual increase in immunization coverage of 24% while ORT use in clinics has risen from less than 20% of clinics utilizing ORT to more than 60% in those countries covered by the CCCD Child Survival project. Use of ORT for cases of acute dehydration has increased to approximately 35%.

611960

Discussion:

This amendment will provide an additional \$42,000,000 to extend the project from FY 1989 to FY 1991 and expand to \$89,000,000 the U.S. support to a multi-donor effort to improve child survival activities in sub-Saharan Africa. The multi-donor Child Survival program in Africa now has coverage in virtually all countries, however in some it does not have both immunization and ORT services.

Besides the U.S., major donors are UNICEF, WHO and Italy; the U.K., France, Canada and Germany also provide less assistance. The centerpiece of U.S. support is A.I.D.'s Combatting Childhood Communicable Diseases (CCCD) Child Survival project currently active in twelve countries, with planned expansion to two more. The CCCD Child Survival effort focuses on immunization, ORT and malaria treatment along with lesser emphasis on child spacing and nutrition. This project, taken together with other AID bilateral and central activities, assists child survival to some degree in 23 countries. UNICEF is working in 43 sub-Saharan African countries.

The multi-donor child survival effort has a target population ultimately encompassing all of sub-Saharan Africa. The specific target groups are pregnant women, infants and children under the age of five years.

The purpose of the CCCD Child Survival Project is to increase the ability of African governments to:

- control measles, polio, tuberculosis, diphtheria, pertussis and tetanus (through enhancing their capacities to develop and administer immunization programs)
- provide simple and effective treatment for the control of diarrheal disease and
- provide simple and effective treatment of fevers for malaria and antimalarial chemoprophylaxis for pregnant women.

The CCCD Child Survival will:

A) increase immunization coverage to 80% in the 14 countries which receive AID support under the project and, through the regional support component of the project together with the assistance of other bilateral and multilateral donors, assist other African countries achieve comparable levels of immunization coverage;

B) increase to 60% the coverage of treatment of acute diarrheal disease and treatment of fevers for malaria in the 14 countries which receive AID support under this project;

C) through the regional support component of the project, increase to comparable levels ORT coverage in 4 other countries receiving A.I.D. bilateral support and one country receiving ORT support from British ODA.

At the current time the average immunization coverage level in Africa is about 35% of children having received measles immunization by age 2, and the average utilization of ORT is about 20%. These rates are up considerably from the 5-10% level experienced at the beginning of the project. By the end of the project, it is expected that average infant mortality rates will decrease to 90/1000 live births from the current average levels of 120/1000 live births.

The Africa Bureau rationale for extending through FY 91 and providing \$42 million in additional funds to the CCCD Child Survival project are:

A) successful implementation experience during the first 56 months of the project which provides confidence the expanded objectives can be met;

B) Congressional guidance to the Agency regarding plans for assisting governments receiving development assistance to attain 80% immunization coverage by December 31, 1990 and the Agency's Child Survival Strategy which accords high priority to programs which promote immunizations and ORT on a nationwide scale; and

C) favorable evaluations, audits and reviews that indicate the project is on track and performing well. Project evaluations in 1985 and 1986 recommended extension and expansion of the project.

The CCCD Child Survival project is structured to mandate participating countries to assume increasing responsibility for project costs throughout the life of the project. Given the present African economic situation, participating countries have not been able to assume all the financial obligations required by the project. However, studies indicate that program costs can be recovered and sustained by participating African governments. Project-initiated activities will be monitored after the project completion date to evaluate success and sustainability.

This amendment will provide:

\$11.6 million	to carry project activities to September 30, 1989 in 12 countries
\$13.3 million	to extend LOP two years for 12 countries
\$ 1.8 million	to strengthen health education and nutrition-related ORT activities
\$14.3 million	to add a 13th country (Nigeria)
\$ 1.0 million	to support to WHO/AFRO for African Immunization Year

TOTAL: \$42 million

Illustrative Financial Summary:

<u>Regional Support Activities</u>	LOP Funding
Project design	.7
Technical assistance and supervision	22.9
Training	7.8
Health information systems	1.9
Operations research	1.0
<u>Country Specific Activities</u>	
Technical assistance	26.6
Commodities and Local Costs	25.3
<u>Evaluation</u>	1.3
Subtotal	87.5
Contingency	1.5
Total	89.0

The increased funding for the project is proposed to come from the Health (\$28,000,000) and the Child Survival Fund (\$14,000,000) accounts. The Africa Bureau has budgeted funds in sufficient amounts in its FY 86 CP and FY 88 ABS submission. Funding required for the CCCD Child Survival project can be sustained given projected Africa Bureau budget reductions of 12% in FY 87 and 20% in FY 88. This level of funding is not expected to seriously impact on the availability of health funding for bilateral health projects, but it does focus the regional health project portfolio of the African Bureau rather exclusively on child survival issues through FY 90 according to the current budget projections and expected Africa Bureau allocations between regional and bilateral portfolios.

The participation of Gray amendment organizations in activities under this amendment will be encouraged to the maximum extent possible. To this end and where appropriate, the standard language pertaining to the solicitation documents in the RFP and the CBD will be applied as noted in Attachment C.

Findings

On the basis of the analysis contained in the Project Paper Amendment, the Director of AFR/TR has concluded that the project is technically, socio-economically and financially sound. The intent and requirements of section 611(a) of the FAA have been met.

The African Bureau Environmental officer concurs with the findings of the Director AFR/TR that this Project continues to meet the criteria for Categorical Exclusion from environmental review in accordance with Section 216.2(c)(2)(VIII) of the FAA.

This is a regional activity, and as such, human rights issues are considered at the time bilateral agreements are made with individual countries.

Congressional Notification

Congress was apprised of AID's intent to extend two years and provide \$42,000,000 additional funding for the CCCD project on June 13, 1986. The CN expired without objection.

Recommendation: That you (1) sign below to extend the project completion date to September 30, 1991, and (2) sign the attached authorization amendment to increase life-of-project funding from \$47,000,000 to \$89,000,000 (an increase of \$42,000,000).

Approved *[Signature]*

Disapproved _____

Date 7/30/86

Attachments:

Attachment A	Project amendment
Attachment B	IIE and Project Checklist
Attachment C	Gray Amendment Guidance

AFR/TR/HPN:DEckerson:cwo:07/31/86:X78105:N22030

Clearances:

GC:HFry		Date
AFR/TR:KSherper	<u>Draft</u>	Date <u>7/30/86</u>
AFR/PD/CCWAP:HHelman	<u>Draft</u>	Date <u>7/29/86</u>
AFR/DP:JGovan	<u>Draft</u>	Date <u>7/30/86</u>
AFR/CONT:TRattan	<u>Draft</u>	Date <u>8/10/86</u>
AFR/TR/HPN:GVanderVlugt	<u>Draft</u>	Date <u>7/30/86</u>
AFR/TR/PRO:JWood	<u>Draft</u>	Date <u>7/30/86</u>

AFRICA CHILD SURVIVAL INITIATIVE
COMBATTING CHILDHOOD COMMUNICABLE DISEASES PROJECT
AMENDMENT

Second Revision,
July 30, 1986

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EXECUTIVE SUMMARY

The Combatting Childhood Communicable Disease project amendment is proposed in view of the following:

-The project has been successful to date -- it is generally on track and there is good evidence that it can accomplish the relatively ambitious goals and objectives established.

-The Congressional directive for the development of a plan to achieve 80 percent immunization coverage in those countries to which AID provides development assistance and the provisions of additional funds for child survival programs in FY 85 and 86.

-The Administrator's child survival strategy which directs the development of child survival programs targeting both ORT and immunizations, programs of national scope, programs which concentrate on issues of recurrent costs, national sustainability and private sector involvement and which specifies eight countries in Africa to which support is to be provided.

-The recommendation of the Third and Fourth Year CCCD evaluations that the project should expand in terms of length of project and countries covered. The original recommendation was to expand to 16 countries, but with the selection of Nigeria, project management does not feel that further expansion beyond 14 countries would be prudent.

In terms of progress to date, the CCCD project has produced the following results:

Immunization coverage in CCCD project country operational areas is increasing an average 14 percent annually.

Utilization of ORT in hospitals for cases of acute dehydration in project operational areas has increased by approximately 37 percent, (six countries).

This amendment will provide an additional \$42,000,000 to extend the project for two years to FY 1991 and expand to \$89,000,000 the U.S. support to a multi-donor effort to improve child survival activities in sub-Saharan Africa. The purpose of the CCCD project is to increase the ability of African governments to:

- control measles, polio, tuberculosis, diphtheria, pertussis and tetanus (through enhancing their capacities to develop and administer immunization programs)
- provide simple and effective treatment for the control of diarrheal disease and
- provide simple and effective treatment of fevers for malaria and antimalarial chemoprophylaxis for pregnant women.

The multi-donor effort has a target area of ultimately all of sub-Saharan Africa. The target population is pregnant women, infants and children less than the age of five years. With this amendment to the CCCD program, project activities will extend to Nigeria and one other country, increasing the project's coverage to 14 sub-saharan countries. By project end, the under five population in CCCD countries will total more than 42 million children.

The goal of the CCCD project is to:

- A) increase immunization coverage to 80% in the 14 countries which receive AID support under the CCCD project,
- B) increase to 60% the coverage of treatment of acute diarrheal disease and treatment of fevers for malaria in facilities of the 14 countries which receive AID support under the CCCD project.

As a result of the CCCD project effort to control immunizable diseases, diarrhea and malaria, it is expected that in CCCD-assisted countries major outputs will be:

1. A 50% reduction in disease specific mortality rates for measles, neonatal tetanus, pertussis, diarrhea disease and malaria in the age group 0-5
2. A reduction by 50% of disability from polio
3. An overall reduction in infant and child mortality by 25% which would decrease average mortality rates to 90/1000 live births from the current average levels of 120/1000 live births in CCCD-assisted countries.

Financial Summary:

<u>Regional Support Activities</u>	OBLIGATIONS	
	FY81-85	LOP
Project design	.7	.7
Technical assistance and supervision	6.4	22.9
Training	1.6	7.8
Health information systems	.7	1.9
Operations research	.3	1.0
<u>Country Specific Activities</u>		
Technical assistance	7.0	26.6
Commodities and Local Costs	13.0	25.3
<u>Evaluation</u>	.3	1.3
Subtotal	30.0	87.5
Contingency		1.5
Total	30.0	89.0

The increased funding for the project is proposed to come from the Health (\$28,000,000) and the Child Survival Fund (\$14,000,000) accounts. The African Bureau has budgeted funds in sufficient amounts in its FY86 CP and FY87 ABS submission. This level of funding for the CCCD project is not expected to seriously impact on the availability of health funding for bilateral health projects but it does focus the regional health project portfolio of the African Bureau rather exclusively on child survival issues through FY90 according to the current budget projections and expected Africa Bureau allocations between regional and bilateral portfolios.

II. REVISED PROJECT DESCRIPTION

A. Revised Objectives for the CCCD Project Extension

The objectives of the project revision are more specific than was possible to state at the beginning of the project in 1981. They are described in narrative form here and in tabular form in the revised logical framework matrix.

The goal of the project is to reduce mortality caused by vaccine preventable diseases, diarrheal disease and malaria by 50% in those countries served by the CCCD project with a subsequent reduction of 25% in age 0-5 mortality in those countries. This represents a reduction in the infant mortality rate from an average level of 120 to an average level of 90.

The project purpose remains to strengthen the African's ability to control, manage and reduce mortality from vaccine preventable diseases, acute dehydrating diarrhea and malaria. The targets are i) that 80% of the target population in AID supported countries will be immunized by December 31, 1990, ii) that 60% of cases of acute fevers in infants and children will be treated with appropriate antimalarials within 48 hours of onset of symptoms, and iii) that 60% of cases of dehydration associated with diarrhea which present for treatment at health facilities and 40% of cases which receive care at home will be adequately treated within 48 hours of onset of symptoms.

The revision of objectives and targets in this project involves significant increases above the objectives stated in the project paper. The rationale for the increase in the case of immunizations is directly responsive to the congressional directive to plan for 80% immunization coverage levels in those countries receiving development assistance and, in the case of ORT and malaria treatment, the result of confidence gained from successful implementation experience to date.

The number of infants and children to be covered by the revision is also considerably in excess of the numbers covered under the original project paper. (300%). This is due to the analysis of those countries receiving assistance from other CDA donors and the resultant identification of those countries which will not receive sufficient amounts of other donor assistance to achieve A.I.D.s child survival goals. Nigeria was identified as the highest priority for additional A.I.D. Child Survival support in Africa.

Output and input levels also increase commensurately as are specified in the logical framework matrix.

B. Project Scope and Implementation

The change incorporated in this Amendment is a substantive increase in the magnitude of outputs and a two year extension of the project assistance completion date. The Amendment is made as a result of: a) the successful implementation experience of the first 56 months of the CCCD project, b) the finding of the Third and Fourth Year Evaluations that if certain administrative modifications are made, current staff would be able to manage a project with a scope of 16 countries rather than the 12 country project which can be undertaken with the present LOP budget (see implementation arrangements), c) the greater than expected Congressional and A.I.D. interest in supporting child survival activities in African countries as documented in amendments to the FAA, A.I.D.'s Child Survival Strategy, A.I.D.'s Immunization Strategy, A.I.D.'s draft strategy on ORT., A.I.D.'s draft strategy on nutrition, and d) a reevaluation of expected CDA donor support to African countries and A.I.D.'s guidance on donor coordination. The two year extension is required to carry to completion a new country-specific activity expected to begin in FY86 in Nigeria and to extend support in some 4-6 countries already underway through December 30, 1990.

C. Project Components And Progress To Date

The project will continue all components incorporated in the original project paper. The components have become more discretely defined during the first 56 months of the project and are briefly described here.

1) Project Components

The CCCD Project is comprised of an interrelated set of activities which are designed to achieve Africa-wide and country-specific child survival objectives of reduced mortality and disability from vaccine preventable diseases, acute dehydrating diarrhea and malaria. The discrete activities included at the country-specific level are: 1) general technical assistance provided by resident and TDY advisors as required, 2) the development of a national institutional capacity to undertake ongoing training required to sustain child survival activities of an acceptable quality and in the quantity required to meet project objectives. Almost invariably, this is accomplished by relatively minor modifications to existing training institutional capacity and does not require sizeable developmental efforts, 3) the development of a national institutional capacity sufficient to design and manage large scale integrated health and ORT-related nutrition education efforts. This is frequently the most difficult and resource intensive institutional development component of the CCCD Project. It requires basic reorientation of existing national institutions, equipment, supplies and

large quantities of technical assistance, 4) the development of a health information system capable of providing timely information on national immunization, ORT and Malaria treatment activities of a quality sufficient for informed program management. It is a difficult task to design and reach agreement with all parties on the content of a national health information system. The difficulty of that task does not imply the need for major assistance or expenses of the type ordinarily thought of as necessary for development of national institutions. Existing health information institutions are normally more than adequate for the purposes of implementing CCCD health information system components, 5) commodities-vehicles, cold chain equipment, vaccination equipment, vaccines, ORS, antimalarials, health education equipment and health information systems equipment, and 6) local costs in relatively small amounts for training, fuel and other transportation.

In addition to country specific activities, the project also undertakes certain support activities at a multi-country regional level. They are selected on the basis of activities which can be undertaken more efficiently on a multi-country basis than country by country. The principal regional activities are training of certain personnel categories including epidemiologists, senior level program managers, cold chain repair technicians, national health education managers and technicians for identification of chloroquine resistant malaria. Other activities funded on a regional basis are regional ORT Demonstration Centers, the publication of a quarterly child survival information bulletin and operations research. Since the major portion of regional activities are implemented under the auspices of WHO/AFRO no large scale institutional development is contemplated on a regional basis.

The third and by far the smallest component of the CCCD project was for the provision of relatively small amounts of commodity assistance to non-CCCD bilaterally supported countries. It was management's intention to minimize to the extent possible this component of the project and that has been accomplished. The only activity carried out under this component has been the distribution of approximately three million doses of measles vaccine to non-CCCD bilateral countries at a cost of approximately 300,000 U.S. dollars.

While population activities are not included specifically among its project components, CCCD will work closely with African governments and interested agencies to strengthen the integration of child spacing counseling and services in broader maternal and child health services and child survival programs. (The proposed CCCD project in Nigeria has been designed specifically to compliment and work synergistically with AID-supported population projects).

2) Progress To Date

A summary of accomplishments to date, management and project and recurrent costs is presented below.

a) General Progress

Project agreements have been signed with 12 countries, the target originally established for the end of FY 85. Project activities in

immunizations and in oral rehydration therapy are currently underway in nine of the countries, and malaria treatment in six countries. For each country provided assistance by the CCCD project the major components of assistance, beyond general technical assistance, are for training of personnel, health education, health information systems and operations research. Training activities have begun in seven countries and have already gone through several cycles in Zaire and Togo. Expanded health education activities are underway in six of the countries.

The 1985 annual report is attached as Annex 1. The following information has been extracted from this report and CCCD country specific documents.

b) Progress In Achieving Objectives

Zaire is the only country to have completed three years of CCCD assistance by December 31, 1985. During that period the project has supported the increase in the portion of the country with access to child survival services from 21% to 60%. In that same time, measles immunization coverage has increased from 23% to 40% and children receiving the first dose of DPT vaccine from 36% to 62%. This represents an average annual increase of 24% above prior year levels. The use of ORT has also markedly expanded from 25% of hospitals and clinics to currently 83% of hospitals and 60% of clinics utilize ORT.

In the two countries where activity has been underway for more than two years, Liberia and Togo, the number of immunizations provided has more than doubled in two years. In Liberia, this is reflected in an increase in measles vaccine coverage in children less than age one from 7% in 1982 to 40% in 1985 and from 17% to 30% for receipt of first DPT vaccine. In Togo, in the approximately 45% of the country covered by the CCCD project immunization coverage has gone from 3% for measles vaccine to approximately 25% with similar findings for DPT immunization. This represents more than a 100% increase annually in immunization coverage in these two countries which must be judged against the extremely low initial levels. In Togo use of ORT in hospitals and clinics has increased from less than 10% of such facilities utilizing ORT in 1983 to 90% of facilities currently utilizing ORT. In Togo, the CCCD project has been the critical factor in establishment of a national malaria treatment policy which was promptly implemented on a nationwide basis and resulted in a marked expansion of chemoprophylaxis of pregnant women and improved treatment regimens at lower cost for infants and children.

No significant progress in ORT or malaria treatment has been made in Liberia.

Six countries had more than one year but less than two years experience with the CCCD project by December 31, 1985. They were CAR, Congo, Lesotho, Swaziland, Malawi and Rwanda. The results of national level CCCD activities in these countries were not uniform. Tables 1 through 6 illustrate these countries' progress in the three interventions as well as in Zaire, Liberia and Togo.

Immunization coverage has increased annually an average of 14% and use of ORT in hospitals an average of 37% in eight CCCD countries. The diffusion of ORT technology has been extremely rapid in Malawi with CCCD project assistance and in Swaziland with support in part by CCCD project funding but under the leadership of the Mass Media and Health Practices Project. Virtually all facilities now use ORT in a technically

appropriate fashion. An even more impressive result of the increased use of ORT had occurred in Lesotho where very high case-fatality rates from diarrheal disease have been reduced by a carefully designed Diarrheal Disease Control program.

In malaria, the CCCD project has provided continent wide leadership in the area of development of malaria treatment policies and plans in the face of increasing resistance of Plasmodium falciparum to chloroquine. It is not an overstatement to claim that the CCCD project is responsible for the first positive action by a bilateral or multilateral donor to systematically improve the treatment of malaria -- possibly the largest killer of children in Africa.

For the eight countries where reports are available through December 31, 1985, measles vaccination coverage rates have increased above beginning project levels by 42%. If these rates of increases can be maintained, these eight countries will achieve an average rate of measles immunization above the 80% level by December 31, 1990. It must be pointed out that progress beyond the current level of about 40% average coverage will be more difficult to achieve than was progress to date. The use of ORT in most clinics and hospital facilities has markedly increased above the previously very low levels and there is also early data which indicates upwards of 30% of cases of acute diarrhea now receive home or facility based ORT, (Table 4). It is reasonable to predict that by the completion of the CCCD project that the use of ORT in cases of dehydration due to diarrhea will reach a level between 60 and 80% and that virtually all health facilities will have initiated its use.

c) Progress In Implementing Program Components

The CCCD project concentrates on four standard support components in addition to general technical assistance. They are training, health education, health information systems and operations research.

i) Training - Several types of inter-country training were proposed to be carried out under the CCCD project. The types of training which were to be done on an inter-country basis were in specialized areas where the training requirements of individual countries were not large enough to justify training in each country.

In January 1985, a Grant Agreement was signed with WHO/AFRO which supports inter-country training in the several areas over 4 years. Prior to the establishment of the Grant Agreement with WHO/AFRO only two inter-country training activities had been undertaken, one course in Liberia and one course in Lesotho. Both courses were middle level management training for CCCD project implementation. The implementation of those two courses served both to improve the training materials and to demonstrate that the assistance of WHO/AFRO was absolutely essential in order to carry out inter-country training in the amounts thought necessary. The current Grant Agreement with WHO/AFRO was initiated about 2 1/2 years later than originally expected due to intractable differences of opinion between AID and WHO/AFRO regarding project management issues.

The current agreement does concentrate more on management related training than was originally anticipated due to the increasing recognition of the extent of problems imposed by weak management infrastructure and increasing confidence that appropriately targeted

training and technical assistance may bring about an amelioration of some of the management problems. In 1985, courses were carried out for training EPI and CDD program managers, refrigerator repair technicians, epidemiologists and a regional ORT training center was established in Kinshasa. A total of 9 inter-country training courses have been completed training approximately 200 individuals.

Training activities were broadened considerably throughout the project during CY 1985, (Table 7). Coordination of training activities and development of generic training materials were provided by the staff of the Training and Development Branch, International Health Program Office, CDC, Atlanta. A wide range of national training activities were implemented in project countries.

Atlanta-based training activities continued to focus on the development of generic Mid-Level Manager training materials. Field testing of the English version was completed at the Swaziland course in February 1985. A contractor was engaged during the spring to produce draft French materials which were field-tested in the Congo and Rwanda with the assistance of two experienced training consultants. In mid-1985 a graphic artist was hired to develop camera-ready graphic materials.

Other major Atlanta-based activities included:

-- Supported national Mid-Level Manager training courses in Swaziland, Liberia, Congo and Rwanda through the provision of training materials, supplies, facilitators and consultants.

-- Provided a health education consultant for the Liberia Mid-Level Manager training course which resulted in the development of a module on Community Health Education.

-- Provided a training consultant to Malawi who adapted modules on Immunization and Treatment of Diarrhoea as well as developing a new module on Nutrition and Growth Monitoring.

-- Field-tested a methodology for the evaluation of Mid-Level Manager training courses in Malawi.

-- Planned and assisted with the implementation of the Second Consultative Meeting held in conjunction with an AID-sponsored African Regional Conference on Oral Rehydration Therapy.

-- Provided technical assistance to the Peace Corps for review of training materials being developed for volunteers involved in CCCD-related assignments.

iii) Health Education - In contrast to the progress made in the CCCD bilateral projects (Table 8), the regional health education component has languished. This activity is for in-service training of senior level health educators to provide them the requisite skills to manage nationwide integrated public information/health education programs focussed on child survival initiatives in African countries. The regional health education component is the only unequivocal management failure of the CCCD project to date. Exclusively due to poor advice, faculty decision making and inabilities to work through what should be

routine administrative procedures, the regional health education component has not yet begun, but is expected to do so in the near future with a grant agreement to the University of Ibadan managed by CDC.

The difficulties in implementing the regional health education component led to increased emphasis being placed on health education at the country level in the CCCD bilateral projects. The 1983 external evaluation recommended de-emphasizing this regional component and concentrating on country specific activities. The experience to date shows that combining traditional face-to-face health education and mass media health communications is the most effective way of creating and maintaining public demand for health services. The experience in Swaziland, where this combination is being used, has led to increased collaboration with the S&T Bureau project HEALTHCOM.

The PASA with Peace Corps has provided CCCD countries additional support in the areas of health education/promotion, training and supervision, as well as formulation of health education strategies at the national level. It is quite evident by program review reports that Peace Corps Volunteers have been a success in strengthening service delivery. Evaluation to confirm this success is currently being performed. The number of Peace Corps Volunteers assigned to the project are as follows:

Peace Corps Volunteers assigned to CCCD Programs
by country as of April 1986

	<u>In the field</u>	<u>Requested for '86-'87</u>
Central African Republic		1
Lesotho	1	
Liberia	5	6
Malawi	5	1
Togo	4	6
Zaire	43	20

ii) Health Information Systems (HIS) covers a wide variety of data on health status, disease occurrence and health program activities. In general, the status of HIS in Africa both in individual countries and at a regional level (WHO/AFRO) is less well developed than in any other continent in the world. Health information that is vital to the planning, execution and monitoring of priority child survival activities is generally either not available or extremely flawed by long delays, incomplete data and inaccuracies. The CCCD project is supporting a multi-pronged program of HIS improvement both in CCCD bilateral countries and in collaboration with WHO/AFRO. The purpose of these interventions is to assure improved timeliness, completeness and accuracy of health information essential for the management of health programs. This will be accomplished by adaptation of existing disease surveillance and program monitoring procedures and institutionalized through the creation of improved data management capabilities by use of microcomputer technology and training of appropriate Ministry of Health staff in their use. The results will be the availability of more reliable baseline data on health status and program performance and the creation of a system to routinely collect such data and monitor the progress of priority child survival programs.

The specific HIS activities in bilateral countries include:

(a) Management Information System (MIS)

Starting with CY 1985, each bilateral CCCD country is producing an annual report which focuses on the most pertinent indicators of program development and is based on the utilization of microcomputer graphic capabilities to display data in a easy to understand format. The new MIS format of annual reports compares the most recent values of selected program indicators with previous years since 1980. The annual reports are developed by CCCD program staff in-country and will provide clear documentation of the progress in program implementation. During CY 1986 IHPO/CDC is developing computer software that will facilitate the entry of data for tables and the automatic generation of graphs. The data from the individual country MIS calendar year reports will be pooled to create a database with high priority program indicators of child survival activities in the CCCD bilateral countries. This should be available on-line in FY 87.

(b) HIS Improvements

Through use of CDC Atlanta staff, CCCD Field Epidemiologists and consultants (particularly from the U.S. Bureau of the Census), the CCCD program is reviewing HIS procedures in countries with bilateral CCCD projects. These reviews focus on the procedures for data analysis, utilization and dissemination of data through periodic feedback bulletins to health staff. A particular focus of CCCD/HIS consultations has been on the utilization of microcomputer technology to reduce the amount of time required for data entry and analysis (one of the major sources of delays in data availability) and appropriate training of health staff in HIS procedures. In each bilateral CCCD country a plan for HIS improvement has been developed.

It is vitally important to measure the use of CCCD recommended interventions (childhood immunizations, appropriate treatment of diarrhea and malaria) in the community. The CCCD project is developing a standardized health practices survey based on the WHO EPI vaccination coverage survey. The first health practices survey was carried out in Guinea in June 1986. The U.S. Bureau of the Census is collaborating to develop training materials and survey manuals so that this survey can be carried out in additional countries. In collaboration with the Bureau of the Census, a simplified "user-friendly" software program for data entry of the results of the household-based health practices survey is being developed.

(c) Health Facility Surveys

Practices of health workers in health facilities are important in the implementation of the CCCD program. The CCCD project is developing procedures which can be used during routine supervisory visits to assess health worker practices in relation to immunizations, treatment of diarrhea and treatment of malaria. The objective is to obtain simple indicators of the compliance with recommendations for CCCD/child survival practices. These health facility surveys have been field tested in Guinea and Zaire.

The CCCD project has been carrying out field tests of methods to evaluate changes in mortality in relationship with the use of CCCD services (vaccination, oral rehydration therapy, and malaria treatment). The Mortality and Use of Health Services (MUHS) surveys were carried out in 1984 in subnational areas of Liberia, Togo and Zaire. Estimates of child mortality rates (deaths per year per 1000 children 0-4 years old) varied considerably: Liberia 96.8, Togo 19.4, Zaire 27.1. Based on review of these initial MUHS surveys by outside experts in demography, health education and epidemiology follow-up "re-interview" surveys were carried out in all three countries. These re-interview surveys involved re-contacting and re-interviewing 20% of the women interviewed in the original MUHS surveys. These re-interview surveys were completed in 1985 and showed considerably higher estimated mortality rates. Experience with the MUHS surveys indicates that mortality surveys cannot be routinely carried out or institutionalized in developing countries in Africa. The CCCD project will carry out additional follow-up surveys in the original MUHS areas when program implementation indicators reach a high enough level.

On a regional basis, the CCCD strategy for improving health information available has been to collaborate with WHO/AFRO. Because of delays in the establishment of the WHO/AFRO CCCD grant agreement until its signing in January 1985, the development of HIS activities with WHO/AFRO has not developed as rapidly as desired. The specific activities are:

(1) Epidemiologic bulletin - The CDC and the CCCD WHO/AFRO grant agreement will collaborate to help WHO/AFRO begin the publication of an epidemiologic bulletin in FY 1987. This bulletin will be modeled on the CDC MMWR and the WHO Weekly Epidemiologic Report. It will initially be published quarterly and will provide countries and program managers with up-to-date information on the occurrence of disease and development of programs. It should be an extremely important stimulus to improved reporting to WHO/AFRO and program development.

(2) HIS improvement - To date, WHO/AFRO has not submitted specific proposals for HIS activities under the CCCD/AFRO grant agreement. It is hoped that the types of development of HIS in bilateral CCCD programs can be more widely implemented through the WHO/AFRO CCCD grant agreement. This will provide strengthened, institutionalized national systems to monitor health program performance on an on-going basis, including annual sample surveys (simplified, 30 cluster WHO model) to validate surveillance and service delivery statistics.

iv) Operations Research - The operations research component of the CCCD project began promptly and is approximately on schedule. To date 33 projects have been funded and 9 have been completed, (Table 9). The third year CCCD project evaluation acknowledged the excellent performance of the CCCD project's operations research component and suggested two modifications to current activities. The first is to focus operational research on the needs of CCCD bilateral projects for problem resolution and the second is the need to lower the investment of field staff time in operations research project management. The fourth year evaluation further specified that operations research should be performed almost exclusively at the country specific level with perhaps a small regional operational research portfolio managed by WHO/AFRO.

There have been some unexpected achievements. Two of the most important ones are in the area of policy dialogue. The first of these is that when

the project began there was a desire, with little expectation of results, to encourage governments to consider alternative financing systems to the current free provision of public health services. Surprisingly, project personnel have been able to convince governments of most of the project countries to seriously consider fee-for-service systems. They have been established in Zaire and Liberia and are currently under active consideration in most other countries. The second area is that of impact on health sector management. Both the second year and third year evaluations underscored the importance of provision of assistance to this ubiquitous problem area. Project management was able to include this area as a major emphasis in the Grant Agreement with WHO/AFRO and in the summer of 1985 began to make more consultant assistance available to country-specific activities. The third area is in the measurement of mortality trends. With rather modest amounts of project resources it has been possible to document infant and childhood mortality levels in three of the CCCD countries by means of a survey questionnaire submitted to an approximately 5,000 family cluster sample. Project management has some confidence that the survey questionnaire developed can successfully document the 25% decrease in infant and childhood mortality rates projected to result from CCCD project implementation. The fourth area is the remarkable success of the annual consultative meetings in producing an exchange of technical and managerial information between participating countries. The value of such an exchange of experience among peers has led to much more rapid progress in many countries than would have otherwise been possible.

d) Changed Emphasis of Support Provided Through the CCCD Project:

In addition to the extension of life of project completion date and additional resources, the amended project will incorporate some changes in training, health education, operations research, health information and technical assistance provided, as well as some changes in project authority leading to more efficient management procedures.

Activities during the period 1986-1991 focus less attention on operations research due to the feasibility of obtaining assistance from other AID funded projects for that purpose. The major remaining operations research activity during the remainder of the project will study the efficacy of routine antimalarial chemoprophylaxis in pregnant women under conditions of increasing resistance of *Plasmodium falciparum* to Chloroquine. Increased emphasis will be placed on health and ORT-related nutrition education assisted by the HEALTHCOM project, health information systems with particular concentration on mortality measurements, on cost and financing considerations and on management training and technical assistance. All these changes are already being implemented within current project authority and result in slight changes in proportional budgets for these areas.

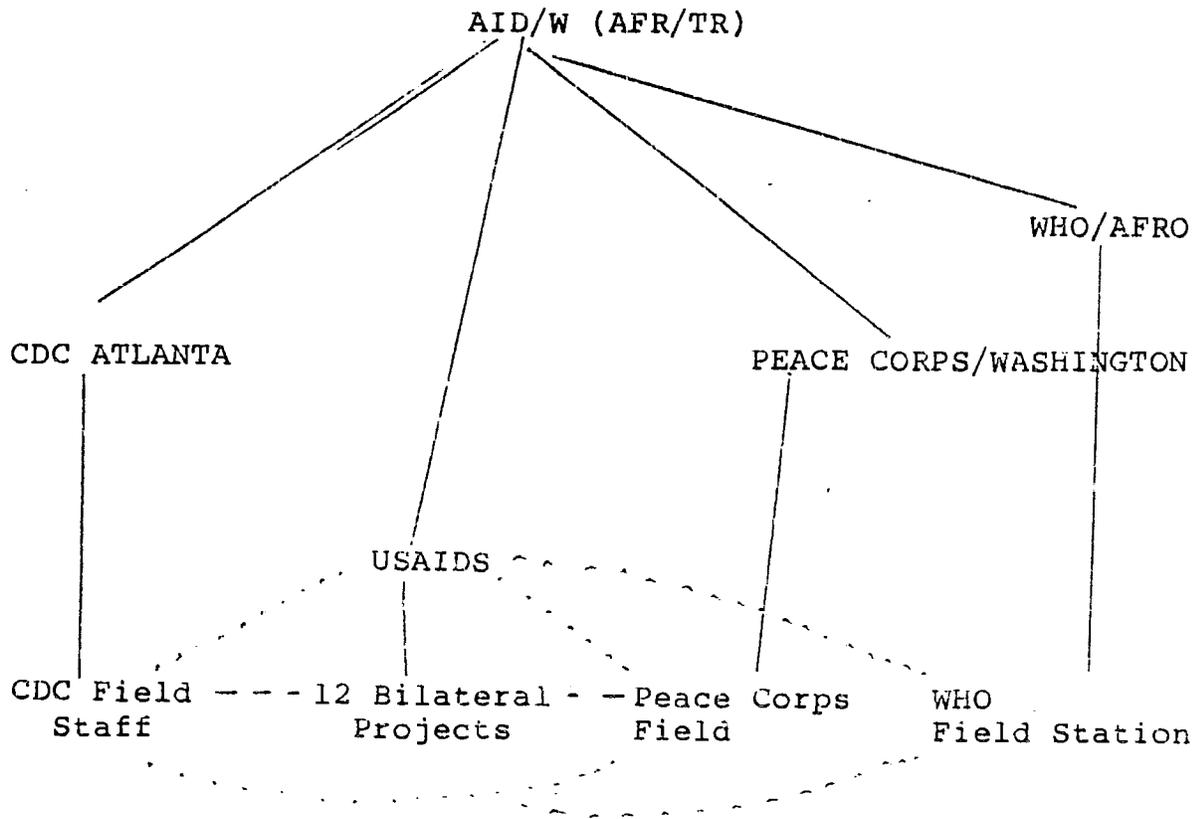
The number of overseas staff will also increase by one individual from 17 to 18 in FY 87.

One other minor modification to management practices is that authority is sought to waive the requirement for French tests for native French speakers and AID orientation for individuals who have left AID employment within the previous 5 years. This authority is requested in the interests of avoiding waste in government.

During the life of the CCCD project, consideration has been given to the addition of other child survival interventions. The parameters of a decision to add other interventions are very clear. The major trade-off is between a potentially more efficient project in terms of lives saved per dollar spent if other effective technologies could be added at low marginal cost versus the likelihood that the whole endeavor would become too diffuse and complex. No other technologies are proposed for addition at this time. It is reasonable to anticipate that AID may add vitamin A supplementation or acute lower respiratory illnesses to its child survival initiatives as the results of current research become available. At that time AFR/TR will reexamine the feasibility of CCCD support to these areas. In the meantime focus will be maintained on the three existing technologies with minimal support to growth monitoring or child spacing activities as deemed appropriate and feasible on a country by country basis.

e) Project Implementation Arrangements

The CCCD project is implemented by several agents and attempts to coordinate with other multilateral and bilateral agencies providing assistance to African governments in immunization ORT and malaria treatment. Implementation arrangements are complex and sometimes difficult to perform. At the time of original project approval, consultants were contracted to devise a management plan and a management information system. A copy of the revised management information system is attached to this paper as Annex I - the 1985 CCCD Annual Report.



Technical - - - - -
Executive Management _____
Liaison and Coordination

The specific responsibilities of the various parties are listed below.

i) AFR/TR is responsible for the overall implementation and coordination of the CCCD project in Africa. AFR/TR has a staff of 2 1/4 individuals responsible for the following tasks: 1) management of CDC/PASA; 2) management of Peace Corps/PASA; 3) management of the WHO/AFRO Grant Agreement; 4) all program authorization, budgeting, planning and program evaluations; 5) management of centralized procurement; 6) coordination of all CDC and Peace Corps activities with USAID's and other components of AID; and 7) coordination with other donors.

ii) The Centers for Disease Control is delegated authority to provide and coordinate all technical assistance to field bilateral programs and to implement inter-country project components of epidemiological support, operational research and health education. AID funds are provided for this purpose through a PASA. To date approximately 16 million dollars have been expended by CDC in performance of the technical assistance role in Africa. CDC carries out these responsibilities by means of a 10 person professional staff (and eight support staff) in Atlanta and 17 field officer's. CDC field staff are not assigned any management responsibility for field CCCD projects, with the exception of operations research. They are expected to devote all their effort to provision of and coordination of technical assistance required by field programs.

iii) USAID's - USAID's are delegated all project management responsibilities for bilateral projects with some important exceptions which ease their management burden extensively. Exceptions are mobilization and management of technical assistance (done by CDC), project development (done by CDC), project approval, development of ProAgs and project evaluation (done by AFR/TR) and management of procurement services agent (done by AFR/TR). The USAID Director exercises oversight in the areas where responsibilities are exercised by AFR/TR and CDC but does not have to utilize his staff for performance of these tasks. The USAID's are solely responsible for all other executive management and administrative support requirements of the bilateral projects.

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

v) WHO/AFRO - WHO/AFRO is exclusively responsible for carrying out inter-country training and health information systems components of the CCCD project. The Grant Agreement is directly managed by AFR/TR with the assistance of a CDC Liaison Officer stationed in Brazzaville whose duties are to identify and communicate ways in which the bilateral CCCD projects can utilize services provided by the WHO/AFRO - CCCD Grant Agreement.

f) Coordination

Coordination within the CCCD project is also multi-tiered and complex due to the scale of the project, the particular needs for coordination at the country level in Africa and the number of donors involved in child survival programs.

i) Coordination with other AID projects. AID supports several other projects which potentially impact on child survival programs in Africa. They are:

a) Primary Health Care Technologies, (PRITECH) and Resources for Child Survival, (REACH), 1983-88 implemented by two contractors, one of which concentrates on oral rehydration therapy and one of which concentrates on immunizations, (as well as health financing). Total AID funding is 40 million and scope is worldwide.

b) Diarrheal Disease Research, 1985 - 1990 implemented on a worldwide basis with total AID funding of 18 million.

c) Primary Health Care Operation Research, (PRICOR) 1980-1990. This project is worldwide in scope and has funded to date 11 projects in Africa.

d) Communication for Child Survival (HEALTHCOM) 1985-89 - 13 million dollars AID funding. Support will be provided for up to six mass media health and nutrition education activities in Africa, five of which will strengthen CCCD activities.

e) Dietary Management of Diarrhea 1985-1988 - 2 million dollars AID funding. This worldwide project with one site in Nigeria will develop appropriate dietary regimens for nutritional rehabilitation during and after episodes of diarrhea.

f) Bilateral projects in Mauritania, Chad, Niger, Uganda, and in Cameroon in 1986-87 address ORT and immunization activities some with assistance from PRITECH and CCCD projects.

Coordination is expected to take place in two discrete ways between the CCCD project and other AID funded projects. With respect to PRICOR, the Diarrheal Disease Research Projects, and the Dietary Management of Diarrhea Project - activities funded by these projects complement and do not duplicate to any significant degree any support which could be provided by the CCCD project. AFR/TR, USAID staff and field staff of CCCD projects are expected to identify ways in which PRICOR and Diarrheal Disease Research projects can complement CCCD initiatives or in which CCCD field staff can promote activities by these two projects.

With respect to USAID bilaterally supported child survival projects, CCCD can and has provided modest amounts of technical assistance when requested to do so by the bilateral mission with the concurrence of AFR/TR. This type of assistance can be expected to increase but coordination roles remain clear. USAIDs determine if assistance is required and the CCCD project attempts to be generally responsive within personnel constraints at that time. The coordination between the centrally funded projects Primary Health Care Technologies (PRITECH) and Resources for Child Health (REACH) is more problematic. The scope of CCCD and the S&T projects is quite similar. The principal differences are that PRITECH and REACH tend to focus on implementation of a single health care technology while CCCD promotes the simultaneous strengthening of three technologies. Coordination between PRITECH, REACH and CCCD occurs at the AID/W level where agreement is reached between S&T/HEA and AFR/TR on which countries and activities should be supported by the projects. At this time the governing principal of such decision is that

PRITECH and REACH provide technical assistance in support of projects managed and funded by USAID's and in some instances by CCCD.

2) At the country level, each government where there is a CCCD project is encouraged to establish a coordination committee which includes relevant governmental, private, voluntary, and international organizations. At the present time the majority of CCCD supported countries have elected to establish such committees.

3) At the international level CCCD coordination is achieved through Cooperation for Development in Africa (CDA) Health Technical Advisory Committee which is constituted of the representatives of the seven CDA countries, UNICEF, WHO and 3 African delegates. The committee performs this role in a poor to fair fashion. More effective international coordination of donor support to child survival programs in Africa is sorely needed but appears not to rank very high on the political agendas of any of the governments providing such support.

3 CCCD Program Costs

The most useful indicators to use for judging the efficiency of AID supported child survival programs is the AID cost per child covered per year. It must be noted that this figure does not in any way get at the extremely important concern of total recurrent costs which will accrue to a nation in continuing child survival initiatives. Problems of recurrent costs and what the CCCD project is doing about them will be addressed later in this document. The specification of AID cost per child covered per year allows the Agency to determine where a fixed amount of AID resources can reach the most children. The CCCD project is the Agency's largest child survival initiative but is also one of its more efficient measured in terms of AID cost per child covered per year.

With the current eight year project projected to cost 58 million dollars approximately 24.7 million years of child covered by child survival services will be provided at an AID cost of approximately \$2.35 per child year coverage. This is already a very low figure in comparison to other health projects the Agency supports in Africa or other regions. With the proposed extension of the CCCD project by two years, extending assistance in Zaire and Malawi and the addition of Nigeria, the AID total cost will be approximately 89 million dollars providing approximately 70 million years of child coverage by AID supported child survival efforts at a cost of about \$1.30 per child year coverage. This is due in major part to much smaller unit costs in working in larger countries which spreads over more children the very high costs of technical assistance and supervision.

4 CCCD Progress in Recurrent Costs and Prospects for Sustainability Beyond PACD

In recognizing the need to address the issue of recurrent costs and project sustainability beyond PACD, the CCCD project emphasizes two elements of its strategy in its bilateral project agreements. The first requires that national governments implement a program whereby they assume an increasing financial responsibility for recurrent costs. The second element of the CCCD strategy focused on engaging national governments in policy dialogue regarding alternative financing systems, fees for service, community financing of some costs, inscription fees etc. The first element of this strategy was adopted after consideration

that few AID or other donor assisted health projects have been successful in getting national governments to shift public resources to ensure continuation of their projects. The second element aims at assisting governments in studies leading to programs of cost recovery and auto-financing.

The CCCD experience to date and findings from multiple project evaluations indicate that national governments of CCCD bilateral project countries have begun to address both elements of the CCCD strategy. While the strict requirements of a phase-in of 25% in year 2, 50% in year 3, and 75% in year 4, has generally not been met during these times of fiscal restraint and shrinking national resources, national governments have proposed approaches which provide optimism regarding their capacity to meet recurrent cost requirements. Specifically in Zaire, project expansion was scaled down and the LOP was extended to fit the government's schedule for assuming recurrent costs. The burden of recurrent costs was thereby reduced to a manageable level and stretched over a longer implementation period. Extensions of LOP in other bilaterals will provide a more realistic phase-in schedules. While some projects will extend the phase in period of recurrent costs, it is conceivable that others may accelerate their assumption should government resources become more readily available.

The CCCD experience to date and findings from multiple project evaluations indicate that host governments have made remarkable progress in addressing issues of health economics. Cost studies have been undertaken in six bilateral projects: Congo, Malawi, Rwanda, Swaziland, Togo, and Zaire. These have served to open the dialogue between AID, CCCD and national personnel. Country specific health economic data are available upon which countries can formulate cost recovery schemes. Findings in the Togo study showed that a modest user fee of approximately 75 CFA francs should cover recurrent costs associated with the delivery of CCCD interventions. Governments are benefiting from an unprecedented volume of data upon which to plan and implement modest but viable cost recovery schemes. Zaire and Liberia have made substantial progress in instituting fee-for-service systems. Zaire has a successful scheme to recover ORS and chloroquine costs. The earlier obstacles to progress appear to be resolving themselves as national governments, USAID missions and CCCD project personnel become more conversant in health economics. With start-up costs leveling off, with improved health information systems and with recent country studies completed, national governments are in a particularly favorable position to assume the burden of recurrent costs.

II. RATIONALE FOR PROJECT AMENDMENT

The CCCD project is the major child survival initiative of the Africa Bureau. To date, project results have been impressive, (see attached 1985 Annual Report - Annex 1)

The CCCD project is designed to transfer program costs to participating countries in a phased manner, and is beginning to show results. The cost per child vaccinated by the CCCD project is presently \$2.30, a cost that is remarkable given the constraints inherent to the Africa development.

With this amendment the CCCD project will extend operations to two new sites in Africa. At present, these sites have been identified to be Nigeria and possibly one country in the Sahel.

Taken together, these two project sites represent an additional beneficiary target group more than double the present program. By expanding in this way, project immunization delivery costs are projected to be substantially reduced.

Specifically, this project amendment for extension and increased funding is based on;

A) successful project experience to date, (the project is generally on track and there is good evidence that it can accomplish the relatively ambitious goals and objectives established)

B) The administrator's child survival strategy which directs the development of child survival programs targeting both immunizations and ORT, programs that emphasize focused nutrition interventions such as dietary management of diarrhea, programs of national scope, programs which concentrate on issues of recurrent costs, national sustainability and private sector involvement and which specifies eight countries in Africa to which support is to be provided. The CCCD project assists two of those countries, Zaire and Malawi, and proposes assistance to Nigeria in this amendment, and

C) the congressional directive for the development of a plan to achieve maximum immunization coverage in those countries to which AID provides development assistance and the provisions of additional funds for child survival programs in FY 85 and 86,

D) The recommendation of the Third and Fourth Year CCCD Evaluations that the project should expand in terms of length of project and countries covered. The original recommendation was to expand to 16 countries, but with the selection of Nigeria for the 13th country project management does not feel that further expansion beyond a 14th country is prudent.

In relation to donor community assistance in Africa to the three areas of the CCCD program focus, the rationale for an expansion of AID support to the CCCD project is different for each of the three health care technologies comprising the CCCD project. They are therefore analyzed separately.

A) Immunizations - Immunizations have traditionally comprised an area of greater donor assistance than ORT or malaria. That continues to be the case. Several donors are quite active in Africa. UNICEF provides substantial amounts of commodities to virtually all African countries. WHO has been successful in the establishment of agreements on immunization policies and program principals in all African countries as well as providing modest amounts of technical assistance and commodities. Training is the major WHO contribution. Up until this time DANIDA has provided adequate amounts of donor assistance to Kenya and Tanzania although their projects have about reached established completion dates. The U.K. provides assistance in Gambia. Recently Italy announced the establishment of a contribution to UNICEF of 100

million dollars to support immunization programs in 26 African countries. AID through CCCD and bilateral projects support immunization programs in 14 African countries and new bilateral projects providing support to immunizations are planned in three countries during FY86-87.

The list of AID and Italian supported countries overlaps somewhat and some countries where AID provides development assistance are not included in either list. Specifically Italy proposes to provide some assistance to six countries where CCCD currently provides assistance and to all five with USAID bilaterally funded or proposed funding in support of immunization programs. The countries where no assistance is currently provided by AID or other donors nor proposed to be provided by Italy, are Nigeria, Sao Tome and Principe, Botswana, Madagascar, Zambia, Zimbabwe, Seychelles, Mauritius and Gabon. AID must consider how it is to meet the congressional immunization goals for immunizations in at least the first four countries listed above.

B) ORT - The past, current and proposed donor assistance for ORT in Africa is significantly less than for immunizations. The multilateral donors of UNICEF and WHO are equally committed to ORT as to immunizations but basic program planning and implementation infrastructures are not yet in place in the majority of African countries to a degree sufficient to absorb significant amounts of UNICEF and WHO resources. Bilateral donors other than AID provide almost no assistance to ORT programs in Africa. U.K. provides assistance in the Gambia. AID provides assistance in 12 countries through the CCCD project. USAID's provide support in Uganda and (assisted by PRITECH) 4 Sahelian countries and 2 new bilateral projects will begin in FY 86-87. The following countries receive little if any bilateral donor support for ORT Programs: Cape Verde, Mali, Sudan, Somalia, Burkina Fasso, Guinea-Bissau, Kenya, Tanzania, Djibouti, Sierra Leone, Ghana, Benin, Nigeria, Equatorial-Guinea, Sao Tome and Principe, Gabon, Angola, Mozambique, Zambia, Zimbabwe, Botswana, Madagascar, Seychelles and Mauritius.

C) Malaria - The situation with respect to expansion of malaria treatment assistance in African countries is simplest of all. Substantial assistance is only currently being provided in six African countries all by the CCCD project. All countries except Botswana, and Lesotho urgently need such assistance and technical assistance supply constraints are such that the CCCD project can only expand into new countries at a rate of about two countries per year. Between now and the proposed revised LOP data of September 1991, assistance will be expanded a total of 12 countries.

Monitoring of CCCD Project Impact After 1991

The CCCD Project represents a major AID investment in support of child survival activities in Africa. Monitoring of the longer term impact of the CCCD Project after the proposed end of project in 1991 to confirm project success in sustaining reduced levels of mortality will be important. In fact, the probability of the availability of high quality data to monitor the program impact is quite great. The specific mechanisms for post project monitoring are as follows:

o The foundation for follow-up of the CCCD Program impact would be the improved Health Information Systems (HIS) being implemented in the

countries with bilateral programs and with WHO/AFRO. The CCCD support for improved HIS should create institutionalized improvements of the capability of individual countries in the WHO Africa Region to identify high priority information of health and indicators of program performance, collect the appropriate data efficiently, analyze the data and publish/distribute the pertinent findings in a timely fashion. In particular, the CCCD Program is developing annual (calendar year) national reports that include data on program performance (for example, immunizations performed by age group, packets of ORS distributed, tablets of chloroquine distributed), disease surveillance (cases of measles, cases of diarrhea etc.), and utilization of health services by the public. Using the revised CCCD Management Information System (MIS) the countries will be able to gather the data needed to generate graphic presentations of high priority indicators of program performance in the annual reports. The CCCD Project is emphasizing institutionalization of the HIS improvements through provision of appropriate micro-computer hardware and software and training of nationals in CCCD bilateral countries in use of micro-computers and the analysis of HIS data. With WHO/AFRO, the CCCD Project is collaborating in the start up of an epidemiologic bulletin that will be distributed quarterly to all of the member nations of the African region of WHO. This publication should provide the first systematic "feedback" of program performance data and epidemiologic investigations to the countries in Africa. CCCD staff will provide technical collaboration to WHO/AFRO in the improvement of the collection, analysis and "feedback" of program performance data on child survival activities in Africa.

- o Each of the CCCD interventions (immunizations, treatment of diarrhea, treatment of malaria) is a high program priority for WHO, UNICEF and other major international health agents. WHO, UNICEF and other agencies will continue to carry out program monitoring and periodic evaluations of these activities (particularly immunizations and diarrheal disease control). These results will be readily available to help monitor the impact of CCCD interventions after 1991.

- o Technical collaboration to evaluate the impact of the CCCD Project could be provided from CDC, School of Public Health, or other AID funded projects.

- o The evaluation of impact on overall mortality is technically more complicated than impact on specific diseases in program activities. The options would include additional follow-up studies on the CCCD/MUHS areas and targeting of mortality estimation surveys such as the AID funded Demography and Health Survey (DHS) for CCCD bilateral countries.

III. FINDINGS OF PROJECT EVALUATIONS AND AUDITS:

To date 18 evaluations have been done; three of the overall project, 14 of country-specific activities and one of the WHO/AFRO grant agreement. Six of the evaluations have been external and 12 were internal. An audit of the project has also been performed by the Regional Office of the Inspector General for Audits in Dakar.

A) General Overview Of Findings

The findings of the evaluations have varied according to country, project component and specific circumstances, however several general problems seem to be widely shared. They are:

- i) problems of recurrent cost assumption by national governments; there are at least two aspects of this problem -- one is the actual difficulty which national governments have in shifting budgetary allocations in a time of contracting budgets and the second is the difficulty in getting all CCCD parties to take the problem sufficiently seriously to take remedial measures,
- ii) generic or horizontal national management problems -- basic problems regarding how to request budgets, control vehicles, supervision of employees etc. have been identified as major obstacles to accomplishment of objectives in all countries, and
- iii) lack of coordination among donors and national governments has created problems in planning in most countries.

There are also some general positive findings as well. The most important of these is the generally excellent quality and high level of dedication of national field staff assigned to CCCD activities. A second finding is the unexpectedly large returns from well planned policy dialogue in the areas of development of alternative financing systems and development of national malaria policy.

The CCCD project does not propose to significantly alter its evaluation schedule which at the current time requires 14 reviews or evaluations annually. The information and insights obtained are invaluable in making management adjustments.

B) Specific Evaluation and Audit Recommendations and Project Management Plans in Responce

The Fourth Annual Evaluation of the CCCD project was performed in March 1986 and the final report submitted in May, 1986.

The principal recommendations were:

- i) Extend CCCD project by three years through fiscal year 1991 and increase LOP funding by 20 million dollars.

AFR/TR response - seeks to extend the project through fiscal year 1991 and increase LOP funding by 42 million dollars. Action is expected to be completed by early August, 1986.

- ii) Assure continuation of the CCCD project interventions after the end of the project by working with governments on auto-financing systems. (see also audit recommendation 6)

AFR/TR response - AFR/TR will strongly suggest that all AID and CDC parties associated with each CCCD field project formally agree to implement the language incorporated in CCCD grant agreements regarding alternative financing systems and phasing of AID and national government financial contributions and further agree that the continuation of and

the level of AID support be governed by the level of national financial contributions to project activities. Cable will be drafted for AA/AFR authorization by the time of the January 1987 progress report to the audit report, (discussed below).

iii) Ask that CDC and WHO/AFRO develop on a priority basis a senior management training program.

AFR/TR response - CDC plans a seminar on this issue June 25, 1986 which will be followed by proposed implementation plan for AID/W review. The plan should be submitted by January 1987.

iv) Codify the operating principles to be used by AID, CDC, HEALTHCOM and PRITECH in the United States and in those countries which have CCCD bilateral programs.

AFR/TR response - There is no obvious difference of opinion between the parties involved. It simply needs codification. AFR/TR will write a memo for S&T and CDC clearance and distribution by August 1986.

v) Accelerate health education activities including mass media to create a demand for project intervention.

AFR/TR response - While the findings and recommendations are accurate ones much progress has been made in the past year (see Table 8).

AFR/TR will further strengthen health and ORT-related nutrition education by providing approximately 1.3 million dollars to mobilize the resources of the S&T funded HEALTHCOM project to assist in 6 CCCD countries. First obligation will be made in FY 86.

vi) Encourage the development of an agreement between USAID and WHO/AFRO whereby operational research protocols for CCCD will be reviewed in Brazzaville.

AFR/TR response - AFR/TR is not enthusiastic regarding continuation of the regionally funded operations research component due to difficulty experienced in maintaining research focused on operational problems of the CCCD project and the high overhead required to review, assist and evaluate research funded. Nonetheless, we have advised WHO/AFRO that we would be willing to consider a proposal to include operational research management in the WHO/AFRO grant agreement. No target date is specified.

vii) Development of better criteria for the implementation of the Health Information Systems Component of the AID-WHO/AFRO grant agreement.

AFR/TR response - Since neither AID nor CDC nor WHO/AFRO is able to enunciate such criteria, AID has determined not to provide funds for the Health Information Systems component of the AID-WHO/AFRO grant agreement with the exception of \$100,000 for the publication of an epidemiological bulletin for which there is general agreement regarding feasibility and utility.

An audit of the CCCD project by the Regional Inspector General for Audits, Dakar, was performed during January-May 1986. Their executive summary has been reviewed in draft. Their draft recommendations and AFR/TR proposed responses are outlined below.

i) Improve CDA donor coordination of child survival activities in sub-Saharan Africa by: a) determining the status of CDA donor country and international organization commitments to the Africa-wide program including results of their activities in those countries; b) periodically sharing with other donors and international organizations data on program implementation, successes, and problems and c) periodically reporting results of donor supported child survival activities in Africa.

AFR/TR response - Items a and b are currently accomplished in major part by the Health Technical Committee of the Cooperation for Development in Africa which meets at six monthly intervals. These current efforts are being strengthened by more precisely defining the content and procedures for information sharing between donors. Item c will be accomplished by establishing a six month internal report to USAIDs and other interested parties of AID/W donor coordination activities in health. The first report will be forwarded to the field by December, 1986.

ii) Direct the USAIDs to assume a more active role in promoting donor coordination at the bilateral level and require the USAIDs to periodically report on the effectiveness of the donor coordination mechanism and specific donor activities within their respective countries.

AFR/TR response - We propose that the AA/AFR authorize a cable directing USAIDs to assume a more active role in promoting donor coordination at bilateral levels specifying activities they should perform or support and establishing the content and interval of reports regarding the donor coordination mechanism and specific donor supported activities in their country. Cable will be drafted in October 1986 during the formal review period of the audit report.

iii) Recommend that the AA/Africa Bureau in conjunction with the Centers For Disease Control develop a plan to measure the impact of the project in reducing the mortality and morbidity rates associated with the project targeted diseases.

AFR/TR response - A plan has been developed over the past two years. Baseline surveys have already been carried out in Liberia, Togo and Zaire.

iv) Require the USAIDs, in conjunction with the Centers For Disease Control to: a) develop a CCCD plan for each participating country which specifies what the host country needs and what AID assistance can provide to develop host country institutional capability in regard to health education, training, health information systems and operations research; b) specify the objectives and time frames in developing the host country's institutional capability; c) report periodically on progress achieved in developing the host country's institutional capability, in reducing mortality and morbidity rates due to target diseases, and in expanding immunization coverage and access to malaria and oral rehydration therapy.

AFR/TR response - This is the only recommendation of the audit report for which AFR/TR is ambiguous on how to respond. We clearly recognize the strengths of the planning model implicit in the auditors findings; we acknowledge that the planning model utilized by the WHO initiated worldwide Expanded Programme on Immunizations and Control of Diarrheal Diseases is a different one, that of rolling implementation plans with horizons of about two years, rigorous evaluations, a built-in ideology of

learning from failures and a greater than normal flexibility to rapidly make corrections and we also know that AID has adopted wholeheartedly the long term objectives planning model and has very little flexibility in considering the merit of alternatives. It is also the case that only modest effort would be required to add to the rolling implementation plans currently utilized an overlay of longer term institutional capacity objective plans. The audit recommendation is certainly feasible to accomplish. It will require further consideration for AFR/TR to conclude whether the recommendation is sufficiently valid that it should be generally implemented. AFR/TR will work toward a more thorough and informed response by the January 1987 progress report.

v) Request WHO/AFRO to submit reports at least every six months.

AFR/TR response - Currently WHO/AFRO is required to submit 3 standard reports annually on forms supplied from the CCCD management information system, while more thorough informal reports are provided during the visit of the project manager at approximately 4 monthly intervals. AFR/TR accepts the audit recommendation and has incorporated the change in reporting requirements in the grant agreement amendment currently under negotiation with WHO/AFRO.

vi) The Africa Bureau in conjunction with the other Cooperation For Development in Africa countries, multilateral donors and the African governments develop a coordinated plan for meeting the project recurrent costs in each country. The plan should also provide implementation options based on reducing funding levels of host governments.

AFR/TR response - The auditors have identified a very critical problem and have made a very constructive recommendation. The difficulties AFR/TR has faced in prior attempts to address this issue are a) a lack of agreement by all AID and CDC parties particularly at the field level that recurrent costs are a major factor in institutionalizing national child survival services. Many just wish the problem wasn't there and some deny that it is of relevant concern. b) a relative lack of sophistication in health economics within AID and CDC resulting in caution and delay in addressing the problem and c) an ambiguity regarding the appropriateness of phasing the level of AID support on national resource commitments particularly during the current period of diminishing budgets. In this situation the auditor's recommendation carries considerably more weight than did AFR/TR exhortation. AFR/TR proposes that the AA/AFR authorize a cable directing that a coordinated plan for meeting project recurrent costs in each country be developed providing guidelines and establishing a timetable and reporting requirements. The cable should be prepared by December, 1986.

vii) a) specify coordination duties of the regional liaison officer with the USAIDs and CDC technical officers, b) develop a system to periodically notify USAIDs of project funded WHO/AFRO training courses and c) establish policies and procedures that ensure candidates from bilateral countries receive priority selection for project funded WHO/AFRO training.

AFR/TR response - with respect to items a & b AFR/TR took such remedial action in March and April of 1986. AFR/TR is not prepared to respond to item c) since we consider to do so would be detrimental to the Africa-wide scope of the regional support components of the CCCD project.

The auditors also noted that considerable progress is being made in achievement of project objectives and informally stated that the CCCD project was the best of the six regional projects they had reviewed, to some extent due to the adherence to a rigorous evaluation cycle and the extensive oversight of AID/W project managers.

IV CCCD PROJECT AMENDMENT FUNDING AND MANAGEMENT

Each of the major CCCD components has its own implementation plan i.e. each of the 12 countries, the CDC/PASA, The Peace Corps PASA, and the WHO/AFRO Grant agreement. Table 10 summarizes major action items over the life of project.

A. Proposed Funding

The original project paper estimated project costs at \$47,000,000. The funding source was entirely from the DA/HEA account. The second amendment to the CCCD project amended the source of funding to include \$2,000,000 funding authority from the SDP account, reducing D.A. account funding to \$45,000,000.

The Sahel contribution was subsequently reduced to \$527,000, leaving the final D.A. amount at \$46,473,000. At the time of the second amendment to the CCCD project authorizing SDP account funding, it was understood that financial commitments were being made that exceeded the authorized LOP funding level of \$47,000,000 and that a subsequent increase in authorized LOP funding would be required.

The total of additional funding which would be required to carry the project at a level of 13 emphasis countries to its current PACD of September 30, 1989 is approximately 11.6 million. The majority of additional funding requested is required to extend the LOP by two years (13.3 million), to increase the health education component of projects (1.8 million), to add a 13th country, Nigeria. (14.3 million) and provide additional assistance to WHO/AFRO in support of AFRICAN Immunization year (1.0 million). The new LOP funding total is 89.0 million. See Tables 11, 12, and 13.

B. Management Plan

One of the concerns in extending this project and expanding to two additional countries is one of management. In the twelve ongoing country projects, CDC technicians are on the ground and no significant management problems have been reported. It is expected that the current management system will adequately serve these twelve countries as well as the proposed 14th subproject. At present, CDC personnel are fielded after concurrence by the respective AID Missions. The CDC field technicians report to the counterparts in ministries of health with administrative oversight by the AID health and/or population staff. The CDC staff in Atlanta provides administrative backstopping as well as technical support, especially in identifying and providing logistic support for technical experts who are requested to solve specific problems. Two CDC officers are detailed to AFR/TR/HPN to help provide overall coordination and technical support.

A principal management concern in amending this project is that of management of the proposed activity in Nigeria. The management plan as proposed by the team which designed this subactivity is as follows:

-For reasons of cost and technical oversight, responsibility for the recruitment and support of the various types of long- and short-term technical assistance should be assumed by UNICEF in Nigeria and to three AID centrally-funded projects:

- CCCD, through the Centers for Disease Control in Atlanta;
- Technologies for Primary Health Care (PRITECH); and
- Communications for Child Survival (HEALTHCOM).

-To assure coordination of technical inputs, the CDC project coordinator in Nigeria, in collaboration with the Nigerian program manager, should be assigned supervisory responsibility over the other long-term specialists (except the UNICEF technical officer) and all short-term specialists.

-To facilitate the administrative tasks associated with this supervisory responsibility, the CDC project coordinator should be authorized to hire a program assistant and administrative assistant (local hire). The project coordinator should also be authorized to maintain a special operating account in country to take care of emergencies.

-A Project Coordinating Committee composed of the AID/W project officers for CCCD (who would become the permanent chair), PRITECH, and HEALTHCOM and a representative of UNICEF/New York, should be established to assure coordination of project management at the level of the implementing agencies in the United States.

-A special effort, involving a three-month consultancy of a CDC epidemiologist, will be required to organize a proposed Youth Epidemiology Service (YES).

-In the first year or two, the YES activity should be limited to one five-state zone.

-It is projected that most commodity procurement would be undertaken by UNICEF. However, for procurement of U.S. source and origin commodities, AFR/TR/HPN would be responsible.

-USAID/Nigeria would not be involved in day-to-day program management, but should, in conjunction with the Federal Ministry of Health, play an active role in policy and program oversight. It is estimated that project oversight by AAO/Lagos will require no more than 15 to 20 percent of either direct-hire officer's time.

Table 14 illustrates additional management resources that are available from REDSO/WCA, AFR/TR/HPN, CDC in Atlanta and from cooperating agencies.

Financial Management at CDC

For each fiscal year of the CCCD project, CDC provides to AID an estimated budget. This budget consists of at least three components; Headquarters Costs, Overseas Costs Handled by CDC Headquarters, and Overseas Costs Paid at Post. These budgets are incorporated into PASA

Amendments which authorize CDC's expenditures of funds for subsequent reimbursement by AID. In some cases, it may be desirable to treat a budget category separately. In these situations, another budget component may be added. Examples include the budget covering OCCGE activities in Burkina paid for with Sahel funds and the Malaria Chemoprophylaxis in Pregnant Women study.

The Headquarters component includes such items as salaries for backstopping support, domestic and international travel for headquarters staff and consultants, shipments of supplies/equipment, communications costs, printing, contractual services, supplies, equipment, and cooperative agreements.

The Overseas Costs Handled by CDC Headquarters component contains similar categories of items, but pertain to overseas assignees. Salary and benefit costs, change-of station travel entitlements, shipment of supplies and equipment to post, personal services contracts, and supplies and equipment procured by CDC/A for overseas assignees are included in this category.

Both the Headquarters and the Overseas Costs Handled by CDC Headquarters components include a 20% overhead.

The Overseas Costs Paid at Post component is comprised of the same object class categories mentioned above, but the costs are incurred at post. Such items primarily support the CDC overseas assignee (in-country travel, house rental, utility costs, drivers and guards, official vehicle support, household and office furniture and appliances). On occasion, items are also funded under this budget category which are "other than assignee support costs." Examples include travel of country nationals to attend inter-country training courses, post-awarded personal services contracts for temporary employees to participate in special surveys, and professional services arranged through purchase orders at post. Because these costs are handled at post, and CDC's involvement is not as great, an overhead rate of 5% is applied to these charges. In this category, CDC's administrative role is primarily a bookkeeping one.

Suballocation is the term for the funds sent to field personnel at post for in-country operating expenses. Prior to assigning a person at post, CDC cables the USAID/Embassy to establish a suballocation. This suballocation provides CDC fiscal data and a dollar ceiling for charges during the quarter. Within 6 weeks following arrival, the assignee is required to submit an annual budget to CDC Headquarters. For subsequent FY quarters, CDC sends quarterly suballocations by cable based on the field assignee's request. USAID/Embassy is authorized to certify and disburse funds up to that amount in accordance with post policies and procedures for AID direct hire employees. The assignee is responsible for submitting monthly reports to CDC accounting for obligated funds. USAID/Embassy is responsible for assuring suballocations are not exceeded and for processing vouchers through the Regional Finance Center in Paris for submission to the Centers for Disease Control.

Because CDC operates on a fiscal year basis, each suballocation must be closed as of September 30 each year. Necessary funds are projected through that date; any additional funds required are provided by suballocation cable or any remaining funds in the suballocation are rescinded. New fiscal data is provided each October.

TABLE 1

IMMUNIZATION COVERAGE (AGE 12-23 MONTHS)
IN CCOD COUNTRIES WITH \geq 1 YEAR EXPERIENCE

	<u>1983/84</u>	<u>1985</u>
CONGO	32**	40*
LESOTHO	38*	65*
LIBERIA	4**	16**
MALAWI	55*	35*
RWANDA	21*	48*
SWAZILAND	27*	40*
TOGO	5**	32**
ZAIRE	20**	40**

* NATIONAL SURVEY DATA

** MAJOR URBAN AREAS

TABLE 2

IMMUNIZATION COVERAGE (AGE 12-23 MO)

IN CCGD COUNTRIES WITH \geq THAN 1 YEAR EXP.

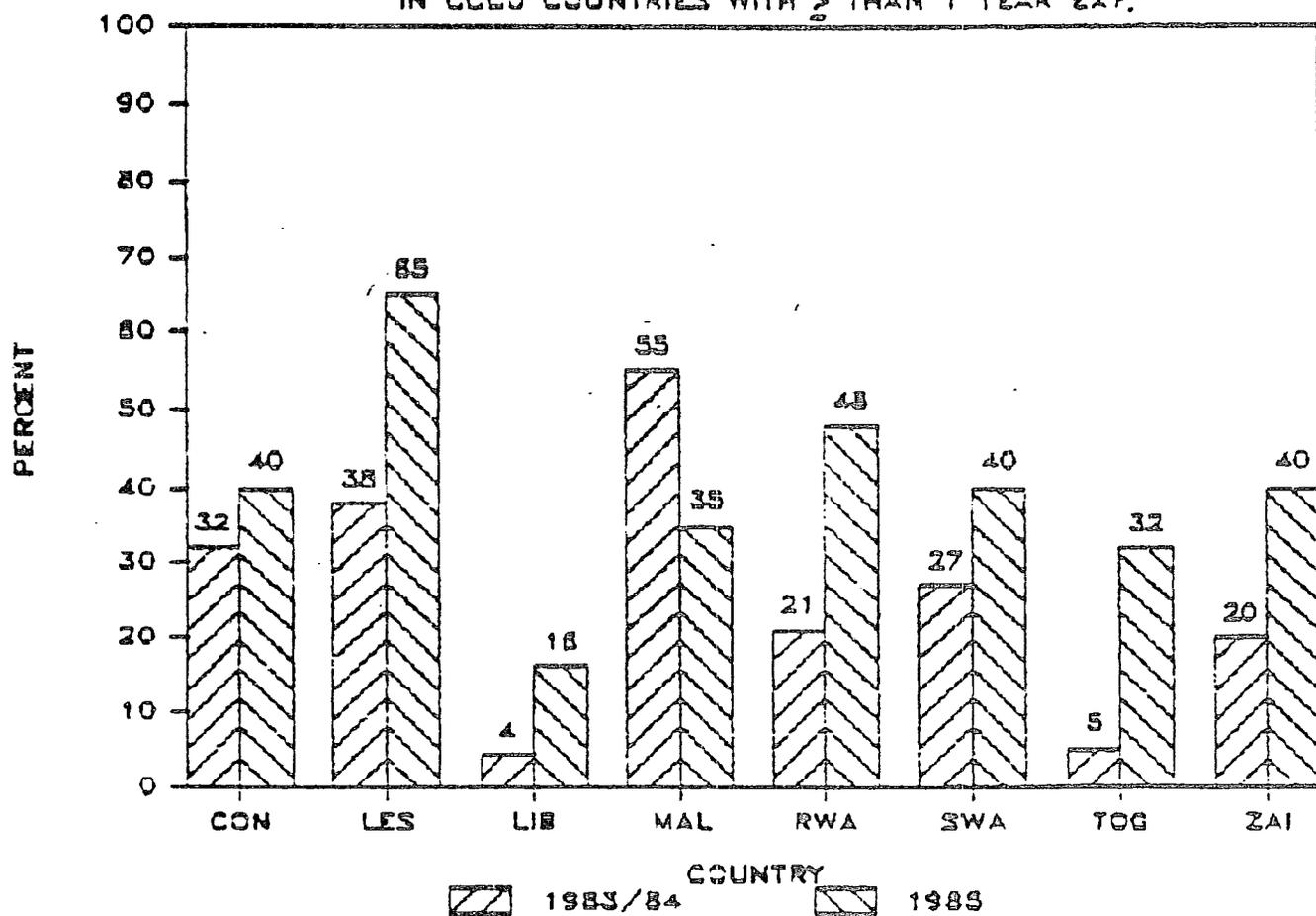


TABLE 3

PERCENT OF HOSPITALS USING ORT
 IN AREAS COVERED BY CCCD
 (CCCD COUNTRIES WITH \geq 1 YEAR EXPERIENCE)

COUNTRY	PRE-CCCD	ORT DEMONSTRATION/ 1985 TRAINING CENTER	
CAR	NA	NA	
CONGO	10	18	X
LESOTHO	80	100	X
LIBERIA	NA	NA	
MALAWI	15	95	X
RWANDA	NA	NA	
SWAZILAND	32	95	
TOGO	10	90	
ZAIRE	20	83	X

Percent of diarrheal episodes treated at home with ORT

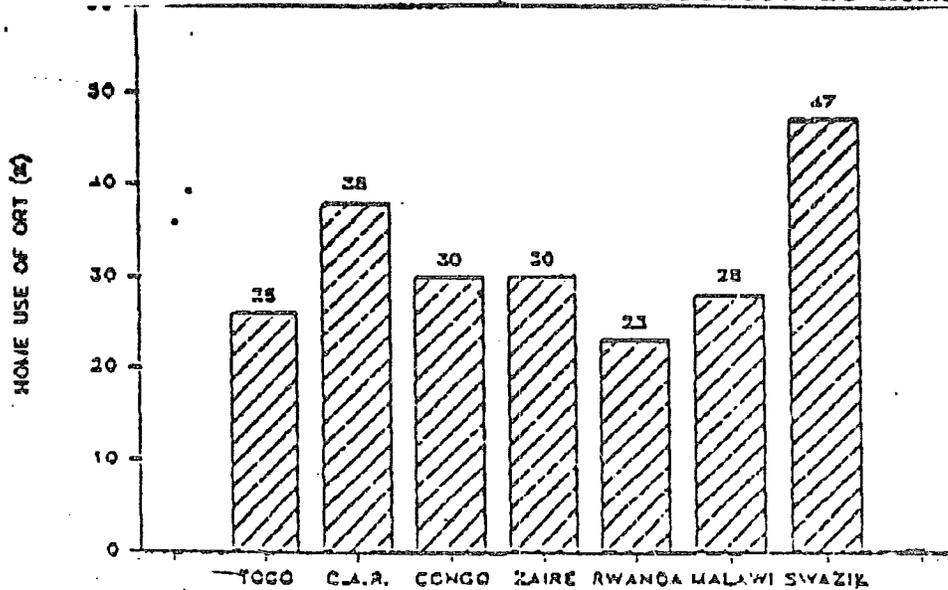
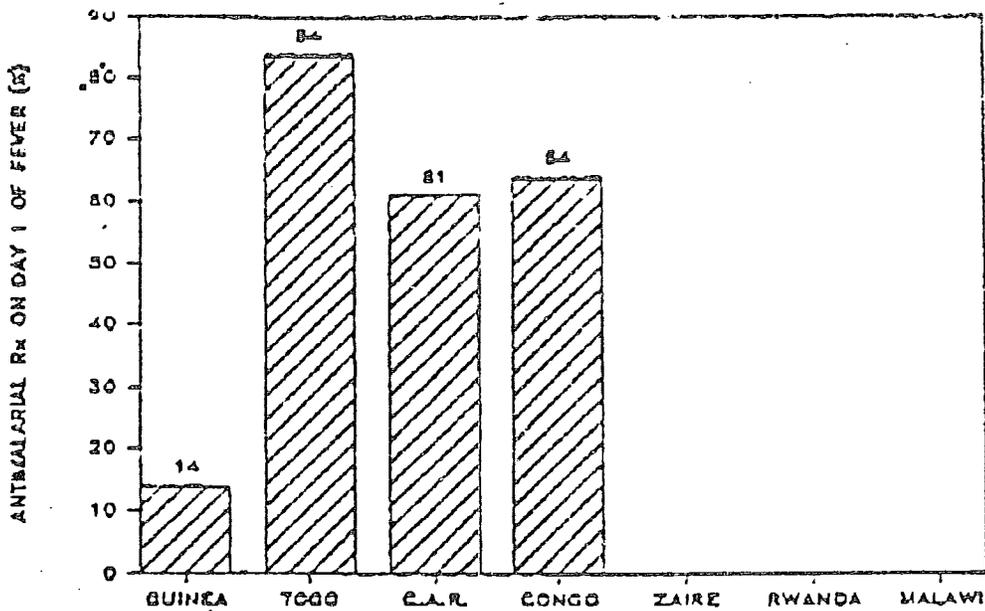
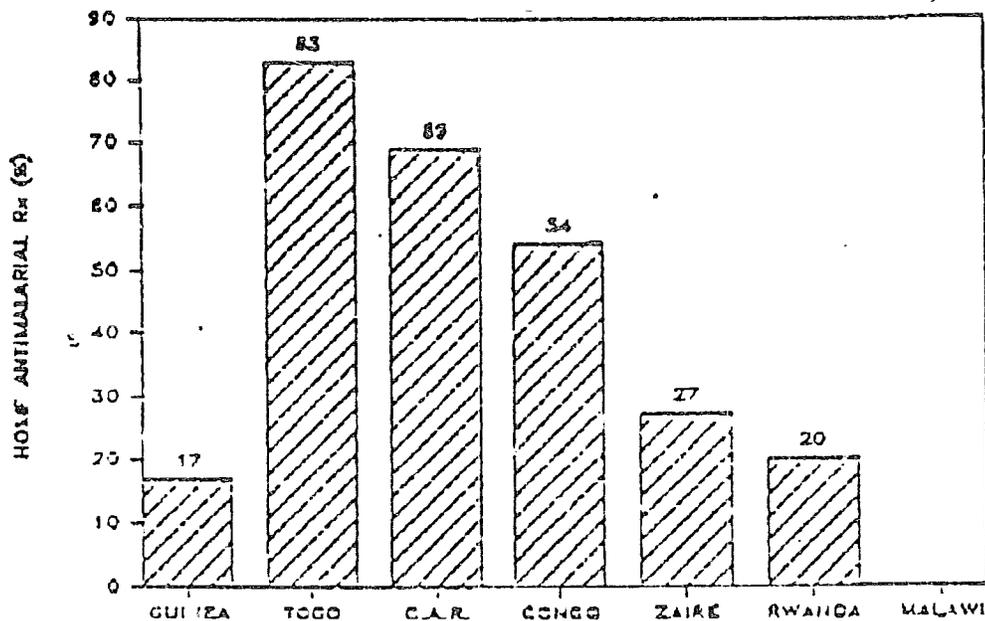


TABLE 5

Percent of cases of fever treated at home with antimalarials



Percent of fever episodes treated by antimalarials on day 1

MALARIA INTERVENTIONS IN CCGD COUNTRIES
WITH ≥ 1 YEAR EXPERIENCE

<u>COUNTRY</u>	<u>RESISTANCE TO CHLOROQUINE</u>	<u>TRAINING PROGRAMS</u>	<u>SURVEILLANCE MECHANISM ESTABLISHED</u>	<u>NATIONAL PLAN</u>	<u>POLICY IMPLEMENTED</u>
A. E.	YES	YES	IN-PROGRESS	YES	IN-PROGRESS
NGO	YES	YES	YES	YES	YES
SO THO		NO MALARIA			
BERIA	NO	NO	NO	NO	NO
LAHI	YES	YES	YES	YES	YES
ANDA	YES	YES	YES	YES	YES
AZILAND	YES	YES	YES	YES	YES
SO	NO	YES	YES	YES	YES
RE	YES	YES	YES	YES	YES
COUNTRIES IMPLEMENTING INTERVENTIONS		88%	75%	88%	75%

INCLUDES LESOTHO

Table 7

TRAINING ACTIVITIES SUMMARY
BY TYPE OF TRAINING, BY COUNTRY,
IN PERSON-DAYS, CY 1985

CCCD Countries	Senior-Level	Mid-Level	Peripheral Level	HIS/Survey	ORT	Peace Corps	Malaria In-vivo	TOT	EPI Campaign	Cold Chain
CAR	<u>0</u>	<u>110</u>	<u>0</u>	<u>100</u>	<u>0</u>	<u>NA</u>	<u>150</u>	<u>0</u>	<u>NA</u>	<u>NA</u>
Congo	<u>36</u>	<u>300</u>	<u>NR</u>	<u>93</u>	<u>365</u>	<u>NA</u>	<u>324</u>	<u>0</u>	<u>270</u>	<u>NR</u>
Guinea*	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Ivory Coast*	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Lesotho	<u>NR</u>	<u>80</u>	<u>3397</u>	<u>0</u>	<u>NR</u>	<u>NA</u>	<u>NA</u>	<u>400</u>	<u>NA</u>	<u>NR</u>
Liberia	<u>28</u>	<u>126</u>	<u>96</u>	<u>121</u>	<u>0</u>	<u>45</u>	<u>0</u>	<u>0</u>	<u>1898</u>	<u>NR</u>
Malawi	<u>0</u>	<u>5262</u>	<u>2043</u>	<u>819</u>	<u>219</u>	<u>135</u>	<u>55</u>	<u>0</u>	<u>NA</u>	<u>0</u>
Rwanda	<u>NR</u>	<u>42</u>	<u>220</u>	<u>400</u>	<u>NR</u>	<u>NA</u>	<u>120</u>	<u>0</u>	<u>NA</u>	<u>NR</u>
Swaziland	<u>NR</u>	<u>330</u>	<u>800</u>	<u>0</u>	<u>NR</u>	<u>NA</u>	<u>55</u>	<u>NR</u>	<u>NA</u>	<u>NR</u>
Togo	<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>105</u>
Zaire	<u>1507</u>	<u>1970</u>	<u>2683</u>	<u>NR</u>	<u>NR</u>	<u>1378</u>	<u>900</u>	<u>NR</u>	<u>NA</u>	<u>NR</u>

*Training Activities Not Initiated Until CY 1986

NR - Not Reported

NA - Not Applicable

**TOT (Training of Trainers)

TABLE 8

STATUS OF HEALTH EDUCATION/PROMOTION
 CCCD BILATERAL PROJECTS, JANUARY 1986

Activity	Burundi	CAR	Congo	Guinea	Ivory Coast	Lesotho	Liberia	Malawi	Rwanda	Swazi	Togo	Zaire
"Pre-programming"	o	++	++	++	++	++	++	++	++	++	++	++
HE Coordinator designated	?	++	++	o	o	++	o	++	++	?	++	++
Baseline formative data collected	o	+	+	o	o	+	+	?	+	+	+	+
HE assessment/work plan developed as part of EPI, CDD, and/or Malaria plans	o	+	+	o	+	+	+	+	+	+	+	+
PCV descriptions prepared PVC's requested	N/A	+	N/A	N/A	N/A	++	++	++	N/A	o	++	++
Educational materials developed	o	+	+	o	o	+	+	+	o	+	+	+
Health worker training w/public ed. materials diffusion	o	o	o	o	+	+	+	?	o	+	+	+
Multi-media message diffusion	o	+	+	o	+	+	+	?	o	+	+	+
Reporting/monitoring of coverage	o	o	o	o	o	o	o	o	o	+	o	?
Program redesign												
Final Evaluation	N/A -----											

KEY: ++ - Fully completed + - Partially completed/underway ? - Status uncertain o - No

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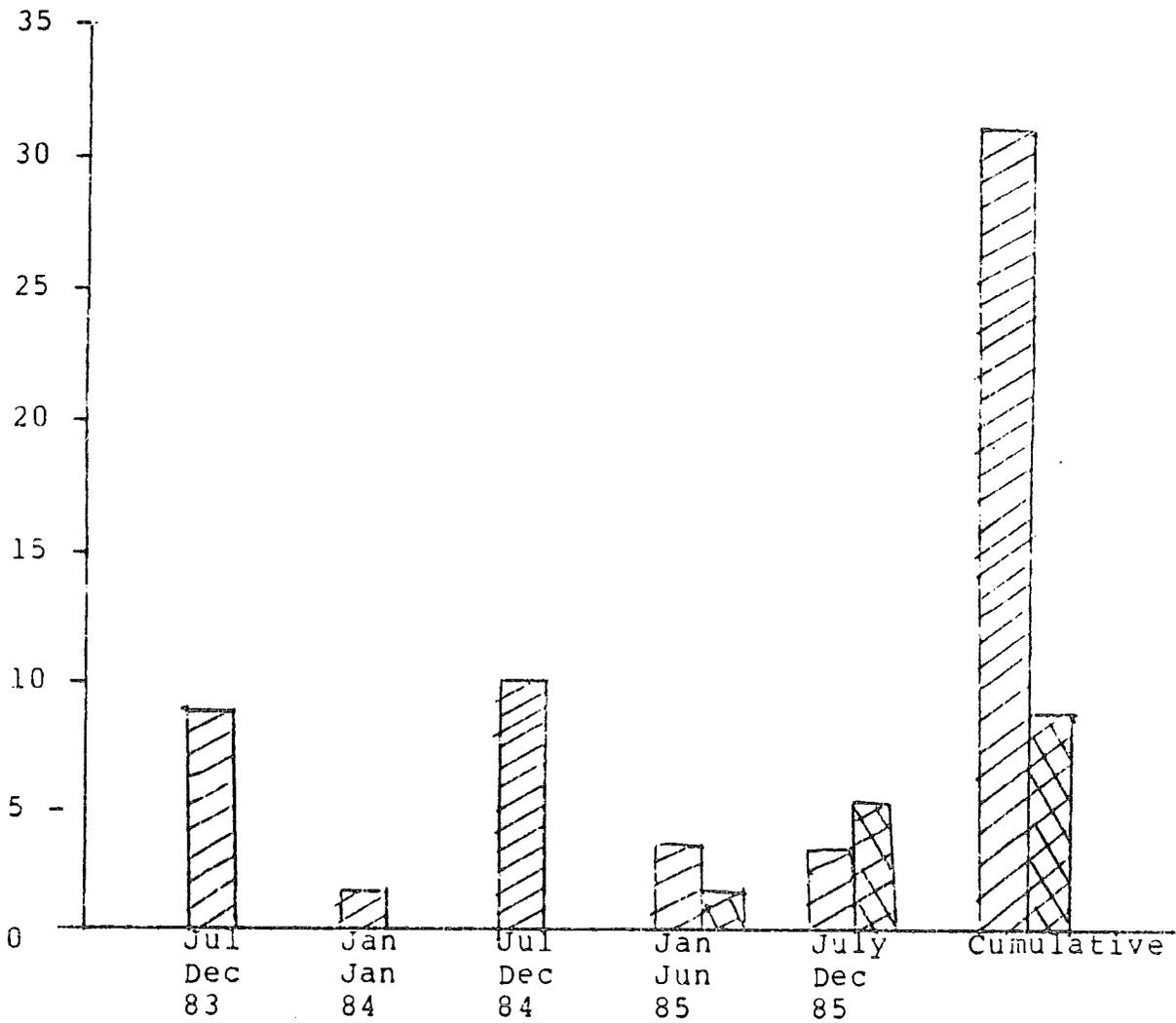
TABLE 9

CCCD AFRICAN APPROVED AND COMPLETED

Operations Research Projects

by 6 month period

1983 - 1985

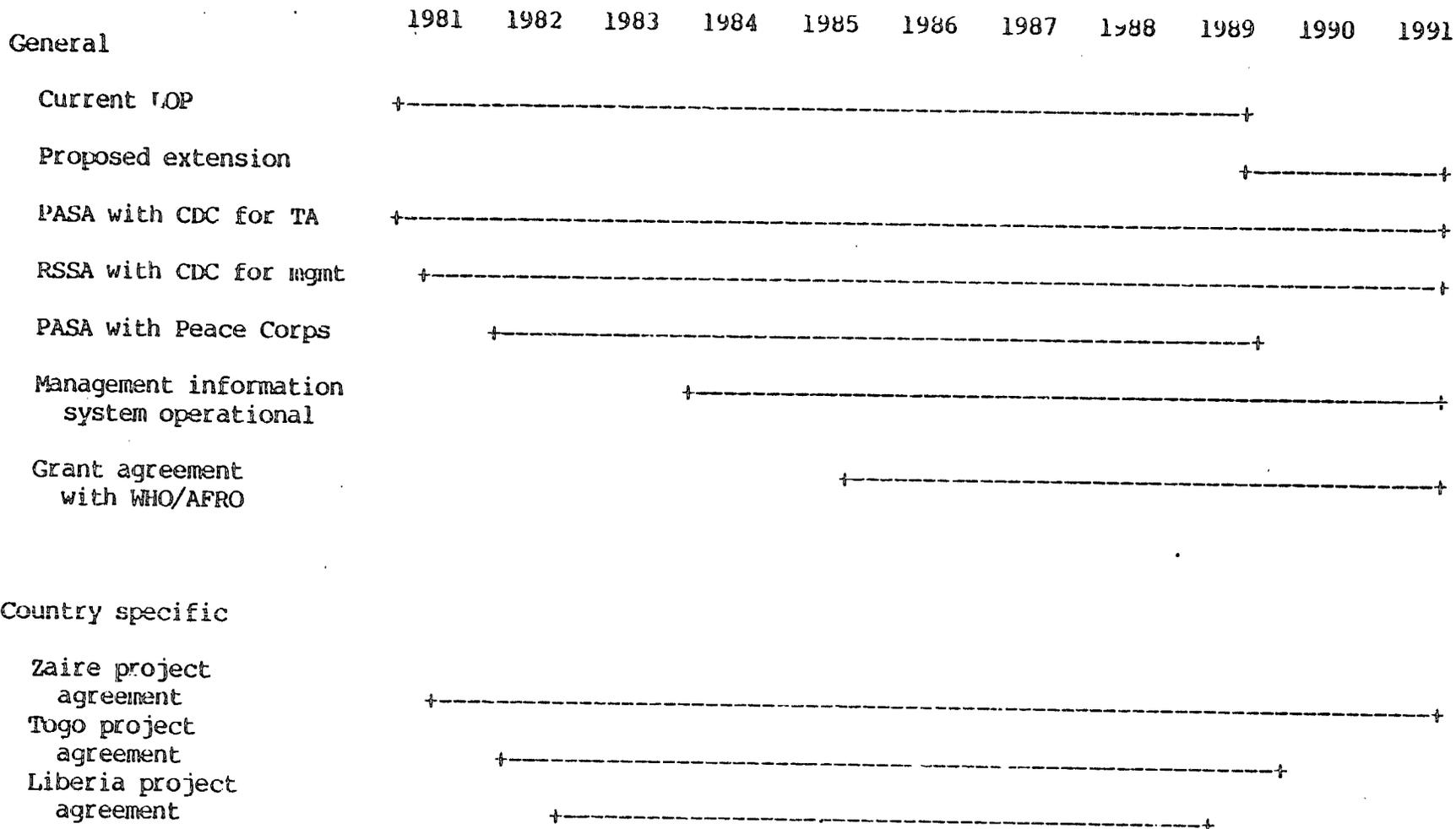


 Approved

 Completed

Table 10

Combatting Childhood Communicable Diseases
698-0421
Implementation Plan Summary

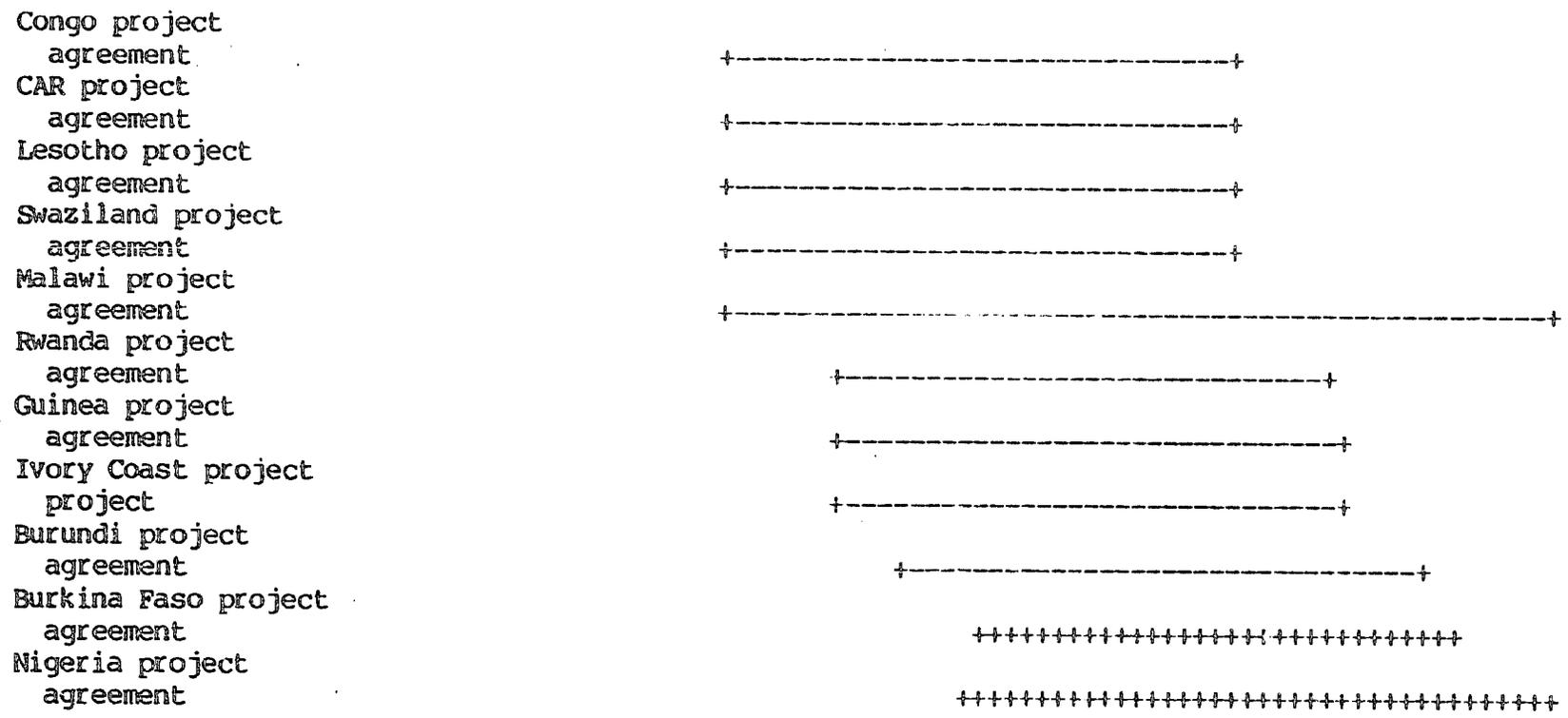


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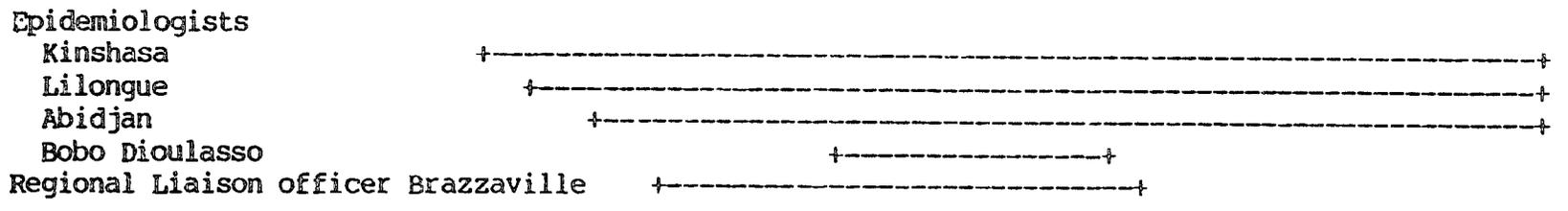
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Table 10 con't.

1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991



Regional staff placement



40

50

Table 11

EXPENDITURES BY PROJECT YEAR

(\$ 000)

	FY86	FY87	FY88	FY89	FY90	FY91	TOTAL
Bilateral projects							
commodities	2,300	2,300	2,000	2,000	1,200	200	10,000
local costs	1,000	1,000	800	800	400	100	4,100
Resident Field Staff	3,848	4,839	4,366	3,790	2,840	1,420	21,103
Short-term consultants	630	830	830	740	770	590	4,390
CDC/Atlanta supervisory and support staff	1,590	2,562	2,170	1,890	1,420	710	10,342
Measles vaccine	532	400	350	300	200	100	1,882
Evaluation	415	425	380	330	250	255	2,055
OPS research	450	400	100	100	100	--	1,150
WHO/AFRO grant agreement	1,000	1,000	750	500	250	--	3,500
Enhanced health education TA	150	500	500	500	150	--	1,800
RSSA	224	235	247	170	178	187	1,241
Peace Corps	100	50	50				200
Contingencies	100	150	250	200	150	100	950
Total	12,339	14,691	12,793	11,320	7,508	3,662	62,713
Pre FY 86 Expenditures	26,287						
FY 86-91 Expenditures	62,713						
TOTAL	89,000						

Table 12

BUDGET TABLES
OBLIGATIONS BY FISCAL YEAR
(\$ 000)

	FY86	FY87	FY88	FY89	FY90	FY91	TOTAL
CDC PASA	6,449	7,881	5,688	6,100	3,372	1,700	30,990
CDC RSSA	224	235	247	170	178	80	1,134
Peace Groups PASA	48						48
Task Orders PRITECH	200	250	250				700
Task Orders Health Com	150	500	500	500	150		1,700
IQC Task Orders	395	415	400	350	250	250	1,960
Measles Vaccine Contract	532	000	360	310	200	100	1,592
Nigeria and UNICEF Grant Agreement	2,000	2,000	2,000	2,000	1,478		9,478
Zaire Grant Agreement	2,000						2,000
Malawi Grant Agreement		450	450				900
Other bilateral grant agreements	1,395						1,395
WHO/AFRO	2,313	516	1,000	750	500	250	5,129
Miscellaneous	154	190	185	160	120	60	759
Contingency		110	220	220	120	70	740
Total	15,750	12,547	11,310	10,000	6,438	2,500	58,545

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Table 13

FUNDING BY PROGRAMMATIC ACCOUNT

	all prior years	FY86	FY87	FY88	FY89	FY90	FY91	TOTAL
HEA	29,825	11,750	10,547	9,310	8,000	4,438	600	74,473
CSF	--	4,000	2,000	2,000	2,000	2,000	2,000	14,000
SDP	527	--	--	--	--	--	--	527
TOTAL	30,455	15,750	12,547	11,310	10,000	6,438	2,600	89,000

Table 8

532

AVAILABLE SOURCES OF MANAGEMENT ASSISTANCE TO NIGERIA (PERSON MONTHS)1

SOURCES OF MGT. ASSIST. PROJECT PHASE	CY86 Design	CY87 START-UP	CY88 MID-PROJECT	CY89 PHASE-OUT	CY90 OR	CY91 EXTEND
I. REDSO/W						
LEGAL ²	3	2	X	X	X	X
FISCAL	2	X	X	X	X	X
CONTRACTING ²	3	3	2	2	2	2
PROGRAM	3	X	X	3	X	3
EVALUATION	X	X	X	4	X	2
POPULATION	4	3	3	3	3	3
HEALTH	3	3	2	2	2	2
II. AID/W						
AFR BUR	6	6	6	6	6	6
S&T BUR ⁴	3	3	X	X	X	X
III. CDC						
U.S. PROFESS -IONAL PSC	6	24	20	24	20	24
IV. CONTRACT SERVICES³	6	24	24	24	24	24
V. OTHER DONORS						
UNFPA	3	TO BE DETERMINED. POTENTIALLY SUBSTANTIAL, IF THESE AGENCIES ASSUME MAJOR SUPPORT ROLES				
UNICEF	3					
WORLD BANK	3					

-
- Potential resources for management support to health and population activities, additive to AAO staff. Includes TDY field support as required. X = continuing or ad hoc support.
 - May require AID/W supplemental assistance to REDSO/W.
 - Part-time services; not to exceed 9 months per person-year additive to AAO or REDSO/W staff.
 - Numerous short term TA visits by S&T contractors may also contribute to

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 79 to FY 91
Total U.S. Funding \$89,000,000
Date Prepared: June 10, 1986

Project Title & Number: Combatting Childhood communicable Diseases 698-0421

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>To improve the health status of the pediatric population of sub-Saharan Africa.</p>	<p>50% reduction in disease specific mortality rates for diseases preventable by immunizations, diarrhea disease and malaria in the age groups 0-5, reduction by 50% of disability from polio and an overall reduction in infant and childhood mortality by 25%.</p>	<p>serial mortality studies in a sample of countries and lameness surveys.</p>	<p>Assumptions for achieving goal targets: Adequate baseline data will be available or will be collected by special surveys.</p> <p>Participating governments will support the development and maintenance of data collection systems.</p>
<p>Project Purpose: Strengthen the Africans' ability to control:</p> <ul style="list-style-type: none"> o Six childhood communicable diseases (measles, polio, tuberculosis, diphtheria, pertussis (whooping cough) and tetanus) through Expanded Program for Immunization (EPI). o Diseases of local importance such as yellow fever and yaws. Provide simple treatment for the Control of Diarrhea Diseases (CDD), and o Treatment of fevers for malaria. 	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <p>80% of target population in AID supported countries fully immunized against the six EPI diseases.</p> <p>60% of cases of acute diarrhea and fevers effectively treated.</p>	<p>immunization coverage surveys, diarrhea and malaria treatment practices. surveys and facility case treatment reports.</p>	<p>Assumptions for achieving purpose: Participating countries will continue to place a high priority on CCCD and developing PHC programs and will provide adequate resources to support these activities. WHO and other regional organizations will continue to provide support and training in developing country-specific health care programs. Participating countries will actively seek participation in CCCD programs.</p>

Outputs:

1. No. of countries with CCCD projects	1. 30 countries with CDA supported CCCD projects 14 with AID support	1. CCCD management information system	Participating countries will make adequate and appropriate personnel available for participant training health education and health information systems.
2. Trained Personnel	2. 15,000 upper, mid and peripheral health personnel trained	2. evaluations	
3. Health Education Programs	3. health education campaigns completed in 14 countries		
4. Health Information Systems	4. CCCD health information system operational in 14 countries		
5. Operations Research Projects	5. operational research projects completed in 15 countries.		

Inputs:

1. Technical Assistance	Implementation Target	1. CCCD management information systems	Assumptions for providing inputs: MOHS develop ways and means of distributing and utilizing:
2. Training Courses	(Type and Quantity)	2. evaluations	
3. Data Systems Courses Developed for Disease Surveillance, Program Management	224 Person Years 220 courses given	3. quarterly implementation	
4. Health Education and Promotion	5 Data Systems developed		a. Oral rehydration salts;
5. Operations Research	60 or activities		b. CCCD health promotion materials.
6. Commodities	Measles Vaccine (16,000,000 doses) Cold Chain Equipment Vehicles (200-4/wheel drive 500 bicycles) Immunization Supplies and Equipment Oral Rehydration packets (20 million).		Participating country has the ability to provide personnel, building space and other support. T/A personnel can be recruited and assigned to project as needed.

INITIAL ENVIRONMENTAL EXAMINATION

AMENDMENT

Project Country: Africa Regional

Project Titles: Combatting Childhood Communicable Diseases
Project No. 698-0421

Funding: FY 1981 - 1990 \$89,000,000

IEE Prepared by: AFR/TR/HPN, W. Ching

Environmental Action Recommended: Categorical Exclusion

This amendment continues to meet the criteria for Categorical Exclusion under the terms of the original ~~project paper~~; this amendment increases the amount of funding by \$42 million (LOP increases from \$47 million) and the Project Assistance Completion Date (PACD); this amendment provides \$14 million to fund an activity in Nigeria for five years (1986-1990). Implementation components will include:

- Health Information Systems development
- Training (Management, Technical, Financial)
- Health Communication, and
- Logistical Support

Concurrence: (Bureau Environmental Officer) APPROVED _____ x _____
Bessie L. Boyd, AFR/TR/PRO



DISAPPROVED _____

DATE AUG 8 1986

CLEARANCE: GC/AFR _____
DATE 8/11/86

5C(2) PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A. includes criteria applicable to all projects. Part B. applies to projects funded from specific sources only:

B.1. applies to all projects funded with Development Assistance loans, and
B.3. applies to projects funded from ESF.

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

A. GENERAL CRITERIA FOR PROJECT

1. FY 1986 Continuing Resolution Sec. 524; FAA Sec. 634A.

A Congressional Notification was sent on June 13, 1986. The CN expired without objection.

Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project.

2. FAA Sec. 611(a)(1). Prior to 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

b) Yes

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

NA

4. FAA Sec. 611(b); FY 1986 Continuing Resolution Sec. 501. If for water or water-related land resource construction, has project met the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See AID Handbook 3 for new guidelines.) NA
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project? NA
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. CCCD is regional project
7. FAA Sec. 601(a). Information and conclusions whether projects will encourage efforts of the country to:
- (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.
- a) No
- b) No
- c) No
- d) No
- e) No
- f) No

8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

The project will provide technical assistance from a number of sources some of which will be obtained in the U.S.

9. FAA Sec. 612(b), 636(h); FY 1986 Continuing Resolution Sec. 507. 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.

Approximately two-thirds of the costs associated with the project in country specific programs will be paid in local currencies; the regional programs will be supported primarily by foreign exchange.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No

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

Yes

12. FY 1986 Continuing Resolution Sec. 522. 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?

NA

13. FAA 118(c) and (d). Does the project comply with the environmental procedures set forth in AID Regulation 16. Does the project or program take into consideration the problem of the destruction of tropical forests? Categorical Exclusion applies
14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)? NA
15. FY 1986 Continuing Resolution Sec. 533. Is disbursement of the assistance conditioned solely on the basis of the policies of any multilateral institution? NA
16. ISDCA of 1985 Sec. 310. For development assistance projects, how much of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, 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)? 10% of the activity that is over and above the amount to CDC etc may be available for activities under the Gray amendment.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance
Project Criteria

a. FAA Sec. 102(a), 111, 113, 281(a). 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, 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; (b) 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; (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, (e) utilize and encourage regional cooperation by developing countries?

a) Immunizations and improved health care will benefit the poor.

b) NA

c) Project will respond to country requests for improved health care.

d) Women play an important role in the implementation of the project

e) The major part of the project is a regional effort.

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- b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used? Yes, project emphasizes low-cost health delivery system.
- c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? NA
- d. FAA Sec. 110(a). Will the recipient country provide at least 25% 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
- e. FAA Sec. 122(b). 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? Yes

f. 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

g. FAA Sec. 281(b). Describe extent to which program 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 civil education and training in skills required for effective participation in governmental processes essential to self-government.

The project recognizes and takes i to account the particular health needs and desires of the people and concentrates its efforts in child survival as a major contrib.

2. Development Assistance Project
Criteria (Loans Only)

- a. FAA Sec. 122(b). Information an conclusion on capacity of the country to repay the loan, at a reasonable rate of interest. NA
- b. 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% of the enterprise's annual production during the life of the loan? NA

3. Economic Support Fund Project
Criteria

- a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of part I of the FAA? NA
- b. FAA Sec. 531(c). Will assistance under this chapter be used for military, or paramilitary activities? NA
- c. ISDCA of 1985 Sec. 207. Will ESF funds be used to finance the construction of, or the operation or maintenance of, or the supplying of fuel for, a nuclear facility? If so, has the President certified NA

that such country is a party to the Treaty on the Non-Proliferation of Nuclear Weapons or the Treaty for the Prohibition of Nuclear Weapons in Latin America (the "Treaty of Tlatelolco"), cooperates fully with the IAEA, and pursues nonproliferation policies consistent with those of the United States?

d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

NA

5C(3) - STANDARD ITEM CHECKLIST

Listed below are the statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by imposing limits on certain uses of funds.

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. Procurement

- | | | |
|----|---|---|
| 1. | <u>FAA Sec. 602.</u> Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed? | Action memorandum reference to the Gray amendment refers. |
| 2. | <u>FAA Sec. 604(a).</u> Will all procurement be from the U.S. except as otherwise determined by the President or under delegation from him?? | Yes |
| 3. | <u>FAA Sec. 604(d).</u> 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? | NA |
| 4. | <u>FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a).</u> If offshore procurement of agricultural commodity or product 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.) | NA |

5. FAA Sec. 604(g). Will construction or engineering services be procured from firms of countries which receive direct economic assistance under the FAA and which are otherwise eligible under Code 941, but which have attained a competitive capability in international markets in one of these areas? Do these countries permit United States firms to compete for construction or engineering services financed from assistance programs of these countries? NA
6. FAA Sec. 603. Is the shipping excluded from compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum 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? NA
7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? If the facilities of other Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? Yes

8. 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

9. FY 1986 Continuing Resolution 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

B. Construction

1. FAA Sec. 501(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used? NA

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? NA

3. 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 CP)? NA

C. Other Restrictions

1. FAA Sec. 122(b). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter? NA

2. 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? NA

3. 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? NA

4. Will arrangements preclude use of financing: Yes
 - a. FAA Sec. 104(f); FY 1986 Continuing Resolution Sec. 526. (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo Yes

- sterilization; (3) to pay for any biomedical research which relates, in whole or part, to methods or the performance of abortions or involuntary sterilizations as a means of family planning; (4) to lobby for abortion? Yes
- b. FAA Sec. 488. To reimburse persons, in the form of cash payments, whose illicit drug crops are eradicated? Yes
- c. FAA Sec. 620(g). To compensate owners for expropriated nationalized property? Yes
- d. FAA Sec. 660. To provide training or advice or provide any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes
- e. FAA Sec. 662. For CIA activities? Yes
- f. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes

- g. FY 1986 Continuing Resolution, Sec. 503.
To pay pensions, annuities, retirement pay, or adjusted service compensation for military personnel? Yes
- h. FY 1986 Continuing Resolution, Sec. 505.
To pay U.N. assessments, arrearages or dues? Yes
- i. FY 1986 Continuing Resolution, Sec. 506.
To carry out provisions of FAA section 209(d) (Transfer of FAA funds to multilateral organizations for lending)? Yes
- j. FY 1986 Continuing Resolution, Sec. 510.
To finance the export of nuclear equipment, fuel, or technology? Yes
- k. FY 1986 Continuing Resolution, Sec. 511.
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? Yes
- l. FY 1986 Continuing Resolution, Sec. 516.
To be used for publicity or propaganda purposes within U.S. not authorized by Congress? Yes

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Department of State

Attachment C
OUTGOING
TELEGRAM

PAGE 01 STATE 244910

6498 003100 AID0001

ORIGIN OFFICE AFDP-00
INFO AFPA-03 AFSA-01 AFPA-04 AFCW-03 AFCA-05 CMGT-02 CTR 02
SDB-02 AIDA-01 HELD-01 1310 13 309
INFO LOG-00 AF-00 1000 R

DRAFTED BY: AID/AFR/POL. ADUSMAN: PDC
APPROVED BY: AID/AFR/POL. HAUSMAN
AID/AFR/PD: H HARDING (INFO) AID/SER/CM: DEAN (INFO)
-----106330 890217Z 88

R 090200Z AUG 85 ZEX
FM SECSTATE WASHDC
TO USAID MISSIONS IN AFRICA

UNCLAS STATE 244910

AIDAC NAIROBI FOR REDSO/ESA ABIDJAN FOR REDSO/WCA

E.O. 12356: N/A

TAGS:

SUBJECT: FURTHERING THE SMALL BUSINESS ACT AND GRAY
AMENDMENT OBJECTIVES

1. WE ARE PASSING ALONG TEXT OF MEMO FROM FRANK MONCADA
(SER/CM), THAT YOU SHOULD BE AWARE OF WHEN PREPARING CBO
NOTICES ON CONTRACTING ACTIONS.

2. THIS CANCELS AND SUPERSEDES CTR 85-16, ENTITLED
FURTHERING GRAY AMENDMENT OBJECTIVES.

- THE FOLLOWING DIRECTIVE IS APPLICABLE TO ALL AID/W AND
MISSION CONTRACTS TO BE AWARDED UNDER THE FULL AND OPEN
COMPETITION PROCEDURES ESTABLISHED IN PART 6.1 OF THE
FEDERAL ACQUISITION REGULATION (FAR). THIS DIRECTIVE IS
NOT APPLICABLE TO CONTRACTS SET ASIDE UNDER THE S (A) OR
SMALL BUSINESS PROGRAMS.

- IN FURTHERANCE OF THE SMALL BUSINESS ACT AND THE
AGENCY'S GRAY AMENDMENT OBJECTIVES, THE DEPUTY
ADMINISTRATOR HAS DIRECTED THE INCLUSION OF THE
FOLLOWING LANGUAGE IN EACH COMMERCE BUSINESS DAILY
NOTICE REQUIRED BY FAR PART 1, AND IN THE INSTRUCTIONS
TO OFFERORS OR BIDDERS (SECTION 2) OF THE RELATED

SOLICITATION DOCUMENT.

- BEGIN QUOTE. CONTRACTING WITH SMALL BUSINESS CONCERNS,
SMALL DISADVANTAGED BUSINESS CONCERNS, AND WOMEN-OWNED
SMALL BUSINESS CONCERNS.

- AID ENCOURAGES THE PARTICIPATION TO THE MAXIMUM EXTENT
POSSIBLE OF SMALL BUSINESS CONCERNS, SMALL DISADVANTAGED
BUSINESS CONCERNS, AND WOMEN-OWNED SMALL BUSINESS
CONCERNS IN THIS ACTIVITY AS PRIME CONTRACTORS OR
SUBCONTRACTORS IN ACCORDANCE WITH PART 19 OF THE FEDERAL
ACQUISITION REGULATION. IN THIS RESPECT, IT IS
ANTICIPATED THAT AID (FYI. THIS WAS PREVIOUSLY QUOTE
PRIME CONTRACTOR UNQUOTE - END FYI) WILL MAKE EVERY
REASONABLE EFFORT TO IDENTIFY AND MAKE MAXIMUM
PRACTICABLE USE OF SUCH CONCERNS. ALL SELECTION
EVALUATION CRITERIA BEING FOUND EQUAL, THE PARTICIPATION
OF SUCH CONCERNS MAY BECOME A DETERMINING FACTOR FOR
SELECTION. END QUOTE. SHULTZ

UNCLASSIFIED

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1985 ANNUAL REPORT



COMBATting CHILDHOOD COMMUNICABLE DISEASES

**AFRICA REGIONAL PROJECT
(698-0421)**

AGENCY FOR INTERNATIONAL DEVELOPMENT
In Cooperation With

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

Participating Agency Service Agreement
PASA No. BAF 0421 PHC 2233

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INTRODUCTION

Combating Childhood Communicable Diseases (CCCD) is a USAID funded Child Survival project of technical cooperation to strengthen African capabilities to decrease child mortality and improve child health. 1985 was the fourth year of the 8 year project. CCCD is implemented by several different agencies: the Government Health Ministries of 12 African nations, the U. S. Centers for Disease Control (CDC), the World Health Organization African Regional Office (WHO/AFRO), and the U.S. Peace Corps.

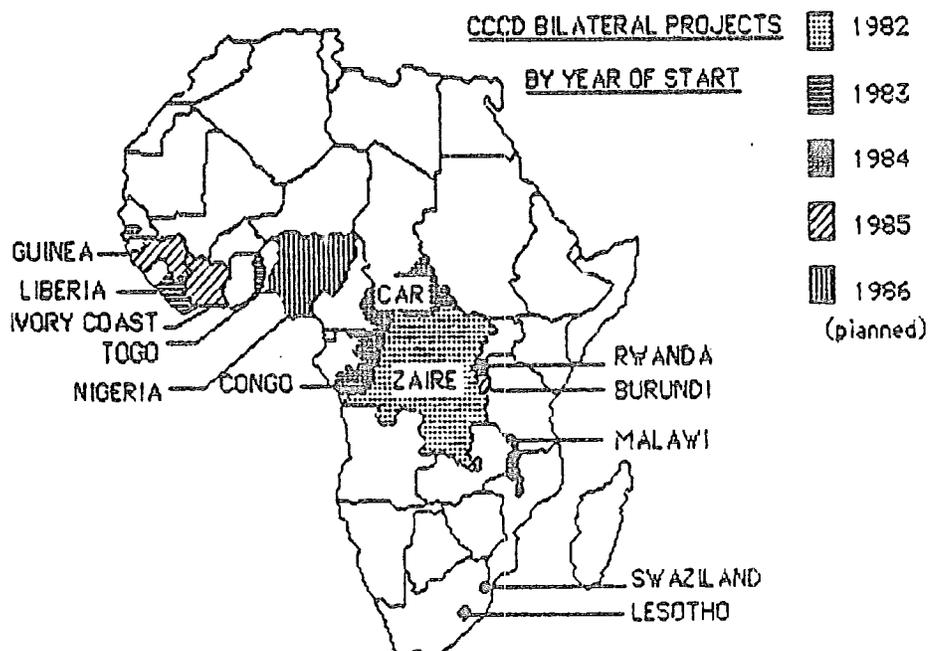
Several other agencies and projects are collaborating with CCCD in supporting Child Survival activities in Africa: the West European/North American organization Cooperation for Development in Africa (CDA) has endorsed CCCD as its major initiative in the health sector; the French Ministry of Cooperation and Development, through its Fonds d'Aide et Cooperation (FAC), is a partner in the CCCD project in Congo; the British Overseas Development Agency (ODA) has a CCCD bilateral agreement with the Government of The Gambia; and the sister child survival projects funded by AID's Science and Technology Bureau, including the Technologies for Primary Health Care Project (PRITECH), the Resources for Child Health Project (REACH), and the Communications for Child Survival Project (HEALTHCOM). Close collaboration is also maintained with WHO Geneva, UNICEF, and the Task Force for Child Survival.

The major accomplishments during 1985 and the constraints to achievement of CCCD objectives are detailed in the following pages. Several of these are particularly noteworthy and bear special mention here.

- Three bilateral CCCD project agreements were signed, bringing to full authorized complement (12) the number of AID funded country projects.
- AID and WHO/AFRO signed a grant agreement and agreed on a workplan for AFRO's implementation of intercountry training and health information systems development in support of CCCD.
- The Third Year CCCD Evaluation (internal) was carried out; recommendations included increasing the number of bilateral projects, lengthening the life of project, increasing the funding ceiling, deferring any additional disease interventions, and revising the CCCD Management Information System (MIS).

This report represents the first annual report utilizing the revised MIS. CDC/IMPO would appreciate your comments and suggestions regarding the present report (see address p. 34).

USAID BILATERAL CCCD PROJECTS



COUNTRY	TOTAL POPULATION (000)	START	FINISH	USAID BUDGET (\$000)	LOCAL BUDGET (\$000)
ZAIRE	32 648	8/82	12/91	4 849	4 167
TOGO	2 860	4/83	4/87	1 140	373
LIBERIA	1 890	8/83	8/87	830	217
C A R	2 526	5/84	5/88	571	217
LESOTHO	1 519	5/84	5/88	578	375
MALAWI	6 983	6/84	3/88	1 423	1 331
RWANDA	5 904	6/84	5/88	1 072	956
CONGO	1 702	6/84	6/88	667	500
SWAZILAND	631	6/84	6/88	703	285
GUINEA	5 735	6/85	12/87	885	650
IVORY COAST	9 513	6/85	4/89	1 691	5 014
BURUNDI	4 631	9/85	3/88	834	233
TOTAL (1985)	76 542				
NIGERIA (proposed)	94 431				
TOTAL	170 973				

°Proposed

THE CCCD PROGRAM

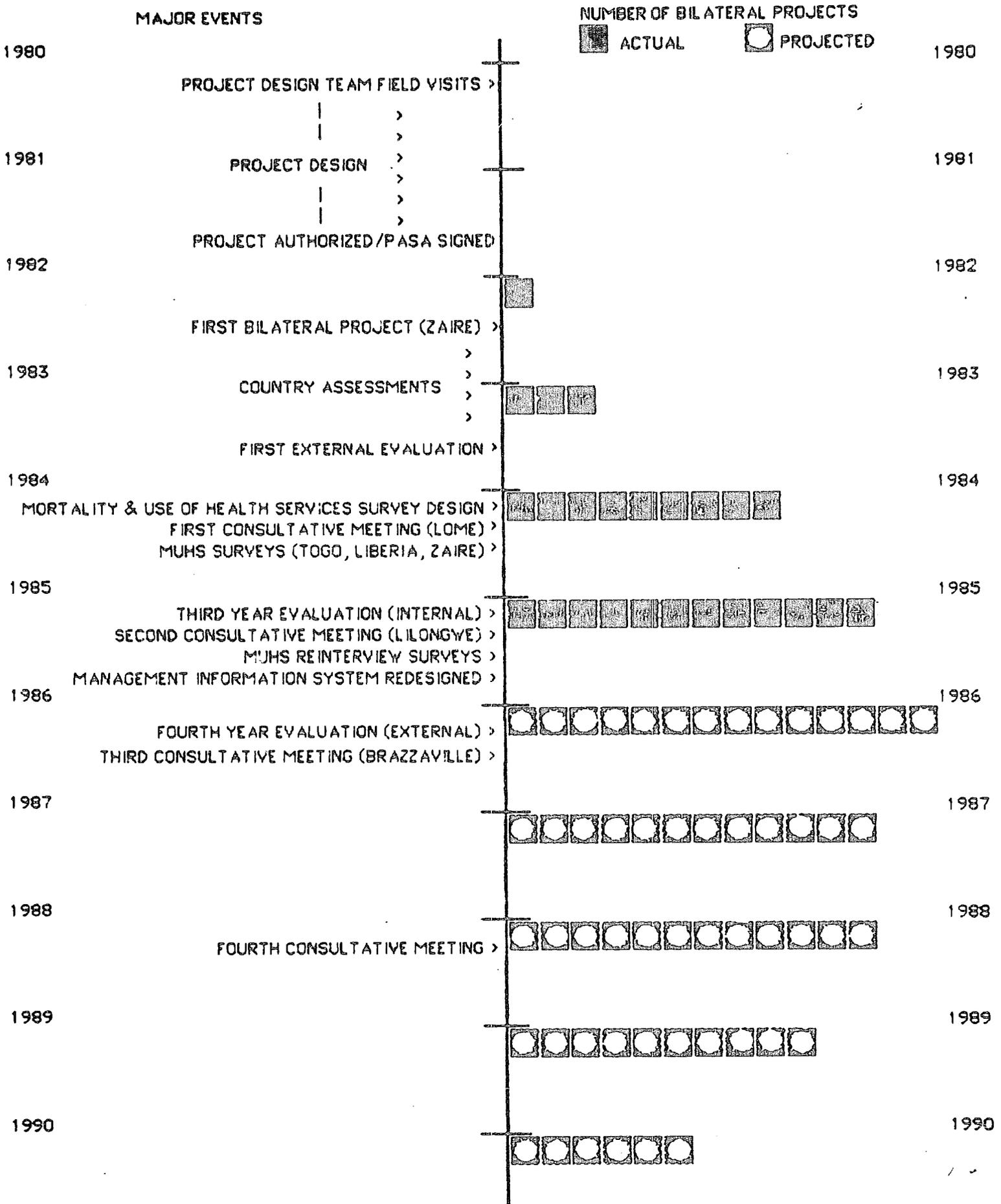
- OBJECTIVE** Reduce morbidity and mortality of African children (0-4 years) through strengthening national capability to:
- o Immunize infants and fertile age women (see pp. 6-7)
 - o Treat diarrhoeal dehydration with appropriate case management, emphasizing Oral Rehydration Therapy (ORT) (see pp. 8-9)
 - o Treat fever in children presumptively as malaria (see pp. 10-11)
 - o Provide malaria chemoprophylaxis to pregnant women

- STRATEGY** Promote and follow World Health Organization (WHO) policies and procedures and provide program support through the following intercountry and bilateral services:
- o Training (see pp. 12-13)
 - o Health Education/Promotion (see pp. 14-15)
 - o Health Information Systems (see pp. 16-19)
 - o Operational Research (see pp. 20-21)
 - o Technical Cooperation (see pp. 22-25)

INDICATORS AND SPECIFIC TARGETS IN CCCD OPERATIONAL AREAS:

<u>Indicator</u>	<u>Baseline Levels</u>	<u>1989 Target</u>
Infant Mortality	100-200/1000	-25%
1-4 Mortality	10-20/1000/Year	-25%
Neonatal Tetanus Mortality	5-20/1000	-50%
Measles Mortality	20-60/1000	-50%
Vaccination Coverage	10%	80%
Newborn Tetanus Protection	5%	50%
Health Facility Use of ORT	1%	50%
Community Use of CRT	1%	20%
Presumptive Malaria Treatment	20%	70%

CCCD TIMELINE

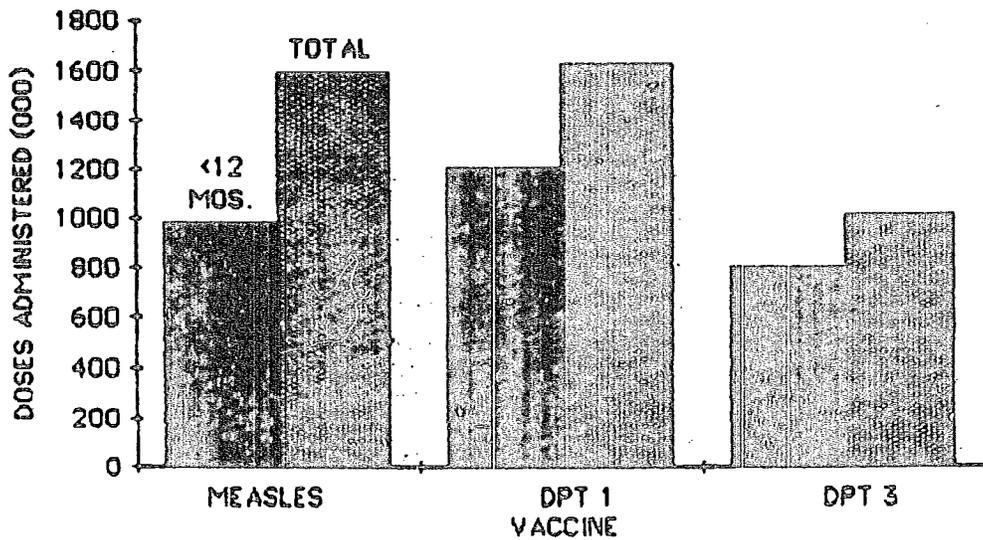


IMMUNIZATION

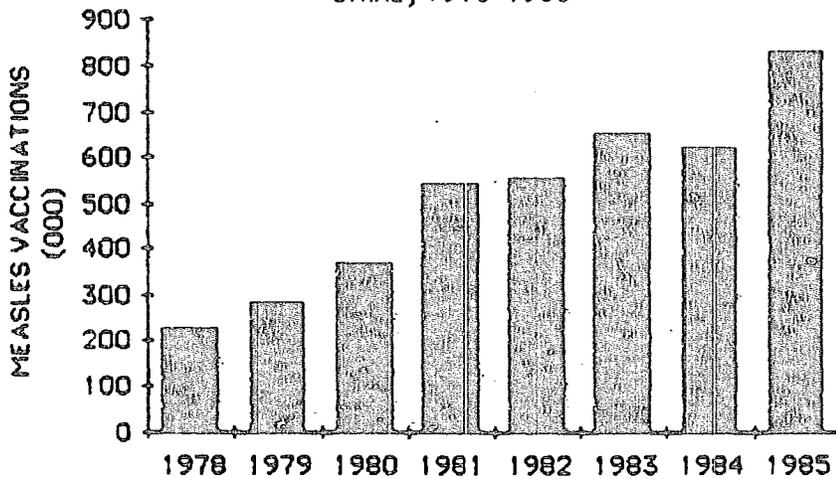
Objectives	<p>Reduce morbidity and mortality of childhood diseases preventable by immunization</p> <p>Achieve 80% coverage with BCG, measles, and 3 doses of DPT and polio vaccines by 12 months of age</p> <p>Achieve 80% coverage with 2 doses of tetanus toxoid of at risk pregnant women</p>
Indicators	<p>Percent of perinatal immunizations performed using sterile needle and sterile syringe</p> <p>Number of immunizations performed</p> <p>Percentage of children 12 - 23 months of age vaccinated</p> <p>Number of cases of target diseases</p>
Achievements	<p>Vaccine storage and distribution ("Cold Chain") established in all CCGD countries</p> <p>Staff trained in effective methods of vaccine delivery</p> <p>1.6 million children provided with at least one vaccine in 1985</p> <p>Vaccination coverage increasing in most countries</p>
Problems	<p>Limited access and coverage in rural areas</p> <p>Suboptimal community participation and low acceptance of immunization</p> <p>Measles transmission in children too young for measles immunization</p> <p>Measles transmission in areas having \geq 50% vaccination coverage (see graph mid-page 17)</p>

IMMUNIZATION ACTIVITIES

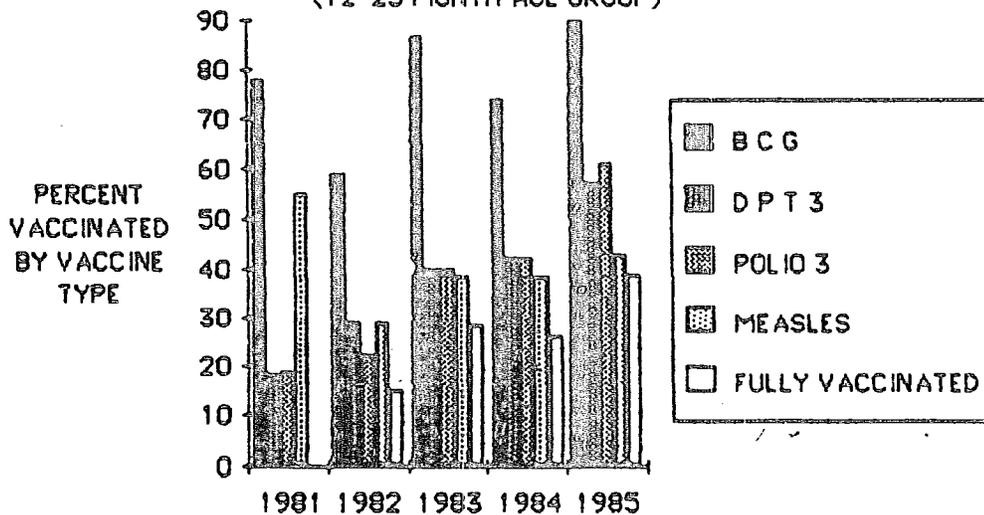
TOTAL VACCINATIONS CCCD-WIDE, 1985
(SELECTED VACCINES, BY AGE)



NUMBER OF MEASLES VACCINATIONS,
ZAIRE, 1978-1985



VACCINATION COVERAGE, SWAZILAND
1981-1985
(12-23 MONTH AGE GROUP)

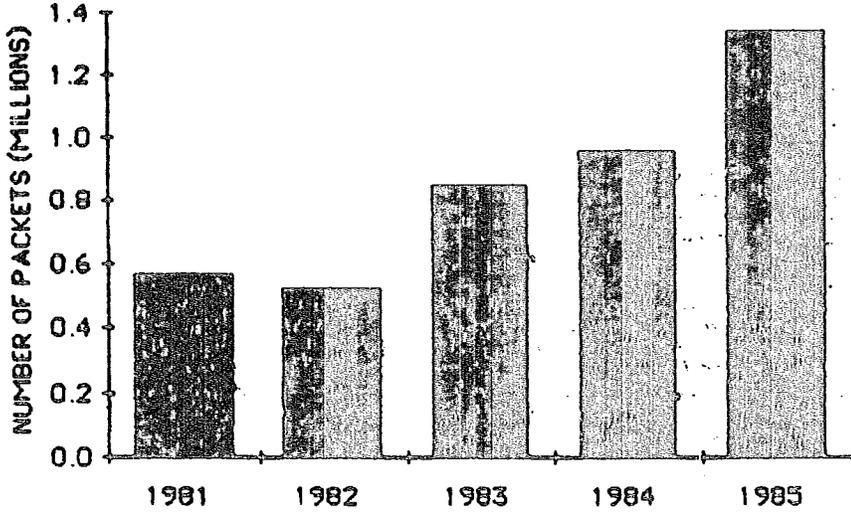


DIARRHEAL DISEASE CONTROL

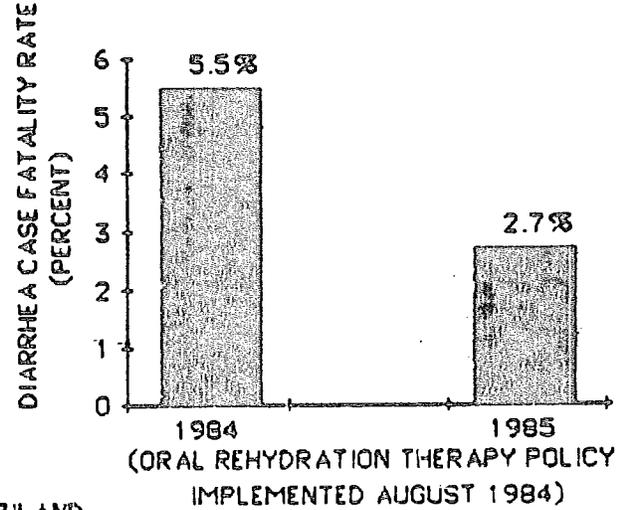
Objectives	<p>Reduce mortality due to severe dehydration secondary to diarrhea</p> <p>Improve clinical management of diarrhoeal disease at health facilities</p> <p>Improve community recognition and treatment of diarrhoea.</p>
Indicators	<p>Percent of health facilities using appropriate clinical management</p> <p>Percent of cases treated appropriately at home</p> <p>Diarrhoea deaths</p> <p>Diarrhoeal case fatality rates in hospitals</p>
Achievements	<p>ORT units established in pediatric facilities in Zaire, Lesotho, Malawi, Ivory Coast and Congo</p> <p>WHO training centers for clinical diarrhoea case management developed in Zaire and Malawi</p> <p>Reported ORT use greatly increased in all CCCD countries</p> <p>Surveys of ORT practices conducted in Rwanda, Ivory Coast and Lesotho</p> <p>Significant decrease in diarrhoeal case-fatality rate, Mama Yemo Hospital, Kinshasa, Zaire</p>
Problems	<p>Development of national policies, appointment of national coordinators</p> <p>Appropriate recommendations for home treatment</p> <p>Inadequate hands-on training of project staff</p> <p>In-country ORS production</p> <p>Inadequate (sometimes inappropriate) health education, training</p>

CCCD DIARRHEAL DISEASE ACTIVITIES

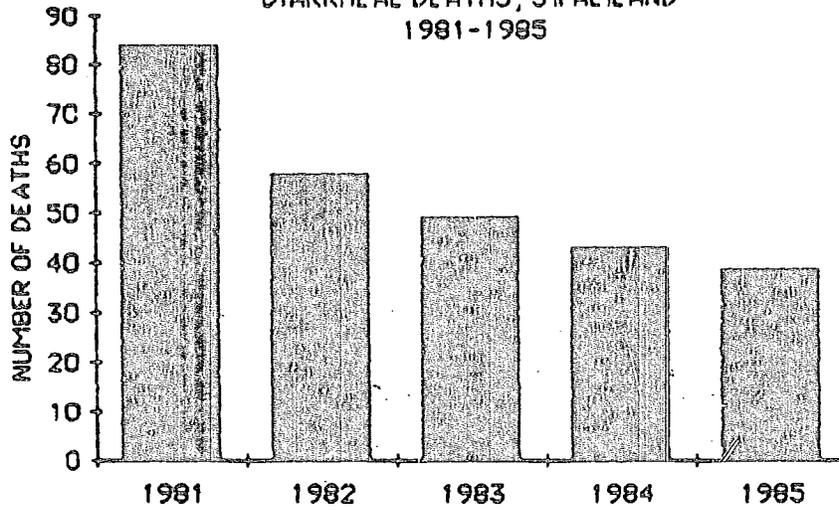
O R S DISTRIBUTION IN ZAIRE



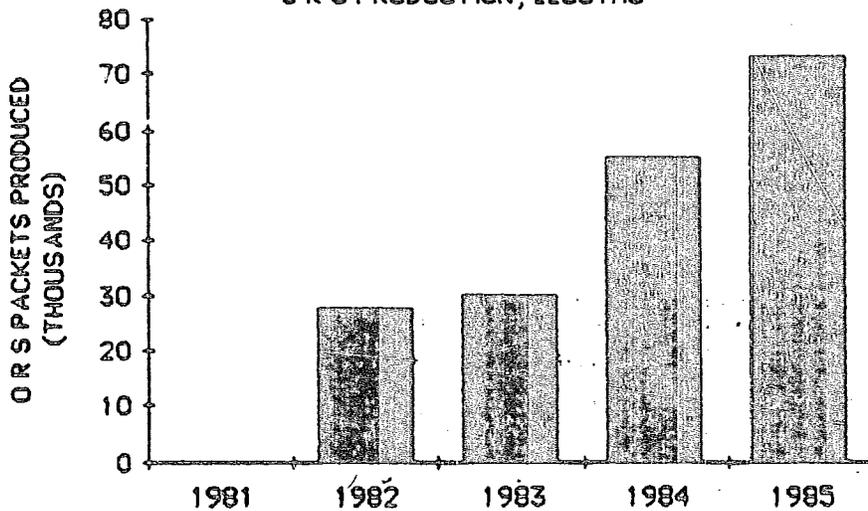
CASE-FATALITY RATES AMONG HOSPITALIZED DIARRHEA CASES, (AGE 0-5 YEARS) MAMA YEMO HOSPITAL, KINSHASA, ZAIRE



DIARRHEAL DEATHS, SWAZILAND 1981-1985



O R S PRODUCTION, LESOTHO

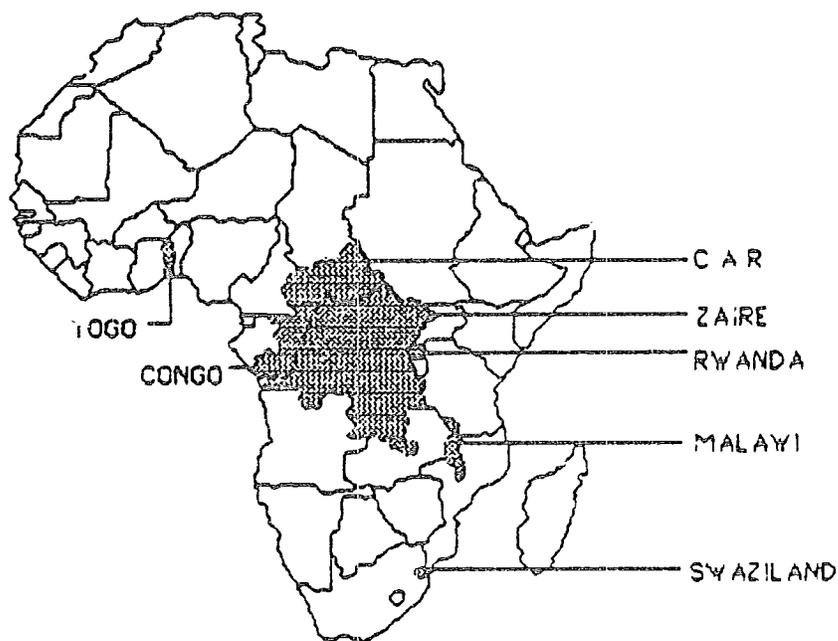


MALARIA

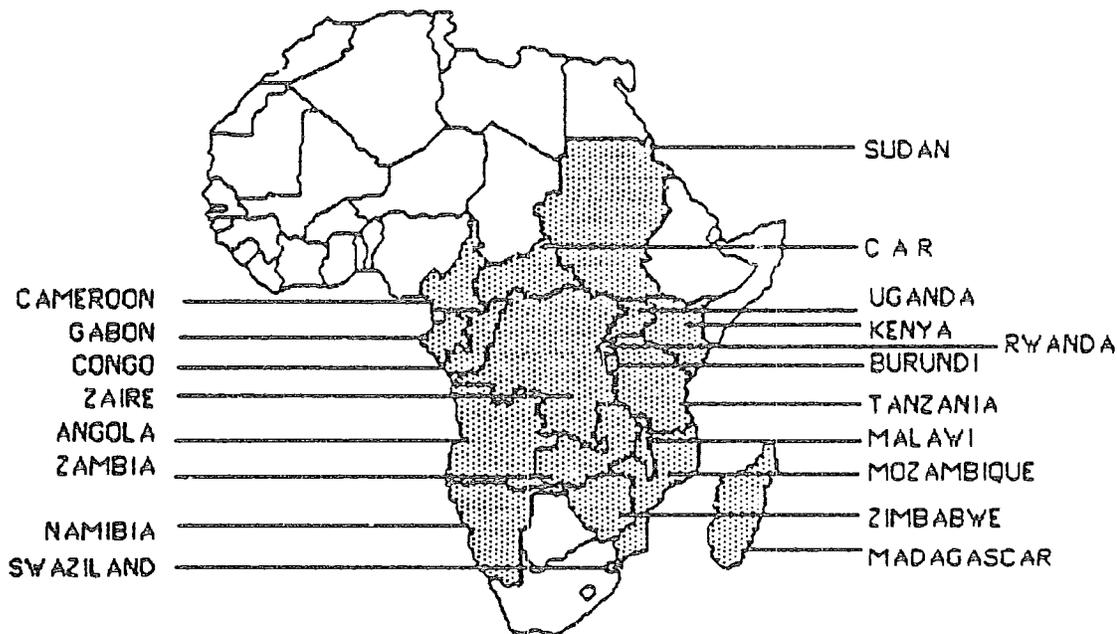
Objectives	<p>Reduce under five deaths due to malaria</p> <p>Decrease maternal and neonatal morbidity and mortality caused by malaria</p> <p>Develop national strategies for clinical management of malaria at health facilities and presumptive treatment in communities</p> <p>Develop sentinel surveillance for malaria parasite drug sensitivity</p>
Indicators	<p>Number of countries with national malaria policy</p> <p>Number of countries with sentinel surveillance for drug sensitivity</p> <p>Percent of health facilities using recommended treatment procedures for malaria</p> <p>Percent of fever cases in community treated appropriately</p>
Achievements	<p>National malaria treatment policies established in Malawi, Togo and Zaire</p> <p>Sentinel sensitivity surveillance established in C A R, Congo, Malawi, Togo and Zaire</p> <p>Clinical study on treatment of severe malaria carried out in The Gambia</p> <p>Use of appropriate drug therapy increasing in most countries</p>
Problems	<p>Spread of chloroquine resistance across Africa from east to west</p> <p>Toxicity of second line drugs</p> <p>High cost of alternative drugs</p>

MALARIA

COUNTRIES FROM WHICH STAFF HAVE BEEN TRAINED IN IN VIVO DRUG RESPONSE TESTING THROUGH CCCD



CHLOROQUINE-RESISTANT
PLASMODIUM FALCIPARUM
1985



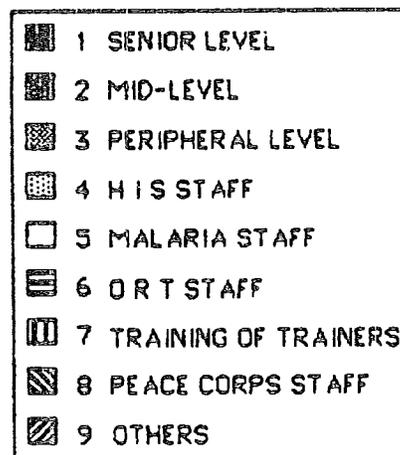
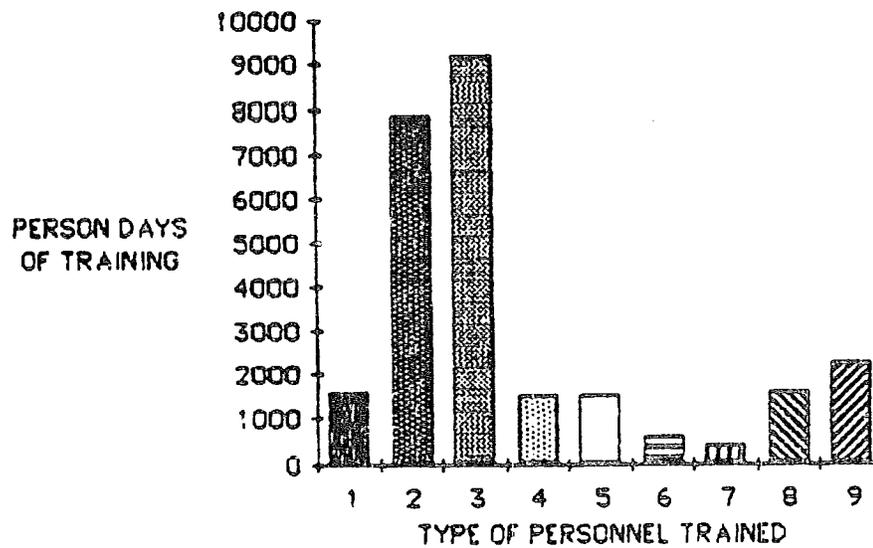
TRAINING

Objectives	<p>Improve skills of African health workers in delivering preventive and curative services</p> <p>Improve CCCD countries' ability to plan, conduct and evaluate training</p> <p>Provide assistance in assessing CCCD training needs and identifying training resources</p> <p>Develop training strategies for health workers engaged in control of childhood infectious diseases</p>
Indicators	<p>Number of CCCD countries with:</p> <ul style="list-style-type: none"> <input type="checkbox"/> national training plan <input type="checkbox"/> training coordinator <input type="checkbox"/> appropriate peripheral level training materials <p>Number of health staff trained</p>
Achievements	<p>Over 5000 health workers trained in 1985</p> <p>Generic CCCD mid-level managers course development completed</p> <p>Local adaptation of training materials in 7 countries</p> <p>Training plans and strategies developed in 5 countries</p>
Problems	<p>Plans for senior management training not yet developed</p> <p>Plans and materials for peripheral level training require further development and evaluation</p>

CCCD TRAINING ACTIVITIES

PERSON DAYS OF TRAINING BY TYPE OF TRAINING

1985



HEALTH EDUCATION/PROMOTION

Objectives	<p>Maximize utilization of EPI, CDD and malaria treatment services at health facilities</p> <p>Facilitate adoption of specific behaviors in the home/community during episodes of diarrhea and fever</p>
Indicators	<p>Number of countries having conducted behavioral and educational diagnosis (baseline Knowledge, Attitudes and Practices - KAP - surveys)</p> <p>Number of countries with health education action plans</p> <p>Vaccination coverage rates</p> <p>Percent of diarrhea and fever episodes treated at home with some form of ORT and antimalarial</p>
Achievements	<p>Baseline KAP surveys conducted in 5 countries</p> <p>Health education plans in support of one or more of the CCCD interventions prepared in 6 countries</p> <p>Special promotional campaigns implemented in 3 countries</p> <p>Educational materials produced and distributed in 7 countries</p> <p>Mid-level training module on health education revised</p> <p>Cooperative Agreement application received from University of North Carolina for intercountry training in health education planning and management</p>
Problems	<p>Inadequate data collection for health education planning and evaluation</p> <p>Inadequate integration and development of health education in tandem with the 3 CCCD interventions</p>

STATUS OF HEALTH EDUCATION/PROMOTION

CCCD BILATERAL PROJECTS

1985

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

KEY:

 FULLY COMPLETED

 PARTIALLY COMPLETED/UNDERWAY

 STATUS UNCERTAIN

 NO

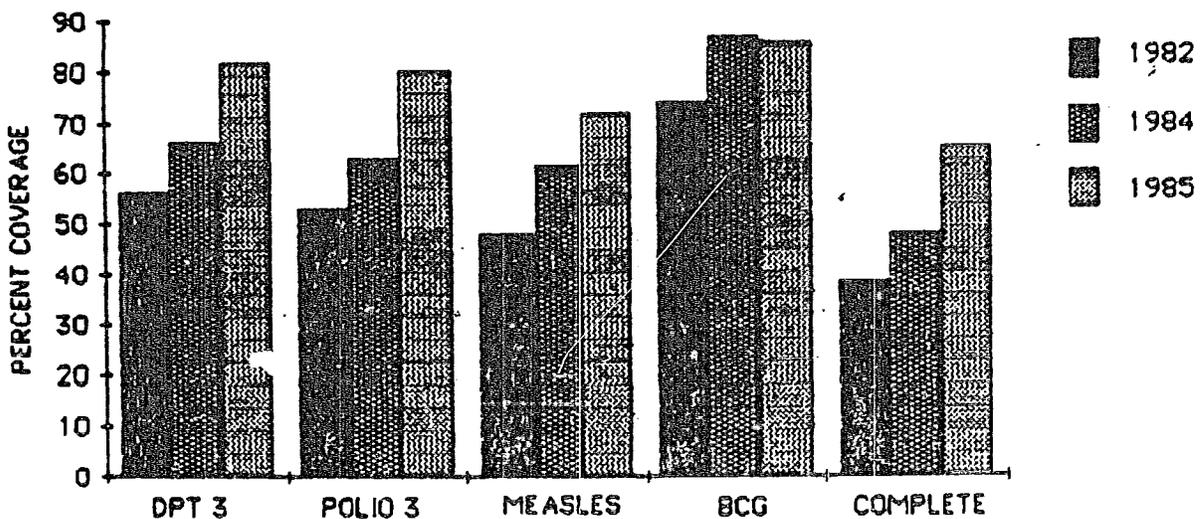
 NOT APPLICABLE

HEALTH INFORMATION SYSTEMS

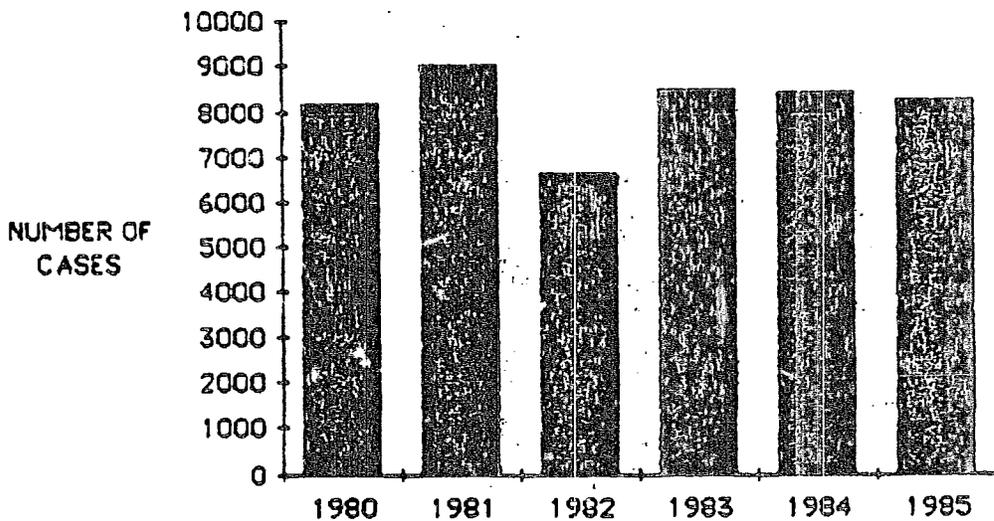
Objectives	<p>Strengthen ongoing systems of disease surveillance - data collection, analysis and use</p> <p>Document morbidity and mortality from target diseases</p> <p>Measure effectiveness of interventions in reducing morbidity and mortality</p>
Indicators	<p>Number of CCCD countries with systems to:</p> <ul style="list-style-type: none"> <input type="checkbox"/> monitor supplies storage and distribution <input type="checkbox"/> measure service availability at health facilities <input type="checkbox"/> determine community health practices <input type="checkbox"/> conduct morbidity surveillance <input type="checkbox"/> measure mortality
Achievements	<p>Developed a Management Information System which provides a format for country reports and a model for national use of health information</p> <p>Computerized annual CCCD country reports</p> <p>Developed survey methods to determine health practices at health facilities and in community</p> <p>Continued assessment and strengthening of CCCD country health information systems</p> <p>Conducted household interview surveys to measure mortality (MUHS surveys - see pages 18-19)</p>
Problems	<p>Delays and incompleteness of reporting</p> <p>Uncertain quality of health information</p> <p>Lack of feedback to collectors of health information</p> <p>Poor use of available health information by many host governments for program decision-making</p> <p>Imprecise mortality estimates from MUHS surveys</p>

HEALTH INFORMATION SYSTEMS

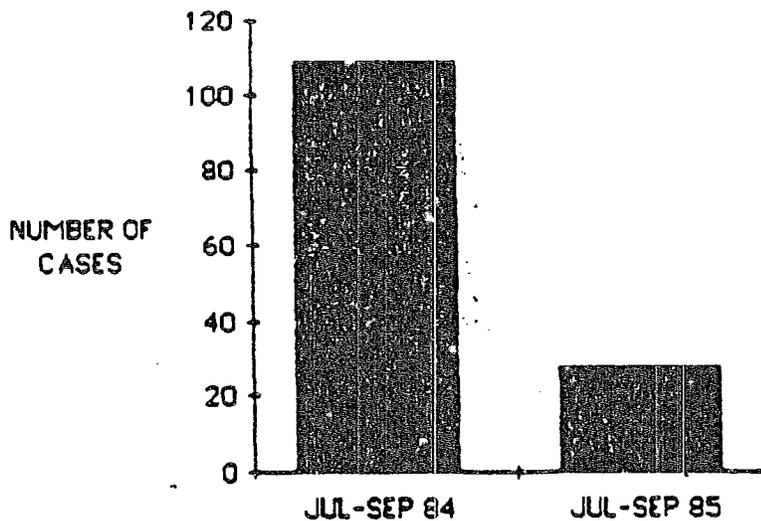
IMMUNIZATION COVERAGE, LESOTHO, 1982-1985
(AGE 12-23 MONTHS)



MEASLES IN KINSHASA, ZAIRE
REPORTS FROM 14 SENTINEL SITES



PERTUSSIS IN LESOTHO



MORTALITY

- September, 1983 CCCD external evaluation identified need for better mortality data and development of methodology to monitor changes in mortality rates in order to demonstrate program effectiveness

- December, 1983 Mortality and Use of Health Services survey (MUHS) designed

- January, 1984 Survey design reviewed by external consultants in demography and anthropology

- July - September, 1984 MUHS surveys carried out in Liberia, Togo and Zaire

- January, 1985 External review of MUHS surveys recommended reinterview survey of sub-sample all 3 countries and independent demographic analysis

- June - September, 1985 Reinterview surveys carried out in Liberia, Togo and Zaire

- November, 1985 Results compiled and submitted for independent analysis

INFANT AND UNDER FIVE MORTALITY

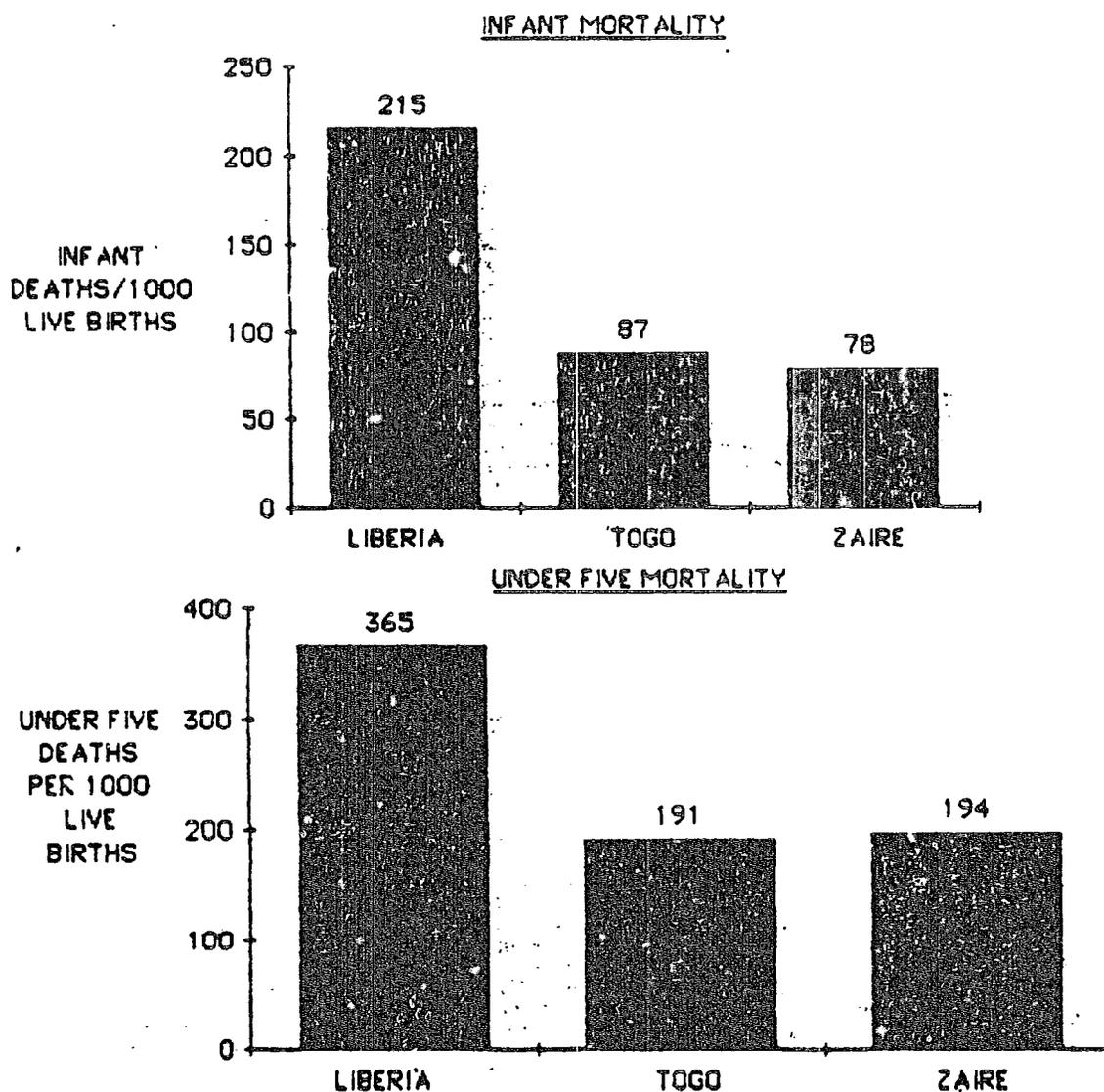
RESULTS OF CLUSTER SAMPLE AND REINTERVIEW SURVEYS

IN SUBNATIONAL AREAS OF THREE CCCD COUNTRIES

COUNTRY	AREA	MORTALITY RATES PER 1000 LIVE BIRTHS			
		SAMPLE SURVEYS		REINTERVIEW SURVEYS	
		INFANT	UNDER FIVE	INFANT	UNDER FIVE
TOGO	PLATEAUX	31	80	87	191
ZAIRE	KINGANDU	44	115	78	194
ZAIRE	PAI KONGILA	42	--	--	--
LIBERIA	3 COUNTIES	189	301	215	365

MORTALITY ESTIMATES OBTAINED IN REINTERVIEW SURVEYS

SUBSAMPLES OF SUBNATIONAL AREAS OF TOGO, ZAIRE AND LIBERIA

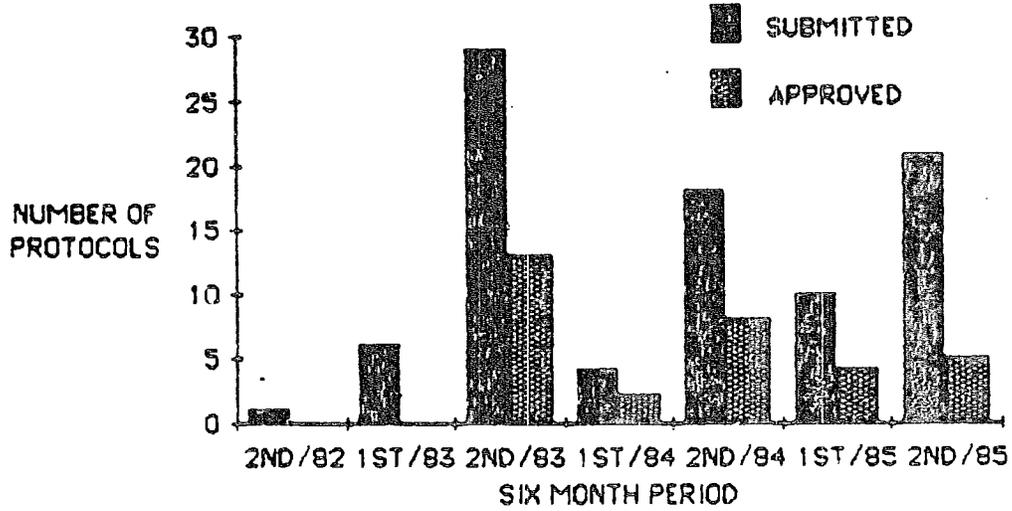


OPERATIONAL RESEARCH

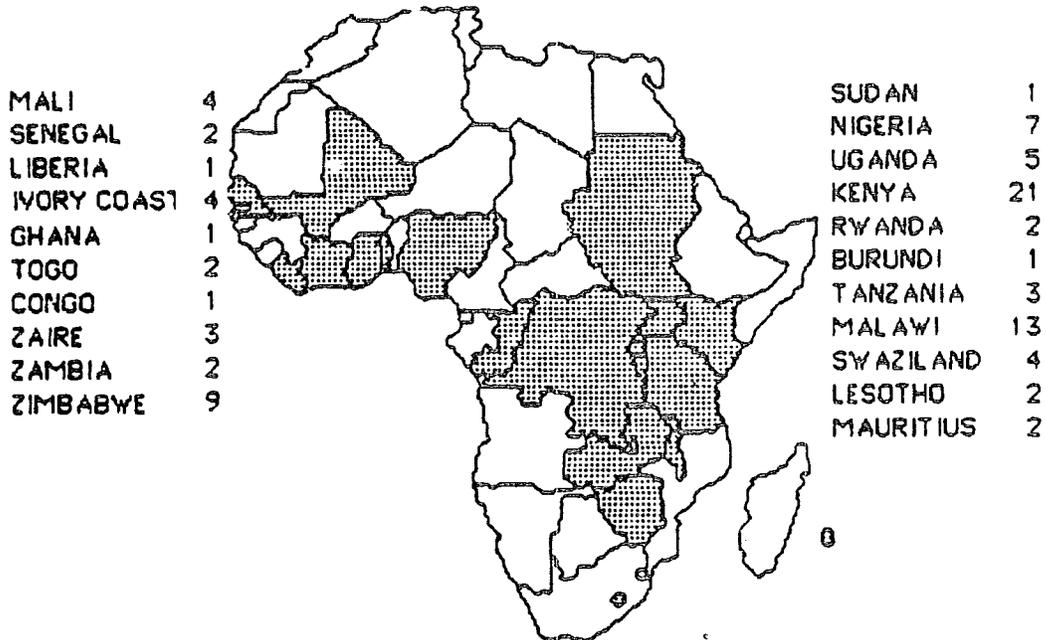
Objectives	<p>Identify and solve operational problems constraining achievement of CCCD targets and objectives</p> <p>Develop African capability to conduct operational research</p>										
Indicators	<p>Number of protocols submitted, approved, completed, published</p> <p>Impact of research projects on program operations</p>										
Achievements	<table border="0" style="width: 100%;"> <tr> <td style="padding-right: 40px;">Protocols Received</td> <td style="text-align: right;">89</td> </tr> <tr> <td>Protocols Approved</td> <td style="text-align: right;">32</td> </tr> <tr> <td>Protocols Funded</td> <td style="text-align: right;">31</td> </tr> <tr> <td>Projects Completed</td> <td style="text-align: right;">3</td> </tr> <tr> <td>Published</td> <td style="text-align: right;">0</td> </tr> </table>	Protocols Received	89	Protocols Approved	32	Protocols Funded	31	Projects Completed	3	Published	0
Protocols Received	89										
Protocols Approved	32										
Protocols Funded	31										
Projects Completed	3										
Published	0										
Problems	<p>Small research projects require substantial time-intensive technical collaboration in the design, field work, and analysis stages</p> <p>CCCD field staff and Research Review Committee members have not been able to provide sufficient support to all researchers, particularly in countries which do not have bilateral CCCD programs</p>										

OPERATIONAL RESEARCH ACTIVITIES

**OPERATIONAL RESEARCH PROTOCOLS
SUBMITTED AND APPROVED BY 6
MONTH PERIODS**



COUNTRIES OF ORIGIN OF SUBMITTED PROTOCOLS



BILATERAL PROJECT SUMMARIES

BURUNDI

- o The Project Agreement was signed August 30, 1985.
- o Technical Officer has been selected; personal services contract pending.
- o Project commodity orders have been initiated by USAID Mission.

CENTRAL AFRICAN REPUBLIC

- o First Year Review of project recommended assignment of full-time Technical Officer; arrangements completed for detail of State Department employee for this position.
- o Surveys were carried out to establish baseline data regarding morbidity, mortality, vaccination coverage, and knowledge/attitudes/practices related to malaria and diarrhea to assist with policy and work plan development.
- o A multiple antigen immunization campaign was carried out in the capital city, Bangui, to avert an anticipated measles epidemic (following 2 years of low transmission and little immunization); coverage of 80% of the target population was achieved.

CONGO

- o In response to a recommendation made at the First Year Review of the project, a full-time national CCCD coordinator was appointed to work as counterpart to the CDC Technical Officer.
- o Urban and rural cost studies were conducted to study the potential for sustained service delivery after completion of bilateral assistance; cost recovery methods, e.g. fee for service, to be studied.
- o Despite highest ever levels of immunization coverage (40% children 12-23 months fully immunized nationally), major measles epidemic was experienced through most of country; CCCD epidemiologic investigations found up to 1/3 of cases in <9 month age group (ineligible for measles immunization).
- o Diarrhea and malaria activities strengthened with establishment of CRT units in 19 urban health facilities and instituting chloroquine sensitivity monitoring.
- o Chloroquine sensitivity monitoring initiated.

GUINEA

- o The CCCD Project Agreement was signed and the CDC Technical Officer assigned in September.
- o Guinean CCCD counterparts were identified and assigned.
- o Implementation planning and commodity procurement are under way.

BILATERAL PROJECT SUMMARIES (CONT.)

IVORY COAST

- o The Technical Officer arrived at post in October, following execution of the Project Agreement.
- o Ivorian counterparts were assigned.
- o Planning and procurement are proceeding.

LESOTHO

- o CCCD fully operational in all 19 Health Service Areas (HSA) of Lesotho.
- o CCCD decentralized training plans developed and implemented in all 19 HSA's; under these plans over 2000 health staff will receive CCCD training by the end of 1987.
- o National immunization coverage rate (fully immunized 12-23 months age group) increased from 40% (1983) to 49% (1984) to 65% (1985).

LIBERIA

- o Fraught with problems a year ago, the Liberia project implemented most of the recommendations made at the First Year Review and finally started service delivery in August.
- o A cost recovery policy was approved and implementation of a fee for service system has begun; 25 cents paid for an immunization card entitles holder to full EPI series.
- o CCCD played key role in extensive planning for National immunization Week designed to accelerate EPI coverage; originally scheduled for November, campaign rescheduled for January because of civil unrest following attempted coup.
- o The Mortality and Use of Health Services (MUHS) verification survey was completed
- o USAID Mission support for the project and active participation of the Health and Population Officer provided a positive impact on CCCD.

MALAWI

- o Hosted Second Annual CCCD Consultative Meeting and Africa Regional Workshop on Oral Rehydration Therapy in March.
- o CCCD is operational nationwide.
- o A national policy on malaria treatment was established, based on the findings of research sponsored by CCCD.
- o A national policy was developed on oral rehydration therapy; each of 3 regions has a team to promulgate policy, develop ORT corners in health facilities, train and supervise staff, and monitor ORT implementation.
- o In the face of a major decrease in immunization coverage in the target aged children (from 55% fully immunized in 1984 to 35% in 1985 - as measured by survey), CCCD staff made recommendations on management, planning, and technical issues directed at reversing this decline. Weaknesses in the Malawi health information system make ongoing monitoring of health data difficult.

BILATERAL PROJECT SUMMARIES (CONT.)

RWANDA

- o CCCD implementation began with the arrival of the CDC Technical Officer, the establishment of offices and a coordinating committee, and receipt of start-up commodities.
- o Training has been conducted in mid-level management, ORT and chloroquine sensitivity monitoring to permit implementation of these activities.
- o A national diarrhea and malaria KAP survey was conducted to help develop national control policies and plans.

SWAZILAND

- o First Year Review recommended assignment of full-time Technical Officer; personal services contract will be awarded in January 1986.
- o CCCD supported a Mass Media and Health Practices project to develop and promote the national diarrheal disease program.
- o Immunization coverage as measured by survey has declined slightly since 1983; the following actions have been taken to address this problem:
 - Appointment of an EPI Committee to review plans and activities;
 - Reappointment of former EPI Director (after position had been vacant for a year);
 - Training and health education materials developed to address needs identified in community and clinic KAP surveys.

Togo

- o The mid-term CCCD evaluation was conducted by an independent international team between November 4 - 24, 1985.
- o Implementation of diarrheal disease intervention is lagging behind other CCCD activities, apparently because of organizational problems in the Ministry of Health.
- o Vaccination coverage survey findings in Maritime Region where CCCD started in 1984:

YEAR	BCG	DPT3	POLIO3	MEASLES	FULLY IMMUNIZED	
					RURAL	URBAN
1984	33%	3%	3%	3%	0%	5%
1985	64%	21%	18%	34%	12%	32%

- o All physicians-in-charge of medical sectors (21) and one-third of all public health paramedical personnel (319) have received CCCD training.

BILATERAL PROJECT SUMMARIES (CONT.)

ZAIRE

- o A full-time director of CCCD was appointed to replace the previous director who during 1985 had been assigned other duties and could devote only a small amount of time to CCCD.
- o Two senior level appointments were made to the CCCD staff to assume responsibilities for diarrheal disease control and malaria treatment components of the program.
- o The midterm evaluation of CCCD/Zaire was carried out in February by an international team led by WHO.
- o The Government of Zaire has not been able to provide its full share of CCCD funding; program expansion has been curtailed as a result.
- o In view of delays in expansion and the accompanying setback in the timetable for achieving objectives, the evaluation team recommended an extension in the life-of-project (LOP); USAID Zaire and the Ministry of Health have subsequently requested such an extension (to 1991) in order to accomplish original objectives of CCCD while permitting more time for Zaire to absorb the recurrent costs.
- o Diarrhea case fatality rates in Kinshasa's largest hospital, Mama Yerno, dropped 50% (5.5% to 2.7%) since ORT was established there in August 1984.
- o With the help of a locally produced ORT manual, 50 health staff from 35 urban facilities were trained and these facilities are providing ORT.
- o An intercountry training course on chloroquine sensitivity monitoring was held for 45 specialists from Zaire, Congo, CAR and Rwanda; surveys conducted as part of the course documented the current chloroquine resistance situation, showing that resistance is widespread.

OTHER COUNTRIES

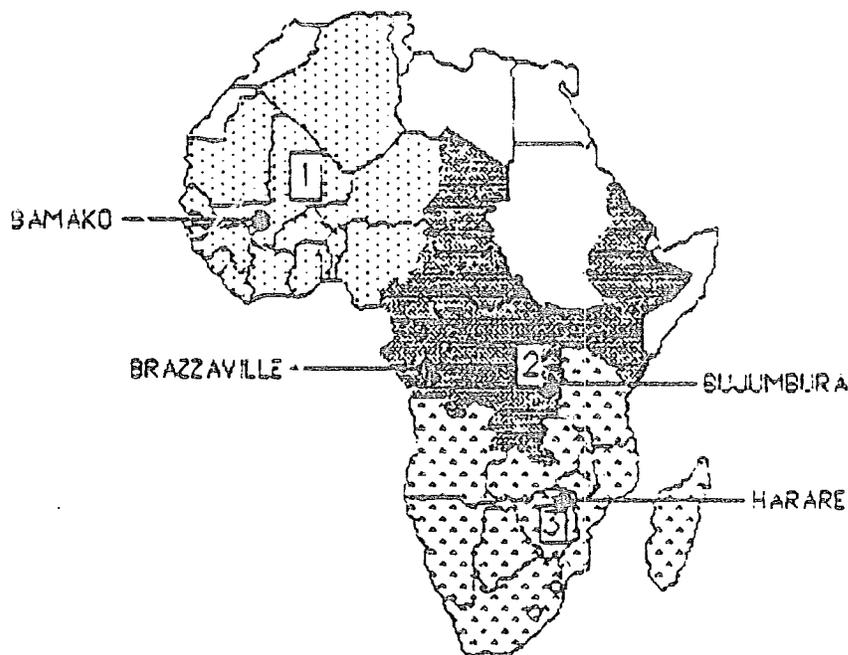
- o The Third Year CCCD Evaluation recommended increasing the current ceiling of 12 bilateral projects to 16; a proposal for this increase is going through the AID approval process.
- o In anticipation of approval for additional CCCD bilateral activities, a country assessment was conducted in Nigeria by CCCD and PRITECH (AID's Technologies for Primary Health Care project); a project proposal is being reviewed by AID.
- o Plans for a CCCD project in the Sahel collapsed when the USAID Mission in Burkina Faso decided against increasing its health project portfolio; AID Washington and CDC have requested reconsideration.

WHO AFRICAN REGIONAL OFFICE (AFRO)

In January 1985, AID signed a Grant Agreement with WHO/AFRO which provides for AFRO's support of CCCD through intercountry training and health information systems activities over a 4 year period. The training element offers opportunities to participants in a variety of courses, with emphasis on the strengthening of technical and managerial skills. The health information system component of the Grant Agreement focuses on the publication of an AFRO Epidemiological Bulletin, due to begin in 1986.

AFRO, under the leadership of a new Regional Director, began a major reorganization during 1985. Each of the 3 sub-regions is being strengthened with the establishment of sub-regional offices in Bamako, Bujumbura, and Harare. These offices will carry out many of the functions previously handled by the Regional Office in Brazzaville.

SUB-REGIONS OF THE WHO AFRICAN REGION



NO ✓ REMEDIAL ACTIONS

PROVED PROGRAM MANAGEMENT

than 9 months
(nation)

17
N



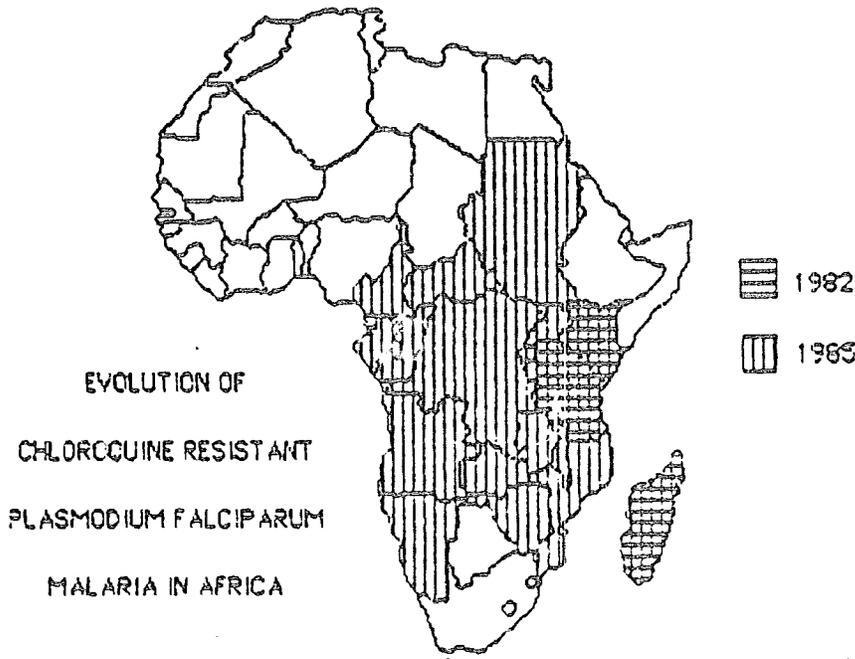
4 months

hydration fluids

of home treatment
available fluids

20. MAJOR CONSTRAINTS AND REMEDIAL ACTIONS (CONT.)

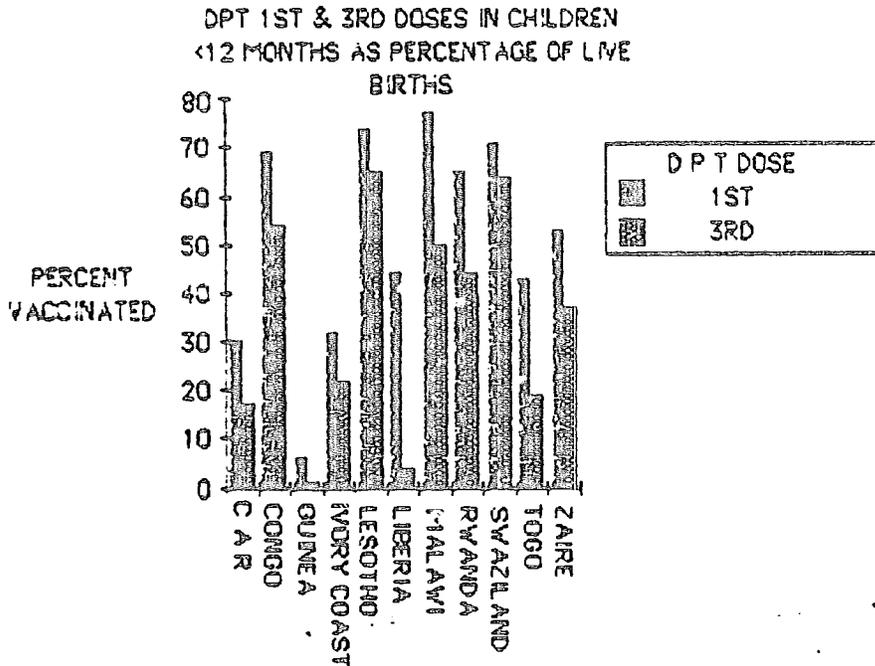
Increasing resistance of malaria parasite to chloroquine



- Development of sentinel surveillance for malaria drug sensitivity
- Development of national malaria treatment policies

2. UTILIZATION OF SERVICES BY THE COMMUNITY

High immunization drop out rates in some countries



- Operational research on problem identification, resolution and evaluation

MAJOR CONSTRAINTS AND REMEDIAL ACTIONS (CONT.)

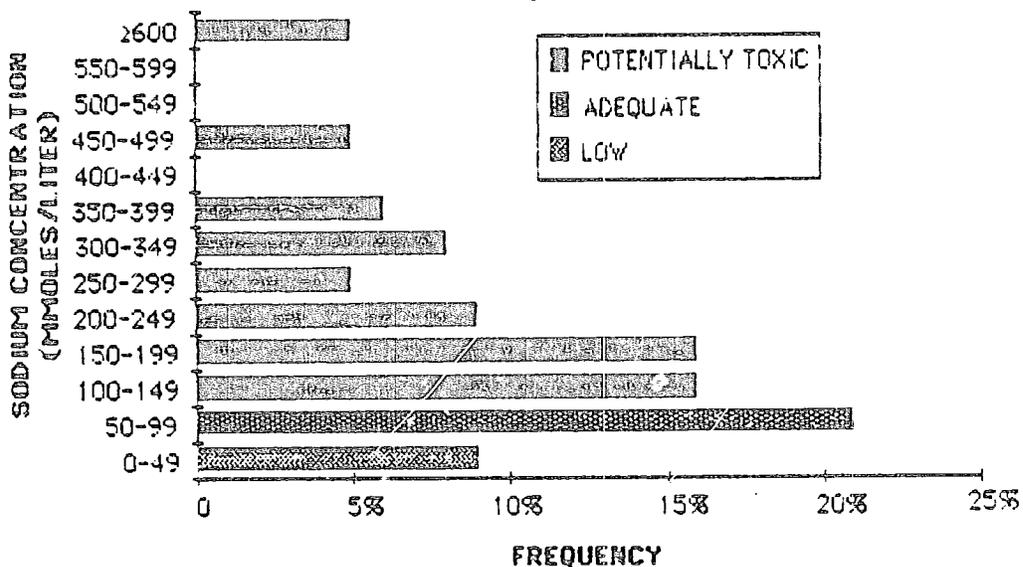
3. SERVICE DELIVERY

- Use of same needle and syringe for multiple injections
- Survey of current practices of needle use
- Provision of equipment, training and supervision

- Use of inadequate quantities of ORS in clinical management of diarrhoea at health facility level
- Supervision
- Training

- Use of ineffective or dangerous home remedies for treating diarrhoea (e.g., fluid restriction, enemas, antibiotics, improper preparation of recommended fluids)

SODIUM CONCENTRATIONS OF SUGAR-SALT SOLUTIONS PREPARED AT HOME, RWANDA, 1985 (N=63)

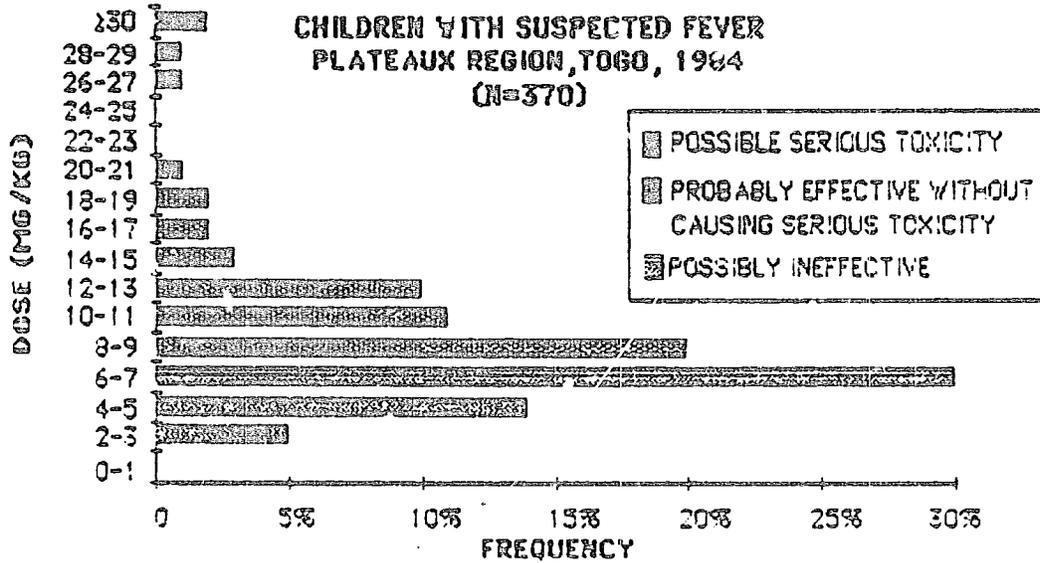


- Studies of current health practices
- Education in appropriate treatment, emphasizing easy-to-teach home-available fluids for prevention of dehydration

MAJOR CONSTRAINTS AND REMEDIAL ACTIONS (CONT.)

Use of less than adequate dose of antimalarials at community level

DOSES OF CHLOROQUINE ADMINISTERED DURING FIRST 24 HOURS OF HOME TREATMENT



Education of drug dispensers

Treatment of malaria with injectables, an expensive and unsafe practice, frequently associated with post-injection paralysis

Togo Data Before and After Training

YEAR	ANTI-MALARIAL INJECTION	ORAL CHLOROQUINE
1983	56%	44%
1985	18%	82%

Professional education on advantages of oral malaria therapy in terms of safety, efficacy and cost

MAJOR CONSTRAINTS AND REMEDIAL ACTIONS (CONT.)

4. MONITORING AND EVALUATION

Ineffective and delayed use of available national health data

Introduction of micro-computers and feedback

Inadequate understanding of community health practices and their predictors

Development and testing of PRACTICES SURVEY, including follow-up of sub-sample

5. AFFORDABILITY AND SUSTAINABILITY

Lack of funding for essential drugs

Reimbursable procurement of chloroquine and ORS (Zaire)

Limited and shrinking budgets for recurrent costs

Fee for service and other cost recovery plans

Poor understanding of cost-effectiveness in health planning (e.g. relative cost of ORT vs IV in diarrhea management)

Cost studies

CCCD STAFF

AFRICA

USAID BILATERAL PROJECTS

<u>COUNTRY</u>	<u>NATIONAL COORDINATOR</u>	<u>TECHNICAL OFFICER</u>	<u>USAID PROJECT OFFICER</u>
ZAIRE	MANBU MA-DISU	JEANNEL ROY	GLEN POST FELIX AWANTANG
TOGO	KARSA TCHASSEU	KEVIN MURPHY	RUDY THOMAS
LIBERIA	ROSE MACAULEY	JIM THORNTON	BETSY BROWN
MALAWI	GEOFFREY LUNGU	REGGIE HAWKINS	CHARLES GURNEY
LESOTHO	H. T. BCROTHO	JOHN NELSON	DEAN BERNIUS
SWAZILAND	G. MATSEBULA	JOHN NELSON	CHARLES DEBOSE
CONGO	GABRIEL MADZOU	KAREN HAWKINS-REED PIERRE EOZENOU (FAC)	FELIX AWANTANG
C A R	JEAN LIMBASSA	KAREN HAWKINS-REED	K. MONTGOMERY
RWANDA	A. NTLIVAMUNDA	MARYANNE HEILL	CARINA STOVER
GUINEA	FASSOU HABA	DIANNA GERSKI	MARK WENTLING
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REFERENCE DOCUMENTS

General	CCCD Project Paper CCCD Project Description CCCD Workplan 1982-83 CCCD Workplan 1983-84 CCCD Workplan 1984-85 CCCD Workplan 1985-86
Bilateral	Country Assessment Reports - 14 Bilateral Project Grant Agreements (ProAgs) - 12
Periodic Reports	Monthly reports from CCCD field staff Quarterly reports from field staff (through 1984) Annual reports from each bilateral project, 1985 Quarterly Reports (project-wide MIS) Annual Reports (project-wide MIS), 1983, 1984
Evaluations	Bilateral project review reports Bilateral project evaluation reports First External Evaluation, September 1983, report Internal Evaluation, January 1985, report
Special Reports	Consultant Reports Cost Studies Mortality and Use of Health Services (MUS)

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

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