

FY 95 Results Reviews (R2s)

Summary Review of R2s by Sub-Region and Sector

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1. Introduction: The R2s

USAID's AFR Bureau and the USAID missions in sub-Saharan Africa have distinguished themselves in the past through the use of logical "results frameworks" as a basis for program planning, monitoring, and reporting. These frameworks specify not only the goals and objectives of a given operating unit but also the indicators by which progress toward these goals and objectives will be assessed. Until recently, official reporting of these frameworks and corresponding progress made each fiscal year took the form of "Assessments of Program Impact," or APIs, submitted by each unit. Having observed the AFR Bureau's initial success with this operational step toward managing for results, USAID/Washington has now developed an agency-wide process requiring that each unit submit a "Results Review," more commonly known as "R2" (or "R2a"), to track the progress and impact of unit activities each fiscal year. When linked with a "Resource Request" (or "R2b"), the Results Report will form the first half of an annual comprehensive planning document, the "R4," specifying the rational links between a unit's objectives, activities, and funding requirements.

The purpose of this document is to review AFR units' reporting on Population, Health, and Nutrition (PHN) activities in the first round of the R2s, which specifically address program impact and progress in FY 1995. For analysis of some of the more recently initiated programs (Mozambique, Madagascar, South Africa), R2 reporting was supplemented by more detailed or updated country strategy plans. In most cases, operating units in the AFR region have already submitted several APIs in past years. The R2 thus continues a fairly well-established process of reporting program impact through the use of carefully selected indicators. In the PHN sector, this experience has led to a deliberate honing and fine-tuning of program indicators for child survival, population, and HIV/AIDS prevention and control activities.¹

The first round of R2s submitted by USAID missions and regional operating units under the AFR Bureau provides substantial evidence that the selection and use of appropriate program indicators has improved. In many cases, indicators that were commonly found in the APIs but are difficult to measure in a reliable and timely manner, or to credibly link with program activities, have been dropped. Meanwhile a fairly well-defined set of standardized PHN indicators has emerged to help units more accurately and consistently gauge the successes and shortcomings of program activities. Much progress remains to be made, however, particularly in developing methods to accurately gauge progress toward many intermediate results which do not easily lend themselves to consistent quantitative measurement, such as those involving sector reform, service quality, or demand for services.

This report consists of a broad overview of the PHN content in the AFR R2s followed by a "subsector-by-subsector" (population, child survival, HIV/AIDS) examination of the selection and use of specific program indicators by individual units. For each of the three subsectors, the review and analysis is broken down into each of the three USAID subregions (East, Southern, and West Africa). Commentary addresses both the validity of a given indicator and the extent to which the data reported may reflect positive program impact.

¹ See, for example, guidance from the AFR Bureau to USAID missions in "Population, Health, and Nutrition Indicators for Assessments of Program Impact (APIs) and Results Packages. Oct. 17, 1995."

1.1. R2s submitted with PHN Reporting in the AFR Region

R2s were submitted by 20 country missions and five regional programs in sub-Saharan Africa.² Of the total of 25 R2s, 21 reported on activities for sustainable development in the PHN sector. In all, 15 missions report on activities in population, 12 report on child survival activities, and 13 report on HIV/AIDS prevention and control activities. Of the five regional programs, two report on activities in all three PHN subsectors. Table 1.1 below summarizes the number of R2s submitted, the number reporting in each PHN subsector, and the level at which they include PHN activities in their results framework.

Table 1.1. R2s in the AFR Region: Areas of PHN activity, by sub-region and level of reporting

	# of R2s submitted	# with Strategic Objective in:			# w/ Special Objective, etc., in:		
		Pop.	Child Survival	HIV / AIDS	Pop.	Child Survival	HIV / AIDS
East Africa missions	5	5	2	4	0	0	0
Southern Africa missions	6	3	4	2	0	0	3
West Africa missions	9	6	4	1	1	1	3
Regional programs	5	1	1	1	2	1	1
TOTAL	25	15	12	8	3	2	7

This table specifies the number of missions and regional programs involved in each area but does not differentiate between "stand-alone" activities and those which are integrated with other subsectors. As indicated in the four tables on the following pages, three of the country missions (Malawi, Ethiopia, Zambia) and one regional program have Strategic Objectives (SOs) integrating all three program areas (population, child survival, and HIV/AIDS). Four country missions, primarily in West Africa (Mali, Niger, Senegal, Mozambique), have SOs integrating just population and child survival and three (all in East Africa) integrate population and HIV/AIDS in an SO without child survival. Only one mission SO (C.A.R.) integrates child survival and HIV/AIDS without population. USAID/Nigeria is the only mission in Africa with separate SOs dealing with these subsectors (population and child survival, in this case).

Nearly half of the programs (7 of 15) dealing with HIV/AIDS do so through a Special Objective (4) or another program area short of a specific SO; the remainder of the countries active in HIV/AIDS integrate these activities into an SO with child survival and/or population activities.

² For the purposes of this analysis, the "Small Country Program" R2 is treated as the R2 for USAID/Central African Republic. This R2 also covered activities in Sierra Leone, Congo, and Sao Tome and Principe, but no PHN activities were reported in these countries.

1.2. PHN sector activity in the AFR region

1.2.1. PHN activities in East Africa

In USAID's East Africa sub-region, R2s were submitted by five country missions, each with an SO integrating population with child survival and/or HIV/AIDS prevention. As table 1.2 indicates below, two missions have SOs in child survival, and four in HIV/AIDS. For a detailed listing of each mission's specific SOs and IRs in the PHN sector, see Appendix A.

Table 1.2. East Africa Missions submitting R2s: Areas of PHN activity

<u>Mission</u>	<u>Strategic Objectives</u>
Ethiopia	Pop./C.S./HIV
Kenya	Pop./HIV*
Madagascar	Pop./C.S.
Tanzania	Pop./HIV
Uganda	Pop./HIV

*USAID/Kenya's program includes health sector reform activities under SO1 as well as maternal and child health (MCH) interventions through the PL480 Title II program.

1.2.2. PHN activities in Southern Africa

In USAID's Southern Africa sub-region, R2s were submitted by six country missions, each of which works in the PHN sector at some level. As table 1.3 below indicates, three of the R2s reported on population at the SO level, four reported on child survival at the SO level, and five reported on HIV/AIDS prevention, two at the SO level and the three under Special Objectives or in other program areas.

Table 1.3. Southern African Missions submitting R2s: Areas of PHN activity

<u>Mission</u>	<u>Strategic Objectives</u>	<u>Special Objectives, etc.</u>
Malawi	Pop./C.S./HIV	-
Mozambique*	C.S.	HIV (in SO3)
Namibia	-	HIV (in SO1)
South Africa*	C.S.	-
Zambia	Pop./C.S./HIV	-
Zimbabwe	Pop.	HIV

*Refers to new programs (see Appendix A).

1.2.3. PHN activities in West Africa

In USAID's West Africa sub-region, R2s were submitted by eight country missions, the small country program, and two regional programs. All but one of the mission R2s dealt with PHN sector issues. As the table below indicates, all of the remaining mission R2s reported on population activities, five specifically included child survival/health activities, and five covered HIV/AIDS prevention activities.

Table 1.4. West Africa missions submitting R2s: Areas of PHN activity

<u>Mission</u>	<u>Strategic Objectives</u>	<u>Special Objectives, etc.</u>
Benin	-	Pop./HIV
C.A.R.*	C.S./HIV	-
Ghana	Population	HIV
Guinea	Population	C.S.(PL480)
Guinea-Bissau	-	-
Mali	Pop./C.S.	-
Niger	Pop./C.S.	-
Nigeria	Pop., C.S.	HIV
Senegal**	Population	HIV

* - Small Country Program (see footnote 2).

**USAID/Senegal's program also includes health sector reform and MCH activities under SO1.

1.2.4. PHN activities by regional programs in the AFR region

Five regional programs submitted R2s, three of which included activities for sustainable development in the PHN sector. REDSO/WCA (West & Coastal Africa) has an SO integrating activities in all three subsectors. REDSO/ESA (East & Southern Africa) does not have an SO in PHN but deals with all three areas in its support to missions and directly reports on sustainable health and nutrition activities related to regional information network development. The Sahel Regional program includes only minimal PHN content, also related to the development of regional information networking, in this case on population issues. Neither the Greater Horn of Africa Initiative (GHAI) nor the Initiative for Southern Africa/Regional Center for Southern Africa (RCSA) directly report on sustainable development activities in the PHN sector.

Table 1.5. Regional Programs submitting R2s: Areas of sustainable PHN activity

<u>Regional program</u>	<u>Strategic Objectives</u>	<u>Activities w/in other SOs</u>
GHAI	-	-
RCSA	-	-
REDSO/ESA	-	Pop./C.S./HIV
REDSO/WCA	Pop./C.S./HIV	-
Sahel Regional	-	Pop.

2. Population

Population, or family planning, is the PHN subsector most commonly found in AFR region R2s. This section is split into subsections on East, Southern, and West Africa. Each sub-regional section includes a review of the current population situation, the status and performance ratings of USAID population programs, a table showing the population indicators used by each mission, and an indicator-by-indicator review of USAID program progress and impact. Regional program information is discussed within the appropriate sub-region. The following brief review of population program indicators applies to all three sub-regions; abbreviations are provided as keys to the indicator grids provided later for each sub-region.

A. Impact / Outcomes: The highest-level program impact indicators for population activities are population growth rate (**PGR**) and total fertility rate (**TFR**). As TFR is more closely linked to family planning activities, and is directly derivable from household surveys such as the Demographic and Health Survey (DHS), it is a preferred goal-level indicator of population program impact.

B. Service Use: Contraceptive prevalence rate (**CPR**) is the most commonly used indicator to track use of family planning services. Missions typically track CPR for modern methods among women of reproductive age (usually 15-49). Some are particularly interested in use of longer-acting methods (**LAM**). Where CPR is not available, calculations are often based on the distribution of contraceptives, quantified as "Couple-Years of Protection" (**CYP**).

C. Service Supply: **CYP** is more accurately used to indicate the overall *supply* of family planning services. (An issue which is rarely addressed is that condoms, while typically fully included in calculations, are to a great extent used for STD prevention rather than contraception.) Other indicators of supply are Service Delivery Points (**SDP**) (typically counted with reference to specific quality criteria) and Social Marketing sales (**SM**) of condoms and other family planning commodities. Related indicators of *access* measure service supply with respect to the targeted population. Also related to service supply are indicators of changes in a nation's population **policy** environment.

D. Demand for Services: Indicators related to *demand* for family planning services include those measuring people's knowledge of and attitudes toward methods of family planning (**ka**) and especially their desire to limit family size. Another indicator incorporating elements of both supply and demand is the **unmet** need for family planning, i.e. the difference between demand for and use of modern contraception.

2.1. Population in East Africa

Although countries in East Africa have somewhat higher rates of contraception than those found in West Africa, fertility rates in many countries are nearly as high. According to projections by the UN and DHS findings, the highest fertility rates are found in Ethiopia (by far the most populous nation in the sub-region), Uganda, and Somalia. In most countries where use of modern contraceptives has significantly increased since the 1980s, the total fertility rate has dropped to six or fewer children per woman of reproductive age. Table 2.1 provides the latest data available on these population indicators in each country in the sub-region.

Table 2.1. Population, Fertility and Contraceptive Prevalence in East Africa, c. 1995.

	Population in millions (1995)	Total Fertility Rate (1995)	Contraceptive Prevalence Rate, modern methods (CPR-mm)		
			CPR	Year	Source
Burundi	6.4	6.5	1.2	1987	DHS
Djibouti	0.6	5.6	-	-	
Eritrea	3.5	6.1*	4.0	1995	DHS
Ethiopia	60.6	6.8	2.6	1990	U.S. Census Bur.
Kenya	28.3	5.4**	20.7	1993	DHS
Madagascar	13.9	5.9	5.5	1992	DHS
Rwanda	8.0	6.3	13.3	1992	DHS
Somalia	7.3	6.8	-	-	
Sudan	30.1	5.6	5.8	1990	DHS
Tanzania	29.7	5.7	11.3	1994	DHS
Uganda	19.6	6.8*	7.4	1995	DHS

Source: Projections by UN, U.S. Census Bureau (1994), *-1995 DHS, **-1993 DHS.

Variation within the region is considerable. Contraceptive use in Kenya is approaching levels of southern African nations, which have the highest rates on the continent. However, CPRs in most countries remain below 10 percent for modern methods, closer to the trend in West Africa.

2.1.1. East African Programs with Population Activities

All five of the USAID missions in East Africa submitting R2s have an SO in family planning. Grading of the R2s at the March/April 1996 country review sessions examined program maturity, progress (of mission efforts), and impact (on host country conditions). East African population programs, as reported in the R2s for FY 1995, were given the following scores, on a scale of 1 (lowest) to 5 (highest):

Table 2.2. Population Scores for East Africa USAID R2s

<u>Mission</u>	<u>Program Maturity</u>	<u>Progress</u>	<u>Impact</u>
USAID/Ethiopia*	1	3	-
USAID/Kenya	5	5	5
USAID/Madagascar	-	4	-
USAID/Tanzania**	4	4	4
USAID/Uganda	2	2	2

* - scored together with CS activities.

** - scored together with HIV/AIDS activities.

2.1.2. Population Program Indicators used in East Africa

Table 2.3 provides a representation of the various indicators used by the five East African missions to track impact and progress in family planning. The letters indicate at which level the indicator is found within the R2 Results Framework: Goal (G), Sub-goal (SG), Strategic Objective (SO), or Intermediate Result (IR). East African missions are most concerned with indicators dealing with fertility levels (TFR), use of contraception (CPR), and the supply of contraceptive methods (CYP, SM, SDPs). Three missions have indicators related to demand (ka) for contraceptives, an important intermediate result in population programs, but two of these only examine knowledge of services and/or their location without reference to desire to use family planning.

Table 2.3. Family Planning Indicators used by East Africa missions for R2 reporting.

Country	PGR	TFR	CPR	CYP	SM	SDPs	ka
Ethiopia			SO		IRs	IRs	
Kenya	SG	SO	IR		IR*	IRs	IR
Madagascar		SO	IR	IR		IRs	IR
Tanzania		SG	SOs				IRs
Uganda		SO	IR	IR	IR*		

* - included primarily as HIV/AIDS prevention indicators.

2.1.3. R2 Reporting on Population Indicators: Progress & Impact in East Africa

A. Population Outcomes in East Africa: Population Growth Rate, Total Fertility Rate

One mission (Kenya) reports on **population growth rate** (PGR) at the goal level and four report on **total fertility rate** (TFR), three at the SO-level and one at the goal level.

- USAID/Kenya reports that the country's population growth rate has declined from 4.1% per year in 1980-85 to an estimated 2.7% in 1995. (No data source is provided.) The mission also reports TFR dropping from 8.1 in 1977-78 to 6.7 in 1984-89, 5.4 in 1990-93, and 5.0 in 1995. These data indicate outstanding long-term success in slowing population growth in Kenya. The 1995 figures, however, are based on projections from trends evidenced by the 1993 DHS and thus do not really represent new data.

- USAID/Madagascar reports on TFR as an SO-level indicator, using the 1992 DHS baseline of 6.1. No new data are available since the DHS.

- USAID/Tanzania now reports on TFR at the subgoal-level. The mission is awaiting data from the 1996 DHS in order to update the baseline figure of 6.3 from the 1991/92 DHS.

- USAID/Uganda reports TFR in intervention areas as an SO-level indicator. The mission provides a baseline of 7.4, a nationwide figure from the 1988/89 DHS. A TFR of 6.8 is reported from the 1995 DHS, representing an impressive decline of "half a child," as the mission puts it. Modest USAID activities began in 1989; the figure of 7.4 is for the period 1985-88, while the new TFR is presumably for the period 1992/3-95. The R2 reporting matrix specifies "total fertility reduced to 6.9 in intervention areas", but the narrative does not specify intervention areas (DISH districts?).

B. Use of Population Services in East Africa: Contraceptive Prevalence

All five missions active in population track **contraceptive prevalence rate** (CPR) for modern methods of contraception. (Also included here are tallies of users of family planning (FP) services.)

- USAID/Kenya reports that CPR (among women in union) continues to rise since the 1993 DHS finding of 20.9% for modern methods. Based on statistics from the Kenya national contraceptive distribution system, the mission estimates CPR in 1995 at about 25%. (DHS data and 1995 projections on method-specific prevalence rates are also provided on p. 8 of the USAID/Kenya R2.)

- USAID/Madagascar reports a remarkable rise in CPR to 9.1%, high above the 1992 DHS finding of 5.1% (among women in union). The new figure is from a UNICEF multi-indicator cluster survey. The mission feels that the data are comparable and adds that the increase is substantiated by increases in couple-years of protection (CYP) distributed and service availability as measured by SDPs. Specific community- and workplace-based distribution programs are taking off rapidly and contraceptive use has reportedly risen from 0% to 50% in some factories.

- USAID/Ethiopia will monitor contraceptive use in urban and peri-urban areas within the "Southern Nations and Nationalities People's Region" (SNNPR). Baseline data are not yet available. The

mission estimates that the use rate is currently less than 5% and has set a target of 10-15% for 2002. The mission also is reporting on the increase in numbers of new users of NGO FP services through the Consortium of Ethiopian Family Planning NGOs (COFAP). From a baseline of "0" (no date), the mission reports 11,900 new users in 1995 and has set a target of over 350,000 new users by 2002.

- USAID/Tanzania reports on CPR for modern methods among both married and all women of reproductive age. (The figure for married women was to be discontinued following last year's API but has been retained in the R2.) The mission does not have new data to report since last year's API, which provided 1994 CPRs of 11.3% among all women and 13.4% among married women. Both figures indicate rapid and substantial progress since the 1991/92 DHS, which provided respective baselines of 5.9% and 6.6%. In the R2 narrative, the mission also reports that new acceptors of FP and first attendances at FP clinics have each risen by 50%.

- USAID/Uganda reports on CPR as an IR-level indicator, starting with a very low baseline figure of 2.5% for all women of reproductive age from the 1988/89 DHS. According to the 1995 DHS, this figure has risen to 7.4%, a very substantial increase in use of FP (though not as high as the 8.7% the mission had estimated in the API for 1994, based on CYP).

C. Supply of Population Services in East Africa: Access, Availability, and Quality

Unlike the other sub-regions, only one mission in East Africa provides data on **Couple-Years of Protection (CYP)** as a program performance indicator. CYP is an aggregate of the level of protection provided by various forms of contraception distributed (and presumably used) in a given country.

- USAID/Uganda reports CYP distributed through SOMARC and AVSC:

SOMARC, promoting sales of condoms and oral contraceptives, reports an impressive 50% increase since 1994 to over 60,500 CYP in 1995. Prior to 1994, since the 1991 baseline of just 2,014, SOMARC had been able to double CYPs annually. The mission's target is to more than double this total to nearly 140,000 by 1998.

AVSC reported a 26% decline to just under 30,000 in permanent method CYPs for 1995. This was the first decline since the 1988 baseline of 4,250. The mission suspects that reporting problems may be to blame and still expects to be able to reach the target of nearly 80,000 in 1998.

All three missions also report **social marketing sales** of condoms and other contraceptives as indicators at the IR level. Like CYP, these data measure contraceptive supply, but success in creating self-financing social marketing programs has wider implications regarding sustainability. Although condoms are frequently used to prevent STDs as well as unwanted pregnancies, data are rarely disaggregated to reflect different reasons for condom use.

- USAID/Ethiopia will report on the numbers of condoms and oral contraceptives sold in focus areas. The mission has reported some progress on condom sales, providing a baseline of less than 500,000 per month in 1993 and a 1995 figure of 1,600,000 per month in 1995. Sales of oral contraceptives had not begun as of calendar year 1995.

- USAID/Uganda reports rapid increases in condom sales through SOMARC (also reflected in CYPs above). From a baseline of 302,000 in 1991, sales reached 3,800,000 in 1994 and 5,980,000 in 1995.

The mission's target for SOMARC is to exceed 10 million by 1998. The mission also provides figures on condom distribution (not sales) by NGOs funded by USAID. The mission presumably would like this figure to decrease as CSM sales rise. NGO distribution reached 6.8 million in 1995, slightly above the 1994 total, but is projected to decline to just one million by 1998.

- USAID/Kenya provides data on growing sales of TRUST condoms under its HIV/AIDS IR (summarized here under HIV/AIDS, below).

Missions concentrating on improvements in quantity and quality of PHN services may attempt to quantify the number (or geographic distribution) of **service delivery points (SDPs)** meeting desired criteria.

- USAID/Kenya tracks five indicators monitoring progress toward improving availability of family planning services and reports that 1995 performance targets were attained or nearly attained for four of the five indicators. Three of the indicators measure increase in FP SDPs and the other two measure the quality of services offered at these SDPs:

- Reporting current progress since 1984 baselines, the mission cites rises in the number of USAID-supported sites offering voluntary surgical contraception from 4 to 124 (well above the 1995 target of 76), the number of public sector sites offering FP from 577 to 1,200 (well below the target of 2,404 by 1995), and the number of private/NGO sites offering FP from 181 to 1,000 (meeting the 1995 target).

- The mission also reports progress on two indicators of the quality of services offered at public sites: in 1995, 80% of district stores were stocked with adequate (3-month) supplies of low-dose oral contraceptives and 75% had adequate supplies of condoms. The target for each indicator was 80%. The reported shares for 1995 represent substantial progress since 1989-90 baselines of 35.5% for oral contraceptives and just 18.9% for condoms.

- USAID/Madagascar reports remarkable increases in the number of medical sites providing FP services. Since 1987, when 72 sites provided FP services, the number has risen to 492 in 1995, with the most dramatic annual increase (95 sites) occurring in the last year of reporting. In the private sector alone, the number of sites has risen from just 6 in 1987 to 44 in 1995, including 20 new sites in the past year. Both total and private sites are ahead of schedule to meet the mission's 1997 targets of 630 and 42.

- USAID/Ethiopia is tracking the number of public SDPs providing FP services in the SNNPR (no data yet) and the number of NGO SDPs providing FP services in other focus areas. From a baseline of "0", NGO SDPs have increased to 38, thanks to the expanding efforts of Pathfinder International. A target of 274 NGO SDPs has been set for the end of CY1996.

- USAID/Ethiopia is also tracking the number of social marketing outlets providing condoms and oral contraceptives. Thanks (at least in part) to the efforts of Population Services International, condom outlets have doubled from a baseline (no year) of about 4,000 to 9,500 in 1995, well on the way to the target of over 10,500 by the end of CY1996. No oral contraceptives sales sites have been established yet, but the mission has set a target of 250 outlets by the end of CY1996.

D. Demand for Family Planning Services in East Africa

Missions with IEC activities frequently seek data on **knowledge** and **attitudes** as IR indicators of progress generating demand for family planning or health services. Of the three countries monitoring these indicators in East Africa, the level of acceptance of family planning is lowest in Madagascar, where the mission tracks women's knowledge of sources of contraceptive methods.

- USAID/Madagascar reports that 90% of women now know where to obtain contraception. This represents an exceptionally rapid increase from the 1992 DHS baseline of 46%. The new figure, from UNICEF's 1995 multi-indicator cluster survey, already exceeds the mission's 1997 target of 75%. It is unclear how comparable the data are; they are not discussed in the mission's narrative.

- USAID/Tanzania is one of the only missions to track knowledge of family planning among both women *and* men (USAID/Senegal is another). Under the mission's IR of "Increased knowledge of and access to FP services," only the following baselines are available: 77% of women and 82% of men ages 15-49 know at least 3 modern methods of family planning (1994 KAPS), and 65% of women and 71% of men ages 15-49 know a source for modern methods of FP (1991/92 DHS).

- USAID/Kenya is one of just two missions in the AFR region reporting on an indicator addressing women's desired family size (the other is USAID/Ghana). Kenya's indicator of "unmet demand for contraceptives" is actually a composite measure of the discrepancy between TFR and desired TFR. While this can suggest the extent to which existing demand for family planning has been satisfied, a more commonly used indicator of "unmet need" compares the share of women *using* means of family planning (CPR) with those desiring means of family planning. A problem with either indicator for monitoring program performance is that any successful efforts to increase demand could have a contravening effect on progress as measured by the indicator. In any case, USAID/Kenya reports that the discrepancy between actual and desired TFR has been lowered from 2.7 in 1989 (implying a DTFR of 8.7) to just 1.0 in 1995 (implying a DTFR of 6.0).

2.2. Population in Southern Africa

Although countries in Southern Africa have some of sub-Saharan Africa's lowest population growth rates, current levels still exceed those found in most other parts of the developing world. Demographic and health surveys (DHSs) in several countries have found the total fertility rate (TFR) to be rapidly declining as use of modern contraceptives (CPR) increases. Table 2.4 provides the latest data available on these population indicators in each country in the sub-region.

Table 2.4. Population, Fertility and Contraceptive Prevalence in Southern Africa, c. 1995.

	Population in millions (1995)	Total Fertility Rate (1995)	Contraceptive Prevalence Rate, modern methods (CPR-mm)		
			CPR	Year	Source
Angola	10.1	7.0	-	-	-
Botswana	1.4	4.7	32	1988	DHS
Lesotho	2.0	5.0	-	-	-
Malawi	9.8	7.0	8	1992	DHS
Mozambique	16.0	6.3	-	-	-
Namibia	1.7	5.1	26	1992	DHS
South Africa	41.5	4.0	60	1994	Kaiser Survey
Swaziland	1.0	4.7	14	1988	CDC
Zambia	9.4	5.7	9	1992	DHS
Zimbabwe	11.1	4.3*	42	1994	DHS

Source: UN projections (1994), *- 1994 DHS

While current levels of contraceptive use in Botswana, Zimbabwe, and South Africa are the highest on the continent, rates found by recent DHSs in Malawi and Zambia are still below 10 percent for modern methods. Fertility rates in the latter two countries, as well as Angola and Mozambique, remain well above 5 children per woman of reproductive age.

2.2.1 Southern African Missions with Population Programs

Three of the USAID missions in Southern Africa submitting R2s have a Strategic Objective in family planning. Two additional missions which did not submit R2s, USAID/Botswana and USAID/Swaziland, reported on SOs in family planning in last year's APIs. USAID/Mozambique is also planning to become involved in population but no activities or indicators are reported in the mission's R2. Grading of missions' R2s at the March 1996 country review sessions examined program maturity, progress (of mission efforts), and impact (on host country conditions). Southern African population programs, as reported in the R2s for FY 1995, were given the following scores, on a scale of 1 (lowest) to 5 (highest):

Table 2.5. Population Scores for Southern Africa USAID R2s

<u>Mission</u>	<u>Program Maturity</u>	<u>Progress</u>	<u>Impact</u>
USAID/Malawi*	3	3.5	4
USAID/Zambia*	3	3	2/3
USAID/Zimbabwe	5	5	5

* - scored together with CS and HIV/AIDS activities.

2.2.2. Population Program Indicators used by Southern African Missions

A review of USAID population program indicators appears on p. 5 above. Table 2.6 below lists the various types of indicators used by the three Southern African missions to track impact and progress in family planning programs. The letters indicate at which level the indicator is found within the R2 Results Framework: Goal (G), Strategic Objective (SO), or Intermediate Result (IR). Southern African missions are most concerned with indicators of contraceptive utilization (CPR) and supply (CYP, SDPs). As elsewhere in the AFR region, there is a notable scarcity of indicators monitoring the generation of demand for contraceptives, an important intermediate result in most population programs.

Table 2.6. Family Planning Indicators used by Southern Africa missions for R2 reporting.

Program	TFR	CPR	LAM	CYP	SM	SDPs	ka
Malawi	G	SO		IR	IRs	IRs	
Mozambique		SO*			IR*		IR*
Zambia		SO		IR	IR		IRs
Zimbabwe	SO	IR	IR	IR	IR	IRs	

* - indicators proposed in "Results Framework: SO3."

2.2.3. R2 Reporting on Population Indicators: Progress & Impact in Southern Africa

A. Population Outcomes in Southern Africa: Total Fertility Rate

Just two of the missions' R2s, Malawi and Zimbabwe, reported on the **total fertility rate (TFR)** as an indicator of program impact. USAID Zimbabwe tracks national and rural TFR at the SO level. USAID/Malawi tracks TFR at the goal level.

- USAID/Zimbabwe reports that TFR has dropped to 4.3 children per woman of reproductive age, according to the findings of the 1994 DHS, representing an impressive 33 percent reduction in just ten years. This rate is below the mission's original target of 4.5 for 1998, which has now been lowered 4.0. The mission also reports on TFR in rural areas, which now stands at 4.9 (as compared to 3.1 in rural areas).

- USAID/Malawi has not had any new TFR data to report since the 1992/93 DHS baseline of 6.7. The mission ambitiously envisions a lowering of TFR to 5.2 by 2000.

B. Use of Population Services in Southern Africa: Contraceptive Prevalence

All three missions active in population track **contraceptive prevalence rate (CPR)**. USAID/Malawi also tracks the share of longer-acting methods within CPR. In addition to the

three countries discussed here, USAID efforts have contributed to significant increases in CPR in Botswana, as was reported in last year's API.

- Zimbabwe did not have any new data to report, relying on last year's impressive DHS figures for CPR at 42% for modern methods (mm) and 48% for all methods among married women of reproductive age. The figure for mm is rapidly approaching the mission's target of 48% by 1998. Longer-acting methods accounted for 7.1% of modern methods in 1994, a sizable gain over the previous year (estimated at 4%) but still far below the target of 17% for 1998.

- USAID/Malawi reported an estimated CPR for married women of 8.6% for 1995 (based on service statistics), slightly higher than the 1992 DHS finding of 7.4%.

- USAID/Zambia has no new CPR data since its 1992 DHS, which found 15.2% of women 15-49 using a modern method of contraception. The mission's target is ambitious, to exceed 30% by 2001. For improvements in method mix, the mission is also tracking the number of methods used by over 1% of women, starting with a DHS baseline of 3 in 1992 and aiming for a target of 7 by 1998. USAID/Zambia has proposed another apparent indicator of use of FP services, "% of new acceptors who continue to use FP," at the IR level under "improved quality of FP strategies."

- USAID/Mozambique (Country Strategy Plan) has also proposed tracking CPR as a program indicator at the SO level.

C. Supply of Population Services in Southern Africa: Access and Availability

All three missions active in family planning list **Couple-Years of Protection (CYP)** at the IR level. CYP is an aggregate of the level of protection provided by various forms of contraception distributed (and presumably used) in a given country. Because data are usually available on an annual basis through contractors, such as PSI, and other routine reporting systems, CYP levels are often the basis of estimates of CPR when no survey data is available.

- USAID/Zimbabwe did not have any new data to report. As reported in last year's API, CYP distributed for all modern methods increased modestly between 1992-94 (152,000 -> 124,000 -> 167,000). Much of the increase can be attributed to longer-acting methods, for which CYP rose more sharply (25,000 -> 30,000 -> 44,000).

- USAID/Malawi reported a very sharp increase in CYP to 109,500 in 1995, well above 1994 (68,000) and the 1993 baseline (65,250). The mission intends to help double the 1995 total to 213,000 by 1997.

- USAID/Zambia has not yet started to report on CYP, which it lists as an IR indicator of access.

All three missions also report **social marketing sales** of condoms and other contraceptives as indicators at the IR level. Like CYP, these data measure contraceptive supply, but success in creating self-financing programs has wider implications regarding sustainability.

- USAID/Zimbabwe does not report crude CSM figures but does track the share of contraceptives

supplied by the private sector. The proportion has reportedly increased from 4.5% in 1988 to 14% in 1994, close to the mission's target of 17% by 1998. In its results reporting table, the mission also includes data on declining public financing for family planning and rising cost recovery by the ZNFPC, but appears to have dropped these as performance indicators.

- USAID/Malawi reports a massive increase in annual condom sales in 1995 at 4,000,000, dwarfing the 1992 baseline of 140,000. Reported CSM sales had increased to 193,000 in 1993 but dropped to a reported "0" in 1994, when the SOMARC project was phased out. With the commencement of a PSI program, the mission hopes to increase annual sales to 7,500,000 by 2000. The mission also provides annual data on free distribution of condoms, which also rose sharply in 1995 to 10,000,000, the level at which the mission wishes free distribution to remain through the end of the decade.

- USAID/Zambia plans to track annual sales of socially marketed oral contraceptives, for which a 1995 baseline of "0" has been set. The mission's target for 1998 is 300,000.

Missions concentrating on PHN sector reform and improvements in PHN service quality may attempt to quantify the number (or geographic distribution) of **service delivery points (SDPs)** meeting desired criteria.

- USAID/Malawi tracks three SDP indicators as well as a geographic access indicator at the IR level. The mission reports that the number of community-based distribution (CBD) agents providing limited FP services increased radically to 578 in 1995, reflecting substantial progress over the 1993 baseline of 134 and the 1994 figure of 374. Increases in MOH and CHAM (NGO) facilities providing FP services have been more modest but significant. In 1995, 14 hospitals were reported providing comprehensive services and 386 facilities were providing "core" services, well above 1992 baselines of 8 and 175, respectively. The mission did not report new data on average distance to modern contraceptives, for which a 1992 baseline of 6.3 km. is given.

D. Demand for Population Services in Southern Africa

Missions with IEC activities frequently seek data on **knowledge** and **attitudes** as IR indicators of progress generating demand for family planning or health services. USAID/Zambia is the only southern African mission reporting this kind of data for a program indicator.

- USAID/Zambia has established DHS baselines for two indicators of women's knowledge of contraception. The DHS found that 91% of married women know of at least one modern method of contraception and 87% know a method and a source for accessing that method. The mission has ambitiously set targets of 100% for each indicator for 1998.

- USAID/Mozambique ("Results Framework-SO3") proposes to track the percent of women who know at least two methods of family planning as an IR-level indicator.

2.3. Population in West Africa

West Africa exhibits the world's highest population growth rates. Unlike other parts of Africa and the developing world, fertility levels in West Africa have only recently begun to decline as population programs make inroads into increasing use of family planning services. DHSs in various West African countries indicate that TFRs are gradually declining from a high range of 6.5-7.5 children per woman of reproductive age prevailing during the 1980s. As indicated in table 2.4 below, less than six percent of women have reported using contraceptives in all but one of the West African nations that have had a DHS, far below rates in East and Southern Africa. Table 2.4 provides the latest data available on total population, fertility rates, and contraceptive prevalence rates for 23 countries in USAID's West Africa subregion.

Table 2.7. Population, Fertility and Contraceptive Prevalence in West Africa, c. 1995.

	Population in millions (1995)	Total Fertility Rate (1995)	Contraceptive Prevalence Rate, modern methods (CPR-mm)		
			CPR	Year	Source
Benin	5.5	6.9	0.7	1982	US Census Bur.
Burkina Faso	10.3	6.3	4.4	1993	DHS
Cameroon	13.5	5.5	4.3	1991	DHS
Cape Verde	0.4	4.1	-	-	-
Central African Rep.	3.2	5.1*	3.2	1995	DHS
Chad	5.6	5.7	-	-	-
Congo	2.5	6.1	-	-	-
Cote d'Ivoire	14.3	5.7*	4.3	1994	DHS
Equatorial Guinea	0.4	5.7	-	-	-
Gabon	1.2	5.5	-	-	-
Gambia	1.0	5.4	-	-	-
Ghana	17.5	5.5*	10.1	1993	DHS
Guinea	6.5	6.8	1.0	1992	DHS
Guinea-Bissau	1.1	5.6	-	-	-
Liberia	3.1	6.6	5.5	1986	DHS
Mali	9.4	6.9	1.4	1987	DHS
Mauritania	2.3	5.2	0.3	1981	US Census Bur.
Niger	9.2	7.3	2.0	1992	DHS
Nigeria	101.2	6.2	3.5	1990	DHS
Senegal	9.0	5.8	4.9	1993	DHS
Sierra Leone	4.5	6.3	-	-	-
Togo	4.4	6.3	3.0	1988	DHS
Zaire	44.1	6.5	-	-	-

Source: UN Projections, U.S. Census Bureau,
*DHS finding (see CPR for year).

2.3.1 West African Programs with Population Activities

Seven of the eight West African country missions submitting R2s, as well as the regional REDSO/WCA program, are active in family planning. Grading of R2s at the March 1996 country review sessions examined program maturity, progress (of mission efforts), and impact (on host country conditions). In many cases, population activities were scored together with child survival and/or HIV/AIDS activities. West African population programs, as reported in the R2s for FY 1995, were given the following scores on a scale of 1 (lowest) to 5 (highest):

Table 2.8. Population Scores for West Africa USAID R2s

<u>Mission</u>	<u>Program Maturity</u>	<u>Progress</u>	<u>Impact</u>
USAID/Benin*	2	2	2
USAID/Ghana	4	4	4
USAID/Guinea	5	4	3
USAID/Mali**	5	4	3
USAID/Niger***	4	3	2
USAID/Nigeria	4	4	4
USAID/Senegal	2	4	4
REDSO/WCA****	1	3	1

* - scored together with HIV/AIDS activities. ** - scored with education and other "Youth" activities.
 *** - scored with Child Survival activities. **** - scored with Child Survival and HIV/AIDS activities.

2. Population Program Indicators used in West Africa

Table 2.9 provides a representation of the various indicators used by the different West African missions and the regional program to track impact and progress in family planning (see p. 5 above for a description of population program indicators). The letters indicate at which level the indicator is found within the R2 Results Framework (see key).

Table 2.9. Family Planning Indicators used by West African programs for R2 reporting.

Program	PGR	TFR	CPR	LAM	CYP	SM	SDPs	Policy	ka	Unmet
Benin										
Ghana	SG	SO	IR	IR	IR		IRs		IRs	IR
Guinea		SG	SO		SO	SO	IRs	IRs	IRs	
Mali			IR							
Niger		G	SO		IR		IR	IR		
Nigeria			pr		SO	IR				
Senegal	SG	SO	IR		pr	pr			IR	
REDSO/WCA			SO							

Key: G: Goal. SG: Sub-goal. SO: Strategic Objective. IR: Intermediate Result.
 pr: progress reported without reference to specific level w/in framework.

2.3.3. R2 Reporting on Population Indicators: Progress & Impact in West Africa

A. Population Outcomes in West Africa: Total Fertility Rate

Four of the missions report on the **total fertility rate (TFR)** as an indicator of program impact. Significant drops have been particularly well documented in two countries which have each had two DHSs, Ghana and Senegal. Both missions track TFR at the SO level. This year's R2s for West Africa do not provide any new data on TFR that didn't appear in last year's APIs.

- In last year's API, USAID/Ghana reported that its 1993 DHS had found a TFR of 5.5 children per woman of reproductive age, significantly lower than the 6.4 found by the 1988 DHS.
- In Senegal, the 1992/93 DHS found a TFR of 6.0 as compared to 6.6 in 1986. As a result, the mission has lowered its national target for 1997 from 6.0 to 5.7. In target regions, the mission reports that TFR fell from 7.0 in 1986 to 6.3 in 1993.
- USAID/Guinea reports on TFR at the sub-goal level. The mission suspects that its 1992 DHS baseline of 5.7 is too low. (Unlike all other DHSs, the Guinea DHS was not conducted with the participation of Macro Systems, Inc.) In the timeline, the mission cites the World Bank's figure of 6.5 for 1992, cites the Population Reference Bureau's TFR of 6.0 for 1993 and 1994, and sets an ambitious target 5.5 for 1998.
- USAID/Niger includes TFR as an indicator under its mission vision (i.e., goal), citing the 1992 DHS baseline of 7.4 and setting a moderate target of 7.2 for 1999.

B. Use of Population Services in West Africa: Contraceptive Prevalence Rate

Contraceptive prevalence rate (CPR) is a far more responsive indicator of family planning efforts. Increases in CPR are assumed to indicate subsequent declines in fertility. Six of the seven missions active in population and the REDSO/WCA program track, or plan to track, CPR as a program indicator. Two of the missions, Ghana and Nigeria, have also proposed to track the share of **longer-acting methods** within CPR, though only Ghana reported on this in this year's R2 (with conflicting figures from DHS and govt. sources). CPRs in West Africa are among the lowest in the world but are gradually climbing; USAID efforts are definitely making a difference here.

- Survey data reported in last year's APIs showed the CPR for modern methods climbing above 10% for the first time in Ghana and Nigeria. While Ghana's rate of 10% among all women is from the 1993 DHS, Nigeria's reported CPR of 11.3% is from a Nigerian Government Survey which may or may not be compatible with 1990 DHS findings of just 4% for modern methods, but the vast increase in CPR in Nigeria is supported by other survey findings as well as service data on CYP distributed.
- In USAID/Mali's R2, the mission reports CPR to have risen to 7% in 1995, high above the baseline of 1.3% found by the 1987 DHS. The 1995 figure, however, is based on CYP distribution; a more accurate figure will soon be available from the 1995 Mali DHS. In its

narrative, the mission also reports encouraging data from recent surveys indicating increased contraceptive use and knowledge in Bamako and PVO project areas.

- USAID/Senegal estimates that CPR has passed above 6% nationwide. The mission tracks CPR in urban areas as an IR-level indicator, estimating that it has more than doubled the mission's 1986 baseline to exceed 15% in 1995. The mission reports a modest increase in the four target regions from 1.2% in 1986 to around 2.5% in 1993.

- Estimates in R2s for Guinea and Niger indicate that CPR continues to gradually climb but remains below 5 percent.

- The regional program REDSO/WCA has proposed to track CPR with a targeted level of increase of one percentage point per year (no methodology was elaborated).

C. Supply of Population Services in West Africa: Availability, Quality, and Policy Environment

Because reliable estimates of CPR are only available through surveys, most missions also report **Couple-Years of Protection (CYP)**, an aggregate of the level of protection provided by various forms of contraception distributed (and presumably used) in a given country. CYP levels are often the basis of estimates of CPR when no survey data is available, but they are used more accurately as indicators of service supply. CYP data are usually available on an annual basis through contractors such as Population Services International and through other routine reporting systems. Five of the missions in West Africa provided data on CYP in this year's R2s:

- In Ghana, the CYP level estimated for 1995 (493,000) is nearly five times higher than the 1988 baseline of 107,000, following a steady climb in the 1990s. The share of longer-acting methods (which are necessarily more heavily weighted within CYP) has reportedly risen from 21 percent in 1988 to an estimated 31 percent for 1995.

- In Nigeria, CYP reported for 1995, at 6.7 million, are nearly double the 1993 total and high above the 1990 baseline of 1.8 million. The 1995 figure surpasses the mission's target for 2000; however, the methodology used to arrive at these figures, and particularly the percentage increase for 1995, are difficult to understand.

- Senegal, having reported only a marginal net increase from 1991-94, reported significant progress for 1995. The 1995 CYP figure of about 164,000 stands high above the 1993 total (114,000) and is more than triple the baseline of 54,000 for 1986.

- In Guinea, CYP have reportedly tripled from under 13,000 in 1992 to 39,000 in 1995. CYP distributed in the private sector have increased 2.5 times since the 1992 baseline and CYP distributed in the public sector have risen from a baseline of 0 in 1992 to 10,000 (25% of total) in 1995. *[Mission may have changed condom conversion factors, resulting in higher CYP figures for 1994 and 1995; earlier formula results in 25,000 total and 6,200 public sector for '95.]*

- Niger, having lowered its estimates after adopting the prevailing definition for CYP used in the USAID community, reports a marginal increase to about 43,000 (1995 estimate), only slightly above figures for 1993 and 1994 but well above the 1990 baseline of 24,000.

Social marketing of condoms and other contraceptives is designed to make population programs self-financing and thus more sustainable. Missions in Guinea and Nigeria report on social marketing figures as program indicators; Senegal also provides data on social marketing activities. The figures reported are components of CYP but only include commodities sold (not those distributed free, and not total commodities imported).

- In Guinea, condom sales in the private sector have steadily increased since 1992 and appear to be on track to meet the target of 3,000,000 for 1996. For 1995, the mission also reported the first private sales of oral contraceptives and injectables. In the public sector, the mission reported sales of condoms steadily increasing in 1993-95, while sales of oral contraceptives, spermicide, injectables, and IUDs have increased by 2-3 times since 1993. (all data from PSI)

- USAID/Nigeria's Contraceptive Social Marketing program reports rapidly rising condom sales but declining sales of pills (according to the table) and IUDs between 1993 and 1995. Planned marketing of Depo-Provera has been cancelled. The mission takes pride in the increased demand generated by the program but expresses concern over the viability of unsubsidized commercial distribution and the impending cut-off of commodities for Nigeria. *(Along with CYPs, these figures are difficult to reconcile. The R2 narrative has different, increasing figures for pills; HIV/AIDS section has different figures for condom sales.)*

- USAID/Senegal reports that its contraceptive social marketing program exceeded its sales target by 42% in the first ten months of full operation, distributing nearly 900,000 condoms through 252 pharmacies and 80 depots. The mission considers this a major success story in the Senegalese context of tight government control of contraceptive and medical sales.

Missions concentrating on PHN sector reform and improvements in PHN service quality may attempt to quantify the number (or geographic distribution) of **service delivery points (SDPs)** meeting the mission's desired criteria.

- USAID/Ghana promotes increased availability family planning services in both the public and private sectors. The mission's IR indicator for the public sector has been dropped as the MOH reached the target of 5,000 outreach sites with FP services in 1993. In the private sector, the mission continues to track the activities of the Ghana Social Marketing Foundation (GSMF) and the Ghana Registered Midwives' Association (GRMA). These organizations, both primarily supported by USAID, report on contraceptives distributed (contributing to the missions' calculation of private sector CYP) and the number of distribution points. According to the mission's R2, GSMF retail sales outlets have increased from 4500 in 1992 to nearly 7200 in 1995, still well short of the target of 10,000 but enough for GSMF to attain CYP targets. GRMA reportedly has 213 members providing FP services, below both the 1992 baseline (251) and the target of over 400 for 1995 (apparently there have been reporting problems). However, the mission reports that GRMA has also been meeting its CYP targets.

- USAID/Guinea provides similar data on public and private FP distribution points under IR2.2, "Improved FP information and commodity delivery." The mission reports that 106 public health centers or hospitals now offer these FP services, up from just 16 in 1992 and attaining the mission's target of 100 several years in advance. For community-based distribution sites, a baseline of 50 in 1995 has been established with a targeted expansion to 450 sites by 1998. In

the private sector, traditional and non-traditional sites offering FP information and commodities now total 3,710, ten times higher than the 1992 baseline of 340 and just short of the 1998 target of 3,750. (all data from PSI)

- USAID/Niger reports on availability of FP/MCH services through several indicators dealing with geographic access and raw numbers of SDPs. In Niger's nascent private sector, just 43 facilities are reportedly providing FP and/or MCH services; only 6% of the population lives within 5 km. of a private facility offering FP services. These are 1995 baselines; no targets have been set. The mission also reports on the number of geographic departments covered by social marketing efforts, a figure which has risen from 0 in 1993 to the target of national coverage (all 7 departments plus Niamey) in 1995.

Many missions are active in family planning **policy** reform through research, advocacy, constructive dialogue, and other activities which are often difficult to fit within the results framework.

- USAID/Niger plans to report on progress toward a policy environment which advocates fewer restrictions on access to modern FP methods and favors the further development of private health service providers. No quantitative scale is suggested, but a note describes the mission's success in fostering the participation of most Islamic parties in FP campaigns and the passage of a law authorizing cost recovery in the health sector.

- USAID/Guinea tracks developments in host country's population policy by applying a quantitative scale of 1-10 to otherwise qualitative policy developments.

D. Demand for Family Planning Services in West Africa

Missions with IEC activities frequently seek data on **knowledge** and **attitudes** as IR indicators of progress generating demand for family planning or other health services. Most common is knowledge of one method (or three methods) of modern contraception. Another indicator which hinges on demand is **Unmet need** for family planning.

- USAID/Guinea reports estimates by PSI that "specific knowledge" of contraceptive methods has risen rapidly to exceed mission targets for 1995. Nationwide knowledge at 53 percent is nearly double the 1992 baseline. Even more impressive are PSI's estimates for Forest Region (10.5% in 1992, 52.5% in 1995) and Upper Guinea (7.0% in 1992, 35% in 1995). The mission also reports on increasing knowledge of methods in the capital, Conakry (63.8% in 1992, 90% in 1995) and has set 1995 baselines for four regional capitals.

- USAID/Ghana, drawing from DHSs in 1988 and 1993, reports gains both in demand and supply of modern methods of family planning. The mission reports that "demand satisfied" for modern methods of contraception (the inverse of "unmet need") has increased slightly from 26.8% to 34.4% between 1988 and 1993). At the same time, demand has apparently also increased: far fewer women "do not intend to use a contraceptive method in the future because of lack of knowledge" (24% in 1988, 12% in 1993), slightly more women believe their husbands approve of family planning (52->60.3%), and many more husbands actually do claim to approve of family planning (77->87%). The mission is awaiting results of a 1995 consumer tracking survey to

update its reporting on each of these indicators.

- USAID/Senegal reports only marginal progress in increasing knowledge of modern contraceptive methods among men and women in rural areas. While reported levels of knowledge among men are approaching the modest targets set by the mission, levels among women lag far behind both their (more ambitiously) targeted levels and the current levels among men.

3. Child Survival / Health

"Child survival" activities include health and nutrition interventions designed to improve the chances of African infants and children to survive early childhood in a healthy manner which prepares them for a productive future. This area also includes elements of reproductive health as well as broader health sector reform activities intended to strengthen the primary health care (PHC) services vital to improved maternal and child health. This section is split into three subregional sections, each including a review of current infant and child health conditions, the status and performance ratings of USAID child survival programs, a table listing the kinds of child survival indicators used by each mission, and an indicator-by-indicator review of USAID program progress and impact. The following brief review of child survival program indicators applies to all three sub-regions; abbreviations in bold text are provided as keys to the indicator tables provided for each sub-region.

A. **Impact / Outcomes:** Indicators of health outcomes are generally used to show changes at the goal level. These include life expectancy at birth (**LE0**), infant mortality rate (**IMR**), under-five mortality rate (**U5MR**), child (ages 1-4) mortality rate (**CMR**), nutritional status (**NS**), and disease incidence (**dis**). Another health outcome indicator, the maternal mortality ratio (**MMR**), was reported in some APIs (Nigeria, Guinea) but has been dropped as an R2 indicator.

B. **Service Use:** Commonly found at the SO or IR level are indicators of service utilization (**use**) and healthy practices, including rates of vaccination coverage among children (**Vacs**) and women of reproductive age (**TT2+**), use of prenatal care services by pregnant women (**Pren**), use of oral rehydration therapy to treat diarrhea (**ORT**), the practice of exclusive breastfeeding (**EB**) or other infant feeding indicators, and proper treatment of fever (**fev**). Most indicators of these indicators are measured through population-based surveys.

C. **Demand for Services:** An important prerequisite to increased use of services may be increased demand, including heightened awareness of the need and/or location for such services. Where USAID programs use demand-oriented indicators, they are typically found at the IR level. Indicators of demand are less commonly used for child survival programs than for family planning or HIV/AIDS prevention. Those that are used relate to people's knowledge and attitudes (**ka**) about health services and practices.

D. **Service Supply:** Also at the IR level are supply-oriented indicators of the quantity of service delivery points (**SDPs**), frequently tallied with respect to certain quality criteria, and the availability of key health inputs such as water and sanitation (**W&S**). Related indicators of access (**acc**) measure service supply with respect to the targeted population. Service quality indicators include facility-based measurements of provider performance (**perf**), typically examining case management (**cm**) of childhood diseases (there may be some overlap with service use indicators here). Also related to service supply are indicators used to monitor broader health sector developments. In the R2s, these indicators examine financial resources dedicated to the sector (**\$\$**), desired changes in health policies (**Pol**), efforts to strengthen health care systems (**Sys**) through improved planning, reporting, training, or other management practices, and levels of community participation (**CP**) in health care delivery.

3.1. Child Survival and Health in East Africa

Most East African countries have shown steady improvement in child survival since the 1960s but many, particularly Uganda, Ethiopia, Sudan, Eritrea, Rwanda, and Burundi, have faced major setbacks in the face of violent internal struggles and population dislocation. In the 1990s, new obstacles, including the HIV/AIDS pandemic and increased impact from malaria due to resistant strains, threaten to reverse much of the progress that has been achieved. Figures 1 and 2 present some basic trends in child survival in East Africa, based on projections and estimates by the UN, the US Bureau of the Census, and CIHI.

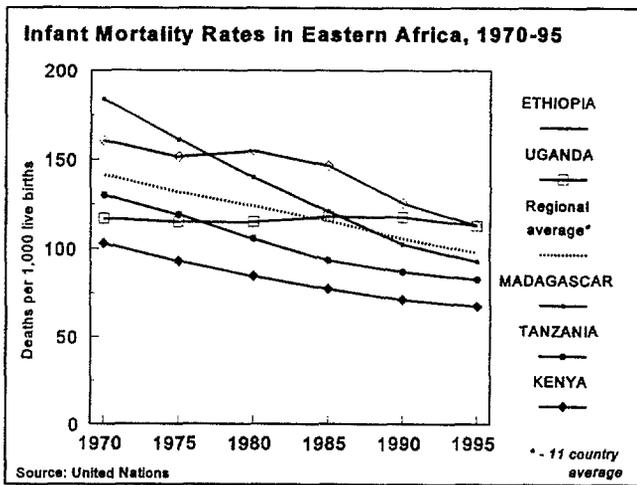


Figure 1.

Kenya has some of the lowest mortality rates in sub-Saharan Africa, though results from Kenya's 1993 DHS indicated that the pace of improvement has slowed there. Meanwhile, Kenya's neighbors to the north and west lie at the other extreme. Improving conditions in Madagascar and Tanzania place these two nations close behind Kenya's progress. Uganda, where levels of infant and child mortality were once among the lowest in the region, improvement has lagged since the 1960s. Until recently, current rates in Uganda were thought to be the highest in East Africa, but preliminary results of the 1995 Uganda DHS indicate a U5MR below 150, well below the regional average. Peace in Ethiopia and Eritrea presents an opportunity to improve health conditions in these high-mortality nations.

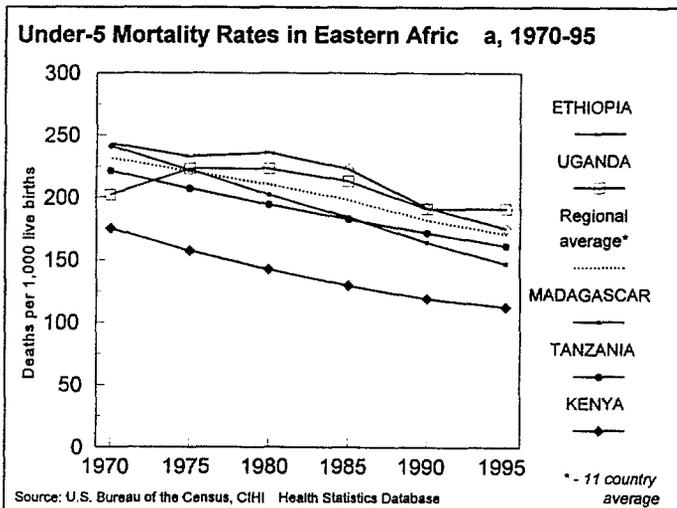


Figure 2.

3.1.1. East African Programs with Child Survival / Health Activities

As previously indicated in table 1.1 (p.2), just two of the East African missions submitting R2s - USAID/Madagascar and USAID/Ethiopia - have programs explicitly addressing child survival. Both are relatively new initiatives and program reporting is thus quite limited. USAID/Kenya also addresses maternal and child health care in its program of broader sectoral reform, but is not considered to have a bona fide child survival program. Another East African mission, USAID/Eritrea, is implementing child survival activities but did not submit an R2. East African child survival programs, as reported in the R2s for FY 1995, were given the following scores on a scale of 1 (lowest) to 5 (highest):

Table 3.1. Child Survival/Health Scores for East Africa USAID R2s

<u>Mission</u>	<u>Program Maturity</u>	<u>Progress</u>	<u>Impact</u>
USAID/Ethiopia*	1	3	-
USAID/Madagascar	-	2	-

* - scored together with Population activities.

3.1.2. Child Survival / Health Program Indicators used in East Africa

Table 3.2 summarizes the indicators used to measure child survival program impact and progress in East Africa. Although only two missions are directly engaged in child survival activities, all five report on health sector indicators, either explicitly within the results framework (indicated by caps) or just within the R2 narrative (small letters).

Table 3.2. Child Survival/Health Indicators used by East Africa USAID programs for R2s

	IMR	U5MR	CMR	NS	dis	use	Vacs	SDPs	W&S	\$\$	Pol
Ethiopia	ir*			ir*		SO	ir*	IRs	ir*	IRs	IR*
Kenya	g	g								IRs	
Madagascar					irs*	IR	irs*	irs*	irs*		irs*
Tanzania	G		G					ir			
Uganda		G		G							

* - proposed indicators, no reporting yet.

3.1.3. R2 Reporting on Child Survival Indicators: Progress & Impact in East Africa

A. Health Outcomes: Mortality, Nutritional Status, Disease Incidence

The highest-level indicators of child survival, IMR and U5MR, are typically reported at the goal or sub-goal level, indicating that the mission, although desiring and monitoring for

improvement, does not consider positive change to be within its *manageable* interest. In East Africa, only USAID/Tanzania and USAID/Uganda, neither of which is a CS mission, explicitly track mortality rates within the R2. USAID/Ethiopia has discussed tracking IMR within its incipient CS program. USAID/Kenya has also discussed infant and under-five mortality rates in its past APIs.

- USAID/Tanzania does not have new data to report on its goal-level indicators on infant and child mortality since the 1991/92 DHS findings of 92 (IMR) and 55 (Child (1-4) mort. rate).

- USAID/Uganda reports that U5MR has lowered from 188, as found by the 1988 DHS, to 147 deaths per 1,000 live births, as reported preliminarily by the 1995 DHS. This rate is significantly better than the U5MR of about 190 projected before the DHS (see figure 2).

Nutritional status is another indicator of health outcomes. It is easier to measure on an annual basis, but, as with IMR and U5MR, the significance of change is sometimes difficult to establish with respect to mission activities. USAID/Uganda tracks nutritional status at the goal level; USAID/Ethiopia is also considering tracking nutritional status.

- USAID/Uganda reports that chronic malnutrition among children under four years of age has declined from 43% according to the 1988/89 DHS to 38% as reported by Uganda's 1995 DHS. As the mission states, the improvement is probably somewhat better than suggested by the data as the earlier DHS excluded worse-off northern regions of the country. (This assertion can be tested when the final report of the 1995 DHS is available and northern regions can be disaggregated to make a fair comparison.) "Chronic malnutrition" usually refers to stunting (low height for age); data for the "under-four" age group are not readily available in the DHS report, requiring calculation for reporting or verification.

- REDSO/ESA is planning to monitor levels of acute malnutrition under its SO to facilitate effective delivery of USAID humanitarian assistance in Eastern and East Africa.

Disease incidence: USAID/Madagascar has proposed monitoring incidence rates for polio and measles as IR-level indicators, but has not established a baseline. In countries where health information systems are still under development, the quality of data contributing to incidence rates may not be sufficient to reflect program impact, particularly in the case of measles.

B. Utilization of Health Services & Healthy Practices

More responsive and effective program reporting for some CS programs has been possible through indicators of service utilization or healthy behavior or practices. USAID/Ethiopia has proposed monitoring the "utilization of P/PHC services" by the population in program areas and provides a general baseline ("20-40%") and a target (30-50% by 2002) but does not specify what the data are actually measuring.

Vaccination coverage rates are commonly used as an index of service utilization. In East Africa, none of the missions have reported vaccination coverage rates as program indicators in

the past, but two of the new CS programs, in Ethiopia and Madagascar, are now proposing to track rates at the IR level.

- USAID/Madagascar has not set baselines but has set 1999 targets for vaccination coverage for the following antigens: BCG (90%), measles (80%), and full immunization (80%) among children and tetanus toxoid (TT2+) among pregnant women (50%).

Although these coverage rates are not yet part of the mission's R2 reporting framework, in the narrative the mission reports 1995 data from a Catholic Relief Services (CRS) Title II program indicating that *participating* mothers are more likely to have prenatal TT2+ coverage (94% as opposed to 44% from the 1992 DHS) and their children are more likely to be immunized against measles (65%, cf. 54% from the 1992 DHS).

Another common indicator of healthy practices is the oral rehydration therapy (ORT) use rate for children with diarrhea:

- USAID/Madagascar is tracking ORT use as an SO-level indicator, citing a 1992 DHS baseline of 26%. For 1995, the mission reports a moderately higher rate of 32% from UNICEF's multi-indicator cluster survey. The mission also provides CRS data indicating a 40% use rate by *participating* mothers in 1995.

C. Demand for Child Survival / Health Services

Typically found at the IR level are indicators monitoring the necessary conditions to increased use of healthy practices and services. These include measures of demand for and supply of services. None of the East African missions track indicators associated with demand, though USAID/Madagascar has proposed monitoring for "improved CS and nutrition knowledge nationwide by the year 2000."

D. Supply of Child Survival / Health Services

Far more IR-level indicators in the health sector revolve around the supply of services and more particularly the quality of those services provided.

- USAID/Madagascar has proposed tracking IR-level indicators monitoring access to sanitation and other services ("target population receiving CS, nutrition, sanitation and prenatal services") at select sites, dissemination of health messages for caretakers, the number of workers trained in integrated case management (ICM), and the number of health workers correctly using ICM.

- USAID/Ethiopia will monitor for "increased P/PHC service availability in SNNPR" at the IR level but has not defined an actual indicator. The mission also proposes to monitor access to water and sanitation, the degree of health education provided, the number of community health agents (CHAs) trained, and the number of clinics constructed.

- USAID/Tanzania reports on increased access to private health services within the R2 narrative describing improvements in transportation under the mission's SO2, "Increased private sector participation in the Economy." An impact assessment of the Njombe-Makete

Road found that utilization of private health care services served by the road increased 30% between May 1993 and 1995.

Other indicators of the quality of interventions monitor the extent of systems development, including the gathering and use of data for information systems, as well as broader **policy** and planning concerns.

- USAID/Madagascar proposes monitoring the development of national **policies** for control of diarrheal disease, malaria, fever, and acute respiratory infections (ARIs).

- REDSO/ESA is examining the regional growth of health **information** networks under its SO of "increased utilization of critical information by USAID and other decision-makers in the region." From 1994 baselines of "0", the program reports 2 institutions and 100 individuals participating in information networks dealing with integration of MCH, family planning, and HIV/AIDS services and health care financing issues. REDSO/ESA also reports on "models" and "technologies" developed and evaluated through its activities. The R2 identifies Ethiopia, Tanzania, and Uganda as East African countries where REDSO/ESA has been particularly active in the PHN sector.

A final group of health sector indicators monitor the degree to which and process by which financial **resources** are dedicated to the health sector.

- USAID/Ethiopia has IR-level indicators monitoring the **share of the national budget** being allocated to the health sector and the share of the recurrent health budget used for institutions providing P/PHC. According to the R2 reporting grid, government spending on health has risen from just 3.2% in 1992 to 6.2% of the national budget in 1995, well on the way to the mission's goal of 9% by 2001. The mission takes credit here for taking the lead in promoting policy reform. The health budget's share for PPHC services reportedly remained at 31.5% in 1995, the same level reported for 1993, still far short of the target of 50% for 2001.

- USAID/Ethiopia also tracks **cost recovery**, monitoring the share of recurrent costs covered by funds generated and held within the sector. A baseline is provided (7% generated, 0% retained) but no progress is reported toward the targets of 20% generation and 100% retention.

USAID/Kenya has long been active in health sector reform and tracks similar indicators: the share of the health budget dedicated to rural health care and PPHC and the amount of "cost-sharing" revenue available at the district level for PPHC services. Through the activities of the Kenya Health Care Financing (KHCF) project, the mission takes credit for increasing generation of local revenue for PPHC services beyond the 1995 target level of 40 million Kenyan Shillings per year. As the R2 reports, steady increases over the 1990-91 baseline of 6.8 million Kenyan Shillings led to 48.4 million Shillings generated in 1994-95. Thus local **cost recovery** now provides "nearly \$1 million per year in additive funding to support MCH services and control of infectious diseases." MOH **allocations to rural/PPHC** have also reportedly increased from 13.7% of MOH expenditures in 1984 to 25% in 1994. The latter figure, however, represents a slight drop from the level of 28.6% reported for 1993 and still falls short of the mission target of 30% for 1995. The significance of these data is not addressed in the mission's narrative.

3.2. Child Survival and Health in Southern Africa

Although many Southern African countries have achieved far better rates of child survival than found elsewhere on the continent, new obstacles, including the HIV/AIDS pandemic and increased impact from malaria due to resistant strains, threaten to have reverse much of the progress. Figures 1 and 2 present some basic trends in child survival in southern Africa, based on projections and estimates by the UN, the US Bureau of the Census, and CIHI.

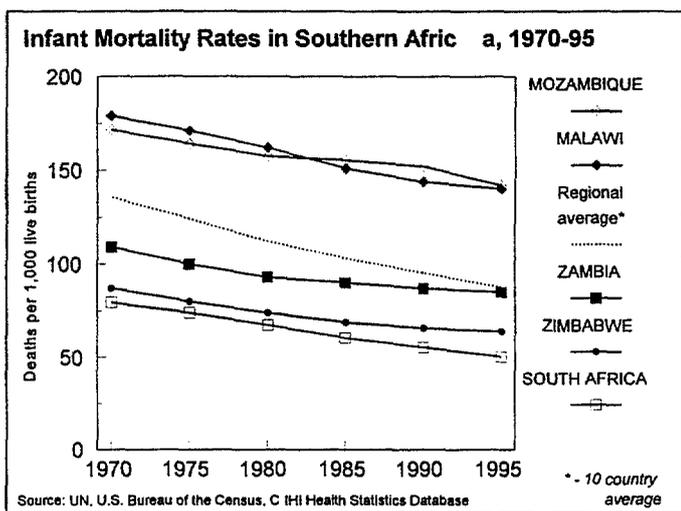


Figure 1.

As with the population data, variation within the southern Africa is substantial. Mortality rates in Malawi and Mozambique are among the highest on the continent, but are gradually improving. The lowest rates of infant and under-five mortality, in South Africa, mask significant inequities within that country, where the IMR among the "African" (black) population is thought to be up to seven times higher than among whites. In Zambia, a country which has suffered economic difficulties and severe impact of HIV/AIDS in the 1990s, conditions are thought to have possibly deteriorated in the past 10 years.

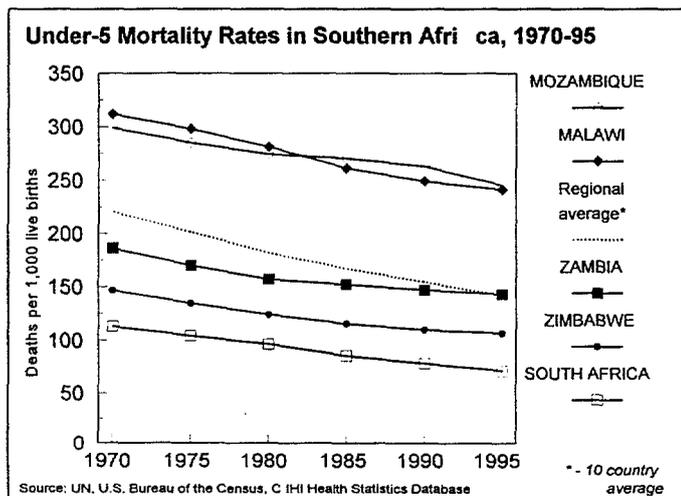


Figure 2.

3.2.1. Southern African programs with Child Survival / Health activities

As previously indicated in table 1.1 (p. 2), four missions in Southern Africa have an SO involving CS activities. USAID/Malawi, however, is the only Southern African mission reporting ongoing activities within an established CS program. The other three CS programs are still in their initial stages. The changing political climate in Mozambique and South Africa has created unprecedented opportunities for cooperation and progress in child survival in those countries. USAID/South Africa, which is focusing on sectoral reform and particularly equity, has not begun to report on indicators. R2 reporting by USAID/Mozambique, which is just coming out of a transitional phase, is more reflective of past efforts in emergency humanitarian assistance than the current program designed for sustainable development in a peaceful setting. USAID/Zambia is another relatively new program but has established and reported on CS indicators in its R2.

Southern African child survival programs, as reported in the R2s for FY 1995, were given the following scores on a scale of 1 (lowest) to 5 (highest):

Table 3.3. Child Survival/Health Scores for Southern Africa USAID R2s

<u>Mission</u>	<u>Program Maturity</u>	<u>Progress</u>	<u>Impact</u>
USAID/Malawi*	4	3/4	3/4
USAID/Mozambique	1	3	2
USAID/South Africa	<not scored>		
USAID/Zambia*	3	3	2/3

* - scored together with Population and HIV/AIDS activities.

3.2.2. Child Survival / Health Program Indicators used in Southern Africa

The following table summarizes the indicators used to measure child survival program impact and progress in Southern Africa. Abbreviated headings refer to indicator groups reviewed on p. 23 above.

Table 3.4. Child Survival/Health Indicators used by Southern African programs for R2s

Program	IMR	NS	Vacs	TT2+	ORT	EB	fev	ka	acc	SDPs	Sys	CP
Malawi	G	G	G		SO		IRs	IR	IR	IR		
Mozambique	G*	SO,G*	SO*	SO*	SO*	SO*		IR*	IR*	IRs*	IRs*	IR*
South Africa									IR*	IRs*	IRs*	
Zambia			SO,IR		SO	IR				IRs	IRs	IR

* - indicators proposed, no reporting yet.

3.2.3. R2 Reporting on Child Survival Indicators: Progress & Impact in Southern Africa

A. Health Outcomes: Mortality and Nutritional Status

The highest-level indicators of health status and child survival, **IMR** and **U5MR**, are typically reported at the goal or sub-goal level, indicating that the mission, although desiring and monitoring for improvement, does not consider positive change to be within its *manageable* interest. Only USAID/Malawi reports on IMR in Southern Africa.

- As in last year's API, USAID/Malawi reports DHS data on infant mortality from 1992. The rate of 134 deaths per 1,000 live births is well below the mission's baseline of 151 for 1984. The mission has set a target of 120 for 2000.
- USAID/Mozambique has proposed monitoring IMR, U5MR, and the maternal mortality ratio (MMR) as goal-level indicators ("Results Framework-SO3").

Nutritional status, another indicator of health outcomes, is easier to measure on an annual basis, but, as with IMR and U5MR, the significance of change is sometimes difficult to establish with respect to mission activities. USAID/Malawi tracks NS indicators at the goal level while Mozambique has monitored NS at the SO level.

- USAID/Malawi reports that prevalence of moderate stunting (weight-for-height) among rural children remained around 50 percent in 1995, the same as the 1992 DHS baseline, while severe stunting among urban children rose to 19 percent in 1995 from the 1992 baseline of just 11 percent.
- USAID/Mozambique reported on global acute malnutrition (low weight-for-height) in monitored populations as an R2 indicator for its transitional "Objective 1: Avoid drought-related and war-related death and famine". While data reported under last year's APIs indicated that conditions were improving, at least among monitored populations, new data in the R2 is not comparable. The mission is considering various nutritional status indicators under its new results framework, which will include an SO focussing on increased use of MCH services. Weight-for-age, which is sensitive to long-term malnutrition, has been proposed to measure adequate nutritional status as a goal-level indicator.
- REDSO/ESA is planning to monitor levels of acute malnutrition under its SO to facilitate effective delivery of USAID humanitarian assistance in Eastern and Southern Africa.

B. Utilization of Health Services & Healthy Practices

More responsive and effective program reporting for CS and other health activities has been possible through "lower-level" indicators of service utilization and healthy behavior or practices, and, at the next level as a requisite to increased utilization, supply and demand of services. **Vaccination coverage rates** incorporate elements of both service utilization and supply (availability). Southern African missions reporting these rates in the R2s include USAID/Malawi and USAID/Zambia.

- USAID/Malawi reports on full vaccination coverage among children by age one as a goal-level indicator. The mission reports that coverage declined to 61% in 1995 from the 1992 baseline of 67% and the 1993 figure of 70%.

- USAID/Zambia plans to utilize vaccination coverage rates at various levels in its results framework. At the SO level, the mission reports on measles coverage by age one as a use indicator. From the 1995 MOH baseline of 72%, the mission has set a target of 80%(?) coverage by 2001. Under IR3.1, the mission will track coverage with the third shot of DPT (DPT3) by age one to monitor "decreased missed opportunities for preventive services." The mission has set a 1995 MOH baseline of 72% and a target of 90% DPT3 coverage for 2001.

- USAID/Mozambique is also currently planning to include reporting on vaccination rates (DPT3,TT2+) at the SO-level in its results framework ("Results Framework-SO3").

Common indicators of healthy child care practices include the **ORT Use Rate** among children with diarrhea and the practice of **exclusive breastfeeding** through four (or six) months. USAID/Malawi has also proposed program indicators on proper **treatment of fever**; these could be considered service quality indicators but are included here because measurement is population-based (not facility-based), so that levels of use of services will play a major determining role.

- USAID/Malawi reports that ORT use rate, an SO-level indicator, has risen remarkably from 63% (1992 DHS) to 78% in 1995, based on a multi-indicator survey (MICS). The MICS data may or may not be compatible with DHS reporting; the next R2 submission by Malawi will have 1996 DHS data on ORT use.

- USAID/Malawi has set the following baselines for "timely and correct treatment of malaria" from the 1992 Malaria KAP Survey: 16% of children with fever are given first-line anti-malarial treatment within 48 hours of onset and 17% of children with fever are given the correct dosage. For both indicators, the mission has set targets of 60% by 2000.

- USAID/Zambia also reports on ORT use at the SO level, citing the 1992 DHS baseline of 63.7%. The mission has set a target of 90% ORT use by 2001. USAID/Zambia also plans to monitor prevalence of exclusive breastfeeding (up to six months) as an IR indicator of "increased awareness of promotive and preventive strategies by caregivers." A baseline will be set when the next DHS is conducted.

- USAID/Mozambique has proposed several indicators of MCH service use in addition to vaccination coverage rates, including ORT use rate, use of prenatal care by pregnant women, and exclusive breastfeeding up to four months, all at the SO level ("Results Framework-SO3").

C. Demand for Child Survival / Health Services

An important intermediate result contributing to increased use of healthy practices and services is demand for health services, an area in which few missions have established indicators for child survival. Like service supply, demand is typically measured at the intermediate result (IR) level. In Southern Africa, two missions have chosen to track related

indicators measuring caretakers' **knowledge** and attitudes.

- USAID/Malawi has established an indicator monitoring the percentage of people with knowledge of malaria transmission. This will measure the success of IEC efforts supported by the mission in order to reduce morbidity and mortality due to malaria. A 1992 survey established that 72% of heads of households can identify mosquitos as the cause of malaria. The mission set a target of 90% by 2000.

- USAID/Mozambique has proposed monitoring knowledge in households of location of MCH/FP services (Country strategy plan). The mission's more recent elaboration of a results framework for SO3 did not include this but specified "knowledge of diarrheal diseases" - the percent of women who know the signs of dehydration - as an IR-level indicator. Another IR indicator, "the proportion of mothers and children requesting services at delivery points," is presented as a "care-seeking" indicator of demand still to be refined (Res.Frmwk-SO3).

D. Supply of Child Survival / Health Services

Far more IR-level indicators monitoring the necessary conditions to increased utilization focus on the supply of services. These are commonly expressed in terms of **access**, a population-based measurement of service supply.

- USAID/Malawi is monitoring the number of people in targeted areas with access to safe water *due to USAID-supported interventions*. This indicator is designed to reflect the work of various PVOs. From a baseline of 77,000 in 1994, the mission reports that 218,000 people now have access to safe water. A target of 400,000 is set for 2000.

- USAID/South Africa is developing an IR, "Access to integrated package of PHC services increased." Related indicators are likely to be population-based as the mission is focussing on the "majority disadvantaged population."

- USAID/Mozambique plans to monitor "the proportion of the target population that lives within ten kilometers of a health facility that is staffed with trained personnel and equipped with essential supplies." A related indicator of access, also at the IR level, is "the proportion of the target population reached by community health workers." (Results Framework-SO3)

Other indicators of supply focus on the service delivery points (SDPs) themselves. These indicators are not limited to raw tallies of SDPs but typically seek to assess service quality as well, particularly with regard to adequate supplies, programs, staff training, and performance.

- USAID/Malawi: According to the R2, only 2% of rural private outlets stocked first-line anti-malarial drugs in 1995, well below the mission's targets of 35% by 1998 and 60% by 2000.

- USAID/Zambia has proposed monitoring

(1) the quality of ARI treatment by health workers: the proportion of under-fives with cough or difficulty breathing who were correctly assessed and treated according to National ARI policy. No data has been reported yet.

(2) the proportion of health centers with trained staff who are routinely using integrated case management (ICM). Baseline: 0% (1995). Target: 50% (2001).

(3) the proportion of health center staff who have participated in a community health promotion activity. Baseline: 0% (1995). Target: 35% (2001).

- USAID/Mozambique (Results Framework-SO3) proposes to monitor the following:

- (1) proportion of health facilities equipped to provide essential MCH services
- (2) number of community-based birth attendants equipped to provide safe delivery services
- (3) proportion of facility-based providers trained in integrated case management
- (4) number of community health workers trained in integrated case management

Other indicators of service supply and quality monitor the extent of **systems development**, including the gathering and use of data for information systems as well as broader **policy** and **planning** concerns and levels of **community participation**.

- USAID/Zambia is monitoring:

- (1) **information systems**: the "improved flow and use of data at all levels" through a measure of the share of health centers which "monitor 10 indicators and use the data to improve health status." From a baseline of 0% in 1995, the mission hopes to raise the share to 83% of health centers by 2001.
- (2) **MOH planning process**: "improved technical capacity of district, provincial, and central MOH" by tracking the proportion of district health plans which are "technically sound based on a composite score." Through an annual review of plans, the mission hopes to find an increase from 0% in 1995 to 95% in 2001.
- (3) **community participation**: the proportion of districts with neighborhood health committees contributing to annual district health plans. This is presented as an indicator of improved (community) access to CS services. Baseline: 0% (1995). Target: 80% (2001).
- (4) **private sector participation**: "private sector strategic framework and implementation plan presented to MOH." The mission would like to see this happen by 1997.

- USAID/South Africa is proposing IRs in the following areas of systems development:

- (1) effective health care **referral**
- (2) PHC managers' effective use of **management** skills (provincial and below)
- (3) efficiency and effectiveness of PHC services (?)
- (4) strengthened and institutionalized **training** programs at provincial level
- (5) effective use of **information systems** (provincial and below)

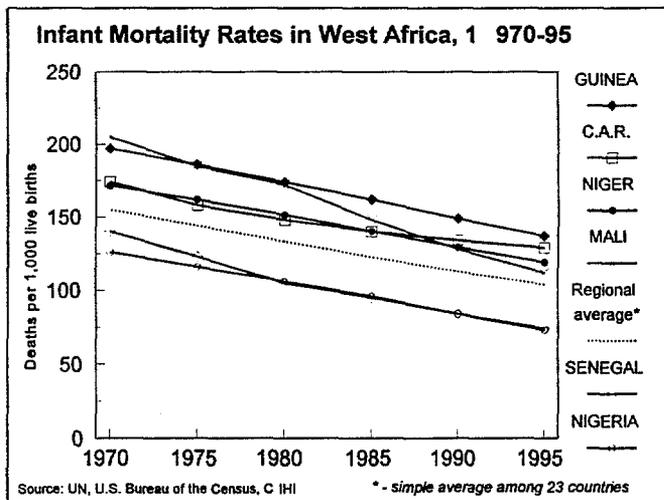
- USAID/Mozambique (Results Framework-SO3) proposes to monitor the following:

- (1) number of national, provincial, and district-level health providers trained in **management**
- (2) MOH Annual Reports show **analysis of data** collected (yes/no)
- (3) percentage of managers...at the district and provincial levels who have a **work plan**
- (4) percentage of government **budget** allocated to primary health care in focus areas
- (5) percent of...managers who have and understand his/her job description
- (6) % of facilities with personnel who report 1+ visits by a **supervisor** in the past 3 months
- (7) number of communities with **health committees**
- (8) number of **community-based programs** supporting primary health care

- REDSO/ESA is examining the regional growth of health **information** networks under its SO of "increased utilization of critical information by USAID and other decision-makers in the region." From 1994 baselines of "0", the program reports 2 institutions and 100 individuals

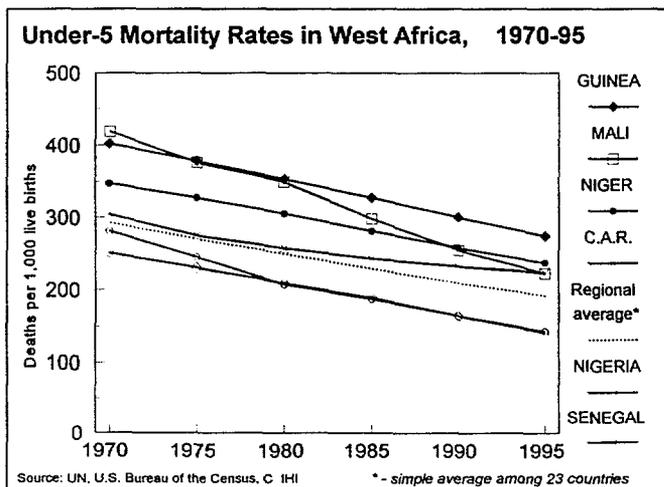
participating in information networks dealing with integration of MCH, family planning, and HIV/AIDS services and health care financing issues. REDSO/ESA also reports on "models" and "technologies" developed and evaluated through its activities. Although the majority of the reporting concerns East Africa, the R2 identifies Mozambique and South Africa as two countries where REDSO/ESA has been particularly active in the PHN sector.

3.3. Child Survival and Health in West Africa



Figures 1 and 2 present some basic trends in child survival in West Africa, based on projections and estimates of mortality by the UN, the US Bureau of the Census, and CIHI. Levels of infant and under-five mortality in West Africa are among the highest in the world. While the Sahelian nations in particular - Mali, Niger, Chad, and Burkina Faso - exhibit some of the highest mortality rates, many lower-income coastal nations are thought to suffer equally high or higher rates.

Figure 1.



Ongoing civil strife in Liberia and Sierra Leone can only serve to perpetuate the poor health conditions in those nations. Meanwhile, the more prosperous coastal nations such as Senegal, Cote d'Ivoire, Ghana, and Nigeria, fall well below the regional average. The data presented here for the Central African Republic does not reflect the more positive findings of the 1994/95 DHS, which indicated an IMR of 97 and a U5MR of 157 deaths per thousand live births.

Figure 2.

3.2.1. West African Programs with Child Survival / Health activities

Six of the nine country programs in West Africa and the regional REDSO/WCA program have some level of CS/health activities. As previously indicated in Table 1.1 (p.2), just four country programs have SOs directly involving child survival / health activities. Missions in Mali and Niger have long-term programs to promote improvement of child survival services. Similar efforts in the Central African Republic (C.A.R.) fall under USAID's "Small Country Program." Missions in Senegal and Guinea do not explicitly pursue SOs in child survival but are nonetheless engaged in some health sector activities. USAID/Nigeria's efforts are limited to PVO activities in the north of the country. West African CS programs, as reported in the R2s for FY 1995, were given the following scores on a scale of 1 (lowest) to 5 (highest):

Table 3.5. Child Survival / Health Scores for West Africa USAID R2s

<u>Mission</u>	<u>Program Maturity</u>	<u>Progress</u>	<u>Impact</u>
USAID/C.A.R.*	4	4	3
USAID/Guinea	<PL480 program, not scored>		
USAID/Mali**	5	4	3
USAID/Niger***	4	3	2
USAID/Nigeria	1	1	1
USAID/Senegal	<not scored (SO1 = pop. only)>		
REDSO/WCA****	1	3	1

* - scored together with HIV/AIDS activities. ** - scored together with population activities.
 *** - scored w/ pop., education, and "Youth" activities. **** - scored w/pop. and HIV/AIDS activities.

3.2.2 Child Survival Program Indicators used in West Africa

The following table summarizes the various program indicators used by USAID missions engaged in child survival / health activities.

Table 3.6. Child Survival/Health Indicators used by West Africa USAID programs for R2s

Program	LE0	IMR	U5MR	NS	Dis	Vacs	TT2+	ORT	EB	Pren	ka	SDPs	perf	\$\$
Benin	sg	G										spo		sg
C.A.R.		SO				IR		IR		IR			IR	
Ghana	G													
Guinea	SG		G			SG								
Mali	SG	SO				IR	IR			IR		IRs		
Niger			G	G			IR			SO		IRs	IR	
Nigeria					IRs	IRs	IR							
Senegal								IR	IR		IR	pr		
REDSO/WCA														SO

Key: G: Goal. SG: Sub-goal. SO: Strategic Objective. SpO: Special Objective.
 IR: Intermediate Result. pr: progress reported without reference to specific level w/in framework
 Small letters indicate indicator level implied but not specified.

3.2.3. R2 Reporting on Child Survival Indicators: Progress & Impact in West Africa

A. Health Outcomes: Life Expectancy, Mortality, Nutritional Status

The highest-level indicators of health status and child survival, **LE0**, **IMR**, and **U5MR**, are typically reported at the goal or sub-goal level, indicating that the mission, although desiring and monitoring for improvement, does not consider positive change to be within its *manageable* interest. Reporting on these indicators for performance monitoring is constrained by limited availability of reliable and comparable data. Estimates are available from a wide variety of sources but are typically based on indirect projections which are not useful for performance monitoring. Thus, data reported at the goal level for LE0 (Benin, Ghana, Guinea, Mali), IMR (Benin), and U5MR (Guinea, Niger) has been of limited value for API and R2 reporting. A case in point is the U5MR data reported by USAID/Guinea, alternatively citing World Bank projections and DHS findings for various years; it is hard to discern any trend from these data.

While reporting of IMR and U5MR based on annual or periodic values has not been very practical, reliable sources, especially the DHSs, have indicated that infant and child mortality rates are indeed declining in most of these countries. This is of course very important information to track and report, even if it doesn't necessarily "fit" well with the more regularly available data used to monitor program performance. Unlike most missions reporting on mortality levels, USAID/Mali and the C.A.R. report on IMR at the SO level.

- USAID/Mali has not reported any new data since establishing a baseline IMR of 106 deaths per 1,000 live births, based on the 1987 DHS. The mission hopes to be able to report positive progress when the findings of the 1995 DHS are available.

- For Central African Republic, the Small Country Program reports IMR at 97 deaths/1,000 live births, as recently found by the 1994/95 DHS. This represents an improvement over the 1986 baseline, but the degree is uncertain as the baseline of "111-143" is based on various surveys conducted in the 1970s and 1980s. The mission set a target of 55 for 1997, calculated from an ambitious target of "50% reduction" from 111 by the end of the SCS project, but comments that the proposed level of reduction may be revised to 20%, implying a more manageable target IMR of about 89 for 1997.

- USAID/Nigeria has listed IMR and U5MR as SO indicators in past APIs, but has not reported new data since the 1990 DHS baselines and didn't address these indicators in the R2.

Nutritional status, another indicator of health outcomes, is easier to measure on a regular basis, but, as with IMR and U5MR, the significance of change is sometimes difficult to establish with respect to mission activities. USAID/Niger is the only West African mission monitoring nutritional status.

- USAID/Niger reports that stunting (as measured by weight-for-height) among children reporting to health centers nationwide has steadily decreased to less than half the baseline level of 16% from the 1992 DHS. Monitoring stunting nationwide as a goal-level indicator, the mission plans to add indicators for selected districts and vulnerable areas. Other indicators of

nutritional status were used in the API reporting process but have been discontinued.

B. Utilization of Health Services & Healthy Practices

More responsive and effective program reporting for CS and other health activities has been possible through "lower-level" indicators of service utilization, healthy behavior or practices, and the supply and demand of services. **Vaccination coverage rates** incorporate elements of both service utilization and availability. Surprisingly, missions in West Africa were until recently the only ones in sub-Saharan Africa tracking vaccination coverage rates as part of program performance monitoring. Missions in Niger, Nigeria, Mali, and C.A.R. all track vaccination rates among infants (BCG, DPT3, Polio3, Measles) and/or women of reproductive age (TT2+) at the IR level. Guinea has recently begun to track complete immunization of children as a goal-level indicator. All but the C.A.R. start with extremely low baselines from the late -80s/early -90s.

- USAID/Mali has reported impressive gains in full immunization coverage of infants by age one. From the 1987 baseline of just 5%, the rate steadily increased to 58 percent by 1994. Data for 1995 presented by vaccine indicate that some ground may have been lost (DPT3 is just 42%). Also at the IR level for Mali is TT2+ coverage among women of reproductive age. In the R2, the mission reports that progress has been made since 1989 in both urban and rural areas, but the overall coverage level of 19 percent in 1995 was still well below the mission target (30% for rural areas in 1995).

- USAID/Niger, citing GON data, has reported the first major rise in national measles coverage since the DHS baseline of 20% for 1992. The 1995 level of 43% exceeded the mission's SO targets, which were subsequently revised upward. At the IR level, TT2+ rates among pregnant women have stagnated around 30% since the 1992 DHS baseline of 21%. The mission reported that the rise in measles coverage was associated with a strengthened response to a measles epidemic as well as two national vaccination days. USAID assistance to Niger's EPI, including vaccine procurement, was pivotal to the effective national response not only to the measles epidemic but to an even deadlier meningitis epidemic in 1995.

- In the Central African Republic, the Small Country Program is tracking coverage levels for all four major childhood vaccines at the IR level. Current coverage levels among children age 12-23 months found by the 1994/95 DHS (77% for BCG, 48% for DPT3, 46% for Polio3, and 52% for Measles) are better than in many other West African nations but fall well below the 1991/92 baseline of "80%", which is no surprise, as the narrative explains, following the nation's two-year general strike (1992-93). The high baseline, reportedly reflecting "expensive donor-financed mobile vaccination campaigns," is given as an estimate with no reference to specific antigens. This figure appears to be the 1991 coverage figure reported by WHO for measles. (Other WHO figures for 1991, among children 12-23 mos., are 77% for Polio3, 77% for DPT3, and 85% for BCG.) The program has set a target level of 90% coverage by 1997.

- Developments in Nigeria similarly highlight the limited control missions have over some outcomes. While mission input may contribute to vaccination trends, USAID/Nigeria is hardly to blame for the host country's plummeting rates. Coverage with childhood vaccines is reportedly now below the mission's 1990 baselines, dropping below 20 percent for DPT3, Polio3, and measles in 1995. Meanwhile, a rate of just 2.7% was given for TT2+ coverage in

Lagos State in 1995.

- USAID/Guinea, at the goal level, reports rapidly rising levels of full coverage of infants, citing a very high UNICEF figure of 67% for 1995. No reference is made to the 1992 DHS, which found just 16.3% of infants fully immunized by age one. Relevance to the mission's program is unclear.

Indicators of healthy child care practices include the percentage of pregnant women who receive **prenatal care**, the **ORT Use Rate** among children with diarrhea, and the practice of **exclusive breastfeeding** through four months. Programs in Senegal, Mali, Niger, and the C.A.R. track one or more of these indicators to show program impact:

- USAID/Senegal is tracking ORT use (with a baseline of 18% in 1993) and exclusive breastfeeding (7% in 1993). The mission also reports on knowledge of ORT among mothers (see section C below). The mission plans a "mini-DHS" in 1996 to update these indicators.

- USAID/Mali reports on the "percentage of prenatal consultations in project areas." According to PVO reports, nearly 75% of pregnant women were receiving prenatal care in 1993 in areas with baselines of 66% (SCF, 1991), 31% (CARE, 1991), and 49% (WV, 1992).

- USAID/Niger monitors the use of prenatal care among pregnant women (30% baseline in 1992) as an SO-level indicator. Exclusive breastfeeding was dropped as a program indicator.

- The Small Country Program reports that use of prenatal services by "mothers" (pregnant women) in the C.A.R. has increased from 48% in 1991/92 to 67% as found by the 1994/95 DHS, including 94% of mothers in the capital, Bangui. This indicator is provided under the IR to decrease malarial mortality through effective case management and prenatal care. Under the IR to control diarrheal diseases, ORT use in the C.A.R. has reportedly risen from just 5% of mothers in 1988 to 34.1% as found by the 1994/95 DHS. (Related indicators on proper case management of diarrhea and malaria appear to be facility-based and are treated below under supply of services.)

C. Demand for Child Survival / Health Services

While increased demand for health services may be an important intermediate result contributing to increased use of healthy practices and services, few missions in West Africa have established demand-oriented indicators for child survival. Only USAID/Senegal, a mission which does not even have an SO specifically addressing child survival, tracks an indicator related to demand:

- USAID/Senegal is monitoring knowledge of ORT among mothers as an IR indicator, setting a baseline of 31% from the 1992/93 DHS.

D. Supply of Child Survival / Health Services

Far more IR-level indicators monitoring the necessary conditions to increased utilization focus on the supply of services. Missions working to improve service quality and availability track various indicators quantifying **service delivery points** (SDPs). Although grouped together

here for convenience, these indicators are designed to capture a wide variety of developments depending on the criteria specified. These include availability of a particular type of service, availability of drugs, supplies, and/or trained staff, existence of effective cost recovery, information, or management systems, or any other aspect of service delivery the mission is monitoring. Also included in the discussion here are facility-based indicators designed to monitor service quality through assessment of provider performance.

Service quality:

- USAID/Niger proposes to monitor the proportion of SDPs with a basic minimum of resources (staff & supplies) and the share of children treated according to established protocols for childhood diseases in selected districts. For the latter indicator, the mission set a 1994 baseline of 27% for two districts and a target of 80% for 1998.

- In the Central African Republic, the Small Country Program reports on case management of diarrheal diseases and fever (indicative of malaria) and states that indicators are under development to monitor effective treatment of acute respiratory infections (ARIs). Effective case management of chronic diarrheal diseases (CDDs) has reportedly reached 50% in two of five regions in 1995, on the way to the target of 50% in all 5 regions (the R2 does not specify whether this is facility- or population-based data). For case management of fever, the program provides an estimated baseline of 50% effective management of cases treated at health facilities in 1991/92. The program's target is 90% of cases by 1997. For 1995, the program reports that 520 health agents had been trained in malaria case management.

Cost recovery, Community participation:

- USAID/Niger, one of several donors promoting cost recovery in the health sector in Niger, monitors the number of hospitals and other MOH facilities with user fee collection systems, starting with baselines of 0 for 1992-93. For 1995, the mission reported 3 of 8 hospitals and 68 other facilities with fee collection. While the hospital count is on schedule, other facilities are lagging somewhat; targets for 1999 are all 8 hospitals and 420 other MOH facilities.

- USAID/Mali tracks the number of (1) "new village health centers established, staffed with trained personnel, and financed from local community funds" and (2) "village pharmacies fully stocked with essential drugs and contraceptives."

Village health centers meeting the specified criteria started with a baseline of 0 in 1989 and had only reached 5 by 1993, but the mission reported a massive increase to 134 in 1995, exceeding the target of 120 set for 1996. The number of village pharmacies meeting the mission's standard, also starting at 0 in 1990, grew rapidly to 300 by 1993 and then skyrocketed to 650 in 1995, well above the mission's target of 500 set for 1996.

- The Small Country Program reports significant progress in cost recovery in the Central African Republic but does not include any related performance monitoring indicators.

Private sector development:

- USAID/Mali reports that the number of private health practitioners has increased from a baseline of 9 in Bamako in 1990 to 41 nationwide in 1992 to 231 nationwide in 1994, already surpassing the target of 225 set for 1996.

- USAID/Niger's indicators on number of private FP/MCH sites as well as access to public FP/MCH sites are discussed under FP above.

- USAID/Benin reports that the number of NGOs active in health or family planning has increased from 7 prior to 1991 to 18 in 1995. This relates to the mission's efforts to strengthen the NGO movement in various sectors (a D/G activity).

Systems development:

- USAID/Niger is also monitoring (1) whether a "functional National Health Information System [is] providing decision-makers with relevant data," to be determined by production of activity reports and studies, and (2) several indicators of disaster preparedness focussing on national systems of monitoring and response, all under IR1.4.

Also in the broad area of service supply, some missions working for health sector reform track levels of **public resource mobilization** for the PHN sector, most commonly monitoring government allocations to health as a share of total government expenditure. Some also focus on budget shares for certain desired programs such as PHC or rural health care.

- USAID/Benin reports on government spending on health at the sub-goal level. This is primarily contextual information; no direct relation to mission activities is presented.

- REDSO/WCA proposes to facilitate "more efficient, effective utilization and mobilization of donor resources for FP, HIV/AIDS, and MCH." A further statement from the performance monitoring plan encompasses donor resources as well.

4. HIV/AIDS Prevention

HIV/AIDS prevention and control efforts supported by USAID focus on (1) increasing awareness at the policy level and at the personal level of the threat posed by HIV/AIDS and (2) supplying and encouraging the use of measures to prevent HIV transmission, particularly condoms. Also included in this PHN sub-sector are efforts to improve surveillance and treatment for sexually-transmitted diseases (STDs) in general. The following paragraphs summarize program indicators commonly used by USAID missions. Abbreviations refer to column headings on the subregional tables presented on the following pages.

A. **Impact / Outcomes:** The highest-level indicator used to measure HIV/AIDS program impact and progress is the HIV seroprevalence rate (**HIV**), use of which is somewhat controversial as it is unclear whether prevention programs are at all capable of making the level of HIV actually decrease over time. Missions with broader STD programs may choose to monitor other STD incidence or prevalence rates (**STD**), which like HIV seroprevalence are measures of health outcomes.

B. **Service Use / Healthy Behavior:** Measures of changing behavior patterns (**Beh**), such as levels of condom use or promiscuity, are typically found at the SO level.

C. **Demand for Services:** Indicators of intermediate results toward improved behavior typically focus on people's knowledge of and attitudes toward (**ka**) HIV/STD transmission and prevention.

D. **Supply of Services:** IR indicators monitoring the supply of preventive services include condom social marketing (**CSM**) figures, service delivery points (**SDPs**), the number of **clients served** by these points, measures of the quality of treatment of STDs (**Qual**), and indicators on **planning** efforts or organizational capacity (**cap**) to combat HIV/AIDS.

4.1. HIV/AIDS in East Africa

East Africa includes some of the countries most severely ravaged by the HIV/AIDS pandemic. To provide context on the numbers of people affected in each country in East Africa, Table 4.1 presents estimated HIV seroprevalence levels among adults as well as the total number of AIDS cases reported by each country to WHO.

Table 4.1. Adult HIV prevalence at end of 1994: WHO provisional working estimates.

	Adult HIV prevalence	Number of infections	Cumulative AIDS cases reported*
BURUNDI	2.7%	75,000	7,024
DJIBOUTI	3.0%	8,000	768
ERITREA	3.2%	50,000	1,664
ETHIOPIA	2.5%	588,000	19,443
KENYA	8.3%	1,000,000	56,573
MADAGASCAR	0.1%	2,500	22
RWANDA	7.2%	250,000	10,706
SOMALIA	0.3%	10,000	13
SUDAN	1.0%	125,000	1,258
TANZANIA	6.4%	840,000	53,247
UGANDA	14.5%	1,300,000	46,120

*Totals reported to WHO through 12/15/95 (data quality is low, varies by country).

4.1.1. East African programs with HIV/AIDS prevention activities

As indicated in Tables 1.1 and 1.2 (pp. 2-3), four of the five East African missions submitting R2s with PHN activities include HIV/AIDS prevention within a Strategic Objective. The one which does not is the mission in Madagascar, which has East Africa's lowest estimated levels of HIV prevalence and AIDS incidence. Table 4.2 below specifies the scores on a scale from 1 (lowest) to 5 (highest) assigned to each country program during the AFR Bureau's R2 review process. Progress and impact scores were quite favorable for the more established programs in Tanzania and Uganda.

Table 4.2. HIV/AIDS Scores for East Africa USAID R2s

<u>Mission</u>	<u>Program Maturity</u>	<u>Progress</u>	<u>Impact</u>
USAID/Ethiopia	2	3	2
USAID/Kenya	3	3	2
USAID/Tanzania*	4	4	4
USAID/Uganda	4	4	4

* - scored together with Population activities.

4.1.2. HIV/AIDS program indicators used in East Africa

Table 4.3 summarizes the various indicators used by East African missions with HIV/AIDS programs. Abbreviations in the column headings refer to types of indicators outlined above on p. 42; within the body of the table, SO and IR refer to the level in the results framework at which missions track and report data.

Table 4.3. HIV/AIDS/STD Indicators used by East Africa USAID programs for R2s

	HIV	Beh	K	SDPs	#Clients served	Condom Supply
Ethiopia				IR	IR	IR
Kenya		SO,IR	IRs			IR
Tanzania		SOs	IRs			
Uganda	SO	IRs			IRs	IR

4.1.3. R2 reporting on HIV/AIDS indicators: Progress & impact in East Africa

A. Health Outcomes: HIV Seroprevalence

HIV seroprevalence is rarely cited as a performance indicator but is frequently provided for contextual purposes. USAID/Uganda is the only East African mission which includes HIV seroprevalence in its results framework and the only mission in the AFR region reporting on HIV seroprevalence as an indicator at the SO-level. USAID/Malawi has recently moved this indicator from the SO level to the goal level, beyond the mission's "manageable interest." In past APIs, several other missions (Kenya, Botswana, Zambia) reported on HIV seroprevalence at the goal level but dropped the indicator before the R2s.

USAID/Uganda's R2 submission includes an annex explaining their continued use of HIV seroprevalence as a program performance indicator. The mission makes a strong case for the validity and usefulness of its data indicating reductions in HIV seroprevalence at some antenatal clinics. The ability to show such a trend is unique to USAID/Uganda, though USAID/Malawi has shown similar data indicating a levelling of seroprevalence there. The central question is: Do reductions in prevalence among young pregnant women in Uganda signify a reduction in HIV transmission (incidence) rates? The mission asserts that its carefully and openly gathered "biological" data, combined with positive trends reflected in behavioral data, indicate that the mission has been supporting effective methods to slow the spread of HIV/AIDS.

- USAID/Uganda reports that HIV seroprevalence rates continued to decline in 1995 for five of nine groups being tracked at sentinel surveillance sites (antenatal clinics and "AIDS Information Centers") in three cities (Kampala, Jinja, Mbarabara). All nine groups show reductions since 1992. The mission has set targets of continuing declines of one percentage point per year at each of the three antenatal clinics for 1996-98. Also highlighted in the

narrative is the halving of HIV seroprevalence among pregnant women ages 15-19 in Kampala, from 26% in 1992 to 13% in 1995.

- USAID/Kenya no longer monitors HIV seroprevalence as an explicit program indicator but provide a summary of national surveillance data and analysis in the narrative. National HIV prevalence among adults is thought to have increased from 3.5% in 1990 to 5.7% in 1993 and 6.7% at the end of 1994. [WHO's estimate for end of 1994 is 8.3%] The mission's narrative also provides impressive estimates of cases of HIV and other STDs prevented by USAID interventions - "as many as 110,000 HIV infections and 1,300,000 STD cases averted through 1993" - but these data are difficult to substantiate.

- USAID/Ethiopia does not report on HIV seroprevalence, but, like USAID/Kenya, provides an estimate of the number of HIV infections prevented through mission interventions (condom sales): assuming that 1,000 condoms prevent one infection in high-risk groups, the mission "conservatively" estimates that it has helped prevent 48,000 cases of AIDS.

B. Use of HIV Prevention Services and Safer Practices

Many USAID missions working in HIV/AIDS choose indicators of patterns of risky **behavior**, such as level of condom use or degree of promiscuity, as the highest measures of program impact (i.e., at the SO-level).

- USAID/Kenya is tracking the percentage of men reporting 2+ sexual partners as an SO level indicator. The baseline of 31.7% is from a 1993 data; no updates or targets are provided. At the IR-level, the mission cites the percentage of people 15-49 reporting use of a condom during their most recent sexual encounter with a "non-regular" #providing a 1995 baseline of 52%. (These data are from AIDSCAP surveys.) In the narrative, the mission reports on two additional indicators on condom use by men which are not part of the R2 Results Framework: regular use increased from 3% to 7% and ever-use from 17% to 27% of men between 1989 and 1993 (presumably DHS data).

- USAID/Uganda, at the IR level in its R2, is tracking the proportion of clients at various HIV counselling and education facilities who report having "non-steady" partners. Between an unspecified baseline year and 1994, the share was halved among clients receiving counselling or education at the AIDS Information Center in Kampala (7%->2.6%), the Post-Test Club (3%->1.7%), or the Islamic Medical Association (13%->5%). More modest but still positive findings were reported from CHUSA (15%->12%) and the Rakai AIDS Information Network (17%-15%). No discussion of these data appears in the narrative; the mission only notes that this kind of data are difficult to gather (and interpret) as many people are reluctant to acknowledge or discuss sexual contact outside of marriage. The mission plans to also monitor consistency of condom use in high-risk situations. The mission also provides anecdotal information from "case studies" in intervention communities to help determine the degree and significance of behavioral change.

- USAID/Tanzania is tracking the percentage of women and men using a condom in their most recent sexual intercourse with a "non-regular" partner as SO-level indicators. Baselines from the 1994 KAPS are 18.7% among women and 35.7% among men. The 1996 DHS will

provide intermediate reporting toward the 1997 targets of 27% among women and 52% among men.

C. Demand for Services: Knowledge and attitudes

The key prerequisite to improved behavior is increased **knowledge** about HIV/AIDS/STD transmission and prevention as well as improved **attitudes**. Survey questions testing respondents' knowledge presumably provide us with slightly more reliable data than do questions relying on respondents' reported behavior or attitudes.

- USAID/Kenya reports on the proportion of people who can identify at least 2 acceptable means to prevent sexual transmission of HIV, providing an AIDSCAP baseline of 67% for 1995. The mission finds this level to be unacceptably low, especially considering that awareness of AIDS as a disease is "nearly universal."

- USAID/Uganda does not track knowledge of HIV prevention as a program indicator but reports in the narrative that only 21% of women cited the condom as a means to prevent AIDS, according to the 1995 DHS. This type of finding hinges to a large degree on how the question is asked; the mission also reports that studies in intervention communities indicate that as many as 78-85% of women know that condoms can prevent HIV infection.

- USAID/Tanzania, under the IR "Increased knowledge and access to HIV/AIDS information and services," has set the following 1994 baselines (from KAPS) and (modest) 1997 targets:

% of women who know having only one partner is a way to avoid AIDS:	40%	->	44%
% of men who know having only one partner is a way to avoid AIDS:	44%	->	47%
% of women who know using a condom is a way to avoid AIDS:	36%	->	39%
% of men who know using a condom is a way to avoid AIDS:	49%	->	52%
% of women who know a source for condoms:	51%	->	54%
% of men who know a source for condoms:	66%	->	69%

D. Supply of Services: Service delivery points and condom social marketing

Indicators dealing with supply of HIV/AIDS and STD prevention services monitor both quality and quantity of services being provided. Examples are tallies of **service delivery points**, commodities distributed or sold (especially condoms), provider performance measures, and related measures of supply with respect to the population served (e.g., geographical access). Missions in Ethiopia and Uganda have IR-level indicators monitoring the supply of STD prevention in health facilities:

- USAID/Ethiopia has three indicators on preventive services under its IR "Increased availability of HIV/AIDS prevention and control services in focal areas." The first is condoms sold, reviewed below. The second is the "number of sites offering integrated HIV/AIDS prevention and control services." As a baseline, the mission reports 19 sites under AIDSCAP support; this is actually the number of STD clinics assisted by AIDSCAP. The third indicator is a tally of the number of female clients receiving HIV/AIDS prevention and counselling in focus areas. A baseline of "0" (no date) is followed by 1995 data on male and female clients:

13,843 clients served, including 6,833 males and 4,971 females in the public sector and 699 males and 1,340 females served by NGOs.

- USAID/Uganda, under IR4.3, "Increased correct STD diagnosis and treatment...in intervention communities," is planning to report the number of STD cases treated by NGOs and DISH districts as well as performance assessment reports from NGO grantees and DISH supervisors.

Condom social marketing (CSM) figures are commonly used to indicate availability of preventive means as well as the sustainability of condom supply.

- USAID/Kenya, citing PSI data, reports impressive increases in social marketing sales of TRUST condoms. After a baseline of "0" (no date), sales increased steadily from just 319,000 in 1990 to 6,000,000 in 1995. The mission's target for 1995, however, was 7,000,000. The narrative also provides figures on monthly sales, which have increased from 26,000/month in 1990 to 500,000/month in 1995.

- USAID/Ethiopia has reported progress on condom sales, as discussed here under population program reporting. The mission provides a baseline of less than 500,000 per month in 1993, an actual figure of 1,600,000 per month in 1995, and a target of over 2,000,000 per month by the end of CY1996. In the narrative, the mission reports that over 48 million condoms have been sold with USAID support since 1992.

- USAID/Uganda reports rapid increases in condom sales through SOMARC, as reported here under population programs. From a baseline of 302,000 in 1991, sales reached 3,800,000 in 1994 and then increased by 55% to 5,980,000 in 1995. Free distribution by NGOs reached 6.8 million in 1995, slightly above the 1994 total, but is projected to decline to just one million per year by 1998.

4.2. HIV/AIDS in Southern Africa

Southern Africa includes some of the areas most severely ravaged by the HIV/AIDS pandemic. To provide context on the numbers of people affected in each country in Southern Africa, table 4.4 below presents estimated HIV seroprevalence levels among adults in each country as well as the total number of AIDS cases reported by each country to WHO.

Table 4.4. Adult HIV prevalence at end of 1994: WHO provisional working estimates.

	Adult HIV prevalence	Number of infections	Cumulative AIDS cases reported*
ANGOLA	1.0%	48,000	895
BOTSWANA	18.0%	125,000	3,110
LESOTHO	3.1%	28,000	515
MALAWI	13.6%	650,000	39,989
MOZAMBIQUE	5.8%	400,000	455
NAMIBIA	6.5%	45,000	5,101
SOUTH AFRICA	3.2%	650,000	8,405
SWAZILAND	3.8%	150,000	590
ZAMBIA	17.1%	700,000	32,491
ZIMBABWE	17.4%	900,000	41,298

*Totals reported to WHO through 12/15/95 (data quality is low, varies by country).

4.2.1. USAID Missions with HIV/AIDS Programs

As indicated in tables 1.1 and 1.4 (pp. 2-4), missions in Zambia and Malawi, report on HIV/AIDS prevention activities within an integrated SO. USAID/ Zimbabwe also has an HIV/AIDS Special Objective which it is planning to integrate into its family planning SO. USAID/Mozambique is developing activities in HIV/AIDS which are included in the mission's new SO in MCH services (child survival). USAID/Namibia also reports on HIV training as part of an SO dealing with more general adult training opportunities.

Table 4.5. HIV/AIDS Scores for Southern Africa USAID R2s

<u>Mission</u>	<u>Program Maturity</u>	<u>Progress</u>	<u>Impact</u>
USAID/Malawi*	4	3/4	3/4
USAID/Namibia**	2	2	2
USAID/Zambia*	3	3	2-3
USAID/Zimbabwe	1	4	1

* - scored together with Population and Child Survival activities.

** - scored within SO in "Improved training opportunities for historically disadvantaged adults."

4.2.2. HIV/AIDS / STD program indicators used in Southern Africa

Table 4.6 summarizes the various indicators used by Southern African missions with HIV/AIDS programs, using abbreviations for categories of indicators defined on p. 42 above.

Table 4.6. HIV/AIDS/STD Indicators used by Southern Africa USAID programs for R2s

Program	HIV	STD	Beh	ka	CSM	SDPs	Qual	Cap
Malawi	G	IR	SOs	IRs	IR	IR	IRs	
Mozambique**				IR*	IR*			
Namibia								IR
Zambia			SOs				IR	
Zimbabwe			SpOs*	SpO*				

Key: G: Goal. SO: Strategic Objective. SpO: Special Objective. IR: Intermediate Result.
* - proposed, not reported yet. ** - as specified in SO3 Results Framework (Feb. 13, 1996).

4.2.3. HIV/AIDS / STDs: Progress & impact reported in Southern Africa R2s

A. Health Outcomes: HIV Seroprevalence and other STD prevalence

HIV seroprevalence is rarely cited as a performance indicator but is frequently provided for contextual purposes. USAID/Malawi is the only Southern African mission which includes HIV seroprevalence in its results framework, albeit at the goal level, beyond the mission's "manageable interest." The mission also reports on prevalence of syphilis among urban women as an indicator at the IR level.

- USAID/Malawi reports that HIV seroprevalence among urban adult women (at antenatal clinics in Blantyre) continues to gradually rise, reaching 32.8% in 1995. Although the mission includes a target/projection of 31% for 2000, it is not clear that attaining such a goal is feasible. Data reported for Lilongwe indicate a lower but more rapidly rising level of HIV prevalence among pregnant women. The mission also reports rates in rural areas, where 85% of the population lives, and interprets the data to indicate that the rate of HIV *transmission* is slowing. To help inform this interpretation, more 1995 data are expected in April 1996.

- USAID/Malawi reports that prevalence of syphilis among pregnant women in urban areas is maintaining a level of 12-13%. The mission has set a target of 8% for 2000 but has been able to report only minimal progress since the baseline of 13.4% for 1989.

B. Use of HIV Prevention Services and Safer Practices

The highest impact missions working in HIV/AIDS can hope to measure is in changing patterns of risky **behavior**, i.e. increasing the use of condoms, decreasing promiscuity, etc.

- USAID/Malawi reports on use of condoms and number of sexual partners as indicators at the SO level. Condom use among men and women has increased substantially from the respective baselines of just 7.2% and 1.4% in 1992. In 1995, the mission reports that 30% of men and 18% of women report using condoms. The figure for men has already surpassed the target of 25% for 2000. Reporting on men's and women's average number of sexual partners in the previous four weeks has not yet begun; baselines are scheduled for 1996.
- USAID/Zambia provides data on condom use to prevent AIDS as an SO-level indicator, providing a 1992 baseline from the DHS that 7.8% of women ages 15-49 believe that AIDS can be prevented *and* reported using condoms to prevent AIDS. The target is to double this share by 1997. Also at the SO-level, mission also tracks the proportion of formal sector employees who report having two or more sexual partners in the previous six months. A 1995 baseline of 36%(?) is provided, with a targeted drop to 25% by 1997.
- USAID/Zimbabwe has proposed the following SO-level indicators: % of sexually-active young adults reporting condom use; % of population reporting non-regular sexual partners.

C. Demand for Services: Knowledge and attitudes

The key prerequisite to improved behavior is increased **knowledge** about HIV/AIDS /STD transmission as well as improved **attitudes**. Survey questions testing respondents' knowledge presumably provide us with slightly more reliable data than do questions relying on respondents' reported behavior or attitudes.

- USAID/Malawi has set baselines for two sets of indicators on knowledge of HIV preventive practices. The 1992 DHS found that 56% of men and 41% of women cited "limited number of partners" as a method to prevent AIDS and 30% of men and 12% of women cited condom use. The mission reported very encouraging survey data for 1995, though it was not directly comparable to DHS data. Targets set for 1997 are 75% of men and 60% of women for knowledge of limiting partners and 50% of men and 30% of women for knowledge of condom use.
- USAID/Zimbabwe has proposed the following SO-level indicator:
% population reporting appropriate perception of risk of HIV infection.
- USAID/Mozambique has proposed monitoring the percentage of women who know how HIV/AIDS and other sexually-transmitted infections are transmitted.

D. Supply of Services:

Condom social marketing (CSM) figures are commonly used to indicate availability of preventive means as well as the sustainability of condom supply. Reporting on condom distribution by USAID/Malawi is discussed here under population activities on p. 5. USAID/Mozambique has also proposed including condom sales as a program indicator.

Also dealing with supply issues are tallies of **service delivery points (SDPs)** and related

measures of the population with access to specified SDPs:

- USAID/Malawi reports on the share of employees with access to employer-based HIV/AIDS information services. From a 1992 baseline of 10%, the share reportedly increased to 26% in 1995; the mission has set a target of 90% for 2000.

Also monitoring supply of HIV/STD prevention services are facility-based indicators which focus on **service quality**.

- USAID/Malawi is monitoring the share of STD patients who (1) are given education and counselling and (2) are assessed and treated in an appropriate way. For education and counselling, the mission has set a baseline of 29% for 1994 and a target of 60% for 2000. For assessment and treatment, the mission has set a baseline of 13% for 1994 and a target of 60% for 2000.

- USAID/Zambia also plans to monitor the share of STD cases which are correctly managed by health services. No data has been reported yet for this service quality indicator.

One more type of measure of the supply of HIV prevention services examines the overall **capacity of the private sector** to contribute:

- USAID/Namibia, under its SO to improve training opportunities for historically disadvantaged adults, is providing awareness training in HIV/AIDS prevention through local NGOs. Performance indicators under this SO quantify the number of training programs implemented by NGOs, the number of people reached receiving, and the number of NGOs meeting various organizational criteria established by the mission. Unfortunately, reporting covers a variety of sectors and it is not possible to disaggregate HIV/AIDS-specific data, the HIV component is discussed in a fair amount of detail in the narrative.

4.3. HIV/AIDS in West Africa

Table 4.7 below summarizes recent WHO data on HIV prevalence and reported AIDS incidence in West African nations. Compared to other sub-Saharan regions, West Africa has so far escaped much of the widespread pain and suffering due to AIDS, but the region is vulnerable to the deadly impact of the pandemic as seen in East and Southern Africa. While HIV seroprevalence levels are somewhat lower in West Africa, the existence of strong epicenters in Cote d'Ivoire and Burkina Faso, the high volume of population movement between countries, and the lack of functional social services throughout much of the region all point to a worsening crisis.

Table 4.7. Adult HIV prevalence at end of 1994: WHO provisional working estimates.

	Adult HIV prevalence (%)	Number of infections	Cumulative AIDS cases reported*
BENIN	1.2	27,000	1,066
BURKINA FASO	6.7	300,000	3,722
CAMEROON	3.0	175,000	5,375
C.A.R.	5.8	85,000	4,463
CHAD	2.7	75,000	3,457
CONGO	7.2	80,000	7,773
COTE D'IVOIRE	6.8	390,000	25,236
EQ. GUINEA	1.1	2,000	157
GABON	2.3	13,000	990
GAMBIA, THE	2.1	11,000	369
GHANA	2.3	172,000	15,890
GUINEA	0.6	17,000	1,681
GUINEA-BISSAU	3.1	15,000	707
LIBERIA	1.3	17,000	191
MALI	1.3	58,000	2,594
MAURITANIA	0.7	7,000	130
NIGER	1.0	40,000	1,729
NIGERIA	2.2	1,050,000	1,591
SENEGAL	1.4	50,000	1,573
SIERRA LEONE	3.0	60,000	162
TOGO	8.5	150,000	5,609
ZAIRE	3.7	680,000	26,131

*Totals reported to WHO through 12/15/95 (data quality is low, varies by country).

4.3.1. West African programs with HIV/AIDS prevention activities

Four West African missions - in Senegal, Ghana, Benin, and Nigeria - report on HIV/AIDS prevention activities within "Special Objectives" in their R2 submission. For the Central African Republic, USAID's Small Country Program includes HIV/AIDS prevention within an integrated Strategic Objective including child survival activities. The REDSO/WCA program also encompasses HIV/AIDS prevention and control within its integrated PHN SO.

Table 4.8. HIV/AIDS Scores for W. Africa USAID R2s

<u>Program</u>	<u>Program maturity</u>	<u>Progress</u>	<u>Impact</u>
USAID/Benin*	2	2	2
USAID/C.A.R.**	4	4	3
USAID/Ghana	3	4	4
USAID/Nigeria	3	3	3
USAID/Senegal	2	4	3
REDSO/WCA*	1	3	1

* - scored together with Population and Child Survival activities.

** - scored together with Child Survival activities.

4.3.2. HIV/AIDS program indicators used in West Africa

Table 4.9 summarizes the various indicators used by USAID programs to monitor performance of HIV/AIDS and STD prevention activities. Abbreviated column headings are drawn from the review of HIV program indicators on p. 42 above.

Table 4.9. HIV/AIDS/STD Indicators used by West Africa USAID programs for R2s

Program	HIV	Beh	K	CSM	Qual	Planning
Benin				spo		
C.A.R.	SO			ir		
Ghana		SpO	SpO		SpIRs	
Nigeria		SpIR	SpIRs	SpO		
Senegal	SpO	SpIR	SpIR			SpIR
REDSO/WCA		SO				

Key: SO: Strategic Objective. SpO: Special Objective. IR: Intermediate Result. SpIR: IR for SpO. Small letters indicate implicit level of reporting.

4.3.3. R2 reporting on HIV/AIDS indicators: Progress and impact in West Africa

A. Health Outcomes: HIV Seroprevalence

HIV seroprevalence is rarely cited as a performance indicator but is frequently provided for contextual purposes. USAID/Senegal and the Small Country Program (C.A.R.) are the only programs in West Africa which include HIV seroprevalence in their results frameworks.

- USAID/Senegal reports on HIV seroprevalence at the goal level (under HIV/AIDS Target of Opportunity), beyond the mission's "manageable interest." The mission provides a baseline of 1% for 1994 and repeats the figure for 1995 and for its performance target for 1996, implying that the mission's goal is to stabilize prevalence of HIV.

- In the Central African Republic, stabilized HIV prevalence is the target for one of two indicators under the SO integrating child survival and HIV/AIDS. From a baseline of 6.9% of pregnant women infected with HIV in 1990, seroprevalence among pregnant women has reportedly risen to 9.3% in 1994 and 12.9% in 1995. The R2 narrative reports that rates have reached 18-20% in some regions and "the diseases has reached epidemic proportions." The program's target is "stabilized or reduced rates" by 1997.

B. Use of HIV Prevention Services and Safer Practices

Most missions working in HIV/AIDS aim for changing patterns of risky behavior, i.e. increasing use of condoms, decreasing promiscuity, etc., as the highest level of impact for which they will be held accountable. Unfortunately, survey data on these kinds of issues is not the most reliable. Few missions have developed and convincingly reported progress in this area.

- USAID/Senegal proposes to monitor condom use in targeted populations among persons aged 15-49 with a non-regular partner in the last 12 months.

- USAID/Ghana reports that 61 percent of men and women reporting intercourse with a non-regular partner use condoms regularly, according to a 1993 survey. Results are pending from a 1995 tracking survey.

- REDSO/WCA proposes to monitor the proportion of men with multiple partners who report consistent use of condoms.

C. Demand for Services: Knowledge and Attitudes

The key prerequisite to improved behavior is increased knowledge about HIV/AIDS/STD transmission as well as improved attitudes. Survey questions testing respondents' knowledge presumably provide us with slightly more reliable data than do questions relying on respondents' reported behavior or attitudes.

- USAID/Senegal monitors the proportion of targeted populations that can identify appropriate

means of protection from HIV infection. From a 1994 baseline of 71%, the mission estimates the share to have risen to 81% in 1995, on line to reach the target of 90% for 1996.

- USAID/Ghana proposed to increase the percentage of people who can cite two ways to prevent HIV infection from 61% to 75%. Results of a 1995 survey are not yet available.

- USAID/Nigeria tracks the proportion of men and women who are "knowledgeable" of HIV transmission. The share is thought to have risen from 47% in 1993 to 55% in 1994; the mission has set a target of 80% for 2000. USAID/Nigeria also proposes indicators of (1) the proportion of men and women altering attitudes and behaviors concerning HIV transmission (reporting that "21-30% of target CAWS consistently use condoms in high-risk situations" as a baseline) and (2) the proportion who are able to identify signs and symptoms of common STDs and who know where to seek treatment (no data).

D. Supply of Services: Condom Social Marketing, STD Service Quality, etc.

Condom social marketing (CSM) figures are commonly used to indicate availability of preventive means as well as the sustainability of condom supply.

- USAID/Benin presents condom distribution figures from PSI and the National AIDS Control Program. A total of nearly 2.3 million condoms distributed in 1995, a 35 percent increase over 1994 and nearly seven times more than in 1990. PSI sales represented 90 percent of the 1994 total.

- In the Central African Republic, PSI has reportedly sold and distributed over 5.2 million condoms, exceeding the 1997 target of 3.5 million. Unfortunately, FY1996 budget cuts threaten to end PSI's activities in September 1996, according to the Small Country Program R2.

- USAID/Nigeria repeats its condom sales figures to indicate condom availability. Since 1990, sales have more than tripled to 55,000,000 in 1995.

Some missions are monitoring the development of adequate **planning** processes to deal with the onslaught of HIV/AIDS and the **quality** of STD services in the host country.

- USAID/Senegal proposes to measure the share of public health plans containing evidence of strategic planning processes in national and regional plans for HIV/AIDS.

- USAID/Ghana lists improved diagnosis and treatment of STDs as an IR under its HIV/AIDS Special Objective. The mission reports that STD management guidelines have been developed and implemented and that treatment protocols are currently being developed.

- USAID/Ghana also reports on the construction and completion of zonal laboratories (one finished, three under way in 1995) and progress in HIV prevalence reporting from 10 sentinel sites (complete for low-risk groups, only 1/10 for high-risk groups in 1994).

Appendix A.
Strategic Objectives and Intermediate Results in the PHN Sector,
by AFR operating unit

Table A1. East Africa R2s: Strategic Objectives and Intermediate Results in the PHN Sector

Ethiopia

- SO2 Increased use of primary and preventive health care (PPHC) services
- IR2.1 Increased budgetary resources dedicated to the health sector
- IR2.2 Increased availability of and demand for modern contraceptive services in focus areas
- IR2.3 Increased availability of HIV/AIDS prevention and control services in focus areas
- IR2.4 Increased availability of PPHC services in the Southern Ethiopian People's Region
- IR2.5 Increased private sector involvement (commercial & non-profit) in health services

Kenya

- SO1 Decrease fertility nationwide and reduce HIV/AIDS high-risk behaviors
- IR1.1 Increase modern contraceptive use
- IR1.2 Decrease high-risk behaviors in high HIV-seroprevalence areas
- IR1.3 Increase financial resources for family planning/maternal & child health and HIV/AIDS/STD services

Madagascar

- SO4 Reduce total fertility
- IR4.1 Increase modern contraceptive use
- IR4.2 Increased use of effective child survival and nutrition interventions by health workers and caretakers

Tanzania

- SO3 Increased use of family planning and HIV/AIDS preventive measures
- IR3.1 Increased knowledge and access to family planning services
- IR3.2 Increased knowledge and access to HIV/AIDS information and services

Uganda

- SO4 Stabilize health status of Ugandans
- IR4.1 Increased use of modern family planning in intervention communities
- IR4.2 Increased condom use in intervention communities
- IR4.3 Increased correct STD diagnosis and treatment in intervention communities
- IR4.4 Reduced number of persons with casual sex partners in intervention communities

Table A2. Southern Africa R2s: Strategic Objectives, Special Objectives, and Intermediate Results in the PHN Sector

Malawi

- SO3 Increased adoption of measures to reduce fertility and risk of HIV transmission while promoting child health practices
- IR2.1 Increase access to and quality of family planning services
- IR2.2 Increase access to and quality of STD/HIV/AIDS information and services
- IR2.3 Increase access to and quality of selected child health services

Mozambique

Transitional program:

- SO1 Avoid drought-related and war-related famine and death
- SO3 Contribute to reintegration of populations into stable & productive social & economic activities

*FY1996-2001 Strategic Plan**

- SO3 Increased use of essential community-based MCH services in focus areas
- IR3.1 Increased access to community-based services
- IR3.1.1 Increased community support for basic health services
- IR3.1.2 Increased supply of essential services
- IR3.1.3 Improved human resources and skills development
- IR3.2 Increased demand for community-based services
- IR3.2.1 Improved knowledge and behavior of mothers and children
- IR3.3 Strengthened management of decentralized, essential services
- IR3.1.1 Innovative planning, budgeting, and financial reforms
- IR3.1.2 Improved personnel and supervisory systems

* - IRs 3.1-3.3 from R2; next level of IRs from "Results framework: SO3 (2/13/96)"

Namibia

- SO1 Improved training opportunities for historically disadvantaged adults (includes HIV/AIDS awareness activities)

South Africa (proposed for FY1997/98)

- SO3 More equitable, unified, and sustainable system delivering integrated primary health care (PHC) services to all South Africans
- IR3.1 Access to integrated package of PHC services increased
- IR3.2 Effective health care referral system operating
- IR3.3 PHC managers at provincial level and below effectively utilizing enhanced management skills
- IR3.4 Efficiency and effectiveness of PHC service delivery increased
- IR3.5 PHC training program strengthened and institutionalized at provincial level
- IR3.6 Information systems at provincial level and below being used effectively for program development, management, and monitoring

Zambia

- SO3 Increased use of practices that improve child and reproductive health
- IR3.1 Improved quality of preventive, promotive, and curative child survival strategies
- IR3.1.1 Improved technical capacity of district, provincial, and central MOH
- IR3.1.1.1 Improved flow and use of data at all levels
- IR3.1.1.2 Improved case management by health care workers
- IR3.1.2 Improved awareness of promotive and preventive strategies by caregivers
- IR3.1.3 Improved access to child survival services
- IR3.1.3.1 Formation of community-health center partnerships
- IR3.1.3.2 Greater participation of the private sector
- IR3.1.3.3 Decreased missed opportunities for preventive services
- IR3.2 Increased quality of family planning strategies
- IR3.2.1 Improved awareness of family planning services
- IR3.2.2 Improved access to family planning services
- IR3.2.2.1 Greater participation of the private sector
- IR3.2.2.2 Expanded method mix
- IR3.3 Increased quality of HIV/AIDS preventive measures

Zimbabwe

- SO3 Reduced fertility
- IR3.1 Increased contraceptive use
- IR3.2 Better contraceptive use
- IR3.3 Increased private sector support for family planning
- IR3.4 More sustainable financing of public sector family planning service delivery
- SpO Decreased HIV high-risk behavior by selected occupational groups

Table A3. West Africa R2s: Strategic Objectives, Special Objectives, and Intermediate Results in the PHN Sector

Benin

- SpO1 Improve governance and reinforce democracy (includes NGOs in CS & Pop.)
- SpO2 Expanding the availability, quality and use of sustainable family planning and HIV prevention services

Central African Republic (USAID Small Country Program)

- SO Reduce infant and child mortality and incidence of HIV/AIDS
- IR1 Expand program of immunization
- IR2 Control diarrheal diseases
- IR3 Decrease maternal mortality through effective case management & prenatal care

Ghana

- SO2 Reduce fertility
- IR2.1 Increase the use of modern methods of family planning
- IR2.2 More appropriate contraceptive mix
- IR2.2.1 Increase availability of family planning services and commodities
- IR2.2.2 Increase family planning knowledge and approval
- SpO Increase knowledge and practice of HIV/AIDS risk reduction behavior
- IR1 Improved diagnosis and treatment of STDs
- IR2 Improved HIV/AIDS surveillance
- IR2.1 Zonal laboratories constructed and operational
- IR2.2 All ten sentinel sites provide complete reports on prevalence in high- and low-risk groups

Guinea

- SO2 Increased ability of families to determine household size
 - IR2.1 Family planning population policy formulated and implemented
 - IR2.2 Improved family planning information and commodity delivery
 - IR2.3 Increased demand for contraceptive services
- (PL480 Title II activities include nutrition and health interventions by OIC and Africare)

Mali

(as reported in R2)

- SO3 Improve delivery of health and educational services
- IR3.1 Improve health care (includes family planning)

(new framework presented in R2)

- SO1 Changed social and economic behaviors among youth in targeted geographic areas
- IR1.1 Quality reproductive health services benefit youth
- IR1.2 Young parents capable of ensuring child survival

Niger

- SO1 Increase use of selected family planning and maternal/child health and disaster mitigation practices
- IR1.1 Increased and improved FP/MCH services in the public sector
- IR1.2 An expanded and improved private sector, including NGOs, providing FP and MCH promotion and services
- IR1.3 Improved environment for health services, including policy reform
- IR1.4 National capacity to predict & respond to food security & health-related disasters
- IR1.5 A public that is better informed of key public health policies and legislation affecting citizens' rights and responsibilities

Nigeria

- SO1 Increased voluntary use of family planning
- IR1.2 Increased availability of modern contraceptives
- SO2 Improved maternal and child health practices
- IR2.1 Improved immunization practices and coverage
- SpO Improved HIV/AIDS/STD prevention and control practices

Senegal

- SO1 Decrease family size
- IR1.1 Increase use of modern contraceptives
- IR1.2 Increase knowledge of modern contraceptive methods in rural areas
- SpO Stabilization of the prevalence rate of sexually-transmitted HIV in Senegal

Table A4. Regional Program R2s: Strategic Objectives related to the PHN Sector

REDSO/ESA

- SO1 Effective program and technical support to all ESA missions
- SO2 Increased utilization of critical information by USAID and other decision makers in the region

REDSO/WCA

- SO1 Improved access to and use of family planning/MCH and HIV/AIDS services

Sahel Regional

- SO3 Decision makers have ready access to information on food security, population, and the environment

Appendix B.
USAID Mission Reporting on
Major PHN Sector Indicators
in APIs and R2s

Child Survival, Health and Population Data from APIs & R2s:

<i>Reduction in Infant and Child Mortality (IMR, U5MR)</i>	<i>B1</i>
<i>Vaccine-Preventable Disease Reduction (coverage rates)</i>	<i>B4</i>
<i>Diarrheal Diseases: ORT Use Rates</i>	<i>B6</i>
<i>Effective Malaria Treatment</i>	<i>B7</i>
<i>Total Fertility Rate</i>	<i>B8</i>
<i>Contraceptive Prevalence Rates / Couple-Years of Protection</i>	<i>B9</i>
<i>Primary Health Care / Family Planning Service Delivery Points</i>	<i>B13</i>

Child Survival, Health and Population Data from APIs & R2s

Reduction in Infant and Child Mortality

Country	Indicator	Baseline	API '92	API '93	Data Source	API '94	Source	R2a '95	Source
Benin	Infant mortality (goal - proxy for income distribution)	88 (1980)			?				
Cameroon	Infant mortality Child Under 5 mortality	88 (1987) 155 (1987)		80 (1990) 127 (1990)	'87 Census '90 World Bank				
C.A.R.	Infant mortality	111-143 1980s			various surveys			97	1994/95 DHS
Chad	Infant mortality	127-180		Not reported	Various Sources	not reported			
Ghana	Infant mortality (goal indicator) under 5 mortality (only reported)	140 (1960) 153 (1988)	100 (1990)	Not Reported	Various	132 (1993)	DHS	dropped dropped	
Guinea	Infant mortality (not being tracked) under 5 mortality (goal-level) females males	145 (1992) 237 (1992) 224 229			None World Bank, WDR	(1992) 238 265	DHS DHS	226 238 265	unclear "WDR, w/ revised #s for 1990-3" seems to be typo in R2

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Country	Indicator	Baseline	API '92	API '93	Data Source	API '94	Source	R2a '95	Source
Kenya	Infant mortality (sub-goal)	75 (1985)	68 (1991)	67 (1992)	Unicef	61 (1993)	Unicef		
	Child Under 5 mortality (sub-goal)	113 147 1985	108 80 (1991)	108 74 (1992)	Unicef/ World Bank	90 (1993)	Unicef/ W.Bank		
Lesotho	Infant mortality	106 (1986)	95 (1992)						
Madagascar	Under 5 mortality (goal: for sustainable growth)			177.7 (1992)	DHS	no new data			
Malawi	Infant mortality (SO)	151 (1984)	159 (1987)	135 (1992)	1984 Family Formation Survey	135.8 (1992/3)	DHS	134 (1992/93)	DHS
	Under 5 mortality (SO)	238 258 (1984)	257 (1984)	234 (1992)		233.8 (1992/3)	DHS		
Mali	Infant mortality (SO)	107 (1987)	102 (1992)	111 (1993)	'87 DHS '92 CERPOD '93 OPTIONS	100 (1993)	estimate	1987 base of 106 no new data	'87 DHS
Niger	Under 5 mortality (Goal)	219 (1989) 287 (1988)	215 (1990)	318 (1992)	World Bank Census '92 DHS GON (88)	326.1 (1992)	DHS		"Age-spec. mortality rates,.... see DHS"
Nigeria	Infant mortality (SO)	90 91.4 (1990)		87 (1992)	'90 DHS	no new data			
	Under 5 Mortality (SO)	192.4 (1990)				no new data			

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Country	Indicator	Baseline	API '92	API '93	Data Source	API '94	Source	R2a '95	Source
Senegal	infant mortality (not tracked as an API indicator)					131 (1992)	DHS	not reported	
Tanzania	Infant mortality (sub-goal)	103 ('81-'86)		92 ('87-'91)	DHS	92 ('92-94)	estimate		no new data
	under 5 mortality	163 ('72)		141 ('87-'91)	DHS	not reported			
	Child mortality (94 sub-goal)	55 ('87-'91)		55 ('87-'91)	DHS	55 ('92-94)	estimate		no new data
Uganda	Infant mortality	188 (89)		205 (1991)	'88 DHS	not reported			
	under-5 (R2goal)	188 DHS			'91 Census			147	1995 DHS
Zambia	Infant mortality (sub-goal)	97 (1980)		107 (1992)	DHS	no new data			
	under 5 mortality (sub-goal & target of opportunity)	152 (1992)		191 (1992)	DHS	no new data			

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Vaccine Preventable Disease Reduction

Vaccine Coverage Rates

Country	Indicator	Base Year	API 1992	API 1993	API '94	R2FY95
Cameroon	Measles TT2 for women of child bearing age	15% (1989) 15% (1989)	37% (1991) 37% (1991)	Reports were from 3 project areas changes from '91-'93 are 35%-55%; 35%-60%; and 37%-50%		
C.A.R.	BCG, DPT3, Polio3, Measles (12-23 mos.)	80% (91/92)				77,48,46,52%
Guinea	Percent of fully immunized infants [by age one: 1992 DHS has 16.3%]	30% (1990) R2:55%(92)	49% (1992)	Not reported.	n.r.	55%(93),67%(95) UNICEF
Malawi	Full coverage by age one (R2 goal level)	92: 67%				93: 70% 95: 61%
Mali	Percent of fully immunized infants (1 yr.) (Program Outcome indicator) for women of child bearing age (TT2+) (Program Outcome indicator)	5% (1987) 1989: 30% urban [7% rural]	41% (1991) [91tot: 19% 92tot: 8%]	36% (1993) 10% (1993 total)	34% (92) 1993: BCG 76% DPT3 45% meas 51% no new data	45% (1993) 58% (1994) 1995: BCG 77% DPT3 42% meas 51% 95tot: 19% 94urb: 44% 94rur: 17%
Mozambique	Measles coverage WVRD target area SCF target area	20% (1991) 50% (1987)	73% (1992) 66% (1992)		n.r.	
Niger	Measles coverage at 1 year, natl. (SO) [R2: selected districts (no data)] TT2+ for women of child bearing age (IR)	19% (1989) R2:20.4 (92) R2: 21 (92)	23.7% (1991)	21% (1992)(DHS)	20%(93) 15%(94)	SNIS: 92-95: 21,20,27,43% 21,35,32,30%

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Country	Indicator	Base Year	API 1992	API 1993	API '94	R2FY95
Namibia	% of fully immunized infants at 1 year	10% (1984)	45% (1991)		?	not reported
Nigeria	Unclear trend just reported Program Outcome Indicators (4): DPT3 OPV3 Measles TT2+	80% (1990) 20.8% 20.7% 21.0% 40.9%	DHS	30% (1992)	'93 '94 33%, 36% 34%, 35% 40%, 39% 29%, 36%	'95 FMOHSS <20% <20% <20% 2.7% (Lagos)
Zambia	Measles by age one (R2 SO) DPT3 by age one (R2 IR)	72% (1995) 72% (1995)				72% (1995) 72% (1995)

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ORT Use Rates

Country	Indicator	BaseYr.	API 1992	API 1993	API 1994	R2a for FY95
Burkina Faso	Child w/ Diarrhea treated with ORT (not tracked as API indicator)	16% (est.) (1987)			40% (1993) (DHS)	
C.A.R.	Percent of mothers using ORT (IR)	5% (1988)				34% (95DHS)
Ghana	Percent increase of mothers using ORT	56% (1989)	80% (1992)	Not reported		
Madagascar	Child w/ Diarrhea treated with ORT (Program Outcome Indicator) ORS packets distributed	26% (1992)		30% (1993) 500,000 (1992); 800,000 (1993)	30% (1994) (MOH)	32% (1995) (UNICEF)
Malawi	Cases treated with ORT % of under 5s given appropriate fluids during last diarrheal episode (PO ind)	56% (1993)		50% (1992-DHS)	58% (1994)	63% (92DHS) 78% Unicef95
Mali	Mothers using ORT for treatment	5% (1990)	66% (1992)	Not reported		
Mozambique	Mothers in target area using ORT	14%	30-42%			
Nigeria	% of under 5s who received correct home management of diarrhea by care provider (PO ind)	60% / 30%? (DHS 1990)				
Senegal	Child diarrhea cases treated with ORT	18% 1992/93DHS				1994: 24% 1995: 31%
Zambia	ORT use rate (R2: IR)	63.7%	1992 DHS			baseline only

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Effective Malaria Treatment

Country	Indicator	Base Year	APIs	R2 for FY95
Malawi (PO Indicators)	<p><u>API indicators: PO level</u> Percent seeking care % of under 5s receiving first-line anti-malaria treatment at home during last malaria episode % of population surveyed who received recommended first-line malaria treatment % of pregnant women who received recommended first-line malaria treatment during pregnancy. % of adults who identify mosquitoes as the malaria vector % of health workers who correctly treat patients</p> <p><u>R2 Indicators: IR level</u> % of people with knowledge of malaria treatment % first-line treatment of malaria within 48 hours of onset % correct dose given of first-line treatment during last fever episode</p>	<p>N/A 15% (1993) 56% (1993) 60% (1993) 55% (1993) not available 59% (1992) 16% (1992) 17% (1992)</p>	<p>90% (1992) 6% (1994) Next Reporting Year: 1996</p>	<p>baseline only baseline only baseline only</p>
Niger	% children presenting w' malaria, ARIs, malnutrition and DDs treated according to established protocols in selected districts	27% (1994) (pilot study)		est. 80% in '95 (pilot study)
Nigeria	% of under 5s seen at health facilities w/ ARI, fever (malaria), and/or diarrhea who received care meeting standards for clinical assessment, treatment, and parental counselling (PO indicator)	no data		not reported

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Total Fertility Rate

Country	Indicator	Base Year	API 1992	API 1993	API 1994	R2 for FY95
Burkina Faso	TFR (implied goal)	7.2 (1985)			6.9 (1993)	
Botswana	TFR goal	5.0 (1988)			5.1 (1994) (proj.?)	
Cameroon	TFR	6.4 (1988)		5.8 (1991)		
Cote D'Ivoire	TFR	7.4				
Ethiopia	natl. urban rural	TFR sub-goal TFR TFR sub-goal	6.4 (1990) 3.5 (1990) 6.9 (1990)			baselines only
Ghana	TFR SO	6.4 (1988)	N/A	Not Reported	5.5 (1993)	no new data
Guinea	TFR sub-goal	6.5 (1989)	6.5 (1991)	6.0 (1993)	6.0 (1994)	no new data
Kenya	TFR SO	7.7 (1989)	6.5 (1991)	5.4 (1993)	5.0 (1994)	5.0 (proj95)
Lesotho	TFR	5.2 (1986)	5.8 (1992)			
Madagascar	TFR SO	6.6 (1992)(1990)		6.1 (1993)	6.1 (1992)	no new data
Malawi	TFR SO	7.6 7.2 (1984)	7.6 (1992)		6.7 (1992/93)	no new data
Niger	TFR (R2 goal)	7.1 (1965)	7.2 (1990)	7.4 (1992 -DHS)	no new data	G ind: 7.4 for 92 base...95est
Nigeria	TFR	7.5 (1982)		6 (1990)	not reported	not reported
Rwanda	TFR	8.5 (1990)	7.3 (1992)	6.2 (1992)		
Senegal	TFR SO	6.6 (1986)	NR	6.0 (1993)	no new data	6.1 (94-5 est.)
Tanzania	TFR (R2 subgoal)	6.3 (1991)				no new data

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Country	Indicator	Base Year	API 1992	API 1993	API '94	R2FY95
Uganda	TFR SO	7.4 (1988)	7.3 (1992)	Not reported	baseline only	6.8 (95DHS)
Zambia	TFR sub-goal	7.2 (1980)			6.5 (1992)	
Zimbabwe	natl. TFR SO	5.5 (1988)			4.4 (1994)	4.3 1994
	rural TFR SO	6.2 (1988)			?	4.9 DHS

Contraceptive Prevalence Rates/Couple Years Protection

am=all methods mm=modern methods wra=women ages 15-49 mwra=married women ages 15-49

Country	Indicator	Base Year	API 1992	API 1993	API 1994	R2 for FY 1995
Botswana	CPR- am, wra CYP	28.9% (1988) 68,363 (1988)			29.3% (1994) 89,028 (1994)	
Burkina Faso	CPR	less than 1% (1986)			4.2% (1993 DHS)	
Cameroon	CYP CPR	30,000 (1990)	33,000 (1993)	4.35% (1991)		
Cote D'Ivoire	CPR-modern	3.5%				
Ethiopia	CPR - natl CPR - rural CPR - urban	4.8% (1990) less than 2% (1990) 14% (1990)			baselines only	new SO indicator: increased cont. use in urban/periurban SNNPR: < 5%(95)

Country	Indicator	Base Year	API 1992	API 1993	API 1994	R2 for FY 1995
Ghana	CPR-am	12.8 (1988)	18 (1992)	14.8 (1993) [?]	10.1% (mwra,1993) 33.7% (1993, DHS) 19.6% (1993, CS) 223,230,348,358* (1991-4,*94=proj.) 27,25% (1993,94)	'95 data tba '95 CS data tba 402 (1994) 493 (1995 est) 29.4, 31 (94,95est)
	CPR-mm	5.2 (1988)				
	%longer-term meths	25% (1988) (DHS)				
	CYP	107 (1988)				
	%longer-term meths	21% (1988)				
Guinea	CPR ?? modern methods	2% (1990)	1.7% (1991)		1992 DHS data: Forest: 0.8% Upper: 0.6% Conakry: 3.9% [National: 1.3%]	PSI estimates, '95 4.3% 3.9% n.a. Natl: 4.6% 1993-5: 15,135; 18,550; 39,000; 14000 (94), 28500 4550 (94), 10,500
	CYP-total					
	CYP-private (PSI)	12,807 (1992)				
	CYP-public (PSI)	0 (1992)				
Kenya	CPR-all methods CPR-modern	9% (1984) 9% (FY94API)	17% (1991) [14.7% (89)]	26% (1993) 20.9% (1993)	21.7% (1994) wra	25% (proj95)
Madagascar	CPR-all methods CPR-modern	3% (1991)		17% (1992) 5.1% (1992)	no new data	5.4 (93), 9.1%(95) (95 fromUNICEF)
	CYP	72,000 (1992)			79,000 (1993), 108,000 (1994)	84,000, 126,000, 137,000 (93-95)
Malawi	CPR-modern	1% (1984) 1.1% in 94API	5.5% (1992)	7.4% (1992/93) (mwra)	no new data	1991: 5.9% 1992: 7.4% (DHS) 1995: 8.6% (est.)
	CYP (R2 ind.)	65,250 (1993)				CYP: 68,000 ('94) 109,500 ('95)

NR

Country	Indicator	Base Year	API 1992	API 1993	API 1994	R2 for FY 1995
Mali	CPR	1.3% (1987)	3.5% (1992)		4.0% (94 - est.?)	94: 5.4% 95: 7.0%
Niger	CPR (R2 SO) mm, w 15-49 CYP (for APIs, UNFPA formula) CYP for R2-USAID	2.3% (1992) 29,948 (1990) 23,959 (1990)	52,533 36,856 (91)	47,851 (1993) 47,742 (1992)	61,758 (1993) 71,000 (1994 est.)	93-95 ests: 2.6, 3.8, 4.4% (based on CYP) 93-95: 38,512 41,752 43,287est
Nigeria	CPR-all methods CPR-modern CPR-long-lstng/clin. CYP	6% (1990) 3.5 3.8% (1990) 2.3% (1990) 1.8 million (nd)	[<--1990]	14.6% (1992) 7.8% (1992)	9.3, 11.3% (1993,4) 2.8, 4.1% (1993,4) baseline only	8% (90)- > 22% (93) 3.5m(93) 6.7m(95)
Senegal	CPR-mm,urban CPR-mm, national (rprtd but not trkd) CYP (reported but not routinely tracked)	6.7 (1986) [3.5% (1992)] 54,400 (1986)	10.4 (1991)	11.9 (1993) 4.8 (1993) 101,000 (1991)	no new data 5.6% (1994 est.) 1992: 73,968 1993: 106,986 1994: 114,600	13.6, 15.4% (94-5) 6.1% (1995 est.) [fax has # users] 1995: 163,237 [1995: 164,291 - mission fax]
Swaziland	CPR (def.?)	17% (1988)			22% (1992)	
Tanzania	CPR-mm,MWRA CPR-mm, WRA	10.4 6.6% (1991/2) 5.9% (1991/92)		6.6 (married-1992) 5.9 (single)	13.4% (1994) 11.5% (1994)	13.4% (1994) from 94 TKAPS 11.3% (1994)

Country	Indicator	Base Year	API 1992	API 1993	API 1994	R2 for FY 1995
Uganda	CPR-all methods CPR-modern CYP-DISH CYP-SOMARC CYP-AVSC new R2 baseline	5% (1988) 2.5% (1988) N.A. 1,987 (1991) 17,375 (1992) 4,250 (1988)			8.7% (1994?) (8 districts only) <u>92 93 94</u> No data 8473, 20729, 42995 21763, 48720	7.4% (95DHS) <u>SOMARC, 91-5:</u> 2014, 8780, 16485 40375, 60518 <u>AVSC, 92-5:</u> 15710, 24430, 39652, 29358
Zambia	CPR-am, WRA CPR-mm, WRA CYP # methods > 1%	15% (1992) 9% (1992) 1992: 3			baselines only no data yet	no new data no data yet new indicator
Zimbabwe	CPR-am, MWRA CPR-mm, MWRA CPR: long-lasting as % of total mm CYP (all mm) CYP (longer acting)	43% (1988) 36% (1988) 3.9% (1988) 151,849 (1992) 24,948 (1992)			48% (1994) 42% (1994) 4% (93), 7.4% (94) <u>93 94</u> 124,376 167,109 30,367 43,608	same data ll/mm: 7.1% (94) same

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Primary Health Care/Family Planning Service Delivery Points

Country	Indicator	Base Year	API 1993	API 1994	R2 for FY 1995
Cameroon	Full range family planning provided Private providers	3812	10249		
Ethiopia	# SDPs providing FP services: - SNNPR (govt.) - focus areas (NGOs) # condom outlets # oral contr. outlets # sites offering integrated HIV/AIDS p&c	tbd 0 NGOs @ 4,000 (n.d.) 0 in 1995 19 (AIDSCAP)			95: 38 NGO SPDs 95: 9,500 0
Ghana	Full range family planning % of MOH sites offering 3+ cont.meths. # of MOH sites offering FP services # of retail outlets for FP social marketing # of GRMA members providing FP svcs.	95% (1993) 4567 (1992) 4,500 (1992) 284 (1992)	No data provided 5,000 (1993)	95% (1993) 5088 (1993,1994) 5800 (1994) 275 (93), 226 (94)	[MOH target reached] 7195 (1995) Revised figures: 251 (92), 184 (93) 210 (94), 213 (95)
Guinea	Full range FP (public P/PHC sites) Community-based (w/FP info & cmdts) Private providers Traditional outlets Non-traditional outlets Community-based outlets	0 (1991) 0 (1991) 0 (1991) 0 (1991) 0 (1991)	16 (92), 50 (93) 545 [?]	70 (1994) <u>1992, 1993, 1994:</u> 40, 145, 200 300, 340, 825 -, 80, 80	106 (95) (PSI) 50 (1995) 1995: 3710 total 235 3475 (added into non-t)
Kenya	Public family planning sites Private facilities for family planning # USAID-sptd sites w/vol.surg.contr.	750 (1989) 181 (1984) 4 (84), 49 (89)	1,004 (1993) 800 (1993)	1086 (1994) 838 (1994)	1088,1200 (1994-5) 1,000 (1995) 65,100,124 (93-95)

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Country	Indicator	Base Year	API 1993	API 1994	R2 for FY 1995
Madagascar	Public and private family planning sites % of public medical sites with FP svcs	72 (1987) 6% (1987)	150 (1992)	205 (93), 297 (94) 17,19,24% (92-4)	492 (95) 44% (95)
Malawi	# facilities w/ comp. child spacing svcs. MOH CHAM Clinics providing core child spacing svcs. Comm.-based dist. of contraceptives	1 (1992) 7 (1992) 2 (1984) 0 (1984)	326 (1993) 134 (1993)	3 (1993, 1994) 7 (1993, 1994) 175, 326 (1992,4) 420 (1994)	MOH+CHAMhosp 92 93 94 95 8 11 11 14 175 326 na 386 na 134 374 578
Mali	Village health centers with trained staff R2: New VHCs w. staff & financed locally Stocked village pharmacies (ess.drugs,cont) # of private health practitioners	3 (1989) 0 (1989,91,92) 0 (1990) 9 (Bamako, 90)	-94 59 (1992) 257 (92), 300 (93)	5+5 (93), 17+100 (94) no new data Natl:	92, 93 94 95 0 5 17est. 134 257 300 347e 650 41 116 231 na
Niger	# facilities providing family planning # facilities providing immunizations R2: % sites w/ basic min. of resources # of private facilities w/ FP or MCH svcs	201302 no data 43 of 65 (1995)	281342		no longer reported no longer reported no data 43 of 65 (1995)
Nigeria	Private sector sites w/ full range FP svcs	no data		no data	not reported
Rwanda	Family public facilities	319 (1991)	323 (1992)		
Tanzania	% of pub & priv dispensaries offering FP	67% (1991/92)		80% (1994)	not reported
Uganda	Public facilities w/5 or more FP methods R2: "Health facilities in DISH districts"	50 (1991)	72 (1992)		no data
Zambia	% of delivery points with 3+ methods # of FP service/distr. points public sector private sector	no data no data no data		no data no data no data	not reported

7/6

Appendix C.
Child Survival Success Stories
from selected R2 narratives

- *Malawi*
- *Nigeria*
- *Zambia*
- *Niger*
- *Mali*
- *Senegal*

Prepared by Lisa Nichols-Diakite,
Center for International Health Information (CIHI)

CHILD SURVIVAL SUCCESS STORIES FROM AFRICA R2'S

Malawi:

Malaria is one of the leading causes of illness and one of the major causes of death among children under five in Africa. USAID support in Malawi of operational research and policy reform has led to improvements in not only Malawi's malaria programming but also has directly contributed to regional and international knowledge of malaria and its control.

After an assessment supported by USAID and CDC, Malawi became the first country in Africa in 1993 to officially change its national drug policy replacing chloroquine with sulfadoxine pyrimethamine or SP (Fansidar). Impact since this change has already been noted with a decline in the case fatality rate for all malaria of 12.9%, 18.8% for cerebral malaria and 13.3% for anemia. This translates into an estimated 2,000 deaths averted in 1995 alone.

Nigeria:

In spite of early apprehension that there would be Government obstruction, USAID Nigeria has succeeded in expanding the role of NGO's and the private health sector in the national health program. Key health decision and policy makers in the Government of Nigeria have actually made positive statements acknowledging this newly legitimized role. Activities spear headed by USAID in this area have included (a) a comprehensive assessment of NGO capacity and capability, (b) creation of US-Nigeria NGO partnerships, (c) development of innovative NGO community based programs focused on the role of women as decision makers, (d) support for service delivery and community mobilization and (e) concentration of effort and resources on institutional and program sustainability, starting at the design stage.

Zambia:

In Zambia, significant reform in health at the policy level has occurred over the past few years culminating in the signing by the President of Zambia of the National Health Services Act in 1995. In an effort to build on the momentum of the reform movement, USAID Zambia funded the "Zambia National Conference on Public/Private Partnership in Health," attended by approximately 60 participants representing the Government of Zambia, donors and other stakeholder groups. This conference provided, for the first time, a forum for the public and private health sectors to communicate with each other, identify actual and potential areas of collaboration, discuss constraints and solutions to private sector health development, and enabled them to recommend critical next steps.

Niger:

Since the previous year in Niger, immunization coverage for measles increased from 27% to 43% for the target group. Part of this was due to the response to the measles epidemic that occurred in February to June of 1995 and the National Vaccination Days which were held in the Fall of 1995. Ongoing technical assistance from USAID to the Ministry of Health accomplished: enhanced capacity to manage the overall MOH budget, counterpart funds, material inventory, personnel, pharmaceuticals, information, and national, departmental and district planning. These improvements contribute to the sustainability of the health programs overall, including child survival.

Mali:

USAID in Mali has supported the development of the RAPID model and training of Ministry of Health personnel in the use of the RAPID model at the policy planning level. The success of these efforts was seen during the RAPID presentations in 1995 which had a galvanizing impact on the Government of Mali's planning process. A Malian-led demonstration of this model stimulated consensus among Government planners to increase the percentage of budget allocated to health and education in the 1995 budget exercise.

Significant progress in eradication of the Guinea Worm reduced by 67% the incidence of reported cases in southern Mali. This progress has led to 1995 being declared as the beginning of the three-year process for certification of eradication of the Guinea Worm in Mali by the United Nations.

Decentralization of the health sector, which has been strongly supported by USAID, led to an unprecedented increase in demand for community health centers. Communities are showing a willingness to support these health services financially and are mobilizing their participation in the management and operations of these centers.

USAID funded an Infection Prevention Conference in Mali, which had both Malian and international participants, and which discussed and disseminated the best health practices for use by health workers. As a result of this conference, the rate of post procedure infection at five health sites in Bamako declined by almost 50%.

Senegal:

It was found in a 1994 USAID funded assessment of the quality of treatment of diarrhea cases by health service providers that only 5.4% of health workers provided adequate treatment. In response to these findings, the Ministry of Health in Senegal, with USAID support, has updated training materials and retrained health providers in child survival. The program has established rehydration units in health facilities throughout the target regions, and begun training district and regional health teams in effective supervision of these activities.

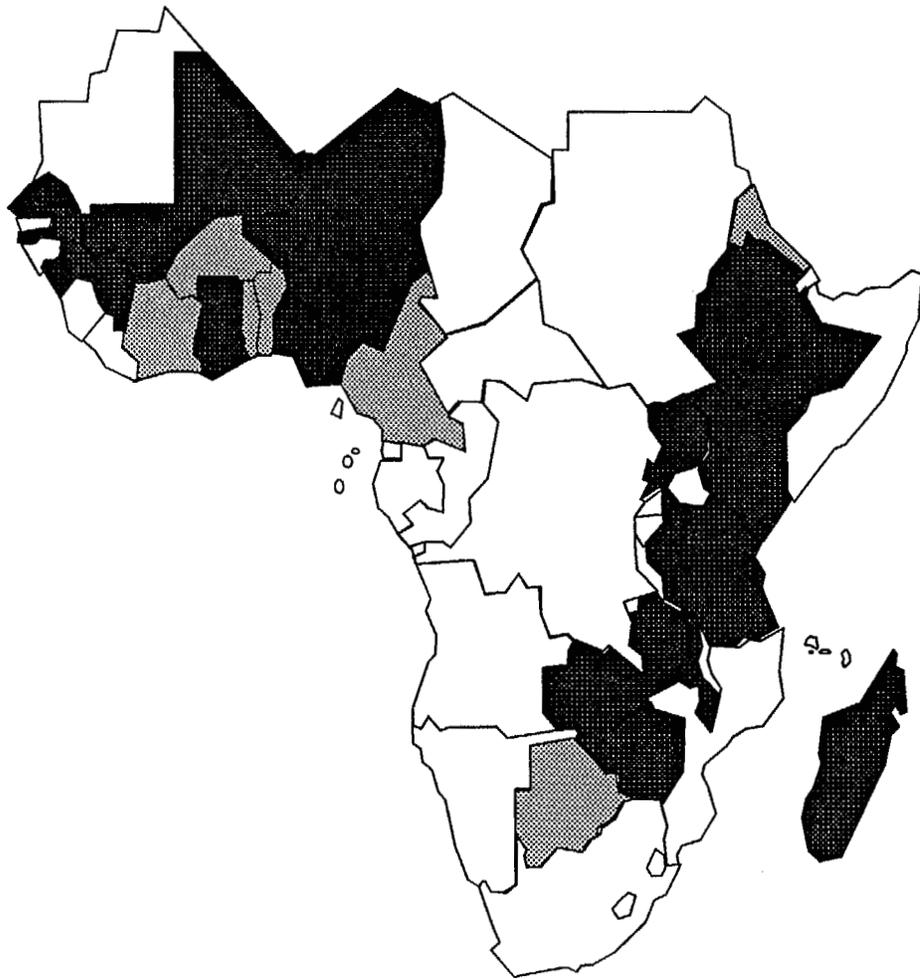
Appendix D.
Graphic Presentations of R2 Reporting

Prepared by Tim Rogers,
Center for International Health Information (CIHI)
May 30, 1996

D1-D4: Population graphics
D5-D6: Child Survival / Health graphics
D7-D9: HIV/AIDS Prevention graphics

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Missions with Strategic Objectives in Population / Family Planning:



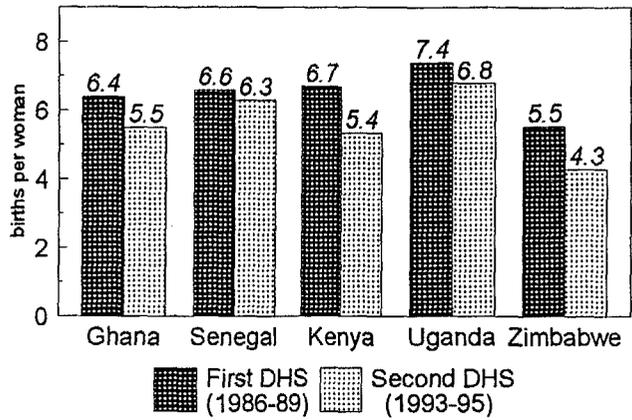
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|---|------------|----------|
| ■ | Ethiopia | Niger |
| | Ghana | Nigeria |
| | Guinea | Senegal |
| | Kenya | Tanzania |
| | Madagascar | Uganda |
| | Malawi | Zambia |
| | Mali | Zimbabwe |

Other countries where USAID supports Population / Family Planning activities:

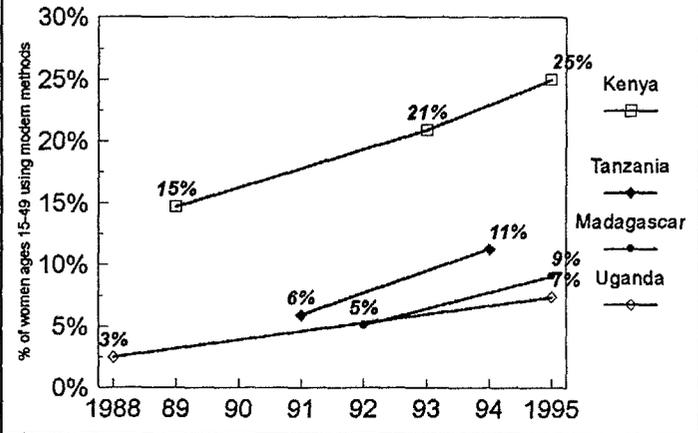
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| ■ | Benin | Cote d'Ivoire |
| | Botswana | Eritrea |
| | Burkina Faso | Togo |
| | Cameroon | |

Total: 21 countries in the AFR region

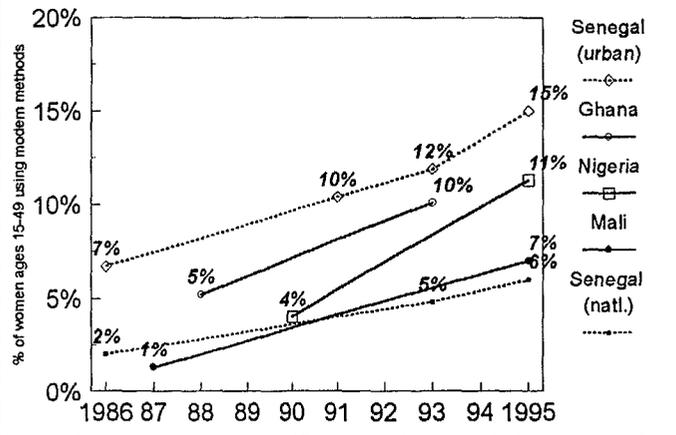
Fertility Rates found by Demographic & Health Surveys



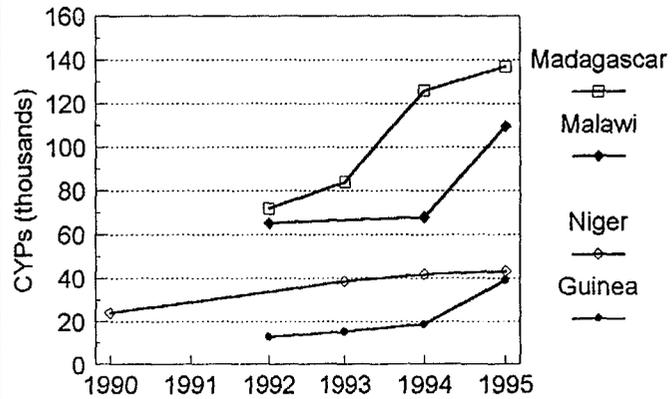
Contraceptive Prevalence Rates in East Africa as reported by USAID missions for FY 1995 R2s



Contraceptive Prevalence Rates in West Africa as reported by USAID missions for FY 1995 R2s

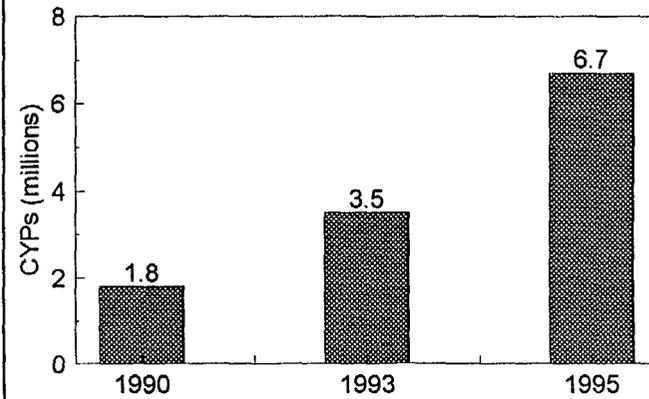


**Commodities for Family Planning:
Couple-Years of Protection (CYP)**



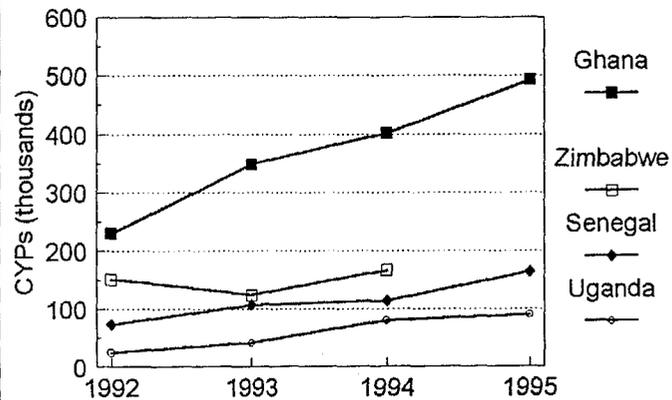
Source: USAID R2s & APIS

**Commodities for Family Planning in Nigeria:
Couple-Years of Protection (CYP)**



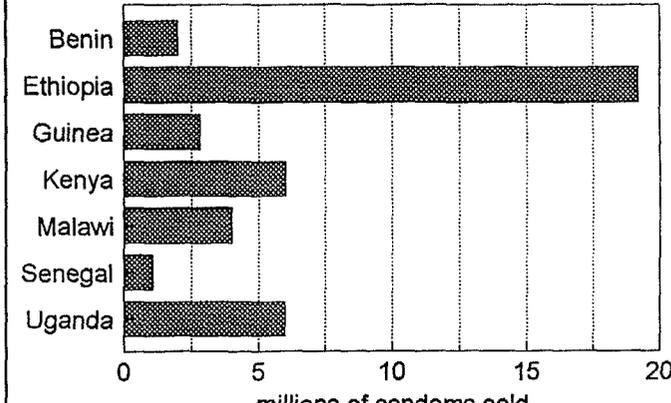
Source: USAID/Nigeria

**Commodities for Family Planning:
Couple-Years of Protection (CYP)**



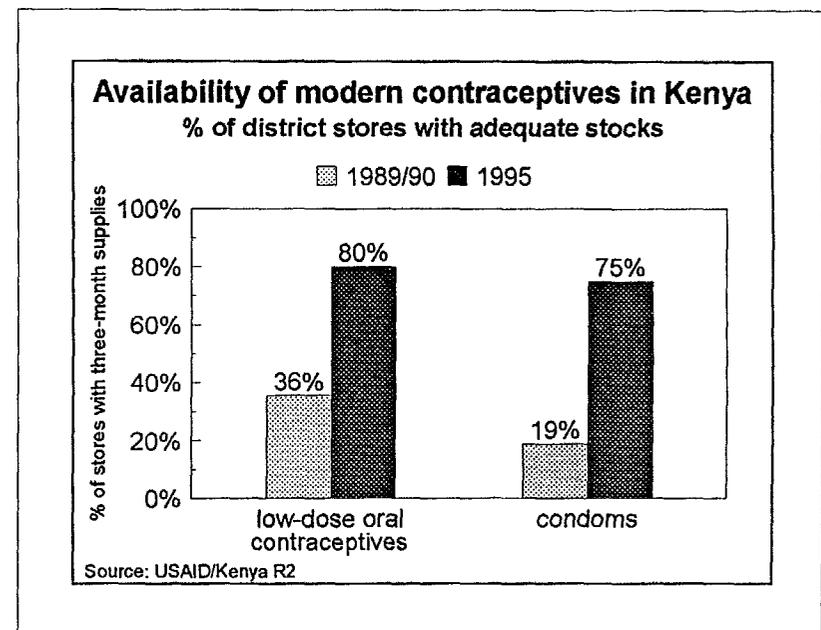
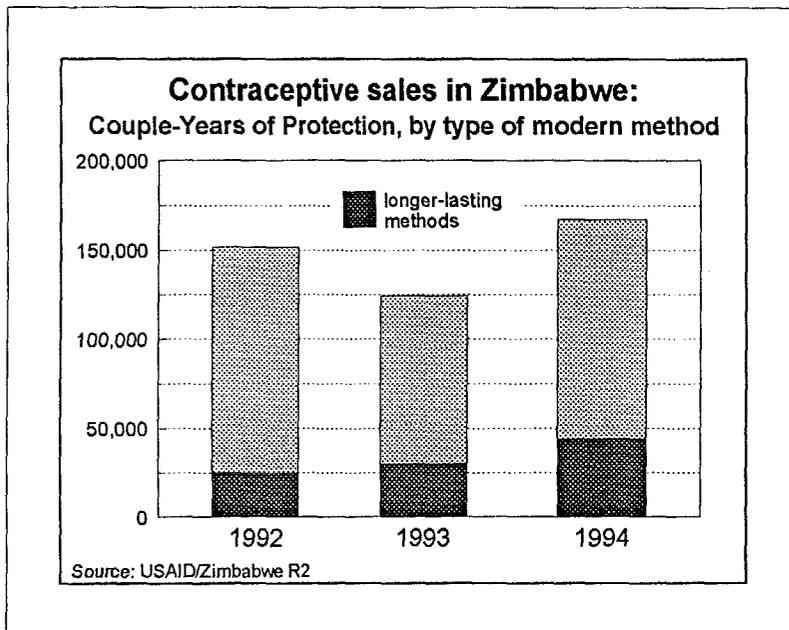
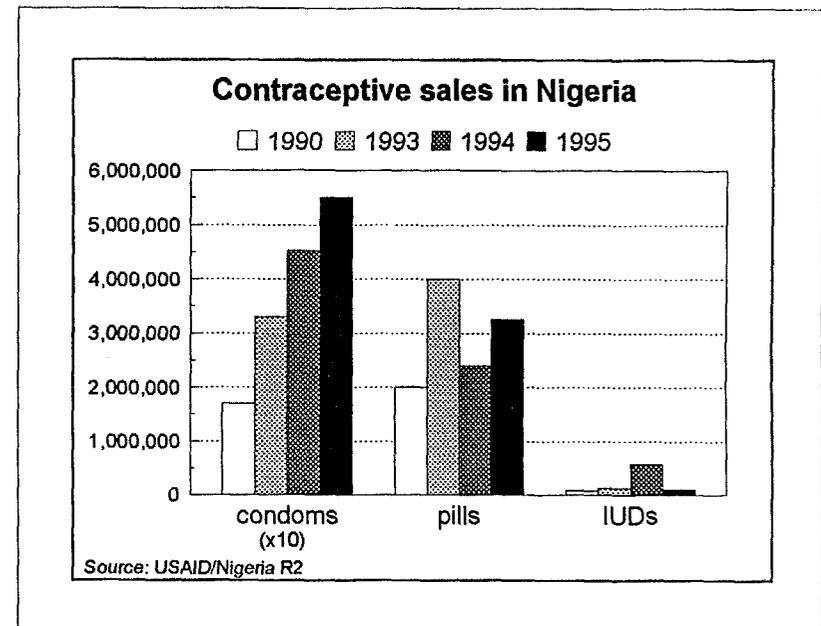
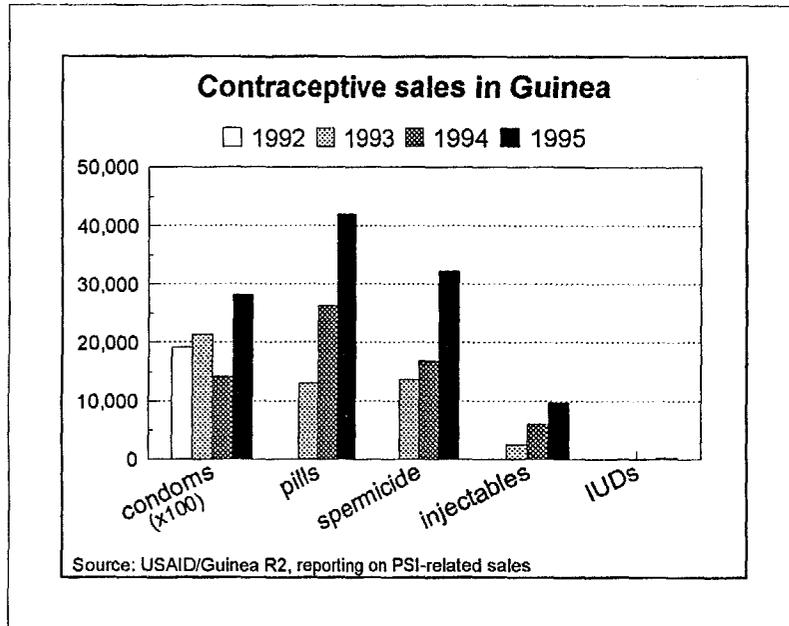
Source: USAID R2s & APIS

**Condom Social Marketing:
Sales in 1995**



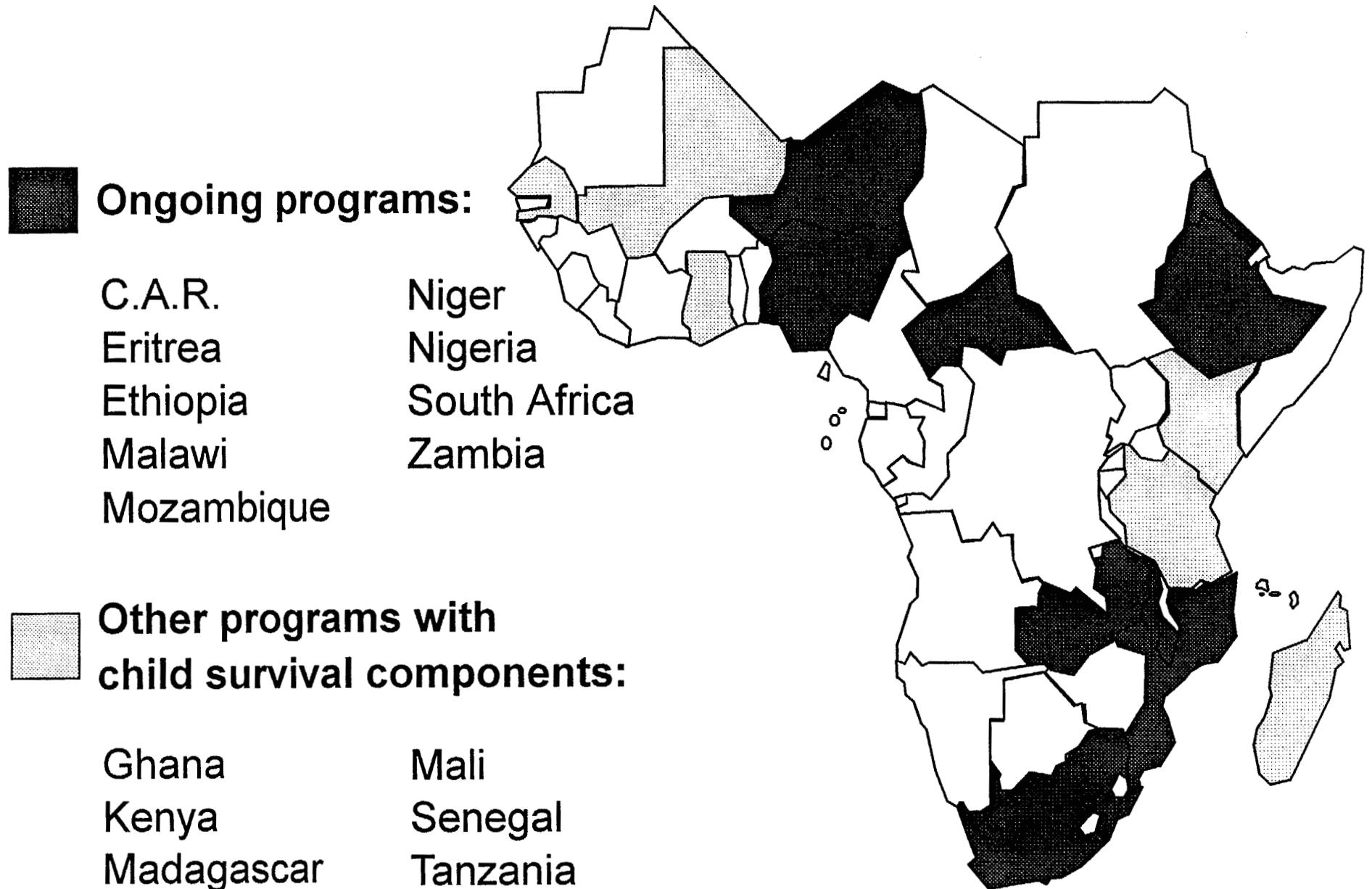
Source: USAID R2s

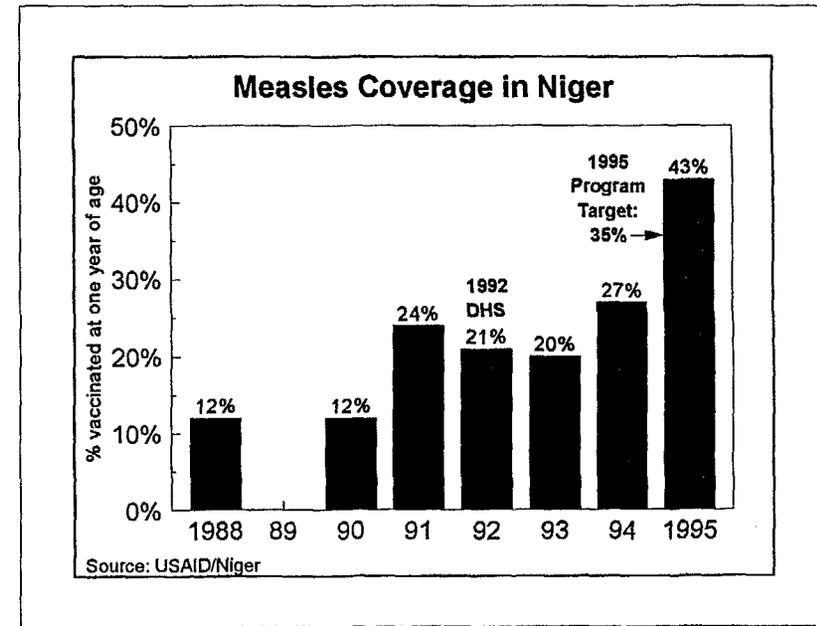
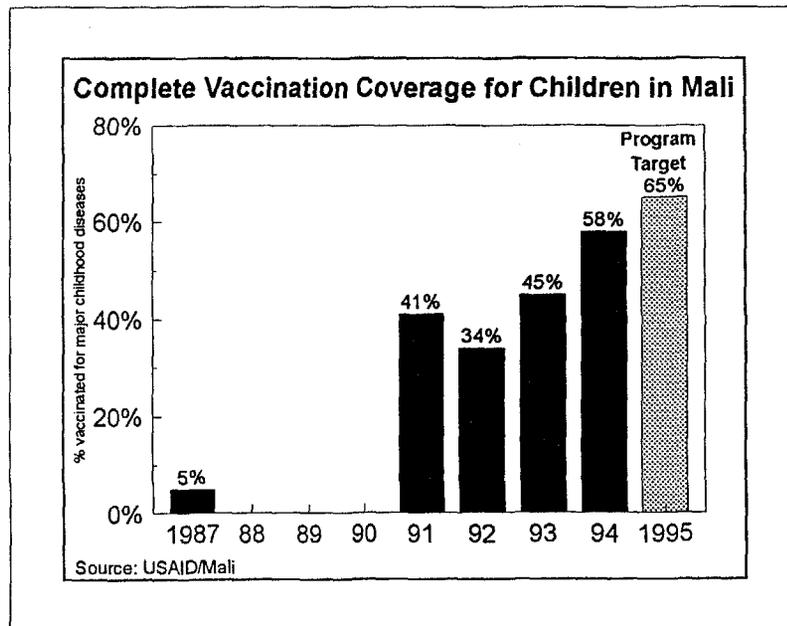
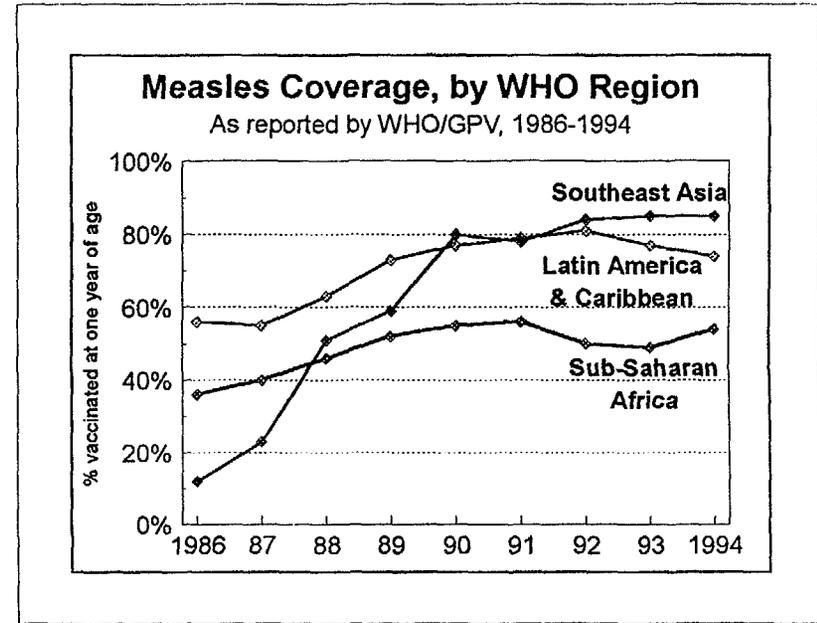
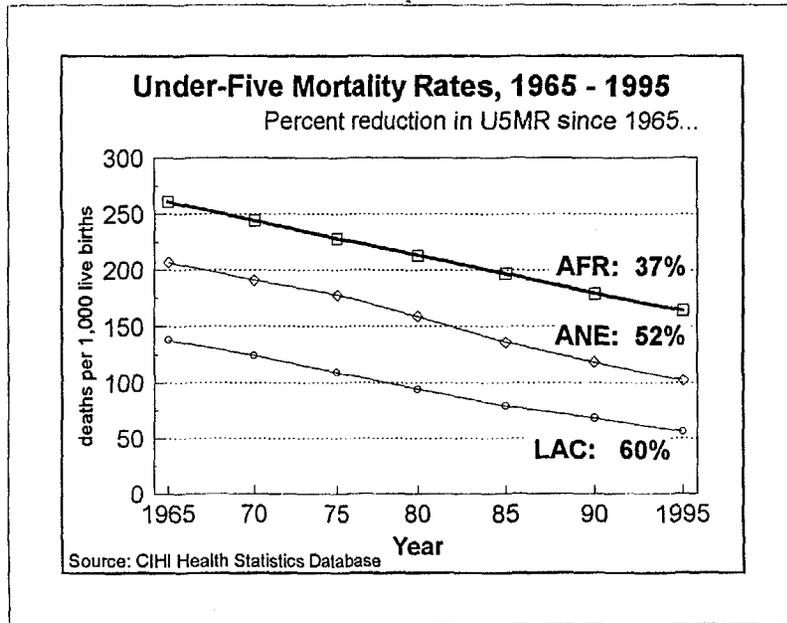




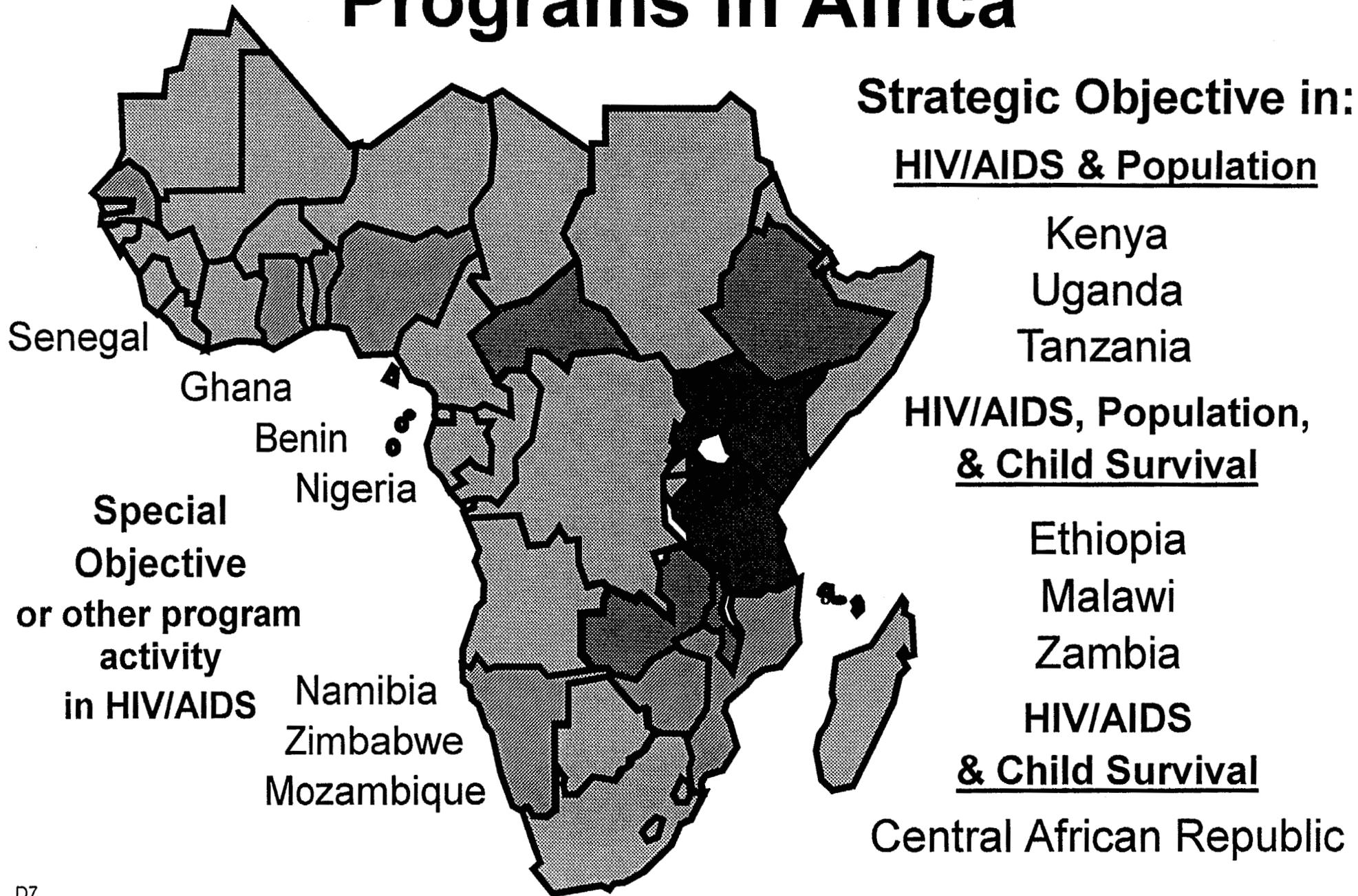
DB4

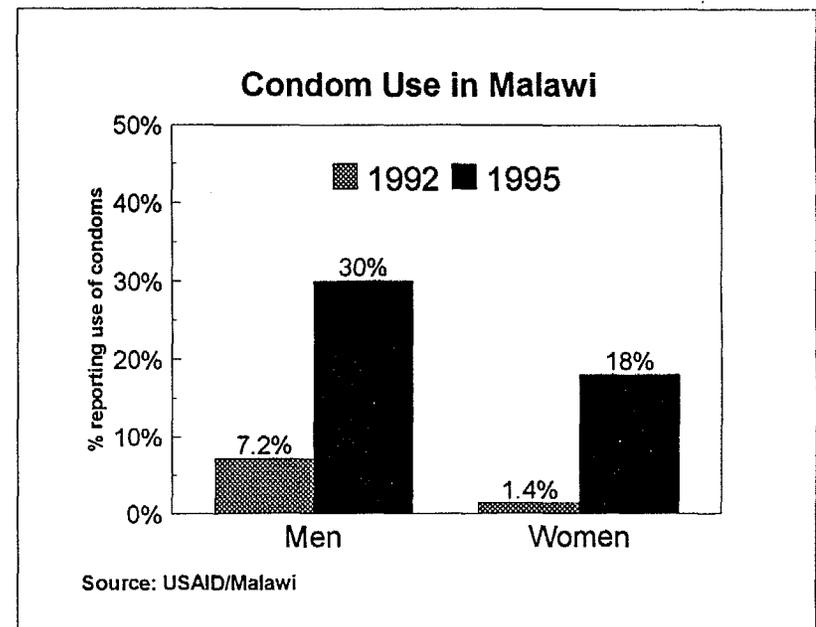
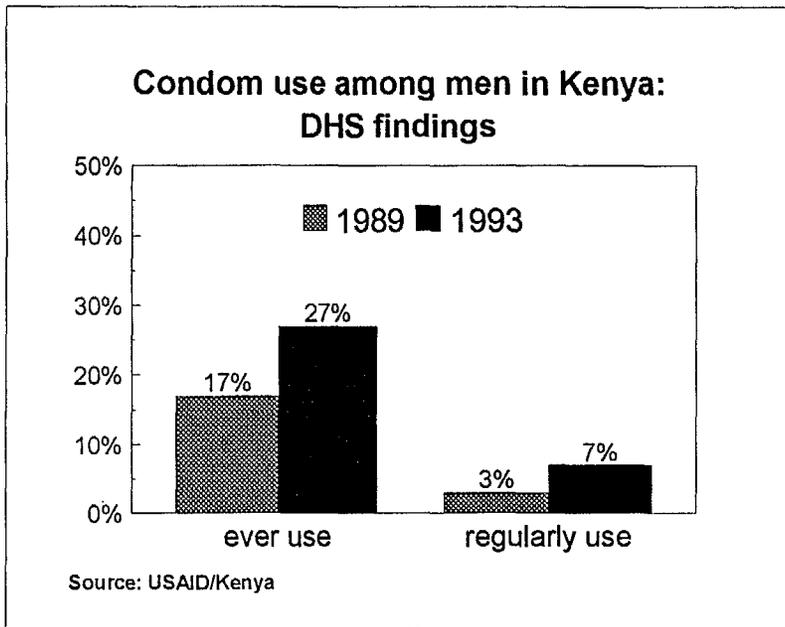
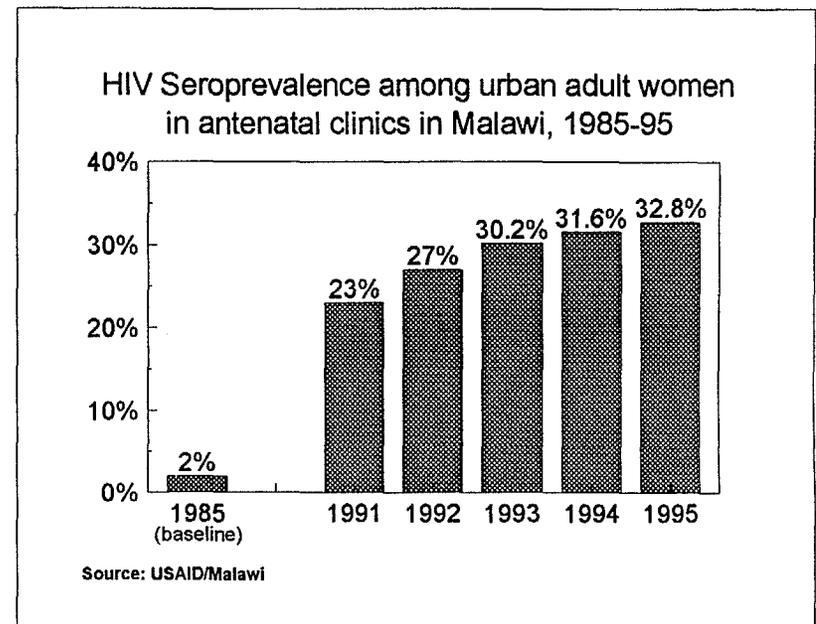
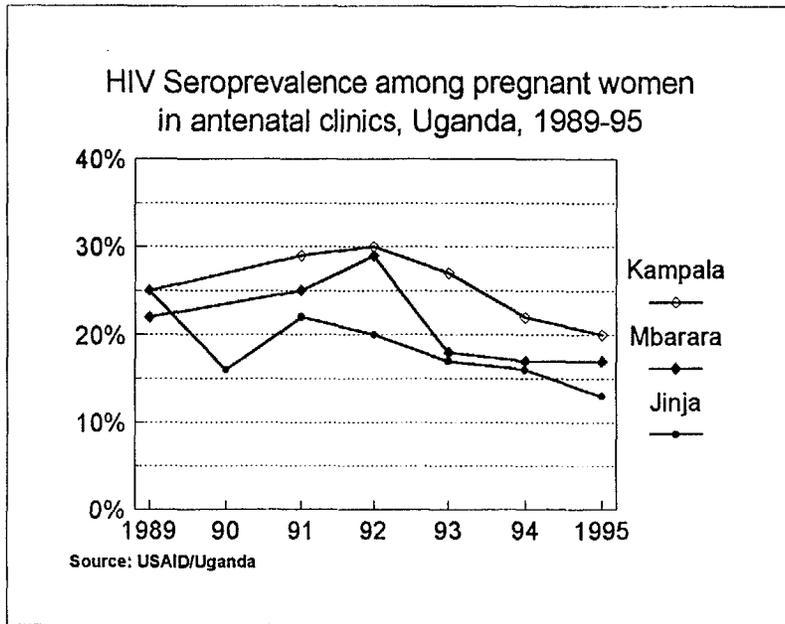
Child Survival Programs in Africa

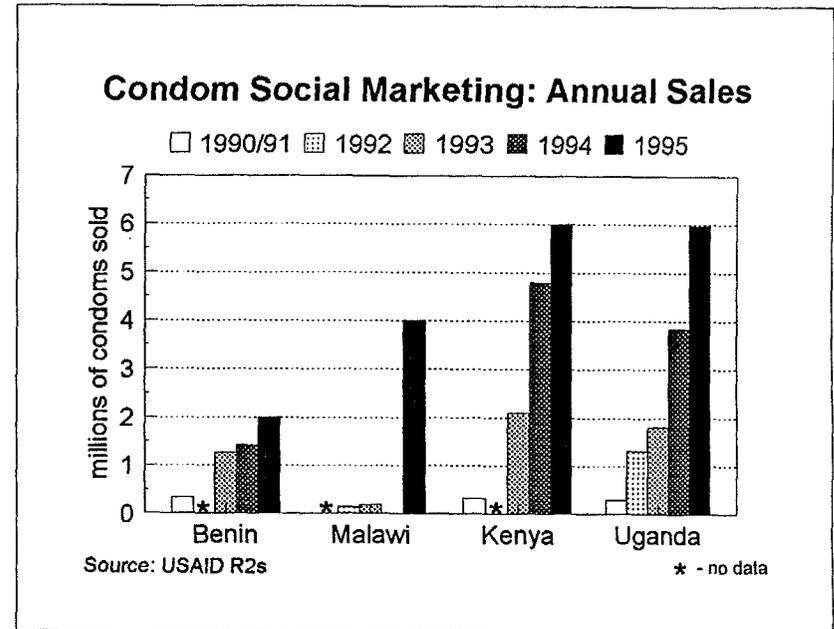
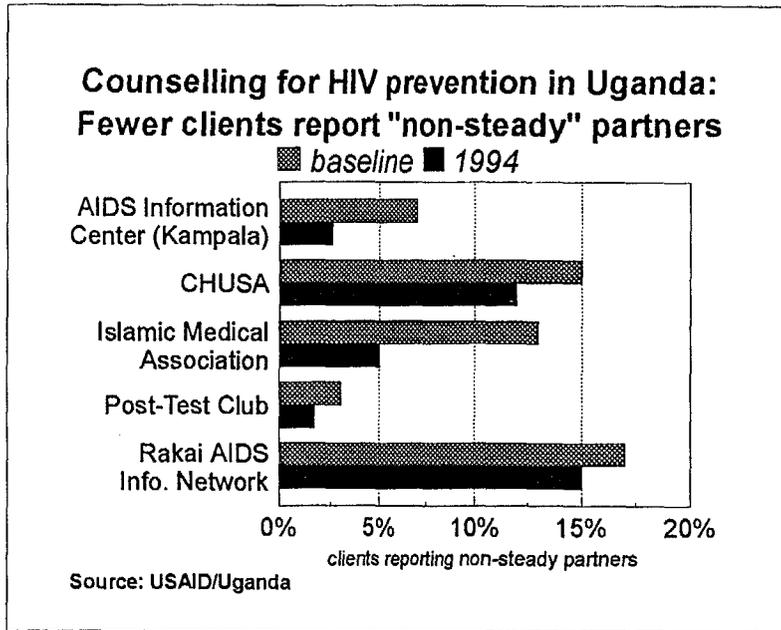




HIV/AIDS Prevention and Control Programs in Africa







- ### HIV/AIDS Prevention & Control: USAID Program Indicators
- HIV seroprevalence
 - Behavioral indicators
 - Condom use
 - Limiting partners
 - Indicators of knowledge & attitudes
 - Knowledge of HIV transmission
 - Knowledge of means to prevent HIV transmission
 - Service supply indicators
 - Condom supply: Social Marketing
 - Quality of STD case management

