

**AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT IDENTIFICATION DOCUMENT
FACESHEET (PID)**

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| 1. TRANSACTION CODE A = Add C = Change D = Delete <input type="checkbox"/> A | Revision No. | DOCUMENT CODE 1 |
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| 2. COUNTRY/ENTITY Africa Regional | 3. PROJECT NUMBER 698-0462 |
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| 4. BUREAU/OFFICE A. Symbol: AFR B. Code: 06 | 5. PROJECT TITLE (maximum 40 characters) Africa Regional Child Survival Support |
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|----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|------------------------|
| 6. ESTIMATED FY OF AUTHORIZATION/OBLIGATION/COMPLETION A. Initial FY: 87 B. Final FY: 92 C. PACD: 94 | 7. ESTIMATED COSTS (\$000 OR EQUIVALENT, \$1 =) | |
| | FUNDING SOURCE | LIFE OF PROJECT |
| | A. AID | 15,000 |
| | B. Other U.S. | 1. 2. |
| | C. Host Country D. Other Donor(s) | |
| TOTAL | | 15,000 |

| 8. PROPOSED BUDGET AID FUNDS (\$000) | | | | | | | |
|--------------------------------------|-------------------------|-----------------------|---------|--------------|---------|--------------------|---------|
| A. APPROPRIATION | B. PRIMARY PURPOSE CODE | C. PRIMARY TECH. CODE | | D. 1ST FY 87 | | E. LIFE OF PROJECT | |
| | | 1. Grant | 2. Loan | 1. Grant | 2. Loan | 1. Grant | 2. Loan |
| (1) CSF | 510S | 500 | - | 1,800 | - | 15,000 | - |
| (2) | | | | | | | |
| (3) | | | | | | | |
| (4) | | | | | | | |
| TOTALS | | | | 1,800 | - | 15,000 | - |

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| 9. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each) 300 540 563 350 | 10. SECONDARY PURPOSE CODE 300S |
|----------------------------------------------------------------------------------------------|-------------------------------------------|

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|-------------------------------------------------------------------------|-------|-------|-------|-------|--|--|--|
| 11. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each) | | | | | | | |
| A. Code | BRW | BUW | NUTR | TECH | | | |
| B. Amount | 5,000 | 3,000 | 6,000 | 1,000 | | | |

12. PROJECT PURPOSE (maximum 480 characters)

To assist selected African countries in formulating and implementing child survival activities compatible with their resources and level of development.

13. RESOURCES REQUIRED FOR PROJECT DEVELOPMENT

Staff: Technical resources acquired through S&T contracts (REACH, HEALTHCOM, and others) will total about 20 person-weeks; AID direct-hire support (AFR/TR/HPN and AFR/PD) will total about four person-weeks.

Funds \$23,000 (PD & S)

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|-----------------------------------------|-----------------------------|------------------------------------------------------------------------------------------|
| 14. ORIGINATING OFFICE CLEARANCE | Signature: Keith W. Sherper | 15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION |
| | Title: Director, AFR/TR | |

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| 16. PROJECT DOCUMENT ACTION TAKEN <input type="checkbox"/> S = Suspended <input type="checkbox"/> A = Approved <input type="checkbox"/> D = Disapproved CA = Conditionally Approved DD = Decision Deferred | 17. COMMENTS |
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| 18. ACTION APPROVED BY | Signature | 19. ACTION REFERENCE | 20. ACTION DATE MM DD YY |
| | Title | | |

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PROJECT IDENTIFICATION DOCUMENT

AFRICA REGIONAL CHILD SURVIVAL SUPPORT PROJECT
(698-0462)

Agency for International Development
Washington, D. C. 20523

February 6, 1987

2

TABLE OF CONTENTS

| | <u>PAGE</u> |
|-------------------------------------------------------------------------|-------------|
| EXECUTIVE SUMMARY | |
| I. Program Factors..... | 6 |
| A. Nature of the Problem..... | 6 |
| B. AID and Africa Child Survival Strategies..... | 6 |
| C. Relevant Past Experience | 8 |
| D. Project Focus..... | 10 |
| II. Project Description..... | 11 |
| A. Background..... | 11 |
| B. Project Goal and Purpose..... | 13 |
| C. Expected Outputs and Achievements..... | 13 |
| D. Project Activities and Inputs..... | 13 |
| E. Estimated Costs and Financing..... | 16 |
| III. Implementation..... | 17 |
| A. Management..... | 17 |
| B. Monitoring and Evaluation..... | 18 |
| IV. Factors Affecting Project Selection and Further Development..... | 19 |
| A. Social Considerations..... | 19 |
| B. Economic Considerations..... | 19 |
| C. Proposed Implementing Agency..... | 20 |
| D. AID Support Requirements and Capability..... | 20 |
| E. Design Issues..... | 20 |
| F. Design Strategy..... | 21 |
| G. Recommended Environmental Threshold Decision..... | 22 |
| H. Gray Amendment..... | 23 |
| V. Logical Framework..... | 24 |
| ANNEXES | |
| <u>ANNEX A: AID Child Survival Strategy</u> | |
| <u>ANNEX B: Africa Bureau Child Survival Action Program</u> | |

EXECUTIVE SUMMARY

The Africa Regional Child Survival Support (ARCSS) project is a six year \$15.0 million regional project to accelerate the pace of child survival activities in Africa. It is designed to meet child survival program needs in Africa beyond the scope of existing projects.

Consistent with the Agency and Africa Bureau Child Survival strategies, it is aimed at achieving increased coverage with key interventions that have been identified as being the most cost-effective means of reducing infant and child mortality. These interventions (immunizations, ORT, nutrition, malaria treatment, water, child spacing) will be implemented in a way that strengthens institutional capacities based on lessons learned from CCCD and other child survival programs in Africa. The groundwork will thus be laid for a new generation of bilateral child survival projects that are sustainable in the long term and more effective in reducing infant and child mortality.

The goal of this project is to advance the state of the art and momentum of child survival activities presently underway in Africa in order to more effectively reduce infant and young child mortality. The purpose of this project is to assist selected African countries in formulating and implementing child survival activities compatible with their resources and level of development.

The particular problem that this project addresses is the gap between the need to rapidly expand the proportion of African populations with access to key child survival services and the limited managerial and financial capacities of African governments to absorb new assistance in this area. To address this problem, the ARCSS project will adopt a two-pronged approach by: 1) providing intensive assistance to a limited number of countries (two to four) at the intermediate level to prepare them for large, coverage oriented programs and 2) providing limited assistance to a larger number of countries (six to ten) in a few key areas or themes such as nutrition, financing, training, mass media communications, and monitoring and evaluation.

Other approaches that were considered and rejected include operational support for 3-4 intensive sites for institution building and ad hoc funding of child survival requests from the field in a broad range of areas.

ARCSS project priorities are based on those established in the 1986 Agency and Africa Bureau Child Survival Strategies (Annexes A and B). These include emphasis on institutionalization of services through training and attention to health care financing, use of modern social marketing approaches for health and nutri-

tion education, increasing private sector participation, improved management and a selected country focus.

It is anticipated that specific subprojects will increase the sustainability of ongoing child survival efforts, expand their coverage, or bring focus to comprehensive primary health care programs. An important role this project is expected to play is to help put together financial packages using funds from various AID and other donor sources to support large scale programs. The main emphasis of ARCSS is therefore: to strengthen the financial viability of effective large scale child survival programs; provide training to ensure that essential program planning, management, supervision, implementation and evaluation skills are developed to undertake the new generation of child survival programs; develop, strengthen, and/or expand service delivery systems for immunization, selected nutrition activities, diarrheal disease control including ORT and water, and treatment of malaria.

Project-funded inputs needed to accomplish these activities would include: (1) field based long-term technical assistance, (2) short-term technical assistance, (3) training, including in-country training, short-term training in the U.S. and elsewhere, and human resource assessments, (4) funds for equipment, supplies, and local costs.

Countries selected for intensive assistance will include those that have a good likelihood of graduating to high quality, extensive child survival programs within the next three to five years. These subprojects will emphasize development of in-country capacity to absorb substantial bilateral or multilateral assistance following ARCSS involvement. Subproject proposals may come from a variety of sources such as government agencies, public or private host country institutions, private voluntary organizations, or multilateral organizations working in a country.

A set of criteria for selecting subprojects will be developed during Project Paper design, including prioritization of countries, substantive areas that should be emphasized and organizational attributes.

Mechanisms for channeling assistance would include: buy-ins to existing regional and centrally-managed contracts, cooperative agreements, and grants to entities with a track record of providing well managed and effective assistance to African countries in child survival or related areas; new procurements may also be necessary. The Project Paper will include a review of intermediaries already involved in child survival in Africa and the pros and cons of using existing channels to build upon current activities. The project will have the capability to use funds from a wide range of accounts that are expected to fund

child survival projects in the future. All Africa Bureau countries are eligible for assistance under this project.

A major feature of ARCSS is the decentralization of project management so that direct-hire and contract personnel who are closest to the site of field operations have the greatest management responsibility and day-to-day control over the project. Missions will manage local operations with existing staff or personnel hired under ARCSS for this purpose. It is expected that existing S&T, FVA and regional project managers will be responsible for the activities that ARCSS may buy into. Overall project coordination and fund allocation will reside in AFR/TR/HPN, and the project will fund one-third the cost of a child survival/nutrition advisor for that office. REDSOs will play a key role in ARCSS, and be responsible primarily for supervising project-funded regional child survival coordinators who will backstop Missions, PVOs and other implementing agencies. The coordinators will be the key linkages between field activities and management staff in AID/W.

I. PROGRAM FACTORS

A. Nature of the Problem

A reduction in excessive mortality and morbidity rates in the developing world is increasingly being recognized as an essential component of overall development. AID has moved rapidly to address this issue by emphasizing increased coverage of populations in AID-assisted countries with a small set of proven interventions as the main direction of our efforts in health. In April of 1986, the Administrator approved the Agency's Child Survival Strategy "as a basis for sharpening the focus of our programs and as a basis for accomplishing the goals that the Agency has set to reduce the preventable deaths of children" in the developing world.

Since 1985, additional funds have been appropriated by Congress for AID to accelerate its efforts in the field. The Administrator has sent several directives to the field and sponsored two international conferences on ORT, a key child survival intervention. Other donor agencies, some with AID support, have also moved rapidly to expand their efforts in this area. Africa, with the worst mortality in the world, has seen a proliferation of these activities. While a number of countries have now developed plans, received some start-up assistance and in some cases begun focused child survival programs on a pilot scale, very few have launched programs on a scale needed to make an impact on infant and child mortality rates.

Most countries have weak health infrastructures and few indigenous technical resources. Serious recurrent cost problems make the development of sustainable public sector programs very difficult. African countries have limited experience in harnessing the resources of the private sector.

The problem is to find the best alternative to address this gap between the need to rapidly expand coverage with selected interventions and the limited service infrastructure and financial resources available. The ARCSS project is aimed at assisting African countries to conduct preparatory work and develop the institutional capability needed to undertake a new generation of high quality, large-scale programs and make effective use of the donor assistance available for child survival.

B. AID and Africa Child Survival Strategies

Of all children born in sub-Saharan Africa, an estimated one in five will not survive until the fifth birthday. The major factors in infant and child deaths in Africa are dehydration due to diarrhea, communicable diseases, malnutrition and vector-borne malaria. Immunizations (available against measles, diphtheria, whooping cough, tetanus, polio and tuberculosis), oral rehydra-

tion therapy for diarrhea, growth monitoring, and breastfeeding are proven interventions that can prevent up to one half of the childhood deaths in developing countries.

In the Agency strategy approved in 1986, immunization, ORT, nutrition and child spacing are cited as being critical to child survival. A significant reduction in the numbers of child deaths is to be accomplished by the end of 1990. The Agency's Blueprint for Development also includes among its goals the reduction of infant mortality to less than 75/1000 and the reduction of mortality in children under five to less than 10/1000.

The Agency Child Survival Strategy includes the following elements:

- o focus on ORT and immunization, and support for nutrition and birth spacing as the primary interventions;
- o special efforts focussed on a limited number of "emphasis" countries;
- o involvement of the private sector;
- o support for a results-oriented research program related to child survival.

The ARCSS project design is consistent with each of these elements and will support a limited number of priority countries in expanding their coverage with key interventions, emphasizing privatization.

The unique development problems and conditions prevalent in Africa are reflected in the Africa Bureau Child Survival Action Program.

Specific targets set for the Africa region Child Survival Action Program, to be achieved by the end of 1990 are:

1. To reduce the infant mortality rate to less than 75 per 1000 in selected countries.
2. To fully vaccinate 80% of children under 2 years of age in selected countries.
3. To assure access to appropriate and correct case management of diarrheal diseases episodes for children under 5 years of age.
4. To provide access to voluntary family planning information and birth spacing methods for 80% of women.
5. To reduce the number of malnourished children under 80% weight-for-age to less than 10%.
6. To provide access to an appropriate anti-malarial treatment for at least 80% of children under 5 years of age who have fever/malaria.

The ARCSS project will complement the activities of ongoing programs to help meet these targets. ARCSS will thus facilitate the operationalization of Agency and regional directives in a focussed way, commensurate with the modest managerial and budgetary resources available.

C. Relevant Past Experience

Africa Bureau's Combatting Childhood Communicable Diseases (CCCD) Project has led the way as the Agency's first and largest child survival project. Begun in 1981, this ten-year project is currently authorized for \$89 million with the objectives of reducing morbidity and mortality of African children (0-4 years) and strengthening national capabilities in immunizations, treatment of diarrheal dehydration emphasizing ORT, and malaria treatment and prophylaxis. Through CDC, it provides support for regional and bilateral programs in training, health information systems, health education and promotion, and operational research.

It is currently assisting 13 countries with bilateral programs and has been able to demonstrate increases in immunization coverage and ORT use in health centers. Lessons learned from this project that can be incorporated in the ARCSS project are:

- o importance of providing continuity in technical assistance, preferably, through long-term advisors; their location in Ministries of Health or other indigenous policymaking or service delivery organizations for strengthening local capacity and being able to address key issues such as health financing, pharmaceutical supply and management, privatization, and decentralization;

- o need for a comprehensive national strategy and supportive policies in health financing that cover all private and public sector systems and include cost recovery mechanisms for sustaining a focussed package of child survival interventions;
- o key role of multi-tiered, skills-oriented training aimed at decentralizing and developing management and leadership attributes and carried out over a long period of time;
- o need to tailor intervention packages, nature and level of inputs, implementation schedules and output targets to the stage of development of child survival programming in each country.

In addition to shifting the emphasis of current CCCD programs in the above directions, mass-media and modern social marketing techniques and the use of simple impact indicators for tracking progress are being increasingly emphasized in CCCD programs. These elements will also receive special attention in ARCSS subprojects.

By providing assistance for selected nutrition interventions and directly supporting non-governmental entities, ARCSS will complement CCCD, which does not include these elements at present. ARCSS will also emphasize ORT and health financing interventions to complement CCCD activities.

Centrally managed projects such as PRITECH, REACH, HEALTHCOM and Maternal and Infant Nutrition have primarily provided short-term technical assistance, sponsored assessments and workshops, developed guidelines and protocols, and helped raise awareness and commitment to pursuing child survival programs. AID assistance has also gone to international private voluntary organizations (PVOs) and multilateral agencies to begin new initiatives in child survival as a part of their ongoing programs in Africa.

These projects and CCCD will continue to be used as the primary source of short-term T.A., technical guidelines, networking and information exchange activities. ARCSS will complement these activities by emphasizing long-term rather than short-term technical assistance, and by supporting operational costs of intermediate level programs that may have been started up through these other Agency efforts. Centrally funded activities will be the most likely pool from which subprojects for ARCSS will be developed. Two to four countries are expected to develop into intensive ARCSS sites, eventually graduating to full-fledged bilateral, regional or multilateral programs. Another six to ten countries will receive more limited assistance in key "theme" areas to be identified during Project Paper design. The latter will help to advance isolated activities to an intermediate level.

In summary, ARCSS is expected to help fill the gap between limited host-country absorptive capacity on one hand, and managerial and financial requirements for rapidly bringing on line new child survival programs on the other. It will do so by incorporating lessons learned from the CCCD and centrally managed projects for improving the state of the art of the next generation of child survival programs.

D. Project Focus

The focus of this project is two-fold: 1) to design, implement and evaluate child survival programs in two to four countries that are at an intermediate stage and can be moved up to full-fledged bilateral, regional or multilateral programs; 2) to provide limited assistance to six to ten countries in key "theme" areas to be identified during Project Paper design for the purpose of advancing start-up activities or enhancing the effectiveness of existing bilateral programs (CCCD or mission funded).

Alternative approaches that were considered include: setting up a flexible non-specific fund to respond to requests for a broad range of activities, and selection of subprojects for funding periodically; funding source for UN and centrally-managed contracts; fund long term interventions in 3-4 countries for institutional development. These were rejected due either to a lack of sufficient focus that is essential for the limited resources available or for not adequately responding to the Agency and Bureau strategies for rapidly moving towards high coverage.

The Project Paper design will be based on an analysis of current experience in AID and outside in the area of child survival programming for Africa. This will cover the following types of questions:

- o Which high priority AID countries most need intermediate level assistance? Which countries are likely candidates for larger scale programs? Which ones need assistance to advance to the intermediate level?

- o What interventions are the most needed to address infant and child mortality and as a vehicle for strengthening local capabilities of the health sector?

- o What is the nature and level of assistance needed most urgently during the next four to six years by countries at different stages of development?

- o What are the potential sources of funding that could form a part of a financial package to support a new generation of improved child survival programs?

The vast majority of activities currently underway in Africa in child survival represent important preliminary work needed to lay

the groundwork for intermediate level programs. The Project Paper design will include a review of these activities in AID-assisted countries. Existing data bases such as the Child Survival and Health Data Base at ISTI, information available through CCCD, PRITECH, HEALTHCOM, Maternal and Infant Nutrition, REACH and other donor agency-funded programs will be used as the primary source of information for this exercise. In addition, mission CDSS will be reviewed to determine mission interest in child survival and ARCSS.

Several outputs will result from this review: 1) the definition of criteria for selecting subprojects for funding. It is expected that countries will be prioritized on the basis of need and AID importance and weight given to subprojects from high priority countries. Certain types of interventions that are considered key to improving sustainability or effectiveness in the next generation of child survival programs will also receive emphasis. Organizations that meet the criteria established in the Project Paper will similarly be given additional weight. These may include attributes such as the ability to expand and grow to manage advanced child survival programs, and the ability to attract funding from diverse sources; 2) a preliminary assessment of which programs can absorb ARCSS resources prior to being launched as full fledged, national child survival programs appropriate for regional, multilateral or bilateral assistance; 3) which countries need assistance at start-up stage to advance to the intermediate level and which advanced country programs need assistance to further improve their state of the art; 4) the Project Paper will also explore the most cost-effective means of linking up the resources available from centrally managed and regional programs with ARCSS. Personnel involved in these projects will provide important substantive input to the design; 5) an assessment of whether additional resources from ARCSS are needed to develop or strengthen a mechanism for data gathering and analysis to remain cognizant of child survival activities in the region.

Criteria for Selection of Subprojects: Subprojects at the country level will be funded based on criteria that relate to country or geographic location, technical content or programmatic focus, and organizational attributes. The likelihood of a program graduating to a full-fledged bilateral or multilateral project will be especially important.

II. PROJECT DESCRIPTION

A. Background

A reduction in maternal, infant and young child morbidity and mortality is a necessary outcome and an essential input for

development in Africa. The application of cost-effective health and nutrition interventions now available for large scale use can prevent at least one-half of infant and young child deaths and improve the health status of women and children significantly.

With an average of 121 infant deaths per 1,000 live births in sub-Saharan Africa, infant mortality in the region is the worst of any in the world.

The ultimate cause of the vast majority of these deaths is malnutrition combined with an endemic disease or acute diarrhea. Endemic diseases include malaria and immunizable diseases such as measles, tetanus, pertussis, diphtheria and polio.

The low level of public and private investment in the health sector in Africa has delayed an effective response to the deleterious conditions affecting child survival. Per capita annual health expenditures by African governments average between \$1 and \$10, allowing little for health service infrastructure. Most of the expenditures by governments are used for salaries, and few governments have recognized the importance of enlisting the private sector in health efforts. ARCSS will emphasize privatization, alternative financing schemes and recurrent cost analyses.

Prior to this decade, the Agency's health strategy in Africa relied on attempts to establish comprehensive primary health care systems. Seven major country projects were launched in Africa; most later proved to be too ambitious, cumbersome or complex. They were neither sustainable nor effective in reducing mortality and morbidity. Fiscal 1981 marked the beginning of the Africa Bureau's CCCD project which is also the Agency's first attempt to focus on specific cost-effective measures which are more readily implemented and target specific childhood diseases with appropriate technologies. Since then, centrally funded projects especially PRITECH, REACH, HEALTHCOM, Maternal and Infant Nutrition, and PVO grants have improved the state-of-the-art of this targetted child survival approach.

The AID and Africa Bureau Strategies on child survival identify areas of focus for AID's involvement where results are possible and where the U.S. has experience and expertise. Goals and targets have been identified that place the burden on USAID missions in selected emphasis countries to monitor and promote nationwide programs to deliver key interventions whether they are AID or other donor-funded. The role of the ARCSS project is to facilitate the acceleration of child survival programming in Africa to meet these objectives using the benefit of past experience and the groundwork laid by other Agency activities.

B. Project Goal and Purpose

1. Goal

The goal of this project is to advance the state of the art and momentum of child survival activities presently underway in Africa in order to more effectively reduce infant and young child mortality.

2. Purpose

The purpose of this project is to assist selected African countries in formulating and implementing child survival activities compatible with their resources and level of development. The particular problem that this project addresses is the gap between the need to rapidly expand the proportion of African populations with access to key child survival services and the limited managerial and financial capacities of African governments to absorb new assistance in this area. To address this problem, the ARCSS project will adopt a two-pronged approach by: 1) providing intensive assistance to a limited number of (two to four) carefully selected countries to prepare them for large, coverage oriented programs and 2) providing limited assistance to a larger number of (six to ten) countries in a few key areas or themes to be selected during Project Paper design for the purpose of improving their state of the art or advancing start up activities to intermediate level programs.

C. Expected Outputs and Achievements

The project will produce two to four expanded and improved child survival programs in Africa. These will have a higher coverage with key interventions and be capable of becoming financially sustainable in the long term. In addition, training, technical assistance, operations research and information exchange activities will have improved the state of the art of child survival activities in another six to ten countries or advanced them to an intermediate level. The specific numbers and content areas of training courses, seminars, workshops, publications and other products generated from this project will be estimated during Project Paper development.

D. Project Activities and Inputs

The Agency and Bureau strategies identify the following eight "emphasis" countries in Africa for additional resources during the next five years based on their population size, infant and child mortality rates, governmental commitment to child survival activities, existing infrastructure and management capabilities, and lack of other donor support:

| | |
|--------|---------|
| Kenya | Nigeria |
| Malawi | Senegal |
| Mali | Sudan |
| Niger | Zaire |

Of these countries, Africa Bureau's CCCD project provides bilateral assistance to three countries, namely, Malawi, Nigeria and Zaire. Niger, Senegal and Sudan are either bringing bilaterals on line this fiscal year or have already done so. S&T/HEA's PRITECH project is working in Kenya and Mali in close collaboration with missions. The ARCSS project will give priority to developing bilateral or multilateral child survival programs in other AID priority countries where start-up child survival activities may be well underway. In addition, the project will provide assistance to CCCD and "emphasis" countries in complementary areas which may include ORT, nutrition, financing and training.

The project consists of two types of activities:

a. Intensive project sites where child survival activities already underway at the intermediate level will be expanded, refined, improved and adapted over a four to six year period so that they can graduate to full fledged bilateral (mission or regionally funded) or multilateral programs. The level of assistance in these countries is estimated to be approximately \$1.0 to \$2.0 million per site over the life of project.

b. A larger number of project sites, where either start-up activities can be moved to the intermediate stage of development following ARCSS support or existing bilaterals improved in key theme areas over a two to five year period. The level of assistance here is likely to range from \$300,000 to \$600,000 over the life of project.

A smaller proportion of project funds will be used for activities that are needed to enhance the operational feasibility of the umbrella project such as, regional coordination meetings, technical workshops, development and dissemination of technical and guidelines and protocols, regional training, a regional procurement facility for essential drugs, strengthening of Africa child survival databases, long-term regional advisors to backstop country activities and others.

In order to implement the above, the project will be conducted in three phases: 1) Preparatory phase, during which subproject identification and design of interventions will be the main focus; 2) implementation phase, when the bulk of in-country work on policy, assessments, implementation of interventions, information exchange, etc. will occur; 3) evaluation and conclusion phase.

Phase one will be preceded by project design work during which criteria for subproject selection will be developed, potential countries for the first year of the project will be identified, procurement mechanisms identified and targets set for project evaluation. To set targets and provide indicators that are objectively verifiable, an initial assessment, compilation and review of documents from existing child survival projects in Africa will be carried out during Project Paper design. More detailed reviews of projects and organizations will be conducted as a part of the process of identifying targets of opportunity for ARCSS funding each year. The Project Paper preparation will thus set the stage for Phase one.

During phase one, long term advisors will be hired and placed in key field positions such as at REDSOS and AID/W. A simple mechanism for tracking the nature, level and effectiveness of various child survival activities will be instituted during the early stages of ARCSS project implementation to facilitate the identification of targets of opportunity. Country visits will be made to explore the potential for ARCSS support, bilateral agreements will be negotiated, and in-country field personnel located for the initial sites.

Phase two will see the continuation of identifying potential project sites. The bulk of ARCSS resources will be spent on project implementation during this stage.

Activities and inputs at the country level will be tailored to local needs. The level of assistance will vary in intensive versus other sites. The nature of assistance and inputs, however are likely to be similar. These will be identified on a case by case basis in subproject documents and financial plans. Judging by the experience of other child survival activities and umbrella projects, the following types of inputs are anticipated:

- o short or long term technical assistance;
- o short or long term training in the host country, in the U.S. or in a third country;
- o information management;
- o local direct costs (per diem; travel/transportation; production or procurement of education and training materials, oral rehydration salts, growth charts and scales) for policy development, health and nutrition education, human resources development, service delivery and operations research activities;
- o purchase of basic medical equipment/supplies; provision of audio-visual and other training aids; procurement of vehicles where necessary;
- o recurrent costs and local salaries will be financed only with exceptional justification and where a phase-out plan exists.

Cooperating country and other donor contributions will be sought to the greatest feasible extent including personnel and in-kind contributions (office space, clinic facilities, transportation, clerical and professional services, etc.). Projects which investigate cost recovery through fee-for-services, sale of ORS packets etc., will be given high priority.

F. Estimated Costs and Financing

The growing demand for child survival activities and budgetary constraints will necessitate exceptionally high subproject selection standards and careful money management for ARCSS. Apportionment of funds between intensive sites and other activities will be determined based upon projected availability of funds and field submission of plans for the forthcoming budget year. These plans will provide a brief description of each activity and its estimated cost. Preliminary apportionment of budget year funds will be determined annually on the basis of relative need and program merit.

One of the key roles for ARCSS will be its ability to activate other sources of funds for important child survival activities in Africa. Seed or nucleus funds from ARCSS are expected to attract, leverage or lead in to other donor money as well buy-ins from S&T, PVO and regional projects. Appropriate uses of local currencies and counterpart funds will be explored wherever a potential exists to attract these resources for child survival activities. Therefore the sum of the impacts of these activities will be far greater than the \$15.0 million.

Table I illustrates the proposed ARCSS budget requirements by fiscal year. It is estimated that program focus for funding will be as follows: policy development and coordination 5 percent, human resources development 20 percent, information/education programs 15 percent, public and private sector service delivery including commodities 50 percent, operations research including evaluation, data collection, analysis and dissemination 10 percent.

TABLE I
ILLUSTRATIVE ARCSS BUDGET REQUIREMENTS BY FISCAL YEAR
(\$ 000's)

| | |
|-------|-------|
| FY 87 | 2,000 |
| FY 88 | 2,500 |
| FY 89 | 3,000 |
| FY 90 | 3,000 |
| FY 91 | 3,000 |
| FY 92 | 1,500 |

ARCSS contribution levels reflect a balance between program needs, absorptive capacity, management capability, and budgetary constraints. They assume continuation or expansion of

other child survival assistance by AID and other donors, including establishment of new bilateral projects. A total of \$15.0 million is the estimated level of funding required over a six year period.

An important feature of ARCSS will be its ability to buy into other Agency projects and to amend existing contracts and grants, as well as to provide a mechanism for other Agency units to buy into a regional child survival program. Because child survival activities are likely to be funded by a wide range of appropriation accounts including but not limited to Health, Population, ESF, ARDN, Sahel, PL-480, local currency accounts and EHR, ARCSS will have the capability to program resources from a multiplicity of accounts.

Table II is an illustrative budget by functional categories.

TABLE II
ILLUSTRATIVE FUNCTIONAL CATEGORIES FOR PROJECT ARCSS
(\$ 000's)

| Functional Category | Amount |
|------------------------------------------------------------|--------------|
| 1. Technical Assistance | |
| Long Term | 6,200 |
| Short Term | 2,400 |
| 2. Local Costs and Training | 4,000 |
| 3. Information Management and Other Regional Activities | 900 |
| 4. Other Costs | <u>1,500</u> |
| Total | 15,000 |

III. IMPLEMENTATION

A. Management

A major feature of ARCSS is the decentralization of project management so that direct-hire and contract personnel who are closest to the site of field operations have the greatest management responsibility and day to day control over the project. Long term advisors will be contracted to work under REDSO supervision. Missions will manage local operational costs with existing staff or personnel hired under ARCSS for this purpose. The project will fund one-third the cost of a child survival/nutrition advisor for AFR/TR/HPN. The project design team will review and recommend the best means of procuring these contract personnel, either as PSCs or consultants through 8(a) firms or through existing contracts and grants. It is expected

that existing S&T, PVO and regional project managers will be responsible for the activities that ARCSS buys into. Overall project coordination and fund allocation will reside in AFR/TR/HN.

Because some of the subproject design responsibilities may be beyond the technical capacity of some USAIDs, technical and managerial support will be provided by AID/W (S&T Health, S&T Nutrition and AFR/TR/HN), REDSO, and by contract personnel based in the region.

REDSOs will play a key role and be responsible primarily for supervising projectfunded regional child survival coordinators who will backstop missions, PVOs and other implementing agencies.

The coordinators will be responsible for sub-contracting small, non country specific activities and will be the key linkages between field activities and management staff in AID/W who are severely constrained in terms of numbers of technical personnel and travel funds.

B. Monitoring and Evaluation

1. Ongoing Monitoring

Field performance monitoring will be provided principally by USAID and REDSO field personnel in subproject countries. In addition, project funded coordinators based in the region will travel extensively to support health/nutrition program design and implementation.

2. Management Reviews

The first substantive management review will be held during the FY 1988-89 cycle, and annually thereafter. AID/W will conduct semi-annual management reviews to assess the status of budget allocations and obligations.

3. Project Evaluation

A final project evaluation will be made at the end of the fifth project year. The purpose of the evaluation will be to assess project performance and impact of the subprojects individually and collectively. The output indicators of the various subprojects will serve as the quantifiable measures to be evaluated for overall project performance. A major evaluation question will be whether to proceed with a follow-on project and if so what improvements might be made in project design.

IV. FACTORS AFFECTING PROJECT SELECTION AND FURTHER DEVELOPMENT

A. Social Considerations

The primary beneficiaries of this project will be infants, young children and mothers whose lives will be saved and health status improved. Its secondary beneficiaries will be the individuals receiving training, and public and private sector functionaries who are the recipients of technical assistance and better information.

Since most child survival interventions rely heavily on the participation of mothers of children under five years of age, women will be especially benefitted through this project.

Training, health education and technical assistance will take into account established social patterns. Special sensitivity will be required in dealing with health financing issues. In much of Africa, "free" health services have been promised as right of citizenship making the the raising of revenues to finance health services a more protracted process.

B. Economic Considerations

The proposed project encompasses a number of components including technical assistance, training, information exchange and others.- These activities cannot simply be attributed a rate of return to serve as an economic justification for project funding. However, economic considerations must and do play a key role in the project design.

During project identification, a number of less cost-effective approaches were rejected. In this design, the most judicious mix of focus and flexibility have been combined to maximize effectiveness within the limited resources available.

One of the substantive areas of focus in this project is to improve the financial viability of child survival programs. Through the judicious application of technical assistance, small studies and information exchange activities, through policy dialogue and the application of improved project design principles the long-term rates of return and sustainability of major health investments will be enhanced. The project will also help mobilize private and public sector resources.

A cost-benefit analysis of this project is not considered appropriate because of the large number of assumptions and imputed values. Cost-effectiveness analysis, on the other hand, is feasible. The cost-effectiveness of different options for providing long and short term technical assistance, training,

information exchange and project management will be explored and presented under project paper design. For example, the best way to build upon existing activities in Africa will be a major priority.

C. Proposed Implementing Agency

The Agency for International Development Bureau for Africa (AFR/TR/HPN) will be the implementing agency in cooperation with select institutions who serve as hosts for the proposed resident long-term advisors and as field implementers of subprojects.

D. AID Support Requirements and Capability

Support for project implementation and monitoring will be provided with available in-house AID personnel. AFR/TR will be responsible for project management. Additional technical resources may be drawn from S&T Bureau experts in health and nutrition.

E. Design Issues

1. What is the ideal balance between focus and flexibility? To set specific boundaries on resource use, it was considered essential to clearly define the specific role and problem to be addressed by this project to allow design work to be completed in sufficient depth for approval. However the funding mechanisms, procurements, nature of inputs and interventions could remain flexible until Project Paper development and if necessary, during the early implementation stages of the project. A set of criteria to be developed during Project Paper design will help maintain focus during the life of the project.
2. Given the desire to build upon work already occurring, how best can the project technical services be organized? Alternatives include: open competition, using existing contractors or a combination of both. With a broad range of ongoing centrally and regionally funded activities in the region, to what extent should preference be given to working through established intermediaries such as CDC, PRITECH, REACH, and others rather than introducing a new contractor or grantee?
3. What should the distribution of management responsibilities be across AID/W, REDSOs and USAIDs? How can the existing REDSO health and population activities be amplified using ARCSS resources for the Agency's high priority child survival initiative?

4. What should be the distribution of resources across the two main elements of the project, which are, intensive work at four to six sites aimed at developing major bilateral programs, and limited assistance to a larger number of countries to disseminate selected technologies?

5. To what extent should this project become involved in other donor coordination? In intensive sites and in the region as a whole?

6. What role should the project play in CCCD versus non-CCCD countries? What are the priorities in expanding CCCD? Close coordination and exchange of technical and operational information is anticipated. No formal linkages are envisioned until the project design team identifies a need for such a linkage.- This could be either for working in the same countries or provision of technical services or buy-ins for other services. Collaboration in complementary areas such as testing new technologies in growth monitoring, vitamin A or studying the feasibility of a central drug procurement mechanism are likely.

F. Design Strategy

Technical experts with Africa experience in key areas (such as immunizations, selected nutrition interventions, ORT, health financing, human resources development, pharmaceutical management, and privatization) will participate in the elaboration of the more detailed project design. Such input should be accessible through child survival projects in the S&T Bureau, in particular REACH, Maternal and Infant Nutrition, PRITECH and HEALTHCOM, and through CCCD.

Input from field missions is essential for further development of the project. Their needs in technical assistance, training, information exchange, essential drug procurement and operational research will help define areas of focus especially for the non-intensive regional support component of the project. In addition to content areas considered important, the field could help identify procurement modes that would be least burdensome and most effective mechanisms for channeling the assistance.

A central design concern for this project is where to place scarce resources. The project paper design will address this issue more fully by conducting a thorough review of the match between AID's current portfolio, including projects coming on line during this fiscal year, and the stated goals, targets and key elements of AID's child survival strategy for Africa.

The project paper will contain a list of criteria which will be applied to requests for assistance, and the process by which these criteria may be amended and subprojects reviewed and

selected to ensure that they remain sufficiently focussed on key gaps identified in the portfolio of AID central, regional and bilateral projects.

The following issues will be reviewed as a basis for developing criteria for funding and establishment of output targets:

- o which child survival "emphasis" countries identified in the Strategy are not adequately covered by mission or regional child survival activities? Are there any non-"emphasis" countries that should be high priority for this assistance, and why?

- o which of the key child survival interventions (immunization, ORT, nutrition, malaria treatment and child spacing) is/are not presently receiving adequate attention especially in priority countries, and why?

- o what lessons of experience can we incorporate from child survival-type activities conducted in Africa under projects such as CCCD, PRITECH, REACH, HEALTHCOM, Maternal and Infant Nutrition and PVO Child Survival Grants that will help accelerate the implementation of large-scale, high quality child survival programs in Africa? Specifically, what methodologies, approaches, types of organizations, operational tools have worked best in the areas of human resources development, health financing, nutrition, privatization, pharmaceutical supply and management, covering the costs of preventive care, decentralization?

G. Recommended Environmental Threshold Decision

Section 216.2 C Categorical Exclusion Subsection (2), (1), (V) and (XIV) of Environmental Procedures for AID specifies that for the type of project activities proposed above an initial environmental examination (IEE) and an environmental impact statement (EIS) are not generally required.

Based on the above guidance AFR/TR/PRO will request a negative determination for this project and that no further environmental examination be undertaken.

H. Gray Amendment

The Project Paper design will determine the most efficient mode(s) for acquiring project management, and technical services for ARCSS. These may include inter alia PSCs, PASAs, or institutional contractors. Wherever possible, consideration will be given first to 8(a) contractors and historically black colleges and universities (HBCUs). In particular, HBCUs may be contracted to provide some of the training planned under the project. The design team will be specifically instructed to consider 8(a) and HBCUs for the procurement of various services.

V. LOGICAL FRAMEWORK

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS | MEANS OF VERIFICATION | IMPORTANT ASSUMPTIONS |
|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| <p><u>Goal:</u> To reduce infant and child mortality in selected African countries.</p> | Reduction in IMR and Child Mortality Rates. | Clinic records and population-based surveys. | Political, economic and social conditions will not detrimentally affect target groups. |
| <p><u>Purpose:</u> Assist countries in formulating and implementing expanded and improved child survival programs.</p> | Increase in the number, coverage and quality of immunization, ORT, nutrition, malaria treatment programs. | Project evaluation. Project implementation reports. | Sufficient host country and donor resources remain available. |
| <p><u>Outputs:</u> 1. New bilateral child survival programs initiated.</p> | Two to four bilateral child survival programs funded and staffed. | USAID CDSS, Action Plans and portfolio reviews. | Child survival remains high funding priority in AID and Bureau. Mission staffing constraints addressed. |
| <p>2. Improved design, implementation or evaluation of child survival programs.</p> | Six to ten child survival programs with better designs, recurrent cost analysis, decentralized management, private sector involvement, integration with nutrition, and/or monitoring and evaluation mechanisms. | Program plans, implementation reports and evaluation. | Sustained commitment of resources by host countries other donors and AID. Availability of technical assistance. |
| <p>3. Improved policies, programs and studies in financing health care costs.</p> | Two to four countries with changes in health financing policies or programs, or analysis of recurrent costs and alternative means of financing. | Institutional records, policy documents, national development plans, published studies. Project evaluation. | National governments will request assistance and accept recommendations. |
| <p>4. Establishment or strengthening of essential drugs procurement and supply.</p> | Regional vaccine/drug procurement mechanism explored and improved pharmaceutical management systems established in two to three countries. | Project evaluation. Project implementation reports. | National governments will request assistance and agree to participate in regional supply system. |
| <p>5. Establishment of growth monitoring and nutritional surveillance systems linked with appropriate interventions.</p> | Growth monitoring and surveillance systems established in three to five countries. | Project evaluation. Project implementation reports. | Host country interest and past experience with growth monitoring or nutritional surveillance. |

LOGICAL FRAMEWORK (continued)

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 6.Design and implementation of mass media, social marketing activities for health and nutrition. | Three to four countries with strengthened social marketing and mass media components in their immunization, ORT and/or nutrition programs. | Project evaluation. Project implementation reports. | Host countries will have sufficient understanding and interest to request assistance. |
| 7.Individuals trained in: -planning and management of child survival programs -health financing and recurrent cost analysis -use of social marketing for child survival interventions -lactation management -monitoring/evaluation of mortality, morbidity and growth impacts of child survival programs. | National training plans developed, training coordinators placed and appropriate peripheral training materials available in three to four countries. 20-30 senior managers and 500-1000 health workers trained. Two regional training sites strengthened. | Project implementation reports. Roster of participants, their pre- and post-training performance and attitudes surveyed. | Trained personnel remain in key management and service delivery positions sufficiently long, and are given the opportunity to use their new skills. African institutions will be interested in providing training to other country participants. |
| 8.Information on child survival technologies, programs, policies gathered and disseminated. | Existing information centers in Africa and the U.S. strengthened to improve information gathering, analysis and dissemination. | Information request log. Computerized data base tested. User survey of usefulness. Mailing records of number, title and recipients of publications. | Existence of information centers that can be improved with limited support. |

THE ADMINISTRATOR

April 1, 1986

THE A.I.D. CHILD SURVIVAL STRATEGY

TO THE STAFF OF THE AGENCY FOR INTERNATIONAL DEVELOPMENT:

I have, several times in the last year, underlined the importance I attach to the Agency's Child Survival Programs. At my request, The Child Survival Task Force has developed and I have approved the following strategy as guidance to field missions. I call upon each mission to use this strategy as a basis for sharpening the focus of our health and related programs and as a basis for accomplishing the goals that the Agency has set to reduce the preventable deaths of children.



M. Peter McPherson
Administrator
Agency for International Development

A.I.D. CHILD SURVIVAL STRATEGY

INTRODUCTION

Fifteen million children under age 5 die each year in developing countries. The deaths of these children account for more than half of all deaths in developing countries. In this environment, malnutrition, disease, unsanitary conditions, closely spaced births and lack of maternal education all interact in a vicious circle. Two key technologies, oral rehydration therapy (ORT) and immunization, can break into the circle and significantly reduce infant and child death and disability associated with these factors and help build a sustainable health delivery system. Up to half of the deaths in children, or one quarter of all deaths in the developing world, could be prevented by these interventions. They are the "twin engines" of this strategy.

The magnitude of child mortality and the fact that we have proven, effective interventions--ORT and immunization--which can help save half of these children are the bases for making child survival the focus of A.I.D.'s health program.

A.I.D. has joined other donors in a worldwide effort to achieve certain targets in child survival by the end of the decade. The aim is to prevent two million deaths through the use of ORT, and to collaborate in all international efforts to provide continuing immunizations for all the world's children. The Agency's Blueprint for Development also includes among its goals the reduction of infant mortality to less than 75/1000 and the reduction of mortality in children under five to less than 10/1000.

A.I.D.'s focus will be on developing a sustained capacity in each country to effectively provide ORT, immunizations and other important child survival interventions in nutrition and birth spacing to their vulnerable populations.'

A.I.D. has been funding activities aimed at child survival for a number of years. In FY 1985, additional funds appropriated by Congress for child survival and related health programs allowed A.I.D. to accelerate its efforts to improve the health of children in A.I.D.-assisted countries. In FY 1986 Congress again appropriated additional funds for child survival. For FY 1987 A.I.D. is requesting a separate Child Survival Account. Funding for child survival will also come from many other accounts including Health, Population, ESF, Agriculture, Sahel, and PL 480. In future years funding will continue to come from a variety of agency accounts reflecting the multi-disciplinary requirements of this strategy.

This strategy establishes the improvement in the health and survival of children and mothers as the priority goal of the Agency's health program.

A.I.D.'S FIVE YEAR CHILD SURVIVAL STRATEGY

A.I.D.'s Child Survival Strategy seems to reduce significantly the number of child deaths in LDC'S by the end of the decade. ORT and immunization are the twin instruments for achieving this goal. These two interventions will be used as the base upon which to build effective health care systems. All designated emphasis countries should have nationwide ORT and immunization programs (drawing on A.I.D. and/or other support as appropriate).

Although ORT and immunization are the primary interventions upon which we plan to focus, birth spacing and a focused nutrition package emphasizing breastfeeding, improved weaning practices, and growth monitoring are also critical to child survival. They are an integral part of our child survival strategy.

The two above paragraphs describe the focus of A.I.D.'s Child Survival Strategy. Within the Agency's health program, child survival will have priority. However, it is recognized that in some circumstances, other health interventions could be critical to achieving child survival goals or to address other important health needs. The case will have to be made on an individual basis that, within a particular country context or setting, they are more appropriate than the child survival activities described above.

THE IMPLEMENTATION OF A.I.D.'S STRATEGY FOR CHILD SURVIVAL INCLUDES THE FOLLOWING ELEMENTS

- o Focus on ORT and immunization as "Twin Engines;"
- o Support for (and coordination with) other important child survival interventions such as nutrition and birth spacing;
- o Support for a results-oriented research program related to child survival;
- o Special efforts focused on a limited number of "emphasis countries;" and,
- o Involvement of the private sector.

SELECTIVE INTERVENTION APPROACH

The decision to focus on ORT and immunizations is based on the direct impact that these interventions can have on child survival and the capacity of these two "engines" to drive the development of a sustainable health system capable of meeting the health needs of the vulnerable populations.

IMMUNIZATION

Detailed guidance on the design of immunization activities is incorporated in the Agency's Immunization Strategy (January 1986).

The Immunization Strategy has six principal elements:

1. A primary target group of children under one year of age;
2. Emphasis on vaccines, to meet the needs of children and fertile-aged women, especially measles and tetanus-toxoid;
3. Development of county-specific plans, coordinated with other donors;
4. Major focus on target countries so as to maximize health benefits that can be obtained with available resources;
5. Emphasis on institutional capacity development to sustain host country immunization service delivery;
6. Continued research on vaccine development, immunization technology improvements, and health service delivery.

CONTROL OF DIARRHEAL DISEASE - ORAL REHYDRATION THERAPY:

Oral rehydration therapy (ORT) programs within the context of overall diarrheal disease control have eight principal elements:

1. Emphasis on support for coherent and comprehensive national ORT programs in coordination with other donors.
2. Appropriate nutrition interventions in addition to fluid therapy, especially dietary management of diarrhea (breastfeeding, feeding during episodes, refeeding) and appropriate hygiene interventions, especially sanitation education.

3. In concert with expanded services, use of comprehensive approaches to communication, including mass media, to promote and sustain the correct use of ORT and improved feeding and hygiene practices.
4. Provision for appropriate training, including physician training, as well as adequate supplies of salts within the overall national program.
5. Support for the World Health Organization formula for oral rehydration salts and for an appropriate combination of home-mix and packet-based programs, recognizing that there are community-specific factors that require adaptation to local conditions and resources.
6. Involvement of the private sector to prescribe, distribute, and promote ORT and to produce the packets.
7. Efforts to build and finance a sustained capacity to deliver ORT and other child survival services.
8. Research on improved formulae, vaccine development, communication techniques and service delivery.

NUTRITION

In the nutrition area, the interventions most closely related to child survival include:

1. Promotion of exclusive breastfeeding to 4-6 months to reduce the probability of infectious diseases, diarrheas and associated weight loss.
2. Promotion of proper weaning practices including the introduction of solid foods between 4 to 6 months, with continuation of breastfeeding.
3. Feeding during diarrhea to prevent serious weight loss and increased feeding after episodes of diarrhea and other infectious diseases.
4. Growth monitoring to detect growth faltering and to serve as a catalyst for prescribing appropriate followup interventions, i.e. ORT, feeding, etc., in a timely fashion.
5. Vitamin A supplementation where appropriate.
6. Targeted supplementary feeding programs to children under three years old and pregnant women under PL 480 Title II where there is serious risk of malnutrition.

BIRTH SPACING

In the area of birth spacing, the interventions most closely related to child survival include:

1. Promotion of appropriate breastfeeding.
2. Provision of a full range of voluntary family planning services and supportive activities as articulated in the Agency's Family Planning Strategy.

ACHIEVING MAXIMUM IMPACT AND SUSTAINABLE PROGRAMS

There are three important aspects of A.I.D.'s Child Survival Strategy which are critical to achieving maximum impact and long term sustainability. They are: institutionalization of services, use of modern communication strategies, and collaboration among donors.

INSTITUTIONALIZATION OF SERVICES: Sustained host government commitment is perhaps the most important part of a successful child survival program. The institutionalization of ORT and immunization services within developing countries depends upon their technical, financial and institutional viability. All three are critical to the sustained impact and effectiveness of these interventions. The importance of child survival activities and the need for institutionalization of these efforts should be part of all A.I.D. policy dialogue. All A.I.D. child survival programs must seek to develop local capacity to sustain the provision of services. This may require discussions with host countries on the reallocation and mobilization of health care resources. In all new child survival initiatives, careful analysis and planning for recurrent costs should be incorporated in the project design. Where the institutional and financial capacity to sustain these programs is weak, time-limited donor assistance for recurrent costs may be considered.

Although one-time mobilization campaigns may be critical to create public awareness and stimulate a demand for these services, the existence of an indigenous capacity to manage and deliver such services is essential to ensure that new cohorts of children will receive similar care. In countries where a health infrastructure already exists, A.I.D. will focus assistance on introducing or strengthening the ORT and immunization components of these systems and developing retail sales activities. In countries where it is lacking, A.I.D. will incorporate plans for developing the public and private infrastructure to undertake these child survival service programs.

UTILIZING THE PRIVATE SECTOR: Every effort should be made to explore opportunities for involvement of the private sector, to complement or supplement public sector programs. To the extent practicable, the private sector should be utilized to prescribe, distribute, and promote ORT and to produce the packets as well as to distribute vaccines. PVO's also should be used to implement programs where appropriate.

MODERN COMMUNICATION STRATEGIES: Although ORT and immunization programs already exist in many A.I.D.-assisted countries, lack of knowledge and low use levels persist. It is likely, therefore, that demand creation will be a key element of child survival activities. Experience has shown that modern marketing and communication techniques can be successfully applied to programs which have a social objective. Although mass media is apt to be part of most strategies, this must often be combined with person-to-person communication strategies. It is essential that demand creation efforts be carefully coordinated with adequate supplies and trained personnel. For ORS (oral rehydration salts, used in ORT), as for family planning, a social marketing approach should be considered.

SELECTED COUNTRY FOCUS

Currently, A.I.D. supports ORT and immunization activities in more than 50 countries. A.I.D.'s resources need to be concentrated to achieve maximum impact. During the next five years, A.I.D. will place special emphasis on programs in a selected number of countries where child survival problems are especially severe in order to maximize the effectiveness of the services and their impact on infant and child mortality. A.I.D.'s child survival effort for the remainder of the decade will be concentrated in the following countries:

| | |
|------------|----------|
| Bangladesh | Mali |
| Bolivia | Morocco |
| Ecuador | Nepal |
| Egypt | Niger |
| Guatemala | Nigeria |
| Haiti | Pakistan |
| Honduras | Peru |
| India | Senegal |
| Indonesia | Sudan |
| Kenya | Yemen |
| Malawi | Zaire |

THE PROCESS OF SELECTING THESE COUNTRIES INVOLVED
CONSIDERATION OF THE FOLLOWING FACTORS:

- o Total number of infant and child deaths;
- o Infant mortality rates;
- o Immunization and ORT coverage levels;
- o Mobilization and absorptive capacity (including accessibility of population and availability of mass media and infrastructure);
- o Degree of government commitment to child survival, measured in terms of allocation of local resources and in terms of strong identification of local leadership (political, religious and other) with these efforts;
- o Availability of funds from development assistance, ESF, Sahel and PL 480 and opportunities for programming these funds;
- o Opportunities for effective donor collaboration aimed at achievement of common goals for improving child survival;
- o Expectation that A.I.D. will continue to maintain a large program and sizable presence over the next three to five years.

IN THESE "EMPHASIS COUNTRIES," THE PLANNED A.I.D. COMMITMENT INCLUDES:

- o Sustained bilateral funding for child survival activities for at least the next 3-5 years;
- o A coordinated approach involving support for U.S. and indigenous PVO's, international organizations and other U.S. agencies such as the Peace Corps;
- o Priority A.I.D./W support for the management and technical staff required to conduct child survival activities and for training to upgrade the skills of A.I.D. and host country staff.

This strategy is equally applicable to non-emphasis countries; however, the A.I.D. personnel and program resources for child survival activities in non-emphasis countries will be limited. Consequently, our efforts will have to emphasize policy dialogue and the influence obtainable through coordinated efforts with the donors. PVO's and the Peace Corps are also options for achieving child survival objectives in "non-emphasis" countries where A.I.D. bilateral programs and staffing are a major constraint. Even where there are no A.I.D. bilateral resources, we would expect child survival to be part of our policy dialogue in support of effective action by other donors and the host country to save children's lives.

COLLABORATION WITH OTHER DONORS

A.I.D. and other donors (UNICEF, WHO, UNDP, PAHO, etc.) have joined together in the worldwide effort to achieve goals for both ORT and immunization by the end of the decade. By 1990, the infrastructure and programs should be in place to avert the deaths of two million children who will otherwise die from diarrhea and related dehydration. A.I.D. has also pledged to collaborate in an international effort to provide immunizations for all the world's children, with specific coverage goals defined at the country level. The challenge of meeting the internationally agreed goals and the inevitable limits on available funding means that we must strive to achieve maximum impact. Multi-donor collaboration at the country and sub-regional level is an important part of this international child survival effort.

Missions in the design of their country strategy and accomplishment of their program objectives should take fully into account the capacities of these other institutions. In this regard, a close program relationship has developed with UNICEF which has programs in many countries directly supportive of the A.I.D. strategy. The closest field coordination in support of country program goals is encouraged.

FUNDING

Funding for the Agency's child survival effort will come from funds earmarked specifically for child survival and the regular Health account. Population, Agriculture, Sahel, ESF and PL 480 accounts will also be used for child survival activities wherever appropriate.

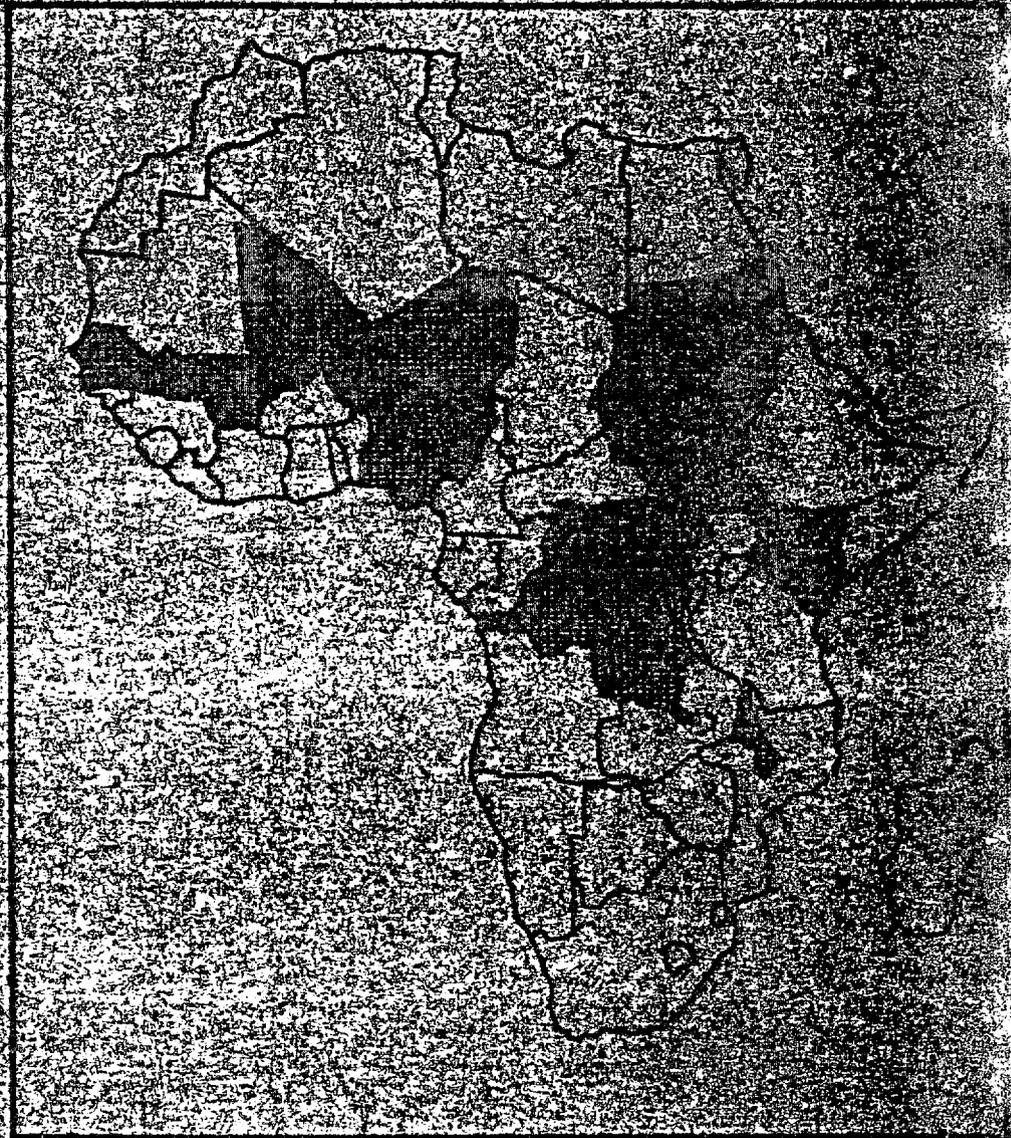
PL 480 Title II and Section 416 programs can provide essential support for country child survival initiatives. Title II programs provide an excellent logistics system for transportation and distribution of supplies, particularly to and within hard-to-reach areas. It also provides established contacts with communities and vulnerable groups. Title II food resources can be used to prevent serious malnutrition and may be used in combination with ORT to manage diarrhea episodes and reduce rapid weight loss. The food may also serve as an incentive to bring mothers for other child survival interventions.

MONITORING AND EVALUATION

Very specific Agency objectives have been set for our child survival efforts. Monitoring and evaluation are an essential component of child survival activities. A.I.D.'s field missions are responsible for project management and program monitoring of their country programs. In addition, in collaboration with other concerned donors as appropriate, they will need to develop baseline data, benchmarks and a system of regular, at least annual, reporting on country specific child survival targets.

The Regional Bureaus will oversee and coordinate country performance. The Child Survival Task Force will monitor Agency performance and, in collaboration with other donors, track progress towards the world community's goals of universal immunization, access to ORT and reduced infant and child mortality.

Child Survival Action Program CSAP



CHILD SURVIVAL STRATEGY

1987 - 1991

BUREAU FOR AFRICA

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

AFR/TR

November 7, 1986

Table of Contents

| | <u>Page</u> |
|--------------------------------------------------|-------------|
| I. Introduction | 3 |
| II. Executive Summary | 4 |
| III. Overview | 6 |
| IV. Summary of Agency Child-Survival Strategy | 8 |
| V. How Africa Differs | 9 |
| VI. Africa Child Survival Objectives and Targets | 10 |
| VII. Africa Child-Survival Interventions | 12 |
| A. Immunization | |
| B. Diarrheal Disease Control | |
| C. Nutrition and Famine Relief | |
| D. Family Planning | |
| E. Malaria | |
| VIII. Related Africa Bureau Interventions | 18 |
| A. Training | |
| B. Private Sector | |
| C. Management | |
| IX. Focus Countries | 20 |
| X. Non-Focus Countries | 20 |
| XI. Building Sustained Capacity | 20 |
| XII. Coordination with Other Donors | 21 |
| XIII. Implementation Plan for 1987 - 1991 | 22 |

Annexes

1. AID Worldwide Child-Survival Strategy
2. Mandate for Increased Emphasis on Child Survival
3. Tables and Graphs
4. Project Listing
5. Financial Summary
6. Personnel Summary

I. Introduction

The purpose of this document is to articulate AID's strategy for child survival activities in Africa over the next five-year period (FY 1987 - 1991). While these activities will follow closely the Agency's worldwide strategy for child survival programs (see Annex 1), the special conditions found in Africa necessitate certain departures from the Agency strategy, particularly in terms of emphasis.

Africa-specific differences include:

- o Emphasis on child spacing due to very high fertility and need to offset the demographic impact of child survival action program (CSAP)
- o Some emphasis on parasitic and other major diseases (malaria, onchocerciasis, schistosomiasis, dracunculiasis, AIDS)
- o Famine relief, nutrition, and early warning links to child survival
- o Emphasis on training of management, program planning, and service delivery personnel.

These Africa-specific modifications will be highlighted in this paper, along with the rationale for them.

In addition to a general survey of objectives and proposed strategies for child survival programs in Africa, interventions will be discussed and an attempt will be made to place them in both historical and operational context.

Comments and criticisms are welcome from any interested party.

II. Executive Summary

Prior to this decade, the Agency's health strategy was focused on attempts to establish primary health care systems in the developing nations. In the African context, seven major country projects were launched; most later proved to be too ambitious, cumbersome or complex. Insufficient attention was paid to financial sustainability. While there were a number of positive gains attributable to these projects, it was clear that due to their high cost and basic designs, they were unlikely to have the desired impact on morbidity and mortality, at least in the near term. Fiscal 1981 marked the beginning of the the Africa Bureau's Combatting Communicable Childhood Diseases (CCCD) project, which began to focus on specific, cost-effective measures which were more readily implemented and targetted specific childhood diseases with appropriate technologies.

Recognizing the emotional and financial costs of extremely high infant and child mortality in the developing world, the U.S. Congress created a new appropriation account in fiscal 1985 entitled Child Survival, in concert with a UNICEF global initiative.

In April of 1986, the Administrator approved the Agency's Child-Survival Strategy "as a basis for sharpening the focus of our health and related programs and as a basis for accomplishing the goals that the Agency has set to reduce the preventable deaths of children" in the developing world. This strategy stresses two key technologies, oral rehydration therapy (ORT) and immunization, as the "twin engines" to break the cycle of disease, malnutrition and death among children in many developing country environments. In addition, both child spacing and nutrition are cited as being critical to child survival.

The Africa Bureau has looked at this strategy in the context of African child health problems and has determined that treatment of malaria must be included in order for the strategy to be meaningful for the continent. A conscious effort has been undertaken to program more child survival activities, particularly in the eight "emphasis countries" in Africa (Kenya, Malawi, Mali, Niger, Nigeria, Senegal, Sudan and Zaire). A major new effort is being undertaken in Nigeria and a bilateral child survival project is scheduled for funding this fiscal year (FY 87) in the Cameroon. Many of the existing bilateral and centrally-funded programs in health will be expanded to incorporate additional immunization, ORT, nutrition, child spacing and malaria control components.

As part of future child survival efforts, new projects and programs in Africa must include plans for both financial and institutional sustainability during the design stage. Also, the Africa Bureau currently is reviewing its strategy for training in both health and population in order to better concentrate resources on child survival activities.

III. Overview

Clearly, infant mortality in Africa is the worst of any region of the world. With an average of 121 infant deaths per 1,000 live births, sub-Saharan Africa compares poorly with the rest of the developing world, including India and China, where the average Infant Mortality Rate (IMR) is 87 deaths per thousand. The IMR's in Africa range from 190 in Guinea and Sierra Leone, 184 in Somalia and 161 in Chad to 109 in Nigeria, 83 in Zimbabwe, 77 in Kenya and 34 in Mauritius. In general, West Africa and the Sahelian countries have higher IMR's than east and central Africa. By comparison, the United States has an IMR of 10.5 and Northern and Western Europe are at nine per thousand.

Childhood mortality rates, for those between the ages of one and five, range from 50 per 1,000 in Guinea and Sierra Leone to 20 in Nigeria, 13 in Kenya and 3 in Mauritius. Hence, of all children born in sub-Saharan Africa, one in five will not live until the fifth birthday.

The factors behind these high rates of mortality are a combination of negative forces, including high fertility, a plethora of endemic diseases, malnutrition, dehydration due to diarrheal diseases, inadequate water supplies and low investments in the health sector by African governments. Often, a combination of malnutrition with an endemic disease or acute diarrhea is the ultimate cause of mortality, rather than any single health factor. Endemic diseases include malaria (which is increasingly resistant to chloroquine in some areas), immunizable diseases such as polio, diphtheria, tetanus, measles and pertussis (whooping cough), as well as tropical diseases such as onchocerciasis (river blindness), schistosomiasis (bilharzia) and dracunculiasis (guinea worm). Only an estimated 27 per cent of sub-Saharan Africans have access to safe water supplies and per capita annual health expenditures by African governments average between \$1 and \$10, allowing for little health service infrastructure. Most of the expenditures by governments are used for salaries, and few governments have recognized the importance of enlisting the private sector in public health efforts.

It must be stressed that aggregate mortality data for Africa do not paint a complete picture. These figures mask urban - rural differences and most often are estimates based on old censuses and surveys and in which mortality rates are uniformly assumed to have declined. Also, the health effects of the recent drought in the Sahel have not been included in the calculations.

At present, AID is targetting its child survival assistance to eight African countries comprising a population of about 210 million, or 44 percent of the total sub-Saharan population. The total population of those countries to which AID assistance is not now being given is approximately 137 million, or 28 per

cent of the population. Most of these countries receive assistance from UNICEF, WHO or other donors. For example, in Angola, Ethiopia, Mozambique and Tanzania, the UNICEF Universal Child Immunization Program has made major commitments out of a \$100 million donation from the Government of Italy. Other major bilateral donors include France (mainly West Africa), Sweden, Norway, Canada, Denmark, Germany, Japan, Belgium, the Netherlands, and the United Kingdom. Other multilateral donors include the European Economic Community, the African Development Bank and the World Bank. In virtually all countries with AID missions, close collaborative arrangements are maintained with other donors in order to avoid duplication and to promote mutually supportive child survival activities.

Tables, graphs and charts with more specific detail can be found at Annex 3.

IV. Summary of Agency CSAP Strategy

A.I.D.'s Child-Survival Strategy seeks to reduce significantly the number of child deaths in developing countries by the end of the decade. ORT and immunization are the twin instruments for achieving this goal. These two interventions will be used as the base upon which to build effective health care systems. All designated emphasis countries (see below) should have nationwide ORT and immunization programs, drawing on either A.I.D. or other donor support.

Although ORT and immunization are the primary interventions, birth spacing and a focused nutrition package emphasizing breastfeeding, improved weaning practices, and growth monitoring are also critical to child survival. They are an integral part of the child survival strategy.

Within the Agency's health program, child survival activities clearly will have priority. However, it is recognized that in some circumstances, other health interventions could be critical to achieving child survival goals or to address other important health needs. The case will have to be made on an individual basis that, within a particular country context or setting, they are more appropriate than the child-survival activities described above.

Implementation of A.I.D.'s Strategy for Child Survival

The Agency strategy includes the following elements:

- o Focus on ORT and immunization as the "twin engines;"
- o Support for (and coordination with) other important child-survival interventions such as nutrition and birth spacing;
- o Support for results-oriented research program related to child survival;
- o Special efforts focused on a limited number of "emphasis" countries; and,
- o Involvement of the private sector.

In addition, the Africa Bureau will focus on malaria treatment, enhanced training aimed at supporting child survival project activities, and other selected diseases endemic to Africa which impinge on child health and survival.

45

V. How Africa Differs

While there are manifold similarities among conditions found in LDC's worldwide, including in Africa, the countries of Africa south of the Sahara encompass a set of development problems which seem in fact different from those of other regions, at least in degree if not in their essential character. Among these special conditions are the following five which are particularly striking:

- o Severe economic problems and prospects -- the 48 nations of sub-Saharan Africa include many for which the economic outlook is bleak, even under favorable circumstances;
- o Very High Fertility -- Kenya's well-documented population is growing at over 4% per annum; other African states are similarly situated for such exceptionally high demographic growth rates, particularly as infant and child mortality falls in response to child-survival initiatives;
- o Many sub-Saharan states are drought- and famine-prone, with millions of people living at the survival margin; cataclysmic natural and political events occur with startling frequency and regularity; children are very often the first victims;
- o An unusually weak human and institutional base characterizes most African nations, as compared to other major regions of the world; coupled with the very fragile economic base, this presents special problems for program planning and for institutionalization of child survival programs;
- o Parasitic and other lethal contagious and debilitating diseases are more prevalent in Africa, and take a relatively higher toll in the lives of infants and children than elsewhere, often when an infant or child has more than one affliction at one time.

Each of the above sets of conditions has been taken into account in planning a child-survival strategy for the Africa Bureau, as is reflected in the following section.

VI. Africa Child Survival Objectives and Targets

Infant mortality (deaths in the first year of life) ranges from 4 percent to 20 percent of all live births in Africa each year. Child mortality, or deaths of children aged one to five, ranges between 1 and 5 percent. Thus, from five to 25 percent of all children born in Africa die before their fifth birthday. Of all mortality each year in Africa, over one-half is attributable to infants and children.

Contributing significantly to high infant and child mortality in Africa are universally high birth rates. Statistical studies throughout the world show that when the interval between births is less than two years, which often is the case in Africa, infant mortality can double or triple compared to children born more than two years after their previous sibling.

The major factors in infant and child deaths in Africa are dehydration due to diarrhea, communicable diseases, malnutrition and vector-borne malaria. Often, several of the foregoing health problems combine and lead to death. Communicable diseases include diphtheria, whooping cough (or other upper respiratory infection), polio, measles, tuberculosis and tetanus, all of which can be prevented through vaccination.

Approximately 50% of these deaths in children under five years of age are caused by conditions for which effective and inexpensive interventions are available. Measles, DPT, and polio immunizations and oral rehydration therapy (ORT), and the provision of adequate pre-natal care, including tetanus vaccination, are examples of proven technologies that could prevent up to one half of the childhood deaths in Africa.

Objectives

The objectives of the Africa Bureau Child Survival Action Program are as follows:

1. To reduce morbidity and mortality in the under five population in selected countries in Africa.
2. To strengthen the capabilities of African governments and the private sector institutions to plan, implement and evaluate programs to improve child health and survival.

Targets By 1991

The targets of the Child Survival Action Program, to be achieved by 1991, are:

1. To reduce the Infant Mortality Rate (IMR) to less than 75 per 1000 per annum in selected countries.
2. To fully vaccinate 80% of children under 2 years of age in selected countries.
3. To assure access to appropriate and correct case management of diarrheal disease episodes for children under 5 years of age.
4. To provide access to voluntary family planning information and birth spacing methods for 80% of women.
5. To reduce the number of children under 80% weight for age to less than 10%.
6. To provide access to an appropriate anti-malarial treatment for at least 80% of children under 5 years of age consulting for fever/malaria.

VII. Africa Child-Survival Interventions

A. Immunizations

Widespread access to immunization would substantially reduce childhood deaths and disease (particularly those caused by measles and neonatal tetanus). The six targeted diseases, which coincide with those identified by WHO's Expanded Programme of Immunization (EPI) are: measles, diphtheria, pertussis (whooping cough), polio, tuberculosis and tetanus. In Africa, the 80% vaccination coverage target among children under two years of age is highly desirable; in fact, several countries have reached levels near the target. Even so, it will probably not be possible to immunize 80% of children against all the target diseases of the EPI program in all AID-assisted countries in Africa by the end of 1990.

The strategy objectives for immunization are:

1. The primary target group for immunizations are children under one year of age and women of fertile age.
2. The vaccines to be emphasized are measles among infants and tetanus toxoid for fertile women.
3. A secondary objective of AID support is to help develop a primary health care infrastructure able to deliver immunizations in a sustained manner for the foreseeable future. Specifically, immunizations would be available on a regular basis from as many of the existing health facilities as appropriate. As a national immunization capability is established, other child-survival health interventions can be added to the system.
4. In addition, national immunization campaigns will be used as appropriate to increase demand for immunization services. AID efforts will be coordinated with other donors (particularly UNICEF, Rotary International and bilateral donors) to assure the most effective assistance to national immunization programs.
5. Attaining high immunization coverage levels and reduction of cases and deaths caused by the target diseases will require widespread social mobilization with the maximum possible involvement of private agencies and groups.
6. Continued research on vaccine development, sterilization of injection equipment, and health education are essential. One pressing priority is the development of a safe measles vaccine effective before the age of nine months.

VII. B. Control of Diarrheal Disease (CDD)

The guiding principle of AID's diarrheal disease control strategy is the reduction of childhood deaths due to dehydration caused by diarrhea through appropriate case management which can be provided by professional health care providers or by mothers, in health facilities or in the home.

National programs should be comprehensive in nature, but realistic and feasible. Different components should be implemented in a step-wise fashion. Because diarrhea case management practices are primarily of a curative nature (they are only implemented when illness occurs), it is logical to begin program implementation at the health facility level. At an early stage of strategy implementation, AID should seek to assure that all children brought to health facilities with acute diarrhea should be appropriately treated; that is, principles of oral rehydration therapy should be established which include:

- 1) fluid and electrolyte replacement,
- 2) early feeding, and
- 3) referral to a better equipped facility if indicated.
- 4) education of mothers.

In order to assure that these principles are understood and implemented, each AID-supported CDD program should seek to establish one or more training sites for health professionals and/or private sector workers such as pharmacists where hands-on experience in the management of acute diarrhea in children can be learned.

AID should seek to increase the availability of ORS through all distribution channels, including the private sector through social marketing and social advertising. This entails ensuring that supplies, particularly of ORS are regular and ample and that distribution systems are properly designed and effective. To accomplish this, cooperation with other agencies and indigenous organizations should be pursued. Where it is deemed both feasible and necessary, anthropological studies should be undertaken to better understand consumer beliefs and practices.

Access is also part of availability and needs to be expanded at two levels: health facilities and communities. Training of health workers needs to continue until it is comprehensive, and, while this is being carried out, new providers of ORS (pharmacists, merchants, CHWs, mothers) should be trained and enlisted into the program. Health education through the best use of available communication channels (mass media) should be used at this stage to encourage mothers and caretakers to seek treatment for diarrhea from individuals trained in good case-management techniques.

Finally, when these systems are in place and functioning well, attention should be paid to the final stage of implementation--the promotion of home therapy. Ideally, prior research will have gone into the identification of the best available home fluid. The end result would be widespread effective use of the best available means of reducing mortality due to diarrheal diseases: the administration of adequate quantities of effective oral rehydration solutions, early re-introduction of appropriate foods to children with diarrhea, and appropriate referral of more severe cases to facilities where adequately trained health personnel are competent to manage them.

ORT and diarrheal disease control efforts will be strengthened in the Africa region by exploring low-cost water and sanitation interventions to provide for improved water resources. Focus will be given to strengthening and expanding the outreach of existing PVO and Peace Corps water and sanitation programs in Child Survival emphasis countries.

VII. C. Nutrition and Famine Relief

The synergism between malnutrition and major infectious diseases (especially diarrheal disease, measles, whooping cough and maternal malaria infection during pregnancy) are well known. Improving nutritional status during the first five years of life will make a substantial contribution to improved child survival. Specific goals of the Africa Bureau Nutrition Strategy are:

1. To protect breast feeding and to reverse its decline where appropriate;
2. To improve density, quality, frequency and amount of food given to weaning age children;
3. To promote dietary approaches for the case management of diarrhea and other infectious diseases;
4. To increase the coverage and improve the effectiveness of growth monitoring activities; and
5. To target supplementary feeding programs on mothers and young children at high risk of inadequate nutritional status.

Additional objectives likely to be directly supportive of the nutrition strategy for child survival are prevention, treatment and research on:

1. vitamin A anemia
 2. iron deficiency anemia
 3. improved nutritional status of pregnant and lactating mothers.
- 51

To be effective, especially in a resource-constrained environment, nutritional programs need to be targetted toward populations most at-risk. With few exceptions, such populations tend not to be geographically grouped so as to minimize logistical problems, thus the need for accurate targetting is underscored. Identification of at-risk groups implies some sort of nutritional surveillance system capable of detecting food emergencies, such as famine early warning systems (FEWS) attempt to do.

Certain problems particular to nutritional surveillance tend to be important in impacting child nutrition:

- o Endemic malnutrition
- o Regular, periodic, catastrophic famine which has major impacts on child survival in Africa
- o Documented seasonal food shortages, a major problem in Sahelian countries, which leads to nutritional stress and mortality
- o Yearly variability in food production at local or regional level, independent of overall national-level production, which results in marginal areas repeatedly exposed to food shortages, threatening child survival on the local level
- o Feeding practices, not well-documented in much of Africa, have obvious relation to child survival. Nutritional surveillance information can be helpful in identifying feeding practices which are in need of modification to improve child survivorship.

Early warning systems, such as the Africa Bureau's new FEWS project, can help to target populations at risk, both for program planning and for crisis management purposes.

In Africa, where nutritional deficiencies tend to be linked primarily to inadequate food production and availability, famine early warning systems and simple nutritional surveillance systems will serve as essential linkages to Africa Bureau food production initiatives and P.L 480 assistance to enable AID's agricultural portfolio to be integrated with child survival needs.

Information from these nutrition surveillance systems also will be used to monitor the impact on child survival from structural readjustment programs which are becoming a growing concern in Africa today. This will enable further linkages to be made between food aid programs and nutritional needs. In some

cases, it is envisioned that P.L. 480 proceeds will be used for local-cost funding for child survival activities. Over the next five years, the Africa Bureau will emphasize improved infant and child feeding, dietary management of diarrhea, and growth monitoring as primary nutrition interventions for child survival within the region. These activities will be underscored by concerted efforts to develop famine early warning systems and nutritional surveillance systems at the regional and country level.

VII. D. Child Spacing

The guiding principles of AID's Family Planning strategy are (1) to provide individuals with the freedom to choose the number and spacing of their children; and (2) to do so while bringing national and regional growth rates to a level which is consistent with and can be supported by economic growth and productivity. These goals, which need to be tailored to individual countries, can be achieved through research, program implementation, and periodic monitoring and evaluation.

A program of biomedical, social sciences, and operations research should be planned for those countries which are just beginning to provide voluntary family planning information and services in order to provide the most accurate information available regarding local determinants of contraceptive use, to involve local research institutions and policy-makers in the implementation process, and to solve identified problems of supply, demand, logistics, and management.

Policy discussions should be held with national planners to discuss the links between high birth rates and high infant mortality, low socio-economic and educational status of women, and cultural and legal barriers to limiting births. A high level of government commitment needs to be obtained in order for a family planning program to be successful and sustainable.

Elements of a program need to include the development of effective information and service delivery systems through both the public and private sectors (social marketing, community-based distribution and other techniques), and encouraging the increased use of newly available services. Cooperation with other donors and the private sector should be stressed.

Finally, a successful program will have pursued a course of decreasing dependence on external support. The transfer of contraceptive technology, data collection and analysis techniques, distribution systems and, perhaps most of all, improved management practices, combined with cost-recovery schemes and continued political support should all be clear end-points of AID strategy.

VII. E. Malaria

Malaria is a more serious threat to child survival in Africa than in other parts of the world. It is estimated that as many as one million African children die from malaria infection each year. Hence, child survival efforts in Africa must include a malaria control component. The rapid spread of chloroquine resistance to southern and central Africa has made malaria control more difficult. The most appropriate malaria control strategy for Africa is presumptive treatment of acute attacks of fever-inducing illness compatible with malaria symptoms with appropriate antimalarial drugs (principally chloroquine). The WHO recommended chemoprophylaxis against malaria during pregnancy is not widely used in Africa. There is preliminary evidence suggesting that low dose (5 mg/kg) weekly doses of chloroquine for chemoprophylaxis is not effective. The specific strategy objectives for malaria includes:

1. Promotion of prompt treatment of young children presenting with fever compatible with malaria with appropriate antimalarial drugs.
2. Development of surveillance systems to monitor the in vivo response of malaria infections to antimalarial drugs (especially chloroquine).
3. Development and implementation of national malaria control plans based on monitoring of response to antimalarial drugs and prompt treatment of children with appropriate antimalarial drugs.
4. Operations research to define the most appropriate program interventions to reduce the risks of maternal malaria infection for low birth weight infants and decreased child survival. These investigations must look to the practical problems of supply of antimalarial drugs and compliance of pregnant women, as well as the response of malaria infections in pregnant women to various antimalarial drugs (especially chloroquine).
5. the selective use of insecticide spraying in appropriate areas (principally in cities).

VIII. Related Child Survival Activities

An effective child-survival strategy in Africa must address a complexity of issues broader than EPI, oral rehydration, birth spacing and nutrition. Training directed at child survival activities and projects must be rationalized with a view towards supporting projects and long-term institutionalization. The private sector must be enlisted as an alternative delivery system which most often can be more cost effective than public sector institutions. Sound management must be a keystone of all our activities in these endeavors, a factor that has been identified as a serious constraint in past efforts.

VIII. A. Training

At present, training for child survival and population in Africa is done on an ad hoc basis or is aimed at long-term institutional development that may take far too long to produce results. Most, if not all, bilateral child survival and population projects have training components which are designed by field staff without focusing on present and future needs, without a full examination of regional and international training opportunities, and without consideration of economies of scale that might be gained by combining child survival and population training or by creating regional training institutions. In a period of increasingly constricting budgets, the Bureau has commissioned a study to produce an Africa-wide training strategy for both child survival and population. Regional institutions such as the East and South Africa Management Institute (ESAMI) in Arusha, Tanzania, the Center for African Family Studies (CAFS) in Nairobi and the School of Public Health in Kinshasa are examples of institutions that could be developed into centers of excellence for training in child survival.

VIII. B. Private Sector

Private sector involvement in child survival is considered to be central to achieving Bureau objectives. The following areas should be considered in all country-specific planning:

o Social Marketing -- There are currently two active contraceptive social marketing projects in Africa -- Ghana and Nigeria. Using all the principles of modern marketing, including market research, incentives for distributors, wholesalers and retailers, mass media advertising and an aggressive, subsidized pricing policy, social marketing projects seek to use existing distribution networks to increase the availability of contraceptives in nationwide projects. This method also may be used for oral rehydration products, as will be tested in Ghana, in conjunction with the contraceptive

5

marketing project. New contraceptive marketing projects are planned for Zimbabwe, Kenya, Mali, Somalia and Niger. It is planned to expand to other countries, as well as to add oral rehydration to at least several of the projects. In Nigeria, UNICEF (under the ACSI-CCCD project) will work with local manufacturers to upgrade quality control and will use mass media advertising to increase demand.

o Social Advertising -- In the Gambia, mass media advertising was used to both teach proper oral rehydration mixture and how it is administered. Mass media is used in numerous countries to announce vaccination campaign days: where and when to take children for immunizations. Other child survival messages should be developed, after consumer research, for promotion through the mass media.

o Private Enterprise -- The Enterprise Project, funded by the Office of Population, already is demonstrating that private business can be enlisted in the child survival effort. In Nigeria, 20 companies with more than 5,000 employees were approached about providing family planning services in their employee health clinics. Nineteen of these companies requested to take part in the project, although funding was available for only one of them. The company selected will purchase contraceptives from the social marketing project (at wholesale) and sold to employees. The company's health clinic employees will receive training in family planning service delivery and then the project should be self-sustaining. This effort can easily be expanded to other companies, and other child survival "engines" could be added once the initial intervention has been institutionalized.

o Local production -- In larger population countries, local production of oral rehydration salts is both cost effective and culturally more acceptable. In Ghana, for example, the centrally-funded SUPPORT project is providing technical assistance in quality control to ensure that proper mixtures are derived in each batch of salts, which will be sold by the social marketing project. As noted above, it is planned to provide quality control technical assistance to UNICEF for local production of ORS there. This effort will be expanded to at least four other countries during the next five years.

VIII. C. Management

One of the crucial aspects of child-survival projects and programs is management. Without adequate managers, all of the funds and effort now being concentrated in this area will not result in long-term institutionalization of child survival interventions, or hopefully, primary health care.

IX. Focus Countries

During the next five years, eight countries in Africa will be emphasized for child-survival activities. These focus countries are:

| | |
|--------|---------|
| Kenya | Nigeria |
| Malawi | Senegal |
| Mali | Sudan |
| Niger | Zaire |

These countries were selected as "emphasis countries" based on the following criteria:

- o population size
- o infant and child mortality rates
- o governmental commitment to child survival activities
- o existing infrastructure and management capabilities
- o lack of other donor support

The list of Africa bureau emphasis countries will be reviewed annually, with countries achieving child survival objectives being removed from the list and other countries being added as policies or other factors change. These identified countries will receive a major share of funding from a variety of sources for child survival activities.

X. Non-Focus Countries

Non-focus African countries will remain eligible for AID child survival funding so long as funds are available after projects and programs for the emphasis countries have been met. Non-emphasis countries with specific, critical health problems such as high incidence of malaria will be addressed on a case-by-case basis.

XI. Building Sustained Capacity

Financing activities for child survival activities and programs will be developed in an effort to assure financial viability and sustainability. Full cost recovery in health in Africa is a particular problem in that free popular medical care has been promised by many governments.

In the region, however, there recently have been notable departures from this tradition. Kenya, for instance, has expressed an interest in developing health financing projects as a major element of AID's health sector assistance and in

Zaire a fee for service system in government hospitals was introduced in 1985. The Sudan AID mission reports (August 1986) that the Minister of Health has initiated fee for service mechanisms in GOS hospitals and has received National Assembly support. The governments of Nigeria, Rwanda and Liberia also are beginning to implement fee-for-service charges at their health facilities.

The Africa Bureau fully supports the guidelines established by the Agency as described in the July 1986 Memorandum for the Executive Staff.

XII. Coordination with Other Donors

The Africa Bureau, both in multilateral fora and in individual countries, works closely with other donors in child survival activities. Collaboration with multilateral entities is as follows:

- o Cooperation for Development in Africa (CDA) -- The Health Technical Committee of CDA meets semi-annually, chaired by a representative of AFR/TR, to exchange information on technical information, projects and funding. The CDA membership includes the United Kingdom, Canada, France, Italy, West Germany and the United States. At present, AFR/TR is coordinating an effort to exchange microcomputer data files on all child survival and health-related activities so that all donors will have a complete picture of donor activity in a country.

- o UNICEF - The major donor in Africa child survival activities, UNICEF also has a regional grant from AID to supplement their efforts. The Italian Government has pledged \$100 million over five years for immunization activities and AID has granted the organization \$6 million for child survival efforts in Nigeria, to be conducted in collaboration with the ACSI-CCCD project (\$8 million). There is close collaboration with UNICEF in virtually all African countries in child survival in which AID also is working.

- o United Nations Development Programme (UNDP) -- AID granted UNDP \$3.5 million in fiscal 1985 for child survival projects in seven African countries. Presently under consideration is an amendment to this grant to add nutrition projects in several more African countries.

- o World Health Organization (WHO) -- Both the bilateral and regional missions, as well as AFR/TR, are in close contact with both WHO in Geneva and with their regional office in Brazzaville. WHO plans to incorporate more birth spacing in its Africa programs and has worked closely with REDSO/WCA on health manpower training in West Africa for the past ten years.

XIII. Implementation Plan for 1987 - 1991

1. Increase the number of bilateral mission funded child-survival projects by four by 1990.
2. Expand regional child survival interventions (ACSI-CCCD, training) from 14 to 20 countries by 1991.
3. Expand technical assistance support to child-survival activities through continued funding and expansion if indicated of the following projects and activities and activities: PRITECH, REACH, WASH, HEALTHCOM and SUPPORT.
4. Increase PVO support for child-survival activities from six in FY 87 to 15 in FY 91
5. Coordinate, where possible, with population sector programs to maximize access and usage of both services.
6. Increase support to WHO, UNICEF, and UNDP for targeted child-survival activities.
7. In areas of famine (refugees, natural disaster) and in coordination with UN and Food for Peace initiatives, PVO support for the alleviation of hunger and the maintenance of health will be developed more fully.
8. Implement five pilot projects and studies on approaches to working with communities to strengthen nutrition monitoring and expand interventions in eight countries.
9. Research funding will focus on new priority technologies (S&T), development of African capabilities in research and in operational research in five countries.

MANDATE FOR INCREASED COMMITMENT TO CHILD SURVIVAL

Recent enhanced interest in child survival as the top priority for health sector interventions has been manifested in several ways. Within AID, recognition of the potential impact of ORT has led to the agency's sponsorship of two international conferences on oral rehydration therapy, as well as regional ORT conferences in Asia and Africa. More recently, immunization has been added to AID's priority list, becoming the second of the twin engines for the AID Child Survival Strategy. The Bellagio Conference and the follow-up meeting in Cartagena provided forums for all the leading international and bilateral agencies to focus on developing common strategies for the implementation of child-survival programs in the developing world.

In Africa, the Africa Bureau's Combatting Childhood Communicable Diseases Project has led the way as the Agency's first and largest Child Survival project. UNICEF and WHO are working in concert with AID and other donors in strengthening child-survival programs around the world. Special emphasis has been given to Africa because of the special needs there. Recently, Italy pledged \$100 million to UNICEF for expanded immunization programs in Africa. UNICEF has shifted 100 of its overseas staff positions to posts in Africa, in part to help expand activities in the child-survival sector.

In FY 1985, additional funds appropriated by Congress for child survival allowed AID to accelerate its efforts to improve the health of children in AID-assisted countries and passed a resolution (S.CON.RES.78) "In support of universal access to immunization by 1990 and accelerated efforts to eradicate childhood diseases". In FY 1986 Congress again appropriated additional funds for child survival. For FY 1987 AID requested a separate child survival account. Funding for Child Survival activities and projects will also be derived from from other accounts, including Health, Population, ESF, Sahel, and PL480. In future years funding will continue to come from a variety of Agency accounts, reflecting the multi-disciplinary requirements of this strategy.

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| COUNTRY | \$000s FY1985 | PERCENT | \$000s FY1982-86 | PERCENT | 1984 POPUL (MILLIONS) | POP AS % AFRICA | AID P/CAPITA FY82--86 | 1984 IMR | 1984 CBR | 1984 BIRTHS | 1984 # INFANT DEATHS | 1984 % INFANT DEATHS |
|------------|------------------|---------|---------------------|---------|--------------------------|--------------------|-----------------------------|-------------|-------------|----------------|----------------------------|----------------------------|
| NIGERIA | 0 | 0.0% | 0 | 0.0% | 88.1 | 20.6% | 0 | 134 | 49 | 4316900 | 578465 | 23.6 |
| ETHIOPIA | | | | | 32.0 | 7.5% | | 146 | 47 | 1504000 | 219584 | 9.0 |
| ZAIRE | 33294 | 4.2% | 113673 | 3.2% | 32.2 | 7.5% | 4 | 111 | 46 | 1481200 | 164413 | 6.7 |
| SUDAN | 142000 | 18.0% | 671434 | 19.0% | 21.1 | 4.9% | 32 | 123 | 47 | 991700 | 121979 | 5.0 |
| S. AFRICA | | | | | 31.7 | 7.4% | | 95 | 35 | 1109500 | 105403 | 4.3 |
| TANZANIA | 0 | 0.0% | 11836 | 0.3% | 21.2 | 4.9% | 1 | 102 | 46 | 975200 | 99470 | 4.1 |
| KENYA | 42000 | 5.3% | 251505 | 7.1% | 19.4 | 4.5% | 13 | 86 | 53 | 1028200 | 98425 | 3.6 |
| GHANA | 1000 | 0.1% | 5368 | 0.2% | 14.3 | 3.3% | 0 | 102 | 48 | 686400 | 70013 | 2.9 |
| MOZAMBIQUE | 13000 | 1.6% | 38000 | 1.1% | 13.4 | 3.1% | 3 | 114 | 45 | 603000 | 68742 | 2.8 |
| BURKINA F | 1790 | 0.2% | 15242 | 0.4% | 6.7 | 1.6% | 2 | 210 | 48 | 321600 | 67536 | 2.8 |
| UGANDA | 7900 | 1.0% | 39349 | 1.1% | 14.3 | 3.3% | 3 | 96 | 46 | 657800 | 63149 | 2.6 |
| MALAWI | 9700 | 1.2% | 42109 | 1.2% | 6.9 | 1.6% | 6 | 170 | 51 | 351900 | 59823 | 2.4 |
| ANGOLA | | | | | 7.8 | 1.8% | | 153 | 47 | 366600 | 56090 | 2.3 |
| MALI | 12000 | 1.5% | 52693 | 1.5% | 7.6 | 1.8% | 7 | 153 | 46 | 349600 | 53489 | 2.2 |
| IVORY COAS | | | | | 9.2 | 2.1% | | 126 | 46 | 423200 | 53323 | 2.2 |
| NIGER | 25000 | 3.2% | 107594 | 3.0% | 6.3 | 1.5% | 17 | 144 | 51 | 321300 | 46267 | 1.9 |
| SENEGAL | 35000 | 4.4% | 138143 | 3.9% | 6.5 | 1.5% | 21 | 146 | 48 | 312000 | 45552 | 1.9 |
| CAMEROON | 20500 | 2.6% | 98745 | 2.8% | 9.4 | 2.2% | 11 | 108 | 44 | 413600 | 44669 | 1.8 |
| GUINEA | 2600 | 0.3% | 11352 | 0.3% | 5.6 | 1.3% | 2 | 164 | 47 | 263200 | 43165 | 1.8 |
| SOMALIA | 50740 | 6.4% | 236481 | 6.7% | 5.7 | 1.3% | 41 | 146 | 47 | 267900 | 39113 | 1.6 |
| SIERRA L | 1300 | 0.2% | 7848 | 0.2% | 3.9 | 0.9% | 2 | 206 | 45 | 175500 | 36153 | 1.5 |
| ZAMBIA | 15000 | 1.9% | 94304 | 2.7% | 6.6 | 1.5% | 14 | 105 | 48 | 316800 | 33264 | 1.4 |
| CHAD | 13725 | 1.7% | 39047 | 1.1% | 5.0 | 1.2% | 8 | 147 | 44 | 220000 | 32340 | 1.3 |
| MADAGASCAR | 5000 | 0.6% | 10000 | 0.3% | 9.8 | 2.3% | 1 | 70 | 46 | 450800 | 31556 | 1.3 |
| RWANDA | 6238 | 0.8% | 29275 | 0.8% | 5.8 | 1.4% | 5 | 106 | 49 | 284200 | 30125 | 1.2 |
| BENIN | 0 | 0.0% | 0 | 0.0% | 3.9 | 0.9% | 0 | 153 | 49 | 191100 | 29238 | 1.2 |
| ZIMBABWE | 28000 | 3.6% | 231000 | 6.5% | 8.3 | 1.9% | 28 | 73 | 47 | 390100 | 28477 | 1.2 |
| BURUNDI | 4300 | 0.5% | 22796 | 0.6% | 4.7 | 1.1% | 5 | 121 | 47 | 220900 | 26729 | 1.1 |
| CAR | 2000 | 0.3% | 6200 | 0.2% | 2.6 | 0.6% | 2 | 147 | 46 | 119600 | 17581 | 0.7 |
| LIBERIA | 57122 | 7.2% | 259924 | 7.3% | 2.2 | 0.5% | 118 | 153 | 45 | 99000 | 15147 | 0.6 |
| TOGO | 3100 | 0.4% | 17144 | 0.5% | 2.9 | 0.7% | 6 | 108 | 47 | 136300 | 14720 | 0.6 |
| MAURITANIA | 8862 | 1.1% | 26705 | 0.8% | 1.8 | 0.4% | 15 | 142 | 50 | 90000 | 12780 | 0.5 |
| CONGO | 1000 | 0.1% | 5000 | 0.1% | 1.7 | 0.4% | 3 | 128 | 44 | 74800 | 9574 | 0.4 |
| LESOTHO | 10300 | 1.3% | 52810 | 1.5% | 1.5 | 0.4% | 35 | 120 | 41 | 61500 | 7380 | 0.3 |
| GAMBIA | 4000 | 0.5% | 16855 | 0.5% | 0.7 | 0.2% | 24 | 197 | 49 | 34300 | 6757 | 0.3 |
| NAMIBIA | | | | | 1.1 | 0.3% | | 119 | 43 | 47300 | 5629 | 0.2 |
| GUINEA-B | 2500 | 0.3% | 10920 | 0.3% | 0.8 | 0.2% | 14 | 147 | 42 | 33600 | 4939 | 0.2 |
| BOTSWANA | 10000 | 1.3% | 51784 | 1.5% | 1.0 | 0.2% | 52 | 82 | 50 | 50000 | 4100 | 0.2 |
| GABON | | | | | 1.0 | 0.2% | | 116 | 35 | 35000 | 4060 | 0.2 |
| SWAZILAND | 7597 | 1.0% | 35851 | 1.0% | 0.6 | 0.1% | 60 | 134 | 48 | 28800 | 3859 | 0.2 |
| COMOROS | 400 | 0.1% | 1880 | 0.1% | 0.5 | 0.1% | 4 | 92 | 46 | 23000 | 2116 | 0.1 |
| EQ GUINEA | 1000 | 0.1% | 5000 | 0.1% | 0.3 | 0.1% | 17 | 142 | 42 | 12600 | 1789 | 0.1 |
| DJIBOUTI | 3500 | 0.4% | 15486 | 0.4% | 0.3 | 0.1% | 52 | 100 | 47 | 14100 | 1410 | 0.1 |
| CAPE VERDE | 2000 | 0.3% | 11660 | 0.3% | 0.3 | 0.1% | 39 | 81 | 35 | 10500 | 851 | 0.0 |
| MAURITIUS | 2000 | 0.3% | 14000 | 0.4% | 1.0 | 0.2% | 14 | 30 | 23 | 23000 | 690 | 0.0 |
| SAD T/PRCP | 300 | 0.0% | 600 | 0.0% | 0.1 | 0.0% | 6 | 69 | 39 | 3900 | 269 | 0.0 |
| REUNION | | | | | 0.5 | 0.1% | | 14 | 23 | 11500 | 161 | 0.0 |
| SEYCHELLES | 2000 | 0.3% | 10000 | 0.3% | 0.1 | 0.0% | 100 | 19 | 24 | 2400 | 46 | 0.0 |
| REG AFR | 151056 | 19.2% | 472141 | 13.3% | | | | | | | | |
| REG SA | 26000 | 3.3% | 112744 | 3.2% | | | | | | | | |
| REG SAHEL | 23761 | 3.0% | 148236 | 4.2% | | | | | | | | |
| TOTALS--> | 788485 | 100% | 3542734 | 100.0% | 428.4 | 100.0% | 785 | 5750 | 2131 | 19905400 | 2450411 | 100.0 |

| COUNTRY | POPULATION MILLIONS | POP AS % AFFILI- | 1984 INF | 1984 CBF | 1984 BIRTHS | INFANT DEATHS | % OF ALL INFANT DEATHS | 1984 CDF | TOTAL DEATHS YF | DEATHS/1000 POP |
|-------------|------------------------|---------------------|-------------|-------------|----------------|------------------|------------------------------|-------------|--------------------|--------------------|
| NIGERIA | 96.1 | 20.6% | 134 | 49 | 4316900 | 579465 | 23.5% | 17 | 1497700 | 4.7 |
| ETHIOPIA | 32.0 | 7.5% | 146 | 47 | 1504000 | 219584 | 5.0% | 23 | 736000 | 6.3 |
| ZAIRE | 32.2 | 7.5% | 111 | 46 | 1461200 | 164417 | 6.7% | 17 | 547400 | 4.7 |
| SUDAN | 21.1 | 4.9% | 127 | 47 | 991700 | 121979 | 5.0% | 17 | 356700 | 4.7 |
| S. AFRICA | 31.7 | 7.4% | 95 | 35 | 1109500 | 105407 | 4.3% | 16 | 317000 | 2.7 |
| TANZANIA | 21.2 | 4.9% | 102 | 46 | 975200 | 99476 | 4.1% | 14 | 296800 | 3.8 |
| KENYA | 19.4 | 4.5% | 86 | 50 | 1028200 | 88425 | 3.6% | 17 | 252200 | 3.6 |
| GHANA | 14.3 | 3.3% | 102 | 46 | 686400 | 70013 | 2.9% | 16 | 228800 | 4.4 |
| MOZAMBIQUE | 13.4 | 3.1% | 114 | 45 | 603000 | 68742 | 2.8% | 17 | 227800 | 4.7 |
| BURKINA | 6.7 | 1.6% | 210 | 49 | 321600 | 67536 | 2.6% | 22 | 147400 | 6.0 |
| USANDA | 14.3 | 3.3% | 96 | 46 | 657800 | 63149 | 2.6% | 15 | 214500 | 4.1 |
| MALAWI | 6.9 | 1.6% | 176 | 51 | 351900 | 59827 | 2.4% | 19 | 131100 | 5.2 |
| ANGOLA | 7.8 | 1.8% | 157 | 47 | 366600 | 56096 | 2.3% | 22 | 171600 | 6.6 |
| MALI | 7.6 | 1.8% | 157 | 46 | 349600 | 53469 | 2.2% | 22 | 167200 | 6.0 |
| IVORY COAST | 5.2 | 2.1% | 126 | 46 | 423200 | 53327 | 2.2% | 17 | 156400 | 4.7 |
| NIGER | 6.3 | 1.5% | 144 | 51 | 321300 | 46267 | 1.9% | 22 | 138600 | 6.0 |
| SENEGAL | 6.5 | 1.5% | 146 | 48 | 312000 | 45552 | 1.9% | 18 | 117000 | 4.9 |
| CAMEROON | 9.4 | 2.2% | 106 | 44 | 413600 | 44669 | 1.8% | 18 | 169200 | 4.9 |
| GUINEA | 5.6 | 1.3% | 164 | 47 | 263200 | 43165 | 1.8% | 19 | 106400 | 5.2 |
| SOMALIA | 5.7 | 1.3% | 146 | 47 | 267900 | 39113 | 1.6% | 21 | 119700 | 5.8 |
| SIERRA L. | 3.9 | 0.9% | 206 | 45 | 175500 | 36152 | 1.5% | 19 | 74100 | 5.2 |
| ZAMBIA | 6.6 | 1.5% | 105 | 46 | 316800 | 37264 | 1.4% | 16 | 105600 | 4.4 |
| CHAD | 5.0 | 1.2% | 147 | 44 | 220000 | 32346 | 1.3% | 23 | 115000 | 6.3 |
| MADAGASCAR | 9.8 | 2.3% | 70 | 46 | 450600 | 31556 | 1.3% | 16 | 176400 | 4.9 |
| RWANDA | 5.8 | 1.4% | 106 | 45 | 284200 | 36123 | 1.2% | 18 | 104400 | 4.9 |
| BENIN | 3.9 | 0.9% | 150 | 45 | 191100 | 29238 | 1.2% | 19 | 74100 | 5.2 |
| ZIMBABWE | 6.3 | 1.5% | 70 | 47 | 350100 | 26477 | 1.2% | 13 | 107900 | 3.6 |
| BURUNDI | 4.7 | 1.1% | 121 | 47 | 220900 | 26729 | 1.1% | 21 | 96700 | 5.8 |
| CAF | 2.6 | 0.6% | 147 | 46 | 119600 | 17581 | 0.7% | 20 | 52000 | 5.5 |
| LIBERIA | 2.2 | 0.5% | 153 | 45 | 99000 | 15147 | 0.6% | 15 | 33000 | 4.1 |
| TOGO | 2.9 | 0.7% | 108 | 47 | 136300 | 14720 | 0.6% | 18 | 52200 | 4.9 |
| MAURITANIA | 1.8 | 0.4% | 142 | 50 | 90000 | 12786 | 0.5% | 22 | 39600 | 6.0 |
| CONGO | 1.7 | 0.4% | 128 | 44 | 74800 | 9574 | 0.4% | 18 | 30600 | 4.9 |
| LESOTHO | 1.5 | 0.4% | 126 | 41 | 61500 | 7380 | 0.3% | 12 | 18000 | 3.3 |
| GAMBIA | 0.7 | 0.2% | 197 | 49 | 34300 | 6757 | 0.3% | 28 | 19600 | 7.7 |
| NAMIBIA | 1.1 | 0.3% | 119 | 43 | 47300 | 5629 | 0.2% | 14 | 15400 | 3.8 |
| GUINEA-B | 0.8 | 0.2% | 147 | 42 | 33600 | 4939 | 0.2% | 22 | 17600 | 6.0 |
| BOTSWANA | 1.0 | 0.2% | 82 | 50 | 50000 | 4106 | 0.2% | 16 | 16000 | 4.4 |
| SABON | 1.0 | 0.2% | 116 | 35 | 35000 | 4060 | 0.2% | 20 | 20000 | 5.5 |
| SWAZILAND | 0.6 | 0.1% | 134 | 48 | 28800 | 3859 | 0.2% | 16 | 9600 | 4.4 |
| COMOROS | 0.5 | 0.1% | 92 | 46 | 23000 | 2116 | 0.1% | 17 | 8500 | 4.7 |
| EQ GUINEA | 0.3 | 0.1% | 142 | 42 | 12600 | 1789 | 0.1% | 18 | 5400 | 4.9 |
| DJIBOUTI | 0.3 | 0.1% | 100 | 47 | 14100 | 1410 | 0.1% | 21 | 6300 | 5.8 |
| CAPE VERDE | 0.3 | 0.1% | 81 | 35 | 10500 | 851 | 0.0% | 8 | 2400 | 2.2 |
| MAURITIUS | 1.0 | 0.2% | 30 | 23 | 23000 | 690 | 0.0% | 7 | 7000 | 1.9 |
| SAG T/PRCP | 0.1 | 0.0% | 69 | 39 | 3900 | 269 | 0.0% | 10 | 1000 | 2.7 |
| REUNION | 0.5 | 0.1% | 14 | 23 | 11500 | 161 | 0.0% | 6 | 3000 | 1.6 |
| SEYCHELLES | 0.1 | 0.0% | 19 | 24 | 2400 | 46 | 0.0% | 8 | 800 | 2.2 |
| TOTALS--> | 428 | 100.0% | | | 19905400 | 2450411 | 100.0% | | 7315700 | 4.7 |

AFR/TR:WT:10/9/85

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62

Trends in ~~infant and child mortality~~ in Africa
(Drafted by NYinger AFR/TR/POP 2/11/85)

Sources of Data

There are three readily available sources of national level infant (ages 0-1) and child (ages 1-4) mortality data for Africa: The United Nations (UN), the World Bank (WB) and the Population Reference Bureau (PRB). Although UN data underlie the WB and PRB estimates, the figures do differ slightly. Variations arise because all the figures are basically extrapolations from inadequate data sources--poor or out-of-date censuses and sample surveys, and the three groups make slightly different educated guesses about the parameters. In general, however, infant and child mortality rates from all sources lie within the same range for any given country. In following sections of this memo, data will be drawn from the World Bank, 1984 World Development Report.

The effects of drought

Unfortunately, the kinds of aggregate statistics available from the UN, WB and PRB are not useful for tracking the effects of severe drought on infant and child mortality, and in fact over time, show a continuous downward trend in both infant (IMR) and child (Ch.MR) rates. ("Normal" mortality levels will be discussed below.) Further, assuming the underlying data were adequate enough to be sensitive to drought effects, statistics usually take 2 or 3 years to update and thus increases in the IMR would show up only after a time lag. For example, 1984 PRB estimates for the drought stricken countries compared to 1982. WB estimates indicated slightly increased infant mortality levels in Ethiopia, Niger, and Mali, constant levels in the Sudan, Mauritania, and the Ivory Coast, and decreased levels in Somalia, Chad, and Senegal. Small scale village studies of the 1970s drought in the Sahel indicated that infant mortality does not necessarily rise. Because fertility declines during drought, those babies who would have been at highest risk of dying are never born. At least one study found that the downward (i.e., improving) trend in infant mortality rates actually continued, but at a slower rate. The fertility effects of drought would not protect children age 1-4 and one might expect to see a rise in the child death rate. Unfortunately, available data are insufficient to demonstrate this effect.

"Normal" Infant and Child Mortality

In 1982, the IMR range was from 190 deaths per 1000 births in Guinea and Sierra Leone, 184 in Somalia and 161 in Chad to 109

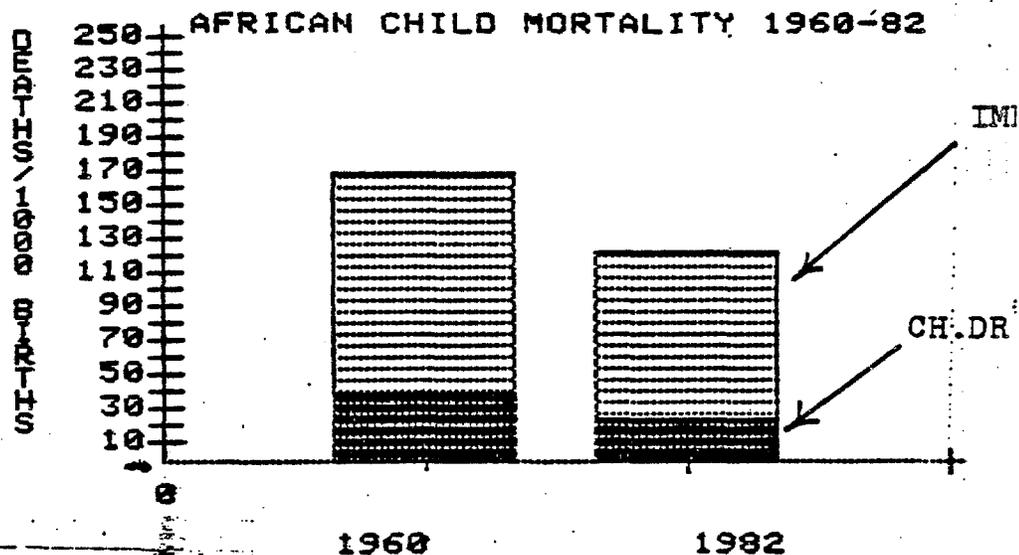
in Nigeria, 83 in Zimbabwe, 77 in Kenya, and 34 in Mauritius, with the overall average for Sub-Saharan countries being 121. In 1962 the overall average was 168, and the range was from 235 in Sierra Leone to 70 in Mauritius. In 1962, eight countries recorded levels over 200--meaning that at least 20% of all babies born died during their first year, and only one country was below 100. In 1982, the World Bank estimated that no African country had an IMR over 200 and nine had levels under 100. In general, the 1982 IMRs are about 3/4 the 1960 rates. Despite these improvements, the levels in Africa are still the highest in the world. The overall average for low income countries, including China and India, is 87 deaths per 1000 births, for middle income countries 76 per 1000, and for industrial market economies 10 per 1000. In general, West Africa and the Sahelian countries have higher IMRs than east and central Africa. Some exceptions are Malawi and Somalia which have high "West African" levels, 134 and 187 respectively, and Ghana (86), Liberia (91) and the Cameroons (92) which have "East African" levels.

Child death rates appear to have fallen slightly more than IMRs with the average 1982 rate of 24 being 3/5 the 1960 level of 41. The rank order is essentially the same as for IMR with the range being from 50 deaths per 1000 1-4 year olds in Guinea and Sierra Leone to 20 for Nigeria, 13 for Kenya and 3 for Mauritius.

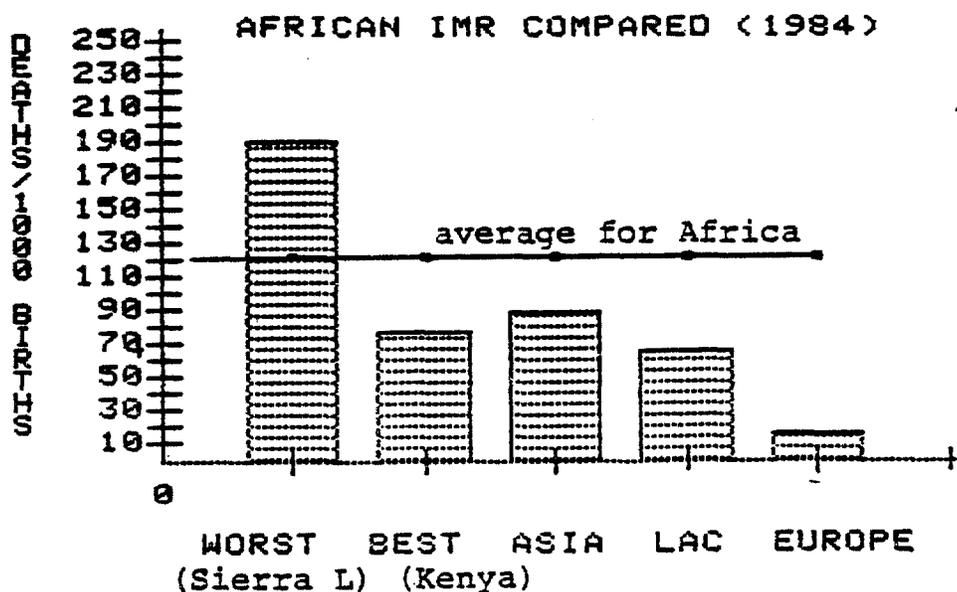
The high levels of infant and child mortality in Africa mean that of all the babies born, on average only 86% will survive to age 5, in Guinea and Somalia only 79%, in Senegal 81%, Ethiopia and the Ivory Coast 86%, Nigeria 87%, Kenya 91%, and 96% in Mauritius. The overall average for low income countries is a 90% survival rate and for the industrial market economies, 99%.

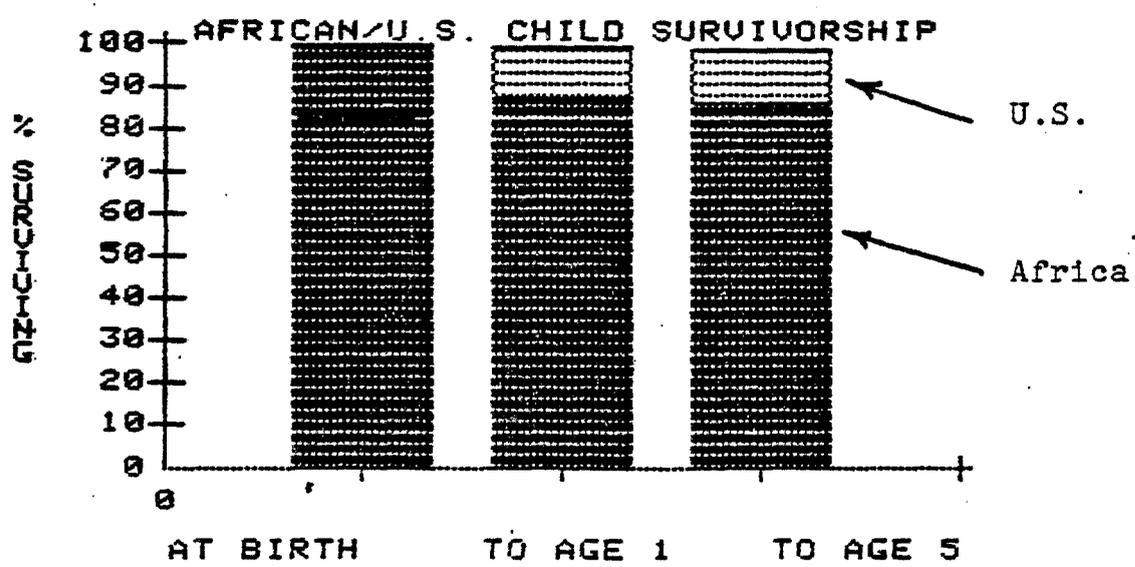
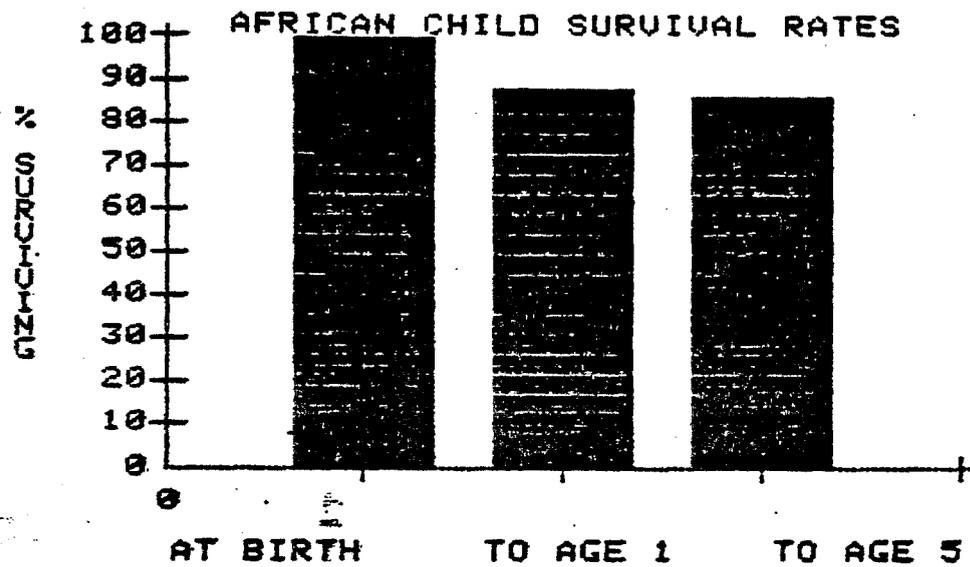
As a closing note, it must be stressed that aggregate mortality data for most African countries do not necessarily paint the complete picture. Not only do the aggregate figures mask urban-rural differences, but also mortality levels projected from old censuses and surveys are uniformly assumed to include declines. It would, therefore, be imprudent to consider them sufficiently reliable at the country level to influence many program decisions.

64



* IMR=Infant Mortality Rate (age 0-1)
 ** CH.DR=Child Death Rate (age 1-4)





| COUNTRY | IMR82 | IMR60 | CH. DR82 | CH. DR60 |
|------------|-------|-------|----------|----------|
| SIERRA L | 190 | 235 | 50 | 72 |
| GUINEA | 190 | 222 | 50 | 65 |
| SOMALIA | 184 | 213 | 47 | 61 |
| ANGOLA | 165 | 216 | 29 | 63 |
| CHAD | 161 | 210 | 37 | 60 |
| BURKINA F | 157 | 234 | 36 | 71 |
| SENEGAL | 155 | 178 | 34 | 45 |
| GUINEA-B | 150 | 190 | 31 | 44 |
| MALAWI | 137 | 206 | 29 | 58 |
| NIGER | 132 | 178 | 27 | 45 |
| MAURITANIA | 132 | 178 | 27 | 45 |
| MALI | 132 | 179 | 27 | 45 |
| RWANDA | 126 | 167 | 25 | 40 |
| BURUNDI | 123 | 143 | 24 | 31 |
| TOGO | 122 | 201 | 25 | 55 |
| ETHIOPIA | 122 | 172 | 25 | 42 |
| UGANDA | 120 | 139 | 22 | 28 |
| SUDAN | 119 | 168 | 23 | 40 |
| IVORY COAS | 119 | 167 | 23 | 40 |
| CAR | 119 | 170 | 23 | 41 |
| BENIN | 117 | 173 | 23 | 42 |
| MADAGASCAR | 116 | 177 | 23 | 45 |
| NIGERIA | 109 | 190 | 20 | 50 |
| ZAIRE | 106 | 150 | 20 | 32 |
| ZAMBIA | 105 | 164 | 20 | 38 |
| MOZAMBIQUE | 105 | 154 | 20 | 34 |
| TANZANIA | 98 | 144 | 18 | 31 |
| LESOTHO | 94 | 137 | 17 | 29 |
| CAMEROON | 92 | 134 | 16 | 28 |
| LIBERIA | 91 | 173 | 16 | 42 |
| GHANA | 86 | 132 | 15 | 27 |
| ZIMBABWE | 83 | 100 | 14 | 19 |
| KENYA | 77 | 112 | 13 | 21 |
| CONGO* | 68 | 118 | 10 | 23 |
| MAURITIUS | 34 | 70 | 3 | 11 |

*Figures for the Congo seem implausibly low (CF PRB Figure of 128 IMR for 1982)

EXAMPLES OF ESTIMATED ACCESS AND USE RATES FOR ORAL REHYDRATION THERAPY
for countries with active CDD programmes and from which the most
data were available, 1983

| Country | ORS access rate (%) ^a | ORS use rate (%) ^b | ORT knowledge rate (%) ^c | ORT ever used (%) ^d |
|-------------|----------------------------------|-------------------------------|-------------------------------------|--------------------------------|
| Bangladesh | 20 | 8 | 25 | 6 |
| Bolivia | 35 | | | |
| ✓ Botswana | 85 | | | |
| Colombia | 35 | 15 | | |
| Cuba | 80 | | | |
| Egypt | 50 | 16 | | |
| ✓ Gambia | | | 80 | 47-66 |
| Haiti | 60 | 35 | | |
| Honduras | 60 | 26 | | |
| Indonesia | 33 | 17 | | |
| Jamaica | 40 | 15 | | |
| Jordan | 32 | 6 | | |
| ✓ Lesotho | 21 | | 80 | 50 |
| Maldives | 100 | 25 | | |
| Nepal | 14 | | | |
| Nicaragua | 80 | 45 | | |
| Pakistan | 33 | 6 | | |
| Philippines | 70 | 25 | | |
| Sri Lanka | 20 | 4 | | |
| ✓ Sudan | 23 | 3 | | |
| Suriname | 40 | 5 | | |
| Thailand | 60 | 35 | | |
| Viet Nam | 35 | 5 | | |
| Zimbabwe | | | 80 | 50 |

^aEstimated proportion of diarrhoea episodes with reasonable access to oral rehydration salts (ORS). In 6 countries estimates were based on reported ORS distribution or supply figures assuming 10% of episodes require ORS and that 50% of packets remain undistributed, spoil, or for other reasons are not available to diarrhoea cases in the 0-4 years age group.

^bEstimated proportion of diarrhoea episodes actually treated with ORS.

^cProportion of mothers who indicated they knew about oral rehydration therapy (ORS or household fluids).

^dBangladesh - proportion of diarrhoea episodes treated with household fluids; other countries - proportion of mothers who have ever used ORS or household fluids to treat diarrhoea.

AFRICAN REGION: ESTIMATED IMMUNIZATION COVERAGE
AND DELIVERY (1985 UPDATE)

| COUNTRY | GEOGRAPHIC COVERAGE % | FULLY IMMUNIZED UNDER ONE % | IMMUNIZATION DELIVERY | | |
|-------------------------|-----------------------------|--------------------------------------|-----------------------|---------------|----------------------|
| | | | H/FACILITY % | OUTREACH % | MOBILE TEAMS % |
| ALGERIA | 95 | 30 | 50 | 30 | 20 |
| ANGOLA | 35 | 46 | 75 | 0 | 25 |
| BENIN | 85 | - | - | - | - |
| BOTSWANA | 100 | 62 | 85 | 15 | 0 |
| BURKINA FASO | 10 | 5 | 5 | 0 | 95 |
| BURUNDI | 94 | 55 | 100 | 0 | 0 |
| CAPE VERDE | 100 | ... | ... | ... | ... |
| CENTRAL AFRICAN REP. | - | - | - | - | - |
| CHAD | 40 | 40 | - | - | - |
| COMOROS | ... | - | - | - | - |
| CONGO | 65 | 50 | 65 | 0 | 35 |
| EQUATORIAL GUINEA | 60 | 20 | 70 | 30 | 0 |
| ETHIOPIA | 16 | - | 92 | 8 | - |
| GABON | 80 | 30 | - | - | - |
| GAMBIA | 100 | 55 | 75 | 25 | 0 |
| GHANA | ... | - | - | - | - |
| GUINEA | ... | - | - | - | - |
| GUINEA BISSAU | 70 | 15 | 50 | 30 | 20 |
| IVORY COAST | ... | - | - | - | - |
| KENYA | 43 | 30 | 80 | 20 | - |
| LESOTHO | 100 | 58 | - | - | - |
| LIBERIA | - | - | 80 | 20 | 0 |
| MADAGASCAR | 60 | 40 | 70 | 10 | 20 |
| MALAWI | 85 | 55 | - | - | - |
| MALI | 21 | - | - | - | - |
| MAURITANIA | 100 | 13 | 20 | 10 | 70 |
| MAURITIUS | 100 | 50 | 10 | 90 | 0 |
| MOZAMBIQUE | - | - | - | - | - |
| NAMIBIA | 100 | 70 | 75 | 25 | 0 |
| NIGER | 100 | - | - | - | - |
| NIGERIA | 60 | 15-25 | 60 | 20 | 20 |
| REUNION | ... | - | - | - | - |
| RWANDA | 100 | 50 | 75 | 25 | 0 |
| SAO TOME AND PRINCIPE | 100 | 65 | 100 | 0 | 0 |
| SENEGAL | 100 | 20 | ... | - | - |
| SEYCHELLES | - | - | ... | ... | ... |
| SIERRA LEONE | 92 | 27 | - | - | - |
| ST HELENA | ... | - | - | - | - |
| SWAZILAND | - | 24 | - | - | - |
| TOGO | 70 | 6 | - | - | - |
| UGANDA | 25 | - | - | - | - |
| UNITED REP. OF CAMEROON | 24 | 14 | 70 | 30 | 0 |
| UNITED REP. OF TANZANIA | 100 | 18-30 | 90 | 5 | 5 |
| ZAIRE | 50 | 24 | 60 | 30 | 10 |
| ZAMBIA | 100 | 80 | 75 | 25 | 0 |
| ZIMBABWE | 100 | 45 | 55 | 35 | 10 |

... Data not available

- Estimate not given

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69

Africa Bureau
Office of Development Planning
African Child Survival Program
Summary - FY's 85 - 86 - 87 - 88
(\$000)

| APPROPRIATION | FY 1985 ACTUAL | | FY 1986 | | FY 1987 | | FY 1988 | |
|-------------------------------|-------------------|-----------------|----------|--------|----------|--------|----------|--------|
| | OBLIG. PROJECT | OBLIG. \$ CS | APR. OYB | \$ CS | REV. ABS | \$ CS | REV. ABS | \$ CS |
| <u>DEVELOPMENT ASSISTANCE</u> | | | | | | | | |
| Health | 46,464 | 19,217 | 36,664 | 20,314 | 27,097 | 20,767 | 26,080 | 17,900 |
| Sahel Development Program | 16,795 | 2,902 | 12,384 | 5,938 | 14,140 | 5,840 | 7,310 | 3,830 |
| Economic Support Fund | 1292 | 232 | 0 | 0 | 0 | 0 | 0 | 0 |
| Child Survival Fund | 3500 | 3500 | 4000 | 4000 | 2000 | 2000 | 2000 | 2000 |
| Africa Bureau Total | 68,051 | 25,851 | 53,048 | 30,252 | 43,237 | 28,607 | 35,390 | 23,730 |

dp

Ernest

Africa Bureau
Office of Development Planning
African Child Survival Program
FY's 85 - 86 - 87 - 88

| COUNTRY/TITLE/NUMBER | APPROP. | FY 1985 ACTUAL | | FY 1986 | | FY 1987 | | FY 1988 | | |
|-------------------------------|---------------|----------------|--------------|----------|-------|----------|-------|----------|-------|--|
| | | OBLIG. PROJECT | OBLIG. \$ CS | APR. OYB | \$ CS | REV. ABS | \$ CS | REV. ABS | \$ CS | |
| DEVELOPMENT ASSISTANCE | | | | | | | | | | |
| Cameroon: (631) | | | | | | | | | | |
| MCH Support | - 0056 Health | 0 | 0 | 0 | 0 | 3010 | 2000 | 4900 | 2000 | |
| Cameroon PDS | - 0510 Health | 0 | 0 | 400 | 0 | 0 | 0 | 0 | 0 | |
| Congo: (679) | | | | | | | | | | |
| Nutrition Ed. II | - 0006 Health | 188 | 188 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Kenya: (615) | | | | | | | | | | |
| Health Plng./Info | - 0187 Health | 100 | 100 | 0 | 0 | 0 | 0 | 0 | 0 | |
| FP Ser. & Support | - 0232 Health | 250 | 250 | 2479 | 2479 | 1394 | 1394 | 0 | 0 | |
| PVO Co-Financing | - 0236 Health | 2000 | 600 | 0 | 0 | 1008 | 1000 | 0 | 0 | |
| Kenya PDS | - 0510 Health | 65 | 0 | 20 | 0 | 106 | 0 | 0 | 0 | |
| Lesotho: (632) | | | | | | | | | | |
| Rural Water/Sanit | - 0088 Health | 1294 | 129 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Liberia: (669) | | | | | | | | | | |
| Primary Health Care | - 0165 Health | 3021 | 1500 | 3610 | 2235 | 1573 | 1573 | 0 | 0 | |
| PVO & NGO Support | - 0211 Health | 0 | 0 | 0 | 0 | 200 | 100 | 800 | 400 | |
| Liberia PDS | - 0510 Health | 30 | 0 | 30 | 0 | 53 | 0 | 30 | 0 | |
| Malawi: (612) | | | | | | | | | | |
| Health Inst. Dev. | - 0211 Health | 2000 | 200 | 1920 | 200 | 1000 | 200 | 0 | 0 | |
| Family Planning | - 0226 Health | 0 | 0 | 0 | 0 | 0 | 0 | 3500 | 2500 | |
| Somalia: (649) | | | | | | | | | | |
| PVO Dev. Partners | - 0138 Health | 2000 | 2000 | 4600 | 750 | 1100 | 600 | 0 | 0 | |
| Sudan: (650) | | | | | | | | | | |
| Rural Health Supt. | - 0030 Health | 1082 | 541 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Sudan PDS | - 0510 Health | 50 | 0 | 350 | 0 | 50 | 0 | 50 | 0 | |

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11

Africa Bureau
Office of Development Planning
African Child Survival Program
FY's 85 - 86 - 87 - 88

| COUNTRY/TITLE/NUMBER | APPROP. | FY 1985 ACTUAL | | FY 1986 | | FY 1987 | | FY 1988 | |
|---------------------------|---------|----------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| | | OBLIG. | OBLIG. | AFR. OVB | \$ CS | REV. ABS | \$ CS | REV. ABS | \$ CS |
| Swaziland: (645) | | | | | | | | | |
| Health Plng./Mgt. - 0215 | Health | 130 | 13 | 0 | 0 | 0 | 0 | 0 | 0 |
| Rural Health Dev. - 0220 | Health | 2000 | 1000 | 983 | 550 | 1000 | 500 | 1000 | 500 |
| Togo: (693) | | | | | | | | | |
| Rural Water Supply- 0210 | Health | 1680 | 160 | 0 | 0 | 0 | 0 | 0 | 0 |
| Health Sector Plng.-0228 | Health | 0 | 0 | 0 | 0 | 911 | 900 | 1500 | 1500 |
| Uganda: (617) | | | | | | | | | |
| Oral Rehydration - 0107 | Health | 2050 | 2050 | 550 | 550 | 0 | 0 | 0 | 0 |
| Zaire: (660) | | | | | | | | | |
| Basic Rural Health- 0086 | Health | 110 | 50 | 0 | 0 | 0 | 0 | 0 | 0 |
| School Pub. Health- 0101 | Health | 2000 | 400 | 2235 | 200 | 0 | 0 | 0 | 0 |
| Basic Rur. Health II-0107 | Health | 4250 | 2125 | 2500 | 1250 | 4000 | 2000 | 4000 | 1500 |
| Kimbangulst Hosp. - 0122 | Health | 0 | 0 | 750 | 100 | 0 | 0 | 0 | 0 |
| Shaba Ref. Water Sup-0116 | Health | 2250 | 225 | 0 | 0 | 0 | 0 | 0 | 0 |
| Shaba Ref. Health - 0114 | Health | 2500 | 250 | 0 | 0 | 0 | 0 | 0 | 0 |
| Zaire PDS - 0510 | Health | 100 | 0 | 85 | 0 | 100 | 0 | 0 | 0 |
| Africa Regional (698) | | | | | | | | | |
| Africa Reg. CCCD - 0421 | Health | 6836 | 6836 | 11750 | 11750 | 10500 | 10500 | 9500 | 9500 |
| SH Delivery Sys. - 0398 | Health | 3100 | 600 | 500 | 250 | 0 | 0 | 0 | 0 |
| Oncbo. Phase II. - 0399 | Health | 1982 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Health Constraints- 0408 | Health | 3853 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Health Inst. Imp. - 0412 | Health | 375 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| AFR. Manpower II - 0433 | Health | 0 | 0 | 930 | 0 | 0 | 0 | 0 | 0 |
| AFR. Dev. Support - 0464 | Health | 0 | 0 | 250 | 0 | 300 | 0 | 300 | 0 |
| Israel Trng. - 0465 | Health | 0 | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| AIDS Control Prog.- 0468 | Health | 0 | 0 | 1000 | 0 | 0 | 0 | 0 | 0 |
| AID/W PDS - 0510 | Health | 1160 | 0 | 1672 | 0 | 800 | 0 | 500 | 0 |
| Total | | 46,464 | 19,217 | 36,664 | 20,314 | 27,097 | 20,767 | 26,080 | 17,900 |

7/9

Africa Bureau
Office of Development Planning
African Child Survival Program
FY's 85 - 86 - 87 - 88

| COUNTRY/TITLE/NUMBER | APPROP. | FY 1985 ACTUAL | | FY 1986 | | FY 1987 | | FY 1988 | |
|----------------------------------|---------|----------------|--------------|---------------|--------------|---------------|--------------|--------------|--------------|
| | | OBLIG. PROJECT | OBLIG. \$ CS | APR. OYB | \$ CS | REV. ABS | \$ CS | REV. ABS | \$ CS |
| SAHEL DEVELOPMENT PROGRAM | | | | | | | | | |
| Burkina: (686) | | | | | | | | | |
| Rural Water Supply- 0228 Sahel | | 1200 | 120 | 0 | 0 | 0 | 0 | 0 | 0 |
| FP Support - 0260 Sahel | | 0 | 0 | 1041 | 1041 | 290 | 290 | 0 | 0 |
| Strengthen Health - 0251 Sahel | | 0 | 0 | 1750 | 1750 | 0 | 0 | 0 | 0 |
| Chad: (677) | | | | | | | | | |
| Oral Rehy Therapy - 0934 Sahel | | 350 | 350 | 0 | 0 | 0 | 0 | 0 | 0 |
| Mali: (688) | | | | | | | | | |
| Integrated FH Ser's-0227 Sahel | | 0 | 0 | 1200 | 1200 | 1950 | 1950 | 2850 | 2850 |
| Niger: (683) | | | | | | | | | |
| Rural Health Imp. - 0208 Sahel | | 1400 | 200 | 900 | 100 | 0 | 0 | 0 | 0 |
| Rural Sec. Support- 0254 Sahel | | 0 | 0 | 3373 | 1687 | 6000 | 3000 | 1960 | 980 |
| Senegal: (685) | | | | | | | | | |
| Rural Health Ser. II-0242 Sahel | | 3514 | 2232 | 0 | 0 | 900 | 100 | 0 | 0 |
| FH Services II - 0248 Sahel | | 9450 | 0 | 0 | 0 | 2500 | 500 | 0 | 0 |
| Sahel Regional: (625) | | | | | | | | | |
| Oncho. Control - 0966 Sahel | | 0 | 0 | 2500 | 0 | 2500 | 0 | 2500 | 0 |
| Sahel Pop Init. - 0969 Sahel | | 881 | 0 | 1620 | 160 | 0 | 0 | 0 | 0 |
| Total | | 16,795 | 2,902 | 12,384 | 5,938 | 14,140 | 5,840 | 7,310 | 3,830 |

Africa Bureau
Office of Development Planning
African Child Survival Program
FY's 85 - 86 - 87 - 88

| COUNTRY/TITLE/NUMBER | APPROP. | FY 1985 ACTUAL | | FY 1986 | | FY 1987 | | FY 1988 | |
|------------------------------|---------|----------------|--------------|----------|-------|----------|-------|----------|-------|
| | | PROJECT | OBLIG. \$ CS | AFR. OYB | \$ CS | REV. ABS | \$ CS | REV. ABS | \$ CS |
| ECONOMIC SUPPORT FUND | | | | | | | | | |
| Zimbabwe: (613) | | | | | | | | | |
| Child Space & Fert- 0219 ESF | | 1292 | 232 | 0 | 0 | 0 | 0 | 0 | 0 |
| CHILD SURVIVAL FUND | | | | | | | | | |
| Africa Regional: (698) | | | | | | | | | |
| Child Survival Fund-0513 CSF | | 3500 | 3500 | 4000 | 4000 | 2000 | 2000 | 2000 | 2000 |

SOURCES: AFRICA FY 1988 ABS COUNTRY SUBMISSION'S TO PPC FOR FY 1987 AND FY 1988 HEALTH LEVELS.
AFRICA FY 1986 OYB FOR ACTUAL HEALTH LEVELS IN FY 1986 AS OF 07/25/86.
AFRICA FY 1986 OYB FOR ACTUAL CHILD SURVIVAL LEVELS IN FY 1986 AS OF 07/25/86.
AFRICA FY 1985 ACTUAL LEVEL'S FROM PH/PIAS REPORT DATED SEPT 30, 1985.
AFR/TR/HPM STATE CABLE # 210404 TO FIELD MISSION'S DATED JULY 06, 1988

CABLE RESPONSES
SENEGAL - DAKAR 07848
TOGO - LOME 03559
ZIMBABWE - HARARE 03911
ZAIRE - KINSHA 10906
CHAD - NDJAME 03698
NIGER - NIAMEY 05057
MALI - BAHAKO 04188
UGANDA - KAMPALA 02188
CAHEROON - YAOUND 06352

AFR/DP/PAB:GCauvin:07/11/86:07/16/86:07/21/86:07/24/86:07/25/86:07/28/86:ID# 2663F

22

Annex 5

AFRICA BUREAU HPN FUNDING BY ACCOUNT
FY 83 - FY87 (000's)

| | FY 83 ACTUAL | FY 84 ACTUAL | FY 85 ACTUAL | FY 86 OYB | FY 87 ABS |
|-------------------|-----------------|-----------------|-----------------|--------------|--------------|
| HEALTH | | | | | |
| D.A. | 31032 | 27069 | 46596 | 32811 | 29648 |
| SAHEL | 6000 | 11344 | 7764 | 3450 | 8960 |
| OFDA/TFAF | 0 | 0 | 19650 | 12011 | 0 |
| CENTRAL S&T | 82 | 1502 | 1720 | 1309 | 2195 |
| CSAP | | | 3500 | 9200 | 7000 |
| | <hr/> | <hr/> | <hr/> | <hr/> | <hr/> |
| | 37114 | 39915 | 79230 | 58781 | 47803 |
| POPULATION | | | | | |
| D.A. | 11714 | 15642 | 15023 | 26100 | 23000 |
| SAHEL | 3400 | 1572 | 10331 | 5999 | 8435 |
| E.S.F. | 0 | 0 | 1232 | 0 | 0 |
| CENTRAL S&T | 30000 | 29000 | 42500 | 36600 | 39400 |
| | <hr/> | <hr/> | <hr/> | <hr/> | <hr/> |
| | 45114 | 46214 | 69086 | 68699 | 70835 |

- 1) OFDA FUNDS FOR FY 87 NOT ALLOCATED
- 2) INCLUDES \$5.2 MILLION EARMARK FOR FVA/PVC IN FY 86

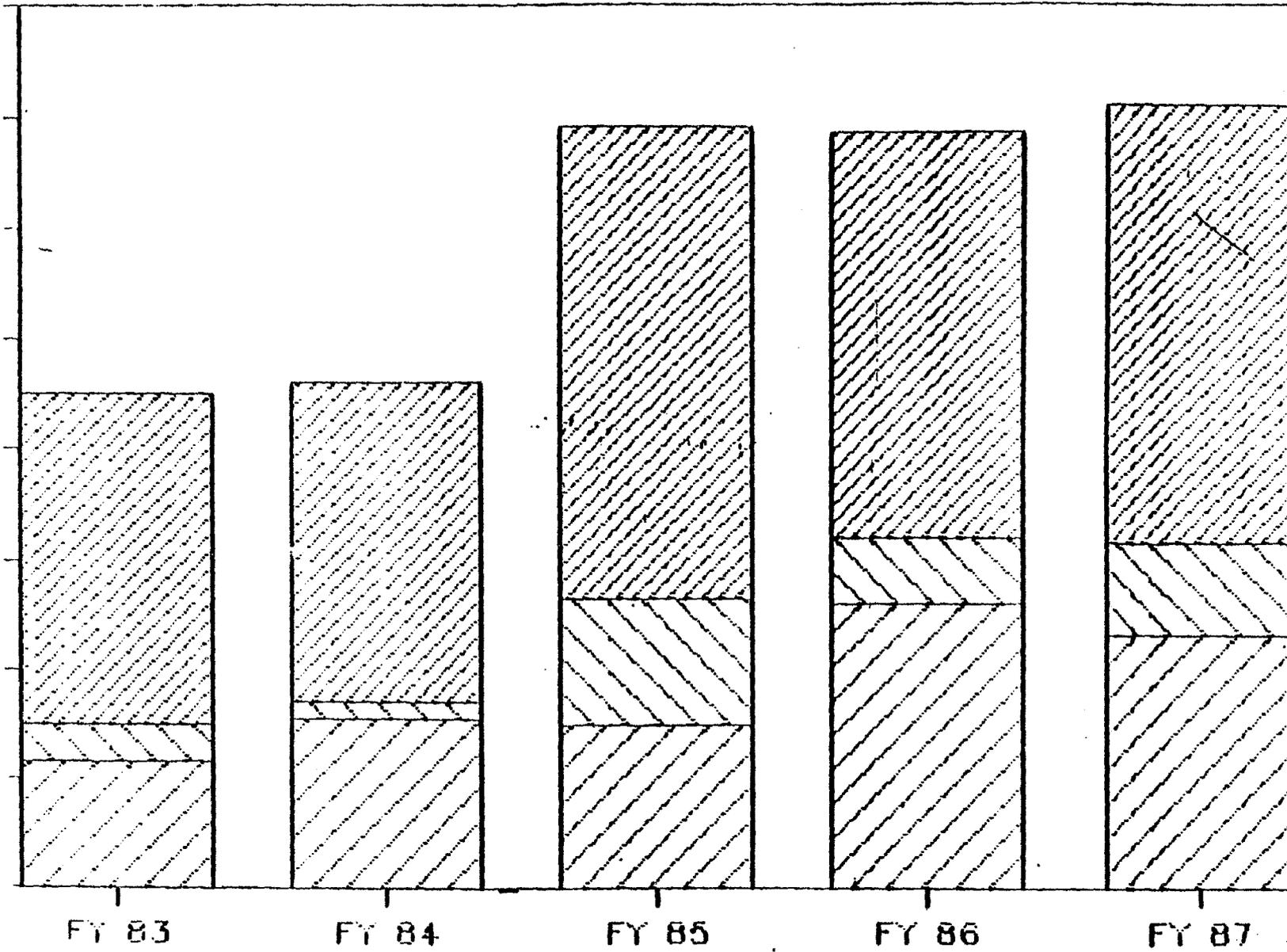
IRCES

FY 87 - CP - AFR/DP - 2/19/87
 AFR/TR Database
 AFR/SWA TABLES
 OFDA TABLES

15

AFRICA POPULATION FUNDING

FY 83 - FY87



U.S. FISCAL YEARS (FY87 PROJECTED)

D.A.

SAHEL & ESF

S & T

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76

Africa Bureau
Office of Development Planning
African Child Survival Program
FY's 85 - 86 - 87 - 88

| COUNTRY/TITLE/NUMBER | APPROP. | FY 1985 ACTUAL | | FY 1986 | | FY 1987 | | FY 1988 | |
|---------------------------|---------|----------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| | | OBLIG. | OBLIG. | AFR. OVB | \$ CS | REV. ABS | \$ CS | REV. ABS | \$ CS |
| Swaziland: (645) | | | | | | | | | |
| Health Plng./Mgt. - 0215 | Health | 130 | 13 | 0 | 0 | 0 | 0 | 0 | 0 |
| Rural Health Dev. - 0220 | Health | 2000 | 1000 | 983 | 550 | 1000 | 500 | 1000 | 500 |
| Togo: (693) | | | | | | | | | |
| Rural Water Supply- 0210 | Health | 1680 | 160 | 0 | 0 | 0 | 0 | 0 | 0 |
| Health Sector Plng.-0228 | Health | 0 | 0 | 0 | 0 | 911 | 900 | 1500 | 1500 |
| Uganda: (617) | | | | | | | | | |
| Oral Rehydration - 0107 | Health | 2050 | 2050 | 550 | 550 | 0 | 0 | 0 | 0 |
| Zaire: (660) | | | | | | | | | |
| Basic Rural Health- 0086 | Health | 110 | 50 | 0 | 0 | 0 | 0 | 0 | 0 |
| School Pub. Health- 0101 | Health | 2000 | 400 | 2235 | 200 | 0 | 0 | 0 | 0 |
| Basic Rur. Health II-0107 | Health | 4250 | 2125 | 2500 | 1250 | 4000 | 2000 | 4000 | 1500 |
| Kimbangulst Hosp. - 0122 | Health | 0 | 0 | 750 | 100 | 0 | 0 | 0 | 0 |
| Shaba Ref. Water Sup-0116 | Health | 2250 | 225 | 0 | 0 | 0 | 0 | 0 | 0 |
| Shaba Ref. Health - 0114 | Health | 2500 | 250 | 0 | 0 | 0 | 0 | 0 | 0 |
| Zaire PDS - 0510 | Health | 100 | 0 | 85 | 0 | 100 | 0 | 0 | 0 |
| Africa Regional (698) | | | | | | | | | |
| Africa Reg. CCCD - 0421 | Health | 6836 | 6836 | 11750 | 11750 | 10500 | 10500 | 9500 | 9500 |
| SH Delivery Sys. - 0398 | Health | 3100 | 600 | 500 | 250 | 0 | 0 | 0 | 0 |
| Oncbo. Phase II. - 0399 | Health | 1982 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Health Constraints- 0408 | Health | 3853 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Health Inst. Imp. - 0412 | Health | 375 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| AFR. Manpower II - 0433 | Health | 0 | 0 | 930 | 0 | 0 | 0 | 0 | 0 |
| AFR. Dev. Support - 0464 | Health | 0 | 0 | 250 | 0 | 300 | 0 | 300 | 0 |
| Israel Trng. - 0465 | Health | 0 | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| AIDS Control Prog.- 0468 | Health | 0 | 0 | 1000 | 0 | 0 | 0 | 0 | 0 |
| AID/W PDS - 0510 | Health | 1160 | 0 | 1672 | 0 | 800 | 0 | 500 | 0 |
| Total | | 46,464 | 19,217 | 36,664 | 20,314 | 27,097 | 20,767 | 26,080 | 17,900 |

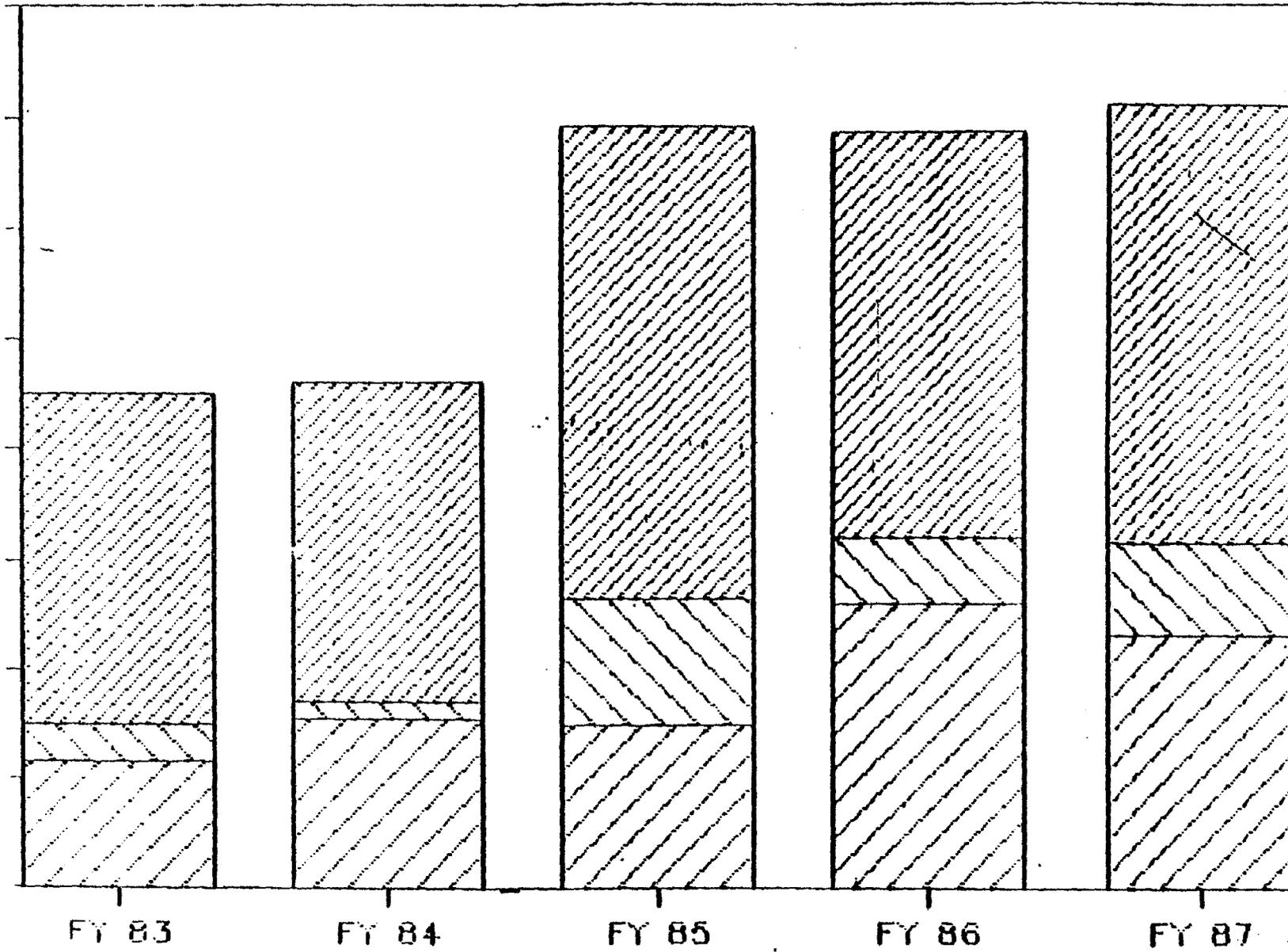
7/92

Africa Bureau
Office of Development Planning
African Child Survival Program
FY's 85 - 86 - 87 - 88

| COUNTRY/TITLE/NUMBER | APPROP. | FY 1985 ACTUAL | | FY 1986 | | FY 1987 | | FY 1988 | |
|----------------------------------|---------|----------------|--------------|---------------|--------------|---------------|--------------|--------------|--------------|
| | | OBLIG. PROJECT | OBLIG. \$ CS | APR. OYB | \$ CS | REV. ABS | \$ CS | REV. ABS | \$ CS |
| SAHEL DEVELOPMENT PROGRAM | | | | | | | | | |
| Burkina: (686) | | | | | | | | | |
| Rural Water Supply- 0228 Sahel | | 1200 | 120 | 0 | 0 | 0 | 0 | 0 | 0 |
| FP Support - 0260 Sahel | | 0 | 0 | 1041 | 1041 | 290 | 290 | 0 | 0 |
| Strengthen Health - 0251 Sahel | | 0 | 0 | 1750 | 1750 | 0 | 0 | 0 | 0 |
| Chad: (677) | | | | | | | | | |
| Oral Rehy Therapy - 0934 Sahel | | 350 | 350 | 0 | 0 | 0 | 0 | 0 | 0 |
| Mali: (688) | | | | | | | | | |
| Integrated FH Ser's-0227 Sahel | | 0 | 0 | 1200 | 1200 | 1950 | 1950 | 2850 | 2850 |
| Niger: (683) | | | | | | | | | |
| Rural Health Imp. - 0208 Sahel | | 1400 | 200 | 900 | 100 | 0 | 0 | 0 | 0 |
| Rural Sec. Support- 0254 Sahel | | 0 | 0 | 3373 | 1687 | 6000 | 3000 | 1960 | 980 |
| Senegal: (685) | | | | | | | | | |
| Rural Health Ser. II-0242 Sahel | | 3514 | 2232 | 0 | 0 | 900 | 100 | 0 | 0 |
| FH Services II - 0248 Sahel | | 9450 | 0 | 0 | 0 | 2500 | 500 | 0 | 0 |
| Sahel Regional: (625) | | | | | | | | | |
| Oncho. Control - 0966 Sahel | | 0 | 0 | 2500 | 0 | 2500 | 0 | 2500 | 0 |
| Sahel Pop Init. - 0969 Sahel | | 881 | 0 | 1620 | 160 | 0 | 0 | 0 | 0 |
| Total | | 16,795 | 2,902 | 12,384 | 5,938 | 14,140 | 5,840 | 7,310 | 3,830 |

AFRICA POPULATION FUNDING

FY 83 - FY87



FY 83

FY 84

FY 85

FY 86

FY 87

U.S. FISCAL YEARS (FY87 PROJECTED)

D.A.

SAHEL & ESF

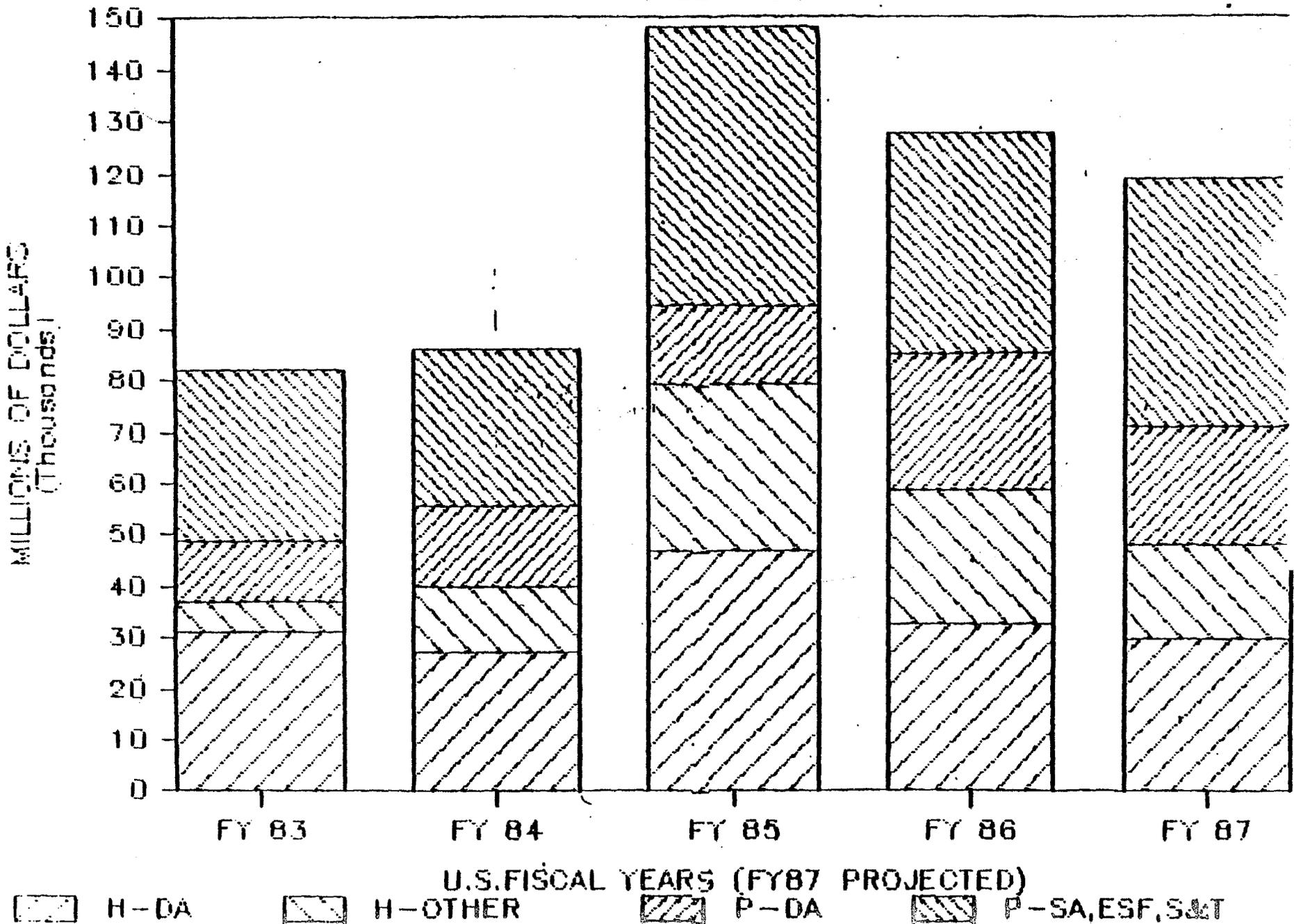
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76

AFRICA HPN FUNDING

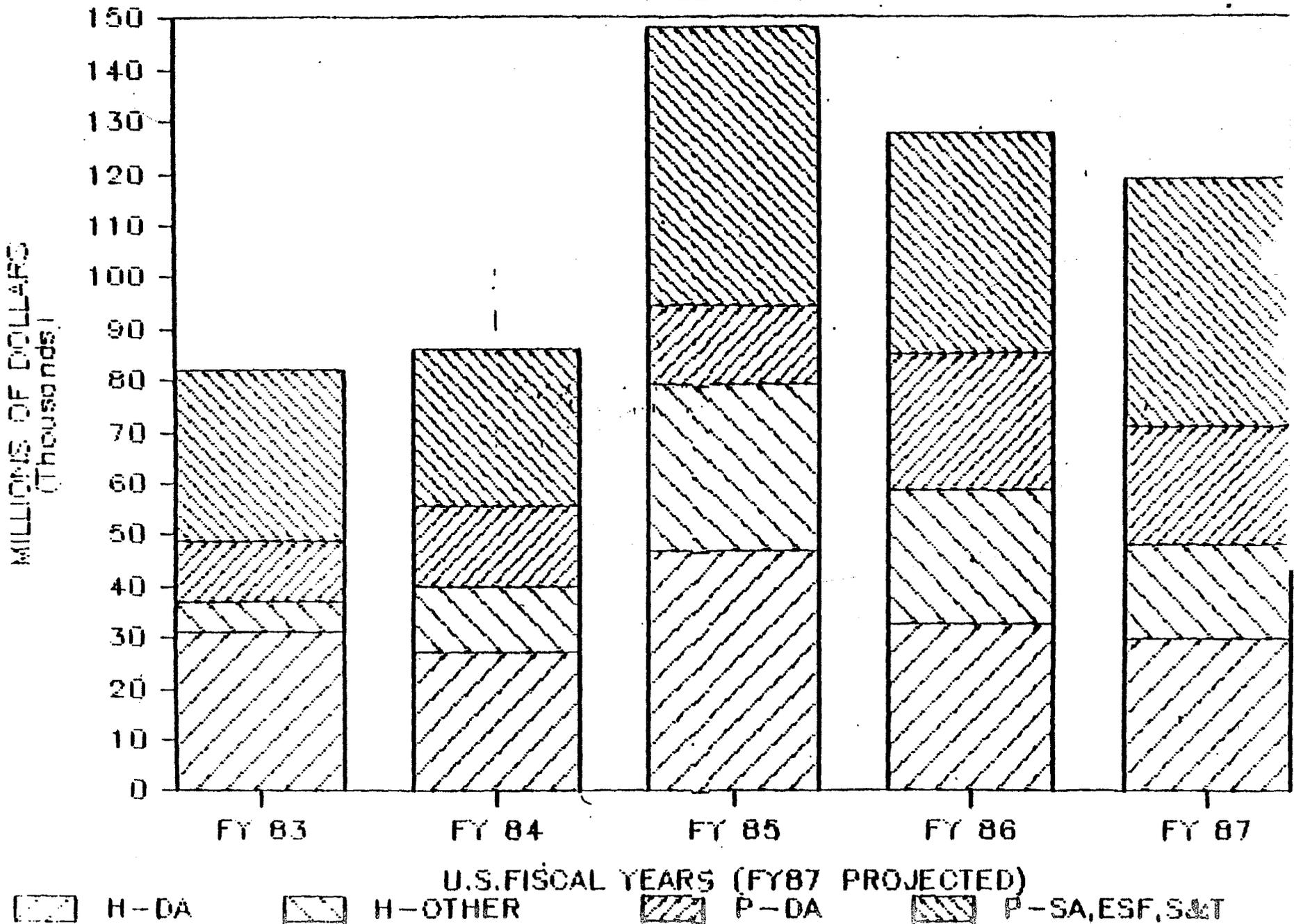
FY 83 - FY87



11

AFRICA HPN FUNDING

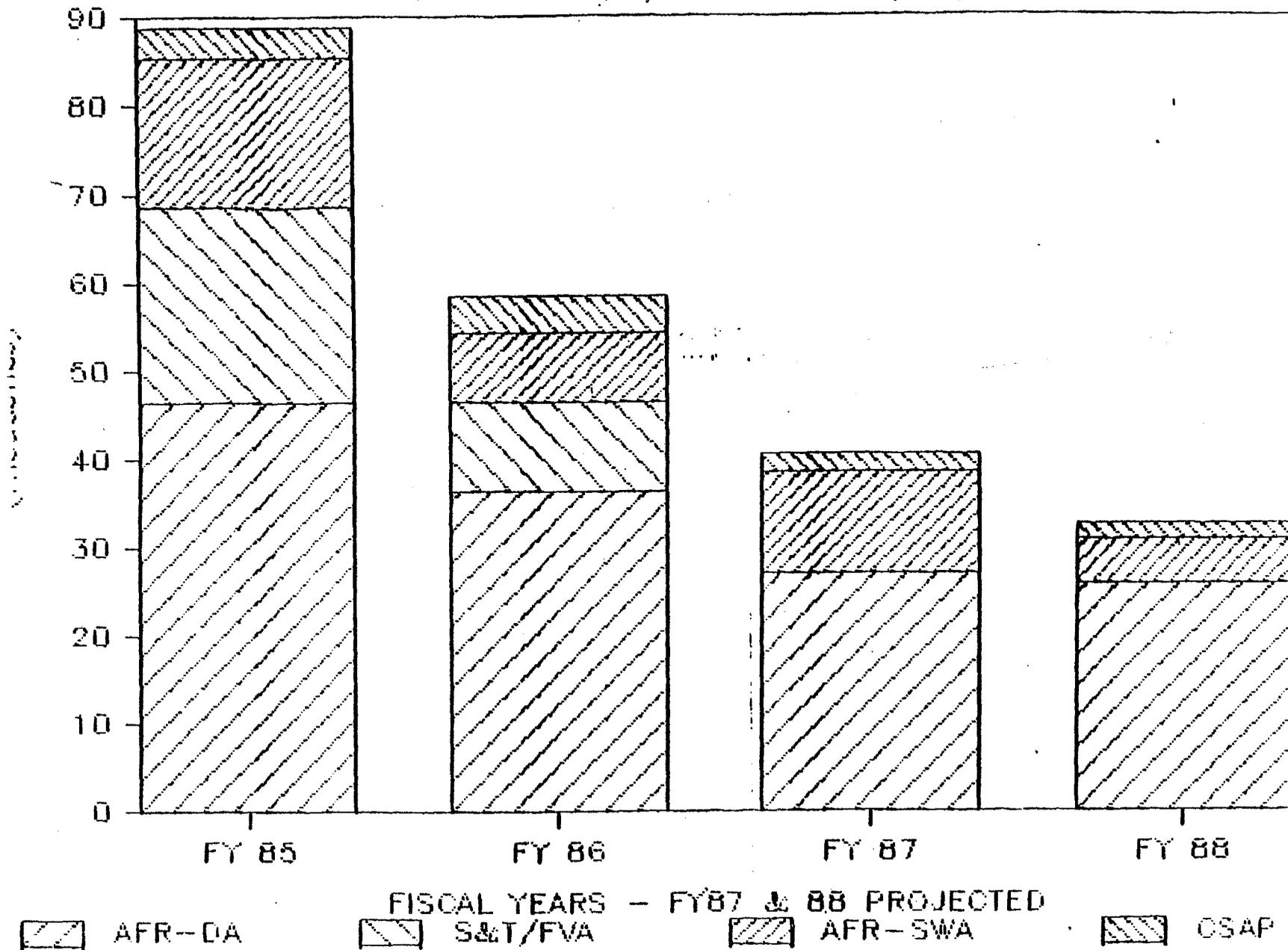
FY 83 - FY87



11

AFRICA HEALTH FUNDING

SOURCE = AFR/DP & TR - 7/28/86



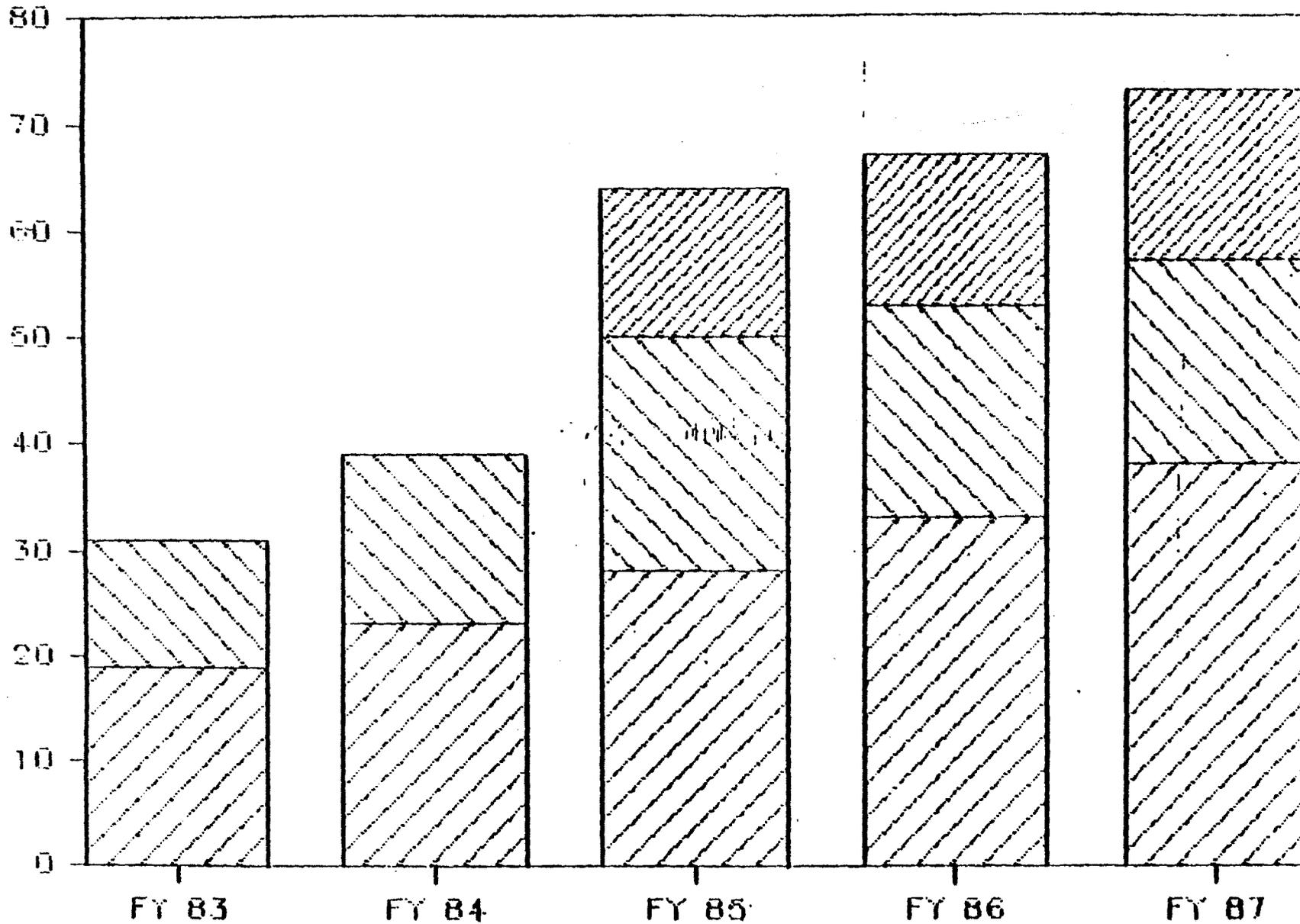
COMMITTEE ON AFRICAN DEVELOPMENT AND EMPHASIS IN THE HEALTH SECTOR

Smith

79

HEALTH & POPULATION PERSONNEL

AFRICA BUREAU FY83 - FY87



FISCAL YEARS - FY87 PROJECTED

HEALTH

POPULATION

HE. & POP.

Chart 7

HEALTH, POPULATION, NUTRITION AND ECONOMIC INDICATORS IN AID ASSISTED AFRICAN COUNTRIES

HPN INDICATORS

| | INDIAN OCEAN | | | | EAST AND SOUTHERN AFRICA | | | | | | | | | | | | ASIA* THAI- LAND |
|-----------------------------------------------------|----------------|----------------------|----------------------|--------------|--------------------------|------------|---------------|--------------|------------|--------------|--------------------|-------------|-------------|----------------------|---------------------|-------------|------------------------|
| | MAUR- ITIUS | MAD- AGAS- CAR | SEY- CHEL- LES | COM- OROS | ZIM- BA- BWE | KEN- YA | BOT- SWANA | LES- OTHO | SU- DAN | SOMA- LIA | TAN- ZA- NIA | UGAN- DA | MALA- WI | MO- ZAM- BIQUE | SWA- ZI- LAND | ZAM- BIA | |
| <u>Family Planning - 1985</u> | | | | | | | | | | | | | | | | | |
| % Contraceptive Women (15-49) | 50 | 1 | NA | NA | 14 | 8 | 8 | 7 | 5 | 1 | NA | NA | NA | NA | NA | NA | 56 |
| % Population Under 15 Years | 33 | 44 | 37 | 46 | 48 | 52 | 50 | 50 | 46 | 45 | 46 | 48 | 48 | 46 | 47 | 47 | 38 |
| Crude Birth Rate | 21 | 45 | 26 | 46 | 47 | 54 | 50 | 42 | 47 | 47 | 50 | 50 | 52 | 45 | 48 | 48 | 25 |
| Total Fertility Rate | 2.7 | 6.4 | 4.1 | 6.3 | 6.6 | 8.0 | 6.6 | 5.8 | 6.6 | 6.6 | 7.1 | 6.9 | 6.9 | 6.1 | 6.5 | 6.5 | 3.5 |
| % Women Using Modern Contraceptives | 32 | NA | NA | NA | 7 | 4 | NA | 2 | 4 | NA | NA | NA | NA | NA | NA | NA | 54 |
| <u>Health - 1985</u> | | | | | | | | | | | | | | | | | |
| Crude Death Rate | 7 | 17 | 7 | 16 | 12 | 13 | 13 | 16 | 17 | 21 | 15 | 15 | 20 | 17 | 17 | 15 | 6 |
| Infant Mortality | 27 | 67 | 14 | 88 | 70 | 82 | 79 | 110 | 118 | 142 | 98 | 94 | 165 | 110 | 113 | 109 | 51 |
| Life Expectancy At Birth (Years) - Total (M & F) | 67 | 50 | 68 | 50 | 56 | 53 | 54 | 49 | 48 | 43 | 50 | 52 | 45 | 49 | 52 | 51 | 63 |
| <u>ECONOMIC - 1985</u> | | | | | | | | | | | | | | | | | |
| PER CAPITA GNP (In Dollars) | 1,150 | 290 | 2,400 | NA | 740 | 340 | 920 | 470 | 400 | 250 | 240 | 220 | 210 | NA | 890 | 580 | 810 |
| <u>Population Growth - Mid 1985</u> | | | | | | | | | | | | | | | | | |
| Total, M & F (Millions) | 1.0 | 10.0 | 0.1 | 0.5 | 8.6 | 20.2 | 1.1 | 1.5 | 21.8 | 6.5 | 21.7 | 14.7 | 7.1 | 13.9 | 0.7 | 6.8 | 57.2 |
| Women (15-49) Millions | 0.3 | 2.3 | .02 | 0.1 | 1.9 | 4.2 | 0.2 | 0.4 | 4.9 | 1.6 | 4.7 | 3.2 | 1.6 | 3.1 | 0.1 | 1.5 | 26.2 |
| Women (15-49) Year 2020 | 0.4 | 6.5 | .02 | 0.3 | 6.8 | 17.2 | 0.9 | 0.9 | 13.5 | 3.5 | 17.3 | 11.2 | 5.1 | 9.2 | 0.5 | 5.0 | 22.2 |
| Natural Rate of Increase | 1.5 | 2.8 | 1.9 | 3.0 | 3.5 | 4.1 | 3.7 | 2.6 | 2.9 | 2.6 | 3.5 | 3.5 | 3.2 | 2.8 | 3.4 | 3.3 | 1.9 |
| Years to Double Total Population | 47 | 25 | 37 | 24 | 20 | 17 | 19 | 27 | 24 | 27 | 20 | 20 | 22 | 25 | 22 | 21 | 36 |
| Projected Total Pop. Year 2020 | 1.6 | 26.8 | 0.1 | 1.0 | 28.1 | 68.0 | 3.5 | 3.7 | 33.2 | 14.1 | 70.7 | 43.7 | 20.5 | 36.0 | 1.8 | 20.7 | 67.6 |

Sources: Population Reference Bureau's Population Data Sheet and the World's Women (1985)
 U.N. World Population Prospects. Population Studies #86 (1985)
 Gross National Product Per Capita Figures, World Bank Atlas (1985)

Explanatory Note: * As a point of reference and comparison, of the AID assisted countries in Asia, Thailand has the highest percentage of contracepting women (15-49) while in all of Africa, Maritius has the highest, and which is a key factor in favorably influencing other HPN and Economic indicators

POPULATION AND HEALTH PERSONNEL
 AFRICA BUREAU
 FY 83 - FY 86

| | FY 83 ACTUAL | FY 84 ACTUAL | FY 85 ACTUAL | FY 86 OYB | FY 87 ABS |
|------------------|-----------------|-----------------|-----------------|--------------|--------------|
| TH | | | | | |
| DIRECT HIRE | 14 | 14 | 13 | 13 | 14 |
| PSC | 1 | 1 | 1 | 1 | 1 |
| CCCD (CDC) | 4 | 8 | 14 | 19 | 23 |
| SUBTOTAL | <u>19</u> | <u>23</u> | <u>28</u> | <u>33</u> | <u>38</u> |
| ----- | | | | | |
| ATION and HEALTH | | | | | |
| DIRECT HIRE | | | 13 | 13 | 15 |
| PSC | | | 1 | 1 | 1 |
| SUBTOTAL | <u>0</u> | <u>0</u> | <u>14</u> | <u>14</u> | <u>16</u> |
| | | | | | |
| ATION | | | | | |
| DIRECT HIRE | 9 | 10 | 11 | 11 | 13 |
| PSC | 1 | 3 | 5 | 5 | 6 |
| IDI | 2 | 3 | 6 | 4 | 0 |
| SUBTOTAL | <u>12</u> | <u>16</u> | <u>22</u> | <u>20</u> | <u>19</u> |
| PERSONNEL | 31 | 39 | 64 | 67 | 73 |
| | ***** | ***** | ***** | ***** | ***** |

SOURCES:
 AFR/RA (CCCD)
 S&T/POP (POPULATION)
 WORLDWIDE STAFFING PATTERN (1/30/86)

81