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AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT IDENTIFICATION DOCUMENT FACESHEET (PID)	1. TRANSACTION CODE <input type="checkbox"/> A = Add <input type="checkbox"/> C = Change <input type="checkbox"/> D = Delete	DOCUMENT CODE 1
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2. COUNTRY/ENTITY Africa Regional	3. PROJECT NUMBER 698-0476
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4. BUREAU/OFFICE Africa	A. Symbol AFR	B. Code 06	5. PROJECT TITLE (maximum 40 characters) Africa Public Health and Population
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6. ESTIMATED FY OF AUTHORIZATION/OBLIGATION/COMPLETION A. Initial FY: 9 1 B. Final FY: 9 8 C. PACD: 0 0	7. ESTIMATED COSTS (\$000 OR EQUIVALENT, \$1 =) <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">FUNDING SOURCE</th> <th style="width: 50%;">LIFE OF PROJECT</th> </tr> <tr> <td>A. AID /W</td> <td>52,000</td> </tr> <tr> <td>B. Other U.S. 2. Mission Buy-Ins</td> <td>43,000</td> </tr> <tr> <td>C. Host Country</td> <td></td> </tr> <tr> <td>D. Other Donor(s)</td> <td></td> </tr> <tr> <td style="text-align: center;">TOTAL</td> <td style="text-align: center;">95,000</td> </tr> </table>	FUNDING SOURCE	LIFE OF PROJECT	A. AID /W	52,000	B. Other U.S. 2. Mission Buy-Ins	43,000	C. Host Country		D. Other Donor(s)		TOTAL	95,000
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TOTAL	95,000												

8. PROPOSED BUDGET AID FUNDS (\$000)							
A. APPRO-PRATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. 1ST FY 91		E. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) SS	500R	500			1,500	95,000	
(2)							
(3)							
(4)							
TOTALS					1,500	95,000	

9. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each) 510 530 400 410 440 300	10. SECONDARY PURPOSE CODE 400
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11. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)							
A. Code	INTR	DEL					
B. Amount							

12. PROJECT PURPOSE (maximum 480 characters)

To increase the sustainability, efficiency and effectiveness of Africa public health and family planning systems in delivery of services.

13. RESOURCES REQUIRED FOR PROJECT DEVELOPMENT

Staff:

KHKK

14. ORIGINATING OFFICE CLEARANCE	Signature: Richard Cobb Title: Director, AFR/TR	15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION MM DD YY
	Date Signed: 11/21/92 MM DD YY	MM DD YY

16. PROJECT DOCUMENT ACTION TAKEN <input type="checkbox"/> S = Suspended CA = Conditionally Approved <input type="checkbox"/> A = Approved DD = Decision Deferred <input type="checkbox"/> D = Disapproved	17. COMMENTS
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**AFRICA PUBLIC HEALTH AND POPULATION
SUPPORT PROJECT**

(698-0476)

TABLE OF CONTENTS

- i. Table of Contents
- ii. Acronyms

- I. Project Summary

- II. Program Factors
 - A. Conformity with Recipient Country Strategies and Programs
 - B. Relationship with Development Fund for Africa Action Plan and Operational Approaches

- III. Project Description
 - A. Major Problems: Demographic, Health, and Sustainability Issues
 - B. Related Constraints
 - 1. Host Country Capacities
 - 2. Support Systems
 - 3. Planning, Policies and Resources
 - 4. A.I.D. Sectoral Analyses and Programming
 - C. Project Goal and Purpose
 - D. Expected Achievements/Accomplishments
 - E. Project Outline and How It Will Work
 - 1. Regional Core Component
 - 2. Country-Level Buy-in Component
 - 3. How It Will Work

- IV. Factors Affecting Project Selection and Further Development
 - A. Social Considerations
 - B. Economic and Financial Considerations
 - C. Relevant Experience with Similar Projects
 - D. Project Management and A.I.D. Support Requirements
 - E. Estimated Costs and Methods of Financing
 - F. Design Strategy
 - G. Recommended Environmental Threshold Decision
 - H. A.I.D. Policy Issues

- Annexes
 - A. Statement of Goals and Functions, Office of Technical Resources
 - B. Preliminary APHP project management structure in the Health, Population and Nutrition Division
 - C. Preliminary Log Frame
 - D. Initial Environment Examination
 - E. Rationale for a Consolidated Regional Project
 - F. Preliminary Estimated Budget by Component and by Year
 - G. Bibliography

LIST OF ACRONYMS

ACSI-CCCD	Africa Child Survival Initiative-Combatting Childhood Communicable Diseases Project
AFRO	Africa Regional Office of the World Health Organization
AFR/TR	Bureau for Africa, Office of Technical Resources
AIDS	acquired immunodeficiency syndrome
AIDSCOM	AIDS Technical Support Project
APHP	Africa Public Health and Population Support Project
API	Assessment of Program Impact
BuCen	Bureau of Census
CAFS	Center for African Family Studies
CDC	Centers for Disease Control
CPSP	Country Program Strategy Paper
DFA	Development Fund for Africa
DHS	Demographic Health Survey
ESS	epidemiologic surveillance system
EPI	Expanded Program on Immunization
FHI-II	Family Health Initiative Project (Phase II)
FP	family planning
FTE	full-time equivalent
HAPA	HIV/AIDS Prevention in Africa Project
HealthCom	Communications for Child Survival Project
HIS	health information system

HPN	health, population and nutrition
HRDA	Human Resources Development Assistance Project
IEC	information, education and communication
LOP	life of project
MIS	management information system
MotherCare	Maternal/Neonatal Health and Nutrition Project
NGO	non-governmental organization
ODA	official development assistance
OE	operating expenses
ORT	oral rehydration therapy
PASA	participating agency service agreement
PACD	project activity completion date
PHC	primary health care
POPTECH	Population Technical Assistance Project
PP	project paper
PRITECH II	Technology for Primary Health Care II Project
PSC	personal services contract
PVO	private voluntary organization
REACH II	Resources for Child Health II Project
REDSO	Regional Economic Development Support Office
RSSA	Resource Sharing Service Agreement
RUR	Office of Research and University Relations in the Bureau for Science and Technology
EATS	Family Planning Service Expansion and Technical Support Project

S&T	Bureau for Science & Technology (A.I.D)
TA	technical assistance
TAACS	Technical Advisor(s) for AIDS and Child Survival
WHO	World Health Organization

Africa Public Health and Population Support
Project Identification Document (698-0476)

I. PROJECT SUMMARY

The 1980s witnessed major improvements in key health, population and nutrition (HPN) indicators of progress in Africa: infant and child mortality continued to decline steadily as immunizations, diarrheal control programs and other preventive health measures became widely available in rural areas; at the same time, fertility declined measurably in recent years in several countries. However, even as a number of African countries made progress in framing broad policies and implementing public health and family planning programs, most health status indicators in Africa remain among the lowest in the world. Also, the gains that have been made, both in terms of benefits and activities, are mostly not sustainable. The focus on mainly vertical interventions generally has resulted in inefficient and redundant support systems--health care financing, management, training, and information systems development. At the same time, insufficient country-level sectoral analysis and planning, unsupportive policies, lack of resources and inadequate management of resources hinder sustainability, efficiency and effectiveness of HPN programs.

Concurrently, the new Development Fund for Africa (DFA) Action Plan encourages integration of services for child survival and AIDS with family planning services and a more comprehensive approach in dealing with HPN issues. Also, the DFA is encouraging USAID missions in Africa to develop bilateral HPN activities, which is changing the role of HPN regional projects.

The ten-year Africa Public Health and Population (APHP) Support project responds directly to the evolving focus and strategies of African country-level HPN activities and of A.I.D. assistance. The overall goal of the APHP project is to improve health status in sub-Saharan Africa through reduced fertility, decreased childhood mortality and morbidity, lower incidence of HIV/AIDS, and reduced malaria. To help achieve this goal, the project purpose is to increase sustainability, efficiency, and effectiveness of African public health and family planning systems in delivery of services.

The APHP project approach associates APHP with the success of the bilateral HPN programs in Africa through improved programming, performance and impact of those programs. Through both a regional-funded core component and a mission-funded buy-in component, the APHP project will:

A. Promote sustainability and integration, where feasible, of technical interventions by investing in support systems, and in institutions that strengthen long-term indigenous programs and capacities, especially in key areas where most USAID missions historically have not been able to invest successfully.

B. Expand support to Agency, Bureau and field missions in assessing and reporting impacts of HPN programs, and provide leadership in improving A.I.D.'s sectoral policies and planning.

C. Continue broad, flexible authorization for support across a well-defined cluster of HPN activities, including short-term enhancements to existing bilateral or other-donor projects; support bridge activities leading to new bilateral country agreements, and provide access to technical assistance not available through other Agency mechanisms.

D. Consolidate the current three regional HPN projects to achieve management efficiencies and to encourage broader sectoral analysis and reporting.

II. PROGRAM FACTORS

A. Conformity with Recipient Country Strategies and Programs

African countries during the 1980s underwent major transformations in public health and population policies--changes that collectively provide the basic rationale for the new APHP project strategy. Ten years ago, African leaders generally supported hospital and clinic-based, curative approaches and knew little about preventive and primary health care. Today, a number of African governments are adopting formal policies favoring restructuring of health investments towards greater investment in preventive and primary health care. Ten years ago, very few sub-Saharan governments supported the notion that reducing high fertility and rapid population growth should be high priorities for attaining national development objectives. Now virtually all countries have policies that encourage family planning as part of maternal and child health, and many explicitly urge their populations to adopt smaller family sizes. The 1980s witnessed a genuine, if quiet, revolution in African public health and population policies and strategies at broad levels. However, ensuring sustainable programs, with indigenous financing and strong African technical leadership, constitutes a crucial challenge for the 1990s.

B. Relationship with Development Fund for Africa Action Plan and Operational Approaches

The appropriation legislation that established the Development Fund for Africa (DFA) in December 1987 specified that A.I.D. should aim to obligate ten percent of the DFA for "health and child survival" and ten percent for "voluntary family planning." This is consistent with previous Congressional special accounts, earmarks and targets in the HPN sector since the late 1960s. Little more than a year after the DFA's inception, the Bureau for Africa produced a full blueprint for action under the new account.¹ The action plan contains four major objectives. Of these, Strategic Objective One calls for improved management of African economies, and Target 1-3 under this objective aims for "improved equity and efficiency in providing key public goods, particularly in the areas of family planning, health, (and) education..."(p. iii). Strategic Objective Three, "developing the potential for long-term increases in productivity," implies a healthy labor force.

The action plan encourages integration of services for child survival and AIDS with family planning services, and calls for a more comprehensive approach to dealing with child survival than just the "twin engines" of immunization and oral rehydration therapy (ORT). The plan notes that A.I.D. aims to improve the health of children under five and reproductive-age women. In addition, the action plan points out that additional resources will be required to sustain health and family planning programs. More cost recovery and broader donor participation are called for, and systems for management, information, and financing need greater emphasis.

Likewise, the DFA Action Plan mandates that new approaches be found to more efficiently manage the Agency's work in Africa. The plan commits the Bureau "to focus on program and project... vehicles which permit more flexibility for shifting funds." As more missions negotiate bilateral HPN activities throughout sub-Saharan Africa, the APHP Support project consolidates the Bureau for Africa regional project portfolio relating to child survival, family planning/population, and HIV/AIDS. APHP is a management-efficient, regionally-focused and analytic project leading to appropriate policies and sustainable programs that will improve health and nutrition, control rapid population growth, and prevent and control the spread of HIV/AIDS. Annex E provides a detailed rationale for consolidating the regional HPN projects.

The DFA's flexibility is coupled with clear reporting requirements; the Bureau agreed to give special attention to measuring and reporting the impact of its programs. For the HPN

¹ U.S. Assistance for Africa, The Development Fund for Africa: An Action Plan, May, 1989, AFR/DP. See especially pp. 14-19.

sector, APHP will provide the Bureau with the capacity both to meet this responsibility, and to provide leadership in identifying and taking action on critical sectoral issues. APHP will provide a focal point for synthesizing cross-national experience, and a mechanism for assisting missions to establish systems for the Assessment of Program Impact (API).

Concomitantly, the Bureau's Office of Technical Resources (AFR/TR) formally adopted a new statement of goals and functions in May 1990, thoroughly reviewed and endorsed within TR and across senior levels of management in the Bureau (Annex A). This statement stresses that TR's highest priority is to provide analyses of selected sectoral and cross-sectoral issues. Support for implementing in-country programs remains an important function, but of lower priority than at any time in the past. APHP reflects both the new prioritization of TR functions and DFA Action Plan management objectives.

III. PROJECT DESCRIPTION

A. Major Problems: Demographic, Health and Sustainability Issues

The 1980s witnessed major improvements in key HPN indicators of progress in Africa: infant and child mortality continued to decline steadily immunizations, diarrheal control programs and other preventive health measures became widely available in rural areas; at the same, fertility declined measurably in recent years in several countries. Levels of fertility and mortality, however, remain high and inconsistent with broader social and development objectives. The processes underlying the positive trends are fragile and dependent on external resources, while new risks to health of tragic proportions have emerged over the past decade, especially AIDS.

Despite some recent gains, fertility in sub-Saharan African countries remains the highest anywhere in recorded history. Population growth has emerged as a profound underlying constraint to progress across all sectors. With completed fertility averaging six-to-eight children per woman (except in southern Africa), dependency levels--combined with Africa's enormous economic problems--are making it increasingly difficult to adequately feed, clothe, educate, and care for children. African governments are recognizing the inverse relationships between population growth and child health, quality of education, agricultural productivity, and equitable income distribution. Governments also are concerned about assuring adequate technical training and jobs, as well as maintaining nutritional status. Rapid urban growth taking place throughout much of the region further exacerbates these difficulties.

Over the past 30 years infant and child mortality rates decreased by nearly 50 percent in sub-Saharan Africa. Despite these steady declines, the actual number of under-five deaths in Africa continues to increase every year (see Figure 1). Morbidity and mortality rates for African children remain the worst in the world.

During 1990, nearly 24.5 million children will be born in sub-Saharan Africa. An estimated 4.2 million of these children will die before their fifth birthday (a projected under-five mortality rate of more than 170 deaths per 1,000 live births). More than half of these deaths occur in the first year of life. Major contributors to the continuing high child mortality in Africa include resurgent malaria, which is now drug resistant, dehydration due to diarrhea, malnutrition, acute lower respiratory infections, and vaccine-preventable diseases such as measles and neonatal tetanus. Short birth intervals also contribute significantly to infant and child mortality, and in some areas, AIDS is wiping out the hard-won gains of child survival programs. As of 1990, about 200,000 HIV-infected infants have been born in sub-Saharan Africa, and during the 1990s, an additional million or more are expected.

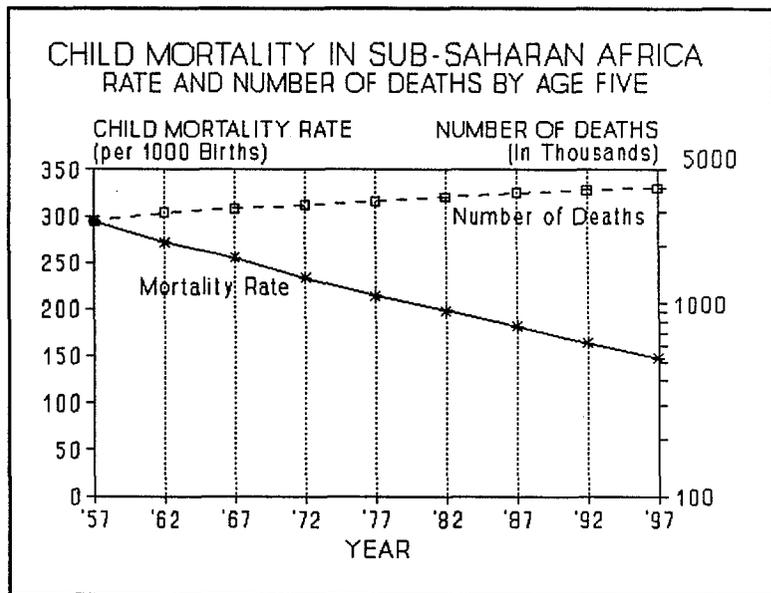


Figure 1

The World Health Organization (WHO) estimates that by mid-1990 approximately five million persons were infected with HIV in Africa, more than half the total worldwide. This includes roughly two-and-one-half million women, or about 80 percent of the global total of infected women, and an equal number of men, accounting for more than 40 percent of the global total of infected men. WHO estimates that one of every 40 adults in sub-Saharan Africa is now infected with HIV and that the incidence is increasing. In many African cities, current HIV-infection levels could cause a doubling or tripling of the total adult mortality rate and a 50 percent increase in the child mortality rate during the 1990s. The HIV seroprevalence in rural areas of Africa remains much lower than that recorded in large urban areas, but is increasing.

The relationship between these health factors is extremely important. In nearly all cases to date of recorded fertility decline, child mortality rates reached comparatively low levels

about a decade or more prior to fertility declines. And indeed, measurable declines in fertility finally are being detected in a few African countries (e.g., Botswana, Kenya, and Zimbabwe). To bring about widespread declines in fertility, sustained attention must be devoted to both child survival and family planning, both separately and together, in both private and public sectors. A.I.D. and other donor-assistance strategies, in general, have attacked these problems separately, in terms of both the technical interventions and the service delivery mechanisms. Host governments and donors are realizing, however, that programs aimed at reducing fertility, improving child survival and nutrition, and also controlling HIV/AIDS have synergistic effects. In any given country situation, the most appropriate means of optimizing this synergism remains to be determined; for example, through more integration of the service delivery programs or consolidation of individual support systems.

Although a number of African countries made substantial progress during the 1980s in framing broad policies and implementing public health and family planning programs, most health status indicators in Africa remain among the lowest in the world. Much remains to be done to expand direct health delivery services to reach a larger percentage of the population. At the same time, and as importantly, the gains that have been made, both in terms of benefits and activities, are mostly not sustainable.

Recent A.I.D. evaluations of sustainability in HPN programs in Tanzania, Zaire and Senegal, as well as in two countries in Central America clearly indicate the increased difficulties of sustaining HPN activities in the African context of economic crises and weak implementing institutions. Further, the African country evaluations highlighted similar project characteristics related to sustainability. Program design factors that were found to be critical in sustaining operations and benefits include:

- Projects were integrated within existing and normal administrative structures and did not operate as vertical, donor-driven activities;
- The host government demonstrated commitment to the project by providing national financing of at least part of costs;
- The interventions were effective in reaching clearly defined objectives; and
- There was a strong training component in the project that developed national capacities to maintain and improve project operations.

A.I.D. and other donors continue to make major investments in HPN programs throughout Africa. In FY 90 alone, A.I.D. provided almost \$100 million for HPN activities. A.I.D. and host

governments have considerable experience with service delivery programs but must now focus on the wider issues of sustainability of these programs while continuing to expand primary health care services.

B. Related Constraints

Related constraints that hinder the development of more sustainable programs in the region include:

1. Limited country-level institutional and human resource capacity.
2. Inefficient and redundant support systems--health care financing, management, training, and information systems development.
3. Insufficient country-level sectoral analysis and planning, unsupportive policies, lack of resources and inadequate management of resources.

Concurrently, at the Bureau for Africa level, the development of sustainable host-country programs and policies is hindered by :

4. Insufficient sectoral impact analyses, strategy development and planning within A.I.D.

Following is a discussion of each of these four constrains.

1. Host Country Capacities

During the 1990s, both public and private health delivery systems will be called upon to continue providing needed services in the face of burgeoning populations, major health problems demanding new solutions (e.g., HIV disease and malaria), and a resource base that, from the public side at least, is expected to increase minimally at best. The limited institutional and human resource capacities throughout Africa to respond to these challenges affect all aspects of public health programs in Africa, including the other constraints discussed in this section. Increased emphasis on human resource development is urgently required.

While all three Africa-regional projects have training components, emphasis has been at the supervisory and basic health worker levels, and neither ACSI-CCCD, Family Health Initiatives II (FHI-II), nor HIV/AIDS Prevention in Africa (HAPA) have directly provided the in-depth professional training that a cadre of African health professionals will need to provide strong program leadership. African training institutions need to be strengthened to ensure on-continent capacity to provide comprehensive training for health managers at every level as well as short-term training for different cadres in various aspects of public health and population that may be needed (such as

epidemiologic investigations, financial planning and management, urban health planning, demography, economic analysis, environmental health, and partnerships with the private sector). In addition, African institutions must develop their own research capacities linked to the training. U.S. institutions have unusual capabilities to assist.

Greater emphasis on strengthening African institutions will be necessary in order to provide the needed training and research support on-continent. While a number of outstanding African institutions are being developed, such as the University of Kinshasa School of Public Health, and others are being planned, these do not yet have the resources, support and breadth of expertise to become sustainable. The World Bank likewise has recently realized how very little investment has been made in this area in recent years and is actively encouraging more donor commitment.

2. Redundant and Inefficient Support Strategies

Currently, HPN programs at country levels are characterized by: (1) support systems that are inadequate to foster efficient and effective management of needed technical interventions, and (2) by a dearth of trained personnel who can manage and improve the systems. HPN support systems--health care financing, management, training, information systems development, information, communication and education (IEC) and supervision--often are limited to a few, separate technical interventions and are duplicative.

For example, in order to formulate effective and efficient policies and programs, public health managers and decision-makers need data that is accurate, reliable, current, and relevant. Improved epidemiologic surveillance systems (ESSs) that track morbidity and mortality patterns, and better routine health and management information systems (H/MISs) are needed. Presently, the best information/surveillance systems in Africa are quite limited in scope. Although software currently available would permit data to be compared and used across different fields, such as training, supervision, financing, IEC, and logistics, the systems to permit such worthwhile interactions are not in place.

Just as information systems often are limited to a few, separate technical interventions, systems for management, training, supervision, IEC, and even financing may be limited as well as duplicative. At the district level, for example, the same managers and providers frequently are responsible for whatever intervention-specific activities are carried out in their area (on behalf of the same beneficiaries). Yet logistics systems for immunizations, contraceptives, and antibiotics may remain entirely separate for arbitrary reasons. Similarly, central or regional supervisors may cover only malaria or family planning. At the national or regional level, entirely separate training

teams may be developed for family planning, for HIV/AIDS, and for immunizations, control of diarrheal diseases and malaria.

While it is often appropriate and necessary to focus on limited interventions or even a single intervention in the early stages of program development, once an activity is well established (with a delivery infrastructure and public demand), it becomes difficult to justify the increased costs and decreased program efficiencies involved in maintaining a number of separate vertical programs. In general, to encourage program sustainability, support systems need to be widely shared across clustered technical areas.² However, the most effective ways of consolidating support systems across vertical programs and of integrating the vertical programs themselves remain to be determined.

An on-going World Bank study on the organization and management of disease control programs points out that the choice is not between exclusive vertical or horizontal programs, but rather how to make use of both modes in the most cost-effective and efficient way. Operational studies and analyses to determine the most appropriate means of integrating support systems and developing relevant strategies should be a regular feature of the maturing programs over the next decade.

3. Planning, Policies, and Resources

An increasing shortage of resources to meet the accelerating needs in the health and population sector, ineffective and detrimental policies and poor utilization of available resources are long-term constraints affecting almost every level of the HPN sector in Africa.

Given that African populations will continue to increase rapidly during the 1990s and that prospects for increased public-sector HPN financing are poor, new ways will have to be found to ensure that needed services can be adequately financed over the long term. A number of African programs have successfully implemented cost-recovery schemes (e.g., in Zaire and Liberia) or subsidized social marketing programs, particularly for contraceptives (e.g., in Ghana, Cameroon, and Zaire). However, such systems are fairly basic. Cost recovery could be improved through better accounting and financial-management procedures; at the same time more efficient systems (including pre-payment schemes) need to be designed and equity considerations more fully explored.

Besides better, more efficient health care financing, increasing use of private sector resources will be essential during the next decade. Traditionally, governments in sub-Saharan Africa have

² Bossert, T., "Can They Get Along Without Us? Sustainability of Donor-Supported Health Projects in Central America and Africa," Soc. Sci. Med., Vol.30, 1990.

tried to provide too much. Clearly governments will have to cut back on services they provide directly in the years ahead. Now is the time for governments to use other in-country resources, both private-sector for-profit firms and individuals as well as non-governmental organizations (NGOs).

Often policy reform is needed to permit more efficient health delivery. In the Central African Republic, for example, A.I.D. assisted the government in formulating a new law that permitted its health facilities to charge for their services. Another, complementary possibility would be to convince governments to shift their resources away from costly curative services (which are better suited to cost recovery) toward more high-impact preventive services, as is being done in Kenya. Additional policy-focused analyses are required to facilitate and focus policy dialogue at the mission level.

In addition, given accelerating demands for assistance, and the likelihood that aid levels for the continent will not grow significantly over the next decade, it is increasingly critical to assure that external assistance is programmed in close coordination with other donors. A recent study commissioned by AFR/TR indicates that with a different approach substantial additional resources could be mobilized for the health sector.³ Whereas eight percent of external development financing is disbursed for the HPN sector worldwide, only 3.7 percent of such financing is disbursed for the sector in sub-Saharan Africa. Moreover, the study shows that more than a billion dollars of committed donor funds per year (all sectors) has not been disbursed in the region.

The study also makes clear that sectoral planning at the country level generally is poor, and that donor priorities often dominate host-country programs and undercut a more rational planning process. More donor meetings and roundtables will not solve the problem. Host country officials need to learn to plan their health programs more effectively and to justify their needs in a way that will attract the mix of external resources that can meet those needs. They also need to learn which specific donors have both the resources and development policies to meet their sectoral needs and how best to approach those donors. (This may well be difficult to discern since many donors have no in-country HPN representative.)

4. A.I.D. Sectoral Analyses and Planning

U.S. assistance plays a major role in Africa in the HPN sector. A.I.D. provides approximately fifteen percent of total official

³ Howard, LM: "An Assessment of Donor Coordination and External Financial Mobilization for Health, Population and Nutrition in Sub-Saharan Africa," The Pragma Corporation, 1989.

development assistance (ODA) from all sources to the continent and remains the largest single donor. In the fertility/family planning subsector, A.I.D. contributes more than sixty percent of ODA. Over \$110 million per year is currently planned for HPN activities in FY 91 and FY 92 and these amounts will most likely grow with increased DFA levels. At the Bureau level, both in Missions and in AFR/Washington, comprehensive analysis, planning, impact assessment, and reporting often have been inadequate to support sectoral programming and policy dialogue, as has been stressed in a variety of Bureau fora.

Given the importance of the A.I.D. contribution and the need to focus this contribution on sustainability of HPN programs, much more cross-national, cross-sectoral and health policy-related analyses within Africa are needed. APHP provides the means to undertake sectoral analyses and strategies that will serve both the Bureau and USAID field missions, especially in measuring and reporting on impact. Similarly, to meet DFA objectives, missions and AFR/TR need to ensure that systems to produce better, more comparable data are in place, along with the resources to perform timely, in-depth studies and analyses that encompass the entire sector. In general, the Agency's approach to strategic sectoral planning has been fragmented, e.g., HIV/AIDS-specific or limited to child survival, with insufficient consideration accorded to broader issues, such as the overall impact of sectoral policies and programs on productivity. A mechanism, such as an HPN sectoral analytic agenda, is needed to identify and analyze priority sectoral issues, to test different approaches, and to frame a more comprehensive HPN sectoral strategy.

C. Project Goal and Purpose

Given the continued extremely poor health status, the overall goal of the APHP project is to improve health status in sub-Saharan Africa through reduced fertility, decreased childhood mortality and morbidity, lower incidence of HIV/AIDS, and reduced malaria.

This is an ambitious goal, with any one project in Africa influencing only marginally the overall health status of all Africans and especially children and mothers. In moving towards this goal, the APHP project will focus on: the cost-effectiveness and quality of the large A.I.D. bilateral HPN portfolio, key systemic and integration problems that are cross-national in nature, long-term capacity-building (both broadly speaking in host countries and within the Africa missions and AFR/Washington), and activities with the highest potential for impact. Accordingly, the project purpose is to increase the sustainability, efficiency and effectiveness of African public health and family planning systems to deliver services.

This approach associates APHP with the success of the bilateral HPN programs in Africa. By improving the sustainability,

effectiveness and efficiency of the more than \$1 billion in A.I.D. funds expected to be spent on HPN activities over the next decade, APHP will leverage substantial impact. In order to do this, APHP must be responsive to both mission and host government support needs while maintaining a regional analytic focus on important cross-national sectoral issues. In addition, the APHP approach acknowledges the evolving emphasis on institutional and integration issues for the 1990s crucial to improving health status in sub-Saharan Africa.

D. Expected Achievements/Accomplishments

By the end of its ten-year life, APHP is expected to achieve or accomplish the following:

1. More sustainable, efficient and effective systems to support HPN programs developed and in place, including innovative consolidation of these support systems where appropriate.
2. Critical HPN programming and policy issues identified and analyzed; program guidance developed and utilized by field missions and host governments.
3. Increased utilization of HPN services.
4. Strengthened institutional capacity and increased human resources.
5. Increased financing available for HPN programs.

E. Project Outline and How It Will Work

The Africa Public Health and Population Support project is designed to be a logical follow-on to the ACSI-CCCD, FHI-II, and HAPA projects. APHP will build on the most successful elements of the predecessor projects, retaining elements that have proved useful (for example, giving USAIDs access to S&T projects and providing the Bureau and missions with a mechanism for carrying out its analytic work). At the same time, the new project will shift the emphasis toward developing the systems, human resources, and policies to ensure that HPN programs can be sustained. The project will consist of two major components: a regional AFR/TR-funded core and a mission-funded buy-in component.

1. Regional Core Component
 - a. Analytic Support to Bureau and Missions

APHP will strengthen the Bureau's capacity to provide regional and country-level analysis, strategic planning and guidance in

the sector. The project will serve as the Bureau's main mechanism for assessing and reporting the impact of sectoral strategies and investments. Indeed, APHP will provide the principal means for the Bureau and missions to monitor trends, evaluate the sectoral progress and impact of the DFA, and provide policy and program guidance in the HPN sector.

To accomplish these objectives, a plan or analytic agenda designating priority topics for analyses will be developed in consultation with the REDSOs and field missions during the project design (and periodically refined thereafter). The plan will specify strategic issues, studies and technical assistance to be funded by the core budget. Issues are expected to include both broad policy matters as well as service-delivery and program-performance questions of regional significance. For example:

- o Develop frameworks for consolidation of support systems within vertical intervention programs.

- o Estimate impacts of high fertility, nutrition and infectious diseases (e.g., HIV/AIDS, malaria) on economic productivity.

- o Systematically codify the experience of country health and family planning policy-reform efforts in order to develop sector-level indicators and to measure impact.

- o Develop projection models like the HIV/AIDS impact model (A.I.M.) to influence USAID and host-country sector policy, plans and resource allocation.

- o Determine specific targets and benchmarks for the HPN sector that could be included in the DFA Action Plan.

- o Contrast program performance during the 1990s across the spectrum of 'consolidated' versus 'vertical' organizational approaches to support systems.

- o Develop a model on cost savings/benefits of HPN country interventions (an expansion of the RAPID III model).

Analytic activities will reinforce the ability of the Bureau and field missions to formulate program indicators for both efficiency and effectiveness and to monitor and evaluate program impact. The analyses under APHP will be designed to provide technical direction and programmatic leadership to the Bureau and missions. To enable the regional project to serve as a catalyst for missions to assess and implement new policy and program directions, a limited amount of focused country-specific technical assistance will be core funded. Such TA for in-country analytic support will be linked to broader objectives of developing sectoral indicators, formulating strategic program

guidance, and synthesizing impact across countries. The TA could include support in setting up information and surveillance systems, in strengthening population and health data bases, in consolidating support systems across vertical interventions, or in developing country-level indicators to measure impact.

APHP's analytic component is conceived as a problem-solving mechanism to address priority sectoral issues. It is a dynamic process: framing priority strategic issues, undertaking studies and analyses to address the issues, testing solutions, solving problems, reporting the findings and developing strategic program guidance, and then again refining the strategic issues and questions.

In addition, APHP will provide field missions and country programs with information and feedback on lessons learned from HPN programs that could be applied regionally, and will support regional workshops to enable participating countries to share and benefit from each other's experiences. This type of "cross-fertilization" has been a unique and valuable feature of the ACSI-CCCD Project.

b. Capacity Building

To foster national technical and managerial capacities, the APHP core will support a regional approach that will focus on increasing the skilled and trained manpower in the health sector and improving the forecasting, planning and utilization of those personnel. Technical assistance will be targeted to national institutions that serve or could serve regional teaching, training or research needs in health or family planning. The PP design will identify how the project's capacity-building component can complement and interface with the S&T portfolio. The S&T University Linkages project is expected to provide one mechanism for leveraging human-resource capacity building and strengthening institutional development in the sector. APHP also is expected to develop a simple institutional-assessment methodology as well as capacity-building indicators to be used by both the Bureau and field missions.

Given the difficulties and poor record of improving capacity on the continent and of strengthening African institutions, the project design needs to carefully assess what reasonably can be accomplished by a regional project. AFR/TR has identified a process to more clearly define APHP's role in capacity building. TR brought together an expert panel for a roundtable discussion with representatives from AFR/DP, AFR/PD, S&T, and TR to review the lessons learned from a quarter century of experience in this field, to frame the key issues, and to lay out options to be explored during the PP design. At that time, a cost analysis and feasibility assessment will be undertaken to determine the optimal APHP approach, including the role (if any)

the project will undertake in direct interventions and the role the project will play in stimulating or leveraging field-mission programs.

Operations research that relates to questions of regional importance will be identified by the Bureau, missions, and REDSOs in the formulation of the project's analytic agenda. The design and implementation of regionally-funded operations research will be linked to developing the capability of African investigators to carry out operational and health services research. Such research could include, for example, a study to evaluate revised approaches to community malaria control or to assess a new government-regulated private sector, for-profit contraceptive retail sales program that could have important implications throughout the region.

c. Resource Mobilization

APHP intends to support the rationalization of HPN sector planning and financing. The project aims to explore possible mechanisms for mobilizing increased donor resources for the sector and for instituting better in-country sectoral planning and resource allocation. Project core funds will be made available to support such a mechanism or activity if it is considered to be feasible and promising.

This component would involve multiple donors (including NGOs) and should be organized by a multilateral rather than bilateral donor. Already one possible mechanism, to be organized by the WHO Regional Office for Africa (AFRO), is being advanced, and has the preliminary support and potential involvement of the World Bank, African Development Bank, and the Belgian Cooperation. Important components of the proposed mechanism include liaison with external sources (donors), preparation of guidelines for African countries, training for host-government officials in identifying potential sources of support and in rationalizing the potential financial supply with demand, and technical assistance to countries in financial and HPN planning and in proposal writing.

Such a mechanism could, for example, include two long-term advisors. One advisor could be based in Washington, D.C. (or Geneva or elsewhere) and could provide liaison and updated information on global sources of HPN financing for Africa. This advisor could also provide liaison with USAIDs and AFRO, could assess regional financial needs in relation to potential sources, and could participate in regional training.

A second advisor, based in Brazzaville for example, could provide direct technical assistance to support African governments and USAIDs at the country level in identifying financial needs and constraints to external financing, in analyzing the needs compared to potential sources, in mobilizing the financing

(assist in selecting sources, preparing proposals, etc.), and in conducting country-level workshops.

As needed to complement the above assistance in planning external resources, country programs could also gain access to technical assistance through APHP or S&T for additional support in sectoral planning and analysis and to ensure that in-country resources are programmed in coordination with donor support. These analyses would encompass private sector means of implementing and financing HPN program objectives and would include an assessment of the policy and legal constraints to better resource use.

2. Country-Level Buy-in Component

APHP will facilitate missions' access to technical assistance in family planning, child survival, and HIV/AIDS. Country-level buy-ins are expected to include both a technical-intervention focus and a systemic, analytic focus. APHP's technical focus will encompass the cluster of family planning, HIV/AIDS and other sexually transmitted diseases, vaccine-preventable diseases, diarrheal diseases/dehydration, nutrition/improved child feeding, maternal care, breastfeeding, high-risk births, acute respiratory infections, and malaria. The specific country priorities will be determined by the missions and the host governments and assistance will be tailored to their specific needs. Although APHP buy-in access will be available to all missions, based on buy-ins under the current three regional projects, it is envisioned that the level and type of mission buy-ins will vary significantly between those missions with bilateral HPN programs and those missions without bilateral programs. In all cases, missions in Africa require a flexible mechanism to support critical country-level HPN activities for which programming alternatives are not appropriate.

It should be noted that APHP does not include core-funded long-term country-specific support such as the ACSI-CCCD project has undertaken in the past. In general, USAIDs will have to use their own operational year budgets (OYBs) to carry out country-specific activities and programs under APHP.

a. Missions with Bilateral HPN Activities

For the approximately 23 missions in Africa with current or planned bilateral HPN activities, APHP could assure access to Africa-focused technical assistance in order to:

- carry out sectoral or cross-sectoral assessments (e.g., analyzing the potential cost savings in the agricultural and educational sectors that could be realized by intensifying HIV/AIDS-control and family planning programs);

- develop support systems that encompass the cluster of technical interventions (e.g., to strengthen information and surveillance systems and ensure that data on both health and family planning parameters are included); or
- support and improve the design of country strategies, HPN sector-assistance programs and cross-cutting HPN projects (e.g., activities to improve financing, management and training relating to child survival, family planning, and HIV/AIDS interventions).

These are a few examples where APHP is expected to provide access to specialized TA for missions and host countries.

In addition, missions with bilateral HPN activities may use APHP to gain access to service-delivery mechanisms directly for specific interventions not included in their bilateral programs. This is especially important for HIV/AIDS-related assistance, which generally is not included in bilateral HPN programs and projects.

b. Missions without Bilateral HPN Activities

Although bureau policy encourages missions to develop bilateral HPN projects, some missions, especially those in smaller countries and Category II countries, may not have bilateral HPN projects for a number of reasons. APHP could benefit missions without such projects by providing a contract mechanism for carrying out sectoral activities without the transaction costs of developing a full bilateral. (Full project designs currently cost in the order of \$250,000 over a two-year timeframe; about \$1.5 million total during 1989.) Of course, USAIDs would still need to assess carefully their country situation and needs, and to develop a detailed country-specific action plan. This mechanism may be particularly valuable for missions seeking to obligate funds for HIV/AIDS activities in settings where a bilateral in-country project may not be appropriate, or for missions that desire to build on their country-specific ACSI-CCCD activities but are not yet ready to undertake a full-scale bilateral project. Also, missions without bilateral HPN projects would be able to have access to specialized, Africa-focused TA, according to their particular needs.

3. How It Will Work

For both core-funded and Mission-funded activities, the APHP project approach will maximize the use of existing Agency contractual relationships instead of developing new ones. AFR/TR will forge a new partnership with S&T that will maximize the use of existing TA resources within the Agency. Emphasis will be placed on developing a more innovative and easily accessible arrangement or expansion of existing S&T contracts to meet Africa

Bureau and mission needs, while retaining programmatic direction within AFR/TR.

Missions will be encouraged to buy in directly to S&T projects if mission buy-in funds can be attributed to the DFA. Where a suitable project already exists, as in the case of the S&T Health-funded Health Financing and Sustainability Project (936-5974) (and the buy-in ceiling is determined to be sufficient), APHP will provide guidance and assistance for field missions to gain access to such assistance. Where a regional authorizing mechanism is needed by missions, APHP will provide that mechanism. At the same time, where current S&T projects do not provide the expertise needed by missions or the APHP core, the project will work with S&T to try to make the needed assistance available through new or amended S&T projects.

Where critically-needed assistance cannot be arranged through S&T or where other alternatives do not exist, the Bureau will explore the feasibility of offering such assistance directly through APHP. In order to shift staff effort toward management of policy and analytic issues with less emphasis on contract management, the aim will be to minimize the total number of APHP-specific TA agreements managed by AFR/TR.

Several missions have underlined the need for continued access to the type of TA that CDC has provided in ACSI-CCCD (i.e., to combat malaria and other child survival problems and to strengthen information systems and epidemiologic surveillance). The PP design team again will review these needs and propose the most efficient and cost-effective mechanisms for addressing them, e.g., through an APHP-specific participating agency service agreement (PASA) with CDC, through expanding an existing S&T PASA, or otherwise.

A thorough review of the buy-in process is now underway and will be described in the PP. The objective will be to outline options for modernizing the process that would allow all missions direct access to S&T resources while maintaining DFA attribution. Success in achieving this objective would result in important AFR/TR administrative efficiencies. Absent a breakthrough in this arena, APHP-authorized subprojects and buy-ins to Africa-specific technical assistance will be processed as simply and expeditiously as is prudent and feasible, based on the FHI-II/HAPA models.

Increased divestment to missions of regional project management functions coupled with Agency manpower constraints suggest that a proactive role in APHP be defined for the Regional Economic Development Support Offices (REDSOs). The APHP analytic agenda will be programmed in conjunction with REDSOs. In order to provide continuing regional technical support to African field missions, the core will have the capacity, as HAPA, ACSI-CCCD and FHI-II currently do, to fund long-term technical advisors based

in the REDSOs. Advisors would assist the missions in the design, implementation, evaluation and analytical activities critical to APHP project objectives, serve as extension agents for the implementation of Bureau program and policy guidance and play a key role in maintaining the quality of APHP technical assistance.

IV. FACTORS AFFECTING PROJECT SELECTION AND FURTHER DEVELOPMENT

A. Social Considerations

The social feasibilities of public health and family planning projects within A.I.D. have been overwhelmingly demonstrated over the past twenty years. Yet social analyses are awkward features of regional and world-wide A.I.D. project documentation--especially projects in the 'social sectors' of health, family planning and education. To explore Agency conventions as background for this PID, AFR/TR reviewed social analysis portions of over twenty project papers: all AFR regional projects in the HPN sector, AFR regional projects in a few other sectors, S&T Bureau health and population projects, and several recent AFR mission HPN projects. Some regional/worldwide HPN project authorizations have virtually no 'social analyses' beyond listing direct and indirect beneficiaries (almost uniformly: infants, children, reproductive-age women, couples, households, communities, host-country ministry and nations--more or less in that order). We did not find a single social analysis that identified social groups that would "stand to lose" from HPN projects (a common feature of economic reform and non-social sector projects).

Social analyses as background for the APHP Project Paper may be similarly slim, since much of the subject matter of the APHP project, in fact, will consist of support for social and economic analyses of health and population dynamics as they may be made to enhance overall development efforts in Africa (e.g., per the section, "Analytic Support to Bureau and Missions"-III.E.1.a.). In our review, mission project authorizations were found to be far more specific and informative. Missions sometimes develop projects that are aimed towards specific groups, for example: urban vs. rural; the poorest; special occupational groups, and so forth. AFR/TR has already begun to provide analyses (including social soundness aspects) to missions for their preparation of CPSPs and projects, a process that would intensify under APHP. The preparation of the project paper will entail soliciting expert views on the priority that should be given to broad social analytic issues, testing the short list of issues offered earlier (III.E.1.a.) and the current approach of the Bureau for Africa in Assessment of Program Impact. The PP will provide a specific listing of those indicators and analytic issues judged most important for near-term and long-term

attention, and it will sketch a plan of action for improving API, producing studies highly relevant to mission programming and reporting.

Improving equity in access to key public health services, and helping to alleviate poverty are central to the purposes of all HPN and education activities of the Agency, and will be enduring features of AFR's strategy through the APHP project. Via APHP, AFR/TR studies will help identify those groups least served and most disadvantaged, and will help identify measures to most cost effectively reach them and ways to advocate and achieve durable policy changes.

B. Economic and Financial Considerations

APHP consolidates previous regional support projects in health, family planning and HIV/AIDS, provides training and institution-building activities to strengthen African institutions, and seeks to improve, inter alia, sectoral analysis, planning and resource mobilization to achieve increased sustainability, efficiency and effectiveness of service delivery systems. Through these activities, the APHP will contribute to achieving DFA Target 1-3 of improved equity and efficiency in providing key public services particularly health, family planning services, education and transportation infrastructure. It will help in reducing the falling, but still unacceptably high rates of mortality and morbidity as well as in reducing the high rates of fertility in sub-Saharan Africa. The relevant economic consideration for this project is its cost-effectiveness in achieving the objectives of mortality, morbidity and fertility rate reductions and reduction of the incidence of HIV/AIDS in comparison with reasonable alternative approaches for achieving the same objectives. This project is justified to the extent that the regional support function provided through the project contributes to the development of more effective and sustainable interventions in health, population and nutrition.

The analysis for the project paper will not attempt to carry out a benefit-cost analysis because of the pitfalls associated with valuing human life and the insurmountable difficulties associated with attempting to quantify the effect of regional support activities on ultimate changes in goal-level indicators. Instead, the analysis will be made in terms of cost-effectiveness. Starting with the objectives of mortality, morbidity and fertility rate reductions (some quantitative targets were set in the DFA Action Plan, May, 1989), the analysis will first describe the need for certain support functions in order to develop and implement effective programs. It will then illustrate the cost-effectiveness of the approach that is proposed for providing these support functions as compared with other plausible approaches for providing the same support functions.

This paper argues that there are two fundamental reasons for the proposed consolidation of regional support activities. The first is the well-researched and documented synergy between fertility and mortality reduction, hence the value of a flexible integrated approach which does not artificially separate project interventions in fertility and mortality. The second is the improved management of the support function that will make it possible to focus increased attention on the results of the activities rather than primarily input- and process-oriented management. The project paper will illustrate with examples the types of management-time savings and cost savings as well as improvements in the quality of planning and programming that will be made possible through this integrated approach to health, population and nutrition program development and support.

Given the tenuousness of the links between planning, monitoring, training and related activities to the ultimate effectiveness of health and family planning interventions, it is not to be expected that the cost-effectiveness analysis for this project will result in numbers that clearly demonstrate the superiority of approach A to approaches B and C. However, it should be possible to describe clearly the expected cost-effectiveness of the approaches analyzed with qualitative discussions of the advantages and disadvantages of each approach.

The economic analysis will also discuss the factors that influence the decision about the magnitude or scale of the proposed regional support activity such as, inter alia, the expected growth in the demand for health and family planning services and the sustainability of these services when they are appropriately designed.

C. Relevant Experience with Similar Projects

The APHP Support project is modeled on the successful components of three current regional projects, FHI-II, ACSI-CCCD and HAPA. The programming flexibility that is inherent in the FHI-II and HAPA projects provided the conceptual framework for the APHP project. The achievements that can be gained from focused technical assistance, such as the ACSI-CCCD project demonstrated, shaped the project emphasis on strengthening key support systems and analytic capacity.

The FHI-II project was authorized in August 1986, with LOP funding of \$20 million and a PACD of September 1994. FHI-II was designed as an umbrella project developed for flexibility and speed in meeting population/family planning needs in Africa beyond the scope of bilateral activities. A management assessment, undertaken between December 1989 and March 1990, noted that "it is clear that FHI-II has made a substantial contribution to advancing Agency and host country population objectives in Africa. However, procedures and staff in AFR/TR/HPN are inadequate to track and monitor subproject

activities, coordinate with other AID or donor population projects or to carry out the strategic planning and reporting required by the Bureau. Additionally, the present management/fiscal structure and procedures are not adequately monitoring FHI-II performance, nor are there comprehensive monitoring or reporting systems which allow either individual subproject or overall FHI-II project accomplishments to be reconciled with expenditures."

AFR/TR and the APHP design have addressed most if not all of the issues identified in the FHI-II assessment. For example, the Bureau of Census (BuCen) has assisted in developing a management information system to track and monitor fiscal and programmatic information for both the FHI-II and ACSI-CCCD projects, an expanded role for REDSO has been outlined in APHP, and a reorganization of AFR/TR/HPN staff work effort is expected to allow adequate time for strategic planning and program reporting.

The HAPA project was authorized in June 1988 and has a June 1991 PACD. The project was patterned on the FHI model. An external evaluation of the project will be conducted early in 1991, but again demand for access to AIDS assistance mechanisms through HAPA has been heavy.

The ACSI-CCCD project, authorized in FY 1981, predated the Agency's increasing emphasis on child survival. Lessons learned over the life of the project include: technical-intervention templates for immunization and diarrheal disease programs required substantial modifications in each country setting; exchange of country-level experiences among all ACSI-CCCD countries was useful but could have had more impact with wider dissemination; the focus on two selective interventions showed important impact on infant and child mortality rates, but did not address systemic or institutional problems leading to little sustainability of activities; the project had major problems leveraging change when just working with two interventions; and, because ACSI-CCCD was mainly core-funded, research and evaluation agendas were externally driven instead of responding to specific mission and host country needs.

APHP will use the technical achievements of the ACSI-CCCD project, particularly in the area of epidemiologic surveillance and information systems, as a foundation for strengthening these program elements in the new regional project. Increased emphasis will be placed on strengthening the HPN institutions and systems to increase sustainability and effectiveness.

D. Project Management and A.I.D. Support Requirements

The justification for consolidating the existing regional projects relates in part to the synergy and interrelationships between family planning, HIV/AIDS, and child survival programs, and to the recognition that support systems often can cut across

interventions, resulting in more efficient, sustainable programs. In line with the DFA approach, APHP favors comprehensive sectoral analysis and also provides the flexibility to shift resources toward sub-sectors or activities that are performing well, and a way from those that are faring poorly. Annex E provides a more comprehensive rationale for consolidating the regional HPN projects.

The following changes and their management implications will occur as a result of consolidation of the current regional projects.

1. Country-specific projects will not be funded by APHP core funds or managed by AFR/TR. Administrative, contracting and logistic actions associated with ACSI-CCCD, HAPA and FHI-II country-specific project implementation will be absorbed by the missions.

2. Contracting mechanisms will be streamlined. Under the current regional projects there were five PASAs, eight grants, and one cooperative agreement for regional project technical assistance. APHP objectives will be to reduce significantly the number and complexity of contract actions and to use, to the fullest extent, existing Agency resources especially in S&T.

3. Direct hire work effort will be refocused. A preliminary AFR/TR project management structure (Annex B) will permit A.I.D. direct-hire staff to focus on carrying out analysis, formulating sectoral strategy and developing policy and program impact indicators. The shift in regional project focus from implementing in-country project activities to using 'core' resources and technical assistance to leverage Bureau program and policy, should permit HPN staff to realign their work with less time spent on the myriad day-to-day contractor communications, logistics and liaison activities. Increased use of S&T technical assistance should shift a significant portion of the contract management and oversight burden to on-going S&T projects.

4. A project MIS will be developed as recommended in the recent FHI-II mangement assessment.

5. The REDSOs will play a key role in framing the project's (and AFR/TR's) overall analytic agenda. REDSOs will also provide technical assistance in support of APHP objectives, will assist in monitoring project progress, will participate in project analyses, designs, and evaluations, and will assist missions (particularly Schedule B missions) in preparing PIO/Ts.

At the country level, USAIDs will be responsible for the implementation and management of the mission-funded APHP project activities in their country. As noted above, APHP will serve to authorize activities across the A.I.D. HPN menu. Thus, project officers will not have to deal with multiple project

authorizations, as may be the case currently. Especially if there were only one USAID HPN officer, the APHP mechanism would simplify program management. Moreover, if the USAID were not adequately staffed to manage the project, APHP could also provide the authorization to supplement the direct-hire staff with a technical advisor for AIDS and child survival (TAACS), child survival or population fellow, or other type of personnel that could assist in project management.

E. Estimated Costs and Methods of Financing

The planned ten-year APHP Support project will have an estimated life-of-project cost of \$95 million. Required A.I.D. financing for the core program is estimated to be about \$52 million while Mission buy-ins are estimated to be around \$43 million. These figures are preliminary estimates at this time; the PP design will ascertain more specific mission demands for buy-ins and types and levels of core-funded support. Table 1 provides a breakdown of the various cost categories and preliminary cost estimates for each category. Annex F provides a detailed preliminary budget by category and by year over the ten-year LOP.

Table 1
AFRICA PUBLIC HEALTH AND POPULATION SUPPORT PROJECT
PRELIMINARY BUDGET - ESTIMATED COSTS (\$'000)

	PROJECT TOTAL		Total
	Core	Buy-In	
I. Analytic Support			
A. Technical Assistance	\$18,100	\$14,875	\$32,975
B. Specific Studies/ Analyses	\$4,320	\$0	\$4,320
C. Comm./Equip. for LT TA	\$500	\$0	\$500
D. Conferences/Workshops	\$2,800	\$0	\$2,800
E. Oper. Research, Epid. Surveil., HIS	\$4,950	\$2,700	\$7,650
II. Capacity Building			
A. Linkage Grants	\$7,200	\$0	\$7,200
III. Resource Mobilization			
A. Short-term TA	\$2,375	\$0	\$2,375
B. 2 LT Advisors	\$5,000	\$0	\$5,000
C. Workshops/conferences	\$0	\$1,000	\$1,000
IV. Other Mission Buy-Ins			
A. Other ST TA needs	\$0	\$5,800	\$5,800
B. Tech. Intervention Sup	\$0	\$15,000	\$15,000
V. Administrative Contract			
A. 2 LT Contractors	\$2,850	\$0	\$2,850
SUB-TOTAL PROJECT	\$48,095	\$39,375	\$87,470
Contingency/Inflation (8%)	\$3,848	\$3,150	\$6,998
TOTAL PROJECT	\$51,943	\$42,525	\$94,468
ROUNDED TO:	\$52,000	\$43,000	\$95,000
	55%	45%	

The methods of financing for the APHP project will most likely include direct contracts, participating agency service agreements (PASAs), and cooperative agreements. Again, the PP will delineate the exact methods for financing the required project assistance.

F. Design Strategy

In developing the project paper, AFR/TR will be assisted by a multidisciplinary team of public health, family planning and management consultants contracted and managed by TvT Associates. The contractor design team will incorporate Africa-specific professional skills in: (1) public health management and administration, (2) social science, (3) economics (4) public health planning as related to child survival, HIV/AIDS, population and family planning, (5) financial management and planning, and (6) A.I.D. program development and evaluation.

Among the issues to be examined during the project paper (PP) design are the following program and implementation issues:

Program Issues

1. APHP accords major management responsibilities to field missions. Given growing OE constraints, the Bureau needs to assure that HPN direct-hire staff (Backstop 50) will be sufficient to carry out these responsibilities. Otherwise, additional in-country oversight must be arranged. One possibility to consider would be to assign additional TAACS or APHP-funded staff to the field missions and to strengthen their oversight from BS-50 staff in the regional offices or in A.I.D./W. However, one drawback to this course of action is the current prohibition against using DFA funds for TAACS. This issue will be re-examined during the PP design.

2. Buy-ins to S&T Directly: It is unclear whether missions will be able to buy in directly to S&T projects using non-authorized, unobligated funds, and retain DFA attribution of these funds. The Bureaus should develop an accounting mechanism to assure attribution so that APHP will not need to serve as an authorizing mechanism for "pass-through" to S&T projects.

Implementation Issues

1. Technical Assistance: A comprehensive analysis of mission technical assistance needs that the project might meet through core TA contracts or buy-ins to S&T will be developed. In conjunction with a projection of mission TA needs, a survey of the S&T portfolio is necessary as are negotiations with S&T to facilitate intra-Agency TA planning.

2. Management: In order for AFR/TR to achieve a balanced broad sectoral approach to planning and allocating project resources, the criteria and policies for apportioning core resources and processing missions' requests for core funding will need to be developed.

An analysis of the management and fiscal/administrative component of the proposed APHP project will need to be conducted in order to assess Agency, Bureau and mission administrative and management capabilities in areas relevant to the implementation of the APHP project and to determine how the management plan outlined in the APHP PID (see Annex B) will impact on the Bureau management burden. The PP will outline management-information needs and ways to streamline project buy-in procedures, options for the most efficient ways to reduce the project-management and fiscal/administrative burden, and the staffing capabilities needed in AFR/TR for project implementation.

3. Institutional Strengthening and Mobilization of Resources: The PP design will include an assessment of the costs and programmatic feasibility of various options for the APHP capacity-building component. A detailed strategy will be developed specifying the role of the regional project, and identifying key institutions and the level and magnitude of effort required to produce a measurable impact on manpower development in the sector. Also, the PP will analyze and define the options available for structuring the project component related to mobilizing external resources.

4. Evaluation: Evaluation of a regional project that focuses on analysis, systems development and institutional strengthening presents unique problems and opportunities. A strategy for evaluating the impact of the project's core component will be developed as part of the PP design.

G. Recommended Environmental Threshold Decision

The project activities fall within the class of action subject to a categorical exclusion, as described in Provision 22 CFR 216.2 (c)(i), (viii), and (xiv), thus, no further environment review should be necessary. These provisions include activities which are (i) education, technical assistance, or training programs; (viii) programs involving nutrition, health care or population and family planning services, and: (xiv) studies, projects or programs that are intended to develop the capability of recipient countries to engage in development planning. This project clearly fits these categories of categorical exclusion, thus not subject to further environmental review. The Initial Environmental Examination is shown in Annex D.

H. A.I.D. Policy Issues

An issue for discussion during the PID review is as follows:

1. Under the DFA, the Bureau has been designating separate emphasis countries for child survival, family planning, and HIV/AIDS. However, this practice has favored vertical analysis and programming. To foster overall HPN sectoral analysis, planning, and programming, it would be desirable to discontinue designating sub-sectoral emphasis countries. Rather, each country would be approached and analyzed in an integrated manner, and then once needs and priorities are established at the host-country and USAID levels, country planning and programming would proceed (in accordance with the CPSP and API).

ANNEXES

BUREAU FOR AFRICA
OFFICE OF TECHNICAL RESOURCES
STATEMENT OF GOAL AND FUNCTIONS

GOAL: AFR/TR supports the overall effort of the Africa Bureau to increase socio-economic growth and improve the quality of life for the peoples of Africa by:

1. DEVELOPING STRATEGIES AND PROVIDING SECTORAL ANALYSES FOR THE BUREAU AND THE FIELD.

Our Products

Our focus is on six sectors

and on cross-cutting issues, such as:

- Health
- Family Planning
- Basic Education
- Natural Resources
- Agribusiness and Marketing
- Agricultural Research

- Employment and Labor Productivity
- Human Resource Development
- Food Security and Nutrition
- Global Climate Change
- Population and Demographics
- Capacity Building
- Technology Development and Transfer

2. SUPPORTING THE WORK OF THE FIELD IN IMPLEMENTING STRATEGIES, MEASURING IMPACT, AND OBTAINING RESOURCES.

Our Services

We assist Missions and the Bureau in activities such as:

- Developing indicators and designing data collection systems
- Carrying out studies and impact evaluations
- Forging linkages with donors, regional organizations and universities
- Managing regional projects and backstopping Missions

3. PROVIDING TECHNICAL LEADERSHIP AND SHARING INFORMATION.

Our Colleagues and Constituents

We work with a wide range of groups:

- African institutions
- Other A.I.D. offices and U.S. government agencies
- Bilateral and multilateral donors
- Voluntary organizations
- Universities
- Congress
- Think-tanks

In order to:

- Communicate priorities and programs of the Development Fund for Africa
- Disseminate results of impact studies and policy work
- Acquire additional support and resources
- Stay current on development issues

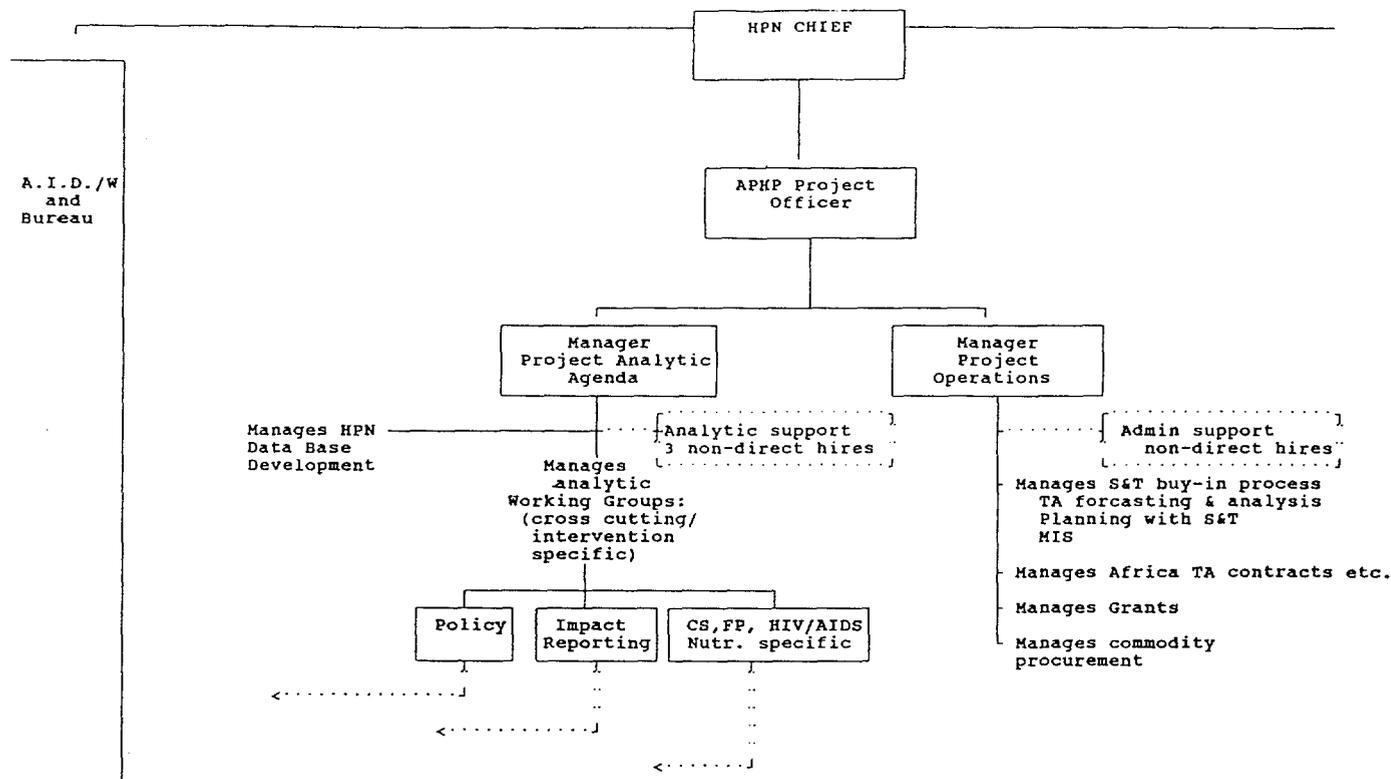
4. SERVING AS A CENTER FOR TRAINING AND DEVELOPMENT OF TECHNICAL AND PROFESSIONAL STAFF.

Our People

We provide an environment for our staff to participate in strategy work; to involve themselves in issues of the day; to improve management skills; to expand their contacts inside and outside AID; and take full advantage of training and professional opportunities.

Annex B

THE APHP PROJECT MANAGEMENT STRUCTURE



The proposed APHP project management structure will permit A.I.D. direct-hire staff to focus on analysis, sectoral strategy and guidance, allocating project resources, donor coordination and sectoral monitoring and evaluation. The objectives of the management structure are:

- o to minimize the amount of time A.I.D. direct hire staff devote to management and administration of regional project operations and maximize the time available for sectoral planning and analysis,
- o to assure a balance, broad-based approach to strategic planning and the allocation of core resources while assuring special interest issues in child survival, population, malaria and HIV/AIDS are not diluted, and
- o to outline clear lines of authority with roles and responsibilities spelled out; investing A.I.D. direct hire staff with prime decision making powers and delegating routine administrative procedures to non direct-hire personnel.

Project decision-making and management will be invested in three direct-hire positions; project officer, and managers of the analytic agenda and of project operations. It is anticipated that in the start-up phase of the project a total of two FTEs will be needed for the management and administration of project activities (Project officer .5 FTE; manager of the analytic agenda 1 FTE and manager of project operations .5 FTE). All HPN direct-hire staff will participate in the analytic functions of the project, either as members of working groups on cross-cutting issues or as coordinators for specific analytic activities, e.g., nutrition. It is expected that other HPN direct-hire staff will devote approximately 40% of their time to project analytic

issues. The 6 non-direct hire HPN staff, (AAAS and child survival fellows, RSSAs, TAACS or contractors) will be supervised by the managers of the analytic and program operations group. It is anticipated that approximately 60% of non-direct-hire time will be in support of project activities.

The project officer will be responsible for coordinating the Analytic and Operations Groups, approving project plans and budgeting, and managing donor coordination activities. The project officer would function as chairman of the three-person project management group.

The manager of the project analytic agenda will be responsible for identifying project analytic issues and HPN staff or contracting mechanisms to carry out studies, coordinating cross sectoral working groups and sub-sectoral studies, and developing the HPN data bases.

The manager of project operations will be responsible for managing the S&T buy-in process, administering Africa-specific TA contract agreements and Grants, maintaining the MIS and supervising the administrative contractor. During the start-up phase of the project it would be preferable to have a direct-hire in this position. However, once S&T negotiations are completed, and routine procedures and policies are established a non-direct hire, such as a TAACS (a non-direct hire with the authorization to assume supervisory, managerial and contractual duties of direct hire personnel) could assume major responsibility for coordination of this cluster of activities. If a non-direct hire assumes these responsibilities the position title should reflect a lower level of decision making authority, i.e., "coordinator".

The administrative contractor will provide personnel to facilitate routine day-to-day project management as well as coordination within the Agency and with organizations providing project technical assistance.

A thorough assessment of the proposed organization structure, management and administrative structure of the project will be conducted for the project paper. Attention will be focused on ways to optimize use of TR resources in project management, refining the organization structure, outlining functions, responsibilities and lines of authority for project personnel and identify the administrative, management and technical capabilities and staffing pattern needed in AFR/TR/HPN to implement the project.

ANNEX C

Project Name : APHP Support Project

Est. Completion :

Date of Revision:

Design Team : AFRICA BUREAU

Narrative Summary (NS)	Measureable Indicators (OVI)	Means of Verification (MOV)	Important Assumptions
<p>Goal: 1 Improve health status through decreased childhood mortality and morbidity, decreased fertility, reduced malaria and lower incidence of HIV/AIDS in sub-saharan Africa</p>	<p>1.1 decrease in total fertility rates reduction in infant and child mortality and morbidity reduction in HIV/AIDS incidence</p>	<p>1.1 Demographic & Health Survey and other survey data census data epidemiologic surveillance HIV serosurveys</p>	<p>(goal to supergoal) 1.1 Improvements in health status will not be offset by other factors, such as civil violence, famine, or declining economic conditions</p>
<p>Purpose: 1 increased sustainability, efficiency and effectiveness of African public health and family planning systems in delivery of services</p>	<p>1.1 more sustainable, efficient and effective systems to support HPN progrms developed and in place critical HPN programming and policy issues identified and analyzed; programs guidance developed and utilized by field missions and host governments increased number of clients for HPN services strengthened institutional capacity and increased human resources increased financing available to HPN programs</p>	<p>1.1 Bureau strategy documents APHP management information system (MIS) mission and country reports project evaluations project reports donor reports</p>	<p>(purpose to goal) 1.1 host governments and A.I.D. continue focus on bilateral HPN activities; support for service delivery activities continues on mainly bilateral basis private sector and NGOs become more involved with service delivery economic and political environments remain/become conducive to sustainability other donor resources continue to be available for HPN programs host governments willing to change/integrate vertical programs and/or support systems as needed</p>
<p>Outputs: 1 ANALYTIC SUPPORT improved Mission and Bureau data systems, analysis and reporting on performance and impact of HPN sector. Policy and program guidance developed based on program analysis. information systems (ESS, HIS, and MIS) in participating countries collecting integrated, multipurpose impact, management and service delivery data Project analytic agenda for HPN developed and analyses carried out in close coordination with REDSOs and Missions</p>	<p>1.1 AFR/TR population and health data base and MIS in place special studies commissioned to address Bureau analytic agenda. indicators for program efficiency/effectiveness and sustainability developed sectoral trends monitored and reported impact of sectoral investments analyzed and reported regional and country HPN strategies developed country sectoral program analyses conducted</p>	<p>1.1 APHP project reports</p>	<p>(output to purpose) 1.1 Missions and host governments fully participate in broad level of studies and analyses Missions and host governments utilize and implement recommendations of relevant analyses A.I.D. assistance levels for bilateral HPN programs remain constant or increase Missions and host governments request project support</p>

<p>2 REGIONAL CAPACITY BUILDING</p> <p>key public health and family planning training and teaching institutions strengthened</p> <p>3 RESOURCE MOBILIZATION</p> <p>multilateral mechanism developed to increase mobilization of external resources</p> <p>in-country resurces for HPN activities identified and mobilized</p> <p>4 Flexible mechanism established to enable Missions to supprot needed sectoral activities not appropriate throughother mechanism</p>	<p>technical and management assessment of information system conducted in countries utilizing project inputs</p> <p>data used for decision making and management of resources</p> <p>2.1 policy, management and technical assessment conducted in targeted training institutions.</p> <p>management and technical assistance provided</p> <p>operational research studies of regional importance conducted by institution</p> <p>3.1 multilateral donor group provides technical assistance and training, donor liaison and guidelines to assist countries to gain access to external resources</p> <p>4.1 Mission buy-in levels for country activities</p>	<p>2.1 APHP program reports and MIS</p> <p>evaluations</p> <p>institution reports</p> <p>3.1 donor reports</p> <p>4.1</p>	<p>2.1 missions and host governments request project services</p> <p>governments and institutions request project assistance</p> <p>multilateral donor collaboration mechanism established</p> <p>3.1</p> <p>4.1</p>
<p>Activities:</p> <p>1.1</p> <p>2.1</p> <p>3.1</p>	<p>Inputs/Resources:</p>	<p>1.1</p> <p>2.1</p> <p>3.1</p>	<p>(activity to output)</p> <p>1.1</p> <p>2.1</p> <p>3.1</p>

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ANNEX D

INITIAL ENVIRONMENTAL EXAMINATION
CATEGORICAL EXCLUSION

PROJECT COUNTRY: Africa Regional
PROJECT TITLE: Africa Public Health and
Population Project (698-0476)
IEE PREPARED BY: Susan Merrill, AFR/PD/CCWA
ENVIRONMENTAL ACTION RECOMMENDED:

Positive Determination _____
Negative Determination _____
Categorical Exclusion X
Deferral _____

SUMMARY OF FINDINGS:

This Program is eligible and recommended for categorical exclusion pursuant to Section 22 CFR 216.2(c) because it will not have an impact on the physical and natural environment; and because pursuant to the provisions of 22 CFR 216. 2 (c)(2)(i)(viii), and (xiv) it will fund technical assistance, analyses, studies, academic or research workshops and meetings; and health and family planning activities; and is intended to develop the capability of the recipient country to engage in development planning.

CONCURRENCE:

Bureau Environmental Officer:
John J. Gaudet (AFR/TR/ANR)

APPROVED:
DISAPPROVED:
DATE:

CLEARANCE:

GC/Africa: KEM

DATE: 8/20/90

ANNEX E

The Rationale for a Consolidated Regional Project

APHP builds on the systems and successful activities of three current regional projects: ACSI-CCCD, which solidly supports the Bureau's child survival strategy; FHI II, which operates in congruence with the Bureau's population and family planning strategy; and HAPA, through which much of the Bureau's program to prevent and control HIV/AIDS is carried out. The project activity completion date (PACD) for HAPA is June 30, 1991, while that for ACSI-CCCD is September 30, 1991. FHI-II is scheduled to continue until September 30, 1994.

The three regional HPN projects (ACSI-CCCD, FHI II, and HAPA) account for a surprisingly large percentage of bureau obligations in the HPN sector. The Bureau obligated about \$65 million of 'core' funds and about \$50 million of mission 'buy-in' funds through these three regional projects during the first three years of the DFA. Core funds accounted for almost 20 percent of all DFA funding for HPN activities in Africa (most of it through ACSI-CCCD); including buy-ins, these three projects have accounted for nearly 35 percent of total HPN obligations. Since the DFA started in 1988, 10 missions have major programs under ACSI/CCCD, eight missions have FHI-II activities and eight have HAPA buy-ins. A great deal of project activity has been managed by remarkably few USDH personnel. Large regional projects have been efficient in this context, with low 'transaction costs' to the A.I.D. system. However, much of the management has been centralized in the U.S. Now, to foster greater sustainability of A.I.D.'s programs, among the most basic changes in Bureau operations under the DFA, Bureau management is urging Missions to design their own, bilateral population and health programs.

Indeed, eleven missions plan to design bilateral HPN projects during FY91-92, and four of these are in missions with no current bilateral HPN projects. Despite these important trends, African missions will continue to need a flexible regional mechanism for HPN programming to complement bilateral projects or to undertake activities in technical areas not included in the bilateral projects. Preliminary indications from missions during the PID design process are that even more specialized or cross-cutting requests will continue to be demanded.

Regional projects have served the Bureau well in meeting Congressional mandates, and in fostering transnational technical collaboration. Regional authorizations make it possible to support critical activities that do not fit under country agreements, and they help enforce concentration on issues of regional significance that usually is not possible (or even desirable) in mission programs and in AID/W central bureaus.

Overall rationale for consolidating the current three regional projects into APHP involve two related themes: (1) more efficient management within TR of regional HPN activities and (2) comprehensive sectoral (as opposed to sub-sectoral) analysis, planning and programming.

As discussed in Section IV.D., the consolidated APHP project will have fewer contractual mechanisms and more rational oversight and management responsibilities than the current combined three regional projects. Likewise, under the predecessor projects, planning, analysis, programming, and reporting essentially are limited to the project's sub-sectoral focus. Similarly, although the Bureau for Science and Technology (S&T) offers missions an extraordinary array of technical services, all but a few S&T projects by design are sharply limited in scope. A more consolidated approach is needed to ensure that the new regional project takes maximal advantage of the DFA mandate and flexibilities, fosters efficiencies within the sector, and focuses on appropriate sectoral (and cross-sectoral) analyses and strategies.

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ANNEX F -- Table 1
AFRICA PUBLIC HEALTH AND POPULATION SUPPORT PROJECT
PRELIMINARY BUDGET - ESTIMATED ANNUAL COSTS (\$000)

COMPONENT	Unit Cost	YEAR ONE			YEAR TWO			YEAR THREE			YEAR FOUR			YEAR FIVE			YEAR SIX		
		Core	Buy-In	Total	Core	Buy-In	Total	Core	Buy-In	Total	Core	Buy-In	Total	Core	Buy-In	Total	Core	Buy-In	Total
I. Analytic Support																			
A. Technical Assistance																			
1. Long-term:																			
-3 Analysts in AFR/TR/HPN	\$150	\$225		\$225	\$450		\$450	\$450		\$450	\$450		\$450	\$450		\$450	\$450		\$450
-4 Advisors in REDSDs	\$250				\$1,000		\$1,000	\$1,000		\$1,000	\$1,000		\$1,000	\$1,000		\$1,000	\$1,000		\$1,000
-Advisors in Missions(BI)	\$250		\$1,250	\$1,250		\$1,250		\$1,250		\$1,250		\$1,250		\$1,250		\$1,250		\$1,250	\$1,250
2. Short-term:																			
-24 p/m per year (Core)	\$25	\$150		\$150	\$600		\$600	\$600		\$600	\$600		\$600	\$600		\$600	\$600		\$600
-12 p/m per year (BI)	\$25		\$300	\$300		\$300		\$300		\$300		\$300		\$300		\$300		\$300	\$300
B. Specific Studies/ Analyses (4 per year)																			
	\$120				\$480		\$480	\$480		\$480	\$480		\$480	\$480		\$480	\$480		\$480
C. Commodities/Equip for LT TA																			
		\$100		\$100				\$100		\$100				\$100		\$100			\$100
D. Conferences/Workshops																			
		\$100		\$100	\$300		\$300	\$300		\$300	\$300		\$300	\$300		\$300	\$300		\$300
E. Operational Research, Epidem. Surveil./HIS (Core) (Buy-In)																			
					\$550		\$550	\$550		\$550	\$550		\$550	\$550		\$550	\$550		\$550
						\$300	\$300		\$300	\$300		\$300	\$300		\$300	\$300		\$300	\$300
II. Capacity Building																			
A. Grants for Inst. Linkages																			
-1 per year	\$900				\$900		\$900	\$900		\$900	\$900		\$900	\$900		\$900	\$900		\$900
III. Resource Mobilization																			
A. Short-term TA																			
	\$25	\$125		\$125	\$250		\$250	\$250		\$250	\$250		\$250	\$250		\$250	\$250		\$250
B. 2 LT Advisors																			
	\$250	\$500		\$500	\$500		\$500	\$500		\$500	\$500		\$500	\$500		\$500	\$500		\$500
C. Workshops/conferences																			
			\$100	\$100		\$100		\$100		\$100		\$100		\$100		\$100		\$100	\$100
IV. Other Mission Buy-Ins																			
A. Other ST TA needs																			
	\$20		\$400	\$400		\$600	\$600		\$600	\$600		\$600	\$600		\$600	\$600		\$600	\$600
B. Tech. Intervention Sup.																			
			\$1,500	\$1,500		\$1,500	\$1,500		\$1,500	\$1,500		\$1,500	\$1,500		\$1,500	\$1,500		\$1,500	\$1,500
V. Administrative Contract																			
A. 2 LT Contractors																			
	\$150	\$150		\$150	\$300		\$300	\$300		\$300	\$300		\$300	\$300		\$300	\$300		\$300
SUB-TOTAL PROJECT																			
		\$1,350	\$3,550	\$4,900	\$5,330	\$4,050	\$9,380	\$5,430	\$4,050	\$9,480	\$5,330	\$4,050	\$9,380	\$5,430	\$4,050	\$9,480	\$5,330	\$4,050	\$9,380
Contingency/Inflation (8%)																			
		\$108	\$284	\$392	\$426	\$324	\$750	\$434	\$324	\$758	\$426	\$324	\$750	\$434	\$324	\$758	\$426	\$324	\$750
TOTAL PROJECT																			
		\$1,458	\$3,834	\$5,292	\$5,756	\$4,374	\$10,130	\$5,864	\$4,374	\$10,238	\$5,756	\$4,374	\$10,130	\$5,864	\$4,374	\$10,238	\$5,756	\$4,374	\$10,130

NOTE: This budget assumes that Missions will be able to buy-in directly to S&T projects for most buy-in requirements. If attribution to the DFA continues to be a problem and buy-in through APHP is required, the buy-in budget will be considerably higher.

83

ANNEX F -- Table 1
AFRICA PUBLIC HEALTH AND POPULATION SUPPORT PROJECT
PRELIMINARY BUDGET - ESTIMATED ANNUAL COSTS (\$000)

COMPONENT	Unit Cost	YEAR SEVEN			YEAR EIGHT			YEAR NINE			YEAR TEN			PROJECT TOTAL		
		Core	Buy-In	Total	Core	Buy-In	Total	Core	Buy-In	Total	Core	Buy-In	Total	Core	Buy-In	Total
I. Analytic Support																
A. Technical Assistance																
1. Long-term:																
-3 Analysts in AFR/TR/HPN	\$150	\$450		\$450	\$450		\$450	\$450		\$450	\$225		\$225	\$4,050	\$0	\$4,050
-4 Advisors in REDSOs	\$250	\$1,000		\$1,000	\$1,000		\$1,000	\$1,000		\$1,000	\$500		\$500	\$8,500	\$0	\$8,500
-Advisors in Missions(BI)	\$250		\$1,250	\$1,250		\$1,250	\$1,250		\$1,250	\$1,250		\$625	\$625	\$0	\$11,875	\$11,875
2. Short-term:																
-24 p/m per year (Core)	\$25	\$600		\$600	\$600		\$600	\$600		\$600	\$600		\$600	\$5,550	\$0	\$5,550
-12 p/m per year (BI)	\$25		\$300	\$300		\$300	\$300		\$300	\$300		\$300	\$300	\$0	\$3,000	\$3,000
B. Specific Studies/ Analyses (4 per year)																
	\$120	\$480		\$480	\$480		\$480	\$480		\$480	\$480		\$480	\$4,320	\$0	\$4,320
C. Commodities/Equip for LT TA																
		\$100		\$100			\$100	\$100		\$100	\$100			\$500	\$0	\$500
D. Conferences/Workshops																
		\$300		\$300	\$300		\$300	\$300		\$300	\$300		\$300	\$2,800	\$0	\$2,800
E. Operational Research, Epidem. Surveil./HIS (Core) (Buy-In)																
		\$550		\$550	\$550		\$550	\$550		\$550	\$550		\$550	\$4,950	\$0	\$4,950
			\$300	\$300		\$300	\$300		\$300	\$300		\$300	\$300	\$0	\$2,700	\$2,700
II. Capacity Building																
A. Grants for Inst. Linkages																
-1 per year	\$900	\$900		\$900	\$900		\$900	\$900		\$900				\$7,200	\$0	\$7,200
III. Resource Mobilization																
A. Short-term TA	\$25	\$250		\$250	\$250		\$250	\$250		\$250	\$250		\$250	\$2,375	\$0	\$2,375
B. 2 LT Advisors	\$250	\$500		\$500	\$500		\$500	\$500		\$500	\$500		\$500	\$5,000	\$0	\$5,000
C. Workshops/conferences			\$100	\$100		\$100	\$100		\$100	\$100		\$100	\$100	\$0	\$1,000	\$1,000
IV. Other Mission Buy-Ins																
A. Other ST TA needs	\$20	\$600		\$600	\$600		\$600	\$600		\$600	\$600		\$600	\$5,800	\$0	\$5,800
B. Tech. Intervention Sup.		\$1,500		\$1,500	\$1,500		\$1,500	\$1,500		\$1,500	\$1,500		\$1,500	\$15,000	\$0	\$15,000
V. Administrative Contract																
A. 2 LT Contractors	\$150	\$300		\$300	\$300		\$300	\$300		\$300	\$300		\$300	\$2,850	\$0	\$2,850
SUB-TOTAL PROJECT																
		\$5,430	\$4,050	\$9,480	\$5,330	\$4,050	\$9,380	\$5,430	\$4,050	\$9,480	\$3,705	\$3,425	\$7,130	\$48,095	\$39,375	\$87,470
Contingency/Inflation (8%)																
		\$434	\$324	\$758	\$426	\$324	\$750	\$434	\$324	\$758	\$296	\$274	\$570	\$3,848	\$3,150	\$6,998
TOTAL PROJECT																
		\$5,864	\$4,374	\$10,238	\$5,756	\$4,374	\$10,130	\$5,864	\$4,374	\$10,238	\$4,001	\$3,699	\$7,700	\$51,943	\$42,525	\$94,468

ROUNDED TO: \$52,000 \$43,000 \$95,000

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