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THE  
INSPECTOR  
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Regional Inspector General for Audit

DAKAR

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WASHINGTON, D. C. 20523

Office of the  
Deputy Inspector General

November 7, 1986

MEMORANDUM FOR Mark L. Edelman, AA/Africa Bureau

FROM: *James B. Durnil*  
James B. Durnil, Deputy Inspector General

SUBJECT: Audit of the Combating Childhood Communicable  
Diseases Project (Audit Report 7-698-87-1)

This report presents the results of audit of the Combating Childhood Communicable Diseases project--AID's major activity in support of child survival in sub-Saharan Africa. This \$89 million AID project is part of a more than \$500 million combined effort by international donors and recipient countries to reduce disease-related mortality and morbidity rates in children under five years of age. The program results audit was made to assess AID's (1) coordination role in the child survival program, (2) project progress including the system to measure results, (3) recipient country participation including financial support, and (4) management of the project.

The audit found AID's project management particularly good for this complex project. AID officials in Washington and those in the audited missions worked very hard to carry out the project's many activities. The RIG/A/WA has stated ". . . this is the best managed of the regional projects we have reviewed to date." Good progress was made immunizing children and pregnant women against infectious diseases, treating diarrhea and malaria, and increasing the number of health care centers.

The audit identified several problems which seriously reduce the long-term benefits AID expects from its child survival efforts. AID did not succeed in coordinating donor efforts at the policy level and in the individual countries. Project progress in reducing mortality and morbidity rates was based on indicators rather than precise measurements. Not enough had been done to assure that recipient countries would have the trained people and money to continue the project when donor assistance ended. Also, AID needed to better coordinate activities in individual countries with regional activities.

The Africa Bureau agreed to carry out seven of eight reported recommendations. The Bureau was studying the recommendation to develop plans to better measure recipient country ability to continue child survival activities when the project ends. The full text of the Bureau's comments is included as Appendix 1.

We appreciate the assistance and cooperation of the Africa Bureau staff and the many people in the field with whom my audit staffs in Dakar and Nairobi had the pleasure to work. Please let me know within 30 days of further actions taken in response to the report recommendations.

## EXECUTIVE SUMMARY

Each year, up to 25 percent of sub-Saharan African children die before the age of five from childhood communicable diseases, diarrhea and malaria. Therefore, a \$500 million child survival program was initiated to help reduce the mortality and morbidity rates among children in 30 to 35 sub-Saharan nations. The program is administered through (1) the Cooperation for Development in Africa, comprised of seven member countries; (2) international multilateral agencies such as the World Health Organization, and (3) African governments. Donor countries were to contribute \$250 million of the \$500 million. AID's \$89 million Combating Childhood Communicable Diseases project is part of this program. The U.S. was designated by the Cooperation for Development in Africa as the lead donor and principal coordinator.

The objectives of the AID project, authorized in 1981, were to (1) immunize and treat the target population against six childhood diseases, diarrhea, and malaria, and (2) develop host governments' institutional capability to continue project activities. By June 30, 1986 AID had obligated \$34.5 million for the project and spent \$19.2 million. As of September 1986, AID had authorized bilateral projects in 13 sub-Saharan countries. The project was managed by AID/Washington's Africa Bureau and implemented by the U.S. Department of Health and Human Resources Center for Disease Control in Atlanta, Georgia; the World Health Organization; and the USAID Africa missions receiving project monies.

The Office of the Regional Inspector General for Audit/West Africa performed a program results audit of AID's participation in the child survival program. Audit objectives were to (1) assess AID's coordinating role in the program, (2) assess progress of AID's project and the system to measure results, (3) determine whether the host countries adequately supported the project, and (4) evaluate AID management of the project.

AID's overall coordination of the multi-donor child survival program was not effective. In AID's bilateral projects, the target population was being inoculated or treated for diseases; however, project impact was not adequately measured. In addition, host governments did not provide the required financial support to the project. Although AID needed to better coordinate bilateral and regional training activities, its overall project management was good.

Progress was made immunizing the target populations against infectious diseases, treating diarrhea and malaria, training, and increasing the number of health care centers. Project management was enhanced because of a good annual evaluation system and the dedicated service to the project by AID/Washington and USAID personnel.

As the lead donor of the Cooperation for Development in Africa program, AID was to coordinate efforts with bilateral and multilateral donors to make the best use of resources. Although the Africa Bureau attempted to coordinate efforts in the child survival program, it did not effectively do so. According to the Africa Bureau project officer, officials of donor countries did not adequately share information on their programs. At the country level, Missions did not effectively promote coordination efforts. Consequently, AID lacked the necessary information to make the best use of AID resources under the overall child survival program. The Bureau agreed with report recommendations to improve donor coordination.

AID Handbook 3 required establishment of a management information system to monitor and measure the project's progress in meeting objectives. However, the objectives were not measurable because adequate baseline data surveys on mortality and morbidity were not performed in all countries. Furthermore, project agreements required neither the establishment of objectives and timeframes nor the submission of reports on the status of host government institutional development. The World Health Organization was to play a major role in institutional development, but timely progress reports on its activities were not required. As a result, AID could not determine project impact. This report recommends that the Africa Bureau develop plans to measure (1) the reduction of mortality and morbidity and (2) the development of the host countries' institutional capabilities to continue the child survival program. The Bureau agreed to make further effort to measure the projects' impact on mortality and morbidity rates, but wanted to further study the recommendation aimed at measuring host country capabilities.

AID policy stresses host government self-reliance, not dependency. Project agreements required the host countries to fund certain recurrent project costs, and eventually, to fund all project costs. However, because of financial constraints, host governments did not meet their commitments. This resulted in slow project progress and cutbacks in project objectives. Also, lacking a system to do so, USAIDs did not adequately monitor host government contributions. Some host governments may not be able to continue project activities when AID assistance terminates. The Bureau agreed to a report recommendation to develop a plan to meet project costs in host countries.

AID intended to support and strengthen host country child survival programs through World Health Organization sponsored training programs. However, little information on these training opportunities were provided to AID-assisted bilateral programs and only limited participation took place. The Africa Bureau failed to adequately define the AID-designated regional liaison officer's responsibilities. As a result, host country institutional development was limited. The Bureau agreed to

clarify the duties of the regional liaison officer, and to improve opportunities for individuals from AID-assisted bilateral programs to participate in regional training.

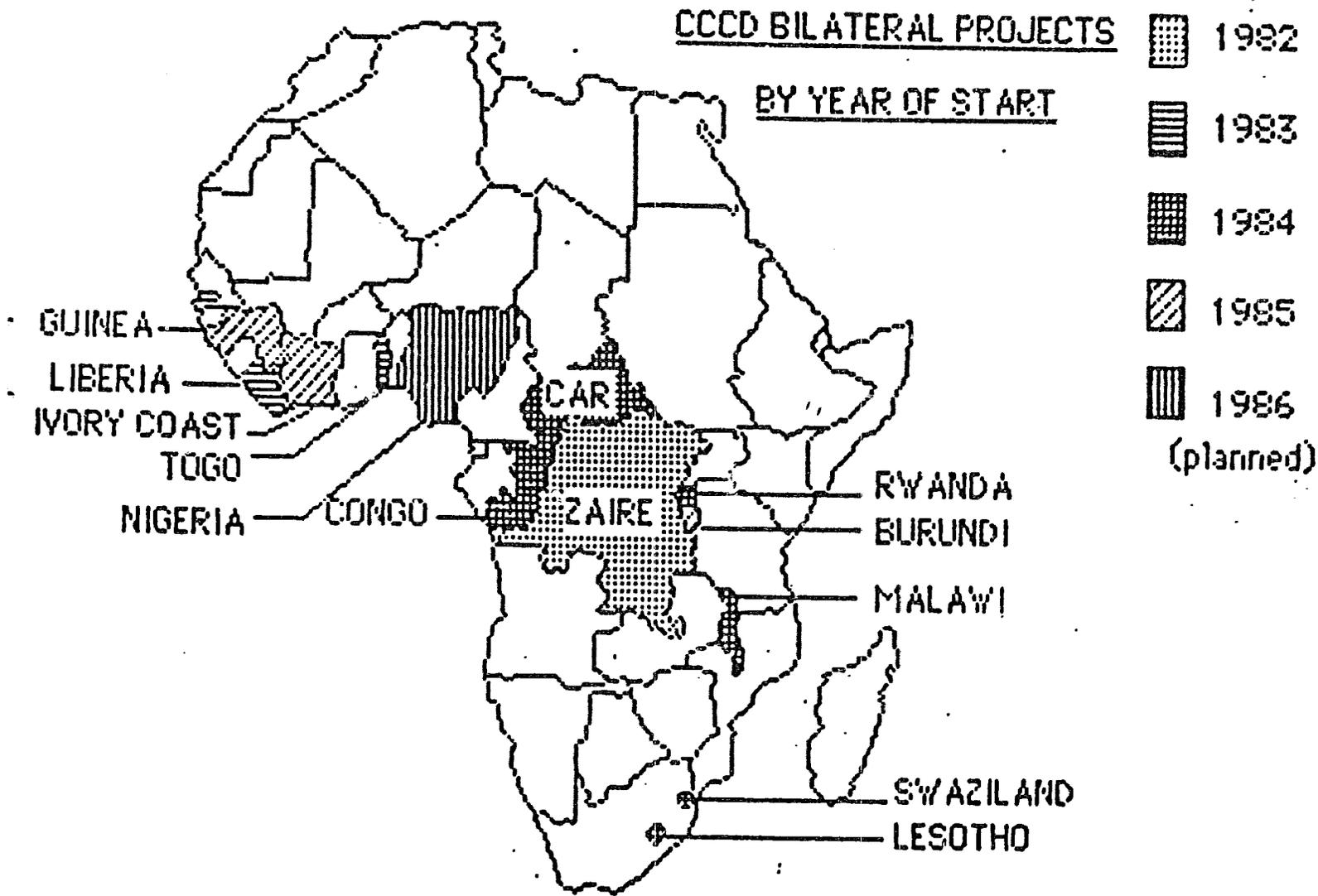
Although the Africa Bureau agreed with most of the audit findings and recommendations, the Bureau was concerned that the draft audit report did not reflect Bureau and AID Mission attempts to coordinate with donors and encourage host countries to make contributions. Also, the Bureau believed the report did not reflect the project's effective management which had been noted in the Regional Inspector General for Audit/West Africa transmittal memo to the draft audit report.

The Bureau also stated that such issues as donor coordination, host country contributions, and measurement of impact on mortality and institutional development were ones problematic to all AID and donor projects. The Africa Bureau believed project management had demonstrated impressive attempts to effectively deal with these issues.

Africa Bureau comments have been incorporated in the final audit report and the full text of the comments is included as Appendix 1. As a result of actions taken and planned, seven of eight report recommendations are resolved and can be closed upon completion of corrective action. The recommendation on measuring host country capability to continue project activities after AID assistance ends remains open pending additional Bureau study and comment.

*Office of the Inspector General*

# USAID BILATERAL CCCD PROJECTS



AUDIT OF THE COMBATING  
CHILDHOOD COMMUNICABLE DISEASES  
PROJECT

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AUDIT OF THE COMBATING CHILDHOOD COMMUNICABLE  
DISEASES PROJECT  
PART I - INTRODUCTION

A. Background

Bilateral and multilateral donors and African governments are participating in a \$500 million child survival program in sub-Saharan Africa to help reduce mortality and morbidity due to childhood communicable diseases such as measles, malaria and diarrhea. The bilateral donors, comprising the Cooperation for Development in Africa (CDA)<sup>1/</sup> and multilateral agencies such as the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF) were to contribute approximately \$250 million of the \$500 million to support programs in 30-35 African countries.

The U.S. contribution was through AID's Combating Childhood Communicable Diseases (CCCD) project. Begun in 1981, this ten-year project was authorized for \$89 million to pay for technical assistance, training and commodities such as vaccines, oral rehydration solutions, and chloroquine.

Accepting this project as one of its program initiatives, the CDA designated the U.S. as lead donor and principal coordinator of the overall effort. In order to better coordinate program activities, the CDA established a Health Technical Committee to exchange technology and program experience, and increase resources to Africa's childhood disease control activities. African countries receiving bilateral assistance were to contribute personnel and other resources and to eventually assume full support. The project also included regional activities to support the individual country programs. As of June 30, 1986, AID had obligated \$34.5 million, and spent \$19.2 million. AID had authorized bilateral projects in 13 sub-Saharan countries as of September 1986 (see Exhibit 1).

The CCCD project had two major objectives: (1) immunize the target population in each recipient country against six childhood diseases <sup>2/</sup>, and treat diarrhea and malaria, and (2) develop host government institutions to continue the effort after AID assistance terminated.

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<sup>1/</sup> Belgium, Canada, Federal Republic of Germany, France, Great Britain, Italy and the U.S.

<sup>2/</sup> Measles, polio, tuberculosis, diphtheria, pertussis, and neonatal tetanus.

The project is managed by AID/Washington's Africa Bureau and implemented by the Center for Disease Control (CDC) through a Participating Agency Service Agreement with the Department of Health and Human Services, by The African Regional Office of the World Health Organization (WHO/AFRO) through an AID grant, and by grants to each of the participating countries (see Exhibit 2).

B. Audit Objectives and Scope

The Office of the Regional Inspector General for Audit/West Africa made a program results audit with objectives to:

- assess AID's coordinating role in the child survival program;
- assess AID project progress including the system to measure results;
- determine whether AID recipient countries were contributing to the project as planned; and
- assess AID's management of the project.

The audit was made at AID/Washington; CDC/Atlanta; WHO/AFRO, Brazzaville, Congo and in five bilateral countries -- Zaire, Congo, Togo, Malawi and Lesotho. The audit team reviewed project documentation, held discussions with officials of AID, CDC, WHO, recipient countries, and several international and other donor representatives. Audit fieldwork was completed in June 1986 and the Africa Bureau was provided a draft audit report in August 1986. Africa Bureau comments, received in late September 1986, have been considered in this final report. The full text of Bureau comments is in Appendix 1. The audit was made in accordance with generally accepted government audit standards.

AUDIT OF THE COMBATING CHILDHOOD  
COMMUNICABLE DISEASES PROJECT

PART II - RESULTS OF AUDIT

AID's overall coordination of the multi-donor child survival program was not effective. In AID's bilateral projects, the target population was being inoculated or treated for diseases; however, project impact was not adequately measured. In addition, host governments did not provide the required financial support to the project. Although AID needed to better coordinate bilateral and regional training activities, overall project management was good.

Progress was made in immunizing the target populations against infectious diseases, treating diarrhea and malaria, providing training, and increasing the number of health care centers. Project management was enhanced because of a good annual evaluation system, and the dedicated service of AID/Washington and USAID personnel.

The Africa Bureau needs to improve coordination of both donor efforts in the child survival program and activities at the country level. A plan should be developed to measure project progress in reducing mortality and morbidity rates and in developing host country institutional capability. Furthermore, the Bureau needs to devise a plan for meeting project costs, and better integrate AID's regional and bilateral project activities.

The report contains eight recommendations directed towards improving donor coordination, measuring project impact, addressing host country funding constraints, and improving the project's bilateral and regional interactions.

A. Findings and Recommendations

1. Need to Improve Donor Coordination

As the lead donor of the Cooperation for Development in Africa (CDA) program, AID was to coordinate efforts with bilateral and multilateral donors to make the best use of resources. Although the Africa Bureau attempted to coordinate efforts in the child survival program, the Bureau did not effectively do so. According to the Africa Bureau project officer, donor countries' officials did not adequately share information on their programs. At the country level, Missions did not effectively promote coordination efforts. Consequently, AID lacked the necessary information to make the best use of AID resources under the overall child survival program.

Recommendation No. 1

We recommend that the Assistant Administrator, Bureau for Africa, improve donor coordination of child survival activities in sub-Saharan Africa by:

- (a) determining the status of donor country and international organization contributions to the Africa-wide program, including the results of donor activities in the recipient countries;
- (b) periodically sharing data on program implementation, successes, and problems with other donors and international organizations, and
- (c) periodically reporting results of donor activities to the USAID missions.

Recommendation No. 2

We recommend that the Assistant Administrator, Bureau for Africa require participating USAID missions to:

- (a) more effectively promote donor coordination in the individual countries, and
- (b) periodically report on the effectiveness of donor coordination and specific donor activities within their respective countries.

## Discussion

AID policy <sup>1/</sup>, is to coordinate assistance with other donors and to work with host country ministries when establishing in-country coordinating mechanisms. The CCCD project paper emphasized the need for coordination and identified several coordination levels: the CDA group meetings, the CCCD Advisory Council, and in-country coordination. As the lead donor, AID was assigned the role of principal coordinator. This coordination process should ensure that all needed information routinely flows through the various levels to help prevent confusion and duplication of efforts.

The audit disclosed, however, that coordination did not evolve as intended on the CDA, CCCD Advisory Council or country levels. As a consequence, AID did not have enough information about the status and results of other donor activities.

CDA level - The Africa Bureau attempted, but did not succeed in promoting effective coordination of donor efforts at the CDA level. The CDA representatives met seven times since the start of the CCCD project, and an eighth meeting was scheduled, according to the AID representative who chairs this group. However, he said, these meetings have not resulted in improved coordination because member countries lacked political commitment and interest.

Only two member countries, for example, complied with the Africa Bureau request to submit a listing of the scope, focus, funding level and duration of their health projects. Furthermore, Africa Bureau officials did not know if the members directed their field representatives to jointly engage the national governments in a dialogue on the procedures for and support of country level coordination. As a result, AID did not get thorough information on financial assistance provided to sub-Saharan African countries by its CDA partners.

Advisory Council level - The Advisory Council was to provide direction and policy guidance to the overall CCCD project, but the Council and the related technical working groups never met. Therefore, since the beginning, the project was being implemented without a clear, common donor policy. Each donor was left to implement its assistance program according to its own policy.

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<sup>1/</sup> "Blueprint For Development: the Strategic Plan of the Agency for International Development" (undated), and AID Policy Paper, "Recurrent Costs" dated May 1982.

In the Congo, for example, AID had opted to treat malaria once a patient was affected, while the German assistance organization had decided to prevent the patient from being affected. In the meantime, the host country was confused as to which of the competing approaches should be used to formulate a national policy on malaria. This confusion limited the Government of Congo's development of a clear and definitive malaria policy.

USAID/Zaire officials, who monitor the Congo program, believed the Germans were not only attempting to prevent the disease but were also treating malaria patients. In addition, they did not believe there was confusion about a malaria policy. However, project officials in both Washington and the Congo told the auditors that differences in the approach to malaria treatment caused confusion for the Government of the Congo in developing a malaria policy.

Country level - Although some USAIDs assisted in establishing coordination committees and maintained regular informal contact with other donors, they did not effectively coordinate efforts. Zaire and Togo both set up coordination committees comprised of donor and government officials. Yet neither committee effectively improved coordination because members did not adhere to the meeting schedules. Malawi, Lesotho, and the Congo failed to establish donor coordination committees.

Host government, AID and donor officials in the five countries visited said that they coordinated informally in the absence of meetings and frequently consulted each other on their respective activities; nonetheless, instances of duplication occurred. In Zaire, for example, one CCCD project official told us that AID and other donors had provided the same commodities, such as refrigerators and motorcycles, to one health center, while other health centers received none. The project office was not informed of these duplicative donations.

Counter productive practices also occurred. In the Congo, for example, several donors provided immunizations for the same targeted childhood diseases as the CCCD project. Because the project and organizations had not collaborated, these organizations immunized a significant portion of the Congolese target population without adhering to the World Health Organization prescribed immunization schedule. According to one donor, this practice was counterproductive because vaccines for different diseases must be administered to children at specific stages and intervals to be effective.

The Africa Bureau and the USAIDs were not reporting to each other on their respective CCCD coordination activities. Although not required, Africa Bureau coordination reports would assist USAIDs in learning about overall CDA efforts for CCCD

activities, and USAID coordination reports on donor activities in each country would assist the Africa Bureau. This flow of information would enhance AID's coordination role and facilitate problem resolution.

For many reasons, AID has been unable to organize systematic, formal coordination at the headquarters and country level. But if the CCCD project is to have the broad, positive impact it aims to achieve, coordination must be improved, and it is AID's responsibility to do so.

#### Management Comments

The Africa Bureau concurred with the finding and recommendations. The Bureau stated that an August 1986 meeting had been held among UNICEF, AID, and CDC officials on the status of UNICEF's child survival activities in all AID bilateral countries. A new \$6 million CCCD grant had been signed with UNICEF for child survival activities in Nigeria. In August 1986, a draft listing of health projects in Africa was developed from the Organization for Economic Cooperation and Development data. The list provides information on donor contributions by amount, type, and purpose of contribution for each year from 1973 to 1985. An updated list will also be made available to the Health Technical Committee for the CDA meeting planned for November 1986.

At the meeting, efforts will be made to strengthen the cooperation between donors by more precisely defining the content and procedures for information sharing. In addition, a cable summarizing the November meeting will be sent to the USAIDs.

In addition, the Africa Bureau will direct the USAIDs to assume a more active role in promoting donor coordination at bilateral levels by specifying the activities they should perform or support and guidelines for donor activity reports.

#### Office of Inspector General Comments

Bureau actions undertaken or planned are responsive to the recommendations. Recommendations 1 and 2 are therefore considered resolved and will be closed upon completion of corrective actions. The Bureau's actions to improve donor coordination should ensure more effective use of the \$500 million to be spent for child survival activities in sub-Saharan Africa.

2. Need to Improve the Management Information System to Better Monitor Project Progress on the Bilateral Programs

AID Handbook 3 required establishment of a management information system to monitor and measure the project's progress in meeting objectives. However, the project objectives were not measurable because adequate baseline data surveys on mortality and morbidity were not performed in all countries. Furthermore, project agreements required neither the establishment of objectives and timeframes nor reports on host government institutional development. The World Health Organization was to play a major role in institutional development, but timely progress reports on its activities were not required. As a result, AID could not determine project impact.

Recommendation No. 3

We recommend that the Assistant Administrator, Bureau for Africa, in cooperation with the Centers for Disease Control, develop a plan to measure project progress in reducing mortality and morbidity rates associated with the targeted diseases.

Recommendation No. 4

We recommend that the Assistant Administrator, Bureau for Africa, require each USAID, in cooperation with the Centers for Disease Control, to:

- (a) develop a child survival plan for each participating country, which specifies host country needs and what AID can provide to develop host country institutional capability in the areas of health education, training, health information systems and operations research;
- (b) specify the objectives and timeframes for developing the host country's institutional capability; and
- (c) report periodically on project progress in developing host country institutional capability and reducing mortality and morbidity rates.

Recommendation No. 5

We recommend that the Assistant Administrator, Bureau for Africa, request the World Health Organization to submit progress reports at least every six months.

Discussion

AID Handbook 3 requires that AID establish a management system to provide reliable data on program results for effective

program management and sound decision-making. The management system should include (1) definition of objectives; (2) development of quantitative indicators of progress toward these objectives; (3) orderly consideration of alternative means for accomplishing such objectives; and (4) adoption of methods for comparing actual against anticipated results of programs and projects.

Because of an incomplete and ambiguous project information system, little data existed to accurately measure the project's progress in reducing mortality and morbidity associated with the CCCD targeted diseases, and in developing the recipient countries' institutional capability.

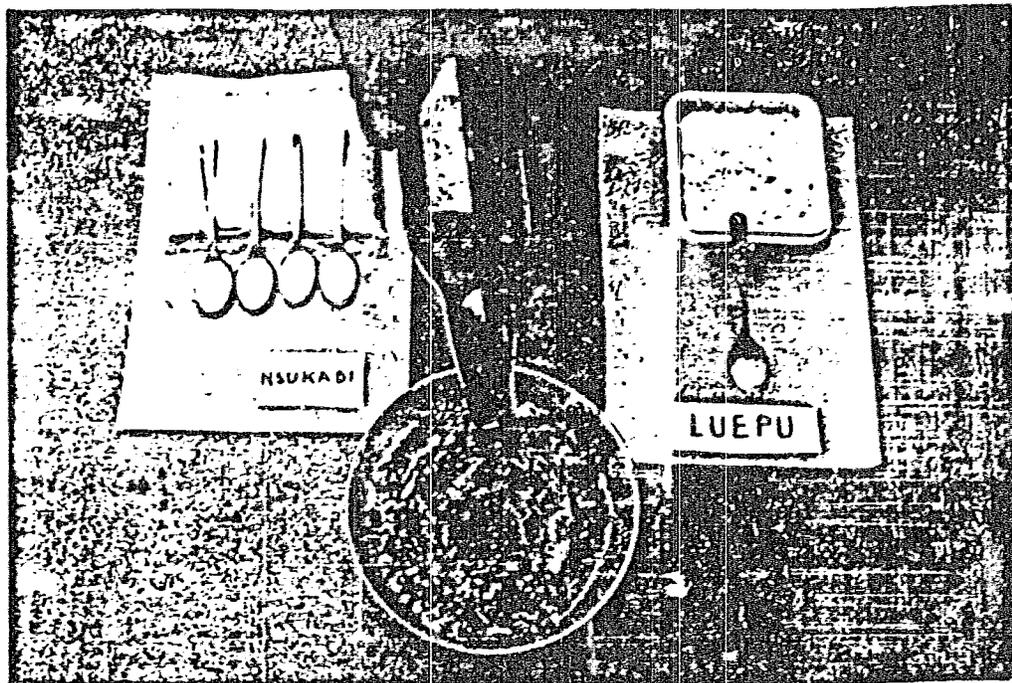
Reduction of the mortality and morbidity rates - A tracking system was to be set up to monitor and measure (1) the reduction of mortality and morbidity rates and (2) access to treatments for the targeted diseases among children and pregnant women. However, in all countries reviewed, mortality and morbidity systems were inadequate (see Exhibit 3). For example, one project goal was to reduce the mortality and morbidity rates by 50 percent through intensive immunization activities, use of oral rehydration in diarrhea cases, and chloroquine in malaria cases. Efforts had been made to collect data on the targeted population's access to oral rehydration solution and chloroquine, and the number of immunizations provided (see Exhibit 4). However, this data was not effectively used to measure reductions in mortality and morbidity rates because baseline data were not representative of the target populations or did not cover all targeted diseases.

In Zaire, for example, a large country consisting of nine regions, surveys were only conducted in the two regions of Kinshasa and Bandundu. Likewise, in Togo (five regions), mortality surveys only covered the Plateaux and Maritime regions. Surveys in the Congo (10 regions) concentrated on malaria and diarrhea in the urban areas of Brazzaville and Pointe Noire (the political and economic capitals of the country), and failed to address the six childhood communicable diseases.

Health specialists associated with the bilateral projects said that baseline data surveys were not performed either in sufficient number or with the required accuracy because of (1) the high cost of undertaking these surveys (one survey in Zaire cost an estimated \$140,000), and (2) inadequate survey methodology for mortality and morbidity.



Child Immunization - Zaire



DIARRHEA TREATMENT

Oral rehydration solution consisting of sugar, salt, and clean water

Africa Bureau and CDC/Atlanta officials believed the project was having impact, but agreed progress was difficult to measure. The Africa Bureau project officer said that they were working on ways to better measure project impact.

Four years after the start of the CCCD project, neither the Africa Bureau nor the USAIDs knew what impact the U.S. assistance had in reducing child mortality and morbidity in sub-Saharan Africa. AID should develop a plan of action to measure project impact.

Host Country Institutional Capability - The institutional development goal of the project was to progressively build within Sub-Saharan governments "... permanent national organizations to immunize all under one year olds, to treat the under five year old population for diarrhea and to control other selected endemic diseases in children on a sustained basis." To accomplish this goal the project provided assistance at both the country and regional levels in four components: health education/promotion, health information systems, operations research, and training.

Progress in the four project components was made to varying degrees in the five countries visited (see Exhibit 5).

-- In Zaire 960 persons had been trained versus the 895 planned; while in Togo, only 342 of the planned 1,000 persons were trained.

-- In Zaire, the health information system (HIS) was computerized and providing basic information on project activities; however, in the Congo, the HIS had not been developed.

-- One hundred sixty operations research activities were planned project-wide, but only 27 had been approved as of October 1985. Of the countries visited, Malawi had three, Togo had two, Zaire and Lesotho had one each, and the Congo had none.

-- In Malawi, little had been accomplished in health education/promotion; whereas in Lesotho, impressive gains were made in developing health education training modules and in creating health education materials, including radio messages, treatment charts and immunization schedules.

Despite the above activities and the project's emphasis on institution-building, USAID and CDC officials could not determine progress in developing the host government institutional capability. For example,

-- The project agreements specified the number of trainees in total. However, in many countries project officials did not

determine the number and type of trainees (doctors, nurses and health workers) needed in the project to develop institutional capabilities.

-- Although numerous Health Information System (HIS) activities were being conducted in all countries, the CDC/Atlanta specialist stated that detailed plans had not been developed for implementing an integrated HIS structure. Thus the inputs necessary to establish an effective HIS at the individual country level were not determined, resulting in host governments not knowing what was needed to develop and/or strengthen HIS capability.

-- Project documentation did not specify the number of researchers and the level and nature of expertise needed to develop institutional capability in operations research.

-- In the area of health education/promotion, the numbers and types of personnel needed to implement and manage health education programs were generally not specified.

Project impact could not be measured because the elements of a management information system for that purpose had not been developed. For example, plans which delineated what each country needed in the four project components, and how AID and other donors could meet those needs, had not been prepared in any of the five countries. In addition, the project grant agreements did not require (1) the establishment of institution-building objectives and timeframes and (2) the periodic submission of progress reports on developing host country immunization, malaria and diarrhea programs.

Furthermore, WHO/AFRO did not provide timely progress reports on its health information system or regional training activities because the grant agreement specified that WHO/AFRO submit such reports only every two years. WHO/AFRO regional activities were intended to play a major role in developing a CCD institutional base in the participating countries. In our view, biennial reports are too infrequent to effectively monitor these project activities.

#### Management Comments

The Africa Bureau agreed with two of the three recommendations, but deferred action on the recommendation concerning host country institutional capability. As concerns project impact, it stated that significant efforts had been made to develop reliable measures of mortality and morbidity. Because previous extensive surveys had proved expensive, time-consuming and difficult to institutionalize, the Bureau had relied on other data sources such as demographic and health surveys. Additional methods for obtaining indicators for program success

were being developed. The Bureau planned to submit its enhanced strategy to measure mortality and morbidity to the CCD recipient countries for comment by January 1987.

The Bureau said that it was deferring decision on the issue of developing a separate plan specifying host country institutional capability, needs, objectives and timeframes. It believed the current country-specific project assessments and agreements included institutional capability development concerns, needs and plans, and that the management information system reflected host country development.

The Bureau also stated that WHO/AFRO submitted progress reports in March and July 1986 and will continue to submit future reports.

#### Office of Inspector General Comments

Bureau actions taken and planned are responsive to recommendations 3 and 5, which are considered as resolved. Recommendation number 4 is open pending further Bureau study and response. Concerning recommendation number 4, the Africa Bureau provided updated project progress information on immunization coverage and access to malaria and oral rehydration therapy. As a result we revised part (c) of that recommendation.

In further response to recommendation number 4, the Bureau provided additional information on progress achieved in development of host country capabilities. This information was intended to replace certain data in Exhibit 5. However, audit work performed did not verify the Bureau-provided information and, in some cases, was contrary to that provided. For example, during the audit we found that the development of health education promotion units in the five countries visited had barely started or was unknown. In its response, the Bureau stated that all five countries had developed such units. We question whether broad statements of achievement, when measured against broad objectives, provides a meaningful indicator of institutional development progress. These broad measurements exist in varying degrees in the other three project components. As a result, we have not modified Exhibit 5 as the Bureau had requested.

The development of the host countries' capability to continue project activities after AID funding terminates is a major project objective. We believe that AID management needs clear objectives, specific timeframes, and regular reporting on institution-building in order to monitor project progress and determine if U.S. funds are spent effectively for that purpose.

### 3. Need to Devise Plans for Meeting Project Costs

AID policy stresses host government self-reliance, not dependency. Project agreements required most host countries to fund certain recurrent project costs, and eventually, to fund all project costs. However, because of financial constraints, host governments did not meet their commitments. This resulted in slow project progress and cutbacks in project objectives. Also, lacking a system to do so, USAIDs did not adequately monitor host government contributions. Some host governments may not be able to continue project activities when AID assistance terminates.

#### Recommendation No. 6

We recommend that the Assistant Administrator, Bureau for Africa, in cooperation with other Cooperation for Development of Africa countries, multilateral donors, and the African governments, develop a plan for meeting project costs in each country. The plan should also provide implementation options based on reduced funding levels of host governments.

#### Recommendation No. 7

We recommend that the Assistant Administrator, Bureau for Africa, require the USAIDs to establish systems for:

- (a) obtaining data on host government contributions to the project as required by the grant agreements, and
- (b) reporting periodically to the Africa Bureau on host government contributions.

#### Discussion

According to AID policy, donor support should eventually terminate and each country should replace that support with their own resources. In complying with this policy, AID's project grant agreements required host governments to fund certain project recurrent costs and assume a proportionately greater share of other operating costs, such as vaccines, vaccine supplies, and anti-malarial and diarrheal medications. By the end of the project, four of the five countries visited were to assume all costs to ensure the continuation of project activities. To help ensure the sustainability of the program, fees for services (auto-financing) systems were emphasized in some grant agreements. In addition, AID Handbook 3 requires USAID monitoring of project activities, including host government contributions.

The audit found that (1) host government financial contributions were inadequate and (2) USAIDs did not establish effective systems to monitor these contributions.

Host government contributions - In the five countries visited, host government financial contributions were not provided as specified in the project agreements (see Exhibit 6). Zaire, one of the first bilateral CCCD countries, had government funding shortfalls since the project began in 1983. Through its regular budget, the Government of Zaire provided only 45 percent of the required project operating costs in 1983 and 35 percent in 1984. In 1985, the Government of Zaire provided funds to cover only 60 percent of project staff salaries, and did not fund other operating costs, such as gasoline, per diem, and shipping. In Lesotho, host government contributions of only 24 percent of the amount required led to slow project progress in the first year. The second year contribution improved considerably to 73 percent.

Funding constraints were more serious in the Congo than in some other AID bilateral countries. The Congo government contributed only 28 percent of its agreed upon funding for two years (1984-85). Moreover, the Congo government did not budget any funds for the project in 1986. This situation remained unresolved at the time of our audit in April 1986.

The three auto-financing systems we reviewed were not functioning as intended because host governments either did not develop or adequately monitor systems to see that funds were properly spent. For example in Zaire, the government did not ensure that funds received from the sale of diarrhea and malaria treatments were used to pay for more treatments. Instead, funds were used to cover the salaries of project personnel who had not been paid in months. Without the willingness of other donors to resupply these commodities, Zaire could not have continued its diarrhea and malaria treatment program.

AID's assessment of host governments' ability to fund recurrent costs was unrealistic since most CCCD bilateral countries visited were under extreme economic hardships and International Monetary Fund austerity measures. For example, in Zaire, CCCD budget cuts of more than 50 percent could be attributed to the September 1983 currency devaluation of approximately 500 percent and IMF required reductions in public sector expenditures. Similarly, the Congo had cash flow problems because of low oil prices. The 1986 national budget had been revised downward three times and was only one half its original amount.

The lack of host government funding was a major constraint to project progress in three of the five countries visited. Project activities were not expanding in some instances to the rural areas because of the lack of funds to transport cold chain refrigerators and supplies, to purchase training materials, or fund supervisory visits. Project officials said

that if the donors had not paid for vaccines and other commodities, project progress would have been further constrained.

Many bilateral CCCD countries will require project extensions because of the slow progress caused by the lack of host government funding. USAID/Zaire was in the process of reducing from 50 percent to 25 percent the objective of decreasing mortality and morbidity, and planned to decrease its anticipated coverage for diarrhea and malaria treatment. Other countries were expected to make similar reductions.

AID management, host government, and other donor officials in three countries agreed that the major impediment to project success was the problem of host government funding. However, AID's policy of stressing host government self-reliance may not be achieved under current economic conditions. Donors agree that future assistance must be increased and extended for longer periods of time if projects are to continue as originally programmed. However, one donor representative stated that his organization did not want to be a "grocery store" for developing countries, and did not believe the financial hardships of those countries reason to automatically increase donor assistance.

USAID financial monitoring - In three of the five countries visited, USAID data on host government financial contributions was incomplete or not available because a USAID system to obtain such information was not established. Therefore, in those cases, the audit obtained financial information primarily through discussions with AID, CDC, and host government officials. In the five countries visited, USAID and CDC were not periodically reporting to the Africa Bureau on host country financial contributions because they were not required to do so. As a result, USAIDs and the Africa Bureau did not have adequate information to make timely decisions on host government financial problems.

Conclusion - The ability of host governments to continue funding AID projects is critical to economic development. Without such assurance, scarce AID and other donor resources are wasted. The recurrent cost problem in this project must be addressed by AID, other donors and the host governments. A coordinated plan is needed outlining what CCCD activities can be accomplished with realistic host government and donor resources. In addition, AID needs to better monitor host government contributions to the project.

#### Management Comments

The Africa Bureau concurred in the finding and recommendations. They were developing guidelines for USAIDs to

#### 4. Need to Better Integrate AID's Regional Training Activities with the Bilateral Programs

AID intended to support and strengthen host country child survival programs through World Health Organization sponsored training programs. However, little information on these training opportunities were provided to AID-assisted bilateral programs and only limited participation took place. The Africa Bureau failed to adequately define the AID-designated regional liaison officer's responsibilities. As a result, host country institutional development was limited.

#### Recommendation No. 8

We recommend that the Assistant Administrator, Bureau for Africa:

- (a) establish coordination duties of the regional liaison officer when coordinating training activities with the USAIDs and Centers for Disease Control technical officers, and
- (b) develop a system to periodically notify USAIDs of project-funded World Health Organization/Africa Regional Office training courses.

#### Discussion

The Combating Childhood Communicable Diseases (CCCD) project paper stated that countries participating in the CCCD project were to have the option to use and draw support from regional training programs. Under a project grant agreement, the Africa Regional Office of the World Health Organization (WHO/AFRO) was assigned the primary responsibility for this training. AID assigned a regional liaison officer to WHO/AFRO headquarters in Brazzaville, Congo to determine how individual countries, especially those with CCCD bilateral projects, could best utilize WHO/AFRO services.

However, the CCCD bilateral programs were not receiving adequate support from the WHO/AFRO training program. After long delays signing the WHO/AFRO grant agreement, the first training course started in June 1985. As of March 1986, 164 Africans had been trained with only 30 (18 percent) coming from CCCD participating countries. Three bilateral project directors stated that they did not provide trainees because they had little or no information on the training courses. In fact, two directors, who acted as course facilitators for a WHO/AFRO training course in March 1986, were unaware that the course was financed by the CCCD grant agreement.

USAIDs were not systematically informed of WHO/AFRO training courses for two reasons.

First, the Africa Bureau did not clearly establish the regional liaison officer's coordination role between WHO/AFRO and the bilateral projects. In early 1985 the regional liaison officer's coordination duties were informally delineated but not implemented. These duties included developing information on WHO/AFRO project activities and coordinating how bilateral CCCD projects could best utilize WHO/AFRO training. CDC officials intended to incorporate these duties into the liaison officer's 1985 workplan. However, the workplan did not address the coordination of participating country training needs with WHO/AFRO activities. As a result, this coordination did not take place. After the auditors brought this matter to the attention of Africa Bureau officials, they planned to clarify and formalize the liaison officer's duties and responsibilities so that coordination between WHO/AFRO and the bilateral countries would be emphasized.

The second reason bilateral project managers were not informed of training courses was because WHO/AFRO operating procedures were based on a quota system which did not specify that all sub-Saharan countries be notified of all project-funded training courses. Under the WHO/AFRO notification system the regional officers in charge of the particular training areas were responsible for (1) sending out notification letters of upcoming WHO/AFRO courses, (2) deciding which countries received letters, and (3) deciding on the number of candidates to be accepted from a given country. One regional officer stated that he forwarded letters to countries that had not sent many candidates, and to countries where need existed. Another official believed that emphasis should be placed on countries not having bilateral CCCD programs.

Consequently, there was no assurance that participating CCCD countries would receive notification of WHO/AFRO training. Furthermore, none of the notification letters indicated that WHO/AFRO courses were sponsored by the CCCD project. Several WHO representatives in the individual countries said that if WHO/AFRO had indicated courses were CCCD-sponsored, they would have better informed the appropriate personnel.

The failure of WHO/AFRO to train CCCD participating country candidates limited the institutional development of those countries, resulting in less effective project implementation. Several CCCD project directors said training needs could have been reduced and the project enhanced if candidates had attended CCCD sponsored WHO/AFRO courses. For example, both Zaire and the Congo would have sent candidates to a senior-level epidemiology course in 1985 if they had been properly informed.

The WHO/AFRO notification system needs to ensure that all bilateral CCCD countries receive notification of courses.

Letters should also indicate that courses are CCCD-sponsored. The efforts of the Africa Bureau to clarify the duties and responsibilities of the liaison officer, when formalized, should improve coordination and communication between participating countries and WHO/AFRO.

Management Comments

On March 25, 1986, AID, WHO/AFRO, and CDC officers agreed upon (1) the duties and responsibilities of the liaison officer, and (2) a system to periodically notify countries of project funded WHO/AFRO training courses. Under the system, WHO/AFRO would notify its national and regional representatives, the liaison officer would notify the CCCD field officers, and AID/Washington would notify the USAIDs. The system was scheduled to begin in September 1986.

Office of Inspector General Comments

Based on the above actions, part (a) of the recommendation is considered closed upon issuance of this report. Part (b) of the recommendation is considered resolved and will be closed upon completion of corrective action.

## B. Compliance and Internal Control

### Compliance

The audit disclosed two instances of non-compliance with AID Handbooks and project grant agreements. These included (a) the lack of an adequate system to measure project progress towards objectives (finding 2), and (b) the failure of host governments to meet required recurrent cost payments (finding 3).

Other than the conditions cited, nothing came to our attention that would indicate that untested items were not in compliance with applicable laws and regulations.

### Internal Control

Administrative controls needed improvement, but accounting controls were generally adequate. Finding 1 discusses the need to establish a reporting system on donor coordination and finding 2 discusses the need for more frequent reporting on WHO/AFRO activities. Finding 4 notes that AID should ensure that bilateral project countries are adequately informed of regional training opportunities.

AUDIT OF THE COMBATING CHILDHOOD  
COMMUNICABLE DISEASES PROJECT

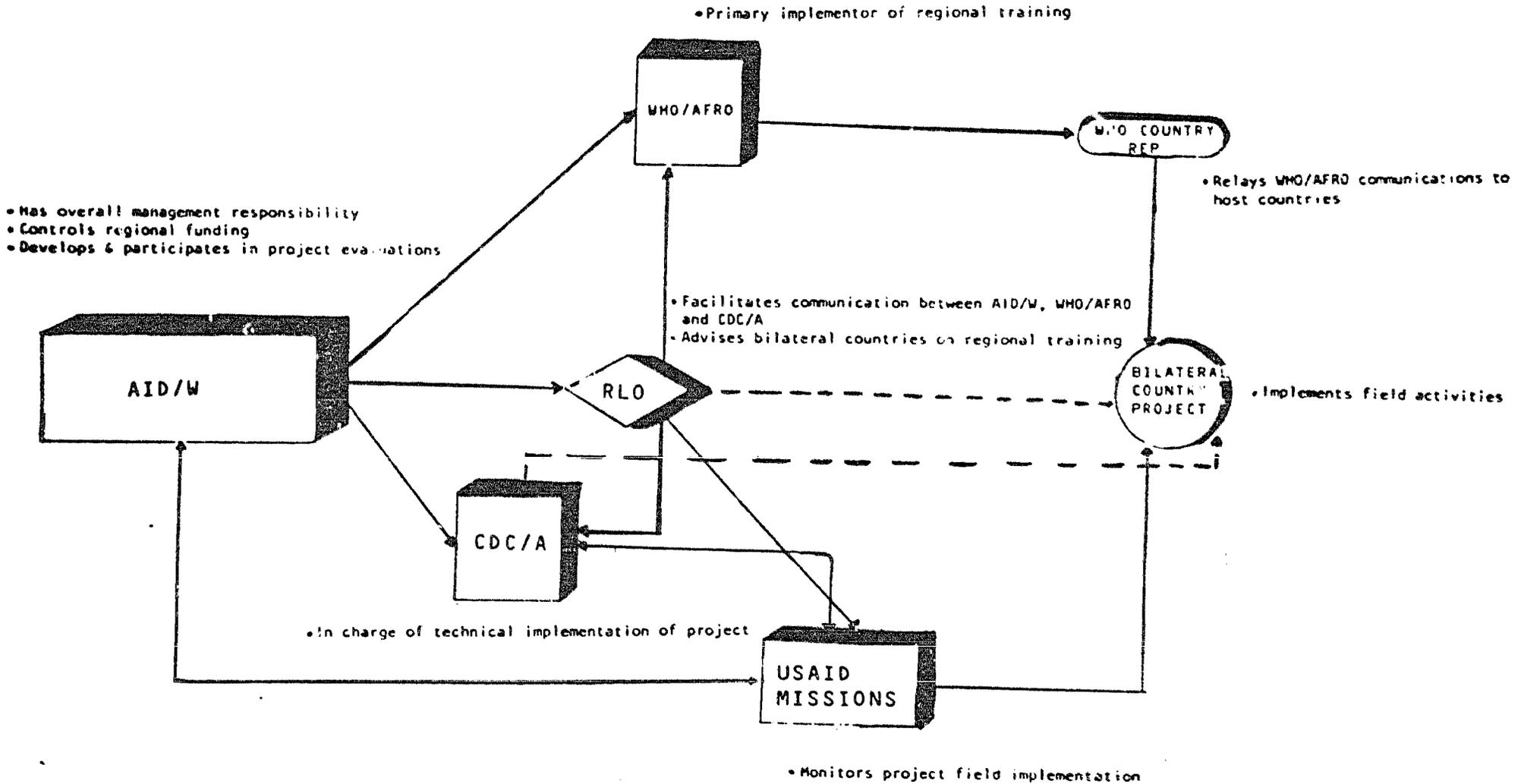
PART III - EXHIBITS AND APPENDICES

AID Project  
Funding by Country as of June 30, 1986  
(\$000)

	<u>Obligations</u>	<u>Expenditures</u>	<u>Date Proag Signed</u>
<u>Bilateral Countries</u>			
Cent. African Rep.	\$691,000	\$255,000	May 1984
Congo	655,000	168,000	June 1984
Burundi	250,000	0	August 1985
Guinea	885,000	2,000	June 1985
Ivory Coast	880,000	0	June 1985
Lesotho	416,000	154,000	May 1984
Liberia	674,000	382,000	August 1983
Malawi	1,428,000	95,000	June 1984
Nigeria <sup>1/</sup>	None	None	--
Rwanda	1,072,000	434,000	June 1984
Swaziland	716,000	234,000	June 1984
Togo	1,140,000	418,000	April 1983
Zaire	<u>5,046,000</u>	<u>2,596,000</u>	August 1982
Bilateral Countries' Funds	\$13,853,000	\$4,738,000	
Regional Support Funds	<u>20,706,000</u>	<u>14,478,000</u>	
<u>Total</u>	<u>\$34,559,000</u>	<u>\$19,216,000</u>	

<sup>1/</sup> Authorized August 13, 1986 for \$14.3 million.

# Combatting Childhood Diseases Project Organization and Management Structure



**Key**

WHO/AFRO- World Health Organization/Africa Regional Office  
 CDC/A- Centers for Disease Control/Atlanta  
 RLO- Regional Liason Officer

**LEGEND: Communication Links**

————→ Direct  
 - - - - -→ Indirect

• Responsibilities of the various parties

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**COMBATING CHILDHOOD COMMUNICABLE DISEASES PROJECT**  
Planned vs. Achieved Decreases in Mortality and Morbidity  
 As of December 1985

Target Categories	<u>LESOTHO</u>		<u>CONGO</u>		<u>MALAWI <sup>1/</sup></u>		<u>TOGO</u>		<u>ZAIRE <sup>3/</sup></u>	
	<u>Planned (LOP)</u>	<u>Achieved</u>	<u>Planned (LOP)</u>	<u>Achieved</u>	<u>Planned (LOP)</u>	<u>Achieved</u>	<u>Planned (LOP)</u>	<u>Achieved</u>	<u>Planned (LOP)</u>	<u>Achieved</u>
<u>Mortality/Morbidity</u>										
-Neo Natal Tetanus	30%	NK	80%	NK	NK	NK	50%	NK	50%	NK
-Polio	30%	NK	80%	NK	NK	NK	50%	NK	50%	NK
-Pertussis	NK	NK	NK	NK	30%	NK	NK	NK	NK	NK
-Measles	30%	NK	80%	NK	30%	NK	NK	NK	50%	NK
-Tuberculosis	NK	NK	NK	NK	NK	NK	NK	NK	NK	NK
-Diphtheria	NK	NK	NK	NK	NK	NK	NK	NK	NK	NK
-Diarrhea	NK	NK	50%	NK	60%	NK	50%	NK	50%	NK
-Malaria	NK	NK	50%	NK	30-35% <sup>2/</sup>	NK	50%	NK	50%	NK

<sup>1/</sup> Only target reduction figures for mortality are considered for Malawi.

<sup>2/</sup> 35% for children under 5 and 30% for pregnant women.

<sup>3/</sup> If AID/W concurs, Zaire intends to revise downward the target objectives for mortality and morbidity.

NK - Not Known

LOP - Life of Project

**COMBATING CHILDHOOD COMMUNICABLE DISEASES PROJECT**  
Percentages of Planned and Achieved Immunization Coverages and Access to  
Oral Rehydration and Malaria Therapy  
 As of December 1985

<u>Target Categories</u>	<u>LESOTHO</u>		<u>CONGO</u>		<u>MALAWI</u>		<u>TOGO</u>		<u>ZAIRE</u>	
	<u>Planned (LOP)</u>	<u>Achieved<sup>1/</sup></u>	<u>Planned (LOP)</u>	<u>Achieved</u>	<u>Planned (LOP)</u>	<u>Achieved</u>	<u>Planned (LOP)</u>	<u>Achieved</u>	<u>Planned (LOP)</u>	<u>Achieved<sup>2/</sup></u>
<u>Interventions</u>										
Immunization (EPI)	NK	50%	80%	40%	80%	35%	65%	12% Rural 32% Urban	70%	40% <sup>3/</sup>
- BCG	NK	88%	80%	80%	85%	83%	65%	64%	80%	57%
- DPT	65%	67%	80%	59%	65%	50%	65%	21%	50%	37%
- Polio	65%	66%	80%	59%	65%	45%	65%	18%	50%	60%
- Measles	70%	65%	80%	52%	70%	47%	65%	34%	70%	40%
- Tetanus/Women	NK	NK	80%	NK	45%	32%	65%	34%	70%	50%
Diarrhea	80%	NK	80%	18% <sup>4/</sup>	60%	98% <sup>4/</sup>	65%	100% <sup>4/</sup>	70%	67% <sup>4/</sup>
Malaria	NK	NK	80%	NK	30%-45%	NK	65%	NK	70%	100%

<sup>1/</sup> As of December 1984

<sup>2/</sup> These coverage figures are based on the national population and not on the CCCD target population in the 141 zones of the PROAG.

<sup>3/</sup> The national coverage figure given for Zaire is for the first two quarters of 1985.

<sup>4/</sup> Health facilities with ORS

\* As of December 1984

LOP - Life of Project

COMBATING CHILDHOOD COMMUNICABLE DISEASES PROJECT  
Objectives and Achievements in Project Components  
 As of December 1985

Target Categories	<u>LESOTHO</u>		<u>CONGO</u>		<u>MALAWI</u>		<u>TOGO</u>		<u>ZAIRE</u>	
	<u>Planned</u>	<u>Achieved</u>								
<u>Components</u>										
Health Information Systems	NQ	NK								
Operations Research Studies <sup>1/</sup>	NQ	NK	NQ	NK	10-14	NK	NQ	NK	NQ	NK
Health Education/Promotion	NQ	NK	NQ	NK	10-14	NK	NQ	NK	NQ	NK
Training <sup>2/</sup>	1040	1098	500	38	NQ	<u>3/</u>	1000	342	895	960

NOTE: Training target figures are taken from the grant agreements; they are not broken down by personnel categories, i.e., doctors, nurses, etc.

NK - Not Known

NQ - Not Quantified

<sup>1/</sup> Number of Studies

<sup>2/</sup> Number of Trainees

<sup>3/</sup> Number of trainees could not be determined because information system was unclear.

COMBATING CHILDHOOD COMMUNICABLE DISEASES PROJECT  
Comparison of Planned Vs. Actual Contributions  
of Participating Countries

Year	Z A I R E			T O G O			C O N G O		
	<u>Planned</u>	<u>Actual</u>	<u>% Contributed</u>	<u>Planned<sup>4/</sup></u>	<u>Actual<sup>5/</sup></u>	<u>% Contributed</u>	<u>Planned</u>	<u>Actual<sup>5/</sup></u>	<u>% Contributed</u>
1983	\$2,650,678 <sup>1/</sup>	\$1,180,847	45%		\$ 9,500		---	---	---
1984	533,375 <sup>2/</sup>	188,625	35%		31,593		\$ 13,143	0	0%
1985	400,000 <sup>3/</sup>	120,350	30%		48,883		120,000	\$37,500	31%
TOTAL	<u>\$3,584,053</u>	<u>\$1,489,822</u>	<u>42%</u>	<u>\$250,000</u>	<u>\$89,976</u>	<u>36%</u>	<u>\$133,143</u>	<u>\$37,500</u>	<u>28%</u>

<sup>1/</sup> 1983 Rate of exchange Zaire 5.9 = \$1. Planned contribution Zaire 15,639,000. Actual Zaire 6,967,000.

<sup>2/</sup> Sept. 1983 devaluation changed exchange rate to Zaire 32 = \$1. Planned contribution Zaire 17,068,000. Actual Zaire 6,036,000.

<sup>3/</sup> Project requested for 1985 Zaire 16,000,000, but received Zaire 4,814,000. Exchange rate is estimated at Zaire 40 = \$1.

<sup>4/</sup> \$373,000 was Togo's 4-year planned contribution through 1987, planned annual contributions were not indicated. The \$250,000 represents our estimate of the planned contribution after 32 months of project implementation.

<sup>5/</sup> Exchange rate CFA 400 = \$1.

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COMBATING CHILDHOOD COMMUNICABLE DISEASES PROJECT  
Comparison of Planned Vs. Actual Contributions  
of Participating Countries

<u>Year</u>	<u>L E S O T H O</u>			<u>M A L A W I</u>		
	<u>Planned</u>	<u>Actual</u>	<u>% Contributed</u>	<u>Planned<sup>1/</sup></u>	<u>Actual</u>	<u>% Contributed</u>
1984	\$39,300	\$ 9,319	24%	\$374,300	\$204,077	55%
1985	<u>40,600</u>	<u>29,676</u>	73%	<u>425,300</u>	- <sup>2/</sup>	-
TOTAL	<u>\$79,900</u>	<u>\$38,995</u>	<u>49%</u>	<u>\$799,600</u>	<u>2/</u>	<u>3/</u>

<sup>1/</sup> Figures are for fiscal years 1984/85 and 1985/86.

<sup>2/</sup> Actual contributions not available.

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ACTION: AID-2 INFO: DCM RIG

VZCZCTAA043LSC831

PP RUTADS

DI RUEHC #2446/01 2681620

ZNR UUUUU ZZH

P R 251625Z SEP 86

FM SECSTATE WASHDC

TO RUTADS/AMEMBASSY DAKAR PRIORITY 0057

INFO RUEHBZ/AMEMBASSY BRAZZAVILLE 3459

RUEHAI/AMEMBASSY KINSHASA 1756

RUEHLG/AMEMBASSY LILONGWE 0414

RUFHPC/AMEMBASSY LOME 7619

RUEHRU/AMEMBASSY MASERU 0219

RUEHNR/AMEMBASSY NAIROBI 6464

RUFHPH/ CDC ATLANTA 1745

BT

UNCLAS SECTION 01 OF 05 STATE 302446

AIDAC, NAIROBI FOR REDSO

E.O. 12356: N/A

TAGS:

SUBJECT: AFRICA BUREAU RESPONSE TO THE DRAFT AUDIT  
REPORT OF THE COMBATTING CHILDHOOD COMMUNICABLE DISEASES  
PROJECT - (E980421) - AUDIT REPORT NO. 7-698-86

REFERENCE: DAKAR 98425

DAKAR FOR RIG/A/WA, BRAZZAVILLE FOR COLLINS PASS TO  
BASSETT, KINSHASA FOR AWANGTANG, LILONGWE FOR GURNEY,  
LOME FOR POPP, MASERU FOR DE GRAFFENREID, CDC FOR IHPO

1. SUMMARY: THE PURPOSE OF THIS CABLE IS TO RESPOND TO THE 1986 AUDIT PERFORMED BY THE RIG/A/WA OF THE COMBATTING CHILDHOOD COMMUNICABLE DISEASES (CCCD) PROJECT. PARA 2 ENTITLED EXECUTIVE SUMMARY IS TO BE INSERTED IN PAGE FIVE OF THE DRAFT AUDIT REPORT. PARA 3 PROVIDES THE RECOMMENDATIONS OF THE AUDIT REPORT AND THE AFRICA BUREAU RESPONSES TO THESE RECOMMENDATIONS. PARA 4 PROVIDES A DISCUSSION OF RECOMMENDATIONS 3 AND 4. PARA 5 NOTES REVISIONS REGARDING FACTUAL DATA. END SUMMARY.

## 2. EXECUTIVE SUMMARY

THE AFRICA BUREAU IS IN AGREEMENT WITH THE MAJORITY OF THE AUDIT FINDINGS AND RECOMMENDATIONS. THE PERFORMANCE OF THE AUDIT WAS TIMELY. THE PROJECT IS CURRENTLY AT ITS HALFWAY MARK; HAS RECENTLY RECEIVED AUTHORIZATION INCREASING ITS PROJECT LIFE, FUNDING LEVEL, AND COUNTRY SPECIFIC ACTIVITIES FROM 12 COUNTRIES TO 14; AND WILL SOON BE INITIATING ITS LARGEST BILATERAL ACTIVITY IN NIGERIA WITH UNICEF.

THE RECOMMENDATIONS REGARDING DONOR COORDINATION, HOST COUNTRY CONTRIBUTIONS, AND CCCD WHO/AFRO COORDINATION

HAVE BEEN WELL RECEIVED AND WILL BE FULLY IMPLEMENTED, HOWEVER THE AFRICA BUREAU IS CONCERNED THAT THE REPORT (ESPECIALLY THE EXECUTIVE SUMMARY) DOES NOT REFLECT BUREAU AND MISSION ATTEMPTS TO COORDINATE DONORS AND ENCOURAGE HOST COUNTRY CONTRIBUTIONS, NOR DOES IT APPEAR TO REFLECT THE PROJECT'S EFFECTIVE PERFORMANCE IN MANAGEMENT WHICH WAS REFERRED TO AS QUOTE THE BEST MANAGED OF THE REGIONAL PROJECTS REVIEWED TO DATE...UNQUOTE.

SUCH ISSUES AS DONOR COORDINATION, HOST COUNTRY CONTRIBUTIONS, AND THE MEASUREMENT OF IMPACT ON MORTALITY AND INSTITUTIONAL DEVELOPMENT ARE ONES PROBLEMATIC TO ALL AID AND DONOR PROJECTS. THE AFRICA BUREAU BELIEVES THE CCCD PROJECT HAS DEMONSTRATED IMPRESSIVE ATTEMPTS TO EFFECTIVELY DEAL WITH THESE ISSUES. CCCD INITIATED AND CHAIRED ALL CDA HEALTH TECHNICAL COMMITTEE MEETINGS AND MET FORMALLY AND INFORMALLY WITH DONORS AT THE COUNTRY LEVEL. CCCD HAS TO DATE, PERFORMED FEASIBILITY STUDIES OR COST STUDIES IN EACH OF THE BILATERALS THE AUDITORS VISITED EXCEPT FOR ONE, HAS ESTABLISHED STRICT PROJECT COST CONTRIBUTION REQUIREMENTS IN ALL PROJECT AGREEMENTS, AND HAS OFTEN SCALED BACK PROJECT IMPLEMENTATION PACE OR DISCONTINUED AID DISPURSEMENTS WHEN HOST COUNTRY CONTRIBUTIONS WERE NOT FORTHCOMING, IN THE ATTEMPT TO PROMOTE HOST COUNTRY FINANCIAL SUSTAINABILITY. AS TO THE RECOMMENDATION SUGGESTING THE PROJECT IMPROVE THE MANAGEMENT INFORMATION SYSTEM (MIS) BY DEVELOPING A PLAN TO MEASURE MORBIDITY AND MORTALITY REDUCTION: AID AND CDC STAFF RESPONSIBLE FOR PROJECT MANAGEMENT AND IMPLEMENTATION BELIEVE THE EXISTING MIS USED BY CCCD

PROVIDES SUBSTANTIAL INFORMATION ON PROJECT OUTPUT AND IMPACT AND A STRATEGY IS ALREADY IN PLACE TO MEASURE CHANGES IN MORTALITY AND MORBIDITY. LASTLY, ACTION IN RESPONSE TO RECOMMENDATION 4 REGARDING INCREASED DOCUMENTATION OF INSTITUTIONAL DEVELOPMENT WILL BE DEFERRED UNTIL THE NEXT PROGRESS REPORT SCHEDULED FOR JANUARY 1987 WHILE PROJECT OFFICIALS DETERMINE APPLICABILITY TO CURRENT PROJECTS AND THE IMPLICATIONS FOR REQUIRING SUCH INCREASED DOCUMENTATION IN PROJECT EFFORT.

### 3. FINDINGS AND RECOMMENDATIONS

#### (1) NEED TO IMPROVE DONOR COORDINATION

##### RECOMMENATION NO. 1.

THE ASSISTANT ADMINISTRATOR, BUREAU FOR AFRICA IMPROVE DONOR COORDINATION OF CHILD SURVIVAL ACTIVITIES IN

## SUB-SAHARAN AFRICA BY PERFORMING THE FOLLOWING:

(A) DETERMINE THE STATUS OF DONOR COUNTRY AND INTERNATIONAL ORGANIZATION CONTRIBUTIONS TO THE AFRICA WIDE PROGRAM, INCLUDING THE RESULTS OF DONOR ACTIVITIES IN THE RECIPIENT COUNTRIES

(B) PERIODICALLY SHARE DATA ON PROGRAM IMPLEMENTATION, AND PROBLEMS WITH OTHER DONORS AND INTERNATIONAL ORGANIZATIONS

## PROGRESS TO DATE:

ON AUGUST 25, 1986 A DRAFT LISTING OF HEALTH PROJECTS IN AFRICA BASED ON INFORMATION FROM THE ORGANIZATION FOR ECONOMIC COOPERATION & DEVELOPMENT (OECD) WAS PREPARED. THIS LIST PROVIDES DONOR CONTRIBUTIONS IN THE AREA OF HEALTH FROM 1973 TO 1985 REGARDING THE AMOUNT, TYPE AND PURPOSE OF CONTRIBUTION EACH YEAR BY DONOR. AN UPDATED VERSION OF THIS LIST WILL BE AVAILABLE FOR THE HEALTH TECHNICAL COMMITTEE MEETING OF THE COOPERATION FOR DEVELOPMENT IN AFRICA PLANNED IN NOVEMBER.

ON AUGUST 20, 1986 A MEETING WAS HELD AMONG UNICEF, AID AND CDC OFFICIALS IN NEW YORK TO DISCUSS THE STATUS OF UNICEF CHILD SURVIVAL ACTIVITIES IN THE 13 CHILD SURVIVAL CCCD BILATERAL COUNTRIES.

IN SEPTEMBER A CCCD GRANT OF 6 MILLION DOLLARS IN SUPPLEMENTARY FUNDING WAS SIGNED WITH UNICEF. THIS GRANT SIGNIFIES INCREASED COLLABORATION BETWEEN UNICEF AND AID IN THE IMPLEMENTATION OF CHILD SURVIVAL ACTIVITIES IN NIGERIA. AID, UNICEF, AND THE GOVERNMENT OF NIGERIA WILL BE WORKING TOGETHER DURING THE NEXT FIVE YEARS TOWARDS STRENGTHENING NIGERIAN CAPABILITY TO REDUCE INFANT MORTALITY AND MORBIDITY. UNICEF, THROUGH THIS GRANT HAS AGREED TO PERFORM TRAINING AND PROCUREMENT OF COMMODITIES FOR AID IN NIGERIA.

## PLAN OF ACTION:

AS MENTIONED ABOVE, THE SECOND MEETING OF THE HEALTH TECHNICAL COMMITTEE OF THE COOPERATION FOR DEVELOPMENT IN AFRICA FOR 1986 HAS BEEN SCHEDULED FOR NOVEMBER, IN WEST GERMANY. EFFORTS WILL BE MADE TO STRENGTHEN COOPERATION BY MORE PRECISELY DEFINING THE CONTENT AND PROCEDURES FOR INFORMATION SHARING BETWEEN DONORS. THE CHIEF OF AFR/TR/HPN, AND THE CDC TECHNICAL COORDINATOR FOR THE CCCD PROJECT WILL ATTEND THIS MEETING. ?

(C) PERIODICALLY REPORT RESULTS OF DONOR ACTIVITIES TO THE USAIDS.

## PLAN OF ACTION:

A CABLE SUMMARIZING THE NOVEMBER MEETING OF THE HEALTH TECHNICAL COMMITTEE OF THE COOPERATION FOR DEVELOPMENT IN AFRICA WILL BE SENT TO THE USAIDS IN DECEMBER, 1986.

SIMILAR CABLES WILL BE SENT FOLLOWING FUTURE SUCH MEETINGS.

RECOMMENDATION NO. 2.

THE ASSISTANT ADMINISTRATOR, BUREAU FOR AFRICA:

(A) DIRECT THE USAIDS TO MORE EFFECTIVELY PROMOTE DONOR COORDINATION IN THE INDIVIDUAL COUNTRIES AND (B) REQUIRE USAIDS TO PERIODICALLY REPORT ON THE EFFECTIVENESS OF DONOR COORDINATION AND SPECIFIC DONOR ACTIVITIES WITHIN THEIR RESPECTIVE COUNTRIES.

#### PLAN OF ACTION

A CABLE WILL BE DRAFTED FROM THE ASSISTANT ADMINISTRATOR DIRECTING USAIDS TO ASSUME A MORE ACTIVE ROLE IN PROMOTING DONOR COORDINATION AT BILATERAL LEVELS SPECIFYING ACTIVITIES THEY SHOULD PERFORM OR SUPPORT AND ESTABLISHING THE CONTENT AND INTERVALS OF REPORTS REGARDING THE DONOR COORDINATION MECHANISM AND SPECIFIC DONOR ACTIVITIES IN THEIR COUNTRY. THE CABLE WILL BE DRAFTED IN EARLY OCTOBER, 1986 REQUESTING THE FIRST REPORT (SUMMARIZING STATUS OF DONOR COORDINATION ACTIVITIES) TO BE SENT IN BEFORE THE NOVEMBER CDA HEALTH TECHNICAL COMMITTEE MEETING.

(2) NEED TO IMPROVE THE MANAGEMENT INFORMATION SYSTEM TO BETTER MONITOR PROJECT PROGRESS ON THE BILATERAL PROGRAM.

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## RECOMMENDATION NO. 3.

THE ASSISTANT ADMINISTRATOR, BUREAU FOR AFRICA, IN CONJUNCTION WITH THE CENTERS FOR DISEASE CONTROL, DEVELOP A PLAN TO MEASURE PROJECT PROGRESS IN REDUCING THE MORTALITY AND MORBIDITY RATES ASSOCIATED WITH THE TARGETED DISEASES.

## PROGRESS TO DATE:

AIR/TR/HPN AND CDC BELIEVE THAT THE CURRENT MIS (WHICH NOW INCLUDES MEASURES OF FACILITY AND COMMUNITY PRACTICES) IS ADEQUATE TO MONITOR PROGRAM IMPLEMENTATION AND THE IMPACT ON SELECTED TARGET DISEASES.

## PLAN OF ACTION:

AIR/TR/HPN AND CDC WILL OUTLINE THEIR CURRENT STRATEGY TO MEASURE MORTALITY AND MORBIDITY ASSOCIATED WITH TARGET DISEASES. THIS STRATEGY WILL BE COMMUNICATED TO THE CCCD COUNTRY-SPECIFIC PROJECTS FOR COMMENTS BY JANUARY, 1987.

## RECOMMENDATION NO. 4

THE ASSISTANT ADMINISTRATOR, BUREAU FOR AFRICA, REQUIRE EACH USAID, IN CONJUNCTION WITH CDC, TO:

(A) DEVELOP A CHILD SURVIVAL PLAN FOR EACH PARTICIPATING COUNTRY, WHICH SPECIFIES HOST COUNTRY NEEDS AND WHAT AID CAN PROVIDE TO DEVELOP HOST COUNTRY INSTITUTIONAL CAPABILITY IN THE AREAS OF HEALTH EDUCATION, TRAINING, HEALTH INFORMATION SYSTEMS AND OPERATIONS RESEARCH;

(B) SPECIFY THE OBJECTIVES AND TIMEFRAMES FOR DEVELOPING THE HOST COUNTRY'S INSTITUTIONAL CAPABILITY;

(C) REPORT PERIODICALLY ON PROJECT PROGRESS IN DEVELOPING HOST COUNTRY INSTITUTIONAL CAPABILITY, REDUCING MORTALITY AND MORBIDITY RATES, AND EXPANDING IMMUNIZATION COVERAGE AND ACCESS TO MALARIA AND ORAL REHYDRATION THERAPY.

## PLAN OF ACTION:

ACTION WILL BE DEFERRED ON THIS RECOMMENDATION UNTIL THE NEXT PROGRESS REPORT, (SEE PARA 4 BELOW FOR DISCUSSION).

## RECOMMENDATION NO. 5

THE ASSISTANT ADMINISTRATOR, BUREAU OF AFRICA REQUEST THE WORLD HEALTH ORGANIZATION TO SUBMIT PROGRESS REPORTS AT LEAST EVERY SIX MONTHS.

## PROGRESS TO DATE

THIS RECOMMENDATION HAS BEEN IMPLEMENTED. A REVIEW OF THE CCCD WHO/AFRO GRANT AGREEMENT IS PERFORMED

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QUARTERLY INVOLVING THE CCCD PROJECT OFFICER, THE CCCD REGIONAL LIAISON OFFICER, AND WHO/AFRO OFFICIALS. A PROGRESS REPORT IS PREPARED BY WHO/AFRO IN ADVANCE OF THE REVIEW. A REVIEW WAS PERFORMED IN MARCH, AND JULY OF THIS YEAR, WITH ANOTHER SCHEDULED IN DECEMBER, 1986. PROGRESS REPORTS ARE AVAILABLE FOR MARCH AND JULY.

PLAN OF ACTION:

TO CONTINUE TO REQUEST THE QUARTERLY PROGRESS REPORTS.

(3) NEED TO DEVISE PLANS FOR MEETING PROJECT COSTS

RECOMMENDATION NO. 6

ASSISTANT ADMINISTRATOR, BUREAU FOR AFRICA IN CONJUNCTION WITH OTHER COOPERATION FOR DEVELOPMENT OF AFRICA COUNTRIES, MULTILATERAL DONORS, AND THE AFRICAN GOVERNMENTS, DEVELOP A COORDINATED PLAN TO MEET PROJECT COSTS IN EACH COUNTRY, INCLUDING IMPLEMENTATION OPTIONS BASED ON REDUCED FUNDING LEVELS OF HOST GOVERNMENT.

PROGRESS TO DATE:

ON JULY 26, 1986 THE ADMINISTRATOR PROVIDED IN A WORLD WIDE CABLE (STATE 234273) A SUMMARY OF THE AGENCY'S HEALTH FINANCING GUIDELINES. THE CABLE STATED THAT A.I.D. WILL CONCENTRATE POLICY DIALOGUE AND PROGRAM ASSISTANCE ON PROMOTING SUSTAINABLE HEALTH PROGRAMS. THE CCCD PROJECT OFFICER IS PREPARING A PACKET OF MATERIALS INCLUDING THE AGENCY'S HEALTH FINANCING

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GUIDELINES THAT WILL BE SENT TO CCCD PROJECT COUNTRY MISSIONS AS REFERENCE MATERIALS FOR PROMOTING HOST COUNTRY HEALTH FINANCING.

PLAN OF ACTION:

THE CCCD PROJECT OFFICER WITH ASSISTANCE FROM OTHER AID OFFICERS AND AID CONTRACTORS WILL DEVELOP A GUIDELINE FOR MISSIONS TO USE IN DEVELOPING A CCCD PLAN FOR HOST

COUNTRIES TO MEET PROJECT COSTS INCLUDING IMPLEMENTATION OPTIONS BASED ON REDUCED FUNDING LEVELS. THE PLAN WILL BE COMPLETED BY DECEMBER, 1986 AND CABLED OUT UNDER THE ASSISTANT ADMINISTRATOR'S AUTHORIZATION TO THE FIELD IN JANUARY, 1987 REQUESTING MISSIONS TO WORK WITH NATIONAL GOVERNMENTS AND DONORS IN DEVELOPING THE HOST COUNTRY-SPECIFIC PLAN. IT SHOULD BE NOTED THAT A FEW CCCD COUNTRY-SPECIFIC PROJECTS HAVE WORKED VERY CLOSELY WITH THEIR HOST COUNTRIES IN THIS AREA OF MEETING PROJECT COSTS.

THIS ISSUE WILL BE ADDRESSED IN THE NEXT HEALTH TECHNICAL COMMITTEE MEETING OF THE COOPERATION FOR DEVELOPMENT IN AFRICA FOR DONOR INPUT AND ASSISTANCE.

RECOMMENDATION NO. 7

THE ASSISTANT ADMINISTRATOR, BUREAU FOR AFRICA REQUIRE THE USAIDS ESTABLISH SYSTEMS TO:

- (A) OBTAIN DATA ON HOST GOVERNMENT CONTRIBUTIONS TO THE PROJECT PER THE GRANT AGREEMENT, AND
- (B) REPORT PERIODICALLY TO THE AFRICA BUREAU ON HOST GOVERNMENT CONTRIBUTIONS

PLAN OF ACTION:

A CABLE WILL BE DRAFTED FROM THE ASSISTANT ADMINISTRATOR, BUREAU FOR AFRICA THAT WILL REQUIRE THE USAIDS TO ESTABLISH SYSTEMS TO DOCUMENT HOST GOVERNMENT CONTRIBUTIONS TO THE PROJECT AND TO REPORT EVERY 6 MONTHS ON THE CONTRIBUTION STATUS. THE CABLE WILL BE SENT IN NOVEMBER, 1986.

- (4) NEED TO BETTER INTEGRATE AID'S REGIONAL TRAINING ACTIVITIES WITH THE BILATERAL PROGRAMS.

RECOMMENDATION NO. 8

THE ASSISTANT ADMINISTRATOR, BUREAU FOR AFRICA

- (A) SPECIFY COORDINATION DUTIES OF THE REGIONAL LIAISON OFFICER WITH THE USAIDS AND CENTERS FOR DISEASE CONTROL TECHNICAL OFFICERS, AND (B) DEVELOP A SYSTEM TO PERIODICALLY NOTIFY USAIDS OF PROJECT-FUNDED WORLD HEALTH ORGANIZATION/AFRICA REGIONAL OFFICER TRAINING COURSES.

## PROGRESS TO DATE:

ON MARCH 25, 1986 A MEETING WAS HELD TO DISCUSS THE DUTIES AND RESPONSIBILITIES OF THE LIAISON OFFICER. DUTIES AND RESPONSIBILITIES WERE MUTUALLY AGREED UPON AMONG AID, WHO/APRO, AND CDC OFFICERS AND THESE WERE WRITTEN DOWN FOR THE RECORD.

ADDITIONALLY A SYSTEM WAS AGREED UPON THAT WOULD PERIODICALLY NOTIFY COUNTRIES OF PROJECT FUNDED WHO/APRO TRAINING COURSES. THE SYSTEM IS AS FOLLOWS: ONCE A TRAINING SCHEDULE IS DEVELOPED, WHO/APRO COMMUNICATES THIS SCHEDULE TO ITS NATIONAL AND REGIONAL REPRESENTATIVES. THE LIAISON OFFICER THEN COMMUNICATES THIS SCHEDULE TO THE CCCD FIELD OFFICERS AND AID/W ANNOUNCES THIS SCHEDULE TO THE USAIDS.

## ACTION PLAN:

TO TRY THIS SYSTEM SEPTEMBER 1986 WHEN THE 86/87 WORKPLAN FOR TRAINING IS COMPLETED. THE NEXT CCCD AUDIT PROGRESS REPORT WILL SUMMARIZE THE PROJECT'S EXPERIENCE WITH THE SYSTEM DESCRIBED ABOVE.

## 4. DISCUSSION REGARDING RECOMMENDATIONS 3 AND 4:

A. RE RECOMMENDATION 3: THE OVERALL PROJECT OBJECTIVE FOR THE CCCD PROJECT IS A 25 PERCENT REDUCTION OF MORTALITY RATES AMONG CHILDREN LESS THAN FIVE YEARS OF

AGE. IT IS UNDERSTOOD THAT THESE REDUCTIONS WOULD BE ACHIEVED AFTER 4 - 5 YEARS OF PROGRAM IMPLEMENTATION IN AREAS PROVIDED WITH CCCD PROGRAM SERVICES.

THE CCCD PROJECT, IN ITS STRATEGY TO MEASURE MORTALITY REDUCTION HAS MADE SIGNIFICANT EFFORTS TO DEVELOP RELIABLE METHODS FOR MORTALITY ESTIMATION. MORTALITY AND USE OF HEALTH SERVICES (MHS) SURVEYS WERE PERFORMED IN THE FIRST THREE CCCD PROJECTS--LIBERIA, TOGO AND ZAIRE-- WITH SUBSEQUENT FOLLOW-UP/REINTERVIEW SURVEYS CARRIED OUT FOR VERIFICATION. SINCE THESE SURVEYS PROVED EXPENSIVE, TIME-CONSUMING AND DIFFICULT TO INSTITUTIONALIZE; THE PROJECT RELIES ON OTHER SOURCES OF MORTALITY DATA SUCH AS DEMOGRAPHIC AND HEALTH SURVEYS PERFORMED BY WESTINGHOUSE UNDER CONTRACT WITH AID. THE MONITORING STRATEGY FOR THE CCCD PROJECT IS SIMILAR TO THOSE OF OTHER AID CHILD SURVIVAL ACTIVITIES IN THAT MORTALITY IS MEASURED IN A FEW SELECTED AREAS OF A COUNTRY PROJECT OR IN A FEW SELECTED COUNTRIES OF A REGIONAL PROJECT.

THE CCCD PROJECT IS CONTINUING DEVELOPMENT OF A MANAGEMENT INFORMATION SYSTEM (MIS) FOR NATIONAL CCCD PROJECTS. THE MIS GATHERS AVAILABLE PROGRAM DATA ON PROCESS INDICATORS OF THE IMPLEMENTATION OF CCCD INTERVENTIONS AND OUTCOME MEASURES SUCH AS THE NUMBERS OF MEASLES CASES AND PROPORTION OF CHILDREN BEING PROPERLY TREATED WITH ORAL REHYDRATION AND ANTI-MALARIAL DRUGS. THE MIS PRESENTS THIS DATA IN A GRAPHIC FORM

COMPARING RECENT PERFORMANCE (LAST DATA FOR 1985) WITH PREVIOUS YEARS, AS EXEMPLIFIED IN THE 1985 CCCD ANNUAL REPORT.

IN ADDITION, THE CCCD PROJECT IS DEVELOPING TWO ADDITIONAL METHODS FOR OBTAINING IMPORTANT INDICATORS OF PROGRAM SUCCESS: (A) A HOUSEHOLD BASED HEALTH PRACTICES SURVEY AND (B) A HEALTH FACILITY SURVEY TO ASSESS THE PERFORMANCE OF HEALTH WORKERS.

B. IN REFERENCE TO RECOMMENDATION 4: THE ISSUE OF DEVELOPING A SEPARATE PLAN SPECIFYING HOST COUNTRY INSTITUTIONAL CAPABILITY NEEDS, OBJECTIVES, AND TIMEFRAMES, WITH PROGRESS REPORTS IS CURRENTLY UNDER AFR/TR/HPN AND CDC CONSIDERATION. THE CCCD COUNTRY-SPECIFIC PROJECT ASSESSMENTS AND AGREEMENTS INCLUDE INSTITUTIONAL CAPABILITY DEVELOPMENT CONCERNS, NEEDS, AND PLANS ALTHOUGH THEY ARE NOT PRESENTED IN THE MANNER REQUESTED BY THE AUDIT REPORT. THE CCCD MIS PROVIDES INFORMATION ON PROGRAM PROGRESS WHICH REFLECTS HOST COUNTRY INSTITUTIONAL CAPABILITY DEVELOPMENT. ANY SPECIFIC ACTION PERFORMED IN RESPONSE TO THIS RECOMMENDATION WILL REQUIRE ADDITIONAL REVIEW AND DISCUSSION AMONG AFR/TR/HPN, CDC, USAID, AND CCCD FIELD OFFICIALS.

##### 5. FACTUAL DATA:

- A. EXHIBIT 3 OF THE REPORT CONTAINS PLANNED VS ACHIEVED DECREASES IN MORTALITY AND MORBILITY. IT SHOULD BE NOTED THAT THESE PLANNED TARGETS ARE LOP TARGETS.

B. EXHIBIT 4 CONTAINS INCOMPLETE DATA REGARDING PERCENTAGES OF PLANNED AND ACHIEVED IMMUNIZATION COVERAGES AND ACCESS TO ORT AND MALARIA TREATMENT.

"- C. CDC HAS PLANS CONTAINING OBJECTIVES AND ACHIEVEMENT FOR EACH OF THE PROJECT COMPONENTS SHOWN IN EXHIBIT 5 AS NOT KNOWN OR NOT QUANTIFIED.

4. REVISIONS OF THE ABOVE EXHIBITS, OTHER RELEVANT DOCUMENTS AND MEMORANDA HAVE BEEN SENT VIA DEL COURIER TO RIG/A/WA. WHITEHEAD

BT  
#2446

NNNN

COMBATTING CHILDHOOD COMMUNICABLE DISEASES PROJECT  
Objectives and Achievements in Project Components  
 As of December 1985\*

Target Categories	<u>LESOTHO</u>		<u>CONGO</u>		<u>MALAWI</u>		<u>TOGO</u>		<u>ZAIRE</u>	
	Planned	Achieved*	Planned	Achieved*	Planned	Achieved*	Planned	Achieved*	Planned	Achieved*
	LOP									
<u>Components</u>										
Health Information Systems Established	Yes	Begun	Yes	Begun	Yes	Yes	Yes	Begun	Yes	Yes
Operations Research Studies <sup>1/</sup>		2		1	10-14	13		2		3
Health Education/Promotion Unit*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Training <sup>2/</sup>	1040	1098 <sup>4/</sup>	500	38 Sr level	No	<sup>3/</sup>	1000	931	895	960 <sup>4/</sup>

NOTE: Training target figures are taken from the grant agreements; they are not broken down by personnel categories, i.e., doctors, nurses, etc.

NK - Not Known

NQ - Not Qualified

<sup>1/</sup> Number of Studies

<sup>2/</sup> Number of Trainees

<sup>3/</sup> Number of trainees could not be determined because information systems was unclear.

<sup>4/</sup> Number of trainees trained in 1985 only not LOP.

List of Report Recommendations

	<u>Page</u>
<u>Recommendation No. 1</u>	4
We recommend that the Assistant Administrator, Bureau for Africa, improve donor coordination of child survival activities in sub-Saharan Africa by:	
(a) determining the status of donor country and international organization contributions to the Africa-wide program, including the results of donor activities in the recipient countries;	
(b) periodically sharing data on program implementation, successes, and problems with other donors and international organizations, and	
(c) periodically reporting results of donor activities to the USAID missions.	
<u>Recommendation No. 2</u>	4
We recommend that the Assistant Administrator, Bureau for Africa require participating USAID missions to:	
(a) more effectively promote donor coordination in the individual countries, and	
(b) periodically report on the effectiveness of donor coordination and specific donor activities within their respective countries.	
<u>Recommendation No. 3</u>	8
We recommend that the Assistant Administrator, Bureau for Africa, in cooperation with the Centers for Disease Control, develop a plan to measure project progress in reducing mortality and morbidity rates associated with the targeted diseases.	

Recommendation No. 4

8

We recommend that the Assistant Administrator, Bureau for Africa, require each USAID, in cooperation with the Centers for Disease Control, to:

- (a) develop a child survival plan for each participating country, which specifies host country needs and what AID can provide to develop host country institutional capability in the areas of health education, training, health information systems and operations research;
- (b) specify the objectives and timeframes for developing the host country's institutional capability; and
- (c) report periodically on project progress in developing host country institutional capability and reducing mortality and morbidity rates.

Recommendation No. 5

8

We recommend that the Assistant Administrator, Bureau for Africa, request the World Health Organization to submit progress reports at least every six months.

Recommendation No. 6

14

We recommend that the Assistant Administrator, Bureau for Africa, in cooperation with other Cooperation for Development of Africa countries, multilateral donors, and the African governments, develop a plan for meeting project costs in each country. The plan should also provide implementation options based on reduced funding levels of host governments.

Recommendation No. 7

14

We recommend that the Assistant Administrator, Bureau for Africa, require the USAIDs to establish systems for:

- (a) obtaining data on host government contributions to the project as required by the grant agreements, and
- (b) reporting periodically to the Africa Bureau on host government contributions.

Recommendation No. 8

18

We recommend that the Assistant Administrator, Bureau for Africa:

- (a) establish coordination duties of the regional liaison officer when coordinating training activities with the USAIDs and Centers for Disease Control technical officers, and
- (b) develop a system to periodically notify USAIDs of project-funded World Health Organization/Africa Regional Office training courses.

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