

**AN AFRICAN FRAMEWORK FOR DESIGN
AND IMPLEMENTATION OF
CHILD SURVIVAL INTERVENTIONS:
FOCUSED INTERVENTIONS FOR IMPACT
STRENGTHENED SYSTEMS FOR SUSTAINABILITY**

This framework was developed with input from USAID's
Regional and Mission HPN Officers and
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LIST OF ACRONYMS

ARI	acute respiratory infections
ACSI-CCCD	Africa Child Survival Initiative - Combating Communicable Childhood Diseases
BASICS	Basic Support for Institutionalizing Child Survival
CDD	control of diarrheal disease
CQI	continuous quality improvement
DHS	demographic health surveys
EPI	expanded program for immunizations
HIS	health information system
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
IMR	infant mortality rate
MIS	management information system
MOH	ministry of health
NGO	non-governmental organization
NPA	non-project assistance
NPA	national plans of action
OE	operations expenditures
ORT	oral rehydration therapy
PHC	primary health care
PHN	population, health, and nutrition
PRITECH	Technologies for Primary Health Care Project
PVO	private voluntary organization
QA	quality assurance
STD	sexually transmitted disease
TAACS	technical advisors for AIDS and child survival
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Despite impressive gains in recent decades, the health of Africa's children remains a critically important issue. Infant and child mortality rates have declined as immunizations, oral rehydration therapy, and other simple, low-cost treatment and prevention strategies have proven effective. USAID has played a leading role in the implementation of these strategies through focused interventions, typically coordinated at the national level. However, the success of these interventions in Africa has been compromised by weak supporting institutions and health systems, which too often lack the capacity to sustain effective health service delivery at local and national levels.

Child mortality in sub-Saharan Africa, at 175 deaths per 1,000 live births, is considerably higher than for any other region in the world. Child illness and death represent an enormous handicap in Africa's efforts for sustainable development, adversely affecting educational status, family planning programs, and productive economic growth. USAID's continued active involvement and leadership in child survival in Africa is critical if the continent is to effectively address the challenges it faces in achieving better child health.

This Framework for Design and Implementation of Child Survival Interventions recommends viable strategic directions for child survival interventions based on countries' needs and capabilities—with an emphasis on strengthening institutions and basic health systems that benefit not only child survival programs, but also family planning and a range of essential preventive and curative health services. The Framework reinforces, and is reinforced by, initiatives of other major donors contributing to health in Africa. It is consistent with the USAID Population, Health, and Nutrition (PHN) Guidelines. The Framework presents strategic directions for USAID for the time period 1994–2000. It also provides an overview of the Agency's 1987 **Child Survival Strategy for Africa**, reviewing progress made on the major goals established in that document.

The document presents a series of key approaches to implementation derived directly from lessons learned through USAID's Child Survival programs in Africa. These approaches to implementation, described in detail in Section II, include a continued emphasis on successful *focused interventions*—immunizations, improved child nutrition, control of diarrheal diseases, child spacing, malaria prevention and control, management of acute respiratory infections, and HIV/AIDS prevention and control. At the same time, and depending on countries' needs and USAID's comparative advantages, USAID will focus increasingly on support for *strengthening health systems*, including essential drug supply, management information systems, supervision, quality assurance, and training systems. These systems typically have been weak in Africa; strengthening them is a prerequisite to ensuring that the success of child survival interventions is sustained.

To complement the strengthening of service delivery and health systems, USAID will support efforts to increase public *demand* for child survival services and will stress the importance of *community involvement* in health management decisions and financing at the local level. To increase coverage rates of an essential package of health services, USAID will promote *public-private partnerships* connecting governments with private providers and non-governmental organizations (NGOs).

This Framework also emphasizes the role of *policy dialogue*, managed by host country governments, to identify, analyze, and resolve policy constraints. Many African countries have *decentralized* authority and responsibility for health care. USAID will consistently support the policy changes needed and the managed implementation of this process while avoiding the tendency to "balkanize" the country among donors.

USAID recognizes that the development of sustainable services in the African context is a long-term goal and will therefore require long-term commitments on the part of host governments and donors. The multiple approaches to implementation that are required to promote *sustainability*—including strengthening management capacity, implementing cost recovery systems, and promoting host country ownership—will be incorporated at the design stage of USAID projects.

Based on epidemiologic, demographic, and social similarities among countries, the Framework suggests a subregional approach to support the implementation of child survival programs at the country level in sub-Saharan Africa. With limited financial resources, and faced by communicable diseases (such as cholera, dysentery, and HIV/AIDS) that cannot be controlled successfully at the national level only, this approach takes advantage of the benefits of sharing experiences and lessons learned across countries, as well as the excellent technical assistance available to USAID at the subregional level.

I. DISCUSSION OF THE PROBLEM OF CHILD SURVIVAL IN AFRICA

In 1987 the U.S. Agency for International Development's Africa Bureau established a strategy for child survival. Considerable progress has been made in meeting the principal objectives outlined in that strategy: to reduce morbidity and mortality rates for Africa's under-five population, and to strengthen the commitment and capacity of African governments and private institutions to undertake child survival initiatives. With some exceptions, infant and under-five mortality rates have declined in USAID-assisted countries in Africa. Immunization coverage and oral rehydration use rates have increased, and African governments have committed themselves to policy changes, such as decentralization and cost recovery, which improve the prospects for long-term, sustainable, and effective health systems.

However, Africa's continued economic difficulties and, in some countries, political instability have seriously strained health systems. Gains in child survival in Africa have been considerably less than in other regions of the developing world. Combined with Africa's high rate of population growth, relatively slow progress in child survival means that in the 21st century Africa will have a strikingly high share of the world's infant mortality. Most African ministries of health face declining budgets, and the increasing prevalence of AIDS poses additional challenges to health systems. Africa currently faces a difficult time in which hard fought gains in child survival are threatened. In some countries child mortality rates have increased recently.

Child survival is an essential element of overall development strategies for African countries. Well-established links exist among child survival, family planning, and maternal health and education programs. Child survival programs can provide the basis for a package of essential health care, especially for the poorest population segments. Investments in child survival are investments in future generations and future development prospects.

In this context USAID's assistance for child survival programs will continue to be critically important. Successful child survival interventions have shown that low-cost, efficient technologies exist that can successfully address the major causes of child mortality. Experience has also shown that these technologies must be supported by functioning health systems to achieve more than limited success. The principal challenge for the 1990s will be to continue to emphasize focused interventions, while strengthening integrated service delivery systems and reinforcing the long-term capacities of African governments for health planning and management. The principal goal of this combined approach is positive and permanent change in health system performance and household practices and attitudes.

A. Trends in Child Survival in Africa

On average, infant mortality in USAID-assisted countries in Africa has declined from 113 deaths per 1,000 births in 1985 to 102 deaths in 1991. Under-five mortality in these countries has declined during the same time period from 189 per 1,000 to 163. Immunization and oral rehydration programs have played an important role in bringing about these mortality reductions. In USAID child survival emphasis countries in Africa, immunization coverage rates for children 12-23 months almost doubled between 1985 and 1991 for BCG, DPT3, polio3, and measles. In USAID-assisted countries, the use of oral rehydration therapy increased from 10 percent of child diarrhea cases in 1985 to 40 percent in 1993.

In attempting to build on these positive trends, African countries are grappling with a shortage of resources and with epidemiologic and demographic changes that complicate child survival efforts. AIDS presents an

enormous challenge—as of 1990, an estimated 500,000 infants in Africa were infected with HIV. Acute respiratory infections (ARI) and malaria are also important causes of child mortality; their treatment is complicated by increasing resistance to drugs.

High rates of population growth will place extraordinary strains on health systems. The World Bank projects that, at the current growth rate (2.9 percent per year), Africa's population will increase from 531 million in 1990 to 964 million in the year 2010, and will be well over two billion by the year 2050. The number of children under five in Africa will rival that of Asia. African ministries of health will need a great deal of institutional support to plan for and manage this demographic challenge successfully.

Rural-to-urban migration within countries and the expansion of disadvantaged slum areas in and around cities create additional problems for child survival. In the slums of Nairobi, for example, the infant mortality rate is 200 per 1,000, while the rate for Kenya as a whole is 74 per 1,000. Overall, the percentage of Africa's population living in urban areas will increase from 15 percent in 1950 to a projected 40 percent by the year 2000.

The relationship between the education and health of mothers and child morbidity and mortality rates has been well established. In Kenya children of mothers with seven or more years of schooling are 53 percent less likely to die before the age of two than children whose mothers have no schooling. The nutritional status of the mother bears a direct impact on the birth weight of her child. Immunization of mothers against tetanus has proven to be an effective intervention to prevent neo-natal tetanus.

B. Constraints

- (1) Institutional weaknesses. The limited capacity of many African governments to deliver effective health care to their populations remains a principal constraint. Many ministries of health lack essential human resources, particularly in planning, management, and research. As a result of human and financial resource constraints, logistics and support systems often provide support inadequate to ensure effective service delivery.

Government policies discourage health care providers in the private, for-profit and private, voluntary sectors from addressing many of the shortcomings in government-provided health care coverage. In countries where these sectors account for an important share of health care delivery, there is often insufficient cooperation and communication between government policy makers and private organizations providing health services.

- (2) Resource availability and allocation. In the context of general economic difficulties, government expenditures on health have decreased in recent years, and operational and management problems continue to create inefficiencies in health care systems. Existing systems tend to be imbalanced in their coverage; an estimated 50 percent of Africans do not have routine access to modern health care.

In most African countries scarce health resources are disproportionately allocated for relatively expensive, curative care for urban populations to the detriment of poorer, rural populations. The distribution of ministry of health personnel in most African countries shows a similar emphasis on cities at the expense of rural areas.

- (3) Political instability. In several African countries political instability and insufficient food security have impeded the implementation of widespread, successful child survival programs. There are currently from 10 to 15 million refugees and displaced persons in Africa, beyond the reach of regular health systems. Malnutrition resulting from food shortages has severely affected health status in some African countries, as witnessed by the effects of the drought in southern Africa in 1991–1992. Children are among the most vulnerable groups in society, and are often the first victims of warfare and famine.

In some countries political instability and food security concerns argue for emphasizing short-term strategies to prioritize the needs of vulnerable groups. However, even in difficult circumstances, it is important for USAID to support improvements in health systems that eventually will lead to increased capacity for health care delivery.

C. **Lessons Learned from Child Survival in Africa**

- The major causes of child morbidity and mortality are linked and mutually reinforcing. Research and experience have shown that chronic and untreated undernutrition puts many children at high risk for infectious disease and death. Furthermore, the burden of infections is an important cause of undernutrition. These findings argue for an integrated approach to service delivery—coordinating preventive and curative care and paying careful attention to the child’s nutritional status. Malnutrition, in moderate and severe forms, correlates strongly with infant and child morbidity and mortality.
- Proven technologies exist for lowering infant and child mortality rates. When applied according to correct technical standards, immunizations and effective case management of diseases (as with diarrhea) are successful in preventing illness and death. Existing disease control strategies that have proven effective in Africa can prevent 60 percent of childhood deaths—including those due to immunizable diseases, dehydration, malaria, and pneumonia.
- For long-term impact child survival technologies must be accompanied by sustained improvements in health systems. Supporting systems, including health communication, logistics and drug supply, supervision, and the appropriate collection and use of data, are all necessary for effective service delivery in child survival. Improvements in health systems for child survival simultaneously increase access to primary health care and provide essential support for family planning programs and other health interventions.
- Ministries of health need long-term institutional strengthening. Ministries need support to increase their planning and management capacities.
- A combination of national leadership and local action encourages community involvement and sustainable recovery of costs. In a decentralized system the central ministry of health can play an important role in promoting equitable coverage of the population and ensuring universal application of correct technical standards. Community participation in health care management orients the provision of services to local needs and increases coverage and utilization rates.

- Encouraging demand for health services is essential. In most areas of Africa health care service delivery efforts cannot reach effective levels of coverage without active strategies to inform and educate populations and to promote the use of services and products.
- By mobilizing the resources of NGOs and the private commercial sector, governments and donors can increase effective health care coverage. Partnerships between ministries of health and NGOs lead to greater access to standardized, effective health care. In addition, the commercial private sector can play a key supporting role through social marketing, local pharmaceutical production, and service delivery, helping to shift financing burdens away from ministries.

D. Previous and Ongoing Activities (USAID and Other Donors)

In fiscal year 1985 the U.S. Congress created an appropriation account for the promotion of child survival in developing countries. From 1985 to 1993, \$1.56 billion was disbursed through this account, \$359 million of which was disbursed in the Africa region. The Child Survival fund has had a great impact, despite its relatively small size (never more than 3.7 percent of the total USAID budget). UNICEF and the World Health Organization (WHO) have been among USAID's principal partners in supporting child survival programs in Africa. The World Bank has played an increasingly active role in child survival efforts, as have several bilateral donors.

The USAID Child Survival Strategy of 1986 was followed closely by the Africa Bureau Child Survival Strategy in 1987 (discussed in more detail below). Through effective technical assistance (long- and short-term) and emphasis on the so-called twin engines of immunization and oral rehydration, USAID's support has contributed directly to lowering mortality and morbidity rates among infants and children in Africa. By stressing the importance of community involvement in health care, the creation of demand for health services, and innovative approaches such as social marketing, USAID has promoted a comprehensive and long-term approach to child health.

USAID has provided technical assistance and support for African health programs through a variety of mechanisms. Bilateral projects in several countries have provided comprehensive support for child survival. The Africa Bureau Regional Africa Child Survival Initiative-Combating Communicable Childhood Diseases (ACSI-CCCD) project, operational from 1981 to 1993, supported 13 African countries for interventions in immunization, control of diarrheal diseases, and malaria control. Centrally funded projects such as REACH and PRITECH have provided long-term assistance in 15 African countries, supporting, respectively, immunization and oral rehydration programs. The centrally-funded BASICS Project continues to support these activities, with an emphasis on integration of child survival interventions.

Strong international commitment to child survival was reinforced by the 1990 World Summit for Children. Representatives from 152 countries pledged continued support for improving the lives of children. Ambitious international goals came out of the summit for increasing immunization coverage rates, lowering the number of diarrhea-related deaths, and improving infant and child nutrition. Each of these goals is acutely pertinent and deserving of support in Africa. This Framework for Design and Implementation is designed to promote the same goals as those outlined at the World Summit, and to support the individual national plans of action (NPA) that resulted from the Summit.

II. THE 1987 USAID CHILD SURVIVAL STRATEGY FOR AFRICA

A. Description of the 1987 Strategy

In 1987 the Africa Bureau developed its first **Child Survival Strategy for Africa**, closely following the 1986 Agency-wide **USAID Child Survival Strategy**. Both of these documents emphasized strong interventions for immunizations and oral rehydration therapy (ORT), in addition to child spacing, nutrition, malaria, and AIDS. The 1987 Africa Bureau document listed eight emphasis countries: Kenya, Malawi, Mali, Niger, Nigeria, Senegal, Sudan, and Zaire. These countries were selected based on such criteria as population size, infant and child mortality rates, governments' commitment to child survival activities, and immunization and ORT coverage rates.

The objectives of the 1987 Child Survival Strategy for Africa were as follows:

- (1) To reduce morbidity and mortality in the under-five population, particularly in selected emphasis countries in Africa.
- (2) To strengthen the financial and policy commitment of African governments to child survival, as well as the capability of African governments and private institutions to plan, implement, sustain, and evaluate programs to improve child health and survival.

B. Progress Toward the Goals of the 1987 Strategy

The 1987 Strategy proposed specific goals (see below) noting that these goals were ambitious, and for some emphasis countries very difficult to achieve. The Strategy encouraged USAID missions to set country-specific targets in accordance with realities of the country situation. For each goal stated below, a brief indication of the status of efforts to achieve the goals (as of 1990) follows.

- (1) To reduce the infant mortality rate (IMR) to less than 75 per 1,000 per annum. Despite the lowering of IMR rates in nearly all African countries, this goal has not been met. Measuring progress toward this target has been complicated by the absence of routine vital events registration systems in most African countries. Most countries were limited to conducting a Demographic and Health Survey (DHS) to measure infant and child mortality rates. Appendix I shows the most recent estimates for African countries—no geographic region achieved the 1990 goal. Among individual countries, eight reported an IMR in 1991 at or below the target. Another 25 countries reported an IMR above 125 per 1,000.
- (2) To immunize 80 percent of children under five years of age. Although considerable progress has been made in immunization coverage, this goal has not been achieved on a regional basis. UNICEF declared that worldwide the goal of an 80 percent immunization rate was achieved in 1990, but immunization rates in Africa were lower. UNICEF estimated that in 1990, 60 percent of African children were immunized against measles. Recent reports from several countries in Africa suggest that immunization rates are declining from the levels achieved in 1990.
- (3) To ensure wide access to appropriate and correct case management of diarrheal disease episodes for children under five years of age. Both access and use rates for ORT have increased significantly

in most African countries. Progress in promoting ORT has been compromised frequently, however, by weak supporting health systems.

- (4) To provide access to voluntary family planning information and birth spacing methods for 50 percent of all couples. Although measures of access rates to family planning services are not frequently reported, recent reports of contraceptive prevalence rates from many African countries suggest that use rates, while increasing, are still low.
- (5) To reduce the percentage of children under 80 percent weight for height to less than 10 percent. Data to measure progress against this goal are limited. In most countries, however, it appears that the goal has not been met.
- (6) To provide access to an appropriate anti-malarial treatment for at least 80 percent of children under five years of age seeking treatment for fever and malaria. This goal generally remains unmet in most African countries. While strategies for case management are well understood, countries have not been successful in implementing programs to deliver such management adequately. Important causes of this general failure to implement successful case management programs include weak health infrastructures that have resulted in poor availability of anti-malarial drugs and a lack of health personnel trained to develop sound program policies and plans, manage program implementation, and provide malaria case management.

III. BASIS FOR THIS FRAMEWORK

A. The Rationale for Child Survival in Africa

Continued USAID support for child survival in Africa is critical. Despite progress made, child morbidity and mortality rates in Africa are the highest of any region in the world. Infant mortality rates in sub-Saharan Africa are 55 percent higher than in low-income countries outside Africa. More than two million African infants die annually—and demographic trends suggest that this number will increase.

However, proven technologies exist to lower infant and child mortality rates. Immunizations, effective case management of diarrhea and other diseases, promotion of exclusive breast-feeding and other nutrition interventions, and health education all have a dramatic impact on child health at relatively low cost. When combined with effective and sustainable health systems, these techniques can address the problems of child and infant mortality successfully.

High child morbidity and mortality rates are crippling overall development efforts in African countries. Child illness decreases the productivity of parents and creates pressures for the family to spend money it does not have. Learning is compromised by illness-related absences, and by malnutrition, which leads to reduced learning capacity for children. In short, returns to investments in human capital, and capacity for future economic development, are diminished greatly by malnutrition and preventable childhood diseases.

Successful child survival programs also contribute to slowing population growth rates. Throughout the developing world birth rates have declined as confidence in the survival of children and the use of modern contraception have increased. This trend has been less notable in Africa, where infant and child mortality rates have not yet reached sufficiently low levels to affect population growth significantly. However, in

Kenya, where infant mortality decreased from 130 per 1,000 in 1960 to 74 per 1,000 in 1989, the fertility rate has declined from 7.8 to 6.7 during the same time period.

In Africa child survival programs provide an especially important link between health systems and families. Family planning programs have been slower to take hold in Africa than in other regions of the world, for a variety of social and cultural reasons. Mothers are more likely to seek assistance for a child's illness than for their own contraception needs. By targeting mothers and children as a unit, health systems can take advantage of consultations for child survival programs to introduce mothers to family planning and maternal nutrition programs. Well-managed child survival programs can provide the credibility and systems support that family planning programs in Africa need.

Where effective health systems are available to support child survival initiatives, these systems provide the basis for a package of essential health care and family planning services that benefits the entire population—a package of services that is a highly cost-effective means of improving health care, particularly for rural and poor populations. Elements of a successful health system—including supervision, provision of essential drugs and supplies, and monitoring systems—support, in addition to child survival programs, family planning programs, pre- and post-natal care, and general outpatient care.

For all of these reasons, child survival programs in Africa deserve USAID's strong continued attention through the remainder of the 1990s. Child survival programs face particular challenges in Africa, and offer special opportunities for gains for other health and family planning programs. USAID's approach to child survival in Africa must take these factors into account. While consistent with Agency-wide priorities for the conception and implementation child survival programs, this USAID Framework for Design and Implementation of Child Survival Interventions for Africa also responds to the many factors particular to, or particularly important in, sub-Saharan Africa.

B. Purpose and Use of This Document

The Africa Bureau has developed this Framework for Design and Implementation to provide USAID missions and Africa Bureau staff with a list of recommended priority focused interventions, systems support strategies, and issues that should be considered in the implementation of child survival activities for the remainder of the 1990s. An additional purpose of the document is to assist USAID, ministries of health, and other donors in identifying the focused interventions and support systems that must function adequately in countries if they are to achieve the World Summit for Children goals. The Bureau anticipates that the Framework will be particularly useful in the following circumstances:

- (1) For development of country program strategies. The Framework for Design and Implementation identifies the Bureau's goals, objectives, strategic directions, and implementation approaches for Africa child survival efforts during the 1990s and provides monitoring and evaluation strategies and indicators that can be used to measure progress toward the goals and objectives. Mission personnel are encouraged to review the Framework as they formulate new country strategies and monitoring and evaluation plans.
- (2) For design of new child survival projects. Those responsible for preparing project identification documents and project papers should review the Framework and ensure that the most important focused interventions, support strategies, and implementation issues are addressed in the project design.

- (3) For policy dialogue with other donors and ministries of health. USAID missions are encouraged to use the Framework in discussions with ministries of health to assess their current capacity to implement required interventions and those areas for which additional technical and financial support will be required. The Framework also describes USAID comparative advantages—providing a basis for discussions with other donors to coordinate support for different programs and activities.

IV. OBJECTIVES AND GOALS FOR CHILD SURVIVAL IN AFRICA, 1994–2000

A. Objectives

The objectives of the Africa Bureau Framework for Design and Implementation of Child Survival Interventions are designed to support and implement the USAID PHN Guidelines, with emphasis on the particular challenges facing Africa. The objectives are:

- To reduce morbidity and mortality in Africa's under-five population through successful implementation of targeted interventions.
- To strengthen health systems in Africa, to ensure adequate personnel and logistical support for specific interventions, and to increase coverage and utilization rates for health services.
- To strengthen the capacities of public and private African institutions to provide and manage high-quality health care services.

B. Goals for the Year 2000

The goals of this Framework for Design and Implementation of Child Survival Interventions are consistent with the overall USAID PHN Guidelines and the specific goals resulting from the 1990 World Summit for Children. The following are goals for Child Survival in Africa, to be achieved by the year 2000:

- To maintain high levels of immunization coverage (at least 80 percent of children under one year of age) against diphtheria, pertussis, tetanus, measles, poliomyelitis, and tuberculosis and against tetanus for women of child-bearing age.
- To reduce significantly the number of measles cases and deaths resulting from measles, as major steps to eventual global eradication of measles.
- To eliminate neonatal tetanus deaths.
- To eradicate poliomyelitis.
- To reduce by one-third deaths due to acute respiratory infections in children under five years of age.

- To reduce by 50 percent deaths due to diarrhea and dehydration in children under five years of age, through the appropriate and correct case management of diarrhea cases in the health system and at home.
- To provide access to an appropriate anti-malarial treatment for at least 80 percent of children under five years of age seeking treatment for fever and/or malaria.
- To reduce the percentage of children under 80 percent weight for height to less than 10 percent.
- To increase significantly the proportion of children who are exclusively breast-fed from birth to the age of four to six months.
- To increase significantly rates for access to and use of public sector health services.
- To support institutional capacities and health support systems in the public and private sector, leading to significant improvements in the ability of African countries to provide and manage effective health care for their populations.
- To expand existing health coverage through the public sector and through public-private sector partnerships.

All African countries cannot be expected to achieve these goals and specific objectives by the year 2000. However, USAID missions in Africa are expected to adopt the general objectives and goals, and to establish a work plan that identifies specific targets for the year 2000 as well as for achieving World Summit goals as reflected in countries' National Plans of Action (NPA).

V. STRATEGIC DIRECTIONS FOR THE 1990s

To meet the objectives detailed above, USAID missions will need to work with host country governments and other donor organizations to adopt strategic directions for child survival that are integrated with and reinforce other health and family planning interventions. Promotion of an essential package of primary health care and clinical services is the most practical and cost-effective means of improving the health of African populations.

The Framework supports implementation of child survival programs as part of this package of essential health and family planning services. Other major donors in the health sector in Africa likewise have called for promotion of an essential package of health services. This concept is consistent with the objectives of the USAID PHN Guidelines, as well as the specific goals resulting from the 1990 World Summit for Children and endorsed by the United States. In the design and implementation of child survival programs in Africa, USAID will use the following strategic directions:

- To continue the successful implementation of focused interventions while promoting integration at the service delivery level. Child survival interventions will need to address the leading causes of child mortality through integrated interventions for control of diarrheal disease (CDD), acute respiratory infections (ARI), malaria, and immunizations. Malnutrition, often an underlying cause of child mortality, also must be addressed through promotion of exclusive breast-feeding, positive weaning practices, maternal nutrition, and other nutrition interventions. One promising approach

already underway is the implementation of the Sick Child Algorithm, an integrated treatment protocol for the most important childhood illnesses.

- To strengthen health support systems required for sustainable service delivery, including supervision, provision of essential drugs and supplies, and information systems. Once effectively put into place, these systems will support the entire package of clinical care, family planning, and primary health care services. Improving the quality of services to meet the needs and expectations of the population will be an important step toward increasing use rates for health systems and ensuring their long-term viability.
- To provide institutional support for ministries of health. Given financial constraints and demographic and epidemiologic trends, African ministries of health will need institutional strengthening. In particular, ministries' capacities for planning and for ensuring effective support systems (including supervision, drug supply, and information systems) must be strengthened.
- To encourage partnerships of ministries of health with NGOs and the commercial private sector, to access additional resources for the provision of health care and to increase coverage.
- To promote equitable coverage of populations. In promoting integrated and effective service delivery, health care coverage of a nation's population should be as balanced as possible in geographic and demographic terms. In addition, vulnerable groups such as poor urban populations and refugees deserve special attention and can be targeted through specific interventions.
- To promote demand for services, with an emphasis on increasing use rates and level of community participation. While increasing the efficiency of health service delivery, additional steps must be taken to increase the population's confidence in the health system, demand for services provided, and participation by the community in the management of resources at the local level. Health communication through a variety of channels, community outreach, and social marketing offers options for motivating populations. Each of these approaches requires a thorough understanding of the determinants of behavior and demand.
- To target mothers and children as a unit. Mothers are the primary caretakers for children under five years of age; the health of mothers and their children is closely linked. A comprehensive approach to child survival must be reinforced by simultaneous efforts to improve the health and educational status of women, leading to effective child spacing and healthier children.
- To improve donor coordination. Donors have arrived at a consensus concerning the importance of child survival in Africa. Increasingly, donors are organizing around a common set of child survival objectives, and are supporting the strategy outlined in this document. WHO, UNICEF, and The World Bank are investing increased resources in child survival efforts. By coordinating approaches with other donors, USAID can help to ensure that these investments are translated into long-term, sustainable gains. USAID will emphasize its comparative advantages, including technical assistance, in strengthening the institutional capacities of ministries of health and promoting opportunities to work with the private sector.

VI. KEY APPROACHES TO IMPLEMENTATION

The following key approaches are the most important tools USAID missions have at their disposal to ensure effective implementation of child survival (and other) programs. The key approaches complement the Strategic Directions presented in Section V of this Framework, providing additional detail to be considered for conception and implementation of programs. For each key approach, the most important points are presented below. A complete discussion of each key approach is provided in Appendix I.

Focused Intervention Approach and Integration

- Existing approaches and technologies have been validated as appropriate solutions to address the key health problems influencing mortality rates among infants and children.
- Emphasis on these high-impact interventions needs to be sustained. The specific focus of attention and resources must be determined according to the needs of each country.
- These interventions include expanded program for immunizations (EPI), CDD, ARI, malaria, nutrition, HIV/AIDS prevention, and case management of the sick child.
- These interventions normally require a management focus in each country. However, care must be taken to integrate interventions at the service delivery level and at the level of first-line management and supervision.
- Services should be organized so that every client contact ensures that the complete needs of the mother and child are addressed and that opportunities are not missed (including screening sick children for vaccinations and referring their mothers for family planning).
- Support systems (including supervision, training, and logistics systems) should reinforce integrated service delivery.

Systems Strengthening

- Child survival interventions cannot be sustained without a functioning health system.
- USAID child survival programs will address technical interventions and the need to strengthen essential support systems (facilities, logistics, manpower development, information, management, financing, and research). The emphasis given to each component depends on the needs of each country's health system and the configuration of donor assistance.

Policy Dialogue

- Policy dialogue should be managed by the host country and should include the principal donor agencies concerned with health.
- Consideration will be given in each country context to non-project assistance (NPA) and project assistance as mechanisms to stimulate policy dialogue.

- USAID will be active in identifying and resolving policy constraints and supporting development of policies that remove barriers to effective and accessible health care. Key policy areas include:
 - decentralization,
 - cost recovery,
 - private sector involvement,
 - policies to support focused interventions, and
 - budget allocations for curative and preventive care.

Sustainability

- USAID missions will join with the host government and other donors in each country to develop sustainable child survival services. Components of sustainability include:
 - the quality of services,
 - access and coverage,
 - the utilization of services,
 - a self-sufficient resource base for service delivery,
 - effective program management,
 - support for institution and capacity building, and
 - demand and its determinants.
- Consideration of the different elements of sustainability will be incorporated at the design stage of USAID projects.
- USAID will recognize that the development of sustainable services in the African context is a long-term goal and will therefore require long-term commitments on the part of host governments and donors.

Decentralization

- Most African countries are attempting to decentralize authority and responsibility for health care. USAID will support the policy changes needed and the managed implementation of this process.
- In supporting decentralization USAID will work with the government, NGOs, and other donors to ensure that sufficient attention is paid to standardization of services offered across regions and to equitable coverage.
- USAID will support host country and city government efforts to strengthen service delivery and outreach activities in rapidly growing peri-urban areas, where special opportunities exist to have an impact on highly vulnerable populations. City governments should play a key role in these activities.

Involvement of the Private Sector and NGOs

- Child survival should be promoted through all available channels to increase access to and coverage of appropriate services. This may include NGOs, private practitioners, traditional healers, and the commercial sector.
- In many African countries the private sector already provides a substantial part of health services at relatively low cost to the government.
- Wherever possible, professional medical (particularly pediatric) and health associations should be encouraged to support and participate in child survival program development and implementation.
- USAID will encourage ministries of health to develop partnerships with NGOs and private providers by sharing approaches and materials; by including them in training courses; and, more generally, in the planning, implementation, and evaluation of services at all levels. Professional medical and health associations should be encouraged to support and participate in child survival program development and implementation.

Community Participation and Empowerment

- USAID will assist government and NGO efforts to establish and strengthen consumer participation in health care management at all levels of the health system.
- Particular emphasis should be placed on preparing community groups to take an active role in management of local services and cost recovery systems.
- USAID will assist host country efforts to promote collaboration with community organizations working in health-related areas, including water and sanitation committees, food production and distribution groups, and schools.

Community and Household Behavior Change

- USAID will promote the use of appropriate research methodologies in developing initiatives for behavior change that take into account community, family, and individual characteristics.
- USAID will promote approaches to program planning and implementation that take into account the clients' needs, health-seeking choices, and perception of child survival services.
- USAID programs will support health education at national and local levels to take full advantage of different and complementary health education methods and channels.
- An appropriate balance should be sought among face-to-face education, the use of the mass media, community outreach activities, and communication channels traditionally used in each community (including church, theater, and songs).

Human Resource Development

- USAID will participate with the host country and other donors in country assessments of the training needs for child survival for managerial and technical skills.
- USAID will consider its comparative advantage and the cost-effectiveness of different training options to develop an appropriate mix of:
 - long- and short-term training,
 - pre-service and in-service training,
 - in-country, regional, and training abroad, and
 - training different categories of personnel.
- In general, USAID will support improvement of quality and effectiveness of African national and regional training institutions.
- USAID will assist host countries to explore performance-based incentive systems, which could include official recognition, awards, training opportunities, and cost sharing in cost recovery systems, among others.
- USAID will support efforts to define the roles and responsibilities of different categories of health personnel and to maximize the use of lower-level personnel in a rational manner, leading to increased access to effective service delivery.

Quality Assurance

- USAID will support ministries of health in developing and monitoring technical standards for child survival focused interventions, with emphasis on case management, counseling, supervision, and referrals.
- USAID will support ministries of health in ensuring that different providers of health care—in the context of a client-centered approach—to carry out the problem-solving activities necessary to apply the standards developed with a view to increasing patient satisfaction and service use rates.
- USAID will assist the government in reinforcing a minimum package of components necessary to maintain and improve quality service delivery. These components will include:
 - a functioning supervision system,
 - an adequate supply of drugs and equipment,
 - competency-based pre-service and in-service training, and
 - a management information system that permits active monitoring of service delivery quality.

Applied Research

- Applied research should be used to address well-defined issues arising from program implementation.
- Decision-makers and program implementors should be involved in defining the issues to be researched and in carrying out the research, to promote a sense of ownership among those groups.

- Discussion and dissemination of results should be incorporated into research planning to maximize use of the findings by decision-makers.
- USAID will assist in strengthening African national and regional capacities to carry out research (researchers) and use the results (decision-makers).

Measurement of Performance and Impact

- USAID will assist in developing and monitoring long-term and intermediate indicators of:
 - morbidity and mortality,
 - increased access to and use of services,
 - increased quality of services (minimum package of quality care, including indicators for different support system components—for example, a functioning supply or supervision system), and
 - increases in knowledge and desired behaviors in the population.

Child Advocacy

- USAID will encourage African national and multilateral organizations, professional associations, and NGOs working at all levels to act as advocates for children's health and well-being—representing children's health interests in policy debates and decisions concerning allocation of resources.

Coordination with Other Donors

- USAID will support governments playing the lead role in coordinating donor assistance and developing policies and strategies for child survival services (focused interventions and strengthening of support systems).
- USAID will work with host country governments and other donors to coordinate inputs to avoid overlap and maximize the comparative advantage of each agency.

VII. SUBREGIONAL APPROACHES TO COMPLEMENT COUNTRY PROGRAM IMPLEMENTATION

Changing epidemiologic patterns, increasingly scarce financial resources, and viable sources of technical support all argue for a subregional approach to support and complement implementation of USAID's country programs for child survival in Africa. Priorities and programs for each country must be shaped and determined by the specific realities of that country. Subregional support for country programs will require USAID direct hire or contractor staff to work at a subregional level and to be responsible for supporting programs in several countries. It does not imply, however, that country programs would be given less emphasis.

Disease patterns in Africa are changing. The spread of HIV/AIDS, cholera, and dysentery ignores national borders. ARI and malaria are increasingly resistant to standard treatments; control of these diseases necessitates coordination and cooperation across countries. Subregional support will also be appropriate

where similarities among countries lead to implementation of similar country programs; implementation of a particular country program with subregional support must be derived from needs and analysis at the country level.

As USAID faces the challenges of increasing program impact and efficiency while determining where to invest increasingly scarce resources, coordination at the subregional level in Africa offers many advantages—in terms of meeting USAID’s program priorities, maximizing impact, and complementing the input of other donors. Coordinating input and technical assistance across a subregion fosters the sharing of experiences and lessons learned among countries, and leads to shared approaches to implementation. In addition, subregional support will provide the flexibility to continue helping important and specific programs in countries that may face a reduction in USAID personnel.

USAID can take advantage of similarities among countries to implement programs on a subregional basis, and to encourage sharing experiences and lessons learned in several countries of a subregion. In many cases African organizations and institutions are already working within subregions to coordinate research and share information across countries. Shared administrative patterns, cultural ties, and similar perceptions among countries argue further for approaching public health interventions from a subregional point of view.

VIII. MONITORING AND EVALUATION

This section suggests approaches for designing appropriate indicators to measure and evaluate performance and impact. To reflect the Framework’s emphasis on focused interventions and systems strengthening, suggestions are provided below for both types of programs. Measurable and direct impact on the health status of populations is emphasized, as is delivery of effective, integrated health services.

A. Focused Interventions

USAID missions aiming to improve the quality of health services are encouraged to specify the service or services to be used in evaluating performance. This does not suggest that efforts to improve service quality should be limited to a vertical program, but rather that outcomes must be specific to be measurable. Some examples follow:

For case management services (including diarrhea, malaria, and pneumonia); indicators of quality are those outcome indicators related to provider performance:

- The proportion of patients seen by the provider who meet national diagnostic criteria for the disease episode, and who are diagnosed correctly.
- The proportion of patients diagnosed with the disease episode by the provider who are prescribed treatment in accordance with national policy.

For immunization services, recommended indicators are the following:

- The proportion of infants completely immunized before one year of age (generally collected through immunization coverage surveys).
- The proportion of infants who are immunized with DPT1 after six weeks of age.

- The proportion of infants who are immunized with measles after nine months of age and before one year of age.
- The proportion of children protected at birth against neonatal tetanus (through maternal immunization).
- Missed opportunities: the proportion of infants who attended a clinic and were eligible to be immunized against measles, but who were not immunized during that visit.

B. Strengthening Health Systems

As health and family planning programs expand and increase their attention to systems strengthening, USAID missions should report on increases in the numbers of health facilities providing certain services or providing a full package of “quality, effective health and family planning services.” Performance can be viewed in terms of the improved functioning of certain health systems or in terms of improved quality, access, and use of health service(s). Systems-strengthening activities frequently attempt to improve functioning of training, supervision, health information systems, logistics, and health education.

Sample indicators for systems-strengthening activities that address these areas include:

- Supervision. Proportion of facilities with personnel who report one or more visits by their supervisor in the past three months.
- Health information systems. The proportion of reports (facility to district and district to national) received within the required period of time.

Additional indicators for measuring the impact of health systems strengthening efforts are:

- Availability and rational use of essential drugs. The percentage of cases correctly treated with appropriate essential drugs.
- Access. Access typically is defined in terms of the percentage of the population living within a reasonable (locally defined) distance to a health facility that has a sufficient supply of vaccines, drugs, commodities, and equipment during a specified time period and that has staff trained to provide the specified health service.

If immunizations represent the indicative health service for which access is measured, access is defined in terms of the percentage of the population living within a reasonable distance of a health facility that routinely has vaccines available and that has staff who were trained or retrained to give immunizations in the last three years.

- Use. Use of health services also must be specific to a certain type of service for the purposes of evaluation. If immunizations represent the indicative health service, use is calculated as the percentage of the target population of infants who receive DPT1 during the time period.

If a curative service or case management service represents the indicative health service, utilization is calculated as the percentage of cases of the particular condition expected during a given time period (based on an estimated incidence rate) that were actually treated during the time period.

APPENDIX I. KEY APPROACHES TO IMPLEMENTATION

A. FOCUSED INTERVENTION APPROACH AND INTEGRATION

- Existing approaches and technologies have been validated as appropriate solutions to address the key health problems influencing mortality rates among infants and children.
- Emphasis on these high-impact interventions needs to be sustained. The specific focus of attention and resources must be determined according to the needs of each country.
- These interventions include EPI, CDD, ARI, malaria, nutrition, HIV/AIDS prevention, and case management of the sick child.
- These interventions normally require a management focus in each country. However, care must be taken to integrate interventions at the service delivery level and at the level of first-line management and supervision.
- Services should be organized so that every client contact ensures that the complete needs of the mother and child are addressed and that opportunities are not missed (including screening sick children for vaccinations and referring their mothers for family planning).
- Support systems (including supervision, training, and logistics systems) should reinforce integrated service delivery.

The so-called twin engines of child survival, EPI and CDD (specifically ORT) have had considerable success in reducing child morbidity and mortality in Africa as elsewhere. This is reflected in the average values of key indicators: EPI coverage worldwide has jumped from 20 percent in 1980 to an estimated 80 percent in the early 1990, and between 1984 and 1992, ORT use worldwide (excluding China) increased from 12 percent of diarrhea episodes in children to 46 percent. We also have learned that attention to EPI and CDD interventions needs to be sustained for results to be consolidated and improved.

Monitoring of mortality and morbidity trends shows that several other illnesses/conditions must be addressed to promote child survival in the current African context. These include *malaria, malnutrition, acute respiratory infections, high-risk births, and maternal health and nutrition*. HIV/AIDS among women and children is also a growing child survival theme in Africa.

Malaria. About 30 percent of all child deaths in Africa are attributable to malaria, and maternal malaria infection is a main cause of low birth weight in newborns. The prevention and control of malaria, especially improving early detection and case management, is crucial in promoting child survival.

Malnutrition. Malnutrition increases a child's susceptibility to illness and death and is a contributing factor in up to 60 percent of child deaths. Approaches to improved child nutrition include promotion of breast-feeding, interventions to control micronutrient deficiencies,

improved infant feeding practices, supplementary feeding programs, nutrition education, vitamin A supplementation, and growth monitoring to stimulate action at the household level. Improved maternal nutrition also should contribute to improving child nutrition.

Acute Respiratory Infections (ARIs). ARIs account for between 15 and 25 percent of deaths among children under five. The case management strategy should include an early recognition of pneumonia, prompt treatment of non-severe cases at home with standard antibiotics, and quick identification and referral of severe cases to an appropriate health facility.

Child spacing. Too many children, born too close together, to mothers too young or too old, increases the risk of malnutrition and infectious disease among children. Increased use of contraceptives should improve child spacing and reduce high-risk births.

Maternal health and nutrition. Poor maternal health and nutrition are major contributing factors to low birth weight, increased vulnerability of newborns to infections, and perinatal and neonatal mortality. Maternal interventions such as tetanus toxoid immunization, prenatal and delivery care, improved maternal nutrition, and contraception emerge as high priority for child health.

HIV/AIDS and other sexually transmitted diseases (STDs). HIV/AIDS and other STDs are becoming increasingly major threats to mothers and children. The contribution of AIDS to child mortality is expected to increase. Prevention and control of STDs, including HIV/AIDS interventions directed toward the mother and child, should be improved and strengthened.

It is thus clear that child survival interventions must be broader than the “twin engines.” It is also clear that a focused, systematic approach to problems must be maintained as well to obtain desired and measurable impact. A careful assessment in each country will indicate which interventions are likely to have the most impact, depending on the magnitude of the problem, configuration of donor support, and host country commitment and priorities.

The need for a client-centered approach to service delivery also has arisen from implementation experience. The principle of making each client contact an opportunity to address the different needs of the child and its mother is an important departure from current practice in many countries. The integration of services must be approached from this standpoint—i.e., integrated attention to the client at the service delivery level. Field experience has shown this to be a practical approach in many cases—mothers are referred to family planning services at vaccination sessions in Burundi, nutrition assessment of the child is included in ORT corners in the Sahel, and EPI programs have made strides in identifying and curtailing missed opportunities.

The Sick Child Treatment Algorithm developed by WHO and UNICEF is an important instrument that should improve training and supervision and assist health staff in implementing an integrated approach to the child who reaches the health facility.

The fact that services are integrated at the delivery point does not mean that a management focus for the different child survival interventions is superfluous. Indeed, in a decentralized and integrated health system, a strong management focus that sets standards, develops harmonized curricula and educational materials, coordinates operations research, and develops monitoring and evaluation tools is key to

effective client-centered service delivery. However, this requires the program staff in the ministry of health at central and often regional levels to work closely together to play the role of policy-makers and technical advisors to district and local-level implementors.

The challenge for activities such as supervision, training, and health education/communications, where clearly not all subjects can be treated with the service provider or client at one time, is to make sure that all priority areas are covered adequately by the system, while themes for discrete supervision, training, or education activities are chosen systematically on the basis of the particular current problems of the service provider or client. Thus, for example, a supervision check-list should be integrated so that it covers all priority service delivery and outreach activities, but the supervisor will choose the focus for each supervision visit, according to the priority problems of the health facility and community.

B. SYSTEMS STRENGTHENING

- Child survival interventions cannot be sustained without a functioning health system.
- USAID child survival programs will address technical interventions and the need to strengthen essential support systems (facilities, logistics, manpower development, information, management, financing, and research). The emphasis given to each component depends on the needs of each country's health system and the configuration of donor assistance.

The child survival strategy of the 1980s, based largely on a selective primary health care approach, has been a qualified success. There is a growing consensus that while EPI and ORT efforts were very successful during the 1980s, coverage levels have plateaued or are even decreasing. Child survival interventions cannot be sustained without a functioning health system. More attention must be given to reinforcing the support components of integrated health systems. Each level (national, regional, and district) of an integrated health system must include subsystems to support health interventions. Essential support components include:

facilities (buildings, equipment, and maintenance);
logistics (medicines, supplies, transportation, and communications);
manpower development (formal education, in-service training, and supervision);
management (planning, monitoring, and evaluation);
information (health surveillance and program monitoring);
financial (cost recovery and financial management); and
supervision.

In many countries these support components are nonfunctional or inadequate. The respective roles of the national, regional, and district levels in the management of support systems are often unclear, inefficient, and overly bureaucratic. Too often improvements are piecemeal without coherent integration, conflicts exist between top-down and bottom-up approaches, and vested interests in the status quo protect existing vertical support systems. USAID will work with governments to support long-term improvements in support systems as part of a cohesive national strategy.

USAID will support systems strengthening by providing technical assistance for the needs assessment, design, financing, and implementation of essential support components for focused interventions of child survival. This will include, but not be limited to:

Facilities. Modest investments in renovation of existing buildings and provision of basic equipment would increase the morale of health workers and improve the quality of care. Cost recovery mechanisms can support maintenance of buildings and equipment.

Logistics. The establishment of regional supply depots managed by the ministry of health or not-for-profit NGOs and adhering strictly to an essential medicines list is a cost-effective option for maintaining a secure supply line to health districts and health centers.

Manpower development. The definition of roles and responsibilities for health personnel within a decentralized health system should maximize the training and use of personnel at all levels of the system. USAID will assist in the design of an appropriate and integrated mix of training opportunities for child survival managerial and technical skills.

Management. Management systems should include delegation of more personnel management to the regional/district level, provisions for management of performance-based incentive system of health personnel, and preparation of community groups in the management of local services and cost recovery systems.

Information. A management information system (MIS) should monitor the technical standards for focused interventions and support components of the health system. The MIS should promote analysis and decision-making at the health center level as well as data compilation, analysis, and feedback from the district and regional levels.

Financial. As more countries initiate cost recovery systems, the experience and lessons learned by the NGO/private sector in cost recovery, personnel motivation, and financial management should be examined and applied to decentralized public sector health systems.

Supervision. Effective systems for supervision of health workers are essential. To be cost-effective, supervision at the health center must be integrated, incorporating several focused interventions while giving appropriate attention to actual practices of health workers (for example, a health worker rehydrating a child with diarrhea). Supervision should correct mistakes and encourage health personnel while providing them with continuing education.

C. POLICY DIALOGUE

- Policy dialogue should be managed by the host country and should include the principal donor agencies concerned with health.
- Consideration will be given in each country context to both NPA and project assistance as mechanisms to stimulate policy dialogue.
- USAID will be active in identifying and resolving policy constraints and supporting development of policies that remove barriers to effective and accessible health care. Key policy areas include:
 - decentralization,
 - cost recovery,
 - private sector involvement,
 - policies to support focused interventions, and
 - budget allocations for curative and preventive care.

Dialogue about policy is the government's prerogative. In a policy dialogue process managed by the government, donors can assist greatly in identifying problems and proposing solutions. Donors provide technical expertise and experience in critical policy areas; they also can facilitate the policy dialogue process itself through workshops and shared experiences.

USAID has been developing mechanisms, such as **NPA**, as it seeks to gain leverage with governments and bring about policy reform. Experience with NPA is still limited, but encouraging. Both NPA and traditional project assistance can be used as incentives to bring policy issues to the attention of governments, as part of efforts by USAID and its partner donors to work toward constructive policy reform.

USAID will continue to work with governments and partner donors to bring about important policy changes. Important issues for reform include, but are not limited to the following:

Decentralization reflects the political changes occurring in many African countries, as governments devolve power, responsibility, and resources to regional, district, and local levels. Governments are realizing their limitations in the provision of health services, recognizing that regional, district, and local health staff have the capacity to manage services effectively on their own. The increase in the number of trained staff, the improvement of roads and communication, the growth of demand for health care services caused in part by better communication—all of these factors argue for decentralized, more efficient delivery of health services adapted to local needs and concerns. Policies favoring decentralization include increasing the autonomy of ministry of health services at the regional and district levels, and encouraging establishment and maintenance of community health committees, which give populations a direct voice in the management of their health care.

Cost recovery represents another recognition on the part of many central governments—that free services cannot be maintained. In the face of serious budget constraints, real public spending on health care has been in decline. Asking clients to pay for services is a logical step if services are to survive. Cost recovery commits the public health service to providing services

worth paying for. Research and experience have shown that populations are willing to pay for health care that they perceive to be of high quality; use rates have increased for well-managed public sector cost recovery systems. Supportive government policy, including permitting local health centers to manage funds and reinvest profits, is essential for successful cost recovery.

Private-sector involvement. In many African countries private health care providers cover 50 percent or more of the population. Private providers include private modern and traditional practitioners, private voluntary organizations (PVOs), and NGOs. Government can forge constructive links between the public and private sectors, and enter into partnerships with NGOs covering large segments of the population.

Governments also can remove disincentives that hamper the private health care sector, including disproportionate taxes, import duties, medical barriers, and outmoded curricula. A strong private sector will never lead to the complete absence of government in the health sector; there will always be need for regulation and a social safety net for people who cannot pay for services.

Focused interventions depend on government support at the policy level, including the formulation, dissemination, and enforcement of effective treatment and referral protocols. For focused interventions to succeed, strong support systems are also essential—so that drugs and other basic supplies are available, personnel are motivated and well-trained, and appropriate referral takes place. These systems also require policy-level support—for example, for effective training and drug supply policies.

Curative and preventive care. Heavy investment in curative services, especially in large tertiary-care hospitals and the provision of sophisticated curative procedures, is not cost-effective for the broader population. Greater emphasis on prevention reflects a broader constituency that includes middle- and lower-class citizens. Policies promoting preventive care are considerably more cost-effective for the population as a whole.

D. SUSTAINABILITY

- USAID missions will join with the host government and other donors in each country to develop sustainable child survival services. Components of sustainability include:
 - the quality of services,
 - access and coverage,
 - the use of services,
 - a self-sufficient resource base for service delivery,
 - effective program management,
 - support for institution and capacity building, and
 - demand and its determinants.
- Consideration of the different elements of sustainability will be incorporated at the design stage of USAID projects.

- USAID will recognize that the development of sustainable services in the African context is a long-term goal and will therefore require long-term commitments on the part of host governments and donors.

Definition. According to most of the recent literature on sustainability, a project is sustained if all or a significant part of the health benefits it produces are sustained for three or more years beyond the life of the project. Some argue that a project is sustainable if during its life it played a role in reorganizing the health sector or creating stronger institutions for project implementation. While continued donor funding to extend project services is not considered to be inconsistent with a sustainable approach, national sources of funding are generally preferable.

The African context introduces a number of variables that make it necessary to develop a more flexible definition of sustainability. The relatively recent colonial heritage, social heterogeneity, heavy hand of state control, current move to democratization of political processes and liberalization of markets, and subsequent political instability and weakening of key institutions are only a few of the variables that distinguish the African situation from those that prevail in other parts of the developing world.

In Africa institution building and system strengthening, therefore, constitute important components of any sustainable project. These goals are important measures of success for transition to increased self-reliance on national institutions and financing over the long term. A successful strategy of reinforcing institutions and strengthening health systems will require that USAID, other donors, and host governments take a long-term view of sustainability—and provide the commitments necessary to ensure the success of a long-term strategy.

Designing a sustainable project. USAID-financed projects will incorporate criteria for sustainability from the design stage of the project. These criteria include the following points:

Flexibility must be built into the project to allow for addition of new components and adoption of new approaches as needed, as well as elimination of components and/or input that prove to be ineffective. The project should be equally flexible in adjusting its geographic coverage.

Incentives play a crucial role in sustainability of projects. Consumers, service providers, and managers/administrators of the project all must have sufficient stake not only in the quality and efficiency of service delivered, but also in the continuation of project activities.

Effectiveness enlarges a project's supportive constituency and hence its sustainability. To be effective a project must have clearly defined goals and outputs, and a set of activities focused on those goals. To be effective a project also should avoid the risks of being spread thinly functionally and/or geographically.

Integration is essential to sustainability. Project activities should be integrated progressively into the mainstream health service delivery structure. Vertical and autonomous structures of project implementation should be avoided. While they are effective, vertical structures seldom develop the broad-based supportive constituency required to sustain them beyond the period of donor funding.



Decentralization that would give some decision-making powers to consumers and providers of services enhances a project's effectiveness and hence its sustainability. Measures should be taken to ensure that inequitable distribution of resources is addressed and that standards of service delivery are maintained.

Community participation should be encouraged through establishment of *community health committees* principally for two reasons: cost recovery and health education to generate demand for project services. The project design should take into consideration the direct and indirect costs of establishing and maintaining such committees.

Demand for project services. If people-level impact is the ultimate measure of success of USAID-funded projects, demand factors have to be included in the set of indicators of project sustainability. In the final analysis a service delivery project is not sustainable if it cannot generate demand for its services. Quality of care is an important factor of demand.

Public/private sector partnership in delivery of services must be encouraged. The public sector should be encouraged to progressively pull out of provision of services that could be privatized without any risk of significant negative public health consequences. *Government's role should gradually evolve from financier/provider of care to financier/regulator of care.* In a resource-poor environment, government revenues cannot be relied on to continue financing all health services.

Mode of project financing during implementation plays a crucial role in determining sustainability of project activities. The progressive absorption of recurrent costs by the national budget increases the degree of sustainability. Cost recovery through user-fees and other forms of private financing of recurrent costs is preferred to inclusion in the national budget, especially in those instances where public finances are weak and unreliable.

A sustainable health care financing scheme requires fairly accurate estimates of costs of services to be financed. *Child survival projects should encourage development of methodologies for costing of services, fee-setting, and financial management procedures.*

E. DECENTRALIZATION

- Most African countries are attempting to decentralize authority and responsibility for health care. USAID will support the policy changes needed and the managed implementation of this process.
- In supporting decentralization USAID will work with the government, NGOs, and other donors to ensure that sufficient attention is paid to standardization of services offered across regions and to equitable coverage.
- USAID will support host country and city government efforts to strengthen service delivery and outreach activities in rapidly growing peri-urban areas, where special opportunities exist to have an impact on highly vulnerable populations. City governments should play a key role in these activities.

Health care decentralization is the transfer of authority from the ministry of health to regional and district units for planning and management of public health systems. The concept of decentralized integrated health systems is not new, yet few African countries have succeeded in creating a viable dynamic national health system based on this approach. The problem appears to lie not with the concept, but with the process. While most countries support the health district concept as a model for decentralization, few have established **and** implemented policies to permit the transition from a centralized health care system to decentralized integrated health systems.

One of the important contributions that child survival has made to decentralization is to focus attention on the development of health care oriented to the needs of the population. This in turn has increased attention to the creation of geographically defined health districts as the operational unit to manage primary health care. From the perspective of ministries of health, the health district is an effective unit for decentralization, a target for top-down guidance. The district also serves as an effective administrative unit for communities to exert influence from the bottom up, thereby being heard by higher-level government providers of health.

To support the decentralization process, USAID will help strengthen national political commitment and central government administrative support for decentralization policies that provide regional and district-level health systems adequate authority to plan and manage financial, material, and manpower resources. USAID will also provide technical and financial assistance in the design and organization of effective models for decentralized health systems, both for rural and peri-urban populations, to promote equity and have an impact on highly vulnerable populations.

USAID will assist in building managerial and financial capacity within the decentralized health system (district, regional, and national) to improve and sustain the support systems for focused interventions. In supporting decentralization, USAID, governments, other donors, and NGOs must consider several key issues:

The population-based definition of a health district permits standardization of planning, supervision, and statistical reporting of all medical activities within a defined geographical area. This increases accountability and provides the denominator for monitoring, evaluation, and impact assessment of health care service activities. Decentralization requires the definition of an assistance package of standards, procedures, and resources required to develop and sustain the health system at each level. International aid agencies can provide appropriate development assistance to develop standards, and must ensure that their projects conform to national standards.

Improved coordination of government, non-government, and international organizations to avoid overlap and maximize the comparative advantage of each agency is necessary and possible—by identifying partnerships between health districts and aid agencies. So-called Balkanization, or the non-coordinated implementation of differing PHC approaches in different areas, can be avoided by focusing attention on health districts rather than on donors, and by emphasizing that aid assistance is part of the national primary health care strategy.

The efficacy of the ministry of health is increased through decentralization by relieving top management officials of routine tasks that can be performed at the regional or district level. The

decentralization process however, must define the responsibilities at each level of the system, not just at the district level.

The delimitation of health districts around existing referral hospitals (including those managed by NGOs) can improve donor coordination and promote equity. An initial inventory of delimited health districts, for example, can identify and plan for priority investments in developing the physical health infrastructure.

Decentralization can lead to more flexible, innovative, and creative management of support systems and focused interventions. Regional and district units may be able to test innovations and experiment with new policies and programs in selected areas without having to justify them for the whole country. This also permits more community involvement in planning and management of a system best adapted to local needs.

F. INVOLVEMENT OF THE PRIVATE SECTOR AND NGOS

- Child survival should be promoted through all available channels to increase access to and coverage of appropriate services. This may include NGOs, private practitioners, traditional healers, and the commercial sector.
- In many African countries the private sector already provides a substantial part of health services at relatively low cost to the government.
- Wherever possible, professional medical (particularly pediatric) and health associations should be encouraged to support and participate in child survival program development and implementation.
- USAID will encourage ministries of health to develop partnerships with NGOs and private providers by sharing approaches and materials; by including them in training courses; and, more generally, in the planning, implementation, and evaluation of services at all levels. Professional medical and health associations should be encouraged to support and participate in child survival program development and implementation.

The private sector consists of modern private, for-profit practitioners and institutions (commercial); private non-profit establishments (non-governmental organizations—NGOs); and traditional healers. This sector is much larger than most governments are willing to admit. As real per capita public expenditure on health has declined, private expenditure on health exceeds public expenditure in the majority of countries for which data are available.

An essential starting point for development of a strategy for the private sector is an assessment of its size and distribution, as well as the type of services it provides and the factors influencing its development. USAID will continue to support research and analysis activities as an essential first step in the process of formulating policies regarding the private sector.

The private sector provides tremendous opportunities for making child survival services geographically and economically more accessible. The lion's share of public funding has been going to urban hospitals

that provide secondary and tertiary care. **Privatization** of this level of care will release public resources that can be used to increase the coverage and quality of primary health care in general, and child survival activities in particular, in rural and underserved areas.

USAID has developed a successful approach of promoting partnerships with the private, commercial sector to distribute and promote family planning and oral rehydration supplies through **social marketing**. Excellent opportunities exist for building on this approach, introducing a larger set of commodities and supporting a wider range of activities.

By entering into partnerships with **NGOs**, governments can dramatically increase coverage of and access to effective health care services. USAID will work with NGOs and governments to promote such partnerships, including shared technical standards for training, supervision, and logistics systems. Where possible, NGOs should be incorporated into decentralized government primary health care programs. NGOs often are willing and able to become the referral and administrative center for management of a health district on behalf of the ministry of health.

In addition, **professional medical and health associations** offer an opportunity to reinforce child survival interventions. These associations should be encouraged to support and participate in child survival program development and implementation.

The role of government. The central objective in promoting public/private partnership is to shift public responsibility gradually from financier/provider of health care to financier/regulator of health care. In working toward this objective, USAID will consider several major issues:

- Setting standards and sharing implementation with the private sector. Government's role in developing technical standards for focused child survival interventions and supporting systems is particularly important. Government also must ensure that NGOs and private practitioners implement these standards.
- Financing arrangements that are supportive of the private sector should be developed and adopted. Implementation of user fees at public facilities, development of public and private health insurance, use of subsidies and tax relief, access to credit and foreign exchange, and allowing private practice in public facilities are among options that can be considered. Sliding-scale user fees combined with progressively higher fees for higher level services in the public sector will create demand for alternative sources of care as well as the risk necessary to generate demand for insurance coverage.
- Health insurance is a major source of finance of secondary and tertiary care in the private sector. Governments can play active roles in development of insurance coverage in a variety of ways, including legislating compulsory coverage, using taxes and subsidies, and providing reinsurance to limit risk. USAID will provide assistance to develop such schemes and to influence the systems to be developed to include coverage of child survival activities.
- Private sector regulation constitutes a major responsibility. Many ministries of health (MOH) may not have the capacity yet for all of the activities involved in effective regulation of health care in the private sector, including fixing and monitoring fees, determining services to be

provided and regulating their distribution, and controlling quality of services and ethical standards.

- Managing the public/private partnership requires strong ministries of health. USAID will seize the opportunity to provide the assistance necessary to build the required level of strength and will use its participation as leverage to influence policy in the financing, provision, and regulation of child survival activities in the public and private sectors.

G. COMMUNITY PARTICIPATION AND EMPOWERMENT

- USAID will assist government and NGO efforts to establish and strengthen consumer participation in health care management at all levels of the health system.
- Particular emphasis should be placed on preparing community groups to take an active role in management of local services and cost recovery systems.
- USAID will assist host country efforts to promote collaboration with community organizations working in health-related areas, including water and sanitation committees, food production and distribution groups, and schools.

Community participation and empowerment are essential for creating effective, equitable, and sustainable health systems. Communities should be involved in all stages of health service development and implementation, from conceptualization and planning through monitoring and evaluation. Such involvement will:

increase the likelihood that community priorities and needs will shape the design and implementation of health services, an important requirement for sustainability;

open channels of communication between the service providers and those being served, which is particularly crucial in planning and implementing health education programs; and

support a multisectoral approach at the community level, particularly linking water and sanitation and education activities that complement health services.

An important step toward community participation is acceptance by health personnel of the fact that they do not have all the answers and that only through collaboration will solutions be found. Support should be given to help reorient the work of health personnel to a community outreach mode. This may entail revision of guidelines and job descriptions, re-training, rescheduling, problem-solving on transportation issues, and exchanges of experience.

As an example, the Bamako Initiative, launched in 1988, is attempting to involve communities on a much wider scale than in the past in building and strengthening health systems. Under the initiative users of a health center or pharmacy pay for services and drugs. These revenues are retained by the health centers and managed by local elected committees, which reinvest them in additional drugs, incentive payments for health workers, and other improvements.

Many lessons have been learned over the course of the last 15 years from the Bamako Initiative and other interventions about how to form and train committees for community health management. What is less well-known is how to establish a community committee that will continue to function over the long-term. Some kind of periodic supervision/support is necessary for sustainability. However, putting this responsibility solely on the shoulders of an already overburdened health staff is not practical. Periphery-level personnel and PVO staff from all sectors must join together in a coordinated manner with community organizations. Collaboration among sectors, donors, and NGOs at higher levels will be needed to facilitate this in the field.

USAID's role in this area will be to:

- (1) Support research and information-exchange about alternative and, particularly, successful models for sustainable community participatory organization.
- (2) Provide technical assistance and funds to plan community participation components for all health projects.
- (3) Furnish technical assistance and funds for training community organizers, as well as for workshops that will give community leaders skills in problem solving and generation and use of donor funds.
- (4) Provide initial funding for community financing schemes, which is replenished as the project proceeds.

USAID can work with governments to ensure that each project plan includes realistic and achievable community participation component. Project plans sometimes have contained community participation or equity provisions, such as those relating to women, that have been ignored during implementation or honored only in cursory ways. USAID can assist governments to monitor and evaluate the implementation of these provisions.

H. COMMUNITY AND HOUSEHOLD BEHAVIOR CHANGE

- USAID will promote the use of appropriate research methodologies in developing initiatives for behavior change that take into account community, family, and individual characteristics.
- USAID will promote approaches to program planning and implementation that take into account the clients' needs, health-seeking choices, and perception of child survival services.
- USAID programs will support health education at national and local levels to take full advantage of different and complementary health education methods and channels.
- An appropriate balance should be sought among face-to-face education, the use of the mass media, community outreach activities, and communication channels traditionally used in each community (including church, theater, and songs).

Few improvements in health status will endure in the absence of changes in community and individual attitudes and behavior. Health education and community empowerment provide people with the knowledge and skills to act in a healthier way as well as creating expectations and demands for services—all prerequisites for sustainability of any improvement of health status or service delivery.

Approaches to program planning and implementation will take into account the clients' needs, health-seeking choices, and perception of child survival services. Similarly, appropriate research methodologies will be used to develop initiatives for behavior change that take into account individual, family, and community beliefs, needs, and priorities, as well as economic and social realities.

Initiatives for behavior change should take advantage of different and complementary health education methods and channels. An appropriate balance will be sought among face-to-face education, the mass media, community outreach activities, and traditional communication channels in each community such as churches, theater, and traditional leaders.

As health service decentralization proceeds, health educators at national, regional, and local levels should prepare and implement comprehensive technical, management, and training programs to ensure the long-term viability of health education strategies. These programs will most likely be components of larger plans encompassing a variety of health services. USAID can employ its comparative advantage in technical assistance and training to support countries in developing the training and supervisory capacity of health educators at all levels.

To ensure that all personnel understand the importance of health education, USAID will assist governments to integrate appropriate information and training on health education—particularly counseling and community outreach skills—into all pre-service training curricula for doctors, nurses, and allied health professionals.

Emphasis should be placed on competency-based training of these skills during in-service training courses, whether these are specific health education workshops or workshops focusing on public health interventions. Appropriate health education duties should be incorporated into the job descriptions of all health personnel, continuing education, and supervision activities should be used more effectively to improve the quality of counseling and outreach activities.

Efforts to monitor the effects of health education activities should be supported and results disseminated widely and discussed. This feedback can be used to problem-solve and as a motivating factor for field workers. Other creative mechanisms, such as prizes, awards, and training opportunities, should serve as incentives for excellent high performance in health education.

The private sector should be an important component of any national health education strategy. Using social marketing techniques that USAID has supported with great success throughout the world, the private sector becomes a provider of goods and services and a health educator.

I. HUMAN RESOURCE DEVELOPMENT

- USAID will participate with the host country and other donors in country assessments of the training needs for child survival for managerial and technical skills.

- USAID will consider its comparative advantage and the cost-effectiveness of different training options to develop an appropriate mix of:
 - long- and short-term training,
 - pre-service and in-service training,
 - in-country, regional, and training abroad, and
 - training different categories of personnel.
- In general, USAID will support improvement of quality and effectiveness of African national and regional training institutions.
- USAID will assist host countries to explore performance-based incentive systems, which could include official recognition, awards, training opportunities, and cost sharing in cost recovery systems, among others.
- USAID will support efforts to define the roles and responsibilities of different categories of health personnel and to maximize the use of lower-level personnel in a rational manner, leading to increased access to effective service delivery.

Correct application of available child survival technologies depends on competent and well-informed health care personnel. A mix of health personnel with managerial and technical skills should be placed appropriately and equitably at all levels of the health system to better sustain child survival interventions. USAID will participate with the host country and other donors in a country assessment of the medical and public health training needs for child survival and will support formulation of a comprehensive human resources development plan.

Child survival training must address pre-service and in-service needs. USAID will support needs assessment for pre-service training in child survival, with emphasis on curriculum development, training of trainers, and—most importantly—on-the-job competency-based training and continuing education.

Trained senior- and mid-level personnel for health and child survival leadership, management, and research are still needed. USAID has made a significant contribution to preparing African leadership in public health, perhaps the single most important factor in the improved approach toward public health that can be seen in most African countries. USAID will continue to promote linkages with U.S.-based schools of public health to provide graduate training in various technical and managerial aspects of public health.

Selected graduate programs have been established in some African countries (for example, Senegal, Zaire, Zimbabwe) with emphasis on field-oriented training, based on partnerships between universities and government departments responsible for public health programs. Building on these and other initiatives, USAID will collaborate with governments and donors at national and inter-country levels to prepare and finance plans to strengthen health leadership, management, and research capacity for child survival in Africa. USAID will help improve the quality and effectiveness of African national and regional training institutions.

Child survival has taken off in selected African countries, but only after national program manager positions were filled with individuals who have had graduate training in, for example, public health. The success of child survival depends also on the actual services provided to the clients at the delivery

sites by community health workers, nurses, midwives, and other health personnel. USAID will support efforts to define the roles and responsibilities of different categories of health personnel and to maximize the use of lower-level personnel in a rational manner, leading to increased access to effective service delivery.

USAID will assist host countries in addressing health sector personnel management problems that contribute to low performance of child survival programs in Africa. Low wages and salaries, poor managerial controls, weak supervision, and poor working conditions are among them. Host governments and agencies involved in child survival should explore performance-based incentive systems, which could include official recognition, awards, training opportunities, and cost sharing in cost recovery systems, to boost morale and motivation of qualified and dedicated health personnel.

J. QUALITY ASSURANCE

- USAID will support ministries of health in developing and monitoring technical standards for child survival focused interventions, with emphasis on case management, counseling, supervision, and referrals.
- USAID will support ministries of health in ensuring that different providers of health care—in the context of a client-centered approach—to carry out the problem-solving activities necessary to apply the standards developed with a view to increasing patient satisfaction and service use rates.
- USAID will assist the government in reinforcing a minimum package of components necessary to maintain and improve quality service delivery. These components will include:
 - a functioning supervision system,
 - an adequate supply of drugs and equipment,
 - competency-based pre-service and in-service training, and
 - a management information system that permits active monitoring of service delivery quality.

Studies have suggested that the low use rate of child survival services offered by the public sector in Africa is directly related to the inadequate quality of those services. Deficiencies in patient counseling and health education, diagnosis, treatment, essential supplies, logistics, health personnel competence and morale, and supervision all contribute to inadequate quality of care.

To ensure the impact of child survival interventions, improving quality of services is as essential as increasing coverage. For example, if a measles immunization campaign meets target coverage rates, but close examination shows that a great proportion of the administered vaccines were ineffective because of poor maintenance of the cold chain, the impact of the intervention is compromised and resources are wasted due to poor quality.

Quality assurance (QA) has tended to focus on systematic monitoring and evaluation of the quality of clinical practices. Important efforts have been initiated in many countries in Africa to improve quality by establishing standards and assessing practices against the standards. Results of such assessments have been discussed widely and fed into training, monitoring, and supervision.

Useful systematic assessments have been undertaken, particularly of the case management of diarrheal diseases, acute respiratory infections, family planning, supervision activities, and the work of primary health care workers. These have produced information that is invaluable for supervisors and trainers, for raising awareness of service providers, and for informing decision-makers of the practical implications of current policies.

Setting standards, and monitoring performance by these standards, is an essential component of successful quality assurance. The QA approach is being broadened, with strong support from USAID, to include the tools and methods of continuous quality improvement (CQI) and to take into account the underlying systems that affect case management in health facilities. CQI assumes that service delivery problems are the result of inefficient, poorly designed, or malfunctioning processes, rather than ineffective staff. Improving the appropriate part of a process or system where a problem has been identified usually will correct the problem.

The challenge now for USAID is to build in a CQI approach to all child survival interventions aimed at increasing patient satisfaction and service use rates, as well as providing more cost-effective quality care. This will require:

Building local capacity for assessment and for problem-solving systems—including commitment from leadership and practical approaches such as CQI working groups.

Conducting assessments of service delivery systems to define current quality levels and identify weak areas.

Strengthening supervisory systems so that they become important components of the QA process, where supervisors actively engage in performance monitoring and problem solving.

Upgrading management information systems, which include data that facilitate continuous assessment and improvement of quality of care.

Modifying training programs to incorporate competency-based training for essential routine tasks.

Addressing low morale among health workers.

Building applied research capabilities used to develop, test, and refine quality assurance approaches.

Disseminating successful quality improvement strategies within and among countries.

K. APPLIED RESEARCH

- Applied research should be used to address well-defined issues arising from program implementation.

- Decision-makers and program implementors should be involved in defining the issues to be researched and in carrying out the research, to promote a sense of ownership among those groups.
- Discussion and dissemination of results should be incorporated into research planning to maximize the use of the findings by decision-makers.
- USAID will assist in strengthening African national and regional capacities to carry out research (researchers) and use the results (decision-makers).

Which child survival interventions should work and what does or does not work? What proven child survival technology will be or will not be culturally appropriate and acceptable in a given setting? To answer these two questions, decision-makers and program managers will need reliable data and information. Applied research should be promoted and strengthened as an integral component of the health systems.

USAID will participate with host country officials and other donors to ensure use of research in child survival strategy development, program management, and service design. Resources must be allocated to develop new or improved strategies and interventions and more effective evaluation measures for delivery of interventions whose efficacy is already established.

Decision-makers and program implementors should be involved in defining the issues to be researched and, insofar as possible, in carrying out the research, to promote a sense of ownership among those groups. USAID will assist host countries to support mechanisms by which decision-makers, program managers, and researchers interested in child survival get together to define technical and managerial problems to be researched, plan and implement research, and discuss use of the research findings. Such mechanisms should be promoted at all levels of the health systems.

USAID-supported African child survival programs have often had a research component. Each program has had its own approach in promoting applied research. USAID will build on lessons learned from those programs and will assist in strengthening African national and regional capacities for carrying out research and, more important, for making use of results. Discussion and dissemination of results should be incorporated into research planning to maximize use of the findings by decision-makers. USAID will support mechanisms to improve exchange of research and evaluation results within and across countries.

L. MEASUREMENT OF PERFORMANCE AND IMPACT

- USAID will assist in developing and monitoring long-term and intermediate indicators of:
 - morbidity and mortality,
 - increased coverage and use of services,
 - increased quality of services (minimum package of quality care, including indicators for different support system components—for example, a functioning supply or supervision system), and

— increases in knowledge and desired behaviors in the population.

Experience from the ACSI-CCCD Project shows that health information systems within countries often do not receive adequate financial and institutional support. USAID will support host country policies that recognize the value of good information in planning, implementing, and evaluating sound health programs and that provide adequate support for information systems.

USAID will include within its health information systems (HIS) activities well-defined training programs to increase national and peripheral capacity to develop and manage national HIS and to analyze and use health information to respond to the public health needs of the nation. Epidemiology and management training programs will be provided as needed to assist countries in these efforts.

Although the **World Summit for Children** goals represent the basis for most child survival program implementation, information needs for monitoring progress toward these goals are different at different levels within the health system. USAID will participate in a working group that will be convened to develop a minimum set of indicators that can be used at national and local levels to monitor progress toward World Summit objectives.

Morbidity and mortality. In the United States routine vital events registration is used as the basis for measuring mortality. Such routine systems do not exist in most developing countries and USAID will assist countries receiving assistance to develop functioning vital events registration systems.

USAID will also support identification of simple methods for measuring mortality and guidelines and training for collecting and using mortality data and other health information at the local level.

USAID will also continue to support demographic health surveys (DHS) as an interim mechanism for monitoring progress toward the **World Summit for Children** mortality reduction goals. These surveys are conducted in collaboration with host country MOH staff and, consequently, transfer skills in survey design and implementation. However, they are expensive and ultimately cannot be sustained alone by most USAID-assisted countries.

Coverage, quality, and use of services. Indicators of coverage, quality, and use of selected child survival services have been developed and often can be calculated from routine service delivery reports. USAID will promote training, primarily for peripheral-level health workers, in using these indicators to monitor program implementation. USAID will promote development of the training systems component of routine health information systems in an effort to provide managers with coverage data. Data on the use of case management strategies are collected through community survey methodologies, and USAID will support development of training materials and policies that will enhance MOH skill in conducting community surveys.

Direct facility-based observation of health worker performance, either during supervisory visits or during health facility training needs assessment surveys, remains the most effective method for measuring the quality of health services being provided and for measuring change in the level of quality of these services. USAID will support development of MOH policies that promote the supervisory and continuing education systems necessary to evaluate and maintain quality health service delivery continually.

Numerous support strategies are also required to implement high-quality health services. Consequently, in addition to monitoring the quality of services, it is necessary to monitor routinely the implementation of support services known to affect directly the quality of services that a health system can provide. Support systems include continuing education and logistics. USAID will support identification of appropriate indicators for monitoring the implementation and impact of training activities. Indicators for monitoring the performance of the logistics and supply systems have been identified and USAID will focus efforts here on building MOH capacity to collect, analyze, and use appropriate data on the performance of logistics systems.

Increase in knowledge and desired behaviors in the population. Data on community knowledge and practices are essential for planning and implementing appropriate child survival interventions and for evaluating the changes in behavior that are expected to result from these programs. Data on community beliefs and practices are collected most often through community survey methodologies or focus group discussions and key informant interviews.

M. CHILD ADVOCACY

- USAID will encourage African national and multilateral organizations, professional associations, and NGOs working at all levels to act as advocates for children's health and well-being—representing children's health interests in policy debates and decisions concerning allocation of resources.

The sustainability of child survival activities in Africa may depend on the strength of local constituencies for children and their health. Such constituencies should be active in raising the national consciousness for children's health needs, lobbying governmental efforts for policy change and resource allocation in support of children's welfare and health. Those groups also can be instrumental in monitoring and ensuring improved quality of child survival activities.

In collaboration with other donor agencies, USAID will assist host countries to assess the size, type of activities, and distribution of such local advocacy groups. USAID will support the identification and the strengthening of these child survival advocacy groups.

In many developed countries organizations representing professionals whose work is directly related to health and welfare constitute major constituencies for children. These include professional organizations of pediatricians, obstetricians, teachers, nurses, social workers, and public health professionals. Women's and parents' groups are also instrumental in promoting child survival.

USAID will promote and support linkages of U.S.-based professional and advocacy groups to provide technical and managerial assistance to their counterpart in Africa for increased child health and welfare advocacy. These linkages should ensure an effective transfer of skills for long-term development and growth of such professional and advocacy groups, especially those representing the consumer of child survival services.

N. COORDINATION WITH OTHER DONORS

- USAID will support governments playing the lead role in coordinating donor assistance and developing policies and strategies for child survival services (focused interventions and strengthening of support systems).
- USAID will work with host country governments and other donors to coordinate inputs to avoid overlap and maximize the comparative advantage of each agency.

Coordination of donors is essential to avoid duplication of efforts and maximize effect. Governments must take the lead role in organizing coordination among donors—governments should state their priorities for donor assistance clearly and ensure that donor input fits into a cohesive strategy. USAID and its partner donors can encourage governments to take on this lead role by coordinating approaches and by proposing programs and input that are consistent and mutually reinforcing. Donors must have a long-term perspective for the development of health programs, and avoid proposing to governments short-term solutions that are not consistent with long-term strategies.

USAID is and must continue to be a leader in promoting donor coordination in Africa. USAID's strong programs and field credentials make the Agency a credible advocate for child survival among its colleagues in the donor community. USAID's technical expertise and experience are invaluable to government officials seeking to combine donor resources in the most effective way.

One of USAID's comparative advantages is its field staff—the long-term presence of health experts in Africa available for country-wide and regional deployment. USAID has long been a leader in African child-survival programs, taking particular interest in EPI, CDD, and ways to integrate services. With this experience, USAID can provide leadership among donors, promoting complementary policies and programs that enhance the contributions of all parties in the child-survival community.

Regular donor meetings are a straightforward mechanism that USAID can facilitate by the simple provision of some logistic and material support; however, such meetings will be chaired by government. Regular, scheduled meetings that are predicated on the complementary roles of all parties can go a long way toward making donor coordination a reality. In helping to arrange such meetings, USAID also will be acknowledging its own need to consult with its partner donors and its commitment to integrated donor inputs.

APPENDIX II. STATISTICS FOR SUB-SAHARAN AFRICAN COUNTRIES

Population 1992 (millions) ¹	Mortality 0-1 year 1992 (per 1000) ^{1,5}	Mortality 0-5 years 1991 (per 1000) ^{1,5}	Ratio of infant/ child mortality rates	GNP per capita 1990 (\$)
Angola ¹ 9.90	170	292	1.72	610
Benin 4.90	88	147	1.67	380
Botswana 1.30	45	58	1.29	2,530
Burkina Faso 9.50	101	150	1.49	290
Burundi 5.80	108	179	1.66	210
C.A.R. 3.20	105	179	1.71	390
Cameroon 12.20	65 ⁵	117	1.80	850
Cape Verde ¹ 0.38	44	60	1.36	750
Chad 5.80	123	209	1.70	210
Comoros ¹ 0.59	90	130	1.45	500
Congo 2.40	82	110	1.34	1,020
Côte d'Ivoire 12.90	91	124	1.36	690
Djibouti ¹ 0.47	113	158	1.40	1,210
Equatorial Guinea ¹ 0.37	118	182	1.54	330
Ethiopia 53.00	123	208	1.69	120
Gabon 1.20	95	158	1.66	3,780

Gambia, The	133	220	1.65	360
¹ 0.91				
Ghana	103	170	1.65	400
16.00				
Guinea-Conakry	135	230	1.70	460
6.10				
Guinea-Bissau	141	239	1.70	180
1.00				
Kenya	51	74	1.45	340
25.20				
Lesotho	108	156	1.44	580
1.80				
Liberia	146	217	1.49	450
¹ 2.80				
Madagascar	93 ⁵	163 ⁵	1.75	210
12.80				
Malawi	143	226	1.58	200
10.40				
Mali	122	220	1.80	270
9.80				
Mauritania	118	206	1.75	500
2.10				
Mozambique	167	287	1.72	80
14.90				
Namibia	62	79	1.27	1,460
¹ 1.50				
Niger	123 ⁵	318 ⁵	2.59	310
8.30				
Nigeria	87 ⁵	192 ⁵	2.21	290
96.00 ⁷				
Rwanda	131	222	1.69	270
7.50				
Sao Tome	65	85	1.31	400
¹ 0.12				
Senegal	90	145	1.61	710
7.70				
Sierra Leone	144	249	1.73	210
4.40				
Somalia	125	211	1.69	150
9.20				

South Africa	53	70	1.32	2,560
¹ 39.80				
Sudan	100	166	1.66	420
¹ 26.70				
Swaziland	74	107	1.45	1,050
¹ 0.79				
Tanzania	111	176	1.59	120
27.80				
Togo	86	137	1.59	410
3.80				
Uganda	111	185	1.67	250
18.70				
Zaire	121	188	1.55	220
39.90				
Zambia	108 ⁵	192 ⁵	1.78	420
8.60				
Zimbabwe	60	86	1.43	640
10.60				

Vaccination coverage:

	ORT use rate 1987-91 ¹	Measles rate (1 yr. old) 1990-91 ^{1,4}	DPT immun. rate (1 yr. old) 1990-91 ^{1,4}
Angola	40	27	48
Benin	60	68	45
Botswana	78	86	64
Burkina Faso	36	38	
Burundi	75	83	49
C.A.R.	25	25	24
Cameroon	35	34	84
Cape Verde	78 ²	88 ²	5 ²
Chad	21	12	15
Comoros	71 ²	71 ²	79 ²
Congo	64	74	26
Côte d'Ivoire	47	37	16
Djibouti	68 ²	77 ²	51 ²
Equatorial Guinea	11 ²	3 ²	21 ²
Ethiopia	17	21	38
Gabon	76	78	10
Gambia, The	33	77 ²	39 ²
Ghana	39	39	21
Guinea-Conakry	35	65	
Guinea-Bissau	52	63	5
Kenya	59	74	69
Lesotho	69 ²	69 ²	68
Liberia	55	28	9
Madagascar	40	50	11
Malawi	78	81	14
Mali	39	34	41 ²
Mauritania	29	26	54 ²
Mozambique	50	42	30
Namibia	71	87	
Niger	23	17	54
Nigeria	46	44	35
Rwanda	81	85	24
Sao Tome	57 ²	77 ²	46 ²
Senegal	46	51	27
Sierra Leone	54	56	60
Somalia	30	18	78
South Africa	63	67	

Sudan	59	63	37
Swaziland	66 ²	73 ²	85 ²
Tanzania	75	79	83
Togo	51	61	33
Uganda	73	76	30
Zaire	31	32	45
Zambia	76	79	89
Zimbabwe	83	83	77

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	% children 0-4 years underweight 1980-91 ¹	Population growth rate 1980-91 ^{1,2}	Total fertility rate 1991 ^{1,2}	Contraceptive prevalence (modern) rate ^{2,3,5}
Angola		2.9	7.20	
Benin		2.9	7.10	1.0 ³
Botswana	15	3.2	5.20	33.0 ²
Burkina Faso		2.6	6.50	8.2 ⁵
Burundi	38	2.9	6.80	1.0 ³
C.A.R.		2.6	6.20	2.5 ⁶
Cameroon	17	2.9	5.80	4.3 ⁵
Cape Verde		2.7 ²	5.42 ²	
Chad		2.2	5.90	
Comoros		3.7 ²	6.82 ²	
Congo	24	2.9	6.30	
Côte d'Ivoire	12	3.8	7.40	1.0 ³
Djibouti		3.8 ²	6.60 ²	
Equatorial Guinea		2.2 ²	5.50 ²	
Ethiopia	38	2.6	7.00	
Gabon		3.6	5.20	
Gambia, The		2.8 ²	6.50 ²	
Ghana	27	3.3	6.10	15.0 ⁶
Guinea-Conakry		2.6	7.00	
Guinea-Bissau	23	2.0	5.80	
Kenya	14	3.5	6.40	27.0 ²
Lesotho	16	2.7	4.80	4.0 ³
Liberia		3.2	6.80	6.0 ²
Madagascar	33	3.2	6.60	
Malawi	24	4.3	7.60	3.3 ⁶
Mali	31	3.0	7.10	2.9 ⁶
Mauritania	48	2.7	6.50	
Mozambique		1.7	6.50	
Namibia	29	3.0	6.00	
Niger	49	3.3	7.10	2.3 ⁵
Nigeria	36	3.3	6.60	4.0 ³
Rwanda	33	3.1	8.50	8.0 ³
Sao Tome		2.5 ²	5.12 ²	
Senegal	22	2.8	6.20	2.4 ⁵
Sierra Leone	23	2.4	6.50	
Somalia		2.6	7.00	
South Africa		2.5	4.20	45.0 ³

Sudan	20	3.0	6.20	6.0 ³
Swaziland		3.7 ²	6.72 ²	14.0 ⁶
Tanzania	48	3.4	6.80	10.4 ⁶
Togo	24	3.0	6.60	3.0 ³
Uganda	23	2.9	7.30	5.0 ²
Zaire		3.3	6.70	
Zambia	25	3.5	6.50	8.7 ⁵
Zimbabwe	12	3.3	5.50	40.0 ³

Adult literacy rate 1990 ¹	Estimated HIV-1 Seroprevalence (urban) 1991 ⁶	% Pop. w/ access to health serv. 1985-88 ^{1,2}	Population per: ²	
			Physician	Nurse
Angola 42.0	1.3%	30	17,753	1,013
Benin 23.0	0.5%	18		
Botswana 74.0	3.6%	89		
Burkina Faso 18.0	8.8%	49	57,327	1,682
Burundi 50.0	17.5%	61	21,000	4,375
C.A.R. 38.0	9.3%	45		
Cameroon 54.0	21.0%	41		
Cape Verde 37.0	0.0%		38,358	3,395
Chad 30.0	1.1%	30		
Comoros 48.0			12,290	2,268
Congo 57.0	9.0%	83		
Côte d'Ivoire 54.0		30		
Djibouti 12.0		68 ²	4,183	506
Equatorial Guinea 50.0				
Ethiopia n/a	2.1%	46	78,777	5,391
Gabon 61.0	2.5%	90		
Gambia, The 27.0	0.1%	90 ²	11,688	

Ghana	2.2%	60	20,463	1,669
60.0				
Guinea-Bissau		64 ²	7,262	1,129
36.0				
Guinea-Conakry	0.6%	47		
24.0				
Kenya	15.0%		10,132	
69.0				
Lesotho	0.1%	80	18,614	
73.6 ²				
Liberia	0.0%	39		
40.0				
Madagascar	0.0%	56	9,780	
80.0				
Malawi	22.8%	80	11,338	
41.2 ²				
Mali	0.4%	15	23,508	
32.0				
Mauritania	0.0%	40	11,901	1,182
34.0				
Mozambique	1.1%	39		
33.0				
Namibia				
n/a				
Niger		41	53,608	3,675
28.0				
Nigeria	2.8%	66	6,424	900
51.0				
Rwanda	30.3%	27	74,946	4,301
50.0				
Sao Tome				
57.0				
Senegal	0.2%	40		2,031
38.0				
Sierra Leone	3.5%	36.2 ²	13,618	1,089
21.0				
Somalia	0.0%	27	19,948	1,898
24.0				
South Africa	1.0%			
n/a				

Sudan	0.1%	51	10,192	1,259
27.0				
Swaziland	2.3%			
55.0				
Tanzania	11.5%	76	24,988	5,488
91.0				
Togo		61	8,703	1,236
43.0				
Uganda	29.5%	61		
48.0				
Zaire	6.0%	26	13,537	1,880
72.0				
Zambia	24.5%	75	7,154	
73.0				
Zimbabwe	18.0%	71	7,181	997
67.0				

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SOURCES FOR STATISTICS:

- 1 The State of the World's Children, UNICEF, 1993 and 1994.
- 2 Social Indicators of Development, 1991-92, The World Bank - Johns Hopkins University.
- 3 Child Survival - A Seventh Report to Congress on the USAID Program (FY 1991).
- 4 Comparative Studies 1 - Immunization, Demographic and Health Surveys, 1990.
- 5 Demographic and Health Surveys sponsored by USAID, 1990-1992.
- 6 Data generated by USAID projects and provided by the Center for International Health Information (CIHI).
- 7 World Bank, World Development Report, 1993.

APPENDIX III. USAID'S COMPARATIVE ADVANTAGES IN AFRICA

USAID has comparative advantages in the following areas in Africa:

- **Supporting institutions.** USAID's support for a large number of regional and national organizations has encouraged the long-term development and capacity building of these organizations. USAID has also supported the planning and management capacities of ministries of health through technical assistance and training.
- USAID promotes national-scale applications of **appropriate child survival technologies**, in conjunction with institutional strengthening. Working in concert with WHO, UNICEF, and other donors, USAID projects have successfully assisted national programs for immunizations, CDD, and exclusive breast-feeding. Newer technologies (ARI, vitamin A, feeding messages) are being added, as ministries move to more comprehensive programs, integrating "vertical" health services for more effective treatment of the child.
- **Technical assistance.** For long- and short-term technical assistance, USAID can call on a wide range of experts from cooperating agencies and universities. USAID has been the leading donor in providing technical assistance in several key areas related to child survival—including support for service delivery systems, logistics, operations research, management information systems, and the application of innovative approaches such as working with the private sector.
- **Strong field staff.** USAID has a cadre of technically skilled and experienced professionals able to work with host country governments, local organizations, and other donors to tailor USAID's assistance to meet the country's specific needs. USAID's field staff are funded through operations expenditures (OE) and program funding, and include direct hire staff, fellows, TAACS (Technical Advisors for AIDS and Child Survival), and resident advisors fielded by cooperating agencies.
- **Network of cooperating agencies.** A wide variety of projects and organizations funded by USAID offer specific technical expertise and experience. This network provides USAID with flexibility in program implementation and in assisting governments.
- **Innovation.** USAID and its cooperating agencies are particularly adept at attempting new approaches and incorporating lessons learned into ongoing efforts. USAID successfully uses operations research to identify problems and test solutions. Public education and marketing through the mass media, introduced through USAID programs, have increased demand for child survival services.
- **Leading efforts to engage the private sector and NGOs.** USAID has taken the lead among donors in promoting partnerships with the private sector. Social marketing, promotion of health and family planning services through employers' infrastructure, and local production of pharmaceutical products are among USAID's initiatives with the private sector.
- **Training.** USAID's support of training has been effective for short-term, in-service training and for long-term public health training in the United States.