MID-TERM EVALUATION

COMBATTING CHILDHOOD COMMUNICABLE DISEASES

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Executive Summary:

The AID Combatting Childhood Communicable Diseases project, authorized in September, 1981, is soundly conceived and designed and well received by knowledgeable Africans. Other donor participation has not evolved as rapidly as had been hoped but interest is growing. AID has a unique opportunity to finance, and more important, to facilitate an important international program in health in Africa. A sustained program in Africa over the next 10-15 years can make a major contribution to the reduction of African childhood morbidity and mortality and support the establishment of well organized, trained National Primary Health Care services.

Summary of Recommendations:

AID in the administration of the CCCD project and CDA/CCCD program should:

1. Give high priority to the development of senior African management and technical personnel.

2. Assess the scope and character of other donor participation, public and private, in CCCD type activities; promote African awareness of the CCCD program and encourage external assistance including assistance from Private Voluntary Agencies.

3. Establish cooperative relations with WHO/AFRO; separate the intercountry (regional) projects into distinct intercountry activities. Give priority to Intercountry Training and Health Information Systems with WHO/AFRO. Review Operations Research and Health Education activities, as outlined in the report, with the goal of encouraging direct support to national programs.

4. Support and increase the effectiveness of the CDA Health Technical Committee and other ad hoc coordinating arrangements such as at sub-regional levels; establish national CCCD coordinating committees.

5. In future country assessments emphasize senior management personal needs; develop standardized methodology for recurrent cost analysis and analyze each bilateral program; promote the use of beneficiary fees, along with government budget funds for operating costs and external assistance to fund vaccines and basic medical supplies.

6. Develop epidemiologic techniques to measure the efficacy of the CCCD program.

7. Encourage the support of CCCD in multidonor councils by AID top management.

8. Appoint a senior seasoned African Bureau program manager with experience in international program planning and negotiation.

9. Review the country selection process to emphasize how the AID/CDC role can be applied to the greatest advantage.

10. Develop plans for further participation of other major African countries in CCCD not necessarily through regular AID funded bilateral projects; work through the Club/CILSS system for introducing CCCD in the Sahel.

11. Review the AID/CCCD project's budget strategy recognizing the long-term nature of national CCCD program development

12. Address several administrative and financial management questions spelled out in the report.

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COMBATTING CHILDHOOD COMMUNICABLE DISEASES IN AFRICA

MID-TERM EVALUATION REPORT

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I. INTRODUCTION

The AID Combatting Childhood Communicable Diseases project was authorized by the Administrator on September 25, 1981. The project provides $47,000,000 over an eight year period as AID's part in an international program to reduce the morbidity and mortality from childhood communicable diseases in Africa.

"The objective of the project is to increase the ability of African governments to:

- control measles, polio, tuberculosis, diphtheria, pertussis and tetanus under the WHO sponsored Expanded Programme on Immunization.

- provide simple and effective treatment for Diarrheal Disease
- control diseases of local importance, such as Yaws and Yellow Fever.

The treatment of malaria in children under five and pregnant women was added to the project objectives. It is now a major disease category covered by the project.

The CCCD is also a multidonor program sponsored by the Cooperation for Development in Africa (CDA). This seven nation bilateral assistance coordinating group has established a CDA Health Technical Committee to facilitate the exchange of technology and program experience and to promote an increased allocation of resources to Africa's childhood diseases control objectives. In addition to the seven major donors in CDA there are numerous other international contributors both public and private which are working on African childhood diseases and related health programs. The AID project builds on the on-going and new CCCD type activities of the African Governments and facilitates the coordination of the many donors.

The CDA/CCCD program does not have an independent policy and strategy. It is designed as an integral and contributing part of WHO's worldwide programs and policies on childhood diseases.

The AID/CCCD project authorization states that AID would be supporting 15-20 country programs during the eight year period. About $28.8 million has been earmarked for this purpose (including inflation). The country programs include technical assistance in planning and operations, training of field staffs, disease surveillance and evaluation and commodity support.

The project also provides funds for four intercountry (regional) activities as support to the individual African country programs. The four include:

- intercountry training at the senior and middle management level.
- health information services
- health education
- operations research

The project provides $18.2 million (including inflation) for these intercountry activities.

II. THE EVALUATION: PURPOSE AND PROCEDURE

At the time of authorization of the AID/CCCD project, a requirement was added for a mid-term evaluation prior to the commitment of FY 1984 funds. The authorization stated:

"Within two years from the date of authorization of this project, the Africa Bureau shall evaluate the progress of the project and the Assistant Administrator for the Africa Bureau shall determine in writing whether AID will continue to support the project and whether the project authorization should be amended prior to the obligation of funds in FY 1983." (amended to FY 1984)

The Evaluation Team was organized in July, 1983 with W. Haven North, Special Assistant to the Administrator, AID and Dr. F. Marc LaForce, Chief, Medical Service, VA Medical Center, Denver, and Professor of Medicine, University of Colorado School of Medicine. Noel Marsh, former AID/CCCD project manager, joined the team to provide background information and guidance to the Evaluation Team. Richard Solloway from AID's Controller's office reviewed the Washington/CDC financial management arrangements but did not participate in the African trip.

The Evaluation Team's review included extensive conversations with AID health and management staff, the Centers for Disease Control: International Health Program Office in Atlanta; WHO/Geneva; USAID, CDA and the Ministry of Health personnel in Malawi; USAID, CDC, and Ministry of Health and Peace Corp personnel in Zaire; USAID and Embassy staff in Congo, and the Director and staff of WHO/AFRO. There were also meetings with U.K. representatives in Malawi and Belgian health officials in Zaire.

The Team attended the CDA Health Technical Committee conference in Zaire on September 23-24. The conference provided an opportunity to meet with representatives of the seven major CDA/CCCD donors, UNICEF, WHO/AFRO and WHO/Geneva and four African experts in public health. This meeting also permitted the Evaluation Team to observe the coordination activities of CDA/CCCD.

The Team reviewed a substantial volume of project documents and studies and examined the program in detail in Atlanta with all the principal CDC staff responsible for the CCCD program. The AID Controller representative met with the CDC staff, Atlanta, examined the financial management plans for the project, and discussed the outcome of CDC implementation efforts with two AID field controllers.

On the field trip the Team observed the country assessment process and attended the Malawi Ministry of Health/CDC final review of the CCCD assessment. In Zaire, the Team had ample opportunity to review the on-going Zaire AID/CCCD project. Meetings with CDC field staff and WHO/AFRO provided a comprehensive view of all aspects of the program.

III. MAJOR CONCLUSIONS

The Evaluation Team concludes from its review of the CCCD project that:

1. The project is soundly conceived, is well received by African governments and can make a major contribution to the reduction of child mortality in Africa.

2. At this time it is not possible to judge the appropriateness of the objectives and targets presented in the program agreements. This judgement will have to await the assessment of actual experience; in some instances, the targets may be exceeded; in others the targets may be optimistic. The quantitative targets should not become too rigid and drive the program to the extent of undermining the building of African institutional capabilities for self-sustaining programs.

3. The technologies of the three interventions (EPI, Oral Rehydration and treatment of fevers with chloroquine are well accepted and practicable though subject to continuing evaluation.

4. The integration of the three interventions in a Primary Health Care system is sound and effective and essential to the sustained development of both CCCD activities and PHC.

5. The intensive development of African senior program management and supervisory staff and the training of African program personnel are critical to the accomplishment of the CCCD objectives; this training should receive high priority. The training and placement of senior supervisory personnel at national and local levels is particularly important in the first stages of any programs.

6. In Africa there exists a broad base of bilateral, multilateral and private donor participation in PHC/CCCD type activities. The scope and character of this assistance needs to be assessed in detail. A strategy for facilitating and promoting a greater focus of assistance should be developed within CDA. The overall objectives of CCCD cannot be achieved without substantially greater donor participation.

7. WHO/AFRO is important to the program. The basis for a cooperative AID/WHO relation exists with recognition of WHO/AFRO's broad policy-making responsibilities as the representative of African Ministries of Health. In addition WHO/AFRO plays a major role in intercountry training and as a focal point for an African health information system.

8. The intercountry (regional) components of the CCCD program are important complements to the national programs. They should not become overly structured and interlocked organizationally as a group as each component has distinct implementation characteristics. The focus of the CCCD program is in the individual national programs supported by certain intercountry services. Specifically:

a. Intercountry training of management personnel and the health information system should be the responsibility of WHO/AFRO with AID/CDC technical and financial support.

b. Health education for the purposes of CCCD, should be integrated with the national programs, and not stand as a separate intercountry component. Limited intercountry activities in health education training can be subsumed in Intercountry Training activities.

c. Operations Research as now planned with small grants should be a distinctive AID/CDC activity as an adjunct to the work of the field epidemiologists owing to its small scale and pilot-type activity. A Memorandum of Understanding on Operations Research implementation will be required. Plans for any long-term regional institutionalization, outside individual national programs should be reviewed with WHO/AFRO to avoid duplication and to support to WHO's Operations Research program.

9. The CDA Health Technical Committee and other periodic _ad hoc_ intercountry meetings should continue as forums to exchange technical and program information without policy making or management responsibilities. Frequent informal and non-institutionalized coordinating arrangements are essential to preserving as well as strengthening donor and African cooperation. Within national programs, a standing multidonor council comparable to Comite Directeur in Zaire is highly desirable.

10. The sustainability of the CCCD program rests on a) the intensive build up of African professional and managerial staffs within well planned PHC systems and b) well thought out plans for covering recurrent costs. The initial assessments and subsequent national program evaluations should focus on these two conditions as prerequisites to the initiation and continuation of external assistance.

11. On recurrent costs:

- a methodology for analyzing the cost implications and revenue generation capabilities of CCCD within the PHC system should be developed;

- analyses should be prepared for each national program to guide national policy formulation; comparative experience should be exchanged between countries.

Although the Evaluation Team cannot reach a firm conclusion on recurrent cost implications for sustaining CCCD programs, experience to date suggests that a combination of beneficiaryfees, government budget support and external assistance for the purchase of vaccines and medical supplies can sustain the CCCD program for the coming decade.

Beneficiaries fees for vaccines will have to be modest if local participation is to be encouraged. But such fees for ORT and Malaria treatment should be integrated with the PHC operating costs with the aim of local self-sustainability ofas much of the PHC program as is possible. Experience in Africa has demonstrated a willingness of African people to contribute to the costs of effective health care although capacities to pay vary greatly between countries and even between regions within countries.

12. It is essential that techniques be developed and used periodically to measure the progress of the CCCD program in its reduction of childhood mortality.

13. AID has a vital role in ensuring the success of the CCCD program. As AID is the CDA health coordinator and the major donor, AID top management has a responsibility for a) sustaining AID's participation and b) promoting at the international policy level greater participation by other donors.

14. The Africa Bureau should ensure that a full time senior experienced international program manager is assigned to the CCCD program. The scope of this person's responsibilites goes well beyond in-house administrative functions. He/she has a central role in maintaining the broad vision of the CCCD program objectives and in serving as a catalyst for international cooperation. Building and maintaining productive relations with a diverse community of bilateral and multilateral participants and professional expertise is a vital task in the achievement of the programs' objectives and a successful AID project.

IV. Primary Childhood Disease Interventions.

The CCCD program has as its main objective to decrease mortality in African children under 5 years of age by providing vaccines for those diseases preventable by vaccination, by developing treatment services for acute diarrheal episodes through oral rehydration and lastly by emphasizing presumptive therapy for fever in under 5's and presumptive therapy and/or prophylaxis of pregnant women with chloroquine.

The EPI component of the CCCD program is firmly based on scientific data and practical experience. The WHO/EPI has been a very successful program and the technological base for the EPI component profits heavily from the experience accrued through this program.

Oral rehydration therapy can have a major impact on childhood mortality. Data from Haiti and Bangladesh clearly prove this point. It is important to emphasize that oral hydration therapy starts with simple salt and sugar solutions prepared in the home. Packaged ORT salts are for the most part more appropriate for health centers and hospitals.

Malaria control has shifted from a vector control strategy to one which emphasizes presumptive treatment of fevers with chloroquine. While an overall strategy for malaria control has not yet evolved, the presumptive treatment of fevers in underfives and the prophylactic treatment of pregnant women with chloroquine on a trial basis are sound proposals for thepresent and are consistent with the first tactical variant of the WHO/AID strategy.

The CCCD objectives are clearly linked with Primary Health Care programs. In fact, several of the CCCD country assessments have pointed out the utility of such a program as a step in the maturation of a primary health care program.

V. AID/CCCD Bilateral Projects

A. Status of Country Coverage

The AID/CCCD project was designed to permit AID to be both timely and flexible in responding to requests for assistance. Since the authorization is for the entire project, individual country projects can be started with country assessments. If the assessments are reviewed favorably, the country projects can begin within four to six months. This process also lends itself to a variety of models ranging from a major AID involvement to a very minor one in which the USAID provides only technical advice and minor training assistance to round out what is being provided by other donors.

So far AID has received 19 requests for country assessments. Ten have been completed, 4 are in process and another 5 are at the request stage. In addition, the Gambia country project was taken over by the UK as a direct CDA/CCCD activity. Each assessment has followed a slightly different pattern and resulted in a different mix of donor inputs but all follow the general strategy set out under the CCCD program. This can best be illustrated by the following summary:

<u>Projects Approved or Started</u>

<u>Zaire</u>: AID/CDC conducted the assessment with the Government of Zaire. The assessment was favorably reviewed and a project agreement signed in August 1982. It was based on an established EPI program that had been supported earlier by AID. Other donor involvement, primarily Belgian, has been formally linked to CDA and increased Belgian assistance is anticipated. Project activities are overseen by a coordinating committee including AID, Belgian Health Assistance Office, UNICEF, WHO, and Peace Corp.

<u>Togo</u>: The assessment was carried out by CDC and the Togo Government. It was approved and the project has started. The direct involvement of other donors has so far not been significant but the French recently stated a possible interest. Chloroquine has been donated by the Arab Gulf States.

<u>Liberia</u>: The assessment was prepared by CDC and the Government of Liberia. The project has been scaled down to fit within Liberia's budget. UNICEF is involved but other donor participation is minimal.

<u>Ghana</u>: The Canadians participated with AID, CDC, and the Ghana Government in the assessment. Both the Canadians and AID decided that little could be accomplished in the current economic environment and the project has been deferred.

Congo: The French participated in the assessment with CDC and the Congo Government. It was reviewed by AID and found to be technically and financially sound. The decision was made to move forward with a country project following agreement with the French on what aspects they would be willing to fund. After the Kinshasa CDA meeting, the French indicated that if they receive a formal request from the Government of Congo, they would be willing to fund a substantial portion of the project. They would initially need to reprogram funds already earmarked for the Congo. The most likely input for the U.S. would be a technical officer's services.

CAR: CDC conducted the assessment with some French participation. The French have indicated an interest in financial support under similar terms to the Congo project.

Swaziland: CDC conducted the assessment with the Swaziland Government. The UK has agreed to finance the long-term training costs if requested by the government. AID will finance the majority of the necessary donor assistance but UNICEF will provide some support.

Lesotho: The situation is similar to Swaziland with the UK funding long term training and AID funding the remainder. One technical officer stationed in Lesotho will also cover the Swaziland project.

Gambia: AID was asked by the UK to continue for three months the services of a technical officer who had been working on the EPI part of SHDS. This extension would enable the UK to start their CCCD program at the beginning of their new fiscal year. This was done and the UK is proceeding but somewhat behind schedule.

Senegal: CDC personnel were provided to assist the USAID Mission Assessment team design a Mission funded CCCD type project. This project is now designed to be closely linked to the CCCD intercountry activities.

Assessments in Process

Malawi: This assessment has just been completed by CDC with the participation of a UK ODA medical officer assigned to the ministry. If approved by AID, it is likely to be a joint UK/ AID undertaking similar to the Swaziland formula.

Burundi: The assessment has been completed with some Belgian participation. It will be scheduled for review at the same time as the Rwanda assessment with the view of having one technical officer cover both countries if AID funding is approved.

Rwanda: The assessment is scheduled for October. UNICEF has expressed an interest in assisting in Rwanda.

Guinea: The assessment was conducted by CDC with German participation. It has yet not been reviewed.

Interest Expressed in Having Assessments

Somalia: The Italians are taking the lead and AID has collaborated with them in the planning and offered to assist in the assessment if requested. It is assumed that Italy would provide most of the funds for such a project.

Sierra Leone: The Germans were to participate in a joint assessment with AID which was cancelled. It is assumed that it will be be rescheduled. The French have also expressed interest in participating. AID/CDC plans a minor role.

Ivory Coast: An informal request has been relayed through REDSO/WA. Conditions are such that AID could provide minimal but key technical inputs that might result in a low cost, high impact intervention.

Mali and Niger: Inquiries have been made but since no Sahelian funds are allotted to the AID/CCCD, no action has been taken. (see following section on the Sahel)

Cameroon: The USAID expects a request from the Cameroon Government in early CY 1984 regarding a CCCD project.

The approach emphasizing bilateral CCCD projects illustrated by the above country summary is sound. AID soon will have to determine the number of countries to be AID financed. One trend that appears to be emerging is that AID provides technical planning and operations services with CDC officers while the major external costs for equipment and supplies and training comes from other donors. If this pattern proves viable, AID may want to provide technical services to a larger number of countries and limit the other forms of bilateral assistance. The AID funded WHO/AFRO intercountry activities provide another source of important CCCD assistance to African countries in which AID may not otherwise be active.These intercountry activities reinforce established AID bilateral CCCD projects. UNICEF is also an important participant with whom AID/CDC should continue to work closely.

One unresolved question is the lack of participation in CCCD of major African countries such as Nigeria, Sudan, Ethiopia, Zimbabwe, Kenya, and Tanzania. The latter two benefit from assistance from DANIDA. DANIDA and other non CDA donors should continue to be encouraged to associate themselves with the CCCD strategy. Steps should be taken to develop CCCD policy leadership and management capabilities in these major countries. Informal CDA discussions and review of individual

country situations will be necessary to determine how best to advance CCCD in these major countries. The work in the smaller countries and in Zaire should provide valuable practical experience to help guide program development in the larger countries.

Because of the funding restrictions of the Sahel Development Program, no AID/CCCD project funds can be provided to the eight Sahelian countries. AID should reexamine this limitation. However, introducing CCCD to the Sahelian countries - an important omission at present - should be arranged through the Club du Sahel/CILSS. The CCCD program provides well thought-out plans, technologies, and training systems that can be applied in the Sahel and help reorient Sahelian health priorities. It would provide an opportunity to revive the Club du Sahel/CILSS health sector. The CCCD assessment procedure should be carried out through the Club du Sahel/CILSS with multidonor participation.

B. Assessments: Malawi and Overall Review

The assessment process is the first step to the formalization of CCCD country projects. At the discretion of the African country, a team composed of national representatives, CDC and other appropriate donor agencies such as WHO UNICEF or other CDA members are invited to review information pertinent to CCCD. Usually within three weeks an extensive review of health plan documents, progress in EPI, diarrheal disease control and malaria can be completed. Other issues examined include current programs, initiatives in primary health care and ability to accept and sustain a CCCD program.

Malawi Assessment

From September 6-13, the Evaluation Team had the opportunity to interact wth a CCCD assessment team in Malawi. The Evaluation Team attended final briefings with the Permanent Minister of Health as well as a final review chaired by the Chief Medical Officer, Malawi Government.

The closing session was attended by several ministries such as Planning, Finance, Health, Nursing, Purchasing and Primary Health Care as well as representatives from CDC (Atlanta), USAID (Washington and Malawi) and WHO. A complete draft of the assessment had been completed and distributed on September 9th and copies had been reviewed by all interested agencies and ministries.

The final session was a detailed review of the draft document. The review group made a number of specific suggestions but it was clear that the CDC/Malawi assessment

team had accurately determined the health care issues that would be affected by CCCD. The team had correctly translated programmatic needs into realistic suggestions whereby a CCCD initiative could strengthen the Government of Malawi's primary health care program.

Other than minor textual changes the sole area where substantive questions were asked involved the budget. There was confusion about which costs should be considered recurrent and would have to be assumed at the end of the project by the Government of Malawi. At the end of the discussion, it seemed clear that costs being proposed could be assumed by the government since the entire project focused on strengthening an existing program.

The Evaluation Team concludes that:

- As a group the country assessments form a remarkable set of documents. The format is excellent and as summaries of health initiatives they are interesting and useful.

- The assessments have formed the basis for bilateral agreements in Zaire, Togo and Liberia. One potential problem has been the rather generous objectives proposed in some projects. For example, the current Zaire goals in the agreement seem ambitious and may need redefinition.
- The assessment process had hoped to include broad representation particularly from countries who might be interested in helping fund such a project. This simply has not worked well with the major input coming from CDC epidemiologists and technical officers. If further assessments are requested, it should be clearly established at the outset who will be the principal donor for any project that may result from the assessment process.

- One problem in all assessments has been the issue of recurring costs. In some assessments this issue was well handled whereas in others the issue of who would assume recurrent costs was not clear. Future assessments need to emphasize this issue.

C. On-Going Project: The Zaire Experience

The Evaluation Team was specifically charged with reviewing the overall CCCD project in Zaire. Our review, while not done in depth, was performed with the object of determining whether major problems in the implementation of the project had occurred during the first year that might have bearing on the overall CCCD project.

The Zaire National Health Plan 1982-86, which promotes an integrated primary health care system, is being implemented in phases so that 60% of the population will be served (have access to health services) by 1986. It provides the base for

health activities in Zaire. Health assessments estimate that approximately 35% of the children born in Zaire will die before they reach their fifth birthday. Measles, malaria, and diarrheal diseases are the principal causes of mortality.

The AID/CCCD project is designed to strengthen the Zairian Government's ability to plan, implement, and evaluate health programs within the context of Primary Health Care. Building on the existing Programme Elargi de Vaccination (PEV), the CCCD/PEV project aims to reduce childhood mortality by addressing the major childhood communicable diseases. The project comprises three strategies to prevent diseases or their sequelae: (1) vaccinating children and pregnant women, (2) treating suspect cases of malaria in children and giving malaria prophylaxis to pregnant women, and (3) treating episodes of diarrheal disease in children with oral rehydration. The project plans to expand these three activities to 17 urban and 124 rural health zones by 1986.

To date about 25 percent of the population has access to vaccination programs. Current plans aim at increasing this coverage to 60% of the population by 1986. The 1982-86 plan is a decentralized plan. It emphasizes the training of Chiefs of Zonal Medical Services who will be charged with implementing CCCD activities in their respective zones.

PEV/CCCD teams exist in each region. Some have sub-regional groups. These groups are responsible for vaccine storage, technical input and evaluations in their respective areas. They report to the national PEV office.

A major training effort for Zonal Medical chiefs has begun. The first step was the development of a series of training modules whereby CCCD activities are integrated into planning activities at the zonal level. This effort involved Zaire/PEV, WHO (Geneva and AFRO), Centre International de L'Enfance in Paris, CDC Atlanta and Belgian Medical Cooperation. In addition a series of brief handouts (fiches) have been prepared to assist zonal chiefs in training health center personnel.

Supervision of trained zonal chiefs has been spotty and represents a major weakness of the current program. While the training materials are excellent it is important to emphasize that training is a continum with supervision as an essential component. It is intended that each trained zonal chief will be visited twice a year. The responsibility for these supervisory visits has not been worked out. A preferable arrangement would include a two person team with one a zonal chief from another zone and the second from the PEV (central or regional) office.

Such plans may have to wait until a sufficient number of zonal chiefs have been trained. Nonetheless, a specific plan which deals with supervision needs to be developed. Such a plan will require more regional or central staff since it seems unlikely that current manpower could effectively cover this important responsibility.

Several operations research projects were discussed with the CCCD Regional Epidemologist. They include a study of measles in Kinshasa, vaccination of ill cildren attending clinics and a study of presumptive treatment of fevers with chloroquine. All of these projects fall within the scope of CCCD operational research. Data from such studies would be useful to the program. However, few linkages to local institutions have been developed. Rather the Regional Epidemiologist has identified important areas where more data are needed. While there is no question that these topics are important, counterparts to assist in the research effort need to be identified.

One year ago the PEV program in Zaire was evaluated by an international team. Recommendations to the Ministry of Health stressed problems in evaluation and difficulties in communication between interacting agencies. Other recommendations that seemed particularly relevant included (1) improved knowledge of zonal chiefs of their target groups; (2) improved supervision in zonal centers; (3) improved surveillance activities; and (4) integrated regional and national supervisory activities. While progress has been made in several of these areas, problems, particularly with finances and supervision, remain.

The Evaluation Team reviewed the milestones in the original Zaire Project Agreement with USAID and PEV personnel. Several of these objectives should be redefined. For example infant and childhood mortality is to be reduced by 50% in participating areas within four years primarily by halving deaths due to preventable diarrheal diseases and by immunization and malaria treatment. Related subobjectives emphasized the delivery of immunization, cholorquine and ORT services at a level sufficient to reach these goals. While these objectives are laudable and in fact represent the core of the proposal, more definition of the these objectives needs to be done.

Survey techniques to measure morbidity and mortality from CCCD diseases must be developed and tested so that objectives can be quantified. A national poliomyelitis lameness survey is being completed. A survey to measure under 5 mortality needs to be done. The importance of this effort cannot be overestimated since such survey data would provide the yardstick by which program objectives can be measured.

Objectives should be defined according to urban and rural areas and need to be clarified as to services already being provided.

Management plans are being developed for tracking ORT and chloroquine which will soon be introduced into the CCCD program. It is important that such a tracking system be in place at the very beginning.

Planned accomplishments for the first two years were carefully outlined in the Project Agreement. While many of these objectives have been met; some have not. Specific comments include:

-Integration of CCCD within the primary health care initiative is excellent.

-Planning documents for PEV, CDD and primary health care activities are of high quality.

-Integration of CCCD with the SANRU Rural Health project is good and there is a good chance that these links may provide the opportunity to assess problems as the CCCD program moves from an urban program into a rural one.

-An Operational Research component for malaria in 2 to 4 rural health zones is specifically stated as a two-year accomplishment. Little has been done with this project. The advisability of such a project given all program needs at the present time needs to be reviewed.

-Specific statements relating to mass media health education and health education programs need to be modified.

-Surveillance activities are being strengthened. Cold chain to reference hospitals and health centers while not specifically examined does not seem to be a problem. The vaccine distribution system is also good. ORT and chloroquine distribution is being grafted onto the current distribution system of PEV vaccines.

-There is general agreement that a fee structure will be established for ORT and chloroquine therapy and for the vaccination card. Hopefully such a system will allow for partial or complete self-financing.

-A major constraint on the expansion of CCCD in Zaire is (1) insufficient senior personnel in Kinshasa and (2) shortage of trained supervisory personnel at the regional level. Building up this staff capacity should be given urgent attention.

D. Sustainability

The long-term prospects for the CCCD program rest on the development of African institutional and financial structures. The Zaire project review, discussed above, brought out clearly the primacy of management and supervisory training and well thought out financial support plans and policies.

PHC/CCCD Staff Development: The CCCD program, through its incorporation in PHC, provides a sound basis for developing institutional structures. The WHO/CDC training modules, both management and technical, provide excellent mechanisms for developing well qualified and uniformly oriented PHC/CCCD personnel. The combination of standardized training plans with country adaptations can induce a systematic and relatively standard approach to national health program development. This is often not the case in other sectors.

The institutional framework for CCCD activities is a national Primary Health Care organization plan covering both central and local operations. While CCCD activities cannot and should not function outside of a PHC system, they can provide direction, and organizational discipline with relatively rapid benefits.

The Evaluation Team urges that priority in all CCCD program planning be given to the early and rapid development of key African personnel in management and supervisory positions in a PHC organizational structure.

Financial Sustainability: The need for more financial analysis at the time of the assessments or development of the grant agreements has already been noted. The Evaluation Team concludes that the increase in recurrent cost as a result of the introduction of a CCCD project activities can be expected to be mininal. The reasons are as follows:

- The CCCD project largely builds on what already exists.

- Most of the needed administrative technical and logistic staff can be provided by utilizing and retraining existing staff.

- Two of the three interventions namely ORT and chloroquin treatment for malaria lend themselves well to self-financing. Other than establishing a minimal fee for vaccination cards, vaccination charges would have an adverse effect on coverage. Since this was a constant theme of all the experts with whom the Team met, the Evaluation Team concludes that no attempt be made to push the concept of self-financing for vaccinations. The fact

that there seem to be an ample number of donors who are capable of providing vaccines to the third world, adds to the practicability of this recommendation. As African governments' economic and financial situations improve, vaccines costs should, of course, be shifted to their budgets. The curative aspect of CCCD lends itself to local self-financing. This self-financing of local PHC services should be encouraged as an essential part of each country project. The amount of added costs that CCCD services will add to the recurrent budgets should not be great.

CCCD can help build and strengthen the existing primary health care structure but expansion of CCCD will depend on the availability of the primary health infrastructure. Thus, until that structure is in place, which will require significant investment, CCCD expansion will be limited and the project in itself will not drive up recurrent costs.

E. Donor Coordination In Country

The Evaluation Team concludes that a great deal of the relevant field activity of CDA members and other donors, public and private, is not recorded and recommends that an attempt be made to capture this information. Such data would best be obtained at the country level. In large part it would consist of approximations and best estimates by the people most familiar with what is going on. The Evaluation Team recommends that AID/CDC develop a simple set of guidelines for the technical officers on estimating procedures and some general rules on what to count as CCCD related activity. This procedure should be developed and tested and, if it appears useful, incorporated into the MIS system.

The amount of donor coordination taking place in Zaire is impressive. The Zaire PEV/CCCD multidonor advisory committee (Comite Directeur) chaired by the Directeur du Programme, Ministry of Health met during the Kinshasa CDA meeting and gave a practical demonstration of the potential for donor coordination at the bilateral level.

The Evaluation Team suggests that this experience be written up as an article for the CCCD Bulletin in the hopes that other incountry multidonor coordination emulate the Zairian experience.

VI. AID/CCCD Intercountry Projects

A. Overview

The intercountry (regional) program of CCCD as laid out in the Project Paper includes Intercountry Training, Health Information, Health Education and Operations Research. Each of these components has distinctive characteristics. Their management must, therefore, be flexible in structure and varied in approach. These activities are a principal mechanism for extending the CCCD concepts, technologies, and methods throughout Africa whether or not African countries receive AID bilateral assistance. There is the long-term requirement for African regional institutional participation in CCCD as an African program beyond the participation of AID and other donors. The following sections spell out how the Evaluation Team sees each of these components being carried out.

- Intercountry training and the development of training materials should be under the leadership of WHO/AFRO with AID/CDC technical and financial support.

- The Health Information System should be under WHO/AFRO leadership with AID/CDC technical and financial support with a view to creating a permanent African wide H.I.S. capability.

- Health Education should be deemphasized as a distinct regional category and the funds applied to building health education activity into the above intercountry training work and to supplement directly bilateral programs with health education services.

- Operations Research should continue as an <u>ad hoc</u> adjunct of the CDC epidemiologists in strengthening individual Africans researchers in CCCD related operations and providing necessary information for improving CCCD interventions. The responsibility for OR should be decentralized as much as possible. Plans for any long-term intercountry institutionalization of Operations Research including the OR review committees, should be reviewed with WHO/AFRO. It may be that some direct support to WHO/AFRO's own OR activities is advisable. The opportunities for helping to develop national epidemological institutional capabilities should be encouraged from the outset of any AID-funded program.

B. Training

Training activities are focussed on two phases of training - intercountry and national. The intercountry phase will train national level managers or other personnel whose administrative or supervisory responsibilities indicate that they would profit from such a course. Modules have already been developed byCDC/WHO. Such training programs within the EPI program have been very successful in the past. Cold chain training courses developed by WHO/EPI would also be included on a regular basis.

It would be best to draw on the technical and logistic expertise of WHO/AFRO by asking their help to coordinate and identify participants and facilitators for intercountry CCCD and cold chain courses.

To maintain quality and uniformity any training materials used in CCCD training courses should be jointly approved by CDC and WHO.

An important recent priority has been the development of a mid level management training program for CCCD. An excellent mid-level program has just been completed in Zaire and has already been described. Part of this effort included the development of training materials specific for health center use.

It is important that the mid-level training programs be country-specific. The Zaire model is a good one. Post course supervision needs to be emphasized. Mid level training programs should be developed with input from donor agencies and WHO. As already mentioned the broad technical representation used to generate the modules for the Zaire CCCD course is exemplary. It is essential that mid level managers training materials developed as part of bilateral agreements be consistent with WHO policy.

C. Health Education

Health education is the least well developed of the CCCD initiatives. In conversations in Malawi and Zaire, Program Managers accept its importance but believe that health education needs to be country specific and frequently, within countries, region-specific. IHPO/CDC is in the process of recruiting a full-time health educator. Linkages with the University of Ibadan in Nigeria and the WHO Center in Lome, Togo are in the discussion stage. If these linkages are to be developed further, they should be worked out as part of the WHO/AFRO Intercountry Training program.

A USAID contractor specifically studied the question of health education in CCCD and recommended a series of strategies. We have reservations about the strategies in this document.

Under these strategies the major portion of the $2.0 million set aside of Health Education in the "regional project" would be allocated to African or U.S. contractors. These would, in turn, provide technical assistance and training services to individual countries. The Evaluation Team is concerned about this relatively costly indirect approach given the limited experience base for health education activities in Africa. We would urge that these funds go directly to bilateral country programs as integral parts of the CCCD projects making maximum use of in-country African health experts to develop local health education activities as part of the CCCD operations. A small portion of the $2.0 million could be used to set up intercountry-training courses, however Individual country program funds could be used to obtain African regional health technical support as the Ministries of Health believe desirable.

The use of Peace Corp Volunteers in health education is also envisioned. The team suggests a careful review to determine whether the Peace Corp can provide volunteers with appropriate locally oriented health education skills and whether African Governments will accept them in the field.

The health education component of CCCD as it is currently summarized, therefore, needs to be reviewed and redefined. The hiring of a Health Educator in IHPO is an important step. It seems appropriate to decentralize Health Education out of the "regional" component and develop it more intensively and specifically as part of bilateral agreements. Creating health education resources which could supplement bilateral CCCD programs were enthusiastically received whenever discussed.

D. Health Information System

This component of CCCD is an effort at improving the quality of information generated within countries and to strengthen the information base through WHO/AFRO. The program will not only emphasize improving surveillance data on CCCD diseases but will seek to improve measurements of health indicators such as infant mortality rate and the 1-4 mortality rate.

The proposed plan for a Health Information system is a good one; however, the goals cannot be achieved unless an agreement is reached with WHO/AFRO. WHO/AFRO has computer capacity that is an excellent resource for the H.I.S.

E. Operations Research

The Operations Research component of CCCD seeks to identify and solve operationally important problems relative to CCCD while at the same time increasing national capabilities to do such research.

To accomplish this task research review committes are being formed in the CCCD sub-regions of West and East Africa. These review committees will have broad representation from academic institutions, Ministries of Health and donor agencies. Review committees will meet to review submitted protocols. Committees can approve projects up to $10,000 per year and about five such awards will be made per committee per year. Consultations with CCCD field epidemiologists are expected to take place and each field epidemiologist will undertake one or more projects. Research priorities will focus on operational problems related to childhood communicable diseases.

The Regional Epidemiologist for East Africa has met with individuals from several academic institutions and is planning to have the East Africa Research Review Committee meet late this year at which time guidelines and procedures will be discussed. Solicitation of research proposals will immediately follow and it is hoped that the committee will review protocols, possibly, in June and make the awards at that time. Every effort will be made to assist new investigators in the preparation of such applications.

At the same time, WHO/AFRO has expressed interest in participating in the intercountry aspects of OR. AID/CDC should discuss with WHO/AFRO its ideas with the view of possible support. It is important that the operations research activities pay particular attention to improving national capabilities to do research. In that light it is unrealistic to expect that all submitted protocols will be of outstanding quality. In fact, the program runs the risk of concentrating grants to academic institutions that are already experienced in grant preparation.

In the initial grants, simplicity and likelihood of completion of the project should be emphasized although it should be expected that some projects will not be completed. In fact, one could argue that if this does not happen then the grantees chosen might be at too sophisticated a level.

Early research projects should emphasize the development of simple survey techniques which can measure program needs.

Alternative approaches to OR to be considered are:

- Intercountry program with WHO/AFRO and,

- National review committees to support bilateral OR development.

Annex B lists a number of points to be worked out in implementing Operational Research grants. A Memorandum of Understanding on these and other implementation items will need to be developed between AFR/RA and CDC.

F. Cooperation with WHO/Africa Regional Office

As a result of the meeting with Dr. Quenum and his staff on September 26, there is now a basis for proceeding with intercountry (regional) component of the AID/CCCD project. The proposed letter to Dr. Quenum (attachment A) provides the guidelines for proceeding. We recommend that AID move as quickly as possible in working out the intercountry activities with WHO/AFRO. The key considerations behind these guidelines that AID should bear in mind are:

- the concept of a single regional project within the AID/CCCD project is deemphasized. The focus is on AID/WHO intercountry activities which support national programs. Thus the proposal is for separate grant agreement for each IC activity. It should also provide more flexibility in operations by delinking the IC activities from each other permitting each to move at its own pace.

- the goals and targets are, and should be represented, as those established by WHO for CCCD intervention and as those of the individual African governments.

- the responsibility for planning and administration of intercountry activities should be clearly placed on WHO/AFRO, adhering as closely as possible to WHO/AFRO's system for planning and implementation and for coordination with African Governments. AID/CDC will be invited to assist in the planning process.

- The concept of an AID/WHO-AFRO Advisory Council has been dropped and was not discussed at the September 26 meeting. It should not be reopened. This is consistent with CDA philosophy of avoiding formal structures for the coordination and management of CDA programs. The CDA Health Technical Committee as a technical and information exchange without policy or management functions is all that is required. WHO/AFRO should continue to be encouraged to participate in presenting to the CDA Health Technical Committee WHO/African CCCD policy developments as well as specific project undertakings. WHO/AFRO may set up or use existing WHO committees to review separate intercountry CCCD support activities.

- AID will need to revise its terminology to use terms that are not ambiguous or insensitive in the WHO and African situation. The word "regional" is particularly confusing; we suggest "intercountry" be used for those portions of the AID project now listed as regional, e.g. Intercountry Training, Intercountry Health Information etc. WHO/AFRO prefers technical cooperation to technical assistance,cooperating countries to donors. "Technical Cooperation between Developing Countries", which AID can support through the Intercountry Projects, is likewise important within WHO/AFRO setting.

- The two principal areas of AID/WHO/AFRO cooperation should be Intercountry Management Training and Intercountry Health Information Systems development. Health Education training should be integrated with the IC training activity to the extent any intercountry activity is justified. The Operations Research component was important to WHO/AFRO in the meeting. We should attempt to find some way to be responsive.

AID should attempt to be as accomodating as possible in supporting WHO/AFRO activities in CCCD. The cooperative arrangement should avoid the image and substance of WHO/AFRO functioning as an AID "contractor." The negotiation of individual cooperative activity plans and grant agreements and the subsequent implementation will be difficult. It will require patience and sensitivity.

VII. International Coordination and Other Donors in CDA/CCCD

The magnitude and extent of CDA and other donor participation in the CCCD program anticipated in the project paper does not appear to have materialized at least in the manner envisioned at the time of design. There appears to be a number of reasons for this including:

a. the relatively short time the program has been underway;

b. the lack of any systematic means of obtaining informaton on the bilateral activities. Relying on only the direct and clearly identified CCCD interventions such as those made by the UK will result in a significant understatement of what other donors and private organizations are doing or have been stimulated to do as a result of the coordinated CDA effort in this area. Requesting other CDA members at the headquarters level to compile and exchange this information has not yielded any useful results. If we are to get this information, AID will have to obtain it at the country level.

c. a need for continuous contact between the CDA technical people. More time and effort will be required to communicate and stimulate the CDA technical people in their respective capitals to make their policy people more aware of what is happening in this particular CDA initiative and to increase communications with their field people concerning their interest and support of the CCCD concept.

d. a need to have the CCCD become recognized as an African-multidonor supported program and not just a U.S. initiative. Other donors may be more willing to pledge their support or identify their contributions as CCCD related if it appeared to be less of a U.S. initiative and had more explicit African expressions of interest to CDA donors. More effort needs to be made by AID and CDC to lower the U.S. profile in this project. Even though care has been taken to refer to the CCCD activity as a CDA and African initiative, the project is still conceived by many as an AID/CDA project. The existence of U.S. technicians in the field makes some U.S. identification inevitable and even desirable but there needs to be a more conscious and carefully articulated strategy for projecting the CCCD program as an African CDA supported effort.

The concept of complementary component parts of a country program supplied by several donors in addition to the single donor identification with a specific country project may help to move the program more in this direction and create the basis for perceiving it as an African program.

For example, in Zaire, the Belgians are providing far more direct and indirect assistance in support of CCCD activities than has been recognized or recorded and have been for sometime. As one Belgian said, "some of our people have been doing CCCD work for a long time without knowing it was CCCD."

e. Much more needs to be done to make African governments and professional health personnel aware of the objectives, policies, strategies and technologies of the CCCD program. Progress in additional CCCD programs will come only as African governments establish CCCD as a priority national program and request external assistance. WHO/AFRO has as key role as well in encouraging African government participation, particularly in those countries with minimal Western relationships.

In addition to the direct bilateral programs of the CDA members and other interested government donors such as DANIDA, there are a large number of Private Voluntary Agencies working in Africa in CCCD related activities. Many of them receive national government financing similar to AID grants to PVOs. This PVO community interest in health in the U.S., Canada, Germany, UK, and France in particular should be informed about CCCD to facilitate their focus on consistent approaches to African childhood communicable diseases. This orientation work should be pursued both in the individual African countries and at the home office for the major PVO contributors.

The CDA Health Technical Committee, as observed in the Kinshasa meeting, is a sound coordinating mechanism. By not taking on policy or management decision roles for CCCD, it preserves the flexible open setting in which numerous interested participants can operate and exchange information. The underlying purpose of this CDA committee is to educate and promote CCCD and thereby encourage the donor community to reorient existing and additional resources to a common strategy and technology. Given the constant turnover of country representatives this committee helps provide continuity as well.

The Evaluation Team suggests that others such as DANIDA, OCEAC, OCGGE, major PVOs be included as well as other dimensions of African expertise. The African participation on technical aspects of CCCD was excellent at the Kinshasa meeting. It can be strengthened by providing more opportunities for the African professionals to participate in the program. The CDA Health Technical Committee might consider holding sub-group meetings with African country representatives, e.g. for East Africa, or Southern countries, or Central Africa, etc..

VIII. CCCD Program Management

A. AID's Role and Staffing

Since implementation began, the project has been managed by a senior project manager able to provide approximately 50% to 60% of his time to CCCD and an physician technical manager under a RSSA arrangement who has spent 100% of his time on the CCCD. This mix worked out reasonably well but as the project gains momentum and the CDA cooperation aspects become more active, it will require additional management time from AID.

The project manager position is now vacant. It should be filled by a senior, experienced Foreign Service Officer with sufficient breadth to enable him or her to deal with other senior officials from CDA, WHO/AFRO and other donor groups in a decision-making capacity. This person has a vital international leadership role not just in-house project management.

This position should be 100% dedicated to managing the CCCD project and serving as AID's CDA facilitator. The technical manager's position should be continued and staffed with a full-time RSSA person. In planning for this position, allowance should be made for the fact that there is a likelihood that the incumbent could be reassigned in the summer of 1984 when the present RSSA terminates. The complexity of the project will require some overlap and "grooming". The person in this job should be an MD or have a strong health background and have considerable overseas operations experience.

African Bureau and Agency leadership have an important role in advancing the CCCD program. Through their periodic policy discussions with other Western donors active in Africa, they can encourage support through bilateral assistance programs.

B. The Management Information System (MIS)

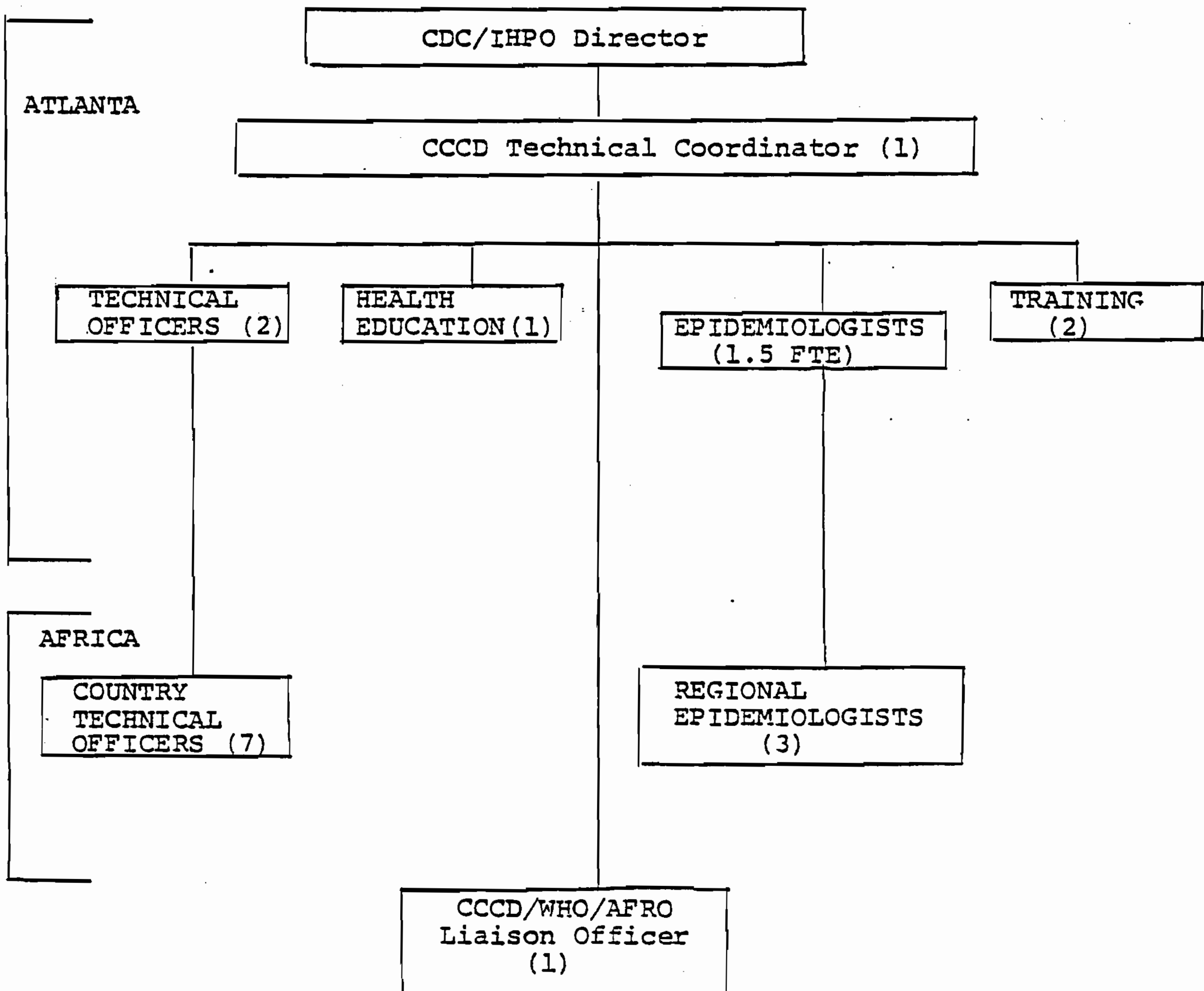
Because the project is complex, a more complete management information system has been developed to keep CDC Atlanta informed about what was happening in the field and allow AID to have ready access to the information needed to manage the PASA and keep current with project progress. A system was designed which has now been on trial in CDC Atlanta for the past three months. It is due to be tested in Togo and Zaire next month.

The initial field testing of the current MIS should be limited. At the end of four months, the entire system should be reviewed to assess its utility and cost effectiveness. An attempt should be made to reduce the reporting burden. Since most of the reporting is mechanical in nature, it is also suggested that the field personnel be permitted to acquire local contract assistance to prepare these reports in order to mininize the diversion of effort from their main functions with the host country governments.

The current MIS is programmed only to capture costs associated with the PASA. However, in order to have a complete picture and understanding of the financial status of the project, the MIS should capture financial data for the entire project. This means that monies obligated and disbursed under the bilateral agreements and by AFR/RA should also be included within the MIS. At the same time, it is necessary to identify and to decide upon the project elements which are common to the bilateral, PASA, and regional (AFR/RA) funds. Obviously, this is necessary in order to be able to analyze and to manage all project funds in a meaningful manner.

C. <u>Centers for Disease Control Administration</u>

The CDC/Atlanta is the main implementing agency for AID/ CCCD since it is responsible for the technical management of AID-financed activities. The current professional staff located in Atlanta and Africa is as follows:



The breakdown in physicians assigned to the project is such that an aggregate of two positions (combined partial salaries of four physicians) are responsible for supervising activities of three regional epidemiologists. Atlanta based physicians are also involved in developing training material, performing field assessments and serving as technical support for CCCD activities. The proposed seven technical officers in bilateral programs are supervised by two officers in Atlanta who devote full time to the project. The Operations Officer is the overall coordinator and principal liaison with AID. The Evaluation Team concludes:

- The technical expertise offered by CDC for CCCD activities is high quality. IHPO has an enviable international reputation in epidemiology and training.

- The current physician distribution within the program needs to be reviewed. Currently two Atlanta based positions, shared by four physicians, supervise and develop technical material for three field epidemiologists.

- The possibility of transferring work staff to Africa is an attractive one but may be precluded because of budgetary implications.

- The location of the CCCD (Regional) Liaison Officer should be reevaluated on the basis of the WHO/AFRO negotiations.

- Serious thought should to be given to transferring the Regional Epidemiologist from Abidjan to a country with a bilateral program. Epidemologic expertise is a precious resource and can certainly be of value to a bilateral CCCD program. As an alternative, AID could consider a small bilateral program in the Ivory Coast

- CDC personnel in the field and Atlanta have an important responsibility with AID staff for encouraging and facilitating African government participation and other donor assistance. Guidelines would be helpful for operating staff on steps they can take to encourage broader participation.

D. Budget Strategy:

The AID/CCCD project funding for the eight year period does not now need to be changed. As the program gathers momentum however, there will be increasing pressure to increase the overall authorized project level. Annual levels will need to be maintained to keep up the momentum of AID's participation. It is evident from the Zaire country project that the four year period is too short to establish an effective, self-sustaining CCCD national program. The eight

year period for the overall project should provide a more suitable time frame for each country project. Periodic country project evaluations will help determine shifts in project emphasis and time periods.

If AID is to fully fund a number of bilateral country projects with the extended time period noted, overall project funding constraints will occur within the next year. The Evaluation Team suggests that AID work out a new project budget strategy. Some guidelines are:

- conserve project funds for activities where the U.S. can make the most effective contribution; this is primarily in technical planning, operations management and training assistance. Medical supplies, equipment may more advantageously be financed by other donors.

- encourage USAID Missions interested in CCCD health projects to use their own bilateral budget resources such as in Senegal but drawing on CCCD expertise. After the first four years in Zaire, for example, the USAID Mission should be in a position to finance the next phase which will clearly be necessary.

- restructure the "regional" budget to earmark funding for the primary activities in training and health information separately. AID/WHO/AFRO cooperative activities should be adequately funded first. Residual amounts can then be reserved to support supplementary assistance to promote health education and operations research on a case-by-case basis, primarily through bilateral projects but also with WHO/AFRO.

E. Administrative and Financial Management Questions

A review of the administrative and fiancial components of the AID/CCCD project point to several areas requiring attention in the project's management.

1. Unexpended Balances (Pipeline): The PASA's estimated unexpended balance at the end of FY 1983 will be approximately $5.6 million. Funds of $511,200 for the CDC PASA were first obligated in FY 1979. Funds were also obligated in FY 81 and 82, and again in August 1983 in the amount of $7,902,031. Working with CDC, it is estimated that the PASA's unexpended balance at the end of FY 1983 will be $5.6 million. This is principally due to a combination of factors: fewer CDC officials posted overseas in FY 1983 than expected, the large obligation in August 1983 for FY 1984 anticipated expenditures, and the general slow start up of the project. It should also be noted that CDC identifies accrued expenditures in accordance

with PASA reimbursable procedures, i.e., CDC fully accrues an obligation at the time it is made, and the net result is that the reported unexpended balance (pipeline) is lower than what we are accustomed to under AID project accounting practices. Consequently, the actual pipeline is greater than it appears. As mentioned earlier, the need for funds in FY 1984 is dependent upon the posting of additional CDC officials overseas and the ability to accelerate implementation

-AFR/RA in conjunction with CDC, should closely monitor implementation, and thereby accrued expenditures, to determine the amount of funds which need to be obligated in FY 1984.

2. Cost Comparison: A current estimated breakdown for CCCD LOP funding follows:

Item	Amount
Regional Support	
Regional personnel assigned to Africa	$ 7.2 (16%)
CDC Atlanta Staff	10.3 (22%)
Central Commodity Procurement	1.0 (2%)
Misc. Central Funding RSSA Contracts	1.1 (2%)
Subtotal - Regional	19.6 (42%)
Bilateral Support and Activities	
Bilateral Projects	$10.4 (22%)
Technical personnel assigned to bilateral projects	8.5 (18%)
Operations Research	0.6 (1%)
Health Educ. inter-country training	0.6 (1%)
Other inter-country training	5.1 (11%)
Health information systems inter-country activ.	1.4 (3%)
Peace Corps	0.8 (2%)
Subtotal - Bilateral	$27.4 (58%)
Grand Total	$47.0 (100%)

NOTE: Overhead included in the above items is estimated at $5.8 million or 12% of the total $47 million.

A comparison was made for the period 1983 between the estimated figures in the Project Paper and in the PASA. The results follow.

The Period Chosen FY 1983

Tech. Asst. (PASA)		Proj. Paper		PASA Est.	Diff.
U.S. Sup. Staff		$ 387		$ 977	(590)
Salaries & Bens.	$ 245		$508		$263
Support Cost	50		167		117
Travel	92		302		210
Field Staff		1,240		2,101	(861)
Sales & Allow	1,140		1,943		803
Travel	100		158		58
CDC Overhead		310		395	(85)
U.S. 20%	305		326		21
U.S. 5%	5		69		64
TOTAL	$1,937		$3,473		($1,536)

Possible reasons for a higher CDC dollar estimate in the PASA are:

The average cost per PASA employee overseas was underestimated. The per person in project paper estimate overseas is $120,000 annually. The per person in the PASA is estimated at approximately $190,000 first year start up costs. Also the CDC overseas overhead was underestimated in the project paper.

(An analysis of accrued expenditures for FY 1983 was not made because: M/FM accounting records do not reflect expenditures by category and expenditures in one year may be against obligations made in a prior fiscal year.)

-The project manager in AFR/RA should take advantage of the MIS to capture financial data for the entire project. This will enable AFR/RA to analyze and to manage all project funds in an efficient manner.

3. FAAS charges: Where should FAAS charges for CDC employees be charged? Under the project, it was perceived that approximately 10 CDC officials would be assigned to permanent full-time positions. Since the project did not identify what funds would be used to cover the FAAS charges attributable to them, it appears that it would be the Agency's limited

Operating Expense (OE) funds. However, this could have a severe impact on the Agency, since the annual charges could range from $2,000 to $25,000 depending upon the country. Just the same, it is appropriate for the project to absorb the FAAS charges, but the issue is "what is the mechanism?"

-AFR/RA should identify the amount of funds that must be obligated under the CDC PASA for FAAS charges, and by identifying the funds under line "Retained for AID Direct Reimbursement" of the PASA, CDC overhead (OH) charges can be avoided. M/FM/BUD concurs with the above procedure and it will provide upon request further detailed guidance regarding the accounting procedure.

4. Bilateral Project Accounting: Who will be responsible for the accounting of a bilateral agreement in a country where no AID mission exits? It is expected that the project will fund bilateral agreements in countries where no AID mission exits. However, it is still necessary that accounting for the project be in accordance with Chapter 13, Project Accounting, of the Controller's Guidebook. Consequently, this will require that the accounting take place where an AID accounting station exits.

-AA/AFR, AFR/M, and ARF/RA should coordinate and identify the mission(s) which will assume the accounting responsibility of a bilateral agreement in a country where no AID mission exists.

5. Timekeeping: One of the purposes of the MIS is to provide a very comprehensive accounting of how the CDC staff spends its time. CDC began collecting timekeeping data in February 1983 and each month they have improved on their accuracy. However, as of August 1983 certain questions regarding timekeeping policies and procedures remained unresolved, principally due to lack of monitoring of the timekeeping system by AFR/RA. These include how to report leave, travel time, and overtime. The AID PASA office believes that timekeeping procedures are the responsibility of each office. Additionally, secretarial and administrative support time were included under program management rather than as separate categories. CDC prepared a "Guidelines To Assist In Filling Out The Time Allocation Forms," but there was no evidence that it had been reviewed and accepted by AFR/RA.

The significance of how time is reported relates to how the information is to be used. During initial conversations with AFR/RA it was thought that the information would be used to calculate the PASA billing charges; whereas, CDC officials thought the information should be used, at most, only for

negotiating subsequent PASA agreements. However, a PASA agreement for FY 1984 was signed in late July 1983, and there was no evidence that the timekeeping data were used in negotiating it.

-AFR/RA should work with CDC to establish mutually acceptable policies regarding timekeeping procedures.

ANNEX A

Dear Dr. Quenum,

I have received Mr. North's and Professor LaForces' report on the meeting with you on September 26 on the AID Combatting Childhood Communicable Diseases (CCCD) project. I wish at the outset to express our appreciation for your personal leadership of the meeting with your staff.

The Evaluation Team has recommended and we agreed to provide you with a letter with guidelines for AID/WHO/AFRO cooperation. the following paragraphs summarize what we understand to be the points of consensus arising from the September 26 meeting.

A. General

1. The long-term goals set by WHO and its member states for reducing African childhood mortaility and morbidity provide the basic policy direction for the CCCD project.

2. Individual African governments establish their own CCCD objectives and determine resource requirements for achieving them.

3. Support for national programs may come from a number of bilateral program resources including AID bilateral CCCD agreements. It is hoped that the Cooperation for Development in Africa (CDA) coordinating arrangement will encourage other cooperating government assistance for bilateral CCCD project.

4. Support for African national CCCD programs also is provided by WHO/AFRO; the requirements for which are derived from the individual African country programs. AID is prepared to cooperate with WHO/AFRO in intercountry CCCD activities in support of the national programs.

B. Areas of AID/WHO/AFRO Cooperation

The two principal areas for cooperation are:

1. Intercountry Technical Cooperation on training for senior management and supervisory personnel associated with CCCD.

2. Intercountry Technical Cooperation on Health Information System Development.

We would be pleased to proceed as expeditiously as possible in developing specific project plans and grant agreements in these two areas.

3. In the areas of Operations Research and Health Education, the Evaluation team has recommended that AID proceed more cautiously working through our bilateral projects and using our field staff to work with individual African researchers in carrying out their research projects. We hope that this experience will help us identify areas where AID can operate in longer term institutional arrangements. AID funding for Operations Research involves some special considerations of U.S. Government policy that we must take into account.

Health Education is such a country and even local culturally specific activity we may find that available resources should be directed to supplement individual country programs. Some intercountry training, however, may be feasible as well under B1. We will want to consult with WHO/AFRO on both of these activities as our ideas and experience evolves.

C. Development of Intercountry Technical Cooperation Projects

1. In the two principal project areas mentioned above, we look to WHO/AFRO to take the lead in preparing proposals for our joint consideration. WHO/AFRO will want to consult, we understand, with African governments on intercountry technical cooperation requirements according to its own procedures. The format for the proposals may be those that WHO/AFRO customarily uses for its project planning. Since AID funding is on an annual basis, we suggest the planning time frame be one or two years.

2. AID/CDC specialists are available to work with WHO/AFRO in this intercountry project planning.

3. To facilitate WHO/AFRO's planning work, AID will provide an indicative planning figure for the level of funds available for the FY 1984 fiscal year for each of area of activity. This figure does not constitute a commitment of that level but only a guideline for planning. We are, of course, open to and encourage other external funding support WHO/AFRO may wish to arrange.

4. WHO/AFRO and AID/CDC will review together the proposed activity plan.

5. AID will then prepare grant agreements based on WHO/AFRO's proposals for joint signature and obligation of funds. To provide flexibility and to permit each Intercountry Technical Cooperation project to proceed at its own pace, AID will prepare separate grant agreements.

6. To assist WHO/AFRO with the extra staff workload associated with the CCCD activities, the grant agreements will provide a fixed percentage overhead amount and funding for supplementary contract personnel services.

7. The FY 1984 indicative planning levels for the Intercountry Training $_________, and for the Health Information System $_________.

8. Reports: We are agreeable to WHO/AFRO using its own reports and arrangements for providing AID information on the status of each Intercountry project. WHO/AFRO's procedure on reports could be spelled out in the project proposals. Financial reporting requirements will be specified in the grant agreements. We will aim to keep the reporting burden to a minimum but it may be necessary from time to time to have supplementary information to respond to special Congressional interests.

9. AID will continue to draw upon the Centers for Disease Control, Atlanta (CDC) to provide much of the technical expertise AID requires for project planning and implementation particularly for bilateral activities. To enhance close working relationships and to facilitate day-to-day communications, AID has arranged to have a CDC officier assigned to Brazzaville to serve as a CCCD liaison with WHO/AFRO.

I believe the above points are consistent with the discussions at the September 26 meeting as reported to me by the Evaluation Team. There, of course, will be points that we missed or need clarification which we will want to work out as we proceed.

If the above are acceptable guidelines for our cooperation, we encourage WHO/AFRO to proceed as expeditiously as possible in preparing the specific proposals on Intercountry Training and Health Information. We can then review these together and discuss other areas for cooperation.

I would welcome a reply from you with your concurrence, observations and any questions on the above guidelines. We look forward to a promising cooperative relationship on the important problem of African childhood diseases.

Sincerely,

Assistant Administrator
Bureau for Africa

ANNEX B

OPERATIONAL RESEARCH

Under the PASA agreement, CDC is responsible for carrying out the operational research component. However, after initial discussions with AFR/RA and CDC, it was apparent that this segment of the project is still in its infancy and comprehensive, detailed implementing procedures had not yet been developed. Subsequent discussions pointed the following as some of the issues to be worked out in a Memorandum of Understanding:.

a. Prior USAID or American Embassy approval, and host country approval, if human research is involved, of all operational research proposals, including those to be carried out by CDC officials.

b. Research Review Committee review of Operational Research proposals not funded by bilateral agreements.

c. Formation of Research Review Committees, their location and approval of Committee members.

d. AFR/RA and CDC approval for operational research proposals in excess of $10,000.

e. AFR/RA and CDA approval of laboratory oriented proposals.

f. Responsibility for purchase of expendable and non-expendable material and supplies.

g. Use of proforma purchase orders or contracts for operational research proposals with specific clauses on: human research involved, limitations on the use of the results of the operational research proposals and how the results are to be used; payments associated with an operational research proposal tied to a deliverable product.

h. National Institute of Health policies on establishing Research Review Boards.