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Report to the Chairman, Subcommittee on International Operations and Human Rights, Committee on International Relations, House of Representatives

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FOREIGN ASSISTANCE

Contributions to Child Survival Are Significant, but Challenges Remain

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The Honorable Christopher H. Smith
Chairman, Subcommittee on International
Operations and Human Rights
Committee on International Relations
House of Representatives

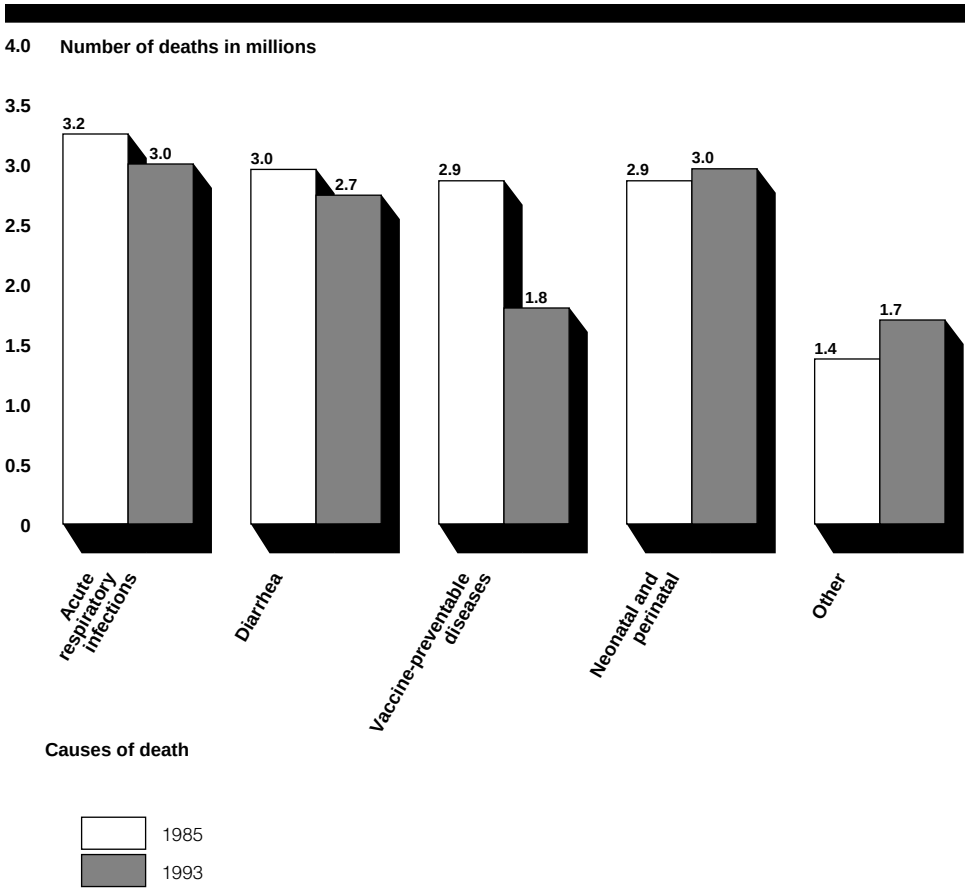
Dear Mr. Chairman:

In response to your request, we have reviewed the U.S. Agency for International Development's (USAID) child survival activities. You were concerned whether child survival funds were being used to fund activities other than those emphasized in the authorizing legislation. Specifically, we (1) assessed how child survival funds are being used and (2) identified USAID's child survival activities and accomplishments.

Background

According to a 1995 World Health Organization (WHO) report, the three major threats to the survival of children under age 5 in developing countries are diarrheal dehydration, acute respiratory infections (e.g., pneumonia), and vaccine-preventable diseases. WHO's 1995 report stated that 13.3 million children under age 5 died in developing countries in 1985 and that 12.2 million children under age 5 died in 1993. Figure 1 shows the causes of death for children under age 5 in developing countries, and figure 2 shows 1994 mortality rates for children under age 5 worldwide.

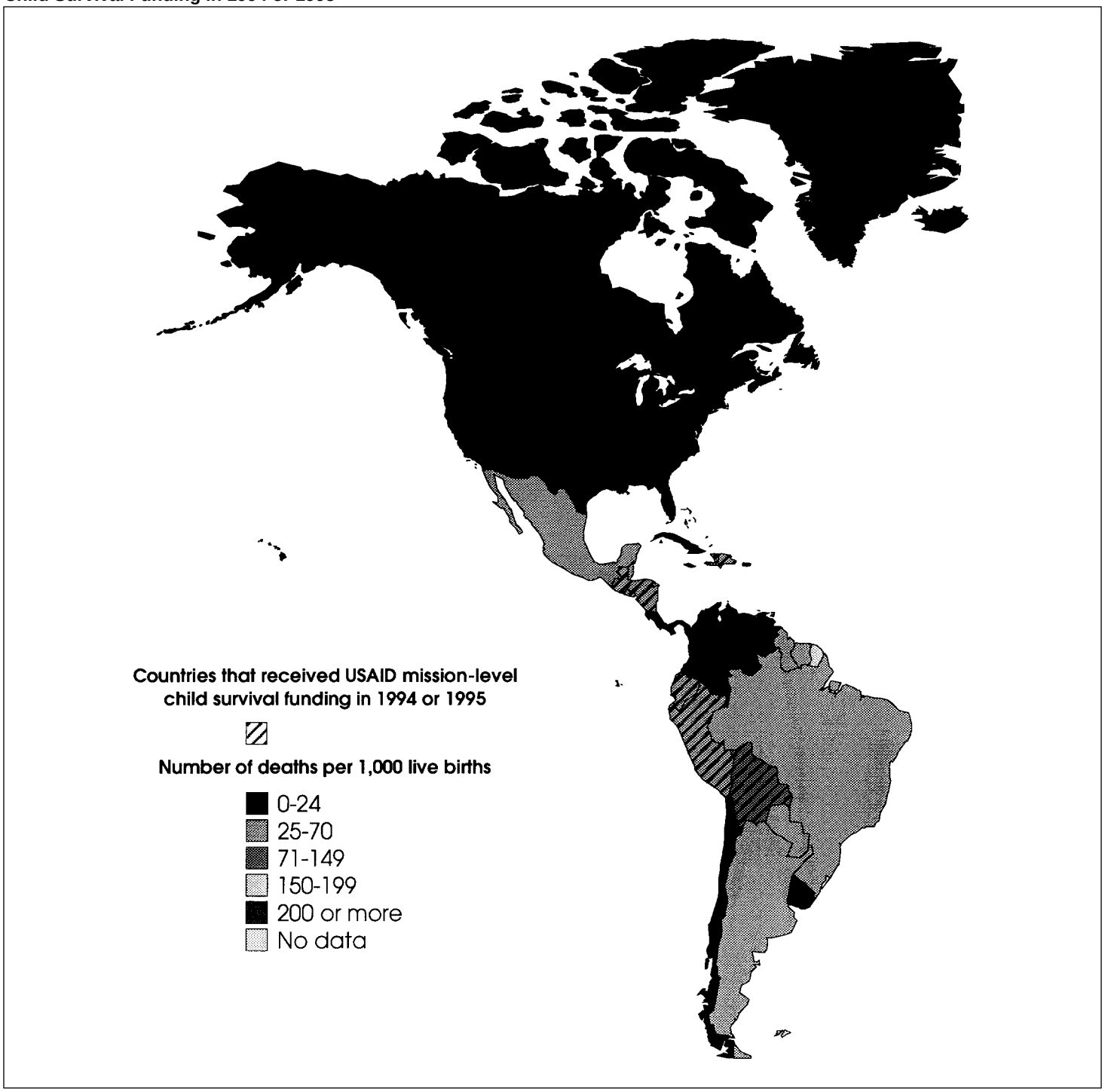
Figure 1: Causes of Death Among Children Under Age 5 in Developing Countries, 1985 and 1993

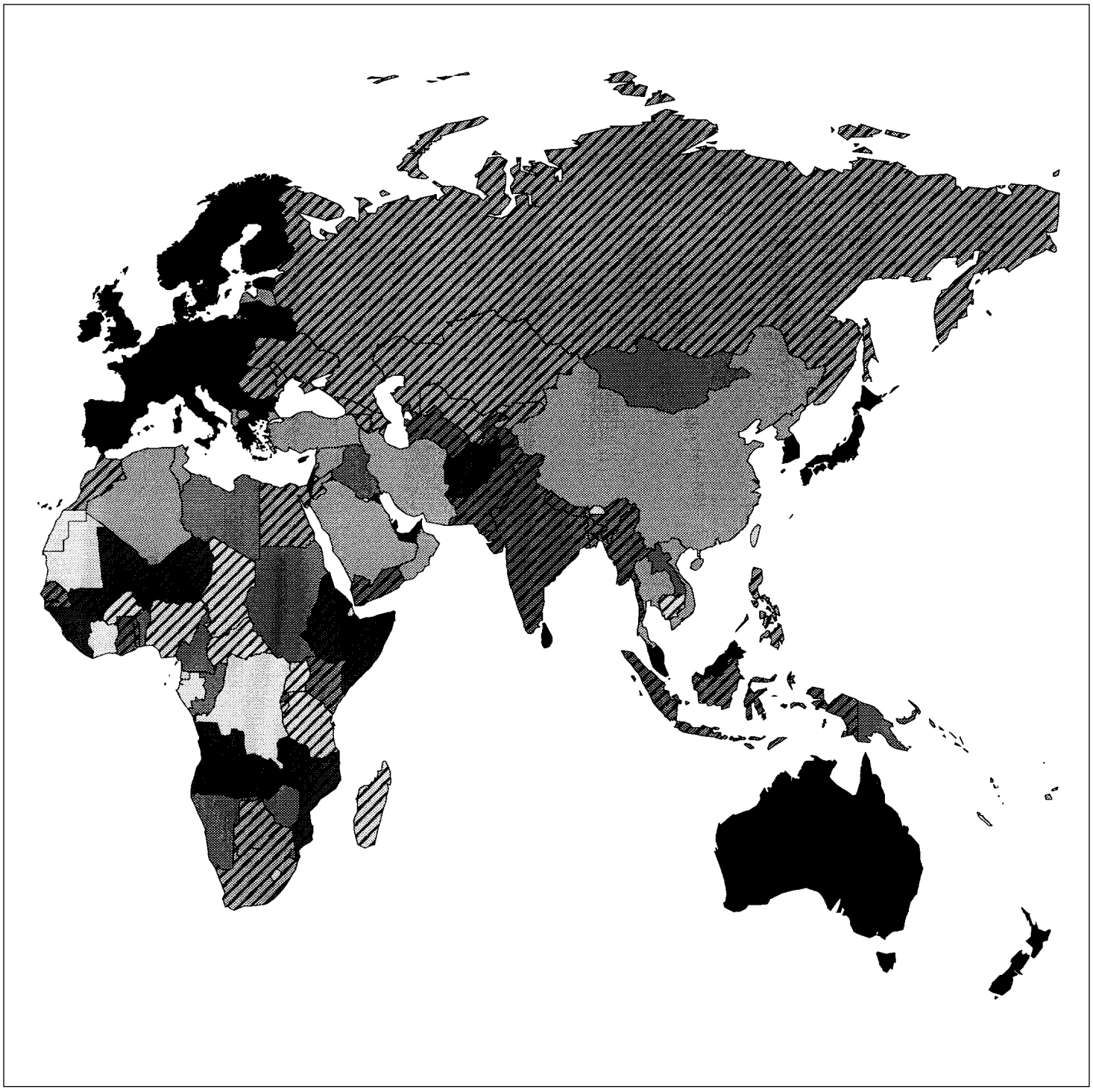


Note: Neonatal and perinatal causes include birth asphyxia, neonatal tetanus, congenital anomalies, birth trauma, prematurity, and neonatal sepsis and meningitis. Other causes include malaria, accidents, malnutrition, congenital syphilis, meningitis, human immunodeficiency virus (HIV)-related complications, and other causes.

Source: WHO.

Figure 2: Mortality Rates in 1994 for Children Under 5 Years of Age and Countries That Received USAID Mission-Level Child Survival Funding in 1994 or 1995





Source: U.N. Children's Fund (UNICEF) and USAID/Center for International Health Information.

Since 1954, USAID and its predecessor agencies have been involved in activities to improve child survival in the developing countries. Since the passage of Public Law 480 in 1954, U.S. food assistance has been provided to children and pregnant and lactating women. In the 1960s, USAID began building health clinics and funding research on treatments for diarrheal disease and the prevention of malaria. One of the specific objectives of the Foreign Assistance Act of 1961, the primary legislation governing U.S. foreign aid, was to reduce infant mortality.

In the 1970s, USAID began to focus on providing appropriate health interventions for common health problems in communities with the greatest needs. Activities related to child health included field studies on oral rehydration and vitamin A therapy and malaria research.

In 1984, Congress enacted legislation requiring a program designed to address child survival.[1] Section 104(c)(2)(A) of the act, as amended, provides in relevant part that:

"In carrying out the purposes of this subsection, the President shall promote, encourage, and undertake activities designed to deal directly with the special health needs of children and mothers. Such activities should utilize simple, available technologies which can significantly reduce childhood mortality, such as improved and expanded immunization programs, oral rehydration to combat diarrhoeal diseases, and education programs aimed at improving nutrition and sanitation and at promoting child spacing."

Because the statutory language is broad and emphasizes but does not limit USAID to the specified interventions, USAID has considerable latitude in developing child survival activities appropriate to the community being served.

In February 1985, in response to the authorizing legislation, some of USAID's ongoing child health efforts were consolidated into a child survival program. USAID provided mission-level child survival assistance to 31 countries in 1985, but it placed special emphasis on 22 countries that had especially high mortality rates. For each of these 22 countries, USAID developed a detailed child survival strategy, in cooperation with the host government, to deal with the country's specific needs and circumstances. USAID's policy was to sustain bilateral child survival funding in these countries for at least 3 to 5 years and provide technical support and training on a priority basis.

[1]Section 104(c)(2) of the Foreign Assistance Act, as amended, 22 U.S.C. 2151b(c)(2).

Over the years, the congressional appropriations committees have continued to emphasize the importance of the basic interventions mentioned in the authorizing statute, particularly immunizations and oral rehydration therapy. In some years, the committees have also directed USAID to support particular activities, including the promotion of breastfeeding, research and development of vaccines, and prevention of vitamin A and other micronutrient deficiencies through food fortification, tablets, and injections.

USAID's child survival program has evolved in the 1990s to where it no longer is a separate program, but is encompassed within USAID's sustainable development strategy as a component of its population, nutrition, and health sector. (See app. I for a more detailed description of USAID's current child survival objectives and approach.)

Results in Brief

Since 1985, USAID has classified obligations totaling over $2.3 billion for activities in at least 83 countries as child survival. However, due to the way Congress directs funding to child survival, particularly since 1992, and USAID's approach to tracking and accounting for such funds, it is not possible to determine precisely how much is actually being spent on child survival activities. Between 1985 and 1995, USAID reported that it spent about $1.6 billion, or 67 percent of the child survival funds, for four types of activities: immunizations, diarrheal disease control, nutrition, and health systems development. USAID also reported that about 41 percent of the total amount identified as child survival has been used to address the three major threats to children under age 5 in the developing countries: diarrheal dehydration, acute respiratory infections, and vaccine-preventable diseases.[2]

USAID has also included as child survival some of the funds it has spent on activities such as health care financing, health systems development, and vector control.[3] During our field visits, we also noted that part of the cost of rehabilitating a railroad bridge and constructing a water tower in Mozambique and carrying out urban sewerage projects in Egypt were identified as child survival expenditures. USAID said the projects in Mozambique were critical for reducing child mortality because they supported access to water, food, and health services.

[2]These diseases are related to activities emphasized in the 1984 authorizing legislation, which included immunizations, oral rehydration, and nutrition.

[3]Vector control involves controlling organisms, such as insects, that transmit diseases.

USAID and other donors have made important contributions toward improving child mortality rates in many countries. In 9 of the 10 countries receiving the most USAID mission-level child survival assistance since 1985, mortality rates for children age 5 and under have dropped. In addition, 5 of these 10 countries achieved mortality rates by 1994 of 70 or fewer deaths per 1,000 live births—a goal set for the year 2000 at the World Summit for Children.[4] Both USAID and independent evaluations have pointed out successes, such as collaboration with other donors to immunize children and promote oral rehydration therapy in the treatment of diarrheal disease. In the four countries we visited—Bolivia, Guatemala, Egypt, and Mozambique—USAID provided child survival assistance for some activities that directly benefited children.

In fiscal year 1995, USAID's child survival funding was used in 17 countries that had an under-5 mortality rate of 70 or fewer deaths per 1,000 live births. USAID mission-level funding for child survival in these countries was $89.5 million, or 31 percent of the total child survival funding obligated in that year. On the other hand, many countries that were far from achieving the goal, such as those in sub-Saharan Africa, did not receive assistance for child survival. According to USAID, most of these countries did not receive assistance because USAID did not have a program in the country, had closed out assistance, or was in the process of closing out assistance due to budgetary or legal reasons or because sustainable development programs were not considered feasible. USAID has continued child survival activities in countries that have achieved better than average under-5 mortality rates because some of these countries still have pockets of populations with severe problems. Additionally, according to USAID, some countries that have improved their mortality rates need continued support to sustain the levels achieved.

How Child Survival Funds Are Used

Between fiscal years 1985 and 1995, USAID reported that it obligated over $2.3 billion for the child survival program. Child survival projects and other activities attributed to child survival may be funded through USAID's overseas missions directly or through its four regional bureaus or its central bureaus (see table 1).[5]

[4]The goal was stated as a reduction of 1990 under-5 mortality rates by one-third or to a level of 70 deaths per 1,000 live births, whichever is greater.

[5]Central bureaus is an informal term used to distinguish some USAID headquarters bureaus from the regional (geographic) bureaus that are responsible for USAID missions. Primarily, the central bureaus that fund child survival activities are (1) the Bureau for Humanitarian Response and (2) the Bureau for Global Programs, Field Support, and Research. (Other central bureaus include the Bureau for Policy and Program Coordination and the Bureau for Management.)

Table 1: Obligations for USAID Child Survival Activities Through Central Programs and by Geographic Region, Fiscal Years 1985-95

Dollars in thousands

Fiscal year	Central programs	Africa	Asia and the Near East	Europe and the New Independent States	Latin America and the Caribbean	Total
1985	$44,695	$27,242	$27,287	0	$33,009	**$132,233**
1986	30,452	30,203	56,181	0	38,774	**155,610**
1987	39,655	36,650	59,586	0	48,579	**184,470**
1988	42,795	36,347	39,148	0	54,329	**172,619**
1989	42,228	67,548	52,477	0	41,095	**203,348**
1990	47,840	45,379	44,746	$2,311	45,311	**185,587**
1991	59,574	57,342	67,424	3,549	63,237	**251,126**
1992	98,639	60,220	45,723	6,704	61,162	**272,448**
1993	102,995	61,931	54,107	12,285	60,087	**291,405**
1994	94,010	48,973	39,578	19,378	41,204	**243,143**
1995	107,104	58,234	47,818	44,227[a]	28,431	**285,815**
Total	**$709,987**	**$530,069**	**$534,075**	**$88,454**	**$515,218**	**$2,377,804**

Note: Numbers may not add due to rounding.

[a]USAID officials said that fiscal year 1995 data available from the Bureau for Europe and the New Independent States were not final, as of August 1996, and therefore may not be accurate.

Source: USAID/Center for International Health Information.

The number of countries receiving mission-level child survival assistance in a single fiscal year increased from 31 in 1985 to about 43 in 1995. During this 11-year period, USAID provided mission-level assistance on a continuing basis for some countries, such as Egypt, whereas other countries received funding in only 1 year. A total of 83 developing countries received some mission-level child survival funding during this period. The amounts ranged from $9,000 for Oman to $137 million for Egypt. As shown in table 2, of the 10 countries that have received the most child survival assistance from USAID missions, 5 were in the Latin America and Caribbean region, 4 were in the Asia and Near East region, and 1 was in the Africa region.

Table 2: Ten Countries Receiving the Most USAID Mission-Level Assistance Attributed to Child Survival and Their Mortality Rates for Children Under Age 5

Dollars in thousands

		Funding		Under-5 mortality rate[a]	
Country	**Region**	**FY 1985-95**	**FY 1995**	**1980**	**1994**
Egypt	Asia/Near East	$136,860	$27,001	180	52
El Salvador	Latin America/ Caribbean	81,230	2,587	120	56
Haiti	Latin America/ Caribbean	78,440	10,887	195	127
India	Asia/Near East	68,772	900	177	119
Mozambique	Africa	62,494	9,793	269	277
Bolivia	Latin America/ Caribbean	60,566	3,264	170	110
Philippines	Asia/Near East	58,194	0	70	57
Honduras	Latin America/ Caribbean	53,550	2,201	100	54
Peru	Latin America/ Caribbean	50,443	1,388	130	58
Bangladesh	Asia/Near East	48,001	2	211	117

[a]The mortality rate represents the number of deaths per 1,000 live births.

Source: USAID/Center for International Health Information and UNICEF.

USAID Supports Activities Through Many Organizations

USAID provides funding to other organizations to implement health and population services. USAID guidance states that U.S. assistance must help build the capacity to develop and sustain host country political commitment to health and population programs, as well as enhance the ability of local organizations to define policies and design and manage their own programs. USAID's policy is to involve both the public and private sectors and give special attention to building, supporting, and empowering nongovernmental organizations (NGO) wherever feasible.

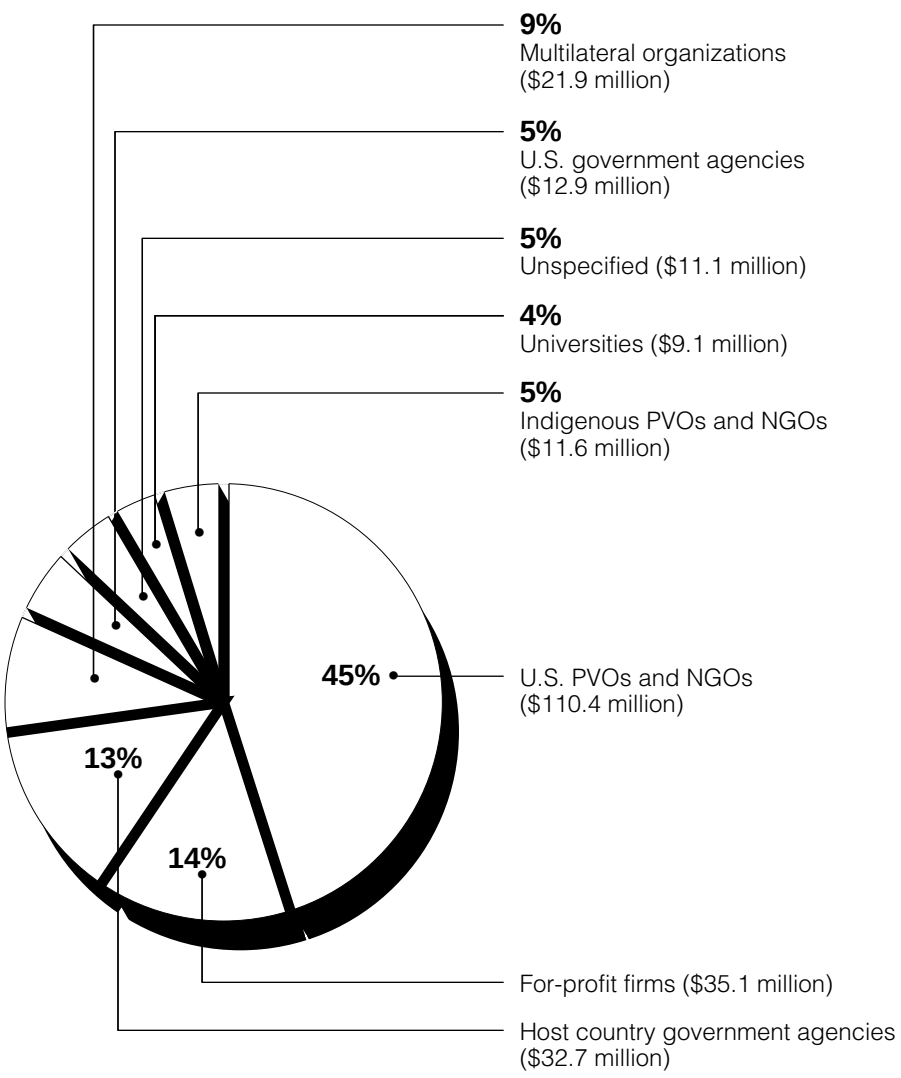
USAID-supported child survival activities involve U.S. and foreign not-for-profit NGOs, including private voluntary organizations (PVO); universities; for-profit contractors; multilateral organizations; and U.S. and foreign government agencies. Figure 3 shows that U.S. NGOs received about 45 percent of fiscal year 1994 child survival funding.[6] At least 35 U.S. PVOs and 22 other U.S. NGOs participated in USAID's child survival programs

[6]This special analysis was performed by USAID with fiscal year 1994 data. Data for other fiscal years were not readily available.

during that year as primary grantees.[7] For-profit businesses and host country governments together accounted for another one-quarter of the funding. The remainder went to multilateral organizations, such as UNICEF; U.S. government agencies, including the Centers for Disease Control and Prevention; and indigenous NGOs.

[7]Because some primary grantees and contractors may have awarded subgrants or subcontracts to other organizations, a complete count of organizations involved was not readily available. In addition, the data included only organizations that received funding obligations in 1994, excluding any organizations with ongoing USAID programs that received funding in previous years but did not receive any in 1994.

Figure 3: Types of Organizations That Received USAID Child Survival Funds, Fiscal Year 1994



Note: The total of these obligations does not correspond to those in table 1 because the data used to develop this chart came from a different source. However, the difference is not material (less than 1 percent).

Source: USAID.

USAID generally uses the different types of organizations for different purposes or for implementing different types of activities. No one single group or organization typically performs the full range of activities that the agency sponsors. For example, in all the countries we visited, PVOs were involved at the community level with direct delivery of some of the basic health interventions. In Guatemala, a for-profit contractor provided technical assistance for the computer hardware and software programs that USAID installed in the Ministry of Health to computerize its health data.

Funding Supports Different Types of Activities

Between 1985 and 1995, activities related to the three major causes of death among young children—acute respiratory infections, diarrheal diseases, and vaccine-preventable diseases—received about $972 million, or 41 percent of the child survival funds. Table 3 shows funding levels attributed to child survival by type of activity from 1985 to 1995.

Table 3: USAID Funding by Type of Child Survival Activity, Fiscal Years 1985-95

Dollars in thousands

Activity	1985	1986	1987
Immunization	$30,313	$50,370	$50,898
Nutrition[a]	27,534	22,261	26,319
Diarrheal disease control/oral rehydration therapy	38,060	34,769	45,200
Health systems development	N/A	N/A	N/A
Child spacing/high-risk births	6,346	7,540	10,001
Water quality/health	N/A	N/A	N/A
Acute respiratory infections	N/A	N/A	N/A
Maternal health[b]	N/A	N/A	N/A
Malaria	N/A	N/A	N/A
Health care financing	N/A	N/A	N/A
Orphans and displaced children	N/A	N/A	N/A
Vector control and tropical diseases	N/A	N/A	N/A
Environmental health	N/A	N/A	N/A
Other	29,980	40,670	52,052
Total	**$132,233**	**$155,610**	**$184,470**

1988	1989	1990	1991	1992	1993	1994	1995	Total
$38,495	$44,017	$32,184	$37,785	$51,752	$67,378	$58,903	$36,236	**$498,331**
25,542	31,386	29,192	51,041	51,692	52,284	43,903	80,684	**441,838**
37,469	42,996	29,653	31,904	39,053	38,252	26,037	26,855	**390,248**
N/A	22,293	21,600	41,393	58,170	46,085	40,406	26,967	**256,914**
16,144	13,567	11,475	17,092	13,135	21,412	17,259	15,154	**149,125**
N/A	10,289	10,119	10,547	14,593	12,260	15,293	11,059	**84,160**
N/A	5,907	5,990	9,582	14,058	15,096	14,868	18,391	**83,892**
N/A	4,889	9,317	10,178	8,197	8,685	6,766	18,338	**66,370**
N/A	5,530	6,746	9,812	9,395	11,946	8,456	10,877	**62,762**
N/A	N/A	6,332	9,970	8,139	5,892	6,215	12,474	**49,022**
N/A	N/A	N/A	N/A	3,429	9,874	2,844	19,025	**35,172**
N/A	1,124	1,733	2,353	835	2,241	2,193	6,681	**17,160**
N/A	N/A	N/A	N/A	N/A	N/A	N/A	3,075	**3,075**
54,969	21,350	21,246	19,469	N/A	N/A	N/A	N/A	**239,736**
$172,619	**$203,348**	**$185,587**	**$251,126**	**$272,448**	**$291,405**	**$243,143**	**$285,815**	**$2,377,804**

Note: N/A indicates an activity category that was not specified in USAID coding procedures during that year. Before 1989, many of the activities that were not listed as separate categories were included in the "other" category. Numbers may not add due to rounding.

[a]Nutrition is further broken out into the following activity areas: micronutrients; vitamin A; breastfeeding; growth monitoring and weaning foods; nutrition management, planning, and policy; and other nutrition.

[b]Before 1989, maternal health activities were supported under the high-risk birth category.

Source: USAID/Center for International Health Information.

Identifying Amounts Used Specifically for Child Survival Is Difficult

USAID is unable to determine with any degree of precision how much funding is actually being used for child survival activities because (1) of the way Congress has directed funding; (2) USAID guidance allows considerable flexibility and variation in attributing child survival funds; (3) the amounts reported are based on estimated percentages of projected budgets, which sometimes are not adjusted at the end of the year to reflect any changes that may have occurred; and (4) the amounts reported are not directly based on specific project expenditures. USAID plans a new information management system that may improve the precision of the data for its child survival activities.

From fiscal year 1985, when the child survival program officially began, through fiscal year 1995, appropriations statutes have mandated spending of at least $1.8 billion for child survival activities. From fiscal years 1985 to 1991, funds appropriated by Congress for child survival went into a separate functional account under USAID's development assistance account. Additionally, for several years prior to fiscal year 1992, the appropriations laws not only earmarked money for child survival, but the appropriations committees' reports also expressed the intention that other accounts within the development assistance account should provide substantially more money for child survival activities. Beginning in fiscal year 1992, the functional account was eliminated and subsequent laws appropriating moneys to USAID contained an earmark for child survival activities that could be drawn from any USAID assistance account. Since 1991, Congress has substantially increased the level of funds designated for child survival through earmarks (from $100 million in direct appropriations in fiscal year 1991 to $250 million in fiscal year 1992).

USAID issued guidance in 1992 and 1996 about the types of activities that were allowed to be attributed to child survival. Additionally, the agency's budget office issues annual instructions for reporting on project activities. These instructions name types of activities that may be attributed to child survival and give broad discretion to USAID officials to determine the percentage of funding that can be reported as child survival. However, the instructions do not provide specific indicators for determining attribution, such as the percent of children in the population served for water projects. Moreover, some mission officials responsible for recording project activities told us that the guidance for making attributions was not clear to them.

In our discussions with USAID officials, we found that the process of attributing funds to child survival activities was imprecise and that mistakes occurred. As a result, the percentage of funds designated as child survival varied widely for similar activities. For example, USAID used child survival funds for the construction of water systems in all four countries we visited. USAID guidance suggested 30 percent of the total budget of water and sewerage projects as an appropriate level to attribute to child survival, but child survival funds comprised from 3 to 100 percent of the funding for some of these projects.

According to an official at the USAID mission in Egypt, the mission has a policy of attributing 3 percent of sewerage projects and 6 percent of water projects to child survival. In contrast, the Health Sector II project in

Honduras attributed 70 percent of the $16.9 million water and sanitation component to child survival. According to a mission official, the justification for this level of attribution was that children under age 5 comprised approximately 70 percent of the deaths due to water-borne diseases in rural areas. Another activity funded by this project was the construction of area warehouses. About $72,000, which was 26 percent of the cost, was attributed to child survival. The justification USAID provided for this attribution was that these warehouses, which were used to store medical supplies, have contributed to the decline in the infant mortality rate in Honduras.

The funding amounts reported as child survival are based on estimated percentages of total project obligations for types of child survival activities carried out under individual projects. These estimates are made by project or budget officers and are supposed to be based on a knowledge of project plans and activities. However, mission officials told us that they generally did not change the activity assignments or percentages, even though changes in available funding or project plans may occur during the year. For example, $800,000 in child survival funding was attributed to a basic education project in Ethiopia in 1994. A mission official told us that the child survival activity did not actually take place, but the reports provided to us by USAID included child survival funding for this project.

USAID reports on funds attributed to child survival and other activities are not based on expenditures. USAID stated that its activity reporting system was never intended to track expenditures for programs and that Congress was aware that reported funding represented estimates of obligations. However, according to USAID officials, a new information system is underway that will link budgets, obligations, and expenditures and enable the agency to track funds more accurately.

USAID officials said that the new system would be able to link some child survival assistance with actual expenditures in cases in which a distinct child survival activity has been defined. However, in other cases, reported funding will continue to be based on the project manager's estimate of the percentage of funding attributable to child survival. USAID began implementing the new system in July 1996 for all new commitments made at headquarters, and it plans to extend the system to the overseas missions by October 1996.

USAID's Contribution to Child Survival

USAID has made significant contributions, in collaboration with other donors, in reducing under-5 mortality rates. Among the 10 countries receiving the most USAID mission-level child survival assistance, all but one improved their under-5 mortality rate between 1980 and 1994. Five countries achieved the World Summit goal of 70 or fewer deaths per 1,000 live births. The number of deaths from the three major causes of under-5 mortality declined during this time, but the largest decrease was for vaccine-preventable diseases.

USAID can claim some far-reaching accomplishments in immunizations. Between 1985 and 1994, 26 of the 59 countries that received some mission-level assistance specifically for immunization activities achieved USAID's goal of 80-percent immunization rates.[8] Through collaboration with the Pan American Health Organization (PAHO), UNICEF, Rotary International, other international organizations, and the individual countries, USAID helped to bring about the eradication of poliomyelitis in the Americas. USAID's Children's Vaccine Initiative project supports a revolving fund, called the Vaccine Independence Initiative, that is managed by PAHO and UNICEF. This fund, which received $3.8 million of child survival funding between 1992 and 1995, is used to help developing countries purchase vaccines.

One of USAID's most important accomplishments in diarrheal disease control occurred before 1985 with the discovery that oral rehydration salts could be used to treat the dehydration that occurs with diarrheal diseases and causes death. USAID has also had positive results in efforts to increase usage of oral rehydration therapy, although only four countries where USAID has provided mission-level child survival assistance have usage rates above 80 percent.[9]

USAID's recent diarrheal disease control efforts have been aimed at promoting sustainability by transferring technology to developing countries so that they can manufacture the salts. USAID has also contributed to research on the importance of vitamin A supplementation and efforts to incorporate vitamin A into local food supplies around the world.

[8]The immunization goal applies to the third dose of diphtheria, pertussis, and tetanus.

[9]The Interagency Coordinating Committee, which was created to work on the World Summit goals and includes USAID, PAHO, UNICEF, and other international agencies, agreed to a goal of 80 percent for the use of oral rehydration therapy in cases of diarrhea in children under 5. However, USAID stated in its 1991 Child Survival Report to Congress that the goal was for 45 percent of diarrheal episodes to be treated with oral rehydration therapy.

USAID's Center for Development Information and Evaluation (CDIE) concluded in a 1993 report that USAID's child survival activities had achieved many successes and made a significant contribution in expanding child survival services and reducing infant mortality in many countries.[10] The CDIE report cited the importance of USAID's role in vaccinations and stated that the agency had supported other major donors, such as UNICEF, through coordination and the provision of needed resources. Another evaluation conducted independently by RESULTS Educational Fund and the Bread for the World Institute concluded in a January 1995 report that USAID's child survival activities had made an important contribution to reducing deaths among children under age 5 in countries receiving USAID assistance.[11]

In the four countries we visited, USAID's contributions through child survival activities were evident. For example, in Mozambique, USAID supports PVOs that provide child survival services and other types of humanitarian and development assistance. We visited several sites where World Vision Relief and Development was implementing a child survival project. Among the activities we observed were vaccinations for children under age 3, monitoring of children's growth, prenatal examinations, and the construction of latrines.

In Bolivia, PROSALUD health clinics we visited offered general medical services; childbirth and pediatric care; immunizations; family planning; and dental, pharmacy, and laboratory services. PROSALUD is a Bolivian private, nonprofit organization initiated and operated with USAID child survival funds. Between 1991 and 1996, USAID provided the PROSALUD project with $6.5 million, of which $6.2 million, or 95 percent, was attributed to child survival. The 26 PROSALUD clinics and its hospital charge small user fees that enable the organization to partially self-finance its operations.

We also visited Andean Rural Health Care, a U.S. PVO that provides community health care in Bolivia through clinics and volunteers. The volunteers are trained at the health centers on how to make home visits to

[10]CDIE conducted evaluations of child survival activities between 1989 and 1993 in six countries: Indonesia, Morocco, Haiti, Bolivia, Egypt, and Malawi. These countries were selected for evaluation because they represented 27 percent of the countries that received special emphasis on child survival, including sustained funding. Also, they were considered representative of the range of agency experience with regard to regions, approaches, program sizes, and country conditions.

[11]RESULTS Educational Fund and the Bread for the World Institute are educational and research organizations that focus on hunger and poverty issues, including the provision of low-cost health care measures in developing countries. They do not receive funds from USAID. Their January 1995 report, Putting Children First, was based on a review of 1991 USAID activities.

(1) provide families with oral rehydration salts, (2) treat diarrheal diseases and acute respiratory infections, (3) promote vaccinations by health center staff, and (4) monitor the growth and health of family members (see fig. 4).

Figure 4: An Andean Rural Health Care Volunteer in Bolivia Weighing an Infant During a Home Visit

In Guatemala, we visited a clinic operated by APROFAM, which is a private, nonprofit organization that provides family planning services as well as selected maternal-child health services, such as pre- and postnatal care, child growth monitoring, and oral rehydration therapy. Under the current USAID grant, APROFAM received about $2.5 million in child survival funding, representing 15 percent of its total USAID funds. We also visited a pharmaceutical plant in Guatemala where USAID provided equipment and technical assistance to manufacture packets of oral rehydration salts used in the treatment of diarrheal disease dehydration (see fig. 5). The packets are to be distributed through Ministry of Health facilities. This plant was a component of USAID's $20 million child survival project started in 1985 to assist the Ministry of Health.

Figure 5: USAID-Funded Equipment at a Plant That Manufactures Oral Rehydration Salts in Guatemala

In Egypt, we visited urban and rural health clinics that administered vaccinations and oral rehydration therapy and had laboratories that were equipped to perform medical tests. According to USAID officials, these health clinics also provided treatment for acute respiratory infections and family planning activities.

Additional Activities Address Child Survival Objectives

For fiscal years 1993-95, USAID reportedly spent about $478.9 million, or 58 percent of child survival funding, on interventions that directly address the causes of death of children under the age of 5—immunizations, diarrheal disease control, nutrition, and acute respiratory infections. However, the amounts used for immunizations and diarrheal disease control were less in 1994 and 1995 than they had been in 1993. During the same period, USAID spent about $341.5 million on such areas as health systems development, health care financing, water quality, and environmental health (a new area).

In Mozambique, USAID attributed child survival funds for the construction of a water supply system in Chimoio by the Adventist Development and Relief Agency to serve as many as 25,000 residents (see fig. 6). About $2.5 million, or 40 percent, of the project's almost $6.2 million cost was attributed to child survival. USAID described this project as an exception where such infrastructure activities would be appropriately attributed to child survival.

Figure 6: Water Tower in Mozambique That Was Partially Funded as Child Survival

Since 1992, the USAID mission in Egypt has designated as child survival about $6.5 million for water and wastewater infrastructure development.[12] Egypt's sewerage projects include the design, construction, and operation

[12]USAID has provided over $2 billion for water and wastewater projects in Egypt since 1975.

of wastewater treatment plants and systems, and water projects include the construction of water treatment plants, which provide potable water to urban areas.

The 1993 USAID/CDIE report recommended that water infrastructure projects not be funded as child survival because child survival resources were not considered adequate to construct enough water systems to have a measurable impact on national health indicators. The report also stated that the results of other child survival interventions appear to be greater than the results obtained from investing in water and sanitation and that oral rehydration therapy and interventions related to acute respiratory infections should be given higher priority.

In Mozambique, reconstruction of a railroad bridge crossing the Zambezi River between Sena and Mutarara was considered child survival (see fig. 7). The goal of this project was to rehabilitate roads so that land movement of food and other relief assistance, the return of displaced persons and refugees, and drought recovery activities could occur. The railroad bridge was modified to accommodate vehicles and pedestrian traffic. Of the project's $10.8 million budget, $1.9 million was attributed to child survival as nutrition in 1993 and 1994.

Figure 7: Railroad Bridge in Mozambique That Was Repaired With Child Survival Funding

Although the railroad bridge in Mozambique was considered a nutrition intervention, other infrastructure projects that have used child survival funding were classified as water quality/health, health systems development, and health care financing. Between 1993 and 1995, USAID attributed about $38.6 million in child survival funds to water quality/health, $113.5 million to health systems development, and $24.6 million to health care financing. Examples of activities related to health systems development include the construction of warehouses for government medical supplies in Honduras. An example of a health care financing activity in Bolivia is PROSALUD, which USAID established to be a self-financing health care provider.

USAID attributed $30 million of the international disaster assistance funds to child survival in fiscal year 1995. The projects that USAID's budget office counted as child survival included activities that benefited children, such as health and winterization activities in the former Yugoslavia, a water drilling program in northern Iraq, an emergency medical and nutrition project for displaced persons in Sudan, the purchase of four water purification/chlorination systems in Djibouti, and community health care in two regions of Somalia. Additionally, the conference report accompanying the fiscal year 1996 foreign operations appropriations act authorized USAID to attribute $30 million of disaster assistance funding to child survival.

USAID Does Not Assist Some Countries With Severe Child Survival Problems

USAID's guidance states that child survival assistance will be provided to countries with mortality rates for children under age 5 at or above 150 per 1,000 live births. However, USAID does not provide assistance to some of the 30 countries with the most serious under-5 mortality problems. For example, many countries in sub-Saharan Africa, which have the most serious child survival problems, do not receive USAID child survival assistance for mission-level projects. According to USAID, the agency does not have a mission in these countries, had closed out assistance, or was in the process of closing out assistance because of budgetary or legal reasons or because sustainable development programs were not considered feasible. (See app. II for details regarding under-5 mortality rates and amounts of USAID mission-level assistance for developing countries.)

On the other hand, USAID attributes mission-level child survival funds to activities in 17 countries that have a mortality rate of 70 or fewer deaths per 1,000 live births. In fiscal year 1995, USAID used about $89.5 million of child survival funding for activities in these 17 countries. Among these

countries were several in the former Soviet Union, including Georgia, which had an under-5 mortality rate of 27 per 1,000 live births. By contrast, in fiscal year 1995, USAID used $53.4 million of child survival funding in 15 of the 30 countries that had the most serious problems with under-5 mortality—rates above 150 per 1,000 live births.

In 1995, Egypt continued to have the largest share of mission-level assistance attributed to child survival ($27 million), as it has over the last decade.[13] UNICEF reported Egypt's under-5 mortality rate in 1994 as 52; however, USAID indicated that its most recent data showed that the rate was 80.6.

Agency Comments and Our Evaluation

In commenting on a draft of this report, USAID indicated that it focused its child survival efforts in countries with high rates of under-5 mortality and other factors that indicated a great need for assistance. USAID stated that (1) national mortality rates are averages that often mask pockets of high child mortality, (2) the achievement of a target mortality rate is not a reason to stop support of efforts because gains need to be sustainable, and (3) child survival programs are not in some of the most needy countries because of legal, budgetary, and sustainability reasons.

USAID issued new guidance in April 1996 that indicates that infrastructure is not generally considered to be an appropriate use of child survival funds. USAID stated that the infrastructure cases we cited, all of which began before April 1996, were isolated examples. USAID further stated that the bridge rehabilitation and water works construction projects in Mozambique were needed to reduce child mortality after the civil turmoil in that country.

USAID also commented that its current financial reporting system was never intended to be used to track any program area on an expenditure basis. USAID indicated that a new information management system that is being implemented has been designed to track funding for each activity by linking budgets, obligations, procurements, and expenditures.

After reviewing USAID's comments, we have deleted the recommendations that we presented in our draft report. In its comments and subsequent discussions, USAID provided us with sufficiently detailed information to adequately explain the reasons why some countries with very severe child

[13]Egypt receives Economic Support Funds related to the Camp David Accords. These funds have been used for child survival as well as other projects related to different agency objectives.

mortality problems do not receive direct U.S. aid and others with lower mortality rates do. USAID's new operating procedures have the potential to address, for the most part, how its child survival activities will be linked to USAID's objectives and how its project activities will be measured. Our concern that USAID's new information management system provide accurate obligation and expenditure data is being addressed by USAID. We are still concerned, however, about the clarity of the guidance provided to USAID's activity managers for determining the percentage of funding and expenditures attributable to child survival when a broader activity contributes to USAID's child survival objectives. We are, however, making no specific recommendations in these areas.

USAID also provided clarifications and corrections to the draft, and we have incorporated these changes where appropriate. USAID's comments are in appendix III.

Scope and Methodology

To understand the extent, nature, and progress of USAID's child survival activities, we reviewed the authorizing and appropriations legislation for 1985-95 and the accompanying committee reports and selected USAID project documents, including planning and program implementation documents, internal and external project evaluations, funding reports, health activity reports, and project files. We also held extensive discussions with officials from USAID, WHO, PAHO, UNICEF, USAID contractors, PVOs, and host governments and program beneficiaries. We visited USAID missions in Bolivia, Egypt, Guatemala, and Mozambique to directly observe the nature of USAID's child survival activities being implemented in the field. We selected these countries because they received significant child survival funding, had various types of child survival projects, and provided regional differences. During our fieldwork, we analyzed data for most of the USAID missions' ongoing projects and visited 63 project sites. In addition to the fieldwork, we also talked with USAID project officers in two other countries.

We analyzed USAID strategic objectives, program goals, and funding documentation to determine the linkage between funds attributed to child survival and USAID's child survival objectives. We analyzed the most recent data on USAID funding attributed to child survival for 1985-95, which we obtained from the contractor that operates USAID's Center for International Health Information. At the time of our review, obligation data for fiscal year 1995 were not fully validated; therefore, some of the fiscal year 1995 obligation data are subject to change. According to USAID officials, the 1995

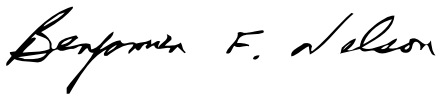
data had to be recoded, and the process was not completed by August 1996.

We conducted our review between May 1995 and August 1996 in accordance with generally accepted government auditing standards.

As arranged with your office, unless you publicly announce its contents earlier, we plan no distribution of this report until 30 days after the date of this letter. We will then send copies of this report to the Administrator, USAID; the Director, Office of Management and Budget; the Secretary of State; and other interested congressional committees. We will also make copies available to others on request.

Please contact me at (202) 512-4128 if you or your staff have any questions concerning this report. Major contributors to this report are listed in appendix IV.

Sincerely yours,



Benjamin F. Nelson
Director, International Relations
and Trade Issues

Contents

Figures

Abbreviations

AIDS	acquired immune deficiency syndrome
CDIE	Center for Development Information and Evaluation
HIV	human immunodeficiency virus
NGO	nongovernmental organization
PAHO	Pan American Health Organization
PVO	private voluntary organization
UNICEF	U.N. Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

Child Survival Objectives and Program Guidance

Objectives

In February 1985, in response to the legislation authorizing child survival activities, the U.S. Agency for International Development (USAID) established the child survival program to consolidate some of the agency's ongoing efforts related to reducing deaths among children in developing countries. Although USAID provided mission-level child survival assistance to 31 countries in 1985, it placed special emphasis on 22 countries that had especially high mortality rates.

The child survival program for these 22 countries was originally guided by USAID's Child Survival Task Force. This task force helped to develop a detailed child survival strategy for each country, in cooperation with the host government, to deal with the country's specific needs and circumstances.

USAID's policy was to sustain mission-level child survival funding in these countries for at least 3 to 5 years and provide technical support and training on a priority basis. Special attention was also to be given to program monitoring and evaluation and coordination with private voluntary organizations (PVO), international organizations, and other U.S. agencies.

From 1985 to 1991, child survival appropriations went into a functional account for child survival set up under an overall development assistance account. Beginning in fiscal year 1992, Congress designated a specific amount for child survival, which could be drawn from any USAID appropriation. In the 1990s, child survival was incorporated into USAID's broad strategy for development assistance. According to the agency's 1995 Guidelines for Strategic Plans, USAID's current emphasis is on sustainable and participatory development, partnerships, and the use of integrated approaches.[1]

The agency's five goals are to encourage broad-based economic growth, build democracy, stabilize world population and protect human health, protect the environment, and provide humanitarian assistance.

USAID's population, health, and nutrition sector has priority objectives in four areas: family planning, child survival, maternal health, and reducing sexually transmitted diseases and human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS).

[1]These guidelines, also known as implementation guidelines, are supplementary references to the 1994 Strategies for Sustainable Development to help shape the development of or revisions to unit strategic plans.

Agency guidelines indicate that the core of the sector is family planning but that balanced strategies are encouraged. USAID's guidance on child survival states that activities are to focus on the principal causes of death and severe lifelong disabilities, and programmatic emphasis should be on children under the age of 3. Further, the guidance states that child survival service delivery is to be focused on the community; the primary health care system; and, to a limited extent, the first-level hospitals. Emphasis is to be on enabling caretakers to take effective action on behalf of their children's well-being and ensuring gender equity in children's access to preventive and curative health. Although USAID considers health and population services to be important, the agency does not provide them directly; instead, it tries to improve the capacity, infrastructure, systems, and policies that support these services in a sustainable way.

In its 1994 Strategies for Sustainable Development,[2] USAID stated that the agency's population and health programs would concentrate on countries that contribute the most to global population and health problems[3] and have population and health conditions that impede sustainable development.[4] Agency guidance states that any of the following key factors indicate the need to consider developing strategic objectives that address family planning, child survival, maternal health, and reduction of sexually transmitted diseases and HIV/AIDS:

- annual total gross domestic product growth less than 2 percent higher than annual population growth over the past 10 years,
- unmet need for contraception at or above 25 percent of married women of childbearing age,
- total fertility rate above 3.5 children per woman,
- mortality rate for children under age 5 at or above 150 per 1,000 live births,
- stunting in at least 25 percent of children under age 5,[5]
- maternal mortality rate at or above 200 deaths per 100,000 live births, and

[2]This document provides USAID's vision for achieving sustainable development and explains its goals and objectives.

[3]According to the guidance, these countries have large numbers of very young and older women bearing children; many closely spaced births; high numbers of infant, child, and maternal deaths; high female illiteracy; large numbers of women with an articulated but unmet need for family planning services; and large numbers of persons infected with HIV or increasing rates of HIV infection.

[4]These countries have fertility and population growth rates that outstrip the country's ability to provide adequate food and social services, growth rates that threaten the environment, significant reproductive health problems due to heavy reliance on unsafe abortions, health conditions that impede the ability of children to learn and the ability of adults to produce and participate, increasing rates of HIV infection, and significant gender gaps in education.

[5]Stunting is height for age at least two standard deviations below mean.

- prevalence of sexually transmitted diseases at or above 10 percent among women aged 15 to 30.

Because USAID has identified global population growth as an issue of strategic priority agencywide, guidance states that strategies directed at family planning, child survival, maternal health, and reduction of sexually transmitted diseases and HIV/AIDS—all of which must be considered together—will receive particular attention in those countries where the unmet need for contraception is the greatest. USAID stated that other concerns would also include under-5 mortality, maternal mortality, prevalence of sexually transmitted diseases, and stunting.

USAID's long-term goal is to contribute to a cooperative global effort to stabilize world population growth and protect human health. Its anticipated near-term results over a 10-year period are (1) significant improvement in women's health, (2) a reduction in child mortality by one-third, (3) a reduction of maternal mortality rates by one-half, and (4) a decrease in the rate of new HIV infections.

Program Guidance

USAID issued guidance in 1992 and 1996 about the types of activities that are allowable uses of child survival funds. The guidance named specific types of activities that may be considered to fall under the child survival program and gave broad discretion to USAID officials to determine the proportion of funding that could be reported as child survival. The annual instruction manual for coding activities and special interests further specifies how activities are to be reported.

According to agency guidance and instructions, some activities are automatically funded in their entirety as child survival. These activities are

- diarrheal disease control and related research,
- immunization and child-related vaccine research,
- child spacing/high-risk births,[6]
- acute respiratory infection,
- vitamin A,
- breastfeeding promotion,
- growth monitoring and weaning foods,
- micronutrients, and

[6]Child spacing and high-risk birth activities may be funded by either child survival or population funds. According to the guidance, these activities may be financed with child survival funds only when the emphasis of the project is on reducing infant and child mortality rates. Population funds should be used when the project is primarily designed to provide options for limiting family size.

- orphans and displaced children.

Other activities can be partially funded as child survival. USAID's guidance stated that project managers could decide the percentage for the following activities that could be reported as child survival, even though suggested percentages were provided for some:

- health systems development;
- nutrition management, planning, and policy;
- other nutrition activities;
- health care financing;
- environmental health;
- vector control;
- water and sanitation;
- women's health; and
- malaria research and control.

Under-5 Mortality Rates and USAID Mission-Level Funding in Developing Countries

Dollars in thousands

Country	Status	Under-5 mortality rate[a] 1980	Under-5 mortality rate[a] 1994	1994 Under-5 population (in millions)	Child survival funds[b] 1985-95	Child survival funds[b] 1995
Niger	1	320	320	1.8	$21,148	$2,500
Angola	2	261	292	2.1	1,830	0
Sierra Leone	3	301	284	0.8	127	113
Mozambique	1	269	277	2.8	62,494	9,793
Afghanistan	3	280	257	3.3	30,959	0
Guinea-Buissau	2	290	231	0.2	0	0
Guinea	2[c]	276	223	1.3	0	0
Malawi	1	290	221	2.1	22,949	3,562
Liberia	4	235	217	0.6	6,900	0
Mali	1	310	214	2.1	42,880	5,346
Gambia	4	278	213	0.2	122	0
Somalia	3	246	211	1.8	9,559	2,339
Zambia	1	160	203	1.7	4,200	4,200
Chad	3	254	202	1.1	9,532	0
Eritrea	1	260	200	0.6	7,149	519
Ethiopia	1	260	200	10.3	20,194	6,664
Mauritania	3	249	199	0.4	581	0
Bhutan	3	249	193	0.3	0	0
Nigeria	1	196	191	20.1	29,218	1,016
Zaire	4	204	186	8.3	12,365	0
Uganda	1	181	185	4.2	15,476	2,119
Cambodia	1	330	177	1.8	33,978	8,494
Burundi	3	193	176	1.2	2,941	0
Central African Republic	3	202	175	0.6	7,369	1,360
Burkina Faso	3	246	169	1.8	3,311	0
Madagascar	1	216	164	2.6	5,540	3,308
Tanzania	1	202	159	5.2	2,270	2,090
Lesotho	3	173	156	0.3	293	0
Gabon	3	194	151	0.2	0	0
Cote d'Ivoire	3	170	150	2.8	2,153	0
Benin	2	176	142	1.0	553	0
Rwanda	1	222	139	1.4	5,202	1,447
Laos	3	190	138	0.9	0	0
Pakistan	1	151	137	23.6	37,153	3,067
Togo	3	175	132	0.7	11,403	0

(continued)

Dollars in thousands

Country	Status	Under-5 mortality rate[a] 1980	Under-5 mortality rate[a] 1994	1994 Under-5 population (in millions)	Child survival funds[b] 1985-95	Child survival funds[b] 1995
Ghana	2	155	131	3.0	$2,088	0
Haiti	1	195	127	1.1	78,440	$10,887
Sudan	4	200	122	4.6	10,579	0
India	1	177	119	116.6	68,772	900
Nepal	1	180	118	3.5	12,893	1,229
Bangladesh	1	211	117	17.1	48,001	2
Senegal	1	221	115	1.4	12,738	1,553
Yemen	2	210	112	2.7	9,346	0
Bolivia	1	170	110	1.1	60,566	3,264
Cameroon	3	173	109	2.2	14,833	0
Congo	3	125	109	0.5	0	0
Myanmar (Burma)	1	146	109	6.4	3,344	100
Swaziland	3	151	107	0.1	3,004	0
Libyan Arab Jamahiriya	4	150	95	0.9	0	0
Papua New Guinea	3	95	95	0.6	800	0
Kenya	1	112	90	5.1	21,353	312
Turkmenistan	2	N/A	87	0.6	79	0
Tajikistan	2	N/A	81	1.0	1,262	0
Zimbabwe	2	125	81	1.9	2,796	0
Indonesia	1	128	80	21.9	42,234	3,006
Namibia	2	114	78	0.2	0	0
Mongolia	2	112	76	0.3	0	0
Iraq	4	83	71	3.3	0	0
Guatemala	1	136	70	1.8	46,790	903
South Africa	1	91	68	5.6	3,883	3,883
Nicaragua	1	143	68	0.8	22,075	2,661
Algeria	3	145	65	3.6	0	0
Uzbekistan	2	N/A	64	3.2	124	0
Brazil	2	93	61	17.8	0	0
Guyana	2	88	61	0.1	0	0
Peru	1	130	58	2.9	50,443	1,388
Philippines	2	70	57	9.2	58,194	0
Ecuador	1	101	57	1.4	23,325	1,183
El Salvador	1	120	56	0.8	81,230	2,587
Morocco	1	145	56	3.4	16,843	1,400
Kyrgyzstan	2	N/A	56	0.6	159	0

(continued)

Dollars in thousands

Country	Status	Under-5 mortality rate[a] 1980	Under-5 mortality rate[a] 1994	1994 Under-5 population (in millions)	Child survival funds[b] 1985-95	Child survival funds[b] 1995
Turkey	3	141	55	7.5	0	0
Botswana	3	94	54	0.2	$392	0
Honduras	1	100	54	0.9	53,550	$2,201
Egypt	1	180	52	8.1	136,860	27,001
Azerbaijan	1	N/A	51	0.8	10,894	9,150
Iran	4	126	51	10.4	0	0
Kazakhstan	2	N/A	48	1.6	484	0
Vietnam	3	105	46	10.1	0	0
Dominican Republic	1	94	45	1.0	13,985	1,195
China	4	65	43	107.3	0	0
Albania	2	57	41	0.4	0	0
Belize	3	56	41	0.03	4,755	0
Lebanon	1	40	40	0.4	875	395
Syrian Arab Republic	4	73	38	2.6	0	0
Moldova	2	N/A	36	0.4	29	0
Saudi Arabia	3	90	36	2.8	0	0
Paraguay	2	61	34	0.7	0	0
Tunisia	3	102	34	1.0	40	0
Thailand	3	61	32	5.4	1,748	0
Armenia	1	N/A	32	0.4	19,476	15,356
Macedonia	2	69	32	0.2	0	0
Mexico	2	87	32	11.8	0	0
Solomon Islands	3	56	32	0.1	500	0
Russian Federation	2	N/A	31	8.4	5,650	0
North Korea	4	43	31	2.6	0	0
Romania	1	36	29	1.3	2,461	2,141
Georgia	1	N/A	27	0.4	19,495	17,226
Argentina	3	41	27	3.3	0	0
Oman	3	95	27	0.4	9	0
Latvia	3	N/A	26	0.2	0	0
Ukraine	2	N/A	25	3.0	1,558	0
Jordan	2	66	25	0.9	9,700	0
Venezuela	3	42	24	2.8	0	0
Estonia	3	N/A	23	0.1	0	0
Yugoslavia	3	44	23	0.7	0	0
Mauritius	3	42	23	0.1	0	0

(continued)

Dollars in thousands

Country	Status	Under-5 mortality rate[a] 1980	Under-5 mortality rate[a] 1994	1994 Under-5 population (in millions)	Child survival funds[b] 1985-95	Child survival funds[b] 1995
Belarus	2	N/A	21	0.6	$31	0
Uruguay	3	42	21	0.3	0	0
United Arab Emirates	3	64	20	0.2	0	0
Lithuania	2	N/A	20	0.3	0	0
Panama	2	31	20	0.3	0	0
Trinidad and Tobago	3	40	20	0.1	0	0
Bulgaria	2	25	19	0.5	0	0
Sri Lanka	2	52	19	1.8	1,370	0
Colombia	2	59	19	3.9	0	0
Bosnia and Herzegovina	2	38	17	0.2	0	0
Poland	2	24	16	2.5	1,991	0
Costa Rica	3	29	16	0.4	0	0
Chile	3	35	15	1.5	1,440	0
Slovakia	2	N/A	15	0.4	0	0
Malaysia	3	42	15	2.7	0	0
Croatia	1	23	14	0.3	355	$355
Hungary	2	26	14	0.6	0	0
Kuwait	3	35	14	0.2	0	0
Jamaica	1	39	13	0.3	3,562	501
Cuba	4	26	10	0.9	0	0
Czech Republic	2	N/A	10	0.7	0	0
South Korea	3	18	9	3.5	0	0
Slovenia	3	18	8	0.1	0	0
Hong Kong	3	13	6	0.3	0	0
Singapore	3	13	6	0.2	0	0

(Table notes on next page)

Legend:

1 USAID has a presence in the country and a child survival program.

2 USAID has a presence in the country, but no activities were attributed to child survival in fiscal year 1995.

3 USAID had no presence in the country and supported no mission-level programs, as of August 1996, although some funding may be provided through regional or other mechanisms.

4 USAID was legally restricted from operating in these countries as of 1996.

Note: N/A in the table is used for countries for which the information was not available, primarily because these countries did not exist in 1980. Fiscal year 1995 child survival funding data were current as of July 30, 1996. USAID officials said that figures reported for missions under the Bureau for Europe and the New Independent States were not final at that time and may not be accurate. The table does not include the West Bank/Gaza area, which received $585,900 in USAID mission-level funding between 1985 and 1995.

[a]The mortality rate represents the number of deaths per 1,000 live births for children under age 5, or the probability of dying between birth and exactly 5 years of age.

[b]Mission-level assistance is obligated by USAID field missions. These amounts do not include USAID central or regional funds that may also have gone to these countries.

[c]USAID is designing a child survival program for Guinea to start after the beginning of fiscal year 1997, according to a USAID official.

Source: The U.N. Children's Fund and USAID/Center for International Health Information.

Comments From the U.S. Agency for International Development

Note: GAO comment supplementing those in the report text appears at the end of this appendix.

U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

JUL 23 1996

Mr. Henry L. Hinton, Jr.
Assistant Comptroller General
National Security and International Affairs Division
U.S. General Accounting Office
441 G Street N.W. - Room 4039
Washington, D.C. 20548

Dear Mr. Hinton:

I am pleased to provide the U.S. Agency for International Development's (USAID's) formal response on the draft GAO report entitled "FOREIGN ASSISTANCE: Contributions to Child Survival are Significant, but Program Needs Refocusing" (July 1996).

We appreciate the GAO's recognition of the contributions of USAID's child survival program. This program has achieved significant results in saving children's lives worldwide.

However, we are concerned that in a number of instances, USAID's child survival program and the findings of the review team are not accurately conveyed. There are some key omissions that misrepresent USAID's efforts. In addition, a number of misleading generalizations are not supported by the evidence cited, or by the extensive review undertaken by the GAO. The title of the report and some of the statements, conclusions, and headings suggest far greater problems than the examples indicate.

The enclosure includes specific responses to the report's recommendations, as well as clarifications and some suggested wording changes that will more accurately represent USAID's child survival program and the work of the GAO staff.

Thank you for the opportunity to respond to the GAO draft report and for the courtesies extended by your staff in the conduct of this review.

Sincerely,

Larry E. Byrne
Assistant Administrator
Bureau for Management

320 TWENTY-FIRST STREET, N.W., WASHINGTON, D.C. 20523

See p. 28.

Now in app. II.

Now on p. 27.

ENCLOSURE
USAID COMMENTS ON GAO DRAFT REPORT
FOREIGN ASSISTANCE: Contributions to Child Survival Are Significant, but Program Needs Refocusing (Job Code 711137)

I. RESPONSE TO RECOMMENDATIONS:

Recommendation 1: ...focus child survival funding on those countries that have the most serious mortality rates for children rather than spreading the assistance across many countries with less serious problems, especially those that have already achieved the World Summit goals for children's mortality rates

USAID past and present guidance for child survival and population and health programs highlights high infant/under-five mortality rates (IMR/U5MR)[1] as criteria for programming along with several other factors, including magnitude, as well as the severity of, child mortality; operational feasibility; absorptive capacity; and the policy environment. As a consequence, USAID focuses its child survival efforts in countries with high rates of under-five mortality, as well as in countries where need is great, as identified through other factors. It is important to note that a number of the countries with very high under-five mortality rates are not countries where USAID is operating. While infant and under-five mortality rates are universally recognized as key indicators of progress in improving child survival, average national mortality rates are not the only indicators of need, and national mortality rates often mask great disparities within a country.

- Of the 30 countries included in Appendix III of the draft report with U5MR above 150/1000, 13 are not USAID assisted countries. In 1995, USAID had child survival programs in all but six of the others, and since then has started child survival activities in two of these.

- The five countries specifically cited in the report (p. 8)--Sierra Leone, Gambia, Chad, Mauritania and Burundi-- are countries where USAID: (1) does not have a program; (2) has closed out assistance; or (3) was in the process of closing out assistance for budgetary or legal reasons, or because sustainable development programs were not feasible at the time.

- National mortality rates are averages that often mask pockets of high infant or child mortality, and they can also

[1] There is a distinction between child mortality and under-five mortality rates. Child mortality rates refer to the proportion of deaths to total births between ages one and five; under-five mortality rates are the proportion of deaths under age five. Under-five mortality is more appropriately used in this context as it also reflects deaths to infants.

mask some of the work that must continue to be done in these countries to ensure that mortality rates continue to decline and do not rise again, or that other threats to child health are allayed.

-- In Egypt, UNICEF reported U5MR to be 52 in 1994, but the 1995 demographic and health survey found the actual U5MR to be 80.6/1000. At the same time, there is tremendous regional variation. In rural Upper Egypt (which alone has a population of 20 million-- larger than many countries), U5MR is 146.7/1000 (per 1995 DHS). USAID's maternal and child health programs are targeted to these high risk areas in Upper Egypt and to other areas and groups where need is greatest.

-- In Peru, according to the 1991/92 DHS, infant mortality in Lima was 30/1000 live births; however, in Mariatequi, one of USAID's priority regions, infant mortality was 101/1000.

- Reaching a target is not in itself a reason to stop support of efforts in a certain area or program. Critical to that judgement is the extent to which the gains in an area have been made sustainable. Our experience in immunization, where many countries reached the targeted 80% level by a stated deadline, was that the extraordinary resources and social mobilization efforts undertaken to reach a goal could not be sustained in every country. Thus, in the health and child survival sector, USAID has made sustainability a focus, as it has in its overall development program. This often means that we continue transitional assistance in child survival for a period of time even after targets have been met.

- The draft report also omits any mention of the fact that the Egypt program-- noted as the largest recipient of child survival funding-- is funded with Economic Support Funds that are not fungible or transferrable to other countries.

See p. 28.

Recommendation 2: ...reconsider the extent to which child survival funds should be used for infrastructure projects, such as water towers, road improvements and bridges

USAID guidance on the use of child survival funds is clear on the allowable uses of these funds.[2] Infrastructure is not among the uses described as acceptable in this guidance, and is not

[2] FY 1992 Child Survival Earmark cable, (State 179607) dated June 5, 1992; and 1996 Child Survival and Disease Earmark Definition, (State 68007) dated April 3, 1996.

considered a generally appropriate use of child survival funds. The cases cited in the draft GAO report are isolated, limited examples that do not support the conclusion. Moreover, these activities have a much stronger linkage to child survival than implied in the report, and took place under extraordinary conditions in a country recovering from a devastating civil war. In both of the examples cited from Mozambique, the activities were focused on specific, extremely vulnerable populations for whom access to water or access to food and health services would make the crucial difference in survival. In both cases, the activity was critical for reducing child mortality.

Now on pp. 7 and 26.

- In Mozambique, rather than simply "rehabilitate a bridge" as referred to in the draft report (p. 8), USAID turned what was once a railroad bridge into a vehicle and pedestrian bridge to permit highly vulnerable populations access to health services, emergency assistance and food markets. This access was crucial to the survival of hundreds of thousands of children in the area.

Now on p. 24.

- The rehabilitation of the Chimoio water works (p. 14) was designed and funded in the wake of severe drought which not only drove rural populations into urban and peri-urban areas such as Chimoio, but also left densely populated peri-urban areas with little to no water. Children are most vulnerable to dehydration and death due to diarrheas, which are even more threatening when water sources dry up. The repair of this water facility was critical to the survival of children in the area, and therefore, a portion of the activity was attributed to child survival.

See pp. 28 and 29.

Recommendation 3: ...ensure that the new information system will link obligations with specific child survival expenditures and report expenditures rather than relying on attributions of budget allocations as child survival activities.

USAID's new program operations procedures require that operating units establish a set of development "activities" to support strategic objectives, in lieu of the previous project structure. The New Management System (NMS) has been designed to track funding for each activity by linking budgets, obligations, procurements and expenditures. USAID's operating units now have the flexibility to define child survival assistance (as well as other assistance areas) as distinct activities, where feasible. In these instances, the actual expenditures for the child survival activity will be captured in the NMS. Where a broader activity contributes to the Agency's child survival objectives, the activity manager will determine the percentage of funding and expenditures attributable to child survival based on Agency criteria and his/her knowledge of the activity. The NMS provides the capability for the activity manager to revise the percentages as the need arises; therefore, expenditures attributable to child

survival will be more precise than the current activity coding/special interest coding system (AC/SI) allows.

II. CLARIFICATIONS AND CORRECTIONS:

In addition to the concerns noted above, there are some other key omissions and broad generalizations with very limited examples that result in a misrepresentation of USAID's child survival program and strategy.

Contributions of USAID's Child Survival Program

The draft report provides a brief overview of a few of USAID's accomplishments in child survival. This overview could be bolstered with some additional specifics about the depth and breadth of USAID's contributions.

- Not only did USAID help in eradicating polio in the Americas, USAID was the largest donor to this effort, providing key technical input, as well as resources.
- USAID was the primary sponsor of the seminal research demonstrating the value of vitamin A supplements in reducing child mortality. As a result, vitamin A supplementation, fortification and education has been incorporated into programs all over the world, helping to avert millions of deaths to young children.
- USAID led the initial research on oral rehydration therapy to treat acute diarrhea. Since then, USAID has been the leader in successful promotion, in both the public and private sectors, of its use worldwide to treat what was the major cause of under five mortality.
- USAID conceived and supported the key research that showed that the most common, life threatening forms of Acute Respiratory Infections (ARIs) in children in remote areas could be successfully diagnosed and treated with low cost antibiotics by specially trained health workers. USAID is now developing and testing vaccines to prevent ARIs.

USAID's Child Survival Strategy, Objectives and Program Focus

The report makes global, generalized statements about USAID's child survival efforts, implying that these efforts are not appropriate or clearly linked to our strategy. USAID has a very clear and focused child survival program that is directly and explicitly linked to our sustainable development strategy. Several references in the draft report imply otherwise:

See comment 1.

- **pp. 8, 14 and 21.** The report notes that "we identified some activities supported with child survival funds that do not relate directly to child survival, ..." (p 8), and later: "Because of the broader focus, [of USAID's sustainable development strategy], there is no clear link with the many projects and activities identified as child survival and USAID's sustainable development strategy for health and population."(p 14). Only examples from Mozambique are cited, accounting for a very small percentage of USAID's overall efforts. USAID's child survival activities are primarily focused on reducing child mortality and morbidity. As the report itself notes, the two largest funding categories for USAID's child survival efforts are focused on two of the three major causes of death among young children (p.32). USAID also devotes a significant portion of funding to the third leading cause of death-- acute respiratory infections.

Now on pp. 7 and 13.

- There is a very clear link between USAID's child survival activities and the objectives of USAID's strategy for population and health within our overall sustainable development strategy. USAID has identified five goals necessary to achieve our primary mission of fostering sustainable development. One of the five is stabilizing world population and protecting human health through reducing child mortality, maternal mortality, unintended pregnancies, and STI/HIV/AIDS transmission. As part of our strategic objective to reduce child mortality, USAID's activities focus on the leading causes of morbidity and mortality and on building sustainable systems to ensure that improvements in child health are perpetuated.

Now on p. 27.

- **p. 18.** The draft report refers to disaster assistance counted as child survival; however, it omits any discussion of the real connection to child survival. These programs are indeed saving the lives of children, who are generally the most vulnerable in disaster situations, by providing nutrition and basic health services. In 1995, after extensive discussions, Congressional staff and USAID agreed that it was legitimate to count a proportion of disaster assistance as part of USAID's child survival activities. The draft report makes no reference to this agreement or to the contributions disaster assistance makes to child survival.

See comment 1.

The concerns noted above can be addressed through wording changes in the GAO report:

- p. 8, 1st paragraph. Replace the first sentence with:

  However, we identified some **instances where** activities supported with child survival funds **are not directly within the scope of the child survival program.**

- p. 14. Replace subheading with:

  Some child survival activities not clearly linked with strategy

- p. 14, 1st paragraph. Replace the second sentence with:

  However, there are some projects and activities identified as child survival **that are not directly linked to USAID's child survival program** and USAID's sustainable development strategy for health and population.

USAID Strategy and Guidelines

In several places, the report makes incorrect references to USAID's population and health strategy, misrepresenting the role and significance of child survival within the strategy and its goals.

Now on p. 36.

- Pages 37/38 indicate that USAID guidance gives particular attention to countries "where the unmet need for contraception is greatest". Unmet need for contraception is not the only factor included in Agency guidance or strategies. Our population and health strategy is a carefully integrated one, and we have taken steps to ensure that the program is implemented holistically. Therefore, the guidance includes not only unmet need for contraception as a factor for emphasis, but also under-five mortality, maternal mortality, etc. The official guidelines state:

  > "Achieving USAID global strategic goals for PHN in a time of serious resource limitations will require particular attention to countries which contribute the most to global population growth, **levels of under-five and women's reproductive mortality and serious morbidity**, and the spread of HIV infections, as well as to those countries where these health and population-related conditions stand as major impediments to sustainable development. (USAID Guidelines for Strategic Plans, March 1995, Annex A)

Now on p. 36.

- Page 38 misrepresents USAID's long term goal for this sector. The goal is "Stabilizing world population **and protecting human health**", as stated in the Strategies for

Sustainable Development, the implementation guidelines, and the Agency strategic framework issued in September 1995.

Now on p. 34.

- On pages 7 and 35, references are made to the elements of USAID's population and health strategy. USAID has four objectives leading to its goal of stabilizing world population and protecting human health. These are: reducing unintended pregnancies; reducing child mortality; reducing maternal mortality, and reducing transmission of STI/HIV/AIDS. For a brief period, the latter two objectives were combined under the rubric of "reproductive health" (including in the 1995 guidelines), but since then, reproductive health has been broken into maternal health and STI/HIV/AIDS reduction.

These concerns can be addressed through the following changes:

Now on p. 36.

- p. 38, line 2. Insert **under-five mortality, maternal mortality, prevalence of STIs, and stunting** after "contraception".

Now on p. 36.

- p. 38, first full sentence. Insert **and protecting human health** after "stabilize world population".

See comment 1.

- p. 7, first paragraph, second sentence. Replace "and reproductive health" with **maternal health and reduction in transmission of STIs/HIV/AIDS.**

See comment 1.

- p. 7, first paragraph, last sentence. Insert **greatest magnitude and severity of need, particularly in countries with** after "focused on countries with" and before "mortality rates for children".

Now on p. 34.

- p. 35, first paragraph. Replace the last sentence with:

  USAID's population, health and nutrition sector has **four** priority objectives: family planning, child survival, **maternal health, and reducing STIs/HIV/AIDS.**

Funds Tracking

Now on pp. 7 and 15.

The GAO report states that "USAID cannot accurately determine how much is actually being spent on child survival activities because: (1) USAID allows flexibility in attributing child survival funds; and (2) the amounts reported are based on project-level budgets which are not linked to Agency data about specific procurement and expenditures for projects. USAID officials use inconsistent criteria in determining what portion of a project will be counted as child survival." (p. 8/9) This statement and the third recommendation omit some important information about USAID's tracking systems.

- The current activity coding/special interest coding system (AC/SI) is based on obligation data. It was established in FY 1989 in order to provide the Agency with a way to project two years into the future which program areas obligations would take place and to provide a detailed description of actual obligations by program area once a fiscal year ended. Over the years, as Congress has increased the number of directives and earmarks, this system has been used to help determine if the Agency is meeting those directives and earmarks, even though it was never intended for that purpose.

  It was also never intended to be used to track any program area on an expenditure basis, and we have always made it clear to the Congress that what we are tracking is based on estimates of obligations.

  The NMS has been designed to link budgets, obligations, procurements and expenditures for USAID activities. The system will track actual expenditures for interventions defined as an "activity" under USAID's new program operations procedures and will identify expenditures for other areas based on a coding structure similar to the AC/SI codes. The NMS will ensure greater accuracy in identifying expenditures attributable to child survival since project officers have the capability to revise percentages if funding levels or other aspects of an activity change.

- When the Congress specifies funding for a particular type of activity by means of an earmark (as opposed to a directive) the Agency also uses accounting Budget Plan Codes (BPCs) to track the earmark. Unlike the AC/SI coding, BPCs allow the Agency to track a specific type of activity, such as child survival, to ensure that all funds are used only for this earmark. Obligations and expenditures reflect the BPCs when posting transactions in the accounting system. They also ensure that any reprogramming and recoveries that occur in future years are used for the original earmark. The effort in doing this, however, involves a great deal of staff time to maintain the separate BPC accounts, especially when there is more than one earmark to track.

Now on p. 15.

- On page 9, the reference to use of "inconsistent criteria in determining what portion of a project will be counted as child survival" misrepresents how decisions about allocations are actually done. The criteria are consistent; however, the attribution changes according to the circumstance and the specific project activities. The Agency has provided very clear guidance on how the AC/SI coding system is to be used. It has also provided very explicit guidance on what types of activities may be attributed to child survival. The GAO report (p. 20) also

Now on pp. 16 and 17.

refers to variation in attribution of water and sewage projects. The fact that one mission may attribute 3% of a water and sewage project to child survival, while another attributes 100% of a similar project to child survival, is based on the judgement of the project officer and his/her knowledge of that specific project. Most coding errors are caught and corrected during the annual budget reviews. Specifically, the guidance cited offers 30% of water and sanitation activities to be attributed to child survival as broad guidance to project officers. However, the guidance goes on to note that "the amount actually coded (and counted as child survival) is, however, best determined by the project manager, based on his/her knowledge of the project".

See comment 1.

- The footnote on page 8 says that USAID's information systems currently do not report on the countries where central or regional funds are spent. This is incorrect. In the past this was true, but since 1995, USAID has been reorienting its budget allocation process so that country levels include central and regional funds, as well as direct bilateral assistance.

To address some of these issues, we suggest the following language:

See comment 1.

- p. 8, footnote. Replace last sentence with:

  In 1995, USAID's information systems **began to** report on the country where central or regional funds are spent.

Now on p. 15.

- p. 9, top paragraph. Replace the second sentence with:

  USAID officials use **criteria that allow for considerable flexibility and variation** in determining what portion of a project will be counted as child survival.

III. OTHER CORRECTIONS:

- The title of the report is misleading and is not supported. The report identifies some limited problems, but the title implies that problems are far more widespread. We recommend: **Contributions to Child Survival are Significant, but Limited Concerns were Identified.**

- References to child mortality rates should be replaced with under-five mortality rates throughout the report. Under-five mortality is more commonly used and is more appropriate in this context.

Now on p. 1.

- The draft report refers to the decline in the number of deaths among children between 1985 and 1993 (p. 9). It

should be noted that overall population continued to increase-- approximately 6,000,000 more children were born in 1993 than in 1985. As a result, the real impact on reducing child mortality is greater than just the numbers would indicate.

Now on p. 8.

- Pages 7 and 18 refer to the World Summit goal of reducing child mortality to 70 per 1000. This should read: World Summit goal of **a one-third reduction in under-five death rates or a reduction to 70 per 1,000 live births - whichever is lower.**

Now on p. 24.

- Page 14, first sentence, refers to clinics in Egypt. In addition to vaccinations and equipment for medical tests, these clinics offer the full range of maternal and child health services. This reference would be more accurate if stated as follows:

  In Egypt, we visited health clinics, in urban and rural areas where **maternal and child health services are provided, including vaccinations, oral rehydration therapy, treatment for acute respiratory infections, and child spacing.** These clinics also have equipment for medical tests.

Now on p. 28.

- p. 19, first paragraph, last sentence: should read **under-five morality rate** rather than child survival rate.

Now on p. 17.

- p. 21, second paragraph, last two sentences, should be reworded as follows:

  USAID began implementing the system in July 1996 for all new commitments made at headquarters. The Agency plans to extend the system to overseas missions by **October 1, 1996.**

The following is GAO's comment on USAID's letter dated July 23, 1996.

GAO Comment

1. We have revised this report since the time we provided it to USAID for comment. As a result, there are some instances in which the information discussed in USAID's letter is no longer included in our report.

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