WHO REGIONAL OFFICE
FOR AFRICA

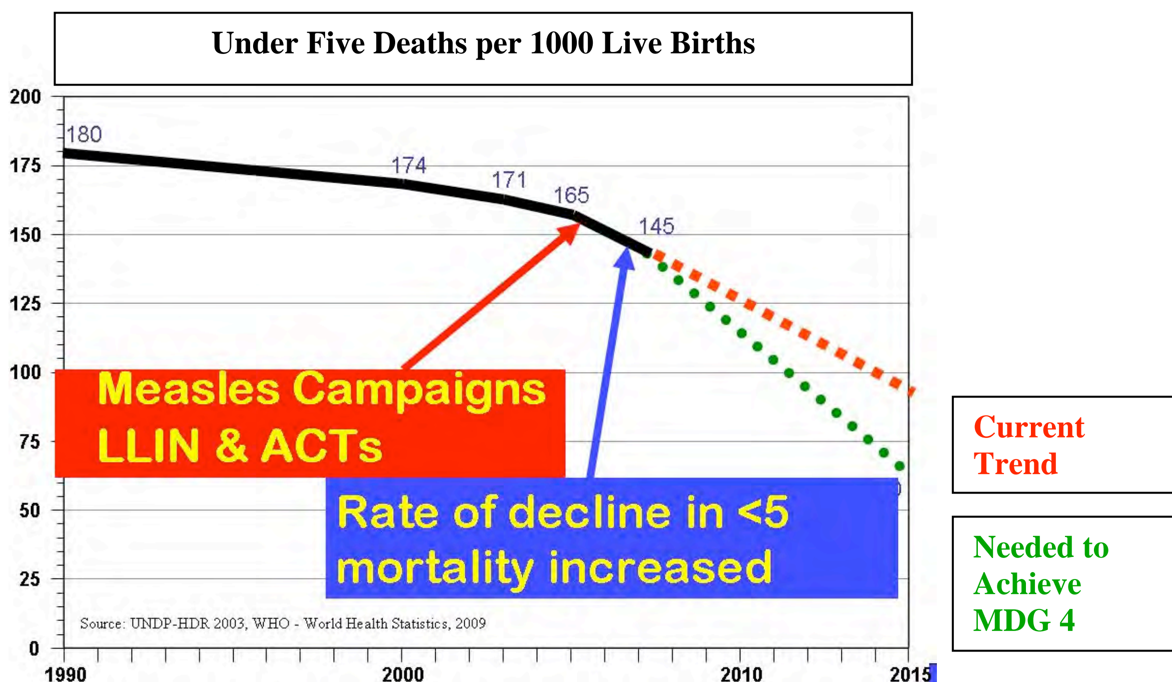
USAID GRANT TO WHO/AFRO AFRO-G-00-04-0001 (2005-2009) FINAL EVALUATION - MAY 5-29, 2009

PROGRESS TOWARD MILLENNIUM DEVELOPMENT GOAL 4:
REDUCE UNDER FIVE MORTALITY BY 2/3rds BETWEEN 1990 & 2015

(*NOTE: THE INCREASED SLOPE ASSOCIATED WITH 4 STRATEGIES*)

1. Mass Measles Campaigns
2. Procurement and Distribution of 173 Million Long Lasting Insecticide Treated Nets (LLINs)
3. Introduction of Rapid Diagnostic Test for Malaria
4. Increased use of Artemisinin Combination Therapy for treatment of Malaria (ACTs)

Under Five Deaths per 1000 Live Births



Current Trend

Needed to Achieve MDG 4

EVALUATION TEAM

Dr. Soce Fall – WHO/AFRO, ATM Division
Dr. Phanuel Habimana – WHO/AFRO, DRH Division
Dr. Sambe Duale – Africa 2010/AED – Tulane University-USAID
Dr. Roy Miller – USAID
Dr. Stanley Foster – Global Health – Emory University –Team Leader

INTRODUCTION

During the last five years, 2004–2009, the United States Agency for International Development (USAID) has provided the World Health Organization Regional Office for Africa (WHO/AFRO) a grant of $37 million dollars to strengthen WHO/AFRO capacity to support African Nations in achieving the Health Millennium Development Goals (MDGs) 4, 5, and 6. Thirty-four million dollars came from the USAID Africa Bureau and three (3) million dollars from USAID Missions. A majority of funds are used to support development of norms, standards and tools and provide technical assistance at Country, Inter-Country, and Regional levels.

As the 2004–2009 grant is coming to an end, USAID and WHO/AFRO decided to jointly review the work carried out in the last five (5) years. The review had three (3) objectives.

1. Assess and document the accomplishments and lessons learned over the last five years of the grant.

2. Review the grant financing and management arrangements, as well as monitoring and reporting activities implemented under the grant.

3. Provide guidance on ways to design a new five (5) year grant in light of the findings of the assessment and changes within WHO/AFRO and the region as a whole.

A joint USAID and WHO/AFRO Team, headed by Dr Stanley O. Foster of Emory University, carried out the evaluation during the period May 5-29, 2009. The report of the evaluation of the 2004-2009 USAID Grant to WHO/AFRO is made up of four (4) different sections:

Section 1: Executive Summary and Recommendations
Section 2: Context of the Evaluation: Actors, Schedule of Work
Section 3: Description of the ten (10) program areas funded by the grant
Section 4: Reports of country visits to:

- Democratic Republic of Congo
- Ethiopia
- Kenya
- Liberia

The evaluation report can be obtained from USAID's Development Experience Clearinghouse. It can be viewed and downloaded from the Clearinghouse website: http://dec.usaid.gov. This summary report draws from the main report. It presents the main findings, recommendations and challenges.

HISTORICAL CONTEXT

The mission of WHO/AFRO is to provide technical orientation and support to countries of the African region to address major health issues. The strength and comparative advantage of WHO/AFRO resides in its mandate as a technical health agency to support African countries in developing sound policies and technical guidelines for the planning, implementation, and monitoring of programs to address priority health problems in Africa, especially the prevention and control of infectious diseases. Countries rely heavily on strategies and guidelines developed by WHO when shaping their national health programs.

The USAID and WHO/AFRO partnership started in 1993 with an initial grant to WHO/AFRO for malaria support. This initial grant to the Division of Disease Control was later expanded to include vaccine preventable diseases and epidemic preparedness and response. In 1995, USAID initiated a second four year grant to WHO/AFRO and followed this with a new five (5) year Grant (1999-2003) expanding the support to multiple program areas of the WHO/AFRO Division of Disease Control (DDC) and the Division of Reproductive Health. The U.K. Department for International Development (DfID) also developed a direct Grant with WHO/AFRO for the same time period to support disease control projects, especially the WHO-Southern Africa Malaria Control Program (SAMC) for the purpose of reducing malaria morbidity and mortality and malaria transmission in the sub-region though the development of evidence based working models of country and inter-country malaria control programs.

The 1999–2003 Grants aimed to strengthen WHO/AFRO's capacity to meet the following objectives:

- Control malaria within the context of the Roll Back Malaria Initiative, with an emphasis on community-based interventions and the monitoring and evaluation of program results and impact;
- Contribute to the reduction in childhood morbidity and mortality at health facilities and the community level through Integrated Management of Childhood Illness (IMCI);
- Strengthen immunization systems in Africa to achieve a higher level of routine immunization coverage, within the context of polio eradication and disease control initiatives;
- Strengthen national and inter-country capacities in epidemic preparedness and response;
- Contribute to the strengthening/establishment of an effective Integrated Disease Surveillance and Response (IDSR) system;
- Strengthen capacity of health systems and community level actions in support of the Making Pregnancy Safer (MPS) Initiative; and
- Strengthen Reproductive Health programs through evidence-based "best practices" and research results.

As the 1999-2003 USAID Grant period was coming to an end, a joint WHO/AFRO, USAID, and DFID review was carried out to identify achievements and lessons learned in moving forward the overall AFRO Agenda for disease control and prevention in Africa. Based on a positive final review of grant in 2003, USAID/AFR/SD awarded a new five-year grant to WHO/AFRO in September 2004.

WHO/AFRO was to use the new 2004–2009 grant to support the following objectives of its areas of work:

1. Controlling malaria within the context of Roll Back Malaria (RBM) so that by the year 2030, malaria will neither be a major contributor to mortality and morbidity, nor of significant socioeconomic consequence in Africa.

2. Contributing to the reduction in childhood morbidity and mortality from common childhood illnesses such as pneumonia, diarrhea, malaria, measles, and malnutrition.

3. Strengthening immunization systems within the current context of polio eradication and disease control initiatives in Africa, to reach a higher level of sustainable routine immunization coverage.

4. Controlling tuberculosis with an emphasis on community-based action as well as TB/HIV activities in selected countries.

5. Contributing to an effective IDSR system that enables improved forecasting and detection of epidemics, enhanced quality of planning, rational resource allocation, and improved monitoring and evaluation of intervention programs.

6. Improving maternal and newborn health through increased accessibility to skilled attendance during pregnancy and childbirth.

7. Contributing to reduction of maternal mortality through the repositioning of family planning programs into maternal and child health programs.

8. Contributing to the reduction in childhood morbidity and mortality by scaling up pediatric HIV/AIDS prevention and control interventions.

9. Contributing to the achievement of MDG-4 and MDG-5 through improved nutrition for vulnerable groups including pregnant women, lactating mothers, infants and young children.

The 2005–2009 USAID GRANT EVALUATION PROCESS

The Team

In consultation between WHO and USAID, a five person team was selected for the review. The review took place from May 5- June 30, 2009. The team members were:

Dr. Soce Fall – WHO/AFRO, ATM Division
Dr. Phanuel Habimana – WHO/AFRO, DRH Division
Dr. Sambe Duale – Africa 2010/AED – Tulane University – USAID
Dr. Roy Miller – USAID
Dr. Stanley Foster – Global Health – Emory University –Team Leader

MAJOR FINDINGS

1. WHO/AFRO IS A KEY ACTOR IN HEALTH DEVELOPMENT IN AFRICA

- Facilitates Annual Regional Committee Meetings where Regional Health Policies are established.
- Establishes Norms, Standards, and Tools for Promotion, Prevention, and Treatment.
- Serves as a technical advisor to Ministries of Health.
- Supports Ministry of Health requests for technical assistance through:
  - Posting of National Professional Officers (NPO) and International Professional Officers (IPO) at country level.
  - Technical assistance from Inter-Country Support Teams (IST) based in Libreville, Gabon; Ouagadougou, Burkina Faso; and Harare, Zimbabwe.
  - Technical support from WHO Regional Office in Brazzaville, Congo.
- Provides leadership and technical coordination at country level:
  - UN Agencies (WHO, UNICEF, UNFPA, UNIFEM, UNAIDS, World Bank, UNDP, UNEP, FAO).
  - NGO, Bilateral and Multilateral Health Sector Partners.
  - Academic and Regional Institutions.
  - Health Task Forces (e.g.; Immunization, Reproductive Health).
- Assists countries in identifying funding sources, preparing quality grant submissions and addressing implementation bottlenecks.

2. PROGRESS TOWARD MDGs 4, 5, 6

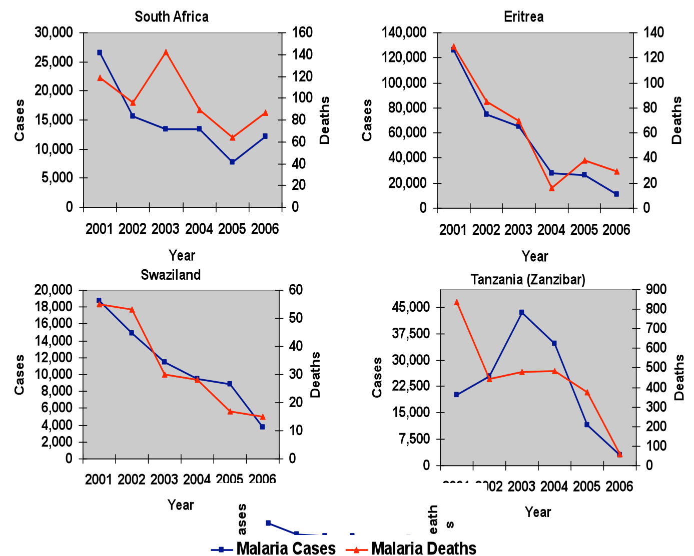
- MDG 4: Significant progress in reducing Under-Five mortality
- MDG 5: Little progress toward reducing maternal mortality
- MDG 6: Significant progress in Malaria, moderate progress in HIV, and limited progress with TB

MDG 4: Reduce <5 Mortality by 2/3rds by2015 (Baseline 1990)

MALARIA

WHO with its partners (the President's Malaria Initiative, Roll Back Malaria Partnership, and Multilateral and Bilateral Partners) introduced and coordinated a new malaria strategy in Africa. This strategy includes promotion of insecticide treated bednets (173 Million Long Lasting Insecticide Treated Bednets procured between 2004 and 2008); introduction of Rapid Diagnostic Tests for diagnosing malaria; and replacement of ineffective malaria drugs, Chloroquine and Sulfadoxine-Pyrimethamine (Fansidar), with effective Artemisinin-based Combination Therapy (ACTs). Malaria morbidity and mortality are falling. Figure 1.

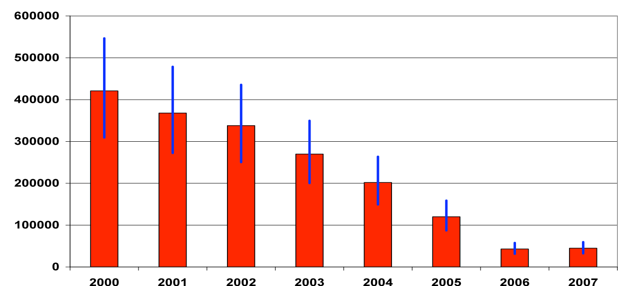
FIGURE 1: Malaria Morbidity and Mortality



MEASLES

The Measles Initiative (American Red Cross, CDC, UNICEF, United Nations Foundation, and WHO) campaigns have reached 90% of target age children in most countries. The new strategy provides a second dose opportunity for all children nine (9) months to 14 years in Year One and follow up second opportunities to children nine (9) months to five (5) years every 2-3 years. Measles morbidity and mortality are falling. Figure 2.

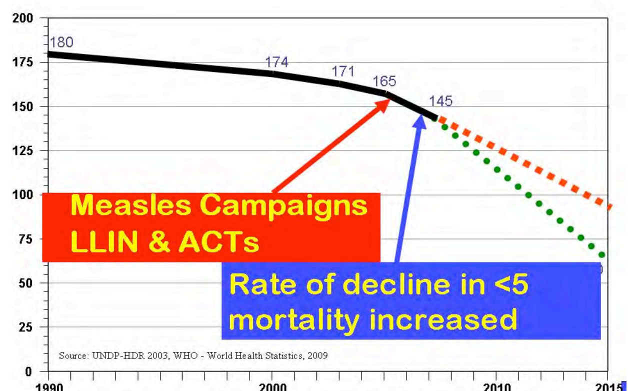
FIGURE 2: Measles Deaths in Africa 2002-2007



UNDER-FIVE MORTALITY

The rate of decline in Under Five mortality has accelerated and is expected to fall further in the next five years, Figure 3. This decrease will be verified by the next rounds of country Demographic and Health Surveys. Figure 3.

FIGURE 3: Under Five Mortality in Africa

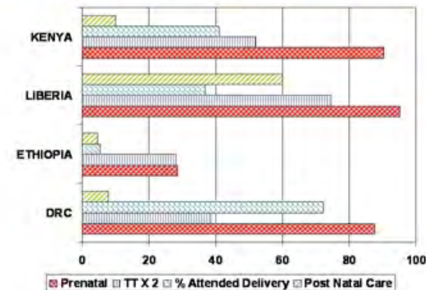


MDG 5: Reduce Maternal Mortality Ratio by 2015

ACCESS TO MATERNAL HEALTH SERVICES

Current levels of contraceptive use, prenatal care, tetanus toxoid coverage, delivery by trained attendant, access to emergency obstetrical care (EmOC), and postnatal care are extremely low and incompatible with the achievement of MDG 5. Figure 4 provides data on the 4 countries visited by the evaluation team.

FIGURE 4: MATERNAL HEALTH INDICATORS 4 COUNTRIES

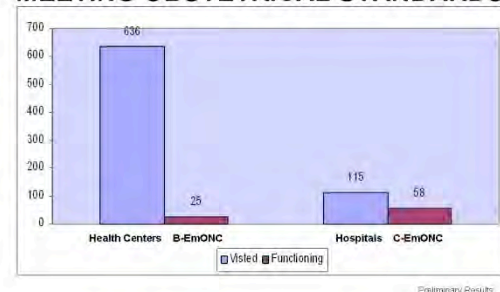


ACCESS TO QUALITY EMERGENCY OBSTETRIC CARE

- In many countries, there is a lack of access to facilities with quality Emergency Obstetrical Care (EmOC).
- A recent survey of 751 health facilities (Health Centers and Hospitals) in Ethiopia found that only 83 (11%) met quality standards for EmOC. Figure 5.

Figures 5-7 come from a UNICEF/WHO/UNFPA Survey carried out in Ethiopia in 2009.

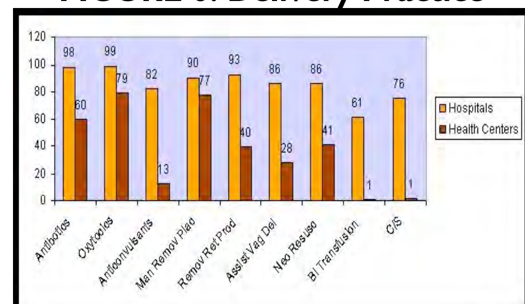
FIGURE 5: STATUS OF FACILITES MEETING OBSTETRICAL STANDARDS



AVAILABILITY OF SAFE DELIVERY PRACTICES

Figure 6 provides data from the same survey on practices available by type of facility. Major gaps are identified.

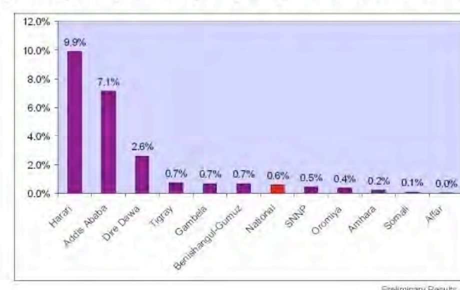
FIGURE 6: Delivery Practice



CESAREAN SECTION RATES

Reductions in Maternal Mortality Ratio require that 10-15% of deliveries be by Cesarean Section. Figure 7 from Ethiopia show unacceptably low rates of delivery by C-section.

Figure 7: % Births delivered by C-Section by Region, Ethiopia; Expected 10-15%



MDG 6: AIDS, TB, and MALARIA

AIDS

- WHO works with Countries and partners to develop and update National HIV/AIDS Strategic Plans.
- WHO supports countries in accessing and implementing Global Health Initiatives (GFATM, PEPFAR, GAVI).
- WHO is working with countries to integrate PMTCT services in all ANC and reproductive health services.
- Over 20 million Africans are living with AIDS, Figure 8.
- Given the implementation of ART programs, HIV infected individuals are living longer and prevalence rates are increasing.
- Incidence rates are beginning to decline.

TB

- Increasing percentage of TB cases tested for HIV. Figure 9.
- Increasing percentage of cases of HIV/TB co-infection on dual therapy. Figure 10.
- Progress is slow in diagnosing and treating non HIV TB. Figure 11.
- Multi Drug Resistant TB is increasing.

MALARIA

- See page 5–the section on Malaria.

Progress toward the MDG targets reflects investments by many donors and, most important of all, national governments. The USAID grant to AFRO is one contribution among many.

Figure 8

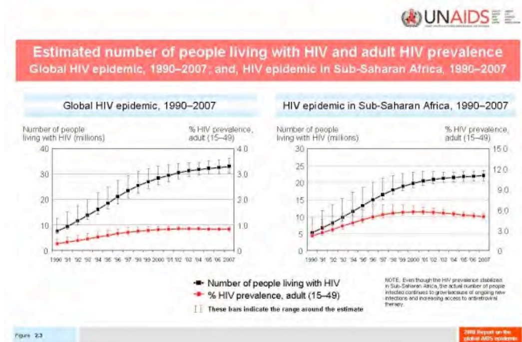


Figure 9: HIV Conselling and Testing of TB patients 2004-2007

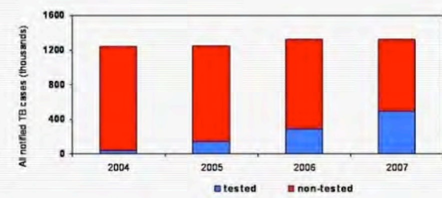


Figure 10
TB/HIV patients on ART 2004-2007

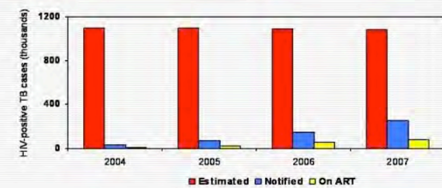
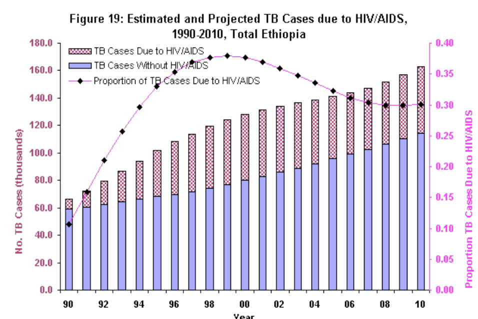


Figure 11



3. STRENGTHS OF WHO/AFRO AND COMPLEMENTARITY TO USAID: EVALUATION TEAM FINDINGS

STRENGTHS OF WHO/AFRO

- Highly qualified personnel serving at three levels
  - Country – National and International Professional Officers serving at country level
  - Inter-Country – Technical Resource at 3 locations capable of immediate response to countries.
  - WHO Regional Office with responsibility for policy, norms, standards, monitoring and evaluation, research, and assistance to countries.
- Leader and coordinator of technical assistance at the country level
  - Interviews with USAID, UNICEF, CDC and ministries of health officers revealed near unanimous recognition of the unique role of WHO as a technical bridge and policy resource to Ministries of Health.
- Major Change of WHO Presence in Africa
  - Evolution from small office to major development partner (750 staff in Nigeria and 180 staff in Ethiopia.)
  - Regional Director's delegation of authority to Divisional Directors, Inter-Country and Country Level.
  - Recognized resource of leadership and expertise in response to epidemics including surveillance, laboratory strengthening, and epidemic control.

4. KEY FINDINGS OF THE EVALUATION

- This report documents significant contribution to and improvements in health status by African countries, WHO, and development partners.
- The evaluation team is unanimous in its conclusion that the USAID Grant has contributed significantly to WHO/AFRO's effectiveness in strengthening the capacity of African countries in improving the health of their people.
- The progress made by WHO, African countries and partners during the last five years and the changing health priorities require a reassessment of needs and opportunities for the next USAID Grant to WHO. An extension of the current grant format is not appropriate.

5. ISSUES AND RECOMMENDATIONS FOR 2010-2014 USAID GRANT TO WHO *(i=Issue; R=Recommendation): These have been numbered 1-15 to facilitate ongoing dialogue and monitoring. The WHO and USAID focal points should be in regular contact to facilitate exchange and identify and resolve "bottlenecks."*

i.1	The USAID Grant primarily supports WHO staff working at country, inter-country, and regional levels to strengthen country capacity to effectively implement health promotion, prevention and treatment strategies. While it is difficult to tie inputs to specific results, the data presented in Section Three (Program Areas) and Section Four (Country Reports) show clearly that WHO technical assistance is strengthening country health programs. The evaluation team is unanimous in concluding that the USAID grant support is increasing the access, quality, and effectiveness of health programs in African Countries.
R-1	USAID recognizes the uniqueness of its grant in strengthening WHO technical country,

	inter-country and regional team's capacity. (See 3 column table on page 15). USAID formally commend WHO/AFRO and its member countries for the improvements of health and well-being in Africa.

i.2	Current USAID Grant expires September 30, 2009.
R-2	USAID should extend the WHO/AFRO grant for 5 years (2010-2014).

i.3	The WHO/AFRO decentralization of programs to the Division level is commended. Current communication between the various divisions and the focal point at USAID Washington (currently Mary Harvey) in terms of proposals, dialogues, and reports are intermittent and unsynchronized.
R-3	WHO/AFRO appoints a contact person to coordinate communication between WHO AFRO and the USAID focal point.

i.4	WHO/AFRO is the only organizational entity able to collate, analyze, and disseminate surveillance data coming from African countries. Progress is being made in 33 of 46 countries. The Communicable Disease Surveillance Plan for 2009-2013 has an excellent set of objectives for strengthening surveillance at the country level (Sections 4.1-4.3); it lacks, however, specific objectives for Disease Surveillance and Response at the Regional Level..
R-4	WHO and CDC carry out a joint review of the Communicable Disease Surveillance Plan and develop specific objectives for Surveillance and Response at the Regional Level. This review should assess the feasibility of tracking completeness of reporting at district and country levels, weekly surveillance of priority and epidemic diseases, and development of a weekly online epidemiologic bulletin to provide surveillance feedback at the regional level. This review should also reexamine the country surveillance framework developed close to ten years ago and assess appropriate allocation of resources to the country level for disease surveillance and response.

i.5	Only a few programs, e.g., Malaria, Measles, and HIV have adequate data to monitor incidence, prevalence, and program impact. Most indicators submitted in the program proposal (requested by USAID as standard indicators) and in materials provided to the evaluation team are process indicators: policies workshops held, policies developed, technical assistance provided, training courses carried out, and number of people trained. Such indicators, without evidence of changed performance at the operational level, are of minimal value. Policy and capacity strengthening are of no value unless services are provided in a timely manner and meet quality standards. One country reported on training for use of Zinc when Zinc was not available in country. Capacity strengthening should only be implemented when and where materials promoted in the training are available at service delivery levels for immediate use after training.
R-5	Future work plans and program reports should provide a balanced set of objectives and indicators including process, outcome, and impact. Process inputs need to be linked to expected outcomes and impacts. In reporting to USAID, expenditures need to be linked to activities and results.

i.6	African countries are making incredible progress in several areas: immunization, malaria,

	and, in part, HIV. Three areas are, however, identified as major obstacles to the achievement of the MDGs: **Maternal Health** including timing of births, prenatal care, safe delivery, access to quality emergency obstetrical care, and post-partum care. **Neonatal Care** – Given that an increasing proportion of <5 mortality is neonatal, neonatal care needs to be improved including the availability of antibiotics at the level of delivery. **Tuberculosis** – Progress is being made with TB-HIV co-infection. Non-HIV TB is an increasing issue which threatens the health and development of the continent.
R-6	WHO/AFRO carefully assess these three issues to identify areas for program strengthening.

i.7	The 2005-2009 Grant with its ten program areas is overly complex and does not maximize the potential for synergies within the WHO/AFRO USAID partnership.
R-7	In the 2010-2014 USAID Grant to WHO, decrease the number of program areas from ten to six . Select program areas for future partnership that best meet the following criteria: Clear documentation of the health need Evidence that the program is, in fact, effectively addressing the health need A clear vision of program goals, objectives, strategies, and monitoring and evaluation plan that will be undertaken over the next five years A full recognition of the roles and budgetary needs at the Country Ministry, the Country WHO Office, the Inter-Country Teams, and WHO/AFRO Definitive plans to maximize the WHO/AFRO USAID partnership including those of USAID's collaborating partners.

i.8	Maximum impact on health occurs when personnel and resources are provided at the country level. The team commends the WHO/AFRO policy on resource allocation as admirable and appropriate.
R-8	Budgetary allocations for the 2010-2014 USAID Grant should follow the current WHO financial allocation guidelines. 60% at Country level 20% at Inter-Country Level 20% at WHO Regional Office Level

i.9	A number of positions to be funded by the USAID grant have remained vacant for prolonged periods of time.
R-9	Annual reports should include a listing of positions that were designated for USAID support and the names of the persons filling those positions. Filling of currently vacant positions to be funded by the 2010-2014 USAID Grant should follow the guidelines recommended for the 2010-2014 USAID Grant above (Recommendations 7 and 8 above).

i.10	Since the introduction of IMCI, non-pneumonia cases of fever have been treated as malaria. The malaria indicator surveys using Rapid Diagnostic Tests (RDTs) are showing that only a small percentage of fever cases (10-30%) are in fact malaria (varies by country

	& season). Further reductions in under-five mortality beyond measles, pertussis, malaria, pneumonia and under-nutrition will require an improved understanding of unexplained fevers. A hospital study from Kenya on which blood cultures were obtained provides useful information (N Engl J Med. 2005 Jan 6; 352(1):39-47). In that study, Streptococcus pneumoniae, non-typhoidal salmonella, Haemophilus influenzae, Escherichia Coli, and Staphylococcus aureus were the most frequent isolations.
R-10	WHO should develop, with academic and research institutions, a strategy for assessing non-malaria causes of fever. This information will be needed to upgrade the IMCI protocol and, more importantly, IMCI effectiveness.

i.11	Pneumonia accounts for a significant proportion of non-malaria cases of fever. Several countries are not using the IMCI guidelines for diagnosis and treatment of pneumonia.
R-11	Diagnosis and treatment of pneumonia will significantly decrease under five mortality and contribute to the achievement of MDG 4. Cases meeting the IMCI definition for pneumonia should be treated with antibiotics. WHO has just issued new recommendations for the treatment of pneumonia at the level of first contact (community or health facility) (Lancet Infectious Diseases 9:185-196.).

WHO recommendations for early antimicrobial treatment of childhood pneumonia have been effective in reducing childhood mortality, but the last major revision was over 10 years ago. The emergence of antimicrobial resistance, new pneumonia pathogens, and new drugs have prompted WHO to assemble an international panel to review the literature on childhood pneumonia and to develop evidence-based recommendations for the empirical treatment of non-severe pneumonia among children managed by first-level health providers. Treatment should target the bacterial causes most likely to lead to severe disease, including Streptoccocus pneumoniae and Haemophilus influenzae.

The best first-line agent is amoxicillin, given twice daily for 3-5 days, although co-trimoxazole may be an alternative in some settings. Treatment failure should be defined in a child who develops signs warranting immediate referral or who does not have a decrease in respiratory rate after 48-72 hours of therapy. If failure occurs, and no indication for immediate referral exists, possible explanations for failure should be systematically determined, including non-adherence to therapy and alternative diagnoses. If failure of the first-line agent remains a possible explanation, suitable second-line agents include high-dose amoxicillin-clavulanic acid with or without an affordable macrolide for children over 3 years of age.

i.12	Choices as to priorities in health are increasingly determined by fund availability and allocation, rather than need.
R-12	WHO/AFRO increase its presence at decision level for Global Health Initiatives.

i.13	WHO/AFRO prepares comprehensive reports on each program component that serve the needs of multiple donors. Given the ever changing environment within USAID, these reports will contribute to the advocacy for continued funding of WHO/AFRO when they are referenced more directly to the contribution of the USAID grant and to the overall performance of the program component..
R-13	When submitting the comprehensive annual report to USAID, highlight the contribution

	of USAID funds to the results achieved by each component.

i.14	Many in WHO country offices are not aware of the scope of USAID health portfolio at the country level.
R-14	WHO /AFRO alert its country offices of potential opportunities of synergies through ongoing communication and collaboration with USAID and its cooperating partners.

i.15	Many in USAID are not aware of the strengths of WHO as a development partner at the country level.
R-15	USAID alert its missions of opportunities to collaborate with WHO.

6. CHALLENGES

- The global economic crisis is having an adverse effect on health in Africa.
- As the number of cost effective interventions available for health promotion, prevention, and development increase, development of sustainable strategies for implementation will be required. Ethiopia's training and deployment of 30,000 Health Extension Workers has great potential and merits careful monitoring.
- Based on the Paris, Accra, and Ouagadougou declarations, the importance of partner leadership and coordination remains a challenge. WHO/AFRO has been tasked with leading the dialogue on Harmonization for Health in Africa among U.N. agencies in the African region.

7. CONCLUSION

The evaluation of the USAID Grant to WHO/AFRO for the period 2004 to 2009 was carried out in a participatory way jointly by USAID and WHO/AFRO team led by an independent expert. The evaluation report summarizes in the few pages here documents significant contributions to improvements in health status by African countries, WHO, and development partners. **T**he USAID Grant has contributed to WHO/AFRO's effectiveness in strengthening the capacity of African countries in improving the health of their people.
The progress made by WHO, African countries and partners during the last five years and the changing health priorities require a reassessment of needs and opportunities for the next USAID Grant to WHO.

To consolidate achievements to date and accelerate efforts by African countries toward reaching the MDGs, it will be critical for WHO/AFRO and USAID to coordinate efforts with other UN and health development partners. The coordination between WHO/AFRO and USAID has been good. However, the potential for realizing a greater mutual benefit has not yet been fully tapped. To do so requires additional effort by the Bureau for Africa at USAID and WHO/AFRO to facilitate linkages at country, regional, and central levels to promote joint activities that further the common agendas of the two organizations. Similarly, the staff at each level within WHO/AFRO should take full advantage of the technical and financial contributions of USAID and its implementing mechanisms to the development and implementation of health programs in African countries.