unicef

Final Report to CIDA

Accelerating Child survival & development

A Results-based Approach in high under-5 mortality areas

May 2005

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Executive Summary

Eleven West and Central African countries began to implement an accelerated child survival and development programme (ACSD) in 2002, supported by the Canadian government, with the objective of demonstrating, within a very short period of time, how integrated implementation of low-cost key effective interventions can have a dramatic impact on child survival. Survey and monitoring results suggest that between 2002 and 2004, increased coverage of a package of selected high-impact interventions in demonstration districts in Senegal, Mali, Benin and Ghana with a population of 3 million, **reduced the under-five mortality rate by 20%,** estimated to vary from 25% in Senegal, 21% in Mali, 17% in Ghana, and 16% in Benin in comparison with control districts, saving an estimated five and a half thousand children a year.

Expansion districts in these four countries and in a further 7 countries, with a population of 14 million, implementing a less comprehensive package of interventions, achieved a reduction of 10% in the under-five mortality rate, saving more than twelve and a half thousand children annually. In expansion countries this ranged from 14% in Guinea Bissau to 5% in Cameroon. Analysis of results shows **major gains in utilization of routine preventive health services** (EPI immunization, Vitamin A supplementation, and ANC attendance) as well as significant increases in use of Insecticide Treated Bednets (ITNs).

The total ACSD programme, impacting on a population of 17 million people, is saving over 18 thousand child lives per year.

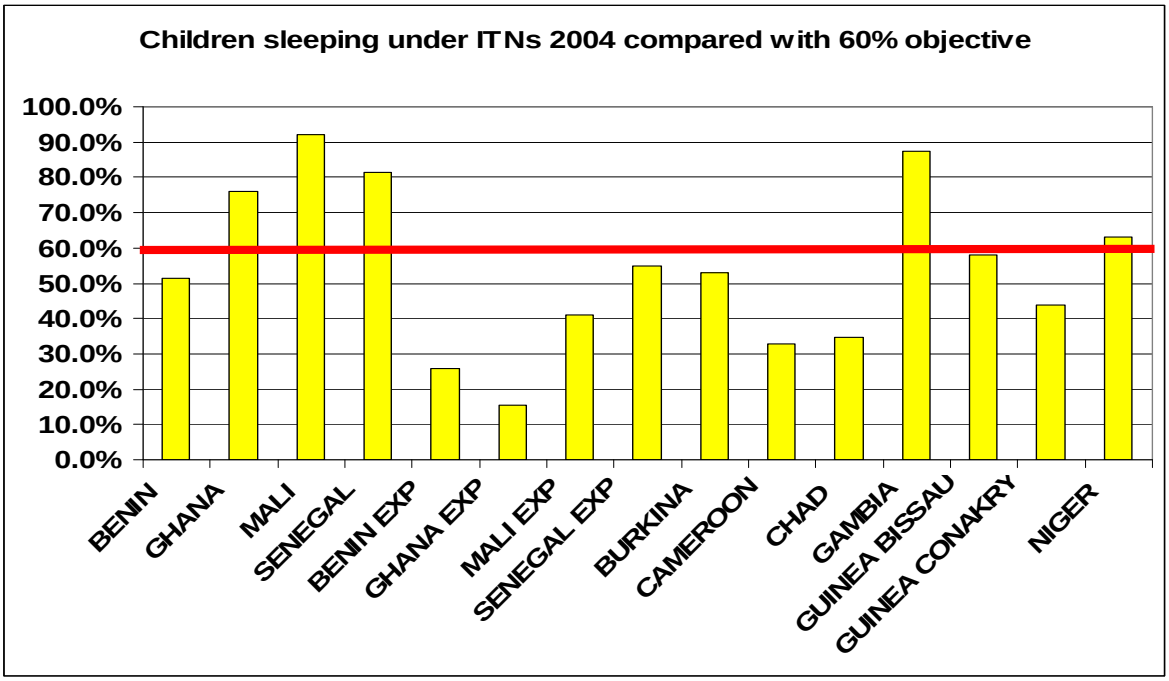
The overall Programme Expenditure for this strategy in the eleven countries was **less than half a dollar per capita per year**, (ranging from 0.30 cents in Mali to around $1 in Niger). The proportion of this cost attributable to CIDA funding is **less than a quarter per capita per year** (varying from $ 0.12 per capita/year in Mali to $ 0.47 per capita/year in Senegal).

ABOVE 15% U5MR REDUCTION GOAL	**SENEGAL**	**25%**
	MALI	**21%**
	SENEGAL EXPANSION	**18%**
	GHANA	**17%**
	BENIN	**16%**
BETWEEN 10 AND 15% U5MR REDUCTION	**GUINEA BISSAU**	**14%**
	GUINEA CONAKRY	**12%**
	BENIN EXPANSION	**11%**
	BURKINA FASO	**10%**
	CHAD	**10%**
BELOW 10% U5MR REDUCTION	**MALI EXPANSION**	**9%**
	GAMBIA	**9%**
	NIGER	**9%**
	CAMEROON	**5%**
	GHANA EXPANSION	**3%**

The impact of the increased coverage of key interventions on the under-five mortality rate has been estimated using the MBB tool and the efficacies of the evidence-based interventions included in the Lancet series on Child survival and on Neonatal survival. These results have surpassed the expected impact on child mortality included in the original agreement with CIDA of a reduction of 15% in U5MR by the end of 2004

in high impact districts in 4 countries. The impact on U5MR reduction for all countries was calculated based on increased coverage from 2001 (baseline) to 2004 (survey results or adjusted coverage, validating 2004 routine monitoring data against a comparison of 2003 survey results and 2003 routine monitoring data).

By the end of 2004, the average coverage of Vitamin A in ACSD districts reached 83% (ranging from 58%-100% in different countries); 48% (ranging from 12%-92%) of children aged under-five were sleeping under insecticide treated bednets; Measles coverage averaged 70% (ranging from 52%-82%); 67% of children were protected by DPT3 (ranging from 57%-90%); Tetanus immunization reached 65% (ranging from 29%-100%); 51% of pregnant women attended ANC3 (ranging from 31%-80%) and IPT with fansidar for pregnant women rose to 58% (ranging from 43%-67%).



The coverage of some interventions was more limited, especially for certain family-based activities such as exclusive breastfeeding, complementary feeding, and home care of diarrhea, and for clinical care of ARI. Survey results in 2003 had already indicated this, and improved understanding of the constraints and opportunities in implementing intervention packages led to some strategy changes in 2004 aimed at sustaining high coverage already attained for some interventions and improving coverage of other key activities. The high impact districts in Benin, Ghana, Mali, and Senegal have placed greater emphasis in 2004 on increasing coverage of key family practices. By the end of 2004, coverage of these family practices increased by 12% for ORT and by 7% for Community management of Malaria, while breastfeeding levels did not rise in most countries (a 20% increase was recorded in Senegal) and care in health facilities remained low (no significant improvement was noted in clinical management of ARI, Malaria or Skilled delivery in ACSD districts compared to control districts).

The average approximate cost in ACSD districts was **US$ 407 per life saved**, ranging from US$ 234 in Mali to US$2,564 in Cameroon. The **cost to CIDA was US$ 220 per life saved**. The low cost per life saved is due to a dramatic increase in Vitamin A supplementation, Measles immunization and ITN coverage in very poor settings with the highest mortality rates. In Ghana and Cameroon, where the baseline for Vitamin A coverage was already high, at 82% in Ghana and 69% in Cameroon, and where Measles coverage was also very high, the impact on the under-five mortality rate has been lower, resulting in fewer lives saved at a higher cost.

Total UNICEF and CIDA Expenditure in ACSD Programme and Costs per Life saved										
ACSD COUNTRIES	Total Progr Exp/year		CIDA Progr. Exp/year		Total Progr. Exp./cap/yr		CIDA Progr. Exp/cap/yr		Total Progr Exp per life saved	CIDA US $ per life saved
SENEGAL	$	1,034,693	$	719,422	$	0.68	$	0.47	$ 372	$ 258
BENIN	$	1,061,732	$	667,944	$	0.45	$	0.29	$ 571	$ 359
MALI	$	2,033,021	$	811,146	$	0.30	$	0.12	$ 234	$ 93
GHANA	$	1,024,742	$	855,165	$	0.34	$	0.29	$ 631	$ 526
Average	**$**	**5,154,187**	**$**	**3,053,677**	**$**	**0.38**	**$**	**0.22**	**$ 345**	**$ 204**
GUINEA BISSAU	$	241,017	$	100,645	$	0.44	$	0.18	$ 299	$ 125
GUINEA CONAKRY	$	320,120	$	163,299	$	0.64	$	0.32	$ 689	$ 351
CHAD	$	215,763	$	171,638	$	0.36	$	0.29	$ 375	$ 298
BURKINA	$	340,038	$	102,042	$	0.61	$	0.18	$ 742	$ 223
GAMBIA	$	138,865	$	97,773	$	0.49	$	0.35	$ 1,127	$ 793
NIGER	$	613,728	$	169,332	$	1.07	$	0.29	$ 1,222	$ 337
CAMEROON	$	308,386	$	105,754	$	0.67	$	0.23	$ 2,564	$ 879
Average	**$**	**2,177,916**	**$**	**910,482**	**$**	**0.62**	**$**	**0.26**	**$ 714**	**$ 299**
TOTAL ACSD	**$**	**7,332,103**	**$**	**3,964,159**	**$**	**0.43**	**$**	**0.23**	**$ 407**	**$ 220**

In addition to CIDA funding, US$ 11 million were leveraged from UNICEF regular resources and other sources for ACSD interventions, to complement the US$ 19 million from CIDA, excluding funding for vaccinations. This includes both UNICEF's own resources and funding raised from other sources. By end of 2003, most countries had used all CIDA funds and secured other sources of funding to maintain programme activities, but in some cases were unable to expand to the extent planned. The main constraint in most countries in moving forward with this very promising programme is the shortage of funding for 2005 (and in some cases for 2004). The challenge is to maintain the momentum generated by this innovative programme and to intensify advocacy for countries to mainstream ACSD into national health policies and programmes in the context of Poverty Reduction Strategies and Health Sector Reforms, and to leverage funding for accelerated Child Survival in Medium Term Expenditure Frameworks, Basket Funding and Budget Support.

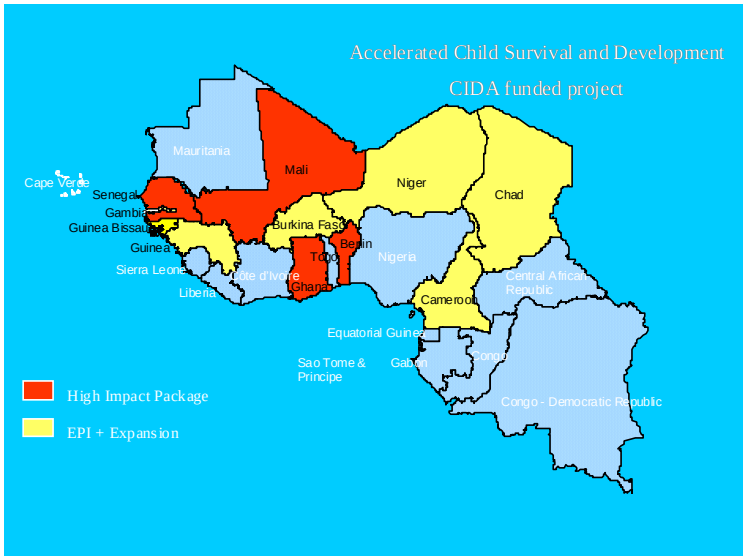
A small number of countries (notably Mali and Senegal) did not spend all of the funding received from CIDA, mainly due to the interest manifested by other donors in the programme that succeeded in generating sufficient additional funding to cover some of the planned activities. The remaining unspent CIDA funds have been set aside to conduct Coverage surveys in all ACSD programme areas and for Impact surveys in the high impact districts in 4 countries. This will enable verification of the achievement of the ACSD objective by assessing reductions in U5MR since 2000/2001.

The initial success of the ACSD strategy has being widely shared with partners involved in child survival in each country. In implementing districts, ACSD has provided a foundation for other initiatives such as operational research on community management of ARI and malaria, and the introduction of the new ORS formula. The strategy has been replicated and expanded in other districts (14 million people were initially targeted, but by the end of 2004 ACSD had reached a population of 17 million.) The strategy has also been adopted by other countries in the region, has been integrated within national health strategies, and is today a reference in accelerating child survival and development through packages of evidence-based interventions. .

This report aims to update the intermediary report submitted to CIDA in May 2004, in the light of current progress in implementing ACSD in the eleven West and Central African countries.

1. The Accelerated Child Survival and Development (ACSD) strategy

A disproportionate number of the 11 million annual child deaths worldwide occur in West and Central Africa. In response to this, UNICEF selected three high impact packages of cost-effective interventions and innovative activities aimed at substantially reducing child mortality, focusing specifically on the most vulnerable, and began implementing this approach in 16 high mortality districts in 4 countries in West and Central Africa, targeting an initial population of 3 million people. The Canadian Government supported this initiative for Accelerated Child Survival and Development (ACSD), providing CND $3 million in 2001 and CND $26 million in 2002. Over a three-year period from 2002-2004, implementation was expected to result in an average 15% reduction in under-five mortality in the 16 high impact demonstration districts in four countries. Expansion of these interventions was planned in a phased way to other poor, high mortality districts in 11 West and Central African Countries. In the longer term (i.e. by 2010), once interventions are established, a reduction of 35% in child mortality is anticipated in these districts in the 11 countries.



1.1 Population coverage

The initial ACSD strategy was adopted by UNICEF in 2002 as a regional approach for the Western and Central Africa region with a view to expanding the initiative beyond the initial 11 countries. Throughout programme implementation, the targeted population has been considerably higher than the initial anticipated figure of 3 million. Four countries, Mali, Benin, Senegal, and Ghana implemented the full, high-impact intervention package in the 16 High-Impact Demonstration Districts. These four countries, along with the other 7 participating West and Central African countries (Burkina Faso, Chad, Cameroon, Gambia, Guinea Bissau, Guinea Conakry, and Niger), also implemented an EPI+ and ITN intervention package and initiated ANC in Expansion Districts. Since 2002, the programme has been working with nearly 100 districts: 16 high-impact districts in 4 countries, all districts in 10 entire regions the same 4 countries, and 31 expansion districts in 7 other countries. The actual targeted population since 2002 includes 3 million people in high-impact countries, 10.5 million in expansion districts in the same countries, and 3.5 million in expansion countries, a **total targeted population of 17 million people, with 3 million children under-five**.

For evaluation purposes, coverage of the interventions was measured in collaboration with CDC Atlanta through large scale coverage surveys carried out in the high-impact districts and in comparison districts in the summer of 2003, and in expansion districts from December 2003 to January 2004. 2004 survey results (where they existed) and 2004 routine monitoring data (validated and adjusted against a comparison of 2003 survey results and 2003 monitoring data to ensure accuracy) were compared with 2001 baseline data to confirm trends of increased coverage of key ACSD interventions by the end of 2004 and to calculate impact. Where no viable 2004 data were available, the 2003 survey results were used.

1.2 The three intervention packages originally selected for this programme include:

1.2.1 Immunization plus

- Routine immunization and periodic measles catch-up
- Vitamin A supplementation bi-annually
- Distribution and promotion of Insecticide Treated Nets for all children who are fully vaccinated as well as pregnant women, and re-dipping of bednets every six months

1.2.2 Antenatal Care

- Intermittent preventive treatment (IPT) of malaria with SP (Fansidar) for pregnant women
- Tetanus immunization during pregnancy to prevent maternal & neonatal tetanus
- Supplementation with iron/folic acid during pregnancy and with Vitamin A post-partum

1.2.3 Improved management of pneumonia, malaria and diarrhea

- Promotion of exclusive breastfeeding for six months, timely complementary feeding
- Improved and integrated management (at the health facility, community and family levels) of children suffering from ARI, malaria and diarrhea, including home-based ORS use, treatment of malaria with anti-malarial blisters, and treatment of ARI with antibiotic blisters
- Promotion of household consumption of iodized salt

1.3 Recapitulation of coverage results 2002/2003 already reported in the Progress Report 2004

1.3.1 Intervention districts and intervention packages actually implemented

Three types of district were distinguished in the initiative, namely control districts, high-impact districts, and expansion districts. High-impact districts are those initially targeted for implementation in 4 countries (Benin, Ghana, Mali and Senegal), where all three Intervention Packages listed above were implemented. Expansion districts refer to other areas in the high-impact countries, and to expansion districts in 7 other countries (Burkina Faso, Cameroon, Chad, Gambia, Guinea Bissau, Guinea Conakry, and Niger), where the initial emphasis was on the Immunization plus package. Control districts - where no support was provided by UNICEF to the above intervention packages - were selected in comparative areas for high-impact and expansion districts in Benin, Ghana, Mali, and Senegal, as well as in comparative areas in five of the expansion countries, to enable comparisons to be made of the evolution in the coverage of key interventions.

1.3.2 Coverage surveys

Surveys to measure coverage results were carried out in 2003 after more than 18 months of ACSD intervention. Analysis of results showed major gains mainly in vaccination levels, Vitamin A distribution, ITN use, and ANC visits. Results also indicated that insufficient emphasis was placed on community IMCI (c-IMCI), necessitating major promotion of family/community based activities such as exclusive breastfeeding, complementary feeding, use of ORT and re-dipping of bednets. Survey results also indicated that ANC+ activities needed to be reinforced through further training of health workers in outreach strategies and strengthening communication strategies to ensure better quality and effective coverage of key interventions. In response to coverage results and analysis, participating countries revised priorities for the remaining duration of the implementation period and reoriented implementation strategies accordingly.

1.3.3 Coverage results by intervention: EPI+

Increased coverage in immunization and Vitamin A supplementation was achieved in all of the districts, with remarkable increases in some instances. Nine out of the eleven countries achieved over 75% Vitamin A supplementation coverage (4 surpassing the objective of 90%), 8 countries reached DPT3 coverage of over 70%, and 7 achieved Measles immunization coverage of 70% or over.

1.3.4 Coverage results by intervention: ANC +

In both Senegal and Mali, the proportion of pregnant women attending 3 or more antenatal care visits more than doubled, and increased in Ghana from 58% to 80%, attributed largely to ITN distribution linked to

initial ANC consultation, while remaining stable in Benin where it had already reached 80%. The estimated Tetanus coverage in all four countries was 40% or above, reaching 66% for Senegal.

1.3.5 Coverage results by intervention: IMCI+

Results from some of the IMCI interventions were limited, including essential family practices such as exclusive breastfeeding and complementary feeding. This result illustrates the difficulty involved in promoting behavioral changes that necessitate commitment for a period of time, e.g. exclusive breastfeeding for 6 months, and the need for an intensive, interpersonal approach to facilitate this type of behavioral change.

Emphasis was placed on increasing first-line prevention and care at community level, with little focus on improving clinical care. Delivery by a skilled attendant at facility level improved only marginally, unrelated to any specific ASCD strategy, as no significant difference was recorded compared to control districts.

2. Update on Coverage Results by end December 2004: Evolution against Baseline / Control / Objectives

2.1 Expanded Programme of Immunization Plus (EPI+)

EPI+ concentrated on reinforcing the use of immunization as an entry point for a series of **population-oriented activities**, including Vitamin A supplementation and re-dipping of bednets. Some countries added deworming of under-fives to the EPI+ package to reduce malnutrition and loss of micronutrients. The outreach approach was continued in all ACSD districts with the objective of maintaining high coverage of DPT3 and Measles immunization, and of Vitamin A supplementation through a combination of:

- Securing provision of vaccines and vaccination equipment;
- Increased access by cold chain consolidation and logistics provision (motorbikes or vehicles at different service delivery levels);
- Reinforced supervision to ensure the quality of routine services, community participation in monitoring, provision of equipment (safety of injection), and campaigns to boost routine services (Measles, Polio NIDs);
- Systematic supplementation with Vitamin A;
- Performance contracts with community health workers to catch up on all defaulters.

Catch-up EPI linked with LLITN distribution
Burkina Faso

A campaign to rapidly increase bednet coverage in a short period of time in two ACSD districts in Burkina Faso succeeded in distributing 30,000 subsidized LLITNs and in re-dipping 10,000 ITNs in four days, covering a total of 30% of the target group of under-fives and pregnant women. This distribution was in addition to routine bednet distribution and re-dipping, which reached 25% of under-fives and 38% of pregnant women in 2003, and over 50% in 2004, and illustrated the potential of campaigns to massively boost coverage when demand has already been created. To profit from the campaign, EPI catch-up was carried out, with health workers screening children, identifying and vaccinating defaulters from routine immunization services.

EPI Defaulter Catch-up : Guinea Conakry

In Guinea Conakry, three EPI catch-up activities were carried out in 2003 in all villages in two ACSD health districts, with a population of 488,823 of whom 19,533 were children less than one year old. Low coverage areas were specifically targeted after careful mapping during micro-planning sessions held by the health district management team, health center staff and health center community management committees. These immunization activities were extended to all remote areas 10Km or more from the health center that are not included in routine outreach activities. These areas in theory should be covered by mobile teams but this is not always done due to funding restrictions at district health team level. CIDA funding was used for operational costs such as perdiems for health centre staff, transport costs, supervision costs for the district health team and for a local consultant, as well as social mobilization through local radio broadcasting and interpersonal communication with community leaders. Family participation was achieved through promotion activities carried out by the members of the Health Centre Management Committees, local leaders and community health workers. Between 2002 and 2003, coverage in ACSD districts increased from 51% to 88% for DPT3, and from 53% to 93% for Measles. 73% of children aged 12-23 months were fully immunized, in comparison with 27% in the 2 control districts.

A strategic shift in the outreach approach occurred in 2004, moving not alone from relying on health centre-based services to increased emphasis on outreach services, but also orienting outreach to planning and implementing twice-yearly **Child Health Days** in every village with the aim of reaching each child with key interventions. Child Health Days include:

- A door-to-door strategy to ensure defaulter tracing and EPI catch-up, sensitization of pregnant women to attend ANC and/or to deliver at a health facility, ORS use, and re-dipping and improved use of ITNs;
- Strong community involvement in planning, identification of "Zero Dose" children after NIDs, and actively searching defaulters;
- Increasing access to Birth registration for every newborn.

Child Health Days : Senegal

In July 2004, the 7 districts in Kolda and Tambacounda, with a population of 1,487,116 organized door-to-door Child Health Days to offer a package of free preventive services to under-fives in the context of the ACSD approach. The intervention package consisted of Vitamin A supplementation for children aged 6-59 months and for post-partum women, re-dipping bednets in households and catch-up measles and yellow fever for children aged 12-23 months.

Results from Child Health Days include 185,819 re-treated bednets; 96% coverage in Vitamin A (261,732 children 6-59 months); 70% Vitamin A supplementation for 76% of post-partum women (6,790 women), and measles vaccination for 2,284 children aged 12-23 months.

Three recommendations were made based on this exercise:

- Organize systematic Child Health Days once a year before the rainy season (May)
- Reinforce routine Vitamin A supplementation for under-fives and post-partum women and routine bednet re-dipping
- Integrate further activities (IPT for pregnant women, data collection on children without birth certificates with a view to certification) within future Child Health Days and campaigns based on routine coverage data

Increased coverage of immunization and Vitamin A supplementation was achieved in all of the districts, with remarkable increases in some instances, due to systematic Vitamin A supplementation at each contact and inclusion in immunization campaigns. Nine out of eleven countries achieved over 75% Vitamin A supplementation coverage (3 surpassing the goal of 90%), and at least 70% Measles and 80% DPT3 immunization coverage was achieved in 9 countries. In the ACSD implementation districts in Senegal, ITN coverage among young children and pregnant women rose from 1% to 81%, while at the same time routine DPT3 immunization levels rose from 34% to 84%. In the ACSD implementation districts in Mali, ITN coverage among young children and pregnant women rose from 6% to 92%, and routine measles immunization coverage more than doubled (from 38% to 89%). The strategy of re-dipping bednets every 6 months was systematically integrated into EPI and ANC activities, especially within the 6 monthly Child Health Days and the door-to-door strategy. This will ensure that current coverage levels are maintained and should result in a sustainable increase in ITN coverage. As ITN distribution and re-impregnation of bednets have been integrated in EPI activities, coverage trends for Vitamin A, Measles, DPT3 and ITNs follow the same pattern in most countries.

Child Health Week : Ghana

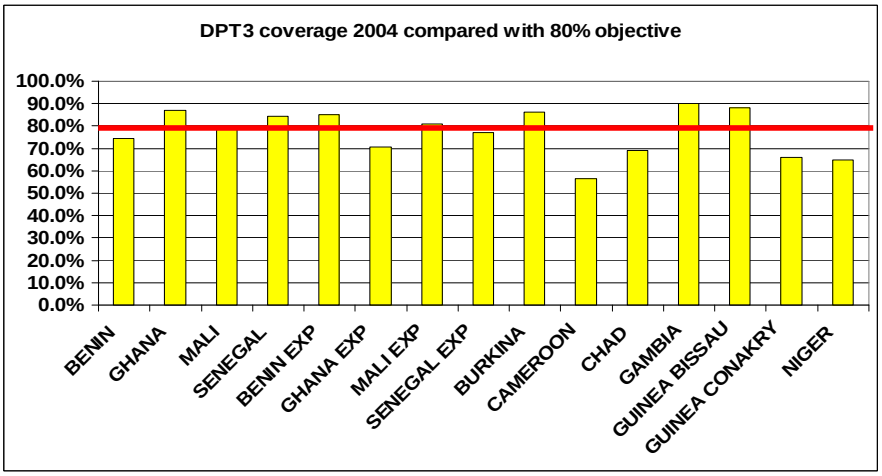
As part of efforts to reach more children with cost-effective child survival interventions, Ghana decided to set aside one week in May 2004 to promote child survival and development, called Child Health Week. A few days before this week, health personnel and community health volunteers embarked on a communication campaign to raise awareness about the benefits that children derive from routine immunization, Vitamin A supplementation, and sleeping under an ITN. During the week, health workers ensured that services were available at all health centers and hospitals and also in some outreach sites. All 6 ACSD high-impact districts in the Upper East region, with a population of 961,246, took advantage of the Child Health Week and organized an extensive communication campaign on child survival interventions.

MOH administrative data reveal that the number of infants vaccinated peaked in May 2004 compared to May 2003, resulting in 87% of children receiving DPT3 in 2004 (adjusted monitoring) as compared with 72% in 2003 (ACSD survey) and 78% in 2002 (INHS). Four hundred thousand bednets were retreated nationwide during the week.

2.1.1 DPT3 immunization for children aged 12-23 months: ACSD objective 80%

DPT3 coverage reached a total average of 77%, ranging from 57% to 90% in different countries.

DPT3 coverage 2004 as compared with the 80% objective



HIP Countries

DPT3 12-23 months		HIGH IMPACT DISTRICTS					
		BASELINE 2001		MID TERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	Data	66.4%	73.4%	49.0%	81.1%		74.6%
	Source	DHS 2001	DHS 2001	Household survey CDC 2003	Cluster survey CDC Dec 2003		Adjusted monitoring 2004
GHANA	Data	77.9%	78.1%	75.5%	77.8%	78.5%	87.0%
	Source	INHS 2002 survey	INHS 2002 survey	DHS 2003	DHS 2003	adjusted monitoring 2004	Adjusted monitoring 2004
MALI	Data	35.7%	33.4%	58.2%	82.7%	58.2%	78.7%
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003	Control survey 2003	Adjusted monitoring 2004
SENEGAL	Data	34.1%	33.7%	51.6%	64.7%	51.6%	84.3%
	Source	DHS MALI 2001	DHS 1999	Mali control survey 2003	ASCD survey	Mali control survey 2003	Adjusted monitoring 2004

In both Mali and Senegal there was a major improvement with DPT3 coverage at about 80% or more in both high-impact and expansion districts, in comparison to the control areas where the coverage rose to just 50%. Both high-impact and expansion districts remained stable at about 80% in Benin and Ghana, as well as control districts in Ghana, while Benin sustained coverage levels despite a coverage reduction in control districts.

Expansion Districts in 4 HIP Countries

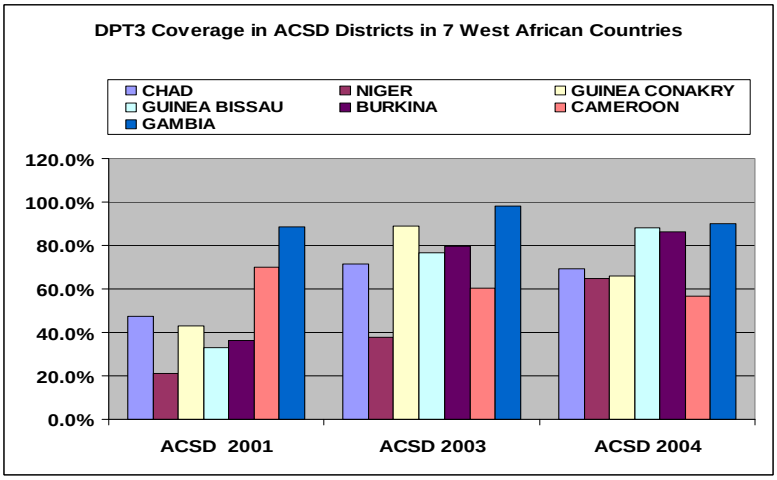
DPT3 12-23 months		EXPANSION DISTRICTS					
		BASELINE 2001		MID TERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN EXP	Data	66.4%	83.7%	49.0%	87.3%		85.1%
	Source	DHS 2001	DHS 2001	Household survey CDC 2003	Household survey CDC 2003		Adjusted Monitoring 2004
GHANA EXP	Data	77.9%	59.7%	75.5%	62.2%	78.5%	70.6%
	Source	INHS 2002 survey	INHS 2002 survey	DHS 2003	DHS 2003	adjusted monitoring 2004	Adjusted monitoring 2004
MALI EXP	Data	35.7%	38.1%	58.2%	66.9%	58.2%	81.0%
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003	Control survey 2003	Adjusted Monitoring 2004
SENEGAL EXP	Data	34.1%	33.7%	51.6%		51.6%	77.1%
	Source	DHS MALI 2001	DHS 1999	Mali control survey 2003		Mali control survey 2003	Monitoring 2004

Expansion Countries

DPT3 12-23 months		EXPANSION DISTRICTS					
		BASELINE 2001		MID TERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BURKINA	Data	50.0%	36.4%	64.6%	79.7%	96.8%	86.4%
	Source	2001 EPI monitoring	2001 EPI monitoring	EPI review 2003	EPI review 2003	adjusted monitoring 2004	Adjusted monitoring 2004
CAMEROON	Data	64.0%	70.0%	60.4%	60.4%	74.0%	56.6%
	Source	Adawa Baseline survey 2003	Adawa Baseline survey 2003	DHS 2004	DHS 2004	adjusted monitoring 2004	adjusted monitoring 2004
CHAD	Data	17.3%	47.5%	3.7%	71.5%	25.7%	69.1%
	Source			EPI Survey 2004	EPI Survey 2004	adjusted monitoring 2004	adjusted monitoring 2004
GAMBIA	Data	82.2%	88.7%	93.0%	98.2%	100.8%	90.0%
	Source			2003 EPI Survey (NBW)	2003 EPI Survey (LRD)	adjusted monitoring 2004	adjusted monitoring 2004
GUINEA BISSAU	Data	68.0%	33.0%	76.0%	76.6%	75.0%	88.0%
	Source	2001 EPI monitoring	2001 EPI monitoring	ACSD survey	CDC analysis EPI survey 2004	adjusted monitoring 2004	Adjusted monitoring 2004
GUINEA CONAKRY	Data	43.0%	43.0%	45.0%	88.9%	40.0%	66.0%
	Source	2000 EPI Nat.Survey	2000 EPI Nat.Survey	Jan 2004 EPI Survey	Jan 2004 EPI Survey	adjusted monitoring 2004	adjusted monitoring 2004
NIGER	Data	24.8%	21.0%	25.8%	37.9%	79.3%	64.7%
	Source	MICS 2000	MICS 2000	EPI survey 2004	EPI survey 2004	adjusted monitoring 2004	Adjusted Monitoring 2004

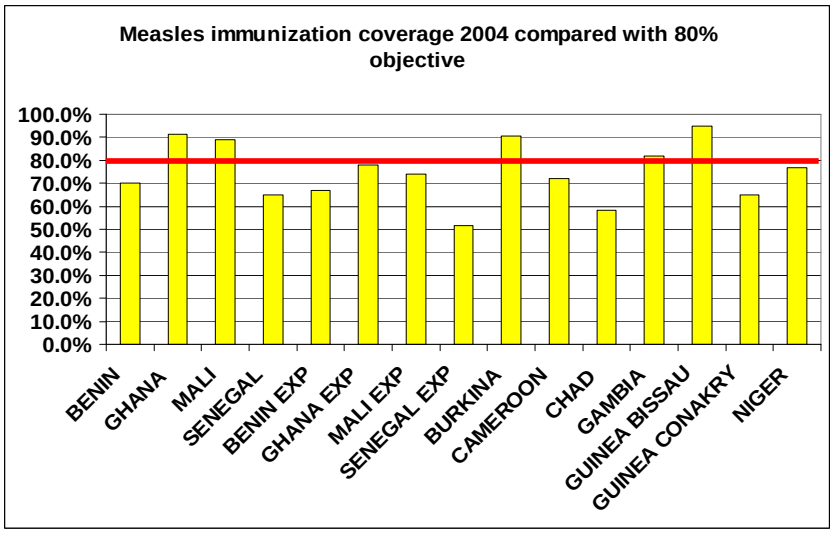
Chad, Guinea Conakry, and Niger achieved strong improvement in expansion areas (60-75%) with stagnation at low levels in control districts except in Niger. Burkina and Guinea Bissau showed strong increases (80%) in both expansion and control districts. Both areas in Gambia remained stable at over 90% and in Cameroon at about 60%. High levels occasionally found in control areas can be explained by the fact that national averages have sometimes been used when specific data for control areas was not available.

Chad faced a five month shortage of antigens throughout the country due to non payment of the EPI bill in 2003, yet despite this major constraint, the ACSD strategy still achieved significant increased coverage. In Cameroon, while routine monitoring data indicates a stable immunization coverage rate at around 80%, the latest DHS (2003) reported a 60% coverage rate, which brought the adjustment of the 2004 monitoring data to 57% in expansion districts. In Niger, the baseline was low at 21%, and in the remote zones of Maradounfa and Matameye DPT3 coverage increased by over 40% during the 3 years of continuous ACSD support.



2.1.2 Measles immunization for children aged 12-23 months: ACSD objective 80%

Measles coverage 2004 compared with the objective of 80%



A national Measles campaign was conducted at least once a year in each country, often linked to ITN distribution. The average coverage in Measles immunization was 70%, with a range from 52% to 95% in different countries.

HIP Countries

There was a substantial improvement in measles coverage in Mali and Ghana in both high-impact (around 90%) and expansion districts (around 80%), while Benin remained stable at about 70% in both districts compared to a decrease in the control areas. Senegal recorded some increase in high-impact districts but not in expansion areas.

Measles Immunization in children 12-23 months		HIGH IMPACT DISTRICTS					
		BASELINE 2001		MID TERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	Data	61.9%	70.2%	48.5%	70.2%		70.2%
	Source	DHS 2001	DHS 2001	Household survey CDC 2003	Cluster survey CDC Dec 2003		Adjusted monitoring 2004
GHANA	Data	78.4%	78.6%	79.5%	91.2%	92.0%	91.2%
	Source	IHN 2002 survey	IHN 2002 survey	DHS 2003	DHS 2003	adjusted monitoring 2004	DHS 2003
MALI	Data	48.1%	37.8%	56.4%	83.4%	56.4%	88.8%
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003	Control survey 2003	Adjusted monitoring 2004
SENEGAL	Data	51.3%	51.8%	51.3%	70.6%	51.3%	64.8%
	Source	DHS MALI 2001	DHS 1999	Mali control survey 2003	ASCD survey	Mali control survey 2003	Adjusted monitoring 2004

Expansion Districts in 4 HIP Countries

Measles Immunization in children 12-23 months		EXPANSION DISTRICTS					
		BASELINE 2001		MID TERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN EXP	Data	61.9%	77.1%	48.5%	72.2%		66.8%
	Source	DHS 2001	DHS 2001	Household survey CDC 2003	Household survey CDC 2003		Adjusted Monitoring 2004
GHANA EXP	Data	78.4%	52.0%	79.5%	76.0%	92.0%	78.0%
	Source	IHN 2002 survey	IHN 2002 survey	DHS 2003	DHS 2003	adjusted monitoring 2004	DHS 2003
MALI EXP	Data	48.1%	43.3%	56.4%	63.1%	56.4%	74.2%
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003	Control survey 2003	Adjusted Monitoring 2004
SENEGAL EXP	Data	51.3%	51.8%	51.3%		51.3%	51.5%
	Source	DHS MALI 2001	DHS 1999	Mali control survey 2003		Mali control survey 2003	Monitoring 2004

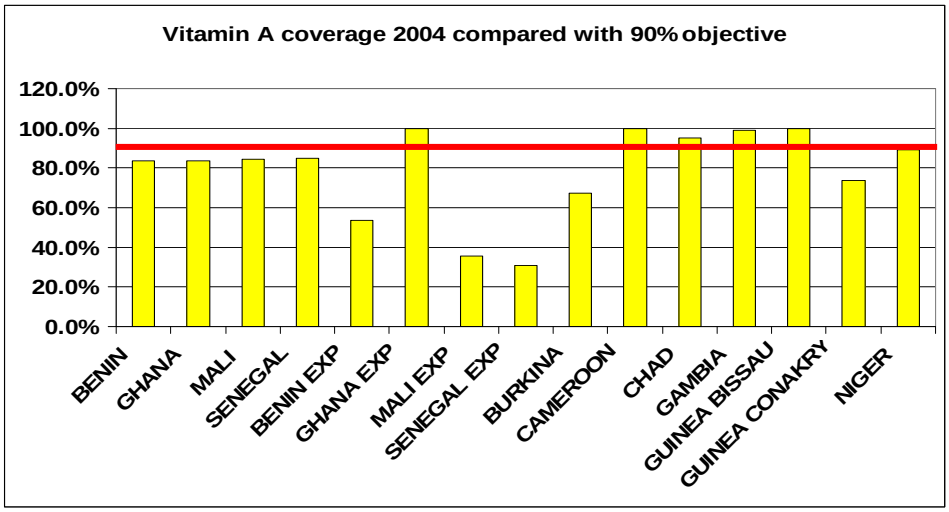
Expansion Countries

Measles Immunization in children 12-23 months		EXPANSION DISTRICTS					
		BASELINE 2001		MID TERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BURKINA	Data	45.7%	48.8%	65.0%	71.8%	75.0%	90.7%
	Source	2001 EPI monitoring	2001 EPI monitoring	EPI review 2003	EPI review 2003	ACSD survey May 2004	Adjusted monitoring 2004
CAMEROON	Data	59.0%	62.3%	60.4%	60.8%	66.0%	72.0%
	Source	Adawa Baseline survey 2003	Adawa Baseline survey 2003	DHS 2004	DHS 2004	adjusted monitoring 2004	adjusted monitoring 2004
CHAD	Data	24.5%	20.3%	10.4%	66.2%	7.4%	58.1%
	Source			EPI Survey 2004	EPI Survey 2004	adjusted monitoring 2004	adjusted monitoring 2004
GAMBIA	Data	90.2%	90.1%	98.2%	100.0%	81.1%	82.0%
	Source	EPI cluster survey 2001		2003 EPI Survey (NBW)	2003 EPI Survey (LRD)	adjusted monitoring 2004	adjusted monitoring 2004
GUINEA BISSAU	Data	55.0%	29.0%	76.1%	85.4%	75.1%	95.0%
	Source	2001 EPI monitoring	2001 EPI monitoring	ACSD survey	CDC analysis EPI survey 2004	adjusted monitoring 2004	Adjusted monitoring 2004
GUINEA CONAKRY	Data	40.0%	40.0%	61.6%	94.7%	42.6%	65.0%
	Source	2000 EPI Nat.Survey	2000 EPI Nat.Survey	Jan 2004 EPI Survey	Jan 2004 EPI Survey	adjusted monitoring 2004	adjusted monitoring 2004
NIGER	Data	25.0%	28.0%	33.0%	44.9%	44.9%	76.9%
	Source	MICS 2000	MICS 2000	EPI survey 2004	EPI survey 2004	adjusted monitoring 2004	Adjusted Monitoring 2004

There was a significant increase in measles coverage in Chad (from 20% to around 60%), in Burkina Faso (from 48% to 90%), in Niger (from 28% to 77%), and in Guinea Bissau (from 29% to 95%) with much lower increases in control areas. Coverage levels in Guinea Conakry increased to 65% while stagnating in control districts. Coverage remained high and stable in Gambia at over 80% and in Cameroon at around 70%.

2.1.3 Vitamin A supplementation: ACSD objective 90%

Vitamin A coverage in 2004 compared with the 90% objective



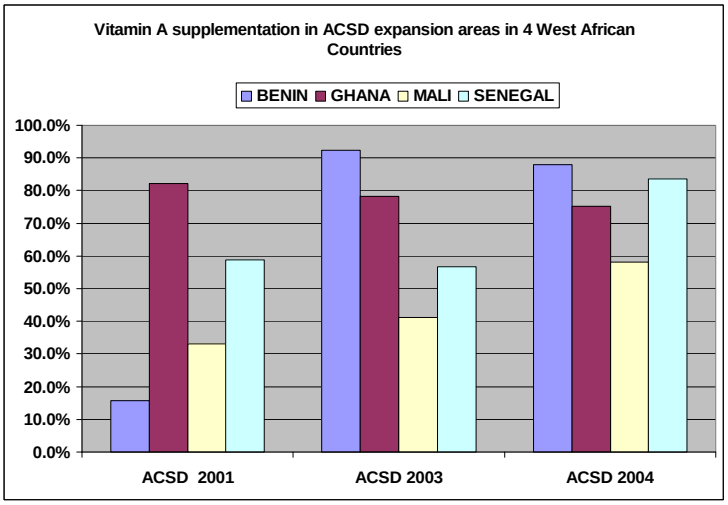
HIP Countries

Vitamin A in the last 6 months children 6-59 months		HIGH IMPACT DISTRICTS					
		BASELINE 2001		MIDTERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	Data	14.8%	10.4%	53.4%	94.9%	53.4%	83.7%
	Source	DHS 2001	DHS 2001	Household survey CDC 2003	Cluster survey CDC Dec 2003	Household survey CDC 2003	Adjusted monitoring 2004
GHANA	Data	64.2%	82.2%	84.8%	85.5%	100.0%	83.5%
	Source	INHS 2002 survey	INHS 2002 survey	DHS 2003	DHS 2003	adjusted monitoring 2004	Adjusted monitoring 2004
MALI	Data	31.5%	33.9%	35.6%	78.5%	35.6%	84.3%
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003	Control survey 2003	Adjusted monitoring 2004
SENEGAL	Data	30.4%	58.8%	31.0%	76.0%	31.0%	84.8%
	Source	DHS MALI 2001	DHS 1999	Mali control survey 2003	KPC survey	Mali control survey 2003	Adjusted monitoring 2004

There was a major increase in Vitamin A coverage levels in Benin and Senegal to over 80% in both high-impact and expansion districts. Coverage levels in Ghana were already high and remained stable at 80% in all districts, while in Mali there was a major increase to 80% in high-impact and to 60% in expansion districts. In both Mali and Senegal control areas stagnated at around 30%, while in Benin there was a moderate improvement in control districts.

Expansion Districts in 4 HIP Countries

Vitamin A in the last 6 months children 6-59 months		EXPANSION DISTRICTS					
		BASELINE 2001		MIDTERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN EXP	Data	14.8%	15.7%	53.4%	92.4%	53.4%	87.9%
	Source	DHS 2001	DHS 2001	Household survey CDC 2003	Household survey CDC 2003	Household survey CDC 2003	Adjusted Monitoring 2004
GHANA EXP	Data	64.2%	82.2%	84.8%	78.3%	100.0%	75.3%
	Source	INHS 2002 survey	INHS 2002 survey	DHS 2003	DHS 2003	adjusted monitoring 2004	Adjusted monitoring 2004
MALI EXP	Data	31.5%	33.2%	35.6%	41.3%	35.6%	58.2%
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003	Control survey 2003	Adjusted Monitoring 2004
SENEGAL EXP	Data	30.4%	58.8%	31.0%	56.8%	31.0%	83.6%
	Source	DHS MALI 2001	DHS 1999	Mali control survey 2003	KPC survey	Mali control survey 2003	Adjusted Monitoring 2004



This chart visualizes the evolution of Vitamin A coverage in Expansion districts in the 4 High Impact countries.

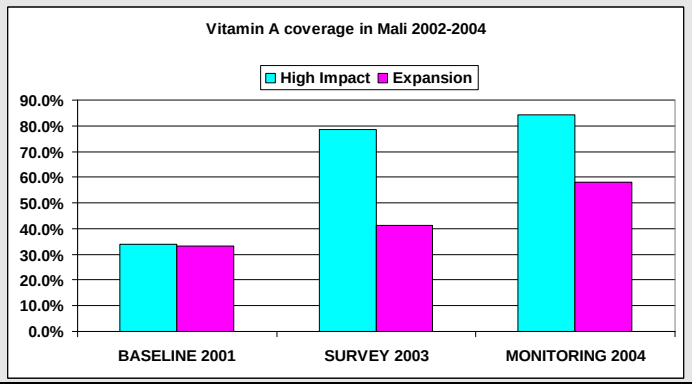
Expansion Countries

Vitamin A in the last 6 months children 6-59 months		EXPANSION DISTRICTS					
		BASELINE 2001		MIDTERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BURKINA	Data	99.8%	78.5%	77.1%	88.8%	33.1%	67.4%
	Source	2001 EPI monitoring	2001 EPI monitoring	Monitoring 2003	Monitoring 2003	ACSD survey 2004	ACSD survey 2004
CAMEROON	Data	56.0%	69.5%	101.1%	89.4%	97.0%	100.0%
	Source	Adawa Baseline survey 2003	Adawa Baseline survey 2003	Monitoring 2003	Monitoring 2003	Monitoring 2004	Monitoring 2004
CHAD	Data	36.2%	20.4%	90.0%	61.3%	95.0%	95.0%
	Source			EPI survey 2004	EPI survey 2004	Monitoring 2004	Monitoring 2004
GAMBIA	Data	11.3%	10.3%	85.8%	99.1%		
	Source	MICS 2000	MICS 2000	2003 EPI Survey (NBW)	2003 EPI Survey (LRD)		
GUINEA BISSAU	Data	50.0%	50.0%	68.7%	87.6%	80.0%	100.0%
	Source	2001 EPI monitoring	2001 EPI monitoring	ACSD survey	CDC analysis EPI survey 2004	Monitoring 2004	Adjusted monitoring 2004
GUINEA CONAKRY	Data	98.0%	63.0%	69.4%	85.7%	66.4%	73.7%
	Source	Monitoring 2001	2000 EPI Nat.Survey	Jan 2004 EPI Survey	Jan 2004 EPI Survey	adjusted monitoring 2004	adjusted monitoring 2004
NIGER	Data	58.8%	66.0%	86.5%	93.2%	87.0%	89.3%
	Source	MICS 2000	MICS 2000	EPI survey 2004	EPI survey 2004	adjusted monitoring 2004	Adjusted Monitoring 2004

The average Vitamin A coverage increase was +20%. There was a strong improvement in Vitamin A coverage in Chad, Cameroon, Gambia, Guinea Bissau and Niger to over 90% in both expansion and control districts, (100% in expansion areas in Cameroon and Guinea Bissau), probably due to national campaigns. Coverage levels stagnated at around 70% in Burkina Faso and Guinea Conakry. In Chad, despite a shortage of Vitamin A, resulting in a 61% coverage rate in 2003, 95% coverage was reached in 2004 after stock repletion and an intense campaign linked to the NIDS and the outreach approach. In Senegal, where a shift took place from Vitamin A supplementation in conjunction with campaigns to more sustainable routine systematic supplementation, coverage initially dramatically dropped, but was restored to above 80% coverage in 2004. Vitamin A has thus been distributed through a combination of mechanisms, including NIDs, ITN and other campaigns, and integrated within routine services.

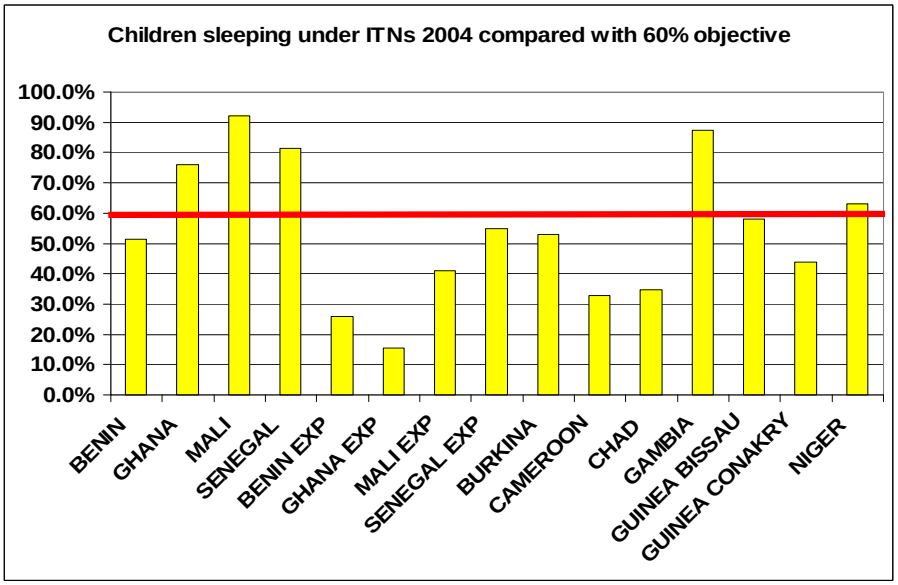
Vitamin A Supplementation

Vitamin A supplementation for children aged 6-59 months has been strongly supported in all ACSD countries. National strategies have been developed to assure twice-yearly Vitamin A supplementation, integrated within routine services or linked to NIDs and re-dipping campaigns. In Benin in 2003, 95% of under-five children in high impact districts and 92% in expansion zones received twice yearly Vitamin A supplementation, while only 53% received it in control zones. This coverage was maintained in 2004 with a slight decline at 84% in high impact and 88% in expansion districts in 2004. In Mali, supplementation with Vitamin A, exclusive breastfeeding and complementary feeding are included in the community-based package. In HIP districts Vitamin A coverage was 34% in 2001 (DHS), 79% in 2003 (survey), reaching an estimated 84% in 2004 (adjusted data based on comparison of survey and monitoring data in 2003). In expansion districts, Vitamin A coverage was 33% in 2003, 41% in 2003 and 58% in 2004.



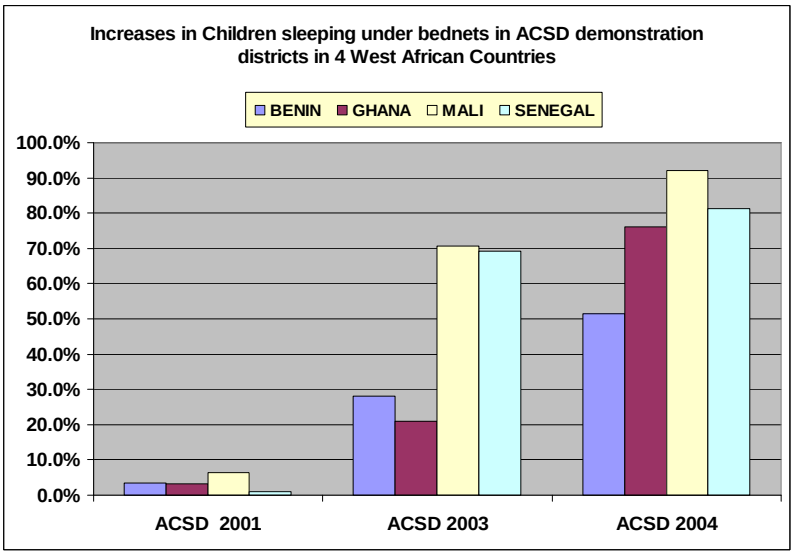
2.1.4. Use of Insecticide Treated mosquito Nets (ITNs): ACSD objective 60%

ITN coverage 2004 compared with the 60% objective



HIP Countries

Percent of children sleeping under a treated bednet the previous night		HIGH IMPACT DISTRICTS					
		BASELINE 2001		MID TERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	Data	5.3%	3.4%	8.8%	28.1%		51.5%
	Source	DHS 2001	DHS 2001	Household survey CDC 2003	Cluster survey CDC Dec 2003		PSI survey nov 2004
GHANA	Data	0.8%	3.1%	1.9%	21.0%		76.0%
	Source	INHS 2002 SURVEY	INHS 2002 SURVEY	DHS 2003	DHS 2003		adjusted monitoring 2004
MALI	Data	0.9%	6.4%	8.6%	70.7%		92.2%
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003		adjusted monitoring 2004
SENEGAL	Data	0.9%	1.1%	8.6%	69.2%		81.3%
	Source	DHS MALI 2001	DHS 1999	Mali control survey 2003	KPC survey		Adjusted monitoring 2004

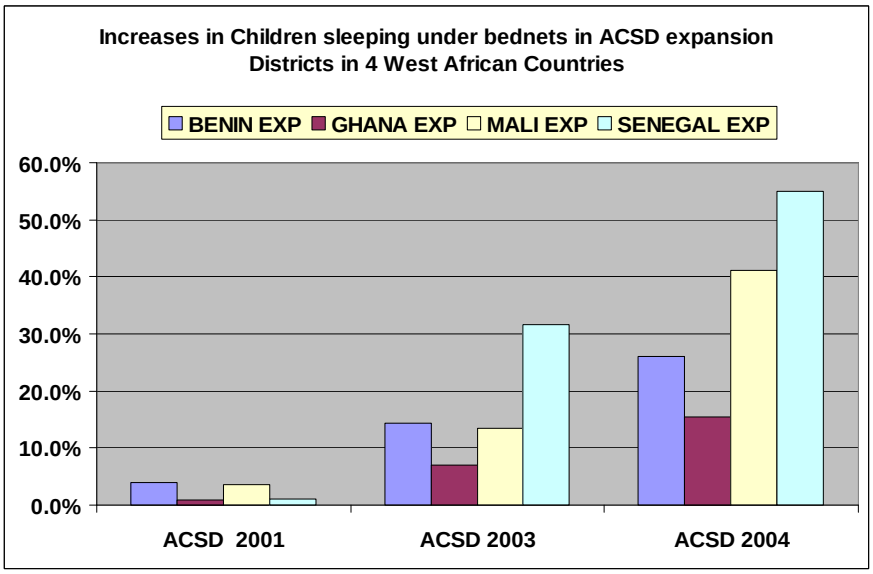


There were strong increases in the number of households ***possessing a bednet*** in all high-impact districts, ranging from 66% in Benin to over 80% in Ghana, Senegal, and Mali, in all cases with increases significantly stronger than in control districts. The number of ***pregnant women and children aged under-five sleeping under ITNs*** increased to between 80% and 90% in Mali and Senegal, to 76% in Ghana and 52% in Benin. In expansion districts, there was a strong increase in ITN use by pregnant woman and children aged under-five, rising to over 50% in Senegal, over 40% in Mali, and to 26% in Benin. The increase in Ghana was 16% for under-fives and non-significant for pregnant women. In both high-impact and expansion districts ITN coverage in control districts remained very low.

Mali carried out a very successful door-to-door re-dipping of bednets before the 2003 rainy season, resulting in an 84% increase in ITN use in HIP districts, leading to an average 13.58% attributable decrease in U5 mortality. In expansion districts in Mali, ITN use increased by 34%, resulting in a 5.26% decrease in U5MR. This door-to-door strategy was replicated by other countries in 2004 in all districts facing a shortage of LLITNs, but where over 30% of households, even in very poor settings, possessed at least one bednet. Training and involvement of community health workers, free distribution of insecticide tablets at household level, and increased social mobilization and communication with partner involvement resulted in a dramatic increase in ITN use in all ACSD districts in 2004. The door-to-door strategy is a key factor in the success of the ACSD approach, contributing to an overall increase of 43% in children sleeping under ITNs, leading to an estimated 7% decrease in U5MR.

Expansion Districts in 4 HIP Countries

Percent of children sleeping under a treated bednet the previous night		EXPANSION DISTRICTS					
		BASELINE 2001		MID TERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN EXP	Data	5.3%	3.9%		14.3%		25.98%
	Source	DHS 2001	DHS 2001		Cluster survey CDC analysis Dec 2003		Household survey Jan 2005
GHANA EXP	Data	0.8%	0.9%	1.9%	7.0%		15.5%
	Source	INHS 2002 SURVEY	INHS 2002 SURVEY	DHS 2003	DHS 2003		Adjusted monitoring 2004
MALI EXP	Data	0.9%	3.6%	8.6%	13.5%		41.1%
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003		adjusted monitoring 2004
SENEGAL EXP	Data	0.9%	1.1%	8.6%	31.7%		55.0%
	Source	DHS MALI 2001	DHS 1999	Mali control survey 2003	KPC survey Nov 2003		Proxy: Monitoring 2004 PW under ITNs

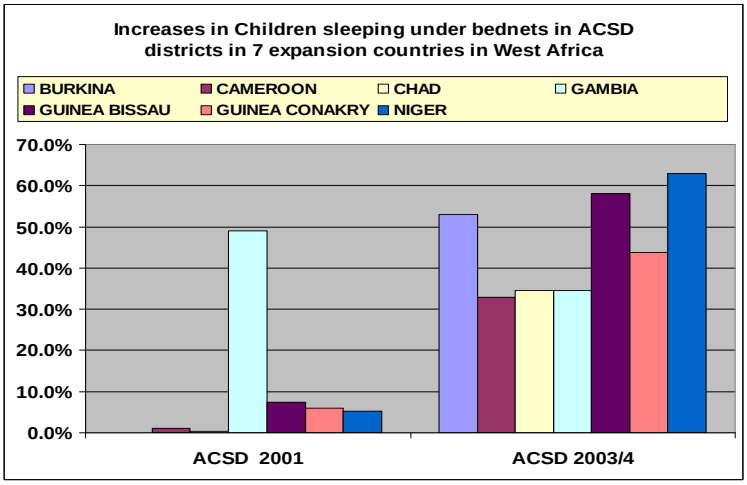


Expansion Countries

The number of households in possession of a bednet increased strongly to over 60% in Niger, Guinea Conakry, Chad, and Burkina Faso. Guinea Bissau had already attained over 60% coverage. The percentage of pregnant women and children aged under-five sleeping under an ITN increased to over 50% in Burkina Faso, Guinea Bissau, and Niger. Neither Guinea Conakry nor Chad have data available for 2004; 2003 survey data shows ITN use at around 40%.

Percent of children sleeping under a treated bednet the previous night		EXPANSION DISTRICTS					
		BASELINE 2001		MID TERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BURKINA	Data	12.4%		6.8%	28.5%		53.0%
	Source	Enquete base 0 RBM 2001		DHS 2003	DHS 2003		Estimation based on number ITNs distributed to U5
CAMEROON	Data	0.3%	1.1%			10.0%	32.9%
	Source	Adawa Baseline survey 2003	Adawa Baseline survey 2003			Monitoring 2004	Monitoring 2004
CHAD	Data		0.3%	0.0%	34.6%		
	Source			Monitoring 2004	ACSD survey 2004		
GAMBIA	Data	49.0%	49.1%	37.1%	87.5%		
	Source	MICS 2000	MICS 2000	2003 EPI Survey (NBW)	2003 EPI Survey (LRD)		
GUINEA BISSAU	Data		7.4%		28.5%		58.1%
	Source		Average 2001 EPI monitoring		CDC analysis EPI survey Jan 2004		Adjusted monitoring 2004
GUINEA CONAKRY	Data		6.0%	0.2%	43.8%		
	Source		2000 EPI Nat.Survey	Jan 2004 EPI Survey	Jan 2004 EPI Survey		
NIGER	Data		5.2%		14.7%		63.0%
	Source		MICS 2000		Monitoring 2002		Monitoring 2004

Since the 2003 survey when ITN distribution had just commenced in the expansion districts, a dramatic increase in coverage was noted, averaging +55% for all 11 countries. ITN coverage among under-five children has reached an average coverage rate of 52%, ranging from 16% to 92%, with five of the expansion zones reaching over 50%. The Abuja target of 60% coverage should be achieved by all countries by the end of 2005.



ITNs (and LLITNs) are distributed free or at a highly subsidized price. The policy shift towards using LLITNs is in the process of being implemented but there is an international shortage of LLITNS as demand is currently outstripping supply. UNICEF Supply Division is working closely with manufacturers and suppliers to ensure that supplies increase and prices remain affordable. As a large number of households in most countries possess a mosquito net, twice-yearly house-to-house re-dipping with insecticide is the recommended strategy to rapidly raise coverage, and give effective repellent protection within households while awaiting LLITN availability. This is increasingly carried out in conjunction with twice-yearly Child Health Days. Distribution of either insecticide tablets (KOTAB) or ITNs is linked with ANC and EPI to consistently target the vulnerable and to increase effective coverage of all (mainly preventive) population-oriented activities.

ITNs and Birth Registration : Gambia

In Gambia, a mass campaign in May 2003 to re-impregnate mosquito nets was accompanied by a nationwide drive for birth registration for children under-five, resulting in ***an increase in birth certificate coverage from 11% to 61% within a period of one week.*** This approach served to highlight how the outreach strategy, decentralized to community level and thereby providing easily accessible services, can be equally successful for health-related interventions as for a fundamental human rights issue such as birth registration. As a result of the public interest and demand generated by this approach, birth registration was integrated nationwide into maternal and child health outreach services. Other initiatives in integrating birth registration within ACSD included: In Benin, birth registers were introduced in all villages (population 514,000) in the two high-impact districts in 2003, supported by reinforced community mobilization and local leadership. In Mali, birth registration monitoring was integrated into the key family practices package as well as hygiene sanitation, and safe drinking water. In 2001, birth registration was at 48% (DHS). In 2004, monitoring data showed 75% birth registration in a health center within the ACSD districts and 29% in a center in a control district.

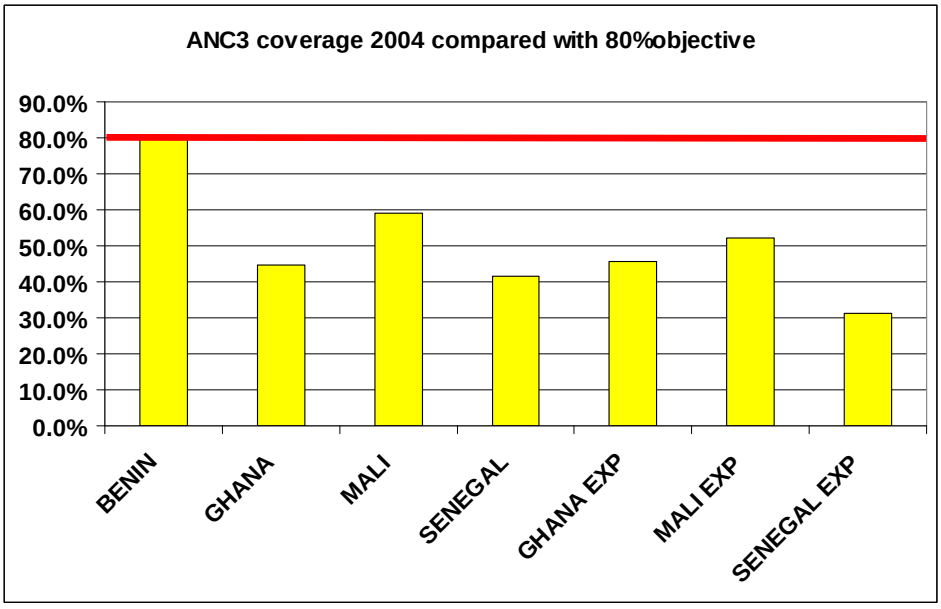
2.2 Antenatal Care Plus (ANC+)

ANC+ focused on further training of health workers on the importance of quality ANC+ interventions, and training in improved communication strategies to ensure that women are aware of the impact of interventions such as iron/folic acid supplementation, TT2 vaccination and IPT on the health of their unborn child. In 2003, in response to increasing chloroquine resistance, national policies in most countries began supporting the shift from chloroquine chemoprophylaxis to Intermittent Preventive Treatment of malaria with fansidar, which was immediately implemented in Mali, introduced in Benin at the end of 2003, and in Senegal and Ghana in 2004, where all malaria prevention up to 2003 was through chemoprophylaxis.

Since 2004, IPT with fansidar for pregnant women has been introduced in expansion countries where an IPT policy had been adopted, namely Burkina Faso, Guinea Conakry, Cameroon, and Gambia. Important additional ANC strategies in all countries included tetanus immunization reinforced through mother support groups, community involvement to improve compliance of ferrous-folic acid supplementation, awareness-raising for delivery at a health centre by a skilled professional, training and supervision to increase quality of care and to ensure that the 8 components of ANC are provided at each visit. Finally, ITN distribution linked with ANC has been shown to be an important factor in attracting pregnant women to attend antenatal care.

2.2.1 ANC3: ACSD objective 80% (no ANC3 objective for expansion countries)

ANC3 coverage 2004 compared with the 80% objective



HIP Countries

Percent pregnancies with 3+ ANC visits		HIGH IMPACT DISTRICTS					
		BASELINE 2001		MIDTERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	DATA	69.5%	80.3%	72.2%	79.7%		
	SOURCE	DHS 2001	DHS 2001	Household survey CDC 2003	Household survey CDC Aug 2003		
GHANA	DATA	48.8%	58.7%	47.8%	44.6%		
	SOURCE	INHS 2002 survey	INHS 2002 survey	DHS 2003	DHS 2003		
MALI	DATA	30.1%	24.9%	37.0%	54.2%	37.0%	59.0%
	SOURCE	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003	Control survey 2003	Adjusted monitoring 2004
SENEGAL	DATA	37.3%	15.0%	35.9%	41.2%	35.9%	41.5%
	SOURCE	DHS MALI 2001	DHS 1999	Mali control survey 2003	KPC survey 2003	Mali control survey 2003	Adjusted monitoring 2004

Promotion of ITNs and free distribution at Antenatal care consultations was more than likely at the origin of a significant increase in ANC attendance in both high-impact and expansion districts in Mali and in Senegal where baseline coverage was low. Coverage in control areas remained stable. No 2004 data is available for Benin or Ghana, but 2003 data shows that 80% of pregnant women in Benin attend at least three antenatal consultations, and the coverage rate remains very stable (survey 2003). Coverage in Ghana remained stable at around 45% in all districts (DHS).

Expansion Districts in 4 HIP Countries

Percent pregnancies with 3+ ANC visits		EXPANSION DISTRICTS					
		BASELINE 2001		MIDTERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN EXP	DATA	69.5%		72.2%			
	SOURCE	DHS 2001		Household survey CDC 2003			
GHANA EXP	DATA	48.8%	48.5%	47.8%	45.6%		
	SOURCE	INHS 2002 survey	INHS 2002 survey	DHS 2003	DHS 2003		
MALI EXP	DATA	30.1%	18.5%	37.0%	38.1%	37.0%	52.2%
	SOURCE	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003	Control survey 2003	Adjusted Monitoring 2004
SENEGAL EXP	DATA	37.3%	15.0%	35.9%	40.0%	35.9%	31.3%
	SOURCE	DHS MALI 2001	DHS 1999	Mali control survey 2003	KPC survey 2003	Mali control survey 2003	Adjusted Monitoring 2004

2.2.2 Iron/folic acid supplementation: ACSD objective 75% (no objective for expansion countries)

HIP Countries

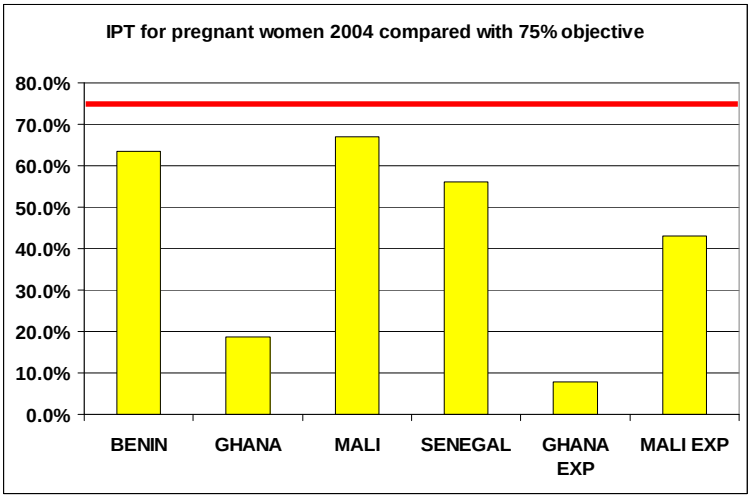
Percent of pregnant women who received 90 doses of iron		HIGH IMPACT DISTRICTS					
		BASELINE 2001		MID TERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	DATA	27.5%	31.5%	36.5%	33.4%		
	SOURCE	DHS 2001	DHS 2001	Household survey CDC 2003	Household survey CDC Aug 2003		
GHANA	DATA	4.9%	44.0%	7.8%	9.1%		
	SOURCE	IHN 2002 survey	IHN 2002 survey	DHS 2003	ACSD survey 2003		
MALI	DATA	4.4%	5.4%	8.2%	14.7%		
	SOURCE	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003		
SENEGAL	DATA	4.9%	NA	8.0%	26.7%	8.0%	41.5%
	SOURCE	DHS MALI 2001	DHS 1999	Mali control survey 2003	ACSD survey 2003	Mali control survey 2003	Adjusted monitoring 2004

Coverage rates stagnated in Benin, Ghana, and Mali. Some improvement was seen in high-impact districts in Senegal, potentially linked to higher ANC3 attendance. The only country with data for expansion districts was Benin and an insignificant increase was recorded. While pregnant women attending ante-natal visits are consistently provided with a 90-day supply of iron tablets, compliance is notoriously difficult.

The coverage data on iron supplementation is problematic as the indicators used are not the same. Data collection should focus on two separate indicators, a) coverage rates for distribution of a 90-day supply of iron tablets to pregnant women, and b) coverage rates for pregnant women who actually consume the 90-day supply of iron. The data from the table suggests that both indicators have been used in some cases, for example Ghana where the coverage rate is very low (probably indicative of the % of pregnant women consuming iron), except for the ACSD IHN 2002 survey baseline (which probably used the indicator of pregnant women receiving iron). For this reason the graph on evolution of iron intake compared to the objective as been omitted.

2.2.3 Intermittent Preventive Treatment of malaria (IPT): ACSD objective 75% (no IPT objective for expansion countries)

Evolution of IPT coverage from 2002-2004 against the 75% objective



HIP Countries

Percent of women receiving fansidar for prevention of malaria during last pregnancy		HIGH IMPACT DISTRICTS					
		BASELINE 2001		MID TERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	DATA	0.7%	28.4%	25.4%	16.9%		63.5%
	SOURCE	DHS 2001	DHS 2001	Household survey CDC 2003	Household survey CDC Aug 2003		(Monitoring 2004: 80% of ANC3+)
GHANA	DATA	0.0%	NA	6.0%	18.8%		
	SOURCE	INHS 2002	INHS 2002	DHS 2003	DHS 2003		
MALI	DATA	1.9%	0.9%	10.6%	46.4%	10.6%	67.0%
	SOURCE	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003	Control survey 2003	Adjusted monitoring 2004
SENEGAL	DATA	1.8%	NA	5.4%	2.5%	5.4%	56.1%
	SOURCE	DHS MALI 2001	DHS 1999	Mali control survey 2003	KPC survey 2003	Mali control survey 2003	Adjusted monitoring 2004

Change in national policy to adopt IPT with fansidar to prevent malaria during pregnancy occurred first in Mali in 2002, and was then gradually initiated in the neighboring countries of Senegal, Ghana and Benin, replacing the use of chemoprophylaxis with chloroquine that had remained the national policy until changes late in 2003 and early 2004.

Once implementation commenced in HIP districts, IPT coverage rapidly reached about 60% in Benin, Mali and Senegal (closely linked to ANC coverage trends), with stagnating low coverage in control areas. Expansion areas in Mali increased to around 45%. Little change occurred in Ghana, linked to very late adoption of new policies with respect to drug use, and delays in implementation.

Some of the Expansion countries, including Burkina Faso, Cameroon, Gambia, Niger and Guinea Conakry adopted a policy on IPT with fansidar in 2004 and have recently commenced implementation.

The initial programme objectives included a 75% objective for IPT of malaria with either chloroquine or fansidar. However, given the increasing resistance to chloroquine in West Africa and the fact that most countries have either adopted a policy of IPT treatment with fansidar or are in the process of changing their current policy, this report deals only with IPT using fansidar.

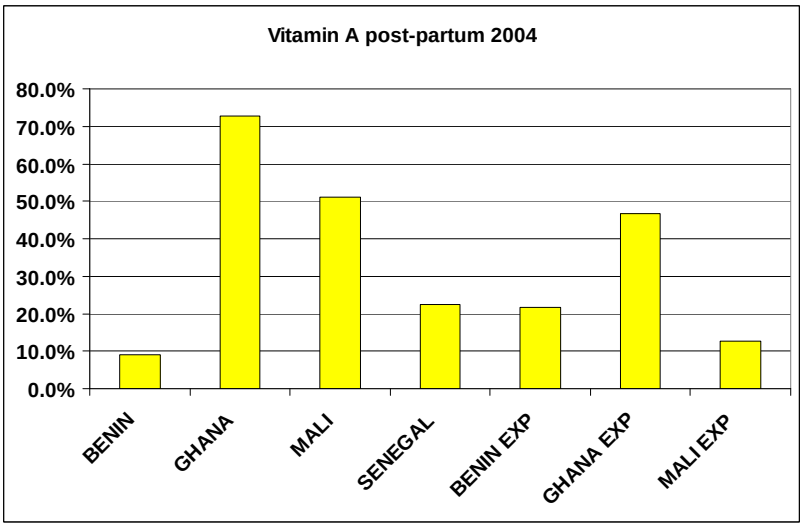
Expansion Districts in 4 HIP Countries

Percent of women receiving fansidar for prevention of malaria during last pregnancy		EXPANSION DISTRICTS					
		BASELINE		MID TERM		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	DATA						
	SOURCE						
GHANA	DATA	0.0%	0.0%	6.0%	7.9%		
	SOURCE	INHS 2002	INHS 2002	DHS 2003	DHS 2003		
MALI	DATA	1.9%	2.1%	10.6%	16.1%	10.6%	43.0%
	SOURCE	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003	Control survey 2003	Adjusted Monitoring 2004
SENEGAL	DATA	1.8%	NA	5.4%	NA	5.4%	NA
	SOURCE	DHS MALI 2001	DHS 1999	Mali control survey 2003	KPC survey 2003	Mali control survey 2003	Adjusted Monitoring 2004

2.2.4 Vitamin A post-partum

There was no preset objective for post-partum Vitamin A supplementation and this was not reported on in the 2004 progress report. However, it is included here as it is increasingly considered to be an important contributory factor to maternal and child survival, has therefore been added to ACSD interventions in most countries, and is listed in the objectives of the majority of ACSD countries for 2005-2006.

Vitamin A Post-Partum coverage 2004



HIP Countries

Percent of women receiving vitamin A within 2 months after the last birth		HIGH IMPACT DISTRICTS					
		BASELINE 2001		MID TERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	Data	27.5%	5.4%	17.6%	19.9%		9.0%
	Source	DHS 2001	DHS 2001	Household survey CDC 2003	Household survey CDC Aug 2003		Household survey Jan 2005
GHANA	Data	70.9%	70.9%	47.7%	72.9%		
	Source	INHS 2002 SURVEY	INHS 2002 SURVEY	DHS 2003	DHS 2003		
MALI	Data	9.9%	11.0%	10.9%	37.1%	10.9%	51.1%
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003	Control survey 2003	Adjusted monitoring 2004
SENEGAL	Data	12.6%	NA	9.3%	24.5%	9.3%	22.4%
	Source	DHS MALI 2001	DHS 1999	Mali control survey 2003	KPC survey 2003	Mali control survey 2003	Adjusted monitoring 2004

Post-partum coverage in Vitamin A stagnated at low levels in Benin and at around 70% in Ghana. Some increase occurred in Mali and Senegal, especially in Mali where there was a 40% increase in high-impact districts but no significant increase in expansion areas.

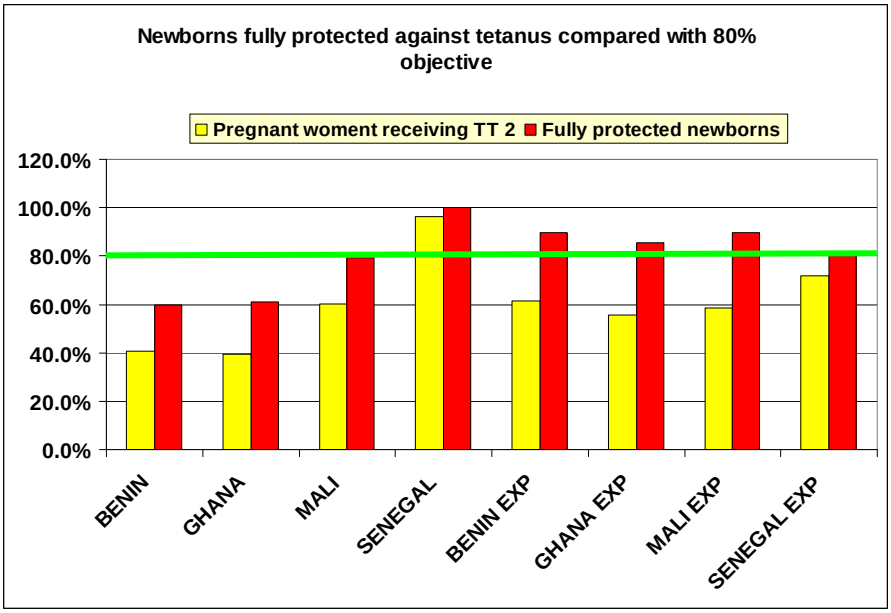
Expansion Districts in 4 HIP Countries

Percent of women receiving vitamin A within 2 months after the last birth		EXPANSION DISTRICTS					
		BASELINE		MID TERM		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	Data	27.5%		17.6%		21.8%	
	Source	DHS 2001		Household survey CDC 2003		Household survey Jan 2005	
GHANA	Data			47.7%	46.8%		
	Source			DHS 2003	DHS 2003		
MALI	Data	9.9%	5.5%	10.9%	12.7%		
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003		
SENEGAL	Data						
	Source						

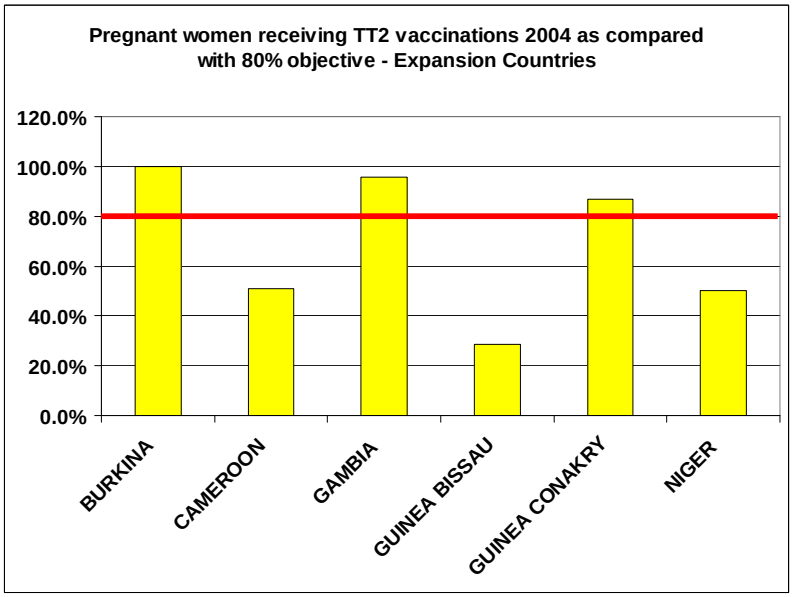
2.2.5 Children fully protected against tetanus at birth: ACSD objective 80% for TT2 immunization of pregnant women

The percentage of children fully protected against tetanus at birth is estimated based on the difference between TT2 vaccination of pregnant women and data on children fully protected at birth from the 2003 surveys. TT2 coverage averaged 65% in all ACSD districts (shown in red in the table below). However, the percentage of newborns fully protected against tetanus at birth is much higher than the figures for TT 2 coverage, as pregnant women have regularly received the 5 required tetanus doses prior to their current pregnancy. This does not emerge through routine monitoring data, which measures tetanus vaccinations administered, rather than numbers/percentages of fully vaccinated women. The 2003 surveys already showed a difference of more than +20% between TT2 coverage and fully immunized newborns, and it is estimated that this is now higher.

Fully Protected Newborns coverage 2004 compared with the 80% objective



Pregnant women receiving TT2 vaccinations 2004 compared with 80% objective – Expansion Countries (no data available for Chad)



HIP Countries

Percent of pregnancies receiving two or more TT injections		HIGH IMPACT DISTRICTS					
		BASELINE		MID TERM		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	TT 2	52.2%	43.8%	55.1%	49.0%		40.8%
	Full TT	70.6%	64.0%	74.5%	71.6%		59.6%
	SOURCE	DHS 2001	DHS 2001	Household survey CDC 2003	Household survey CDC Aug 2003		Adjusted monitoring 2004
GHANA	TT 2	51.0%	53.0%	50.0%	45.6%	47.0%	39.6%
	Full TT	78.4%	81.5%	76.9%	70.1%	72.3%	60.9%
	SOURCE	INHS 2002 survey	INHS 2002 survey	DHS 2003	DHS 2003	adjusted monitoring 2004	adjusted monitoring 2004
MALI	TT 2	18.6%	22.2%	38.8%	58.8%	38.8%	60.3%
	Full TT	27.0%	29.2%	56.3%	77.4%	56.3%	79.4%
	SOURCE	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003	Control survey 2003	Adjusted monitoring 2004
SENEGAL	TT 2	20.3%	43.6%	38.9%	66.0%	38.9%	96.3%
	Full TT	28.0%	48.8%	53.6%	73.9%	53.6%	100.0%
	SOURCE	DHS MALI 2001	DHS 1999	Mali control survey 2003	ACSD survey 2003	Mali control survey 2003	Adjusted monitoring 2004

In Mali and Senegal, there were strong increases both in TT2 vaccination for pregnant women and in children fully protected against tetanus at birth in both high-impact and expansion districts, with Mali reaching the 80% objective compared to control districts which went up to around 50%. This is associated with, and probably partially due to, the increase in ANC3 visits linked to the highly subsidized distribution of bednets to pregnant women. However, Benin and Ghana expansion and control districts remained stable at about 80%, while high-impact districts only achieved 60%. This is due to missed opportunities in Benin,

where highly subsidized bednets are distributed to pregnant women and where ANC3 coverage is 80%, and linked to stagnation in coverage of ANC3 in Ghana (below 50%).

Expansion Districts in 4 HIP Countries

Percent of pregnancies receiving two or more TT injections		EXPANSION DISTRICTS					
		BASELINE		MID TERM		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN EXP	TT 2	52.2%	48.9%	55.1%			61.3%
	Full TT	70.6%	71.5%	74.5%			89.5%
	SOURCE	DHS 2001	DHS 2001	Household survey CDC 2003			monitoring 2004
GHANA EXP	TT 2	51.0%	54.0%	50.0%	47.7%	47.0%	55.7%
	Full TT	78.4%	83.0%	76.9%	73.3%	72.3%	85.6%
	SOURCE	INHS 2002 survey	INHS 2002 survey	DHS 2003	DHS 2003	adjusted monitoring 2004	Adjusted monitoring 2004
MALI EXP	TT 2	18.6%	15.8%	38.8%	38.7%	38.8%	58.7%
	Full TT	27.0%	20.8%	56.3%	59.2%	56.3%	89.7%
	SOURCE	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003	Control survey 2003	Adjusted Monitoring 2004
SENEGAL EXP	TT 2	20.3%	43.6%	38.9%			71.8%
	Full TT	28.0%	48.8%	53.6%			80.3%
	SOURCE	DHS MALI 2001	DHS 1999	Mali control survey 2003			Monitoring 2004

Expansion Countries

Percent of pregnancies receiving two or more TT injections		EXPANSION DISTRICTS					
		BASELINE		MID TERM		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BURKINA	TT 2	32.0%	27.7%	70.0%	77.7%	92.5%	100.0%
	SOURCE	2001 EPI monitoring	2001 EPI monitoring	EPI Review 2003	EPI Review 2003	adjusted monitoring 2004	Adjusted monitoring 2004
CAMEROON	TT 2		42.0%		54.0%		51.0%
	SOURCE		2002 Monitoring		2003 Monitoring		2004 Monitoring
CHAD	TT 2						
	SOURCE						
GAMBIA	TT 2	93.7%	94.1%		95.7%	86.7%	
	SOURCE	MICS 2000	MICS 2000		ACSD Survey 2003	2004 monitoring	
GUINEA BISSAU	TT 2	42.0%	28.3%	38.0%	32.0%	36.0%	28.7%
	SOURCE	2001 EPI monitoring	2001 EPI monitoring	2003 monitoring	2003 monitoring	2004 monitoring	monitoring 2004
GUINEA CONAKRY	TT 2		52.0%				87.0%
	SOURCE		2000 EPI Nat.Survey				Monitoring 2004
NIGER	TT 2	13.3%	41.1%		40.8%		50.3%
	SOURCE	Monitoring 2002	Monitoring 2002		monitoring 2003		Monitoring 2004

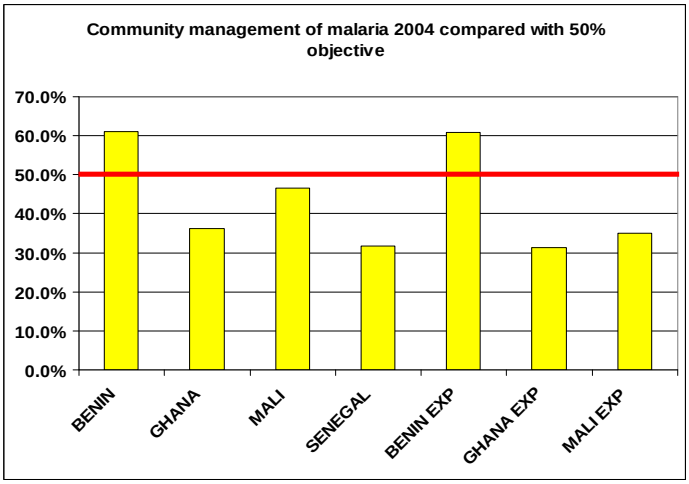
TT2 vaccination levels for pregnant women stagnated at or below 50% in Guinea Bissau, Cameroon, and Niger, while Burkina Faso, Gambia and Guinea Conakry showed a strong increase in coverage to over 80%.

2.3 Integrated Management of Childhood Illness Plus (IMCI+)

Following the 2003 survey results, in 2004 IMCI+ placed a major emphasis on community activities to reinforce family and community involvement in basic preventive and curative care. Community health workers were intensified IEC for exclusive breastfeeding, complementary feeding and reinforcement of diarrhea management and malaria management at community level. Following the 2003 survey results, a strong focus was placed on community management in all HIP districts, specifically on home care of diarrhea and malaria. Use of the new ORS formula, improved malaria management, and operational research on community management of pneumonia resulted in a rapid increase in coverage of community management of childhood illness. Operational research in Senegal led to a rapid increase in community management of ARI (cf. Operational Research on Pneumonia: Community ARI Management in Senegal, page 33).

2.3.1 Community management of malaria: ACSD objective 50% (no objective for Expansion Countries)

Community Malaria Management Coverage 2004 compared with the 50% objective



HIP Countries

Percent of children with fever receiving treatment with fansidar or choloroquine		HIGH IMPACT DISTRICTS					
		BASELINE 2001		MID TERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	Data	34.3%	50.5%	42.8%	49.0%		61.0%
	Source	DHS 2001	DHS 2001	Household survey CDC 2003	Household survey CDC Aug 2003		Household survey Jan 2005
GHANA	Data	40.6%	19.4%	29.5%	36.3%		
	Source	INHS 2002 Survey	INHS 2002 Survey	DHS 2003	DHS 2003		
MALI	Data	30.8%	25.9%	32.7%	46.6%		
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003		
SENEGAL	Data	30.8%	34.3%	32.7%	31.8%		
	Source	DHS MALI 2001	DHS 1999	Mali control survey 2003	ASCD survey		

Community management of malaria increased slightly in high-impact districts in Benin, Ghana, and Mali, but not in Senegal. Coverage in expansion districts in Benin increased to 61%, but there was no coverage increase for the other three countries in expansion zones.

Expansion Districts in 4 HIP Countries

Percent of children with fever receiving treatment with fansidar or choloroquine		EXPANSION DISTRICTS					
		BASELINE		MID TERM		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN EXP	Data	34.3%		42.8%			60.9%
	Source	DHS 2001		Household survey CDC 2003			Household survey Jan 2005
GHANA EXP	Data	40.6%	39.3%	29.5%	31.4%		
	Source	INHS 2002 Survey	INHS 2002 Survey	DHS 2003	DHS 2003		
MALI EXP	Data	30.8%	26.6%	32.7%	35.1%		
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003		
SENEGAL EXP	Data						
	Source						

Increasing resistance of malaria to chloroquine, necessitating more frequent recourse to clinical care, has lead to a change in policy for first line treatment in many African countries. Blister packs of chloroquine were by and large not introduced at community level, and caretakers were encouraged to seek appropriate anti-malarial drugs at clinical facilities while awaiting implementation of the new policy and availability of ACT blister packs at community level. There is huge potential for coverage increase through availability of appropriate drugs for timely treatment at community level when access to clinical care remains a strong constraint. However, increased access to quality drugs for communities must be accompanied by improved information and knowledge among caregivers to result in a significant improvement in malaria management.

Increasing access to adequate and timely treatment for any child with fever was the main reason that countries supported community management of Malaria, through social marketing of blister packs and training community workers under the supervision of the health center. The recent recommendation to switch from chloroquine to combination therapy, preferably containing an artemesin-based drug (ACT), in chloroquine-resistant areas has presented a challenge for ACSD to develop a strategy and to ensure access to ACT at community level. Senegal adopted combination therapy as the first line treatment for malaria in health centers in 2003, using a non-artemesin combination (amodiaquine+sulfadoxine pyrimethamine), with ACT as an alternative treatment, and they are currently moving towards ACT as first-line therapy. Ghana is also in the process of policy change and adopting ACT as the new malaria therapy policy for first-line malaria treatment. This introduces added constraints for accessibility to these drugs at community level, as they are only available at health centers, and are currently also in short supply while awaiting an increase in international production. UNICEF is advocating for policy change operational research to enable community management of malaria using ACT.

2.3.2 Community management of Acute Respiratory Infection (ARI) : There was no preset ACSD objective

Across the region, antibiotics are drugs usually kept secure at health centre level. This lack of community access to adequate antibiotics remains the major bottleneck to timely effective ARI management. Community treatment of pneumonia has been initiated in some countries through operational research, in collaboration with USAID and other partners. Initial results show that an increase in quality management of ARI at community level resulted in a national policy change in Senegal, with 97% of children with pneumonia receiving adequate and timely antibiotic treatment. This was used as an example for UNICEF/WHO policy guidelines on ARI for widespread replication. Strong partnerships have been built, particularly with PSI, for distribution and social marketing of malaria blister packs at community level to intensify community malaria management.

Operational Research on Pneumonia : Community ARI Management in Senegal

Senegal carried out operational research on community case management of pneumonia in the context of the ACSD approach, with support from UNICEF and USAID-BASICS, with the objective of analyzing the feasibility of introducing antibiotic use at community level.

METHODOLOGY:
A feasibility study was carried out in 4 ACSD districts over a period of 18 months, with a population of 532,970, involving children aged 2 - 5 years who developed a cough or breathing difficulties.

THE INTERVENTION PACKAGE:

- ***Training:*** 113 community health agents working in 90 health posts received three days training on case management of ARI for children aged 2-59 months and on using antibiotics.
- ***Equipment and supplies :*** Following training, all of the community health agents received a kit of materials (chronometer , cotrimoxazole , stock-taking charts for cotrimoxazole, register, case management forms, and reference files).
- ***Supervision :*** Post-training supervision was organized at health centers once a month in each health district.
- ***Awareness-raising :*** At district level, awareness-raising sessions on ARI prevention and treatment were held with community leaders during routine communication activities.

RESULTS:

- 89% of cases of cough/cold, 95% of pneumonia cases, and 64% of cases of serious pneumonia were correctly identified
- 80% of cases of cough/cold and 97% of pneumonia cases were correctly treated. 69% of serious pneumonia cases were referred for more specialized care.
- 71% of cases of cough/cold were monitored on the 3rd or 4th day; 95% of cases treated with cotrimoxazole, and 43% of referred cases were monitored on the 3rd or 4th day.
- 98% compliance was recorded with respect to timing and completion of treatment for cases treated with cotrimoxazole.

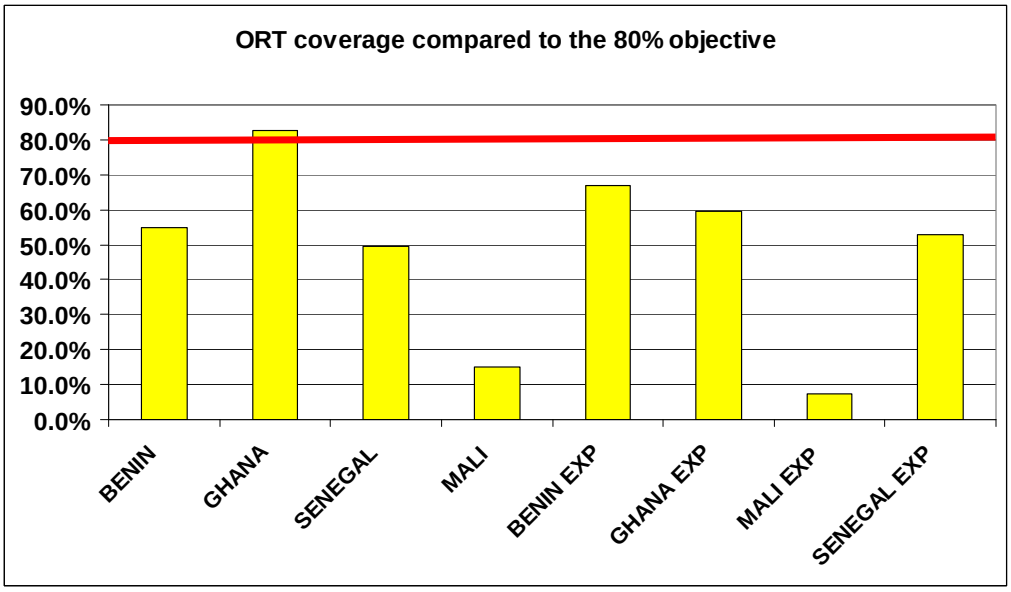
RECOMMENDATIONS:
On the basis of this research, the MoH has adopted the extension of community case management of ARI to districts meeting the following preconditions: Existence of functional health posts, trained and capable community health agents, and regular supervision by health centers.
Scaling up the approach will require training, supervision, communication strategies, data collection and strategies to motivate community health agents. Operational costs to implement this approach per district are estimated as follows:
For a district of 150,000 inhabitants, with 10 health posts and 6 outposts per health post, a total of 60 outposts, operational costs to implement this approach amount to just under 32,000 US$, or 530 $ per health outpost:

- Initiation : 755 $
- Awareness-raising : 2,600 $
- Training : 5,855 $
- Cotrimoxazole : 1,200 $
- Balance : 9,000 $
- Timer : 720 $
- Tools : 300 $
- 5 post-training refresher sessions : 11,400 $
- Total cost : 31,830 $
- Cost per health outpost : 530 $
-

NB: This does not include technical assistance costs, or activities at central level including advocacy.

2.3.3 Oral Rehydration Therapy (ORT): ACSD objective 80% (no objective for Expansion Countries)

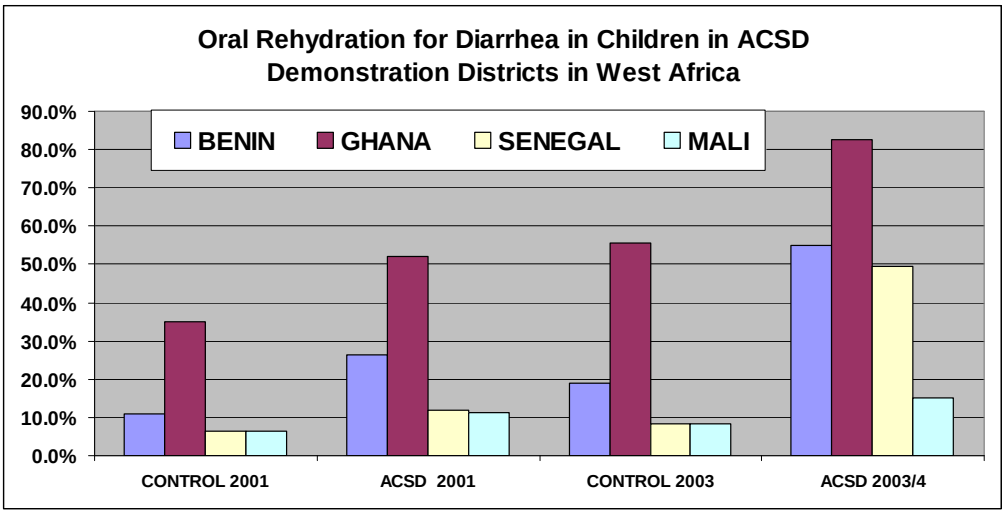
ORT coverage 2004 compared with the 80% objective



HIP Countries

Use of ORT remained stable in Benin in both high-impact and expansion districts at around 50%, and increased to 80% in Ghana in high-impact areas and to 50% in expansion areas. Control districts in expansion areas showed a similar increase, as opposed to control areas in high-impact districts where coverage was significantly lower. Coverage levels stagnated at a preoccupying low level in Mali, while a strong improvement took place in Senegal with coverage rising to around 50% in both high-impact and expansion areas, linked to strong promotion of ORT in the context of cIMCI, including the introduction of the new ORS formula and the diffusion of WHO/UNICEF guidelines on community management of diarrhea which revitalized the focus on diarrhea. Availability of ORS at community level and training community health workers to disseminate better information to caretakers helped to increase awareness of timely use of ORT for diarrhea management.

Percent of children given ORT for recent diarrhea		HIGH IMPACT DISTRICTS					
		BASELINE 2001		MID TERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	Data	39.4%	50.3%	43.4%	56.3%		55.0%
	Source	CERTI 2001	CERTI 2001	Household survey CERTI 2003	Household survey CERTI Aug 2003		Household survey Jan 2005
	Data	10.8%	26.3%	18.9%	15.4%		55.0%
	Source	DHS 2001	DHS 2001	Household survey CDC 2003	Household survey CDC Aug 2003		Household survey Jan 2005
GHANA	Data	35.0%	52.2%	55.7%	82.7%		
	Source	INHS 2002 survey	INHS 2002 survey	DHS 2003	DHS 2003		
MALI	Data	6.5%	11.4%	8.3%	15.2%		
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003		
SENEGAL	Data	6.5%	11.8%	8.3%	24.7%	8.3%	49.6%
	Source	DHS MALI 2001	DHS 1999	Mali control survey 2003	ASCD survey	Mali control survey 2003	KPC Survey Oct Nov 2003



Expansion Districts in 4 HIP Countries

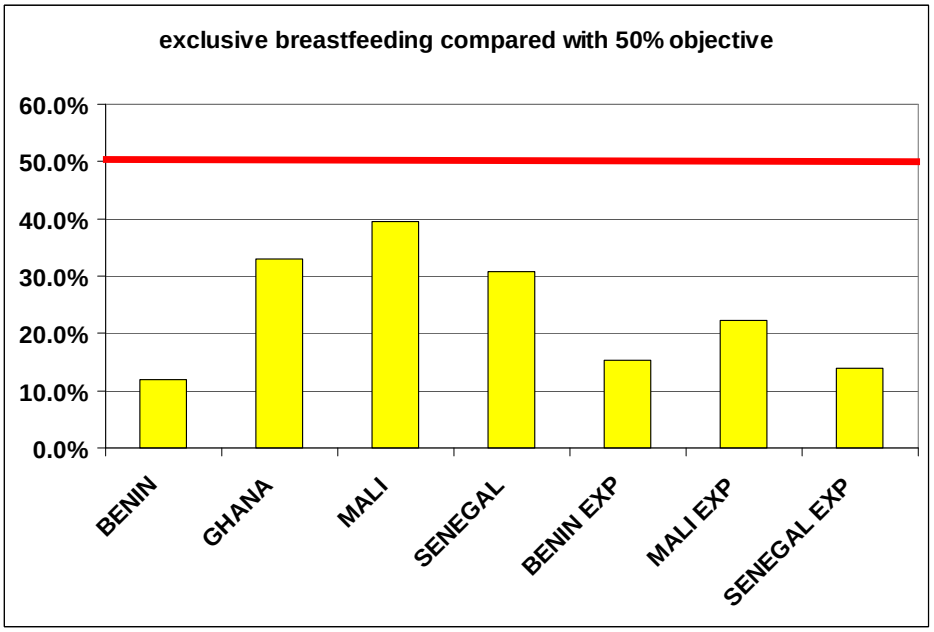
Percent of children given ORT for recent diarrhea		EXPANSION DISTRICTS					
		BASELINE		MID TERM		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN EXP	Data	39.4%	63.4%	43.4%			67.0%
	Source	CERTI 2001	CERTI 2001				household survey Jan 2005
	Data	10.8%	71.8%	18.9%			67.0%
	Source	DHS 2001	DHS 2001				household survey Jan 2005
GHANA EXP	Data	35.0%	29.0%	55.7%	59.4%		
	Source	INHS 2002 survey	INHS 2002 survey	DHS 2003	DHS 2003		
MALI EXP	Data	6.5%	13.1%	8.3%	7.5%		
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003		
SENEGAL EXP	Data	6.5%	11.8%	8.3%		8.3%	52.9%
	Source	DHS MALI 2001	DHS 1999	Mali control survey 2003		Mali control survey 2003	KPC Survey Oct Nov 2003

Linking with Other Initiatives : Guinea-Bissau

In Guinea-Bissau, 4 community managed centers catering for 500 children under-five from 41 villages provide care, socialization, education, protection, health and nutrition services for under-fives. An ECD management committee composed of local service providers, traditional leaders, mothers and other care givers provide assistance, and monitor activities and indicators. ACSD interventions were initiated in 2004, with targets monitored for immunization, Vitamin A supplementation, use of ITNs and information sharing on nutrition, including exclusive breastfeeding and hygiene. Birth registration is also ensured.

2.3.4 Exclusive breastfeeding up to 6 months/complementary feeding: ACSD objective 50% (no objective for Expansion Countries)

Exclusive Breastfeeding coverage 2004 compared with the 50% objective



HIP Countries

Percent of children <=6 months exclusively breastfed		HIGH IMPACT DISTRICTS					
		BASELINE 2001		MID TERM 2003		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	Data	31.4%	21.8%	22.7%	19.4%		12.0%
	Source	DHS 2001	DHS 2001	Household survey CDC 2003	Household survey CDC Aug 2003		Household survey Jan 2005
GHANA	Data	54.0%	36.6%	54.0%	32.9%		
	Source	INHS 2002 survey	INHS 2002 survey	DHS 2003	ACSD survey 2003		
MALI	Data	18.2%	39.5%	18.4%	29.2%		39.5%
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003		Adjusted monitoring 2004
SENEGAL	Data	18.2%	10.4%	18.4%	21.4%		30.8%
	Source	DHS MALI 2001	DHS 1999	Mali control survey 2003	ASCD survey		KPC survey oct nov 2003

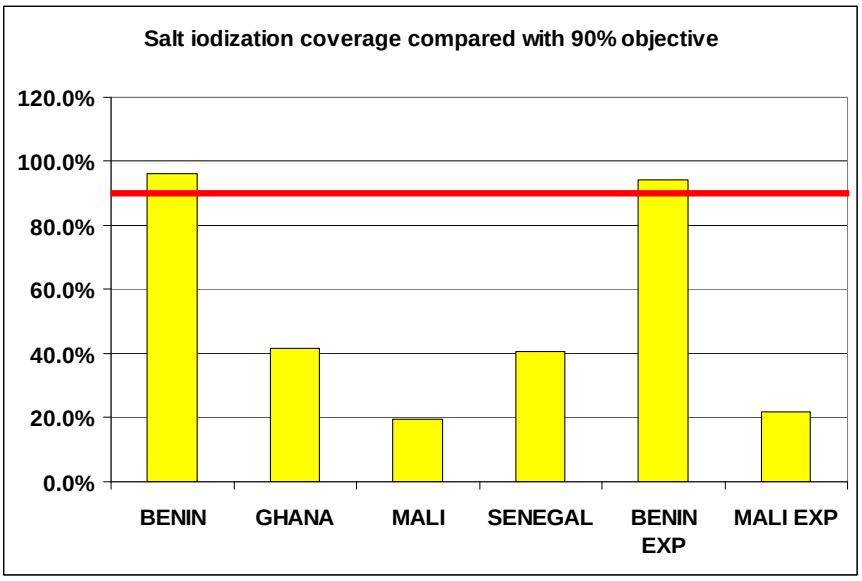
Coverage of exclusive breastfeeding remained stable in Mali, Benin and Ghana in both high-impact and expansion districts. Coverage in Senegal increased from 10% to 30% in high-impact areas, while control areas remained stable at around 20%. This may be linked to the increased emphasis on the cIMCI approach in Senegal during 2004, including more intensive IEC focused on pregnant women. Complementary feeding remained stable in all four countries. Changing behavior at family level, such as exclusive breastfeeding and timely complementary feeding, requires ongoing awareness-raising, information provision, and availability of appropriate food products at household level, and remains one of the most challenging interventions in ACSD. (Data for both exclusive breastfeeding and complementary feeding for Mali was adjusted due to anomalies in high coverage found in surveys, with unexplained wide fluctuations in data between monitoring and surveys.)

Expansion Districts in 4 HIP Countries

Percent of children <=6 months exclusively breastfed		EXPANSION DISTRICTS					
		BASELINE		MID TERM		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN EXP	Data						15.3%
	Source						Household survey Jan 2005
GHANA EXP	Data	54.0%	34.0%				
	Source	INHS 2002 survey	INHS 2002 survey				
MALI EXP	Data	18.2%	29.0%	18.4%	22.3%		
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003		
SENEGAL EXP	Data	18.2%	10.4%	18.4%	13.9%		
	Source	DHS MALI 2001	DHS 1999	Mali control survey 2003	KPC survey Nov 2003		

2.3.5 Salt iodization: ACSD objective 90% (no objective for Expansion Countries)

Salt iodization coverage 2004 compared with the 90% objective



HIP Countries

Percent of children living in households with iodized salt		HIGH IMPACT DISTRICTS					
		BASELINE		MID TERM		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	DATA	87.7%	79.5%	85.7%	92.5%		96.2%
	SOURCE	DHS 2001	DHS 2001	Household survey CDC 2003	Household survey CDC Aug 2003		Household survey Jan 2005
GHANA	DATA	52.0%	49.5%	52.0%	41.5%		
	SOURCE	INHS 2002 SURVEY	INHS 2002 SURVEY	DHS 2003	ACSD survey 2003		
MALI	DATA	23.5%	27.3%	23.5%	19.5%		
	SOURCE	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003		
SENEGAL	DATA	23.5%	50.0%	23.5%	40.7%		51.7%
	SOURCE	DHS MALI 2001	DHS 1999	Mali control survey 2003	ASCD survey		KPC survey oct nov 2003

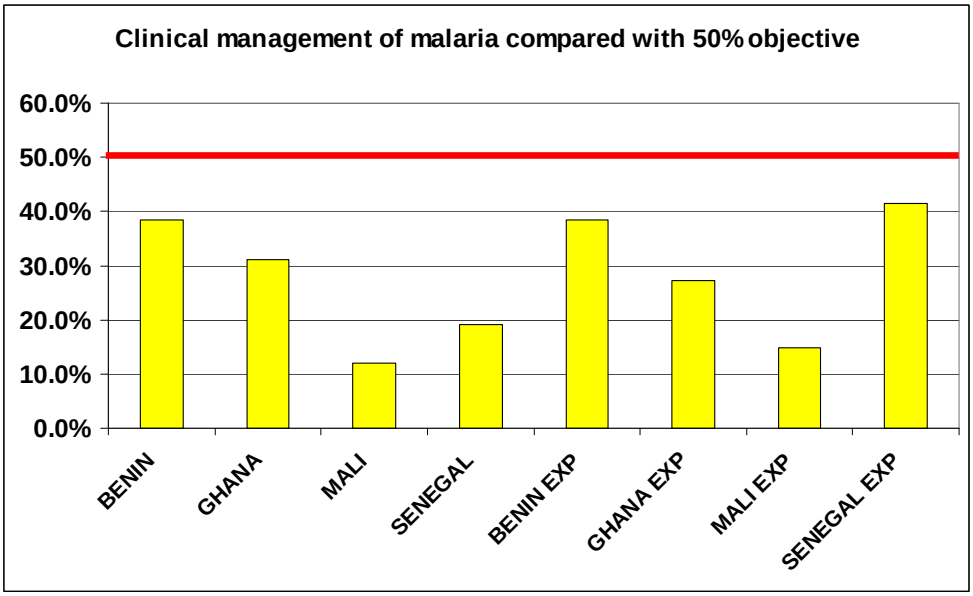
There was little improvement in salt iodization coverage in high impact or expansion districts. Baseline coverage in Benin was high, and increased by 15% in high impact districts. Ghana, Mali and Senegal remained stable with low coverage, as did control districts in these countries.

Expansion Districts in 4 HIP Countries

Percent of children living in households with iodized salt		EXPANSION DISTRICTS					
		BASELINE		MID TERM		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	DATA	87.7%					94.3%
	SOURCE	DHS 2001					Household survey Jan 2005
GHANA	DATA	52.0%	60.2%				
	SOURCE	INHS 2002 SURVEY	INHS 2002 SURVEY				
MALI	DATA	23.5%	21.8%	23.5%	21.8%		
	SOURCE	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003		
SENEGAL	DATA	23.5%	50.0%				
	SOURCE	DHS MALI 2001	DHS 1999				

2.3.6 Clinical management of malaria: ACSD objective 50% (no objective for Expansion Countries)

Clinical Management of Malaria coverage 2004 compared with the 50% objective



HIP Countries

Percent of children with fever receiving treatment at a health facility		HIGH IMPACT DISTRICTS					
		BASELINE		MID TERM		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	Data	15.9%	39.0%	22.9%	22.6%		38.4%
	Source	DHS 2001	DHS 2001	Household survey CDC 2003	Household survey CDC Aug 2003		Household survey Jan 2005
GHANA	Data	61.0%	53.3%	29.7%	36.6%		31.2%
	Source	INHS 2002 survey	INHS 2002 survey	DHS 2003	ACSD survey 2003		DHS 2003
MALI	Data	15.2%	19.0%	12.3%	12.1%		
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003		
SENEGAL	Data	15.2%	42.6%	12.3%	28.6%	12.3%	19.2%
	Source	DHS MALI 2001	DHS 1999	Mali control survey 2003	ASCD survey	Mali control survey 2003	KPC Oct nov 2003

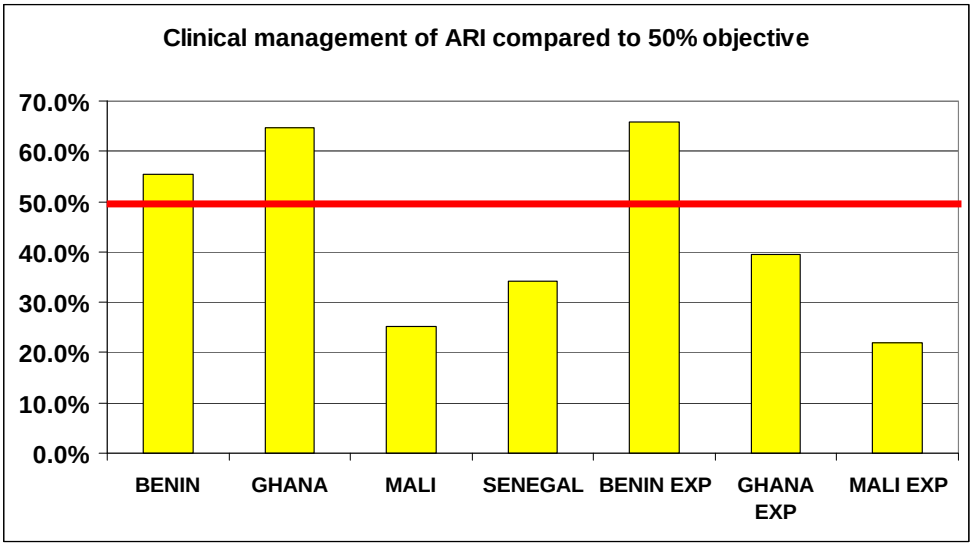
There was no significant change in clinical management of malaria in Mali or Senegal. Some fluctuation occurred in Benin and Ghana in both high-impact and control areas, most likely attributable to data issues and/or seasonality. The surveys took place in different seasons and malaria is particularly seasonal, increasing during rainy seasons.

Expansion Districts in 4 HIP Countries

Percent of children with fever receiving treatment at a health facility		EXPANSION DISTRICTS					
		BASELINE		MID TERM		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN EXP	Data	29.8%					38.5%
	Source	DHS 2001	DHS 2001	Household survey CDC 2003			Household survey Jan 2005
GHANA EXP	Data	61.0%	61.0%	29.7%	27.2%		
	Source	INHS 2002 survey	INHS 2002 survey	DHS 2003	DHS 2003		
MALI EXP	Data	15.2%	17.7%	12.3%	14.8%		
	Source	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003		
SENEGAL EXP	Data	15.2%	NA	12.3%		12.3%	41.5%
	Source	DHS MALI 2001	DHS 1999	Mali control survey 2003		Mali control survey 2003	KPC Oct nov 2003

2.3.7 Clinical management of Acute Respiratory Infection (ARI): ACSD objective 50% (no objective for Expansion Countries)

Clinical Management of ARI coverage 2004 compared with the 50% objective



HIP Countries

Percent of children with breathing difficulty taken to a health facility		HIGH IMPACT DISTRICTS					
		BASELINE		MID TERM		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	DATA	14.7%	42.2%	29.7%	30.5%		55.5%
	SOURCE	DHS 2001	DHS 2001	Household survey CDC 2003	Household survey CDC Aug 2003		Household survey Jan 2005
GHANA	DATA	32.7%	54.2%		39.4%	50.8%	64.8%
	SOURCE	INHS 2002 SURVEY	INHS 2002 SURVEY		ACSD 2003	DHS 2003	DHS 2003
MALI	DATA	16.9%	17.9%	23.8%	25.1%		
	SOURCE	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003		
SENEGAL	DATA	16.9%	33.1%	23.8%	34.2%		
	SOURCE	DHS MALI 2001	DHS 1999	Mali control survey 2003	ASCD survey		

There was no significant change in clinical management of ARI in Mali or Senegal. Some fluctuation occurred in Benin and Ghana in both high-impact and control areas, most likely attributable to data issues and/or seasonality. The surveys took place in different seasons and malaria is particularly seasonal, increasing during rainy seasons.

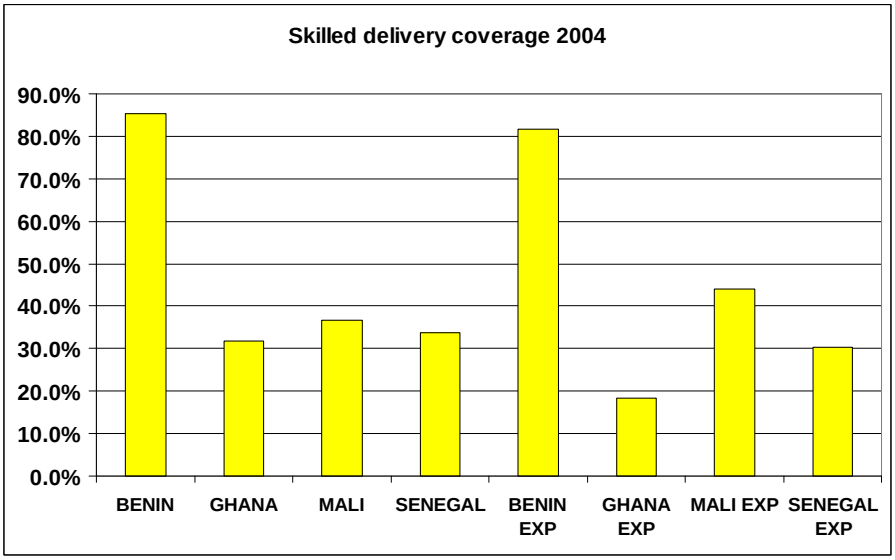
In Senegal, as quality antibiotic blister packs for ARI treatment were available and used at community level, utilization of clinical services stabilized. In Ghana and Benin, where operational research has not yet been implemented, demand for clinical care increased as a result of intense IEC by community health workers, influencing caretakers to seek quality care for children.

Expansion Districts in 4 HIP Countries

Percent of children with breathing difficulty taken to a health facility		EXPANSION DISTRICTS					
		BASELINE		MID TERM		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN EXP	DATA	29.6%					65.9%
	SOURCE	DHS 2001					Household survey Jan 2005
GHANA EXP	DATA	32.7%	32.5%			50.8%	39.4%
	SOURCE	INHS 2002 SURVEY	INHS 2002 SURVEY			DHS 2003	DHS 2003
MALI EXP	DATA	16.9%	16.1%	23.8%	21.9%		
	SOURCE	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003		
SENEGAL EXP	DATA	16.9%	33.1%				
	SOURCE	DHS MALI 2001	DHS 1999				

2.3.8 Skilled delivery

Skilled delivery coverage 2004



HIP Countries

Percent of deliveries assisted by medically trained personnel (LAST PREGNANCY)		HIGH IMPACT DISTRICTS					
		BASELINE		MID TERM		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	DATA	71.3%	91.7%	73.3%	80.2%		85.3%
	SOURCE	DHS 2001	DHS 2001	Household survey CDC 2003	Household survey CDC Aug 2003		Household survey Jan 2005
GHANA	DATA	22.1%	28.0%	33.3%	27.8%	27.5%	31.9%
	SOURCE	INHS 2002 SURVEY	INHS 2002 SURVEY	DHS 2003	DHS 2003	adjusted monitoring 2004	monitoring 2004
MALI	DATA	14.2%	16.2%	39.0%	35.6%		36.6%
	SOURCE	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003		Adjusted monitoring 2004
SENEGAL	DATA	13.5%	15.8%	40.4%	36.7%	40.4%	33.8%
	SOURCE	DHS MALI 2001	DHS 1999	Mali control survey 2003	ASCD survey	Mali control survey 2003	Adjusted monitoring 2004

Skilled delivery coverage in Benin remained at a stable high at over 70% in control areas and over 80% in high-impact and expansion districts. Ghana stagnated with low coverage at around 20-30%; coverage in Mali and Senegal increased from 20% to less than 40% in both high-impact, expansion and control areas, indicating that this was due to factors little related to programme activities.

Expansion Districts in 4 HIP Countries

Percent of deliveries assisted by medically trained personnel (LAST PREGNANCY)		EXPANSION DISTRICTS					
		BASELINE		MID TERM		LATEST END 2004	
		CONTROL	ACSD	CONTROL	ACSD	CONTROL	ACSD
BENIN	DATA	83.9%					81.8%
	SOURCE	DHS 2001		Household survey CDC 2003			Household survey Jan 2005
GHANA	DATA	22.1%	11.1%	33.3%	18.3%	27.5%	18.3%
	SOURCE	INHS 2002 SURVEY	INHS 2002 SURVEY	DHS 2003	DHS 2003	adjusted monitoring 2004	Adjusted monitoring 2004
MALI	DATA	14.2%	15.4%	39.0%	37.4%	39.0%	44.1%
	SOURCE	DHS III 2001	DHS III 2001	Control survey 2003	ACSD survey 2003	Control survey 2003	Adjusted Monitoring 2004
SENEGAL	DATA	13.5%	15.8%	40.4%			30.4%
	SOURCE	DHS MALI 2001	DHS 1999	Mali control survey 2003			Monitoring 2004

UNICEF's strength lies in reinforcing service delivery and system strengthening at community and outreach levels. While clinical care is essential to child survival, particularly in reducing maternal and neonatal mortality, vast resources are required for gradual, sustainable improvement. This has not been a major focus of UNICEF's direct support for ACSD. The programme has focused on increasing awareness and demand through communication incorporated within community and population-oriented approaches, including efforts to increase timely use of services if necessary after administering basic care at household or community level, and on improved linkages between communities and health centers. Unfortunately, very few initiatives on Safe motherhood, neonatal intervention or clinical care have been implemented. These interventions occur at clinical level, requiring the 24 hour presence of skilled professionals. Scaling up clinical care interventions necessitates overcoming major constraints including availability of human resources, as well as geographical and financial accessibility, requiring in-depth changes within health systems. UNICEF's strategy has included strong advocacy for policy development for improved clinical care, and to leverage resources for fixed delivery services, including provision of Emergency Obstetric Care (EmOC) which is essential to reducing neonatal and maternal mortality.

Safe motherhood

In Guinea Conakry complementary funds provided by Belgium supported emergency obstetric and neonatal care in the two high-impact districts (strengthening health system capacity through provision of essential equipment, reinforcing referral and contra-referral systems through the installation of a radio communication network, linking all peripheral health facilities with the first referral level (district hospital), strengthening health workers' capacity through a series of training sessions in the field of obstetric and neonatal care and improving financial accessibility through introducing micro health insurance schemes. ANC3 attendance rose from 54% in 2001 to 70% in 2004 and TT2+ coverage in pregnant women increased from 51% to 87% in the same period. The rate of deliveries assisted by a professional health attendant rose from 21% in 2001 to 24% in 2004 while a slow increase was seen in the C-Section rate, increasing from 1.9% of expected deliveries in 2001 to 2% in 2004. In Matameye in Niger, the UNICEF supported Safe Motherhood programme strengthened the referral system using traditional birth attendants to improve blood donations and antenatal care within the community; 770 TBAs were trained in Emergency Obstetric Care (EmOC). In Mali, as a pre-requisite for ACSD implementation, all HIP and expansion HIP organized referral and evacuation within the Safe Motherhood framework. Between 2001 and 2004, the number of referral and evacuation centers increased from 25 to 34. EmOC indicators are slowly beginning to improve, with the rate of caesarians rising from 0.4% in 2003 to 0.9% in 2004; the rate of case management of obstetric complications rose from 6% to 9% during the same period.

3. Impact of the ACSD strategy on the under-five mortality rate

3.1 Overview of the ACSD impact on U5MR reduction

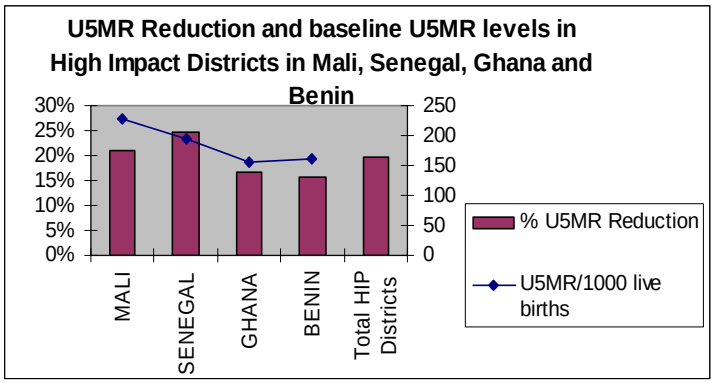
Reduction in U5MR and numbers of Child Lives Saved in ASCD Program					
High Impact Districts	Target Population	U5MR/1000 live births	# Annual Child Deaths	% U5MR Reduction	# Lives saved per year
MALI	1,264,492	229	14478	21%	3037
SENEGAL	313,420	195	2995	25%	739
GHANA	961,246	155	7016	17%	1176
BENIN	514,735	160	3377	16%	534
Total HIP Districts	**3,053,893**		**27,866**	**20%**	**5,486**
Expansion Areas	Target Population	U5MR/1000 live births	# Annual Child Deaths	% U5MR Reduction	# Lives saved per year
MALI	5,455,859	229	62470	9%	5651
SENEGAL	1,218,682	195	11645	18%	2046
GHANA	2,033,462	155	14842	3%	449
BENIN	1,820,276	160	11941	11%	1324
GUINEA CONAKRY	502510	177	3825	12%	465
GAMBIA	282218	135	1372	9%	123
CAMEROON	459025	142	2470	5%	120
GUINEA BISSAU	547,275	211	5774	14%	806
CHAD	592,093	200	5803	10%	575
BURKINA	556,334	184	4709	10%	458
NIGER	574,673	280	5793	9%	502
Total Expansion Areas	**14,042,408**		**130,642**	**10%**	**12,519**
Total HIP+Expansion	**17,096,300**		**158,508**	**11%**	**18,006**

Conclusion

The impact on U5MR has been estimated using the efficacy levels for key childhood interventions published in the Lancet Publications on Child Survival (2003) and Newborn Survival (2005). In the "High Impact Districts" in four countries, with a total population of 3 million, the reduction in U5MR is 20% on average, varying from 25% in Senegal to 16% in Benin, saving an estimated five and a half thousand children a year. In Expansion districts in eleven countries, with a population of 14 million, the U5MR reduction is 10%, saving over twelve and a half thousand children annually.

The total ACSD programme, impacting on a population of 17 million, is saving over 18 thousand child lives per year.

3.2 U5MR reduction in comparison with baseline in High Impact Districts in 4 HIP Countries



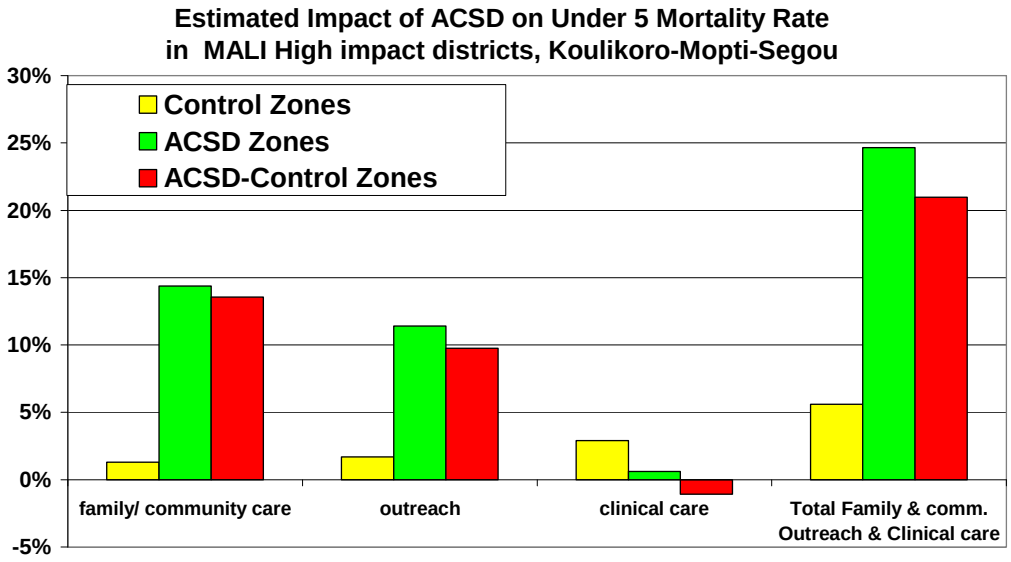
Baseline U5MR levels in the ACSD areas in Mali and Senegal were high, namely 229 and 195 deaths per 1000 live births respectively. In both of these countries, reductions in the U5MR were strongest, at over 20% in each case. Benin and (Northern) Ghana had significantly lower baseline U5MR values, at 160/1000 live births for Ghana and 155/1000 live births for Benin, and subsequently lower U5MR reductions of 16-17%.

3.3 Controlled impact on U5MR reduction in 4 ACSD High Impact (HIP) Countries

The four graphs below illustrate the estimated impact on the U5MR of the coverage increases resulting from the high impact package of Child Survival Interventions in the ACSD areas (shown in green). Changes in coverage in control areas (shown in yellow) are balanced against ACSD coverage changes in order to estimate the "controlled" impact on U5MR attributable to the ACSD programme (shown in red). For example, if a substantial increase in coverage of a particular intervention is recorded both in ACSD and control areas, the control increase is deducted from the ACSD increase to give a "controlled result", as the conclusion is that the increase is not due specifically to ACSD programme interventions but rather to National Health System strengthening, national campaigns, other Health Programs in the control areas, or to other factors.

As explained earlier in this report, the selected control areas: Sikasso and Kayes in Mali, Mono in Benin, and Upper West Region in Ghana were regions in each of these countries with epidemiological profiles and baseline health systems performance –as indicated by DHS- comparable to the ACSD areas. As one of the two control regions in Mali (Kayes) bordered the Senegal ACSD regions, the mid 2003 data from the Kayes region were also used as a control for the Senegal ACSD region. As Kayes joined ACSD mid 2003, a different control region will be used for Senegal in future coverage and mortality surveys.

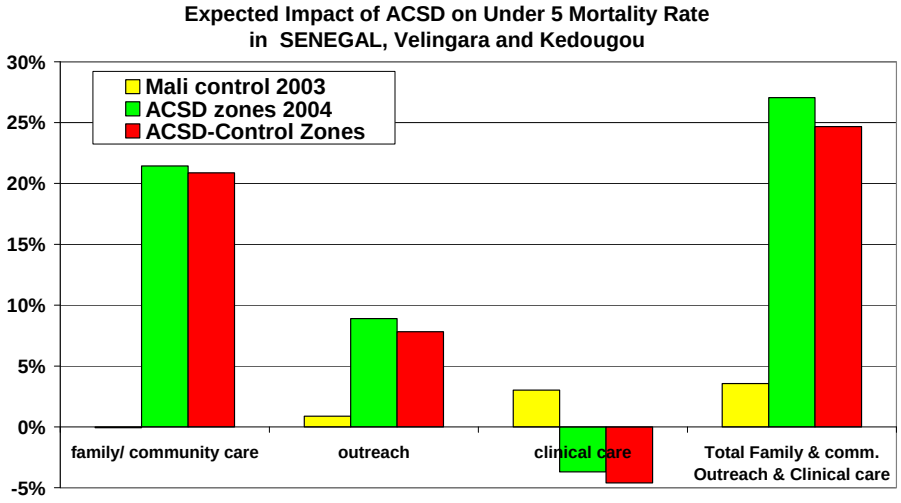
3.3.1 Mali: Controlled ACSD impact: 21%



In the High Impact demonstration Districts in Mali, the estimated reduction in the U5MR is close to 25% compared to the 2001 baseline. Over half of this impact is attributable to Family/Community level Care, thanks to the combination of massive distribution of free ITNs to all pregnant women and door-to-door re-impregnation, community management of Malaria, and use of ORT. Most of the rest is due to outreach services, particularly Vitamin A supplementation and Measles vaccination where coverage of both interventions increased by 50%.

The estimated U5MR reduction in the control areas is very modest so the "controlled impact" (i.e. ACSD increased coverage minus control area coverage, shown in red) is only 3% less than the actual impact in the ACSD areas, namely **21%**.

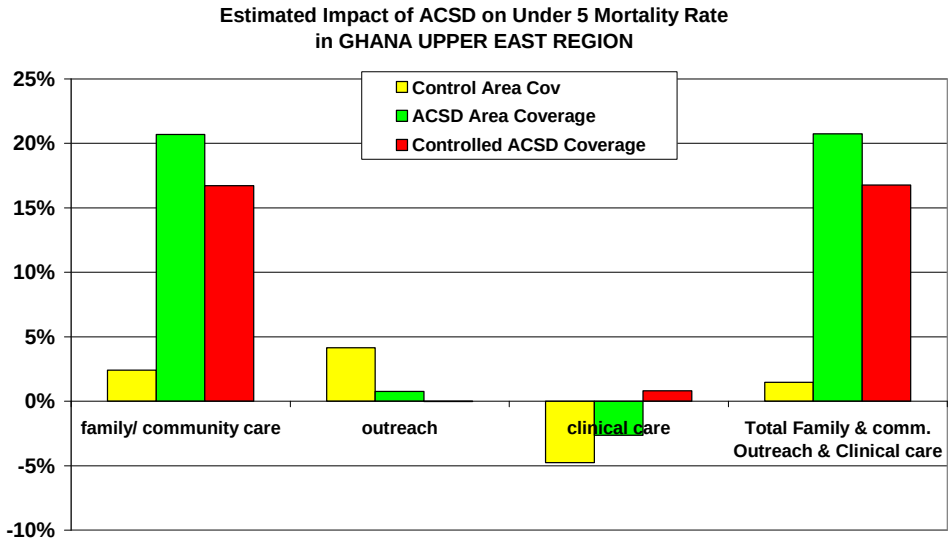
3.3.2 Senegal: Controlled ACSD impact: 24%



The U5MR was reduced by an estimated 27% in the High Impact demonstration Districts in Senegal, compared to the 2001 baseline. This impact is mainly attributable to the strong focus placed in the Senegal ACSD HIP districts on improved Family/Community level Care, especially use of ITN's, ORT and increased Exclusive Breastfeeding. Outreach contributes to about 8% of the impact, mainly due to Vitamin A supplementation (85% coverage), high coverage of fully immunized children, and TT2 vaccination of pregnant women.

The estimated U5MR reduction in the control areas is very modest, but there is a slightly negative impact from clinical care in ACSD areas (coverage of clinical malaria management decreased, possibly due to full scale introduction of and increase in family/community level malaria management, resulting in a decrease in use of clinical services) which is included to the "controlled impact" (shown in red). However, even taking into account this decrease, the "controlled result" is only 3% less than the actual impact in the ACSD areas, namely **24%.** Three years of implementation of the ACSD strategy has demonstrated how substantial progress can be made, even in the poorest settings, towards reaching MDG4 of under five mortality reduction.

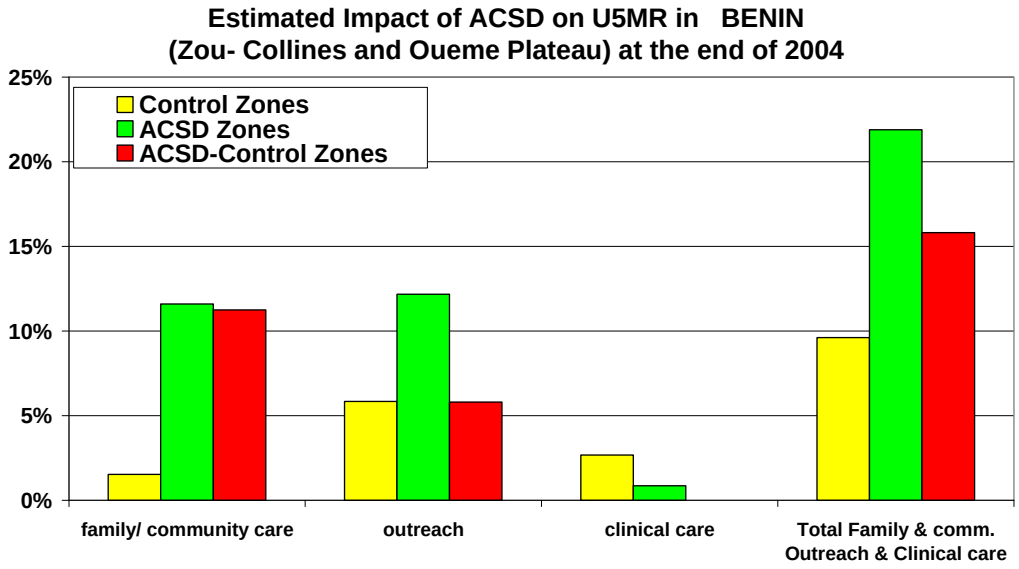
3.3.3 Ghana: Controlled ACSD impact: 17%



In the High Impact demonstration Districts in Ghana, U5MR is estimated to be reduced by over 20% compared to the 2001 baseline. Again, most of this impact is due to Family/Community level Care, attributable to a 44% increase in ITN use, a 27% increase in use of ORT, and a 34% increase in community management of malaria. Outreach services had no significant impact, mainly because of the initial high baseline level for Vitamin A supplementation.

The estimated U5MR reduction in the control areas in clinical care is very modest due to a negative impact of a decrease in clinical care, but as clinical care coverage has also decreased in the ACSD area, the "controlled impact, (shown in red) of 4% less than the actual impact in the ACSD areas, namely **17%**.

3.3.4 Benin: Controlled ACSD impact: 16%

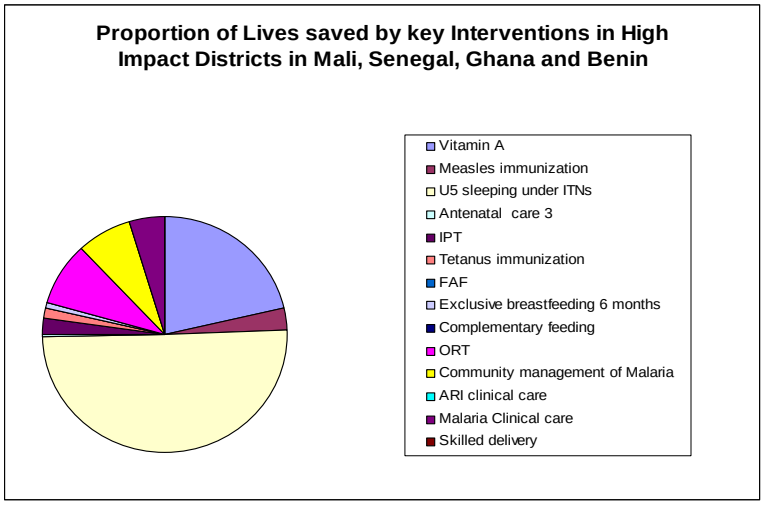


In Benin, the estimated reduction in U5MR is over 22% in the High Impact demonstration Districts, compared to the 2001 baseline. Half of this impact is attributable to Family/Community level Care, where there was a 45% increase in children sleeping under ITNs, and an improvement in community management of malaria and diarrhea (ORT). Introduction of community blister packs for malaria treatment planned for 2002 was delayed due to increased chloroquine resistance. The rest of the impact is a result of increased coverage of outreach services, including a 35% increase in Vitamin A supplementation, and use of IPT for malaria. IPT with fansidar was introduced early in 2004, and rapidly rose to 66% coverage. A substantial increase in coverage with Vitamin A supplementation in the control areas, due to national campaigns, triggered nearly 6% reduction of U5MR through outreach in the Control areas.

Clinical care coverage in the control areas increased more than in the ACSD areas, leading to an estimated U5MR reduction in the control areas of nearly 10%;

These impacts of outreach and clinical care in the control areas, reduce the "controlled" impact (shown in red) by 7% in the ACSD areas, namely to **16%**.

3.4 Key interventions impacting on U5MR reduction in High Impact Districts in 4 HIP Countries

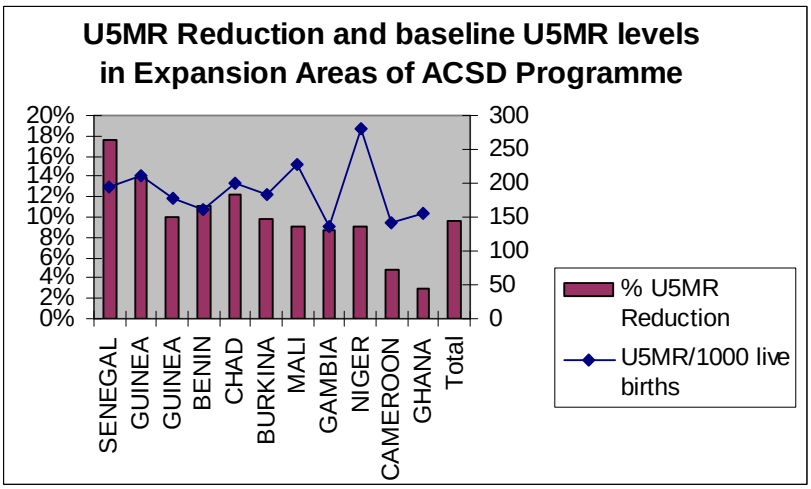


This pie chart shows the aggregate impact on U5MR of interventions in the High Impact Demonstration Districts in the four countries. Half of the U5MR reduction is attributable to ITN use; nearly a quarter to Vitamin A supplementation; 10% to ORT; and 10% to Community Management of Malaria. IPT and Measles immunization together contributed 6% to U5MR reduction.

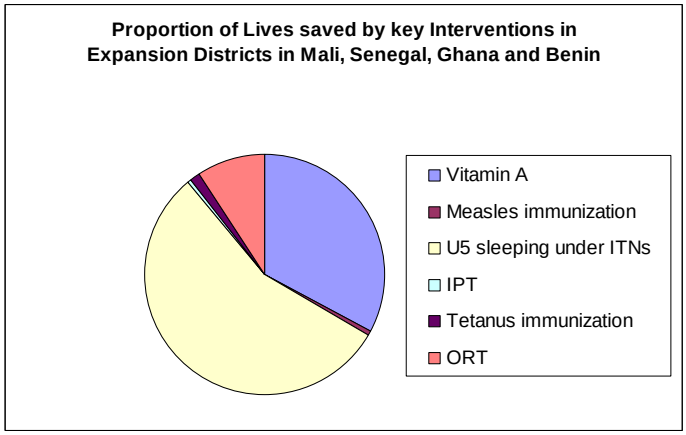
3.5 U5MR reduction in comparison with baseline in Expansion Districts in 11 Countries

In Expansion districts (both in HIP countries and Expansion countries) the reduction in U5MR varies quite widely, from highs of 18%, 14% and 12% in Senegal, Guinea Bissau and Guinea Conakry, to 5% and 3% in Cameroon and Ghana respectively, with expansion areas in the other 6 countries showing impacts around 10%.

This graph shows that in the expansion areas, the relationship between baseline U5MR and the % reduction in U5MR is less clear-cut than in the high impact districts.

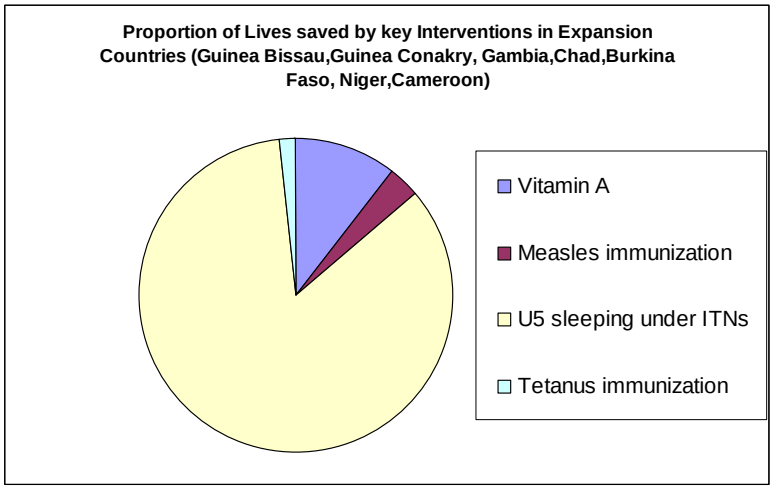


3.6 Key interventions impacting on U5MR in Expansion Districts in 4 HIP Countries



As described earlier in this report, the expansion areas in Mali, Senegal, Ghana and Benin cover a large population of over 5 million. Here a "minimum" package was implemented since 2002 consisting of Immunization and Vitamin A supplementation as well as distribution and mass re-treatment with insecticide of bed-nets. Following the 2003 surveys, more focus was placed on IPT and ORT promotion. As expected, ITN use contributes to over half of the impact on U5MR, Vitamin A supplementation to one third, and ORT to 10% of the U5MR reduction.

3.7 Key interventions impacting on U5MR in Expansion Countries



In the seven Expansion Countries where the same "minimum" package was implemented since 2002 as in the expansion areas in the 4 HIP countries, ITN use contributes 85% of the impact, Vitamin A 10%, and Measles and Tetanus Immunization combined 5%.

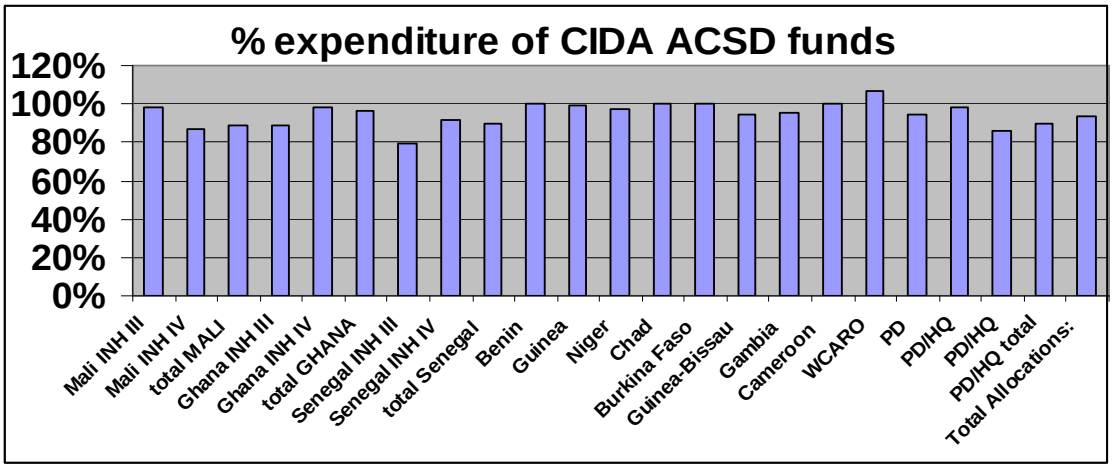
4. Programme Expenditure 2002-2004

Total ACSD expenditure over the four years 2001-2004 in the 11 countries was US$ 27 million, of which 57% was CIDA funding (US$ 15.2 million), for a population of 17 million people, amounting to an annual average per capita cost of 0.43 cents, of which 0.23 were provided by CIDA.

4.1 Expenditure of CIDA funding

Recipient	PBA Ref.	Funds Allocated		Expenditure as of 31-Dec-04	Unspent Balance as of 31-Dec-04	% expenditure
		CAD	USD	USD	USD	
Mali INH III	SC010406	959,625.00	611,223.55	599,339.22	11,884.33	98%
Mali INH IV	SC020341	5,050,399.00	3,149,942.36	2,731,573.29	418,369.07	87%
total MALI		6,010,024.00	3,761,165.91	3,330,912.51	430,253.40	89%
Ghana INH III	SC010405	959,625.00	611,223.55	541,662.39	69,561.16	89%
Ghana INH IV	SC020342	5,050,399.00	3,149,942.36	3,100,248.24	49,694.12	98%
total GHANA		6,010,024.00	3,761,165.91	3,641,910.63	119,255.28	97%
Senegal INH III	SC010404	639,750.00	407,482.37	323,406.87	84,075.50	79%
Senegal INH IV	SC020344	3,370,434.00	2,099,963.23	1,920,739.66	179,223.57	91%
total Senegal		4,010,184.00	2,507,445.60	2,244,146.53	263,299.07	89%
Benin	SC020343	3,370,434.00	2,099,963.23	2,100,962.58	-999.35	100%
Guinea	SC020633	834,734.00	524,989.25	522,503.85	2,485.40	100%
Niger	SC020634	834,734.00	524,989.25	513,007.80	11,981.45	98%
Chad	SC020635	834,734.00	524,989.25	523,450.48	1,538.77	100%
Burkina Faso	SC020636	500,840.00	314,993.30	314,132.34	860.96	100%
Guinea-Bissau	SC020637	500,840.00	314,993.30	297,512.56	17,480.74	94%
Gambia	SC020638	500,840.00	314,993.30	301,888.54	13,104.76	96%
Cameroon	SC020639	500,840.00	314,993.30	316,072.14	-1,078.84	100%
WCARO	SI020512	841,034.00	524,990.75	561,754.94	-36,764.19	107%
PD	SI010411	441,000.00	280,890.54	264,549.47	16,341.07	94%
PD/HQ	SI020513	1,137,502.00	754,319.01	741,850.25	12,468.76	98%
PD/HQ	SI020971	2,672,236.00	2,039,878.07	1,746,082.08	293,795.99	86%
PD/HQ total		4,250,738.00	3,075,087.62	2,752,481.80	322,605.82	90%
Total Allocations:		***29,000,000.00***	***18,564,759.97***	***17,420,736.70***	***1,144,023.27***	94%

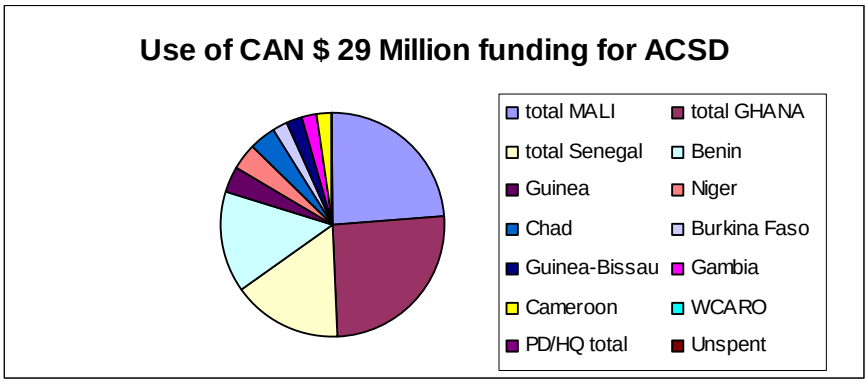
On average over 94% of the Can$ 29 million received from CIDA was spent by 31 December 2004. Some countries including Benin, Guinea Conakry, Chad, Burkina Faso, and Cameroon spent 100% of their funding by the end of 2004, and all other countries spent over 85%, as well as UNICEF Headquarters and the West African Regional Office (WCARO). (This is visualized in the graph below.) Some countries including Mali, Senegal, Benin, and Niger succeeded in leveraging substantial additional funding, raising the overall amount available for implementation of planned ACSD interventions.



An overall unspent balance of around 1 million US dollars has been kept aside for household Coverage surveys in all ACSD programme areas and for Under Five Mortality Impact surveys in the High Impact ACSD Demonstration Districts and control areas in Mali, Senegal, Benin and Ghana. These impact surveys were initially planned for the end of 2004, but on the advice of the Center for Disease Control (CDC) and UNICEF Statisticians it was postponed to the end of 2005 in order to enable verification of the achievement of the ACSD objective by assessing reductions in U5MR since 2000/1. As in 2003, these household surveys will have large sample size (40,000 households per site) and will be carried out and analyzed under the supervision of CDC Atlanta. These surveys will also be used to validate the reported coverage increases that indicate a reduction of over 15% in U5MR in each of the HIP districts in relation to the control areas. In parallel to the Impact surveys a full cost analysis of programme implementation and impact in these districts will be implemented. The coverage surveys in the expansion areas were similarly postponed to 2005 to coincide with the 2005 round of MICS surveys. Coverage information will also be collected in the same "control" districts as in 2003 to validate the reported increases in coverage in relation to the control areas in all expansion districts.

4.1.1 Expenditure of CIDA funding per country

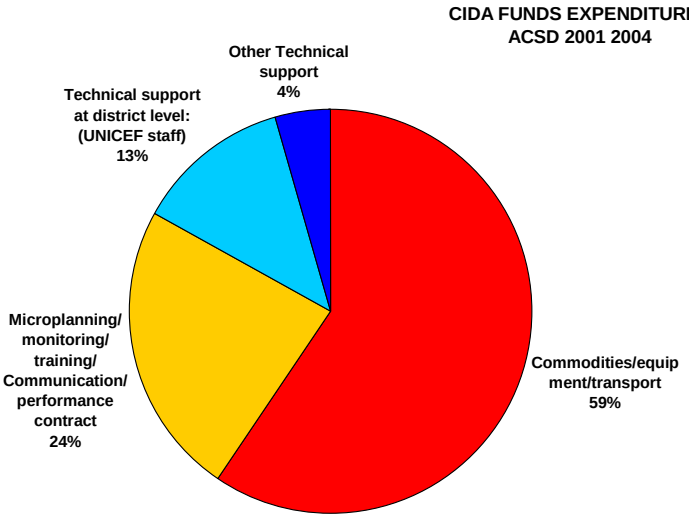
Two thirds of CIDA funds (around US $ 11 million) were spent in the four High impact countries of Benin, Ghana, Mali, and Senegal with a total population of 13.5 million people benefiting from the ACSD programme. Funding for both HIP and Expansion districts is combined in the chart for these four countries.



Mali and Senegal, where baseline U5MR levels were very high, received the largest country allocations, followed by Ghana and Benin. 16% of CIDA funds (around US $ 2.8 million) was spent in the 7 Expansion countries, targeting a population of around 3.5 million. Over US$ 1.6 million (9% of CIDA funds) was allocated to UNICEF supply in Copenhagen to secure a buffer stock of ITNs in order to influence a reduction in the price of ITNs on the international market and secure procurement throughout 2003 and 2004. In 2004, the ITNs of this buffer stock were distributed to HIP countries, particularly to Mali, to facilitate the large scale expansion of the ACSD programme to cover over 6 million people.

Finally, an additional US$ 1.5 million (8% of CIDA funds) was used by UNICEF Headquarters in New York and the Western and Central Africa Regional Office to provide technical support for the eleven countries, and to conduct and analyze the coverage surveys, in close collaboration with CDC.

4.1.2 Breakdown of Programme Expenditure using CIDA funding



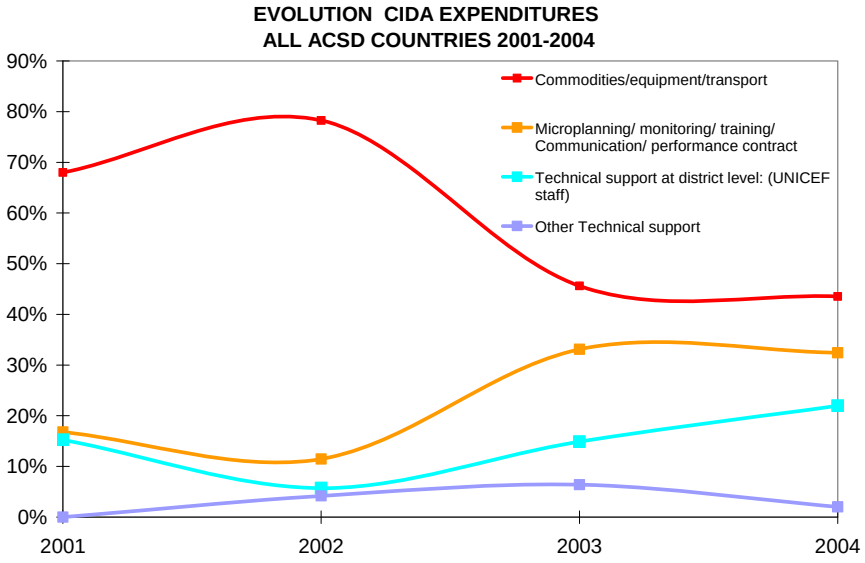
The breakdown of expenditure of CIDA funding is as follows:

- The majority of the total CIDA ACSD programme funding, nearly 60%, was used to purchase commodities such as ITNs and drugs, as well as essential equipment for programme implementation and vehicle and motorbike purchase to enable these commodities to reach children in need. Investment costs included basic health center rehabilitation and provision of cold chain equipment for health centers and at district level.
- A quarter of the funds were spent on "software" including training, supervision, micro-planning, programme monitoring, social mobilization, IEC, and performance contracts for key actors in programme implementation, including incentives for Community Health and Nutrition Workers (CHNWs).
- 13% was spent on salaries and travel costs of UNICEF staff responsible for support and supervision of ACSD programme implementation at field level.
- 4% was spent on other technical support, especially for CDC involvement in conducting and analyzing the 2003 household surveys that took place in each of the 11 countries.

4.1.3 Evolution of expenditure of CIDA funds 2001-2004

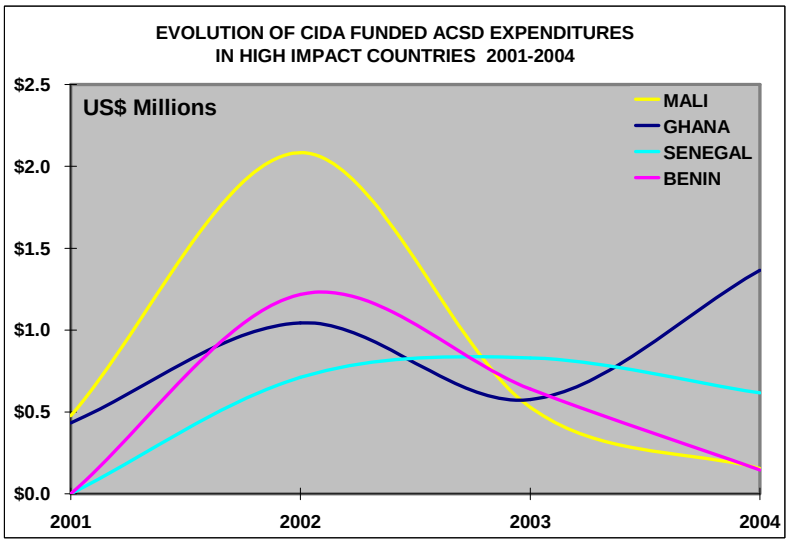
The line graph below clearly illustrates that commodity purchase and distribution was front-loaded, consuming between 70% and 80% of funds in 2001 and 2002 when the ACSD programme began. It was during this phase that initial extensive purchase of bednets, drugs, and equipment took place. Recurrent costs throughout each year included support staff, smaller quantities of essential drugs, supplies, micronutrients, and equipment, and support for micro-planning, monitoring, performance contracts, training and communication. The evolution over time shows that the "software", especially supervision, monitoring, training in response to needs identified, and communication activities consumed an increasing proportion of expenditure as the programme matured. This entailed a corresponding increase in the amount of technical

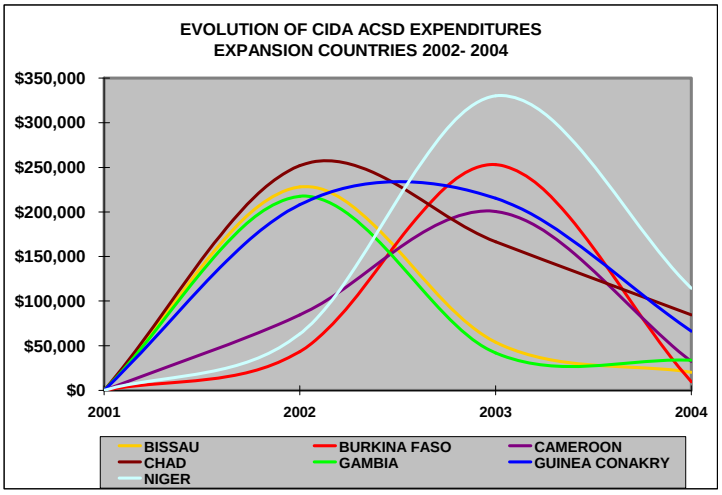
support needed to reinforce the capacity of national staff to provide adequate training and supervision, and to improve social mobilization and communication techniques with communities.



This graph shows how in Mali and Benin, CIDA funds were frontloaded, whereas in Senegal the expenditure pattern was more evenly spread over time. Ghana increased the spending of its CIDA funds in 2004 in an attempt to further accelerate the coverage of high impact interventions in the ACSD districts (in response to the disappointing results of the mid-2003 Household survey).

The expansion countries show a wide variation in expenditure patterns for CIDA funds, with Guinea Bissau, Chad, and Gambia frontloading expenditure. Expenditure of CIDA funds in Niger, Burkina Faso and Cameroon started considerably later. This can be partially attributed to late receipt and distribution of funds for some countries. Some expansion countries also anticipated needs and purchased commodities from early in 2002, while others started using funds after conducting micro-planning exercises at the end of 2002 and in early 2003. This may at least partially explain the better results achieved in Guinea Bissau and Chad as compared to Niger and Cameroon.

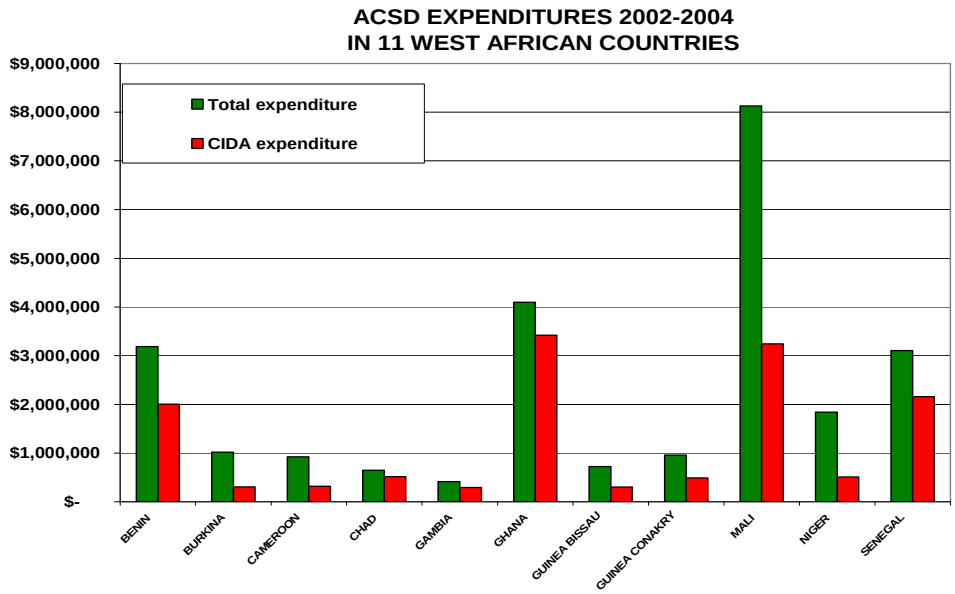


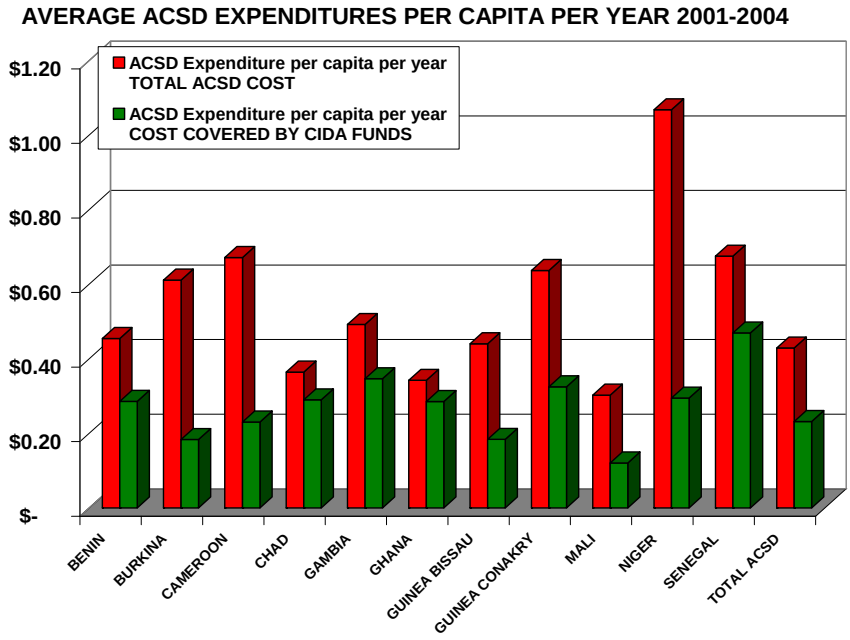


4.2 Total ACSD expenditure and funding from other sources for ACSD at Country level

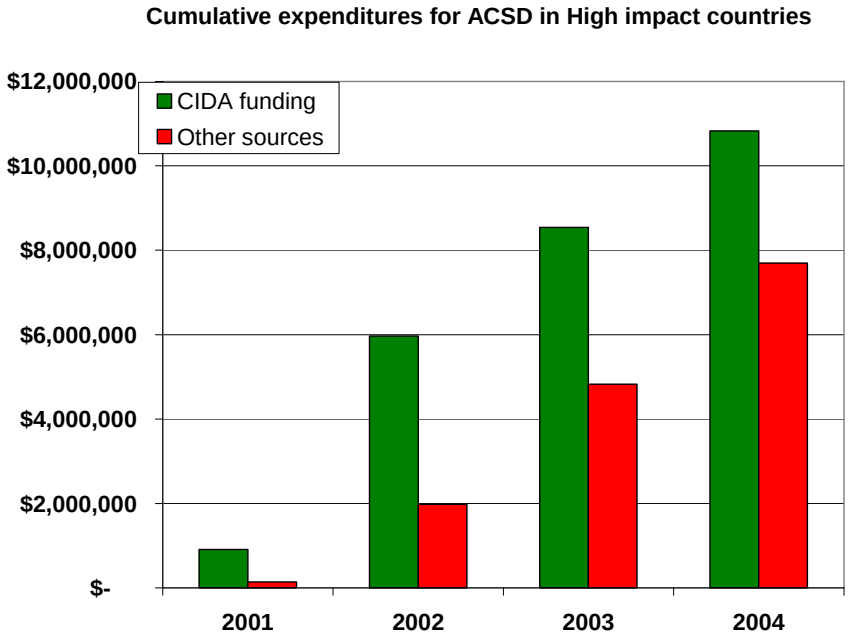
The ACSD Budget proposed to CIDA in 2001/2 included a "cost-sharing" on a 50-50 basis between CIDA and UNICEF's own resources and already existing other supplementary funds, in order to ensure that UNICEF's own resources would not be substituted but rather leveraged by CIDA funds. In the 11 ACSD countries, in addition to US $ 14 million CIDA funding, over US$ 11 million from other funding sources were used for ACSD interventions, excluding funding for vaccinations from GAVI. This includes both UNICEF's own resources and funding raised from other sources. Rapid interest generated by the ACSD approach served to secure funds from donors including USAID, the Netherlands Government, the Japanese Government, and various UNICEF national committees (including UK, Netherlands, and Canada). All vaccinations and injection equipment was funded through GAVI, which is not included in the graphs below, as details on the expenditure of GAVI funds in the ACSD Program areas were not available at the time of this analysis. As the GAVI funding far exceeds $ 1 million per year for the 17 million population targeted by ACSD, and less than half of the salary costs for time spent by UNICEF staff on supporting the ACSD Programme was paid from CIDA funds, the 50-50 cost sharing arrangement has been respected.

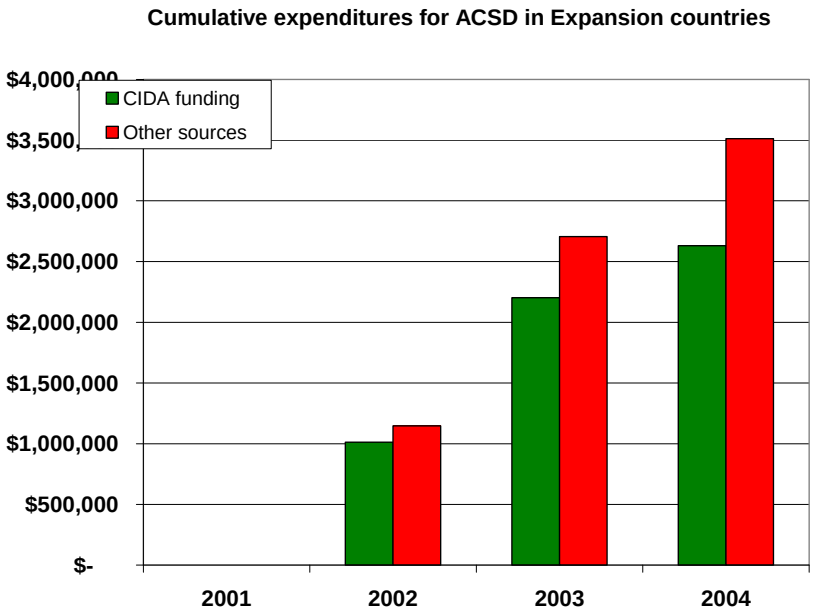
The graphs below illustrate the cost-sharing of ACSD activities in different countries:



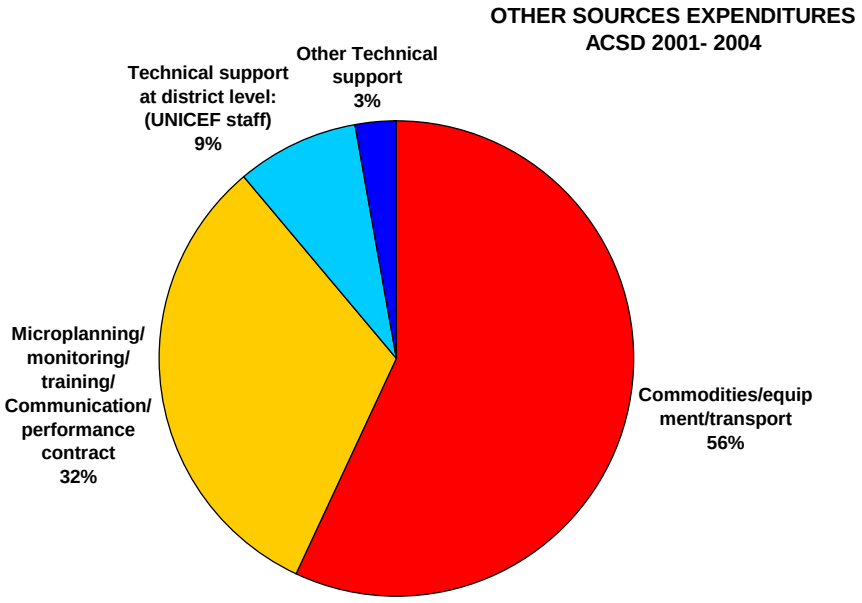


The two graphs below illustrate the evolution of CIDA and other Funds spent between 2001 and 2004. Both sources evolved in the same direction and remained in balance during the entire programme period, in line with the agreements made with CIDA in 2001/2.





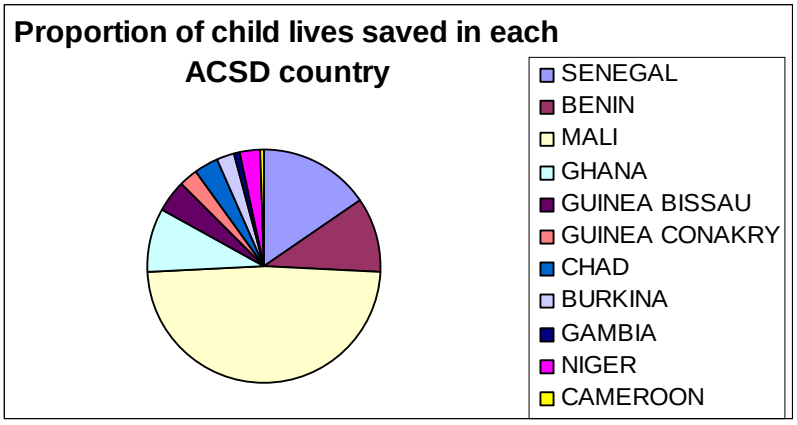
4.2.1 Breakdown of Programme Expenditure using funding from other Sources



The graph above shows that the expenditure of the $ 11 million mobilized from other sources for the ACSD followed the same pattern as expenditure of CIDA funds.

5. Estimation of Cost per Life year saved

5.1 Numbers of Child Lives saved each year in each of 11 participating countries



Of the over 18,000 child lives saved each year, almost half are saved in Mali where the ACSD programme targets 60% of the National Population, and where a major impact on U5MR has been achieved in both the demonstration "high impact" districts (targeting over 1 million people) and in the expansion districts (targeting all other areas in the 4 intervention regions) with a total population of over 6 million. Senegal, Benin, and Ghana account for about one third of the total number of lives saved as 6 entire regions with a total population of 7 million people benefit from the ACSD programme (high impact and expansion districts combined), and the impact on U5MR has been substantial especially in the high impact demonstration districts.

5.2 ACSD Programme Cost per Life Saved

Total UNICEF and CIDA Expenditure in ACSD Programme and Costs per Life saved

ACSD COUNTRIES	Total Progr Exp/year	CIDA Progr. Exp/year	Total Progr. Exp./cap/yr	CIDA Progr. Exp/cap/yr	Total Progr Exp per life saved	CIDA US $ per life saved
SENEGAL	$ 1,034,693	$ 719,422	$ 0.68	$ 0.47	$ 372	$ 258
BENIN	$ 1,061,732	$ 667,944	$ 0.45	$ 0.29	$ 571	$ 359
MALI	$ 2,033,021	$ 811,146	$ 0.30	$ 0.12	$ 234	$ 93
GHANA	$ 1,024,742	$ 855,165	$ 0.34	$ 0.29	$ 631	$ 526
Average	**$ 5,154,187**	**$ 3,053,677**	**$ 0.38**	**$ 0.22**	**$ 345**	**$ 204**
GUINEA BISSAU	$ 241,017	$ 100,645	$ 0.44	$ 0.18	$ 299	$ 125
GUINEA CONAKRY	$ 320,120	$ 163,299	$ 0.64	$ 0.32	$ 689	$ 351
CHAD	$ 215,763	$ 171,638	$ 0.36	$ 0.29	$ 375	$ 298
BURKINA	$ 340,038	$ 102,042	$ 0.61	$ 0.18	$ 742	$ 223
GAMBIA	$ 138,865	$ 97,773	$ 0.49	$ 0.35	$ 1,127	$ 793
NIGER	$ 613,728	$ 169,332	$ 1.07	$ 0.29	$ 1,222	$ 337
CAMEROON	$ 308,386	$ 105,754	$ 0.67	$ 0.23	$ 2,564	$ 879
Average	**$ 2,177,916**	**$ 910,482**	**$ 0.62**	**$ 0.26**	**$ 714**	**$ 299**
TOTAL ACSD	**$ 7,332,103**	**$ 3,964,159**	**$ 0.43**	**$ 0.23**	**$ 407**	**$ 220**

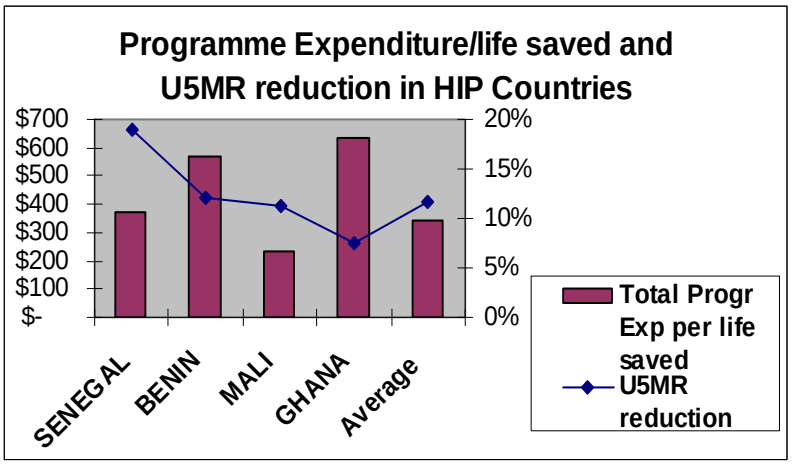
Over US$ 7 million per year was spent on the ACSD programme from 2002-2004, of which nearly US$ 4 million was CIDA funds (expenditure in Mali and Senegal commenced in 2001). This amounts to a total ACSD programme expenditure from all funding sources of $ 0.43 per capita per year, varying from $ 0.3 in Mali to over $ 1 in Niger. The proportion of this cost attributable to CIDA funding is $ 0.23 per capita per year (ranging from $ 0.12 per capita/year in Mali to $ 0.47 per capita/year in Senegal).

Combining these average annual ACSD expenditures with the number of Child Lives estimated to be saved every year (see 5.1. above) gives an ACSD Programme Cost per life saved of, on average, $ 345 in Mali, Senegal, Ghana and Benin for the High Impact Demonstration Districts and Expansion areas combined. In these countries the annual ACSD expenditure was $ 5 million, of which $ 3 million was covered by CIDA funding. The cost per life saved varies from $ 234 in Mali to $ 631 in Ghana; the CIDA expenditure per life saved is just over $ 204 for those 4 countries, varying from $ 93 in Mali to $ 526 in Ghana.

In the expansion countries the average annual total expenditure of both ACSD and CIDA funds was substantially less ($2 million and $1 million respectively), as a smaller population was targeted with a "leaner" intervention package (consisting essentially of EPI+, ITNs and Vitamin A supplementation, but without the ANC+ and IMCI+ packages). The cost per life saved varies from under $ 300 in Guinea Bissau ($ 125 from CIDA expenditure) to over $ 2500 in Cameroon ($ 879 from CIDA funds).

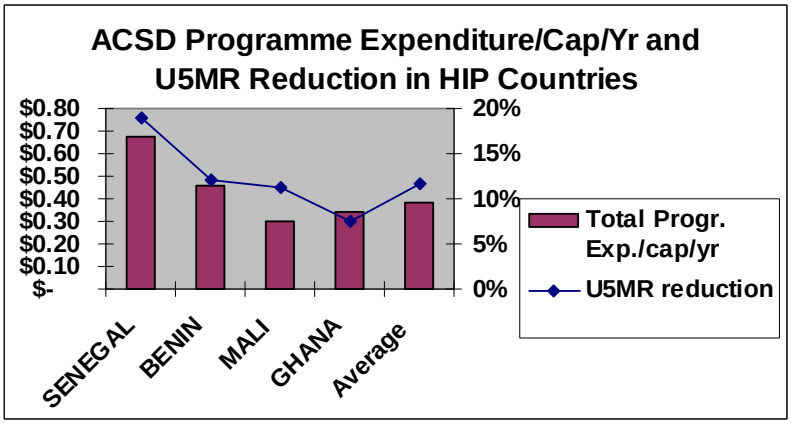
Note: UNICEF accounting procedures do not allow differentiation of expenditure on the different types of districts, which is why spending data for both high-impact and expansion districts are combined for the 4 High Impact Countries. A specific costing exercise will be included in the Impact Surveys planned for the high impact districts in order to differentiate expenditure from that in expansion districts.

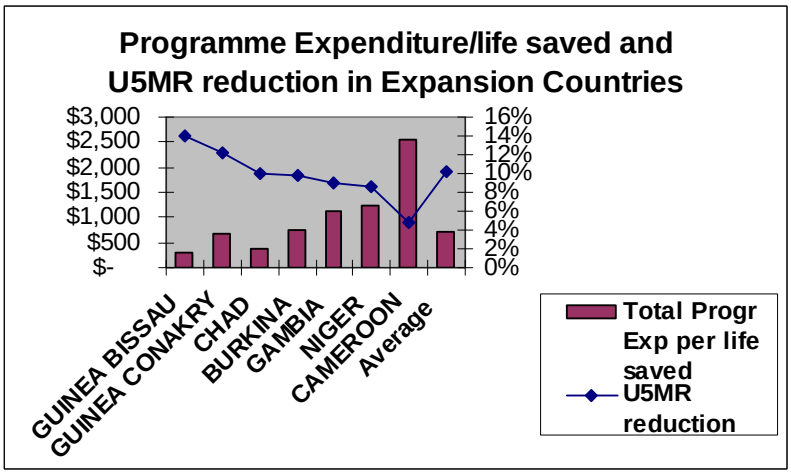
5.3 Relationships between the levels of U5MR reduction, Programme Expenditure per Capita/Year and the Cost per life saved



These graphs illustrate why ACSD programme implementation in Senegal and Mali was more cost-effective than in Benin and Ghana. In Senegal a relatively high programme expenditure per capita/year is associated with a high U5MR reduction (19%). In Mali and Benin, U5MR reductions are similar (11% and 12% respectively) but the programme expenditure per capita/year is lower in Mali. Ghana has a programme expenditure per capita/year only slightly higher than Mali, but has a much lower U5MR reduction (7%).

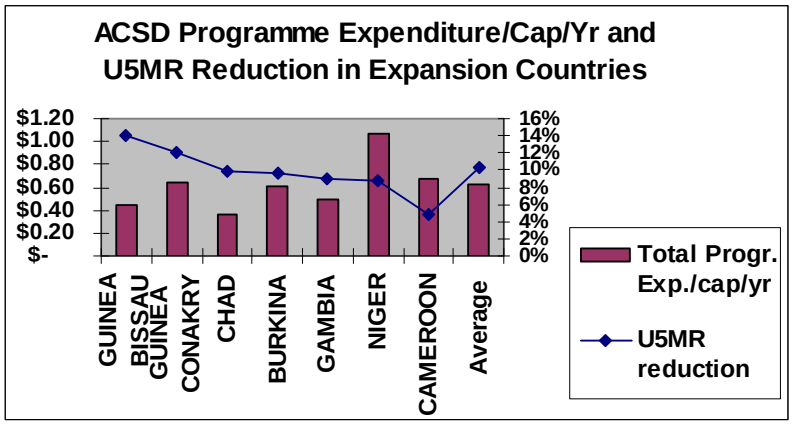
The higher baseline U5MR rates in Mali and Senegal (230 and 195 respectively) further reduce the cost per life saved in relation to the % of U5MR reduction and programme expenditure per capita/year in comparison to Benin and Ghana with U5MR levels of 150-160.





The cost-effectiveness of the ACSD programme varied widely in the expansion countries. Four countries, Guinea Bissau, Chad, Guinea Conakry, and Burkina Faso all reduced U5MR by 10% or more, at an ACSD programme cost per life saved of under $ 1,000.

U5MR reductions in Niger and Cameroon were below 10%, with a high programme expenditure per capita/year (>$1 in Niger and $ 0.67 in Cameroon) which together contribute to a programme expenditure per life saved of over $ 1,000.



6. Long-term Sustainability and Replicability of Interventions

6.1 Micro-planning and Monitoring

6.1.1 Community-based micro-planning and monitoring

A primary strategy used to ensure sustainability is community-based micro-planning and monitoring. A tool for situation analysis, communication strategy development, monitoring and micro-planning was developed with and for communities in the course of ACSD implementation in West and Central Africa. This has enabled communities to become involved in identifying obstacles to delivery and effective use of the three intervention packages, in analyzing specific local causes, selecting corrective actions with the involvement of stakeholders (community members, local health staff, supervisors, and managers), micro-planning priority interventions, implementing them at family and community level, and monitoring progress. Priorities included in this monitoring and micro-planning tool are promotion and utilization of ITNs, exclusive breastfeeding for 6 months, complementary feeding, and treatment of diarrhea, malaria and ARI. This ownership has led to more effective programme planning and implementation, and improved defaulter tracing, and provides a solid foundation for continuation of activities. This tool has been introduced in six countries, Senegal, Mali, Benin, Guinea Conakry, Niger, and Burkina Faso, and training provided for community members in its use.

Expansion to countries not involved in ACSD

Many countries not involved in ACSD implementation expressed an interest in participating in community training in micro-planning and monitoring. Congo Brazzaville, Cote D'Ivoire, Mauritania and Sierra Leone participated in training sessions and shared communication materials enabling them to replicate this approach.

6.1.2 Service-based micro-planning and monitoring

Service-based micro-planning and monitoring has also been an important strategy, using coverage monitoring results to measure changes by health workers and their supervisors over time, enabling health workers to understand the effect of management practices on evolving service coverage and programme implementation. The monitoring method used has followed the planned strategy of organizing the major factors influencing household utilization of health care into a hierarchy of determinants for effective coverage, namely availability, geographic accessibility, utilization, continuity and quality. Indicators for each determinant were agreed upon at the beginning of every reporting period by the health centre staff and supervisors for every intervention.

6.2 Support strategies for sustainability

Other cross-cutting support strategies have been used throughout programme implementation to reinforce capacity and ownership to ensure the sustainability of the approach. These strategies include:

A results-based approach to service delivery at community level was promoted. To facilitate this, performance contracts for effective coverage of intervention packages were developed with all partners at local level, including NGO's and other public and private providers. This worked particularly well in Mali where contracts were signed with providers, including with local NGO's to ensure bednet provision. In most countries, to encourage CHNWs to provide good coverage with the community, a performance contract was initiated with results-based incentives. Results indicators are based on key activities such as birth registration, defaulter tracing, DPT3 coverage, ITN re-dipping and Vitamin A coverage. These results are then shared with community members with the involvement of local leaders, allowing analysis of the

CHNW's performance and mobilizing locals to assume increasing responsibility for, and commitment to, community and family-based care.

Bicycles were used as incentives for CHNWs to ensure defaulter tracing and registration of pregnant women, as well as promoting birth registration. During community meetings with leaders, the CHNW presents activities and results (e.g. the number of children immunized, the number of pregnant women registered, the number of pregnant women sleeping under ITNs). If a high level of coverage is sustained over a period of a year, the CHNW could be granted ownership of the bicycle. This incentive was also used to reduce the problem of bicycle maintenance.

Mali : Performance Contracts

A performance contract is a contractual reference and management tool that defines the responsibilities, expectations and means to be mobilized by different agents to attain intervention objectives in a district, a health zone or even in a village.

Performance contracts are established with a view to obtaining genuine commitment from central actors (village authorities, village health agents, health teams, community leaders, etc.) to carry out their respective roles as identified in ACSD planning exercises. Performance contracts have proved to be very useful in establishing results-based planning and monitoring linked with clear allocation of responsibilities to different actors.

Performance contracts also facilitate dialogue with communities, enabling:

- realistic monitoring
- increased commitment on the part of actors involved
- continuous dialogue for the duration of the contract
- capacity enhancement through ongoing training and skill acquisition.

Performance contracts are signed by administrative, political and health authorities in the district, personnel from the FELASCOM (National Federation of Community Health Associations), ASACO (Community Health Association), CSCOM (Community Health Center), and the Mayor of the commune. Several different types of contract have been established in the course of implementing the ACSD programme. These include:

- Service provision: at household/community level, a service provision contract linking the community association/NGO with the ASACO in the health region
- CSCOM: an individual contract for each member of the technical health team from the community. The Mayor oversees the contracts that detail each CSCOM agent's tasks, expected results, performance-based rewards and sanctions in the event of non-performance.
- ASACO: a contract is established between the circle and the ASACO, committing the ASACO to produce specific results and the health circle to ensure supplies necessary for service delivery.
- The Circle Reference Centre: the technical team (doctor, midwife, manager) is responsible for supervising and providing technical assistance to the CSCOM, particularly in micro-planning, monitoring and resource provision.
- Regional Health Direction: The Regional Director is committed to providing resources and technical assistance necessary for the circle, based on the different contracts, to ensure ACSD implementation.

The main lesson that has been learned from using performance contracts is that they provide a successful means of mobilizing commitment at all levels, from community to higher management. Signing a contract effectively engages the individual to adopt not only a contractual but also a moral responsibility to obtain expected results. The collective force of contracts at all levels of intervention provides more cohesion in social mobilization to achieve results and improve child survival indicators.

Image boxes for use by the CHNWs have been developed on malaria, diarrhea, ARI and nutrition and the accompanying texts translated in different local languages, considerably strengthening the CHNWs capacity to educate the community on essential child survival strategies.

Benin

Supervision of CHNWs posed some problems, with health centre-based staff having trouble visiting them on a regular basis. To address this problem an additional approach was adopted, which consists of gathering the CHNWs from the catchment areas of a given health centre at the health facility every two months. This allows for exchanges between the CHNWs, for recycling on certain topics, and for restocking of medicine (chloroquine/paracetemol) and other commodities (ORS, bednets and Kotabs).

Integrated technical and managerial training: A shortened version of IMCI training for health facility and community level was developed and health workers trained in the technical and managerial aspects of delivering the high impact integrated packages and improving family care practices through a community-based approach.

Improving supply systems for procurement and distribution down to community level of affordable quality essential drugs and commodities especially bednets, effective anti-malarial drugs, ORS and micronutrient supplements was emphasized and reinforced.

Lessons Learned in Chad

- Allocating clear, results-based responsibilities to each central actor through participative micro-planning has been key to ACSD success.
- Performance contracts have served essentially as management and monitoring tools, facilitating definition of responsibilities and expectations both with local Health Committees and with service providers from the Health Centers. An intense social mobilization campaign prior to establishing the contracts was of major importance in gaining acceptance of the strategy by community leaders.
- Monthly and bi-annual monitoring meetings were very beneficial in helping all involved to become aware of progress made and in developing strategies to address identified bottlenecks.

Advocacy with Traditional Chiefs for Routine Vaccination : Niger

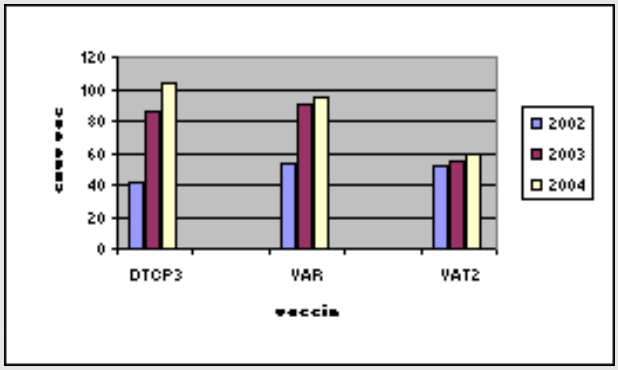
The health district of Madarounfa in Niger was one of two districts chosen for ACSD interventions in 2002, based on its low level of EPI coverage, with DPT3 coverage at 42%, measles at 53% and TT2 at 52%. The objective of attaining 80% vaccination coverage by 2004 among children aged less than 11 months was established.

The population of Madarounfa has a significant component of nomads, estimated at 20% of the population. living in camps dispersed throughout the department, moving frequently with their herds of cattle in search of pasturage. An estimated 33% of children have no access whatsoever to basic health services due to inadequate geographical coverage, poverty, nomadism, and lack of information, particularly on vaccination. Tribal chiefs are held in high esteem among this community. UNICEF has a signed agreement with the Association of Traditional Chiefs of Niger in the context of the Cooperation Programme. This agreement was used as a basis for advocacy with tribal chiefs to promote routine EPI vaccination with their communities.

In 2003, with Canadian funding for ACSD, 240 tribal chiefs (locally called Hardos) were grouped into cohorts of 25, provided with detailed information on the importance of childhood vaccinations, and briefed on the current situation with respect to vaccination coverage among children in their communities. The objective of this training was to inform the chiefs of the advantages of vaccinations, the vaccination calendar, and defaulter tracing.

Chiefs were urged to carry out social mobilization among their respective communities and continuous advocacy in support of routine EPI. The tribal chiefs ensuing commitment to EPI was manifested through an unprecedented increase in vaccination coverage in the district, as illustrated in the following table and graph, confirming the importance of engaging leaders and populations in improving children's health:

	2002	2003	2004
DPT3	42	86	103
Measles	53	90	95
TT2	52	55	59



6.3 Inclusion of ACSD in PRSPs, SWAps, MTEFs

6.3.1 Policy development and resource leveraging

An important strategy within this initiative is the development of collaborative partnerships, including with the Ministries of Health and Finance in each country, involving staff at central, provincial and district level in joint planning, implementation and monitoring of ACSD initiatives. The MBB approach, added to ACSD, is enabling implementation of a more rights-based and results-based approach strategy, linking funding to outcome, with an estimation of the impact on under-five and maternal mortality. UNICEF health officers from ACSD countries have been trained in MBB analysis and have applied this tool to ACSD survey results. Further regional workshops are planned in collaboration with the World Bank and WHO to respond to the demand to use the MBB approach in taking ACSD interventions and strategies to scale and to support evidence-based investment decisions when governments and donors allocate resources to child health in the context of Medium-Term Expenditure Frameworks (MTEFs), Sector Wide Approaches (SWAps), and National Budgets. MTEFs are substantially increasing health expenditure and focus on approaches with a

high impact on attaining the MDGs, including in Mali where the health budget doubled after the MBB approach was used in preparing the MTEF in 2003. ACSD is also being used to influence incorporation of increased child survival provisions in Poverty Reduction Strategic Plans (PRSP), National Health Plans, and Health Sector Reforms, incorporating an approach that is both child-friendly and results-oriented. This includes policy development and resource allocation for improved clinical care, particularly for skilled ante-natal care services.

In Guinea-Bissau, ACSD targets for EPI and ITN use were adopted in 2004 as national targets and are being implemented and monitored nationwide, guiding other partners and donors. A national policy was adopted on twice-yearly Vitamin A supplementation, integrated as part of routine child care services including immunization, and this is incorporated in the updated U5 growth monitoring card. This policy is currently under review to incorporate Vitamin A supplementation within twice-yearly Child Health Days as well as specifying supplementation for lactating women.

Influencing National Policy and Leveraging Funding : Mali

In 2002 ACSD strategies were included in the national Poverty Reduction Strategy (PRSP) in Mali, particularly for improving child survival preventive and care practices at household level. The Medium Term Expenditure Framework (MTEF) 2003 was developed on the basis of ACSD strategies with results-based management tools.

The Monitoring Committee for the Ministry of Health's National Health and Development Programme (Prodess) followed the success of ACSD closely. When positive evaluation results of coverage increase and impact of ACSD interventions emerged, the Monitoring Committee decided to generalize the ACSD approach nationwide (measles coverage was 38% in 2001 and 83% in 2003; DPT rose from 33% in 2001 to 83% in 2003; U5 sleeping under an ITN was 6% in 2001 and 71% in 2003; the expected impact on U5 mortality reduction was about 20 % in 2003 after two years of ACSD implementation).

The ACSD strategy forms the backbone of the second phase of the National Health and Development Programme (Prodess II) 2004-2009, which incorporates PRSP goals and MTEF budgeting for accelerated child survival.

Applying the MBB approach to ACSD has enabled UNICEF to build a strong rights-based and results-based case for investing in child survival and development, linking funding to outcomes and impact on under-five and maternal mortality rates. UNICEF is strengthening its assistance to central and local government authorities and civil society structures to orient towards building strong, equitable and outcome-oriented district-based health systems, and is playing an increasingly stronger role in shaping and influencing partnerships both externally and internally in support of child-friendly, results-oriented National Health Plans, and Health Sector Reforms, PRSPs, and UNDAFs, and in leveraging resources through SWAPs and Medium-Term Expenditure Frameworks (MTEFs) through active, focused participation in these processes. UNICEF can play a major role in influencing the design of health policies, strategies and budgets in favor of children, in a context where the bulk of ODA is increasingly undesignated direct budget support, providing clearer linkages between investments and health outcomes that have direct relevance to the MDGs. Collaboration has been strengthened among the World Bank, UNICEF and WHO to respond to the challenge to use the MBB approach to take ACSD to scale through incorporation in MTEFs and SWAps, facilitating the establishment of linkages based on the selection of high-impact child survival interventions,

identification of scaling-up operational bottlenecks, costing of activities to resolve these bottlenecks, and estimating impact on under-five mortality and effective coverage. Application of this approach in Mauritania and Mali has resulted in almost doubling the health budget to support MDG-oriented strategies and plans. In 2005, an external validation of the tool will be carried out, followed by the production of tool kits and training materials. MBB has been used at country level to prepare MTEFs in Benin, Mali, Mauritania, Madagascar, Mozambique, Niger, and Rwanda. In Ethiopia, MBB has been used to assess the cost and potential impact of various service delivery options to enhance the contribution of health services to the MDGs. In India it is currently used as a planning tool for reallocating funding within the health sector as well as orienting expenditures for a newly developed national health project supported by several donors, including the World Bank, USAID, DFID and the EU.

Leveraging Funds for Malaria Prevention in Benin

UNICEF Benin, in partnership with NGOs, adopted an approach to promote and distribute subsidized bednets to pregnant women and under-five children using maternities, women's groups, and EPI sessions, bringing the percentage of children sleeping under an impregnated net from 3.4% to 43%. The success of this approach has succeeded in leveraged substantial additional funding for malaria prevention. Global Funding of over US$ 2 million was allocated to Africare for a proposition based on replicating this approach in the departments of Mono and Couffo, and USAID funding of $ 450,000 was channeled through UNICEF to extend the approach to the departments of Donga and Attacora, covering an additional population of 1,963,766.

Using HIPC to purchase Vitamin A : Burkina Faso

The Government of Burkina Faso procured 3,000,000 Vitamin A capsules with Highly Indebted Poor Country (HIPC) funds and administered them countrywide to 6-59 month old children in 2004. Some of the HIPC funds were also used for operational costs. To complement Canadian assistance in Vitamin A supplementation, the Government has committed to Vitamin A supplementation nationwide for children aged 7-10 years.

6.4 Partnerships

Public-private partnerships are increasingly becoming a major feature of UNICEF's operating environment. Throughout programme implementation, a multi-sectoral and multi-disciplinary approach to child survival and development was promoted to achieve global, regional, national and sub-national alliances and partnerships. UNICEF is a founding member of the interim Child Survival Partnership and hosts the interim secretariat in New York since August 2004. The partnership's first initiative has been to organize high-level visits in high-mortality countries to help raise the visibility of child survival on the political agenda. India established a national child survival partnership, whereas Ethiopia's newly adopted health extension package strategy has the reduction of U5MR as one of its primary objectives. Two UNICEF regional networks, namely Eastern and Southern Africa, and Western and Central Africa are in the process of developing a joint child survival acceleration strategic framework, building on existing good practices in ACSD.

ACSD has been adopted as the regional health strategy by UNICEF in West Africa and efforts are being

made at national, intra-regional and international levels to share the strategy and expand it to other countries. This is being done in close collaboration with key partners to engage partner buy-in and joint support actions in the priority countries, to enable national policy and health policy development, financing and setting up systems and favorable conditions for delivery of family care, outreach services and clinical care, as well as family and community empowerment.

National partnerships around child survival have been established in the participating countries, including:

- In Mali, the monitoring committee for the National Health Development Programme (PRODESS) has recommended expanding ACSD throughout the country. Some key partners such as USAID are already enrolled in extending ACSD to new districts. Monthly meetings with partners are organized to discuss programme implementation, including ITN distribution strategies, support for regular outreach service delivery, and community-based issues.
- In Benin, under the leadership of the national malaria programme, UNICEF built up strong partnerships with PSI and Africare to promote and distribute ITNs. Africare and USAID want to replicate the ACSD approach (promotion and distribution of subsidized bednets through UFC and ANC) in other departments of the country. The national malaria control programme is also very keen on expansion of the approach nationwide.
- In Ghana, ACSD has promoted partnerships at regional level to accelerate implementation of interventions by District Health Authorities, e.g. with Kwame Nkrumah University of Science and Technology (KNUST), the School of Medical Sciences, Ghana Red Cross, Navrongo Health Research Centre and District Assemblies.
- In Senegal, partnerships were established with the World Bank and BASICS for c-IMCI, and with USAID to establish an ITN voucher system linked with antenatal visits. In Niger, UNICEF accelerated EPI+ coverage with support from JICA and other partners within the InterAgency Coordination Network, including the International Red Cross, Rotary International, Helen Keller International and WHO.
- In Guinea Bissau, progress in ACSD implementation succeeded in leveraging resources from Plan International for strengthening routine immunization and ITN provision, with the World Bank for cold chain supplies and equipment, ITNs and motorbikes, and with the Spanish Committee for UNICEF for water and sanitation installations in health centers, schools and targeted communities.
- In Burkina Faso, the national malaria programme was the leader in ITN promotion and re-dipping, in partnerships with PSI and Plan Burkina Faso, and replicated the UNICEF approach to ITN distribution for nationwide implementation financed by the Global Fund.
- In Gambia, a vibrant partnership with WHO, Medical Research Council, Riders For Health, UNVs and communities succeeded in combining birth registration with a mass bednet re-dipping campaign.
- In Niger, a strong partnership was established with JICA and GAVI on ITNs, and with a local NGO Cabinet Effors who trained 450 TBAs in community level blood donations and in voluntary testing of pregnant women.
- In Cameroon, strong partnership between UNICEF, JICA and the Government through regular and HIPC-Initiative funds enabled rapid implementation of the government's commitments in favour of ITN distribution and reinforcement of EPI+ activities nationwide.
- In Guinea Conakry the Immunization Coordination Committee succeeded in building a strong partnership between the EPI programme and UNICEF, WHO, GAVI, USAID, Rotary Club, JICA and some NGOs for both routine and supplementary immunization activities. This committee deals also with Vitamin A distribution with additional partners such as Helen Keller International. UNICEF is promoting an active partnership between the National Malaria Programme, the Safe Motherhood programme, the IMCI National Coordination, the Global Funds, WHO, USAID/PSI and JICA (multi-bilateral cooperation agreement) to increase availability of ITNs and introduce IPT for pregnant women.
- In Chad, a strong ACSD partnership has been built with the Ministry of Health and other Ministries. Key implementation partners within the Ministry of Health are EPI, the National Diarrheal Diseases and ARI Programme, and the National Malaria Programme. The Ministry of Territorial Administration is an

important player in mobilizing and involving communities, and thanks to the performance contracts, solid relationships have been built with communities and their representatives. The Ministry of National Education and of Social Affairs are responsible for the development component. Existing partnerships with WHO, the Rotary Club and the World Bank in the concerned districts were clearly strengthened by the ACSD approach.

- Implementation of community IMCI was strengthened by a strong partnership including the WHO regional office, country offices, BASICS, USAID and national and international NGOs (Africare, AED, Plan International, World Vision, and others).

7. Future planning and recommendations for 2005-2006

ACSD activities will be reinforced in all participating districts in the 11 countries, and expanded to ultimately reach all districts in each of these countries. The long term objective is to reach nationwide scaling up of ACSD in each country as a concerted attempt to meet MDGs 4&5. Emphasis will be placed on system strengthening to reduce under-five mortality, on incorporation of child survival priorities in National Health Strategies and budgetization in National Budgets, SWAps, and MTEFs. Additional countries expressing an interest in ACSD will be included. Extensive efforts will be made to share ACSD experiences on a widespread scale, with the aim of expanding the ACSD approach through involvement of partners within participating countries, and also with a view to expanding the approach to other countries.

As UNICEF's direct strength lies in reinforcing community and outreach levels, in empowering communities, and in strengthening basic health services, the programmme will continue to focus on two essential strategies: a) sustaining planned, population-oriented outreach care, and b) reinforcing family and community-based care. Clinical care requires substantial investment and longer term human resource commitment by the MOH and other partners, along with a vast amount of equipment and restructuration, and is a further step along the line in the child survival and development strategy. However, UNICEF will advocate for improved national and local budgeting for clinical care services, and will continue IEC activities to increase use of, and demand for, clinical care. Involving and empowering communities as opposed to targeting them will be an important part of this strategy, aimed at magnifying the effect of interventions and increasing the accountability of clinical care providers.

7.1 Outreach: Increasing Population-oriented Activities

Three years of ACSD implementation have reinforced evidence of the type of interventions that impact strongly on child survival and improve the health and nutritional status of children and pregnant women, and have reconfirmed the value of using existing services and strategies to increase coverage of effective interventions. Classical activities such as immunization will continue to be accompanied by the innovative strategies that have been implemented during the first phase of ACSD in West Africa, with an ongoing focus on high levels of mortality reduction through cost-effective interventions. Extensive IEC and micro-planning involving community leaders and health workers in organizing outreach activities have increased demand for population-oriented approaches such as EPI and ANC. High EPI+ coverage will be maintained in participating ACSD countries using the same strategy, expanded to new districts within these countries and to additional countries. Emphasis will be placed on community involvement in monitoring and micro-planning exercises, active search of defaulters, and tracking defaulters and zero dose children. The strategy will be expanded to other districts and regions, integrated within the national EPI strategy.

An important aspect of the ongoing approach will be to reinforce routine outreach services to systematically plan and implement a child health package, with 100% coverage in all villages every six months, even in very remote areas. This package will be implemented during bi-annual **Child Health Days**, with interventions for children who have not benefited from routine EPI+, thereby ensuring that all children are reached and that high coverage rates are maintained. This will include Vitamin A supplementation, deworming, re-dipping ITNs, ferrous sulfate and folic acid supplementation, IPT, and distribution of anti-malarial blister packs for improved access to malarial drugs. Health workers will capitalize on each child contact to encourage integrated key strategies on child survival (ORS use, use of bednets, exclusive breastfeeding, etc.) and to increase ANC demand. Incorporation of ANC activities, including TT immunization, IPT and ferrous-sulfate supplementation in Child Health Days will be promoted. In the long term, reinforcement of routine EPI activities should strengthen outreach services and lead to ongoing sustained high national coverage.

Linking EPI and ANC with malaria control will continue to be an important approach. Malaria remains a major cause of child deaths and is complex to treat as it has both curative and preventive components.

Linking malaria control with EPI and ANC provides access to the main target group, namely pregnant women and young children, and as the same health staff members are generally involved at district and peripheral levels, training and supervision requirements are similar. The operational infrastructure of EPI programmes is already well developed in most countries and can therefore act as a vehicle for delivery of malaria interventions, increasing coverage of both malaria and EPI interventions. Outreach will also increasingly be used as a vehicle for other child rights-based activities, such as reinforced mobilization of communities and local leaders to link outreach activities to birth registration.

WHO and UNICEF have been working since 2001 on a protocol for operational research on IPT for infants (IPTi). Operational research indicates that providing three doses of IPTi, at the same time as routine EPI vaccinations, can reduce clinical malaria and anemia during the first year of life. While awaiting the results on the efficacy of IPTi in different malaria transmission settings, and the effects on sero-conversion to routine childhood immunizations, operational research on IPTi will be carried out in some ACSD countries during 2005-2006 to secure national acceptance of the strategy. IPT with fansidar for pregnant women will be expanded within ANC services.

7.2 Reinforcing community/household-based services and care practices

Increased emphasis will be placed on reaching the most vulnerable, using a rights-based approach to focus attention on tailoring services to the needs of the poor and enabling families and communities to adopt good health and nutrition practices and demand quality care. Progress has been made in reaching more children in vulnerable families, but the challenge still remaining is to apply the ACSD combination of innovative micro-planning and social mobilization activities to expand use of regular routine services to reach marginalized children, and to incorporate this strategy within National Health Policies.

Information, Education, and Communication (IEC) is a key component of the community strategy. The communication component of the programme is based on communication for behavioral change with respect to health and nutrition practices at community level. While interpersonal communication is one of the most effective approaches to communication, it requires substantial support in community organization and training in participatory communication skills if it is to be effective. The communication strategy, rather than concentrating on message dissemination to produce desired changes in a target audience, focuses on incorporating a human rights-based approach to programming, centered on community capacity development. This approach helps community members to engage in dialogue over health and nutrition problems within the community, and to choose solutions for themselves. Technical support is provided to facilitators at community level, including health workers and CHNWs with a strong emphasis on developing participatory communication skills to involve community members, particularly child carers, in debate and reflection on childcare priorities and practices. Community capacity has been enhanced through involvement in micro-planning, implementing activities and in tracing defaulters to ensure improved coverage of the most important interventions for every child. Health worker involvement is an essential part of this process, linking in with health centre services.

Integrated Communication Plan : Burkina Faso

An Integrated Communication Plan was developed in Burkina Faso, engaging the Ministry for Information, health agents and communities as communication relays for information diffusion and behavioral change. This has been linked with the ACSD strategy, aiming at influencing child-health friendly practices among parents and communities with respect to immunization and other child survival interventions. The strategic axes of the Communication Plan are advocacy, social mobilization and behavioral change communication, focused particularly on community leaders.

Major initiatives that will be continued and reinforced include:

- Increased focus on ORS (introduction of the new formula), exclusive breastfeeding and complementary feeding
- Community management of ARI and of Malaria
- RED (Reach Every District) approach with community involvement, emphasizing defaulter tracing
- Twice yearly re-dipping of ITNs
- Links between Traditional Birth Attendants and Midwives for improved access to safe deliveries and subsequent neonatal survival and development activities

A major focus will continue to be placed on early initiation of breastfeeding, exclusive and prolonged breastfeeding, and complementary feeding through effective counseling for pregnant and breastfeeding women and their partners, and community-wide IEC. Exclusive breastfeeding rates among 0-6 month olds are slowly on the rise in several countries, including Gambia, Mali, Ghana, Benin, Senegal, and Burkina Faso, but this crucial child survival strategy need consistent reinforcement. Advocacy will take place among participating countries to translate the UNICEF-WHO Global Strategy for infant and young child feeding into national strategies. Nigeria and Ghana have already begun this process and other countries including Senegal, Mali, Ivory Coast and Burkina Faso are preparing to revise existing national policies and strategies to align them with the Global Strategy.

A focus will be placed on implementing the strategies from the recently diffused WHO-UNICEF pamphlets on **community level management of diarrhea and ARI**, based on the operational research on using antibiotic blisters in Senegal. These focus on improved prevention and management of diarrhea and acute respiratory infections, with family-based recognition and home care of children suffering from these ailments, and timely care seeking and treatment compliance for ARI. With diarrhea still one of the top killers of children, the use of **zinc** in a 10-14 day treatment of childhood diarrhea has been proved to have a significant impact on reducing the duration and severity of diarrhea. Zinc treatment also acts as a preventative, reducing the risk of another bout of diarrhea for the next 2-3 months. The cost of treatment is about 20 cents. UNICEF has agreed with JHU, WHO, USAID and other partners to pursue the development of multiple suppliers of zinc products and is working on free or subsidized zinc in order to interest both suppliers and countries to adopt zinc treatment. Operational research on using zinc to treat diarrhea will be promoted in ACSD countries. Focusing mainly on reinforcing community capacity to prevent and manage illness, advocacy for new operational research on artemesin-based combination therapy (ACT) at community level is underway in participating countries that have changed their national policies for malaria management. Use of blister packs for community treatment of malaria and ARI, combined with ORT and zinc for diarrhea, will significantly reduce mortality due to these three pathologies.

ACRONYMS

ACSD	Accelerated Child Survival and Development
ACT	Artemisinin-based Combination Therapy
ANC+	Ante-Natal Care Plus
ARI	Acute Respiratory Illness
BASICS	Basic Support for Institutionalizing Child Survival
CDC	Centre for Disease Control
CHNW	Community Health and Nutrition Worker
c-IMCI	Community Integrated Management of Childhood Illness
DHS	Demographic and Health Survey
DPT3	Third dose of Diphteria-Pertussis Tetanus Immunization
EmOC	Emergency Obstetric Care
EPI+	Expanded Programme of Immunization Plus
HIP	High-Impact Package
IEC	Information, Education, and Communication
IECD	Integrated Early Childhood and Development
IMCI+	Integrated Management of Childhood Illness Plus
IPT	Intermittent Preventive Treatment against Malaria for pregnant women
IPTi	Intermittent Preventive Treatment against Malaria for infants
ITN	Insecticide-Treated Mosquito Net
LLITN	Long-Lasting Insecticide-Treated Mosquito Net
MBB	Marginal Budgeting for Bottlenecks
MDG	Millennium Development Goal
MICS	Multiple-Indicator Cluster Survey
MoH	Ministry of Health
MTEF	Medium-Term Expenditure Framework
NIDs	National Immunization Days
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PRSP	Poverty Reduction Strategic Plan
PSI	Population Services International
RBM	Roll Back Malaria
RED	Reach Every District
SWAp	Sector Wide Approach
TT2	Second dose of Tetanus Immunization
U5MR	Under-Five Mortality Rate
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WCARO	Western and Central African Regional Office
WHO	World Health Organization

ATTACHEMENTS

- **Key Effective Interventions in ACSD High Impact Countries/ Expansion Countries**
- **CIDA budget allocations to eleven ACSD implementing countries**
- **CIDA Funding expenditure per country 2001-2004**
- **Other Sources expenditure per country 2001-2004**
- **Total expenditure (CIDA and Other Sources) per country 2001-2004**

Key effective interventions ACSD HIGH IMPACT PACKAGE	GHANA				BENIN				MALI				SENEGAL			
	COVERAGE			U5MR REDUCTION	COVERAGE			U5MR REDUCTION	COVERAGE			U5MR REDUCTION	COVERAGE			U5MR REDUCTION
	Baseline	2004	Increase		Baseline	2004	Increase		Baseline	2004	Increase		Baseline	2004	Increase	
Vitamin A	82.2%	83.5%	0.0%	0.00%	10.4%	83.7%	34.7%	5.27%	33.9%	84.3%	46.3%	7.49%	58.8%	84.8%	25.4%	4.47%
Measles immunization	66.7%	88.0%	11.0%	0.53%	59.9%	61.8%	1.9%	0.08%	23.8%	68.1%	33.6%	0.82%	32.5%	78.0%	39.0%	1.06%
U5 sleeping under ITNs	3.1%	76.0%	71.8%	11.56%	3.4%	51.5%	44.6%	7.20%	6.4%	92.2%	78.1%	12.90%	1.1%	81.3%	74.1%	11.50%
Antenatal care 3	58.7%	44.6%	-13.1%	-0.12%	80.3%	79.7%	0.0%	0.00%	24.9%	59.0%	27.2%	0.23%	15.0%	41.5%	26.5%	0.23%
IPT	0.0%	18.8%	12.8%	0.15%	0.0%	63.5%	38.1%	0.46%	0.9%	67.0%	57.4%	0.67%	1.8%	56.1%	50.7%	0.62%
Tetanus immunization	53.0%	39.6%	-12.4%	-0.57%	43.8%	49.0%	0.0%	0.00%	22.2%	60.3%	17.9%	0.55%	43.6%	96.3%	34.1%	1.42%
FAF	4.9%	9.1%	0.0%	0.00%	31.5%	33.4%	0.0%	0.00%	5.4%	0.0%	0.0%	0.00%	4.9%	41.5%	33.5%	0.02%
Exclusive breastfeeding 6 mont	36.6%	32.9%	0.0%	0.00%	21.8%	12.0%	0.0%	-0.30%	39.5%	39.5%	0.0%	0.00%	10.4%	30.8%	20.2%	2.41%
Complementary feeding	49.5%	41.5%	0.0%	0.00%	60.8%	59.2%	0.0%	0.00%	27.3%	0.0%	0.0%	0.00%	50.0%	51.7%	0.0%	0.00%
ORT	52.2%	82.7%	9.8%	2.74%	26.3%	55.0%	20.6%	4.43%	11.4%	0.0%	0.0%	0.00%	11.8%	49.6%	36.0%	6.86%
Community management of Ma	19.4%	36.3%	16.9%	1.27%	50.5%	61.0%	0.0%	0.00%	25.9%	0.0%	18.8%	2.81%	34.3%	31.8%	-2.5%	-0.37%
ARI clinical care	54.2%	64.8%	0.0%	0.00%	42.2%	55.5%	0.0%	0.00%	17.9%	0.0%	0.0%	0.00%	33.1%	34.2%	0.0%	0.00%
Malaria Clinical care	53.3%	31.2%	0.0%	0.00%	39.0%	38.4%	0.0%	0.00%	19.0%	0.0%	-6.9%	-1.11%	42.6%	19.2%	-23.4%	-4.60%
Skilled delivery	28.0%	27.8%	0.0%	0.00%	91.7%	85.3%	0.0%	0.00%	16.2%	36.6%	0.0%	0.00%	15.8%	33.8%	0.0%	0.00%
Under five mortality reduction				**16.76%**				**15.82%**				**20.98%**				**24.67%**
Lives Saved				**7,016**				**3,377**				**14,478**				**2,995**

Key effective interventions ACSD EXPANSION PACKAGE	GHANA EXPANSION				MALI EXPANSION				BENIN EXPANSION				SENEGAL EXPANSION			
	COVERAGE			U5MR REDUCTION	COVERAGE			U5MR REDUCTION	COVERAGE			U5MR REDUCTION	COVERAGE			U5MR REDUCTION
	Baseline	2004	Increase		Baseline	2004	Increase		Baseline	2004	Increase		Baseline	2004	Increase	
Vitamin A	82.2%	75.3%	-6.9%	-0.92%	33.2%	58.2%	20.9%	3.08%	15.7%	92.4%	33.6%	4.47%	58.8%	83.6%	24.2%	3.56%
Measles immunization	52.0%	78.0%	12.4%	0.03%	43.3%	74.2%	22.6%	0.43%	77.1%	66.8%	0.0%	0.00%	51.8%	51.5%	0.0%	0.00%
U5 sleeping under ITNs	0.9%	15.5%	13.5%	2.64%	3.6%	41.1%	29.8%	4.63%	3.4%	41.0%	34.1%	6.51%	1.1%	55.0%	46.2%	7.17%
IPT	0.0%	0.0%	0.0%	0.00%	2.1%	43.0%	32.2%	0.36%	0.0%	0.0%	0.0%	0.00%	0.0%	0.0%	0.0%	0.00%
Tetanus immunization	54.0%	55.7%	0.0%	0.00%	15.8%	58.7%	22.7%	0.54%	48.9%	61.3%	9.5%	0.12%	43.6%	71.8%	9.6%	0.12%
ORT	29.0%	0.0%	9.7%	1.26%	13.1%	7.5%	0.0%	0.00%	63.4%	67.0%	0.0%	0.00%	11.8%	0.0%	39.3%	6.71%
				3.02%				**9.05%**				**11.09%**				**17.57%**
Lives Saved				**14,842**				**11,941.01**				**62,470**				**11,645**

Key effective interventions ACSD EXPANSION PACKAGE	CAMEROON				NIGER				GAMBIA				CHAD			
	COVERAGE			U5MR REDUCTION	COVERAGE			U5MR REDUCTION	COVERAGE			U5MR REDUCTION	COVERAGE			U5MR REDUCTION
	Baseline	2004	Increase		Baseline	2004	Increase		Baseline	2004	Increase		Baseline	2004	Increase	
Vitamin A	69.5%	0.0%	0.0%	0.00%	66.0%	89.3%	0.0%	0.00%	10.3%	0.0%	14.3%	1.26%	20.4%	95.0%	20.8%	2.09%
Measles immunization	62.3%	72.0%	0.0%	0.00%	28.0%	76.9%	29.0%	1.05%	90.1%	82.0%	0.0%	0.00%	20.3%	58.1%	37.8%	0.67%
U5 sleeping under ITNs	1.1%	0.0%	22.1%	4.87%	5.2%	63.0%	57.8%	7.61%	49.1%	87.5%	38.4%	7.73%	0.3%	34.6%	34.3%	7.15%
Tetanus immunization	42.0%	0.0%	0.0%	0.00%	41.1%	50.3%	0.0%	0.00%	94.1%	95.7%	0.0%	0.00%	0.0%	0.0%	0.0%	0.00%
				4.87%				**8.67%**				**8.99%**				**9.91%**
Lives Saved				**2,470**				**5,793**				**1,372**				**5,803**

Key effective interventions ACSD EXPANSION PACKAGE	BURKINA				CONAKRY				BISSAU			
	COVERAGE			U5MR REDUCTION	COVERAGE			U5MR REDUCTION	COVERAGE			U5MR REDUCTION
	Baseline	2004	Increase		Baseline	2004	Increase		Baseline	2004	Increase	
Vitamin A	78.5%	67.4%	0.0%	0.00%	63.0%	85.7%	22.7%	2.02%	50.0%	100.0%	20.0%	1.78%
Measles immunization	48.8%	90.7%	12.6%	0.22%	40.0%	94.7%	33.1%	0.47%	39.3%	95.0%	35.6%	0.50%
U5 sleeping under ITNs	12.4%	53.0%	40.6%	9.24%	6.0%	43.8%	37.8%	8.74%	7.4%	57.8%	50.4%	11.68%
Tetanus immunization	27.7%	100.0%	11.9%	0.27%	52.0%	87.0%	35.0%	0.92%	28.3%	0.0%	0.0%	0.00%
				9.73%				**12.15%**				**13.96%**
Lives Saved				**4,709**				**3,825**				**5,774**

CIDA budget allocations to eleven ACSD implementing countries

Canadian Government - Program Against Hunger, Malnutrition and Disease
Vitamin A Plus - Integrated Health and Nutrition Program (Phase III)
CIDA Project: M-010775

Total Contribution: **CAD** **3,000,000.00**
Funds Received:

		Date Rcvd	USD
CAD	**3,000,000.00**	**10-Apr-01**	**1,910,820.01**

Allocations and Implementation:

Recipient	PBA Ref.	CAD	USD	Expenditure	Unspent	Remarks
		CAD	USD	as of 31/Dec/2003	Balance	
Senegal	SC010404	639,750.00	407,482.37	323,406.87	84,075.50	
Ghana	SC010405	959,625.00	611,223.55	541,662.39	69,561.16	
Mali	SC010406	959,625.00	611,223.55	599,339.22	11,884.33	no expenditure in 2003; 2002 statement
PD	SI010411	441,000.00	280,890.54	264,549.47	16,341.07	no expenditure in 2003; 2002 statement
Total Allocations:		***3,000,000.00***	***1,910,820.01***	***1,728,957.95***	***181,862.06***	

Canadian Government - Program Against Hunger, Malnutrition and Disease
Vitamin A Plus - Integrated Health and Nutrition Program (Phase III)

	CAD	**3,000,000.00**	**16-Dec-03**	**2,290,080.00**
Total Received		**26,000,000.00**		**16,653,940.00**
Unpaid Balance	**CAD**	**0.00**		

Allocations and implementation as of 31 December 2004:

Recipient	PBA Ref.	Funds Allocated		Funds Received		Expenditure as of 31-Dec-04	Unspent Balance as of 31-Dec-04
		CAD	USD	CAD	USD	USD	USD
Mali	SC020341	5,050,399.00	3,149,942.36	5,050,399.00	3,149,942.36	2,731,573.29	418,369.07
Ghana	SC020342	5,050,399.00	3,149,942.36	5,050,399.00	3,149,942.36	3,100,248.24	49,694.12
Benin	SC020343	3,370,434.00	2,099,963.23	3,370,434.00	2,099,963.23	2,100,962.58	-999.35
Senegal	SC020344	3,370,434.00	2,099,963.23	3,370,434.00	2,099,963.23	1,920,739.66	179,223.57
Guinea	SC020633	834,734.00	524,989.25	834,734.00	524,989.25	522,503.85	2,485.40
Niger	SC020634	834,734.00	524,989.25	834,734.00	524,989.25	513,007.80	11,981.45
Chad	SC020635	834,734.00	524,989.25	834,734.00	524,989.25	523,450.48	1,538.77
Burkina Faso	SC020636	500,840.00	314,993.30	500,840.00	314,993.30	314,132.34	860.96
Guinea-Bissau	SC020637	500,840.00	314,993.30	500,840.00	314,993.30	297,512.56	17,480.74
Gambia	SC020638	500,840.00	314,993.30	500,840.00	314,993.30	301,888.54	13,104.76
Cameroon	SC020639	500,840.00	314,993.30	500,840.00	314,993.30	316,072.14	-1,078.84
WCARO	SI020512	841,034.00	524,990.75	841,034.00	524,990.75	561,754.94	-36,764.19
PD/HQ	SI020513	1,137,502.00	754,319.01	1,137,502.00	754,319.01	741,850.25	12,468.76
PD/HQ	SI020971	2,672,236.00	2,039,878.07	2,672,236.00	2,039,878.07	1,746,082.08	293,795.99
Total Allocations:		***26,000,000.00***	***16,653,939.96***	***26,000,000.00***	***16,653,939.96***	***15,691,778.75***	***962,161.21***

CIDA Funding expenditure per country 2001-2004

TOTAL POPULATION 2001 2004 *17096300*

CIDA FUNDING EXPENDITURES 2001	MALI	GHANA	SENEGAL	BENIN	BISSAU	BURKINA FASO	CAMEROON	CHAD	GAMBIA	GUINEA CONAKRY	NIGER	WCARO	HQ	TOTAL 11 COUNTRIES CIDA FUNDING 2001-4
Essential drugs, supplies and micronutrients	271,454	323,115											0	594,569
Essential equipment (transport, cold chain)	52,976	106,770											0	159,746
% commodities/equipment/transport	68%	99%											0%	68%
microplanning/monitoring/training/communication	153,641	4,026											28,587	186,254
performance contracts (wages/incentives etc.)	0	0											0	0
% "software"	32%	1%											14%	17%
% direct service delivery costs	100%	100%											14%	85%
Technical support: (UNICEF staff)	0	0											169,097	169,097
%Technical support: (UNICEF staff)	0%	0%											86%	15%
Other Technical support	0	0											0	0
% Other Technical support	0%	0%											0%	0%
Total additional costs for ACSD	**478,072**	**433,911**											**197,683**	**1,109,666**
Additional cost per capita per year	***0.07***	***0.14***												***0.06***

CIDA FUNDING EXPENDITURES 2002	MALI	GHANA	SENEGAL	BENIN	BISSAU	BURKINA FASO	CAMEROON	CHAD	GAMBIA	GUINEA CONAKRY	NIGER	WCARO	HQ	TOTAL 11 COUNTRIES CIDA FUNDING 2002
Essential drugs, supplies and micronutrients	969,852	708,624	211,198	427,111	203,040	0	33,240	196,812	142,948	175,704	0	0	0	3,068,529
Essential equipment (transport, cold chain)	1,056,604	70,334	324,560	361,717	19,178	0	40,675	5,557	68,902	24,641	62,501	0	0	2,034,667
% commodities/equipment/transport	97%	75%	75%	65%	97%	0%	88%	80%	97%	96%	99%	0%	0%	78%
microplanning/monitoring/training/communication	55,832	124,493	132,007	161,977	5,712	13,475	6,926	49,607	3,152	6,166	887	63,748	121,188	745,170
performance contracts (wages/incentives etc.)	1,552	0	0	0	0	0	0	0	0	0	0	0	0	1,552
% "software"	3%	12%	19%	13%	3%	31%	8%	20%	1%	3%	1%	65%	45%	11%
% direct service delivery costs	100%	86%	94%	78%	100%	31%	96%	100%	99%	99%	100%	65%	45%	90%
Technical support: (UNICEF staff)	0	141,396	42,443	38,562	0	0	0	0	0	1,748	0	2,759	145,886	372,793
%Technical support: (UNICEF staff)	0%	14%	6%	3%	0%	0%	0%	0%	0%	1%	0%	3%	54%	6%
Other Technical support	0	0	981	203,732	0	30,000	3,586	0	2,493	0	0	31,306	1,148	273,245
% Other Technical support	0%	0%	0%	17%	0%	69%	4%	0%	1%	0%	0%	32%	0%	4%
Total additional costs for ACSD	**2,083,840**	**1,044,847**	**711,189**	**1,217,368**	**227,930**	**43,475**	**84,427**	**251,976**	**217,496**	**208,258**	**63,388**	**97,813**	**268,221**	**6,520,227**
Additional cost per capita per year	***0.31***	***0.35***	***0.46***	***0.50***	***0.42***	***0.08***	***0.18***	***0.43***	***0.77***	***0.41***	***0.11***			***0.38***
	2,083,840	1044847	711,189	1193098	227929.6	43475	84426.69	251976	217496.1	208258.1	63388.16	97812.89	268221.5	6,495,957

CIDA FUNDING EXPENDITURES 2003	MALI	GHANA	SENEGAL	BENIN	BISSAU	BURKINA FASO	CAMEROON	CHAD	GAMBIA	GUINEA CONAKRY	NIGER	WCARO	HQ	TOTAL 11 COUNTRIES CIDA FUNDING 2003
Essential drugs, supplies and micronutrients	35,734	134,404	213,724	219,017	0	145,960	29,155	243	0	9,727	142,124	0	1,566,637	2,496,723
Essential equipment (transport, cold chain)	83,803	10,459	158,821	31,661	0	14,634	24,245	52,798	279	5,160	5,833	0	0	387,694
% commodities/equipment/transport	23%	25%	45%	39%	0%	63%	27%	32%	1%	7%	45%	0%	77%	46%
microplanning/monitoring/training/communication	407,835	184,805	217,644	180,166	16,452	87,230	77,572	77,298	39,273	185,077	160,336	284,928	133,690	2,052,307
performance contracts (wages/incentives etc.)	0	0	0	5,638	0	0	0	36,160	0	0	0	0	0	41,798
% "software"	77%	32%	26%	29%	30%	34%	39%	68%	93%	86%	49%	62%	7%	33%
% direct service delivery costs	100%	57%	71%	68%	30%	98%	65%	100%	94%	93%	93%	62%	84%	79%
Technical support: (UNICEF staff)	0	245,173	149,236	87,442	37,554	0	67,646	0	0	15,383	21,910	0	318,378	942,722
%Technical support: (UNICEF staff)	0%	43%	18%	14%	70%	0%	34%	0%	0%	7%	7%	0%	16%	15%
Other Technical support	0	884	90,315	116,272	0	5,081	1,810	0	2,557	0	0	177,101	10,964	404,984
% Other Technical support	0%	0%	11%	18%	0%	2%	1%	0%	6%	0%	0%	38%	1%	6%
Total additional costs for ACSD	**527,372**	**575,724**	**829,740**	**640,283**	**54,006**	**252,905**	**200,427**	**166,499**	**42,109**	**215,347**	**330,203**	**462,029**	**2,029,669**	**6,326,315**
Additional cost per capita per year	***0.08***	***0.19***	***0.54***	***0.26***	***0.10***	***0.45***	***0.44***	***0.28***	***0.15***	***0.43***	***0.57***			***0.37***

CIDA FUNDING EXPENDITURES 2004	MALI	GHANA	SENEGAL	BENIN	BISSAU	BURKINA FASO	CAMEROON	CHAD	GAMBIA	GUINEA CONAKRY	NIGER	WCARO	HQ	TOTAL 11 COUNTRIES CIDA FUNDING 2004
Essential drugs, supplies and micronutrients	1,024	663,387	249,737	62,218	0	0	0	0	28,314	29,385	0	0	20,495	1,054,560
Essential equipment (transport, cold chain)	126,726	62,372	0	1,699	0	0	-9,500	6,297	0	19,234	398	0	0	207,226
% commodities/equipment/transport	82%	53%	40%	44%	0%	0%	-29%	7%	84%	73%	0%	0%	8%	44%
microplanning/monitoring/training/communication	25,590	296,147	265,697	9,109	0	4,712	27,987	39,477	3,487	15,202	64,263	1,913	185,970	939,554
performance contracts (wages/incentives etc.)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
% "software"	16%	22%	43%	6%	0%	48%	86%	47%	10%	23%	56%	100%	74%	32%
% direct service delivery costs	99%	75%	83%	50%	0%	48%	57%	54%	94%	96%	57%	100%	83%	76%
Technical support (UNICEF staff)	0	335,095	67,873	68,357	20,000	5,035	13,808	38,673	1,911	2,472	49,742	0	34,538	637,504
%Technical support (UNICEF staff)	0%	25%	11%	47%	100%	52%	43%	46%	6%	4%	43%	0%	14%	22%
Other Technical support	1,959	9,175	34,032	4,798	0	0	113	0	0	0	0	0	9,041	59,118
% Other Technical support	1%	1%	6%	3%	0%	0%	0%	0%	0%	0%	0%	0%	4%	2%
Total additional costs for ACSD	**155,299**	**1,366,176**	**617,339**	**146,181**	**20,000**	**9,746**	**32,409**	**84,448**	**33,712**	**66,292**	**114,404**	**1,913**	**250,044**	**2,897,962**
Additional cost per capita per year	***0.02***	***0.02***	***0.40***	***0.06***	***0.04***	***0.02***	***0.07***	***0.14***	***0.12***	***0.13***	***0.20***			***0.17***

CIDA FUNDING EXPENDITURES 2001- 2004	MALI	GHANA	SENEGAL	BENIN	BISSAU	BURKINA FASO	CAMEROON	CHAD	GAMBIA	GUINEA CONAKRY	NIGER	WCARO	HQ	TOTAL 11 COUNTRIES CIDA FUNDING 2001-2004
Essential drugs, supplies and micronutrients	1,278,063	1,829,530	674,659	708,346	203,040	145,960	62,394	197,055	171,263	214,815	142,124	0	1,587,132	7,214,380
Essential equipment (transport, cold chain)	1,320,109	249,935	483,381	395,077	19,178	14,634	55,420	64,652	69,181	49,034	68,733	0	0	2,789,334
% commodities/equipment/transport	80%	61%	54%	55%	74%	52%	37%	51%	82%	54%	42%	0%	58%	59%
microplanning/monitoring/training/communication	642,899	609,471	615,348	351,253	22,164	105,417	112,485	178,372	45,913	206,445	225,486	350,588	471,873	3,937,713
performance contracts (wages/incentives etc.)	1,552	0	0	5,638	0	0	0	36,160	0	0	0	0	0	43,350
% "software"	20%	18%	29%	18%	7%	34%	35%	42%	16%	42%	44%	62%	17%	24%
% direct service delivery costs	100%	79%	82%	73%	81%	87%	73%	92%	98%	96%	86%	62%	75%	83%
Technical support: (UNICEF staff)	0	721,664	259,552	194,360	57,554	5,035	81,454	38,673	1,911	19,603	71,652	2,759	667,898	2,122,116
%Technical support: (UNICEF staff)	0%	21%	12%	10%	19%	2%	26%	8%	1%	4%	14%	0%	24%	13%
Other Technical support	1,959	10,059	125,328	324,801	0	35,081	5,509	0	5,050	0	0	208,408	21,153	737,347
% Other Technical support	0%	0%	6%	16%	0%	11%	2%	0%	2%	0%	0%	0%	1%	4%
Total additional costs for ACSD	**3,244,582**	**3,420,659**	**2,158,267**	**2,003,832**	**301,936**	**306,126**	**317,263**	**514,913**	**293,318**	**489,898**	**507,995**	**561,755**	**2,748,056**	**16,868,598**
Additional cost per capita per year	***0.12***	***0.29***	***0.47***	***0.28***	***0.18***	***0.18***	***0.69***	***0.87***	***0.35***	***0.32***	***0.29***			***0.99***

Other Sources expenditure per country 2001-2004

OTHER SOURCES EXPENDITURES 2001	MALI	GHANA	SENEGAL	BENIN	BISSAU	BURKINA FASO	CAMEROON	CHAD	GAMBIA	GUINEA CONAKRY	NIGER	WCARO	HQ	TOTAL 11 COUNTRIES OTHER SOURCES NEEDS 2005
Essential drugs, supplies and micronutrients	0	0												0
Essential equipment (transport, cold chain)	0	6,000												6,000
% *commodities/equipment/transport*	0%	54%												4%
microplanning/monitoring/training/communication	0	2,160												2,160
performance contracts (wages/incentives etc.)	0	0												0
% *"software"*	0%	19%												2%
% *direct service delivery costs*	0%	73%												6%
Technical support at district level: (UNICEF staff)	0	0												0
%Technical support at district level: (UNICEF staff)	0%	0%												0%
Other Technical support	0	2,958												2,958
% Other Technical support	0%	27%												2%
Total additional costs for ACSD	**128,000**	**11,118**												**139,118**
Additional cost per capita per year	***0.02***	***0.00***												***0.01***

OTHER SOURCES EXPENDITURES 2002	MALI	GHANA	SENEGAL	BENIN	BISSAU	BURKINA FASO	CAMEROON	CHAD	GAMBIA	GUINEA CONAKRY	NIGER	WCARO	HQ	TOTAL 11 COUNTRIES OTHER SOURCES NEEDS 2006
Essential drugs, supplies and micronutrients	0	0	108,689	0	51,220	0	33,240	0	0	45,613	734,121			972,882
Essential equipment (transport, cold chain)	0	119,194	84,815	0	45,105	0	40,675	2,540	0	0	5,720			298,050
% *commodities/equipment/transport*	0%	37%	59%	0%	76%	0%	88%	4%	0%	36%	100%			43%
microplanning/monitoring/training/communication	0	202,330	135,628	0	28,508	0	6,926	9,740	0	56,644	0			439,776
performance contracts (wages/incentives etc.)	0	0	0	0	0	0	0	0	0	0	0			0
% *"software"*	0%	63%	42%	0%	22%	0%	8%	15%	0%	45%	0%			15%
% *direct service delivery costs*	0%	100%	101%	0%	98%	0%	96%	19%	0%	80%	100%			57%
Technical support at district level: (UNICEF staff)	0	630	-2,663	49,970	0	0	0	30,500	0	25,000	0			103,437
%Technical support at district level: (UNICEF staff)	0%	0%	-1%	21%	0%	0%	0%	47%	0%	0%	0%			3%
Other Technical support	0	0	0	0	1,700	0	3,586	22,500	0	0	0			27,786
% Other Technical support	0%	0%	0%	0%	1%	0%	4%	34%	0%	0%	0%			1%
Total additional costs for ACSD	**958,000**	**322,155**	**326,468**	**234,864**	**127,048**	**0**	**84,427**	**65,280**	**3,142**	**127,257**	**739,841**			**2,988,482**
Additional cost per capita per year	***0.14***	***0.11***	***0.21***	***0.10***	***0.23***	***0.00***	***0.18***	***0.11***	***0.01***	***0.25***	***1.29***			***0.17***

OTHER SOURCES EXPENDITURES 2003	MALI	GHANA	SENEGAL	BENIN	BISSAU	BURKINA FASO	CAMEROON	CHAD	GAMBIA	GUINEA CONAKRY	NIGER	WCARO	HQ	TOTAL 11 COUNTRIES OTHER SOURCES NEEDS 2006
Essential drugs, supplies and micronutrients	0	0	38,662	0	105,509	424,458	29,155	0	0	45,541	340,490			983,815
Essential equipment (transport, cold chain)	0	0	6,800	0	35,077	56,760	24,245	0	0	0	3,618			126,500
% *commodities/equipment/transport*	0%	0%	37%	0%	68%	75%	27%	0%	#DIV/0!	38%	100%			25%
microplanning/monitoring/training/communication	0	43,167	76,631	0	54,333	97,306	77,572	0	0	49,935	0			398,943
performance contracts (wages/incentives etc.)	0	0	0	0	0	0	0	0	0	0	0			0
% *"software"*	0%	86%	63%	0%	26%	15%	39%	0%	#DIV/0!	41%	0%			9%
% *direct service delivery costs*	0%	86%	100%	0%	95%	91%	65%	0%	#DIV/0!	79%	100%			34%
Technical support at district level: (UNICEF staff)	0	6,775	0	62,948	0	0	67,646	30,000	0	25,000	0			192,368
%Technical support at district level: (UNICEF staff)	0%	14%	0%	27%	0%	0%	34%	60%	#DIV/0!	0%	0%			4%
Other Technical support	0	0	0	0	1,983	60,437	1,810	20,000	0	0	0			84,230
% Other Technical support	0%	0%	0%	0%	1%	9%	1%	40%	#DIV/0!	0%	0%			2%
Total additional costs for ACSD	**2,441,500**	**49,942**	**122,092**	**235,881**	**205,423**	**638,961**	**200,427**	**50,000**	**0**	**120,476**	**344,108**			**4,408,810**
Additional cost per capita per year	***0.36***	***0.02***	***0.08***	***0.10***	***0.38***	***1.15***	***0.44***	***0.08***	***0.00***	***0.24***	***0.60***			***0.26***

OTHER SOURCES EXPENDITURES 2004	MALI	GHANA	SENEGAL	BENIN	BISSAU	BURKINA FASO	CAMEROON	CHAD	GAMBIA	GUINEA CONAKRY	NIGER	WCARO	HQ	TOTAL 11 COUNTRIES OTHER SOURCES NEEDS 2006
Essential drugs, supplies and micronutrients	0	18,830	112,642	0	42,680	0	0	0	31,747	139,959	189,240			535,098
Essential equipment (transport, cold chain)	0	18,386	0	0	16,614	0	-9,500	0	23,154	12,000	60,000			120,654
% *commodities/equipment/transport*	0%	13%	23%	0%	67%	0%	-29%	0%	46%	68%	100%			18%
microplanning/monitoring/training/communication	0	257,878	384,608	0	29,023	58,677	27,987	0	52,829	45,769	0			856,772
performance contracts (wages/incentives etc.)	0	0	0	0	0	0	0	0	0	0	0			0
% *"software"*	0%	87%	77%	0%	33%	78%	86%	0%	44%	21%	0%			23%
% *direct service delivery costs*	0%	100%	100%	0%	100%	78%	57%	0%	90%	89%	100%			41%
Technical support at district level: (UNICEF staff)	0	0	0	104,616	0	0	13,808	17,096	0	25,000	0			160,521
%Technical support at district level: (UNICEF staff)	0%	0%	0%	15%	0%	0%	43%	100%	0%	0%	0%			4%
Other Technical support	0	0	0	0	0	16,348	113	0	12,406	0	0			28,867
% Other Technical support	0%	0%	0%	0%	0%	22%	0%	0%	10%	0%	0%			1%
Total additional costs for ACSD	**1,360,000**	**295,094**	**497,250**	**710,618**	**88,644**	**75,026**	**32,409**	**17,096**	**120,136**	**222,728**	**249,240**			**3,668,242**
Additional cost per capita per year	***0.20***	***0.10***	***0.32***	***0.29***	***0.16***	***0.13***	***0.07***	***0.03***	***0.43***	***0.44***	***0.43***			***0.21***

OTHER SOURCES TOTAL 2001 - 2004	MALI	GHANA	SENEGAL	BENIN	BISSAU	BURKINA FASO	CAMEROON	CHAD	GAMBIA	GUINEA CONAKRY	NIGER	WCARO	HQ	TOTAL 11 COUNTRIES OTHER SOURCES NEEDS 2005 - 2006
Essential drugs, supplies and micronutrients	0	18,830	259,993	0	199,409	424,458	62,394	0	31,747	231,113	1,263,851			2,491,795
Essential equipment (transport, cold chain)	0	143,580	91,615	0	96,796	56,760	55,420	2,540	23,154	12,000	69,338			551,204
% *commodities/equipment/transport*	0%	24%	37%	0%	70%	67%	37%	2%	45%	52%	100%			27%
microplanning/monitoring/training/communication	0	505,535	596,867	0	111,864	155,983	112,485	9,740	52,829	152,348	0			1,697,651
performance contracts (wages/incentives etc.)	0	0	0	0	0	0	0	0	0	0	0			0
% *"software"*	0%	75%	63%	0%	27%	22%	35%	7%	43%	32%	0%			15%
% *direct service delivery costs*	0%	98%	100%	0%	97%	89%	73%	9%	87%	84%	100%			42%
Technical support at district level: (UNICEF staff)	0	7,405	-2,663	217,534	0	0	81,454	77,596	0	75,000	0			456,326
%Technical support at district level: (UNICEF staff)	0%	1%	0%	18%	0%	0%	26%	59%	0%	0%	0%			4%
Other Technical support	0	2,958	0	0	3,683	76,785	5,509	42,500	12,406	0	0			143,841
% Other Technical support	0%	0%	0%	0%	1%	11%	2%	32%	10%	0%	0%			1%
Total additional costs for ACSD	**4,887,500**	**678,308**	**945,811**	**1,181,364**	**421,115**	**713,987**	**317,263**	**132,376**	**123,278**	**470,461**	**1,333,189**			**11,204,652**
Additional cost per capita per year	***0.18***	***0.06***	***0.21***	***0.16***	***0.26***	***0.43***	***0.69***	***0.22***	***0.15***	***0.31***	***0.77***			***0.66***

Total expenditure (CIDA and Other Sources) per country 2001-2004

GRAND TOTAL EXPENDITURES 2001 2004	MALI	GHANA	SENEGAL	BENIN	BISSAU	BURKINA FASO	CAMEROON	CHAD	GAMBIA	GUINEA CONAKRY	NIGER	WCARO	HQ	TOTAL 11 COUNTRIES GRAND TOTAL FUNDING NEEDS 2005-2006
Essential drugs, supplies and micronutrients	1,278,063	1,848,360	934,651	708,346	402,449	570,418	184,690	197,055	203,010	445,928	1,405,975			8,178,945
Essential equipment (transport, cold chain)	1,320,109	393,515	574,996	395,077	115,974	71,393	7,313	67,192	92,336	61,034	138,071			3,237,009
% commodities/equipment/transport	32%	55%	49%	35%	72%	63%	32%	41%	71%	53%	84%			46%
microplanning/monitoring/training/communication	642,899	1,115,006	1,212,214	351,253	134,028	261,400	226,391	188,112	98,742	358,793	225,486			4,814,324
performance contracts (wages/incentives etc.)	1,552	0	0	5,638	0	0	0	36,160	0	0	0			43,350
% "software"	8%	27%	39%	11%	19%	26%	37%	35%	24%	37%	12%			20%
% direct service delivery costs	40%	82%	88%	46%	90%	89%	69%	75%	95%	90%	96%			66%
Technical support at district level: (UNICEF staff)	0	729,069	256,889	411,894	57,554	5,035	189,500	116,270	1,911	94,603	71,652			1,934,376
%Technical support at district level: (UNICEF staff)	0%	18%	8%	13%	8%	0%	31%	18%	0%	0%	4%			8%
Other Technical support	1,959	13,017	125,328	324,801	3,683	111,866	0	42,500	17,456	0	0			640,610
% Other Technical support	0%	0%	4%	10%	1%	11%	0%	7%	4%	0%	0%			3%
Total additional costs for ACSD	**8,132,082**	**4,098,966**	**3,104,078**	**3,185,197**	**723,051**	**1,020,113**	**607,894**	**647,289**	**416,596**	**960,359**	**1,841,184**			**24,736,808**
Additional cost per capita per year	***0.30***	***0.34***	***0.68***	***0.44***	***0.44***	***0.61***	***0.44***	***1.09***	***0.49***	***0.64***	***1.07***			***1.45***