

AGENCY FOR INTERNATIONAL DEVELOPMENT  
**PROJECT REVIEW PAPER FACESHEET.**  
 TO BE COMPLETED BY ORIGINATING OFFICE

1. TRANSACTION CODE ("X" appropriate box)  
 Original     Change  
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PRP  
 712.  
 DOCUMENT CODE  
 2

2. COUNTRY/ENTITY  
 MALI

3. DOCUMENT REVISION NUMBER

4. PROJECT NUMBER  
 688-11-520-208

5. BUREAU  
 a. Symbol: APR    b. Code:

6. PROPOSED PP SUBMISSION DATE  
 mo. yr.  
 04 | 76

7. PROJECT TITLE - SHORT (stay within brackets)  
 Rural Health Services Development

8. ESTIMATED FY OF AUTHORIZATION/OBLIGATION  
 a. INITIAL FY: 78    b. FINAL FY: 80

9. ESTIMATED TOTAL COST (\$000 or equivalent, \$1 = )

a. FUNDING SOURCE	FIRST YEAR FY <u>IQ</u>			ALL YEARS		
	b. FX	c. L/C	d. Total	e. FX	f. L/C	g. Total
AID APPROPRIATED TOTAL	500		500	4,691		4,691
(Grant)	( 500 )	( )	( 500 )	( 4,691 )	( )	( 4,691 )
(Loan)	( )	( )	( )	( )	( )	( )
Other 1.						
U.S. 2.						
HOST GOVERNMENT		73	73		1,190	1,190
OTHER DONOR(S)						
<b>TOTALS</b>	<b>500</b>	<b>73</b>	<b>573</b>	<b>4,691</b>	<b>1,190</b>	<b>5,881</b>

10. ESTIMATED COSTS/AID APPROPRIATED FUNDS (\$000)

a. Approp-riation (Alpha Code)	b. Primary Purpose Code	c. Primary Tech. Code	FY <u>IQ</u>		FY <u>77</u>		FY <u>78</u>		ALL YEARS	
			d. Grant	e. Loan	f. Grant	g. Loan	h. Grant	i. Loan	j. Grant	k. Loan
P1		590	500		750		1,313		4,491	
	Title X		-		200		-		200	
<b>TOTALS</b>			<b>500</b>		<b>950</b>		<b>1,313</b>		<b>4,691</b>	

11. PROJECT PURPOSE(S) (stay within brackets)     Check if different from PID

To assist the GOM in developing a low-cost health delivery system to meet the needs of the rural poor who comprise over 90% of Mali's population.

12. WERE CHANGES MADE IN PID FACESHEET DATA, BLOCKS 12, 13, 14, or 15? IF YES, ATTACH CHANGED PID FACESHEET.

Yes     No

13. PLANNING RESOURCE REQUIREMENTS (staff/funds)

14. ORIGINATING OFFICE CLEARANCE

Signature: Ronald J. Devine

Title: Country Development Officer

Date Signed: mo. day yr. 13/16/76

15. Date Received in AID/W. or For AID/W Documents, Date of Distribution  
 mo. day yr.

C-1

AGENCY FOR INTERNATIONAL DEVELOPMENT  
**PROJECT IDENTIFICATION DOCUMENT FACESHEET**  
 TO BE COMPLETED BY ORIGINATING OFFICE

1. TRANSACTION CODE (NOT APPROPRIATE BOX)  
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PID  
 DOCUMENT CODE  
 1

2. COUNTRY/REGIONAL ENTITY/GRANTEE  
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3. DOCUMENT REVISION NUMBER

4. PROJECT NUMBER

5. BUREAU  
 A. SYMBOL AFR  
 B. CODE 1

6. PROPOSED NEXT DOCUMENT  
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7A. PROJECT TITLE - SHORT (STAY WITHIN BRACKETS)  
 [ ]

8. ESTIMATED FY OF AUTHORIZATION/OBLIGATION  
 A. INITIAL FY 77    B. FINAL FY 79

7B. PROJECT TITLE - LONG (STAY WITHIN BRACKETS)  
 [ PILOT RURAL MCH CLINIC/TRAINING CENTERS ]

9. ESTIMATED COST (LIFE OF PROJECT) (\$000 OR EQUIVALENT, \$1 = 400)

PROGRAM FINANCING		AMOUNT
A. AID APPROPRIATED		1,640
B. OTHER U.S.		
C. HOST GOVERNMENT		120
D. OTHER DONOR(S)		
TOTAL		1,640

10. ESTIMATED COSTS/AID APPROPRIATED FUNDS (\$000)

A. APPROPRIATION (ALPHA CODE)	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE	FIRST YEAR		ALL YEARS	
			D. GRANT	E. LOAN	F. GRANT	G. LOAN
PH			300		1520	
TOTAL			300		1520	

11. OTHER U.S. (\$000)

A. PROGRAM TYPE	B. FIRST YEAR	C. ALL YEARS
TOTAL		

12. PROJECT GOAL (STAY WITHIN BRACKETS)  
 [ To provide health services to the rural population of Mali. ]

13. PROJECT PURPOSE(S) (STAY WITHIN BRACKETS)  
 [ To develop 3 Pilot MCH Clinic/Training Centers which through use of polyvalent teams will deliver adequate modern rural health services including nutrition, family planning, environmental health and health education. ]

14. PLANNING RESOURCE REQUIREMENTS (STAFF/FUNDS)  
 ( See Attached Narrative )

15. ORIGINATING OFFICE CLEARANCE

SIGNATURE: Ronald D. Levin *Ronald D. Levin*

TITLE: COUNTRY DEVELOPMENT OFFICER

DATE SIGNED: NO. DAY YR.

16. DATE RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

NO. DAY YR.

PROJECT REVIEW PAPER  
MALI  
RURAL HEALTH SERVICES DEVELOPMENT

DESIGN TEAM:

Dr. Stephan Joseph, Harvard University

David Cole, Harvard University

Dr. Hannelor Vanderschmidt, Harvard Health  
Manpower Development Center

Murray Mould, AFR/DS

STAFF :

Country Development Officer, Ronald B. Levin

CDO Project Officer, Byron Golden

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and Village Health Workers
- B. Training of Health Personnel in the U.S.

MALI RURAL HEALTH SERVICES DEVELOPMENT - PRP

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SECTION I: PRIORITY AND RELEVANCE

The objective of this project is to assist the GOM in the design, realization, and evaluation of a pilot rural health system which will have the following characteristics.

a. Effective distribution of basic health services (emphasizing health promotive and disease preventive activities) at the most peripheral level of social organization, i.e. the village; with progressive levels of organization up through sub-district, district, regional and national levels. (Fig. 1, p. 4)

b. Integration with other sectors of rural community development activity (especially agricultural production and basic education).

c. Demonstration that such a functioning pattern of health services can be operated at an annual per capita cost of \$3 (of which \$1 will be retrieved by the GOM from revenue derived from the sale of medicines).

This magnitude of government expenditure (\$2 per person per year) will make possible the wider national replication of the system, so as to reach the 90% of the population of Mali that lives outside the few major urban clusters (current Malian annual per capita health expenditures are \$1.70).

This project perspective is congruent with the highest priority emphasis in the health strategy of the GOM as expressed in the 5-Year-Health Plan for 1974-78 ("Commission Nationale des Ressources Humaines - Rapport du Groupe Santé - Affaires Sociales").

This priority was reiterated to the PRP team in detail by national and regional officials in Health and Development Ministry Services. Despite this, health services in Mali are currently bogged down by

- a. categorical fragmentation,
- b. lack of appropriate resources (fiscal, material, and manpower), and
- c. inability to reach beyond the sub-district level to the rural villages where the vast bulk of the population lives. (Fig. 2, p. 5)

The current project design, which has the endorsement of Malian officials, is aimed at

- a) integrating the diverse and fragmented elements of a health assistance strategy described in the D.A.P. and previous PID's and PRP's into a coherent rural health services strategy and
- b) demonstrating to the GOM that such a strategy can reach dispersed rural populations and improve health conditions in the villages at an operating cost allowing wide replication throughout the nation.

The components of this AID project, which will be described in detail in the following sections of this report, include:

1. Technical assistance in the development, realization, and evaluation of community health services in pilot areas in diverse regions of Mali.
2. Supply of equipment, drugs, and material for use in the demonstration areas and elsewhere, at an annual per capita cost within the constraints of the proposed model.
3. Technical assistance in training of key personnel for effective rural health services delivery. This will include, in the local pilot areas, the village health worker and the various levels of supervisory health professionals at arrondissement, cercle, and regional levels. At the national level, training/technical assistance will be focused upon improvement of administrative, supply

and logistic capabilities. As the project proceeds, the experience and preliminary results from the pilot areas will be fed into national health planning and health manpower training activities as a stimulus and aid to wider replication of the rural health services model.

The successful demonstration of the proposed model, at an operational cost within the reach of the GOM, could have beneficial repercussions in other developing countries facing similar health resource constraints.

FIG. 1 - MALI - SCHEMA OF GEOGRAPHIC ADMINISTRATIVE ORGANIZATION

(All Figures rough approximations)

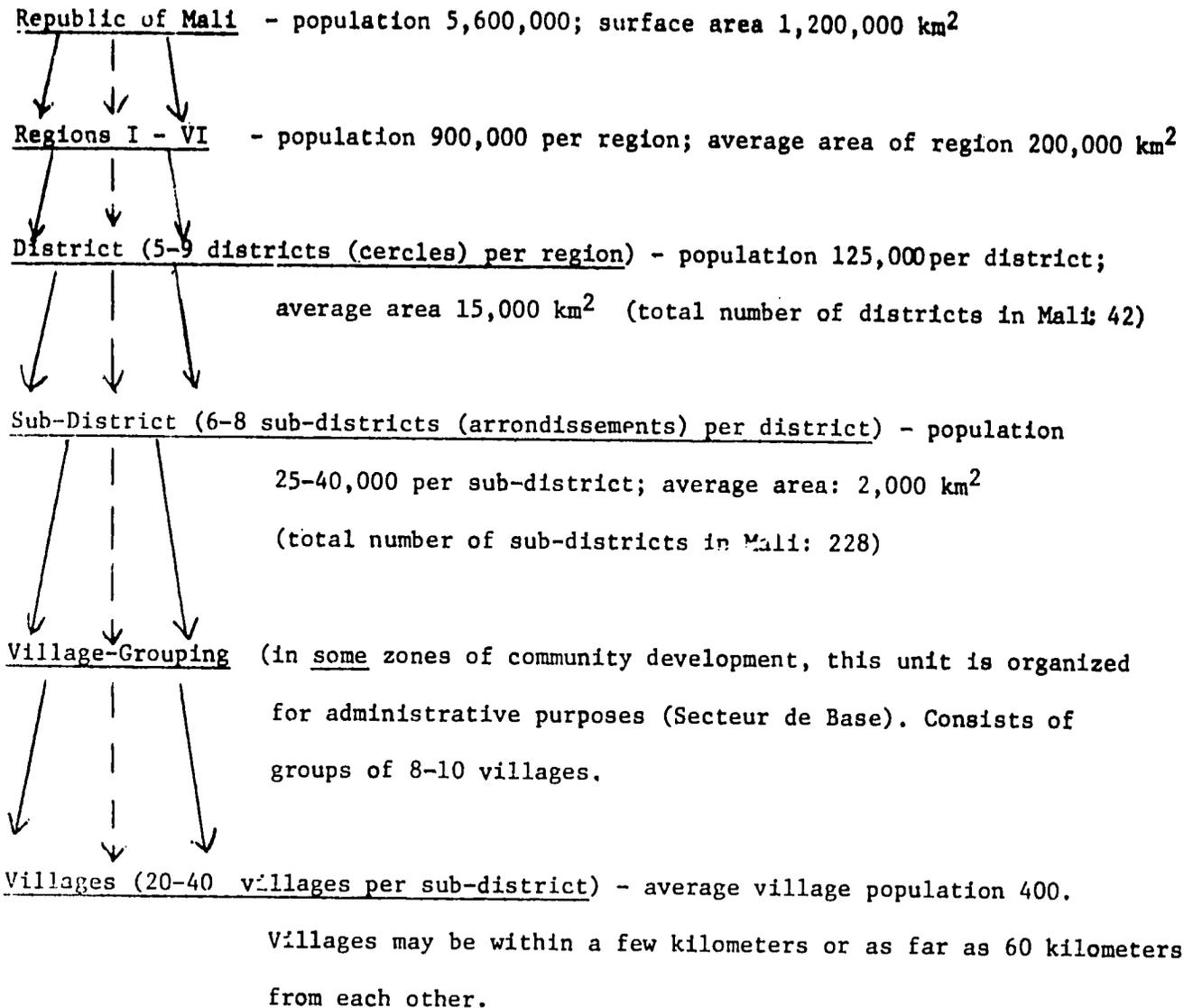


FIG. 2 - GEOGRAPHIC SCHEMA OF EXISTING RURAL HEALTH SERVICES 1)

- Regional Level - Hospital of 150-200 beds, with maternity and Maternal and Child Health Clinics (PMI's). One to 3 physicians; nurses at various levels of qualification. Center of Grand Epidemic Service (SGE) activities.
- District Level - Dispensary with 8-10 beds plus maternity with 6-10 "hospital" beds. PMI may or may not be functioning. Possibly one physician - usually not. Person in charge is usually "Infirmier d'Etat" (Registered Nurse-level), assisted by approximately 3-5 "Infirmières auxilliaires (Practical Nurses) or occasionally by a full "Infirmière d'Etat" and 1 midwife. Grand Epidemic Service may reach this level once or more yearly.
- Sub-District Level - Dispensary staffed by single "Infirmière Auxilliaire". In some regions (notably III and II), rural maternities staffed by "matrone rurale"(midwife/medical practitioner - basic literacy plus 6-12 months training). Grand Epidemic Service usually does not reach yearly.
- Village Level - No effective sustained contact with government health system. Infirmière Auxilliaire or midwife or matrone may visit occasionally, especially for obstetric emergency. Grand Epidemic Service seldom reaches.

1) Severe transport and communications gaps exist between all vertical levels of health administration.

SECTION II: PROJECT DESCRIPTION

In order to achieve the project objectives stated in the preceding section, the following project components will be undertaken (a Time-Table for project action will be found below, under Section VIII "Implementation Plan and Project Development Schedule", budgetary considerations are discussed in Section VII, Financial Plan).

An overview of project activities includes:

- (I) the selection of appropriate pilot zones,
- (II) the selection and training of public health workers at various levels within the zones,
- (III) the process of community diagnosis (baseline and continuing health survey in pilot and "control" areas),
- (IV) the implementation of health promotive, disease preventive, and simple diagnostic/curative health services in the pilot areas,
- (V) the provision of medicines and equipment necessary for the functioning of the low-cost rural health system, and
- (VI) progressive spread and replication of these activities to a wider national context.

(I) Selection of Appropriate Pilot Zones:

The PRP team visited three rural zones in Mali; after discussions with USAID and GOM officials, it was recommended that activities be carried out in Regions V and III (year 01), then Region II (year 02), and possibly in Region VI or I (year 03). Considerations involving regional and area choice are presented below:

- Region 2 (Bamako): In northern half, where AID Mali Livestock Project is to be implemented.
- Region 3 (Sikasso): In the Sikasso or other district, where the Health Service has been trying to build a village health program based on the training and supervising of rural midwives and village health workers.
- Region 5 (Mopti): In the Koro, Bankass, Douentza or Bandiagara districts, where "Opération Mils" is already functioning, and its Director and his assistants have expressed a strong willingness to cooperate, in conjunction with the regional health services, in implementing a system for extending health services to the village level.
- In the Mopti and possibly other districts, in conjunction with "Opération Pêche" (Fishing) which has already organized a limited health service in coordination with their community development activities with limited funding being provided by FED (European Development Fund).
- Region 6 (Gao): Where AID will be supporting a rice and sorghum project in an area of extremely scarce food production and major nutritionally related health problems.
- Region 1 (Kayes): In support of possible an OMVS or bilaterally supported agriculture production project.

The main characteristics of the different zones which make them attractive as trial areas are:

In Nara and Gao in the Sahel zones, livestock raising is the main activity and the population is semi-nomadic.

The eastern part of Region 5 is an arid zone with a predominantly Dogon population and evidence of potentially serious overpopulation. Current efforts to increase water supplies and raise agricultural productivity provide an opportunity to achieve a demographic transition from high to low birth and death rates. Thus it would be a good region for testing health services-related approaches to reduced fertility in a rural setting.

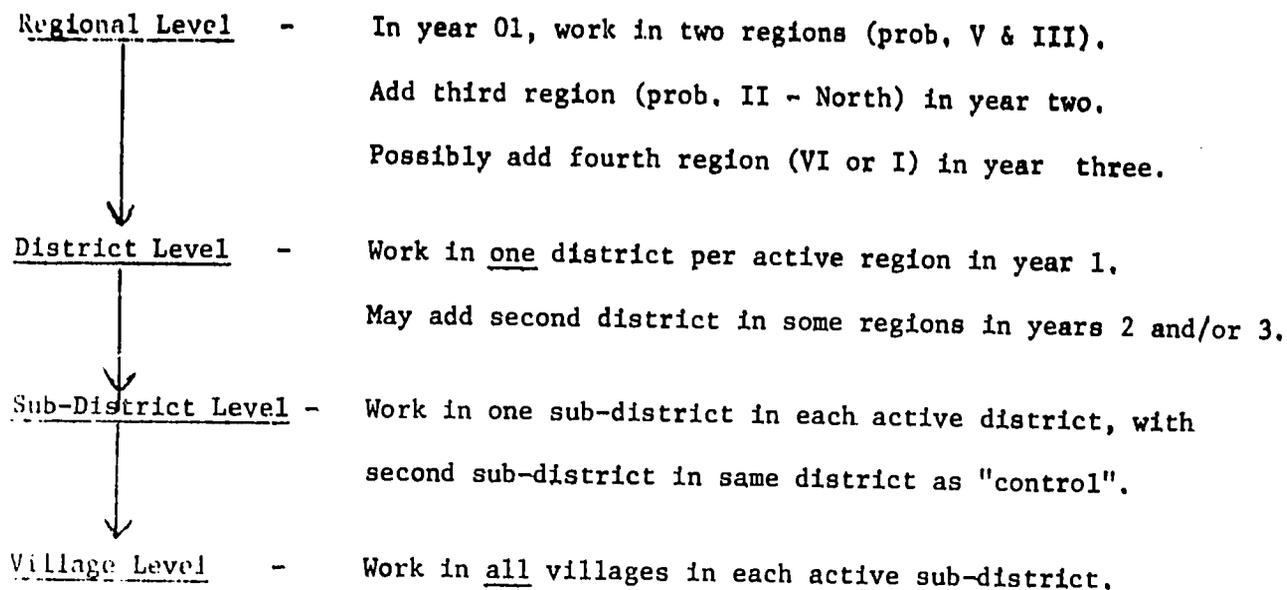
"Opération Pêche", based in Mopti, is focused on a river-oriented population that lives predominantly on boats and along the banks of the inland delta. There is a high incidence of malaria and other parasitic and infectious diseases. This "Opération" on the river offers a means for rapid information dissemination (or "demonstration/spread effects") given the mobile nature of the population.

Region 3 has somewhat more water and more favorable agricultural production conditions, yet onchocerciasis (river blindness) has contributed to low population density and limited productivity. In addition, there is concern among health authorities in the region that trypanosomiasis (sleeping sickness) is resurgent in the area.

In Region 3 the main emphasis of the health project would be to assist the existing regional health service extend its programs beyond the village-grouping level down to the village level. In all the other regions, the health project

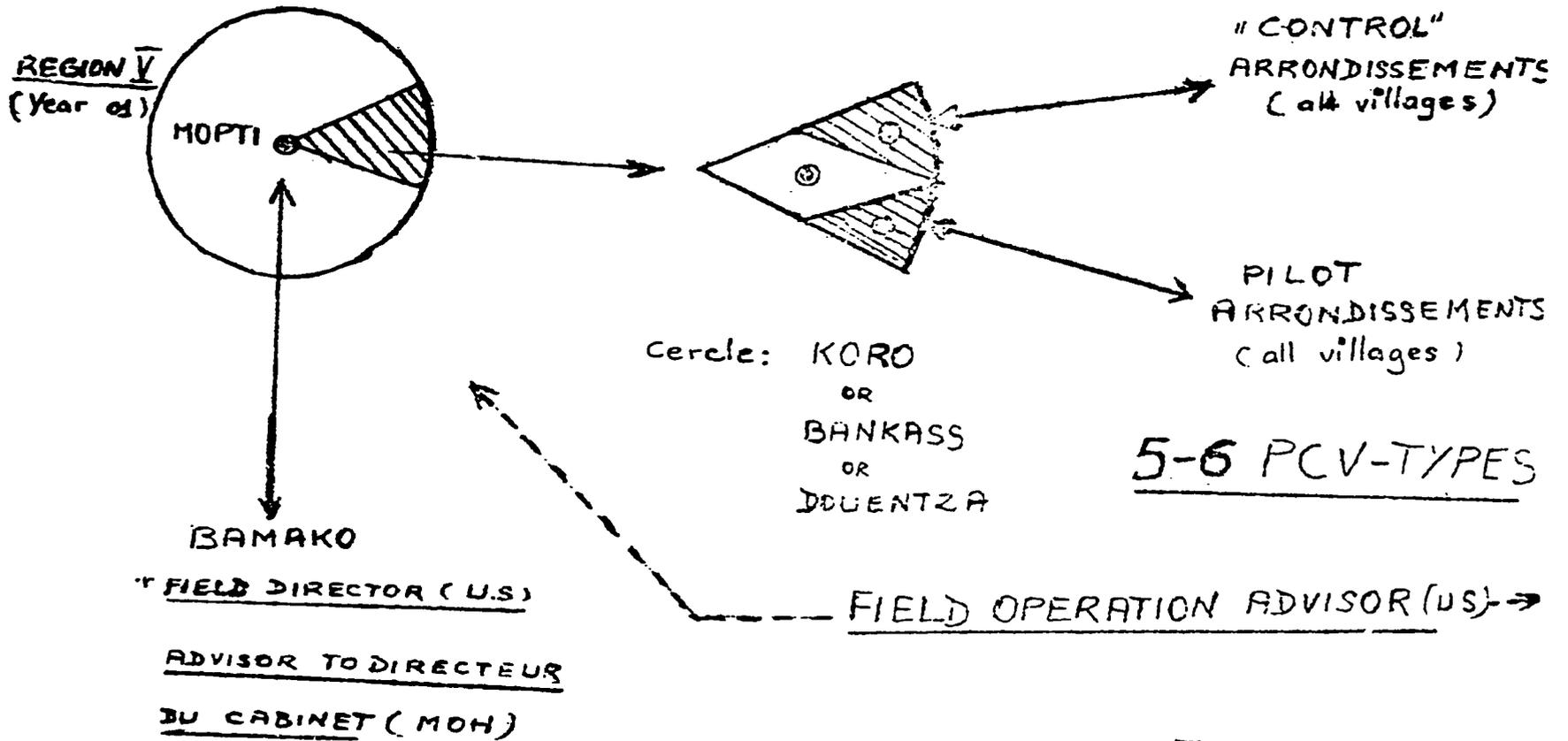
would be working with the community development and production "Opérations" and the existing health services to expand and extend their services to the village level. Within each region, the PRP team agrees with GOM officials that a single sub-district within one district be designated as the first test zone, and that a similar sub-district serve as a "control" zone. Definitive selection of these areas will be made as a first step in project implementation. (Figs. 3 and 4, pp. 10 and 11).

FIG. 3 - GEOGRAPHIC SCHEMA OF PROPOSED PILOT RURAL HEALTH SYSTEM



REGIONAL PUBLIC HEALTH  
ADVISOR (U.S.) TO DIRECTOR  
OF RURAL DEVELOPMENT  
AND REGIONAL HEALTH DIRECTOR

# SCHEMA FOR RURAL HEALTH DELIVERY SYSTEM



SIMILAR SCHEME FOR

- REGION III (late year 01)
- REGION II NORD (year 02)
- REGION VI or I (year 03)

(II) Selecting and Training of Health Workers for the Rural Health System

The successful implementation of this project depends upon the identification, appropriate training, and support of Malian health workers at various levels. Those proposed in this project include the village level worker (Animatrice de Santé de Village) - 1 or more per active village<sup>1</sup>); the sub-district level public health worker (Agent de Santé Rurale) - 3 per active sub-district, so as to allow for 2 "permanent" workers and one trainer to move on to the development of the next sub-district; the district level public health worker (Agent de Santé de Cercle) - 1 per active district; the regional level public health supervisor (Adjoint de Santé Publique Régionale) - 1 per active region.

The numbers of these workers per active test area, and their US Technical Assistance counterparts, are presented in Fig. 5, page 14). In addition, there will be a Bamako-based U.S. technician, Field Director of the USAID project, serving as a high level advisor in the Ministry of Health for overall project coordination and administration, and central assistance in improving management, administration, planning, and logistic capabilities related to the project zones and, later, on a broader national level.

The training of health workers at the various levels will be based on an analysis of the functions to be performed at each level, matched with a knowledge of the specific local conditions arising from the community diagnosis process described below under (III). A major innovation of project activities will entail the training of regional, district, and sub-district personnel to be

<sup>1</sup>) Since the village health worker may be the sole source of medicines for general distribution (both "free" and "for purchase") to villagers, the village may well select the village health worker and periodically review job performance. It may be that the traditional medical practitioner at the village level will often become the "village health worker", thereby combining traditional and innovative approaches to curative and preventive health practices.

trainers and supervisors of the village-level workers (many of whom will be illiterate or semi-literate).

See Annex A for a description of some of the major tasks and functions of Malian health workers at the various levels of the proposed system. Further specificity and choice of tasks for training will be carried out in the earliest phase of project implementation.

FIG. 5 - PERSONNEL STRUCTURE FOR PROPOSED  
PILOT RURAL HEALTH ZONES

LEVEL	Existing Malian Health Workers	"New" Malian Public Health Workers	U.S. Technicians During Pilot Phase	Total Public Health "New" Personnel (Malian/US) All Regions
National	-	0	1	0/1
Regional (in 4 Regions)	see Fig. 2	1 Regional Pub. Health supervisor/region	1 Regional Pub. Health Advisor/region	4/2
District (1 per active region)	1 Inf. d'Etat several Inf. Aux. 1 midwife	1 Agent de Santé Publique de Cercle/district	1 Field Operations Advisor/District	4/4
Sub-District (1 per active district)	1 Inf. Auxilliaire 1 matrone rurale	2 Agents de Santé Rurale/ test zone 1 Agent/"control" zone	Possible PCVs or similar workers to extend reach of T.A. personnel, 2-3/sub-district	15 <sup>(1)</sup> / 9-12 PCV's
Village (20-40/ active sub-district)	No Govt. health workers at present	1 or more (volunteer) animatrice de santé/ active village	0	250 <sup>(1)</sup> /0

(1) may increase, depending on number of "active" sub-districts.

(III) Community Diagnosis

In each of the test areas, a baseline community diagnosis will be carried out by sub-district, district, and regional public health personnel and advisors, with the assistance of village level workers as they are trained. The major elements of this diagnosis are outlined under functions a) 1-9 of the village level worker in the Annex A. Asterisked items in this list refer to diagnostic elements to be assessed in the "control" areas as well as in the pilot areas. Continuous assessment of these parameters will provide a comparative view of project progress and health status improvement in pilot and "control" areas. In addition, specific local health information and health-related cultural patterns provided by the community diagnosis process will be fed into the training and re-cycling (continuing education) of pilot area personnel, and eventually will shape preventive and diagnostic/curative services in these areas and on a wider national scale.

(IV) Provision of Health Promotive, Disease Preventive, and Simple Diagnostic/Curative Health Services in the Pilot Areas

The backbone of these services rests on the skills of the village level health worker. An initial estimate of services that can be provided by villagers trained locally in the sub-district (for perhaps 1 month, with continuing education at the village level) is outlined in the preceding discussions under a), b), and c). In addition, public health personnel at higher local levels will back-up and support this service structure. The U.S. Technical Assistance personnel will assist in the organization and training process for these service functions.

(V) Logistic Support - Medicine and Equipment

To provide the basic necessities for the functioning of this system, AID will supply a stock of simple medicines, transport, and equipment. GOM contributions will add to this stock (from own resources and other donor contributions) and local contributions are available in the form of labor and local materials for rural maternity construction as needed. To avoid the technical and political problems (expressed concerns of GOM/MOH) of great disequilibrium between pilot areas and the rest of the district, this material support will be spread over the entire district in which the pilot area is found. (Mobilette transport will be provided only in pilot and, to a lesser extent, in "control" areas). The medicines to be supplied in the pilot area are estimated at \$2 or 880 MF per capita, approximately half of which will be distributed free and the other half sold.\* Prior to the authorization of this project, it is necessary for the MOH to develop implementation plans with the assistance of the CDO for: (1) the organization of a staff responsible for distribution of the equipment, supplies and medicines; (2) the development of a system of controls and locations for the medicines which would be sold and distributed free; and (3) the definition of a system of GOM financing of supplies and equipment which they will supply. For the rest of the cercle a supply of medicines equal to the current national average of \$.40 or 176 MF will be assured from AID supplies. Also as part of the early survey of each district, an assessment will be made of the existing facilities (normally several dispensaries and maternities for each district), and minimum basic equipment should be supplied either through GOM financing - for locally available items - or through AID financing for imported items. The cost of equipping these facilities is difficult to estimate prior to the selection of the district and the actual field survey, but it is unlikely to exceed \$10,000 per district for the 4-5 districts of active operations, or \$50,000 in all.

\* Non-recoverable cost for operation of pilot system will be approximately \$ 1 for medicines and \$1 for personnel, equipment, and logistic support.

(VI) Extension and Replication of Pilot Zone Activities to a Wider National Context

Information and experience arising out of the logistic, system organization and health worker training activities of the pilot zones (compared with "control" areas) will be fed into the national MOH structure on a progressive, continuing basis as part of annual project evaluation and more frequent formal reports to the MOH. Also, early experience in the initial test areas will modify activities in successively developed pilot areas.

The Bamako-based Field Director will provide the key channel for integrating this information into the planning, administrative, and training functions of the MOH.

By the latter stages of the project, sufficient experience and data should have been amassed to provide the GOM with convincing and usable information with which to extend the rural public health system to a broad national basis. It is here that the low-cost, low-technology dependent, auxiliary personnel features of the proposed program become critical; providing a feasible implementation of the system at an expenditure level that the GOM can undertake.

MOH officials have already expressed an interest in utilizing the pilot zones (as they develop) for a field-training base for their national health manpower training institutions.

In addition to the practical demonstration aspects described above, the pilot and "control" zones will play an important role in more formal evaluation concerning the effectiveness, efficiency, and development stimulating potential of such a village based rural health system. A preliminary description of this evaluation scheme follows:

The Evaluation Process

Because one of the basic objectives of this project is to demonstrate the effectiveness of an alternative approach to improving health conditions in rural

areas, it is essential to gather accurate information on the initial and evolving health status of the concerned population, on the project inputs and other factors affecting that status, and also to obtain similar information on nearby "control" groups for comparative analysis.

The first stage of involvement in one of the pilot zones should be to collect accurate demographic information on the inhabitants of all the villages in two sub-districts. On the basis of this information, one sub-district would be chosen for inclusion in the test zone and the other used as a "control". The initial survey would be carried out by the arrondissement (sub-district) health worker under the supervision by the district public health agent and expatriate technicians. From the contacts made during the survey, the potential village health workers could be identified.

Once the village health program gets underway, the village health workers will keep records of all births, deaths and migrations of persons within their village. They will also keep regular weight and arm circumference charts on all infants and young children, and will record vaccinations and other significant actions affecting the infant's health. The health workers will also record information on apparent causes of disease and death. Whether additional information can be collected by the village health workers, and how it can be done effectively, will have to be tested during the initial stage of project implementation.

The medicines supplied to the village health worker will be recorded and an attempt made to record treatment of persons from the pilot area villages in the nearby dispensaries and maternities. Again, how much can be done with a largely illiterate populace will have to be tested, and methods developed for

making record-keeping very simple. Particular attention should be given to recording information concerning measures to control fertility.

The control villages should be surveyed on an annual basis to obtain information on births, deaths, and migrations, and also to assess whether there have been any significant changes in health status or practices. The records of the local curative health services will be reviewed periodically to see if there is any change in the utilization of such facilities by persons from active, control and other villages. Also the flow of medicines through the curative facilities and other distribution channels will be monitored. Because one aspect of the project is to assess the effective demand for various types of medicines, some experiments will be conducted with varying prices on different medicines and recording the changes in quantities sold, with due attention being given to the ease of access to alternative sources of medicine.

Finally, some records will be kept on the production, availability and prices of the main agricultural crops and on the available water supply, as these factors are likely to have a significant effect on health conditions.

The objective of all this data gathering is obviously to ~~try~~ to obtain statistically respectable estimates of the effects of various factors, especially the projected health interventions, on the health status of the target populations. A first major evaluation of the initial 50 villages will have to be made only two years after the new health interventions have been introduced. This may well be too early to discern any significant impact on birth or death rates, but it still may give some indication of the effectiveness of alternative measures. If the project is continued, further evaluations could be made after five or even ten years to assess the longer-run impact of changing health services and economic conditions on health status. Personnel of the Ministry of Health will be trained

to carry out these evaluations by participating in the early evaluation efforts and through training outside of Mali if this seems appropriate.

Another dimension of evaluation will be in terms of the relative effectiveness of organizing the village health activities through the production operations - such as Opération Mils or Pêche in Region V, and Mali Livestock in Region II, or through the regular health services in Region III. Other factors to be addressed include:

- a. whether traditional healers, midwives or newly recruited women or men are more or less effective as village health workers;
- b. what approaches to training and supervision are most effective;
- c. whether compensation of village health workers must come from outside or can be handled adequately within the village context;
- d. how different cultural and tribal groups respond to various health interventions, including those relating to fertility;
- e. how health interventions should be modified to best serve nomadic, semi-nomadic, river dwelling and/or sedentary farming populations.

SECTION III: AID AND OTHER RELEVANT EXPERIENCE

The development of a peripherally based rural health system resting upon the skills of appropriately trained and supervised village level health workers is the most pressing contemporary issue in health services in developing countries. In addition, the inter-relationships between health, nutrition, population dynamics, and economic development goes to the heart of the question: "Can an acceptable quality of life be achieved and sustained in the LDC's?" The proposed project design in Mali, one of the poorest of the LDC's, aims directly at these questions, as discussed in the preceding two sections.

Relevant recent AID experience and forthcoming projects that bear on these issues include:

1. The DEIDS projects
2. Strengthening Health Delivery Systems in Africa
3. Sahel R&R (ref. nutrition and local context)
4. Danfa project/Ghana
5. Other population and health projects

Further, the recent WHO emphasis on development and support of basic health services and the training of village level auxiliaries (see "Health by the People" ed. by K. Newell and also policy statements by Dr. G. Mahler, D.6/WHO) provide a clear thrust in this direction.

In Africa, the policies of the WHO regional office strongly support this approach (see policy statements by Dr. A. Quenum, REG. Dir. for Africa/WHO).

Additional (but by no means exhaustive) important activities/writings that bear on these questions include the innovative health system in China and Tanzania, the WHO-supported rural MCH activities in Indonesia (see Maurice King et al), the work of Carrol Berhorsy in Guatemala, the work of David Morley in West Africa (see "Pediatric Priorities in the Developing World"), the Narangwal and Knanna studies in India (AID-supported), the rural and urban "Promotores" projects in Colombia (see Aguierre et al, Echeverri et al), and many others.

In the opinion of the Project Design team, the current situation in Mali (with its extreme resource and geographic constraints, its health and nutritional problem, its philosophy of integrated rural development, its stated acceptability of family planning as a nationwide health measure) offers an ideal setting in which to synthesize past experience in an innovative manner, and to assist in putting in place a functioning rural health system at a cost level that can be replicated and sustained by LDC governments.

As stated previously, the successful demonstration and replication of this system could have profound beneficial influence, not only in Mali and other Sahelian countries, but in many resource constrained LDC's. It would provide the strongest evidence of the reversal of existing traditional health systems in many LDC's, which are oriented towards centralized, high-cost, high technology curative health services that effectively reach only a tiny fraction of the population.

In addition to the evaluation parameters discussed in the previous section,

and as important assessments of the feasibility and impact of the proposed rural health system, the following social indicators will be assessed as part of this project:

Social Indicators:

In addition to the demographic and health status, economic status, and other direct output measurements of this rural health project, the following social indicators will be assessed:

1. The role of village based health services as an integral part of local and regional community development, and
2. the interactions between health, nutrition, family planning, and improved agricultural production as a stimulus to the demographic transition (from high birth and high death rates to low birth and low death rates).

Included in these social indicators will be the following qualitative and quantitative assessments;

I Qualitative	II Quantitative
1. Integration of various levels of health workers (village, sub-district, district, region) into broader community development programs.	1. Numbers of workers trained and operating; task and performance analyses.
2. Recruitment of village level workers and effective liaison with traditional (i.e. non-western) health systems	2. " "
3. Utilization of literate and semi-literate women in the village based health services	3. " "
	../...

../...

- |   |  |
|---|--|
| 4. Improved health and nutritional status at the village level, esp. of infants, children and child-bearing women | 4. Health (mortality and morbidity) and nutritional indices. Fertility rates and birth intervals.                  |
| 5. Increased agricultural productivity of working age males and females   | 5. " " and agricultural production   |
| 6. Replication of pilot system in other zones of country  | 6. Numbers and distribution of persons served by the system  |
|   | 6.a. Costs of operating wider system: efficiency of cost-recovery via sale of drugs                                |
|   | 6.b. Efficiency and effectiveness of <u>volunteer</u> village health workers; numbers, task analysis - see No. 1-4 |

(many of these indices will require longer term follow-up evaluation, i.e. 5, 10, 15, even 20 years.)

SECTION IV: BENEFICIARIES

The ultimate beneficiaries of this project, assuming that it can be successfully implemented, will be the total population of Mali, especially the 90+ percent living in rural areas, and who are now largely untouched by the existing health services and facilities. Attempts to expand the existing system by providing more supplies, equipment, and training would be likely to have only a minimal impact because the existing system is unable to reach the bulk of the population effectively. The alternative proposed in this PRP is to develop a different approach that will break through to the village level in a manner that will have a significant impact on village health conditions and at a cost that will permit replication.

Initially, the main beneficiaries will be the 80,000 persons in the 200 villages of the pilot zones. They should begin to experience improved health conditions - lower mortality and morbidity rates, better nutrition and, possibly, reduced fertility rates - within several years of initiation of the health services in the pilot zones. Secondary beneficiaries will be the other residents of the district in which the pilot zones are located, because of the increased supplies of medicines and equipment provided to the maternities and dispensaries in the district.

As the system is replicated throughout the other parts of the country, the number of beneficiaries will increase accordingly. Also as the health conditions of the population improve, the productivity of the population will also rise, and conversely as productivity increases as a result of the various rural production programs, health conditions will also improve.

The two are mutually reinforcing, and this project, by trying to tie them together at the local level, attempts to strengthen that reinforcement.

The role of women will be significantly enhanced by this project because village women will be drawn into an active role of promoting village health, both as village level health workers and as "consumers" of services. Their burdens of ill health will be reduced, and the availability of family planning information and resources will give them and their families greater control over their own lives.

The underlying social issues addressed by the project include the following:

1. Distribution "equity" in health and community development services between the urban and rural village masses.
2. "Self-care" and local responsibility by rural populations.
3. Integration of traditional rural modes of individual and collective behaviour (especially regarding health care) with modern techniques of developing and delivering health services.
4. The utility of health services at the community level as a catalyst for other development activities, and vice versa.
5. The alteration of existing inappropriate health professional roles and functions to roles and functions appropriate to the needs and settings of the rural masses.

While the increased knowledge and tangible results related to these issues will evolve over the life of the project, it should be emphasized that the rural population of Mali lives as close to the margin of minimal nutrition, health, and economic well-being as the rural population of almost any developing country. The integrated approach to improved and more broadly distributed health, nutrition, avoidance of excess/unwanted fertility, and economic well-being proposed in this project, if successful and replicated nation-wide, could have an impact on the most critical issues of social, economic, and political equity and "quality of life" in the development of Mali. Thus, the thrust of this project is entirely consistent with the AID Congressional Mandate of emphasizing assistance to the rural poor.

The policy of the GOM regarding family planning is to endorse it as a health promotive measure for mothers and children. The GOM is in the process of moving from a Bamako urban family planning activity to seeking the ways and means for making family planning services available in rural areas. The design of this project provides a mechanism for supporting the implementation and progressive spread of this policy.

SECTION V: FEASIBILITY ISSUES

Administrative Feasibility

The Project Design team visited the likely sites for the pilot projects and discussed the feasibility of organizing health services within those regions. In regions II, III, and V there was a strong positive response from regional and district officials to such projects. Also, the Directors of Cabinet of the Ministry of Health and the Ministry of Rural Development gave strong support to the approach, and to the proposed combining of health and production initiatives.

Because of the pilot nature of the operations during the first three years, most of the feasibility issues relate to the problems of carrying out field operations in remote rural areas. It will be necessary to staff the project with persons who are familiar with, and willing to work among, isolated rural populations. While the Sikasso region and parts of the Mopti region are relatively accessible, the Nara District in Region II is so remote that field operations should only be started there after some experience has been gained in other regions.

The ability of the Ministry of Health to deliver medicines and supplies to remote areas may also pose a problem. Therefore, one of the activities included in the project will be to provide technical assistance in the management of that supply system at the national, regional, and local level.

One of the initial duties of the Country Project Director will be to examine the distribution and supply system in conjunction with the MOH, and arrange to provide assistance for improvement where appropriate. The Regional

Public Health advisors will be concerned with the timely distribution of project equipment, supplies, and medicines throughout the region, and the Field Operation advisors will concentrate on distribution and control throughout the district with particular emphasis on the test zones.

Another operational issue concerns the problem of training village health workers (who will often be illiterate or semi-literate) to carry out the functions described in Part II above. It will be important to have technical assistance from persons experienced with this level of training and who also understand the cultural factors bearing upon the roles which village health workers are expected to perform. Further, they must have competence in the health content of the areas in which training will be provided. (See Appendix A for detailed treatment of the development and implementation/evaluation/redesign of effective rural health training programs.)

An expressed MOH concern over the possible unbalancing effects of uneven distribution of personnel, equipment, medicines (and public attention) in the districts selected for the pilot zones, needs to be addressed more fully in the final design of the project. The estimates regarding current and projected per capita costs and replication costs are tentative and it is probable that a reasonable spread effect will result around the pilot areas to counteract any effects.

Peace Corps/Mali has indicated a strong desire to participate in this project. However, should the Peace Corps be unable to fill the full quota of requisite sub-district and village level expatriate volunteers, then the

contractor would need to recruit, train and finance these low cost volunteers - a possible additive project cost. The MOH has indicated willingness to have PCV's participate in this project.

SECTION VII: FINANCIAL PLAN

Mali's national budget for 1975 amounted to 38 billion MF which is equal to US\$95 million or approximately \$17 per inhabitant. (Population in 1975 is about 5.6 million). The health portion of the total budget has been running about 10 percent or \$1.70 per capita. The predominant share of these expenditures is concentrated in the national capital and other urban centers so that the portion reaching the rural areas is probably no more than 50 cents per capita and most of this stops at the main town of the district or sub-district.

A figure of \$2 per capita has been used for planning purposes as the value of medical services that can be supplied to the rural population. To achieve this on a nationwide scale would require a major reorientation of current expenditures away from the high cost curative facilities. While it is unreasonable to expect a dramatic change in a few years, the ultimate success of this project will depend on the demonstration to the Ministry of Health and the GOM of the efficacy of a rural oriented program and a steady increase over the next twenty years of the share of expenditures devoted to this type of program. Within twenty years it is not unreasonable to expect a 50 percent increase in the real per capita budget levels and health expenditures.

The following assumptions have been used for estimating the costs of the pilot program on a per capita basis:

- a. That the costs of medicines supplied free will be \$1 or 440 MF per capita.
- b. That the salary costs of the regional and district health officials directly involved in the program will be prorated in proportion to the share of the pilot region population in the total population under their jurisdiction.
- c. The sub-district worker's salary would be counted in full, while the village worker would be either a volunteer or supported in kind by the village.
- d. Equipment costs would be prorated over the expected life of the equipment and population served.
- e. Operating costs are estimated on an annual basis.

Annual Cost Estimates for Operating Pilot Program in One Sub-District of 50 Villages and 20,000 Population:

Personnel:

	MF
- Agent de Santé Rural; one per sub-district at MF 300,000p.a.	300,000
-Agent de Santé Publique de Cercle; one-sixth of time per sub-district at MF 480,000 p.a.	80,000
- Adjoint de Santé Publique REgional; 1/36 of time per sub-district at MF 600,000 p.a.	16,600
- Animatrice de Santé de Village: 50 per sub-district at no salary	<u>    - 0 -    </u>
	396,600 MF

Transportation:

- Mobilette for Agent de Santé Rural; one per sub-district at MF 120,000	
Depreciation over 3 years	40,000 MF
- Operations & repairs at MF 20/mile for 5,000 miles	100,000 MF
- Mobilette for Agent de Santé Publique de Cercle, one sixth per sub-district	
Depreciation, operation, repairs	24,000 MF
- Four-wheel drive vehicle for Adjoint de Santé Publique Régional: 1/36 portion	
Depreciation: 800,000:36	22,000 MF
Operation, repairs 1,800,000:36	
at MF 120/mile for 6,000 miles (30¢/mile)	<u>65,000 MF</u>
	251,000 MF

Equipment and Supplies:

- Scales, one per village (50 villages) at MF 20,000 - Depreciation over 5 years	200,000 MF
- Weight charts and other record keeping materials at MF 40 per capita x 20,000	800,000
- Promotional materials and supplies at MF 40 per capita x 20,000	<u>800,000</u>
	1,800,000 MF

Medicines:

- Medicine supplies through local pilot zone free distribution at 400 MF per capita x 20,000	8,000,000 MF
Estimate of current value of health services supplied through existing health facilities at 80 MF per capita	3,600,000 MF

Per capita expenditures are MF 13.8 million: 20,000 or about MF 700 per capita = \$1.59.

While this per capita cost estimate for the proposed program (when full operational) is estimated at US\$ 1.59, the costs during the demonstration period will be higher because the supervisors at the district and regional level will be supervising a swollen complement of subordinates, i.e. higher personnel costs.

The attached Summary Budget indicates an initial AID three-year cost of \$2,722,000 with a GOM local currency contribution for project and project-related (part-time services of regularly salaried MOH personnel) costs. Given GOM acceptance of the feasibility of the project's approach to rural health services, GOM replication costs in project years 04 and 05 increase to \$438,000 and \$446,000, respectively, or 40% and 51% of the AID grant costs in these years.

To assure GOM local currency contributions and the continuity of donor assisted health sector projects, the GOM in its "Five Year Plan for Economic and Social Development (1974-78)" proposes the creation of a National Health Fund similar to the already established National Road Fund. Contributions to the fund would come from: (1) The national budget; (2) local and regional budgets; (3) a health tax; (4) profits from state owned enterprises; (5) receipts from health units; (6) receipts from MOH institutes and laboratories; (7) subsidies from the National Lottery, National Institute of Provident Societies, and the National Insurance and Reinsurance Fund; and (8) financial gifts.

Project funding (both AID direct costs and contract funded costs) can be met by an IQ obligation of \$500,000 and an FY 1977 obligation of \$950,000 (including \$200,000 in Title X allocations). FY 1978 obligations of \$1,313,000 would provide sufficient funding for the initial three-year cost of \$2,722,000. The full complement of contract funded technicians increases fourth year AID funded costs to \$1,098,000, whereas fifth-year phase-out requirements total \$871,000, matched by a corresponding increase in GOM project contributions.

A total AID five-year requirement of \$4,691,000 assumes GOM acceptance of the project generated rural health services system sometime before the end of project year three (see CPI and PPT attached as Appendices F and G).

BUDGET

US\$ Cost Estimates for three years, FY IQ(76)-78

1. Contract Personnel

A. Long-term: 17 person years \$70,000/year (1) \$  
1 senior health advisor, team leader 1,176,000  
2 regional advisors  
4 regional field operations specialists

B. Short-term: 12 person months 72,000

1,248,000  
-----

2. Participants

Five long-term 75,000

Six short-term 30,000

105,000  
-----

3. Commodities

Equipment:  
- Vehicles, 4 wheel drive vehicles for 5 at \$10,000 50,000  
Mopti test zone 2  
Nara test zone 2  
Team leader 1

2 wheel drive vehicles 2 at \$5,000 10,000  
Sicasso test zone 2

- Mobilettes for district: 26 at \$450 11,700  
and sub-district

- Scales for village level animateurs, 200 at \$50 10,000

- Equipment for maternities and dispensaries 12,000  
in pilot districts

93,700  
-----

(1) Includes contract overhead.

- Medicines		\$
- for test zones		360,000
- for district in which test zones located (see attached sheet for basis of estimation)		<u>460,000</u>
		820,000
		-----
4. <u>Other Costs</u>		
A. Local hire secretaries, typists, drivers		30,000
B. Office supplies		30,000
C. Operations - travel, gasoline, repairs		70,000
D. Training Materials		20,000
E. Campus Coordinator		<u>60,000</u>
		210,000
		-----
SUMMARY:		
1. Contract Personnel	\$ 1,248,000	
2. Participants	105,000	
3. Commodities	93,700	
	<u>820,000</u>	913,700
4. Other Costs		<u>210,000</u>
		\$ 2,476,700
5. Inflation Factor 10%		<u>247,670</u>
		\$ 2,724,370
		=====

Basic for Estimating Expenditures on Medicines

Assumptions: 1. That \$2 worth of medicines will be supplied for each inhabitant in the test zone for each year of the test period.

2. That \$0.40 worth of medicines will be supplied for all other inhabitants in the district in which the test zone is located for each year of the test period. National budget expenditures on medicine in 1974-75 averaged \$0.40 per capita.

Districts in which test zone is expected:

Koro (or Duentza) for 3 years: (population 150,000)

Test zone: pop. 20,000 x \$2.00 x 3 years ..... \$ 120,000

Population outside zone: 100,000 x \$0.40 x 3 yrs.... 120,000

Nara for 2 years: (population 120,000)

Test zone: pop. 20,000 x \$2.00 x 2 years ..... 80,000

Population outside zone: 100,000 x \$0.40 x 2 yrs. .. 80,000 \$ 400,000

Sikasso for 2 years: (population 245,000)

Test zone: pop. 20,000 x \$2.00 x 2 yrs. .... 80,000

Population outside zone: 225,000 x \$0.40 x 2 yrs. .. 180,000

Duentza or Bandiagara or Koro for 1 year: (pop. 140,000)

Test zone: pop. 20,000 x \$2.00 x 1 year ..... 40,000

Population outside zone: 120,000 x \$0.40 x 1 yr. ... 48,000

Gao for 1 year: (Population 100,000)

Test zone: pop. 20,000 x \$2.00 x 1 year ..... 40,000

Population outside zone: 80,000 x \$0,40 x 1 yr. .... 32,000 420,000

\$ 820,000  
=====

SUMMARY BUDGET  
(\$000)

	<u>PY-01</u>	<u>PY-02</u>	<u>PY-03</u>	<u>Sub-Total PY01-03</u>	<u>PY-04</u>	<u>PY-05</u>	<u>Summary Total PY 01-05</u>
<b>I. <u>Personnel</u></b>							
Long-term (4) a)	294	406	476	1,176	490	208	1,946
Short-term	36	36	-	72	-	36	108
Sub-Total	330	442	476	1,248	490	316	2,054
<b>II. <u>Participants</u></b>							
Degree (5)	-	75	-	75	-	-	75
Short-term (6)	-	15	15	30	-	-	30
<b>III. <u>Commodities</u></b>							
Vehicles (6)	30	30	-	60	-	-	60
Mobilettes (26)	6	6	-	12	-	-	12
Scales (200)	5	3	2	10	2		12
Medicines - Test Zone	80	120	160	360	160	160	680
- Gen'l Coverage	142	178	140	460	249	249	958
Sub-Total	269	430	320	1,019	421	409	1,849
<b>IV. <u>Other Costs</u></b>	57	76	77	210	87	67	364
Inflation Factor 10%	65	95	87	247	98	79	424
<b>TOTAL</b>	<u>721</u>	<u>1043</u>	<u>960</u>	<u>2,724</u>	<u>1096</u>	<u>871</u>	<u>4,691</u>
<b>GOM Contribution in Program Zone:</b>	73	103	130	306	438	446	1,190

SECTION VIII: IMPLEMENTATION PLAN AND PROJECT DEVELOPMENT SCHEDULE

A. PRE-PROJECT ACTIONS:

This proposed project would be implemented through AID direct funding/ implementation actions for US participant training and commodity procurement. The major share of project implementation should be undertaken by a university or private health services contractor.

Whereas this proposal currently is in the PRP stage, for several reasons the Country Development Office would prefer that this proposal be considered as a draft project paper which can be more fully developed in AID/W in consultation with CDO/Bamako and PRP contractor team members from the Harvard Institute for International Development when the latter's technical report is made available through APHA. Such an approach could accelerate project approval. Moreover, the GOM has demonstrated its growing disenchantment with repeated study team visits to Mali. The MOH has made this point and one regional health official stated that he cared not to receive any future "study" delegations.

The third major consideration in moving quickly to project authorization is the need to reconfirm AID's interest in health services and planning to affect the rural poor in Mali. The stop-gap measures of R&R activities merely saved many of them from extreme suffering. Now it is appropriate to build on this momentum and the central government's awareness of the condition of the rural masses. To this end, the pre-project action plan attached as Appendix B, illustrates that if we move to full AID/W development of the PP before the end of FY 1976 and if sole

source contracting is viewed as the best approach to project implementation. (and this is the view of CDO/Bamako) then the project will be operational more than 6 months faster than the conventional approach to project development and implementation.

**B. PROJECT ACTIONS:**

Accordingly, given favorable consideration of the above factors, the country project director (contract) would arrive in Bamako for pre-project orientation and confirmation of administrative and logistic support by November 1, 1976, and project operations would begin in pilot zone No. 1 by January 1977.

The CPI and PPT indicate that two pilot and "control" zones will be operational by the end of project year (PY) 01. A third zone is mobilized early in PY-02, and the option of a fourth zone is provided for in PY-03. Initial GOM/MOH receptivity and feedback should indicate by midway through PY-02 whether this fourth zone and potential GOM replication in other zones are feasible and warranted. Final determination on the course of action for PY-04 and PY-05 (AID and GOM expansion and replication) will be based on the external evaluation planned for PY-03/months 06-08. Consequently, current estimates for PY's 04 and 05 are tentative and may be reduced or enlarged, subject to the formal 2 1/2 year evaluation.

CDO/Bamako anticipates that AID/W soon will nominate a candidate to fill the allotted Public Health Advisor position within the Mission's FY 1976 approved staffing plan although to be funded from this project. This advisor

will have primary Mission responsibility for the sizable AID portion of project implementation, i.e. commodity management and participant selection monitoring and follow-up. In addition to the advisor's responsibilities for contract management and annual project evaluations, the incumbent will provide vital liaison among all parties involved in project implementation - the ministries of Health, Education, Plan, Finance, and Rural Development, the separate Opérations and MOH regional health directors, the contract team and Peace Corps/Bamako and project PCVs.

The project purpose is centered on the eventual adoption by the GOM of a tested rural health delivery system. In order to achieve this acceptance, special project emphasis is to be placed on nurturing the management capacity of the MOH to develop a long-range health strategy covering budgeting, personnel requirements, national health education objectives and the implementation of a National Health Development Fund. The PRP team and CDO/Bamako are heartened by the new vital signs at the MOH and are guardedly optimistic about the ability of the MOH to gear up to the task of providing adequate health services to Mali's rural population.

## ANNEX A

### FUNCTIONS OF MALIAN PERSONNEL IN THE PILOT AREAS

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#### 1. Village Level Health Worker (Animatrice de Santé de Village)

##### a. Community Diagnosis and Evaluation (ongoing)

- \*1. Continuous census of births, deaths, migrations, marriages
- \*2. Birth weights
- \*3. Age-specific death and fertility rates
- \*4. Parity and gravidity of pregnant females
- 5. Health and family planning utilization, by age, sex, type of service
- \*6. Weight and arm circumference charting of infants and young children, by age and sex
- 7. Simple diagnostic categories, by age and sex (examples - diarrhea, fever, respiratory or skin ailment, abnormal delivery, trauma, hemorrhage, tetanus, etc.)
  - for mortality
  - for morbidity
- \*8. Vaccination status (scarification)
- \*9. Feeding and weaning practices

\* ) - also done in "control" areas.

b. Health Promotion and Disease Prevention

- Health Educa-  
tion and  
Demonstration
- ( 1. Simple infant care and newborn care
  - (
  - ( 2. Breast feeding and supplementation
  - (
  - ( 3. Weaning and transition foods
  - (
  - ( 4. Child-spacing and family planning advice
  - (
  - ( 5. Hygiene in the home
  - (
  - ( 6. Safety in the home, fields, village
- Health Education  
and  
Stimulus for  
Community  
Action
- ( 7. Village hygiene (water and excreta, vector control)
  - (
  - ( 8. Vaccination - logistic link for Service de Grands
  - (
  - ( Endemies
  - (
  - ( 9. Improved food production (home and village gardens,
  - (
  - ( eggs?, etc.)
- Direct  
Preventive  
Actions
- (10. "Nivaquinization" of infants, young children, and
  - (
  - ( pregnant women (malaria suppression)
  - (
  - (11. Iron supplements in pregnancy
  - (
  - (12. Tetanus vaccination of pregnant women in 3rd trimester
  - (
  - (13. Sterile razor blades and cord ties for village
  - (
  - ( midwives.
14. Referral to sub-district level of:
- A. Abnormal pregnancies
  - B. Failure-to-thrive infants - (severe)
  - C. Kwashiorkor and marasmus
  - D. Severe and acute and chronic illness
- ../...

## E. Trauma (severe)

## F. Contraception

i.e. - makes referrals to sub-district level, or "lines up" for next visit to village of sub-district health worker; also can monitor follow-up diagnosis and treatment at the village level.

c. Direct Diagnosis and Treatment (also includes health education)

1. Simple early oral treatment of diarrhea, water, salt, sugar solutions by finger-pinch (needs sugar and salt - use standard local containers)
2. Home treatment of early malnutrition, using locally made foods
3. Simple treatment of respiratory infections (cough mixture, antibiotics, criteria)
4. Simple treatment of skin infections (soap, antibiotics)
5. Malaria (oral treatment feasible in most cases)
6. First aid (soap and antiseptic, bandages, immobilization, local heat)
7. Follow-up and assure treatment of chronic disease (e.g. tb, leprosy). Follow-up contraceptive supply.
8. Distribution of appropriate medicines will be made by Village Health Worker (both free and purchased medicines).

2. Arrondissement-Level Public Health Worker (Agent de Santé Rurale)

- Carries out initial community diagnosis
- Monitors continuous evaluation (see 1 A above)

- Participates in development of training program for "animatrices"
- Trains "animatrices"
- Supervises animatrice functions
- Acts as administrative and logistic link between district and village levels.

3. District-Level Public Health Worker (Agent de Santé de Cercle)

- Supervises functions of sub-district level agents within district in both test and "control" areas
- Participates in development of training program for sub-district level workers (and village level workers)
- Trains sub-district level workers (and village level workers)
- Assists sub-district level workers in expanding village-level activities
- Acts as administrative and logistic link between regional and district level.

4. Regional Level Public Health Worker (Adjoint de Santé Publique Rurale)

- Acts as deputy to either the regional medical officer or Director of Rural Development for purposes of training, supervision, administration, supply flow, and evaluation activities at all levels within the test and "control" areas in the region.

(See Appendix A for a more detailed description of proposed training methods.)

MALI RURAL HEALTH SERVICES DEVELOPMENTPOSITION DESCRIPTIONS

- I. Country Project Director (Contract-Funded)
  - A. Based in Bamako.
  - B. Coordinates all aspects of project development including planning, implementation and evaluation.
  - C. Provides liaison among contract team, home office, USAID, Ministry of Health, Ministry of Rural Development, Ministry of Education and other Malian entities.
  - D. Encourages and monitors channeling of USAID and GOM central resources into project demonstration regions, as appropriate, including funds, personnel, training, equipment, and medicines.
  - E. Works to achieve integration into national level programs of "results" of demonstration regions for replication/expansion elsewhere in Mali.
  - F. Acts as back-up and supervisor for other contract technicians (based in demonstration zones) who will have primary responsibility for technical supervision and administration of district-level and village-level personnel and operations.
  - G. Ensures development of viable and reliable commodity (medicines) management system extending from MOH to pilot and "control" zones.
- II. Regional Public Health Advisor(s) (Contract-Funded; two for life of project)
  - A. Based in capital of region.
  - B. Coordinates all aspects of project in region extending out to the village-level.
  - C. Provides liaison among project personnel, Regional Director of Rural Development, and Regional Director of Public Health.
  - D. Insures timely distribution of project equipment, supplies, and medicines.

- E. Coordinates and designs, implementation and evaluation of training programs, community diagnosis study and health education programs for test zones within region.
- F. Provides timely advice on project implementation to Country Project Director.

Field Operation Advisor(s) (Contract-Funded; four for life of project)

- A. Resides part-time in both regional capital and district capital in test zone.
- B. Responsible for design and implementation of project within test zone at district, sub-district and village level including implementation and "control" zones.
- C. Supervises U.S. Peace Corps-type volunteers at sub-district and village level.
- D. Assists in conducting health worker training programs and in designing, conducting and evaluating community diagnosis study.
- E. Insures appropriate distribution and control of equipment, supplies, and medicines throughout district with particular emphasis on test zone.
- F. Works to achieve coordination of project activities with activities of Operation and/or other directly productive economic activities in the test zone.

ANNEX C

PROCUREMENT SOURCE WAIVER

I. Waiver required: A procurement source waiver from AID Geographic Code 000 (U.S.) to Geographic Code 935 is required for motor vehicles and moby-  
lettes. As discussed below, the primary basis for the waiver is that U.S. vehicles  
cannot be used effectively in Mali because of the unavailability of spare  
and repair parts and the lack of experience in the use and maintenance of  
U.S. motor vehicles.

The total amount of the waiver will not exceed \$71,700 which will be  
apportioned as follows for the Mali Rural Health Service Development Projects:

- 5	Landrovers	\$50,000
- 2	Citroën "Baby Bruce" (2 wheel drive)	10,000
- 26	Mobylettes	11,700
		-----
		\$71,700

II. Justification: Mali, like the other Sahelian States, faces a situation  
in which imports emanate almost entirely from France and other EEC countries.  
This trade pattern, which has developed over many years of close association  
between Mali and Europe, has resulted in Malians being trained in the use and  
maintenance of European-made goods and in the establishment of European distri-  
bution and service facilities in Mali. American manufacturers, distribution  
and service firms are only recently beginning to take a tentative and still  
insignificant look at the Malian market. As a result, special parts for U.S.  
made equipment are not available in Mali, and Malians are not trained in the  
basics of maintenance. In the past, audits and inspections of AID projects  
in the Sahelian area have been sharply critical of the difficulties of host  
governments in maintaining U.S. motor vehicles after project phaseout.

We believe that motor vehicles and mobylettes which are essential to  
the successful implementation of the project, are, in effect, not available  
from eligible sources. The concept of availability from eligible sources  
means effective availability. For motor vehicles and mobylettes to be truly  
available from an eligible source, they must not<sup>only</sup> be of a type that

theoretically can be used for the project, but they must also be of a type that the host country can use effectively over a normal useful life in light of the availability of spare parts and the ability to service and maintain the motor vehicles and mobbyettes.

We also believe that there are compelling political considerations that support this waiver. It is necessary for the United States to provide motor vehicles that can be maintained effectively, and for which spare parts are available, in Mali. Otherwise, the political benefits to be obtained from providing the proposed assistance will be frustrated, and the image of effectiveness of the United States will be impaired, if the motor vehicles and mobbyettes financed by the United States are of a sort that cannot be used effectively by Mali over a normal useful life.

These motor vehicles and mobbyettes are essential to the success of the project and the Government of Mali (GOM) does not have the foreign exchange necessary to procure them. Other donors are not interested in providing funding because of heavy involvement in other sectors or other geographic areas in Mali.

For these reasons it is necessary, in order to carry out the purposes of the FAA, to waive the requirement of Section 636 (i) of the FAA that motor vehicles and mobbyettes procured for the project be manufactured in the United States. In addition, it is necessary to authorize procurement of the above-described motor vehicles and mobbyettes from Geographic Code 935 countries because the exclusion of procurement from these sources would seriously impede attainment of U.S. foreign policy objectives and the objectives of the foreign assistance program.

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

INSTRUCTION: THIS IS AN OPTIONAL FORM WHICH CAN BE USED AS AN AID TO ORGANIZING DATA FOR THE PAR REPORT. IT NEED NOT BE RETAINED OR SUBMITTED.

Life of Project:  
From FY \_\_\_\_\_ to FY \_\_\_\_\_  
Total U.S. Funding: \_\_\_\_\_  
Date Prepared: \_\_\_\_\_

PAGE 1

Project Title &amp; Number: \_\_\_\_\_

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes: (A-1)</p> <p>1. To provide improved health services to the rural poor which comprise over 90% of the Malian population.</p>	<p>Measures of Goal Achievement: (A-2)</p> <p>1. Adoption by the GOM of a low-cost health delivery system which focuses on up-grading health facilities at the rural village level</p> <p>2. Continuous expansion of rural health delivery system on a time-phased basis as part of GOM long-range health development plan.</p> <p>3. Decreased morbidity, mortality, and balanced birth rate/per capital GNP function.</p>	<p>(A-3)</p> <p>1. Five-year plans, 1979-83, 1984-1988, etc.</p> <p>2. Annual budgetary and personnel allocations in GOM health plans.</p> <p>3. MOH records of health system utilization.</p>	<p>Assumptions for achieving goal targets: (A-4)</p> <p>1. Actual GOM long-term commitment to rural health delivery system.</p> <p>2. Institutional capability for data collection, tabulation analysis, etc.</p> <p>3. Continued official GOM plan to reduce birth rate.</p> <p>4. Donor assistance forthcoming to assist GOM in underwriting a national rural health system at approximately \$2/capita/year.</p>

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Life of Project:  
From FY \_\_\_\_\_ to FY \_\_\_\_\_  
Total U.S. Funding \_\_\_\_\_  
Date Prepared: \_\_\_\_\_

AID 1020-20 11-731  
SUPPLEMENT 1

Project Title & Number Mali Rural Health Services Development

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Purpose: (B-1)</p> <p>1. To achieve the national adoption of a tested rural health delivery program and assure adequate preparation for its implementation.</p>	<p>Conditions that will indicate purpose has been achieved: End-of-Project status. (B-2)</p> <p>1. Completion of a 3-year pilot testing program and analysis of results.</p> <p>2. GOM review of tested program and adoption of it as a national program.</p> <p>3. GOM preparation of manpower training and other plans necessary for implementation over a 10-15 year period.</p>	<p>(B-3)</p> <p>1. Periodic reports on implementation and fiscal analysis of results.</p> <p>2. GOM policy statements, plans, legislation and budget decisions.</p> <p>3. Completion of planning documents.</p>	<p>Assumptions for achieving purpose: (B-4)</p> <p>1. Actual GOM commitment to broad distribution of rural health services and emphasizing health promotion, disease prevention, and simple diagnosis and treatment.</p> <p>2. GOM capability to underwrite a national rural health system at approximately \$2/capita/year.</p>
<p>SUB-PURPOSE I: To design, implement and evaluate a pilot rural health system which will:</p> <p>a) bring health services to the village level, emphasizing health promoting and disease preventive activities;</p> <p>b) be integrated with other community and economic development activities, especially production and education;</p> <p>c) be capable of replication by holding costs to the GOM below US\$2/capita/year.</p>	<p>1. Establishment of pilot programs serving</p> <p>a) 50 villages or 20,000 persons during year 1.</p> <p>b) 150 villages or 60,000 persons by end of year 2.</p> <p>c) 250 villages or 100,000 persons by end of year 3.</p> <p>2. Achieve coordination with agricultural production operations and educational programs in the test areas at the village, arrondissement, cercle and regional levels.</p>	<p>1. Reports from and regular visits to the pilot villages.</p> <p>2. Field evaluation of working relationships between health and other workers at various levels, and reports on joint operations such as conduct of health courses in rural schools.</p>	<p>1. Same as project purpose assumptions (above)</p> <p>2. GOM commitment to assign adequate field personnel to carry out the project.</p>

AID 1020-20 (1-73)  
SUPPLEMENT 1

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Life of Project: \_\_\_\_\_  
From FY \_\_\_\_\_ to FY \_\_\_\_\_  
Total U.S. Funding \_\_\_\_\_  
Date Prepared: \_\_\_\_\_

Project Title & Number: Mali Rural Health Services Development

PAGE 2

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Purpose: (B-1)</p> <p>Sub-Purpose II: To achieve the adoption and to initiate replication throughout Mali of the rural health system tested in the pilot zones during years 04 and 05 of project.</p>	<p>Conditions that will indicate purpose has been achieved: End-of-Project status. (B-2)</p> <ol style="list-style-type: none"> <li>1. Completion of a thorough evaluation of the pilot programs.</li> <li>2. Reorientation of the existing health system to adopt the proven aspects of the pilot program.</li> <li>3. Reorientation of local and national training programs to support the new system.</li> <li>4. Development of a realistic long-range manpower plan for national health services.</li> <li>5. Strengthening of health planning and management to support the new system.</li> </ol>	<p>(B-3)</p> <ol style="list-style-type: none"> <li>1. Receipt of analytic studies.</li> <li>2. Policy statements of GOt, legislation and budget allocations.</li> <li>3. Curriculum and reports of training institutions.</li> <li>4. Published as part of GOt national health plan.</li> <li>5. Quality of planning documents and evaluation of management system.</li> </ol>	<p>Assumptions for achieving purpose. (B-4)</p> <p>(Same as previous "Purpose" assumptions, but expanded to national level.)</p>

**PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK**

Life of Project: \_\_\_\_\_  
 From FY \_\_\_\_\_ to FY \_\_\_\_\_  
 Total U.S. Funding \_\_\_\_\_  
 Date Prepared: \_\_\_\_\_

AND 1972 24 11 11  
 SUPPLEMENT 1

Project Title & Number: \_\_\_\_\_

PAGE 3

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS										
Project Outputs: (C-1)	Magnitude of Outputs: (C-2)	(C-3)	Assumptions for achieving outputs: (C-4)										
<p>1. Establishment of pilot projects (years 01-03)</p> <p>2. Training of Health Workers at            Village - A            Sub-district - B            District - C            Region - D            three-year total trained.</p> <p>3. Five persons trained and returned to key MOH positions, training in U.S. for one year each at MSc and MPH levels.</p>	<p>1. Pilot projects established for 50 villages (20,000 people) each, one sub-district, one district, one region:            During years      Cum.No. of pilots</p> <table style="margin-left: 20px;"> <tr><td>01</td><td>1</td></tr> <tr><td>02</td><td>3</td></tr> <tr><td>03</td><td>4</td></tr> <tr><td>04)</td><td>subject to evaluation &amp; GOM acceptance for replication.</td></tr> <tr><td>05)</td><td></td></tr> </table> <p>2. A - 1 or more/village            B - 3/sub-district            C - 1/district            D - 1/region</p> <p style="margin-left: 20px;">A - 250            B - 12-16            C - 4            D - 3-4</p> <p>3. Project reports.</p>	01	1	02	3	03	4	04)	subject to evaluation & GOM acceptance for replication.	05)		<p>1. Pilot projects in place and operating according to project design schedule.</p> <p>2. Health workers trained and in place.</p> <p>3. Project Reports.</p>	<p>1. GOM provision of full administrative cooperation and assignment of requisite GOM personnel and support for project working zones.</p> <p>Arrival and placement technical assistance personnel, vehicles and commodities at beginning of year 01.</p> <p>2. Personnel are made available through MOH and at village level for training and duty assignment.</p> <p>3. GOM/MOH acceptance of rural delivery system and appropriate individuals identified for U.S. training directly relevant to project purpose and project support systems.</p>
01	1												
02	3												
03	4												
04)	subject to evaluation & GOM acceptance for replication.												
05)													

AID 1020-76 (11-73)  
SUPPLEMENT 1PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORKLife of Project: \_\_\_\_\_  
From FY \_\_\_\_\_ to FY \_\_\_\_\_  
Total U.S. Funding \_\_\_\_\_  
Date Prepared: \_\_\_\_\_

Project Title &amp; Number: \_\_\_\_\_

PAGE 3

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Outputs: (C-1)	Magnitude of Outputs: (C-2)	(C-3)	Assumptions for achieving outputs: (C-4)
4. Community Diagnosis Report for project zones (pilot and "control" areas).	4. 1 report for each zone.	4. Available six-eight months after start-up technical assistance in each zone.	4. Appropriate survey techniques yield reliable and valid data on Malian habits related to health.
5. Replicable course of studies, including teaching aids, A-V material, etc. for health trainees/workers.	5. 1 syllabus refined from materials generated from different socio-cultural test zones (multi-language).	5. Syllabus.	5. Sufficient socio-cultural similarities exist among regions.
6. Replicable short-term refresher course (recyclage).	6. Extant courses for: Infermières, Matrones, sage-femmes, village health workers.	6. Syllabus.	6. same as No. 5 above.
7. Evaluation of pilot project.	7. Annual reports for each of the first two years of project implementation. Summary evaluation report at end of three years.	7. Reports based on community diagnosis reports, project and contract documentation.	
8. Improved health status in pilot villages.	8. Demographic, morbidity, and infant mortality, nutritional, and economic development and social indicators DATA.	8. DATA from pilot/'control' surveys (see narrative sections "Evaluation" and "Social Indicators".)	8. Other environmental/health conditions being equal to current conditions.

AID 1020-20 (11-73)  
SUPPLEMENT 1PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORKLife of Project: \_\_\_\_\_  
From FY \_\_\_\_\_ to FY \_\_\_\_\_  
Total U.S. Funding \_\_\_\_\_  
Date Prepared: \_\_\_\_\_

## Mali Rural Health Services Development

PAGE 2

Project Title & Number NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Project Purpose: (B-1)	<p>Conditions that will indicate purpose has been achieved: End-of-Project status. (B-2)</p> <p>3. Conduct training programs for village volunteers and arrondissement, cercle and regional health professionals associated with the test areas.</p> <p>4. Establishment of an information system for determining initial health and living conditions in pilot and control areas, measuring changes in mortality, morbidity and fertility over the life of the project and thereafter, and measuring the costs and other benefits of the project.</p> <p>5. Achievement of an adequate flow of appropriate medicines and supplies to the test areas and surrounding cercle, within the cost constraints of a system of rural health services that the GOM can afford to replicate.</p>	<p>(B-3)</p> <p>3. Technician participation in preparation, conduct and supervision of training courses.</p> <p>4. Reports flowing from the information system plus frequent field checks of the reliability or biases in reporting different types of information.</p> <p>5. Reports from pilot zones and visits to rural health stations and regional and national supply centers.</p> <p>6. Monitoring of distribution reports from the health supply agencies.</p>	<p>Assumptions for achieving purpose: (B-4)</p> <p>3. GOM capabilities to achieve functional collaboration between the M.O.H. and Min. of Production (Rural Development) and the "Grandes Opérations".</p> <p>4. Sufficient field personnel including junior level field workers (Peace Corps or other) to make checks on accuracy of reports.</p> <p>5. Controlling the rate of expansion of the pilot zones to not outstrip the information systems effectiveness.</p> <p>6. Development of adequate logistic capabilities in M.O.H. (with U.S. T.A.).</p>

PROJECT ACTION PLAN  
~~XXXXXX~~

Country:	Project No:	Project Title:	Date:	Original	Approval:	
		RURAL HEALTH SERVICES DEVELOPMENT	/ /	Revision #		
<u>CFI DESCRIPTION</u>		<u>ALTERNATIVE "A"</u>	<u>ALTERNATIVE "B"</u>			
1. 4/9/76 Draft PRP/PP reviewed by AID/US Project Committee 2. 4/15/76 ECPR review and approval of PP 3. 7/5/76 ProAg, PIO/T and PIO/Cs signed 4. 8/5/76 "Sole-Source" TA Contract signed 5. Aug-Sept./76 U.S. Contract Chief of Party recruited and trained in Bambara language  <u>FY 1977 - 1st Quarter:</u> 6. 10/1/76 Chief of Party (Project Country Director) on-site Recruitment and training Contract Regional Advisor, Contract Field Advisor Recruitment and training PCV-types 7. Nov.-Dec./76 Project Director country orientation and preproject admin. arrangements 8. 1/6/77 Pilot Zone 1 Contract Regional and Field Advisors, PCV-types and MOH Health Workers on-site Arrival vehicles and commodities for Pilot Zone 1 9. 1/13/77 Begin on-site training course for MOH health trainers/workers 10. 3/1 Village Health Workers recruited  <u>FY 1977 - 3rd Quarter</u> 11. 4/1/77 Training of Village Health Workers begins 12. 6/1/77 Pilot Zone 1 operational.		1. Same as Alt. A 2. Same as Alt. A 3. Same as Alt. A 4. 8/15/76 RFP issued  <u>FY 1977 - 1st Quarter</u> 5. 10/15/76 Analysis of proposals and negotiation of contract 6. 12/1/76 TA contract signed 7. Jan-Feb./77 U.S. Contract Chief of Party recruited and trained in French and Bambara 8. Jan-March/77 Recruitment and training of contract Regional and Field Advisors, PCV-types  <u>FY 1977 - 3rd Quarter</u> 9. 4/1/77 Project Country Director orientation and preproject admin. arrangements 10. 5/1/77 Contract Regional and Field Advisors, PCV-types and MOH health workers on-site Arrival vehicles and commodities for Zone 1 11. 5/8/77 Begin on-site training course for MOH trainer workers 12. June-July/77 Rural Agricultural Land Preparation and Planting 13. 8/1/77 Village Health Workers recruited 14. 9/1/77 Training of Village Health Workers begins  <u>FY 1978 - 1st Quarter</u> 15. 11/1/77 Pilot Zone 1 operational				

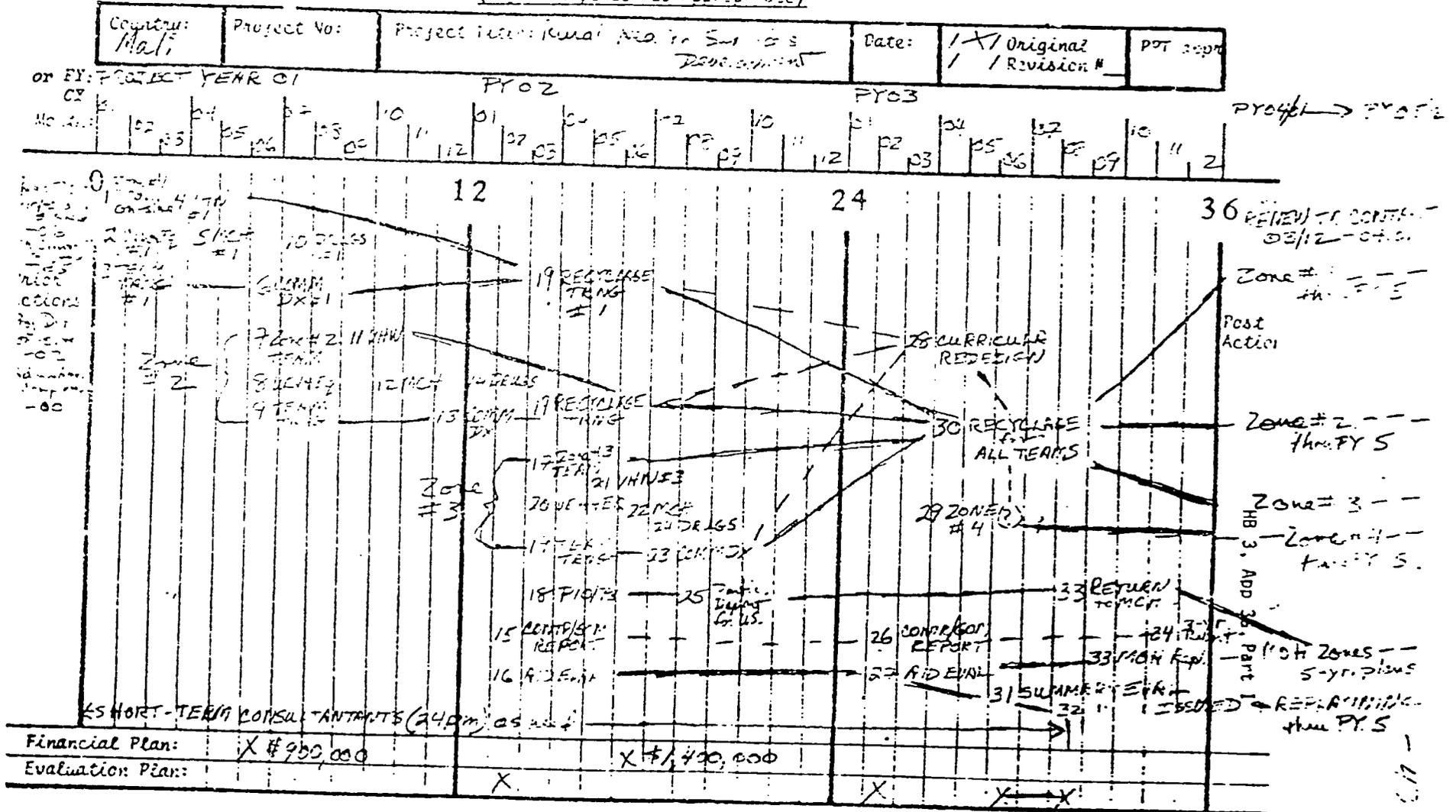
HB 3, App 36, Part 1

## PPT FORM

Country:	Project No:	Project Title: Rural Health Services Development	Date:	/x / Original / / Revision #	Approd:
<u>CPI DESCRIPTION</u>					
Month of Prior Actions					
- 06 ProAg, PIO/T and PIO/Cs signed					
- 05 TA contract signed					
- 02 Chief of Party, trained in Bambara language					
arrives on site					
- 00 Completion of preproject admin. arrangements					
- - - - - Project Year 01 Begins - - - - -					
<u>Year/Mo</u>					
1. 01/00	Pilot Zone No. 1 Advisors, MOH Health trainers/work-				
2. 01/00	kers, and PCV-types (Zone No. 1 Team) on-site				
3. 01/00	All-terrain vehicles and equipment for zone 1 on-				
4. 01/00	site to coincide arrival contract personnel				
5. 01/00	Orientation and training of zone 1 team begins				
6. 01/03	Recruitment and one-month training of zone 1				
7. 01/03	village health workers (VHW's)				
8. 01/04	Equipment for zone 1 maternities on-site				
9. 01/06	Community Diagnosis Study completed in Zone 1				
0. 01/06	Pilot Zone 2 team on-site				
1. 01/06	Vehicles and equipment for zone 2 on-site				
2. 01/06	Orientation and training zone 2 team				
3. 01/07	Drugs for zone 1 on-site				
4. 01/09	Recruitment and training of zone 2 VHW's				
5. 01/10	Equipment for zone 2 maternities on-site.				
6. 01/12	Community Dx Study completed in Zone 2				
7. 02/01	Drugs for Zone 2 on-site				
8. 02/02	First-year Contractor/GOM report issued				
9. 02/02	USAID 1st Annual Evaluation completed				
0. 02/03	Pilot Zone 3 team on-site				
1. 02/03	PIO/Ps signed and Eng. Trng. for five U.S. partici-				
2. 02/03	pants				
3. 02/03	Orientation and training of Zone 3 team and re-				
4. 02/03	cyclage training of Zone 1				
5. 02/03	Vehicles and equipment for zone 3 on-site				
6. 02/05	Recruitment and trng. of Zone 3 VHWs				
7. 02/06	Equipment for Zone 3 maternities on-site				
8. 02/08	Community Dx Study completed in Zone 3				
9. 02/08	Drugs for Zone 3 on-site				
0. 02/00	Five Health Participants depart for US Trng.				
1. 03/02	Second-year Contractor/GOM report issued				
2. 03/02	USAID 2nd Annual Evaluation completed				
3. 03/03	Curricula redesign				
4. 03/04	Decision/selection re. possible Zone 4 Pilot				
5. 03/04	Recyclage Training for Teams 1, 2, and 3				
6. 03/06	Initiate 2 1/2 year summary project evaluation				
7. 03/08	Summary Evaluation Report issued				
8. 03/08	U.S. Participants return to MOH service				
9. 03/08	Planning for MOH Replication of Rural Health				
0. 03/08	Services System in non-USAID assisted zones.				
1. 03/11	Begin preparing summary 3-year contractor's				
2. 03/11	report.				

PPF Form  
(May be Expanded as Appropriate)

ANNEX G



PROJECT PERFORMANCE NETWORK

APPENDIX A ( See Section II - Project Description)

NOTES ON A TRAINING PROGRAM FOR REGIONAL, CERCLE, ARRONDISSEMENT AND VILLAGE HEALTH WORKERS.

In addition to the primary on-site apprenticeship training of public health workers at the various levels described, this appendix presents a preliminary outline of more formal educational methods to be utilized in achieving project manpower objectives.

The Problem

Achieving the primary goals and objectives of the project necessitates changing the attitudes, habits and behaviour of villagers with reference to such areas as child nutrition, weaning practices, family planning, sanitation and other health promotive and disease preventive activities.

Effecting behaviour change in such basic areas is difficult. The difficulty is compounded by the fact that AID knows little about the cultural patterns of the diverse Malian communities. Further, training of village health workers has to be conducted in a local language to a group of illiterate or semi-literate people. This poses problems of how to transmit basic skills, knowledge and attitudes without strong reliance on the written word.

To approach a problem of such magnitude, the following are essential:

- cultural sensitivities and knowledge
- selection of individuals as trainers and trainees with sensitivity and demonstrated skill in working with people;
- assessment of present behaviour patterns of villagers relating to health and disease and of reinforcements operating in the society;
- assessment of the state of the art in training illiterate population in health matters. Existing bibliographic materials include:

1. literature on training illiterate populations in health matters;
2. manuals and audio-visual materials for training such populations;
3. methods for evaluating education programs including illiterates.

### Goals

The overall goals of the training program are to train project personnel in the development/design, implementation and evaluation of village level health workers.

### Population to be trained

The population to be trained include:

1. a cadre of public health workers who also operate as trainers: regional, cercle, and arrondissement health workers, nurses, midwives and auxiliary nurses, with approximately 6-9 years of elementary education and 3 years of health training.
2. Trainees: a group of illiterate or semi-literate village workers to serve as health educators and providers of simple primary and preventive medicine to their village community.

### Instructional Situation

Trainers, 7-10, will receive training at the regional or cercle levels. Facilities will be simple. Electricity may or may not be available. Training will be carried out in French or local language.

Trainees, 50, will be trained at the arrondissement level, in a simple village setting. No electricity is available. Training will be conducted primarily in the local language, and in part in French.

## Responsibilities

### Health Workers with Training Responsibilities:

1. Plan and implement a community diagnosis including health status assessment, assessment of social, cultural and behavioural patterns of the community;
2. Evaluate data from the community diagnosis;  
plan, implement and evaluate a course of studies for village health workers;
4. select candidates as village health workers;
5. monitor village health workers;
6. evaluate changes in health status and in village health worker performance as well as changes in village health worker knowledge, skills and attitude before and after instruction;
7. revise instructional program on basis of teaching experience. Devise a replicable instruction program.

### Village Health Workers:

1. deliver health education to villagers in areas of nutrition, maternal and child health, family planning, and disease prevention;
2. implement preventive programs;
3. perform simple clinical procedures (see list of tasks and functions of village level workers in Section II).

Terminal competencies (End of First Formal instruction Period) - will be followed by programs of on-site continuing education.

Health Workers/Trainers:

1. Community Diagnosis: Given a case study is able to perform diagnosis as in responsibility No. 1 above.
  2. Evaluation: Given same case history is able to select, implement and analyse evaluation data from community diagnosis.
  3. Plan, implement and evaluate course: Given data from his arrondissement, is able to plan course of studies relevant to the health needs of villagers, especially mothers and children.
  4. Student Selection: Given data from his arrondissement, is able to select and defend selection procedures.
  5. Monitors village health workers: Given a case study is able to plan and implement a method for monitoring a health project involving villagers in a rural setting.
  6. Evaluate change in health status and trainee performance overtime: Given a case study is able to plan such an evaluation.
- Village Health Workers Terminal Competencies (end of first formal instruction period - will be followed by programs of on-site continuing education: same as Responsibilities (see p. 3)).

#### Design of Training Program

##### Health Workers/Trainers:

1. Community Diagnosis: Techniques for performing a community diagnosis are taught via discussion and problem solving methods, both written and verbal.  
  
Participants construct instruments to be used in diagnosing their own community and assist with community diagnosis in villages.

2. Evaluate data from community diagnosis: Given written and visual materials case studies and "canned data", participants analysis and evaluate data; they decide whether training is or is not a solution. In cases where training is contra-indicated, they select alternatives to training which may involve administrative solutions or solutions involving planning ways of establishing or maintaining behaviours through rewards or withholding of rewards. They then evaluate data from their own community diagnosis.
3. Plan course of studies for village health workers: Given data analysis from community survey involving their own arrondissement, participants devise training program for village health workers. They utilize non-formal methods of instruction including group discussion, pictures, diagrams, cassettes, flannel boards, cuisinaire rods, (or equivalent), rhymes, games and role plays, etc.
4. Selection of candidates: Students as a group design an instrument (s) and procedures for selecting candidates. They test their instruments and procedures on "fake" applicants who have been instructed to play a given role. They refine their methodology. Then they select candidates for their own arrondissement.
5. Monitoring health workers: Students learn procedures for monitoring. They develop a monitoring plan for own set of villages.
6. Evaluate changes in health status, performance of workers and in knowledge, skills, and attitudes: Learns evaluation skills as they relate to the program. Given a set of dummy data, participants prepare and interpret a report on the changes in health status and the other variables.

7. Revise training programs for village health workers on basis of evaluation data and a design replicable instruction program.

**Trainees:**

1. Health Education: Given set of health education skills, instructor demonstrates ways of delivering such an education program by teaching the animatrices in the same manner as he would ask them to teach the villagers. The instructor observes the students teaching each other and later teaching a villager(s) under supervision.
2. Implement preventive program: Given set preventive skills, students discuss ways of performing and implementing these. In cases where skills (i.e; inoculation, preparation of weaning foods, etc are involved, students practice performing the skill.
3. Simple clinical procedures: Students learn to perform these skills by watching the instructor, then performing each procedure under supervision.

Continuing on-site education for rural health personnel

The health personnel (from Infirmiers d'Etat through auxilliaires mid-wives and matrones rurales) working in pilot zone, cercle and arrondissement levels will be given continuing/periodic retraining in areas of health promotive, disease prevention, and basic curative medicine and in planning and administration of local health programs. Such training is important to integrate these workers into the rural public health system activities.

~~Use~~ . Use of the pilot areas as sites for continuing education under field conditions will permit:

- a) on-going re-cycling of pilot zone personnel at periodic intervals
- b) field bases for more appropriate education for the national health training institutions

- c) generation of information and experience to feed into the formal curriculum at those national-level training institutions.

In addition to the "continuous" apprenticeship training of pilot area workers especially village health workers as they implement and refine the project activities, the project envisages annual or biennial refresher courses of approximately 1 week in duration. These courses will also serve as an evaluation of the training process itself; this knowledge can then be fed back into the succeeding training programs.

It must be emphasized, however, that the most important (qualitatively and quantitatively) training of the village health workers will involve practical, on-site (village), apprenticeship activities.

TRAINING OF HEALTH PERSONNEL IN THE UNITED STATES

<u>Degree/Subject</u>	<u>Qualification level</u>
1. MPH in Health Planning and Administration	(MD or R.N.)
2. MPH in Biostatistics/Epidemiology	(MD or R.N.)
3. MSc or MBA in Health Services Administration	(Pharmacist)
4. MSc in Health Education	(R.N.)
5. "MSc" in Health Services Pedagogy	(R.N. or MD)

All of the above are one-year degree programs for implementation during years 02-03 of the project. Trained personnel would return to key MOH positions directly relevant to rural health planning and administration.

Short-term training will be determined according to needs analysis as the project progresses, and likely two/three-months, non-degree programs in the United States for senior-level MOH officials are:

Health Policy and Management (Harvard)

Health Planning (John Hopkins)

UNITED STATES GOVERNMENT

# Memorandum

TO : Distribution

DATE: 3/11/80.

FROM : USAID/MALI/PROG, H. Vaitaitis *HV*

SUBJECT: 688-0208, Rural Health Services, Grant Agreement Amendment No.4.

Subject Agreement, which provides incremental funding of \$260,000, is forwarded herewith for your files.

Distribution:

USAID/MALI

Director

Program Office (2 signed)  
Technical Division Office Files (2)  
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AFR/SFWA - L. Hillson (1) *Werlin*  
AFR/DR/SFWAP - Edmund Sullivan (2)  
DS/DIU/DI (2)



QUATRIEME AMENDEMENT  
A L'ACCORD DE SUBVENTION DU PROJET  
ENTRE  
LE GOUVERNEMENT DE LA REPUBLIQUE DU MALI  
ET  
LES ETATS-UNIS D'AMERIQUE  
POUR  
LE DEVELOPPEMENT DES SERVICES DE SANTE RURALE

In Date du: 10 MAI 1980

No. du Projet: 688-0208

Affectation: 72-11X1012

Allocation : 812-50-688-00-69-01

Année Fiscale: 1980

Subventions Antérieures:

Année Fiscale 1977: 450.000\$

Année Fiscale 1978: 735.000\$

Année Fiscale 1979: 1.115.000\$

L'Accord de Subvention du Projet pour le Développement des Services de Santé Rurale en date du 13 Mai 1977, tel qu'il a été amendé ("l'Accord"), est amendé de nouveau en vue de fournir une augmentation de DEUX CENT SOIXANTE MILLE Dollars des Etats-Unis (260.000\$U.S.) et d'apporter d'autres changements comme suit:

1. Dans l'Article 3, Section 3.1., le Premier Paragraphe est amendé par la suppression de "DEUX MILLIONS TROIS CENT MILLE dollars des Etats-Unis (2.300.000\$ U.S.)" et par son remplacement "DEUX MILLIONS CINQ CENT SOIXANTE MILLE dollars des Etats-Unis (2.560.000\$U.S.)".

2. Substituer à l'Attachement I à l'Annexe I de l'Accord le Plan Financier ci-joint.

FOURTH AMENDMENT  
TO THE PROJECT GRANT AGREEMENT  
BETWEEN  
THE GOVERNMENT OF THE REPUBLIC OF MALI  
AND  
THE UNITED STATES OF AMERICA  
FOR  
RURAL HEALTH SERVICES DEVELOPMENT

Dated: MAY 10 1980

Project Number: 688-0208

Appropriation: 72-11X1012

Allotment : 812-50-688-00-69-01

Fiscal Year : 1980

Previous Grants:

Fiscal Year 1977: \$450,000

Fiscal Year 1978: \$735,000

Fiscal Year 1979: \$1,115,000

The Project Grant Agreement for Rural Health Services Development dated May 13, 1977, as amended ("Agreement") is further amended to provide an increase of TWO HUNDRED SIXTY THOUSAND Dollars (U.S.\$260,000) and to make other changes as follows:

1. In Article 3, Section 3.1., in the First Paragraph, delete "TWO MILLION THREE HUNDRED THOUSAND dollars (U.S.\$2,300,000)" and substitute in lieu thereof "TWO MILLION FIVE HUNDRED SIXTY THOUSAND dollars (U.S.\$2,560,000)".

2. Substitute for Attachment I of the Grant Agreement the attached Financial Plan.

2. Sauf en ce qui concerne les amendements spécifiques apportés par le présent document, l'accord reste en stricte application.

3. EN FOI DE QUOI, le Gouvernement de la République du Mali et les Etats-Unis d'Amérique, chacun agissant par l'intermédiaire de son représentant dûment autorisé, ont fait signer ce Quatrième Amendement en leur nom et l'ont fait publier à la date de l'année susmentionnée.

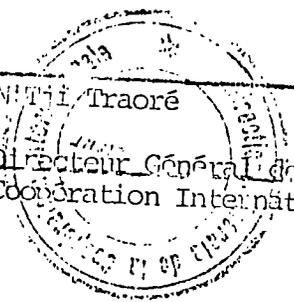
3. Except as specifically amended hereby, the Agreement remains in full force and effect.

IN WITNESS WHEREOF, the Government of the Republic of Mali and the United States of America, each acting through its duly authorized representative, have caused this Fourth Amendment to be signed in their names and delivered as of the day and year above written.

GOVERNEMENT DE LA REPUBLIQUE DU MALI

N'Ni Traoré

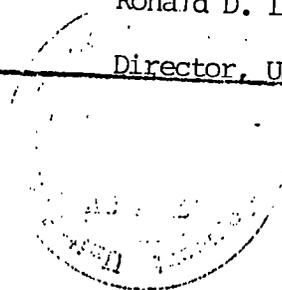
Directeur Général de la  
Coopération Internationale, p.i.



THE UNITED STATES OF AMERICA

By : Ronald D. Levin

Title: Director, USAID



PLAN FINANCIER DU PROJET  
 PROJECT FINANCIAL PLAN

Montant (en milliers de dollars)  
 Amount (\$000)

Apports au Projet Project Inputs	Jusqu'au 30 Septembre 1979, Révisé Through <u>September 1979, Revised</u>		Année Fiscale 1980 <u>Fiscal Year 1980</u>		Total à ce jour <u>Total to date</u>	
	A.I.D.	Bénéficiaire	A.I.D.	Bénéficiaire	A.I.D.	Bénéficiaire
1. Assistance Technique Technical Assistance	1.278	-	-	-	1.278	-
2. Formation des Participants Participant Training	35	-	40	-	75	-
3. Biens d'Équipement Commodities	485	-	-	-	485	-
4. Autres Coûts Other Costs	297	462	150	185	447	647
5. Frais Imprévus/Inflation Contingency/Inflation	<u>205</u>	<u>-</u>	<u>70</u>	<u>-</u>	<u>275</u>	<u>-</u>
<b>TOTAL</b>	<u>2.300</u>	<u>462</u>	<u>260</u>	<u>185</u>	<u>2.560</u>	<u>647</u>

a/ Cette rubrique peut s'appliquer pour les augmentations de coûts imprévus dans les Articles 1-4 pour les montants n'excédant pas 20% du montant déjà alloué à la rubrique en cours d'augmentation suivant accord entre les Parties.

a/ This line item may be applied against unforeseen cost increases in items 1 through 4 in amounts not to exceed 20% of the amount already budgeted for the line item being increased and subject to written agreement between the Parties.

RFP

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I. PROGRAM DESCRIPTION

Mali - Rural Health Development Project No. 688-11-590-208

A. Scope of Work

1. General

This project is to provide to the Government of Mali (GOM), technical assistance in training and upgrading of Malian auxiliary health personnel and in the development of significantly more effective rural system, with emphasis on health promotion and disease prevention at the peripheral (village) level, improved supervision at all levels and logistical organizations to support these services at all governmental levels.

Intergration of the rural health activities with other sectors such as agricultural production and basic education will be emphasized.

2. Specific

a. The specific objectives of this project are to:

-design implement and evaluate a demonstration rural health system -- which will:

(a) bring health services to the village level, emphasizing health promotive and disease prevention.

(b) be intergrated with other community and economic development activities such as agricultural production and education.

(c) have an operational cost of \$200 U.S. or less per capita.

(d) promote responsibility and authority for health services in the community, or as close to it, geographically and culturally, as possible, to improve the health status of the majority of the population, with necessary linkages and support from the overall health delivery system.

-encourage GOM adaption of the demonstration project as the basis for a national rural health system and promote implementation of the project.

-conduct manpower recruitment, training and development for GOM personnel at various levels within the demonstration zone.

-develop and promote logistic lines, supplies and equipment at all levels within the demonstration zone.

-develop annual health budgets which emphasize rural health service systems shown to be cost effective.

b. The technicians provided by the contractor will be responsible for:

- assisting and advising senior GOM health officials in developing improved health services for the rural poor and the creation of an appropriate organizational structure
- advising the GOM in health planning and health management
- assisting GOM in a demonstration project as the basis for a national rural health system and assist the MOH in adequate implementation of the project.

- identifying candidates for training at all levels and assist in training programs.
- advising GOM in the selection and purchase of commodities related to the project.

c. Position description of U.S. technician - Annex A.

B. Reports

1. Quarterly progress reports will be submitted by the Contractor to AID/Washington, AFR/SFWA/Mali (3 copies) and the USAID/Mali Project Manager (9 copies) within 30 days after the end of each period.
2. Monthly and annual reports will be submitted by the Contractor to the USAID/Mali Project Manager (3 copies) within 10 days after the end of such periods.
3. The Contractor will also prepare an annual report summarizing problems and progress made to accomplish project objectives. Distribution same as paragraph 1 above.
4. The Contractor will submit to the USAID/Mali Controller a monthly report (1 copy) of cumulative actual expenditures in the same line item detail as the contract budget. The monthly report will also show accruals - expenses which have been incurred but not yet billed to AID.

C. Personnel

1. The Contractor will bear full responsibility for adequate staffing to meet contract objectives. The A.I.D. estimate of team composition and estimated duration of assignment for the first 18 months of the contract are set forth below:

<u>Position</u>	<u>Number</u>	<u>Man-Months in Location</u>
Public Health Physician (team leader)	1	18
Public Health Planners	2	18
Public Health Advisors	2	18
Short term Consultants	various	10
Campus Coordinator (½ time)	1	5 (in U.S.)

2. Specific qualifications and/or experience preferred for project technicians (U.S.)

a. Public Health physician (team leader)

-should possess a MD degree from an approved medical school, and a MPH degree or its equivalent.

-should have had experience in rural health delivery service. in rural LDC's, preferrably in Africa.

-should have experience in program development.

-should be fluent in French.

b. Public Health Planner

-should possess a MPH degree or its equivalent from an approved school.

-should have experience in rural health planning and development.

-should be able to counter-part MOH personnel on a regional level (supervisory)

-should be fluent in French.

c. Public Health Advisors

-should have a B.S. degree from an approved school in one of the biological science, preferrably a MPH degree.

-should have experience in rural health, preferrably in LDC's and/or in Africa.

-should be able to function with counter-parts on district level or below.

-should be adaptable to rural, village life and work.

-should speak French fluent.

d. Consultants - Various experts in Rural Health Delivery Services to provide short-term consultation to the project staff and host government as needed.

3. The offeror may propose alternative team composition and duration of assignment.

D. Estimated Term of Contract

Funds are available for the first 18 months of this contract. It is

estimated that the project will be completed in 1980. In the preparation of the cost proposal, only estimated costs for the first 18 months of the contract should be reflected.

E. Logistic Support

1. One local secretary will be funded under the contract and all other secretarial assistance will be provided by MOH.
2. The Cooperating Country will furnish the Contractor with office space, office equipment and supplies and in-country transportation.
3. The contractor will provide its employees with full support, including, but not limited to housing, maintenance and utilities, and equipment.

F. Miscellaneous

1. Dependents will be permitted to accompany contractor employees.
2. Contractor employees will be entitled to duty free privileges.
3. Contractor employees will not receive APO privileges.
4. Contractor employees will not receive U.S. Government sponsored health care.

MALI RURAL HEALTH SERVICES DEVELOPMENTPOSITION DESCRIPTIONS: U.S. Technical Assistance Personnel1. PUBLIC HEALTH PHYSICIAN (TEAM LEADER) (3/3)

- A. Based in Bamako at Ministry of Health; Counterpart to Director of Health Services or his Deputy.
- B. Coordinates all aspects of project development, including planning, implementation and evaluation, and project administration in Mali.
- C. Provides liaison among contract team in Mali, contract University in U.S., USAID-Mali, Ministry of Health, Ministry of Rural Development, Ministry of Education and other Malian entities.
- D. Supervises and monitors channeling of USAID and GOM central resources into project demonstration Regions, as appropriate, including funds, personnel, training, equipment, and medicines.
- E. Works to achieve integration into national level programs of "results" of demonstration zone activities for replication/expansion elsewhere in Mali.
- F. Acts as back-up and supervisor for other contract technicians (based in demonstration zones) who will have primary responsibility for technical supervision and administration of Arrondissement-level and village-level personnel and operations.
- G. Ensures development of viable and reliable commodity (medicines, etc.) management system extending from MOH to demonstration and comparison zones.

2. Regional PUBLIC HEALTH PLANNER (Contract-Funded; two for life of project)

- A. Based in capital of Region.

- B. Coordinates all aspects of project in Region, extending out to the village-level.
  - C. Provides liaison among Region's project personnel, Regional Director of Rural Development, and Regional Director of Public Health (counterpart).
  - D. Ensures timely distribution of project equipment, supplies, and medicines.
  - E. Coordinates and designs implementation and evaluation of training programs, community diagnosis study and health education programs for demonstration zones within Region.
3. PUBLIC HEALTH ADVISOR ) (Contract-Funded; three for life of project)
- A. Resides in Cercle capital in demonstration zone, with much time spent in Arrondissement villages.
  - B. Responsible for design and implementation of project within demonstration zone at Cercle, Arrondissement, and village levels.
  - C. Supervises Arrondissement-level workers (U.S. Technicians and Malian personnel) at Arrondissement and village levels.
  - D. Assists in conducting health worker training programs and in designing, conducting and evaluating community diagnosis studies.
  - E. Ensures appropriate distribution and control of equipment, supplies and medicines throughout Cercle, with particular emphasis on Demonstration Arrondissement.
  - F. Works to achieve coordination of project activities with activities of Opération and/or other directly production-oriented economic development activities in the demonstration zone.
  - G. MOH Counterpart at Cercle level.

## II. TECHNICAL EVALUATION CRITERIA

The following are the technical evaluation criteria, including the relative weights, that will be used in evaluating all proposals submitted in response to this solicitation:

<u>Technical Evaluation Criteria</u>	<u>Weight</u>
(1) <u>General Quality and Responsiveness of Proposal</u>	
(a.) Completeness and Thoroughness	
(b.) Responsiveness to All Terms and Conditions	
(c.) Acceptability of Proposed Contract Format	
	<u>10</u>
(2) <u>Organization, Personnel, and Facilities</u>	
(a.) Evidence of Good Organization and Management Practice (5)	
(b.) Record of Past Performance (5)	
(c.) Qualifications and Availability of Personnel	
(c-1) Specialists experienced in general development problems (10)	
(c-2) Specialists with relevant A.I.D. experience in development problems of less developed African countries (20)	
(c-3) Specialists with relevant professional experience in areas related to this specific project, including demonstrated capability in rural health manpower training and development (10)	
(c-4) Specialists with relevant professional education and training background for this specific project (10)	
(c-5) Demonstrated experience and familiarity of the offerer (firm and specialists) of A.I.D. priority areas in health and development (10)	
(c-6) Specialist fluent in French (S-3,R-3 level or above (10)	
(3) <u>Technical Approach</u>	
(a.) Understanding of Project	
(b.) Proposed Work Plan	
(c.) Staffing Pattern	
	<u>70</u>
<b>T O T A L</b>	<u>20</u> <u>100</u>

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## ACTION MEMORANDUM FOR THE ADMINISTRATOR

THRU : ES  
FROM : AA/PPC, Philip Birnbaum  
SUBJECT : Proposed Project: Mali Rural Health (688-0208)

*part in CP info*

Problem: To approve life of project funding in the form of a \$3,890,000 technical assistance grant. In addition two waivers are requested for (a) vehicle procurement and (b) 25% host country contribution as required in Section 110 (a) of the Foreign Assistance Act.

Discussion: The proposed project is designed to introduce, on a pilot basis, low cost rural health services in selected areas of Mali. The project is responsive to the concerns of the Congressional Mandate as it attempts to upgrade the quality of life of the rural population in the pilot areas by delivering health services not now available. The project is also responsive to the Mali DAP which recommended AID involvement in rural health activities.

The project, which has been developed on a collaborative basis with Government of Mali health authorities includes the following elements:

(a) Effective distribution of basic health services (emphasizing health promotion and disease prevention) at the most peripheral level of social organization, i.e. the village. Improved supervision to support **these services** will be organized at appropriate levels between the national and village levels.

(b) Integration of rural health activities described above with rural community development initiatives taking place in existing agriculture and livestock production activities.

(c) Demonstration that such health services can be delivered at an annual per capita cost of \$3, of which \$1 would be retrieved by the Government of Mali from revenue derived from the sale of medicines in the project areas.

The direct beneficiaries of the pilot project will include 80,000 rural villagers in four selected areas of Mali, who will receive health care services valued at \$3 per year in contrast to present services not exceeding 50 cents a year. Selected villagers will receive training which will enable them to be health delivery agents at the village level. The beneficiaries include the strengthened supervisory levels between the village and national levels as well as the Government of Mali itself which may be presented with the workable low cost rural health delivery system ready for replication.

The present technical assistance grant will provide a total of \$3,890,000 in AID funds over the life of this pilot project. The funding by year is as follows:

FY 1977	\$ 460,000
FY 1978	1,126,000
FY 1979	1,415,000
FY 1980	<u>889,000</u>
	\$3,890,000

The project agreement will contain a Malian counterpart contribution of \$870,500 (18% of total project) which consists primarily of personnel costs and present level medical supply costs.

On November 17, 1976 the Africa Bureau Executive Committee for Project Review (ECPR) met to consider the subject project. The general finding of the ECPR was that the project was sound and should be authorized for initial funding in FY 1977. In addition, the following points were critically examined during the ECPR review and appraisal of the project.

1. Financial Control within the Project. The ECPR recommended that the \$1 being retrieved from the sale of medicines by the Government of Mali (see discussion item c.) be utilized primarily to assure efficient implementation of the pilot project with any remaining funds being retained for replication. In regard to medicine procurement a CP will be incorporated into the ProAg to assure that an acceptable plan for equitable distribution has been agreed upon prior to ordering medicines.

2. Family Planning. The ECPR and PHA/POP accepted the recommendation in the PP that no population funds be programmed for the first year of the project. It is agreed that a family planning expert will be involved in collaborating with the Government of Mali health officials during the first year of the project to determine appropriate family planning interventions for introduction into the rural scene.

3. Procurement. The project requires a procurement source waiver from AID Geographic Code 000 (U.S.) to Geographic Code 935 for the following vehicles:

7 Landrovers (incl. 10% spare parts)	\$ 77,000
30 Mobylettes	<u>13,500</u>
	\$ 90,500

A full justification for this waiver is found on pages 1-3 of the Project Paper.

4. Host Country Contribution. The project will receive only 18% of its funding in cash <sup>and</sup> ~~of~~ kind from Malian sources. This does not conform with the requirements of Section 110 (a) of the Foreign Assistance Act, but does in fact reflect a strong commitment by the Government of Mali which is rated by 1974 IBRD statistics to be the poorest country in Africa. It was recommended by the ECPR that the 25% host country contribution be waived.

5. Finally; the technical, economic, social, financial and environmental aspects were reviewed by the ECPR and found to be satisfactory.

Recommendations

1. That by your signature below, you approve the entire proposed grant project (\$3,890,000) for its proposed life (FY 1977-80).

APPROVED \_\_\_\_\_

DISAPPROVED \_\_\_\_\_

DATE \_\_\_\_\_

2. That you authorize Code 935 procurement of motor vehicles in the amount of \$90,500 as described in pages 1-3 of the Project Paper.

APPROVED \_\_\_\_\_

DISAPPROVED \_\_\_\_\_

DATE \_\_\_\_\_

5. That you waive the requirement of 25% host country contribution to the project as required in Section 110 (a) of the Foreign Assistance Act.

APPROVED \_\_\_\_\_

DISAPPROVED \_\_\_\_\_

DATE \_\_\_\_\_

Clearances:

aFR/DR:JKelly

AFR/DR:JWithers

AFR/SFWA:DShear

AFR/GC:STisa

AFR/DP:CWard

PPC/DPRE:NCohen

GC:GMorgan

SER/FM:TBlacka

AA/AFR:SScott t



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DRAFTED BY AFR/DR:JHEARD:GH  
APPROVED BY AFR/DR:JWITHERS  
AFR/DR:JKELLY  
AFR/DR:JGRAHAM  
AFR/DR:CWITTEN  
AFR/DR:LHILLSON  
AFR/SFWA:HGRAY  
AFR/GC:STISA  
PPC/DPRE:JWELTY  
AFR/DP:WTATE AFR/DR:SKLEIN

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F.O. 11652:N/A

TAGS:

SUBJECT: MALI RURAL HEALTH ECPR REVIEW

REF: BAMAKO 4160

1. SUBJECT REVIEW WAS HELD 17 NOVEMBER WITH OVERALL POSITIVE FINDINGS. ACTION MEMO TO A/AID FOR PROJECT APPROVAL TOGETHER WITH FINALIZED PPWILL BE PROCESSED ASAP.

2. SPECIFIC FINDINGS AND GUIDANCE FROM REVIEW ARE AS

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PAGE 02

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FOI LONS:

A. VILLAGE HEALTH - NON-PAYMENT: ECPR RECOMMENDED "EXPRESSION OF CONCERN" THAT THUS FAR LOCAL MECHANISMS FOR COMPENSATION ARE NOT WORKED OUT. THIS ELEMENT SHOULD RECEIVE PRIORITY AND CONTINUING FOCUS OF CDO AND TECHNICAL ASSISTANCE TEAM. ECPR SEES CONCEPT OF VOLUNTEERS AS ONE WORTH CLOSE STUDY FOR POSSIBLE REPLICATION IN DEVELOPMENT OF SAHEL, IF IT WORKS. EXPERIMENTATION MAY INCLUDE, IF NECESSARY, TESTING DIFFERENT FORMS OF COMPENSATION, IN KIND AND CASH.

B. PROCEEDS FROM SALE OF MEDICAL SUPPLIES: CONSIDERABLE DISCUSSION CENTERED ON BOTH ACCOUNTABILITY AND DESTINATION OF PROCEEDS. RE FORMER, PROAG SHOULD INDICATE THAT SYSTEM FOR ASSURING ACCOUNTABILITY WILL BE DEvised PRIOR TO FIRST DISBURSEMENT FOR COMMODITIES, ALTHOUGH DEGREE WAS LEFT FLEXIBLE, I.E. "STRICT" VS. "ADEQUATE".

RE UTILIZATION OF PROCEEDS, ECPR RECOMMENDED THAT REVENUE GENERATED BE UTILIZED FOR STRENGTHENING OF PROJECT, PREFERABLY IN ZONE WHERE COLLECTED. IN THE UNLIKELY EVENT THAT "EXCESS" RESERVES ACCUMULATE, THESE SHOULD BE EARMARKED FOR RECURRENT COST AFTER PROJECT PERIOD OR REPLICATION AS INDICATED IN PP.

C. DRUG DISTRIBUTION: ECPR RECOMMENDED A CP TO DISBURSEMENT FOR COMMODITIES SHOULD BE AN ACCEPTABLE PLAN FOR EQUITABLE DISTRIBUTION, AND CONTROL OF AID SUPPLIED MEDICINES.

D. FAMILY PLANNING: THE ECPR AND PHA/POP ACCEPTED RECOMMENDATION THAT NO POPULATION FUNDS BE PROGRAMMED FOR FIRST YEAR OF PROJECT. ECPR ALSO ACCEPTED PHA/POP RECOMMENDATION THAT FAMILY PLANNING EXPERT BE INCLUDED ON TEAM FOR FIRST ANNUAL EVALUATION. ECPR EXPRESSED CONCERN, HOWEVER, THAT CDO MAKE SERIOUS EFFORTS TO CONVINCe GOM THAT EFFECTIVE FAMILY PLANNING IS ESSENTIAL TO PREVENT POPULATION GROWTH FROM DESTROYING THE PERCENTAGE IMPROVEMENTS IN DEVELOPMENT AND THAT EFFECTIVE FAMILY PLANNING, ALTHOUGH A LOW

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3. ENVIRONMENTAL: PROJECT GIVEN CLEAN BILL OF HEALTH BY AFR/DR ENVIRONMENTAL OFFICE. NEGATIVE DETERMINATION BEING PREPARED.

4. CDO REMINDED THAT ABOVE FINDINGS ARE TENTATIVE PENDING CLEARANCE/INACTON MEMO APPROVAL PROCESS. ROBINSON



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PROCESS MUST BE STATED AT SOME POINT.

F. WAIVER REQUESTS: ECPR RECOMMENDED APPROVAL OF WAIVER REQUESTS FOR COUNTERPART CONTRIBUTION AND VEHICLE PROCUREMENT.

F. FOUR-YEAR LIFE OF PROJECT: ECPR HAD NO PROBLEM WITH THIS, BUT RECOMMENDED THAT COMPLETE EVALUATION OF PROJECT BE CARRIED OUT AT APPROPRIATE TIME DURING THIRD YEAR OF PROJECT, FINDINGS TO BE REVIEWED BY AID/W BEFORE FOURTH YEAR OBLIGATIONS.

G. REPLICABILITY AND RECURRING COST (REFER TO ISSUES MEMO): ECPR ACCEPTED NOTION OF CONTINUING NEED FOR EXTERNAL SUPPORT FOR REPLICATION. OTHER DONORS SHOULD BE ENCOURAGED EARLY IN PROJECT. AID ITSELF SHOULD REMAIN OPEN ON QUESTION OF FOLLOW-UP ASSISTANCE. ALSO, MAGNITUDE OF RECURRING COSTS TO BE ASSUMED EACH YEAR BY GOM DURING I.O.P. AND THEREAFTER SHOULD BE QUANTIFIED AND DISCUSSED WITH GOM AT TIME OF PROAG NEGOTIATION SO GOM WILL HAVE CLEAR UNDERSTANDING OF FISCAL REQUIREMENTS AFTER AID WITHDRAWAL.

H. CUMULATIVE EFFECT OF MULTIPLE PROJECT COST AND LOGISTIC/ADMINISTRATIVE SUPPORT: ECPR ACCEPTED NEED FOR STUDY OF CUMULATIVE EFFECT ON NATIONAL BUDGET AND GOVERNMENTAL APPARATUS OF MULTI-PROJECT HUMAN AND OTHER COST CONSIDERATIONS PLUS INCREASING BURDEN OF TOTAL LOGISTIC, MAINTENANCE, SPARE PART AND ADMINISTRATIVE REQUIREMENTS. THIS IS A PROGRAM RATHER THAN A PROJECT ISSUE, HOWEVER, AND THE FRAME OF REFERENCE AND SCENARIO FOR SUCH ANALYSIS IS LEFT FOR DEFINITION IN THE PROGRAM/DAP CONTEXT.

I. PROPRIETARY PROCUREMENT: REFTEL REQUEST FOR PROPRIETARY PROCUREMENT FOR TECHNICAL ASSISTANCE NOT CONSIDERED PRUDENT BY ECPR DUE SEVERAL CONSIDERATIONS: ANTICIPATED ADVERSE REACTION FROM OTHER POTENTIAL CONTRACTORS, LACK OF PROVEN PREDOMINANT COMPETENCE, NO GUARANTEE THAT SAME TECHNICIANS WOULD BE USED AS THOSE OF EARLIER DESIGN TEAMS, SAVINGS IN TIME NOT SEEN AS THAT GREAT OR IMPORTANT, ETC.

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UNITED STATES GOVERNMENT

# Memorandum

6880208 (8)  
PD-AAC-192

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TO : SEE DISTRIBUTION

DATE: May 20, 1976

FROM : Review Committee

SUBJECT: ECPR Issues Paper on Mali Rural Health Services Development

The attached PRP has been reviewed by AID/W technical offices and the American Public Health Association. Based on these reviews and written recommendations to AFR/DR for further project design, the following issues emerge for consideration by the ECPR:

A. Issues

1. Health Training

Should training programs be limited to health personnel directly involved in the project zones or should other Malian health workers receive such training?

2. Coverage

Should test zones be expanded to give full health services coverage to a greater portion of the rural population, with a concomitant increase in project costs, and should the concept of "control zones" be retained or eliminated?

3. Nutrition

Should a nutrition analysis, as part of the community diagnosis, be accompanied by corrective/adaptive nutrition training as an integral aspect of the preventive health care and village action programs?

4. Water and Waste Disposal

Should analysis and funding for water/sewerage interventions be provided as an integral project component, i.e. upgrading of existing facilities and creation of new potable water sources/sewage disposal systems?

5. Financing

Should the Financial Analysis section of the current PRP be expanded, or is it sufficient to support this type of project which



is "pilot" in nature? For example, is the proposed cost of \$1.75 per capita, with an additional \$1.00 per capita expenditure by villagers for commercially purchased medicines, really replicable nationally?

B. Guidance for the PP Team (Points to be considered during PP design stage)

1. Training

a. How, where, for how long, and through what facilities will training of village health workers (VHWs) take place? How will VHWs relate to indigenous health personnel? How will collaboration with existing national health training schools and regional health training facilities (e.g. WHO regional African centers) be developed?

b. What GOM plans and facilities exist for periodic upgrading and retraining of Malian health personnel?

2. Coordination of Project Activities with MOH

What will be the two-way flow for decisions, personnel, commodities, etc. between MOH and project areas? What is the appropriate level for the country project director to interact with the MOH? What specific opportunities exist for meaningful coordination between project activities and the work of the Ministry of Rural Development in its agricultural operations?

3. Village Health Workers

Selection, village acceptance, training duties and remuneration of village health workers should be elaborated on.

4. Evaluation

Specific base-line proposals for annual evaluations need to be developed and related to the independent evaluation planned for 2½ years after the commencement of project operations.

C. Recommendation

That AID/W approve subject project after resolution of above issues and issue detailed guidance message for PP design team.

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UNITED STATES GOVERNMENT

# Memorandum

TO : SEE DISTRIBUTION

DATE: May 25, 1976

FROM : AFR/DR, Princeton Lyman 

**FILE COPY**

SUBJECT: Recommendations to Meet Issues Raised for ECPR Review  
 of Mali Rural Health Services Development Project

A. Responses to Issues

1. Coverage

While the PRP, as designed, proposes to set up control zones and pilot demonstration (target) zones, more attention needs to be directed to the logistic, operational and resource problems related to such a model. In addition, the feasibility and/or desirability of consciously restricting health services to population groups must be considered. With this in mind; we should opt for a model in which the individuals in the pilot demonstration zone serve as their own control. In such a model, base-line studies would only be done on new population groups immediately prior to expansion or replication of the model into new areas. The latter appears to be a more feasible model and should result in earlier replication of a debugged

pilot demonstration project, particularly after the first few years of the project. The replication of project-type activities could take place in adjacent zones as projected in the PRP.

2. Health Training

The training component of this project is intended initially to provide a para-medical training program for the workers in pilot demonstration areas. In the future the training program is to be used as a model for training para-medical workers for other areas. As a first step, the PP should address the capacity and needs for training of such health workers for the target areas during PY 01. The PP should also address itself to items such as: the methods and timing for expansion of the training program; the methods and timing for eventual replication of the training program for other areas of the country (after PY 03); the sites of training, both didactic and field; and the potential source and entry levels for trainees. Inasmuch as the training component of this project is one of the activities to strengthen the health delivery system of Mali, the PP should address itself to the approaches to be used to institutionalize this program to serve national training needs. In a similar vein, the PP should address itself to existing capabilities for training of individuals at this level, additional resources needed for this program, and resources needed for a national program of this type.

### 3. Nutrition

The PP should address itself to the needs for nutritional assessments including making this one of the first items of business during PY 01, particularly for the target zones. In addition, guidelines for community-level nutritional analyses should be designed into the project as part of the community diagnosis, the health care package, and the curriculum for the health manpower training and public school programs. Nutritional education for the populations in the target areas should also be addressed.

### 4. Water and Waste Disposal

In addition to the interim message on water and sanitation provided in the health care package taught to villagers, the short-term services of a hydrologist/sanitation expert will be required during PY 01 to develop a profile of the needs, costs and action plan to improve village water and waste disposal facilities for all test zone villages. The PP should earmark \$100,000 in FY 77 funds for water/sanitation studies of potable water supply and improvement of environmental sanitation (low-cost improvement and construction of facilities in test zones during PYs 02 and 03). The PP should discuss GOM's current capacity, including assistance from other donors, in this regard (well improvement/sanitation facilities, equipment and trained personnel and GOM budget) both for project needs and for MOH replication in subsequent years. Any subsequent A.I.D. support to this component would be subject to a PP amendment.

### 5. Financial Analysis

The PRP analysis should be expanded to include MOH budget and personnel analyses, including projections for financing of training, personnel and commodities for project zones. (This latter analysis will prepare the MOH planning unit for an appreciation of the costs and interventions required for eventual replication of the program in other parts of the country.) With respect to the assumption that villagers will spend \$1.00/capita/year on medicines, the PP analysis should provide verification based on current experience in Mali and data on expenditures on medicines by rural populations in similar situations in other developing countries.

### 6. Family Planning (Not an "Issue" in "ECPR Issues Paper")

The PP should clearly set out what the current GOM policy is in family planning and particularly its program, views and acceptance of family planning commodities. The PP should state how and what family planning and MCH activities will be integrated into the project's health care package, consistent with the evolving GOM family planning policy. This analysis should include requirements for FP/MCH consultant services as well as anticipated commodity requirements during PYs 01-03. PHA/POP should explore prior to final PP design whether Types "A" and "B" maternity kits are eligible for financing under the \$35,000 in Title X funds earmarked for commodities in FY 1977.

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ACTION AID-31

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EO 11652: N/A  
SUBJ: MALI RURAL HEALTH DEVELOPMENT-OTHER DONOR  
COORDINATION.

REF: (A) BAMAKO 962, (B) STATE 111037

1. INFORMATION ON OTHER DONOR ACTIVITIES IN THE HEALTH  
SECTOR RECEIVED BY CDO ON MAY 5. THIS CABLE IS CDO  
SYNTHESIS OF INFO RECEIVED. PLEASE INCLUDE SUBSTANCE AS  
SECTION IV OF SUBJECT PRP.

2. HAN 1974-75, DONORS MADE MAJOR CONTRIBUTIONS TO THE  
HEALTH SECTOR. THE CASH CONTRIBUTIONS WERE ESTIMATED TO  
BE APPROXIMATELY \$3.5 MILLION WHICH IS MORE THAN HALF OF  
THE ANNUAL \$6.0 GOM HEALTH BUDGET. APPROXIMATELY 50  
PHYSICIANS OR 40PERCENT OF THE PHYSICIANS IN COUNTRY ARE  
PROVIDED UNDER DONOR ASSISTANCE PROGRAMS. WHILE THERE  
IS VERY LITTLE COORDINATION AMONG DONORS, HEALTH  
ASSISTANCE PROJECTS ARE FOUND IN EVERY REGION OF THE  
COUNTRY. THERE IS NO DUPLICATION OF EFFORT BECAUSE OF  
MALI'S OVERWHELMING NEED AND DEPENDENCE ON ASSISTANCE.  
DONORS CHOOSE PROJECTS FROM A GOM SHOPPING LIST OF  
PRIORITY WITHIN THE SECTOR OR MAY DEVELOP THEIR OWN

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AGENCY FOR INTERNATIONAL DEVELOPMENT <b>PROJECT REVIEW PAPER FACESHEET.</b> TO BE COMPLETED BY ORIGINATING OFFICE		<b>1. TRANSACTION CODE</b> ("X" appropriate box) <input checked="" type="checkbox"/> Original <input type="checkbox"/> Change <input type="checkbox"/> Add <input type="checkbox"/> Delete	<b>PRP</b> <hr/> <b>DOCUMENT CODE</b> 2
<b>2. COUNTRY/ENTITY</b> MALI		<b>3. DOCUMENT REVISION NUMBER</b>	
<b>4. PROJECT NUMBER</b> 688-11-520-208	<b>5. BUREAU</b> a. Symbol: AFR    b. Code:	<b>6. PROPOSED PP SUBMISSION DATE</b> mo. yr.    04   76	
<b>7. PROJECT TITLE - SHORT (stay within brackets)</b> Rural Health Services Development <input type="checkbox"/>		<b>8. ESTIMATED FY OF AUTHORIZATION/CBLIGATION</b> a. INITIAL FY: 78    b. FINAL FY: 80	

**9. ESTIMATED TOTAL COST (\$000 or equivalent, \$1 = )**

a. FUNDING SOURCE	FIRST YEAR FY 10			ALL YEARS		
	b. FX	c. L/C	d. Total	e. FX	f. L/C	g. Total
AID APPROPRIATED TOTAL	500		500	4,691		4,691
(Grant)	( 500 )	( )	( 500 )	( 4,691 )	( )	( 4,691 )
(Loan)	( )	( )	( )	( )	( )	( )
Other 1.						
U.S. 2.						
HOST GOVERNMENT		73	73		1,190	1,190
OTHER DONOR(S)						
<b>TOTALS</b>	<b>500</b>	<b>73</b>	<b>573</b>	<b>4,691</b>	<b>1,190</b>	<b>5,881</b>

**10. ESTIMATED COSTS/AID APPROPRIATED FUNDS (\$000)**

a. Appropriation (Alpha Code)	b. Primary Purpose Code	c. Primary Tech. Code	FY 10		FY 77		FY 78		ALL YEARS	
			d. Grant	e. Loan	f. Grant	g. Loan	h. Grant	i. Loan	j. Grant	k. Loan
PI		590	500		750		1,313		4,491	
	Title X				200		-		200	
<b>TOTALS</b>			<b>500</b>		<b>950</b>		<b>1,313</b>		<b>4,691</b>	

**11. PROJECT PURPOSE(S) (stay within brackets)**     Check if different from PID

To assist the GOM in developing a low-cost health delivery system to meet the needs of the rural poor who comprise over 90% of Mali's population.

**12. WERE CHANGES MADE IN PID FACESHEET DATA, BLOCKS 12, 13, 14, or 15? IF YES, ATTACH CHANGED PID FACESHEET.**

Yes     No

**13. PLANNING RESOURCE REQUIREMENTS (staff/funds)**

<b>14. ORIGINATING OFFICE CLEARANCE</b> Signature: <i>Ronald J. Deitz</i> Title: Country Development Officer		<b>15. Date Received in AID/W. or For AID/W Documents, Date of Distribution</b> Date Signed: mo. day yr.    12   16   76
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UNITED STATES GOVERNMENT

# Memorandum

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**FILE COPY**

TO : SEE DISTRIBUTION

DATE: November 11, 1976 57

FROM : AFR/DR, John Withers *John Withers*

*John Withers  
27887*

SUBJECT: AFR/Executive Committee (ECPR) Meeting on PP for Rural Health - Mali

The ECPR will meet at 2:30 p.m. on Wednesday, November 17, 1976, in Room 6320 NS to consider issues and other factors bearing on authorization and implementation of the project.

An issues paper is attached for your review prior to the meeting.

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UNITED STATES GOVERNMENT

# Memorandum

TO : The Africa Bureau Executive Committee  
for Project Review (ECPR)

DATE: November 11, 1976

FROM : AFR/DR, John Withers

SUBJECT: Issues Paper for Mali Rural Health PP

## I. General

The subject PP was reviewed by the project committee on September 7, 1976. The general finding was that the project is sound and responsive to the Congressional Mandate as an innovative low-cost approach to development of a host country capacity to reach its most disadvantaged groups with minimal essential health services. The project committee recommends approval of the project subject to resolution of the following issues.

## II. Specific Issues

### A. The Village Health Worker - Non-Payment Issue.

Discussion: The village health worker, a critical action agent in the project, is not to be paid by the project or by the GOM. Local mechanisms for compensation are yet to be worked out, but will probably consist of a combination of revenues from the sale of selected medicines and community support in cash or kind. An equitable system of rewards and controls preventing abuse needs to be developed. The project committee was concerned on both compensation and control issues, especially in relation to the distribution and sale of medicine.

Recommendation: An equitable system of compensation for the Village Health Worker with adequate controls should be developed and built into the Project Agreement (perhaps a type of local revolving fund could be developed - see following issue).

### B. Proceeds from Sale of Medical Supplies.

Discussion: It is proposed that cash generated at the local level, from the sale of medicines, be transmitted to the National Level semi-annually for deposit in a controlled account for use in later project replication, or- if the project is not replicated - for some other mutually agreed health sector use. The project committee



was concerned over the lack of programming for these resources and the fact that they will not be retained at the local level.

Recommendation: The Project Agreement should spell out for what uses these resources will be spent as well as provide for strict accountability for the proceeds of sales and the possibility for retention of funds at the cercle or arrondissement level for the strengthening of the project and related services in the corresponding zone.

C. Drug Distribution.

Discussion: AID-supplied medicines will be channeled to the zones through the MOH to regional and cercle levels. The development of adequate and reliable logistic systems to assure the flow and tracking of the commodities remains to be developed although some ideas are provided in the PP.

Recommendation: The distribution system for drugs should be designed and negotiated with the GOM for inclusion in the project agreement. The system should assure that distribution is fair, equitable and adequately controlled. A periodic commodity reporting system should be included.

D. Family Planning.

Discussion: The project committee, faced with strong opposition from the CDO to incorporation of a family planning element upon initiation of the project, recommended that population funds only be allocated from the second year onward, pending a determination that a family planning component can be legitimately and appropriately built into the project or designed as a complementary activity.

Recommendation: That no population funds be obligated for Mali in FY 77. (PHA/POP has agreed to this.) Subsequent proposed obligations should be reviewed and cleared by the Africa Bureau with clearance from the CDO. Such a determination would be based on the first year evaluation.

E. Waiver for Counterpart Requirement (p. 4 of PP)

Discussion: Based on the assertion, from IBRD statistics, that Mali is the poorest country in the world with extremely limited financial resources to meet the needs of its citizens, a waiver is requested to allow a GOM contribution of 18% of total project cost.

Recommendation: The waiver should be granted.

F. Waiver for Code 935 Procurement of Vehicles (p. 1 of PP)

Discussion: A standard (for the Sahel) Code 935 procurement source waiver is requested for the purchase of seven Landrovers and 30 Mobylettes.

Recommendation: The waiver should be granted.

G. Four-year Length of Project.

Discussion: Given the institution building and innovative nature of this project a four-year life can be strongly supported. Obligations ~~beyond the end of~~<sup>2/16/78</sup> the third year, however, must be based on a thorough evaluation of the effectiveness of the project up to that point.

Recommendation: A complete project evaluation should be scheduled for the end of the third project year (over and above planned surveys, annual comparative evaluations, and monitoring activity.) Findings should be reviewed by AID/W prior to fourth year obligations.

H. Replicability.

Discussion: As this is a "social" rather than an economic or production project, neither a conventional cost/benefit analysis, nor a viability analysis was attempted. Cost is clearly an issue, however, with respect to replicability.

In the case of health, of the 1975 national budget of \$95 million, approximately 10% was destined for the sector, or approximately \$1.70 per capita. The predominant share of this goes to fixed costs of facilities and personnel in the capital city and other urban centers so that the portion reaching rural areas is probably no more than \$.50 per capita. Yet a planning figure of \$2.00 per capita has been set as a reasonable amount for planning health services that can be supplied to the rural population. To provide this amount will require a major reorientation of current expenditures away from high cost, primarily urban facilities (in effect, resource redistribution).

The ultimate success of the project (in terms of selling a concept to the GOM) and its replicability will depend on the demonstration effect of the project of the cost effectiveness and efficacy of a rural-oriented health program of this nature. The project committee, while satisfied as to the cost effectiveness of the project in an absolute sense (approximately \$2.00 per capita effected) was not sanguine concerning replicability and expansion without continuing external assistance.<sup>1/</sup>

Recommendation: That there be a full realization of the need for continuing external inputs if the system is to be expanded. It is recommended that other donor assistance, through the Club des Amis, be encouraged in support of replication once the project approach has been validated.

1/ See page 4.

1/ A corollary to the issue in the context of the Mali country program is that the issue of cost feasibility really needs to be viewed in a larger perspective than just this project. It is possible, for example, in the case of this initiative and a number of others in Mali to show financial feasibility of a discrete activity. It is suspected, however, that if all activities funded by AID and other donors currently and due for implementation over the next few years were to be added up in terms of human, other operating, and capital cost requirements from the GOM, a serious overburdening of the budget would become evident as well as a growing lack of capacity to deliver on counterpart commitments. Given this perspective, it is recommended that an analysis be carried out of current and planned GOM counterpart commitments in terms of human resources, operating costs and investment costs against total available GOM revenues and other programmable resources. Based on the findings of such an analysis AID could tailor planned inputs more realistically and deal more effectively with the cost issue which arises on every new project.