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SAVE THE CHILDREN/US

MALI FIELD OFFICE
CHILD SURVIVAL 8 ANNUAL REPORT FY 1993

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YEAR I

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GLOSSARY

CBA	Child Bearing Age
CDD	Control of Diarrheal Diseases
CS	Child Survival Project
DIP	Detailed Implementation Plan
EPI	Expanded Program for Immunization
FT	Family Trainers
HIS	Health Information System
KAP	Knowledge Attitudes and Practice
MOH	Ministry of Health
NGO	Non Governmental Organization
ORT	Oral Rehydration Therapy
SC	Save the Children
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
UNICEF	United Nations Children Fund
USAID	US Agency for International Development
VHC	Village Health Committees

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I. OVERVIEW OF YEAR ONE

A. Comparison Actual Accomplishments versus Year One Objectives

In general, progress toward end-of-project objectives is satisfactory. In particular, ORT and basic literacy objectives are well ahead of schedule; EPI coverage, slightly below the 55% objective for Year One, should be improving over the next few months because of the resolution of MOH financing difficulties. The following tables give an indication of selected first year results.

Table 1. LITERACY

OBJECTIVES	PERCENT	TARGET NUMBER	TARGET DATE	ACHIEVED TO DATE
Family trainers trained as literacy trainers	80%	35	9/93	100%
VHCs with 1+ literate member	80%	250	9/93	84.3%
VHCs with 1+ literate woman member	80%	250	9/95	34.9%

All the Family Trainers were trained as literacy trainers in FY93. Although 210 VHCs out of 249 (84.3%) now have at least one literate person, 69 VHCs underwent the advanced post-literacy course in order to accomplish the HIS tasks asked of them by the FTs, nurses and supervisors. The FTs carried out the training over a two-week period and grouped VHC members together. There were 147 participants in total of whom 27 were women. 11 FTs ran a training program with the assistance of their supervisors. Major topics were the recording of vital events, ORT use and immunization coverage. The FT together with the VHC is responsible for social mobilization for immunization and also for disease surveillance.

Table 2. MATERNAL AND ADOLESCENT HEALTH

OBJECTIVES	PERCENT	TARGET NUMBER	TARGET DATE	ACHIEVED TO DATE
Villages with 1+ trained TBA	75%	250	9/95	49%
Pregnant women with 2+ prenatal consultations	65%	8000	9/95	23%

The project nurses have been conducting recycling training of the TBAs at the request of the Kolondieba Health Center. They also carry out on-the-job training. The nurses with the TBAs ensure pre- and post-natal consultations in the villages and refer as necessary. It has been decided that the best way to deal with the health of adolescent girls is through the Village Schools.

Other indicators for the maternal and adolescent health component will be measured during the midterm evaluation. These include:

1. Percentage of pregnant women who know how to seek prenatal care
2. Percentage of pregnant women who have a trained TBA or health professional assist at their delivery.
3. Percentage of pregnant women who received one postnatal checkup.
4. Percentage of girls aged 12-19 years who know their nutritional needs and are able to identify practices that ensure their normal physical development
5. Percentage of girls aged 15-19 years who learn protective behaviors for pregnancy and motherhood, with emphasis on safe pregnancy and childbearing, ORT, immunization, and breastfeeding.
6. Percentage of adolescents aged 12-19 years who know 3 methods of STDs and AIDS prevention.

Table 3. IMMUNIZATION

OBJECTIVES	PERCENT	TARGET NUMBER	TARGET DATE	ACHIEVED TO DATE
Children 12-23 mos. completely vaccinated as of 7/93	55%	6000	9/93	50.3%
Women of child bearing age immunized (2 TT)	90%	29,250	7/93	86.1%

The other immunization indicator; percentage of cases diagnosed by FTs, VHCs as measles, neonatal tetanus, or pertussis, who have been reported to the health post and followed up by the MOH, will be measured during the MTE.

Table 4. NUTRITION AND BREASTFEEDING

OBJECTIVES	PERCENT	TARGET NUMBER	TARGET DATE	ACHIEVED TO DATE
Children under 3 yrs. weighed at least quarterly	70%	18,000	9/93	65.2%
Women CBA attending 1+ nutrition demonstrations. (3rd qtr's - Year 1 only)	80%	26,000	9/94	24.2%

The FT VHC are responsible for quarterly weighing and follow-up. Nutrition education and demonstrations are organized by two village "animatrices" who have been trained and are members of the VHC.

Other indicators for the nutrition/breastfeeding components will be measured during the midterm evaluation. These include:
1. Percentage of mothers with severely or moderately malnourished children who attended at least one nutrition demonstration session
2. Percentage of mothers with children <24 months who are competent in the preparation of appropriate weaning foods.
3. Percentage of infants who are exclusively breastfed up to 3 months old, and receive appropriate supplementation from 4 months on.

Table 5. MALARIA PREVENTION

OBJECTIVES	PERCENT	TARGET NUMBER	TARGET DATE	ACHIEVED TO DATE
Women of CBA trained in malaria prevention	65%	26,000	9/95	55.6%

The VHCs are responsible for sensitization and the animatrices emphasize the correct preventive and prophylactic practices during nutrition education and demonstration sessions. The VHCs are responsible for the organization and training.

Other indicators for the malaria component include: Percentage of village pro-pharmacies which have a stock of Chloroquine tablets, and percentage of VHCs which have a reliable supply of tablets in their kits. They will be measured during the midterm evaluation.

Table 6. CONTROL OF DIARRHEAL DISEASES

OBJECTIVES	PERCENT	TARGET NUMBER	TARGET DATE	ACHIEVED TO DATE
Mothers using ORT in the treatment of diarrhea	80%	26,000	9/96	73%

Control of diarrheal diseases is the responsibility of the FT and the VHC. The VHCs are assuming increasing responsibility for the conduct of training sessions and for recording the use of ORT for diarrheal episodes.

Other indicators for the CDD component include: Percentage of mothers who are trained by VHC members in ORT preparation and use, including home available fluids and cereal based ORT; Percentage of women who know the importance of acquiring clean water in a manner that maintains the cleanliness of the well or other sources, and know the importance of applying appropriate sanitation measures.

B. Training

The project completed the following training for project staff:

1. Retraining of all 34 Family Trainers and nurses in family planning and in nutrition. Topics covered included basic information on reproduction, the organization of village animators, the transmission of messages to the villagers, communication techniques, how to use different contraceptive methods (in this case, condoms and spermicides), and management of supplies. In nutrition, topics included the different food groups, seasonal variations, the advantages of breastfeeding (including exclusive breastfeeding), maternal nutrition, the different types of malnutrition, the causes, how to prevent, weaning practices, growth monitoring, organization of a nutrition education and demonstration session, and malaria and its prevention.
2. Training of 3 new Family Trainers and one new nurse in child survival, family planning, malaria control, community development, and Bambara language literacy.
3. Training of SC Assistant Health Coordinator (Dr. Sacko) in Epi-Info, cost-recovery, and implementation and use of SC/Mali health information systems.

SC/Mali held the following workshops to train a number of NGOs involved in health activities. These opportunities permit SC/Mali to increase its staff capability through using them as trainers.

1. Workshop on the importance of non-health interventions in the success of child survival programs (Kolondieba, 10/92, given to 30 NGOs through the NGO health consortium, the "Pivot Group for Health")
2. Workshop on health information systems, given in Bamako in April of 1993.

The project also completed the following training for non-paid village based extension workers, and community members:

1. Training of 69 (28%) VHCs in advanced literacy for health.
2. Training of community members as "animateurs en planning familial" (Village Family Planning Agents)--11 men, 11 women. One man and one woman in each target village were selected for the community base distribution of condoms and spermicides. As well as covering topics such as the transmission of messages and the use of the different methods, these animators were trained in the distribution and management of supplies.
3. Training of "animatrices villageoises en nutrition" (Village Nutrition Trainers, all women) in 114 villages by the SC/M nurse/ nutritionist. Two women from each village are selected to lead nutrition education and demonstrations in their villages. These women are part of the VHC and are trained by the nurse-nutritionist and the family trainers.

C. Technical Support

The project received the following technical assistance for child survival field activities:

SC HQ-based training in the use of Health Information Systems for project assistant coordinator and SC's new computer specialist. Dr. Katherine Kaye of SC's Health Unit and Ken Herman, programmer of the HIS, led the workshop. Professor Sally Findley of Columbia University, a frequent advisor of SC/M, participated with the Mali team.

Training of project's staff by Dr. Michel Pacqué, the representative of the British NGO Sightsavers for the community-based distribution of Ivermectin to combat river blindness.

Technical visits by Family Health International staffer Karen Katz, assisting SC/M with the analysis of the family planning data. SC/Mali is funded by USAID/Bamako to conduct operations research in Family planning. Results and lessons learned from this component will improve the overall delivery of family planning/child spacing services.

CERPOD (the demographic institute of the Institut du Sahel) carried out with project staff a re-census of Kolondieba District, over four weeks in April-May 1993; end of data entry expected by 1 October 1993. This CERPOD/Save the Children re-census acts as an independent check on the quality of SC/Mali HIS data, gives a uniform

census data for subdistricts which had been enrolled in a staggered fashion, and will give a more detailed profile of educational levels and women's fertility history.

D. Village Health Committees

There is a VHC in every one of the 249 villages in the project zone. 90% of the VHCs meet at least once a quarter. There are between 6-8 people in each VHC. Common discussion issues center around the following points.

The work of a newly-established, non-literate VHC includes the following:

(1) organizing and participating in all health discussions in the village
(2) assisting FT in health activities such as growth monitoring, and social mobilization for vaccination; under the supervision of the FT, follow-up with mothers whose children are unvaccinated or underweight
(3) ensuring that all village women of CBA know how to prepare ORT; monitoring the use of ORT for children who have diarrhea
(4) assuring the cleanliness of village well(s) and public spaces
(5) notifying FT of all births, deaths, and migrations in the village
(6) assisting FT in gathering verbal autopsy data
(7) reporting all cases of measles, tetanus, whooping cough to FT or local health officials.
(8) Organization of nutrition education and demonstration sessions

In Year Two of CS8, a strong accent will be put on bringing all VHCs to a level of basic literacy for health (defined as being able to fill out birth, death, and migration rosters). Currently, 84% of VHCs (210 of 249) have at least one literate member, and 35% (87 of 249) have at least one literate woman member. Put another way, 88% of the total population of the zone lives in villages with a VHC with at least one literate member; 45% of the total population lives in villages with a VHC with at least one literate woman member.

The strategy for improving literacy skills is detailed below in section VI.E.2. A basic list of indicators for the functionality of literate VHCs is given in appendix C of the project DIP, "Indicators of Village-Level Self-Management for Health."

In Year Three of CS8, the emphasis will be placed on increasing the utility and functionality of the VHCs' literacy skills, and giving training in more complex tasks and problem-solving. VHCs will, for example, be trained to follow systematically morbidity related to diarrhea and to fever, and to conduct verbal autopsies.

E. Linkages

The following is a description of the project's linkage with MOH and other health and development activities:

1. Ministry of Health: The Minister of Health visited the project zone and commended Save the Children on national television for showing that Mali's poor health indicators "are not an inevitability". The project maintains a close collaboration with the local health center in vaccination, onchocerchosis control, and case referral for high-risk pregnancies and malnutrition.

2. The Dutch government has shown its confidence in SC/M's methodology by inviting us to replicate our child survival approach in a second district of southern Mali starting in 1994.

3. A research group composed of Mali's School of Medicine, the National Institute of Health, and Tulane University has approached SC/M about a five-year collaborative research project in malaria transmission and control; SC/M was selected largely because of the reputation of our health information system.

4. Collaboration continues with CERPOD in demographics studies and the use of the HIS in decision making)

5. SC/Mali works closely with UNICEF in the promotion of the use of vaccination services and the establishment of community-run health centers

6. The project collaborates with Sightsavers in the control of onchocerciasis infection

7. Collaboration with the USAID funded, AED-run (Academy of Educational Development) Nutrition Communication Project continue in using and testing strategies, and educational materials.

8. The NGO health consortium (the "Groupe Pivot/Survie de l'Enfant"), managed by SC/M, has been accepted as a respected partner in all national health policy debates. See also Section VII for a description of the consortium's large new role in coordinating NGO activities in family planning and AIDS prevention in Mali.

F. Professional Health Staff

No professional health staff have joined SC/M since the submission of the DIP. There have been two relevant changes in the overall field office structure since the DIP: (1) Peter Laugham, formerly Deputy Director, has become Director of SC/Mali; Dr. Michelle Poulton, formerly Director of SC/M, is now serving full-time as SC West Africa subregional Director (Mali, Burkina Faso, Gambia, Tunisia, Cameroon); (2)

Mr. Ibrahim Camara has been named SC/M computer specialist, and will devote a significant part of his time to the strengthening of the HIS.

An updated organizational chart is appendix A.

II. CHANGES MADE IN PROGRAM DESIGN

The following is a description of changes made on the project design during Year 1.

A. Measurable Objectives

Growth monitoring objectives have been revised downward to allow for periodic absences of children and for the difficulty of organizing weighings during the rainy season (summer). The new and old objectives for the percentage of all children < 36 months who will be weighed quarterly are:

	Year One	*Year Two*	*Year Three*
New	*65%*	*75%*	*80%*
Old	*70%*	*85%*	*100%*

As before, special efforts will be made to ensure the monthly weighing of all children known to be at risk.

B. Type or Scope of Child Survival Interventions

No major changes. See, however, Section VI of this report for changes made in DIP in the light of reviewer comments.

C. Location or Number of Project Beneficiaries

The only change concerns our approach to adolescent health. We have decided that the most effective way to treat questions of responsible parenthood, child protective behaviors, and AIDS/STD prevention in depth with adolescents is through our Village Schools. These subjects will form part of the second and third year curricula of the Village Schools' three year cycle. Section III c. contains detailed description.

Since the Village Schools are now at their beginning (240 second-year students in 1993-94, and 1,200 first-year students as of November 1993), we will reach the youth/adolescent population more slowly than projected in the proposal and in the DIP, but much more intensively. We estimate that by September 1995, we will have graduated 1,200 second year students (2d yr. curriculum: personal hygiene, nutrition, first aid, ORT, vaccination, and malaria prevention) and 240 third year students (3d yr.

curriculum: responsible parenthood/child spacing, AIDS/STDs, village health management). By the year 2000, we hope to have at least 160 schools in operation, with 3,200 second year and 3,200 third year students per year.

In the meantime, both boys and girls are still encouraged to attend community discussions and training sessions on AIDS and STDs, and adolescent girls are encouraged to continue attending sessions on safe pregnancy and maternal nutrition.

D. Budget

No changes.

III. CONSTRAINTS, UNEXPECTED BENEFITS, AND LESSONS LEARNED

A,B. Constraints and their Resolution:

As mentioned in previous reports, the non-payment of salaries of the EPI nurses by the civil administration has led to their demotivation and lengthening the periods between mobile team visits to outlying villages. However, this constraint has apparently been overcome as the District Administrator has instructed the District Health Officer to pay the EPI nurses out of the health center's revenues (curative receipts). If this arrangement holds firm, we should see a return to vaccination rates among the highest in Mali (+/- 80%). Furthermore, when the proposed decentralization of political power occurs, and local officials become elected rather than appointed, it is likely that their will be a restoration of confidence in local taxation, and the EPI program will overcome this financing problem.

In Bohi, one of the villages of our USAID/Bamako-funded family planning pilot project, traditional leaders have raised questions about the religious acceptability of child spacing. Mme. Fatoumata Kané, our family planning nurse, and Bakary Keita, our literacy coordinator who is also a former nurse, gave reasoned and persuasive responses during community discussions. One previous project serving as a guide for us is SC/Gambia and Population Council's collaboration in enlisting the support of Moslem religious clerics (Imams) in family planning programs. (1)

The existence of traditional, informal child-minded structures in many villages offers another channel for getting health messages across.

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1. The Influence of Village Level Health and Birth Spacing Meetings Conducted by Religious Leaders on Contraceptive Acceptance and Continuation Rates, April 1992

C. Unexpected Benefits

In a dramatic reversal of previous MOH policy, the Malian government has approved the community-based distribution of the pill by non-medics. Many women have told us that their interest in child spacing would be much greater if the pill were available, so we feel we are on the threshold of a large advance in contraceptive utilization rate.

One potentially great reinforcement of our health programs, developed since the writing of the CS8 proposal, is the "Village School" model. Over the last twelve months, SC/M has helped 24 communities build their own schools; the communities have also named school committees, selected teachers, and enrolled nearly 1,500 students (50% of them girls). SC has provided technical and organizational support, trained the teachers, and prepared the Bambara-language pedagogical materials in collaboration with the National Pedagogical Institute. Over the next decade the Village School model has the potential for providing a basic education, including a solid grounding in primary health, to every child in Kolondieba, which currently has a 10% primary school enrollment rate. This will be a tremendous investment in the future, and some of its greatest benefits should be in improved health and well-being for women and children.

D. Lessons Learned

As a result of a literacy baseline survey conducted by the FTs in August 1993, we have a much better idea of the gender distribution of literacy. We are well on our way toward the general literacy target for VHCs, but only 35% of VHCs have women members, while our end-of-project objective is 80%.

Two multidisciplinary SC/M surveys on the attitudes and practices surrounding early childhood in Kolondieba (2,3) reemphasized the importance of older sisters and brothers in taking care of their younger siblings. Thus, one of the most importance roles of the Village School will be to organize 6-to-15 year olds to monitor the health status of the children in their compounds. Since the Village Schools are intended to recruit at least one child from each compound, this should greatly increase health monitoring.

Communities are showing considerable willingness to pay for preventive health services. Currently 4 of the 9 "advanced strategy" EPI nurses in Kolondieba district are paid by the villages served rather than by the MOH. The project will promote the same concept in other villages.

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2. "Etude sur les attitudes et pratiques qui entourent la petite enfance à Kolondiéba," SC/Mali and the Malian Higher Institute for Training and Applied Research, January 1993.

3. "Perspectives d'amélioration des garderies traditionnelles bamanan de Kolondiéba," SC/Mali and ISFRA, July 1993.

In some villages, traditional birth attendants have opted out of trainings because of their advanced age. In such cases, the village often names an "assistant" TBA, who is young enough to easily absorb reproductive health, literacy and other health training, and who will eventually take over from the older TBA.
The project is promoting that strategy with VHCs.

IV. PROGRESS IN HEALTH INFORMATION DATA COLLECTION

A. Characteristics and Effectiveness of Project HIS

Tier 1 and 2 indicators have been developed for each of the objectives and will be tracked through the community-based HIS. It is designed to keep track of a range of village population statistics from basic census records to personal health records. While the HIS employs manual methods at the village level, reporting at all other levels is incorporated into a computerized system which aggregates and analyzes the detailed village data and prepares reports to suit the needs of the users.

Following an initial family registration, each family of the district has an enrollment card; basic and health information from the enrollment is used to create women's and children's rosters kept and used by the FTs. Rosters contain data on immunization, growth monitoring, ORT training, pregnancy, family planning practices, etc. System updating is conducted on a continuous basis. A simpler HIS in local language (Bambara) has been developed for use by the VHCs. The HIS is used to ensure that each member of the community receives appropriate health services. Data are also used for planning and decision-making.

Data entry has been finished for the original zone of Kolondieba, and should be completed by the end of October 1993 for Zantiebougou. This will free up computer time for analysis. According to the recensus and "situation analysis" recently completed by CERPOD, the accuracy of SC/M's HIS data is quite satisfactory.

B. How and by whom HIS data are being used

Data are used at all levels of project implementation. VHCs use HIS data to pinpoint unvaccinated children and women and growth-faltering children. The HIS also serves as a record of births and deaths, useful not only as health information but for other civic uses (identity cards, removing deceased family members from tax rolls, etc.). It has become common to refer to compounds in the village by their HIS number, painted in white on the compound's outside wall. As VHCs become better acquainted with the longitudinal HIS data, it will also show them a picture of improved village health over time.

Family Trainers (FT) use HIS data to organize attendance at vaccination and growth monitoring sessions, training of mothers in control of diarrheal diseases, family

spacing, and Malaria prevention, to get a good estimate of the nutritional status of the children in a village and an accurate identification of individual children who are or have been at risk. HIS data can also be used to gauge the organization of a village for better health, or to compare inputs (FT's time invested, trainings, etc) with indicators of intermediate impact (vaccination rates, growth patterns). Through the manual registers, FTs can determine what health trainings an individual woman has attended. And of course, FTs use HIS to prepare a monthly report to their supervisors

Health supervisors, based in the subdistrict towns, use HIS data aggregated by FT to determine their efficiency and effectiveness in carrying out project activities such as training of mothers in the control of diarrheal diseases, and to calculate vaccination coverage, and malnutrition rates. HIS data also give an indication of the effectiveness of the EPI nurse, and guide supervisors in helping the EPI nurses establishing their month's program. Supervisors have used HIS data to examine causes of child death, and to work with FTs to design village-by-village literacy strategies for VHCs.

Nurse/Midwives use HIS data to follow-up on previous pre and postnatal consultations, especially at-risk cases. The Family Planning Nurse follows contraceptive acceptors, continuing users, dropouts, and couple years of protection, as well as referrals and follow-up at subdistrict health posts.

Drs. Doumbia and Sacko, the project coordinator and his deputy, use HIS data to determine the project's vaccination and malnutrition rates, cause of death surveillance, as well as other general population and demographic information (e.g. mortality and birth rates). The project covers a large enough population (140,000+ persons) to make reliable estimates of maternal mortality rates, and the most common causes of these mortalities.

Other SC sectors use HIS information and ID numbers frequently. Before any education, enterprise, or natural resource management survey is conducted, staff gather HIS information about the size, sex, and age distribution of the villages concerned. For example, in recruiting students for the Village Schools, education staffers consulted the HIS to ensure that the village had enough children, to ensure that each compound would be represented by at least one child, and afterwards to calculate the enrollment rate for the village.

HIS data is also ideal for random sampling, and for relating SC/M inputs (literacy, credit) with impacts on maternal and child health status.

The Kolondieba district health center uses our HIS data in its regular reports--our HIS is the best non-clinic-based data in the region. The HIS is also an effective way to link expenses with effectiveness; e.g. we could demonstrate the impact of the non-payment of EPI nurse salaries on vaccination rates, which led to the instruction to pay the nurses out of curative receipts.

On the regional and national levels, a number of partners have sought us out largely because of our HIS, including:

- Sightsavers for a community-based Ivermectin program that uses our HIS data to ensure complete distribution.
- NIH/Tulane/School of Medicine malaria research team, which intends to establish a five-year research project on malaria transmission and control, wants to involve VHCs of SC/M impact area in a systematic monitoring of febrile morbidity.
- CERPOD (demographic institute), which sees Kolondieba partly as a "demographic observatory" because of the longitudinal demographic and health information data available, will be working with SC/M and Columbia University to test hypotheses on the effect non-health interventions (literacy, credit) on health status.
- UNICEF's nutrition unit, which sees SC/M's HIS growth monitoring and other data as probably the richest source of such longitudinal information in Mali.

C. Needs for Further Refinement

An SC/M-funded, computer programmer/trainer will be working full-time starting October 1; one of his priorities will be staff training in the optimal use of the computerized HIS. The computer specialist will devise ways of producing program reports more rapidly (a report covering the whole district can take two hours to produce), in order to make the HIS data more accessible for spontaneous action research queries.

Dr. Sacko will undertake a verification of SC/M's low infant mortality rates (between 60 to 80 per 1,000, while the national rate is 166/1,000). "Lot quality analysis" techniques will be used to ensure that SC/M is not underreporting deaths.

Starting 9/93, project-level reporting will be monthly, rather than quarterly. Because field reports will be analyzed against the HIS data, feedback to FTs will be provided more frequently (monthly). This is expected to increase the level of project's performance. Also, vaccination rates, growth monitoring data, and prenatal care information will be analyzed more closely at all levels.

SC/M will organize its growth monitoring data for easier analysis. Quarterly weighings of all children under 3 will all be done in the same month. Moderately and severely malnourished children will be followed separately, with different protocols for follow-up.

For the planned Dutch-funded primary health care project in Yorosso District (June 1994-May 1998), SC/M plans to develop a streamlined, less expensive HIS (using fewer FTs) that will be entirely adoptable by the MOH.

V. BUDGET AND EXPENDITURES

A. Budget Revisions

There have been no budget changes.

B. Pipeline Analysis

The pipeline analysis is appendix B.

C. Cost/service correlations

The average monthly cost of SC/M's nurse-midwives, pre and postnatal care activities is about $1,875. In the third quarter, maternal care costs were $5,090.94. The midwives saw 582 pregnant women, at an average cost of $8.66 per woman. The cost per pregnant woman receiving at least two prenatal consultations was $29.33 (n=169). Since most of the costs associated with the midwives are recurrent (especially salaries), this latter average cost can be greatly reduced if the nurses schedule their village visits more efficiently. Steps are being taken to this effect. The HIS averages about $1,250 per month, or less than $0.01 per inhabitant per month.

D. Explanation of Higher Unit Costs

Amount budgeted for fuel in grant has been inadequate. SC/M is currently seeking complementary funding in family planning and malaria prevention that should ease both Salaries and Other Direct cost line items. (the latter including fuel).

The project is covering a population of approximately 150,000 and an area of more than 10,000 sq. km. In addition, the government has instituted a compulsory "solidarity tax" that has added an average of 20% to salaries. The fluctuations of the dollar vis-a-vis the local currency have also had their effect on fixed charges, such as salaries. Overall, we have to conclude that we have insufficient funds for the population we are covering and for our objectives-- and additional funding from other sources is currently being sought.

VI. FOLLOW-UP OF D.I.P. REVIEW COMMENTS

First off, SC/M would like to thank the DIP reviewers for their thorough reading of our plan and their useful comments.

A. General Concerns and Recommendations

(1) With regard to the reviewers' comments on the "lack of clear distinction" between the Kolondieba (old) and Zantiebougou (new) zones, SC/M agrees that separate

objectives are in order, but we hold that the basic activities and approach should be the same.

Most of our activities are recurrent: participatory collection and analysis of health information, prenatal consultations, baby weighings, community organization for vaccination, and various health trainings and activities. These will not differ greatly between Kolondieba and Zantiebougou. What will differ is the level of experience, functionality and responsibility of the VHCs, and this will be reflected in the coverage rates and indicators, rather than in the strategies of intervention themselves.

The family registration in Zantiabougou subdistrict took place in December 1992 - January 1993. This had been preceded by the baseline KAP survey in May-June 1992. The preliminary analysis was done and women's and children's rosters were completed. Data entry began and was expected to be completed by October 1993. For Zantiebougou, there is a total population of 22,207 inhabitants, 10,719 male and 11,488 female. There are 4,487 women of child-bearing age, 1,894 girls aged 12-19 and 2,691 children aged 0-3 years. An additional nurse and three FTs were recruited, but, in fact, experienced staff from the Kolondieba district was placed in the new sub-district. For example, Marie Berthe, the nurse previously covering the Kolondieba central sub-district, is now posted in Zantiebougou, upgrading of the TBAs. Mobilization in ORT, growth monitoring and immunization is under way as well as pre- and post-natal counseling. The integration of the program and its contribution to the immunization campaign in Bougouni, the capital of Zantiebougou, have been the subject of a series of meetings with the Medical Officer in charge of Bougouni district.

Since the CS4 final evaluation and the Zantiebougou baseline were conducted at the same time, we already have two parallel CS8 baselines for the two zones; a copy of this comparison is attached as appendix C of this report. The baseline data shows a considerable disparity in health services and conditions between Kolondieba and Zantiebougou. It is likely that differences will exist even at the end of the project, in the maturity of the VHCs and therefore their capacities, and in immunization coverage. Nevertheless, steps are being undertaken to introduce literacy and wells programs into the subdistrict in FY94, and nutrition programs will be added. Good relations are presently being established with the Bougouni health center.

The field office set all of the DIP objectives in the light of the rates in the two zones. The following separate objectives have been chosen for Zantiebougou.

INDICATORS	BASELINE *Zantiebougou*	GRANT OBJECTIVE *Zantiebougou*	*Whole Zone*
VHCs w/1+ literate member	84.0%	100%	100%
VHCs w/1+ lit. woman member	31.8%	60%	80%
Villages w/1+ trained TBA		50%	75%
Complete vaccination 12-23 mos.	6.7%	50%	80%
Women CBA w/2+ TT vaccinations	36.5%	80%	90%
Pregnant women w/2+ consultations	3.2%	50%	50%
Mothers using ORT for diarrhea	0.0%	50%	90%
Children weighed quarterly	1.6%	80%	80%
Women CBA knowing ways to prevent malaria	42.9%	65%	65%

(2) SC/M agrees with the comment that some of our objectives are process rather than outcome oriented. This has been particularly true, for example, of the emphasis on training rather than morbidity reduction for ORT and malaria prevention. We have measured training inputs because training has been necessary to establish health protective behaviors in the villages. In addition, outcome objectives would have required a closer following of morbidity than we could originally have managed, especially since our FTs visit each village on average only twice a month. However, now that the VHCs are reaching a certain level of experience in health management, the committee members will be able to follow morbidity on a daily basis, as well as behavioral change over time. In the long run, it is the VHCs who will best be able to measure the impact of the training inputs on families' behaviors. SC will work with advanced VHCs to develop simple indicators both of behavioral change and of reduced morbidity.

(3) In order to develop one coherent DIP, data has been aggregated from the two districts. In reality, however, data will be collected and analyzed separately for each district. The project will report on indicators per district as recommended.

B. Case Management of Diarrheal Diseases.

(1) Verification of whether mothers are using their knowledge to treat dehydration will come from the VHCs as described above. FTs and health supervisors also make regular spot-checks. Of course, mother's ORT practices will also be investigated during midterm and final evaluations.

(2) SC/M promotes home-prepared ORT using the name "keneya-ji" (literally, "water of health"). Mothers mix one liter of clean water with 8 pieces of sugar (40g) and 2 pinches of salt (4g). They are told that the mixture should taste "like tears, but not too salty." Cereal-based ORT fluids are light porridges using on millet, maize, or rice, with sugar, salt, and a bit of karité butter (made from the oil of the shea-nut tree).

C. Nutrition

(1) SC/M's nutrition strategy is as follows:

- Train FTs to diagnose cases malnutrition and refer serious cases to health posts.
- Train mothers to identify very early the basic symptoms of marasmus and kwashiorkor, and to take appropriate corrective measures.
- SC/M trains at least two women per village as Village Nutrition Agents; these women will be capable of diagnosing malnutrition, and of organizing monthly nutrition demonstrations for village mothers.
- FTs and VHC are to weigh all children quarterly.
- The following children, identified through the project's HIS, will be weighed on a monthly basis:
  (a) children born within the last 3 months,
  (b) malnourished children, sick children,
  (c) children who are growth faltering
  (d) children whose mother has given birth to a younger sibling
  (e) children whose mother has died
  (f) low birthweight babies (< 2.5 kg) until they have reached normal weight.
- For children determined to be malnourished, FT and VHC will follow up with a VHC visit to the child's home to discuss the child's condition with his/her parents. VHC will follow the case on a continual basis, and generally has a mandate to intervene if the child's parents are not taking proper action.

(2) SC/M agrees that the attendance of mothers of malnourished children at nutritional demonstrations is not adequate in itself. In addition to the demonstrations, other interventions such as home visits, and referral of severe cases will be conducted as described above (point 1). SC/Mali is working very closely with the health centers and posts to increase their capacity to treat severely malnourished children. Informal support for the transport of referred cases is currently discussed with VHCs.

Also, during the first two quarters of Year Two, SC/M will set an objective for improvement, in the aggregate, of the status of malnourished children. The baseline will be the rates of 33% moderately and 7.9% severely malnourished children (thesis of Beffon Cissé on the incidence of malnutrition in the central subdistrict). SC/M will make a quarterly rough estimate of moderate and severe malnutrition at the district, subdistrict, and individual FT levels, by dividing the number of children in the yellow and red bands by the numerator of all children weighed. We recognize that this calculation may underestimate malnutrition, since the children not weighed may be those most at risk, but it is the most readily accessible information. It should be clear that this indicator will be an aggregate measure of our effectiveness at the FT, subdistrict, or project level, but will not monitor the improvement of individual malnourished children. This will be done by using the growth monitoring card and other HIS data.

(3) The following approach for VHC monitoring and management of cases of malnutrition, with the assistance of the FTs, is under discussion among SC/M staff. It requires a certain level of VHC literacy to succeed.

- The VHCs will establish a notebook for malnourished children, with a separate page started for each child when that child is declared malnourished. Each VHC contact (weighing, home visit, referral) with the child will be described and dated in the notebook, family context and reactions noted, and advice given by the VHC recorded. The child's progress will be followed regularly.
- When it is determined that the child is no longer malnourished, this will be noted at the bottom of the page. Should the child die, this will be noted as well.
- The FT will consult this notebook each time he/she visits the village, both to know which homes to visit for follow-up, and to estimate how many children have entered and left the "malnourished" category during the month.
- Health supervisors will also use the notebook to gauge the effectiveness and assiduity of both the FT and the VHC.
- The fact of writing down these details on the child's condition, and following up regularly, will underline the seriousness with which the VHC takes the problem and its solution. At the same time, VHCs and SC/M should be very discreet with a written record that could be embarrassing to the family concerned.

SC/Mali HIS data, checked against the data collected through the system described above, will be used to measure rates of mild, moderate, and severe malnutrition quarterly. A comparison between the rates of moderate, and severe malnutrition over time will identify the progress made by the project to improve nutritional status of the children. The reason, however, that the DIP did not have an objective for change in the estimated number of children with moderate or severe malnutrition is because malnutrition is a multifactoral conditions. The indicator described above will improve drastically if lack of knowledge and/or motivation on the part of the mother are the causes of the child malnutrition. If, however, malnutrition, is caused by lack of economical resources, problems within the household, drought, etc., the interventions described above will not be effective.

(4) Highlights of SC/Mali's nutrition curriculum, including weaning messages, are appendix D. Materials used include audio-visual materials and Bambara-language handbooks produced by the Nutrition Communication Project. The education strategy is as follows: there is one nurse/nutritionist on staff who has devised a strategy to decentralize. She trains the FTs according to the program described in I, B.. Two "animatrices" are then selected form each village to train mothers. The nurse/nutritionist with the FTs then trains the "animatrices" in nutrition education and demonstration techniques. The content of the nutrition education sessions are centered particularly around growth-monitoring, good eating-habits for young children and how to react in cases of malnutrition. One session will last about one hour, take on particular theme that seems to be of priority and will be aimed at changing negative behaviors and encouraging positive behaviors in feeding habits and nutrition. In sessions on weaning-habits, emphasis is laid on the critical nature of the weaning period. The different stages of weaning are taken through step-by-step (with a description of the physical development of a child at different ages, e.g. 6-7 months, child is sitting up), the importance of breast-milk and the changes to the diet of the child up to the age of three. The sessions on weaning are closely linked in with the sessions on growth-monitoring and the interpretation of the growth-monitoring chart.

(5) SC/Mali agrees with the reviewer that educational messages should focus on the time spent feeding, rather than food composition. This will be included in the design of the project's nutrition improvement activities.

In general, breastfeeding infants are fed whenever they are hungry. Weaned or semi-weaned children eat whenever they are hungry as well, so that infrequency of eating only becomes a problem when children have no appetite (especially sick weaned children), or when food is scarce. Note that SC/M counsels mothers to feed moderately malnourished children at least five times a day.

(6) SC/M proposed an objective to increase exclusive breastfeeding because we learned in the CS-IV final evaluation that many women did not understand that exclusive breastfeeding meant no water and no infusions. This objective proposes a target of increasing by 80% the number of infants who are exclusively breastfed up to three months. This means that the current 35.9% would increase to 64.6% by the end of the project's third year. Project staff feels that this objective is achievable. However to conform with the DIP review comments, the objective will be revised downwards to read:

"50% of infants will be exclusively breastfed up to three months of age."

The ability to drastically improve that behavior is hindered by the deep-seatedness of the habit of giving children infusions, especially to treat illnesses.

(7) The percentages are different because the objective is formulated differently in each section. The project objective (section D2.) was developed during the proposal phase, i.e. before the baseline survey. Since, the baseline percentage for exclusively breastfed children was 35.9%, we can compute an 80% improvement as 64.6% or approximately 60%. When the DIP was developed the wording of the objective was changed to the one listed in section 5c.5. The target, however, of 60% remains the same for both of them.

(8) The reason why SC did not include an objective that would measure the change in the mothers ability to interpret the growth card is because SC approach requires that the objectives focus on the beneficiaries. We would like, however, to follow the reviewer advice by adding this indicator to the project's monitoring system.

In our experience, the colored bands are easy for mothers to interpret, whether or not they are literate. What is more difficult to interpret, since it doesn't have accessible graphics, is the vaccination card; we have listed an indicator for women's ability to interpret it in the DIP.

(9) Increasing intake is definitely one of our messages for maternal and child health, and safe pregnancy and delivery. Our nurse-midwives weigh each pregnant woman during her consultation, as well as monitoring uterine height, anemia, oedemas, and blood pressure; thus we can establish an increase or decrease after a second consultation. SC/M will analyze the nurse-midwives' data to determine the percentage of women currently gaining weight during pregnancy, and to see if our messages or practices in this regard need to be strengthened. This indicator will be also added to our monitoring system

Research currently being conducted by medical student Assetou Fofana on the factors influencing women's participation in pre- and post-natal consultations is likely to be of interest in this regard.

(10) Vitamin A curriculum and vitamin A messages regarding dietary vitamin A consumption are attached to this report. Messages regarding the inclusion of vitamin A in weaning foods are also addressed. The delivery of these messages and their support mechanisms will follow the same strategy outlined in the DIP's section 5, Nutritional Improvement.

(11) Project staff agree fully that on this comment. We hope that the project's vitamin A interventions could contribute to a reduction in morbidity and mortality among preschool children.

(12) SC/M's doctors have been reluctant to have TBAs arrange vitamin A supplementation, because of potential problems with over dosage and conservation. This strategy can be piloted with some of the stronger VHCs.

(13) SC/M is conscious of USAID's real interest in the promotion of vitamin A. The reviewers are also conscious of SC/M's strong preference for dietary sources of vitamin A (to avoid the logistical complexities and questionable sustainability of an EPI-like operation). The project would like to include in its midterm in April or May of 1994 evaluation a training module on vitamin A that explains the modalities, benefits and risks/complexities of vitamin A supplementation and takes into account our preference for dietary sources.

SC/M has also decided to request that this year's thesis student from the School of Medicine study the prevalence and effects of Vitamin A deficiency among the children and women of Kolondieba. This student should be chosen within the next quarter.

(14) As reviewers find that the proposed survey about Lean season vitamin A sources will not provide more definitive conclusions, SC/M will not conduct it.

(15) Night blindness ("surofiyen," in Bambara) is known to the general public and is recognized as a distinct malady. Traditional healers also recognize that it is reversible, and recommend liver as a cure. However, specific data on night blindness is not currently available.

(15) Full-blown cereal banks have been established in twenty villages, and they require a good deal of community organization and preparation (a functioning village credit and savings fund, for example). Thus, though promising. they are not as yet a solution that can cover the whole project zone.

The cereal banks program was set up with several objectives in mind, one of which was to ensure the availability of cereals within the community during the period known as the "hungry season" or the season before the cereals come in i.e. May/June to September in most villages in SC's program area. Villagers take out a loan from the credit program in December or January, and purchase grain at the time supplies are most abundant and prices are low. They store in an improved granary until the "hungry season" and then sell back to the villagers at a higher price than purchase, but much lower than those on the open market. People have the advantage of having cereals on their doorsteps at lower prices than at the market. The UCOVEC or central union of village funds in Kolondieba has now set up a central cereal bank with cereals from the villagers and from the national cereal marketing board. For not only are cereal banks safeguards against food-shortages, they are also money-making concerns. The big, fat and rapacious outside merchant is also driven out of the circuit.

Recently, however, SC/M's nurse-nutritionist and her village nutrition agents have been trying to set up smaller, women-run food banks specifically aimed at supplementing the diets of women and children most at risk. The food stocked in these banks might be bean or peanut powder, or dried leaves or vegetables, as well

as cereals. It will take some time before it is evident whether this strategy will work.

D. Maternal care

(1) SC/M makes strong efforts to detect high-risk pregnancies early, and to make preparations for the evacuation of women at-risk to Kolondieba Town. Traditional birth attendants are trained to assist at normal births, and to recognize and refer high-risk pregnancies. At the time of their training, TBAs learn about potential cases of high risk pregnancies, early warning signs of complicated deliveries, and how to act when they encounter such cases. TBAs also receive a kit including a sterile blade, alcohol, and bandages for the umbilical cord. The TBA charges 300-500 francs ($1.00-$1.65 US) per delivery, which pays for resupply. TBAs also receive training in certain post-partum procedures, such as abdominal massage, stanching uterine bleeding, and the removal of parts of the placenta remaining in the uterus after delivery.

When the decision is made to evacuate the pregnant woman to the health center in Kolondieba Town, transport available will vary from village to village, but would most likely be a cart, a bicycle, or a moped. The health center has two well-trained physicians on staff capable of dealing with obstetrical emergencies; it is rather the subdistrict health posts which are staffed only with nurses, and which are thus unprepared for dealing with surgery. The district health center is up to four hours by moped from certain outlying villages--thus SC/M's emphasis on early detection of problems and systematic, foresightful preparation for delivery.

(2) As mentioned in the DIP (point 5c.7), the issue of low birth weight babies will not be addressed. This decision was made because of the inability of the 34 project extension workers to be present during the delivery of each child in a population of 137,900. With increased training of VHCs, and TBAs in literacy and numeracy, the project will train few of them in weighing newborn on a pilot basis.

If a child's weight at birth is less than 2.5 kilograms, the FT and the VHC inform the mother that the child will need special care. Messages given include the importance of colostrum, the importance of Vitamin-A rich foods in the mother's diet, the importance of frequent breastfeeding, and the necessity of having the baby weighed monthly. In addition, the FT and the VHCs should question the mother about her eating habits and health during pregnancy, and give appropriate counsel about maternal nutrition.

If the child's weight is significantly below 2.5 kg, the mother will be instructed to take him/her to a health post immediately.

(3) Men are the co-equal targets of our family planning interventions. Bambara culture accords a good deal of importance to child spacing, so most of our raising of men's

consciousness regarding safe pregnancy and delivery takes place during discussions of complications arising from pregnancies too closely spaced.

E. Monitoring and Evaluation/Literacy and Village Self-Management for Health

(1) & (2) Dr. Souaibou Sacko, SC/M assistant health coordinator, will be responsible for the smooth running of the HIS, as well as the analysis and interpretation of its results. He will be supported by a computer specialist who will maintain the machines, provide spreadsheet and database training, and in enhance the user-friendliness of ProMIS. In addition, the change from quarterly to monthly project-level reporting on routine data (especially immunization, malnutrition, and pre- and post-natal consultations) will ensure that up-to-date and extensive data is at the fingertips of the project's planners.

Specific research projects to be carried out in Year Two include an in-depth analysis of infant and maternal mortality and their causes, and an exploration of the interrelation of increased literacy and maternal/child health status.

All modification of objectives is based on information from the HIS. For example, the percentage decrease in severe and moderate malnutrition will be projected based on an analysis of previous levels and trends. Likewise, an objective for increased dietary intake for pregnant women will be based on routine data gathered by SC/M's nurse-midwives.

As a result of the senior staff meeting called to put together the 1992-93 annual report and DIP changes, Drs. Doumbia and Sacko convened all of SC/M's health staff (FTs, supervisors, nurses, and the HIS staff) in order to reiterate the importance of quality data for decision-making at all levels, and to encourage FTs and through them VHCs to use HIS data proactively at their level (e.g. intervillage competition regarding vaccination rates).

For additional information on the use of HIS data in program planning and development, see paragraph IV.B. of this annual report.

(3) Literacy rates in Mali are among the lowest in the world (10%) and the environment is remarkably non-literate (no posters, no signs, no documents visible in most houses). To the extent that we are trying to make villages capable of long-term sustainable management of their own health, literacy training is indispensable, both on a basic level (acquaintance with the alphabet and calculation) and on a specialized level for health (familiarity with basic health records, their importance, and their use).

As the reviewers noted, over 80% of the VHCs already have members possessing the basic level of literacy, and it should be eminently possible to increase this percentage to 100% before the end of the grant.

However, the percentage of VHCs that have literate women members is low, about 35%. We have a particular interest in having literate women members, for the following reasons: (1) VHCs are an ideal way to promote women's leadership in villages, since women's responsibility for children's health is undisputed; (2) women, particularly after marriage are more stable than men; young literate men in particular often migrate to cities looking for work, which can leave a VHC without a literate member; (3) literate women become role models for girls' education and thus eventually for more educated mothers; (4) women are less likely than men to make demands for remuneration.

Our end-of-project objective is to have a literate woman member in at least 80% of VHCs. The specific challenge in this strategy is that SC/M's literacy program, though large, only covers 90 of the 250 villages in the project zone; thus, we need to devise alternative strategies for literacy training.

We have analyzed the literacy situation village by village, noting (1) if there is an agency conducting literacy activities in the village (SC/M, the cotton authority, the GRM cooperatives authority, or others); (2) the adult literacy rate in the village; (3) the number of literate men and literate women in the village; (4) the number of persons on the VHC, and among them, the number of literate male and literate female members. The results of this survey, organized FT by FT, are attached as appendix E.

The health supervisors and literacy staff will now take this data and meet with each FT, going over the literacy situation of each village and coming up with a individualized plan to bring basic literacy to the women and men of the committee. There are four basic scenarios:

(a) A village which already has a VHC with at least one male member and one female member who are literate (35%). Strategy: Focus on increasing the functionality of the VHCs, through a continued advanced literacy training for health.

(b) A village which already has a VHC with one or more literate male members, but no literate female members, even though there are literate women in the village. (n=44, or 18%). Strategy: Recruit the literate women villagers for the VHC--this simple action will mean that 50% of VHCs will have literate female members.

(c) A village which already has a VHC with one or more literate male members; in this village there are no literate women, but there is a literacy center (run by SC/M, the cotton authority, or others; cotton-authority literacy has traditionally been oriented exclusively toward male cotton farmers). (26%). Strategy:

Request the literacy center to make special efforts to train the women in basic literacy, even if women do not participate in their normal curriculum.

(d) A village which has no literate VHC members, and no literacy center (21%). Strategy: This is the difficult scenario, especially because it is culturally difficult for women to leave their villages for long periods of time to take training courses. Strategies: (1) recruiting a trainer from the literates of a neighboring village or a graduate from the schools in Kolondieba Ville; (2) intensive training for a village man or woman to become the literacy trainer for his/her village; (3) the FT or SC subdistrict literacy agent can conduct special literacy courses (not the best solution, given the time and frequency of visits necessary).

Based on these strategies, it should be eminently possible to reach the goal of 60% of the VHCs having a literate female member by the end of Year Two, and 80% by end of Year Three.

As mentioned above, widespread VHC basic literacy is the project goal in Year Two, while in Year Three SC/M will shift its attention to the uses and reinforcement of literacy for health.

F. Sustainability

(1) Most payment for services will, at least initially, be organized on the community level, and will usually pay for the salary and transport of a health agent. In effect, the community will subsidize services for those families and individuals with few or no liquid resources. Women generally find the money to purchase chloroquine as a treatment for fever, but are not in the habit of purchasing it as a prophylaxis for children and pregnant women, even though this is the message promoted by the MOH and by SC/M. Likewise, women will pay for iron and folic acid when the TBA or SC/M nurse-midwife instructs them to, but do not supply themselves automatically during pregnancy. These are issues that will be explored in further depth with the expansion of village pharmacies and thus the availability of basic medicines under the supervision of the VHCs.

(2) Indicators on the autonomy of VHCs were included in the DIP (Appendix C). These are our basis for estimating the sustainability of health benefits and behaviors. FTs are responsible for fostering the competence, autonomy, and responsibility of the VHCs of the villages they serve. Supervisors are instructed to evaluate FTs concerning the progress of their VHCs toward autonomy. The project manager and his assistant will be responsible of following the progress of the project, including its sustainability using the monitoring system.

VII. OTHER INFORMATION:

One complementary activity of SC/M's, at the level of the capital city and national health policy, is worth mentioning. The support SC/M received from USAID/PVC office during the last six years has increase the expertise of the Field Office to embark on large primary health care programs. This expertise prompted USAID/mission in Mali to trust SC/M to coordinates the NGO health consortium (the "Groupe Pivot"), which has been given the task to produce two health strategies for NGOs in Mali: (1) a nationwide strategy for family planning promotion and AIDS prevention, and (2) a strategy for child survival interventions in Mali's underserved, resource-poor, and strife-torn northern regions.

An ambitious family planning/AIDS prevention strategy has been completed and approved by USAID/Bamako, which has offered the Groupe Pivot, through SC/M, a $1.5 million grant to fund and coordinate NGO efforts in family planning and AIDS prevention. The bulk of this money is to be subgranted to local and international NGOs. The newly-favorable national policy environment for family planning, and a new openness at policy levels to NGOs, will make this project an exciting and effective one.

MALI FIELD OFFICE
CHILD SURVIVAL 8 ANNUAL REPORT FY 1993
APPENDICES

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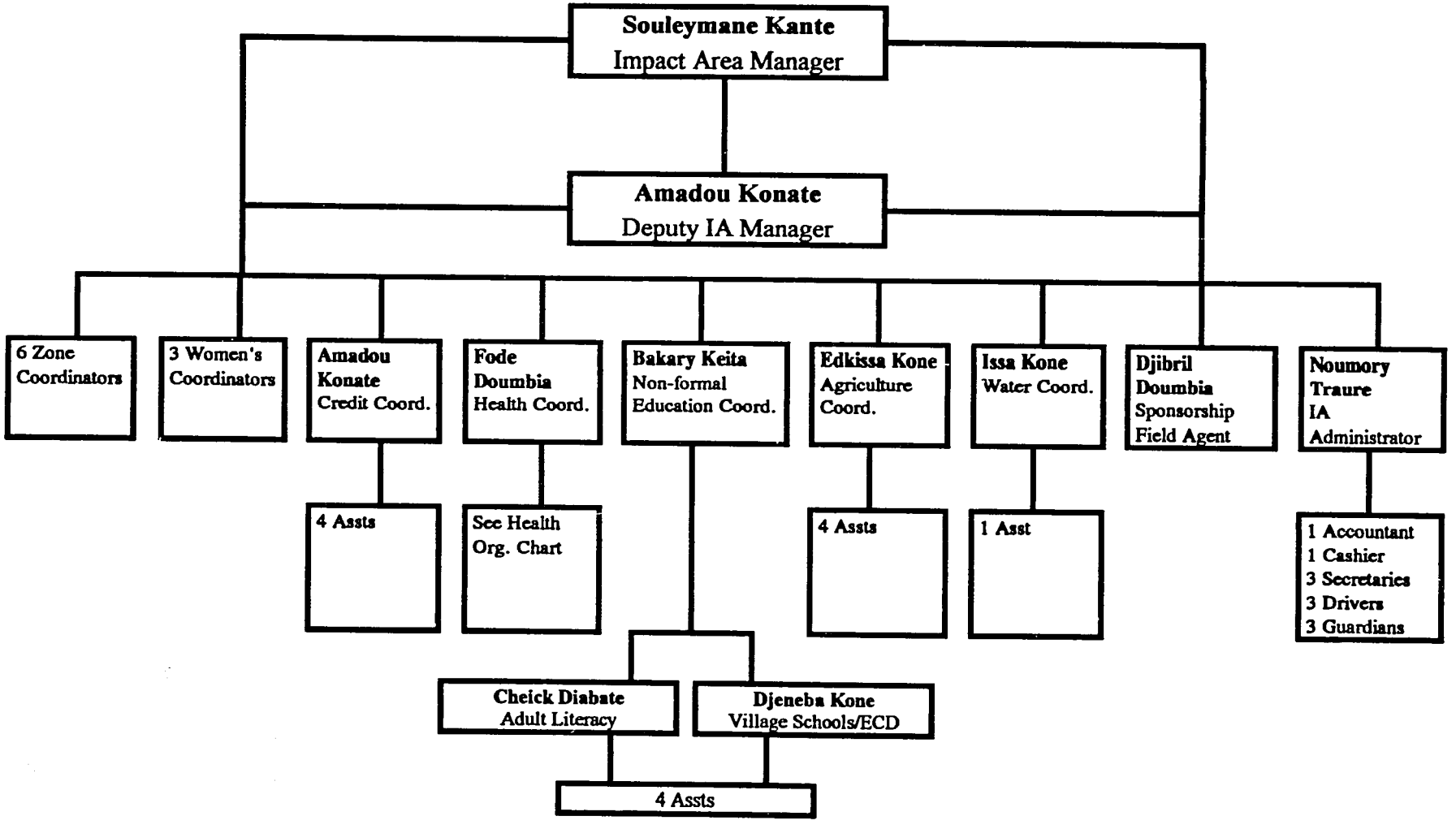
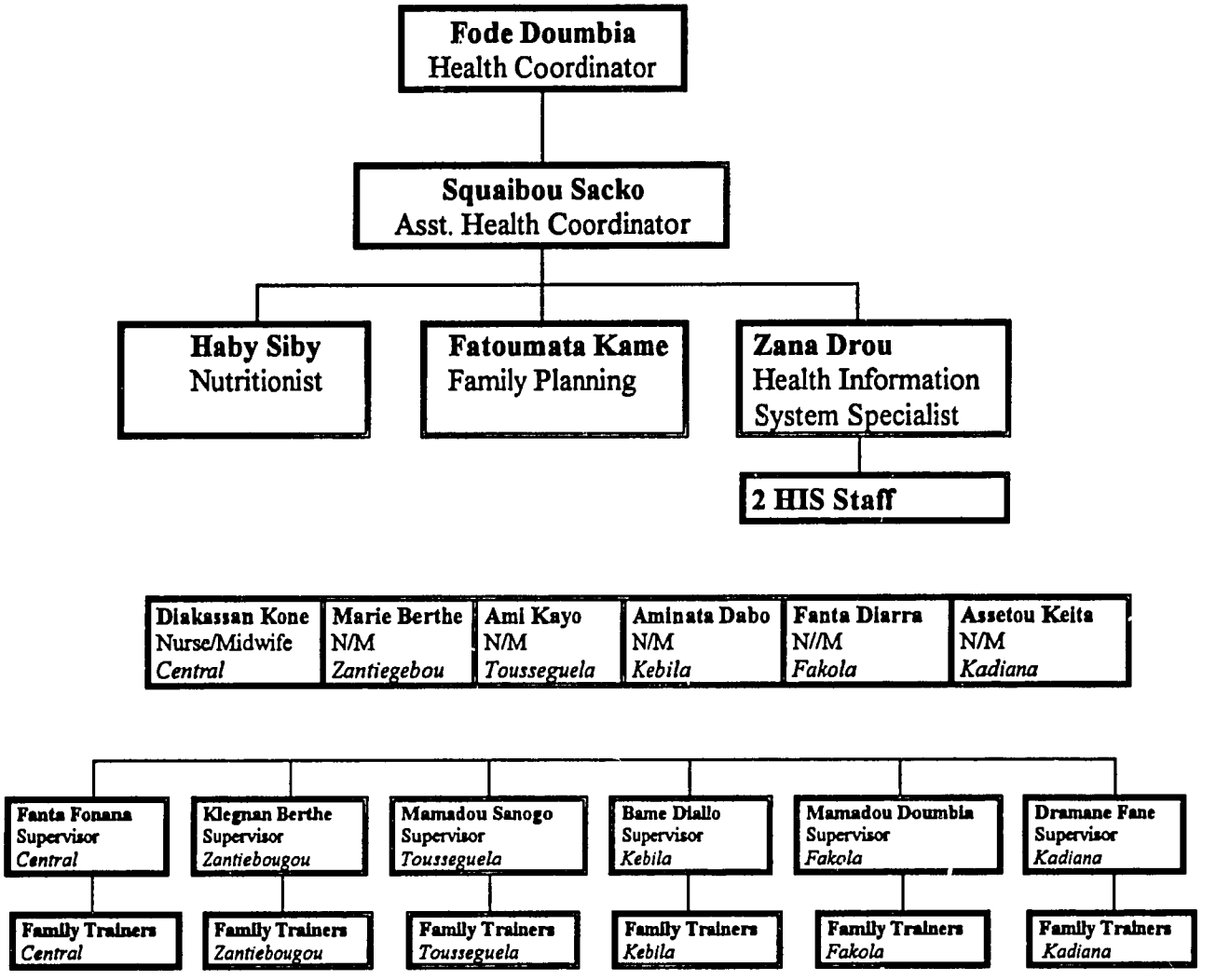
Mali Field Office **Appendix A.1: Organizational Chart-FY94** **Kolondieba Office**



Appendix A.2: Organizational Chart-FY94



SAVE THE CHILDREN
Pipeline Analysis

Appendix B

COOPERATIVE AGREEMENT FAO-0500-A-00

21-Oct-93

CHILD SURVIVAL VIII: MALI

	YEAR 1: EXPENSES VS. PLANNED BUDGET						LOG: CUMULATIVE EXPENSES VS.TOTAL GRANT			
	EXPENSES 07/31/93	PLANNED BUDGET	BALANCE	% SPENT	BUDGET YEAR 2	BUDGET YEAR 3	CUMULATIVE ACTUAL	TOTAL BUDGET	BALANCE	% SPENT
Evaluation	8,967.38	6,000.00	(2,967.38)	149.5%	6,000.00	6,000.00	8,967.38	18,000.00	9,032.62	49.8%
Personnel	137,347.37	143,831.00	6,483.63	95.5%	157,341.00	139,873.00	137,347.37	441,045.00	303,697.63	31.1%
Travel	182.24	6,000.00	5,817.76	3.0%	6,000.00	6,000.00	182.24	18,000.00	17,817.76	1.0%
Communications	8,824.71	14,000.00	5,175.29	63.0%	9,000.00	9,000.00	8,824.71	32,000.00	23,175.29	27.6%
Facilities	3,986.83	1,500.00	(2,486.83)	265.8%	1,500.00	1,500.00	3,986.83	4,500.00	513.17	88.6%
Other direct	32,870.48	18,642.00	(14,228.48)	176.3%	19,970.00	20,000.00	32,870.48	58,612.00	25,741.52	56.1%
Procurement										
Supplies*	2,325.93	5,000.00	2,674.07	46.5%	5,000.00	5,000.00	2,325.93	15,000.00	12,674.07	15.5%
Consultants		0.00	0.00		0.00	0.00	0.00	0.00		
Services		0.00	0.00		0.00	0.00	0.00	0.00		
sub-total Procurement	2,325.93	5,000.00	2,674.07	46.5%	5,000.00	5,000.00	2,325.93	15,000.00	12,674.07	15.5%
Total Direct	194,504.94	194,973.00	468.06	99.8%	204,811.00	187,373.00	194,504.94	587,157.00	392,652.06	33.1%

Year 1 = Sept.30,1992 – Sept. 30, 1993
Year 2 = Oct. 1, 1993 – Sept. 30, 1994
Year 3 = Oct. 1, 1994 – Sept. 30, 1995

Budget revised to Amendment 3
*Supplies are individually under $500 per item.

Appendix C.
CS-8 BASELINE RESULTS

		Old Zone (*Kolond.*)	New Zone (*Zantie.*)	Both
	DEMOGRAPHICS			
1	Mean Age of Mother (yrs)	28.2	26.8	27.9
	% Mothers <= 19yrs	9.6	14.3	10.6
2	Mean Age of Child (mos.)	8.1	7.3	8.0
	EDUCATIONAL LEVELS			
3a	Mothers' Highest Level of Education			
	None	90.7	88.9	90.3
	Koranic school (Arabic)	1.7	4.8	2.3
	Adult literacy (Bambara)	1.7	4.8	2.3
	Primary school (French)	5.1	1.6	4.3
	Post-primary school	0.8	0.0	0.7
3b	% Mothers Literate	5.5	3.2	5.0
	BREASTFEEDING AND NUTRITION			
4	% Mothers breastfeeding	99.2	100.0	99.3
6a	% Giving water	81.6	77.8	80.8
6b	% Giving milk	35.1	36.5	35.4
6c	% Giving porridge	56.1	39.7	52.6
6d	% Giving fruit	56.5	44.4	54.0
6e	% Giving carrot/mango	54.4	42.9	52.0
6f	% Giving leaf sauces	42.0	30.6	39.7
6g	% Giving meat, fish	49.4	29.0	45.2
6h	% Giving beans, peanuts	43.1	29.0	40.2
6i	% Giving eggs	33.5	25.8	31.9
6j	% Adding leaves	43.1	33.9	41.2
6k	% Adding honey, sugar	45.6	22.6	40.9
6l	% Giving karite butter	45.0	32.3	42.3
	Exclusive breastfeeding rate	34.3	40.9	35.9
7	When supplement breastmilk?			
	4-6 months	31.4	11.1	27.2
	0-4 months	0.4	0.0	0.3
	6+ months	60.3	52.4	58.6
	Don't know	7.9	36.5	13.9
8	What foods to add?			
	Don't know	5.0	11.1	6.3
	Karite butter	79.0	77.8	78.8
	Liver, milk	40.6	15.9	35.4
	Green leafy	43.9	36.5	42.4
	Other	10.5	11.1	10.6

Appendix C.
CS-8 BASELINE RESULTS

		Old Zone (Kolond.)	New Zone (Zantie.)	Both
	GROWTH MONITORING			
9	Child has growth card			
	Yes	70.2	3.2	56.1
	No, lost it	2.5	11.1	4.3
	No, never had	27.3	85.7	39.5
10	Kids w/card weighed in past qtr	86.9	50.0	86.5
	% all kids weighed past qtr	61.3	1.6	48.7
11	If kid in red, mother should			
	Take to health post	56.7	0.0	44.9
	Take to trad'l healer	35.3	0.0	27.9
	Other	14.7	1.6	12.0
	Don't know	21.8	98.4	38.2
	MALARIA			
12	Child had fever in last 2 wks	22.2	15.9	20.9
13	If yes, mother took what action			
13a	Nothing	0.0	0.0	0.0
13b	Took to health post	20.8	10.0	19.0
13c	Took to trad'l healer	52.0	20.0	47.6
13d	Took to vill. health agent	7.5	10.0	7.9
13e	Gave chloroquine	66.0	70.0	66.7
13f	Other	22.6	50.0	27.0
13g	Don't know	0.0	10.0	1.6
14	Important actions against fever			
14a	Nothing	0.4	0.0	0.3
14b	Take to health post	43.1	15.9	37.4
14c	Take to trad'l healer	59.0	38.1	54.6
14d	Take to vill. health agent	11.7	3.2	9.9
14e	Give chloroquine	69.9	68.3	69.5
14f	Other	15.1	30.2	18.2
14g	Don't know	4.2	7.9	2.0
15	In order to avoid malaria...			
15a	Nothing: impossible to avoid	4.2	9.5	5.3
15b	Fill in ditches	15.9	3.2	13.2
15c	Sleep under bednet	5.9	1.6	5.0
15d	Cut grass around village	28.0	6.3	23.5
15e	Burn repellent plants	43.5	14.3	37.4
15f	Other	40.6	27.0	37.7
15g	Don't know	15.5	47.6	22.2

Appendix C.
CS-8 BASELINE RESULTS

		Old Zone (Kolond.)	New Zone (Zantie.)	Both
	CONTROL OF DIARRHEAL DISEASES			
16	Child had diarrhea in last 2wks	15.5	12.7	14.9
17	If child had diarrhea, mother			
	Breastfed more than usual	40.5	12.5	35.6
	Breastfed as usual	37.8	25.0	35.6
	Breastfed less than usual	21.6	50.0	26.7
	Stopped breastfeeding	0.0	0.0	0.0
	Child wasn't breastfeeding	0.0	12.5	2.2
18	If child had diarrhea, mother			
	Gave more liquids than usual	59.5	50.0	57.8
	Gave same liquids as usual	13.5	0.0	11.1
	Gave less liquid than usual	13.5	12.5	13.3
	Stopped giving liquid	0.0	0.0	0.0
	Breastfed only	13.5	37.5	17.8
19	If child had diarrhea, mother			
	Gave more semisolid than usual	45.9	12.5	40.0
	Gave same semisolid as usual	24.3	25.0	24.4
	Gave less semisolid than usual	13.5	12.5	13.3
	Stopped giving semisolid	0.0	0.0	0.0
	Breastfed only	16.2	50.0	22.2
20	When child had diarrhea, mother...			
20a	Did nothing	0.0	25.0	4.4
20b	Used ORT packet	18.9	0.0	15.6
20c	Used sugar-salt solution	73.0	0.0	60.0
20d	Used cereal ORT	13.5	0.0	11.1
20e	Used infusion/liquids	43.2	25.0	40.0
20f	Used antibiotics/antidiarrh.	32.4	50.0	35.6
20g	Used other	24.3	37.5	26.7
21	Mother sought advice re child's diarrhea	75.7	16.7	67.0
22	If sought advice, from whom?			
22a	Hospital	3.6	25.0	6.3
22b	Health post	17.9	0.0	16.1
22c	Private clinic	0.0	0.0	0.0
22d	Pharmacy	0.0	0.0	0.0
22e	Village health agent	32.1	0.0	29.0
22f	Traditional healer	39.3	0.0	35.5
22g	TBA	14.3	0.0	12.9
22h	Parents/friends	42.9	33.3	41.9
22i	Other	14.3	0.0	13.3

Appendix C.
CS-8 BASELINE RESULTS

		Old Zone (Kolond.)	New Zone (Zantie.)	Both
23	What symptoms cause you to seek advice?			
23a	Don't know	7.1	27.4	11.3
23b	Vomiting	29.0	14.3	25.9
23c	Fever	34.5	11.1	29.6
23d	Dehydration	29.0	22.2	27.6
23e	>14 days	29.4	17.5	26.9
23f	Bloody stools	9.7	7.9	9.3
23g	Lack of appetite	25.6	14.3	23.3
23h	Weakness or fatigue	45.0	27.0	41.2
23i	Other	21.0	12.7	19.3
24	Actions when child has diarrhea			
24a	Don't know	3.3	22.2	7.3
24b	Hospital/dispensary/maternty	51.9	23.8	46.0
24c	More to drink than usual	61.1	22.2	53.0
24d	Smaller more frequent feeds	32.2	7.9	27.5
24e	Stop giving liquids	1.3	1.6	1.3
24f	Stop giving food	1.2	1.6	1.3
24g	Other	22.6	34.9	25.2
25	Recovery from diarrhea			
25a	Don't know	10.0	33.3	14.9
25b	Smaller more frequent feeds	37.2	53.5	39.7
25c	More food than usual	61.1	25.4	53.6
25d	Other	16.3	6.3	14.2
	IMMUNIZATION			
26	Has the child been vaccinated			
	Yes	79.5	28.6	68.9
	No	20.1	68.3	30.1
	Don't know	0.4	3.2	1.0
27	At what age should child be vaccinated against measles?			
	6 months or younger	14.6	19.0	15.6
	7 months	0.8	1.6	1.0
	8 months	1.7	0.0	1.3
	9 months	51.3	60.3	53.2
	10 months	0.8	0.0	0.7
	Don't know	30.7	19.0	28.2
28	Why vaccinate women for tetanus			
	Protect mother and child	81.6	30.2	70.9
	Protect mother only	6.3	3.2	5.6
	Protect child only	4.6	11.1	6.0
	Don't know/other	7.5	55.6	17.5

Appendix C.
CS-8 BASELINE RESULTS

		Old Zone (Kolond.)	New Zone (Zantie.)	Both
29	How many Tt vaccinations should a woman receive?			
	1	5.9	17.5	8.3
	2	38.1	6.3	31.5
	3+	49.0	28.6	44.7
	None	0.4	0.0	0.3
	Don't know	0.0	47.6	15.2
30	Child has vaccination card			
	Yes	77.0	17.5	64.6
	No, lost	2.1	12.7	4.3
	No, never had	20.9	69.8	31.1
31	Vaccination rates 12-23 months			
	BCG	93.0	33.3	82.6
	OPV1	91.5	20.0	79.1
	OPV2	76.1	6.7	64.0
	OPV3	49.3	6.7	41.9
	DPT1	91.5	20.0	79.1
	DPT2	76.1	6.7	64.0
	DPT3	49.3	6.7	41.9
	Measles	73.2	6.7	61.6
	Fully vaccinated	49.3	6.7	41.9
	DPT dropout (DPT1-DPT3/DPT1)	46.1	66.7	47.1
32	Mother has maternal vacc card			
	Yes	88.3	47.6	79.8
	No, lost it	7.1	17.5	9.3
	No, never had	4.6	34.9	10.9
33	If yes, how many Tt vaccinatns?			
	1	2.8	23.3	5.4
	2+	97.2	76.7	94.6
	% ALL mothers surveyed rcvg 2+	85.8	36.5	75.5
	MATERNAL HEALTH CARE			
34	Mother has prenatal visit card			
	Yes	60.1	14.3	50.5
	No, lost it	6.3	6.3	6.3
	No, never had	33.6	79.4	43.2
35	If yes, how many prenatal visits?			
	1	20.4	22.2	20.5
	2+	79.6	77.8	79.5
	% ALL mothers w/2+ prenatal visits	49.2	3.2	39.4

Appendix C.
CS-8 BASELINE RESULTS

		Old Zone (Kolond.)	New Zone (Zantie.)	Both
36	Mother currently pregnant			
	Yes	3.3	0.0	2.6
	No	96.7	100.0	97.4
	Don't know	0.0	0.0	0.0
37	If no, do you want another child in the next 2 years?			
	Yes	14.3	9.5	13.3
	No	82.7	82.5	82.7
	Don't know	3.0	7.9	4.1
38	If no, using family planning?			
	Yes	16.6	8.8	14.8
	No	83.4	91.2	85.2
39	If yes, what main method?			
	Sterilization	0.0	0.0	0.0
	Norplant	0.0	0.0	0.0
	Injectables	0.0	0.0	0.0
	Pill	6.0	0.0	5.3
	IUD	0.0	0.0	0.0
	Diaphragm	0.0	0.0	0.0
	Condom	0.0	0.0	0.0
	Spermicide	0.0	20.0	2.6
	Breastfeeding only	18.2	0.0	15.8
	Rhythm	3.0	0.0	2.6
	Abstinence	72.7	40.0	68.4
	Coitus interruptus	0.0	20.0	2.6
	Traditional method	0.0	20.0	2.6
	Other	0.0	0.0	0.0
	Modern contraceptive usage rate	0.8	1.6	1.0
40	Pregnant women should visit a health agent how many times?			
	Never	0.4	0.0	0.3
	Once	2.9	6.3	3.6
	Twice	15.9	65.1	26.2
	Three times	12.1	4.8	10.6
	Four or more times	50.6	23.8	46.0
	Don't know	18.0	0.0	13.2
41	What should a pregnant woman's diet consist of?			
	Don't know	3.8	14.3	6.0
	Protein-rich foods (meat,eggs..)	84.1	5.8	77.2
	Green vegetables and leaves	91.8	85.5	90.6
	Other	23.8	30.2	25.2

Appendix C.
CS-8 BASELINE RESULTS

	Old Zone (*Kolond.*)	New Zone (*Zantie.*)	Both
42 Who cut your child's cord?			
Mother herself	0.0	1.6	0.3
Family member	6.7	4.8	6.3
TBA	82.4	81.0	82.3
Health agent	10.1	11.1	10.3
Other	0.8	1.6	0.7
Don't know	0.0	0.0	0.0

Appendix D

HIGHLIGHTS OF SC/MALI NUTRITION CURRICULUM FOR HEALTH AGENTS AND VILLAGE HEALTH COMMITTEES

1. Definition of Nutrition Terms ("nutrition," "food/feeding", "malnutrition," "weaning, " etc)

2. The Three Food Groups

3. Locally Available Foods, by Season and Food Group

4. The Advantages of Breastfeeding (benefits of exclusive breastfeeding, importance of colostrum, role of breastfeeding in child spacing, etc)

5. Maternal Nutrition (eat much and well; importance of foods rich in vitamin A, iron, protein; avoiding alcohol, certain medicines; family should give expectant mother best pieces of food)

6. Different Types of Malnutrition (marasmus, kwashiorkor, proteino-caloric malnutrition)
   - Extremely serious: 1/3 of severely malnourished children brought to hospital die in first week

7. Causes of Different Forms of Malnutrition
   - Marasmus: unsupplemented breastfeeding beyond age of 6 months, early interruption of breastfeeding, death of mother, bottlefeeding, low birthweight
   - Kwashiorkor: interruption of breastfeeding due to new pregnancy, unbalanced diet especially at weaning (too much grain, not enough protein), infectious disease (esp. measles)

   Also: lack of understanding of dietary needs, closely-spaced pregnancies, other illnesses (malaria, diarrhea).

8. Prevention of Malnutrition
   - Nutrition education leading to improved dietary practices
   - Regular growth monitoring and nutritional appraisal of child
   - Vaccination, especially for measles
   - Birth spacing
   - Improving environmental hygiene (especially water sources, latrines)
   - Garden projects
   - Livestock raising

9. Treatment of Malnutrition
   - Enriched foods (e.g. bean purée, dried fish porridge, egg yolk, bean/peanut powder mixed with porridge)
   - Referral of severe cases to subdistrict health post
   - Signs of recovery: appetite, smiling, interest in surroundings, disappearance of oedemas, weight gain, normal stools

10. Weaning Practices
    - Weaning is one of the most critical moments for a child's health; sudden weaning is a common cause of malnutrition
    - Gradual weaning is preferable, starting at age of 6 months:
      6-7 months: breastmilk + light porridge + fruit juice
      8-11 months: breastmilk + porridge enriched with peanuts, fish, beans, egg yolk; fruit juice or fruit; fish or meat broth; bean, vegetable, or potato purée

12+ months: breastmilk + above foods + family's meal
18-24 months: weaning is completed

- Even in the case of mother's subsequent pregnancy, the child should continue to breastfeed--mother's milk is still good for the baby.
- As the child grows, porridges should be more and more enriched with other foods, and more frequent
- The mother should sit with the child and observe how much he/she eats.

11. Monitoring of Children's Growth
    - Measure of child's development and good health, and to catch malnutrition at an early stage
    - Opportunity to discuss other health issues with mothers
    - Interpretation of the bands of the growth monitoring chart:
        Green: the child is growing normally
        Yellow: Danger: the child should be fed nourishing foods at least five times per day.
        Red: The child needs special care, from the health post
    - VHC should question each mother with a child in the red or yellow band to ascertain the cause of the faltering, whether sickness or diet

13. How to Organize a Nutrition Education Session (materials, lesson plan, follow-up)

14. Practical Recipes for Good Nutrition (using local foods)
    Protein supplementation: Grain + peanuts or beans and/or animal protein
        e.g. Millet porridge enriched with peanuts and beans
        Bean purée enriched with dried fish powder
        Meat bouillon
    Vitamin supplementation: Grain + dark green leaves and/or animal protein and/or pulses and tomatoes
        e.g. Purée of squash or sweet potato
        Fruit juice (give fruit itself after 7 months)
    Carbohydrate supplementation: Grain + oil and/or meat
        e.g. Millet porridge enriched with karité-nut butter

Appendix E

SITUATION D'ALPHABETISATION DES COMITES VILLAGEOIS EN SANTE
PAR ANIMATEUR FAMILIAL ET PAR ARRONDISSEMENT

9/20/93
Page 1

VILLAGE	ENCADRE? SC	CMDT	CAC	AUT	NON		POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
ARRONDISSEMENT DE Central													
Diakite Kadiatou													
* Mena	y	y	n	n			662	8.8 %	20	9	5	0	0
Boussala	y	y	n	n			192	5.2 %	5	0	3	1	0
* Mpiebougoula	y	y	n	n			341	17.6 %	25	5	4	2	0
* Selle	y	y	n	n			184	7.6 %	5	2	5	2	0
Kolomba	y	y	n	n			352	19.3 %	30	4	5	2	2
Kara	y	y	n	n			549	14.6 %	40	0	4	4	0
Djissan	n	y	n	n			437	8.2 %	8	10	4	0	1
Dialakoro-S	y	y	n	n			148	14.9 %	9	2	3	0	1
* Sodioula	y	y	n	n			410	23.4 %	40	8	2	1	0
Bougoula	y	y	n	n			144	5.6 %	4	0	5	1	0
Diarrala	y	y	n	n			472	8.5 %	20	0	4	1	0
TOTAL Diakite Kadiatou							3,891	12.1 %	19	4	4.0	1.3	0.4

CVS AYANT ALPHABETES 10 AVEC MEMBRES FEMMES ALPHABETES 3
CVS TOTAUX 11 91 % 11 27 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
3,229 83 % 937 24 %

Goumbale Dicko													
Boundio-ba	y	n	n	n			2,049	2.5 %	19	7	12	5	4
* Kola	n	y	n	n			222	14.4 %	10	6	8	2	0
Famorila	y	n	n	n			258	17.8 %	13	10	5	2	1
Sitin	n	y	n	n			450	9.9 %	20	0	4	2	0
* Koloni-Boundio	y	n	n	n			419	13.8 %	25	4	8	3	0
Zambougou	n	n	n	n	X		219	1.8 %	2	0	7	1	0
Quakoro	y	n	n	n			299	20.1 %	25	5	6	2	4
Tinko	n	y	n	n			1,051	3.0 %	11	5	11	2	2
TOTAL Goumbale Dicko							4,967	10.3 %	16	5	7.6	2.4	1.4

CVS AYANT ALPHABETES 8 AVEC MEMBRES FEMMES ALPHABETES 4
CVS TOTAUX 8 100 % 8 50 %

VILLAGE	ENCADRE? SC	CMDT	CAC	AUT	NON	POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
% POP TOTALE AYANT CVS ALPHABETISE						4,967	100 %	% POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)		3,657	74 %	
Kone Mamadou												
Dengouala	n	y	n	n		136	8.6 %	8	0	6	2	0
Ouronian	n	y	n	n		240	8.3 %	10	0	4	1	0
Korokoro	n	y	n	n		229	3.5 %	4	0	6	2	0
Tokoumala	n	y	n	n		176	9.1 %	8	0	6	1	0
Neguemala	n	n	n	n	X	213	0.0 %	0	0	4	0	0
Fareko	n	y	n	n		271	4.4 %	6	0	5	1	0
* Kignan	n	y	n	n		292	11.6 %	15	2	6	1	0
Korossina	n	y	n	n		303	4.0 %	6	0	4	0	0
* Tjitiena	n	y	n	n		276	13.0 %	16	2	6	2	0
Banankoro	n	n	n	n	X	221	1.8 %	2	0	5	2	0
TOTAL Kone Mamadou						2,407	6.4 %	8	0	5.2	1.2	0.0

CVS AYANT ALPHABETES 8 AVEC MEMBRES FEMMES ALPHABETES 0
CVS TOTAUX 10 80 % 10 0 %

% POP TOTALE AYANT CVS ALPHABETISE 1,891 79 % — % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S) 0 0 %

Kone Soungalo												
Kalakan	n	y	n	n		1,278	3.9 %	25	0	6	3	0
Niankourazana	n	y	n	n		560	3.9 %	11	0	6	3	0
* Falani	n	y	n	n		279	5.7 %	7	1	6	1	0
Diarrakoun	n	y	n	n		274	1.5 %	2	0	6	2	0
Zanina	n	y	n	n		326	0.6 %	1	0	7	1	0
Makana	n	y	n	n		500	12.0 %	30	0	5	1	0
Ntjinina	y	y	n	n		892	12.3 %	30	25	7	2	3
Katiola	n	y	n	n		228	1.9 %	2	0	6	1	0
Boromba	n	y	n	n		402	6.5 %	13	0	6	1	0
TOTAL Kone Soungalo						4,739	5.4 %	13	3	6.1	1.7	0.3

CVS AYANT ALPHABETES 9 AVEC MEMBRES FEMMES ALPHABETES 1
CVS TOTAUX 9 100 % 9 11 %

% POP TOTALE AYANT CVS ALPHABETISE 4,739 100 % — % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S) 892 19 %

VILLAGE	ENCADRE? SC	CMDT	CAC	AUT	NON	POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
Sangare Mamadou												
Blakala	n	n	n	n	X	1,041	3.3 %	17	0	10	1	0
Tiendaga	n	n	n	n	X	451	3.5 %	8	0	12	1	0
Zangouna	n	n	n	n	X	296	2.0 %	3	0	11	0	0
Kissa	n	n	n	n	X	517	0.8 %	2	0	9	1	0
Dialakoro-Y	n	n	n	n	X	318	0.6 %	1	0	8	0	0
Diandiana	n	n	n	n	X	368	2.2 %	3	1	9	0	1
Tintiri	n	n	n	n	X	835	2.6 %	11	0	9	1	1
TOTAL Sangare Mamadou						3,826	2.2 %	6	0	9.7	0.6	0.3

CVS AYANT ALPHABETES 5 — AVEC MEMBRES FEMMES ALPHABETES 2
CVS TOTAUX 7 71 % — 7 29 %

% POP TOTALE AYANT CVS ALPHABETISE 3,212 84 % — % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S) 1,203 31 %

Sanogo Moussa												
Toutiala	n	n	n	n	X	702	2.3 %	6	2	6	1	1
Missala	n	n	n	n	X	213	0.0 %	0	0	5	0	0
Mafele	n	n	n	n	X	495	0.8 %	2	0	6	0	0
Zena	n	n	n	n	X	556	0.4 %	1	0	5	1	0
Bogodougou	n	n	n	n	X	572	2.4 %	7	0	8	1	0
Fana	n	n	n	n	X	253	0.0 %	0	0	8	0	0
TOTAL Sanogo Moussa						2,791	1.0 %	3	0	6.3	0.5	0.2

CVS AYANT ALPHABETES 3 — AVEC MEMBRES FEMMES ALPHABETES 1
CVS TOTAUX 6 50 % — 6 17 %

% POP TOTALE AYANT CVS ALPHABETISE 1,830 66 % — % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S) 702 25 %

Sou Kadiatou												
Koloni-Foulala	n	y	n	n		1,469	8.4 %	50	12	8	2	2
Mpiediana	y	n	n	n		203	29.6 %	15	15	7	1	3
Kologo	y	n	n	n		250	7.2 %	6	3	5	1	1
* Togoya	y	n	n	n		991	1.8 %	8	1	5	3	0

VILLAGE	ENCADRE? SC	CMDT	CAC	AUT	NON	POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
Fofo	y	n	n	n		191	15.7 %	15	0	4	0	0
Ngolobala	y	n	n	n		236	28.8 %	24	10	8	2	2
Neriko	n	y	n	n		325	12.3 %	20	0	6	1	0
Zimpiala	n	y	n	n		464	12.9 %	30	0	6	0	0
Danfanani	n	y	n	n		455	4.8 %	11	0	6	0	0
Niamala	n	n	n	y		502	12.7 %	22	10	5	0	2
Kignana	y	n	n	n		221	19.9 %	10	12	6	2	1
Ntomina	y	n	n	n		177	37.3 %	21	12	6	2	1
Tenemakana	y	n	n	n		168	22.6 %	17	2	11	2	2
TOTAL Sou Kadiatou						5,652	16.5 %	19	6	6.4	1.2	1.1

CVS AYANT ALPHABETES 10 AVEC MEMBRES FEMMES ALPHABETES 8
CVS TOTAUX 13 77 % 13 62 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
4,542 80 % - 3,226 57 %

Togola Issa												
Sinzeni	n	y	n	n		779	1.5 %	6	0	6	1	0
Niamou	n	n	n	n	X	792	1.5 %	4	2	9	1	1
Bladieni	y	n	n	n		287	29.3 %	18	24	6	2	3
Sokolon	y	n	n	n		274	24.8 %	26	8	7	2	1
* Zandiougou	n	n	n	n	X	145	4.1 %	2	1	5	1	0
Zan	y	n	n	n		559	16.1 %	15	30	7	2	3
Diedieni	n	n	n	n	X	67	6.0 %	2	0	6	0	0
TOTAL Togola Issa						2,903	11.9 %	10	9	6.6	1.3	1.1

CVS AYANT ALPHABETES 6 AVEC MEMBRES FEMMES ALPHABETES 4
CVS TOTAUX 7 86 % 7 57 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
2,836 98 % 1,912 66 %

TOTAL ARRONDISSEMENT Central 31,176 9.1 13 4 6.3 1.3 0.6

CVS AYANT ALPHABETES 59 AVEC MEMBRES FEMMES.ALPHABETES 23
CVS TOTAUX 71 83 % 71 32 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)

VILLAGE	ENCADRE? SC	CMOT	CAC	AUT	NON	POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
	27,246				87 %			12,529		40 %		

ARRONDISSEMENT DE Fakola

Bocoum Hamadoun

	SC	CMOT	CAC	AUT	NON	POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
* Sokourani	y	y	n	n		2,431	3.0 %	23	13	8	1	0
Soromana	n	y	n	n		517	3.1 %	8	0	3	1	0
Gama	n	n	n	n	X	245	2.4 %	3	0	4	1	0
Dani	n	n	n	n	X	233	3.4 %	4	0	4	2	0
Kotla	y	n	n	n		656	13.4 %	28	16	6	2	3
Donterake	y	n	n	n		758	8.4 %	18	14	9	3	1
TOTAL Bocoum Hamadoun						4,840	5.6 %	14	7	6.5	1.7	0.7

CVS AYANT ALPHABETES 6 AVEC MEMBRES FEMMES ALPHABETES 2
CVS TOTAUX 6 100 % 6 33 %

% POP TOTALE AYANT CVS ALPHABETISE 4,840 100 %
% POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S) 1,414 29 %

Kone Adama

	SC	CMOT	CAC	AUT	NON	POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
* Garango	y	y	y	n		560	8.6 %	21	3	6	2	0
Santieni	n	n	n	n	X	362	3.9 %	7	0	6	1	0
Gourouko	n	n	n	n	X	1,691	3.4 %	26	3	8	1	1
* Fangouan	y	n	n	n		489	4.5 %	9	2	6	2	0
Ngodiarala	n	n	n	n	X	405	2.5 %	5	0	6	1	0
Ngokila	n	n	n	n	X	297	2.7 %	4	0	5	2	0
TOTAL Kone Adama						3,804	4.3 %	12	1	6.2	1.5	0.2

CVS AYANT ALPHABETES 6 AVEC MEMBRES FEMMES ALPHABETES 1
CVS TOTAUX 6 100 % 6 17 %

% POP TOTALE AYANT CVS ALPHABETISE 3,804 100 %
% POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S) 1,691 44 %

VILLAGE	ENCADRE? SC	CMDT	CAC	AUT	NON	POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
Kone Souleymane S.												
Farako	y	y	n	n		1,064	5.6 %	24	6	10	3	1
* Digan	n	y	n	n		1,236	3.7 %	21	2	9	3	0
Fatou	n	n	n	y		262	3.1 %	4	0	9	2	0
Kah	y	y	n	n		1,049	3.2 %	12	5	8	1	2
Zantoumala	n	n	n	n	X	971	2.5 %	12	0	7	3	0
Finiko	n	n	n	n	X	250	2.4 %	3	0	6	2	0
TOTAL Kone Souleymane S.						4,832	3.4 %	13	2	8.2	2.3	0.5

CVS AYANT ALPHABETES 6 AVEC MEMBRES FEMMES ALPHABETES 2
CVS TOTAUX 6 100 % 6 33 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
4,832 100 % 2,113 44 %

Sangare Alou												
* Bougoula	n	n	n	n	X	1,342	4.0 %	26	1	4	2	0
Farafing	y	y	n	n		1,086	1.7 %	9	0	5	2	0
Siana	n	n	n	y		922	1.1 %	5	0	6	2	0
Zoa	n	n	n	n	X	457	1.3 %	3	0	5	1	0
TOTAL Sangare Alou						3,807	2.0 %	11	0	5.0	1.8	0.0

CVS AYANT ALPHABETES 4 AVEC MEMBRES FEMMES ALPHABETES 0
CVS TOTAUX 4 100 % 4 0 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
3,807 100 % 0 0 %

Sangare Bakary												
Zeguere	y	y	y	n		1,659	10.2 %	60	25	7	2	2
* Soronko	y	n	y	n		609	5.9 %	15	3	5	2	0
Neguepie	y	n	y	n		267	11.2 %	10	5	7	2	1
Foutiere	n	n	n	n	X	453	2.2 %	5	0	6	2	0
Kolonzan	n	n	n	n	X	236	2.5 %	3	0	6	2	0
TOTAL Sangare Bakary						3,224	6.4 %	19	7	6.2	2.0	0.6

VILLAGE	ENCADRE? SC	CMDT	CAC	AUT	NON	POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
CVS AYANT ALPHABETES	5					AVEC MEMBRES FEMMES ALPHABETES		2				
CVS TOTAUX	5	100 %						5		40 %		
% POP TOTALE AYANT CVS ALPHABETISE	3,224	100 %				% POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)		1,926		60 %		
Traore Mariam												
Fakola	y	y	y	n		2,707	1.1 %	11	4	6	1	2
Dionkoni	y	y	n	n		596	2.7 %	8	0	6	2	0
* Dembasso-Ouman	n	n	n	y		1.326	1.3 %	8	4	3	2	0
* Diamogo	y	n	n	n		317	3.2 %	12	1	6	2	0
* Mpiensana	y	y	n	n		843	1.7 %	5	2	4	3	0
TOTAL Traore Mariam						5,789	3.1 %	9	2	6.0	2.0	0.4
CVS AYANT ALPHABETES	5					AVEC MEMBRES FEMMES ALPHABETES		1				
CVS TOTAUX	5	100 %						5		20 %		
% POP TOTALE AYANT CVS ALPHABETISE	5,789	100 %				% POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)		2,707		47 %		
TOTAL ARRONDISSEMENT Fakola						26,296	4.2	13	3	6.4	1.9	0.4
CVS AYANT ALPHABETES	32					AVEC MEMBRES FEMMES ALPHABETES		3				
CVS TOTAUX	32	100 %						32		25 %		
% POP TOTALE AYANT CVS ALPHABETISE	26,296	100 %				% POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)		9,851		37 %		
ARRONDISSEMENT DE Kadiana												
Diarra Issa												
Nangalasso	n	y	n	n		1,704	4.3 %	30	7	6	1	2
Kamacho	n	y	n	n		289	4.8 %	7	0	4	2	0

VILLAGE	ENCADRE? SC	CMDT	CAC	AUT	NON	POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
Maribougou	y	y	n	n		817	15.2 %	47	15	7	3	1
Niala	y	y	n	n		374	11.8 %	17	5	4	2	2
Tiediougouba	y	y	n	n		305	12.5 %	15	4	5	1	2
Yamaribougou	n	y	n	n		148	21.6 %	16	0	4	1	0
TOTAL Diarra Issa						3,637	11.7 %	22	5	5.0	1.7	1.2

CVS AYANT ALPHABETES 6 AVEC MEMBRES FEMMES ALPHABETES 4
CVS TOTAUX 6 100 % 6 67 %

% POP TOTALE AYANT CVS ALPHABETISE 3,637 100 %
% POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S) 3,200 88 %

Djenepo Kassim

Debena	n	n	n	n	X	2,252	0.0 %	0	0	4	0	0
Donfanaba	n	n	n	n	X	429	0.9 %	2	0	3	0	0
Dendio	y	n	n	n		293	3.9 %	8	5	3	1	1
Kountio	n	n	n	n	X	1,050	0.0 %	0	0	3	0	0
Sanankoro I	n	n	n	n	X	44	0.0 %	0	0	2	0	0
Tie	y	n	n	n		270	11.1 %	3	7	4	1	1
TOTAL Djenepo Kassim						4,337	3.5 %	3	2	3.2	0.3	0.3

CVS AYANT ALPHABETES 2 AVEC MEMBRES FEMMES ALPHABETES 2
CVS TOTAUX 6 33 % 6 33 %

% POP TOTALE AYANT CVS ALPHABETISE 563 13 %
% POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S) 563 13 %

Doumbia Adama

* Blendio	y	y	n	n		837	4.1 %	15	2	6	2	0
* Doubasso	y	y	n	n		328	9.1 %	10	5	6	2	0
Noumoula	n	y	n	n		170	7.1 %	6	0	6	3	0
Seble	n	y	n	n		334	6.6 %	11	0	6	2	0
* Koni	n	y	n	y		1,060	4.2 %	15	7	6	1	0
Ouable	n	y	n	n		1,094	2.9 %	16	0	6	3	0
TOTAL Doumbia Adama						3,823	5.7 %	12	2	6.0	2.2	0.0

CVS AYANT ALPHABETES 6 AVEC MEMBRES FEMMES ALPHABETES 0

VILLAGE	ENCADRE? SC	CMDT	CAC	AUT	NON		POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
CVS TOTAUX			6			100 %				6	0 %		

% POP TOTALE AYANT CVS ALPHABETISE 3,823 100 %

% POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S) 0 0 %

Konate Siaka													
• Ouarakana	y	y	n	n		902	6.2 %	21	7	6	3	0
• Dialakoro	n	y	n	n		486	5.3 %	11	2	5	2	0
Donkerela	y	y	n	y		1,673	7.1 %	51	8	7	3	2
Fala II	y	y	n	n		837	7.9 %	23	5	6	2	1
Soumba	n	y	n	n		251	4.0 %	5	0	4	2	0
Toulouia	n	y	n	n		559	5.4 %	15	0	5	2	0
TOTAL Konate Siaka						4,708	6.0 %	22	4	5.5	2.3	0.5

CVS AYANT ALPHABETES 6 AVEC MEMBRES FEMMES ALPHABETES 2
CVS TOTAUX 6 100 % 6 33 %

% POP TOTALE AYANT CVS ALPHABETISE 4,708 100 %

% POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S) 2,510 53 %

Ouattara Soungalo													
Fala I	n	n	n	y		263	4.6 %	6	0	4	3	0
Gonkoro	n	n	n	n	X	1,683	0.1 %	1	0	3	0	0
Kakoly	n	n	n	n	X	491	0.4 %	1	0	4	1	0
Moron	n	n	n	n	X	1,356	0.0 %	0	0	5	0	0
• Sanankoro II	y	n	n	n		479	4.2 %	7	3	5	3	0
TOTAL Ouattara Soungalo						4,272	1.9 %	3	1	4.2	1.4	0.0

CVS AYANT ALPHABETES 3 AVEC MEMBRES FEMMES ALPHABETES 0
CVS TOTAUX 5 60 % 5 0 %

% POP TOTALE AYANT CVS ALPHABETISE 1,233 29 %

% POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S) 0 0 %

Traore Adama													
Kadiana	n	n	n	n	X	2,814	0.0 %	0	0	6	0	0
Siala	y	y	n	n		710	6.2 %	22	0	4	3	0

VILLAGE	ENCADRE? SC	CMDT	CAC	AUT	NON	POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
Torokoro	n	y	n	n		274	7.3 %	10	0	4	1	0
Kokouna	n	n	n	n	X	162	0.0 %	0	0	4	0	0
Sikoro	n	n	n	n	X	331	0.0 %	0	0	5	0	0
Tionkourani	n	n	n	n	X	81	0.0 %	0	0	4	0	0
TOTAL Traore Adama						4,372	2.2 %	5	0	4.5	0.7	0.0

CVS AYANT ALPHABETES 2 AVEC MEMBRES FEMMES ALPHABETES 0
CVS TOTAUX 6 33 % 6 0 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
984 23 % 0 0 %

Traore Nantenin												
Tiongui	y	n	n	n		1,458	5.3 %	30	9	9	4	4
Goufien	y	n	n	n		275	16.7 %	13	10	5	1	2
Sokourani	y	n	n	n		444	6.8 %	8	7	7	2	2
Tiampa	y	y	n	n		851	0.9 %	4	0	8	0	0
Tiogole	n	y	n	n		137	2.9 %	2	0	4	0	0
Ziasso	n	y	n	n		381	1.0 %	2	0	5	0	0
TOTAL Traore Nantenin						3,546	5.6 %	10	4	6.3	1.2	1.3

CVS AYANT ALPHABETES 3 AVEC MEMBRES FEMMES ALPHABETES 3
CVS TOTAUX 6 50 % 6 50 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
2,177 61 % 2,177 61 %

TOTAL ARRONDISSEMENT Kadiana 28,695 5.3 11 3 5.0 1.4 0.5

CVS AYANT ALPHABETES 28 AVEC MEMBRES FEMMES ALPHABETES 11
CVS TOTAUX 41 68 % 41 27 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
17,125 60 % 8,450 29 %

VILLAGE	ENCADRE? SC	CMDT	CAC	AUT	NON	POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
ARRONDISSEMENT DE Kebila												
Doumbia Idrissa												
Dialaninkoro	n	y	n	n		879	6.6 %	20	9	9	2	1
Bohi	n	y	n	n		1,607	19.2 %	106	48	6	3	2
Nkrefienla	n	y	n	n		470	8.1 %	14	5	5	3	2
* Bafaga	n	y	n	n		2,188	4.7 %	45	6	13	4	0
Sinzimba	n	y	n	n		180	10.0 %	9	0	3	2	0
Kokouna	n	y	n	n		308	9.1 %	12	2	6	2	1
TOTAL Doumbia Idrissa						5,632	9.6 %	34	12	7.0	2.7	1.0

CVS AYANT ALPHABETES 6 AVEC MEMBRES FEMMES ALPHABETES 4
CVS TOTAUX 6 100 % 6 67 %

% POP TOTALE AYANT CVS ALPHABETISE 5,632 100 % % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S) 3,264 58 %

Kamissoko Karim												
Mantagala	y	y	n	n		372	13.4 %	15	10	5	1	2
Ngola	y	y	n	n		545	31.2 %	46	39	7	5	1
Koroni	y	n	n	n		202	13.9 %	11	3	6	3	2
Massamakana	y	n	n	n		1,038	8.7 %	32	13	6	4	2
Bella	y	n	n	n		319	10.0 %	14	2	6	2	2
Dialakoroni	y	n	n	n		264	29.5 %	22	17	6	4	2
Konna	y	n	n	n		311	29.6 %	29	17	6	3	2
Diaka	y	n	n	n		2,040	3.5 %	35	1	6	3	3
Dekoro-Fougala	y	n	n	n		134	10.4 %	4	3	3	1	1
Ntiobala	y	y	n	n		853	4.7 %	16	4	6	2	3
TOTAL Kamissoko Karim						6,078	15.5 %	22	11	5.7	2.8	2.0

CVS AYANT ALPHABETES 10 AVEC MEMBRES FEMMES ALPHABETES 10
CVS TOTAUX 10 100 % 10 100 %

% POP TOTALE AYANT CVS ALPHABETISE 6,078 100 % % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S) 6,078 100 %

Sangare Sadio

VILLAGE	ENCADRE? SC	CMDT	CAC	AUT	NON	POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
Massala	n	y	n	n		1,194	3.2 %	19	0	6	2	0
Tiguiya	n	n	n	y		340	1.8 %	3	0	6	2	0
Gouaran	n	y	n	n		392	9.7 %	19	0	6	2	0
Diomana	n	n	n	n	X	202	0.0 %	0	0	5	3	1
Sekana	n	y	n	n		523	4.6 %	12	0	6	3	0
* Winkala	n	y	n	n		1,041	9.6 %	30	20	6	1	0
Famokola	n	n	n	n	X	162	0.0 %	0	0	4	0	0
TOTAL Sangare Sadio						3,854	4.1 %	12	3	5.6	1.9	0.1

CVS AYANT ALPHABETES 6 AVEC MEMBRES FEMMES ALPHABETES 1
CVS TOTAUX 7 86 % 7 14 %

% POP TOTALE AYANT CVS ALPHABETISE 3,692 96 %
% POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S) 202 5 %

Sangare Sekou												
Samba	n	y	n	n		1,284	3.3 %	19	7	6	3	2
Dialakoroba	n	y	n	n		1,299	1.8 %	10	2	10	2	1
* Koroba	n	y	n	n		380	6.3 %	10	2	5	1	0
* Falani	n	y	n	n		464	7.8 %	15	3	6	3	0
TOTAL Sangare Sekou						3,427	4.3 %	13	3	6.8	2.3	0.8

CVS AYANT ALPHABETES 4 AVEC MEMBRES FEMMES ALPHABETES 2
CVS TOTAUX 4 100 % 4 50 %

% POP TOTALE AYANT CVS ALPHABETISE 3,427 100 %
% POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S) 2,583 75 %

Sissoko Anzoumane												
Kebila	y	y	n	n		2,538	2.5 %	20	12	11	4	1
Bougoula	n	y	n	n		1,372	10.1 %	49	20	7	3	3
* Ntountouroula	y	y	n	n		564	8.9 %	22	3	4	2	0
Kongo	y	n	n	n		554	5.8 %	12	4	6	2	2
* Bilaba-Kokouna	n	y	n	n		546	3.3 %	7	2	8	2	0
Bankoumana I	y	n	n	n		383	3.1 %	5	1	6	1	1
Toulomadio	y	y	n	n		398	9.0 %	10	8	5	2	1
TOTAL Sissoko Anzoumane						6,355	6.1 %	18	7	6.7	2.3	1.1

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VILLAGE	ENCADRE? SC	CMDT	CAC	AUT	NON	POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F

CVS AYANT ALPHABETES 7 AVEC MEMBRES FEMMES ALPHABETES 5
CVS TOTAUX 7 100 % 7 71 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
6,355 100 % 5,245 33 %

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TOTAL ARRONDISSEMENT Kebila						25,346	8.9	20	3	6.2	2.4	1.1

CVS AYANT ALPHABETES 33 AVEC MEMBRES FEMMES ALPHABETES 22
CVS TOTAUX 34 97 % 34 65 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
25,184 99 % 17,372 69 %

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ARRONDISSEMENT DE Toussequeia

Keita Amadou

* Wakoro	y	y	n	n		975	1.8 %	6	3	6	2	0
* Bessina	y	n	n	y		277	13.7 %	17	2	6	2	0
Diedieba	y	y	n	n		701	4.3 %	15	0	7	2	0
Kankeia	n	n	n	n	X	124	0.0 %	0	0	5	0	0
Ouoropana	y	n	n	n		188	5.3 %	5	0	6	2	0
Sanankoro	n	n	n	y		132	3.0 %	2	0	6	0	0
Sikoro	n	n	n	n	X	96	0.0 %	0	0	7	0	0
TOTAL Keita Amadou						2,493	4.0 %	6	1	6.1	1.1	0.0

CVS AYANT ALPHABETES 4 AVEC MEMBRES FEMMES ALPHABETES 0
CVS TOTAUX 7 57 % 7 0 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
2,141 86 % 0 0 %

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Kone Amadou T.

VILLAGE	ENCADRE? SC	CMOT	CAC	AUT	NON		POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
Kone Amadou T.													
Tousseguela	y	y	n	n			1,887	2.4 %	17	6	11	1	3
Bogola	y	y	n	n			55	10.9 %	3	0	6	4	0
Falani	n	y	n	n			270	3.0 %	4	0	4	1	0
Kolona	y	y	n	n			690	12.8 %	40	4	9	5	2
Ngolola	n	y	n	n			230	2.6 %	3	0	2	0	0
Sokolondie	y	y	n	n			416	9.1 %	17	2	7	3	3
Tienkoua	y	y	n	y			254	14.2 %	17	1	4	3	1
Fogoba	n	y	n	n			322	7.5 %	10	2	6	4	1
TOTAL Kone Amadou T.							4,124	7.8 %	14	2	6.1	2.6	1.3

CVS AYANT ALPHABETES 7 AVEC MEMBRES FEMMES ALPHABETES 5
CVS TOTAUX 8 88 % 9 63 %

% POP TOTALE AYANT CVS ALPHABETISE 3,894 94 %
% POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S) 3,569 87 %

VILLAGE	ENCADRE? SC	CMOT	CAC	AUT	NON		POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
Kone Kassim													
Kolosso	y	y	n	n			1,254	12.3 %	52	25	6	2	1
Benogobougou	n	n	n	n		X	241	0.0 %					
Diedieni	y	y	n	n			416	12.0 %	15	10	4	2	1
Diessou	n	y	n	n			176	2.3 %	2	0	2	0	0
Diodia	n	n	n	y			144	5.6 %	4	0	3	1	0
* Negela	y	y	n	n			701	10.0 %	25	10	4	2	0
* Tienkounco	y	y	n	n			794	9.8 %	24	15	5	3	0
Zana	y	y	n	n			360	12.2 %	22	0	4	2	0
* Zangouala	y	y	n	n			301	7.3 %	8	3	4	1	0
TOTAL Kone Kassim							4,387	7.9 %	19	8	4.0	1.6	0.3

CVS AYANT ALPHABETES 7 AVEC MEMBRES FEMMES ALPHABETES 2
CVS TOTAUX 9 88 % 9 22 %

% POP TOTALE AYANT CVS ALPHABETISE 3,970 90 %
% POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S) 1,670 38 %

VILLAGE	ENCADRE? SC	CMOT	CAC	AUT	NON		POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
Sissoko Balla S.													
Kelekele	y	y	n	n			2,006	4.0 %	24	16	7	1	2
Findiala	y	y	n	n			899	6.9 %	20	11	6	3	1
* Kouen	y	n	n	y			633	8.5 %	17	10	6	3	0

VILLAGE	ENCADRE? SC	CMDT	CAC	AUT	NON	POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
Sassila	n	n	n	n	X	113	0.0 %	0	0	3	0	0
TOTAL Sissoko Balla S.						3,651	4.9 %	15	9	5.5	1.8	0.8

CVS AYANT ALPHABETES 3 AVEC MEMBRES FEMMES ALPHABETES 2
CVS TOTAUX 4 75 % 4 50 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
3,538 97 % 2,905 80 %

TOTAL ARRONDISSEMENT Tousseguela 14,655 5.5 14 4 2.4 1.0 0.3

CVS AYANT ALPHABETES 21 AVEC MEMBRES FEMMES ALPHABETES 9
CVS TOTAUX 28 75 % 28 32 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
13,845 92 % 8,144 56 %

ARRONDISSEMENT DE Zantiebougou

Kone Amadou

Balankelebougo	n	n	n	n	X	77	5.2 %	2	0	4	0	0
Todougou-Kolon	n	y	n	n	X	1,387	0.0 %	0	0	8	3	0
Neguela	n	n	y	n		384	1.0 %	2	0	6	0	0
Dionkele-Sokor	n	n	n	y		222	2.7 %	3	0	7	3	0
Dionk.-Sokoura	n	y	n	n		267	0.0 %	0	0	7	1	0
Gouantou	n	y	n	n		533	1.9 %	5	0	6	3	0
Diomon	n	y	y	n		305	2.0 %	3	0	7	3	0
Ntjondougou-Ko	n	n	y	n		559	4.3 %	7	5	8	3	2
TOTAL Kone Amadou						3,734	2.1 %	3	1	6.6	2.0	0.3

CVS AYANT ALPHABETES 6 AVEC MEMBRES FEMMES ALPHABETES 1
CVS TOTAUX 8 75 % 8 13 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)

VILLAGE	ENCADRE? SC	CMDT	CAC	AUT	NON	POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
	3,273				88 %			559		15 %		
Mariko Mariam												
Sirakoro	n	y	y	y		659	9.8 %	27	2	7	2	2
Kimy	n	y	n	n		520	7.7 %	15	5	8	2	1
Sidio	n	y	n	n		188	8.5 %	7	1	6	1	1
Falaba	n	y	y	y		660	17.3 %	32	25	8	2	3
Tonfa	n	y	n	n		1,024	2.5 %	10	3	12	3	2
Toumou	n	y	n	n		807	3.7 %	15	0	8	3	0
Boundioni-Djou	n	y	n	n		521	2.7 %	7	0	6	2	0
Sorona	n	y	n	n		455	6.2 %	13	1	6	2	1
TOTAL Mariko Mariam						4,834	7.2 %	16	5	7.6	2.1	1.3

CVS AYANT ALPHABETES 8 AVEC MEMBRES FEMMES ALPHABETES 6
CVS TOTAUX 3 100 % 8 75 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
4,834 100 % 3.506 73 %

Sangare Amadou													
* Beko-Sokoro	n	n	n	n	X	808	4.0 %	15	1	8	4	0
Beko-Bougoula						223	0.0 %					
Sola	n	n	y	n		1,009	8.3 %	30	12	12	6	2
* Faradie	n	n	n	n	X	541	4.1 %	10	1	7	2	0
Oure	n	n	n	n	X	654	1.2 %	4	0	6	2	0
Mpiakala	n	n	n	n	X	422	1.4 %	3	0	7	3	0
Gouana	n	n	n	n	X	421	0.5 %	1	0	9	1	0
Soron	n	n	n	n	X	435	0.5 %	1	0	8	1	0
* Zamblebougou	n	n	n	n	X	50	4.0 %	0	1	3	1	0
* Beko-Togodo	n	n	n	n	X	165	15.8 %	12	1	6	1	0
TOTAL Sangare Amadou						4,728	4.0 %	8	2	7.3	2.3	0.2

CVS AYANT ALPHABETES 9 AVEC MEMBRES FEMMES ALPHABETES 1
CVS TOTAUX 10 100 % 10 10 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
4,505 95 % 1,009 21 %

55

VILLAGE	ENCADRE? SC	CMDT	CAC	AUT	NON	POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F
Sissoko Amadou Fily												
* Die	n	y	y	n		550	4.7 %	10	3	7	4	0
Bassa	n	n	n	n	X	160	0.0 %	0	0	4	0	0
Firako	n	n	n	n	X	330	0.0 %	0	0	4	0	0
Korosso	n	n	n	n	X	313	0.6 %	1	0	4	1	0
Kombe-Bogola	n	n	n	n	X	250	1.6 %	2	0	4	1	0
Mamissa	n	y	y	n		1,071	5.0 %	21	6	5	2	1
Niagaie	n	y	n	n		343	1.2 %	2	0	4	2	0
Zantogola	n	n	n	n	X	176	0.0 %	0	0	2	0	0
Sala						150	0.0 %					
Flokolon	n	n	n	n	X	399	0.0 %	0	0	6	1	0
TOTAL Sissoko Amadou Fily						3,742	1.3 %	4	1	4.4	1.2	0.1

CVS AYANT ALPHABETES 6 — AVEC MEMBRES FEMMES ALPHABETES 1
CVS TOTAUX 10 67 % — 10 10 %

% POP TOTALE AYANT CVS ALPHABETISE — % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
2,926 78 % — 1,071 29 %

Traore Salif												
Zantiebougou	n	n	n	n	X	1,628	0.6 %	1	4	13	1	4
Koury	n	n	y	n		566	12.0 %	17	17	10	3	1
* Fala	n	n	n	n	X	291	2.1 %	2	1	7	2	0
Zandiela	n	y	n	n		479	13.8 %	15	18	11	4	2
Sountou	n	y	n	n		180	5.6 %	5	0	9	2	0
Belekoni	n	n	n	n	X	206	4.9 %	5	0	9	2	0
Monzondougou-K	n	n	y	n		978	5.5 %	12	15	12	5	2
Bougoula	n	y	n	n		841	8.8 %	22	15	11	6	1
TOTAL Traore Salif						5,169	6.6 %	10	9	10.3	3.1	1.3

CVS AYANT ALPHABETES 8 — AVEC MEMBRES FEMMES ALPHABETES 5
CVS TOTAUX 8 100 % — 8 63 %

% POP TOTALE AYANT CVS ALPHABETISE — % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
5,169 100 % — 4,492 87 %

TOTAL ARRONDISSEMENT Zantiebougou 22,207 4.1 8 3 7.2 2.1 0.6

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VILLAGE	ENCADRE? SC CMDT CAC AUT NON	POP TOTAL	TAUX D'ALPHABETISME ADULTE	#ALPHABETES AU VILLAGE H	F	#MEMBRES-CVS TOT	ALPHABETES H	F

CVS AYANT ALPHABETES 37 AVEC MEMBRES FEMMES ALPHABETES 14
CVS TOTAUX 44 84 % 44 32 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
20,707 93 % 10,637 48 %

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TOTAL ZONE DE PROJET 148,375 6.7 13 4 6.1 1.7 0.6

CVS AYANT ALPHABETES 210 AVEC MEMBRES FEMMES ALPHABETES 87
CVS TOTAUX 250 84 % 250 35 %

% POP TOTALE AYANT CVS ALPHABETISE % POP TOTALE AYANT CVS AVEC FEMME(S) ALPHABETISEE(S)
130.101 88 % 66,983 45 %

Appendix F. Child Survival 8
Annual Workplan, 10/93-9/94

	FIRST QUARTER Oct-Dec	SECOND QUARTER Jan-Mar	THIRD QUARTER Apr-Jun	FOURTH QUARTER Jul-Sep
GENERAL PROGRAM MANAGEMENT				
Quarterly senior staff meeting on health	X	X	X	X
Quarterly project health staff meetings	X	X	X	X
Refresher training for health supervisors	X			
Midterm Evaluation/HO Tech assistance			X	
Health sector annual retreat/project review			X	
HEALTH INFORMATION SYSTEM				
VHCs/FTs collect village health info (ongoing)				
FTs report monthly health info for 5-7 villages by 15th of following month	XXX	XXX	XXX	XXX
Nurse-midwives report on women's health for subdistrict by 15th of following month	XXX	XXX	XXX	XXX
Supervisors aggregate subdistrict monthly health info for 4-9 FTs by 30th of following month	XXX	XXX	XXX	XXX
Project coordinators aggregate project monthly health info 40 days after end of month (i.e. February 10 for December info)	XXX	XXX	XXX	XXX
Quarterly report submitted to USAID/Washington	X	X	X	X
LITERACY				
FTs work to make all VHCs literate	X	X	X	X
Trainings to improve functionality of already literate committees		X	X	
Village School trains children and adolescents in literacy and improved health behaviors	X	X	X	
Research on the effect of literacy on health status	X	X	X	X
MATERNAL AND ADOLESCENT HEALTH				
TBA training		X		
Pre- and post-natal consultations	XXX	XXX	XXX	XXX
Prenatal consultation research project	XX			
Maternal mortality research	X	X		
Family planning Post-project KAP survey	X			
Tech assistance on family planning (FHI)	X X			
Family planning activities expansion planned		X	X	X
Training for project staff on community-based distribution of the pill	X			
Staff training on AIDS	X			
AIDS prevention program at village level		XXX	XXX	XXX
AIDS research project	XXX	XXX	XXX	

Appendix F. Child Survival 8
Annual Workplan, 10/93-9/94

	FIRST QUARTER Oct-Dec	SECOND QUARTER Jan-Mar	THIRD QUARTER Apr-Jun	FOURTH QUARTER Jul-Sep
CONTROL OF DIARRHEAL DISEASES				
VHCs train and assist mothers in ORT	XXX	XXX	XXX	XXX
FTs monitor VHC ORT activities	XXX	XXX	XXX	XXX
Develop simple forms for VHC to monitor incidence of diarrhea	XXX			
Train literate VHCs in use of forms		XXX	XXX	
IMMUNIZATION				
VHCs/FTs mobilize communities for vaccinatn	XXX	XXX	XXX	XXX
Disease surveillance	XXX	XXX	XXX	XXX
Train literate VHCs in use of vacc cards, vacc registers		XXX	XXX	
Infant mortality research	XXX	X		
NUTRITION AND BREASTFEEDING				
Weighings of normal-weight children	X	X	X	X
Weighings of malnourished children	XXX	XXX	XXX	XXX
Community trainings by "animatrices villageoises en nutrition"	XXX	XXX	XXX	XXX
Establishment of village cereal banks	X	XXX		
MALARIA				
Community trainings in malaria prevention	X		XX	XXX
Establishment of village pharmacies		XXX	X	
Project with NIH/Tulane/School of Medicine			XXX	XXX
Testing of treated curtain enterprises		XXX	X	
OTHER				
Dutch-funded CS project baseline survey		X		
Dutch-funded CS project activities			X	XXX

Notes:
(1) Research of Assetou Fofana, Malian School of Medicine, on factors influencing women's decisions to seek pre- and post-natal consultations
(2) Research by Dr. Souaibou Sacko on MMR and its determinants
(3) Research by Fulbright scholar Craig Lamberton on village attitudes and practices regarding AIDS and AIDS prevention