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**MIDTERM EVALUATION
INTEGRATED FAMILY HEALTH
SERVICES PROJECT
(IFHS)**

by

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GLOSSARY

AED	Academy for Educational Development
AMIFA	Malian Association for Adult Education
AMPPF	Malian Association for the Protection and Promotion of the Family
AVSC	Association for Voluntary Surgical Contraception
BMCD	Malian Credit and Savings Bank
DAF	Administrative and Financial Office
DH&S	Deloitte, Haskins & Sells
DNSP	National Public Health Administration
DNPFSS	National Administration of Social and Health Education and Planning
DSF	Family Health Division
EPI	Expanded Program of Immunization
EPS	Education for Health
FP	Family planning
FPLM	Family Planning Logistics Management Project
GRM	Government of the Republic of Mali
ICORT	International Conference on Oral Rehydration Therapy
IEC	Information, Education and Communication
IFAHS	Mali Integrated Family Health Services Project
INRSP	National Institute of Public Health Research
IPPF	International Planned Parenthood Federation
KAP	Knowledge, attitude and practices
MCH	Maternal/child health
MSP-AS	Ministry of Public Health and Social Assistance
NGO	Non-governmental organization

ORT	Oral rehydration therapy
PDS	Health Development Project
PIO/T	Project Implementation Order/Technical
PLMCD	Program to Fight Diarrheal Diseases
PRITECH	Primary Technologies for Health - USAID-financed organization to provide technical assistance to improve primary health care
SOMARC	Social Marketing Program for Contraceptives
UNICEF	United Nations Children's Emergency Fund
UNFPA	United Nations Fund for Population
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

In 1986, USAID/Mali and the Government of the Republic of Mali (GRM) signed an agreement to conduct an Integrated Family Health Services (IFAHS) project. The project duration is six years and it has a budget of \$9.6 million including the GRM contribution (estimated at \$1.6 million). The project provides funding to assist 15 Maternal and Child Health Centers in the District of Bamako and the region of Koulikoro to establish integrated MCH services. Project funds are used to renovate and complete the equipment of the 15 target centers; to purchase essential drugs including contraceptives; and to provide technical assistance (long- and short-term), training (in country and abroad) and IEC. Long-term technical assistance was planned for project financial administration, coordination of the technical assistance, and training. Short-term technical assistance was planned in training, IEC, family planning maternal/child health, and child survival.

In addition, the project provides funding to construct the headquarters of the Malian Family Planning Association (AMPPF). The AMPPF is a private non-governmental organization (NGO) affiliated with IPPF. At the time of project design, the agency was providing 60 percent of all family planning services in Mali. The project design also earmarked funds for the AMPPF to design and implement an IEC campaign to promote family planning.

The project design called for a midterm evaluation at the end of the first phase of the project. This evaluation was postponed until March/April 1989. The terms of reference for the evaluation requested that the assessment be focused on process rather than impact. The evaluation was conducted over a period of three weeks and included four phases: consultation of documents; meetings with project staff and with other concerned individuals; visits to target cities; report preparation; and presentation of the results of the evaluation to the project team, USAID and GRM officials. The evaluation team was composed of three Malians who are not associated with the project but work for the Government of the Republic of Mali, and two US public health specialists, one of whom works for A.I.D.

The evaluation revealed that all the components of the project were considerably behind schedule in their implementation. Although a certain amount of planning has taken place, none of the centers visited by the evaluation team had taken any action to change the way they deliver MCH services. Some senior staff members of the centers visited had attended planning meetings, but at the level of the midwives who deliver services, the project was largely unknown.

The IEC program is one of the supporting elements of the

project. Work on this project component, however, has not started. One of the early elements of the project was to have been the construction of the AMPPF headquarters and the renovation of the 15 target centers. The construction of the AMPPF started in April/May 1989, a good two years behind schedule. None of the renovation to the centers has started yet. The addition to the building of the Family Health Division (DSF) may start before the rainy season. During the early phase of the project, orders for the commodities should have been placed to allow ample time for delivery of equipment, drugs and contraceptives. These materials were ordered so late into the project that the delays in delivery are now posing enormous problems for the implementation phase as these materials should be available for the start-up of activities. In addition, the follow-up on orders, some of which were placed almost a year ago, has been very weak.

The project design called for three studies to be conducted at the onset of the project to record basic information for planning purposes and to be used as benchmarks for later evaluations. The study of the centers was completed but the social marketing study is still in the final phases of analysis. The study on cost recovery was not conducted. A financial study was completed but it was not in the original project design and its usefulness is mixed.

The delays are due in part to the fact that insufficient qualified staff are assigned to the project and that the persons who are assigned to the project have competing responsibilities.

One of the major supporting activities of the project is the training element. This element is also behind schedule mostly because the long-term technical assistance has not yet been hired. The delay in hiring is caused by the lack of office space for the consultant, resulting from the delays in construction and the decision to build an addition to the DSF building rather than rent space for the project team, as called for in the design. As the training strategy has not yet been finalized, it is likely that the project will experience further delays.

The financial management of the project is now under control. The project could not be certified for a long time because the project accounting infrastructure was not sufficient to ensure rigorous control systems. Two accountants were assigned to the project but they were immediately sent abroad for training, leaving the project with insufficient staff to carry out the separate accounting functions as mandated by A.I.D. regulations. Because of the delays with almost every technical aspect of the planned activities, the project is underspending.

The technical management of the project is the joint responsibility of the project director, the USAID technical

officer and the long-term technical advisor. Both the GRM and USAID changed the staff responsible for the project shortly after the project start. These staff changes have resulted in a late start of several crucial elements of the project. According to the project design, the long-term technical advisor was to be hired at the end of the project's second year. Fortunately, the hiring date was advanced to the beginning of the second year of the project. Since her arrival, the long-term technical advisor has made the project move forward and has initiated work on all elements of the project. At the time of the evaluation, the health status of the long-term technical advisor was not good, however, and further delays may occur as a result of her poor health.

In the project design, the role of the AMPPF was not spelled out clearly, leaving to the project team the burden of defining avenues for collaboration. Too much emphasis has been placed on administrative regulations and protocol and not enough on the means to reduce the administrative red tape and to reach the ultimate goal of the project and to initiate services.

Future Directions

The evaluation team, in an effort to assist with the goal to put this project back on track, has made a long list of recommendations. The recommendations, although numerous, constitute a set of actions that ought to be considered with care by the project management team. These actions alone, however, cannot save the project unless it becomes clearly understood that the goal and objectives of the project are being confused with the goals and objectives of the Family Health Division. While this may be good in terms of the integration of the project within the GRM structure, it should be recognized that the project has in itself a set of goals and objectives that must be achieved so that the project can become successful. Emphasis on accomplishing the goal and objectives of the project must be increased. Discussions between USAID/Mali and the DSF are needed to define the role of the AMPPF in this project.

1. INTRODUCTION

1.1 Project Description

The Mali Integrated Family Health Services (IFAHS) project is a six-year program costing \$9,600,000. The project agreement signed in July 1986, stipulates that USAID will contribute \$8,000,000 and that the Malian government will contribute the equivalent of \$1,600,000.

The purpose of the project is to assist the Maternal/Child Health (MCH) and Family Planning (FP) Program of Mali, in order to reinforce and integrate MCH/FP services into 15 health centers located in the District of Bamako (10 centers) and the Region of Koulikoro (5 centers). The project will also have the goal of reinforcing and assisting the Malian Association for the Protection and Promotion of the Family (AMPPF). Below is a list of the selected centers:

List of IFAHS Project Target Centers

DISTRICT OF BAMAKO

REGION OF KOULIKORO

- | | |
|-------------------------------|-----------------------------|
| 1. Central MCH/FP center | 11. Koulikoro MCH/FP center |
| 2. Missira MCH/FP center | 12. Dioila MCH/FP center |
| 3. Niaréla MCH/FP center | 13. Kati MCH/FP center |
| 4. Korofina MCH/FP center | 14. Banamba MCH/FP center |
| 5. Lafiabougou MCH/FP center | 15. Kangara MCH/FP center |
| 6. Hamdallaye MCH/FP center | |
| 7. Djikoroni MCH/FP center | |
| 8. Badalabougou MCH/FP center | |
| 9. Sogoniko MCH/FP center | |
| 10. Mali ward MCH/FP center | |
| | 16. AMPPF Clinic |

The primary activity of the project is to integrate the various MCH/FP services into a number of health facilities. To do so, the project provides support activities including a training program, Information, Education and Communication (IEC) activities, technical assistance in several fields, renovation and construction work, materials and medicine (including contraceptives) and a research and evaluation program.

The project was planned in three phases. The first phase (to last 18 months) was for project establishment. During the second or interim phase (six months), long-term technical assistance staff was to begin working. During the third, or operational phase (four years), IEC activities, construction and

training were to take place. During this final phase, the project was to prepare to transfer the program to the Malian health system.

It is important to note here that the concept of integration, which is at the very heart of this project, involves two separate aspects. On the one hand, since the goal of the project is to integrate the provision of services within health facilities, the program calls for revising the care provision methods in all target centers. A patient who comes in for a given service will be given information about other services the center offers. In this way, she can take advantage of all the services she needs without having to make a second trip. To this end, the project must conduct support activities in the following three areas: renovating target centers and equipping them so that the services can be physically reorganized; establishing an IEC program to inform patients about available services and to encourage them to take advantage of these services; and conducting basic studies to determine the effects of the project at its completion and to establish the foundations for the subsequent steps of a national program.

The notion of integration also involves the way in which the project is implemented. It is fairly clear that the developers of the concept of this project did not intend it to be fully integrated into the Family Health Division (DSF) of the National Public Health Administration (DNSP) until the completion of the project. Project documents indicate that the original plan stipulated a vertical action to support DSF's efforts and to assist it in integrating services into target health facilities. Integration was to occur at the end of the project. Malian authorities signed a cooperative agreement that was somewhat ambiguous because of the way certain sentences were translated into French.

Shortly after the documents were signed, the parties involved discussed the concept of integrating the project into the DSF. The Malian party insisted that the project be integrated into the DSF program according to national project integration policy. With this principle in place, the foundation of the project itself was modified as compared to its original concept. Some of the delays in planned activities are the result of this change in orientation, because certain aspects of the project no longer corresponded to the provisions of the original documents. This agreement was not covered by documentation in the form of a review of the logical framework for the implementation of the project or the project implementation plan.

A major goal was added to the project when the decision was made to integrate it into the Family Health Division from the beginning. This involved reinforcing DSF's organization in the area of MCH/FP and preparing for the transfer of technology acquired in the 15 pilot centers to all health facilities in the

country that are involved in MCH/FP. This objective is very important because it was the focus of many of the activities during the first two phases of the project.

1.2 Objectives of the Evaluation

The subsidy agreement stipulates that a mid-project evaluation must be conducted during the second year of the project, i.e., at the end of the first phase. This examination midway through the Integrated Family Health Services (IFAHS) project has the following goals:

- To assess the project implementation process and determine its status;
- To verify that the management organization and systems are in place to achieve project goals;
- To identify the problems encountered so that specific recommendations can be made for phase three of the project; and
- To determine whether the project requires new orientations based on needs identified in the field.

This evaluation was to focus on "the project procedure rather than the impact" of the program, which cannot yet be measured. The evaluation is expected to yield constructive criticism to be used as a basis to redirect project efforts. (The terms of reference for the evaluation are provided in Appendix A.)

1.3 Members of the Evaluation Team

The team in charge of evaluating the IFAHS project was multi-disciplinary and included Malian representatives and USAID consultants.

The team was made up of five members:

- Mrs. Nadine Burton: Public Health Consultant, Team Leader;
- Mrs. Neen Alrutz: Nutrition Specialist, AID Bureau of African Affairs, Washington, DC;
- Mr. Siné Coulibaly: Evaluator/Economist, National Administration of Social and Health Education and Planning (DNPFS), Programming and Evaluation Studies Division;
- Dr. Allaye Diallo: Community Health Specialist, Bamako District DRSP;
- Mr. Amadou Bengaly: Public Finance Specialist, Administrative and Financial Office (DAF)/Health.

The team's work was coordinated by the representative from the National Administration of Social and Health Education and Planning (DNPFS).

Dr. Madina Bâ Sangaré accompanied the evaluation team during its visits. The team was accompanied by a regional worker during field visits.

1.4 Evaluation Methods

The evaluation took place from March 20 to April 7, 1989. According to the Project Paper, the evaluation was to have taken place between January and March 1988, at the end of phase one, but was postponed until 1989 due to delays during the project establishment phase.

At an orientation meeting held on March 21, 1989, the evaluation team prepared a working schedule (provided in Appendix B), and its evaluation plan. DSF staff were quite competent in organizing appointments and meetings. DSF also provided the team with a vehicle and driver to facilitate outings and meetings. The Malian representatives on the team were effective in seeing to it that meetings with government organizations were arranged. This rapid and effective management of the evaluation team's needs allowed the evaluators to meet with many people (names and organizations are provided in Appendix C) in a relatively short period of time. Thus, the team had very good working conditions under which to conduct the research behind this document.

The evaluation involved four work phases, the first two of which were conducted simultaneously in order to save time. In the first phase, the team studied available documents concerning the project (the list of documents the team consulted is provided in Appendix D). It must be noted that project personnel had prepared and organized in advance the documents the team consulted. This did much to facilitate the evaluation process. The documentation was excellent and included numerous reports, reference memoranda and other supporting materials.

The second phase of the evaluation involved meetings with the persons involved in the project and site visits (Appendix E). Meetings included interviews with the Project Leader, Technical Assistance Team and the different project participants in the Malian Ministry of Public Health and Welfare (MSP-AS). The team also held discussions with USAID representatives and AMPPF officials.

The sites selected for field visits were suggested by the Project Manager and approved by the team. The following centers were visited: Koulikoro MCH/FP center, Katibougou Health Center, Missira MCH/Maternity Clinic, Lafiabougou MCH/FP center,

Hamdallaye Maternity Clinic, Banamba Health Center and Kangaba Health Center. These centers are described briefly in Appendix E.

The third phase of the evaluation was the capsule presentation of the team's research and the writing of the draft evaluation report. The evaluators shared the responsibilities of analysis and writing the document.

In the fourth phase, the evaluation report was submitted to officers from USAID, DNSP, DNPFS and AMPPF during the coordination meeting held on April 6, 1989. The document was amended on April 7 to reflect the joint work at the coordination meeting.

The evaluation team left project officers with a working document in French for future planning purposes. An English translation of this document will be submitted to USAID at a later date.

2. PROJECT ACTIVITY COMPONENTS

As discussed below, there were major delays in all project activities. These observations should be prefaced by mentioning the positive aspects of the project. Its integration within the DSF is a very positive contribution. Avoiding the creation of a separate framework for project activities is more consistent with Malian government national policy, which consists of integrating all foreign assistance projects into the regular systems to promote the continuation of the efforts when the projects end. On the other hand, the project targeted only a small number of health centers in two of the country's eight regions. Furthermore, the project's field of operations does not go beyond the circle level, although the majority of the Malian population resides in rural areas. Then again, if the project had been conducted on a vertical basis, its program would only have affected the target health facilities. By basing the project within DSF, all efforts to improve services in the target centers served as a foundation for the general reorganization of MCH/FP programs for the entire country. Of course, the reorganization of an entire national MCH/FP program takes more time to organize than just the improvement of the services in 15 target centers. This partially explains the delays the evaluation team observed in the work.

Still, DSF counts among its assets the implementation of the preparatory framework for reorganizing the services in the health centers targeted by the project. Each center was visited and its needs assessed. Although the MCH/FP national training strategy has not yet been developed, a working plan was designed that serves as a basic foundation; the awareness of the importance of IEC has grown; and standards and procedures have been developed.

Finally, it should be noted that personnel changes that occurred during the first year of the project contributed greatly to the general delay in the project. Indeed, no activities were undertaken before the second year of the project and the arrival of long-term technical assistance. From that point on, the project was behind schedule and the delay could not be made up. Considerable preliminary work was not completed until 1988.

2.1 Improvement of MCH/FP Services

The main goal of the IFAHS project is to improve the services offered by participating MCH/FP centers and AMPPF, the private family planning agency. This improvement primarily involves the techniques of intervention, integration of services, clinic management, information systems, personnel training, equipment for centers, and miscellaneous health materials and supplies.

Four technical components -- nutritional monitoring, immunization, oral rehydration therapy (ORT) and voluntary family planning (FP) -- were selected to receive special support under this project.

According to the Project Paper, the implementation of the activities was to start around the beginning of the third year (September 1988). Because of the changes and delays in the construction work, in receiving equipment and medicine, in placement of long-term technical assistance in training, and in the review of national MCH/FP procedure policy, however, there was virtually no sign of the IFAHS project at the health center level at the time of the evaluation.

Improvement of Malian government health complex services involves two basic components: personnel training and integration of all services offered so that the various routine patient consultations can be handled the same day, and mothers and children do not have to make repeat visits. These activities have not begun in any of the 15 centers covered by the project.

With the upcoming placement of the long-term technical assistance in training and the review of national policies, manuals and training plans, it is hoped that the problem will be resolved and that local personnel training can begin before late 1989.

Furthermore, total integration of health center services may not be a realistic objective, albeit a desirable one. Because of the lack of personnel, especially in rural areas, it could be difficult to provide all services on a daily basis in some less fortunate centers.

The current strategy of the 1989 work plan, which targets the MCH/FP centers of Missira and Banamba as the pilot sites for introducing the new MCH/FP standards and procedures, will allow a careful look at how this integration can be realized objectively.

2.2 Information, Education and Communication Program

There is little to be said about IEC activities, because the program has not begun. The DSF, which is the national organization responsible for IEC in national MCH/FP programs, has not yet prepared its plan of action. A working meeting has been held and others are planned. Some preliminary tasks have been completed, but the work of formulating the IEC program has only just begun in the past three months. The interim program involved only the study of documents, use of some basic data, and a statement of problems.

The Project Papers present the IEC program as an aid in improving services and a way to stimulate increased use of MCH/FP services.

It was planned for AMPPF to play the main role in family planning IEC and for DSF to undertake the IEC program for other services. The operating budget for the IEC component is \$264,000, with a total of \$88,000 being intended for AMPPF. Short-term technical assistance funds are also available for both partners in the IEC program. As discussed in Section 5 on AMPPF, the Project Paper did not define the methods for cooperation between the project and AMPPF. This factor delayed the cooperative work between these organizations.

The Academy for Educational Development (AED) worked with DSF to try to stimulate progress in the IEC program, especially in the area of nutrition. AED proposed cooperative measures to DSF that seemed to solve the problem stemming from the fact that the project plan made no provision for long-term technical assistance in IEC. This omission was even more problematic because of the IEC component's importance to the completion of this program.

2.3 Construction, Renovation, Materials, Equipment and Medicine

A. Construction and Renovation Planning

The construction and renovation component was planned to finance varying degrees of structural improvements for the 15 target centers in the project: construction of a new MCH facility at the Djikoroni Health Center; construction of a warehouse in Koulikoro; and construction of a building to serve as AMPPF headquarters in a convenient location in the center of Bamako.

It was planned for the project to rent the housing for project personnel. During the initial months of the project, Malian directors expressed the desire for the money allocated for the rental of the project headquarters to be devoted to adding an additional story to the DSF's existing building. This request was approved by USAID and was covered by a project amendment and budget adjustments.

According to the project implementation plan, the Construction/Renovation component should be implemented as follows:

- Engineering form (two months before the signing of the grant agreement);
- Construction of AMPPF (construction program began in 1986 and ended around July 1988); and
- Renovation of 15 centers, construction of the Djikoroni MCH/FP center and the addition of the DSF (construction beginning around April 1989 and ending approximately six to ten months later).

B. Construction of the AMPPF Headquarters and Clinic

This component has been delayed considerably, since it was to be completed in July 1988. The delay was caused by the administrative procedures needed to ensure AMPPF's official status to allow it to take possession of its headquarters upon completion of the construction. To regularize its NGO status, AMPPF first had to sign a Frame Agreement with the Malian government and establish a memorandum of understanding with the Ministry of Public Health and Welfare. In order to begin work, a leasing contract also had to be signed with the railroad administration owning the land on the future building site.

The architectural plan for the AMPPF building was designed and developed carefully, with the assistance of an Association for Voluntary Surgical Contraception (AVSC) consultant specializing in surgical clinic construction. The plan was approved by DSF and studied by physicians.

As of the time of the evaluation, all preliminary construction documents were available and construction had just begun. The contracting agreement stipulates that work will be finished in late 1989 (310 days).

C. Renovation and Construction of 15 Health Centers

As a result of the DSF and USAID (Engineering Office) joint missions, the construction and renovation needs of the 15 target centers of the project were discussed and a plan of action was developed. A report was submitted to the architect, who developed the plans submitted to the different partners.

The competitive bidding for the 15 centers is scheduled for April 1989. This component is also running behind schedule, a situation which may have negative repercussions on the operational phase of the project.

D. Addition to the DSF

As explained above, the addition of a story to the DSF building was the result of a change in the project. This construction has given rise to certain questions:

- Can the existing structure accommodate a second story? In order to solve this problem, the Malian government had to provide USAID with a construction notice on the existing building releasing USAID from all liability.
- Can the construction site safety be ensured (because the building will be occupied while the work is in progress)? The construction firm promised to take additional safety measures while the work is under way.

The architectural plans were drawn up and approved by all parties. The request for proposals was issued and a local firm selected. The company proposed that work begin in April and be completed in two months, before the rainy season begins.

E. Orders for Equipment, Materials, Medicine and Contraceptives

A detailed procurement plan for materials and equipment is included in the Project Paper. This plan was modified, however, because it did not correspond to the country's health needs. A new list of materials was prepared for each of the levels of operation corresponding to service needs. One lot of locally purchased office furniture and equipment has already been divided among several centers. All orders for materials, equipment and medicine from the United States are far behind schedule. It must be noted that other organizations consulted for references (UNFPA and UNICEF) concerning problems in bringing equipment in from other countries, did not seem to indicate major problems. The combination of complex administrative procedures in the USAID equipment procurement system, an ineffective follow-up system and local administrative sluggishness appear to have been the main reasons behind these delays.

A special waiver was approved for project vehicles, and direct procurement was opened to the local market. Three of the vehicles provided for under the project were purchased within the deadlines established.

Prior to the project, AMPPF and UNFPA had been handling contraceptive supplies for the country's entire family planning program. AMPPF was out of stock for several months in 1988, so no contraceptives had been ordered under the project, and the contraceptives ordered under the UNFPA project were late;

therefore, all health facilities in the country went without contraceptives for periods ranging from four months in urban areas to over six months in rural locations. The March 1988 order for contraceptives was not delivered until October 1988. The emergency order systems were not used. Another order has just been placed for 1989 (cable dated February 1989). In December 1988, the personnel involved with the orders at USAID, DSF and AMPPF underwent contraceptive logistics training to prevent this problem from recurring in the future.

The project initially made no provisions for medicines, but the team observed the need for essential medicine in the target health facilities and placed an order in September 1988, which has not yet been filled.

2.4 Special Studies

Three studies were planned within the context of the project. To date, only the baseline data study reports have been available. It should be noted that DH&S conducted a financial management system study (not mentioned in the Project Paper) that served as a basis for the project's financial management system. This study is discussed in Section 4.

A. Baseline Data Study

Planned for a two-month period during the first quarter of the first year of the project (autumn 1986), this study (assigned to Family Health International [FHI]) could not be conducted until April 1987. The document was completed in September 1987.

The study essentially involved the following data analyses:

- Populations served by the target centers
- Physical structures of the target centers
- Materials and equipment in target centers
- Supply and inventory of equipment in target centers concerning vaccines, contraceptives and first aid supplies
- Medical and paramedical staff in target centers
- Services provided (organization, activity content, records, notebooks and other service statistics)
- Nutritional monitoring
- Oral rehydration therapy
- Immunization for pregnant women and children 6 years of age and under
- Family planning: available methods, method selection criteria, contraceptive methods available for lactating

women, side effects of various methods, follow-up examinations, personnel training and alternative service programs

- Health education needs

Two additional studies were conducted under the same project: a retrospective study on women using contraceptives conducted by AMPPF and a study of baseline data in the Upper Valley. Conclusions were drawn and pertinent recommendations made in all of these areas.

B. Cost-Recovery Study

This study was to have been conducted during the first year of the project, between the 5th and 6th months. It was cancelled because a similar study (just published) was in progress at the National Institute of Public Health Research (INRSP). Other similar studies have been conducted, leading to the implementation of experimental systems. The regions selected were those covered by the health development project (PDS) in the region of Kayes, primarily in the Circles of Kita, Bafoulabé and Kéniéba, under a project financed by the World Bank. Cost-recovery system results seem very promising in these regions. Although these studies are interesting and useful, they do not specifically deal with MCH/FP care cost recovery.

C. Study on Social Marketing for Contraceptives

The third study under the project was planned to be conducted during the 10th to 14th months of phase one. Its goal was to evaluate the feasibility of private commercial distribution of contraceptive methods and other items such as oral rehydration salt packets.

The study, conducted by SOMARC in November 1986, yielded the following conclusion: A project for the social marketing of contraceptives is a good idea and an important way to attain family planning objectives.

This study also resulted in a draft document for the social marketing program. The goal of the SOMARC project is to increase the availability and use of contraceptives in low-income groups, to develop means using commercial marketing and distribution techniques, and to establish a cost-recovery plan.

The final document has not been completed, but the SOMARC workshop to be programmed shortly, will be assigned the task of submitting a social marketing concept to the Ministry of Public Health and Welfare.

3. HUMAN RESOURCES

3.1 Malian Staff

Both the Project Paper and the project grant agreement stipulate that a full-time Project Manager would be appointed "to direct and coordinate all GRM implementation activities within the context of the project." Table 9 (Estimated Annual GRM Personnel Inputs) from the English version of the Project Paper also provided for six other full-time GRM employees under the project. However, this table (provided in Appendix G) is not included in the French version of the Project Paper, and no references to any other full-time persons are made elsewhere.

GRM immediately informed USAID after the agreement was signed that the project had to be integrated into the Ministry of Public Health and Welfare's regular operations in the Family Health Division. Thus, within the context of the total integration of the IFHS project into DSF operations, the Project Manager and all other staff members were only able to devote part of their normal working time to the project, on an as-needed basis, in addition to their GRM duties.

Currently, with the exception of the full-time bilingual secretary, a part-time accountant and two drivers, Malian staff in the various sections (Nutrition, Education for Health, CMD and MCH) and related units are engaged each month in project activities at different levels, depending on the types of activities to be undertaken.

Although DSF has capable physicians and other persons who are well-trained and competent in their respective fields, the section chiefs are still in great demand on other health projects and activities under way in Mali. Thus, their availability to participate in activities necessary for the project to move forward is not always ensured.

Although the IEC project component has not yet begun in the target centers, the Education for Health (EPS) section of the DSF seems to have a shortage of trained personnel continuously available for IEC activities. The EPS section is now being reorganized to try to make more staff available on an ongoing basis to work full time on IEC activities in DSF's MCH/FP centers; still, more project assistance in the area of IEC seems necessary, considering how important IEC activities are to the success of the project.

For the training component, the review of all training-related activities at the national level was assigned to the DSF training unit, assisted by short-term consultants. Unfortunately, because of the great responsibilities of unit members and unforeseen problems with consultants, the training program has not

yet been completed, despite the assistance from the Training Division of the National Administration of Social and Health Education and Planning (DNPFS). (The DNPFS is itself experiencing a shortage of personnel and is overloaded with work.)

3.2 Technical assistance

The Project Paper called for the recruitment of three long-term advisors: a team leader/administrator, a financial management advisor and a training advisor. The team leader arrived earlier than planned (October 1987 instead of July 1988), the financial director was hired in September 1987, and the training advisor, who was scheduled to come on board in July 1988, has still not arrived.

The team leader and financial director are both very competent and have several years of experience working with USAID in developing countries. Their creativity, technical expertise and complementary skills have contributed immeasurably to the progress of the project to date.

According to the Project Paper, the implementation schedule for the long-term training advisor was as follows: 12th month (July 1987) -- finish Project Implementation Order/Technical (PIO/T); 1st month of the second year (August 1987) -- public job announcement; 3rd month of the second year (September 1987) -- select a candidate; 5th month of the second year (November 1987) -- sign contract; and first month of the third year (July 1988) -- install training advisor.

The recruitment of the long-term training advisor was delayed because of the Project Manager's hesitation to add a third technical assistant to an already overcrowded office. The decision at the beginning of the project to add a story to the DSF building instead of renting available space for project personnel prevented the timely implementation of the project by delaying the recruitment of the badly needed long-term training advisor for almost two years, thereby delaying the overall training program.

On March 31, 1989, the Project Manager provided USAID with a job description for the long-term training advisor. As soon as DSF and USAID agree on this job description, the procedure for recruiting a long-term training advisor will be initiated.

The Project Paper does not provide for the recruitment of a permanent full-time IEC advisor. As mentioned above, however, more assistance in IEC is desirable, considering the need and the vital importance of IEC activities to the success of the project.

3.3 Training of Personnel

A principal component of the IFAHS project focuses on improving the quality of services provided in health centers. In order to ensure this improvement, considerable project resources are earmarked for training activities. The Project Paper provides on-site training in various technical fields in a third country and in the United States, for all levels of health personnel. The main objectives are to improve the quality of service in the areas of immunization, family planning, nutrition and fighting diarrheal diseases. The training is provided in the fields of administrative and financial management, data system entry and supervision. Funds have been set aside to allow decision makers and other managers involved in developing long-term health strategies to participate in conferences and seminars abroad.

The training program provided in the Project Paper was revised in May 1988. Two managers now taking accounting courses in the United States should return to Mali to work on the project around January 1990. In 1987 and 1988, senior Family Health Division and Region Managers were trained in Mauritius and Côte d'Ivoire. The project also financed the MSP-AS Bureau Director's participation in the ICORT conference in the United States. (A complete list of these training activities is provided in Appendix H).

The domestic training program included a June 1988 meeting at which chief physicians in the 15 target health centers in the project discussed the results of the baseline data study conducted by FHI in March 1987 and a retrospective study on family planning patients conducted by AMPPF. In December 1988, the project financed a seminar on contraceptive inventory management.

However, as indicated in the 1988 annual report on the subject of MCH/FP training, "...with those in existence already deemed inadequate to meet the real needs of the personnel working in the field ... the DSF Chief decided to stop all domestic training in 1988 in order to develop new strategies and prepare new training modules, placing more emphasis on the practical aspect." Thus, the development of training modules and manuals has delayed instructor training, which in turn will delay the training of personnel in the regions and health centers.

The Project Paper calls for the services of short-term consultants specializing in training to determine MCH and FP training needs, to develop training plans, and to set up programs and coordinate training for the instructors, who, at the national and regional levels, will be responsible for the basic instruction and retraining of all health personnel in the 15 circles covered by the project.

The terms of reference for the training consultants were dictated largely by the decision to establish a national training strategy and a long-term training program before undertaking any training within the country. Thus, experts made three visits for short-term studies on training between July 1988 and January 1989.

The experts (Bosc/UNICEF and Aubel/USAID) were to work with the DSF training unit and the DNPFS training section, primarily for the following purposes:

- To determine the needs at all levels for personnel training in MCH;
- To develop an MCH/FP training reference manual;
- To develop standardized training modules for different MCH/FP levels (circles, arrondissements, villages), placing special emphasis on the integration of these areas;
- To develop an operating plan for MCH/FP training;
- To develop a follow-up plan for trained workers;
- To develop a national MCH/FP training strategy; and
- To develop a schedule for implementing a national MCH/FP training strategy, and one for IFAHS project zones as well.

More than four months of DSF and DNPFS training personnel consultation and time were devoted to the above activities.

A last eight-week consultation was scheduled for March or April 1989 in order to complete these tasks and lead a workshop on instructor training. After her second visit, the consultant determined that the work should have been done in cooperation with Malian training staff (as was the case during her prior visit). The DSF Director, however, insisted that the consultant work more or less alone, using training unit staff only on an as-needed basis. The consultant, who disagreed with the terms of reference, refused to come to conduct the third consultation visit, even though she had said she was planning to return.

A request for additional technical assistance to complete these tasks and lead the instructor training workshop was submitted to USAID in mid-February 1989, but it is unlikely that a qualified instructor will be found immediately, especially since the terms of reference require eight consecutive weeks of technical assistance. It is generally unlikely that qualified instructors would be available for that amount of time on such short notice.

4. PROJECT ACCOUNTING AND FINANCIAL MANAGEMENT

As stated in the Project Paper, the Mali Integrated Family Health Services project is managed by the United States Government through the Agency for International Development (USAID) and by the Government of the Republic of Mali (GRM). Financing is provided for a period of six years (\$8 million from USAID and \$1.6 million from the GRM).

4.1 Description of the Management System

A. Source of Funds

The \$8 million that constitute USAID's participation in the IFHAS program come from Sahel development program funds. The support from the Malian Government (from its central budget) covers operating expenditures (including salaries) and in-kind contributions (e.g., buildings). It is expected that the value of the Government's contribution will increase in value due to a decrease in the value of the dollar. The gap to be offset on products imported on a duty-free basis under the project should also be considered in the Malian counterpart because this is the normal procedure with all projects in Mali, as the DAF/Health Director explained to the evaluation team. The Project Paper does not take this into account. The financial management advisor proposed that this be added as an amendment in the annual report.

B. Accounting System

The accounting system is based on a manual developed by Deloitte Haskins and Sells (DH&S) as the result of a preliminary study conducted at the beginning of the project. This manual has been utilized since modifications suggested by the project financial management advisor and approved by both parties were made.

According to this system, the first accounting rule is the distinction between local expenditures made by the project and approved by USAID, and direct expenditures made by USAID, especially for construction.

The second accounting rule is that of budgetary commitment: each expenditure must be covered by annual programming. Activities are programmed according to the work plan and undisbursed commitments are rebudgeted at the end of the period. A monthly statement showing salaries paid to citizens, as well as the value of the land, project headquarters and other structures that GRM makes available to the project, makes it possible to keep track of the evolution of GRM's contribution. A

monthly report summarizes the financial status of the project and is subject to USAID auditing.

C. Management of Funds and Accounting Records

A double-entry bookkeeping system that keeps track of project expenditures through credits and debits of line items has determined the method of project funds management. It must be pointed out that the changes in the accounting manual primarily involved the separation of responsibilities of the accounting staff concerning cash, procurement and accounting work. This is to prevent making excessive amounts of cash available to the accountant in order to reduce temptations. Thus, all funds that USAID provides for the project are deposited into an account at Banque Malienne de Crédit et Dépôt (Malian Credit and Savings Bank) (BMCD). All parties to whom the project owes money, including employees, are paid by check.

The following documents support the accounting system in use:

- The commitment book, in which commitments are recorded, showing the situation with respect to the budget;
- The journal, in which expenditures and transactions are recorded as they take place;
- The bank ledger, which includes bank transactions;
- The cash ledger, which summaries cash receipts and disbursements; and
- Inventory sheets, which are kept in the warehouses to record flows of items in stock.

D. Revenues from the Sale of Health Charts

Community participation in maternal/child health and family planning activities is planned to be introduced in the form of payments for health charts for patients who visit MCH/FP centers. According to MCH personnel in Missira, the charges for the health charts are projected as follows:

- Pregnancy notebooks: 200 francs;
- Child follow-up notebooks: 200 francs;
- Immunization cards: 100 francs
- Plastic sleeves to protect notebooks and cards: 25 francs;
- Child growth sheets: 50 francs; and
- Family planning cards: free of charge.

As stated earlier, the project was to conduct a cost recovery study during its first year. This study has not yet been conducted. For further details on this subject, see Section 2.4.

For the administration of these revenues, project management provides a central fund at the project headquarters located in the DSF, in which revenues from the health centers covered by the projects will be deposited. These revenues will be used to finance the replacement of notebook inventories. There are also plans to set up local funds in various centers once staff have been trained to manage the funds responsibly.

4.2 Analysis of the Situation

The evaluation team made the following observations during its research:

A. Accounting System

During the first year of the project, no accounting records were kept, so that the FCFA 2,707,375 advanced by GRM was not covered by accounting entries. Books were not kept until the financial management advisor arrived and the accounting manual was approved.

At the time of the evaluation, the project had a part-time accountant in addition to the financial management advisor. It must be pointed out, however, that the two accountants the Ministry of Public Health and Welfare (MSP-AS) assigned to the project are in the United States for two years of courses, according to training program provisions. Thus, the project does not have sufficient accounting staff to handle the accounting activities stipulated in the DH&S manual. GRM cannot assign replacement accountants to the project because of the lack of qualified personnel.

B. Maintaining Accounting Records

As mentioned above, there is a delay in the recording of transactions due to the lack of a full-time accountant. Consequently, the accounting records are not kept efficiently and some information is missing.

C. Management of Funds

Since the certification of the project towards the end of the second year, funds have been released in accordance with programmed and budgeted activities. Because there was no accounting system at the beginning of the project, the first

release of funds from USAID occurred in May 1988 to reimburse GRM advance funds. The USAID advance did not arrive until June 1988. Funds paid in May and June amounted to FCFA 28,620,045. It must be noted that activities on the whole were implemented with considerable delay, and thus the funds paid in June 1988 were not of the same value as the ones planned for that date at the beginning of the project. Despite the budgetary modifications made in June 1988, the situation more than two years after the project signing is as follows:

- Expenditures from US contribution: \$877,000 (11 percent)
- Expenditures from Malian contribution: \$44,000 (3 percent).

This comes to a rate of 9.6 percent for expenditures made and paid out of projected funds.

The balance sheet as of January 30, 1989 shows a total contribution of FCFA 55,451,809 after the last payment from USAID amounting to FCFA 26,831,764.

Moreover, MSP-AS, the cosigner of this agreement through the intermediary of the DAF Administrative and Financial Director for Expenditures, has not yet undertaken an independent financial and accounting audit to verify that the funds from this bilateral cooperative effort are being managed effectively, because the Director believes that USAID's management system is sufficiently strict. Furthermore, a financial audit of the project is scheduled for 1989.

D. Revenues from Notebooks

An FCFA 23,000,000 allocation is planned for printing notebooks and growth sheets. The first order involves FCFA 3,000,000 and is not yet available.

Procedures are under way to reduce the price for notebooks to FCFA 150, to the extent that legal provisions advocate free maternal/child health care.

Because the project activities have not yet actually begun in the project health centers, we could not judge the applicability of the system for managing health chart revenues.

5. THE AMPPF'S ROLE

The AMPPF was created in 1971 through a Research Center for International Development (CRDI) grant. In 1972, when the French law of 1920 prohibiting advertising on contraceptives was repealed, the association opened a family planning clinic in the Niaréla area and began to conduct activities to motivate the people of Bamako. In 1976, AMPPF joined the International Federation of Family Planning Associations (IPPF). In 1981, AMPPF set up regional field units in the cities of Ségou, Sikasso, Mopti, Kayes and Koulikoro.

The AMPPF has the primary goal of "maintaining the balance and contributing to the harmony of the family." To reach this goal, the association implements a program of services and IEC in family planning supported by training and research activities in the reproduction health field. In addition to support from IPPF, the association receives various financing from several international NGOs specializing in family planning. The AMPPF volunteer bureau also includes influential members of Malian society who are working to promote the association's efforts to increase access to contraception for the Malian population.

The AMPPF clinic serves approximately 75 to 80 patients per day, or approximately 47 percent of all Malian women who use contraception. It is also noted that the central MCH/FP center in Bamako serves approximately 20 percent of the women in the whole country. This leaves approximately 33 percent of women for the rest of the health organizations in Mali. The GRM instituted its family planning program in MCH/FP centers about 13 years ago, but, despite the need, this program was not aggressive. Bamako, where approximately 10 percent of the Malian population lives, is Mali's only city in which the contraceptive use level exceeds 5 percent.

Family planning NGOs have contributed to the development of family planning programs in many countries. NGOs are characteristically flexible and able to intervene without administrative complexities in this area when the population expresses the need for family planning services. It is often easier for NGOs to intervene than it is for government organizations that must take into account more conservative factors and their responsibility towards the country's entire population. NGOs play a spearheading role, and their activities eventually become institutionalized. The role of NGOs in family planning does not end with the creation of a national family planning program; they must continue to stimulate the public sector in new areas. Thus, it is clear that MSP-AS and AMPPF family planning programs must complement rather than compete with each other.

AMPPF's NGO status was not formalized until 1988. Despite the absence of a legal basis for its status, the association received a few subsidies and the Malian government's tacit approval in the form of government personnel seconded to the AMPPF clinic. The need for official cooperation with the DSF within the context of the IFAHS project led the association to make its NGO status official with the Malian authorities. AMPPF thus first had to obtain a Frame Agreement with GRM and then establish a cooperative agreement with MSP-AS, its supervisory ministry.

These legal procedures, which were not anticipated in the project plan, were significant factors in the delay in the construction of the new AMPPF headquarters, which is one of the two areas of cooperation between AMPPF and DSF under the IFAHS project. This construction, which should in the end provide AMPPF with a new building for its headquarters, could not begin without this regularization. It must be noted that few efforts were made to accelerate the administrative procedure to make AMPPF's NGO status official.

The reasons why the AMPPF's IEC program has not yet begun are not clear. The program should have begun during the initial months of the project and would thus be into the third year of activities. The problem can be attributed partially to the ambiguity in the project implementation plan, which does not specify how AMPPF and DSF are to cooperate. AMPPF authorities understood that they were being asked to propose an IEC action program that, once approved, could lead to the release of project funds provided for this purpose. On the other hand, DSF, which is the organization designated to cover national family planning strategy, believes that AMPPF's role consists of participating in IEC program working groups within the DSF. DSF clearly perceives its role as dominating the IEC component. The Project Paper, however, states the following about AMPPF:

This agency will play the primary role in preparing the IEC campaign in the field of family planning.

In this case, one can only wonder why those who designed the IFAHS project decided to stimulate cooperation between the private sector and the public sector concerning Mali's family planning program. When the project was developed, the Malian family planning program was over ten years old (family planning was integrated into MCH activities in the MCH/FP centers in 1976). During this period, the prevalence of contraceptive use in Mali remained at and still does not exceed 2 percent (approximately 9 percent in Bamako). With only one clinic in operation in Bamako, AMPPF served 66 percent of Malian contraceptive users in 1985, and still serves 47 percent of them today. AMPPF is an important

partner in the Malian family planning program. Unfortunately, relations between AMPPF and DSF are strained.

6. GENERAL ADMINISTRATION AND ORGANIZATION

6.1 Institutional Framework

Responsibility for project implementation was assigned to the National Public Health Administration (DNSP) in order to permit access to sufficient and appropriate technical background, and to ensure efficiency in all major agencies. The DNSP is in charge of implementing the National Program for Maternal/Child Health and Family Planning, and has suitable experience as the executing agency for the USAID/Mali Rural Health Services Development Project.

Other agencies such as the DSF and its internal units, the National Welfare Administration, and the National Administration of Social and Health Education and Planning, have gained experience in their work and have adequate technical backgrounds.

AMPPF, the private Malian family planning agency and the principal promoter of family planning in Mali, will certainly make a positive contribution in the implementation of the Voluntary Family Planning component.

6.2 Organization

Initial plans were to set up a Project Administration. The DNSP had the task of appointing the Project Manager and other qualified Malians for the project team. As the executing agency, the DNSP handles all project coordination.

The project's national headquarters are currently at the DSF, one of the five divisions of the DNSP. The head of the DSF was appointed Project Manager.

At the regional level, the Regional Family Health Division chiefs are responsible for project implementation in their corresponding regions, and they coordinate and supervise the activities of the circle health centers.

At the circle level, the chief physicians are responsible for project implementation in the health centers where they coordinate and supervise the activities of the various services.

6.3 Project Administration

A. USAID's Responsibilities

The USAID/Mali Project Division is in charge of project

management. The Public Health Officer heads the project and is assisted by a Malian population program specialist.

The Mission Engineering Office monitors and assists the renovation/construction component. USAID handles procurement abroad.

In effect, USAID has transferred authority to the project team, which has managed those activities since the funds were released. USAID provides follow-up to monitor status and coordination. Follow-up tools used for that purpose are

- An annual operating plan,
- A monthly financial report, and
- An annual and quarterly report.

USAID/Mali also prepares a quarterly report which is sent to USAID/Washington, and financial audits of the project are conducted every month.

B. The Malian Government's Responsibilities

The National Public Health Administration (DNSP) of the Ministry of Public Health and Welfare is the project executing agency.

C. AMPPF's Responsibilities

AMPPF is primarily responsible for implementing the Voluntary Family Planning subcomponent. Since AMPPF belongs to the private sector, AMPPF's duties include receiving contraceptives for the private sector. The association will also play the principal role in preparing the IEC family planning campaign and will share its collaborative experience.

7. GENERAL RECOMMENDATIONS

7.1 Improvement of Services

A. Summary of Observations

On the one hand, MCH services are already integrated to some extent within the target health facilities, because all MCH/FP services are performed by the same staff on a weekly schedule. Conducting all of the MCH/FP activities every day, however, poses problems due to the small number of trained health workers, the limited facilities and the chronic lack of equipment in most of the target centers.

Specific national programs, such as the Expanded Program of Immunization (EPI) or the Program to Fight Diarrheal Diseases (PLMCD), receive extensive support at the centers. Areas with no specific program, as in the case of nutritional monitoring and family planning, are often neglected.

The regulations for distribution of contraceptives, particularly the pill, are too restrictive and do not correspond to the country's circumstances or the low risk associated with that method, especially considering the maternal mortality risk in rural areas.

B. Recommendations

1. Integration of services would be very desirable. Each center should be encouraged to find a local solution to optimize service integration in spite of barriers specific to the center. Supervisory visits should not only serve to determine whether the peripheral staff is doing its job, but should also be used to encourage center staff to use its imagination in finding local solutions.
2. Special effort should be devoted to developing nutritional monitoring and family planning activities throughout the country, but especially in facilities targeted by the project.
3. Distribution of contraceptive pills by a staff that received simplified training should make it possible to offer these services on the most widespread basis. Extensive literature is available on the subject and there are many programs the DSF could use as models.

7.2 Information, Education and Communication

A. Summary of Observations

No IEC activities have yet been carried out under the project, even though they were supposed to begin in the third quarter of 1988. Center staffs are inadequate and have not received IEC training. Although long-term technical assistance would have been desirable, the project made no provisions for it.

Moreover, because of the DSF IEC section chief's special expertise on the subject, he is very sought after by other national programs. He does not have the time to devote exclusively to MCH/FP activities. His deputy, however, has the necessary qualifications and could devote more time to the project.

The peripheral staff expects too much from the central level, and the central level does not make sufficient efforts to encourage creativity on the part of the peripheral staff. The example of the Skilled Midwife (maîtresse sage-femme) in Katibougou should be followed (see Appendix E). There surely must be other motivated persons who have ideas to develop locally.

The AED proposed an agreement within the scope of this project, by which a long-term IEC consultant would be brought in. The consultant's terms of reference would be to assist DSF not only in the area of nutrition, but also in MCH/FP activities.

B. Recommendations

4. Considering the importance of the IEC component and the substantial needs in this area, a solution must be found to provide the project with long-term IEC technical assistance without further delay. Assistance should be provided to both DSF and AMPPF. Additional inputs from AED seem to be the most reasonable solution.
5. A pilot program of small subsidies for local creative IEC activities should be established and targeted towards project objectives. Subsidies should be on the order of FCFA 300,000 per project, with a maximum of 10 projects during the first year. The management of the program's FP component could perhaps be assigned to AMPPF if DSF is unable to manage it.

7.3 Construction and Renovations

A. Summary of Observations

Generally speaking, the construction and renovation component suffered a considerable delay in scheduled activities, due to the heavy administrative burden of the parties concerned (GRM, USAID, AMPPF). In addition, the modifications added at the start of the project, which involved the addition of another floor to the DSF building, had a delaying effect on the entire procedure.

B. Recommendations

6. Rigorous monitoring of the revised schedule and adherence to building regulations is essential.
7. Monitoring of the construction firm should be handled by the USAID engineer for the contract between USAID and that firm.
8. The contract between the construction firm and the MSP-AS should be monitored by the latter.
9. Monitoring should also be provided by USAID's health project officer and the project financial management officer so that senior authorities can be notified if project operations are imperiled by delays.

7.4 Equipment, Medicine and Contraceptives

A. Summary of Observations

USAID's procedure for ordering equipment and medicine, including contraceptives from outside the country, is very cumbersome. None of the parties concerned monitors orders strictly enough.

B. Recommendations

10. Careful planning of orders should prevent stock shortages. Officers at all levels should be trained. (The seminar on equipment logistics held in December 1988 was just the first step in this process.)
11. Orders should be prepared keeping in mind the time frames dictated by the system.
12. The equipment manager, health project officer at USAID, and project manager should monitor the project closely.

13. For current orders and any future problems with responses from Washington, special communication with the technical health resources office (AFT/TR/HPN) should be established so that it can intervene and help solve the problem.
14. Emergency systems should not be considered an easy solution in lieu of proper planning and sound management of medicine and contraceptives. Nevertheless, it may be useful to teach the USAID staff to implement emergency ordering procedures for contraceptives when absolutely necessary, in order to prevent any future stock shortages.
15. Planning should include programs to fight AIDS through the use of condoms. These programs and DSF must cooperate closely when expecting condoms from A.I.D.

7.5 Service Statistics and Operational Research

A. Summary of Observations

The social marketing study is far behind schedule and the cost-recovery study was not done, although it was planned for December 1986. A systematic study of priority needs in maternal/child health education was not conducted, although it was planned for March 1987.

There is no grasp of child feeding practices, knowledge and problems in the target regions. The continuation rate of women accepting family planning is very low, and statistical monitoring has not been conducted.

The statistical records observed in the centers were relatively well kept. FP forms are currently being revised.

B. Recommendations

16. The negotiations on social marketing should be expedited and completed. This should be considered a major priority.
17. The cost recovery study should be conducted by March 1990, and should take into consideration the work done by INRSP and other pilot programs in that field.
18. Studies on priority training needs should be conducted between now and September 1989.

19. A Knowledge, Attitude and Practices (KAP) survey on child feeding methods should be conducted, studying the factors that influence feeding behavior, between now and December 1989.
20. A systematic study of the reasons for abandoning contraceptive methods should be conducted. The statistical record should be modified so that the continuation rate can be evaluated in the future. This study should be assigned to AMPPF, since it will serve as the basis for an IEC campaign.
21. In order to improve record keeping, continuing education should be provided for workers in charge of service statistics. If necessary, use the USAID Contraceptive Management Project (FPLM) to improve the statistical records and logistic aspects of family planning programs.
22. AMPPF should be involved in revising the FP forms in view of its extensive experience in that area.

7.6 Human Resources

A. Summary of Observations

The program's education component is behind, and any further delay will have a negative impact on the improvement of services. Quite often the DSF team (section or unit chiefs) or the AMPPF staff involved in developing certain crucial project activities are unavailable because of their numerous responsibilities.

No training was offered at the health centers and communities targeted by the project.

B. Recommendations

23. The long-term technical assistance training officer should be recruited immediately so that he can start working by August 1989. A temporary office should be rented for this person if the DSF addition is not finished.
24. The short-term educational consultant's terms of reference should be reduced in order to attract a highly qualified consultant to handle the most urgent tasks.
25. A monthly work schedule for the various sections of the DSF involved in the project activities should be established to ensure worker availability. This working

procedure could also be useful in the peripheral structures.

26. Community training activities such as the one financed by the Malian Association for Adult Education (AMIFA) and AFROPOC in 1988 in Sanakoroba and Nara, should be promoted to train community health workers, traditional midwives, hygienists, community development workers specializing in nutrition, etc.

7.7 Accounting and Financial Management

A. Summary of Observations

An analysis of the project's financial management system shows that the latter has not functioned as recommended by the DH&S manual, in part because the project lacks accounting staff, and because the officer available to the project only works part-time. Consequently, some transactions such as depreciation are not accounted for due to lack of time, and some documents are not kept up to date.

B. Recommendations

27. A balance sheet as recommended in Section 11 of the DH&S should be created.
28. The depreciation of vehicles, furniture and other project equipment should be calculated.
29. The system of separation of accounting functions should be reinforced as soon as the accountants trained abroad return to the country. These accountants should be kept available to the project. The effort undertaken to establish sound accounting systems that the project's target health facilities should be continued.
30. The possibilities of standardizing the accounting management systems of the various projects housed at the DSF should be studied.
31. The MSP-AS might consider asking for USAID assistance in training DAF workers to understand the strict financial and accounting management systems that most donor organizations require.

7.8 AMPPF's Role

A. Summary of Observations

Government structures in Mali do not usually assign the implementation of national-scale programs to national NGOs like AMPPF. Consequently, any cooperative effort involves lengthy task definitions and programming aspects are developed painstakingly. The population to be served suffers as a result.

The project paper should have provided more effective guidance for the two parties concerned by clearly specifying their roles in the project implementation plan. The manner in which AMPPF was to be guided through the use of short- and long-term technical assistance should have been specified. Although the project budget contains amounts earmarked to finance AMPPF's IEC program, the manner in which the IEC funds and short-term technical assistance could be made available to AMPPF should have been clearly defined.

The highly-qualified AMPPF IEC division chief has just been transferred, and his departure is regrettable. The remaining IEC staff in that division is quite experienced but limited in number.

B. Recommendations

32. AMPPF should fill the staff openings in its IEC division as soon as possible.
33. Between now and September 1989, AMPPF should submit a draft implementation plan for the IEC program it will head. The plan should include a budget that takes account of the amounts intended for that part of the program in the IFAHS project budget. DSF will study the program and have approval authority along with USAID. An implementation plan will supplement the project in order to establish a cooperative framework between DSF and AMPPF.
34. In order to assist AMPPF in setting up an IEC program, a short-term consultant will be contracted between now and July 1989 for a three-week period.
35. The technical financial management officer will work with the AMPPF accounting department to obtain USAID accreditation for the association between now and September 1989, to enable the project to provide it with the funds to implement the program.

7.9 General Project Administration and Organization

A. Summary of Observations

The responsibilities of USAID and GRM are clearly defined, but the procedures for cooperation with AMPPF have not been clarified.

Although the project's relationships with UNICEF, PRITECH and UNFPA are defined in the five-year plan, they need to be strengthened. Quarterly consultation meetings are stipulated under the operating plan.

The project was initially intended to provide for a vertical implementation structure. In practice, it was fully integrated into the DSF organizational structure, and the reinforcement of DSF was not a major objective in the project design. In addition, the project targeted 15 health organizations at the circle and communal levels, even though DSF's responsibilities cover the entire Malian health pyramid and the majority of Malians live in rural areas.

The 1989 working plan seems very ambitious despite its concordance with the project implementation plan, because the team leader will have to be absent for several months.

B. Recommendations

36. A revision of the project implementation plan would be desirable. DSF should perform this work in cooperation with long-term technical assistance from USAID to outline the current situation.

Rather than lead to endless negotiations, this task should make it possible to clarify certain operational aspects of the project which need definition. An amicable half-day round table discussion should suffice to clarify the situation.

37. The 1989 work plan should be updated. The absence of the team leader should be taken into consideration and a solution should be sought.
38. Considering the fact that the service-providing component did not begin as planned, it would be desirable to review the situation between May and July 1990. This situation analysis will make it possible to complete what should have been observed during the mid-project evaluation and to ensure that the recommendations in this report are taken into consideration. The team assigned the work would have to include an IEC specialist.

APPENDICES

Appendix A
TERMS OF REFERENCE FOR THE EVALUATION

Appendix A

Terms of Reference for the Evaluation

MINISTRY OF
PUBLIC HEALTH
AND WELFARE
- - - - -

REPUBLIC OF MALI
ONE PEOPLE - ONE GOAL - ONE FAITH
- - - - -

NATIONAL ADMINISTRATION OF SOCIAL
AND HEALTH EDUCATION AND PLANNING

**TERMS OF REFERENCE FOR THE MID-PROJECT EVALUATION
OF THE INTEGRATED FAMILY HEALTH PROJECT**

I. SCOPE OF THE PROJECT

The Integrated Family Health Project (IFAHS 688-0227) extends over six years and involves \$9.6 million of financing, of which \$1.6 million is being furnished by the Government of the Republic of Mali and \$8 million by USAID through a bilateral agreement.

The project was authorized on July 14, 1986, and the project assistance closing date has been set at July 31, 1992. The Grant Agreement signed with the Government on July 30, 1986 authorized an initial commitment of \$1.2 million. Two amendments to the project signed on May 8 and August 31, 1987 committed \$1.7 million and \$750,000, respectively, bringing the total USAID commitment to U.S. \$3,650,000. A third amendment now in process will allocate \$750,000 [amount crossed out], thus leaving an uncommitted balance of \$3.5 million. During the first 18-month phase, the project operated with prefinancing from the Administrative and Financial Health Unit in the amount of FCFA 3.7 million.

The goal of the project is to assist the GRM in reducing the morbidity/mortality rate in Bamako and the Upper Valley Operation (OHV) resulting from contagious infant diseases, diarrhea, malnutrition and improper birth spacing. The project objective is to assist the GRM's Mother and Child Health and Family Planning Program, to support and integrate services in 15 MCH/FP centers in Bamako and the OHV zone, and to help the Malian private family planning agency (AMPPF) to improve its services.

The project includes one main component and three sub-components. The main component will consist of improving nutritional monitoring services, immunization, Oral Rehydration Therapy (ORT) and voluntary family planning.

In addition to receiving training in the four areas mentioned, health workers will also be trained in management techniques, health planning and supervision.

Each MCH/FP center will be provided with a standard equipment package consisting of clinical equipment and supplies.

The private sector aspect of the project will consist of providing AMPPF with the technical assistance and equipment to improve and expand direct family planning services and community education campaigns.

The second component consists of:

- a) Renovation of 15 MCH/FP centers;
- b) Construction of a warehouse in Koulikoro for storage of health equipment; and
- c) Construction of a new clinic in Djikoroni and the new AMPPF headquarters.

The third component will undertake Information, Education and Communication (IEC) activities, with the goal of promoting the MCH/FP segment of the project.

The fourth component will finance special studies on baseline statistics, cost recovery, social marketing and financial management. The project will be divided into three phases of implementation:

- the first phase, lasting 18 months, corresponds to the project start-up period;
- the second phase, 6 months long, is the interim period; and
- the third phase, 4 months, corresponds to the operational period.

The Grant Agreement stipulates a mid-project evaluation during the second year of the project, i.e., at the end of the first two phases.

II. OBJECTIVES OF THE EVALUATION

The mid-project evaluation of the integrated family health project is intended:

1. To assess the project implementation process and determine its status.
2. To verify whether the management structure and systems are in place to achieve the desired results.

3. To identify the problems encountered so that specific recommendations can be made for phase three.

4. To decide whether new orientations should be applied to the project based on needs identified in the field.

The evaluation is considered an "evaluation of procedure" rather than of "impact," expected to yield constructive criticism.

The expected results will be used as the basis of a detailed report outlining the evaluation team's major observations and conclusions, with recommendations for subsequent action.

The evaluation team is to submit the draft report to the Ministry of Health and USAID/Bamako prior to its final approval.

The final report will be submitted to both partners (Malian Government and USAID/Washington) no later than 30 days after the draft report is approved.

III. MISSIONS ASSIGNED TO THE EVALUATION TEAM

The team's mission will be:

1. To study the official reference documents: signed project documents, amendments added, project implementation letters, approved financial reports, quarterly reports from the technical assistance team, and data studies prepared for the project.

2. To assess the project's status in relation to the plan of action, identify procurements, bottlenecks and opportunities to be explored.

3. To examine the 1989 project implementation plan for each project component.

4. To examine the long-term technical assistance team's adequacy and effectiveness and make recommendations for future use of short- and long-term technical assistance to achieve project objectives.

5. To verify whether the roles of the various partners (GRM, USAID and AMPPF) are clearly defined and whether the commitments are being met, and draft recommendations if needed.

6. To review USAID's role in project administration and management, and redefine the nature of its support for domestic organizations in charge of project implementation in the operational phase.

7. To conduct interviews and discussions with the staff involved in project implementation.

8. To examine the current working relations and the assignment of responsibilities for all Family Health Division staff, AMPPF, and the technical assistance team, so as to determine the management's overall ability to implement the project and achieve the established goals, with particular emphasis on the training and IEC components. To make recommendations for any necessary improvements.

9. To evaluate the methodology for improving data, the efficiency of data collection efforts, the potential use of the information gathered, and the interrelationships of data collection among the different project components.

10. To examine the interrelationships between this and other DSF projects, including activities financed by PRITECH, UNICEF and UNFPA.

11. To examine the proposals for project activities at the arrondissement and community levels, and make recommendations on their implementation.

IV. MEMBERS OF THE EVALUATION TEAM

The team in charge of the evaluation will be multidisciplinary and include Malian representatives and consultants provided by USAID.

The team will be made up of 5 members, distributed as follows:

- DNPFFS 1 (one) Evaluator/Economist Representative
- DAF 1 (one) Public Finance Specialist
- DNSP 1 (one) Community Health Specialist
- USAID 2 (two) Representatives (including one international expert).

The evaluation team will be accompanied on field visits by a regional worker.

The work of the evaluation team will be coordinated by the representative of the National Administration of Social and Health Education and Planning.

V. EVALUATION METHODS

Date: The evaluation will begin during the second half of March and will last three weeks.

The evaluation being coordinated by the National Administration of Social and Health Education and Planning will be done using the following methods:

Phase One: Review of documents and meetings

- Study of available documents on the project and its implementation at the central level (Activity Reports);
- Meeting with the technical assistance team and project leader;
- Meeting and interviews with the various project partners (MSP-AS, DNSP, DNPFFS-Project Administration, USAID, AMPPF and other partners, etc.);
- Preparation of field visit.

This phase will last one week.

Phase Two: Field visit

The field visit will be conducted in the project's pilot zones and will consist of a visit to the health centers receiving project support, discussion and interviews with the socio-health staff involved in the project, and finally, collection of baseline data.

The purpose of the field visit is to take account of the accomplishments under the project and to assess the integration of the project activities into the Maternal/Child Health Services.

This phase will last one week.

Phase Three: Analysis of information gathered and writing of the evaluation report

- Analysis of the data and information gathered during the first two phases;
- Capsule presentation of information and writing of evaluation report;
- Discussions with the USAID project leader and the technical assistance team;

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- Presentation of the draft report to USAID and the Ministry of Public Health and Welfare.

This phase will also last one week.

Appendix B
SCHEDULE OF THE EVALUATORS' ACTIVITIES

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Appendix B

Schedule of The Evaluators' Activities

MONDAY, MARCH 20

10:00 Introduction of the team (U.S. part)
to the Malian Ministry of Public
Health and Welfare officers.

TUESDAY, MARCH 21

10:00-2:30 Evaluation team orientation meeting.

WEDNESDAY, MARCH 22

7:30-8:30 DRSP-District of Bamako;

9:30-10:30 DRSP-Region of Koulikoro;

10:30-1:00 Koulikoro MCH/FP center;

1:30-2:00 Katibougou Health Center;

3:00-4:00 Team meeting.

THURSDAY, MARCH 23

9:00-12:00 Missira MCH/FP center;

12:30-2:30 Consultation of project files and
team meeting.

FRIDAY, MARCH 24

7:30-10:30 DSF. Meetings with various members
of the project staff;

10:30-11:30 USAID staff;

11:30-12:00 Team meeting.

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SATURDAY, MARCH 25

8:00-9:30	Lafiabougou MCH/FP center;
10:00-12:00	Hamdallaye Maternity Clinic;
12:00-1:00	DSF IEC staff;
1:00-2:00	Architect;
2:00-2:30	Team meeting.

MONDAY, MARCH 27

9:00-11:00	Dr. S. Bocoum
11:00-11:30	Team meeting
11:30-2:30	Examination of project documents and files

TUESDAY, MARCH 28

8:00-9:00	DSF
9:30-10:30	DNPFSS-Training Division
10:30-11:30	DNPFSS-Statistics Division
12:00-1:00	DAF
2:00-4:30	Dr. Maryse Pierre Louis

WEDNESDAY, MARCH 29

8:00-11:00	AMPPF
12:00-1:00	UNFPA
1:00-2:00	UNICEF
2:00-3:00	USAID/Equipment Management Office

THURSDAY, MARCH 30

7:00-4:00	BANAMBA
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FRIDAY, MARCH 31

7:00-3:00

KANGABA

SATURDAY, APRIL 1

8:00-4:30

Team meeting

MONDAY, APRIL 3

8:00-2:00

Team meeting

THURSDAY, APRIL 6

Capsule presentation meeting

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Appendix C
LIST OF PERSONS INTERVIEWED

Appendix C

List of Persons Interviewed

USAID/BAMAKO

Mr. N. Woodruff GDO
Mr. T. Sangaré GDO
Mr. M. Ireland
Mr. M. Traoré

MINISTRY OF PUBLIC HEALTH AND WELFARE

Mr. M. Traoré, Office Director
Mr. B. Touré, DNPFS
Dr. J.B. Brière de Lisle, DNSP

ORIENTATION MEETING

Mr. A. Maiga, DNPFS
Mr. A. Tounkara, AMPPF
Dr. S. Bocoum, DSF
Dr. M. Bâ, DSF
Mr. T. Sangaré, USAID

DISTRICT OF BAMAKO

Dr. M. Kanté, DRSP
Dr. F. Traoré, DRSF

REGION OF KOULIKORO

Dr. M. Coulibaly, DRSP
Mrs. M. Keita, DRSF
Mrs. M. Dembelé, DRSF

KOULIKORO MCH/FP center

Mrs. D. Sidibé, Skilled Midwife
Miss M. Sy, Midwife

KATIBOUGOU MCH/FP center

Mrs. F. Traoré, Skilled Midwife
Mrs. N. Coulibaly, Midwife

MISSIRA MCH/FP center

Dr. S. Diallo, Chief Physician
Dr. A. Keita

LAFIABOUGOU MCH/FP center

Dr. R. Samaké, Chief Physician

HAMDALLAYE MATERNITY CLINIC

Dr. F. Diabaté, Chief Physician

FAMILY HEALTH DIVISION

Dr. S. Bocoum
Dr. M. Bâ
Mr. R. Kristem
Dr. F. Coulibaly
Dr M. Pierre-Louis
Dr. A. Sidibé
Dr. B. Mountaga
Dr. D. Sékou
Mrs. A. Traoré
Mrs. A. Touré

DNPFSS

Mrs. O. Traoré, Training Program Division
Mr. D. DicKo, Statistics Section

DAF

Mr. M. Tabouré, Director

AMPPF

Mr. L. Sidibé
Mr. A. Tounkara

UNFPA

Mr. M. Touré

UNICEF

Dr. G. Cornale
Mrs. K. Ly

BANAMBA

Dr. I. Diallo
Dr. K. Traoré

KANGABA

Dr. H. Touré
Dr. Z. Coulibaly
Mr. K. Traoré

Appendix D
LIST OF DOCUMENTS CONSULTED

Appendix D

List of Documents Consulted

1. Etude des données de base. Rapport final. [Baseline Data Study. Final Report]. Family Health International, September 1987.
2. Assessment and Project Planning Visit for the Nutrition and Communication Project. Trip Report. Academy for Educational Development, October/November 1988.
3. Mali Trip Report: Needs Assessment for Training in Family Planning. INTRAH, October 1986.
4. Enquête démographique et de santé au Mali [Demographic and Health Survey of Mali]. DHS, 1987.
5. AID Policy Paper. Population Assistance. Bureau for Program and Policy Coordination, USAID, September 1988.
6. Guidelines for Preparation of Consultants' Reports. POPTECH, February 1989.
7. Project Grant Agreement Between the Republic of Mali and the United States of America acting through the Agency for International Development. AID, July 1986.
8. Termes de référence de l'évaluation à mi-terme du projet intégré de santé familiale au Mali [Terms of Reference for the Mid-Project Evaluation of the Mali Integrated Family Health Project]. Project 625-0227. (In French and English)
9. IFAHS monthly reports.
10. Social Marketing Subproject Paper for Family Health Initiatives II, Draft 1989.
11. Integrated Family Health Project Paper 1986. (in French and English)
12. AID Evaluation Handbook. April 1987.
13. Analyse du draft de la visite effectuée à l'AMPPF par une équipe du projet IFHAS [Analysis of the draft from an IFHAS project team's visit to AMPPF].
14. Frame Agreement Between the Government of the Republic of Mali and the Malian Association for the Protection and Promotion of the Family.
15. Analyse de situation des services de SMI au Mali [Situation Analysis of MCH Services in Mali]. UNICEF, November 1987.

16. Programme de santé maternelle et infantile. Plan quinquénnal [Mother and Child Health Program. Five-Year Plan], 1988-1992.
17. Project Implementation Reports. Years 1987-1988.
18. Programme annuel d'activités de la division de santé familiale scolaire et sportive 1989 [Annual Program of Activities of the Division of Family, School and Sports Health 1989]. Region of Koulikoro.
19. Quarterly and annual report files.
20. Technical assistance team terms of reference file.
21. PIO file on training, short-term technical assistance and equipment.
22. Memo file.
23. SOMARC file.
24. AMPPF file.
25. AED file.
26. PFLM file.
27. MSH file.
28. POP COUNCIL file.
29. Financial file.
30. FHI file.
31. EDS file.
32. District of Bamako file.
33. Region of Koulikoro file.
34. Vehicle file.
35. Project assets inventory file.
36. 1988-89 Annual Plan.
37. MCH/FP Five-Year Program.
38. DSF Operating Plan.

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39. Project personnel file.
40. Report on a visit to AMPPF, October 6-11, 1988.
41. 1988 Annual Report.

Appendix E
DESCRIPTION OF SERVICE CENTERS VISITED

Appendix E

Description of Service Centers Visited

The evaluation team's visits to the service centers in the Region of Koulikoro and the District of Bamako are reported below in chronological order.

BAMAKO HEALTH DISTRICT

Located on both sides of the Niger River, the District of Bamako has an area of 267 km² and accommodates about 10 percent of the population of Mali (646,163 according to the 1987 census). It was created in 1977 by Ordinance No. 77-44/CMLN for territorial and administrative reorganization of the Republic of Mali.

The district is divided into six communes.

On the left bank of the Niger River:

Commune I has a population of 132,767 in nine wards served by three health facilities, only one of which (Korofina-Nord Health Center) is a dependency of the MSP-AS.

Commune II has a population of 106,658 and ten wards served by four health facilities. The two main health centers in the commune are the Missira MCH/FP center Maternity Clinic and the MCH/FP center facility in Niaréla.

Commune III has a population of 94,998 in 19 wards served by eight health facilities. The two main communal health facilities are the dispensaries in Bolibana and Dravéla. Gabriel Touré Hospital, the Family Health Application Center (central MCH/FP center facility) and the G Point Hospital are located in Commune III but have special status.

Commune IV is the most populated of the communes in the district, with a population of 140,640 in eight wards. The commune has five health facilities to serve the population, the four main ones being the Hamdallaye and Djikoronni Maternity Clinics and the MCH/FP center facilities in Hamdallaye and Lafiabougou.

On the right bank of the river:

Commune V has a population of 107,754 in nine wards, served by three health facilities, the two main ones being the MCH/FP center facility in Badalabougou and the Mali Ward Maternity Clinic.

Commune VI is quite large, accounting for about one-third of the district. Its population of 88,556 in six wards is served by a single health facility, Sogoniko MCH/FP center Maternity Clinic.

For services, the entire district has 16 physicians, 103 midwives, 42 state nurses, 79 health nurses, 149 health aides and 4 community development technicians.

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The target population of the District of Bamako is divided as follows:

Communes	Children 6 Years and Under	Women of Child- bearing Age	Pregnant Women
I	26,952	24,502	6.125
II	23,138	21,035	5,258
III	20,862	18,965	4,741
IV	29,845	27,132	6,783
V	23,477	21,343	5,335
VI	17,878	16,253	4,063
Total	142,152	129,230	32,308

Source: 1987 Census

KOULIKORO

The Circle of Koulikoro is in the center of Region 2. It includes one commune, seven arrondissements, 32 development sectors and 253 villages. Its surface area is 5,930 km², accommodating a population of 187,390. Over 80 percent of the population lives in rural areas. Children six years and under represent 23 percent of the population (41,226); women of childbearing age (15-44 years), 21 percent (39,352); children 14 years and under, 45.5 percent (85,262).

The five principal diseases among children five years and under in Koulikoro are malaria, diarrhea, respiratory infections, stomatitis and conjunctivitis. Among women, the five main diseases are malaria, gastroenteritis, respiratory infections, conjunctivitis and stomatitis. (Baseline Data Study, September 1987.)

The percentage of births in a supervised environment in the Circle of Koulikoro is estimated at 14 percent. (Region of Koulikoro, Annual Program of Activities of the Division of Family, School and Sports Health, 1989. February 1989.)

After a visit to the Regional Director of Health in Koulikoro, the evaluation team returned to the MCH/FP center facility in Koulikoro on March 22, 1989, where they were greeted by Mrs. Diassa Sidibé, a Skilled Midwife, and her assistant, Miss Mariama Sy, a Midwife. These women explained the center's services statistics system to the team and took them to visit the MCH/FP center facility and the maternity clinic. MCH activities are distributed throughout the week as follows: one day per week is devoted to immunization, three days for prenatal examinations, and one day for family planning; consultations for medical treatment are held every day. Activities related to nutritional monitoring and infant growth,

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including the weighing of children and nutritional counseling for mothers, are held at the social center once a week. The team was unable to observe the delivery of services in this center because it was late in the day and the patients had gone.

The Koulikoro Center staff includes 1 chief physician, 1 state nurse, 2 first-level nurses, 13 health aides, and 1 social aide.

The MCH/FP center staff reported these problems: frequent shortages of contraceptive supplies (for more than six months in 1988) and the need to train the staff in IEC. The staff members interviewed did not seem to be up to date on the activities of the IFHAS project, but it should be noted that the chief physician was on his rounds and the team was unable to meet him.

The MCH/FP center facility in Koulikoro was built in 1964. Planned renovations under the IFHAS project include repairs for the MCH/FP center facility and the maternity clinic, at a cost of FCFA 5,950,900. An additional provision has been made for equipment and top-priority medicines, which center staff are awaiting impatiently. Plans were also made to build a supply warehouse in Koulikoro, but the construction was covered by another project. The project should also provide training for several workers.

KATIBOUGOU

Katibougou belongs to Mali's second administrative region, namely, Koulikoro. This region has a total population of 1,200,000 in six circles. The commune of Koulikoro includes the locality of Katibougou.

The locality extends along the Niger River to the northeast of the city of Koulikoro. Thus, the population consists mostly of farmers, fishermen and livestock breeders. Katibougou receives support from the Rural Polytechnic Institute (IPR). This institute, a vestige from colonial times, has trained a considerable number of Malian managers, some of whom belonged to the elite during the country's fight for independence. Experiments in agriculture and livestock breeding are still conducted today to train apprentices and students. We should mention that the institute has 2,000 apprentices and students, 50 instructors and 130 national health service officials.

From the health pyramid standpoint, Katibougou is a development sector that includes nine other villages besides the Village of Katibougou. It has one MCH/FP center Facility-Maternity Clinic established in 1978, where all family health activities have been conducted since 1982. This health facility is among the most respected of its kind in terms of results and service quality.

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This locality was selected for an evaluation team site visit because it is representative of the type of activities that can be managed at the arrondissement level.

The Skilled Midwife has conducted community health activities for several years with very limited means. Her community program includes maternal/child health activities, training of traditional midwives to assist in childbirth outside the health facilities, and distribution of condoms in the villages.

The Family Health Division wants to support the efforts in Katibougou and would like the evaluation report to include a recommendation to establish a pilot project at the arrondissement level, with Katibougou as the site.

MISSIRA MCH/FP center FACILITY AND MATERNITY CLINIC

The Missira MCH/FP center facility/maternity clinic is one of the four health facilities in Commune II of Bamako. The other three are the MCH/FP center facility in Niaréla, the dispensary in Qinzambougou, which has not operated since 1988, and the public service infirmary.

The health facility in Missira serves ten wards in the commune. During its visit the evaluation team was able to observe MCH activities at the center, including the following: prenatal examinations, consultation with sick children and adults, injection and dressing application room, pharmacy, social center, maternity clinic, oral rehydration room, infant growth monitoring room, expanded program on immunization (EPI), and the family planning room. The Missira MCH/FP center facility is the first of the centers participating in the project to offer MCH services on an integrated basis. During our visit all services were functioning at the same time. The evaluation team was able to observe an informal talk with mothers coming in for prenatal examinations, on the topic of health and the environment.

In addition to conducting activities within the center, the Missira MCH/FP center facility personnel covers five wards (Bakarybougou, TSF, Dougouba, hippodrome and the industrial zone with outpatient services (prenatal consultations, immunizations and preventive consultations for infants). The facility also has a school and sports medicine program and handles the legal medicine activities for the commune.

The center is run by a doctor, Mrs. S. Diallo, and her assistant, Dr. A. Keita, and has a total of 73 staff members.

During our visit the center's chief physician explained to the evaluation team that the physical reorganization of services was begun as the result of five working meetings between the DSF teams and the center staff under the IFHAS project. Since February 1989 the center has offered integrated services and patients can obtain all services the center offers in a single visit.

LAFIABOUGOU

This is a dispensary/MCH/FP center facility complex and seat of the Commune IV health center. It is headed by Dr. Samaké Raki Bâ.

Accommodations

- | | |
|---|---|
| - Physician's office | - Injection room |
| - Secretary's office | - EPI office |
| - Accounting office | - ORT room |
| - Consultation room
for sick infants | - Dressing application
room |
| - Prenatal consultation
room | - Adult infirmary or
consultation room |

Activities

Immunization (under the PEV)
Family planning
Preventive monitoring
Oral Rehydration Therapy (ORT)
Consultation for sick infants
Information, Education and Communication (IEC)
Nutrition presentations

Staff

Physician = 1	Lab Technician = 1
Midwife = 4	Social Assistant = 1
State Nurse = 5	Administrative Assistant = 1
Health Nurse = 8	Accountant = 1

HAMDALLAYE MATERNITY CLINIC

The maternity clinic in the Hamdallaye ward is one of the oldest in Bamako. It was built in 1960 and renovated in 1984 with a grant from the Canadian government. The renovations made it possible to provide the maternity clinic with a permanent source of drinking water and to do major replastering work that turned it into one of the nicest maternity clinics in Bamako. In 1987, the clinic was endowed with a surgical unit by AVSC, enabling it to perform Caesarian sections and gynecological surgery, including tubal ligations. A gynecologist has been assigned to this service since that time. Each year 4,000 women come to Hamdallaye to give birth.

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Most parturients receive prenatal examinations at the Hamdallaye MCH/FP center facility, which is in a different location.

The resident gynecologist, Dr. Diabaté, received the IFHAS project evaluation team. Before giving the team a tour of the facilities, she described her service's activities. In order to facilitate the integration of MCH activities within her service, Dr. Diabaté started an awareness program for husbands and wives to ensure that infants born at the maternity clinic are vaccinated. At the time of the legal birth registration, the parents are called in with their child. During that visit, the infants receive the BCG and

the parents are advised on subsequent immunizations and family planning.

The maternity clinic has a program of informal talks on family planning and other MCH/FP center care for new mothers before they leave the clinic. Parturients stay at the clinic for about 48 hours, but are kept longer if warranted by the health of the mother or the infant. Dr. Diabaté performs about 20 tubal ligations by minilaparotomy per quarter. The AMPPF IEC service provides regular informal talks on family planning for area women at the clinic offices.

BANAMBA

Chief Physician: Ismael Diallo

Assistant to the Chief Physician: Kalifa A. Traoré

Banamba is one of the seven circles in the Region of Koulikoro, with a population of 111,364 living in six arrondissements. Of these inhabitants, 9,242 live in the central arrondissement. The circle covers 28 development sectors and 205 villages. The principal ethnic groups are the Sarakolés, Bambara, Peulh, and a minority of Maures. The main activities are agriculture, livestock breeding and trade (conducted by the City of Banamba).

The health center in Banamba is organized as follows:

- 1 outside consultation clinic
- 1 seven-bed mother-and-child hospital ward
- 1 seven-bed men's hospital ward (with an isolation area)
- 1 surgical unit and 2 six-bed non-surgical wards
- 1 Public Health and Hygiene Service
- 1 Major Endemic Disease Service

1 laboratory

1 ten-bed maternity clinic and a surgical ward for women (Caesarians); the midwife's office serves as an MCH/FP center room

1 social service

There are six more arrondissement health centers; the central one is in Kiban, which is a major development sector in the Circle of Banamba.

The health center has the following staff:

2 Physicians
1 Midwife
2 Health Technicians
3 State Nurses
1 Health Nurse
2 Health Assistants
4 Traditional Midwives
4 Unskilled Laborer
1 Driver

A cost recovery system was instituted under the Regional Health Program for the sale of tickets in the Circle of Banamba and other circles.

In addition, the International Sponsorship Plan, an NGO which operates in many sectors including the health sector, has been active in the circle since 1976 to finance construction, fuel, supplies, equipment and staff per diems.

KANGABA

Located 85 km southwest of Bamako, the Circle of Kangaba has a population of 52,130 in two arrondissements, Narena and the Central Arrondissement. The circle has a total of 12 development sectors comprising 56 villages. The population includes 5 percent children one year and under, 20 percent children six years and under and 20 percent women of childbearing age. Kangaba is one of seven circles in the Region of Koulikoro.

The evaluation team was received by the chief physician of the health center, which has

2 Physicians
2 Technical Health Workers
2 Midwives
2 Medical Technicians
1 Health Technician

2 Traditional Midwives
6 Health Aides
3 Assistants

The MCH/FP activities serve 4,000 inhabitants in the City of Kangaba, plus the population in the other villages. With the current status of staff and equipment, it would be difficult to integrate all of these activities so they could be offered every day. We noted that these activities are scheduled during the week. In Kangaba about 41 percent of the births take place at the health center, and 38 percent of women of childbearing age and 75 percent of children are vaccinated.

The cost recovery system has been a major influence on women's visits to the center. Prices are established as follows:

- FCFA 500 = Prenatal consultation booklets. Price includes services provided during the consultation period: Nivaquin treatment, etc.
- FCFA 600 for childbirth at the central level; and
- FCFA 300 for arrondissements and development sectors.

The staff is optimistic in view of the apparent recovery in spite of this system.

Appendix F
LIST OF OFFICIAL PARTICIPANTS

Appendix F

List of Official Participants Seminar on Contraceptive Inventory Management December 1988

1. CHIEF PHYSICIANS FROM THE REGIONAL FAMILY HEALTH DIVISIONS

Mrs. COULIBALY Fatou SISSOUMA	District of Bamako
Dr. Attaher TOURE	Kayes
Mrs. KEITA Massaran	Koulikoro
Dr. Soma COULIBALY	Sikasso
Dr. Massambou SACKO	Ségou
Dr. Bogoba DIARRA	Mopti
Dr. Aly TEMBELY	Tombouctou
Dr. Fadouba KONE	Gao

2. REGIONAL MIDWIVES

Mrs. FOFANA Fanta KONE	District of Bamako
Mrs. KANTE Marie KELEMA	Kayes
Mrs. DEMBELE Kadia N'DIAYE	Koulikoro
Mrs. KEITA Marie Laurence	Sikasso
Mrs. BORE Sounoumba COULIBALY	Ségou
Miss Kadiatou SYLLA	Mopti
Mrs. DEMBELE Fanta DIALLO	Tombouctou
The regional midwife	Gao

3. SERVICE REPRESENTATIVES

Mrs. Kadidiatou M'BAYE	CERPOD
Mr. TOUNKARA Adama	AMPPF
Mr. Magassa DIADJIRI	AMPPF
The Chief Physician of the test center	
Miss Oumou FOFONA	AIDS Committee
Dr. SANGARE Madina	DSF
Mrs. BOCOUM Kadidia	DSF
Mrs. TOURE Aminata	DSF
Mr. Cheick Omar DIAKITE	DSF
Mrs. KONATE Saran DIARRA	DLP

In addition to the 26 participants, other persons who were not invited asked and received permission to attend this seminar.

Appendix G

ESTIMATED ANNUAL GRM PERSONNEL INPUTS TO PROJECT

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ESTIMATED ANNUAL GRM PERSONNEL INPUTS TO PROJECT

CATEGORY OF PERSONNEL	PROJECT STAFF	DSF STAFF	CNI STAFF	CMD STAFF	MCH/FP COMPLEX AND AMPPF STAFF	TOTAL PERS/MNTH PER MONTH	BASE MTHLY SALARY FCFA	VALUE GRM PERSNL CONTRIBUTION
DOCTOR		3	2	3	1	33	20.4	68,200
MID-WIFE		1	4			90	46.6	34,600
STATE NURSE				2		46	23.3	34,600
HEALTH NURSE						75	37.5	26,800
HEALTH AIDE						187	93.5	25,900
MATRONE						11	5.5	14,000
SOCIAL ASSISTANT						3	1.5	34,600
SOCIAL AIDE						10	5	34,600
COMMUNITY DEVELOP TECH						2	1	34,600
ACCOUNTANT		1	1			2	2.3	38,500
STATISTICAL/ACCTANT AIDE		2	2		1	4	4.3	26,800
SECRETARY			2		1	13	6.95	30,900
CLEANER			1			68	34.15	19,100
GUARD						12	6	18,500
CHAUFFEUR			1			17	8.65	19,100
TOTAL						296.65		107,039,940

- NOTES: 1/ Numbers of GRM project, DSF, CNI, CMD and AMPPF staff from discussions with MSP/AS on 11/9/85
2/ Numbers of MCH/FP complex staff from MSP/AS (1985) "Rapports de Missions de Supervision: District de Bamako"
3/ It was assumed that GRM project staff will spend 100% of their time on project activities
5/ It was assumed that DSF, CNI, and CMD personnel will spend 15% of their time on project activities
6/ Monthly salary data from the CAF (Cellule Administrative et Financiere).

Appendix H
LIST OF PERSONS TRAINED ABROAD

Appendix H

List of Persons Trained Abroad

Financial Management, United States (1987-1990):

Diawara, Yacouba
Traore, Boubacar

Family Planning, Mauritius (7/13/87 - 9/4/87):

Dr. Sissoko, Miriam	MCH/FP center Djikoroni
Dr. Daou, Aissata Boucoum	MCH/FP center Badalabougou
Mrs. Toure, Loko Toure	Djikoroni Garnison Maternity Clinic
Mrs. Coulibaly, Nah Traore	MCH/FP center Katibougou
Mrs. Magassi Coulibaly	MCH/FP center Banamba
Mrs. Toure, Nana Cisse	MCH/FP center Niarela

Family Planning, United States (9/14/87 - 2/10/87)

Dr. Boucoum, Mariam Suzanne Maiga, DSF

MCH/FP Program Planning, Cote d'Ivoire (10/31/88 - 11/26/88)

Lalla, Mint Dah, DSF

International Conference on Oral Rehydration (ICORT), and other official visits to USAID/Washington, United States (12/9/88 - 12/23/88)

Traore, Mamadou Namory.

Appendix I

**SUMMARY OF THE MEETING ON THE MIDTERM EVALUATION
OF THE INTEGRATED FAMILY HEALTH SERVICES (IFAHS)**

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Appendix I

Summary of the Meeting on the Midterm Evaluation of the Integrated Family Health Services (IFAHS) Project

Ms. K.K.

Ministry of Public Health and Social Affairs
National Administration of Social and Health Education
and Planning Ministry of Public Health and Welfare
Republic of Mali

The meeting concerning the midterm evaluation of the Integrated Family Health Services (IFAHS) was held on Tuesday May 16, 1989, at 10:45 am in the conference room of the National Administration of Social and Health Education. The meeting was presided over by Dr. Bokar Toure, the National Director of Planning and Health and Social Training. The meeting was attended by:

Dr. Bokar M. Toure, National Director of Planning and Health and Social Training
Mr. Brehima Siaka Diallo, Head of DEPE/DNPFSS
Dr. Ms. Sangare Madina, Family Health Division/ DNSP
Mr. Abdou Tounkara, AMPPF
Mr. Tata Sangare, USAID
Mr. Neil Woodruff, USAID
Mr. Rachid Krichen, Family Health Division
Mr. Sine Coulibaly, DNPFSS (Evaluation Coordinator)
Mr. Modibo Maiga, DNPFSS (Meeting recorder)

The goal of the meeting was to review the second draft of the evaluation report developed by the evaluation team.

The meeting concluded that this second draft, which is a copy of the first one corrected and revised following the recommendations made by the Family Health Division, also has several deficiencies, as was pointed by remarks made on both content and format by the DNPFSS (Dr. Bokar Toure, Mr. Brehima S. Diallo) and DSF Officials (Dr. Ms. Sangare Madina Ba).

REMARKS ON FORM

The remarks made concern the heavy style and the awkward sentences which do not reflect clearly what the authors mean and therefore can lead to many different interpretations. The National Director of Planning and Health and Social Training concentrated on this aspect of the report, underlining the fact that the French language has its own particular phrasing and that the way certain sentences were put was very misleading and confusing and could lead to guesses and erroneous interpretations. Thus, he strongly recommends reviewing and rewriting certain paragraphs and sentences.

The above criticism applies to the first paragraph on page 8. The way the paragraph is written does not get across the ideas the authors want to express, mainly the experience and the benefits that the DSF could gain from the Integrated Family Health Services Project.

Dr. Bokar Toure asked that this paragraph be rewritten. He also mentioned that the paragraph on page 10, concerning the delays in the implementation schedule, could be improved if it were rewritten taking into account the reasons for the delays and resulting consequences for the implementation plan.

The Malians have also commented on the paragraphs concerning the project integration within DSF and the disruption in the flow of contraceptive supplies. Regarding the latter, it was asked that the whole paragraph be reviewed to better state the problem, because the way it is now put makes one think that everything went well before the project and that the starting of the project was one -- or maybe the reason -- for that supply problem. In the same line, Mr. Abdou Tounkara with AMPPF mentioned that his association never played the role given to it by the evaluation team. This role (contraceptive supply) is not (as he insisted) part of its mission.

The paragraph on IEC does not explain well the reasons for the delays in that field; it should be better argued. Certain paragraphs like the one on the role played by the Directory of Administration and Finance (DAF), the one on the AMPPF role, and the last sentence on page 27 have been modified.

DNPFSS has also asked that the role played by the training division be mentioned. Nothing is said concerning that role, it seems it was put aside.

REMARKS ON CONTENT

As far as the Malians are concerned, the evaluation has been done with preconceived ideas, motiveless prejudices, and therefore the document has some personal viewpoints of the authors that are not based on scientific and impartial grounds.

In the same line of thought, Dr. Bokar Toure thinks that the paragraph on the integration of the project within DSF is confusing in its content as it puts aside the fact that the Department of Public Health and Social Affairs tries to integrate the projects within the existing structures. Thus, according to this policy there is no room for a vertical project.

For the evaluation team the integration of the project within the DSF was a major constraint on the success of the activities implemented by the project. The National Director and

the representative of DSF opposed such a view as, according to them, everything was done as if the project were a vertical structure. It was adapted to the national institutional framework.

Another problem -- and not one of the least -- noted in this paragraph is the way integration is looked at. The document does not underline the consensus reached by the Malians' counterpart and their partner for the integration of the project within the DSF. It seems as if the Malian officials decided it on their own, without consulting their partner.

The history of the project is not given. The Director insisted that information be collected to underscore the fact that there has been a correspondence between the Malians and USAID concerning the integration of the Integrated Family Health Services within the existing structures, in particular the DSF.

The unfortunate comparison between the Family Health Division and AMPPF is a matter of incorrect content as it underlines the fact that NGO activities are efficient as opposed to the ones initiated by the DSF. Therefore, it seems, that for the authors, NGOs are more flexible, more efficient than the Governmental structures as far as family planning is concerned. This idea, which is simply a slanderous accusation, can be found on pages 25 and 26. DNPFS officials (Dr. Toure and Mr. Diallo) have requested that those lines definitively be deleted.

Finally, the evaluation team seems to conclude that the project is a failure. The Malians pointed out that it is too early to say that as this midterm evaluation was only about procedure. Only a final evaluation on impact could reach a conclusion on success or failure.

The second draft should be substantially revised, at least, that is what the Malians think.

As for the USAID officials, their expression was "independent evaluation," which leaves the evaluators perfectly free to express their points of view, whatever they are, even if it is contradictory to USAID views. Thus, according to Ms. Tata Sangare, her organization (USAID) has no comments.

Dr. Bokar Toure does not agree with that. He reminds us that you cannot allow the evaluation team to use the French language as they please, and to be that subjective, saying things which are groundless and which cannot be argued. We do not have to pay for the consequences of misinterpretation and the document should be corrected each time it is necessary, he added.