

PD AR 5-07 B
89413

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT DATA SHEET		1. TRANSACTION CODE A A = Add C = Change D = Delete	Amendment Number	DOCUMENT CODE 3
2. COUNTRY/ENTITY MALI		3. PROJECT NUMBER 688-0227		
4. BUREAU/OFFICE AFR		5. PROJECT TITLE (maximum 40 characters) Integrated Family Health Services		
6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY 07/31/92		7. ESTIMATED DATE OF OBLIGATION (Under "B," below, enter 1, 2, 3, or 4) A. Initial FY 86 B. Quarter 3 C. Final FY 89		

8. COSTS (\$000 OR EQUIVALENT \$1 =)						
A. FUNDING SOURCE	FIRST FY 86			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	313	100	413	5,719.4	2,280.6	8,000.0
(Grant)	(313)	(100)	(413)	(5,719.4)	(2,280.6)	(8,000.0)
(Loan)	(-)	(-)	(-)	(-)	(-)	(-)
Other U.S.						
1.	-	-	-	-	-	-
2.	-	-	-	-	-	-
Host Country	-	-	-	-	1,600.0	1,600.0
Other Donor(s)	-	-	-	-	-	-
TOTALS	313	100	413	5,719.4	3,880.6	9,600.0

9. SCHEDULE OF AID FUNDING (\$000)									
A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) SH	4438	440		-	-	8,000	-	8,000	-
(2)									
(3)									
(4)									
TOTALS						8,000	-	8,000	-

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)						11. SECONDARY PURPOSE CODES			
12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)									
A. Code									
B. Amount									

13. PROJECT PURPOSE (maximum 480 characters).
 To assist the Maternal and Child Health/Family Planning Program of the GRM to strengthen and integrate services in 15 MCH/FP complexes in Bamako and the OHV area and to assist the private family planning agency in Mali (AMPPF) to upgrade its services.

14. SCHEDULED EVALUATIONS					15. SOURCE/ORIGIN OF GOODS AND SERVICES						
Interim	MM	YY	MM	YY	Final	MM	YY	<input type="checkbox"/> 000	<input checked="" type="checkbox"/> 941	<input checked="" type="checkbox"/> Local	<input type="checkbox"/> Other (Specify)
			11	87		11	92				

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)

Payment Verification Concurrence
 George R. Jenkins, CON" 7/14/86

17. APPROVED BY	Signature <i>Eugene R. Chiavaroli</i>	Date Signed MM DD YY 07/14/86	18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION MM DD YY
	Title Eugene R. Chiavaroli Mission Director		

Return to
Joyce M. Wolfeld
→ REDSD/WCA



INTEGRATED FAMILY HEALTH SERVICES PROJECT

(688-0227)

XX
USAID/BMAGO
XX

PROJECT PAPER

Implementation plan -
page 50
pg 23 - part 1 of 1
(16) - conditions present

ACTION MEMORANDUM FOR THE DIRECTOR, USAID/MALI

From • Zach Hahn, DEO

Subject • Mali Integrated Family Health Services Project, 688-0227,
Project Authorization

I. Problem: Your approval is requested for a grant of \$8,000,000 from the Sahel Development Program (SDP) appropriation to the Government of the Republic of Mali (GRM) for the Mali IFAHS project. An obligation of \$1,200,000 is planned in FY 1986.

II. Discussion

A. Project Description

This six year project will provide institutional support to the Department of Public Health (DNSP) of the Ministry of Public Health and Social Affairs (MSP/AS) and affiliated GRM entities, and to the private family planning agency, the Malian Association for the Protection and Promotion of the Family (AMPPF). With this support the GRM will be able to strengthen and integrate its services in 15 maternal and child health and family planning (MCH/FP) Complexes in Bamako and the "Operation Haute Vallee" (OHV) area, and the AMPPF will be able to upgrade its services.

The project has one main and three supporting components.

The main component, Service Upgrading, will improve services in nutritional surveillance, vaccination, oral rehydration therapy (ORT), and voluntary family planning. In addition to training in the four areas mentioned above, health personnel will also learn management techniques, supervision, recordkeeping, and health planning. A standard set of commodities consisting of clinical equipment and furnishings also will be provided to each MCH/FP complex. The private sector portion of the project will involve providing the AMPPF with technical assistance and commodities to upgrade and expand direct family planning services and community education campaigns.

The second component involves a) renovation of the 15 MCH/FP complexes and a Koulikoro warehouse for storage of health materials and b) construction of a two-room addition at the Family Health Division (DSF) in the MPH, a new dispensary at Djikoroni, and a new AMPPF building.

The third component undertakes Information, Education, and Communication (IEC) activities to promote the MCH/FP program in this project.

The fourth component finances special studies on baseline utilization statistics, cost recovery, and social marketing.

The IFAHS project is consistent with the Mission's strategy objective of enhancing food security in Mali. A lowered fertility rate will contribute to ameliorating the disparity between food production and consumption requirements. The project will also help in restructuring the population age distribution under which a producer (working adult) will have to support less consumers (children).

Immediate beneficiaries of the project will be the population of the project zone vulnerable to health problems, women of reproductive age (15-44) and young children (0-5). Other immediate beneficiaries will be the about 900 health personnel trained under this project. Ultimate beneficiaries will be all the inhabitants of the project zone, most of whom will be members of the direct beneficiary families.

B. Financial Summary

The total cost of the project is estimated at \$9,600,000 of which A.I.D. will contribute \$8,000,000 and the GRM \$1,600,000 as noted below:

	A.I.D.	GRM	Total
		(\$1000)	
Technical Assistance	2,785		2,785
Training	631		631
Commodities	1,578		1,578
Operating Expenses (incl. salaries)	384	1,203	1,587
Renovation & Construction, Land, Buildings	881	94	975
Inflation (5%)	1,217	303	1,520
Contingency (7%)	524		524
Life of Project Totals	<u>8,000</u>	<u>1,600</u>	<u>9,600</u>

C. Socio-Economic, Technical, and Environmental Description

The Project Paper includes appropriate technical, institutional, financial, economic, and social soundness analyses to support its acceptability and feasibility. The economic analysis shows positive benefits to the extent they are measurable based on data currently available. Further data will be provided by the baseline utilization statistics study.

The financial analysis addresses the issue of recurrent costs. While the Mission feels that it is unlikely that the project recurrent costs will be met by the GRM, the analysis states that

recurrent costs are likely to be met by GRM budget allocations, predictable support from other donors in specific areas such as vaccines, oral rehydration salts (UNICEF) and contraceptives (U.S.). In addition, cost recovery measures such as fees for services will be tried. During our Mission review of the Project Paper held on January 14, 1986, it was decided that the recurrent cost problems inherent in this type of project should not be an issue which would delay project authorization.

The Africa Bureau Environmental Officer has granted a "categorical exclusion" for MCH/FP activities and a "negative determination" for the renovation and construction activities of the project.

D. Implementation Plan, Gray Amendment Objectives, and Conditions and Covenants

The Implementation Plan provides a realistic timetable for carrying out project activities and achieving the project purpose. The principal GRM Implementing Agency will be the Department of Public Health (DNSP). Three long term technical assistance personnel for 132 PM and 48 PM of short-term assistance will be funded. Long term technical assistance will be procured through direct contracting.

Consideration was given to implementing the project through an 8(a) firm but because of cost and financial management requirements, it was decided to contract with individuals instead of firms during phase I of project implementation. This issue will be considered further during the course of the project.

The Financial Analysis and Illustrative Budget and its Worksheets contain a detailed analysis of the project cost, as required by FAA Section 611 (a). Renovation and construction estimates will be refined by a local Architectural and Engineering firm and approved by the Mission engineering office immediately before these activities begin.

A Financial Management Specialist will establish the project management system including appropriate accounting and commodity control records to satisfy the requirements of FAA Section 121 (d). No funds will be placed under the control of the GRM until such time as the said system is established and certified.

The statutory checklists have been completed satisfactorily and are attached at Annex IX.C.

Appropriate Conditions Precedent and Covenants for inclusion in the Grant Agreement are identified in the Project Authorization.

E. Responsible Offices

The Mission will provide a Project Officer experienced in health development planning for implementation of the project. AFR/PD/SWAP will be responsible for AID/W backstopping of this project.

III. Waivers

An already approved source/origin waiver for the procurement of vehicles and spare parts in the total estimated amount of \$160,000 from A.I.D. Geographic Code 935 has been attached as Annex IX.F to the Project Paper.

IV. Justification to Congress

A Congressional Notification (CN) was forwarded to Congress on June 12, 1986 and the waiting period expired on June 27, 1986.

V. Prohibition Of Abortion Related Activities

As required by A.I.D. regulations, the Project Grant Agreement will contain the appropriate clauses prohibiting funding of abortion related activities.

VI. Recommendation

That you sign the attached Project Authorization and thereby approve life-of-project funding of \$8,000,000 for the Mali Integrated Family Health Services Project as described in the attached Project Paper.

Approved: Eugene R. Chiavaroli
Eugene R. Chiavaroli

Disapproved: _____

Date: July 14, 1986

Clearances:

- F. Zamora GDC/HLS [Signature]
- B. Huddleston GDO [Signature]
- K. Romwall CONT/B&A [Signature]
- G. Jenkins CONT [Signature]
- M. Ireland MGMT [Signature]
- L. Koski ENGR [Signature]
- Z. Hahn DEO [Signature]
- C. Robertson PROG [Signature]
- R. Simmons PROG [Signature]
- J. Anderson DD [Signature]
- E. Dragon RLA/Dakar (draft) [Signature]

Attachment:

- 1. Project Authorization
- 2. Project Paper

PROJECT AUTHORIZATION

Name of Country : Mali

Name of Project : Integrated Family Health Services

Number of Project: 688-0227

1. Pursuant to Section 121 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Integrated Family Health Services Project for the Republic of Mali involving planned obligations of not to exceed \$8,000,000 in grant funds over a six year period from the date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB allotment process, to help in financing foreign exchange and local currency costs for the project. The planned life-of-project is six years from the date of initial obligation.

2. The project will provide institutional support to the Department of Public Health (DHP) in the Ministry of Public Health and Social Affairs (MSP/AS) and affiliated entities of the Government of the Republic of Mali (GRM), and to the private Malian family planning agency, the "Association Malienne pour la Protection et la Promotion de la Famille" (AMPPF). With this support the Government of Mali will be able to strengthen and integrate its services in 15 Maternal and Child Health/Family Planning (MCH/FP) Complexes in Banako and in the Haute Vallée Koulikoro area and, the AMPPF will be able to upgrade its services.

The project has the following components:

(1) "Service Upgrading", the main component, consists of: nutritional surveillance, vaccination, oral rehydration therapy (ORT), and voluntary family planning. In addition, health personnel will learn management techniques, supervision, recordkeeping, and health planning. A standard set of commodities consisting of clinical equipment and furnishings will be provided to each MCH/FP Complex. The private sector portion of the project will involve providing the AMPPF with technical assistance and commodities to upgrade and expand its services which will consist of direct family planning services and community education campaigns.

(2) "Renovation" of the 15 MCH/FP Complexes and a Koulikoro warehouse for storage of health materials, and "Construction" of a two room addition at the Division of Family Health (DFH), a new dispensary at Djikoron and a new AMPPF building.

(3) "Information, Education, and Communication" (IEC) to promote the HCH/FP activities undertaken by this project.

(4) "Special Studies" on Baseline Utilization Statistics, Cost Recovery, and Social Marketing.

3. The Project Agreement which may be negotiated and executed by officers to whom such authority is delegated in accordance with A.I.D. Regulations and Delegations of Authority shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

a. Source and Origin of Commodities, Nationality of Services

Except as A.I.D. may otherwise agree in writing:

(1) Commodities financed by A.I.D. under the project shall have their source and, except for motor vehicles, their origin in the Cooperating Country or in countries included in Geographic Code 941.

(2) Pursuant to a source/origin waiver approved for this project by the Assistant Administrator for Africa, approximately \$163,000 worth of motor vehicles financed by A.I.D. under this project may have their origin, and, if need be, their source, in countries included in Geographic Code 935.

(3) Except for ocean shipping, the suppliers of commodities or services financed by A.I.D. shall have the Cooperating Country or countries included in A.I.D. Geographic Code 941 as their place of nationality.

(4) Ocean shipping financed by A.I.D. under the project shall be only on flag vessels of the United States, other countries in Code 941, and the Cooperating Country.

b. Conditions Precedent

(1) Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee shall, except as the Parties may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D.:

a) a statement setting forth the names and titles of persons or person having the authority to act as the representative or representatives of the Grantee, as specified in Section 8.2., together with a specimen signature of each such

b) a nomination, in writing, of a person acceptable to A.I.D. for appointment on a full-time basis to the position of Project Director, and a written delegation of authority which

will give full authority to the Project Director to direct and coordinate all GRM implementation responsibilities under the Project.

c) a written certification that the Centre National d'Immunisation (CNI) has central cold storage facilities that are sufficient in quantity and quality to receive and store vaccine shipments donated by this project.

(2) Prior to the disbursement under the project, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, for technical assistance to, or commodities and construction for, the "Association Malienne pour la Protection et la Promotion de la Famille" (AMPPF), the Grantee shall, except as A.I.D. may otherwise agree in writing, furnish A.I.D. an agreement between AMPPF and the Grantee which provides that AMPPF will have ownership of the land and building constructed under the Project for AMPPF, and appropriate commitments that AMPPF will carry out activities assigned to it under the Project.

(3) Prior to the release of funds directly to the Grantee, the Grantee shall establish a system of accounts which will be certified by the Administrator of A.I.D. as being sufficient to meet the requirements of Section 121(j) of the Foreign Assistance Act of 1920, as amended.

c. Special Covenants

a) Project Evaluation.

The Parties agree to establish an evaluation program as part of the Project. Except as the Parties otherwise agree in writing, the program will consist of two evaluations, a mid-term evaluation in the second year of the project and a final evaluation in the sixth year.

The mid-term evaluation will:

- 1) assess progress to date including planned versus actual implementation of activities;
- 2) conduct a preliminary examination of each project component against input and output indicators, planned versus actual commitments and disbursements of funds, and continuing validity of assumptions.

The final evaluation will:

- 1) evaluate the project's attainment of objectives;
- 2) assess, to the degree feasible, the overall development impact of the project; and,
- 3) based on the findings, determine the practicality and desirability of a possible follow-on effort.

d. Covenants

The Grantee agrees that it will:

a) provide, on a timely basis, sufficient numbers of qualified personnel and of skilled and unskilled workers to assure successful implementation of the project and achievement of the project purpose.

b) insure that all design, engineering, and construction work financed under the project will be undertaken by private architectural, engineering and construction firms, unless A.I.D. agrees otherwise in writing;

c) undertake specific measures to assure that women participate in all training programs, and partake of the professional advancement opportunities under all project components;

d) provide A.I.D., no later than one year prior to the Project Assistance Completion Date (PACD), a written plan for maintaining project benefits, including, but not limited to, the envisaged means of meeting any recurrent costs reasonably foreseeable as a result of this project;

e) undertake every reasonable effort to insure that each participant trained overseas under this project continues to work in maternal and child health family planning;

f) undertake consultation with USAID/Mali during the second, third and fourth years of project implementation concerning the development of population policies in Mali. The Grantee will agree further to include in these discussions senior officials of the Ministry of Public Health and Social Affairs among the Italian representatives;

g) prior to the commencement of the third year of project implementation, conduct studies concerning both Cost Recovery and Social Marketing of contraceptives and oral rehydration salts. The Grantee further agrees to undertake a good faith effort to implement all reasonable recommendations arising out of the studies.

Date: July 14, 1966

Clearances: As shown on
Action Memorandum

Eugene R. Chiavaroli
Director
USAID/Mali

LIST OF ABBREVIATIONS

AMPPF	- Association Malienne pour la Protection et la Promotion de la Famille.
AVSC	- Association for Voluntary Surgical Contraception
CCCD	- Combatting Childhood Communicable Diseases
CDC	- Centers for Disease Control
CDSS	- Country Development Strategy Statement
CEDPA	- Center for Development and Population Activities
CMD	- Programme National de Lutte Contre Les Maladies Diarrheiques
CNI	- Centre National d'Immunisation
CPR	- Contraceptive Prevalence Rate (% women 15-49 using FP)
DNAS	- Département National des Affaires Sociales
DNPFSS	- Département National de Planning et Formation Sanitaire et Sociale
DNSP	- Direction Nationale de la Santé Publique
DSF	- Division de la Santé Familiale
EPI	- Expanded Program for Immunization
FED	- Fonds Européens de Développement
FHI	- Family Health International
FP	- Family Planning
GNP	- Gross National Product
GRM	- Gouvernement de la République du Mali
IEC	- Information, Education, Communication
IFAHS	- Integrated Family Health Services Project
INRSP	- Institut National de la Recherche en Santé Publique
INTRAH	- International Training in Health
IPPF	- International Planned Parenthood Federation
IUD	- Intra Uterine Device
JHPIEGO	- John Hopkins Program for International Education in Gynecology
MOHSA	- Ministry of Health and Social Affairs
MSPSA	- Ministère de la Santé Publique et Affaires Sociales
OHV	- Opération Haute Vallée
OMP	- Office Malien de Pharmacie
ORS	- Oral Rehydration Salts
ORT	- Oral Rehydration Therapy
PCS	- Population Communications Services, John Hopkins
PM	- Person Months
PMI	- Protection Maternelle et Infantile
PPM	- Pharmacie Populaire du Mali
PRICOR	- Operational Research in Primary Health Care
PRITECH	- Primary Health Care Technologies
RAPID	- Resources for Awareness of Population Impact on Development
REDSO/WCA	- Regional Economic Development Support Office/ West and Central Africa
SDSS	- Sahel Development Strategy Statement
SHDS	- Strengthening Health Delivery Systems
STD	- Sexually transmitted diseases
TA	- Technical Assistance
UNFPA	- United Nations Fund for Population Activities
UNICEF	- United Nations Children's Fund
USAID	- United States Agency for International Development
WHO	- World Health Organization
WWTF	- World Wide Training Funds

EXECUTIVE SUMMARY
Mali Integrated Family Health Services (688-0027).

This is a six year \$8,000,000 project which will provide institutional support to the Department of Public Health (DNSP) and affiliated GRM entities, under the Ministry of Public Health and Social Affairs and to the private Malian family planning agency, the AMPPF. With this support the GRM will be able to strengthen and integrate its services in 15 Maternal and Child Health/Family Planning (MCH/FP) Complexes in Bamako and in the Haute Vallee Koulikoro area and, the AMPPF will be able to upgrade its services.

The project has one main and three supporting components:

(1) "Service Upgrading", the main component, consists of four subcomponents in the public sector: nutritional surveillance vaccination, oral rehydration therapy (ORT) and, voluntary family planning. In addition to training in these four subcomponents, health personnel will learn management techniques, supervision, recordkeeping, and health planning. A standard set of commodities consisting of clinical equipment and furnishings will be provided to each MCH/FP Complex. The private sector portion of the project will involve providing the AMPPF with technical assistance and commodities to upgrade and expand its services which will consist of direct family planning services and community education campaigns.

(2) Renovation to varying degrees at the 15 MCH/FP Complexes and at a Koulikoro warehouse for storage of health materials, construction of a two room addition at the Division of Family Health (DSF), a new dispensary at Djikoroni and a new AMPPF building.

(3) Information, Education, and Communication (IEC) to promote the MCH/FP activities undertaken by this project.

(4) Special Studies on Baseline Utilization Statistics, Cost Recovery, and Social Marketing.

Successful implementation will result in the following:

Provision of a full complement of MCH/FP services by participating MCH/FP Complexes, including: prenatal, intrapartum, and postnatal care; voluntary family planning; well child clinic with nutritional surveillance; oral rehydration therapy; and, vaccination against diphtheria, whooping cough, tetanus, measles, and polio.

Improved clinic supervision and management, including reliable health service statistics and patient records, stock control systems for vaccines and contraceptives, and routine referrals among services.

More knowledgeable and productive MCH/FP personnel.

Increased utilization of MCH/FP services (in terms of absolute numbers and percentage of population served) and increased community knowledge of and practice of preventive health and voluntary family planning.

AMPPF operating out of a new, improved facility, offering expanded services to clients and a more effective IEC program to the community.

1. SUMMARY

A. FUNDING, GRANTEE, TERM OF PROJECT

The total cost of the Mali Integrated Family Health Services Project (IFAHS) is estimated at \$9,600,000 of which A.I.D. will contribute \$8,000,000 of Sahel Development Program funds. The Grantee, the Government of the Republic of Mali (GRM) will contribute the local currency equivalent of \$1,600,000 (assuming an exchange rate of \$1 = 350 FCFA).

The term of the project is six years from the date of initial obligation. Accordingly, the Project Assistance Completion Date (PACD) is estimated to be on or about July 31, 1992.

I.B. PROJECT PURPOSE:

The project purpose is: to assist the Maternal and Child Health and Family Planning Program of the GRM to strengthen and integrate the services of 15 maternal and child health/family planning (MCH/FP) center complexes in Bamako and the Operation Haute Vallée (OHV) area and to assist the Bamako-based private Malian family planning agency (Association Malienne pour la Protection et la Promotion de la Famille, or, AMPPF) to upgrade its services.

I.C. SUMMARY PROJECT BACKGROUND AND DESCRIPTION

The origins of this project date back to 1982, when a PID for a five year \$3,515,000 effort was designed. That PID envisioned a broad range of 'unclearly related activities, including: strengthening of the national pharmaceutical system through technical assistance and policy change dialogue; improving the nursing school curriculum; upgrading maternal and child health and family planning (hereinafter MCH/FP) services in eight Health Center Complexes (only four of which were in Bamako district); and, improving the Ministry of Health's (MSP/AS) management and financial planning.

Review of this first PID led to a completely revised more focused second PID later in 1983 for a four year \$3,460,000 effort. This second design concentrated on upgrading MCH/FP services in eight Health Center Complexes, four in Bamako, one in Sikasso, one in Segou, one in Koulikoro, and one in Mopti.

There was a hiatus in PID revision and finalization. In May

1985, the Mission submitted to and AID/W approved the latest PID for \$6,054,000 for a seven year project involving ten health center complexes in Bamako and five in the Haute Vallee Koulikoro region. The present project paper is slightly modified at the suggestion of AID/W and, as a result of improved planning, is now a six year project at a LDF funding of \$8,000,000.

The activities of the current project take place at all ten existing GRM MCH/FP Complexes in the Bamako District and at five GRM MCH/FP Complexes in the contiguous Haute Vallee Koulikoro region. In addition, the project involves the participation of the Bamako-based Malian private family planning agency, the AMPPF.

Project activities are organized into one main component (Service Upgrading) and three other supportive components (Renovation/Construction, and Information, Education, and Communication, and Special Studies).

The main component, the "Service Upgrading Component" is divided into four subcomponents: nutritional surveillance, vaccination, oral rehydration therapy (ORT), and voluntary family planning. These subcomponents were selected because they are deemed to be among the health system's least developed MCH/FP services and because a relatively modest investment in their upgrading is predicted to have a significant positive family and public health impact.

The second component is the "Renovation/Construction Component". The project finances repair, structural improvements of varying scope for each MCH/FP Complex, construction of a new dispensary at the Djikoroni health complex in Bamako, addition of a contraceptive stockroom and adjacent room for a statistics office at the Division of Family Health (Division de la Santé Familiale, or DSF), and renovation of the regional health materials warehouse of Koulikoro. In addition, the project finances construction of a new AMPPF headquarters office and service center in a very accessible location in central Bamako.

"Information, education and communication (IEC)" is the third component, the activities of which promote MCH/FP services through various media, such as television, radio, posters, presentations at meetings of leadership and special interest groups. A special effort will be made to involve men in family planning programs through educational campaigns for the military, police, government and religious leaders. Community, political, religious and educational leaders who can play an important role in supporting and sanctioning the MCH/FP program will participate in study and/or observational visits to other countries to give them an informed and, hopefully, contagious enthusiasm for MCH/FP activities. At the MCH/FP Complex level, this component will consist of group and individual health education.

The fourth component, the "Special Studies Component",

consists of three parts: (1) a Baseline Study of Utilization Statistics which, in addition to collecting baseline data, will recommend certain quantifiable End of Project Status (EOPS) Indicators (2) a Cost Recovery Study which will focus on a fee-for-service strategy and other ways of meeting recurrent costs of the GRM's MCH/FP program; and, (3) a Social Marketing Feasibility Study to determine the feasibility of private, commercial distribution of barrier method contraceptives (condoms, foams) and other commodities such as ORS packets. If the study indicates marketing feasibility, a Social Marketing pilot activity may be undertaken to yield further information.

The project has three main phases which are summarized below. A graphic presentation of the implementation activities can be found in the Project Implementation Schedule Chart in Annex IX.B.

The first phase is the Project Authorization and start-up phase. The period covered begins just after this project paper is approved by the Mission and up to month 18 after the Project Agreement is signed. The main focus will be on Engineering and Construction, Studies, Out-of-Country Training, and Administrative and Financial Support for the project.

Starting the second year a Financial Management Advisor will be in place under a personal services contract to establish a project management system, financial accounting procedures, and commodity inventory control that meets the requirements of Section 121 (d) certification. At about the fourth year of the project, he/she will also train and supervise two project accountants who will have been sent for two year training in accounting during the first and second years.

An interim phase will take place from month 18 to 24 of the project. During this time, the the last two technical assistants will be contracted. But before this takes place there will be an assessment to confirm technical assistance requirements and in-country training plans.

A mid-term evaluation will take place at the end of the first phase to assess the state of readiness of continuing other planned activities and to make recommendations. A mid-term financial audit will also take place at this time.

The last phase will be for implementation and will cover the period from on or about month 24 to the end of the project. The long term technical assistance consisting of the Nurse Clinician/Administrator and the Training Advisor will arrive.

The team leader will remain in country four years and will provide expertise in the four technical areas being upgraded and on-the-job assistance as well as training in clinic management, supervision and health planning. The Training Advisor will be

responsible for planning and implementing all training activities for the project. This last phase will include the remaining Renovation and construction activities. Finally, the equipment, supplies and services will be put in place.

Other technical assistance, much of which will come from centrally funded projects, will include personnel for IEC activities, training, needs assessment for training, commodities management, information systems, special studies, and miscellaneous assistance. Expertise from the Association for Voluntary Surgical Contraception (AVSC) will be arranged through a buy-in arrangement. Local technical assistance will consist of architectural and engineering expertise (A&E) and construction services.

A.I.D. will finance US- and locally-procured equipment and furniture for the MCH/FP Complexes and for AMPFFF. Other purchases include family planning supplies, vaccines and related expendables, growth monitoring and immunization cards, promotional and public relations materials, a project office computer, construction materials, and vehicles and spare parts.

U.S.-procured equipment and furniture for the MCH/FP Complexes and the Project Office will be contracted through a Procurement Services Agent (PSA) having an Indefinite Quantity Contract (IOC) with USAID. Vaccines and family planning supplies will be procured with the assistance of the Science and Technology Bureau (S & T) Population and Health offices in AID/W.

Extensive training will be undertaken by this project. Special attention is also being placed on clinic management, supervision, information system development, and health planning.

Before the training program is finalized, an assessment of personnel roles and qualifications needed to run a full-service MCH/FP Complex service will be performed. The assessment will also include a review of the numbers and qualifications of existing staff, in order to assure that project training is applicable. A substantial amount of the remaining training is devoted to IEC matters and health education. Training in financial accounting, commodity management and statistics also is being provided.

Forty-eight person months of long term and 490 of short term training will be included. Of the total 490 person months of short term training, 431 are in-country, 46 are short-term third country, and 13 are short-term in the United States. To support this level of training, in addition to the Training Advisor, ten person months of technical assistance is for training specialists in various disciplines.

A variety of operational costs will be financed by this project. A project office will be rented, furnished and provided with utilities and expendable supplies. Salaries of locally hired support personnel for this office will be paid. Vehicle

maintenance and petrol, oil, and lubricants (POL) are included.

The GRM will contribute the full-time services of its Project Team members (Project Director, Deputy Director, Chief Accountant, and two Assistant Accountants) and the part-time participation of the Bamako District Public Health Director, the Koulikoro Regional Public Health Director, and the Project Advisory Committee members. Finally, personnel from participating MCH/FP Complexes will be involved as required.

The GRM's contribution also includes the use of MCH/FP Complex facilities for carrying out the project activities, land for AMFFF headquarters construction, newspaper space, television and radio time for IEC and health education activities, and some operational costs.

This summary description is intentionally skeletal. A more complete discussion is contained in the Detailed Project Description section. Readers are referred especially to the Introduction and Project Rationale section of this Description and to the Project Implementation Plan for a comprehensive discussion of the project and how it is expected to proceed.

I.D. IMPLEMENTING AGENCY AND PARTICIPATING HEALTH SECTOR ENTITIES

The implementing agency of this project is the National Department of Public Health (Direction Nationale de la Santé Publique, hereinafter referred to as DNSP), a major department within the Ministry of Public Health and Social Affairs (Ministère de la Santé Publique et des Affaires Sociales, or MSP/AS). Detailed discussion of the participating entities is presented in the Monitoring and Administrative Section of the Implementation Plan and in the Institutional Analysis (Annex IX.N.). Nevertheless, a short sketch of "Who's Who" for the project is presented here.

The DNSP will nominate the Project Director and assure that other qualified Malian members of the Project Team are nominated. As implementing agency, it is responsible for overall project coordination. At the same hierarchical level within the Ministry are two other participating departments, the National Department of Planning and Health and Social Affairs Training (Direction Nationale de la Planification et de la Formation Sanitaire et Sociale, or DNPFSS), which will play a central role in project training activities, and the National Department of Social Affairs (Direction Nationale des Affaires Sociales, or DNAS), which is charged with carrying out nutritional surveillance, *inter alia*.

Additionally, there are two national programs for discrete health concerns which report directly to the DNSP. The first, the National Immunization Center (Centre National d'Immunication,

or CNI), will play the major role of the vaccination subcomponent of the Service Upgrading Component. The second, the National Program Against Diarrheal Diseases (Programme Nationale de Lutte Contre les Maladies Diarrhéiques, or CMD) will bear the primary technical responsibility for ORT subcomponent activities.

Four divisional departments are under the direction of the DNSP, the most important for the project being the Division of Family Health (Division de la Santé Familiale, or DSF). The DSF is comprised of three sections. The Maternal and Child Health Section (Santé Maternelle et Infantile) oversees MCH/FP activities. The Nutrition Section is in charge of the technical aspects of nutrition activities and develops the nutrition surveillance program administered by the Department of Social Affairs. Finally, the Health Education Section (Education pour la Santé) directs IEC and health education program activities.

The DSF has become the GRM entity charged with government family planning efforts. Accordingly, it will be the primary public sector implementor of the family planning subcomponent of the Service Upgrading Component. The DNSP will nominate the Project's Deputy Project Director who will come from the DSF.

Implementation of family planning activities in the private sector will be through the AMPFF, which sometimes has been assigned the lead in both selected technical and promotional efforts because of its relatively predominant capability. The results of any AMPFF lead efforts will be shared with the DSF and there will be close collaboration between the private agency and public division in implementing the family planning related IEC activities.

I.E. SUMMARY FINANCIAL PLAN

The total cost of the project is estimated at \$9,600,000 of which A.I.D. will contribute \$8,000,000 and the GRM \$1,600,000 as noted below:

	A.I.D.	(\$1000) GRM	Total
Technical Assistance	2,785		2,785
Training	631		631
Commodities	1,578		1,578
Operating Expenses (incl. salaries)	384	1,203	1,587
Renovation & Construction, Land, Buildings	881	94	975
Inflation (5%)	1,217	303	1,520
Contingency (7%)	524		524
Life of Project Totals	8,000	1,600	9,600

More detailed financial information is set forth in the Financial Analysis and in the Budget Worksheets at Annex IX.J. and in Section V. Financial Plan and Detailed Budget

I.F. AUTHORIZED GEOGRAPHIC CODE

Except as A.I.D. may otherwise agree in writing:

(1) Commodities financed by A.I.D. under the project shall have their source and, except for motor vehicles, their origin in the Cooperating Country or in countries included in Geographic Code 941.

(2) Pursuant to a source/origin waiver already approved by the Assistant Administrator for Africa, approximately \$163,000 worth of motor vehicles financed by A.I.D. under this project may have their origin, and, if need be, their source, in countries included in Geographic Code 935.

(3) Except for ocean shipping, the suppliers of commodities or services financed by A.I.D. shall have the Cooperating Country or countries included in A.I.D. Geographic Code 941 as their place of nationality.

(4) Ocean shipping financed by A.I.D. under the project shall be financed only on flag vessels of the Cooperating Country or the United States.

I.G. WAIVERS REQUIRED

A source/origin waiver from A.I.D. Geographic Code 000 to Code 935 to permit the procurement of about \$160,000 worth of vehicles was approved by the Assistant Administrator for Africa.

I.H.1. CONDITIONS PRECEDENT

(1) Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee shall, except as the Parties may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D.:

a) a statement setting forth the names and titles of persons or person having the authority to act as the representative or representatives of the Grantee, as specified in Section 8.2., together with a specimen signature of each such

b) a nomination, in writing, of a person acceptable to A.I.D. for appointment on a full-time basis to the position of Project Director, and a written delegation of authority which will give full authority to the Project Director to direct and coordinate all GRM implementation responsibilities under the Project.

c) a written certification that the Centre National d'Immunisation (CNI) has central cold storage facilities that are sufficient in quantity and quality to receive and store

vaccine shipments donated by this project.

(2) Prior to the disbursement under the project, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, for technical assistance to, or commodities and construction for, the "Association Malienne pour la Protection et la Promotion de la Famille" (AMPPF), the Grantee shall, except as A.I.D., may otherwise agree in writing, furnish A.I.D., an agreement between AMPPF and the Grantee which provides that AMPPF will have ownership of the land and building constructed under the Project for AMPPF, and appropriate commitments that AMPPF will carry out activities assigned to it under the Project.

(3) Prior to the release of funds directly to the grantee, the Grantee shall establish a system of accounts which will be certified by the Administrator of A.I.D. as being sufficient to meet the requirements of Section 121(d) of the Foreign Assistance Act of 1980, as amended.

SPECIAL COVENANTS

a) Project Evaluation.

The Parties agree to establish an evaluation program as part of the Project. Except as the Parties otherwise agree in writing, the program will consist of two evaluations, a mid-term evaluation in the second year of the project and a final evaluation in the sixth year.

The mid-term evaluation will:

- 1) assess progress to date including planned versus actual implementation of activities;
- 2) conduct a preliminary examination of each project component against input and output indicators, planned versus actual commitments and disbursements of funds, and continuing validity of assumptions.

The final evaluation will:

- 1) evaluate the project's attainment of objectives;
- 2) assess, to the degree feasible, the overall development impact of the project; and,
- 3) based on the findings, determine the practicality and desirability of a possible follow-on effort.

COVENANTS

The Grantee agrees that it will:

a) provide, on a timely basis, sufficient numbers of qualified personnel and of skilled and unskilled workers to assure successful implementation of the project and achievement of the project purpose.

b) insure that all design, engineering, and construction work financed under the project will be undertaken by private architectural, engineering and construction firms, unless A.I.D.

agrees otherwise in writing;

c) undertake specific measures to assure that women participate in all training programs, and partake of the professional advancement opportunities under all project components;

d) provide A.I.D., no later than one year prior to the Project Assistance Completion Date (PACD), a written plan for maintaining project benefits, including, but not limited to, the envisaged means of meeting any recurrent costs reasonably foreseeable as a result of this project;

e) undertake every reasonable effort to insure that each participant trained overseas under this project continues to work in maternal and child health family planning;

f) undertake consultation with USAID/Mali during the second, third and fourth years of project implementation concerning the development of population policies in Mali. The Grantee will agree further to include in these discussions senior officials of the Ministry of Public Health and Social Affairs among the Malian representatives;

g) prior to the commencement of the third year of project implementation, conduct studies concerning both Cost Recovery and Social Marketing of contraceptives and oral rehydration salts. The Grantee further agrees to undertake a good faith effort to implement all reasonable recommendations arising out of the studies.

I.I. SUMMARY FINDINGS

This project is ready for implementation and is considered financially, economically, socially, and environmentally sound, and technically feasible.

I.J. STATUTORY CHECKLISTS

This project meets all applicable statutory criteria. Appropriate checklists are included in Annex IX.C.

I.K. PROJECT ISSUES

Issues which have arisen under this project have been resolved. A discussion of these issues is contained in the "Project Issues" section below.

I.L. CONSIDERATION OF SMALL, DISADVANTAGED, MINORITY AND WOMEN-OWNED FIRMS

Consideration for the long term technical assistance services was given to all forms of contracting, including small, disadvantaged, minority and women owned firms. Due to the fact that the technical assistance needs were small and because of budget considerations it was decided that personal services contracting was the best method. Nevertheless, as the first phase of the project progresses contracting mode will be

reconsidered.

I.M. PROJECT TEAM MEMBERS

1. USAID/MALI

Robert Huddleston, Chief, General Development Office
Francisco Zamora, Health Development Officer
Roger Simmons, Chief, Program Office
Celeste Robertson, Assistant Program Officer
Zachary Hahn, Design and Evaluation Officer
Keith Komwall, Financial Analyst
Leslie Koski, Chief Engineer
Hamicire Daou, Engineer
Tata Sangare, Senior Program Specialist
Gaoussou Traore, Program Assistant, Design and
Evaluation Office
Maimouna Dienapo, Program Assistant, Crops
Mamadou Diarra, Financial Management Specialist, Sahel
Regional Financial Management Project

2. REDSO/WA

Joyce Holfeld, Regional Officer
Thomas Stephens, Regional Procurement Officer
Julie DeFler, Project Development Officer

3. Contractor (fielded by International Science and
Technology Institute)

Elizabeth Stephens, Team Leader
Dayl Donaldson, Economist
Laura Evison, Training Specialist

4. GRM

Dr. Paul Diarra, Département National de la Santé
Publique, Chairman
Dr. Lilliane Barry, Division de la Santé Familiale
Mme. Djaminatou Diallo Kaba, Département National de la
Planification et de la Formation Sanitaire et So
Mme. Thiam, Institut National de la Recherche en Santé
Publique
Mr. Boncena Naiga, Direction Nationale de l'Hygiène
Publique et de l'Assainissement.

II. BACKGROUND

II.A. COUNTRY SETTING

II.A.1. Physical Characteristics, Political, and Economic Situation

Territorially, Mali is the largest country in West Africa, covering about 478,764 square miles (1,240,000 square kilometers), or, roughly the combined area of Texas and California. Only about two percent is cultivated. There is a large desert zone in the north and a savannah region in the center and south. A fertile belt of land follows the flow of the Niger River. Mali is landlocked, surrounded by seven countries: Algeria, Niger, Burkina Faso, the Ivory Coast, Guinea, Senegal, and Mauritania. This location makes importation of European and U.S. items difficult and expensive. The climate in Mali is generally hot and dry with a short rainy season between mid-May and mid-October, and with heavy dust storms between February and April.

Mali's population at the end of 1984 was estimated at 7.7 million inhabitants, a majority of who live in the southern third of the country along the Niger River. There are four major ethnic groups: the Nomads (Fulhs, Tamacheq, and Maures), the Mandigos (Bambaras and Malinkés), the Burkinabé (Sénoufous and Miniankas) and the Soudanais (Sarakholés, Sonrai, and Dogons). Although French is the official language, many local languages and dialects are spoken. Bambara is the first language for half the population and can be understood by eighty percent of the people. When measured in 1976, adult literacy was reported to be ten percent. The World Development Report of 1985 of the World Bank reports a female literacy rate of six percent.

Mali became independent September 22, 1960, and, since June, 1979, has been a constitutional, single party republic governed by the Democratic Union of the Malian People (UDPM). Administratively, Mali is divided into seven regions and the capital district of Bamako. Each region consists of from five to nine districts (cercles), which are divided into arrondissements, which in some areas are divided into sectors (secteurs de base), each of which consists of a number of villages.

Mali is among the five poorest nations in the world according to the 1985 World Bank Development Report, with a per capita gross national product of only 160 U.S. dollars (hereinafter comparable U.S. figures will be set forth in parentheses to give perspective, in this case, \$14,110). Traditionally about eighty percent of the population has been agrarian--agriculturalist, semi-nomadic, and pastoral. A recent severe drought has resulted in massive crop failures and herd losses. Consequently, many of the traditionally rural population are seeking alternatives for economic survival.

Urban migration is a favored alternative, and urban growth

rates have lately accelerated precipitously. Overall annual urban increase is estimated at seven percent, but Bamako, the capital city and focus of the project, is growing at an annual rate of ten percent. As of 1984 the population of Bamako was 620 thousand. The other four significant Malian cities have population ranging from 37 thousand to 65 thousand. Twenty percent of the Malian population is estimated to live in towns of over five thousand people. Communication between population centers is poor, as is public utility provision within them.

II.A.2. Health Profile

Some pertinent statistics will illustrate the generally poor health status of the Malian population (see Annex IX.N.). The life expectancy at birth has been estimated between 42 and 46 years (US: 75). The mortality rate for infants under age one is estimated at 173/1000 live births (US: 10.5/1000). The mortality rate for children age 2 - 5 is about 31/1000 (US: less than 1/1000).

For infants under age one, the following pattern emerges. From birth to 28 days (the neonatal period), about 20-30 percent of the deaths are due to neonatal tetanus, about 15-30 percent to birth trauma and in-utero insults resulting from maternal malnutrition and/or pregnancy complications, and the remainder, 40-60 percent, to a combination of late neonatal infections (respiratory and diarrheal diseases) and birth defects. From twenty eight days to one year (the post-neonatal period), the two leading causes of death are respiratory and diarrheal diseases. For children between one and two, six communicable childhood diseases (measles, diphtheria, whooping cough, tuberculosis, polio, and tetanus), and diarrhea leading to dehydration account for half of the deaths. Data from African countries with similar conditions indicate that measles has a case fatality ratio of 10-20 percent, whooping cough, 5-10 percent, and polio, 30 percent, and that more than three episodes per year per child of diarrheal disease can be anticipated.

Among malnourished children, diarrheal disease has a mortality per episode of 10-20 percent. Gastrointestinal tract diseases are especially fatal among children under age three. An estimated five thousand children in Mali die annually from dehydration.

Other diseases contributing to the low life expectancy, include malaria, cholera, meningitis, rickettsiosis, schistosomiasis, sleeping sickness, anthrax, leprosy, and a wide variety of parasitic worm diseases which either are endemic or occur in epidemic outbreaks at regular intervals.

Poor nutrition increases the gravity of all of these illnesses, especially for children under five. The daily caloric intake per capita is estimated at 74 percent of the 1982 recommended requirement (US: 137 percent). The poor nutritional

status in the Bamako area can be illustrated by a 1982 ad hoc survey at the Bamako Gabriel Toure Hospital's pediatric ward which found about half of hospitalized children experiencing severe malnutrition (marasm or Kwashiorkor). The poor nutritional status is further evidenced by the fact that the majority of the population falls well below the age-for-weight Harvard standard and most children fall below acceptable weight-for-height standards. According to some reports, about 20 percent of deaths of children aged one through four are attributable to malnutrition, especially in urban areas.

Malian resources available to rectify this problematic health profile are extremely limited. The MSF/AS budget as a percent of total government expenditure is declining and now is reported at about 3.5 percent. In 1982 the GRM expenditure for health as a percentage of total GRM expenditure was 2.8%, which, in real terms, was lower than 1960. The annual per capita health budget, ranking among the lowest in the world, is sixty US. cents per person. Another measure, per capita annual health expenditure, has been estimated at between two to three US. dollars (US: \$1,500).

Further, it is unclear that the scarce public resources available for health are being allocated in a manner which predictably will optimize health benefits. For example, a reported 80 percent of MSF/AS expenditures are spent on salaries and another five percent for medical evacuations (mostly to France), perhaps 5% for facilities' maintenance, and a small fraction for vehicle repair and replacement.

The remaining health care resources are used to support two national hospitals, two secondary hospitals (Kolokani and Kati), six regional hospitals, 46 district (cercle) health centers, 287 arrondissement health centers, and about 370 other centers of which an estimated 240 are health centers with maternities. These facilities are staffed by 3,327 employees consisting of 170 physicians (of whom 102 are Malian), 1,411 first grade nurses, 549 state registered nurses, 296 midwives, 499 trained traditional birth attendants, 300 village health workers, 20 pharmacists, and 82 dental technicians.

The inevitable consequence of the low budget allocations, poorly equipped facilities, and insufficiently trained personnel is a low level of health care. This project is designed to implement a well-defined, discrete program to improve the above-described situation in the project zone.

II.A.3. Demographic Profile

Malian demographic statistics present a sobering picture for the country's development. The current population of 7.7 million is growing at the annual rate of 2.8 percent (US: 0.7 percent),

which means that the average annual GNP growth (1965-1983) of 1.2 percent will have to increase to 3 percent if the already low living standards are not to decline further. This population growth rate is of even more crucial importance for an area such as Bamako, whose growth is further augmented by urban migration.

Mali's crude birth rate is estimated at 49/1000 (US: 16/1000), the crude death rate at 21/1000 (US: 9/1000), the maternal mortality at 17/1000, the fertility rate at 6.7 children per women of child bearing age (US: 1.8), the percent of population under age 5 at 25 percent, the percent of the population under age 15 at 46 percent (US: 22 percent), the percent of the population over age 64 at 2.7 percent (US: 12 percent), the percent of population consisting of women of reproduction age at 20 percent (one fifth of whom are pregnant at any given time), and the dependency ratio of 1.81 (or, almost two children per adult in the work force). Mali's population doubling time is 25 years (US: 100 years), and its population is projected to reach 18.99 million in the year 2010.

These high population growth rates and related demographic figures are highly influenced by various traditional practices and attitudes. Most women marry at the relatively young age of 16 and are exposed to pregnancy throughout their reproductive years. An estimated 40 percent of married women are involved in polygamous unions. Women are encouraged and/or pressured by husbands, mothers, mothers-in-law, and friends to have a maximum number of children. Occasionally, in polygamous marriages, there is competition among wives for the husband's approval by having more children.

Traditionally, children have been highly valued for inheritance, social status, and economic security. High infant and child mortality rates lead couples to have "extra" children as "insurance" and to provide an adequate supply of labor for the family unit. Needless to say, these constant childbearing obligations have placed women in a highly disadvantaged position both socially and health-wise.

The strong pro-natalist orientation notwithstanding, Malians have an equally strong tradition of birthspacing, which sometimes is as long as a two to three years interval between children. Birthspacing in the past has been achieved primarily by postpartum sexual abstinence and through the protection conferred against pregnancy by breastfeeding. In urban areas, however, traditional birthspacing is more difficult to achieve. Men and women are together more often and the practice of sending the wife to the husband's mother in the next village soon after delivery is not as common. In some instances, where mothers bottle-feed, the woman loses the natural protection against pregnancy conferred by breastfeeding. Fertility has also remained high due to the early start of child bearing and its continuation until the end of the reproductive years.

The pronatalist attitudes are beginning to moderate,

particularly in urban areas where couples are becoming more aware of the economic burden of large families. The high costs of feeding, clothing, and educating children are beginning to have an impact. For these couples, modern contraceptive methods could be a very welcome change. (A more complete discussion is contained in the Social Soundness Analysis section.)

II.A.4. Malian Policy Setting Concerning MCH/FP Subsector

The policy climate in Mali, both at the official and at the family level, is receptive and favorable to an integrated family health project such as that described herein. At the official level the GRM has shown its commitment to arresting the vicious cycle of high infant and maternal mortality rates coupled with high fertility by giving a high priority to the development and expansion of MCH/FP services in its 1981 - 1985 Five Year Development Plan. This government commitment also is reflected in formal policy statements and in organization of service strategies. Indeed, recent government actions have supported squarely three of the subcomponents of this projects' Service Upgrading Component.

In response to the high incidence of childhood communicable disease, the GRM initiated in 1981 an expanded program for immunization (EPI). The above-mentioned National Immunization Center (Centre National d'Immunisation, or CNI) was established to plan, implement, supervise, and evaluate the program. In June, 1985, the CNI developed a comprehensive strategy and action plan for providing immunization nationwide.

In 1979, the GRM established a national commission on diarrheal diseases mandated to develop an action plan to combat childhood diarrheal diseases. The plan was developed in 1981 when responsibility for distribution of commodities and supplies was placed with the Epidemiology Division of the MSP/SA, and responsibility for promotional and educational activities was placed with the National Department of Social Affairs (DNAS). Since June, 1985, responsibility for the ORT program has been shifted to the multidisciplinary National Program Against Diarrheal Diseases (Programme National de Lutte Contre les Maladies Diarrhéiques, or CMD), which is receiving assistance from the AID funded Primary Health Care Technologies (PRITECH). In this instance, as with CNI for immunization, the national program with its influentially placed implementing unit, was created to give enhanced visibility to the activity.

In the field of family planning, in 1972 the GRM distinguished itself as the first African government to repeal a 1920 French law prohibiting the advertising, sale, and distribution of contraceptives. Thus, it became the first sub-Saharan francophone country to officially sanction family planning services as a measure to reduce mortality and morbidity among women and children.

As early as 1973 the GRM introduced family planning in its health facilities. In 1975 the MSP/AS created the predecessor entity of what, in 1978, would become the, above-mentioned Division of Family Health (DSF) to administer the MCH/FP program. Also, in 1972, the government sanctioned the founding of the private family planning agency, the AMPFF, at which time its role was more educational and less clinical than at present. Finally, continued GRM emphasis on family planning is demonstrated by a 1983 Ministry of Plan population policies seminar, which recommended a more clearly defined position on population policy and stressed the role of demographic factors in development planning.

II.B. OTHER DONOR ASSISTANCE

Donor contributions to the health sector of medical personnel, technical assistance, training, construction, vehicles, petrol, spare parts, and commodities, are estimated to constitute at least fifty percent of the annual MSP/AS budget. This figure probably is substantially underestimated because donors do not always report the value of nonproject technical assistance and other ad hoc and in-kind contributions.

Multi-lateral donors include the World Bank, the World Health Organization (WHO), UNICEF, UNFPA, the European Community, and the UNDP. Major bilateral donors include Belgium, China, France, Germany, Italy, Japan, Saudi Arabia, the Soviet Union, Switzerland, and the United States. Although the ranking of donors changes from year to year, the United States has been among the top 7 donors to the health sector over the past five years. A summary of donor assistance to the health sector is provided in the table titled "Mali: Donor Support to the Health Sector."

At present, donors are supporting aspects of some MCH/FP services (nutrition, immunizations, ORT and family planning) proposed to be strengthened by this project. This support is described below to indicate that the proposed project inputs do not duplicate, but rather complement, existing donor support for MCH/FP activities.

II.B.1. Nutrition

Most donors do not have inputs, other than in selected areas, to strengthen nutritional surveillance activities such as growth monitoring and nutritional counseling. This project will make a unique contribution through training and commodity inputs to support nutrition activities and IEC in the project area.

11.B.2. Immunizations

The CNI has recently completed a document outlining the assistance required to carry out a national EPI program. The estimated cost of the national program for the period 1985 to 1991 is 2,255 million FCFA (US \$5.6 million) of which 1,978 million FCFA (US \$4.9 million) is the requested level of donor assistance for salaries, training, vehicles, petrol, spare parts, cold chain and other equipment, vaccines, and the other like, [CNI, April, 1985, Requete Concernant le Programme Enlargi de Vaccination].

The World Health Organization (WHO) is providing long-term technical assistance to the national CNI office, and supporting immunization activities in the Bandiagara, Baoueli and Kolokani cercles of the Mopti, Segou and Koulikoro regions respectively. UNICEF is also supporting immunization activities in the Gao and Tombouctou regions as part of its emergency relief efforts. AID contributions of training and commodities such as vaccines, cold chain equipment, and expendables for the project zone will not duplicate other donor efforts.

11.B.3. Diarrheal Disease Control

The principal donors supporting the CMD (National Program Against Diarrheal Diseases) are USAID (through PRITECH) and UNICEF. Total donor support for the CMD program over the period 1985 to 1988 is 265 million FCFA (US \$0.66 million), of which PRITECH support is nearly 50 percent. MSP/AS support for the program is 4.5 million FCFA (US \$0.11 million) or 14 percent of the total.

The WHO's inputs to the CMD program are principally in the form of technical assistance in training and evaluation, and in support of training at the national, regional, and cercle levels. UNICEF is providing support at the national level to develop a capability in the Malian Pharmaceutical Factory (built by the People's Republic of China) to produce ORS packets, to develop educational materials, and to evaluate the program. UNICEF also is supporting efforts to sensitise and the populations of Gao and Tombouctou about ORT, and has provided a vehicle for supervisory purposes. UNICEF is committed to providing sufficient ORS packets to Mali until such time as the Malian Pharmaceutical Factory can produce them.

Finally, PRITECH is providing long-term and short-term technical assistance in the areas of training, health education, evaluation, production, and distribution of ORS packets and also is providing health education materials (see Table titled "National Program for Diarrheal Disease Control".)

Given the already relatively extensive inputs to the CMD

program, the proposed project will focus on ensuring that training has been adequate and is reinforced in the project area. The project will provide equipment and materials to assure that each participating MCH/FP complex has a functioning ORT unit. ORS packets will be provided by UNICEF and/or will be available through the Malian Pharmaceutical Factory when production starts.

II.B.4. Family Planning

Donor assistance to Mali in family planning comes primarily from the UNFFPA and from centrally-funded USAID population activities. For the period 1985 to 1988, the UNFFPA will provide \$420,000 to support the continuation and expansion of MCH/FP efforts in the areas of Koulikoro, Mopti and Segou. UNFFPA assistance will include third-country and in-country training, IEC activities, vehicles and petrol, and commodities (equipment and contraceptives). [MSF/AS (Decembre 1984) Développement d'un Programme de Santé Maternelle et Infantile Planification Familiale, document de l'accord de projet entre le GRM et le FNUAP. #MLI-85-P03].

In the areas of program management training and IEC, there is a potential for overlap with this project. Thus, once the project team is in place, co-ordination with UNFFPA in third-country training in FP program management and in development of family planning IEC messages will be necessary to avoid duplication.

II.C. A.I.D. CENTRALLY AND REGIONALLY FUNDED ACTIVITIES

Centrally and regionally funded activities bearing on this project involve primarily family planning. The most significant include: MCH/FP training for nurses and administrators through INTRAH; post graduate training for physicians and nurses in FP and OB/GYN through JHPIEGO; support to the AMFFF, including contraceptives for national distribution, from IPFF; and, IFAVS support in establishing a voluntary sterilization units at the Gabriel Toure hospital and another maternity in the greater Bamako area. This project will build upon the previous INTRAH training and co-ordinate the A.I.D. training efforts to prevent overlap. During its life, this project will fill some of the gap left by the termination of IPFF contraceptives by supplying contraceptives to AMFFF (and to the MSF/AS) for the project zone.

A detailed listing and description of Centrally funded projects can be found in Annex IX.L.

Table 1

MALI: DONOR SUPPORT TO THE HEALTH SECTOR

1984

<u>Name of Donor</u>	<u>Location</u>	<u>Type of Assistance</u>	<u>Duration</u>	<u>Cost</u>
MULTI-LATERAL World Bank	Kayes Region - Kita - Bafoulabe - Kenieba	Construction of: a. 3 regional hospitals b. 36 dispensaries - Creation of planning unit in MSP/AS - Support to PPM - Water supply & sanitation	1983-1990	\$17 million
World Health Organization	- National " " " - Sikasso Region	- Technical Assistance (including to the CNI) - Scholarships - Conferences - Applied Research (w/ SHEDS) - Nutrition	On-going " "	1985 \$0.3 million
UNICEF	- National - Dire, Gao and Tombouctou	- Commodities - Medical teams, equipment	On-going	1985: \$1.8 million 1986: \$2.1 million
UNFPA	- National	MCH & EPI		
European Community (FED)	- National	- Finance NGO activities in water, food production, cooperatives and ophthamology.	On going	1980-1984: approx \$3.8 million per year
UNDP	- National	- Construction and equipment of national and regional laboratories.		

BILATERAL

French-Belgian	- Gao and - Tombouctou	17 physicians to run nutrition/feeding centers and disease control programs for measles, meningitis and cholera.	On-going
China	- Kati	- Surgical team - Inputs to pharmaceutical factory	
France	- National - Bamako	- 24 physicians - Commodities (medicines, medical supplies, and lab. equipment) to Medical School, teaching hospital, Point G and Communicable Disease Service (SGE)	1983:\$2.8 million
Germany	- National - Selingue	- Schistosomiasis control - Basic health services	
Italy	- Segou	Health & nutrition project w/ORT, EPI & nutrition activities	In design for \$5 million
Japan	- National	- Medical equipment to MSP/AS facilities	
Soviet Union	- Bamako and Segou	- 25 physicians to Gabriel Toure and Segou hospitals.	
Switzerland	- National - So.Sikasso	- Training physicians & nurses - VHW/Midwife program	1984: \$0.50 million

II.D. RELATION OF THIS PROJECT TO MISSION AND A.I.D. STRATEGY

II.D.1. A.I.D. Strategy

The activities, purpose, and goal of this project are congruent with many of the important themes articulated in the Administrator's June, 1985 "Blueprint for Development". The four subcomponents of the "Service Upgrading Component" squarely address three of the five key problems of the Blueprint's program focus: (1) in relation to hunger, i.e., reducing the percent of children under age five suffering from clinical and severe undernourishment to less than 20 percent of the age group; (2) in relation to disease and early death, i.e., reducing infant mortality to less than 75/1000, reducing child mortality (age 1-4) to less than 10/1000, and achieving a life expectancy at birth of 60 years for the population as a whole; and, (3) in relation to unmanageable population pressures, i.e., enabling access for at least 80 percent of couples to a wide range of acceptable voluntary family planning services.

Institution building is addressed through the extensive level of training being provided in a variety of technical areas, as well as in clinic management, supervision, and information systems, public health planning, financial management, commodity control, and, indeed, in training itself will strengthen the participating MSP/AS entities and the MCH/FP Complexes.

Technology transfer, will take place during the IEC activities and Malian participation in the Special Studies Component, especially the baseline study with its statistical focus. The AMPPF's family planning services will be updated by addition of a voluntary female sterilization facility through the assistance of AVSC.

Involvement of the private sector and market forces, will be assured through three project activities: (1) the substantial assistance and training earmarked for the AMPPF and its further strengthening so that it can, on defined occasions, assume a leading role and share its expertise with appropriate public sector entities; (2) the cost recovery/fee-for-service study, the consequence of which predictably will be increasing use of free market pricing mechanisms and approaches to service provision; and, (3) the social marketing study, which, by definition, explores and tests the feasibility of using the private sector and market forces to supplement other activities.

Finally, this project also promotes the A.I.D. policy emphasis on women in development. Most of the direct beneficiaries will be women, primarily as recipients of MCH/FP Complex and/or AMPPF services but also as participants and in-country trainees under the project.

II.D.2. Sahel Development Program Strategy

This project is consistent with the most recent Sahel Development Strategy Statement which states that family planning benefits are not "... achieved in lieu of investments in agriculture," but rather are complimentary and additional.

II.D.3. USAID/Mali Strategy

The US has had a longstanding commitment to MCH/FP activities in Mali through centrally funded and regional projects such as INTRAH, JHPIEGO, PRICOR, IPAVS, IPPF, WWTF, FHI, SHDS, RAPID, CEDPA, CCCD, PRITECH, and PCS. Through these programs A.I.D. has funded training for hundreds of people, developed good relationships with the MSP/AS and the ANPPF, and established predominant expertise in this area.

Current Mission strategy is to capitalize on this expertise by selecting an integrated family health services project which will contribute in important ways to the Mission's primary objective in Mali of enhancing rural household productivity and income through agricultural development. The eventual reduction in the population growth rate, will result in higher per capita agricultural production, a healthier workforce, and a greater proportion of society who will be producers instead of consumers of resources.

The present situation, in which a large, dependant, non-productive population increases the absolute amount of food needed to be produced and diverts investment from other opportunities has contributed to Mali's poverty. A more balanced population composition would permit a more profitable use of resources. This is where an effective MCH/FP program can have an positive impact.

III. DETAILED PROJECT DESCRIPTION

III. A. INTRODUCTION AND RATIONALE

III.A.1. Developmental Need for this Project and Introduction

The statistics set forth in the health and demographic profiles of the Background Section establish the general state of health of the vast number of Malians to be extremely poor -- too poor for a citizenry charged with developing their nation. Individuals cumulatively dissipated by disease and malnourishment cannot produce at optimal levels. Nor can a nation with a growing population and scarce (and insufficiently growing) resources offer its people an equal or better standard of living for the future. A nation with a disproportionate part of its population in the dependent, under-15-year age group cannot have a large enough producer base to achieve significant development goals.

One way to make significant contributions towards ameliorating Mali's development problems is to develop and implement well planned assistance to maternal and child health and family planning delivery services.

The present delivery system is experiencing certain problems and constraints which will be the focus of this project. To begin with, there is an evident need to strengthen services such as (1) nutritional surveillance; (2) vaccination; (3) oral rehydration therapy; and, (4) family planning services. Integration of these four services with each other and with other relatively better developed MCH/FP services (such as prenatal, intrapartum or delivery, and postpartum care) is insufficient. Personnel skills in MCH/FP services, clinic management, and health planning need upgrading. Clinical equipment and furnishings are either non-existent or in poor condition and need to be replaced. In certain situations working space needs to be constructed or repaired.

Other problems are also evident. The quantities of health-related and family planning supplies are insufficient. What's more, an effective commodity management system for contraceptives, vaccines, and other supplies needs to be installed. Determining commodity needs for reordering, rotating stock, and improving distribution are made more difficult in the absence of such a system. Recordkeeping practices for service statistics and patient records need revision in order to optimize data utilization and improve patient care. Finally, there exists inadequate community awareness of the MCH/FP services and benefits being offered.

Unless and until these problems and constraints can be overcome, MCH/FP activities cannot make an effective contribution to ameliorating the larger developmental problems cited at the outset of this discussion.

This project has been designed to address the above problems in a specific project zone, Bamako district and the OHV region. This, admittedly, mostly urban zone was purposely chosen for several reasons (see Issues Section below). Firstly, the area is relatively contained, easily accessible and known to USAID/Mali through other project activities (namely, Operation Haute Vallée, the Mission's largest agricultural support activity). These things contribute to administrative and logistical feasibility, an important lesson learned from previous health projects. Secondly, the population is relatively more sophisticated, literate and more amenable to using modern MCH/FP services.

This project has chosen a vertical and an integrated approach to providing family planning services. This double sided approach involves working with the government health services and the private voluntary family planning agency. In a pronatalist society such as Mali where the infant and child mortality rates are astonishingly high, modern family planning has a chance of being accepted only if couples are assured that their children are going to survive--thus, the need for integrated delivery of family health services. But, it is still recognized that for many others the local family planning agency can also be effective in providing family planning services.

The specific activities to be undertaken by this project to reduce the constraints to the provision of comprehensive, quality MCH/FP services will now be described. These activities will be carried out in 15 MCH/FP Complexes and at the AMPPF. The GRM Complexes most often consist of a maternal-child health center, a maternity (or birthing center), and a dispensary, although there are variations on this theme. These units may be housed in separate structures (the norm), semi-detached buildings, or the same structure, depending on the facilities of any given Complex. This project will support those facilities that impact on mother and child health.

On the other hand, although the AMPPF has regional offices around Mali, most of its services are provided out of one location in Bamako. When the new building is completed it will become the headquarters for all AMPPF operations.

III.A.2. Conceptual Framework: Project Components

The activities of this project are organized into four components which, in combination, present a mirror image of the problems described immediately above. They are: the "Service Upgrading" Component, the "Renovation/Construction" Component, the "Information, Education, and Communication (IEC)" Component, and the "Special Studies" Component. The first component is the main component, while the others are supportive.

III.A.2.a. The Service Upgrading Component

This main component addresses itself to technical needs, service integration, clinic management, information systems, personnel training, center equipment, furniture, and selected expendable health supplies. The objective is to upgrade the quality of health services provided by the participating MCH/FP Complexes and by the private family planning agency, the AMPPF.

This component is divided into four subcomponents: nutritional surveillance, vaccination, oral rehydration therapy, and voluntary family planning. These MCH/FP areas are currently most in need of improvement and integration with other services. Activities pursuant to each subcomponent will be undertaken in the GRM Health Complexes while only family planning activities will be pursued at the AMPPF.

III.A.2.a.1) Nutritional Surveillance Subcomponent

Nutritional Surveillance is the foundation of "well-child" care because an adequately nourished child is more resistant to disease. The most visible activities here are child weighing and growth monitoring. When mothers avail themselves of this service regularly, nutritional surveillance will provide an opportunity for regular interaction between mothers and health personnel.

Public education and outreach will be an active component of the program in order to promote the use of this service by mothers. Health Complex personnel will receive detailed instruction on growth monitoring methods and their use as a tool for detecting health problems in children. Health Complexes will be supplied with weighing scales, growth cards and growth charts. Clients will be instructed as to the information's interpretation for each child, receive individual instruction on nutritional matters, and participate in group nutritional demonstrations. Severe cases of malnourishment will be referred to other more intensive health facilities and the progress will be followed up by the trained nurses.

III.A.2.a.2) Vaccination Subcomponent

Vaccination is an important ingredient of well-child care. The ultimate aim of this subcomponent is to strengthen the vaccine distribution, maintenance, and service systems for the 15 Health Complexes in order that safe viable vaccine is available whenever needed for the target population.

Health Complex personnel will receive training in all aspects of vaccination practices such as cold chain management, scheduling, recording, injecting, dosages, and patient education. Vaccines for measles, whooping cough, tetanus, diphtheria, and polio will be provided for children. Tetanus toxoid for pregnant women will also be available. Syringes, needles, one

refrigerator for each Health Complex, other appropriate clinical equipment and vaccination cards for each child also are being financed.

The project team will work closely with the National Center for Immunizations (CNI) to establish a reliable vaccine distribution system for all of the clinics. Procurement of vaccines will be from U.S. sources and will commence the first year of the project until the sixth year. Vaccine needs calculations are outlined in Annex IX.J.6.

III.A.2.a.3) Oral Rehydration Therapy (ORT) Subcomponent

ORT's value as a technological breakthrough for cutting diarrhea-related child deaths in half is becoming well recognized in Mali. However, more work needs to be done to integrate this intervention into regular service delivery. Health Complex personnel will be instructed in its use, especially as a preventive measure which can be used to avoid less safe treatments, such as intravenous rehydration. In the very rare case where intravenous intervention is necessary, subclavicular rehydration will be discouraged. Mothers will be educated about ORT and on preparing home solutions. The CMD has advised that it foresees adequate supplies of ORS packets being supplied to the project area by UNICEF for the life of the project; accordingly, A.I.D. will not duplicate this effort.

The project's main focus in this area will be to assure that Oral Rehydration services are operational in each MCH/FP Complex. All the necessary equipment, supplies, training, and space will be in place. Project team personnel will provide regular supervision of the health workers to assure that this service is operating well.

III.A.2.a.4. Voluntary Family Planning Subcomponent

The family planning subcomponent is a key element of this project because of its potential for reducing infant mortality, which now stands at 173 deaths per 1000 live births for children under one year. Infants of closely spaced births, generally have lower birth weights, are more susceptible to disease and experience a higher mortality rate. This subcomponent has equal potential for reducing maternal mortality, which occurs twice as frequently among women having over four births and among those having births under age 18 and over age 35.

Family planning is being provided on a completely voluntary basis as a health measure to prevent multiple, closely spaced births which adversely affect the health of mothers and children. Health Complex workers and AMFPF personnel will be trained in advising clients about family planning methods according to this health rationale.

The family planning technologies being offered under this subcomponent include both modern contraceptive methods and natural family planning. It should be emphasized that according

to USAID policy, abortion, which is illegal in Mali, will not be offered nor will referrals for abortion be made.

Health workers at the GRM Complexes and the AMPPF will update their technical and educational skills relating modern contraceptive methods through extensive project-financed training. Clients wishing to practice family planning will be given a choice of contraceptive methods and their preferences honored unless there are compelling opposing medical reasons. In these cases, an acceptable substitute will be offered.

Distribution of A.I.D. donated contraceptive supplies through the MCH/FP Complexes and AMPPF will be free of charge to clients. These supplies will include oral contraceptives, spermicides, condoms, and IUDs. AMPPF also will offer an additional option--completely voluntary and informed female surgical contraception through the initial assistance of AVSC. In all cases, clients will receive a thorough explanation of the benefits and possible complications of surgical family planning services so that an informed choice can be made.

In the worksheets on contraceptive requirements the reader will notice that the 1984 contraceptive prevalence (use) rate is estimated at five percent. This figure is the best available estimate based on existing statistics and expert opinion. However, to avoid misunderstanding, it must be stated candidly that this estimate is speculative and is being used primarily for purposes of determining the magnitude of the contraceptive order. A more reliable figure for analytical purposes will be derived from the baseline study and the INSAH/Westinghouse KAP study that will be carried out.

III.A.2.a.5) Other Service Upgrading Activities

The preceding descriptions of the subcomponents have indicated the topic-oriented training that will support each. An essential element of service upgrading at the GRM Health Complexes will be integration of all services offered so that routine referrals of clients take place as needed. Training in clinic management and supervision, health planning, health information systems development, and patient record keeping will be provided to facilitate this integration.

A comprehensive training plan is included as part of the Implementation Plan. Before the training plan is finalized, a Needs Assessment will be made of the discrete service requirements, personnel roles, and qualifications necessary to effectuate a completely integrated operation of a full-service MCH/FP Complex. The Assessment will analyze personnel training needs in relation to the human resources in place. A final training program will be designed to supplement any technical and/or managerial insufficiencies which currently constrain effective MCH/FP service provision.

In addition to the commodities already mentioned, a standardized set of basic clinical equipment and furniture will be provided to each GRM Complex. Since some of this equipment will become unusable from ordinary wear and tear, its replacement is envisioned during the final project year. The AMPPF also will receive furniture to supplement its current supply. Equipment lists are set forth in Annex IX.J.

III.A.2.b. The Renovation/Construction Component

This component is important for both government and private facilities and is closely allied with the Service Upgrading Component in that it measurably contributes to improvement of health services. The meagre MSP/AS budget allocation does not permit adequate repairs of existing MCH/FP facilities. To undertake the upgrading activities described under the previous component and neglect the state of disrepair of the physical structures in which this upgrading will take place would seriously undermine, if not make impossible, the success of the primary project component.

Accordingly, a program of renovation and construction to varying degrees has been developed in response to the poor condition of the participating Complexes. In the discussion below, MCH/FP Complexes located in Koulikoro region are marked with an asterisk, those in Bamako are not.

The following five Complexes (Category 1) will receive minor renovations, to include painting, cleaning, and small repairs at an estimated per Complex cost of \$10 thousand: Quartier Mali, Niarela, Badalabougou, Lafiabougou, and PMI Central.

The following seven Complexes (Category 2) will receive moderate renovations, including painting, cleaning, and substantial repairs for windows, doors, roofs, walls, at an estimated per Complex cost of \$15 thousand: Missira*; Banamba*; Dioula*; Kangaba*; Koufina; Sogoniko; and, Koulikoro*.

The following two Complexes (category 3) will receive major renovations, including painting, cleaning, major repairs as in the above group, and some structural changes (such as room or verandah addition, or moving walls to better organize space) at an estimated per Complex cost of \$35 thousand: Hamdallaye and Kati*.

One Complex (Category 4) will receive major renovations, painting, cleaning, and construction of a new building at an estimated cost of \$114 thousand: Djikoroni.

This component also will finance addition of a contraceptive stockroom and an adjacent room for a statistics office at the DSF, and renovation of the regional warehouse of Koulikoro. An illustrative table of envisioned renovation/construction work for the MCH/FP Complexes is presented at Annex IX.J.7.

In addition, a new headquarters and service center for the AMPPF is being constructed under this component on land donated by the government. The service center will include a minilaparotomy facility, established and equipped with the assistance of AVSC.

This project will finance the services of a local architectural and engineering (A & E) firm, of local construction contractor(s), and locally-procured construction materials. The A & E firm services will include design, preparation of the contract documents, tendering, selection of the contractor, negotiation of the contract, and supervision of the works construction firm(s) in coordination with the Mission.

Host country contracting is envisioned for the renovation and construction activities. Renovation and construction plans may change as more information is obtained about other donors' contributions to the health facilities involved.

III.A.2.c. The Information, Education, and Communication (IEC) Component

Even with fully equipped, furnished and staffed complexes, some services would still be underutilized due to lack of public awareness. The IEC Component undertakes to correct this situation through a series of promotional and educational endeavors. All available media including television, radio, and print will be used. Special programs are included for influential and religious leaders, as well as group and individual presentations at the complexes and the AMPPF.

Because men are definitively important in the conduct of family life and in setting developmental priorities, special efforts will be made to enlist their support for MCH/FP activities and their participation in family planning. Initial target groups of men will include government leaders, the military, and the police.

Community, political, religious, and educational leaders can be very instrumental in sanctioning and gathering support for MCH/FP activities. Through short study tours and observational visits (mostly in Africa) they will be able to obtain some ideas of what is possible by witnessing, first-hand the progress made elsewhere in comparable conditions.

The AMPPF will assume the lead role in family planning IEC and share its expertise with appropriate MSP/AS entities. The MSP/AS will prepare the bulk of IEC materials on other MCH subjects.

This project will finance training in IEC and in health education to a wide variety of health personnel. It also will finance locally-procured services for the preparation of IEC materials and promotional campaigns and commodities such as audio-visual aids, film, graphic supplies, and the like.

III.A.2.d. The Special Studies Component

This component consists of three key studies scheduled for the first year of the project which will yield valuable information to the GRM for future decisions concerning health services financing and planning. The first study is the Baseline Study of Utilization Statistics which is needed to supply pre-evaluation data. Current statistics are either unreliable or do not exist. On the basis of the data gathered and analyzed, end of project indicator targets for contraceptive prevalence rate, vaccination coverage, and the like, will be established.

The second study is the Cost Recovery Study, which will recommend strategies for increasing revenues to finance health services so that their quality, availability, and sustainability may increase. This study will update and analyze information on health sector and MCH/FP subsector recurrent costs, and on MSP/AS policies concerning participation of the population in financing and beneficiaries' ability to pay for recurrent costs of health services and commodities. It also will analyze the merits of retaining fees collected at different administrative levels in the health system and make recommendations as to the potential for unit pricing of selected items in a way that will maximize revenues but minimize any adverse impact on consumer demand. Additional information concerning this study is set forth in the Cost Recovery Study Profile at Annex IX.M.6.

The third study is the Social Marketing Feasibility Study which will assess the feasibility of private, commercial distribution of barrier method contraceptives and of other commodities, such as ORS packets. If indicated, a social marketing pilot activity may be undertaken to test feasibility and gather additional information.

This project will cooperate closely with the regionally-funded Sahel Institute survey entitled "Knowledge, Attitudes, and Practices" which will investigate a variety of maternal, child health and family planning matters, including nutritional status indicators, diarrheal incidence, and attitudes about family planning. This survey is notable in that men as well as women will be interviewed. Although this project will not contribute funds to the study, it will collaborate closely to assure that issues of special interest to this project are addressed.

III.B. PROJECT GOAL

The overall goal to which this project contributes is the reduction in morbidity and mortality in Bamako and the Opération Haute Vallée (OHV) area resulting from childhood communicable

diseases, diarrhea, malnutrition, and inadequate birthspacing.

Progress toward goal achievement will be determined by assessing:

(1) longterm (more than 25 years) reduction of morbidity and mortality rates for childhood immunizable diseases, infant diarrhea, childhood nutritional disorders;

(2) decreased pregnancy-related illness in women;

(3) increased intervals between births and lower birth rates; and,

(4) higher contraceptive prevalence.

The major assumptions for goal achievement are: continued GRM commitment to meeting recurrent costs of maintaining MCH/FP services either from budget funds and/or by cost recovery measures; and, GRM promotion of contraceptive social marketing.

III.C. PROJECT PURPOSE

The purpose of this project is to assist the Maternal and Child Health and Family Planning Program of the GRM to strengthen and integrate services in fifteen MCH/FP Complexes in Bamako and the OHV area and to assist the private family planning agency in Mali, (Association Malienne pour la Protection et la Promotion de la Famille, or AMPPF) to upgrade its services.

End of project status conditions indicating that this purpose has been achieved include:

(1) provision of the full complement of MCH/FP services including prenatal, intrapartum, and postnatal care; voluntary family planning; well child services with nutrition surveillance and immunization against diphtheria, whooping cough, tetanus, measles, and polio; and, oral rehydration therapy (ORT);

(2) stock control systems for vaccines and contraceptives;

(3) improved clinic supervision and management techniques;

(4) increased staff productivity (number of clients served, increased technical range of services provided);

(5) improved health service statistics and patient records;

(6) renovated facilities equipped with standard equipment /supplies;

(7) Oral Rehydration Therapy used routinely, not just in emergencies;

- (8) increased knowledge in the project zone population about preventive health and FP measures and how to access them;
- (9) increased use of MCH/FP services by project area population (both in absolute numbers and as a percent of the population);
- (10) referrals among MCH/FP services will be routine, prompt, and effective;
- (11) new, improved, project-constructed facility for AMPPF;
- (12) at AMPPF, provision of a full range of voluntary FP services, including voluntary surgical fertility management;
- (13) improved project zone IEC led by AMPPF and jointly carried out by AMPPF and GRM;
- (14) continued strengthening by personnel trained under this project of their respective organizational units;
- (15) reliable baseline statistics existing and realistic performance targets founded thereon for education use;
- (16) reliable information existing concerning health service financing issues; and,
- (17) reliable information existing concerning social marketing issues and feasibility.

Major assumptions for achievement of the purpose of this project are: continued GRM and AMPPF cooperation; release by MSF/AS of health personnel for training and for supervision as necessary; and, GRM support for vigorous IEC campaigns.

III.D. PROJECT OUTPUTS

This project is expected to produce the following outputs which together should achieve the project purpose:

- improvement and integration of four selected MCH/FP services in participating Complexes: nutrition; vaccination; ORT; and, voluntary family planning;
- integration of above services with prenatal, intrapartum, and postpartum services;
- regularly scheduled health education for all services mentioned above for groups and individuals;
- personnel/service/training Needs Assessment;
- collection, organization, and retention of health service statistics for GRM Complexes and the AMPPF;
- individualized patient record keeping instituted as part of standard operating procedures;
- adequately supplied Complexes with standard set of equipment, furnishings, vaccines, and contraceptive supplies;

- growth monitoring and vaccination cards will be available as needed;
- renovation and construction of Complexes as planned;
- new Djikoroni dispensary
- new AMPPF headquarters, including surgical unit;
- AMPPF equipment and furniture are supplemented through local purchase;
- DSF storeroom and statistics office built;
- Koulikoro warehouse renovated;
- project office rented and equipped;
- trainers trained in health care subjects and IEC;
- health personnel from Complexes and AMPPF trained in nutrition, vaccination, ORT, and FP as appropriate; also, advanced level training;
- supervisory personnel trained in clinic management and supervision;
- PFM pharmacist/assistants trained in contraceptive subjects
- upgraded skills for personnel participating in third country and US training;
- study tours and workshops for influential leaders to increase MCH/FP awareness;
- Malian staff skills and technology updated through conference attendance;
- MCH/FP promotional and educational campaigns;
- Special Studies in Baseline, Cost Recovery, and Social Marketing;
- 121 (d) certifiable project accounting system;
- finalized training plan;
- finalized procurement plan;
- annual workplans;
- quarterly implementation reports
- evaluation and audits

III.E. PROJECT INPUT

The following inputs will be provided to realize the above set forth outputs:

III.E.1. A.I.D.

a. Technical Assistance

- 1) Long Term, 11 Person Years (PY)
 - a) Nurse clinician/Administrator (Team Leader) 4 PY
 - b) Training Advisor 2 PY
 - c) Financial Manager 5 PY
- 2) Short Term, 48 Person Months (PM) in the following fields:
 - a) IEC 4 PM
 - b) Information systems 3 PM

- c) Needs Assessment 2 PM
- d) Training 9 PM
- e) Commodities management 3 PM
- f) Baseline statistics 2 PM
- g) Cost Recovery 2 PM
- h) Social Marketing 9 PM
- i) Evaluation personnel 6 PM
- j) Audit personnel 10 PM
- k) Additional as appropriate 6 PM
- l) Association for Voluntary Surgical Contraception

b. Local Services

- 1) IEC graphics 12 PM
- 2) Architectural and Engineering (dependent on construction)

c. Training: short term: 490 PM, of which:

- 1) in country 431 PM
- 2) third country 46 PM
- 3) U.S. 13 PM

long term: 48 PM (accountants)

d. Commodities

- 1. Equipment and Furniture
- 2. Vaccines, vaccine cards, and related expendables
- 3. Family Planning supplies
- 4. IEC and health education materials

e. Vehicles

f. Operational Expenses

III.E.2. GRM

a. GRM Project Team Members

- 1. Project Director (from DNSF)
- 2. Deputy Project Director (from DSF)
- 3. Chief Accountant
- 4. Two assistant accountants
- 5. Bamako District Director of Public Health
- 6. Koulikoro Regional Director of Public Health

b. Advisory Committee Members

c. MCH/FP Complex personnel

d. MCH/FP Complex facilities

e. Facilities for training sessions

f. Land for AMPFF headquarters

g. Operational Expenses

III.E.3. AMPFF

a. personnel

b. IEC expertise

For itemized budgetary information concerning these inputs, see the Financial Plan Analysis Section herein. The necessary vehicle waiver is set forth at Annex IX.F.

Additional information on the relationships between the goal, purpose, outputs, and inputs of this project is provided in the Logical Framework at Annex IX.E.

Additional information on the practical implementation of this project is provided in the "Introduction and Project Rationale" subsection of this Detailed Project Description, and in the Implementation Plan following this section.

IV. IMPLEMENTATION PLAN

IV.A. IMPLEMENTATION SCHEDULE

Project activities are programmed to occur over a six year period from the date of initial obligation by signing of the Project Agreement. Accordingly, the Project Assistance Completion Date (PACD) is estimated to be on or about July 31, 1992.

The project has three main phases which are summarized below. A graphic presentation of the implementation activities can be found in the Project Implementation Schedule Chart in Annex IX.B.

FIRST PHASE

The first phase is the Project Authorization and start-up phase. The period covered begins just after this project paper is approved by the Mission and up to month 18 after the Project Agreement is signed. The main focus will be on Engineering and Construction, Studies, Out-of-Country Training, and Administrative and Financial Support for the project.

Prior to the signature of the Project Agreement several activities will be well under way. Supplies and equipment lists for an eventual contract with an I/C procurement service agent and scopes of work for the architectural and engineering (A & E) services and the four main studies (cost recovery, social marketing, baseline utilization statistics, and training needs assessment) will be complete. In addition, a P/O/C for the purchase of vehicles will be ready for processing immediately after the Project Agreement is signed.

The first technical assistant to be hired will be the Financial Management Expert who is scheduled to arrive one year after the Project Agreement is signed. A P/O/I will have already been prepared and advertising for the position will begin on month 2 of the first year. By month 5 the selection for this position will be made and the contract signed by month 7. He/she will arrive 5 months later to begin setting up the required financial and administrative controls for the project.

Strict financial controls, generally accepted accounting procedures, and commodity/inventory monitoring will be implemented to assure that project funds are used as envisioned in this document, that commodities reach their prescribed destinations and that they are distributed for project purposes to the intended beneficiaries. A Commodity Management Specialist will arrive around month 14 to assist the Financial Management Expert to develop an inventory and supply control system for the supplies and commodities expected during the course of the project.

The first phase of the project will also be devoted to doing preliminary studies that will provide useful information to the implementers during subsequent phases. At start of project, a request will be sent to AID/W for contracting with an IOC firm to do the Baseline Utilization Statistics Study. This study will take place over a two month period during the first quarter of year one. Other IOC funded studies also taking place during the first year include: Cost Recovery (months 5 and 6), Training Needs Assessment (months 8 and 9), and Social Marketing (months 10 to 14). The option of buying into existing centrally funded projects for the latter studies will also be considered. In addition, it should be noted that the Sahel Institute's Health and Demographic Survey (KAP Study) will also be taking place during this time and will provide valuable information for the project.

The start of out-of-country training activities will begin around the third month. Previous to that the DNSP, will be requested to nominate candidates for the scheduled training sessions. The candidates will be processed by the Mission and sent to courses chosen by the Mission's Health Office and the DNSP. In-country training will be taking place through the INTRAH program already developed and separately funded for Mali during the first two years of the project. The project funded in-country training will begin during the third year in which case possibilities may exist for "buying into" INTRAH training or other central projects.

Two GRM accountants will be chosen by month one of the project to study out of country for a two year accounting course. If necessary they will first take 9 months of English language courses locally. Upon their return to Mali they will work and be trained by the Financial Management Expert, who will remain until the end of year six.

Construction will be executed through two methods. Firstly, an Architectural and Engineering (A&E) firm will be hired to design the buildings and renovation activities. Secondly, a local construction firm will be contracted to carry out the actual construction and renovation activities. The A&E firm will monitor and report to the Mission's Engineering Office on the work being done by the construction firm.

Advertising for A & E services will take place during the second month of the first year and a firm will be chosen before the fourth month. The A & E firm will design the AMPPF building in consultation with the Mission, the DNSP and a representative from AVSC who will provide expertise on patient flow considerations and design of the surgical services room. Although renovation and construction activities for the 15 MCH/FP complexes will not take place until the latter part of the third year, the A&E firm will also develop the specifications for this work at the same time.

Since the AMPPF building is scheduled to be started on month

10 of the first year, the A & E firm shall have the architectural specifications and designs by month seven. A scope of work will be prepared for the PIO/T for the construction and advertising for the work shall begin immediately thereafter. A construction firm will be chosen by month ten and have the building completed one year later.

Early during the first year, the DNSP will present their nominations for the members of the Project Team. The Malian counterparts will work with the Mission's Health Office to begin planned activities. The project office will not be rented until the second year of the project, since no intensive in-country activities will begin until the arrival of the Financial Management Expert. The Project Team will be involved in facilitating the preliminary studies, identifying candidates for out-of-country training, following up on construction activities, and establishing the financial and commodity management control systems, among other things. Conference attendance for the Malian staff is also planned if available and needed during the year.

One vehicle will be ordered during the first year for use of the Malian project team. No advances can be made until a 121 (d) certifiable accounting system is established. Therefore, operational expenses, such as gasoline and vehicle repair, will be reimbursed to the GRM during the first year as they are incurred. Once the Financial Management Expert arrives and sets up the correct accounting system, advances will be possible. A second vehicle will be procured during the second year but order during month 8 of the first year.

An office for the Project team will be ready by month 1 of the second year and equipment and supplies will be in place shortly thereafter. Auxilliary office personnel to include a bilingual secretary, janitors, and guards to be hired by the time the office is ready.

In month 12 of the first year the PIO/T's for the selection of a Team Leader and Training Advisor to implement the project will be prepared. Advertising for these two positions will begin month 1 of the second year, a selection will be made by month 3, and the contracts will be signed by month 5. These consultants will be on board by month 1 of the third year to begin the major implementation and training activities.

INTERIM PHASE

An interim phase will take place from month 18 to 24 of the project. During this time, the the last two technical assistants will be contracted. But before this takes place there will be an assessment to confirm technical assistance requirements and in-country training plans.

A mid-term evaluation will take place at the end of the first phase to assess the state of readiness of continuing other planned activities and to make recommendations. A mid-term financial audit will also take place at this time.

Advertising and selection procedures will begin for selecting a contractor for renovation and construction work in the 15 NCH/FP centers, the DSF, and the Koulikoro warehouse. A detailed scope of work and architectural drawings will have been already prepared by the A & E firm.

IMPLEMENTATION PHASE

This last and most important phase will cover the period from on or about month 24 to the end of the project. The long technical assistance consisting of the Nurse Clinician/Administrator and the Training Advisor will arrive.

* The team leader will have a strong background in clinic management and supervision, and in public health. This person will remain in-country four years and will provide advice in the four technical areas being upgraded and on-the-job assistance as well as training in clinic management, supervision and health planning.

* The Training Advisor will remain in country two years and will have experience in curriculum design, development of training materials, IEC, and training evaluation. This person will develop curricula and training aids, schedule and coordinate short term training assistance for a unified and appropriate training program based on the Needs Assessment results. He/She will participate in training of trainers in-country courses and help select candidates for out-of-country training.

Major training activities will begin around the middle of the third year and continue throughout the Life of Project. After the Training Advisor leaves at the end of the fourth year, a Malian counterpart trained during the project shall continue training activities. Local services in IEC to support the training program will be procured by the project team during the third, fourth, and fifth years of the project.

- PIO/C's for vaccines and contraceptives will be processed. Vaccines will be procured through M/SER/AAM and contraceptives procurement will be facilitated through Science and Technology/Population Bureau (AID/W) and the Africa Bureau Health, Nutrition, and Population office. Commodities from the U.S. will arrive around the middle of the third year. Health supplies such as vaccines and contraceptives will be ordered month 6 and arrive around month 10 of every year starting the second year. But, in order to participate in a national immunization effort in which many other donors are involved this, project will finance vaccine procurement during the first year.

Construction and renovation activities for the 15 MCH/FP complexes, the DSF, and the Koulikoro warehouse will take place around the middle of the third year. The A & E firm will be responsible for the supervision of the work and will report directly to the Mission Engineer.

A final evaluation and a final financial audit will be performed during the last year of the project.

IV.B.1. Monitoring

The bilateral Project Team is responsible for the preparation and timely presentation to A.I.D. of annual workplans, quarterly reports, and the final project report. These reports will review project inputs and outputs, adherence to the envisioned implementation schedule of this Project Paper as modified by annual work plans, and problem areas with recommended corrective action. Any standardized format and/or minimum contents will be established as part of the project management system.

IV.B.2. A.I.D. Responsibilities

The General Development Office of USAID/Mali will assume responsibility for managing this project. This office currently is staffed by a direct hire Health Development Officer to serve as the Project Officer and who will have no other bilateral portfolios to oversee. He will have a local hire Senior Program Specialist in Health and Population to assist.

The Mission's Office of Engineering will assist with and monitor the Renovation and Construction Component as described above and Management and Controller's Offices will cooperate with the General Development Office in the procurement of local services and of shelf items--although, the actual procurement activities will be carried out by the Project Team. The Mission's Design and Evaluation Office will assist in preparing documentation (such as Project Implementation Letters) to facilitate project activities.

The Mission will ask for AID/W assistance in contracting for a Procurement Services Agent through an IGC. AID/W will also be requested to assist in the procurement of vaccines and contraceptives. USAID/Mali will have the specialized services of the Regional Legal Advisor in Dakar, and REDSO/WCA personnel such as health and population advisors, the Regional Procurement Officer, and the Regional Contracts Officer.

The above-described resources are considered adequate to handle USAID/Mali's administration and monitoring responsibilities under the project.

IV.B.3. GRM Responsibilities

The National Department of Public Health (Direction Nationale de la Santé Publique, or DNSP) within the Ministry of Public Health and Social Affairs (Ministère de la Santé Publique et des Affaires Sociales, or MSP/AS) is the implementing agency for this project. It will receive strong support from one of the divisions subordinate to it charged with maternal and child health and family planning, the Division of Family Health (Division de la Santé Familiale, or DSF). Because of its overall responsibility for family planning, this division will assure the primary host country role in implementing the Voluntary Family Planning Subcomponent as it relates to the public sector. Included in this role is the receipt of donated contraceptives earmarked for the public sector, for which a storeroom is being constructed by the project on DSF premises.

Determine the
implementing agency
to DSF

The DSF is composed of three sections, each of which will have a role in implementation. The Maternal and Child Health Section (Santé Maternelle et Infantile) oversees the MCH/FP Complexes. Accordingly, it will be important to all activities under the Service Upgrading Component. The Nutrition Section is in charge of the technical aspects of the nutrition surveillance program which, as described below, is implemented elsewhere in the Ministry. The Health Education Section (Education pour la Santé) will participate in the IEC Component and its clinic based health education.

Two other departments at the same organizational level as the DNSP are relevant to this project, the National Department of Planning and Health and Social Services Training (Direction Nationale de la Planification et de la Formation Sanitaire et Sociale, or DNPFSS), and the National Department of Social Affairs (Direction Nationale des Affaires Sociales, or DNAS). The DNPFSS has overall responsibility for training and will participate in planning and coordination of the extensive training under this project while the DNAS is charged with implementing nutritional surveillance activities.

Also at the department level are two national programs of central importance to this project. Both are responsible directly to the DNSP. The first, the National Immunization Center (Centre National d'Immunization, or CNI) will take the primary host country role in implementing the Vaccination Subcomponent and will be the recipient of donated vaccines. The second, the National Program Against Diarrheal Diseases (Programme National de Lutte Contre les Maladies Diarrhéiques, or CNM) will assume the leading role for the technical supervision of the Oral

Rehydration Therapy Subcomponent.

An organizational chart of the Ministry is set forth at Annex IX.N. A review of the chart combined with the above discussion shows that activities of all project components except training and part of the nutrition program are handled by entities directly responsible to the DNSP. In the case of these exceptions, responsibility is placed in entities at the same organizational level, from which close collaboration can be expected.

The DNSP, in its project leadership role will be responsible for assuring that qualified Malian Project Team members are assigned to the project, that qualified participants are selected for training, that space and candidates are available for all in-country training, that time and personnel are made available for the planned extensive on-the-job training and strengthened supervision at MCH/FF Complexes, that media and appropriate institutions cooperate in IEC campaigns, that land is donated for the new AMPPF headquarters, and that qualified SRM personnel participate in evaluations and cooperate in audits. The DNSP will nominate the Project Director and the Deputy Project Director who will come directly from the DSF.

IV.B.4. AMPPF Responsibilities

The AMPPF will assume primary implementation responsibility for the Voluntary Family Planning Subcomponent as it relates to the private sector. This responsibility includes receipt of contraceptives earmarked for the private sector. This agency also will take the lead in preparing the voluntary family planning IEC campaign, and will share its expertise and collaborate closely with the DSF.

IV.C. PROCUREMENT PLAN

IV.C.1. Technical Assistance

The Mission has determined direct A.I.D. contracting to be the best mechanism for undertaking the project, in most instances, however, construction activities will be through host country contracting.

Local services also will be procured under this project--the most important of which are the above-discussed architectural and engineering and construction contractors.

IV.C.2. Commodities

A detailed Commodity Procurement Plan is set forth at Annex IX.K. The categories of commodities required by this project, along with a description of their respective procurement methods,

is summarized as follows. Project vehicles, for which a waiver already has been approved (set forth at Annex IX.F.) will be procured directly by USAID/Mali under full and open local competition. U.S.-procured clinical equipment and supplies and furnishings (and end-of-project replacements) for the MCH/FP Complexes and the project office, will be procured through an IQC FSA. The computer needed for the project office costs under \$100 thousand (\$10 thousand), and accordingly SER/IRM approval is not required. Vaccines and related expendables will be procured with assistance from AFR/TR/HNF and contraceptives with the assistance of the S & T Population Office.

The locally procured equipment and furniture for the MCH/FP Complexes, the AMFFF, and the project office, and IEC materials will be shelf item procurement obtained by the Project Team.

IV.C.3. TRAINING

Training will be procured as much as possible through buy-in arrangements with the various centrally funded projects or through Indefinite Quantity Contracts. The Training Needs Assessment will make recommendations on how best to structure the training.

IV.D. TRAINING PLAN

About \$719 thousand over the life of the project has been allocated for 48 PM of long term and 490 PM of short term training. Of the latter, 431 PM will be in-country, 46 PM of which will be third country, and 13 of which will be in the United States. This allocation reflects the high priority assigned by the Mission to manpower development and the recognition by both the Mission and the GRN of the need for skilled, appropriately-trained manpower to carry on the GRM's maternal and child health and family planning program.

More detailed plans and refined schedules will be developed during the implementation phase based on the results of the Needs Assessment. A preliminary Training Plan is set forth in this section.

Table 2

TRAINING PLAN

KEY

WK = week

= number of people

PM = person months

T.A. = technical assistance

PERSONNEL TO BE TRAINED	TYPE OF TRAINING	LENGTH of TRNG	TOTAL TECHNICAL ASSISTANCE	YEAR ONE		YEAR TWO		YEAR THREE		YEAR FOUR		YEAR FIVE		YEAR SIX	
				#	PM	#	PM	#	PM	#	PM	#	PM	#	PM
1. TRAINERS-- Members of national and the Koulikoro region training teams. (incl. CNI and CMD--diarrheal disease control staff)	Nutrition surveillance, vaccination, DRT, FP, IEC, health education, clinic management	4 WK	3 PM (plus assistance from Long Term)					15.0	15.0			15.0	15.0		
2. State nurses from 15 target clinics and the AMPPF	Nutrition surveillance, vaccination, DRT, Introduction to FP methods, IEC/ health education, clinic management	2 WK	1.5 PM							20.0	10.0			10.0	5.0
3. Practical nurses, matrones, social workers, from 15 target clinics and AMPPF; Community development technicians in Koulikoro Region	Nutrition surveillance and growth monitoring	1 WK	2 PM					45.0	11.3	30.0	7.5	30.0	7.5		
4. Practical nurses, matrons, social workers, patient care aids from 15 target clinics and AMPPF; Community development technicians in Koulikoro. Various volunteers.	Health education and IEC with emphasis on Nutrition, Vaccination, DRT, and FP	1 WK	2 PM					80.0	20.0	80.0	20.0	80.0	20.0	80.0	20.0

				YEAR ONE	YEAR TWO	YEAR THREE	YEAR FOUR	YEAR FIVE	YEAR SIX
5. Physicians and midwives in 15 target clinics and AMPPF	Theoretical and clinical family planning training to update skills and knowledge	3 days	1 PM			30.0 4.0	30.0 4.0	30.0 4.0	30.0 4.0
6. Same as above	Advanced, integrated family planning/family health including theory and practice (INTRAH program)	5 WK	0			15.0 18.0		15.0 18.0	
7. Field supervision team for 15 target clinics. Representatives from long term T.A., District and Regional DSF, and national training team	Review of family planning, ORT, vaccination, nutrition surveillance, IEC, health education. In-depth clinic management, supervision, motivation, and education. team concept.	3 WK	1 PM			10.0 7.5	10.0 7.5	10.0 7.5	
8. All clinic personnel in 15 target clinics	Clinic by clinic training and supervisory visits to improve clinic functioning	2 days teach clinic, 3X/year = 6 days per clinic per-year	0 (longterm T.A. will participate)			500.0 50.0	500.0 50.0	500.0 50.0	500.0 50.0
						Figures based on a total staff of approximately 500 persons in the 15 target clinics. Each person will receive the equivalent of about 3 days of training each year.			
9. Pharmacist assistants (PPM employees)	Seminar on contraceptives	1 day	0.5 PM			150.0	5.0		

				YEAR ONE	YEAR TWO	YEAR THREE	YEAR FOUR	YEAR FIVE	YEAR SIX
10. Senior service delivery personnel (i.e., physicians, midwives and state nurses); Candidates from DNSP, DSF, regional and district management and supervisory personnel, CNI and diarrheal disease control personnel	Short-term 3rd country training in: --IEC --family planning --commodity control --statistics --health care management --nutrition --vaccination --ORT --MCH/Public health nursing-advanced --financial management	1 to 3 months	0	6.0 12.0	5.0 9.0	4.0 8.0	2.0 4.0	2.0 4.0	
11. Same as above	Short-term training in USA: --health care management --nutrition (infant/child) --IEC --family planning	1 month	0	3.0 3.0	3.0 3.0	3.0 3.0	2.0 2.0	2.0 2.0	
12. Community, political, and religious leaders; high-level MCH personnel; educators	Study tours, workshops and seminars in various MCH fields, especially family planning and infant/child nutrition and health planning	2 WK	0			6.0 3.0	6.0 3.0	6.0 3.0	
T.A. total= 12 PM				9 15	8 12	708 140	830 113	690 131	620 79

(Project staff will also attend special conferences. Usually 3rd country)

Training totals: 490 Person Months

IV.E. EVALUATION PLAN

Two evaluations have been planned, a mid-term in the second and a final in the sixth year. The first evaluation will assess progress to date, including planned versus actual implementation of activities, preliminary examination of each project component against input and output indicators, planned versus actual commitments and disbursements of funds, and continuing validity of assumptions.

On the basis of this evaluation, the implementation schedule and budget for subsequent phases will be revised to effectuate substantive course corrections, if indicated. The second evaluation will assess achievement of project purpose and consider the desirability of a follow-on effort. Some quantifiable indicators will be set by recommendations made by the Baseline Utilization Statistics Study.

In addition to these evaluations, the Project Team and the Mission will conduct an annual review of service statistics and user data prior to placing additional orders of vaccines and contraceptives. Any necessary adjustments in the type, amount, and scheduling of deliveries will be made on the basis of these reviews.

IV.F. FINANCIAL AUDIT REQUIREMENTS

This project will be audited for financial compliance to USAID standards once in the second year and once in the sixth year. It has been determined that the GRM does not have sufficient internal audit capabilities to provide adequate financial and compliance assurances for this project. RIG/A/WA cannot commit to provide the required audit coverage. Therefore, provision has been made for non-federal audits of the project and funds have been budgeted in the amount of \$160,000.

IV.G. BASIS FOR PROJECT FINANCIAL MANAGEMENT SYSTEM

The project shall establish its own bank account, with a mandatory co-signing procedure consisting of the Malian Project Director and the Director of the DNSP.

An appropriate internal control system will be established including the basic auditing standards and procedures as follows:

- o Plan of organization which provides appropriate segregation of functional responsibilities.
- o System of authorization and records procedures adequate to provide reasonable accounting control over assets, liabilities, revenues and expenses.
- o Sound practices to be followed in performance of duties and functions of each of the organizational departments.
- o Personnel of quality commensurate with responsibilities

Compliance with the Project Agreement conditions of utilisation of funds should be insured and reinforced.

Establishment of appropriate accountability standards for the procurement, management and control of inventories (commodities, equipment, fixed assets, furniture, and supplies).

Installation of appropriate reporting system that meets USAID and GRM requirements.

Before funds are released, the project should have:

- o a double entry accounting system supported by a chart of accounts and the appropriate ledgers and journals such as,
 - Cash receipts disbursements and petty cash journals
 - Accounts payable journal and subsidiary ledger
 - General journal
 - Accounts receivable (trial balance)
 - Fixed assets subsidiary ledger
 - Commodities subsidiary ledger
 - Payroll journal
- o a budgetary accounting system supported by groups of accounts in the chart of accounts to identify adequately receipt and expenditure of funds conforming to the previously approved appropriate budget categories and the appropriate journal or ledger to control budgetary encumbrances.
- o an accurate and timely reporting system in the appropriate formats with meaningful details required by USAID and GRM such as,
 - the balance sheet
 - the income statement
 - the statement of encumbrances and disbursements
- o detailed policy and procedures manual

V. FINANCIAL PLAN

V.A. A.I.D.

For this project, A.I.D. will provide \$8,000,000 in Sahel Development Program grant funds for technical assistance, training, vehicles, commodities, operating expenses, construction and renovation, evaluation, and an audit over a six year period to assist the GRM to strengthen and integrate services in 15 MCH/FP complexes in Bamako and the Haute Valle Koulikoro region and to assist the Malian private family planning agency (AMPPF) to upgrade its services. The A.I.D. grant constitutes about 83 percent of the total project cost. The funding will be obligated in amounts sufficient to meet the expenditures envisioned in the summary table entitled "Summary of Project Costs by Year and Source of Financing," or to meet any amendments to this schedule.

V.B. GRM

The GRM will provide in-kind and personnel contributions valued at \$1,600,000 over a six year period to cover personnel, commodities, land, facilities (for training especially), and operating expenses. The host government contribution constitutes about 17 percent of the total life of project funding (A.I.D. and GRM), and about 19 percent of the A.I.D. life of project funding.

	A. I. D.	((\$1000) GRM	Total
Technical Assistance	2,785		2,785
Training	631		631
Commodities	1,578		1,578
Operating Expenses (incl. salaries)	384	1,203	1,587
Renovation & Construction, Land, Buildings	881	94	975
Inflation (5%)	1,217	303	1,520
Contingency (7%)	524		524
Life of Project Totals	8,000	1,600	9,600

Two summary tables and a Detailed Budget are set forth below. The summary tables are titled "Summary of Project Costs by Year and Source of Financing" and "Summary of Project Cost Estimates by Use and Source of Financing." The Detailed Budget identifies expenditures by expense category (technical assistance, training, commodities, etc.), by year, and by type of funding (foreign exchange or local cost). Worksheets for the Detailed Budget are set forth at Annex IX.J. Inflation has been computed by inflating costs for each successive year by five percent. Long term personnel costs have been based on a family of four.

These summaries and the Detailed Budget show that the

proposed funding is adequate to accomplish the project purpose in a timely manner, and, accordingly, that the project is financially viable.

For the reasons summarized in the Summary, Financial Analysis and Recurrent Cost Review and fully discussed in the Financial Analysis and Recurrent Cost Review at Annex IX.M., the GRM is deemed able to finance its contribution to the project and has a reasonable probability of financing a majority of recurrent costs.

V.C. ASSESSMENT OF THE METHODS OF IMPLEMENTATION AND FINANCING

<u>Method of Implementation</u>	<u>Method of Financing</u>	<u>Amount (\$1000)</u>
--Technical Assistance (also Eval. & Audits)	Direct Pay	2,785
--Training (U.S. & 3rd Cnty)	Direct Pay	632
--Vehicles	Direct Pay	124
--US Procured Commodities, (vaccines & contracep.)	Direct Pay	1,070
--Locally Procured Commodities	By Technical Asst.	384
--Operating Expenses (includes local trnging)	By Technical Asst.	384
--Renovation/Construction (includes A&E)	Direct Pay	881
--Other Support, Contingency	Direct Pay	524

All payments made under this project will be made by USAID/Mali, either directly or through thirty day advances to the Technical Assistance contractor, as above indicated. Every effort has been made to alleviate cash management and overall accountability problems. The reader is referred to the discussion at the Implementation Schedule narrative concerning the establishment of a project management system which satisfies the requirements of Section 121(d).

V.D. TITLE TO PROPERTY

Title to vehicles, equipment, furniture, IEC materials, vaccines, contraceptives, and other commodities purchased with A.I.D. funds under this grant shall vest in the DNSP after project termination while the building, equipment and supplies given to the AMPPF shall become the property of the AMPPF.

Table 3

SUMMARY OF PROJECT COSTS BY YEAR AND SOURCE OF FINANCING

SOURCE OF FINANCING	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	(US \$ 000)	
						YEAR 6	TOTAL
USAID/Mali	331	1,154	1,999	997	795	984	6,260
Inflation 1/	17	115	316	215	220	335	1,217
Contingency 2/	24	89	162	85	71	92	524
Sub-total	372	1,358	2,477	1,297	1,086	1,411	8,000
GRM	94	0	301	301	301	300	1,297
Inflation 1/	5	0	48	65	83	103	303
GRAND TOTAL	466	1,358	2,778	1,597	1,387	1,711	9,600

Notes: 1/ Inflation rate of 5 percent used for estimates.

2/ Contingency of 7 percent applied only to USAID/M inputs, as GRM inputs are not likely to change in quantity or cost over the LOP.

Table 4

SUMMARY OF PROJECT COST ESTIMATES BY USE AND SOURCE OF FINANCING
(US \$000)

USE	USAID/M		GRM		TOTAL	
	FX	LC	FX	LC	FX	LC
Technical Asst/Personnel	2,785	89	0	1,070	2,785	1,160
Training	612	107	0	6	612	113
Vehicles (purchase only)	0	124	0	0	0	124
Commodities	1,070	384	0	0	1,070	384
Operational Expenses	0	273	0	126	0	399
Construc/Bldg/Land	0	816	0	94	0	910
Sub-total Inputs	4,466	1,794	0	1,297	4,466	3,090
Inflation 1/	911	307	0	303	911	610
Contingency 2/	376	147	0	0	376	147
GRAND TOTAL	5,753	2,247	0	1,600	5,753	3,847
Combined.....		8,000		1,600		9,600

Notes: 1/ Inflation rate of 5 percent used for estimates.

2/ Contingency of 7 percent applied only to cost of USAID/M inputs; as GRM inputs are not likely to increase in quantity or cost over the LOP.

Table 5
APR 2, 1986

INTEGRATED FAMILY HEALTH SERVICES PROJECT
PROJECT DESIGN SUMMARY
BUDGET

-(in thousands of U.S. dollars)

INPUTS	YEAR 1		YEAR 2		YEAR 3		YEAR 4		YEAR 5		YEAR 6		PROJECT TOTAL	
	FX	LC	FX	LC										
1. TECHNICAL ASSISTANCE														
a) Long-term:														
1. Team Leader														
4 p/y @ \$150/y					150.0		150.0		150.0		150.0		600.0	
2. Training Advisor							150.0		150.0				300.0	
2 p/y @ \$150/y							150.0		150.0				300.0	
3. Financial Manager														
5 p/y @ \$150/y			150.0		150.0		150.0		150.0		150.0		750.0	
Long-term subtotal.....	1650.0													
b) Short-term:														
1. Required Specific Expertise														
a. IEC specialists														
4 p/m @ \$15/m					30.0		30.0						60.0	
b. Information system specialist														
3 p/m @ \$15/m					45.0								45.0	
c. Needs Assessment for Training														
2 p/m @ \$15/m	30.0												30.0	
d. Training specialists														
9 p/m @ \$15/m					30.0		60.0		30.0		15.0		135.0	
e. Commodities mngt. specialist														
3 p/m @ \$15/m			45.0										45.0	
f. Additional TA (as approp)														
3 p/m @ \$15/m			45.0		45.0		45.0		55.0		65.0		255.0	
g. AVSC Buy-in														
5 p/m @ \$15/m			50.0		45.0		25.0						120.0	

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	page 2
2. To Conduct Special Studies							
a. Baseline Util. Statistics							
2 p/m @ \$15/m	30.0						30.0
b. Cost Recovery							
2 p/m @ \$15/m	30.0						30.0
c. Social Marketing Specialist							
9 p/m @ \$15/m	30.0	30.0	30.0	30.0	15.0		135.0
3. To conduct evaluations/audit							
a. Mid-term Evaluation							
3 p/m @ \$15/m (after 18 months)		45.0					45.0
b. Final Evaluation						45.0	45.0
3 p/m @ \$15/m						45.0	45.0
c. Mid-term and Final Audits							
			80.0			80.0	160.0
Short-term subtotal.....	1135.0						
SUBTOTAL I. TECHNICAL ASSISTANCE...	2785.0						
II. TRAINING							
a) Short term, 3rd Country (TP 10)							
18 persons (tuft & airfare)	17.5	15.0	12.0	6.0	6.0		56.5
37 p/m @ \$100/day(\$3000mth)	36.0	27.0	24.0	12.0	12.0		111.0
b) Short term, USA (TP 11)							
12 persons (tuft & airfare)	21.0	21.0	21.0	14.0	14.0		91.0
12 p/m @ \$100/day(\$3000mth)	9.0	9.0	9.0	6.0	6.0		39.0
c) Study tours/wkshps/seminars							
1. U.S. or 3rd Country (TP12)							
18 persons (tuft & airfare)			21.0	21.0	21.0		63.0
9 p/m @ \$100/day(\$3000mth)			9.0	9.0	9.0		27.0
*Minister of Health							
1 p/m @100/day(\$3000mth)+airfare	6.0						6.0
2. Malian Prj Staff Conf Attendance				5.0	5.0	5.0	20.0
d) Training 2 Accountants							
4 p/yr @ \$50,000 yr		100.0	100.0				200.0
English Language Training							
2 persons @ \$9,000 person	18.0						18.0
SUBTOTAL II. TRAINING.....	631.5						

III. COMMODITIES

a) Equipment & Furniture

1. 15 MCH/FP complexes/U.S.
(see Budget Worksheet)

2. 15 MCH/FP complexes/LOCAL
(see Budget Worksheet)

3. for AMPPF

4. for Project team office

5. Replacement equipment
(for VI. a1 and a2)

b) IEC Commodities

1. FP (AMPPF)

2. Other (MSP/AS)

c) FP commodities

(see Budget Worksheet)

d) Vaccines and expendables

(see Budget Worksheet)

e) Shipping/incountry/transport

--35% total cost commodities

(FX=a1,a5,b,c,d)

--PSA contract 8% of costs & shipping

(FX=a1,a5.)8% plus 8% of 35%(FX=a1,a5)

--Banking Charges 2% of costs (FX=a1,a5)

f) Vehicles (LDP)

2 fourwheel @ \$22/vehicle

2 vans @ \$19/van

2 cars @ \$14/car

--Spare Parts(15% of vehicles costs)

SUBTOTAL III. COMMODITIES..... 1577.8

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	
1. 15 MCH/FP complexes/U.S. (see Budget Worksheet)			156.9				156.9
2. 15 MCH/FP complexes/LOCAL (see Budget Worksheet)			84.1				84.1
3. for AMPPF		15.0					15.0
4. for Project team office		20.0					20.0
5. Replacement equipment (for VI. a1 and a2)						50.0 25.0	50.0 25.0
b) IEC Commodities							
1. FP (AMPPF)			2.0 20.0	20.0	20.0	20.0	2.0 80.0
2. Other (MSP/AS)			6.0 40.0	40.0	40.0	40.0	6.0 160.0
c) FP commodities (see Budget Worksheet)		40.0	47.5	71.1	97.7	127.8	384.1
d) Vaccines and expendables (see Budget Worksheet)	23.0	28.0	29.4	30.3	31.0	31.9	173.6
e) Shipping/incountry/transport							
--35% total cost commodities	8.1	23.8	84.6	35.5	45.0	73.4	270.4
(FX=a1,a5,b,c,d)							
--PSA contract 8% of costs & shipping			16.9			5.4	22.3
(FX=a1,a5.)8% plus 8% of 35%(FX=a1,a5)							
--Banking Charges 2% of costs (FX=a1,a5)			3.1			1.0	4.1
f) Vehicles (LDP)							
2 fourwheel @ \$22/vehicle				22.0		22.0	44.0
2 vans @ \$19/van				36.0			36.0
2 cars @ \$14/car	14.0	14.0					28.0
--Spare Parts(15% of vehicles costs)	2.1	2.1	8.7			3.3	16.2
SUBTOTAL III. COMMODITIES.....	1577.8						

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	page 4
IV. OPERATIONAL EXPENSES							
a) Office Rental (5 years @ \$150 mth)		10.2	10.2	10.2	10.2	10.2	51.0
b) Petrol, Oil, Lubricants (POL)	3.0	5.0	6.0	8.0	8.0	8.0	38.0
c) Vehicle Maintenance	1.7	2.0	2.5	2.5	3.5	4.0	16.2
d) Maintenance project office		2.0	2.0	2.0	2.0	2.0	10.0
e) Exchangeable Office Supplies		2.0	5.0	5.0	5.0	5.0	22.0
f) Utilities(phone,elec,water)		4.0	11.0	11.0	11.0	11.0	48.0
g) Salaries office local hire							
1. Bilingual secretary 5 p/y @ \$12/y		12.0	12.0	12.0	12.0	12.0	60.0
2. Ancillary staff 14 p/y @ \$2/y		4.0	6.0	6.0	6.0	6.0	28.0
h) In-country Training							
1. Training of trainers(TP1)			5.0		5.0		10.0
2. State nurses(TP2)				5.0		3.0	8.0
3. Prac.Nurses, Midwives, etc.(TP3,4)			8.0	9.0	8.0	9.0	32.0
4. Physicians & Midwives(TP5,6)			5.0	2.0	6.0	2.0	15.0
5. Field Training Team(TP7)			3.0	2.0	3.0		8.0
6. Supervision/On-the-job train (TP8)			3.0	3.0	3.0	3.0	12.0
7. Pharmacists(TP9)					2.0		2.0
i) Local Services							
a. FP IEC Graphics (AMPPF) 4 p/a @ \$2/a			4.0	4.0			8.0
b. Other IEC Graphics (MSP/AS) 8 p/a @ \$2/a			6.0	6.0	4.0		16.0
SUBTOTAL IV. OPERATIONAL EXPENSES.	364.2						

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6		page 5							
V. CONSTRUCTION/RENOVATION															
a) AMPPF facility	48.0	400.4						448.4							
b) MCH/FP clinic/maternalities															
1. Cleaning/painting															
5 cplx @ \$10/cplx			50.0					50.0							
2. Minor renovations															
7 cplx @ \$15/cplx			105.0					105.0							
3. Major renovations															
2 cplx @ \$35/cplx			70.0					70.0							
4. New Construct/Renov.															
1 cplx @ \$114/cplx			114.0					114.0							
c) Addn to DSF (storeroom & stat office)			22.8					22.8							
d) Renov. Whse. Koulikoro			5.6					5.6							
e) A & E (8% Total Constr)	3.8	32.0	29.4					65.3							
SUBTOTAL V. CONSTR/RENOVAT.....	881.1														
SUBTOTAL OF ALL COMPONENTS.....	6259.6	258.6	72.6	628.8	524.7	1297.5	701.3	844.9	151.7	641.7	153.7	794.5	189.5	4466.0	1793.6
VI. Inflation 5% per annum	1217.1	12.9	3.6	62.9	52.5	205.0	110.8	182.5	32.8	177.1	42.4	270.1	64.4	910.6	306.5
GRAND SUBTOTAL	7476.6	271.5	76.3	691.7	577.2	1502.5	812.1	1027.4	184.5	818.9	196.1	1064.6	253.9	5376.6	2100.1
VII. Contingency 7%	523.4	19.0	5.3	48.4	40.4	105.2	56.8	71.9	12.9	57.3	13.7	74.5	17.8	376.4	147.0
GRAND TOTAL.....	8000.0	290.5	81.6	740.1	617.6	1607.7	868.9	1099.3	197.4	876.2	209.8	1139.1	271.7	5752.9	2247.1

FX=Foreign Exchange
 LC=Local Currency
 TP=Training Plan

PROJECT TOTAL..... 8000.0

VI. PROJECT ANALYSES SUMMARIES

VI.A. TECHNICAL

The technologies to be employed in this project have proven their effectiveness generally and in contents similar to that of the project zone. None are inordinately or inappropriately complicated and all are safe. Nutritional surveillance, vaccination, and ORT require minimal training of health workers and are easily understood by parents who must bring their children to a MCH/FP Complex according to a prescribed schedule and/or take certain follow-up or preventive actions on their own at home. Health education materials, primarily for illiterate audiences, are being provided to reinforce the instructions of health workers. Many of these materials are for mothers to take home.

Even technologies which require specialized training, such as that for voluntary surgical contraception, are easily performed in the Malian context. The minilaparotomy, the surgical technology to be used, was chosen precisely because it was relatively simple and safe. Assistance from AVSC in training and equipment provision will assure high technical quality of this service. All of the other voluntary family planning methods being provided are safe and effective, given the presence of trained, well-supervised personnel. The adequate and appropriate training and supervision of health personnel is one of the primary undertakings of this project. A full discussion of the feasibility of the technologies chosen for this project, especially those related to voluntary family planning, is set forth in the Technical Feasibility Analysis at Annex IX.M.

VI.B. INSTITUTIONAL

The location of Implementing Agency responsibility was placed in the DNSF in order to permit access to sufficient and appropriate technical expertise, assure managerial competence, and control resources and personnel from all relevant entities. The DNSF is charged with executing the national child health and family planning program and has previous, satisfactory experience in serving as Implementing Agency for a USAID/Mali Rural Health Services Development project. Other entities, such as the DSF and its constituent units, the DNAS, and the DNPFS are experienced in carrying out their duties and have sufficient technical expertise. The two new national programs, the CNI and CMD, have inherited competent personnel from predecessor entities and are receiving substantial long term assistance from WHO and UNICEF (for CNI) and from PRITECH (for CMD).

The private Malian family planning agency participating in this project predictably will make a very positive contribution to implementation of the voluntary family planning subcomponent. The AMPPF has been the prime promoter of FP in Mali. It has received and will continue to receive centrally funded support in

the areas of FP studies, voluntary surgical sterilization, and IEC campaigns. The GRM contributes to the AMPPF in the form of salaries for some of the personnel and limited operational expenses.

VI.C. FINANCIAL AND RECURRENT COST

The Financial Analysis attached at Annex IX.M. demonstrates that, certain past difficulties in allocating sufficient amounts for MCH/FP Complex operating expenses and disbursing what monies are allocated in a timely manner notwithstanding, the GRM will be able to finance its contribution to the project and, further, will be able to fund post-project recurrent costs. Accordingly, this project is financially viable. It uses personnel already in place and strengthens existing institutions; it does not create new positions or institutions which would be a significant additional fiscal burden on the GRM in the future.

Because of the current freeze on government salaries, there will be no augmentation of personnel costs accruing from more skilled MCH/FP workers. Even if there were a slight augmentation, it would be more than counterbalanced by the quantitatively and qualitatively higher per worker productivity. Other post-project recurrent costs such as building maintenance of MCH/FP Complexes, equipment maintenance and replacement, contraceptive and vaccine procurement and distribution, and supervision of MCH/FP personnel also are likely to be met. These items either already are included in the GRM's recurrent budget (supervision, building and some equipment maintenance), are likely to receive continued donor support (contraceptives, and vaccines), or are going to receive increasing funds from the current MSP/AS emphasis on initiating fees for service for formerly free services and on other cost recovery measures.

VI.D. ECONOMIC

An economic analysis using cost-benefit, cost-effectiveness, and cost per beneficiary methods indicates that this project constitutes a sound investment for A.I.D. and GRM funds from an economic point of view. Several findings support this conclusion. Application of two cost-benefit analysis methods to voluntary family planning endeavors in other developing countries has shown high positive returns, with the proportion of social benefits to individual/family benefits sufficiently high to warrant government subsidization of family planning programs.

Regarding cost-benefit analysis of the health activities of this project, quantification of the health benefits to be realized is necessarily inexact, but crude estimates indicate a sufficiently significant reduction in infant mortality to warrant undertaking the project. Cost-effectiveness analysis indicates that this project's activities, its mix of activities, and its project zone siting have been selected to maximize cost effectiveness.

And, finally, the per direct beneficiary life of project

estimates cost of \$25.45 (yearly cost of \$4.25) and the per capita life of project cost if all beneficiaries are included of \$11.75 (yearly, \$1.96) are considered reasonable in light of the benefits to be realized.

VI.E. SOCIAL SOUNDNESS

A number of existing socio-cultural factors must be analyzed to determine the appropriateness of the proposed activities for Mali. There are a number of historical and political influences that explain the current state of affairs of which the most important include the following:

The Colonial Heritage. Countries such as Mali were left with very limited resources with which to achieve developmental gains. This colonial experience has had numerous implications. Mali inherited a political system based on the French model which in many cases does not address itself to its needs. Mali's educational system is incongruent with the necessities of the country not only in its structure but also in its content and intellectual perspective. For example, the public health concept commonly taught in the United States is a foreign approach to health education. This has resulted in a cadre of health personnel with a narrow medical focus on health instead of a family or community orientation.

Ethnic Diversity. Four major tribal groups exist in Mali, adding to the complexity of the population picture. This has had many implications, not the least of which is the need to maintain political and social cohesion at the national level. Furthermore, communication is rendered problematic by the existence of numerous local languages. Not all of the inhabitants speak the official languages of French and Bambara. Although inter-tribal conflict is not evident in Mali, the collective desire among the different ethnic groups may be to increase their numbers and consequently, their political clout.

In terms of fertility, tremendous diversity exists between ethnic groups. In general, though, fertility has been high while mortality has dropped. As the population becomes increasingly urbanized, new problems have surfaced that seriously threaten the country.

Urbanization. There also exists differences between urban and rural populations. In the rural areas fertility and mortality are high and some traditional birthspacing occurs. In the urban area, fertility is high, mortality is low, and traditional birthspacing is less common because of tendency towards monogamy, some bottlefeeding, and adoption of western values.

Religious Factors. As in all cultures, beliefs and customs regulating family life and sexual relations are particularly

influenced by religious factors. Islam has played a role in shaping Mali's attitudes toward population. While it is true that Islam encourages the begetting of children and forbids the compulsory limitation of childbearing, scholars point out that the Koran instructs believers to have only as many children as they can support and care for. Islam is not opposed to contraception and several references can be found in the Scriptures acknowledging that the Prophet did not object to child spacing when both spouses were in agreement.

The role of Women. Partially due to the Islamic influence, the role of women in Mali has historically been rigidly prescribed. Women have fewer legal rights and their position is weakened by the widespread practice of polygamy. Men have been more reluctant to give up on the idea that more is better. Many of the laws in the country reinforce the man's dominance in society.

In the urban areas, there are a few signs that women's status is improving somewhat, albeit slowly. The most prominent group behind this is the national women's union (UNIFEM) which has become increasingly active in promoting women's rights, including the right to regulate her fertility.

Government policies toward population matters. The Malian government has officially endorsed family planning for the benefit of the health of mothers and children, although there exists no formal population policy to address the issue of high and increasing rates of population growth as they impact on social and economic development. However, there have been many indications that these attitudes are changing. International Donors and lending institutions have been encouraging Mali to adopt a more progressive and reasonable population stance and the evidence seems to be that they are responding. There has been more openness to discuss population planning. Finally, there is no doubt that the local family planning association (AMPPF) has been given much latitude in providing services, technical assistance, and distributing contraceptives.

The project which is proposed has taken into account these and many other factors affecting the family planning issue. The activities proposed are feasible. Training will be done by personnel experienced with the cultures and societies present in this area of the world. The technologies employed are those that for the most part exist already although on a limited scope. Social, religious, political and cultural constraints to implementing this project have been examined. This project does not foster social problems, deprive some groups to benefit others, nor does it create new structures which would fit clumsily with present entities. The project strengthens the institutions to the benefit of Malian society at large. In addition, the results of studies such as the INSAH's KAP Study will provide valuable information before the start of certain activities. Therefore this project is considered feasible and socially sound.

VII. CONDITIONS, COVENANTS, and NEGOTIATING STATUS

VII.A. CONDITIONS

VII.A.1. Conditions Precedent to Initial Disbursement

(1) Prior to the first disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, the Grantee shall, except as the Parties may otherwise agree in writing, furnish to A.I.D., in form and substance satisfactory to A.I.D.:

a) a statement setting forth the names and titles of persons or person having the authority to act as the representative or representatives of the Grantee, as specified in Section 8.2., together with a specimen signature of each such

b) a nomination, in writing, of a person acceptable to A.I.D. for appointment on a full-time basis to the position of Project Director, and a written delegation of authority which will give full authority to the Project Director to direct and coordinate all GRM implementation responsibilities under the Project.

c) a written certification that the Centre National d'Immunisation (CNI) has central cold storage facilities that are sufficient in quantity and quality to receive and store vaccine shipments donated by this project.

(2) Prior to the disbursement under the project, or to the issuance by A.I.D. of documentation pursuant to which disbursement will be made, for technical assistance to, or commodities and construction for, the "Association Malienne pour la Protection et la Promotion de la Famille" (AMPPF), the Grantee shall, except as A.I.D., may otherwise agree in writing, furnish A.I.D., an agreement between AMPPF and the Grantee which provides that AMPPF will have ownership of the land and building constructed under the Project for AMPPF, and appropriate commitments that AMPPF will carry out activities assigned to it under the Project.

(3) Prior to the release of funds directly to the Grantee, the Grantee shall establish a system of accounts which will be certified by the Administrator of A.I.D. as being sufficient to meet the requirements of Section 121(d) of the Foreign Assistance Act of 1980, as amended.

VII.B. Covenants

SPECIAL COVENANTS

a) Project Evaluation.

The Parties agree to establish an evaluation program as part of the Project. Except as the Parties otherwise agree in writing, the program will consist of two evaluations, a mid-term evaluation in the second year of the project and a final evaluation in the sixth year.

The mid-term evaluation will:

- 1) assess progress to date including planned versus actual implementation of activities;
- 2) conduct a preliminary examination of each project component against input and output indicators, planned versus actual commitments and disbursements of funds, and continuing validity of assumptions.

The final evaluation will:

- 1) evaluate the project's attainment of objectives;
- 2) assess, to the degree feasible, the overall development impact of the project; and,
- 3). based on the findings, determine the practicality and desirability of a possible follow-on effort.

COVENANTS

The Grantee agrees that it will:

- a) provide, on a timely basis, sufficient numbers of qualified personnel and of skilled and unskilled workers to assure successful implementation of the project and achievement of the project purpose.
- b) insure that all design, engineering, and construction work financed under the project will be undertaken by private architectural, engineering and construction firms, unless A.I.D. agrees otherwise in writing;
- c) undertake specific measures to assure that women participate in all training programs, and partake of the professional advancement opportunities under all project components;
- d) provide A.I.D., no later than one year prior to the Project Assistance Completion Date (PACD), a written plan for maintaining project benefits, including, but not limited to, the envisaged means of meeting any recurrent costs reasonably foreseeable as a result of this project;
- e) undertake every reasonable effort to insure that each participant trained overseas under this project continues to work in maternal and child health family planning;
- f) undertake consultation with USAID/Mali during the second, third and fourth years of project implementation concerning the development of population policies in Mali. The Grantee will agree further to include in these discussions senior officials of the Ministry of Public Health and Social Affairs among the Malian representatives;
- g) prior to the commencement of the third year of project implementation, conduct studies concerning both Cost Recovery and Social Marketing of contraceptives and oral rehydration salts. The Grantee further agrees to undertake a good faith effort to implement all reasonable recommendations arising out of the studies.

VII.C. NEGOTIATING STATUS

The GRM has worked with the Mission through a special committee to develop this project paper. They have indicated their agreement with the nature and the components of this project paper.

VIII. PROJECT ISSUES

VIII.A. Would it be better to do a focused family planning project alone?

A non-integrated family planning project alone is likely to reach a smaller percentage of women. There exists a large number of women frequenting MCH/FP services who would not be motivated to use family planning unless they have reason to believe that the chances of survival for their existing children are good. This is a logical conclusion for those living in a situation of very high infant and child mortality. Unless these rates are lowered, couples will continue to have "insurance births".

If a project includes activities carefully selected to reduce infant and child mortality and morbidity, as does this project, and if mothers are educated as to the benefits involved in family planning, then a necessary first step will be taken toward developing a clientele for voluntary family planning. And it is clear that MCH/FP complexes are the most appropriate places for reaching a large number of potential family planning acceptors.

Information about voluntary family planning should be available during the provision of all other maternal and child health services. Referrals from one service to the other should be routinely performed.

The Mission has chosen to recognize the value of both integrated and focused family planning services. Doing only one type of intervention by itself will leave a portion of the potential clients unserved. This is why in addition to working at the 15 MCH/FP Complexes, assistance is also being provided to the AMPPF.

It should also be noted that the GRM, recognizing the above issues, will not, at this time, accept a single purpose voluntary family planning program. The GRM's insistence on also having an integrated approach to family health seems well founded for this place and time.

B. Is a project zone confined to Bamako and the OHV Region, that is to say, essentially urban, consistent with AID's policy priority on agricultural and rural development?

In this instance, the restriction to an essentially urban area with limited rural extensions into the contiguous region is justified on several grounds. First, USAID/Mali learned from its recent experience with the Rural Health Services Development Project, 608-0208, that it is very difficult, if not impossible, to obtain an acceptable degree of positive health impact with a rural health project in Mali at this time. The main constraints are an almost non-existent infrastructure (roads, utilities,

communications, qualified personnel) which makes implementation and continuation of activities extremely difficult and costly.

The choice of project zone for this project was partially governed by considerations of geographic accessibility, which, in turn would enhance manageability and reduce the management burden on the Mission. All the MCH/FP Complexes are within only a few hours' drive from Bamako. Further, the Mission already has operational activities in the proposed project zone and can use its information and distribution systems in the area. More importantly the choice of zone was governed by the presence of factors conducive to projects success: a relatively high literacy rate; a higher than usual status of women; relatively high purchasing power; better health facilities to begin with; adequately staffed MCH/FP Complexes; lower transportation costs; and, of greatest significance, a population more receptive to family planning and to MCH activities.

The May 9, 1985 AID/W ECFR applauded this urban focus and specially advised against expanding the geographic area (see State 152247 of May 17, 1985, at paragraph 2 summary and paragraph 2A). The Administrator's June, 1985 "Blue Print for Development" specifically mentions the legitimacy of urban projects, particularly in the area of health. The combination of these factors indicate that the delineation of the project zone with an urban focus was a prudent decision at this time. Enlarging the geographic scope can be considered either at the mid-term evaluation or when and if a follow-on project is contemplated.

IX. ANNEXES

1/19/20

IX.A. PID APPROVAL CABLE

State 152247

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AID
AND
OEM
ECOR
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UNCLAS

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RR RUTABD
DE RUEHC #2247/01 1372140
7LR UUUUUU 77H
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EM SECSTATE WASHDC
TO RUTABD/AMEMBASSY BAKARO 9493
INFO RUEHAB/AMEMBASSY ABIDJAN 4249
BT
UNCLAS SECTION 01 OF 02 STATE 152247

ACTION TAKEN:
DATE:
INITIALS:

AIDAC

E.O. 12356: N/A

TAGS:

SUBJECT: MALI INTEGRATED FAMILY HEALTH SERVICES
PROJECT 68E-G227 PID REVIEW

TO	ACT	INFO
DIR		✓
D/DIR		✓
PROG	✓	
DEO		✓
MGMT		✓
CONT		✓
ATK		
CHOPS		
LVST		
GDO/HA		✓
SDPT		
JAO/DIR		
JAO/GSO		
JAO/ER		

1. ECPR FOR THE SUBJECT PIC MET 5/9/85. JJOHNSON, DAA/AFS/CWA CHAIRED THE MEETING. THE PID WAS APPROVED AND THE MISSION IS HEREBY AUTHORIZED TO PROCEED WITH DEVELOPMENT OF THE PP WITH PROJECT AUTHORIZATION TO TAKE PLACE IN THE FIELD.

2. THE ECPR AGREED THAT THE PID PRESENTS A WELL-PLANNED PROPOSAL FOR PROVIDING BASIC HEALTH AND FAMILY PLANNING SERVICES IN AN AREA WHERE THEY ARE URGENTLY NEEDED. THEY PARTICULARLY COMMENDED THE PROJECT FOR ITS FOCUS ON A MORE URBAN AREA, WHERE ACCEPTABILITY OF FP SERVICES IS LIKELY TO BE HIGHER, AND FOR ITS WORK THROUGH THE PRIVATE

ITALIAN FP AGENCY (AMPPF). THE ECPR MADE SEVERAL RECOMMENDATIONS, HOWEVER, AS GUIDANCE FOR THE PP, WHICH ARE SUMMARIZED BELOW:

A. COULD THE PROJECT HAVE GREATER IMPACT WITH MORE RESOURCES? AID/W SUPPORTS MISSION PLAN TO PROCEED PROMPTLY AND BUILD SOLID PROGRAMMATIC BASE FOR

INITIAL ACTIVITIES BEFORE EXPANDING PROJECT. GIVEN THE CRITICAL NEED IN THIS AREA, HOWEVER, AS WELL AS THE FACT THERE APPEARS TO BE ADEQUATE FUNDING AVAILABLE IN MALI PROGRAM LEVELS FOR FAMILY HEALTH ACTIVITIES, THE ECPR SUGGESTS THAT THE PP DESIGN TEAM EXPLORE THE POTENTIAL OF THE FP JUSTIFIED, FOR PROGRAM ENHANCEMENT AND EFFORTS TO INCREASE QUALITY AND QUANTITY OF SERVICES CONTRACEPTIVES PROVIDED TO EXISTING TARGET POPULATION TO EXPANDING GEOGRAPHIC AREA. THE ECPR ALSO

RECOMMENDS THAT THE PP SHOULD INCLUDE POSSIBILITIES OF AMENDING THE PROJECT FOR INCREASING THE PROJECT OUTREACH AS SOON AS THIS IS CLEARLY FEASIBLE; FOR EXAMPLE, AFTER THE MID-PROJECT EVALUATION.

B. THE PP SHOULD CLARIFY HOW THIS PROJECT WILL BE

COORDINATED WITH OTHER DONOR ACTIVITIES (E.G., THE WORLD BANK AND WHO/UNICEF JOINT NUTRITION SUPPORT PROGRAMS) AS WELL AS THE MANY CENTRALLY-FUNDED AID HEALTH AND POPULATION PROJECTS NOW ACTIVE IN MALI. THE PP TEAM SHOULD IDENTIFY A COHESIVE STRATEGY FOR USING THESE RESOURCES TO COMPLEMENT EFFORTS OF THE BILATERAL. IT SHOULD ALSO CONSIDER HOW THE BILATERAL PROGRAM WILL RELATE TO PLANNED SAHEL REGIONAL AND CENTRALLY-FUNDED HEALTH AND POPULATION ACTIVITIES IN MALI.

C. A THOROUGH AND CONCISE INSTITUTIONAL FEASIBILITY ANALYSIS NEEDS TO BE PERFORMED AS PART OF THE PP DEVELOPMENT PROCESS, EMPHASIZING WAYS OF INCREASING THE PRIVATE SECTOR ROLE IN DELIVERY OF MCH AND FP SERVICES IN MALI. THE PID DEMONSTRATES PRAISEWORTHY EFFORT TO USE EXISTING MALIAN HEALTH AND FAMILY PLANNING INSTITUTIONS, BOTH IN THE PRIVATE AND PUBLIC SECTORS. THE PP TEAM SHOULD UNDERTAKE A MORE DETAILED ANALYSIS OF THE RELATIONSHIPS AMONG THESE DIFFERENT COUNTERPART IMPLEMENTING AGENCIES TO IDENTIFY THE ROLE EACH WILL PLAY

MANAGEMENT, SHOULD DECIDE WHAT EVIDENCE OF COMMITMENT TO THE PROJECT IS NEEDED AMONG THESE VARIOUS AGENCIES, AND FOR WHICH COMMITMENTS THE GRAFUDAGRAMONU SHOULD MAKE CONDITIONS PRECEDENT AND COVENANTS.

D. THE PP TEAM SHOULD DEVELOP A PROJECT TRAINING PLAN, EMPHASIZING HOS - ANDOPH RD COUNTRY, SHORT-TERM TRAINING. TRAINING IS CRUCIAL, ESPECIALLY IN ORT, IMMUNIZATIONS AND NUTRITION, AND IT IS AN INTEGRAL PART OF THE MCH/FP "SERVICE PACKAGE;" FURTHERMORE, A RECENT AFR/TR/HN REVIEW OF AID/PHC PROJECTS SUGGESTS THAT TRAINING ACTIVITIES HAVE BEEN AMONG AID'S MOST SUCCESSFUL INTERVENTIONS. AS EARLY AS POSSIBLE IN THE PROJECT IMPLEMENTATION, THE TRAINING PLAN SHOULD BE EXPANDED, IDENTIFYING WHO NEEDS TO BE TRAINED IN WHAT TOPICS AND STRESSING FOLLOW-UP. THIS ANALYSIS SHOULD ALSO EXAMINE WHAT HAS HAPPENED TO PARTICIPANTS PREVIOUSLY TRAINED IN AID-SUPPORTED PROGRAMS. TRAINING WHICH MIGHT OTHERWISE BE SUPPORTED THROUGH CENTRALLY-FUNDED AID PROJECTS SHOULD BE FUNDED UNDER THIS BILATERAL PROJECT TO THE EXTENT PRACTICAL.

E. THE PP SHOULD PROVIDE DETAILED DISCUSSION OF TECHNICAL PROGRAM AND ACTIVITIES TO BE INCLUDED IN THE MCH/FP SERVICE PACKAGE.

RECENT VENTILATORS, ORT, IMMUNIZATIONS, AND FP SERVICES ARE ALL MENTIONED AS ACTIVITIES IN THE MCH/FP SERVICE PACKAGE. THESE WILL ALL REQUIRE TRAINING, EMPLOYMENT OF TECHNICAL EXPERTISE. IT IS UNCLAS IF THE PROPOSED PROJECT WILL MEET THESE REQUIREMENTS, PARTICULARLY ...

ET
#2247

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RR RUTABD
DE RUEHC #2247/02 1372140
ZNR UUUUU ZZH
R 172138Z MAY 85
FM SECSTATE WASHDC
TO RUTABO/AMEMBASSY BAMAKO 9494
INFO RUEHAB/AMEMBASSY ABIDJAN 4250
BT
UNCLAS SECTION 02 OF 02 STATE 152247

AIDAC

MOTIVATION OF EXISTING MCH/FP WORKERS IS ALREADY CITED AS A PROBLEM. IMPROVED SUPERVISION OF HEALTH WORKERS WILL IMPROVE MOTIVATION, BUT THE PID DOES NOT EXPLAIN WHO WILL CARRY OUT THIS SUPERVISION OR WHERE IT WILL COME FROM--THE CENTRAL MINISTRY, WITHIN THE MCH/FP CENTERS OR ELSEWHERE? THESE QUESTIONS NEED TO BE CLEARLY ANSWERED IN THE PP. FUNDS TO PURCHASE SCALES FOR GROWTH MONITORING SHOULD ALSO BE INCLUDED IN THE PROJECT BUDGET.

F. A MARKETING FEASIBILITY STUDY ON CONTRACEPTIVES SHOULD BE PERFORMED AS SOON AS POSSIBLE, EITHER AS PART OF THE PROJECT DEVELOPMENT PROCESS OR EARLY IN THE LDF.

THE PID PROPOSES USING THE PARASTATAL PHARMACIE POPULAIRE DU MALI (PPM) FOR CONTRACEPTIVE SALE AND DISTRIBUTION. PRIVATE RETAIL OUTLETS MAY PROVIDE A MORE EFFECTIVE CHANNEL. THE ST/POP SOCIAL MARKETING FOR CHANGE (SGMARC) PROJECT MAY BE ABLE TO PROVIDE TECHNICAL ASSISTANCE FOR PERFORMING A MARKETING SURVEY ON THE POTENTIAL FOR COMMERCIAL SALE OF CONTRACEPTIVES. (IN ORDER TO GAIN ACCESS TO THIS RESOURCE, THE MISSION SHOULD SEND A CABLE REQUEST TO ST/POP). IN ITS ON-GOING POLICY DIALOGUE WITH THE GPM, THE MISSION SHOULD ALSO CONSIDER WAYS OF ENCOURAGING GREATER PRIVATE SECTOR PARTICIPATION IN THE MARKETING AND DISTRIBUTION OF HEALTH AND FAMILY PLANNING SUPPLIES AND SERVICES.

G. THE ECPR DEVOTED SOME DISCUSSION TO NUTRITION ASPECTS OF THE PROJECT, AND WHILE IT DOES NOT SEE THE NECESSITY TO INCLUDE A NUTRITIONIST SPECIALIST ON THE FP TEAM, IT DOES RECOMMEND THAT THE MISSION ENSURE THAT AT LEAST ONE MEMBER OF THE TEAM HAVE THE CAPABILITY TO ADEQUATELY COVER THIS SUBJECT. THE PP DESIGN TEAM SHOULD ALSO INCLUDE PROJECT DEVELOPMENT OFFICER.

H. ECPR NOTED THAT THE PROJECT OFFERS OPPORTUNITIES FOR INVOLVEMENT OF GRAY AMENDMENT ENTITIES EITHER AS PRINCIPAL CONTRACTOR OR THROUGH A JOINT VENTURE (WHERE THE GRAY AMENDMENT ENTITY HAS RESPONSIBILITY FOR A SPECIFIC ELEMENT OF THE PROJECT). THEREFORE, PP SHOULD DESCRIBE ALTERNATIVE CONTRACTING OPPORTUNITIES FOR INVOLVEMENT OF GRAY AMENDMENT ENTITIES IN THE IMPLEMENTATION OF THE PROJECT AND PROVIDE MISSION'S RATIONALE FOR CONTRACTING

UNCLAS

MODE RECOMMENDED.

I. THE MISSION MUST PREPARE AN INITIAL ENVIRONMENTAL EXAMINATION AND SUBMIT IT TO THE AFRICA BUREAU ENVIRONMENTAL OFFICE FOR APPROVAL PRIOR TO APPROVAL OF THE PROJECT. THE IEE SHOULD CONSIST OF TWO PARTS: CATEGORICAL EXCLUSION FOR THE MCH/FP ACTIVITIES AND NEGATIVE/POSITIVE DETERMINATION FOR THE CONSTRUCTION COMPONENT.

J. THE PP DESIGN PROCESS SHOULD INCLUDE DEVELOPMENT OF A PROJECT EVALUATION PLAN. THIS PLAN MAY CONSIST OF MID- AND END-OF-PROJECT EVALUATIONS, ANNUAL REVIEWS OR SUCH OTHER EVALUATION MECHANISMS AS THE DESIGN TEAM DETERMINES ARE APPROPRIATE.

K. IT APPEARS FROM THE PP DESIGN SCHEDULE THAT THE DESIGN WILL NOT BE COMPLETED BEFORE JULY 1985. THE BUREAU HAS, THEREFORE, DECIDED THAT THE PROJECT SHOULD BE OBLIGATED IN FY86 AND NOT IN FY85 AS ORIGINALLY PLANNED. THE PROJECT DESIGN SHOULD, HOWEVER, PROCEED AS SOON AS POSSIBLE SO IT CAN BE AUTHORIZED IN EARLY FYS6. DAK

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INTEGRATED FAMILY HEALTH SERVICES PROJECT (689-0227)

Table 6
May 29, 1986

PROJECT IMPLEMENTATION SCHEDULE

PROJECT ACTIVITIES	AGENT	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6
PRO-AG SIGNED	MSN/GRM(*)						
I. TECHNICAL ASSISTANCE							
A. Long Term							
--PID/T's Completed (FM)	MSN (-1)						
--Advertise (FM)	MSN		(2)(4)FM				
--Contractor selected	MSN/GRM		(5)FM				
--Contract signed (FM)	MSN		(7)FM				
--PID/T's Compl't (TL/TR)	MSN		(12)				
--Advertise (TL/TR)	MSN		(1)(2)TL&TR				
--Contractors selected	MSN/GRM		(3)TL&TR				
--Contract signed (TL/TR)	MSN		(5)TL&TR				
--Teachleader (TL)				(1)			
--Trainer (TE)				(1)			
--Financial Manager (FM)			(1)				
B. Short Term							
--IEC specialists	MSN/W			(4)(5)	(4)(5)		
--Inform. Systems Spec.	MSN/W		(6)(8)				
--Needs Assess. Train #	MSN/W	(9)(9)					
--Training Specialists	MSN/W			(5)(8)	(3)(4)	(5)(6)	(5)(6)
--Commodit. Manag. Spec.	MSN/W		(2)(4)				
--Additional TA	MSN/W		(6)	(6)	(6)(7)	(6)(7)	
--Baseline Study*	MSN/W	(1)(2)					
--Cost Recovery Study*	MSN/W	(5)(6)					
--Social Marketing Study	MSN/W	(10)(12)(11)(2)		(4)(5)	(4)(5)	(1)	
--Midterm Evaluation	MSN/W		(6)(9)				
--Final Evaluation	MSN						(6)(8)
--Mid and Final Audits	MSN			(4)(5)			(6)(8)
--PID/T's prepared*	MSN (-1)						

Listed below are statutory criteria applicable generally to FAA funds, and criteria applicable to individual fund sources. Development Assistance and Economic support Fund.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FAA Sec. 481; FY 1985 Continuing Resolution Sec. 528. Has it been determined or certified to the Congress by the President that the government of the recipient country has failed to take adequate measures or steps to prevent narcotic and psychotropic drugs or other controlled substances (as listed in the schedules in section 202 of the comprehensive Drug Abuse and Prevention Control Act of 1971) which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully? NO

2. FAA Sec. 620(c). If assistance is to a government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) the debt is not denied or contested by such government? NO

3. FAA Sec. 620(e)(1). If assistance is to a government, has it (including government agencies or sub-

divisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps toward such citizens or entities?

4. FAA Sec. 620(a), 620(f), 620(D); FY 1985 Continuing Resolution Sec. 512 & 513. Is recipient country a communist country? Will assistance be provided to Angola, Cambodia, Cuba, Laos, Syria, Vietnam, Lybia, or South Yemen? Will assistance be provided to Afghanistan or Mozambique without a waiver? NO
5. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction by mob action of U.S. property? NO
6. FAA Sec. 620(1). Has the country failed to enter into an agreement with OPIC? NO
7. FAA Sec. 620(o); Fishermen's Protective Act of 1967, as amended, Sec. 5.
(a) Has the country seized or imposed any penalty or sanction against, any U.S. fishing activities in international waters? NO

(b) If so, has any deduction required by the Fishermen's Protective Act been made? NO
8. FAA Sec. 620(g); FY 1985 Continuing Resolution Sec. 518. (a) Has the government of the recipient country been in default (a) NO

for more than six months on interest or principal of any AID loan to the country? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the appropriation bill (or continuing resolution) appropriates funds?

(b) NO

9. FAA SEC. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the amount of foreign exchange or other resources which the country has spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur).
10. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?
11. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears were such arrearages taken into account by the AID Administrator in deter-

N/A The project account is Sahel Development Program

NO

N/A

The country is not in arrears

mining the current AID Operational Year Budget? (Reference may be made to the Taking into Consideration memo).

12. FAA Sec. 620A; FY 1985 Continuing Resolution Sec. 521. Has the country aided or abetted, by granting sanctuary from prosecution to, any individual or group which has committed an act of international terrorism? Has the country aided or abetted, by granting sanctuary from prosecution to, any individual or group which has committed a war crime? NO
13. FAA Sec. 666. Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA? NO
14. FAA Sec. 669, 670. Has the country, after August 3, nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan). NO
15. ISDA of 1981 Sec. 720. Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. of Sept. 25 and 28, 1981, and failed to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the Taking into Consideration memo). YES, SUCH ACTION HAS BEEN TAKEN INTO ACCOUNT
16. FY 1985 Continuing Resolution. N/A Project account is

population functional account, does the country (or organization) include as part of its population planning programs involuntary abortion? am. However, abortion is illegal in Mali.

17. FY 1985 Continuing Resolution Sec. 530. Has the recipient country been determined by the President to have engaged in a consistent pattern of opposition to the foreign policy of the United States? NO

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy? NO
N/A

2. Economic Support fund Country Criteria FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the country made such significant improvements in its human rights record that furnishing such assistance is in the national interest? N/A

5C(2) PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A. includes criteria applicable to all projects. Part B. applies to projects funded from specific sources only: B.1. applies to all projects funded with Development Assistance loans, and B.3. applies to project funded from ESP.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

B. GENERAL CRITERIA FOR PROJECT

1. FY 1985 Continuing Resolution Sec. 525; FAA Sec. 634A; Sec. 653(b).

(a) Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project;
(b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that amount)?

(a) Through standard Congressional Notification procedures.

(b) Yes

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

(a) Yes

(b) Yes

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?

No further Malian legislative action is necessary.

4. FAA Sec. 611(b); FY 1985 Continuing Resolution Sec. 501. If for water or water-related land resource construction, has project met the standards and criteria as set forth in the Principles and Standards for Planning water and Related Land Resources, dated October 25, 1973, or the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See AID Handbook 3 for new guidelines).

N/A

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1

Mission Director's 611(e) Certification is not required because

million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?

this is not a Capital Assistance project.

6. FAA Sec. 202. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.

NO

N/A

This project will collaborate closely with centrally and regionally funded projects, such as AVS, PRITECH, and other with appropriate orientation and expertise.

7. FAA Sec. 601(a). Information and conclusions whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

(a) As a maternal and child health family planning project, this project has minimal relation to international trade; (b) the project directly supports and strengthens the Italian private family planning agency and, further, explores private, commercial marketing of preventive health and voluntary family planning supplies which heretofore were distributed gratuitously; (c) the substantive focus of this project has minimal relation to these entities; (d) monopolistic practices will be discouraged by the project's support of free market channels to distribute health and contraceptive supplies; (e) technical efficiency of industry and commerce will be improved through private marketing and cost recovery efforts; and, (f) the substantive focus of this project has no relation to this

- subject.
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

U.S. clinical equipment furniture, vaccines, and contraceptive supplies are being procured in significant quantity, and a U.S. Procurement Service Agent firm and a U.S. Technical Assistance firm are being engaged to procure commodities and personnel respectively.
 9. FAA Sec. 612(b), 636(h); FY 1985 Continuing Resolution Sec. 507. Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

There are no foreign currencies owned by the U.S. to use. The Host Country is contributing significant numbers of personnel, whose salaries it is paying during the life of the project.
 10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

NO
N/A
 11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

YES
 12. FY 1985 Continuing Resolution Sec. 522. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world market at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of competing commodity?

N/A
 13. FAA 118(c) and (d). Does the project comply with the environmental procedures set forth in AID Regulation 16. Does the project

YES

or program taken into consideration the problem of the destruction of tropical forests?

Yes - there will be no impact whatsoever on tropical forests.

14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)?

Four years of the services for a Financial Management Advisor and additional services of a commodity management specialist are being procured to establish a project management system which has adequate measures for accounting and for controlling receipt and expenditure of project funds.

15. FY 1985 Continuing Resolution Sec. 536. Is disbursement of the assistance conditioned solely on the basis of the policies of any multi-lateral institution? NO

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

This project is financed by funds appropriated pursuant to Section 121(c), as amended, "Sahel Development Program-Implementation".

- a. FAA Sec. 102(b), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local government al institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women

N/A

in the national economies of developing countries and the improvement of women's status, (e) utilize and encourage regional cooperation by developing countries?

b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used?

N/A

c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

N/A

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or, activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed country")?

N/A

e. FAA Sec. 110(b). Will grant capital assistance be disbursed for project more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"? (H.O. 1232.1 defined a capital project as "the construction, expansion, equipping or alteration of a physical facility or facilities financed by AID dollar assistance of not less than \$100,000, including related advisory, managerial and training services, and not undertaken as part of a project of a predominantly technical assistance character."

N/A

f. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

N/A

g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.

N/A

2. Development Assistance Project Criteria (Loans Only)

a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan, at a reasonable rate of interest.

N/A

b. FAA Sec. 620(a). If assistance is for any productive enterprise which compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

N/A

3. Economic Support Fund Project Criteria

a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the extent possible, does it reflect the policy directions of FAA Section 102?

N/A

b. FAA Sec. 531(c). Will assistance under this chapter be used for military, or paramilitary activities?

N/A

c. FAA Sec. 534. Will ESF funds be used to finance the construction of, or the operation or maintenance of, or the supplying of fuel for, a nuclear facility? If so, has the President certified that such use of funds is indispensable to nonproliferation objectives?

N/A

d. FAA Sec. 602. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account

N/A

(counterpart) arrangements been made?

4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.) N/A
5. FAA Sec. 604(g). Will construction or engineering services be procured from firms of countries which are direct aid recipients and which are otherwise eligible under Code 941, but which have attained a competitive capability in international markets? Do these countries permit United States firms to compete for construction or engineering services financed from assistance programs of these countries? N/A
6. FAA Sec. 603. Is the shipping included from compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percentum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? NO
7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? If the facilities of other Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? YES
8. International Air Transportation Fair Competitive Practices Act, 1974. If air transportation of

persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? YES

9. FY 1985 Continuing Resolution Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? YES

B. Construction

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used? This is not a capital project. The modest renovation and construction to be undertaken will be performed by local firms.

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be financed, will they be let on a competitive basis to maximum extent practicable? YES

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the CP)? N/A

C. Other Restrictions

1. FAA Sec. 122(b). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter? N/A

2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Controller General have audit rights? N/A

3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or YES

assists the foreign aid projects or activities of the Communist-bloc countries?

4. Will arrangements preclude use of financing:
- a. FAA Sec. 104(f); FY 1985 Continuing Resolution Sec. 527.
(1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or part, methods or the performance of abortions or involuntary sterilizations as a means of family planning; (4) to lobby for abortion? (1) YES
 - b. FAA Sec. 620(g). To compensate owners for expropriated nationalized property? YES
 - c. FAA Sec. 660. To provide training or advice or provide any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? YES
 - d. FAA Sec. 662. For CIA activities? YES
 - e. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? YES
 - f. FY 1985 Continuing Resolution, Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for military personnel? YES
 - g. FY 1985 Continuing Resolution, Sec. 505. To pay U.N. assessments, arrearages or dues? YES
 - h. FY 1985 Continuing Resolution, Sec. 506. To carry out provisions

- of FAA section 209(d) (Transfer of
 FAA funds to multilateral
 organizations for lending)? YES
- i. FY 1985 Continuing Resolution,
Sec. 510. To finance the export
 of nuclear equipment, fuel, or
 technology or to train foreign
 nationals in nuclear fields? YES
- j. FY 1985 Continuing Resolution,
Sec. 511. Will assistance be
 provided for the purpose of aiding
 the efforts of the government of
 such country contrary to the
 Universal Declaration of Human
 Rights? NO
- k. FY 1985 Continuing Resolution,
Sec. 516. To be used for publicity
 or propaganda purposes within U.S.
 authorized by Congress? NO

IX.D. HOST COUNTRY REQUEST FOR PROJECT

Mme C.A./
MINISTÈRE
DE LA
SANTÉ PUBLIQUE
ET DES
AFFAIRES SOCIALES

REPUBLIQUE DU MALI
UN PEUPLE - UN BUT - UNE FOI

Koulikoro, le 4 FEVR. 1986

N° 128 /MSP-AS/ CAB



*Le Ministre de la Santé Publique
et des Affaires Sociales*

(-)

/))onsieur le Directeur de l'U.S.A.I.D.

à BAMAKO

OBJET : Projet intégré de Santé
Familiale et Planification familiale
dans le District de Bamako
et la Région de Koulikoro
Votre Réf. : 688-0227

S/C de Monsieur le Ministre des Affaires Etrangères
et de la Coopération Internationale à KOULOUBA

/))onsieur le Directeur,

Suite à l'élaboration par votre organisme et l'Equipe Centrale de mon département du document provisoire du projet ci-dessus cité, j'ai l'honneur de vous demander d'envisager la possibilité de financement de ce dernier dont la mise en oeuvre revêt un intérêt tout particulier pour mon département.

En vous remerciant par avance de votre sollicitude à l'égard de nos problèmes de développement Socio-sanitaires, je vous prie d'agréer, Monsieur le Directeur, l'assurance de ma considération distinguée./-

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MINISTÈRE
DES AFFAIRES ÉTRANGÈRES
ET DE LA
COOPÉRATION INTERNATIONALE

6

REPUBLIQUE DU MALI
Un Peuple - Un But - Une Foi



2/2186

G&C/HLS

AID

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No. MAECI/DGCI/DCEB/S3/1

No

867

Le Ministère des Affaires Etrangères et de la Coopération Internationale présente ses compliments à l'Ambassade des Etats Unis d'Amérique (US-AID) à BAMAKO, et a l'honneur de lui faire parvenir ci-joint, la lettre n° 0128/MEP-AS/CAB du 4 Février 1986 du Ministère de la Santé Publique et des Affaires Sociales, relative au Projet intégré de Santé Familiale et Planification Familiale dans le District de BAMAKO et la Région de Koulikoro.

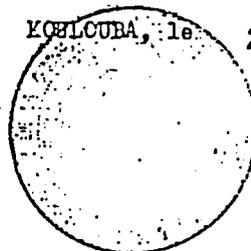
Le Ministère saurait gré à l'^Ambassade de son appui auprès des autorités compétentes de son pays en vue du financement de ce projet.

Le Ministère des Affaires Etrangères et de la Coopération Internationale remercie d'avance l'Ambassade des Etats Unis d'Amérique (US-AID) de sa bienveillante entremise et saisit cette occasion pour lui renouveler les assurances de sa haute considération. - †

YCELCUBA, le 20 FEV. 1986

AMBASSADE DES ETATS UNIS D'AMERIQUE

- BAMAKO -



IX.E. LOGICAL FRAMEWORK

Table 7

PROJECT DESIGN SUMMARY
LOGICAL FRAME WORK

Life of Project: FY86 to FY92
Total U.S. Funding: \$8,000,000
Date Prepared: APRIL 2, 1986

Project Title and Number: INTEGRATED FAMILY HEALTH PROJECT 688-0227

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>GOAL: To assist the GRM to reduce morbidity/mortality in Bamako and the OHV area resulting from childhood communicable diseases, diarrhea, malnutrition, and inadequate birthspacing.</p>	<p>1. Long term (>25 yrs.) reduction of morbidity/mortality rates for: --childhood immunizable diseases --infant diarrhea --childhood nutritional disorders --women birth related illnesses</p> <p>2. Increased interval between births and lower birth rates</p> <p>3. Higher Contraceptive Prevalence</p>	<p>1. MCH/FP complexes statistics in Bamako. 2. AMPPF statistics. 3. Malian Census statistics (if any) 4. Special studies 5. Other donors and AID statistics</p>	<p>1. GRM increasingly committed to meeting recurrent costs of maintaining MCH/FP services either from budget funds and/or cost recovery measures. 2. GRM promotes social marketing of contraceptives.</p>
<p>PROJECT PURPOSE: To assist the Maternal and Child Health/Family Planning Program of the GRM to strengthen and integrate services in 15 MCH/FP complexes in Bamako and the OHV area and to assist the private family planning agency in Mali (AMPPF) to upgrade its services.</p>	<p>End of Project Status: 1. Participating MCH/FP complexes provide full complement of MCH/FP services including: prenatal, intrapartum, postnatal care; voluntary IFP; well child clinic; nutritional surveillance; immunization: diphtheria, pertusis, tetanus, measles, and polio; oral rehydration 2. Stock control systems for vaccines and contraceptives 3. Improved clinic supervision and management techniques 4. Increased productivity of staff (number clients served, number services provided) 5. Improved health service statistics and patient records 6. Renovated facilities equipped with standard equipment/supplies</p>	<p>1. Mid-term and final evaluations 2. MCH/FP complex statistics/record reports 3. Quarterly and other project reports 4. Site visits 5. Financial audits 6. Community questionnaires, meetings with leaders 7. AMPPF records, statistics, and site visits 8. Participant and in-country training reports 9. Baseline study and supplemental information 10. Cost recovery study and followup activities 11. Social Marketing study and followup activities 12. Technical assistance reports</p>	<p>1. GRM and AMPPF will continue their cooperation 2. Health personnel will be released for training and for supervision as necessary 3. GRM supports vigorous IEC campaign</p>

:7. Oral rehydration therapy used :routinely not just in emergencies	:13. AID reports and records	:
:8. Increased knowledge in popula- :tion about preventive health and :FP measures and how to access them	:14. Other donor reports and :statistics	:
:9. Increased utilization of ser- :vices (percentage-wise and in :absolute numbers) by population	:	:
:served	:	:
:10. Referrals among services will :be routinely and effectively done	:	:
:11. AMPPF will be operating out :of a new and improved facility	:	:
:12. AMPPF will have voluntary :FP services and voluntary surgical :fertility management services	:	:
:13. AMPPF offering an improved IEC :program in the community and :assisting the GRM with its program	:	:
:14. Health personnel trained under :the project will continue to :strengthen their organizational :units	:	:
:15. Reliable baseline statistics :will exist to be used by evaluation :teams	:	:
:16. Reliable information will exist :concerning health financing issues	:	:
:17. Reliable information will exist :concerning social marketing issues	:	:
:	:	:

	MAGNITUDE		
OUTPUTS:			
1. Improvement and integration of four selected health care services in participating complexes:	--15 MCH/FP complexes	Project workplans	1. Qualified GRM personnel are made available to project
(1) nutrition		Project, AID, GRM and technical assistance reports and records	2. Land for AMPPF building is obtained in the appropriate location on time
(2) vaccination		Project Evaluations	3. Oral rehydration salts are available from UNICEF throughout project life
(3) oral rehydration		Project Audit	
(4) voluntary family planning		Participant and in-country training reports and follow-up surveys	4. GRM maintains the vaccine cold chain throughout the project area
2. Integration of above services with prenatal, intrapartum, and postpartum services	--15 MCH/FP complexes		
3. Regularly scheduled health education for all seven services mentioned above (groups and individuals)	--15 MCH/FP complexes		
4. Personnel Serv/Trng Needs Assess	--1 Study		
5. Collection, organization, and retention of health service statistics for GRM Complexes and the AMPPF	--15 MCH/FP complexes		
6. Individualized patient record-keeping instituted as part of standard operating procedures	--15 MCH/FP complexes		
7. Adequately supplied complexes with standard set of equipment/furnishing, vacc., contraceptives	--15 MCH/FP complexes		
8. Growth monitoring/vacc. cards will be available as needed	--15 MCH/FP complexes		
9. Ren/Constr of centers as planned:	-- 1 complex major renov./construc. 5 centers minor renovation 7 centers moderate renovation 3 centers major renovation		
10. New headquarters for AMPPF including surgical unit	--1 new headquarters		
11. AMPPF equipment/furniture supplemented through local purchase	--\$15 thousand worth of equipment		
12. GSF storeroom and statistics office built	--2 rooms		

13. Koulikoro warehouse renovated	!--1 renovated warehouse	:
14. Project office rented and equipped	!--1 office	:
15. Trainers trained in health care subjects and IEC	!--15 persons	:
16. Health personnel from complexes and AMPPF trained in nutrition, vaccinations, DRT and FP, as appropriate; also advanced level	!--140 persons (15 at advanced level)	:
17. Pharmacists and others trained contraceptive subjects	!--150 persons	:
18. Supervisory personnel trained in clinic management and supervision;	!--30 persons	:
17. Upgraded skills for personnel participating in 3rd country and U.S. training	!--Third country: 22 persons U.S. : 15 persons	:
18. Study tours and workshops to increase MCH/FP awareness of influential leaders	!--2 Accountants L.T. in U.S.	:
19. Malian project staff skills and technology updated through conference attendance	!--30 persons	:
20. MCH/FP preceptonal and educational campaigns (IEC)	!--Malian team	:
21. Special Studies: Baseline, Cost Recovery, and Social Marketing	!--One broadly based campaign	:
22. 121(d) certifiable project accounting system	!--3 studies	:
23. Finalized master training plan	!--1 system	:
24. Finalized procurement plan	!--1	:
25. Annual workplans	!--5	:
26. Evaluations and Fin. audits	!--mid-term and final	:
27. Financial audits	--mid-term and final	:
28. Quarterly Implementation reports	!--4 per year	:

	Type and Quantity	
INPUTS:		AID project records and vouchers
I: AID		ERM project and financial records
A. Technical Assistance		
1. Long term		PIO/Ts, PIO/Cs, and PIO/Ps
a. Team Leader	Four (4) person-years	
b. Training Specialist	Two (2) person-years	
c. Financial Manager	Five years	
2. Short term	Forty-eight (48) person months (with additional under AVSC)	
B. Local Services IEC	Twelve (12) person months	
C. Training	See training plan	
D. Commodities		
1. Equipment and Furniture (U.S. and local)	For more complete information see Financial Analysis, Implementation	
2. Vaccines and related expend.	Schedule, Procurement Plan,	
3. Family Planning supplies	Commodity and Equipment lists,	
4. IEC and health education materials	Training Plan, and Budget	
E. Vehicles		
F. Operational Expenses		
II. ERM		
A. ERM Project team members:		
1. Project Director		
2. Deputy Director		
3. Chief Accountant		
4. Two Assistant Accountants		
5. Bamako District Public Health Director		
6. Koulikoro Regional Public Health Director		
B. Advisory Committee Members:		
C. MCH/FP complex personnel		
D. Land for AMPPF headquarters		
E. Operational Costs		

IX.F. SOURCE/ORIGIN WAIVER

108W

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D C 20523

ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR FOR AFRICA

FROM : AFR/PD, Laurence Hausman *Chen by fm*

SUBJECT: MALI - Integrated Family Health Services Project,
(688-0227); Source, Origin and Section 636(i) Waivers
for Vehicles

I. Problem: Your approval is required to authorize a source and origin waiver from AID Geographic Code 941 (Selected Free World) to AID Geographic Code 935 (Special Free World), and the waiver of Section 636(i) of the Foreign Assistance Act of 1961, as amended, for the procurement of motor vehicles and spare parts financed under the subject project.

II. Background:

- A. Cooperating Country: Republic of Mali
- B. Nature of Funding : Grant
- C. Project : Mali Integrated Family Health Services (688-0227)
- D. Description of Commodities:
 - 3 EA Long-wheel-base four-wheel-drive utility vehicles, approximate unit cost of \$19,000, plus unit spare cost of \$2,850.
 - 3 EA 13-to 15-person vans, approximate unit cost of \$16,300, plus unit spare cost of \$2,445.
 - 3 EA Four-door sedans with heavy duty suspension, approximate unit cost of \$12,000, plus unit spare cost of \$1,800.
- E. Approximate value of commodities sought:
 - Subtotal vehicles \$141,900
 - Subtotal spare parts. \$ 21,285
 - Total \$163,185
- F. Procurement Source and Origin: France and Japan

III. Discussion: The Mali Integrated Family Health Services project is in the process of being authorized in the field under Delegation of Authority No. 140. Prior to authorization, the Mission has requested that this waiver be approved. In accordance with AID Handbook 1B, the procurement of commodities

from Geographic Code 935 under a grant-financed project for Mali requires a source and origin waiver. Under Handbook 1B, Chapter 5B4a(7), a waiver may be granted for project goods for "such other circumstances as are determined to be critical to the success of project objectives." Moreover, a waiver of Code 935 requires a certification by you that "the exclusion of procurement from Free World countries other than the Cooperating Country and countries included in Code 941 would seriously impede the attainment of U. S. foreign policy objectives and objectives of the foreign assistance program."

In addition, Section 636(i) of the Foreign Assistance Act, as amended, prohibits the procurement of non-U.S. manufactured vehicles. However, the provisions of Section 636(i) may be waived when special circumstances are deemed to exist. According to HB 1B, Chapter 4C2d(1)(b), a waiver for the procurement of non-U.S. manufactured vehicles may be granted if there is a "present or projected lack of adequate service facilities and supply of spare parts for U.S.-manufactured vehicles."

IV. Justification

A. Source and origin waiver

The Mali Integrated Family Health Services project is a six-year effort consisting of four components, all of which require sturdy vehicles for implementation of their activities. The project involves upgrading maternal and child health and voluntary family planning services in the Bamako and Operation Haute Vallee area immediately adjacent to Bamako. Although the project zone is primarily urban, even the main thoroughfares are unpaved and plagued with enormous holes which impose inordinate wear and tear on vehicles and reduce their normal service life to under two years. Dust rising from these streets also contributes to short vehicles service life. Vehicles break down easily, but only the most widely used spare parts can be obtained; and maintenance capability exists for only the most common makes of vehicles.

Well-functioning vehicles are imperative for successful implementation of this project. Vehicles will be used to transport vaccines and contraceptive supplies to their distribution points. They also will be used to transport supervisors and project team members (about 12 people) to the 15 maternal and child health health care/family planning

facilities in the project zone. Finally, bulky, heavy, and delicate audio-visual equipment used for health promotion campaigns and for training sessions will need to be transported regularly.

The above discussion established that spare parts availability and maintenance and repair capability are essential to successful, timely implementation. Project activities cannot proceed according to schedule if vehicles are out of service for significant periods of time. In the case of this project, there is the danger that vaccines will deteriorate if the vehicle delivering them to their storage or distribution point breaks down. These special circumstances, therefore, meet the criteria for authorizing a source and origin procurement waiver as identified in Handbook 1B, Chapter 5B4a(7), which states "such other circumstances as are determined to be critical to the success of project objectives."

In light of the unusually short vehicle life in and around Bamako, the necessity of procuring one of each kind of vehicle (i.e., utility vehicle, van and sedan) every two years is foreseen and reflected in the quantities set forth in this waiver request.

B. Waiver of Section 636(i)

At present, no U.S. vehicle manufacturer is represented in Mali. As a consequence, there is no distribution network of spare parts for U.S. made vehicles, nor is there a maintenance and repair capability because local mechanics are totally unfamiliar with U.S. brands. It is, therefore, believed that the special circumstances criterion set forth in Handbook 1B, Chapter 4C2d(1)(b), is satisfied and that Section 636(i) should be waived.

V. Recommendation: For the above reasons, it is recommended that you:

1. Approve a source and origin waiver from AID Geographic Code 941 to Code 935 to permit the procurement of non-U.S. manufactured vehicles and spare parts;
2. Conclude that special circumstances exist which merit a waiver of section 636(1) of the Foreign Assistance Act of 1981, as amended; and

3. Certify that exclusion of procurement of these project vehicles and spare parts from Free World countries other than the cooperating country and countries included in AID Geographic Code 941 would seriously impede the attainment of U.S. foreign policy objectives and the objectives of the foreign assistance program.

APPROVED: _____

[Handwritten Signature]

DISAPPROVED: _____

DATE: _____

[Handwritten Date: Jan 8, 1986]

Clearance: DAA/AFR/CWA: LRichards: *[Signature]*
AFR/PD: CPeasley: (Draft)
AFR/PD/SWAP: CCantell: (Draft)
AFR/SWA: LWerlin: (Draft)
AAM/OS/AFR: SDean: (Draft)
GC/AFR: BBryant: *[Signature]*

[Handwritten Signature]
Drafted: USAID/Bamako: SPS Shah/PD/SWAP: 12/17/85, 12/27/85
Doc. No. 2809M

IX.G. INITIAL ENVIRONMENTAL EXAMINATION

ANNEX IX.G.

INITIAL ENVIRONMENTAL EXAMINATION

Project Location : Mali
Project Title : Mali Integrated Family Health Services
688-0227
Funding : FY 1986
Life of Project \$8,009,400
IEE Prepared by : Francisco Zamora
Health Development Officer
USAI/Bamako
January 23, 1986

Environmental Action Recommended: Negative Determination

Concurrence: Eugene Chiavaroli Jan. 23, 1986
----- DATE
Eugene R. Chiavaroli
Mission Director

APPROVAL: Bessie L. Boyd JAN 28 1986
----- DATE
AFR/Bureau Environmental Officer
Bessie L. Boyd, AFR/TR/SDP

CLEARANCE: GC/AFR 1/30/86
----- DATE

INITIAL ENVIRONMENTAL EXAMINATION

Examination of Nature, Scope and Magnitude of Environmental Impact

The proposed project to provide improved maternal and child health and family planning services through improvements in the present health delivery system will have no significant impact on the physical environment in Mali.

A. Description of Project

The total cost of the Mali Integrated Family Health Services Project (IFAHS) is estimated at \$9,608,300 of which A.I.D. will contribute \$8,009,400 of Sahel Development Program funds. The Grantee, the Government of the Republic of Mali (GRM) will contribute the local currency equivalent of \$1,598,900 (assuming an exchange rate of \$1 = 350 FCFA).

The term of the project is six years from the date of initial obligation. Accordingly, the Project Assistance Completion Date (PACD) is estimated to be on or about May 30, 1992.

The project purpose is to assist the Maternal and Child Health and Family Planning Program of the Government of the Republic of Mali to strengthen and integrate the services of fifteen maternal and child health/family planning (MCH/FP) center complexes in Bamako and the Operation Haute Vallée (OHV) area and to assist the Bamako-based private Malian family planning agency (Association Malienne pour la Protection et la Promotion de la Famille, or, AMPPF) to upgrade its services.

The activities of this project take place at all ten existing GRM MCH/FP Complexes in the Bamako District, at five GRM MCH/FP Complexes in the contiguous OHV region of Koulikoro, and at the Bamako-based private Malian family planning agency, the AMPPF. Project activities are organized into one main component (Service Upgrading) and three other supportive components (Renovation/Construction, Information, Education, and Communication, and Special Studies).

The main component, the "Service Upgrading Component" is divided into four subcomponents: nutritional surveillance, vaccination, oral rehydration therapy (ORT), and voluntary family planning. These subcomponents were selected because they are deemed to be among the health system's least developed MCH/FP services and because a relatively modest investment in their upgrading is predicted to have a significant positive family and public health impact.

The second component is the "Renovation/Construction

Component". In the public sector part, the project finances repair and structural improvements (and in one case, a structural addition) of varying scope for each MCH/FP Complex. The addition of a contraceptive stockroom and an adjacent room for a statistics office at the Division of Family Health (Division de la Santé Familiale, or DSF), and renovation of the regional health materials warehouse of Koulikoro are also financed. Also included is the construction of a dispensary in the Djikoroni neighborhood in Bamako. In the private sector, the project finances construction of a new AMPPF headquarters office and service center in a very accessible location in central Bamako.

"Information, education and communication (IEC)" is the third component, the activities of which promote MCH/FP services through various media, such as television, radio, posters, presentations at meetings of leadership and special interest groups. A special effort will be made to encourage men to practice family planning through educational campaigns for the military, police, government and religious leaders. Community, political, religious and educational leaders who can play an important role in supporting and sanctioning the MCH/FP program will participate in study and/or observational visits to other countries to give them an informed and, hopefully, contagious enthusiasm for MCH/FP activities. At the MCH/FP Complex level, this component will consist of group and individual health education.

The fourth component, the "Special Studies Component", consists of three parts: (1) a Baseline Study of Utilization Statistics which, in addition to collecting baseline data, will recommend certain quantifiable End of Project Status (EOPS) Indicators (2) a Cost Recovery Study which will focus on a fees-for-service strategy and other ways of meeting recurrent costs of the GRM's MCH/FP program; and, (3) a Social Marketing Feasibility Study to determine the feasibility of private, commercial distribution of barrier method contraceptives (condoms, foams) and other commodities such as ORS packets. If the study indicates marketing feasibility, a Social Marketing pilot activity may be undertaken to yield further information.

Each component is supported by technical assistance and commodities. In the area of long-term technical assistance, A.I.D. will finance a Nurse Clinician/Administrator as Team Leader (4 PY), and a Training Advisor (2PY). Short-term technical assistance in a wide range of specialties, as well as, expertise from the Association for Surgical Contraception (AVSC) will be provided. Also included are short-term services of local personnel for IEC activities local architectural and engineering expertise (A&E) and construction services. "Small, disadvantaged, minority or women owned" (8A) firms will be considered for implementation of all technical assistance.

In the area of commodities, A.I.D. will finance US- and locally-procured equipment and furniture for the MCH/FP Complexes

In the area of commodities, A.I.D. will finance US- and locally-procured equipment and furniture for the MCH/FP Complexes and for AMPPF. Other purchases include family planning supplies, vaccines and related expendables, growth monitoring and immunization cards, promotional and public relations materials, a project office computer, construction materials, and vehicles and spare parts.

U.S.-procured equipment and furniture for the MCH/FP Complexes and the Project Office will be contracted through a Procurement Services Agent (PSA) having an Indefinite Quantity Contract (IQC) with USAID. Vaccines and family planning supplies will be procured with the assistance of the Science and Technology Bureau (S & T) Population office in AIQ/W.

Extensive training will be undertaken by this project to support all but the "Renovation/Construction Component". The perponderance of the effort is directed to the "Service Upgrading Component". Special attention is also being placed on clinic management, supervision, information system development, and health planning.

A variety of operational costs will be financed by this project. A project office will be rented, furnished and provided with utilities and expendable supplies. Salaries of locally hired support personnel for this office will be paid. Vehicle maintenance and petrol, oil, and lubricants (POL) are included.

The GRM will contribute the full-time services of its Project Team members (Project Director, Deputy Director, Chief Accountant, and two Assistant Accountants) and the part-time participation of the Bamako District Public Health Director, the Koulikoro Regional Public Health Director, and the Project Advisory Committee members. Finally, personnel from participating MCH/FP Complexes will be involved as required.

The GRM's contribution also includes the use of MCH/FP Complex facilities for carrying out the project activities, land for AMPPF headquarters construction, newspaper space, television and radio time for IEC and health education activities, and some operational costs.

B. Identification and Evaluation of Environmental Impact

The only probable component, due to its physical nature, that could have an environmental impact is Renovation and Construction. But since the location and scale of this activity is routine and relatively small in scope, it is considered not significant. The construction sites are areas in town already well developed and the renovation is in existing buildings. None of the construction methods and materials will pose any significant environmental threat.

<u>Impact Areas and Sub-Areas</u>	<u>Impact Identification and Evaluation</u>
-----------------------------------	---

- | | |
|--|---|
| a. Land use | |
| (1) Changing character of land through: | |
| (a) Increasing the population | N |
| (b) Extracting natural resources | N |
| (c) Land Clearing | N |
| (d) Changing soil character | N |
| (2) Altering natural defenses | N |
| (3) Foreclosing important issues | N |
| (4) Jeopardizing man or his works | N |
| b. Water quality | |
| (1) Physical state of water | N |
| (2) Chemical and biological states | N |
| (3) Ecological balance | N |
| *note: water is available at site | |
| c. Atmospheric | |
| (1) Air additives | N |
| (2) Air pollution | N |
| (3) Noise pollution | N |
| d. Natural resources | |
| (1) Diversion, altered use of water | N |
| (2) Irreversible, inefficient commitments | N |
| e. Cultural | |
| (1) Altering physical symbols | N |
| (2) Dilution of cultural traditions | N |
| f. Socio-economic | |
| Changes in economic/employment patterns | N |
| g. Health | |
| (1) Changing a natural environment | N |
| (2) Eliminating an element in an ecosystem | N |
| (3) Other factors | N |
| h. General | |
| (1) International impacts | N |
| (2) Controversial impacts | N |
| (3) Larger program impacts | N |

Narrative Evaluation of Impacts

The project will have no effect on land, water or other natural resource use and will introduce no foreign elements into the atmosphere. The potential changes which could be brought about by the project are cultural and, eventually, economic.

Cultural: The project's ultimate goal is to increase the rate of contraceptive use in the project area. All family planning services are completely voluntary. There will be no forced cultural changes. Experience in Mali has shown that the existence of family planning services, in no way, causes opposition in the community. The Social Soundness analysis (Annex IX.M.5) concludes that the elements of the project are not likely to cause social problems.

Socio-Economic: The socio-economic impact will be positive. Families with fewer and healthier children will make better use of their incomes. This concept, eventually extended on a nationwide basis, could result in meaningful development gains for the country as a whole.

Recommendation for Environmental Action

That you indicate your concurrence on the attached sheet for a Negative Determination supporting the decision that the proposed Integrated Family Health Services Project will not have a significant effect on the human environment as supported by this Initial Environmental Examination.

IX.H. DRAFT CONGRESSIONAL NOTIFICATION

CONGRESSIONAL NOTIFICATION

1. Advice of Program Change

- Country: Mali
- Project Title: Integrated Family Health Services
- Project No.: 688-0227
- FY 87 CP Reference: Annex I, Africa Program (exact page no. not known as final bound copies not yet received by the Mission. Original PPSS Reference found in Mission's FY 84 CP Submission.
- Appropriation Category: Sahel Development Program
- Life of Project Funding: \$8,000,000 - Grant
- Intended FY 86 Obligation: \$1,200,000 - Grant

This is to advise that AID intends to obligate \$1,200,000 in FY 1986 for the activity described in the attached data sheet.

The initiation of this new project will allow the agency to assist the Malian Government in strengthening and integrating its maternal and child health/family planning program. When the project was initially developed in FY 82, the proposed life of project funding was estimated at \$3,460,000. However, the subsequent design in FY 85 elevated this amount to \$8,000,000. The increase in costs is due to an expansion of planned child care services in the maternal/child health care and family planning fields, the inclusion of construction component, and rising costs since the original submission.

The \$1,200,000 will be used for project start-up activities, including commodities, training and construction.

2. Planned Program Summary Sheet

Country: Mali
Title: Integrated Family Health Services
Project Number: 688-0227
Funding Source: SDP
Type: Grant
Status: New
Proposed Obligation: FY86
Life of Project Funding: \$8,000,000
Initial Obligation: FY 86
Estimated Final Obligation: FY 91

Purpose:

To assist the maternal and child health/family planning program of the Malian Government to strengthen and integrate services in 15 clinics in Bamako and the Haute Vallee Region and to assist the family planning agency in Mali (AMPPF) to upgrade its services.

Background:

Experience in Mali has shown that there is an unmet need and demand for MCH/FP services. These services include family planning, nutritional surveillance and counseling, immunization for childhood diseases, oral rehydration, pre and postnatal care, and health education. The evaluation of MCH/FP services conducted jointly by the International Fertility Research Program (IFRP) and the Center for Disease Control (CDC) indicated that there were organization weaknesses in the Ministry of Health's (MOH) programs. The MOH concurs with the major finding of the evaluation which concluded that FP services were not integrated with other MCH services provided at the same delivery sites, that shortages of FP supplies were reported in over 50% of the centers, and that staff lacked adequate training and supervision.

The Rural Health Services Delivery Project (63C-0202), which recently ended, showed that services cannot be delivered in the absence of an adequate support structure. The solution is to provide the necessary training, planning, management, commodities, equipment, and services for the system to function properly.

Project Description:

This is a six year project which will provide institutional support to the Department of Public Health (DHP) and affiliated GRM entities, and to the private Malian Family Planning Agency, the AMPPF. With this support the GRM will not only be able to strengthen and integrate its services in 15 MCH/FP complexes in Bamako and in the Haute Vallée Region, but, the AMPPF will be able to upgrade its services as well.

The project has one main and three supporting components: (1) "Services Upgrading", the main component, consists of four subcomponents in the public sector - Nutritional surveillance, vaccination, oral rehydration therapy and voluntary family planning. In addition to training in these four subcomponents, health personnel will learn management techniques, supervision, recordkeeping, and health planning. A standard set of commodities consisting of clinical equipment and furnishings will be provided to each complex. The private sector portion of the project will involve providing the AMPPF with technical assistance and commodities to upgrade and expand its family planning services and community education.

(2) Renovation of 15 MCH/FP complexes and a warehouse, and construction of a two-room addition at the Division of Family Health (DSF), a new dispensary at Djikoroni and a new AMPPF building.

(3) Information, education, and communication to promote the activities undertaken by this project.

(4) Special studies on baseline utilization statistics, cost recovery, and social marketing.

Relationship to AID Country Strategy

This project supports USAID's principal objective of helping Mali achieve food security. Unless the rate of population growth is moderated, gains made in food production may be nullified.

Host Country and Other Donors

The project will coordinate with other donors to assure that no duplication of effort occurs. The project design outlines the forms of cooperation that will exist with organizations such as UNICEF and UNFPA in the areas of Oral Rehydration, Immunizations, and Training.

Beneficiaries

Personnel from the HCH and the AMPPF will receive training, equipment and supplies which will enable them to increase the quality and quantity of services for the primary beneficiaries who are mothers and children in Damako and the Haute Vallee Region benefiting from improved HCH/FP services. The total beneficiaries are estimated at 313,400.

Summary Financial Plan

Technical Assistance	\$3,151,700
Commodities	1,540,900
Construction	815,300
Training	494,500
Inflation/Contingency	1,761,300
Operating Expenses	235,800
LOP Total	\$8,000,000

IX.I. PARTICIPANT TRAINING AVAILABILITY

12(a)

PARTICIPANT TRAINING
- AVAILABILITY ASSESSMENT

Out of country training for the project is divided into short and long term training. No problems of availability of candidates are anticipated. Two accountants from the Ministry of Health will receive long term training in financial accounting during phase I of the project. This training is most likely to take place in the United States. Short term training will be held at various locations in Africa and in the United States in subjects dealing with maternal child health/family planning.

The Ministry has already identified the two candidates for the long term training. One of the candidates was the accountant for a previous USAID bi-lateral project (Rural Health Services Development Project, 688-0208). He is familiar with USAID procedures and is, therefore, a good candidate. The other comes from the CAF (Cellule Administrative et Financiere), the Ministry's financial and accounting unit. Both accountants obtained their degrees from Malian accounting schools and have several years of accounting experience.

Candidates for short term training in the United States and in other African countries are already being considered. Previous experience with the Ministry of Health has shown that candidates for these courses have always been available. No shortage of candidates is anticipated for the present project. The Project Agreement will contain a clause stating that the government will have personnel of sufficient number and quality to carry out the objectives of the project.

IX.J. ILLUSTRATIVE BUDGET WORKSHEETS

TABLE 8

SUMMARY OF GRM INPUTS TO INTEGRATED FAMILY HEALTH PROJECT

INVESTMENT	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	(US \$ 000)	
						YEAR 6	TOTAL
Training-facilities 1/	0.0	0.0	2.3	1.4	1.8	0.9	6.4
Land-AMPPF 2/	93.8	0.0	0.0	0.0	0.0	0.0	93.8
RECURRENT							
Salaries 3/	0.0	0.0	267.6	267.6	267.6	267.6	1,070.4
Vehicle FDL & Maint. 4/	0.0	0.0	9.0	9.0	9.0	9.0	36.0
Utilities 5/	0.0	0.0	15.0	15.0	15.0	15.0	60.0
Bldg. Maint. & Sppls 6/	0.0	0.0	7.5	7.5	7.5	7.5	30.0
Sub-total	93.8	0.0	301.4	300.5	300.9	300.0	1,296.6
Inflation (5% per annum)	4.7	0.0	47.6	64.9	83.0	103.1	303.4
GRAND TOTAL	98.5	0.0	349.0	365.4	383.9	403.1	1,600.0 (rounded)

- Notes: 1/ Assumed rental value of space used for training equals \$450/mth. and that in-country training requires 3 months of space in 1987, 5 months in 1988, 3 months in 1989, and 4 months in 1990, and 2 months in 1991.
- 2/ Assumed 2,500 sq. meters of space required for AMPPF facility and grounds @ 15,000 FCFA (US \$ 37.50) per sq. meter.
- 3/ See Table VI.2 -- for details on salary input calculations.
- 4/ Assumed that the GRM will allocate the equivalent of three vehicles per year for project activities of distribution of contraceptives, vaccines and ORS sachets. It was estimated that \$3,000/year are required per year per vehicle for petrol, oil, lubricants and maintenance.
- 5/ Assumed that utilities cost \$1,000/complex/year.
- 6/ Salary of cleaners included with personnel figure above. Assumed that other maintenance costs are \$500/complex/year.

TABLE 9

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	16,695,360
MID-WIFE	1	4			90	46.6	34,600	19,348,320
STATE NURSE			2		46	23.3	34,600	9,674,160
HEALTH NURSE					75	37.5	26,800	12,060,000
HEALTH AIDE					187	93.5	25,900	29,059,800
MATRONE					11	5.5	14,000	924,000
SOCIAL ASSISTANT					3	1.5	34,600	622,800
SOCIAL AIDE					10	5	34,600	2,076,000
COMMUNITY DEVELOP TECH					2	1	34,600	415,200
ACCOUNTANT	1	1		1	2	2.3	38,500	1,062,600
STATISTICAL/ACCTANT AIDE	2	2			4	4.3	26,800	1,382,880
SECRETARY		2		1	13	6.95	30,900	2,577,060
CLEANER		1			68	34.15	19,100	7,827,180
GUARD					12	6	18,500	1,332,000
CHAUFFEUR		1			17	8.65	19,100	1,982,580
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).

TABLE 10: SPECIFICATIONS AND COST ESTIMATES FOR STANDARD
FURNITURE/EQUIPMENT PACKAGE FOR MCH/FP CENTERS
U.S. PROCUREMENT

ITEM	SPECIFICATIONS	UNIPAC #	NUMBER PER CENTER	NUMBER FOR 15 CENTERS	COST PER UNIT	TOTAL COST FOR 15 CENTERS
INFANT CLINICAL WEIGHING SCALE	HEAVY DUTY, BEAM BALANCE, METRIC	0145520	1	15	\$250.00	\$3,750.00
OTOSCOPE-OPHTHALMOSCOPE	SPECIALIST SET WITH BATTERIES DIAGNOSTIC SET	0661200	2	30	\$125.00	\$3,750.00
STETHOSCOPE	BIAUREL, COMPLETE	0686000	12	180	\$15.00	\$2,700.00
STETHOSCOPE	FOETAL, PINARD, MONAURAL	0686500	6	90	\$7.00	\$630.00
SPHYGMOMANOMETER	100 MM DIAL, VELCRO CUFF, CARRYING CASE, HAND ANEROID	0683000	5	75	\$110.00	\$8,250.00
EXAMINATION LAMP	FLOOR STAND, GOOSE NECK, 220V	0117000	2	30	\$75.00	\$2,250.00
SCALE, ADULT	FLOOR MODEL, BALANCE BEAM, METRIC HEAVY CAST LEVER, HEIGHT ROD	0140500	1	15	\$250.00	\$3,750.00
EXAMINATION STOOL	REVOLVING ADJUSTABLE HEIGHT BASIC, METAL	0169000	3	45	\$40.00	\$2,700.00
SPECULUM, VAGINAL	VAGINAL, BI VALVE, GRAVES, MEDIUM, STAINLESS STEEL	0777500	15	225	\$15.00	\$3,375.00
OB-GYN EXAMINATION TABLE	BASIC MODEL WITH HEEL STIRRUPS AND LEG HOLDERS, DROP LEAF, HEAVY GAUGE SHEET STEEL TOP, BAKED ENAMEL TOP	0185000	2	30	\$500.00	\$15,000.00
INSTRUMENT TRAY COVERED	COVERED STAINLESS STEEL 310 X 195 X 63MM	0276500	10	150	\$37.00	\$5,550.00
THERMOMETER	CLINICAL, RECTAL CELSUIS	0481060	36	540	\$1.75	\$945.00
INSTRUMENT TRAY COVERED	COVERED STAINLESS STEEL 225 X 125 X 50MM	0270000	10	150	\$35.00	\$5,250.00
WATER FILTER	ALUMINUM OR ENAMEL WITH 4 STERASYS CANDLES	56199902	3	45	\$50.00	\$2,250.00
REFRIGERATOR FOR VACCINE	REFRIGERATOR 220V, 210 L 7.4 CuFT ELECTRIC	1153020	1	12	\$950.00	\$11,400.00
REFRIGERATOR FOR VACCINE	REFRIGERATOR 220V, 210 L 7.4 CuFT KEROSENE/ELECTRIC	1153020	1	3	\$950.00	\$2,850.00

THERMOMETER	:VACCINE STORAGE, DIAL, BI-METAL, : CELCIUS	: 1185055	: 2	: 30	: \$7.00	: \$210.00
VACCINE COLD BOX	:LARGE, 31 LITER CAPACITY	: 1185055	: 1	: 15	: \$300.00	: \$4,500.00
VACCINE CARRIER	:CARRIER COMPLETE WITH ICE PACKS	: 1185010	: 1	: 15	: \$35.00	: \$525.00
ICE PACKS	:POLYETHENE FOR COLD BOXES(SET OF 4)	: 1185010	: 6	: 90	: \$5.00	: \$450.00
TRAY	:CAFETERIA TYPE, FIBERGLASS, : 350 X 450 MM	: 2091500	: 10	: 150	: \$10.00	: \$1,500.00
ALCOHOL LAMP	:WITH SCREW CAP, WICK, 60ML, METAL	: 0530000	: 4	: 60	: \$15.00	: \$900.00
IUD INSERTION	:MEDICAL KIT	: 0530000	: 5	: 75	: \$250.00	: \$18,750.00
SHEETING	:RUBBER DOUBLE COATED HARDON : 910 MM WIDE @\$4.00/METER : 17 GAUGE	: 0360000	: 60	: 900	: \$4.00	: \$3,600.00
COMPUTER, PROGRAMS, & PERIPHERALS	:IBM PC-XT 256 K RAM WITH INTERNAL : 10 MEGABYTE DISK DRIVE;2 HALF- : HEIGHT 360 K DOUBLE SIDED DISK : DRIVES; AST 6 PAC PLUS MEMORY : EXPANSION BOARDS 384K; IBM MONO- : CHROME DISPLAY; PARADISE GRAPHICS; : ADAPTER CARD; EPSON LQ1500 PRINT- : ER; IBM PC-XT EPSON LQ1500 : INTERFACE; ACME TRANSFORMER : 220/120, 1KVA; DOS 3.0; 8087 : PROCESSING UNIT; SOLA MINI UPS, : 600VA, 220V, 50 HERTZ; LOTUS 123; : WORDSTAR 2000; DBASEIII; 50 EPSON; : LQ1500 PRINTER RIBBONS, 132 CHR; : 30 BOXES DISKETTES(10/BX), 5.25" : DD/DS; 5 CARTONS PAPER, 9.5 X 11, : 20 LBS.;5 CARTONS PAPER, 14 7/8" : X 11", 20 LBS.; 6 OUTLET POWER : STRIP; SCREWDRIIVER KIT; CHIP : EXTRACTOR KIT; DISK HEAD : CLEANING KIT; 4 DISK HOLDER BINS : (50 DISKS); XT HARDWARE MAIN- : TENANCE MANUAL; DUST COVERS FOR : COMPUTER AND PRINTER.					: \$10,000.00
						: \$114,835.00

TABLE 11: SPECIFICATIONS AND COST ESTIMATES OF EQUIPMENT
SETS FOR 15 MATERNITIES--US PROCUREMENT

ITEM	SPECIFICATIONS	UNIPAC #	NUMBER PER CENTER	NUMBER FOR 15 CENTERS	COST PER UNIT	TOTAL COST FOR 15 CENTERS
DELIVERY TABLE	LABOR BED WITH DELIVERY CAPACITY	0101000	1	15	\$600.00	\$6,600.00
MIDWIFERY KIT	TYPE 3 WITH ALUMINUM CASE	9902101	3	45	\$150.00	\$4,950.00
FORCEPS	HEMOSTAT STRAIGHT 160MM STAINLESS STEEL	0727500	7	105	\$25.00	\$2,750.00
SCISSORS	STRAIGHT SURGICAL 140MM STAINLESS STEEL	0743500	7	105	\$25.00	\$2,750.00
NEEDLE HOLDER	STRAIGHT NARROW JAW 150ML	0743500	7	105	\$30.00	\$3,300.00
CATGUT #1	SUTURE MATERIAL PLUS HALF CIRCLE NEEDLE 12 SUTURES TO BOX	0563000	12	180	\$10.00	\$1,800.00
SPECULUMS	VAGINAL, BIVALVE, GRAVES MEDIUM SIZE	0777500	24	360	\$15.00	\$3,960.00
STETHOSCOPES	BIAURAL, COMPLETE	0686000	10	150	\$15.00	\$1,650.00
SPHYGMOMANOMETER	300 MM DIAL, CUFF, HAND HELD	0683000	10	150	\$110.00	\$12,100.00
RUBBER SHEETING	HARDON, 17 GAUGE @ \$4/METER	360000	60	900	\$4.00	\$2,640.00
						\$42,020.00

TABLE 12: SPECIFICATIONS AND COST ESTIMATES FOR STANDARD FURNITURE AND EQUIPMENT FOR 15 MCH/FP CENTERS, LOCAL PURCHASE

ITEM	SPECIFICATIONS	REFERENCE	NUMBER PER CENTER	NUMBER FOR 15 CENTERS	COST PER UNIT	TOTAL COST FOR 15 CENTERS
BENCH	WOODEN 1' X 8'	NA	6	90	\$34.00	\$3,060.00
TABLE	WOODEN OR METAL	NA	5	75	\$86.00	\$6,450.00
CHAIR	METAL STRAIGHT BACK	NA	10	150	\$17.00	\$2,550.00
BED	METAL FRAME	NA	2	30	\$114.00	\$3,420.00
MATTRESS	WITH PLASTIC COVERING	NA	2	30	\$57.00	\$1,710.00
WASTEBIN	PLASTIC	NA	5	75	\$11.00	\$825.00
MEASURING SPOON	METRIC, SET OF 4	NA	6	90	\$2.25	\$202.50
MEASURING CUP	METRIC, PLASTIC	NA	6	90	\$1.00	\$90.00
MEASURE	GRADUATED 100GML, PLASTIC	NA	5	75	\$6.00	\$450.00
FUNNEL	PLASTIC, ALL-PURPOSE, ASSORTED SIZES	NA	6	90	\$1.00	\$90.00
TEASPOON	STAINLESS STEEL	NA	24	360	\$0.50	\$180.00
BOTTLE	PLASTIC, SCREW CAP, ROUND, 1 LITER	NA	48	720	\$1.00	\$720.00
STEP	WOODEN BLOCK FOR OB/GYN TABLE	NA	1	15	\$23.00	\$345.00
WASH BASIN	PLASTIC	NA	8	120	\$11.00	\$1,320.00
TAPE MEASURE	PLASTIC, 1.5 METER	NA	6	90	\$1.00	\$90.00
STOVE	BUTANE GAS, TWO BURNERS	NA	1	15	\$175.00	\$2,625.00
BUTANE GAS BOTTLE	BOTTLE WITH CONNECTOR	NA	2	30	\$60.00	\$1,800.00
STERILIZING POT	ALUMINUM, LARGE, HEAVY DUTY	NA	4	60	\$23.00	\$1,380.00
BRUSHES	VARIOUS SIZES FOR CLEANING	NA	12	180	\$6.00	\$1,080.00
BROOM	LONG HANDLE STRAW	NA	6	90	\$11.00	\$990.00
BUCKETS	PLASTIC FOR CLEANING	NA	5	75	\$6.00	\$450.00
SHELVES	SHELVES FOR KOULIKORO WAREHOUSE	NA	1	1	\$685.00	\$685.00
CARDS, IMMUNIZ/GROWTH MONITOR	FOR ABOUT 100,000 CHILDREN	NA				\$8,000.00
						\$38,512.50

TABLE 13: SPECIFICATIONS AND COST ESTIMATES FOR EQUIPMENT SETS
FOR 11 MATERNITIES
LOCAL PURCHASE

ITEM	SPECIFICATIONS	REFERENCE	NUMBER PER CENTER	NUMBER FOR 15 CENTERS	COST PER UNIT	TOTAL COST FOR 15 CENTERS
BENCH	WOODEN, 1' X 8'	INA	4	44	\$35.00	\$1,540.00
TABLE	WOODEN, 4' X 6'	INA	1	11	\$85.00	\$935.00
CHAIR	METAL, STRAIGHT BACK	INA	2	22	\$17.00	\$374.00
BEDS	METAL FRAME	INA	12	132	\$125.00	\$16,500.00
MATTRESS	LOCAL WITH PLASTIC COVER	INA	12	132	\$55.00	\$7,260.00
AIR CONDITIONERS	220 V, THROUGH WALL UNIT	INA	2	30	\$65.00	\$19,030.00
						\$45,639.00

Table 14

BUDGET FOR CONTRACEPTIVES: PUBLIC SECTOR AND SOCIAL MARKETING PILOT

YEAR	# PILL CYCLES	COST PILLS	# IUDS	COST IUDS	#PACKS FOAM	COST FOAM	# CONDOMS	COST CONDOMS	TOTAL COST
2	96.154	\$12,500	1,289	\$1,199	3,349	\$3,818	120,576	\$4,823	\$22,340
3	116.315	\$15,121	1,320	\$1,228	4,052	\$4,619	559,008	\$22,360	\$43,328
4	138,286	\$17,977	1,438	\$1,337	4,817	\$5,491	1,033,850	\$41,354	\$66,160
5	162,763	\$21,159	1,602	\$1,490	5,670	\$6,464	1,570,265	\$62,811	\$91,923
6	189,988	\$24,698	1,782	\$1,657	6,618	\$7,545	2,176,712	\$87,068	\$120,969

PROJECT TOTAL..... \$322,380

Note: 1/ Pill cycles, number of IUDs, and number of packs of foam required are from Table 15 with 20% added for inventory management and contingencies.

2/ Pill cycles estimated to cost \$0.13/cycle in 1985.

3/ IUDs estimated to cost \$0.93/ IUD in 1985.

4/ Pack of foaming tablets estimated to cost \$1.14/pack in 1985.

5/ Number of condoms required from Tables 5 and 6 with 20% added for inventory management and contingencies.

6/ Condoms estimated to cost \$0.04/condom in 1985.

Table 15

CONTRACEPTIVE REQUIREMENTS: PUBLIC SECTOR PROGRAM

YEAR	WRA	CFR	CONTRCPT USERS	PILL USERS	PILL CYCLES	IUD USERS	#IUDs	SECNDRY	#PACKS FOAM	#CONDOMS
								METHOD USERS		
2	174,444	0.08	13,956	7,396	96,154	5,722	1,299	837	3,349	120,576
3	187,574	0.09	16,882	8,947	116,315	6,921	1,320	1,013	4,052	145,858
4	200,705	0.10	20,071	10,637	138,296	8,229	1,438	1,204	4,817	173,409
5	214,755	0.11	23,623	12,520	162,763	9,685	1,602	1,417	5,670	204,103
6	229,787	0.12	27,574	14,614	189,988	11,306	1,782	1,654	6,618	238,243

- Note: 1/ WRA = Women of reproductive age. Estimated to equal 21% of the target population and increasing at 7% per annum.
- 2/ CFR = Contraceptive prevalence rate. Using available statistics and expert opinion, the urban CFR was estimated to have equalled 5 percent in 1984. For purposes of estimating project contraceptive requirements, it was assumed that the urban CFR would increase by 1 percent per annum over the period 1984 to 1991.
- 3/ Contraceptive users = Product of WRA and CFR.
- 4/ Contraceptive users were assumed to use a particular contraceptive method according to the following percentages:
- | | |
|------------------|-----|
| Pill | 53% |
| IUD | 41% |
| Secondary Method | 6% |
- Source: IFRP (1981) Mali: Analyse des Donnees de Service de l'Association Malienne pour la Protection et la Promotion de la Famille, p. 33.
- 5/ Pill users were assumed to use 13 cycles per year. Secondary method users were assumed to use 4 packs of foam tab. per year and 144 condoms. Source: DHHS (June 1985) Logistic Guidelines for Family Planning Programs, Atlanta: CDC, p. 47.
- 6/ IUDs were estimated to equal the difference in IUD users each year plus 10% of this number for expulsions and reinsertions.

Table 16

CONTRACEPTIVE REQUIREMENTS: SOCIAL MARKETING PILOT PROGRAM

YEAR	MRA	CFR	CONTRCPT USERS	CONDOMS
3	222,210	0.01	2,222	319,982
4	238,935	0.02	4,779	688,133
5	255,660	0.03	7,670	1,104,451
6	273,556	0.04	10,942	1,575,684

- Note: 1/ According to the Implementation Plan, the Social Marketing Study will occur in Year 1 of the project. Assuming the set-up for the pilot project requires one year, distribution of contraceptives through the private sector would start in Year 3 (1988).
- 2/ MRA = Men of reproductive age. Estimated to equal 25% of the target population and increasing at 7% per annum.
- 3/ CFR = Contraceptive prevalence rate for males. It is assumed that men will be the primary consumers of contraceptives through the private sector. For the purposes of this Project Paper it has been arbitrarily decided that male CFR would equal 1 percent in the first year of CSM pilot increase by 1 percent per annum.
- 4/ Users of contraceptives distributed through the private sector were assumed to use 144 condoms/year. Source: DHHS (June 1985) Logistic Guidelines for Family Planning Programs, Atlanta: CDC. p. 47.

Table 17

VACCINES AND EXPENDABLES BUDGET

NAME VACCINE, DOSES & COST	YEAR 3	YEAR 4	YEAR 5	YEAR 6
DPT				
Doses (000): BAMAKO	83.5	85.7	88.0	90.5
KOULIKORO	123.4	127.5	130.3	133.7
Cost	\$6,206	\$6,396	\$6,548	\$6,727
FOLIO				
Doses (000): BAMAKO	83.5	85.7	88.0	90.5
KOULIKORO	123.4	127.5	130.3	133.7
Cost	\$5,793	\$5,970	\$6,112	\$6,278
MEASLES				
Doses (000): BAMAKO	27.8	28.5	29.3	30.1
KOULIKORO	41.1	42.5	43.4	44.5
Cost	\$6,889	\$7,100	\$7,269	\$7,467
TETANUS TOXOID				
Doses (000): BAMAKO	55.7	57.2	58.7	60.3
KOULIKORO	82.4	84.6	86.9	89.2
Cost	\$3,451	\$3,545	\$3,639	\$3,737
NEEDLES				
Number (000): BAMAKO	25.1	25.7	26.4	27.1
KOULIKORO	37.0	38.2	39.1	40.1
Cost	\$1,862	\$1,918	\$1,964	\$2,018
SYRINGES				
Number (000): BAMAKO	2.5	2.6	2.6	2.7
KOULIKORO	3.7	3.8	3.9	4.0
Cost	\$5,214	\$5,369	\$5,500	\$5,650
TOTAL COST	\$29,415	\$30,297	\$31,032	\$31,876
PROJECT TOTAL COST....	\$122,620			

Note: 1/ Formula for calculating vaccine dosage requirements:

= Target population X % Coverage X # Doses Required for Fully Immunized Child + Wastage

where:

- Target population equals 5% of the population under 5 years of age and 5% of the population equal pregnant women in the Bamako District and the cercles of Banamba, Dioila, Kangaba, Kati and Koulikoro regions.
- Coverage is assumed to equal 80%.

- Dosage requirements: DPT and Polio vaccines require 3 doses per child, measles vaccine requires 1 dose/child, and tetanus toxoid requires 2 doses per pregnant woman.
 - Wastage assumed to equal 25% of the vaccine doses required.
- Source: MSF/AS (Juin 1985) Programme Elargi de Vaccination, Programme Nationale Couvrant tout le Territoire de la Republique du Mali, pp. 123-125 and 129-130.

- 2/ Estimated cost per 20 doses DPT = US \$ 0.65/vial.
- 3/ Estimated cost per 20 doses of polio vaccine = US \$ 0.56/vial.
- 4/ Estimated cost per 50 doses of measles vaccine = US \$ 5.00/vial.
- 5/ Estimated cost per 20 doses tetanus toxoid vaccine = US\$ 0.50/vial.
- 6/ Estimated that one reusable needle would be required per 10 doses.
- 7/ Estimated cost per 12 needles = US \$ 0.36.
- 8/ Estimated one reusable nylon syringe required per 100 doses.
- 9/ Estimated cost per syringe = US \$ 0.85.

Table 18

INTEGRATED FAMILY HEALTH SERVICES PROJECT (688-0227)
RENOVATION AND CONSTRUCTION ACTIVITIES

SITES	DOORS AND WINDOWS	ELECTRICITY PLUMBING	ROOF AND CEILING	FLOOR & PLASTER	PAINTING	COST FCFA	EXTENSION AREA COST/M sq	TOTAL FCFA
A. KOULIKORD								
--Warehouse	1 door 2X2.5m 1 window 1.2X1.3m	2 new light fixtures 1.2X2m	replace the roof 12X7.5m overhang 2X3m	concrete floor	Painting inside and outside	1,950,900		1,950,900
--MCH/FP Clinic	7 new doors & windows 6X2m	check plumbing toilet repair septic tank	repair roof	floor repairs	Painting inside and outside	1,600,000		1,600,000
--Maternity	6 doors and 4 windows to be changed	septic system repair wash- basin and sink	wood ceiling to be installed	floor repairs	Painting inside and outside	2,400,000		2,400,000
B. HAMDALLAYE								
--MCH/FP Clinic	All doors and windows to be changed	ventilator new lines exterior toilets. Air conditioner	roof repair ceiling repair	floor repair tile repair	Painting inside and outside	14,000,000	Extension for waiting area including new roof	14,000,000
C. DJIKORDNI								
--Maternity	25x10m Renovation and	new construction of dispensary and reorganization of space				ASE firm 10,000,000	Construction of new dispensary 30,000,000FCFA for 120m sq	40,000,000

D. KOROFINA	:Replacement/ :repair of doors & windows	:Checking & :repairing elec- :tric system.	:Repair or :replace water :pump. Clean :watertank & :general plumb- :ing and heater :problems	:	:	:Painting :inside and :outside	: 8,000,000	:	: 8,000,000
--Maternity MCH/FP Clinic	:	:	:	:	:	:	:	:	:

E. DSF	:	:	:	:	:	:	:	:Construction of :two rooms : 4XB=32m sq e : 250,000 FCFA :per m sq	: 8,000,000
A&E to design	:	:	:	:	:	:	:	:	:

F. KATI	:	:	:	:	:	:	:	:	:
--MCH/FP Clinic	:Some doors & :windows to be :repaired	:Repair :exterior :toilets	:Small repair :on roof	:Garden :flagstone :installed	:Some :painting	:	: 600,000	:	: 600,000
--Maternity	:	:Electrical :work & :toilet repairs	:	:	:Painting :inside and :outside	:	: 450,000	:Extension of 2 :rooms: : 11X4m=44m sq : 44m sq X :250,000FCFA/m sq	: 450,000 : 11,000,000

G. AMPPF	:	:	:	:	:	:	:	:MAIN BLDG. : 280X2=560m sq : 560m sq X :250,000FCFA/m sq	: 140,000,000
Building of double story building, and perimeter wall; also guard house, storage room & exterior toilets	:	:	:	:	:	:	:	:180m X :20,000FCFA/m	: 3,600,000
:	:	:	:	:	:	:	:	:Hangar, guard :house & :exterior :toilets	: 13,350,000

ENGINEERING ANALYSIS

1. Engineering Requirements and Scope of Work:

The engineering aspects of this project deal with layout, construction and renovation of Maternité, PMI and ancillary structures.

2. Engineering Philosophy and Approach to Construction:

With function as the paramount objective and in order to minimize design time, overall cost, supervision requirements and procurement problems, a standardized modular approach will be taken which lends itself to replicability and allows flexibility in site adaptation. Site preparation will be minimal providing for adequate drainage and preserving the natural landscape (trees) as much as possible. Foundation excavation will be kept to a minimum utilizing manual labor. The skills and materials (masonry block and reinforced concrete) are generally available throughout the country. Prices of materials in the Kangaba, Kiola, Banamba area will probably be slightly higher than Bamako due to the additional cost of transportation.

The following concepts will be incorporated as standards for construction:

- a. All buildings will be single story except AMPPF building which will be two stories.
- b. Standard steel trusses and or steel I beams (depending on span length) will be used on the office building and ancillary structures.
- c. Standard reinforced concrete floor slab, column and perimeter beam design will be used on all buildings.
- d. Standard reinforced concrete roof slabs will be used on AMPPF building.
- e. Standard corrugated galvanized sheet metal roofing will be used on the roofs of the office building and ancillary buildings.
- f. Standard reinforced concrete framing masonry core block will be used on perimeter walls and interior load bearing walls.
- g. Non load bearing interior curtain walls will use 10 cm masonry core block.
- h. Standard floor finish will be vinyl tile.

i. Standardized plumbing and electrical fixtures will be used to the extent possible.

3. Considerations for all Sites:

Positive drainage from building sites will be established to assure access under the maximum rainfall conditions of record. Sufficient floor slab elevations shall be established above surrounding terrain and proper grading to assure adequate run off and drainage away from the building sites.

All inside painting will be oil base paint to 2 level of 1.50m for protection and ease of washing.

Outside painting will be in "FOM"

4. Method of Contracting:

All project construction will be contracted through the AID Direct contracting method. A private A & E firm will be selected and hired to develop architectural designs, cost estimates and bid documents. The A & E will also do the supervision of the construction. An AID direct contract will be used with the A & E. All bid documents will be approved by USAID.

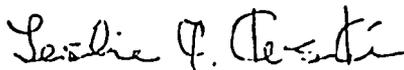
5. USAID Support Capacity:

USAID Engineering Office will provide guidance to the A & E firm to ensure that construction planning and approval process are in conformity with AID regulations. Also, USAID will review and approve the construction plans, cost estimates and bid documents. The present engineering staff of USAID consisting of two FSN engineers and an USDH engineer will be able to provide the required engineering back up services, e.g. review and approve plans, cost estimates and bid documents; approve progress payments and payments for work supervision.

6. 611 (a) Certification:

I have reviewed the preliminary plans and specifications for the construction to be carried out under the project.

I have further reviewed the cost estimates based on these plans and specifications. It is my opinion that the cost estimates presented in project paper reasonably reflect actual construction costs in Mali. All detailed plans and drawings will be prepared and reviewed by USAID.



Leslie Koski
GDO Engineer

LIST OF FOUR DIFFERENT A & E FIRMS

1. Mr. Amadou Diadié TOURE
Atelier d'Architecture et d'Aménagement

BP. 2037 - Tel. 22-62-16,
Bamako.

2. Mr. Daba Cisse
Bureau d'Etudes d'Architecture et d'Urbanisme

(BEAU) - Tel. 22-46-62,
Bamako.

3. Mr. Lassama Sandiakou SISSOKO
Cabinet d'Architecture

BP. 405,
Bamako.

4. Gaoussou Abdoul Gadre Konaté, Adama SANGARE
Cadet Architecture - Etudes techniques - Expertise bâtiments

BP. 317,
Bamako.

memorandum

DATE: January 9/ 1986

REPLY TO
ATTN OF: Hamidou Kebe, GDO/ENGR *M. Kebe*
THRU: RHuddleston, GDO/Officer
SUBJECT: IFAHS Project No.688-0227 - AMPPF Building Location Visit

TO: Francisco Zamora, GDO/H.S

On December 20, 1985 the Engineering Officer Mr. Leslie C. Koski and I, visited the AMPPF building location. The location is situated in Quolofobougou Bamako and is limited by the railway on the North side. The soil seems to be a combination of laterite and clay.

Electricity and water conveying is available. Because of the neighbourhood of Lido road and in order to assure a good foundation steadiness and a good functioning AID Engineers request following observations to be considered by A&E designer.

1. Two portals (entrance and exit)
2. Two parkings (office staff and visitors)
3. Foundation holes with 60cm depth
4. Foundation concrete beam
5. A distance of 20m between the office fence and the railway.

If an adequate septic system is realized, this location will be well-indicated and without any negative consequence on the environment.

IX.K. COMMODITY PROCUREMENT PLAN

Annex IX.K. COMMODITY PROCUREMENT PLAN

1. Responsibilities

a. The implementing agency for this project will be the DNSP. Host country contracting for project commodities is not anticipated.

b. USAID/Mali: The Mission project officer is responsible for initiating procurement actions in coordination with the Project Team. Contracting for project commodities and services (including contracting for a PSA) will be initiated by USAID/Mali. In most instances, when contract costs exceed the Mission's contracting authority, contracting will be completed by REDSU/WCA or AID/W. Procurement of project commodities and technical services for this project will be AID-direct contracting and will therefore be carried out in accordance with the AID Acquisition Regulation (AIDAR) which became effective in April, 1984.

Other smaller actions, such as procurement of short-term technical services and PSCs, will be done by the USAID.

2. Commodity Procurement

a. It is envisioned that procurement of commodities will be undertaken using one of the following four methods:

1. Some of the proposed project commodities will be procured using AID-direct contracting procedures. However, project commodities currently planned for procurement directly by USAID/Mali are limited to project vehicles and possibly some shelf-item procurement. This reduced involvement by USAID in carrying out the actual procurement is intended to minimize the administrative burden to USAID/Mali and to the Project Team.

Procurement will be in accordance with the AID Acquisition Regulation (AIDAR), AID Handbook 14. In instances in which a contract will exceed the contracting authority of USAID/Mali, the contract will be executed by AID/W or REDSU/WCA. For small value procurement under \$25,000, purchase orders will be used. For commodity procurements in excess of the small value limitation, full and open competition will be required unless other than full and open competition has been authorized in

accordance with the criteria set forth in the AIDAR. Procurement of computer equipment of less than \$100,000 does not need SER/IRM approval.

2. A second method of procurement will be to utilize a procurement services agent (PSA). AID/W currently has eight PSAs contracted as ITCs. A worksheet P10/C detailing the commodities required, item costs, insurance and freight, estimated PSA fee, estimated banking charges, and other specific instructions will be prepared and sent to AID/W, M/SER/COM, for processing and issuance of a work order to one of the ITCs. If a specific ITC firm is required, this should be specified in the worksheet P10/C. Equipment to be procured by the PSA has been identified and includes all medical equipment which will be procured from the U.S. for the 15 MCH/FP complexes.

The PSA will be responsible for procurement, freight forwarding, consolidating procurements, shipping, insurance and follow-up reports. Once AID/W has issued the work order to the selected ITC, financing documents will be established to include 1) a Mission issued direct letter of commitment with the PSA for the PSA fee only and 2) a bank letter of commitment with the PSA as approved applicant (issued by FM, AID/W), to finance the commodities, insurance and freight.

3. A third method of procurement will be to process orders through AID/W. This applies to contraceptives and vaccines required for this project. In the case of contraceptives, a worksheet P10/C is prepared and sent to S&T/Population. In addition, yearly contraceptive requirements for the project are to be sent to S&T/Population in accordance with HB15. Vaccines are procured by sending worksheet P10/Cs to M/SER/COM which will then initiate procurement action.

4. A final method of procurement will be the procurement of local purchases by the Project Team. This will consist primarily of locally available furniture for offices and the 15 health complexes.

b. Regardless of the method of procurement utilized, procurement actions will be initiated as soon as possible following the signing of the Project Grant Agreement and the meeting of the conditions precedent. A schedule of commodity procurement requirements is incorporated into the detailed implementation plan contained in this project paper. The project officer also can call upon the services of the Regional Commodity Management Office,

REDSO/WCA, to assist in implementing the procurement process. Procurement rules and regulations concerning competition, source and origin, shipping, insurance and marking requirements will be observed in conformance with AID Handbooks.

3. Commodity Eligibility

All commodities intended for procurement as part of the project are eligible for AID financing and will be procured only from AID Geographic Code 941 plus host country except for items designated for shelf-item procurement (extended to code 935 countries) or which have an approved source/origin waiver.

4. Transportation and Insurance

Commodities will be procured on a CIF Bamako basis. Commodities will be shipped on U.S. flag carriers unless a transportation waiver has been approved. While most commodities will be delivered by sea shipment, some essential and smaller items may be shipped by air if appropriate (i.e., vaccines, computer). Marine Insurance will be placed in AID Geographic Code 000 (U.S. only).

5. Delivery Schedule

The schedule for delivery of commodities has been integrated into the implementation schedule. Due to the sometimes irregular schedule of U.S. flag carriers to Dakar, additional time has been allowed for shipping delays and inland transportation to Bamako. The PSA contractor will be informed of delivery requirements in the PIO/C.

6. Shelf-Item Procurement

The project will utilize approximately \$433,600 for local cost procurement, primarily for office equipment and supplies for the 15 health Complexes. Procurement using the shelf-item rules will be in accordance with Handbook 1, Suppl B, Chapter 18. Since most of these items will be locally-produced and less than \$250,000 will be spent on shelf-items a waiver will not be required.

Prices paid for locally procured commodities will be no more than the lowest available competitive prices and purchases will be in accordance with good commercial practices.

Commodities on the local market that are imported from non-Free World Countries are not eligible for AID financing. Invoices for payment should state the source and origin of locally purchased materials if practicable. Vehicles are not considered items under the shelf-item rule but POL and construction materials are if obtainable with local cost financing.

7. Waivers

A waiver already approved by the AA/AFR was necessary for the procurement of vehicles since the total value was over \$50,000. The justification for procurement of the vehicles is that there is no service or maintenance support in Mali for U.S. manufactured vehicles.

IX.L. CENTRALLY AND REGIONALLY FUNDED RESOURCES

ANNEX IX.L. CENTRALLY AND REGIONALLY FUNDED RESOURCES AVAILABLE OR COMPLEMENTARY TO THE MALI INTEGRATED FAMILY HEALTH SERVICES PROJECT.

CENTRALLY FUNDED RESOURCES AVAILABLE TO THIS PROJECT.

Technical expertise and resources required to design, implement, and evaluate components of the Mali Integrated Family Health Project are available through the wide array of AID's centrally funded projects. Any cooperating agency funded by the central AID/W mechanism generally has predominate capability in a specific technical area (e.g. it has assembled technical experts, has worldwide experiences in project design and implementation, and has a proven track record).

This project can draw on centrally funded resources through two mechanisms:

1) The bilateral project can request that a centrally funded cooperating agency perform a specific task, and the cost for that activity be covered by central funds. To use this mechanism, the activity requested by the bilateral project must be within the scope and mandate of the centrally funded contract/cooperative agreement, and must be considered one of the envisioned outputs of the contract/cooperative agreement. The specific task to be performed must mutually satisfy the requirements of the bilateral project and the cooperating agency.

2) The bilateral project also can "buy-in" to a centrally-funded contract/cooperative agreement for a specific scope of work. This scope of work must fall within the overall mandate of the centrally-funded cooperating agency. A "buy-in", then, is basically an amendment to an AID/W (i.e. centrally funded) contract or cooperative agreement for which the bilateral project provides funding for a supplementary activity. The advantages of a buy-in are as follows: a) the mission controls the parameters of the scope of work; b) the mission can have the activity implemented quickly because the centrally-funded contract/cooperative agreement has already been competed; and c) the mission can buy-in to an agency which has predominate capability, which gives advance assurance of the agency's level of expertise and previous accomplishments.

In addition, a buy-in can be cost-effective: overhead costs are generally less expensive, and often the cooperating agency will contribute from its corecosts additional technical assistance as well as other financial or support services. Most centrally funded contract/cooperative agreements now have a life of project funding ceiling which accommodate 25-40 percent for bilateral buy-ins.

While there are many resources upon which this project can

draw, the following is an illustrative list of potential resources identified as appropriate for contributing to this project's activities. This list of potential resources focuses on those agencies which have had previous working experience in Mali or those agencies which are directly involved in technical areas related to this project's activities, namely, service delivery, training, information/education/communication, and special studies.

Centers for Disease Control (CDC)

CDC provides technical assistance in the development, management, and evaluation of MCH/FP programs. Specific CDC activities include: 1) evaluation of contraceptive distribution systems; 2) development and/or improvement of management information and logistic systems; 3) workshops for LDC personnel involved in program management and evaluation systems, including maintenance of service statistics and contraceptive commodity control and distribution systems; 4) design and implementation of patient flow analysis models; 5) contraceptive requirement analysis; 6) evaluation of completeness and quality of data systems; and, 7) studies concerning the health and demographic impact of family planning activities. In 1981, CDC conducted an evaluation of MCH/FP services in both MSF/AS and AMPPF facilities.

Family Health International (FHI)

FHI is a research oriented organization. FHI purpose is to test, assess, and improve fertility regulation technologies and to disseminate information on their respective safety, effectiveness and acceptability. FHI, in collaboration with host country institutions: 1) conducts clinical trials on safety and efficacy of various methods under local conditions; 2) trains overseas clinicians and researchers in relevant reproductive health technologies and/or research methodologies; 3) evaluates factors related to the availability and accessibility of reproductive health services; 4) assesses impact of MCH/FP modalities and delivery systems; 5) conducts epidemiological studies of family planning methods; and, 6) disseminates data findings through publications, seminars, workshops and conferences.

FHI has conducted several surveys in Mali including on analysis of patient records at AMPPF and MSF/AS facilities to determine the demographic profile of contraceptive users (e.g. age, parity, education, reproductive history) as well as contraceptive preferences. FHI is currently assisting AMPPF in developing a recording system to enhance overall data collection on clinic users.

Futures Group, Social Marketing Project (SOMAR)

SOMAR's purpose is to increase the availability, knowledge about, and correct use of contraceptives among eligible couples in LDCs. Its strategy is to use commercial marketing, and promotional and distribution techniques to deliver affordable contraceptives and to inform potential users about its products and their correct use. SOMAR's functions include providing technical and financial assistance to design and implement new social marketing programs for CDCs; providing technical assistance to ongoing programs; conducting special studies to improve the implementation and/or expansion social marketing activities; and training personnel as needed for social marketing efforts.

Georgetown University, National Family Planning Project

The purpose of this Georgetown program is to improve knowledge, availability, acceptability, and effectiveness of natural family planning (NFP). To achieve this purpose, Georgetown conducts biomedical, operations and social science research; and provides technical assistance in the development and implementation of NFP training, IEC, and service delivery activities. Georgetown also sponsors special seminars and workshops on NFP.

Association for Voluntary Surgical Contraception (AVSC)

AVSC's purpose is to make high quality voluntary surgical contraceptive (VSC) services available as a component in health and family planning services. AVS provides technical and financial assistance: to ensure quality control and high medical standards in VSC service delivery; to support information and counselling to guarantee voluntary participation; to train qualified personnel to perform VSC services; and, to make available necessary equipment and facilities to support surgical services.

AVSC has already been involved in Mali. It has trained personnel, equipped, facilities, and provided technical support for development of surgical units at Gabriel Touré Hospital and Hamdallye maternity. AVSC is expected to continue its support for these activities. Under this project, AVSC will participate in the development of outpatient VSC services, specifically minilaparotomy under local anesthesia, at the AMPPF facility.

Johns Hopkins University - Population Communication Services (PCS)

PCS's purpose is to develop effective information, education, and communication (IEC) programs to support population/family planning efforts. PCS provides technical and

financial assistance in : 1) identification of IEC needs for family planning programs; 2) market and audience surveys; 3) design, implementation and assessment of IEC activities; and, 4) design and publication of IEC support materials.

FCS has already worked closely with AMPPF in developing a small scale project to create an awareness of the benefits of family planning, and to increase the practice of family planning methods. FCS/AMPPF have approached this task by developing IEC strategies to enhance patient education and community education. In addition, FCS/AMPPF have developed a plan of action for mass media activities which should be implemented in 1986.

Johns Hopkins University - Program for International Education in Gynecology and Obstetrics (JHPIEGO)

JHPIEGO trains physicians and nurses in reproductive health. JHPIEGO develops in-country training capability and also provides standard courses in Baltimore or in third-country (e.g. Tunisia, Morocco, and Zaire). JHPIEGO has various courses which deal with subjects such as maternal and infant care, high risk pregnancy, infertility, sexually transmitted diseases, voluntary surgical contraception, and basic reproductive health issues. JHPIEGO also works to incorporate reproductive health issues into medical and nursing school curriculums. Over the past five years, 12 malian physicians and nurses have been trained under the auspices of JHPIEGO.

Management Sciences for Health, Transfer of Primary Health Technologies (PRITECH) Project

PRITECH provides short-term consulting services as well as financial assistance with the primary aim of technology transfer in the areas related to nutrition, immunization, and oral rehydration. The project focus on technological issues related to service delivery (e.g., development of cold chain structures, production of oral rehydration salts). PRITECH also assists LDC governments in developing national plans and strategies for primary health care services. In Mali, PRITECH is providing assistance to the MSP/AS for a national plan for oral rehydration services and is investigating the possibility of in-country production of oral rehydration salts. PRITECH has a technical consultant in residence in Mali.

University of Michigan, University Overseas Service Program

Through internships, the University of Michigan provides technical assistance to LDC MCH/FP programs while concurrently providing overseas experience to recent university graduates or

mid-career professionals in health and population related fields. Interns are selected on the basis of skills identified as relevant to LDC program needs and are recruited to serve 18-24 months in the overseas program. Priority is given to AID-supported projects in Africa.

University of North Carolina. Program for International Training in Health (INTRAH)

The purpose of INTRAH is to strengthen or develop the capacity of LDC institutions to design, implement, and evaluate MCH/FP training programs. INTRAH's primary focus is in developing management and clinical skills for nurse/midwives, as well as developing service skills of paramedical, auxiliary, and community level workers. Specifically, INTRAH provides technical assistance; to strengthen LDC training institution capability; to fill needs for specific technical expertise for on-going programs; and, to conduct training programs and incorporate findings into subsequent course curriculums.

To date, INTRAH has been the most visible cooperating agency in Mali. INTRAH has assisted in the training of over 300 nurse/midwives and auxiliary personnel. It is expected that INTRAH will continue to be involved in Mali and will provide technical assistance in the development of project training activities. In early 1985, INTRAH will open an office in Abidjan, the Ivory Coast, to serve West Africa and will be available to provide timely services to Mali.

University Research Corporations. Primary Care Operations Research Project (PRICOR)

PRICOR's purpose is to improve, through operations research, the quality, accessibility, and cost-effectiveness of primary health care programs. PRICOR provides short - and long - term technical assistance for the design, implementation, and evaluation (which is emphasized) of preventive health services. PRICOR focuses on primary care measures (e.g., oral rehydration, immunization, and anti-parasitic drugs for young children) as well as prenatal, maternity, and postpartum care for women. PRICOR has had several major projects which have investigated cost-recovery and financial self-sufficiency of preventive health care service programs.

REGIONAL AND CENTRALLY FUNDED PROJECTS COMPLEMENTARY TO THE PROJECT

The following are current on-going centrally or regionally funded efforts which are not directly related to this project,

but are indeed complementary.

Health and Demographic Survey of Mali

Under the auspices of the Sahel Population Initiatives Project, Sahel Institute, (INSAH) in collaboration with Westinghouse Public Applied Systems, Demographic and Health Surveys (DHS) Project, will conduct a national population and health survey in Mali. Preparatory work has already begun. Field work will take place in the fall of 1986, and final data analysis and report are scheduled for fall, 1987, availability.

The national survey will provide information to plan health and population programs and to better understand the relationship between social and psychological factors and childbearing and fertility regulation. Moreover, this survey will provide estimates of fertility, contraceptive prevalence, infant and child mortality, health status of young children (under age 3), patterns of diarrhea treatment, immunization coverage, and levels of contraceptive knowledge, attitudes, and practices. The survey will also include men, and therefore will yield information on husbands' knowledge, attitudes and preferences regarding family planning.

This survey will cover 90% of the population of Mali (nomads are excluded) including: a representative rural and urban sample of 3500 women aged 15-49; a subsample of 1000 men married to or the partner of the interviewed women; and, a subsample of 1000 children under age 3 for height and weight measurement.

Because this survey is expected to be completed in late 1987, it should provide useful planning data to the Mali Integrated Family Health Project. However, it should be noted that, because the survey sample will be small in the project area, survey participants cannot be linked to project participants. Thus unfortunately, this data will not be useful as baseline data to measure project impact, and the bilateral project will have to undertake its own efforts for this purpose.

REVIEW OF POLICIES, LAWS AND REGULATIONS RELATED TO POPULATION, FAMILY LIFE, AND STATUS OF WOMEN in the Sahel

The Sahel Institute, with funding from and in collaboration with Columbia University's Development Law and Policy Program, will conduct a regional project to review the governmental policies, laws, and regulations affecting population, family life, and status of women in the Sahel. This review will be conducted in four Sahelian countries: Mali, Burkina Faso, Senegal, and, Niger.

The review will cover official policies, laws and

regulations as well as traditional and religious laws and rules. The subjects related to family planning to be reviewed include: the legality of the various fertility regulation measures; regulations affecting the import, advertising and sale of contraceptives; the legal requirements for prescription or disbursement of services and who has the legal right to provide services. In addition, the legal review will look into the various legal aspects of family life practices, particularly as they relate to the status of women (including legal rights in divorce, inheritance, work, ownership of property and material goods).

This policy and legal review will begin in early 1986 and the final report is expected by early to mid-1987. Since this review will cover official policies, laws, and regulations in Mali, the information gained should be useful in this project's program planning and complementation processes.

ST/POP: Contraceptive Procurement Program

In 1983, ST/POP developed a central procurement system from which the purchases of contraceptives can be made. Before the development of the central system, each centrally funded or bilateral project was required to purchase needed contraceptives on an ad hoc basis. Now, all contraceptive needs are consolidated into a single yearly purchase which has resulted in significant cost reduction of all products purchased. Currently the central procurement system provides for the purchase of standard and low-dose oral contraceptives, a progestin-only pill, condoms, Copper T IUDs, and vaginal foaming tablets. Current procedure calls for funds for bilateral programs to be transferred to ST/POP's budget allowance.

IX.M. PROJECT ANALYSES

ANNEX IX.M.1. TECHNICAL FEASIBILITY ANALYSIS

For each of the activities to be undertaken by this project, the chosen technologies have records of effectiveness and appropriateness in contexts similar to that of the project zone.

Nutritional Surveillance

Nutritional Surveillance using growth monitoring charts is a simple technology which many health workers have learned and illiterate mothers have understood elsewhere in Africa. The most significant constraint is motivating mothers to participate. In some African countries supplementary foods are provided as an incentive to participate in well-child clinics. This will not be done under this project, primarily because experience has shown that a feeding program misdirects incentive. If such a program is used as the incentive to attend well-child clinics, the incentive disappears when food is no longer available. The importance of nutritionally balanced home feeding is poorly learned or practiced. A nutritional surveillance program is much stronger when based on the more compelling health benefits. Another reason for not including a feeding program is the expense and the impossibility of its continuation after the project.

Vaccination

The vaccines provided through this project (measles, diphtheria, whooping cough, tetanus, and polio--and tetanus toxoid for pregnant women) have world-wide proven effectiveness. In a geographic area the size of the project zone there should be less difficulty in maintaining the cold chain i.e., maintaining vaccine cold and viable. To assure a working cold chain down to the MCH/FP Complex level, this project is providing a refrigerator for each Complex. The availability of vaccination services should be attractive to the project zone population in light of the devastating effects of recent outbreaks of measles and the observable effectiveness of vaccination in that instance.

Oral Rehydration Therapy

As stated in the Background section herein, ORT has been cited as a "technological breakthrough ... that has proven its potential for cutting diarrhea-related child deaths in half" in developing countries. The technology is relatively simple and unexpensive, and easily applied by both health workers and mothers. Other means of treating diarrhea-related dehydration, such as intravenous perfusions, are more dangerous and costly than ORT.

Voluntary Family Planning

1. Overview

Worldwide experience has shown that substantial health benefits in preventing infant and maternal deaths accrue from voluntary planning and that, indeed, childbearing generally is more hazardous than use of temporary contraceptive methods. The following table is illustrative.

Category of Maternal deaths	Estimated annual deaths per 100,000 women in developing countries	
	Under age 35	Over age 35
Maternal deaths with no contraception	60	160
Deaths from side effects of oral contraceptives among non-smokers	1	23
Deaths among side effects of oral contraceptives among smokers	7	85
Deaths from side effects of IUD	2	4
Deaths from side effects of condoms	0	0

1/ Source: Healthier mothers and children through Family Planning, Population Report, Series J Number 27, June 1985.

Family planning methods have been proven safe and beneficial to health. Complications from the use of temporary contraceptive methods are rare, and usually minor. Serious complications can be prevented or reduced with proper client screening, surveillance, early problem identification and proper management of the complication.

Family planning methods also have been proven effective in preventing unwanted births when used properly. For example: sterilization is 99.6 percent effective in preventing pregnancies; oral contraceptives, 99 percent IUDs, 97.8 percent; condoms, 90 percent; and spermicides, 80-90 percent. Failures (i.e., pregnancy) in use of pills and barrier method are related mostly to improper use.

Experience in developing countries having educational and socio-economic levels similar to that of Mali show that family planning programs are technically feasible. Further, these programs are effective, and acceptable. Sri Lanka, for example, has achieved a contraceptive prevalence rate (percent of women aged 15-49 using a contraceptive method) of 57 percent. Costa Rica, 66 percent; Indonesia, 48 percent; and Tunisia, 31 percent. In Africa, family planning programs have been a recent innovation. Nevertheless, some African countries have achieved impressive contraceptive prevalence rates such as 50.6 percent in Mauritius, 29 percent in Botswana, and 25 percent in Zimbabwe.

Generally, family planning program success depends less on technical feasibility than on the level of official policy support for family planning and the availability of high quality, low cost services. The GRM has demonstrated its support of voluntary family planning, and its request for this project is evidence of this commitment. Facilities and training provided under the project will provide easy access to high quality family planning service for the project zone population.

2. Feasibility of the Family Planning Technologies Being Provided

Three factors are decisive in establishing the feasibility of any family planning technique: availability of adequately trained and supervised service providers; adequate and reliable supply of contraceptive commodities; and, an informed, motivated clientele.

a. Trained service providers

This project trains all physicians and nurse/midwives responsible for direct family planning services in the project zone to assure technical excellence of the services provided. Training subjects will include: counseling and maintenance of client motivation techniques; health benefits and medical risks of each method; client medical screening and evaluation; contraindications of each method and appropriate alternatives;

selection of the appropriate method for each client; provision of the preferred method to each client (e.g., pill distribution, IUD insertion); and, identification and management of complications.

The Project Team and other "trained trainers" will regularly supervise and give on-the-job training to service provider health personnel to identify technical and clinical problems in service delivery and enhance staff proficiency.

b. Adequate, Reliable Contraceptive Supply

Because regular use of expendable contraceptive supplies is essential to the effectiveness of any voluntary family planning program, an adequate, reliable supply is essential. This adequacy and reliability depend on planning, development of efficient distribution systems, and inventory control. This project finances the short term assistance of a Commodity Management Specialist to develop a well organized contraceptive supply, distribution, and storage system which will prevent supply interruptions. This person will work with the Mission's Project Support Unit (PSU) which will be in charge on following up on the implementation of the system by the Project Team. As implementation experience is gained, the Project Team will need to refine the supply mixture projections of 53 percent orals, 41 percent IUDs, and 6% condoms and foam because, a major family planning effort being relatively new to Mali, information for projecting supply needs was limited.

The Commodity Management Specialist also will have to consider the problem of contraceptive deterioration. Some contraceptives are more durable than others, with prolonged storage of IUDs posing the fewest problems. Properly packaged oral contraceptives have proved to be stable and slow to deteriorate, although heat and direct sunlight theoretically increase the risk of deterioration. Barrier methods are less durable under harsh storage conditions. Foams and gels may dissolve in hot and/or humid climates. Rubber products such as condoms eventually deteriorate when exposed to heat and direct light. For optimum life of contraceptive commodities, storage is recommended in dry, ventilated warehouses at temperatures between 15°C and 30°C. This project takes the less than ideal Malian climate into account by renovating the Koulikoro warehouse and constructing sufficient, appropriate contraceptive storage facilities at the DSF office in Bamako. The above-mentioned advisors will collaborate with the Project Team to assure that the closest practical approximation of optimal storage conditions is provided. However, the Malian climate still may adversely affect shelf life, and this possibility will be the subject of regular monitoring.

c. Informed, motivated clientele

Health workers will assure that clients are informed about the variety of family planning methods being provided under this project (pills, IUDs, foaming vaginal tablets, condoms, natural family planning, and voluntary surgical contraception). Each client has familiar preferences and needs and no one method is "perfect". Health workers will assist clients in making an informed, appropriate choice of contraceptive method by stressing safety and effectiveness. Regarding safety, contraindications can mandate the non-use of certain methods. Regarding effectiveness, women for whom another pregnancy presents a life-threatening condition or those firm in their decision for no more children are likely to choose one of the most effective methods.

After a method of family planning has been selected, trained health workers will counsel clients as to proper, consistent use, symptoms of complications, and the necessity to return to the health center for regular monitoring (especially for pill and condoms users). Method specific visual aids and take-home pamphlets will be provided for message reinforcement and motivation enhancing. These informational materials will be in local languages for literate clients (6% of Malian women are estimated to be literate), but most materials will be for nonliterate audiences. Motivational and informational family planning activities at MCH/FP Complexes will be conducted during other NCH/FP services such as prenatal and well-baby clinics to maximize access to the client on this important subject and to maintain motivation of users.

3. Method Specific Considerations

The peculiarities of the various contraceptive methods have been taken into account by this project as follows:

a. Oral Contraceptives

There is a wide range of oral contraceptive formulas available today, but experience has shown that clientele are less confused and family planning programs more effective when the choice is narrowed. All women will start on low dose combined pills (30-35 MCG estrogen) and move up to the "Standard" DMSE if problems are encountered after a 3-month trial.

The combined oral contraceptives are indicated for use by nonpregnant women who desire the most reliable means of reversible contraception. The pill may be started after any menstrual period. It may be started immediately after spontaneous abortion, or in the immediate postpartum period for non-nursing mothers. As many women in Mali nurse their children, oral contraceptives should be deferred for the time they are breastfeeding and another form of contraception should be used.

Generally, the complications resulting from pill use are not

life threatening and easily can be managed with early detection and proper management. The greatest technical disadvantage of the pill is that it requires daily use. If not taken properly, pregnancy can occur. To simplify pill taking the 28 day cycle of pills (instead of the 21 day cycle) will be used in this project. Also, the clients will be advised of the action to take if a pill is missed.

Absolute contraindications to use of oral contraceptives include history of or existing condition of thromboplebtis, thromboembolism, stroke, severe liver disease, cancer of the breast or reproductive system, or pregnancy. Relative contraindications include significant hypertension, severe migraine headache, advanced age, smoking, cervical dysplasia, and diabetes. The majority of these conditions can be identified by adequate medical history taking and physical examination by MCH/FP Complex staff.

As previously indicated under this project, clinic workers, responsible for pill distribution will be trained in medical screening and patient evaluation. The project will provide a medical record form, which will serve as a checklist for screening as well as document medical contraindications. In addition, the project will provide the necessary medical equipment for physical examination and medical monitoring. The project will not provide equipment and supplies for cervical cancer screening and cytology testing because the incidence of cancer is relatively small and, accordingly, this technology is not considered cost effective for the results it will yield.

b. Intrauterine Devices (IUD)

IUD's are safe and effective, have minimal side effects, and require only one insertion for prolonged protection. Their contraceptive effect is not directly related to each act of intercourse, and the contraceptive effect is readily reversible by removal. IUDs are appropriate for any aged woman, and can be used post partum and by lactating women. They are particularly suitable to women who have had several pregnancies and want long-term reversible protection. However, at this time, IUD's are no longer recommended for nulliparas because of the risk of subsequent infertility secondary to the increased incidence of PID and ectopic pregnancy.

Absolute contraindications include known pregnancy, history of known or suspected cervical or uterine malignancy, and acute or chronic pelvic inflammatory infection or sexually transmitted disease. To guard against IUD use in situations in which there are contraindications, this project is providing the necessary equipment to do pelvic examinations. However, laboratory agents to detect sexually transmitted disease are not being funded because these diseases are not always clinically symptomatic in women and, therefore, many cases would be missed.

Under this project the IUD technology being provided is the "Copper T," pursuant to A.I.D. policy effective beginning FY 1986. The advantages of this technology over the most widely used alternative, the "Lippes Loop" are greater effectiveness, longer shelf life, and fewer complications. Project personnel will be trained in insertion and removal of "Copper Ts", and, because the Malian program is new, "untraining" of personnel accustomed to Lippes Loop methodology should be minimal.

c. Foams

Vaginal foaming tablets (as opposed to Emko, other foams, or jellies) are being provided by this project. There are no technical or clinical problems. The only constraints to effectiveness are improper use and insufficient motivation, especially because the husband's cooperation is required.

d. Condoms

Condoms also are being provided. These also pose no technical problems and the major constraints are proper use and motivation. An additional problem could arise in Mali if, as in some other African countries, condoms have the reputation of being used with prostitutes and, therefore, are resisted when husbands attempt condom use with their wives.

e. Voluntary surgical contraception

This project is financing a voluntary surgical contraception/fertility clinic at the AMPPF with assistance from the Association for Voluntary Surgical Contraception (AVSC). The surgical procedure being used is the minilaparotomy which is performed under local anesthesia as an outpatient procedure from which patient routinely recover in 3-5 days. Of all the sterilization procedures, this is the simplest with the fewest complications. It has no more risk than any routine outpatient surgical procedure.

This contraceptive option is particularly suited for women firm in their decision not to have more children, and for those for whom a pregnancy would constitute a life threatening situation, such as those with heart diseases, repeated cesareans, multiparity, and diabetes. It is unsuitable for women with the following absolute contraindications: obesity; rigid pelvic viscera; and, retroverted or retroflexed positions of the uterus, all of which can be identified readily by medical screening and examination. In addition to averting these contraindications, clinic workers also must be trained to evaluate any contraindications to surgery itself, such as anemia, hematoma of wounds, wound access, tears in the mesosalpex, uterine perforation, bladder or bouded injury, and adverse reaction to the local anesthesia.

Life threatening complications are extremely rare if standard precautions are followed, as they will be in this project. Thorough medical screening and examination will be conducted. Physicians and assisting health personnel will be thoroughly trained in performing the procedure and in managing complications, and emergency equipment (such as laparotomy kits, and the like) will be available in the event of surgical accident. AVSC is providing assistance precisely because of its proven track record in minimizing complications, maintaining high standards of quality control, and delivering consistently excellent service. It will provide much of the equipment and all of the personnel training and client information materials.

ANNEX IX.M.2. INSTITUTIONAL ANALYSIS

In reading this Analysis, the reader is referred to the Ministry of Public Health and Social Affairs (MSP/SA) organizational chart at Annex IX.N. As has been previously stated, the DNSP, is the GRM Implementing Agency for this project. This is the entity within the ministry charged with the delivery of health services. Previous A.I.D. experience in implementing health projects has demonstrated that the DNSP has a sufficiently effective organization and adequately trained personnel to serve well as Implementing Agency.

The other GRM entity which will play a key implementation role, the DSF, reports directly to the DNSP and has extensive experience in the technical administration of the national maternal and child health and family planning program. It has three distinct sections which parallel important activities of this project: Maternal and Child Health, Nutrition and Health Education; each staffed with specialists in these fields. The DSF has implemented numerous training activities supported by A.I.D. under the centrally-funded INTRAH project, and also by UNFPA and by other donors. Thus, it has proved its effectiveness as a cooperating entity. Regional offices of public health (Direction Régionale de la Santé Publique), at the same organizational level as the DSF, have extensive experience in carrying out the administrative aspects of the just-mentioned activities and will be called on in Damako district and Koulikoro Region.

The national programs for vaccination (CNI) and diarrheal disease control (CMD) both are new, but there is reason to expect that they have the resources and expertise contribute effectively to project activities. Regarding the CNI, it has long term technical assistance from WHO and support from UNICEF in undertaking some rural relief efforts. CNI currently has adequate, well-functioning central cold storage facilities to meet its needs and to receive the vaccines donated under this project before they are distributed to the MCH/FP Complexes, where project-donated refrigerators will be in place to assure continued vaccine quality.

Regarding the CMD, it is receiving long and short-term technical assistance and financial support from the A.I.D. centrally-funded PRITECH program. With PRITECH assistance and the presence of experienced GRM personnel who served in predecessor entities, it appears CMD is qualified to carry out its project responsibilities.

Other MSP/AS entities which will have a role in this project (DNAS for nutrition and DNPFS for some training coordination) are at the same level as the DNSP, experienced in their specialities, and accustomed to coordinating for implementing efforts similar to those required under this project. The above analysis indicates that Implementing Agency responsibility for this project has been placed low enough to draw on sufficient and

appropriate technical expertise, but high enough to assure managerial competence, and to command resources and personnel from all relevant entities. The private Malian family planning agency participating in this project, the AMPPF, is Mali's most experienced provider of voluntary family planning services accounting for 63 percent of these services in Mali. It was founded in 1971 with the help of the Canadian Research Institute (IDRC). It has become an affiliate of the International Planned Parenthood Federation (IPPF), which continues to provide support. It also is officially recognized by the GRM, which subsidizes a portion of AMPPF salaries. The leadership of the AMPPF is influential. Its Executive Secretary is a former regional governor and its National Coordinator was Chief of the Cabinet of the Ministry of Agriculture.

The AMPPF received and will receive support from USAID centrally funded projects in areas germane to this project. Family Health International (FHI) facilitated AMPPF's carrying out several family planning studies. The Association for Voluntary Sterilization (AVS) provided technical assistance and equipment to facilitate AMPPF's establishment of a voluntary sterilization program at Gabriel Toure hospital, and it will provide similar support under this project. Population Communications Service (PCS) and AMPPF recently signed an agreement to facilitate AMPPF's undertaking IEC activities in the private and public sector. The PCS project will yield valuable data for use by the Integrated Family Health Services Project.

IX.M.3. FINANCIAL ANALYSIS AND RECURRENT COST REVIEW

The purpose of this analysis is to provide an assessment of the Government of the Republic of Mali's (GRM) ability to finance its contribution to the project and post-project recurrent costs. Sections of this analysis are as follows:

1. Summary of information on the Malian macroeconomic situation and its influence on GRM financing of health sector programs.
2. Analysis of trends in GRM and regional government financing for health services.
3. Summary of current MSP/AS policy regarding cost recovery for health services.
4. Estimation of the recurrent costs of the proposed USAID/M project.
5. Discussion of financing for post-project recurrent costs, emphasizing assessment of the feasibility of cost recovery schemes.

Malian Macroeconomic Situation

During the 1970's, the average annual growth rate of Mali's GDP was 4.3 percent per annum. However, with an estimated population growth rate of 2.8 percent, annual per capita GDP growth during the decade was only 1.6 percent. By the late 1970's, a combination of poor economic policies, declining world prices for Malian exports, increasing petroleum prices, and adverse environmental conditions, had pushed the Malian economy into a difficult crisis:

"The central government deficit amounted to one-third of revenue; losses of public enterprises had reached 20 percent of sales; the balance of payments deficit on the current account (excluding official transfers) represented 19 percent of GDP, and the public payroll was often not met on time."

- CDSS, FY'85

During the early 1980's, the GRM has undertaken, with the assistance of multi and bi-lateral donors, a number of economic reform measures including restrictions on public sector hiring and a freeze on public sector salaries. Nevertheless, the ratio of salary to non-salary public expenditures is almost 2 to 1 and the lack of adequate funds for operating expenses, equipments, and materials constrains the functioning of public sector

programs.

Trends in Government Financing for Health Services

The health sector has a relatively small claim on the GRM investment budget. In 1980, only 1.7 percent of government investment was obligated for health investments. By 1985, almost 6 percent of government investment funds were earmarked for the health sector, and were 4 times higher in real terms than in 1981. This level of investment reflects the availability of donor funds for health sector investments, and the problems of allocating sufficient financing for the recurrent costs of health sector activities. Over the same period, the percent of total GRM recurrent expenditure allocated to the health sector declined from 8.6 percent in 1981 to 7.5 percent in 1985, but increased in real terms by 25 percent (see table entitled "Trends in Health and Total Public Expenditure").

Analysis of recurrent health expenditures at the national and regional levels indicates a disproportionate allocation of the budget for salaries as compared to expenditure for other operating expenses (materials/supplies, transport, building maintenance, etc.). Over the period from 1981 to 1985, the proportion of recurrent health expenditure for salaries increased from 69 to 73 percent of total recurrent expenditure (see table entitled "Trends in Allocation of Recurrent Health Expenditure").

Salaries are paid directly by the MSP/AS to health personnel. For other operating expenses, the MSP/AS allocates to each facility a fixed amount for expenses such as for medical supplies, petrol and vehicle maintenance, equipment repair, and miscellaneous administrative and building maintenance supplies. It was reported to the design team that these allocations have been insufficient to cover the full operating costs of MSP/AS facilities, and monies sometimes were not received by facilities on a regular and timely basis. This situation is expected to change with a more streamlined organization, better management of MCH/FP Complexes, and a new and growing emphasis on fees for service and other cost recovery measures.

TRENDS IN HEALTH AND TOTAL PUBLIC EXPENDITURE
1981 - 1985

	1/	1/	2/	Millions FCFA	
	1981	1982	1983	3/ 1984	3/ 1985
INVESTMENT					
Total Government	3,265.2	3,398.6	3,598.8	3,973.4	4,575.4
MSP/AS-current (% of Total)	56.3 1.7%	173.3 5.1%	180.0 5.0%	203.0 5.1%	270.0 5.9%
4/					
MSP/AS - real (% Annual Change)	50.7 -	161.7 218.9%	161.9 20%	176.4 14.5%	255.7 79.3%

RECURRENT

Total Government	39,324.3	41,001.2	44,555.7	46,335.0	53,883.9
MSP/AS & Region Hlth current (% of Total)	3,375.1 8.6%	3,579.6 8.7%	3,710.6 8.3%	3,663.4 7.9%	4,023.0 7.5%
MSP/AS & Region Hlth-real (% Annual Change)	3,040.6 -	3,333.0 9.6%	3,336.9 0%	3,182.8 -4.6%	3,809.7 19.7%

- Notes: 1/ Coppel, Claudine (Fevrier 1984) Etude sur les Charges Recurrentes de Sante, Bamako: UNICEF/Mali, pp. 271 - 275.
Figures given in current million Malian francs. Converted to FCFA at a rate of 2 MF=1 CFA.
- 2/ Direction Nationale du Budget (-) Budget d'Etat, 1984, Recapitulation Generale, Bamako: Ministere des Finances. Figures given in current million Malian francs. Converted to FCFA at a rate of 2 MF=1 FCFA.
- 3/ Direction Nationale du Budget (-) Budget d'Etat, 1985, Recapitulation Generale, Bamako: Ministere des Finances. Figures given in current million FCFA.
- 4/ GDP deflator from IMF internal documents and are equal to: 1981=11.0, 1982=7.1, 1983=11.2, 1984=15.1, 1985=5.6.

MSP/AS Policy Regarding Cost Recovery

The problem of the gap between the recurrent costs of public health programs and available government financing is widely recognized and has been well-documented (see Bibliography). During the past 5 years the GRM has increasingly focused on this problem, through: 1) participation in Sahel regional, and in national seminars on recurrent costs; and, 2) development (with the IMF) of public policy to address imbalances in the allocation of available recurrent budgetary funds. The MSP/AS has been included in this general government-wide debate, and development of policies concerning the participation of the population in financing health services is emerging. For example, drugs are no longer distributed free-of-charge at public facilities. Rather, patients are given a prescription to be filled at the closest PPM outlet. At present, the MSP/AS is also encouraging different projects and regions to experiment with fee collection for other health commodities and services. For example, the EPI program charges 250 to 500 FCFA for a complete series of childhood immunizations. This sum is collected when the child first starts the vaccination series and is given a vaccination card to maintain a record. These revenues are used to defray the cost of kerosene to keep cold chain equipment functioning. In other areas, maternities are collecting 500 FCFA or more for birth delivery services. Although ORS packets currently are distributed free-of-charge, it is envisioned that when the Pharmaceutical Factory produces ORS packets locally, these will be sold through public facilities and PPM outlets for 30 to 40 FCFA per packet. Finally, the MSP/AS is studying the advisability of instituting a service fee at public facilities to increase the availability of revenue to defray non-personnel operating costs.

Project Recurrent Costs

The discussion below will focus on estimation of project recurrent costs which will require GRM financing over the life of the project, and GRM, donor, or beneficiary financing after the end of the project. A subsequent section will discuss the feasibility of financing these estimated post-project recurrent costs.

GRM Financing of Recurrent Costs Over the Life of Project

The GRM will provide at a minimum 769,960,000 FCFA of financing for project-related expenditure items as follows over the LOP. (see tables entitled "Summary of GRM Inputs to Integrated Family Health Project" and "Estimated Annual GRM Personnel Inputs to Project.") All the recurrent expenditure items are currently financed by the GRM.

Additional Recurrent Costs Requiring Financing after the End of the Project

In order for the project investment to be sustained after the end of AID support, financing will have to continue for the recurrent costs of several project activities. These activities include: 1) supervision of MCH/FP Complex personnel; 2) maintenance of MCH/FP buildings; 3) maintenance and replacement of equipment; and, 4) acquisition and distribution of contraceptives, and vaccines, and expendables. It is important to note that no new GRM personnel will be employed for this

project. Thus additional GRM financing will not be required for salaries at project termination. Further, it should be noted that USAID's choice of project site was in part based on a concern to minimize recurrent costs related to transportation.

During the project, supervisory visits will be made to each MCH/FP Complex three times a year by DNSP personnel and district/regional supervisory personnel. To continue these supervisory visits, modest funds will be required for the petrol and maintenance costs of vehicles. Because all of the MCH/FP Complexes are within a two hour drive of Bamako, supervisory visits will not require payment of per diem. In addition, the GRM is currently providing petrol and maintenance funds for a DSF supervisory vehicle and for at least one car for each MCH/FP Complex. It is anticipated that at the project's end, the three project vehicles then in use will replace older vehicles, and will be allocated the petrol and maintenance budget for vehicles currently in use in by the DSF or MCH/FP Complexes.

A major concern of the design team has been whether the improvements made in the physical structures of the MCH/FP Complexes will be maintained after the project. There are several factors which indicate continued maintenance is possible. First, many of the MCH/FP structures were built before the 1960's, and thus their need for renovations is the result of depreciation over a 25 year-plus time span. Second, MSP/FP personnel figures indicate that 68 cleaners are assigned to the 15 MCH/FP Complexes in the project zone. Thus, from the staffing point of view, there is no reason for routine building maintenance to suffer. Third, the MCH/FP Complexes are all constructed of locally-available materials with local labor; thus premiums for imported construction materials, or highly skilled labor are not required. Fourth, communities already have demonstrated their willingness to contribute labor and materials to make significant improvements in MCH/FP Complexes (e.g., the community of Kangaba in Koulikoro, has recently poured a new concrete floor for its PMI). In summary, there is reason to believe that the GRM and/or participating communities will maintain improvements made in the physical structures of the MCH/FP Complexes.

The estimated annual recurrent cost for maintenance and repair of equipment purchased by this project are as follows¹:

	<u>US \$</u>	<u>ECFA</u>
Equipment and Supplies Procured off-shore	\$7,000	2,800,000
Equipment and Supplies Procured locally	\$5,000	2,000,000
TOTAL	<u>\$12,000</u>	<u>4,800,000</u>

 1/ These estimates are based on the assumptions that: 1) selected items on the equipment tables in the budget worksheets will need to be replaced every five years, and, 2) off-shore procurement is done through UNIPAC (with prices several times lower than for the same item purchased in the U.S.), and that 1985 prices for off-shore goods must be inflated at 5 percent per year.

The estimated annual recurrent costs for provision of vaccines and contraceptives in the project area in 1992 are estimated as follows:

<u>Commodities</u>	<u>US \$</u>	<u>FCFA</u>
Vaccines	33,495	13,398,000
Contraceptives	114,135	45,654,000
<u>Transport</u>		
Overseas to bamako	51,620	20,648,000
In-country Distribution	4,221	1,688,400
TOTAL	<u>203,471</u>	<u>81,388,400</u>

This total amount of 81 million FCFA is equal to 2.0% of the MSP/AS's recurrent budget of 4,023 million FCFA in 1985 (or 7.5% of the non-salary recurrent budget of 1090.9 million FCFA) and 1.4 percent of the estimated MSP/AS's total recurrent budget of 5,660.8 million FCFA in 1992¹.

 1/ The MSP/AS recurrent budget for 1992 was estimated by applying the historical (1981 to 1985) rate of increase in current FCFA of 5 percent to the MSP/AS recurrent budget for 1985.

Financing for Post-Project Recurrent Costs

As indicated in the previous section, it is anticipated that the GRM will be able to absorb post-project recurrent costs for supervision and building maintenance because these are already part of its recurrent budget. Likewise, assuming continued donor commitment for family planning and immunization activities, it seems probable that USAID or other donor assistance will provide Mali with vaccines, cold chain equipment and expendables, and within the foreseeable future. Thus, the additional recurrent costs arising as a result of the project which will require GRM financing will consist primarily of:

	<u>ECFA</u>
Equipment and Supplies Procured Locally	2,000,000
POL and Maintenance for Vehicles to Distribute Vaccines	4,000,000
Kerosene for Refrigerators	800,000
TOTAL	<u>6,800,000</u>

This total amount of 6.8 million FCFA is equal to 0.2 percent of the MSP/AS's recurrent budget of 4,023 million FCFA in 1985 (or 0.6 percent of the non-salary recurrent budget of 1,090.9 million FCFA and 0.1 percent of the MSP/AS's estimated recurrent budget of 5,660.8 million FCFA for 1992¹). This modest increase should be within the absorptive capacity of the MSP/AS.

1/ The MSP/AS recurrent budget for 1992 of 5,660.8 million FCFA was estimated by applying the historical (1981 to 1985) rate of annual increase of 5 percent (in nominal terms) to the MSP/AS recurrent budget for 1985.

Potential for Cost-Recovery for Health Services

Although Mali is likely to benefit from significant donor assistance for health sector activities for the foreseeable future, donors often shift sectoral funding priorities or funding priorities within a sector. This fact, in conjunction with pressures on the GRM to contain the growth of public expenditures, adverse climatic conditions, and world price trends which affect the growth of the Malian economy, dictates that Third World countries consider how additional revenue can be collected from the beneficiaries of health services to pay the recurrent costs of providing these services.

Three surveys conducted in Mali the early 1980's suggest that Malians already pay for health services, sometimes significant amounts of their incomes. For example, a World Bank-financed study in the Kayes Region (reported on by Ainesworth, 1983 and Birdsall et.al, 1983) found that individuals paid from 250 to 3,750 FCFA for hospital-related care, from 48 to 1,210 FCFA for treatment by traditional practitioners and 560 FCFA for tetanus toxoid vaccines and 1,020 FCFA for DPT vaccines. A second survey by Coppel (1984) on small samples in Mopti and Tombouctou found extraordinarily high per treatment expenditures, which are not reported here because of their implausibility. Finally, an AID-financed survey of 486 individuals in the Koro Region found that on average, households spent 25 percent of their monthly income on health services¹. Specifically the study found Koro households spent on average 1,877 FCFA per treatment from a modern facility (median = 600 FCFA), and 1,960 FCFA per treatment from a traditional practitioner (median = 75 FCFA) and 660 FCFA per treatment for transportation (median = 0 FCFA). The findings from these surveys suggest that in spite of the low incomes of Malian households, there is a willingness to pay for health services. The proposed project will finance a study to assist USAID/Mali in its on-going policy dialogue about financing recurrent costs of public sector programs. It is expected that the findings of the study will inform and recommend to project staff appropriate cost recovery strategies which might be employed in the project area, (for details see Description of Cost Recovery Study, which follows).

1/ This finding is extraordinarily as households in other poor countries average expenditures of only from 2 to 5 percent of their income on health.

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ANNEX IX.N-4. ECONOMIC ANALYSIS

This Analysis addresses the question of whether this project constitutes a sound investment for A.I.D. and GRM funds from an economic point of view. The discussion considers cost-benefit, cost-effectiveness, and cost per beneficiary issues.

A. Cost-Benefit Analysis

Ideally an economic analysis of this project would involve estimation of the benefits and costs of the project (shadow-priced to represent their actual economic value), discounting these to calculate the net present value (NPV) of the project, and comparison of this figure to NPVs for possible alternative investments. Although assessment of the costs of the proposed Integrated Family Health Services project is relatively straightforward, assigning a monetary value to the benefits, such as a human life (either as a birth or as a death averted) is not conceptually as clear-cut and makes benefit calculation difficult, even with the best of data. The methodological approaches for application of cost-benefit analysis to the voluntary family planning, and to the health activities supported by the project, and their limitations, are discussed below.

1. Voluntary Family Planning

Application of cost-benefit analysis to family planning programs has taken one of the following approaches. One approach, developed by Coale and Hoover, is to evaluate the effect of reduced population growth rates on per capita income using a macroeconomic model. The other approach, developed by Enke and Zaiden, is to calculate the present value of the expected consumption of the individual over his/her lifetime, and subtract the present value of what s/he would be expected to produce over a lifetime¹. Application of these approaches to evaluation of family planning programs in other developing countries has shown high positive returns, with the proportion of social benefits to individual/family benefits sufficiently high to warrant government subsidization of family planning programs².

1/ Yinger, M. et.al. (February 1983) "Third World Family Planning Programs: Measuring the Costs," Population Bulletin, Vol. 38, No.1.

2/ Lewis, M. (September 1984) Pricing and Cost Recovery Experience in LDC Family Planning Programs, background paper for the World Development Report, 1984, Washington, D.C., IDRD, pg. 6.

A minimum estimate of benefits from the family planning activities supported by the project can be estimated as the discounted sum of GRH health and educational expenditures saved by averting a birth³. If information on the urban Contraceptive Prevalence Rate (CPR) were available, estimation of the number of births averted as a consequence of project activities could be made by subtracting the current rate of increase in the CPR from the acceleration of increase of this rate expected as a consequence of project activities, and association of the resulting difference in the CPR to the number of births averted.

Although the births directly averted by the project will also result in fewer births in the future (i.e. the unborn cannot become parents), it is reasonable to assume that these additional births averted would not result in significant present benefits because they would most likely occur at least 20 years after the beginning of the project.

2. Project Health Activities

The health activities of this project--nutritional surveillance, vaccination against five highly fatal childhood communicable diseases, and ORT--have substantial social profitability which is easier to visualize than to quantify. The benefits of these health activities are unambiguous, significant, and numerous. Their realization makes an immediate and essential difference in the lives of the population of the project zone. First, significant health benefits can be expected, such as a decrease in the high infant, child, and maternal mortality rates, a decrease in the incidence of the diseases vaccinated against, and a decrease in general morbidity rates due to stronger children whose growth has been monitored to identify health problems early.

3/ There are undoubtedly other governmental savings, and positive environmental externalities, which would result as a consequence of increasing contraceptive prevalence and decreasing the number of births as a result of this project. Thus, the assumption that project benefits equal only government savings on education and health will lead to underestimation of the benefits of the project, and hence an underestimate of its net present value (NPV).

Unfortunately, reliable information on the urban CPR for Mali, or on its rate of change, is not available. The "Baseline Utilization Statistics Study" will yield information from which a determination of the economic soundness of the family planning investment can be made at the end of the project.

Accruing from these decreases in mortality and morbidity will be various important economic benefits, such as: an increased number of economically productive community members attendant on a decreased mortality rate, a positive return on the costs of rearing a child upon the child's becoming a productive adult, as opposed to a waste of those expanded resources if the child dies; lower fertility usually attendant upon lower infant mortality--with the consequential eventual benefit of a population with a better balance between productive and dependent individuals (i.e., a smaller population percentage in the under age 15 group and a larger in the 20-50 age group); lower absenteeism from work and school due to illness; higher quality and quantity of work and increased concentration ability of students due to a decrease in chronic debilitating health problems; decreased curative medical costs; decreased expenditures for rehabilitative services and appliances for the handicapped (i.e., polio victims); and, decreased costs of material losses due to enteric diseases that impair intestinal nutrients.

In principle, reductions in health treatment costs are measurable. However increases in the beneficiaries utility (or quality of life) and productivity are extremely difficult to quantify. Further, insufficient baseline information exists to determine other than the following crude estimate of the reduction in mortality which will result from project interventions.

Data from similar countries in Africa and elsewhere suggest that the six communicable childhood diseases (measles, diphtheria, pertussis, tuberculosis, polio and tetanus), and diarrhea leading to dehydration form about half of the under two mortality rates, with the rest going to respiratory tract infections, malaria and other, less prevalent, diseases. If our immunization program reaches about 50% of the target population (our cost estimates used a figure of 70% coverage), and if the same can be assumed for the oral rehydration program, then the under three mortality rate will be reduced by about 25%. An infant mortality rate of approximately 160/1000 live births would be lowered, at these immunizations rates, to about 120/1000.

Whatever the new, reduced figure might be, a rise in the rate of natural population increase due to a lower mortality rate is the most likely short-term outcome. This result is a natural demographic development stage which most LDC's will pass through. For the individual families who receive both childhood immunization and voluntary family planning, the ultimate goal of fewer but healthier children will be achieved. During the baseline survey for the project, efforts to collect information which will quantify more precisely current levels of infant/child and maternal mortality and morbidity will be made.

B. COST-EFFECTIVENESS ANALYSIS

Given the difficulty of assigning an economic value to a human life, cost-effectiveness analysis of social sector projects is often employed to determine which alternative intervention will achieve the desired objective(s) at the lowest cost. The following observations can be made:

1. Project activities in nutritional surveillance, immunization, and ORT have been selected for promotion by AID and other donors because of their relative cost-effectiveness in reducing infant/child morbidity and mortality.

2. A discrete, isolated voluntary family planning project (which is one alternative to undertaking voluntary family planning in Mali) predictably would yield an almost zero return on A.I.D.'s investment because of lack of clients. Families in pronatalist societies desiring to reach and maintain a certain family size are not amenable to voluntary family planning unless there is some increased assurance that existing children will survive. Hence, a discrete program would not be cost effective under present circumstances.

3. The project site of Samako and the OHV region was selected to minimize the transportation costs per beneficiary of the logistics related to carrying out project activities and distribution of project commodities. At the same time, selection of this project area maximizes the likelihood of benefits from project activities for preventive health and family planning by working among an urban population that is relatively better educated and more receptive to adopting new behaviors.

C. Reasonable Cost Per Beneficiary

The above-mentioned benefits, however elusive of quantification, are obtainable at a very reasonable per beneficiary cost. To illustrate, calculations will be made on the basis of both total direct (314,300) and total (direct and presently countable indirect) beneficiaries (681,900). If the A.I.D. contribution is rounded to \$8 million, the per capita direct beneficiary cost is \$25.45 over the life of the project, or \$4.25 per person per year, the per capita total beneficiary cost is \$11.75 over the life of the project, or \$1.96 per year. Both of these figures are reasonable prices to pay for the predictable benefits to be realized.

ANNEX IX.11.5. SOCIAL SOUNDNESS ANALYSIS

In order to examine whether this project makes sense for Mali, a description of the existing socio-cultural picture is necessary. But first, Mali must be examined in the African context because Africa, as compared to other continents, is at a stage of development that lags many years behind other geographical areas of the world. In the demographic area in particular, it is only lately that the effects of population dynamics are beginning to be considered as inseparable to social and economic development--while other continents like Asia and Latin America have passed this stage. In fact, the rate of growth in the African countries continues to increase faster than anywhere else in the world. Mali finds itself in this unfortunate situation with a population growth rate of 2.8 percent annually. As mortality begins to decline, the rate will go up even higher unless fertility is lowered.

Although, Mali has of lately increased its involvement in family planning activities, there still exists many socio-cultural barriers that can best be explained by a discussion of historical factors which have shaped these attitudes.

Factors Shaping Mali's Attitudes Toward Population Matters

There are a number of historical and political factors that explain the current state of affairs of which the most important include the following:

The Colonial Heritage. While Africa is not the only region to have been colonized, domination of the African continent took a somewhat distinctive form. The fact that these colonies first served primarily as sources of slaves rather than as new lands to be settled and exploited by the colonizers is significant. This meant not only that control would be strict in many ways, but that building viable physical and political infrastructures would not be of highest priority. Countries such as Mali were left with very limited resources with which to achieve developmental gains. Another factor of major importance was that the colonial period came to an end later in Africa than elsewhere, with independence coming to most African states only in the early 1960's.

This colonial experience has had numerous implications for Mali, as it has for other African states. When Mali gained its independence it inherited a political system based on the French model which in many cases does not address itself to the needs of a newly independent and totally different nation. Much of the legislation enacted during the colonial period remains in force. An example is the 1920 French law prohibiting the sale of contraceptives. While rescinded years ago in France, this law took several years to be rescinded in Mali.

The educational system in Mali has also been inherited from colonial days. This is true not only of the structure but of the

content and intellectual perspective which it reflects. Primary, secondary, and university curricula are focused on subjects which have been of interest in France. This is especially evident in certain areas, such as demography, the study of which is approached from a decidedly European intellectual perspective, based upon the demographic conditions under which those nations have developed. The public health perspective commonly taught in the United States therefore, is a foreign concept in Mali where the French have instilled a more medical approach to health education. This has resulted in a cadre of health personnel with a narrow medical focus on health instead family or community orientation.

Ethnic Diversity. Four major tribal groups exist in Mali, adding to the complexity of the population picture. This has had many implications, not the least of which is the need to maintain political and social cohesion at the national level. Furthermore, communication is rendered problematic by the existence of numerous local languages. Not all of the inhabitants speak the official languages of French and Bambara. Although inter-tribal conflict is not evident in Mali, the collective desire among the different ethnic groups may be to increase their numbers and consequently, their political clout.

In terms of fertility, tremendous diversity exists between ethnic groups. On one end of the spectrum are the nomads, such as the Tamacheq, who in general have smaller families probably occasioned by the necessities of frequent travel. At the other end are the sedentary populations such as the Bamana who have historically maximized their childbearing in order to have sufficient labor to work the fields and compensate for high infant mortality. In general, though, fertility has been high while mortality has dropped. As the population becomes increasingly urbanized, new problems have surfaced that seriously threaten the country.

Urbanization. There also exists differences between urban and rural populations. While urban couples are more likely to accept the family planning message because economic matters impact them more severely, rural people are more likely to practice some sort of traditional birthspacing such as abstention or breastfeeding. Polygamy which is more common in the rural areas may even have some utility as a birthspacing method by providing outlet for the husband when one wife has just given birth. Infant mortality is higher in the rural areas due to lack of health services and poorer living conditions. In summary, in the rural areas fertility and mortality are high and some traditional birthspacing occurs. In the urban area, fertility is high, mortality is low, and traditional birthspacing is less common because of tendency towards monogamy, some bottlefeeding, and adoption of western values.

Religious Factors. As in all cultures, beliefs and customs regulating family life and sexual relations are particularly influenced by religious factors. It is thus easy to see the inherent conflict between, on the one hand, Western notions of planning the size and structure of a family for "practical" reasons and, on the other hand, adherence to a traditional view of these aspects of life being controlled by Deities. Convincing the people of the value of having smaller families is made more difficult.

Although Islam is the dominant organized religion in Mali, significant numbers practice various forms of animism. Here, even Islam has taken a unique orientation strongly influenced by traditional beliefs. These tend to be based on mystical explanations of the world thus making more scientific or rational reasons for addressing population factors less important.

Islam has played a role in shaping Mali's attitudes toward population. Unfortunately, it has historically been interpreted as being opposed to contraception, although educated Muslims, including religious leaders, are increasingly reinterpreting this position. While it is true that Islam encourages the begetting of children and forbids the compulsory limitation of childbearing, scholars point out that the Koran instructs believers to have only as many children as they can support and care for.

Islam is not opposed to contraception and several references can be found in the Scriptures acknowledging that the Prophet did not object to child spacing when both spouses were in agreement. The traditional method of contraception was withdrawal but all safe and legitimate contraceptives are permitted. Even surgical sterilization is permitted under compelling reasons such as health of the mother or child and other family problems.

The role of Women. Partially due to the Islamic influence, the role of women in Mali has historically been rigidly prescribed. In spite of the important productive role which they play in this predominantly agricultural society, the major socially-acceptable and recognized role for women is that of wife and mother. Women have fewer legal rights and their position is weakened by the widespread practice of polygamy. Such conditions, in which children are seen as symbols of male virility, have not been conducive to acceptance of the notion that women can, or should, control their own fertility. Men have been more reluctant to give up on the idea that more is better. Many of the laws in the country reinforce the man's dominance in society. For example, the children in a marriage belong to the father in case of divorce.

In the urban areas, there are a few signs that women's status is improving somewhat, albeit slowly. The most prominent group behind this is the national women's union (UNFID) which has become increasingly active in promoting women's rights, including the right to regulate her fertility.

Government policies toward population matters. The Malian government has officially endorsed family planning for the benefit of the health of mothers and children. However, there exists no formal population policy to address the issue of high and increasing rates of population growth as they impact on social and economic development. Past government pronouncements have been that Mali is underpopulated, that vast areas of unsettled and unexploited land exists, and that out-migration is a serious problem. However, there have been many indications that these attitudes are changing. International Donors and lending institutions have been encouraging Mali to adopt a more progressive and reasonable population stance and the evidence seems to be that they are responding.

Numerous articles have been sanctioned for publication in the official newspaper "L'Essor" which discuss the many deleterious effects of unchecked population growth on national development. The women's union has been permitted to openly promote family planning as a woman's right to achieve personal development. This is evidenced by the display of family planning banners occasionally displayed in public thoroughfares and active lobbying.

There has been an openness to discussed population planning. The government has hosted multi-national seminars on population and, in 1983, agreed to send top government officials to participate in in-country AID sponsored RAPID presentations. Finally, there is no doubt that the local family planning association (AFPPF) has been given much latitude in providing services, technical assistance, and distributing contraceptives.

The project which is proposed has taken into account these and many other factors affecting the family planning issue. The activities proposed are feasible. Training will be done by personnel experience with the cultures and societies present in this area of the world. The technologies employed are those that for the most part exist already although on a limited scope. Social, religious, political and cultural constraints to implementing this project have been examined. This project does not foster social problems, deprive some groups to benefit others, nor does it create new structures which would fit clumsily with present entities. The project strenghtens the institutions to the benefit of Malian society at large. Therefore it is considered feasible.

Detailed Description of the Cost Recovery Study

The problem of a gap between the recurrent costs of public, health sector programs and available government financing in Mali is well documented¹. Government-wide the allocation of the recurrent budget to salaries in lieu of other items is skewed, and staff lack inputs with which to accomplish their tasks.

Discussion of the problems of resource allocation, the recurrent cost financing gap, and of mechanisms to finance recurrent costs is and will continue to be a significant area for USAID/Mali policy dialogue. To assist the Mission in these discussions, the project will finance a study on health sector recurrent costs and mechanisms for their financing. It is envisioned that the study will:

1. Review, summarize, and update available information about the recurrent costs of health sector activities, focussing particularly on the recurrent costs of the MCH/FP program.

2. Review, summarize, and update information about MSP/AS policies concerning the participation of the population in financing the recurrent costs of health services and commodities.

3. Review, summarize and update information on the potential for beneficiaries to pay for health services and commodities. Updating this information will include the collection and analysis of information about pilot efforts now underway to collect payments for MCH/FP interventions, and about communities support for health activities. Pilot project experience (either in Mali or elsewhere in the Third World) with bearing on questions of pricing and financing MCH/FP recurrent costs should also be included.

4. Review the role, if any, of donors in discussions with the GRM or MSP/AS concerning resource allocation and cost recovery policies for the health sector.

5. Analyze/Review the merits and feasibility of retaining fees collected at different administrative levels in the health system. Analyze the appropriate items and unit of pricing in order to maximize revenues and minimize adverse impact on consumer demand.

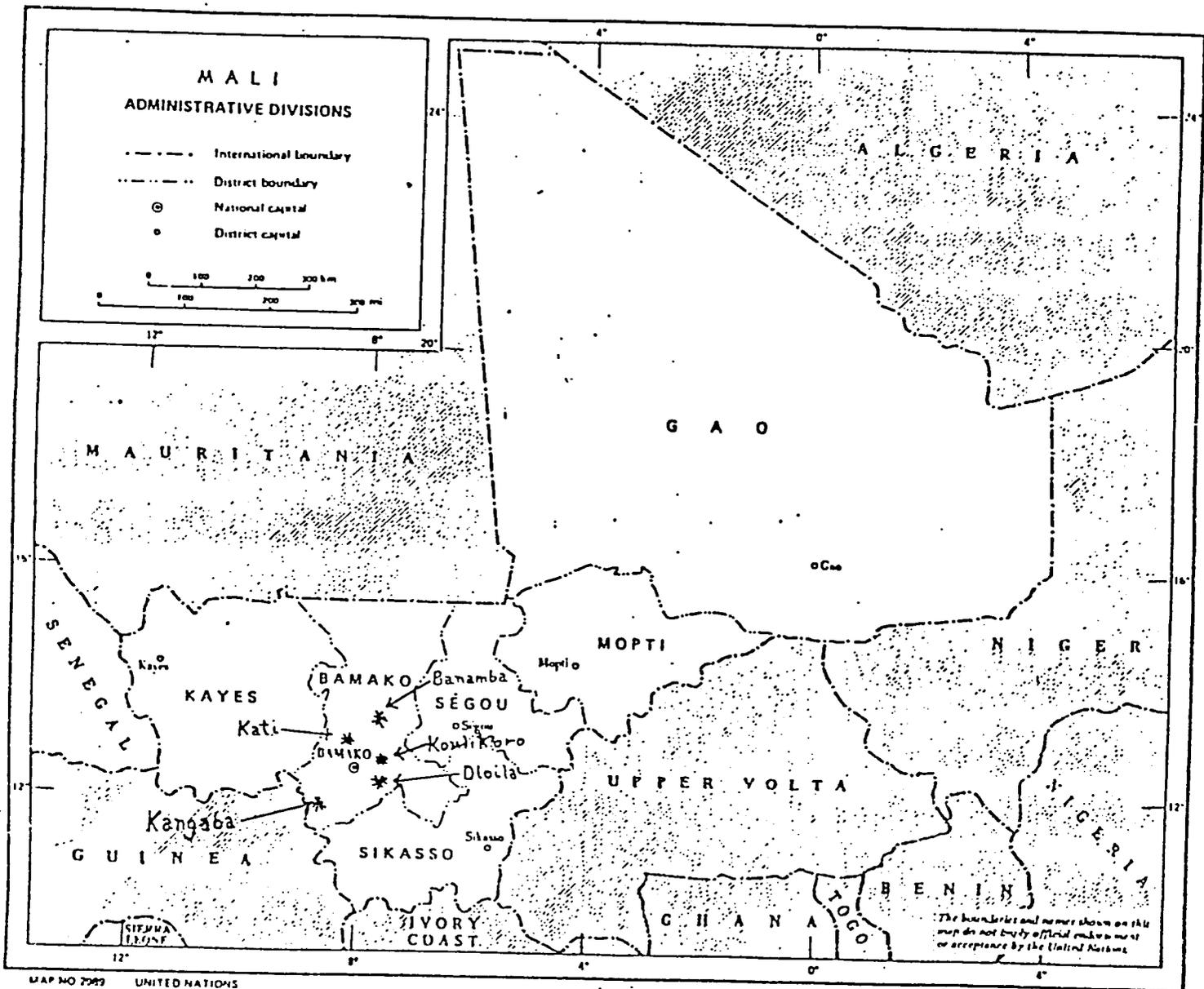
6. Set out recommendations for the MSP/AS and USAID/Mali as to the studies, pilot efforts, and technical assistance required to further the development of GRM policy to rationalize the allocation of health resources and to increase the availability of resources from all sources.

1/ See bibliography for Annex VI.2 "Financial Analysis"

7. Recommend appropriate pricing policy for contraceptives and family planning services delivered at government facilities, the AMPPF and contraceptive sales through the PPM (if this has not been carried out for development of the social marketing program).

It is anticipated that the results of this study will assist USAID/Mali with policy dialogue in this area, and also will identify financing interventions which can be applied and evaluated on a systematic basis in the project area.

IX.N. ADDITIONAL TABLES, CHARTS, AND MAPS



Point G

Koulouba

BAMAKO

Vers le Lido

** Commune I
Korofina

**
Commune II
Missira

Chemin de Fer

Vers Koulikoro

Chemin de Fer

**
Commune IV
Siabougou

**
Commune IV
Hamdallaye

** Niaréla
Commune II

**
Centrale
Commune
III

**
Commune VI
Sogoniko

Vers
Sangaha

**
Commune IV
Sikoroni

Vers
l'aéroport.

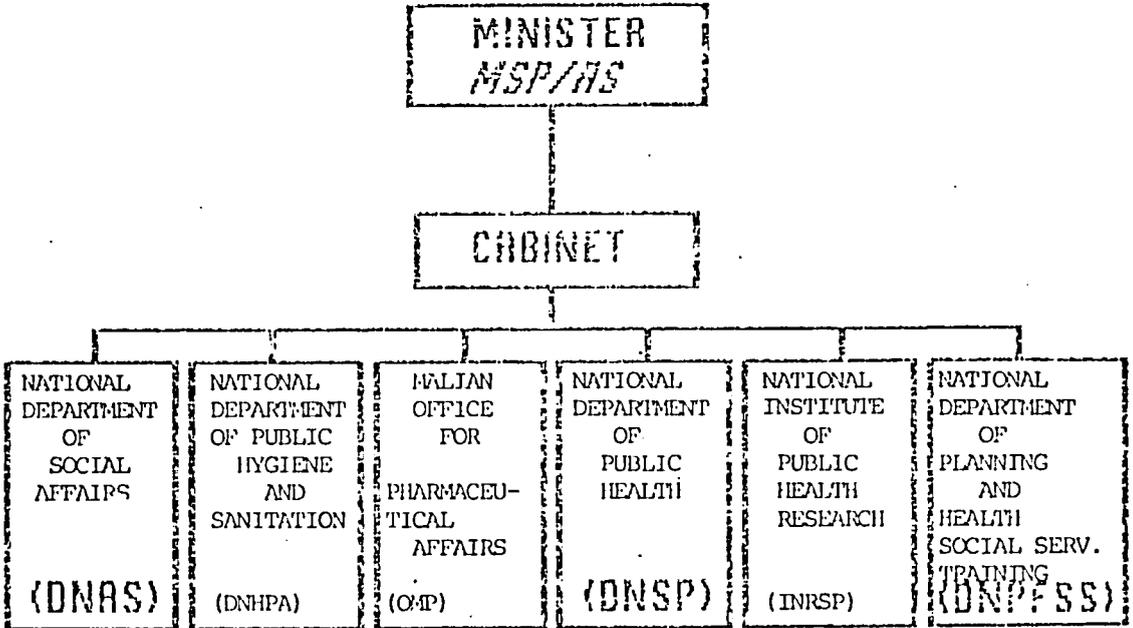
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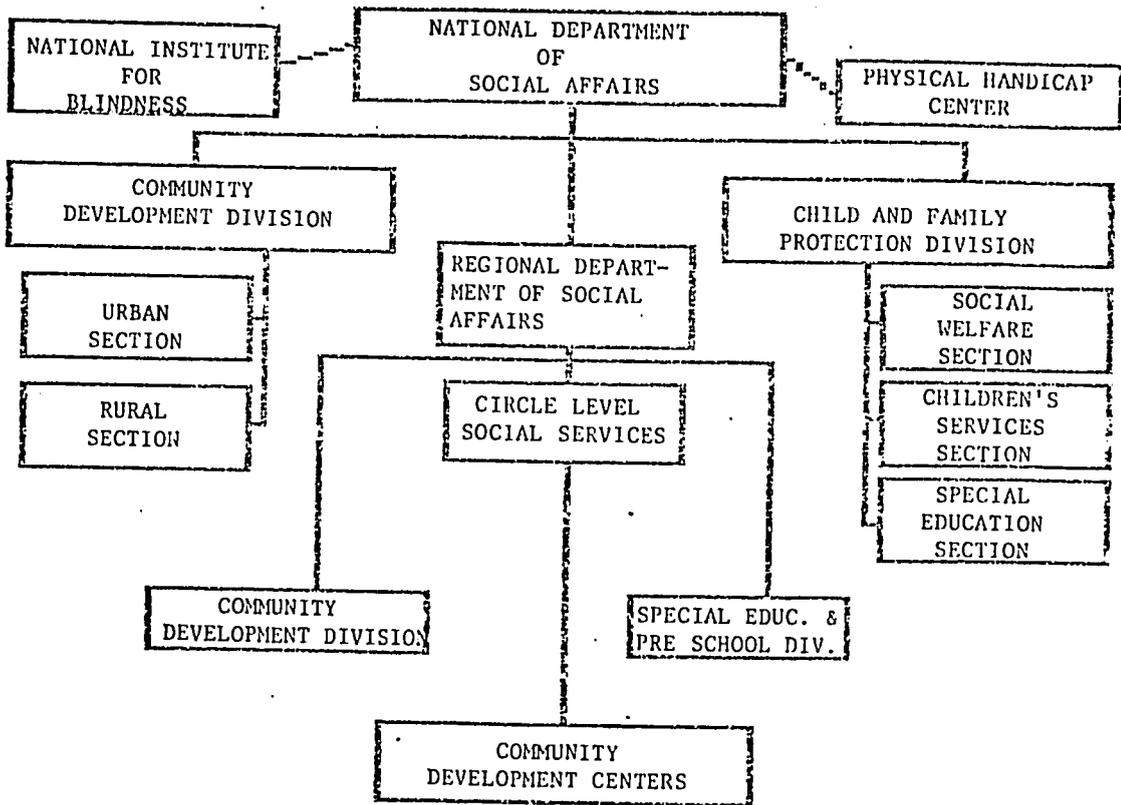
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Commune V
Badalabougou

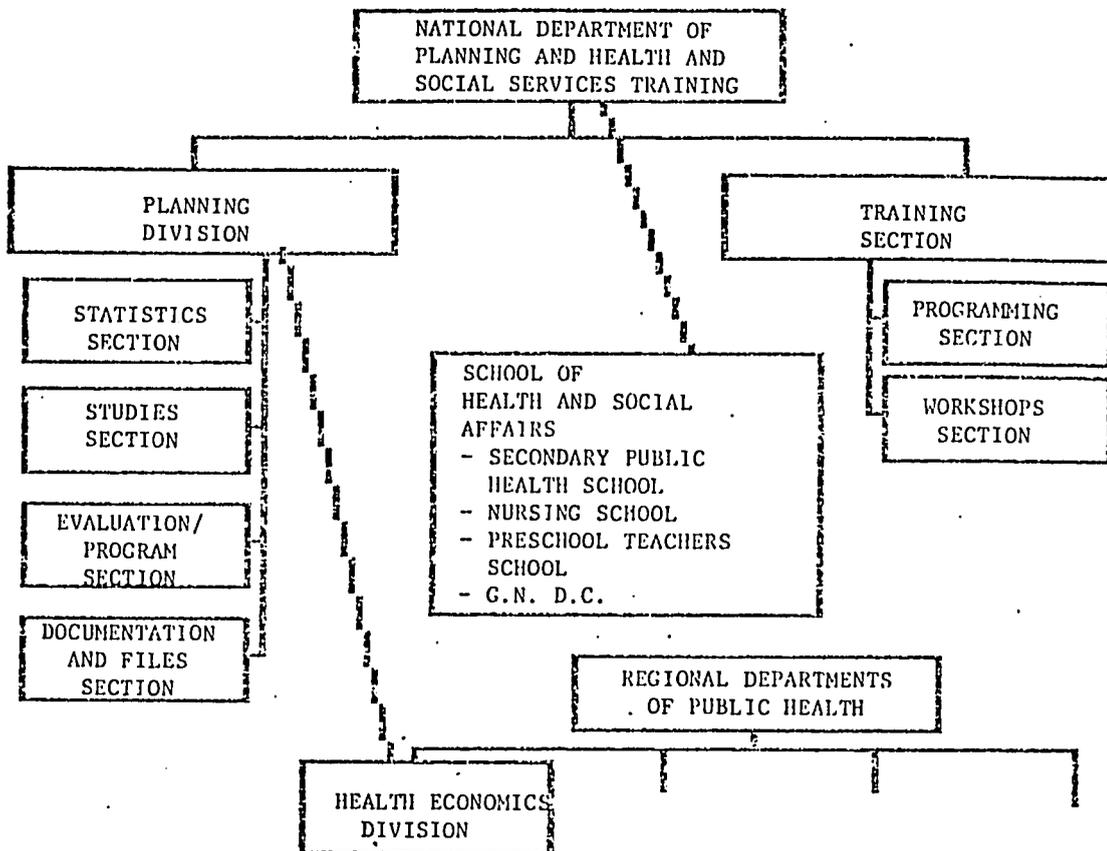
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Commune V
Quartier Mali

ORGANIZATIONAL CHART

MINISTRY OF PUBLIC HEALTH AND SOCIAL AFFAIRS

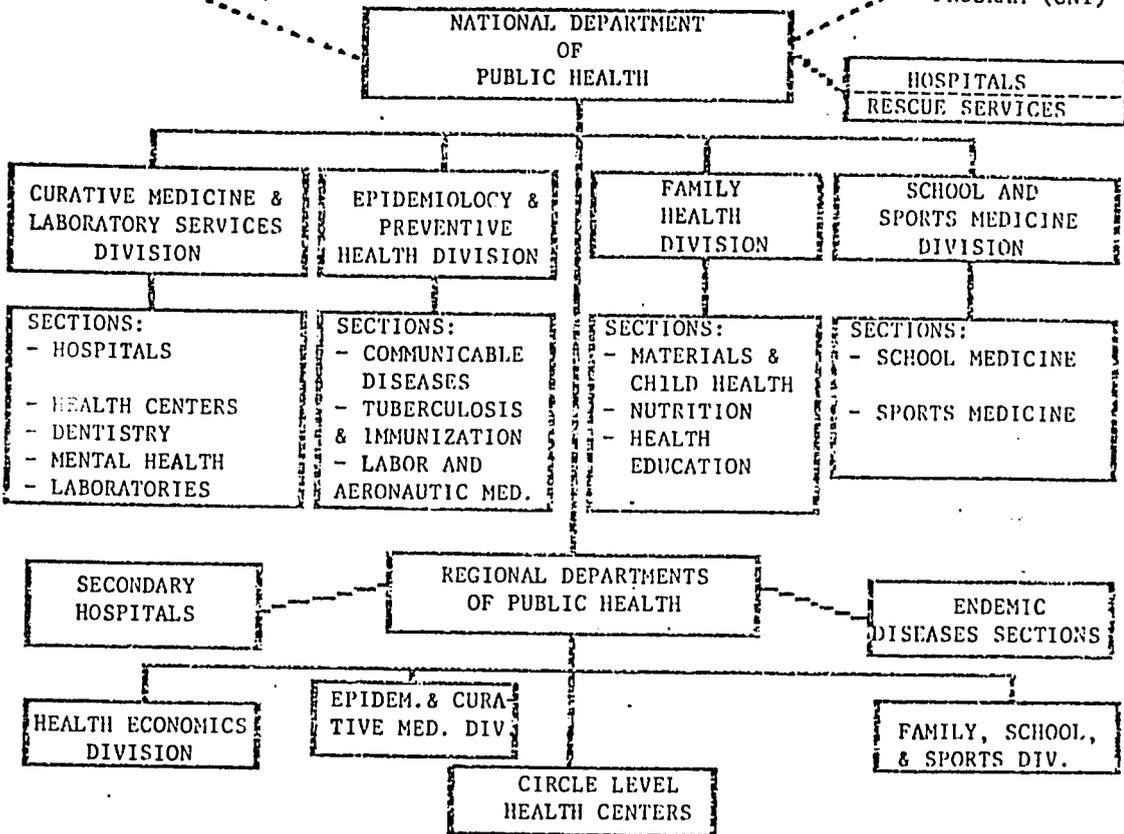






NATIONAL ANTI-DIARRHEA PROGRAM (CMD)

NATIONAL IMMUNIZATION PROGRAM (CNI)



POPULATION PYRAMID MALI

Profil de la
Population 1980

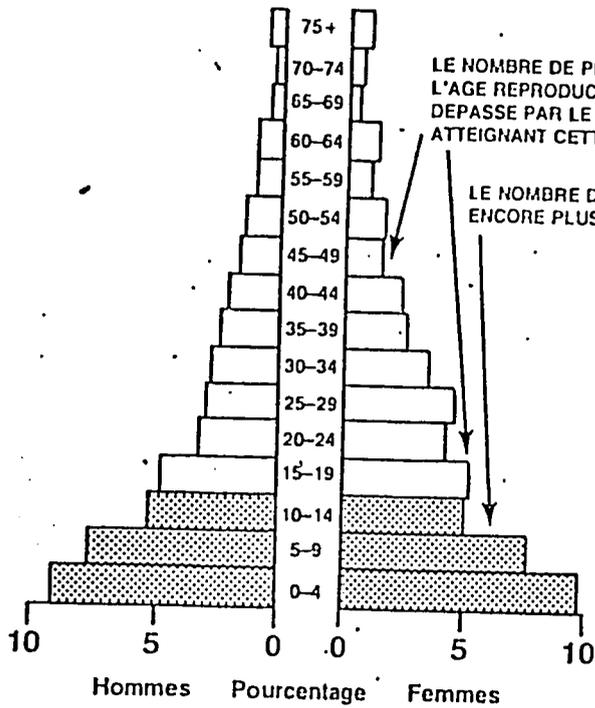


TABLE 19

Estimated Population¹, 1984
Bamako and Five Districts of Koulikoro

Location	MCH Centers	Total pop.	0-5 (25%)	Women 15-44 (21%)
Commune I	Korofina	94,000	23,500	19,700
Commune II	Niarela Missira	130,000	32,500	27,300
Commune III	PMI Centrale	105,000	26,300	22,000
Commune IV	Lafiabougou Hamdallaye Djikoroni	114,000	28,500	24,000
Commune V	Quartier Mali Badalabougou	84,000	21,000	17,700
Commune VI	Sogoninko	60,000	15,000	12,600
(Bamako Subtotal)		(587,000)	146,800	123,300
Koulikoro		26,000	6,500	5,500
Kati		41,000	10,200	8,600
Diola		7,000	1,800	1,500
Banamba		12,000	3,000	2,500
Kangaba		8,000	2,000	1,700
(Koulikoro Subtotal)		(94,000)	23,500	19,800
		=====	=====	=====
TOTAL		681,000	170,300	143,100

1) Sources

Bamako District: 1984 official estimates from each commune headquarters

Koulikoro: based on 1976 census figures plus 5% annual growth rate.



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USAID MALI
 AMBASSADE AMERICAINE



Bamako (I.D.)
 Dept. of State
 Washington, D.C. 20520

Bamako December 3, 1985

MALI INTEGRATED FAMILY HEALTH SERVICES, 688-0227

FAA SECTION 611(e) CERTIFICATION

I, Eugene Chiavaroli, principal officer of the Agency for International Development in the Republic of Mali, having taken into account, among other things, the maintenance and utilization of projects in the Republic of Mali previously financed or assisted by the United States, do hereby certify pursuant to Section 611(e) of the Foreign Assistance Act of 1961, as amended, that in my judgment the Republic of Mali has both the provisional capability and the human resources capability to effectively implement, utilize, and maintain the proposed Mali Integrated Family Health Services Project, 688-0227.

This judgment is based upon the analysis as detailed in the Mali Integrated Family Health Services Project Paper, and is subject to the conditions imposed therein.

Eugene Chiavaroli
 Director

Jan 30, 1986
 Date