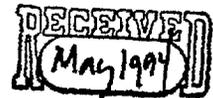


PD-ABN-598
92581



CARE International in Mali

Macina Child Health Project/Phase II

FINAL EVALUATION

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NOVEMBER 1993

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ACKNOWLEDGEMENTS

The members of the final evaluation team for the Macina Child Health Project would like to thank the personnel of CARE Mali in Bamako and Macina; the staff on the Regional Directorate for Health in Segou; the personnel at the health services in Macina Circle; administrative authorities in Macina; and the populations of the villages in the district of Macina for their warm welcome and cooperation during the period of the evaluation. The evaluation team sincerely appreciated the contributions provided by the different partners towards the development of this report.

ACRONYMS and DEFINITIONS

Arrondissement	Administrative sub-division of a Circle (sometimes referred to as "district")
Circle	Administrative sub-division of a region in Mali
AED	Academy for Educational Development
AMPPF	Malian Association for the Protection and Promotion of the Family
CSA	Centre de Sante d'Arrondissement
CLD	Comite de Developpement Local
CSCOM	Centre de Sante Communautaire (Community Health Center)
DAZA	Development of Ariz Zone Agriculture
DRSP	Direction Regionale de la Sante Publique (Regional Directorate for Health)
EPI	Expanded Program for Immunization
FAW	First Aid and Sanitation Worker
FP	Family Planning
FY	Fiscal Year (CARE: July 1 to June 30)
GRM	Government of the Republic of Mali
IEC	Information, Education, Communication
IMR	Infant Mortality Rate
KAP	Knowledge, Attitudes and Practices
MALI	Macina Literacy Initiative
MCHP	Macina Child Health Project
MOH	Ministry of Health
MUAC	Measurement of Upper Arm Circumference
NCP	Nutrition Communication Project
PHC	Primary Health Care
PIS	Project Information System
RTA	Regional Technical Advisor

SSS	Sugar Salt Solution (locally made ORS)
SSS/Macina	GRM Health and Social Service department in Macina Circle (Services socio-sanitaires)
SSP	Regional PHC project financed by Dutch Government
STD	Sexually Transmitted Disease
TT	Tetanus Toxoid vaccine
TBA	Traditional Birth Attendant
VHC	Village Health Committee
VHW	Village Health Worker (FAW and TBA)

EXECUTIVE SUMMARY

A final evaluation was conducted for the Macina Child Health Project Phase II, from September 18 to October 18, 1993. Project funding was provided by USAID/WA and CARE, for \$605,000 and \$295,000 respectively. The final evaluation was to measure progress towards goals and project impact at the beneficiary level for the Phase II project years 1990 to 1993. In addition, the evaluation was to make concrete recommendations for the orientation of the proposed MCHP Phase III. The project's goal was to reduce infant and child morbidity and mortality, with separate but interrelated objectives focusing on the Child Survival interventions of: immunization, diarrheal disease control, nutrition, maternal health, hygiene and sanitation, malaria prevention, and family planning education. Other structural objectives covered sustainability activities.

The final evaluation team was composed of four persons, two from CARE, one from USAID/Mali, and one from the Ministry of Health/Mali. The team spent two weeks in the project catchment area, and two weeks in Bamako. Due to technical difficulties, a full report was not completed by the end of the mission, but a Preliminary Findings report was submitted, containing the essential conclusions and discussion for Phase III.

The investigation consisted of document review, staff, collaborator, and beneficiary interviews, statistical comparison, and analysis and interpretation of the May 1993 Knowledge, Attitudes, and Practice (KAP) survey. Sources of statistical information included primarily the Project Information System, data from the National Center for Immunization, and the KAP survey coded by EPIInfo.

In the final analysis, while the Macina Child Health Project Phase II made noticeable progress over the course of three years, it did not, strictly speaking, fully achieve the goals and objectives as set out in the project document. The objectives were adequately conceived to reflect the contextual needs of the communities they targeted, however when it came time to measure impact, serious flaws in the formulation of objectives and the absence of indicators required a more severe judgement on the part of the evaluators.

The project strategy was based on two stages for village interventions: "training" and "maintenance". During the first two years of MCHP's intervention in a particular village, intensive training of the population was conducted by MCHP's field staff. Once a village demonstrated satisfactory knowledge of project interventions, they advanced to the maintenance stage, with emphasis on reinforcing preventive primary health care practices of the villagers, and supporting a local health management structure (Village Health Committees). At the time of the evaluation, out of 81 villages, there were only 21 organized and trained village health committees, 5 of which are in non-MCHP villages. There were

53 trained traditional birth attendants, and 60 first aid workers, out of a projected 250.

Highlights from the investigation found that:

1. Phase II inherited an EPI total coverage rate of 51% in 1990, and managed to improve this to 61% by the first trimester in 1993. This is still short of the EPI national target of 80%. As the coverage rate increased modestly, the dropout rate also increased. This is almost at 50%, and should be cause for concern.

2. A comparison of 1990 with 1993 diarrheal disease incidence and SSS use rate indicates a decline in both incidence and use rate. The SSS use rate in 1993 averages out to be actually lower than that of 1990/60%, 1993/43%. According to these statistics, MCHP not only did not achieve its diarrheal disease goal, but also lost the edge that it may have had going into Phase II.

3. Strictly speaking, the progress made in malnutrition detection and improvement is the most sound of all the components. From 1990 to 1993, one sees a virtual inversion of the statistics, as children pass out of one category to another - from 'malnourished' 90/44% - 93/20%; to 'mild' 90/32% - 93/35%; to 'normal' 90/24% - 93/45%.

4. For the maternal health component, modest progress appears to have been made in pre-natal consultations, moving more quickly in Phase II villages than in Phase I. The real test for "improved pregnancy management", is the use of a sterile razor during delivery. This practice was already quite high in 1990/87%. But by the end of 1993, there was a dip in sterile razor use in Phase II villages, from 90/87% to 93/81%.

5. While the family planning activity did not reach its predicted objective of 60% knowledge acquisition, there has been a marked increase in the knowledge level of modern methods between 1992 and 1993 (refer to table). There appears to be a remarkable leap in family planning practice, from 3% in 1992 to an average of 13% in 1993, according to the KAP survey.

6. As concerns the malaria prevention activities, though the 1993 KAP survey indicates that 90% of the sample responded that their children sleep under mosquito nets, this cannot be interpreted to mean "effective management." (goal states 60% will practice effective management). 50% of the respondents indicated that they take chloroquine during suspected malaria episodes, but this is most likely based on self diagnosis, as only 10% refer to their village health agent for treatment, and only 7% go to the health center.

In conclusion, while some of the interventions registered modest progress, the objectives of the Macina Child Health Project were not achieved in a systematic, global manner. The small successes in isolation suggest an erratic, sometimes haphazard

application of efforts, and defy attempts to identify common denominators across interventions that contributed to their achievement.

Based on these findings, the final evaluation team made recommendations that addressed problems specific to the interventions (see attached), and prepared a separate review of Phase III. The essential recommendation for Phase III is to scale down considerably, and re-design the community management approach.

A. Recommendations for Interventions

- A.1. Reduce the number of objectives and specify adequate indicators that will provide appropriate criteria by which to measure progress.
- A.2. Integrate the birth spacing interventions with safe birth activities. At present, the participating villages select the Village Birth Spacing Agent, who is not necessarily a Village Health Worker. The project should associate the Village Health Workers with the Birth Spacing trainings. These individuals are in a key position to counsel clients during treatment, pre-natal and post natal consultations.
- A.3. A restocking protocol should be established between CARE and SSP/Segou to assure the availability of contraceptive products in a timely fashion and avoid the occasional stockouts that occur at the district levels.
- A.4. Where there is a Village Health Committee, the integration of the Village Birth Spacing Agent into the committee structure should not be neglected, nor left to chance. This would facilitate the acceptance of this activity as part of maintaining good health.
- A.5. The project must take the initiative on a malaria prevention and treatment activity, though the national protocol is still on the drawing board. MCHP should work with the Chief Medical Officer in developing a protocol for the Macina Circle while waiting for the national one to be defined. (See Malaria; Phase III Comments).
- A.6. The diarrheal disease control intervention should be revised to better apply the principles of Oral Rehydration Therapy, and the hygiene and sanitation intervention should be integrated in, not to stand alone. Nutrition activities should focus principally on nutrition as concerns prevention and treatment of diarrheal disease - the number one health problem for children in the target group. Applied nutrition activities will have a greater chance of success when they are presented in the context of immediate problems facing mothers of small children.
- A.7. Re-assess the current EPI strategy with the SSS/Macina, and review the Phase III decision to retire from EPI activities.
- A.8. Consider retiring the Child-to-Child component, in light of the conclusions in this evaluation.

I. INTRODUCTION

A. Project Background

The Macina Child Health Project was the follow-on of Phase I, funded in 1986 by a U.S. Agency for International Development Child Survival II Grant. The project's goal was to reduce infant and child morbidity and mortality, to be achieved by targeting the care-takers of children aged 0 - 5 years, with an emphasis on women 15 - 44 years of ages.

Phase II, funded by a USAID Child Survival VI Grant, expanded activities into the five districts that make up Macina Circle: Monimpé, Kolongo, Sarro, Saye and Central in the Segou Region of Mali. In collaboration with the Ministry of Public Health (MOPH) and most recently, the Dutch bilateral primary health care project (SSP-Segou), MCHP provided preventive primary health care training in more than 80 villages and hamlets serving approximately 56,000 people.

B. Project Strategy

Primary health care education training concentrated on immunization, nutrition, diarrheal disease control, prevention of high risk births, hygiene and sanitation, family planning in the form of birth spacing, and finally, village health committee/worker training.

The project supplied the principal financial and material support for the Expanded Program for Immunization (EPI) for Macina Circle. During the first phase of the project, CARE was responsible for implementing the national EPI "attack strategy". During the second phase, MCHP turned the EPI operational and implementation responsibilities over to the local Ministry of Health and Social Services of Macina. MCHP continues to provide logistical and financial support for EPI.

The Macina Child Health Project developed a strategy based on two stages for village interventions: "training" and "maintenance". During the first two years of MCHP's intervention in a particular village, intensive training of the population was conducted by MCHP's field staff. Once a village demonstrated satisfactory knowledge of project interventions, they advanced to the maintenance stage of activities. In these villages, the emphasis was on reinforcing preventive primary health care practices of the villagers, and supporting a local health management structure (Village Health Committees).

Birth Spacing was introduced at the end of Phase II as a pilot activity to establish community-based family planning IEC and community-based distribution of contraceptives in 18 communities.

B. Recommendations for Management

- B.1. Supervisory visits by field staff should be reduced to allow adequate time for input into new and ongoing project initiatives. A concrete way in which the supervisors can participate in decision making should be established by CARE as part of the supervisor's responsibilities.
- B.2. Once a year, three to six months before annual appraisals take place, a questionnaire should go out to supervisors and field staff. This questionnaire should contain items on the extent to which the staff feels implicated in decision making, things not going well and suggestions as to how they should be improved. Anonymity of the staff should be maintained in filling out the questionnaire.
- B.3. The final evaluation team recommends a suspension of all data collection activities for the first six months of the Phase III project in order that the senior staff, i.e., the Project Manager, Field Coordinator and the supervisors have adequate time to establish measurable, quantifiable objectives, benchmarks and their corresponding indicators. In addition, process objectives and their corresponding benchmarks should be established for each impact objective. These objectives and progress to date should be repeated in each quarterly, semi-annual and annual report issued.
- B.4. As well, during this six month period, training should be provided to the Field Coordinator in data analysis and manipulation; training to the supervisors in data analysis and how this data can enhance their supervisory capabilities and provide feedback to the monitrices, MOH staff and villagers; and training for the monitrices on the meaning of the data they collect and how this data can benefit their villages by increasing their impact. These trainings should occur at multiple times throughout the project period.
- B.5. Plans should begin immediately for a study to examine the cost effectiveness of the project interventions and management.
- B.6. To improve collaboration between counterparts, it may be wise to assign one project supervisor to the Dutch counterpart and one to the MOH to provide these individuals with the most up to date information regarding the objectives of Phase III, upcoming evaluations, visits from Bamako staff and the progress to date. During this same meeting, the supervisor could receive information on planned meetings between MOH and/or Dutch collaborators. This would ease the burden on the Project Manager and allow the supervisors to be more engaged in project planning. The Project Manager could be informed as part of the weekly staff meeting between supervisors or more frequently as needed.

The strategy was developed in close collaboration with the Service Socio-Sanitaire of Macina (SSS/Macina) and the SSP-Segou project. For this pilot program, CARE, SSS/Macina and SSP-Segou conducted studies, designed IEC interventions and established community-based distribution (CBD) systems. The SSP-Project added contraceptives to its essential drugs program. The effort was also coordinated with the Ministry of Health's Division of Family Health and the Malian Association for the Protection and the Promotion of the Family (AMPPF), both of which provided training assistance.

MCHP interventions were complemented by activities in four other projects in the CARE-Mali's Macina Sub-Office. The Macina Wells Project installed large-diameter open wells to supply drinking water and water for household needs and livestock. The Development of Arid Zone Agriculture (DAZA) Project initiated dry season gardening, agroforestry activities and food security initiatives. The Macina Literacy Initiative (MALI) project promoted literacy and numeracy in Bambara; and Macina Environmental Sanitation Support (MESS) implemented basic sanitation and community organization activities in the town of Macina.

C. Project Finances

Major funding for the first and second phases has been provided by the United States Agency for International Development (USAID), through Child Survival II and IV Grant Agreements and the Private Voluntary Organization co-financing project. An extension grant was financed by USAID-Mali. CARE-USA, CARE-Austria and two private donors made up the balance.

D. Phase II: Final Evaluation - Terms of Reference

The final evaluation of Phase II Macina Child Health Project was to assess the degree of achievement of project objectives for the period of 1990 to 1993. In addition, CARE/Mali is preparing a third and final phase of preventive health care and community organizing activities in the Macina Circle. This final evaluation analyzed the project strategies and their effectiveness, in an effort to better orient and finalize the design for Phase III positioning.

As well, the final evaluation was to incorporate the standard questions of the principal donor, the U.S. Agency for International Development-Washington. In addition to basic questions of goals achievement, USAID final evaluation questions highlighted the issues of sustainability, estimated recurrent costs and projected revenues, project expenditures and cost recovery attempts.

CARE/Mali requested that the final evaluation respond to key questions concerning implementation and impact of interventions, collaboration with other CARE projects and partners, staff development and efficiency of the Project Information System.

Sustainability issues looked at training of government health service personnel and promotion of Village Health Committees.

E. Macina Child Health Project Objectives

The following list of objectives were originally outlined in the Detailed Implementation Plan in 1990, revised during the Mid-Term Evaluation in 1992, and served as the basis for the Final Evaluation of Phase II, 1993:

1. To increase and maintain at 80% the number of children under one who are completely immunized through regular, permanent immunization sites in five districts in Macina Circle;
2. To increase to and maintain at 90% the number of women between the ages of 15 and 45 who have received complete tetanus toxoid (TT) coverage through regular, permanent immunization sites in five districts in Macina;
3. To ensure that an adequate infrastructure is in place for the Government of Mali (GRM) to continue Expanded Program for Immunization (EPI) activities throughout Phase II of the Project and in the post-project period. The necessary material and equipment will be available and the GOM personnel will be fully trained;
4. To increase to 50% the number of adults who can state the importance of EPI for women and children;
5. To increase to 80% in 60 Phase I villages and 60% in 30 Phase II villages the number of women who practice effective management of diarrheal disease for their children under two;
6. To increase to 80% in 60 Phase I villages and 60% in 30 Phase II villages the number of women who use local resources to practice improved nutritional management for themselves and their children under two;
7. To increase to 75% in 60 Phase I villages and 60% in 30 Phase II villages the number of women who practice improved pregnancy management and safe birth practices;
8. To increase to 70% the number of children between the ages of 6 and 14 years who recognize the importance of immunization, participate in village clean-up activities and promote better nutrition.
9. To increase to 60% in 40 Phase I villages the number of families who know about one or more modern methods of family planning and where to locate family planning services;
10. To increase to 60% the number of families able to practice

malaria prevention and management for themselves and their children in 90 project villages;

11. To enhance the potential of sustainability of project activities through the training of community supported village health workers in 90 villages;
12. To increase to 70% the number of households which maintain a clean drinking water supply and b) improved sanitation practices.

F. Team Profile

The Phase II final evaluation team was made up of four members that had considerable experience with primary health care and child survival projects in West Africa. The team was composed of the following individuals:

Ms. Denise Gordon Diarra - Project Manager, Macina Child Health Project, CARE International in Mali.

Dr. Idrissa Maiga - Director of Planning Division, Segou Regional Health Directorate.

Ms. Marydean Purves - Team Leader - West Africa Regional Technical Advisor for Primary Health Care, CARE International, based in Togo.

Ms. Dorothy Stephens - Child Survival Technical Advisor, - U.S. Agency for International Development, Mali.

G. Review of Mid-Term Evaluation Recommendations

The 1992 mid-term evaluation was process-oriented, and proposed 24 recommendations for implementation by the project. The project wrote a response, in which they outlined their plans for adopting certain of the recommendations. The following assessment is a check on how effective the subsequent changes or additions were. It treats only those recommendations that had a programmatic orientation with influence on ultimate project impact. For a more in-depth reading of the Mid-Term Evaluation, please refer to project archives.

Recommendation 3: "...no village expansion unless phase-out in some existing areas or increase number of extension agents..."

The project actually phased out of 11 villages in 1992, and since the mid-term evaluation, has only added one village.

Recommendation 4: "decentralize supervisory meetings to the district level..."

The project introduced this approach shortly after the MTE. It met with some initial resistance from the extension agents, but the Ministry of Health counterparts especially appreciated this approach, taking turns to serve as host.

Recommendation 5: "...installation of EPIInfo...more formal training in software management for Field Coordinator and Administrative Assistant..."

Recommendation 23: "...review of information needs, to streamline data collection and analysis procedures."

EPIInfo was installed in 1992. Three staff members participated in a training in 1992. However, the Field Coordinator during the final evaluation stated that he had received no 'formal' training in EPIInfo. The experience of the evaluation team in its efforts to extract data in a timely and up-to-date manner would suggest that a streamlining did not take place.

Recommendation 6: "...review material supports/educational materials, target for specific audiences (men and children)..."

Recommendation 18: "...review educational strategies to minimize redundancy and monotony..."

According to the Field Coordinator, no new materials were developed, however a technical guide was developed to help the extension agents enlist the village leaders. In 1992, the Nutrition Communication Project began working with the extension workers on message development for nutrition activities, and this apparently had positive impact on the problem of monotony. It should be noted, though, Ministry of Health officials at different levels (Health Post Supervisor, Coordinator/Health Services, 10/93) stated that monotony was still a significant problem in message delivery.

Recommendations 7 and 16: "...incorporating nutrition health messages targeted to children via Child-to-Child program activities..."

Child-to-Child activities were incorporated by some of the extension agents, with differing degrees of success. The 1993 KAP survey tested children for message comprehension on EPI and Diarrheal Disease management, but with no specific nutritional emphasis. The results were mixed, and it appears that in order for this kind of strategy to be successful, a more formal and systematic tactic should be used.

Recommendation 8: "...continue logistical and material support for EPI (materials and moto maintenance)..."

A conscious decision was made to reduce the level of logistical support, as the Circle takes on greater responsibility for maintenance. Project priority was placed on helping Macina Health Center develop two fixed vaccination sites at the district level. However, serious cold chain sustainability problems on the part of the Macina Health Center, were apparent in the final PIR (June 1993), and these concerns were reinforced in conversation with the Chief Medical Officer at Macina Health Center (10/93). The Ministry of Health is not able to garner salary support from the community for its vaccination agents, much less the proposed moto maintenance support expected to come from the same community.

Recommendation 10:"...expand hygiene messages to include prevention of water-related diseases [dermatosis and bilharziosis]..."

These diseases were targeted with prevention messages, as verified by village interviews and children's responses in the KAP study, 7/93, 10/93.

Recommendations 12/13:"...educational messages on maternal health expanded to include GYN exams and infections, sterility, adolescent pregnancy...include men in discussions..."

The maternal health and safe birth messages remained as written. Adolescent pregnancies and men were targeted with the development of the Birth Spacing pilot project.

Evaluator's note: The recommendation 12 ref " GYN exams/infections, sterility", does not appear to be based on any disease prevalence finding during the MTE, either interview or statistically-based. Based on the encouraging, but still modest improvement in safe birth practices (KAP survey 7/93, PIR 6/93), the messages were best left at their simple stage for greater comprehension. The sterility theme appears to have been picked up for the Phase III project strategy, but again without any conclusive evidence of need. This issue will be addressed further on in the Phase III discussion.

Recommendation 15:"...development of a malaria [prevention] implementation strategy..."

The project chose to integrate messages on malaria prevention and control into the existing hygiene and sanitation messages. A specific objective was added to the project strategy. However, one of the corresponding indicators states 'effective management of malaria episodes', which implies a prophylaxis protocol. This has proved impossible to measure, as no specific protocol message was designed by the project. It is worth noting that the number one disease at the household

level is malaria, as learned in the village interviews and the Macina Health Center statistics. Integrated hygiene messages cannot conclusively be said to help prevent malaria, as sanitation is not the only factor in disease control.

II. EVALUATION METHODOLOGY

A. Purpose of the Evaluation

The purpose of the final evaluation was as stated:

- o To assess the degree of achievement of stated project objectives;
- o To provide an analysis of project strategies which will be of help in detailing the planning for Phase III.

As a final evaluation, questions concerning impact were necessary, yet of equal importance was the need to examine in some depth, the project approach, in order to position for Phase III - which was already written and approved for funding.

In addition, the USAID Child Survival matrix of questions was added in order to assess the sustainability aspects of the project.

Specifically, the Terms of Reference asked these questions:

- o Financial and logistical support of GRM EPI service: Were the recommendations of the coverage survey (May 92) applied?
- o Collaboration with other CARE projects:
How have the literacy skills been used by village health workers and committees? Is there a consistency in policies and procedures among the different projects? How has the collaboration between the Macina Wells and Macina Child Health Projects reinforced the "impact" of CARE in the target villages?
- o Collaboration with SSS/SSP:
How could the collaboration with SSS and SSP have been more effective?
- o Promotion of village health committees (including the training of village health workers):
How effective/appropriate is the approach for mobilizing villages for establishing health committees? How effective /appropriate is the training given to village health workers and committees? How much of the training is being applied? How well is it being applied? Was supervision and follow-up adequate? How functional are the committees?
- o Health education program: How effective are the techniques used for the health education component?
- o Training of Government Health Service personnel: How has the training provided to the GRM Health Service personnel been

applied?

- o Staff development: How have staff training sessions been applied to the program operations?
- o Project Information System: Is the data gathered useful and complete? Are the data gathering techniques reliable? How is the data used in the project management?
- o Impact: What have been the consequences (both intended and unintended) of the project on the lives of the beneficiaries?

Questions concerning the family planning pilot project were deleted from the TOR; due in large part to the very short period of time that the pilot has been operational.

B. Investigation Framework

The investigative design of the evaluation was developed in different stages: pre-field, field work, and post field consolidation (please see annex for all evaluation instruments).

B. 1. Pre-Field Work

Pre-field work consisted of constructing a project time-line, beginning in 1986 with Phase I, and continuing up to the September, 1993 evaluation date. Significant events were charted along the time-line, including staff additions, new village selections, trainings, collaboration with other projects, downsizing, etc. This chart provided points of reference throughout the month-long investigation. An organigram was designed to show the project in organizational relationship to its partners, however close or distant. Relationships were qualified according to certain elements: written agreement; exchange of funds, material, equipment, staff; decision-making capacity. This later served to identify people for interviews, and the kind of information the interviewer might expect to get from them.

An investigation framework was drawn up. This identified the questions to be answered (objectives achieved, sustainability, collaboration), the form the information should take (qualitative or quantitative), what sources might provide the information (documents, statistics review, interviews, staff), and which member of the team would be responsible for the research. An on-going document review complemented all of these pre-field exercises.

B. 2. Field Work

The evaluation team spent two weeks in the field, conducting interviews and visiting villages in the project catchment area. As earlier mentioned, the organigram defining organizational relationships served as a guide for identifying persons to be

interviewed, and to what depth. Three levels of interviews were defined: persons in a primary capacity; secondary capacity; and tertiary capacity. Questionnaires were drawn up to treat each level. Eighteen persons were interviewed between the Regional (Segou) and Circle (Macina) levels, in addition to all available staff members. A staff questionnaire was sent to Mali in advance by the RTA, and these were filled out by fifteen staff members. The field interviews were divided among the team members, and a round-the-table technique was used at the end of each day in order to highlight for others the important points of each individual interview. This information was then recorded on a grid for reference purposes in the discussion on collaboration. It was not the intention of the evaluation team to compose a separate section of the results of these qualitative interviews.

To complete the field work, an informal survey with a small number of questions was administered to a limited number of people based on non-random sampling - in this case, on the basis of easy accessibility. This method is valid, and can be statistically analyzed, provided the information is recorded in a systematic fashion. Ten villages, two from each arrondissement within the project catchment area, were originally chosen. Due to time constraints, the last arrondissement was dropped from the program, leaving eight villages in the survey. The questions were administered through interpreters to a purposeful selection of men, women and children. All interviewees were asked the same questions. Please refer to the discussion under Conclusions. page 33.

B. 3. Statistics Collection

The evaluation team drew up a table to demonstrate progression over time from 1990 to 1993 for the intervention protocols. Information was retrieved from the Project Information System (PIS), national EPI coverage statistics, data from the baseline study of the Nutrition Communication Project, and the project's July 1993 KAP survey, to fill in this table and provide definitive results in order to pronounce whether the objectives had or had not been achieved.

B. 4. Post-field Work

The final week was spent in Bamako, consolidating and writing up results according to the findings. Again, a round-the-table technique was used to elicit comments from team members about the findings and conclusions that each had to offer concerning their assignments from the investigation framework.

B. 5. Constraints

The Detailed Implementation Plan (DIP), written in 1990 was not considered an official document of reference, and could not be used as a reliable source of baseline information to check against

statistics or progress. Baseline indicators were never drawn up, and throughout the life of the project, indicators changed form and content numerous times, but with no apparent justification. No protocol criteria was established for certain objectives (malaria, village committee functionality) and as such it can be said that the observations regarding those objectives herein are informed, but not absolute.

The evaluation team encountered a number of difficulties in the course of data gathering. Despite a well-documented and extensively organized PIS, it does not offer an up-to-the-minute progress report on where the project is towards achieving its goals. Progressive measurements of intervention progress over time were obtained only after a lengthy process of manual extraction, data compilation, and in some cases, manuscript review. The project objectives, with their achievement percentages divided according to village association with the project ("phase I and phase II" villages) were not entered into the PIS as the benchmark for measuring progress over time.

In addition, the Ministry of Health statistics at the Macina Circle level were not up-to-date, and a last-minute search was necessary at the Regional level to obtain EPI coverage and drop-out rates. These were reviewed with the National Immunization Center, who were not able to confirm their reliability.

The presence of the project manager on the evaluation team was cause for question among collaborators on five counts. The concern was for biased research. The decision to include the project manager on the evaluation team was made in May 1993, approved by CARE HQ, and thoroughly discussed with the project manager herself. At each juncture that the question came up, the issue was aired, and the inquirer's concerns were noted. The project manager acknowledged that an appearance of bias could construe the results, and assured her team members and those who openly questioned her participation, of her full attention to perform in as objective a manner as possible - the learning experience for her overriding a subjective interest to "protect" the project. The evaluation team as a whole agreed that the project manager's presence on the team was justified, and did not present any obstacle to obtaining accurate and in-depth information necessary for the investigation to proceed.

The village interviews had to be conducted through translation. The simple questionnaire was written first in French, and translated into Bambara. A proposed session on how to conduct interviews with a translator was judged to be unnecessary by the translators. However, once in the field, at least two of the evaluation team interviewers experienced difficulties with the interview/translation process; i.e., inaccurate translation, inattentive translators, or too much talking by the translator. A review session as proposed, prior to the field work, may have

PROJECT PROGRESSION BY INTERVENTION PHASE II. 1990-1993

INTERVENTION/ INDICATOR	1990	1991		1992		1993		SOURCES
		PHASE I	PHASE II	PHASE I	PHASE II	PHASE I	Phase II	
EPI DTC 3 and MEASLES • TOTAL COVERAGE • DROP-OUT RATE	51% 35%	46% 27%		42% 41%		61% 42%		1990 - NCI/RDS = 1991 - NCI/RDS = 1992 - NCI/RDS = 1993 - Jan-June; NCI/RDS =
EPI TT2	44%	70%		82%		11%		1990 - NCI/RDS 1991 - NCI/RDS 1992 - NCI/RDS 1993 - Jan-June; NCI/RDS
DIARRHEAL DISEASE • 2 WEEK FREQUENCY	16%	24%	48%	15%	23%	12%	14%	1990 - KAP/Qualls 1991 - PIS* 1992 - PIS* 1993 - KAP 7/93
DIARRHEAL DISEASE • SSS USE RATE	60%	37%	6%	49%	30%	52%	35%	1990 - KAP /Qualls 1991 - PIS* 1992 - PIS* 1993 - KAP 7/93
MALNUTRITION • Detection rates: - Normal - Mild - Malnourished	24% 32% 44%	+ 	+ 	+ 	+ 	+ 	45% 35% 20%	1990 - Nutrition Comm. Project (NCP) using Weight/Age 1991 - + 1992 - + 1993 - NCP Mini KAP 2/93
Maternal Health • Pre-Natal Consultation	N/A	66%	31%	67%	41%	68%	49%	1991 - PIS* 1992 - PIS* 1993 - PIS*
Maternal Health • TBA assisted births	N/A	25%	25%	16%	5%	28%	10%	1991 - PIS* 1992 - PIS* 1993 - KAP 7/93
Maternal Health • Post Natal Consultations	N/A	N/A	N/A	N/A	N/A	23%	15%	1993 - KAP Study 7/93

* Project Information System monitored primarily for activity implementation factors and not for progress towards goals. However, the system appears to provide a fairly reliable indicator of activities output.

+ MCHP uses MUAC System for malnutrition detection; MUAC is not as refined as Weight/Age measure but does provide a proxy indicator for broad categories for nutritional status.

= National Center for Immunization/Regional Directorate Segou

PROJECT PROGRESSION BY INTERVENTION PHASE II. 1990-1993

INTERVENTION/ INDICATOR	1990	1991		1992		1993		SOURCES
		PHASE I	PHASE II	PHASE I	PHASE II	PHASE I	Phase II	
Maternal Health • Birth using: - Sterile razor - Clean cloth	87% 90%	97% 97%	79% 73%	78% 97%	67% 79%	98% 97%	66% 85%	1990 - PIS* 1991 - PIS* 1992 - PIS* 1993 - PIS*
Family Planning - Knowledge of modern methods • Condom Sperm Pill	N/A	N/A	N/A	4% 27%	4% 27%	27% 43% 16%	16% 19% 29%	1992-KAP Birth Spacing 5/92 1993-KAP Birth Spacing 9/93
Family Planning - Use of modern methods • Condom Sperm Pill	N/A	N/A	N/A	3%		14%	12%	1992-KAP Birth Spacing 5/92 1993-KAP Birth Spacing 9/93
Malaria Prevention - Use of Mosquito Nets	N/A	N/A	N/A	N/A	N/A	90% CHILDREN		1993 - KAP 7/93
Malaria Prevention • "Effective Treatment"	N/A	N/A	N/A	N/A	N/A	50% CHLOROQ. 7% REFERRAL		1993- KAP 7/93
Hygiene/Sanitation • Latrines • Clean compounds • Chlorinated water	77% 88%	85% 93% 13%	50% 75% 8%	84% 88% 9%	65% 74% 5%	78% 80% 13%	72% 81% 12%	1990 - PIS* 1991 - PIS* 1992 - PIS* 1993 - PIS*

*Project Information System monitored primarily for activity implementation factors and not for progress towards goals. However, the system appears to provide a fairly reliable indicator of activities output.

helped to avoid some of these difficulties.

Finally, the evaluation team lost some of its cohesion upon return to Bamako, as the USAID member could no longer continue, due to other professional responsibilities. In fact, this team member was a substitute at the last minute by USAID in place of the originally assigned person. As well, the bulk of project documentation was in English, posing a serious constraint for the Malian team member, whose English language capacity was extremely limited. In addition, he was not computer literate.

III. EVALUATION CONCLUSIONS

III.A. Objectives and Indicators

The Macina Child Health Project interventions were considered in two categories - health and structural. The health interventions included: immunization; diarrheal disease management; nutrition management; maternal health; hygiene and sanitation; and most recently, birth spacing. The structural interventions include: EPI program sustainability; village health structure development via the reinforcement of committees and village health worker networks; and interstructural collaboration with other CARE projects and the Malian government. The discussions for each intervention looked at certain elements:

- the objective and its indicators: were they properly formulated, feasibility in both scope and target;
- quantitative achievements toward the objective (table 1);
- trends toward impact (table 2);
- strategy and logistical considerations: were they sufficiently developed, adequate means in light of their complexity, operational aspects;
- sufficient technical and managerial capacity to achieve the objectives; and lessons learned.

At the time of the development of the Detailed Implementation Plan, no project schematic was drawn up with defined indicators. In order to make some progressive comparisons, the evaluators gleaned proxy indicators from a variety of sources into two tables: a non-definitive table using statistics from the Project Health Information System and others sources where necessary as noted, to capture trends over the life of Phase II; and a table illustrating results from 128 individual interviews that reflect trends towards impact. Please refer to section IE. for the complete list of revised objectives. The objectives for which no empirical data could be collected are reviewed in the KAP survey results discussion. These include: objective 4, knowledge on the importance of EPI; and objective 8, knowledge among children about EPI and hygiene practices; in addition to all the other KAP behaviors

targeted by the study.

A.1. Objectives 1, 2, 3: Immunization

" To increase and maintain at 80% the number of children under one who are completely immunized through regular, permanent immunization sites in five districts in Macina Circle."

Indicators (USAID/CS):

1. % children 12 to 23 months who received DPT1.
2. % children 12 to 23 months who received DPT3.
3. % children 12 to 23 months who received measles vaccine.
4. % change between DPT1 and DPT3 doses for children 12 to 23 months [(DPT1 - DPT3) + DPT1 x 100].

2. To increase to and maintain at 90% the number of women between the ages of 15 and 45 who have received complete tetanus toxoid (TT) coverage through regular, permanent immunization sites in five districts in Macina.

Indicator (USAID/CS):

1. % mothers who received two doses of tetanus toxoid prior to the birth of her youngest child less than 24 months of age.
3. To ensure that an adequate infrastructure is in place for the Government of Mali (GOM) to continue Expanded Program for Immunization (EPI) activities throughout Phase II of the Project and in the post-project period. The necessary material and equipment will be available and the GOM personnel will be fully trained.

Indicators (evaluation team):

1. Number of GRM staff fully trained in EPI procedures.
2. Necessary equipment in place (vehicles, motorcycles, refrigerators, gas burners) available.
3. Complete cold chain stocked and functioning.
4. Sufficient operational resources (fuel, maintenance, etc.)

Background:

MCHP operated the EPI mechanism for Macina Circle beginning in 1987, underwriting all aspects of the organization, implementation, and supervision of the vaccination strategy. Over the course of six years (1987-1993), MCHP trained 26 personnel in EPI techniques and organization, including a refresher course at the debut of Phase II in January, 1991. During the second phase, MCHP turned the EPI operational and administrative responsibilities over to the local Ministry of Health and Social Services of Macina. MCHP continued to financially support EPI. Funds were put at the disposition of the

Macina SSS for training purposes. An all-terrain vehicle and all motorbikes were turned over to the Macina Circle administration. All necessary supplies and basic equipment were still provided by the project (see annex "PEV Macina"). An EPI coverage survey was conducted by MCHP for the National Center for Immunization in the spring of 1992. This coverage survey was considered the most authoritative source for EPI rates in the Circle.

Discussion:

Phase II inherited a 51% total coverage rate in 1990, and managed to improve this to 61% by the first trimester in 1993. This is still short of the EPI national target of 80%. Many consider this goal ambitious, but as it was set by the Ministry of Health (in consultation with UNICEF's Summit Goals program), the project had no prerogative to alter it. As the coverage rate increased modestly, the dropout rate also increased. This is almost at 50%, and should be cause for concern. The fact that it was already 40% in 1992 should have drawn the attention of the Macina SSS, and the MCHP for that matter. Anecdotal evidence would suggest that these rates may be due to a drop in supervision once MCHP was no longer directly implicated in the execution of EPI.

It should be noted, however, that the statistics may not be reliable. During the investigation, the evaluation team requested the current EPI data from the Macina Circle offices, who were unable to provide them. A subsequent check at the Regional Directorate level disclosed the above reported figures. These were presented to the NCI for verification, and while they had exactly the same statistics, they cautioned against their absolute accuracy. In particular, the unexplained plunge of Tetanus toxoid in 1993 (even though it is for the first semester) for women raises doubts about the previous high rates of 1991 and 1992. The epidemiologist on the evaluation team, and the member responsible for investigating the EPI objectives, attributed the dramatic plunge in coverage rates to a gradual but pervasive breakdown in EPI implementation. Macina SSS has taken note of these disturbing trends, and feels it provides a compelling argument for maintaining EPI financial and material support in Phase III; claiming that without MCHP backing, EPI in Macina Circle will dissolve entirely. Yet, despite an assured supply of fuel from MCHP, there were periods of inactivity on the part of the mobile team and the advanced strategy. Despite a vehicle, supervision was not conducted on a systematic basis. Despite an available source of funding, there were no refresher courses organized for EPI by the Macina SSS. And despite an extensive inventory of materials and equipment supplied by MCHP to Macina SSS level, it cannot be ascertained if these items reached the peripheral level. It would appear that with or without MCHP assistance, EPI in Macina Circle is limping along, and the trend suggests even worse. The one element that the project cannot control, and the element that may be key, is the issue of adequate personnel and remuneration for those personnel. As long as

the national level MOH is not able or willing to assign more staff to Macina Circle, and pay their salaries, the prediction is that EPI and other programs risk sliding progressively downward.

A. 2. Objective 5: Diarrheal Disease Control

" To increase to 80% in 60 Phase I villages and 60% in 30 Phase II villages the number of women who practice effective management of diarrheal disease for their children under two."

Indicators (USAID/CS):

1. Continued fluids - % children (less than 24 months) with diarrhea in the last two weeks who were given the same amount or more of fluids other than breastmilk.
2. Continued foods - % children (less than 24 months) with diarrhea in the past two weeks who were given the same amount or more food.
3. ORT use - % children (less than 24 months) with diarrhea in the past two weeks who were treated by ORT.

Background:

MCHP's diarrheal disease component recognized water quality, nutrition, and sanitation as critical strategy factors. MCHP began coordinating with the CARE Wells Project in 1990. In fact, project villages were chosen on the basis of whether the Wells Project was present. This approach worked for a time, but it eventually became evident that MCHP could not keep pace with the Wells Project as it entered new villages. The goals of the two projects, while not at cross-purposes, had different time-frames and scope. Once a well was completed in a village, the Wells Project moved on. MCHP entered villages to help establish community structures. However, the Wells Project quickly recognized the merit and necessity of complementing its actions with hygiene and sanitation education, and to that end, assumed the financial responsibility for two MCHP monitrices.

Discussion:

The objective for this component is not precise enough to respond to the standard indicators for progress in diarrheal disease management. Indeed, the objective targets womens' behavior, and not the reduction of diarrheal disease incidence as a standard measurement. For the purposes of the evaluation, logic suggests that if "effective management" is defined as administration of Oral Rehydration Therapy, this should translate into an increase in the SSS use rate; and if mothers are practicing "effective management" of diarrheal episodes, the two week frequency rate should diminish.

A comparison of 1990 with 1993 indicates a decline in both

incidence and use rate. The decline in incidence is very slight, and is sandwiched between higher incidence rates for both 1991 and 1992. The SSS use rate in 1993 averages out to be actually lower than that of 1990 ($\frac{52\% + 35\%}{2}$) = 43%. According to

2

these statistics, MCHP not only did not achieve its goal, but also lost the edge that it may have had going into Phase II. Some possible explanations could lie in the protocol that was being taught by the monitrices. It appears that the accent was on how to mix a home solution, instead of a more comprehensive ORT management strategy that includes referral. CDCP and WHO both acknowledge the problems in promoting ORS or SSS as a 'medicine' to use at the onset of diarrheal disease, in exclusion of a total breastfeeding, fluids, food and referral policy. An inquiry at the Macina Health Center revealed that there are no ORT Units anywhere in the Circle, and beyond administering ORS in sachet form (depending on availability) or counseling SSS, there is no systematic emphasis on the other three factors in ORT. The KAP survey reported 5% mothers refer to the health post or center for diarrheal episodes. A disturbing 22% of the respondents stated they use 'modern medicines' to treat diarrhea. The KAP did not inquire as to whether these were prescribed or purchased on the open drug market. The survey, in its first analysis, did not even discuss this trend. It bears investigation as part of Phase III, and may even provide the orientation for a project indicator.

MCHP missed an opportunity with the Wells Project do to some cross-verification of diarrheal disease incidence against water quality improvement. It does not appear that the two projects coordinated monitoring efforts. The Wells Project manager stated that he had not seen the MCHP project document, and was not familiar with its goals. In 1991, water quality tests for "fecal coliform" of 16 CARE wells showed all 16 to be above the accepted levels. This may explain the higher diarrhea frequency rates. In any event, it should have alerted MCHP to survey the water supply more systematically, as part of the prevention strategy.

A.3. Objective 6: Nutrition

" To increase to 75% in 60 Phase I villages and 30 Phase II villages the number who use local resources to practice improved nutritional management for themselves and their children under two years (less than 24 months)."

Indicators (Nutrition Communication Project):

1. Malnutrition detection rates:
 - normal
 - mild
 - malnourished

(Please refer to KAP survey results for eight more knowledge and practice indicators).

Background:

The nutrition component was designed to coordinate with the CARE Agriculture Project (DAZA), in a combination of good nutrition messages and promotion of household gardens that provide nutrients mentioned in the messages. The monitrices were to conduct nutrition demonstrations using products promoted by the agriculture project. In 1990, the Academy for Educational Development (AED) conducted a nutrition baseline survey as part of its Nutrition Communication Project (NCP), selecting a number of sites to be monitored over the years in conjunction with project activities. Macina Circle was included in the sites, thus providing the project with baseline nutritional data. The NCP introduced the GRAAP techniques for nonformal adult education in 1990, training MCHP monitrices in December 1990, and June 1991. Following the 1992 mid-term evaluation which indicated deficiencies in the efficacy of the nutrition education approach (women could recite the food groups, but couldn't recognize malnutrition), malnutrition detection activities were begun. The Measurement for Upper Arm Circumference (MUAC) technique was introduced to mothers, as both a detection and a mobilization tool. Six-month intervals were organized for MUAC Malnutrition Detection Days, which became a village-wide festivity. In addition, these nutrition messages, and ideally, activities, were to be the cornerstone of the Child-to-Child program.

Discussion:

Strictly speaking, the progress made in malnutrition detection and improvement is the most sound of all the components. From 1990 to 1993, one sees a virtual inversion of the statistics, as children pass out of one category to another - from 'malnourished', to 'mild', and from 'mild' to 'normal'. This is good news for Macina Circle in general. However, MCHP cannot necessarily take credit for this improvement, as neither its objective, nor its indicators, proposed to measure for a decrease in malnutrition. The NCP measured weight for age, while the MCHP used MUAC, which is not accurate enough for determining subtle but critical changes in nutritional status. It was also discovered that the colored strips (red/severe, yellow/moderate, green/mild or normal) had no unit for measurement on them - giving an even less precise indication of nutritional status. The objective was geared more toward household food security and local technologies than towards prevention or treatment of malnutrition. Knowledge, in this case, does least to promote practice. Too many factors are out of the project's realm: water for gardens; household economic priorities; food taboos; availability of foods; and the failure of the health system to provide recuperative care. In addition, the objective includes mothers in the catchment for "improved nutrition management", yet no direct messages, actions or indicators were directed at mothers' nutritional status.

As regards the collaboration between the agriculture project and

MCHP, it appears to have been a very casual arrangement. Not all villages in the MCHP catchment area had a DAZA project, and of those that did, household gardens weren't necessarily being promoted. The DAZA project is primarily a production-for-commercial use project, while MCHP sought nutrition improvement through consumption of local products. In some ways, these projects may be at cross purposes. In any event, it is difficult to qualitatively assess the effect of the inter-project collaboration where it may have existed, as there are no joint monitoring or cross-monitoring tools. Like the Wells project manager, the DAZA project manager had never even read the MCHP document, and was not aware of its nutrition goals as defined. Proof of the difficulties in coordination bear out in the KAP survey and the village interview results, where mothers state that they had difficulty finding the necessary ingredients to prepare the recipes prescribed by the monitrices.

A.4. Objective 7: Safe Birth Practices

" To increase to 75% in 60 Phase I villages and 60% in 30 Phase II villages the number of women who practice improved pregnancy management and safe birth practices."

Indicators (USAID):

1. One or more ante-natal visits (card) - percent of mothers who had at least one ante-natal visit (card) prior to the birth of her youngest child less than 24 months of age.

Indicators (KAP 7/93):

1. % pregnant women who were examined by a TBA (> 4 times).
2. % mothers who went for post-natal consultation after their last pregnancy.
3. % births assisted by a TBA.
4. % mothers who gave birth in "good hygienic conditions."

Background:

High risk birth is defined as pregnant women who receive no prenatal education and care and whose delivery is not assisted by a trained health worker. The project conducted health education sessions and trained 53 (out of 250 proposed by the DIP). Traditional Birth Assistants in hygienic delivery practices and problematic pregnancy detection in collaboration with the Dutch SSP program and the Macina Health Center. In villages where Village Health Committees had not yet been established (the required structure for hosting TBAs), project monitrices conducted health education sessions for villagers on hygiene matters related to pregnancy and childbirth. Project monitrices recorded every delivery in their villages. Every mother was interviewed about her

infant delivery preparations: assistance by a TBA, use of sterile razor, clean sheets, immunizations and pre-natal check-ups.

Discussion:

The USAID/CS indicator for pre-natal consultation requires only one visit to establish conformity, as did the MCHP project information system. Yet the indicator on the 1993 KAP survey requires four visits. The difference between one visit and four may be a contributing factor that explains low TBA use rate and high maternal mortality rates. Nevertheless, modest progress appears to have been made in pre-natal consultations, moving more quickly in Phase II villages than in Phase I. But it must be taken together with the other indicators to establish whether the multiple practice objective has been achieved. There was erratic progress in TBA-assisted births, with a slide in 1992. Project staff explained that only 20% of the villages recording in the PIS have TBAs, thus the percentage for TBA-assisted births would correspond low. As with other project activities, the issue of human resources is a very real one here. The capacity of Macina SSS to train and supervise TBAs is very limited. There is one mid-wife for Macina Circle. She is actively involved in the trainings, but her duties at the health center have prevented her from supervising village-based TBAs. As long as the project exists, TBAs will be trained, but it is the local health services that must guarantee the sustainability of this intervention.

Post natal visits were not routinely monitored by the project. The statistics of 23% and 15% for Phase I and II villages respectively, are very low. The rate of post natal consultations for Macina Circle is roughly 17% (Regional Ministry of Health 1992). The project does not put as much of an accent on this message as it does for pre-natal visits. This should be re-considered, as post-natal visits are prime opportunities to discuss birth spacing and other maternal health issues.

The real test for "improved pregnancy management", according to other authoritative sources (UNICEF, WHO), is the use of a sterile razor during delivery. As indicated, this practice was already quite high in 1990. Project staff note that there was a prior maternal health education effort in the project catchment area before MCHP began its work, and this could account for the relatively high behavior practice. In addition, sterile razors are apparently included in the First Aid Worker kit, as well as the TBA kit. The project should strive to discover the reason for the dip in sterile razor practice in Phase II villages from 1992 to 1993. It is interesting to note that, while mothers are not necessarily using project-trained TBAs, they are independently using sterile razors.

A.5. Objective 9: Family Planning

" To increase to 60% in 40 Phase I villages the number of families who know about one or more modern methods of family planning and where to locate family planning services."

Indicators (FP KAP 9/93):

1. Percent of families (husband or wife) who can cite one or more modern methods of family planning.
2. Percent of families (husband or wife) who can cite where to locate modern family planning services.

Background:

The Birth Spacing component was initiated in May 1993 in 18 localities in the Macina Circle, including the district capitals of Sarro and Macina. This evaluation treats the intervention in a very limited capacity, as the project counts its execution time as only five months preceding the evaluation (debut of contraceptive sales). According to the Birth Spacing strategy document, a more in-depth evaluation will take place in March 1994.

The strategy hinged on the sale of contraceptive products (pills, condoms, spermicide) at the local level by a Village Birth Spacing Agent (VBSA). These VBSAs were selected by their communities, trained and given an initial stock of contraceptives by the project, in collaboration with SSS/Macina and SSP-Segou. MCHP arranged with SSP-Segou, the managers of the essential medicines/cost recovery system in Macina Circle, to include selected contraceptives on the list.

Discussion:

While the activity did not reach its predicted objective of 60% knowledge acquisition, there has been a marked increase in the knowledge level of modern methods between 1992 and 1993. The 1992 KAP was a baseline survey in 29 villages prior to activities launch. The 1993 KAP survey was conducted in the 18 communities participating in the Birth Spacing Pilot Phase. These areas have been receiving Birth Spacing messages since December 1992, and have had access to contraceptive products at the village level since May, 1993.

Though no specific objective for use was established in the project document, the KAP study surveyed for use and the same conclusions may be drawn. The villages surveyed in 1993 have increased access to information and contraceptive products, suggesting that accessibility was a key factor in people's decisions to use modern methods. Thus, the project recorded a remarkable leap in practice, from 3% in 1992 to an average of 13% in 1993, according to the KAP.

The proposed evaluation in March 1994 should attempt to verify these statistics.

When surveying for the location of family planning services, 30% responded the "health center" while 61% responded "Family Planning Agent" in Phase I villages. (Birth Spacing KAP, 9/93). This suggests that the IEC component was effective, providing people with a reliable source at the local level.

The project's approach to Birth Spacing was innovative and participative, designed in conjunction with the SSS/Macina and the beneficiary population. Considerable resources were dedicated for initial start-up, as this intervention required commodities. The evaluation noted that there did not seem to be a conscious integration of this activity into the safe birth component. Because of the profit potential, VBSAs were predominantly male. However, the safe birth activities were conducted primarily by and with women. It is important to keep in mind that these two components should be integrated in all possible ways, and not be left to grow in a parallel fashion that could outstretch the other, less 'lucrative' activities (see Phase III comments).

For a more in-depth discussion of the KAP survey results, please refer to the proceeding chapter.

A.6. Objective 10: Malaria Prevention and Control

" To increase to 60% the number of families able to practice malaria prevention and management for themselves and their children in 90 villages."

Indicators (KAP 7/93):

1. Percent of families for whom all members sleep under mosquito nets.
2. Percent of families that know the importance of proper disposal of waste water.
3. Percent of families that effectively manage malaria episodes.

Background:

The 1992 mid-term evaluation made a specific recommendation to begin malaria intervention activities as soon as possible, given the prevalence of the disease. Due to the already over-extended program agenda, MCHP decided to integrate prevention messages into the hygiene and sanitation activities. Messages focused essentially on the evacuation of stagnant water, sleeping under mosquito nets, referral to health center, etc. A malaria expert had been contacted and technical and educational materials had been solicited.

Discussion:

The objective did not specify what "effective management" of malaria entailed. The education campaign linked malaria to village clean-up activities. Yet only 16% of the KAP survey respondents linked malaria to stagnant water. No actions, such as subsidized mosquito nets or chloroquine sales were initiated, apart from chloroquine in the First Aid kits. Thus, though the 1993 KAP survey indicates that 90% of the sample responded that their children sleep under mosquito nets, this cannot be interpreted to mean "effective management." 50% of the respondents indicated that they take chloroquine during suspected malaria episodes, but this is most likely based on self diagnosis, as only 10% refer to their village health agent for treatment, and only 7% go to the health center.

During the field interviews, when the 1993 evaluation team asked "What was the most frequent ailment in your household?" The response was overwhelming "Malaria" or one of the common accompanying symptoms (headache, fever). This was the same response as in the 1992 mid-term evaluation, and re-confirmed in the year-end health service statistics posted by the Macina Health Center. This suggests an overwhelming need to expand and go more in-depth with malaria intervention activities.

A.7. Objective 11: Sustainability

" To enhance the potential of sustainability of project activities through the training of community supported village 5 health workers (VHW) in 90 villages."

Indicators (KAP 7/93):

1. Percent of villages with active village health workers (performing according to task).
2. Percent of villages in which the village health workers and health committees were supervised the month preceding the KAP.
3. Percent of villages with village health committees who have a motivation system in place for their village health workers.

Indicators (DIP, Project Training Plans):

1. Number of VHWS trained.
2. Number of VHWS still practicing (education sessions, clean-up activities, home visits).
3. Number of village health committees formed.
4. Number of village pharmacies still functioning.
5. Number of villages with a functioning health agent compensation system.

Background:

MCHP began seriously organizing village health committees and training village health workers (TBAs and FAWs) in Phase II. The

organizational principle required that a village put together a health committee in order to provide a structure for the village health workers, and to allow for the establishment of a village pharmacy and its bookkeeping mechanism. However, in some cases, alternative measures allowed for the formation of a village health team, a purely technical unit made up of TBAs, FAWs, and a malnutrition detection team. Sometime in 1990 or 1991, MCHP linked up with "Operation Rizier de Segou", a development project sponsored by the State Rice Cooperative. This project had extension agents organizing functional literacy programs at the village level. MCHP determined that in order for the village health committees to be effective, some of its members must have literacy and numeracy skills. Local village members were selected, who participated in a 45 day training and then returned to their village to instruct others. This activity subsequently became an independent project financed by USAID in 1991 (Macian Literacy Initiative - MALI). In the 1992 mid-term evaluation, it was noted that the bookkeeping system for the VHCs was too complicated and needed revision.

Discussion:

At the time of the evaluation, out of 81 villages, there were only 21 organized and trained village health committees, 5 of which are in non-MCHP villages. There were 53 trained traditional birth attendants, and 60 first aid workers, of a projected 250. It was impossible to determine the level of activity of all of these village health workers. The evaluation team was unable to determine if the literacy factor had an impact on the success of village health committees. According to a limited review by the KAP study, it did not appear to make a great deal of difference in the ability to manage the committees (see KAP study results). The recommended revisions of the bookkeeping system do not appear to have been effective.

Despite an extensive outline in the 1990 DIP on sustainability, the project did not build in monitoring factors, nor did it appear to grasp certain essential elements that contribute to or hinder progress towards sustainability; such as health worker remuneration, replenishment of pharmacy kits, district-initiated training, women's participation, inter-project monitoring, feedback to villages on their health status, and village-initiated requests/activities. The lack of a clear definition of what constitutes a self-sustaining village, hindered the ability of the team to address this issue in the final evaluation. CARE never completely withdrew from villages that had reached the status of maintenance phase and thus, there exist no villages which have completely gone through the system, and are now functioning independently.

The project never determined the value quality of health for its communities. The fact that there are no paid VHWs, that committees

appear to be poorly managed, that many of the pharmacy kits are understocked or even empty, suggests that the system is not a priority as it was presented and organized for the villagers.

During the final evaluation visits to villages, it was noted that in villages where a health team was active independent of a health committee, people were just as satisfied with the team as in those villages that had both a committee and a team. It would be worthwhile studying what difference a village health committee makes over a village health team. According to the SSS field coordinator, virtually all health committee presidents are male, as are the treasurers. In villages where there are only health teams, the balance of women and men appears to be more equitable - as women participate in the malnutrition detection unit and as TBAs, without being overseen by a health committee. Is the added structure of a committee actually necessary? Does it, by its implied bureaucratic function, inhibit women's participation? Are there more occasions of financial mismanagement within committees as opposed to independent health teams? These issues may bear investigation during Phase III.

A.8. Objective 12: Hygiene and Sanitation:

" To increase to 70% the number of households which maintain a) clean drinking water supply and b) improved sanitation practices."

Indicators (Project Technical Guide/Hygiene, KAP 7/93):

1. Percent of families with latrines in their compounds.
2. Percent of latrines maintained according to the rules established by the project.
3. Percent of clean compounds.
4. Percent of households that filter their drinking water.
5. Percent of households that chlorinate their drinking water.
6. Percent of households with a regular monthly clean-up routine.

Background:

The specific hygiene and sanitation objective was added in 1992, after the mid-term evaluation. Prior to this, hygiene and sanitation practices had been investigated in a limited baseline survey in 1991 (Final Report, Baseline Survey, villages of Kolongo and Monimpe; Sara Pacque-Margolis.) In early 1992, a spot check revealed that very few people were treating their water, despite the educational messages given by the monitrices. An intensive campaign was launched to promote chlorination of water, and a temporary mechanism was installed whereby the monitrices purchased supplies of chlorine with money collected from villagers. An investigation into subsidized chlorine supplies was begun. The PIS incorporated variables for monitoring water treatment practices. The last water quality test was conducted in early 1991.

Discussion:

The results of the 1992 brief chlorination campaign were impressive: chlorination went from 6% to 26% in the space of four months. But as the table shows, this was not sustained. Once the monitrices stopped obtaining the chlorine for the villages, the practice dropped off. A proposition for a mass purchase of subsidized chlorine never appears to have gotten off the ground. For the villagers, the problem is compounded - a question of cost, access, and mix. As it is, there is conflicting data between the PIS reports for water treatment and the KAP survey.

The PIS records that in 1990, latrines were present in 64% of all compounds. By 1993, this had risen to 75%. Again, this differs from the data in the KAP survey, which found that 62% had latrines. During the final evaluation visits to villages, the teams noted the presence and condition of latrines in the compounds that they visited. This purely anecdotal evidence did not conform with either statistic; in the eight villages visited, three had no latrines at all, using the surrounding bush for defecation purposes. In a spot check of latrines, one out of three was not considered to be in good hygienic condition.

The indicators suggest that either chlorination or filtering would constitute "clean drinking water". However, research states that filtering, while having aesthetic value and eliminating guinea worm cocepods, does not disinfect water. Thus, the 87% noted in the KAP study cannot actually substantiate achievement of the goal. A very low 7%/12% rate for chlorination would be the actual measure against achievement.

In conclusion, while some of the interventions registered modest progress, the objectives of the Macina Child Health Project were not achieved in a systematic, global manner. The small successes in isolation suggest an erratic, sometimes haphazard application of efforts, and defy attempts to identify common denominators across interventions that contributed to their achievement.

III.B. KAP SURVEYS: May 1993 and September 1993

B.1. Resume

A knowledge, attitudes and practices survey was conducted in May, 1993 in the Macina Child Health Project catchment zone. The primary purpose of the survey was to provide final baseline information for interpretation and inclusion in the project's final evaluation, and to serve as baseline data for Phase III project activities. A supplementary KAP survey on Birth Spacing and Family Planning practices was conducted in September, 1993, primarily to provide baseline data for the Phase III project design, and establish parameters for a more in-depth evaluation programmed for March, 1994.

This discussion is a concise presentation of the most important aspects of the analysis prepared by the survey team. It does not treat each variable, rather only those judged to be strongly indicative of new adopted correct behaviors. In addition, the discussion does not examine operational or project management factors that may or may not have bearing on the KAP results. For in-depth information on how the survey was conducted and the statistical analysis, please refer to KAP Survey, Macina Child Health Project, July 1993. No statistical comparison was made to the 1991 Baseline KAP Survey done in non-project villages (which were eventually integrated into the project) at this time. This should be the object of a more in-depth interpretation prior to Phase III implementation.

Certain constraints were noted in the interpretation process that may have bearing on the validity of the results. The KAP study was not organized according to project objectives, rather according to intervention. In addition, the Detailed Implementation Plan did not provide original indicators for the project objectives. The survey plan consequently outlined indicators based on lesson plans developed throughout the life of the project. In some cases, no indicators were provided, and the team members on the final evaluation drew up proxy benchmarks. In other cases, a different information source was referenced for importation of statistics into the KAP analysis, mainly the Project Information System (PIS). However, the viability of this kind of cross analysis was questioned by the evaluators, given that not all the variables were the same from one type of instrument to the other. The May 1993 KAP sample size included children from 0 to 5 years, while the project objectives target children 0 to 11 months in some cases, and 0 to 23 months in other cases. This may pose a problem when looking at degrees of disease susceptibility and the efficacy of project protocol interventions for younger children versus older children. While the project objectives were divided according to Phase I and Phase II villages, the KAP study did not desegregate in its data collection and final analysis, and a subsequent tease-out was necessary at the last minute. The bulk of the indicators are process-oriented. Conclusions about knowledge leading to practice, with impact reflected in disease reduction were at the discretion of the final evaluation team.

B.2. General Observations (by objective)

B.2.1 EPI Knowledge

Mothers know that EPI protects their children from disease, and are eager to participate in village immunization activities. This was reinforced during the village interviews, when a number of people cited EPI as the activity most appreciated, and the one that led to the greatest change in the village (fewer diseases, less serious incidents of disease). The fact that few can cite all six of the EPI diseases does not deter them from using EPI services. The most

predominant disease cited, measles, also happens to be related to a killer epidemic in 1991. Perhaps a better indicator of mothers' knowledge of EPI would have been to ask about the vaccination calendar - when to vaccinate for what. This is particularly important for measles vaccine, as it is the final indicator for a completely vaccinated child.

B.2.2. Effective Management of Diarrheal Disease

Slightly less than half of the respondents knew how to correctly prepare SSS, yet almost two thirds (Phase I) are administering the solution to their child with diarrhea. This confirms what WHO and CDCP have been suggesting - that home solutions have too much margin for error, and it may be best to just push fluids, feeding, and referral. The results also highlight another standard protocol slip - just teaching ORS administration as opposed to practicing complete Oral Rehydration Therapy. While encouraging, the results are progressively weaker the more in-depth the probe becomes. No responses correlated with breastfeeding; supplemental feeding was at 22%/13%, and referral was a negligible 8%/0%.

Given that there are 37° separate but sequential steps required to correctly mix and administer a sugar/salt solution, it may be more effective to concentrate on the four major messages of effective management: liquids at the first sign of diarrhea; continued (breast)feeding and liquids during diarrhea; supplemental (breast)feeding and liquids post-diarrhea; referral to the health center at the end of the second day of diarrhea.

B.2.3. Improved Nutritional Management

None of the indicators for this objective can accurately reflect progress among mothers using local resources to practice improved nutritional management, as the behavior determinants are not aligned with the objective. Even a measure for reduced malnutrition could not necessarily prove that mothers are practicing better management. Nevertheless, mothers benefitted from the nutrition education messages and MUAC activities in one major way; they are able to identify malnutrition in their child as a disease that must be corrected. At that point, the management breaks down. Only one indicator can actually measure impact in terms of the project's nutrition objective, and that is mothers practicing better nutritional management. Reported practice is very weak; out of 300 mothers interviewed, only 64 actually prepared an enriched meal for a child, and out of those 64, only 13 made correct measurements. A very small minority of mothers gave project-recommended foods. This may suggest that there are other factors beyond the mothers' control that inhibit their ability to apply good nutrition practices - namely the lack of prescribed foods or resources to purchase such foods. The DAZA project, which was to have worked in collaboration with MCHP, did not apparently have a systematic household garden strategy. Among the local resources cited by mothers to give to their children; cereals, meat and fish, figured

highest. These items appear to be no different than what mothers traditionally give to their small children. The definition of "local resources" for 85% of the mothers did not mean breastmilk. The project did not include breastfeeding as one of its areas of intervention, as evidenced by the lack of emphasis on breastfeeding during diarrhea episodes, and now the absence of breastmilk in the mothers' citation of local resource choices. A sound nutrition strategy begins with breastfeeding.

Probing during the village interviews revealed that women had difficulty finding the necessary ingredients to prepare the counseled recipes.

B.2.4. Improved Pregnancy/Safe Birth Management

Counting only women who had pre-natal consultation ≥ 4 times (as required in the indicator) the figure is considerably lower than that which was reported in the KAP analysis (47% for an average of one visit). In addition, the PNC visit was overwhelmingly made at the Health Center. Not a bad practice in itself, but the project has put great effort into training Traditional Birth Attendants to do pre-natals as part of the safe birth services they offer in the village. Tradition still appears to prevail, as women who had not used a project TBA figured at 72%/90% - preferring instead, mother, aunt, sister, friend. When examining the reasons for not using TBA assistance, the bulk of their responses could be considered the consequences of no regular pre-natal consultation: "abrupt onset of labor, unavailability of the TBA at the onset of labor, lack of knowledge of need..."). Whether it figures into a woman's decision, the fact that a TBA charges for her services, was not explored. As for women who gave birth in "hygienic conditions", there is considerable discrepancy in defining the term. Medically speaking, a sterile razor must be part of the conditions. Thus, it was judged that the responses in the KAP could not qualify as accurate because no question allows for this response.

B.2.5. Child-to-Child Activities

The Child to child activity was formally introduced into the project in January 1990 with the intention of targeting children, 6 - 14 years of age for education messages. The approach is based on the fact that older children are often made responsible for taking care of their younger siblings throughout the day. Using games, songs and stories, the monitrice delivered various messages concerning hygiene, diarrhea and immunization.

The project experimented with the use of "report cards" to children participating in the sessions. As each message was learned, the child would receive a stamp in the card. When the card was completely stamped, a "graduation" ceremony would be held.

Once again, an objective was written for which the indicators are unable to capture the results. As pure knowledge indicators, half the children could cite the importance of vaccination, 80% could cite at least one water-related disease (of which 40% specifically stated diarrhea), and 13% could correctly state the ingredients and the measures for preparing SSS. In field interviews for the KAP survey (conducted in May, 1993), and the final evaluation (conducted in October, 1993) it was extremely difficult to approach the children. One of the surveyors for the KAP remarked, "it was not very evident that Child-to-child activities were happening in the zone: During the October surveys, when asked, "What was your favorite activity with the monitrice?", many responded that they did not remember.

The sum total of the indicators cannot represent achievement towards the objective. Recitation of a series of diseases, or ingredients, is not determinant of anything other than possibly a good memory. No preliminary research was carried out to examine just how involved children are in the care of their younger siblings, although tradition suggests that they are indeed, largely responsible for the younger children during the course of the day while mothers work in the fields. This makes a compelling argument for training these children in feeding and preventive care (ORT, etc.) techniques. However, the program appears to have been administered in a rather haphazard fashion. The program was largely dependent on the inclination of the particular monitrice involved. All monitrices participated in a Child-to-Child workshop in September 1990. While some made extraordinary efforts to work with children, others were not so inclined. As part of the IEC strategy, messages and written report cards in Bambara were used. However, it is doubtful that the children are literate. There is only one village in the catchment area with a primary school (which instructs in French), seven with Koranic schools (which instruct in Arabic), and nine with literacy centers (which instruct adults in Bambara).

The evaluation team felt that the approach of the Child-to-Child program raised some questions about the balance of work for girl children and boy children. Informal questioning in the villages about clean-up activities suggested that older women and girl children were the ones most often assigned to this task.

This is to say that considerable energy is being expended for this activity with low impact results. The simplification of messages and more action-oriented practices were key as suggested in the mid-term evaluation of 1992. However, unless the project is going to invest resources into appropriate visual aids for children of this region, a constant rejuvenation of ideas about working with children, and a more systematic monitoring of progress, the project should spend considerably less time on this activity.

B.2.6. Birth Spacing: (KAP Study 9/93)

The newest intervention in the project portfolio needs more time to act in the field before a solid reading can be taken. However, after only four months of activity, there is some information being absorbed: 27%/16% know of condoms; 43%/19% know of spermicides; and 16%/29% know about the pill. Taken as an average, this is 27% for Phase I, and 21% for Phase II. A KAP study done in 1992 in the same area (assumed) shows a somewhat lower knowledge level: 4% for condoms, and 27% for the pill. Use rate is very low, except for a reported condom use rate in Phase I villages at 12%. Primary outlets for contraceptive products are cited as health center (30%/47%) and FP agent (61%/19%). Information gathered about sterility is anecdotal, for the most part. Persons were asked if they knew of women who were "victims of sterility". These were women who had never had a child. An overwhelming 75% of people questioned claimed to know of a woman who did not have children. 60% claimed to know of a woman who had only one child - the KAP definition of secondary sterility. This form of second-hand information is not very reliable, as all persons interviewed could be referring to the same one or two women. The variety of causes of sterility go from "divine intervention" (22%), to violent stomachaches (37%) and to STDs (2%). The health center was cited by 82%/75% as the place to go to correct sterility. The information is too limited in its scope and depth to draw any conclusions or make cross-analyses.

B.2.7. Malaria Prevention

The questionnaire was particularly weak in sounding for malaria knowledge or practice. The use of mosquito nets was not an innovation of the project, therefore the fact that 91% of the respondents' children reportedly sleep under a mosquito net cannot be attributed to project education efforts. When compared to the results of the village interviews, people claimed that the project response to malaria was education about stagnant water. However, only 16% of the KAP respondents cited malaria as a danger of stagnant water. "Effective management" of malaria is not defined, however it is tabulated. 50% practice Chloroquine administration but no treatment protocol was cited (dose precision, diagnostic). In the village interviews, the most recurrent ailment at the household level was malaria, and a distinction was even made for cerebral, or convulsive malaria among children. The malaria intervention strategy of the project needs considerable revision.

B.2.8. Sustainability through VHWS

The KAP study was not necessarily the tool to use for this inquiry. The indicators devised are for a numerical reading, and unless all 21 village health committees were visited and interviewed, it cannot be representative. As it is, of the 21 village health committees officially recognized, only 7 received a supervision

visit in the last 10 months. The criteria for "functioning" VHCs has yet to be determined. For anecdotal information on the activities of certain committees, it serves to highlight some problems. According to the KAP, and in a personal communication with the SSS Coordinator, no VHC has installed a systematic reimbursement for services rendered by village health workers. (The tradition of giving something to birth attendants cannot be attributed to project organizational activities). As a means for verifying the functionality of village health workers, their first-aid kits were inventoried. Only half of the nine committee kits were sufficiently stocked. The traditional birth attendants seem to be the most organized and functional unit, but again the success cannot necessarily be attributed to the project (there was a TBA training activity in the current MCHP catchment area in 1987, not initiated by MCHP).

B.2.9. Hygiene and Sanitation:

75% of the villages claim to have a regular clean-up calendar, although no observation was possible. Individual interviews with villagers confirm the likelihood that this occurs with some regularity. Villagers often made mention of a "before- and-after" situation; before being a state of extremely unhygienic conditions, and after being a state of swept communal areas, reserved lots for garbage, etc. However, the interviewers noted in their passage through the eight villages that cleanliness is relative. Co-habitation with animals is still a common practice, and if juxtaposed against the threat of theft, no amount of sanitation education may persuade a villager to let his animals out of his immediate sight. As concerns water treatment, it is a bit of a puzzle to interpret what the project might have hoped to see. A disappointing 7% chlorinate their water. As it is, all of the villages surveyed possessed a CARE-installed well. The campaign to motivate and instigate participation for construction of the wells accentuated the potability of well water*. Thus, the later messages of adding chlorine to the "already potable" well water may not have seemed logical. In addition, the factors of cost and accessibility of chlorine supply seemed to have played a role in limiting the adoption of this practice. Compare this to 87% who filter their drinking water through a cloth. Complementary information reveals that cloth filtering is a long-standing practice independent of the project's messages (neighboring towns of Macina and Markala practice cloth filtering). It appears to have mostly aesthetic value, as cloth filtering does not disinfect against most water-borne diseases **. Look at the modest but consistent decline in diarrheal disease frequency rate. What effect could greater chlorination use have on reducing this frequency rate even further? This may merit some Operations Research in Phase III. Finally, 62% of households visited had a latrine in their compound. The data for latrine treatment is confounded, but suggests a treatment pattern in the area of 86%. The project messages promoted treatment of latrines with coal, ashes, or old batteries (acid). A large

percentage (90%) also claim to treat their latrines with soapy water, which is not a practice to encourage. The saturating effects of the water do far more damage than the trace effects of the disinfecting soap.

* (water quality tests in early 1991 for "fecal coliform" of 16 CARE wells showed all 16 with above-standard levels).

** (Guinea worm cocepods are effectively filtered out using a tightly woven cloth)

C. Village Interview Results

C.1. Resume

An informal survey with a small number of questions (eight) was administered to a limited number of people (128) based on non-random sampling - in this case, on the basis of easy accessibility. This method is valid, and can be statistically analyzed, provided the information is recorded in a systematic fashion (in this case, tally sheets). This informal, small-scale survey was conducted from 4 - 7 October, 1993 in eight villages in the project catchment area. Ten villages, two from each arrondissement within the project catchment area, were originally chosen. Due to time constraints, the last arrondissement was dropped from the program, leaving eight villages in survey. The questions were administered through interpreters to a purposeful selection of individuals from distinct categories - two men, two women, two children, two health agents and two leaders. All interviewees were asked the same questions. An average of twenty-two minutes was spent with each interviewee. Results were tallied at the end of each day, and a final tally was completed on the last day. The following discussion identifies trends toward project impact at the village level. These trends should be qualified as an appreciation only, and are not to be construed as absolute. Biases are taken into consideration, being that all of the interpreters and two of the interviewers were in some way associated with the project, and recognized as being so. Thus, answers may have been weighted to please, however carefully the teams sought to tease this out. Only descriptive responses were recorded in the summary; "I don't know", "I don't care", etc. were not added to the tabulation. Thus not all totals add up to 128. Refusal to interview was respected, however very few persons strenuously declined to cooperate.

C.2. Question Number One

The first question: What is the most frequent ailment in your household?, was asked in order to set a parameter for later questions as to whether the project addressed immediate household health concerns. The predominant response (33/123) was Malaria. This is consistent with the most recent Macina Circle statistics on disease prevalence (insert from MC). When asked how the project actions addressed this problem, 68/115 stated prevention advice. This is consistent with the project protocol, which outlines integrated hygiene and sanitation messages and use of mosquito nets. In addition, people were asked what action they personally took towards solving their health problem. A three-way split appeared, with malaria prophylaxis being the treatment of choice by a slim margin. When asked where the person obtained the medication, the supplier was generally the Village Health Worker (non-tabulated). The system of Village Health Workers and village pharmacy was put in place by the project. Thus, this response can

also suppose a project effect.

C.3. Question Number Two

The second question: What health problems did you have before the project arrived?, was chosen in an effort to get a historical sense of progression over time vis-a-vis their current health preoccupation identified in question one. Stomachache and diarrhea were the major illnesses noted. The project is credited with bringing about an improvement as

concerns these two problems, by 102/111 respondents. This would correspond with the project activities that addressed water-borne diseases via installation of concrete-lined open wells, and water filtering and treatment systems for home management.

C.4. Question Number Three

The third question: Is there a village health committee in your village?, was asked primarily for verification purposes, as all VHCs are already known to the project. Without prompting, people made distinctions between village health committees and village health teams. 60/114 claimed knowledge of their village health committee, and 41/114 claimed knowledge of a village health team. (The village health teams are strictly technical in nature, consisting of first aid workers, trained birth attendants, and nutrition detection agents, and having no management or organizational responsibility. A health team is ultimately a component of a village health committee). When asked what kind of service the village health committee or health team offered to solve health problems, the predominant response was education/prevention (45/99). This was followed by First Aid Worker and Trained Birth Attendant organization - an indicator of a functioning health team, if not a health committee.

C.5. Question Number Four

The fourth question: Should the project withdraw, what will you do about your health situation?, was asked to sound out about the sustainability of the project activities. 100/135 responses stated that they would continue the education/prevention activities initiated by the project. 22/135 indicated in some way that they would turn to their health committee. This suggests that the project health messages and educational activities were appropriate, adaptable, and adopted. Nine responses suggested a negative impact, in that people would do nothing more without the heavy influence of project extension agents, and one person indicated that villagers may revert to the previous status quo. This was a First Aid Worker, who may be judged to have a vested interest in seeing the project return to his village.

C.6. Question Number Five

The fifth question: What activity did you appreciate the most?, insisted as much as possible on a prioritization by the respondent that would correlate 'appreciate' with 'useful'. This qualification was perhaps the most difficult to make by the respondents, and often required more than one restating of the question in the local language by the interpreter. The responses were typically very general: everything was cited by 22/108 persons; village sanitation by 19/108 persons; water/wells treatment by 15 persons. The bulk of the responses were single digit scattered over a variety of activities: 38/108 for EPI, village pharmacy, SSS preparation, etc. The question cannot really provide any insight on impact of one intervention over another.

C.7. Question Number Six

The sixth question: What project activity did you least appreciate (find the least useful/did not understand)?, again tried for an elimination of general appreciation in order to find out those messages or activities which needed improvement in their targeting or protocol. Again, a majority response, 74/86, stated Nothing. It may be that a culture-bound reticence to express dislike or disapproval inhibited respondents from making critical distinctions between those activities very useful, and those which did not appear to have bearing on their lives. Were they to actually state as much, they may reason that this would result in the loss of that particular activity, and other undesirable consequences. Nevertheless, 5 responses identified nutrition advice, including nutrition detection activities (MUAC) as difficult to understand. Probing in three cases suggested that the women had difficulty finding the necessary ingredients to prepare the counseled recipe. It would be difficult to draw conclusions from this information.

C.8. Question Number Seven

The seventh question: Are you informed regularly about project data collection feedback?, was inserted at the request of the project manager, who had applied a recommendation from the mid-term evaluation, that suggested feedback be given from the monthly home-visit surveys by the extension agents. A large majority do not receive feedback, but did offer ideas as to how this might be done; via the health promoter to the village chief, or the health promoter to the health team. The issue at stake is not so much whether they receive feedback, but what that information might mean to them. It must be relevant to their situation and actionable, otherwise it serves no purpose.

C.9. Question Number Eight

The eighth question: What change has the project brought about

in your village?, directly looked for impact appreciation. Out of 143 responses, 47 cited a **clean village** as the most predominant change. 27/143 stated that there was now a **possibility to prevent disease**, suggesting a self-empowering action on the part of the villagers. 17/135 cited a source of potable water as the most visible change due to the project, and 14/135 stated that there were now fewer diseases.

This information is helpful in rounding out some of the material generated by the KAP study and routine PIS monitoring. It was an interesting exercise in free interview techniques, and offered the occasion to search specifically for opinion, and to uncover unexpected factors.

IV. MANAGEMENT ISSUES

A. Project Information System

Project monitoring and evaluation was dependent on the Project Information System (PIS). The system was computerized and became fully operational in the Spring 1991. Prior to the departure of the Computer Consultant in June 1991, a manual was developed which explained the system and limited skill transfer training was conducted with other project staff prior to his departure. All collected data was entered and managed on the database using the computer software program DBASE3+. Computer hardware presently includes a Zenith Supersport 286, Toshiba 386SX and an Epson FX 1050 printer.

The field coordinator was responsible for the Project Information System which included overall data quality control, data analysis and report writing. The administrative assistant was responsible for data entry and cross-checking raw data which had been compiled. The project's three supervisors screened all data collection submitted by the monitrices for accuracy and were responsible for data compilation.

Project reporting occurred on a monthly, quarterly and annual basis. MCHP prepared monthly and quarterly reports. French copies of the monthly reports were distributed to local health officials, USAID Mali and other non-governmental organizations. Both the quarterly and annual reports responded to the respective reporting requirements of USAID Washington and CARE International. Internally, project personnel were updated on recent analyses or findings at monthly staff meetings. To facilitate data collection, a variety of forms were developed and are described below.

At the height of the data collection activities there were nine different data collection instruments.

B.1. Village Identity Record (Fiche d'Identite de Village)

This instrument provided baseline information on a project village. It contained data on the social conditions, economic activities, ethnicity, accessibility to water and health care facilities.

This information provided possibilities for enhanced cross-tabulating capabilities between social and economic conditions and project activities. One example in which this record was routinely used was the comparison of the malnutrition rates between Phase I and Phase II villages. This record was updated annually at the beginning of a campaign year.

B.2. Project Activity Level Record (Fiche d'indicateurs de niveau par activite)

This instrument registered the level of advancement for each village by intervention and was updated on a monthly basis by both the monitrice and her supervisor. Using a scale of 1 to 10, villages were assessed on knowledge acquisition (Training Phase, 1-5) and practice (Maintenance Phase, 6-10).

This record was a means to track individual village progress for any given activity. Based on input by the monitrice, at the end of a campaign year, a particular village was targeted for a punctual survey to ascertain it's ability to move from the Training to the Maintenance Phase. The monitrice's assessment was checked against this record. This record also served as a planning tool. The monitrice organized the monthly calendar of activities based on the previous month's activity levels. The supervisor verified the monitrice's calendar against the Project Activity Level Record.

B.3. Health Indicator Record (Fiche d'indicateurs sanitaires)

Initially, information was collected monthly on the different health practices based on project's interventions such as: number of clean concessions visited, number of cases of diarrhea in the last two weeks, diarrhea treatment practices, number of women who progressively or abruptly weaned their children, etc.

Starting January 1992 this information was collected on a trimester basis with 30% of the female population of a village surveyed. This record allowed the project to track global progress, or if cross-tabulated with the Village Identity Record, specific progress of project villages, or villages in a certain zone or certain distance from Macina as an example.

This record was the most appropriate place to have inserted indicators that addressed the project's objectives. Information which responds to Objective 4, percent of women using SSS was tracked, but the other objectives were not.

B.4. Expanded Program for Immunization Record (Fiche PEV)

This record tracked immunizations received among the target population in each village. The monitrices recorded all new births and reviewed vaccination cards to note type of vaccine and date received. This information was supplied to the Field Coordinator once a year.

This record was used to track the vaccine coverage rate in project villages. A notebook with this information was kept with the monitrice or at the village level, if there were literate persons, to monitor children and follow their vaccination progression.

B.5. Health Promoter Activity Record (Fiche d'Activite Mensuel)
This form provides summary information on specific activities in terms of the intensity of different interventions (number of educations sessions) and community participation (number of participants). This data is compiled on a monthly basis and used for various monthly, trimester and annual reports and to track activity targets.

B.6. Pregnancy and Childbirth Hygiene Record (Fiche de l'Hygiene de la Grossesse et de l'Accouchement)

This is a summary of delivery practices of women who have given birth in the last month. A woman were surveyed as to whether she delivered in hygienic conditions, received pre-natal consultations, etc. This information was forwarded to the project office on a trimester basis.

B.7. Nutrition Record (Fiche de Nutrition)

This form was filled out following a mass malnutrition detection using the upper arm measure of children aged 1 - 5 with a tri-colored ribbon. The project targets two detections a year for each village.

The results permitted the project to evaluate the level of participation and the rate of malnutrition in the different participating villages.

B.8. Child-to-child Record (Fiche d'Enfant pour enfant).

This record is used to track the different interventions used with village children 6-14 years of age, concerning EPI, Diarrhea, Nutrition and Hygiene. This form is similar to that of the Health Promoter Activity Record and captured information with regards to numbers of children participating in a particular activity each month.

B.9. Birth Spacing Record (Fiche d'Espacement des Naissances)

Although never in use, the project anticipated the addition of this form to track the contraceptive prevalence rate and side effects from the different birth control methods on a trimester basis.

In general, the final evaluation team felt that the project collected far too much information, that the information was not used to the extent it could have been and that project staff lacked training in data manipulation and analyses and what limited analyses were conducted were not used to enhance decision making capabilities. In addition, neither the CARE Macina, the CARE Bamako, the CARE New York, the USAID Mali nor the USAID Washington offices ever discerned the gap in the data collection instruments as they corresponded to the data collection needs of the project, i.e., that they lacked critical data elements vital to determining whether the objectives had been met.

C. Evaluation

Over the life of Phase II, 10 separate punctual evaluations were conducted. Very little of this information could be used in the final evaluation because it was determined that the data breakdown did not correspond to that of the objectives, e.g., the project's objective is interested in the immunization coverage rate for children aged 0-11 months, however the immunization coverage rate study captured information on children aged 0-23 months. In another example, a KAP study was conducted which included questions which corresponded to several of the objectives, however there was no breakdown between villages that had entered into the project in Phase I and those that had entered in Phase II. These are just two of the numerous examples how the project could have better analyzed it's data needs prior to committing resources for a study.

D. Human Resources

D.1. Personnel: Background

At the project's peak, 20 full-time professionals and two support staff were on board. Senior management included the project manager, field coordinator and three supervisors. Their administrative tasks were complemented by the presence of the project assistant. In addition, 15 staff members were monitrices who were responsible for providing community health education and trainings for the establishment of village health committees in 93 villages and one hamlet. On the average, each monitrice monitored and conducted activities in four to seven villages. The actual number depended upon the progress the village had made towards establishing a self-sufficient village health committee. On the average, monitrices were assigned four to seven training phase villages or nine maintenance phase villages. In early 1992, the project developed policy in which only experienced monitrices were assigned to maintenance phase villages.

In January 1993, the monitrices were notified of the project's closing in June 1993, at which time they received their final salary settlements. Project senior staff received contracts until October 1993, in order to close out project activities, supervise certain villages and assist with the final evaluation. The Birth Spacing Coordinator of MCHP was reassigned in September 1993 to the Primary Health Care division of the CARE-Mali mission in close association with the Health and Education Coordinator. It is anticipated that she will maintain her contact with MCHP and continue to serve as a trouble-shooter.

Detailed job descriptions, clearly delineating lines of authority and responsibilities for the professional technical positions were available.

D.2. Personnel: Discussion

The mid-term evaluation found staff turnover to be relatively high. Only 25% of the professional staff had worked in the project since its inception and some villages had had at least three or four different monitrices. Questions arose as to the effect the loss of the momentum in the health education interventions and the lack of project field staff continuity, would have on sustainability.

In the mid-term evaluation, the issue of seasonal contracts arose. No project field activity occurred during the months of July and August. The decision to select this type of contractual arrangement was originally based on the unavailability of villagers during the planting and harvesting season and village inaccessibility during the rainy season. However, discontent among project staff and uneasiness concerning job security were cited as a deterrent. In this evaluation, it was suggested that this discontent (often disguised as personal reasons for quitting) contributed significantly to the high rate of resignations.

In September 1993, a staff questionnaire was answered by 15 staff members. Included in the questions were items about the project goal, present duties, rating systems and the whether or not their tasks corresponded with they had been hired to do and were doing presently. In addition, a large part of the questionnaire asked for responses to the extent of being implicated in decision making, the extent to which project staff felt they were having a direct impact on the project and the general project atmosphere. The responses received were from a range of personnel including, monitrices, supervisors and senior staff. In general, project staff was very aware of the project's goal, rating system. Job descriptions correlated with actual tasks. However, results concerning involvement in decision making proved surprising to senior management, and reflected a high level of frustration with regards to the impact project staff felt they were having on the project. In general, staff felt that decisions were made by the Project Manager (oftentimes in conjunction with the Field Coordinator) and that they were left to fulfill the role of implementer. The majority of respondents (nine) felt that the atmosphere could have been improved and listed a myriad of reasons, including one's opinions not being taken seriously, feeling discouraged, feeling frustrated and a confusion between personal and private life.

D.3. Project Supervision

In conformity to the organizational structure, a decentralized supervisory system was used to monitor staff performance and activity progress. On a day-to-day basis, the project manager had direct supervisory responsibility for two staff members, and the field coordinator for three field supervisors, who were responsible for supervising four to six monitrices.

Daily supervisory field visits were conducted by the supervisors. In a given six-week period, each monitrice was monitored at least once in each of her assigned villages. The mid-term evaluation recommended that the project reduce the frequency of supervisory visits as a way of including the supervisor in the planning and designing of the program. The decrease in frequency of supervisory visits was implemented, however no concrete alternative use of the supervisors' time was offered to them. They were asked to develop alternative uses for their time. None of the supervisors was able to comply with this task. The five-day supervisory visit schedule remained in place throughout the remainder of the project.

The project was encouraged to explore the possibility of decentralizing the meeting process and holding district level supervisory meetings. This was accomplished during the last year of the project. When questioned, District level health officials were quick to point this out as a positive point of collaboration between the MOH and CARE. Both the field coordinator and project manager made field visits, usually four or five times per month. At an administrative level, the project manager was in constant contact with the Bamako office through a daily radio exchange. She received bimonthly visits from the Coordinator of Health and Education Programs and quarterly visits from either the Assistant Director or the Director.

The project developed a supervision manual and guidelines which outlined performance indicators and provide a structured format for constructive criticism and performance evaluation.

D.4. Staff Development

Staff trainings figured prominently as part of MCHP activities (see annex). Local trainings which included the entire MCHP staff as well as international trainings which were expertise-specific, provided the opportunity to learn new things and to exchange information on a myriad of topics. Such topics included family planning, child survival, evaluation, nutrition, lessons learned and refresher courses. Once trained, the personnel returned to train other staff, village health workers or villagers.

The mid-term evaluation recommended more formal training in DBASE 3+ and EPIINFO for the Field Coordinator and the Administrative Assistant. The Administrative Assistant subsequently received a one-day training in EPIINFO. The Field Coordinator continued to self-teach. In examining the statistics captured under Phase II, there were many gaps in information. In addition, information is gathered in quantity however not always appropriately analyzed. This would indicate that those persons manipulating the information are still not adequately trained.

D.5. Project Collaboration

In eighteen face-to-face interviews with collaborators at different levels, two predominant, but somewhat contradictory sentiments were voiced. When asked about the strong point of project collaboration, a majority declared the project routinely consulted their counterparts for input about programming. Yet the weak point in the project's collaboration came at the implementation level, where the overwhelming opinion was that the project implemented unilaterally. Thus, while a semblance of equal input appeared to be the routine, it actually left different impressions. The Chief Medical Officer (CMO) at Macina found it cumbersome to meet with the MCHP Project Manager on a regular basis. Yet the Project Manager found time to be a constraint in dropping in on the CMO as often as would permit her to remain up to date on activities within the Health Center. The Macina Dutch collaborators were said to be working too independently, according to internal and external sources.

V. RECOMMENDATIONS

The final evaluation team made specific recommendations as regards the execution of the various interventions, should Phase III continue to apply itself in generally the same manner. Some suggestions are made for project management and supervision, also in the event that Phase III maintains the same basic structure as the previous phase.

In addition, the final evaluation team made recommendations on major structural changes for Phase III.

A. Recommendations for Interventions

- A.1. Reduce the number of objectives and specify adequate indicators that will provide appropriate criteria by which to measure progress.
- A.2. Integrate the birth spacing interventions with safe birth activities. At present, the participating villages select the Village Birth Spacing Agent, who is not necessarily a Village Health Worker operating where Village Health Committees exist. The project should nevertheless associate the Village Health Workers with the Birth Spacing trainings. These individuals are in a key position to counsel clients during treatment, pre-natal and post natal consultations.
- A.3. A restocking protocol should be established between CARE and SSP/Segou to assure the availability of contraceptive products in a timely fashion and avoid the occasional stockouts that occur at the district levels.
- A.4. Where there is a Village Health Committee, the integration of

the Village Birth Spacing Agent into the committee structure should not be neglected, nor left to chance. This would facilitate the acceptance of this activity as part of maintaining good health.

- A.5. The project must take the initiative on a malaria prevention and treatment activity, though the national protocol is still on the drawing board. MCHP should work with the Chief Medical Officer in developing a protocol for the Macina Circle while waiting for the national one to be defined. (See Malaria; Phase III Comments).
- A.6. The diarrheal disease control intervention should be revised to better apply the principles of Oral Rehydration Therapy, and the hygiene and sanitation intervention should be integrated in, not to stand alone. Nutrition activities should focus principally on nutrition as concerns prevention and treatment of diarrheal disease - the number one health problem for children in the target group. Applied nutrition activities will have greater chance of success when they are presented in the context of immediate problems facing mothers of small children.
- A.7. Re-assess the current EPI strategy with the SSS/Macina, and review the Phase III decision to retire from EPI activities.
- A.8. Consider retiring the Child-to-Child component, in light of the conclusions in this evaluation.

B. Recommendations for Management

- B.1. Supervisory visits should be reduced to allow adequate time for input into new and ongoing project initiatives. A concrete way in which the supervisors can participate in decision making should be established by CARE as part of the supervisor's responsibilities.
- B.2. Once a year, three to six months before annual appraisals take place, a questionnaire should go out to supervisors and field staff. This questionnaire should contain items on the extent to which the staff feels implicated in decision making, things not going well and suggestions as to how they should be improved. Anonymity of the staff should be maintained in filling out the questionnaire.
- B.3. The final evaluation team recommends a suspension of all data collection activities for the first six months of the Phase III project in order that the senior staff, i.e., the Project Manager, Field Coordinator and the supervisors have adequate time to establish measurable, quantifiable objectives,

benchmarks and their corresponding indicators. In addition, process objectives and their corresponding benchmarks should be established for each impact objective. These objectives and progress to date should be repeated in each quarterly, semi-annual and annual report issued.

- B.4. As well, during this six month period, training should be provided to the Field Coordinator in data analysis and manipulation; training to the supervisors in data analysis and how this data can enhance their supervisory capabilities and provide feedback to the monitrices, MOH staff and villagers; and training for the monitrices on the meaning of the data they collect and how this data can benefit their villages by increasing their impact. These trainings should occur at multiple times throughout the project period.
- B.5. Plans should begin immediately for a study to examine the cost effectiveness of the project interventions and management.
- B.6 To improve collaboration between counterparts, it may be wise to assign one project supervisor to the Dutch counterpart and one to the MOH to provide these individuals with the most up to date information regarding the objectives of Phase III, upcoming evaluations, visits from Bamako staff and the progress to date. During this same meeting, the supervisor could receive information on planned meetings between MOH and/or Dutch collaborators. This would ease the burden on the Project Manager and allow the supervisors to be more engaged in project planning. The Project Manager could be informed as part of the weekly staff meeting between supervisors or more frequently as needed.

C. Phase III Document Recommendations

The final evaluation team for the Phase II Macina Child Health Project reviewed the Phase III project document Macina Community Health Project in consequence of several major findings during investigations. Following are recommendations and justifications based largely on these findings. They are organized according to the four major elements of the project strategy.

- o **Strengthen the GRM health services at the Circle and Arrondissement level: 3.1.1. cross ref with 3.2.2/3.2.3**

The proposal to reinforce the health services capacity at the Circle level is sound. Given the referral system that is being advocated which directs health care seekers up the system, and the government's disengagement from the Arrondissement level, CARE's other activities will only work if there is some support at the Circle level. The nature and form of that support may need to be revised. As a matter of definition, CARE is not actually strengthening the GRM health services at the Circle, rather their health planning services. This is an important distinction, as CARE does not propose to get involved in supporting service delivery at the Circle level, and does not want it interpreted as such. A number of factors need to be considered in examining what form this assistance will take. From a personnel perspective, SSS/Macina may not be able, in the first year, to reinforce its staff at the Circle level - nor at the Arrondissement level. As it stands, two (out of five) Arrondissement health officers are retiring before December 1993, and there are no replacements in sight (personal communication; Dr. Fofana). If this is a likely scenario, CARE may want to condition its presence on the reinforcement of personnel, as is doing SSP, in order to pressure the GRM. The Chief Medical Officer at Macina Circle has advocated this position for CARE. In addition, it would be strategically advantageous to locate the Phase III project at the Macina Health Center itself. CARE wants to work that structure; CARE needs to be inside and investing. Certain physical plant modifications would be necessary. A review of the current electricity capacity of the Health Center revealed that the solar energy system put in place in April 1993 is not powerful enough to run fans, printers or sterilizing equipment (see technical sheet in annexes). If CARE is to import and integrate a first-rate Health Information System, it will have to insure the energy needs of the Health Center. If referral is toward quality care at the Circle level, a minimum level of mechanical operating capacity is necessary. It isn't proposed that building space be added, but that MCHP personnel be located next to SSS counterparts. Finally, as concerns personnel and the type of technical assistance CARE is looking to provide over the entire scope of activities and the heavy accent on cost recovery; it makes sense to look for a Health Economist, or someone with solid Operations Research

experience for Project Manager. For the public health/protocol questions, the SSS is adequately staffed to respond to the technical aspects.

To summarize:

- specify health planning services instead of health services
 - condition Phase III on a concrete promise of added staff from the Ministry of Health
 - locate the project office at the Macina Health Center
 - make modifications to the MHC's electrical power capacity, and some material input to office installation
 - recruit for a Health Economist or Operations Research background
- o Develop/establish village health infrastructure to be managed by rural populations.

Phase III has based this element on the foundation laid by Phase II in terms of its success rate in establishing and maintaining village health committees, and a network of village health workers. At this writing, out of 81 villages, there are 21 official health committees, 5 of those not actually belonging to the Project catchment area. No criteria for functionality were ever established, and over the course of 10 months, only 7 of these committees benefitted from one supervision visit by the SSS/MOH. Of a projected 500 village health workers (1990 DIP), 113 are actually trained, but not guaranteed to be practicing. No village health committee to date has inaugurated a system of payment for its village health workers. No village health committee is functioning at the expected "self-management" level predicted by the DIP in 1990. The Phase III projections are for an additional 45 village health committees, and 300 village health workers. Supervision, the Achilles heel of a community health network of this dimension, is to be the responsibility of the SSS/Macina. In short, where Phase II was weakest, Phase III may only compound the error. The recommendations are to scale back the number of VHC, VHWS, put the accent on assuring a systematic quality, supervision mechanism for those VHCs already created, and plan more modestly for those yet to be created.

To summarize:

- establish within the document, the criteria for functionality of village health committees, with a rating system and incentives/disincentives for action/inaction on the part of the VHCs.
- establish within the document, incentives and disincentives (attached to funding or material supply) for action/inaction on the part of SSS/Macina in terms of supervision.

- reduce the number of new VHCs to train and supervise from 45 to 30.
- reduce the number of FAWs and TBAs to train and supervise from 150 respectively to 90.
- assure that by the end of Phase III, 50 VHCs rather than 75, will be functioning.

CSCOM Development

Phase III appears to make CARE responsible for the implementation and functioning, by year end 1997, of 8 inter-village CSCOM management committees. To borrow from the experience of PSPHR, after 2 years and 60 million dollars to establish CSCOMs, not one is in place and functioning. Achieving 8 over the course of four years is beyond ambitious. It is recommended that Phase III propose an initial pilot activity to SSS/Macina for the creation of the first prototype CSCOMs, and organize at the most, 2 CSCOMs. Use the experience to articulate lessons learned and strategic issues for CSCOM creation.

To summarize:

- persuade SSS/Macina to reduce from 8 to 2 at the most, the number of CSCOMs to establish in the given time frame. Specify these as prototype/pilot exercises.
- o Put in place a village based Family Planning IEC and service delivery system.

The Phase III document should correct some misinformation as regards the background of the Phase II Family Planning activities. The pilot phase did not actually start until May 1993, as opposed to September 1992. By the time the KAP study was done in September 1993, there had been only four months of actual on-the-ground activity. The Chief Medical Officer did not participate in the training of trainers organized by AMPPF. These adjustments may have bearing on the level at which the FP component re-enters the project. As of the end of Phase II, no accurate stock counts were able to be obtained, no "head count" was obtained to ascertain how many of the 60 plus FP agents were still functioning.

The issue of sterility deserves special mention. Phase III proposes to do education and referral on sterility via MCHP staff at the village level. Yet, no figures on sterility prevalence are cited anywhere in the document, to justify such a risky and complex undertaking. If the project endeavors to talk about sterility as a disease on its own, with causes and effects and possible treatments, what can it offer in the way of services - starting from detection through to treatment and/or correction? Is the project prepared to finance the special apparatus (counseling, diagnostic, primary treatment, etc) that need to be in place at least at the Circle level in order to satisfy the demand this endeavor may create? Apart from referring a sterile couple to

Bamako, it is not likely they will receive satisfaction. It is strongly recommended that Phase III avoid any direct engagement with sterility issues. Preferable to educate and counsel on sexually transmitted diseases in the context of reproductive health; consequences of which include AIDS and sterility. Notwithstanding the diplomatic concession ("Family planning services must be balanced with services for those who cannot have children") that this component appears to make, it is a complex endeavor for an extremely limited audience.

To summarize:

- strike all references to sterility as an independent phenomenon that Phase III may take on (pp 10, 42, Int. Goal 3, indicators).

- redirect the effort towards education, prevention and treatment options for STDs (including AIDS).

- bring the selection of CBD villages into line with the village health committee down sizing.

- Do not do CBD where there is no other CARE involvement. Family planning interventions, including condom distribution, should be closely linked with maternal health interventions.

- o **Increase knowledge and practice of Preventive Health Measures.**

While the results of the village interviews conducted were encouraging as concerns the felt effects of CARE's interventions, the KAP results provide a more detailed view of what actually is occurring (or not occurring) in terms of behavior and attitude change. Progress has been made in every protocol area tested, but the objectives were not achieved to the level stated in the Phase II documents. Thus, the Phase III strategy must really insist on acquisition of behaviors, and proof of systematic application. Definitely, a new approach to information and skills transfer must be studied. The major complaint about the education messages and their delivery was the monotony and dull repetition that eventually set in. This occurred where well-trained health promoters, with many seminars, workshops and manuals at their disposal, were operating. One can only imagine the initial difficulties that the village health workers will experience as they replace the health promoters in the mobilization and education process.

As for adding to the basket of activities "not sufficiently covered", one must be extremely careful to avoid an activities-driven component that village health workers will pick and choose from, without a real grasp of the global purpose of what they are doing - conscientisation of the villagers toward their own health

situation, and how to take charge of it. It is suggested that village health workers conduct participatory rural health appraisals with their populations prior to beginning their mobilization activities. The project can be relatively sure of what will be discovered in terms of the health profile of most of the villages, as enough general epidemiological monitoring has been conducted. But the fact that the villagers assess their own situation will greatly aid the community ownership factor.

The specific intervention of Dracunculosis eradication is an anomaly for Phase III that should be eliminated. Indeed, WHO has declared a goal of eradication by 1996, but 16 reported cases over a period of three years would not appear to justify a specific intervention, with an objective of 100% eradication, by the project. It is suggested that the project let the National Program be responsible for eradication. Should their actors come into the Circle to conduct activities, the project may assist with logistics. Malaria is a much more pressing problem that deserves singular mention in the document, as opposed to Guinea Worm. The malaria activities of the project should go beyond education and prevention messages. The project should promote specified treatment protocols, how to recognize acute malaria episodes (fever, convulsion) especially in children, malaria prophylaxis for pregnant women, and the possible sale of treated mosquito nets through the village pharmacy.

To summarize:

- propose to do participatory rural health appraisals in villages with the VHWS;
- eliminate the specific Dracunculosis intervention altogether, including the indicator of 100% eradication;
- revise and accent the malaria intervention strategy, including more specific indicators for prophylaxis and treatment.

In specific reference to the Project Information System, several observations are forthcoming. A distinction should be made between Project Information System, and Health Information System (A new programming tool is now available from WHO, EVAL/EPIInfo, which goes beyond the strict statistical data analysis, and helps with interpretation of results). The PIS is a tool that has been used to monitor implementation of project actions, and could be adapted to track progress towards objectives. A Health Information System is used to monitor disease prevalence and decreases/increases in incidence. Both are necessary in order to have an in-depth portrait of the project's impact and effect on its beneficiaries. The current PIS needs to be streamlined. A sentinel site monitoring system (ref UNICEF) may be feasible to install, especially given the project's vast network throughout the Circle. Better integration with other project monitoring systems (Wells, DAZA, Alpha) is expected. This would facilitate

triangulation of data, and conclusions could be drawn about the inter-sectorial approach that can only be speculated on at present.

To summarize:

- note in the document a revision of the PIS to include objectives and indicators, with particular attention to the USAID/Child Survival standard indicators;
- note in the document the integration of a Health Information System;
- note in the document the possibility of setting up a Sentinel Site survey system after the UNICEF model;
- note in the document the intention to integrate some of the related projects monitoring indicators.

In specific reference to the project document itself;

- review for elimination of any mix of French/English terms;
- revise the objectives and indicators to be SMART (Sustainable, Measurable, Actionable, Replicable, and limited in Time), and standardized according to CARE/PHC and USAID/CS guidelines.
- include an Executive Summary.

VI. PIPELINE ANALYSIS

The Macina Child Health Project began in 1986, with financing from USAID Washington. This initial financing covered Phase I, 1986 - 1989. Upon conclusion of Phase I, CARE/Mali was obliged to:

1. Establish a new project proposal for further funding under Phase II;
2. Bridge the funding gap between Phase I and II during the delay period before funding was in the pipeline.

A new project proposal and agreement was establishment, covering the period from August 1, 1990 to August 31, 1993. The project funding proposal was for \$900,000 of which USAID/Washington approved \$604,994. Matching funds for 25%, as specified in Child Survival central fund arrangements, must come from the project executor (CARE/Mali).

CARE/Mali turned to USAID/Mali for the bridge funding. Thus, in 1989, MCHP received \$150,000 from USAID/Mali, and began a precedent for their participation in the project. A budget amendment was made that increased the USAID/Mali contribution to \$318,000 in total. This was on condition that CARE/Mali increase its contribution from 25% to 33%.

In 1993, USAID/Washington contributed another \$10,000.

The Macina Child Health Project made no attempt to analyze its cost effectiveness capacity in either its Phase I or Phase II projects. Thus the issue of sustainability continues to elude the designers.

53

Actual Expenditures to Date
 (10/01/90 to 06/30/93)

Projected Expenditures Against
 Remaining Obligated Funds
 (07/01/93 to 12/31/93)

Total Agreement Budget
 (Columns 1 & 2)
 (10/01/90 to 12/31/93)

COST ELEMENTS

I. PROCUREMENT

- A. Supplies
- B. Equipment
- *C. Services/Consultants
 - 1. Local
 - 2. Expatriate
- SUB-TOTAL I

II. EVALUATION

SUB-TOTAL II

III. INDIRECT COSTS

- HQ/HO Overhead
- SUB-TOTAL III

IV. OTHER PROGRAM COSTS

- A. Personnel
- B. Travel/Per Diem
 - 1. In Country
 - 2. International
- C. Other Direct Costs
- SUB-TOTAL IV

TOTAL FIELD

* Excludes Evaluation Costs

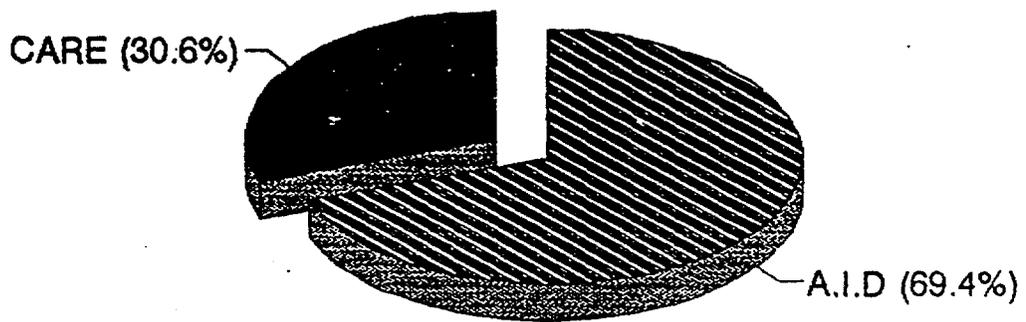
	A.I.D	CARE	TOTAL	A.I.D	CARE	TOTAL	A.I.D	CARE	TOTAL
A. Supplies	376	35,470	35,846	0	66,956	66,956	376	10,500	10,876
B. Equipment	6,105	36,641	42,746	0	19,331	19,331	6,105	93,000	99,105
*C. Services/Consultants									
1. Local	5,545	11,883	17,428	0	41,111	41,111	5,545		
2. Expatriate	0	6,107	6,167	5,500	0	5,500	5,500		5,500
SUB-TOTAL I	12,026	90,161	102,187	5,500	127,398	132,898	17,526	103,500	121,026
II. EVALUATION	12,636	0	12,636	22,298	0	22,298	34,934	4,397	39,331
SUB-TOTAL II	12,636	0	12,636	22,298	0	22,298	34,934	4,397	39,331
III. INDIRECT COSTS									
HQ/HO Overhead	39,227	39,936	79,163	8,169	0	8,169	47,396	21,216	68,612
SUB-TOTAL III	39,227	39,936	79,163	8,169	0	8,169	47,396	21,216	68,612
IV. OTHER PROGRAM COSTS									
A. Personnel	384,076	207,505	591,581	(163,001)	251,179	88,178	221,075	40,569	261,644
B. Travel/Per Diem									
1. In Country	14,809	6,984	21,793	10,641	11,569	22,210	25,450		25,450
2. International	10,063	4,040	14,103	(7,089)	12,476	5,387	2,974		
C. Other Direct Costs	105,173	209,476	314,649	160,468	85,285	245,751	265,639	101,139	366,778
SUB-TOTAL IV	514,121	428,005	942,126	1,017	360,509	361,526	515,138	141,708	656,846
TOTAL FIELD	578,010	558,102	1,136,112	36,984	487,907	524,891	614,994	270,821	885,815

COST ELEMENTS	Actual Expenditures to Date (10/01/90 to 06/30/93)			Projected Expenditures Against Remaining Obligated Funds (07/01/93 to 12/31/94)			Total Agreement Budget (Columns 1 & 2) (10/01/90 to 12/31/93)		
	A.I.D.(DC&MAL	CARE	TOTAL	A.I.D.(DC&MAL	CARE	TOTAL	A.I.D.(DC&MAL	CARE	TOTAL
I. PROCUREMENT									
A. Supplies	32,302	35,470	67,772	11,699	66,956	78,655	44,001	10,500	54,501
B. Equipment	6,473	36,641	43,114	(368)	19,331	18,963	6,105	93,000	99,105
*C. Services/Consultants									
1. Local	48,640	11,883	60,523	14,430	41,111	55,541	63,070		
2. Expatriate	4,550	6,167	10,717	950	0	950	5,500		5,500
SUB-TOTAL I	91,965	90,161	182,126	26,711	127,398	154,109	118,676	103,500	222,176
II. EVALUATION	12,636	0	12,636	65,518	0	0	78,154	4,397	82,551
SUB-TOTAL II	12,636	0	12,636	65,518	0	0	78,154	4,397	82,551
III. INDIRECT COSTS									
HQ/HO Overhead	53,304	39,936	93,241	(5,908)	0	(5,908)	47,396	21,216	68,612
SUB-TOTAL III	53,304	39,936	93,241	(5,908)	0	(5,908)	47,396	21,216	68,612
IV. OTHER PROGRAM COSTS									
A. Personnel	457,846	207,505	665,351	(155,809)	251,179	95,370	302,037	40,569	261,644
B. Travel/Per Diem									
1. In Country	20,594	6,984	27,578	25,621	11,569	37,190	46,215		46,215
2. International	10,063	4,040	14,103	32,881	12,476	45,357	42,944		
C. Other Direct Costs	129,105	209,476	338,581	168,584	85,285	253,869	297,689	101,139	398,828
SUB-TOTAL IV	617,608	428,005	1,045,613	71,277	360,509	431,786	688,885	141,708	830,593
TOTAL FIELD	775,513	558,102	1,333,616	157,598	487,907	645,505	933,111	270,821	1,203,932

* Excludes Evaluation Costs

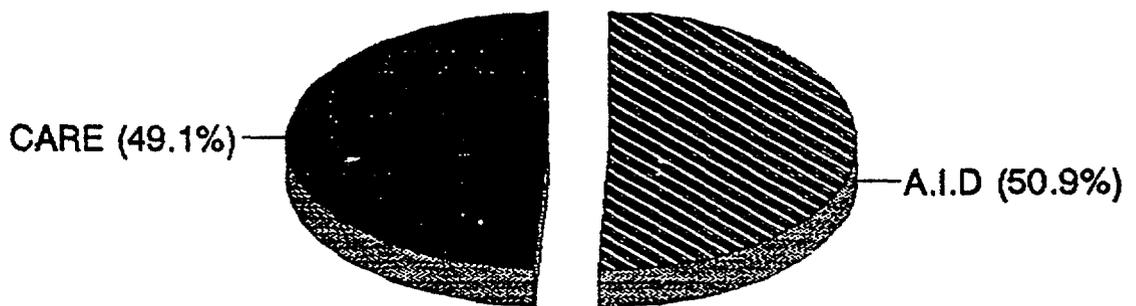
MCHP PIPELINE ANALYSIS

AGREEMENT BUDGET (OCT 90 TO DEC 93)



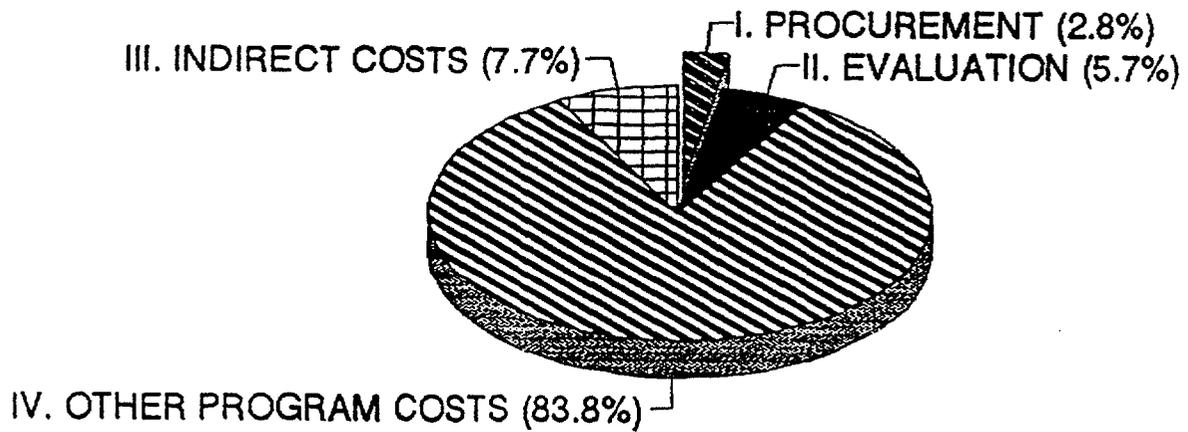
MCHP PIPELINE ANALYSIS

ACTUAL EXPEND. TO DATE (OCT 90 TO JUN 93)



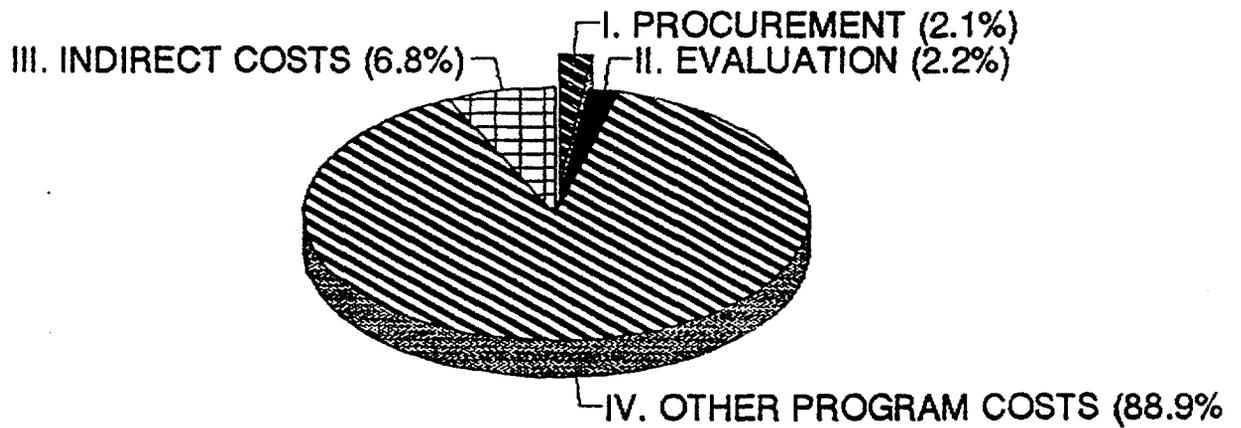
AID (DC) MCHP PIPELINE ANALYSIS

AGREEMENT BUDGET (OCT 93 TO DEC 93)

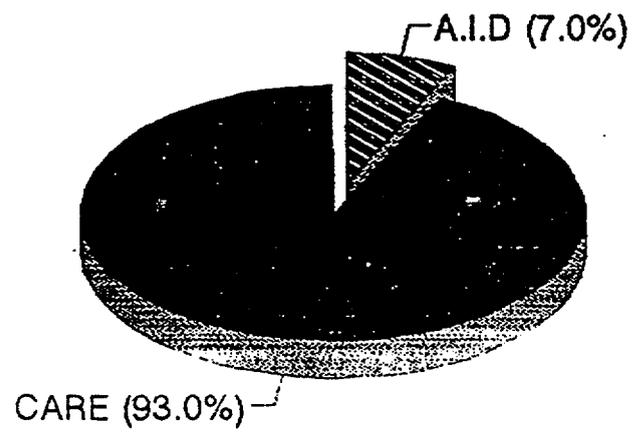


AID (DC) MCHP PIPELINE ANALYSIS

ACTUAL EXPEN. TO DATE (OCT 93 TO JUN 93)



MCHP PIPELINE ANALYSIS
PROJECTED EXPENSES (JUL 93 TO DEC 93)



VII. ANNEXES

- list of persons contacted
- evaluation calendar
- data collection instruments
- terms of reference
- village chronology Phase I and II
- project chronology
- list of project trainings
- EPI materials and equipment list
- technical report on Macina Health Center solar capacity
- list of documents

LIST OF PERSONS CONTACTED

- BAMAKO
 - Lynn Gorton - Health Officer USAID
 - Robin Anthony - Nutrition Communications Project (AED)
 - Dr. Victor Petvarguine - National Center for Immunization
 - Dr. Sidi Konaré - Director, National Center for Immunization

- Bureau/CARE BKO
 - Peter Buijs - Assistant Country Director
 - Nanette Alvey - Health and Education Coordinator
 - Marc de Lamotte - Country Director
 - Abdoulaye Diarra - Accountant
 - Mme Djénèba Yattara - Programs Officer

- SEGOU
 - Dr. Massambou Sacko, Director, Regional Health Directorate
 - Dr. Jurrien Toonen, SSP Segou - Project Manager
 - Dr. Anafa Ag Ikatahit, Regional Director EPI
 - Mr. Malick Coulibaly, Coordinator AMPPF - (Association Malienne pour la Planification Protection de la Famille)

- Macina Health Center
 - Dr. Famory Fofana, Chief Medical Officer SSS Macina
 - Dr. Sékou Traoré, Technical Advisor SSP Macina
 - Mr. Modibo Diallo, Coordinator SSC Macina
 - Mr. Mahamane Farka, Director PEV Macina
 - Mr. Djerry Kanté, District Health Agent- Kolongo
 - Mr. Jean Koné, District Health Agent - Sarro
 - Mr. Dolo, District Health Agent - Saye
 - Mr. Damassa Tangara, District Health Agent - Monimpé

- CASIER Operation Riz Segou/ MACINA
 - Mr. Vincent Dembelé, Chef Casier ORS Macina

- CARE\MACINA STAFF
 - Mr. Perry Rushlau, Macina Suboffice Coordinator
 - Ms. Denise Gordon Diarra, MCHP Project Manager
 - Mr. Karim Maïga, DAZA Project Manager
 - Mr. Modibo Bâh, ALPHA Project Coordinator
 - Mr. Sanga Camara, WELLS Project Coordinator
 - Mr. Djoukou Coulibaly, Field Activities Coordinator
 - Ms. Mariam Famanta, Supervisor
 - Ms. Maimouna Maïga, Supervisor
 - Ms. Traore Fatou Diaw, Supervisor

PROGRAMME FOR EVALUATION

Monday, 20 September - Friday, 24 September

- * Team members meet, begin evaluation design and document review. Develop data collection instruments, plan programme for Macina.

Monday, 27 September - Saturday, 9 October

- * Team members travel to Macina, conduct investigations, data collection, report writing.

Monday, 11 October - Friday, 16 October

- * Team members return to Bamako, continue report consolidation, data verification and final editing.

PROGRAMME FOR SEGOU/MACINA

27/9/93 - 8/10/93

Monday, 27 September

- * 7 hrs: depart for Segou/Macina
- * 10 hrs: arrive Segou
- * interviews: Dr. Sacko, Directeur Reg./Sante
Dr. Anafa, Responsable PEV
Responsable AMPPF
Dr. Toonen, Directeur/SSP
- * 15 hrs: depart Segou
- * 20 hrs: dinner and installation

Tuesday, 28 September

- * 7hrs30 - 9hrs30 - meet with Macina Project staff, briefing
- * tasks for staff - arrange logistics for visits to villages
 - translate interview guidelines (Dr. Idrissa)
 - review village chronology, trng. lists
 - arrange interviews
 - interview senior staff
- * 10hrs, Translate interview guidelines (Dr. Idrissa/staff)
Logistics for week two (Denise)
Senior staff interviews (Marydean/Dorothy)
- * 13hrs, Interviews or individual reading time
- * 16hrs.- 17h30 Team Meeting

Wednesday, 29 September

- * 8hrs, Team meeting
- * 9hrs, Visits to Chefs de Poste (Marydean and Dorothy):
 - Sarro, Jean Kone
 - Saye, A. Dolo
- * 9hrs, Visits to CARE Project Offices and Casier ORS (Dr. Idrissa and Denise)
- * 13 hrs, Statistics Gathering/Health Services (Dr. Idrissa and Denise)
- * 16hrs - 17h30 Team Meeting

Thursday, 30 September

- * 8hrs, Team Meeting
- * 9hrs, Interviews (Dorothy and Marydean)
 - Dr. Sacko
 - Dr. Traore
 - Farka Mahamane
 - Modibo Diallo
- * 9hrs, Statistics Review and Tables (Dr. Idrissa and Denise)
- * 13hrs, Group work

Friday, October 1

- * 8hrs, Team meeting
- * 9hrs, Visits to Chefs de Poste (Marydean and Dorothy)
 - Kolongo, Kante
 - Monimpe
- * 9hrs, Organize annexes for report (Denise and Dr. Idrissa)
- * 14hrs, Group work: Organization of report

Saturday, October 1

- * Meetings as needed, individual work

Monday, October 3

- * 7h30, Team Meeting
- * 8hrs, Teams leave for village interviews

PEOPLE TO INTERVIEW/Macina	INTERVIEWER
Dr. Fofana, Medecin Chef Mr. Diallo, Coor. SSS Farka Mahamane, Resp. PEV Mr. Dembele, Chef Casier/ORS Perry Rushlau, Coor. CARE Sangha Camara, Wells Project CARE Karim Maiga, ALPHA Project CARE Dr. Traore, Cons. Tech./SSP	

DATA COLLECTION INSTRUMENTS

QUESTION REPOINDRE	GENRE D'INFORM	SOURCE	RESP.	DATE ACHEV	COMMENTAIRE
Objectif 1 (PEV)	Quantitative: . chiffres . rapports mensuel . %	. Enquete . Couverture Vacc. 92 . Rapports PEV-DRSP . Cahiers PEV du projet du bureau/Macina	MAIGA		
Objectif 2 (PEV)	Quantitative: . chiffres . rapports mensuels . %	. Enquete Couverture Vaccinale 1992 . Rapports PEV . Fiche HGA/Macina	MAIGA		
Objectif 3 (PEV)	Quantitative: Qualitative: . Observation	. Rapports de Formatio C/S Macina . Rapport Bi-Annuel C/S Macina . Rapports du Projet trim. PIRs (GARE) . Rapport Mensuel (CARE) . Visites sur le Terrain Entretiens . Document: "Semaine du PEV" . Fiche de Stock Rapport . Rapports de Ravitaillement	MAIGA		
Objectif 4 (PEV)	. Quantitative % . Qualitative (Connaissance)	Enquete KAP 7/93 . Adultes interroge . Rapport Mensuel . Fiche Indicateur Sanit.	MAIGA		

QUESTION REPOINDRE	GENRE D'INFORM	SOURCE	RESP.	DATE ACHEV	COMMENTAIRE
Objectif 5 LUTTE CONTRE LE MALADIES DIARRHEIQ	Quantitative: % Qualitative Niveau d'efficacite Observation -> Visite ->	.Enquete CAP 7/93 .Rapports Mensuels .PIR du Projet .Enquete SSP-Segou .Demonstration .Unites de TRO	Marydean		
Objectif 6 NUTRITION	Quantitative: % Qualitative: Niveau de Connaissance Verification par Interview des femmes	Enquete CAP 7/93 Interview Sur le Terrain des femmes	Marydean		
Objectif 7 MATERNITE SANS RISQUES	.Quantitative: % Qualitative:	.Enquete CAP 7/93 .Rapports Mensuel C/S Macina .Consult. Pre-Natal .PIRs ,Rapports Mensuel	Denise		
Objectif 8 Enfant Pour enfant	.Quantitative: % Qualitative: Connaissance	.Enquete CAP 7/93 .Interviews .PIRs .Rapport Mens. (CARE)	Denise		

QUESTION REPONDRE	GENRE D'INFORM	SOURCE	RESP.	DATE ACHEV	COMMENTAIRE
Objectif 9 Espace Naissance	.Quantitative .Qualitative Connaissance	.Enquete CAP EN 9/9 .Rappports Mensuel Centre de Sante Macina Consultation Pre-Natal	Denise		
Objectif 10 Paludisme	.Quantitative % Connaissance/Pratique Observation	.Enquete CAP 7/93 .Rappports Mens. (CARE) .Visite Sur le terrain	Denise		
Objectif 11 Soutenabilite	.Qualitative .Discussion "Appreciation"	.Rapport Mens.(CAR .Rapport Bi-Annuel Centre de Sante de Macina .Rapport Program de Budget (Rapport Trimestriel SSP) .Interview .Observation .PIRs	Marydean		
Objectif 12 Hygiene et Assainissement	.Quantitative % .Qualitative Pratique Observation	.Enquete CAP 7/93 .Interviews .Rapport Mens. (CARE) .PIRs	Marydean		
ANALYSE D BUDGET	Pipeline Analysis	.Budget .Rapport Financier			Diarra/CARE-Mali
NATURE DE COLLAB. AVEC AUTRES PR INSTIT COLLAB.	.Quantitative \$. .Equip. PEV .Qualitative Appreciations	.Interviews .Accord (NCP) .DRSP .PIRs			Maiga/Marydean
EFFICACITE DU SYSTEME D'INFORM. DU PROJET	.Adequate .Approprie .Fiable .Mesurable .Utilisation Retro-Information	.Interview avec Informaticien .Medecin Chef Rappports de tout genre	Denise Dorothy		
GESTION INTERNE PSIM	.Qualitative .Rappports .Interview	Staff Rappports			Dorothy

INTERVIEW GUIDELINES:
Persons Associated in a Secondary Capacity

- [] Chief Medical Officer, MOH
- [] Technical Advisor, SSP/Segou
- [] SSP/Segou Project Director
- [] SSS Coordinator, Macina Health Center
- [] District Health Officer (5)
- [] CARE Wells Project Director
- [] Project Coordinator, NCP
- [] Director, Casier ORS
- [] Director, EPI

Please use this interview guide to conduct informational interviews for persons associated with the project. Remember to:

- read the question exactly as written;
- check for comprehension ("do you understand the question?" is the question clear to you?")
- probe if necessary; ask **how, why, what.**
- don't settle for yes/no answers, please.

-
1. Please tell me how you are associated with the project in organizational terms.
(probe: written agreement w/project? supervisory capacity? administrative oversight? financial engagement? material engagement?)
 2. Have you seen a copy of the MCH project document? Can you tell me what the goal of the MCH Project is.
 3. Please describe for me a typical transaction that would occur between your service and the project.
(signing a paper, receiving materials, receiving/giving funds, reserving a vehicle, setting up an activity).
 4. Have you participated in any project activity (training, evaluation, education session, monitoring...)? Please elaborate.
 5. What, in your opinion, is the project's greatest single accomplishment? Please elaborate.
 6. What, in your opinion, was the project's greatest single error? Please elaborate.
 7. What, in your opinion, is the project's most effective activity? Please elaborate.
 8. What, in your opinion, is the project's least effective activity? Please elaborate.
 9. What, in your opinion, is the project's greatest strength?
 10. What, in your opinion, is the project's greatest weakness?
- 100

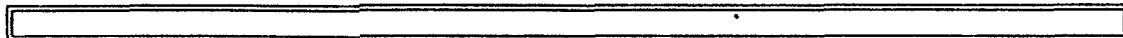
INTERVIEW GUIDELINES:
Persons Associated in a Tertiary Capacity

- [] Coordinator, Macina Sub-Office
- [] Project Director, ALPHA
- [] Project Director, DAZA
- [] Project Director, MESS
- [] Project Director, TEN
- [] Health Officer, USAID/Bamako

Please use this interview guide to conduct informational interviews for persons indirectly associated with the project.

Remember to:

- read the question exactly as written;
- check for comprehension ("do you understand the question?" is the question clear to you?")
- probe if necessary; ask **how, why, what.**
- don't settle for yes/no answers, please.



1. Please tell me what kind of association you have with the project.
(probe: organizational, advisory, operational, financial)
2. Have you seen a copy of the MCH project document? Can you tell me what the goal of the MCH Project is.
3. Please describe for me a typical transaction that would occur between your service and the project.
(signing a paper, receiving materials, receiving/giving funds, reserving a vehicle, setting up an activity).
4. Have you participated in any project activity (training, evaluation, education session, monitoring...)? Please elaborate.
5. What is the most positive aspect you are aware of regarding the project? Please elaborate.
6. What, is the least positive aspect you are aware of regarding the project? Please elaborate.
7. What are you aware as the project's most effective activity? Please elaborate.
8. What are you aware of, as the project's least effective activity? Please elaborate.
9. What, in your opinion, is the project's greatest strength?
10. What, in your opinion, is the project's greatest weakness?

INTERVIEW SAMPLE AND STRATEGY

81 villages over 5 Arrondissements

\ /
2 villages per arrondissement
1 advanced, 1 in training

\ /
10 villages

4 women	4 men	4 children
1 ASC	1 ACT 1 Chef	1 leader

\ /
16 persons per village

160 persons

In each village: 2 interviewers

1 interviewer

2 men
2 women
2 children
1 ASC
1 leader

1 interviewer

2 men
2 women
2 children
1 chef
1 ACT

\ /
16 persons

2 teams of 2 persons/team = 4 persons

\ /
40 persons/interviewer

16 persons/day/team

\ /
5 days

GUIDE D'ENTRETIEN:
Bénéficiaires du Projet

(Villageois, ASC, ACT, Chefs, Leaders)

PRENDRE QUELQUES MINUTES AFIN D'EXPLIQUER QUI ETES VOUS, POURQUOI VOUS POSEZ DES QUESTIONS. DIRE QUE VOUS AVEZ BESOIN DE CONSEIL AFIN DE MIEUX TRAVAILLER AVEC LES VILLAGEOIS DANS L'AVENIR. DEMANDEZ QU'ILS SOIENT AUSSI HONNETE ET OUVERT QUI POSSIBLE AVEC LEURS REPONSES...

1. Quelle est la maladie la plus fréquente dans votre foyer?
 - 1a. Qu'est ce que le projet a fait envers cette maladie?
 - 1b. Qu'est ce que vous avez fait a votre niveau envers cette maladie?
2. Quel est le problème de santé que vous aviez avant l'arrivée du projet?
 - 2a. Est ce que ce problème a été amélioré depuis l'installation du projet?
3. Y a-t-il un comité de santé dans votre village?
 - 3a. si oui, qu'est ce que le CSV a fait pour résoudre vos problèmes de santé?
4. Au cas où le projet se retirerait, qu'allez vous faire?
5. Quelle est l'activité du projet dont vous avez apprécié de plus?
6. Quelle est l'activité du projet dont vous avez apprécié de moins?
7. Êtes vous informés sur les résultats des questions que le projet vous pose chaque mois? si oui, comment cela se fait? si non, pourriez-vous nous proposer un moyen pour le faire?
8. Qu'est ce que le projet vous a apporté comme changement dans votre foyer? dans votre village?

N'oubliez pas de noter HOMME/FEMME/ENFANT/CHEF/ASC/ACT/LEADER SUR VOTRE FICHE DE REPONSE, AVEC LE NOM DU VILLAGE ET LA DUREE DE L'ENTRETIEN.

CARE MALI
MACINA CHILD HEALTH PROJECT PHASE II
FINAL EVALUATION

TERMS OF REFERENCE

1. CARE - Mali: Macina Child Health Project (MCHP)
2. TOR prepared by: Nanette Alvey
3. Date TOR prepared: August 6, 1993
4. Evaluation point person: Nanette Alvey; ACD Health/Ed
5. Project Funding Cycle: FY90 - FY93 (10/90 - 9-93)
6. Donors: USAID/W (CS VI), USAID/Mali, CARE USA, CARE-Osterreich, Edward Ryan

7. BACKGROUND

The Macina Child Health Project (MCHP) began in 1986 with the goal of reducing infant and child morbidity and mortality in the administrative district of Macina Circle in the Ségou region. MCHP is now at the end of its second phase of operations which began in September 1990. CARE Mali is currently seeking funds for a third and final phase of the project.

Over the past seven years, MCHP has worked to improve preventive health practices in 93 of the 246 villages of Macina Circle, serving approximately 41,000 people. The project focuses on diarrheal disease control, hygiene and sanitation, immunization, nutrition, and maternal health. In 1992, a birth spacing component was introduced and is now operating in 22 villages.

The intensive child survival interventions focus on changing health behaviors of the caretakers of small children, primarily women between the ages of 15 and 45 years. Recently, the project has targeted older children and men as alternate care takers. MCHP also offers logistical and outreach support to the government health center in Macina for immunization services to small children and women of childbearing age throughout the entire Macina Circle (population 150,000).

A guaranteed water supply is an important criterion by which MCHP selects its villages. In this regard, MCHP has worked closely with CARE Mali's Macina Wells Project by entering villages where an improved supply of water has been secured to permit better sanitary conditions. In Macina, CARE also operates an agriculture/gardening project, a literacy project and a town sanitation project all of which complement and reinforce the efforts of MCHP.

MCHP has worked closely with the Ministry of Health, Solidarity and Elder Persons and the Dutch funded Primary Health Care Project (SSP).

Many evaluations and studies have been conducted throughout the life of the project including mid-term evaluations in April 1988 and April 1992, a baseline study (12/91) and several KAP surveys (1/90, 9/92, 7/93). (See the complete list attached.)

The 1992 mid-term evaluation found that the project objectives had been well-conceived and that the project had made more than satisfactory progress toward attaining these objectives. It was also stated that given the pace at which the target villages are advancing and the scope of change anticipated by the project, it was recommended that CARE Mali seek to continue MCHP project activities after the 93 campaign.

A proposal has been submitted to donors for a continuation of MCHP for a third and final phase. Phase III will continue to work towards improving preventive health practices but will focus on building and strengthening local health institutions and services. This has the objective of ensuring sustainable services in primary health care and family planning.

8. PURPOSE OF THE EVALUATION

This evaluation is the final evaluation of the second phase of MCHP but will also serve to assist in the development of the third phase. Thus, there are two primary objectives of the evaluation:

- * To assess the degree of achievement of stated project objectives.

The original project objectives have been modified during the project to include birth spacing activities.

- * To provide an analysis of project strategies which will be of help in detailing the planning for phase III.

The evaluation team is expected to analyze the effectiveness of project strategies. The results of the evaluation will be used by the Project Manager and the Sector Coordinator as well as the Government Health Services and the SSP in finalizing the design of the third phase.

In addition to the project beneficiaries, it is expected that the team will involve all MCHP partners in the evaluation process (Government Health Services at regional, circle and arrondissement levels; SSP personnel at Circle and regional level, and the Association Malienne pour le Planification Familiale - AMPPF).

9. KEY QUESTIONS

9.1 Results

To what degree were the project objectives met? (See list of objectives attached.)

9.2 Implementation

Financial and logistical support of GRM EPI service:

- * Were the recommendations of the coverage survey (May 92) applied?

Collaboration with other CARE projects:

- * How have the literacy skills been used by village health workers and committees?
- * Is there a consistency in policies and procedures among the different projects?
- * How has the collaboration between the Macina Wells and Macina Maternal and Child Health Projects reinforced the "impact" of CARE in the target villages?

Collaboration with SSS/SSP:

- * How could the collaboration with SSS and SSP have been more effective?

Promotion of village health committees (including the training of village health workers):

- * How effective/appropriate is the approach for mobilizing villages for establishing health committees?
- * How effective/appropriate is the training given to village health workers and committees?
- * How much of the training is being applied? How well is it being applied?
- * Was supervision and follow-up adequate?
- * How functional are the committees?

Health education program:

- * How effective are the techniques used for the health education component?

Training of Government Health Service personnel:

- * How has the training provided to GRM Health Service personnel been applied?

Family Planning:

- * How reliable is the contraceptive supply system?
- * How sustainable is the village "boite de pharmacie" program?

Staff development:

- * How have the staff training sessions been applied to the project operations?

MIS:

- * Is the data gathered useful and complete?
- * Are the data gathering techniques reliable?
- * How is the data used in the project management?

9.3 Impact

What have been the consequences (both intended and unintended) of the project on the lives of the beneficiaries.

10. Proposed Evaluators

1. CARE: Marydean Purves, RTA PHC - CARE, Team Leader
2. CARE: Denise Gorden, MCHP Project Manager
3. USAID: Fanta Macalou, Program Specialist
4. GRM: Dr. Idrissa Maiga, Epidemiologist

11. Time Frame

Sept. 20 - Oct. 16, 1993

FHA/PVC GUIDELINES FOR FINAL EVALUATION
& SUSTAINABILITY ASSESSMENT OF CHILD SURVIVAL PROJECTS
ENDING IN 1993 (CS-VI)

The final evaluation team should address each of the following points. If at all possible, respond to each point in sequence.

I. SUMMARY OF PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

- A1. State the objectives of the project, as outlined in the Detailed Implementation Plan, and state the accomplishments of the project related to each objective.
- A2. Describe any circumstances which may have aided or hindered the project in meeting these objectives, and explain any unintended benefits of project activities.
- A3. Attach a copy of the project's Final Evaluation Survey, and state the results for each relevant indicator (see Table 1).

B. Lessons Learned

- B1. Outline the main lessons learned regarding the total project that are applicable to other PVO C.S. projects, and/or relevant to A.I.D.'s support of these projects.

II. PROJECT SUSTAINABILITY

A. Sustainability Status

- A1. At what point does A.I.D. funding for this child survival grant end?
- A2. At what point does the organization plan to cease child survival project activities?
- A3. How have major project responsibilities and control been phased over to local institutions? If this has not been done, what are the plan and schedule?

B. Estimated Recurrent Costs and Projected Revenues

- B1. Identify the key child survival activities that project management perceives as most effective and would like to see sustained.

- B2. What expenditures will continue to be needed (i.e. recurrent costs) if these key child survival activities are to continue for at least three years after child survival funding ends?
- B3. What is the total amount of money in US dollars the project calculates will be needed each year to sustain the minimum of project benefits for three years after CS funding ends?
- B4. Are these costs reasonable given the environment in which the project operates? (e.g. local capacity to absorb cost per beneficiary)
- B5. What are the projected revenues in US dollars that appear likely to fund some child survival activities for at least three years after A.I.D. CS funding ends?
- B6. Identify costs which are not likely to be sustainable?
- B7. Are there any lessons to be learned from this projection of costs and revenues that might be applicable to other child survival projects, or to A.I.D.'s support of those projects?

C. Sustainability Plan

- C1. Please identify number and position of project staff interviewed, and indicate the extent of their involvement in project design, implementation and/or monitoring/evaluation.
- C2. Briefly describe the project's plan for sustainability as laid out in the DIP, or other relevant A.I.D. reports.
- C3. Describe what sustainability-promoting activities were actually carried out by the PVO over the lifetime of the project.
- C4. Indicate which aspects of the sustainability plan the PVO implemented satisfactorily, and which steps were never initiated. Identify any activities which were unplanned, but formed an important aspect of the PVO's sustainability effort.
- C5. Did any counterpart institutions (MOH, development agencies, local NGOs, etc.), during the design of the project (proposal or DIP), make a financial commitment to sustain project benefits? If so, have these commitments been kept?

C6. What are the reasons given for the success or failure of the counterpart institutions to keep their commitment?

D. Monitoring and Evaluation of Sustainability

D1. List the indicators the project has used to track any achievements in sustainability outputs and/or outcomes.

D2. Do these indicators show any accomplishments in sustainability?

D3. What qualitative data does the PVO have indicating a change in the sustainability potential of project benefits?

D4. Identify in-country agencies who worked with the PVO on the design, implementation, or analysis of the midterm evaluation and this final evaluation.

D5. Did the PVO receive feedback on the recommendations regarding sustainability made by the technical reviewers of the proposal and DIP? Did the PVO carry out those recommendations? If not, why not?

D6. Did the PVO carry out the recommendations regarding sustainability of the midterm evaluation team? If not, why not?

E. Community Participation

E1. Please identify community leaders and members interviewed and indicate which group(s) the leaders represent.

E2. Which child survival activities do community members and leaders perceive as being effective at meeting current health needs?

E3. What activities did the PVO carry out to enable the communities to better meet their basic needs and increase their ability to sustain effective child survival project activities?

E4. How did communities participate in the design, implementation and/or evaluation of child survival activities?

- E5. What is the number of functioning health committees in the project area? How often has each met during the past six months? Please comment on whether committee members seem representative of their communities.
- E6. What are the most significant issues currently being addressed by these health committees?
- E7. What resources has the community contributed that will encourage continuation of project activities after donor funding ends?
- E8. What are the reasons for the success or failure of the committees to contribute resources for continuation of effective project activities?
- F. Ability and Willingness of Counterpart Institutions to Sustain Activities
- F1. Please identify persons interviewed and indicate their organization and relationship to the child survival project.
- F2. What linkages exist between the child survival project and the activities of key health development agencies (local/municipal/district/provincial/state level)? Do these linkages involve any financial exchange?
- F3. What are the key local institutions the PVO expects to take part in sustaining project activities?
- F4. Which child survival project activities do MOH personnel and other staff in key local institutions perceive as being effective?
- F5. What did the PVO do to build skills of local MOH personnel or staff of key counterpart NGOs? Did they teach them to train CHWs, or manage child survival activities once A.I.D. funding terminates?
- F6. What is the current ability of the MOH or other relevant local institutions to provide the necessary financial, human, and material resources to sustain effective project activities once CS funding ends?
- F7. Are there any project activities that counterpart organizations perceive as effective?

G. Project Expenditures

- G1. Attach a pipeline analysis of project expenditures.
- G2. Compare the budget for planned expenditures identified in the DIP with the actual expenditures at the end of the project. Were some categories of expenditures much higher or lower than originally planned?
- G3. Did the project handle the finances in a competent manner?
- G4. Are there any lessons to be learned regarding project expenditures that might be helpful to other PVO projects, or relevant to A.I.D.'s support strategy?

H. Attempts to Increase Efficiency

- H1. What strategies did the PVO implement to reduce costs, increase productivity, or make the project more efficient?
- H2. What are the reasons for the success or failure of the attempts to reduce costs, increase productivity or efficiency of this project?
- H3. Are there any lessons to be learned regarding attempts to increase efficiency that might be applicable to other PVO child survival projects or to A.I.D.'s support of these projects?

I. Cost Recovery Attempts

- I1. What specific cost-recovery mechanisms did the PVO implement to offset project expenditures? If cost recovery was part of the project, who managed implementation?
- I2. Estimate the dollar amount of cost recovery obtained during the project. What percent of project costs did this revenue cover? Did the cost recovery mechanisms generate enough money to justify the effort and funds required to implement the mechanisms?
- I3. What effect did any cost recovery activity have on the PVO's reputation in the community? Did the cost recovery venture result in any inequities in service delivery?

- I4. What are the reasons for the success or failure of the household income generating activities of this project?
- I5. Are there any lessons to be learned regarding cost recovery that might be applicable to other PVO child survival projects or to A.I.D.'s support strategy?

J. Household Income Generation

- J1. Did the project implement any household income-generating activities?
- J2. Estimate the dollar amount of income added to a family or household's annual income, as a result of the income-generating activity of the project.
- J3. Did the revenues contribute to meeting the cost of health activities? What percentage of project costs did income generation cover?
- J4. Are there any lessons to be learned regarding household income generation that might be applicable to other PVO child survival projects or to A.I.D.'s support strategy?

K. Summary of Sustainability

- K1. Please give a brief (no more than one page), succinct summary of the responses to the previous questions concerning:
- the project's accomplishments (in terms of outputs and/or outcomes) in enabling communities to meet their basic health needs, and in promoting sustainability of effective child survival activities;
 - the project's competence in carrying out its sustainability promoting activities;
 - any lessons to be learned regarding sustainability that might be applicable to other PVO child survival projects, and/or relevant to A.I.D.'s support of these projects.

III. EVALUATION TEAM

- A1. Attach a list of all members of the final evaluation team and indicate institutional affiliation.
- A2. Indicate who is the author of the evaluation report.

PROJECT VILLAGE CHRONOLOGY AND PROGRESSION

VILLAGE	ENTRY YEAR	DAZA	ALPHA	WELLS	EXIT YEAR (HEALTH)	VHC	REASON ?
* 1992 Bangou - Bambara	1987	Yes	Yes	1 PGD - 1988 2 PHD - 1993			NO PROGRESS AND VILLAGE TOO SMALL
* 1992 Bangou - Marka	1987	Yes	Yes	1993			
Berta	1987			1987 and 1991 (2 wells)			
Diassebouyou	1987			1991			
* 1991 Diombougouba	1987		Yes	1987			
Diassebouyou	1987						
Diosso	1987	Yes		1987 & 1993 (2)			
• 1992 Dioumédiela	1987		Yes	1987			
Faka wèrè	1987						
• 1992 Folomana	1987		Yes	1988 & 1993 (2 wells)	•		
Fondiéla	1987			1989	1 - 1992		
Gan	1987			1988			
Goro	1987			1988 and 1993	2 - 1992		
Guena	1987			1987			
Guenda	1987			1987	3 - 1992		
Hery wèrè	1987				4 - 1989		
Kama	1987			1988	5 - 1991		
Kara	1987	Yes	Yes	1987 & 1991 (2 wells)	6 - 1992		
• 1991 Ke-Bozo	1987			1988			

PROJECT VILLAGE CHRONOLOGY AND PROGRESSION

VILLAGE	ENTRY YEAR	DAZA	ALPHA	WELLS	EXIT YEAR (HEALTH)	VHC	REASON ?
Kokry - Bozo	1987				7 - 1991		NO PROGRESS AND VILLAGE TOO SMALL
• 1992 Koloko	1987		Yes	1988			
Komara	1987			1987	8 - 1992		
Kordona-Sidoni	1987	Yes		1990	9 - 1992		
Konkonkourou	1987		Yes	1988			
Konona	1987		Yes	1987	10 - 1989		
Kouan	1987	Yes		1987	11 - 1992		
Kowaodian	1987	Yes		1989			
Mangoni	1987		Yes	1987 & 1993 (2 wells)			
Maribougou	1987						
Massa-wèrè	1987			1988			
Merou	1987			1987	12 - 1991		
• 1992 Ninga-Bambara	1987		Yes	1988			
Ninga Peulh	1987						
Ouana - Mama	1987			1988			
Pimperimbougou	1987						
Sakounou	1987			1988	13 - 1989		
* 1991 Sampara	1987		Yes	1990			
Sellè	1987			1988			

PROJECT VILLAGE CHRONOLOGY AND PROGRESSION

VILLAGE	ENTRY YEAR	DAZA	ALPHA	WELLS	EXIT YEAR (HEALTH)	VHC	REASON ?
Kondo	1989						NO PROGRESS AND VILLAGE TOO SMALL
Ouanana	1989			1989			
Toumou	1989			1989	1 - 1991		
Wani	1989	Yes					
Diado	1990			1990			
Diamertogo	1990			1990			
Drih	1990			1990			
Fiah	1990			1990			
Kalala	1990	Yes		1990			
Kotoumou	1990			1990 & 1993 (2 w)			
Moutiqué	1990			1990			
N'Gouna	1990			1990			
Nianamado	1990			1990			
Ouana	1990	Yes		1990	1 - 1992		
Payaka	1990	Yes		1990			
Tènè	1990	Yes		1990			
Bouba - Maribougou	1991						
Damidié	1991	Yes		1991	1 - 1992		
Diangou	1991			1991			
Djekoye	1991			1991			
Fintiguila	1991			1992			
Gniné	1991			1992			

PROJECT VILLAGE CHRONOLOGY AND PROGRESSION

VILLAGE	ENTRY YEAR	DAZA	ALPHA	WELLS	EXIT YEAR (HEALTH)	VHC	REASON ?
Selleye	1987		Yes	1990	14 - 1992		NO PROGRESS AND VILLAGE TOO SMALL
Siame	1987	Yes	Yes	1987	15 - 1989		
Sogoli	1987			1987			
Soumouni	1987	Yes		1987			
Tièlan	1987		Yes	1988			
Tilema	1987			1987	16 - 1989		
☛ 1991 Touara	1987	Yes		1988			
☛ Wan	1987		Yes	1988			
☛ 1992 Zambala	1987		Yes	1988			
Founou	1988	Yes		1987			
Kanan	1988	Yes		1989			
Kenné	1988			1988 & 1991			
Kingolola	1988			1988			
Kiran	1988			1989			
Korona - Wadié	1988			1989	1 - 1992		
☛ 1992 Missena	1988		Yes	1989			
N*Golokouna	1988			1988 & 1991			
* 1992 Nenena	1988		Yes	1989			
* 1991 Nianzana	1988	Yes	Yes	1989			
Niènemou	1988			1989			
☛ 1992 Niambougouni	1988		Yes	1989			
Siratiguibougou	1988			1991			

PROJECT VILLAGE CHRONOLOGY AND PROGRESSION

VILLAGE	ENTRY YEAR	DAZA	ALPHA	WELLS	EXIT YEAR (HEALTH)	VHC	REASON ?
Kalakoin	1991			1992			NO PROGRESS AND VILLAGE TOO SMALL
Kaminidjon	1991						
Kanquira	1991			1992			
Kationa	1991			1991			
Kerta	1991			1991			
Kien	1991			1992			
Klengolola	1991	Yes		1991			
Koulebouyou	1991			1991			
Koungodiani				1991			
N'Golomazana				1992			
N'Gomidjila				1991			
Niamana	1992						
Nientilela	1991						
Sanga	1991			1992			
Socoura	1991			1991	2 - 1992		
Solila	1991	Yes		1992			
Somana	1991			1991			
Tallibougou	1991			1992			
Tangana	1991			1992			
Tongolo	1991	Yes		1992			
Tougouma	1991	Yes		1992			
Wella	1991			1992			

- 1986 Project operates in Sarro, Central districts
Nov: Project agreement signed GOM
Staff:
Project Manager
Expatriate
20 Health Promoters:
Malian Nurses
Mid-wives
Technical Advisor:
Malian Medical Doctor
2 Chauffeurs
Dec: EPI launched in Mali
Baseline survey initiated
- 1987 -- 6 week training education techniques
-- Activities: Hygiene and Sanitation
Nutrition
Diarrhoeal Diseases
-- 1 HPs meet bi-weekly project meetings
-- April: Tech. Advisor Dr. Danoua Malle recruited
-- Activities initiated in 22 pilot villages
-- June: 21 villages added for total of 43 villages
- 1988 -- July: EMERGENCY YELLOW FEVER CAMPAIGN
-- Mid-term Evaluation
-- Sept: New Project Manager Susan Farnsworth
-- 16 HPs in field and 4 with EPI mobile team
-- 10 villages in Sarro added; 85 project villages total
-- Project hires Mid-Wife for the Macina Health Center
(4 month contract)
-- VACCINATION OF ALL WOMEN OF CHILDBEARING
AGE FOR TETANUS INSTEAD OF JUST PREGNANT
WOMEN
-- HP's mopeds renewed with new policy of
rent-to-buy
-- New Chief Medical Officer to Macina
- 1989 -- USAID Mali funded amendment grant
-- 65 Project Villages
-- MOH assume PEV execution
-- EPI Coverage Survey implemented
-- June: Compression of 5 HPs
-- July: USAID Interim Grant until 9/90
-- 10 Project Health Promoters remaining
-- Compression of 1 supervisor
-- New Project Manager Mark Chornia
-- 1 Project Supervisor remaining
-- Compression of 10 villages
-- 55 Project Villages remaining
-- Oct: 1 supervisor and 2 HPs resign
-- 8 HPs and 0 Supervisors in project remaining
-- Dec: Final Evaluation Phase I
-- Refresher training for all HPs
-- Staff reduction by 5 HPs and 1 supervisor
(compression)
-- Final Evaluation of Phase I
- 1990 -- Jan: Furnished 10 mopeds EPI Adv. Strategy
-- Tier approach to village monitoring initiated
-- Child to child activities start
-- Vitamin A study (AED)
-- May: 21 HPs and 2 supervisors hired
-- 12 Health Promoters
-- 2 Supervisors in Project
-- 12 new project villages added
-- 67 Project Villages
-- Sept: Refresher training: Rural education
-- Inter-Village meeting: organized
-- Oct. GRAAP training
-- Intense approach with Wells Project
Hygiene education
Salaries of certain HP's?
-- Oct: Debut Phase II activities
-- Vehicle donated to Macina Health Center for EPI
-- 12 project vill. added/Sayo: Project total: 79 villages
- 1991 -- Jan: Project Information System computerized
-- Feb. Bambara literacy training in 16 villages
-- MARCH 28 COUP D'ETAT
-- May: Technical Advisor Dr. Sita Sidibe' contract ends
-- June: First training of VHCs/MWs
-- June: Field Coordinator's Suzanne Dumais departs
-- June: Project Manager Denise Gordon arrives
-- Jun: Level 5 Survey - 19 villages advance
-- June: Year End Reflection Week
-- Aug: 4 villages dropped for total of 75 project villages
-- Sep: 16 villages (Monimpe and Kolongo) added to project
-- 2 villages Sarro added for total of 93 villages
-- MEASLES EPIDEMIC SEGOU REGION
-- Accord SSP signed
-- Malnutrition Detections begin
-- Aug: Recruitment of 6 new HPs for total of 15
-- Sep: Regeneration Week: HP training
-- Sep: Bambara Literacy training for staff
-- Oct.: Field Coordinator recruited
-- Nov: Project Administrative Assistant recruited fr. among HP's
-- Dec: Base Line survey: Monimpe/Kolongo village
-- Dec: Birth Spacing strategy researched
- 1992 -- Jan: GRAAP Training Initiation
-- April: NCP training: Face to Face Counseling
-- April: Mid-term Evaluation
-- April: Birth Spacing Coordinator recruited
-- May: Birth Spacing KAP survey-30 localities
-- May: Vaccination Coverage Survey
-- June: Level 5 Survey - 16 villages adv; 10 dropped; 83 project village
-- 1 hamlet added for hygiene activities only
-- June: End of Year Reflection Week
-- July: Computer Training Supv/Coord/Proj. Asst
-- Aug: NBC Today Show filming of MCHP
-- Sept. Refresher training in Bambara Literacy: HPs
-- Sept. Bambara Literacy Initiation Training: Supervisors
-- Sept: Beginning Year Training
-- Nov: NCP Training: Group approach
-- Nov: Training of Trainers Birth Spacing Training
-- Evaluation/Monitoring wkshp: Field Coord. Niger
-- Evaluation/Monitoring wkshp-USAID/Field Coord/Proj. Asst
-- MEASLES EPIDEMIC - SAYE
-- Dec: Start of monthly meetings district level every 2 months
-- Dec: 2 villages hygiene interventions completed, leave project
-- Total Project Villages: 81 villages and 1 hamlet
- Jan: Village Wells Management Training
-- EPI meetings with agents in each district w/medecin chef
-- April: Coordinator for Health and Education Programs Recruited
Nanette Avey takes over MCHP from ACD Peter Buils
-- June: CARE Macina Wells construction ends in Macina Cercle
-- July: KAP Survey
-- Sept. Birth Spacing KAP Survey
-- Sept. Final Evaluation Phase II
-- Phase II end: 81 project villages and 1 hamlet (hygiene activities only)
52 villages in stabilization
29 villages in formation

FORMATION ORGANISEE PAR LE PROJET SANTE INFANTILE DE MACINA
1990 - 1993

FORMATION	PARTICIPANTS	
	PSIM	SANTE PERSONNEL
FORMATION 1990		
1 INITIATION METHODE GRAAP	15	15
2 DETECTION MALNUTRITION/VITAMIN A	17	2
3 EDUCATION POUR LA SANTE RURALE	16	3
FORMATION 1991		
4 SUPERVISION	8	14
5 SEMAINE DE REFLECTION/ACTIVITES DU PROJET	18	2
6 SEMAINE DE REGENERATION/REVUE DES TECHNIQUE ANIM.	19	2
7 NOUVELLE MONITRICES	6	
8 ALPHABETISATION BAMBERA/INITIATION	15	8
9 FORMATION DES FORMATEURS/ CSV	6	8
10 DEVELOPPEMENT COMMUNAUTAIRE/CESAO		1
11 NCP	6	4
FORMATION 1992		
12 DEVELOPPEMENT COMMUNITAIRE/CESAO	1	3
13 NCP	5	4
14 ALPHABETISATION BAMBERA/RECYCLAGE		
15 INFORMATIQUE	3	
16 COMMUNICATION RURALE/PVO PIVOT	1	
17 ESPACEMENT DES NAISSANCES/STAFF	12	10
18 SUIVI ET EVALUATION DES PROJET USAID	1	
19 ALPHABETISATION INITIATION/SUPERVISEURS	3	
20 NOUVELLE MONITRICE	1	
FORMATION 1993		
21 PLANNING FAMILIALE CLINIQUE	1	2
22 EN- FORMATION DES FORMATEURS		
23 SEMAINE DE REFLEXION	18	2
24 ATELIER/GESTION DES PUIIS	2	1
25 GESTION DES PUIIS	18	1
26 RECOUVREMENT DES COUTS	1	
27 ETUDE DE BASE/ DIORO	2	
28 SEMINAIRE DE SUIVI ET EVALUATION/NIAMEY	1	
29 PLANNING FAMILIALE-GESTION DES PROGRAMMES	1	
30 EN CANADA/ORGANISE PAR PNUD		
31 ESPACEMENT DES NAISSANCES/ANIMATEURS		10

F.E.V. M A C I N A

EQUIPEMENTS - MATERIELS - FOURNISSEURS

DESIGNATION	NIVEAU CERCLE	NIVEAU E.M.	NIVEAU ARRDT	RECU DE CARE	OBSERVAT
<u>Chaîne de froid</u>					
-Congelateur electrolux.....	1			2	
-Refrigerateur Sibir.....	1		4	5	
-Boite Isotherme 22 l.....	3	2	4	11	dont 2 r à CARE
-Porte vaccin 1,7 l.....	4	4	12	22	"-
-Accumulateur.....	200	100	240	19/10	1400 rendu
- " - pour porte vaccin.....	40	40	100	200	
- " - avec trou.....	20	20	40	80	
-Thermomètre à cadran.....	12	6	20	42	2 rendus
-Niveau bulle d'air.....	2		4	6	
-Trousse à outil.....	1		4	5	
-Lot pièces rechange congél. Réfr.	1		4	1	
- " - " réfrig.	1		4	5	
<u>Matériels d'injection</u>					
-Séringues NEV les stérilisables	800	1600	1.600	3.000	
-Baguette rechange/Séringue.....	200	1200	400	800	
-Séringue 2 cc Verre.....	200		400	600	
- " - 5 cc plastique.....	50	50	200	300	
- " - 5 cc Verre.....	50			100	
-Séringue BCG.....	86	6	6	36	
-Corps rechange seringué BCG....	60	12	24	96	
-Aiguilles pour seringue CC.....	3.600	2.400	7.200	13.200	
-Ped objet		2		4	
-Lot pièces de rechange Ped objet		2		4	
-Aiguilles pour reconstitution..	240	240	480	960	
- " - pour BCG.....	360	360	480	1.200	
-Trousse BCG complète.....	2	1	4	7	2 rendu
-Pincés stérilisateurs.....	6	4	12	22	
-Réchaud à pétrole.....	2	1	8	11	2 rendu
-Minuterie 60 mn.....	2	2	8	12	
-Pierre d'affutage.....	1	1	4	6	
-Entonnoir plastique.....	4	2	16	22	
-Cuvette Haricot 825 cc.....	4	4	8	16	
-Boite/4 seringues.....	4	2	16	22	
- " - à instruments + couvercle..	4	4	8	16	
- " - à pst + couvercle.....	2	1	4	7	
-Seau 12 l + couvercle.....	1	1	4	6	
-Flacons 20 cc eau bidistillée..		2.000		2.000	
-Stérilisateur à vapeur/8/4 seringué			8		
- " - à vapeur /42	4	3		7	
<u>Divers</u>					
-Baril 200 l (essence).....		2			2 rendu
- " - 200 l (pétrole).....	2				
- " - 60 l (pétrole).....			8		
-Jerrican 20 l.....	2	2	8		
-Bidon 20 l.....					
-Tables pliantes acier.....	1	2			
-Chaises pliantes acier.....	4	6		10	
-Classieurs métalliques 5 casiers!			4	0	
-Classieurs métl. 10 casiers.....	1			1	
-Calculatrice électronique.....	1	2	4	7	1 rendu
<u>LOT DE MATERIELS CAMPING</u>		0		0	
-Lit de camp.....		7		7	
-Fourneau à thé.....		1		1	
-Fourchettes.....		6		6	

MATERIEL P.E.V. ARRONDISSEMENT DE: SAYE

DESIGNATION	QUANTITE	OBSERVATIONS
<u>1- CHAINE DE FROID</u>		
- Réfrigérateur SIBIR.....!	1	!
- Caisse Isotherme (avec 24 accumul. !	1	!
- Porte-vaccin.....!	2	!
- Accumulateur pour la caisse isoth. !	60	!
- Accumulateur (porte vac in).....!	30	!
- Accumulateur (porte flacon).....!	10	!
- Thermomètre à cadran.....!	5	!
- Trousse à outils.....!	1	!
<u>- MATERIEL D'INJECTION</u>		
- Seringue 1 cc PEV.....!	400	!
- Bague O de rechange.....!	100	!
- Seringue 2 cc en verre.....!	100	!
- Seringue 5 cc en plastique.....!	50	!
- Seringue BCG 1 cc.....!	6	!
- Corps de rechange seringue BCG....!	6	!
- Aiguille de reconstitution BCG....!	120	!
à Aiguille BCG.. .. . !	120	!
- Aiguille pour seringue 1cc PEV....!	1.800	!
- Trousse BCG complète... .. . !	1	!
- Stérilisateur à pression.....!	2	!
- Stérilisateur à ébullition XXX!	1	!
- Stérilisateur à ébullition BCG....!	4	!
- Pinces stérilisateur.....!	3	!
- Réchaud à pétrole.....!	2	!
- Minuterie.....!	2	!
- Pierre d'afutage.....!	1	!
- Entonnoir plastique.. .. . !	4	!
- Cuvette haricot.....!	2	!
- Boîtes pour 4 seringues.. .. . !	1	!
- Plateaux à instruments.....!	2	!
- Boîte à pansement.....!	1	!
- Seau plastique avec couvercle.....!	1	!
<u>3- DIVERS</u>		
- Baril 60 litres.....!	2	!
- Jerican 20 litres.....!	2	!
- Calculatrice.....!	1	!
- Hèle métallique.....!	1	!

LE CHEF DE POSTE MEDICAL

LE PRESIDENT DU COMITE DE DEVELOP
D'ARRONDISSEMENT.

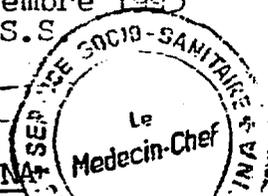
-Couteaux.....	1	1
-Louches.....	6	6
-Bols à café.....	2	2
-Pot d'1 litre.....	2	2
-Casserole.....	1	1
-Cafetière.....	6	6
-Verres à thé.....	2	2
-Thières moyennes.....	1	1
-Assiettes métalliques.....	6	6
(Lampes/Torches/Liquides. (Torches.	2	2
-Pile blonde (pqt).....	6	6
-Serviettes.....	2	2
-Cadenas pour castrines.....	2	2
-Allumettes (pqt).....	2	2
-Eau de javel.....	1	1
-Cantine.....	6	6
-Cuillère à soupe.....	6	6
- " " à Café.....	6	6
-Assiettes plastiques.....	6	6
MATERIEL DE BUREAU		
-Bics bleu (btes).....		8
-Marker.....		15
-Regles en bois.....		25
- " " plastiques.....		25
-Crayons de papier.....		75
-Carbones.....		3
-Stencil.....		3
-Bics rouges (bte).....		28
-Blocs notes.....		28
-Gommes.....		45
-Cahiers 200 pages.....		50
-Blouses.....		12
-Rouleau papier chevale.....		2
-Papier pelure.....		2
-Chemises cartonnées.....		40
-Classeurs.....		10
AUTRES		
-Pétrole.....		260 1)
-Savon (carton).....		1 + 1C morcea
-Alcool.....		8 1
-Savon OMO sachets.....		20
-Lampes à pétrole.....	2	2
MOYENS LOGISTIQUES		
-Véhicule tout terrain.....	1	1
-Accord.....		2
-Hobyettes.....	10	10

Macina, le 11 Novembre 1987
Le Médecin-Chef

Signé: Samorye CISSE

Copie Certifiée Conforme
Macina, le 28 septembre 1993
Le Médecin-Chef S.S.S

Dr. Famory FOFANA



BEST AVAILABLE COPY

Il existe deux groupes de plaques solaire au niveau du service socio-sa-
re de Macina

IER GROUPE=

- Nombre de plaque solaires prévus par l'Oeuvre d'Aide à l'Enfance du
Monde..... = 30
- Nombre de plaque solaire installés..... = 25
- Batiment cible= maternité équipé d'un bloc opératoire
et le chateau d'eau.
- Nombre d'ampoules électrique actuellement fonctionnelles 5
- Non fonctionnelles..... 26

2EME GROUPE

- Nombre de plaques solaires prévus par l'Oeuvre d'Aide à l'Enfance du
Monde..... 14
- Nombre de plaques solaires installés..... 10
- Batiments cibles= PMI et Dispensaires
- Nombre d'ampoules électriques actuellement fonctionnelles 18
- Non fonctionnelles..... 19

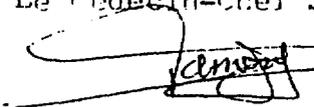
REMARQUES=

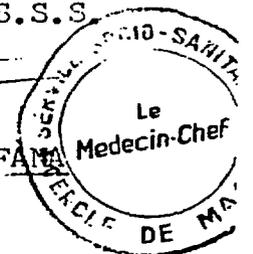
L'installation solaire tel qu'il se présente actuellement presente que
lacunes .

- * elle ne produit pas du 220 volts
- * des ventilateurs sont installés mais ne fonctionnent pas
- * il n'y a pas de convertisseur de 12 volts en 220 volts
- * le matériel de stérilisation (un poupinet) et d'éclairage du bloc
toire sont malheureusement délaissé car leur fonctionnement nécessite
220 volts.
- * Le système de ventilation des bureaux est dans la même situation . /

Macina, le 6 Octobre 1993

Le Médecin-Chef S.S.S.


Dr. Famory FOFANA



12. RESOURCE DOCUMENTS AVAILABLE

Evaluations, Surveys, and Technical Assistance Reports:

MCHP Project Proposal (April 1986)

Grant Agreement (August 1986)

Interim Assessment of MCHP (April 88)

Project Proposal (Dec. 1988)

Grant Agreements; USAID Mali (Sept. 89)

Final Evaluation Report , Phase I (1989)

Project Proposal; CS VI (Jan. 90)

KAP Survey, Noreen Qualls (1/90)

Technical Assistance Report on Health Education, Nancy McCharer (April 90)

Grant Agreement CSVI (August 90)

Detailed Implementation Plan, Phase II (Sept. 90)

Nutrition Communication Project, KAP survey (1990)

RTA-PHC Technical Assistance Report (Nov. 91)

RTA-Pop Technical Assistance Report (Dec. 91)

Contrat de Gré à gré CARE - DRPASPF -SSP/Ségou (March 92)

Baseline Survey Report, Sara Margolis (Dec 91)

Mid-term Evaluation, Erma Manoncourt, et.al. (April 92)

KAP Birth Spacing , Chuanpit Chua-oon (Sept. 92)

RTA-Pop Technical Assistance Report (Oct. 92)

Stratégie de Volet PF (Dec. 92)

Proposal for Phase III (July 1993)

CAP Survey, MCHP Staff (July 93)

Rapport de Formation des animateurs Villageois en EN (Juin 93)

Nutrition Communication Project, KAP Survey (Feb. 1993)

National Immunization Center, Statistics

On-going Reports and Miscellaneous Documents:

Project Implementation Reports (Annual Report 90,
Quarterly PIR Jan 91 - June 93)
Annual Child Survival Report (FY91)
Project Information System
Monthly Reports
Child to Child documents
Détection de la Malnutrition - Guide pour l'Animateur Rural
La Supervision
Grille des Messages