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ACSI-CCCD Project - Guinea
Final Evaluation Report
April - May 1991

Prepared for

Agency for International Development
(AFR/TR/HPN)
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By

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LIST OF ACRONYMS/ABBREVIATIONS*

A. ENGLISH ACRONYM		FRENCH EQUIVALENT
ACSI-CCCD	African Child Survival Initiative-Combatting Childhood Communicable Diseases	
ADB	African Development Bank	
A.I.D.	Agency for International Development	
AIDS	Acquired Immune Deficiency Syndrome	SIDA
A.I.D./AFR	Agency for International Development/Africa Bureau	
A.I.D./W	Agency for International Development/Washington	
ARI	Acute respiratory infections	IRA
ARC	Atlantic Resources Corporation	
BCG	Bacille de Calmette Guérin (tuberculosis)	BCG
BDI	Birch and Davis International	
CBA	Refers to women of child bearing age 15-45	FAP
CDC	Centers for Disease Control	
CDD	Control of Diarrheal Disease	LMD
CMR	Childhood mortality rate	
C.S. or CS	Child Survival	
DIP	Detailed implementation plan	
DPT	Diphtheria/pertussis/typhoid	DTC
ED	Essential drugs	ME
EOP	End-of-project	
EPI	Expanded program of immunizations	PEV
EPI/PHC/ED	Expanded program of immunizations/ Primary Health Care/Essential Drugs	PEV/SSP/ME
FP	Family planning	
GOG	Government of Guinea	
GTZ	Gesellschaft für Technische Zusammenarbeit (German)	
HEP	Health Education and Promotion	EPS
HIS	Health information systems	SNIS
IGO	Inter-governmental organization	
IMR	Infant mortality rate	
IUD	Intrauterine device	DIU
KAP	Knowledge/aptitude/practice	
LOP	Life of the project	
MCH	Maternal and Child Health	SMI

* Note: Since some documents are in French (e.g. appendices), we have cross-referenced the French equivalent. This list contains only existing abbreviations (e.g. PHC = PEV). When no equivalent abbreviation actually existed, we have used the one in the original language (e.g. BEPR). No attempt was made to translate or create new i.e. misleading acronyms.

MOPH	Ministry of public health	MSPP
MSH	Management Sciences for Health	
MTE	Mid-term evaluation	
NGO	Non-governmental organization	ONG
NNT	Neonatal tetanus	
ORS	Oral Rehydration Salts or Solution	SRO
ORT	Oral Rehydration Therapy	T.R.O.
OR	Operational research	R.O.
PACD	Project anticipated completion date	
PASA	Participating Agency Service Agreement	
PCV	Peace Corps Volunteer	
PHC	Primary Health Care	SSP
PRITECH	Technologies for Primary Health Care Project	
ProAg	Project agreement	
PVO	Private voluntary organization	ONG
REACH	Resources for Child Health Project	
R.O.	Recherche Opérationelle	O.R.
SSS	Sugar and Salt Solution	
TBA	Traditional birth attendant	AT
TT	Tetanus toxoid	VAT
T.A.	Technical assistance	A.T.
TO	Technical Officer	
UNICEF	United Nations Children Fund	UNICEF
URC	University Research Corporation	
USAID	United States Agency for International Development	
VHW	Village Health Worker	ATS
WB	World Bank	BM
WHO	World Health Organization	OMS

B. FRENCH ACRONYM
ENGLISH EQUIVALENT

A.T.	Accoucheuse traditionnelle	TBA
A.T.	Assistant Technique	T.O.
ATS	Agent technique de la santé	VHW
BCG	Bacille de Calmette Guérin (tuberculosis)	BCG
BEPR	Bureau d'Etudes, de Planification, et de Recherches (Office of studies, planning and research)	
BM	Banque Mondiale	WB
BND	Budget National pour le Développement (National budget for investment)	
DIU	Dispositif Intra-Uterin	IUD
DPS	Directeur/direction Préfectoral(e)de la Santé (District Health Director & direction)	
DTCoq	Diphtérie/Typhoïde Coqueluche	DPT
EPS	Education Promotion de la Santé	HEP
FAP	Femme en âge de procréer	CBA
FG	Franc Guinéen = Guinean currency	
IRS	Inspection Régionale de la Santé (Regional health inspecteur)	
LMD	Lutte contre les maladies diarrhéiques	CDD
ME	Medicaments essentiels	ED
MSF	Médecins-Sans-Frontières (French PVO_	
MSPP	Ministère de la Santé Publique et de la Population	MOPH
OMS	Organisation Mondiale de la Santé	WHO
ONG	Organisation Non-gouvernementale	NGO
PEV	Programme Elargi de Vaccinations	EPI
PEV/SSP/ME	Primaires/Medicaments Essentiels	EPI/PHC/ED
	Programme Elargi de Vaccinations/Services de Soins	
RO	Recherche Opérationnelle	OR
SCIO	Service National de Coordination des Interventions des (National NGO Coordinating Committee)	ONG
SIDA	Syndrome Immuno-deficitaire acquis	A.I.D.S
SMI	Soins Maternels et Infants	MCH
SNIS	Système National d'Information Sanitaire	HIS
SRO	Sels de réhydratation orale	ORS
SSP	Soins de Santé Primaires	PHC
TRO	Thérapie de réhydratation orale	ORT
UNICEF	Fonds des Nations Unies pour l'Enfance	UNICEF
VAT	Vaccin anti-tetanique	TT

**FINAL EXTERNAL EVALUATION OF THE ACSI-CCCD PROJECT
THE REPUBLIC OF GUINEA**

EXECUTIVE SUMMARY

This final evaluation of Guinea's ACSI-CCCD project was initiated by USAID/Conakry and by A.I.D./Washington/AFR/TR/HPN (Health, Population and Nutrition Division, Office of Technical Resources, Bureau for Africa) and conducted by a team of four experts during April and May 1991.

The purpose of Guinea's ACSI-CCCD project is to strengthen three primary health components, including:

- immunization of infants, pregnant and fertile aged women;
- treatment of acute dehydrating diarrheas with ORT; and
- presumptive treatment of fever with antimalarial drugs.

A 25 percent reduction in the mortality of under-fives by 1991 is a key project objective.

Guinea's project covers five districts, three in the capital city, and two in rural Guinea. Strategies deployed include monitoring, operations research (OR), health education and training through assistance from the Center for Disease Control, the implementing agency.

Team members reviewed the considerable project-related literature that was produced during LOP, interviewed key officials and health workers at all levels, and observed on-site project activities. The body of the report is organized around four major areas:

- Project outcome;
- Support Strategies;
- Management of project resources; and
- External environment of the project.

Team members were selected because of their expertise in management and information systems, knowledge of child survival programming, and health education and training.

Guinea has demonstrated remarkable political will and self-reliance in launching a public health strategy for the decade of the 1990s that serves as a model for other countries in the West African region that have had greater resources but achieved less impressive results.

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HS*

In general, the immunization coverage rates of the project zone are higher than the national averages. Although far from the objectives of 80 percent coverage for infants and 60 percent for pregnant women, the sustained progress is impressive. In just three years, national coverage of infants tripled from five to 15 percent. In the project area, the coverage of pregnant women at 38 percent is almost five times higher than the national average.

*mead man
MCS*

Although there is anecdotal evidence of changed prescription patterns in health workers regarding ORT and chloroquine, the mortality rate from **diarrheal disease** and **malaria** has not been reduced by 50 percent, a project goal. Thus the anticipated impact of three modern technologies in a country where most of the health problems are related, directly or indirectly, to poverty were greatly overestimated.

Considerable progress toward the goal of a functional **Health Information System** has been accomplished. In addition to the ACSI-CCCD project, several other organizations have been involved, including the EPI/PHC/ED (national) program, the African Development Bank, the United Nations (WHO, UNICEF), Médecins Sans Frontières, and the International Development Research Centre.

A variety of scattered activities occurred through short-term consultancies and training. However, because of insufficient continuity and follow-up, the transfer of requisite skills and means to the Guinean personnel has been largely inadequate. In addressing the issue of how the HIS is going to survive, improve and reach its goal of meeting the statistical, research, and epidemiological needs of the health system, the major problem faced is the lack of a clear strategy or plan of action for the future of the HIS. Also, at this stage, there is no guarantee of adequate, sustained assistance from any foreign or domestic partner.

The **operational research** component of the ACSI-CCCD project has been among the weakest, especially in terms of sustainability. Though a variety of positive actions were taken, especially in the last two years of the project, there has been no systematic follow-up and assistance. Thus the project is ending without having transferred adequate research skills and resources to the Ministry of Public Health's (MOPH) Office of Studies, Planning, and Research (BEPR) personnel.

Training is perceived as one of the most active components of the ACSI-CCCD project. This support activity has had a much greater impact on health center personnel than at the levels of project coordinators and prefectural health directors. It has undoubtedly played a significant role in strengthening the national integrated health program.

The BEPR of the Ministry of Health and Population is in charge of health training, but it lacks adequate competent personnel and materials and has a limited operating budget. Centralized supervision deals mostly with daily management problems rather than training needs and thus the possibilities of continuing education programs remain weak.

The project has achieved most of the objectives presented in the 1988 amendment. Remarkable progress has been achieved in **health education**. Changes have occurred through the restructuring of the Prevention Service of the Ministry and the reinforcement in training and equipment provided by the World Bank and the ACSI-CCCD project.

The health education service is now capable of defining a strategy for health education in Guinea. Ninety percent of the activities in the 1991 plan of action have been realized, with health

personnel gaining adequate knowledge. Peace Corps Volunteers played a role in the decentralization of the health education activities.

In trying to evaluate the impact of health education without the benefit of a survey, the team could only rely on the increase in the number of consultations at health centers since the training of the health personnel. Although there is some anecdotal impact of the ORT messages on mothers' knowledge, the effective transfer of this knowledge into mothers' practices has been less obvious.

The **internal structure of the project** and its interface with its external environment is a highly complex one. It involved many partners, both organizational and individual, during the LOP. Of the 48 health centers covered by the project, only 15 are presently integrated into the national PHC system (PEV/SSP). This is a major issue for sustainability.

The ACSI-CCCD project has to its credit a good share of **highly educated and qualified staff** at all levels, with a high degree of motivation to achieve project goals. We noted a gross imbalance in the distribution of health workers between health centers in Conakry, the capital, and the facilities in Kindia and Téliélé. While highly trained, health workers in the centers have a predominantly curative orientation.

Despite limitations in staff and office space, the project is credited with overcoming formidable obstacles in the procurement of commodities, goods and the disbursement of funds. Most project personnel seem to have a good understanding of the issues and constraints facing the project. However, management tools such as regular staff meetings and performance evaluations are not being used effectively. The single most frequent need expressed by interviewees at any level of the project was the one for more competence in management.

The **building** used by the project is in sub-standard condition, and does not provide adequate office space for project staff. Although a new facility is under construction, because of slow disbursement in counterparts funds, the building is far behind schedule, and will not be operational by PACD.

After overcoming initial obstacles and delays in the **delivery of vehicles** and in the **procurement of goods**, project staff has been able to secure an ongoing supply of commodities (EPI, ORT, chloroquine) needed to support project output. However, the ACSI-CCCD project is not perceived as having developed the ability to effectively manage project vehicles and commodities. In terms of sustainability, this issue is perhaps the most critical aspect of the project.

Consistent with the project's complex structure, the **funding process** from various sources (i.e. bilateral, counterpart, sub-allocation, cost-recovery) has been generally slow and cumbersome. The limited time availability of Mission staff for ACSI-CCCD issues, together with the project staff's initial lack of knowledge and experience of lengthy and complex USAID administrative procedures and requirements set the stage for difficulties and delays. Slow disbursements of counterpart funds have been noted by informants and documented in previous evaluation reports.

Cost recovery at the health centers is well-organized. The team, however, was not able to elucidate to what extent the income generated is sustaining recurrent costs, nor how this system affects the utilization of the services by the community.

The GOG's commitment to health is demonstrated in its national policies reflecting the priorities set forth by the Bamako Initiative, namely a commitment to primary health care, cost recovery, access to essential drugs, and opening of the private sector. Government officials interviewed had a good understanding of the problems faced by the project, and also of the GOG's own limitations. The team observed a keen interest in improving performance and results. The major constraint is the government's inability to match resources with its stated commitment.

USAID officials have a good grasp of the issues facing the project. The Mission's major constraint in the supervision and backstopping of the ACSI-CCCD project was its lack of a health officer for most of LOP. Thus ACSI-CCCD supervision was done by other mission staff members who were willing to take on this added responsibility without the benefit of a much needed expertise in health.

A number of donors and NGOs are present and active in Guinea, especially in the health sector. The GOG has recognized and values the contributions of national and international donors and NGOs. Although a national committee for the coordination of the activities of the NGOs (SCIO) exists, this entity, perceived as ineffective and unnoticed, is largely underutilized.

As only one third of the project's 48 health centers is presently supported by the national PHC system, we cannot stress enough the importance and urgency of initiating the process of integrating the remaining 33 centers. Since most of the health centers should have no difficulty meeting the criteria for integration, it is vital that the process be initiated rapidly, while the momentum is still present. The sooner the integration takes place, the more likely health center activities previously supported by ACSI-CCCD project have a chance to continue undisrupted.

After a slow and difficult start, the project is beginning to show some progress in an otherwise difficult and complex socioeconomic and administrative environment. Although the team documented immediate results in terms of numbers of mothers and children that benefited from the project's interventions (EPI, ORT, malaria control), it is too early and difficult to precisely measure an objective health impact in terms of morbidity, mortality, or even on the socioeconomic development of the communities served.

It is too late now to make major adjustments in terms of project output (EPI, ORT, malaria control), support strategies (health education, training, operational research), and even allocation of resources that will not be institutionalized. But the time has arrived to assure a smooth transition from being a "USAID"-sponsored ACSI-CCCD project to becoming a full "GOG"-owned project. This will be the time for initiating the full integration of project health centers into the national programs, and perhaps seeking alternative sources of funds. How the former ACSI-CCCD communities will fare after PACD will be a true test of the project's impact, and the GOG's ability to promote the health of its people.

The Executive Summary covers the key recommendations arising out of the evaluation exercise. In addition, the team was asked to consider the transition issues the Mission must face as the project approaches its end in September 1991. These issues are addressed at several places in the evaluation report pertaining to activities, strategies, buildings and project staff. Others that deal specifically with the handling of remaining funds, vehicles and commodities are addressed in Section V.

I. INTRODUCTION

1. BACKGROUND OF THE PROJECT

A. Summary of the Project's objectives

The objectives of the ACSI-CCCD program are to reduce morbidity and mortality of African children by strengthening national capacity to:

- immunize infants and women of childbearing age;
- provide appropriate case management, e.g. ORT, for children with diarrhea;
- provide appropriate treatment of children with fever/malaria; and
- provide malaria chemoprophylaxis to pregnant women.

The strategies are to promote and follow WHO's policies and procedures and provide program support through the following intercountry and bilateral services:

- training,
- operational research,
- health information systems,
- health education, and
- technical cooperation.

The following tables provide a comparison of the objectives of the project and the results achieved to date. (This data appears in greater detail in Appendix A tables (mostly taken from Appendix A-39 to A-49):

TABLE I.1 SUMMARY OF OBJECTIVES AND RESULTS

1. Target Population

	Project Area	Guinea
Population	1,548,194	6,166,433
Children (0-11)	45,146	256,525
Pregnant women	78,958	314,490

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summary
some key pts*

*+ text N/A
in context*

2. Immunization Coverage

	Objectives (CCCD)	1986 (Guinea)	'89 Status (CCCD Zones)	Status (National)	Dose given (CCCD)
BCG	80%	46%	50%	30%	31,990
DPT	80%	10%	21%	15%	13,086
Polio3	80%	8%	21%	15%	13,086
Measles	80%	--	41%	16%	12,770
TT	60%	17%	38%	08%	30,012
Fully immunized	80%	5%	20%	15%	

90 data in report - why not use that instead or report

3. Other indicators

	Objectives	Status (*)
Mortality: Infant & child	25% decrease	--
Neonatal tetanus	25% decrease	1984: -- 1990: 7/1,000
Inpatient diarrhea	50% decrease	1984: 8.8% 1990: 11.4%
Inpatient malaria	50% decrease	1984: 9.1% 1990: 6.2%
Measles ('86 report)	50% decrease	--
Morbidity: Measles (children < 5)	50% decrease	1984: 1/1,000 1990: 2/1,000
Whooping cough	--	1984: 24/10,000 1990: 1/10,000
Disability (Poliomyelitis)	50% decrease	1984: 5/100,000

-7

new
explan.

1990: 5/100,000

Effective Diarrhea Management at H.C.	90% correct	? 1988: 20% 1990: 5%
at Home	50% correct	--
Effective Malaria Management at H.C.	90% correct	1989: 2%
at home	50% correct	--

(* See Appendix A-Page 39 (Table #13))

B. Project setting and environment

In the past eight years, Guinea's economy has undergone dramatic changes for the better. Indicators for the improved situations include, but are not limited to:

- a myriad of privately owned shops and small businesses (pharmacies, food retail stores, restaurants) flourishing in Conakry and upcountry;
- a better public infrastructure i.e. paved roads, repainted street signs and functioning traffic lights, a brand new international airport with active electrically operated luggage claim conveyors;
- public transportation including regularly scheduled buses, is working well;
- fire trucks, ambulances, police cars and private vehicles are in good state of maintenance. Fuel is in abundant supply at electrically operated gas stations;

All these are indicators of a young and vibrant economy. The changes are more marked in Conakry than in rural areas, and, with the exception of public transportation systems (roads, airport), are more evident in the private sector than in the public services such as health.

C. Project Evolution

The following table provides a summary of the major events which have taken place during project implementation.

TABLE I.2
Summary of Project Chronology
(according to major documents)

Document Number	Document Date	Document Title	Author's Name	Agency Name
01:	May 1983	CCCD Issue Paper	--	--
02:	January 1984	MCH Evaluation	--	--
03:	June 1985	Grant Agreement	--	--
04:	March 1986	1985 Annual Report	D. Gerski	--
05:	March 1987	1986 Annual Report	D. Gerski	--
06:	May 1986	Pritech workshop	--	--
07:	August 1986	Cost Recovery		REACH
08:	January 1987	Pritech		MSH
09:	March 1987	CCCD staff meeting	--	--
10:	May 1987	CCCD project evaluation	Brown Mock	URC --
11:	January 1988	1987 Annual Report	--	--
12:	April 1988	Extension Plan	--	--
13:	October 1988	CCCD Project Amendment		AFR/W
14:	January 1989	1988 Annual Report	--	--
15:	March 1989	Cost Recovery Study	Evlo Waty	REACH --
16:	August 1989	Mid-Term Evaluation	F. Correl Finlay S. Stanfield	ARC/BDI
17:	January 1991	1990 Annual MIS report	--	

2. THE EVALUATION PROCESS

The final external evaluation of the ACSI-CCCD project in Guinea took place between April 14 and May 10, 1991. The objective as stated in the scope of work for the evaluation (see Appendix 2) was to: (1) review actual versus planned achievement of the project purpose and objectives; (2) document factors accounting for success or failure of the project components; (3) estimate the sustainability of development accomplishments; (4) provide a series of recommendations to assist the ministry of health in further development of child survival activities beyond the PACD; and (5) identify lessons learned from this project as guidance for future similar development activities. (In addition, the team was asked by the Mission to identify a set of transition issues which need to be dealt with as one project closes down and the project's activities, resources, and investments are taken over by other parties such as the government and/or other donors. The evaluation was conducted by a team consisting of:

- o Jean-Paul Heldt, MD, MPH, Management Specialist and Team Leader
- o Patrick G. Kelly, MD, MPH, Primary Health Care Physician/Epidemiologist
- o Baroureissy Tall, MD, Public Health Specialist representing MOPH
- o Aïssatou Lô, MPA, Health Educator/Training Specialist

The first and last members participated in a Team Planning Meeting in Washington, where they received background information, reviewed project documents, discussed the project with other donors, and prepared for the in-country assignment. They were joined in Guinea by the other two team members.¹

The team reviewed extensive documentation in Washington as well as in Guinea. The list of documents examined appears in Appendix 3. The team met with a variety of key individuals associated or knowledgeable about the country including in Guinea central level MOPH and collaborating agency officials. The team also interviewed health workers at various levels of the system and observed health worker performance at health centers in all three "préfectures" served by the project. A list of persons interviewed appears as Appendix 4.

In Guinea, USAID/Conakry arranged for hotel reservations and provided logistic support; the project staff provided unabated administrative and logistic support (access to printers, office

¹It had been the intention to have the whole team meet in Washington prior to the in-country visit but this was not possible in the end. Given the frequent changes in planning and scheduling the evaluation, the absence of the Technical Officer in Guinea during the team's visit, the occurrence of unrest during the Guinea visit and other challenges and obstacles, this evaluation effort was fraught with difficulties from the beginning. Though these have effected somewhat the final outcome, the team nevertheless hopes that its efforts will be found to be of use to A.I.D. and the other clients in assessing the ACSI-CCCD project in Guinea and in pointing out useful lessons for the future.

space, in-country travel). Those with whom the team met were available for questions and logistical support throughout the in-country stay, for which the team expresses its sincere gratitude to all (For a list of team activities, see Appendix C-1).

3. ORGANIZATION OF THE REPORT

The team organized the report according to the following outline. The first set of issues looked at involved project outcome and dealt with core interventions. The discussion takes place in the following order:

- Immunization activities - E.P.I.
- Control of Diarrheal Disease - C.D.D.
- Malaria Control
- Health Impact

Then the report analyzes the support strategies and activities that have been implemented to reach the project objectives:

- Health Information Systems
- Operations Research
- Training and Technical Assistance
- Health Education

Finally, the team assessed the project resources and how they have been managed:

- Project Structure and Organization
- Human Resources
- Logistical and Technical Resources
- Financial Resources
- Relations with External Environment

In order to present the team's findings and recommendations in a relatively consistent manner, for each above mentioned section of this report (except in the core interventions, where lessons and recommendations are integrated and treated as a whole), an effort has been made to follow this sequence:

0. Introduction
1. Finding: i.e. progress achieved and constraints encountered
2. Conclusions
3. Lessons learned
4. Recommendations (with special attention to transitional issues)

- for ACSI-CCCD project staff
- for MOPH

■ for USAID

Lessons learned or recommendations that are directed at a principal agency or client are identified at the end of each by parentheses.

II. PROJECT OUTCOME (CORE INTERVENTIONS)

1. CONCEPTS AND METHODS FOR IMPACT ANALYSIS

A. Introduction

The progress achieved in health in Guinea in the last six years has been truly remarkable. The World Bank team that studied the population, health and nutrition sectors at the beginning of the second Republic of Guinea in 1984, found a country that exhibited all of the symptoms of extreme poverty: inadequate and polluted water, poor sanitation, substandard housing, low educational levels, enormous transportation and communication problems, eroded and over-worked fields, high levels of morbidity and mortality and an essentially non-functional health system. Everything needed to be done. Now several years later the country is still poor and still faces enormous socioeconomic problems.

The striking difference in the health sector is that Guinea (along with Benin) has played a pioneering and leadership role in the West African region by developing a model program that led to the Bamako Initiative. Today we find an integrated national health program that already covers one-third of the country, actively engages local communities as full partners and has initiated the sound management practices that are necessary for medically effective, cost-effective, sustainable Primary Health Care.

The ACSI-CCCD project predates the National Primary Health Care Program and aided in its design. Furthermore, the project has continued to work with the National Program as it ends its activities, as noted later in the report.²

B. Terms of reference

The epidemiological analysis of this section looks specifically at the outputs of the ACSI-CCCD project for the three technical interventions (Immunizations, Oral Rehydration Therapy of children with diarrhea and the use of Chloroquine for the presumptive and preventive treatment of Malaria). The quantitative objectives of the project are summarized in Table 1 on page 1 of Appendix A.³

Selected objectives proposed by the World Health Organization to be attained by 1995 are presented on page 3 to permit comparison with the project's objectives.

²Given the limitations on the length of the total report, the subsequent analyses have been put into Appendices A-1 to A-49 accompanied by a Table of Contents. The first Appendix, A-1a, contains a list of definitions used in this section.

³References in this section, II, to tables and figures, etc., are all to Appendix A.

C. The ACSI-CCCD project

The creators of the Africa Child Survival Initiative had a vision, although in retrospect it was a limited one. An abundant, international health literature showed that medical interventions per se rarely if ever have a significant impact on the ecology of morbidity and mortality in developing countries. Certainly not in the short run. Nevertheless, it was proposed that the "Twin Engines" (or "Magic Bullets") of immunizations against six childhood diseases and oral rehydration therapy for diarrhea, accompanied by chloroquine for malaria would rapidly result in the reduction of morbidity and mortality rates from 25 to 50 percent for children under five. The amendment that extended the project stressed that the indicators that had been initially proposed were generic for the entire program and that project managers in each specific country should explicitly adapt them to their specific situation. For example, of all the countries participating in the program, Guinea's percentage of children under one completely immunized was the lowest at five percent. It was simply not realistic that in a few short years coverage could be increased to 80 percent, in spite of the fact that WHO and UNICEF were aiming for 90 percent coverage by 1990.

? ^{a follow on} Now as ACSI-II is being planned we see that the scope of interventions suggested is being expanded to include such important parts of the problem as nutrition (including deficiencies in vitamin A and anemia), acute respiratory diseases, family planning, reduction of maternal mortality, A.I.D.S., etc. ^(no service interventions) The second important difference in approach is the realization that there is no sustainable "quick fix"; thus the proposal that the follow-up program be for the entire decade of the 1990's.

D. Geography and Integration

The maps on pages 4-6 in Appendix A give a quick view of Guinea and the ACSI-CCCD project area. The Republic of Guinea is divided into 4 regions which from west to east represent four distinct ecological zones: coastal lowlands, mountainous, sahelian, forest.

The project has been specifically limited to three prefectures in the coastal or maritime region: Conakry, Kindia and Téliimélé. In spite of this, it was, particularly in its early years a highly welcome and integrated partner in the development of the country's health system at the national level. For example, many of the studies that were done through the project were very useful in helping the government to launch its national integrated strategy and accompanying Health Information System. Today about one-third of the project assisted health centers are already integrated into the national program, with plans for more underway.

Thus the distinction between project and non-project activities is often artificial. It creates, however, an excellent indicator for answering the question of sustainability. On the other hand, if it makes the job of evaluating specific project impact more difficult.

E. Conceptual models of health

v. Guinean
original notes
PS - interesting

In order to talk about impact some notion of the current health status in Guinea is needed. The conceptual model presented on pages 7 to 15 attempts to give a comprehensive description of the ecology and determinants of health based on the four major indicators suggested by the World Health Organization:

- Political
- Socioeconomic
- Utilization of health services
- Health status

Am A

Another tool that has been used is the Physical Quality of Life Indicator (PQLI), which is derived from a combination of the infant mortality rate, life expectancy at birth and the proportion of literate adults. Figure 1 and Table 3 on pages 16-17 show Guinea in juxtaposition with its neighbors. Such a limited definition of health is of little use, for no one could convincingly argue today that the quality of life is better in Liberia than in Guinea.

A compromise between the complex and the simplistic models consists of the twelve global indicators used by WHO every two years to evaluate a country's measurable progress towards the goal of health for all by the year 2000. This analysis is presented on pages 18-21 and shows that while indicators of political will are relatively strong and mechanisms of implementation have been created, the country has just begun its journey towards achievement of the WHO norms.

F. Population

An epidemiological analysis requires reference to denominators; that is, the population at risk. Unfortunately until the next national census, which will not occur before 1993, no one knows with any accuracy the magnitude of the Guinean population and its rate of growth. Furthermore, with analysts using different estimations, results are not comparable and are often not very convincing, especially when the author has used the original estimates from the 1983 census without any attempt to adjust the figures to the present. Four different hypotheses for population size and growth trends are shown on pages 24-25, the geographical presentations of population density and growth rates on pages 22-23 being based on hypothesis A. The trouble with the 1983 census is that for political reasons the numbers were inflated to attempt to hide the reality of the mass exodus of Guineans fleeing from the first Republic. The latest World Bank estimates (1990) have deflated the population by about 1.7 million. (Hypothesis C) Hypothesis D comes from a suggestion given to us at the State Secretariat for Decentralization. Deflate the 1983 figures by 10 percent and use an annual rate of increase of 2.7 percent. This is the guide that we have used for this analysis, which gives the following estimates for 1990:

Guinea	6,332,926

Conakry	1,137,178
Kindia	214,676
Télimélé	244,474
<hr/>	
ACSI-CCCD Zone	1,596,328 = 25 percent/total population

G. Demographic Indicators

From the published data in Table 6 on page 28, smoothed estimates of trends for the last 30 years are calculated on page 29 and presented graphically on pages 26-27.

The lines are essentially horizontal in Figure 3, showing that Guinea with a total fecundity rate of 6-7 and an annual growth rate of 2.7 percent has been and continues to be a pronatalist society, with a population doubling time of about 26 years. Looking at Figure 4, one has the impression that the infant mortality rate is falling slightly (10 percent reduction over the last 5 years). However, a recent study by WHO in Guinea cites a level of 160 per 1000 live births, which if true, means that there is no downward trend. The truth of the matter is that no one knows the real level. Guinea has also started to study the problem of maternal mortality, with current preliminary estimates of the rate ranging from 500-1000 per 100000 live births, about 200 times greater than that found in industrialized countries. ✓

H. Patterns of morbidity and mortality

As shown on pages 30-32, the government estimates of the major causes of childhood morbidity and mortality in 1986 remain essentially unchanged in 1990. Given that acute respiratory infections were and remain one of the three big killers of children it is regrettable that an ARI intervention was not part of the project package. What has been found in some countries with high immunization rates are that fully protected children are now dying from their respiratory infections. Table 9 on page 33 serves to remind us that seasonal variation must also be considered when evaluating health needs and strategies. The questionnaires on pages 47-49 represent an adaptation of those used by WHO in Uganda to estimate immunization coverage, childhood prevalence of diarrhea and malaria and infant mortality. Unfortunately not enough time was allotted to the evaluation team to do such a survey.

2. IMMUNIZATION ACTIVITIES - E.P.I.

As has been stated in prior evaluations, the EPI component of the three technical interventions has been the strongest. This is not surprising, since the EPI program in Guinea has existed for 10 years and it was one of the two major thrusts of the ACSI-CCCD project. A variety of process indicators provide impressive evidence of a relatively well functioning service:

- Refrigerators that are maintaining vaccines in the proper temperature range (We did observe, however, more yellow flames than we would have liked.)
- Proper sterilization of needles and syringes
- People trained to give proper doses at the proper age
- Home-based records for mother and child
- Work plans based on estimates of the number of children to reach in the year with an advanced strategy to find them in their villages.

could have used more 1990 data - why not - not complete?

The graphs and data on pages 34-39 provide an analysis of the impact of the EPI. Figure 7 shows that, in general, the coverage rates of the project zone are higher than the national averages. Although far from the objectives of 80 percent coverage for infants and 60 percent for pregnant women, the sustained progress is impressive. In just three years, national coverage of infants tripled from five percent to 15 percent. In the project area, the coverage of pregnant women at 38 percent is almost five times higher than the national average. The high coverage rates that were reported in 1986 (Table 11, page 36) were based on a survey that was carried out immediately after a national campaign, and thus were not sustained.

The data on page 37 were found during a two-day visit to the prefecture of Kindia. Some of the important findings include:

- Local estimates of coverage are significantly higher than those derived from data in Conakry (32 percent versus 17 percent). The explanation may be a combination of data lost at the central level and different estimates of the groups at risk.
- Comparing ACSI-CCCD centers with those in the national program (EPI/PHC/EM - Phases I and II), it appears that integrated centers have higher coverage rates than ACSI-CCCD assisted ones. Ranking the centers from best to worst and testing this hypothesis with the Rank-Sums Test, we found these differences to be statistically insignificant. The explanatory variable that was significantly correlated with coverage was simply whether or not the health center was located in a town on the national highway. Access, it would seem, is a major constraint, not only for people to come to the centers but also for supervisory visits. It should also be noted that until recently most peripheral centers were staffed by only one person. Now in the prefecture of Kindia we are told that no center has less than three people.

The graph and data on pages 38-39 show the evolution of reported cases of four of the six diseases covered by the immunization program. Taking measles as a proxy indicator for the success of the program, we see a dramatic fall in reported cases in 1983, that has remained low to the present in spite of a vastly improved reporting system. It is noteworthy that the drop occurred three years before the start of the ACSI-CCCD project. The number of measles cases reported for 1990 translates to 40/100000 population, which is exactly the objective set by WHO for 1995. Given that the national average immunization coverage rate for measles is only 16 percent, one would expect that the number of cases is being under-reported and there may well be a rebound in the future.

Polio and neo-natal tetanus are two diseases that WHO hopes will be eradicated by 1995. Guinea's statistics for 1990 show one case of polio/100000 and 2.4 cases of neo-natal tetanus/100000. These are certainly underestimates of the current reality, although in all of the health centers we visited, no one could remember having recently seen a case of neo-natal tetanus.

3. CONTROL OF DIARRHEAL DISEASES (CDD)

The most remarkable change that one notices in Guinea is that while just a few years ago virtually all cases of diarrhea were treated with antibiotics such as Ganidan and Ampicillin, now the notion of oral rehydration, with few exceptions, is accepted and practiced by health workers. For this intervention the impact of the ACSI-CCCD project was nation-wide, particularly in the area of training and helping the government to develop its national strategy. In virtually all of the ACSI-CCCD assisted centers, special ORT rooms exist. The national program uses the rehydration packets but does not have these special rooms.

Figure 11 on page 40 shows that cases of diarrhea vary from month to month throughout the year. The data in Table 14 on page 40 cite the number of children treated for diarrhea in the ACSI-CCCD zone in 1990. The calculation of needs was based on an estimate of five episodes per child per year and the assumption that only 10 percent of cases required ORT at health centers. If this is a reasonable estimate then the coverage of needs is only 10 percent, with an average of 1.5 packets being given per episode. Several surveys have been carried out to estimate diarrhea prevalence and home treatment. Two comments will be made on these surveys:

+ (?)
■ There seems to be confusion between incidence, prevalence and the relationship between them. The 1989 quotes a survey in Kindia that found a 17 percent two-week prevalence rate, suggesting 8.9 episodes of diarrhea/child a year. The numbers do not add up. Assuming no seasonal variation, and an average duration of four days, 8.9 cases/child per year implies a two-week prevalence of 41.5 percent.

■ Surveys seem to consistently show that over half of the mothers treat diarrhea in their children with some sort of oral liquids. We were unable to find a definition of what is considered to be correct treatment, so we are unable to say if the project objective of 50 percent effective treatment has been reached.

Visits to health centers showed that the equipment and packets were there, treatment guidelines were posted on the walls and there were very few patients, even at the national training center at Donka hospital. One problem that needs to be corrected was that many of the scales were not properly set, some being off as much as 500 grams.

The team that went to the prefecture of Téliimélé was able to collect health center specific data for both diarrhea and malaria cases for 1988-1990. It is interesting to note that the estimate of coverage of needs was 20 percent in 1988, the first year of the program, falling to seven percent in 1989 and five percent in 1990. If this is an indicator that mothers have now learned to hydrate

their children at home, it is good news. If it is a sign of poor training, supervision or education of the community, then it is a situation that needs to be corrected.

Data and analysis of the evolution of mortality in children hospitalized for diarrhea are presented on page 42. The remarkable statistic is that the number of hospitals reporting has increased from three in 1986 to 37 in 1990. As for the mortality rate there is no evidence of the reduction of 50 percent that the project hoped to achieve. ✓

4. MALARIA CONTROL

As with the treatment of diarrhea, there has also been a systematic change in the way patients suspected of having malaria are treated. Just a few years ago they were all given injections of Quinine or other anti-malarials. Today the presumptive treatment of all fevers with oral Chloroquine is now the norm.

In attempting to estimate the percent of children's needs covered, we estimated five febrile episodes per year. Data collected at Téli-mélé, showed that if these estimates are "in the ballpark" then only two percent of needs are being met. If malaria is really the major killer of children then we need to know what this means. Are our estimates for the number of fevers a year too high? Are mothers using traditional treatments or buying drugs in the markets? Concerning the objective of 50 percent of mothers treating their children correctly for malaria at home, we found no definition of what that means.

As for mothers receiving chloroquine at their prenatal visits we found no data to estimate the coverage of need. We were impressed to see that some ACSI-CCCD centers had already added iron/folic acid tablets to the prenatal packet, recognizing that anemia is one of the major problems of pregnancy.

Data and analysis of children hospitalized for malaria are shown on page 43. Thirty-seven hospitals are now reporting and there is no indication that the case-fatality rate has been reduced by 50 percent during the life of the project. What happened in 1985 to cause one child in five to die? Is this a reporting error or did the hospital run out of medicine?

5. HEALTH IMPACT OF CORE INTERVENTIONS

There is no evidence that any of the generic objectives set by the authors of the ACSI-CCCD have been achieved in Guinea. As previously stated, the health status of Guinea at the beginning of this project was the worst of all of the countries involved, using any indicator one would care to choose. For this reason and the fact that there were virtually no reliable pre-project baseline data, the quantitative objectives should have been reasonably set as called for in the project extension document.

No one can deny that Guinea has demonstrated remarkable political will and self-reliance in launching a public health strategy for the decade of the 90's that serves as a model for other countries in the West African region that have had greater resources and less impressive results.

6. LESSONS LEARNED

- The anticipated impact of three modern technologies in a country where most of the health problems are related directly or indirectly to poverty were greatly overestimated. (For All/USAID)
- Foreign assistance in sub-saharan Africa must be for the long term. It should have the flexibility to adapt to changing national strategies, particularly when those strategies are evolving rapidly and have a greater chance of being effective and being sustained than those of the donors. (For All/USAID)
- The importance of a real partnership with the communities and the difficulty of achieving that kind of a relationship have been greatly underestimated, particularly in a country where the people were oppressed by the government for a generation. The supply/demand model of health service utilization on page 45 demonstrates that even if the health system provides services that are available, accessible, acceptable, and affordable, they will not have much impact unless the communities have the knowledge, attitudes and practices necessary to translate their needs and wants into effective demand. (For All/USAID)
- Primary Health Care is not as easy or as cheap as many would like to believe, particularly in a country with continuing population pressure and foreign exchange problems and where everything is a priority. (For All/USAID)

7. SUSTAINABILITY

In a country at this stage of socioeconomic development there are no guarantees. One of the major external shocks that is currently putting pressure on Guinean resources is the massive influx of refugees fleeing from the civil war in Liberia.

8. RECOMMENDATIONS

- It would seem rational to recommend that the project do everything possible to integrate all ACSI-CCCD assisted health centers into the national program as soon as possible, whether before or after the end of the project. Most of the communities are ready and willing to meet their part of the bargain, and one of the main constraints is the purchase of the 30 months supply of the essential medicines that are needed to launch each center. The danger of rapid expansion is that in certain sections of the Ministry of Health, personnel are already stretched to the limit and that without continued assistance in training, and material and technical support such expansion will be accompanied by a decrease

in quality. Such a result would be the exact opposite of the current strategy that envisions gradual growth of the program while maintaining and improving the quality of services. The needs of the BEPR are particularly critical and will be addressed in the chapter on the Health Information System. (ACSI-CCCD/MOPH/USAID)

III. SUPPORT STRATEGIES AND ACTIVITIES

1. MONITORING ISSUES (HEALTH INFORMATION SYSTEMS)

A. Discussion

key needed on table

The qualitative indicators in the scope of work for the evaluation of the Health Information System and Operational Research are summarized in Table 2 on page 2 in Appendix A. The symbol "+" means that the activity is relatively strong, "±" means that activities have started but are still relatively weak.

The National Health Information System (SNIS) is managed by the Bureau of Studies, Planning and Research (BEPR). The major activities include the following:

- Data collection, compilation and analysis of all statistical reports received from health institutions,
- Dissemination of the results through the production of an Annual Statistical Report,
- The creation of a centralized data bank for training and research, and
- The elaboration of action plans for training and research.

The SNIS was created in 1988 with the help of the African Development Bank through its program of institutional reinforcement. Today data are received from the following institutions:

- 173 health centers (50 percent of the national total)
- 29 prefectural hospitals
- 8 Major hospitals (Grandes Formations Hospitalières)

The health center reports are monthly and those of the hospitals quarterly. In addition, biannual reports are received from the prefectural medical directors.

The different reports consist of tables of morbidity and mortality data as well as information concerning personnel, equipment and buildings. The tables cover 40 diseases for the health centers, 72 for the prefectural hospitals and 110 for the major hospitals. In 1989, 97 percent of the expected reports were received.

The ACSI-CCCD project has worked in close collaboration with the SNIS, examples of which include:

- A workshop on operational research in May 1989 (With IDRC)
- Assistance to the statistical and epidemiological sections through short term training in Conakry and Kinshasa, an introduction to several computer programs (Epi-Info, Dbase III Plus and Harvard Graphics, and the repair of the BEPR's two computers).
- Assistance in developing the information system: type of data to be collected, data quality, periodicity of the reports and analyses, and flexibility of the system. The Annual Statistical

Report for 1989 was a result of this collaboration.

- Provision of some office supplies (paper, etc.)

B. Problems

In order to ensure the viability and sustainability of the system, it is urgent to address the following priority problems:

- The one functioning computer is inadequate for training and work purposes. (Bull Micral, 512 kb memory, 20 Mb disk drive) There are no lap-tops. Today virtually all of the analyses are done manually by three people.
- The absence of a full-time computer professional in the Ministry of Health.
- The absence of preliminary analysis capabilities in the prefectures resulting in an excessive work load in the BEPR. This problem will be exacerbated as the national integrated health program continues to expand.
- Since its creation in 1988, the SNIS has not had the means to undertake supervisory and evaluation visits outside of Conakry.
- Inadequate budget for the production of the number of copies needed of the Annual Reports.

C. Conclusions

In spite of its problems, the SNIS has been able to lay the groundwork for a system that represents considerable progress toward the goal of a functional Health Information System. Several organizations have helped, including the EPI/PHC/EM program, the African Development Bank, the United Nations (WHO, UNICEF), Médecins Sans Frontières, the International Development Research Centre and the ACSI-CCCD project. Given the fact that the survival of the national health program requires a viable health information system, that the ACSI-CCCD project, with CDC/Atlanta resources, had considerable comparative advantage over other donor agencies and that the 1989 external evaluation underlined the urgent need for strengthening of the SNIS both at the central and peripheral levels, it is surprising that the inputs of the ACSI-CCCD were so few. A variety of scattered activities occurred (short term consultants and training), but there appears to have been inadequate continuity and follow-up for the transfer of requisite skills and means to the Guinean personnel. How is the SNIS going to survive, improve and reach its goal of being able to address the statistical, research, and epidemiological needs of the health system?

Last year WHO provided 10 scholarships for training of 10 Guineans in epidemiology and the French have shown an interest in helping to establish an epidemiological system based on sentinel posts. The major problem is that there is no clear strategy or plan of action for the future of the SNIS and as yet no guarantee of adequate, sustained assistance from any partner foreign or domestic.

D. Recommendations

- The Ministry of Health needs to take the initiative to identify a partner ready to provide the long-term assistance needed by the BEPR. (MOPH)
- The BEPR's needs assessment, currently under preparation, should be presented to the ACSI-CCCD project as soon as possible so that resources may be transferred to the BEPR before the end of the ACSI-CCCD project. This includes the data bank that exists in the project's computers which should be inventoried and adequately documented to avoid a lapse during the transition phase. (MOPH)

2. OPERATIONS RESEARCH

A. Discussion

Operational research in the health sector is very limited in Guinea. At the national level, the BEPR is theoretically in charge of research coordination and assistance but at present it does not have adequate qualified personnel, equipment and budget to do the job. Furthermore, there is as yet no centralization of data and reports of research carried out in Guinea.

A variety of studies were done under the auspices of the ACSI-CCCD project, most of them by short term consultants. In May 1989 a workshop was organized by the project and the International Development Research Centre (IDRC). At the end of the workshop 23 research subjects had been identified with four research protocols having been developed.

Unfortunately this introduction to research methodology has not produced any palpable results to date because of lack of follow-up, and continuing technical and material and financial assistance. Two research proposals -- one on impregnated mosquito nets and one on essential medicines -- have been submitted to USAID through the ACSI-CCCD project, but have not as yet been assured of financial support.

B. Problems

With the available SNIS data, the Guinean health research community theoretically has scope to analyze a variety of themes important for improving the health system. In spite of this resource, operational research has not been able to get started for several reasons:

- Few people have the requisite research skills,
- Data available are often of questionable quality,
- There is as yet no BEPR strategy which defines the research priorities, and
- People who would like to do research are not aware that the BEPR is there to help them both in the preparation of protocols in the search for financing.

C. Conclusions

The operational research component of the ACSI-CCCD project has been weak, especially in terms of sustainability. As we noted in the analysis of the Health Information System, a variety of positive actions were taken, but the problem, especially in the last two years of the project, was a lack of systematic follow-up and assistance. Therefore, the project is ending without having transferred adequate research skills and resources to the BEPR personnel.

D. Recommendations

- The Ministry of Health needs to identify partners ready to provide both short and long-term help needed by the BEPR. There are many organizations whose mandate is to provide such assistance. IDRC, for example, has already shown its willingness to help and could be asked for continuing assistance. In areas related to population and family planning, the Population Council would be interested. (MOPH)

3. TRAINING AND TECHNICAL ASSISTANCE

A. Findings

Through the project's literature review and interviews with the heads of the Ministry of Public Health, the Ministry of Population, the project, and the Health Directors in the Prefectures, it is evident that training has been one of the project's most dynamic components. This was demonstrated by the external evaluation of training done in 1987, when 70 percent of the total personnel slotted for training during the course of the project were trained.

However, within two years all those targetted for training had received training, as noted in the 1989 evaluation report. Since then, training activities have been in the form of refresher courses at the health centers level for the expanded vaccination program, the anti-diarrheal program, and the anti-malarial program.

Since the last evaluation, the main training activity has been health education for trainers and executers of various programs in the project. The MOPH provided considerable support to the BEPR through the training of its Director of Information in Zaire in September 1990. The project had previously assisted the BEPR in training over 40 participants in operational research methodology. (see Appendix B-1)

According to the project document amended in May 1988, the main objectives were to:

- develop a national training plan with defined strategies, and
- guarantee the training of 90 percent of the health personnel from the project area in management and techniques of care.

A national training plan has not yet been developed, except by the MOPH administrators. Some changes have taken place in the management of training at the center over the past two years.

Until recently, training was handled by the Office of Administrative and Financial Affairs (DAF), which was more concerned with personnel management than technical or administrative performance. The evolution of Primary Health Care programs between 1986 and 1989 affected the decision by MOPH to transfer the management of the training from the DAF to the BEPR, in particular to the Operational Research Division, directed by a public health physician with a masters in research.

The training role of the BEPR is to:

- elaborate a master plan for training all health personnel that integrates all project training plans;
- define training strategies and ensure the monitoring and evaluation of training activities (its 1991 and 1992 action plans emphasize training needs in light of existing health problems);
- establish priorities; and
- determine realistic training needs.

In order to fill the void in the structure for managing training and to face their training needs, the ACSI-CCCD project and the National EPI/PHC/ED Program unilaterally developed their own training capacity by creating a training commission. The ACSI-CCCD project commission consists of the ACSI-CCCD program coordinator, the anti-diarrheal disease program coordinator, the anti-malaria program coordinator, and the head of health education programs. These officials combine their roles in the framework of the ACSI-CCCD project with their roles in the framework of the national program. The commission of the national training program is well structured and can call upon skilled Guinean public health experts as well as their collaborators in UNICEF and WHO. This commission appears to function very efficiently under the leadership of the National Director of Prevention, who is also the president of FORHSE (Power to Optimize Human Resources in Health); a newly created inter-ministerial group aimed at strengthening skills in health.

It must be noted, however, that the ACSI-CCCD project has not yet developed either a master training plan nor annual plans. Training and refresher courses continue to be done on a case by case basis according to the needs determined to execute the project. There are signs of a decentralization in training at the level of DPS in Kindia and Téliimélé, although the efforts are still weak and unstructured. There is no instrument to evaluate performance at the level of services or follow-up of training. The supervision checklist is incomplete, unquantified, and not used for training purposes.

The target in terms of personnel to be trained has even been exceeded: up from the 500 scheduled, 645 have been trained in vaccination techniques, maintenance of the cold chain, statistical reports, management of a SRO unit, and in treatment and prevention of malaria. In the health centers visited in Conakry, we were able to find at least two persons trained in ORT, five trained in EPI, and, if all the personnel trained during the mass campaigns are counted, the total number of persons trained doubles. In Kindia and Téliimélé, all the heads of centers were trained

and they began to train new personnel at the level of their centers (three to four per health center).

Training has had a net impact on personnel performance at the level of service delivery. Heads of centers recorded an improvement in the quality of services and an increase in the use of the services, especially after training in HEP and in community mobilization techniques.

The project organized annual refresher sessions for health center personnel for the three intervention programs. As much as the training of the executing officials was solid and regularly reinforced, the training of project and DPS managers was weak in management, communications technique, teaching, operational research, and health information systems. The project leaders have each done one to two three-week introductory training sessions on computers, given outside of the country, but there was virtually no capacity to reinforce this training at the project office level.

None of the project coordinators ensure that training activities are coordinated. One training session for trainers took place in 1986 to launch the project, but only two of the 18 persons trained are today involved in project training activities. However, eight of them were recruited by the national program's training commission. Two other training sessions for trainers were held within the framework of the ACSI-CCCD program but the efforts have not been followed up in the sense of reinforcing the experience at the level of different project heads, having been introduced to the techniques of training. It is not evident that a transfer of skills took place at this level; this is explained by the lack of mastery of the different stages of training, beginning with the evaluation of needs to the evaluation of the performances done after training.

Though one does not find project (or national) personnel specifically skilled in teaching or communications techniques who could be responsible for managing the training, there are a number of skilled Guinean personnel in most public health fields and considerable training experience in these different areas. These will be an invaluable asset for training at the point the BEPR becomes fully operational in training management.

The evaluation team felt the urgent need of the DPS to have more experience in training trainers during the period when the project is drawing to a close and the Districts receive newly assigned personnel. Their staff quadruples near the end of the project, and they lack skill in supervision training and management. On the other hand, their health centers have made progress toward integration into the national program yet this highlights a greater need for training and supervision. They lack reinforcement in techniques of communication, management, operational research, and information systems management that would allow for full decentralization of project activities.

No training manual has been produced. However, the project used different brochures created by the three intervention programs along with the ACSI-CCCD project manual in order to ensure training. These brochures and decision-making charts were largely disseminated to the health centers in the three project areas.

✓ The efforts to coordinate with the university were unsuccessful on the part of both the ACSI-CCCD project as well as the national program. The fact that the schools of medicine are run by the Ministry of Education makes coordination more difficult. In addition, there are problems associated with the school of medicine adopting public health programs. The National Program leaders and training advisor feel that if their training modules are not adopted by the university at the end of the project, they will fail in the medium-term because all the health personnel, before working in the framework of the National Project, come from health schools within the university. In their opinion, this is the most difficult task that BEPR and the National Project will have to resolve in the future.

Supervision is done on a regular basis in Conakry, with three supervisors based in the project office, conducting management activities rather than training activities for the health centers. This is done on a less regular basis in Kindia and Téliimélé, each of which have two supervisors. In these two prefectures, limited access to certain areas during rainy seasons limits supervision to the first half of the year. The health centers on the route are twice as supervised as those located elsewhere. A supervision checklist has been used since 1990, but it is incomplete and unquantified. For the time being, it is used on site at the end of a training session, but it has not been periodically scrutinized in order to identify the recurring gaps where a refresher course would be useful in specific areas.

B. Conclusions

FN The training targets for the project were exceeded. Training has been more concentrated among health center personnel than among project managers, in this case the DPS and coordinators from different components. Teaching, operational research, health information system, and management need to be strengthened. There was an effort to decentralize training under the full responsibility of the DPS. The health center directors are able to train their personnel on site regarding the different intervention programs.

The project helped strengthen training in the framework of the National Program; eight of the participants in the first trainers training seminar in the 1986 are active in the National Program training commission. Moreover, support to training was provided in order to strengthen logistics, the cold chain, and health education within the framework of the National Program.

The project helped strengthen the BEPR and the national health education department by financing computer training needs, operational research, and health promotion.

The MOPH designated the BEPR as a structure to manage training, but it does not have the human or financial resources necessary to execute its main material tasks. For the time being, internal training needs are met by the training commissions of the ACSI-CCCD project and the National EPI/PHC/ED Program. Certain other skills are available in public health associated with a certain degree of experience in training. There is no master plan or annual training plan at the project level. The experience gained in training trainers is not sufficient, although the technical assistance in this area was useful to enable initial training sessions to take place. However, a

consolidation of experiences and a decentralization of training skills was lacking at the level of DPS.

The use of supervision as a training instrument remains weak. Supervision is not decentralized in Conakry, and no health center directors have been trained in supervisory techniques.

There is no system to formally and systematically evaluate the impact of training aimed at skills acquired, quality, or use of the departments.

The training modules are standardized with those of the National Program in matters concerning the EPI/CDD/Malaria components.

C. Recommendations

- Support BEPR efforts to conduct training by supplying a long term scholarship for training a specialist in training; (MOPH)
- Prepare an action plan for training for 1991-1992, aimed at meeting the need of refresher sessions for health center personnel in specific areas identified after analyzing the supervisory files or after observing the performances of the officials in service delivery. The plan will also aim at strengthening the training of DPS, project coordinator, and officials of BEPR, management of the health education department, management of information systems, communication and learning techniques, and operational research. This plan will be financed with counterpart funds beginning in October 1991. (MOPH)
- Provide timely technical assistance to this department and continue to help elaborate the different stages of the training master plan and management training tools during implementation of the 1991 and 1992 action plans. (MOPH)
- Strengthen the decentralization of training at the level of DPS and Heads of Centers. (MOPH)
- Decentralize and strengthen the quality of supervision by improving the training of supervisors and supervisory instruments; use these instruments as a means of identifying training needs. (MOPH)
- Integrate training activities into the framework of the national program, which, in the long term, must integrate its modules into the teaching system of the health schools run by the School of Medicine. (MOPH)

4. HEALTH EDUCATION

A. Findings

Health education has been one of the most dynamic and active components since the last project evaluation in August 1989. Dramatic changes have taken place in this area at all levels.

While the 1987 and 1989 evaluations cited the weakness of the health education department in infrastructure and human and material resources, as well as its inability to respond to various health education needs, this evaluation applauds the remarkable progress that has been made in this sector.

The health education department was strengthened by a reorganization of the Prevention Department, which includes the Health Promotion Division. This division, in turn, contains three sections: hygiene and environment, school and university health, and health education. A national policy for Health Education and Promotion (HEP) is currently being defined. A first step was taken with an inter-sector meeting on the development of health education at which participants outlined the central premises, defined the priorities, and drew up an annual action plan for 1991. The strategies defined by the action plan are: training, information, research, monitoring of activities, supervision, and evaluation. The action plan was implemented with the support of CDD, EPI/PHC/ED, and PDSS projects, and MSF/France.

According to the Director of the Prevention Department, the department has not yet reached its optimum operating level because of departmental budgetary constraints. The department still needs a public health physician to run audio-visual production, a social anthropologist to conduct surveys and research, and a contractual specialist to handle and maintain equipment.

The Prevention Department and its divisions are located in newly renovated, adequately furnished offices. The Health Education Department is housed in a three-story building built as part of the World Bank-financed PDSS project. The department has received the following equipment from the ACSI-CCCD project: one television, one video and camera, two tape players with radio, video cassettes, one photocopier, one typewriter, and a vehicle with fuel based in the project office. The Health Education Section currently has seven people: a department head, two assistants, one official seconded to the ACSI-CCCD project, two officials assigned to the AIDS project, and one seconded to the PDSS project.

As part of the effort to strengthen the health education section, a number of staff have received third country training:

- o the Section Chief and his assistant were sent to Canada,
- o the head of the ACSI-CCCD project in HEP as applied to EPI was sent to Zaire, as were the Chief of the Health Promotion Division, the HEP head of the ACSI-CCCD project, the Peace Corps volunteer in Conakry, and the Coordinator of the

CDD Program were trained in HEP as applied to the CDD Program in Zaire in October 1990.

After the training programs, the participants respectively drew up an HEP/EPI action plan for 1990 and an HEP/CDD action plan, which is awaiting financing for 1991. - 10/1/89

The HEP/EPI action plan was executed to 90 percent by combining training, preparation of teaching materials, dissemination of educational messages on diarrhea, and management of activities. Training was decentralized at the health center level by training 17 trainers, DPS, and supervisors from five prefectures of the project, and training Peace Corps volunteers, who were counterparts of the supervisors in Kindia and Téliimélé. The project had previously collaborated with the Peace Corps in Conakry in the training of the two health education volunteers assigned to the ACSI-CCCD project from June-September 1989. These HEP trainers trained a total of 210 representatives, among them 120 in health centers in Conakry, 40 in Kindia, and 50 in Téliimélé.

The trainers in Téliimélé helped organize and train five health promotion committees in collaboration with the national EPI/PHC/ED national program. This remains to be done in the prefecture of Kindia.

Preparation of educational material for mothers and health personnel was made possible as a result of the various baseline surveys conducted on the behaviors of health personnel and mothers on the three components done in collaboration with the HEP section and project consultants (Gordon et al, 1988; Vodounou, 1988; Glick, 1989). Four posters were made, three of which were disseminated. One poster is on the signs of dehydration, one on the ORT, and one (done in collaboration with UNICEF) on EPI diseases. The two posters on decision-making and the treatment of malaria with chloroquine are in the final stages of production. Others in the preparation:

- approximately 10,000 flyers (aimed at mothers) on the preparation of SRO;
- five technical files for health personnel in each project intervention;
- observation files for three interventions and control guide of an HEP session; and
- small posters on EPI done in collaboration with UNICEF.

Concerning the dissemination of messages, the project supported three radio spots in Pulaar on the prevention and treatment of diarrhea, which were broadcasted bimonthly for two months. They were broadcast by Labé rural radio, which covers eight of the country's prefectures. There are plans to translate the messages into the other languages spoken in the country. Considering that earlier surveys showed the 70 percent of the population has access to radio, the impact could be far reaching. A song on vaccination for the strategy proposed in Conakry has already been prepared for release in the near future. Dissemination of the educational material has been decentralized at the level of every health center in three prefectures.

With respect to the management of activities, the central team for health education described the HEP action plans of the Prefecture of Conakry, and helped the teams in Kindia and Téliimélé

prepare their action plans for 1990 and first quarter of 1991. The team has made regular supervisory visits to the 14 health centers in Conakry, and four supervisory visits to each of the sub-prefectures of Kindia and Téliimélé since January 1990. They have prepared training plans using observation instruments developed to identify training needs. In addition, the team introduced and supervised home visits to Conakry in order to reach the children who were not fully vaccinated.

The central team anticipates helping the teams in Kindia and Téliimélé write up the 1991 actions plans, following the final production and dissemination of educational materials on the prevention of malaria; supervise the training of health promotion committees in Kindia; complete HEP/EPI training in 18 health centers of Conakry; and implement the HEP/CCD action plan for 1991.

negative The health education activities applied to EPI were evaluated in the area of Conakry in December 1989. The acquisition of knowledge on the messages to transmit is dramatic: 90 percent of the personnel were familiar with the messages to be transmitted and the level of knowledge received by message doubled between the pretest and post-test. However, effective transmission of messages is still weak. According to the Director of the Health Promotion Division, out of ten women questioned when leaving the office, only three had totally understood the messages. The majority of the women only remembered the next appointment and the usefulness of keeping the vaccination card. This is explained by the fact that the health care provider-receiver relationship was very weak before the introduction of health care education in the center activities.

perhaps Insofar as the impact of HEP on the ORT, an important change has taken place. In 1988, only 11 percent of the children received oral rehydration; today 60 percent of the mothers in Conakry have access to the ORT via 26 centers. Twelve centers offer ORT services in Kindia, 14 in Téliimélé and 47 others in the rest of the country. One study conducted by the CDD coordinator in Conakry in March 1990 on a sampling of 33 mothers had the following results: 66 percent had already heard of the ORT - 27 (80 percent) from health centers and 17 (20 percent) from television; 36 percent already used the ORT; 30 percent correctly prepared the solution; 26 percent thought that the ORT stopped diarrhea; 20 percent thought the ORT replaced lost water; and 16 percent did not know what it was for. The same study, observing the recommendations usually given by the health care personnel, confirms the conclusions of the Cutts study done in March 1989, namely that anti-diarrheals constituted the first recourse in case of diarrhea. Sixty-one percent of personnel observed recommended anti-diarrheals, 34 percent SRO salt, and 4 percent antibiotics. These observations motivated a Declaration of General Policy of MOPH, which identifies the ORT as the treatment of choice for a child suffering from diarrhea.

The major problems perennially affecting these activities are:

- the availability of vehicles in order to strengthen the training and supervisory activities of health center officials and allow them to conduct the necessary surveys and monitoring of the impact of HEP activities;
- the transfer of skills from trainers and supervisors to the DPS supervisory level and heads of centers;

- the acquisition of skills in monitoring health education activities and the handling and analysis of data; and lastly
- the effective budgeting and financing of activities.

B. Conclusions

There has been remarkable progress in the restructuring and operation of the Health Promotion Division/Health Education Section, which gives this component more credibility.

The current organization and operation of the Health Promotion Department is adequate for long-term management of health education activities, but it must be strengthened in terms of human, material, and financial resources -- specifically, for the development of teaching material, surveys, and research.

The project largely carried out the activities stipulated in the 1988 amendment, namely:

- provided technical assistance for the different surveys conducted in order to gather the information necessary for developing educational materials;
- provided assistance for training trainers;
- provided help in the development of health education teaching materials; and
- provided assistance in operational research.

The action plans for 1990 and 1991 were based on the findings of the various KAP surveys done with the project. Despite delays in financing by the project, 90 percent of the 1990 action plan was executed.

The educational material produced by the project was largely disseminated and posted. However, it has not been sufficiently or effectively utilized by personnel.

Learning what messages must be disseminated is important at the level of health personnel, but the actual dissemination of the information still poses a big problem in the sense that personnel do not always take the time necessary to talk to mothers.

Although no KAP survey has measured the real impact of HEP/EPI activities for two years, the project heads and physicians running the health centers have observed that:

- the health centers are used more than before health education was implemented.
- as a result of the support given by Peace Corps volunteers, the activities in Kindia and Téliimélé have been decentralized, and the central HEP office has been strengthened in training methods for trainers, production of teaching material, and evaluation of activities. The transfer of the 3rd year volunteer, an HEP specialist, to the head of HEP/ACSI-CCCD was noteworthy. This volunteer is able to conduct most activities but needs additional training in techniques to evaluate activities and handle the data collected.

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C. Recommendations

- Immediately execute the 1991 HEP/CDD action plan, without waiting for financing, by applying the same strategy as the 1990 HEP/EPI action plan, which trained health officials at sites where they worked. (MOPH)
- Provide refresher sessions to health officials in HEP/EPI and preparing an HEP/Malaria action plan from now until the end of the project; these activities will be financed out of counterpart funds for FY 1991-92. (MOPH)
- Integrate HEP activities into the national EPI/PHC/ED program through the Health Promotion national service. (MOPH)
- ✓ ■ Conduct a KAP³ survey in order to measure the HEP/EPI impact on mothers and take corresponding measures; follow the same strategy for the other components. (MOPH)
- Improve the training of supervisors and heads of centers in HEP and decentralize the supervision of this activity to their level. (MOPH)
- Strengthen the Health Promotion Department and its Health Education section by providing a vehicle with the necessary fuel for carrying out activities. This department should take into account the indicators defined by the project and strengthen all the activities already undertaken, guarantee their monitoring, and take corrective measures. Specifically, more radio broadcasts of messages should be done in the country's principle languages. (MOPH)
- Continue and strengthen assistance by the Peace Corps in the area of health promotion. ~~(USAID/PEACE CORPS)~~

IV. PROJECT RESOURCES MANAGEMENT

1. PROJECT STRUCTURE AND ORGANIZATION

After assessing the outcome achieved and the support activities initiated by the project, we now consider the project's setting (i.e. internal and external environment) and the resources deployed to make both strategies and results possible.

A. Findings

The structure of the project and its external environment is a highly complex one. Different interviewees, or the same people at repeat interviews were often unable to provide consistently coherent information as to project structure (See also Appendix C-2). We were not able to elucidate conclusively the exact interface and interaction between ACSI-CCCD project staff/activities and MOPH's staff, services, and facilities at various levels.

Of the 48 health centers covered by the project, roughly one third (15) are presently integrated into the national PHC system (PEV/SSP). In terms of sustainability, this will be the major issue to address. After PACD, only the central ACSI-CCCD office contractual staff and infrastructure will be dissolved. Project staff already employed by MOPH will not be affected by the EOP.

B. Lessons learned

✓ In projects that start out as vertical interventions (e.g. EPI, ORT, malaria control), it is desirable to start the process of integration early on in the project. (ALL)

In any project, but particularly in a difficult environment like Guinea, it is judicious to start project activities on a small scale (perhaps one or two préfectures) and expand to others as experience is gained and the infrastructure consolidated at all levels. (A.I.D.)

C. Recommendations (with special attention to transition issues)

■ It will be a special challenge for the project staff at all levels (central office, préfectures) to initiate the integration of the remaining 33 health centers. We cannot overstate the urgency of this process. It will not be completed by PACD, but hopefully well on its way to allow the activities to be sustained. (MOPH/USAID)

■ Project staff, together with MOPH and USAID, should seek alternative sources of funding: several potential donors have expressed a keen interest in furthering ACSI-CCCD activities. (ACSI-CCCD)

2. HUMAN RESOURCES ISSUES

A. Findings: Progress achieved

The ACSI-CCCD project has to its credit a good share of highly educated and qualified staff at all levels. Many doctors and health workers had public health training in addition to their medical and technical education. While it was not possible to observe their hands-on performance over time, we perceived overall a high degree of motivation to achieve project goals. Although the technical officer (TO) was not physically present during our visit, we received positive feedback on his performance and his acceptance by project staff, counterparts, Guinean officials and USAID personnel. Repeat interviews, however, revealed that administrative issues over LOP often overshadowed his or her technical competence. The transfer of technical, computer, and managerial skills is perceived by project staff to be insufficient.

Despite limitations in staff and office space, the TO is credited with overcoming formidable obstacles in the procurement of commodities, goods and disbursement of funds. During his tenure, the TO has paid no less than seven supervisory visits to Téliimélé, the most remote préfecture covered by the project.

With few exceptions, all project staff have a good understanding of the issues and constraints facing the project. Weekly internal staff meetings at the central office are good opportunities for discussing results, problems (e.g. training, supervision, monitoring), and submitting action plans. On the first Friday of the month, national program coordinators, officials from USAID, directors of health centers and the DPS are invited to participate in these meetings. However, memos or minutes are not kept systematically. Thus it is not clear how follow-up is handled. It would have been helpful for the team to attend some of those meetings but this did not take place.

Report writing, once a monthly activity, is now a quarterly and annual exercise. In the absence of the TO, we were not able to assess whether report writing was used as a participatory management tool. At the health centers, record keeping activities were generally well understood and carried out. One director had developed his own management information systems for drugs, cash flow, project activities, and had made a simple but effective organigram of his unit.

B. Findings: Constraints encountered

We noted a gross imbalance in the distribution of health workers between health centers in Conakry, the capital, and the facilities in Kindia and Téliimélé. One center in Conakry has 39 employees, while the peripheral units average only three to four. One source informed us that Conakry health centers have recently participated in an exercise designed at rationalizing the use of personnel. The current plan is to have two shifts of roughly 15 - 20 health workers each in order to insure a 24-hour operation of health centers. Before this exercise, some health centers in Conakry had close to 200 health workers on the payrolls. At the national ORT center, a highly trained physician was almost exclusively dispensing ORT packets.

Highly trained, health workers in the centers have a predominantly curative orientation. This reflects a similar emphasis in the prevailing nursing, medical and technical curricula. We also observed unequal performance among various health agents. We saw several instances of over-prescription for simple cases of bronchitis or unspecified fever. In one center, a mother had just given birth to a baby girl. The midwife did not know that silver nitrate or tetracycline ointment must be administered within hours to prevent neonatal eye infections. Nor was the drug available. One team member returned to the center with the ointment, and demonstrated to the midwife how to administer it. Besides such anecdotal evidence, however, the team had no other effective way of measuring project personnel efficiency.

The single most frequent need expressed by interviewees at all level of the project was the one for more competence in management (e.g. personnel, supervision, administration, finances). Indeed, we observed several deficiencies in this area:

- With two notable exceptions, staff members had no job descriptions to guide them in their work. One supervisor had made up his own checklist of supervisory activities;
- As mentioned earlier, minutes of weekly staff meetings are often not being kept;
- Although personnel files are maintained for the two employees hired by the project (i.e. administrative assistant and one driver) other files pertaining to attendance records, application documents (e.g. C.V.), salary, contract, and other important papers are not kept;
- Except in one case, no performance evaluation has been conducted and documented;
- Long-term planning and periodic evaluation activities are not routinely practiced. Even our evaluation visit, because of the time factor, was perceived as an "external" sanction, rather than a management tool.
- The frequency of supervisory visits by central project personnel to rural health centers is far from optimal. While the TO has visited the most remote préfecture on average three times a year, his national counterparts have barely made one visit per annum. This "hands-off" involvement of national counterparts is perceived as a serious obstacle to long-term sustainability.
- With few exceptions, there has been a frequent project staff turn-over, especially at the national level. This contributes adversely to effective institutional memory and continuity in project output.
- In rural as in urban health centers, the units are generally underused.
- Health centers personnel are not used to operating at full capacity, which results in long waiting lines, despite a daily low output. In one center, by ten o'clock, there were still 15 mothers waiting to have their children vaccinated. The bottle-neck came from an ill-organized management sequence. While two of his colleagues sat idle, it was the same health worker who

checked the immunization record, cashed the money for the immunization cards, gave the vaccine, and made follow-up instructions. The team demonstrated to the staff a more efficient sequence of distributing tasks among themselves. This issue was also noted in the 1989 evaluation report. Only effective management training and ongoing supervision can bring about further improvements in this area.

As Guinea has few national experts in technical areas such as EPI, ORT, malaria control, these professionals are in high demand. ACSI-CCCD interventions have immensely benefited from their expertise, yet at the same time the project suffered from their involvement in outside responsibilities. As the number of nationals trained in public health grow, however, this issue should become less important.

Sustainability of the personnel component after PACD should not pose a major problem. Although contractual project employees will be laid-off, most project staff are public servants who are already integrated in the public service administration. However, because of the weak management system that is in place, effective supervision of health workers at all levels will continue as a concern for the public health system.

C. Lessons learned

A project, to succeed, in addition to financial and human resources, requires the setting up of an effective management system. (ALL)

D. Recommendations (with special attention to transitional issues)

■ Technical assistance in applied management is needed at all levels. Workshops and seminars, can serve this purpose, but preferable is long-term, on-site assistance, training and supervision. The training should include all aspects of management such as planning, supervision, evaluation, accounting and financial management, personnel management, logistics, time management, techniques for effective communication, teaching, training, and health education. (MOPH)

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■ We recommend that assistance should be given, and timely arrangements made for helping contractual project employees find other work opportunities. (USAID)

■ The GOG and MOPH should explore new policies to redeploy Guinea health professionals in a more equitable urban-rural balance and to provide incentives for increasing personnel continuity. (MOPH)

3. LOGISTICAL AND TECHNICAL RESOURCES

A. Findings: Progress achieved

The project office is housed in an old building located conveniently near EPI's central warehouse.

The project possesses a fleet of five vehicles in good working conditions, and of motorcycles used by DPS and health centers in performing their supervisory activities. At the peripheral level, the health centers are well staffed, and most of the facilities are in a good state of maintenance.

After overcoming initial delays, the project, both centrally and at the health center level, has been blessed with an ongoing supply of commodities (i.e. EPI, ORT, chloroquine). In respect to fuel supply, two team members observed in one préfecture that health centers that are integrated in the national PHC system seem to encounter slightly more difficulties than those that are not integrated. This finding, however, was not confirmed by the two other members visiting another préfecture. There is no conclusive evidence that a difference actually exists.

B. Findings: Constraints encountered

The building used by the project is sub-standard, and does not provide office space for each staff member. While all national counterparts had their own office, we noted that no special office space had been allocated to the technical officer. He is currently sharing a room with the project administrative assistant. Perhaps to remedy this situation, the project had initiated the construction of a new facility in the backyard at the same location. Because of slow disbursement in counterparts funds, the construction is far behind schedule and is not likely to be operational by PACD.

While supply of fuel has not been an obstacle, central project staff noted serious delays in the delivery of project vehicles and in the procurement of project commodities. After lengthy administrative procedures to order project vehicles, the vehicles were further held up at the Conakry port for several months.

Although opinions on this issue differ greatly, the ACSI-CCCD project is not perceived as having developed the ability to manage project fleet and commodities. As of May 1991, because of lack of space and inadequate security at the project building, three of nine Conakry-based project vehicles were parked at the residence of the TO. Project commodities, such as ORS packages and chloroquine tablets, previously stored at the TO's house, were in the process of being transferred to a container situated in the backyard of the project building. According to one source, only the TO and USAID's project officer have access to the container. According to another source, the ACSI-CCCD project coordinator should also have a key to the container, but this could not be verified independently). The mission staff is also concerned about late requests for commodities and vehicles so close to PACD, and the last project implementation letter (PIL # 8) has stirred no little debate as to the relevance of ordering (and receiving) goods so late in the LOP.

In terms of sustainability, the management of project vehicles and commodities appears to be a very weak component of the project though there are a range of views on this issue.

C. Lessons learned

There is a need for orientation of new project staff to USAID procurement requirements. Project

staff must be made aware of the necessity to analyze long-term needs and submit timely procurement calendars. Face-to-face communication seems critical to achieve a mutual understanding of opportunities and limitations. (USAID)

D. Recommendations (with special attention to transitional issues)

■ Special consideration needs to be given to the disposition after PACD of the project's material resources -- project vehicles, appliances and commodities. The TO's input will be critical. While USAID recognizes that MOPH needs vehicles and commodities to carry on activities previously supported by the project, it is also concerned about the MOPH's ability to absorb and effectively manage project vehicles, computers, and commodities. So far, no mutually acceptable solution appears to have been found. In respect to the delivery of essential drugs, the option of a sub-grant to other donors has been suggested. (USAID)

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March 67
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■ The MOPH is urged to move ahead with the building under construction. Once functional, the facility could house activities designed to complete the full integration of the remaining 33 centers. The allocation of funds and manpower is critical for a smooth transition. (MOPH)

■ The disposition of vehicles and commodities during the transition requires a mutual understanding on needs and limitations. Two-way communication is critical at this stage to ensure a smooth transition. (ALL)

4. FINANCIAL AND ACCOUNTING ISSUES

A. Findings

The project involved four main sources of funding:

- o bilateral funds,
- o counterpart funds (PL480),
- o funds generated from the cost-recovery mechanism initiated by the project, and
- o sub-allocation funds (on which little data are available) bilateral/central funds.

i. Bilateral Funds

The project disposed of a LOP budget of US\$1,530,000 (earmarked in total). Line items in this budget include:

- vehicles, office equipment (computers, copier), cold chain (refrigerator),
- supplies e.g. immunization, chloroquine, essential drug packages, ORS packages,
- some personnel (administrative assistant, driver),
- maintenance, and

■ support for activities such as training abroad, health education, O.R., audit.

These ^{refers to} centrally-funded items are handled through the Mission's controller, and the regional bureau in Abidjan. ACSI-CCCD funds are part of a much larger portfolio (e.g. economic policy reform, education, manpower development, agriculture).

With US\$1,530,000.00, the ACSI-CCCD LOP budget represents 2.08 percent of the sum of LOP funds (US\$73,544,866) managed by the Mission. If we translate this proportion into a time factor, we arrive at roughly 1 hour of Mission staff time that can be budgeted for project activities per week (two percent of a 40 hours week = 48 minutes per week).

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This limited time availability of Mission staff for ACSI-CCCD issues was compounded by the project staff's initial lack of knowledge and experience of lengthy and complex USAID administrative procedures and requirements. Difficulties and delays were bound to arise.

As of March 31, 1991, the project has spent US\$909,000.00 (60 percent), leaving a balance of unused funds of US\$621,000.00. This end of project statement reflects a very low start, and cannot exclusively be traced to USAID administrative procedures. Other factors such as the country environment and overall weakness of management capacity must be taken into consideration.

ii. Counterpart Funds (PL480)

Counterpart funds are to be disbursed by the GOG for such items as:

- salaries of national personnel;
- maintenance of buildings and office space;
- procurement of locally available commodities (e.g. fuel) and equipment; and
- logistics of project activities such as health education.

Slow disbursements of counterpart funds have been noted by informants and documented in previous evaluation reports. Yet, somehow, the ingenuity of ACSI-CCCD project staff was able to overcome budgetary and cultural constraints: for two years in a row, ACSI-CCCD was the first project to receive its counterpart funds.

TABLE IV.1 National Budget for ACSI-CCCD Project -- 1991

Approved	440,856,470 FG
Allocated	317,517,505 FG (72.02 percent of approved budget)
Used	212,794,749 FG (48.26 percent of approved budget)
Balance	228,061,721 FG (51.73 percent of approved budget)

iii. Funds generated from the cost-recovery mechanism initiated by the project.

Cost recovery at the health centers is well-organized. EPI cards and ORT packages are sold for FG50 a piece, chloroquine is priced at FG200 a dozen. In a local, privately-owned pharmacy in Téliimélé, chloroquine is selling at FG 1125 per dozen (up from FG 400 in 1988).

TABLE IV.2 Income Generated in Project Préfectures (4/14/90 to 6/12/90) (FGs)

Conakry I	1,014,275
Conakry II	6,330,980
Conakry III	6,816,850
Kindia	1,162,460
Téliimélé	1,438,000
misc.	50,000

	16,812,565 = 24,018US\$

For these data to be useful in decision-making, their management needs serious reconsideration. It would be useful, for each préfecture, to tabulate the data by:

- month, quarter, and year;
- health center(s);
- number of beneficiaries for each ACSI-CCCD interventions; and
- number of health personnel at each unit.

*in part
not* Fifty percent of the funds recovered are channeled through the DPS to a national account in Conakry. Health center personnel retain 25 percent of the generated income as incentive and 25 percent to pay for recurring costs. This incentive may account for the efficient functioning of the cost recovery system at the health center level. The team, however, was not able to elucidate to which degree the income generated is sustaining recurrent costs, nor how this system affects the utilization of the services by the community.

Anecdotal evidence of several mothers (present at a health center) indicates that cost is not an issue compared to the benefits of having their children vaccinated. But low clinic attendance, and limited output of core project interventions may force project staff and decision-makers to look into fee-for-service, yet these factors along with other constraints (cultural, geographic, quality of services) pose potential obstacles to reaching the majority of the community.

B. Lessons learned

The management of centrally funded projects represents a special challenge for USAID missions. Especially in small missions, with limited staff availability, it would be helpful to brief new

project teams (such as ACSI-CCCD) on USAID administrative procedures and procurement requirements.

It is not ^{just} the amount of funds available that determines the degree of success of a project; timely disbursement and ongoing support to project activities are as critical. x

C. Recommendations (with special attention to transitional issues)

- Since Guinea's experience with cost recovery is relatively recent, the GOG, with the assistance of donors, should follow-up on a previous cost recovery feasibility study. This study, however, was limited by an absence of baseline data. (MOPH) (2)
 need's gone
 explanation
- As the ACSI-CCCD project comes to an end on September 30, 1991, project staff and MOPH, assisted by USAID, should take early steps to identify new donors to carry on ACSI-CCCD activities beyond the life of the project. The team perceived a readiness among donors (UNICEF, World Bank, EEC, French, German and other countries), but did not have the time to pursue this issue in great depth. Technical assistance may be useful in this respect. (ACSI-CCCD/MOPH)

V. EXTERNAL ENVIRONMENT AND POLICY ISSUES

1. INTERACTION WITH HOST COUNTRY GOVERNMENT

A. Findings

The GOG's commitment to health is demonstrated in its national policies reflecting the priorities set forth by the Bamako Initiative, namely a commitment to primary health care, cost recovery, access to essential drugs, and opening of the private sector. Government officials interviewed had a good understanding of the problems faced by the project, and also by the GOG's own limitations. We noted a keen interest in improving performance leading to better results. There is a great desire to sustain ACSI-CCCD activities through the national program (EPI/PHC/ED). Among the major constraints, however, both reported in documents and noted by the team, are the following which are also illustrated by tables below:

- A general and all pervasive weakness in the GOG management capacity at all levels.
- A scarcity of resources in the face of pressing needs on all fronts; only a small portion of the national budget is being allocated for health. The health sector is allocated three percent of the global investment budget.
- A rapid change and turn-over of key officials who are involved in the ACSI-CCCD project's external network.
- Dialogue between MOPH and USAID Mission is perceived as being cumbersome and not very effective.
- A relatively low involvement in the project's day-to-day operations: No project site had received the visit of high-level GOG officials.
- An excessive dependence on external funding, especially in the health sector. Most of the health budget -- 88 percent -- is carried by external assistance. Twelve percent of health expenditures comes from national resources, which represents only half of a percent of the government's total internal resources.

TABLE V.1 Budget for National Development

	1990	1991
National Percent	285,318,193,000 FG	408,258,769,000 FG = 66.82 percent
External Percent	173,000,000,000 FG	202,739,200,000 FG = 33.18 percent
Total	458,318,193,000 FG	610,997,969,000 FG = 100.00 percent

TABLE V.2 Budget for Health and Social Affairs -- 1991

		% of health budget	% of Gross budget
National	2,287,500,000 FG	12.11%	0.49% of internal funds
External	16,597,400,000 FG	87.89%	8.18% of external funds
Total	18,884,900,000 FG	100.00%	3.10% of total budget

B. Lessons Learned

A project, to be successful, requires commitment, national policies, the allocation of appropriate resources, and the managerial capacity to plan, implement, and evaluate project activities. While the GOG has expressed its commitment in national policies, the allocation of resources lags far behind. Furthermore, its efforts to implement project activities have been seriously hampered by its inadequate managerial capacity. (MOPH)

C. Recommendations (All for MOPH)

- The GOG/MOPH would do well to reconsider the value and priority of health in the overall development process. Other sectors of the economy (agriculture, exploitation of natural resources, road construction, education) are vital ingredients of socioeconomic progress and development. And so is health -- the present generation cannot wait for tomorrow's health impact on national development. Today's adults and children want, and must be a part of national development efforts. To that end, people and communities must be healthy.
- It is important for MOPH to demonstrate its commitment to sustaining ACSI-CCCD activities beyond PACD. Suggestions in this direction include, but are not limited to:
 - completing the project building,
 - integrating the 33 health centers,
 - seeking new donors, and
 - requesting T.A. in specific areas i.e. cost-recovery and management training.
- MOPH should seek, perhaps through long-term technical assistance, to enhance its management capacity at all levels, and make use of incentives and policies to guarantee long-term continuity of key health personnel (both technical and administrative) at all levels.

2. INTERACTION WITH USAID

A. Findings

In our interviews with USAID officials, we found a good awareness of the issues facing the project, and of the problems the project has faced in the past. The mission, after several moves in the past five years, is now housed in a new and very functional building. Key mission personnel, including the current mission director, have paid visits to health centers covered by ACSI-CCCD project. Since 1988, the current Mission health staffer has paid no less than five visits (some earlier as a PCV) to the most remote Préfecture covered by the project. The mission also supported intensive Peace Corps Volunteers activities in project zones, especially in the area of health education (a PCV was stationed in Téliélé Préfecture). Close collaboration has been established between the Peace Corps and the project.

The major constraint the Mission faced in the supervision and backstops of the ACSI-CCCD project was the absence of a health officer in Conakry. The mission never identified the need for a health officer, therefore, one was never recruited. Thus the supervision of ACSI-CCCD was done by other mission staff who were willing to take on this added responsibility without having the much needed expertise in health. This situation was compounded by the rapid change and frequent turn-over of USAID Mission staff at all levels during the life of the project.

The net result is that the project suffered, as an official put it, from a chronic lack of "ownership". An overburdened Mission staff became increasingly "monopolized" and frustrated with project issues which it did not have the time and expertise to deal with. This was complicated by the inexperience of project staff in dealing with USAID's stringent administrative procedures and requirements for financial disbursement (of bilateral funds) and procurement of logistic supplies of commodities (e.g. drugs, vehicles). [For further details, see previous section]

regularly
In our discussions with USAID staff, they expressed a certain confusion over USAID's role in the management of counter-part funds, bilateral funds, and sub-allocation funds. Faced with the paradox of "decentralized" management of a "centrally" funded project, the Mission requested special support from A.I.D./Washington in this respect.

USAID's decision to phase-out its involvement in the health sector at the EOP is based on the need to focus scarce resource on priority interventions. In its efforts to streamline its portfolio, the Mission has decided to concentrate its resources on agriculture, education, access to domestic markets, employment and income-generating activities, and on improving the performance of the very promising private sector including social marketing of family planning methods. Although opinions vary, the team believes the rationality for this choice to be clearly beyond the scope of this evaluation, and thus will not discuss it.

B. Lessons Learned

Among the many variables involved in a project of this magnitude, its success depends heavily on the capacity of the Mission to supervise and backstop all its aspects. This calls for a post in the Mission of a properly trained project officer. (A.I.D.)

C. Recommendations (including transition issues) (All for USAID)

While transition issues relating to activities, strategies, buildings and project staff have been discussed elsewhere, the handling of remaining funds, vehicles, and commodities deserves special attention. Although the Mission will be the ultimate decision-maker, the following points represent our understanding of the usual procedures:

- Items purchased with bilateral funds are to become property of the host country in order to carry on project activities beyond PACD.
- As for the vehicles, the stipulation from USAID to MOPH should be that former project vehicles must be used in support of former project interventions such as EPI, ORT, and malaria control.
- Likewise, commodities (cold chain, ORT, and chloroquine) should be integrated into an existing structure able to carry out project activities. The entity of choice would logically be the National EPI/PHC/ED Program. Each of its three divisions (EPI, ORT, and malaria control) would be allocated its respective type of supply.
- The matter of ownership of items purchased with sub-allocation funds (i.e. computers and copiers) is unclear. If it is USAID's call and there are no other pressing priorities, we recommend that computers be transferred to the BEPR to execute its statistical tasks nationwide. T.A. may be necessary.
- For the remainder of LOP, we recommend that USAID works closely with the project staff and the MOPH to finalize any logistic (vehicles, commodities) and financial (e.g. sub-grant) issues that are pending. Clear communication of administrative constraints to all parties involved will be essential. Technical assistance for this phase-out may be desirable.

no bilateral funds - perhaps with the local grant agreement
✓

3. INTERACTION WITH OTHER DONORS AND NGOS

A. Findings

A number of donors and NGOs are present and active in Guinea, especially in the health sector. The GOG has recognized and values the contributions of national and international donors and NGOs. Under the second Republic, the Ministry of the Interior and Decentralization has set up a national committee for the coordination of NGOs activities (SCIO). A declaration has been

published defining the roles, responsibilities, and modus operandi of both national and international NGOs. Two national conferences have already taken place (1987, March 1989), and another was slated for 1990. The SCIO has also published four issues of "Bulletin de Liaison inter ONG" (No 3 in 1989, No 4 in Dec. 1990).

Nevertheless, it seems that this committee is underutilized, and goes largely unnoticed. For example, none of our interviewees was aware of its existence though several suggested that one should be initiated. One team member "accidentally" ran into the coordinator of SCIO on his way to another meeting.

Although there is such a committee, most donors and health project staff have no formal relation with each other, and obviously not with or through the committee. It was suggested that the committee was under-utilized because of its long and ineffective meetings, with lengthy agendas dealing with issues on a national scale. Thus donors prefer to interact with each other on an ad hoc, topic-driven basis. The GOG also finds it easier to deal with donors and NGOs, on an individual, case-by-case basis.

There is another dilemma that affects effective collaboration between donors, NGOs, and the GOG, and this refers to major differences in policies and priorities. While the GOG is faced with meeting comprehensive needs both nationwide and at the community level, donors and NGOs are often project-driven. Their funding base requires donors and NGOs to restrict themselves to certain areas, whether gender-based (women, children), geographical, or technical areas such as health, agriculture, education. Even within health, priorities may be limited to certain interventions such as EPI or family planning. Therefore, it becomes very difficult to coordinate efforts and activities. This leads to vertical programs whereas the total needs of the community are much more comprehensive and involve a variety of sectors such as health, education, water and sanitation, food production, and road.

As a result, efforts are duplicated and already limited resources wasted. Several informants deplored this situation, as it prevents an effective sharing of information and experience among donors and project coordinators involved in the same sector. A case in point is a health sector review done in 1990. The results of this comprehensive study remain confined to a draft report which has never been circulated. Another donor is doing a similar health sector analysis in 1991.

B. Lessons Learned

Large and lengthy meetings are not effective in coordinating donor and NGO activities in Guinea, or elsewhere.

C. Conclusions

There is an abundant, but loose, and unstructured network of NGOs and donors. Although USAID's decision to abide by PACD has generated much anxiety at all project and GOG levels, there may be opportunities for new collaborative partnerships to carry on former ACSI-CCCD

project activities. The success of this endeavor will be a true test of the project's sustainability in the absence of ACSI-CCCD funds.

D. Recommendations

- MOPH and SCIO members (donors and NGOs) must find a way to coordinate their efforts in a more focussed, topic-driven approach. Perhaps there could be meetings at the highest level between government officials and donor representatives to coordinate national health policies and funding priorities for the nation for the next five to ten years. Also, there could be meetings focussing only on certain topics such as health, education, agriculture, natural resources, water and sanitation. And finally, there could be smaller meetings for managers and staff of projects in specific technical areas such as immunizations, health education, malaria control, primary health care, cost-recovery, and drug distribution. (All)

VI. PROJECT SUSTAINABILITY

1. Findings

In our interviews, many informants talked about integration, sustainability, and institutionalization. In respect to post-PACD, the range of opinions ranged from total optimism to total pessimism. Some believe that project supported interventions will come to a complete halt, while others contend that, since PEV/SSP will integrate all health centers, activities will continue beyond the end of the project. The team suggests a more moderate view.

Since the integration will take some time, the "business-as-usual" approach seems unrealistic given the socioeconomic structure of the nation. However, perhaps with the assistance of other donors, we think that most activities can and will continue, perhaps at a lower level of intensity, at least for some time. This prediction does not hold for all health centers. Since there is a disparity in the current performance of the various centers, it can be expected that health centers with more ingenious and resourceful personnel will be more successful at maintaining the current level of output. If only to that end, staff continuity is essential for sustained activities.

But few seem to have a clear idea of the process involved in handling the transition from a ACSI-CCCD project to a GOG project. There are many issues to be considered; the ones the team feels are the key ones are included in the recommendations throughout the report but especially those listed in the previous section, V.

2. Lessons Learned

Sustainability through institutionalization ought not be seen as something that happens as a matter of course. True sustainability requires concerted efforts on the part of all parties involved. To be effective in the long run, a project must initiate this process early on in the implementation phase (i.e. it must be built into the planning stage).

While vertical programs, to be successful, are heavily donor-dependent, genuine sustainability requires the full integration of project activities into existing national structures. Such integration must be initiated from the onset of the program.

3. Conclusion

We thus cannot stress enough the importance and urgency of initiating the process of integrating the remaining 33 ACSI-CCCD health centers into the national PHC system. The application has to come from the DPS and the concerned communities. Requirements for becoming integrated include the existence of a community-based health community, a viable facility, and a team of four health workers. Since most of the health centers should have no difficulty meeting these criteria, it is vital that the process be initiated rapidly, while the momentum is still present. The sooner the integration takes place, the more likely health center activities previously supported by the ACSI-CCCD project will go on undisrupted.

4. Recommendations

Sustainability is integrally linked with transition issues. The extent to which project activities continue after PACD either with the GOG or with other donor support, is the extent to which project sustainability will have been achieved. As noted above, transition issues have been addressed in recommendation sections, as well as elsewhere, throughout the report but those that most concretely address the transition are those found in Section V.

APPENDIX 1
PROJECT DATA SHEET

Country	Guinea, West Africa
Funding Agency	A.I.D./Washington
Project Title	Africa Child Survival Initiative Combating Childhood Communicable Diseases
Project number	ACSI/CCCD Project # 698-0421.75
Project agreement date	June 22, 1985
Initial completion date	December 31, 1987
Initial funding	US\$ 885,000.00
Extension design	January 1988:
Project amendment date	September 1988
Project completion date	September 30, 1991
New funding amount	US\$ 645,000.00
Total funding	US\$ 1,530,000
Host country exchange rates	1990: US\$1.00 = FG 650
(Franc Guinéen)	1991: US\$1.00 = FG 699
Project agreement	USAID/Conakry and Government of Guinea, Ministry of International Cooperation
USAID Mission directors	Bill Kaschak (9/90 to date)
(during life of project)	[Byron Bahl] [Mark Wentling]
Implementing agency	Center for Diseases Control, Atlanta Scott McKeown [Dianna Gerski]
External Evaluations	May - June 1987 (Brown & Mock) August 1989 - (Correl, Finlay & Stanfield)
Internal reviews	April 1986: 1st Internal review January 1990: 2nd internal review January 1991: 3rd internal review
Contractor	Atlantic Resources Corporations
(for final evaluation)	Birch and Davis International
Note: For more details, See Project Structure -- Appendix C-1	
Final evaluation team:	Jean-Paul Heldt, MD, MPH, Management research consultant, 2212 Wild Canyon Drive, Colton CA 92324 USA, Fax/Phone (714) 824-3345
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	Aïssatou Lô, Midwife, MPA Public Health Consultant P.O. Box 300, Kaolack, Senegal Phone (221) 41.23.51

APPENDIX 2

STATEMENT OF WORK FOR THE EVALUATIONS OF THE
ACSI-CCCD PROJECTS IN GUINEA AND LESOTHOI. PROJECT DATA

A. Project Title: Africa Child Survival Initiative -
Combatting Childhood Communicable
Diseases (ACSI-CCCD)

B. Project Number: 698-0421

C. LOP Funding: 123.6 million

D. Date of Authorization: September 1981

E. PACD: September 1991

F. Project Management: Africa Bureau, Office of Technical
Resources (AFR/TR)

I. OBJECTIVE OF THE CONTRACT

To conduct final evaluations in two countries participating in the Africa Child Survival Initiative - Combatting Childhood Communicable Diseases (ACSI-CCCD) project. The objectives of the external evaluation are to:

- (1) review actual versus planned achievement of the project purpose and objectives,
- (2) document factors accounting for success or failure of the project components,
- (3) estimate the sustainability of development accomplishments,
- (4) Provide a series of recommendations to assist the Ministry of Health (MOH) in further development of child survival activities beyond the PACD, and
- (5) identify lessons learned from this project as guidance for future similar development activities.

II. BACKGROUND

The ACSI-CCCD Project is the Agency's primary child survival project for Africa. The project has been designed to (1) strengthen the ability of African countries to control preventable childhood diseases through immunizations, (2) treat dehydrating diarrheas with oral rehydration therapy and (3) treat and prevent malaria with appropriate antimalarials. In Lesotho, where malaria is not a problem, the control of acute respiratory infections (ARI) has been adopted as the third intervention. These major

interventions are reinforced by support strategies that include, training and supervision, the development of health information systems, health education and operational research. The development of sustainable systems is an over-riding objective in all activities. When completed, the project hopes to achieve a 25% reduction in mortality rates of children less than five years.

The project is implemented through a Participating Agency Service Agreement (PASA) with the International Health Program Office, at the Centers for Disease Control (IHPO, CDC). Separate grants to the World Health Organization, Africa Regional Office (WHO/AFRO) and the Peace Corps support the training and health education component of the Project. In addition, HEALTHCOM, PRITECH, REACH and the Bureau of Census contribute technical assistance to some ACSI-CCCD project countries. Currently, the project is operational in nine African countries: Burundi, Central African Republic, Cote D'Ivoire, Guinea, Lesotho, Nigeria, Swaziland, Togo and Zaire.

The sixth amendment to the ACSI-CCCD Project stipulates that AFR/TR/HPN, with the Missions is responsible for external evaluation of country projects, while the CDC is responsible for impact monitoring. In the implementation of these activities A.I.D. has maintained a schedule of rotating external evaluations every other year with internal reviews in the intervening years. All final evaluations are external.

IIIA. STATEMENT OF WORK FOR GUINEA

The contractor shall recruit, select and manage a team for an external evaluation of the ACSI-CCCD Project in Guinea.

Based on project-specific priorities of the Mission, the evaluation team will:

- (1) review the project agreement, extension design, previous evaluation reports and health information collected by the project,
- (2) The team will interview central level MOH and collaborating agency officials. They will also interview health workers at various levels of the system and if possible, observe health worker performance.
- (3) using available data, assess the plans and outputs (immediate goods and services provided), and report on the effects (on target audience knowledge, attitudes, and practices), quality of services and impact (morbidity/mortality) of the core project interventions, (EPI, CDD and Malaria control) and the support strategies, (training and supervision, health education, HIS and OR),
- (4) document factors accounting for success or failure in the project components,

(5) assess the project's contributions to strengthening the MOH institutional capacity (managerial and financial) to sustain project initiated activities once assistance is completed,

(6) provide a series of recommendations to help the MOH further develop its EPI, CDD and Malaria control services, including associated strategies in training and supervision, health education, HIS and OR.

(7) identify and document lessons learned through this project for the benefit of similar development efforts.

The following questions correspond to broad service delivery and support activities in the EPI, CDD and Malaria components of the project. These questions reflect the areas of concern (activities and process) that are critical for sustaining program effects and impact. The questions are intended to serve as guide to focusing the evaluation.

For each of the project's major interventions (EPI, CDD, and Malaria control) the team should assess:

a) Was a needs assessment of the interventions (EPI, CDD and Malaria) and support strategies (health education, training and supervision, OR, HIS) conducted? Are objectives and targets (coverage, use, access, morbidity/mortality, behavior change, etc) identified? Has the project achieved it's objectives?

b) Is there a management system in place? Has a strategy been developed for the interventions and support strategies? Are national policies, workplans, schedule, standard treatment protocols, internal evaluation system and budgeting and financial controls developed?

c) Has a logistics system been established for procurement, storage, distribution and inventory?

d) Has a system for health worker supervision, with objectives and targets, personnel development, training and workplans been designed and implemented? What were the effects and impact on health worker performance and quality of service delivery?

e) Has a training plan, with workplans and training schedule been established to train personnel to operate the health service delivery and support system? Are training sessions evaluated and follow-up assessment of performance conducted? What are the effects of training on service delivery and health behavior of the target population?

f) Has a health education system with work plans, schedule, materials development, communication and community mobilization activities been established to support project interventions? Were

evaluations of activities conducted? What are the effects of health education activities on service delivery and health behavior?

g) Are operations research needs identified and research conducted? Were OR findings used to correct operational, technical or management problems?

h) Are there information systems (HIS & MIS) developed to provide data for assessment of impact and management decisions? Has an assessment of the HIS/MIS needs been conducted? Is there a strategy and plan for collection of data? Have personnel been trained to manage the system? Is there a supervisory system in place to assure quality control? Are data collected, processed, interpreted, disseminated and used for program decision making?

Sustainability: The team will evaluate the prospects for long term sustainability of the project-funded activities in terms of the following elements which have been identified as important for sustainability.

- a) Effectiveness of technical interventions and the degree to which this effectiveness has been brought to the attention of relevant decision makers and constituencies.
- b) Extent to which project activities are integrated into the MOH at all levels.
- c) Increasing portion of overall project costs borne by national budget and community level cost recovery mechanisms and participation.
- d) The existence of an institutionalized and integrated training program, with a trained cadre of trainers and based on training needs assessments.
- e) High level of mutual respect and national participation in project planning and implementation. National leadership and strength to negotiate with donors has been established.

APPENDIX 3
BIBLIOGRAPHY (ENGLISH)

ACSI-CCCD Staff Meeting: Field Epidemiologist Report - OCCGE. Conakry: Avril 1987.

Catley-Carlson M: The Donors Response - Canadian Aid policy Towards 2000. Development - Journal of SID, 1, 1988.

Centers for Disease Control/U.S. Agency for International Development: 1986 Annual Report. Africa Child Survival Initiative - Combatting Childhood Communicable Diseases. Atlanta: CDC/USAID, 1987.

Centers for Disease Control/U.S. Agency for International Development: 1989-1990 Bilingual Annual Report. Africa Child Survival Initiative - Combatting Childhood Communicable Diseases. Atlanta: CDC/USAID, 1991.

Brown V, and Mock N: Evaluation of ACSI ACSI-CCCD Project: Republic of Guinea. Conakry: University Research Corporation, 14 Mai - 4 June 1987. [*]

Buzzard S.: "Development Assistance and Health Programs: Issues of Sustainability." A.I.D. Program Evaluation Discussion Paper N0. 23, Agency for International Development, Washington, D.C.

Centers for Diseases Control/Agency for International Development: Africa Child survival Initiative - Combatting Childhood Diseases: Quarterly Report: July September 1990. Centers for Disease Control/USAID/GTZ/Government of Guinea, May-June 1983.

Centers for Diseases Control/Agency for International Development: Combatting Childhood Diseases - Guinea: Issues Paper. Conakry: Centers for Disease Control/USAID/GTZ/Government of Guinea, May-June 1983.

Cereseto S and Waitzkin H: Economic Development, Political-Economic System, and the Physical Quality of Life. American Journal of Public Health. Vol. 76, No. 6, June 1986.

Correl F, Finlay J, and Stanfield s: External Evaluation of the ACSI-CCCD Project in the Republic of Guinea. Conakry: Atlantic Resources Corporation/Birch & Davis International, August 1989.

Diallo S, Dieng B, Duffy ME, Robinson S, Waldman R: Guinea Maternal and Child Health Accelerated Impact Project: Final Evaluation. Conakry: Centers for Diseases Control/Agency for International Development/Government of Guinea, January 1984 [*]

International Children Centre: The Bamako Initiative: Primary Health Care Experience. Paris: International Children's Centre, 1990.

Gerski D: 1986 ACSI-CCCD Guinea Report. Conakry, March 1987

Gerski D: 1985 ACSI-CCCD Guinea Report. Conakry, March 1986

King S: Primary Health Care: A Response in Support of a Health Revolution. Development: Seeds of Change.

Lewis S: Realism and Vision in Africa. Development - Journal of SID. 1, 1988.

Makinen M, Block S: Pricing for Cost Recovery in Primary Health Care in Guinea - ACSI-CCCD/Guinea. Arlington: Abt Associates/The Resources for Child Health Project, September 1986. [*]

Malison M, et al.: Estimating Health Service Utilization, Immunization Coverage, and Child Mortality: A New Approach in Uganda. Bulletin of the World Health Organization, 65 (3), 1987.

Mutharika, B. Special Assistance Needs for Africa, With Special Reference to Sub-Saharan Africa. Development: Seeds of Change. 2/3, 1988.

---: Project Grant Agreement between the Republic of Guinea and the United States of America for Combatting Childhood Communicable Diseases in Guinea. Conakry: June 1985.

United Nations Children Fund: A UNICEF Strategy for Sustainable Development: Children and Environment. Development - Journal of SID, 2/3, 1989.

U.S. Agency for International Development: Africa Child Survival Initiative - Amendment. Washington, D.C.: USAID October 1988.

U.S. Agency for International Development: Amplified ACSI-CCCD Project Description. Conakry: April 1988 [*]

U.S. Agency for International Development: A.I.D. Evaluation Handbook. A.I.D. Program design and Evaluation Methodology Report No. 7. Washington, April 1987

U.S. Agency for International Development: Child Survival: A Third Report to Congress on the USAID Program. Washington: USAID, Undated.

U.S. Agency for International Development: 2th Child Survival report to Congress on USAID programs

U.S. Agency for International Development: 5th Child Survival report to Congress on USAID. programs 4/90

Vaughan J and Morrow R: Manual of Epidemiology for District Health Management. Geneva: World Health Organization, 1989.

World Bank: World Development Report. New York: Oxford University Press, 1990.

World Health Organization: Eighth General Programme of Work Covering the Period 1990-1995. Geneva: World Health Organisation, 1987. [*]

---: Annual Management Information System Report - ACSI-CCCD Guinea 1987. Conakry: Africa Child Survival Initiative - Combatting Childhood Communicable Diseases, 1987.[*]

---: Annual Management Information System Report - ACSI-CCCD Guinea 1988. Conakry: Africa Child Survival Initiative - Combatting Childhood Communicable Diseases, 1988.

---: Annual Management Information System Report - Guinea 1990. Conakry: Africa Child Survival Initiative - Combatting Childhood Communicable Diseases, 1990.

* *

BIBLIOGRAPHY (FRENCH)

* *

Banque Mondiale. Guinée: Le Secteur de la Population, de la Santé et de la Nutrition. Washington: Banque Mondiale, Février 1986.

Evlo K et Waty MO.: Recouvrement des Coûts des Activités de Soins du Projet ACSI-CCCD en République de Guinée: Etude de Faisabilité. Conakry: REACH, Mars 1989. [*]

Gaye PA: Ateliers de Formation des Facilitateurs/Superviseurs et Premier Cours Moyen National - Projet ACSI-CCCD/Guinée. Arlington: PRITECH/Management Sciences for Health, May 1986. [*]

Ministère de la Santé Publique et de la Population/UNICEF/Organisation Mondiale de la Santé: Programme Elargi de Vaccination Intégré aux Soins de Santé Primaires/Médicaments Essentiels: Programme de Formation des Centres de Gestion des 72 Centres de Santé Pilotes - Module III. Conakry: MSPP/Commission Participation Communautaire, Janvier 1988.

Ministère de la Santé Publique et de la Population: Annuaire Statistique - 1989. CONAKRY: MSPP/BEPR, 1990.

Ministère de la Santé Publique et de la Population: Développement du Système de Santé Sanitaire: Propositions de Financement. Conakry: OMS, 1990.

Ministère de la Santé Publique et de la Population: Evaluation des Stratégies de la Santé Pour Tous d'ici l'An 2000. Conakry: Ministère de la Santé Publique et de la Population, Janvier 1991.

Ministère de la Santé Publique et de la Population: Fiches d'Evaluation au Cours de la Supervision.

54

Ministère de la Santé Publique et de la Population: Plan d'Action Sanitaire de la Guinée. Conakry: MSPP Octobre 1989.

Ministère de la Santé Publique et de la Population: Plan National Pour le Programme Elargi de Vaccination, Intégré aux Soins de Santé Primaires, en Vue d'Atteindre la Vaccination Universelle des Enfants, 1986 - 1991. Conakry: Ministère de la Santé et de la Population, Avril 1986.

Ministère de la Santé Publique et de la Population: Plan National Pour le Programme Elargi de Vaccination, Intégré aux Soins de Santé Primaires, en vue D'Atteindre la Vaccination Universelle des Enfants, 1986-1991. Conakry: Ministère de la Santé Publique et de la Population, Avril 1986.

Ministère de la Santé Publique et de la Population: Plan Triennal à l'Horizon Glissant Pour la Période 1991 - 1993. Conakry: Ministère de la Santé Publique, Bureau des Etudes, de la Planification et de la Recherche, Janvier 1991.

Ministère de la Santé Publique et de la Population: Projet ACSI-CCCD: Rapport de Synthèse de la Revue Interne - Présentation des Programmes et Activités Retenus Pour 1991. Conakry: Ministère de la Santé Publique et de la Population/Coordination du Projet, Janvier 1991.

Ministère de la Santé Publique et de la Population: Rapport de la Deuxième Mission d'Identification Pour la Réduction de la Mortalité Maternelle au Sénégal. Dakar: Ministère de la Santé Publique/Ministère du Développement Rural/Université de Columbia, Septembre 1989.

Ministère de la Santé Publique et de la Population: Revue Interne du Projet ACSI-CCCD. Kindia: Ministère de la Santé Publique et de la Population, 17-20 Janvier 1991.

Ministère de la Santé Publique et de la Population: Séminaire de Formation sur La Recherche Opérationnelle. Conakry: Ministère de la Santé Publique et de la Population, 2-13 Mai 1989.

Ministère de la Santé Publique: Fiche d'Evaluation du Système de Santé en 1983. Conakry: Ministère de la Santé Publique, Janvier 1984.

Organisation Mondiale de la Santé: Elaboration d'Indicateurs Pour La Surveillance Continue des Progrès Réalisés dans la Voie de la Santé Pour Tous d'Ici l'An 2000. Genève: OMS 1981.

Organisation Mondiale de la Santé: Programme de Budget Programme 1990-1992. Brazzaville: OMS Septembre 1990.

Organisation Mondiale de la Santé: Rapport de la Mission Effectuée Dans le Cadre des Enquêtes Foyers/Ménages Basées sur les 27 Indicateurs Régionaux. Conakry: Organisation Mondiale de la Santé 1990.

Prins A: Mission PRITECH en Guinée. Conakry: PRITECH, January 1987.

République de Guinée: Programme de Redressement National: Perspectives de Développement

SS

à Moyen Terme 1987 - 1991. Conakry: République de Guinée, Sans Date.

Secrétariat de d'Etat à la Décentralisation: Bulletin de Liaison Inter O.N.G. No. 003. Conakry: Ministère de l'Intérieur et de la Décentralisation, République de Guinée, undated.

Secrétariat de d'Etat à la Décentralisation: Bulletin de Liaison Inter O.N.G. No. 004. Conakry: Ministère de l'Intérieur et de la Décentralisation, République de Guinée, December 1990.

Secrétariat de d'Etat à la Décentralisation: "Cadre Institutionnel des Organisations non Gouvernementales de Développement en Guinée. Cadre Organique du Service de Coordination des Interventions des O.N.G. de Développement en Guinée - S.C.I.O." Conakry: Ministère de l'Intérieur et de la Décentralisation, République de Guinée, undated.

United Nations Children Fund: La Situation des Enfants dans le Monde - 1988. New York: UNICEF, 1987.

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APPENDIX A

Table A-1A DEFINITIONS USED IN THE ANALYSIS

One of the major sources of lack of mutual understanding in a project of this complexity, working with multiple partners in a variety of languages, with rapid turnover of personnel is that terms are often used and debated without having ever been explicitly defined and explained. Perhaps ambiguity is a virtue to the extent that it allows flexible interpretations to be made. On the other hand, when one person's clarity is another's confusion, effective communication is extremely difficult. For this reason brief definitions are given of some of the major concepts used in this analysis.

■ **EPIDEMIOLOGY** - Epidemiology is the study of the distribution, frequency and determinants of health problems and disease in human populations. (Vaughan, 1989) Health is not a random event but is directly correlated with persons living in a specific place at a specific time.

■ **HEALTH** - Health represents the quality of life that is more than just the absence of disease and results from more than just medical interventions.

■ **PHC** - Primary Health Care is a strategy that consists of eight (8) components, focusing on people rather than diseases that is now entering an accelerated phase in the last decade of the 20th century.

■ **COMMUNITY PARTICIPATION** - This is more than just getting people to pay for health services both preventive and curative. It must be a full partnership.

■ **DEVELOPMENT** - There are many areas of debate including the role of foreign assistance, the correlation between development and health, the correlation between population and development and the correlation between environmental degradation and population. The experts appear to agree that the socioeconomic crises in sub-saharan Africa are not temporary, that assistance must be long term and that the social consequences of structural adjustment cannot be ignored. In the health sector it is now realized that the mother has been the missing part of the child survival formula and that for Maternal and Child Health programs to be effective the strategy must be an integrated one combining MCH services with family planning, a reduction in the appalling maternal mortality and an improvement of women's status in the society.

■ **IMPACT** - Ideally we would like to have output indicators that are explicit, quantitative and measurable in the short run. Given the problems of gaps in our understanding of the causal relationships between inputs and outputs and the paucity of valid and reliable data, often the best we can do is to use implicit, qualitative, process indicators, looking at trends instead of absolute values

and relying on the subjective opinions of experts for interpretation.

■ **SUSTAINABILITY** - The definition proposed by the Brundtland Commission defines sustainable development as development that meets the needs of the present without compromising the ability of future generations to meet their own needs. (UNICEF, 1989) The challenge is to derive measurable, operational indicators that can be of use in planning, implementation and evaluation.

■ **OPERATIONAL RESEARCH** - This is a systematic approach to the solving of problems through the generation of information that can be of use to decision-makers to improve the effectiveness and efficiency of programs. The steps in the process are problem diagnosis, elaboration of solutions and validation of the solutions. Other terms that overlap with OR include health planning, functional analysis, systems analysis, quantitative decision making and modern management.

■ **INFORMATION SYSTEMS** - Whether for health or management, these systems are necessary tools for the program planning, implementation and evaluation needed to maximize the utilization of scarce resources. Some of the specific tasks for which the data are needed include monitoring, comparing outcomes with stated objectives and informing all parties concerned of the achievements, failures as well as proposals for the future.

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TABLEAU 1
TERMES DE REFERENCE - OBJECTIFS QUANTIFIES

INDICATEUR	AGE	OBJECTIF QUANTIFIE
MORTALITE		
TET. NEONATAL	0-30 J.	REDUCTION DE 25%
MORT. INFANTILE	<1 AN	REDUCTION DE 25%
MORT. JUVENILE	1-4 ANS	REDUCTION DE 25%
CAS DE DIARRHEE HOSPITALISES	0-4 ANS	REDUCTION DE 50%
CAS DE PALUDISME HOSPITALISES	0-4 ANS	REDUCTION DE 50%
MORBIDITE		
ROUGEOLE	0-4 ANS	REDUCTION DE 50%
INVALIDITE (BOITEMENT)		
POLIOMYELITE	0-4 ANS	REDUCTION DE 50%
COUVERTURE VACCINALE		
6 MALADIES DU PEV	0-1 AN	80%
ANATOXINE TETANIQUE	FEMME ENCEINTE A TERME	60%
TRAITEMENT EFFICACE DES CAS		
STRUCTURES SANITAIRES		
DIARRHEE	0-4 ANS	90% CORRECTE
PALUDISME	0-4 ANS	90% CORRECTE
AU NIVEAU COMMUNAUTAIRE		
DIARRHEE	0-4 ANS	50% CORRECTE
PALUDISME	0-4 ANS	50% CORRECTE

TABLEAU 2
 TERMES DE REFERENCES - INDICATEURS QUALITATIFS

VOLET	PEV	LMD	PALUDISME
SYSTEMES D'INFORMATION			
BESOINS IDENTIFIES	+	+	+
CIBLES IDENTIFIEES	+	+	+
OBJECTIFS DETERMINES	+	+	+
STRATEGIE DEVELOPPEE	+	+	+
PLAN D'ACTION - ECHEANCIER	+	+	+
SYSTEMES EN PLACE	+	+	+
POLITIQUE NATIONALE	+	+	+
STANDARDISATION DES TRAITEMENTS	+	+	+
SYSTEME D'EVALUATION INTERNE	+	+	+
CONTROLE DE BUDGETISATION	+	+	+
CONTROLE DE COMPTABILITE	+	+	+
DONNEES (IMPACTE)			
FORMATION DE PERSONNEL	+	+	+
CONTROLE DE QUALITE	+	+	+
COLLECTE	+	+	+
TRAITEMENT	+	+	+
ANALYSES	+	+	+
INTERPRETATION	+	+	+
DIFFUSION DES RESULTATS	+	+	+
UTILISATION DES RESULTATS	+	+	+
RECHERCHE OPERATIONNELLE			
BESOINS IDENTIFIES	+	+	+
CIBLES IDENTIFIEES	+	+	+
OBJECTIFS DETERMINES	+	+	+
STRATEGIE DEVELOPPEE	+	+	+
PLAN D'ACTION - ECHEANCIER	+	+	+
FORMATION DU PERSONNEL	+	+	+
ETUDES REALISEES	+	+	+
RESULTATS UTILISES	+	+	+

key needed

+

+

STRATEGIE GLOBALE DE L'OMS EN MATIERE DE SOINS DE SANTE PRIMAIRES
OBJECTIFS SELECTIONNES POUR 1995

I. DEVELOPPEMENT DES PROGRAMMES

- A. MECANISMES EN PLACE DE COORDINATION ENTRE L'OMS ET CHAQUE PAYS
- B. IDENTIFICATION DES BESOINS D'AIDE EN CONFORMITE AVEC LA STRATEGIE NATIONALE

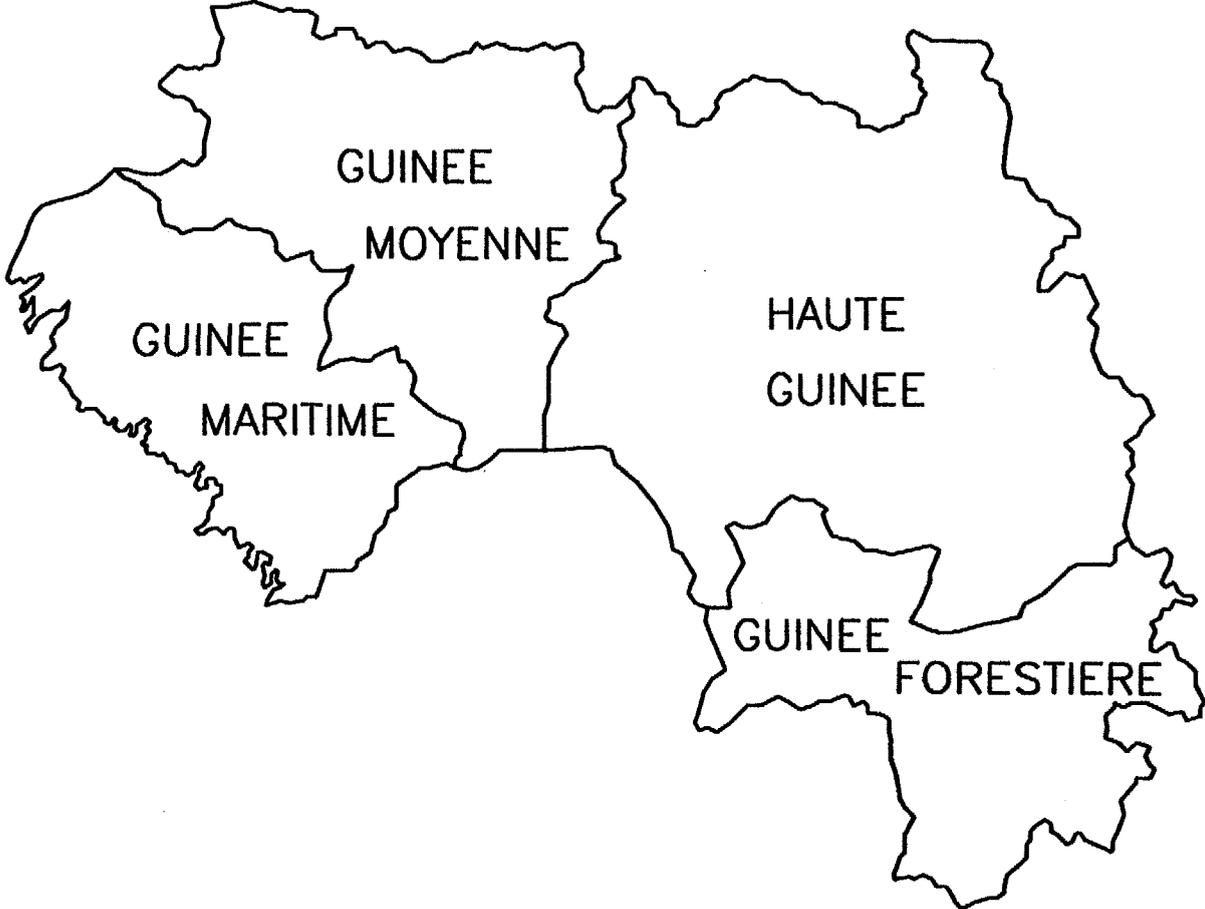
II. INFRASTRUCTURE DU SYSTEME SANITAIRE

- A. 70% DES PAYS AURONT DES SYSTEMES D'INFORMATION SANITAIRES FONCTIONNELS POUR:
 - 1. LA PLANIFICATION
 - 2. LA GESTION
 - 3. L'EVALUATION
- B. RECHERCHE OPERATIONNELLE
 - 1. 70% DES PAYS SERONT EN MESURE DE FAIRE LA RECHERCHE NECESSAIRE
- C. SITUATION LEGALE
 - 1. 50 % DES PAYS AURONT LES TEXTES LEGISLATIFS NECESSAIRES POUR LES SSP
- D. RESSOURCES HUMAINES
 - 1. POLITIQUES EN PLACE POUR LE DEVELOPPEMENT DU PERSONNEL SANITAIRE
 - a. FORMATION
 - b. DEPLOIEMENT
 - c. UTILISATION
- E. EDUCATION POUR LA SANTE
 - 1. 50% DES PAYS AURONT INCORPORE L'EPS DANS LEURS POLITIQUES DE SANTE

III. SCIENCE SANITAIRE ET TECHNOLOGIE

- A. FORMULATION DES OBJECTIFS NUTRITIONNELS EXPLICITE
- B. ADAPTATION DES TECHNOLOGIES APPROPRIEES DANS LES COMMUNAUTES
- C. EXECUTION DES PROGRAMMES POUR L'EAU POTABLE ET L'ASSAINISSEMENT
- D. FORMULATION DES POLITIQUES POUR LES MEDICAMENTS ET VACCINS ESSENTIELS
- E. FORMULATION DU ROLE DE LA MEDICINE TRADITIONNELLE DANS LES SSP
- F. MALADIES DU PROGRAMME ELARGI DE VACCINATION
 - 1. ERADICATION DU TETANOS NEONATAL
 - 2. INCIDENCE ANNUELLE DE ROUGEOLE = MOINS DE 40 CAS/100.000 POPULATION
 - 3. INCIDENCE ANNUELLE DE POLIOMYELITE = MOINS DE 0.1 CAS/100.000 POPULATION
- G. PALUDISME
 - 1. COUVERTURE TOTALE EN MATIERE DE DIAGNOSTIC ET TRAITEMENT
- H. MALADIES DIARRHEIQUES
 - 1. 95% DE LA POPULATION AURONT ACCES A LA RVO
 - 2. LE TAUX DE MORTALITE DES ENFANTS SERA REDUIT DE 50%
 - 3. L'INCIDENCE SERA REDUITE DE 20%
- I. AFFECTIONS RESPIRATOIRES AIGUES
 - 1. 80% DES PAYS AURONT DES PROGRAMMES POUR REDUIRE LA MORTALITE DES ENFANTS
 - 2. 80% DES ENFANTS AURONT ACCES AUX SOINS APPROPRIES

LA REPUBLIQUE DE GUINEE – REGIONS

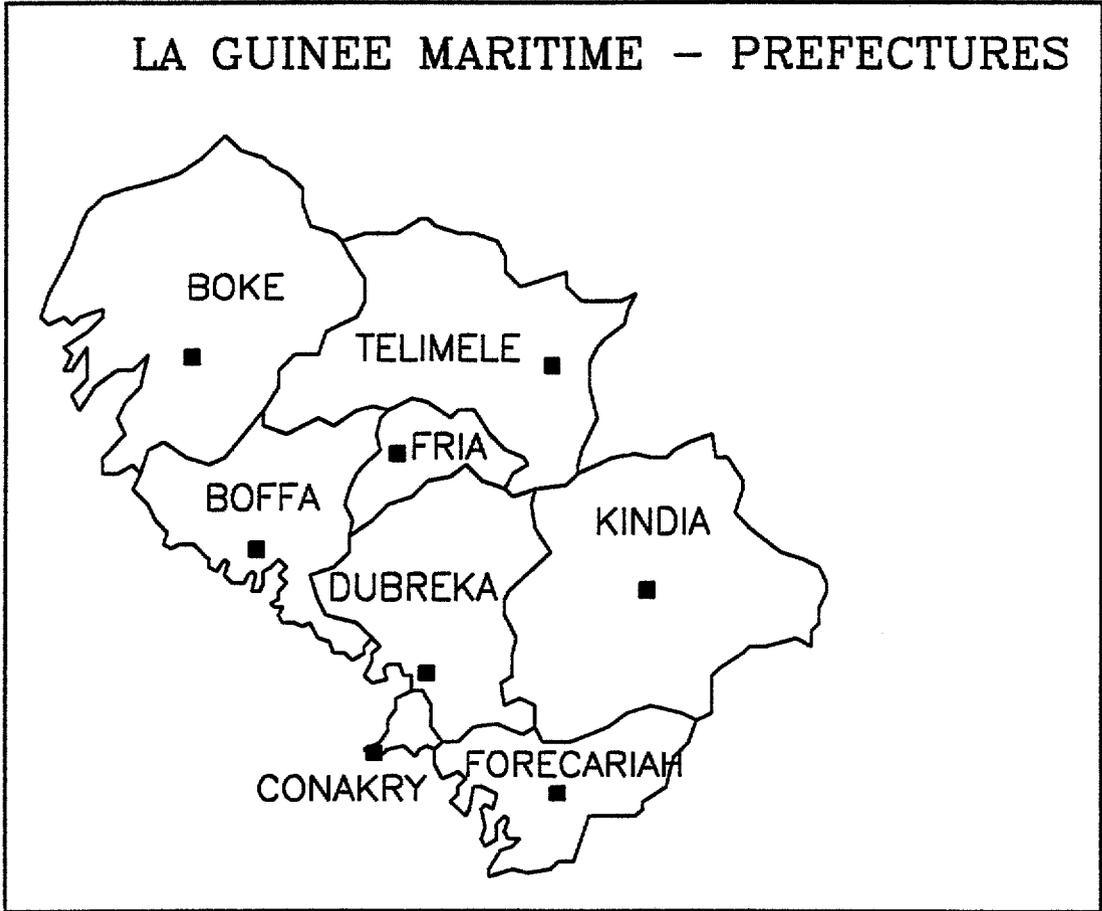


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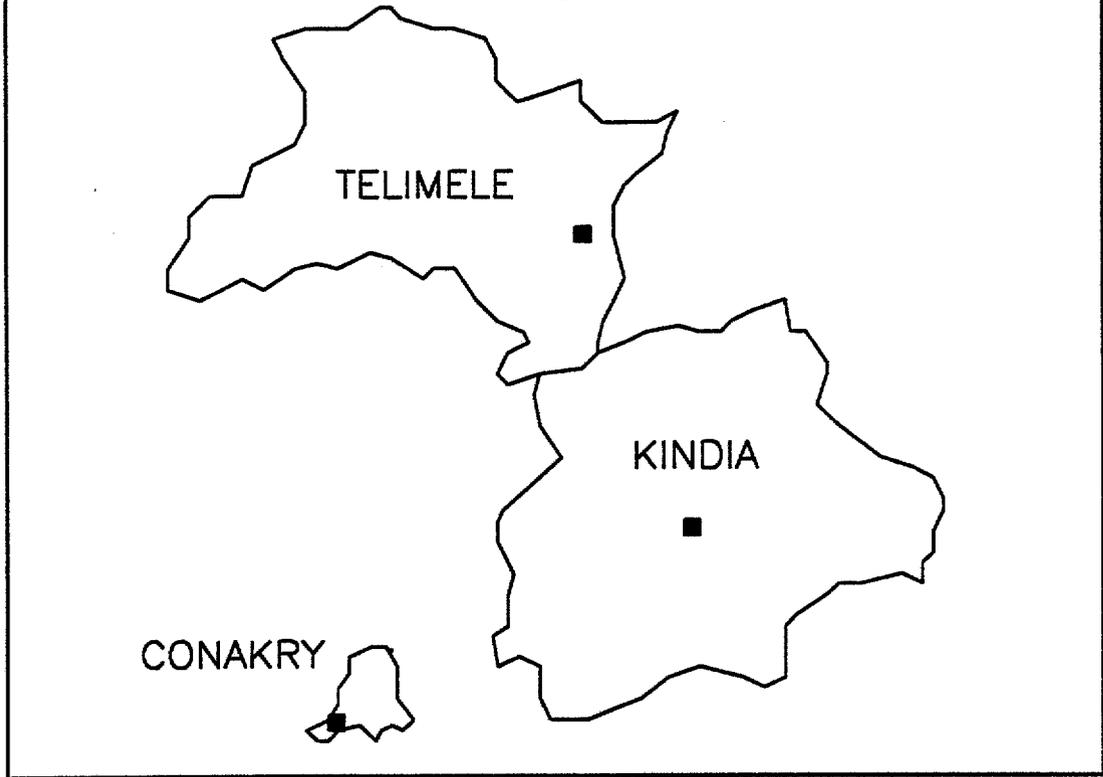
CARTE 1

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LA GUINEE MARITIME – PREFERCTURES



PROJET ACSI/CCCD EN REPUBLIQUE DE GUINEE
AIRE D'INTERVENTION (TROIS PREFECTURES)



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REPUBLIQUE DE GUINEE

ANALYSE DU PROBLEME

I. INDICATEURS POLITIQUES

A. GOUVERNEMENT DE LA GUINEE

1. POLITIQUE DU DEVELOPPEMENT
 - a. REAJUSTEMENT STRUCTUREL
 - b. PROGRAMME D'INVESTISSEMENT ET ACTIONS PRIORITAIRES
 - c. DECENTRALISATION DU PROGRAMME DE DEVELOPPEMENT
2. POLITIQUE DE POPULATION - BUREAU DE RECENSEMENT
3. POLITIQUE D'EDUCATION
4. POLITIQUE D'AGRICULTURE
5. POLITIQUE DE SANTE ET D'ACTION SOCIALE
 - a. APPUI DE LA DECLARATION DE ALMA ATA
LA SANTE POUR TOUS D'ICI L'AN 2000 (OMS - 1978)
 - b. POLITIQUE DE SANTE MATERNELLE ET INFANTILE
 - (1) MERES
 - (a) REDUCTION DE LA MORTALITE MATERNELLE
 - (b) PLANIFICATION FAMILIALE
 - (c) AMELIORATION DE LA CONDITION FEMININE
 - (2) ENFANTS
 - (a) RATIFICATION DE LA CONVENTION DES
DROITS DE L'ENFANT - ONU/NEW YORK
29-30 SEPTEMBRE 1990
 - (b) PROGRAMME ELARGI DE VACCINATION
80% COUVERTURE - ENFANTS < 1 AN
- FEMMES ENCEINTES
 - (c) LUTTE CONTRE LES MALADIES DIARRHEIQUES
 - (d) NUTRITION
 - i) SURVEILLANCE
 - ii) REHABILITATION
 - (e) PROTECTION CONTRE LE PALUDISME
 - (f) LUTTE CONTRE LES AFFECTIONS RESPIRATOIRES AIGUES
 - c. PROGRAMME NATIONAL CONTRE LES MST - SIDA
 - d. LUTTE CONTRE LES GRANDES ENDEMIES
 - (1) PALUDISME
 - (2) TUBERCULOSE
 - (3) SCHISTOSOMIASE
 - (4) ONCHOCERCOSE
 - (5) LEPRE
 - (6) AUTRES
 - e. PROGRAMME NATIONAL D'ASSAINISSEMENT ET
D'APPROVISIONNEMENT EN EAU

ANALYSE DU PROBLEME (SUITE)

- f. POLITIQUE DE DECENTRALISATION DE LA SANTE
 - (1) RENFORCEMENT DES SOINS DE SANTE PRIMAIRES
 - (a) MISE EN OEUVRE DE L'INITIATIVE DE BAMAKO - 1987
 - i) RESSOURCES FINANCIERES ASSUREES
 - ii) STOCK DE MEDICAMENTS ESSENTIELS ASSURE
 - iii) PARTICIPATION ACTIVE DES COMMUNAUTES DANS LA PRESTATION ET LA GESTION DES SERVICES
 - iv) GESTION EFFICACE AFIN DE LIVRER DES SERVICES EFFICACES
 - (2) STRATEGIES ET PLANS D'ACTION LOCAUX
 - (a) COMMUNAUTES RURALES
 - i) ASSOCIATIONS VILLAGOISES
 - ii) GROUPEMENTS D'INTERET ECONOMIQUE
 - iii) COMITES DE SANTE
 - (b) APPUI DES ONG
- g. APPUI A LA RECHERCHE APPLIQUEE
 - (1) TECHNOLOGIES APPROPRIEES
 - (2) MEDECINE TRADITIONNELLE
- h. MISE EN OEUVRE D'UN SYSTEME D'INFORMATION POUR LA GESTION (MIS)
 - (1) STANDARDISATION ET SIMPLIFICATION DES FORMULAIRES A REMPLIR
 - (2) FORMATION ET SUPERVISION DU PERSONNEL EN MATIERE DE STATISTIQUE
 - (3) INTRODUCTION DE L'INFORMATIQUE
 - (4) SURVEILLANCE EPIDEMIOLOGIQUE
 - (a) POSTES ET/OU VILLAGES SENTINELLES
 - (b) ENQUETES PONCTUELLES

ANALYSE DU PROBLEME (SUITE)

II. INDICATEURS SOCIO-ECONOMIQUES

A. ENVIRONNEMENT

1. PHYSIQUE

- a. LES REGIONS ECOLOGIQUES (GEOGRAPHIQUES)
- b. PLUVIOMETRIE
 - (1) QUANTITE (ISOHYETES) ET REPARTITION
 - (2) TENDANCES
- c. EAU - QUANTITE ET QUALITE
 - (1) SOURCES D'EAU
 - (a) FLEUVES ET RIVIERES
 - (b) CANAUX
 - (c) MARES
 - (d) PUIITS TRADITIONNELS
 - (e) FORAGES
 - (f) CHATEAUX D'EAU
 - (g) BORNES FONTAINES
 - (h) ROBINETS A DOMICILE
- d. ALIMENTATION - QUANTITE ET QUALITE
 - (1) AGRICULTURE
 - (2) ELEVAGE
 - (3) PECHE
 - (4) AIDE ALIMENTAIRE
 - (5) ETAT NUTRITIONNEL
- e. LOGEMENT OU HABITAT
 - (1) DIVERSITE
 - (2) NORMES D'HYGIENE

2. SOCIAL

- a. SITUATION DEMOGRAPHIQUE - POPULATIONS
 - (1) TAUX DE CROISSANCE ANNUEL
 - (2) MIGRATIONS
 - (3) URBANISATION
- b. CULTURE - PEUPLEMENT
- c. INSTITUTIONS
 - (1) ORGANISATION POLITIQUE
 - (2) ORGANISATION SOCIALE
- d. TRADITIONS
 - (1) TENDANCES
 - (2) RELATIONS AVEC LE MONDE EXTERIEUR
 - (3) DEGRE D'ORTHODOXIE RELIGIEUSE
- e. EDUCATION - FORMELLE ET INFORMELLE
- f. RELIGION
 - (1) MONOTHEISTE
 - (2) POLYTHEISTE
 - (3) IMPLICATIONS SOCIO-ECONOMIQUES

ANALYSE DU PROBLEME (SUITE)

3. ECONOMIQUE

- a. TRAVAIL
 - (1) SALARIE
 - (2) NON-SALARIE
- b. REVENUS
 - (1) GENERES SUR PLACE
 - (2) ENVOYES DE L'EXTERIEUR
- c. PRIX
 - (1) PRODUITS LOCAUX
 - (2) PRODUITS IMPORTES

B. COMPORTEMENT PSYCHO-SOCIAL DES GENS

- 1. FACTEURS PREDISPOSANTS
 - a. CONNAISSANCES
 - b. CROYANCES
 - c. VALEURS
 - d. ATTITUDES
- 2. FACTEURS FACILITATEURS
 - a. RESSOURCES SANITAIRES
 - (1) DISPONIBILITE
 - (2) ACCESSIBILITE
 - (3) ACCEPTABILITE
 - (4) COUTS ABORDABLES
- 3. FACTEURS DE RENFORCEMENT
 - a. FAMILLE
 - b. COMMUNAUTE
 - c. ENSEIGNANTS
 - d. PERSONNEL DE LA SANTE
 - e. ASSOCIATIONS POUR LE DEVELOPPEMENT

III. INDICATEURS DE PRESTATION DES SERVICES MEDICAUX

- A. SYSTEMES DE SANTE
 - 1. PUBLICS ET PRIVES
 - 2. MODERNES ET TRADITIONNELS
 - 3. CURATIF ET PREVENTIF
- B. INFRASTRUCTURES
 - 1. NOMBRE ET REPARTITION
 - 2. COUVERTURE
 - a. NORMES DE L'OMS
 - b. PAR MALADIE
 - c. PAR GROUPE A HAUT RISQUE
- C. PERSONNEL (PRESTATAIRES DES SERVICES)
 - 1. NOMBRE ET REPARTITION
 - 2. FORMATION
 - 3. DESCRIPTION DES TACHES
 - 4. COMPETENCES
 - 5. MOTIVATION
- D. MATERIEL
 - 1. MEDICAL
 - 2. TRANSPORT
 - 3. LOGISTIQUE
- E. STRATEGIE DE SOINS DE SANTE PRIMAIRES
 - 1. 8 COMPOSANTES ESSENTIELLES
 - a. EDUCATION POUR LA SANTE
 - b. BONNE ALIMENTATION ET NUTRITION
 - c. EAU SAINTE ADEQUATE ET ASSAINISSEMENT DE BASE
 - d. PROTECTION MATERNELLE ET INFANTILE
 - e. VACCINATIONS CONTRE LES 6 MALADIES DU PEV
 - f. PREVENTION ET CONTROLE DES ENDEMIES LOCALES
 - g. TRAITEMENT DES MALADIES ET LESIONS COURANTES
- F. SYSTEMES D'INFORMATION POUR LA GESTION ET L'EVALUATION
 - 1. STATISTIQUES DE SERVICE
 - 2. RECHERCHE OPERATIONNELLE

ANALYSE DU PROBLEME (SUITE)

IV. INDICATEURS DE L'ETAT DE SANTE

- A. POLITIQUE DE SANTE
 - 1. VOLONTE POLITIQUE
 - 2. ALLOCATION DES RESSOURCES - HUMAINES ET BUDGETAIRES
 - a. MEDECINE CURATIVE
 - b. MEDECINE PREVENTIVE
 - 3. DEGRE D'EQUITE
 - 4. PARTICIPATION COMMUNAUTAIRE
 - a. DIAGNOSTIC DES PROBLEMES
 - b. ESTABLISSEMENT DES PRIORITES
 - c. EXECUTION DES PROGRAMMES
 - d. FINANCEMENT
 - e. EVALUATION
 - 5. ORGANISATION
 - a. SYSTEMES EN PLACE
 - b. CHANGEMENTS A REALISER
 - 6. GESTION
 - a. DECENTRALISATION
 - b. DECONCENTRATION
 - c. MODERNISATION
- B. INDICATEURS SOCIO-POLITQUES
 - 1. BUDGET NATIONAL - POURCENTAGE POUR LA SANTE
 - 2. DISTRIBUTION DES REVENUS
 - 3. CONDITIONS DE TRAVAIL
 - 4. TAUX DE SCOLARISATION
 - 5. HABITAT - ENVIRONNEMENT
 - 6. NOURRITURE
 - 7. EAU POTABLE
- C. PRESTATION DES SERVICES MEDICAUX
 - 1. COUVERTURE PAR LE SYSTEME DE SOINS DE SANTE PRIMAIRES
 - 2. COUVERTURE PAR LE SYSTEME DE REFERENCE-RECOURS
 - 3. COUVERTURE AUX NIVEAUX SECONDAIRES ET TERTIAIRES
- D. ETAT DE SANTE
 - 1. MALADIES ENDEMIQUES ET EPIDEMIQUES
 - 2. MORTALITE - GROUPES VULNERABLES
 - a. ENFANTS
 - (1) MORTALITE INFANTILE (MOINS D'UN AN)
 - (2) MORTALITE JUVENILE (MOINS DE 5 ANS)
 - b. MATERNELLE
 - 3. ESPERANCE DE VIE
 - 4. NUTRITION DES MERES ET ENFANTS
 - 5. MALADIES EPIZOOTIQUES IMPORTANTES
 - a. BRUCELLOSES
 - b. CHARBON BACTERIEN
 - c. RAGE
 - d. TUBERCULOSE
 - e. TRYPANOSOMIASES

ELABORATION DES SOLUTIONS

V. ACTIONS NECESSAIRES (STRATEGIES PROPOSEES)

- A. POLITIQUES
- B. SOCIALES
- C. ECONOMIQUES
- D. SANITAIRES
 - 1. SERVICES MEDICAUX
 - 2. INFORMATION, EDUCATION, COMMUNICATION
 - 3. PARTICIPATION COMMUNAUTAIRE
 - 4. SURVEILLANCE EPIDEMIOLOGIQUE
- E. RECHERCHES ET EVALUATION

VI. RESSOURCES NECESSAIRES (UN PLAN D'ACTION)

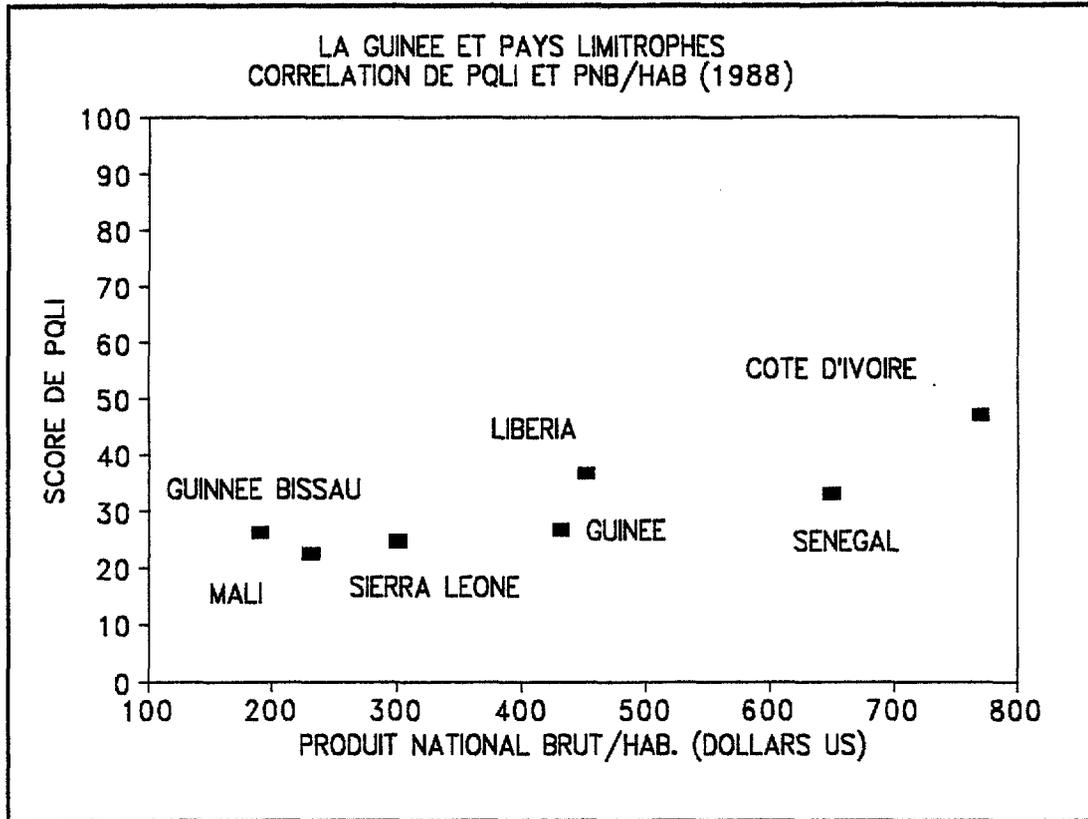
- A. INFRASTRUCTURES
 - 1. SCHEMA D'IMPLANTATION
 - a. SELON L'ECHELON DE SANTE
 - b. DETERMINATION DES ZONES DE COUVERTURE
- B. PERSONNEL
 - 1. EFFECTIFS
 - 2. REPARTITION
 - 3. DEFINITIONS DES PROFILS
 - 4. PRODUCTIVITE
- C. MATERIEL
 - 1. CATEGORIES DIFFERENTES
 - 2. ACQUISITION ET ENTRETIEN
 - 3. REPARTITION
- D. FORMATION
 - 1. NIVEAU (MEDECINS AUX AGENTS DE SANTE COMMUNAUTAIRE)
 - 2. TYPE - PONCTUELLE OU CONTINUE
 - 3. CONTENU DES CURSUS
- E. MOTIVATION
 - 1. MOYENS DE TRAVAIL
 - 2. STANDING SOCIAL
- F. SUPERVISION
 - 1. CONTENU
 - 2. REGULARITE
 - 3. RETRO-INFORMATIONS
- G. GESTION
 - 1. QUANTIFICATION DES BESOINS ET OBJECTIFS
 - 2. UTILISATION EFFICACE DES RESSOURCES
- H. FINANCEMENT
 - 1. SOURCES
 - 2. FORMES
- I. TECHNOLOGIES APPROPRIEES
 - 1. DOMAINES D'INTERVENTION - 8 COMPOSANTES DE SSP
 - 2. INSTITUTIONS RESSOURCES
 - a. NATIONALES
 - b. INTERNATIONALES
- J. STATISTIQUES FIABLES ET OPPORTUNES
 - 1. CATEGORIES MULTIPLES DE DONNEES
 - 2. AMELIORATION DES SYSTEMES D'INFORMATION
 - a. ORGANISATIONNELLES
 - b. TECHNIQUE - INFORMATIQUE
 - (1) MIS, GIS, BANQUES DE DONNEES

VALIDATION DES SOLUTIONS

VII. TESTS DES SOLUTIONS

- A. EXECUTION DES PROJETS AVEC OBJECTIFS MESURABLES
 - 1. CHOIX DES VARIABLES ET INDICATEURS
 - 2. QUALITE DES INDICATEURS
 - a. APPROPRIE
 - b. MESURABLE
 - c. SPECIFIQUE
 - 3. CORRELATION SANTE/DEVELOPPEMENT
 - a. EFFET DE LA SANTE SUR LE DEVELOPPEMENT
 - b. EFFET DU DEVELOPPEMENT SUR LA SANTE
- B. EVALUATION DES RESULTATS VIS-A-VIS DES OBJECTIFS
 - 1. TYPE D'INDICATEUR
 - a. EXPLICITE OU IMPLICITE
 - b. DU PROCESSUS OU DE L'IMPACTE
 - c. A COURT, MOYEN ET LONG TERME
 - 2. POSSIBILITES D'EVALUATION
 - a. PROGRAMMES ET INSTRUMENTS DISPONIBLES
 - b. SYSTEMES D'INFORMATION POUR LA GESTION
 - c. RECHERCHES OPERATIONNELLES
 - 3. SYSTEMES DE SURVEILLANCE PERMANENTES
 - a. TYPE
 - (1) PASSIFS
 - (2) ACTIFS
 - b. MODALITES DE FONCTIONNEMENT
 - (1) CHOIX DES ANTENNES
 - (2) MECHANISMES DE FONCTIONNEMENT ET D'ALERTE
 - c. ORGANISATIONS TECHNIQUES D'APPUI
 - (1) NATIONALES
 - (2) REGIONALES
 - (3) INTERNATIONALES

FIGURE 1



PQLI = INDICE DE QUALITE PHYSIQUE DE VIE
PNB/HAB = PRODUIT NATIONAL BRUT/HABITANT (DOLLARS US 1988)

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TABLEAU 3
LA GUINEE ET PAYS LIMITOPHES
CORRELATION DE PQLI ET PNB/HABITANT (1988)

PAYS	TMI	EVN	ALPH. ADULTE	PLQI	PNB/HAB
COTE D'IVOIRE	95	53	43	47	770
LIBERIA*	130	50	35	37	450
SENEGAL	127	48	28	33	650
GUINEE	143	43	28	27	430
GUINEE BISSAU	134	40	31	26	190
SIERRA LEONE	152	42	29	25	300
MALI	168	47	17	23	230

* CETTE ANALYSE REFLETE LA SITUATION AU LIBERIA AVANT LA GUERRE CIVILE

TMI = TAUX DE MORTALITE INFANTILE
 EVN = ESPERANCE DE VIE A LA NAISSANCE (ANS)
 ALPH. ADULTE = TAUX D'ALPHABETISATION ADULTE
 PQLI = INDICE DE QUALITE PHYSIQUE DE VIE
 PNB/HAB = PRODUIT NATIONAL BRUT/HABITANT (DOLLARS US 1988)

L'INDICE DE QUALITE PHYSIQUE DE DE VIE A ETE INTRODUIT PAR LE "OVERSEAS DEVELOPMENT COUNCIL".

$$PQLI = ((229-TMI)/2.22 + (EVN-38)/0.39 + ALPH. ADULTE)/3$$

TABLEAU 4
DOUZE INDICATEURS MONDIAUX PROPOSES PAR L'OMS
POUR L'EVALUATION DU PROGRES VERS LA SANTE POUR TOUS

INDICATEUR	REALISATIONS
1 LA POLITIQUE DE SANTE POUR TOUS A RECU LA SANCTION OFFICIELLE LA PLUS ELEVEE	1958 - CREATION DE LA PREMIERE REPUBLIQUE
	1969 - PREMIERE CONFERENCE NATIONALE SUR LA SANTE (FORMATION DES BRIGADES SANITAIRES)
	1971 - CREATION DU SERVICE NATIONAL DE MEDECINE TRADITIONNELLE
	1980 - LANCEMENT DU PROGRAMME ELARGI DE VACCINATION
	1981 - SIGNATAIRE DE LA CHARTE AFRICAINE DE DEVELOPPEMENT SANITAIRE (OUA)
	1982 - REORGANISATION DE LA MEDECINE PREVENTIVE (ETABLISSEMENT DU BUREAU DE SSP)
	1982 - FORMATION DES FORMATEURS EN SSP A KANKAN ET LABE (OMS)
	1984 - CREATION DE LA DEUXIEME REPUBLIQUE
	1984 - NOUVELLE POLITIQUE SANITAIRE - PRIORITE A LA MEDECINE PREVENTIVE - ADAPTATION DES SSP AUX SPECIFICITES GUINEENNES - PRIORITE AUX ACTIONS COMMUNAUTAIRES
	1986 - APPUI DE L'ANNEE AFRICAINE DE LA VACCINATION (OMS - BRAZZAVILLE) EVALUATION DU PEV ET NOUVELLE STRATEGIE (UNICEF/OMS/CIE/USAID-CCCD) OBJECTIFS: 80% COUVERTURE DES ENFANTS DE MOINS D'UN AN ET DES FEMMES ENCEINTES A L'AN 1990 INVENTAIRE DES RESSOURCES NATIONALES (HUMAINES ET MATERIELLES)
	1987 - CREATION DE L'UNITE NATIONALE DE COORDINATION DU PEV/SSP/MEDICAMENTS ESSENTIELS ANNEE DE FORMATION INTENSIVE DU PERSONNEL APPROVISIONNEMENT EN EAU POTABLE - 1998 VILLES: 100% CAMPAGNE: 50%
	1988 - APPUI DE L'INITIATIVE DE BAMAKO LANCEMENT DES ACTIVITES DE MONITORAGE
	1989 - PLAN NATIONAL DE DEV SANITAIRE 1990-2000 FORHS - FORCE D'OPTIMISATION DES RESSOURCES HUMAINES POUR LA SANTE

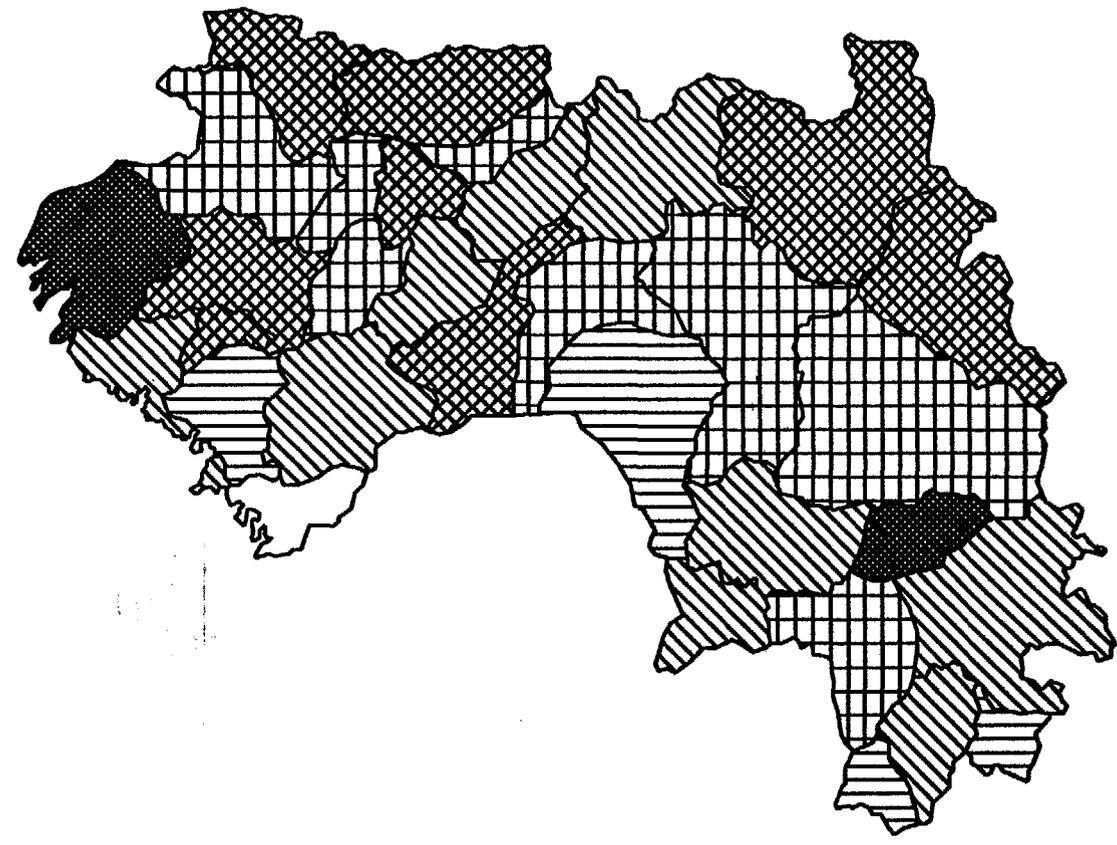
INDICATEUR	REALISATIONS
<p>2 LES MECANISMES DESTINES A ASSOCIER LA POPULATION A LA MISE EN OEUVRE DES STRATEGIES ONT ETE MIS EN PLACE OU RENFORCES, ET FONCTIONNENT EFFECTIVEMENT</p>	<p>- CREATION DU SECRETARIAT D'ETAT POUR LA DECENTRALISATION</p> <p>1987 - COMPOSANTES DE L'UNITE NATIONALE DE COORDINATION DEFINIES</p> <p>- COMITE TECHNIQUE DIRECTEUR GENERAL DE LA SANTE</p> <p>- 4 COMMISSIONS TECHNIQUES LOGISTIQUE ET REPARTITION FORMATION ET SUPERVISION MONITORAGE ET EVALUATION PARTICIPATION COMMUNAUTAIRE</p> <p>- CREATION DES COMMITTEES DE GESTION DES CENTRES DE SANTE</p>
<p>3 AU MOINS 5% DU PRODUIT NATIONAL BRUT EST CONSACRE A LA SANTE</p>	<p>SEULEMENT 2.5% DU BUDGET DE L'ETAT ET CONSACRE A LA SANTE.</p> <p>LES DEPENSES SONT REPARTIES COMME SUIVIT: PERSONNEL (55%) PRODUITS PHARMACEUTIQUES (34%) FOURNITURES (11%)</p>
<p>4 UN POURCENTAGE RAISONNABLE DES DEPENSES NATIONALES DE SANTE ET CONSACRE AUX SOINS DE SANTE LOCAUX</p>	<p>LE PROGRAMME NATIONAL DE PEV/SSP/ME COUVRE A PEU PRES LE TIERS DU PAYS AVEC LES SYSTEMES DE RECOUVREMENT DE COUTS MIS EN PLACE EN PARTERNARIAT AVEC LES COMMUNAUTES</p>
<p>5 LES RESSOURCES SONT EQUITABLEMENT REPARTIES</p>	<p>LA COUVERTURE SANITAIRE DU PAYS N'EST PAS ENCORE HOMOGENE. IL Y A DES DISPARITES REGIONALES ET ENTRE DES ZONES URBAINES ET RURALES EN CE QUI CONCERNE LES INFRASTRUCTURES, LE PERSONNEL ET LE MATERIEL. CE PROBLEME EST BIEN CONNU PAR LE GOUVERNEMENT QUI EST EN TRAIN DE DE CHERCHER ET EXECUTER DES REMEDES</p>
<p>6 LES BESOINS DES RESSOURCES EXTERIEURES SONT SATISFAITS DE FACON SUIVIE PAR DES PAYS PLUS RICHES</p>	<p>PLUSIEURS PARTENAIRES APPUIENT LA STRATEGIE NATIONALE D'UN SYSTEME DE SANTE INTEGRE. LES BESOINS SONT LOIN D'ETRE SATISFAITS</p> <p>ORGANISATION MONDIALE DE LA SANTE UNICEF CENTRE INTERNATIONAL DE L'ENFANCE USAID BANQUE MONDIALE BANQUE AFRICAINE DE DEVELOPPEMENT AUTRES</p>

INDICATEUR	REALISATIONS									
<p>7 LES SOINS DE SANTE PRIMAIRES SONT A LA DISPOSITION DE L'ENSEMBLE DE LA POPULATION, AVEC AU MINIMUM:</p> <ul style="list-style-type: none"> - EAU SAINTE A DOMICILE OU A 15 MINUTES DE MARCHÉ - MESURES D'ASSAINISSEMENT - VACCINATION CONTRE LES 6 MALADIES DU PEV - SOINS DE SANTE LOCAUX A UNE HEURE DE VOYAGE, AVEC LA POSSIBILITE DE SE PROCURER AU MOINS 20 MEDICAMENTS ESSENTIELS - PERSONNEL QUALIFIE POUR S'OCCUPER DES GROSSESSES ACCOUCHEMENTS ET ENFANTS JUSQU'A L'AGE DE 1 AN 	<p>ZONE URBAINE: 69% MOYENNE NATIONALE = 27% ZONE RURALE : 2%</p> <p>ASSAINISSEMENT ADEQUAT: 12% DE LA POPULATION</p> <p>COUVERTURE VACCINALE EN 1986</p> <p>ENFANTS 0-11 MOIS: 5% FEMMES ENCEINTES : 17%</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">1989</th> <th style="text-align: center;">CCCD</th> <th style="text-align: center;">LA GUINEE</th> </tr> </thead> <tbody> <tr> <td>ENFANTS 0-11 MOIS:</td> <td style="text-align: center;">20%</td> <td style="text-align: center;">15%</td> </tr> <tr> <td>FEMMES ENCEINTES :</td> <td style="text-align: center;">38%</td> <td style="text-align: center;">8%</td> </tr> </tbody> </table> <p>ACCES AUX STRUCTURES SANITAIRES: 30% DE LA POP</p> <p>LA LISTE DES MEDICAMENTS ESSENTIELS EXISTE MAIS IL Y A DES RUPTURES DE STOCK</p> <p>IL Y A UN MANQUE ET UNE MAUVAISE REPARTITION DU PERSONNEL QUALIFIE LES SERVICES DE SANTE SONT EN GENERAL SOUS-UTILISES</p>	1989	CCCD	LA GUINEE	ENFANTS 0-11 MOIS:	20%	15%	FEMMES ENCEINTES :	38%	8%
1989	CCCD	LA GUINEE								
ENFANTS 0-11 MOIS:	20%	15%								
FEMMES ENCEINTES :	38%	8%								
<p>8 L'ETAT NUTRITIONNEL DES ENFANTS EST SATISFAISANT EN CE SENS QUE:</p> <ul style="list-style-type: none"> - AU MOINS 90% DES NOUVEAUX ENFANTS PESENT AU MOINS 2,5 KILOGRAMMES - AU MOINS 90% DES ENFANTS ONT UN POIDS POUR AGE QUI CORRESPONDANT AUX NORMES DE LA "NATIONAL CENTER FOR HEALTH STATISTICS" 	<p>SPECIFICITES REGIONALES: CARENCES EN IODE ET EN VITAMINE A</p> <p>1985: 82% DES NOUVEAUX ENFANTS PESENT AU MOINS 2,5 KILOGRAMMES 1990: 90%</p> <p>1986: 22% DES ENFANTS DE MOINS DE 5 ANS SONT MALNUTRIS</p>									

INDICATEUR	REALISATIONS
9 LE TAUX DE MORTALITE INFANTILE EST INFERIEUR A 50 POUR 1000 NAISSANCES VIVANTES	1988: TAUX DE MORTALITE = 143 POUR 1000 NAISSANCES VIVANTES 1990: 160 (ESTIMATION DE L'OMS)
10 L'ESPERANCE DE VIE A LA NAISSANCE EST SUPERIEURE A 60 ANS	1988: L'ESPERANCE DE VIE = 43 ANS
11 LE TAUX D'ALPHABETISATION DES ADULTES DEPASSE 70%	1988: TAUX D'ALPHABETISATION = 28%
12 LE PRODUIT NATIONAL BRUT PAR HABITANT EST SUPERIEUR A 500 DOLLARS (USA)	1988: US\$ 430

REPUBLIQUE DE GUINEE

TAUX ANNUELS DE CROISSANCE (1977 - 1983)



LEGENDE

-  < 0
-  0.00 - 1.99
-  2.00 - 3.99
-  4.00 - 5.99
-  6.00 - 7.99
-  8.00 +

of

REPUBLIQUE DE GUINEE

DENSITE DE LA POPULATION PAR KILOMETRE CARRE (1983)

LEGENDE

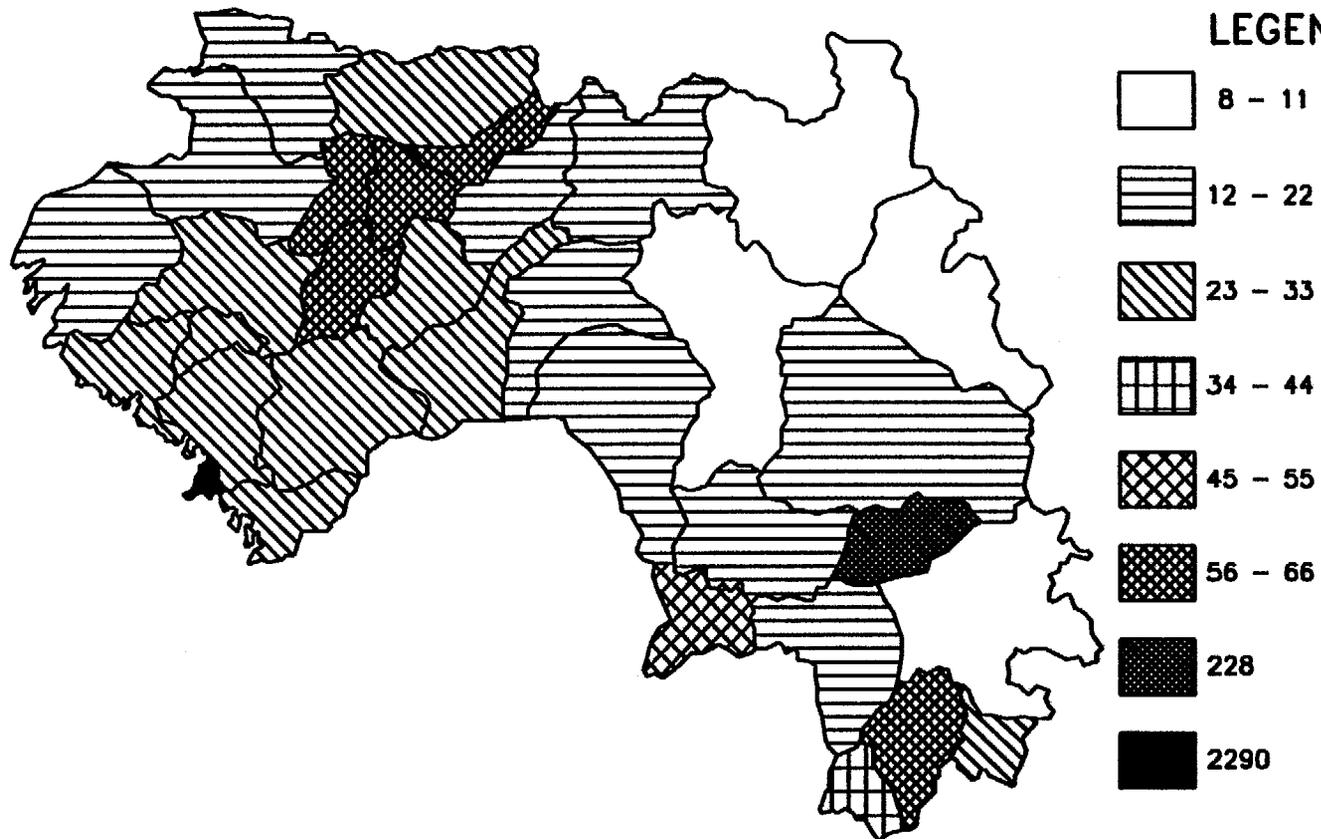
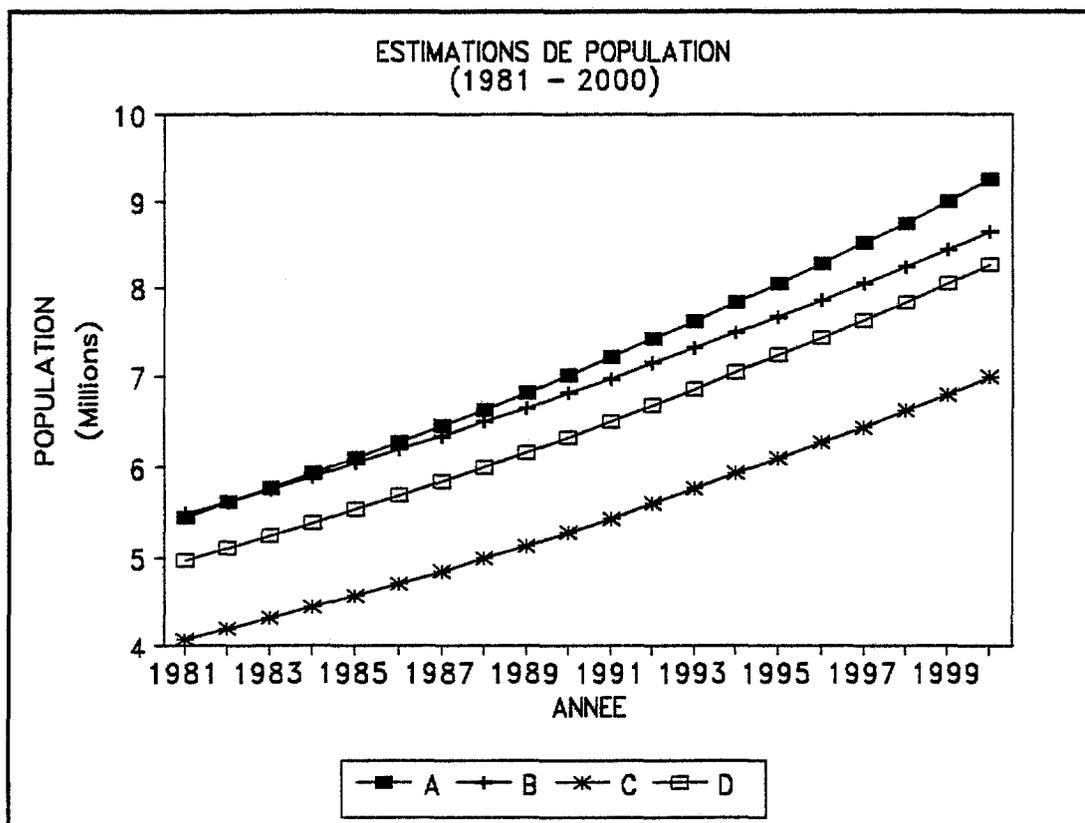


FIGURE 2



SOURCES DES ESTIMATIONS:

- A = BANQUE MONDIALE (1984)
- B = UNICEF (1986)
- C = BANQUE MONDIALE (1990)
- D = SECRETARIAT D'ETAT A LA DECENTRALISATION - GUINEA (1991)

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TABLEAU 5
ESTIMATIONS DE POPULATION
(1981 - 2000)

ANNEE	BM84	UNICEF86	BM88	DECENTRAL
1981	5461810	5490865	4067903	4975503
1982	5619146	5625886	4191217	5113570
1983	5781014	5764228	4317730	5255467
1984	5942882	5905971	4447493	5397365
1985	6109283	6051200	4580555	5543094
1986	6280343	6200000	4716963	5692757
1987	6456193	6348800	4856763	5846462
1988	6636966	6501171	5000000	6004316
1989	6822801	6657199	5146716	6166433
1990	7013840	6816972	5296952	6332926
1991	7210227	6980579	5450746	6503915
1992	7412113	7148113	5608134	6679521
1993	7619653	7319668	5769149	6859868
1994	7833003	7495340	5933822	7045085
1995	8052327	7675228	6102181	7235302
1996	8277792	7859434	6274249	7430655
1997	8509570	8048060	6450050	7631283
1998	8747838	8241214	6629600	7837327
1999	8992778	8439003	6812913	8048935
2000	9244575	8641539	7000000	8266256

HYPOTHESES DES TAUX DE CROISSANCE:

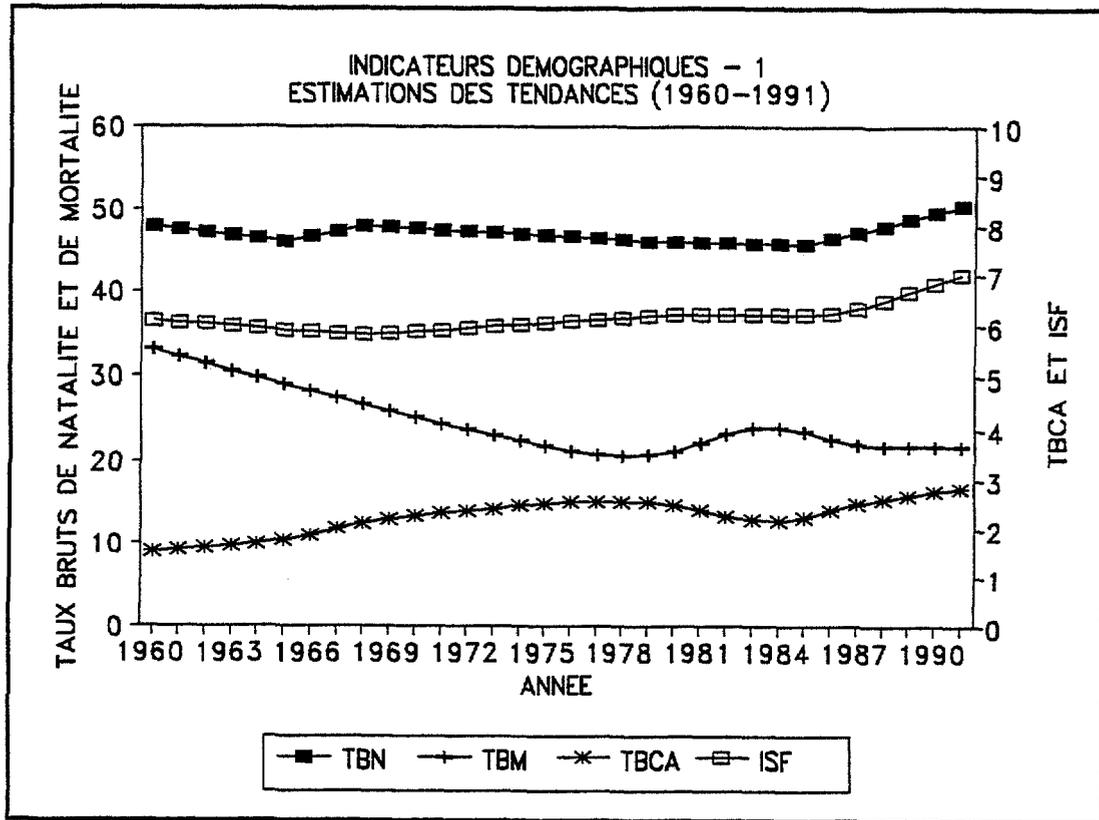
A: $P_t = P_0(1+0.028)^t$
 $T_0 = 1983$
 $P_0 = 5781014$

B: $P_t = P_0(1+0.024)^t$
 $T_0 = 1986$
 $P_0 = 6200000$

C: $POP_{(ANNEE-1976)} = 34033816 / (1+e^{(2.167-0.034(ANNEE-1976))})$
 POPULATION STATIONNAIRE = 34 MILLIONS

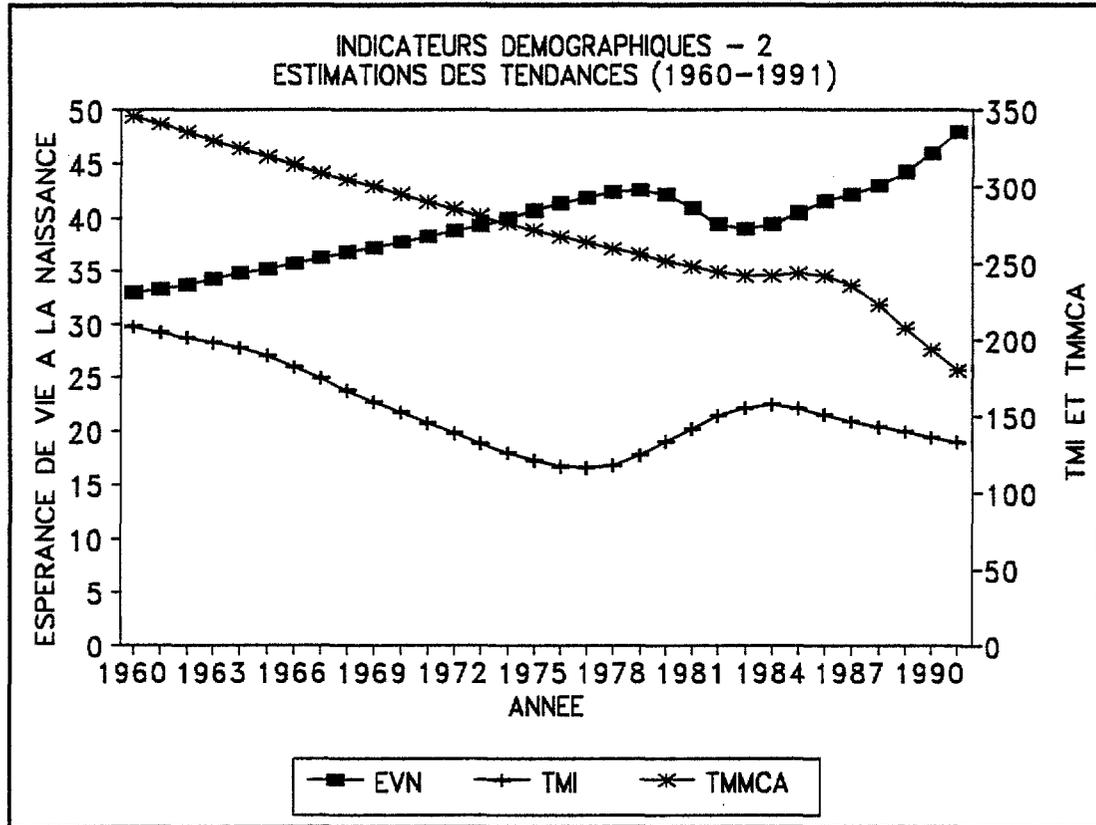
D: $P_t = P_0(1+0.027)^t$
 $T_0 = 1983/1.1$
 $P_0 = 5255467$

FIGURE 3



TBN = TAUX BRUT DE NATALITE
 TBM = TAUX BRUT DE MORTALITE
 TBCA = TAUX BRUT DE CROISSANCE NATURALE
 ISF = INDICE DE FECONDITE SYNTHETIQUE

FIGURE 4



EVN = ESPERANCE DE VIE A LA NAISSANCE
 TMI = TAUX DE MORTALITE INFANTILE
 TMMCA = TAUX DE MORTALITE DES MOINS DE CINQ ANS

TABLEAU 6
 INDICATEURS DEMOGRAPHIQUES
 ESTIMATIONS DES TENDANCES 1960 - 1991

ANNEE	DONNEES PUBLIEES						
	TBN	TBM	TBCA	TMI	EVN	ISF	TMMCA
1960	48.0	33.0	1.5	208	33.0		346
1961							
1962							
1963							
1964							
1965	46.0	29.0	1.7	191		5.9	
1966							
1967				351			
1968	48.0					5.8	
1969							
1970							
1971							
1972							
1973							
1974							
1975							
1976							
1977		20.7		110			
1978							
1979	46.1						
1980		21.0			43.5	6.2	
1981							
1982					39.0		
1983	48.0	20.0	2.8	160	38.0		
1984	49.0	26.0	2.3	156		6.0	236
1985	45.7			186		6.2	
1986		22.0		150	42.0	6.2	255
1987	47.0	23.0		147	42.0	6.2	
1988	48.0	22.0	2.6	143	43.0	6.5	222
1989							
1990							
1991							

TABLEAU 7
 INDICATEURS DEMOGRAPHIQUES
 ESTIMATIONS DES TENDANCES 1960 - 1991

ANNEE	DONNEES PUBLIEES APLANIES						
	TBN	TBM	TBCA	TMI	EVN	ISF	TMMCA
1960	48	33	1.5	208	33	6.1	346
1961	48	32	1.5	204	33	6.0	341
1962	47	31	1.6	201	34	6.0	335
1963	47	31	1.6	198	34	6.0	330
1964	46	30	1.7	194	35	5.9	325
1965	46	29	1.7	189	35	5.9	319
1966	47	28	1.8	182	36	5.9	314
1967	47	27	2.0	174	36	5.8	309
1968	48	27	2.1	166	37	5.8	305
1969	48	26	2.2	159	37	5.8	300
1970	48	25	2.2	152	38	5.9	295
1971	47	25	2.3	145	38	5.9	290
1972	47	24	2.3	138	39	5.9	286
1973	47	23	2.4	132	39	6.0	281
1974	47	23	2.4	126	40	6.0	277
1975	47	22	2.5	120	41	6.0	272
1976	47	21	2.5	117	41	6.1	268
1977	46	21	2.5	116	42	6.1	264
1978	46	21	2.5	118	42	6.1	260
1979	46	21	2.6	124	43	6.2	256
1980	47	21	2.6	133	42	6.2	252
1981	47	21	2.6	141	41	6.1	248
1982	48	21	2.6	150	39	6.1	244
1983	48	21	2.5	155	39	6.0	242
1984	47	22	2.4	157	39	6.1	242
1985	47	23	2.4	155	40	6.1	243
1986	47	23	2.4	151	42	6.2	242
1987	47	22	2.4	146	42	6.3	236
1988	48	22	2.6	143	43	6.5	223
1989	49	22	2.7	140	44	6.6	208
1990	49	22	2.7	136	46	6.8	193
1991	50	22	2.8	133	48	6.9	180

FIGURE 5

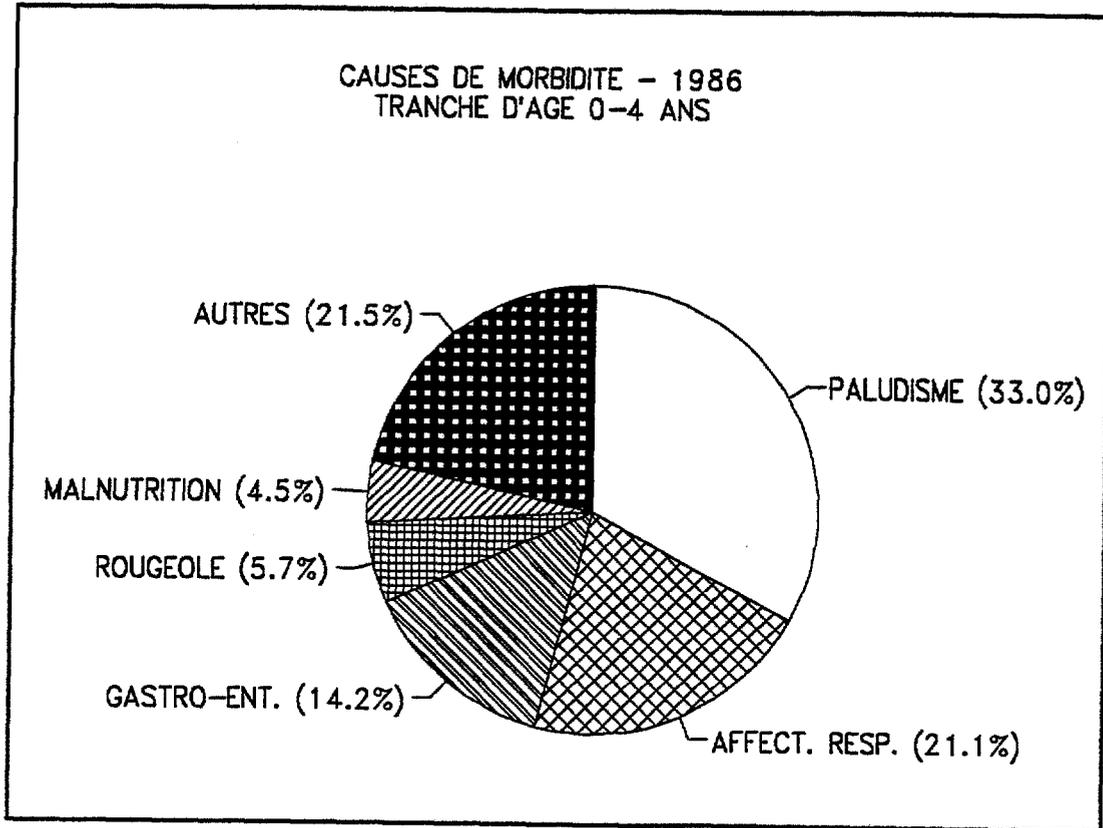


FIGURE 6

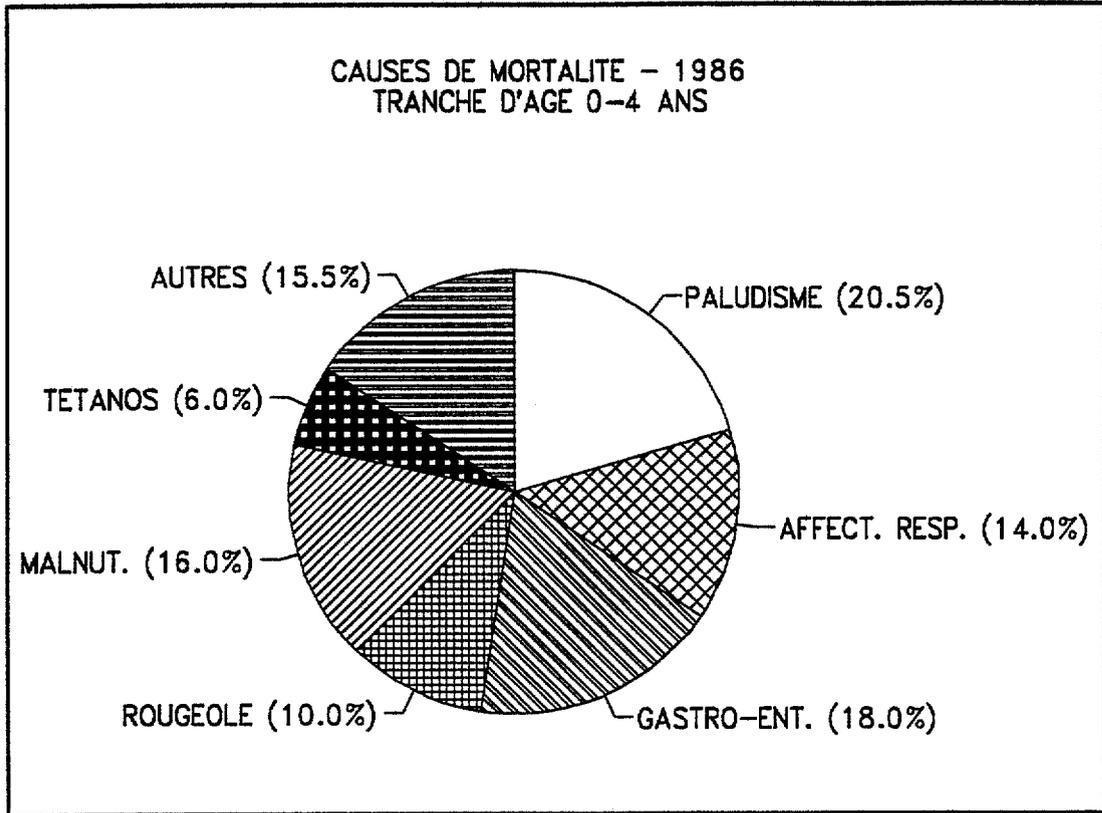


TABLEAU 8
 RAPPORT NOSOLOGIQUE DES STATISTIQUES SANITAIRES
 TRANCHE D'AGE DE 0-4 ANS (1986)

REPARTITION DES CAUSES DE MORBIDITE

MALADIE	%
PALUDISME	33.0
AFFECT. RESP.	21.1
GASTRO-ENT.	14.2
ROUGEOLE	5.7
MALNUTRITION	4.5
AUTRES	21.5
TOTAL	100.0

REPARTITION DES CAUSES DE MORTALITE

MORTALITE	%
PALUDISME	20.5
AFFECT. RESP.	14.0
GASTRO-ENT.	18.0
ROUGEOLE	10.0
MALNUTRITION	16.0
TETANOS	6.0
AUTRES	15.5
TOTAL	100.0

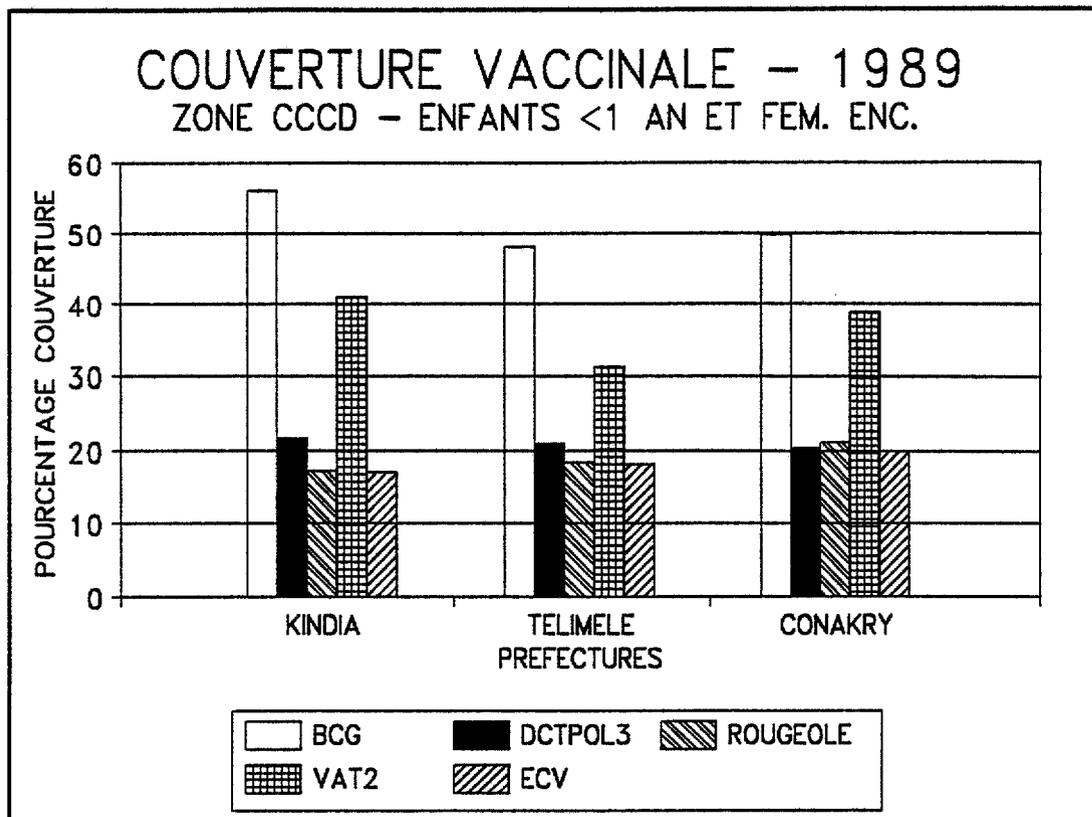
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TABLEAU 9
VARIATION SAISONNIERE DE LA SANTE EN REPUBLIQUE DE GUINEE

INDICATEUR	JAN	FEV	MARS	AVRIL	MAI	JUIN	JUIL	AOUT	SEPT	OCT	NOV	DEC
ENVIRONNEMENT												
HIVERNAGE						■	■	■	■	■		
PENURIE D'EAU			■	■	■							
SAISON CHAUDE			■	■	■							
SAISON FROIDE	■										■	■
MALADIES												
DERMATOSES			■	■	■							
DIARRHEE						■	■	■	■	■		
MALADIES RESP.	■	■									■	■
MST	■	■									■	■
PALUDISME						■	■	■	■	■		
SOUDURE/FAIM						■	■	■	■			

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FIGURE 7



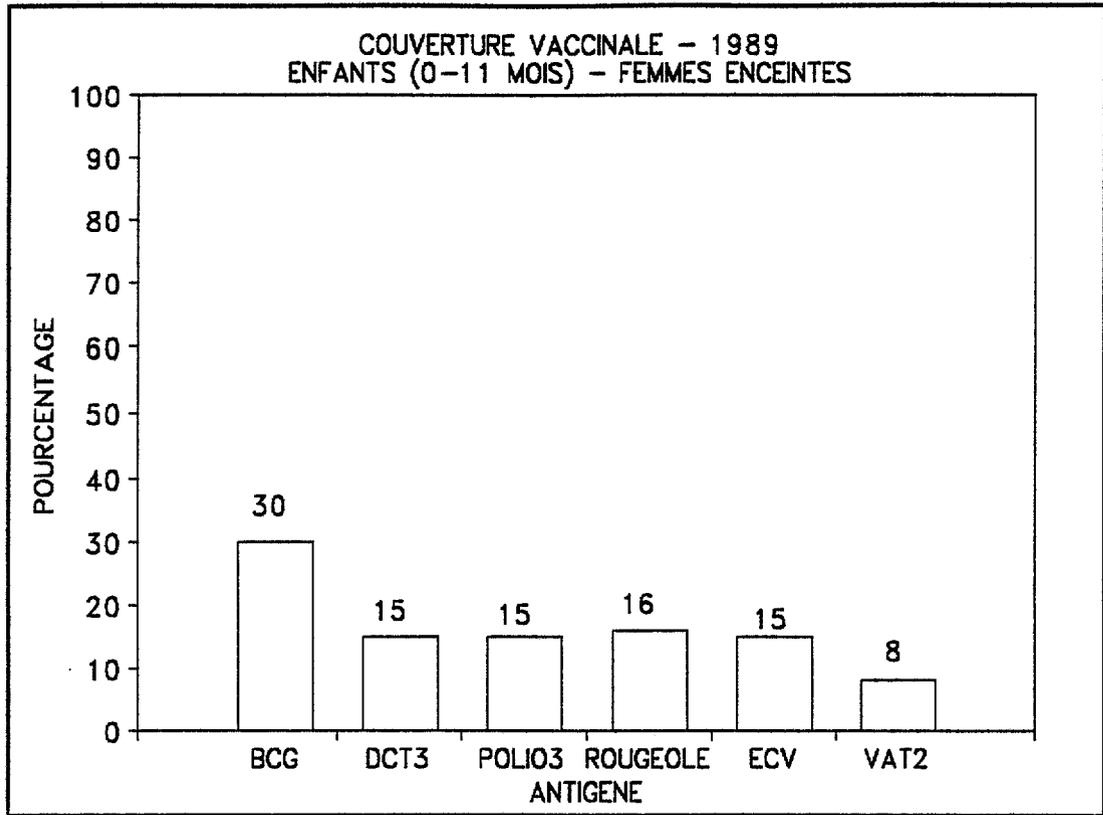
ECV = ENFANT COMPLETEMENT VACCINE = LE TAUX LE PLUS FAIBLE
ENTRE DCTPOL3 ET ROUGEOLE

TABLEAU 10
COUVERTURE VACCINALE - 1989
ENFANTS 0-11 MOIS ET FEMMES ENCEINTEES

VARIABLE	KINDIA	TELIMELE	CONAKRY	ZONE CCCD	NIV. NATIONAL
POP TOT	209032	238047	1101115	1548194	6166433
< 1 AN	8570	9760	45146	63476	256525
F. ENCEINTE	10661	12140	56157	78958	314490
DOSES DU VAC.					
BCG	4808	4702	22480	31990	
DCTPOL3	1848	2034	9204	13086	
ROUGEOLE	1470	1792	9508	12770	
VAT2	4370	3794	21848	30012	
% COUVERTURE					
BCG	56	48	50	50	30
DCTPOL3	22	21	20	21	15
ROUGEOLE	17	18	21	20	16
VAT2	41	31	39	38	8
ECV	17	18	20	20	15

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FIGURE 8



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TABLEAU 11
EVOLUTION DE LA COUVERTURE VACCINALE - GUINEE

ANNEE	ENFANTS (0 - 11 MOIS)					F. ENC.
	BCG	DCT3	POLIO3	ROUGEOLE	ECV	VAT2
1981	4			15		5
1982						
1983						
1984						
1985						
1986	46	10	8	41	5	17
1987						
1988						
1989	30	15	15	16	15	8
1990						
1991						

ECV = ENFANTS COMPLETEMENT VACCINES
F. ENC. = FEMMES ENCEINTES
VAT = VACCIN ANTI-TETANIQUE

TABLEAU 12
ESTIMATION DES GROUPES CIBLES - 1990
PREFECTURE DE KINDIA

SOUS-PREFECTURE	POP TOT	< 1 AN	FEM ENC	FAP
KINDIA CENTRE	85209	3545	4346	19428
BANGOUYA	31969	1330	1630	7289
GBERIAKHORY	7625	317	389	1739
MOLOTA	7089	295	362	1616
MAMBIA	10468	435	534	2387
SOUGETA	15669	652	799	3573
LINSAN	2471	103	126	563
MADINA-OULA	14120	587	720	3219
KOLENTE-GOMBA	13998	582	714	3192
SAMAYA	12651	526	645	2884
FRIGUIAGBE	13406	558	684	3057
TOTAL	214676	8931	10948	48946

POP TOT = POPULATION TOTALE
< 1 AN = ENFANTS DE 0-11 MOIS
FEM ENC = FEMMES ENCEINTES
FAP = FEMMES EN AGE DE PROCREER

ESTIMATION DE COUVERTURE VACCINALE (POURCENTAGE)
ENFANTS DE 0-11 MOIS

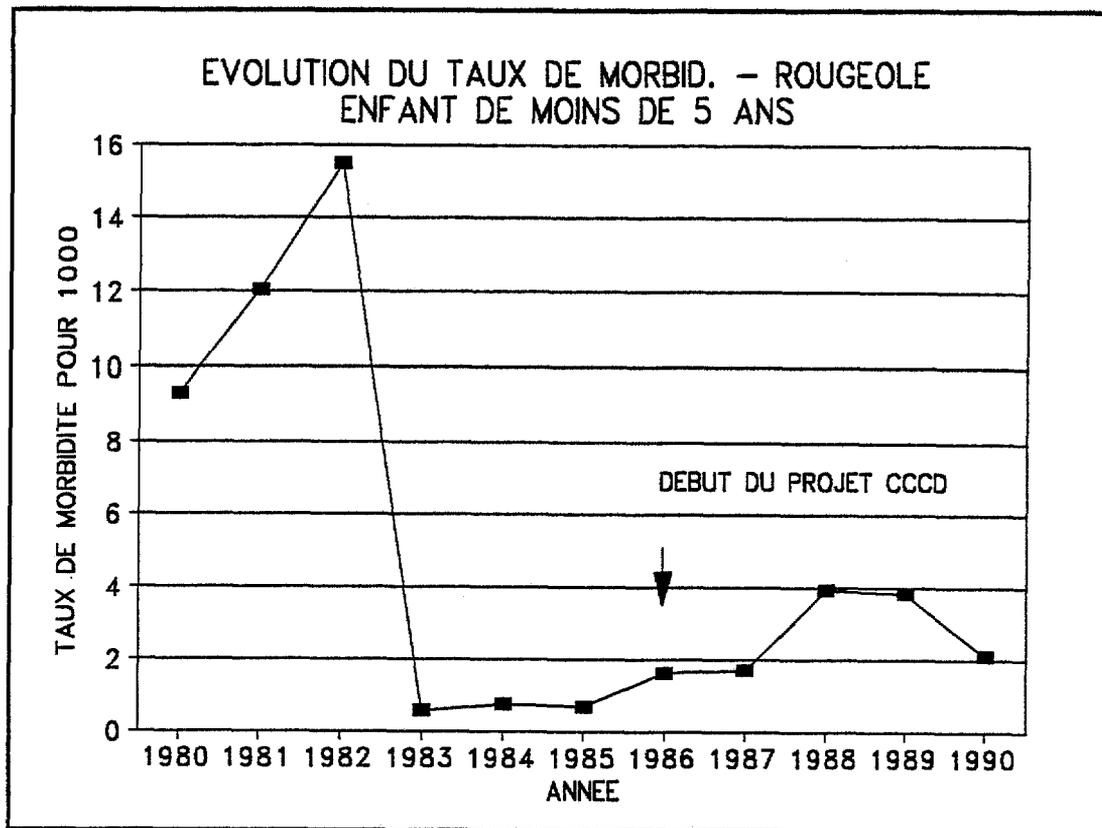
SOUS-PREFECTURE	RN	CCCD	I	II	PEV/SSP/ME	TOTAL	CLASSEMENT
KINDIA	OUI		47		47	47	3
BANGOUYA	NON	10				10	9
GBERIAKHORY	NON	13				13	7
MOLOTA	NON	3				3	11
MAMBIA	OUI	79				79	2
SOUGETA	OUI		20		20	20	5
LINSAN	OUI		121		121	121	1
MADINA-OULA	NON			7	7	7	10
KOLENTE-GOMBA	O/N			12	12	12	8
SAMAYA	NON	17				17	6
FRIGUIAGBE	OUI			39	39	39	4
TOTAL		21	45	28	37	32	

RN = CENTRE/POST DE SANTE SUR LA ROUTE NATIONALE
CCCD = CENTRE DU PROJET CCCD
I = CENTRE PEV/SSP/ME PHASE I
II = CENTRE PEV/SSP/ME PHASE II

CLASSEMENT:

1 = LA PLUS HAUTE COUVERTURE
11 = LA PLUS BASSE COUVERTURE

FIGURE 9



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TABLEAU 13
EVOLUTION DES CAS DECLARES DES MALADIES DE L'ENFANCE

ANNEE	POPTOT	< 5 ANS	ROUGEOLE	POLIO	COQUELUCHE	TET	NEONALE
1980	4841164	919821	8552	32	2315		
1981	4975503	945346	11397	42	4141		
1982	5113570	971578	15038	74	4589		
1983	5255467	998539	578	62	3504		
1984	5397365	1025499	764	49	2420		
1985	5543094	1053188	731	37	1335		
1986	5692757	1081624	1749	24	250		
1987	5846462	1110828	1885	12	83		32
1988	6004316	1140820	4503	172	272		85
1989	6166433	1171622	4499	93	339		189
1990	6332926	1203256	2523	58	99		153

EVOLUTION DES TAUX DE MORBIDITE POUR LES MALADIES DE L'ENFANCE

ANNEE	ROUGEOLE	POLIO	COQUELUCHE	TET	NEONALE
1980	9	3	25	-	
1981	12	4	44	-	
1982	15	8	47	-	
1983	1	6	35	-	
1984	1	5	24	-	
1985	1	3	13	-	
1986	2	2	2	-	
1987	2	1	1	-	2
1988	4	15	2	-	4
1989	4	8	3	-	9
1990	2	5	1	-	7

ROUGEOLE = CAS POUR 1000 ENFANTS < 5 ANS
POLIO = CAS POUR 100000 ENFANTS < 5 ANS
COQUELUCHE = CAS POUR 10000 ENFANTS < 5 ANS
TETANOS NEONATAL = CAS POUR 1000 ENFANTS < 1 MOIS

FIGURE 10

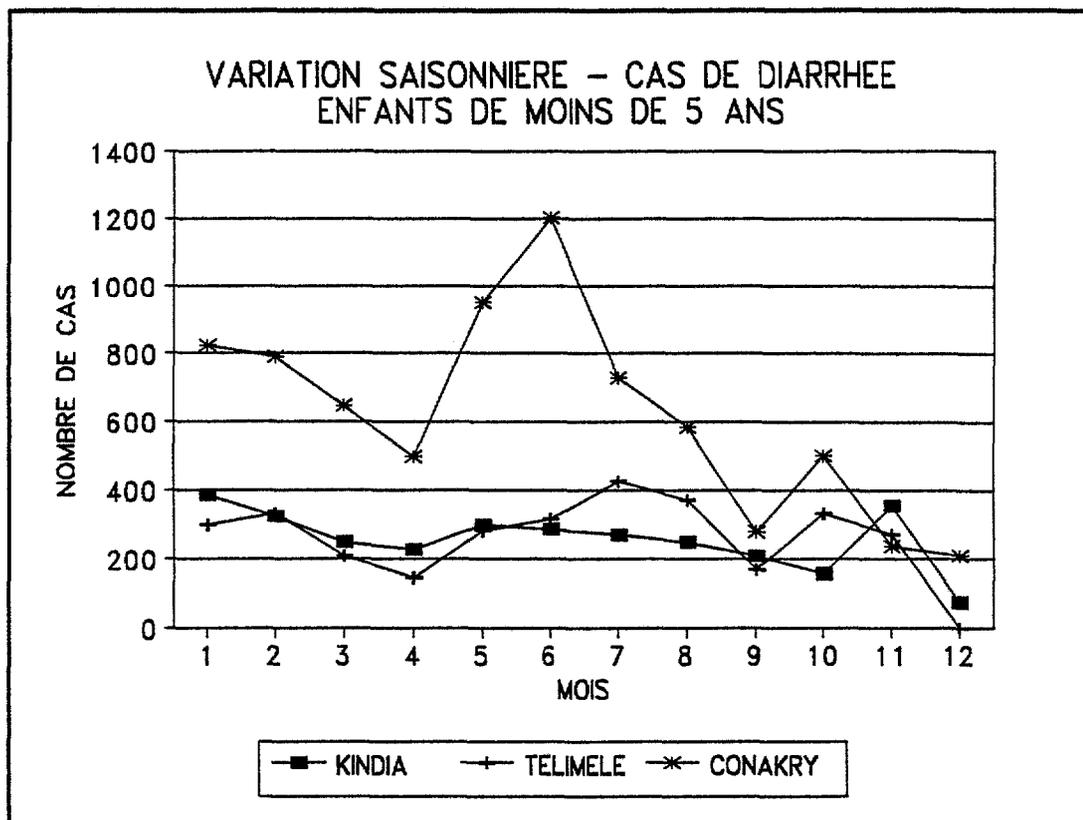


TABLEAU 14
COUVERTURE SANITAIRE: ENFANTS < 5 ANS TRAITES POUR LA DIARRHEE - 1990

PREFECTURE	1	2	3	4	5	6	7	8	9	10	11	12	TOTAL	% BEC	NS/CT
KINDIA	388	323	248	227	298	285	269	249	210	155	358	73	3083	17	1.8
TELIMELE	299	332	209	145	282	318	427	373	167	332	271	0	3155	15	1.8
CONAKRY	823	790	646	498	951	1203	728	587	280	501	236	209	7452	8	1.4
TOTAL	1510	1445	1103	870	1531	1806	1424	1209	657	988	865	282	13690	10	1.5

% BEC = POURCENTAGE DES BESOINS ESTIMES COUVERTS
 = CAS TRAITES DANS LES CS PAR RAPPORT A 10% DES CAS ESTIMES PAR AN
 = CAS TRAITES/(POP. 1990 DE < 5 ANS * 5 EPISODES * 0.1)
 ON ESTIME QUE SEULEMENT 10% DES EPISODES NECESSITENT UN TRAITEMENT AU CS
 NS/CT = NOMBRE DE SRO PAR CAS TRAITÉ

SOURCE: PROJET CCCD - 1990

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TABLEAU 15
ESTIMATION DES GROUPE CIBLES/BESOINS
ENFANTS DE < 5 ANS/DIARRHEE/PALUDISME
PREFECTURE DE TELIMELE

SOUS-PREFECTURE	POP 88	POP89	POP90	< 5 -88 ENF	< 5 -89< ENF	5 -90< 5 -88* ENF	< 5 -89 BESOINS	< 5 -90 BESOINS	< 5 -90 BESOINS
THIONTHIAN	9728	9998	10268	1848	1900	1951	154	950	975
BROUAL	26833	27578	28322	5098	5240	5381	425	2620	2691
MISSIRA	29344	30158	30972	5575	5730	5885	465	2865	2942
SINTA	16874	17343	17811	3206	3295	3384	267	1648	1692
TARIHOYE	11059	11366	11673	2101	2160	2218	175	1080	110
GOUGOUDJE	8062	8286	8509	1532	1574	1617	128	787	808
SANTOU	11710	12035	12360	2225	2287	2348	185	1143	1174
TELIMELE CENTRE	24710	25395	26081	4695	4825	4955	391	2413	2478
KONSOTAMI	10633	10928	11223	2020	2076	2132	168	1038	1066
KOLLET	17306	17786	18266	3288	3379	3471	274	1690	1735
SAREKALY	14570	14974	15379	2768	2845	2922	231	1423	1461
SOGOLON	15152	15572	15993	2879	2959	3039	240	1479	1519
KOBA	10326	10613	10899	1962	2016	2071	163	1008	1035
DARAMAGNAKI	25313	26016	26718	4810	4943	5076	401	2471	2538
TOTAL	231620	238047	244474	44008	45229	46450	3667	22614	23225

* LES UNITES TRO ONT ETE OUVERTES EN NOVEMBRE 88
ESTIMATION DES BESOINS:
CHAQUE ENFANT A 5 EPISODES DE DIARRHEE PAR AN
10% DES CES EPISODES NECESSITENT UN TRAITEMENT
CHAQUE ENFANT A 5 EPISODES DE FIEVRE PAR AN

NOMBRE D'ENFANTS < 5 ANS TRAITES POUR LA DIARRHEE

SOUS-PREFECTURE	1988	% BEC-88	1989	% BEC-89	1990	% BEC-90
THIONTHIAN	19	12	30	3	48	5
BROUAL	33	8	55	2	8	0
MISSIRA	59	13	259	9	199	7
SINTA	69	26	286	17	128	8
TARIHOYE	21	12	47	4	25	2
GOUGOUDJE	32	25	56	7	44	5
SANTOU	49	26	66	6	133	11
TELIMELE CENTRE	220	56	281	12	149	6
KONSOTAMI	85	50	97	9	112	11
KOLLET	34	12	91	5	52	3
SAREKALY	64	28	98	7	107	7
SOGOLON	13	5	39	3	31	2
KOBA	19	12	42	4	49	5
DARAMAGNAKI	-	0	106	4	127	5
TOTAL	717	20	1553	7	1212	5

% BEC = POURCENTAGE DES BESOINS COUVERTS

FIGURE 11

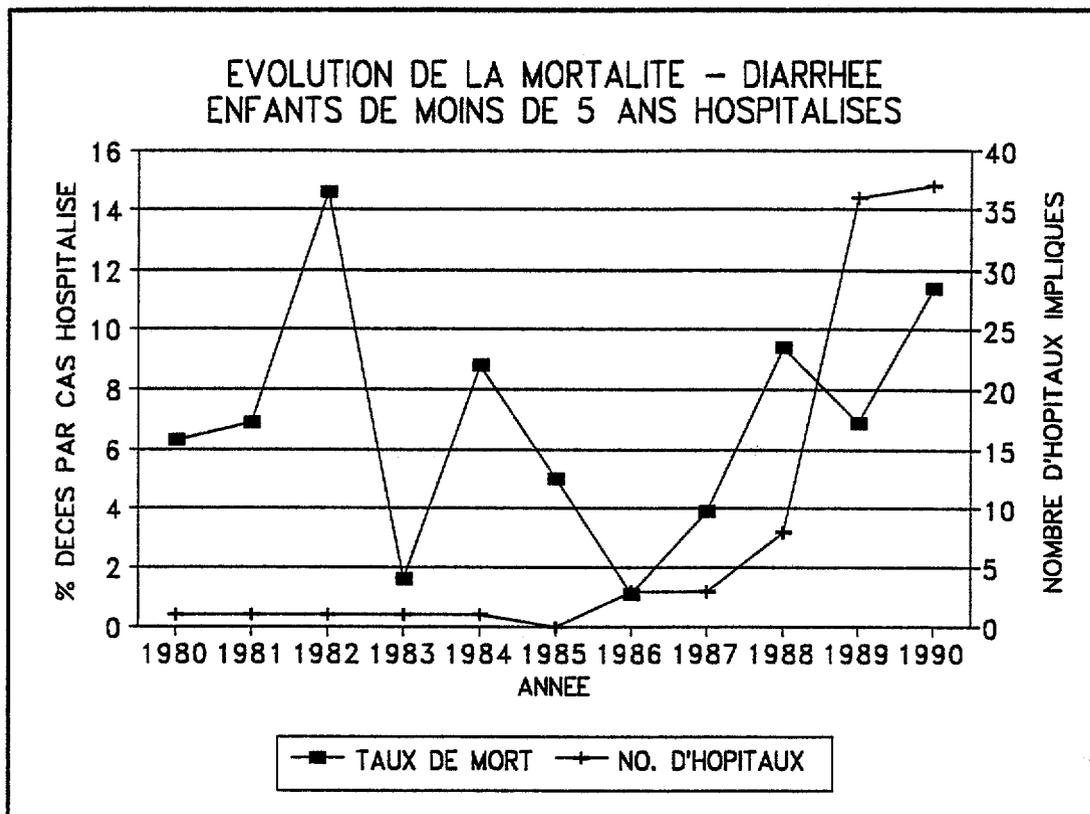


TABLEAU 16
EVOLUTION DES CAS DE DIARRHEE HOSPITALISES
ENFANTS DE MOINS DE 5 ANS

ANNEE	NO. D'HOP	CAS	DECES	% DEC/CAS
1980	1	367	23	6.3
1981	1	317	22	6.9
1982	1	371	54	14.6
1983	1	792	13	1.6
1984	1	373	33	8.8
1985	0	-	-	5.0
1986	3	2096	23	1.1
1987	3	1074	42	3.9
1988	8	566	53	9.4
1989	36	1154	80	6.9
1990	37	989	113	11.4

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TABLEAU 17
 PREFECTURE DE TELIMELE

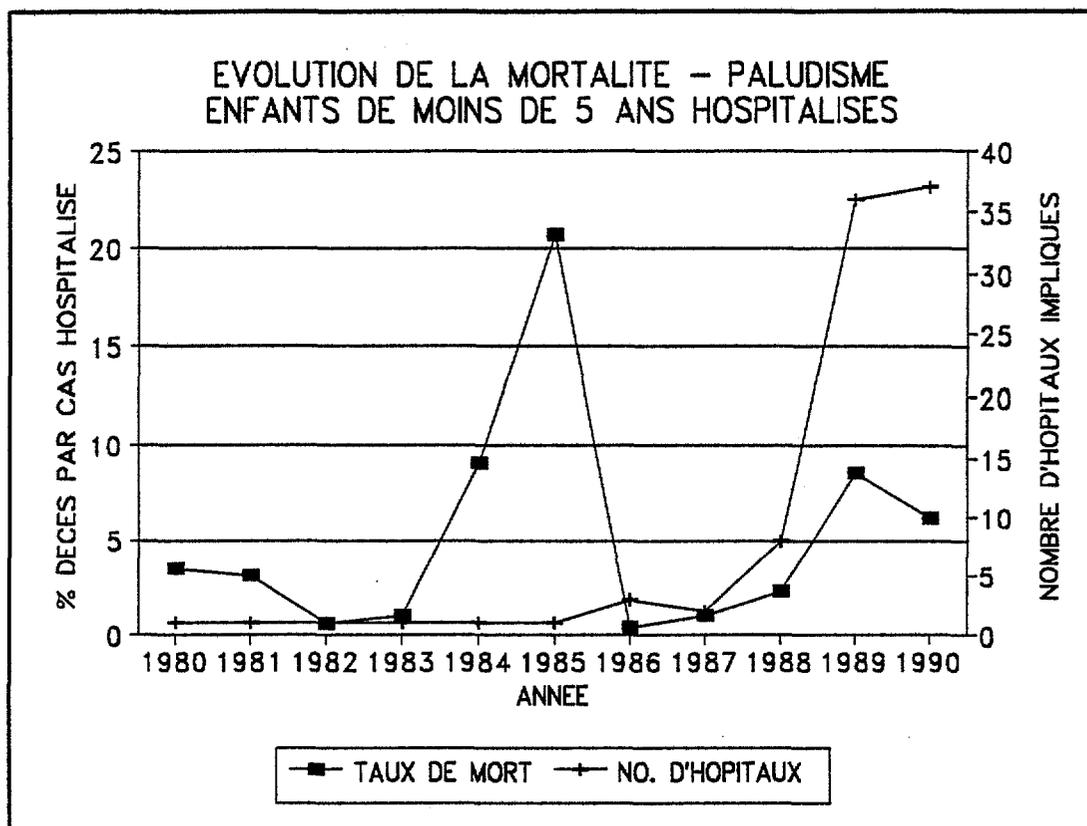
NOMBRE D'ENFANTS < 5 ANS TRAITES POUR LE PALUDISME

SOUS-PREFECTURE	1989	% BEC-89
THIONTHIAN	162	2
BROUAL	206	1
MISSIRA	389	1
SINTA	874	5
TARIHOYE	137	1
GUGGUDJE	170	2
SANTOU	206	2
TELIMELE CENTRE	600	2
KONSOTAMI	263	3
KOLET	119	1
SAREKALY	178	1
SOGOLON	257	2
KOBA	131	1
DARAMAGNAKI	302	1
TOTAL	3994	2

% BEC = POURCENTAGE DES BESOINS COUVERTS

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FIGURE 12



**TABLEAU 18
EVOLUTION DES CAS DE PALUDISME HOSPITALISES
ENFANTS DE MOINS DE 5 ANS**

ANNEE	NO. D'HOP	CAS	DECES	% DEC/CAS
1980	1	376	13	3.5
1981	1	389	12	3.1
1982	1	327	2	0.6
1983	1	1250	13	1.0
1984	1	538	49	9.1
1985	1	237	49	20.7
1986	3	3116	14	0.4
1987	2	1317	13	1.0
1988	8	574	13	2.3
1989	36	1954	168	8.6
1990	37	1964	122	6.2

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DEFINITIONS DES TERMES UTILISES DANS LE MODELE *

.. ..
GROUPE A RISQUE (LA DEMANDE DES SERVICES)

C: CONNAISSANCES

A: ATTITUDES

P: PRATIQUES

SYSTEME SANITAIRE (L'OFFRE DES SERVICES)

D = DISPONIBILITE: LES STRUCTURES SANITAIRES EXISTENT PHYSIQUEMENT

A = ACCESSIBILITE: LES STRUCTURES SONT RAISONNABLEMENT PROCHES

A = ACCEPTABILITE: LES SERVICES SONT CREDIBLES ET S'INTEGRENT DANS LE MILIEU SOCIO-CULTUREL

C = COUT (A LA PORTEE DES BOURSES): LES SERVICES NE COUTENT PAS TROP CHERS ET SONT DONC UTILISES

E = EFFICACITE: LES SERVICES RENDUS ABOUTISSENT AUX RESULTATS FAVORABLES ESCOMPTEES

E = EFFICIENCE: LE RAPPORT COUT/EFFICACITE EST BON, C'EST-A-DIRE AU MOINDRE COUT L'EFFICACITE EST MAXIMALE

* CE MODELE EST UNE ADAPTATION D'UN MODELE UTILISE POUR ANALYSER LE PROBLEME DE MORTALITE MATERNELLE AU SENEGAL

ESTIMATION DE MORBIDITE/MORTALITE/UTILISATION DES SERVICES SANITAIRES
ENFANTS DE MOINS DE 5 ANS

STRUCTURE SANITAIRE:
ENQUETEUR:
PERSONNE INTERVIEWEE:

DATE:
NUMERO DU MENAGE:
NO. DE PERSONNES DANS LE MENAGE:

VARIABLES	ENFANTS VIVANTS ACTUELLEMENT				
	1	2	3	4	5
1 NOM DE L'ENFANT					
2 DATE DE NAISSANCE (JOUR/MOIS/ANNEE)					
3 AGE ACTUEL (MOIS OU JOURS SI < 1 MOIS)					
DIARRHEE					
4 DIARRHEE AUJOURD'HUI? (NON: ALLER A 8)					
5 OUI: DEPUIS COMBIEN DE JOURS?					
6 TRAITEMENT DONNE?					
7 OUI: LESQUELS? (ALLER A 9)					
8 DIARRHEE DERNIERES 2 SEMAINES?					
VACCINATION					
9 CARTE DISPONIBLE (NON: ALLER A 18)					
10 OUI: BCG					
11 DCT1					
12 DCT2					
13 DCT3					
14 POL1					
15 POL2					
16 POL3					
17 ROUGEOLE					
18 CICATRICE BCG					

ESTIMATION DE MORBIDITE/MORTALITE/UTILISATION DES SERVICES SANITAIRES
ENFANTS DE MOINS DE 5 ANS

VARIABLES	ENFANTS VIVANTS ACTUELLEMENT				
	1	2	3	4	5
FIEVRE					
19 FIEVRE AUJOURD'HUI? (NON: ALLER A 23)					
20 OUI: DEPUIS COMBIEN DE JOURS?					
21 TRAITEMENT DONNE?					
22 OUI: LESQUELS? (ALLER A 24)					
23 NON: FIEVRE DERNIERES 2 SEMAINES?					
VARIABLES	ENFANTS DECEDES DANS LES DERNIERS 12 MOIS				
	1	2	3	4	5
24 NOM DE L'ENFANT					
25 DATE DE NAISSANCE (JOUR/MOIS/ANNEE)					
26 AGE A LA MORT (MOIS OU JOURS SI <1 MOIS					
27 DATE A LA MORT (MOIS, ANNEE)					
SYMPTOMES AVANT LA MORT (TOUS LES DECES)					
28 ERUPTION CUTANEE					
29 TOUX					
30 DIARRHEE					
31 FIEVRE					
32 AUTRES					
33 AGE DU DECES AVANT 30 JOURS (NON: FIN)					
34 OUI:TETEE NORM. A LA NAISSANCE (NON:FIN)					
35 CESSATION DE LA TETEE NORMALE?					
36 CONVULSIONS					
37 SPASMES					
38 FREMISSEMENT					

ESTIMATION DE MORBIDITE/MORTALITE/UTILISATION DES SERVICES SANITAIRES
FEMMES AYANT EU AU MOINS UN ACCOUCHEMENT

VARIABLES		REPONSE
1	NOM DE LA FEMME	
2	DATE DE NAISSANCE (ANNEE)	
3	AGE ACTUEL	
4	NOMBRE DE GROSSESSES	
5	AU MOINS UN ACCOUCHEMENT?	
	NON: L'INTERVIEW EST TERMINEE	
	OUI: EN CE QUI CONCERNE LE DERNIER ACCOUCHEMENT:	
6	NOMBRE DE VISITES PRENATALES	
7	CARTE DE VACCINATION DISPONIBLE?	
	NON: ALLER A 11	
8	OUI: VAT1	
9	VAT2	
10	RAPPEL	
11	LIEU DU DERNIER ACCOUCHEMENT	
	SI A DOMICILE:	
12	POURQUOI PAS DANS UNE STRUCTURE SANITAIRE?	
13	ASSISTEE PAR UNE MATRONE?	
	NON: ALLER A 15	
14	OUI: VENUE AVANT OU APRES LA NAISSANCE	
15	RESULTAT DE L'ACCOUCHEMENT: ENFANT VIVANT?	

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REFERENCES

- ACSI-CCCD. Field Epidemiologist Report - OCCG. Conakry: Avril 1987.
- ACSI-CCCD. 1986 Annual Report. Atlanta: Africa Child Survival Initiative - Combatting Childhood Communicable Diseases/Centers for Disease Control, 1987.
- ACSI-CCCD. Annual Management Information System Report - Guinea 1988. Conakry: Africa Child Survival Initiative - Combatting Childhood Communicable Diseases, 1988.
- ACSI-CCCD. 1989-1990 Bilingual Annual Report. Atlanta: USPHS/USAID, 1991.
- ACSI-CCCD. Annual Management Information System Report - Guinea 1987. Conakry: Africa Child Survival Initiative - Combatting Childhood Communicable Diseases, 1987.
- ACSI-CCCD. Annual Management Information System Report - Guinea 1990. Conakry: Africa Child Survival Initiative - Combatting Childhood Communicable Diseases, 1990.
- ARC. External Evaluation of the ACSI-CCCD Project in the Republic of Guinea. Conakry: Atlantic Resources Corporation/Birch & Davis International, August 1989.
- Banque Mondiale. Guinee: Le Secteur de la Population, de la Santé et de la Nutrition. Washington: Banque Mondiale, Février 1986.
- Catley-Carlson, M. The Donors Response - Canadian Aid policy Towards 2000. Development - Journal of SID, 1, 1988.
- CDC. Combatting Childhood Diseases - Guinea: Issues Paper. Conakry: Centers for Disease Control/USAID/GTZ/Gouvernement of Guinea, May-June 1983.
- CDC. Guinea Maternal and Child Health Accelerated Impact Project: Final Evaluation. Conakry: CDC/USAID/Government of Guinea, January 1984.
- Cereseto, S. and Waitzkin, H. Economic Development, Political-Economic System, and the Physical Quality of Life. American Journal of Public Health. Vol. 76, No. 6, June 1986.
- Evlo, K., et Waty, M. Recouvrement des Coûts des Activités de Soins du Projet CCCD en République de Guinée: Etude de Faisabilité. Conakry: REACH, Mars 1989.
- Gaye. P. Ateliers de Formation des Facilitateurs/Superviseurs et Premier Cours Moyen National. Conakry: PRITECH, Mai 1986.
- ICC. The Bamako Initiative: Primary Health Care Experience. Paris: International Children's Centre, 1990.

King, S. Primary Health Care: A Response in Support of a Health Revolution. Development: Seeds of Change.

Lewis, S. Realism and Vision in Africa. Development - Journal of SID. 1, 1988.

Malison, M., et alia. Estimating Health Service Utilization, Immunization Coverage, and Child Mortality: A New Approach in Uganda. Bulletin of the World Health Organization, 65 (3), 1987.

MSP. Fiche d'Evaluation du Système de Santé en 1983. Conakry: Ministère de la Santé Publique, Janvier 1984.

MSP/MDS. Rapport de la Deuxième Mission D'Identification Pour la Réduction de la Mortalité Maternelle au Sénégal. Dakar: Ministère de la Santé Publique/Ministère du Développement Rural/Université de Columbia, Septembre 1989.

MSPP. ANNUAIRE STATISTIQUE - 1989. CONAKRY: MSPP/BEPR, 1990.

MSPP. Plan National Pour le Programme Elargi de Vaccination, Intégré aux Soins de Santé Primaires, en Vue D'Atteindre la Vaccination Universelle des Enfants, 1986 - 1991. Conakry: Ministère de la Santé et de la Population, Avril 1986.

MSPP. Revue Interne du Projet CCCD. Kindia: Ministère de la Santé Publique et de la Population, 17-20 Janvier 1991.

MSPP. Evaluation des Stratégies de la Santé Pour Tous D'Ici L'An 2000. Conakry: Ministère de la Santé Publique et de la Population, Janvier 1991.

MSPP. Programme Elargi de Vaccination Intégré aux Soins de Santé Primaires/Médicaments Essentiels: Programme de Formation des Centres de Gestion des 72 Centres de Santé Pilotes - Module III. Conakry: MSPP/Commission Participation Communautaire, Janvier 1988.

MSPP. Séminaire de Formation sur La Recherche Opérationnelle. Conakry: Ministère de la Santé Publique et de la Population, 2-13 Mai 1989.

MSPP. Fiches d'Evaluation au Cours la la Supervision.

MSPP. Plan D'Action Sanitaire de la Guinée. Conakry: MSPP Octobre 1989.

MSPP. Plan National Pour le Programme Elargi de Vaccination, Intégré aux Soins de Santé Primaires, en vue D'Atteindre la Vaccination Universelle des Enfants, 1986-1991. Conakry: Ministère de la Santé Publique et de la Population, Avril 1986.

MSPP. Plan Triennal à L'Horizon Glissant Pour le Période 1991 - 1993. Conakry: Ministère de la Santé Publique, Bureau des Etudes, de la Planification et de la Recherche, Janvier 1991.

MSPP. Développement du Système de Santé Sanitaire: Propositions de Financement. Conakry: OMS, 1990.

MSPP. Projet CCCD: Rapport de Synthèse de la Revue Interne - Présentation des Programmes et Activités Retenus Pour 1991. Conakry: Ministère de la Santé Publique et de la Population/Coordination du Projet, Janvier 1991.

Mutharika, B. Special Assistance Needs for Africa, With Special Reference to Sub-Saharan Africa. Development: Seeds of Change. 2/3, 1988.

OMS. Elaboration d'Indicateurs Pour La Surveillance Continue des Pr. Réalisés dans la Voie de la Santé Pour Tous d'Ici l'An 2000. Genève: 1981.

OMS. Programme de Budget Programme 1990-1992. Brazzaville: OMS Septe 1990.

OMS. Rapport de la Mission Effectuée Dans le Cadre des Enquêtes Fovers/Ménages Basées sur les 27 Indicateurs Régionaux. Conakry: Organisation Mondiale de la Santé 1990.

Prins, A. Mission PRITECH en Guinée. Conakry: PRITECH, January 1987.

République de Guinée. Programme de Redressement National: Perspective de Développement à Moyen Terme 1987 - 1991. Conakry: République de Guinée, Sans Date.

UNICEF. A UNICEF Strategy for Sustainable Development: Children and Environment. Development - Journal of SID, 2/3, 1989.

UNICEF. La Situation des Enfants dans le Monde - 1988. New York: UNICEF, 1987.

URC. Evaluation of ASCI CCCD Project: Republic of Guinea. Conakry: University Research Corporation, 14 Mai - 4 June 1987.

USAID. Africa Child Survival Initiative - Amendment. Washington, D.C.: USAID October 1988.

USAID. Amplified CCCD Project Description. Conakry: USAID, Undated.

USAID. Child Survival: A Third Report to Congress on the USAID Program. Washington: USAID, Undated.

USAID. Health Sector Analysis for Guinea. Conakry: USAID/JSI/SEATS 1990

Vaughan, J. and Morrow, R. Manual of Epidemiology for District Health Management. Geneva: World Health Organization, 1989.

WHO. Eighth General Programme of Work Covering the Period 1990-1995. Geneva: World Health Organisation, 1987.

World Bank. World Development Report. New York: Oxford University Press, 1990.

APPENDIX B

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Appendix B-1
Summary of Training Activities

MOIS/ANNEE ASSISTANCE	TYPE DE FORMATION	NOMBRE PARTIC.	POSITION AU PROJET	NOMBRE FACILIT	LIEU FORMATION	
MAI 1986	Formation des formateurs pour les volets PEV/LMD/PALU	18	Coord CCCD Resp MSPP Chef de C.S.	1	Conakry	1
AOUT 1986	Formation sur identification vibrion cholérique	5	Agents techn Labo SP/MSPP	2	Conakry	?
AVRIL 1987	Formation en PEV	20	DPS/4 regions	2	Faranah	
1986	Formation formateurs en TRO	2	Med/pediatrie		Dakar	
MAI 1987	Formation en TRO	30	Med/Chef C.S	3	H.Donka	1
JUILLET 87	Formation en TRO	20	Med/Chef C.S.	3	H. Donka	1
JUILLET 87	Formation en mainten des vehicules et chaine de froid	20	Chefs C.S. Conakry	3	Conakry	
SEPT 1987	Formation TRO	18	Chefs C.S.	3	Kindia/Cky	
SEPT 87	Formation en mainten. chaine de froid	5	Chefs C.S. Kindia/Telemele Conakry	3	Conakry	
OCT 87	Formation TRO	10	Agents C.S. Conakry	3	Conakry	
OCT 87	Formation TRO	4	Agents C.S. Kindia/Telemele	2	Conakry	
OCT 87	Formation en sterili materiel vaccination	18	Agents C.S. Conakry	3	Conakry	
DEC 87	Formation TRO	15	Agents/sante Hopital Donka	3	H.Donka	
FEV 87	Formation en TRO	6	V.Corps Paix zones hors Projet	2	Conakry	
MAI 88	Formation en maint. de chaine de froid	17	Agents C.S. Conakry	4	Conakry	

SEPT/OCT 88	Formation en TRO	33	Chefs C.S. Kindia/Telem	4	Telemele
SEPT 88	Intr. micro-inform. appl. a la surveil. epidemiologique	1	Coord LMD		Abidjan
FEV 89	Formation en chimio- resistance palustre	6	Agents labo- C.S. Conakry	1	Conakry
FEV 89	Formation en chimio- resistance	7	Agents labo- C.S. Kindia	1	Kindia
MARS/AVR89	Formation formateurs en LMD/zone horsProjet	38	DPS/DHOP Insp reg/inf. resp./pediat	1	Zerekore/ Kankan/Labe
MAI 89	Seminaire en Recherc operationnelle	20	DPS/Dpedia Univer/R.sc med.trad/ AGBF/PEV/SSP	5	Conakry
AOUT 89	Formation formateurs des agents en educ. pour la sante	14	DPS/Sup/Chefs C.S.	2	Conakry
AOUT 89	Formation Superviseu et Chefs C. utilisant motos a Kindia	26		2	Kindia
SEPT 89	Introduct. micro appl. epidemiologie	3	Coord CCCD Coord LMD/CCCD Assist Admin		Zaire
OCT 89	Formation EPS appliq. au PEV	2	R.Ed.S/CCCD R.PEV/SSP/ME		Zaire
1989	Formation en gestion chaine froid	2	Charge logis. PEV/SSP		Abidjan
MAY 1989	Formation gestion des prog LMD zone francophone/pour A.T.	2	Coord CCCD Assist techn		Abidjan
DEC 89	Formation formateurs strategies promouvoir educ.sante/kindia Telemele	15	Centres sante	2	Conakry
JAN 90	Recyclage agents Cky sur chaine de froid	6	agents C.Ste	1	Conakry

FEV 90	Formation agents Ste en EPS/PEV	120	Agents C.S. Conakry	4	Conakry
MARS 90	Formation agents Ste en EPS/PEV	90	Agents C.S. kindia/Telem.	6	Telemele Kindia
MARS 90	Formation en informat. statistiques	?	Agents BEPR	2	Conakry
JUIN 90	Formation/chimio- resistance palu	4	Agents C.S. Conakry	3	Conakry
JUILLET 90	Formation/chimio- resistance palustre	4	Agents C.S. Conakry	3	Conakry
AOUT 90	Formation formateurs EPS/pour encadrement des comites de sante	6	V. Corps Px Superviseurs Kindia/Telem.	3	Telemele
AOUT/SEPT90	Formation en informatique	2	A. Admin/CCCD Direct.BEPR		Zaire
SEPT/OCT 90	Formation EPS applique LMD	4	Coord LMD R.EPS CCCD V. Corps Px. Chef Promo Sante		Zaire
DEC 90	Formation Tech.enque couvert. vacc.	32	Agents C.S. Conakry	12	Conakry

EDUCATION POUR LA SANTE/Annexe B-2

PROGRES ACCOMPLIS PAR RAPPORT AUX ACTIVITES RECOMMANDEES
PAR L'AMENDEMENT DU PROJET 1988

NO Activites recommandees en 1988

1. Organiser les campagnes de mobilisation sociale pour encourager les meres a frequenter les seances de vaccination;

Resultats: deux campagnes de masse organisees en 1986/1990 par le Programme National PEV/SSP

- visite a domicile dans les quartiers de Ckry
- Strategie avancee en milieu rural a Kindia et Telemele;

2. Developper des messages educatifs concernant le traitement du paludisme domicile insistant sur l'utilisation precoce de la chloroquine;

Resultats:

- 1 affiche "arbre de decision" sur le Palu = en voie de realisation
- 1 affiche sur "traitement du paludisme sont en phase finale de confection;

3. Developper des messages educatifs destines a corriger par la faible utilisation de les pour les enfants diarrheiques.

Resultats:

- confection de spots radiophonique ecoute dans 8 Prefectures pour ===
- confection et diffusion d'1 affiche sur la prise en charge d'1 enfant diarrheique et d'1 affiche sur les signes de deshydratation;
- confection et diffusion de dépliants pour les meres.

4. Equipement du service d'Ed/Ste par le Projet PDSS Banque Mondiale et augmentation du de Mondiale et augmentation du personnel de 3 a 10;

Renovation de la Division de Promotion la sante
construction d'1 batiment abritant la section Educ/Ste et equipement mobilier par Projet PDSS
complement d'equipement mobilier et audiovisuel par Projet CCCD
augmentation du pers. de 3 a 7

5. Conduire des enquetes terrain qui puissent fournir des informations utiles a la confection de messages educatifs appropries ;

Resultats: 6 enquetes ont ete de realisees dont :

- l'enquete de base 1986
- Gordon et Al en 1988
- Vodonou en 1988
- Glick en 1988
- Cutts en 1988
- " en 1989

6. Fournir un appui pour la formation formateurs en Ed/Ste Formation resp EPS pour CCCD et resp PEV/Prog. Nat EPS/PEV
 - Formation resp Div. Promotion Ste,

.. ..
Resp EPS/CCCD,
V. Corps PX.
Coord.LMD en EPS/LMD
Formation 17 formateurs Ckry/Kindia/Telemele
■ Formation 210 pers. de sante en Ed/Ste

7. Developper du materiel didactique pour education pour la sante

Resultats: ont ete elaborees et diffusees 5 affiches dont 2 sur PEV 2 sur Palu, 1 sur LMD, 1 depliant sur TRO, des aides memoires sur Ed/Ste applique sur 3 interventions du Projet

8. Conduire la recherche operationnelle

Resultats: 1 enquete en Mars 1990 faite par le Coord LMD sur habitudes de prescription de pers. de Ste sur impact des messages educatifs/LMD sur les meres mesurer impact EPS/LMD

9. Developper une strategie d'education pour la sante

Resultats: Realisee apres assistance de Vodonou 1988 mais applique seulement avec plan d'action EPS/PEV 1990 plan d'action EPS/LMD 1991 en instance de financement Plan d'action EPS/PALU non encore connu.

EDUCATION POUR LA SANTE ANNEXE B-3
 LISTE DES MATERIELS DIDACTIQUES KPRODUITS PAR
 LA SECTION EPS EM COLLABORATION AVEC LE PROJET CCCD

MATERIEL DIDACTIQUE	NBRE	AUDIENCE CIBLE	PARTENAIRES
1. Affiche intitulé "maladies du PEV"	-- --	Personnel Santé	en collaboration avec UNICEF
2. Affichettes sur le PEV	-- --	Personnel Santé	en collabor. avec UNICEF
3. Affichettes sur la TRO intitulé "donner à boire et à manger"	-- --	Personnel Santé	UNICEF et ECNOMECE
4. Dépliants sur la préparation de la SRO	10,000	Mères	
5. Affiche sur "Arbre de décision" pour traitement Palu	314	Personnel Santé	
6. Affiche sur traite ment du Palu avec chloroquine	1,000	Personnel Santé	
7. Aide mémoire PEV LMD/LAP	1,500	Personnel Santé	
8. Guide d'utilisat. de l'affiche TRO	--	Personnel Santé	
9. Guide de préparat. des sachets SRO	--	Personnel Santé	
10. Fiches d'observat. de pratique PEV/ LMD/LAP	--	Personnel Santé	
11. Guide de contrôle d'1 session EPS	--	Personnel Santé	
12. Guide pour la conduite de causeries éducatives	--	Personnel Santé	
13. Guide pour l'entretien individuel et la démonstration	--	Personnel Santé	

APPENDIX C

Appendix C-1

CHRONOLOGY OF ACTIVITIES

April Activity

Su 14 Travel and arrival of JP Heldt and A. Lo in Washington

Mo 15 Team planning meeting (see agenda)

Tu 16 Team planning meeting - cont'd (see agenda)

We 17 Team planning meeting - cont'd (see agenda)

Th 18 Team planning meeting - cont'd (see agenda)

Fr 19 Team planning meeting - cont'd (see agenda)

Sa 20 Travel: JP Heldt and A Lô depart from National Airport

Su 21 Travel - Cont'd

Mo 22 Travel - Cont'd:

Kelly arrives AM and makes first contacts

Heldt and Lo arrive in Conakry at night

Tu 23 Meeting with Michael Blake/USAID (as a team)

Meeting with CCCD project staff (as a team)

UNICEF (JP Lamarque) (as a team)

MOPH: Dr Koumandian Doumbouya, Directeur de Cabinet (as a team)

Team planning meeting

We 24 Briefing by USAID (as a team)

1st round of interviews with CCCD project staff, (as a team and individually)

Team planning meeting

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Th 25 Dr. Touré, directeur, Médecine Préventive (JPH/AL)

visit to Boulbinet Health Center (team)

Interviews with USAID staff (JPH)

Fr 26 World Health Organization (JPH, PGK)

Donka Hospital - National ORT Center (JPH, PGK)

Donka Hospital - Pediatric Department (JPH, PGK)

Mr. Joseph Destefano, World Bank (JPH)

Dr. M. Diaré, directeur, Ignace Deen Hospital (JPH)

2nd round of interview with CCCD project staff (JPH)

Dr. A. Dieng, Coordinator EPI (JPH)

Sa 27 Dr. A. Dieng, Coordinator EPI (PGK, AL)

Synthesis of first two weeks of evaluation (JPH/BT)

Su 28 team A drives to Téliélé (JPH, BT)

team B travels to Kindia (PGK, AL)

Mo 29 Dr. Amadou Baldé, DPS (JPH, BT)

Mr. Jamesédine Baldé, Préfect, (JPH, BT)

Visit to Sarikali Health Center (JPH, BT)

Visit to Téliélé Health Center (JPH, BT)

Visit to Téliélé Hospital (JPH, BT)

[Team B conducts interviews and visits in Kindia]

Tu 30 Visit Gougoudjé Health Center (JPH/BT)

Visit Sinta Health Center (JPH, BT)

Return to Conakry

[Team B conducts interviews and visits in Kindia]

May Activity

We 01 [Team B conducts interviews and visits in Kindia]

Synthesis of three weeks of evaluation (JPH)

Team B returns to Conakry

Th 02 Team meeting

Visit to EPI/SSP: cold chain

Dr. De Bethune, UNICEF

Mr. Koyaté, directeur, Ministère du Plan, rural affairs (JPH, BT)

Mr. Condé, Ministère des Finances, Directeur, Investment and budget

Mr. Kaba, Ministère à la Décentralisation (NA)

Interviews with USAID staff (JPH)

Fr 03 Team synthesis meeting

Sa 04 Writing of individual sections by team members

Su 04 Writing of individual sections by team members (cont'd)

Mo 04 Writing of individual sections by team members (cont'd)

Tu 07 Collecting and compiling of individual sections

USAID Mission (JPH)

European Economic Community - EEC (JPH)

We 08 Debriefing at USAID Mission (canceled at 10:35)

Th 09 Wrapping-up of evaluation activities;

Payments of support personnel; closing of team account;

Fr 10 Debriefing at Ministry of Health/Population (team)

Debriefing at USAID Mission (team)

Departure of team members from Conakry Airport.

Sa 11 Arrival of team leader in Washington DC

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Su 12 Preparation for debriefing at AID/Washington

Mo 13 Preparation of documents for debriefing

Debriefing

Tu 14 Meeting with Scott McKeown, Technical Officer

Meeting at ARC Headquarters in Reston

We 15 Final meeting with A. Jones

Departure of team leader via National Airport.

Th 16 Translation of French section into English (by professional translator)

Fr 17 Editing of rough draft for style and substance

to Integrating of notes & comments from various sources

Fr 24 Production of final report

Fr 24 Submission of final report via Federal Express

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- Supervisor Conakry IMr. Saïkou Diallo1986 - date
- Conakry IIMr. Kassia Tolno
- Conakry IIIMr. Souleymane Souaré
- TéliméléMr. Mamadouba Cissé, Health educator
- KindiaMr. Mohammed Diallo, Health educator
- Mr. Mamadouba Touré, Health educator
- Mr. Amara Demba Camara, Health educator

- Health center - BoulbinetDr. Camille Soumah02/89 - date
- ORT centerDr. Mariama Hann 1986 - date
- SarikaliMr. Adama Sako06/87 - date
- TéliméléMr. Moussa Kourouma08/87 - date
- SintaMr. Ibrahima Souaré06/87 - date
- GougoudjéMr. Patrice Haba04/91 - date
- Kindia -----

E. CCCD Project

- CCCD coordinatorDr. Moussa Keita06/90 - date
- [Dr. Souleymane Diallo]03/86 - 1990
- [Dr. Fassou Haba]
- CCCD assistant coordinatorDr. Antoinette Hellal02/88 - date
- Administrative assistantMrs. Ilyassou Diaby Diallo ..12/87 - date
- AccountantMr. Oularé Kandas11/87 - date
- Supplies managerMr. Ibrahima Camara06/90 - date
- 2 secretaries
- 5 driversMr. Augustin Camara

F. Health Centers

- Préfecture de Conakry I-II-III22 Health centers (5)
- Préfecture de Kindia12 Health centers (5)
- Préfecture de Télimélé14 Health centers (5)
-
- 48 Health centers (15)*

(*) # of centers that are integrated into PEV/SSP as of 5/91.

APPENDIX D

GUINEA EVALUATION WORKPLAN

Briefing by AID, A.R.C.

Team meeting: distribution of tasks

=====
I. REVIEW OF BACKGROUND INFORMATION
=====

- Proposal
 Detailed Implementation Plan
 First Annual Report
 Mid-Term Evaluation Report
 Scope of work
 Memos

- _____

=====
II. SUMMARY OF ON-SITE ACTIVITIES
=====

A. Contact and interview all the people listed: group vs. individually +++

- USAID officials
 Gouvernement officials
 Project staff
 Representatives for other NGO's
 Community representatives

- _____

B. Inspect project sites: Evaluation by observation

- infrastructure: number, size, location, cleanliness, furniture
 activities: number, nature
 examination of written records: completeness, accuracy

- _____

C. Keep detailed record of:

- Activities in chronological sequence: day-by-day
- List of people seen or contacted (ask for business card)
- Information and suggestions for final report
- Any information pertinent to project activities:
 - report(s)
 - training materials developed
 - forms used
- List/directory of organizations/NGO
- _____
- _____

D. In-country debriefing: AID, MOH, project

E. Prepare tentative report

F. Washington debriefing: Atlantic Resources Corporation, AID,

G. Prepare and submit final report

Worksheets prepared for this evaluation

- Form for recording team activities
- Checklist of people to be interviewed
- Distribution of team members responsibilities
- Worksheet for monitoring project progress at critical stages
- Worksheet for assessing project sites
- Worksheet for assessing educational activities
- Worksheet for assessing employment history & educational background
- Interview form - NGO
- Summary of external network and local resources
- Worksheet for assessing staff competence
- Worksheet for assessing staffing and training needs
- Worksheet for brain-storming and problem-solving
- Evaluation checklist

CHRONOLOGY OF ACTIVITIES

April Activity

Travel

=====
III. LIST OF PEOPLE TO INTERVIEW
=====

A. AGENCIES DIRECTLY INVOLVED IN PROJECT UNDER CONSIDERATION

- Gouvernement officials Minister of Health
 Deputy-Minister of Health

- USAID officials: USAID/Washington
 Mission Director
 Deputy-director
 Health officer

- Implementing agency: country director
 deputy-director
 project director
 Coordinator

- Community leaders
 teachers
 bankers
 businessmen
 patients - clients particularly women
 community health workers - "agents de santé"
 Other

B. AGENCIES INDIRECTLY OR NOT INVOLVED IN PROJECT UNDER CONSIDERATION

IGO's

OTHER PVO's (as appropriate)

- | | |
|--|--|
| <input type="checkbox"/> UNICEF..... | <input type="checkbox"/> GTZ |
| <input type="checkbox"/> U.N.D.P..... | <input type="checkbox"/> Peace Corps |
| <input type="checkbox"/> World Bank..... | <input type="checkbox"/> Save the Child/US |
| <input type="checkbox"/> W.H.O..... | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
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| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

C. INDIVIDUALS INVOLVED OR NOT INVOLVED IN PROJECT UNDER CONSIDERATION

- | | |
|--------------------------------|--------------------------------|
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

Agency for International Development
Washington, D.C. 20523

MEMORANDUM

July 25, 1991

TO: Allen Jones, ARC

FROM: Glenn L. Post, M.D., ACSI-CCCD Project Officer 

SUBJECT: ACSI-CCCD Project--Guinea
Final Evaluation Report (Draft)

I have reviewed the subject draft and find it to be a thoughtful analysis and, in general, an excellent report. Given the various difficulties faced by the team, their work is all the more commendable. As reflected in the attached cable (Conakry 03524), the mission also was satisfied. The mission's comments are useful and you should consider these carefully as you finalize the document. Similarly, you should review CDC's comments (attached), which arrived this morning. Finally, there are a number of points that I feel you should take into consideration.

There are a great many recommendations throughout the report, many more than any of the partners could focus on. The team needs to cull the most important of these and identify them, preferably in or attached to the executive summary. Our experience indicates that these should be limited to a dozen or so.

Regarding pages 1-4, the tables (I.1 and I.2) could be put into an appendix, but the information should be summarized in the text, including any comments and interpretation of the data. Like the mission, I wonder why some of the available 1990 data was not used here and elsewhere (e.g., page 12, paragraph 2).

The team considers the Guinea public health strategy to be a "model" for West Africa (p. vii, para 5), but the results as documented do not appear to justify this tribute. Similarly the team regards health education as "one of the most dynamic and active components" and points to "dramatic changes . . . at all levels" (p. 25, para 1). I think this too is overdone. As shown in pages 25-28, there have been some organizational changes, plans, and activities carried out, but the evidence for impact is weak.

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Additional specific points or comments are as follows:

title page--ACSI-CCCD not ACSI/ACSI-CCCD

p. iv--ACSI=Africa Child Survival Initiative
EPI=Expanded Program on Immunization

p. vii, para 3--Centers

p. 2, Table I.3--Apparent increases in inpatient diarrhea mortality and in measles morbidity deserve some comment.

p. 3, Table I.3--Apparent sharp decrease in effective diarrhea management at health centers deserves comment or explanation.

p. 8, para 1--Suggest you delete the vague "Everything needed to be done."

p. 9, para 2--ACSI-II is no longer being planned. As currently conceived, the new regional project will indeed encompass all the areas/problems mentioned (and more) but will be limited to analysis or research studies. There will be no service delivery component.

p. 9, last line--"it" not "if"

p. 10, para 2, line 3--Should note that the table and figure are in Appendix A.

p. 13, para 4--the 1989 what?

p. 17, para 1--The meaning of the symbols should appear directly on Table 2 rather than in the text.

p. 21, final 4 lines--Not sure I understand, does it mean that the team found at least two persons trained in ORT and five in EPI at each health center? Also, it would probably be better to use "ORT" unit rather than "SRO" unit in the English version. See also p. 26, first bullet and p. 27, para 4 for other examples of "SRO" rather than "ORS" or "ORT."

p. 25, para 4--Do they really need a public health physician to run audio-visual production?

p. 27, para 3, lines 8-9--This is less definite than stated, more in the nature of a possible explanation or conjecture.

- p. 27, para 4, lines 1-3--It does not seem valid to compare (and cite as "an important change") the difference between the 11 percent of children receiving ORT and the 60 percent of mothers having access to ORT.
- p. 33--Comparing the lesson learned with the first recommendation, I wonder if the training would be sufficient in the absence of effective management systems. Also the recommendation is too broad; could it not be focused and prioritized?
- p. 36, para 1--"regionally" not "centrally" funded. Since the project is funded by the Bureau for Africa rather than the central Bureau for Science and Technology (S&T), the funding is considered regional. This distinction also applies to p. 37, second last line and p. 41, para 4, line 3.
- p. 36, para 2--I believe the calculation is in error since it assumes a one-person mission. Moreover, health projects in general--and ACSI-CCCD in particular, with its somewhat complicated regional structure and heavy cable traffic--are relatively more management-intensive than other mission programs.
- p. 38, para 1--Suggest "not only the amount of funds"
- p. 42. first bullet--As far as I know there were no bilateral funds contributed to the Guinea project. Perhaps the "bilateral funds" refer to regional funds obligated (in-country) under the limited scope grant agreement.

ACTION
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AGENCY FOR INT'L DEV.
TELECOMMUNICATIONS CENTER

INCOMING
TELEGRAM

PAGE 01 CONAKR 03524 051420Z 3375 064763 AID8414 CONAKR 03524 051420Z 3375 064763 AID8414
ACTION AID-00

ACTION OFFICE AFTR-05
INFO AFW-03 PAUL-01 AFRD-04 SAST-01 ES-01 STHE-04 STPO-01
AMAD-01 AAAF-03 /024 AB 05/1423Z

INFO LOG-00 AF-00 CIAE-00 DODE-00 EB-00 /003W
-----79F933 051421Z /38

R 051414Z JUL 91
FM AMEMBASSY CONAKRY
TO SECSTATE WASHDC 7192

UNCLAS CONAKRY 03524

AIDAC

AID/W FOR AFR/TR/HPN (GLENN POST)

EO 12356: N/A
SUBJECT: PROJECT CCCD: FINAL EXTERNAL EVALUATION
- REPORT

1. PLEASE BE ADVISED THAT MISSION WAS PLEASED WITH
OVERALL FORMAT AND CONTENT OF SUBJECT EVALUATION DRAFT
REPORT AND PROVIDES THE FOLLOWING COMMENTS:

- A. VACCINATION COVERAGE: WHY WASN'T MORE USE
MADE OF TECHNICAL OFFICER'S 1990 ANNUAL REPORT WHICH
DOCUMENTED 1990 DATA ('89 DATA IS USED IN FINAL
EVALUATION)? COULD TO'S REPORT BE INCORPORATED INTO
AN ANNEX?

- B. CDD (PG. 13, PARA 4): A DEFINITION OF QUOTE
CORRECT TREATMENT UNQUOTE EXISTS WITHIN THE RECENTLY

RATIFIED NATIONAL CDD POLICY. THIS POLICY, OFFICIALLY
ACCEPTED IN MARCH OF THIS YEAR, IS LARGELY BASED ON
RESULTS/RECOMMENDATIONS FROM PROJECT'S CDD COMPONENT.

- C. SUPERVISION (PG. 23, PARA 2): CONAKRY
SUPERVISORS CERTAINLY CONDUCT MANAGEMENT ACTIVITIES
BUT THEY ARE ALSO EXTENSIVELY IMPLICATED IN VARIOUS
TRAINING EXERCISES INCLUDING, PROPER USE OF COLD
CHAIN, EPI AND HEALTH EDUCATION/COMMUNICATION
TECHNIQUES.

- D. TABLE IV (PG. 37): AMOUNTS ARE CORRECT, BUT
DATES SHOULD READ 11/3/89-3/25/91.

- E. ANNEX: REPORT WOULD BE MORE COHESIVE IF ONE
LANGUAGE IS USED (ANNEX IS IN FRENCH).

- F. NATIONAL PLAN VS. PROJECT CENTERS: REPORT IS
NOT CLEAR DISTINGUISHING BETWEEN ESSENTIALLY THREE
TYPES OF CENTERS: PROJECT, PROJECT PLUS NATIONAL
PLAN, AND NATIONAL PLAN. ALL HEALTH CENTERS IN THE
CCCD ZONE HAVE BENEFITTED FROM PROJECT INPUTS.
FIFTEEN HAVE SINCE BEEN INCORPORATED INTO THE NATIONAL
PLAN. THE EVALUATION TEAM COMPARED THESE TWO TYPES OF
HEALTH CENTERS. WHAT WOULD HAVE BEEN MORE INTERESTING
TO COMPARE IS THE DIFFERENCE BETWEEN CCCD PLUS
NATIONAL PLAN CENTERS AND ONLY NATIONAL PLAN CENTERS
(THOSE FOUND OUTSIDE OF CCCD ZONE). TECHNICAL
OFFICER'S ANNUAL REPORT MAKES SOME OF THESE
COMPARISONS.

2. MISSION HOPES THAT AFR/TR/HPN FINDS THESE COMMENTS

USEFUL.
SMITH.

UNCLASSIFIED

JUL 8 1991

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July 25, 1991

Dr. Glen Post
AFR/TR

Dear Glen:

Attached please find our comments on the Guinea evaluation. Thanks for giving IHPO the opportunity to make comments. The following are the joint observations of IHPO staff who have studied the draft report: myself, Kevin Murphy, and Stan Foster.

Please feel free to contact either or all of us for further clarification or commentary.

Best regards,

Jean

(Jean Roy)

INHO Comments: Final Evaluation Report: ACSI-CCCD Guinea Project

Authors should be commended for a fair and well balanced report on the Guinea project. The report's components are succinct, sufficiently informative in terms of data and project structure, and present a good status report on achievements and constraints to date.

As described in the Executive Summary, encouraging progress and achievement was noted in the areas of immunization, HIS, training (peripheral level), health education, and in expansion of PHC. We agree that difficulties occurred in the areas of CDD and malaria although impressive technical and training achievements occurred in the implementation of these interventions. Clearly the area of operational research was difficult to implement for all the reasons cited in the report.

The sections "Findings", "Lessons Learned", and "Recommendations" are very useful information for the mission, CCCD, and for the Ministry of Health. It is not clear, however, to whom the recommendations are directed. It would be helpful if the recommendations were grouped by target audience, i.e. MOH, CCCD, USAID. References to the "transition period" and the "follow-on project" are not clearly defined. Are we to understand that a transition period is envisaged between CCCD and the follow-on project. Recommendations with activities projected for October 1991 and 1992 are clearly outside the CCCD PACD of September 30, 1991. This should be further clarified.

Several recurrent themes are found throughout the report that merit mention and comment.

- A) need to integrate rapidly all CCCD-supported health centers;
- B) sufficiency of technical personnel at the MOH;
- C) lack of MOH leadership or counterparts for skill transfer;
- D) the contextual factors - difficult socioeconomic conditions, and poor infrastructure,
- E) lack of management and administrative support;

A. Integration of the remaining CCCD supported facilities is dependent on the rate of PHC expansion in the national MOH plans. The 15 CCCD centers already integrated into PHC fell within the planned scheduled phase-in. The remaining 33 cannot be absorbed until the governments criteria are met and the capacity for national support exists.

B) References are made on the one hand that sufficient personnel exists at the MOH (pg ix para. 3) but on the other hand several references allude to the lack of personnel (pg ix para. 4). This might result from the fact that while many technical personnel were trained by the project, many of these people have moved on

to other responsibilities. These statements and others throughout the report could be clarified.

C) Again statements indicate there has been sufficient MOH leadership and technical experts but other statements indicate lack of counterparts for continuity and follow-on activities. These are confusing statements. We acknowledge that lack of counterparts was a major factor in cancelling several CCCD technical consultancies; another factor was the lack of follow-up by MOH on recommendations of previous consultancies. Without these two elements, consultancies were indeed cancelled or deferred. Mobility in personnel management accounted in part for the lack of counterparts.

D) The report clearly states the realistic and difficult contextual factors in which the project operated. It recognizes achievements but appears demanding on issues of government ownership and sustainability. Government ownership was difficult to achieve in light of dependency on USAID for commodities, counterpart funds, and the short-lived project implementation period. Within this context, it would be reasonable to focus more on a single vertical approach (maybe CCCD was too ambitious in introducing multiple interventions) and to consider a lengthier project period. The report highlights wonderful achievements, describes what remains to be done, but leaves the reader wondering why the project needs to end.

E) The report leads one to believe that the CCCD technical officer and MOH project staff were expected to be familiar with USAID management and administrative procedures. But the report also indicates that USAID staff was very limited and could not provide adequate and timely support. It should be clarified that the CCCD technical officers in all countries depend on the efficiency of the USAID administrative and management structures for the success of the project. In Guinea, especially in the early years, the MOH and the project suffered setbacks and delays for lack of adequate support from USAID. Central CCCD funds were made available to hire a project administrator at USAID. This offer was not acted upon for over two years.

Lastly, the fact that an important amount of project bilateral funds remain unexpended at the end of project in such a needy country is difficult to understand. It is more difficult to understand the reasons for the cancellation of commodities previously ordered but which were scheduled for delivery beyond the PACD. It will be unfair to judge how well the MOH sustains previously CCCD supported activities if the project, during its lifetime, did not meet all its commitments.

Overall we are pleased with the report and its findings. We would all hope that a mechanism can be identified which will make good use of these findings and assure the application and implementation of the recommendations. So many of them are very good and should be pursued.

Again we commend the authors for tackling a challenging job and doing it well.

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