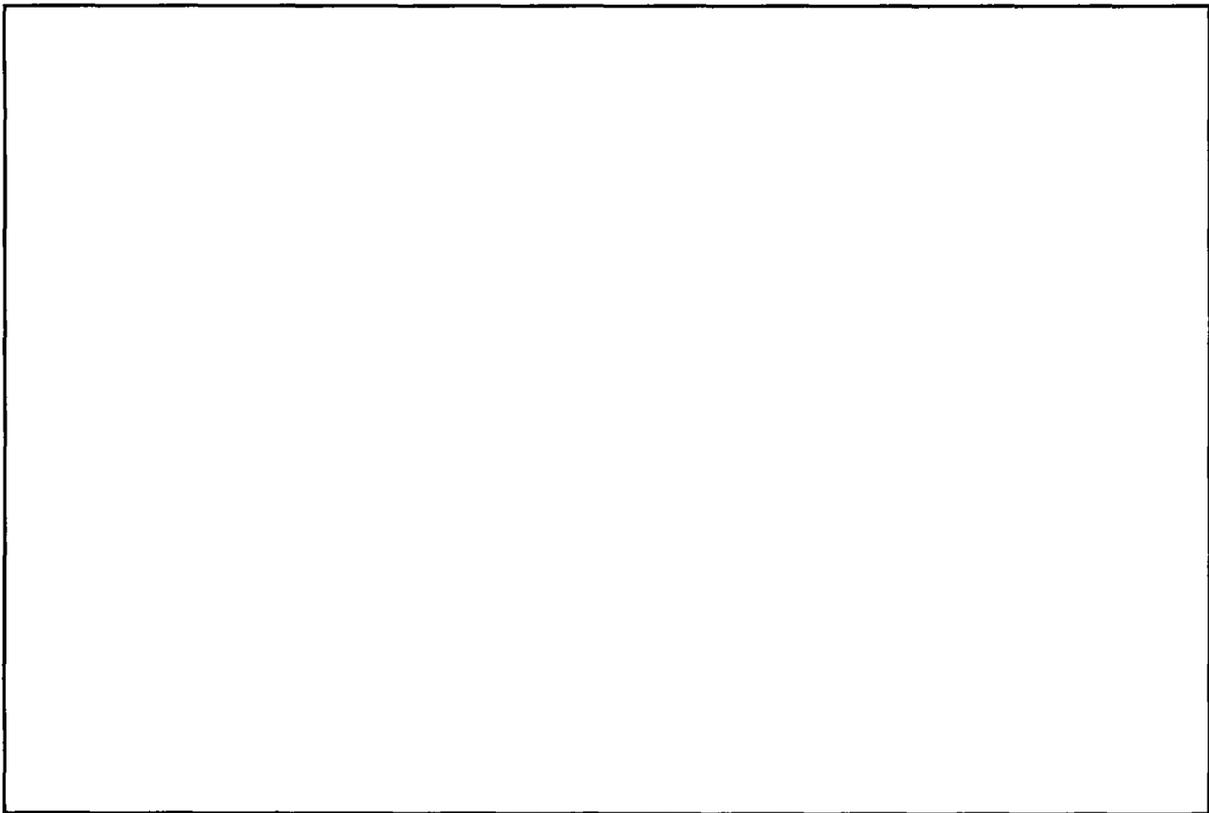


**DIORO CHILD SURVIVAL PROJECT**

**PHASE II**

**FINAL EVALUATION REPORT**



**AFRICARE/USAID/MALI**  
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## LIST OF ABBREVIATIONS

<b>AMPPF</b> .....	<i>Malian Family Planning Association</i>
<b>CBD</b> .....	<i>Community-Based Distribution (of Contraceptives)</i>
<b>CROCEPSS</b> .....	<i>Regional Committee for the Orientation, Design and Study of Health and Social Welfare Programs</i>
<i>c v c</i> .....	<i>Completely Vaccinated Child</i>
<b>DCSP</b> .....	<i>Dioro Child Survival Project</i>
<b>DIP</b> .....	<i>Detailed Implementation Plan</i>
<b>IFAD</b> .....	<i>International Fund for Agricultural Development</i>
<b>IGA</b> .....	<i>Income Generating Activities</i>
<b>IPC</b> .....	<i>Interpersonal Communication</i>
<b>KAP</b> .....	<i>Knowledge, Attitudes and Practices</i>
<b>LDC</b> .....	<i>Local Development Committee</i>
<b>MFPA</b> .....	<i>Malian Family Planning Association</i>
<b>MPA</b> .....	<i>Minimum Package of Activities</i>
<b>NGO</b> .....	<i>Non Governmental Organization</i>
<b>NHP</b> .....	<i>National Health Policy</i>
<b>PHC</b> .....	<i>Primary Health Care</i>
<b>RHPWP</b> .....	<i>Rural Health, Population and Water Project</i>
<b>SRO</b> .....	<i>Segou Rice Office</i>
<i>s s s</i> .....	<i>Sugar-Salt Solution</i>
<b>TBA</b> .....	<i>Traditional Birth Attendant</i>
<b>VHT</b> .....	<i>Village Health Team</i>

**WRA** ..... *Women of Reproductive Age*

## I. INTRODUCTION

**Africare** has implemented the Dioro Child Survival Project (**DCSP**) in the Dioro district (Segou region) since 1989. The project's goal is to reduce morbidity and mortality rates among children between 0 and 5 years of age and women of reproductive age (WRA). After a first phase which covered 30 villages and ended in 1992, the project received funds for a second phase of activities for a period of three years beginning in January 1993. This second phase was designed to enable the project to cover a total of 55 villages with a population of 5 1,000 people.

The main interventions of the DCSP are: immunization of children, nutrition and growth promotion, diarrheal disease control and oral rehydration, maternal health and family planning, and **AIDS/STD** prevention. The DCSP intervention strategies were designed to be implemented according to a program integrating maternal and child health components, with a special emphasis on women's empowerment in the areas of health and community participation.

The DCSP was only able to cover 37 villages, of which 23 "new" villages were selected during the second phase and 14 "old" villages were chosen among those covered during the first phase. The total beneficiary population for the project interventions is estimated to be 36,000 people. During the implementation of this second phase, the majority of efforts in community participation and in **IEC** were concentrated on the 23 new villages.

Two baseline studies were conducted prior to the start-up of Phase II of the DCSP. Given that the project was going to continue its activities in the villages from Phase I, the results of the final evaluation of this first phase, conducted in December 1992, provided a comparative data base for the villages to be covered during Phase II. In addition, the baseline data from the second phase were obtained through a Knowledge--Attitudes--Practices (RAP) Survey conducted in March 1993 in 23 newly selected villages. For this evaluation, the analysis of data collected during the KAP Survey conducted in April 1996 and completed by a qualitative study allows us to study the impact of the project components, the effectiveness of the intervention strategies and issues of sustainability.

\* *The DCSP was only able to cover 37 of the 55 villages initially foreseen due to delays in the implementation during the first year. The main constraints were administrative, such as changes in individuals occupying key positions at project management level and the modification of the Detailed Implementation Plan, and seasonal, in that the rainy season blocked the activities of the field agents new & installed in the villages at the beginning of Phase II.*

## II. METHODOLOGY

This evaluation was conducted using a participative approach at all levels. All of the different actors in the project---at the level of **Africare/Washington, Africare/Bamako**, the Regional Public Health Division, the Dioro management **staff** and the community health field agents---participated actively in the evaluation process.

Under the coordination of the Chief Evaluator, the main activities of the evaluation team consisted of providing all of the information necessary to organize and conduct the evaluation, selecting the villages for the qualitative survey, facilitating contacts with all of the project counterparts, making logistical arrangements, designing data collection instruments, and organizing a feed-back session with the Dioro Local Development Committee.

The means used to collect information to be used for the project evaluation included:

- ▶ intensive reading of main project documents;
- ▶ individual interviews conducted in Bamako: at Africare's national office, at the national office of the Child Survival NGO Pivot Group, at the **Malian** Family Planning Association (MFPA); in Segou: at the Regional Public Health Division and the Circle Public Health Division; and finally, in Dioro: with the project management, with the supervision team and with different collaborating agencies and counterparts;
- group interviews conducted in Dioro with all of the community health field agents and the village health teams, with mothers' groups and health committees opened up to including elders' committees in 14 villages covered by the project.

The choice of villages was initially accomplished through a random sample of 14 villages picked out of a list of 38 villages covered by the project. In order to accommodate the need to study both the factors contributing to the project's successes and failures at the village level, the evaluation team later decided to make a more premeditated choice by picking villages without problems as well as villages with problems. A discussion with the project supervisors and the Segou Regional Public Health Director permitted the evaluators to confirm that among the selected villages, 50% were judged to be "functional" and 50% were judged to be "dysfunctional", according to mutually agreed criteria. The criteria of whether a **village** was "functional" or not were defined according to the activity levels of the health committee and the village health team, and the degree of facility with which the project agents were able to implement activities in the village. At the time of the selection, if two villages chosen in a sector were both judged to be "functional", the next "dysfunctional" village on the list was selected.

The development of data collection tools for the qualitative research took into account aspects that had not been explored by the RAP Survey of April 1996, the level of knowledge about project activities by the beneficiaries and actors, the identification of project benefits, behavior changes among men and women, the performance of health committees and the village health teams, mothers' knowledge about specific interventions and finally, sustainability issues.

Focus group discussions conducted in 14 villages enabled the evaluation team to discuss the project with 462 people, classified as follows:

- ▶ 115 village health committee members, of which 32 were women (Although this represents 27.82% women members overall, it was noted that women actually represent 47% of health committee members in the Phase II villages surveyed.)
- ▶ 30 traditional birth attendants
- ▶ 18 male village health workers (*animateurs*)
- ▶ 11 female village health workers (*animatrices*)

- ▶ 277 mothers, or an average of 20 mothers per focus group

The qualitative study was carried out over five days and was conducted by the six members of the evaluation team divided into two groups. All of the sectors covered by the project were visited.

### III. ANALYSIS OF PROJECT RESULTS AND LESSONS LEARNED

#### A. PROJECT RESULTS

##### 1. Analysis of Project Results by Component

##### Vaccinations of Mothers and Children

Project Status at Start-Up	DIP Objectives	Results Obtained
14% of children completely vaccinated	At least 80% of 1000 children 0- 11 months of age will be vaccinated in 25 villages of Phase II	79.8% completely vaccinated children
1.6% of children vaccinated	Not defined	93.3% of children vaccinated
39% of mothers know that the tetanus toxoid vaccine (TTV) protects the mother and child	80% of mothers will know that TTV protects the mother and child	56.7% of mothers know that the TTV protects the mother and child
Not explored	80% of the 4700 mothers know the number of contacts necessary to completely immunize their child	Few mothers know the number of contacts necessary
Not explored	80% of mothers will know the dates, times and places of the vaccination clinics	100% of mothers know the dates, times and places of the vaccination clinics
Not explored	80% of 11000 women of reproductive age confirm that their husbands encouraged them to get TTV	Most women confirm that their husbands encouraged them to get TTV
Not explored	80% of mothers will confirm that their husbands encouraged them to get their children vaccinated	The majority of mothers confirm that their husbands encourage them to get their children vaccinated
42.5% of mothers know that vaccination prevents illnesses	Not defined	85.3% of mothers know that vaccination prevents illnesses.
23% of mothers know the age when a child should receive the first vaccination	Not defined	68.3% of mothers know the age when a child should receive the first vaccination

0.83% of mothers know the age when a child should be vaccinated against measles	Not defined	3 1.3% of mothers know the age when a child should be vaccinated against measles
25.8% of WRA have had at least two doses of tetanus toxoid vaccine	80% of 11000 WRA will receive at least two injections of TTV	59.8% of WRA have had at least two injections of TTV

In light of these results, it is clear that the vaccination coverage has improved significantly. This improvement is due to the regularity of the vaccination clinics at the village level, a better organization of the logistical support from the project office, a regular supply of vaccines from the Dioro Health Center, and an improvement in the scheduling of the vaccination clinics which involves the village health teams. The improvement of mothers' knowledge about the advantages of vaccination in preventing illnesses, the locations and dates of vaccination clinics, the ideal age of a child at the time of the first vaccination, and the importance of bringing children to the vaccination clinics were all obtained through innovative IEC strategies targeting women as well as men. These same strategies led men to adopt a more positive attitude toward the vaccination of their wives and children. It is interesting to note that although 2/3 of mothers know the ideal age of a child at the time of the first vaccination, only 1/3 of these women know the age that a child should be vaccinated against measles, and the large majority do not know that five contacts are necessary in order for a child to be completely vaccinated. This could explain the gap between the number of children vaccinated and the number of children completely vaccinated. The IEC channels used by the vaccination component include theater skits on video about the importance of preventive health and about the community organization of vaccination clinics, and the prize of a special local cloth (*pagne*) used by women to wrap babies on their backs. The cloth (*bamounan* in the local language) serves to motivate women and to transmit specific health messages.

Nevertheless, work remains to be done in the IEC component in order to inform women about the necessity of children making five visits to the vaccination clinics before they reach one year of age and in order to motivate women over the age of 15 years who are not pregnant to get the tetanus toxoid vaccine.

## Nutrition and Growth Promotion

<b>Project Status at Start-Up</b>	<b>DIP Objectives</b>	<b>Results Obtained</b>
85.9% of children are breastfed	Not defined	87.2% of children are breastfed
28.9% of children are exclusively breastfed for 4 to 6 months	At least 75% of 4,700 mothers with children under the age of 2 years exclusively breastfeed their children for 4 to 6 months	63.8% of mothers exclusively breastfeed their children for 4 to 6 months
20.4% of children are breastfed immediately after birth	Not defined	41.9% of children are breastfed immediately after birth
17% of mothers know 2 sources of vitamin A	50% of mothers know 2 sources of vitamin A	56.8% of mothers know 2 sources of vitamin A
1% of children weighed during the last 3 months	At least 65% of 7500 children between the ages of 0 and 3 years will be weighed during the last three months	83% of children weighed at least once a quarter
0.42% of children have a growth monitoring card	Not defined	92% of children have a growth monitoring card
Not explored	At least 60% of mothers with malnourished children will receive two visits from village health teams	83.2% of malnourished children received follow-up from the village health teams
Not explored	75% of 7500 mothers of children between the ages of 0 and 3 years will know appropriate weaning foods according to a child's age	100% of mothers' groups know the weaning foods
Not explored	50% of pregnant women receive nutrition counseling	100% of women's groups receive nutrition counseling

The DCSP's impact is more striking in the area of nutrition because, from a past situation where growth promotion was practically non-existent, the strategies used by the project have allowed this activity to become essential to communities. The number of children with a growth monitoring card and the number of children weighed each quarter, the knowledge and the practices of mothers regarding weaning at six months, the improvement in the practice of exclusive breastfeeding and finally the follow-up of malnourished children all attest to the project's impact. The nutrition rehabilitation strategy put in place by the DCSP has ensured nutritional follow-up at the village level by associating the village health teams (WITs). Both female and male members of the VHTs provide advice to mothers as well as fathers, and also give cooking demonstrations and conduct house calls. The use of "enlightened mothers" who are selected during educational talks as positive role models in their knowledge and behaviors concerning child survival, is also very beneficial for weaning practices and nutritional rehabilitation because this strategy promotes woman-to-woman teaching. In addition to these interventions, the IEC strategies targeting not only women but also men concerning the impact of good nutrition on

women’s and children’ health have clearly been effective for, during the quantitative study conducted in the villages, behavior change related to nutrition is evident in that men show a great deal of interest in following children’s growth and buy weaning foods and foods needed by pregnant women.

The **DCSP's** health information system, however, does not enable the project to follow the effectiveness of the nutritional rehabilitation strategy with the monthly data collection forms. These forms need to be modified to show the number of malnourished children having gained weight since the last weighing.

### Diarrheal Disease Control and Oral Rehydration

Project Status at Start-up	DIP Objectives	Results Obtained
53.5% prevalence of diarrhea	Reduction of prevalence of diarrhea by 25%	39.5% reduction
Not explored	41 of 50 villages covered by the project (75%) will have a potable water source	52 potable water sources constructed in 37 villages
8% of mothers correctly prepare SSS	The mothers of at least 60% of children 0-3 years correctly prepare SSS	65.3% of mothers correctly prepare SSS
0.78% of mothers give SSS in case of diarrhea	The mothers of at least 60% of children between the ages of 0 and 3 years give SSS in case of diarrhea	42.5% of mothers give SSS
81% of mothers breast feed during an episode of diarrhea	The mothers of at least 60% of children 0-2 years old will increase breastfeeding, liquids and foods during an episode of diarrhea	83.9% of mothers breastfeed during an episode of diarrhea
50% of mothers give liquids during an episode of diarrhea	“ ” “ ” “ ”	57.3% give liquids during an episode of diarrhea
23% of mothers give solid foods during an episode of diarrhea	“ ” “ ” “ ”	38.1% of mothers give solid foods during an episode of diarrhea
32% of mothers give antibiotics or other medicines during an episode of diarrhea	reduce from 32% to 15% the number of mothers giving antibiotics or other medicines during an episode of diarrhea	reduction from 32% to 25% the % of mothers giving antibiotics or other medicines during an episode of diarrhea

The reduction of the prevalence of diarrhea is linked to the impact of multi-media education, including showing video cassettes produced by the DCSP (*The Dirty Neighbor* and *The Right Solution*), carried out by the village health workers supported by the **Aficare** field agents, as well as to the community management of well water purification, and the improvement in personal and community hygiene. The improvement in mothers’ knowledge and practices during diarrhea

episodes and the diffusion of traditional recipes proven to be effective for oral rehydration have contributed to increase these impact indicators for diarrheal disease control. Once again, the role of the village health team (traditional birth attendants, women and men village health workers), supported by “enlightened mothers” (role model mothers), was a deciding factor in diarrheal disease control. The dynamism observed at the village level around well water purification and the absence of cholera cases in the villages covered by the project during the cholera epidemic during the last quarter of 1995 in the Dioro district attest to the effectiveness of these village health teams. The evaluators noted the high level of satisfaction of the communities concerning the 19 wells constructed by the DCSP, bringing the total number of water sources to 116 in the villages covered by the project. 52 (45%) of these water sources are potable water sources.

### Maternal Health and Family Planning

<b>Project Status at Start-up</b>	<b>DIP Objective8</b>	<b>Results Obtained</b>
3.7% of women of reproductive age (WRA) have a health card	At least 80% of 11,000 WRA will have a health card	64.8% of WRA have a health card
25.5% of WRA have received at least 2 doses of tetanus toxoid vaccine (TTV)	At least 80% of 11,000 WRA have received at least 2 doses of TTV	59.8% of WRA have received at least 2 doses of TTV
Not explored	60% of mothers having given birth during the last year will have received at least one prenatal wnsultation	83.3% of mothers have received at least one prenatal consultation
Not explored	60% of mothers having given birth during the last year will have been assisted by a trained birth attendant	79.1% of mothers having given birth during the last year were assisted by a trained birth attendant
18% of WRA know family planning methods	80% of 11,000 WRA will have heard about family planning methods	86% have heard about family planning methods
Not explored	Atleast 10% of WRA will use a family planning method	24.6% of WRA use a family planning method
30% of women know the advantages of family planning for the health of the mother and the child	Not & fined	88% of women know the advantages of family planning for the health Of the mother and the child
Not explored	SO% of WRA will have discussed maternal health and/or family planning with their husbands	55.6% of WRA have discussed maternal health and/or family planning with their husbands

method, and finally, the number of women who communicate with their husbands about maternal health and family planning. As a result, women’s workloads, particularly the difficult task of

carrying wood for the household cooking, have been lightened, women eat better and also receive more attention **from** their husbands during pregnancy. The factors that contributed to producing this impact are essentially the training and refresher courses for the traditional birth attendants, providing them with equipment and promoting public recognition, as well as the regularity of supervision by the **Africare** field agents. The improvement in couple communication was achieved through an exclusive approach of the DCSP which, through operational research, explored problems linked to couple communication, and produced specific messages as well as appropriate media and channels to diffuse them. It is thus that a video cassette was produced about family communication about pregnancy and shown in villages, and a communication campaign targeting husbands was launched in 1994 to help women communicate about their pregnancies through the use of a non verbal message, the little **green pagne** (traditional cloth), whose meaning is sung by local griots (traditional singers) and listened to by the target groups.

### **AIDS/STDs Prevention**

<b>Project Status at Start-up</b>	<b>DIP Objective8</b>	<b>Results Obtained</b>
90% of the population has heard about AIDS	Not defined	95.7% of the population has heard about AIDS
<b>Modes</b> of transmission were not studied	Not defined	93.2% identify sexual relations
Knowledge of the means of prevention were not studied	Not defined	58.6% <b>identify</b> abstinence and faithfulness; 6 1% identify the use of a condom

Although the **AIDS/STD** prevention component was added to the initial DCSP proposal, with activities starting later (1995), it is nevertheless now as active as the other project components. Baseline data for this component was not collected during the 1993 KAP Survey but data **from** other regional and local sources estimate that 5% of the population in the Segou region is seropositive and that 55% of prostitutes are seropositive. In addition, 90% of adults in the Dioro district have heard about AIDS. Reliable data concerning the modes of transmission and the means of prevention were not available.

The DCSP has limited its interventions in **STD/AIDS** to prevention and essentially targets youth of both genders. An operational research study conducted by the DCSP **staff** in September 1995 enabled them to design an IEC strategy adapted to the needs of adolescents. Today, 18 young male and female peer counselors are working in all of the villages covered by the project, using an audio cassette to tell an educational traditional story, a theater play by adolescent students, a traditional song sung by adolescents and griots (traditional singers), and finally, a theater play by village children about sexually transmitted diseases and AIDS. Although they are not the priority target group, mothers **have** also benefitted by these awareness raising activities, for 28.5% of them cite the youth peer counselors as their sources of information, It only remains for the strategy to include other members of the community- parents as well as traditional and religious leaders- for their combined actions can collectively have a much greater influence on the factors

leading to the spread of STD and AIDS.

**DCSP impact was obtained through a strategy combining (1) a community approach promoting** an active participation of all parts of the community of men and women, (2) an involvement of women in all decisions concerning their health and that of their children, (3) an awareness-raising of men to lead them to support women for their better health and that of their children, (4) an *IEC* strategy **perfectly** adapted to the socio-cultural context.

The community approach has succeeded through awareness-raising campaigns conducted in the villages which followed a workshop-like model that made the communities reflect upon mother and child health problems, possible solutions, and the role of every community member in taking responsibility for health. The project slogan “KONO KULU DE BE BII FO,” or “a flock of birds that flies together make more noise than a single bird flying alone” was born during these days of awareness-raising in the villages. This activity was followed up with periodic feedback to the villages about the results of different activities that had been held. This feedback information was provided by the Afiicare field agents and discussed by the villages, a process which permitted the latter to participate in decision-making concerning their own health.

The involvement of women in decisions concerning their health and that of their children was also born during these awareness-raising days where men, after thinking over the role of women in child survival, recognized that their active participation was absolutely necessary for the success of any child survival project. It is remarkable to note that the training approach adopted by the **DCSP staff allowed a conscientization of men and women about how to handle child survival** problems and yet at the same time preserved social equilibrium. Today women are conscious of participating more fully in the improvement of their health and that of their children.

The awareness-raising of men to bring them around to supporting their women for their health and that of their children began during these awareness-raising days and was followed up by daily educational activities held by the village health workers on pregnancy, nutrition, family planning, STD/AIDS, etc.

**The innovative IEC strategy has demonstrated a strong commitment to adapt to the socio-cultural** context in which the project worked. Through systematic operational research directed towards the solution of problems and obstacles constituting a barrier to the correct implementation of the project components, the IEC strategies used by the DCSP allowed the project to produce an impressive array of material designed to promote attitude and behavior changes which are beneficial to maternal health and child survival. The IEC strategy created and consolidated the development of a solid base of skills within the project staff and reinforced the skills of local human resources within the community, specifically, the village health teams, griots, traditional story tellers and dancing marionettes. At this time, the DCSP has produced six video cassettes, five audio cassettes, three theater plays and other communication media such as *pagnes* (traditional cloths), stickers and brochures. (See in the appendices the list of IEC materials produced by the DCSP). The impact of the DCSP IEC strategy has gone beyond what was required in the project and has raised interest and demand from other **NGOs** and donors at both

the local and national levels. Some of the project's video cassettes have been shown on **Malian** national television and have generated interest and raised awareness from all sides. The principal collaborators of the DCSP in the area of **IEC** have been the Child Survival NGO Pivot Group, the CNIECS (National Center for Information, Education and Communication for Health) and UNICEF.

## 2. **Unexpected Positive and Negative Outcomes of the Project**

### a. **Positive Outcomes**

- (1) Social changes caused by the social mobilization and education activities conducted by the **Aficare** field agents and the village health teams, particularly the village health workers. These changes are essentially the reduction of pregnant women's workload through men taking over the chore of carrying heavy wood for household cooking, and the greater participation of men in assuring better nutrition for pregnant women and children. The improvement of couple communication has brought men and women closer together, in terms of supporting each other, and has led to the beneficial effects targeted by the project in the area of increased responsibility for the health of mothers and children. Among the social changes in progress revealed during the quantitative survey are women being brought closer together in terms of solidarity and in exchanging information between themselves.
- (2) The communities living in the project area are in general now convinced about the impact of hygiene on diarrhea control. The 1995 cholera epidemic, which did not take a single victim in the project area, helped convince populations of the importance of the individual and community hygiene conditions the project had helped the villages meet, particularly the purification of well water.
- (3) The impact of the annual and sector-level health days created as effects: an improved visibility of the project, a good reputation, and increased support **from** collaborators and counterparts in terms of human, material and financial resources at both the local and national levels. Other effects were that the health days created a better sense of responsibility within the general population and improved health knowledge, attitudes and practices. For example, 5.7% of mothers affirm that they were informed about AIDS during these health days.
- (4) The ability of a small team trained with very limited resources to produce in a short time at a local level **IEC** materials that large bilateral projects are often unable to produce with expatriate experts. Today, the material produced by this little team is being used at the national level by much larger projects and even by the national television. Because of its IEC strategy, the DCSP has become a point of reference and a site of attraction in the area of community-oriented strategies for child survival.
- (5) The recognition and support of the traditional role of the ***griot*** as a health educator and

the use of traditional marionettes as a strategic way of gaining the interest of all members of the communities, including the elders, in all of the project's messages. The Health Day organized by the DCSP staff in May 1994 produced greater results than a full year of health education activities.

- (6) The strengthening of project impact through men's behavior change as a result of the decision to transform the role of male village health workers into one of counselors for men on maternal child and health problems.
- (7) The perception at the regional level of the experience of Dioro as the solution to certain problems typically encountered during the implementation of the National Health Policy, specifically, problems in developing a community approach, in achieving full community participation and in improving the quality of preventive health services at the village level.
- (8) Recognition and appreciation by the population and the administrative and health authorities at the regional and national levels of the DCSP's active participation in efforts to eradicate successive epidemics in the Dioro district.

**b. Negative Outcomes**

- (1) Delays in the implementation of the project at the time of the start-up, due to changes in coordinators in Dioro as well as in Africa&Washington, to changes in project officers for the different components, to the revisions made to the Detailed Implementation Plan, and to seasonal constraints caused by the rainy season. Clearly one of the most important consequences of these delays is that the project was not able to cover the 55 villages foreseen, and this was worsened by the fact that 30 of these villages are old villages previously covered during Phase I of the project which had not yet reached the level of sustainability necessary to allow the Africare field agents to relocate their posts.
- (2) Delays and interruptions in the vaccination activities, particularly during 1994, due to the meningitis and cholera epidemics for which the human and material resources of the project were used full time in the effort to eradicate the epidemics.
- (3) Reduction of the government counterparts' involvement in the project due to a change in USAID's per diem policy which forbids the payment of per diem, honorariums or transport costs to host country national working at the local level. This policy considerably effected the counterparts involvement in activities requiring their travel to the villages. The proofis that, of five counterparts who had actively participated in the project's awareness-raising campaigns, only one participated in the last campaign after the announcement of the new policy.

**3. Results of the Final KAP Survey**

This survey was conducted in April 1996 by an expert firm in collaboration with the DCSP staff

It was conducted in 25 of 37 villages of the project (67.56%) and with a sample size of 400 mothers having at least one child who was less than 2 years old. The survey was carried out both in Phase I and Phase II villages and the results comparing the two kinds of villages clearly underlines the positive impact of the new community approach and the new IEC strategies adopted in the Phase II villages on the level of mothers' knowledge and behavior change. (See KAP Survey results in the ).

## **B. PROJECT EXPENSES**

A detailed pipeline analysis of the project is attached to this document, but it can be clearly stated in this section that the budget planned for this project has generally been spent according to implementation needs. The overspending observed in the local expenditures of the project occur particularly in the budget lines of vehicle repair and training and are explained in part by the dilapidated state of the project vehicles, which were not renewed during the second phase of the project, and in part by the needs for IEC material and equipment. As an illustration, the monthly costs of repairs, maintenance and operations of the project vehicles, moto and mobylettes are approximately **\$2000/month (\$1,939.40)**

## **C. LESSONS LEARNED**

The DCSP has benefitted from a fairly long experience in the Dioro district, with two successive phases of implementation which allowed it to learn from its successes and errors and to bring appropriate solutions through innovations that are unique in their domains. The strategies adapted by the DCSP in the areas of community mobilization and IEC are the reason why the project has made an impact in its interventions and today provide a veritable school for all who implement projects where community participation is required. Among the many lessons learned, the most remarkable are:

1. ***The full participation of the community can be attained if the community understands the benefits of what it is being offered the role that it must play as a partner and key player, and so long as its own priorities are taken into account and its social structure and customs are respected***

In the DCSP's case, the failures of Phase I, as well as those of other development projects in the area involved in community approaches, brought the Phase II staff to the decision to break with classic models of community-approach strategies and to adopt new strategies based on the results of operational research. After having identified the nature of problems and their origins, the workshop-style awareness-raising days held by the DCSP staff in each village enabled the project not only to inform the communities but to mobilize them for their active participation. It is thus that appropriate decisions were made by the communities in the areas of choosing functional structures for the project, such as health committee members, village health teams, and also the involvement of women in decision-making concerning their health and that of their children. The functioning of the health committees and the management of recurrent costs within the project such as paying traditional birth attendants and renewing equipment is more problematic in the phase I villages, who did not benefit from the new community approach.

2. ***Women's participation in decision making is not necessarily perceived as a threat to men's authority if the latter understand their own roles and the role of their women in child survival activities.***

This can be accomplished only if the personnel implementing the project is sensitive to the importance of promoting the role of women in child survival, has the competence required to discuss this sensitive topic with a traditionally male-dominated population, and finally, commits itself resolutely to achieve understanding and behavior change by men in this issue. The DCSP has taught us that by understanding and accepting the role that women must play in child survival, men did a better job of taking on their responsibilities as heads of the household by: reducing the workload of pregnant wives, participating significantly in expenses for women's and children's food, urging women to get themselves and their children to the vaccination clinics, asking for information about their children's growth, and, finally, encouraging their wives to use a family planning method to space births. In fact, a social revolution is going on in Dioro; mothers-in-law swear that never in their wildest dreams did they believe that they would see the day when men took over the hard work of carrying wood.

3. ***IEC messages must be designed for men as well as for women, for men's roles are extremely important in maternal and child health and in order to participate in the activities, men must understand why and how they are to do so.***

4. ***A multi-disciplinary team, carefully chosen, trained and regularly supervised can play an extremely important role in preventive health activities at the village level.***

In the DCSP, the model village health team in Phase II is composed of four people, of which the majority are women. The team, usually including two traditional birth attendants (TBAs), one male “animator” and one female “animator” played an important role in the achievement of the project objectives. Each member of this team played both a specific role and a multi-disciplinary role in implementing the interventions at the village level. In particular, we want to underline the extremely important role played by the village health workers in encouraging men to take responsibility for malnourished children and to accept family planning. We also want to underline the level of satisfaction of these village health agents, in particular in the Phase II villages, who are particularly motivated by the recognition, appreciation and support of their roles, the perception of the impact of the interventions, the behavior changes, and the supervision.

5. ***You don't have to be an “expert” to be effective.***

Through the encouragement of a leadership that knew how to validate, consolidate and mobilize their talents, the Dioro team, with a moderate level of training, knew how to meet the challenge of community participation, IEC and supervision.

6. ***The members of the community are capable of taking care of malnourished children.***

Indeed, the strategy for taking care of malnourished children in the village was effective in the sense that it enabled 61.7% of malnourished children to receive follow-up care by associating the efforts of the village health teams and the family, supported by the “enlightened mothers” (role model mothers).

7. ***Project results need to be disseminated in order to raise an interest on the part of beneficiaries, collaborators and counterparts and to mobilize resources.***

The DCSP management knew how to publicize its activities and their impact through the organization of health days, regular information provided to other partner NGOs, to Ministry of Health authorities and the search for an active collaboration with all who intervene in the area of maternal health and child survival. The annual and sector-level health days organized by the DCSP produced a large visibility of the project before the communities and the authorities but it also served as a forum for an exchange between intervening agencies in maternal and child health and as a source of information for the communities.

8. ***The DCSP's intervention strategies allowed the project to assure sustainability of all of the interventions except vaccination and, in some part, growth promotion.***

Behavior change of mothers and fathers **often** is the first significant sign of sustainability, supported by the permanence and the motivation of the village health teams and the community management of recurrent project costs in particular in the Phase II villages.

## IV. PROJECT SUSTAINABILITY

Based on the lessons learned during its first phase of implementation and in light of the feeble sustainability of Phase I, the DCSP in its second phase of intervention began from the start to assure sustainability conditions at both the community level and the level of government institutions.

### A. COMMUNITY PARTICIPATION

The DCSP raised community participation through an approach which permitted the project to inform communities about maternal and health and at the same time enlist all of its members in decision-making about project activities. The community consequently provided a variety of human, material and financial resources as its contribution to the project. This community contribution was organized in such a way as to be sustainable.

#### 1. Human Resources

Among the human resources provided by the communities are the village health committee members, an average of eight per village, the members of the village health teams (four members in the Phase II villages and three in the Phase I villages, including traditional birth attendants, the village health workers, and the youth peer counselors for STD/AIDS prevention). It should be noted that for the 23 villages of Phase II, the selection of these human resources was accomplished through community meetings with the participation of all parts of the community and the project field agents were careful to place a priority on the choice of women as traditional birth attendants and as village health workers. On the other hand, for the 17 old villages from Phase I that were picked up again by the project for coverage, the project's preventive health interventions were started up again without applying the same community participation strategy. The health committees were not re-elected through community meetings, nor were they reoriented, and the old sanitation and first-aid workers were simply re-recruited into the role of village health workers. This explains why the conditions necessary for sustainability are much more apparent in the Phase II villages than in those of Phase I. The health committees are more active, the village health workers are more motivated to carry out preventive health activities, and payments of service fees for delivery are more regular in the Phase II villages.

The health committees have the responsibility of managing revenues and expenses of the project at the village level, specifically, collecting the **funds** needed for certain activities like well water purification, providing financial incentives for the well diggers, paying the traditional birth attendants and restocking their work materials and equipment. This activity is established and sustainable in the sense that it entails absolutely no recurrent costs and in that communication is facilitated by the fact that the village health teams are members of the village health committees.

The village health teams will continue to carry out their activities. The traditional birth attendants are acknowledged by the communities and continue to carry out their activities even in the Phase I

villages where they have difficulty getting paid for their services. The village health workers, in addition to the personal satisfaction that have in observing the impact of their activities, gain a small profit from the sale of contraceptive methods. Based on their repeated requests to be trained to write down children's weights and interpret the growth monitoring chart, it is clear that the village health workers are committed to continuing to carry out these activities. This is likewise for well water purification, nutritional rehabilitation of children, and community based distribution of contraceptives- activities which are currently being conducted without needing assistance from the Africare field agents.

## **2. Financial Resources**

The income generated for the village petty cash boxes for project activities are obtained through the sales of growth monitoring cards, the payment of service fees for delivery, the collection of funds for well water purification, the collection of funds for the organization of community events such as sector-level health days, etc. No cases of mismanagement of **funds** were noted, the only problem observed in this matter was the difficulty of getting people to pay for service fees for deliveries in the Phase I villages.

## **3. Material Resources**

The material resources invested in the project by the communities included the construction of the Africare field agents' housing and particularly the mobilization of materials needed to organize the sector-level health days.

## **B. CAPACITY AND WILLINGNESS OF COUNTERPART AGENCIES TO SUSTAIN THE DCSP ACTIVITIES**

Since the start-up of Phase II, the DCSP has benefitted from the support and the collaboration of the Ministry of Public Health through its regional, departmental and local services. It is thus that the Dioro Health Center Director, who is the counterpart for the project's preventive health component officer, worked directly with the project in the training of the field agents, in providing support for vaccination activities, in organizing the health days, as well as in participating in the impact evaluations of the national health day and the awareness-raising campaign on the little **green pagne**. The Segou Circle Medical Director supported the project's vaccination activities by regularly providing vaccines and the Segou Regional Director of Public Health who is very attentive to the project's progress, invited the project coordinator to participate in the annual meeting of the Regional Committee for the Orientation, Design and Study of Health and Social Welfare Programs (**CROCEPSS**) in 1995. The Segou Regional Director of Public Health participated in this evaluation as a member of the evaluation team.

In addition to the project counterparts in the Ministry of Public Health, four other counterpart agencies worked in close collaboration with the project **staff**, specifically, the local representative of the Ministry of Youth and Sports, counterpart for the project's IEC component officer, and the

local representatives of the Ministry of Agriculture, of the Segou Rice Office and of the International Fund for Agricultural Development (**IFAD**) all acted as counterparts for the project's Community Organization component officer. All of these different counterparts **fully** participated in the revision of the DIP and in specific activities organized by the project, such as the organization of the national health day and the awareness-raising campaigns in the villages. The **IFAD** is actually responsible for providing literacy training for 24 of the project's female village health workers.

In order to improve their participation in the DCSP activities, four of these counterparts received training in the areas of IEC and community participation while the Dioro Health Center Director also received training in contraceptive technology and a training of trainers workshop.

Nevertheless, besides the Dioro Health Center, the government counterpart agencies' capacity or willingness to take over project activities is actually **doubtful**, for although they were dynamic at the beginning, their participation was effected by a decision by **USAID/Mali** to no longer cover the costs of per diems and transport for government workers at the local level. All the same there will in fact exist support for the project activities in the majority of the Phase I villages where the Segou Rice Office intervenes and in the majority of the Phase II villages where the **IFAD** intervenes. In fact, these two agencies work in the same areas in health and **fund** periodic training and refresher courses for traditional birth attendants, as well as nutritional follow-up activities and literacy training.

Although willing to take over vaccination activities, the Dioro Health Center will not have the capacity to conduct them at the same rhythm as the DCSP for there is only one vaccinator whose salary is paid by the Local Development Committee. At the very best, all of the villages will receive a maximum of one to two visits by the vaccinator each year. The Phase I villages that were not picked up again by the project in the second phase are currently receiving vaccination clinics at this rhythm. As a result, measles epidemics occur more frequently in these villages and the Phase II villages, who have been receiving regular vaccination clinics, are actually in terror of finding themselves in the same situation as their Phase I counterparts after the departure of the DCSP. We should note that the project did not take the measures needed to assure the sustainability of growth promotion activities through the timely training of village health workers in recording weights and in interpreting the growth charts. Supervision activities, although regular, did not include overseeing the work of the village health committees, which explains the continuing problem of failure to pay delivery service fees in the Phase I villages.

Appearing on the scene like a life buoy, the National Health Policy (NHP), initiated in Mali in 1990, is bringing into the forefront the idea of sustainability of activities such as those of the DCSP. The NHP serves as a framework for the implementation of primary health care activities by way of a *minimum package of activities (MPA)* that must be provided by Community Health Centers at the grassroots level of health sectors. The Community Health Center is a community structure comprised of a health post, a maternity and a pharmacy of essential medicines situated at the center of a health sector (group of villages) and serving all communities living within a 15 kilometer radius. The **funding** for Community Health Centers is jointly provided by the Rural

Health, Population and Water Project (**RHPWP**) and by the beneficiary populations. Community participation is defined as 25% of the cost of constructing the health center buildings as well as taking over the monthly salaries of the health personnel.

Considered to be the **Malian** government's irreversible option for assuring public health, the National Health Policy is the engine to which all agencies intervening in health in Mali must attach themselves. The process of attaching the DCSP to this engine will be facilitated by the fact that its interventions in maternal health and child survival are already part of the MPA and by the fact that five of the six health sectors chosen by the government health services for the Segou Circle correspond to the sectors where the DCSP is working. Certain villages covered by the DCSP are located far from the government's pre-designated health sectors, including the large village of Tatrira, are officially part of the health sector of a neighboring district. To facilitate the incorporation of the DCSP's activities into the NHP plans, the Segou Circle Medical Director, supported by the Regional Director of Public Health, has scheduled the opening of four Community Health Centers during the first quarter of 1998. As another favorable aspect, some health infrastructures already exist in the health sectors selected by the government, including three maternity wards and a dispensary.

The contribution of the DCSP to the NHP will be made through bringing in innovative strategies in community participation and IEC in order to improve the quality of preventive health services in rural areas. The integration of the DCSP into the NHP activities will occur through the full participation of its personnel in the community organization process to help communities contribute to the construction, **staffing** and management of their Community Health Centers. In order to accomplish all of this, the DCSP needs an extension of its funding and activities for at least two years so that it can work with the Segou Circle government health service and fully participate in the implementation of the National Health Policy in the Dioro district. The evaluation team developed, in collaboration with the Segou Regional Public Health Director, the DCSP staff, and **Africare**, a project extension plan which outlines the DCSP's proposed activities over the next two years. The activities integrating the project into the NHP and their costs should be reviewed and negotiated with the Segou Circle Medical Director and the Regional Public Health Director so that the financial contributions of the Rural Health, Population and Water Project, **USAID** and the local communities can be identified and agreed upon. Finally, a proposal for funding the extension phase should be developed and submitted to **USAID** as soon as possible.

The amount of time designated for the government to go through the process of awareness-raising and community organizing prior to installing Community Health Centers (usually about 14 months) should be shortened due to the high level of community organization already attained by the DCSP in the project area and to the communities' already heightened understanding of the advantages of the DCSP's interventions. It is hoped that, at the time of the Community Health Centers' opening, the Africare field agents will be recruited by the communities to work as their own salaried **staff**, paid by the village health committees. In this way, these field agents will be able to continue to supervise the preventive activities in the villages.

In conclusion, the evaluators can confirm that the project’s sustainability will be in large part assured through the communities’ taking over of the activities and the recurrent costs by way of the **functioning** of the new Community Health Centers.

**C. SUSTAINABILITY PLAN, OBJECTIVES, ACTIVITIES AND RESULTS**

Goal 1: *Increase the capacity of the Malian government services to continue maternal health and child survival activities after the end of the project*

<b>Objectives/Indicator</b>	<b>Activities</b>	<b>Results</b>
Identify at least 3 counterparts for the different DCSP components	5 counterparts identified	Involvement in the activities
Assure 8 training <b>courses</b> for the project <b>staff</b> and counterparts	2 1 training courses for the project <b>staff</b> in leadership, supervision	> 100% of the community development objective, IEC, operational research, 75% of the objective for participation in DCSP's main activities during two years
	0 training courses for the health counterpart in EPI INFO	HIS incomplete, no system to know the number of children completely vaccinated in the district

Goal 2: *Improve the communication, the cooperation and the collaboration between the different Malian government counterpart agencies that correspond to each of the three main project components*

<b>Objectives/Indicator</b>	<b>Activities</b>	<b>Results</b>
<p><b>Number</b> of meetings and other <b>unspecified</b> activities</p>	<p>Participation of the DCSP in 1 Regional government health planning committee in Segou</p> <p>Weekly meetings with the Segou Circle Medical Director</p> <p>3 Awareness raising activities organized with 5 counterparts</p> <p>1 health day organized with 5 counterparts</p> <p>2 impact evaluations with the health <b>counterpart</b></p> <p>information exchange between the project <b>staff</b> and counterparts</p>	<p>1 out of 3 Regional meetings attended (33%) of the objective met. No input from the DCSP in the Segou Circle's five-year health plan Regular supply of vaccines</p> <p>75% of the objective for transfer of skills</p> <p>100% of the objective for transfer of skills</p> <p>100% of the objective for transfer of skills</p> <p>facilitated collaboration</p>

**Goal 3:**      *Increase capacity of communities to continue maternal health and child survival activities after the end of the project*

<b>Objectives/Indicators</b>	<b>Activities</b>	<b>Results</b>
55 health committees elected	4 days of awareness raising in 23 villages in Phase II, health committees exist in 14 of the old villages that were picked up again by the project	37 of 55 villages covered by the project; 67% of the objective reached
110 traditional birth attendants trained in 55 villages	Selection and training of 62 traditional birth attendants, of which 48 in 24 villages in Phase II and 14 in Phase I	62 traditional birth attendants in 37 villages; 56.36% of the objective
55 male village health workers selected and trained in 55 villages	Selection and training of 37 male village health workers in preventive health activities	Improvement in men's understanding of project interventions; 67% of the objective reached
55 female village health workers elected and trained in 55 villages	Selection and training of 37 female village health workers in preventive health activities	Improvement in women's understanding about preventive health activities; 67% of the objective reached
At least 1 group of griots, theater troupes, musicians trained in each sector	Selection, training and utilization of 13 griots, musicians, storytellers, 5 theater troupes, 7 marionette troupes	Behavior change among men and women
12 sector-level health days (two per sector)	6 sector-level health days	Increased community awareness, 50% of the objective
2 refresher courses for traditional birth attendants	organization of 1 refresher course for 62 traditional birth attendants	79.1% child births are assisted
2 training seminars in interpersonal communication for male village health workers	organization of one seminar for 24 village health workers	men convinced of the need to participate in maternal and child health activities

**Goal 4:** *Improve the social status of women, including their public image and their individual- and group-efficacy, in order to empower them to participate fully in activities and in decision-making concerning their health and that of their children.*

<b>Objectives/Indicators</b>	<b>Activities</b>	<b>Results</b>
At least 75% of <b>women</b> village health workers will be involved in income-generating activities	Activity was not directed towards the women village health workers but towards mothers	Objective not reached
At least 50% of women village health workers will be trained in management of small business enterprises and in accounting	Activities not conducted	Objective not reached
At least 75% of women village health workers will be literate	Organization of a literacy training for 24 village health workers	66.66% of the objective reached
Women village health workers will express more self-confidence	Training, supervision and empowerment of women village health workers by the <b>Africare</b> field agents	Women village health workers motivated to do their work because they feel appreciated and admired by mothers
Men and women will have positive attitudes towards women's participation in activities and decision-making	Awareness-raising days for men and women on their respective roles	Women's participation attained in activities and decision-making
Men's knowledge about the project components will improve and having positive attitudes, they will encourage women to participate in all of the activities	Awareness-raising days, IEC activities and education/catalyzing	Women encouraged by men to participate in all of the activities
More men and women will discuss maternal health issues together	IEC activities and the role played by the village health workers	56.6% of women discuss maternal and child health issues with their husbands

## **V. CONCLUSIONS AND RECOMMENDATIONS**

Because of the social mobilization and IEC strategies implemented in the Phase II villages, the DCSP was able *to* accomplish a large majority of its objectives in maternal health and child survival, community participation, and women's empowerment for their health and that of their children. This accomplishment has led to a strong acquisition of health-related knowledge and skills at the level of the village health teams and health committees as well as at the level of mothers and fathers. The strengthening of the number and the multi-disciplinary nature of the village health teams, supported by the Africare field agents, allowed the routine implementation of all of the project activities. The IEC strategies were successful because they were based on the results of operational research and on innovative solutions using local traditional resources.

Involving men in health activities and involving women in decision-making concerning their health and that of their children allowed the project to increase and broaden its coverage of maternal health and child survival.

Because of an enlightened, encouraging and motivating leadership in the project, the DCSP staff experienced a strengthening of their skills by way of on-the-job training. The staffs collaboration with their counterparts at the local level allowed the project to implement a multi-sectoral approach.

The documentation of the project activities permitted them to be shared with all collaborators, **NGOs** and other donors.

The project's sustainability, already well advanced, will be completely assured by its integration into the National Health Policy plans to which the project will bring its "know-how" in the areas of community participation and IEC.

Nevertheless, the weaknesses observed within the project are due to its failure to continue to follow the same specific community participation strategy that was developed in the Phase II villages. It is this specific strategy that determines the outcome of the composition and the quality of work of the health committees, the selection of the village health workers and their commitment to preventive health activities, and finally, the communities' payment of services fees for child birth deliveries.

## **Recommendations**

1. Assure a minimum project extension of two years in order to allow the project to consolidate the sustainability of its activities. In order to do so, **Africare** must negotiate funding for a grant from **USAID** to cover this extension period.
2. Assure the sustainability of all of the project activities by integrating it into the National Health Policy plans, through the opening and the operations of Community Health Centers. In order to do so, the DCSP management staff in Dioro should negotiate with the health authorities at the Segou Circle and Segou Regional levels so as to include the schedule for opening the four Community Health Centers planned in the 1997 financial budget, so as this will happen at the very latest during the 1998 quarter. A proposal describing the interventions necessary to put Community Health Centers in place, their costs, and a plan for sharing funding responsibilities among the Rural Health, Population and Water Project, **Africare** and the communities should be developed and submitted to **USAID** as soon as possible.
3. Consolidate the sustainability of the **DCSP's** activities by (a) correcting the dysfunctional status of the Phase I villages by applying the same community organization strategy that was used in Phase II, in other words, awareness-raising workshops on maternal and child health, and the respective roles and responsibilities of every member of the community; (b)

recuperate the 18 villages from Phase I that remain to be covered by the project; (c) train the village health workers in how to record weights and interpret growth charts; (d) put the village health teams completely in charge of educational talks in the villages, and; (e) supervise the health committees' activities. The frequency of supervision should be reduced to one visit a month per village; this supervision visit should be oriented toward consolidating the skills of the village health teams.

4. Remove the Africare field agents out of their current sites and post them in Dioro, Nonongo and Tatrira, which will be new sites from which they will be able to carry out their vaccination and supervision activities.
5. Encourage and develop strategies for income-generating activities for the village health teams in order to provide them with financial incentives and to consequently increase the sustainability of their activities.
6. Increase discussion and analysis of the impact of the **STD/AIDS** component and strengthen the prevention strategies by including parents and also young married adolescents in the target groups.
7. Assure the sustainability of the community-based distribution through a supply system for contraceptives that is put in place following negotiations with the Segou Circle government health service.
8. Create a Center for Exchange and Training in action-research so as to share the project's experiences and to disseminate its strategies and IEC materials.

# **DIORO CHILD SURVIVAL PROJECT**

## **FINAL EVALUATION**

### **APPENDICES**

- A. Evaluation Team**
- B. List of People Interviewed**
- C. List of Villages Visited and Logistical Organization**
- D. Results of the Quantitative Survey**
- E. Results of the Qualitative Study**
- F. List of IEC Materials produced by the DCSP**
- G. List of Documents produced by the DCSP**
- H. Status of Wells in the Villages**
- I. Extension Timeline for the DCSP**
- J. DCSP Pipeline--Budget**

**APPENDIX A:**  
**EVALUATION TEAM**

1. **Mrs. Aissatou Lô, MPA, Public Health Consultant, Team Leader**
2. **Ms. Laura Hoemeke, MPH, Health Programs Manager, Africare/Washington, Africare Headquarters Representative**
3. **Dr. Youssef Konaté, MPH, Regional Health Director, Evaluation Team Member**
4. **Ms. Dorothy Stevens, MPH, NGO Manager, USAID/Bamako, Evaluation Team Member**
5. **Mr. Aly Cissé, Youth Strategic Objective Programs Follow-up Manager, USAID/Bamako, Evaluation Team Member**
6. **Mr. Yaya Coulibaly, IEC Officer, DCSP/Dioro**
7. **Ms. Mariam Camara, Obstetric Nurse, Preventive Health Officer, DCSP/Dioro**

## APPENDIX B:

### LIST OF PEOPLE INTERVIEWED

1. **McKinley Posely, Country Representative, Africare/Bamako**
2. **Kerry Sly, Administrative Assistant, Africare/Bamako**
3. **Yéréfollo Mallé, Head of Projects, Africare/Bamako**
4. **Modibo Ma'fga, Coordinator of Health Pivot Group/Bamako**
5. **Dr. Samba Tour& Head of the Clinical Division, AMPPF/Bamako**
6. **Dr. Youssouf Konaté, Regional Health Director, Segou**
7. **Guillaume Bakadi, Coordinator DCSP/Dioro**
8. **Lydia Clemmons, Former Coordinator DCSP/Dioro**
9. **Dr. M'Baye Bambi Bâ, Medical Director, Segou Circle**
10. **Paul Sangala, Administrator, DCSP/Dioro**
11. **Yaya Coulibaly, IEC Officer DCSP/Dioro**
12. **Mariam Camara, Preventive Health Officer DCSP/Dioro**
13. **Bagalo Yaro, Community Organization Officer DCSP/Dioro**
14. **Almamy Coulibaly, Health Field Agent, Africare, N'gan**
15. **Alimatou TraorC, Health Field Agent, Africare, Koro**
16. **Binta Kantao, Health Field Agent, Africare, Nonongo**
17. **Mamadou Kaba TraorC, Health Field Agent, Africare, Tatrима**
18. **Adjaratou Samaké, Yolo**
19. **Tata Diara, Health Field Agent, Africare, Nioh**
20. **Sanata TraorC, Agriculture Field Agent, Africare, Babougou**
21. **Dioro District Administrator**
22. **Issakha TraorC, Head Nurse, Dioro Health Center**
23. **Mamadou Coulibaly, Youth and Sport Officer, Dioro Arrondissement**
24. **Abdoulaye Diarra, FIDA Representative, Dioro**
25. **Massa Moctar TraorC, Representative, Dioro**