

**Plan Mali
Kita Program
Child Survival XVII
Project
MALI**



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(OCTOBER 2004 – SEPTEMBER 2005)

IMPLEMENTING AGENCY

**Plan Mali Country Office
in partnership with**

Ministry of Health

LOCATION

***Kita District, Mali
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Name and position of individuals involved in writing and editing this report

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ACRONYMS

ARI	- Acute Respiratory Infection
AMACO	- Local NGO in Kaarta
ARAFD/C	- Consortium of local NGOS (ACD, ARAFD and ODILE)
ARI	- Acute Respiratory Infection
ASACO	- Association of community health
BCC	- Behavioral Change Communication (CBC)
CBO	- Community Based Organization
CDD	- Control of Diarrheal Disease
CO	- Country Office
CS	- Child Survival
CSCom	- Community Health Center (Health Facility)
CSRéf	- Health Care Center of reference (Referral Health Facility)
CSTS	- Child Survival Technical Support
DD	- Diarrheal Disease
DHO	- District Health Office
DIP	- Detailed Implementation Plan
EPI	- Expanded Program of Immunization
FA	- Field Area
FELASCOM	- Local Federation of Associations of Community Health
HF	- Health Facility
HFMC	- Health Facility Management Committee (ASACO)
HIS	- Health Information Systems
HMIS	- Health Management Information System
IH	- International Headquarters (Plan)
IHFA	- Integrated Health Facility Assessment
IEC	- Information Education and Communication
IMCI	- Integrated Management of Childhood Illness
KPC	- Knowledge, Practice and Coverage
LQAS	- Lot Quality Assurance Sampling
MoH	- Ministry of Health
M/E	- Monitoring and Evaluation
NID	- National Immunization Day
OSM	- Operation Support Manager
PC	- Project Coordinator
IMCI	- Integrated Management of Childhood Illness

- PU - Program Unit
- PUM - Program Unit Manager
- PDRIK - Integrated Rural Development Project of Kita
- RO - Regional Office
- SCM - Standard Case Management
- GSM - Grants Support Manager
- PSM - Program Support Manager
- TBA - Traditional Birth Attendant
- TH - Traditional Healer
- USAID - United States Agency for International Development
- USNO - US National Office (Plan International)
- VHC - Village Health Committee (CSV)

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1.LIST OF SUSTAINABILITY INDICATORS

1.0 PLAN MALI CHILD SURVIVAL PROJECT AT A GLANCE

Project duration	30 September 2001 – September 29, 2006
Project area	A catchment of 26 CSComs located in the Kita District in the South Eastern part of Kayes Region in Mali
Total population in the project Area:	The total population is 315,520 but the project committed to reach 260,458 (73%) by the end of the 5 years
Target beneficiaries	98,973
MOH health facilities in project area	1 hospital (CSRéf) and 10 CSComs (Health Centers). There are supposed to be 26 CSComs.
Social and economic profile of population in the project area	The inhabitants of the project comprise various ethnic groups most of whom most are Moslem. The target group lives as peasant farmers and engage in petty trade during the drier season. Droughts are common and insufficient water supply is a significant constraint. Female Genital Cutting is nearly universal.
Overall Goal	To assist the MOH to improve the health status of children aged under five and women of reproductive age (15-49 years) in Kita district through the following 4 outcomes: better health promotion behaviors in households, increased utilization by the CSComs by communities, strengthened ability of the ASACOs to support the new decentralized services, and improved quality and accessibility of health care through CSComs offering the minimum activities package (MAP).
Project interventions	<ul style="list-style-type: none"> - Malaria Case Management (MCM) - Improving Immunization Coverage - Diarrhea Case Management (DCM) - Pneumonia Case Management (PCM)
Strategies	<ul style="list-style-type: none"> - Improved supervision and training to MOH health workers and volunteers - Support and non-financial incentives for community health volunteers. - Strengthened community partnership and cost recovery - Promotion of project's objectives through innovative BCC/IEC strategies
Project objectives	<p>1. Behavioral: Women of reproductive age and mothers of children under-five years will be practicing healthy behaviors and seeking medical care by trained health service providers;</p> <p>2. Increased access to services: Communities and families will have increased access to health education and quality care and essential medicines;</p> <p>3. Quality of care: MOH personnel, community health volunteers and other service providers will be practicing appropriate integrated management of sick children particularly malaria, pneumonia and diarrhea case management.</p> <p>4. Institutional strengthening: ASACOs, implementing NGOs and district MOH facilities will be developed and strengthened to support and implement activities that enhance child survival.</p>

2.0 MAIN ACCOMPLISHMENTS OF YEAR FOUR

The project is now working with 23 CSComs areas, which is slightly above the targeted 22 CSComs areas it had planned to work in by the end of the 4th year. The project is well aware of the challenges facing it and has formulated concrete steps with her partners to surmount these challenges. Some of the major tasks performed during the fourth year of Plan Mali's Child Survival (CS) Project in Kita district are: Sharing the Mid-Term evaluation findings and recommendations with partners, Phasing into the 30 villages of Kaarta Region, Beginning work with the CSComs, ASACOs and VHCs in this area by formalizing an agreement with AMACO (local NGO) to implement field activities and enhance the management capacities of the ASACOs, Basic training for Health Staff in IMCI case management in this new area, Training of Community volunteers from this phase-in area in C-IMCI, Supervision of community level activities in the entire project area and a Sustainability study based on the 1st phase of the project. Dissemination of child survival messages was done in local language through peer education efforts of the project animators and volunteers, local theatre groups and through 3 local radio stations.

The project has developed its phasing-in approach to ensure ownership by the local partners by signing MOUs. Local government, NGOs and ASACOs are mobilized for joint planning and implementation following the baseline survey. Key startup activities during phase-in include the formation and training of VHCs (CSVs), selection and training of relays and capacity strengthening of the ASACOs.

Joint program supervision was a major activity throughout the year and established that Relays are tracking project data well and are actively engaged in Immunization activities. Key challenges at Village level is that there is a lack of regular planning meetings by the Village Health Committees (CSVs) and that needed support to the Relay does not always come through from the CSV and this demotivates the Relays. Also the Heads of Health Post or CSCom health workers do not regularly supervise Relays. Relays interaction with the community in regard to counseling and behavior change were also found to be weak. Findings at the CSCom level suggests that the ASACOs are legally registered entities but still have weak financial and management skills reflecting through lack of up to date contracts with the staff of the CSCom, high user fees fueled by dwindling utilization of services by the community and ineffective drug and supplies (stock) management, and having a lack of clear operational plans for the CSComs. A major part of the corrective action had to do with retraining, re-equipping and redistribution of the Animators who are the project frontline staff hired by the sub grantee NGOs.

The project has been conducting regular LQAS limited to the areas where it has phased in activities. It has conducted 4 LQAS surveys to date. DHO staff, NGOs partner staff and CS Plan staff work together during the development, implementation and analysis of the survey. This is a strategy to build partner capacity and to institutionalize the LQAS monitoring process especially with the District Health System.

On the national front Plan Mali received funding from the World Bank to implement the multi-sectoral AIDS Program (MAP). Plan Mali is the lead agency. This funding has presented the opportunity to integrate Child Survival Programming within the community initiatives of the program.

2.1 Major Achievement on DIP indicators:

2.1.1 Objective on Behavioral Practices:

Women of reproductive age, pregnant women and caregivers of children under 5 practice healthy behaviors and seek medical care from a trained provider when it is needed.

Indicators	Baseline (Oct 2001)	Achievement (To date)	Target (Sept 2006)
Malaria Case Management/Pneumonia Case Management:			
Mothers of children 0-23 months who know 2 signs indicating that a child needs care	35.3	90.6	60
Children 0-23 months who were sick who received at least the same amount, or more than usual, to drink	26.6	68.5	60
Children 0-23 months who were sick who received at least the same amount, or more than usual, to eat	21	50.3	60
Children 0-23 months who slept under an impregnated Bednet the night prior to the survey	3.9	22.5	60
Mothers of children 0-23 months who reported taking Chloroquine during the last pregnancy	55	82.2	80
Control of Diarrheal Disease			
Mothers of children 0-23 months who correctly describe how to prepare ORS	-	77.1	80
Improving Immunization Coverage			
Children 0-23 months who are fully vaccinated	51	69.5	71
Mothers of children 0-23 months who reported receiving at least 2 doses of TT during their last pregnancy	24.1	79.0	60

2.1.2 Objective on increased access to Services and Supplies:

Communities have increased sustainable access to health education, quality care and essential medicines.

Indicators	Baseline (October, 2001)	Achievement (To Date)	Target (September 2006)
Malaria Case Management/Pneumonia Case Management:			
Mothers of children 0-23 months with a consultation card/booklet	14	84.9	60
Children 0-23 months who slept under an impregnated Bednet the night prior to the survey	3.9	22.5	60
Mothers of children 0-23 months who reported taking Iron and Folic Acid during last pregnancy	65	79.6	80
Control of Diarrheal Disease			
Mothers of children 0-23 months who correctly describe how to prepare ORS	-	77.1	80

Indicators	Baseline (October, 2001)	Achievement (To Date)	Target (September 2006)
Children 0-23 months who had diarrhea within the last 2 weeks who had received ORS or other home fluids	25.2	-	75
Improving Immunization/Other Service Coverage			
Children 0-23 months who have an Immunization Card	49	90.7	80
Mothers of children 0-23 months who reported attending at least three ante-natal consultations during their last pregnancy	14	55.9	60
Mothers of children 0-23 months who reported having been attended by a trained health worker during the last childbirth/assisted Childbirth.	68.6	65.1	80

2.1.3 Objective on Quality of Care:

MOH personnel and community volunteers (CHWs, TBAs) practice appropriate case management of malaria, diarrhea and pneumonia and provide quality counseling.

Indicators	Baseline (October, 2001)	Achievement (To Date)	Target (September 2006)
Malaria Case Management/Pneumonia Case Management:			
Mothers of children 0-23 months who know 2 signs indicating that a child needs care	35.3	90.6	60
Children 0-23 months who were sick who received at least the same amount, or more than usual, to drink	26.6	68.5	60
Children 0-23 months who were sick who received at least the same amount, or more than usual, to eat	21	50.3	60
Children 0-23 months who slept under an impregnated Bednet the night prior to the survey	3.9	22.5	60
Mothers of children 0-23 months who reported taking Chloroquine during the last pregnancy	55	82.2	80
Control of Diarrheal Disease			
Mothers of children 0-23 months who correctly describe how to prepare ORS	-	77.1	80
Improving Immunization/Other Service Coverage			
Children 0-23 months who are fully vaccinated	51	69.5	71
Mothers of children 0-23 months who reported receiving at least 2 doses of TT during their last pregnancy	24.1	79.0	60
Mothers of children 0-23 months who reported attending at least three ante-natal consultations during their last pregnancy	14	55.9	60
Mothers of children 0-23 months who reported having been attended by a trained health worker during the last childbirth/assisted Childbirth.	68.6	65.1	80

Indicators	Baseline (October, 2001)	Achievement (To Date)	Target (September 2006)
Mothers of children 0-23 months who reported having received Vitamin A within 40 days of birth of the last child	-	40.1	60

2.1.4 Institutional objectives:

Local NGOs, MOH and community-based institutions have developed and strengthened capacity to support child survival activities on a sustainable basis.

Indicators	Accomplishments/Activity
Institutional:	
<u>Capacity</u> Supervision	The local NGOs, DHO (CSRéf) and the Cs project have built capacity in performing joint supervisions together including conducting rapid assessments using LQAS, IHFA
<u>Viability</u>	ASACOs have benefited immensely in filing for official registration and opening and operationalizing bank accounts

2.1.5 Sustainability:

S.N.	Sustainability	Accomplishments/Activity
1.	Behavioral Sustainability	- Most Mothers know signs that indicate that a sick child needs care
2.	Institutional Sustainability	- Local ASACOs are running the CSComs with close collaboration of MOH and the VHCs - Skill transfer to DHO, NGOs and Plan Mali regular staffs on CS activities including LQAS.
3.	Financial Sustainability	- All programs are implemented through MOH and DHO;

3.0 SUSTAINABILITY PLAN:

CS sustainability assessment framework workshop was held in Kita in May 2005. Key stakeholders including MoH (DHO), and partners participated in workshop. Plan Mali CS project defined its vision of sustainability as “That all our community members, especially mothers and children stay healthy”. This workshop familiarized participants with current thinking on sustainability assessment and identified 63 priority indicators in the 3 dimensions of the Child Survival Sustainability Assessment (CSSA) framework. (**Annex 1**).

Preliminary measurements for each of the indicators in the two components of Dimension 1 were obtained from the LQAS results and the District Health Register. Because the project had already contracted a local organization affiliated to the University of Mali Medical School, CREDOS, to perform a sustainability study in response to the MTE recommendations, it was decided that CREDOS would collect baseline measurements of the identified indicators as part of the mandate of this study. The workshop did come out with a snapshot of where the local system (Kita District) is in terms of attainment of their vision with regards to Dimension 1. The scores highlight an emerging to intermediate sustainability situation for health outcome and health services.

Dimension	Component #	Component	Indices
1	1	Health Outcome index	36.5
	2	Health Services index	38.7
2	3	Organizational Capacity Index	-
	4	Organizational Viability index	-
3	5	Community Capacity index	-
	6	Environmental index	-

4.0 PHASE OUT PLAN:

The Phase-out strategy hinges in enlisting the ownership of project partners in program activities. The policy environment in Mali is very conducive to maintaining and strengthening the role of the ASACOs and Village Health Committees (CSVs) in grassroots level health activities. The project has therefore been working with these organizations, together with the DHO, local municipalities, the Ministry of Social Services and the sub grantee NGOs that are local institutions, to secure continuity of activities.

Plan Mali wishes to scale up the lessons learnt in this project as well as consolidated the technical manpower that has been built through this project to its entire health program in the country. To this end the founding Project Coordinator, Dr. Souleymane Bagayoko, was promoted as Plan Mali’s National Health Advisor in the course of the year. Dr. Sita Sidibe who was his assistant was confirmed as the new project coordinator.

In preparation for phase-out the project has decided to divide NGO supervision responsibilities between the M/E Officer, Elie Coulibaly, and the HIS Officer, Mamadou Seck, who are project staff, to allow for a mentoring process as well as provide seamless supervision at field area level.

5.0 CONTRIBUTING FACTORS FOR SUCCESS:

Staff and team:

- Competent staff
- High morale and good team work

Backstopping and management support

- Adequate technical backstopping from Mali CO and IH
- Adequate management support from Mali CO, PU and OSU

Partnership and networking

- Good partnership with local NGOs and local HFs and MOH
- Good networking and coordination with all stakeholders from district to national levels

Community mobilization

- Mobilization of specific interest groups linked with the program intervention
e.g. ASACOs
- Mobilization of community health volunteers in health activities
- Mobilization of local health committees

6.0 HINDRANCE FACTORS:

CONSTRAINTS	ALLEVIATING STRATEGIES
Working with Animators hired through Local NGOs.	The Animators are hired by the local NGOs and serve as the frontline staff for the project. There have been significant delays in program implementation because of this arrangement, because it creates several layers. There has not been a direct line of control between the Project Coordinator and the frontline staff. Furthermore the tools for work including the motorbikes that these Animators use are old and compromise the timeliness and quality of the program. The Project is working very closely at the operational level with the Lead Animator who supervises the other animators. The CS project has also divided the program area into two and tasked the M/E Officer and HIS Officer to cover each area and provide facilitative supervision to the NGO staff.
Concordant construction of CSComs	PDRIK did not come through with their promise to help construct CSComs. As a result there are several areas not served by a CSCom but which still have community level behavior change initiatives supported by the project. The experience has been that it is difficult to sustain health interest at the community level from volunteers and the community alike where linkages are absent between the CSCom and the people. Plan is still continuing to advocate for the construction of more CSComs to provide greater access to health facilities for the community and to forge stronger and more sustainable linkages with the health system.
Low Facility Utilization	CSComs are supposed to pay 100% of the local Health Worker compensation and purchase additional stock of medicines/supplies. CSComs self sustain by having a policy that allows collection of user fees from clients as well as receiving contributions from the catchment population. However these contributions are irregular and CSComs have had to demand user fees from very poor clients who would otherwise have been exempted. This practice keeps away clients. The less the clientele base the higher the fees will have to be charged to stay afloat. The project is working at improving utilization by community mobilization through the ASACOs and CSVs. It is also advocating for a greater role of the municipalities and other partners in the running of CSComs.
Attrition of Relays (CHWs)	Lack of Refresher training and recognition of what good they do is responsible for the high turnover of Relays. Linking Relay Supervision with the physical presence of the CSCom staff, together with periodic updates/refresher trainings to volunteers is what the project is now focusing on.
Low coverage of some key essential behaviors among the community	The project is utilizing in-country IEC materials based on the C-IMCI model to communicate behavior change through the Animators and Relays. The project adopted to use the Doer-Nondoer Analysis to identify the key promoting factors to such behaviors as exclusive breast-feeding to augment these materials. The project is using the local Radio station to share CS messages

7.0 REQUIRED TECHNICAL ASSISTANCE

- Technical assistance will be required for the final evaluation.

8.0 CHANGE IN PROJECT DESIGN

- No significant changes have been made in the project design and implementation during this period (October 2004 to September 2005).

9.0 OVERALL MANAGEMENT OF THE PROJECT

The project staff worked very closely in collaboration with the local health facility staff and volunteers (CHWs and TBAs), mothers' groups, child clubs, local health facility support committees (ASACOs) and partners. Altogether, there is 13 field staff that includes 8 Animators hired by ARADF/C and 5 by AMACO. Animators operate their field activities from their own assigned supervisory field area offices. In addition, there is also 2 core technical staff in the project to support CS Project Coordinator and the field team. These are the M/E Officer and the HIS Officer. The core team is responsible for undertaking training, health information system management, BCC/IEC coordination and administrative and financial function, and overall coordination and management of the project activities. Plan Mali's Country Office through Program Unit Office located at Kita technically and administratively supports the core team. It receives regular support as and when needed from National Health Advisor. In addition, the project is also getting technical, management and administrative backstopping from Plan's Washington Office that is also the project's link between Plan and USAID. The management structure of the project has been designed in a way that facilitates a participatory approach to decision making. While project staff and the different Plan and partner's offices perform distinct roles and responsibilities, day to day planning, decision-making and implementation is done at the field level. Management and staff review work during monthly staff meetings.

Animators are assigned a respective field area each and they each report to one of 2 Lead Animators. The core team has strengthened the capacity of NGO Partners to perform their assigned activities. The Project Coordinator coordinates work with the district health office. The Project Coordinator is responsible for overall management, implementation and quality of the project as well as for technical backstopping to the field team. The Project Coordinator administratively reports to the Program Unit Manager but technically reports to the National Health Coordinator.

9.1 Financial Management

Monthly financial reports, following a pre-agreed format, are sent by Project Coordinator (PC) to Mali CO and then to IH. Plan Mali's already established financial system (General Ledger) tracks project expenditure. Expenditure is broken down according to specific codes like training, equipment, supplies and supervision. Project expenditure reports are reviewed for USAID compliance and then submitted to USAID. The project annual budget for the coming fiscal year, based on its DIP approved workplan, is consolidated with the Plan Mali Budget for the following year and is sent to the West Africa Regional Office of Plan for approval. Annual budget approval from IH and RO is received each year before stating the Fiscal Year. Plan's corporate general ledger system assigns a project specific number to enable accurate tracking of project expenditures.

The project works with the sub grantee NGOs to monitor and ensure monthly financial reporting of budget spent as per planned.

9.2 Human Resources

Community level Volunteers (4-8 hours per week): CHWs (Relays) and TBAs are responsible for counseling with mothers and collating data in the project intervention areas. They are also responsible for diagnosing sick children with malaria, pneumonia and diarrhea and providing first level treatment or referral. They also support maternal and neonatal care by providing iron and vitamin supplementation and motivating pregnant women to avail of antenatal care. With the VHCs they work with communities to identify common health problems and find solutions together. They are responsible for convening Mothers' Group on a monthly basis. On average there are 2 CHWs per Village.

ASACO is another group of community volunteers. There is one ASACO for each CSCom and they provide management support to the CSCom.

MoH staff: One Health Worker is tasked with running each CSCom and is answerable to both the MOH and the ASACO who provides his/her compensation. This staff is responsible for regular MoH health interventions, which includes IMCI and MNC services and is responsible for outreach activities and supportive supervision to CHWs and TBAs.

NGO Partners: The NGO partners are responsible for providing Animators and assisting in BCC/IEC/HIS activities. They also build governance capacity of the ASACO and CSV and serve to strengthen community Interest groups e.g. Child Clubs.

Core CS Staff (100% effort): There is a total of 5 staff including administration/finance and support. The major task of Project staff is to build community and DHO capacity to demand for and deliver quality service. Project staffs do not directly deliver services.

Plan Staff: The Senior Health Program Manager (IH) and the Health Associate (IH) dedicate 10% and 25% of their time respectively as project backstops. The Plan Mali National Health Advisor dedicates 15% of his field time and the Program Unit Manager dedicates 25% of his time for management support towards the project. The CD, PSM and GSM dedicate 5% of their time to the project.

9.3 Communication Systems and Team Development

The technical backstopping team at Plan's Washington DC Office shares relevant technical information to the field office as they receive it, particularly from CSTS and CORE. The CS Project Coordinator is in the CSTS list-serve and receives periodic Bookmarks via the Internet, which the project has access to. The PC and majority of project staff are fluent in French. The project office has reliable email, Internet, telephone, and fax facilities.

9.4 Relationship with Local Partners

The major partners of Plan CS Project are District Health Office (DHO), Local Health Facilities and its management committees (ASACOs), ARADF/C and AMACO. In addition, other collaborating partners include FELASCOM, Municipal Councils and UNICEF. Plan CS Project coordinates actively with these local partners while designing and implementing programs in the project area and always in close collaboration with the community and DHO. Coordination meetings are held with all the district level partners on a monthly basis. The project had included the staff of partner organizations in relevant training to build their capacity in their respective interventions.

9.5 PVO Coordination/Collaboration in Country

Save the Children (US), Helen Keller International, Ministry of Health Headquarters, UNICEF and the World Bank are some of the collaborating agencies at the national level. Communication and sharing through meetings has taken place on and off. This has been helpful in enhancing field level capacity through sharing best practices. Plan is the primary agent for the MAP program, which is funded by the World Bank. Through this program Plan meet regularly with a wide range of collaborating and implementing partners.

9.6 Other Relevant Management Systems

The project follows the Plan Mali system for procurement of Supplies and Equipments. All requests for equipment and supplies are made to the Program Unit located at Kita district. The program unit examines prices and quality from several suppliers, collecting at least three official bids on items costing more than \$ 250 as per guidelines. The program unit makes a purchase order once the vendor is chosen and the item is shipped directly to the CS Project Office. The program unit is also responsible for purchasing and delivering items not available in local markets. The Administration and Finance Officer inspects the goods upon receipt to ensure their quality. Items valued at more than \$250 are recorded in the inventory at the PU. A copy of this inventory is also maintained at the CS project office for dual tracking. Each item is given a number before being sent to the regular users. Items valued at less then \$ 250 are recorded in the same way but the inventory is maintained only at the CS Project Office. In case an item requires technical inspection, PU invites appropriate persons to be a part of the assessment team.

10.0 RELATIONSHIPS WITH LOCAL MISSION

Plan Mali's relationship with the Local Mission at Bamako is healthy. Plan has been participating in partner meetings called by the Mission. Local Mission representatives were debriefed on the Child Survival Sustainability Assessment Workshop conducted by Plan last May. During each visit from IH, Plan has always organized debriefing meetings at the Mission. Plan Mali and the Local Mission are striving to maintain regular communication. Plan Mali is warming up to actively compete for future Mission Requests For Application.

11.0 RESPONSE TO PRIORITY RECOMMENDATIONS ON MID-TERM EVALUATION

The Mid term evaluation proposed 7 priority recommendations below.

- 1) The project should conduct an evaluation of the CSCom areas that it has phased out of to see how well the health agents, ASACOs, VHCs and relays are doing in managing the health activities without project support. If there are problems then the project should take steps to address them in a timely manner.
- 2) In order to strengthen the sustainability of the relays, the evaluation team recommended that the Chef du Post (CDP) become the supervisor of the relays and their activities. This could be done at the time of regular outreach visits to the villages and/or through monthly meetings of all the relays at the CSCom. There are some administrative arrangements that need to be made in order for the CDP to supervise the village relays but once this is done there would be a system in place for on-going supervision of village health activities. This could start by having the CSCom team and the animators conduct joint team supervisions in the surrounding villages. Then after the animators leave, the supervision system would be in place. This would strengthen the sustainability of relay and village health committee activities. The on-going supervision of the relays would also strengthen their motivation, particularly if they were seen as working with the Chef du Post who is very respected in the area. The evaluation team also recommended that the project staff and district health staff attend quarterly supervision meetings done at the CSComs. Their presence would encourage the other actors (ASACOs, CSCom staff, VHCs and relays) to attend and get involved in the process. They also pointed out that if the district staff were there, there would be more likelihood that the mayors would participate in the relay supervision meetings. This is important given that the mayors have access to their own source of funds and would be more likely to spend them on relay activities if they were involved in their management.
- 3) If PDRIK comes through with funding this year for the construction of the 10 CSComs that they are promising, then the project needs to work with them and the MOH to see how to equip the facilities and carry out the corresponding community activities with the limited project resources. If PDRIK does not come through with the anticipated funding, then the project needs to decide how many more CSComs it can realistically work with by the end of the project. Once the CS project has the results of the CSCom phase-out evaluation discussed above, it will be able to decide whether it should put more resources into new CSCom areas or if it should devote them to strengthening the sustainability of the old zones.
- 4) Recommend that the project contract a short-term BCC consultant to help them design a strategy that includes behavior change targets and strategies as well as awareness raising communications activities. It would be useful to employ more entertaining cultural formats that could be used to create interest in the villages such as stories, songs, street theater, and other methods.

- 5) The CS project needs to follow through on its original plan to acquire and/or develop IEC materials that are appropriate for the target audiences. The health messages need to be reinforced through support materials. Also the materials would help the relays with their educational tasks.
- 6) If resources permit, the project should consider acquiring another vehicle for the work in the new CSComs in the far northern section of the district. It should also consider replacing some of the worn out motorbikes being used by the animators
- 7) In order to strengthen some of the intervention activities, the project should consider providing breastfeeding technical assistance to improve technique and promote exclusive breastfeeding in the communities.

Progress made since CS project mid-term evaluation

Recommendation	PLANNED ACTIONS	PROGRESS
1, 2 and 3.	<p>To conduct research on sustainability of the project.</p> <p>Reorganize Supervision and place emphasis put on the phase-out zone</p> <p>Redeployment of some NGO Animators in some phase out areas</p> <p>Involvement of the Chief of Post, ASACO members and Zone leaders in the close</p>	<p>Plan already conducted an in-house sustainability workshop with its partners following the Child Survival Sustainability Assessment Framework (CSSA). CREDOS, a local research organization, were part of this process and are currently concluding the study. A final report with recommendations is expected in December 2005.</p> <p>A new supervision plan has been elaborated by the CS team and is being implemented. More emphasis is put on the phase-out zones.</p> <p>Two animators are presently in charge of the phase out zone</p> <p>Chief of Post are in charge of the follow up of community health worker and</p>

Recommendation	PLANNED ACTIONS	PROGRESS
	monitoring of community health workers including having regular community meetings	further discussions are going out in the framework of the new Country Project Outline of Plan to support this facility led supervision in all Plan program areas.
2.	<p>Organization of a workshop for a dialogue between the different actors and ways of motivating CHW and their involvement in the ASACOs activities.</p> <p>Support exchange visit for community health workers in the PU.</p> <p>Involvement of CHW in some income generation, paid health activities such as campaigns (National Immunization day, Fight against the trachoma).</p>	<p>The workshop has been held and one of the recommendations (of the workshop) was to allow that CHWs receive free treatment at the CSComs and that ASACO should play a leading role in the motivation of “community health workers”</p> <p>CHWs are now involved in various activities and do receive incentives.</p>
4,5 and 7. Community health workers and NGO Animators conduct less/ineffective IEC activities for some key practices that include hand washing, promotion of the exclusive breast feeding etc	Plan Mali chose to place focus on the strengthening of the Community IMCI protocol for community level workers in Mali that focuses on multiple key practices instead of choosing to hire a BCC Consultant or a Breast-feeding consultant as this was found to be costly. The Community IMCI protocol has job aids for community level workers. Community IMCI training with a focus on counseling for Behavior change to be implemented for CHW, staff and ASACO members.	Chiefs of Health Posts, CHW and NGO animators have already received practical training on the community component of IMCI.

Recommendation	PLANNED ACTIONS	PROGRESS
	Procure IEC Materials	Relevant IEC materials are being dispatched to the local NGOs.
<p>6.</p> <p>Considering the extension of the project in difficult access zones, the actual logistics (vehicle and old and insufficient number of motorbikes) may not allow an effective and efficient follow up of activities.</p>	<p>Supply additional motorcycles.</p> <p>Repair existing motorcycles.</p> <p>Replace one vehicle in Kita pool, which the CS project could have access to.</p>	<p>The procurement of new motorcycles has been initiated but the motorbikes have not been received yet.</p> <p>A new vehicle is actually in the Kita pool and is being used by both CS and Plan Program staff.</p>

12.0 WORK PLAN OF ACTIVITIES FROM OCTOBER 2005 TO SEPTEMBER 2006

OBJECTIVES	ACTIVITIES	PERIOD												Responsible	Responsible for follow up	
		S	O	N	D	J	F	M	A	M	J	J	A			S
1. To Insure the implementation of activities	Conducting social mobilization, BCC Activities by NGOs partner	X	X	X	X	X	X	X	X	X	X	X	X	X	NGOs Partners	CSP Staff
		X	X	X	X	X	X	X	X	X	X	X	X	X		
		X	X	X	X	X	X	X	X	X	X	X	X	X		
		X	X	X	X	X	X	X	X	X	X	X	X	X		
2. To Scale up the project	Coverage of the 4 new areas	X	X											Health District Staff	CSP Staff and MOH	
3. To Increase the vaccination coverage	Conducting social mobilization	X	X	X	X	X	X	X	X	X	X	X	X	Health District/NGO /ASACO/ CBO Staff	Health District/ CSP Staff	
	Support routine vaccination in permanent center	X	X	X	X	X	X	X	X	X	X	X	X	Health District/NGO /ASACO/ CBO Staff	Health District/ CSP Staff	
	Support Advanced vaccination strategy	X	X	X	X	X	X	X	X	X	X	X	X	Health District/NGO /ASACO/ CBO Staff	Health District/ CSP Staff	
	Conducting an applied research	X	X	X	X	X	X	X	X	X	X	X	X	Health District/NGO /ASACO/ CBO Staff	Health District/ CSP Staff	
4. To insure follow-up of activities	Conducting at least 2 LQAS surveys.			X							X			Health District/ NGO Staff	CSP Staff	
	Ensuring regular monitoring of key activities			X						X				Health District/ CSP Staff	CS Coordinator /PUM	

OBJECTIVES	ACTIVITIES	PERIOD														Responsible	Responsible for follow up
		S	O	N	D	J	F	M	A	M	J	J	A	S			
5. To strengthen the project achievements	Conducting joined meeting and supervisions activities with health District.			X			X			X					Health District/ CSP Staff	CSP Coordinator	
	Conducting regular supervision of CSP activities by the Staff		X	X	X	X	X	X	X	X	X	X			CSP Staff	CS Coordinator /PUM	
6 - To Strengthen the competence of the CBOs and mothers on interventions of the project	Coordinate Health information System activity		X	X	X	X	X	X	X	X	X	X		X	NGO Staff	CSP Staff	
	Conducting home visits in each household		X	X	X	X	X	X	X	X	X	X		X	NGO Staff	CSP Staff	
	Organizing C-IMCI training for CBOs members			X	X	X	X								NGO Staff	CSP Staff	
	Organize training for ASACO members on financial and administrative management of Health centers							X	X						Consultant	CSP Coordinator	
	Support Coordination meetings with the ASACO members			X			X			X					NGO/ASACO/ Health District Staff	CSP Staff	
	Support meetings with CBO members in all villages		X	X	X	X	X	X	X	X	X		X	NGO Staff	CSP Staff		
7. To Strengthen the capacity of the NGOs partners	Close supervisions of NGOs partners		X	X	X	X	X	X	X	X	X		X	CSP Staff	CSP Coordinator		
	Support of NGO with new logistics			X										CSP Staff	PUM		
8. To Strengthen the capacity of health agents	Support the training of 12 Health Agents in clinical IMCI						X							Health District Officer	CSP Coordinator		
	Routine monitoring and report writing								X					Health District/ CSP Staff	CSP Coordinator		

OBJECTIVES	ACTIVITIES	PERIOD														Responsible	Responsible for follow up
		S	O	N	D	J	F	M	A	M	J	J	A	S			
9. To Maintain a reliable communication policy on the project	Support the production of the CS project newspaper			X			X			X					CSP Staff	CSP Coordinator	
	Coordination meeting with partners			X			X			X					Conseil de cercle (District Council)	CSP Coordinator	
	Participate at the regional level at the meeting of health activities planning				X										Health District Officer	CSP Coordinator	
	Production of the monthly reports	X	X	X	X	X	X	X	X	X	X	X	X	X	CSP Staff	CSP Coordinator / PUM	
	Production of the quarterly reports			X			X			X					CSP Coordinator	PUM	
	Production of the annual report													X	CSP Coordinator	PUM	
10. To complete the sustainability study	Facilitation the applied research by CREDOS			X	X										CREDOS	CSP Coordinator/ PUM	
11. To Reduce the morbidity and the mortality linked to the malaria	Promotion of impregnated mosquitoes bed nets (ITN)		X	X	X	X	X	X	X	X	X	X	X	X	NGO/ ASACO	CSP Staff	
	Supporting 2 mosquito impregnation campaigns			X							X				NGO/ ASACO	CSP Staff	
	Conduct a study of mother perception on net use					X									NGO/CSP Staff	CSP Coordinator	
12. To Evaluate the project	Conduct the final project's evaluation.												X	USAID/USNO/ CSP Staff	USAID/USNO/ CSP Staff /PUM		

OBJECTIVES	ACTIVITIES	PERIOD													Responsible	Responsible for follow up	
		S	O	N	D	J	F	M	A	M	J	J	A	S			
	Production of the Final report										X					Consultant	USAID/USNO/ CSP Staff
	Workshop for the final discussion on the evaluation results.													X		Consultant	USAID/USNO/ CSP Staff

ANNEX 1

MALI INDICATORS for Component 1

Element=Maternal and child Health Situation

Rapid CATCH =Rapid Core Assessment Tool for Child Health

- % Underweight (Under 2 yrs)
- % Child Spacing
- % Children delivered by skilled Birth Attendant
- % TT2 Prevalence
- % Exclusive BF
- % Complementary Feeding (6-9 months)
- % Full Immunization Coverage
- % Measles
- % ITNs
- % AIDS
- % Signs of Illness requiring referral
- % Handwashing
- % Food/Fluids in Illness

MALI INDICATORS for Component 2

- % HF (CSCComs) which receive regular Supervision/Feedback
- % HF (CSCComs) with min. req. levels of technical Staff
- % Personnel Trained in IMCI
- % Personnel Practicing/Complying with IMCI (Assess. For Fever)
- % HF with Availability of Drugs/Supplies
- % HF with Availability of minimal required Equipment
- % Population within 15km radius of HF (CSCComs)
- % of HF providing Curative, Preventive and Promotive (PMA)
- No. of years spent at Facility by qualified personnel

MALI INDICATORS for Component 3

Technical

- ASACO capacity in data collection, analysis and decision making for health
- Clear understanding of the activities that pertain to a CSCCom by ASACO
- FELASCOM ability to actively participate in Regional Health Forums
- BCC Capacity for key family behaviors by Local NGO

Leadership

- ASACO capacity in community mobilization and motivation
- Credibility of ASACO in the eyes of the community

Organizational

- Clear constitution with roles & responsibilities in place for ASACO
- Clear understanding of roles and responsibilities by members of ASACO

Governance

Regular and democratic elections in ASACO

ASACO Ability to resolve conflicts

Presence of Women in ASACO Committee

Mechanism of Feedback from ASACO to community & counter feedback

MALI INDICATORS for Component 4

Resource Mobilization

ASACO has received training on resource mobilization

Resource Mobilization is in place including project proposal writing

Community members contribute to ASACO (Funds, labor, materials)

ASACO undertakes investments and acquires assets over time

Collaboration and Networking

ASACO establishes and maintains strategic contacts with local development agencies

ASACOs have joint projects with other institutions

ASACOs participate in local level development activities/Forums

ASACO is aware of local opportunities and threats facing it

MALI INDICATORS for Component 5

Elements Identified

Technical Capacity of CSV

Managerial and Leadership qualities of CSV

Organizational and Governance capacities of CSVs

Indicators

Technical

CSV capacity in data collection, analysis and decision making for health

Clear understanding of the activities that pertain to a CSV by members

BCC Capacity for key family behaviors by CSV

Leadership

CSV capacity in community mobilization and motivation

Credibility of CSV in the eyes of the community

Organizational

Clear constitution with roles & responsibilities in place for CSV

Clear understanding of roles and responsibilities by members of CSV

Governance

Regular and democratic elections in CSV

CSV Ability to resolve conflicts

Presence of Women in CSV Committee

Mechanism of Feedback from CSV to community & counter feedback

Financial Management

Updated books of Accounts and/or Documentation

Project Management

Existence of Clear micro plans within CSV

Human Resource Management

Ability of CSV to offer Incentives/Motivation

MALI INDICATORS for Component 6

Element Identified

National Political Situation

General enforcement of National Health Policy in place
Enforcement of National Policy in regard to Equity in place

National Stability

Social and Political Stability

Prevalence of FGM

Emancipation of Women

Women Status
Women Literacy

Economic Situation

National Gross Domestic Product
Average Health Expenses Per Outpatient Visit

Environment

Level of Road Infrastructure in Community
Access to Safe Drinking Water

External Environment

Families with Access to Radio