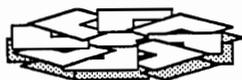


**EVALUATION OF THE AFRICA CHILD  
SURVIVAL INITIATIVE-COMBATTING  
COMMUNICABLE CHILDHOOD DISEASE  
PROJECT IN GUINEA**

**ATLANTIC RESOURCES CORPORATION**



**EVALUATION OF THE AFRICA CHILD  
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COMMUNICABLE CHILDHOOD DISEASE  
PROJECT IN GUINEA**

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## TABLE OF CONTENTS

	PAGE
LIST OF TABLES .....	i
LIST OF APPENDICES .....	ii
ACRONYMS/ABBREVIATIONS .....	iii
EXECUTIVE SUMMARY .....	vi
I. INTRODUCTION .....	1
1. BACKGROUND OF THE PROJECT .....	1
2. THE EVALUATION PROCESS .....	3
3. ORGANIZATION OF THE REPORT .....	4
II. PROJECT OUTCOME (CORE INTERVENTIONS) .....	5
1. CONCEPTS AND METHODS .....	5
2. IMMUNIZATION ACTIVITIES - E.P.I. ....	8
3. CONTROL OF DIARRHEAL DISEASES (CDD) .....	9
4. MALARIA CONTROL .....	10
5. HEALTH IMPACT OF CORE INTERVENTIONS .....	11
6. LESSONS LEARNED .....	11
7. SUSTAINABILITY .....	12
8. RECOMMENDATIONS .....	12
III. SUPPORT STRATEGIES AND ACTIVITIES .....	13
1. MONITORING ISSUES (HEALTH INFORMATION SYSTEMS) .....	13
2. OPERATIONS RESEARCH .....	15
3. TRAINING AND TECHNICAL ASSISTANCE .....	16
4. HEALTH EDUCATION .....	20
IV. PROJECT RESOURCES MANAGEMENT .....	25
1. PROJECT STRUCTURE AND ORGANIZATION .....	25
2. HUMAN RESOURCES ISSUES .....	26
3. LOGISTICAL AND TECHNICAL RESOURCES .....	28
4. FINANCIAL AND ACCOUNTING ISSUES .....	30
V. EXTERNAL ENVIRONMENT AND POLICY ISSUES .....	34
1. INTERACTION WITH HOST COUNTRY GOVERNMENT .....	34
2. INTERACTION WITH USAID .....	35
3. INTERACTION WITH OTHER DONORS AND NGOS .....	36
VI. PROJECT SUSTAINABILITY .....	39
APPENDICES	

## LIST OF TABLES AND GRAPHS

	PAGE
TABLE I.1 Summary of Project Chronology .....	2
TABLE IV.1 National Budget for ACSI-CCCD Project .....	31
TABLE IV.2 Income Generated in Project Prefectures .....	31
GRAPH IV.1 Counterpart Fund Contribution .....	32

## LIST OF APPENDICES

- Appendix A: Epidemiological Data List of Tables (In French)
- Appendix B Project Data Sheet
- Appendix C Scope of Work
- Appendix D Bibliography
- Appendix E List of People Interviewed
- Appendix F Summary Tables of Project Objectives and Results
- Appendix G: Health Education and Training Data
  - G-1: Training activities
  - G-2: Health Education - Objectives and Activities
  - G-3: Health Education - Training Material produced
- Appendix H: Management Data and Other Background Material
  - H-1: Summary of team activities in chronological sequence

## LIST OF ACRONYMS/ABBREVIATIONS\*

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

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

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

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**B. FRENCH ACRONYM**
**ENGLISH EQUIVALENT**


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

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

**EXECUTIVE SUMMARY**

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

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

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

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

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

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

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

Team members had expertise in management and information systems, child survival programming, and health education and training.

Guinea has demonstrated remarkable political will and self-reliance in launching a public health strategy for the decade of the 1990s that serves as a model for other countries in the West African region that have had greater resources but achieved less impressive results. Guinea's results are reflected in its incorporation of elements of the Bamako Initiative into national policy, notably its encouragement of donor contributions on a collaborative basis and its strong coordination of different program elements at various levels of the health system.

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

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

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

**RECOMMENDATION 1:** The evaluation team recommends that prompt and effective steps be taken to integrate all ACSI-CCCD assisted health centers into the national program, preferably

before the end of the project.<sup>1</sup>

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

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

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

**RECOMMENDATION 2:** Priority measures the MOPH needs to address include (a) timely completion of its needs assessment by the planning office (BEPR) and (b) identification of a long-term donor partner to continue assistance to BEPR.

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

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

**RECOMMENDATION 3:** The MOPH needs to ensure that priority training and technical assistance needs are met. Such needs include establishing a long-term scholarship for a training specialist, preparing a 1991-92 training action plan, and obtaining management training tools and a training master plan.

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

The health education service is now capable of defining a strategy for health education in Guinea. Ninety percent of the activities in the 1991 plan of action have been realized, with health personnel gaining adequate knowledge. Peace Corps Volunteers (PCV) played a role in the decentralization of the health education activities.

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

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<sup>1</sup>The Executive Summary presents the report's recommendations in succinct and summary fashion. They appear in greater detail in their respective sections in the body of the report. Those toward the end of the report are intended to address specifically the transition period and are identified as such.

**RECOMMENDATION 4:** The MOPH should consolidate efforts toward a national policy for Health Education and Promotion (HEP) by taking such steps as implementation of the 1991 HEP/CDD action plan; refresher sessions to health officials in HEP/EPI and preparation of an HEP/Malaria action plan; integration of HEP activities into the national EPI/PHC/ED program; and improvement of supervisors' and heads of centers' training in HEP.

**RECOMMENDATION 5:** The MOPH should strengthen the Health Promotion Department and its Health Education section through improved monitoring techniques as well as increased use of radio messages in the country's principal languages.

**RECOMMENDATION 6:** Peace Corps assistance in health promotion should be continued and strengthened.

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

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

**RECOMMENDATION 7:** The GOG should arrange for technical assistance and training in applied management at all levels especially in the key areas of planning, supervision, evaluation, accounting and financial management, and personnel management. From a personnel management perspective, assistance is needed in helping contract project employees find other work opportunities; also, new policies related to job incentives and location ought to be explored by the GOG.

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

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

**RECOMMENDATION 8:** USAID and the MOPH need to give priority attention to what will happen to the project's resources (i.e. funds, vehicles, appliances and commodities) after PACD. The parties need to maintain open communication on these matters to ensure a smooth transition.

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

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

**RECOMMENDATION 9:** The GOG, with the assistance of donors, should up-date an earlier cost recovery feasibility study prepared for the ministry, keeping in mind the study was limited by an absence of baseline data.

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

**RECOMMENDATION 10:** The GOG/MOPH needs to reserve a place for its citizens' health in the overall development process as it sets priorities and assesses the demands and needs of other sectors of the economy such as agriculture, transportation, and education.

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

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

**RECOMMENDATION 11:** MOPH and SCIO members (donors and NGOs) must find a way to coordinate their efforts in a more focussed, topic-driven approach.

As only one third of the project's 48 health centers is presently supported by the national PHC system, we cannot stress enough the importance and urgency of initiating the process of integrating the remaining 33 centers. Since most of the health centers should have no difficulty meeting the criteria for integration, it is vital that the process be initiated rapidly, while the momentum is still present. The sooner the integration takes place, the more likely health center activities previously supported by ACSI-CCCD project have a chance to continue undisrupted.<sup>2</sup>

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

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

The extent to which project activities continue after PACD either with the GOG or with donor support, is the extent to which project sustainability will have been achieved. Therefore under **Sustainability**, the team offers no new recommendations but would reiterate and emphasize certain of those already presented in the report, especially the first recommendation about the need to integrate the remaining health centers, those pertaining to the transition period, and those about the need for identifying donor or other partners and for strengthening efforts at coordination throughout the system.

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<sup>2</sup>This report compares project and project plus national plan centers. Had there been more time available, the team could have also compared project plus national centers with only national plan centers. The 1990 Annual Report for Guinea makes some of these comparisons.

## I. INTRODUCTION

### 1. BACKGROUND OF THE PROJECT

#### A. Summary of the Project's objectives

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

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

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

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

The ACSI-CCCD project area includes over 1.5 million of Guinea's population, approximately 25 percent of the total. (See Appendix F for Tables that present data on which this discussion is based.) This includes an estimated 18 percent of the country's child population (ages 0-11) and about 25 percent of the national population of pregnant women.

Trends in immunization coverage show positive trends since 1986 especially in the CCCD zones. Trends in other indicators (Table F.3) including mortality and morbidity are more mixed such as those showing apparent increases in inpatient diarrhea mortality and in measles morbidity. These are perhaps best explained by the notable gains made in record keeping. The state of records in Guinea still leaves considerable room for improvement yet, when it is recalled that less than a decade ago regional or national level health statistics were largely unavailable, it becomes clearer how much headway has been gained.

#### B. Project setting and environment

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

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

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

### C. Project Evolution

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

TABLE I.1  
Summary of Project Chronology  
(according to major documents)

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

## 2. THE EVALUATION PROCESS

The final external evaluation of the ACSI-CCCD project in Guinea took place between April 14 and May 10, 1991. The objective as stated in the scope of work for the evaluation (see Appendix C) was to: (1) review actual versus planned achievement of the project purpose and objectives; (2) document factors accounting for success or failure of the project components; (3) estimate the sustainability of development accomplishments; (4) provide a series of recommendations to assist the ministry of health in further development of child survival activities beyond the PACD; and (5) identify lessons learned from this project as guidance for future similar development activities.

In addition, the team was asked by the Mission to identify a set of transition issues which need to be dealt with as one project closes down and the project's activities, resources, and investments are taken over by other parties such as the government and/or other donors. Given the constraints on time and resources, the team did what it was able to on this issue; some of the recommendations were primarily formulated to address the transition issues.

The evaluation was conducted by a team consisting of:

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

The first and last members participated in a Team Planning Meeting in Washington, where they received background information, reviewed project documents, discussed the project with other donors, and prepared for the in-country assignment. They were joined in Guinea by the other two team members.<sup>3</sup>

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

In Guinea, USAID/Conakry arranged for hotel reservations and provided logistic support; the

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<sup>3</sup>It had been the intention to have the whole team meet in Washington prior to the in-country visit but this was not possible in the end. Given the frequent changes in planning and scheduling the evaluation, the absence of the Technical Officer in Guinea during the team's visit, the occurrence of unrest during the Guinea visit and other challenges and obstacles, this evaluation effort was fraught with difficulties from the beginning. Though these have effected somewhat the final outcome, the team nevertheless hopes that its efforts will be found to be of use to A.I.D. and the other clients in assessing the ACSI-CCCD project in Guinea and in pointing out useful lessons for the future.

project staff provided unabated administrative and logistic support (access to printers, office space, in-country travel). Those with whom the team met were available for questions and logistical support throughout the in-country stay, for which the team expresses its sincere gratitude to all (For a list of team activities, see Appendix H-1).

### 3. ORGANIZATION OF THE REPORT

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

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

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

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

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

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

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

0. Introduction
1. Finding: i.e. progress achieved and constraints encountered
2. Conclusions
3. Lessons learned
4. Recommendations (ones directed at transitional issues are so identified)

■ for ACSI-CCCD project staff  
■ for MOPH  
■ for USAID

The primary agency or client to which lessons learned or recommendations are directed are identified at the end of each by parentheses.

## II. PROJECT OUTCOME (CORE INTERVENTIONS)

### 1. CONCEPTS AND METHODS FOR IMPACT ANALYSIS

#### A. Introduction

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

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

The ACSI-CCCD project predates the National Primary Health Care Program and aided in its design. Furthermore, the project has continued to work with the National Program as it ends its activities, as noted later in the report.<sup>4</sup>

#### B. Terms of reference

The epidemiological analysis of this section looks specifically at the outputs of the ACSI-CCCD project for the three technical interventions (Immunizations, Oral Rehydration Therapy of children with diarrhea and the use of Chloroquine for the presumptive and preventive treatment of Malaria). The quantitative objectives of the project are summarized in Table 1 on page A-01 of Appendix A.<sup>5</sup>

Selected objectives proposed by the World Health Organization to be attained by 1995 are presented on page A-03 to permit comparison with the project's objectives.

#### C. The ACSI-CCCD project

The creators of the Africa Child Survival Initiative had a vision, although in retrospect it was a limited one. An abundant, international health literature showed that medical interventions per

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<sup>4</sup>Given the limitations on the length of the evaluation report, supporting information and data for the subsequent analyses in the report are listed in Appendix A. The first item in the appendix is a list of definitions used in II and III, 1 of the report.

<sup>5</sup>References in this section, II, to tables and figures, etc., are all to Appendix A.

se rarely if ever have a significant impact on the ecology of morbidity and mortality in developing countries.<sup>6</sup> Certainly not in the short run. Nevertheless, it was proposed that the "Twin Engines" (or "Magic Bullets") of immunizations against six childhood diseases and oral rehydration therapy for diarrhea, accompanied by chloroquine for malaria would rapidly result in the reduction of morbidity and mortality rates from 25 to 50 percent for children under five. The amendment that extended the project stressed that the indicators that had been initially proposed were generic for the entire program and that project managers in each specific country should explicitly adapt them to their specific situation.<sup>7</sup> For example, of all the countries participating in the program, Guinea's percentage of children under one completely immunized was the lowest at five percent. It was perhaps overly optimistic to expect in a few short years coverage could be increased to 80 percent, in spite of the fact that WHO and UNICEF were aiming for 90 percent coverage by 1990.

#### D. Geography and Integration

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

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

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

#### E. Conceptual models of health

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

- Political
- Socioeconomic

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<sup>6</sup>There is also evidence to the contrary, however; global data from countries as diverse as Bangladesh, Senegal, Haiti and Zaire have documented that measles vaccine, for instance, can increase child survival in the 25 percent range and similar findings exist for TT.

<sup>7</sup>The rationale here was that, by setting epidemiologically relevant targets, an internationally comparable yardstick to monitor performance was made available that could in turn contribute to dramatic improvements in immunization.

■ Utilization of health services  
 ■ Health status

Another tool that has been used is the Physical Quality of Life Indicator (PQLI), which is derived from a combination of the infant mortality rate, life expectancy at birth and the proportion of literate adults. Figure 1 and Table 3 on pages A-16 and A-17 in Appendix A show Guinea in juxtaposition with its neighbors. Such a definition of health is, however, limited as well as subjective and therefore is of little use.

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

F. Population

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

Guinea	6,332,926
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Conakry	1,137,178
Kindia	214,676
Télimélé	244,474
-----	
ACSI-CCCD Zone	1,596,328 = 25 percent/total population

G. Demographic Indicators

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

The lines are essentially horizontal in Figure 3, showing that Guinea with a total fecundity rate of 6-7 and an annual growth rate of 2.7 percent has been and continues to be a pronatalist

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

#### H. Patterns of morbidity and mortality

As shown on pages A-30 to A-32, the government estimates of the major causes of childhood morbidity and mortality in 1986 remain essentially unchanged in 1990. Given that acute respiratory infections were and remain one of the three big killers of children it is regrettable that an ARI intervention was not part of the project package. What has been found in some countries with high immunization rates are that fully protected children are now dying from their respiratory infections. Table 9 on page A-33 serves to remind us that seasonal variation must also be considered when evaluating health needs and strategies.

### 2. IMMUNIZATION ACTIVITIES - E.P.I.

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

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

The graphs and data on pages A-34 to A-39 provide an analysis of the impact of the EPI. Figure 7 shows that, in general, the coverage rates of the project zone are higher than the national averages. Although far from the objectives of 80 percent coverage for infants and 60 percent for pregnant women, the sustained progress is impressive. In just three years, national coverage of infants tripled from five percent to 15 percent, a trend that continued for 1990 as well. In the project area, the coverage of pregnant women at 38 percent is almost five times higher than the national average. The high coverage rates that were reported in 1986 (Table 11, page A-36) were based on a survey that was carried out immediately after a national campaign, and thus were not sustained.

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

- Local estimates of coverage are significantly higher than those derived from data in Conakry (32 percent versus 17 percent). The explanation may be a combination of data lost at the central

level and different estimates of the groups at risk.

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

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

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

### 3. CONTROL OF DIARRHEAL DISEASES (CDD)

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

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

■ There seems to be confusion between incidence, prevalence and the relationship between them. The 1989 survey quotes a survey in Kindia that found a 17 percent two-week prevalence rate, suggesting 8.9 episodes of diarrhea/child a year. The numbers do not add up. Assuming no

seasonal variation, and an average duration of four days, 8.9 cases/child per year implies a two-week prevalence of 41.5 percent.

■ Surveys seem to consistently show that over half of the mothers treat diarrhea in their children with some sort of oral liquids. We were unable to find a definition<sup>8</sup> of what is considered to be correct treatment, so we are unable to say if the project objective of 50 percent effective treatment has been reached.

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

The team that went to the prefecture of Téliimélé was able to collect health center specific data for both diarrhea and malaria cases for 1988-1990. It is interesting to note that the estimate of coverage of needs was 20 percent in 1988, the first year of the program, falling to seven percent in 1989 and five percent in 1990. If this is an indicator that mothers have now learned to hydrate their children at home, it is good news. If it is a sign of poor training, supervision or education of the community, then it is a situation that needs to be corrected.

Data and analysis of the evolution of mortality in children hospitalized for diarrhea are presented on page A-42. The remarkable statistic is that the number of hospitals reporting has increased from three in 1986 to 37 in 1990. As for the mortality rate there is no evidence of the reduction of 50 percent that the project hoped to achieve. At the same time, the presence of high case fatality rates in diarrhea should not necessarily be interpreted as a sign of failure; in fact, in successful programs rates usually go up as mild cases are increasingly treated as outpatients. The 1990 CCCD report for Guinea supports this latter point: "The trend at Donka hospital has been a steady decrease in hospital admissions with a concomitant increase in diarrhea cases seen at Conakry Health Centers."

#### 4. MALARIA CONTROL

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

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

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<sup>8</sup>A definition does exist within the recently ratified national CDD policy. This policy, officially accepted in March 1991, is largely based on results from ACSI-CCCD project's CDD component. (Mission Cable, Conakry 03524)

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

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

Note should also be made of malaria's growing role as a major killer in Africa. The spread of Plasmodium falciparum chloroquine resistance along the west coast of Africa has increased morbidity--Guinea is no exception as the 1990 CCCD report shows--and this disease will further threaten development by its impact on the working as well as the child population.

## 5. HEALTH IMPACT OF CORE INTERVENTIONS

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

No one can deny that Guinea has demonstrated remarkable political will and self-reliance in launching a public health strategy for the decade of the 1990's that serves as a model for other countries in the West African region that have had greater resources and less impressive results.

## 6. LESSONS LEARNED

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

in a country with continuing population pressure and foreign exchange problems and where everything is a priority. (All)

## 7. SUSTAINABILITY

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

## 8. RECOMMENDATIONS

RECOMMENDATION 1: The evaluation team recommends that prompt and effective steps be taken to integrate all ACSI-CCCD assisted health centers into the national program, preferably before the end of the project. Most of the communities are ready and willing to meet their part of the bargain. One of the main constraints is the purchase of the 30 months supply of the essential medicines that are needed to launch each center. The danger of rapid expansion is that in certain sections of the Ministry of Health, personnel are already stretched to the limit and that without continued assistance in training, and material and technical support such expansion will be accompanied by a decrease in quality. Such a result would be the exact opposite of the current strategy that envisions gradual growth of the program while maintaining and improving the quality of services. The needs of the BEPR are particularly critical and will be addressed in the chapter on the Health Information System. (ACSI-CCCD/MOPH/USAID)

### III. SUPPORT STRATEGIES AND ACTIVITIES

#### 1. MONITORING ISSUES (HEALTH INFORMATION SYSTEMS)

##### A. Discussion

The qualitative indicators in the scope of work for the evaluation of the Health Information System and Operational Research are summarized in Table 2 on page A-2 in Appendix A.

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

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

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

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

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

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

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

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

##### B. Problems

In order to ensure the viability and sustainability of the system, it is urgent to address the

following priority problems:

■ The one functioning computer is inadequate for training and work purposes. (Bull Micral, 512 kb memory, 20 Mb disk drive) There are no lap-tops. Today virtually all of the analyses are done manually by three people.

■ The absence of a full-time computer professional in the Ministry of Health.

■ The absence of preliminary analysis capabilities in the prefectures resulting in an excessive work load in the BEPR. This problem will be exacerbated as the national integrated health program continues to expand.

■ Since its creation in 1988, the SNIS has not had the means to undertake supervisory and evaluation visits outside of Conakry.

■ Inadequate budget for the production of the number of copies needed of the Annual Reports.

### C. Conclusions

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

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

### D. Recommendations

Recommendation 2: Priority measures the MOPH needs to address include:

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

## 2. OPERATIONS RESEARCH

### A. Discussion

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

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

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

### B. Problems

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

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

### C. Conclusions

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

### D. Recommendations

Recommendation 2: The recommendation above under HIS also applies here. On the issue of a partner, there are many organizations whose mandate is to provide such assistance, both short and long-term. IDRC, for example, has already shown its willingness to help and could be asked for continuing assistance. In areas related to population and family planning, the Population Council would be interested. (MOPH)

### 3. TRAINING AND TECHNICAL ASSISTANCE

#### A. Findings

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

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

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

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

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

A national training plan has not yet been developed, except by the MOPH administrators. Some changes have taken place in the management of training at the center over the past two years. Until recently, training was handled by the Office of Administrative and Financial Affairs (DAF), which was more concerned with personnel management than technical or administrative performance. The evolution of Primary Health Care programs between 1986 and 1989 affected the decision by MOPH to transfer the management of the training from the DAF to the BEPR, in particular to the Operational Research Division, directed by a public health physician with a masters in research.

The training role of the BEPR is to:

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

In order to fill the void in the structure for managing training and to face their training needs, the ACSI-CCCD project and the National EPI/PHC/ED Program unilaterally developed their own training capacity by creating a training commission. The ACSI-CCCD project commission consists of the ACSI-CCCD program coordinator, the anti-diarrheal disease program coordinator, the anti-malaria program coordinator, and the head of health education programs. These officials

combine their roles in the framework of the ACSI-CCCD project with their roles in the framework of the national program. The commission of the national training program is well structured and can call upon skilled Guinean public health experts as well as their collaborators in UNICEF and WHO. This commission appears to function very efficiently under the leadership of the National Director of Prevention, who is also the president of FORHSE (Power to Optimize Human Resources in Health); a newly created inter-ministerial group aimed at strengthening skills in health.

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

The target in terms of personnel to be trained has even been exceeded: up from the 500 scheduled, 645 have been trained in vaccination techniques, maintenance of the cold chain, statistical reports, management of a ORT unit, and in treatment and prevention of malaria. (See Appendix G for a Summary of Training Activities.) In the health centers visited in Conakry, we were able to find at least two persons trained in ORT, five trained in EPI<sup>9</sup>, and, if all the personnel trained during the mass campaigns are counted, the total number of persons trained doubles. In Kindia and Téliimélé, all the heads of centers were trained and they began to train new personnel at the level of their centers (three to four per health center).

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

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

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

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<sup>9</sup>these numbers are specific to the Conakry health centers; rural centers do not have these complements of staff.

the evaluation of needs to the evaluation of the performances done after training.

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

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

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

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

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

## B. Conclusions

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

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

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

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

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

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

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

### C. Recommendations

Recommendation 3: The evaluation team recommends that the following training and technical assistance needs be addressed and prioritized in the following order:

- Support BEPR efforts to conduct training by supplying a long term scholarship for training a specialist in training;
- Prepare an action plan for training for 1991-1992, aimed at meeting the need of refresher sessions for health center personnel in specific areas identified after analyzing the supervisory files or after observing the performances of the officials in service delivery. The plan will also aim at strengthening training in the following areas: training of heads of centers, DPS personnel, project coordinator, and officials of BEPR, management of the health education department, management of information systems, communication and learning techniques, supervision and supervisory techniques, and operational research. This plan will be financed with counterpart funds beginning in October 1991. The plan should also needs to provide for the integration of training activities into the national program framework so that the training modules can eventually be incorporated into the School of Medicine's curricula; and
- Provide timely technical assistance to this department and continue to help

elaborate the different stages of the training master plan and management training tools during implementation of the 1991 and 1992 action plans. (MOPH)

#### 4. HEALTH EDUCATION

##### A. Findings

Health education has been one of the most dynamic and active components since the last project evaluation in August 1989. Dramatic changes have taken place in this area at all levels. (See Appendix G for a table showing the progress made in health education since the 1988 recommendations.)

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

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

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

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

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

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

CCCD project, the Peace Corps volunteer in Conakry, and the Coordinator of the CDD Program were trained in HEP as applied to the CDD Program in Zaire in October 1990.

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

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

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

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

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

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

With respect to the management of activities, the central team for health education described the HEP action plans of the Prefecture of Conakry, and helped the teams in Kindia and Téliimélé prepare their action plans for 1990 and first quarter of 1991. The team has made regular supervisory visits to the 14 health centers in Conakry, and four supervisory visits to each of the sub-prefectures of Kindia and Téliimélé since January 1990. They have prepared training plans using observation instruments developed to identify training needs. In addition, the team

introduced and supervised home visits to Conakry in order to reach the children who were not fully vaccinated.

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

The health education activities applied to EPI were evaluated in the area of Conakry in December 1989. The acquisition of knowledge on the messages to transmit is dramatic: 90 percent of the personnel were familiar with the messages to be transmitted and the level of knowledge received by message doubled between the pretest and post-test. However, effective transmission of messages is still weak. According to the Director of the Health Promotion Division, out of ten women questioned when leaving the office, only three had totally understood the messages. The majority of the women only remembered the next appointment and the usefulness of keeping the vaccination card. These figures can be attributed to the weak health care provider-client relationship that prevailed before the emphasis on improved motivation and attitudes that has resulted from recent health care education in the center activities.

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

The major problems perennially affecting these activities are:

- the availability of vehicles in order to strengthen the training and supervisory activities of health center officials and allow them to conduct the necessary surveys and monitoring of the impact of HEP activities;
- the transfer of skills from trainers and supervisors to the DPS supervisory level and heads of centers;
- the acquisition of skills in monitoring health education activities and the handling and analysis of data; and lastly
- the effective budgeting and financing of activities.

## B. Conclusions

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

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

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

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

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

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

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

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

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

### C. Recommendations

Recommendation 4: Consolidate efforts toward a national policy for Health Education and Promotion (HEP) by taking the following steps in the following sequence:

- Immediately execute the 1991 HEP/CDD action plan, without waiting for financing, by applying the same strategy as the 1990 HEP/EPI action plan, which trained health officials at sites where they worked.
- Provide refresher sessions to health officials in HEP/EPI and preparing an HEP/Malaria action plan from now until the end of the project; these activities will be financed out of counterpart funds for FY 1991-92.
- Integrate HEP activities into the national EPI/PHC/ED program through the Health Promotion national service.

- Conduct a KAP survey in order to measure the HEP/EPI impact on mothers and take corresponding measures; follow the same strategy for the other components.
- Improve the training of supervisors and heads of centers in HEP and decentralize the supervision of this activity to their level. (MOPH)

Recommendation 5: Strengthen the Health Promotion Department and its Health Education section by providing a vehicle with the necessary fuel for carrying out activities. This department should take into account the indicators defined by the project and strengthen all the activities already undertaken, guarantee their monitoring, and take corrective measures. Specifically, more radio broadcasts of messages should be done in the country's principle languages. (MOPH)

Recommendation 6: Continue and strengthen assistance by the Peace Corps in the area of health promotion. (USAID/PEACE CORPS)

#### IV. PROJECT RESOURCES MANAGEMENT

##### 1. PROJECT STRUCTURE AND ORGANIZATION

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

###### A. Findings

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

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

###### B. Lessons learned

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

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

###### C. Recommendations (with special attention to transition issues)

Recommendation 1: The evaluation team recommends that prompt and effective steps be taken to integrate all ACSI-CCCD assisted health centers into the national program, preferably before the end of the project. Most of the communities are ready and willing to meet their part of the bargain. One of the main constraints is the purchase of the 30 months supply of the essential medicines that are needed to launch each center. The danger of rapid expansion is that in certain sections of the Ministry of Health, personnel are already stretched to the limit and that without continued assistance in training, and material and technical support such expansion will be accompanied by a decrease in quality. Such a result would be the exact opposite of the current strategy that envisions gradual growth of the program while maintaining and improving the quality of services. The needs of the BEPR are particularly critical and will be addressed in the chapter on the Health Information System. (ACSI-CCCD/MOPH/USAID)

Recommendation 2: While the assessment is going on, the MOPH needs to take the initiative to identify a partner ready to provide the long-term assistance needed by the BEPR (see Operations Research Recommendations). (MOPH)

## 2. HUMAN RESOURCES ISSUES

### A. Findings: Progress achieved

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

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

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

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

### B. Findings: Constraints encountered

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

Highly trained, health workers in the centers have a predominantly curative orientation. This reflects a similar emphasis in the prevailing nursing, medical and technical curricula. We also observed unequal performance among various health agents. We saw several instances of over-prescription for simple cases of bronchitis or unspecified fever. In one center, a mother had just given birth to a baby girl. The midwife did not know that silver nitrate or tetracycline ointment

must be administered within hours to prevent neonatal eye infections. Nor was the drug available. One team member returned to the center with the ointment, and demonstrated to the midwife how to administer it. Besides such anecdotal evidence, however, the team had no other effective way of measuring project personnel efficiency.

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

■ The frequency of supervisory visits by central project personnel to rural health centers is far from optimal. While the TO has visited the most remote préfecture on average three times a year, his national counterparts have barely made one visit per annum. This "hands-off" involvement of national counterparts is perceived as a serious obstacle to long-term sustainability.

■ With few exceptions, there has been a frequent project staff turn-over, especially at the national level. This contributes adversely to effective institutional memory and continuity in project output.

■ In rural as in urban health centers, the units are generally underused.

■ Health centers personnel are not used to operating at full capacity, which results in long waiting lines, despite a daily low output. In one center, by ten o'clock, there were still 15 mothers waiting to have their children vaccinated. The bottle-neck came from an ill-organized management sequence. While two of his colleagues sat idle, it was the same health worker who checked the immunization record, cashed the money for the immunization cards, gave the vaccine, and made follow-up instructions. The team demonstrated to the staff a more efficient sequence of distributing tasks among themselves. This issue was also noted in the 1989 evaluation report. Only effective management training and ongoing supervision can bring about further improvements in this area.

■ With two notable exceptions, staff members had no job descriptions to guide them in their work. One supervisor had made up his own checklist of supervisory activities;

■ As mentioned earlier, minutes of weekly staff meetings are often not being kept;

■ Although personnel files are maintained for the two employees hired by the project (i.e. administrative assistant and one driver) other files pertaining to attendance records, application documents (e.g. C.V.), salary, contract, and other important papers are not kept;

■ Except in one case, no performance evaluation has been conducted and documented;

■ Long-term planning and periodic evaluation activities are not routinely practiced. Even our evaluation visit, because of the time factor, was perceived as an "external" sanction, rather than a management tool.

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

should become less important.

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

### C. Lessons learned

In addition to financial and human resources, a successful project requires the setting up of an effective management system. (ALL)

### D. Recommendations (with special attention to transitional issues)

Recommendation 7: Technical assistance in applied management is advised at all levels. Workshops and seminars, can serve this purpose, but preferable is long-term, on-site assistance, training and supervision. The training should include all aspects of management particularly the key ones of planning, supervision, evaluation, accounting and financial management, and personnel management. (MOPH)

From a personnel management perspective, the following steps should be taken:

- assistance should be given, and timely arrangements made for helping contractual project employees find other work opportunities. (USAID)
- The GOG and MOPH should explore new policies to redeploy Guinea health professionals in a more equitable urban-rural balance and to provide incentives for increasing personnel continuity. (MOPH)

## 3. LOGISTICAL AND TECHNICAL RESOURCES

### A. Findings: Progress achieved

The project office is housed in an old building located conveniently near EPI's central warehouse. The project possesses a fleet of five vehicles in good working conditions, and of motorcycles used by DPS and health centers in performing their supervisory activities. At the peripheral level, the health centers are well staffed, and most of the facilities are in a good state of maintenance.

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

### B. Findings: Constraints encountered

The building used by the project is sub-standard, and does not provide office space for each staff

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

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

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

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

#### C. Lessons learned

There is a need for orientation of new project staff to USAID procurement requirements. Project staff must be made aware of the necessity to analyze long-term needs and submit timely procurement calendars. Face-to-face communication seems critical to achieve a mutual understanding of opportunities and limitations. (USAID)

#### D. Recommendations (with special attention to transitional issues)

Recommendation 8: Special consideration needs to be given to the disposition after PACD of the project's material resources -- project vehicles, appliances and commodities. The TO's input will be critical. While USAID recognizes that MOPH needs vehicles and commodities to carry on activities previously supported by the project, it is also concerned about the MOPH's ability to absorb and effectively manage project vehicles, computers, and commodities. The disposition of vehicles and commodities during the transition requires a mutual understanding on needs and limitations. Two-way communication is critical at this stage to ensure a smooth transition. So far, no mutually acceptable solution appears to have been found. In respect to the delivery of essential drugs, the option of a sub-grant to other donors has been suggested. The MOPH is urged to move ahead with the building under construction. Once functional, the facility could house activities designed to complete the full integration of the remaining 33 centers. The allocation of funds and manpower is critical for a smooth transition. (ALL)

#### 4. FINANCIAL AND ACCOUNTING ISSUES

##### A. Findings

The project involved four main sources of funding:

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

##### i. Bilateral Funds

The project's LOP budget amounted to US\$1,530,000 (earmarked in total). Line items in this budget include:

- vehicles, office equipment (computers, copier), cold chain (refrigerator),
- supplies e.g. immunization, chloroquine, essential drug packages, ORS packages,
- some personnel (administrative assistant, driver),
- maintenance, and
- support for activities such as training abroad, health education, O.R., audit.

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

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

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

##### ii. Counterpart Funds (PL480)

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

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

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

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

Approved	440,856,470 FG
Allocated	317,517,505 FG
Used	212,794,749 FG
Balance	228,061,721 FG

These figures for 1991 represent a significant increase in counterpart funds over previous years and a further indication of the GOG's commitment to ACSI-CCCD (see Graph IV.1 from the 1990 ACSI-CCCD project annual report for Guinea shows a steady increase in the disbursement of counterpart funds since 1986-87.)

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

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

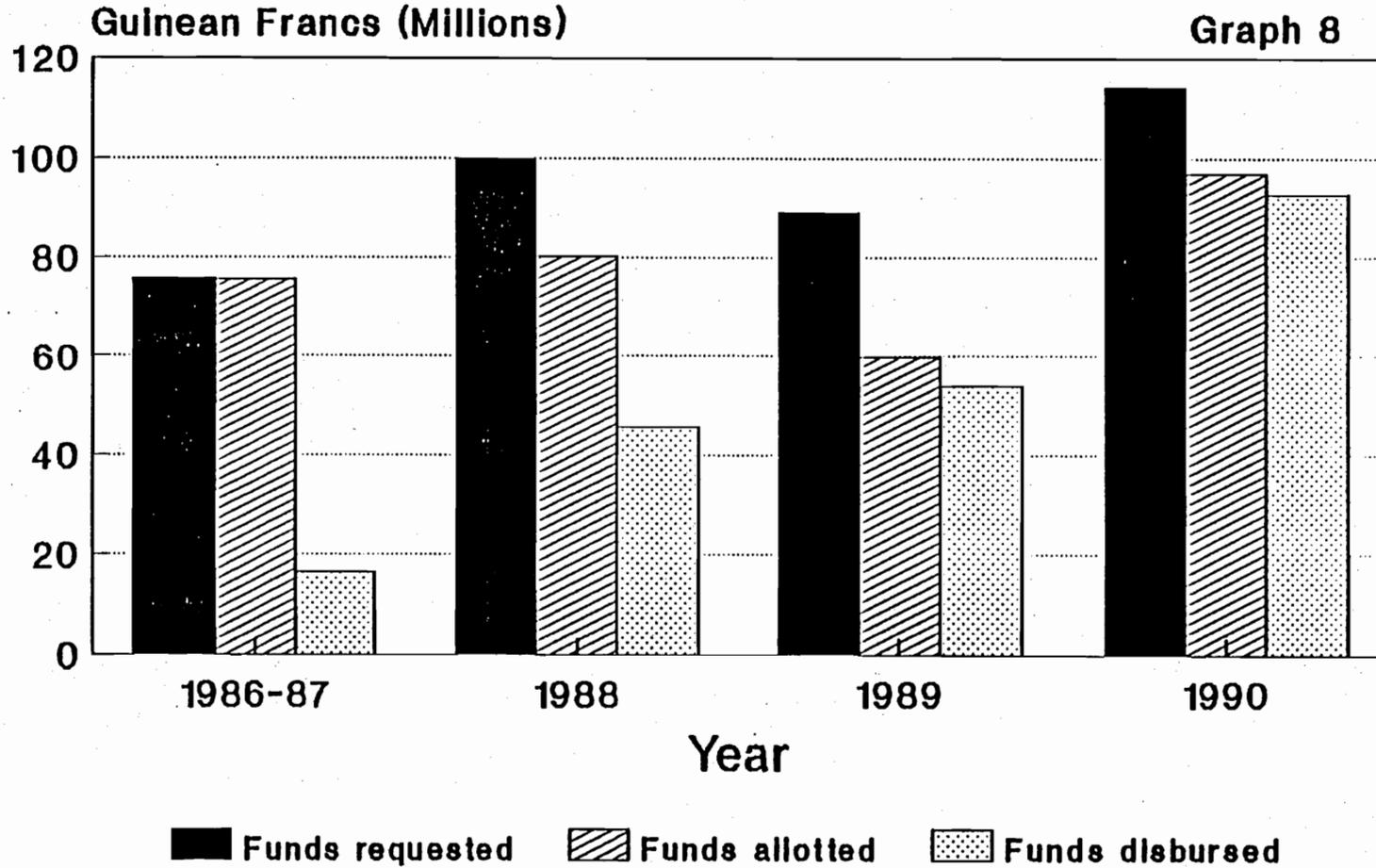
TABLE IV.2 Income Generated in Project Préfectures (4/14/90 to 6/12/90) (FGs)

Conakry I	1,014,275
Conakry II	6,330,980
Conakry III	6,816,850
Kindia	1,162,460
Télimélé	1,438,000
misc.	50,000
	-----
	16,812,565 = 24,018US\$

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

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

# Counterpart Fund Contribution CCCD/Guinea, 1986 - 1990



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

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

#### B. Lessons learned

The financial management of regionally funded projects represents a special challenge for USAID missions. Especially in small missions, with limited staff availability, it would be helpful to brief new project teams (such as ACSI-CCCD) on USAID financial and administrative procedures and procurement requirements.

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

#### C. Recommendations (with special attention to transitional issues)

Recommendation 9: Since Guinea's experience with cost recovery is relatively recent, the GOG, with the assistance of donors, should up-date an earlier cost recovery feasibility study prepared for the ministry, keeping in mind the study was limited by an absence of baseline data. (MOPH)

Recommendation 2: As noted above, early steps need to be taken to identify new partners or donors to carry on ACSI-CCCD activities beyond the life of the project. The team perceived a readiness among donors (UNICEF, World Bank, EEC, French, German and other countries), but did not have the time to pursue this issue in great depth. Technical assistance may be useful in this respect. (ACSI-CCCD/MOPH)

## V. EXTERNAL ENVIRONMENT AND POLICY ISSUES

### 1. INTERACTION WITH HOST COUNTRY GOVERNMENT

#### A. Findings

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

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

#### B. Lessons Learned

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

#### C. Recommendations

Recommendation 10: The GOG/MOPH would do well to reconsider the value and priority of health in the overall development process. Other sectors of the economy (agriculture, exploitation of natural resources, road construction, education) are vital ingredients of socioeconomic progress and development. And so is health -- the present generation cannot wait for tomorrow's health impact on national development. Today's adults and children want, and must be a part of national development efforts. To that end, people and communities must be healthy. (MOPH)

## 2. INTERACTION WITH USAID

### A. Findings

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

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

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

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

USAID's decision to phase-out its involvement in the health sector at the EOP is based on the need to focus scarce resources on priority interventions.<sup>10</sup> In its efforts to streamline its portfolio, the Mission has decided to concentrate its resources on agriculture, education, access to domestic markets, employment and income-generating activities, and on improving the performance of the very promising private sector including social marketing of family planning methods. Although opinions vary, the team believes the rationality for this choice to be clearly beyond the scope of this evaluation, and thus will not discuss it.

### B. Lessons Learned

Among the many variables involved in a project of this magnitude, its success depends heavily

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<sup>10</sup>Hence the Mission's experience pro and/or con with ACSI-CCCD really had little, if anything, to do with this decision.

on the capacity of the Mission to supervise and backstop all its aspects. This calls for a post in the Mission of a properly trained project officer. (A.I.D.)

C. Recommendations (including transition issues)

Recommendation 9: With respect to transition, the handling of remaining funds, vehicles, and commodities deserves special attention. Although the Mission will be the ultimate decision-maker, the following points will need to be addressed:

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

3. INTERACTION WITH OTHER DONORS AND NGOS

A. Findings

A number of donors and NGOs are present and active in Guinea, especially in the health sector. The GOG has recognized and values the contributions of national and international donors and NGOs. Under the second Republic, the Ministry of the Interior and Decentralization has set up a national committee for the coordination of NGOs activities (SCIO). A declaration has been published defining the roles, responsibilities, and modus operandi of both national and international NGOs. Two national conferences have already taken place (1987, March 1989), and another was slated for 1990. The SCIO has also published four issues of "Bulletin de Liaison inter ONG" (No 3 in 1989, No 4 in Dec. 1990).

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

to another meeting.

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

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

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

#### B. Lessons Learned

More effective mechanisms--not large, lengthy meetings--need to be identified and tried that can effectively coordinate donor and NGO activities in Guinea.

#### C. Conclusions

There is an abundant, but loose, and unstructured network of NGOs and donors. Although USAID's decision to abide by PACD has generated much anxiety at all project and GOG levels, there may be opportunities for new collaborative partnerships to carry on former ACSI-CCCD project activities. The success of this endeavor will be a true test of the project's sustainability in the absence of ACSI-CCCD funds.

#### D. Recommendations

Recommendation 10: The GOG/MOPH would do well to reconsider the value and priority of health in the overall development process. Other sectors of the economy (agriculture, exploitation of natural resources, road construction, education) are vital ingredients of socioeconomic progress and development. And so is health -- the present generation cannot wait for tomorrow's health impact on national development. Today's adults and children want, and must be a part of national development efforts. To that end, people and communities must be healthy. (MOPH)

**Recommendation 11:** MOPH and SCIO members (donors and NGOs) must find a way to coordinate their efforts in a more focused, topic-driven approach. Perhaps there could be meetings at the highest level between government officials and donor representatives to coordinate national health policies and funding priorities for the nation for the next five to ten years. Also, there could be meetings focussing only on certain topics such as health, education, agriculture, natural resources, water and sanitation. And finally, there could be smaller meetings for managers and staff of projects in specific technical areas such as immunizations, health education, malaria control, primary health care, cost-recovery, and drug distribution. (All)

## VI. PROJECT SUSTAINABILITY

### 1. Findings

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

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

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

### 2. Lessons Learned

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

### 3. Conclusion

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

### 4. Recommendation:

The extent to which project activities continue after PACD either with the GOG or with donor support, is the extent to which project sustainability will have been achieved. Therefore under Sustainability, the team offers no new recommendations but would reiterate and emphasize certain of those already presented in the report, especially the first recommendation about the need to integrate the remaining health centers, those pertaining to the transition period, and those about the need for identifying donor or other partners and for strengthening efforts at coordination throughout the system.

## **APPENDIX A**

Appendix A: Epidemiological Data List of Tables (In French)

Page #	Title	Nature	#
A-i	Definitions Used in the Analysis		
A-01	Termes de References (objectifs quantifies)	Tableau	1
A-02	Termes de references (indicateurs qualitatifs)	Tableau	2
A-03	Objectifs de l'OMS pour 1995	--	
A-04	Regions de la Guinee	Carte	1
A-05	La Guinee Maritime	Carte	2
A-06	La zone du projet ACSI-CCCD	Carte	3
A-07/15:	Cadre conceptuel de la sante	--	
A-16	Correlation du PQLI et PNB/hab	Figure	1
A-17	Correlation du PQLI et PNB/hab	Tableau	3
A-18/21:	Douze indicateurs mondiaux de l'OMS	Tableau	4
A-22	Taux annuels de croissance par prefecture	Carte	4
A-23	Densite de la population par prefecture	Carte	5
A-24	Estimations de population	Figure	2
A-25	Estimations de population	Tableau	5
A-26	Indicateurs demographiques - 1	Figure	3
A-27	Indicateurs demographiques - 2	Figure	4
A-28	Indicateurs demographiques (donnees publiees)	Tableau	6
A-29	Indicateurs demographiques (estimations des tendances)	Tableau	7
A-30	Causes principales de morbidite	Figure	5
A-31	Causes principales de mortalite	Figure	6
A-32	Morbidite/mortalite - 1986	Tableau	8
A-33	Variation saisonniere de la sante	Tableau	9
A-34a	Couverture vaccinale - 1989 (zone ACSI-CCCD)	Figure	7
A-34b	Couverture vaccinale - 1989	Tableau	10
A-35	Couverture vaccinale - 1989 (niveau national)	Figure	8
A-36	Evolution de la couverture vaccinale	Tableau	11
A-37	Donnees de la prefecture de Kindia (PEV)	Tableau	12
A-38	Evolution de la rougeole	Figure	9
A-39	Variation saisonniere de la diarrhee	Figure	10
A-40a	Evolution des maladies de l'enfance	Tableau	13
A-40b	Enfants traites pour la diarrhee	Tableau	14
A-41	Donnees de la prefecture de Telimele (diarrhee/palu)	Tableau	15
A-42a	Evolution de la mortalite - diarrhee	Figure	11
A-42b	Evolution de la mortalite - diarrhee	Tableau	16
A-43	Telimele - enfants traites pour le paludisme	Tableau	17
A-44a	Evolution de la mortalite - paludisme	Figure	12
A-44b	Evolution de la mortalite - paludisme	Tableau	18
A-45	Model d'utilisation des services sanitaires	Figure	13

## Table A-1A DEFINITIONS USED IN THE ANALYSIS

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

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

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

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

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

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

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

and relying on the subjective opinions of experts for interpretation.

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

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

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

**TABLEAU 1**  
**TERMES DE REFERENCE - OBJECTIFS QUANTIFIES**

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

TABLEAU 2  
 TERMES DE REFERENCES - INDICATEURS QUALITATIFS

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

The symbol "+" means that the activity is relatively strong,  
 "+" means that activities have started but are still relatively  
 weak.

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

I. DEVELOPPEMENT DES PROGRAMMES

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

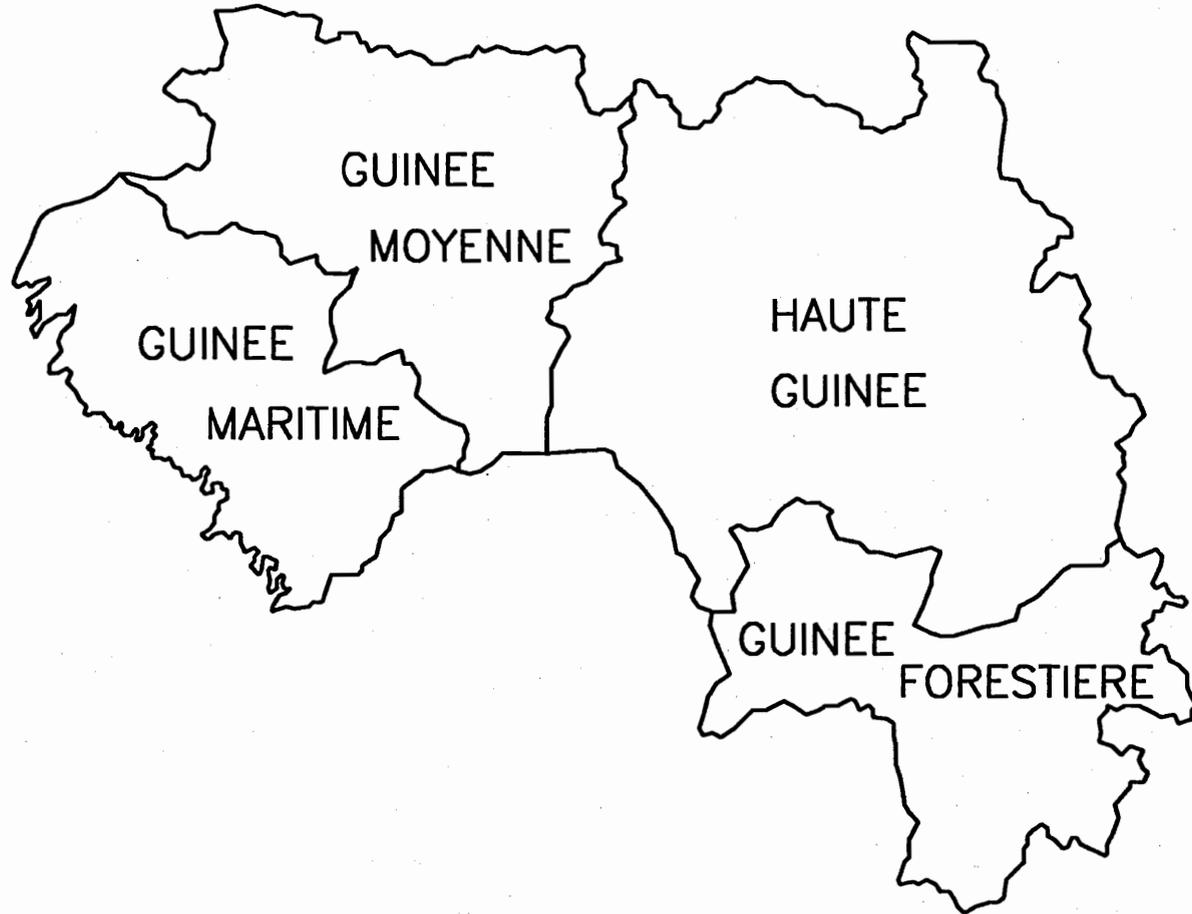
II. INFRASTRUCTURE DU SYSTEME SANITAIRE

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

III. SCIENCE SANITAIRE ET TECHNOLOGIE

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

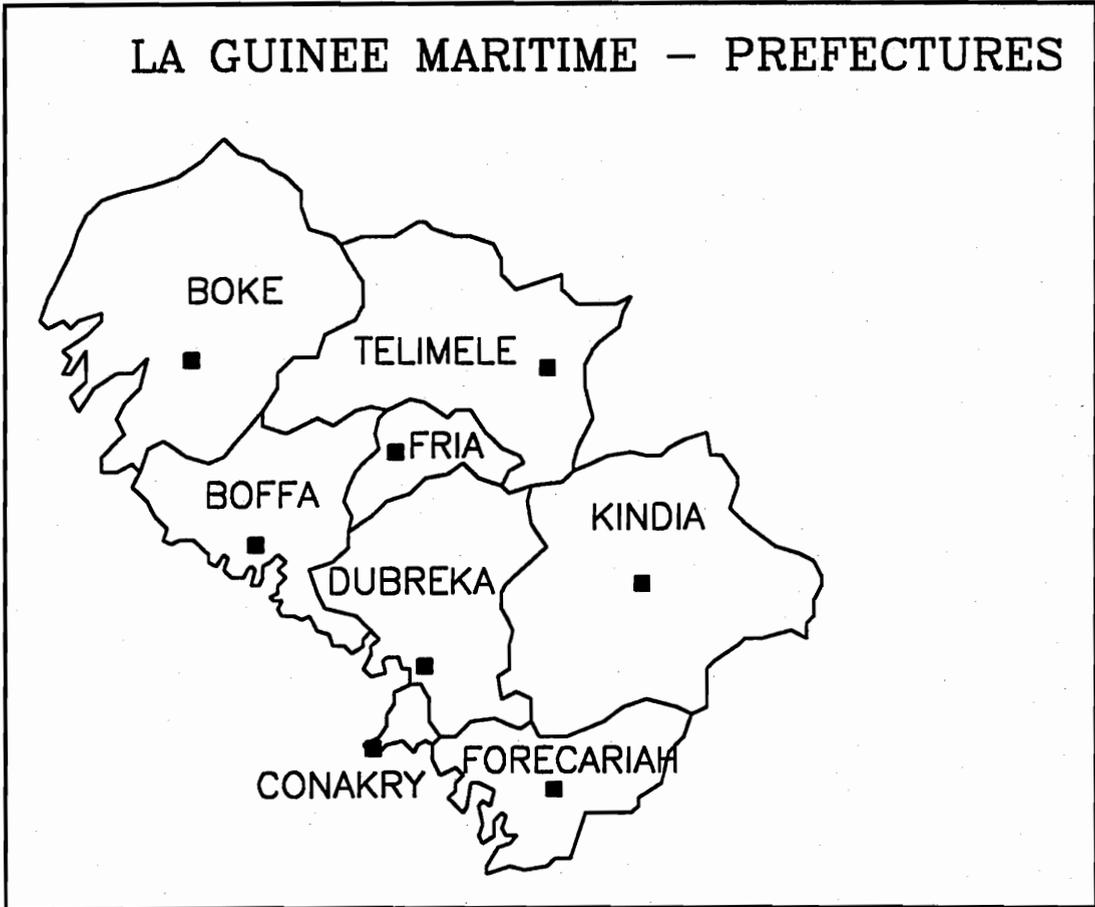
# LA REPUBLIQUE DE GUINEE – REGIONS



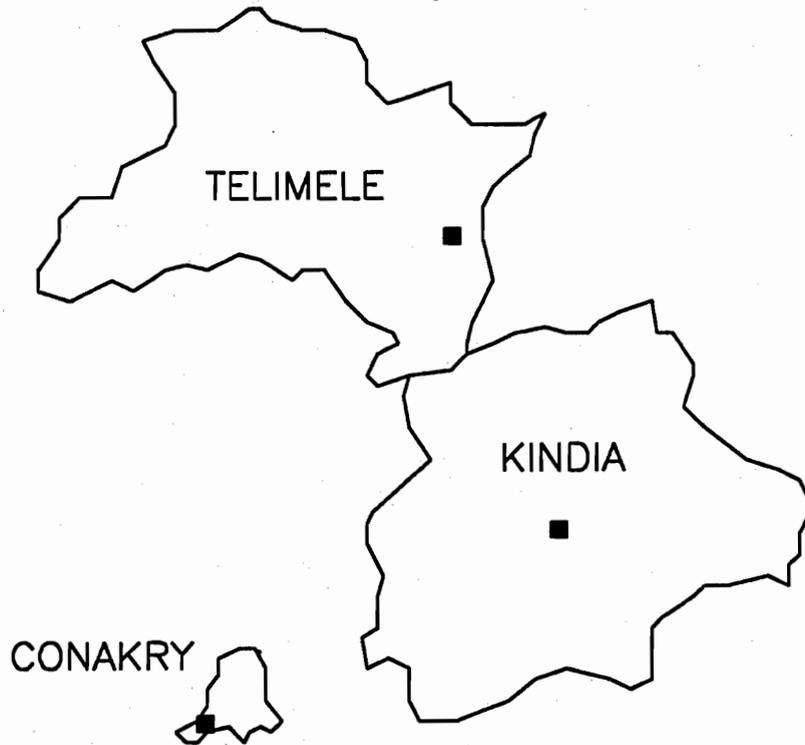
A-04

CARTE 1

# LA GUINEE MARITIME – PREFERCTURES



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



I. INDICATEURS POLITIQUES

A. GOUVERNEMENT DE LA GUINEE

1. POLITIQUE DU DEVELOPPEMENT

- a. REAJUSTEMENT STRUCTUREL
- b. PROGRAMME D'INVESTISSEMENT ET ACTIONS PRIORITAIRES
- c. DECENTRALISATION DU PROGRAMME DE DEVELOPPEMENT

2. POLITIQUE DE POPULATION - BUREAU DE RECENSEMENT

3. POLITIQUE D'EDUCATION

4. POLITIQUE D'AGRICULTURE

5. POLITIQUE DE SANTE ET D'ACTION SOCIALE

a. APPUI DE LA DECLARATION DE ALMA ATA

LA SANTE POUR TOUS D'ICI L'AN 2000 (OMS - 1978)

b. POLITIQUE DE SANTE MATERNELLE ET INFANTILE

(1) MERES

- (a) REDUCTION DE LA MORTALITE MATERNELLE
- (b) PLANIFICATION FAMILIALE
- (c) AMELIORATION DE LA CONDITION FEMININE

(2) ENFANTS

- (a) RATIFICATION DE LA CONVENTION DES DROITS DE L'ENFANT - ONU/NEW YORK 29-30 SEPTEMBRE 1990
- (b) PROGRAMME ELARGI DE VACCINATION 80% COUVERTURE - ENFANTS < 1 AN - FEMMES ENCEINTES
- (c) LUTTE CONTRE LES MALADIES DIARRHEIQUES
- (d) NUTRITION
  - i) SURVEILLANCE
  - ii) REHABILITATION
- (e) PROTECTION CONTRE LE PALUDISME
- (f) LUTTE CONTRE LES AFFECTIONS RESPIRATOIRES AIGUES

c. PROGRAMME NATIONAL CONTRE LES MST - SIDA

d. LUTTE CONTRE LES GRANDES ENDEMIES

- (1) PALUDISME
- (2) TUBERCULOSE
- (3) SCHISTOSOMIASE
- (4) ONCHOCERCOSE
- (5) LEPRE
- (6) AUTRES

e. PROGRAMME NATIONAL D'ASSAINISSEMENT ET D'APPROVISIONNEMENT EN EAU

ANALYSE DU PROBLEME (SUITE)

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

II. INDICATEURS SOCIO-ECONOMIQUES

A. ENVIRONNEMENT

1. PHYSIQUE

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

2. SOCIAL

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

ANALYSE DU PROBLEME (SUITE)

3. ECONOMIQUE

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

B. COMPORTEMENT PSYCHO-SOCIAL DES GENS

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

III. INDICATEURS DE PRESTATION DES SERVICES MEDICAUX

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

ANALYSE DU PROBLEME (SUITE)

IV. INDICATEURS DE L'ETAT DE SANTE

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

V. ACTIONS NECESSAIRES (STRATEGIES PROPOSEES)

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

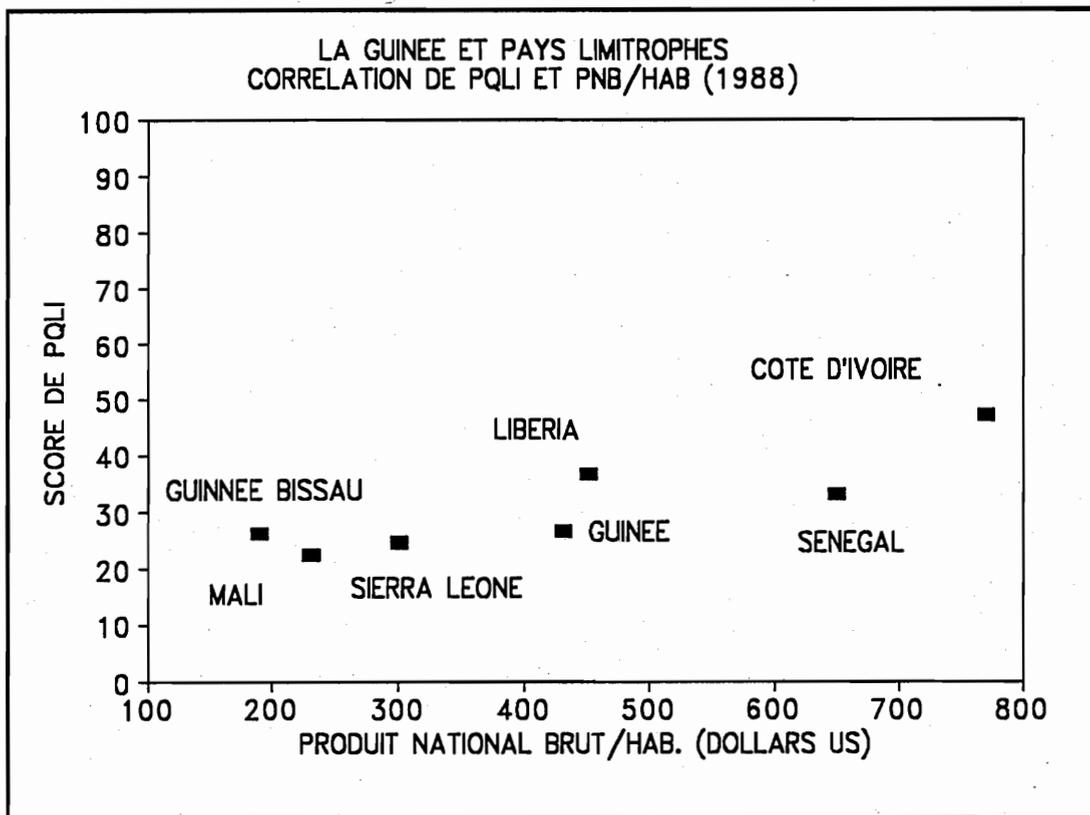
## VI. RESSOURCES NECESSAIRES (UN PLAN D'ACTION)

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

VII. TESTS DES SOLUTIONS

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

FIGURE 1



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

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

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

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

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

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

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

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

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

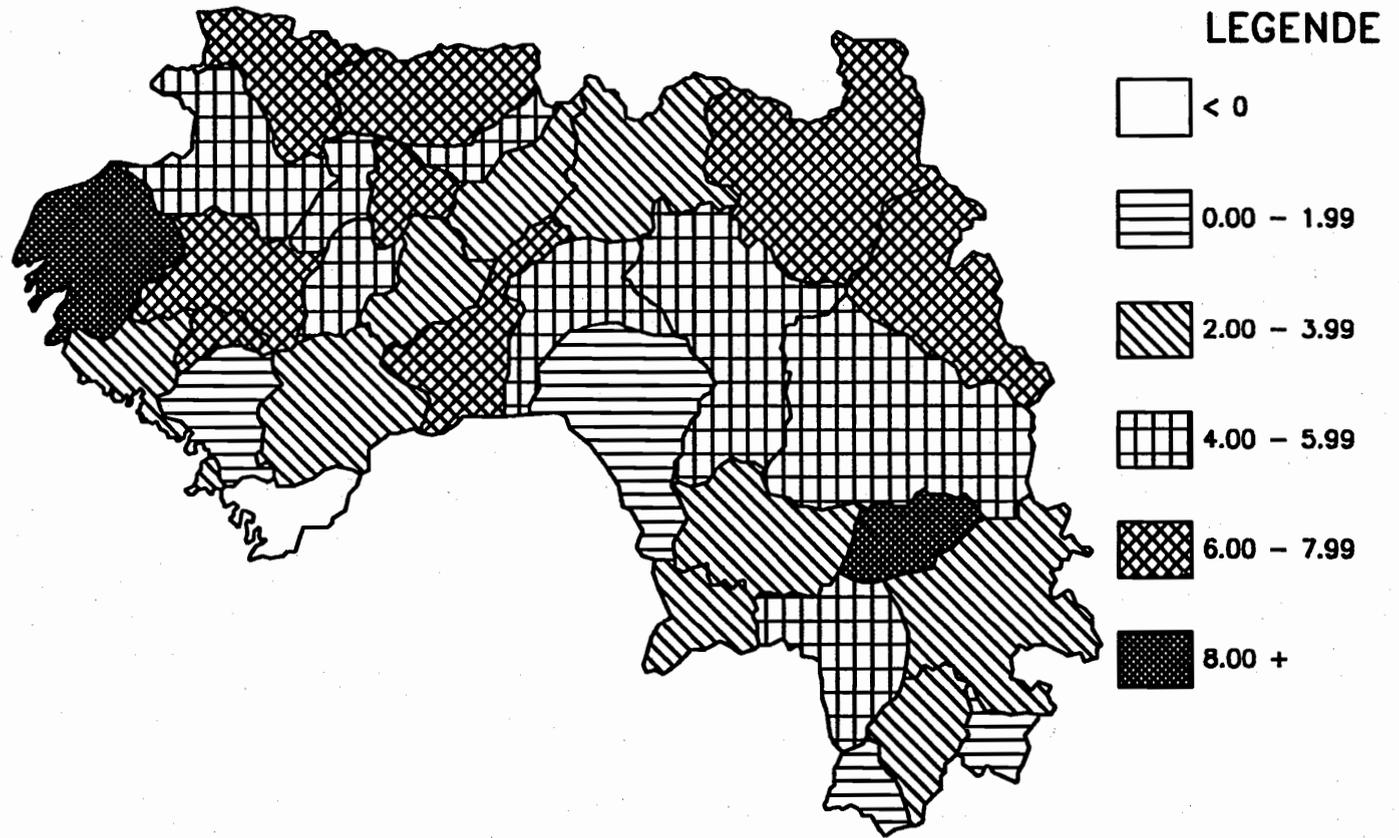
INDICATEUR	REALISATIONS
<p>2 LES MECANISMES DESTINES A ASSOCIER LA POPULATION A LA MISE EN OEUVRE DES STRATEGIES ONT ETE MIS EN PLACE OU RENFORCES, ET FONCTIONNENT EFFECTIVEMENT</p>	<p>- CREATION DU SECRETARIAT D'ETAT POUR LA DECENTRALISATION</p> <p>1987 - COMPOSANTES DE L'UNITE NATIONALE DE COORDINATION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

INDICATEUR	REALISATIONS												
<p>7 LES SOINS DE SANTE PRIMAIRES SONT A LA DISPOSITION DE L'ENSEMBLE DE LA POPULATION, AVEC AU MINIMUM:</p> <ul style="list-style-type: none"> <li>- EAU SAINTE A DOMICILE OU A 15 MINUTES DE MARCHE</li> <li>- MESURES D'ASSAINISSEMENT</li> <li>- VACCINATION CONTRE LES 6 MALADIES DU PEV</li> <li>- SOINS DE SANTE LOCAUX A UNE HEURE DE VOYAGE, AVEC LA POSSIBILITE DE SE PROCURER AU MOINS 20 MEDICAMENTS ESSENTIELS</li> <li>- PERSONNEL QUALIFIE POUR S'OCCUPER DES GROSSESSES ACCOUCHEMENTS ET ENFANTS JUSQU'A L'AGE DE 1 AN</li> </ul>	<p>ZONE URBAINE: 69% MOYENNE NATIONALE = 27%  ZONE RURALE : 2%</p> <p>ASSAINISSEMENT ADEQUAT: 12% DE LA POPULATION</p> <p>COUVERTURE VACCINALE EN 1986</p> <p>ENFANTS 0-11 MOIS: 5%  FEMMES ENCEINTES : 17%</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">1989</th> <th style="text-align: center;">CCCD</th> <th style="text-align: center;">LA GUINEE</th> </tr> </thead> <tbody> <tr> <td colspan="3" style="text-align: center;">=====</td> </tr> <tr> <td>ENFANTS 0-11 MOIS:</td> <td style="text-align: center;">20%</td> <td style="text-align: center;">15%</td> </tr> <tr> <td>FEMMES ENCEINTES :</td> <td style="text-align: center;">38%</td> <td style="text-align: center;">8%</td> </tr> </tbody> </table> <p>ACCES AUX STRUCTURES SANITAIRES: 30% DE LA POP</p> <p>LA LISTE DES MEDICAMENTS ESSENTIELS EXISTE MAIS IL Y A DES RUPTURES DE STOCK</p> <p>IL Y A UN MANQUE ET UNE MAUVAISE REPARTITION DU PERSONNEL QUALIFIE LES SERVICES DE SANTE SONT EN GENERAL SOUS-UTILISES</p>	1989	CCCD	LA GUINEE	=====			ENFANTS 0-11 MOIS:	20%	15%	FEMMES ENCEINTES :	38%	8%
1989	CCCD	LA GUINEE											
=====													
ENFANTS 0-11 MOIS:	20%	15%											
FEMMES ENCEINTES :	38%	8%											
<p>8 L'ETAT NUTRITIONNEL DES ENFANTS EST SATISFAISANT EN CE SENS QUE:</p> <ul style="list-style-type: none"> <li>- AU MOINS 90% DES NOUVEAUX ENFANTS PESENT AU MOINS 2,5 KILOGRAMMES</li> <li>- AU MOINS 90% DES ENFANTS ONT UN POIDS POUR AGE QUI CORRESPONDANT AUX NORMES DE LA "NATIONAL CENTER FOR HEALTH STATISTICS"</li> </ul>	<p>SPECIFICITES REGIONALES: CARENCES EN IODE ET EN VITAMINE A</p> <p>1985: 82% DES NOUVEAUX-NEES PESENT AU MOINS 2,5 KILOGRAMMES  1990: 90%</p> <p>1986: 22% DES ENFANTS DE MOINS DE 5 ANS SONT MALNUTRIS</p>												

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

# REPUBLIQUE DE GUINEE

## TAUX ANNUELS DE CROISSANCE (1977 - 1983)



# REPUBLIQUE DE GUINEE

DENSITE DE LA POPULATION PAR KILOMETRE CARRE (1983)

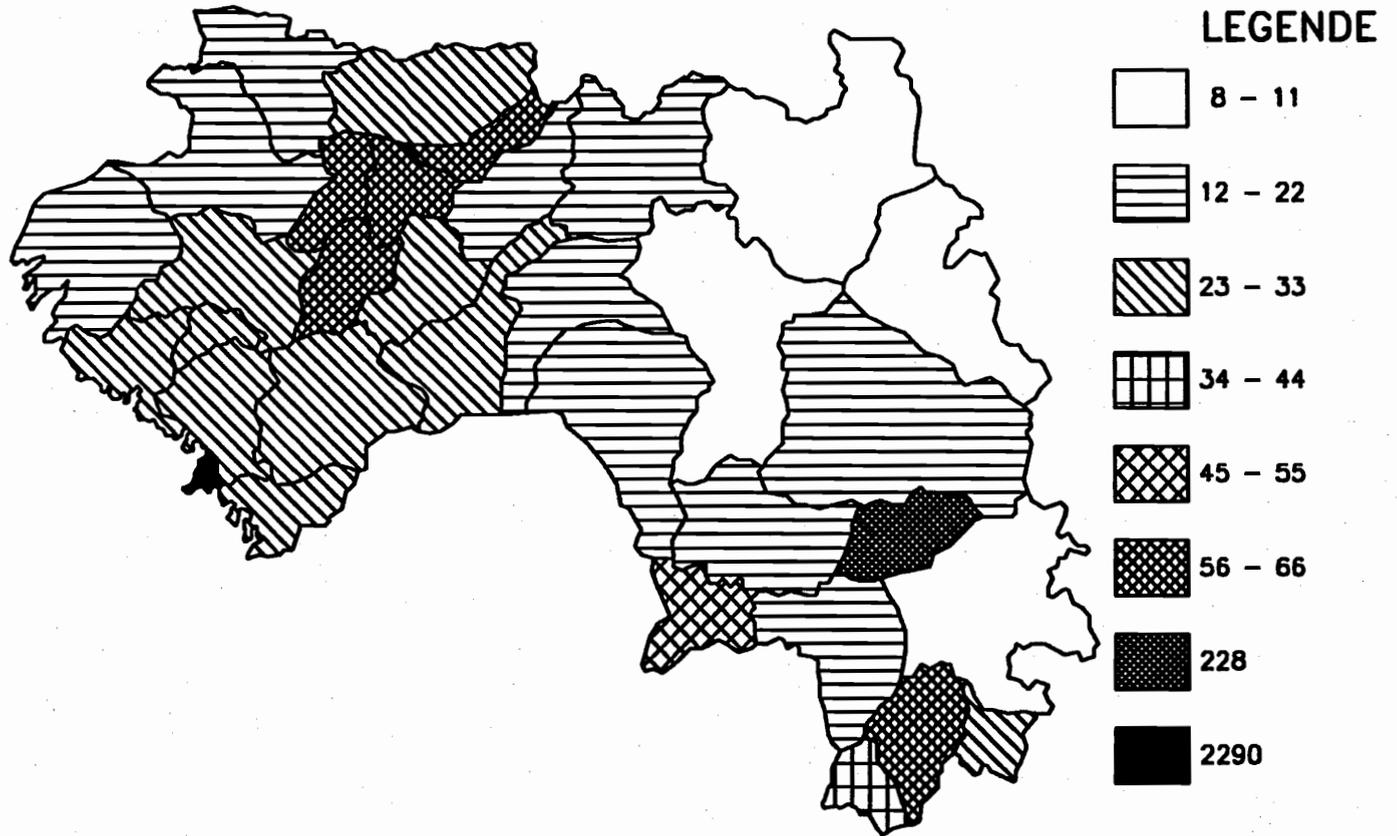
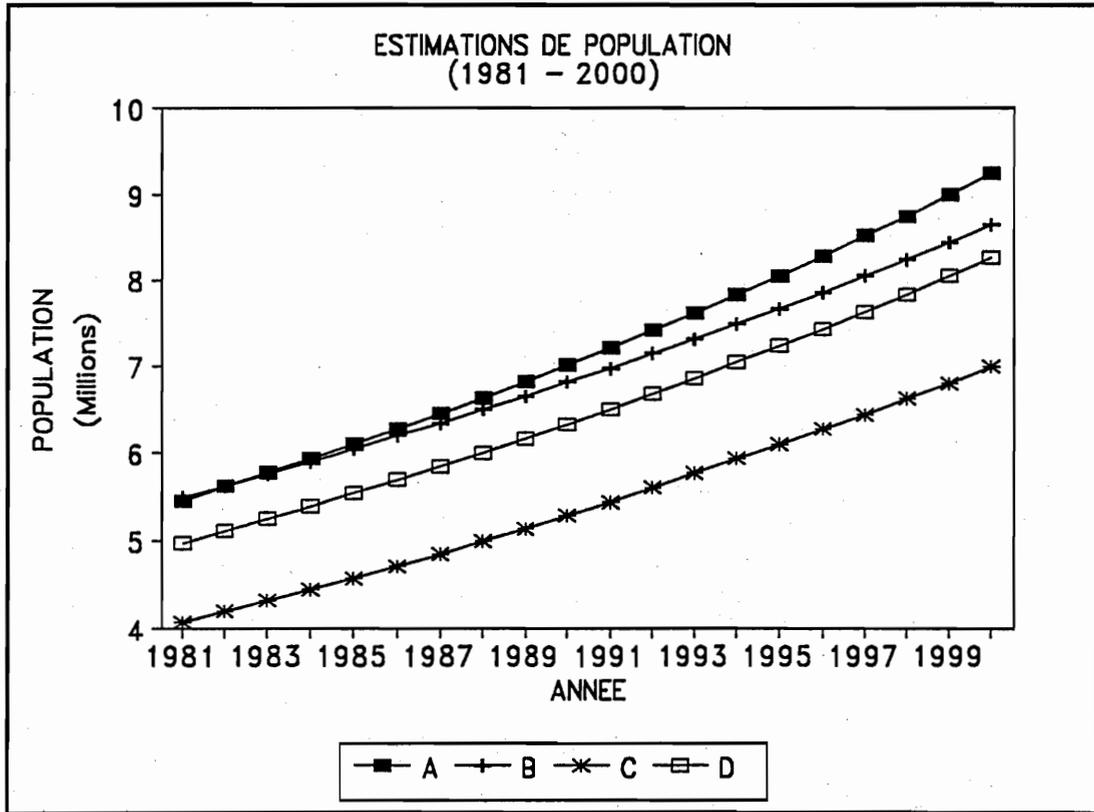


FIGURE 2



SOURCES DES ESTIMATIONS:

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

TABLEAU 5

ESTIMATIONS DE POPULATION  
(1981 - 2000)

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

## HYPOTHESES DES TAUX DE CROISSANCE:

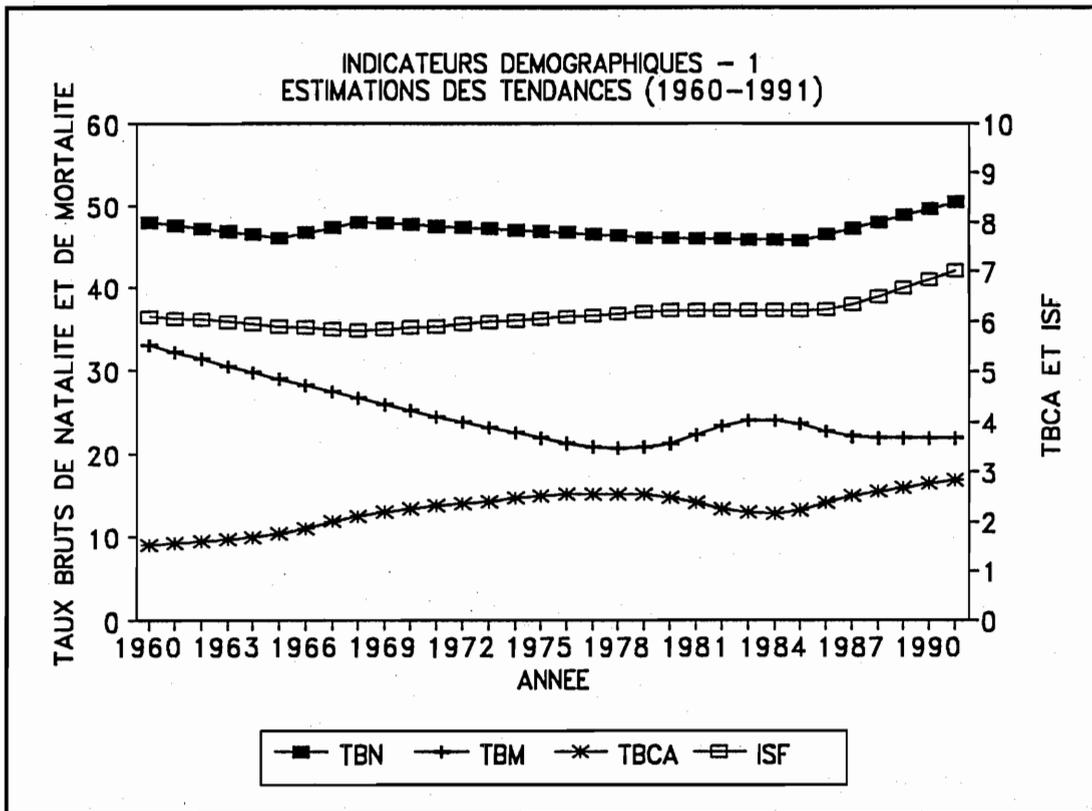
A:  $P_T = P_0(1+0.028)^T$   
 $T_0 = 1983$   
 $P_0 = 5781014$

B:  $P_T = P_0(1+0.024)^T$   
 $T_0 = 1986$   
 $P_0 = 6200000$

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

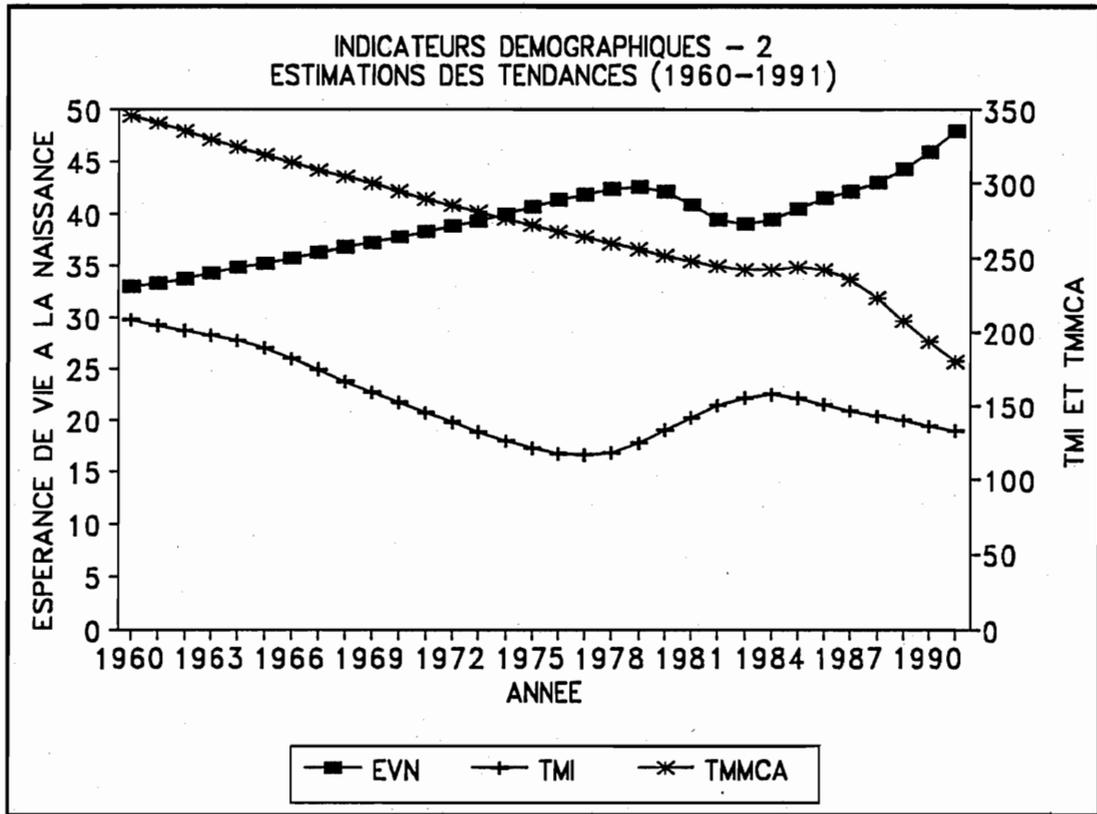
D:  $P_T = P_0(1+0.027)^T$   
 $T_0 = 1983/1.1$   
 $P_0 = 5255467$

FIGURE 3



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

FIGURE 4



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

TABLEAU 6  
INDICATEURS DEMOGRAPHIQUES  
ESTIMATIONS DES TENDANCES 1960 - 1991

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

TABLEAU 7  
INDICATEURS DEMOGRAPHIQUES  
ESTIMATIONS DES TENDANCES 1960 - 1991

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

FIGURE 5

CAUSES DE MORBIDITE - 1986  
TRANCHE D'AGE 0-4 ANS

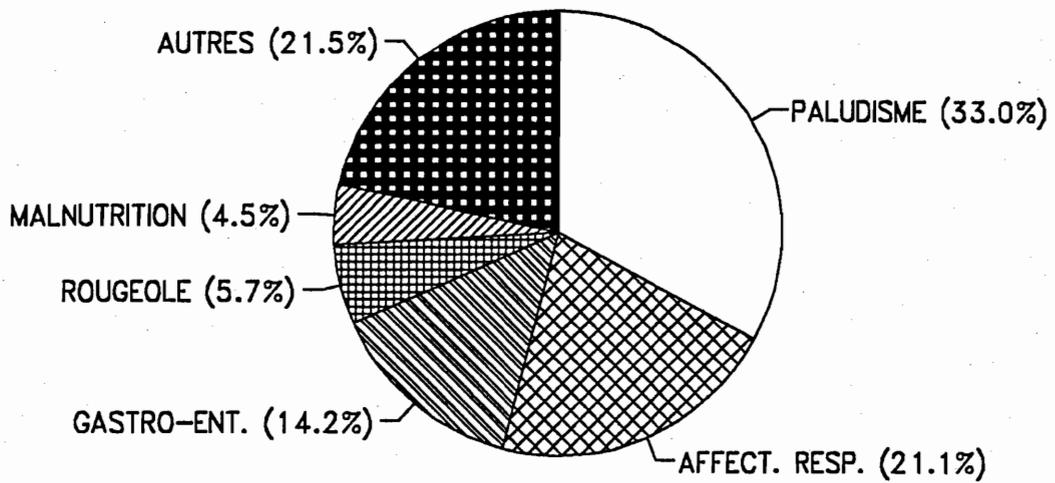


FIGURE 6

CAUSES DE MORTALITE - 1986  
TRANCHE D'AGE 0-4 ANS

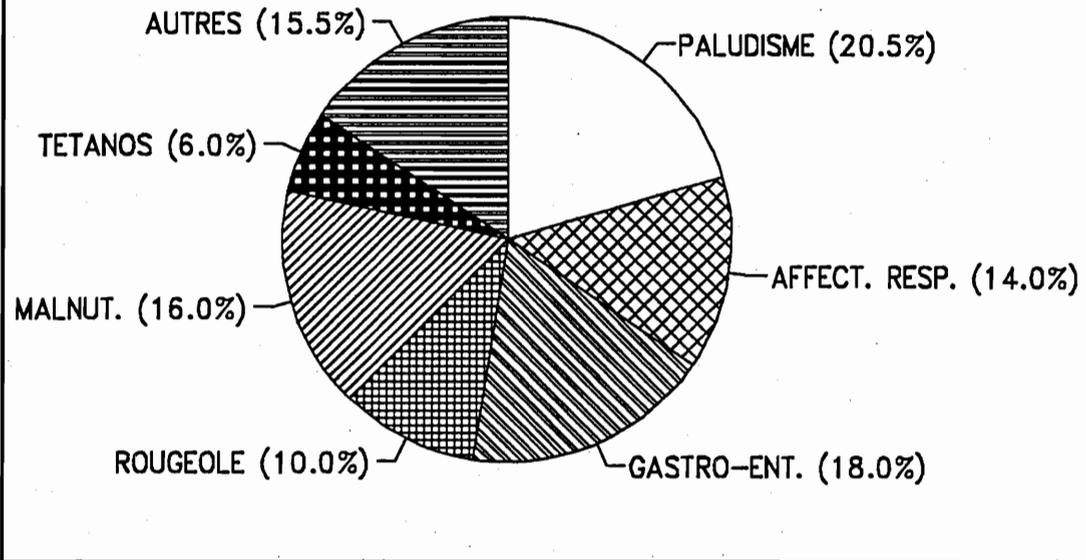


TABLEAU 8  
 RAPPORT NOSOLOGIQUE DES STATISTIQUES SANITAIRES  
 TRANCHE D'AGE DE 0-4 ANS (1986)

REPARTITION DES CAUSES DE MORBIDITE

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

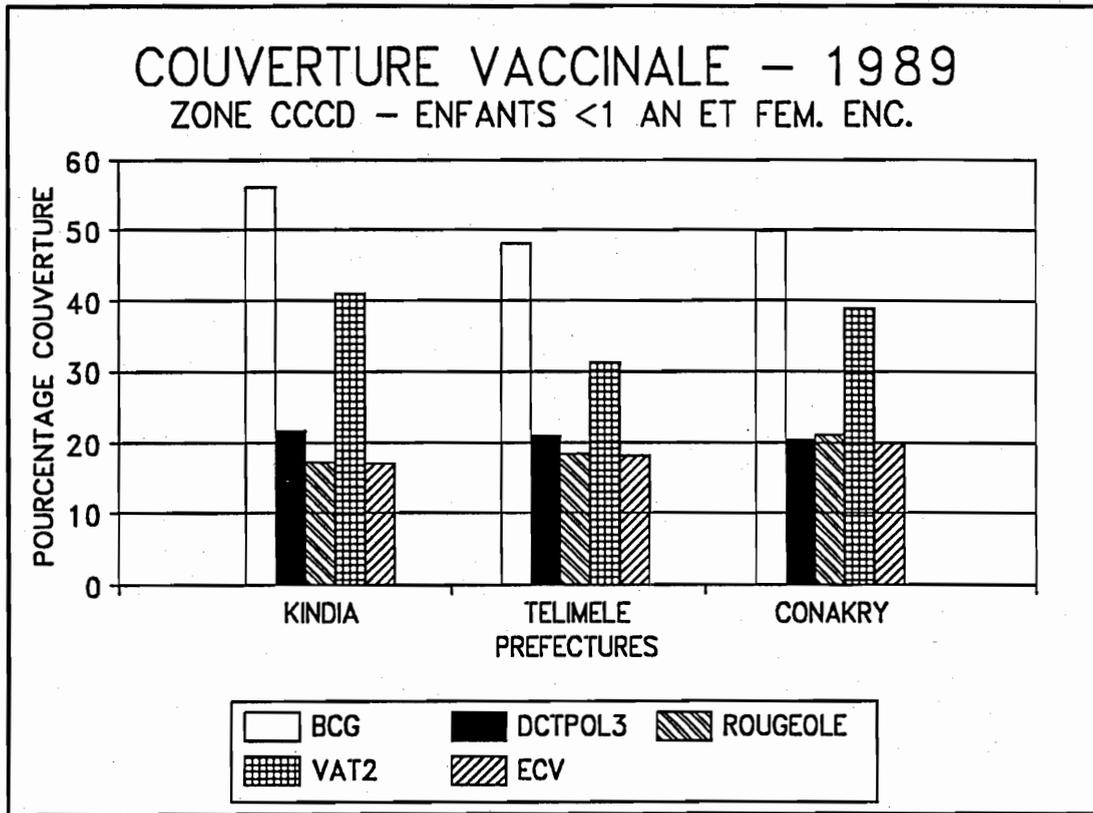
REPARTITION DES CAUSES DE MORTALITE

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

**TABLEAU 9**  
**VARIATION SAISONNIERE DE LA SANTE EN REPUBLIQUE DE GUINEE**

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

FIGURE 7



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

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

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

\*CDC estimates that the percentage of coverage reached 50 percent in the CCCD zone in 1990. (Annual Management Information System Report, 1990)

FIGURE 8

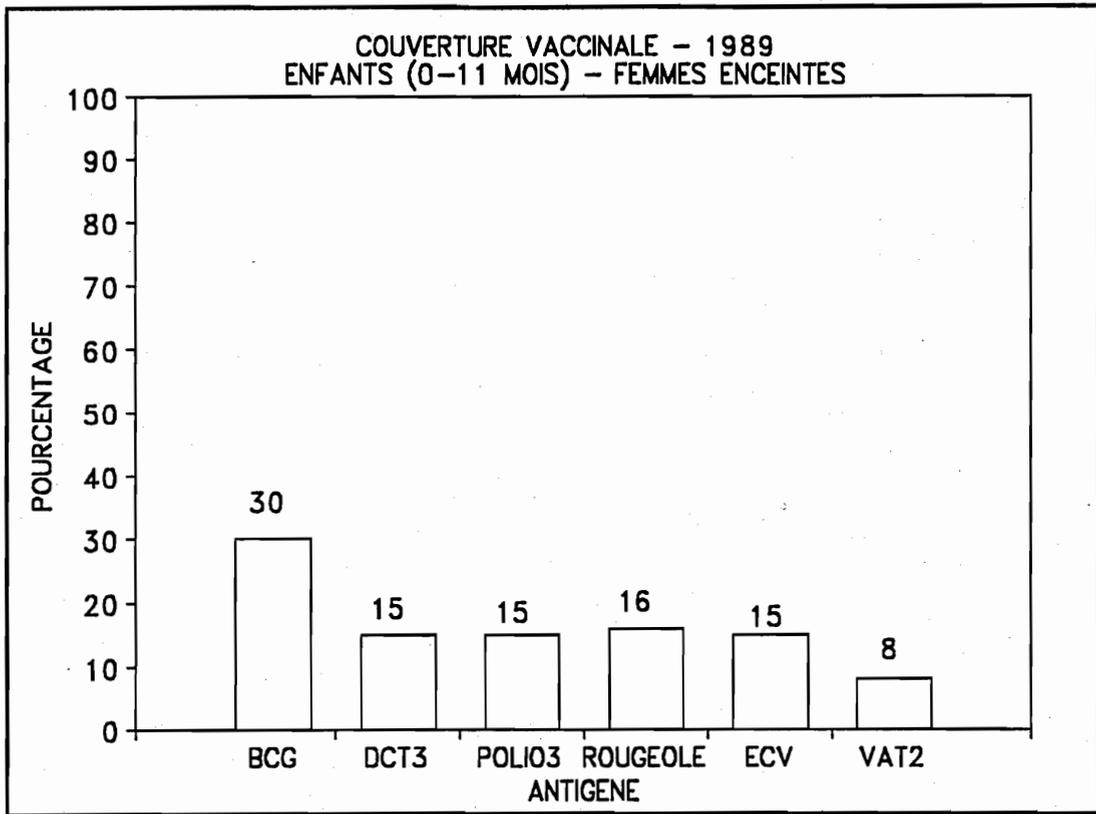


TABLEAU 11  
EVOLUTION DE LA COUVERTURE VACCINALE - GUINEE

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

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

TABLEAU 12  
ESTIMATION DES GROUPES CIBLES - 1990  
PREFECTURE DE KINDIA

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

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

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

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

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

CLASSEMENT:

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

FIGURE 9

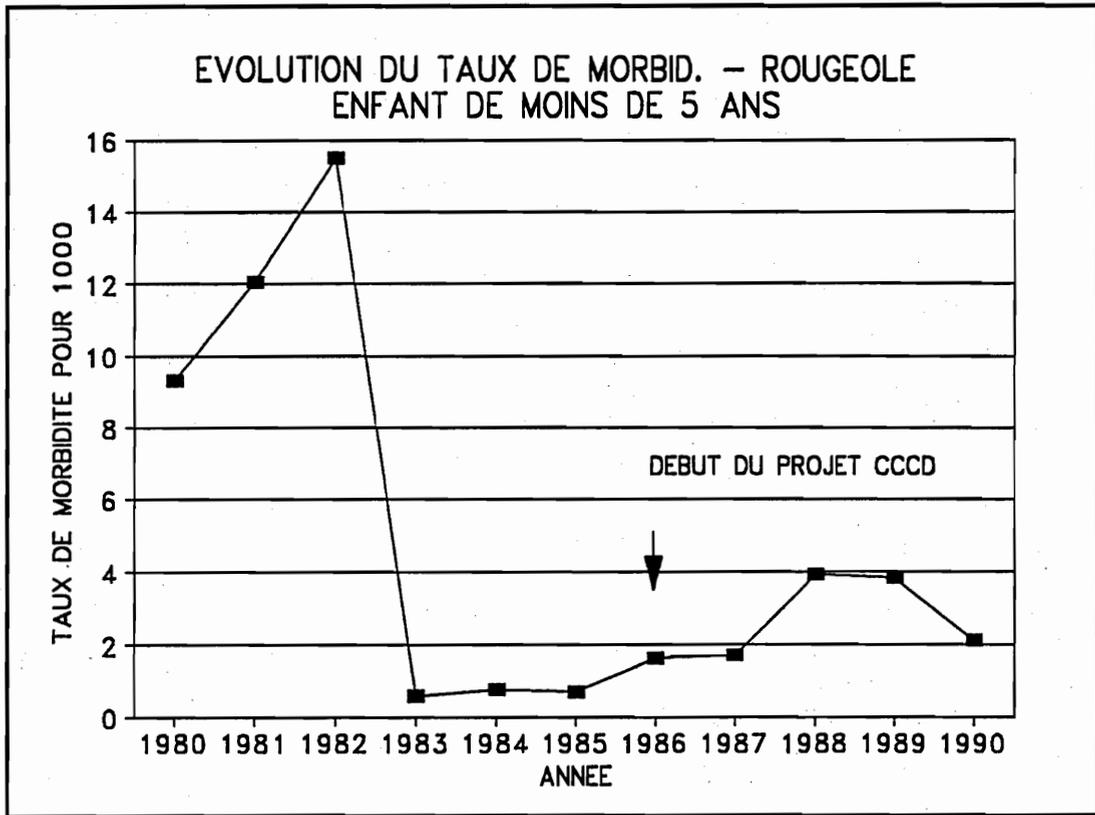


TABLEAU 13  
EVOLUTION DES CAS DECLARES DES MALADIES DE L'ENFANCE

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

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

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

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

FIGURE 10

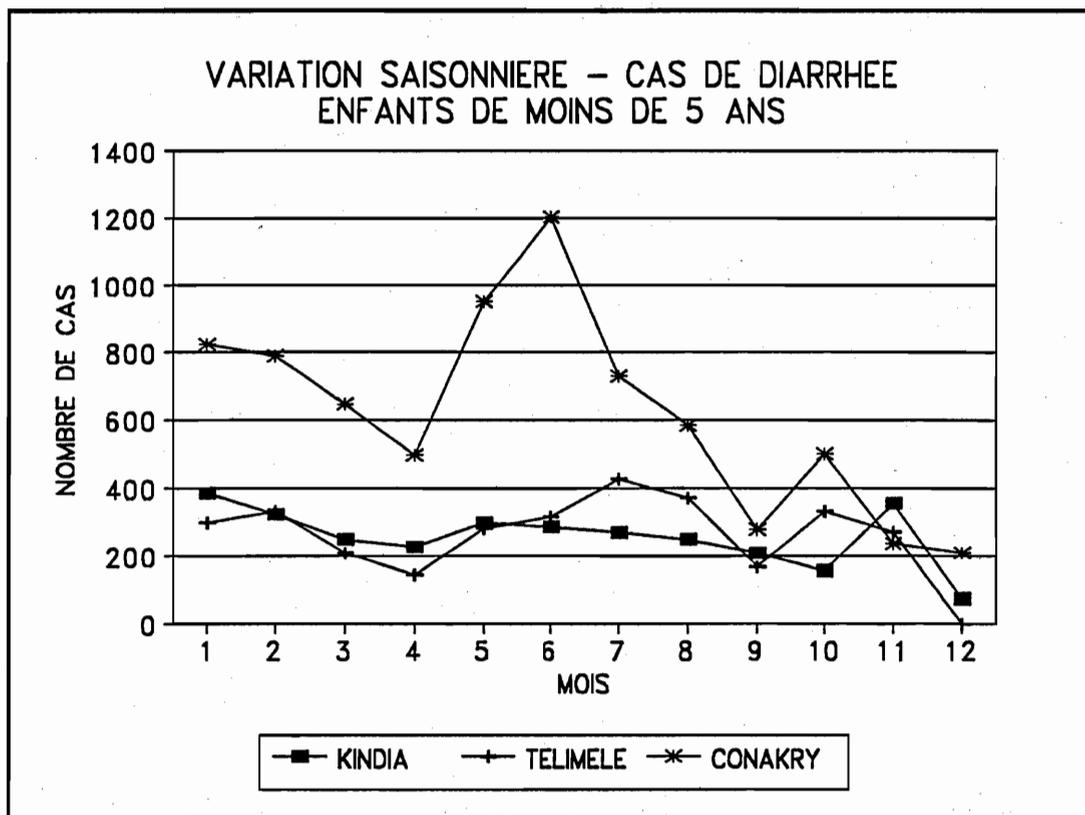


TABLEAU 14  
COUVERTURE SANITAIRE: ENFANTS < 5 ANS TRAITES POUR LA DIARRHEE - 1990

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

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

SOURCE: PROJET CCCD - 1990

TABLEAU 15  
ESTIMATION DES GROUPES CIBLES/BESOINS  
ENFANTS DE < 5 ANS/DIARRHÉE/PALUDISME  
PREFECTURE DE TELIMELE

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

\* LES UNITES TRO ONT ETE OUVERTES EN NOVEMBRE 88

ESTIMATION DES BESOINS:

CHAQUE ENFANT A 5 EPISODES DE DIARRHÉE PAR AN  
10% DES CES EPISODES NECESSITENT UN TRAITEMENT  
CHAQUE ENFANT A 5 EPISODES DE FIEVRE PAR AN

NOMBRE D'ENFANTS < 5 ANS TRAITES POUR LA DIARRHÉE

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

% BEC - POURCENTAGE DES BESOINS COUVERTS

FIGURE 11

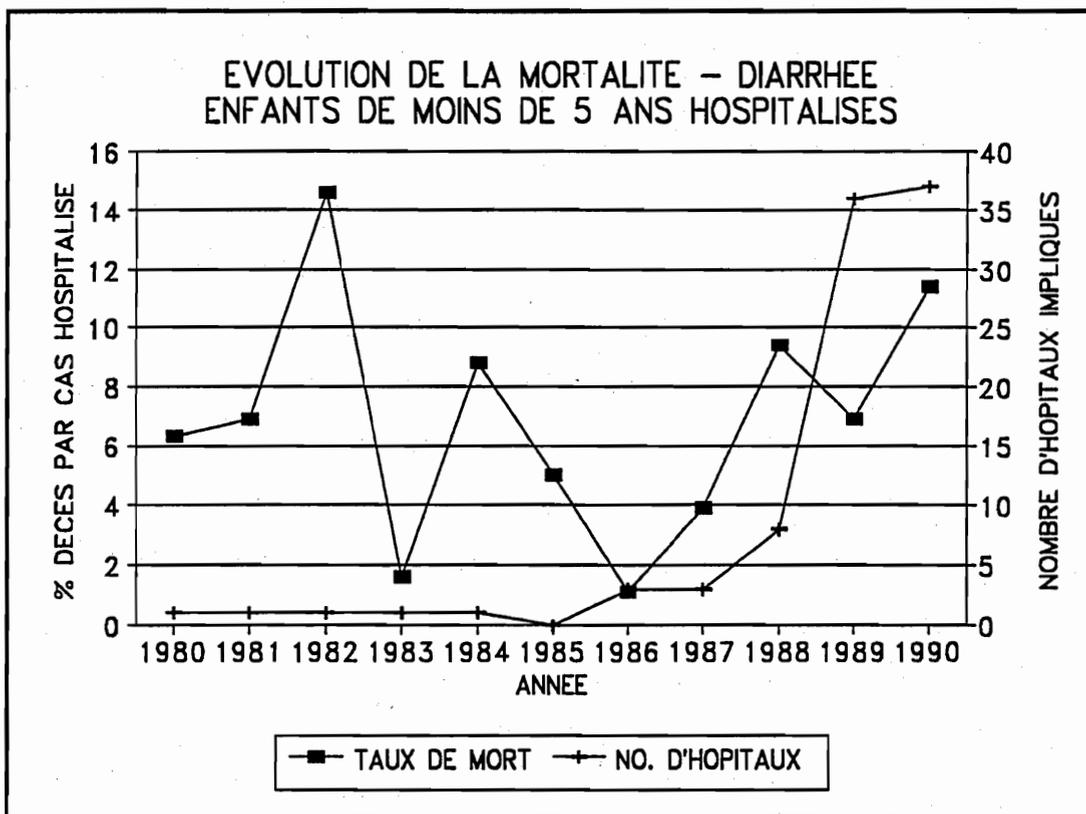


TABLEAU 16  
EVOLUTION DES CAS DE DIARRHEE HOSPITALISES  
ENFANTS DE MOINS DE 5 ANS

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

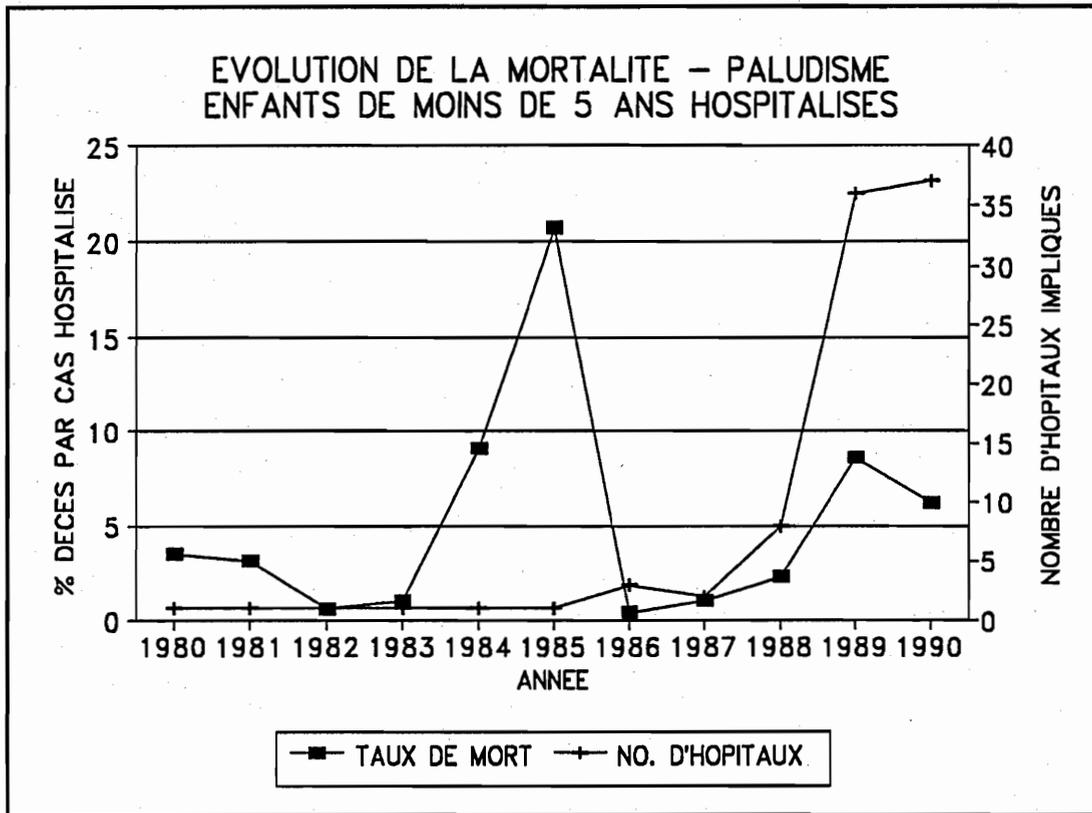
TABLEAU 17  
 PREFECTURE DE TELIMELE

NOMBRE D'ENFANTS < 5 ANS TRAITES POUR LE PALUDISME

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

% BEC - POURCENTAGE DES BESOINS COUVERTS

FIGURE 12



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

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



DEFINITIONS DES TERMES UTILISES DANS LE MODELE \*

GROUPE A RISQUE (LA DEMANDE DES SERVICES)

C: CONNAISSANCES  
A: ATTITUDES  
P: PRATIQUES

SYSTEME SANITAIRE (L'OFFRE DES SERVICES)

D = DISPONIBILITE: LES STRUCTURES SANITAIRES EXISTENT PHYSIQUEMENT  
A = ACCESSIBILITE: LES STRUCTURES SONT RAISONNABLEMENT PROCHES  
A = ACCEPTABILITE: LES SERVICES SONT CREDIBLES ET S'INTEGRENT DANS LE  
MILIEU SOCIO-CULTUREL  
C = COUT (A LA PORTEE DES BOURSES): LES SERVICES NE COUTENT PAS TROP  
CHERS ET SONT DONC UTILISES  
E = EFFICACITE: LES SERVICES RENDUS ABOUTISSENT AUX RESULTATS  
FAVORABLES ESCOMPTEES  
E = EFFICIENCE: LE RAPPORT COUT/EFFICACITE EST BON, C'EST-A-DIRE AU  
MOINDRE COUT L'EFFICACITE EST  
MAXIMALE

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

## **APPENDIX B**

**APPENDIX B  
PROJECT DATA SHEET**

Country .....	Guinea, West Africa
Funding Agency .....	A.I.D./Washington
Project Title .....	Africa Child Survival Initiative Combating Childhood Communicable Diseases ACSI/CCCD Project # 698-0421.75
Project number .....	June 22, 1985
Project agreement date .....	December 31, 1987
Initial completion date .....	US\$ 885,000.00
Initial funding .....	January 1988:
Extension design .....	September 1988
Project amendment date .....	September 30, 1991
Project completion date .....	US\$ 645,000.00
New funding amount .....	US\$ 1,530,000
Total funding .....	1990: US\$1.00 = FG 650
Host country exchange rates .....	1991: US\$1.00 = FG 699
(Franc Guinéen) .....	USAID/Conakry and Government of Guinea, Ministry of International Cooperation
Project agreement .....	Bill Kaschak (9/90 to date) [Byron Bahl] [Mark Wentling]
USAID Mission directors .....	Centers for Disease Control, Atlanta Scott McKeown [Dianna Gerski]
(during life of project)	May - June 1987 (Brown & Mock) August 1989 - (Correl, Finlay & Stanfield)
Implementing agency .....	April 1986: 1st Internal review January 1990: 2nd internal review January 1991: 3rd internal review
External Evaluations .....	Atlantic Resources Corporations Birch and Davis International
Internal reviews .....	
Contractor .....	Jean-Paul Heldt, MD, MPH, Management research consultant,
(for final evaluation)	Patrick Guy Kelly, MD, MPH International Health Consultant
Final evaluation team: .....	Bagoureissy Tall, MD, Bureau d'Etudes, Planification & Research
	Aïssatou Lô, Midwife, MPA Public Health Consultant

## **APPENDIX C**

## APPENDIX C

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

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

B. Project Number: 698-0421

C. LOP Funding: 123.6 million

D. Date of Authorization: September 1981

E. PACD: September 1991

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

I. OBJECTIVE OF THE CONTRACT

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

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

II. BACKGROUND

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

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

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

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

#### IIIA. STATEMENT OF WORK FOR GUINEA

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

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

(1) review the project agreement, extension design, previous evaluation reports and health information collected by the project,

(2) The team will interview central level MOH and collaborating agency officials. They will also interview health workers at various levels of the system and if possible, observe health worker performance.

(3) using available data, assess the plans and outputs (immediate goods and services provided), and report on the effects (on target audience knowledge, attitudes, and practices), quality of services and impact (morbidity/mortality) of the core project interventions, (EPI, CDD and Malaria control) and the support strategies, (training and supervision, health education, HIS and OR),

(4) document factors accounting for success or failure in the project components,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## **APPENDIX D**

APPENDIX D  
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## **APPENDIX E**

## APPENDIX E

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### LIST OF PEOPLE INTERVIEWED OR CONTACTED -- BY AFFILIATION

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#### AID/Washington

■ Chief, Health/Pop./Nutrition	Gary Merritt
■ CCCD Project Officer	Glenn Post (by phone)
■ Former CCCD Project Officer	James Shepperd
■ Former CCCD Assistant Project Manager	Peggy Meites
■	

#### USAID Guinea:

■ Mission director	William Kaschak
■ Human Resources Director	Stephen Grant
■ Project design officer	Colette Chabbott
■ Controller	Carl Lewis
■ Evaluation officer	David Hess
■ Project officer	Michael Blake

#### CDC/Atlanta:

■ CCCD Technical Officer	Scott McKeown
--------------------------	---------------

#### Government of Guinea:

■ Ministry of Public Health/Pop	Dr. Madigbé Fofana
■ General Secretary	Dr. Ousmane Bangoura
■ Directeur National de la Santé	Dr. Kader Condé
■ Chef de Cabinet	Dr. Koumandian Doumbouya
■ Director, Prevention	Dr. Moh. Lamine Touré
■ Director, PEV/SSP/ME	Dr. Boubacar Dieng
■ EPI coordinator	Dr. Boubacar Dieng
■ ORT Assistant coordinator	Dr. Antoinette Hellal
■ Malaria control	Dr. Moussa Keita
■ EPS	Dr. Fassou Haba
■ EPS/Health Promotion	Dr. Barry Saïdou Pathé
■ Health Education	Ms. Aissatou Baldé
■ D.P.S. - .....Conakry I	Dr. Fatoumata Diallo
Kindia	Dr. Ousmane Sow
Télimélé	Dr. Baldé
■ Supervisor.....Conakry I	Saïkou Diallo
Conakry II	Kassia Tolno

Conakry III

Souleymane Souaré

■ Boulbinet Dr. Camille Souma  
ORT center  
Sarikali  
Télimélé  
Sinta  
Gougoudjé

Dr. Mariama Hann  
Adama Sako  
Moussa Kourouma  
Ibrahima Souaré  
Patrice Haba

### ACSI-CCCD Project

■ CCCD coordinator  
■ CCCD assistant coordinator  
■ Administrative assistant  
■ Accountant  
■ Supplies manager  
■ 2 secretaries  
■ 5 drivers

Dr. Moussa Keita  
Dr. Antoinette Hellal  
Mrs Ilyassou Diaby Diallo  
Oularé Kandas  
Ibrahima Camara

Augustin Camara

### PVO & IGO's

■ UNICEF

Peter Delahaye  
Robert Grancourt

■ Peace Corps  
■ World Bank

Kirk Wood  
Edna Johnson  
Joseph Destefano  
Eva Mae Caulker

■ W.H.O.

### OTHER INDIVIDUALS

Charles Habis  
Nancy Pendarvis Harris

Health Sector Review/A.I.D./Washington  
Director, SEATS (JSI)

## **APPENDIX F**

TABLE F SUMMARY OF OBJECTIVES AND RESULTS

F.1. Target Population

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

F.2. Immunization Coverage

	Objectives (CCCD)	1986 (Guinea)	'89 Status (CCCD Zones)	'90 Status (CCCD Zones)	Dose given (CCCD)
BCG	80%	46%	50%	80%	31,990
DPT	80%	10%	21%	70%	13,086
Polio3	80%	8%	21%	50%	13,086
Measles	80%	--	41%	50%	12,770
TT	60%	17%	38%	65%	30,012
Fully immunized	80%	5%	20%	--	

### F.3. Other indicators

		Objectives	Status (*)
Mortality:	Infant & child	25% decrease	--
	Neonatal tetanus	25% decrease	1984: -- 1985: -- 1986: -- 1987: 2/1,000 1988: 4/1,000 1989: 9/1,000 1990: 7/1,000
	Inpatient diarrhea (% = # fatalities/# cases)	50% decrease 30% (MTE)	1984: 8.8% 1985: 5.0% 1986: 1.1% 1987: 3.9% 1988: 9.4% 1 9 8 9 : 1990: 6.9% 11.4%
	Inpatient malaria (% = # fatalities/# cases)	50% decrease	1984: 9.1% 1985: 20.7% 1986: 0.4% 1987: 1.0% 1988: 2.3% 1989: 8.6% 1 9 9 0 : 6.2%
	Measles ('86 report)	50% decrease	--
Morbidity	Measles (children < 5)	50% decrease	1984: 1/1,000 1985: 1/1,000 1986: 2/1,000 1987: 2/1,000 1988: 4/1,000 1989: 4/1,000 1990: 2/1,000 1990: 2/1,000

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Whooping cough	--	1984: 24/10,000
		1985: 13/10,000
		1986: 2/10,000
		1987: 1/10,000
		1988: 2/10,000
		1989: 3/10,000
		1990: 1/10,000
		1990: 1/10,000

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Disability (Poliomyelitis)	50% decrease	1984: 5/100,000
	75% (amendment)	1985: 3/100,000
		1986: 2/100,000
		1987: 1/100,000
		1988: 15/100,000
		1989: 8/100,000
		1990: 5/100,000

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Effective Diarrhea Management at H.C. (ORT)	90% correct (50%, 1986) (80%, MTE)	1988: 20% 1989: 7% 1990: 5%
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at Home	50% correct (20%, 1986)	--
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Effective Malaria Management at H.C. (% of needs covered)	90% correct	1989: 2%
at Home	50% correct (80%, 1986)	--

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

## **APPENDIX G**

## Appendix G-1

SUMMARY OF TRAINING ACTIVITIES

MOIS/ANNEE	TYPE DE FORMATION	NOMBRE PART	POSITION AU PROJ	NBRE FACILIT	LIEU FORMATION	ASSISTANCE TECHN
MAI 1986	Formation des formateurs pour les volets PEV/LMD/PALU	18	Coord CCCD Resp MSPP Chef de C.S.	1	Ckry	1
AOUT 1986	Formation sur iden- tification vibrion cholerique	5	Agents techn Labo SP/MSPP	2	Ckry	?
AVRIL 1987	Formation en PEV	20	DPS/4 regions	2	Faranah	
1986	Formation formateurs en TRO	2	Med/pediatrie		Dakar	
MAI 1987	Formation en TRO	30	Med/Chef C.S	3	H.Donka	1
JUILLET 87	Formation en TRO	20	Med/Chef C.S.	3	H. Donka	1
JUILLET 87	Formation en mainten des vehicules et chaîne de froid	20	Chefs C.S. Ckry	3	Ckry	
SEPT 1987	Formation TRO	18	Chefs C.S.	3	Kindia/Cky	
SEPT 87	Formation en mainten. chaîne de froid	5	Chefs C.S. Kindia/Telemele Ckry	3	Ckry	
OCT 87	Formation TRO	10	Agents C.S. Ckry	3	Ckry	
OCT 87	Formation TRO	4	Agents C.S. kindia/Telemele	2	Ckry	
OCT 87	Formation en sterili materiel vaccination	18	Agents C.S. Ckry	3	Ckry	
DEC 87	Formation TRO	15	Agents/sante Hopital Donka	3	H.Donka	
FEV 87	Formation en TRO	6	V.Corps Paix zones hors Projet	2	Ckry	
MAI 88	Formation en maint. de chaîne de froid	17	Agents C.S. Ckry	4	Ckry	
SEPT/OCT 88	Formation en TRO	33	Chefs C.S. Kindia/Telem	4	Telemele	

SEPT 88	Intr. micro-inform. appl. a la surveil. epidemiologique	1	Coord LMD		Abidjan
FEV 89	Formation en chimio-resistance palustre	6	Agents labo-C.S. Ckry	1	Conakry
FEV 89	Formation en chimio-resistance	7	Agents labo-C.S. Kindia	1	Kindia
MARS/AVR89	Formation formateurs en LMD/zone horsProjet	38	DPS/DHOP Insp reg/inf. resp./pediat	1	Zerekore/ Kankan/Labe
MAI 89	Seminaire en Recherc operationnelle	20	DPS/Dpedia Univer/R.sc med.trad/ AGBF/PEV/SSP	5	Conakry
AOUT 89	Formation formateurs des agents en educ. pour la sante	14	DPS/Sup/Chefs C.S.	2	Conakry
AOUT 89	Formation Superviseu et Chefs C. utilisant motos a Kindia	26		2	Kindia
SEPT 89	Introduct. micro appl. epidemiologie	3	Coord CCCD Coord LMD/CCCD Assist Admin		Zaire
OCT 89	Formation EPS appliq. au PEV	2	R.Ed.S/CCCD R.PEV/SSP/ME		Zaire
1989	Formation en gestion chaine froid	2	Charge logis. PEV/SSP		Abidjan
MAY 1989	Formation gestion des prog LMD zone francophone/pour A.T.	2	Coord CCCD Assist techn		Abidjan
DEC 89	Formation formateurs strategies promouvoir educ.sante/kindia Telemele	15	Centres sante	2	Conakry
JAN 90	Recyclage agents Cky sur chaine de froid	6	agents C.Ste	1	Conakry
FEV 90	Formation agents Ste en EPS/PEV	120	Agents C.S. Ckry	4	Conakry
MARS 90	Formation agents Ste en EPS/PEV	90	Agents C.S. kindia/Telem.	6	Kindia Telemele
MARS 90	Formation en informat. statistiques	?	Agents BEPR	2	Conakry

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

## EDUCATION POUR LA SANTE/Annexe G-2

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

NO Activites recommandees en 1988

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

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

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

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

Resultats:

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

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

Resultats:

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

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

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

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

Resultats: 6 enquetes ont ete de realisees dont :

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

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

- Formation resp Div. Promotion Ste,

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

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

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

7. Developper du materiel didactique pour education pour la sante

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

8. Conduire la recherche operationnelle

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

9. Developper une strategie d'education pour la sante

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

## **APPENDIX H**

Appendix H-1

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CHRONOLOGY OF ACTIVITIES  
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April Activity

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

Mo 15 Team planning meeting (see agenda)

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

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

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

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

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

Su 21 Travel - Cont'd

Mo 22 Travel - Cont'd:

Kelly arrives AM and makes first contacts

Heldt and Lo arrive in Conakry at night

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

Meeting with CCCD project staff (as a team)

UNICEF (JP Lamarque) (as a team)

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

Team planning meeting

We 24 Briefing by USAID (as a team)

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

Team planning meeting

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

---

visit to Boulbinet Health Center (team)

---

Interviews with USAID staff (JPH)

---

Fr 26 World Health Organization (JPH, PGK)

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Donka Hospital - National ORT Center (JPH, PGK)

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Donka Hospital - Pediatric Department (JPH, PGK)

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Mr. Joseph Destefano, World Bank (JPH)

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

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

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Dr. A. Dieng, Coordinator EPI (JPH)

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

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

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

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team B travels to Kindia (PGK, AL)

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Mo 29 Dr. Amadou Baldé, DPS (JPH, BT)

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

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Visit to Sarikali Health Center (JPH, BT)

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Visit to Téliimélé Health Center (JPH, BT)

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Visit to Téliimélé Hospital (JPH, BT)

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[Team B conducts interviews and visits in Kindia]

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Tu 30 Visit Gougoudjé Health Center (JPH/BT)

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Visit Sinta Health Center (JPH, BT)

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Return to Conakry

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[Team B conducts interviews and visits in Kindia]

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May Activity

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

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Synthesis of three weeks of evaluation (JPH)

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Team B returns to Conakry

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Th 02 Team meeting

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Visit to EPI/SSP: cold chain

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Dr. De Bethune, UNICEF

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

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

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Mr. Kaba, Ministère à la Décentralisation (NA)

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Interviews with USAID staff (JPH)

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Fr 03 Team synthesis meeting

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Sa 04 Writing of individual sections by team members

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

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

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Tu 07 Collecting and compiling of individual sections

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USAID Mission (JPH)

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European Economic Community - EEC (JPH)

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

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Th 09 Wrapping-up of evaluation activities;

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Payments of support personnel; closing of team account;

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

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Debriefing at USAID Mission (team)

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Departure of team members from Conakry Airport.

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Sa 11 Arrival of team leader in Washington DC

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Su 12 Preparation for debriefing at AID/Washington

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Mo 13 Preparation of documents for debriefing

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Debriefing

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Tu 14 Meeting with Scott McKeown, Technical Officer

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Meeting at ARC Headquarters in Reston

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We 15 Final meeting with A. Jones

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Departure of team leader via National Airport.

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

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Fr 17 Editing of rough draft for style and substance

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to Integrating of notes & comments from various sources

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Fr 24 Production of final report

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Fr 24 Submission of final report via Federal Express

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