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Africare's  
Dioro Child Survival Project

Dioro, Mali

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# Mid-Term Evaluation Report

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## EXECUTIVE SUMMARY

A midterm evaluation of the Dioro Child Survival Project took place from September 26 to October 8, 1994. The evaluation team was composed of Laura Hoemeke of Africare/Washington, David Atteberry of USAID/Mali, Dandara Kante of the Child Survival Pivot Group of Mali and Catherine Toure, an external consultant. The team used evaluation methods consisting of reviewing project documentation as well as interviewing project staff, collaborators and others. In addition, a field survey in five project villages permitted exchanges with village authorities, health committees, traditional birth attendants, community health workers, groups of men and women and individual mothers. This evaluation also involved extensive interaction with project staff, who participated in the entire process. Feedback sessions of preliminary evaluation results were presented to the project team and principal collaborators in Dioro, in Segou and in Bamako.

The evaluation showed that, given the inadequate coverage of Malian health services and given the fact that some policies may not promote maternal and child health in rural areas, the CS Project in Dioro is pertinent and responds to the needs of the arrondissement. The project, in its second phase, covers 25 of the 82 villages in the arrondissement of Dioro. Project staff are now reflecting on their role in 30 villages formerly covered by the project and will modify strategies based on existing human and material resources and based on degrees of organization in villages. Despite constraints such as modification of strategies, changes in personnel and a major meningitis outbreak, the project has carried out numerous activities and has shown an astonishing vitality. One must emphasize the motivation, the spirit of initiative and of creativity of the project team members, who have been able to find funds and to mobilize resources to meet challenges, especially during the meningitis outbreak and during the Dioro Health Day. The team also has undertaken information-education-communication (IEC) campaigns that lend visibility and enhance the reputation of the project. Applying lessons learned during the first phase of the project, the team adopted a new and original approach that focuses on the improvement of maternal and child health through five components by working on collaboration with partners, involvement of women, participation of community members, encouragement of local potential, education of community members, and integration of income-generating activities. The project's internal structure, which includes program officers responsible for IEC, community organization and health activities, also leads to integration of all project activities.

The project has already achieved important results in the establishment of quality care, behavior change and new attitudes. In terms of sustainability, the project needs to reinforce the existing partnership with the government services, especially regarding supervision of activities. The IEC activities using various innovative channels of communication need to be incorporated into a strategy to coordinate production and diffusion of materials. In order to achieve sustainability, the project should increase its efforts toward a transfer of skills and of responsibilities to village health agents, to bring a sustained support in organization, management, and literacy and to work with them on redefining health service cost recovery system. These actions should include an intervention plan for each village, based on a basic diagnosis of each village.

This second phase of the Dioro Child Survival Project should be extended for an additional six to nine months (through a no-cost extension) in order to allow the project to finish up activities already underway in the villages and to solidify the management of activities. Considering the experience of the project, the level of training and motivation of project staff, and the remaining community needs, it appears also that a third phase of this project will be in order. This new phase should take into account the new Ministry of Health (MOH) policy of promoting community-based health sectors (politique sectorielle). The third phase also should integrate other target groups, such as adolescents, and emphasize education, training and income-generation activities. For greater efficiency and sustainability, USAID should encourage the exchange of results of project evaluations and should consider extending child survival project financing for five-year projects. Africare, as an organization, should focus more on giving projects a "vision" of development, on ensuring a certain continuity and a better orientation of staff, on researching donors for match-funded projects, and on putting as much emphasis on technical support as it does on administrative support.

## EVALUATION PROCESS

The Midterm Evaluation of the Child Survival Project of Dioro, Mali, which took place from September 26 to October 8, 1994, had the following goals:

- to measure the progress in the project execution;
- to look at the relevance of the project implementation and its appropriateness to stated objectives;
- to analyze the sustainability of actions undertaken; and
- to make recommendations for the future of the project, in the short, medium and long runs.

The team was composed of four individuals, in addition to participating project staff:  
Laura Hoemeke of **Africare/Washington**;  
David Atteberry of **USAID/Mali**;  
Dandara Kante of the Child Survival Pivot Group of Mali; and  
Catherine Toure, an external consultant.

The methodology was based on:

- **collecting and working with existing documents**  
periodic reports, trip reports, research reports, organigrams, job descriptions, budgets, maps, training materials, IEC materials (audio cassettes, videotapes, posters, flyers, etc.
- **individual interviews with people and institutions**  
partners and collaborators of the project in Bamako, Segou and Dioro
- **interviews and observations of Africare personnel**  
interviews of staff in Bamako and Dioro; observation of a monthly personnel meeting for all project off ice and field staff; observation of IEC activities (Awareness-Raising Campaigns) in two villages
- **field survey**  
visits to five project villages, including three of the second phase and two of the first phase; villages chosen based on established criteria; meetings in villages that allowed the team to encounter traditional authorities, health committees, trained traditional birth attendants, community health workers, groups of men and women, and individual mothers

Interview and observation forms as well as questionnaires for mothers were used to collect information. The staff of the Dioro Child Survival Project was closely associated with the evaluation process. The major conclusions of the evaluation were shared in feedback sessions with partners at each level (Dioro, Segou and Bamako). A feedback session also was held in Bamako with collaborating partners, Africare/Mali staff and the project staff at the end of the evaluation.

## **I. CONCEPTION**

The second phase of the project began in March 1993. Unfortunately, at this time, conclusions of the final evaluation of the first phase were not yet available. Considering this aspect, and also of a change in the project coordinator, a new detailed implementation plan (DIP) was elaborated several months after the project began activities.

The DIP included the following important innovations that are now being implemented by the project team:

- In its second phase, the project team developed the DIP in close collaboration with partners. This allowed the project to develop a plan that takes into consideration the knowledge acquired by various groups and promotes a greater implication of collaborating agencies.
- The project includes three components managed by three program officers: health, IEC and community organization. Working together, the program officers participate in developing an integrated approach to activities and objectives.
- The project has the general goal of improving maternal and child health through five technical programs and has an integrated community approach that ensures sustainability of activities.

This strategy appears to be quite innovative and allows an approach that encompasses health issues. The strategy also encourages the communities themselves to take charge of their health. The strategy, however, appears to be very ambitious considering the following constraints faced by the project:

- lack of financing for certain activities (match-funded projects);
- a general lack of expertise in Mali in the area of community organization;
- limited period of financing compared to objectives;
- overlapping objectives, making it difficult to focus activities and to set priorities;
- lack of detailed schedule of activities for the entire life of the project in the DIP; and
- lack of indicators to measure certain objectives of the new strategy which may constitute a handicap during the final evaluation.

The major weakness of this second phase of the project remains its geographic coverage and the choice of project villages. The project “pulled out” from 30 villages covered during the first phase--without much discussion with populations--in order to work in 25 new villages. The project originally had planned to cover the 55 villages, with monthly visits and quarterly vaccination sessions in the villages of the first phase. This plan was not put into place, however, and these villages of the first phase were virtually abandoned.

### **Recommendations**

- Schedule final evaluations early enough to use results in developing new projects.
- Take into consideration, in the final evaluation of this second phase, the

- changes causing necessary delays and setbacks in certain activities.
- Conduct the final evaluation in villages of both phases.
- Develop a detailed schedule of activities through the end of the project.
- Research financing for match-funded projects (women's initiatives, water projects, gardening, etc.).
- Develop a plan for villages of the project's first phase (as noted in general recommendations).

## II. PROJECT PROGRESS

The project has carried out an impressive number of activities despite many constraints. Some possible constraints included:

- modification of the DIP after several months of project activities;
- a change in the project coordinator;
- changes in other project staff, including head of health and IEC;
- a major meningitis outbreak which, during six weeks, put project activities temporarily on hold;
- the organization of the Dioro Health Day, which became a national event and required more preparation than initially planned;
- difficulties in securing funds for matching projects, leading to gaps in the project;
- the seasonal calendar and the impossibility of reaching certain villages during the rainy season;
- operational research activities involving project staff and the population, which required additional time but proved to be worthwhile.

Despite these difficulties, the project staff showed a surprising vitality (sometimes difficult to channel) and undertook many activities. Before looking at the list of activities, one must underline the impact of the project's communication campaigns (slogans, badges, flyers, t-shirts, etc.) which have given it high visibility and have made it known at all levels throughout Mali. The Dioro Health Day and the project team's impressive response to the meningitis outbreak also contributed to the good reputation of the project.

Principal accomplishments in the technical components of the project through July 1994 include the following:

### **Vaccination**

From January through June 1994, 18 education sessions with 704 participants were conducted. During the first semester, 2269 children were vaccinated against the EPI illnesses and 38,002 individuals (children under 20 years old) were vaccinated against meningitis.

### **Control of Diarrhea<sup>1</sup> Diseases**

From October 1992 through December 1993, 66 education sessions were held with 962 participants. During the first semester of 1994, field agents led a total of about

15 sessions each month, with 1484 participants in the 25 project villages. In addition, 26 water pumps were repaired and 4 wide wells were constructed.

### **Nutrition**

2486 participants attended education sessions and nutritional demonstrations from October 1992 through December 1993. In 1994, there have been 59 sessions with a total of 1608 participants.

### **Maternal Care and Family Planning**

Vaccination sessions involved more than 1000 women in the first half of 1994. Nearly 500 births were attended by trained traditional birth attendants (TBAs). In addition, 896 participants attended a total of 23 education sessions concerning family planning were conducted.

### **Sexually Transmitted Diseases and AIDS**

Education sessions and film showings reached more than 2500 participants last year.

### **Trainings of Community Volunteers**

Trainings of community health workers included:

- training of 50 TBAs (June 1993)
- literacy training of 25 village health agents (June 1993)
- training of four women leaders in agricultural management in Sarafere (October 1993)

### **IEC Activities**

These activities were numerous, including

- qualitative research on the utilization of a project-constructed maternity and on knowledge, attitudes and practices concerning maternal health
- an awareness-raising campaign of opinion leaders
- an awareness-raising campaign on revitalizing village health structures
- Dioro Health Day
- Health Day video and impact survey
- production and pretesting of stories on AIDS and on nutrition, of a videotape on diarrhea and on auto-medication, of tapes on hygiene and sanitation
- production of stickers on auto-medication

## **III. RELEVANCE**

### **Project**

For the arrondissement of Dioro, the child mortality rate is 159 (per 1000 live births) and the maternal mortality rate is 2350 (per 100,000 live births). Despite the progress of the project, various studies (final evaluation of the first phase, baseline survey for the second phase) showed that the health service coverage is still weak and certain public health programs remain. The arrondissement includes only four health facilities for 82 villages. The health care personnel is limited in number and available logistical means are considerably insufficient.

This child survival program responds to the priorities of the government policy that emphasize the importance of the health of young children and of women. Through five technical interventions, the project covers the principal health problems of maternal and child health. (During the proposed third phase, it is recommended that the project develop other activities that were not originally a part of this project. This includes malaria case management--prophylactic and curative--and acute respiratory infections (ARI). These two illnesses are thought to be principal causes of death of children in the arrondissement of Dioro.)

### **Project Site**

The project, in its second phase, originally was designed to cover 55 villages of the 82 villages in the arrondissement of Dioro, including 30 villages of the first phase and 25 new villages. The decision to begin activities in these new villages, despite the fact that activities had not been consolidated in the villages of the first phase, should be re-examined. Considering the number of field agents and the distance of certain villages, the project staff realized that efforts should be concentrated on the new villages of the second phase. Staff realized, however, that it would be necessary to find a solution for continuing activities in the first phase villages. The expansion of the project throughout the arrondissement would necessitate more human resources and the existence of solid community associations in both villages of the first and second phases of this project in order to assure sustainability of activities.

The choice of second phase villages was made according to their accessibility and their geographic location. Other criteria should have been considered, including motivation, the presence of community associations, and the availability of water. This would have allowed the project to develop different strategies to work with various villages.

The town of Dioro also has benefited from project activities, including the vaccination campaign during the meningitis outbreak, the Dioro Health Day, and the various IEC activities. In the town of Dioro, curative health needs are covered by the Dioro Health Center and preventive health activities, especially IEC activities, are organized by the project.

### **Beneficiaries**

The arrondissement of Dioro includes 76,000 residents, of which 51,000 live in the 55 project villages. The project has two primary target groups: children under five years old (10,350 children) and women of childbearing age (11,000 women). The targeting of these two groups corresponds to Mali's health policies. However, the project also has worked with the several secondary target groups.

- Men also must be considered and need to participate actively in activities promoting maternal and child health. The project has adopted an approach that includes and encourages the participation of men.
- Youth from 6 to 15 years old comprise an important group for the project, one that is targeted by many IEC activities. This age group is involved in care of younger siblings. Youth also have the capacity to learn easily and to retain new ideas. In addition, these are the adults of the future.
- Older women also play an important role in childbearing and in the education

of young children. The project has addressed this group with focused IEC messages, specifically in a taped story on breastfeeding.

The idea of ethnicity does not appear to have been considered by the project in its community approach. Field experiences, however, has showed that even though villages may appear to be culturally homogeneous there may exist certain ethnic nuances to be considered in approaching communities.

### **Recommendations**

- In considering extension of the current project (during the third phase), focus on diversifying target populations and increasing the number of interventions rather than expanding geographically.
- In future proposals, consider focusing on youth as a target group, especially for education on such themes as AIDS prevention, human sexuality and family planning.
- In learning more about project communities, consider all cultural aspects of village life, including those linked to various ethnic groups in villages.
- In planning the next phase of the project, expand the intervention components (adding malaria and ARI case management), especially in IEC and training activities.

## **IV. ACCOMPLISHMENT OF OBJECTIVES BY TECHNICAL COMPONENT**

### **Immunizations**

#### **Immunization Objectives**

Vaccination coverage and educational objectives:

- completely vaccinate 80% of infants 0 to 11 months (3461 infants) by the end of the project;
- 50% of mothers know the sites and timing of vaccination;
- 50% of mothers know the number of **times** a child must be vaccinated during the first year of life; and
- 50% of mothers report that their husbands encourage them to get children vaccinated.

#### **Immunization Strategy**

To reach these objectives, the project adopted a strategy that included:

- **close collaboration between project services and government services**  
The project assures vaccination coverage (monthly vaccination sessions) in the 25 villages of the second phase. In the 30 villages of the first phase, the government's mobile team is responsible for vaccinations.
- a **training of health care personnel**  
Project personnel have been trained and retrained in vaccination administration.

- **IEC activities**  
The project has included education sessions, utilization of town criers, mobilization of village health agents and village leaders, home visits and planning of vaccination sessions in accordance with villages.
- **logistical support**  
The project has contributed to maintenance of the cold chain, distribution of vaccinations and reproduction of health cards when stocks were short.
- **supervision by the director of the Dioro Health Center**  
The health center director supervises all vaccination activities. Data is collected monthly by Africare field agents. In addition, a vaccination register is kept in each village.

### **Immunization Observations**

The midterm evaluation team made the following observations:

- Vaccination objectives appear to have been attained in villages of the second phase, with an adequate vaccination coverage, an effective community mobilization, effective use of education sessions, and a good understanding of the importance of vaccination by mothers (even though they may not always be able to list the diseases covered by EPI).
- Logistic constraints in villages of the first phase include a lack of transport of the mobile team. This has led to problems in coverage in these villages (and no vaccination services in the past several months).
- Difficulties in supervision and data collection are caused by limited personnel (including an overworked director) in the Dioro Health Center.
- Vaccination cards (sold at 100 CFA) often have been unavailable. This has led to problems in evaluating vaccination coverage, especially during the final evaluation of the first phase during which coverage was counted only according to official cards. (Unofficial cards had been issued by the project during the first phase when official cards were unavailable.)

### **Immunization Recommendations**

- With the goal of sustainability and of maximizing coverage, the project should envision providing even more assistance to the Dioro Health Center, possibly by opening a small second vaccination post (where vaccines could be stored) and by increasing logistic support (assuring the cold chain or providing transport) to villages of the first phase.
- For the final evaluation of this phase, in cases where official cards are unavailable, coverage should be evaluated according to village registers.

## **Control of Diarrhea1 Diseases (CDD)**

### **CDD Objectives**

- reduce from 53% to 25% the percent of children having experienced diarrhea in the past two weeks (prior to the survey);
- reduce from 32% to 15% the utilization of antibiotics and/or antidiarrheal medicines during episodes of diarrhea in children under five;

- 60% of mothers can cite the signs of dehydration, explain the preparation of salt-sugar-solution (SSS), describe oral rehydration therapy (ORT) and describe the proper feeding of children with diarrhea; and
- 75% of villages will have a source of potable water.

### **CDD Strategy**

The project's strategy to attain these objectives includes:

- **promotion of sugar-salt-solution (SSS)**  
The project has decided to promote the use of SSS instead of packages of oral rehydration salts (ORS), which are not readily available in the project area. (This supports the MOH CDD strategy.)
- **IEC activities**  
The project has included CDD as a major theme in IEC materials, which promote use of home-based solutions and porridges and messages concerning appropriate nutrition and which discourage auto-medication in case of diarrhea.
- **case management**  
Children at risk of diarrhea and/or severe dehydration are followed and severe cases referred to health facilities.
- **provision of potable water**  
The project has constructed wells and has developed a proposal for a match-funded project for water sources.
- **training of personnel**  
The project's field agents have been trained and the health center director as well as the health program officer have supervised field agents.

### **CDD Observations**

The midterm evaluation team made the following observations:

- The project has produced IEC material and the messages seem to have been diffused.
- Women know what SSS is and are able to explain how to prepare it, but confirmation that it is actually used was not made (and several mothers did not appear to be able to prepare and administer it).
- Mothers do not seem to be able to cite signs of dehydration.
- Mothers surveyed claimed to use modern medications (especially antibiotics) in cases of diarrhea, especially tetracycline sold without prescription in open markets.
- Mothers surveyed also claim to use traditional remedies.
- The project has had difficulties in assuring provision of potable water, especially because match-funding has not been securing for the potable water project. In addition, maintenance of pumps previously installed (by Saudi Arabia) has proven difficult because spare parts are not available.

### **CDD Recommendations**

- Diversify IEC messages, especially to include more on the feeding of children during and after diarrhea.
- Contact organizations involved with the promotion of traditional medicines in order to encourage utilization of effective traditional remedies during diarrhea.

- Reexamine the treatment of children with diarrhea, referring instead to treatment of the “sick child” and encouragement of the “well child.” (Diarrhea in children is often linked to other diseases and can bring on other conditions, including malnutrition.)
- Secure financing for the match-funded project proposal that would assure potable water in project villages. (This is the responsibility of Africare/Washington.)

## Nutrition

### Nutrition Objectives

- 65% of children under three years old in second-phase villages are weighed quarterly;
- 75% of mothers exclusively breastfeed babies through the age of four to six months;
- 50% of mothers are able to cite at least two foods rich in Vitamin A;
- 50% of mothers are able to describe appropriate feeding practices according to the age of children; and
- community and/or individual gardens are planted with project support in order to improve general nutrition in project villages.

### Nutrition Strategy

The project has implemented to following strategy:

- **IEC activities**  
Target messages of IEC have included those on exclusive breastfeeding, correct feeding and weaning practices and feeding children in separate bowls.
- **nutrition demonstrations**  
Field agents have conducted nutrition demonstrations in all project villages.
- **baby weighing**  
Monthly growth monitoring sessions are conducted in all phase two villages.
- **training**  
Field agents have received training in nutrition education.
- a **NCP/CNIECS collaboration**  
The project has collaborated with the Nutrition Communication Project (NCP) and with the National Health IEC Center (CNIECS) on trainings, production of IEC material and operational research.
- **supervision**  
Field agents are supervised by the program officer for health and data is collected on a monthly basis.
- **gardening**  
The projects supports four community villages, financed during the first phase, and one field agent offers technical guidance.

### Nutrition Observations

The midterm evaluation team made the following observations:

- The project has produced IEC material and transmits messages according to

objectives (except those concerning Vitamin A, which have not adequately been incorporated).

- Baby weighing and nutritional demonstrations are conducted and there is active participation on the part of mothers. The sustainability of these activities is uncertain, given that they are conducted primarily by Africare field agents.
- New gardens have not been developed because match funding has not been secured for a gardening proposal developed by the project staff.
- Collaboration with NCP has been positive for the project, especially concerning initial training of field agents. There have, however, been some problems concerning supervision of these activities.
- Data is collected regularly, but indicators do not seem to be relevant to the project's process or outcome.

### **Nutrition Recommendations**

- Reexamine and clarify objectives for the nutrition intervention.
- Develop simple and relevant indicators.
- Reinforce educational messages.
- Secure additional financing for gardening activities.
- Formalize the follow-up and supervision of collaborative efforts with NCP.

## **Maternal Care and Family Planning**

### **Maternal Care/FP Objectives**

- 80% of women 15 to 45 years old have received at least two vaccinations against tetanus (TT vaccine);
- 60% of pregnant women have had at least one prenatal consultation;
- 60% of deliveries have been attended by a trained birth attendant (or trained health agent); and
- 80% of women have heard of family planning and 10% of women (who desire no children within next two years) will use a modern method of family planning.

### **Maternal Care/FP Strategy**

- **expansion of TT target group**  
All women of childbearing age, and not only pregnant women, are vaccinated with TT.
- **TBA training and supervision**  
TBAs are trained, retrained and regularly supervised by field agents and health center staff.
- **IEC activities**  
IEC activities have been reinforced with operational research and messages are geared toward both men and women.
- **high risk cases**  
Criteria for high risk deliveries have been established and personnel are trained to identify risks.

- **FP training**  
Personnel are trained in family planning and volunteers participate in community-based distribution of contraceptives (condoms and spermicides). The project collaborates with the **Malian** Family Planning Association (Association Malienne de la Promotion de Planification Familiale, or AMPPF) in training agents.
- **follow-up and supervision**  
Field agents keep track of all women 15 to 45 years old and data is collected on a monthly basis.
- **cost recovery**  
A system of cost recovery is established for the compensation of TBAs.

### **Maternal Care/FP Observations**

The midterm evaluation team made the following observations:

#### **Vaccination**

- Women surveyed recognize the importance of the TT vaccination.
- TT vaccination has covered all women of childbearing age and vaccination coverage appears to be satisfactory in second-phase villages, but unsatisfactory in villages of the first phase.

#### **Prenatal Consultations**

- Women rarely participate in prenatal consultations, due primarily to socio-cultural constraints. (Some of these constraints were identified during operational research activities.)
- Consultations are assured by Africare field agents, which poses the problem of sustainability. **TBAs** also appear to be confused regarding notions of risks during pregnancy and high risk deliveries. In addition, criteria for high risk pregnancies and deliveries should be reevaluated.
- IEC messages concerning pregnancy are not always adequate. The operational research conducted should be applied to revise IEC messages.

#### **Delivery**

- Women appear to understand the importance of being assisted by trained personnel.
- **TBAs** are, for the most part, accepted village members and committed workers.
- **TBAs**--according to interviews with them--need retraining.
- Cost recovery for **TBAs** does not work effectively in many project villages.

#### **Family Planning**

- A real demand, expressed especially by women, exists in the villages for all family planning methods.
- Contraceptive methods available in the villages (condoms and spermicides) are not those preferred by women.
- The community-based distribution of contraceptives needs to be analyzed and has weaknesses, especially concerning provision of methods, problems of cost recovery and problems with those identified to be distributors.
- Collaboration with AMPPF needs to be examined and improved, especially in the areas of data collection and supervision. In addition, there is confusion regarding relations with AMPPF at different levels (nationally and regionally).

### **Maternal Care/FP Recommendations**

- Reconsider vaccination strategy in villages of the first phase.
- Reexamine prenatal care, looking at sustainability issues at results of operational research, to refine both IEC messages and the role of TBAs.
- Plan for retraining of all TBAs.
- Reflect, with the communities, on system of compensating TBAs for their time, and analyze cost recovery possibilities in general.
- Analyze ways of satisfying the demand for family planning. Review the current system and the collaboration with AMPPF.

## **Sexually Transmitted Diseases (STDs) and AIDS**

### **STD/AIDS Objectives**

The project has not specified objectives for this component, but recognizes its importance and considers it an integral component of health education activities.

### **STD/AIDS Strategy**

The project abandoned the idea of tracking down HIV-positive cases in Dioro, a concept discussed in an add-on AIDS proposal. Instead, the focus has been on IEC, especially with adolescents (12- to 21 -year-olds).

### **STD/AIDS Observations**

The midterm evaluation team made the following observations:

- There is a real and felt need for more information on AIDS. Women surveyed have heard of AIDS, but do not have a clear idea of the disease, causes, symptoms or prevention.
- The project works with both modern and traditional media to transmit AIDS information.
- The project has wisely separated AIDS education messages from those on family planning.
- Health care personnel and Africare field agents commented on an extremely high prevalence of **STDs** in all project villages. However, little information is available on knowledge, attitudes and practices concerning **STDs**.

### **STD/AIDS Recommendations**

- Develop a more detailed strategy on **STDs** and AIDS and establish measurable objectives for this component.
- Focus on specific target groups for this component.
- In a possible third phase of this project, concentrate on this component and plan operational research concerning **STDs** and AIDS.

## V. IMPACT ON DEVELOPMENT

In its second phase, the project has emphasized the discovery and reinforcement of each community's potential strengths. In villages, traditional leaders and health agents have been mobilized. The project also has worked with traditional media resources, including griots (storytellers), town criers and theater groups. The project also has conducted research on existing traditional associations (such as tons) as well as 'modern' associations in order to work with previously established groups and to examine why some of these groups (established village health committees) are dysfunctional. To encourage village participation, the project also works to respond to the felt needs of the communities, including the need for potable water and for income-generating activities. The project also has focused on working with community members to ensure that they understand the goals of the project itself. (Two awareness-raising campaigns have been held in project villages.)

The second-phase strategy also has concentrated on incorporating women into all activities. Increased participation of women and the active support of men are integral parts of this strategy.

The new strategy has led to several measurable objectives:

- 75% of female health agents will have a source of income generation;
- 50% of female health agents will have received training in management; and
- 75% of female health agents will have received training in literacy.

Other less quantifiable indicators to be examined include the confidence level of women, women's stature in communities, support of women's involvement on the part of males, and communication between couples (especially regarding family planning).

In order to attain these objectives, the project has planned a number of activities:

- recruitment of women as village mobilizers;
- development of income-generation projects;
- diffusion of specific IEC messages for both men and women;
- awareness- raising campaigns;
- increased participation of women in village health committees; and
- literacy training for women (taking into consideration their limited free time and limited capacity to spend time away from the home).

### Observations

The midterm evaluation team made the following observations:

- Project personnel are well-trained and well-versed on women's empowerment and the importance of women's participation in project activities.
- The project has made progress, especially in terms of IEC and in encouraging all community members to give consideration to the role of women in the success of health and development activities. (The two awareness-raising campaigns held in the villages appear to have been successful.)
- Income-generating activities have not been supported, mostly due to a lack in match funding (and the fact that a proposal for this specific component has not

- yet been developed).
- Literacy training occurred during the first phase, but has not yet begun during the second phase.

### **Recommendations**

- Reflect on the approach to be used in addressing women and consider the importance of feminine leadership within communities. In addition, consider women's solidarity within villages and focus on existing associations of women.
- Promote women's involvement by considering, at the same time, the importance of men and the role they play in communities. (The project has already considered this in its awareness-raising campaigns.)
- Examine the concept of female mobilizers and reconsider their role, qualifications, selection, relationship with TBAs, with the health committees and with all women in the communities.
- Secure financing for match-funded projects to encourage income-generating activities.
- In plans for a third phase, expand the component of income-generating activities.
- Develop a strategy for literacy training, working with collaborating partners to respond to community needs. In addition, expand the literacy component in future proposals.

## **VI. EXECUTION OF PROJECT ACTIVITIES**

### **Health Information System (HIS)**

The project has attempted to put into place an HIS to collect and analyze data. A consultant was hired to develop a new system. In addition, the project administrative assistant was trained and future trainings are planned. Currently, however, the HIS needs to be improved.

### **Indicators**

The project has a list of 47 key indicators and the HIS, in theory, includes 26 forms. This long list of indicators makes the HIS burdensome and difficult to manage. Many of these indicators are relevant to neither project activities nor measurable indicators. Although the project works closely with MOH agents, indicators used by the project are not necessarily those used by the MOH. At the regional level, the director cited difficulties in including project activities in regional reports because of these differences in indicators. In addition, data collected by the project personnel, especially total figures for population groups in the 25 villages of the second phase, conflict with official government data.

### **Data Collection**

Basic data is collected by village health agents (TBAs and health volunteers) and by Africare field agents. Data is collected monthly and is synthesized by the project program officers. A lack of training and illiteracy often causes problems with data collection by village health agents. Field agents complained of a lack of concise forms

for monthly data. Agents also mentioned a perceived need for more training concerning data collection and the HIS.

### **Data Analysis**

Analysis of data collected is conducted by the project's program officers and coordinator. A compilation of data is included in Africare's monthly internal reports, in quarterly reports and in annual reports. The project has had logistical problems (computer-related) in putting in place an effective HIS. Training of program officers in data analysis and HIS would allow for a better understanding on their part of their role in the HIS.

### **Data Reporting**

The project ensures that all partners receive reports, informative correspondence and flyers with current project data. Feedback is less systematic, however, with the project's own field agents. Field agents complained of submitting reports to program officers and not receiving feedback. During the last few months, the project has made an increased effort to provide feedback to villages (especially during recent awareness-raising campaigns and during the Diaro Health Day).

### **HIS Recommendations**

- Develop and implement an HIS with a limited list of indicators (not more than 10), including only those relevant and necessary to the project.
- To the degree possible, use indicators of the MOH in order to allow for incorporation of Africare's data in regional reports.
- Work with other NGOs (especially, perhaps, Save the Children/USA) to improve the HIS.
- Produce simple forms to be used by field agents.
- Promote literacy training to allow village health workers to participate in data collection.
- Train field agents in data collection and analysis.
- Continue to diffuse reports and increase feedback provided to field agents and to village health workers.

## **Community Education and Mobilization**

### **Observations**

IEC activities are a major aspect of project activities and are directed by a project IEC program officer.

### **Objectives**

Several process objectives for education were developed:

- promote healthful behavior;
- transmit specific IEC messages to men and to women;
- organize IEC campaigns using songs, theatre, dances and stories;
- secure funding to conduct operational research and surveys to improve IEC messages;

- develop IEC messages that promote women's empowerment and that enhance women's role in decision making; and
- conduct awareness-raising campaigns.

### **Activities**

The project has conducted several IEC activities, many of which are cited in previous sections of this report. Most of the planned activities have been conducted. The project should review its IEC strategy and calendar in order to plan coordinated production and diffusion of IEC messages and materials.

### **Personnel**

The IEC Program Officer was replaced by an Africare field agent who had not previously been trained in IEC. Despite a lack of formal training in IEC, the program officer appears to be quite competent and capable of performing his duties. Field agents have been trained in IEC activities (during a recent workshop led by the project coordinator and financed by UNICEF). The Youth Mobilizer for the arrondissement of Dioro is the counterpart of the IEC Program Officer and has been an active participant in project activities.

### **Development of Messages and Materials**

The material has been well-conceived and pretested with the population. (An exception is the sticker discouraging auto-medication, which did not appear to have been pretested.) Separate messages have been developed for different target groups, including women, men, adolescents, young children and older women. Operational research has contributed to the refinement of IEC messages.

### **Channels of Communication**

Both traditional and modern communication channels have been effectively used. The evaluation team was able to observe, firsthand, the effectiveness of both types of communication channels. A recent workshop on IEC and Traditional Media was the first such training to be held in Mali. Its impact appears to have been important not only for project staff, but also for UNICEF and other collaborators who are basing future trainings on it. Utilization of videotapes has proven effective in villages, particularly during the first awareness-raising campaign. The project also has used a private Dioro radio station to diffuse information.

### **Diffusion of IEC Material**

The project has produced material which can be multiplied if finances allow. The project should develop a strategy for multiplying and diffusing its material and should look into ways of encouraging

### **Partnerships**

Collaboration was fostered with CNI ECS, UNICEF and NCP. The project was able to work with experts in areas such as nutrition and family planning and project staff contributed extensively--especially in its innovative IEC techniques. The project coordinator also has extensive background in IEC techniques.

## **Recommendations**

- Develop a strategy for producing, multiplying and diffusing IEC material.
- Plan an IEC calendar of activities through the end of Phase II.
- Continue and increase collaborative efforts, especially with the Child Survival NGO Pivot Group (Groupe Pivot de Survie de l'Enfant).

## **Personnel**

Project personnel includes:

- one project coordinator (expatriate)
- three program officers, one responsible for health, one for IEC activities and one for community organization
- five health field agents
- one agricultural field agent
- one administrative assistant
- one secretary
- one guardian
- one driver

## **Observations**

Recruitment of personnel has been conducted with both written and oral testing. The project appears to have hired many young personnel without much experience, but with much motivation.

The system of personnel management appears to have been greatly strengthened with the past several months, with more insistence on the respect of schedules, etc. In addition, a project organigram and job descriptions have been developed. In addition, the project's three program officers appear to have very clear job descriptions and division of responsibilities. The project's organizational structure seems to be clear and simple. Internal training sessions in management and leadership (held in September 1993) have led to a greater team spirit and understanding of roles on the part of project personnel.

Although most of the field agents have been with the project since the onset of Phase I, the staff has had changes in management. The roles of coordinator, health program officer and IEC program officer have been filled by several different individuals. These changes had negative consequences on the execution of project activities and represent a loss of training invested in various personnel. In addition, some personnel mentioned a climate of "insecurity" that some of the personnel changes created.

A positive benefit of changes in personnel was that they allowed internal promotion. Field agents were promoted to serve as program officers, a concept which apparently motivated all personnel. This internal promotion strategy also allows the project to benefit from investments in training and personnel.

The personnel, especially field agents, expressed a deep commitment to the villages and to their work in the field. They described often difficult working conditions, but an expressed an acceptance of these realities.

A high level of motivation and a real team spirit prevail in Dioro. Initiative and self-reliance are encouraged and the entire personnel participates actively in project work sessions..

Discussion and diffusion of information is encouraged and standardized. During daily office staff meetings and monthly personnel meetings, all members of personnel have the opportunity to report on their activities, to discuss problems and to make suggestions to improve the project.

The field agents are supervised by the project's program officers and the coordinator. Field agents expressed their need for more supervision in the field, which would allow them to improve their techniques. They recommended a visit to each field agent at least once a month by one of the program officers.

The personnel benefits also from the positive image of the project, on the part of collaborators, of authorities and of communities. This good reputation has been enhanced by the Dioro Health Day, by the meningitis campaign and by the recent awareness-raising campaign.

The number of personnel appears to be sufficient, given that only 25 villages are currently being covered. If the project, however, would attempt to cover all 55 villages, more personnel would have to be recruited.

### **Recommendations**

- In order to assure project continuity, attempt to recruit coordinator's for at least two-year periods. Recruit early for replacements, especially for project coordinator.
- Attempt to recruit highly-qualified and well-trained personnel, especially for positions of authority within the project.

### **Training of Personnel and Partners**

Training activities planned in the DIP included Epi-Info trainings for the Dioro Health Center Director and for the project's administrative assistant, training for program officers and field agents in management, supervision, community development, primary health care, IEC and operational research methodology and additional computer trainings for personnel.

### **Observations**

The following trainings were conducted:

- Internal Training
- Training on HIS for IEC and health program officers  
February 1993
- International Meeting for Maternal and Child Health Projects, attended by the health program officer  
March 1993
- Computer Training for the administrative assistant  
March 1993

- International AIDS Conference in Uganda, attended by the IEC program officer  
April 1993
- Family Planning Training by AMPPF, attended by Dioro Health Center Director and field agents  
July 1993
- Leadership and Management Training for program officers and administrative assistant  
August 1993
- Leadership and Management Training for field agents  
November 1993
- New Project Vision Workshop: See Big, Start Small, Act Now, attended by all project personnel I  
September 1993
- Workshop to Design the DIP, in Segou, attended by all regional partners  
October 1993
- Operational Research Methodology Training, attended by all project personnel  
November 1993
- Nutrition Training/Retraining of field agents and community organization program officer with NCP/AED/CNIECS  
December 1993

The project also has benefitted from the expertise of other organizations. The project has planned to consider in the future, however, specific training content in order to make the most of personnel time. It also is necessary that other organizations evaluate their own trainings and are able to present clear outlines of training curricula.

The departure of key project personnel has led, unfortunately, to a certain loss of time and money invested in trainings. Several training needs should be considered, notably management and administration training for the administrative assistant, training in community organization and training in HIS and data management for the entire project team.

### **Recommendations**

- Reconsider training in terms of an overall strategy (training needs evaluations, follow-up of trainings and impact studies after trainings).
- Attempt to cover the training needs cited above.
- Develop a schedule of trainings through the end of the project, taking advantage of seasonal constraints to field work during the rainy season in order to increase trainings.
- Continue to focus training on practical issues rather than theoretical or academic teaching.
- Intensify collaboration on trainings by working with the Health Pivot Group, other NGOs and regional and local MOH personnel.

### **Technical Assistance**

External technical assistance has included the use of a consultant during the Phase II Baseline Survey, the visit of a consultant who worked on the HIS, and the

assistance of a student researcher during the operational research on pregnancy and prenatal care.

Internal technical support is offered, above all, by the coordinator, who plays an essential role in the success of this project and has steered the conception, methodology, management, training of personnel and of partners, team spirit, bringing in partners, and increasing visibility and an excellent reputation of the project throughout Mali. Africare/Bamako also has offered technical assistance through visits to the project site. In addition, Africare/Washington's child survival program manager has provided technical assistance during visits. (This position, unfortunately was not filled for more than six months in 1993.)

### **Recommendations**

- Analyze needs and demands and develop precise terms of reference for all external consultants.
- Africare/Mali should develop a more systematic technical assistance approach and determine the role of the Bamako project officer working with the Dioro Project.
- Africare/Washington should put as much emphasis on technical assistance as it does on administrative assistance.
- Africare/Washington should secure funding for match-funded proposals in a timely manner.
- Encourage exchange among all Africare health projects.
- Conduct field visits taking into consideration regular project activities.

### **Studies and Operational Research**

In the DIP, several research activities and studies were proposed:

- the Baseline Survey for Phase II;
- the Midterm Evaluation;
- the Final Survey and Evaluation;
- a general census of all children under five and all women of reproductive age;
- research on community associations and activities in the villages; and
- development of individual intervention plans for each village.

### **Observations**

- The following research activities and studies have been conducted:
  - Baseline Study in the 25 villages of Phase II (March 1993);
  - research on community organization (September 1993);
  - census of target groups in the 25 Phase II villages (October 1993); and
  - operations research on knowledge, attitudes and practices concerning pregnancy, prenatal care and delivery (October--December 1993).
- Research activities have been accompanied by trainings of project personnel in methodology.
- a Survey and research results have been applied to concrete activities, especially in the conception of project strategy and in the development of IEC messages.
- The project has been able to secure funds to finance some research activities.

- The project has diffused results to both partners and to communities.
- The need for future research activities has been identified, including research on STDs and research on traditional remedies for diarrhea1 disease.

### **Recommendations**

- Continue to diffuse results to partners and to project communities.
- Develop lists of reach needs and a schedule of activities to be conducted through the end of the project.
- Reinforce technical collaboration with other partners, including utilization and application of results, sharing of experiences and financing of research activities.

### **Supervision, Monitoring and Evaluation**

The midterm evaluation team discovered both strengths and weaknesses concerning supervision, monitoring and evaluation of project activities.

### **Weaknesses**

- absence of a detailed monitoring plan in the DIP
- difficulties in collaborating with certain partners on supervision of activities (including AMPPF, NCP and MOH services)
- an abundance of project objectives, which have led to a tendency to overload staff and schedules instead of focusing on supervision of current activities
- many planned supervision activities not taking place
- field agents sensing a certain insufficiency in the supervision of their activities and in the monitoring of their reports

### **Strengths**

- daily and monthly meetings with project personnel
- monthly reports produced by field agents and by project program officers
- development of monthly and bi-annual workplans
- willingness to improve collaboration with partners on supervision and evaluation

### **Recommendations**

- Produce a schedule for all supervision and monitoring activities through the end of the project.
- Reinforce supervision of field agents and respond to their monthly reports.
- Develop, with each partner, a plan for supervising and evaluating collaborative efforts.

## **Collaboration**

### **Government Services**

The project has focused on preserving and reinforcing collaboration with Malian government services and agents, especially important in the interest of assuring sustainability of activities. A basic project goal has been to reinforce basic technical services. Close collaboration has included joint efforts to develop the DIP. In addition,

each project program officer--health, IEC and community organization--has worked with a government counterpart. Several indicators were developed to measure the level of collaboration:

- the number of contacts, exchanges and informational meetings held;
- the number of training and retraining sessions held; and
- the number of supervision visits conducted.

Partnership with government services has included collaboration on submission of reports; circulation of information; participation of agents in project trainings; joint efforts in such activities as awareness-raising campaigns, the meningitis outbreak response and Dioro Health Day; production of IEC material; utilization of certain government equipment and facilities (photocopiers, conference rooms, videotapes, etc.); and technical assistance. The degree of collaboration with government services are exceptional compared to that of many NGO projects.

However, several aspects of this collaboration could be improved. The local development committee of the arrondissement of Dioro could play a more prominent role in coordinating agencies and services, and its health committee could more closely coordinate health services and activities. Often, a lack of coordination in schedules of government and private agency activities leads to difficulties and a lack of ability of government agents to participate in some project activities. In addition, a lack of coordination of interventions in villages sometimes leads to confusion on the part of community members and to a duplication of efforts of various agencies. Another problem has been different per diem policies on the part of different agencies. A recent **USAID** banning of per diem has led to a problem in encouraging the participation of government agents in project activities, especially visits to villages. Also, a lack of official agreement (protocol d'accord) with health services at local and regional levels could be an obstacle to collaboration on certain activities. Another problem is the different systems of health information and the differences in indicators measured by the project and those measured by the MOH. Lastly, some government agents affiliated with the project (particularly counterparts to program officers) do not feel as though they have decision-making power and lack the authority to supervise project personnel.

### **Other Partnerships**

In addition to collaboration with government services, the project has developed collaborative relationships with several other agencies. Collaboration with the Peace Corps has been problematic, with volunteers not working as team members and opting for autonomy rather than team work. Collaboration with NCP/AED has allowed the project to develop its expertise in nutrition, especially through training of personnel and through development of IEC materials. Supervision of NCP collaborative efforts has been problematic and overall evaluation of this collaboration will be difficult to conduct, especially since the 16 villages of Dioro covered by the NCP are no longer project villages (but were during Phase I).

### **Recommendations**

- Continue to focus on collaboration with governmental technical services.
- The local development committee should take a leading role in coordinating all

- development activities conducted by all agencies working in the arrondissement
- Reinforce coordination of schedules with government services.
- An development plan should be elaborated for each village, taking into consideration all agencies working in each locality.
- Sign protocols d'accord with government services.
- Reinforce supervision of activities and collaboration with government services on supervision activities.
- Coordinate the choice of indicators and the HIS with those of the MOH.

### **Other NGOs**

Africare has, through its country representative based in Bamako, participated actively in various organizational groups, including **CCA/ONG** (a coordinating body for all NGOs working in Mali), and the Child Survival Pivot Group.

The project has developed a relationship with the Pivot by collaborating on the Dioro Health Day, on the operations research on pregnancy and prenatal care. In addition, a representative of this group, IEC Director Dandara Kante, served as a member of this evaluation team.

The Dioro Health Day provided an ideal opportunity for various **NGOs** and other groups to collaborate. Many **NGOs** participated in this event, presenting their activities and distributing material. The Dioro Health Day also was attended by the Minister of Health of Mali, who lauded the project staff and expressed the desire to make this an annual event.

The project does not work closely with other American **NGOs** working in child survival, but has expressed the desire to enhance this collaboration.

The project has focused on working relationships with local **NGOs**, including the AMPPF and GRAT (a technical assistance NGO). AMPPF is a **Malian** NGO with expertise in family planning. Its long history and sound support as a local NGO distinguish it among **Malian** **NGOs**. There have, however, been difficulties in assuring this collaboration. The program of community-based distribution of contraceptives needs to be reviewed and a supervision plan needs to be developed.

GRAT is a recently established **Malian** NGO that specializes in offering technical assistance in a variety of interventions. This NGO, however, appears to have a limited number of personnel and a limited institutional capacity. The project carried out some water provision activities with GRAT initially, but recent collaboration has been limited.

### **Recommendations**

- Continue to work closely with other **NGOs**.
- Emphasize collaboration with the Pivot Group and reinforce this collaboration, especially regarding exchange of experiences within the group, development of IEC materials, trainings, technical supervision, HIS, and relationships with government services and agents.

- Reinforce exchanges with other American NGOs, especially those working on child survival projects.
- In planning a third phase, investigate the possibility of working directly with one or more local NGOs (in consideration of their institutional strengths and weaknesses).

## **Budget**

### **Observations**

Several budgetary problems seem to be important. Insufficiencies exist, especially regarding equipment (vehicles, motorcycles, audio-visual material, and computers). During the conceptualization of this second phase, certain needs were not considered.

The project appears to have both the willingness and the capacity to manage its finances. Field agents did comment on what they consider to be a very rigorous distribution of fuel for project activities. The management system appears, however, to be both simple and effective.

The administrative assistant would benefit significantly from training in management and computer skills.

The project was able to secure some funds locally in order to conduct certain activities not financed directly by the project (IEC activities, training sessions, etc.). In addition, the project was able to respond admirably during the meningitis outbreak.

**Africare/Washington** must seriously work to secure funds for previously submitted match proposals (water source provision and gardening). Also, the project should develop proposals for other activities, including income generation and additional research activities.

### **Recommendations**

- Research additional funding to extend the current project.
- **Africare/Washington** must secure funds for match projects.
- Continue to seek out funding for research and other complementary activities.
- Plan a training in financial administration for the administrative assistant.

## **VII. SUSTAINABILITY**

The durability of interventions is considered by the project, but certain questions remain as to the sustainability of activities.

## **Village Involvement**

The project has helped to identify village health volunteers, both health workers and **TBA**s. Health workers have the task of offering basic health care; **TBA**s assist in prenatal care and delivery. Certain obstacles seem to limit the role of these volunteers in their communities:

- **choice of individuals**  
Villages have not always been well-directed in terms of choosing health agents. Although, in general, the selection appears to have been judicious, in certain cases there are problems involving age, motivation levels and acceptance on the part of the community.
- **mobility**  
Although most of **TBA**s stay within their communities, many health workers who are young males leave their communities for long periods of time (months, even years) to earn money.
- **understanding of their roles**  
Often, both the volunteers and the communities do not have a clear idea of the role of these individuals within the community.
- **competency and capability**  
The village health workers appear to receive a rather limited initial training, one that does not allow them to respond to many illnesses or health problems. Their competency should be reinforced through additional training and supervision.
- **illiteracy**  
Village health volunteers, especially **TBA**s, are, for the most part, illiterate. This presents problems both in trainings and in maintaining records.
- **compensation for services**  
The system of cost recovery has not been effective in compensating **TBA**s or village health workers. In developing a new strategy to recruit female mobilizers (animatrices), the project should seriously consider compensation of efforts by communities.

## **Community Organization**

The evaluation showed that the village health communities set up in the villages have problems. In fact, the project staff has been concerned about the lack of functioning committees and about the ways committees had been established in the past. The project's new strategy for working with these committees includes basing them on traditional associations and organizations, incorporating women (with the support of men) in activities, and redefining with the villages themselves the qualifications, roles and responsibilities of these committees. The general motivation of communities in managing their own health is to be examined. The willingness of villages to participate actively in this process should be examined village by village. Finally, members of committees should receive support and training in management, organization, and literacy.

### **Involvement of Government Services**

Collaboration with government services is an important aspect of this project. An effective transfer of skills occurs through interaction with the government services. However, when the project ends, government agents will not have the logistical means necessary to continue activities initiated by the project. This already has been demonstrated by the lack of ability of the government to take over vaccinations in the project's Phase I villages. The local development committee also has neither the means, neither the level of coordination necessary to assure certain activities at the end of the project. Considering the government's new policy (politique sectorielle), the project and other agencies should be invited by the state to contribute to development and implementation of policies.

### **Involvement of Local NGOs**

Thus far, the project has interacted with local NGOs periodically, for such events as Dioro Health Day. In general, local NGOs do not appear to have expertise in health. (With the exception, perhaps, of the AMPPF, which has expertise in family planning.) In addition, many local NGOs lack the institutional and financial capacity to manage projects. However, partnership with local NGOs could be beneficial to both the NGOs, who could gain from the project's experience and expertise. and for the communities, who would be participating in more sustainable activities.

### **Recommendations**

- Reinforce the transfer of skills and responsibilities to village health volunteers, especially by organizing additional trainings.
- Work with the new village health committees, offering support and training in organization, management, literacy. etc.
- Reinforce collaboration with government services, especially in supervision of field activities.
- Work with other agencies, including the Child Survival Pivot Group and other NGOs, to address the new government policy (politique sectorielle) and primary health care policies.
- Begin to seek out possible local NGO partners for the third phase of the project.

## **VIII. COST RECOVERY**

The project has begun to implement certain activities related to cost recovery. In theory, TBAs are to be compensated for deliveries with which they assist. In addition, village health workers are to sell stocks of essential medicines. Vaccination and growth monitoring cards also are sold. Communities also contribute (30 percent of costs) to the construction and/or rehabilitation of water sources. Finally, contraceptives are to be sold (at subsidized fees) by community-based distributors.

Some persistent constraints regarding cost recovery include:

- the notion that health services should be free, promoted through gifts of medicines by past projects and by the fact that governmental health services

- have been free
- lack of standardization of costs among projects and agencies
- difficulties in communities to manage funds
- abandoning of certain traditional practices, such as compensating TBAs with money or gifts (cloth, meats, prepared food), in favor of adopting new rules established by projects (such as 500 CFA/delivery) but not respected or followed by communities
- weak buying power and lack of cash, especially on the part of women, who often cannot afford to buy essential medicines or contraceptives

### **Recommendations**

- Develop a cost recovery system to assure essential medicines in the villages.
- Support village health committees, especially in financial management.
- Examine traditional practices that could be incorporate into cost recovery systems.
- Develop proposals concerning income-generating activities for women.
- Collaborate with other agencies to standardize cost recovery elements.

## **IX. PRINCIPAL RECOMMENDATIONS**

Although this report has included suggestions and recommendations throughout, this section will elaborate upon some general recommendations for **USAID**, the Child Survival Pivot Group, Africare and the Dioro Child Survival Project.

### **USAID**

- Allow such projects to continue for longer periods of time (at least five years).
- Continue to allow projects to set dates for such activities as midterm evaluations according to their activities and to seasonal constraints (as was done for this evaluation).
- Allow projects to schedule final evaluations in time to plan for future projects and/or for transferring activities to other agencies and government services.
- Insist upon the participation of **USAID** officers in activities such as evaluations, in order to allow such officers to follow field projects and to allow evaluators and project staff to benefit from **USAID** expertise.
- Work more closely with child survival projects, offering technical assistance and supervision and facilitating exchange among various USAID-funded projects.
- Consider qualitative as well as quantitative results in evaluating the effectiveness of health projects.

### **CHILD SURVIVAL PIVOT GROUP (GROUPE PIVOT SURVIE DE L'ENFANT)**

- Consider its role as advocate for all child survival projects, working with projects such as the DCSP to assist in resolving problems with regional and local government authorities.
- Serve as an advocate to the MOH, attending meetings and representing child survival projects and NGOs to the ministry. Develop guidelines with the MOH

- for NGO participation in such policies as politique sectorielle.
- Provide technical supervision and monitoring for all child survival projects, including the DCSP. Develop a schedule of regular visits to all project sites.
- Develop a resource center that could be accessed by all NGOs, including documents and a variety of IEC materials.
- Catalog all IEC materials in Mali that can be shared among health projects.
- Continue to offer funding for operational research and offer opportunities for NGOs to conduct such research and to share it with other NGOs.

## **AFRICARE**

- Assure continuity of projects and develop an overall strategy, or Africare Vision of Development. Improve upon training and orientation offered to project coordinators before sending them to the field.
- Reinforce technical assistance offered to projects by increasing the number of technical staff working in **Africare/Washington**.
- Decentralize technical support by situating technical managers in Africa.
- Encourage more exchange among Africare's health projects.
- Develop a system for securing match funding for complementary projects to avoid situations such as the current one, where activities have not taken place due to lack of match funding.

## **DIORO CHILD SURVIVAL PROJECT**

- Request an extension of six to nine months for Phase II to allow time to complete planned activities, to evaluate this phase and to develop a proposal for Phase III.
- Assure the continuity of project activities by anticipating the replacement of the coordinator, who is scheduled to leave in June 1995.
- Develop an overall IEC strategy through the end of the project, concentrating on reproducing and diffusing materials that have been produced and on sustainable IEC activities taking place within communities.
- Consecrate time in the next few months to organization and training in villages, training village health volunteers (health workers and TBAs), conducting literacy trainings (especially for women) and supporting village health committees.
- Develop a strategy of intervention for Phase I villages, collaborating with Operation Riz--Segou (a state agency that appears to be intervening in these villages) and with the villages themselves.
- Become involved in the design of the new politique sectorielle by working with the Child Survival Pivot Group, other NGOs, and government services.
- Consider the design of a Phase III. Given the experience acquired by the project, its highly qualified personnel, its current relationships and its good reputation, as well as the needs of this , a third phase is highly recommended. The project could continue to promote maternal and child health, but also should consider working on other issues (such as education and income generation) with other target groups (especially adolescents).