



**CARE INTERNATIONAL IN MALI**

**Koro Community Health Project  
(KCHP)**

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**Semi-Annual Report  
January – June 2002**

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## Acronym List

AIDS	Acquired Immuno-Deficiency Syndrome
ASACO	Community Health Association
BCG	Anti-tuberculosis Vaccine
CBD	Community Based Distribution
COMGEST	Management Committee of the ASACO
CS	Child Survival
CSCOM	Community Health Center
CSref	District Referral Health Center
DG	Democratic Governance
DRC	District level Distribution Depot
DTCP3	3 <sup>rd</sup> injection against diphtheria, tetanus, whooping-cough, and poliomyelitis
FELASCOM	Local Federation of Community Health Associations
FERASCOM	Regional Federation of Community Health Association
HIV	Human Immuno deficiency Virus
IMCI	Integrated Management of Childhood Illnesses
KCHP	Koro Community Health Project
PRODESS	Mali's Health and Social Development Program
RH	Reproductive Health
RTBA	Retrained Traditional Birth Attendant
STI	Sexually Transmitted Infection

## **A. INTRODUCTION**

### **A.1 Background**

Started in 1997 for a five-year period, the Koro Community Health Project (KCHP) is in its last year of implementing activities in clinical and institutional building of partner structures in its program area. These structures are the Community Health Association (ASACO), the Referral Health Center (CSref), the Community Health Center (CSCOM), and the Local Federation of Community Health Associations (FELASCOM). One of the objectives sought by KCHP is to achieve sustainability of these structures.

During its four years of implementation, KCHP activities have been directed toward building the capacity of the management committee (COMGEST) members in key areas of ASACO management and self-evaluation. CSref/CSCOM technical staff have particularly benefited from the achievements in formative supervision and training in Reproductive Health (RH) and Child Survival (CS) to provide better quality service and care to the targeted populations.

In the six-month period covered in this report, KCHP has reviewed the various practical measures for implementing its withdrawal plan, which was initiated in July 2001. In fact, the project set up a reflection forum on participatory approaches and restored partnership ties among the different actors of the development of ASACOs, elected officials and the FELASCOM. This has allowed men and women of all ages and socioeconomic backgrounds to become real actors in the implementation of the action plan.

Despite community involvement in health care management, there are very marked links between the low socioeconomic status of communities and child and maternal mortality indicator rates in the KCHP intervention areas. Also, a strong disparity can be noted between men and women as to access to care, decision-making, and resource distribution. On the other hand, access to quality care also depends on the skills of the technical staff.

In response to solicitations made by COMGEST members in ASACO training sessions, and based on contacts made in formative supervision visits, KCHP intends to ensure a greater empowerment of these sustaining structures. Through increased empowerment, KCHP seeks to achieve sustainability of health activities and promote the emergence of a « new community mentality », which sets up its own development strategies in health. KCHP is also encouraging COMGEST members, and the technical staff of CSref/CSCOM, to adopt new behaviors to manage health problems.

### **A.2. Intermediate Objectives**

The objectives pursued by the project are:

**To improve the capacity and the quality of sustainable reproductive health and child survival services provided by seven CSCOMs in Koro District by 2002.**

**To improve the knowledge and change attitudes and practices of 28,000 mothers and young people of Koro District about key prevention and health care aspects by 2002.**

### **A.3. Approach**

To reach these objectives, KCHP developed two strategic approaches:

#### **A.3.1. Strategy in Clinical Building:**

KCHP seeks to build the capacity of the technical staff of the CSCOMs for an improved quality of care in RH and CS, and to promote greater use of health services by communities. It also enables the formative supervision that underpins this quality of care through the monitoring of policies, standards and procedures of health policy in Mali by the CSCOM technical staff.

#### **A.3.2. Institutional Building and Health Promotion Strategy:**

KCHP seeks to develop skills and build the capacity of COMGEST and FELASCOM members in monitoring and self-evaluation according to the Management Capacity Development Evaluation tool. It links the use of health services, infection prevention, and behavioral change in health, and is conducted through mass media and communication tools such as leaflets, illustrated flipcharts, and literacy booklets.

#### A.4. Profile: Target Population of the Intervention Zone

Target Population	Approx. Number <sup>1</sup>
0-11 months (4%)	3,858
12- 23 months (3.9%)	3,761
0- 23 months (7. 9%)	7,619
0- 36 months (11.7%)	11,285
Child-bearing age women 15-49 years (21%)	20,255
Child-bearing age men 15-59 years (21.4%)	20,641
Pregnant women (5%)	4,822
Young People 10-14 years (13.9%)	13,407
Young People 15-24 years (19.5%)	18,808
Young People 10-24 years (33.4%)	32,215
Total Population, intervention zone	96,451
Total Population for Koro District	289,462

#### B. ACTIVITY RESULTS

I USAID Mali: YOUTH/HEALTH REPORTING FORM  
Koro Community Health Project

Period Covered: January through June 2002

##### USAID Indicators

##### SO Level

***Indicator : Doses of measles vaccine administered to children prior to first birthday (less than 1 year old)***

- a) Number of doses of measles vaccine administered to children 0-11 months old (prior to first birthday): 947
- b) Estimated number of children 0-11 months in population of intervention zone: 3858

***Indicator : Prenatal Care : Number of tetanus toxoid (TT) doses administered to pregnant women***

- a) Number of TT doses administered to pregnant women: 1551
- b) Estimated number of pregnant women in intervention zone: 4822

***Indicator : Couple years of protection (CYP) for modern methods, women of reproductive age (15-49 years old)***

Number of CYP for the following modern methods<sup>2</sup>:

- |                         |       |
|-------------------------|-------|
| i) Oral Contraceptives: | 71.93 |
| ii) IUD:                | N/A   |
| iii) Condoms:           | 3.81  |
| iv) Foaming Tablets:    | 2.73  |
| v) Depo/injectables:    | 50.25 |

***IR-1 Level: Access – Increased access to minimum package of CS and FP interventions at district and commune levels***

***Indicator: Access to CS services***

- a) Number of persons in intervention zone w/in 15 km of facilities offering CS services: 96451
- b) Estimated total number of persons in intervention zone: 96451

***Indicator: Access to FP services***

- a) Number of persons in intervention zone w/in 15 km of facilities offering FP services: 96451
- b) Estimated total number of persons in intervention zone: 96451

***Indicator: Access to peer educators***

- a) Number of 15-24 years olds within 15 km of peer educators offering RH information/ services: 18808
- b) Estimated total number of 15-24 year olds in intervention zone: 18808

<sup>1</sup> These figures are calculated based on the total population furnished by the Referring Health Center in 1998, updated with a natural population growth rate of 3% per annum.

<sup>2</sup> CYPs result from data compiled by peer educators from January through June 2002.

**IR-1 Level: Quality - minimum package of CS and RH interventions provided at district and sub-district levels according to internationally recognized norms and standards.**

**Indicator: Number of Health Workers (HW) trained in IMCI**

- |                                   |                  |
|-----------------------------------|------------------|
| a) Number of HWs trained in IMCI: | N/A <sup>3</sup> |
| b) Number of active HWs:          | N/A              |

**Indicator: Supervision of activities at facilities/sites in target area**

- |   |   |
|---|---|
| a) Number of facilities/sites which had 1 or more visits by their supervisor in the past 3 months | 7 |
| b) Number of facilities/sites in intervention zone:   | 7 |

**Indicator: Referrals of 15-24 year olds by peer educators**

- |  |                  |
|--|------------------|
| a) Number of referrals of 15-24 year olds made by peer educators:                      | 300 <sup>4</sup> |
| b) Total number of peer educators' contacts with 15-24 year olds in intervention zone: | 5000             |

**IR-1 Level: Demand - Increased knowledge, attitudes and practices of individuals, households and communities of minimum package of CS and RH interventions.**

**Indicator: Caretaker knowledge of key child health practices**

- |   |                           |
|---|---------------------------|
| a) number of mothers who recognize at least one danger sign of dehydration: | 10249                     |
| b) estimated total number of mothers in intervention zone:                  | 20255                     |
| c) name of last survey: KAP   | date conducted : May 2002 |

**Indicator: Caretaker knowledge of key child health practices**

- |  |                           |
|--|---------------------------|
| a) number of mothers who recognize at least two warning signs of respiratory infection | N/A                       |
| b) number of mothers who recognize at least one danger sign of respiratory infection   | 13429                     |
| c) estimated total number of mothers in intervention zone:                             | 20255                     |
| d) name of last survey: KAP  | date conducted : May 2002 |

**Indicator: Client knowledge of STI preventive practice**

- |  |                           |
|--|---------------------------|
| a) number of individuals citing at least 2 acceptable ways of protection from STI infection: | 3762                      |
| b) estimated total target population in intervention zone for STI messages:                  | 18808                     |
| c) name of last survey : KAP   | date conducted : May 2002 |

**IR-1 Level: Capacity - Institutional capacity to improve community service delivery**

**Indicator: Cost recovery mechanisms**

- |   |   |
|---|---|
| a) Number of PVO supported facilities :   | 7 |
| b) Number of PVO supported facilities which achieve 100 % recurrent cost recovery : | 6 |

<sup>3</sup> This situation remains critical in Mopti Region, where only Djenne District benefited from IMCI training. The issue of passing to scale is still being reviewed by the Ministry of Health, UNICEF, and WHO

<sup>4</sup> As in previous reports, this refers to results obtained from interviews with peer educator supervisors and CSCOM officials on referral by peer educators. It is an estimate because of difficulties in collecting data from peer educators and CSCOM staff.

## Part II: Impact Indicators:

PROGRESS TO DATE SUMMARY REPORT WITH TARGETS FOR CY							
INDICATORS	DATA SOURCE	1998 Baseline	2000 Mid-Term Eval.	2001	2002		
				Achieved	Planned	Achieved	Deviation from Plan
<b>IG#1: Increase the capacity and quality of sustainable RH and CS services provided by 7 CSCOMs in Koro District by 2002</b>							
% of population within 15 km of fixed health facility offering focused CS interventions	CSCOM	89%	100%	100%	100%	100%	0%
% of population within 15 km of fixed health facility offering FP services, or served by a CBD agent	CSCOM	89%	100%	100%	100%	100%	0%
% of CSCOM staff providing IMCI	CSCOM	0%	N/A	N/A	85%	N/A	/
% of CSCOM staff trained in IMCI	CSCOM	0%	N/A	N/A	85%	N/A	/
% of CSCOM providing integrated quality RH and CS services	CSCOM	0	07	07	07	07	0
% of CSCOMs and CBDs reporting one or more visits from supervisor in past 3 months	CSCOM	0	100%	100%	100%	100%	0%
% of population with access to modern contraceptive methods, drugs and micro-nutrients at village level	Survey	83%	N/A	70%	80%	N/A	/
% of children 12-23 months old fully vaccinated, prior their first birthday	Survey	18.4%	20.0%	55%	55%	28,3%	-26.7%
# doses of measles vaccine administered to children <1 year old	CSCOM	344	3531	4383	4500	5330	830
% of women aged 15-49 having received at least two doses of tetanus vaccine	Survey	23.9%	18.3%	N/A	60%	35,0%	-25%
# of doses TT vaccine administered to pregnant women	CSCOM	1039	1836	5840	4500	7391	2891
% of births to women aged 15-49 assisted by trained attendants	Survey	52.4%	45.7%	N/A	60%	62,6%	+2,6%
# of CSCOMs support by the project which achieve 100% recurrent cost-recovery	CSCOM	0	4	5	7	6	1

**Part III: Process Indicators**

PROGRESS TO DATE SUMMARY REPORT WITH TARGETS FOR CY		DATA SOURCE	1998	2000	2001	2002		
INDICATORS	Planned					Achieved	Deviation from Plan	
<b>G#2: Increase the knowledge, and change the attitude and practices of mothers and young people in Koro District regarding key aspects of health prevention and health care, by 2002.</b>								
% of population ages 15-49 who know where CS and safe motherhood services can be obtained.	Survey	97.4%	86.9%	90%	90%	90,4%	+0,4%	
% of population ages 15-49 who know where focused RH services can be obtained.	Survey	80.9%	60.8%	80%	80%	67,3%	-12,7%	
% of mother who can explain the meaning of growth monitoring measurements taken on children	Survey	17.2%	27.1%	40%	70%	9,5%	-60,5 <sup>5</sup> %	
% of mothers who recognize at least one danger sign of dehydration	Survey	3.6	37,6%	-	40%	50,6%	10,6%	
% of children aged 0-36 months with episode of diarrhea within the past 2 weeks who receive ORS at health center or at home and/or home liquid.	Survey	0.7%	83.1%	85%	85%	90,9%	+5,90%	
% of children under 4 months exclusively breastfed	Survey	43.3%	17.9%	45%	45%	11,3%	-31,4 <sup>6</sup> %	
% of homes using bed nets	Survey	58.9%	61.4%	75%	75%	66,1%	-8,9 <sup>7</sup> %	
% of mother able to explain the link between malaria and bed nets	Survey	93.2%	91%	95%	95%	86,9%	-8,1%	
% of target population (12-24) citing at least two ways to prevent STIs	Survey	15.2%	10%	20%	60%	20%	-40%	
% of sexually active males aged 12- 24 using condom	Survey	45.3%	17.2%	30%	60%	29,7%	-30,30%	
% of sexually active women aged 15-24 using modern contraceptive methods	Survey	1.8%	3.7%	5%	5%	14%	+11%	

<sup>5</sup> Voir dans le narratif paragraphe 4.1.3.

<sup>6</sup> idem .

<sup>7</sup> Regarding use of bed nets and knowledge of link between malaria and bed nets, KCHP's current interventions (training to dip bednets and information campaigns using community-based IEC and radio spots) should bring 2002 achievements up to or beyond plan by close of project.

## **IV: Narrative**

### **4.1. Progress towards Achievement of Objectives**

This chapter deals with the progress of USAID indicators, the activities implemented in this period, the variations between indicators and plan, difficulties encountered and proposed solutions.

#### **4.1.1. Vaccination of children aged 12-23 months and pregnant women**

The deviation from plan (-26.7%) in child vaccination was calculated by comparing data from the 2002 household survey against the target set by KCHP in 1997. While the target was perhaps over-optimistic, the central factor in its nonachievement is a general failure by health workers and village representatives to actively seek children for vaccination and/or boosters. "Child-seeking" consists of actively following children from pre-vaccination to completion of all doses of immunization, and it requires the participation not only of village representatives and vaccination agents but of health workers. Without active child-seeking, children "drop out of sight" and are not included in vaccination campaigns. Although the KCHP provided multiple supports to prevent the phenomenon of drop-outs, the problem has not been fully resolved. The 2002 survey revealed, however, an increase in the percentage of children fully vaccinated prior to their first birthday (28.3) compared to the 2000 survey (20 percent) and baseline (18.4 percent).

Similar problems plagued KCHP's achievements in vaccinating pregnant women against tetanus. Again, while KCHP's initial targets were perhaps ambitious, the deviation of -25% from plan is largely due to problems mobilizing pregnant women for vaccination. Through informal interviews, KCHP finds that women are displeased with the high cost of the vaccine card (100 to 250 F CFA), and simply have too much work to participate in vaccination campaigns. Nonetheless, TT coverage nearly doubled over the life of the project, from 18.3 percent in 1998 to 35 percent in 2002.

#### **4.1.2. Assisted deliveries**

The indicator for assistance at delivery by a qualified birth attendant at village level reached 62.6 percent, slightly above plan. This progress reflects the quality of training provided to retrained traditional birth attendants (RTBAs) through KCHP's RH/CS modules on the one hand, and the fact that RTBAs provide not only quality service but access at the village level on the other.

#### **4.1.3. Health Promotion**

The major reason for the significant gap (-60.5%) between targeted and actual results is inadequate nutrition monitoring of the local health promoters by CSCOM technical staff. The lack of monitoring led to serious morale problems among the health promoters. The project continues to encourage members of the COMGEST to ensure better monitoring by the technical personnel to ensure better access across the zone.

The failure to meet targets with regard to exclusive breast feeding until four months of age (-31.4%) is due primarily to a lax pursuit of promulgation activities on the part of the CSCOM staff during prenatal consultations and in their outreach activities. In order to address this weakness, the project has furnished these health agents with image boxes, which facilitate communications with pregnant and nursing women.

In RH, KCHP did not achieve planned targets for young men's knowledge of ways to prevent STIs including HIV (-40 percent of plan) and for condom use (-30.3 percent), and this is closely linked to a diminution of peer educator activities. The reporting period was characterized by a strong involvement of peer educators, especially those who are out of school, in agricultural work, particularly field preparation. In-school peer educators, in their turn, were involved in final exams. The drop in peer educator activity had a direct impact on knowledge of STI/HIV and on condom sales.

#### **4.1.6. Family Planning**

A comparison of contraceptive sales for the same period in 2001 shows a decrease of 29 percent for oral contraceptives, of 46 percent for condoms, and of 45 percent for foaming tablets. However, depo-provera sales rose by about 85 percent (Table 1). These results are due to contraceptive stock-outs in the District Distribution Depot (DRC), in addition to the reduced activity of peer educators as described above. To avoid long shortages, KCHP will review with DRC officials the causes of stock-outs, and reformulate supply plans so the DRC can ensure contraceptive supply for the CSCOMs (from which peer educators obtain their supplies) in its intervention zone.

Peer educators trained by KCHP took the initiative to form networks within their health areas to better organize IEC sessions and contraceptive supplies. This initiative shows their willingness to take ownership of their RH activities.

**Table 1: Comparison of Contraceptive Sales, First Half 2001 and 2002**

<b>Methods</b>	<b>January-June 2001</b>	<b>January-June 2002</b>
Oral Contraceptives	1513	1079
Condoms	1058	572
Foaming Tablets	747	409
Depo-Provera	21	201

## **4.2 Monitoring of Withdrawal Plan**

### **4.2.1 Establishment of the Consultation Forum**

The previous report noted that KCHP, CSref, and the district council chairman, in their programming meetings, determined the need to set up a consultation forum to discuss "health affairs" and make concrete proposals in order to ensure the sustainability of health activities. Key resource people for this forum include mayors and council presidents in the various health areas covered by KCHP.

The presidential and municipal elections in the first half of 2002 occupied these key resource people, delaying activities until late June. Since that time, the district council chairman made a financial proposal and will be in charge of holding a workshop designed to set up the consultation forum. The district council chairman was selected due to his political representation at the district level. The workshop is scheduled for August 2002 and will bring together actors such as commune mayors, youth services, and youth and women's associations. As a warm-up to the workshop, KCHP and CSref developed a consultation forum protocol and submitted it to the district council chairman for amendment and discussion in plenary.

### **4.2.2 Support to Vaccination**

Previous reports showed erroneous vaccination coverage rates of over 100% for antigens such as BCG and DTCP3. Spurred by these unusual numbers, KCHP organized with CSCOM technical staff a review of all vaccination data for the last three years. Analysis shows significant differences between the data collected at CSCOM level and those compiled in CSref quarterly forms. Moreover, CSref and KCHP supervision teams pointed out some errors by vaccination agents on antigen record cards for children aged 0-3 years. These errors are difficult to correct once they have been compiled and sent to the person in charge of the Health Information System.

Based on their findings, KCHP and the CSref will conduct on a monthly basis two activities as soon as they receive data from CSCOMs:

- Provide training for CSCOM technical staff in vaccination data monitoring.
- Conduct a reflection session on data before compiling them in quarterly records that will be forwarded to the regional level.

Vaccination data are clearly lower than those of the same period last year. This relative decrease is due to difficulties in getting vaccines and consumables, difficulties in mobilizing targets (as described above), and delays in making PRODESS funds available to the Regional Health Directorate for vaccination activities.

To minimize these recurrent difficulties, the Global Alliance for Vaccination and Immunization has involved communal representatives and elected officials in the implementation of vaccination campaign in villages. This initiative enabled a better mobilization of targets in gathering places in villages and a better advance strategy.

In order to avert frequent stock-outs, the head doctor of Koro recommended that CSCOM staff better plan stock flows to minimize losses in vaccine, and better state accurate doses based on targets to ensure reserve stock.

### **4.3. Partner Capacity Building**

#### **4.3.1. Support to FELASCOM's understanding of statutes and internal code of conduct**

KCHP organized a workshop in which FELASCOM members reviewed their statutes and internal code of conduct. Discussions focused on FELASCOM's role in the context of decentralization, and its participation in PRODESS as a health partner. Under the KCHP withdrawal plan, the FELASCOM will take over monitoring ASACOs' action plan implementation.

#### **4.3.2 Support to understanding legal and statutory health regulations and decentralization**

KCHP and the FELASCOM organized a workshop on the legal and statutory regulations governing the health system in Mali. The workshop objective was to make participants (ASACO members and mayors in the KCHP intervention zone) understand the regulations and how they linked with one another, and to lay the foundations of a collaboration among communes, CSref technical staff, and ASACOs in the context of decentralization. The project team and the CSref staff in charge of social development served as facilitators. Discussions focused on legal and statutory regulations such as:

- Mutual Assistance Convention: defines the obligations of the CSCOM and the CSref to better provide vaccination coverage.
- Ordinance 41 / PG of 1959: sets out the legal guidelines for creating an association in Mali.
- Inter-ministerial decree 5092 of 04/2194: concerns the creation of ASACOs in Mali and provides their legal framework.

At the end of the workshop, participants recommended the creation of mutual health insurance schemes to allow local communities to cover their own health care costs. Participants also discussed the concept of a right to health, and women and children's right to vaccination. Participants also debated the need to set up health mutuals. By holding this workshop, KCHP anticipated some decisions for tripartite collaboration (commune- ASACO-CSref technical staff) on health management in the context of decentralization. The project also explained the content of the document concerning tripartite collaboration on health issues.

#### **4.3.3 Training CSref technical staff and CSCOM staff**

As part of the CSref reinforcement plan to care for people living with and affected by HIV/AIDS, KCHP provided financial support to the CSref team's training of 30 chiefs of post and TBAs in counseling people affected by the epidemic.

#### **4.3.4 Support for community health agents in stock management**

To ensure that TBA activities and service quality are sustained, KCHP put at the disposal of ASACOs an important quantity of consumables such as bandages, alcohol, absorbent cotton, tetracycline ointment, razor blades and bleach for use by birth attendants. The consumables supplied by KCHP will last through the rainy season when many parts of Koro are inaccessible. The project reviewed the management of consumables with COMGESTs to avoid future ruptures in TBA supplies at the level of the DRC. During KCHP Community Agents' supervisory visits, ASACOs and RTBAs were trained in stock management and efficient use of consumables in order to prevent outages.

### **4.4 Functionality of ASACOs**

The ASACOs supervised by KCHP are functioning at Level III, meaning that they meet at least 90 percent of democratic governance indicators set out by USAID and the CARE Local Organization Capacity Building Project.

**Table 2:** Results of the 2002 Democratic Governance Survey of ASACOs in Koro District

Indicators	ASACOs				OBSERVATIONS
	2001		2002		
	#	%	#	%	
Self-governance	7	100	7	100	ASACOs in Koro have been classified since December 1999 at Level III, which indicates Community Organizations meeting self-governance criteria. ASACO membership was renewed in 2000 in a transparent manner with the participation of FELASCOM/CSref and FERASCOM. About 65 percent of members re-upped.
Sound Management	7	100	7	100	To reinforce sound ASACO management, KCHP held training sessions in financial and accounting management for ASACO members. This enabled a better and regular keeping of management supports, and activity reports have been submitted to ASACO members in General Assembly.
Civic Action	6	85	3	43	ASACOs conduct civic action to defend the interest of their members. With the decentralization context, these activities developed timidly because of misunderstanding between the roles and duties of mayors and ASACO chairmen on the management of ASACO.
Efficient Action	3	43	0	0	Actions have been very timid. The elections slowed down the drive of COMGEST members to develop civic actions.
Resource Mobilization	5	71	6	85	ASACOs have displayed a commitment to resource mobilization, made possible by training in management and implementation of their action plans. Progress is due to the application of skills acquired in training sessions and workshops. ASACOs give more and more importance to the mobilization of external resources. These resources will come from many sources such as mutuals or health insurance, membership cards, <i>tontine</i> systems.

#### 4.5 Literacy

This second literacy campaign conducted by KCHP helped to consolidate the gains of the newly literate, and to train new students, particularly ASACO members or community agents. Thus the literacy campaign trained 1,359 Level I students and 244 Level II students. The objective of this second campaign is to set up a core of village trainers capable of teaching the same literacy themes to village audiences and to serve as a link with other CARE projects in Koro that have a literacy component.

**Table 3:** Participants in the Second Literacy Campaign

Targets	Men	Women	Total
Trained and retrained trainers	26	2	28
Registered Students	167	192	359
Regular Students	185	174	359
Community Agents	39	59	98
Newly literate in reading	86	31	55
Newly literate in mathematics	82	29	53

#### V Collaboration with the Ministry of Health

In this six-month period, KCHP:

- a) Sent supervisory reports to appropriate officials of the Ministry of Health

yes  no \_\_\_\_\_

b) Sent service statistics to appropriate officials of MOH<sup>8</sup>

yes  no \_\_\_\_\_

c) Participated in meetings or had official contacts with local officials of the MOH to discuss project plans and activities.

yes  no \_\_\_\_\_

### **C Activities planned for the next period**

- Hold two meetings with CSCOM technical staff on how to collect data from target populations on vaccination cards, compile results and read coverage rates by target.
- Put at the disposal of partners all training modules in financial and accounting management, capacity development in management, CS and RH for community agents.
- Create with CSref staff an action plan for avoiding stock-outs between vaccination campaigns in the rainy season.

### **D Conclusion**

This report is of activities that were planned for and executed during the first semester of 2002. It shows that, despite the drop registered with regard to certain health indicators, the maturity of the ASACOs involved in the project has evolved considerably and that the members of the COMGESTs have acquired capacities which will ensure that they manage and continue to develop health care in their zone.

In addition, on the basis of trainings provided by the project, the key actors of community health—ASACOs, FELASCOM, CSref—have developed the capacity to confront the challenges of improving the health care and status of their communities.

This report demonstrates that lessons were learned and improvements made by the project and its partners throughout the project's lifetime. Some key positive results:

- An improved understanding of local health issues and the roles of different actors on the part of the COMGEST
- *A better understanding of national health policies by members of the COMGEST and FELASCOM;*
- Better monitoring of the ASACOs by the COMGEST
- Better coverage of pregnant women by traditional birth attendants.

In summation, these positive aspects are all institutional in nature, ensuring the sustainability of health improvements beyond the end of the project and providing a foundation on which to base further improvements.

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<sup>8</sup> Data from CSCOMs are shared with the Regional Health Directorate, and data from peer educators are shared with the CSref.