



Use of a Revised Version of the FSCCI to Identify and Manage Health and Nutrition Risks and Vulnerability in Guinea

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Objectives: Africare's Food Security and Community Capacity Index (FSCCI) is normally used to summarize different aspects of community capacity by converting rankings on variables and indicators into one total score that serves as a standardized measure of community capacity and can assist projects in tracking intervention impacts on community capacity and the affect of community capacity on project impacts (Africare 2005; 2007). This index has been successfully revised and is now well developed and being applied to all Africare programs.^v

As important as general community capacity is to sustained food security initiatives, there are situations in which specialized capacities are also critical. This paper describes a new index (the FSCCI-SIAC or *Food Security Community Capacity Index – Systeme d'information a asise communautaire*^{vi}). This index was developed by the Guinea Food Security Initiative (GnFSI) and uses some of the basic principals of the FSCCI to target the more specialized capacities that Title II programs need to implement effective growth monitoring promotion and nutritional rehabilitation programs. This paper shows ways that the FSCCI-SIAC can be used to identify districts that are vulnerable in terms of weak capacity to design and manage village-based growth monitoring and rehabilitation programs.

Background: Africare's decision to intervene in the prefectures of Dinguiraye and Dabola in Upper Guinea was justified by the high rate of

malnutrition and food insecurity found in these parts of the region of Faranah. In order to respond to the main health problems, the Title II funded Dinguiraye Food Security Initiative (DFSI) and the succeeding Guinea Food Security Initiative (GnFSI) adopted a health and nutrition strategy based on three key themes (Box 1):

- Improvement of child and maternal health;
- Strengthening of capacities of basic health services; and
- Fighting the spread of HIV/AIDS.



Communities' capacity to manage the growth monitoring system is key to its success in detecting health risks. Photo credit: GFSI Archive.

Box 1. Major Foci of GnFSI Health and Nutrition Strategy

- Improvement of child and maternal health through:
 - Promotion and monitoring of growth through the community-based growth monitoring promotion (*système d'information à assise communautaire* [SIAC]) and community based services (*service à base communautaire* [SBC]);
 - Development and promotion of an innovative community based model, known as the *Foyer d'Apprentissage et de Réhabilitation Nutritionnelle* (FARN) in French and “Hearth Model” in English, for rehabilitation of moderately malnourished children and control of diarrheal diseases;
 - Use of “model mothers” to conduct rehabilitation sessions in their own homes (the essence of the Hearth Program);
 - The promotion of family planning and safer birthing practices;
 - Community level use of prenatal consultation and an innovative Hearth Program^{vii} for pregnant women (FARN/G: *Foyer d'Apprentissage et de Réhabilitation Nutritionnelle des Gestants*);
 - Adequate micronutrient consumption; and
 - Development of community education activities for behavior change through information, education, and communication (IEC).
- Strengthening of capacities of basic health services by:
 - Training district health posts' health agents and
 - Providing institutional and technical support to the decentralized state health structures.
- Fighting the spread of HIV/AIDS through:
 - Public awareness building;
 - Training and equipping community volunteers;
 - Increasing the practice of referring cases of sexually transmitted diseases (STDs) to health centers; and
 - Nutritional rehabilitation of undernourished orphans.

The success of the growth monitoring promotion system to track risk (through detection of changes in malnutrition) depends on the capacity of communities to manage the growth monitoring system. Specifically, community capacity is related to the extent to which the system is supported by the communities in which it works and the development of certain core organizational skills within the communities. One unusual feature of GnFSI, and its predecessor DFSI, has been the consistent emphasis on tracking critical capacities that village development committees (VDC) need to support the strong and resilient growth monitoring promotion program that identifies and manages the principal risks to child health. This emphasis led the project to introduce the FSCCI monitoring indicator in 2001 that tracks these critical capacities: monitoring indicator 1.5 - District development committee scores on support for nutrition initiatives.

Methods: GnFSI developed the FSCCI-SIAC based on the main FSCCI model.^{viii} The data for calculating the FSCCI-SIAC was collected during interviews with members of the village

development committees (VDCs). It is based on three variables and 16 indicators (Table 1). This table—like the table used for the FSCCI—is intended to be a guide for the community to self-assess its strengths and weaknesses in the following key areas.

- Organization and Management. Meetings held for health and nutritional activities, initiative taken for development of nutritional activities, level of community involvement in community growth monitoring promotion activities, level of collaboration with health centers, motivation of community agents, documents of operation, and whether management materials are kept up-to-date (meetings notebook, growth monitoring tools, etc.).
- Community Participation. Supervision and support of community agent activities, awareness-raising within community to participate in health and nutritional activities, contribution in kind of community for culinary demonstrations, participation of community in educational talks and

promotion/growth monitoring (monthly weighing), community knowledge and practices related to hygiene and nutrition, and community involvement in managing growth monitoring program's equipment (e.g., bicycles, scales, pedagogical materials, etc.).

- Capacity for Analysis and Action. Autonomy in decision making, including undertaking activities without outside assistance, capacity to acquire support from other partners (aside from Africare), analysis of hygiene and nutritional problems, and drafting and implementation of hygiene and nutritional action plans. All three variables are directly related to the health and nutrition activities. The total possible points equal 80 and the total score is converted to a percentage.

Results:

Project Impact on Health and Nutrition Rates.

Based on the longitudinal analysis of the project's current indicators and other routine M&E information, it is possible to show various ways that the GnFSI project has reduced household level exposure to routine health and nutrition risks including (Table 2):

- A net reduction of acute and chronic malnutrition levels according to the weight/age criterion for children zero to thirty-six months of age (monitoring indicator 1.2) measured on the basis of regular growth monitoring of children through the community based growth monitoring system (SIAC).
- A net reduction in the levels of chronic malnutrition (impact indicator 1.1) in all Dinguiraye and Dabola districts on average (except for the new districts in Dinguiraye^{ix}).

This compares very favorably to the global malnutrition indicators of Guinea where the reported rates of malnutrition deteriorated, going from 26 percent in 1999 to about 35 percent in 2005.^x

Project Impact on Community Level Capacity for Growth Monitoring Promotion and Community Based Rehabilitation of Moderately Malnourished Children (based on the FSCCI-SIAC). The current FSCCI-SIAC scores for monitoring indicator 1.5 in the GnFSI Indicator

Performance Tracking Table (IPTT) show a clear improvement in capacity related to health and nutrition activities since 2001 for Dinguiraye and 2004 for Dabola. These improvements are related to a number of factors that include the length of project intervention in the zone and poverty levels (Table 2). Specifically, the recorded capacity increased (Table 2):

- From 45 percent of the total possible points in 2001 to 68 percent in 2006 in the original Dinguiraye districts;
- From 50 percent of the total possible points in the new Dinguiraye districts in 2002 to 66 percent in 2006;
- From six percent of total possible points in 2004 for the extreme poverty districts of Dabola to 44 percent in 2006; and
- From seven percent of total possible scores in 2004 for the moderate poverty districts in Dabola to 46 percent in 2006.

The direction of the trends between reduction in malnourished children and improvements in FSCCI-SIAC match. However, the minor improvement in malnourished children in Dabola's moderate poverty districts does not appear to be as dramatic as the improvements in the FSCCI-SIAC score. This led Africare to examine the data on FSCCI-SIAC in an alternative way.

Discussion:

Use of the FSCCI-SIAC to Identify Vulnerable Districts.

If one focuses only on the average FSCCI-SIAC for all districts in each of the broad categories of project villages (new and old Dinguiraye districts and Dabola districts in the extreme poverty and average poverty zones) the trend looks positive (as illustrated by the results presented above and in Table 2). An important factor in terms of long-term sustainability is the percentage of health districts that are classified as very vulnerable in terms of having an extremely weak level of capacity to support growth monitoring promotion and Hearth. To address this issue, GnFSI used the FSCCI-SIAC to identify the most vulnerable districts (much like the MAHFP can be used to identify the most vulnerable group of households) (Table 3). This grouping revealed that 54 percent of the extreme poverty districts in Dabola are classified as having weak community capacity to support growth monitoring and Hearth activities (weak capacity is designated as less than 50 percent on

Table 1. FSCCI-SIAC Variables, Indicators, and Scoring.

Variables	Indicators	None 0	Weak 1	Average 2	Okay 3	Good 4	Excellent 5
Organization and Management	Organization of meeting for health and nutrition activities						
	Undertaking initiative for development of nutrition activities						
	Involvement of community in GMP (SIAC) activities						
	Level of collaboration with health centers						
	Level of motivation of community agents (CA) for health						
	Up-to-date and accurate bookkeeping and management records (meeting records, GMP tools, etc.)						
Community Participation	Supervision and support of community agents (CAs) (for health and nutrition) and their activities/Level of in-kind or cash compensation for Cas						
	Degree of community-level public awareness building about importance of community participation in health and nutrition activities						
	In-kind contribution of community for culinary demonstration (preparation of local porridge, etc).						
	Level of community participation in public awareness sessions and promotion and tracking of GMP (monthly weighing)						
	Degree to which community is informed about health and nutrition activities						
	Involvement of community in management of equipment needed for GMP activities (bicycle repair and maintenance of health kits)						
Capacity to Analyze and Take Action	Independent decision-making for initiating health and nutrition activities						
	Ability to identify outside assistance (other than Africare)						
	Analysis of health and nutrition program problems						
	Elaboration and execution of health and nutrition action plans						

Total possible points = 80.

Table 2. Evolution of Key Indicators for Health and Nutrition Programs in the Projects Affected by Africare's Title II Programs in Guinea, 1997-2006

Yr	Number of Beneficiary Districts Included in the Africare-Facilitated Growth Monitoring ^{xi} (x/y x=number of districts where GMP is active, y=number where project is active in that year)				Number of Beneficiary Districts Executing Hearth Model Program (x/y x=number of districts where Hearth Program executed in that year; y=number of district where the project is intervening in that year)				District Development Committee Scores on Support for Nutrition Initiatives (GnFSI Monitoring Indicator 1.5 GnFSI IPTT, the FSCCI—SIAC)				% Children Underweight (0-36 months-GnFSI Monitoring Indicator 1.2 GnFSI IPTT) ^{xii}				% Children Stunted (GnFSI Impact Indicator 1.1)			
	Dinguiraye		Dabola		Dinguiraye		Dabola		Dinguiraye		Dabola		Dinguiraye		Dabola		Dinguiraye		Dabola	
	O	N	E	M	O	N	E	M	O %	N %	E %	M %	O	N	E	M	O	N	E	M
1997	8/30	n/a											30.8	n/a			29.7			
1998	16/30	n/a												n/a						
1999	30/30	n/a											25.4	n/a			27.2			
2000	30/30	n/a			8/30								18.6	n/a						
2001	30/30	0/20			17/30				45	n/a			20.7	21.9			21.9	21.4		
2002	30/30	20/20			14/30	10/20			56.1	49.9			19.7	29.9			21.5	23.6		
2003	30/30	20/20			4/30	17/20			66	58			19.7	23.4						
2004	30/30	20/20	11/11	14/14	7/30	9/20	4/11	0/14	70	58.1 3	6	6.6	12.29	17.17	21.4	21.6			37.9	39.3
2005	30/30	20/20	11/11	14/14	8/50	10/20	5/11	13/14	69.4	68.5	50.1	54.1	10.6	16.4	16.2	20.2				
2006 *	30/30	20/20	11/11	14/14					68	66	43.5	46.4	15.8	19.3	19.9	17.8	21.4	23.4	23.1	24.4

O=original district; N=new district; E=extreme poverty districts; M=medium poverty districts; SIAC= *système d'information à assise communautaire*

*These data from final survey report.

the FSCCI-SIAC). Similarly, 21 percent of the moderate poverty districts are classified as weak. Comparatively, none of the original districts and only 10 percent of the new districts in Dinguiraye are classified as having weak capacity. This identifies specific districts upon which the capacity building efforts must focus in order to see a more dramatic improvement in malnutrition rates.

The weak capacity to support growth monitoring promotion in Dabola is not surprising because the project selected the poorest and most vulnerable districts of the prefecture and it did not have the same level of activities in these villages (see Annex, Tables 1 and 2).^{xiii} Furthermore, the two-year disruption following the termination of the Maternal and Child Health Initiative has slowed the improvements in VDC capacity development in this zone.

The Link between Community Capacity, Participation in Growth Monitoring, and District-Level Vulnerability to Malnutrition. The villages identified as “weak” based on the FSCCI-SIAC (Table 3) are considered vulnerable because:

- The growth monitoring system has not benefited from the types of skills transfer that it needs to be sustainable and
- This weak capacity hampers the potential that the growth monitoring promotion program may have as an early warning system for community-level risks and shocks.

To date, however, the link between capacity and the patterns of participation in growth monitoring, the independent replication of the Hearth program, and malnutrition levels is not all that clear. Although low levels of capacity are expected to affect the regularity with which growth monitoring occurs, this was not yet the case in 2006 (Table 4). This is because weak village development committees still benefit from monitoring assistance and technical support from field and health agents. This Africare assistance supports community-level activities that reduce malnutrition even when the VDC’s capacity to do this on their own is very weak. Once project funding stops in late 2007, however, it is unlikely that the village development committees that are classified as “weak” can continue these activities on their own. This is the principal reason that Africare requested and received an extension on its

project funding to continue village-level capacity building in weak villages.

An additional factor that needs to be considered when examining the success of capacity building related to health and nutrition and malnutrition rates for Dinguiraye is that of access. The impact of discontinuing or faltering GMP activities on vulnerability is likely to be most serious for the isolated villages. Some of the best evidence for this comes from the two “new” districts in Dinguiraye that have “weak” capacity, but a very low (3.8 percent) percentage of children classified as malnourished. Both villages are in peri-urban areas where health facilities are relatively easy to access. This easy access makes the communities less motivated to engage in their own growth monitoring promotion and support community volunteers charged with executing these and other health programs. However, community members in these peri-urban areas do not suffer the highly negative affects of weak capacity for growth monitoring promotion that more isolated areas would.

Lessons Learned and Recommendations:

Format and Content of the Tool. Africare’s application of a new index based on the main FSCCI model has proved useful in identifying the specialized capacities needed to successfully support interventions related to health and nutrition activities (GMP and Hearth). While it is useful to make modifications to address specialized capacities (as was done in this case) Africare should develop a standard index (FSCCI-SIAC) that can be used to measure these specialized capacities for all Africare programs. This will enhance comparability of capacity to support health and nutrition activities between all Africare projects.

It is certain that other components of food security initiatives would also benefit from a more specialized index of community capacity. Africare introduced two new variables into its main FSCCI in 2004 (Africare 2005 and 2007). One of these new variables is “capacity to manage risk associated with HIV/AIDS.” This study and Africare’s extensive experience in the field has led them to design a pilot testing of an HIV/AIDS capacity index based on the FSCCI and similar to the specialized FSCCI-SIAC pilot tested in the GnFSI. Therefore, the same recommendation can be applied to the HIV/AIDS capacity index and Africare should

also develop a standardized index to track capacity building in relation to HIVAIDS activities in order to facilitate comparability between Africare initiatives.

Use of the FSCCI-SIAC to Identify Vulnerable Districts. While this self-assessment tool appears to be an example of “best practice” that deserves to be shared with other programs, GnFSI needs better information on the characteristics that distinguish “weak” VDCs from those classified as “strong.” Given the data presented here, exploration of these classifications (weak and strong) should also include stratification by urban, peri-urban, and rural areas.

Link between Capacity (FSCCI-SIAC) and Improvements in Malnutrition and Health. One of the issues identified by Bryson and Cohen (In press) is the utility of studying whether improvements in specific project impacts (such as health or nutrition) have a predictable pattern of response to improvements in capacity. This could also explain the less dramatic improvements in Dabola in terms of % of children who were underweight compared to FSCCI-SIAC scores (Table 2). Future projects may want to track this sort of data (which would be part of the standard data collected) in a way that allows for comparing trends between improved capacity and other associated project outcomes.

Table 3. District Level Capacity to Identify and Track Health and Nutrition Risks through the GnFSI Growth Monitoring Promotion Program Based on the Reanalysis of Existing Project Data on the FSCCI-SIAC (Monitoring Indicator 1.5)

Level of Vulnerability Based on Level of Capacity (Based on the FSCCI-SIAC)	Criteria/Conditions	Dinguiraye		Dabola	
		Original Districts	New Districts	Extreme Poverty Districts	Medium Poverty Districts
Least Vulnerable Districts (Strong Capacity) (> or = 70% possible points on the FSCCI-SIAC)	- Community health agent (AC) compensated appropriately - Strong community support for FARN activities -Community support to volunteers in publicizing and arguing for the growth monitoring (SIAC) and nutrition programs	14 (46%)	7 (35%)	1 (9%)	0 (0%)
Vulnerable Districts (Medium Capacity) (50-69%)	-Little compensation given to the community health agents (AC) -Weak community support to FARN -Little support to volunteers for publicizing and arguing for growth monitoring and nutrition programs	16 (53)%	11 (55%)	4 (36%)	11(79%)
Most Vulnerable Districts (Weak Capacity) (<50%)	-Lack of support to the community agents -No contribution to the FARN -No community support for volunteers in either publicizing or arguing for growth monitoring and nutrition programs	0 (0%)	2 (10%)	6 (54%)	3 (21%)
Total		30	20	11	14

Table 4. Link between Institutional Capacity of Village Development Committees (VDC) to Support Growth Monitoring and Health and the Number of Children Monitored, Reported Levels of Malnourished Children, and the Independent Replication of the Hearth Model Programs

Community Capacity to Support GMP (based on the FSCCI-SIAC)		% Children Weighed	# Children Well Nourished	# Children Malnourished *(in yellow and red area on growth chart)	# Hearth Programs Executed	# of Hearth Programs Replicated (i.e., repeated without direct project assistance)***
Most Vulnerable Districts (Weak Capacity) <50%	Original districts	0	0	0	0	0
	New districts	83.7	96.2	3.8**	2	0
	Extreme poverty	86	90.9	9.1	2	0
	Medium poverty	77.6	85.9	14.2	1	0
Vulnerable Districts (Medium Capacity) 50 to 69%	Original districts	87.2	87.5	12.5	27	0
	New districts	77.4	83.5	16.5	25	2
	Extreme poverty	82.7	78.7	21.3	3	0
	Medium poverty	76.1	80.2	19.8	4	0
Least Vulnerable Districts (Strong Capacity) > or =70	Original districts	87.2	92.4	7.6	29	0
	New districts	82.4	82.3	17.7	13	0
	Extreme poverty	85.1	86.9	13.1	0	0
	Medium poverty	0	0	0	0	0
Total of Hearth (FARN) executed /replicated					106	2

**Peri-urban districts

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Annex: Stratification Structure of Africare Districts based on Interventions

Annex Table 1. Evolution of Africare Interventions in Dinguiraye and Dabola Prefectures (1997 - 2006)

Prefectures and Principal Activities	Principal Periods of Africare Interventions				
	MCHI 1997-2001	DFSI 1996-2000	GnFSI 2000-2003	GnFSI+Extension 2004 (Project Amendment)	GnFSI+Extension 2005-2006 (Current Activities under Amended Project)
1. Dinguiraye-Total number of districts	0	30	50	42Active +8 Graduated=50	34 active + 16 graduated=50
“New” project districts where the project is active		30 ^{xiv}	20	20	20
“Original “ project districts where the project is active			30	22	14
Graduated districts				8 ^{xv}	16 ^{xvi}
SO1 Health and nutrition		X	X	X	X
SO2a. Post harvest management		X	X	X	X
SO2b.Agricultural production FY00 -06 Irrigated gardening FY02-06 Food production			X	X	X
Local capacity building		X	X	X	X
Information/awareness building		X	X	X	X
2. Dabola-Total number of districts	42	0	0	25 (approximately 80% were in MCHI)	25
Districts classified as « Average poverty districts » ^{xvii}	38 of the 42 seem to have been in these two categories	0	0	11	11
Districts classified as « Extreme poverty districts »		0	0	14	14
SO1 Health and nutrition	X	0	0	X	X
SO2a Post-harvest management				X	X
SO2b Agricultural production					X irrigated gardening and income generating activities ^{xviii}
Local capacity building (RCB)	X			X	X
Information/awareness building	X			X	X

MCHI – Maternal and Child Health Initiative; SO – strategic objective.

Annex Table 2. Evolution of Africare Health and Nutrition Activities in Dinguiraye (Ding) and Dabola (Dab) (1997-Present)

Project/Activities	1997		1998		1999		2000		2001		2002		2003		2004		2005		2006	
	Dg	Db																		
Title II—DFSI and GnFSI (USAID/Title II) (1997-2005)																				
Maternal and child health	X		X		X		X		X		X		X		X	X	X	X	X	X
Strengthening capacity of the local health services	X		X		X		X		X		X		X		X	X	X	X	X	X
HIV/AIDS prevention							X		X		X		X		X	X	X	X	X	X
Maternal and Child Health Initiative (at Dabola) (USAID -Guinea) (1998-2001)																				
Maternal and child health				X		X		X		X										
Strengthening capacity of the local health services				X		X		X		X										
HIV/AIDS prevention				X		X		X		X										
Africare HIV/AIDS Service Corps (Donner Foundation and Africare/Washington) (8 districts in Dinguiraye) (2003-2004)																				
Public awareness-building for HIV/AIDS													X		X					
Rehabilitation of moderately malnourished HIV/AIDS orphans													X		X					
Increase in referring STD cases to local health services for voluntary testing and enrollment of STDs													X		X					
Community mobilization for prevention and support to households affected by HIV/AIDS													X		X					

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^v See the revised Africare FSCCI guidance (Africare 2007), in this series.

^{vi} SIAC: Community Based Information System

^{vii} DFSI and GnFSI were two of the first NGO programs to introduce the community-based Hearth Model for rehabilitating moderately malnourished children in Sub-Saharan Africare. In 2004, GnFSI introduced another highly innovative program—the Hearth Program for pregnant women (*Foyer d'Apprentissage de Renforcement Nutritionelle des Gestantes – FARNG*). This program educates pregnant women in community settings about the critical importance of diagnostic blood tests (for iron deficiency) and provides vitamin A and iron supplements during pregnancy. The Hearth Program for pregnant women is implemented in collaboration with Helen Keller International (HKI Guinea). The FARNG was expanded to Dabola in 2006?

^{viii} Africare initially developed the main FSCCI under their Institutional Capacity Building grant (FY99-FY03) as an index composed of variables to be used as a standardized measure of community capacity. At that time it had eight variables. It was revised in 2004 to include two new variables for a total of 10. For additional information on the history, variables, and scoring method see Africare (2005).

^{ix} The reason for this difference reported in the final evaluation report is displacement of women and men to gold mining zones close to new districts.

^x *Direction Nationale de la Statistique/ORC MACRO, Enquête Démographique et de Santé, Guinée 2005*, page 170-173, Ministry of Plan 2006.

^{xi} This is not an official indicator of the project, but is based on project records. Monitoring Indicator 1.1 measures “Percentage of eligible children in growth monitoring weighed in last four months” since 2003.

^{xii} This indicator measures children that score in the “yellow” and “red” zone on the growth chart which tracks acute and chronic according to weight/age criteria. This indicator concerns children aged three to 59 months during the first phase of the project (1997-2000), and 24 to 59 months during the second phase (2001-2006).

^{xiii} Despite efforts to harmonize the health/nutrition activities in the two prefectures where the project intervenes (50 districts in Dinguiraye and 25 districts in Dabola), there are certain disparities between the prefectures and districts. This stems in part from the different sequencing of the first and second phases of Title II funding in upper Guinea under the Dinguiraye Food Security Initiative (DFSI) (1996-2000), the Maternal and Child Health Initiative (MCHI) that was executed only in the Dabola districts between 1998 and 2001, and the Guinea Food Security Initiative (GnFSI) (2001- 2005), and the GnFSI extension (2004-2007) (Annex Table A). In addition, some villages have “graduated” and began the process of sustaining project activities independently during the later phases of Africare interventions. For example, the GnFSI extension to 25 additional districts in the prefecture of Dabola took effect only in 2004, while some of the districts in the prefecture of Dinguiraye had benefited from project interventions over a seven to eight year period (the 30 original districts). Additionally, eight of the Dinguiraye districts had graduated from the program in 2004 and were no longer directly assisted by Africare. In addition to the four projects mentioned above, eight of the Dinguiraye districts have benefited from a separate Africare funded HIV-awareness, prevention, and

support program called the Africare HIV/AIDS Service Corps funded through the Donner Foundation (Annex Table B).

These differences in evolution of interventions in the districts of these two prefectures in Upper Guinea led to a complex stratification of the districts and households for the purpose of reporting progress in reducing vulnerability and participating in growth monitoring promotion and Health Model activities. (Table 1). Basically, Dinguiraye districts are divided between original and new project districts and Dabola districts are divided between extreme and moderate poverty districts.

^{xiv} Eight districts integrated in 1997, eight in 1998, and 14 in 1999.

^{xv} No new activities, monitor agriculture and women groups working with unions on agriculture and community based health volunteers.

^{xvi} These are the 16 “original” villages that were integrated into the project in 1997 and 1998 (see footnote 4 above).

^{xvii} District is considered to qualify as being classified in these two categories if one sector of the district was identified as being “chronically poor” by the joint African Development Bank/Government of Guinea mission. The current team estimates that 38 of the 42 districts in the original study fall into either of the two categories. A more fine tuned analysis of “extreme poverty” and “average poverty” is not possible at this date.

^{xviii} Activités Génératrices de Revenues (AGRs), or Income Generating Activities (IGAs).