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Acknowledgements

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List of acronyms

AIDS/SIDA	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ASACO	Association de Santé Communautaire
ATN Plus	Assistance Technique Nationale Plus
BCC	Behavior Change Communication
CAP	Centre d'Académie Pédagogique
CARE	Cooperative for Assistance and Relief Everywhere
CBD	Community Based Distribution
CC	Community Counselor
CHW	Community Health Worker
CS	Child Survival
CSCOM	Centre de Sante Communautaire
CSRef	Centre de Sante de Référence
CTA/ACT	Artesimin Combined Therapy
DPM	Direction Pharmacie et Médicament
DRDSES	Direction Régionale Développement Social et de l'Economie Solidaire
DTC	Directeur Technique CSCOM
ESSC	Equipe Socio-Sanitaire de Cercle
GATPA	Gestion Active de la Troisième Phase de l'Accouchement
GP/SP	Groupe Pivot Sante Population
GRM	Government of the Republic of Mali
CPM	Chef de Post Medical
HCI	Health Care Improvement model
HD	Health District
HEHPs	Household Essentials Health Practices
HIV/VIH	Human Immunodeficiency Virus
LLIN	Long-Lasting Insecticide treated Nets
IDP	Institutional Development Plan
IPC/C	Interpersonal Communication/Counseling
IPT	Intermittent Preventive Treatment
JHU/CCP	John Hopkins University Center for Communication Program
JNV	Journée Nationale de Vaccination (National Vaccination Day)
MDG	Millennium Development Goal
MSQIP	Mali Service Quality Improvement program
MOH	Ministry Of Health
MOP	Malaria Operation Plan
MPA	Minimum Package of Activities
MTCT	Mother to Child Transmission
NGO	Non Governmental Organization
ORT	Oral Rehydration Therapy
PDDSS	Plan Décennal de Développement Socio-Sanitaire
PEF	Programme Enpowerment des femmes et des filles
PGP	Projet de Gouvernance Partagée
PMI	President's Malaria Initiative
PNP	Policy, Norms and Procedures
PRODESS	Programme quinquennal de développement Sanitaire et Social
PSI	Population Services International
RECOTRADE	Réseau des Communicateurs Traditionnels
RH	Reproductive Health
SEC	Soins Essentiels au niveau Communautaire
SIAN	Semaine d'Intensification des Activités de Nutrition
SO	Strategic Objective
SP	Sulfadoxine Pyrimethamine
STI/IST	Sexually Transmitted Infection
TDY	Temporary Duty Assignment
TT	Tetanus Toxoid
USAID	United States Agency for International Development

Executive Summary

The USAID Community-Level Health Program/Keneya Ciwara II (PKC II) is a 5 year program funded by the United States Agency for International Development (USAID) with two phases from October 2008-September 2011, and a two years extension from October 2011 to September 2013. This extension introduced two new initiatives including: the quality care improvement called "collaborative approach", and the Community Essential Health Care (*Soins Essentiels Communautaires* ="SEC").

PKC II has two main components - community health and STI/VIH/SIDA- aiming to improve the use of high impact health services at the community level related to child survival, family planning/reproductive health (CS/FP/RH), Sexually Transmitted Infections and HIV/AIDS (STI/HIV/AIDS).

This consolidated report covers activities conducted during five years from the period of October 1st, 2008 to September 30, 2013.

Key results included the following:

Malaria:
The following malaria prevention and care activities were accomplished at the household and community levels:

- The Youth Ambassadors (YA) conducted malaria activities in schools and in their respective communities. This initiative has mobilized more than 20,000 YA to sensitize peers and parents in 152 schools distributed within 32 Pedogogic Academic Centers ("C*entres d'Animation Pédagogique*").
- Community Leadership engagement in the fight against malaria was one of the key results from the Community Dialogue Initiative. More than 1,000 Community Leaders were engaged throughout 15 health districts. Key results are: (i) significant increase of knowledge on the modes of malaria transmission; (ii) increased perception of malaria as real health risks and means for prevention; and (iii) more than 95% community leaders put into practices their engagement to mobilize and sensitize their communities in the fight against malaria.
- During the Malaria World Day Celebrations and the routine communication events, 1,620 radio spots and more than 800 mini programs were broadcasted and 162 Sidewalks Interviews were conducted, reaching an overall estimated 2 Million of people.
- 192 radio spots, 3 quizzes were organized to promote ITN use and IPT intake by pregnant women.
- 14 TV spots on malaria prevention were broadcasted and 2500 magazines distributed during the "African Football Cup" in February 2013.
- Traditherapeuts continued their malaria prevention and care activities in collaboration with health structures of their intervention areas.

Family Planning:
The following family planning activities were accomplished at the community and district levels:

- 30,201 new acceptors of FP methods registered through CBD activities by relais.
- 507 health care providers, 313 Community Health Agents (ASC), and 329 relais have been trained on FP/RH.
- Depo Provera outreach pilot activites conducted by matrons are implemented in Oulessebougou and Dioila health districts. This initiative may be extended by districts through a cost recovery system.

- 32 Community Health Centres (CSCOMs) were provided with Depo Provera for outreach activities in the districts of Ouelessebougou and Dioila.

Maternal and Child Health:

- ✓ As result of the "colaboratrive approach" initiative implementation, compliance to the new born standard care has increased while post delivery bleeding decreased from 2.05% (2012) to 0.55% (2013), and percentage of maternal complications discovered during post partum dropped from 2.25% (2012) to 0.55% (2013) in the intervention areas.
- ✓ 312 cartoons of 200 boxes ORS/Zinc received from PSI were distributed to the trained relais for diarrhea management at households.

STD/HIV/AIDS

- From 2008 to 2011, under the leadership of Groupe Pivot /Sante Population, 18 NGOs conducted primary and secondary HVI prevention activities. Later the number of NGOs was reduced to eight (8). From 2012, only six (6) NGOs implemented HIV prevention activities.
- Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results is 28,657 (from 2009 to June 2013).
- Number of targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required is 953,340.
- Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required is 603,012.
- Number of cases treated for Sexually Transmitted Infection (STI) is 22,725.

Community Health Associations (ASACOs)

The performance of the ASACOs supported by PKC II in terms of CSCOM management and governance has greatly improved, as outlined below:

- The percentage of ASACOs at maturity stage gradually improved from less than 1% in 2009 to 31% by the end of 2010, to 39% at the end of 2011 and to 62% at the end of 2012.
- The percentage of ASACOs at the growth stage decreased from 55% in 2010 to 49% in 2011 and 38% in 2012.
- The percentage of ASACOs at the starting stage has also decreased from 14% in 2010 to 12% in 2011 and to 4% in 2012.

Key Results of PKC II for the 5 Years from Community Relais and STD/HIV/AIDS Peer Educators key activities are summarized in the following table 1:

Table 1: PKC II Key Results

Key Indicators	October 1, 2008 to September 30, 2013
MALARIA	
Household with LLINs visited by community relais	4 283 305
Children with fever referred to health facilities by community relais	75 321
Children with fever referred to health facilities by traditional Healers	5 988

Key Indicators	October 1, 2008 to September 30, 2013
FAMILY PLANNING	
Health education talks were organized by relais	1 177 153
New acceptors of FP methods registered through CBD activities by relais at household level	30 201
CHILD HEALTH	
Health education talks on the three washing (hands, month, and eyes) organized by relais at household level.	1 177 153
Households reached by relais for aquatabs promotion and distribution	67 168
STD/HIV/AIDS	
Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results (PEPFAR Output - #P11.1.D)	28 657
Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required (PEPFAR Output - #P8.1D)*	953 340
Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	603 012
Number of condoms distributed with USG-funds	3 422 276
Number of cases treated for Sexually Transmitted Infection (STI)	22 725

INTRODUCTION

The five year USAID-funded Health Program / Keneya Ciwara II (PKC II) aims to improve the use of high quality community health services to bring out significant impact at the community level. More specifically, it seeks to ensure the adoption of key family practices at household level in functioning health zones located in the 36 health districts in the eight regions and the District of Bamako of Mali – with an exception for malaria prevention and management activities which have national coverage. These services encompass child survival including Community Essential Health Care (SEC) Initiative , family planning, reproductive health (CH/FP/ RH) including the new initiative of "the quality care improvement called collaborative approach", malaria prevention and management as well as STI/HIV/AIDS prevention and management.

The first initial phase of PKC II program runs from October 2008 to September 2011. A two additional years of the PKC II program from October 2011 to September 2013 has been authorised by USAID. Under this extension period, the program has launched two new initiatives: "the quality care improvement called collaborative approach" to reinforce the quality of maternal and child health care in CSCOMs, and "the community essential health care (SEC)" initiative aiming to extend child health care coverage.

The goal of PKC II, in collaboration with the Civil Society organisations, the Ministry of Health, and the Ministry of Social Development, is to provide technical and material assistance in order to ensure the expansion of optimal health behavior practices, and to promote the use of community health services across Mali. PKC II has two general objectives integrated into its two components:

- ✓ ***Community Health Services:*** Increase the capacity of Community Health Associations (ASACOs) and Community Heath Centers (CSCOMs) and communities to carry out social mobilization around health at the community and household level.

- ✓ ***For STIs/HIV/AIDS:*** Contribute to the reduction in the prevalence of STI, HIV and AIDS in high risk groups by the end of the project.

For the two year extension period from October 2011 to September 2013, PKC II was implemented by a consortium made up of CARE International in Mali (as the lead), the John-Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU/CCP) and IntraHealth International through a total of 14 national NGOs as program activities implementing partners in the field. During the first three years of PKC II (2008-2011), Groupe Pivot / Santé Population was also a member of the consortium.

This consolidated report highlights key results achieved from October 2008 to September 2013.

SECTION 1: High Impact on Health Services

This section addresses specific interventions in the fight against malaria, the promotion of reproductive health and family planning, MCH prevention, and STIs/HIV/AIDS. Some common aspects will be discussed in this section relating to change of behavior towards communication interventions, carried out by the Community Outreach Workers (Community Relais).

1. Malaria

One of the focus areas of the Keneya Ciwara program is malaria prevention and control for pregnant women and children under-5. PKC II has been collaborating closely with Population Services International (PSI) to implement malaria prevention initiatives that increase access to Insecticide Treated Nets (ITNs) by pregnant women and children under-5 through service-linked approaches. Relais also are working with mothers and pregnant women in villages to ensure appropriate use of ITNs. These approaches support the GRM/National Malaria Program efforts to prevent and control malaria effectively, increase attendance to health services and access to ITNs. The ultimately expected outputs of these initiatives are: (i) increased access to ITNs by pregnant women and completely-vaccinated children under-5, (ii) increased use of *Sulfodoxine Pyrimethamine* (SP) as Intermittent Presumptive Treatment (IPT) for malaria by pregnant women, and (iii) referral for the early care seeking.

Malaria prevention and management is part of the PMI activities of PKC II. PKC II has a mandate to support strategies in the PMI framework. Within this framework are BCC activities and technical support including SEC selected activities implementation in 6 selected districts (Niono, Fana, Dioila, Ouelessebougou, Bandiagara and Bankass) in collaboration with ASACOs and CSCOM technical staff. PKC II is also the lead for PMI communications working group in Mali.

1.1. Key Activities and Results:

Pregnant women and their unborn children are extremely vulnerable to malaria, which is a major cause of perinatal mortality, low birth weight and maternal anemia. The disponibility of ITNs at CSCOM level and the mobilization of communities with respect to ITNs through community radios, community networks and household education have led to increased attendance and use of antenatal and post natal services.

PKC II implemented ongoing initiatives such as the Youth Ambassadors in schools and communities, the Community leadership engagement, and the traditherapeuts to strengthen the fight against malaria and to ensure that pregnant women and their newborn are properly protected. Malaria prevention and case management messages were broadcasted on national TV and through community radios.

Key Results and Discussion:

a) **Community Leadership Engagement** in the fight against malaria was one of the key results from the Community Dialogue Initiative. More than 1,000 Community Leaders were engaged throughout 15 health districts. Key results are: (i) significant increase of knowledge on the modes of malaria transmission; (ii) increased perception of malaria as real health risks and means for prevention; and (iii) more than 95% community leaders put into practices their engagement to mobilize and sensitize their communities in the fight against malaria.

b) Youth Ambassador activities against Malaria

The Youth Ambassadors (YA) conducted their activities against malaria in schools and in their communities. This initiative has mobilized more than 20,000 YA to sensitize peers and parents in 152 schools distributed within 32 Pedogogic Academic Centers (*Centres d'Animation Pédagogique: CAP*). In 2013, monitoring activities of the Youth Amabassadors against Malaria were conducted in 5 CAP covering 15 schools (3 per CAP). 340 Youth Ambassadors participated in focus groups for self evaluation. Those YA have interviewed 570 members of their communities as part of the field activities of the monitoring. The monitoring has concluded that:

- The YA initiative is well known by school children and their community members.
- The YAs have played important roles in their communities in promoting malaria prevention messages among their peers and parents.
- The teachers' role in the YA initiative is well appreciated by the school children and parents. Some teachers even played an active Ambasodor role in their respective communities.

From left to right: 1. The School Director meeting with YA in Kita. 2. Auto-evaluation Sesssion by YA. 3. Partnership between YA and thee CSCOM Ciwara d'Or of Djidian. 4. Field visit preparation session. 5. Household members interviewed by YA. 6. Group photo at the end of the monitoring activites.

c) BCC tools production:

In the context of the initiative "Unis Contre le Paludisme" during the Afican Nations Football Cup 2013, PKC II produced two TV spots and duplicated 2500 magazines - "Goal". These spots were also adapted for radio broadcasting.

One thousand (1,000) Job Aids in French and Bambara were duplicated and distributed to Traditional Healers as BCC support in the fight against malaria.

The following Table captures all BCC materials produced and distributed

Table 2: BCC materials produced and distributed

Number	Items	Year 1	Year 2	Year 3	Year 4	Year 5
1	Quality Module 1&2		1 000			
2	Referral Note Book		7 000			
3	Essential Family Practices		10 500			
4	FP Booklet		13 000	6 500		
5	Flyers for Y. Amabassadors		5 000	8 000		
6	T-shirts for Antenatal Care		1 000			
7	Integrated Flipcharts		2 900	1 500		
8	T-shirts for Quality		1 920	1 500		
9	Pins		1 500			
10	Posters for quality services			960		
11	Stickers G & P formats			2 105	700	
12	Family Practices new version			242 000		
13	Poster for Ciwara d'Or				27	
14	CD jingle for promotion				34	
15	Cap for Ciwara d'Or		1 055	600		
16	Cassette for audio malaria		80	50	30	
17	Cassette for early referral		80	50	30	
18	Cassette for ITN utilization		80	50	30	
19	Cassette for contraceptives		80	50		
20	Spots TV & Radio Campaigns					4
21	Magazine Goal CAN 13					2 500
22	Job Aids for traditional healers					1 000
23	Bags for Community Relays			6 000		

c) Traditherapeuts malaria prevention and care activities:

Traditherapeuts continued their malaria prevention and care activities in collaboration with health structures in their intervention areas. Overall, 771 traditherapeuts, equipped with Job Aids, have been trained on malaria symptoms and patient referral to community health centers. The PKC II central team supervised traditherapeuts interventions in 9 districts to reinforce their competencies and collaboration with the health structures on malaria prevention, treatment and severe case referrals to health structures.

Findings from the external evaluation of the implication of traditherapeuts in the fight against malaria revealed:

- ✓ Level of knowledge of 122 out of 176 trained traditherapeuts: 95% of traditherapeuts have appropriate knowledge of the transmission mode of malaria; 96% of traditherapeuts know how to prevent children under 5 years from contracting malaria; and 79% of traditherapeuts know how to prevent pregnant women from contracting malaria.

- ✓ With regard to malaria consequences for children under 5 years, 87% of traditherapeuts identified death, and 42% mentionned defect with impact on the intelligence. As malaria consequence on pregnant women, 74% of traditherapeuts identified death of mother and baby, and 63% cited miscarriage. In order to reduce the malaria consequences, 74% of traditherapeuts recommended early referral to community health centers, and 44% recognized the important role of sleeping under treated mosquito nets.
- ✓ Traditherapeuts acknowledged that major means to sensitize communities on malaria consequences are interpersonal communication, radio broadcastings, and educational talks by health agents as well as community health workers.
- ✓ Major challenges faced by traditherapeuts are related to their low literacy rate, mistrust and lack of sympathy from health agents, poor quality of care in the health centers, and lack of transport for referral cases.
- ✓ Traditherapeuts recommended to scale up the initiative towards other traditherapeuts and to embrace prevention activities in relation to other diseases; to strengthen the collaboration between health providers, community health workers, and traditherapeuts; and to provide institutional and financial support to Associations of traditherapeuts.

e) Activities conducted by community health volunteers (relais):

Community Health Volunteers relais) are one of the key actors in the fight against malaria. Therefore, 117 relais trainers have been trained on the prevention methods against malaria.

The following activities in the fight against malaria were conducted by relais:

✓Households using LLMN visited by relais: 4 283 305
✓Children referred for fever by relais : 75 321
✓Patients referred for fever to CSCOMs by traditional healers: 5 988

f) Essential Community Care (*Soins Esentiels Communautaire = SEC) :*

The objective is to increase the access of households to Maternal, Newborn and Child Health Care (MNCH) at community and CSCOM level by reducing geographic barriers in increasing coverage of high impact health services.

To address gaps in coverage of MNCH services and reduce geographic barriers, the Ministry of Health (MOH) has developed a new Community Essential Care (SEC) Strategy. Under this strategy, the MOH established a new cadre of paid Community Health Agents (CHAs) based at the village level. CHAs are responsible for providing basic MNCH care to a population of 1,500, covering 1-3 villages in the area around the CSCOM and for supervising the work of community health volunteers ("Relais"). CHAs are expected to come from the CSCOM's catchment zone and have at least 9 years of schooling. After training, CHAs provide essential community health care, including treatment and prevention of the major childhood diseases. Although CHAs receive technical support and supplies from CSCOM staff, they are supposed to be managed and paid by ASACOs.

Mali's SEC Strategy is in line with Global Health Initiative (GHI) and USAID objectives around integration and improving health outcomes to achieve MDGs 4 & 5. PKCII filled a critical gap not addressed by existing programs by strengthening implementation of the new SEC Strategy, improving CHAs practices and focusing greater attention at the CSCOM and community level on gender and governance as key interventions to improve effectiveness and sustainability.

PKCII worked with MOH, UNICEF, and other partners to implement SEC activities in six districts (San, Niono, Ouelessebougou, Dioila, Bandiagara, and Bankass. In doing so, PKCII impacted at least 197,000 women and 170,000 children under 5 years of age. PKCII specific objectives in implementing the SEC are:

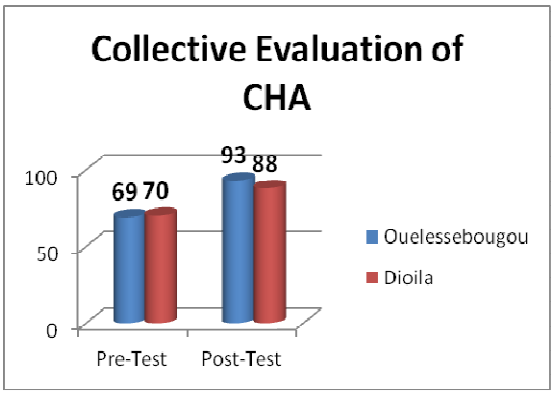
- ✓ Increased access to and quality of maternal and child health services;
- ✓ Increased knowledge and practice of healthy maternal and child health behaviors;
- ✓ Ensured that SEC activities are implemented, managed, and coordinated;
- ✓ Improved management, problem-solving and accountability through participatory governance of key players such as ASACO, Communes, and CSRef, for ownership and sustainability.

PKCII's Implementing Strategy was as follows:

- ✓ Conduct_a situation analysis within the 6 districts to identify gaps and areas of improvement.
- ✓ Design a plan to strengthen SEC interventions in the 6 districts.

Key Results:

- ✓ Situation Analysis conducted in the 6 districts.
- ✓ Strengthening Plan was designed in each district in order to implement and improve SEC interventions.
- ✓ A SEC Community Approach and Coordination Committee were established in the 6 districts.
- ✓ At the end a total of 277 community approach sessions were conducted and 170 Coordination Committees established.
- ✓ CHAs were equipped with various tools ranging from inventory registers to finance, drug, and follow on registers. More than 1,647 various tools were distributed to CHAs.
- ✓ A total of 73 CHAs have been trained in 2 districts: 26 CHAs in Ouelessebougou and 47 CHAs in Dioila. Out of 73 CHAs, 32 were males and 41 females.
- ✓ Collective evaluation of the CHA training revealed that from the pre-test to the post-test, participants in Ouelessebougou district improved their performance from 69% (pre-test) to 93% (post-test). In the meantime, participants in Dioila district improved their performance from 70% (pretest) to 88% (post-test).



g) World Malaria Day Campaign Activities

From 2009 to 2012, PKCII participated each year to the World Malaria Day Campaign Activities. These activities not only are in line with the President Malaria Initiative (PMI) Framework, but are intended to support the National Malaria Program. Radiobroadcasting and TV spots and micro programms on the malaria

prevention and treatment are run during at least one month and starts on April 25th. Before the 2012 political crisis, an average of 65 radios are engaged for the events. But in 2012, only 27 radios all located in the South of the country did participate. Main topics are usually related to: (i) early seeking treatment, (ii) use of treated mosquito nets, and (iii) SP use by pregnant women for malaria prevention. Major achievements are: 1,620 spots and 810 micro programs broadcasted, 162 street interviews organized, and more than 2 million of pople reached.

h) Training of Journalists on the fight against malaria

During the course of the five years and mainly in June 2011, PKCII provided technical and finance support to the National Malaria Program to train journalists and radio animators in the fight against malaria. As follow up of a five day training of 49 participants, 39 action plans are designed and monitored. Action plans are related to broadcasing, reporting and sharing appropriate information with peers in the fight against malaria.

2. Reproductive Health and Family Planning

USAID/Keneya Ciwara is supporting the efforts of the Government of Mali to improve services in reproductive health, as well as to sustain impacts of the national FP campaign and to continue generating demand and increasing use of modern contraceptive methods as necessary steps to repositionning family planning.

Community Health Workers ("relais") are one of key actors in promoting Family Planning. In addition to the Community-Based Distribution of contraceptives by relais, and in order to boost the Contraceptive Prevalence Rate (CPR), USAID / Keneya Ciwara initiated the promotion of Depo Provera through outreach strategy in the districts of Dioila and Ouelessebougou. 32 CSCOMs (18 in Dioila district and 14 in Oulessebougou) were supplied with 6400 units (200 per CSCOM) of Depo Provera for outreach activites conducted by matrons in the health areas. Unfortunately this initiative was conducted in April and May 2013, when most of the project's activities were closing out. By all means, we will recommend continuing this initiative within the probale next upcoming bid.

Moreover from 2008 to 2013, 1,117,153 health education talks on FP were organized by relais. Community-based distribution (CBD) of contraceptives by relais has reached 30,201 new acceptors of FP methods in the last 6 months. Unlike the previous years where National FP campaign was organized in March and April, in 2013, the political, social and military crisis heavily impacted the organization of the FP campaign.

3. Maternal Health and Child Survival

Like several countries, Mali has tried to define and implement an Integrated Maternal, Newborn and Child Health (IMNCH) Strategy. The overall objective of this strategy is to reduce maternal, newborn and child morbidity and mortality in line with the Millenium Development Goals 4 and 5.

PKC II, through the "collaborative approach" and the "community essential health care (SEC) initiatives, is in line with this IMNCH Strategy in order to: (i) improve access to good quality health services; (ii) ensure adequate provision of medical and laboratory supplies, drugs, reproductive health commodities, insecticide treated nets, and the provision and maintenance of basic equipment; (iii) strengthen the capacity of individuals, families and the community to take necessary MNCH actions at home and to recognize when to seek appropriate health care; (iv) improve capacity for organization and management of MNCH services; (v) establish a financing mechanism that ensures adequate funding, affordability, equity, and the efficient

use of funds from various sources; and (vi) strengthen supervision, monitoring and evaluation systems. Activities planned for the "collaborative approach" and the "community essential health care, SEC" initiatives are implemented in six selected health districts (San, Niono, Dioila, Ouelessebougou, Bandiagara, and Bankass).

3.1. Maternal Health:

Under maternal health, the main activity has focussed on the implementation of **quality care improvement** referred to as the **"collaborative approach" initiative.**

The main objective of the "collaborative approach" is to increase the capacity of health providers at CSCOM level to adhere to the norms and standards in the implementation of quality maternal and neonatal services in four health districts - San, Niono, Dioila, and Ouelessebougou.

Indeed, the quality care improvement initiative called "collaborative approach" is implemented and the following activities were conducted:

- ✓ Two manuals of reference and two training guides related to integrated management of maternal and newborn care for assistant midwives and matrons were developed and distributed.
- ✓ One manual of reference on pedagogic competencies for clinical service providers were developed and distributed.
- ✓ Training of 152 qualified service providers was conducted on integrated management of maternal and newborn care.
- ✓ Training of 152 qualified service providers and 83 community actors on the management of collaborative approach and quality insurance focused on Active Management of the Third Stage Labor (AMTSL) and Newborn Care.
- ✓ 39 qualified service providers have been trained on coaching.
- ✓ Training of 104 matrons on integrated management of maternal and newborn care.
- ✓ Realisation of the second coaching visit and the first learning session in the districts of Dioila, Ouelessebougou, Niono and San for 85 members of the quality insurance teams (QIT) ("Equipe d'Assurance Qualité").
- ✓ Organization of the reinforcement of the community approach and the installation of the coordination committees in 183 sites at the health areas level in the districts of Dioila, Ouelessebougou, San and Niono.
- ✓ Provision to 183 Community Health Workers (CHW) with tools for monitoring their activities.
- ✓ Organization of refresher training sessions for 73 CHW on family planning, malaria and children integrated care card.
- ✓ Organization of a learning session for 96 members of the quality insurance teams of Dioila and San.

District Quality Insurance team: first learning session in San

3.2. Child Survival:

The relais and the Community Essential Care interventions were the focus of child survival activities of PKC II:

The following activities were undertaken by relais to reinforce child survival interventions:

- 44 738 households in 27 districts were visited by relais for the promotion of the three (3) key washings: hands, face and mouth.
- 312 cartons of 200 boxes of ORS/Zinc received from PSI were distributed to the trained relais for diarrhea management at households.
- 42 365 households were reached by relais for aquatabs promotion and distribution.

Under the Community Essential Care initiative, the following activities were undertaken to reinforce child survival interventions:

- Organization of the reinforcement of the community approach and the installation of the coordination committees in 183 sites at health area level in the districts of Dioila, Ouelessebougou, San and Niono.

✓ Provision to 183 Community Health Workers (CHW) with tools for monitoring their activities.

Group Work during the CHW training in Diola

3.3 Key Results

The "Collaborative" Initiative aims to improve maternal health and newborn care in four (4) districts: Niono, San, Dioila, and Ouelessebougou.

Following activities have led to tremendous key results:

- Conducted a baseline quality assessment of maternal and neonatal health services (clinical and managerial evaluation) in health facilities;
- Reviewed and finalization of baseline quality assessment tools for health facilities and exchanges with HCI on monitoring indicators for collaborative implementation;
- Implementation of an initial learning session in each of the health districts to orient the district teams on the collaborative approach, share baseline assessment results, and discuss implementation of the package of changes;
- Conducted a final evaluation of quality assessment.

Indeed, comparing data from baseline and final evaluation, it is obvious that the implementation of Collaborative Initiative has yielded tremendous results.

Table 3: Baseline and Final Evaluation of the Collaborative Initiative

Performed Activities	Baseline Evaluation 2012	Final Evaluation 2013	Comments
Implementation of key elements of delivery plan (kit, financial resources, blood donor identification)	4.2%	9.17%	Performance increased by 5 points. This means that pregnant women are aware that they need to have a plan in place before the delivery date.
Service providers are respectful of the norms of the preparedness phase of the AMTSL and newborn care	47.30%	68.8%	Performance improved by 21.5 points. Good results.
Implementation of AMTSL key actions (oxytocin injection, uterus massage, and	66.20%	83.81%	Performance increased by 17.81 points. This means that most of service providers are properly using the AMTSL

Performed Activities	Baseline Evaluation 2012	Final Evaluation 2013	Comments
traction of ombilical cordon)			norms.
Percentage of deliveries performed through partogram tool and guidance	26%	85%	Performance has almost tripled. Delivery process is properly followed. This minimizes any risk of complication.
Respect of women's privacy	25%	87.5%	Good performance
Notification of hemorragia on the partogram form	8%	100%	Excellent performance
Delivery assisted by matrons	-	54.38%	Most of deliveries are assisted by matrons, mainly in rural areas.
Percentage of maternal complications discovered in post partum	2.25%	0.55%	Maternal complications have been drastically reduced. Positive action of the AMTSL implementation.
Post partum Hemorragy registered	2.05%	0.55%	AMTSL application has reduced post partum hemorragy; it will surely have a huge impact on the maternal mortality rate.
Early newborn care (0 to 6 hours after delivery)	50.42%	90%	Good performance
Placenta examination by service providers	67.53%	89.73%	Good performance
FP counseiling during post partum visits	0%	70.84%	FP promotion activities are perfomed in the post partum visits. This reduces the risk of unwanted pregnancy.

4. STIs/HIV/AIDS

As a part of USAID/Mali's health program, and working with the Government of Mali's High National Council in charge of the fight against HIV/AIDS, PKC II through its STI/HIV/AIDS component aimed to contribute to the reduction of STI and HIV/AIDS prevalence among the Most at Risk Population Groups (MARPs). MARPs mainly refer to Men having Sex with Men (MSM), Sex Professionnels (SP), and Truck Drivers. MSM and SP are the most at risk with the prevalence rate respectively at 17% and 24.2 %.

The 2009 Integrated STI and Behavioral Survey (ISBS) revealed that only 40.1% of Sex Professionnels utilize condoms with their partners, leading to high risk behaviors that can result in STI and HIV. In 2006, a survey conducted by Population Council in partnership with CSLS/MS and ARCAD/Sida in Mali revealed that MSM not only are having sex with multiple partners, but that many are also bi-sexual and are not systematically using condoms. Due to the social and religious prejudice and bias, very few interventions are focusing on MSM. There is an urgent need to put focus more efforts on this high risk group, with emphasis on

social change strategies to address social and religious norms that contribute to this group's vulnerability and marginalization.

The main purpose of the STI/HIV/AIDS component is to contribute to the reduction of morbidity and mortality due to STI and HIV/AIDS among MARPs by increasing the access and use of health specific caring structures, and by improving healthy behaviors through the systematic use of condoms. Specific objectives are as follows: (i) increased from 45% to 65% the systematic use of condoms among MARPs; and (ii) increased at 60% the use of health services for treating STI and HIV/AIDS.

Project strategies are mainly related to: (i) peer education; (ii) training key actors on STI/HIV/AIDs problem identification, supervision and treatment; and (iii) ensuring that health centers are provided with appropriate drugs and commodities.

It is important to acknowledge the tremendous efforts and key roles local NGOs have played in the fight against STI and HIV/AIDS in Mali. Indeed, from October 2008 to September 2011, Group Pivot / Sante Population (GP/SP) did play a leadership role in working through these local NGOs. From October 2011 to September 2013, the leadership role was transferred to CARE. The background and breakdown of GP/SP leadership role is as follows:

- ✓ From October 2008 to September 2010, the **18 NGOs** engaged in the fight against STI and HIV/AIDS include: WALE, CAREDEPE, APPF, OMADECOS, CRADE, ADES, ADPS, AMIFA, JIGI, AMPRODE SAHEL, GAAS-Mali, Consortium Sahel, CARD, ADAP, GARDEM, CLUEDUCA, SOUTOURA, and ASAME.
- ✓ From October 2010 to September 2011, the **8 NGOs** still engaged for the fight are: ALPHALOG, CARD, AMPRODE Sahel, CLUEDUCA, SOUTOURA, ARCAD-SIDA, OMADECOS, and JIGI.

Therefore, from October 2008 to September 2011, the project has reached: 263,885 Truck Drivers, 238,060 Ambulatory Vendors, 97,973 Seasonnal Carters, 12,398 MSM, 151,146 Professional Sexworkers, and 16,295 Sand Exploitants. MSM record started to be only from October 2010.

	Oct 2008-Sept 2009	Oct 2009-Sept 2010	Oct 2010-Sept 2011	Total
Truck Drivers	60 821	91 746	111 318	263 885
Ambulatory Vendors	60 592	125 025	52 443	238 060
Seasonnal Carters	33 490	30 493	33 990	97 973
MSM	0	0	12 398	12 398
Professional Sexworkers	7 687	57 497	85 962	151 146
Sand Exploitants	1 354	10 280	4 661	16 295

From October 2011 to September 2013, under CARE's leadership, PKC II has contracted **6 national NGO** (JIGI, SOUTOURA, CLUEDUCA, OMADECOS, ALPHALOG, and AMPRODE Sahel) to implement the STI/HIV/AIDS component. Initially ARCAD /SIDA was also contracted by PKC II. These NGOs are conducting primary and secondary prevention activities covering 26 sites in 6 regions. Activities are being conducted by PKC II partner NGO staff including 7 Coordinators, 14 Animators and 255 Peer Educators. Referrals to health facilities for STI/HIV/AIDS counselling and cases management are also part of the animators and peer educators activities.

More precisely, from October 2011 to June 2013 (because due to the phase-out process, monitoring for local NGO interventions did stop), the project has reached 43,704 MSMs, 128,365 CSWs, and 27,990 Truck Drivers as follows:

		Oct 11 - Sept 12	Oct 12 - June 13	Total
MSM	Newcomers	8 087	1 680	9 767
	Formers	18 508	15 429	33 937
	Total	**26 595**	**17 109**	**43 704**
CSW	Newcomers	19 529	8 187	27 716
	Formers	56 919	43 730	100 649
	Total	**76 448**	**51 917**	**128 365**
Truck Driver	Newcomers	4 303	4 391	8 694
	Formers	9 718	9 578	19 296
	Total	**14 021**	**13 969**	**27 990**

Please refer to the breakdown by sex and age on pages 42 thru 44.

En 2012, ARCAD-SIDA targeted CSWs, PLWA, and MSM, and successfully implemented Positive Health Dignity Prevention Program with the following results:

- ✓ 75 MARP Leaders were engaged in dialogue in order to elaborate prevention strategies;
- ✓ An advocacy workshop was organized with the participation of 208 community leaders and local elected representatives;
- ✓ 90 MARP have participated to Sexual Health Workshop in Bamako's Health Clinics;
- ✓ Close to 120 beneficiaries participated to the quarterly meetings focusing on their vulnerability and how to get protected;
- ✓ 100 Partners of MSM have participated to group activities;
- ✓ 120 Managers of PLWA Association as well as HIV Positives women have been trained on the Leadership Negotiation and use of condoms;
- ✓ 21 women have been trained on micro finance and saving and credit management;
- ✓ Renewable Fund has been created and 21 women have accessed to credit in order to improve their economic status.

BCC animation session in a bar in Sévaré

Key Results, Analysis and Discussion:

- **Training:**

  From 2008 to 2013, the additional following trainings were conducted by local NGOs:

  - 180 Project's Coordinators and Animators have been trained on participatory approach, Social and Behavior Change Communication, and on STI/HIV/AIDS.
  - 20 Local NGO staff and Technical Health Providers have been trained on Sexual Health and Secondary Prevention.
  - 100 Peer Educators /PLWA trained on leadership and condom use negotiation.
  - 24 Agents received theorical and practical training on project design and management.
  - 1,821 Peer Educators trained on SBCC techniques and participatory approach. The breakdown of this training is as follows:
    - From October 2008 to September 2011, 1,110 peer educators were trained, including 60 MSMs (30 MSMs by SOUTOURA and 30 MSMs by ALPHALOG).
    - From October 2011 to June 2013, 711 peer educators were trained, including 200 MSMs, 357 Sew Workers, and 121 PLWA. .

- **Sensitization and Social Mobilization through mass animation, home visit, counseling and video projections, etc:**

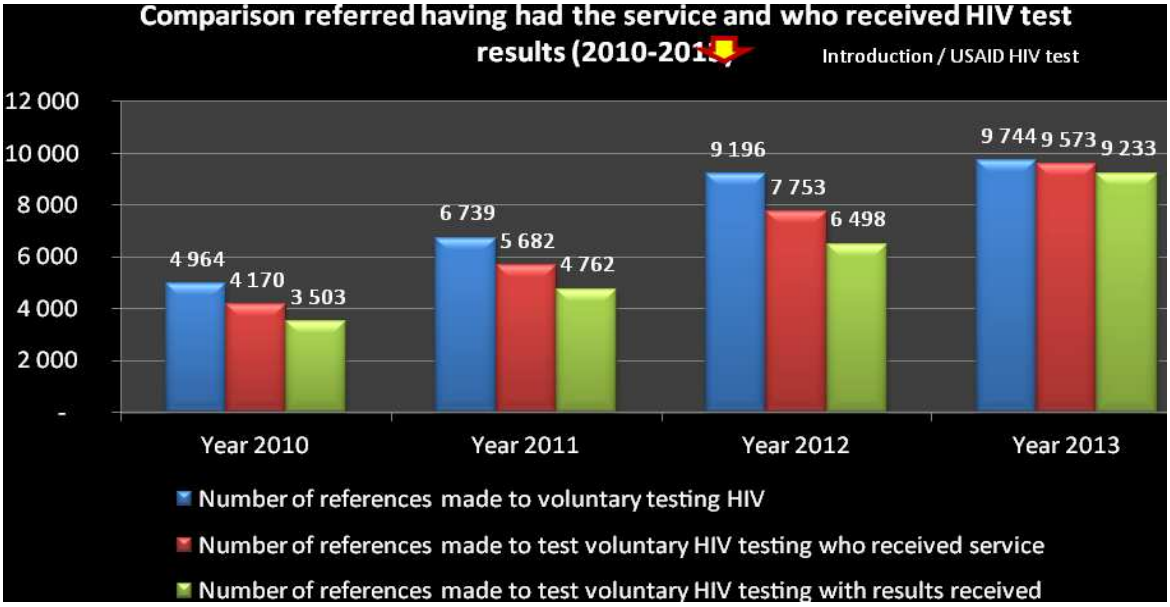
  - 226,408 Sex Professionnels as compared to the target of 135,912 have been reached. Among them 37,750 CSWs were newly identified.
  - 53,307 MSM as compared to the target of 36,060 have been reached; 13,458 were newly identified.
  - 213,942 Truck Drivers reached with 40,317 newcomers.
  - 15,751 PLWA reached with 10,339 newcomers.

Overall within five years, about 1.2 million people have been exposed to STI/HIV/AIDS messages with more than 700,000 people from MARPs and nearly 500,000 partners.

- **Volontary Counseiling and HIV Testing:**

Although from 2009 to June 2013, 28,657 people did receive their HIV test results, the following analysis will only focus on the period ranging from 2010 to 2013. Data from 2009 were not fully complete, because instructions for additional data were only requested from 2010 . From 2010 to June 2013, local NGOs conducted volountary counseling and HIV testing activities within health centers as well during outreach interventions (*Stratégie Avancée*). Out of 30,643 people who were referred to

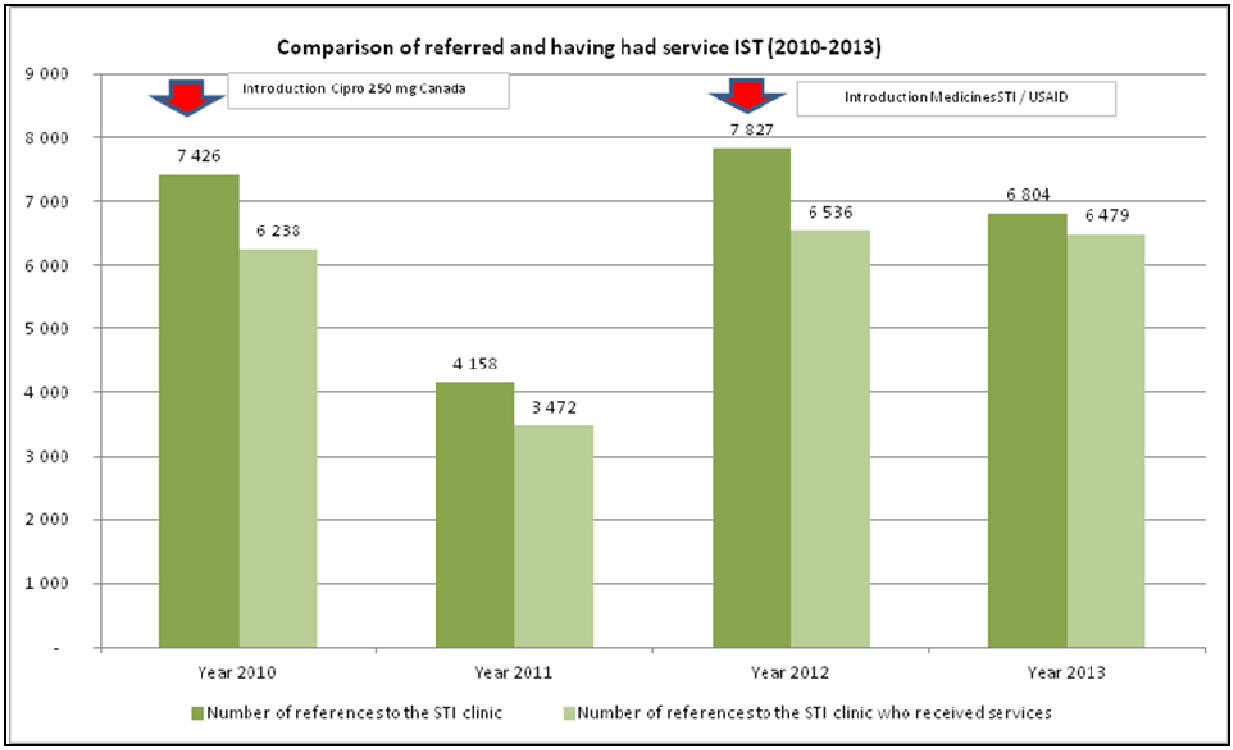
Health Centers for testing, 27,178 people were tested, representing 89% of the total number of referred people. From the tested population, 23,996 people received their results (88%). This is considered significant because noramlly, people are afraid to know their results. Two factors have contributed to these results: (i) the quality of communication messages and interventions, and (ii) the availability of HIV testing kits as well as the availability of drugs for infected people. In reference to the graphic below, in 2013 after nine months, the results are especially imoressive as 96 % (9233/9573) of people tested received their results and are aware of their status.



- **STI referral to the health centers:**

From October 2010 to June 2013, out of 26,215 people referred to health centers for STI seeking treatment, 22,725 received appropriate treatment; it represents 87%.

Service utilization is highly related to pharmaceutical products availability. Indeed, in 2010 referrals to health centers for seeking STI treatments drastically increased when Help Eliminate Deseases and Addiction Canada (HEDAC) provided drugs for treatment: 7,426 referrals occurred as compared to almost no referrals in 2009. The graphic below shows that the stockout of 2011 revealed a decrease in referrals and a new increase when USAID offered STI treatment drugs (Determine, Clearview, and Oraquick) in 2012 to 23 health centers. In 2013, just after nine months, 6,804 referrals were made as compared to 7,827 referrals during the 12 months in 2012. The PKC II team considers these tremendous achievements!



- **Condom Promotion Activities:**

During mass mobilization activities, 30,000 condoms have been used by peer educators for practical demonstration and distribution to target people. Local NGOs have sold or distributed 3.5 million condoms.

- **Mass Mobilization and Special Event:**

Mass media caravan with mass concert was organized by USAID in partnership with PKC II, ARCAD/Sida, JIGI and SOUTOURA, in December 23, 2011 in Communes 1 and 6 of Bamako, in order to boost STI/HIV/AIDS interventions.

Drugs for STI treatment and HIV test Kits received in the CSCOM of Fatoma (District of Mopti)

HIV testing on outreach in Sévaré town (Mopti District)

Section 2: Strengthening the Capacities of the ASACO

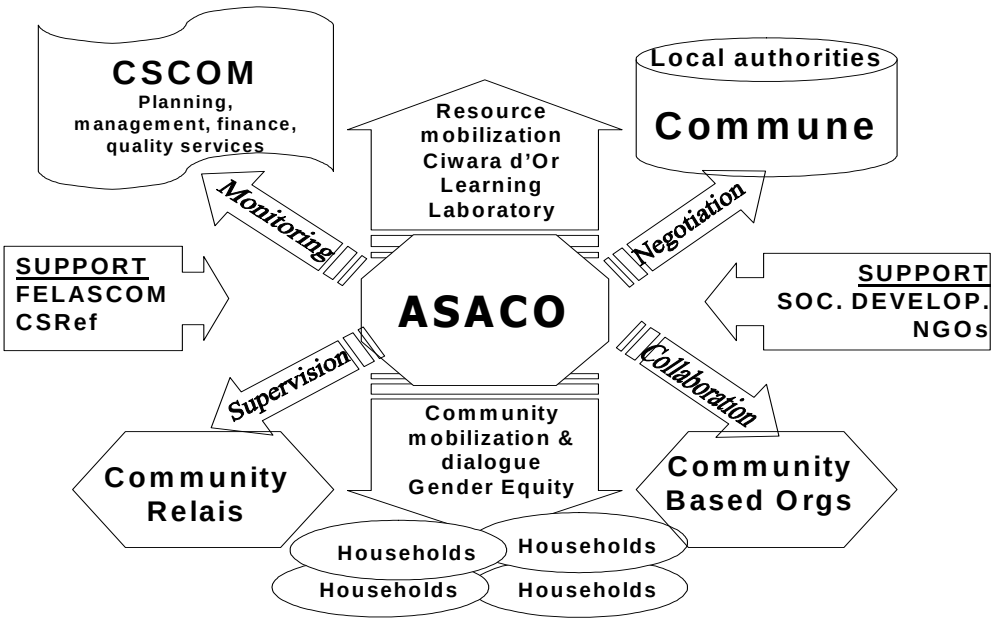
PKC II aims to develop the capacity of the ASACOs to make them quality partners, not only at the community level but also to enable them to achieve the MDG targets. Therefore, USAID/Keneya Ciwara has provided training for ASACOs through NGOs. This training provides them with skills to mobilize their communities to take advantage of quality high impact services, and to provide more consistent and comprehensive outreach services at the village level. USAID/Keneya Ciwara works to expand the availability and quality of the community relais network in each village of the program catchment areas.

Before strengthening the capacity of ASACO, an evaluation assessment is conducted. Based on the findings of the self-evaluation, ASACOs are classified into one of the three following phases: Startup Phase, Growth Phase, and Mature Phase. These phases allow members to clearly distinguish where their activities fit into the rubric, and what aspects of their work need improvement. Community Advisors work with the ASACOs to develop a tailored training plan to address gaps in their capacity as well as build their management skills and strengthen their associations. Trainings include the following:

- Leadership development – Much of the training in this area is intended to build the management skills of the ASACOs to oversee the work of CSCOMs and *relais*.

- Strategic planning – ASACOs receive support in developing a mission statement, written goals, annual and five-year plans, and microplans. The training also stresses the importance of conducting participatory planning processes by including members of the ASACO and technical teams.
- Financial management – capacity building efforts focus on primary sources of funding, how well these sources can cover the needs of the center, and how sustainable they are. Training covers recordkeeping and independent oversight of accounts in order to prevent problems of corruption or confusion.
- Administration and governance – this area looks at promoting good internal governance practices in ensuring representation within the ASACO, especially in terms of gender, selection of members, and the frequency of selection. Additionally, training encourages relationships with partner organizations, and advocating effectively for community health needs when working with other groups, and outreach activities.
- Resource mobilization – ASACOs receive training in how to promote community buy-in through financial or other support of the association as well as soliciting support from civil society and the private sector.
- Personnel management – training covers four areas: contracts, training, policies, and social security. ASACOs are encouraged to work with its technical employees to have the best health center possible and ensure its own employees are qualified and motivated.
- Advocacy – KC II provides training in advocacy that combines theory with concrete examples from the different regions, as well as how to develop fora for discussing and initiating advocacy campaigns. The advocacy training is intended to help to transform ASACOs and communities from reactive health consumers into proactive agents of change.

Below is a diagram which illustrates the central role ASACOs play in Community Health Care.



ASACOs interact with various stakeholders by monitoring CSCOMs, supervising Community Relais, negotiating with Commune and local authorities, and collaborating with community-based organizations.

From 2010 to 2012, PKC II ativities on ASACOs' capacity strengthening have greatly improved their capabilities in planning, administration and financial management. However, findings revealed acceptable performance in terms of staff management and community participation to activities. Partnership between ASACO and Communes presented some weaknesses with a lot of rooms for improvement. ASACO self-evaluation key findings as well as monitoring and supervision activities are as follows:

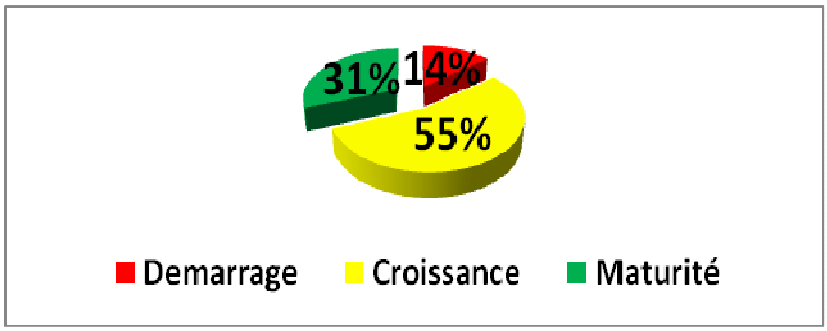
1) **ASACOs self evaluation key findings:**

Dissemination workshops were organized in Kayes, Koulikoro, Bamako, Sikasso, Segou, Mopti to share, with the key stakeholders including the ASACO and the district and regional health authorities, the results of the self evaluation study of the ASACOs conducted in December 2012. The findings show the effectiveness of the approach developed by PKC II to strengthen the ASACOs capacity in the governance of the CSCOMs:

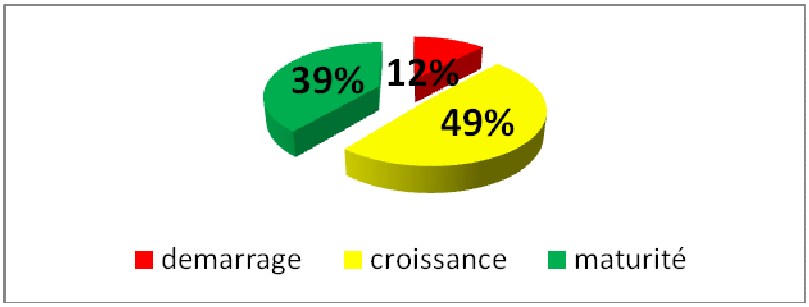
- The percentage of ASACO at "maturity stage" ("phase de maturité") gradually improved from less than a 1% in 2009 to 31% by end of 2010, to 39% at the end of 2011and to 62% at the end of 2012.
- The percentage of ASACOs at the growth stage ("phase de croissance") has declined from 55% in 2010 to 49% in 2011 and to 38% in 2012.
- The percentage of ASACOs at the starting stage ("phase de demarrage") has declined from 14 in 2010 to 12% in 2011and to 4% in 2012.

The following graphs show a summary of ASACO self evaluation key findings:

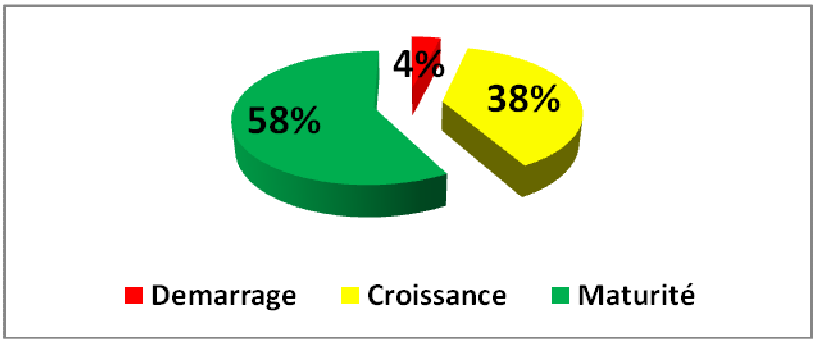
Graph 1: ASACO self-evaluation in 2010



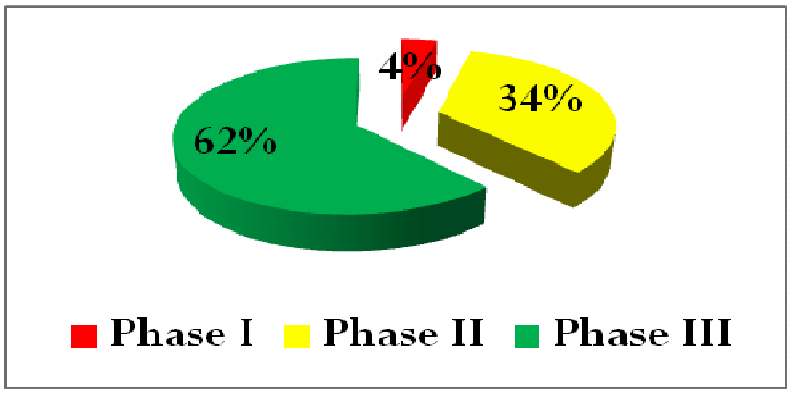
Graph 2: ASACO self-evaluation in 2011



Graph 3: ASACO self-evaluation in 2012



Graph 4: ASACO self-evalation synthesis out of Timbuktu, Gao and Kidal Regions



2) Monitoring and supervision of field activities:

Supervisions of field activities were regularly conducted in all zones excepted Gao, Timbuktu and Kidal for security reasons:

- Monthly and quarterly monitoring activities were organized by NGO partner staff with the participation of PKC II zonal team staff.
- Monthly visits by community advisors to ASACOs/CSCOM were organized.
- Quarterly monitoring and planning meetings were organized with the central and regional team participation. During these meetings, program accomplishments and challenges were shared and discussed; adjustments for improvement made.

PKC II worked mainly through the local NGO partners, the ASACOs and community leaders to perform activities.

Section 3: Mali Quality Improvement Program and the "Ciwara d'Or" Process

The Mali Quality improvement initiative mobilizes community members and local health care providers to work together to improve their centers by focusing on what the center needs and developing plans to meet community and center needs. Standards to win the Gold Ciwara standard include: improving provider performance, and reducing stockouts of commodities (iron/folic acid tablets, *sulfodoxine-pyrimethamine* tablets (SP), ITNs, and family planning commodities such as pills, condom, injectables and spermicides). The Quality Improvement Initiative is implemented in all CSCOMs in Keneya Ciwara program districts. The Gold Ciwara becomes one the national strategy to promote and reward quality services. From 2008 to 2013, 34 CSCOMs are accredited nationwide. The only exception is Kidal Region and this is due to the social, political and military crisis.

Process:

- *Creation of community and provider dialogue groups on quality:* Community representatives organized a series of community consultative meetings to select 10 or more of their members to dialogue with the health center team of about 4 or 5 staff about quality services.
- *Organization of community meetings to develop action plans on quality*: The community dialogue groups developed a consensus quality action plan which engaged support from local authorities, the community, CSCOM, CSRef and USAID/Keneya Ciwara.
- *Creation of CSCOM quality action team:* The execution of the plan requires a quality action team at the CSCOM. The quality action team is generally made up of about ten people chosen from among the members of the dialogue groups.
- *Selection of CSCOM for nomination:* From the onset of the processus, all CSCOMs within the district are assessed and classified based on their performance status in term of providing quality services. The first five CSCOMs which have a good ranking are called "CSCOM Nominees", ready to get engaged into competition for the top position. Therefore the five CSCOM Nominees are requested to develop and implement a Quality Action Plan.
- *Implementation of Quality Action Plan:* Most of the action plans required 4 to 6 months to be implemented. Engaging local authorities and communities, the Quality Action Team ensures that the activities in the plan are completed, positioning the CSCOM for accreditation.
- *Diagnosis of quality services:* During the course of implementing the quality action plan, the CSRef quality improvement team accompanies the CSCOM Quality Action Team. The team supervises the action plan using the Quality Diagnostic Tool and certifies the completion of the action plan, as a pre-requirement for the accreditation of the CSCOM.
- *Formal Accreditation Ceremony:* Accreditation ceremonies serve as a way to reward the communities, and allow the community to recognize the importance of their own accomplishments. Between 2,500 and 3,000 people were involved in each accreditation ceremony, just as attendees. ORTM (the national television station) as well as many national and local radio stations broadcast the events across Mali, letting other areas learn about the process and its accomplishments.

KEY RESULTS:

- 298/332 (90%) community dialogue groups were created in the districts to define quality services.
- 298/332 (90%) quality teams created in the districts.
- 149/152 (98%) CSCOMs were selected to compete for the accreditation.
- 34/46 (74%) CSCOMs were accredited since the project phase 2 began.
- A guide for community dialogue groups on

quality services has been produced.
- A revised Quality Diagnostic Tool for the supervisory team is available.
- A guide on the criteria and selection of Ciwara d'Or CSCOMs is available.

ANALYSIS AND DISCUSSION:

To generate demand for services in the health centers or CSCOM, USAID/Keneya Ciwara has implemented this bold initiative to engage communities in defining the quality of services that suits them in their CSCOM. This initiative has generated much interest and commitment from the communities who seek to make services better in their CSCOM and win the Gold Ciwara Award. The implementation of quality action plans in the community develops community ownership of the process and mobilizes resources for it.

PKC II continued to provide technical as well as financial supports to health districts involved in the quality health approach through the monitoring and promotion of the accreditated CSCOM. A comparative study was conducted within 10 districts and revealed that: (i) quality performance of CSCOM Ciwara d'Or remains high as compared to the not nominated CSCOMs, with an average variance of 20 points; (ii) the variance between nominated CSCOMs and those which were not selected is at 17 points; another very interesting finding is that CSCOM nominees have drastically improved their quality performance, bringing down the gap with CSCOM Ciwara d'Or from 18.52 points during the accredidation evaluation to 2.92 points during the monitoring evaluation.

The Ministry of Health and partners have assumed ownership of the Ciwara d'Or Initiative and this initiative is considered a National Approach. The MOH is planning to adapt the same approach in districts or regions which are performing well. However, it is highly recommended to continue monitoring and promoting CSCOM Ciwara d'Or and the label in order to ensure continued and consistent quality services and increase the use of health services overall by communities.

Table 4: Accredited CSCOMs by district and region are as follows:

Region	District	CSCOM Golden Ciwara
Koulikoro	Koulikoro	Kolebougou
	Ouelessebougou	Tinkele
	Dioila	Wacoro
	Fana	Beleko
	Kati	Safo
Segou	Segou	Togou
	San	Karaba
		Niamana
	Niono	Siribila
Mopti	Mopti	Sevare 1&2
	Bankass	Tori
	Bandiagara	Dé
		Kendie
Timbuktu	Timbuktu	Toya
	Commune I	Asacomsi
		Asacoba

Bamako	Commune II	Asacome
	Commune III	Asacobrab
	Commune IV	Asacola 1
	Commune VI	Asacodjip
		Asacoyir

Region	District	CSCOM Golden Ciwara
Sikasso	Sikasso	Kourouma
	Bougouni	Koumantou
	Koutiala	Molobala
		Peguena
	Kadiolo	Dioumatene

Kayes	Kayes	Dramane
	Kita	Djidian
	Diema	Farabougou
Gao	Diré	Bourem Sidi amar
	Goundam	Bintagoungou
	Niafunke	Dioulabougou
	Ansongo	Basi Haoussa
	Gao	Gadeye

Due to the social and political crisis of 2012, only Safo CSCOM did not have the opportunity to complete the accreditation ceremony. However, this CSCOM has the same level of performance as those with the Ciwara d'Or label.

Section 4: Other Information Relevant to Our Agreement

1. Coordination meetings:

✓ Quarterly technical meetings: These meetings bring in program staff from the work zones to share their views on program strategies and planning and activities implementation. Two (2) quarterly meetings were organized.

✓ Ssupervision: This activity seeks to strengthen the implementation skills of the teams in each zone and to familiarize central level staff with activities in the field. Several supervision visits were organized including the supervision of the HIV/AIDS activities.

✓ PKC II attended the SEC annual review workshop organized by the MOH to measure the accomplishments in SEC initiative implementation after one year. The results are promising. The challenge remains the payment of the CWH salaries, too high for most of the ASACOs' incomes.

2. **USAID Meetings:**

PKC II team attended several meetings organized by USAID:

- Health team including the AORT meetings;
- Open Country Team Meetings;
- Monthly meetings of USAID health program implementing partners.

3. Critical Events:

In 2012, a social and political crisis occurred in Mali which deeply changed the project implementation. Indeed, in March 2012, Mali's elected civilian government was removed in a military seizure of power, and an interim administration was subsequently put in place. There are rebel groups still active in northern Mali and an ongoing international military intervention in the north to dislodge and disrupt terrorist organization and return security and territorial integrity in Mali. Through local NGOs partners (APROMORS in Timbuktu Region, and Nouveaux Horizons in Kidal and Gao Regions) the project has hardly tried to continue working with northern communities. From October 1, 2012, due to the security context and challenges to organize supervision activities in the north, the project team decided to temporally withdraw from the three regions of the North. Therefore, the project increased interventions in the central and southern regions; mainly in Mopti, Sikasso and Segou regions where high concentrations of Internally Displaced People (IDPs) were present and being largely hosted by families in the affected areas.

Another key event which impacted the project implementation was related to the suspension letter issued by USAID Mali on April 2, 2012. It was requested for all grantees and subgrantees "to suspend all USAID-funded development assistance activities, including any contract with the Malian government, until further notification from USAID". "As part of the suspension, contractors are instructed, and grantees are requested, not to undertake any implementing agreement-specified activities".

Fortunately, on April 9, 2012, the Contracting & Agreement Officer requested CARE to "resume certain agreement activities". It was a great relief for the project team and communities. Although USAID/Keneya Ciwara II Project is mainly working with communities and ASACOs, the CSCOMs are under supervision of District staff. It was difficult to work without the district leadership. However, the project ensured that: (i) health centers are functional in terms of commodities and logistics management for essential medicines and supplies, and services; (ii) the extensive network of community health volunteers and women's associations continue; (iii) community health volunteers are provided with essential health products including family planning commodities for community distribution; (iv) Depo-Provera contraceptive is

provided as part of the outreach strategy in two districts (Diola and Ouelessebougou), and the promotion and distribution of ORS/Zinc at household and the promotion of the three key washings: hand, face and mouth, continue; and (v) the work with the six districts (San, Niono, Bandiagara, Bankass, Diola and Ouelessebougou) that have trained community health workers but require supervision and access to essential medicines and supplies, continue.

4. Change in project Leadership and Staffing:

- ✓ Chief of Party Position: Dr. Oumar Ouattara managed the project as Chief of Party from 2008 to 2011. After his resignation, Dr. Kwamy Togbey assumed for the second time the COP position from January 2012 to September 2013.
- ✓ Communication and Social Mobilization Advisor Position: Dr. David Awasum was replaced in 2011 by Ms. Racine Diarra Kamara at the position of Communication and Social Mobilization Advisor.
- ✓ Deputy Communication AdvisorMr. Mohamed Toure has resigned in 2011 from the Deputy position.

Section 5: Lessons Learned and Success Stories

Box 1: From Dialogue to Action

Pastor Ballo of the Evangelic Church of Diema is fighting malaria in jail settings.

During our field visit, we met with CSRef team, World Vision field staff and jail guards. All of them acknowledged the active role played by Pastor Ballo of the Evangelic Church in fighting malaria in jail settings, making protedted jail pensionaries.

All of them raised and confirmed Pastor's availability and determination to fulfill his commitment towards jail pensionaries in term of malaria prevention.

During the first year of his involvement, working with the CSRef, he was able to provise LLIN to each pensionary. This year, he did the same action with World Vision and provided 77 LLINs to the pensionaries of diema jail settings. We even saw them during our visit.

When interacting with Pastor Ballo, he declared to be really convinced of the benefits of the community dialogue approach, and is the main reason for his involvement in preventing malaria in jail.

Pensionaries and their guards are grateful forPastor's action, interest and involvement.

Box 2: "Campaign for the Promotion of CSCOM Ciwara d'Or in Dioumatene

The follow up of the campaign for the promotion of the CSCOM Ciwara d'Or indicates that health indicators are still improving. Indeed, data collected before and 3 months after campaign shows a real improvement in 3 indicators related to seeking cares, immunization VAT 2+, and assisted deliveries. In the other hand, indicators related prenatal care, contraceptive prevalence, and vaccination Penta 3 slightly declined.

The ASACO President and the Deputy Mayor are really grateful to the support and contribution of the USAID Health Keneya Ciwara Program. During more than 9 years, the program has not only enhanced the ASACO's capacity for good governance but provided appropriate support to offer quality and even excellent services to communities.

Cheikna Traoré, ASACO President stated: "Being personally involved from the onset of the quality process in Dioumatene, I can really appreciated progress made by ASACO members as well as the Community Health Center staff. We were able to identify our strengths and weaknesses, identified strategies for improvements and how to maintain high standards. Using PKC II's tools and methodology, we were able to initiate fruitful dialogues with communities in order to tackle challenges and lift bottlenecks for providing quality services. On behalf of all stakeholders, I am engaging to get involved, relays, women and men of our community to increase the CSCOM attendance, and to improve the indicators which did not progress well. Men should be greatly involved in making sure that children and women are seeking timely and appropriate services from the health centers. Men should even carry their children to the health center. I acknowledge that difficulties and challenges are still ahead, but we will face them in order to continue to deserve the label of Ciwara d'Or".

Box 3: Traditional Healers in the fight against Malaria; success case in the Fana District

After malaria technical training provided by USAID Health Program / Keneya Ciwara II, 20 traditional created an association in order to set up rules and regulations around their acitivity implementation. They have trained to refer without delay malaria cases, mainly malaria severe cases.

Though the Commune's assistance, the association organized an important meeting with attendance of the Deputy Prefet, Commune staff, Guard camp members, health center staff, local radios and all traditional healers of Fana. Major recommendations made from this meeting are as follows:

1. All severe malaria cases should be refered to health centers without delay
2. Radiobrodcasting messages and advertisements from traditional healers should be authorized by a special commission

3. Desobedient traditional healers should be disciplined in line with the adopted rules and regulations.
4. At least a health center staff should attend their meetings.

Box 4: Joined efforts in the fight against malaria at Djidian village

Youth Ambassadors and school director at Djidian village joined their efforts in the fight malaria and achieved tremendous results. Initially focused on the Youth Ambassadors, PKC II team found that the School Director was so involved that he became an Ambassador in this fight.

Indeed, the Youth Ambassador Diallo from Grade 8, trained on the malaria model lesson, went to promote malaria prevention in neighboring households. One of the tough questions he did face was why mosquito could not transmit VIH. With the assistance of his School Director, they came back to the household and replied to this inquiry. Diallo was able to share his new knowledge with his peers.

The school director was so involved, assisting Youth Ambassadors in their mobilization and sentization activities that he became also an Ambassador. He greatly contributed in gaining the label Ciwara d'Or. He devoted time, efforts and resources to organize jointly with Youth Ambassadors, malaria prevention activities in 7 surrounding villages and 6 hamlets closed to Djidian village.

Djidian is one of the three villages visited as a follow up of the Pedagogic Academy Center (CAP = "C*entre d'Académie Pédagogique*") in the district of Kita.

Box 5: From dialogue to Action: Mr Koné Diguibani president of the Community Health Association (CHA)/ ASACO of Kourouba visits households in the area of health to ensure the proper use of LLINs

Following dialogue with community leaders, the President of the CHA of Kourouba in the Health District of Ouelessebougou, is committed to making home visits to households in the village to check LLIN use.

The village of Kourouba, where the CHA is located, has a population of 2150 inhabitants in 307 households. In support of the relay, Mr Koné Diguibani called Khadafi visited 307 households in the village and advised the villagers on the utility and how to attach LLIN.

Testimony of Harouna, the Technical Director of CSCOM, with regard to the impact of the action: "I was surprised by the commitment of the President, I cannot give you numbers, but I can ensure you that its action played an important role in decreasing morbidity due to malaria in the village and in increasing the Antenatal Care (ANC) attendance of pregnant women. It is an opportunity for getting their LLIN".

Box 6: When other initiatives confirm a CSCOM Ciwara d'Or as the best of the health district

Wacoro closed the promotion campaigns of the CSCOM Ciwara d'Or in Zone one.

Located in the health district of Dioila, about twenty kilometers from the health center reference, the Wacoro health area consists of 5 villages covering a population of approximately 16,000 inhabitants mainly composed of Bambara who coexist with Fulani.

During the first roundtable with radio Jamako of Dioila in September 19, 2012, presidents of CHA and quality team supported by the technical director of the CHA and Community Advisor largely explained the process "Ciwara d'Or" and how it was conducted in the health district of Dioila. CHA President said: "In 2006, Wacoro had competed in Keneya Ciwara I. But it was Banco Djebe who had been selected. When the process started this time we were with Nangola. Lessons learned from the first edition and our firm determination to get the label "Ciwara d'Or", allow us to occupy the first place in the final evaluation".

In reality, the dynamics created by this approach since its inception has enabled us to invest more in our center's activities and to better understand our role as an actor. Thus we received the "price taraboré", which is national, in Bamako. This commitment and determination have earned us also to be the site of experimentation initiatives and be among the first beneficiaries of the actions of a Danish structure, Bornefonden, which build for us a vaccination unit and donate a motorcycle ambulance. These direct benefits arising from the Ciwara d'Or status encourage us and motivate us to persevere.

The ongoing promotion campaign gives us the opportunity to be in direct contact with the entire population of the area and share with them prospects, challenges and concerns of the moment. Téguéreni, the women groups which includes 30 women's associations across the rural commune of Wacoro, is also used as an opportunity to involve women in the decision making process and in the proper functioning of the CHA.

Box 7: From Dialogue to Action - the Carter of Fangouné fighting against Malaria

My name is Bilisi Camara, notability and advisor of the village chief of Dampa Diarisso, a village located 08 km from the city of Diéma in the Kayes region. I have 63 years this year, two wives and father of 06 children.

Last December at the invitation of the mayor of Diéma, I participated in dialogue with community leaders of the commune in the fight against malaria. I thank the mayor of Diema and Health Program USAID / Keneya Ciwara II for giving me the opportunity to participate in this forum. I would never have imagined that malaria, a disease that we know and we attribute mostly to other causes (sorcerer, eating food too oily, evil eye ...) is the work of a mosquito. It has created a real snap at my level and I was seriously disturbed the hours that followed the presentation of the Chief Medical Officer on its impact.

So, as a carter, I'm used to transport sick people of my village and surrounding to the health center with a retribution.. Since the community dialogue, I am committed to free transport the sick people with signs of malaria. I informed the village about my decision and reassured that even in my absence; my cart and my horse are available.

From January to May 2012, I was asked several times and I have answered all these solicitations. The three cases that have the greatest impact on me were all children who suffered greatly prior to transport to the center. After care, they all have recovered. So I'm happy to know that each case is carried or can be a life saved.

Frankly, the community dialogue has opened my eyes and I discover that very limited resources can be useful to his neighbor and the fight against malaria. My hope is that other leaders like me are realizing the extent of the plague and are involved in this noble fight.

Box 8: The presenter of the Radio Djitoumou of Ouelessebougou undertakes action and keeps a promise

During the dialogue with community leaders of the rural town of Ouelessebougou that is experiencing strong population growth (37,655 inhabitants) because of its proximity to the capital Bamako (80 km). One of the problems discussed is the crucial quota of 15 women per day for ANC, despite the heavy use of the center by pregnant women. To tie the detection of cervical cancer with ANC visits, the health team has decided to provide services to only 15 pregnant women per day during the ANC visits.

Thus Kadiatou Diawara who represented radio Djitoumou in the forum for the fight against malaria has made a commitment to organize radio programs to raise awareness among policy makers in the community about the risks it represents. The organization of these radio emissions with testimonies of women victims of fact in support and advocacy or calls by women leaders associated with this action, have helped lifted the quota for the ANC in the central Community Health Center of Ouelessebougou. Even if the Technical Director of the Centre explained that the quota was related to the coupling of ANC with the detection of cervical cancer.

"I participated in the dialogue with community leaders of the town at the invitation of the mayor and Programme Keneya Ciwara II. To increase the number of pregnant women who should benefit from ANC visit, I decided to use my role as a woman leader with access to modern means of communication to denounce this situation. At the beginning the health staff was unhappy, but at the end this unfair measure was totally lifted. Our sisters and their companions are now delighted to have full access to the ANC services".

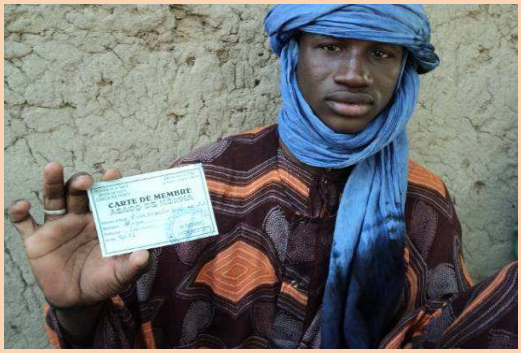
Box 9: Collaboration between ASACO and Commune can yield financial resources and ownership

Strong relationship between Community Health Association (ASACO) and Commune through the Mutual Assistance Agreement (MAA) is used as means for generating financial resources, community ownership and improvement of health services utilization. In the Konna Community Health Center (CSCOM) in the Mopti Region, through the collaboration between ASACO and Commune, financial mobilization and community ownership have been greatly improved.

Indeed, based on this collaboration, the Konna Commune granted to ASACO $400 USD for community mobilization on health services ownership and utilization in terms of prenatal and post natal care, delivery, care seeking, and referral at CSCOM level. Through this health service promotion, ASACO was able to drastically increase the number of CSCOM users. ASACO has been able to sell 181 membership cards at the cost of $2/card. The Health Officer in charge of the

CSCOM stated that the attendance rate and the number of deliveries at health center have greatly increased. The card owners are quickly treated and are eligible to benefit for cost reduction.

In line with its mandate, USAID/Keneya Ciwara II has not only strengthened the capacities of ASACOs to improve the administrative and financial management of CSCOMs, but also initiated the collaboration between ASACO and Commune through the signed Mutual Assistance Agreement. The ultimate goal of this agreement is to enhance the financial mobilization and CSCOM ownership by communities. Therefore, communities are proud to increase the access and use of quality health services.



New CSCOM card owner originated from Ninga village to the Konna ASACO

Box 10: Fighting MSM Stigmatization to prevent STI and HIV/AIDS Dissemination

The growing fear of stigmatization makes though for MSMs to openly express their sexual status. Indeed, culturally and from religious point of view, men having sex with men is classified as sin. Malian families and communities are strongly against the MSM phenomenon and have created stigmatization environment. Homophobia stems from deep rooted cultural beliefs and values where heterosexism is centered on the community ideals.

Homosexuals are stigmatized, denied of health care, and are victims of harassment and hate crimes. The primary consequence of the stigmatization is the spread of STI and HIV/AIDS among MSM community in particular and the sexually active population in general. The HIV/AIDS prevalence rate among MSM population is 27.6% (37 out of 134, through CESAC survey conducted in 2007), very higher as compared to the overall sexually active population (1.3%, ISBS, 2006). Sexually active homosexual and bisexual men with multiple partners are at increasing risk for getting HIV/AIDS. Mali like many South Sahara African countries is dealing with major social issues caused by the stigmatization of homosexuals and people living with HIV/AIDS. A great deal of these issues is perpetuated by ignorance and lack of politics focusing in homosexual communities.

MSM and people infected with HIV/AIDS are also facing difficulties receiving treatment in health facilities because health workers discriminate against them, provide poor care, talk to them in demeaning manners and even denying them treatment.

Government, private institutions, civil society organizations, local and international NGOs and donors, are fighting MSM stigmatization to prevent STI and HIV/AIDS dissemination. Through USAID funding, CARE/Keneya Ciwara II Health Project is intensifying interventions towards MSM stigmatization reduction. Advocacy interventions are conducted towards community and civil society organizations (local NGOs and CBOs) in order to facilitate their buy in into the fight against MSM stigmatization.

The risk of stigmatization is the spread of STI and HIV/AIDS among MSM population. However, until the Malian government health care, law enforcement, and popular culture take active steps to end the stigmatization associated with HIV/AIDS and homosexuality, there will be no progress against the discrimination. The following two examples demonstrate how appropriate information can facilitate people involvement in the fight against stigmatization.

The material stock manager of "Batimat" located in the same building with local NGO SOTOURA, was reluctant to see MSM people seeking health services within the NGO clinic. He was uttering severe insults towards the HIV/AIDS clinic service beneficiaries. He even introduced process to withdraw the NGO from this compound. However, when the NGO Manager and Keneya Ciwara (PKCII) staff explained and gave reliable information with regard to the objectives in providing services to MSM population, he became an active promoter and defender of MSM. Through his involvement, he is contributing to reduction of the spread of STI and HIV/AIDS. SOTOURA NGO is focusing on AIDS prevention, treatment, care, support,

and ensuring to MSM their human rights protections in legislation and policies on HIV/AIDS. (SOTOURA NGO, quarterly report, 2012).

A young MSM was denied from accessing to health services when he declared being MSM and his HIV/AIDS positive status. The health service provider stigmatized the victim and strongly refused to offer services. After sensitization from the SOUTORA NGO Manager and PKCII staff with regards to the outcome of MSM stigmatization, the health service provider became one of the reliable advocates to guiding MSM actions to prevent them from HIV/AIDS. (SOTOURA, quarterly report, 2012).

Box 11: NGO ALPHALOG's Contribution to the STI and HIV/AIDS risk reduction among MSM groups

In Segou city, ALPHALOG did a great job by strengthening the capacity of 60 MSM for preventing them from contracting STI and HIV/AIDS. Indeed, 30 Studiants, identified as MSM were sensitized and supervised by the Physician of Darsalam Health Center. During the routine consultation within two schools, the physician has noticed that several studiants have contracted ano rectal STI. By creating a friendly and confidential working environment, studiants have been able to share their MSM status. Most of these studiants were engaged in prostitution as a means to make money and fight their poverty.

MSM HIV+ or with STI get ARV or appropriate STI medication. Physician reinforces their negotiation skills and promotes the use of condom as means of prevention. As tremendous results: 60 trained MSM declared systematic use of condoms and lubricants during their sexual intercourse; moreover 186 MSH went through the HIV testing and know their status.

Box 12: Making the Relays more Effective

Relays are useful players in the health system, but they work much more, and more effectively with close supervision. This indicates that CSCOM staff or ASACO members will have to take on supervision of the relays, even after the project ends to ensure continuity. Relays are volunteers to assist families in performing essentially healthy practices. Taking into consideration that volunteerism is different from free of charge or gratis, it can sometimes be difficult to motivate relays to prioritize health education activities. It is important to find ways to motivate them.

Moreover, finding literate relays and having a gender balance among the relays are very challenging. Relays who are illiterate often have difficulties in using the provided forms for recording information. Additionally, relays in some areas have begun to organize themselves into syndicates, an act which has had both positive and negative effects. It does allow the relays to be more organized and work together for activities, but it has also led to some groups of relays demanding cash payment for their work.

Finally, very urban areas, such as Bamako and regional capitals, are not especially conducive to the relay system as a form of communication. Urban communities are larger and less cohesive than small villages, and the relays have less success there. Future projects should develop different methods for urban area communication.

Box 13: Community Health Association (ASACO), key player for CSCOM Management and Good Governance

Mali was one of the first countries to open its health system to private community-based and NGO-based health care. The Ministry of Health, in the context of the Bamako Initiative, authorized the creation of the country's first health center managed entirely by the community, through a Community Health Association (ASACO). Mali is proud of the more than 900 community centers (CSCOMs) that have been opened since that time in nearly every part of the country under an aggressive policy to expand geographic coverage of primary health care. These private, not-for-profits, community-based health associations constitute a unique feature of the Malian health system and form the foundation of the health pyramid.
Keneya Ciwara Project has conducted many activities to ensure the capacity building and institutional growth of ASACOs—the community health associations that manage CSCOMs—training them in new skills and relying on them to carry out important project activities. This allows for better community mobilization, commitment, and ownership over health services. ASACO members do get more involved in activities, and activities run more smoothly when they better understand their roles and responsibilities, and when they have better skills in management and good governance.

Section 6: Recommendations

Quality Improvement of Services through Ciwara d'Or Approach

The Ciwara d'Or Approach should be officially part of the national strategy to promote and reward quality services. This successful approach should be scaled up in all districts throughout Mali. Even districts of the same region should compete and gain the label of quality. Indeed, the Ciwara d'Or initiative has generated much interest and commitment from the communities who seek to make services better in their CSCOMs and win the Gold Ciwara Award referred to as Ciwara d'Or. The implementation of community level quality action plans fosters community ownership of the process and mobilizes resources to support it.

Essential Community Care

The Essential Community Care is defined as integrated preventive, curative and promotional services implemented at the community level to reduce morbidity and mortality at the household and community levels. Health Community Agent (*Agent de Santé Communautaire* = ASC) is playing a key role and creates the relationship between communities and CSCOMs. By providing care at the household and community level, ASCs are performing a tremendous job and this should continue.

Collaborative Approach

The main objective of the "collaborative approach" is to increase the capacity of health providers at CSCOM to adhere to the norms and standards in the implementation of quality maternal and neonatal services. As highlighted in this report, this is greatly contributing to the reduction of maternal and neonatal morbidity and mortality and thus critical that the approach continues to be promoted by health actors in Mali.

Integrating Health, WASH, and Nutrition Programming

The upcoming USG projects should continue to promote and support healthy households and communities by creating and delivering interventions that lead to improvements in access, practices, and health outcomes related to nutrition, water supply, sanitation, and hygiene.

Collaboration and Coordination

Project impact can be maximized greatly through strategic collaboration, coordination and integration with all relevant stakeholders, hosting implementing partner group (IPG) meetings with other USG implementing partners, Government of Mali, UN organizations, and civil society.

Section 7: Key Indicators

Evolution of Key Indicators						Total
Key indicators	**FY2009**	**FY2010**	**FY2011**	**FY2012**	**FY2013**	
MALARIA						
Household with LLINs visited by community relais	-	-	1 817 771	1 902 993	562 541	**4 283 305**
Children with fever referred to health facilities by community relais	-	-	38 293	25 806	11 222	**75 321**
Children with fever referred to health facilities by traditional Healers	-	-	2 630	2 102	1 256	**5 988**
FAMILY PLANNING						**-**
Health education talks were organized by relais	-	25 947	937 387	169 081	44 738	**1 177 153**
New acceptors of FP methods registered through CBD activities by relais at household level.	-	-	17 816	9 510	2 875	**30 201**
CHILD HEALTH						**-**
Health education talks on the three washing (hands, month, and eyes) organized by relais at household level.	-	25 947	937 387	169 081	44 738	**1 177 153**
Households reached by relais for aquatabs promotion and distribution.	13 154	13 963	4 584	1 883	33 584	**67 168**
STD/HIV/AIDS						**-**
Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results (PEPFAR Output - #P11.1.D).	4 662	3 503	4 762	6 498	9 233	**28 657**
Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required (PEPFAR Output - #P8.1D)*.	163 944	315 041	283 128	132 815	58 412	**953 340**
Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required.	7 687	57 497	84 606	99 091	59 159	**308 040**
Number of condoms distributed with USG-funds	-	631 503	1 877 654	754 909	158 210	**3 422 276**

2. Key Targets

Level	Indicator	Description	Target group	Cumulative Target				Cumulative Result			
				Y1	Y2	Y3	Y4-5	Y1	Y2	Y3	Y4-5
6	Ciwara d'Or accreditation	CSCOM services and operations comply with standards defined in quality improvement action plan	40 CSCOM	25% (10)	25% (10)	25% (10)	25% (10)	32.5% (13/40)	52.5% (21/40)	85% (34/40)	
5	Ciwara d'Or process	Nominees selected for Cd'Or accreditation, quality improvement committee formed, quality assessment conducted, quality improvement action plans elaborated, implemented and progress monitored	664 CSCOM	20% (133)	30% (199)	45% (299)	50% (332)	4,6% (44/953)	15,8% (105/664)	22,44% (149/664)	
3	Relais operational sustainability	Relais trained, equipped, supervised and supported by ASACO and CSCOM with all basic operational costs (transport means, visual aids, supervision) of the	25100 CSCOM	20% (5021)	30% (7531)	40% (10041)	45% (11250)	34,76% (8724)	66,47% (16 686)		

Level	Indicator	Description	Target group	Cumulative Target				Cumulative Result			
				Y1	Y2	Y3	Y4-5	Y1	Y2	Y3	Y4-5
		relais work covered by ASACO's budget									
2	ASACO maturity	ASACO complies with standard criteria of institutional maturity as defined by PDI self assessment tool	664 CSCOM	20% (133)	25% (166)	30% (199)	35% (232)	6,61% (63/953)	30,87% (205/664)	39,02% (254/651)	62,45% (346/554)
1	PDI training cycle completed	ASACO management committee has completed all training modules proposed by GPSP for the institutional development of ASACO	664 CSCOM	40% (266)	100% (664)			99,89% (952/953)	100% (664/664)		

Location by category, age and sex of those reached by the BCC activities in STI / HIV / AIDS (October 2011 - September 2012)

	Désignation	MSM		Total	Others				Total	Together				Total général
		Men			Men		Women			Men		Women		
MSM	Age groups	10-14 ans	15 ans et +		10-14 ans	15 ans et +	10-14 ans	15 ans et +		10-14 ans	15 ans et +	10-14 ans	15 ans et +	
	Number of individuals seen for the first time	97	7990	8087	0	1453	0	1148	2601	97	9443	0	1148	**10688**
	Number of individuals seen more than once	92	18416	18508	0	1823	0	1214	3037	92	20239	0	1214	**21545**
	Total	**189**	**26406**	**26595**	**0**	**3276**	**0**	**2362**	**5638**	**189**	**29682**	**0**	**2362**	**32233**
		SW			Others					Together				
		Women			Men		Women			Men		Women		
SW	Number of individuals seen for the first time	497	19032	19529	373	8705	91	1165	10334	373	8705	588	20197	**29863**
	Number of individuals seen more than once	832	56087	56919	375	12513	101	3271	16260	375	12513	933	59358	**73179**
	Total	1329	75119	76448	748	21218	192	4436	26594	748	21218	1521	79555	**103042**
		GR			Others					Together				
		Men			Men		Women			Men		Women		
GrR	Number of individuals seen for the first time	**57**	**4246**	**4303**	**18**	**723**	**23**	**689**	**1453**	**75**	**4969**	**23**	**689**	**5756**
	Number of individuals seen more than once	**108**	**9610**	**9718**	**13**	**806**	**36**	**1249**	**2104**	**121**	**10416**	**36**	**1249**	**11822**
	Total	**165**	**13856**	**14021**	**31**	**1529**	**59**	**1938**	**3557**	**196**	**15385**	**59**	**1938**	**17578**

		PV/VIH			Others					Together				
		Men			Men		Women			Men		Women		
PEOPLE LIVING WITH HIVMen	Number of individuals seen for the first time	0	2898	2898	0	0	0	0	0	0	2898	0	0	2898
	Number of individuals seen more than once	0	1733	1733	0	0	0	0	0	0	1733	0	0	1733
	Total	0	4631	4631	0	0	0	0	0	0	4631	0	0	4631
		PV/VIH			Others					Together				
		Women			Men		Women			Men		Women		
PEOPLE LIVING WITH HIVFemes	Number of individuals seen for the first time	0	7451	7451	0	0	0	0	0	0	0	0	7451	7451
	Number of individuals seen more than once	0	3669	3669	0	0	0	0	0	0	0	0	3669	3669
	Total	0	11120	11120	0	0	0	0	0	0	0	0	11120	11120
		Together			Others					Together				
		Cibles			Men		Women			Men		Women		
Together	Number of individuals seen for the first time	651	41617	42268	391	10881	114	3002	14388	545	26015	611	29485	56656
	Number of individuals seen more than once	1032	89515	90547	388	15142	137	5734	21401	588	44901	969	65490	111948
	Total	1683	131132	132815	779	26023	251	8736	35789	1133	70916	1580	94975	168604

Location by category, age and sex of those reached by the CCC activities in STI / HIV / AIDS (October 2012 – June 2013)

	Désignation	MSM		Total	Others				Total	Together				Total général
		Men			Men		Women			Men		Women		
MSM	Age groups	10-14 ans	15 ans et +		10-14 ans	15 ans et +	10-14 ans	15 ans et +		10-14 ans	15 ans et +	10-14 ans	15 ans et +	
	Number of individuals seen for the first time	60	1620	1680	0	519	0	769	1288	60	2139	0	769	2968
	Number of individuals seen more than once	308	15121	15429	0	1188	0	1027	2215	308	16309	0	1027	17644
	Total	368	16741	17109	0	1707	0	1796	3503	368	18448	0	1796	20612
		SW			Others					Together				
		Women			Men		Women			Men		Women		
SW	Number of individuals seen for the first time	127	8060	8187	82	2057	43	1881	4063	82	2057	170	9941	12250
	Number of individuals seen more than once	460	43270	43730	169	4872	74	4126	9241	169	4872	534	47396	52971
	Total	587	51330	51917	251	6929	117	6007	13304	251	6929	704	57337	65221
		GR			Others					Together				
		Men			Men		Women			Men		Women		
GR	Number of individuals seen for the first time	80	4311	4391	4	725	54	542	1325	84	5036	54	542	5716
	Number of individuals seen more than once	525	9053	9578	7	512	186	972	1677	532	9565	186	972	11255
	Total	605	13364	13969	11	1237	240	1514	3002	616	14601	240	1514	16971

		Together			Others					Together				
		Cibles			Men		Women			Men		Women		
Together	Number of individuals seen for the first time	267	13991	14258	86	3301	97	3192	6676	226	9232	224	11252	20934
	Number of individuals seen more than once	1293	67444	68737	176	6572	260	6125	13133	1009	30746	720	49395	81870
	Total	1560	81435	82995	262	9873	357	9317	19809	1235	39978	944	60647	102804

Annexes

Annex 1: USAID PMP targets and results

Prog. element	Indicator	IP reporting	Geog. focus	FY2009	FY2010	FY2011	FY2012	FY2013	Total
HIV/AIDS	Number of individuals who received testing and Counseling (T&C) services for HIV and received their test results (S)	PKC II	National	4 662	3 503	4 762	6 498	9 233	**28 657**
	Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required (S)	PKC II	Target areas	163 944	315 041	283 128	132 815	58 412	**953 340**
	Number of condoms distributed (C)	PKC II	National	-	631 503	1 877 654	754 909	158 210	**3 422 276**
	Number of contacts with prevention interventions by members of the targeted Most At Risk Populations and other populations (C)	PKC II	National	201 278	79 372	50 954	168 604	102 804	**603 012**
	Number of cases treated for Sexually Transmitted Infection (STI) (C)	PKC II	Target areas	-	6 238	3 472	6 536	6 479	**22 725**
	Number of targeted service delivery points for commercial sex workers (CSW) with available STI services by 1000	PKC II	Target areas	1,76	1,76	1,76	1,76	1,76	**9**

Prog. element	Indicator	IP reporting	Geog. focus	FY2009	FY2010	FY2011	FY2012	FY2013	Total
	CSW (C)								
CROSS CUTTING	Number of policies or guidelines documents developed or updated with USG-assistance to improve access to and use of high impact health services (C)	PKC II	National			7			**7**
	Number of people trained with USG assistance (C)	PKCII/VHI	36 districts	454	484	390	602	-	**1 930**
		PKC II/OTHER	36 districts	-	-	12 622			**12 622**
	Value of expenditures in basic health services by Communes (C)	PKC II	National						**-**
MCH/FP/RH	Number of community-based organizations (ASACOs) supported with assistance from USG (C)	PCK II	36 districts	-	953	664	664	554	
	Number of health care providers trained in FP/RH with USG funds (C)	PCK II	National			507			**507**
	Number of ASCs trained in FP/RH with USG funds (C)	PCK II,	National			313			**313**
	Number of "relais" trained in FP/RH with USG funds (C)	PCK II	National	-	-	12 622			**12 622**

Sources: PKC II Consolidated Five Year Report (October 2008 to June 2013)

NGO partners PKC-II (2008-2013)

ONG partners	Intervention area	Number of ASACO covered for the community component/Sites covered HIV
ONG partenaires Volet Communautaire (2008-2013)		
AMADECOM	Kayes	56
APROFEM		35
ASDAP	Koulikoro	100
ACOD	Sikasso	149
APROMORS	Tombouctou	68
ONG partenaires Volet VIH (2008-2013)		
ARCAD	Bamako, Kayes, Sikasso, Ségou et Mopti	**Bamako :** les 6 communes du District de Bamako, Hall de Bamako (Clinique nocture) **Kayes (visite pour dépisatge avec le car médicalisé).:** Kayes(ville), Sadiola, Diboli ; **Ségou** (ville) ; **Sikasso** (ville) **Mopti** (ville)
SOUTOURA	Bamako	les maisons closes des communes I, II, III, IV, V, VI
OMADECOS	Kayes	Sadiola, Yattéla, Loulo
CLUEDUCA	Sikasso	Districts de Fourou, Kadiolo, Sikasso et Zégoua
CARD	Gao	Ansongo, Labézanga
ONG partenaires Volets Communautaire et VIH (2008-2013)		
ALPHALOG	Ségou	93
		Ségou et San
AMPRODE	Mopti	77
		Sévaré,
JIGI	Bamako et Koulikoro	55
		Commune IV : gares de Médine et de Djikoroni Para, le marché de sable de Djikoroni –Para

NGO partners PKC-II PKC-II (2008-2011)

Locality	Sites	NGO	Sites covered by NGO
Bamako	gares de Médine et de Djikoroni Para, les maisons closes, le marché de sable de Djikoroni –Para et de Kalabankoro, les postes de contrôle de Sénou et de Niamana, les arrêts de Gros porteurs de Faladié et les principaux arrêts des SOTRAMA des Communes I et II	**JIGI**	Commune IV : gares de Médine et de Djikoroni Para, le marché de sable de Djikoroni – Para
		SOUTOURA	les maisons closes des communes I, II, III, IV, V, VI
		ADES	Les principaux arrêts des SOTRAMA de bus et gares des Communes I et II
		AMIFA	Commune VI : les postes de contrôle de Sénou et de Niamana, les arrêts de Gros porteurs de Faladié, marché de sable Kalabankoro
		ADPS	Axe : Sénou, Banankoro, Sanankoroba, Dialakoroba,
Kayes	Kita, Sadiola, Yattéla, Diéma , Loulo, , Diboli	**OMADECOS**	Sadiola, Yattéla, Loulo
		APPF	Kita , Diboli,
Koulikoro	Ouélésséboungou, Kangaba, Kourémalé, Bancoumana,	**ADPS**	Diéma
		JIGI	Kangaba, Kourémalé, Bancoumana,
Ségou	Niono, Dougabougou, Siribala, , San , Bla, Markala	**WALE**	Niono, Dougabougou, Siribala, Markala
		CERDEPE	San, Bla
Sikasso	Bougouni, Karangana Faraguaran, Koumantou, Sanso, Kadiolo, Zégoua, Fourou, Koutiala, et Koury	**ADAP**	Koury, Koutiala, Karangana
		CRADE	Bougouni, Sanso, Koumantou
		CLUEDUCA	Kadiolo, Zégoua, Loulouni, Fourou
		ASAME	Niéna, Heremakono
		GARDEM	Koutiala,
Mopti	Sévaré, Bandiagara, Koundialan, Bankass,	**AMPRODE**	Sévaré,

Locality	Sites	NGO	Sites covered by NGO
	Dialassagou, Koro	**GAAS Mali**	Bandiagara, Koundialan, Sangha
		Consortium -le Sahel	Bankass, Dialassagou, Koro
Gao	Ansongo, Labézanga	**CARD**	Ansongo, Labézanga