

**AGENCY FOR INTERNATIONAL DEVELOPMENT**  
**PROJECT DATA SHEET**

1. TRANSACTION CODE:  A = Add,  C = Change,  D = Delete. Amendment Number: 91688. DOCUMENT CODE: 3. ORIGINAL

2. COUNTRY/ENTITY: MALI

3. PROJECT NUMBER: 688-0270

4. BUREAU/OFFICE: AFRICA  5  5. PROJECT TITLE (maximum 40 characters): AIDS/STD AWARENESS AND PREVENTION

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM DD YY 09/30/01

7. ESTIMATED DATE OF OBLIGATION (Under 'B' below, enter 1, 2, 3, or 4): A. Initial FY 94, B. Quarter 4, C. Final FY 01

8. COSTS (\$000 OR EQUIVALENT \$1 = 500 CFA)

A. FUNDING SOURCE	FIRST FY <u>94</u>			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	( 1,447 )	( 680 )	( 2,127 )	( 5,536 )	( 4,463 )	( 10,000 )
(Loan)	( - 0 - )	( - 0 - )	( - 0 - )	( - 0 - )	( - 0 - )	( - 0 - )
Other U.S. 1.						
U.S. 2.						
Host Country		32	32		225	225
Other Donor(s)						
<b>TOTALS</b>	<b>1,447</b>	<b>712</b>	<b>2,159</b>	<b>5,536</b>	<b>4,688</b>	<b>10,225</b>

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) DFA				- 0 -		2,127		2,127	- 0 -
(2) ST						7,823		7,823	
(3)									
(4)									
<b>TOTALS</b>				<b>- 0 -</b>		<b>10,000</b>		<b>10,000</b>	<b>- 0 -</b>

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY PURPOSE COD

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code

B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

TO LIMIT THE SPREAD OF HIV INFECTION IN MALI

14. SCHEDULED EVALUATIONS: Interim MM YY 03/97, Final MM YY 06/01

15. SOURCE/ORIGIN OF GOODS AND SERVICES:  000,  941,  Local,  Other (Specify) 935

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a \_\_\_\_\_ page PP Amendment.)

17. APPROVED BY: Signature Joel E. Schlesinger, Title Mission Director, Date Signed MM DD YY 09/27/01

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

**AIDS AND SEXUALLY TRANSMITTED DISEASE AWARENESS AND  
PREVENTION IN MALI  
688-0270**

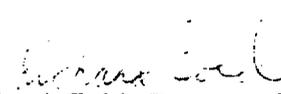
**PROJECT PAPER**

**September 1994**

**UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT  
B.P. 34, BAMAKO, MALI**

## ACTION MEMORANDUM FOR USAID MALI MISSION DIRECTOR

September 26, 1994

  
From: Richard Gold, Program Officer

**Action Requested:** You are requested to authorize the AIDS and Sexually Transmitted Disease Awareness and Prevention Project Paper (688-0270) for life-of-Project funding of \$10.0 million and a Project Assistance Completion Date of September 30, 2001.

**Background:** This is a new project. However, its design draws upon and applies the considerable experience of two regional USAID AIDS projects: AIDS Technical Support (698-0474) and AIDS Control and Prevention (936-5972). USAID Mali has a buy-in with the latter project. The lessons these projects impart are that: 1) the spread of the human immunodeficiency virus (HIV) can be prevented on a limited basis; 2) increased demand for and access to condoms has been a key element of success to date; 3) non-governmental organizations and private voluntary organizations are crucial collaborators in program implementation; 4) diagnosing and treating sexually-transmitted diseases plays a major role in HIV prevention; 5) more knowledge is needed about how to effect changes in sexual behavior, especially in Africa; and 6) a multifaceted, multi-sectoral approach is needed to enact the needed change in individuals and in societies. Funding under the AIDS Control and Prevention Project has been used to support activities in 11 priority countries in Africa.

**Purpose:** AIDS and Sexually Transmitted Disease Awareness and Prevention will be a seven-year grant project. It represents USAID's assistance to the Republic of Mali's second Medium Term Plan for HIV and AIDS Prevention and Control. Its purpose is to limit the spread of HIV. This will be accomplished by raising the awareness of techniques for the prevention of AIDS, HIV and sexually-transmitted diseases and expanding the delivery of services for sexually-transmitted diseases, thereby reducing HIV transmission and improving sexually-transmitted disease case management and reporting. USAID's contribution to the Project is \$10.0 million, which the Host Country Contribution will augment by \$225,000. The 25 percent Host Country Contribution requirement was waived per an Action Memorandum for the Deputy Assistant Administrator for Africa signed and dated 16 August 1994.

USAID project assistance includes three interrelated elements: sexually-transmitted disease control; AIDS awareness and condom promotion for behavioral change; and policy development and coordination.

**Discussion:** The USAID Mali Project Design Committee met June 15, 1994 to discuss the draft Project Paper. The major decisions of this meeting were to make a grant to Plan International instead of entering into a Cooperative Agreement; to include more specific milestone indicators than simply condom sales; to lengthen the period of work within Mali for the long-term sexually-transmitted disease experts; and to make minor textual changes

and clarifications in the text (e.g., noting that the Futures Group is undertaking a market survey of condom pricing in rural areas that will be used to determine condom pricing structures). These decisions were subsequently incorporated into the Project Paper. On July 5, 1994, the Committee presented the Project Paper to the Acting Mission Director. The main decision of this meeting was to add a Program Manager to the Project personnel, which was incorporated into the document.

Pursuant to a September 14, 1994 follow-up meeting between the Director, the Health Division and the Program Office, the Project Paper and the Grant Agreement have incorporated USAID intentions to make AIDS interventions more comprehensive and national in scope. USAID will do this through organizing and coordinating coherently with other actors in the private, not-for-profit and social sectors (e.g. religious organizations and clubs), and with the Government of Mali. USAID envisions the latter's role as a policy setter, information clearing house and coordinator but not a major implementor of AIDS interventions. Also, the definition of this project's sustainability was included; the decision to hire a Malian Project Manager after the present one leaves was included; the goal and purpose statement were related more closely; a sentence was removed concerning free care for AIDS patients; and areas of policy inquiry (e.g. provision of counselling services, essential medicine bidding procedures, orphans) were identified as areas for further Mission consideration.

**Justification:** The Mission Director has been granted the authority to approve this Project Paper per STATE 195334 dated July 21, 1994.

Budget allowances totalling \$2,127,000 were received in STATE 095381, dated April 12, 1994.

USAID Mali was informed in STATE 114267, dated April 30, 1994 that the Congressional Notification expired on March 25, 1994 and will not require additional notification provided that total 1994 obligations do not exceed \$2.250 million.

The Initial Environmental Examination recommended a negative Environmental Threshold Decision per categorical exclusion per 22 CFR 216.2(c) viii. USAID Washington approved and concurred with this decision June 27, 1994.

The requirement stipulated by Section 110 of the Foreign Assistance Act (25 percent Host Country Contribution) was waived by the Deputy Assistant Administrator for Africa in an Action memorandum dated 16 August 1994.

**Recommendation:** That you approve the Project Paper for AIDS and Sexually Transmitted Disease Prevention and Awareness for \$10.0 million with a Project Assistance Completion Date of September 30, 2001.

Approved: *Jane H. Blumson*

Disapproved: \_\_\_\_\_

Date: 9/27/04

Attachments:       Project Paper  
                          Project Authorization  
                          Project Grant Agreement

## PROJECT AUTHORIZATION

Name of Country: Mali

Name of Project: AIDS and Sexually Transmitted Disease Awareness and Prevention

Number of Project: 688-0270

1. Pursuant to Section 496 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the AIDS and Sexually Transmitted Disease Awareness and Prevention Project (the "Project") for The Republic of Mali (the "Cooperating Country"), involving planned obligations not to exceed Ten Million Dollars (US \$10,000,000) in grant funds (the "Grant") over a seven-year period from the date of authorization, subject to the availability of funds in accordance with the USAID Operating Year Budget and Allotment process, to help in financing foreign exchange and local currency costs for the Project. The planned life of the project is seven years from the date of initial obligation.
2. The Project consists of assistance to improve the quality of life of Malians by limiting the spread of HIV infection. The Project will strengthen systems for controlling sexually transmitted diseases, encourage safer sexual behavior and strengthen the National AIDS Control Program. It will accomplish these purposes through training; operations research; and policy development, dissemination and implementation.
3. The Project Grant Agreement, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with USAID regulations and Delegations of Authority, shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as USAID may deem appropriate.
4. a. Source/Origin of Commodities, Nationality of Services
  - (1) Commodities financed by USAID under the Project shall have their source and origin in countries included in USAID Geographic Code 935, except as USAID may otherwise agree in writing.
  - (2) The suppliers of commodities and services financed by USAID under the Project shall have as their place of nationality countries included in USAID Geographic Code 935, except as USAID may otherwise agree in writing.
  - (3) Ocean shipping under the Project shall, except as USAID may otherwise agree in writing, be financed only on flag vessels of the United States or of countries included in USAID Geographic Code 935.

b. Conditions Precedent to First Disbursement

Prior to any disbursement, or to the issuance of any commitment documents under the Project Grant Agreement, the Cooperating Country shall, except as the Parties may otherwise agree in writing, furnish to USAID in form and substance satisfactory to USAID:

- (1) An opinion of counsel acceptable to USAID that the Project Grant Agreement has been duly authorized and/or ratified by, and executed on behalf of, the Grantee, and that it constitutes a valid and legally binding obligation of the Cooperating Country in accordance with all of its terms;
- (2) A statement of the name of the person holding or acting in the office of the Grantee specified in Section 8.2 of the Project Grant Agreement, and of any additional representatives, together with a specimen signature of each person specified in such statement;
- (3) Evidence of the establishment of a separate bank account to deposit all Grant funds received from USAID for the Project.



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Joel E. Schlesinger  
Director, USAID/Mali

9/27/04

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Date

ACTION: AID-2 INFO: AMB DCM ECON

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DIST: AID

JUL 22 1994

AIDAC, ABIDJAN FOR REDSO/WCA, REGIONAL LEGAL ADVISOR

E.O. 12356: N/A

TAGS:

SUBJECT: MALI AIDS AWARENESS AND PREVENTION, AD HOC  
DELEGATION OF AUTHORITY (DOA)

REF: (A) BAMAKO 04635 (B) STATU 035500

THE DIRECTOR, USAID/MALI (OR THE PERSON ACTING IN THAT CAPACITY) IS HEREBY DELEGATED THE AUTHORITY TO APPROVE THE PROJECT IDENTIFICATION DOCUMENT (PID)/PROJECT PAPER (PP) AND AUTHORIZE THE MALI AIDS AWARENESS PROJECT (699-0270), IN ACCORDANCE WITH AFR DELEGATION OF AUTHORITY (DOA) 551, IN AN AMOUNT NOT TO EXCEED (NTE) LIFE-OF-PROJECT FUNDING OF USDOLS 10 MILLION.

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U.S. AGENCY FOR  
INTERNATIONAL  
DEVELOPMENT

ACTION MEMORANDUM FOR THE DEPUTY ASSISTANT ADMINISTRATOR FOR  
AFRICA

FROM:

*William C. Darlene*  
AFR/WA Lucretia Taylor

SUBJECT: Mali AIDS and Sexually Transmitted Disease  
Awareness and Prevention Project (688-0270):  
Waiver of the Host Country Contribution

Problem: Your approval is requested to waive Section 110 of the Foreign Assistance Act of 1961, as amended (FAA), which requires a host country contribution of at least twenty-five (25) percent of the total costs of the AIDS and Sexually Transmitted Disease and Prevention Project (688-0270).

Background: USAID/Mali is preparing the Mali AIDS and Sexually Transmitted Disease and Prevention Project Paper which will provide life-of-project funding of \$10 million. The purpose of the Project is to improve life expectancy by limiting the spread of HIV infection. The Project will address the need to arrest one of the most destructive aspects of AIDS which is the death of individuals in the most productive years of their lives. Other West African nations, such as the Ivory Coast, are experiencing an unprecedented number of deaths in a segment of the population normally relatively free of fatal illnesses. If left unchecked, the spread of HIV infection will increase the number of orphans; increase the child mortality rate and the number of new tuberculosis infections; increase the burden on already stressed health care systems; and decrease the pool of skilled and unskilled workers. The impact of these events will seriously undermine the social and economic fabric of Malian society.

Section 110 of the FAA requires that the host country provide a minimum 25 percent contribution to total project costs. The budget for the host country contribution to the subject project totalled \$225,000 for a total life-of-project funding of \$ 10.2 million. This contributes two percent of total project costs. Given Mali's current financial constraints, as discussed below, it is not possible for the Malian Government to meet this requirement.

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Discussion: Heretofore, because funds for purposes and projects for Sahelian countries were made available pursuant to FAA Section 121, the Agency determined that Sahelian countries were not required to meet the host country contribution requirements of FAA Section 110, which by its terms requires a minimum 25 percent host country contribution for assistance made available pursuant to FAA Sections 103 through 106. As a consequence of the repeal of FAA Section 121, and the addition of the new FAA Section 496 (d), the host country contribution requirement is now applicable to Mali and other Sahelian countries.

A.I.D. regulations implementing FAA section 110 and 124 (d) are set forth in A.I.D. Handbook 3, Chapter 2, Appendix 2G, which provides general considerations which should be taken into account in determining when a waiver of FAA Section 110 would be appropriate. Considerations relating to financial constraints, host country commitment, nature of the project, and phased contribution form the basis for such a determination. These items are discussed below.

Financial Constraints: Mali has been reported by the World Bank to be in severe budgetary and balance of payments difficulties. In addition, Mali's need to finance the investment requirements to take advantage of the export and import substitution opportunities arising from the CFA franc devaluation has placed significant pressure on an already difficult balance of payments situation. Since 1982, Mali has been attempting to stabilize its economic circumstances with the assistance of the International Monetary Fund, the World Bank, and other donors including USAID. Although stabilization remains elusive, the Malian Government is implementing policies to restore fundamental conditions in which growth can occur. Also, Mali has recently undergone a major (50 percent) devaluation of its currency, a situation which doubles the CFA franc amount needed to satisfy the 25 percent host country contribution requirement. Notwithstanding French forgiveness of debts connected with the devaluation, Mali still has a national debt of \$1.5 billion, which is approximately 150 percent of the gross domestic product.

Under the structural adjustment program with the International Monetary Fund, the annual budget deficit estimate for 1994 is 15 percent of the gross domestic product, and the requirement to bring it down to 10 percent by 1996 will make it extremely difficult for the Malian Government to find any additional resources to contribute to the subject project beyond the \$225,000 equivalent it is scheduled to contribute. USAID/Mali believes it is appropriate to waive the FAA Section 110 requirement in light of the Malian Government's financial constraints.

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**Country Commitment:** Despite severe financial constraints, the Government of Mali has demonstrated its commitment to the Mali AIDS and Sexually Transmitted Disease Awareness and Prevention Project by making an in-kind contribution of approximately \$225,000; consisting of personnel, office space and transportation to the total costs of the project. But, this contribution constitutes only two percent of the total project costs, a shortfall of 23 percent of the minimum 25 percent host country contribution requirement.

Pursuant to FAA Section 124 (d) and A.I.D. Handbook 3, Chapter 2, Appendix 2G, Section E.2.B, the host country contribution requirement may be waived on a case-by-case basis for relatively least developed countries. Mali is on the most recently issued list of the United Nations General Assembly's relatively least developed countries and is therefore eligible to be considered for the requested waiver. A waiver of contributions to the subject project is justified based on the information provided herein.

**Authority:** A waiver of the host country contribution requirement is permitted under the provisions of FAA Section 124(d). The authority to exercise the waiver has been delegated by the Administrator to, inter alia, the Assistant Administrator for Africa in A.I.D. Delegation of Authority No. 403. Pursuant to Africa Bureau Delegation of Authority No. 550, the Deputy Assistant Administrator for Africa has the alter ego authority of the Assistant Administrator for Africa and may, there, approve the requested waiver.

**Recommendation:** That you approve this request for waiver of the requirement for the Government of Mali to make a minimum 25 percent host country contribution to the Mali AIDS and Sexually Transmitted Disease Awareness and Prevention Project (688-0270).

Approved: Shate Fields

Disapproved: \_\_\_\_\_

Date: August 16, 1994

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## LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
FY	Fiscal Year
GDP	gross domestic product
GNP	gross national product
GRM	Government of the Republic of Mali
HIV	Human Immuno-deficiency Virus
IEC	information, education and communication
NGO	non-governmental organization <sup>1</sup>
PVO	private voluntary organization <sup>1</sup>
STD	sexually-transmitted disease
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development

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<sup>1</sup>For the purposes of this paper, PVO refers to American organizations and NGO refers to non-American organizations.

## EXECUTIVE SUMMARY

Data on Human Immuno-Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) in Mali leave no doubt that infection is spreading at what appears to be an alarming rate and that the situation could deteriorate rapidly as has happened in many other African countries. The first cases of AIDS in Africa were reported in 1983, and the first diagnosed case in Mali in 1985.<sup>2</sup> In 1987, a national HIV prevalence study found rates of one percent to two percent in the general population and 39 percent in prostitutes.<sup>3</sup> By 1993, these rates had risen to five percent in the general population and 55 percent in prostitutes.<sup>2</sup> These results place Mali among the African countries where HIV infection is spreading at an intermediate rate.

Data on other sexually-transmitted diseases (STDs) indicate that they are endemic and that the problem is serious.<sup>4</sup> Taking into account the level of morbidity, and the available infrastructure, Mali ranked highest priority among Sahel countries by the World Bank in 1992 in its assessment of the need for HIV and sexually-transmitted disease interventions.

Without effective action to control the spread of HIV infection, life expectancy at birth will decrease and development of the economy may well be compromised. The goal of this project is to improve the quality of life in Mali and to do so by limiting the spread of HIV infection. As a result of this project, HIV prevalence in the general population will be kept below 7.5 percent and life expectancy at birth for an average Malian will be able to increase to at least 47 years.

Encouragingly, the Malian Government has developed an ambitious five-year strategy to combat sexually-transmitted diseases and HIV, and several large-scale development projects are attempting to reinforce the health infrastructure<sup>2</sup>. USAID is presented with an excellent opportunity to assist Mali and other donor agencies in these efforts at building a national sexually-transmitted disease and HIV control program. The activities proposed under this project support and reinforce activities in the following three key areas of the Government strategy:

- \* the prevention of sexual transmission through improved case management of sexually-transmitted diseases;

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<sup>2</sup> *Plan Strategique 1994-1998, Revision 4*, National AIDS Committee, February 1994

<sup>3</sup> Brun-Vezinet F. et. al., *HIV-I and HIV-II in Mali*, presented at IV International Conference on AIDS, Stockholm, June 1988.

<sup>4</sup> Guindo, Aicha. *Etude de la Prevalance des Principaux Agents Pathogenes Responsables de MST/SIDA dans une Populations de Femmes en Age de Procreer. Une these (1993) pour obtenir le grade Docteur en Pharmacie presentee devant l'Ecole Nationale de Medecine et de Pharmacie, Mali.*

- \* the prevention of sexual transmission through information, education and communication activities aimed at the general population and high risk groups;
- \* effective program coordination and leadership by the National AIDS Committee through activities in the areas of information exchange, policy development and resource mobilization.

Project activities are designed to achieve the following three outputs: improved STD control; changed behavior to reduce the risk of transmitting the HIV virus; and a National AIDS Committee that exchanges information, develops policies and mobilizes resources.

A. Improved STD control

HIV infection is a sexually-transmitted disease (STD). All patients with other sexually-transmitted disease are at risk for HIV infection because the presence of another STD facilitates HIV transmission and the magnitude of this effect is large.<sup>5</sup> Treating STDs will thus directly help prevent HIV infection and will have secondary health benefits for women and children who bear the greatest burden of complications from STD infections.

Improved STD control will be achieved through improved STD case management, improved surveillance and reporting and improved STD institutional capacity at the National AIDS Committee. Three hundred fifty health workers will be trained to use World Health Organization algorithms for syndromic diagnosis and in counselling to prevent infection. Basic STD laboratory equipment will be supplied to all 46 district level health centers. The project will also include a strong operations research component designed to identify the optimal strategies for STD and HIV control in Mali and provide ongoing input to STD case management. Collaboration with organizations supporting the development of an essential drugs supply system is a key component of the project and the essential drugs list will be revised to include first line drugs for all major STDs.

Improved STD surveillance and reporting will be achieved by incorporating syndromic definitions of key STDs into the national health information system; equipping HIV sentinel surveillance sites with STD laboratory equipment; conducting rapid assessment surveys to provide an overall picture of the evolution of STDs in Mali; and the revision of treatment protocols based on information received from the results of operations research.

Improved STD institutional capacity at the National AIDS Committee will be provided through a long-term technical advisor specialized in STD control and by providing long-term training opportunities for two staff members with the requirement that they return and work for the National AIDS Committee afterwards.

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<sup>5</sup>Over M and Piot P. HIV Infection and Sexually Transmitted Diseases, in Dean Jamison and WH Mosley (editors), Disease Control Priorities in Developing Countries. New York: Oxford University Press for the World Bank. 1991.

In the majority of HIV case-finding studies to date in Mali seropositive individuals have not been notified of their results. They have not been counselled to avoid transmission to their partners nor referred for medical care. Partly this is due to the lack of a clear national policy on counselling. Partly it is an expression of the fear of the medical staff in a health system based on curative care and a society where it is a widespread belief that all diseases are believed to have a cure. Training will be given to key health personnel to ensure they have the skills required to notify all seropositive persons of their results and to counsel them as to how to avoid transmitting the disease to their sexual partners. As a result all people undergoing HIV testing in Mali will in the future, be able to receive counselling both before and after the test.

#### B. Behavior Change

Absent a vaccine, behavior change is the only way to avoid acquiring or transmitting HIV. Increased condom use (as measured by sales) is a key indicator that knowledge and awareness about AIDS has resulted in a positive behavior change.

Non-governmental organizations (NGOs) have already demonstrated their ability to reach and to work effectively with rural and urban populations in Mali, to respond to local priorities and to be flexible in their approach. The project will capitalise on these strengths through an expanded and improved NGO program of STD and AIDS information, education and communication activities aimed at the general population and at high risk groups. The project will further support the NGO activities by assisting with strategy and materials development and providing technical training in HIV and AIDS information, education and communication techniques. The project will also address some of the principal weaknesses identified in the local NGO sector and as a secondary objective, it will seek to build up the long-term institutional capacity of the not-for-profit sector in Mali to provide AIDS prevention and awareness activities.

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To ensure that people can act on the information they receive the NGO's will promote community-based marketing of condoms in collaboration with the existing social marketing strategy. This may involve them taking an active role in distribution but is most likely to be through credit and training for enterprise development.

To provide a focus for positive action, NGOs will promote the development of community-based or self-help groups providing long-term counselling and support for seropositive individuals, AIDS sufferers and their families.

#### C. Improved Central Coordination and Policy Development

Tackling the HIV and AIDS epidemic requires a strong program leadership for the mobilization, coordination and appropriate use of international, national and multi-sectoral financial and human resources. The project will provide long and short-term

technical advise and training and institutional support to the National AIDS Committee to assist it to engage in information exchange, policy development and resource mobilization.

A quarterly newsletter on STD and AIDS in Mali will provide a forum for information and exchange for donors, health planners and NGOs. In collaboration with the Government of Mali and the Ministry of Health, clear-cut policies will be developed on HIV and AIDS related counselling, free distribution of condoms and STD prevention and control. Regular meetings of donors and NGOs will be held to improve coordination and the allocation of resources and a series of presentations to policy makers at national and regional levels on the potential socio-economic impact of HIV and AIDS in Mali will increase awareness of and support to the fight against AIDS.

## I. BACKGROUND

### A. Country Setting

#### 1. Political and Economic

In 1994, three years after the overthrow of the 22-year regime of Moussa Traore and two years after the first Presidential elections, the initial mood of optimism that accompanied the introduction of democratic pluralism and freedom of the press in Mali has been somewhat tempered by the harsh economic realities facing the country. Heavily indebted and forced to cut expenditures, the government has been unable to live up to many of the expectations raised during the period of transitional government.

Throughout 1993, various sectors (including traders, doctors and television and radio personnel) engaged in strikes, though often only one or two day stoppages. More serious, were student riots that followed changes in the attribution of grants, culminating, in April 1993 in the resignation of the Prime Minister, Youssouni Toure and his government. The new government formed under Prime Minister, Abdouleye Sekou Sow was notable for the entry for the first time, of members of two of the principal opposition parties. Later in the year the government was reshuffled and the number of Ministers reduced from 22 to 17 as part of an austerity program. Schools finally reopened in November.

Against this background of student unrest, government reshuffles and general dissatisfaction, the much-predicted CFA franc devaluation occurred in January 1994. Despite the long-term benefits devaluation is expected to bring local investment and the export sector, it has come as a harsh blow to Mali's urban population, faced with substantial price increases for transport and many basic foodstuffs and little hope of an equivalent rise in incomes.

Within weeks of devaluation the student movement renewed its claim for increased grants and fresh outbreaks of violence in Bamako led, for the second time in less than a year, to the closure of all educational establishments and the resignation of the Prime Minister. In an attempt to force early elections the majority of opposition party members withdrew from the government.

The strategy however seems to have back-fired on the opposition and calls for a one day general strike in Bamako went unheeded. Whatever hardship people currently face, there seems to be widespread acceptance that given the government has so little room for manoeuvre, democracy and dialogue are the only way forward.

#### 2. Health

In an economy already under severe stress, the Malian resources available for the health sector are extremely limited. Currently only six percent of national budget expenditure is spent in the health sector of which approximately 80 percent goes on

salaries. The per capita rate of approximately \$1.5 per person ranks among the lowest in the world. Health facilities are poorly equipped, there is an inequitable distribution of resources between urban and rural zones and 80 percent of the budget is spent on curative rather than preventative health care.

The four levels of government-run health services parallel the country's administrative structure, which comprises seven regions plus the capital area, 46 districts or *cercles*, and 286 sub-districts (called *arrondissements*). Bamako has three national hospitals; each region one hospital, except Koulikoro, which is served by Bamako; each district has a small hospital; and most of the sub-districts (264), a health center. National, district, and sub-district facilities perform the same functions: providing curative primary health care for surrounding populations, and referral services for, and supervision of, the next lower level. Mali also has 362 maternities, 322 dispensaries, and 203 pharmaceutical warehouses at the village level.

On the personnel side, the *Ministère de la Santé, de la Solidarité et des Personnes Agées*<sup>6</sup>, with some 60,000 employees, is Mali's second largest ministry. About 2,100 personnel work in health facilities: 250 physicians, 560 registered nurses, 250 midwives, 750 nursing assistants, 65 community development workers and 200 sanitation workers. Although Bamako represents only 8.5 percent of Mali's population, 42 percent of the physicians, 40 percent of the registered nurses, 51 percent of the midwives, 35 percent of the nurses aides, 30 percent of the community development workers, and 37 percent of the sanitation workers are concentrated there.

Recent graduates of the country's four formal health schools have had difficulty finding jobs in the public sector, due to limitations on civil service recruitment. In 1987, for example, only four of 60 graduate physicians, one of 35 graduate pharmacists, and 19 of 85 nurses aides were recruited into the civil service. Slightly over one-third of all graduates were hired either by NGOs, which operate about ten percent of the country's health facilities, mostly in remote areas, the *Pharmacie Populaire du Mali*, the state-run pharmaceutical company; or the *Union Nationale des Femmes Maliennes*, the now defunct women's political union. The private sector, with in 1991 a grand total of 16 licensed private practitioners (9 physicians, 4 registered nurses, 3 midwives) and 45 private pharmacists, has not as yet absorbed the surplus.<sup>7</sup>

What effect has this infrastructure had on health conditions in Mali? Political and economic change aside, the state of health in Mali is deplorable. The life expectancy at birth of an average Malian is 45 years compared to 75 years in a developed country. Some 56 percent of Mali's women and children are exposed to health risks

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<sup>6</sup> Ministry of Public Health, Solidarity and Older Persons

<sup>7</sup>USAID/Mali, The Community Health and Population Project Paper, 1992.

associated with early and late child bearing, closely spaced births, and high parity. Prenatal care, the single most important determinant of infant survival, reaches only 31 percent of Mali's pregnancies. Only 16 percent of children under five have health cards, of whom only a few are fully immunized. Estimates of infantile mortality rates are high, varying from 102 to 122 per thousand depending on the source. Over half these deaths will be caused by diarrhoea or one of six childhood diseases (measles, diphtheria, whooping cough, tuberculosis, polio and tetanus).<sup>8</sup>

A recent analysis<sup>8</sup> identified the following constraints at the level of the health infrastructure:

- \* **Limited Access to Health Care:** Mali's existing organized health care system reaches only approximately 20 percent of the population<sup>9</sup>
- \* **Poor Quality of Health Care:** The health care reaching those 20 percent is characterized by inadequate facilities, insufficient attention to local health needs, a lack of essential medical supplies, poorly trained and unmotivated staff, and poor supervision and management.
- \* **Lack of Affordable Essential Drugs:** Basic drugs are neither affordable nor available in 70 percent of the country, due to poor policies and management of national pharmacy and defunct women's union responsible for drug importation, production, distribution and sales. Mismatches between needs (affordable, essential generic drugs) and supply (costly, non essential brand-name drugs) are widespread.
- \* **Inefficient Use of Sectoral Resources:** Mali has a history of poor sectoral planning, lack of donor coordination, management inefficiencies from centrally-directed disease-control programs, non-integrated public health approaches, lack of attention to decentralized and private alternatives for basic health care, reliance on inefficient parastatals, poor deployment of trained and skilled health care professionals, and a lack of sustainable health financing systems.
- \* **Limited Demand for and Availability of Family Planning Services:** Only 50 percent of urban and 15 percent of rural women of fertile age know of one modern method of contraception. With a contraceptive prevalence rate of 1.2 percent, hearing does not mean using. There is a lack of facilities, of staff capable of prescribing and distributing contraceptives, of culturally appropriate messages and information-education-communication campaigns.

In the last few years, the government has begun to focus on policies that will broaden access to and improve the quality of health care, make essential drugs

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<sup>8</sup> *Ibid.*, 7, p.2.

<sup>9</sup> Defined as living within 15 kilometers of a health center.

available, and promote the rational use of health resources. The outcome to date is an integrated and mutually reinforcing set of policy and strategic reforms that together create a basis for advances in health care delivery. Most noteworthy are:

- \* **Adoption of a National Population Policy** by the Council of Ministers in May 1991. This is a significant step forward in recognizing the importance of population dynamics and their effect on Mali's development policy and economic growth.
- \* **Adoption of the Health for All Strategy** in December 1990 that promotes Primary Health Care and reorients the health care role of the Government of the Republic of Mali (GRM) to strategic, policy management, and support services; improvements in the quality and efficiency of referral care; and the promotion of public health policy.
- \* **Adoption of a Plan for the Survival, Protection, and the Development of the Child** in June 1991. This Plan advocates full integration of child survival interventions into Primary Health Care and Maternal Child Health services, including family planning and birth-spacing activities.
- \* **Adoption of Pharmaceutical Reforms** in March 1991 that give tax exemption to 199 essential generic drugs and chemicals used in their production, while maintaining taxes on all specialty drugs. The import monopoly of the national pharmacy has been revoked and it is prevented from importing specialty drugs that compete with the 60 most essential drugs.
- \* **Adoption of Privatization Reforms** in March 1991 that liberalize conditions for private health practitioners, i.e., medical and paramedical professionals, nurses, health technicians and pharmacists, to set up private practices. Restrictive regulations that imposed fee structures and equipment investments have been abolished.
- \* **Adoption of Family Planning and Information-Education-Communication Reforms** in March 1991 that authorize trained health workers to dispense contraceptives down to the community level. Policy guidelines have been issued stating that there exists no legal basis for refusing family planning services to single women or to married women who do not have spousal consent.
- \* **Adoption of Service Delivery Reforms** that establish the framework for planning, financing, and implementing local health care delivery systems. These will enable communities to control and help finance their health care facilities.

These reforms are supported by the multi-donor, second Health, Population and Water Supply Project (*Project Santé, Population et Hydraulique Rural*) and are complemented by macroeconomic reforms designed to improve resource use and promote

private sector participation. Together they provide an ideal framework for improving health care in Mali.

B. Sexually-Transmitted Diseases, HIV Infection and AIDS: The Current Situation in Mali

The first cases of AIDS in Africa were reported in 1983 and the first diagnosed case in Mali was in 1985. From then through June of 1993, a total of 4,736 people have tested positive for HIV at the two main hospitals in Bamako and cumulatively 1,479 cases of AIDS have been reported. This represents a vast underestimation. The true number of HIV positive individuals in Mali has been estimated at 140,000. Actual deaths from AIDS have been estimated at nearly 12,000 by December 1993.<sup>10</sup>

In 1987, a national study of HIV prevalence found rates of one to two percent in the general population and 39 percent in prostitutes.<sup>11</sup> Results from the 1993 National HIV seroprevalence study conducted by the PNLIS, indicate that overall national seroprevalence has risen to five percent in the general population with variations from two to six percent according to Region and rates of 55 percent in prostitutes and ten percent in truck drivers. These results show levels of HIV infection among Malian prostitutes comparable with the ten to 40 percent seroprevalence of prostitutes in Nairobi and Kinshasa respectively, and place Mali amongst the African countries where HIV infection is spreading at an intermediate rate.

Data on other sexually-transmitted diseases are incomplete but are sufficient to indicate that they are endemic and that the problem is serious. In a 1994 study of women seeking prenatal, family planning and gynecologic care in Bamako, 42 percent were diagnosed with chlamydia infections and 34 percent with gonorrhoea.<sup>12</sup> Taking into account the level of morbidity, and the available infrastructure, Mali ranked highest priority among Sahel countries by the World Bank in their assessment of the need for HIV and STD interventions.

Encouragingly, the Malian Government has developed an ambitious five-year strategy to combat STD and HIV, and there are several existing large-scale development projects that are attempting to reinforce the health infrastructure.<sup>13</sup> USAID is presented with an excellent opportunity to assist Mali and other donor agencies in these efforts at building a national STD and HIV control program.

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<sup>10</sup>*Ibid.*, 2, p. iiv.

<sup>11</sup>*Ibid.*, 4, p. iiv.

<sup>12</sup>*Ibid.*, 5, p. viii.

<sup>13</sup>*Ibid.*, 2, p. iiv.

## C. The Reaction to the AIDS Epidemic in Mali

### 1. The Government

In recognition of the compelling data from other hard hit African countries and the opportunity to limit the spread of HIV and AIDS while the rates are comparatively low, the Malian Government established its National AIDS Committee (known as the *Programme National de Lutte contre le SIDA* [PNLS]) in 1987 and carried out a baseline study of HIV prevalence in the following targeted groups; prostitutes, prisoners, hospital patients and pregnant women.

In 1989, the World Health Organization appointed a Technical Advisor to the National AIDS Committee and the first Medium Term Plan (1989-1993) was elaborated. This had the goal of improving and reinforcing efforts to inform the population about HIV and AIDS and limit the spread of the infection. A review in 1991, identified weaknesses in program management and implementation and, under the transitional government the National AIDS Committee management team was changed.

During the second implementation phase (1991-1993), despite the instability in the Ministry of Health,<sup>14</sup> several initiatives were introduced to strengthen HIV and AIDS prevention efforts, including the decentralization of activities and resources at the regional level, the involvement of NGOs in major HIV and AIDS prevention initiatives, promotion of AIDS prevention activities in other ministries such as Education and Defense, the development of a system of regular supervision and monitoring and the health education of regional authorities during supervisory visits.

However, the program continued to suffer from a lack of government commitment<sup>15</sup> and resources and from poor management. The National AIDS Committee also went beyond the role defined for it by the World Health Organization. Instead of limiting activities to the areas of coordination, policy development and resource mobilization, the National AIDS Committee became actively involved in project management. USAID was amongst the organizations who contributed to this misunderstanding by providing funds that allowed the National AIDS Committee to go beyond government structures, recruit personnel and execute projects.

In 1993, a World Health Organization evaluation team made a series of recommendations for the future strategy and organization of the National AIDS Committee. Following a national consensus meeting, the Ministry of Health, in collaboration with several

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<sup>14</sup> The current Minister of Health is the third since 1991.

<sup>15</sup> Only six percent of the health budget, or less than 0.005 percent of the national budget, is spent on the National AIDS Committee.

other government entities, NGOs and international agencies, developed a second Strategic Plan<sup>16</sup> taking into account the recommendations of the review.

The twin aims of this plan are the prevention of infection by HIV and the reduction of the impact of infection on individuals and on the community. The three principal strategies adopted to limit the spread of infection are:

- \* the prevention of sexual transmission as a result of information, education and communication activities targeting young people, prostitutes, migrants, the armed forces, prisoners, health personnel, traditional healers, community leaders and the general population;
- \* the prevention of sexual transmission through improved case management of sexually-transmitted diseases throughout the country;
- \* the prevention of transmission by blood through a reinforcement of the testing of blood for transfusion and the training of health personnel and traditional healers in sterilization and disinfection procedures.

To reduce the psychological and social impact of HIV infection the strategy envisages:

- \* a range of interventions aimed at seropositive individuals, their caregivers, families and communities;
- \* revising professional guidelines and relevant areas of the law;
- \* introducing support for the integration of AIDS patients into the community.

As part of the Strategic Plan, the role of the National AIDS Committee is to be limited to the areas of coordination, policy development and resource mobilization in line with the World Health Organization's Global Program on AIDS directives.

## 2. Bilateral and Multilateral Donors

External donors have provided almost all financial resources allocated to the National AIDS Committee with USAID providing approximately \$1,250,000 through Fiscal Year 1994. Since 1989, USAID funding has been channelled through an add-on to the AIDS Technical Support and AIDS Prevention and Control Projects and has focused on interventions among high risk groups.

In 1993, United Nations International Children's Emergency Fund (UNICEF) with funding of \$100,000 and small grants up to \$5000 supported the decentralization of AIDS activities in all eight regions of Mali. UNICEF has programmed an

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<sup>16</sup> Plan Strategique 1994-1998, Revision 4, National AIDS Committee, February 1994.

additional \$200,000 for 1994. *Cooperation Suisse* supports a sexually-transmitted disease and HIV prevention and control program (\$20,000 in 1993) in the Region of Sikasso.

The United Nations Development Program, in collaboration with the National AIDS Committee, is developing a \$800,000, AIDS prevention program (1994-97) that will support short-term external technical assistance, program evaluation, audio-visual materials, study tours, short-term training and two vehicles.

The World Bank provided a 1993-94 loan of \$1,500,000<sup>17</sup> and has already financed the National AIDS Committee's telephone system, conference room and documentation center as well as meetings to develop the 1994-97 strategic plan and, in 1993 an STD and HIV prevalence rapid assessment study. World Bank funds will support program coordination, the development of health education support, laboratory equipment and two vehicles.

The World Health Organization provides an administrator to manage its own trust funds and supports the operations of the coordinating unit of the National AIDS Committee with a yearly funding of \$80,000.

The *Cooperation Française* currently supports blood screening at the National Transfusion Center in Bamako. The French are developing a comprehensive new assistance package following the French Government's recent commitment of \$60 million to HIV and AIDS prevention in Africa.

The European Union and Japan are currently discussing support to the National AIDS Committee of 1,000,000 ECUs and two to four million dollars, respectively.

### 3. Non-Governmental Organizations

The NGO community's reaction to the AIDS epidemic in Mali has until recently been very limited both in financial and in geographical terms. This is partly due to lack of funds earmarked for AIDS awareness and prevention but largely due also to ignorance about HIV and AIDS amongst the NGO personnel themselves. The principal supporters of NGO activities to date have been the Canadians (*Solidarité Canada Sahel* and Save the Children Fund), USAID, Plan International and Oxfam, United Kingdom.

Thus, in 1991, *Solidarité Canada Sahel* and Save the Children Fund (Canada) financed a two-year program of AIDS awareness activities, *Project Prévention SIDA*, aimed at young people in urban areas and about 100 villages in the region of Koulikoro. A 1993 external evaluation found significant increases in awareness of AIDS and

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<sup>17</sup> The Malian Government considers this loan as one of its major contributions to HIV and AIDS prevention.

some behavior changes amongst the target population. The evaluators recommended that a second Project phase be funded that takes into account the lessons learned during the first.

At the end of 1992, USAID, through Family Health International provided four young NGOs (*Solidarité SIDA*, *Sahel Action pour le Developpement*, *BAARA KANU*, and *Association Univers Familial*) with a total of approximately \$20,000 to carry out AIDS awareness and prevention activities aimed mainly at young people in Bamako. This program was extended in 1993 to include 11 NGOs. It is due to end in 1994 and be replaced by the current project.

In 1993, Plan International funded eight NGOs to carry out a program of AIDS information, education and communication activities and condom distribution in its two project areas: Kangaba and Banamba. On the basis of this experience, it is developing a seven-year program (for a total cost of nearly \$5 million) to carry out health education activities in 100 *arrondissements*, provide support for HIV and AIDS self-help groups and fund a national media campaign. This Program will complement the new Project.

Also in 1993, the USAID Mali PVO Co-Financing project provided \$1,250,000 over 18 months to the Child Survival Pivot Group,<sup>18</sup> as part of a five-year Family Planning-AIDS project with a total estimated budget of \$7 million. This project will provide training and sub-grants to enable NGOs principally to carry out family planning activities but including a strong AIDS awareness and prevention component. Eight sub-grants have been awarded to date.

Oxfam United Kingdom, a NGO funding organization, has encouraged its local partners to add HIV and AIDS awareness activities to their existing programs. In 1993, they provided training on the relationship between the AIDS epidemic and development for twelve of their NGO partners in the Mopti Region.

Several of the established local NGOs have, as a result of their target beneficiaries and special interests, extended their existing program of activities to include AIDS awareness and prevention. Thus, the Malian Family Planning Association, *Association Malienne pour la Promotion et la Protection de la Famille*, founded in 1972, has incorporated AIDS awareness and prevention in its program to promote contraceptive use. It also plays an important role in supporting other NGOs through training and hiring out audio-visual equipment but cannot meet the current level of demand due to lack of funds.

Two other NGOs, the *Association des Femmes Educatives du Mali* and the *Association Malienne pour la Promotion et l'Insertion de Jeunes* have training programs aimed specifically at young migrant girls in Bamako. Both organizations show films on AIDS followed by discussions during literacy and household management training sessions as

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<sup>18</sup> Created in 1992, the Child Survival Pivot Group is a technical section of the NGO collective called CCA-ONG. It regroups about 60 local and foreign NGOs working in health and acts as a forum for training and professionalization.

part of a broader health education program. In addition, the *Association Malienne pour la Promotion et l'Insertion de Jeunes* has already been involved in counselling seropositive girls. Its members are currently carrying out a study entitled Migrant Girls and AIDS.

D. Relation of this Project to Mission and USAID Strategy

The activities proposed under this project conform to the second overall USAID Mali strategic objective relating to improving the quality of life. The specific indicator corresponding to the proposed activities is life expectancy at birth. AIDS prevention and control is also a Congressional interest area. The Africa Bureau encourages using Development Fund for Africa operational year budgets to support these activities. Moreover, this project fits well within USAID's new Strategies for Sustainable Development. These assert that USAID will concentrate its population and health programs on two types of countries, one of which is where population and health conditions impede sustainable development. The Strategy for Stabilizing World Population Growth and Protecting Human Health notes that limiting the spread of HIV and AIDS is an economical and essential investment in sustainable development. It cites reproductive health care, including prevention and control of sexually-transmitted diseases, especially HIV and AIDS, and improved prenatal and delivery services as on areas where most of USAID's resources will be directed.

USAID Mali recognizes that this Project by itself is but a portion of the numerous interventions required to address HIV and AIDS in Mali. This Project's ability to achieve and sustain gains in this part of the health sector can be realized only through the well-integrated actions of all actors involved: the private, not-for-profit and social sectors, the donors, and the Government of Mali as the lead policy maker for the activities implemented by the former. USAID envisions the Government of Mali's role as being a policy setter, information clearing house and coordinator but not a major implementor of AIDS interventions.

E. Conformity of Strategy with that of Malian Government

The activities proposed under this project align with the Malian Government's strategy as defined in the *Plan Strategique (1994-98)* outlined above. Specifically, the project proposes to support and reinforce activities in the following three key strategy areas:

- \* preventing HIV sexual transmission through improved case management of sexually-transmitted diseases;
- \* preventing HIV sexual transmission through information, education and communication activities aimed at the general population and high-risk groups; and
- \* effective program coordination and leadership by the National AIDS Committee through activities in the areas of information exchange, policy development and resource mobilization.

## II. PROJECT DESCRIPTION

### A. Introduction

Data on HIV and AIDs in Mali leave no doubt that infection is spreading at what appears to be an alarming rate and that the situation could rapidly deteriorate as has been the case in many other African countries.

In 1992, the World Health Organization found diarrhea still to be the principal cause of infant mortality, with malaria also taking a significant toll. Deaths from measles however, had been significantly reduced following widespread vaccination. They predict that AIDS will, by the mid 1990s, take over from malaria and measles and become the second most important cause of death of children in sub-saharan Africa.

AIDS most affects individuals between the ages of 15 and 44, the period when they are most productive at both a national and a household level. Deaths from AIDS risk to exacerbate labor shortages in the agricultural sector undermining food security and basic rural subsistence. They will leave many urban households without their principal wage earner. The increasing social and economic burden of supporting children and the elderly will effectively nullify whatever modest economic progress Mali might otherwise be able to make and perpetuate its dependence on external support.

### B. Project Goal and Purpose

The goal of the project is to improve health care in Mali and the purpose is to do so by limiting the spread of HIV infection.

Without action to control the spread of HIV infection, life expectancy at birth will decrease. Deaths from AIDS will undermine efforts to reduce mortality through immunization, health education and improved nutrition. Development activities in all sectors will be compromised. As a result of this project, HIV prevalence in the general population will be kept below 7.5 percent and life expectancy at birth for an average Malian will be able to increase to at least 47 years.

### C. Strategy and Rationale

To limit the spread of HIV infection the project will focus on three independent but interrelated components, improved STD control, the promotion of behavior change and improved policy development and coordination.

#### 1. Improved STD Control

HIV infection is a sexually-transmitted disease. All patients with other STDs are at risk for HIV infection because the presence of another STD facilitates HIV

transmission and the magnitude of this effect is large. Inflammatory STDs such as chlamydia and gonorrhoea can increase by up to a factor of four the likelihood of acquiring or transmitting HIV infection. For STDs that cause genital ulcers (such as chancroid), the risks are even higher with up to a tenfold increase in the likelihood of HIV transmission. Treating STDs will thus directly help prevent HIV infection and will have secondary health benefits for women and children who bear the greatest burden of complications from STD infections.

Improved STD control will be achieved through improved STD case management, improved surveillance and reporting and improved STD institutional capacity at the National AIDS Committee. Collaboration with organizations supporting the development of an essential drugs supply system is a key component of the strategy. Without access to affordable drugs, many cases of STDs, though properly diagnosed and reported risk going untreated. Health workers will be trained in the use of World Health Organization algorithms for syndromic diagnosis and in counselling to prevent infection. Basic STD laboratory equipment will be supplied to *cercle* level health centers. The project will also include a strong operations research component designed to identify the optimal strategies for STD/HIV control in Mali and provide ongoing input to STD case management.

Improved STD surveillance and reporting will be achieved by incorporating syndromic definitions of key STDs into the national health information system; equipping HIV sentinel surveillance sites with STD laboratory equipment; conducting rapid assessment surveys to provide an overall picture of the evolution of STDs in Mali; and the revision of treatment protocols based on information received from the results of operations research.

Improved STD institutional capacity at the National AIDS Committee will be provided through a long-term technical advisor specialized in STD control and by providing long-term training opportunities for two staff members with the requirement that they return and work for the National AIDS Committee afterwards.

## 2. Behavior Change

Absent a vaccine, behavior change is the only way to avoid acquiring or transmitting HIV. Increased condom use (as measured by sales) is a key indicator that knowledge and awareness about AIDS has resulted in a positive behavior change.

NGOs have already demonstrated their ability to reach and to work effectively with rural and urban populations in Mali, to respond to local priorities and to be flexible in their approach. The Project will capitalize on these strengths through an expanded and improved NGO program of STD/AIDS information, education and communication activities aimed at the general population and at high risk groups. The project will further support NGO activities by assisting with strategy and materials development and providing technical training in HIV/AIDS information, education and communication techniques and in NGO project management.

To ensure that people can act on the information they receive, NGOs will promote community-based marketing of condoms in collaboration with the existing social marketing strategy. This may involve them taking an active role in distribution but is most likely to be through credit and training for enterprise development.

In the majority of HIV case-finding studies to date in Mali, seropositive individuals have not been notified of their results. They have not been counselled to avoid transmission to their partners nor referred for medical care. Partly this is due to the lack of a clear national policy on counselling. Partly it is an expression of the fear of the medical staff in a health system based on curative care and a society where it is a widespread belief that all diseases are believed to have a cure.

USAID has already acted to promote policy development and will continue doing so. As part of the STD control component, training will be given to key health personnel to ensure they have the skills required to notify all seropositive persons of their results and to counsel them as to how to avoid transmitting the disease to their sexual partners. To provide a focus for positive action, NGOs will promote the development of community-based or self-help groups providing long-term counselling and support for seropositive individuals, AIDS sufferers and their families.

### 3. Improved Central Coordination and Policy Development

Tackling the HIV/AIDS epidemic requires a strong program leadership for the mobilization, coordination and appropriate use of international, national and multi-sectoral financial and human resources. Effective absorption of the massive resources generated for HIV prevention requires the development of strategic and operational plans, decentralization of activities, and the coordinated involvement of different governmental and non-governmental organizations including community-based associations.

In addition, many African leaders tend to regard HIV/AIDS as being similar to other and older infectious disease problems. Thus, there is a continuing need to engage and maintain international, national and community decision makers in dialogue about the likely multi-sectoral, socio-demographic and economic impact of HIV and AIDS in sub-Saharan Africa.

The project will provide long and short-term technical advice, training and institutional support to the National AIDS Committee to assist it to engage in information exchange, policy development and resource mobilization. A quarterly newsletter on STD/AIDS in Mali will provide a forum for information and exchange for donors, health planners and NGOs and, in collaboration with the GRM and the Ministry of Health, clear-cut policies will be developed on HIV and AIDS related counselling, free distribution of condoms, STD prevention and control and the rights and responsibilities of HIV seropositive and AIDS patients. Regular meetings of donors and NGOs will be held to improve coordination and the allocation of resources and a series of presentations to policy makers at national and regional levels on the

potential socio-economic impact of HIV and AIDS in Mali will increase awareness of and support to the fight against AIDS.

D. USAID Project Management

USAID will hire a Project Manager and Project Assistant. The former will be responsible for working with the Malian government to select the technical assistance team (STD expert and assistant); and be the principal liaison between the Project and USAID, including responding to requests for information. The latter will be responsible for processing Project administrative needs, including exonerations. A Malian will be trained to replace the incumbent Project Manager at the end of his/her contract.

E. Project Outputs

Project activities are designed to achieve the following three outputs: improved STD control; behavior change reducing the risk of transmission of the HIV virus; and a National AIDS Committee that engages in information exchange, policy development and resource mobilization.

1. Improved STD Control

The incidence of STDs in the general population will decrease through improved STD control. This will reduce the likelihood of HIV infection both directly by curing genital ulcers and inflammation that facilitate transmission and acquisition of the virus and indirectly, because STD patients will be targeted for prevention education. A secondary benefit will be improved health for women and children who bear the major burden of morbidity and side-effects due to STDs. As a result of project activities, a ten percent decrease in the overall incidence of STDs in the general population will be seen when compared with data from the 1993 World Bank rapid assessment survey, used to determine HIV and STD sero-prevalences.

Improved STD control will be achieved through improved STD case management, improved surveillance and reporting of STD and improved STD institutional capacity at the National AIDS Committee.

a. Improved STD Case Management

Improved STD case management will be attained by revising the essential drug list to include first-line STD drugs, providing training for STD diagnosis, treatment and counselling, by providing basic equipment and test kits for STD laboratories at *cercle* level and through improved knowledge of appropriate strategies for STD prevention and case management in Mali.

1) Essential drugs

To revise the essential drug list, the Project will collaborate with the World Bank to ensure that the essential drug list and purchases include first line drugs for the treatment of chancroid and gonorrhoea. This will be done within the first year of activities to ensure that effective and affordable STD treatment is available as soon as possible.

2) Training

To improve clinical STD case management, training will be provided to 350 government primary care health care personnel and 100 other health or health-related personnel (e.g. pharmacists) through a contract to a private sector or non-governmental organization using a specially recruited and trained team of Malian health professionals. Short-term technical assistance will be provided for materials development and training of trainers. Logistical support for the health personnel to be trained will be provided for under the training contract.

Training will be also offered to district-level health personnel, in collaboration with the multilateral Health, Population and Rural Hydrology Project that is building a network of 120 community health centers in the regions of Kayes, Mopti, Koulikouro and Ségou. Although the multilateral project does not operate in the two regions with the highest HIV prevalence (Bamako and Sikasso), collaboration offers the opportunity to add STD diagnostic and treatment to the "minimum package" of clinical services to be offered and in particular to link improved STD diagnosis with a supply system for essential drugs.

Similarly, other organizations supporting the development of the primary health care sector such as the Dutch *Soins de Sante Primaire* project in certain *cercles* of Ségou and Sikasso, will be encouraged to adopt the same protocols and "buy in" to the training programme or materials developed should they wish to. This activity will be coordinated by the National AIDS Committee.

The training will consist of a two-day training session, organized by *cercle* or *commune* level. The first day, both doctors and nurses, will cover the use of the World Health Organization algorithms for the syndromic diagnosis of STDs, and the presumptive treatment of those syndromes where there are no laboratory facilities. Training will also cover the need for referral and management of sex partners, and the inclusion of clinician face-to-face prevention counselling as a part of case management. The second day, principally for doctors will focus on basic laboratory techniques for STD diagnosis, on using the World Health Organization algorithms designed for use when there are basic laboratory facilities and on supervision and case reporting.

Training in HIV counselling skills will also be given to key health professionals to ensure that by Year 3 of the project, all HIV tests are accompanied by pre-test counselling and that all HIV seropositive individuals are notified of their results and

given counselling to avoid infecting their partners. Training sessions will be held annually throughout the life of the project principally so that participants can share their experiences and adapt counselling methods and messages accordingly. Under the NGO component, support will be provided to NGOs to facilitate the establishment of case management centers for seropositives and their families.

Quality of training will be measured according to the ability of trained health personnel to correctly diagnose and treat STDs. The quality of counselling will also be assessed. Monitoring will be carried out at the beginning and end of the first training. One year after receiving training, 70 percent of a representative sample of those trained should be able correctly to diagnose and treat STDs and give accurate counselling on STD prevention. Refresher training following the same pattern will be carried out in Years 3 and 4 of the project and the quality will be similarly monitored.

### 3) STD Laboratories

To improve diagnostic capacity the project will equip and supply a basic STD laboratory at each of the 46 *cercle* level health centers. This laboratory will consist of basic microscopy, gram stain and a rapid test for syphilis. Installation will take place during STD case management training described above. Training will include use of the laboratory and use of the algorithms designated for facilities with basic laboratories.

### 4) Operational Research

The Project will provide improved knowledge of appropriate strategies for STD prevention and case management in Mali through a series of studies to be undertaken by local research institutes and private and non-governmental organizations. These studies will monitor the effectiveness of the strategies adopted and test alternatives. Wherever possible the health personnel providing STD treatment will themselves be implicated in the research. In addition to regular publication of progress reports, a series of workshops and seminars will be organized. Early and widespread diffusion of results together with feedback from practitioners will ensure that wherever possible the research is used to modify and improve the strategies adopted.

One of the first issues to be examined will be the impact on patient compliance of cost recovery for drugs to treat STDs, currently endorsed by the World Bank. Sex partners of patients with STDs are at the highest risk of acquiring STDs but there are disincentives to purchasing expensive drugs, especially in asymptomatic partners. It is unclear if, in the case of STDs, special circumstances (such as non-compliance in asymptomatic patients, treatment of partners, and psycho-social barriers to seeking care) necessitate on-site distribution of free therapeutics.

In addition to the cost of treatment, partner notification is associated with many ethical and psycho-social issues. Research will evaluate the effectiveness

of various partner notification strategies in Mali. It will also examine the cost-effectiveness of single dose therapy that ensures full compliance but is usually more expensive than multiple dose therapy in terms of initial costs for the drug.

Screening might be another issue to be examined. Cost-effectiveness models suggest that for African countries, screening is rarely more cost-effective than treating empirically on the basis of a syndromic diagnosis, or treating after a laboratory test. One potential exception is prenatal screening and consideration will be given to initiating research to examine the cost-effectiveness of routine screening and treatment at family planning and maternal and child health facilities

Finally, research will monitor the performance (sensitivity and specificity) of the World Health Organization algorithms among groups with different prevalence rates for example pregnant women, youths, drivers and prostitutes.

b. Improved STD Surveillance and Reporting

Surveillance for STDs is challenging as the prevalence is high and thus the potential burden of reporting may be high. Also, many infected patients are asymptomatic and therefore difficult to identify and complete diagnosis of STDs, even in symptomatic patients, requires substantial resources for laboratory testing. The current categories used by the Division of Epidemiology for STD reporting do not provide sufficient information to function as an effect surveillance tool. They are either too specific (e.g. syphilis and presumptive gonorrhoea without benefit of laboratory diagnosis), or too non-specific (such as "other").

In an attempt to overcome these difficulties, the Project will use a strategy based on four complementary components: routine case reporting of syndromes, sentinel surveillance; rapid assessment studies; and antibiotic susceptibility testing

1) Routine Case Reporting of Syndromes

Just as the diagnosis and treatment of STDs is to be based on syndromic approach, a passive surveillance system will be introduced based on the reporting of four of the syndromes: AIDS; genital ulcers; cervicitis in women and urethritis in men.

The implementation of the Community Health and Population Services project's health information system offers a unique opportunity to strengthen STD surveillance in this manner, at no cost to this project. The Division of Epidemiology and Community Health and Population Services personnel are currently in the process of revising the list of reportable diseases and in collaboration with this project will substitute the above four STD syndromes for the existing reportable STDs. Training in STD case management (as described above) will include case-reporting so the by the end of Year 2 of the project all health centers will routinely report cases of STD based upon standard observed STD syndromes.

## 2) Sentinel Surveillance

While case reporting has the advantage of geographic completeness, there is a need for more in-depth information about the level of STDs in specific populations. There is also a need to establish whether increased case reporting is due to increases in prevalence or to the effectiveness of information-education-communication campaigns encouraging more people to present for treatment.

An HIV sentinel surveillance system is already established with four out of seven sites functional and the remaining three programmed to start operations in 1994. During Year 1, six of the seven HIV sentinel surveillance sites will be additionally equipped for the surveillance of STDs (the exception being the site based at the blood transfusion center) and supplied with reagents throughout the life of the project. These are facilities where a laboratory and research infrastructure already exists and where an STD diagnostic module may be added with minimal marginal cost.

## 3) Rapid Assessment Studies

At the interface between sentinel surveillance and evaluation research, the project will fund a series of three cross-sectional STD/HIV prevalence studies to assess the prevalence of STD and HIV in Years 2, 4 and 6. These studies will use the same protocols in the same populations and in the same sentinel sites as the World Bank's 1993 Rapid STD and HIV Assessment Study thus enabling their data to be used as a baseline for comparison of temporal trends.

## 4) Antibiotic Susceptibility Testing

Finally, an important component of the surveillance system will be a laboratory program to assess the prevalence of antimicrobial resistant gonorrhoea. Presently the *Institut National de Recherche en Santé Publique* and *Hôpital Point G*, both in Bamako, perform gonorrhoea culture and antibiotic sensitivity on their patients but the results are not published routinely and disseminated to other agencies within the Ministry of Health that are responsible for updating the essential drug list and for providing continuing medical education to clinicians.

Under the Project, the National AIDS Committee will organize the collection and publication of this information on an annual basis, and will distribute the report to all those who can use it. This will include private medical practitioners, pharmacists, NGOs and all medical personnel receiving training under this program. The National AIDS Committee will also coordinate the revision of treatment protocols and drug lists when antibiotic resistance make this a necessity.

c. Improved STD Institutional Capacity

In conjunction with activities under multilateral project, the World Bank is to invest \$1.4 million in infrastructural support to the National AIDS Committee. This project will complement World Bank funding in two ways: by providing a long-term technical advisor to assist the National AIDS Committee in its activities, particularly in the area of STD control and by providing a long-term training opportunity for two National AIDS Committee staff, with the requirement of returning and working for it.

The long-term technical advisor will ensure the quality and timeliness of the "improved STD case management" activities including materials development, training, laboratory supplies and surveillance. The advisor will also provide technical assistance to the National AIDS Committee to determine their needs vis-a-vis the provision of short-term consultants and will function as a catalyst to ensure coordination between the National AIDS Committee and its partners. He or she will facilitate information exchange by overseeing the elaboration and publishing of STD and HIV surveillance reports, training materials, other information and will assist with the design of standard monitoring tools and appropriate systems for supervisory visits.

Long-term training in STD control will contribute to program sustainability and ensure that the National AIDS Committee has members with the skills required to supervise a national STD control program. Ideally, training will provide the staff members with technical expertise in clinical and laboratory aspects of STD and HIV care, epidemiology, public health and program management. The long-term technical advisor should ideally be able to work with staff members before their departure and after their return from training. This will ensure program continuity by providing an overlap of trained STD personnel.

d. STD Control Process Indicators

- \* By the end of Year 1, the essential drug list for STD includes first line drugs for treatment of chancroid and gonorrhea
- \* By the end of Year 2, 350 health personnel at *arrondissement* and *cercle* level (including community health centers nationwide) and at least 100 persons in health related professions (pharmacies, social services etc) will have received training in STD case management
- \* By the end of Year 2, ten health personnel at Regional level will have received training on counselling for seropositive individuals and AIDS sufferers
- \* By the end of Year 4, 90 percent of people trained will have attended a refresher course
- \* By the end of Year 2, 46 *cercle*-level Health Centers will have basic STD laboratory capabilities and these will be supplied throughout the life of the project
- \* Ten research grants will be awarded
- \* By the end of Year 1, six HIV sentinel surveillance sites will be equipped with STD laboratories
- \* Results of laboratory tests of antimicrobial resistance of gonorrhoea from the National Research Laboratory, Gabriel Toure and revised treatment algorithms are published by the National AIDS Committee and distributed annually to everyone receiving training and at least 500 other health personnel and pharmacists
- \* A long-term resident STD advisor will be placed at the National AIDS Committee by the end of Year 1
- \* Two National AIDS Committee staff members will be identified and sent for long-term STD training by the end of Year 2.

e. STD Control Impact Indicators

- \* One year after receiving training, 70 percent of a representative sample of those trained can correctly diagnose and treat STDs and give accurate counselling on STD prevention
- \* By Year 2, 100 percent of people undergoing HIV testing in Mali will receive counselling both before and after the test
- \* The results of research are shown to have confirmed strategies adopted in the field or have led to a modification. Practical experience in the field is also shown to have influenced the research agenda
- \* By the end of Year 2, all health centers will routinely report cases of STD based on standard observed STD syndromes
- \* Six sites provide sentinel surveillance of STDs from Year 2 and throughout the life of the project
- \* Results of rapid assessment surveys in Years 2,4 and 6 complete data from sentinel surveillance and provide an overall picture of the evolution of STD in Mali

2. Behavior Change

Absent a vaccine, behavior change is the only way to avoid acquiring or transmitting HIV. Increased condom use (as measured by sales) is a key indicator that knowledge and awareness about AIDS has resulted in a positive behavior change.

This project will promote behavior change reducing the risk of transmission of the HIV virus by creating an NGO-based AIDS/STD Awareness and prevention component. NGOs, both local and international, have a long and well documented history of reaching and working effectively with rural and urban populations in Mali. The project will capitalise on the strengths of NGOs by providing resources for activities in the following three areas:

- \* an expanded and improved program of information-education-communication activities concerning STDs and AIDS;
- \* improved marketing of condoms as a result of involving NGOs in the promotion and development of community-based condom distribution networks within the framework of the existing social marketing strategy; and
- \* promotion of community level or self-help support groups for seropositive individuals and their families.

The Project will also address some of the principal weakness identified in the local NGO sector and as a secondary objective, it will seek to build up the long-term institutional capacity of the not-for-profit sector in Mali to provide AIDS prevention and awareness activities.

a. Institutional Capacity Building

A management structure for the NGO component will be established in collaboration with a private voluntary organization (PVO) that has experience both in AIDS prevention and awareness and in working in partnership with Malian NGOs. This structure will act as the "umbrella" organization and will be responsible for establishing criteria and procedures for awarding subgrants to NGOs, for carrying out regular supervision of activities, monitoring of impact and for financial reporting to USAID. It will additionally support the NGO activities by assisting with strategy and materials development and by providing training in HIV and AIDS information, education and communication techniques and in NGO management skills.

Although funded from a different source, project management is likely to resemble the Pivot Group structure successfully introduced to Mali by the PVO Co-Financing Project<sup>19</sup>. Development of selection procedures and criteria will build on the experience of the Pivot Groups and that of other organizations involved in funding NGOs to carry out AIDS prevention and awareness activities in particular the USAID funded AIDS project, Plan International and Canada.

For example, to avoid excluding potentially valuable but untested partners, the enthusiasm of the NGOs and their experience of and commitment to working on AIDS prevention will be considered, in the beginning to add more weight to their proposal should they be found to have deficient writing skills or lack of management skills. A system of close supervision and rigorous financial reporting will be established and after a limited period of time (i.e. 6 months) the performance of the NGOs will be formally evaluated. Those that show promise will be retained; those that engage in fiscal negligence, excluded.

As a result of this partnership and training process, at least 10 local NGOs will by the end-of-Project have, as their principal activity, the promotion of STD and AIDS Awareness and Prevention and will have the necessary skills to successfully elaborate and manage projects. One criteria of success will be that the NGO receives funds from a variety of sources. This demonstrates the ability of the NGO to sustain their activities and allows them sufficient independence to develop a long-term strategic approach. Although several Malian NGOs are specialized in AIDS Awareness and Prevention activities, none of them currently have adequate management skills according to PVO Co-Financing criteria.

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<sup>2</sup>: There are currently four Pivot Groups in Mali specialized in the areas of Child Survival, Natural Resource Management, Enterprise Development and Basic Education. Each is lead by a PVO with considerable experience in the relevant area and has between 30 and 60 NGO members (both international and national). The Pivot groups act as a forum for information exchange and training and, increasingly, as structures for awarding sub-grants to NGOs.

b. Information, Education and Communication

Many AIDS prevention and awareness programs have targeted groups such as prostitutes and their clients whose sexual behavior puts them at high risk of both acquiring and transmitting HIV infection. While cost-effective in the sense that it provides resources to the so-called core-group<sup>20</sup>, this approach has had the disadvantage that it supports the popular image of AIDS as a "dirty" disease that only affects people with low moral standards.

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<sup>31</sup> The "core group" consists of individuals who engage in sexual activities that place them at high risk of becoming infected or transmitting HIV. This group is thought to constitute the reservoir of infection which perpetuates the epidemic.

The NGO component of this project will develop a coordinated program of information, education and communication activities to raise awareness and knowledge about STD and AIDS in the population as a whole and in particular to promote "safe" behavior. In view of overall program objectives, information-education-communication will put particular emphasis on the use of condoms both before and outside marriage. Strategies to promote early treatment of STDs including symptom awareness, stressing the link between STDs and HIV and recognizing the need to seek health care without delay will be included.

Four principal types of information-education-communication activities are envisaged: 1) information-education-communication campaigns concentrating on a specific geographic area (e.g. *cercle* or *arrondissement*); 2) information-education-communication activities aimed at specific groups such as prostitutes, commercial drivers and migrants; 3) personnel training and support materials for established NGOs with more general development objectives; and 4) support for media campaigns and in particular the production of local language material (radio broadcasts, booklets and posters). These are discussed next.

1) Localized information-education-communication campaigns

Priority for sub-grants for geographically localized health education campaigns will be given to areas covered by the \$60 million multi-donor health project's network of Community Health Centers (Ségou, Koulikouro, Mopti and Kayes) in order to reinforce the STD control program. However sub-grants will not be exclusive to these areas and the project will collaborate closely with other donors and the NGO community as a whole to ensure an equitable distribution of effort.

A wide variety of information-education-communication techniques will be exploited including video, theater, focus groups, round table discussions and football matches. Video sessions, theater shows and football matches will be preceded or followed by discussions in groups segregated by sex and age. In addition, the widest variety of mediums will be sought and special emphasis will be placed on innovative approaches. NGOs will concentrate on identifying and working through key local personalities whose opinion is respected within their own social group (youths, unmarried girls, married women) or who hold a particular position of respect within the community as a whole (for example, healers, blacksmiths, village health workers, literacy trainers). In this way the project will seek to get AIDS prevention and awareness messages as efficiently as possible to all sectors of the population.

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<sup>20</sup> The "core group" consists of individuals who engage in sexual activities that place them at high risk of becoming infected or transmitting HIV. This group is thought to constitute the reservoir of infection which perpetuates the epidemic.

2) High-risk groups

Sub-grants to work with core groups are most likely to be concentrated in urban centers. Whenever possible, NGOs will use peer-group counselling to transmit prevention and awareness messages. In this way, prostitutes will be used to reach prostitutes, representatives of transport syndicates and associations, to reach commercial drivers and their apprentices and members of migrant associations could be used to counsel migrants as they arrive in urban areas. They could also seek, through village based youth associations, to provide appropriate advice to young men and women before they even leave the village.

Although it is impossible to predict in detail how the NGO component will evolve, it is thought that at any one time approximately ten NGOs will have grants and that up to a total of 25 grants for information-education-communication activities will be awarded. It is envisaged that at least five would be targeted specifically for work with high-risk groups. In the initial stages, immature NGOs may be given short-term (six to 12 month) grants to allow them to develop skills and institutional capacity under close supervision. More mature NGOs will receive grants for a period of not less than three years.

3) Training of general NGO field personnel

There are an estimated 4,000 to 5,000 NGO members and other individuals active in various development programs throughout Mali. This project will exploit this hitherto untapped resource by providing general AIDS awareness training to approximately 20 to 25 percent of them. The goal of this general training will be to provide individuals involved in development who might be working in fields unrelated to AIDS such as credit, micro-enterprise development and natural resource management, with correct AIDS prevention and awareness messages. They will thus be in a position to communicate correct AIDS and STD messages to the population that they regularly visit and know well.

Training for general NGO field personnel will be organized on a regional basis or, individually for the large NGOs. It will cover both STD/AIDS awareness and prevention for the NGO personnel themselves and the most important health messages to be communicated to villagers. Training will also look at appropriate ways to talk about STD and HIV and AIDS and give extension agents the skills to accurately transmit a prevention message whenever the opportunity arises. This will maximize use of the material developed and at relatively little extra cost to the project has the potential to get the message into remote areas, especially important for example in the northern regions. By the end of Year 3, at least 1,000 general NGO field staff will have attended at least one day of training on the transmission and prevention of STD and AIDS including specific training on appropriate messages and communication methods to be used with the general population.

4) Media campaigns

The media has long been perceived as the best mechanism

for reaching a population. Media campaigns will accompany the information-education-communication activities to reinforce particular messages and address issues such as whether or not to have an HIV test and how to react if someone you know is HIV positive. Special attention will be given to changing the image of the condom so that it seen as something that protects both parties rather than as an admission or accusation of infidelity. Under the National AIDS Committee's *1994-98 Plan Strategique*, the World Bank and Plan International are interested in covering the main costs of television and radio production and broadcasting. This project will concentrate on supporting their efforts by addressing costs associated with translation into local languages and the publication of booklets and posters.

c. Improved Condom Marking

To ensure that people can act on the knowledge they acquire from information-education-communication activities the NGOs will promote community-based marketing of condoms in collaboration with the existing social marketing strategy.

Increased condom use (as measured by sales) is a key indicator that knowledge and awareness about AIDS has resulted in a positive behavior change. In 1993, about one million condoms were sold in Mali and a similar number were distributed free of charge. As a result of Project activities in collaboration with the Contraceptive Social Marketing Project, condom sales will increase throughout the life of the project. Cumulative sales will be at least ten million by 1999 and annual sales will reach at least 3 million by the end of the Project.

NGOs will contribute to this overall sales figure by taking an active role in distribution for example from region to *cercle*. They will also train and supply existing village organizations such as health committees and youth associations or trained individuals (health workers). They may also provide credit and training for the promotion of enterprise development, to existing village traders or health-orientated group enterprises who engage in condom selling.

It is anticipated that by the end of Year 2, activities NGOs working in at least 20 *cercles* will support a community-based condom marketing network and that by the end of the project annual sales of condoms through the NGO-supported network will reach at least one million. The efficiency of the network in supplying condoms to rural areas will be evaluated. To ensure a regular supply, no NGO member of the distribution network should be out of stock of condoms on more one occasion per year and then for not more than seven days.

The condom sales network should ultimately become self-financed in that NGOs will buy packs of three condoms at 10 CFA for resale at 50 CFA per pack. This is considerably greater mark-up than other commodities readily available in villages such as tea, sugar and cigarettes. The revenue from sales will act as an incentive to individuals or organizations to continue selling.

d. Support Groups

Relatively few seropositive individuals in Mali have been notified of their results and most have not been counselled to avoid transmission to their partners nor referred for medical care. This is due partly to the lack of a clear national policy on counselling; and is partly an expression of the fear of medical staff in a health system based on curative care.

Other Project components will address these constraints through support to the GRM for the development of a counselling policy and through training of medical staff in pre- and post-test counselling techniques. To provide a focal point for follow up with seropositive individuals and to raise awareness within the general population, NGOs will establish or promote community-based or self-help support groups for seropositive individuals, AIDS sufferers and their families.

Many traditional solidarity networks exist based on family, age-group, village and ethnic ties. For example, village youth groups may be called upon to cultivate the fields of someone who is ill. Certain migrants associations pay the funeral costs of anyone from their area who dies whilst away from home. NGO activities will base themselves as much as possible on these networks and seek to revitalize those that urbanization and the fragmentation of the extended family have weakened. Many NGOs have well established links with community organizations such as Credit Groups and Parent-Teacher Associations. These could be the starting point for new forms of community action to support AIDS sufferers.

Promoting self-help groups will provide HIV seropositive individuals with a mutual support network, a place to get practical advice and the motivation to "live positively." It is also envisaged that they will contribute to lifting the shame and stigma surrounding HIV infection and AIDS. Over the life-of-Project, at least five sub-grants will be given to develop support groups in Bamako and in three other regions.

e. Supervision, Monitoring and Evaluation

Supervision of NGO activities will be provided through bi-annual progress reports and during regular visits to the field by the NGO component management staff. Activities in Bamako and Koulikouro will be supervised from the Bamako office. To facilitate logistics, the project will fund one person in three regional offices. These offices will function as the *antennes* established by the Malian umbrella organization, UNICEF and Oxfam. These offices may be independent or set up within a well established NGO or PVO. In addition to providing supervision they will act as the focus for a decentralized AIDS network for NGOs and will facilitate information exchange with the National AIDS Committee at the regional level.

Rapid, local knowledge-attitude and practices surveys before and after major information campaigns will be used to monitor understanding of and reaction to the different messages and to evaluate the efficacy of different information-education-communication techniques at reaching the various target groups in the village. These surveys will serve to alert staff as to where program changes are needed. Information gained from the surveys will be disseminated widely.

To act as a control, local knowledge, attitudes and practices surveys will also be conducted in villages where no NGOs are active. The Project will contribute to a national knowledge, attitudes and practices survey that will monitor changes in knowledge and attitudes regarding HIV infection and AIDS and prevention strategies over time. Media campaigns will be monitored and their impact on different target groups evaluated.

Condom sales will be considered the most reliable indicator of behavior change coupled with a fall in STD prevalence rate and especially an increase in average reinfection intervals (time since last *chaude pisse* etc).

Evaluations of the entire NGO component will be carried out in Years 2 and 4. The recommendations will be used to reorient project strategy. A final evaluation at the end of Year 6 will be conducted by a team of which at least one person with experience of AIDS prevention programs in other countries is a member. This evaluation will provide recommendations concerning the need for and orientation of future STD and HIV prevention and awareness programs in Mali.

f. NGO-Promoted Behavior Change: Process Indicators

- \* Within six months of the start of the project a management structure for NGO grants with appropriate regulations and procedures, will exist and be operational
- \* By the end of the project at least 25 grants have been made to NGOs for STD/AIDS IEC activities including at least 5 grants for activities aimed at specific groups with high risk behavior
- \* By the end of year 3, 1,000 general NGO field staff will have attended at least one day of training on the transmission and prevention of STD and AIDS including specific training on appropriate messages and communication methods to be used with the general population.
- \* By the end of year 2 at least 20 NGO are members of a condom social marketing network and this network supports or provides community level marketing of condoms in all Cercles
- \* By the end of the project at least 5 grants will have been awarded to NGOs to promote community level or self-help support groups in Bamako and at least three other Regions of Mali

g. NGO-Promoted Behavior Change: Impact Indicators

- \* Condom sales will increase throughout the life-of-Project and cumulative sales will reach at least 10,000,00 by 1999. Annual sales reach at least 3,000,000 by the end-of-Project
- \* By the end-of-Project, at least ten local NGOs will have as their principal activity the promotion of STD and AIDS Awareness and Prevention and will have the necessary skills to successfully elaborate and manage projects according to PVO Co-Financing criteria (increased from zero at present)
- \* No NGO member of the distribution network is out of stock of condoms on more one occasion per year and for not more than a total of seven days
- \* Average annual sales of condoms by the NGO network increase throughout the life-of-Project and reach at least 1,000,000 by 1999

3. Support to National AIDS Committee

A critical component of a successful STD and AIDS prevention and control program is the existence of an effective program management and coordination unit. Tackling the epidemic effectively requires strong program leadership to ensure the mobilization, coordination and appropriate use of international, national and multi-sectoral financial and human resources.

This project will assist the National AIDS Committee to fulfil its leadership roles by increasing the capacity of the central coordinating unit to engage in activities in three specific areas: information exchange, policy development and resource mobilization. The Project will address constraints identified at the National AIDS Committee and will compliment other donor support, principally through short-term technical assistance and training. Equipment supplied to the USAID-financed AIDS project will be transferred to the National AIDS Committee. This project will continue to support operation and maintenance costs. New equipment consisting of a photocopier and desk-top publishing software will be supplied.

a. Information Exchange

Effective information exchange and coordination between Government departments and donors will be a key element to the success of STD and HIV prevention and control in Mali. In line with the 1994-98 Strategic Plan, several parallel agencies within the *Ministère de la Santé* will be involved with different aspects of this project. Such agencies include the *Division de la Santé Familiale*, which will be involved with providing clinical care at government facilities; the multi-donor project which focuses on strengthening the health care infrastructure and on training personnel; the national research institute, which is the country's only reference laboratory and contains the majority of the

STD expertise; the *Division d'Epidemiologie*, which will be responsible for surveillance activities; and the *Pharmacie Populaire du Mali*, which is responsible for the essential drug list and drug distribution. For this project to be viable, it is essential for effective coordination and information exchange occur.

To date, there has been only limited information exchange between donors, NGOs and other parties interested in halting the spread of AIDS. What coordination has taken place has tended to be informal and instigated by a single donor or several NGOs. There is an urgent need for the National AIDS Committee to bring together and share information between its multilateral and bilateral partners (e.g. USAID, UNICEF, UNDP, the Swiss Cooperation, World Bank, World Health Organization, European Economic Community, Japan) and NGOs and NGO umbrella organizations such as Malian Family Planning Association, the Child Survival Pivot Group, Plan International, the Malian NGO umbrella organization and Oxfam.

To improve information exchange, the Project will support coordination meetings held at least once every six months. These meetings will serve to promote discussions among all the organizations active in STD and AIDS prevention and awareness in Mali. Publication and distribution of a quarterly newsletter on STDs and AIDS in Mali will be coordinated by the National AIDS Committee and will provide a forum for donors, health planners, health professionals and NGOs to share information on STD and HIV prevalence and exchange their experiences.

This project will strengthen the National AIDS Committee's capacity to remain abreast of the latest developments in AIDS, HIV and STD through study tours, international conferences and workshops and short-term technical training abroad, through documentation provided by the institutional contractor and through subscriptions to key journals. It will place special emphasis on including the regional AIDS committee members and key regional health personnel in these activities. Seven persons from the central coordinating unit of National AIDS Committee and twenty-two from the regions will be sent to international conferences and workshops.

Local short-term technical assistance will be used as required to overcome personnel shortage or lack of appropriate skills at the National AIDS Committee. Equipment supplied to the USAID-financed AIDS project will be transferred to the National AIDS Committee. This project will continue to support operation and maintenance costs. New equipment consisting of a photocopier and desk-top publishing software will be supplied to assist the National AIDS Committee fulfil its coordination role and facilitate information exchange activities.

b) Policy Development

The development of clear, official policies is crucial to the controlling STDs and fighting AIDS. With respect to this project, a pressing need exists to

develop three specific STD and AIDS-related policies in Mali: STD prevention and control; HIV and AIDS-related counselling; and free condom distribution. In the longer term, a national policy relating to the rights and responsibilities of HIV seropositive and AIDS patients is required. The STD technical advisor will play a crucial role in this process, and close collaboration with other donors and the NGOs will be essential.

1) STD Prevention and control

Mali has never had a formal STD control program. Part of the role of the technical advisor will be to develop, with the National AIDS Committee and the Ministry of Health a set of clear official guidelines for health personnel defining minimum standards for treatment, counselling, partner notification and reporting. Based on the new STD policy, the National AIDS Committee and regional AIDS committees might need to refine regional plans for STD prevention activities. In addition, this project will support the National AIDS Committee to oversee the inclusion of AIDS, HIV and STD prevention activities into other government ministries such as the Ministry of Education, Ministry of Youth, Ministry of Defense and the Ministry of Rural Development as well as the NGOs.

2) HIV and AIDS-related counselling

In the majority of HIV case-finding studies to date in Mali seropositives have not been notified of their results. They have not been counselled to avoid transmission to their partners nor referred for medical care. The Project will promote dialogue between the National AIDS Committee and the Government of Mali and assist them to develop and publish clear official policy guidelines. As a minimum, these will require that all HIV testing be accompanied by pre- and post-test counselling and that all seropositive individuals be notified of their results.

As part of the STD control component of this project, training in pre- and post-test counselling techniques will be offered to key health personnel to ensure they have the skills required to notify all seropositive persons of their results and to counsel them on how to avoid transmitting the disease to their sexual partners. The NGO component will promote, the emergence of community-based or self-help support groups for seropositive individuals, AIDS sufferers and their families.

3) Free condom distribution

In 1993, the National AIDS Committee distributed almost 2 million free condoms to people who came to its headquarters and, through the USAID-financed AIDS project, to hotel and bar managers, prostitutes and their clients. In 1993 the total number of free condoms distributed was over twice the annual number sold by the Social Marketing Project. Free distribution on this scale cannot be sustained and steps have already been taken to limit it. The Project will work with the National AIDS Committee to develop a national policy on free condom distribution providing clear guidelines as to which, if any,

groups can receive them. Free condoms might for example be distributed to people undergoing treatment for STDs or who test positive for HIV. Free condom distribution might also be part of STD and HIV prevention and awareness sessions in schools. Close collaboration with the Condom Social Marketing Project will ensure continuity.

c. Resource Mobilization

Regular meetings of donors and NGOs will contribute not only to improved information exchange but will assist the National AIDS Committee with the coordination and the allocation of resources. Studies carried out under the surveillance, operational research, monitoring and evaluation components of the STD control program will highlight technical problems or geographical areas requiring special attention and give the National AIDS Committee the background data required to both solicit and justify interventions.

To emphasize the potential magnitude of the problem, two studies on the socio-economic and demographic impact of the HIV and AIDS epidemic will be carried out through contracts with local research institutions or consulting organizations. Results of these studies will be published and widely disseminated. A secondary literature analysis will be undertaken and published in a form which makes the relevant data available to decision makers and opinion leaders.

The Project will also supply the National AIDS Committee with the AIDS Impact Model and train personnel in its use. The AIDS Impact Model is a computer model developed by the Futures Group based on the highly-successful RAPID population model. It projects levels of prevalence of AIDS and predicts its socio-economic effects over the next five to twenty-five years in a "generic" African country both in the absence of preventive measures and when selected interventions are implemented. The model will be modified explicitly for Mali and the results of various scenarios will be presented during policy workshops, published and widely disseminated so that they are available to decision-makers.

Finally, to increase commitment to HIV and AIDS prevention, data collected from the aforementioned surveys and studies will be developed into a series of presentations to be made to policy makers at national and regional levels on the potential socio-economic impact of HIV and AIDS in Mali.

d. Information Exchange, Policy Development, and Resource Mobilization: Process Indicators

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|---|---|
| * | By the end of Year 1, National AIDS Committee publish and distribute to at least 1000 people or organizations a quarterly newsletter on STD and AIDS in Mali aimed at providing a forum for information and exchange for donors, health planners and NGOs |
| * | By the end of Year 1, clear-cut policies developed on HIV and AIDS related counselling and free distribution of condoms   |
| * | By the end of Year 1, clear-cut policies developed on STD prevention and control  |
| * | Donor coordination meetings are held every six months   |
| * | Two studies on the socio-economic and demographic impact of AIDS in Mali have been completed  |
| * | By the end of Year 2, at least two scenarios on socio-economic impact of AIDS in Mali developed using the AIDS impact model and are shown to at least 10 policy makers at national and regional levels  |

F. Project Inputs

To realize Project objectives, the following inputs will be provided by USAID to the Government of Mali, i.e., the Ministry of Health and the National AIDS Committee and the Lead PVO:

- |    |   |             |
|----|---|-------------|
| 1. | <u>Overview of Total Project by Component: \$10,000,000</u>                                     |             |
|    | Sexually-Transmitted Disease Control  | \$3,957,600 |
|    | Behavior Change (NGO component)   | 3,159,700   |
|    | Effective coordination (National AIDS Committee)  | 1,052,700   |
|    | USAID long-term technical assistance  | 1,655,000   |
|    | Audits  | 175,000     |
| 2. | <u>Breakdown by Component</u>   |             |
|    | a. <u>Sexually-Transmitted Disease Control: \$3,957,600</u>                                     |             |
|    | <i>Training and support \$361,000</i>   |             |
|    | * Development of STD and HIV training materials   | \$50,000    |
|    | * 46 STD case management trainings over first two years with refresher courses in Years 3 and 4 | \$92,000    |
|    | * 1 HIV counselling training course for up to ten people each year                              | \$7,000     |

- \* 6 trainings for sentinel surveillance laboratories in use of diagnostic equipment during Year 1 with refresher courses in Year 3 \$12,000
- \* 2 long-term training opportunities for National AIDS Committee staff in areas related to STD control and program management \$200,000

*Commodities and equipment \$1,462,500*

- \* Basic STD laboratory equipment for 46 *cercle*-level health centers \$115,000
- \* STD laboratory equipment for six sentinel surveillance centers \$390,000
- \* Supplies for 46 Basic STD laboratories during the life-of-Project \$747,500
- \* Supplies for six STD laboratories at surveillance centers during the life-of-Project \$210,000

*Technical assistance, research and evaluation \$ 2,134,100*

- \* A four-year Technical Advisor with specialist experience of STD Control during Years 1 - 4 \$1,000,000
- \* A seven-year STD Technical Assistant \$164,100
- \* STD case management operational research \$210,000
- \* STD and HIV rapid appraisal studies in Years 3, 5, and 7 \$375,000
- \* Antibiotic susceptibility surveillance \$35,000
- \* STD case management monitoring and evaluation \$350,000

b. Behavior Change (NGO Component): \$3,159,700

*NGO grants, training and support \$1,926,000*

- \* Sub-grants to NGOs \$1,120,000
- \* NGO training and support \$169,000
- \* Media campaigns \$224,000
- \* Operating expenses \$413,000

*Commodities and equipment \$374,000*

*Technical assistance, management and evaluation \$859,700*

- \* Project management (personnel) \$539,200
- \* Monitoring and evaluation \$320,500

c. Effective Coordination: \$1,052,700

*Training and support \$ 549,000*

* 2 training courses per year in program planning and management for central and regional National AIDS Committee members	\$210,000
* Documentation	\$35,000
* Publication and distribution of newsletters and other reports	\$35,000
* AIDS impact model workshops in Years 1 and 2	\$50,000
* Conferences, workshops and study tours	\$156,000
* Office supplies for National AIDS Committee	\$24,500
* Equipment maintenance	\$17,500
* Vehicle operation and maintenance	\$21,000
 <i>Commodities and equipment \$6,000</i>	
* 1 photocopier for National AIDS Committee	\$4,000
* Desk-top publishing software	\$2,000
 <i>Technical assistance \$497,700</i>	
* 63 person-days per year of external technical assistance, per diems and travel costs for coordination, supervision, program and policy development	\$283,500
* 120 person-days per year of national technical assistance and per diems for coordination, supervision, program and policy development	\$214,200
d. <u>USAID Long-Term Technical Assistance: \$1,655,000</u>	
* Seven-year Technical Advisor for AIDS and Child Survival for project management	\$1,550,000
* Seven-year Project Assistant in support of project management	\$105,000
e. <u>Annual Audit of all Three Project Components: \$175,000</u>	

### III. IMPLEMENTATION and MONITORING PLAN

This Implementation and Monitoring plan is a tool to further detail and monitor the Project. It will be added to as new tasks are identified, and will be modified as reality changes. In preparing the plan, the most important conclusion reached was that the objectives of the Project are feasible, from the viewpoint of time and resources.

This section discusses the implementation plan vis-a-vis the three significant Project outputs: improved STD control; behavior change; and a National AIDS Committee that engages in information exchange, policy development and resource mobilization. Improved STD control will be attained through improved STD case management, improved surveillance and reporting of STDs and improved STD institutional capacity at the National AIDS Committee.

#### A. Improved STD Control

##### 1. Year 1

To achieve improved STD control, an institutional contractor must first be hired. This organization will place an STD expert at the National AIDS Committee for two years. This individual will be responsible for all activities under the rubric of STD control. In addition, s/he might be called upon to provide expertise to the National AIDS Committee in forging a collaborative relationship with donors and inter-ministerial partners. Of all of this person's duties, one of the one's having the most long-lasting impact on the Project is that of assisting the National AIDS Committee to identify two individuals (who can be counted upon to return to the National AIDS Committee) for long-term STD training in the United States. The first of these individuals will leave for training during Year 1. The STD expert will work with the second, until the first returns. Other activities under this rubric will include, but not be limited to:

Months	STD Control - Year 1
1	* Recruit STD Technical Advisor
1	* Purchase photocopier and desk-top publishing software
2-3	* Recruit and train STD Case Management Training Team
2-3	* Recruit and train HIV Counseling Trainer
2-6	* Develop training materials
2-6	* Develop information-education-communication pamphlets for patient distribution
2-6	* Develop condom distribution kits, partner referral cards
2-6	* Develop supervisory checklists, reporting forms etc.
2-6	* Revise essential drug list
6	* Develop new STD case reporting system
8 and 11	* Identify one person and send for one year of training abroad
9 and 12	* Write and edit STD and HIV newsletter
6-12	* Publish and disseminate STD and HIV newsletter
6-12	* Hold STD case management training for 175 health professionals and 50 related professions
6-12	* Train ten health professionals in HIV counselling skills
6-12	* Equip 23 <i>cercle</i> health centers with basic STD laboratories
6-12	* Train 23 health personnel in use of basic STD laboratories
6-12	* Supply 23 basic STD laboratories
6-12	* Equip six sentinel surveillance sites with STD laboratories.
6-12	* Train staff at six sentinel surveillance laboratories in use of STD laboratory
11-12	* Supply six STD sentinel surveillance laboratories
12	* Collect, publish and disseminate data on antibiotic susceptibility of gonorrhoea
1-12	* Elaborate research agenda and award initial grants
	* Conduct STD case management monitoring and evaluation

## 2. Year 2

Since the improved STD control component will have been operational for one year, activities during Year 2 will consist basically of an extension of those begun during Year 1, i.e., training of the health personnel at the remaining 23 *cercles*, gathering data from the STD sentinel surveillance sites, equipping the remaining 23 *cercle*-level health centers with STD laboratory equipment, etc. In addition, the first of the two long-term STD trainees will have returned to the National AIDS Committee. This person will work with the STD consultant to comprehend and to be allowed to use the knowledge s/he gained while in the United States.

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Months	STD Control - Year 2
6	* Identify one person and send for one year of training abroad
6 and 12	* Review research agenda and award grants
10	* Refresher training in HIV counselling skills
1-12	* Conduct monitoring and evaluation
"	* STD case management training for 175 health professionals and 50 related professions
"	* Training for 23 health personnel in use of basic STD laboratories
"	* Equip 23 <i>cercle</i> health centers with basic STD laboratories
"	* Train 23 health personnel in use of basic STD laboratories
"	* Supply 46 basic STD laboratories
"	* Supply six STD sentinel surveillance laboratories
"	* Collect, publish and disseminate data on antibiotic susceptibility of gonorrhoea
"	* Publish and disseminate quarterly STD and HIV newsletter, reports and other information as necessary
"	* Conduct STD case management monitoring and evaluation
"	* Collaborate with PPM and World Bank to ensure all primary care facilities are supplied with essential drugs for STD

### 3. Year 3

The foundation of this component of the Project will have been laid, i.e., training to develop institutional capacity and equipping of the laboratories and sentinel surveillance sites. During this year, the second long-term trainee will return and the institutional contractor STD expert will leave. Together, the two long-term STD trainees will, during Year 3, usher in a host of quality assurance activities. These will ensure that quality is maintained at a high level by reinforcing knowledge. In addition, information exchange, one of the cornerstones of Output 3 of the Logical Framework, will have been operational for two years. Health professionals at the peripheral level will have been receiving feedback from their actions for at least two years. In keeping with the self-sustaining goal of Health, Population and Rural Hydrology Project, *cercle*-level health centers will be able to use the information gained from putting into practice their training to make their own decisions about STD care.

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Months	STD Control - Year 3
1-3	* Conduct STD and HIV Rapid Appraisal Study
6 + 12	* Review research agenda and award grants
10	* Hold training and/or refresher training for ten health professionals in HIV counselling skills
1-12	* Hold STD case management refresher training for 175 health professionals and 50 related professions
"	* Supply 46 basic STD laboratories
"	* Supply 6 STD sentinel surveillance laboratories
"	* Collect, publish and disseminate data on antibiotic susceptibility of gonorrhoea
"	* Publish and disseminate quarterly STD and HIV newsletter, reports and other information as necessary
"	* Conduct STD case management monitoring and evaluation
"	* Continue to collaborate with PPM and World Bank on STD essential drug supply
"	* Conduct monitoring and evaluation

#### 4. Years 4, 5 and 6

These Project years will supply constant feedback to the health professionals involved in STD control and to the population, in general. Antibiotic resistance studies will have been conducted for at least two years, providing guidance to the confirmation or modification of the essential drug list. A newsletter will have been published for at least two years, containing information of a regional as well as significance. Health professionals at the periaortal levels will have tangible evidence that their data collection activities are feeding into the development of national policy and that locally, in areas of high STD prevalence, additional resources are being allocated to combat STDs.

Lastly, regular monitoring and overall periodic program evaluations will add to the refinement of Project activities.

Month	STD Control - Year 4
10	* Hold training and/or refresher training for ten health professionals in HIV counselling skills
6 and 12	* Review research agenda and award grants
1-12	* Conduct Monitoring and evaluation
"	* Hold STD case management refresher training for 175 health professionals and 50 related professions
"	* Supply 46 basic STD laboratories,
"	* Supply 6 STD sentinel surveillance laboratories
"	* Collect, publish and disseminate data on antibiotic susceptibility of gonorrhoea
"	* Publish and disseminate quarterly STD and HIV newsletter, reports and other information as necessary
"	* Conduct STD case management monitoring and evaluation
"	* Collaborate with PPM and World Bank on STD essential drug supply
"	

Month	STD Control - Year 5
1-3	* Conduct STD and HIV Rapid Appraisal Study
10	* Hold training and/or refresher training for ten health professionals in HIV counselling skills
	* Review research agenda and award grants
6 and 12	* Supply 46 basic STD laboratories
1-12	* Supply six STD sentinel surveillance laboratories
"	* Collect, publish and disseminate data on antibiotic susceptibility of gonorrhoea
"	* Publish and disseminate quarterly STD and HIV newsletter, reports and other information as necessary
"	* Conduct STD case management monitoring and evaluation
"	* Collaborate with PPM and World Bank on STD essential drug supply
"	* Conduct Monitoring and Evaluation

Month	STD Control - Year 6
10	* Hold training and/or refresher training for ten health professionals in HIV counselling skills
	* Review research agenda and award grants
6 and 12	* Conduct monitoring and evaluation
1-12	* Supply 46 basic STD laboratories
"	* Supply six STD sentinel surveillance laboratories
"	* Collect, publish and disseminate data on antibiotic susceptibility of gonorrhoea
"	* Publish and disseminate quarterly STD and HIV newsletter, reports and other information as necessary
"	* Conduct STD case management monitoring and evaluation
"	* Collaborate with PPM and World Bank on STD essential drug supply

### 5. Year 7

This year will basically follow the same activities as those in Year 5. Quality assurance, operating expenses for sentinel surveillance laboratories, the publication and dissemination of data from the sentinel surveillance sites as well as the quarterly newsletter will figure prominently. Project closeout and recommendations for a new follow on activities will also occur.

Month	STD Control - Year 7
4-8	* As Year 5 * Develop new proposals for STD Control in Mali according to evaluation recommendations

B. Behavior Change

Behavior change will serve to reduce the risk of transmission of the HIV virus. Behavior change will be accomplished through expanding and improving STD and AIDS health education activities to be undertaken by NGOs; improving marketing of condoms using NGOs; and promoting HIV and AIDS case management for seropositive individuals and their families. It is envisioned that all of these activities will be effected under the auspices of an umbrella NGO. Thus, USAID's first step in achieving behavior change will be to hire an umbrella NGO. This organization will be responsible for selecting, training, day-to-day managing, etc. of the NGOs that will be involved in the Project.

1. Year 1

This will be the start up year for this Project component. During this year, the foundation will be laid for the following years. Basic management structures to manage the individual NGOs as well as the outputs of the larger organization will be put into place. Criteria for awarding grants, selection committee, interfacing with the National AIDS Committee for regionalization of activities will all have to be accomplished for this component of the Project to succeed in outlying years. In addition to the aforementioned activities, others will include, but not be limited to the following:

Month	Behavior Change - Year 1
1	* Identify Lead PVO to act as "umbrella" organization
2	* Award grant to Lead PVO
1-2	* Supply commodities and equipment
2-6	* Establish management structure
2-6	* Nominate Selection Committee members, define criteria and establish procedures for NGO sub-grants
2-6	* Identify potential NGO partners
2-6	* Develop materials and strategy
6-12	* Award sub-grants for information-education-communication
6-12	* Award sub-grants for Condom Marketing
6-12	* Award sub-grants for Support Organization
6-12	* Organize NGO management training
6-12	* Organize NGO technical training (information-education-communication/STD and AIDS)
6-12	* Organize Media campaigns
6-12	* Monitor and evaluate NGO activities
6 & 12	* Submit Activity Reports
6 & 12	* Submit Financial Reports

2. Year 2

Once the management structures are in place, Year 2 consists of putting them into practice. This will be the first full year of operation. During this year, grants will

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be awarded, NGOs will receive STD and AIDS specific training and Knowledge-Attitudes and Practices surveys will be conducted in Project areas and activities will be monitored. The umbrella NGO will begin to receive support from the Condom Social Marketing Project in terms of condom social marketing techniques specifically targeted to NGOs. Special condom promotion campaigns will be staged by the Condom Social Marketing Project in areas where a high concentration of NGOs are working.

It is envisioned that by Year 2, a policy governing HIV counselling will have been adopted, diffused and will be regularly practiced by those conducting non-blind HIV tests. NGOs will support this action by establishing centers of support for HIV seropositive individual and their families. These centers will follow the same model as the highly-successful NGO centers in Uganda, TASO. These centers may provide linkages between the infected individual and the community. These linkages may include, but not be limited to providing information on the following: where to go for health care; providing for one's children after one's death; and protecting one's partner against infection.

Month	Behavior Change - NGO Component - Year 2
1-12	* Identify potential NGO partners
"	* Develop materials and strategy
"	* Award sub-grants for information-education-communication
"	* Award sub-grants for condom marketing
"	* Award sub-grants for support organization
"	* Organize NGO training and support
"	* Organize media campaigns
"	* Monitor and evaluate NGO activities and media Campaigns
11	* Conduct External Evaluation
6 & 12	* Submit Activity Reports
6 & 12	* Submit Financial Reports

### 3. Year 3

Based on the results of the external evaluation, Year 3 will yield a confirmation or modification of the strategies to attain the major Project outputs of this component of the Project. Also, grants to the NGOs will be awarded, coordination with the National AIDS Committee for overall NGO activities will occur, as well as coordination with other donors who are awarding grants to NGOs. This will ensure a non-duplication of effort. Results will be seen from the input to NGOs by the condom Social Marketing Project. Year 3 will provide a review of this strategy as well.

Month	Behavior Change - NGO Component - Year 3
1-12	* Identify potential NGO partners
"	* Develop materials and strategy
"	* Award sub-grants for information-education-communication
"	* Award sub-grants for condom marketing
"	* Award sub-grants for support organization
"	* Organize NGO training and support
"	* Organize media campaigns
"	* Monitor and evaluate NGO activities and media campaigns
6 & 12	* Submit Activity Reports
6 & 12	* Submit Financial Reports

4. Years 4, 5 and 6

These years will provide constant feedback to the NGOs working in the field vis-a-vis the success or potential success or their activities. Grants will be given to additional NGOs in areas that have achieved a limited proven success. NGOs providing case management services for seropositives and their families will have been operational for at least two years. Specific approaches that have worked as well as those that have failed will be used to enhance this activity. A national conference for NGOs will occur during Year 4. This conference will enable NGOs to come together as a group to discuss problematic approaches and to learn from others that have surmounted these problems and gone on to discover novel approaches to overcoming them. Years 5 and 6 will consist of providing grants, monitoring grantees and disseminating new information and approaches to other potential grantees.

Month	Behavior Change - NGO Component - Year 4
6	* As Year 2 plus hold National NGO Conference * Replace NGO equipment

Month	Behavior Change - NGO Component - Year 5
6	* As Year 3 plus . . . * Replace Management structure vehicles and computer equipment

Month	Behavior Change - NGO Component - Year 6
	* As Year 2

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5. Year 7

This year will follow basically the same activities as those in Year 3. Based on the results of the external evaluation, Year 7 will yield a confirmation or modification of the strategies to attain the major Project outputs of this component of the Project. Coordination with the National AIDS Committee for overall NGO activities will continue to occur, as well as coordination with other donors who are awarding grants to NGOs. Results will continue to be seen from the input to NGOs by the Condom Social Marketing Project. Project closeout and recommendations for a new follow on activities, will also occur.

Month	Behavior Change - NGO Component - Year 7
4-8	* As Year 3 plus . . . * Draw up proposals for new Behavior Change Component according to recommendations of evaluation

C. Information Exchange, Policy Development, and Resource Mobilization

One of the critical components of a successful HIV and AIDS prevention and control program is the existence of an effective program management and coordination unit. Tackling the HIV and AIDS epidemic requires strong program leadership for the mobilization, coordination and appropriate use of international, national and multi-sectoral financial and human resources. This is the third component of the Project, the output of which is to strengthen the institutional capacity of the National AIDS Committee. Specifically, the National AIDS Committee will engage in information exchange, policy development and resource mobilization by the completion of this Project. This output will be attained through putting in operation an information exchange component, a policy development unit and a resource mobilization component.

1. Year 1

As in the other Project components, this year will consist of writing requests for proposals in which detailed scopes of work will be outlined for the services of external and local consultants. These consultants will assist the National AIDS Committee to develop policy in the areas of HIV and AIDS-related counselling, the free distribution of condoms and STD control. In addition, the purchase of supplies and equipment, training and study tours for Project staff will be conducted. Mechanism for ensuring the exchange of information will be established, including donor coordination meetings and an informative newsletter.

Month	Information Exchange, Policy Development, and Resource Mobilization - Year 1
1-12	* Supply 63 person-days of external technical assistance
1-12	* Supply 120 person-days of national technical assistance
1-3	* Install AIDS Impact Model software and train personnel to use it
4-11	* Develop scenarios on socio-economic impact of AIDS in Mali using the AIDS impact model
	* Hold AIDS impact model workshop
12	* Hold Donor coordination meetings
2 and 8	* Develop policy on HIV and AIDS related counseling
1-6	* Develop policy on free distribution of condoms
1-6	* Develop policy on STD prevention and control
1-6	* Hold training course in program planning and management
3 and 9	* Commission studies of the socio-economic and demographic impact of AIDS in Mali
6	* Write and edit first quarterly newsletter
	* Publish and distribute first quarterly newsletter
10-11	* Supply documentation and journals to National AIDS Committee and Regions
12	* Identify and send participants to conferences and workshops and on study tours
1-12	* Provide office supplies for National AIDS Committee
1-12	* Provide Equipment maintenance for National AIDS Committee
1-12	* Provide Vehicle operation and maintenance for National AIDS Committee

## 2. Year 2

This will be the first fully operational year for the strengthened National AIDS Committee. During this year, the newsletter will seek a wider audience and become the source of information for all persons and organizations working in AIDS in Mali. Policies that were developed during Year 1 will be promulgated throughout the country. Persons responsible for implementing these policies will be trained. Monitoring and feedback to the Ministry of Health will ensure adherence to the progressive implementation of these policies. Exit surveys of individuals undergoing HIV testing and STD diagnoses might be conducted as means to verify that policies are actually being practiced. Wide distribution of the results of these surveys might be employed as positive reinforcement for those individuals implementing the policies. Lastly, this year will see two studies on socio-economic and demographic impact of AIDS in Mali completed. The results of these studies will be used to leverage donor funds.

Month	Information Exchange, Policy Development, and Resource Mobilization - Year 2
1-12	* Supply 63 person-days of external technical assistance
1-12	* Supply 120 person-days of national technical assistance
1-5	* Develop scenarios on socio-economic impact of AIDS in Mali using the AIDS impact model
6	* Hold AIDS impact model workshop
2 and 8	* Hold Donor coordination meetings
3 and 9	* Hold training course in program planning and management
2, 5, 8, & 11	* Write and edit quarterly newsletter
3, 6, 9, & 12	* Publish and distribute quarterly newsletter
1-12	* Supply documentation and journals to National AIDS Committee and Regions
1-12	* Identify and send participants to conferences and workshops and on study tours
1-12	* Provide office supplies for National AIDS Committee
1-12	* Provide Equipment maintenance for National AIDS Committee
1-12	* Provide Vehicle operation and maintenance for National AIDS Committee

### 3. Years 3, 4, 5 and 6

The foundation for the activities of years 3-6 will have already been laid in Years 1 and 2. During these years, additional technical assistance for training, supervisory visits, for the creation or updating of regional and/or national AIDS plans and to assist in the coordination of donor meetings might occur. As in Year 1, scopes of work will be written and contractors chosen. The newsletter will continue to provide the bulk of the AIDS information to the general population, while annual reports will be more targeted to donors. During Year 3, an evaluation of the Project will occur. This will form the basis for confirmation or modification of Project activities.

Month	Information Exchange, Policy Development, and Resource Mobilization - Years 3-6
1-12	* Supply 63 person-days of external technical assistance
1-12	* Supply 120 person-days of national technical assistance
2 and 8	* Hold donor coordination meetings
3 and 9	* hold training course in program planning and management
2,5,8 & 11	* Write and edit quarterly newsletter
3,6,9 & 12	* Publish and distribute quarterly newsletter
1-12	* Supply documentation and journals to National AIDS Committee and Regions
1-12	* Identify and send participants to conferences and workshops and on study tours
1-12	* Provide office supplies for National AIDS Committee
1-12	* Provide equipment maintenance for National AIDS Committee
1-12	* Provide vehicle operation and maintenance for National AIDS Committee
1-12	* Program evaluation Year 3

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5. Year 7

This year will basically follow the same activities as those in Year 6. Based on the results of the external evaluation, Year 7 will yield a confirmation or modification of the strategies to attain the major Project outputs of this component of the Project. Coordination within the Malian Government will continue to occur, as well as coordination with other donors. Quality assurance in the implementation of policy will continue to be monitored. Project closeout and recommendations for a new follow on activities will also occur.

Month	Information Exchange, Policy Development, and Resource Mobilization - Year 7
	* as Year 3 plus . . .
1-6	* elaborate proposals for new program

## VI. FINANCIAL PLAN

### A. USAID Mali's Contribution:

USAID Mali will provide \$10,000,000 under the Development Fund for Africa (DFA) to support STD control, behavior change, effective coordination, USAID long term technical assistance, and audits. The following consists of four summary tables and a detailed budget, illustrating the project's financial plan:

Table 1: Summary of life-of-Project financing

Table 2: Budget summary

Table 3: Detailed budget: Breakdown between foreign exchange and local currency costs per year

Table 4: Assessment of implementation and financing methods

Table 5: Host country contribution

Table 1  
Summary Life of Project Financing  
(\$000)

Budget Line Items	Amount to be Obligated in FY94	Remaining Anticipated Obligation	Total Amount to be Obligated
STD Control	1,020	2,937	3,957
Behavior Change	686	2,474	3,160
Effective Coordination	181	872	1,053
USAID Project Management	215	1,440	1,655
Audits	25	150	175
Total	2,127	7,873	10,000

Table 2: Budget Summary

Version dated 17-Aug

SUMMARY	Year 1		Year 2		Year 3		Year 4		Year 5		Year 6		Year 7		TOTAL \$		Total \$
	LC	FE	LC	FE	LC	FE	LC	FE	LC	FE	LC	FE	LC	FE	Local	Foreign	
STD Control	188,442	835,000	132,448	502,500	263,442	445,000	132,442	445,000	234,442	145,000	109,442	145,000	234,442	145,000	1,295,100	2,662,500	3,957,600
Behavior Change	370,600	315,500	352,100	122,500	347,100	17,500	347,100	78,500	342,100	137,500	347,100	22,500	342,100	17,500	2,448,200	711,500	3,159,700
Effective Coordination	84,600	96,500	75,600	81,500	59,600	90,500	50,600	81,500	59,600	90,500	50,600	81,500	59,600	90,500	440,200	612,500	1,052,700
USAID Long Term TA	15,000	200,000	15,000	250,000	15,000	200,000	15,000	250,000	15,000	200,000	15,000	250,000	15,000	200,000	105,000	1,550,000	1,655,000
USAID Audit	25,000	0	25,000	0	25,000	0	25,000	0	25,000	0	25,000	0	25,000	0	175,000	0	175,000
<b>TOTAL</b>	<b>683,642</b>	<b>1,447,000</b>	<b>600,148</b>	<b>956,500</b>	<b>710,142</b>	<b>753,000</b>	<b>570,142</b>	<b>855,000</b>	<b>676,142</b>	<b>573,000</b>	<b>547,142</b>	<b>499,000</b>	<b>676,142</b>	<b>453,000</b>	<b>4,463,500</b>	<b>5,536,500</b>	<b>10,000,000</b>

Table 3: Detailed Budget: Breakdown of Foreign Exchange and Local Currency Costs per Year

Version dated 23-Aug

1 STD CONTROL	Unit cost	Year 1		Year 2		Year 3		Year 4		Year 5		Year 6		Year 7		Local	Foreign	TOTAL \$	
		LC	FB																
<b>A STD Case Management</b>																			
Develop Training materials		50,000	0	6	0	0	0	0	0	0	0	0	0	0	0	30,006	0	30,006	
23 STD case management training per year	1,000	23,000	0	23,000	0	23,000	0	23,000	0	23,000	0	23,000	0	23,000	0	92,000	0	92,000	
1 HIV Counseling Training per year	1,000	1,000	0	1,000	0	1,000	0	1,000	0	1,000	0	1,000	0	1,000	0	7,000	0	7,000	
23 Equip CSC Laboratory per year	2,500	0	57,500	0	57,500	0	57,500	0	57,500	0	57,500	0	57,500	0	0	113,000	0	113,000	
46 Supply CSC Labs	2,500	0	57,500	0	113,000	0	113,000	0	113,000	0	113,000	0	113,000	0	0	747,500	0	747,500	
Operations Research		30,000	0	30,000	0	30,000	0	30,000	0	30,000	0	30,000	0	30,000	0	210,000	0	210,000	
<b>B STD Surveillance</b>																			
Develop new disease reporting system		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Equip 6 STD Laboratories		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
6 Equipment	65,000	0	390,000	0	0	0	0	0	0	0	0	0	0	0	0	0	390,000	0	390,000
6 Training	1,000	6,000	0	0	0	0	0	0	0	0	0	0	0	0	0	12,000	0	12,000	
6 Supplies	5,000	0	30,000	0	30,000	0	30,000	0	30,000	0	30,000	0	30,000	0	0	210,000	0	210,000	
Conduct rapid appraisal studies		123,000	0	0	0	123,000	0	0	0	123,000	0	0	0	0	0	375,000	0	375,000	
Antibiotic susceptibility surveillance		5,000	0	5,000	0	5,000	0	5,000	0	5,000	0	5,000	0	5,000	0	35,000	0	35,000	
<b>C STD Institutional Capacity Building</b>																			
1 Long Term STD Advisor at PHLS		230,000	0	0	230,000	0	230,000	0	230,000	0	230,000	0	230,000	0	0	1,000,000	0	1,000,000	
2 Long Term STD Assistant at PHLS		23,442	0	23,442	0	23,442	0	23,442	0	23,442	0	23,442	0	23,442	0	164,094	0	164,094	
3 Long Term Training Opportunity for PHLS Staff		50,000	0	0	50,000	0	50,000	0	50,000	0	50,000	0	50,000	0	0	200,000	0	200,000	
<b>D Monitoring and Evaluation</b>																			
		50,000	0	50,000	0	50,000	0	50,000	0	50,000	0	50,000	0	50,000	0	350,000	0	350,000	
<b>SUBTOTAL 1.</b>		<b>188,442</b>	<b>0</b>	<b>132,448</b>	<b>0</b>	<b>233,442</b>	<b>0</b>	<b>445,000</b>	<b>0</b>	<b>445,000</b>	<b>0</b>	<b>445,000</b>	<b>0</b>	<b>445,000</b>	<b>0</b>	<b>1,295,108</b>	<b>2,642,598</b>	<b>3,937,706</b>	

2 BEHAVIOR CHANGE	Unit cost	Year 1		Year 2		Year 3		Year 4		Year 5		Year 6		Year 7		TOTAL \$		Total \$
		LC	FE	LC	FE	LC	FE	LC	FE	LC	FE	LC	FE	LC	FE	Local	Foreign	
<b>A NGO GRANTS</b>																		
10 IEC (10NGOs/yr)	10,000	100,000	0	100,000	0	100,000	0	100,000	0	100,000	0	100,000	0	100,000	0	700,000	0	700,000
20 Development of Condom Marketing	2,000	40,000	0	40,000	0	40,000	0	40,000	0	40,000	0	40,000	0	40,000	0	280,000	0	280,000
5 Counseling and support organisations	4,000	20,000	0	20,000	0	20,000	0	20,000	0	20,000	0	20,000	0	20,000	0	140,000	0	140,000
<b>B NGO PROJECT MANAGEMENT</b>																		
1 Long Term TA	200,000		100,000	0	100,000	0	0	0	0	0	0	0	0	0	0	0	200,000	200,000
Short term TA	20,000	10,000	10,000	0	0	0	0	0	0	0	0	0	0	0	0	10,000	10,000	20,000
1 Project Manager	15,000	15,000	0	15,000	0	15,000	0	15,000	0	15,000	0	15,000	0	15,000	0	105,000	0	105,000
1 Accountant	6,000	6,000	0	6,000	0	6,000	0	6,000	0	6,000	0	6,000	0	6,000	0	42,000	0	42,000
2 Regional Representatives	6,000	12,000	0	12,000	0	12,000	0	12,000	0	12,000	0	12,000	0	12,000	0	84,000	0	84,000
3 Drivers	3,000	9,000	0	9,000	0	9,000	0	9,000	0	9,000	0	9,000	0	9,000	0	63,000	0	63,000
2 Guards	1,800	3,600	0	3,600	0	3,600	0	3,600	0	3,600	0	3,600	0	3,600	0	25,200	0	25,200
<b>Consumables and equipment</b>																		
3 Vehicles	28,000		84,000	0	0	0	0	0	0	0	84,000	0	0	0	0	0	168,000	168,000
6 Computer Equipment	6,000		36,000	0	0	0	0	0	0	0	36,000	0	0	0	0	0	72,000	72,000
3 Photocopier	4,000		12,000	0	0	0	0	0	0	0	0	0	0	0	0	0	12,000	12,000
10 NGO Equipment Kits (motor, AV, Computer)	5,000		50,000	0	0	0	0	0	50,000	0	0	0	0	0	0	0	100,000	100,000
2 Furniture & General Equipment - Regions	5,000	10,000	0	0	0	0	0	0	0	0	0	0	0	0	0	10,000	0	10,000
1 Research NGO Equipment Kit (motor, comp)	6,000		6,000	0	0	0	0	0	6,000	0	0	0	0	0	0	0	12,000	12,000
<b>C NGO TRAINING AND SUPPORT</b>																		
Technical Training (IEC/STD/AIDS)		12,500	0	10,000	0	10,000	0	5,000	0	5,000	0	5,000	0	5,000	0	52,500	0	52,500
Management training		5,000	0	5,000	0	5,000	0	5,000	0	5,000	0	5,000	0	5,000	0	35,000	0	35,000
Ateliers/seminars		4,500	0	4,500	0	4,500	0	4,500	0	4,500	0	4,500	0	4,500	0	31,500	0	31,500
Visits and exchanges		1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	10,500	10,500	21,000
Training materials		1,500	0	500	0	500	0	500	0	500	0	500	0	500	0	4,500	0	4,500
Documentation & films		0	1,000	0	1,000	0	1,000	0	1,000	0	1,000	0	1,000	0	1,000	0	7,000	7,000
Publications (NGO experience)		2,500	0	2,500	0	2,500	0	2,500	0	2,500	0	2,500	0	2,500	0	17,500	0	17,500
<b>Media Campaigns</b>																		
Video/audio tape reproduction		2,000	0	2,000	0	2,000	0	2,000	0	2,000	0	2,000	0	2,000	0	14,000	0	14,000
Booklet & Poster Production		15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	105,000	105,000	210,000
<b>Operating Costs</b>																0	0	0
4 Equipment (Operation & Maintenance)	2,500	10,000	0	10,000	0	10,000	0	10,000	0	10,000	0	10,000	0	10,000	0	70,000	0	70,000
1 Bamako Office supplies and operating costs	17,000	17,000	0	17,000	0	17,000	0	17,000	0	17,000	0	17,000	0	17,000	0	119,000	0	119,000
2 Regional Office supplies and operating costs	8,000	16,000	0	16,000	0	16,000	0	16,000	0	16,000	0	16,000	0	16,000	0	112,000	0	112,000
3 Vehicle Operation and maintenance	3,500	10,500	0	10,500	0	10,500	0	10,500	0	10,500	0	10,500	0	10,500	0	73,500	0	73,500
3 Vehicle Insurance	500	1,500	0	1,500	0	1,500	0	1,500	0	1,500	0	1,500	0	1,500	0	10,500	0	10,500
Staff Training	4,000	4,000	0	4,000	0	4,000	0	4,000	0	4,000	0	4,000	0	4,000	0	28,000	0	28,000
<b>D MONITORING AND EVALUATION</b>																		
1 Travel and Perdiens	4,500	4,500	0	4,500	0	4,500	0	4,500	0	4,500	0	4,500	0	4,500	0	31,500	0	31,500
5 KAP Baseline Studies (NGH), IEC campaigns	3,000	15,000	0	15,000	0	15,000	0	15,000	0	15,000	0	15,000	0	15,000	0	105,000	0	105,000
5 KAP Evaluation Studies (NGO), IEC)	3,000	15,000	0	15,000	0	15,000	0	15,000	0	15,000	0	15,000	0	15,000	0	105,000	0	105,000
National KAP (50% of costs)	6,000	6,000	0	6,000	0	6,000	0	6,000	0	6,000	0	6,000	0	6,000	0	42,000	0	42,000
Media Monitoring (50% of costs)	1,000	1,000	0	1,000	0	1,000	0	1,000	0	1,000	0	1,000	0	1,000	0	7,000	0	7,000
Evaluations (Yrs 2, 4 & 6)	10,000	0	0	5,000	5,000	0	0	5,000	5,000	0	0	5,000	5,000	0	0	15,000	15,000	30,000
<b>SUBTOTAL 2</b>		<b>378,600</b>	<b>315,500</b>	<b>352,100</b>	<b>122,500</b>	<b>347,100</b>	<b>17,500</b>	<b>347,100</b>	<b>78,500</b>	<b>342,100</b>	<b>137,500</b>	<b>347,100</b>	<b>22,500</b>	<b>342,100</b>	<b>17,500</b>	<b>2,448,200</b>	<b>711,500</b>	<b>3,159,700</b>

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3 EFFECTIVE COORDINATION	Unit cost	Year 1		Year 2		Year 3		Year 4		Year 5		Year 6		Year 7		TOTALS		Total \$	
		LC	FE	LC	FE	LC	FE	LC	FE	LC	FE	LC	FE	LC	FE	Local	Foreign		
<b>A. Policy Development, Coordination &amp; Supervision</b>																			
External Short Term TA																			
63 days salaries	300	0	18,900	0	18,900	0	18,900	0	18,900	0	18,900	0	18,900	0	18,900	0	132,300	0	132,300
3 return Air Fares	3,000	0	9,000	0	9,000	0	9,000	0	9,000	0	9,000	0	9,000	0	9,000	0	63,000	0	63,000
63 days Hotel and incidental Expenses	200	0	12,600	0	12,600	0	12,600	0	12,600	0	12,600	0	12,600	0	12,600	0	88,200	0	88,200
Local Short Term TA																			
120 days salaries	240	28,800	0	28,800	0	28,800	0	28,800	0	28,800	0	28,800	0	28,800	0	28,800	201,600	0	201,600
60 days per diems	30	1,800	0	1,800	0	1,800	0	1,800	0	1,800	0	1,800	0	1,800	0	1,800	12,600	0	12,600
<b>B. Information Exchange</b>																			
Documentation	5,000	0	5,000	0	5,000	0	5,000	0	5,000	0	5,000	0	5,000	0	5,000	0	35,000	0	35,000
Newspaper & Other Publications	5,000	5,000	0	5,000	0	5,000	0	5,000	0	5,000	0	5,000	0	5,000	0	5,000	35,000	0	35,000
Conference/Workshop (5 or 2 per year)	6,000	15,000	15,000	6,000	6,000	15,000	15,000	6,000	6,000	15,000	15,000	6,000	6,000	15,000	15,000	78,000	78,000	0	156,000
AIDS Impact Model Workshops	25,000	25,000	0	25,000	0	0	0	0	0	0	0	0	0	0	0	0	50,000	0	50,000
<b>C. Commodities and Equipment</b>																			
1 Copier	4,000	0	4,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,000	4,000
1 Desk top Publishing Software	2,000	0	2,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,000	2,000
<b>D. Training</b>																			
2 Short term training (Program Management)	15,000	0	30,000	0	30,000	0	30,000	0	30,000	0	30,000	0	30,000	0	30,000	0	210,000	0	210,000
<b>E. Operating Costs</b>																			
Office Supplies	3,500	3,500	0	3,500	0	3,500	0	3,500	0	3,500	0	3,500	0	3,500	0	3,500	24,500	0	24,500
1 Equipment Maintenance	2,500	2,500	0	2,500	0	2,500	0	2,500	0	2,500	0	2,500	0	2,500	0	2,500	17,500	0	17,500
1 Vehicle Operation and maintenance	3,000	3,000	0	3,000	0	3,000	0	3,000	0	3,000	0	3,000	0	3,000	0	3,000	21,000	0	21,000
<b>SUB TOTAL 3</b>		<b>84,600</b>	<b>96,500</b>	<b>75,600</b>	<b>81,500</b>	<b>59,600</b>	<b>90,500</b>	<b>50,600</b>	<b>81,500</b>	<b>59,600</b>	<b>90,500</b>	<b>50,600</b>	<b>81,500</b>	<b>59,600</b>	<b>90,500</b>	<b>440,200</b>	<b>612,500</b>		<b>1,052,700</b>
USAID Long-term TA	200,000	15,000	200,000	15,000	250,000	15,000	200,000	15,000	250,000	15,000	200,000	15,000	250,000	15,000	200,000	105,000	1,550,000		1,655,000
USAID Audit	25,000	25,000	0	25,000	0	25,000	0	25,000	0	25,000	0	25,000	0	25,000	0	175,000	0		175,000
<b>TOTAL 1+2+3+4</b>		<b>658,642</b>	<b>1,472,000</b>	<b>575,148</b>	<b>956,500</b>	<b>710,142</b>	<b>753,000</b>	<b>570,142</b>	<b>855,000</b>	<b>676,142</b>	<b>573,000</b>	<b>547,142</b>	<b>499,000</b>	<b>676,142</b>	<b>453,000</b>	<b>4,463,500</b>	<b>5,536,500</b>		<b>10,000,000</b>

B. Assessment of Implementation and Financing Methods

Table 4  
Assessment of Implementation and Financing Methods

Component	Method of Implementation	Method of Financing	Amount (\$)
STD Control: Long term TA, Training, Laboratory Equipment and Supplies, Commodities, Operational Expenses, Evaluation and Research	Direct Contract with an Institutional Contractor <sup>21</sup>	Direct Payment	\$3,957,600
Behavior Change	Cooperative Agreement	Direct Payment	\$3,159,700
PVO Activities	Grants	Direct Payment	\$800,000
Effective Coordination: Short Term TA Training, Supplies, Operational Expenses	Direct Contract with an Institutional Contractor	Direct Payment	\$1,052,700
USAID Long-Term Technical Assistance: TAACS and FSN Replacement	PASA	Direct Payment	\$750,000
USAID Long-Term Technical Assistance: Project Assistant	Direct Contract	Direct Payment	\$105,000
Audit	USAID Contracting Officer	Direct Payment	\$175,000

<sup>32</sup>One institutional contractor will be hired to implement both the STD Control and Effective Coordination components of the project. The maximum total award of the contract will be \$5,010,300 (\$3,957,600 STD Control + \$1,052,700 Effective Coordination).

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C. Government of the Republic of Mali Contribution:

Section 110 of the Foreign Assistance Act requires that the Host Country contribute to a USAID-funded project an amount totalling not less than 25 per cent of the total amount contributed by USAID and the Host Country, unless the requirement is waived by USAID Washington at the request of the Mission Director. The Host Government generally makes this contribution in kind by providing to the project free of charge such things as services of government personnel, time and effort of members of the community, office space, or other needs of the project. The GRM is required to report quarterly on its contribution, and USAID Mali has issued a Mission Order to document this requirement.

The projected host country contribution shown on the table and in the accompanying notes below includes salaries for Malian government personnel in the equivalent amount of 158,050 US DOLS. and rental value of office space for the equivalent of 67,200 US DOLS, totaling to 225,250 US DOLS.. This amount represents 2% of total project which is far less than the required 25% percent contribution which would be 3,292,080 US DOLS..

Table 5  
Host Country Contribution<sup>22</sup>

Budget Line Items	Total
Salaries	158
Office space	67
Total	225

1. Justification of the host country contribution

a. Salaries

This is made up of salaries of the staff of the Project Coordination Unit of the *Programme Nationale de Lutte Contre le Sida*, the implementing unit of the project, and the *Direction Regionale de la Santé Publique* in eight regions plus the District of Bamako. The contributions to salary cost of these services are calculated as follows (at the exchange rate of 500 CFA for 1 US DOL):

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<sup>22</sup>The source of the following information is the *Programme National de Lutte contre le SIDA*.

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i. Project Coordination Unit of the *Programme de lutte contre le Sida*:

The number of employees is 12. The percentage of time devoted by these personnel to project activities is estimated at 60%. Annual salary is estimated at 14,000,000 CFA for the first two years and 14,700,000 CFA for the following five years.

Salary contribution for the Cellule:

14,000,000 CFA X 60% X 2 = 16,800,000 CFA = 33,600 US DOLS.

14,700,000 CFA X 60% X 5 = 44,100,000 CFA = 88,200 US DOLS.

Total 121,800 US DOLS.

ii. Regions:

Eight regions plus the district of Bamako are covered by this project. Annual estimate salary for personnel involved in the project in these regions is 25,000,000 CFA for the first two years of the project and 26,250,000 CFA for the remaining five years. The percentage of time devoted by these personnel to project activities is estimated at 10%.

Salary contribution for the regions are:

25,000,000 CFA X 10% X 2 = 5,000,000 CFA = 10,000 US DOLS.

26,250,000 CFA X 10% X 5 = 13,125,000 CFA = 26,250 US DOLS.

Total 36,250 US DOLS.

Total salary contribution: 121,800 US DOLS. + 36,250 US DOLS. = 158,050 US DOLS..

b. Office space (Rental Value)

This is an estimate of the value of the office space that is being contributed to the project. The project makes use of it free of charge. The project implementing is going to move from the building it is occupying now and the government of Mali is going to provide another building with more space with an estimated rental value of 8,000,000 CFA per year. The project staff is expected to occupy 60 percent of the office space. For the life of the project, total rental value is:

8,000,000 CFA X 60% X 7 = 33,600,000 CFA = 67,200 US DOLS.

D. Audit Provisions

USAID Mali has opted for providing Agency-contracted Financial Audits on behalf of the Malian government's institutions. These financial audits will be performed annually in accordance with AICPA Generally Accepted Audit Standards, the U.S government Auditing Standards and the "Guidelines for Financial Audits Contracted by Foreign Recipients" issued by the USAID Inspector General.

1. USAID Mali's Responsibility:

USAID Mali will select an approved local independent accounting firm to conduct these audits using U.S. Government Auditing Standards. Upon the completion of audit field work, the draft report shall be submitted to the Mission for review in relation with the terms of the Scope Of Work. USAID Mali will forward the final draft audit report to RIG/A/Dakar for desk review.

The audit Liaison Officer for the Mission is the Controller.

2. RIG/A/Dakar's Responsibility:

Using the final draft report, the Regional Inspector in Dakar, Senegal (RIG/A/DAKAR) is responsible for assuring that the work performed under this audit complies with the audit guidelines and the applicable auditing standards. In doing so, RIG/A/Dakar will provide technical advice to the audit firm and USAID Mali.

3. The Government of Mali's Responsibility:

The government of Mali's responsibility is two fold: (1) make all the documentation available to the auditors for the conduct of the audit; (2) assure that the recommendations issued from the audit are properly implemented and closed in a reasonable time.

4. Funding for Audits:

The amount of \$175,000 has been provided under this project to perform one audits per year for the seven year life of project.

## V. PROJECT ANALYSIS SUMMARIES

### A. Technical and Institutional Analysis Summary

#### 1. Improved Sexually-Transmitted Disease Control

##### a. The Current Situation in Mali

##### 1) Clinical Care

There has never been a formal control program for sexually-transmitted diseases in Mali. Their care is a microcosm of health care in general existing within the same environment and subject to all of the same problems. Specifically, access to sexually-transmitted diseases diagnostic and treatment services is limited due to poor access to primary health care, inadequate training of primary care providers, inadequate diagnostic facilities, and a lack of appropriate and affordable drugs to treat sexually-transmitted diseases. Taking into account the level of morbidity, and the available infrastructure, Mali ranked highest priority among Sahel countries by the World Bank in its assessment of the need for HIV and sexually-transmitted diseases interventions.

Encouragingly, the Malian Government has developed an ambitious five-year strategy to combat sexually-transmitted diseases and HIV and there are several existing large-scale development projects that are attempting to reinforce the health infrastructure.<sup>23</sup> USAID is presented with an excellent opportunity to assist Mali and other donor agencies in these efforts at building a national sexually-transmitted diseases and HIV control program.

##### 2) Surveillance

Disease surveillance in Mali is hierarchical, with information flowing from the sub-districts to the districts, then to regions and finally to Bamako where data is collected by the Division of Epidemiology for analysis. Although efforts to improve sexually-transmitted diseases and HIV surveillance have been undertaken by the Division of Epidemiology in the Ministry of Health, surveillance remains weak and case reporting is incomplete. As USAID's contribution to Health, Population and Rural Hydrology Project,<sup>24</sup> its Community Health and Population Services project has a component to build a national medical information system including streamlining the list of reportable conditions, re-designing reporting forms, users manuals, information systems, and providing training to essential personnel.

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<sup>23</sup>Plan Strategique 1994-1998, Revision 4, National AIDS Committee, February 1994.

<sup>24</sup>Projet Sante, Population et Hydraulique Rurale is a multi-donor project to improve the health infrastructure and training of personnel.

### 3) AIDS Reporting

From 1985 through June of 1993, a total of 4,736 people have tested positive for HIV, though there is no formal HIV reporting system. AIDS case reporting has been in effect since 1985, when Mali reported its first case, and there has been a cumulative total of 1,479 as of March 1993. This is assumed to be a gross underestimation as these cases were derived exclusively from the two main hospitals in Bamako, and many cases are undiagnosed or unreported. Over the past three years there has been a doubling of reported cases; 460 cases were reported during 1992, compared with 377 in 1991, and 242 cases in 1990.<sup>25</sup> It is not clear if this represents increased morbidity or increased reporting, but the trend is concerning.

### 4) Sexually-Transmitted Diseases Reporting

There are three sexually-transmitted diseases on the list of over 80 reportable conditions: "*syphilis venerienne symptomatique*," "*gonococcie presumee*," and "*autres maladies veneriennes*."<sup>26</sup> However, since laboratory diagnosis is generally unavailable, reporting is based almost entirely on presumptive cases and gives little useful information. The "other sexually-transmitted diseases" category is so non-specific that it has no utility whatsoever.

### 5) HIV Surveillance Activities

The Division of Epidemiology has established seven sentinel surveillance sites for HIV infection; three in Bamako and four others in the regions (Sikasso, Mopti, and Kayes funded by the Canadians and Ségou funded by the Dutch). All sites share common protocols. None include surveillance for sexually-transmitted diseases.

### 6) Epidemiologic Data: Current Levels of Sexually-Transmitted Diseases and HIV

Studies from 1987 showed, among pregnant women in Bamako (considered representative of the population), a seroprevalence of 0.4 percent for HIV-1 and 1.4 percent for HIV-2. Among prostitutes in Bamako, there was a prevalence of 23 percent for HIV-1 and 27 percent for HIV-2. 1993 results from the HIV sentinel surveillance sites indicate a seroprevalence of two percent of blood donors in Bamako, four percent of women at a pre-natal clinic, and two percent of patients tested at Hospital Point G are infected with HIV.<sup>27</sup> Studies of brothel-based prostitutes in Bamako by the USAID-

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<sup>25</sup>Plan Strategique 1994-1998, Revision 4, National AIDS Committee, February 1994.

<sup>26</sup>Information compiled from the Department of Epidemiology's current reporting forms.

<sup>27</sup>Data gathered from the Department of Epidemiology, HIV sentinel surveillance program, March 1994.

funded AIDS project from 1987 through 1993 indicate an HIV seroprevalence of 39 percent in 1987, 63 percent in 1988, 47 percent in 1991, 74 percent in 1992, and 52 percent in 1993.<sup>28</sup>

Results from a 1993 national seroprevalence study of 4,892 persons from all eight regions, and considered to be representative of the general population indicate a prevalence of HIV-1 of two percent in Gao and Tombouctou, a range of four to six percent in Kayes, Ségou, and Bamako, and six percent in Sikasso. The overall national seroprevalence was estimated at 5.3 percent; with 3.4 percent prevalence for HIV-1, 0.9 percent for HIV-2, and one percent for dual infections.

An excellent critique by the National Research Institute of the available epidemiologic data on HIV concludes that most studies have been limited by severe methodological weaknesses and many are without any scientific merit. Of the seroprevalence studies that could distinguish HIV-1 from HIV-2; generally the prevalence of HIV-1 was double that of HIV-2.<sup>29</sup>

#### 7) Sexually-Transmitted Diseases Incidence and Prevalence Studies

The sexually-transmitted diseases surveillance data for 1991 were as follows: 3,160 cases of syphilis; 14,154 cases of presumptive gonorrhea; and 9,051 cases of "other sexually-transmitted diseases."<sup>30</sup> Data on other sexually-transmitted diseases are even more incomplete, due to lack of reporting, and lack of adequate diagnostic capacity.

In 1991, using laboratory diagnosis, researchers at the National Research Institute conducted a study among 280 newborns at a maternal and child health clinic in Bamako. They found a prevalence of 21.4 percent of newborns with conjunctivitis (60/280). The prevalence of gonorrhea conjunctivitis was 10.7 percent and the prevalence of C. trachomatis was ten percent.

Prevalence studies of brothel-based prostitutes in Bamako by the USAID-financed AIDS project reveal high rates of sexually-transmitted diseases. In 1987 the prevalence of gonococcal infections was 47.5 percent with a confirmation test for syphilis (Venereal Disease Research Laboratory [VDRL]) seropositivity of 24.3 percent.

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<sup>28</sup>Plan Strategique 1994-1998, Revision 4, National AIDS Committee, February 1994.

<sup>29</sup>Kodio B. Revue de la Literature et Synthèse des Connaissances de l'Infection par le VIH et le SIDA au Mali. Ministère de la Santé, Institut National de Recherche en Santé Publique (INRSP), 1993.

<sup>30</sup>Diarra L. Epidemiologie des Infections a VIH au Mali: 1985-1992. Ministère de la Santé, Direction Nationale de la Santé Publique, Division d'Epidemiologie, 1993.

Follow-up studies on the same population in 1991 showed gonorrhea 41 percent and a VDRL seropositivity of 25 percent. Repeat evaluation in 1992 showed gonorrhea seven percent and a VDRL seropositivity of 26 percent. Repeat evaluation in 1993 showed a gonorrhea prevalence of 8.2 percent, trichomoniasis of 15.6 percent, candida 30.5 percent, and 5.7 percent had a positive Rapid Plasma Reagin (another type of confirmatory test for syphilis).

In a 1994 study of 210 women seeking prenatal, family planning and gynecologic care in Bamako, 42 percent of women were diagnosed with chlamydia infections, most of which were asymptomatic; 34 percent were diagnosed with gonorrhea; 2.5 percent were HIV seropositive; and 4.5 percent were VDRL-positive.<sup>31</sup>

#### 8) Rapid Assessment Study

In 1993, the World Bank funded a rapid assessment of HIV and sexually-transmitted diseases prevalence in Mali that examined three sentinel populations: pregnant women; as an unbiased estimator of the population level; prostitutes, a high risk group; and truck drivers and their apprentices, another high risk group. Four geographic areas were chosen to study: Bamako; Sikasso (a region shown in previous studies to have the highest prevalence of HIV and that serves as a port of entry from the hyperendemic countries of Cote d'Ivoire and Burkina Faso); Mopti (a commerce center on the Niger River) and Koutiala (an important crossroads for commercial truck traffic). Preliminary results show four percent HIV prevalence in pregnant women, 55 percent in prostitutes, and ten percent in truck drivers (sexually-transmitted diseases data is unavailable). These results show levels of HIV infection among Malian prostitutes comparable with the ten to 40 percent seroprevalence of prostitutes in Nairobi and Kinshasa.

#### 9) Current Situation and Role of National AIDS Committee

According to the widely-accepted standard set by the World Health Organization, a National AIDS Control Program should be the coordinating body for sexually-transmitted diseases and HIV-related activities across units of the Ministry of Health responsible for surveillance, clinical treatment, pharmacy, laboratory, family planning, and health education activities. In Mali, however, problems exist that suggest a need to build the capacity of the National AIDS Committee to coordinate an integrated sexually-transmitted diseases and HIV response. Although the National AIDS Committee staff should have knowledge of sexually-transmitted diseases, currently there is no one on staff with specialized knowledge in this domain.

#### 10) Conclusions

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<sup>31</sup>Guindo A. *Etude de la Prevalence des Principaux Agents Pathogenes Responsables de MST/SIDA dans une Population de Femmes en Age de Procreer. Un these pour obtenir le grade Docteur en Pharmacie presenté devant l'Ecole Nationale de Médecine et de Pharmacie, 1994. Mali.*

Sexually-transmitted diseases including HIV infection represent a major health problem for Mali. HIV appears to be established among groups thought to represent unbiased estimates of the population (prevalence estimates range from four to five percent), and appears to be quite high in sentinel, high-risk populations (40 to 50 percent in Bamako prostitutes). Although the quality of the data do not permit rigorous temporal analysis, available data suggests that HIV seroprevalence is increasing at a rapid rate in Mali.

b. Project Plan

1) Rationale

HIV is a sexually-transmitted disease. It shares common modes of transmission, common behavioral risk factors, and common hosts with other sexually-transmitted diseases. Other sexually-transmitted diseases facilitate its sexual transmission. The presence of a sexually-transmitted diseases in someone not infected with HIV makes it easier to acquire HIV infection. The presence of sexually-transmitted diseases in someone who is infected with HIV makes it easier to transmit that HIV infection. The magnitude of this effect is large, with studies demonstrating that inflammatory sexually-transmitted diseases may cause a two-to-fourfold increases in the likelihood of acquiring or transmitting HIV infection. For the sexually-transmitted diseases that cause genital ulcers, there may be up to a tenfold increase in the likelihood of HIV transmission.

Thus, treating sexually-transmitted diseases directly prevents HIV infection and has secondary health benefits particularly for women and children who bear the greatest burden of morbidity associated with sexually-transmitted diseases.

2. Project Components

Sexually-transmitted disease Project activities are designed to achieve improved sexually-transmitted diseases control as measured by a decrease in the incidence of sexually-transmitted diseases in the general population. Improved sexually-transmitted diseases control will be attained through improved sexually-transmitted diseases case management; improved surveillance and reporting of sexually-transmitted diseases; and strengthened sexually-transmitted disease management capacity at the National AIDS Committee.

i. Case Management Improvement

- \* adding first-line drugs for treating key sexually-transmitted diseases to the essential drug list;
- \* training health personnel in sexually-transmitted diseases case management;

- \* providing basic sexually-transmitted diseases diagnostic laboratory equipment at the district level; and
- \* making operations research grants
- ii. STD Surveillance and Reporting Improvement
  - \* equipping HIV sentinel surveillance sites with sexually-transmitted diseases laboratory equipment;
  - \* conducting rapid assessment surveys to provide an overall picture of the evolution of sexually-transmitted diseases in Mali; and
  - \* revising treatment protocols based on information received from operations research results
- iii. National AIDS Committee STD Capacity Strengthening
  - \* funding a four-year technical sexually-transmitted diseases advisor; and
  - \* funding long-term training in sexually-transmitted diseases control for two National AIDS Committee staff members

## 2. Behavior Change

### a. Background and Rationale

The first international NGO was registered in Mali in 1967 and the first Malian NGO in 1979. Their number has grown rapidly since 1982 to reach the approximately 400 today.<sup>32</sup>

Their catalytic role in Mali's development process is well-known. Active in all sectors, they have achieved impressive results that make them today the preferred partners of local populations, most bi-lateral aid agencies and even of the Government. NGOs invest an average of 27.5 billion CFA Francs per year<sup>33</sup>, making them the third most important source of funding in the country after bi- and multilateral aid and public funds. The health sector constitutes the third largest area of intervention by NGOs, after agriculture and water supply, and involves approximately 100 of them. The following tables provide some examples of the strengths and weakness of Malian NGOs:

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<sup>43</sup>Data collected from the *CCA-ONG*, the Malian NGO umbrella organization.

<sup>44</sup>Unpublished data compiled by Kunafoni Services, Bamako, Mali, 3/94.

b. NGO Strengths and Weaknesses

1) Examples of NGO Strengths

**EXAMPLES OF NGO STRENGTHS**

- \* Adaptability and flexibility in implementing their activities, hence a capacity to adapt programs to the priority needs of the populations
- \* Commitment, determination and spirit of self-sacrifice, which make it possible for them to work in all kinds of conditions in the field in order to reach their goals
- \* Capacity of personnel to adapt to village living conditions, and therefore to integrate communities and build trust among target populations.
- \* Inexpensive services as a result of voluntary investment by their members and low cost for the means used in carrying out tasks (funding rarely exceeds 2,000,000 CFA Francs in the context of the experiences cited below)
- \* Capacity to take initiatives and to mobilize local populations around community objectives.

## 2) Examples of NGO Weaknesses

### EXAMPLES OF NGO WEAKNESSES

- \* Lack of technical expertise among personnel -- often young graduates without experience, a high turnover rate, preventing capitalization of experience. Regarding AIDS, lack of basic knowledge on the subject, poor mastery of communication techniques and materials. This has led to errors of interpretation and approach, making it necessary to repeat health education sessions among target groups. It has also led to the termination of contracts with certain NGOs.
- \* Inadequate financial support that stems from the inability to raise private capital and to obtain substantial grant funding; NGO inability to develop persuasive project proposals; competition among NGOs at donor level; lack of donor trust in the NGO's management capacity, causing donors to prefer making small, short-term grants with insignificant administrative costs (which make the NGO's institutional development impossible).
- \* Poor organization, often related to inadequate means to fund permanent positions or the monopoly by some influential founding members who prefer to become "jacks-of-all-trades" than sharing responsibilities with other people. A study sponsored by USAID conducted in March 1994 and involving 19 non-government organizations, revealed that certain NGOs are managed by a single individual who is simultaneously the director, accountant, auditor . . .
- \* Frequently, poor management of resources (material, human and financial) reinforces donor reticence to award new grants. According to the same study, only six of the 19 non-government organizations surveyed had provisional budgets.

The consequence of all this is that only a small number of NGOs (about 50 out of 300 registered) are operational. But efforts are under way to correct these weaknesses through the numerous training held by structures like Malian Non-Government Organization umbrella organization, the different Pivot Groups and even bi-lateral agencies that are using NGOs increasingly to implement their projects in Mali.

#### c. NGOs Engaged in AIDS Activities in Mali

NGOs represent a potential major resource in the fight against AIDS. Within the framework a successful partnership, international and Malian NGOs have carried out innovative actions. All the following examples demonstrate that NGOs can

support the fight against AIDS in Mali given their numerous qualities. However NGO activities to date have been somewhat limited in scope, and their funding is often so short-term and so limited that they cannot work effectively.

The AIDS Prevention Project, funded by Solidarity Canada Sahel and Save the Children Fund-Canada from 1991-93, had the objectives of preventing transmission of the AIDS virus, reducing morbidity and mortality related to HIV infection and raising awareness amongst the Canadian public about life in Mali. The target population in the urban and rural areas in and around Koulikoro comprised students, urban street children, rural youth and women of childbearing age. Its May 1993 final evaluation showed that the project had had a positive impact on its partners involved in the intervention. Evaluators recommended continuing it via a second phase, while proposing ways to overcome the weaknesses experienced during the first phase.

The USAID financed Intervention for High-Risk Groups against AIDS Project,<sup>34</sup> which is a component of the National AIDS Committee (*Programme National de Lutte contre le SIDA*), aims to reduce the transmission of AIDS amongst high-risk groups (prostitutes and bar clients) and ultimately the general public. As part of this program, four NGOs were given funds totalling about \$20,000 at the end of 1992. They all carried out awareness raising activities through dances, conferences, film shows, sports events and theater, with free distribution of condoms.

The Family Planning and AIDS Project of the Child Survival Pivot Group was established at the end of 1993 for a duration of five years. It has been funded by the USAID Mali PVO Co-Financing project with an initial grant of \$1,250,000 over 18 months. The total life-of-project budget is about \$7,500,000. Through this project, the Child Survival Pivot Group offers Mali's private voluntary organizations and NGOs a program to promote family planning and AIDS prevention. Training is available to NGO members of the group in family planning, AIDS and health education techniques and in project management. The NGOs can also obtain financial support for activities related to family planning and AIDS or for income generating activities.

In 1993, Plan International supported eight Malian NGOs in its project areas (Kangaba, Banamba) undertaking AIDS related health education activities and condom distribution. The *Association d'Aide et d'Appui aux Groupements* benefitted from receiving two million FCFA of this support. Following this experience, Plan International is considering increasing the scale of its activities through a seven-year project (1994-2001) at a cost of about five million US dollars. The project aims to cover 100 *arrondissements* and involve about ten NGO's in a program of health education activities, in the promotion of self-help associations for HIV positive individuals and AIDS victims and in a large scale media campaign.

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<sup>34</sup>Better known as the Family Health International project.

Oxfam UK encourages Malian NGOs that work in partnership with it, to include an AIDS awareness component in their on-going activities. Thus 12 of Oxfam's NGO partners received training in 1993, on the relationship between development and AIDS.

The Malian Family Planning Association intervenes in the area of family planning. In the context of the fight against AIDS, it plays a leading role both through both its activities (health education, supplying condoms) and through providing support to other NGO's like staff training and hiring audio-visual equipment and films.

The Association of Malian Women Educators focuses on the training of migrant girls and organizes literacy and health education courses. The trainers show movies about AIDS and work with the girls so as to promote behavior change. It touches close to 1,500 migrant girls but has difficulty in responding adequately to the demand from the numerous neighborhoods.

The Malian Association for the Promotion and Insertion of Youth has a project titled "Action Domestic Workers," which also targets migrant girls for sexually-transmitted diseases and AIDS prevention. It has already carried out some counselling activities with girls known to be seropositive or already suffering from AIDS. It is also carrying out a study called Migrant Girls and AIDS --the results are not yet available.

Other associations are also involved in the fight against AIDS through lectures and discussions in schools and with women's groups and associations. In fact, since they work in such a vast sector and often in an informal manner, it is unknown the total contribution of NGO and associations to the fight against AIDS. The examples cited above represent only the well-documented and well-known portion.

d. Needed Support to NGOs and Associations to Fight AIDS/Project Plan

1) Project Components

- \* organizing and coordinating NGO actions and developing a nationwide NGO network. The structure will be decentralized through Lead NGO's at regional level
- \* training NGO personnel and training of trainers in:
  - project design and management
  - knowledge of sexually-transmitted diseases and AIDS
  - health education techniques
  - institutional support and advice techniques
  - community organization techniques
- \* conducting study tours and experience exchanges

\* providing grants for AIDS-related activities (and even for income-generating activities) promoted by the NGOs, as advocated by the Child Survival Pivot group, to increase the participation of the population

\* funding specific social studies with the aim of adapting support materials and health education messages to the specific local conditions and to collect statistical data

\* conducting seminars and workshops

\* documenting and publishing results

## 2) Anticipated Results

The areas of intervention that should be reinforced or created to involve NGOs more effectively in the fight against AIDS are:

\* awareness raised within the general public (in urban as well as rural areas) through health education activities;

\* agents or intermediaries identified and trained at the village level;

\* NGO having participated in studies on the special characteristics of targeted zones to improve and adapt health education messages and support materials;

\* condoms having been promoted and sold through the creation of an NGO distribution network in collaboration with the Social Marketing of Contraceptives project; and

\* increased community support for seropositive individuals and AIDS sufferers through promoting grass-roots initiatives.

## 3. The Mali HIV and AIDS Program Management

### a. Background and Rationale

A critical component of a successful HIV and AIDS Prevention and Control Program is the existence of an effective program management and coordination unit. Tackling the HIV and AIDS epidemic requires a strong program leadership to mobilize, coordinate and use appropriately international, national and multi-sectoral financial and human resources.

In addition, since many African leaders tend to regard HIV and AIDS as being similar to other and older infectious diseases, there is a continuing need to engage and maintain international, national and community decision-makers in dialogue concerning the peculiarities of the HIV and AIDS epidemic. This is crucial in view of its multi-sectoral aspects and socio-demographic and economic impact on a very vulnerable sub-Saharan Africa due mainly to its extensive poverty, poor status of the women and low

education level. According to a World Bank report,<sup>35</sup> "AIDS will cause a slowing of growth of income per capita by an average 0.6 percentage points per year in the ten worst-affected countries in sub-saharan Africa."

b. HIV and AIDS Program Management in Mali

In recognition of the compelling data from other hard hit African countries and the opportunity to limit the spread of HIV and AIDS while the rates are comparatively low, the Government of Mali established the National AIDS Committee in 1987 and finalized the Medium-Term Plan for HIV and AIDS in 1989. The specific objectives of the Medium-Term plan included:

- \* providing information and educated the populations on AIDS;
- \* ensuring the safety of blood transfusion;
- \* improving epidemiologic data collection;
- \* establishing a counselling system;
- \* conducting HIV and AIDS related research including knowledge, attitude and practices surveys and socio-economic impact studies; and
- \* establishing an efficient program management system.

The National AIDS Committee was structured as follows:

- \* National Committee for the Fight against AIDS;
- \* Central Coordinating Unit;
- \* Regional and District (*cercle*) AIDS Control Committees;
- \* Scientific and Technical Council for the Fight against AIDS including five technical subcommittees to advise the National Committee and its coordinating body on specific HIV-related issues;
- \* Follow-up Commission (*Commission Mixte de Suivi*) that includes the Ministry of Health and major donors

In 1991, World Health Organization and the Ministry of Health conducted an external review of the Medium-Term plan that pointed out the limited accomplishments of the National AIDS Committee. The following interrelated weaknesses in program management and implementation were identified:

- \* lack of clear-cut strategic policies to direct and monitor National AIDS Committee activities;
- \* poor program planning and coordination;
- \* lack of credibility of the National AIDS Committee's Central Coordinating Unit and its various committees due to their limited accomplishments; the

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<sup>35</sup>World Development Report 1993, Investing in Health, The World Bank, Oxford University Press.

- Committee's tendency to centralize resources; and the Committee's lack of transparency; and
- \* lack of resources to support planned activities given the limited donors and national support.

The democratic change in 1991 stimulated the removal of the National AIDS Committee management team and the arrival of a more dynamic and open team. Since 1992, despite the instability in the Ministry of Health<sup>36</sup>, important and encouraging initiatives were undertaken to strengthen HIV and AIDS prevention efforts in Mali:

- \* the decentralization of activities and resources at the regional level. (The Swiss Cooperation decided to concentrate its support to the Sikasso region while UNICEF provided small grants to all eight regions);
- \* the involvement of NGOs in major HIV and AIDS prevention initiatives;
- \* the support of AIDS prevention activities in other ministries such as Education and Defense;
- \* the development of standard supervision and monitoring tools for AIDS prevention activities and quarterly supervision visits of the Regional AIDS Committees and AIDS education of regional authorities during such visits;

3) Increased donor support for the aforementioned initiatives

- \* With respective funding of \$200,000 and \$20,000 in 1993, UNICEF and the Swiss cooperation took the lead in encouraging decentralized activities, as indicated earlier. UNICEF has programmed an additional \$200,000 for 1994;
- \* United Nations Development Program, in collaboration with the National AIDS Committee, is developing an \$800,000 1994-1997 AIDS prevention program that will support short-term external technical assistance, program evaluation, audio-visual materials, study tours, short-term training and two vehicles;
- \* The World Bank provided a 1993-1994 loan of \$1,400,000<sup>37</sup> and has already financed the National AIDS Committee's telephone system, conference room, documentation center, meetings to develop the National AIDS Committee 1994-1997 strategic plan and a large sexually-transmitted diseases and HIV prevalence study. These funds will also support program coordination, the development of health education support, laboratory equipment and two vehicles;

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<sup>36</sup>The current Minister of Health is the third one since 1991.

<sup>37</sup>The government of Mali considered this loan from the World Bank as one of its major contributions to HIV/AIDS prevention

- \* The World Health Organization continues to support the operations of the coordinating unit of the National AIDS Committee with a yearly funding of \$80,000;
- \* The European Economic Community and Japan are also currently discussing support to the National AIDS Committee of 1 million ECUs and two-to-four million dollars, respectively.

4) USAID Support to Address the Following Impediments

USAID Mali will encourage the new directions taken by National AIDS Committee and its Central Coordinating Unit and complement other donors support in addressing the following remaining impediments:

- \* The limited number and lack of appropriate training of personnel at the National AIDS Committee Central Coordinating Unit and on Regional AIDS Committees. Currently, the National AIDS Committee Central Coordinating Unit includes six full-time professional and four support staff while regional committees include part-time governmental personnel. There is no trained program planner or manager. Only two physicians from the regions have benefitted from an HIV and AIDS orientation in participating in the last international conferences on AIDS;
- \* The limited equipment available to the National AIDS Committee' Central Coordinating Unit and regional committees for coordination, supervision and support activities. However, the Central Coordinating Unit expects four other vehicles from the World Bank and United Nations Development Program. The National AIDS Committee's equipment includes one functioning computer and one old copier.
- \* The lack of pertinent socio-economic data relevant to the HIV and AIDS epidemic in Mali. This problem may have slowed the National AIDS Committee' efforts to increase both government commitment and public opinion support for HIV and AIDS prevention programs.

USAID will address these remaining impediments by providing technical assistance, training and equipment to enable the National AIDS Committee to function effectively in its coordination role, specifically in the areas of information exchange, policy development and resource mobilization as follows:

- \* local and external short-term assistance to support the Central Coordinating Unit and regional committees in coordination, supervision, program and policy development in four regions (Bamako, Mopti, Kayes and Koulikoro) that already benefit from the USAID Community Health and Population project support. Technical assistance will also assist in designing meaningful coordination mechanisms and National AIDS Committee organizational structures;

- \* equipment and logistics including one copier to the Central Coordinating Unit and relevant HIV and AIDS scientific documentation for the regions and the Central Coordinating Unit. Equipment from the current USAID AIDS project (two computers and a vehicle) is expected to be transferred to the National AIDS Committee's Central Coordinating Unit, as stated in the Project documents;
- \* short-term training in HIV and AIDS and sexually-transmitted diseases related program management and participation to relevant sexually-transmitted diseases and HIV and AIDS conferences;
- \* two studies on the socio-economic and demographic impact of the HIV and AIDS epidemic Mali and secondary literature analysis to make relevant data available to decision makers and opinion leaders;
- \* support of semi-annual liaison newsletters at the central unit of the National AIDS Committee and at the regional levels; and
- \* supply the AIDS Impact model for presentation to government policy and decision makers. The model will be modified explicitly for Mali and shown to policy makers through policy workshops and related documentation.

In addition, to facilitate the flow of information and to build the capacity of National AIDS Committee, the Mission proposes to fund the establishment of small-scale desktop publishing of sexually-transmitted diseases and HIV surveillance reports, training materials, other information.

#### 6) Expected outputs

- \* at least four regional plans for sexually-transmitted diseases and HIV and AIDS developed for the 1994-1997 period and regularly updated and implemented;
- \* at least four sectoral plans for sexually-transmitted diseases and HIV and AIDS developed, updated regularly and implemented by other public sector entities like Ministry of Education, Ministry of Youth, Ministry of Defense, Ministry of Rural Development and the NGOs;
- \* clear-cut policies developed on HIV and AIDS related counselling, right and responsibilities of seropositive and AIDS patients, free condom distribution and sexually-transmitted diseases prevention and control;
- \* appropriate coordination and organizational National AIDS Committee structures developed. Regular supervisory visits and coordination meetings using standard monitoring tools;
- \* two studies on socio-economic and demographic impact of AIDS in Mali completed;
- \* secondary literature analysis of HIV and AIDS related or relevant publication conducted every year to make relevant data available to decision-makers and opinion leaders;
- \* semi-annual information and liaison bulletins issued and distributed widely;

- \* various scenarios on socio-economic impact of AIDS in Mali developed using the AIDS impact model and being shown to policy makers at national and regional levels; and
- \* increased commitment to HIV and AIDS prevention at national and regional levels.

B. Economic and Financial Analysis Summary

This project responds to the need to reduce the spread of AIDS in Mali through a three-pronged approach encompassing the control of sexually-transmitted diseases, active promotion of behavior change, and institutional support for the National AIDS Committee. In so doing, this project should mitigate the economic and social impact of AIDS, which kills its victims in their most productive years and affects members of the relatively-small trained labor force and the sociopolitical elite disproportionately in Sub-Saharan Africa.

To determine the economic and financial worth of the Project, this analysis uses a traditional cost-benefit approach to compute internal rate of returns (IRR) under several Project scenarios.<sup>38</sup> As the following discussion summarizes, these IRRs fully support the proposed Project, a finding that underscores strongly the value of combatting AIDS in Mali.

In more detail, this analysis divides the Project's target population into two groups, the "non-core" group and the "core" group. The core group consists of prostitutes, the military, truck drivers and others characterized by a high rate of sexual activity and, presumably, a high rate of AIDS transmission. The non-core group is the rest of the sexually-active population. Both these groups are assigned a specific level of condom prevalence, or, equivalently in this analysis, condom use, which is assumed to be greater in the core group than in the non-core group due to Project activities. Each group, however, increases its condom use due to Project activities and in each group this use also is assumed to cause reductions in seropositivity and AIDS.

Such reductions from condom use result not only in large savings in treatment costs but also gains from the fact that wage-earners remain productive members of society rather than succumbing to the debilitating effects of AIDS. These gains can be monetized and compared to Project expenditures and condom costs over a 25-year period beginning in 1994. An internal rate of return also can be computed under various scenarios. Specifically, in the base scenario that uses all Project variables as specified the IRR for the financial analysis is 53 percent, a figure that far exceeds the opportunity cost of capital and, therefore, underscores the high return to society from the proposed Project. This figure is based on the

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<sup>38</sup>The internal rate of the return (IRR) is the interest rate required to make the value of the stream of Project benefits equal to the value of the stream of Project costs over a given number of years. This IRR helps policymakers to choose between different Project alternatives in that, *ceteris paribus*, higher IRRs are generally more desirable than lower IRRs.

fact that condoms are currently subsidized. Pricing condoms at their fair market value also produces a high IRR of 50 percent in the economic analysis of this project. Hence, the subsidy does not affect Project worth significantly.

A high IRR does not fully justify the Project on an economic and financial basis. Rather, current interventions must be compared to alternative proposals to determine if one can improve the IRR by changing the Project and, therefore, further increase the gain to society from investment in AIDS prevention and awareness. One possibility is to more strongly target the non-core group, which results in significantly lower IRRs of 35 percent for the financial analysis and 31 percent for the economic analysis. The economic and financial analysis in Annex F examines other possibilities, but all alternatives either demonstrate lower IRRs or entail higher expenditures. Hence, this economic and financial analysis fully supports the proposed Project as it is now defined by demonstrating that resources should be focussed on increasing condom prevalence in Mali.

### C. Social Soundness Analysis Summary

#### 1. Introduction

The analysis of the social implications of health programs is far from complete or perfect in Mali, despite the fact that considering social factors is essential to both understanding disease and implementing concrete actions to eliminate it.

The sociological aspects of health are difficult to control during the design of a specific project because of the wide spectrum of cultural and linguistic differences. Although one could reach the majority of Malians by using just three languages (Bambara, Fulani and French), the same majority does not apply in terms of culture and behavior. Each one of the numerous ethnic groups in Mali seeks to preserve its own cultural and linguistic identity, even though they may be willing to communicate one of the more widely spoken languages.

The huge surface area of the national territory (1,240,000 km<sup>2</sup>) constitutes a major challenge for all projects that aim to reach the maximum number of individuals in as large a geographic area as possible. The rapidly-growing population and high rates of internal and external migration also account for the fact that projected action plans are often rapidly outdated and require frequent revision.

Nevertheless, in terms of social organization, the various ethnic groups in Mali are relatively homogeneous. A hierarchy between men, women and youth on the one hand and a hierarchy of nobles, people of caste and slaves on the other hand, exist in roughly similar forms throughout Mali.

At the level of economic organization, Malian society lives at a basic subsistence level. The predominantly-rural society has been monetarized little and lives

almost exclusively on what it produces. In general, people rarely handle money and practice agriculture, livestock farming and fishing at a subsistence level. A minority of the population is involved in cash crop farming (mostly in cotton, rice and tobacco) and appears somewhat privileged as far as monetary resources are concerned.

## 2. Health Care

Despite efforts undertaken by the Government with bilateral and multilateral assistance, health care in Mali is inadequate. Both in terms of facilities and personnel, everything is perceived in terms of needs and inadequacy. Adequate health facilities, where they exist, are often too far away from the people they are intended to serve. Health coverage is also characterized by marked inequalities. The majority of hospitals, doctors and, in particular, midwives are concentrated in the urban centers (the national capital and regional capitals). The natural consequence is serious understaffing in the rural areas and an unquantified surplus in the towns.

Community and private health centers are beginning to emerge in Mali. Their number is not well-known but they are growing rapidly in urban and peri-urban centers, thus bringing the health facilities closer to the beneficiaries.

## 3. Sexually-Transmitted Diseases and AIDS in Mali

The Malian socio-cultural context as far as sexually-transmitted diseases and AIDS are concerned is still characterized by popular beliefs. The role of God is very important and in fact, few people really believe in AIDS, since for the majority there cannot exist a disease for which people have not been given a cure. Thus the population tends to behave in a casual manner with respect to this disease. Instincts to protect against disease in general and sexually-transmitted diseases and AIDS in particular, are practically non-existent for most people. This probably stems from the fact that traditional medicine, still used by significant numbers of people particularly in rural areas, is essentially curative rather than preventative. Hence, it does not make sense to most people to worry about a disease that they have not yet caught.

Although AIDS spares no single socio-professional category, disease in general is more endemic and deadlier among disadvantaged groups (such as farmers, livestock owners, and fishermen) living in rural areas who have limited access to health facilities.

About twelve donor organizations, including USAID, are paying special attention to the issue of AIDS in Mali. Malian literature about sexually-transmitted diseases and AIDS is scant -- it consists mostly of memoirs and theses written as a graduation requirement by students who often lack the necessary skills in research methodology and surveying specific AIDS projects. These memoirs, theses and reports have been catalogued in the document, Review of Literature and Synthesis of Knowledge about HIV Infection and AIDS in Mali from 1983 to 1993, available from the National Research Institute.

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#### 4. The Issue of Sex in Malian Society

The issue of sex in Malian society is one of respect and silence. Everything that relates to sex should be treated with caution -- as a personal secret. This does not however, prevent certain social groups from discussing sex freely amongst themselves. The formal objective of sexual activity is procreation.

People in Mali engage in sexual intercourse from an early age. Young boys and girls have usually had their first sexual relation by the age of 14. This is the age when girls are usually given in marriage in rural areas. The period characterized by the most intense sexual activity is from ages 14 through 25. Although Malian society in general is not permissive about sex, one can note a growing trend in urban centers and in areas with high levels of migration and socio-economic exchange, for sex to become more commonplace.

In Mali, several sexual practices are considered as unusual phenomena either because they contradict existing moral standards, or because they are ancient practices. This includes traditional rapes, homosexuality, and the abduction of women.

#### 5. The USAID-Funded Sexually-Transmitted Disease and AIDS Project

This project plans to intervene nationwide. USAID has already had a long experience in the matter through the multi-donor national health project, the USAID AIDS project, National AIDS Committee, the *Groupe Pivôt Santé* and the Malian Family Planning Association. The issue of AIDS awareness and prevention is therefore not new to USAID.

The population in the areas covered by the Project consists of farmers, livestock owners, fishermen, civil servants and wage-earners of all kinds. Since they do not all have the same timetable of activities, it may be difficult to reach everyone (individually) at their convenience during project implementation. These people, even those who are regularly employed in the cities, are very poor. Their major preoccupation is food for survival. Will they be able to pay for health care? Also, they move about a lot (seasonal migrants, domestic workers, business trips). The issue of migration is important and needs

to be studied carefully and taken into account in designing AIDS awareness raising and prevention strategies.

The society is very well-structured in the Project areas. Adult males make all major decisions. Women follow the men's lead. Children are a source of cheap household labor. The elders and a few leaders of village opinion have a large decision-making role. People of caste (praise-singers and blacksmiths) and religious leaders are often consulted if obstacles to agreement arise that need to be overcome.

About half the population of the country will benefit directly from the activities of the Project. The remaining half will benefit indirectly through health education activities (e.g. exposure to radio and television programs, getting tee-shirts).

Mali needs most a mechanism to observe trends in sexual behavior, support networks for AIDS sufferers, close consultation among donors, and the involvement of social science research institutions in the fight against AIDS. To better understand the social implications of sexually-transmitted diseases and AIDS, these various needs must be transformed into concrete actions.

VI. OTHER COVENANTS:

- A. The Government of Mali, through the Ministry of Public Health, Solidarity and the Elderly covenants to develop and implement a plan for the proper disposal of blood and blood products. The policy will have been developed by the end of Year 2 of the Project. Implementation will take place thereafter.
- B. The Grantee agrees to undertake consideration of all recommendations of the Project's evaluations. The Parties will negotiate in good faith toward an agreement on their application to the Project.

ANNEX A

**PID APPROVAL CABLE**

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3

ACTION: AID-E INFO: AMB DCM ECON

VZCZCBP0636  
PP RUEHBP  
DE RUEHC #5500 0410132  
ZNR UUUUU ZZH  
P 100132Z FEB 94  
FM SECSTATE WASHDC  
TO RUEHBP/AMBASSY BAMAPO PRIORITY 4430  
INFO RUEHDK/AMBASSY DAKAR PRIORITY 0728  
BT  
UNCLAS STATE 035500

LOC: 241 477  
10 FEB 94 0835  
CN: 19149  
CHRG: AID  
DIST: AID

AIDAC, DAKAR FOR RLA

F.O. 12356: N/A

TAGS:

SUBJECT: MALI - FY 94/95 NEW STARTS AND AMENDMENTS

REF: 93 BAMAPO 09077

35500

1. THE MALI FORESTRY REFORM PROGRAM/PROJECT (688-0267/0268) WAS APPROVED AT A MEETING OF THE AFR/SWA PROJECT REVIEW COMMITTEE ON SEPTEMBER 13, 1993. MISSION DIRECTOR CHARLES JOHNSON ATTENDED THE REVIEW MEETING. DETAILED PAAD/PP DESIGN GUIDANCE SUBJECT SEPTEL. THE DIRECTOR, USAID/MALI (OR THE PERSON ACTING IN THAT CAPACITY) IS HEREBY DELEGATED THE AUTHORITY TO APPROVE THE PAAD/PP AND AUTHORIZE THE MALI FORESTRY REFORM PROGRAM/PROJECT, IN ACCORDANCE WITH AFR DOA 551, IN AN AMOUNT NOT TO EXCEED (NTE) LIFE-OF-PROJECT (LOP) FUNDING OF USDOLS 9 MILLION (PROJECT ASSISTANCE) AND LIFE-OF-PROGRAM FUNDING OF USDOLS 5 MILLION (NON-PROJECT ASSISTANCE). TOTAL LOP FUNDING FOR PROJECT AND NON-PROJECT ASSISTANCE SHALL NOT/NOT EXCEED USDOLS 14 MILLION.

FEB 10 1994

2. THE DIRECTOR, USAID/MALI (OR THE PERSON ACTING IN THAT CAPACITY) IS HEREBY DELEGATED THE AUTHORITY TO APPROVE THE PID/PP AND AUTHORIZE THE MALI AIDS AWARENESS PROJECT (688-0270), IN ACCORDANCE WITH AFR DOA 551, IN AN AMOUNT NOT TO EXCEED (NTE) LIFE-OF-PROJECT (LOP) FUNDING OF USDOLS 5 MILLION.

3. THE MALI DEMOCRACY AND GOVERNANCE PID (688-0269) SHOULD BE SUBMITTED TO USAID/W FOR REVIEW AND APPROVAL, BECAUSE THERE MAY BE SUBSTANTIAL POLICY CONCERNS WHICH MUST BE ADDRESSED IN A LARGER FORUM.

4. THE DIRECTOR, USAID/MALI (OR THE PERSON ACTING IN THAT CAPACITY) IS HEREBY DELEGATED THE AUTHORITY TO APPROVE/AUTHORIZE AN AMENDMENT TO THE EXISTING BASIC EDUCATION EXPANSION PROJECT (688-0258), IN ACCORDANCE WITH

DUE DATE	02/15/94
ACTION	PRM
INFO	
DIR	<input checked="" type="checkbox"/>
PRM	<input type="checkbox"/>
MGT	<input type="checkbox"/>
CONT	<input checked="" type="checkbox"/>
ADO	<input type="checkbox"/>
GDO	<input checked="" type="checkbox"/>
EDO	<input type="checkbox"/>
JAO/GSO	<input type="checkbox"/>
CHRON	<input checked="" type="checkbox"/>

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AFR DOA 551, IN AN AMOUNT NOT TO EXCEED (NTE) THE LIFE-OF-PROJECT (LOP) FUNDING OF USDOLS 31 MILLION.

6. IN ACCORDANCE WITH AFR DOA 551 USAID/MALI MAY APPROVE/AUTHORIZE AN AMENDMENT TO THE COMMUNITY HEALTH AND POPULATION SERVICES PROJECT (688-0248), NOT TO EXCEED LOP FUNDING OF USDOLS 30 MILLION.

8. CERPOD AMENDMENT SUBJECT SEPTEL.

7. MISSION IS ENCOURAGED TO CONTINUE TO UTILIZE THE ASSISTANCE AVAILABLE FROM YOUR RLA IN THE DESIGN AND REVIEW PROCESS FOR ITS PIDS/PPS, AND PARTICULARLY FOR THE ROAD AMENDMENTS FOR WHICH APPROVAL/AUTHORIZATION AUTHORITY HAS BEEN DELEGATED TO THE FIELD.

9. PLEASE KEEP AFR/SWA INFORMED THROUGHOUT THE FINAL DESIGN REVIEW/APPROVAL PROCESS. ALSO, PLEASE ENSURE COPIES OF NEWLY APPROVED PROJECT/PROGRAM DOCUMENTATION AND AMENDMENTS ARE SENT TO USAID/W.

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**ANNEX B**

**STATUTORY CHECKLIST**

**STATUTORY CHECKLIST**

**CRITERIA APPLICABLE TO  
DEVELOPMENT ASSISTANCE ONLY**

**1. Agricultural Exports (Bumpers Amendment) (FY 1994 Appropriations Act Sec. 513(b), as interpreted by conference report for original enactment):** If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?

N/A, assistance will not be used for agricultural development activities.

**2. Tied Aid Credits (FY 1994 Appropriations Act, Title II, under heading "Economic Support Fund"):** Will DA funds be used for tied aid credits?

No

**3. Appropriate Technology (FAA Sec. 107):** Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

No

**4. Indigenous Needs and Resources** (FAA Sec. 281(b)): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

One component of this project focuses on the use of indigenous NGOs to provide AIDS education to the general population. Another component of this project uses local consulting firms to provide needed TA to the National AIDS committee.

**5. Economic Development** (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

Yes, one of the outcomes of this project will be local NGOs versed in resource mobilization for future endeavors.

**6. Special Development Emphases** (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

See 4 and 5 above for a and d. This project will not engage in activities to promote b, c or e, per se.

**7. Recipient Country Contribution** (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with

Waived.

respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

**8. Benefit to Poor Majority (FAA Sec. 128(b)):** If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

Yes, study results will be fed back into strengthening institutional capacity of health centers to better respond to the needs of the poor majority.

**9. Abortions (FAA Sec. 104 (f); FY 1994 Appropriations Act, Title II, under heading "Population, DA," AND Sec. 534):**

a. Are any of the funds to be used to perform abortions as a method of family planning or to motivate or coerce any person to practice abortions?

b. Are any of the funds to be used for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilization?

c. Are any of the funds to be made available to any organization or program that, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?

d. Will funds be made available only to voluntary family planning projects that offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services?

N/A, this is not a population activity.

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning?

f. Are any of the funds to be used to pay for any biomedical research that relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization?

10. **Contract Awards (FAA Sec. 601(e)):** Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

11. **Disadvantaged Enterprises (FY 1994 Appropriations Act Sec. 558):** What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

The Mission is exploring the possibility of using disadvantaged enterprises to implement 80% of the project's activities.

**12. Biological Diversity** (FAA Sec. 119(g): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

No

**13. Tropical Forests** (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act):

**a. A.I.D. Regulation 16:** Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?

**b. Conservation:** Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices;

This is not a tropical forest activity.

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(5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

**c. Forest degradation:**

Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits

and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

d. **Sustainable forestry:** If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

e. **Environmental impact statements:** Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

14. **Energy (FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act):** If assistance relates to energy, will such assistance

focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?

**15. Debt-for-Nature Exchange (FAA Sec. 463):** If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

**16. Deobligation/Reobligation (FY 1994 Appropriations Act Sec. 510):** If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified?

No such exercise is being sought.

**17. Loans**

**a. Repayment capacity (FAA Sec. 122(b)):** Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

**b. Long-range plans (FAA Sec. 122(b)):** Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and

increase productive capacities?

c. **Interest rate (FAA Sec. 122(b)):** If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?

d. **Exports to United States (FAA Sec. 620(d)):** If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

18. **Development Objectives (FAA Secs. 102(a), 111, 113, 281(a)):** Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

See 4 and 5 above.

**19. Agriculture, Rural Development and Nutrition, and Agricultural Research (FAA Secs. 103 and 103A):**

**a. Rural poor and small farmers:** If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

This is not an agriculture or nutrition project.

**b. Nutrition:** Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously-produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

**c. Food security:** Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

**20. Population and Health** (FAA Secs. 104(b) and (c)): If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

All health centers staff will be trained, including staff found at the lowest level (arrondissement) to insure access to STD services for all.

**21. Education and Human Resources Development** (FAA Sec. 105): If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

N/A

**22. Energy, Private Voluntary Organizations, and Selected Development Activities** (FAA Sec. 106): If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

No funds will be provided to the lead PVO for energy research activities.

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

A lead umbrella US-based PVO will be used to provide small grants to indigenous NGOs.

c. research into, and evaluation of, economic development processes and techniques;

d. reconstruction after natural or manmade disaster and programs of disaster preparedness;

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

Funds will be provided to the lead PVO to conduct knowledge, attitude and practice studies on AIDS in collaboration with the Malian government.

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

See 4 and 5 above.

**23. Capital Projects (Jobs Through Export Act of 1992, Secs. 303 and 306(d)):** If assistance is being provided for a capital project, is the project developmentally sound and will the project measurably alleviate the worst manifestations of poverty or

No funds are provided for capital projects.

directly promote environmental safety and sustainability at the community level?

**CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?**

**CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS**

**1. Host Country Development Efforts (FAA Sec. 601(a)):** Information and conclusions on whether assistance will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.

N/A

**2. U.S. Private Trade and Investment (FAA Sec. 601(b)):** Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

N/A

**3. Congressional Notification**

**a. General requirement (FY 1994 Appropriations Act Sec. 515; FAA Sec. 634A):** If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the Appropriations Act notification requirement has been waived because of

Yes

substantial risk to human health or welfare)?

**b. Special notification requirement (FY 1994 Appropriations Act Sec. 520):** Are all activities proposed for obligation subject to prior congressional notification? Yes

**c. Notice of account transfer (FY 1994 Appropriations Act Sec. 509):** If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures? N/A

**d. Cash transfers and nonproject sector assistance (FY 1994 Appropriations Act Sec. 537(b)(3)):** If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted? N/A

**4. Engineering and Financial Plans (FAA Sec. 611(a)):** Prior to an obligation in excess of \$500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? N/A

**5. Legislative Action (FAA Sec. 611(a)(2)):** If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose

of the assistance?

**6. Water Resources (FAA Sec. 611(b)):** If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.)

N/A

**7. Cash Transfer/Nonproject Sector Assistance Requirements (FY 1994 Appropriations Act Sec. 537).** If assistance is in the form of a cash transfer or nonproject sector assistance:

N/A

**a. Separate account:**  
Are all such cash payments to be maintained by the country in a separate account and not commingled with any other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)?

**b. Local currencies:** If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

(1) Has A.I.D.  
(a) required that local currencies be deposited in a separate account established by the recipient government,  
(b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and  
(c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

8. **Capital Assistance** (FAA Sec. 611(e)): If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?

N/A

9. **Multiple Country Objectives** (FAA Sec. 601(a)): Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

N/A

10. **U.S. Private Trade** (FAA Sec. 601(b)): Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

N/A

11. **Local Currencies**

a. **Recipient Contributions** (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

N/A

b. **U.S.-Owned Currency** (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No

12. **Trade Restrictions**

a. **Surplus Commodities** (FY 1994 Appropriations Act Sec. 513(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

N/A

b. **Textiles (Lautenberg Amendment)** (FY 1994 Appropriations Act Sec. 513(c)): Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on

No

articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

**13. Tropical Forests (FY 1991 Appropriations Act Sec. 533(c)(3)(as referenced in section 532(d) of the FY 1993 Appropriations Act):** Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?

No

**14. PVO Assistance**

**a. Auditing and registration (FY 1994 Appropriations Act Sec. 568):** If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

Yes

**b. Funding sources (FY 1994 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"):** If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

Yes

15. **Project Agreement Documentation** (State Authorization Sec. 139 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

Yes

16. **Metric System** (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

Yes

17. **Abortions** (FAA Sec. 104(f); FY 1994 Appropriations Act, Title II, under heading "Population, DA," and Sec. 518):

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?

No

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?

No

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?

No

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? (As a legal matter, DA only.)

N/A

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? (As a legal matter, DA only.)

N/A

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

No

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization?

No

18. **Cooperatives** (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life?

No

19. **U.S.-Owned Foreign Currencies**

a. **Use of currencies** (FAA Secs. 612(b), 636(h); FY 1994 Appropriations Act Secs. 503, 505): Are steps being taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services.

N/A

b. **Release of currencies** (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No

20. **Procurement**

a. **Small business** (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?

Yes

b. **U.S. procurement** (FAA Sec. 604(a)): Will all procurement be from the U.S., the recipient country, or developing countries except as otherwise determined in accordance with the criteria of this section?

Yes

c. **Marine insurance** (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?

Yes

**d. Non-U.S. agricultural procurement (FAA Sec. 604(e)):** If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)

N/A

**e. Construction or engineering services (FAA Sec. 604(g)):** Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.)

N/A

**f. Cargo preference shipping (FAA Sec. 603):** Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates?

No

**g. Technical assistance (FAA Sec. 621(a)):** If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal

Yes

agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

**h. U.S. air carriers**  
(International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

Yes

**i. Consulting services**  
(FY 1994 Appropriations Act Sec. 567): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?

Yes

**j. Metric conversion**  
(Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements

Yes

(length, area, volume, capacity, mass and weight), through the implementation stage?

k. **Competitive Selection Procedures** (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes

l. **Chemical Weapons** (FY 1994 Appropriations Act Sec. 569): Will the assistance be used to finance the procurement of chemicals that may be used for chemical weapons production? No

21. **Construction**

a. **Capital project** (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used? N/A

b. **Construction contract** (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? N/A

c. **Large projects, Congressional approval** (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress? N/A

22. **U.S. Audit Rights** (FAA Sec. 301(d)): If fund is established solely by U.S. contributions and N/A

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administered by an international organization, does Comptroller General have audit rights?

23. **Communist Assistance** (FAA Sec. 620(h)). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries?

N/A

24. **Narcotics**

a. **C a s h** reimbursements (FAA Sec. 483): Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated?

N/A, yes

b. **Assistance to narcotics traffickers** (FAA Sec. 487): Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance?

N/A, yes

25. **Expropriation and Land Reform** (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President?

Yes

26. **Police and Prisons** (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice,

Yes

or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?

27. **CIA Activities** (FAA Sec. 662): Will assistance preclude use of financing for CIA activities? Yes

28. **Motor Vehicles** (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes

29. **Export of Nuclear Resources** (FY 1994 Appropriations Act Sec. 506): Will assistance preclude use of financing to finance--except for purposes of nuclear safety--the export of nuclear equipment, fuel, or technology? Yes

30. **Publicity or Propaganda** (FY 1994 Appropriations Act Sec. 557): Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? No

31. **Marine Insurance** (FY 1994 Appropriations Act Sec. 531): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate? Yes

32. **Exchange for Prohibited Act** (FY 1994 Appropriations Act Sec. 533): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person No

in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law?

**33. Commitment of Funds (FAA Sec. 635(h)):** Does a contract or agreement entail a commitment for the expenditure of funds during a period in excess of 5 years from the date of the contract or agreement?

No

**34. Impact on U.S. Jobs (FY 1994 Appropriations Act, Sec. 547):**

a. Will any financial incentive be provided to a business located in the U.S. for the purpose of inducing that business to relocate outside the U.S. in a manner that would likely reduce the number of U.S. employees of that business?

No

b. Will assistance be provided for the purpose of establishing or developing an export processing zone or designated area in which the country's tax, tariff, labor, environment, and safety laws do not apply? If so, has the President determined and certified that such assistance is not likely to cause a loss of jobs within the U.S.?

No

c. Will assistance be provided for a project or activity that contributes to the violation of internationally recognized workers rights, as defined in section 502(a)(4) of the Trade Act of 1974, of workers in the recipient country, or will assistance be for the informal sector, micro or small-scale enterprise, or smallholder agriculture?

No

ANNEX C

**HOST COUNTRY REQUEST FOR PROJECT**

30 Août 1994

N= 0856

C.P.S-M.S.S.P.A  
ARRIVEE Le 01 SEP. 1994  
N° 0856

0 9 0 3

//-) /)/)ONSIEUR LE DIRECTEUR DE L'USATD-I  
- B A M A K O -  
s/c MADAME LE MINISTRE DES AFFAIRES ETRANGERES, DES  
MALIENS DE L'EXTERIEUR ET DE L'INTEGRATION AFRICAINE  
-BAMKO-

Requête de financement relative  
à la sensibilisation et à la  
Prévention du SIDA et des MST.

Monsieur le Directeur,

J'ai l'honneur de vous soumettre une requête de financement relative à la  
"SENSIBILISATION ET PREVENTION du SIDA/MST au MALI" d'un montant de DIX MILLIONS (10 000 000) de  
dollars US pour la période 1994 - 1996.

Ce vaste projet permettra de renforcer la campagne de lutte contre le SIDA et les  
maladies sexuellement transmissibles sur toute l'étendue du territoire du pays.

En espérant que vous accorderez toute l'attention à la présente requête, je vous  
 prie de croire, Monsieur le Directeur, en l'assurance de ma considération distinguée./.

P.J : Document du Projet

AMPLIATIONS :

- CPS
- DNSP
- PNLsida
- Archives/chrono

BEST AVAILABLE COPY

P/LE MINISTRE P.O.  
LE CHEF DE CABINET P.I

- PROFESSEUR GAOUSSOU KANOUTE -

**ANNEX D**

**LOGICAL FRAMEWORK**

VII. Annex D: Logical Framework

Goal	Objectively-Verifiable Indicators	Means of Verification	Important Assumptions
To improve health care in Mali	* Life expectancy increases from 45 to 47	Government records	* no significant decrease in social programs

Purpose	Objectively-Verifiable Indicators	Means of Verification	Important Assumptions
To limit HIV infection	* By the end of the project average HIV prevalence in the general population in Mali remains less than 7.5% (compared to 5% rate in 1993 World Bank survey)	* sentinel surveillance of HIV infection	* no significant influx of refugees or displaced persons from high prevalence areas

*BEST AVAILABLE COPY*

Outputs	Objectively-Verifiable Indicators	Means of Verification	Important Assumptions
<p>1. <b>Improved STD control</b> as a result of</p> <p>1.1 improved STD case management:</p>	<p>1. <i>Over the life-of-Project, STD incidence in the general population decreases by 10%</i></p> <p>1.1.1. <i>By the end of Year 1, the essential drug list for STD includes first-line drugs for treating chancroid and gonorrhea</i></p> <p>1.1.2. <i>By the end of Year 2, 350 health personnel at <i>arrondissement</i> and <i>cercle</i> level (including community health centers) and at least 100 persons in health related professions (pharmacies, social services etc) will have received training in STD case management</i></p> <p>1.1.3. <i>One year after receiving training, 70% of a representative sample of those trained can diagnose and treat STDs correctly and give accurate counseling on STD prevention</i></p> <p>1.1.4 <i>By the end of Year 4, 90% of people trained will have attended a refresher course</i></p> <p>1.1.5 <i>By the end of Year 2, 46 <i>Cercle</i> level Health Centers will have basic STD laboratory capabilities</i></p> <p>1.1.6 <i>By the end of Year 2, 10 health personnel at Regional level will have received training on counselling for seropositive individuals and AIDS sufferers</i></p> <p>1.1.7 <i>By the end of Year 2, 100% of people undergoing HIV testing will receive pre-and post test counselling</i></p> <p>1.1.8 <i>10 research grants awarded, of which the results of research confirm or modify the strategies adopted in the field and/or practical experience in the field is shown to have confirmed or modified the research agenda.</i></p>	<p>1. <i>Results of World Bank rapid assessment in 1993 and similar surveys in Year 2 and 4; regular reporting of STD syndromes by MoH reporting system</i></p> <p>1.1.1. <i>Essential drugs list</i></p> <p>1.1.2. <i>Training contracts, training records and reports</i></p> <p>1.1.3. <i>Survey in Years 2 and 3</i></p> <p>1.1.4. <i>Training contracts, training records and reports</i></p> <p>1.1.5. <i>Purchase and delivery records, training reports, stock control records, records of analyses undertaken</i></p> <p>1.1.6 <i>Training contracts, training reports</i></p> <p>1.1.7 <i>Surveys of test centers, annual reports</i></p> <p>1.1.8 <i>Grant agreements; published and unpublished research reports; revised project proposals (NGOs), training materials, diagnosis and treatment algorithms</i></p>	<p>* <i>security situation in the north of Mali permits training of personnel and equipping of laboratories in these regions</i></p>

Outputs	Objectively-Verifiable Indicators	Means of Verification	Important Assumptions
<p>1.2 improved surveillance and reporting of STDs</p> <p>1.3. Improved STD Institutional Capacity at the National AIDS Committee</p>	<p>1.2.1. By the end of Year 2 all Arrondissement and Cercle level health centers will routinely report cases of STD based on standard observed STD syndromes</p> <p>1.2.2. By the end of Year 1, six HIV sentinel surveillance sites are equipped with STD laboratories</p> <p>1.2.3. Rapid assessment surveys in Years 3, 5 and 7 complete data from sentinel surveillance and provide an overall picture of the evolution of STD in Mali</p> <p>1.2.4. Results of laboratory tests of antimicrobial resistance of gonorrhoea from the national research institute, Gabriel Toure and revised treatment algorithms are published by PNLs and distributed annually to everyone receiving training and at least 500 other health personnel and pharmacists</p> <p>1.3.1. A long-term resident advisor will be placed at the National AIDS Committee by the end of Year 1</p> <p>1.3.2. Two National AIDS Committee staff members will be identified and sent for long-term STD training by the end of Year 2</p>	<p>1.2.1. Health center records</p> <p>1.2.2. Records and reports from surveillance sites</p> <p>1.2.3. Reports of assessment surveys</p> <p>1.2.4. Copies of publications and distribution list, survey of readers</p> <p>1.3.1. Physical presence of the long-term advisor.</p> <p>1.3.2. Physical absence of National AIDS Committee staff; the payment of tuition to a long-term training institution; the staggered return of National AIDS Committee staff</p>	<p>* CHPS project successfully implements revised health reporting system throughout the country</p> <p>* Planned HIV sentinel surveillance sites are funded and operational</p>

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Outputs	Objectively-Verifiable Indicators	Means of Verification	Important Assumptions
<p>2. <b>Behavior change</b> reducing the risk of transmission of the HIV virus as a result of:</p> <p>2.1 Increased capacity of the not-for profit sector in Mali to engage in AIDS prevention and awareness activities</p> <p>2.2 An expanded and improved programme IEC activities concerning STD and AIDS carried out by NGOs</p>	<p>2. Sales of condoms will increase over the life of the project and cumulative sales will reach at least ten million by 1999 (compared to one million by the Condom Social Marketing Project in 1993)</p> <p>2.1.1. Within six months of the start of the project a management structure for NGO grants with appropriate regulations and procedures, will exist and be operational</p> <p>2.1.2. By the end of the project, at least 10 local NGOs will have as their principal activity the promotion of STD/AIDS Awareness and Prevention and will have the necessary skills to successfully elaborate and manage projects according to PVO Co-Financing criteria (increased from 0 in 1993)</p> <p>2.2.1 By the end of the project at least 25 grants have been made to NGOs for STD/AIDS IEC activities including at least 5 grants for activities aimed at specific groups with high risk behavior</p> <p>2.2.2 By the end of Year 3, 1,000 NGO field development staff will have attended at least one day of training on the transmission and prevention of STD and AIDS including specific training on appropriate messages and communication methods to be used with the general population.</p>	<p>2. Sales figures from the condom social marketing component and commercial condom importers and distributors</p> <p>2.1.1. Organigram, procedures, regulations, reports</p> <p>2.1.2. Grant awards, NGO annual reports, evaluation reports</p> <p>2.2.1 Grant awards, evaluation reports</p> <p>2.2.2 <i>Training contracts and reports</i></p>	

Outputs	Objectively-Verifiable Indicators	Means of Verification	Important Assumptions
<p>2.3 Improved marketing of condoms as a result of incorporating NGOs and community groups in the existing marketing strategy</p> <p>2.4 Promotion of counseling services and community level support for seropositive individuals and their families</p>	<p>2.3.1. By the end of Year 2 at least 20 NGO are members of a community based distribution network and this network supports or provides community level marketing of condoms</p> <p>2.3.2. No NGO member of the distribution network is out of stock of condoms on more one occasion per year and for not more than a total of 7 days</p> <p>2.3.3. Average annual sales of condoms by the NGO network increase throughout the life of the project and reach at least 1,000,000 by 1999.</p> <p>2.4.1 By the end of the project at least 5 grants will have been awarded to NGOs for long term community level support in Bamako and at least three other Regions of Mali</p>	<p>2.3.1. Distribution and sales records, NGO reports</p> <p>2.3.2. NGO reports</p> <p>2.3.3. Sales records and NGO reports</p> <p>2.4.1 Grant agreements, Project proposals</p>	<p>* all NGO members of the Community Based Distribution network and are provided with appropriate and timely support (condoms, marketing materials and media campaigns) by the Social Marketing Project.</p> <p>* National Policy Guidelines on AIDS testing, notification and case management are published by the end of Year 1</p>

Outputs	Objectively-Verifiable Indicators	Means of Verification	Important Assumptions
<p><b>3. Effective Coordination:</b> A National AIDS Committee that engages in information exchange, policy development and resource mobilization is operational</p> <p>3.1. Information exchange component is operational</p> <p>3.2. Policy development unit is operational</p> <p>3.3 Resource mobilization component (to help National AIDS Committee to seek sources from other donors) is operational</p>	<p>3.1.1. By the end of Year 1, National AIDS Committee publish and distribute to at least 1000 people or organizations a quarterly newsletter on STD/AIDS in Mali aimed at providing a forum for information and exchange for donors, health planners and NGOs</p> <p>3.2.1. By the end of Year 1, clear-cut policies developed on HIV/AIDS related counseling, free distribution of condoms and on STD prevention and control</p> <p>3.3.1. Donor coordination meetings have been held every six months</p> <p>3.3.2. Two studies on socio-economic and demographic impact of AIDS in Mali completed</p> <p>3.3.3. By the end of Year 2, at least two scenarios on socio-economic impact of AIDS in Mali developed using the AIDS impact model and are shown to at least 10 policy makers at national and regional levels</p>	<p>3.1.1 Copies of publications, distribution list</p> <p>3.2.1. Policy documents, official guidelines published</p> <p>3.3.1 Minutes of meetings</p> <p>3.3.2. Study contracts, study reports</p> <p>3.3.3. Reports, presentation materials, regular project monitoring</p>	<p>The GRM allows the release of a national policy endorsing the practice of revealing HIV test results to those undergoing testing.</p>

USAID-Finance Inputs	Objectively-Verifiable Indicators	Means of Verification	Important Assumptions
<p>1. Technical Assistance</p> <p>    Longterm</p> <p>    Short term</p> <p>2. Training</p> <p>3. Commodities &amp; equipment</p> <p>4. Laboratory supplies</p> <p>5. Operating Expenses</p> <p>6. Evaluation/Research</p> <p>7. NGO Component</p> <p>8. Audit</p> <p><b>TOTAL</b></p>	<p>2,714,100</p> <p>214,200</p> <p>847,000</p> <p>511,000</p> <p>957,500</p> <p>63,000</p> <p>1,459,500</p> <p>3,159,700</p> <p>175,000</p> <p><u>10,000,000</u></p>	<p>Project Accounting System</p>	<p>USAID disburses project funds in timely manner</p>

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**ANNEX E**

**INITIAL ENVIRONMENTAL EXAMINATION**

**ENVIRONMENTAL EXAMINATION  
OR  
CATEGORICAL EXCLUSION**

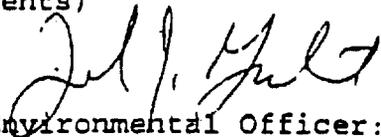
**PROJECT COUNTRY:** Mali  
**PROJECT TITLE AND NO.:** AIDS Awareness and Prevention  
(699-0270)  
**FUNDING:** FY 1995-2001 US \$10.0 mil.  
**IEE PREPARED BY:** Catherine McIntyre, USAID/Bamako

**ENVIRONMENTAL ACTION RECOMMENDED:**

- 1. Negative Determination (for distribution and/or use of commodities for STD testing and HIV screening)
- 2. Categorical Exclusion (for healthcare, family planning components)

**CONCURRENCE:**

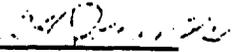
Bureau Environmental Officer:  
John J. Gaudet, AFR/ARTS/FARA



APPROVED: \_\_\_\_\_  
DISAPPROVED: \_\_\_\_\_  
DATE: 07/27/94

**CLEARANCE:**

GC/AFR: 

DATE: 

SUMMARY OF FINDINGS:

The purpose of this project is to limit the spread of HIV in Mali. It will raise the awareness of AIDS, HIV and sexually-transmitted disease (STD) control and prevention. It will also expand the delivery of services for sexually-transmitted disease(s). Project assistance includes three interrelated elements: Control of sexually-transmitted diseases (STDs); AIDS awareness and condom promotion for behavioral change; and a strengthened National AIDS Committee.

A categorical exclusion is recommended on the basis that this project is a program involving health care, population, and/or family planning services, under section 216.2(c)2(viii) of USAID's Environmental procedures (Reg 16).

A negative determination is requested for the activities dealing with sexually-transmitted disease case management because this component of the project does not anticipate any activities directly affecting the environment (such as construction of facilities, water supply systems, waste water treatment, etc.) The project will include the provision of HIV/AIDS prevention control commodities (such as disposable gloves, syringes and other protective materials). These commodities will be distributed regional hospitals and health centers.

Although blood may be drawn for the purpose of STD diagnosis or HIV counselling and testing, proper disposal facilities and techniques are already in use. In this regard, it has been determined through discussions with the Ministry of Health, that commodities provided through the project will be used appropriately and will be disposed of safely. USAID/Bamako, based on Malian government regulations for disposal of contaminated medical commodities, and planned monitoring of how these regulations are followed during the project, is confident that the HIV/AIDS prevention and control commodities supplied under this project will be disposed of in an environmentally safe manner.

Further, following the guidance provided in State 264038(93), copy attached as Annex 1, the Mission Environmental Officer will provide the Bureau Environmental Officer with a more complete report on bio-hazardous waste disposal in Mali.

Annex 1

AID/AFR/FARA/ARTS:JGAUDET:12AIDS1  
08/20/93 7-9029  
AID/AFR/FARA/ARTS:CREINSTMA

PRIORITY

ADDIS ABABA, PRIORITY DAKAR

ROUTINE

NAIROBI, ABIDJAN

AIDAC NAIROBI AND ABIDJAN FOR REDSOS (REGION. ENV. OFF.)

E.O. 12356: N/A

## TAGS:

SUBJECT: DISPOSAL OF BIOHAZARDOUS WASTE GENERATED FROM USAID AIDS PROJECTS

REF: BARBIERO/HOFFMAN FAX (8/19/93)

1. SUPPORT TO AIDS CONTROL (663-0010), USAID/ADDIS ABABA AND AIDS CONTROL AND PREVENTION PROJECT (685-0306), USAID/DAKAR HAVE BOTH PREVIOUSLY RECEIVED CATEGORICAL EXCLUSIONS UNDER REG 16. RECENTLY CONCERN HAS BEEN RAISED IN AID/W REGARDING SAFE DISPOSAL OF BIOHAZARDOUS WASTER GENERATED BY AIDS PROJECTS WHERE STD SCREENING AND HIV TESTING ARE BEING IMPLEMENTED.

2. AFR HAS NOT PREVIOUSLY REVIEWED AIDS PROJECTS ESPECIALLY TO DETERMINE IF CONDITIONS AND PROCEDURES IN EXISTENCE IN SUBJECT HOST COUNTRIES ARE ADEQUATE TO ENSURE THAT RISKS ASSOCIATED WITH BIOHAZARDOUS WASTES ARE MITIGATED.

3. BUREAU ENVIRONMENTAL OFFICER HAS PROVIDED THE EXECUTIVE SUMMARY OF AN AIDS PROJECT IN THE ASIA BUREAU WHERE THESE CONCERNS WERE RAISED AND AN ENVIRONMENTAL ASSESSMENT WAS CARRIED OUT. THE RECOMMENDATIONS MADE FROM THAT ENVIRONMENTAL ASSESSMENT ARE INSTRUCTIVE AND WOULD PROVIDE A ROUGH GUIDE TO THE ESSENTIAL POINTS THAT SHOULD BE REVIEWED IN BOTH SUBJECT PROJECTS.

4. AFR WOULD APPRECIATE INFORMATION FROM MEOS IN SUBJECT MISSIONS BY RETURN CABLE THAT WOULD ADDRESS SIMILAR CONCERNS IN SUBJECT COUNTRIES. PLEASE USE EXECUTIVE SUMMARY BELOW AS A MODEL FOR YOUR REPLIES.

5. FOR ADDIS ABABA: BEO HAS RECEIVED SUMMARY INFORMATION IN RECENT IEE AMENDMENT, AND ON THAT BASIS A NEGATIVE DETERMINATION HAS BEEN APPROVED FOR THE IEE AMENDMENT, WITH THE PROVISIO THAT A MORE DETAILED REPORT ON DISPOSAL OF BIOHAZARDOUS WASTE WILL BE PASSED TO BEO IN THE NEAR FUTURE.

6. EXECUTIVE SUMMARY OF ENVIRONMENTAL ASSESSMENT FOLLOWS:

A.- THE AIDS SURVEILLANCE AND EDUCATION PROJECT (ASEP) IS A JOINT UNDERTAKING OF THE PHILIPINE DEPARTMENT OF HEALTH AND USAID/MANILA TO ESTABLISH THE INSTITUTIONAL MECHANISMS IN THE PUBLIC AND PRIVATE SECTORS TO: A) DEVELOP A NATIONAL HIV/AIDS SENTINEL SURVEILLANCE SYSTEM AND B) EXPAND INFORMATION, EDUCATION AND COMMUNICATION (IEC) ACTIVITIES, TARGETING INDIVIDUALS AT HIGH RISK OF BECOMING INFECTED WITH HIV/AIDS AND RAISING THE GENERAL PUBLIC'S AWARENESS ABOUT THE IMPORTANCE OF PREVENTING HIV INFECTION. THE SENTINEL SURVEILLANCE SYSTEM WILL REQUIRE OBTAINING BLOOD SAMPLES FROM INDIVIDUALS IN SELECTED SENTINEL GROUPS (I.E., HIGH-RISK GROUPS). AS MANY AS THIRTY SURVEILLANCE SITES ARE PLANNED FOR NATIONAL COVERAGE. APPROXIMATELY ONE THOUSAND BLOOD SAMPLES WILL BE COLLECTED EVERY SIX MONTHS AT THE SITES, PRODUCING A CORRESPONDING AMOUNT OF USED MEDICAL MATERIALS WHICH ARE POTENTIALLY HIV CONTAMINATED.

B.- THE PROPER HANDLING OF THESE MATERIALS SO AS TO ELIMINATE OR SUBSTANTIALLY REDUCE THE RISK OF ACCIDENTAL INFECTION OF INDIVIDUALS WHO MAY COME INTO CONTACT WITH THEM WAS THE MAIN FOCUS OF AN ENVIRONMENTAL ASSESSMENT. THE RISK OF ACCIDENTAL INFECTION IS THE "REASONABLY FORESEEABLE ENVIRONMENTAL EFFECT" OF ASEP.

C.- RECOMMENDATIONS OF THE ENVIRONMENTAL ASSESSMENT FOR MANAGING THESE MATERIALS IN WAYS WHICH REDUCE THIS RISK AND ARE NOT ENVIRONMENTALLY HARMFUL ARE AS FOLLOWS:

- THE GENERAL STRATEGY TO BE FOLLOWED IS TO INITIATE DECONTAMINATION OF MATERIALS BY THE TECHNICAL STAFF INVOLVED WITH BLOOD COLLECTION AND BY THE MEDICAL TECHNICIANS CONDUCTING THE TESTING PRIOR TO THE RELEASE OF THESE MATERIALS FOR SUBSEQUENT PROCESSING THROUGH THE HOSPITALS ESTABLISHED PROCEDURES.

- NEEDLES USED WITH VACUTAINERS WILL BE DEPOSITED IN A PUNCTUREPROOF CONTAINER (E.G., POWDERED MILK CONTAINERS) WHICH CONTAINS A FRESH SOLUTION OF SODIUM HYPOCHLORITE. THESE CONTAINERS WILL HAVE A SMALL SLIT OR OPENING CUT IN THEM LARGE ENOUGH TO ALLOW DEPOSITING OF THE NEEDLE IMMEDIATELY AFTER USE. THE MEDICAL TECHNICIAN COLLECTING THE BLOOD SAMPLES WILL BRING A CAN CONTAINING THE SOLUTION TO THE COLLECTION SITE. THESE CANS WILL BE DELIVERED TO THE REGIONAL HOSPITAL/LABORATORY WHERE THEY WILL BE BURIED IN THE HOSPITAL GROUNDS AT A "DEDICATED SITE" FOR THIS PURPOSE TO PREVENT SCAVENGING FOR SALE OR REUSE. SURVEILLANCE WILL BE UNDERTAKEN IN 30 DIFFERENT SITES AND EACH SITE WILL DISPOSE OF ITS OWN WASTE. THE VOLUME OF SODIUM HYPOCHLORITE THAT WILL BE BURIED DURING THE ENTIRE PERIOD OF THE SURVEILLANCE PROGRAM WILL NOT CAUSE A SIGNIFICANT NEGATIVE IMPACT ON THE ENVIRONMENT.

"DEDICATED" BURIAL SITE, CHECKING IN TRASH CANS AT THE LABORATORY, SPOT CHECKS AT BLOOD COLLECTION SITES).

- THESE PROCEDURES AND RESPONSIBILITIES WILL BE SPECIFIED IN THE OPERATIONAL PLAN FOR THE NATIONAL HIV SURVEILLANCE SYSTEM.

- THE COSTS OF THESE PROCEDURES ARE NEGLIGIBLE AND CAN BE ABSORBED BY THE BUDGETS OF THE LABORATORIES (E.G., ONE LITER POWDERED MILK CANS WITH SODIUM HYPOCHLORITE SOLUTION). ASEP FUNDING WILL COVER ALL OTHER SUPPLIES (I.E., VACUTAINERS, ADDITIONAL GLOVES AND SODIUM HYPOCHLORITE SOLUTION, HARD-SIDED CONTAINERS, LEAK-PROOF CONTAINERS LINED WITH ABSORBENT PADS, THE PARTICLE AGGLUTINATION TEST KITS). YY

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FOR USAID/AFR/ANR/NR: JGAUDET;
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E O 12356 N/A
SUBJECT MALI AIDS AWARENESS AND PREVENTION
(688-0270): INITIAL ENVIRONMENTAL EXAMINATION (IEE)

1. THIS CABLE REQUESTS BUREAU ENVIRONMENTAL OFFICER,
APPROVAL FOR CATEGORICAL EXCLUSION FOR THE SUBJECT
PROJECT

2. SUMMARY: THIS NEW PROJECT WILL HAVE A PROJECT
AGREEMENT COMPLETION DATE OF SEPTEMBER 2001 AND
LIFE-OF-PROJECT FUNDING OF 10 MILLION. THE MISSION
ENVIRONMENTAL OFFICER HAS REVIEWED IEE FOR SUBJECT
PROJECT AND RECOMMENDS A CATEGORICAL EXCLUSION END

SUMMARY

3. PROJECT DESCRIPTION. THE PURPOSE OF THIS
PROJECT IS TO LIMIT THE SPREAD OF HIV IN MALI. IT
WILL RAISE THE AWARENESS OF AIDS, HIV AND SEXUALLY-
TRANSMITTED DISEASE CONTROL AND PREVENTION AND EXPAND
THE DELIVERY OF SERVICES FOR SEXUALLY-TRANSMITTED
DISEASE (STD). USAID PROJECT ASSISTANCE INCLUDES FOUR
INTERRELATED ELEMENTS: AIDS AWARENESS AND CONDOM
PROMOTION FOR BEHAVIORAL CHANGE; SEXUALLY-TRANSMITTED
DISEASE CASE MANAGEMENT; POLICY DEVELOPMENT AND
COORDINATION; AND RESEARCH AND EVALUATION.

4. DISCUSSION OF ENVIRONMENTAL ISSUES: THIS
PROJECT DOES NOT HAVE ANY FORESEEABLE EFFECTS UPON
THE ENVIRONMENT, AND QUALIFIES FOR A CATEGORICAL
EXCLUSION UNDER U.S.A.I.D. REGULATIONS 16, SECTIONS
216.2 (C) (1) (I) AND 216.2 (C) (1) (VIII): PROGRAMS
INVOLVING TECHNICAL ASSISTANCE, TRAINING, NUTRITION
HEALTH CARE, POPULATION AND FAMILY PLANNING.

5. RECOMMENDATION: THAT, HAVING DETERMINED THAT
THIS NEW PROJECT IS NOT SUBJECT TO ENVIRONMENTAL
PROCEDURES, THE GENERAL COUNSEL CLEAR AND THE BUREAU
ENVIRONMENTAL OFFICER APPROVE THIS CATEGORICAL
EXCLUSION. PLEASE ADVISE WHEN THIS ACTION HAS TAKEN
PLACE. BLACKFORD

CONCURRENCE AND CLEARANCE:

Concurrence:

John GAUDET, AFR/ARTS/FARA
Bureau Environmental Officer Wik

Date: 5/16/94

Clearance:

Pauline Johnson
GC/Africa

Date: \_\_\_\_\_

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**ANNEX F**

**PROJECT ANALYSES**

## Annex F: Project Analyses

### I. Technical And Institutional Analysis

#### A. Improved Sexually-Transmitted Disease Control in Mali

##### 1. Sexually-Transmitted Diseases and HIV in Mali: the Current Situation

###### a) Clinical Care

Mali has never had a formal control program for sexually-transmitted diseases. Rather, sexually-transmitted diseases are managed clinically in the health care system on an ad hoc basis. Care for sexually-transmitted diseases in Mali is a microcosm of health care in general, existing within the same environment and subject to all of the same problems. Specifically, access to diagnostic and treatment services for sexually-transmitted diseases is limited due to poor access to primary health care, inadequate training of primary care providers, inadequate diagnostic facilities, and a lack of appropriate and affordable drugs to treat the diseases. Laboratory support for diagnosis is inadequate, due largely to the lack of supplies. Sexually-transmitted disease treatment is expensive, drug selection is limited, and the level of compliance is unknown since oral medicines are frequently prescribed and on-site treatment is not practiced routinely [12].

Taking into account the level of morbidity and the available infrastructure, Mali ranked highest priority among Sahel countries in the World Bank's assessment of the need for HIV and sexually-transmitted disease interventions. Encouragingly, the Malian Government has developed an ambitious five-year strategy to combat sexually-transmitted disease and HIV [15], and several large-scale development projects are attempting to reinforce the health infrastructure. Thus, USAID is presented with an excellent opportunity to assist Mali and other donor agencies in these efforts to build a national sexually-transmitted disease and HIV control program.

###### b) Surveillance

Disease surveillance in Mali is hierarchical, with information flowing from the sub-districts to the districts and to regions. Monthly reports are submitted routinely by peripheral-level facilities to the district level, where data is compiled and then sent to the regional level. From there, the Ministry of Health, Public Health, Division of Epidemiology collects the data for collation and analysis.

Although the Division of Epidemiology in the Ministry of Health has undertaken efforts to improve sexually-transmitted disease and HIV surveillance, it remains weak and case reporting is incomplete [12]. However, this situation is about to

change as USAID's contribution to the Health, Population and Rural Hydrology Project,<sup>1</sup> the Community Health and Population Services project has a component to build a national medical information system. As part of the latter, the Division of Epidemiology is streamlining the list of reportable conditions, re-designing reporting forms, users manuals, information systems, and training essential personnel.

1) AIDS reporting

From 1985 through June of 1993, a total of 4,736 people have tested positive for HIV in Mali although it has no formal HIV reporting system. However, AIDS case reporting has been in effect since Mali reported its first case in 1985, and the cumulative total as of March 1993 was 1,479. This is assumed to be a gross underestimation as these cases were derived exclusively from the two main hospitals in Bamako, and many cases are undiagnosed or unreported. Over the past three years, cases have doubled; 460 cases were reported during 1992, compared with 377 in 1991, and 242 in 1990. Whether this represents increased morbidity or increased reporting is unclear, but the trend is concerning.

2) Sexually-transmitted disease reporting

The list of over 80 reportable conditions contains three sexually-transmitted diseases: "*syphilis venerienne symptomatique*," "*gonococcie presumee*," and "*autres maladies veneriennes*." Thus, for syphilis, reporting is not done by stage of disease, and is done mostly without benefit of serology.

When laboratory support is available, diagnosis of syphilis is often made on the basis of syphilis confirmatory tests, without further confirmation. Case reporting for gonorrhea, due to the absence of laboratory diagnosis, is based entirely on presumptive cases and probably reflects a combination of etiologic agents that cause cervicitis and urethritis. The "other sexually-transmitted disease" category is so non-specific that it has no utility whatsoever.

3) HIV surveillance activities

The Division of Epidemiology has, with foreign assistance, established special sentinel surveillance sites for HIV infection. There are seven such sites, three in Bamako (one maternal-child clinic that conducts perinatal surveillance, one transfusion center and one hospital), and four others in the regions. Outside of the capital city, Canada funds sites in the provinces of Sikasso, Mopti, and Kayes; and the Netherlands fund a site in Ségou. All sites share common protocols. None include surveillance for sexually-transmitted diseases.

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<sup>1</sup>Health, Population and Rural Hydrology is a multi-donor project to improve the health infrastructure and training of personnel.

c) Epidemiologic data: current levels of sexually-transmitted disease and HIV

Data on the incidence and prevalence of sexually-transmitted diseases including HIV in Mali come from various seroprevalence studies and sentinel surveillance systems in existence. In addition, the Ministry of Health has used unspecified epidemiologic modeling techniques to estimate the incidence and prevalence of disease, and make projections based on those estimates. For 1994, it estimates an annual incidence of 34,000 new infections in Mali, with 167,000 infected persons, 21,500 of which will have AIDS [15].

1) Surveillance data

Results from the HIV sentinel surveillance sites indicate that two percent of blood donors in Bamako, four percent of women at a pre-natal clinic, and two percent of patients tested at Hospital Point G are infected with HIV [6]. The sexually-transmitted disease surveillance data for the year 1991, the most recent data made available, was as follows: 3,160 cases of syphilis, 123 of which were in persons younger than four years of age and possibly representing congenital syphilis; 14,154 cases of presumptive gonorrhea; and 9,051 cases of "other sexually-transmitted disease." These data are available by age group and gender.

2) HIV seroprevalence studies

Studies from 1987 showed, among pregnant women in Bamako (and thus considered representative of the population), a seroprevalence of 0.4 percent for HIV-1 and 1.4 percent for HIV-2. Among prostitutes in Bamako, the prevalence was 23 percent for HIV-1 and 27 percent for HIV-2.

An excellent critique by the National Research Institute of the available epidemiologic data on HIV concludes that most studies have been limited by severe methodological weaknesses and many lack any scientific merit [9]. Most seroprevalence studies are limited by poor or unspecified methodology, lack of comparability between studies, a lack of serological diagnosis or specific clinical case definitions. Lack of data that can be generalized from prevalence studies of high-risk groups to the population as a whole. Seroprevalence studies were also limited by a high false positivity rate of Eliza Assay (enzyme immunoassay - a "quick" test for HIV) compared to Western Blot (a more reliable test for HIV than Eliza Assay), ranging from eight to 43 percent.

Thirteen seroprevalence studies could distinguish HIV-1 from HIV-2; generally the prevalence of HIV-1 was double that of HIV-2. Studies of brothel-based prostitutes in Bamako by the USAID-funded AIDS project from 1987 through 1993 indicate an HIV seroprevalence of 39 percent in 1987, 63 percent in 1988, 47 percent in 1991, 74 percent in 1992, and 52 percent in 1993 [14].

Results from a 1993 national seroprevalence study of 4,892 persons from all eight regions, and considered to be representative of the general population, indicate a prevalence of HIV-1 of two percent in Gao and Tombouctou, a range of four-to-six percent in Kayes, Ségou, and Bamako, and six percent in Sikasso. The overall national seroprevalence was estimated at 5.3 percent; with 3.4 percent prevalence for HIV-1, 0.9 percent for HIV-2, and one percent for dual infections [17].

3) Sexually-transmitted disease incidence and prevalence studies

Data on other sexually-transmitted disease are even more incomplete due to lack of both reporting and adequate diagnostic capacity. In 1991, using laboratory diagnosis, National Public Health Research Institute researchers found a prevalence of 21.4 percent of newborns with conjunctivitis (60/280) in its prevalence study of gonorrhea and chlamydia among 280 newborns at a Bamako maternal and child health clinic. The prevalence of gonorrhea conjunctivitis was 10.7 percent, with antibiotic resistance to the gonococcal isolates being quite common. The prevalence of C. trachomatis among the newborns was ten percent.

A series of cross-sectional prevalence studies of brothel-based prostitutes in Bamako by the USAID-funded AIDS project reveal high rates of sexually-transmitted diseases [13, 14]. In 1987 showed the prevalence of gonococcal infections was 47.5 percent, (although poor correlation of gram stain with culture suggests that these data lack validity) and a Venereal Disease Research Laboratory (quick test for syphilis) seropositivity of 24.3 percent. Follow-up studies on the same population in 1991 showed gonorrhea 41 percent, trichomonas is two percent, gonorrhea and trichomoniasis together six percent, and bacterial vaginosis and candidal vaginitis 23 percent. Syphilis confirmatory test seropositivity was 25 percent. Repeat evaluation in 1992 showed gonorrhea seven percent other (candida) 22 percent, and a syphilis confirmatory test seropositivity of 26 percent. Repeat evaluation in 1993 showed a gonorrhea prevalence of 8.2 percent, trichomoniasis of 15.6 percent, candida 30.5 percent, and 5.7 percent had a positive rapid plasma reagin.

In a 1994 study of 210 women seeking prenatal, family planning and gynecologic care in Bamako, 42 percent of women were diagnosed with chlamydial infections, most of which were asymptomatic; 34 percent were diagnosed with gonorrhea; 2.5 percent were HIV seropositive; and 4.5 percent were syphilis confirmatory test-positive [8].

4) Rapid assessment study

The World Bank funded a rapid assessment of HIV and sexually-transmitted disease prevalence in Mali [7] that examined three sentinel populations: pregnant women, as an unbiased estimator of the population level; prostitutes, a high-risk group that is thought to serve as a locus for high-frequency transmission of sexually-

transmitted diseases; and truck drivers and their apprentices, another high-risk group thought to serve as a secondary locus of high-frequency transmission. Four geographic areas were chosen to study: Bamako; Sikasso, a region shown in previous studies to have the highest prevalence of HIV and a port of entry from the hyperendemic countries of Cote d'Ivoire and Burkina Faso; Mopti, a commerce center on the Niger River; and Koutiala, an important crossroads for commercial truck traffic.

The study administered a survey to participants and performed a diagnostic evaluation for sexually-transmitted diseases that included gram stain (culture and antibiotic sensitivities for N. gonorrhoea), Eliza Assay (for chlamydia, microscopic examination for trichomoniasis and candida); urine leucocyte esterase (for non-specific inflammation), and serology (for HIV-1 and HIV-2, syphilis, Hemophilus ducreyi, and Herpes simplex).

The rapid assessment has just been completed. Although unable to achieve target sample size, a determination was made to preserve the sampling scheme, thus the results will provide the most accurate view to date of the prevalence of sexually-transmitted diseases in these groups. Preliminary results show four percent HIV prevalence in pregnant women, 55 percent in prostitutes, and ten percent in truck drivers (sexually-transmitted disease data is unavailable). These results show levels of HIV infection among Malian prostitutes comparable with the ten to 40 percent seroprevalence of prostitutes in Nairobi and Kinshasa.

#### 5) The burden of disease

Although the available epidemiological data is inadequate to assess the true burden of disease, some trends and conclusions can be obtained from these studies. Sexually-transmitted diseases including HIV infection represents a major health problem for Mali. HIV appears to be established among groups thought to represent unbiased estimates of the population, and appears to be quite high in sentinel, high-risk populations. The aforementioned studies indicate a strong likelihood that HIV seroprevalence is increasing at a rapid rate in Mali.

#### d) Conclusions

Sexually-transmitted diseases including HIV infection represent a major health problem for Mali. HIV appears to be established among groups thought to represent unbiased estimates of the population (prevalence estimates range from four to five percent), and appears to be quite high in sentinel, high-risk populations (40 to 50 percent in Bamako prostitutes). Although the quality of the data do not permit rigorous temporal analysis, available data suggests that HIV seroprevalence is increasing at a rapid rate in Mali.

In this light, USAID intends to develop an AIDS Prevention Project in conjunction with the Ministry of Health. Project components include improved

sexually-transmitted disease control, in terms of improved sexually-transmitted disease case management and improved surveillance and reporting of sexually-transmitted diseases; behavior change as a result of an expanded and improved program of health education activities, carried out by non-governmental organizations; and an operational National AIDS Committee that will engage in information exchange, policy development and resource mobilization.

Given the synergy between HIV and sexually-transmitted diseases, USAID is committed to assisting Mali develop an improved sexually-transmitted disease control program, the purpose of which is to limit the spread of HIV.

## 2. Project Plan

The following discussion covers the plan to develop a national sexually-transmitted disease control program, and includes components to strengthen clinical case management, disease surveillance, operations research, and to build sexually-transmitted disease capacity at the Ministry of Health.

### a) Introduction

The relationship between HIV and other sexually-transmitted diseases<sup>2</sup> has been termed epidemiologic synergy. HIV is a sexually-transmitted disease, and it shares common modes of transmission, common behavioral risk factors, and common hosts with other sexually-transmitted diseases. Other sexually-transmitted diseases facilitate the sexual transmission of HIV. The presence of a sexually-transmitted disease in someone who is uninfected with HIV makes it easier to acquire HIV infection. The presence of a sexually-transmitted disease in someone who is infected with HIV makes it easier to transmit that HIV infection. Possible explanations for this facilitation include breaks in the genital mucosa providing a port of entrance for the virus; recruitment of uninfected lymphocytes to the mucosa, which then become targets of HIV infection; and recruitment of infected lymphocytes to the genital mucosa that become sources of virus for transmission.

The magnitude of this effect is large, with studies demonstrating that inflammatory sexually-transmitted diseases may cause a two-to-fourfold increases in the likelihood of acquiring or transmitting HIV infection. For the sexually-transmitted diseases that cause genital ulcers, there may be up to a tenfold increase in the likelihood of HIV transmission.

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<sup>2</sup>From the perspective of HIV prevention, the important sexually-transmitted diseases are syphilis and chancroid, which cause genital ulceration; gonorrhea and chlamydia, which cause inflammatory discharge (urethritis in men, cervicitis in women), and trichomoniasis, which causes cervicitis in women. Because of the lack of effective treatment for genital herpes, it is less important for HIV prevention. Syndromes such as candida vaginitis, bacterial vaginosis, genital warts and other human papillomavirus infections, while responsible for morbidity in their own right, are not as important for HIV prevention.

b) Project outputs

Sexually-transmitted disease project activities are designed to achieve improved sexually-transmitted disease control as measured by a decrease in the incidence of sexually-transmitted diseases in the general population. Improved sexually-transmitted disease control will be attained through improved sexually-transmitted disease case management; improved surveillance and reporting of sexually-transmitted diseases; and strengthened sexually-transmitted disease capacity at the National AIDS Committee. Components key to improving case management include: adding first-line drugs to treat key sexually-transmitted diseases to the essential drug list; training health personnel in sexually-transmitted disease case management; providing basic sexually-transmitted disease diagnostic laboratory equipment at the district level; and conducting operations research grants. Components key to improving the surveillance and reporting of sexually-transmitted diseases include: equipping HIV sentinel surveillance sites with sexually-transmitted disease laboratory equipment; conducting rapid assessment surveys to provide an overall view of the evolution of sexually-transmitted diseases in Mali; and revising treatment protocols based upon information received from the results of operations research. Components key to strengthening the sexually-transmitted disease capacity of the National AIDS Committee include: providing two-years of technical training to the Sexually-Transmitted Disease Advisor and providing long-term training in sexually-transmitted disease control for two National AIDS Committee staff members.

1) Sexually-transmitted disease case management

Case management - the diagnosis and treatment of sexually-transmitted diseases - serves both a primary and a secondary prevention role. As a secondary prevention strategy, early diagnosis and treatment of sexually-transmitted diseases can reduce symptoms, complications, and sequelae. As a primary prevention strategy, successful treatment of bacterial sexually-transmitted diseases renders the host un-infectious, interrupts the cycle of transmission, and reduces the reservoir of infected persons. The goals of sexually-transmitted disease case management are summarized as: to cure the bacterial sexually-transmitted diseases; to prevent complications and sequelae of sexually-transmitted diseases; to prevent transmission of sexually-transmitted diseases; and to reduce the efficiency of HIV transmission [11].

Sexually-transmitted disease case management consists of four components: accurate diagnosis; effective therapy; management of sex partners; and prevention counseling. This project will focus on the addition of equipment and training as a means to obtain an accurate diagnosis, management of sex partners and prevention counseling; the addition of drugs to the essential drug list will promote an the use of effective therapy; and operations research as a means to support the aforementioned components.

*The importance of an accurate diagnosis:* This is one of the most problematic areas for sexually-transmitted disease control. A certain level of

laboratory sophistication is necessary to make even the basic etiological diagnosis. Microscopic techniques can be used to diagnose trichomoniasis, and candida, but the gram stain techniques have not performed well in detecting gonorrhea. Culture for gonorrhea and chlamydia are too resource-intensive for most laboratories in Mali, as are serological tests for syphilis and HIV, and other techniques such as enzyme immunoassay, immuno-fluorescent assays, and di-nucleic acid hybridization.

In the areas where etiologic diagnosis is not possible, clinical diagnosis based on the constellation of symptoms and physical findings of the patient is necessary. The World Health Organization has elaborated on algorithms for the diagnosis based on these syndromes [21]. Preliminary data from the USAID-funded AIDS project prostitute study indicate that some of these algorithms perform satisfactorily in high-prevalence populations. For cervicitis, compared to gonorrhea gram stain and culture, the algorithms had a sensitivity of 70 percent, specificity of 85 percent, predictive value positive of 29 percent and predictive value negative 92 percent [14]. Although the protocols will miss a few asymptomatic infected women, the majority will be covered, with a potentially-acceptable rate of false positives (e.g. treating uninfected women). The empiric treatment of cervicitis for chlamydia as well as gonorrhea will improve the efficacy of these algorithms. Data was not available concerning the performance of the algorithms used to diagnose genital ulcer disease. Further research is needed to assess the performance of these empiric diagnostic and treatment protocols in different populations with different prevalence (e.g. male truck drivers), and to develop more refined protocols.

The earlier in the course of infection that it can be diagnosed and treated, the better the likelihood of reducing complications, and the shorter the duration of infectivity. Two determinants of early treatment are problematic and deserve special attention: health-seeking behavior of the infected person; and the accessibility to quality health care facilities. Because sexually-transmitted diseases are often asymptomatic, they often go unrecognized and therefore untreated. This is particularly true in women, for whom its consequences are greatest. However, even when sexually-transmitted diseases are symptomatic, there may be delays in seeking medical assistance; the time between onset of painful chancroid lesion and presentation to a medical facility is often two-to-four weeks in sub-saharan Africa.

The behavior change component of this project will work to improve early treatment, including health education directed at symptom awareness (the link between sexually-transmitted disease and HIV) and will promote recognition of the need to seek health care without delay.

*Training and Equipment:* Treating sexually-transmitted diseases will help prevent HIV infection. Using conservative estimates (odds ratio of 4), Bjorkman has estimated that, in Tanzania, treating 14 cases of sexually-transmitted disease effectively will prevent one case of HIV infection [18]. Thus, sexually-transmitted disease control is a vital strategy for controlling the spread of HIV infection, and will incidently

provide additional health benefits for women and children. (Women and children bear the greatest burden from the complications and sequelae of sexually-transmitted diseases, which include pelvic inflammatory disease, chronic pain, infertility, adverse outcomes of pregnancy such as increased incidence of ectopic pregnancies, increased maternal and neonatal mortality, and increased neonatal morbidity like conjunctivitis, respiratory disease and other severe physical and mental handicaps.)

This project will train primary care providers to use diagnostic algorithms for genital ulcers, urethritis in men, and cervicitis and vaginitis in women. Specifically, at the *arrondissement* community health center and district community health center level, use of algorithms designated for lack of laboratory services. This project will also equip and supply for five years a basic sexually-transmitted disease laboratory at each of the 46 district-level community health centers to consist of basic microscopy, gram stain, and a rapid test for syphilis. Training at the district-level community health center would include use of the laboratory, and use of the algorithms designated for facilities with basic laboratories.

This project will also offer sexually-transmitted disease training to district-level community health centers, in a collaboration with the large, multi-donor (*inter alia* USAID, UNICEF, World Bank) Health, Population and Rural Hydrology project that is building a network of 120 community health centers. Although it will not be in the two regions with the highest HIV prevalence (Bamako and Sikasso), it does offer the opportunity to add sexually-transmitted disease diagnostic and treatment services to these areas. The Project is in the process of adopting a minimum package of clinical services that will be offered at all health centers. Whether sexually-transmitted disease care is integrated as a component of the minimum package or offered as an extra module for centers in high morbidity areas is a question for the Ministry of Health to resolve with input from National AIDS Committee, the large, multi-donor health project, and donor agencies.

*Effective therapy and sexually-transmitted disease drugs:*

To a large extent, effective therapy depends upon effective diagnosis. However, confirmatory laboratory diagnostic testing is not always necessary to provide effective treatment. Presumptive treatment, based on the likely etiologic agent(s) of a specific syndrome, can be a cost-effective alternative to diagnostic testing in many situations. In the case of *N. gonorrhoea*, the widespread prevalence of antimicrobial resistance has complicated the choice of appropriate therapy. Thus, presumptive treatment based on syndromic diagnosis must be supported by an underlying knowledge of the prevalence of disease, the patterns of antibiotic resistance, and the performance of the diagnostic algorithms.

In Mali, the essential drug list (most recent version is 1991) lists 17 antibiotics including amoxacillin, ampicillin, naldixic acid, benzathine penicillin, benzyl penicillin, cloxacillin, oxacillin phenoxymethyl penicillin, procaine penicillin, penicillin V, chloramphenicol, cotrimoxazole, erythromycin, gentamycin, salazosulfapyridine, and tetracycline. It also includes metronidazole. These drugs include agents active against

syphilis (benzathine penicillin), chancroid (erythromycin), chlamydia (tetracycline), and trichomonas (metronidazole).

According to the National Research Institute, penicillin resistance is prevalent among gonococcal isolates, but tetracycline resistance is not, although these data have not been published. Treatment protocols at National Research Institute call for doxycycline (not on the list) as the first-line drug for gonorrhea. The efficacy of this regimen in Mali should be confirmed empirically, and the emergence of tetracycline resistant strains should be monitored closely. Treatment protocols and the essential drug list should be revised to include an efficacious regimen against gonorrhea when such resistant strains are found to be prevalent.

While the current drug list does include a first-line drug effective against chancroid, the treatment protocol at National Research Institute is to use doxycycline, which is not a first-line drug, and not on the essential drug list. Once the essential drug list has been revised, the challenge is to ensure that each primary care site has a sufficient quantity of essential, first-line drugs to treat the sexually-transmitted diseases that are diagnosed. USAID is not in the best position to provide essential drugs, and the World Bank has expressed interest in supporting this aspect of sexually-transmitted disease care in Mali. Unfortunately, once the drugs are purchased, the distribution mechanism is inadequate. The Malian National Pharmacy (*Pharmacie Populaire du Mali*) has a poor track record of establishing an uninterrupted flow of essential drugs to the periphery. USAID is prepared to work with the National AIDS Committee, the Malian National Pharmacy and World Bank to support the existing distribution system, and to assist in establishing a new system that parallels the condom distribution system, i.e., an social marketing sexually-transmitted disease treatment program, as found in Cameroon, should that proves too cumbersome.

*Operations research:* One of the first items operations research will be used to examine the impact of cost recovery for drugs to treat sexually-transmitted disease on patient compliance, currently endorsed by the World Bank. Sex partners of patients with sexually-transmitted diseases are at the highest risk of acquiring sexually-transmitted diseases. Case-finding in this group, called partner notification, is important because many people with either known or asymptomatic sexually-transmitted diseases do not present for health care. On the clinical level, diagnosing and treating the sex partners of sexually-transmitted disease patients will reduce the chances of that patient becoming re-infected. In addition, partner notification can be an important primary and secondary prevention strategy. Partners who are uninfected can take steps to prevent infection, and partners who are infected with a bacterial sexually-transmitted disease can be treated, reducing sequelae and breaking the cycle of transmission. Partners infected with HIV or other incurable viral sexually-transmitted diseases can be counseled to avoid transmission to others.

From the perspective of sexually-transmitted disease control, barriers to compliance and effective treatment will diminish the effectiveness of the

program. For sexually-transmitted diseases, especially in asymptomatic partners, there are disincentives to purchasing expensive drugs. At the *Narela Arrondissement*, community health center, a clinic appointment cost 250 CFA, but the medicine to treat a sexually-transmitted disease may cost 4,000 CFA (\$6) for the patient, and double that to treat a partner. Results from this research will be used to continue cost-recovery activities or to terminate them.

The issue of screening might be examined also. Screening is the identification of asymptotically-infected persons to provide early treatment, thus preventing sequelae and further transmission. Cost-effectiveness models have shown that for African countries, screening is rarely more cost-effective than treating empirically on the basis of a syndromic diagnosis, or treating after a laboratory test [11]. Potential exceptions are screening the blood supply and prenatal screening.

Diagnosing and treating syphilis, gonorrhea, and chlamydial infections in pregnant women prevents transmission to the neonate, and also sequelae in the mother. If routine surveillance activities show that these conditions are prevalent at family planning and maternal and child health facilities, USAID will consider initiating operations research activities that will examine the cost-effectiveness of routine screening and treatment.

## 2) Surveillance

Improved sexually-transmitted disease surveillance and reporting will be achieved by incorporating syndromic definitions of key sexually-transmitted diseases into the national health information system; equipping HIV sentinel surveillance sites with sexually-transmitted disease laboratory equipment; conducting rapid assessment surveys to provide an overall view of the evolution of sexually-transmitted diseases in Mali; and revising treatment protocols based on information received from the results of operations research.

*Using sentinel surveillance sites in targeting:* In Mali, several "core groups" of very sexually active, potentially high-frequency transmitters have been identified. Prostitutes (both brothel-based and clandestine), truck drivers, and migrant workers appear to be at much higher risk of infection and may comprise a reservoir of HIV infection and serve as a locus of spread. Targeting a sexually-transmitted disease treatment program to groups of persons engaging in high-risk behaviors (i.e. frequent sexual contacts, multiple sex partners) is more cost-effective, and can achieve far greater benefit than a program that does not target these core groups [11].

Thus, resources can be allocated efficiently by placing sentinel surveillance sites and enhanced diagnostic and treatment centers in known high-prevalence areas such as Sikasso, Bamako, Mopti and Kayes; and in areas where prostitutes, truck drivers and migrants are likely to live and work, such as Koutiala.

*Incorporating syndromic definitions of sexually-transmitted diseases in the National Health Information System:* Epidemiologic surveillance is the ongoing and systematic collection, analysis and interpretation of health data to assess the current status of a health problem and to monitor its progress [4]. Surveillance is conducted to guide health care policy rationally in the best use of health care resources. Surveillance data can be used to assess the need for new programs, and to evaluate the effectiveness of existing ones.

Unfortunately, the current categories that the Division of Epidemiology uses to report sexually-transmitted disease do not provide sufficient information to serve these functions. The categories are either too specific (e.g. syphilis and presumptive gonorrhea without benefit of laboratory diagnosis), or too non-specific (such as "other"). Surveillance for sexually-transmitted diseases is challenging for several reasons: the prevalence is high, thus the potential burden of reporting may be high; many infected patients are asymptomatic and are therefore difficult to identify; and diagnosis of sexually-transmitted diseases, even in symptomatic patients, requires substantial resources for laboratory testing.

Just as USAID Mali has proposed a syndromic approach to the diagnosis and treatment sexually-transmitted diseases, it proposes that Mali adopt a passive surveillance system relying on the reporting of the syndromes of AIDS, genital ulcers, cervicitis in women, urethritis in men.

The USAID-funded component of the national large, multi-donor health project, the Community Health and Population Services project, includes support to the Malian government to establish a national health information system. This system will offer a unique opportunity to strengthen sexually-transmitted disease surveillance, at no cost to this project. Both Division of Epidemiology and Community Health and Population Services personnel have expressed interest in substituting the four sexually-transmitted disease syndromes for the existing reportable sexually-transmitted diseases.

*Equipping HIV sentinel surveillance sites:* While case reporting has the advantage of geographic completeness, more in-depth information about the level of sexually-transmitted diseases in specific populations is needed. Sentinel surveillance for HIV and laboratory diagnosed sexually-transmitted disease morbidity in selected sites and populations is an important component of a national surveillance program, providing additional information to supplement disease reporting. An HIV sentinel surveillance system is already in place, and serious consideration has been made to utilizing six of the seven existing HIV sentinel surveillance sites for surveillance of sexually-transmitted diseases (with the exception of the transfusion site). At these facilities, a laboratory and research infrastructure already exists, and a sexually-transmitted disease diagnostic module may be added with minimal marginal cost. Thus, USAID Mali proposes to equip the six HIV sentinel surveillance sites with sexually-transmitted disease laboratories to diagnose sexually-transmitted diseases rapidly.

Secondly, an important component of the surveillance system should be a laboratory program to assess the prevalence of antimicrobial-resistant gonorrhea. The National Research Institute and *Hospital Point G*, both in Bamako, have that capability and perform gonorrhea culture and antibiotic sensitivity on their patients routinely. In 1989, resistance to penicillin was 71 percent among isolates from prostitutes in Bamako [10]. There are no published data on resistance to tetracycline. USAID Mali proposes to equip the six sentinel surveillance sites with laboratory equipment to detect antimicrobial-resistant gonorrhea.

Finally, the data that does exist on antimicrobial susceptibility are not published and disseminated routinely to other units within the Ministry of Health that are responsible for updating the essential drug list and for providing continuing medical education to clinicians. Thus, absent any formal coordination, information on the prevalence of various antimicrobial-resistant strains of gonorrhea is retained only by the reference laboratories in Bamako. USAID will support the National AIDS Committee so it will be able to assume a leadership position and take on the responsibility for collecting this information, publishing it annually, distributing the report to those who can use it, and coordinating an effort to revise treatment protocols and drug lists when necessary.

*Conducting rapid assessment surveys:* At the interface between sentinel surveillance and evaluation research, USAID Mali proposes to fund a series of two cross-sectional sexually-transmitted disease and HIV studies to assess their prevalence and HIV in Year 3 and again in Year 5. USAID Mali will use the same protocols in the same populations, and in the same sentinel sites as the World Bank's Rapid sexually-transmitted disease and HIV Assessment Study, and anticipates the capacity to use its data as a baseline to compare temporal trends. In addition, USAID Mali will use data from these assessment to mobilize resources and influence policy decisions.

3) Sexually-transmitted disease institutional capacity building at the National AIDS Committee

*Situation and role:* According to the widely-accepted standard set World Health Organization, a National AIDS Control Program should be the coordinating body for sexually-transmitted disease and HIV-related activities across units of the Ministry of Health responsible for surveillance, clinical treatment, pharmacy, laboratory, family planning, and health education activities. In Mali, however, problems exist that suggest a need to build the capacity of the National AIDS Committee to coordinate an integrated sexually-transmitted disease and HIV response. Although the National AIDS Committee staff should have knowledge of sexually-transmitted diseases, currently no staff member has specialized knowledge in this domain.

*Proposal for building capacity:* In conjunction with activities under the large, multi-donor health project, the World Bank will invest \$1.5 million in the National AIDS Committee for infrastructure. USAID support will complement the

World Bank funding by providing a long-term technical advisor to assist National AIDS Committee in its activities, particularly those in the area of sexually-transmitted disease control, and by providing a long-term training opportunity for two staff members of National AIDS Committee, with the requirement of returning and working for National AIDS Committee. A long-term technical advisor will ensure the timeliness of the "improved sexually-transmitted disease case management" activities, including materials development, training oversight, technical assistance to the National AIDS Committee to determine its needs vis-a-vis the provision of short-term consultants internal and external to Mali, as well as functioning as a catalyst to ensure coordination between the National AIDS Committee and its partners. The long-term advisor will assist the National AIDS Committee to facilitate the flow of information by overseeing the establishment of small-scale desktop publishing of sexually-transmitted disease and HIV surveillance reports, training materials, other information.

Long-term training in sexually-transmitted disease control will assure the program sustainability in placing trained National AIDS Committee staff in a position where they could benefit the program most. Ideally, this training would provide the staff member with technical expertise in clinical and laboratory aspects of sexually-transmitted disease and HIV care, epidemiology, public health, and management experience.

The long-term technical advisor should ideally be able to work with this staff member before his or her departure and after his or her return from training. This would ensure program continuity by providing an overlap of trained sexually-transmitted disease personnel.

### 3. Implementation Plan

#### a) Improved Sexually-Transmitted Disease Case Management

The project implementation plan will be considered as a tool to further detail and monitor the Project. It will be added to as new tasks are identified, and will be modified as reality changes. In preparing the plan, the most important conclusion reached was that the Project objectives are feasible from the viewpoint of time and resources.

The following discusses the implementation plan by Project year vis-a-vis the three significant Project outputs: improved sexually-transmitted disease control; behavior change; and a National AIDS Committee that engages in information exchange, policy development and resource mobilization. Sexually-transmitted disease control will improve through improved sexually-transmitted disease case management, better surveillance and reporting of sexually-transmitted diseases and greater sexually-transmitted disease institutional capacity at the National AIDS Committee.

#### 1) Year 1

To improve sexually-transmitted disease control, an institutional contractor must first be hired. This organization will place a sexually-transmitted disease expert at the National AIDS Committee for two years. This individual will be responsible for all activities under the rubric of sexually-transmitted disease control. In addition, s/he might be called upon to provide expertise to the National AIDS Committee in forging a collaborative relationship with donors and inter-ministerial partners. Of all of this person's duties, the one with the most long-lasting impact on the Project is to assist the National AIDS Committee to identify two individuals (who can be counted upon to return to the National AIDS Committee) for long-term sexually-transmitted disease training in the US. The first of these individuals will leave for training during Year 1. The sexually-transmitted disease expert will work with the second, until the first returns. Other activities under this rubric will include, but not be limited to:

Year 1	Sexually-transmitted Disease Control
1	* Recruit sexually-transmitted disease Technical Advisor
1	* Purchase photocopier and desk-top publishing software
2-3	* Recruit and train sexually-transmitted disease Case Management Training Team
2-3	* Recruit and train HIV Counseling Trainer
2-6	* Develop training materials
2-6	* Develop health education pamphlets for patient distribution
2-6	* Develop condom distribution kits, partner referral cards
2-6	* Develop supervisory checklists, reporting forms etc
2-6	* Revise essential drug list
2-6	* Develop new sexually-transmitted disease case reporting system
6	* Identify one person and send for one year of training abroad
8 and 11	* Write and edit sexually-transmitted disease and HIV newsletter
9 and 12	* Publish and disseminate sexually-transmitted disease and HIV newsletter
6-12	* Hold sexually-transmitted disease case management training for 175 health professionals and 50 related professions
6-12	* Train 10 health professionals in HIV counselling skills
6-12	* Equip 23 <i>cercle</i> health centers with basic sexually-transmitted disease laboratories
6-12	* Train 23 health personnel in use of basic sexually-transmitted disease laboratories
6-12	* Supply 23 basic sexually-transmitted disease laboratories
6-12	* Equip six sentinel surveillance sites with sexually-transmitted disease laboratories
6-12	* Train staff at 6 sentinel surveillance laboratories in use of sexually-transmitted disease laboratory
11-12	* Supply six sexually-transmitted disease sentinel surveillance laboratories
12	* Collect, publish and disseminate data on antibiotic susceptibility of gonorrhoea
1-12	* Elaborate research agenda and award initial grants
	* Conduct sexually-transmitted disease case management monitoring and evaluation

## 2) Year 2

Since the improved sexually-transmitted disease control component will have been operational for a year, activities during Year 2 will consist basically of an extension of those begun during Year 1, i.e., training of the health personnel at the remaining 23 *cercles*, gathering data from the sexually-transmitted disease sentinel surveillance sites, equipping the remaining 23 *cercle*-level health centers with sexually-transmitted disease laboratory equipment, etc. In addition, the first of the two long-term sexually-transmitted disease trainees will have returned to the National AIDS Committee. This person will work with the sexually-transmitted disease consultant to comprehend and to be allowed to use the knowledge s/he gained while in the US.

Year 2	Sexually-transmitted Disease Control
6	* Identify one person and send for one year of training abroad
6 and 12	* Review research agenda and award grants
10	* Refresher training in HIV counselling skills
1-12	* Conduct monitoring and evaluation
"	* Give sexually-transmitted disease case management training to 175 health professionals and 50 related professions
"	* Train 23 health personnel in use of basic sexually-transmitted disease laboratories
"	* Equip 23 <i>cercle</i> health centers with basic sexually-transmitted disease laboratories
"	* Train 23 health personnel in use of basic sexually-transmitted disease laboratories
"	* Supply 46 basic sexually-transmitted disease laboratories
"	* Supply six sexually-transmitted disease sentinel surveillance laboratories
"	* Collect, publish and disseminate data on antibiotic susceptibility of gonorrhoea
"	* Publish and disseminate quarterly sexually-transmitted disease and HIV newsletter, reports and other information as necessary
"	* Conduct sexually-transmitted disease case management monitoring and evaluation
"	* Collaborate with Malian National Pharmacy and World Bank to ensure all primary care facilities are supplied with essential drugs for sexually-transmitted disease

### 3) Year 3

The foundation of this Project component will have been laid, i.e., training to develop institutional capacity and equipping of the laboratories and sentinel surveillance sites. During this year, the second long-term trainee will return and the institutional contractor sexually-transmitted disease expert will leave. Together, the two long-term sexually-transmitted disease trainees will Year 3 will usher in a host of quality assurance activities. These will ensure that quality is maintained at a high level by reinforcing knowledge. In addition, information exchange, one of the cornerstones of Output 3, will have been operational for two years. Health professionals at the peripheral level in will have been receiving feedback from their actions for at least two years. In line with the self-sustaining goal of the large, multi-donor health project, *cercle*-level health centers will be able to use the information gained from putting their training into practice to make their own decisions about sexually-transmitted disease care.

Year 3	Sexually-transmitted Disease Control
1-3	* Conduct sexually-transmitted disease and HIV Rapid Appraisal Study
6 + 12	* Review research agenda and award grants
10	* Hold training and/or refresher training for 10 health professionals in HIV counselling skills.
1-12	* Hold sexually-transmitted disease case management refresher training for 175 health professionals and 50 related professions
"	* Supply 46 basic sexually-transmitted disease laboratories
"	* Supply 6 sexually-transmitted disease sentinel surveillance laboratories
"	* Collect, publish and disseminate data on antibiotic susceptibility of gonorrhoea
"	* Publish and disseminate quarterly sexually-transmitted disease and HIV newsletter, reports and other information as necessary
"	* Conduct sexually-transmitted disease case management monitoring and evaluation
"	* Continue to collaborate with the Malian National Pharmacy and World Bank on sexually-transmitted disease essential drug supply
"	* Conduct monitoring and evaluation

#### 4) Years 4, 5 and 6

These Project years will supply constant feedback to the health professionals involved in sexually-transmitted-disease control and to the population, in general. Antibiotic resistance studies will have been conducted for at least two years, providing guidance to the confirmation or modification of the essential drug list. A newsletter will have been published for at least two years, containing information of a regional as well as significance. Health professionals at the periaortal levels will have tangible evidence that the data collection activities are feeding into the development of national policy and that locally, in areas of high sexually-transmitted disease prevalence, additional resources are being allocated to combat sexually-transmitted diseases.

Regular monitoring and overall periodic program evaluations will help refine Project activities.

Year 4	Sexually-transmitted Disease Control
10	* Hold training and/or refresher training for 10 health professionals in HIV counselling skills.
	* Review research agenda and award grants
6 and 12	* Conduct monitoring and evaluation
1-12	* Hold sexually-transmitted disease case management refresher training for 175 health professionals and 50 related professions
"	* Supply 46 basic sexually-transmitted disease laboratories
"	* Supply 6 sexually-transmitted disease sentinel surveillance laboratories
"	* Collect, publish and disseminate data on antibiotic susceptibility of gonorrhoea
"	* Publish and disseminate quarterly sexually-transmitted disease and HIV newsletter, reports and other information as necessary
"	* Conduct sexually-transmitted disease case management monitoring and evaluation
"	* Collaborate with the National Pharmacy and World Bank on sexually-transmitted disease essential drug supply
"	

Year 5	Sexually-transmitted Disease Control
1-3	* Conduct sexually-transmitted disease and HIV Rapid Appraisal Study
10	* Hold training and/or refresher training for 10 health professionals in HIV counselling skills.
	* Review research agenda and award grants
6 and 12	* Supply 46 basic sexually-transmitted disease laboratories
1-12	* Supply 6 sexually-transmitted disease sentinel surveillance laboratories
"	* Collect, publish and disseminate data on antibiotic susceptibility of gonorrhoea
"	* Publish and disseminate quarterly sexually-transmitted disease and HIV newsletter, reports and other information as necessary
"	* Conduct sexually-transmitted disease case management monitoring and evaluation
"	* Collaborate with the National Pharmacy and World Bank on sexually-transmitted disease essential drug supply
"	
"	* Conduct monitoring and evaluation

Year 6	Sexually-transmitted Disease Control
10	* Hold training and/or refresher training for 10 health professionals in HIV counselling skills. * Review research agenda and award grants
6 and 12	* Conduct monitoring and evaluation
1-12	* Supply 46 basic sexually-transmitted disease laboratories
"	* Supply 6 sexually-transmitted disease sentinel surveillance laboratories
"	* Collect, publish and disseminate data on antibiotic susceptibility of gonorrhoea
"	* Publish and disseminate quarterly sexually-transmitted disease and HIV newsletter, reports and other information as necessary
"	* Conduct sexually-transmitted disease case management monitoring and evaluation
"	* Collaborate with the National Pharmacy and World Bank on sexually-transmitted disease essential drug supply

5) Year 7

Year 7 will basically follow the same activities as those in Year 5. Quality assurance, operating expenses for sentinel surveillance laboratories, the publication and dissemination of data from the sentinel surveillance sites as well as the quarterly newsletter will figure prominently. Project closeout and recommendations for a new follow-on activities will also occur.

Year 7	Sexually-transmitted Disease Control
4-8	* As Year 5 * Develop new proposals for sexually-transmitted disease Control in Mali according to Evaluation Recommendations

4. Monitoring and Evaluation Plan

The Monitoring and Evaluation Plan consists of a system for the monitoring and evaluation of projects that includes, but is not limited to the following:

a) Indicators

Based on selected activities, a process indicator form will be generated, capturing the elements below. This form will be submitted by the Ministry of Health Project Coordinator to the USAID Technical Advisor for AIDS and Child Survival on a bi-annual basis. (The submission of this form will occur one month before the Semi-Annual Project Implementation Reviews.) The Sexually-Transmitted Disease Advisor, located at the National AIDS Committee is anticipated to assist in completing this form initially.

INDICATORS PROCESS - Dorothy, please revise per notes on previous version	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7
Develop training materials	xxxx						
Conduct sexually-transmitted disease case management training	xxxx	xxxx	xxxx			xxxx	xxx x
Conduct HIV counselling training	x	x	x	x	x	x	x
Equip <i>cercle</i> laboratories	xx	xx					
Supply <i>cercle</i> laboratories	xx						
Conduct operations research	xx						
Develop and refine new disease reporting system	xx	x	x				
Equip 6 sexually-transmitted disease sentinel surveillance laboratories	x						
Conduct training personnel of surveillance laboratories	x		x		x		x
Supply surveillance laboratories	xx						
Conduct rapid appraisal studies			x		x		x
Conduct antibiotic susceptibility surveillance	x	x	x	x	x	x	x
Employ sexually-transmitted disease advisor at the National AIDS Committee	xxxx	xxxx				x	x

In addition to the aforementioned process elements, the following quality assurance indicators will be achieved:

- 70 percent of a representative sample of those trained can correctly diagnose and treat sexually-transmitted diseases and give accurate counselling on sexually-transmitted prevention, one year after receiving training;
- 90 percent of people trained will have attended at least one refresher course, by the end of Year 4;
- 100 percent of people undergoing HIV testing will receive pre-and post test counselling, by the end of Year 2;
- 100 percent of *arrondissement* and *cercle*-level health centers will routinely report cases of sexually-transmitted diseases based upon standard observed sexually-transmitted disease syndromes, by the end of Year 2;

- results of laboratory tests of antimicrobial-resistance of gonorrhoea from the National Research Institute, *Gabriel Touré* and revised treatment algorithms are published by the National AIDS Committee and distributed annually to everyone receiving training and at least 500 other health personnel and pharmacists, by Year 2; and
- two National AIDS Committee staff members will be identified and sent for long-term sexually-transmitted training by the end of Year 2.
- Impact Indicator: the prevalence of sexually-transmitted disease is the ultimate impact indicator. The World Bank sexually-transmitted disease prevalence study has provided the baseline for sexually-transmitted diseases. Rapid appraisal studies will be conducted in Years 3, 5 and 7 to monitor the impact indicator.

The Department of Epidemiology will monitor activities in the field, i.e., the monthly submission syndromic sexually-transmitted disease data.

b) Evaluation

The program will monitor the extent and quality of the interventions (process evaluation), and analyze surveillance data to assess if trends in disease levels can be linked to the interventions (outcome evaluation). In addition, a program will sponsor operations research to determine the cost-effectiveness of alternative strategies. For the improved sexually-transmitted disease control Project component, the ultimate impact indicator is the ten percent decrease of sexually-transmitted diseases in the general population over the life-of-Project. Thus, all of the following represent only process indicators:

1) Case management

- The development of training materials for health care professionals: syndromic diagnosis and treatment; laboratory diagnosis when appropriate; counseling, including condom demonstration; and partner referral
- The development of information-education-communication pamphlets for patient distribution, condom distribution kits, partner referral cards, supervisory checklists, reporting forms
- The number of personnel trained, the number of clinics upgraded, the number of patients receiving sexually-transmitted disease treatment, the number of patients seen per facility, the number of information-education-communication pamphlets and condoms distributed to patients, and the number of partners successfully referred for evaluation
- The revision of the essential drug list to include first-line drugs for treatment of chancroid, and gonorrhoea. The number of facilities receiving their essential drugs

2) Surveillance

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The Centers for Disease Control and Prevention has published guidelines for evaluating surveillance systems [4]. This document should help in evaluating the effectiveness of Project efforts to improve the Malian sexually-transmitted disease and HIV surveillance system. The true test for evaluating a surveillance system is whether the data generated is a useful basis for decision-making. Therefore, to evaluate the impact of Project improvements, it is necessary to characterize actions taken as a result of the surveillance data.

In addition, specific system attributes can be evaluated, including its: simplicity and ease of operation, ability to adapt to changing information needs, sensitivity to changing trends in morbidity, and timeliness; and both the willingness of individuals to participate in the system and how well those surveyed represent the population at large.

### 3) Operations research

It is important to build a strong operations research component into the Project. Presently, information about the optimal strategies for sexually-transmitted disease and HIV control are simply not known. How many grants have been issued; published and unpublished research reports issued; and how widely were they distributed can be examined as process indicators for operations research. However, ultimately objective of operations research is its positive impact upon on decision making, updating treatment algorithms, etc. Examples of important research questions include:

- Optimal method of drug financing: currently, essential drugs are provided to patients at a subsidized cost. Should drugs for sexually-transmitted diseases meet the same standard of cost recovery, or do special circumstances (such as non-compliance in asymptomatic patients, treatment of partners, and psycho-social barriers to seeking care) necessitate on-site distribution of free therapeutics?;
- Single versus multiple therapy: single-dose therapy is usually more expensive in terms of initial costs for the drug. However, if non-compliance with multiple dose regimens is common and leads to treatment failures, it may ultimately be more cost-effective to invest in single dose therapy. This may be an important issue in treating partners, who may be asymptomatic and less likely to complete a course of antibiotics;
- Performance of diagnostic algorithms in various settings: the World Health Organization algorithms are designed to be general, their performance has not been validated extensively among different populations within Mali; and
- Partner notification: partner notification programs are associated with many ethical and psycho-social issues. Further research is needed to evaluate the feasibility and cost-effectiveness of various partner notification strategies in Mali.

## 5. A Synopsis of Project Inputs and Outputs

### a) Inputs

- 28 person-months of long-term technical assistance
- 8 person-months of short-term local technical assistance
- 46 essential laboratory kits for district health centers
- 322 (46 centers x 7 years) essential laboratory supply kits for district health centers
- 6 essential laboratory supply kits for sexually-transmitted disease sentinel surveillance site centers
- 24 months of long-term training for two National AIDS Committee staff

### b) Outputs

#### 1) Improved sexually-transmitted disease Case Management

- the inclusion of sexually-transmitted disease first-line drugs for treatment of chancroid and gonorrhea on the essential drug list
- training in sexually-transmitted disease case management for 350 health personnel at *arrondissement* and *cercle* levels and at least 100 persons in health related professions (pharmacies, social services, etc.)
- quality assurance: one year after receiving training 70 percent of a representative sample of those trained can correctly diagnose and treat sexually-transmitted diseases and give accurate counseling on sexually-transmitted disease prevention; attendance at a refresher course for 90 percent of people trained
- basic sexually-transmitted disease laboratory capabilities for 46 *cercle*-level Health Centers
- pre-and post test counselling for 100 percent of people undergoing HIV testing
- confirmation or modification of strategies adopted in the field and/or practical experience based on the award of ten research grants

#### 2) Improved Surveillance and Reporting of sexually-transmitted diseases

- Routine reporting of cases of sexually-transmitted disease based on standard observed sexually-transmitted disease syndromes by all *arrondissement* and *cercle*-level health centers
- Six HIV sentinel surveillance sites equipped with sexually-transmitted disease laboratories
- An overall view of the evolution of sexually-transmitted diseases in Mali
- Annually published and distributed results of laboratory tests of antimicrobial resistance of gonorrhea and revised treatment algorithms

3) Improved sexually-transmitted disease Institutional Capacity at the National AIDS Committee

- Two trained National AIDS Committee staff members

## Annex F: Project Analyses

### I. Technical and Institutional Analysis

#### B. Non-Governmental Organizations

##### 1. Institutional Analysis: Experiences and Perspectives

###### a) Evolution and role of NGOs Malian social life

The first foreign non-governmental organization (NGO) was registered in Mali in 1967 and the first national NGO in 1979. From 1982 onwards their numbers increased significantly, to their present total of approximately 400. Three structures have been established to coordinate NGO activities and improve the efficiency of their interventions: the Committee for the Coordination of the Activities of NGOs (CCA-ONG), an umbrella organization composed of national and international NGOs founded in 1986; *SECO*, a collective of Malian NGOs founded in 1988; and a government body, a national commission composed of representatives from 16 Ministries, responsible for evaluating NGO.

The NGOs' role as development process catalyzers is recognized widely. Active in all the sectors, NGOs have achieved results that make them today the privileged partners of local people, of most bi-lateral aid organizations and indeed even of the government. A study carried out by the umbrella organization of NGOs in 1992 showed that NGOs executed a total of 458 projects from 1978 to 1990 and that 276 were currently underway. The average annual investment by NGOs was 27.5 billion FCFA, making NGOs the third-largest funding source after bilateral donors and Government spending.

More than 6.5 billion people in Mali benefit through community mobilization, from NGOs programs. The health sector constitutes the third most important area of NGO intervention after agriculture and water supply. Nearly one hundred NGOs are involved in health activities.

###### b) NGOs and the fight against AIDS

The NGOs represent a very valuable resource in the fight against AIDS. Within the framework of a successful partnership, foreign and national NGOs have carried out innovative activities. The case studies cited below are by no means the only NGO contributions to the fight against AIDS. They are, however, sufficiently eloquent to indicate the scope of NGO interventions and to enable lessons to be learned. In every case, it is clear that the NGOs, as a result of their various skills and qualities, are capable of contributing effectively to the fight against AIDS in Mali. However, their activities to date are very specific and the funding they have received has often been so limited in amount and so short-term that they have not been operating efficiently.

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1) Project Prevention SIDA

Financed by *Solidarity Canada-Sahel* and the Save the Children Fund, Canada, this project had the objectives of preventing transmission of the HIV virus, reducing morbidity and mortality linked to HIV infection, and raising awareness amongst the Canadian public about the reality of life in Mali.

The target groups in urban and rural areas of Koulikoro were school children, urban street children, rural youths, and future mothers. To reach maximum number of people, the project promoted the creation of AIDS committees in the target villages and trained trainers. Awareness raising was carried out through cultural and sporting events, leaflet and T-shirts. The project reached one hundred villages.

The May 1993 final evaluation showed positive Project impact on the partners organizations involved in the intervention. Each partner acquired experience in project management and felt capable to carry out AIDS prevention activities on its own. Despite the difficulty of evaluating the impact on beneficiaries of project activities in isolation (with numerous other sources of information available), the evaluation demonstrated encouraging results. Comparison of two Knowledge, Attitudes and Practices studies (December 1991 and April 1993) showed that the beneficiaries had an increased awareness of AIDS and begun to change behavior (e.g. using of condoms, using razor blades and syringes only once). However, the study showed that these behavior changes were more pronounced in urban areas (75 percent of those surveyed) than in rural areas (71 percent).

Several difficulties were encountered during the intervention including: the under-estimation of the costs of activities; the use of support materials that were not adapted to the Malian context; the emphasis on acquiring and not on changing behavior; and the follow-up of activities in the field. The evaluation team found the project relevant and effective and recommended its continuation to a second phase, while making several recommendations for correcting weakness identified in the first phase.

2) Intervention for High Risk Groups Against AIDS Project<sup>3</sup>  
(the national NGO component)

The Intervention for High Risk Groups against AIDS project is an integral part of the National AIDS Committee and aims to reduce AIDS transmission amongst high-risk groups, prostitutes and bar clients, and, indirectly, the general public. As part of its activities, four NGOs were financed at the end of 1992, to carry out AIDS awareness activities through health education. They involved were:

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<sup>3</sup>The Family Health International Project.

- *SAHEL ACTION*, which targeted the young people of Hamdallaye raising awareness through sports and cultural events. The overall budget was 1,513,490 F CFA.
- *BAARA KANU*, which received funding of 1,500,000 FCFA. The target groups were the students of *Lycée Askia*, the soldiers at the *Camp Para* barracks and the police force. A shortage of funds and the short-term nature of the funding reduced the effectiveness of the activities.
- *Association pour l'Univers Familial* intervened in schools in Djelibougou and Banconi for a total budget of 1,970,000 F CFA. The NGO's failure to estimate costs accurately during the Project elaboration led to suspending activities during the intervention period.

In general, awareness raising was carried out at evening dances, conferences, film shows, sportive and theatrical events and was accompanied by free condom distribution.

The short duration of the projects did not permit substantial activities but nevertheless the first signs of an impact were discernable. Comparison of results from knowledge, attitude and practices surveys of the target groups and a control population demonstrate the impact of the USAID funded AIDS project funded NGOs interventions. For example:

- 40 percent of the target group demonstrated basic knowledge about AIDS (ways of transmissions, the seriousness of the disease, methods of prevention) compared to 19 percent in the control group;
- 50 percent of the target group considered themselves to be at risk from AIDS compared to 30 percent in the control; and
- 75 percent of the target group had modified their behavior (notably condom use) compared with 70 percent in the control.

The 1993 Project evaluation identified several areas of weakness in the NGO programs: project objectives were not defined clearly; funding was inadequate and activities too short-term; internal follow-up and reporting was inefficient; and the NGO personnel did not master communication techniques well.

### 3) Child Survival Pivot Group - Family Planning and AIDS project

Created in 1992, the Child Survival Pivot Group is a technical branch of the Malian NGO umbrella organization that specializes in health matters and is responsible for coordinating NGOs active in the health sector and for their professionalization. It regroups a total of 60 national and international NGOs.

The family planning and AIDS project was started at the end of 1993 for a five year period. It is funded by the USAID Mali PVO Co-Financing project with a total estimated life-of-project budget of approximately \$7,500,000. Through this project, the Child Survival Pivot Groups offers PVOs and NGOs in Mali a family planning and AIDS prevention program.

In addition to the technical assistance provided to NGOs through an extensive training program covering family planning, AIDS, health education techniques and project management, grant assistance is available to NGOs to undertake AIDS-related and income-generating activities (a strategy aimed at improving participation). Project management training available through the project is aimed at improving the professional skills of the NGOs.

4) Plan International

During 1993, Plan International funded eight Malian NGOs in its project areas of Kangaba and Banamba to carry out AIDS awareness health education campaigns and distribute condoms. The *Association d'Aide et d'Appui aux Groupements* was one of the NGOs concerned and received funds totalling nearly 2,000,000 F CFA. The *Association* has been working for six months in 27 villages in the Koulikoro region. It carried out a three-month awareness raising campaign and trained two literate individuals (each with a certain amount of influence locally) in each village to promote and sell condoms.

Plan International experienced several difficulties with some of the NGOs that had problems either with their approach in the field or with their financial management. These difficulties led to the resolution of one collaboration agreement and to changes in mediums used to pass on messages (e.g. from sporting events to audio-visual). They have not, however, prevented Plan International from making plans to undertake activities on a larger scale through a five-year project (1994-1999) with a total budget of approximately \$4 million. This project aims to carry out a program of health education activities in 100 *arrondissements* using about ten national NGOs, to promote the creation of HIV positive self-help groups and to undertake a vast media campaign.

5) OXFAM UK

OXFAM does not have a specific program of AIDS activities but encourages its national partner NGOs to introduce AIDS awareness raising components into their ongoing activities. As part of this policy, 12 of OXFAM's partner NGOs attended a training course called AIDS and Development given by the Pivot Group in Sévaré and Douentza (September, 1993) and in Koulikoro (October, 1993).

6) The Malian Association for the Promotion and Protection of the Family

The Malian Association for the Promotion and Protection of the Family, a non-profit association founded in 1972, intervenes in area of family planning through health education activities, training health agents, supplying health centers with contraceptive products, medical equipment and materials and through research into family planning.

As far as AIDS prevention goes, the *Association* plays a important role through both its activities (health education, supply of condoms) and by providing assistance to other NGOs (e.g. training personnel, hiring audio-visual equipment and films). However, the level of its own activities and the high number of requests for assistance received from NGOs, associations and groups makes it unable to respond positively to all of them.

7) Association of Malian Women Educators

The Association of Malian Women Educators, *Association des Femmes Educatives du Mali* organizes literacy courses for young migrant girls. During teaching sessions, the female trainers provide information and discuss issues such as hygiene, excision, household management, and emphasize family planning and AIDS particularly. They show films on AIDS and advise the girls on appropriate changes in behavior. The *Association* reaches nearly 1,500 migrant girls but, despite having 27 literacy centers in the District of Bamako, it has difficulties in satisfying the demands received from the numerous neighborhoods. It is a potential channel for AIDS prevention activities.

8) Malian Association for Youth Promotion

The *Association Malienne pour la Promotion et l'Insertion des Jeunes* has a Action Domestic Helpers project that also targets migrant girls for STD and AIDS prevention through health education (film projections accompanied by debates during household management and literacy training sessions). It already counsels girls who know they are seropositive or are suffering from AIDS, both in Bamako and their home villages, in order to prevent transmission to unsuspecting people within their communities. It is currently carrying out a study called AIDS and Migrant Girls but the results are not yet available.

9) Others

Other organizations are also involved through lectures and debates in schools and within women's groups and associations. In fact, since they operate in such a vast sector and an often-informal manner, the full extent of the contribution of NGOs and associations to the fight against AIDS is unknown. The above examples represent only the well- known and documented part.

c) NGO Strengths and Weaknesses

## 1) Summary of Strengths

- In general, NGOs are flexible in the execution of their activities and can adapt their programs to the priorities of the populations. Local populations participate increasingly in the design and implementation of projects and adapt them to their own specific needs.
- The commitment, determination and sacrifice of NGO personnel enable them to work in all sorts of conditions in the field in order to reach their objectives;
- The capacity of field staff to adapt themselves to the conditions of the village life and to integrate the community creates a climate of confidence between them and the local population;
- The reasonable costs of NGOs due to the unpaid contribution of members and the use of very basic means in the execution of their tasks make them an inexpensive tool. Among the examples cited above, grants have rarely exceeded 2,000,000 FCFA;
- The capacity of NGOs to innovate and to mobilize their populations around communal objectives combined with their successful track record mean that they are well respected and listened to by the local populations.

## 2) Summary of Weaknesses

- The personnel are typically often young graduates with no experience, hence lack technical skills. From a professional viewpoint they are highly-mobile, which prevents them from capitalizing on their experience. In the particular case of AIDS, the personnel lack basic knowledge of the disease. Inadequate mastery of communication techniques and materials have led to errors of interpretation and approach. This has meant that some NGOs have had to repeat health education sessions with the target groups;
- Limited financial resources, due to their inability both to generate their own funds and to obtain substantial grants, tend to block NGO initiatives. They often find it hard to elaborate convincing project documents and they often must compete amongst each other for funds. Some donors, lacking confidence in the management capabilities of inexperienced NGOs, prefer to give only small short-term grants with often derisory administrative costs. Such a policy makes the institutional development of the NGOs impossible;
- Poor organization, often due to the lack of resources to fund permanent staff or to the influence of particular founding members who are not willing to share responsibilities with others. A March 1994 USAID survey of 19 NGOs found that certain NGOs are managed by a single person who is simultaneously Director, accountant, auditor etc.; and
- The management of resources (material, human and financial) is often injudicious, making donors wary about giving new grants. The above-cited study found that only six of the 19 NGOs had provisional budgets.

All these factors result in only about 50 out of the registered total of 300 national NGOs being functional. Several attempts are underway to correct these weaknesses through training courses organized by the Malian Umbrella NGO, the various Pivot Groups and even by the bi-lateral aid organizations that are turning increasingly to NGOs to implement their projects in Mali.

These training programs to make NGOs more effective development agents are highly-appropriate considering the numerous potentialities they offer. An additional specialized support program could reinforce their activities.

d. Support for Participating NGOs and Associations

1) Content of the support

i. Developing a NGO Network to Organize and Coordinate

A coordinating structure is required to ensure the efficiency of NGO activities. The structure will operate at the national, regional and local levels. At the national level, the NGO management unit, responsible for conceiving and supervising NGOs activities in the field, should be based in Bamako. The production of publicity messages and support materials will also be centralized to benefit as much as possible, from economies of scale and a harmonization of approach.

A decentralized network of NGOs should also be established to follow up at the regional level. Using existing NGOs as intermediaries for this should help to reduce costs. To facilitate logistical support, it may be necessary for example, to make available a pool of vehicles, office and audio-visual equipment for NGOs operating in the area. Thus, a coordinating NGO (called the Lead NGO) will be designated at the regional level and given certain responsibilities on behalf of the NGO management unit.

The planned decentralization of the National AIDS Committee and the Malian Umbrella NGO will facilitate this organization. For example, once the Malian Umbrella NGO has decentralized, the equipment and car pool could be based within this organization with, if possible, priority for their use given to NGOs involved in AIDS prevention (although this would require them to establish their programs well in advance). Local-level will be structures responsible for initiating and executing projects.

Supervision of projects will be carried out within this framework. Thus, the Lead NGOs will supervise activities in their respective regions. They will receive progress reports from the organizations working in the region and will in turn report to the AIDS Prevention and Awareness Project management unit. Similarly, they will act as intermediaries for transferring funds and supplying condoms.

ii. Training NGO personnel and project partners

Training for NGO personnel and other partners will include training sessions on STD and AIDS, training sessions on the organization and management of NGOs, study trips, seminars and workshops, and publications. The training of trainers will cover knowledge about sexually-transmitted diseases and AIDS and the taboos surrounding the subject so that the trainers will be able to respond to questions asked about these diseases adequately. These trainers will be required, in turn, to transmit the acquired knowledge to other NGOs personnel, to partners Associations and to village agents involved in awareness-raising activities and condom distribution and sale. They will also need to develop the skills of the *animators* involved in awareness-raising to transmit health education messages, run meetings and communicate with the participants.

The *animators* must also be able to win the confidence of the local population so that the latter feel free to confide in them. They will need to be capable of sharing the anxiety and distress of seropositive individuals and AIDS sufferers and to refer people to the appropriate health center for the treatment of sexually-transmitted diseases or the opportunistic infections of AIDS sufferers.

These same *animators* will be involved in the emergence of associative structures providing care for AIDS sufferers and will assist in their organization (creation, nomination of committee, fund-raising activities, assistance in the search for grants). Therefore, including training in community organization and management techniques will be essential.

Training sessions will be organized twice a year in Bamako and in the regions for about 30 persons per session. Refresher training will also be provided according to the needs expressed by the NGOs. Experienced resource persons from the National AIDS Committee, the National Health Education Department, Pivot Groups and other organizations or NGOs will run the training sessions. The project will develop technical handbooks and training manuals and make them available to trainees.

Through the system of awarding sub-grants to NGOs, the project can reinforce the NGOs' organizational and management capacities, e.g. to undertake socio-economic surveys, elaborate project documents (including logical frameworks), schedule activities (using appropriate tools for programme planning, monitoring and auto-evaluation), and present financial reports. Several training opportunities of this sort are available through the Malian Umbrella NGO and the Pivot Groups. Sometimes, therefore, it may simply be a matter of referring NGOs to existing training opportunities rather than organizing special training sessions for them.

Study trips are also an extremely good way to impart information and training. Agents could be sent to visit countries with more advanced AIDS awareness and Prevention programs to learn from their experience, notably in the area

of the community support for seropositive individuals and AIDS sufferers. Similarly, the leaders of such organizations in other countries could be invited to run workshops.

At the end of each project year, seminars or workshops will be organized bringing together the different organizations involved for them to present their achievements, discuss difficulties, and determine the priorities and approach for the coming year. These workshop would will also provide an opportunity to organize media events. For example, the last day of the seminar could be designated a National AIDS Day with synchronized debates on radio and television (including coverage of real case-histories) and an advertising campaign (tee-shirts, specially-printed fabrics and leaflets.) The role of the National AIDS Committee, the bi-lateral aid organizations and the government will be crucial to the success of a such a large-scale media event.

The proceeding of these workshops will be published annually to make them available to everyone working the field of AIDS prevention. The Malian Umbrella NGO has already launched a series of publications concerning the achievements of NGOs in Mali.

### iii. Funding for NGO Programs

NGOs will draft project proposals and submit them to the project management unit. A selection committee composed of the principal actors in the AIDS prevention field will review them and identify the viable projects. Funding will be available to cover the costs of socio-economic studies of the Project area both to ensure that health education activities and health messages are adapted the local context, and to provide baseline data against which to measure the impact of project activities during the final evaluation.

The project budget will take into account all the activities proposed by the NGO (e.g. logistics, fuel, perdiems, audio-visual materials, training sessions etc.) However, producing support materials (cassettes, leaflets, radio messages etc.) will be centralized at the project management unit and done in collaboration with the Social Marketing project. Similarly, the purchase and supply of condoms will not be taken into account. The NGOs will have to organize this for themselves with the Condom Social Marketing Project.

If the NGOs wish to initiate income-generating activities to improve local participation, it may be useful to consider providing funds for this purpose. Strategic activities of this type should only be supported provided that their viability be guaranteed.

Criteria for selecting project proposals should include:

- The existence of a partnership between NGOs or between NGOs and grass-roots organizations; the aim being to promote the emergence of community level structures able to continue activities after the end-of-project;
- The existence of a credible base within the community -- the NGO is known and accepted in its area of intervention as a result of its track-record of successful interventions and is thus able to establish a relationship of trust with the local population;
- A requirement to provide "matching" funds (even if only a small percentage) to demonstrate the sub-grant requester's commitment;
- The willingness of the NGO to act in turn, if necessary, as an "umbrella" organization for partners such as associations and grass-root organizations that can be very effective in the field but are not sufficiently well structured to be able to benefit directly from project funding
- The proposed organization of activities:
  - . locality, target population (to avoid duplication of effort)
  - . local network to be created, with proof of the adhesion of partner organizations (associations, groupements) to the proposals. Grants have been obtained previously in the name of certain grass-roots organizations without them ever being involved in project implementation
  - . proposed strategy for the execution of project activities
  - . expected results and indicators of impact; and
- The internal organization of the NGO (administrative structure, accounting procedures, membership structure)

e) Project Outputs

See those listed in the logical framework.

3. Types of Activities to be Supported or Introduced to Enable NGOs to Participate Effectively in AIDS Prevention and Awareness

a) Awareness-raising through health education

Health education activities to raise of levels of awareness about sexually-transmitted diseases and AIDS in the general population in both rural and urban areas (the zone to be covered comprises the regions of Koulikoro, Kayes and Mopti and the District of Bamako), will aim to persuade people to adopt behavior that reduces the risk of infection by sexually-transmitted diseases and the HIV virus. Messages will include:

- basic information on sexually-transmitted diseases and AIDS (e.g. symptoms, methods of transmission, their seriousness, prevention methods);
- the relationship between other sexually-transmitted diseases and AIDS; and

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- awareness that certain practices like levirate, polygamy, tattoos, excision, circumcision can contribute to the spread of infection.

Awareness-raising activities will concern all the social categories but aim at specific target groups (either those considered at high-risk group or those with well-respected opinions like local leaders). They will be carried out using communication methods and supports developed by the pioneers in AIDS prevention, such as video shows followed by focus group discussion, conferences and discussions animated with participatory methods, and rural radio, television, leaflets, T-shirt, newspaper articles (in the principal national languages).

b) Identifying and training village agents

The size of the AIDS awareness and prevention task is larger than the NGOs alone can accomplish. They will need the support of intermediaries from the project area. NGO personnel who receive training must, in turn, train local resource persons that have been identified as effective channels for spreading the message. Also, the groups and associations for which they act as an umbrella organization. In this case, these partner organizations would receive part of the sub-grant and share tasks in the field as well as responsibility to the management unit.

The training of group leaders, village-level health care agents and traditional midwives will cover health education techniques and AID awareness. These individuals could also stock condoms for sale in the villages. Training will be partly theoretical but supported by practical sessions in the field to ensure that those who receive AIDS awareness and prevention training have the necessary skills to communicate what they have learnt to rest of the community.

c) Condom Promotion and Sale

Raising awareness about AIDS should change behavior - specifically condom use (one of the most concrete proofs that behavioral change has occurred). Promotional activities will aim to improve condom acceptability and accessibility (health education, pricing policy, creation of an NGO-based community distribution network). Some NGOs have already established very efficient distribution networks. For example, the *Association d'Aide et d'Appui aux Groupements* has trained two literate persons per village to undertake health education activities and supply them with condoms to sell.

A regular supply will be assured by means of these local representatives. The project will collaborate with the Social Marketing project to ensure NGOs are supplied with condoms at the *cercle* level. (The price of condoms will be reviewed in light of the marketing study to be conducted in rural areas, Fall 1994.)

d) Care of seropositive individuals and AIDS sufferers

AIDS prevention can only be truly effective when seropositive individuals are informed about their sero-status, so that they can avoid transmitting the virus involuntarily. This implies creating a structure that provides the maximum amount of information and advice about the disease to those who are affected. NGOs and Associations are well-placed to provide such a counselling service through support to grass-roots initiatives in urban and rural areas.

In rural areas, traditional systems of mutual aid already exist. In the case of illness, local people combine forces to do sick person's work. The project will make use of such networks for counselling and support activities by reinforcing their capacity to organization and carry out activities.

Some NGOs could become specialists in this field. Africare and World Education have both expressed interest in working in this area. They could work to promote the emergence of new groups within the civil society that would have their own specific strategies.

A media campaign would precede and accompany these activities so that people take the test, the government takes the responsibility to inform people about their seropositivity, and seropositive individuals and AIDS sufferers can be accepted by society.

#### 4. Implementation Plan

- Create a NGO management unit during the first six months of the project;
- Identify organizations that intervene or would like to intervene in AIDS prevention;
- Form a selection committee within the first six months that consist of the main actors, i.e. the Pivot Group, National AIDS Committee and the social marketing society;
- Select NGOs according to criteria established by the committee (twice a year);
- Create a network of NGOs for health education activities and community-based distribution of condoms in collaboration with the Social Marketing Project. This will take place throughout the life-of-Project through integrating new NGOs;
- Analyze the training needs of NGOs;
- Design a training program and materials during the first six months of the project with improvement to training modules as required throughout the life-of-project;
- Organize training sessions (two training or refresher courses per year on AIDS and health education);
- Award sub-grants to projects selected by the committee (approximately thirty during the project life);
- Supervise visits to the field (once per trimester by the NGO management unit);
- Organize study tours to exchange experiences; and
- Organize seminars and workshops (once per year in different locations accompanied by media campaigns and publish their proceedings.

ACTIVITIES	1st year	2nd year	3rd year	4th year	5th year	6th year	7th year
Establish management structure	xx						
Identify organizations active in AIDS prevention	xxxx						
Form a section committee	xx						
Select NGOs	xx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
Set up a NGO-network for health education and condom distribution	xx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
Analyze training needs	xx	x	x	x	x	x	x
Elaborate training program and materials	xxxx	x	x	x	x	x	x
Organize training sessions	x	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
Finance NGO activities	xx	xxxx	xxxx	xxxx	xxxx	xxxx	xxxx
Supervise visits	x x	x x	x x	x x	x x	x x	x x
Organize study tours	x	x	x	x	x	x	x
Organize seminars and workshops	x	x	x	x	x	x	x
Evaluation		x		x		x	
Publication	x x	x x	x x	x x	x x	x x	x x

## 5. Monitoring and Evaluation Plan

### a) Process Indicators

In addition to the aforementioned process elements, the following outputs will be monitored:

- 1,000 general NGO field staff and rural development agents will have attended at least one day of training on the transmission and prevention of sexually-transmitted diseases and AIDS, by the end of Year 3;
- At least 40 NGOs have identified agents to act as members of a community-based distribution network, by the end of Year 2.
- At least 10 local NGOs will have as their principal activity the promotion of sexually-transmitted diseases and AIDS awareness and prevention and will have the necessary skills to successfully elaborate and manage projects according to the USAID PVO Co-Financing project criteria, by the end-of-Project.

A project monitoring and evaluation system will be established in line with the structure of the NGO network created. For example:

- at the local level, a report form will be completed after each health education session and a monthly report will be sent to the implementing NGO. The form will detail location and date of the health education session, the number of participants (women and men), the topics covered, the support materials used, the main questions raised indicating the preoccupations of the participants, their suggestions, and *animator* comments;
- implementing NGOs will submit monthly financial and progress reports;
- regional Leads NGO will submit quarterly financial and progress reports;
- the NGO project management unit will produce a quarterly financial and progress report;

Both the project management unit and the regional organization will supervise activities in the field, sometimes jointly. Partner organizations and Associations will be trained in auto-evaluation techniques to improve the follow-up of activities at local level.

Two external evaluations will be organized -- the first, a mid-term evaluation at the end of Year 2, and the second at the end-of-Project.

#### 6. Recommendations and Conclusions

The following conclusions can be drawn from the different NGO experiences cited above and perspectives in AIDS prevention activities:

- NGOs reach local populations effectively because they are present throughout the whole country, are available, and are able to produce results. However their lack of technical knowledge about health education techniques and AIDS and their poor management skills limits the impact of their activities;
- NGOs find it difficult to obtain finance; the conditions imposed by donors are often very selective and exclude many NGOs, in particular grass-roots organizations that lack donor-required structure but are very effective in the field. The Intervention for High-risk Groups against AIDS project for example, was able to finance only four NGOs out of 14 applications; the Group Pivot, eight out of 33; and
- several large-scale AIDS prevention interventions are being planned within the NGO community (Plan International, World Education, Africare) and some are already underway (the Family Planning and AIDS project of the Child Survival Pivot Group and Save the Children-USA). Their activities may be duplicated if coordination measures are not taken early.

Thus, it is recommended that:

- funding criteria be made flexible so as to involve as large a number of NGOs as possible, and that a system of strict and frequent supervision should be established to ensure that activities are executed according to plan; and
- a forum for consensus-building among the various actual and potential actors from the NGO community be established in order to harmonize the approach and draw up a plan of activities in which everyone will have a role to play.

## Annex F: Project Analyses

### I. Technical and Institutional Analysis

#### C. Improved HIV and AIDS Program Management

##### 1. Background and Rationale

A critical component of a successful HIV and AIDS prevention and control program is the existence of an effective program management and coordination unit. In light of the experience gained in HIV and AIDS prevention and control and other programs such as Family Planning programs, the critical role of appropriate program management and coordination cannot be overemphasized. Tackling the HIV and AIDS epidemic requires strong program leadership to mobilize, coordinate and use appropriately international, national and multi-sectoral financial and human resources.

In addition, many African leaders still tend to regard HIV and AIDS as being similar to other and older infectious disease problems. Therefore, there is a continuing need to engage and maintain international, national and community decision makers in dialogue concerning the peculiarities of the HIV and AIDS epidemic in view of its multi-sectoral aspect and socio-demographic and economic impact on a very vulnerable sub-Saharan Africa due mainly to its the extensive poverty, poor status of the women and low education level.

The multisectoral implications of the HIV and AIDS epidemic stem from the from the fact that, unlike other communicable diseases, AIDS most affects young adults between the ages of 14 and 45, impacting all aspects of society. Of urgent importance is the need to limit the exacerbation of the manpower shortage by HIV and AIDS that will slow down the economic progress, already affected by a significant shortage of trained personnel across all sectors. According to a World Bank report,<sup>4</sup> "AIDS will cause a slowing of growth of income per capita by an average 0.6 percentage points per year in the ten worst-affected countries in sub-saharan Africa".

##### 2. Critical review of HIV and AIDS Program management in Mali

###### a) The situation to date

The effective absorption of the massive resources generated for HIV prevention requires the development of strategic and operational plans, decentralization of activities, and the coordinated involvement of different governmental and non-governmental organizations including community-based associations. In recognition of the

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<sup>4</sup>The World Bank, \_\_\_\_, The World Bank: Oxford University Press, 1993.

compelling data from other hard hit African countries and the opportunity to limit the spread of HIV and AIDS while the rates are comparatively low, the Government of Mali established the National AIDS Committee in 1987 and finalized the Medium-Term Plan for HIV and AIDS in 1989. The specific objectives of the medium-term plan included:

- providing information and educated the populations on AIDS;
- ensuring the safety of blood transfusion;
- improving epidemiologic data collection;
- establishing a counselling system
- conducting HIV and AIDS related research including knowledge, attitude and practice surveys and socio-economic impact studies; and
- establishing an efficient program management system.

The organizational structure of the National AIDS Committee was designed as follow:

- **National Committee for the Fight against AIDS** in charge of program and policy development;
- **Central Coordinating Unit** to plan and coordinate all resources for the National Committee as well as activities of the various committees;
- **Regional and Districts (*cercles*) AIDS Control Committees** to promote decentralization of National AIDS Committee activities
- **Scientific and Technical Council for the Fight against AIDS** including five technical subcommittees to advise the National Committees and its coordinating body on specific HIV related issues. There are separate Technical subcommittees on Laboratory procedures and blood transfusion, clinical management, Information, Education and Communication-Counselling, Epidemiology and Research.
- **Follow-up Commission *Commission Mixte de Suivi*** that includes the Ministry of Health, major donors to promote donor coordination and monitor implementation of National AIDS Committee activities.

In 1991, World Health Organization and the Ministry of Health conducted an external review of the Medium Term Plan. The review team pointed out the limited accomplishments of the National AIDS Committee and identified the following interrelated weaknesses in program management and implementation including:

- Lack of clear-cut strategic policies to direct and monitor National AIDS Committee activities. For example, the lack of a HIV and AIDS related counselling policy led to the complete absence of any counselling interventions among HIV positive individuals and AIDS patients;
- Poor program planning and coordination. This had been the responsibility of few individuals, acting on ad hoc basis and centralizing and implementing AIDS prevention activities. The various established coordinating and technical

committees were not operational. The central coordinating unit of the National AIDS Committee, divorced from its coordinating function, chose to become an implementing body, managing and implementing various project such as the AIDSCAP project and using project fund to recruit additional personnel for the implementation of AIDS Control and Prevention project activities. This explained also explained the low absorptive capacity related to the implementation of project activities, partially. Out of the \$200,000 programmed by UNICEF for the eight regions only \$90,000 could be disbursed.

- Lack of credibility of the National AIDS Committee's central coordinating unit and its various committees due to their limited accomplishments, National AIDS Committee's tendency to centralize resources and its lack of transparency. This led to the very limited involvement of other government institutions and nongovernmental organizations in HIV and AIDS preventions, and, to the great reluctance from donors to work with the National AIDS Committee central coordinating unit.
- Lack of resources to support planned activities given the limited donors and national support. Besides the modest World Health Organization and United Nations Development Program's contribution for program management, donors contributions included about \$200,000 yearly from USAID Mali to support interventions among commercial sex workers and about \$800,000 from Canada to support the sentinel surveillance system and discrete non-governmental organization and private voluntary organizations activities. The European Economic Community's contribution to strengthening safety of blood transfusions could not be delivered due to European Economic Community's lack of confidence in the Blood Transfusion Center director.

b) Effected Changes by the GRM

The democratic change in 1991 stimulated the removal of the National AIDS Committee management team and the arrival of a more dynamic and open team. Since 1992, despite the instability in the Ministry of Health<sup>5</sup> important and encouraging initiatives were undertaken in order to strengthen HIV and AIDS prevention efforts in Mali:

- the decentralization of activities and resources at the regional level. The *Comites Regionaux de Lutte contre le SIDA* (Regional AIDS control committees) were encouraged to develop budgeted quarterly regional plans that were presented to selected donors for direct funding. The *Cooperation Suisse* decided to concentrate its support to the Sikasso region while UNICEF provided small grants to all eight regions;

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<sup>5</sup> The current Minister of Health is the third one since 1991.

- the involvement of non-governmental organizations in major HIV and AIDS prevention initiatives. For example, the National AIDS Committee's central coordination unit requested a local non-governmental organization (*Carrefour des Jeunes*) in collaboration with Plan International and a non-governmental organization umbrella organization (*Groupe Pivoi*) to take the lead in organizing the development and placement of HIV and AIDS prevention spots on radios and the national Television while facilitating the negotiations with the National Television and easing administrative procedures.
- the support of AIDS prevention activities in other ministries such as Education and Defense. Currently a team is conducting AIDS prevention activities in all military camps following an official request from the Ministry of Defense. On the same line, the National AIDS Committee in collaboration with the Centre National Information and d'Education pour la Santé is also assisting the Ministry of Education in developing a plan to integrate AIDS prevention messages within Ministry of Education's curricula; and
- the development of standard supervision and monitoring tools for AIDS prevention activities and quarterly supervision visits of the Regional AIDS Committees and health education of regional authorities during such visits.

c) Increased Donor Support

Also, there have been increased donors support to encourage and strengthen the aforementioned initiatives:

- With respective funding of \$200,000 and \$20,000 in 1993, UNICEF and the Swiss cooperation took the lead in encouraging decentralized activities, as indicated earlier. UNICEF has programmed an additional \$200,000 for 1994;
- United Nations Development Program, in collaboration with the National AIDS Committee, is developing a \$800,000 1994-97 AIDS prevention program that will support short-term external technical assistance, program evaluation, audio-visual materials, study tours, short-term training and two vehicles;
- The World Bank provided a 1993-94 loan of \$1,400,000<sup>6</sup> and has already financed the National AIDS Committee's telephone system, conference room, documentation center, meetings to develop the National AIDS Committee 1994-97 strategic plan and a large sexually-transmitted disease and HIV prevalence study. These funds will also support program coordination, the development of health education support, laboratory equipment and two vehicles;
- The World Health Organization continues to support the operations of the coordinating unit of the National AIDS Committee with a yearly funding of \$80,000; and

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<sup>6</sup>The Malian government considered this loan from the World Bank as one of its major contributions to HIV and AIDS prevention.

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- The European Economic Community and Japan are also currently discussing support to the National AIDS Committee of 1,000,000 European Community Units and two to four million dollars, respectively.

d) Impediments Still in Existence

USAID Mali will also encourage the new encouraging directions taken by National AIDS Committee and its central coordinating unit and complement other donors support in addressing the following impediments:

- the limited number and untrained personnel of the National AIDS Committee central coordinating unit and Regional AIDS committees do not allow to fulfil meaningful coordination, supervision and policy development activities. Currently, the National AIDS Committee central coordinating unit includes 6 full time professional and four support staff while regional committees include part-time governmental personnel;
- There is no trained program planner or manager. The professional staff is made up of two biologists, two physicians, one psychologist with no training in program management. The health education coordinator is a physician with no expertise in communication. To date, training of the central coordinating unit personnel focused mainly on Diagnosis and Treatment of sexually-transmitted diseases, Epidemiology and participation to AIDS international conferences. Only two physicians from the regions could benefit from an HIV and AIDS orientation in participating in the last international conferences on AIDS;
- Limited equipment is available to the National AIDS Committee's central coordinating unit and regional committees for coordination, supervision and support activities. At the central unit, the National AIDS Committee owns two vehicles for supervision including one allocated to the World Health Organization administrator and two other small vehicles to support activities in Bamako. However, as indicated earlier, the central coordinating unit expects four other vehicles from the World Bank and United Nations Development Program. The equipment of the National AIDS Committee include one functioning computer out of two and one old copier;
- The regional AIDS committees are ill-equipped and lack any equipment or appropriate logistics to support their regional coordinating and supervision activities; and
- There is a lack of pertinent socio-economic data relevant to the HIV and AIDS epidemic in Mali. This problem may have slowed the National AIDS Committee's efforts to increase both government commitment and public opinion support for HIV and AIDS prevention programs.

3. Project Plan

Accordingly, the project proposes to the National AIDS Committee to be able to fully function in its' role of coordination, including information exchange, policy development and resource mobilization.

a) Information Exchange

Information exchange is key to progressing in an epidemic that is changing as rapidly as AIDS. Within the Ministry of Health, there are several parallel agencies that will be involved in the project. The *Direction Nationale de la Santé Publique* contains the Division de la Santé, responsible for clinical care at government facilities, and the *Division Famiale Communitaire*, responsible for population and family planning activities. The large, multi-donor health project, coordinates outside funding in the building of the health care infrastructure, and is responsible for training health care personnel. The National Research Institute contains the country's reference laboratory and is the locus of most of the clinical sexually-transmitted disease expertise. The Division of Epidemiology is responsible for surveillance activities, the *Pharmacie Populaire du Mali* is responsible for developing the essential drug list, and for insuring adequate distribution of drugs.

Currently there are many donor agencies doing many projects impacting on sexually-transmitted disease and HIV prevention efforts in Mali. The World Bank is the most important agency in this field. They have given \$1.5 million in short term technical assistance to National AIDS Committee for logistic support, have conducted their rapid assessment, and plan future activities such as a national consensus meeting. In addition, the Bank has indicated a willingness to assist Mali in obtaining the essential drugs for a national sexually-transmitted disease control program.

To date, there has been only limited information exchange between donors, non-governmental organizations and parties interested in halting the spread of AIDS, usually of an informal nature. This project proposes to support donor coordination meetings as a mechanism to facilitate information exchange and will assist the National AIDS Committee to publish and distribute a quarterly newsletter on sexually-transmitted diseases and AIDS in Mali, aimed at providing a forum for information exchange for donors, health planners and non-governmental organizations.

b) Policy Development

Policy development is crucial to the unification of criteria for the dispatching of a problem. The lack of such policy can result in fragmentation of procedures, inertia and inappropriate procedures. Currently, there exist the immediate need for the development of three specific AIDS and sexually-transmitted disease related policies in Mali: sexually-transmitted disease prevention and control, HIV and AIDS related counselling and the free distribution of condoms.

i. Sexually-transmitted Disease Prevention and Control

Mali has never before had a formal sexually-transmitted disease control program. Part of the role of the technical advisor will be to develop, with the National AIDS Committee and the Ministry of Health a set of clear official guidelines for health personnel defining minimum standards for treatment, counselling, partner notification and reporting.

Based on the new sexually-transmitted disease policy the National AIDS Committee and regional AIDS committees might need to refine regional plans for sexually-transmitted disease prevention activities. In addition this project will support the National AIDS Committee to oversee the inclusion of AIDS, HIV and sexually-transmitted disease prevention activities into other government ministries such as the Ministry of Education, Ministry of Youth, Ministry of Defense and the Ministry of Rural Development as well as the non-governmental organizations.

ii. HIV and AIDS related counselling

Monitoring seroprevalence of specific populations enables public health planners to target prevention resources to geographical areas, and to specific populations where the morbidity is highest. At the individual level, HIV testing can allow infected persons to know their serostatus, and can provide an opportunity to target behavior change counselling to those most likely to spread the disease.

It has been noted by several authors that most HIV case-finding in Mali is not accompanied by clinical intervention [1,9]. Neither in sentinel surveillance activities nor in special studies is there a practice of notifying seropositives of their results, of counselling them to avoid transmission to their partners, or of referring them for medical care. The absence of such intervention by the public health sector severely limits the utility of HIV testing. Simply conducting surveillance to assess the level of infection in the population does not justify its resources.

In addition, this can lead to severe ethical dilemmas, an example being the AIDSCAP study. In this study, personnel are offering the HIV test to prostitutes, are aware of the results, but are not informing the prostitutes of their serostatus. This is particularly problematic in cases where staff are aware that infected women may be using condoms with their clients but not with their boyfriends. When questioned about why known seropositives are not informed of their results and counselled, staff at National AIDS Committee indicate that there is no formal policy written by the Minister of Health permitting them to do so, and that, without such an enabling policy, they are reluctant to provide this basic service. USAID has issued a formal letter requesting clarification. After speaking with Malian government personnel several times on this matter, it was decided to send all prostitutes to a Malian government hospital for testing. This facility would take on the responsibility of providing the women tested with their test results. There was little justification for continuing case-finding activities in the absence of any program to notify

seropositives of their results, refer them for appropriate care, and counsel them to avoid transmission to their partners.

The minimum standard for HIV testing, from both a prevention and an ethical perspective should be that an attempt be made to notify all seropositive persons of their results, and to counsel them as to how to avoid transmitting the disease to their sexual partners.

iii. The Free Distribution of Condoms

In 1993 the National AIDS Committee distributed almost 2 million free condoms to people who come to their headquarters and, through the AIDS Control and Prevention project, to hotel and bar managers, prostitutes and their clients. In 1993 the total number of free condoms distributed was over twice the annual number sold by the Contraceptive Social Marketing project.

Free distribution on this scale cannot be sustained and steps have already been taken to limit it. The project will work with the National AIDS Committee to develop a national policy on free condom distribution providing clear guidelines as to which, if any, groups can receive them. Free condoms might for example be distributed to people undergoing treatment for sexually-transmitted diseases or who test positive for HIV. Free condom distribution might also be part of sexually-transmitted disease and HIV prevention and awareness sessions in schools. Close collaboration with the Condom Social Marketing Project will ensure continuity.

c) Resource Mobilization

i. Policy and Management Capacity

As mandated by the World Health Organization, the National AIDS Committee should be the coordinating body for sexually-transmitted disease and HIV-related activities across units of the Ministry of Health responsible for surveillance, clinical treatment, pharmacy, laboratory, family planning, and health education activities. However, problems exist that suggest a need to build the capacity of the National AIDS Committee to coordinate an integrated sexually-transmitted disease and HIV response. National AIDS Committee is not seen as having a history of working collaboratively with its partners in government and in the community. It is perceived as working in isolation, not attending meetings, not consulting other agencies, not visiting or being aware of the needs in the regions at the primary care level.

4. Project Strategy

The project will provide :

- Local and external short-term assistance to support the central coordinating unit and regional committees in coordination, supervision, program and policy development in the four regions (Bamako, Mopti, Kayes and Koulikoro) which already benefit from the USAID Community Health and Population project support. Technical assistance will also assist in designing meaningful coordination mechanisms and National AIDS Committee organizational structures. A total of 25 person-months of local and 13 of external technical assistance will be supplied.
- Equipment and logistics including one copier to the central coordinating unit and relevant HIV and AIDS scientific documentation for the regions and the central coordinating unit. It is anticipated that the AIDSCAP project equipment which includes two computers and the vehicle will be transferred to the National AIDS Committee central coordinating unit, as stated in the AIDSCAP project document.
- Short-term training in HIV and AIDS and sexually-transmitted disease related program management and participation to relevant sexually-transmitted disease and HIV and AIDS conferences. It is expected that a total of 7 persons from the central unit and 22 from the supported regions will be sent to short-term training and international conference and workshops on AIDS in Africa.
- Two studies on the socio-economic and demographic impact of the HIV and AIDS epidemic Mali and secondary literature analysis to make relevant data available to decision makers and opinion leaders.
- Support of semi-annual liaison newsletters at the central unit of the National AIDS Committee and at the regional levels.
- Supply the AIDS Impact Model for presentation to government policy and decision makers. The AIDS Impact Model has been constructed by the Futures Group following the highly successful RAPID computer population model. This currently projects levels of prevalence of AIDS and its socio-economic effects over the next five to twenty-five years in a "generic" African country. Prevalence in the absence of any preventive measures and prevalence if selected interventions are implemented are projected. The model will be modified explicitly for Mali and shown to policy makers through policy workshops and related documentation.

In addition, to facilitate the flow of information, and to build the capacity of National AIDS Committee, the Mission proposes to fund the establishment of small-scale desktop publishing of sexually-transmitted disease and HIV surveillance reports, training materials, other information.

## 5. Implementation Plan

One of the critical components of a successful HIV and AIDS prevention and control program is the existence of an effective program management and coordination unit. Tackling the HIV and AIDS epidemic requires strong program leadership for the mobilization, coordination and appropriate use of international, national and multi-sectoral financial and human resources. This is the third component of the project, the output of which is to strengthen the institutional capacity of the National AIDS Committee. Specifically, the National AIDS Committee will engage in information exchange, policy development and resource mobilization by the completion of this project. This output will be attained through the operationalization of an information exchange component, policy development unit and resource mobilization component.

*Year 1*

This year will consist of writing requests for proposals in which detailed scopes of work will be outlined for the services of external and local consultants. These consultants will assist the National AIDS Committee to develop policy in the areas of HIV and AIDS related counselling, the free distribution of condoms and sexually-transmitted disease control. In addition, the purchase of supplies and equipment, training and study tours for project staff will be conducted. Mechanism for ensuring the exchange of information will be established, including donor coordination meetings and an informative newsletter.

Year 1	Effective Coordination
1-12	* Supply 63 persondays of external technical assistance
1-12	* Supply 120 persondays of national technical assistance
1-3	* Install AIDS Impact Model software and train personnel in its use
4-11	* Develop scenarios on socio-economic impact of AIDS in Mali using the AIDS impact model
	* Hold AIDS impact model workshop
12	* Hold Donor coordination meetings
2 and 8	* develop policy on HIV and AIDS related counseling
1-6	* develop policy on free distribution of condoms
1-6	* develop policy on sexually-transmitted disease prevention and control
1-6	* hold training course in program planning and management
3 and 9	* Commission studies of the socio-economic and demographic impact of AIDS in Mali
6	* Write and edit first quarterly newsletter
	* Publish and distribute first quarterly newsletter
10-11	* Supply documentation and journals to National AIDS Committee and Regions
12	* Identify and send participants to conferences and workshops and on study tours
1-12	* Provide office supplies for National AIDS Committee
1-12	* Provide Equipment maintenance for National AIDS Committee
1-12	* Provide Vehicle operation and maintenance for National AIDS Committee
1-12	
1-12	

*Year 2*

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This will be the first fully operational year for the strengthened National AIDS Committee. During this year, the newsletter will seek a wider audience and become the source of information for all persons and organizations working in AIDS in Mali. Policies that were developed during Year 1 will be promologated throughout the country. Persons responsible for implementing these policies will be trained. Monitoring and feedback to the Ministry of Health will ensure adherence to the progressive implementation of these policies. Exit surveys of individuals undergoing HIV testing and sexually-transmitted disease diagnoses might be conducted as means to verify that policies are actually being practiced. Wide distribution of the results of these surveys might be employed as positive reinforcement for those individuals implementing the policies. Lastly, this year will see two studies on socio-economic and demographic impact of AIDS in Mali completed. The results of these studies will be used to leverage donor funds.

Year 2	Effective Coordination
1-12	* Supply 63 persondays of external technical assistance
1-12	* Supply 120 persondays of national technical assistance
1-5	* Develop scenarios on socio-economic impact of AIDS in Mali using the AIDS impact model
	* Hold AIDS impact model workshop
6	* Hold Donor coordination meetings
2 and 8	* hold training course in program planning and management
3 and 9	* Write and edit quarterly newsletter
2, 5, 8, & 11	* Publish and distribute quarterly newsletter
3, 6, 9, & 12	* Supply documentation and journals to National AIDS Committee and Regions
1-12	* Identify and send participants to conferences and workshops and on study tours
1-12	* Provide office supplies for National AIDS Committee
1-12	* Provide equipment maintenance for National AIDS Committee
1-12	* Provide vehicle operation and maintenance for National AIDS Committee

*Years 3, 4, 5 and 6*

The foundation for the activities of years 3 - 6 will have already been laid in years 1 and 2. During these years, additional technical assistance for training, supervisory visits, for the creation or updating of regional and/or national AIDS plans and to assist in the coordination of donor meetings might occur. As in Year 1, scopes of work will be written and contractors chosen. The newsletter will continue to provide the bulk of the AIDS information to the general population, while annual reports will be more targeted to donors. During Year 3, an evaluation of the project will occur. This will form the basis for confirmation or modification of project activities.

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Years	Effective Coordination
3-6	
1-12	* Supply 63 persondays of external technical assistance
1-12	* Supply 120 persondays of national technical assistance
2 and 8	* Hold Donor coordination meetings
3 and 9	* hold training course in program planning and management
2,5,8 & 11	* Write and edit quarterly newsletter
3,6,9 & 12	* Publish and distribute quarterly newsletter
1-12	
1-12	* Supply documentation and journals to National AIDS Committee and Regions
1-12	* Identify and send participants to conferences and workshops and on study tours
1-12	* Provide office supplies for National AIDS Committee
1-12	* Provide Equipment maintenance for National AIDS Committee
1-12	* Provide Vehicle operation and maintenance for National AIDS Committee
	* Program evaluation Year 3

*Year 7*

This Year will basically follow the same activities as those in Year 6. Based on the results of the external evaluation, Year 7 will yield a confirmation or modification of the strategies to attain the major project outputs of this component of the project. Coordination within the Malian government will continue to occur, as well as coordination with other donors. Quality assurance in the implementation of policy will continue to be monitored. Project closeout and recommendations for a new follow on activities will also occur.

Year 7	Effective Coordination
1-6	* As Year 3 plus *elaborate proposals for new program

6. Monitoring and Evaluation Plan

A system for the monitoring and evaluation of projects that includes, but is not limited to the following:

a) Process Indicators:

Based on selected activities, a process indicator form will be generated, capturing the elements below. This form will be submitted by the Ministry of Health Project Coordinator to the USAID Technical Advisor for AIDS and Child Survival on

a bi-annual basis. (The submission of this form will occur one month before the Semi-Annual Project Implementation Reviews.) It is anticipated that the sexually-transmitted disease Advisor, located at the National AIDS Committee will initially assist in the filling out of this form.

ACTIVITIES	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	7th year
Develop scopes of work for technical assistance	xx						
Develop regional and sectoral plans	xx						
Conduct AIDS Impact Model workshop	x	x	x	x	x	x	x
Purchase equipment	xx						
Produce newsletter	x x	x x	x x	x x	x x	x x	x x
Attend AIDS and sexually-transmitted disease conferences	xx						
Attend program management training	xx						

In addition to the aforementioned process elements, the following outputs will be monitored:

- at least four regional plans for sexually-transmitted disease and HIV and AIDS developed for the 1994-97 period and regularly updated and implemented;
- at least four sectoral plans for sexually-transmitted disease and HIV and AIDS developed, regularly updated and implemented by other public sectors such as Ministry of Education, Ministry of Youth, Ministry of Defense, Ministry of Rural Development and the NGOs;
- clear-cut policies developed on HIV and AIDS related counselling, right and responsibilities of seropositive and AIDS patients, free distribution of condoms and sexually-transmitted disease prevention and control;
- appropriate coordination and organizational National AIDS Committee structures developed. Regular supervisory visits and coordination meetings using standard monitoring tools;
- two studies on socio-economic and demographic impact of AIDS in Mali completed;
- one secondary literature analysis of HIV and AIDS related or relevant publication conducted every year to make relevant data available to decision makers and opinion leaders;

- at least two scenarios on socio-economic impact of AIDS in Mali developed using the AIDS impact model and shown to at least 10 policy makers at national and regional levels; and
- increased resource commitment to HIV and AIDS prevention at national and regional levels.

b) Impact Indicators:

The prevalence of sexually-transmitted disease is the ultimate impact indicator. The World Bank sexually-transmitted disease prevalence study has provided the baseline for sexually-transmitted diseases. Rapid appraisal studies will be conducted in Years 3, 5 and 7 to monitor the impact indicator.

Activities in the field, i.e., the monthly submission syndromic sexually-transmitted disease data will be monitored by the Department of Epidemiology.

7. Inputs

- 25 person-months of local technical assistance
- 13 person-month of external technical assistance
- 10 persons will received short-term training in project management including two from the National AIDS Committee central coordinating unit and eight from the four regions
- 19 persons will be sent to AIDS conferences and workshops including five from the National AIDS Committee central coordinating unit and 14 from the regions
- One copier for the National AIDS Committee central coordinating unit
- One laptop and related equipment for the computer AIDS Impact Model to be used by the National AIDS Committee central unit and the regions

## Annex F Project Analyses

### II. Economic and Financial Analysis

#### A. Project Rationale

The need for an appropriate response to the AIDS challenge in Sub-Saharan Africa is well-established. The 1992 *Organization Economique de Coopération pour le Développement* report identifying the continuing tragedy of AIDS as the first of two key challenges requiring urgent attention, echoes the 1991 World Health Organization's Global Program on AIDS that estimated that about nine million adults and close to one million children under five throughout the world have been infected with the HIV virus. It noted that Sub-Saharan Africa, with less than ten percent of the world's population, accounts for about 60 percent of total HIV infections, two-thirds of the adult AIDS cases, and 90 percent of pediatric AIDS cases worldwide. Although currently not as affected as other African countries, Mali's need to respond to this challenge is no less urgent.

According to this report, the increasing rate of HIV infection among Africans may more than triple the adult mortality rate and cause significant increases in child mortality, thus threatening to reverse hard-won gains in child survival and in the overall health status in Africa. The economic and social impact of this disease, which kills people in their most productive years, could be immense in Sub-Saharan Africa where a disproportionate number of its victims are in the relatively-small trained labor force and sociopolitical elite.

Absent a vaccine or a cure for AIDS, the Project focuses on prevention through controlling sexually-transmitted diseases, changing behavior and strengthening the National AIDS Committee. That is, the Project aims at slowing down the transmission of AIDS in Mali through a sexually-transmitted disease component that focusses on the case management and surveillance of sexually-transmitted diseases; a behavior change component that focusses on AIDS education and condom promotion; and an institutional component to better serve this more informed population.

#### B. Analytical Model

This analysis takes condom use to be representative of the overall impact of the Project's behavior modification effort, and uses condom prevalence as the principal policy variable. Condom prevalence is further broken down into condom use by a core group and the rest of the sexually active population, the non-core group.<sup>4</sup> In the absence of Mali-specific reliable statistics on the AIDS situation and its potential evolution, the analysis is built

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<sup>4</sup>The core group, essentially prostitutes, the military, truck and taxi drivers, bar clients and adolescent youth, is a small percentage of the population, but its high rate of sexual activity makes it the principal vector for AIDS and, therefore an essential target in fighting the disease.

around a set of parameters whose values are selected to give a reasonable representation of the evolution of AIDS in Mali. These parameters and initial assumptions define what is called the basic scenario for the analytical model. This analysis also makes a series of simulations with alternative values for some of the parameters and policy variables, in order to gauge the probable outcome of Project interventions on the evolution of AIDS in Mali.

The data, parameters and assumptions of the model are shown in Tables 1 through 8. Table 1 shows the distribution of the Malian population based on the 1986 census and on the assumption that each age-sex group increases at the average rate of 3.1 percent. Tables 2 through 7 show the evolution of all variables used in the analysis over a 25-year period beginning in 1994. Table 2 shows the evolution of different aspects of the target population, in the with-and-without Project situation, with the parameters set for the basic scenario in the financial analysis. These parameters are the sexually-active population, condom prevalence, HIV seropositivity, the incidence of new cases of AIDS, and the number of AIDS-related deaths.

Table 3 and 4 show the probabilities of becoming seropositive as a result of unprotected sexual activity with a given number of new partners during a given year. This is derived using the geometric distribution with the probability of becoming infected assumed in the basic scenario. The numbers shown in Table 3 show the probability of getting infected in the latest encounter after having been lucky in all previous ones. Table 4 shows the cumulative probability of getting infected after so many encounters. Columns 2 and 3 of this table show this cumulative probability in a given year after the number of encounters with new partners assumed for the core group and non-core group in the basic scenario. Tables 5, 6 and 7 show Project costs and benefits. Table 5 shows USAID projected costs and an assumed 25 percent expenditure by the host country government. Table 6 shows the differential expenditures in treatment and prevention between the with-and-without Project situation as well as the differential costs and benefits of averting AIDS-related deaths with the Project. Table 7 simply summarizes information the more detailed tables just described.

Finally, Table 8 shows the summary variables of the analysis as well as the data, parameters and assumptions used in the basic and alternative scenarios. The summary values apply to the respective scenarios identified in the top row and correspond to alternative assumptions on the parameters. The assumptions, data and parameters are the basic inputs of the model and condition the summary results shown at the top of the table. The assumptions and parameters of the basic scenario are chosen to provide as reasonable a picture as possible of the Malian situation. This information refers to the population targeted by the Project, the extent of HIV, AIDS and condom prevalence in Mali and the likely evolution of these variables, with-and-without the Project intervention, the share of the population in the core and in the non-core sub-populations, the number of sexual contacts and new partners in a year

in the core and non-core.<sup>5</sup> Table 8 also shows the probability of getting infected with the HIV virus through unprotected sexual contact with an infected partner. The probability of infection while using a condom is assumed to be zero. The only difference between the assumptions of the basic scenario for the economic and financial analysis is the price of condoms, which is significantly lower in the financial analysis.<sup>6</sup> To account for the unavoidable uncertainty involved in selecting the parameters, simulations gauge the extent to which variations on these assumptions affect the expected results.

### C. Results

As already noted, the need for the society to respond as forcefully as it can to the AIDS challenge is well-established and needs no economic analysis to establish it. Nevertheless, this analysis shows that under reasonable assumptions, the economic and financial worth of the proposed Project activities reinforces the case for the proposed interventions. In the basic scenario of the financial analysis, under the assumption of targeting the core group for increased condom use, the internal rate of return is 53 percent.<sup>7</sup> This means that Project activities would be expected to give a higher payoff than almost any alternative investments available. This despite the conservative nature of the benefit stream that does not take into consideration the benefits accruing to individuals who do not acquire other sexually-transmitted diseases or benefits accruing to the children of potential AIDS victims whose lives are changed fundamentally by the loss of one or both parents. Compared with the situation without the Project, this would require condom users to buy an extra \$105,000 of condoms in 1988. The discounted<sup>8</sup> cumulative additional expenditures on condoms up to the year 2019, for the core and non-core group is \$7.6 million. In this scenario, the core would reach a condom prevalence rate of 29 percent while the non-core would reach a prevalence rate of five percent in 1998.

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<sup>5</sup>The couple year protection is based on the number of sexual contacts. However, because of the very high number of sexual contacts in the core, this analysis estimates the probability of becoming HIV positive on the number of new sex partners in a given year.

<sup>6</sup>Although the current USAID policy of selling condoms with a significant subsidy would probably need to be maintained in order to achieve continued increase in condom prevalence, it is instructive to see the costs that this subsidization implies when condom use is significantly higher than today. Absent this subsidy, the cost to individual users would be significantly higher, therefore calling for significant expenditures in this poor economy. These relatively-higher economic expenses give added emphasis to the need to target condom use on the core population. Note also that this analysis does not apply to the entire Malian population, but to a 30 percent subset assumed to be the urban or with significant urban interaction.

<sup>7</sup>The internal rate of return is the interest rate needed to make the stream of benefits equal to the stream of costs. Since it takes time to get the benefits from today's costs, the higher the internal rate of return, the higher the potential payoff of the proposed activities.

<sup>8</sup>Present values are discounted at the customary 12 percent.

If instead the non-core group were targeted, the alternative A in the financial analysis, a net present value of condom use of 7.6 million dollars would result on a significantly smaller internal rate of return of 35 percent.<sup>9</sup> In this case, the increased cost of buying the condoms needed in 1998 would be a significantly higher \$260 million. Not only this alternative is significantly less attractive from a financial point of view, it is also less feasible from a practical one. It would require the condom prevalence to increase by 75 percent per year in the non-core group while the basic scenario calls for a less dramatic increase of 30 percent in the core group.

Using the cost that USAID buys condoms for the Social Marketing of Contraceptives project as the economic cost of condoms and keeping all the other assumptions of the basic scenario in the financial analysis, provides the basic scenario for the economic analysis. The resulting rate of return of 50 percent is only three points below that obtained in the financial analysis, making the basic scenario rather stable relative to condom costs. Note, however, that this simulation shows the condom costs to be of some concern in a poor country like Mali. The net present value of the additional condom costs goes up to 23 million dollars and the additional costs for 1998 alone goes up to \$320,000. The same change in the price of condoms for the alternative A of the financial analysis gives the alternative A for the economic analysis. The economic internal rate of return also decreases by three percentage points, but the change in condom costs is more significant. The additional costs in 1998 would be \$780,000 and the net present value of additional condom costs goes up to \$23 million.

Four additional simulations provide some further insights on the viability of the Project. For Alternative B on the financial analysis, the percentage of the population assumed to be in the core was simply lowered from 15 to 10 percent. This lowers the internal rate of return from 53 to 50 percent, and lowers significantly the costs of reaching a given condom prevalence, as should be expected from the high sexual activity of this group. These costs go down to \$74,000 while the net present value of additional expenditures on condoms goes to \$5.1 million. Alternative C in the financial analysis, raises the probability of getting AIDS from unprotected sexual contact to 30 percent.<sup>10</sup> This scenario results in a dramatic increase of the internal rate of return to 156 percent with no change in costs.

The last two scenarios refer to the economic analysis shown in the basic scenario. Alternative B in the economic analysis increases the cost per condom from 100 FCFA to 150. Relative to the basic scenario in the economic analysis, the internal rate of

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<sup>9</sup>When the core group is not the policy target, prevalence in the core group is assumed to increase at the same rate as was assumed for the non-core group when the core was the policy target (see policy variables in Table 8).

<sup>10</sup>Although this higher probability is thought to be likely in Africa because of poor health conditions, the lower probability was chosen for the Basic Scenario because the core population is believed to be better off. Ongoing efforts to address the other sexually-transmitted diseases should lower the probabilities of getting infected, but these activities should get credit for these improvements in the health status of the population.

return decreases from 50 to 47 percent. Again, this relatively-small change in the internal rate of return is accompanied by a more significant increase in condom costs in 1998 to \$480,000. The NPV of condom use to 2019 rises to 43 million dollars. Alternative C in the economic analysis lowers the percent of the HIV-positive population with AIDS in any given year from 25 to 20 percent, while keeping the other assumptions of the Basic Scenario in the economic analysis. This lowers the internal rate of return from 50 to 34 percent. The corresponding net present value of additional condoms used goes to 23 million dollars and the increase in condom costs in 1998 is 320 thousand dollars.

#### D. Conclusions

This analysis fully supports the proposed Project. Moreover, it suggests strongly that the resources be focused on increasing the condom prevalence in the core group of the most sexually-active. This core group, at 15 percent of the sexually-active, is relatively large. It is much larger than the group of professional and part-time prostitutes and their clients. Cost considerations and other difficulties of reaching the entire core group may even justify a special focus on the narrower group of professional and part-time prostitutes and their clients. The technical analysis identifies this latter group. Focusing closer on it may have a significant payoff if anecdotal evidence that many prostitutes, to make ends meet, are predisposed to forego using condoms for a slightly higher fee.

The relatively high economic returns and the obvious importance of condom use to the public at large would seem to justify continuing to subsidize condom use. On the downside, the costs are significant, and it is not clear that the Malian public would give condom subsidization the priority it deserves in the absence of USAID subsidies. Moreover, it is also not certain that USAID could or would finance a significant increase in condom prevalence. The economic costs of condoms, used in the economic analysis, add the cost of subsidizing condoms to the financial price paid by the user, and give a sobering measure of the financial effort that is required to meet this challenge. It might even point to the need of an even more targeted effort on the group of professional and part-time prostitutes and their clients to include financial compensation for participation in sensitivity seminars by prostitutes whose financial situation often force them to make a choice between participating in training and looking for paying clients.

The alternative of encouraging condom use in the non-core group would be much more expensive, and significantly more difficult with relatively smaller impact on curbing the growth of AIDS. This non-core group is much more dispersed and less likely to accept or to correctly utilize condoms.

## Annex F: Technical Analyses

### III. Social Soundness Analysis

#### A. Introduction

In Mali, health issues have almost always been considered the affairs of doctors alone. Thought to the social and psychological implications of health programs aimed at the general population has been rare. However, analyzing the social soundness is essential when implementing health programs that aim at more than simply the involvement of large numbers of people. The case of AIDS is typical.

In 1985, only one AIDS case had been reported. Today, according to reliable hospital sources, the number of seropositives is about 80,000. This is considerably higher than the official figures (460 in 1992). The important questions to be answered are:

- Where are the non-reported cases?;
- Are they aware of their seropositivity and that they constitute a danger for their families and their friends?;
- What is the government doing to inform them of their seropositivity?; and
- Do seropositives benefit from counselling and care?

In dealing with these issues, Mali is faced with several factors that represent major challenges for the country:

- Distance: Mali covers 1,240,000 square kilometers. A massive logistical effort is required to reach the target groups;
- Ethnic and linguistic multiplicity: this complicates communication and increases the cost of health education activities;
- Poverty: with a GNP of only \$270 per head, health issues are not a national priority;
- Education: Mali has a school enrolment rate of 21 percent, which limits access to both mass and specialized information via the educational system;
- Youth: more than 40 percent of the population range from 15-to-25 years old. These young people are typically ill-informed, poorly-educated and preoccupied with living their sex lives to the full;
- Population: Mali has a population growth rate of 3.7 percent, which increases the propagation of the disease exponentially;
- Urbanization: currently increasing at an annual rate of 4.7 percent, urban growth accentuates the problem of seasonal migration and brings with it problems of unemployment and promiscuity, giving people false images of the world and of easily-satisfied sexuality.

The challenge cannot be met by health personnel alone. The social sciences are in a better position to deal with such health-related issues. There are major difficulties in adapting health policy to the social realities of peoples everyday lives, especially when dealing with sexually-transmitted diseases and AIDS where the principal objective of a health program is not necessarily to cure. Rather, the aim should be to understand the social and psychological reasons that, within each target group, lead certain individuals to protect themselves, whereas others do not.

There is thus a need to involve social scientists to provide the additional skills needed to enable prevention and care policies to be adapted to the realities of different social environments and target groups. The topics requiring investigation and sociological analysis include:

- the social organization of communities;
- the way information is passed on within communities;
- the wealth (economic status) of communities;
- the access to health care;
- the ways that individuals behave (both "normal" and "abnormal" behavior patterns); and
- the issue of national and international migration.

B. Basic Data About Mali

1. Demography<sup>11</sup>

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<sup>11</sup>Source: RGH, perspective of Malian resident population from 1987 to 2022, BCR, June 1992

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Surface Area	= 1,240,000 square km
Total population	= 8.2 millions
Population Density	= 6.2 per square kilometer
Male residents	= 3,733,281 (49 percent)
Female residents	= 3,886,944 (51 percent)
Number of villages per subdistrict	= 787,783
Number of households	= 1,364,079
Rural population	= 6,006,059
Urban Population	= 1,690,289
Number of villages	= 10,000
Urbanization rate	= 4.7 percent
Dependant on agriculture	= 73 percent of the population
Birth rate	= 50 per 1000
Mortality rate	= 22 per 1000
Infant mortality rate (indirect method)	= 195 per 1000
Fecundity rate	= 6.7 percent
Population growth rate	= 3.7 percent
Life expectancy	= 45 years
School enrolment rate	= 21 percent (11 percent of girls)
Gross Domestic Product/inhabitant	= \$270

## 2. Principal Ethnic Groups, Languages and Religions

The following table summarizes the principal ethnic groups in Mali and their respective occupations:

Group	Ethnic Group	Main Occupations
Manding	Bambara Malinké Dioula	farming farming trade
Soudanese	Sarakolé Songhoï Dogon Bozo	farming and trade farming farming fishing
Voltaic	Sénoufo-Minianka Bobo Mossi	farming farming farming
Nomads	Fulani Touareg	herding herding

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Each village is formed right from the beginning according to a classic pattern. As the village grows in importance, people from other clans come to settle. The village chiefs are male and always either the founder of the village or one of his direct descendants. They hold the power to make policy decisions. Typically, their counsellors are selected from amongst close relatives. In general, communities are structured as follows:

- the chief and his counsellors;
- the extended family (composed of several households);
- the associations, called *tons*;
- the age groups; and
- the people of caste (praise-singers, blacksmiths, slaves).

Communities, especially traditional ones, are very hierarchical with each person (man, woman, youth or person of caste) keeping their place and their prerogatives. They are also however, highly convivial: people organize together for baptisms, funerals, theatrical events and other community activities.

Traditional networks of solidarity still play an important role today. For example in Dogon areas, Guinea worm is regarded as a disease that brings shame on the family as it handicaps farmers during the rainy season. However, a support system exists in that when someone falls sick, the youths of the village will cultivate his or her fields.

Nowadays, new solidarity networks are being created around shared village development projects, e.g. in natural resource management, education and health care. These have led to the creation village management committees in numerous communities. Nevertheless, as the domestic economy becomes more monetized and modern technologies are introduced, the extended family system is tending to break up, the traditional chiefs are losing their power and a new generation of decision-makers is emerging: the economically powerful.

#### b) Economic organization

The economy is organized into rural and urban agriculture, rural and urban pastoralism, food harvesting and processing, crafts, and very limited industry. However the vast majority of the population lives at a basic subsistence and self-sufficient level. It produces locally almost everything consumed without necessarily using money except for paying taxes to the state. The issue of subsistence and self-sufficiency is important when considering per capita gross national product, and especially when considering cost-recovery.

#### 4. Health Coverage in Mali

The annual Ministry of Health budget represents eight percent of the National budget -- 0.7 percent of the gross national product or approximately 920 FCFA per

person. Health centers and the social services are generally far from the population they are intended to serve. To access the state health care system, a sick person has to travel on average 20 to 30 kilometers. This represents approximately the distance from an average village to the nearest *arrondissement*-level health center, which is staffed by a single state-registered nurse. Trained health personnel (doctors, midwives and state nurses) are concentrated in the urban centers, creating further urban-versus-rural inequalities in health care provision. The infrastructure consists of:

a) Village health centers

There are approximately 100 village health teams. They consist essentially of first-aiders, usually with basic literacy skills, who have been trained by NGOs. They provide basic primary health care. They are found mainly in the south of the country and where other well-established development organizations and NGOs (e.g. Mopti, Kayes) are located.

b) Health care huts: 322

These exist throughout the country, often where there men and/or women who have received a basic literacy training. They typically consist of a stock of the basic drugs such as aspirin, nivaquine, mercurochrome and alcohol.

c) Sector-level maternity centers: 362

The sectors correspond to the technical and administrative subdivisions within the state agricultural service.

d) Pharmaceutical stores: 203

Because these stores are not yet fully controlled, at the village level some traders open small pharmacies much as they would a village shop. Sometimes the village shop also serves as the pharmacy.

e) Subdistrict (*arrondissement*) health centers: 281

Each sub-district health center serves about 35 villages with an average a total population of 30,000 people.

f) *Cercle* or commune-level health and social services centers: 46

g) Regional-level departments of health and social services: 8

h) Regional hospitals: 6

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i) National hospitals: 3

j) Personnel

All told, there are 249 doctors, 2561 midwives, 562 registered nurses, 749 primary health care nurses, 65 community development workers, and 194 -health technicians.

k) Community and private health infrastructures

These are not centrally-registered and one could only guess at the likely number. Nevertheless, they have been developing rapidly over the last few years especially in urban and peri-urban areas.

## 5. Principal Donor Organizations Involved in AIDS Prevention

The principal organizational donors in AIDS prevention are: the World Bank, the World Health Organization, USAID, the United Nations Development Program, Swiss bilateral aid (*Coopération Suisse*), Canadian bilateral aid (*Coopération Canadienne*), European Development Fund, Dutch bilateral aid and UNICEF.

## 6. Malian Literature Related to STD and AIDS

Dr. Belco Kodio conducted a literature review on sexually-transmitted diseases and AIDS in Mali in August 1993, under the auspices of the French Cooperation, ORSTOM and the National Research Institute, entitled, Revue de la littérature et synthèse des connaissances de l'infection par le VIH et le Sida au Mali 1983-1992. This review analyzes critically the majority of research carried out during the period. Dr Kodio intends to update if possible, his review this year.

### C. Sexually-transmitted Diseases and AIDS in the Malian Socio-Cultural Context

#### 1. Popular Beliefs about Disease

"For an African, medicine would most probably be the fruit of the reflection and questioning about the great mystery of life and death which never ceases to preoccupy him and reflects his strong desire to do all he can to prolong his own life, the most precious of the gifts he has been given. It's also the structure he has elaborated and continues to use in order to dominate the various forces, visible and invisible, that seek to work on him and disturb the cycle and balance of his existence."<sup>12</sup>

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<sup>12</sup> Elon. Ntouzo 'O: (Médecine, pharmacopées traditionnelles et développement Africaine). Quoted by Kalis Diarra

Thus medicine seeks to dominate disease that is perceived as either a visible or an invisible force. As a general rule, disease is considered to be sent by God but God also always gives man the means to cure the disease, whatever it is. Disease is thus something quite natural that is cured naturally. "Natural" diseases, those sent by God, are not dreaded because they can be cured. On the other hand those illnesses considered to be caused by evil spirits or ones enemies are dreaded as they require the intervention of even more powerful forces (traditional healers etc.) that need to be called upon without delay to counteract the spell. Thus, a priori, there is no such thing as a fatal disease, no disease that cannot be cured. This explains the mood of optimism that people display even when asked about the health of a patient who is on the point of dying: "*A ka fisa*", they reply, meaning literally "she/he has improved."

People only worry about unnatural diseases, i.e. those that are not sent by God but by a person with the power to inflict harm on others. All incurable diseases and cases of inexplicable illness fall into this later category. This is why, traditionally, people are so unconcerned and relatively-unworried about diseases. While these beliefs still prevail amongst a population that is highly religious and for the most part illiterate (80 percent), they are being undermined and eroded with the development of modern education and health care and the media.

## 2. The Case of Sexually-Transmitted Diseases and AIDS

Sexually-transmitted diseases, except AIDS, were not regarded as serious diseases, even in Europe, until the end of the 1980's. In Mali, in certain societies, an adolescent boy was ashamed to admit he had not yet caught his first *chaude pise*, (hot piss) -- one entered adulthood by contracting a sexually-transmitted disease. However this adolescent boys teasing should not be allowed to obscure reality; in Malian society as a whole sexually-transmitted diseases are regarded as shameful diseases. They are the proof of: conjugal infidelity, both condemned by religion and an indicator of marital conflict; a bad choice of sexual partners, bringing social discredit; and sexual promiscuity, indicating that a man is generally untrustworthy because he cannot behave respectfully toward women.

For these reasons, people rarely admit openly to having sexually-transmitted disease and treat them discreetly, often clandestinely or through auto-medication. In general, people believe that men catch sexually-transmitted diseases from women of loose morals. In this male-dominated society, the opposite is rarely considered.

## 3. Popular Reactions to Protect Against Disease

Among the non-educated and illiterate population, actions to protect against disease are rare. This is because African medicine is not preventive, but essentially curative. Amulets and incantations are used, but only to protect oneself against unnatural illnesses. Even when sick, some social groups such as women and children are less likely to be given curative treatment. Traditionally they would be treated only when their illness

became very serious. Only able-bodied men who work receive special attention when they are sick.

4. Specific Protective Responses Against sexually-transmitted disease and AIDS

In the past, no such protective response existed. They have appeared recently as a result of the activities of the Malian Family Planning Association (created in 1972) and especially with the 1985-86 appearance of AIDS in Mali. Health education programs have permitted a minority of the population to respond positively and to protect themselves against sexually-transmitted diseases and AIDS. However, these small-scale actions have still left the vast majority of the population vulnerable to infection.

Protective responses against sexually-transmitted disease and AIDS in Mali are, as in most African countries, higher among the prostitutes. Identified as a group at high-risk of infection and transmission, they have benefitted from more follow-up, advice and treatment. In the Ivory Coast, some prostitutes have been trained as educators. "They consider that their knowledge of the means of transmission of the sexually-transmitted disease and AIDS, and the risks linked to their status as prostitutes result in them protecting themselves in all their sexual encounters. They also give advice to their colleagues. In Uganda and Senegal where the population is relatively more highly-educated than in Mali, protective reflexes against sexually-transmitted disease and AIDS are more firmly established, although the levels prevalence remain high".<sup>13</sup>

5. Diseases And Socio-Professional Categories

There are no studies indicating that one socio-professional category in Mali is more susceptible to disease than another. All that can be indicated are the risks to which each category is exposed in its work. Thus, farmers and herders in rural areas rarely have access to clean drinking water, to a well-balanced diet, to preventive medical treatment or to health education. Thus, these are the most exposed to disease. Civil servants and members of the professions, have more assured health care. These groups have at their disposal the means to protect themselves against disease.

6. Diseases and Location

As a general rule, people who live in rural areas suffer more from disease than their urban counterparts. Regional inequalities in health care provision are reflected in the distribution of health infrastructure and personnel; the best-equipped centers and the most highly-qualified staff are almost always found in urban communities and particularly in the capital city.

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<sup>13</sup> Les sciences sociales face aux sida. Center ORSTOM de petit-Bassam - 1993  
(Social sciences and AIDS. ORSTOM Center petit-Bassam - 1993

## 7. Diseases and Access to Treatment

It is impossible to determine accurately the number of people with access to adequate medical care in different parts of the country. What should be appreciated is that access to health care is a function of a variety of factors, including:

- the existence of a health infrastructure;
- the proximity to the health infrastructure;
- the availability of health personnel;
- the level of disposable incomes; and
- the availability of medicines.

These conditions are more often filled in cities than in rural areas. The NGOs could improve the situation in rural areas through well-targeted interventions.

## 8. Sex in The Popular Imagery

One cannot pronounce the word "sex" in any national language in Mali without the risk of being considered impudent, shameless, shocking, vulgar or badly brought up. Someone who had to talk about sex in front of respectable (i.e. adult) people for serious reasons (illness, court cases) would use a widely understood euphemism. For example, referring very modestly and respectfully to "the man's attributes" or "the woman's attributes".

*"In polite conversation, a highly censored language controls the exchanges between parents and their children (and between husband and wife too). Strict application of certain maxims leads to a ritualization of speech and makes it out of the question to talk openly about sexual matters in the presence of ones parents. They would consider such conduct both impudent and embarrassing. Frank speech is replaced by a watered down language which demonstrates both deference and respect, and which appears to reiterate much older forms of speech".<sup>14</sup>*

Under these conditions, it is evident that, for African people in general, including Malians, parental input to a young persons education is supplemented and even replaced, by that of his or her entourage (neighbors, school, sexual partners) and generally by all the different types of group to which she/he belongs.

Different social groups do not have the same attitude or use the same language when talking about sex. Thus, Malian men are relatively guarded in their use of words when talking about sex, even among themselves. Women, on the other hand, typically

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<sup>14</sup> In Trajectoires Sxielles et Amoureuses à Abidjan, Corinne Ginoux Pouyant writes.

express themselves bluntly and without circumspection. Their speech is generally lively and devoid of modesty or restraint. In other words, there is apparently no shame involved in their use of unrestrained speech that is both explicit and realist. Young people discuss sex openly amongst themselves in much the same manner as women.

Moving up the social hierarchy, the expressions used, show an increasing reserve and self-control. People frequently employ euphemisms to avoid being over familiar or vulgar. It is in fact, a ready-made form of speech that depersonalizes and disguises all discussions about sex.

The only difference between the city and the village is that, in the former, anyone who is interested can have access through the media to a wide range of opinions and images of sex. Thus, sex is slowly being de-mystified. However, villages are also being increasingly influenced by the spread of media coverage and by national and international migration.

a) Goals of sexuality

The declared goal of sex is procreation. The sexual act should be considered only within the context of marriage and should result in children (Islam). Polygamy is thus partly explained as a way of satisfying this requirement. However, over and above this religious viewpoint, for the great majority the objective of sex is pleasure although for some (who practice prostitution) it is money.

b) Sex life and partners

In the traditional society, a persons sexual development and choice of partner is controlled carefully. A girl knows that she is given to a particular boy who will, at the appropriate time, marry her. Unless something exceptional happens, all will happen according to plan and they will set up home and live together. The husband can if he wishes, contract other marriages (often when the wife is infertile, infirm or elderly)

In modern society and especially in the towns, the man usually looks for the woman he wants to marry. Before making a final choice, he may have relationships with several women. Thus, a wife may have only one sexual partner during her lifetime while a husband may have had several.

c) Age when sexual relations begin

All the studies relating to this topic indicate that on average, sexual intercourse normally begins around the age of 14. The period of intense sexual activity is between the ages of 14 and 25. It is thus important to target this age group in AIDS prevention programs. For this group, sex is very often linked simply to the act of coitus itself. It is a straightforward moment of pleasure that does not commit either partner.

d) Permissivity and taboo

Malian society is not at all permissive concerning sex. Sex can even be considered a taboo. In many societies, this lack of permissiveness means that young people get married very early (at 13 years old or even younger amongst the Fulani). This is especially the case where the traditional society places a high value on a girl being a virgin at marriage. However, it is increasing the case that sex is becoming banalized in the urban areas and in areas where large-scale migration and socio-economic exchange has occurred. Here, the sexual act is perceived as a recreational activity or a commercial transaction.

9. Some Sexual Phenomena in Mali

**Domestic workers:** Low-paid female domestic workers are numerous in urban centers. They come from the interior of the country to earn enough to buy their wedding trousseau, or simply to escape from the traditional parental control. Generally, they are poorly-paid and fall easily prey to the sexual advances of city men. Their lack of schooling and relevant information put them at high risk of infection by sexually-transmitted disease.

**Secretaries:** Secretaries are almost always attractive, well-dressed, poorly paid and inevitably have a male boss. These women are an easy target for their bosses or other male colleagues who harass them at work. Many of them have difficulties finding husbands as men tend to consider them as being in the high-risk category.

**The kidnapping of women:** This practice exists among certain ethnic groups (for example, Dogon, Bobo and Mossi). It enables one man to challenge another man socially by using subterfuge or violence to steal his most treasured possession: his wife. The woman is often kidnapped several times and in fact her reputation rises according to the number of times she is taken from her husband. So, if she is suffering from an sexually-transmitted disease, she contaminates her various partners.

**Traditional rape:** this practice is found in the Dogon and the Mossi societies. When a man's wife dies during pregnancy or childbirth he is obliged to leave his community and to live alone in the bush until he succeeds in raping a woman and producing the proof that he has done so. Quite clearly, this violent ritual involves scant regard for infection by sexually-transmitted disease.

**Sodomy:** many people believe that anal intercourse will prevent infection by sexually-transmitted disease. The practice is becoming more widespread in Mali, mainly in the urban areas and amongst people with higher levels of education.

Homosexuality: this is a phenomenon exists in Mali but is not considered very widespread. In any event, the homosexual community in Mali is very closed and it has been impossible to confirm whether any of the cases of AIDS are due to homosexual transmission.

D. The Sexually-transmitted Disease and AIDS Awareness and Prevention Project in the Malian Social and Cultural Context

1. Project Areas

The Project will intervene in three regions of the country (Kayes, Koulikoro, Mopti) and in the Bamako District. It will be linked to activities planned under the large, multi-donor health project. Approximately 50 percent of the total population of Mali lives in these regions. USAID is already involved in implementing a large, multi-donor health project. This program will provide the AIDS Awareness and Prevention Project with an adequate framework for providing of health care and information.

USAID Mali has accumulated experience in sexually-transmitted disease and AIDS-related interventions through several of its activities, notably:

- The Interventions for High Risk Groups against AIDS<sup>15</sup> project, financed by USAID is linked to the National AIDS Committee;
- The Social Marketing for Change project in collaboration with the Malian National Pharmacy and the Family Health Division, which is involved in condom promotion and sales principally as a method of birth spacing, but also incidentally to combat sexually-transmitted disease and AIDS;
- Support to the Malian Family Planning and Promotion Association, has been working in this area for many years; and
- The Child Survival Pivot Group, which since has carried out family planning and AIDS awareness activities with U.S. and Malian NGOs since 1993.

The lessons to be learned from their experience to date, are that:

- the decentralization of the fight against AIDS is not yet guaranteed either in terms of autonomy or resources;
- it is essential to create an institutional framework covering the legal and ethical issues raised by AIDS, in order to preserve social cohesion and to avoid discrimination. At present, this institutional framework does not exist in any viable or organized fashion; and
- new channels of communication need to be identified. To date, the official media (state radio and television, free radio stations and the press) have been

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<sup>15</sup> Better known as *Projet FHI*.

used to convey health messages. This has not been entirely successful as most people lack access to these media or don't have the educational background needed to understand the messages. Traditional media (griots, theater, traditional associations, etc...) have been exploited insufficiently despite them being powerful means of mass mobilization.

In Ivory Coast and Senegal, where the population tends to be more highly-educated and have better access to information, counselling and the means of prevention, AIDS Awareness and Prevention activities have moved beyond the narrow confines of the Health Ministries and become the concern of the universities and of civil associations. These countries have been able to develop more stimulating AIDS policies.

The Project will clearly have a impact outside its direct zone of intervention. All health education messages and advice diffused through the national media will benefit the entire country providing that the languages and the support materials used are themselves are accessible to the majority of the population. Thus, indirectly, it will cover the entire country.

## 2. Ethnic Groups in Project Areas

Region	Main Ethnic Groups
Kayes	Soninké, Fulani, Wolof, Moorish
Koulikoro	Manding, Bozo, Fulani
Mopti	Dogon, Fulani, Mossi, Songhoï
Bamako District	All ethnic groups are found in Bamako. Although each group tries to preserve its specific characteristics, bambara is by far the most commonly used language of communication, much more so than French.

Amongst these ethnic groups can be found:

- farmers (the majority): Soninké, Mandingue, Dogon, Songhoï, Mossi
- herders: Peul (note that with the increasing association of agriculture and animal husbandry many farmers are at the same time herders and vice-versa)
- fisherfolk: Bozo

### a) Time Tables

They organize their time as follows

Farmer Timetables:

- April-May: field preparation
- June-July-August: main cultivation period.
- October-November-December: harvesting, stocking, selling
- January-February-March: essentially a period of rest.

Herder Timetables:

- January-February-March-April-May: transhumance with free pasturing of the herd
  - June-July-August-September-October-December: daily guarding and care of the herd
- Note: this busy timetable explains why it is very difficult to involve herders in any activity.

Fisherfolk Timetable:

Occupied all day, every day of the year.

These timetables indicate that the target groups in the Project area are generally very busy. To contact them without disrupting their activities it is essential to establish with them in advance what are the most appropriate periods of the year and times of day. As for the inhabitants of Bamako District, regional centers and other secondary towns, they tend to be more stable and thus easier to reach.

In a country where the GNP per person does not exceed \$270, it is somewhat utopian to talk of urban and rural savings. The vast majority of the population in the Project areas do not really have access to money in the form of hard cash except for a very short period of the year: when trading crops. This money is always well programmed in advance to cover agricultural debts, taxes, and for prestige (e.g. marriages and feasts). Rarely would a part be reserved for health care even in the towns. When health-related expenditure is incurred, it is always seen and dealt with as a catastrophe affecting the family budget.

The issue of migration :

Some 5.4 percent of the total population figure for Mali consists residents who were absent at the time of the survey. In the Project area, the rates of "absent residents" were:

Kayes:	6.49 percent
Koulikoro:	7.11 percent
Mopti:	6.60 percent
Bamako District:	3.09 percent

This migrant population (absent residents) consists mainly of seasonal migrant laborers and female domestic workers. From the health point of view they constitute a highly venerable group as they tend to be poorly educated and have little or no access to health education messages. Sixty percent of "absent residents" are male and 40 percent are female. Approximately 14 percent of the total are in the age range 15 to 19 years old.

Eighty-three percent of "absent residents", migrate within Mali, 15 percent go abroad and two percent go to "unknown" destinations. Mopti and the district of Bamako are amongst the regions that receive the highest numbers of internal migrants. Bamako District alone for example, receives 43 percent of all internal migrants, Mopti 6.3 percent, Koulikoro eight percent and Kayes 5.6 percent. As for "visitors", 90 percent come from within the country, 6.6 percent from abroad and 2.4 percent from unknown locations.

Kayes and Sikasso have the highest number of foreign visitors and the lowest number of visitors from within the country. These foreign immigrants are from Guinea Conakry, Burkina Faso, Mauritania and Senegal. Migrants going abroad go to destinations in the Ivory Coast, Senegal, Ghana, Congo, Gabon, Cameroun and France. The percentage of returned migrants in Mali is 13.3, equivalent to 1,023,614 persons in total.

Note: The issue of migration needs to be carefully studied and taken into account in the design of counselling and health prevention strategies. Diseases need to be monitored on both a national and international basis.

### 3. Social Groupings in the Project Areas

In the Project areas the society is strongly hierarchical. It is a male dominated society where adult men hold all the power. The man providing he supplies the grain to feed the family, has complete authority over it. The woman, however, has an essential role to play and without her there would not even be a family: she cooks, provides ingredients for the sauce, does all the household chores, looks after the young children and is responsible for their upbringing especially that of the girls. She has precious little time left to take care of her own education and health. Children, if they do not go to school, make up the family's unpaid labor force.

The society is also gerontocratic. Elderly people are consulted on all matters regarding the community and they often constitute a barrier to the introduction of innovations, including those related to health. After the elderly the main leaders of opinion are the village political leaders (chief and counsellors) and, increasingly nowadays, retired civil servants who have settled back in the village, former migrants, men who are economically powerful and those who are literate. It is essential when setting up a project to obtain the collaboration of these leaders of opinion.

People of caste, such as the blacksmiths and griots, are found throughout Mali. They are both respected and feared as they possess special powers related to both magic and speech. Their opinions, strongly expressed, frequently weigh heavily in the community decision-making process.

The men of religion, the *imams*, *marabouts* and priests, are respected as being men of God. Also because they possess knowledge and learning. They are often consulted when the community has difficulty in finding a consensus. They must not be overlooked in a society where 85 percent of the population is either moslem or Christian.

#### 4. Potential Number of Projects Participants<sup>16</sup>

Religion	Men	Women	Total
Kayes	514 280	552 727	1 067 007
Koulikoro	587 715	610 253	1 197 968
Mopti	626 941	655 676	1 282 617
Bamako District	328 932	329 343	658 275
Total general	2057868	2 147 999	4 205 867

The source of this data does not given a breakdown by age but the population of Mali is known to be predominantly young. It can be assumed that the Project will involve more than half the total population of the country, all sexes and ages taken together.

#### 5. Project Feasibility

##### a) Administration

Decentralization is a keystone of Government policy. Local communities (collectivities) will be given responsibility for the main activities in their locality. All decision-making will thus be carried out at the local level. The fundamental issue therefore is whether prevention and awareness of sexually-transmitted disease and AIDS activities are perceived as a development priority by the collectivities? Have they been

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<sup>16</sup> RGPH, 1987 Tome 1. But for further details we will particularly refer to "Perspectives de la population résidente du Mali de 1987 à 2022" BCR, June 1992.

integrated into the program along with other development needs; if not, are they really feasible?

b) Organization

In the towns and villages, the population is organized into various political and apolitical associations, *groupements* and *tons* (traditional age-groups). With adequate guidance, the communities are well able to organize themselves and to participate in the implementation of health projects.

c) Geography, people and logistics

Is it in fact possible to be permanently represented in what amounts to half of Mali and to efficiently produce topical messages aimed to reach 50 percent of the total population?

d) Financial resources

Will the Project include an element of cost recovery? Will people have the means to contribute financially?

e) The efficiency of the personnel

Will the NGOs prove effective? Will government employees accept to collaborate with them? Will they not ask to be paid too? A priori, the Project will be feasible only if mechanisms for coordination and intersectorial collaboration are established and respected by all the parties, including the donor.

The population will not be keen to participate unless it perceives that the Project will lead to a genuine improvement. It is thus important that AIDS prevention and Awareness activities be linked to an existing project such as the large, multi-donor health project that already has the support of the people. Sexually-transmitted disease and AIDS, awareness and prevention projects, carried out in isolation from other development activities, would not appear particularly viable especially in rural communities.

6. Obstacles to Project Implementation

The obstacles to project implementation are social, political and religious in nature. Socially, not everyone believes that AIDS exists, people have traditional conceptions of how to treat disease and the majority do not perceive the pandemic nature of AIDS, and AIDS prevention challenges sexual traditions. Politically, people regard AIDS as a problem that only concerns the Ministry of Health, policies adopted to date are unambitious and do not involve the nation as a whole, and the government's lack of financial support for combatting AIDS demonstrates its limited priority. Religiously, Islam and the Catholic

church officially oppose the proposed means of protection (condoms). So, it will be difficult to develop a prevention method that can be publicized widely and will be acceptable to the majority of the population. Prevention and awareness activities are thus likely to benefit particular individuals as a matter of personal conscience, instead of something that manages to mobilize and involve the entire nation.

a) Critical Conditions

Certain conditions could put an end to the Project. One positive condition might be that a cure or an efficient vaccine against AIDS is discovered in the future. Under these circumstances the Project would no longer make sense. One negative condition could be that the religious authorities rise up in opposition to all AIDS projects. Awareness and prevention activities could then no longer be carried out as planned.

Finally, the Project will loose impact if it lasts too long. People are always eager to see results, an immediate impact, and care is needed if they are not to become bored and disinterested.