

# **END OF PROJECT REPORT**

## **Reproductive Health for Youth in Mali Project (RHYM)**

**Submitted to the U.S. Agency for International Development (USAID/Mali)  
by the Centre for Development and Population Activities (CEDPA)  
Cooperative Agreement # 624-A-00-97-00084-02**

**September 30, 2003**



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## LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARH	Adolescent Reproductive Health
ARI	Acute Respiratory Infections
ASDAP	Association de Soutien au Développement des Activités de Population (The Association for the Development of Population Activities)
ASEEM	Association Sikassoise pour l'Encadrement de la Mère et de l'Enfant (The Sikasso Association for the Training of the Mothers and Children)
CEDPA	Centre for Development and Population Activities
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
CS	Child Survival
CYP	Couple-Years of Protection
DHS	Demographic and Health Survey
DSR	Division Santé de la Reproduction (Division of Family Health)
EOP	End of Project
FGC	Female Genital Cutting
FP	Family Planning
GRADE Banlieue	Groupe de Recherche Action pour le Développement de la Banlieue (Research-Action Group for Rural Development)
GRM	Government of the Republic of Mali
HIV	Human Immunodeficiency Virus
IEC	Information, Education, and Communication
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MTE	Mid-Term Evaluation
MSP	Minimum Skills Package
NGO	Non-Governmental Organization
ORT	Oral Rehydration Therapy
PE	Peer Educator
PNLS	Programme Nationale de Lutte contre le SIDA (National Program for the Prevention of AIDS)
PRADO	Programme des Adolescents (under ASDAP)

PVO	Private Voluntary Organization
RH	Reproductive Health
RHYM	Reproductive Health for Youth in Mali (Project)
STI	Sexually Transmitted Infections
USAID	United States Agency for International Development
YD	Youth Development
YL	Youth Leader
YRH	Youth Reproductive Health

## **1.0. EXECUTIVE SUMMARY**

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### 1.1.Overall Achievements under the Cooperative Agreement

The five-year, \$6,206,757 million Reproductive Health for Youth in Mali Project (RHYM), represents a carefully documented and dynamic success story for the United States Agency for International Development (USAID), for the Centre for Development and Population Activities (CEDPA), and for Mali. Implemented under USAID/Mali's Youth Strategic Objective (1997 – 2003), RHYM dramatically improved the reproductive health knowledge, attitudes, and practices of approximately 633,000 young persons between the ages of 10 and 24 in Mali's first five regions. In 2002 alone, RHYM Peer Educators made more than one million contacts with their peers to promote sexual and reproductive health, as well as maternal and child health.

Using a highly innovative youth peer educator strategy, RHYM trained and monitored 2000 volunteer peer educators (PEs) between the ages of 15 and 24 over a period of five years. This was one of the largest groups in the world to engage in a peer educator strategy under U.S. government funding. Peer Educators were trained in reproductive health (RH) information, education and communication (IEC) skills specific to youth, as well as maternal and child health (MCH) and survival, and were well supervised by paid animators. Attrition was relatively low for the five-year intervention—approximately 20 percent over the life of the project (life of the project). Young people who had direct contact with the PEs ranked them first among their preferred source of family planning information (*Info-Stat 2002 KAP Survey*).

Three major KAP surveys over a five-year period testify to the progress and impressive momentum of the RHYM interventions. Many results compare favorably with the 2001 Demographic and Health Survey (DHS), including the fact that 52 percent of the general youth population in project areas used a condom at last sexual encounter compared with approximately 20 percent in the general population as registered by DHS. Other key results included:

- Use of modern contraceptives among targeted youth in the project area increased by 23 percentage points over life of the project, far surpassing the anticipated increase of 6%.
- Against an end of project (EOP) target of 35%, contraceptive prevalence rate (CPR) rose from a baseline of 29% in 1999 to 32% by the mid-term evaluation and 52% by the final evaluation.
- The percentage of the youth population (15-24) treated for sexually transmitted infections (STIs) by medical personnel in a health center increased by 9 percentage points over the life of the project.
- The percentage of assisted births for women under 19 years of age increased from 65.9% in 1999 to 93% at final evaluation.
- The percentage of young women who had had two prenatal consultations increased from 40.4% to 82.3% at final evaluation.

A qualitative study was also completed for Sikasso and Bamako areas, which provided a more in-depth analysis. One major discovery was that fear of infertility was a major barrier to young women's use of the pill or injectables. The qualitative study recommended that PEs be armed with cultural tools to combat misconceptions and rumors, including the supposed non-existence of AIDS. Another recommendation was that a more integrated approach be used, such as joint training sessions, to enable the PEs and health workers to work together, creating consistent and collaborative case management, regular feedback, and systematic monitoring. Going forward, the study proposed that piloting sessions whereby *griots* (storytellers, provided with high-quality information) work with parents to convince them of the importance of knowing how their children can protect themselves and to support dialogue in the household between parents and children that is initiated and sustained by the parents.

The relatively impressive achievements of the RHYM Project, quantified within the evaluation and validated by external studies, indicate that volunteer-based peer education is a highly effective strategy for behavior change among youth in Mali. It appears that changes in knowledge, attitudes, and practices (KAP) were more marked among the youth most closely involved with the project. However, less than one young person in five in the general population is aware of project activities. To increase project results and impact, it will be necessary for the PEs to contact a far greater number of youth. These accomplishments confirm that the RHYM strategy is not only replicable, but ripe for massive scaling up—an opportunity CEDPA believes USAID should be ready to explore in the near future—hopefully in collaboration with the Reproductive Health Division of Mali's Ministry of Health, which is now focusing on youth.

## **2.0. INTRODUCTION**

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### **2.1. Scope of the End of Project (EOP) Report**

The present EOP report covers the entire period of the RHYM Project, which began in October 1997 and ran through September 2002 with an added nine-month extension continuing the project until June 2003. The extension was granted to assure constructive transition of activities while USAID/Mali was completing and approving the new Country Strategy with the Government of the Republic of Mali (GRM) and conducting new procurement cycles. At USAID's request, the extension concentrated exclusively on family planning and STI/HIV/AIDS, omitting the maternal and child health/child survival (MCH/CS) component of the RHYM Project.

### **2.2. Goal, Purpose, SOs and Intermediate Indicators**

The goal and purpose of the RHYM Project activities were: to promote improved family planning (FP) and reproductive health (RH) for youth in Mali in order to increase demand for and use of RH services by youth. However, the three Strategic Objectives (SOs) for the RHYM Project were reduced to two under the extension (eliminating the SO to increase use of MCH/CS services), and the intermediate indicators were revised accordingly.

The present report gives a view of achievements under the RHYM Project separately aggregated for the initial RHYM Project (Table 1) and the extension (Table 2).

### **2.3. The RHYM Project**

The RHYM Project was a cornerstone of youth development efforts in Mali. It was designed to respond to the serious population and health challenges presented by the demographically disproportionate number of young people of reproductive age, who are among the most vulnerable groups in Malian society in terms of RH. Confronted with early marriage, high fertility, and limited access to FP/RH information and services, they in turn experience limited use of contraceptives, which results in rising numbers of unwanted pregnancies and subsequently abortion rates. At the same time, they register low levels of knowledge about STIs and HIV/AIDS and the factors that contribute to a rapid spread of the AIDS pandemic. To compound the problem, young people in Mali have limited employment options, limited educational opportunities, and systems that do little to encourage entrepreneurial initiative.

#### **2.3.1. Strategic Objectives**

The three SOs of the RHYM Project correspond to priorities identified in USAID/Mali's Strategic Objective for Youth: Changed Social and Economic Behaviors among Youth:

SO 1: To increase the use of contraceptives among youth in the project areas by 6%

SO 2: To increase the use of STI/HIV/AIDS prevention, diagnosis, and treatment services among targeted youth in the project area by 4%.

SO 3: To increase the use of MCH and child survival services by young mothers and their children in the project areas by 3%.

### **2.3.2. Intermediate Results**

The RHYM Project targeted the following Intermediate Results (IRs) by end-of-project:

**IR1:** Increased access for youth to RH services

**IR2:** Improved quality of RH services for youth

**IR3:** Increased promotion of RH responsive to youth client needs

**IR4:** Improved capacity to deliver quality youth RH information and services

### **2.4. The Extension**

The extension to RHYM continued technical assistance and support to community-based organizations and NGOs working with youth in FP/RH promotion and STI/HIV/AIDS prevention. It aimed at moving these interventions beyond awareness to behavior change. Under the extension, CEDPA provided training and organizational support to seven NGO partners and government (community) health workers in coordination with the GRM and other USAID implementing partners.

#### **2.4.1. Strategic Objectives**

The extension retained SOs 1 and 2 of the RHYM Project.

#### **2.4.2. Programmatic Results (PRs)**

The extension targeted the following programmatic results (PRs) by the end of the expanded program:

**PR 1:** Strengthened behavior change approaches, including communications materials, among vulnerable youth/adolescent groups

**PR 2:** Strengthened referral systems linking youth whose needs go beyond information and education with “youth friendly” health care or clinic services

**PR 3:** Promoted general contraceptive use for FP purposes, and condom use as dual protection.

### **2.5. CEDPA’s Approach and Contribution**

The RHYM Project design provided a secure framework for strengthening youth development through local partnerships with organizations capable of implementing a volunteer youth peer education strategy in RH. Using carefully established criteria (prior association with CEDPA, organizational longevity, local reputation, prior experience in

YRH, overall management capacity, geographical coverage, leadership, and gender considerations), CEDPA projected a total of 10 NGO partners to be recruited progressively over a period of three years. All partners were expected to implement the RHYM Project at sites where they were already established and integrated into the local community structures—health, education, and/or youth. The purpose of phasing the selections was to jump-start the program with the strongest local organizations, which would, in turn, help CEDPA/Mali reinforce capacity building for subsequent partners. The group would add other partners at the rate of approximately three per year, with the least experienced partners joining the project at a time when they could most easily be absorbed and supported.

The first NGO selected was ASDAP, which met all the criteria and remains the model of integrated YRH activities in Mali. The selection of Association de Soutien au Développement des Activités de Population (The Association for the Development of Population Activities) or ASDAP also resolved the problem of early coverage in the entire District of Bamako and in three of the five project regions (Sikasso, Koulikoro and Segou), where offices were already up and running. ASDAP was also well placed to provide policy guidance to CEDPA and serve as a leadership model to the other nine partners over the life of the project.

Sub-grants were provided to the NGOs to hire a supervisor to oversee project implementation, as well as one coordinator for each major project site, which could also cover adjoining sites. The 12 coordinators were responsible for local program implementation and worked with a team of animators. The animators were in turn responsible for training and supervising the PEs, mentoring “assistants” in the form of youth leaders (who were selected from the PE corps by the PEs), collecting and analyzing data collected by the PEs, and monitoring on-the-ground activities of the PEs for quality and consistency. The projected corps of 104 volunteer youth leaders was created to replace the animators at the end of the project and assure sustainability of the PEs in their respective communities.

All 10 NGO partners prepared their annual work plans and budgets with input from their local counterparts, i.e., community and regional health, education, and youth agents, who expressed a need for targeted training and/or refresher training for their personnel, as well as assistance in IEC, health referrals, and other services.

CEDPA/Mali provided programmatic and management technical assistance to the 10 NGOs over the life of the project, as well as on-the-job training and supervision, and monitoring and evaluation in the field. Progress was measured against baseline indicators by mid-term and final KAP evaluations.

Throughout RYHM, CEDPA exercised solid RH and youth development expertise, developing and implementing strategic partnerships with local NGOs, and increasing the technical and management capacity of the partners. Interventions also drew on CEDPA’s recognized worldwide experience and achievements in empowering women and young girls. A special focus on gender addressed gaps in sexual and reproductive health

knowledge and behavior and specific issues affecting only women, such as female genital cutting (FGC) and early marriage, as well as the challenges of recruiting adolescent girls into the PE corps.

CEDPA relied almost exclusively on NGO-sponsored peer education strategies to achieve project objectives. This experience has set the standard for quality peer education in Mali and offered an important resource to other USAID partners whose strategies include working with PEs. Also important to project implementation have been CEDPA's commitment to:

- Partnership based on mutual need and mutual exchange
- Capacity building
- Integration of youth in development, implementation, and evaluation of all activities
- Gender empowerment
- Network development for youth-serving agencies and for youth themselves
- Social mobilization and advocacy

### **3.0. DISCUSSION OF PRINCIPAL RESULTS UNDER RHYM AND THE EXTENSION**

### **3.0 DISCUSSION OF PRINCIPAL RESULTS UNDER RHYM AND THE EXTENSION**

The following summary is based on both Strategic Objective (impact) level indicators and Intermediate level (process) indicators for the RHYM Project from the February 1999 baseline to the July 2002 endline. Since project evaluations did not cover the Extension (October 2002-June 2003), only process indicators will be discussed for that period.

#### **3.1. Summary of Strategic Objective (SO) Results**

Impact exceeded EOP expectations for seven of the nine indicators.

##### **3.1.1. (SO 1) To increase use of modern contraceptives among targeted youth in the project area by 6%**

Use of modern contraceptives among targeted youth in the project area increased by 23 percentage points over the life of the project, far surpassing the anticipated increase of 6 percentage points. Against an EOP target of 35%, CPR rose from a baseline of 29% in 1999 to 32% by the mid-term evaluation (MTE) and 52% by the final evaluation.

##### **3.1.2. (SO 2) To increase STI/HIV/AIDS prevention, diagnosis, and treatment services among targeted youth in project areas by 4%**

Impact exceeded EOP expectations for two indicators:

- The percentage of clients purchasing condoms increased by 8 percentage points over the life of the project. The baseline of 26.5% had increased to 28.5% by mid-term and by the final evaluation to 34.5% against an EOP target of 30.5%.
- The percentage of the youth population (15-24) treated for STIs by medical personnel in a health center increased by 9 percentage points over the life of the project. The baseline of 53% decreased to 48% at mid-term, but rose to 62% by the final evaluation, against an EOP target of 57%.

However, the percentage of youth ages 15-24 using condoms increased by only 2 percentage points over the life of the project. Condom use was measured at 36% for the baseline, 30% for the MTE and 38% at final evaluation against an EOP target of 40%. Inexplicably, the percentage of condoms used as a method for STI prevention among youth ages 15-24 plummeted by 17.8 percentage points over the life of the project. The percentage increased from a baseline of 50.9% to 53.9% at mid-term, plunging to 33.1% at final evaluation, against an EOP target of 54.9%. The final percentage may possibly be explained by confusion regarding use of condoms as dual protection against pregnancy and STIs as opposed to STIs only, since considerable progress in use of the condom as dual protection was registered in both mid-term and final evaluations.

### **3.1.3. (SO 3) To increase use of MCH /CS services by young mothers and their children in the project areas by 3%**

Impact far exceeded the three percentage point increase targeted at EOP for all four indicators. The percentage of women less than 19 years of age who had an assisted birth increased by a total of 27.1 percentage points over the life of the project, from 65.9% in 1999 to 92% at mid-term and 93% at final evaluation against an EOP target of 68.9%. The percentage of young women who breastfed exclusively for four months increased by a total of 25.1 percentage points over the life of the project, from a baseline of 13.9% to 78% at mid-term to 49% at final evaluation, against an EOP target of 16.9%. The percentage of young women who had had two prenatal consultations increased by a total of 41.9 percentage points, from 40.4% at baseline to 64% at MTE to 82.3% at final evaluation against an EOP target of 43.4%. The percentage of mothers giving oral rehydration therapy (ORT) to their child within 24 hours of onset of diarrhea increased by a total of 25.8 percentage points, from 18.6% at baseline to 32% at MTE to 44.4% at final evaluation against an EOP target of 21.6%.

### **3.2. Summary of Intermediate Results (IRs) and Programmatic Results (PRs) over RHYM the life of the project (through September 30, 2002)**

Process indicators for the RHYM Project measured increased access to YRH services, improved quality of YRH services, increased promotion of RH to meet the needs of youth, and improved capacity to provide quality information on YRH.

#### **3.2.1. (IR 1) Increased Access to YRH Services**

On September 30, 2002, RHYM had a total of 10 NGO partners in five regions of Mali and the District of Bamako, covering a target population of 633,444 young people in the 10–24 age bracket out of a total population of 1,919,528.

The total number of PEs operational at the time were 1,916. Working with 60 Animators and 87 Youth Leaders, who were trained to assist the project Animators, the PEs covered 29 communities in the project area. The target communities housed 18 youth information centers—12 without clinics, and six with clinics pre-dating the project. Throughout the project area Animators and PEs were providing content, spots, and/or live discussions on YRH topics to at least 36 rural radio stations to assure access to RH messages. In 2002 alone, local stations transmitted 328 project-supported broadcasts dealing with themes of FP/contraception, STI/HIV/AIDS, the condom as dual protection, health consequences of excision and best practices in mother-child health for an audience of more than 1,914,274 youth. PEs were using approximately 2000 project-provided portable radios to listen to broadcasts with clients and use the RH messages as the basis for youth discussion groups.

#### **3.2.2. (IR2) Improved Quality of YRH Services**

As confirmed by intensive monitoring and on-site supervisory activities, project staff considered results in this category to be satisfactory by the end of September 2002 and

impressive by the end of the Extension in June 2003. The number of young clients purchasing contraceptives from the PEs had moved from an original baseline of 632 in 1999 to 35,011 in December 2001. By September 2002, the number had risen to 75,291, or more than double the achievement in the previous two-year period, and attaining 77% of the end of project target of 94,832.

The improved performance during the final phase of the project was largely attributable to strategies adopted by CEDPA/Mali and the NGO partners after the 2001 mid-term KAP study, which indicated that PEs were not sufficiently known by their clients. The new strategies (i) established contraceptive sales quotas and self-tracking systems by NGO and PEs; (ii) intensified the IEC activities of the PEs; (iii) used radio broadcasts to make the PEs better known as sources of contraceptive products; and (iv) provided the PEs with tee-shirts, badges, caps and backpacks in order to motivate them and permit them to be recognized by their peers within the context of their activities.

Taking these lessons into account, the Extension adjusted the EOP target upwards to 114,991 and registered record cumulative sales by PEs to youth clients: 42,203 condoms in nine months, for a cumulative total of 117,494 youth purchasing condoms from PEs (102% of the upwardly adjusted goal).

The number of youth referred for STI services by the end of September 2002 was 14,466, or only 16.5% of the initial end-of-project target of 87,308. Although this figure represented progress over the preceding two years, unresolved issues regarding barriers (unrefined tracking systems, economic restraints, the possibility of self-medication) continued to pose problems that were further examined under the Extension.

The number of young mothers referred to health services for high-risk pregnancies attained only 3,583, or 29.2% of the original EOP target of 12,232. However, as a result of the policy of phased training and interventions for the NGO partners (in order to assure absorption and quality), MCH/CS interventions were not integrated into the project until the fourth year. It is assumed that the target would have been reached had interventions in this area begun earlier or the target downwardly adjusted early on to take into account the shorter implementation period.

### **3.2.3. (IR3) Increased Promotion of RH to Meet the Needs of Youth**

RH promotion figures were excellent across the board. The cumulative total of youth counseled or educated in FP/contraception by September 2002 was 483,319, or 131% of the EOP target of 368,085, and for youth counseled or educated in prevention of STI/HIV/AIDS 458,721, or 142% of EOP target of 322,993. Finding their clients well-disposed to basic MCH/CS information, the PEs were able to counsel or educate a cumulative total of 274,112 young mothers in a relatively brief period, achieving 488% of the projected EOP target of 56,115. The number of youth reached by PEs on YRH through Youth Orientation Centers and project-supported clinics was 41,687, or 209% of the EOP target of 19,924. FGC counseling rates were 91.3% of the EOP target of

153,166—a relatively substantial figure given the PEs’ stated difficulty with treating this theme.

A considerable volume of IEC materials were produced and/or distributed by CEDPA/Mali and the NGO partners, including tee-shirts, caps, banners, posters, brochures, stickers, small portable radios, audio and video cassettes, and the *Journal des Jeunes*, a youth-generated newspaper treating RH themes. The recipients of these IEC materials were the PEs, the general population (youth) and the local NGO partners. Throughout the project, CEDPA and the partners also worked collaboratively with the John Snow, INC/PDY Project and the National Center for the Information, Education and Communication (CNIECS) for production of appropriate IEC messages and materials.

#### **3.2.4. (IR2) Improved Capacity to Provide Quality Information on YRH**

Over the life of the project CEDPA provided ongoing technical assistance in program, finance and administration to its 10 national NGO partners. With this enhanced capacity, the partners in turn trained a total of 2,397 PEs, including 87 dynamic and highly motivated youth leaders. During the same period, capacity building was extended beyond the traditional target groups to train or provide refresher training to 469 secondary targets (teachers, religious leaders, women leaders) and 376 government service providers in order to support the PE’s efforts in the field, and referrals of STIs in particular.

### **3.3. Summary of Programmatic Results (PRs) under the Extension (October 2002 – June 2003)**

Because of budgetary limitations, the nine-month Extension of the Cooperative Agreement could only directly support seven of the 10 NGO partners. In order to assure the continuation of the peer education strategy in the affected communities, the three NGOs no longer receiving direct support from CEDPA received modest sub-grants through one of the remaining NGOs, which monitored and reported their results.

#### **3.3.1. (PR1) Strengthened Behavior Change Approaches, Including Communications Materials, among Vulnerable Youth/Adolescents**

Programmatic results for counseling/education in FP as well as STI/HIV/AIDS were outstanding for the nine-month extension period, attesting to the rapid momentum that became apparent during the final year of RHYM and further accelerated during the extension.

The extension *alone* reached:

- More than a third of the cumulative total of young people targeted for counseling/education in FP over the life of the project. A total of 224,982 youth were counseled/educated in nine months, bringing the cumulative total for the Cooperative Agreement to 708,301, or 108.6% of the 651,634 overall objective

- Nearly half (49%) of all youth targeted over the life of the project for counseling/education in prevention of STI/HIV/AIDS. A total of 356,617 youth were counseled/educated in nine months, bringing the cumulative total of the CA to 815,338, or 112% of the total objective of 727,851.

Since the RHYM Project had already produced or made available 130.6% of the project's youth-specific IEC materials, this figure was not adjusted upwards for the nine-month extension. Nonetheless, the extension added four publications, bringing its contribution to 5.3% of the cumulative EOP achievement of 102 publications, or 136% of the EOP target of 75. Likewise, although RHYM had already achieved 91% of the counseling target regarding the consequences of FGC, the extension was able to make 13,580 contacts, or the remaining 9% of the cumulative EOP target of 153,166, bringing the cumulative total to 100%. As mentioned in a number of evaluative materials, the PEs found excision by far the most difficult thematic material, both in terms of client interest, which was perceived to be low, and in terms of the PEs' ability to approach the subject without embarrassment.

### **3.3.2. (PR2) Strengthened Referral Systems Linking Youth whose Needs Go Beyond Information and Education with «Youth-Friendly» Health Care or Clinic Services**

Results in this category also contrast very favorably with start-up figures. Given the numerous difficulties encountered within this framework prior to the extension (inadequate systems for tracking, possibilities of self-medication, and other issues), the EOP target for referrals, initially fixed at 87,308, was reduced to 25,228 with the agreement of USAID. Operating on the readjusted cumulative the life of the project target of 25,228, the PEs were able to refer a total of 19,188 youth over the life of the project, or 76%. Of these referrals, 4,722 young people, or 19%, were referred during the nine-month extension phase.

The indicator referring to the number of youth referred and treated in a health center was new under the extension. It was not previously measured as a process indicator under RHYM. The objective of this indicator was to be able to measure outside the KAP surveys (which did not foresee the distinction between referral and treatment) the percentage of youth referred who were actually *received* at the health centers. (NB: It is still impossible to determine within project parameters how many individuals referred were actually *treated*, since prescriptions are not necessarily filled at the referral site.) Of the 4,722 young people *referred* in nine months, 3,172, or 67%, were actually *received*. This result is fairly satisfactory and confirms the 62,3% cited under the Final Evaluation. In either case, the 60% objective set for the end of the project was more than achieved.

### **3.3.3. (PR3) Promoted General Contraceptive Use for Family Planning and Condom Use as Dual Protection.**

The PEs unquestionably succeeded in playing a major role in providing contraceptives to their peers. During the extension *alone*, 42,203 clients purchased condoms from PEs. This is more than half of the total number of clients who purchased condoms from PEs in

the previous four years (75,291), and 37% of all clients targeted under the the life of the project (114,991). A total of 117,494 clients were reached by PEs over the life of the project, or 102% of the total goal.

At the advent of the extension, CEDPA added an indicator on the number of condoms sold to youth in order to be able to compare this figure with the number of clients recorded in the same nine-month period. For the extension only, then, PEs sold 141,048 condoms to young people, or 83% of the targeted 168,963. Compared with the 42,203 clients having purchased condoms over the same period, this figure reflects sales of approximately three condoms per client over nine months, or an average of one condom per quarter per client. Otherwise calculated, of a total of 633,444 youth 10-24 years old targeted by the project, only 364,710 (aged 15-24 ) are sexually active and thus likely to have bought these 141,048 condoms sold over the nine-month extension. The sales activity carried out in the 29 project communities by the 1,916 operational PEs indicates a rate of eight condoms per month per PE or a mean frequency (use) of one condom per person per quarter.

Although this level of condom use by youth may appear to be insignificant, it is important to note, as cited in the Final Evaluation report, that an undetermined quantity of condoms is also dispensed to young people from other sources of supply—pharmacies, sidewalk shops, and free distribution. The project’s contribution to national distribution and sales of condoms to young people is encouraging. In terms of the number of condoms sold to youth by PEs, results seem unequivocally to emphasize positive behavior change operating at the intervention sites, with young people tending to move toward use of the condom as dual protection, an important goal throughout the preceding phase (Phase 4) of the RHYM Project.

#### **4.0. IMPACT OF THE RHYM PROJECT: KAP SURVEYS, FURTHER ANALYSIS AND QUALITATIVE EVALUATION**

#### **4.0 IMPACT OF THE RHYM PROJECT: KAP SURVEYS, FURTHER ANALYSIS AND QUALITATIVE EVALUATION**

In order to evaluate the achievements of the RHYM Project, several studies were carried out and are summarized within this section. Three highly comparable KAP surveys (baseline, mid-term, and final studies) were conducted over the life of the project (i.e., prior to September 30, 2002). In order to further crosscheck and enrich the “yield” of a number of findings in the three KAP surveys, further analysis was conducted around the themes of marriage (sexuality outside marriage, procreation outside marriage, use of modern contraceptive methods and especially the condom, knowledge of the activities of the PEs by the general population, STIs and their treatment, and FGC). Finally, a qualitative evaluation explored the dynamics, challenges, and impacts of peer education programs implemented by CEDPA’s partners in Bamako and Sikasso.

It is hoped that this rich body of knowledge will considerably enhance the documentation surrounding youth-oriented RH projects, including those concerned with STI/HIV/AIDS, and interventions employing PE methodologies (for any age or interest group), and will provide a continuing source of stimulation and information to Mali’s Ministries of Health, Youth, and Education, not to mention the development community at large. It is also of interest to compare various aspects of RHYM’s results with results of the 2001 DHS, if only to speculate on possible reasons for different rates of progress between the general youth population and the Mali population in general.

For purposes of the present report, summaries of pertinent results from each study are included in the sections that follow, while the comprehensive documents are provided under separate cover. No studies were conducted during the nine-month extension.

##### **4.1. Summary and Discussion of Some Principal Results of the Final KAP Survey<sup>3.1</sup>**

In 1999 the level of *knowledge* of modern contraception was 84% in the general youth population of the project area. By 2002 the levels were 98% in the general population, 99% for direct contacts and 100% for PEs.

The *use* of modern contraception in the target areas has likewise regularly progressed since 1999, when the baseline CPR was 29%. In 2001 the CPR ranged from 32% for the general population to 63% for PEs. The corresponding levels in 2002 were even higher: 79% for PEs, 76% for direct contacts, and 52% for the general population.

As use of contraceptives increased, the proportion of individuals who state their future intentions to start using contraception has appropriately decreased. Thus in 2001, 73% of the general population stated intended future use, while in 2002 only 64% stated intended future use—i.e., 2001 non-users expressing intent to use had presumably become users by 2002.

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<sup>3.1</sup> Summary from the 2002 KAP survey of the RHYM Project by Info-Stat

In 1999 only 63% of youth knew at least two methods of protection against STIs and HIV/AIDS. By 2001, this figure had reached 89% for the PEs and 74% for their direct contacts. It is noteworthy that while in the general population there was little increase in the first half of the program, there was a positive increase from 63% to 72% by 2002.

At the present time 65% of PEs have used a health center or a medical agent for the treatment of an STI, and figures for direct contacts (60%) and the general population (62%) are almost at the same level. (At the beginning of the project, only 53% of the baseline population had ever used these facilities.)

The current level of condom use during last intercourse was 38% for the general population, 61% for direct contacts and 66% for PEs. (In 1999, the baseline was at 36% overall.) The increase in condom use during non-marital sex was even greater. Among the general population, the proportion of youth who always used condoms in this category of contact had risen from 32% in 2001 to 51% in 2002.

Young people are also much more aware of the dual protection afforded by the condom. At the beginning of the program, only 9% used the condom for prevention of both pregnancy and STIs. By 2001, 41% of the PEs, 32% of their direct contacts, and 23% of the youth in the general population were aware of the dual protection afforded by the condom, and by 2002, the level of awareness was at 46% for PEs and 52% for direct contacts and the general population.

In the 1999 baseline, 63% of the general youth population would have refused sexual contact with a partner who refused to use a condom. In the 2002 KAP, a significant majority of young people (82% of PEs, 76% of direct contacts, and 62% of the general youth population) declared that they would refuse sexual contact with a partner who will not use a condom. However, the 2002 percentages are lower than those of 2001, which registered 87%, 83% and 70% respectively. (NB: Paradoxically, in the same interval, use of condoms increased.)

The proportion of individuals who would accept excision or FGC for their daughters was 72% in 1999. By 2001 the level had dropped to 65% in the general population, with a notable decrease among direct contacts (to 43%) and PEs (to 9%). By 2002 the figure had dropped to 29% among the direct contacts.

In the area of MCH, the PEs had a much higher level of knowledge than the direct contacts and the general population. (NB: This portion of the evaluation covers only two years, since MCH interventions began later than YRH.) On the whole, the level of knowledge had increased between 2001 and 2002, with the greatest progress having been made by the PEs, as noted. For example, in 2001, 61% of the PEs understood the use and composition of oral rehydration therapy (ORT), and by 2002 this level had risen to 95%.

Although it is difficult to register substantial behavior change in MCH in this brief interval, it is still possible to note that while the practice of prenatal consultations has

progressed, the number of medically assisted births has not changed significantly. Exclusive breastfeeding and the use of ORT actually decreased from 2001 to 2002. (NB: These results must be considered with some reservations, since the two studies were not executed in ideal conditions in terms of evaluation of corresponding indicators. In addition, the results of the two-year study did not cover identical geographic areas.)

At the beginning of the program, only 15% of the young people had participated in an IEC session led by a PE. Since 1999 this situation has seen a positive change, particularly in 2002, when almost all of the direct contacts had participated in some type of group discussion. Whereas it is true that the data do not suggest a great difference between 2001 and 2002, a positive evolution has still occurred among the direct contacts, accompanied by a similar tendency among the general population.

Referrals made by PEs did not increase between 2001 and 2002. The proportion of youth who said they visited a health center as a result of referral by a PE actually decreased in 2002.

In addition to these general indications of project impact, certain other results of the 2002 study are worth noting. Some were already mentioned in 2001, while others are new and indicate a change during the period since the mid-term evaluation. Most young people who heard about contraceptives know where to find them. In general, the three most frequently cited sources of contraceptives were the pharmacy (78 %), shops or stands (68 %), and health centers (47%). Along with the pharmacies, the PEs are the best-known source of contraceptives among direct contacts. Likewise, PEs, along with the radio and television, are the preferred source of information for all aspects of RH (FP, STI/HIV/AIDS and FGC). However, few members of the general youth population seek contraceptives from PEs, since their role in this regard is not widely known (20%).

In terms of both knowledge and use of PEs as providers of contraceptives/condoms, considerable progress was made between the mid-term and final evaluations. This holds true for both direct contacts and for the general population. The number of young people in the general population seeking condoms through PEs has doubled in the past year, and although the direct contacts in 2001 were more familiar with the pharmacy than the PEs as a source of contraceptives, this is no longer the case.

Spermicides are included among the four contraceptives promoted by the project, yet they are not as well known and less used than pills, condoms, or injectables. Even among the PEs, spermicides are not a favored method.

In general, the majority of young people agree that AIDS is a reality in Mali and that appropriate care should be given to persons living with HIV. The majority of participants also believe that one may drink or eat with the infected person without risk. However, 25% of the young people in the general population do not agree that AIDS is an illness that can strike anyone, and almost half (49%) believe that it is a punishment from God. The idea of AIDS as a divine punishment is still found in significant numbers among the PEs (28%), as well as among their direct contacts (41%).

Almost all young people in the project area have heard about excision or FGC. In fact, the information gathered indicates that contact with the project had a great influence on opinions and attitudes towards the practice. Nonetheless, religion still seems to figure as a predominant factor in favor of excision. In 2002, 30% of the PEs still believed that the practice is dictated by their religion. However, there has been some progress in this regard since the mid-term evaluation, when 41% of the PEs still connected excision with religious constraints.

Use of modern contraception is still higher among young men than young women, specifically condoms. A question concerning condom use at last intercourse indicated much lower levels of use among young women than young men. This situation may reflect understatement on the part of the young women, but it could also indicate differences in perceptions and attitudes between the two sexes with regard to condoms. Among the general population, for example, 32% of the young women, but only 13% of the young men, said they would be willing to have unprotected intercourse if the partner refused to use a condom.

Between 2001 and 2002, progress in using modern contraception/condoms was more marked with young men than young women. Among young girls in the general population, modern contraceptive prevalence rose from 22% to 33%, while for boys in the same category, the current level is 71%, compared to 41% in 2001. Still looking at the general youth population, but with regard to use of the condom during last intercourse, there is hardly any change in behavior in the female population (12%), while the male level rose from 49% (2001) to 65% (2002).

In the regions, the least encouraging results were reported for Kayes and for Ségou. Fewer young people in these two areas recognize the signs of STIs and know how to protect themselves, and fewer know the benefits of the condom as dual protection. Knowledge of appropriate practices in MCH is also much lower in these two regions.

Overall, the previous results show that important progress has been achieved since the beginning of the RHYM Project. At the time of the mid-term evaluation, progress was already visible. It increased significantly between 2001 and 2002, with the most important advances occurring in the area of improved knowledge of sound practices in MCH and in the use of condoms and other modern contraceptive devices.

Beyond these positive indications, it appears that changes in knowledge, attitudes, and practices (KAP) were more marked among the youth most closely involved with the project. Thus the most dramatic shifts in KAP were observed among the PEs, who were trained through the project. Changes in KAP among youth who were in direct contact with the PEs were likewise more marked than in the general population. In 2002, there was a narrowing of the gap in certain cases among the KAP of the PEs, their direct contacts and the general population—for example in the area of use of modern contraception and condoms in sexual intercourse outside of marriage, and in the treatment of STIs. The narrowing gap among the three groups would seem to indicate a

general (and fortunate) tendency among young people to take advantage of new information to improve their attitudes and behavior in the area of reproductive health. It would also seem to indicate that the PEs are accomplishing their mission.

In order to carry on with the current positive evolution, the principal recommendations are similar to those made in 2001. The project should take every opportunity to reinforce behavior change strategies. It will be particularly important a) to encourage the maximum possible number of young people to come into contact with the project, b) to promote the PEs actively among their target groups, and c) to concentrate on PEs, rural radio and television as the primary sources of information for young people. Finally it will be important to take into account the differences between the sexes and among geographic areas.

#### **4.2. Examples of Results and Observations from Further Analysis of the Three Sets of KAP Survey Results<sup>33</sup>**

Further analysis of the three sets of KAP survey results concluded that one of the most important challenges for the future is to substantially increase the base of young people who are aware of project activities. Less than one young person in five in the general population is aware of project activities. To increase project results and impact, it will be necessary for the PEs to contact a far greater number of youth.

At the same time, the study noted that although numerous observers still question the validity of RH/FP programs, believing them to be extravagantly funded and without tangible results, these individuals focus essentially on global indicators such as the contraceptive prevalence rate for an entire population. « Such a focus allows us to deplore a contraceptive prevalence rate of 4% or 6% respectively for women in union in Mali according to DHS 2 and DHS 3, and gives an impression of resistance to change on the part of population. However, in reality, these changes are already underway with young men and young women who have nothing to do with the 6% of Malian women of childbearing age. This is equally true for young married women, even if the major objective of marriage for them is still childbearing.

The study continued to say that the RHYM Project has demonstrated that youth's demand for RH/FP services is high. "Investing in adolescents and young adults permits us to promote healthy RH behavior [for the next generation of parents], which will in turn be adopted quite naturally by their children.... Regardless of the fact that a good deal remains to be done, the PEs are still RH models for young people their age." Even after controlling for a certain number of variables (level of education, age, matrimonial status, exercise of a revenue-generating activity), the PEs exhibit behavior that is clearly more health-seeking than that of youth in the general population. The direct contacts of the PEs likewise exhibit greater health-seeking behavior than that of the other youth in the general population. And in the latter group, those who are aware of the activities of the

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<sup>3.3</sup> Extrait de "Résultats des Analyses Approfondies des Données du Projet SRJM" du Dr M. Guèye, CAREF

PEs or have participated in even a single session animated by the PEs also seem to have healthier behaviors than other young people in the general population. These observations illustrate the effects of the RHYM Project.

Although the analysis recognizes considerable progress between the mid-term and final evaluations in terms of the general population's knowledge of the activities of the PEs, more than four out of five young people in the general population still did not cite the PEs as a source of contraceptive supplies.

Analyzing the characteristics of the PEs, the study indicated that they are considerably older than the rest of the general youth population, with more bachelors degrees among female PEs than among females in the general population. Many more female PEs have been to school than have the females in the general population.

The prevalence of early marriage is weak, but not negligible, for girls. However, increasing numbers of young girls remain unmarried in the 20 to 25 year-old bracket, augmenting the risk of sexual relations outside marriage and the multiplication of sexual partners

The level of condom use was high for male PEs who engage in sexual intercourse. Condom use still remains quite low for female PEs and seems even to have decreased. The differences in levels of condom use are even greater between boys and girls in the general youth population.

Girls register a very high number of STIs. A certain proportion of these cases are probably attributable to symptoms not associated with STIs, but the remainder may be attributable to lack of condom use. Referrals for STIs are more frequent among the PEs, but there is room for improvement.

The study noted a positive correlation between listening to the radio and using condoms for males but not for females.

The probability of having sexual relations for boys is higher when the boy is engaged in income generating activities. The results are unclear for girls. The probability of using a condom is clearly higher when the boy exercises an income-generating activity, but the same effect is not observed with girls engaged in income generation.

### **4.3. Summary of Conclusions and Recommendations from the Qualitative Exploration of Peer Education Dynamics, Challenges and Impact<sup>3.2</sup>**

#### **4.3.1. Conclusions**

The RHYM programs represent timely and appropriate responses to the sexual and reproductive health needs of young people in the two cities of Bamako and Sikasso. It is clear that there has been a great impact on the clients of the PEs and on the PEs

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<sup>3.2</sup> Findings extracted from "Peer Education Programmes Implemented by CEDPA's Partners in Bamako and Sikasso" by Sarah Castle.

themselves, not only in improving knowledge and changing behavior but also in strengthening psychological resources for sexual health such as self-confidence and self-esteem. There appears to have been less of an impact of the programs on the wider community, including parents and societal gatekeepers. These groups were peripheral to the programs, although in general they approved of the aims and goals of peer education.

The factors that account for improved knowledge and attitudes in Bamako compared with Sikasso are not clear, as the quality and effect of the programs seemed similar in both cities. Clearly, the ASDAP/PRADO center is better resourced and more multi-faceted, consistently attracting a clientele of interested and informed young people. However, the community-based, smaller-scale activities of GRADE-Banlieue and ASEEM also found favor with most clients and were, in general, highly effective within the environments in which they operate.

Rather than actually reflecting the characteristics of the programs, the better performance of Bamako's respondents in the quantitative study may be due to the fact that the clientele of PRADO seem to be more educated (with many in higher education) and appear to be slightly older. They are thus more likely to understand and apply sexual health information gained from the peer education program and elsewhere. In addition, the more modern environment of the capital city, with greater media exposure and more widespread urban dynamism, means that safer sexual health messages are reinforced in many ways to young people in this city compared with a regional capital such as Sikasso.

More specifically, the programs appeared to have a significant impact on role of the PEs in the community. They accrued respect and admiration from their peers and other community members and were able to intervene in social disputes where sexual health matters were an issue. This, in turn, strengthened their leadership qualities, their perceived self-efficacy, their public speaking and advocacy skills and is likely to make them a valuable resource within their peer group for years to come. The negative aspects of being a PE relate to the fact that certain discussions result in their being subjected to hostility and insults from a number of clients. In particular, when educators tried to counter clients' disbelief in AIDS and their positive view of excision, they were often insulted and rebuffed. In addition, in Sikasso it appeared the sale of condoms by female educators sometimes resulted in their being viewed as 'loose' by others in their community.

The program, which aimed to reduce HIV risk, appeared to have a fairly high impact according to the testimonies of clients who cited both a decrease in number of partners and an increase in condom use. Nevertheless, both clients and non-clients were knowledgeable about the modes of transmission and methods of protection. Condom availability among clients was greatly enhanced by the program although non-clients reported little difficulty in accessing condoms from shopkeepers and other sources. In addition, the programs succeeded in breaking down barriers to discussions about sex relating to shame and embarrassment. One of the main impediments to condom use, particularly among non-clients, was the belief that they actually would cause infection (including infection with HIV). However a greater barrier to their use was the widespread

rumor that the AIDS pandemic was a phenomenon invented by the West to encourage condom promotion so as to curb the growth of the African population. Peer educators cited this as the greatest impediment to their discussions about HIV.

Motivations to use other methods of family planning related to the beliefs that an early pregnancy would physically weaken a girl and slow her growth, interrupt her studies, and lead to social conflict within her family if it should occur before marriage. In particular, the non-recognition of a child by a father could lead to abortion with consequences to the girl's health and subsequent fertility. Although participants had access to contraceptives through the program, the most noteworthy finding regarding fertility regulation was the widespread belief that both pills and injectables (but particularly the pill) caused long-term sterility and would leave a young woman unable to conceive after marriage. The method of contraception favored by young women was the condom, as they believed that it did not threaten their long-term fertility. While on one hand this is good, as it facilitates dual protection, it is negative in the sense that it relies on male acquiescence and comprehension.

The majority of clients were able to cite the negative consequences of excision ranging from sexual dysfunction, problems in childbirth, and hemorrhage. Non-clients tended to be more in favor of the practice citing the fact they believed it to facilitate labor and that non-excised women were likely to have uncontrollable sexual desires that would weaken them and their partners. However, interestingly and despite the clients' improved knowledge of the risks associated with excision, the majority, including all the male interviewees in Bamako, said that they would excise their daughters. The main negative consequence of not excising was that the child would be called a "*bilakoro muso*" – an insult implying that she is not a true woman and that she is dirty and not fit to socialize with excised women. PEs perceived the main barrier to counteracting excision was that people believe it to be required by Islam. However, among young people, the need to avoid being considered a "*bilakoro muso*" was much stronger than the religious arguments in favor of the practice.

Regarding referrals to health care providers, there was a degree of dissonance between the educators and providers' perspectives. The educators felt that the system worked effectively and recounted how they referred clients regularly, albeit in limited numbers. The providers felt that they saw very few cases (except those based in the PRADO centre). However, they did note that the number of young people referring themselves had increased in recent years and it may be that they are attending clinics but forgetting to bring the reference forms. Nevertheless, none of the clients interviewed had been treated for what they perceived to be an STI at a health facility.

The main complaint by both the educators and the affiliated health personnel was that there was so little contact between them and virtually no follow-up with the referred cases. This indicates the need for more regular communication between the two groups with perhaps more collaborative work in terms of awareness-raising and patient management. In particular, for themes that are difficult to convince their clients (such as

the existence of AIDS), the educators requested the assistance of health personnel at their chats and debates to provide more official and clinical information.

Clients were asked about the centers in the three cities and whether they found them to be suitable, friendly, and interesting. In Sikasso, ASEEM's centre was not as actively used as GRADE-Banlieue's but it was considered to have a good atmosphere and clients of both sexes felt welcome. GRADE-Banlieue's centre was used, primarily for musical rehearsals, but some female clients found it somewhat intimidating. It seemed to have a reputation as being a place where young men and women went to meet each other (to seek sexual partners) and, as such, girls were afraid of getting a bad reputation by going there. In Bamako, PRADO's centre was well appreciated by the educated clients as it had a lot to offer, such as a cyber café and sports activities. However, uneducated clients found it less appealing, some not even knowing that they could use it.

ASDAP's clients who used the PRADO centre were often drawn to the cyber café and possessed computer skills that enabled them to access the Internet and thus increase their contact with the outside world. However, a number of clients had very negative or unpleasant experiences, almost comprising sexual harassment, by people they met in cyberspace. This points to a very clear need for education on Internet safety and anonymity and for the development of Internet skills to enhance education and learning rather than just as a medium for chat.

Turning to communication, young people tended to confide their reproductive and sexual health problems to a best friend or confidante, although a number of clients in Bamako said that they would confide in their mothers. It transpired however, that there is likely to be a self-selection of young people into the program where sexual health communication is already developed. In general, most said that the program did not directly increase parent-child communication. Nevertheless, participation in the peer education sessions may have served to develop indirect communication skills between clients and their mothers and fathers and to foster better discussions with members of their extended families. The general consensus was that there were limited opportunities for improving communication, but that it has to be the parents who initiated the debate within the household; otherwise the child would be considered impolite if s/he brought the subject of reproductive health up first.

The parents who, in general, were relieved that the peer education program took on the responsibility for sexual health education reiterated this view. They expressed a desire to leave young people to inform each other and did not want to take on such a role as they found it embarrassing and shameful. A select number of participant's mothers in Bamako said they communicated better with their offspring since they had participated in the program. However, fathers of clients and non-clients reiterated almost universally that they had no wish to initiate or pursue such discussions.

The "societal gatekeepers" (*griots*, or traditional praise singers; Koranic scholars, muezzins, preachers and other religious leaders; teachers) who had heard of the programs were generally in favor of them although many saw young people's sexual health

problems as being something that the latter had brought upon themselves by following a non-Islamic lifestyle. However, many proved to be remarkably keen to play a role in the programs and indicated that, in particular, they could work with parents to help them better understand their children's situation and to increase parent-child communication. Some had erroneous beliefs about the side effects of contraception or about methods of HIV transmission, but it was clear that, if they had good quality information, selected gatekeepers (and in particular *griots*) could be an asset in mobilizing parents to support safer sexual behavior of their offspring.

#### 4.2.2. Recommendations

- The program has an important effect on the educators themselves by increasing their leadership and advocacy skills. *As the educators move out of the age range targeted by the programs it would be useful to harness their knowledge and enthusiasm to train future generations of educators and to support them in their work*
- The programs did an excellent job of addressing accessibility issues vis-à-vis condoms and in providing facts about HIV and family planning. They have also done an excellent job in breaking down barriers having to do with embarrassment and shame and in facilitating open discussions about reproductive health. *However, all three programs need to arm educators with the cultural tools to combat the many misconceptions and rumors that exist, particularly concerning the supposed non-existence of AIDS and the belief that modern methods of contraception lead to long-term sterility.*
- The referral system does not seem to work effectively (except at ASDAP/PRADO where the providers are actually located in the Youth Center). *The importance of the referral form needs to be emphasized to educators and their clients. At the same time the providers seeing clients at the health facilities need to ask if they have been referred and all cases needs to be systematically noted and followed up. Establishing an accurate reporting system of referrals and treatment follow-up could provide wonderful insights not only into the impact of the program but also into the epidemiology of reproductive health problems among both clients and non-clients. The noting of the client's age on the form should be made mandatory and forms should be standardized between programs.*
- A more integrated approach needs to be taken to enable the educators and the health workers to work together. At the moment there is a sense of frustration on both sides because of a lack of contact. *Joint training, consistent and collaborative case management, and regular feedback need to be introduced to the programs and systematically monitored.*
- The Internet can be used as an important tool to enhance learning about reproductive health and to support safer sexual behavior. At the same time it can also be a source of danger in that many people surfing the net and using chat

rooms are not what they seem. Safety issues need to be taught to cyber café clients at ASDAP/PRADO and to all Internet users. In addition, a joint initiative with “Keneya blown” in Bamako may yield important and effective improvements in the use of the Internet and comprise a great resource for answering questions and in guiding discussions. *‘Keneya blown’ (lit. ‘the hallway to health’) (<http://www.keneya.org.ml/>) is a Bamako-based initiative for medical training and for the diffusion of medical information run by young, dynamic graduates of Mali’s medical school. It would be perfectly feasible to have them manage a site for ASDAP/PRADO’s cyber café clients and other young people in Mali where chats and debates could be managed on-line and information about sexual health could be posted along with replies to any questions young people may ask. Newsletters (from CEDPA, PSI and others) and other relevant material could be posted on the site that could be developed as a real alternative to the chat sites currently accessed by some users.*

- The involvement of parents in young people’s RH is a complicated issue that cannot be easily resolved without alienating both parties. There is a lack of willingness of young people to talk to their parents whilst the latter profess to prefer that others communicate with their offspring. If parental communication is to be increased (and it is debatable whether an attempt to increase it would really be beneficial) this can only be done in specific and limited ways. This will necessitate awareness-raising by other adults whom the parents respect and who can convince them of the importance of communication. There is thus a real role for gatekeepers such as *griots* to work with parents to persuade them of the importance of not only open and frank discussions with their children, but also of encouraging indirect methods of communication. Directly intervening with parents, at least in the beginning, is unlikely to work unless they have been gently introduced to the idea by other community members for whom they have a high regard and to whom they listen. *It may be worth piloting sessions whereby griots (with high quality information) work with parents to convince them of the importance of at least knowing how their children can protect themselves. If this is accepted then the peer educators could work with parents directly to establish a dialogue in the household but making sure that the parents, rather than the children, initiate and sustain it.*

## **5. 0. DISCUSSION OF COSTS AND COST-EFFECTIVENESS**

## **5.0. DISCUSSION OF COSTS AND COST-EFFECTIVENESS**

In addition to having produced results that exceed targets, the 69-month tenure of the RHYM Project was cost effective. The following discussion breaks down funding under the project into expenditures under the sub-grants with the NGO partners and expenditures by CEDPA. It also examines costs for a number of project beneficiaries—total population and target youth population in the project zones, PEs, direct contacts of the PEs, government health workers, and secondary targets such as parents of the PEs, teachers, and religious leaders.

In each case, the costs are reasonable, if not minimal, when compared with the cost to society of poor RH, including STI/HIV/AIDS, among its young people. The average prescription for treating a single episode of an STI costs approximately \$2 in Mali—a sum not easy to come by in rural areas. In contrast, a direct contact session in which a PE promotes YRH and MCH via chats, conferences, home visits, and counseling to another peer represents an average cost of 24 cents per year, or \$1.38 over a 69-month life of the project. Looked at from another perspective, it costs approximately \$150 per year to maintain a volunteer PE in the field (including all technical assistance, training and operational support)--the equivalent of treating 75 cases of STIs. However, we know that a single PE annually counsels an average of 75 young people on prevention of STI/HIV/AIDS.

### **5.1. Sub-Grants to the NGO Partners**

Sub-grants to the 10 NGO partners during the 69 months of the project (RHYM + extension) totaled \$2,941,565, or approximately 50 percent of the total grant under the Cooperative Agreement. This corresponds to an average budget of \$51,156 per NGO per year, or a total of \$294,157 per NGO for the five years and nine months of the total project.

This contribution permitted the NGO partners to cover:

- Project operational costs including salaries for approximately 100 employees (either full or part-time in the 10 project offices and at field level) and a proportion of NGO office administrative costs.
- Field-based training activities and technical support for 2000+ PEs and approximately 850 government (community) health workers and secondary targets (parents of the PEs, teachers, religious leaders, women leaders).
- Community-based IEC/BCC activities, including materials rural radio broadcasts and organization of special events.
- On-site supervision, monitoring, and evaluation.
- VCRs and sound systems, and electrical generators, low-cost portable radios and motorcycles for supervisory staff.

## **5.2. CEDPA's Portion of the Grant**

The remaining 50 percent of the money permitted CEDPA to:

- Reinforce the technical and financial/administrative capacity of the 10 NGO partners and other institutions involved in project implementation (including US-based institution-building and leadership training for the NGO Directors and local training and backstopping/mentoring for local personnel, and annual centralized training of supervisors, animators and Youth Leaders);
- Design, test, and produce training and IEC curricula and materials (in collaboration with JSI/PDY and other partners);
- Train select government partners in the field;
- Design and implement continuing quality improvement (CQI) systems (including supervisory systems); and
- Monitor and evaluate project activities for impact, intermediate targets and qualitative results (three KAP surveys, further analysis of the KAP surveys at EOP, and a qualitative comparison of interventions in project sites in Bamako and Sikasso).
- Cover operating costs, salaries and overhead for the Bamako offices and CEDPA/W.

## **5.3. Average Cost of Technical Assistance to Field-level Beneficiaries**

Under the Cooperative Agreement, CEDPA and the 10 partners provided technical assistance (training, refresher training, monitoring and supervision, capacity building) to approximately 3,432 beneficiaries in the field, including:

- 2,397 PEs (1,223 boys and 1,174 girls)
- 86 project employees (62 Animators et 24 Supervisors)
- 104 Youth Leaders
- 376 government (community) health workers
- 469 secondary targets (parents of PEs, teachers, religious leaders, women leaders, traditional practitioners of excision).

Each of the 3,432 beneficiaries (including the 2,397 PEs) listed above represents an average cost of \$12.50 per month, or \$150 per year.

## **5.4. Average Cost for Total Population and Target Population in the Project Zones**

Located in five regions (Kayes, Koulikoro, Sikasso, Ségou, Mopti) and the District of Bamako, the 29 project communities covered a total population (all ages) of 1,919,528 and a target population of 633,444 young people age 10-24.

The average monthly cost is 2 cents per inhabitant (all ages) and 7 cents per young person 10 – 24 years old, or respectively 24 cents and 84 cents per year.

### **5.5. Average Cost for the Youth Population Contacted Directly by the PEs (Direct Contacts)**

The PEs over life of the project made more than 2 million direct contacts with their peers (youth 10 – 24 years old) to promote youth reproductive health (YRH) and mother/child health (MCH) via chats, conferences, home visits, and counseling. Each of these contacts represents an average cost of 24 cents per year, or \$1.38 over life of the project.

### **5.6. Training Costs for PEs and Other Target Groups in the Field**

Four types of training sessions were offered throughout project implementation: basic training of the PEs (10 days per session), refresher training of the (5 days per session), MCH training of the PEs (5 days per session), service provider training (6 days per training session) and training of secondary targets (5 days per session). Budgetary line items for the expenses include transportation, food, rental of training/meeting rooms, office supplies, per diem for service delivery personnel (government).

Training represents per session and per participant an average cost of \$98 for basic training, \$58 for PE refresher training, \$53 for MCH training, \$127 for training of government service providers and \$52 for training of secondary targets

### **5.7. Conclusion**

These costs are relatively modest considering that the improved knowledge of the PEs, their direct contacts, and even the general population undoubtedly permits them to avoid cases of STI/HIV/AIDS, at risk and unwanted pregnancies, and even excision. In addition, the PEs and Youth Leaders will henceforth constitute permanent and ongoing resources for their communities of residence and for their own future children.

Likewise, the 10 NGO partners can capitalize on the RHYM investment in essential equipment (electrical generators, motorcycles, audio-visual equipment, computer equipment) for a number of years to come, continuing activities with a relatively reduced investment in hardware. These longer-term material investments have been efficiently and effectively transferred to the NGOs for continuing use in their beneficiary communities.

Costs could be considerably reduced in coming years with the implication and participation of the communities, who might provide office space and meeting/training rooms to the NGOs, and continued collaboration with the Youth Leaders, who can cover certain components of the project as volunteers in the future. Increases in the beneficiary population (as a result of replication and scale-up) could also result in significant economies of scale.

## **6.0. PROBLEMS ENCOUNTERED AND LESSONS LEARNED**

## **6.0. PROBLEMS ENCOUNTERED AND LESSONS LEARNED**

Although neither RHYM nor the extension encountered serious problems, it is still relevant to refer to falling currency exchange rates for the U.S. dollar throughout the period of the extension. It seems likewise important to evoke briefly a number of other issues that arose with a certain regularity throughout the project but remained for all practical purposes unresolved—either because RHYM did not manage to find the answers (as with STI referrals), or because they are the kinds of questions all projects encounter and only resolve within a larger audience. These recurring issues, familiar and somewhat cyclical, concern distribution of free contraceptives versus sales at government rates, the higher costs to the project of training government health workers (as opposed to other agents), and the principle of volunteerism for youth PEs versus payment for services.

### **6.1. Problems**

#### **6.1.1. Falling Currency Exchange Rates Against the Dollar**

From October 2002 through June 2003 (or the entire extension period), the rate for the dollar fell dramatically in comparison with the FCFA—from FCFA 655.75 /\$1 to FCFA 545/\$1. This depreciation occasioned a loss of approximately \$67,007 for the period of the extension. In order to maintain the original program for the extension, CEDPA distributed the loss across a number of line items rather than allowing the reduction in funding to have a negative impact on a particular activity.

#### **6.1.2. STI Referrals**

The cumulative number of STI referrals more than doubled during the last two years of the project. However, this corresponds to less than 20 percent of the EOP objective, initially fixed at 87,330 and eventually lowered to the more realistic figure of 25,228 under the extension.

One possible explanation for the weak rate is that youth do not systematically report their symptoms (even if they are able to recognize them). Another possibility is that at the same time the RHYM Project is registering improved results, the numbers of STIs are actually diminishing. It is also possible that with better knowledge of symptoms and treatments, youth are self-medicating, or that economic restraints, particularly in rural areas, do not allow individuals to purchase medication. A final possibility, and not the least likely, is that the confidence level between youth and the service providers in the clinics has still not attained a sufficient comfort level. It will thus be necessary to give the process time in order to establish confidence between the two parties. Information systems are of course critical to learning as much as possible about the path of referrals and the point at which they seem to disappear off the « screen ».

Three aspects seem to be important for successful STI referrals of young people:

- Strengthened training programs for government health agents in RH and especially in the reception and treatment of youth referrals, and hence improved treatment of diagnosed cases.
- Improvement of condom sales and use among the PEs' clients, which would also bring a significant reduction in STI cases. (NB: A corollary of this may well be for all partners and/or the GRM to establish and enforce firm policies against free distribution of condoms (discussed below).)
- Jointly designed and operated tracking systems and feedback loops between projects and health centers receiving youth STI referrals.

### **6.1.3. Contraceptive Sales**

- *Provision of contraceptives to the PEs:* stockouts occur frequently in the national structures, with considerable impact on local availability and sales.
- *Pricing of contraceptives and free distribution by certain agencies:* It has been noted that numerous free distributions occur in the field, and in particular for condoms—by local NGOs, international PVOs and other institutions. This was an important demotivating factor throughout the project for the PEs as well as for their clients.
- *Pricing of condoms:* Even when condoms are sold at government established rates, purchasing power is still quite weak, if not non-existent, among the clients of the PEs (young people 15 to 24) and constitutes a genuine barrier to sales.

### **6.1.4. Training Costs for Government Health Agents**

As indicated in Section 5.6., the average cost per session and per participant for government service providers is \$127, of which more 52 percent is the requisite per diem. Government health agents thus remain the most expensive of all categories of participants benefiting from training—two to three times more expensive than training costs for the PEs, and yet remain a critical link to youth-friendly services for referrals.

### **6.1.5. Volunteerism for PEs**

At various times throughout RHYM, the question of volunteerism among the PEs was re-evaluated and reaffirmed—at one point because certain PEs themselves had raised the issue, at other times because other organizations were paying their PEs within the same communities or catchment areas. Although it was not possible for RHYM to have an impact on the policies of other organizations or projects, it was nonetheless interesting to note that the retention rate for RHYM's volunteer PEs was upwards of 80 percent. The PEs repeatedly stated that they (and their parents in many cases) considered the skills they acquired, as well as their improved status in the community, sufficient remuneration for their efforts. Although volunteerism is not a well-developed social movement in Mali, there is no question that RHYM has provided an inspiring model for youth volunteer work.

### 6.1.6. Lessons Learned

One of the most important lessons learned is that NGOs solicited for project implementation must already be well integrated into the target communities. There should be no “grafts” of NGOs into communities where they are not already operative. Credibility, and eventual success, depends upon strong and positive NGO roots within the community.

Another cardinal principle of the RHYM Project has been consistent support of the volunteer status of the PEs, for which it was important to have the agreement not only of the PEs themselves, but also of their sponsoring NGO and their communities (including parents). It has also been important to recognize the service and achievements of the PEs through various mechanisms—badges, caps, tee-shirts and book bags for identification purposes and to build esprit du corps, exchange programs among PE groups, refresher training, special events and small non-cash awards to recognize success.

Long-term sustainability can only be achieved through preparation *designed into* projects: community support, both spiritual and material throughout the intervention; joint annual planning between the NGOs and their communities; and possibly income-generation mechanisms for the NGOs and the PEs within the community.

The principle of partnership based on an equal exchange has been important to CEDPA and the NGO partners in the RHYM project. Each partner has a unique offering to make to the partnership, which it is important to recognize from the outset. Good partnerships foster collegiality and exchange among all partners. They also ensure an exchange of technical skills rather than one-way transfer.

It was unnecessary and unproductive for the RHYM NGOs to recruit individuals with medical profiles as Coordinators. Job turnover among physicians in Mali is high, and CEDPA found that highly qualified individuals who were not physicians could perform well as Coordinators and assure the continuity of those positions over life of the project.

Although the majority of the peer educators under the RHYM project were literate, literacy was not a requirement for selection. Selection criteria relied more heavily on reputation and overall communication and leadership skills in the rural communities with large numbers of young people who could not read or write. They participated easily in most activities, including training and strategic planning, by using their heightened aural/oral skills and collaborating with literate peer educators to record info as necessary.

Many of RHYM’s strengths resided in its original design, which was clearly defined but flexible, and provided for:

- A collegial partnership between CEDPA and a number of local NGOs partners, who would themselves implement all project activities with technical support from CEDPA;

- Strict selection criteria for the NGO partners, including a requirement that the NGO be present, operational, and well integrated into the targeted community or communities;
- An implementation strategy relying on a corps of carefully selected and highly trained volunteer PEs who were to be recruited from and work in the target communities;
- A well qualified and permanent core of trainers derived from CEDPA/Mali and the NGO partners;
- A strictly enforced ratio of animators to PEs (1 – 30 maximum);
- A strictly enforced ratio of trainers to trainees (1-30 maximum);
- A clearly defined strategy for capacity building (financial and administrative management, information technology, and training systems), which featured a gradual intake of NGO partners, from the oldest and strongest to the weaker, more recently established partner NGOs—a situation which allowed RHYM to make a rapid start-up with minimal investment and to involve NGOs early;
- A gradual integration of technical content for NGO partners and their PEs, beginning with mastery of YRH and moving eventually to MCH/CS;
- Annual sub-contracts between CEDPA and the NGO partners based individual NGO work plans within an integrated overall work plan;
- On-site joint annual planning events involving the PEs to define clear scopes of work between the partner NGOs and government departments of health, education and youth in their respective communities; and
- Regularly scheduled supervision, monitoring and evaluation (including baseline, mid-term and final KAP surveys) against a well-publicized set of process indicators.

## **7.0. ANNEXES**

## ANNEXE A

### TABLES ON PROGRESS UNDER SOs AND INTERMEDIATE RESULTS

This section includes tables summarizing:

- Progress on RHYM impact indicators (Strategic Objectives 1, 2, and 3)  
  
SO 1: To increase the use of contraceptives among youth in the project areas by 6%  
SO 2: To increase the use of STI/HIV/AIDS prevention, diagnosis and treatment services among targeted youth in the project area by 4%  
SO 3: To increase the use of maternal and child health (MCH) and child survival (CS) services by young mothers and their children in the project areas by 3%
- Progress on RHYM Project process indicators (Intermediate Results 1 – 4)  
  
IR 1: Increased youth access to RH services  
IR 2: Improved quality of services for youth  
IR 3: Increased promotion of RH responding to the needs of youth  
IR 4: Improved capacity to provide quality ARH information and services
- Progress on the program extension (9 months) impact indicators (1 - 2)  
  
SO 1: To increase the use of contraceptives among youth in the project areas by 6%  
SO 2: To increase the use of STI/HIV/AIDS prevention, diagnosis and treatment services among targeted youth in the project area by 4%
- Progress on Program extension (9 months) process indicators  
  
PR 1: Strengthened behavior change approaches, including communications materials, among vulnerable youth/adolescent groups  
PR 2: Strengthened referral systems linking youth whose needs go beyond information and education with ‘youth friendly’ health care or clinic services  
PR 3: Promoted general contraceptive use for family planning, and condom use as dual protection

Impact indicators were evaluated for the first time since the beginning of the project by the Mid-Term Evaluation (April 2001) and updated with the results of the final evaluation completed in July 2002. The tables indicate EOP as well as achievements to date. A supplementary column at the process indicator level shows the percentage of achievement with regard to EOP targets.

By the end of June 03 (end of extension), considerable progress had been made, with almost all EOP targets attained or exceeded in the terms of Access, Capacity, Promotion and Quality.

**TABLE 1: RHYM ONLY**

**Strategic Objectives, Intermediate Results and Indicators  
For the CEDPA Reproductive Health for Youth in Mali Project (RHYM)  
As of September 2002**

**SO1: To increase use of contraceptives among youth in the project area by 6%**

**SO2: To increase STI/HIV/AIDS prevention, diagnosis and treatment services among targeted youth in the project area by 4%**

**SO3: To increase use of MCH and CS services by young mothers and their children in the project areas by 3%**

**SO Level Indicators**

<b>Strategies</b>	<b>Indicator</b>	<b>Baseline Data<sup>1</sup></b>	<b>Mid-Term<sup>2</sup> Evaluation</b>	<b>Final<sup>3</sup> Evaluation</b>	<b>End of Project Targets</b>
<b>SO1:</b> To increase use of modern contraceptives among targeted youth in the project area by 6%	Increased CPR for modern methods among youth	29%	32%	52%	35%
<b>SO2:</b> To increase STI/HIV/AIDS prevention, diagnosis and treatment services among targeted youth in project areas by 4%	Increased % of clients purchasing condoms	26.5%	28.5%	34,5%	30.5%

<sup>1</sup> Source: CEDPA/Futures KAP survey 1999

<sup>2</sup> Source: RHYM MID-TERM EVALUATION (KAP), April 2001

<sup>3</sup> Source: RHYM FINAL EVALUATION (KAP), July 2002

Strategies	Indicator	Baseline Data	Mid-Term Evaluation	Final Evaluation	End of Project Targets
	Increased % of youth population, ages 15-24, treated for STIs by medical personnel in a HC	53%	48%	62%	57%
	Increased % of condoms used among youth, ages 15-24 (general)	36%	30%	38%	40%
	Increased % of condoms as a method for STI prevention among youth, ages 15-24	50.9%	53.9%	33.1%	54.9%
<b>SO3:</b> To increase use of MCH <sup>4</sup> and CS services by young mothers and their children in the project areas by 3%	Increased % of assisted births for women less than 19 years of age	65.9%	92%	93%	68.9%
	Increased % of young women who breastfeed exclusively for 4 months	13.9%	78%	49%	16.9%
	Increased % of young women who have had 2 pre-natal consultations	40.4%	64%	82,3%	43.4%
	Increased % of mothers giving ORT to their child within 24 hours of onset of diarrhea	18.6%	32%	44,4%	21.6%

<sup>4</sup> MCH baseline data are from “ Knowledge, Behavior and Coverage on RH and CS”, study by GP/SP in December 1998

## Intermediate Level Indicators

Intermediate Results	Baseline Data	Cumulative to Dec 01	Cumulative to Sept 02 <sup>5</sup>	Progress from Jan. to Sept 02				End of Project Targets	% Attained
				Jan-Mar	Apr-June	July-Sept	Total		
<b>IR1: Increased access for youth to RH services</b>									
# of youth with access to RH information and contraceptives w/in 15 km radius fixed health facilities or community-based distribution agent	57,130	633,444	633,444	-	-	-	-	607,571	104%
# of NGO partners/communities mobilized to address youth specific issues pertaining to FP, STI/HIV/AIDS, MCH, FGC	1	10	10	-	-	-	-	10	100%
# of peer educators trained to conduct YRH activities (education and counseling on FP, STI/HIV/AIDS, MCH, FGC)	26	2117	2117	-	-	-	-	1,950	108,5%
# of Youth Orientation Centers and/or Youth Clinics providing YRH information and/or services to youth	1	17	17	-	-	-	-	14	114%

Intermediate Results	Baseline Data	Cumulative to Dec 01	Cumulative to Sept 02	Progress from Jan. to Sept. 02				End of Project Targets	% Attained
				Jan-Mar	Apr-June	July-Sept	Total		
<b>IR2: Improved quality of RH services for youth</b>									
# of FP clients (youth purchasing contraceptives from peer educators)	632	35,011	<b>75,291</b>	15,147	16,771	8,362	<b>40,280</b>	94,832	77%
# of youth referred for STIs	9	10,059	<b>14,466</b>	2,214	1,383	810	<b>4,407</b>	87,308	16,5%
# of young mothers referred for high risk pregnancies	0	1272	<b>3,583</b>	537	930	844	<b>2,311</b>	12,232	29,2%

<sup>5</sup> “Cumulative to September 02” is total since the beginning of the project

Intermediate Results	Baseline Data	Cumulative to Dec 01	Cumulative to Sept 02	Progress from Jan. to Sept 02				End of Project Targets	% Attained
				Jan-Mar	Apr-June	July-Sept	Total		
<b>IR3: Increased promotion of RH responsive to youth client needs</b>									
# of youth counseled/educated in FP and contraception	13,720	327,442	<b>483,319</b>	61,044	58,573	36,260	<b>155,877</b>	368,085	131%
# of youth counseled/educated on prevention of STI/HIV/AIDS	17,540	233,337	<b>458,721</b>	103,271	74,716	47,397	<b>225,384</b>	322,993	142%
# of youth counseled on consequences of FGC	1,262	62,666	<b>139,985</b>	35,339	27,367	14,613	<b>77,319</b>	153,166	91,3%
# of young mothers counseled/educated on improved maternal child health, including exclusive breastfeeding for 4 months, use of ORT, good feeding practices (nutrition), immunizations for children <5, assisted birth	N/A	65,474	<b>274,112</b>	79,872	107,388	21,378	<b>208,638</b>	56,115	488%
# of NGOs/networks conducting community base IEC	1	10	<b>10</b>	10	10	10	10	10	100%
# of coalitions/networks for YRH in target areas	0	31	<b>51</b>	7	13	0	20	15	206%
# of youth-specific IEC materials produced or made available	4	85	<b>98</b>	5	1	7	13	70	140%
# of advocacy events, workshops, rallies and other activities at household at community levels	0	218	<b>245</b>	7	9	11	27	332	75%
# of youth reached on YRH by PEs (re-group FP, STI/HIV, MCH, FGC, Drug abuse)	71,134	767,237	<b>1,446,585</b>	280,211	268,881	130,256	679,348	729,456	198%
# of youth reached on YRH through Youth Orientation Centers and project sponsored Clinics	0	27,897	<b>41,687</b>	2,371	5,024	6,395	13,790	19,924	209%

<b>Indicators</b>	<b>Baseline</b>	<b>Mid-Term Evaluation</b>	<b>Final Evaluation</b>	<b>End of Project Targets</b>			
Increased knowledge among youth related to knowledge on modern methods of contraception	84%	90% <sup>6</sup>	93%	94%			
Increased knowledge among youth related to STI/HIV prevention (2 methods of prevention)	63%	63%	72%	65%			
Increased knowledge among parents/communities members related to STI/HIV/AIDS prevention	68%	ND	ND	80%			
Increased knowledge of mothers on the importance of							
a) Preventing dehydration	18%	95%	100%	28%			
b) Stopping dehydration	42%	96%	100%	52%			
Increased knowledge of mothers on correct preparation of ORT	37%	28%	34%	50%			
Increased knowledge of youth on consequences of FGC	47%	52%	51%	65%			
Increased knowledge of parents and community members on consequences of FGC	53.5%	ND	ND	63%			

<b>Intermediate Results</b>	<b>Baseline Data</b>	<b>Cumulative to Dec 01</b>	<b>Cumulative to Sept 02</b>	<b>Progress from Jan. to Sept 02</b>				<b>End of Project Targets</b>	<b>% Attained</b>
				Jan-Mar	Apr-June	July-Sept	<b>Total</b>		
<b>IR4: Improved capacity to deliver quality YRH information and services</b>				Jan-Mar	Apr-June	July-Sept	<b>Total</b>		
# of NGO providing training to PEs in YRH	1	10		0	-		0	10	100%
# of Youth Leaders providing supervision to PEs	0	64	104	40	-		40	104	100%

<sup>6</sup> Results are from the mid-term KAP (April 2001) and the Final KAP (July 2002)

**TABLES 2: PROGRESS UNDER EXTENSION**  
**Objectives, Intermediate Results and Indicators**  
**For the CEDPA Reproductive Health for YOUTH IN MALI**  
**As of June 2003**

**SO1: To increase use of contraceptives among youth in the project area by 6%**

**SO2: To increase STI/HIV/AIDS prevention, diagnosis and treatment services among targeted youth in the project area by 4%**

**SO Level Indicators**

Strategies	Indicators	Baseline data	RHYM Final Evaluation <sup>7</sup>	End of Project Targets
<b>SO1: To increase use of modern contraceptives among targeted youth in the project area by 6%</b>	Increased CPR for modern methods among youth	29%	52%	35%
	CYP: <b>3,322</b>			
	Increased knowledge among youth on modern methods of contraception including condoms	84%	93%	95%
<b>SO2: To increase STI/HIV/AIDS prevention, diagnosis and treatment services among targeted youth in project area by 4%</b>	Increased % of clients purchasing condoms from PEs	26,5%	34,5%	30,5%
	Increased use of STI/HIV services (health centers, medical personnel)	53%	62%	60%
	Increased condoms use (general)	36%	38	42%
	Increased condoms use (STI prevention)	50.9%	33.1%	57%
	Increased knowledge among youth on STI/HIV prevention (2 means of prevention)	63%	72%	66%
	Increased knowledge among parents/community members related to STI/HIV prevention and dual protection	N/A	N/A*	65%

\* Not measured under RHYM project

<sup>7</sup> Source: RHYM Final Evaluation (KAP), July 2002

## Intermediate Level Indicators

Intermediate Results	Baseline data	Cumulative to Sept 02 End of RHYM	Progress from Oct 02 to June 03	Cumulative to June 03	End of Project Targets	% attained under RHYM	% attained under extension.	Total % attained
<b>PR1: Strengthened behavior change approaches, including communications materials, among vulnerable youth/adolescent groups</b>								
# of youth counseled/educated in FP and contraception	13,720	483,319	224,982	708,301	651,634	74%	34,5%	108,6%
# of youth counseled/educated on prevention of STI/HIV/AIDS	17,450	458,721	356,617	815,338	727,851	63%	49%	112%
# of youth counseled on consequences of FGC	1,262	139,985	13,580	153,565	153,166	91%	9%	100%
# of youth-specific IEC materials produced or made available	4	98	4	102	75	130,6%	5,3%	136%
<b>PR2: Strengthened referral systems linking youth whose needs go beyond information and education with “youth friendly” health care or clinic services</b>								
# of youth referred for STIs	9	14,466	4,722	19,188	25,228	57,3%	19%	76%
# of referred youth for STIs actually treated at the level of health centers*	N/A	N/A	3,172	3,172	6,457	N/A	49%	49%
<b>PR3: Promoted general contraceptive use for family planning, and condom use as dual protection</b>								
# of FP clients (youth purchasing contraceptives from peer educators)	632	75,291	42,203	117,494	114,991	65%	37%	102%
# of condoms sold to youth *	N/A	N/A	141,048	141,048	168,963	N/A	83%	83%

\* New indicators for CEDPA/Mali

## ANNEXE B

### Récapitulatif des Principaux Résultats de l'Évaluation Finale du Projet

INDICATEURS	Situation		
	en 1999	en 2001	en 2002
<b>1. Contraception et Planification Familiale</b>			
1.1. Connaît au moins une méthode moderne	<i>PE</i>		100%
	<i>CD</i>		98%
	<i>PG</i>	84%	90%
1.2. Connaît pair éducateur comme source de contraceptifs	<i>PE</i>	-	-
	<i>CD</i>		55%
	<i>PG</i>		13%
1.3. Utilise une méthode contraceptive moderne	<i>PE</i>		63%
	<i>CD</i>		45%
	<i>PG</i>	29%	32%
1.4. A eu recours à un pair éducateur comme source d'approvisionnement en contraceptifs	<i>PE</i>		
	<i>CD</i>		32%
	<i>PG</i>	-	9%
1.5. A l'intention d'utiliser la contraception	<i>PE</i>		91%
	<i>CD</i>		78%
	<i>PG</i>	71%	73%
<b>2. IST/VIH-SIDA</b>			
2.1. Entendu parler de IST	<i>PE</i>		99%
	<i>CD</i>		99%
	<i>PG</i>	91%	96%
2.2. Connaît au moins deux signes de IST	<i>PE</i>		75%
	<i>CD</i>		47%
	<i>PG</i>		32%
2.3. Connaît au moins deux mesures de protection	<i>PE</i>		89%
	<i>CD</i>		74%
	<i>PG</i>	63%	63%
2.4. Prévalence des IST dans les 12 derniers mois	<i>PE</i>		17%
	<i>CD</i>		20%
	<i>PG</i>	24%	23%
2.5. N'a pas traité IST	<i>PE</i>		19%
	<i>CD</i>		28%
	<i>PG</i>	30%	34%
2.6. Traitement dans un centre de santé ou par PM (1)	<i>PE</i>		64%
	<i>CD</i>		53%
	<i>PG</i>	53%	48%
2.7. Cite spontanément condom contre IST/VIH	<i>PE</i>		97%
	<i>CD</i>		94%
	<i>PG</i>	69%	84%
PE = Pair Éducateur    CD = Contact Direct    PG = Population Générale			

## Récapitulatif des Principaux Résultats (suite 1)

INDICATEURS	Situation		
	en 1999	en 2001	en 2002
<b>3. Condom</b>			
3.1. Entendu parler du condom	PE	100%	100%
	CD	100%	100%
	PG	99%	99%
3.2. Connaît pair éducateur comme source de condoms	PE	-	-
	CD	62%	77%
	PG	13%	19%
3.3. A utilisé le condom lors du dernier rapport sexuel	PE	62%	66%
	CD	52%	61%
	PG	36%	38%
3.4. A toujours utilisé lors des rapports sexuels à risques	PE	66%	69%
	CD	50%	64%
	PG	32%	51%
3.5. A utilisé le condom pour la double protection (contre grossesse et infection au même titre) lors du dernier rapport sexuel	PE	41%	46%
	CD	32%	52%
	PG	9%	52%
3.6. A eu recours à un pair éducateur comme source d'approvisionnement en condoms	PE	82%	82%
	CD	40%	55%
	PG	10%	21%
3.7. Renoncerait au rapport sexuel si un partenaire refusait l'utilisation du condom	PE	87%	82%
	CD	83%	76%
	PG	63%	62%
<b>4. Excision</b>			
4.1. Entendu parler d'excision	PE	100%	100%
	CD	99%	99%
	PG	97%	98%
4.2. Excision peut avoir effets négatifs sur santé de la femme	PE	95%	98%
	CD	72%	78%
	PG	47%	51%
4.3. L'excision ne présente aucun avantage pour la femme	PE	78%	85%
	CD	58%	64%
	PG	27%	37%
4.4. En a discuté avec quelqu'un	PE	97%	98%
	CD	67%	80%
	PG	43%	45%
4.5. Serait favorable à l'excision de ses filles	PE	9%	7%
	CD	43%	29%
	PG	72%	61%

(1) personnel médical en dehors d'un centre de santé

PE = Pair Éducateur    CD = Contact Direct    PG = Population Générale

## Récapitulatif des Principaux Résultats (suite 2)

INDICATEURS		Situation	Situation
		en 2001	en 2002
<b>5. Santé Maternelle et Infantile</b>			
5.1. Sait que c'est important de prévenir la déshydratation	PE	99%	100%
	CD	98%	100%
	PG	95%	100%
5.2. Sait que c'est important d'arrêter la déshydratation	PE	99%	100%
	CD	99%	100%
	PG	96%	100%
5.3. Connaît au moins deux signes de déshydratation	PE	60%	77%
	CD	47%	55%
	PG	38%	40%
5.4. Connaît SRO/SSS contre la déshydratation	PE	82%	96%
	CD	75%	84%
	PG	67%	68%
5.5. Connaît les ingrédients de la SRO/SSS	PE	61%	95%
	CD	39%	65%
	PG	28%	34%
5.6. Utilisation de la SRO/SSS dans les 24 heures	PE	86%	69%
	CD	58%	64%
	PG	32%	44%
5.7. Connaît au moins un signe d'alerte des IRA	PE	65%	91%
	CD	51%	67%
	PG	42%	53%
5.8. Connaît au moins un signe de danger des IRA	PE	54%	78%
	CD	43%	55%
	PG	35%	40%
5.9. Connaît au moins deux avantages des consultations prénatales	PE	86%	90%
	CD	79%	80%
	PG	72%	72%
5.10. A effectué au moins deux consultations prénatales	PE	86%	92%
	CD	74%	89%
	PG	64%	82%
5.11. Connaît au moins deux avantages de l'assistance à l'accouchement	PE	80%	89%
	CD	77%	79%
	PG	70%	67%
5.12. Accouchement médicalement assisté	PE	100%	95%
	CD	99%	97%
	PG	92%	93%
5.13. Connaît au moins deux avantages de l'allaitement maternel exclusif	PE	63%	81%
	CD	56%	62%
	PG	45%	55%

<b>5.14.</b> Sait que l'allaitement exclusif doit durer 4-6 mois	<i>PE</i>	65%	86%
	<i>CD</i>	47%	57%
	<i>PG</i>	42%	38%
<b>5.15.</b> Allaitement maternel exclusif jusqu'à 4 mois	<i>PE</i>	69%	71%
	<i>CD</i>	73%	51%
	<i>PG</i>	78%	49%

*PE = Pair Éducateur    CD = Contact Direct    PG = Population Générale*

### Récapitulatif des Principaux Résultats (suite 3 et fin)

INDICATEURS	Situation		
	en 1999	en 2001	en 2002
<b>6. Education des Pairs /Utilisation des Services de Santé</b>			
<b>6.1.</b> A assisté à une session d'IEC d'un Pair Educateur	<i>CD</i>	78%	94%
	<i>PG</i>	15%	26%
<b>6.2.</b> A été référé par un Pair Educateur	<i>CD</i>	27%	28%
	<i>PG</i>	9%	7%
<b>6.3.</b> A été dans un centre de santé suite à la référence	<i>CD</i>	77%	74%
	<i>PG</i>	87%	68%
<b>6.4.</b> Dans un centre pour informations/services en PF	<i>PE</i>	26%	27%
	<i>CD</i>	15%	17%
	<i>PG</i>	14%	11%
<b>6.5.</b> Dans un centre pour information/services en IST(1)	<i>PE</i>	25%	33%
	<i>CD</i>	15%	18%
	<i>PG</i>	9%	13%
<b>6.6.</b> Dans un centre pour information/services en VIH/SIDA	<i>PE</i>	25%	30%
	<i>CD</i>	15%	15%
	<i>PG</i>	8%	8%

(1) y compris VIH-SIDA en 1999

*PE = Pair Éducateur    CD = Contact Direct    PG = Population Générale*

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**ANNEX C**

**Population of PVO Intervention Zones**

<b>CEDPA/RHYM PROJECT TARGET POPULATION 12/01</b>				
<b>NGO</b>	<b>LOCALITY</b>	<b>TOTAL POPULATION</b>	<b>Target Population Ages 15-24</b>	<b>Target Population Ages 10-24</b>
			<b>19% of Total Population</b>	<b>33% of Total Population</b>
<b>ASDAP</b>	Bamako	1,016,167	193,072	335,335
	Ségou Commune	101,000	19,190	33,330
	Sébugu	10,116	1,922	3,338
	Koutiala	60,078	11,425	19,826
	Sinsina	11,420	2,170	3,769
	Baguinéda ville	15,411	2,928	5,086
	Baguinéda – extension	23,661	4,496	7,808
		<b>1,237,853</b>	<b>235,192</b>	<b>408,491</b>
<b>ASG</b>	Bougouni	32,226	6,122	10,635
	Garalo (56 villages)	37,863	7,194	12,495
	Manankoro (42 villages)	24,464	4,648	8,073
		<b>94,553</b>	<b>17,964</b>	<b>31,203</b>
<b>ASIFA</b>	Macina	7,949	1,510	2,623
	Kadiolo	35,032	6,656	11,561
	Fourou	4,725	898	1,559
	Zégoua	3,391	644	1,119
		<b>51,097</b>	<b>9,708</b>	<b>16,862</b>
<b>A/DOKE</b>	Kita – communes de Nord, Ouest, Central	22,667	4,307	7,480
	Commune de Djidjan	15,638	2,971	5,161
	Commune de Boudofo	3,420	650	1,129
	Commune de Badenya	6,685	1,270	2,206
	Comm de Bendougou	10,024	1,905	3,308
	Comm Benkady Founia	5,609	1,066	1,851
		<b>64,043</b>	<b>12,169</b>	<b>21,136</b>
<b>ACTION MOPTI</b>	Mopti ville	56,847	10,801	18,760
	Sévaré	21,764	4,135	7,182
	Medina-coura	4,415	839	1,457
	Socoura	3,130	595	1,033
		<b>86,156</b>	<b>16,370</b>	<b>28,432</b>

<b>CAEB</b>	Kolokani	33,832	6,428	11,165
	Djidjéni	29,349	5,576	9,685
		<b>63,181</b>	<b>12,004</b>	<b>20,850</b>
<b>CRADE</b>	Commune Kaladougou (Dioila)	22,949	4,360	7,573
	Commune Sanso	11,278	2,143	3,722
	Commune Koumantou	30,529	5,801	10,075
	Commune Massigui	45,120	8,573	14,890
	Commune Djédougou	24,453	4,646	8,069
		<b>134,329</b>	<b>25,523</b>	<b>44,329</b>
<b>GRADE Banlieue</b>	Commune Sikasso	69,577	13,220	22,960
	Commune Kléla	14,193	2,697	4,684
	Commune Fama	6,545	1,244	2,160
		<b>90,315</b>	<b>17,161</b>	<b>29,804</b>
<b>ASEEM</b>	Commune Sikasso	See above		
	Commune Dandarezzo	20,387	3,959	6,876
	Commune Zangaradougou	3,698	703	1,220
		<b>24,085</b>	<b>4,662</b>	<b>8,096</b>
<b>APPF</b>	Commune Kayes	<b>78,406</b>	<b>14,897</b>	<b>25,874</b>
<b>TOTAL</b>		<b>1,919,528</b>	<b>364,710</b>	<b>633,444</b>

## ANNEX D

### NOMBRE DE SITES ET DE CENTRES D'ORIENTATION ET/OU DE CLINIQUES DES ONGs PARTENAIRES DE CEDPA/MALI

ONGs	Nbre de centres simples	Nbre de centres avec cliniques	Nbre de sites	Noms des Sites
ASDAP	0	3	7	Bamako, Ségou, Koutiala, Koulikoro, Baguinéda, Fana, Bla
ASG	3	0	3	Bougouni, Manankoro, Garalo
GRADE	1	0	5	Dioila, Massuigui, Wacoro, Koumantou, Sanso
A/DOKE	2	0	3	Kita, Djidjan, Namala
A/Mopti	0	2	2	Mopti, Sévaré
CAEB	1	0	2	Kolokani, Djidjéni
GRADE Banlieue	1	0	2	Sikasso, Kléla
ASIFA	2	0	3	Kadiolo, Fourou, Zégoua
ASEEM	1	1	1	Sikasso
APPF	1	0	1	Kayes
<b>TOTAL</b>	<b>12</b>	<b>6</b>	<b>29</b>	

## ANNEX E

### NUMBER OF PEER EDUCATORS BY NGO

<b>NGO</b>	<b>Cumulative Number of PEs Trained (up to September 02)</b>	<b>Number of PEs Currently Operational</b>
ASDAP	877	780
ASG	222	180
CRADE	221	157
A/DOKE	154	136
A/MOPTI	150	120
ASIFA	144	82
CAEB	175	100
GRADE B	199	120
ASEEM	181	171
APPF	74	70
<b>TOTAL</b>	<b>2,397</b>	<b>1,916</b>