HIV/AIDS Strategy
USAID/Mali
2003-2012

Prepared by

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Submitted to:

U.S. Agency for International Development
Washington DC

Last Revised October 2003

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Abbreviations and Acronyms

ABC	Abstinence, Be Faithful, and Condom Use Approach
AIDS	Acquired Immune Deficiency Syndrome
AIM	AIDS Impact Model
BCC	Behavior Change Communication
CDC	Centers for Diseases Control and Prevention
CEDPA	Center for Development and Population Activities
CESAC	Centre d'Ecoute de Soins, d'Animation et de Conseils
CFA	Cooperation Française Africaine Franc (currency)
CIDA	Canadian International Development Agency
CMDT	Cotton/Textiles Marketing Company of Mali (parastatal)
DHS	Demographic and Health Survey
GPA	Global Program on AIDS (WHO)
GP/PS	Groupe Pivot/Santé Population (a network of local health/ family planning NGOs)
GRM	Government of the Republic of Mali
GTZ	German Technical Assistance Organization
HIV	Human Immuno-Deficiency Virus
ISBS	Integrated STI/AIDS Prevalence and Behavior Surveillance System
ICONG	Une ONG, Une Commune
IEC	Information, Education, and Communication
JSI/PDY	John Snow Inc./ Denmisenya Yiriwali
MOH	Ministry of Health
MTCT	Mother-to-Child-Transmission
NGO	Nongovernmental Organization
OHVN	Office du Niger and Office de la Hante Vallee du Niger
PHN	Population, Health, and Nutrition
PLWHA	People Living with HIV/AIDS
PNLS	Programme National de Lutte contre le SIDA (National Program for HIV/AIDS Prevention)
PSI	Population Services International
SO	Strategic Objective
SOMARC	Social Marketing of Change
STI	Sexually Transmitted Infection
TAACS	Technical Advisor in AIDS and Child Survival
TA	Technical Assistance
TCN	Third Country National
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Executive Summary

Twenty years after the emergence of HIV/AIDS, Mali continues to rank among the few sub-Saharan countries with a low-prevalence epidemic in the general population. Mali's national prevalence is estimated at 1.7 percent, according to the 2001 Demographic and Health Survey (DHS) conducted by Macro International, with technical assistance from the Centers for Disease Control and Prevention (CDC).

Early prevention efforts that targeted populations with high-risk behaviors in Mali and across the subregion, combined with wide availability and accessibility of condoms, sustained involvement of international and local nongovernmental organizations (NGOs), and government commitment, have contributed to limiting HIV transmission in Mali. Male circumcision is universal and this may also be a protective factor. Finally, the technical and flexible financial support of USAID and other donors has been critical to this relatively favorable HIV/AIDS situation in Mali today.

- Condom use by vulnerable populations with high-risk behaviors (ticket vendors and truckers) during the last sexual encounter with a female sex worker varies between 79.2 percent and 85 percent. Female sex workers report high condom use during the last sexual encounter with both regular clients (96.0 percent) and new clients (96.7 percent). Condom use during last sexual act by unmarried and divorced men also has been taking hold during the past years, ranging between 30 percent and 43 percent, respectively, according to the 2001 DHS.

- According to the 2001 DHS, the mean number of sexual partners during past 12 months among all men not in union decreased from 0.9 to 0.6 between 1996 and 2001 and among men not in union in the 25–29 year old age range, the mean number of sexual partners during past 12 months decreased during this period from 2 to 1.3.

Mali is at a critical juncture, however. Although HIV/AIDS prevalence in the general population is low, high rates among certain groups: commercial sex workers (29.7 percent); female ambulatory vendors (6.7 percent); ticket vendors (5.7 percent); and truck drivers (4.1 percent), as well as other data, demonstrate a more complex situation. Thirty three (33) percent of the 45 locations sampled in the 2001 DHS already have HIV seroprevalence higher than the national average of 1.7 percent, including five zones with HIV prevalence greater than 3 percent and one zone at 10 percent.

In 2001, 104,000 Malians were living with HIV/AIDS (AIM model, POLICY Project 2002). According to the AIDS Impact Model, 500,000 may be infected in 2010 if prevention efforts are not significantly increased (AIM model, POLICY Project 2002). Sentinel surveillance data from 2002 found a 3.3% prevalence in antenatal clinic attendees, with values ranging from 2.0% to 5.0% across sites (PNLS/CDC 2003).

The risk of a rapid increase of the HIV/AIDS epidemic in Mali exists due to of several interrelated factors, including:

- The 2002 political crisis in Cote d'Ivoire which prompted thousands of Malians who are at high risk of HIV/AIDS infection to return to their homes throughout the country.
- Limited coverage of several high-risk locations and critical bridging populations with targeted HIV/AIDS interventions.

- Lack of relevant interventions that target bridging populations, which are critical to the transmission of HIV to the general population and lead to an increasing number of HIV-positive married men and women, in a context where a high proportion of women and men are in a union (84 percent) and women are in a polygamous marriage (43 percent).
- Gender inequities and traditional cultural norms that encourage the spread of HIV/AIDS, including the early marriage of adolescent girls and young women to older men, which leads to high HIV seroprevalence among these age groups.
- Practice mandating marriage among in-laws upon death of a spouse.
- Large proportion of young urban population facing limited opportunities, sustained and open influence of pornography, and decreasing family and community support.
- The Ministry of Health's (MOH) and local NGO community's limited capacity to address several programmatic challenges and develop the second generation of HIV/AIDS responses necessary for limiting HIV transmission.

Maintaining low seroprevalence in Mali during the next 10 years will require: (a) strong national capacity for careful programming, utilization of available resources, and mobilization of additional resources; and (b) developing, implementing, scaling-up, and monitoring the second generation of coordinated HIV/AIDS responses. The key pillars of this second generation of HIV/AIDS responses include the following:

- Improving quality and coverage of interventions that target the high-risk zones and groups, including commercial sex workers, ambulatory vendors, truckers, tickets vendors, seasonal agricultural workers, cattle raisers, and miners.
- Focusing on risk perception and reduction among key high risk groups and bridging populations such as married men who have non-regular partners.
- Addressing specific gender issues and supporting BCC that engages couples in protecting their families from HIV/AIDS.
- Empowering the regions, circles (districts), and communes (municipalities) to support local responses to HIV/AIDS.
- Enhancing the multisectoral responses to HIV/AIDS.

To assist the Government of Mali (GRM), USAID/Mali will build on measurable achievements from past investments and recent important initiatives by its current implementing agencies. These include:

- Excellent momentum achieved among critical high risk groups.
- An excellent and robust HIV surveillance system providing data on sentinel, high risk and general population groups.
- Existing networks between local and international NGOs that have demonstrated records of accomplishment in the fight against HIV/AIDS in Mali and around the world.
- Introduction of critical interventions, such as model voluntary counseling and testing (VCT) centers available to high risk groups.
- Effective advocacy to engage religious leaders in the fight against AIDS.
- Development of a behavioral and prevalence database, with CDC and Macro International support, to guide program development, implementation, and monitoring.
- Strong government commitment.
- Development of associations of people living with HIV/AIDS (PLWHA) and their commitment to fully participate in prevention, care, and support interventions.

The HIV/AIDS Strategy: USAID/Mali has developed an HIV/AIDS strategic plan that builds on the momentum and achievements of the Mission's current HIV/AIDS activities, and on the technical and comparative advantages provided by USAID. The strategy attempts to respond to priority needs, while remaining within a funding level equivalent to the current $4 million annual budget**.** The HIV/AIDS strategy proposed in this document serves as a "sub-strategy" under USAID/Mali's Health Strategic Objective (SO) 6 *Increased Utilization of High Impact Health Services*. The HIV/AIDS Strategy does not represent a stand-alone strategic objective and does not have a separate PMP. All key indicators for HIV/AIDS are reflected in USAID/Mali's SO6 PMP. In order to facilitate the design of activities under the HIV/AIDS strategy, USAID/Mali did employ a program framework, which will be used for management purposes to follow HIV/AIDS activities, but does not replace the SO6 results framework. Please see Section II.A for the HIV/AIDS program framework and Section II.B for the SO 6 results framework..

The HIV/AIDS program framework will address the following intermediate results which replicate for HIV the more general SO6 intermediate results: (IR1) strengthen the enabling environment for STI/HIV/AIDS services and products; (IR2) increase demand for STI/HIV/AIDS services and products; (IR3) increase access to STI/HIV/AIDS services and products; and (IR4) improve quality of STI/HIV/AIDS services and products. The essential program elements of these intermediate results are listed below.

(IR1) Strengthen the enabling environment for STI/HIV/AIDS services and products:

- Provide technical assistance to the National Program for HIV/AIDS Prevention (PNLS) and MOH to develop, review, and disseminate documents on delivery norms, standards, and procedures for key STI/ HIV/AIDS services.
- Provide technical assistance to implement the annual HIV antenatal sentinel surveillance, triennial Integrated STI/AIDS Prevalence and Behavior Surveillance System (ISBS), and quinquennial demographic and health surveys.
- Support the integration of basic STI/HIV/AIDS reporting in the MOH's Health Information Management System.
- Provide technical assistance to the MOH to develop and implement training a supervision plan for the dissemination and use of algorithms for STI diagnosis and treatment in public and private facilities in high risk zones.
- Provide technical assistance to USAID Strategic Objective Teams 7, 8, 9, and 10 to understand HIV/AIDS issues and opportunities for effective interventions in selected sectors.
- Provide technical assistance to build the capacity of selected national and regional stakeholders (PNLS, selected networks of NGOs, associations of religious leaders such as the Islamic High Council on HIV/AIDS, relevant regional and communal authorities, and planning departments of selected ministries).
- Develop the capacity of local NGOs in the implementation of BCC interventions targeting high risk groups; the development of networking, reporting, and monitoring systems; and the development of management, administrative, and financial systems, including regular performance review of local NGOs and reporting to the PNLS.
- Support regional HIV/AIDS coordination and collaboration in one model region.

(IR2) Increase demand for STI/HIV/AIDS services and products:

- Strengthen BCC interventions that target high-risk groups along major transportation routes, and expand interventions to include seasonal agricultural workers, miners, and cattle raisers.
- Develop advocacy and communication interventions to improve risk perception among high risk youth and married men, especially interventions that engage men and couples in protecting the family unit from HIV/AIDS.
- Direct targeted populations to facilities and networks that provide VCT, effective STI treatment, basic ambulatory care, treatment, and support services for HIV/AIDS-related opportunistic infections.

(IR3) Increase access to STI/HIV/AIDS services and products:

- Strengthen social marketing to support the development and implementation of the second generation of HIV/AIDS responses by:
  - Strengthening nationwide availability and accessibility of affordable condoms, targeting in particular high risk groups.
  - Strengthening social marketing interventions that target specific high risk groups, including seasonal agricultural workers, miners, cattle raisers, and the military.
  - Introducing innovative social marketing interventions that target bridging populations including married men.
  - Expanding availability and accessibility of female condoms among relevant high risk groups, especially commercial sex workers.
  - Contributing to increasing the perception of risk among high risk youth and married men.
  - Contributing to marketing existing facilities that comply with basic standards of counseling, VCT, STI care, and ambulatory care for people living with HIV/AIDS, as requested and negotiated with other implementing partners.
  - Contributing to resource mobilization and leveraging for scaling up the level of interventions.
  - Strengthening operational collaboration with networks of local NGOs and advocacy groups.
- Develop linkages with local NGOs and innovative use of their community-based interventions to target specific high risk groups.
- Develop linkages with reproductive health interventions.

(IR4) Improve quality of STI/HIV/AIDS services and products:

- Support qualitative research to improve the quality of BCC interventions that target high risk youth, with special emphasis on strategies for encouraging and promoting the delayed sexual debut of youth in urban areas and the reduction of sexual partners.
- Provide technical assistance to model VCT centers on quality control related to HIV testing, monitoring, and counseling standards, procedures, and protocols.
- Support the dissemination of service delivery norms, standards, and protocols for voluntary testing and counseling, and basic ambulatory services for PLWHA to targeted public and private facilities.
- Develop and strengthen model, user-friendly centers for STI treatment and counseling of adolescents and commercial sex workers in high risk zones, while making sure that these centers provide appropriate and effective treatment (e.g. no provision of syndromic management of vaginal discharge).

- Strengthen capacity of the National Reference Public Health Laboratory for STI/HIV/AIDS-related diagnosis, surveillance, and operations research.
- Strengthen the three model VCT sites in Bamako, Segou, and Kayes.

Assumptions and Cross Cutting Issues: Three critical assumptions are discussed in this document: recognition that Mali could be at risk of an escalation of the HIV/AIDS epidemic and thus close monitoring of the situation through the surveillance system is critical; USAID commitment to sustaining and expanding current momentum; and no decrease in the commitment of key stakeholders. Two special concerns are also raised: Global Funds and access to available HIV/AIDS resources by local NGOs and civil society; and synergy between USAID/Mali SO 6 (health) and other SOs of the Mission, other SO teams, and multisectoral approaches.

Budget and Implementation Mechanisms: The estimated annual budget is $4 million. Under the Agency's approach for programming HIV/AIDS funds, Mali has been classified as a basic programming country. However, a country may become a priority country for assistance if HIV and STI surveillance data indicate impending changes from concentrated to generalized epidemics. Hence, USAID/Mali will continue to monitor the epidemic through sentinel and other surveillance and request a change in status if necessary.

I. Situational Analysis

A. HIV/AIDS Situation in Mali

According to the 2001 Mali Demographic and Health Survey (DHS), which included for the first time a population-based HIV seroprevalence survey, Mali continues to rank among the countries least affected by HIV/AIDS in sub-Saharan Africa. The number of the adults with HIV in 2001 was estimated at 104,000 (AIM model, POLICY Project 2002) in a total population of men (ages 15–59) and women (ages 15–49) of 4,765,160 (DHS 2001 report).

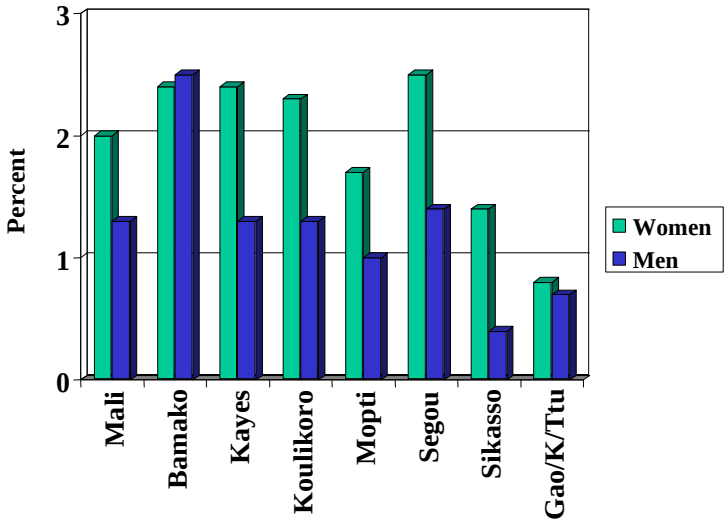
However, the HIV epidemic is established in the general population. The estimated HIV seroprevalence among the adult population (women, aged 15–49, and men, aged 15–59) is 1.7 percent. HIV prevalence is also high among vulnerable populations with high-risk behaviors, including commercial sex workers (28.9 percent), truckers (4.4 percent), ticket vendors (5.4 percent), and ambulatory vendors (6.8 percent).[1] Accordingly, Mali can be classified among countries with a "generalized low-prevalence" epidemic.[2]

The survey confirms that female HIV-infection levels remain higher than male HIV-infection levels, with a rate of 2 percent among women 15–49-years-old and 1.3 percent among men 15–59-years-old. Figure 1 demonstrates the differences in HIV-prevalence levels by region and sex. Bamako has the highest prevalence rate (2.5 percent), followed by the Kayes, Koulikoro, and Segou regions (1.9 percent each). Three other regions have rates lower than the national average: Mopti (1.4 percent), Sikasso (1 percent), and Gao/Kidal/Tombouktou (0.7 percent). Women from Segou have the highest prevalence rate (2.5 percent), followed by those of Bamako and Kayes (2.4 percent each). This higher infection among women has been a consistent pattern in sub-Saharan African countries in the early years of the HIV epidemic.

[1] Integrated STI Prevalence and Behavior Surveillance (ISBS) Final Report, March–December 2000. Centers for Disease Control and Prevention and National Program for the Fight Against AIDS.

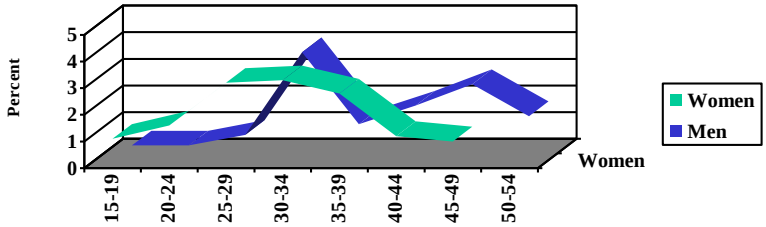
[2] USAID Handbook of Indicators for HIV/AIDS/STI Programs, January 2002, and Draft PHN Field Guide. The Synergy Project.

Figure 1. Seroprevalence rates by region (DHS 2001)



Because first sexual intercourse among Malian women takes place at a relatively young age and usually with older men, HIV prevalence in young women is relatively higher than in young men. As indicated in Figure 2, the Mali DHS (2001) also reveals adolescent girls (15–19-years-old), young women (20–24-years-old), and women (25–29-years-old) are disproportionately infected by HIV/AIDS, with prevalence of 1.1 percent, 1.6 percent, and 3.2 percent, respectively. By contrast, HIV prevalence in adolescent boys, aged 15–19, is 0.3 percent; for young men aged 20–24, 0.3 percent; and men aged 25–29, 0.7 percent. Conversely, at older age ranges (45–49-years-old), men are more infected by HIV (2.6 percent) than women (1.0 percent) of the same age.

Figure 2. Seroprevalence by sex and age in Mali (DHS 2001)



The 2002 sentinel surveillance data among pregnant women are quite consistent with 2001 DHS HIV-prevalence data. The estimated HIV seroprevalence among pregnant women is 3.3 percent; and women aged 25–29 account for the highest HIV seroprevalence (4.8 percent).

In December 1999, the World Health Organization (WHO) reported Mali had about 5,000 people living with AIDS (PLWHA). According to the AIDS Impact Model, developed with the

assistance of the POLICY Project and the use of DHS 2001 data, the estimated number of HIV infections was 104,000, including 14,000 people currently living with AIDS. By 2010, 500,000 Malians may be infected if prevention efforts are not significantly increased.

A rapid analysis of the database on PLWHA from the Centre d'Ecoute de Soins, d'Animation et de Conseils (CESAC, Center for Counseling and Care) indicates married men and women (particularly, housewives), and youth are highly affected by HIV/AIDS.

- Women accounted for 58.9 percent of the 3,067 PLWHA who visited CESAC in 2000–2002.
- In 2000 and 2001–2002, youth 16–24 years of age accounted for 21.3 percent and 16.8 percent of PLWHA, respectively.
- 63 percent of PLWHA were married versus 16.6 percent, unmarried.
- 40.3 percent of PLWHA attending CESAC were housewives ("menageres").[3]

B. Framework for National Response

Since 1987, the WHO's Global Program on AIDS (GPA) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have supported the Government of the Republic of Mali (GRM) efforts to develop a national response and establish the National Program for the Fight Against AIDS (PNLS). Between 1987 and 1998, GRM implemented one short-term plan (1987–1988) and two medium-term plans (1989–1993 and 1994–1998) for the fight against HIV/AIDS. In 1999 and 2000, PNLS developed its third HIV/AIDS Strategy (2001–2005), following an extensive consultative process. This strategy delineates 10 priority areas for interventions. They are:

(1) Promoting a multisectoral response through the active participation of political and civil society leaders.
(2) Promoting behavior change among the general population and specifically among vulnerable populations with high-risk behaviors.
(3) Improving the quality of life for PLWHA.
(4) Reducing and minimizing mother-to-child transmission (MTCT).
(5) Ensuring that diagnosis and treatment of sexually transmitted infections (STI) are available in all health facilities.
(6) Alleviating the burdensome impact of HIV/AIDS on families and communities.
(7) Developing standards and laws that respect the dignity and rights of infected or affected persons.
(8) Expanding health coverage and developing local and community HIV/AIDS-related skills to reduce burden on health services.
(9) Improving control of blood transfusion safety.
(10) Ensuring availability of up-to-date HIV/AIDS-related data, as well as data on the epidemic's impact at the national and regional levels, on general population and vulnerable groups, and in rural and urban areas.

[3] Unpublished analysis of the demographic profiles of PLWHA from CESAC database.

USAID/Mali's existing HIV/AIDS strategy (2001–2005) – to be replaced by the current proposed strategy – is consistent with the GRM strategic plan for the fight against HIV/AIDS and supports many of PNLS's priority interventions.

C. USAID Contributions, 1989–2002

USAID/Mali has provided important and multifaceted support to the National AIDS Control Program (PNLS) since 1989. Between 1989 and 2000, USAID supported HIV/AIDS interventions that:

- Targeted commercial sex workers and their clients.
- Promoted condom use through social marketing activities.
- Encouraged STI prevention and care.
- Strengthened HIV surveillance through the completion of the 2000 Integrated STI/AIDS Prevalence and Behavior Survey (ISBS).
- Educated youth and the general population through a network of international and local NGOs and private voluntary organizations (PVOs).

In addition, since 2001 other activities have been added including:

- Promoting behavior change targeting those most at risk among high-risk groups/high transmitters, medium-risk groups (highly mobile populations), high-prevalence areas, and the general population (especially youth).
- Targeting community leaders, decision makers, and PNLS leadership to develop an enabling environment through advocacy, capacity building for surveillance, program development, management, and technical skills.
- Targeting PLWHA for preventing and decreasing HIV transmission.
- Fostering the use of effective interventions related to STI case management; voluntary counseling and testing and referrals; and high-risk, establishment-based programs and practices.

Specifically, from 1989 to the present USAID has supported the PNLS through:

- AIDSTECH/AIDSCAP projects (1989–1994), managed by Family Health International, supported interventions that targeted brothel-based commercial sex workers in Bamako, including HIV/AIDS education, promotion of condom use, and improved STI case management. This project received $675,000 in funds.
- Social Marketing for Change (SOMARC) program (1992–1999) and John Snow, Inc./Denmisenya Yiriwali (1999–2002), managed by The Futures Group, included nationwide interventions to increase availability, accessibility, and use of condoms.
- Plan International for information, education, and communication activities (IEC), which targeted the general population. Plan received $5 million in funds (1995–2000) and worked with 63 Malian NGOs to achieve this activity.
- Centers for Disease Control and Prevention (1995–2003; total funding for activities, $5 million):
  - Operations research, focusing on STI prevention activities: validation of STI syndromic management algorithms as well as HIV rapid testing algorithms for use in VCT centers.

- Development of nationwide STI case management capabilities and specialized STI clinic services.
- PNLS management reorganization and capacity strengthening.
- HIV surveillance (Integrated STI prevalence and Behavioral Surveillance, antenatal sentinel surveillance, and population-based HIV survey through the 2001 Demographic Health Survey). Thanks to this support Mali has the most comprehensive HIV/AIDS database to date in sub-Saharan Africa.
- Strengthening capacity of the National Research Institute for Public Health (laboratory testing capability and equipment).
- Support to Documentation Center of PNLS (this activity has not yet been implemented effectively).

- International private voluntary organizations (1997–2002) for adolescent reproductive health, including STI/HIV prevention messages. These PVOs included Save the Children USA, CARE, Africare, World Education; Cooperative League of the USA (CLUSA), Center for Development and Population Activities (CEDPA), Population Council, Plan International, and Groupe Pivot/Santé Population (GP/SP).
- Population Services International (PSI) (2001–2003):
  - Research.
  - Voluntary counseling and testing (VCT).
  - Behavior change communication (BCC), condom sales (including female condoms), peer education, and STI referral along transportation routes that target populations with high-risk behaviors (including commercial sex workers and their clients, e.g., truckers and tickets vendors).
  - Advocacy and IEC that target religious leaders, youth, and young couples.

  Total PSI funding is about $2.6 million for 2001–2003.
- The Futures Group/POLICY Project (2001–2004) for HIV/AIDS advocacy activities; average annual funding of $300,000.
- Groupe Pivot/Sante Population (GP/SP) for BCC interventions targeting high risk groups, direct funding of about $400,000. This direct partnership with GP/SP is recent, and follows USAID's certification of this local major NGO.
- USAID direct funding to MOH's Programme National de Lutte Contre le SIDA (PNLS) (1998–2003) for a range of HIV/AIDS-related capacity building, training, and advocacy activities. Average annual funding is about $200,000.

D. Other Donor Contributions

Technical and financial assistance for HIV/AIDS from other donors in Mali is significant. Donors include the Canadian International Development Agency (CIDA), Swiss Development Corporation, European Union, World Bank, UNAIDS, WHO/GPA, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), French cooperation, Plan International, and German Technical Assistance Organization (GTZ). CIDA, Plan International, and Swiss Development Corporation have provided significant and sustained support to HIV prevention and control for the past 10 years. Project assistance for HIV/AIDS from donors other than USAID consists of the following:

- CIDA provides $3 million in projects (2001–2006) that target populations with high- risk behaviors and focus specifically on effective treatment of STIs in the Bamako and Sikasso regions.

- Plan International supports local NGOs, including associations of PLWHA, and established eight VCT centers in 2001.
- The French cooperation's $1.5-million Network for Care of PLWHA project (2001–2004) works in three target regions: Bamako, Mopti, and Sikasso.
- Swiss Development Corporation supports local NGOs for HIV/AIDS prevention in Sikasso. A new project is being developed to start in 2002-2003.
- Bristol-Myers Squibb Foundation's five-year, $16-million (CFA 10 billions) Secure the Future (2001–2006) project provides competitive funding to Malian, Senegalese, and Burkinabe organizations for community-based interventions, including prevention and quality improvement of health care services.
- GlaxoSmithKline's two-year, $180,000 (CFA 109,600,000) Prevention of MTCT of HIV project focuses on 12 sites in Bamako, Sikasso, Segou, and Kolokani.
- A GTZ HIV/AIDS project (Deutsche Mark 4 million) supports PNLS in the Dogon, Mopti region.
- UNAIDS provides technical assistance and an about $200,000 annually for coordination and rapid local responses.
- UNICEF provides technical assistance and limited financial support for MTCT.
- The World Bank and the Netherlands, through the MOH's Program for Health and Social Development (PRODESS), support the HIV/AIDS initiative "Une ONG, Une Commune" (ICONG). This initiative, begun in 2001, fosters contractual relations between MOH and 130 NGOs to strengthen local responses to HIV/AIDS. It currently faces several challenges, including disbursement problems and accountability of funding.

E. Key Programmatic Achievements and Priority Needs

1. Programmatic Achievements

Twenty years after the emergence of HIV/AIDS, Mali continues to rank among the few sub-Saharan countries with a generalized low-HIV-prevalence epidemic. Early prevention efforts targeting populations with high-risk behaviors in Mali and across the subregion, combined with nationwide availability and accessibility of condoms, sustained involvement of international and local NGOs, and the government's commitment have certainly contributed to limiting HIV transmission in Mali.

In Mali today, condom use with a female sex worker by vulnerable populations with high-risk behaviors (ticket vendors and truckers) varies between 79.2 percent and 85 percent. Female sex workers report high condom use during the last sex with both regular clients (96.0 percent) and new clients (96.7 percent).

Also, the mean number of sexual partners during the previous 12 months among men not in a union decreased from 0.9 to 0.6 between 1996 and 2001, according to the Mali DHS. The mean number of sexual partners also decreased from 2 to 1.3 among men not in union at ages 25–29.

USAID and other donors have also built networks between local and international NGOs which have demonstrated records of accomplishment in the fight against HIV/AIDS in Mali. During the past two years, USAID has also introduced important initiatives, including:

- PSI's recent innovative interventions to strengthen BCC that target vulnerable groups and improve risk perception among youth and the general population.
- Introduction of critical interventions, such as model VCT and STI centers.
- Effective advocacy by PSI and the POLICY Project to engage religious leaders in the fight against HIV/AIDS.
- Development of an important HIV seroprevalence and behavioral database to guide program development, implementation, and monitoring.

Government commitment to HIV/AIDS has also been strong. Religious leaders and PLWHA have begun to develop their own associations and increase their participation in prevention, care, and support interventions.

2. Analysis of Priority Needs

According to recent conclusions of the HIV/AIDS review conducted as an initial step in the development of this strategy document, maintaining the relative low-HIV-seroprevalence situation in Mali through the next 10 years will require:

- Building on the current momentum and achievements of USAID and other key-implementing partners.
- Strong national capacity for careful programming, utilization of available resources, and mobilization of additional resources.
- Developing, implementing, scaling-up, and monitoring the second generation of coordinated HIV/AIDS responses.

The key pillars of this second generation of HIV/AIDS responses should include the following:

- Improving quality and coverage of interventions that target the high-risk zones and groups, including commercial sex workers, ambulatory vendors, truckers, tickets vendors, seasonal agricultural workers, cattle raisers, and miners.
- Focusing on risk perception and reduction among key high risk groups and bridging populations such as married men.
- Addressing specific gender issues and supporting BCC that engages couples in protecting their family units from HIV/AIDS.
- Empowering the regions, circles (districts), and communes (municipalities) to support local responses to HIV/AIDS.
- Enhancing the multisectoral responses to HIV/AIDS.

F. Risks and Vulnerabilities to a Rapid Increase of HIV Prevalence in the General Population

Now that the epidemic is established in the general adult population, Mali remains particularly vulnerable to a rapid increase of HIV prevalence because of several interrelated factors, including:

- The 2002 political crisis in Cote d'Ivoire which prompted thousands of Malians who are at high risk of HIV/AIDS infection to return to their homes throughout the country.

- High internal migration among key vulnerable populations with high-risk behaviors and higher infection rates.
- Limited coverage of several high-risk locations and groups with targeted HIV/AIDS interventions. For example, none of the 19 zones of the Cotton/Textiles Marketing Company of Mali (CMDT) nor the seasonal agricultural workers, benefit from any sustained HIV/AIDS interventions. Interventions that target the military, clandestine sex workers (e.g., ambulatory vendors), miners, and cattle raisers and zones that have high interactions with migrants from other countries with high HIV seroprevalence have been very limited or insignificant. Annex 1 provides a list these high-risk sites and their classification based on the current volume of HIV/AIDS interventions.
- Lack of relevant interventions that target the bridging populations critical to the dissemination of HIV in the general population. For example, the lack of interventions targeting married men has already led to an alarming increase in the number of HIV-positive married men and women, in a context where a high proportion of women and men are in unions (84 percent). In addition:
  - Seven out of 10 married men did not use a condom with occasional partners, according to the DHS 2001.
  - In the two VCT centers supported by PSI, 61.2 percent of married women who had one sexual partner during the past twelve months were HIV positive. These data are of particular concern, given the large proportion of married women in polygamous unions (43 percent).
  - Most ambulatory vendors (85 percent) did not use a condom during last sex with a casual partner, which resulted in a higher HIV-seroprevalence rate (6.8 percent) among this bridging population group.
  - No significant HIV/AIDS intervention targets seasonal agricultural workers, who account for a high proportion of the bridging populations.
- Gender inequities and traditional cultural norms that encourage the spread of HIV/AIDS:
  - Early marriage of adolescent girls and young women to older men, resulting in a high HIV seroprevalence among these age groups.
  - Practices mandating marriage among in-laws upon the death of a spouse.
- Large proportion of young urban population facing sustained and open influence of pornography (Satellite TV/RTL 9), as well as decreasing family and community support.
- Limited capacity of the MOH/PNLS and local NGO community to address several programmatic challenges and develop the second generation of HIV/AIDS responses that are necessary to limit further HIV transmission.

In addition, it is important to note that many (33 percent) of the 45 sites sampled in the national HIV seroprevalence survey have HIV seroprevalence higher than the national average of 1.7 percent, including five zones with HIV seroprevalence greater than 3 percent and one at 10 percent.

Finally, the situation surrounding the question of blood safety is worrisome and the extent to which blood safety and injection practices are driving the epidemic in Mali is unknown. According to the Director of the National AIDS Control Program, there have been no studies conducted on the subject. In addition, donor support for blood safety initiatives ended three years ago although limited requests for funding in this area are currently pending. Based on USAID/Mali's experience, the status of blood safety may be cause for concern given the weak capacity of the single national blood bank (based in Bamako), frequent blood shortages, lack of

supplies (syringes, reagents, bottles, etc.) and lack transportation to other regions. Outside of Bamako, all health facilities practice on the spot transfusion from a relative to a client in need of transfusion.

II. Proposed Ten-Year HIV/AIDS Strategic Plan

A. HIV/AIDS Program Framework Objective: Use of HIV/AIDS Prevention Services, Products, and Practices Increased

The expected specific results for the proposed HIV/AIDS Objective are as follows:

- Decrease in proportion of high risk and key bridging groups reporting non-regular sex partners over last 12 months;
- Increased use of condoms with non-regular partners by populations with high-risk behaviors;
- Increased use of condoms with non-regular partners among key bridging groups;
- Decrease in mean number of sexual partners among men not in union ages 25–29 (DHS).

B. Rationale for the Strategy

USAID/MALI has developed an HIV/AIDS strategy that builds on the momentum and achievements of the Mission's current HIV/AIDS activities, as well as on the technical and comparative advantages provided by USAID. The related HIV/AIDS Program Framework is consistent with the Mission's Strategic Objective (SO6) for Population, Health, and Nutrition. The proposed strategy attempts to respond to priority needs, while remaining within a funding level equivalent to the current annual budget of $4 million.

PROGRAM FRAMEWORK FOR HIV/AIDS ACTIVITIES UNDER SO 6

Use of HIV/AIDS Prevention Services, Products, and Practices Increased

Overall Indicators:

1. Non-regular sex partners (married men, DHS; high risk groups, ISBS; USAID/W required indicator)
2. Condom use with last non-regular partner among select high risk groups (truck drivers, ticket touts, ambulatory vendors, sex workers; IBSS, triennial)
3. Condom use with last non-regular partner among married men (DHS)
4. Mean number of sexual partners among men not in union at ages 25–29 (DHS)

Development context indicators:

- Median age at first sex (youth, disaggregated by gender and by 15-19 and 20-24; DHS)
- HIV prevalence among pregnant women ages 15-24 (disaggregated by age: 15-19, 20-24; Sentinel Surveillance; biannual)
- HIV prevalence among high risk groups (truck drivers, ticket touts, ambulatory vendors, sex workers; IBSS, triennial)

Intermediate Result 1
Enabling environment for STI/HIV/AIDS services and products strengthened

Indicators
Ind1.1 VCT policy environment enabled
Ind1.2 MOH Health Information System updated for reporting on STI/HIV/AIDS cases
Ind1.3 Number of civil society institutions' capacities strengthened to implement HIV/AIDS prevention and/or care and support activities.

Intermediate Result 2
Demand for STI/HIV/AIDS services and products increased

Indicators
Ind2.1 Condom sales
Ind2.2 STI clients served
Ind2.3 VCT clients served
Ind2.4 USAID assisted STI clinics
Ind2.5 Knowledge of STI symptoms
Ind2.6 Knowledge of 2 prevention methods

Intermediate Result 3
Access to STI/HIV/AIDS services and products increased

Indicators
Ind3.1 Number of counselors trained
Ind3.2 Proportion of high risk group traveling 5 minutes or less to obtain a condom

Intermediate Result 4
Quality of STI/HIV/AIDS services and products improved

Indicators
Ind4.1 VCT centers meeting established norms, standards, and procedures
Ind4.2 Targeted laboratories meeting quality control standards for HIV testing

The strategy is designed to be sustained by fostering flexible, decentralized, and collaborative programming and financing among Government of the Republic of Mali (GRM), key development and implementing partners, regions, circles (districts), and communes (municipalities).

Relationship of the HIV/AIDS Strategy to the Health Strategic Objective: SO6

The HIV/AIDS Strategy described in this document is not a stand alone strategy and does not represent a separate strategic objective (SO). Rather it is a "sub-strategy" under the USAID/Mali's Health Strategic Objective: SO6: Increased utilization of high impact health services. SO6 is approved for the period FY 03 to FY 12.

As described in the USAID/Mali Country Strategic Plan (CSP), the purpose of USAID/Mali's Strategic Objective (SO6) is to increase use of proven, effective health services in order to address the continued high under-five mortality, maternal mortality, and fertility in Mali.

The strategy focuses on a minimum package of interventions that are expected to have the highest impact in reproductive health and child survival in Mali. Selected interventions: 1) address the outcomes and conditions which contribute most to high mortality and fertility; 2) can be cost-effectively integrated into existing delivery mechanisms such as ante-natal care and community outreach; and 3) can be expanded, such as by conducting semi-annual "vitamin A distribution" and "health day" campaigns and more community outreach activities. The services include:

- Childhood vaccinations (including the vaccines to be introduced with support of the Global Alliance for Vaccines and Immunization) and tetanus toxoid for women of reproductive age
- Twice yearly vitamin A supplementation of children integrated with iron-folate supplementation for pregnant women
- Best practices in Mali of growth monitoring, promotion and child feeding (e.g., exclusive breastfeeding)
- Promotion of insecticide treated bednets/materials and prompt and effective treatment with appropriate anti-malarials, including presumptive treatment of pregnant women at selected intervals
- Promotion of appropriate home fluids and oral rehydration salts for treatment of diarrhea
- Implementation of a full range of proven and effective family planning interventions and approaches implemented at all levels including: social marketing, contraceptive logistics, communication, advocacy, behavior change and IEC appropriate training and management support
- Prevention of STI/HIV transmission, with a special emphasis on high risk groups and bridging populations. SO 6 will also include a continued emphasis on maintaining the surveillance system (including behavioral surveillance) in order to monitor HIV trends and allow timely warning of any changes in prevalence.

SO 6 works through four intermediate result areas, including: IR 1: a supportive policy environment, IR 2: creating the demand for services, IR 3: increasing access to services, and IR 4: improving the quality of services. Through improvements in these areas, populations will be

more likely to seek out health services and adopt positive health behaviors, resulting in improved health status.

The HIV/AIDS Strategy is designed to be implemented within the framework of SO 6 and the HIV/AIDS program framework mirrors the IRs of SO6. In addition, indicators for the HIV/AIDS strategy are incorporated into the PMP for SO6 – there is no separate PMP for the HIV/AIDS strategy (see section on M&E for further detail). USAID/Mali will ensure coordination and harmonization of all activities under SO6 through a SO6 start-up workshop and on-going coordination meetings.

Results Framework for SO6

Increase Use of High Impact Health Services and Improved Health Practices

Performance Indicators:

1. Vulnerable population (pregnant women and children <5) using insecticide-treated bednets (ITN sales)
2. IPT coverage for pregnant women
3. Vitamin A supplementation
4. Iron folate supplementation
5. ORT use (ORS sales)
6. DPT3 coverage
7. Condom use in high risk populations
8. Non regular sex partners
9. Contraceptive prevalence rate (CYP)

Development Context:

- Infant mortality rate
- Total fertility rate
- HIV seroprevalence
- Age of sexual debut

Risks:

- Government commitment to PRODESS diminishes
- HIV/AIDS funding not available bilaterally
- Families' income drops
- Lack of government commitment to family planning

High-Impact Services:

- Child vaccination
- Child Vit A Supplements
- Child nutrition
- Malaria prevention/treatment
- Family Planning
- Home fluids for diarrhea
- STI/HIV prevention

Intermediate Result 1

Policy environment for high impact services and improved practices established

Indicators:

Ind 1.1 Score for contraceptive security
Ind 1.2 Score for standardization of community agents role
Ind 1.3 VCT policy

Intermediate Result 2

Demand for high impact services and practices increased

Indicators:

Ind 2.1 Couple years of protection
Ind 2.2 Bednet sales
Ind 2.3 STI clients served
Ind 2.4 Condom sales
Ind 2.5 VCT clients served
Ind 2.6 USAID assisted STI clinics

Intermediate Result 3

Access to high impact services and practices increased

Indicators:

Ind 3.1 CBD agents trained
Ind 3.2 Outreach services

Intermediate Result 4

Quality of high impact services and practices improved

Indicators:

Ind 4.1 Operational CBD coverage
Ind 4.2 Supportive supervision
Ind 4.3 Key commodity stockout

Geographic Focus and Priority Target Populations

HIV/AIDS activities will target high risk groups and high risk zones. High risk groups already being targeted under USAID/Mali's current program include commercial sex workers, truckers, ambulatory vendors, and ticket touts along major transportation routes and in urban areas. The activities with these groups will be continued and strengthened under the new strategy. The new strategy also plans to expand coverage to other high risk groups and bridging populations including migratory commercial agricultural workers, returning migrants, miners and married men.

To date, USAID/Mali's HIV/AIDS prevention activities have focused on the major transportation routes from Bamako to Senegal, Cote d'Ivoire, and Burkina Faso. Under the new strategy, communications and activities will expand to cover transport routes heading into Northern Mali from Mopti to Gao and from Gao to the border with Niger. In addition, the new strategy will cover the 19 zones of the Cotton/Textile Marketing Company of Mali (CMDT), selected agricultural sites of the Office du Niger and Office de la Haute Vallee du Niger (OHVN), and mining sites. A list of the high-risk sites and their classification according to the current volume of HIV/AIDS interventions, and a map showing these areas is provided in Annex 1.

Target Groups:

Truckers, their Apprentices, Ticket Touts and Roadside Vendors

USAID/Mali and its partners will work with local NGOs to access truckers, their apprentices, ticket touts and roadside vendors with targeted messages of STI/HIV awareness and prevention. USAID/Mali will train NGOs in BCC techniques and provide them with promotional materials and supplies needed to maximize campaign impact.

In addition, a variety of mass media channels will reach these target populations. Billboards promoting condom use appear along the truck routes in addition to posters, and stickers placed on vehicles and roadside establishments. TV and radio spots are also used to raise awareness of the risks of unprotected sex and benefits of consistent and correct condom use. A series of radio programs adapted for a Malian audience have aired on Mali radio and have also been distributed to truck drivers on cassette tape. Under the new strategy, all these campaign activities will continue to complement the IPC outreach activities conducted by local NGOs. Finally, a mobile video unit will be used to attract crowds of truck drivers on break along with a range of other at-risk groups active at truck stops or working along the route.

Commercial Sex Workers

CSWs will continue to be a key focus under the HIV/AIDS strategy. Not only do CSWs interact with truck drivers and other migrant populations, but their rate of HIV infection is also the highest of all the proposed target groups. USAID/Mali has worked with a number of NGOs to reach this critical population through peer education efforts. In the new strategy, outreach to this population will intensify and expand through the network of NGOs. Peer education and other

outreach to CSWs will aim to increase their ability to negotiate condom use. For those sex workers and clients unable or unwilling to negotiate use of male condoms, USAID/Mali will work to increase the supply and accessibility of female condoms.

Migrant Commercial Agriculture Workers

The new strategy will launch an outreach program targeting migrant agricultural workers. Through the local NGO network, USAID/Mali will expand activities and intensify BCC efforts to reach these target populations. Activities will focus on sites in the Office du Niger (Mali's largest rice grower based in Ségou), the Office de la Haute Vallée du Niger (cotton and cereal crops in the Koulikoro region) and the Compagnie Malienne pour le Developement du Textile (CMDT) (Mali's largest cotton grower with 11 processing plants, five of which are in the Sikasso region.)

USAID/Mali will work through the NGO network GP/SP to implement intensive on-site IPC efforts to educate these migrant workers about the risks of STI/HIV infection. Harvest times are occasions when multi-partnering is frequent and sex for money is the norm. This combination of risk factors presents many opportunities for targeting awareness and prevention messages to those that need them the most. Target populations will also be referred to local clinics for STI diagnosis and treatment and to VCT centers if appropriate.

Returning Migrants

The Kayes region accounts for the largest proportion of households with migrants traveling to Europe and to neighboring countries with high HIV seroprevalence rates. The new strategy will intensify BCC activities in this region through local NGOs. BCC messages will emphasize a man's responsibility to protect the health of his family by protecting himself. Messages will also highlight the advantages of knowing one's HIV status and the availability of VCT services in the area.

Miners

The new strategy will work with mining companies to train a network of peer educators (trained and supported through the NGOs) who use BCC kits to educate miners about their risks of HIV infection. Mining companies will share in the costs to develop and support similar on-site HIV/AIDS prevention and awareness programs in other areas.

Married Men with non-regular partners

According to the findings of the 2001 DHS, a higher percentage of women than men in Mali are HIV+. Yet, as discussed earlier, for many of these seropositive women, their only possible risk factor is their spouse: a majority of women do not have partners outside of their marriage nor are they exposed to HIV in other manner. As in many countries around the world, married women are not yet able to negotiate condom use with their spouses. It is therefore important to target men – both married and to-be married (which, together, includes most men) – as the most efficient way to reduce the spread of HIV/AIDS among married women.

A multifaceted approach will be used to reach these men including campaigns that will:

- Reinforce messages of the possible costs of having a relationship outside of marriage, to the man, his spouse, and future children; and
- Increase social pressure on men to protect women through reduction of the number of sexual partners and consistent and correct condom use with non-regular partners.

USAID sponsored projects will continue to work with key community opinion leaders to promote and reinforce the idea that responsible men think of their families. Under the existing strategy Muslim leaders were provided with a series of "fact sheets" to be read to congregations during Friday prayers. These fact sheets will be expanded to include the elements related to gender that encourage the rising prevalence among women. Muslim leaders will remind men of the need for safe sexual behaviors to keep their wives and any unborn children uninfected. Imams will urge men to remain faithful to one partner to protect their families.

Youth

Since 2001, USAID/Mali has been supporting programs which reach out to youth with a number of youth-friendly tools to communicate HVI/AIDS prevention messages. These tools include an MVU, a popular and trendy youth magazine, Journal, and a dynamic radio discussion show. Two DJs, trained in HIV awareness, prevention, and sensitivity, host the radio shows. Each of these entertaining and engaging formats has proven effective in conveying important HIV prevention messages to youth.

Urban youth and youth in high risk zones will be the specific target of BCC efforts. The characteristics of youth (e.g. married or unmarried, in school or out) will be assessed through NGO programs and messages developed as appropriate. Local NGOs will organize special sessions with parent and teacher groups to publicize and discuss research findings about youth, including broader based DHS results. Religious leaders will reach youth with prevention messages at an early age. The new strategy will work with Peace Corps Volunteers (PCVs) to reinforce and sustain media messages with IPC efforts targeting youth and particularly young women. With over 40 Health and HIV/AIDS PCVs throughout Mali, reaching from Kayes to Gao, PCVs are well placed to collaborate on USAID/Mali's HIV activities.

Key Behavior Change Approaches

Focus on men: HIV disproportionately infects adolescent girls and young women when compared with adolescent boys and young men. Because first sexual intercourse among Malian women takes place at a relatively young age and often with older men who are more likely to be infected, prevalence of HIV in young women is usually higher than in young men. The key to preventing infection among adolescent girls and young women is to engage men and point to their unique responsibility in protecting the core family unit from HIV/AIDS for the following key reasons:

- Men are currently the main transmitters of HIV to adolescent girls and young women in the context of early marriage and higher infections among men ready for marriage.
- Men maintain exclusive control of sexual matters during the first years of union.
- Men claim rights to polygamy and responsibility for maintaining equal treatment among spouses and related children.
- Men carry the obligation to marry in-laws upon death of their spouses.
- Men maintain control of the economic resources.

A main concern of the proposed strategy is to improve risk perception among married and to-be-married men and engage them in protecting their legal sexual partners and occasional sexual partners by increasing their use of existing prevention, counseling, care, treatment, and support services. In particular the behavior change message is that of reducing the number of non-regular partners and correct and consistent condom use with these partners. USAID/Mali will develop a multifaceted strategy to improve risk perception among married men and promote communication about HIV/AIDS within the family unit. This strategy is proposed as a way to prevent infections among adolescent girls, young women, and spouses.

Involving Religious Leaders: USAID/Mali will support religious leaders in advocacy, prevention, care, and support activities. Religious leaders, Muslim leaders in particular, play essential social roles in Mali. They bless marriages and, most importantly, they daily counsel numerous young people, adult men and women, and national and community leaders from diverse backgrounds on various subjects. Young people and men and women visit Muslim leaders for spiritual support but, most importantly, for counseling on problems related to family and community disputes, marriage, illnesses, plans for the future, and selected national issues. Another duty of religious leaders is to discuss relevant topics to inform or educate the hundreds of thousands of Muslims who attend the weekly Friday prayer in mosques across the country. HIV and AIDS-related messages have been developed in collaboration with a cross-section of Muslim leaders and these messages will be widely disseminated through Friday sermons and individual counseling sessions.

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USAID/Mali HIV/AIDS Strategy Target Groups

Target Groups	Key Messages	Locations	Intervention
High Risk Groups			
CSWs (F)	Promote condom use Referral	Train/Bus stations Transport routes Bars Mines Brothels	NGO BCC Initiatives Providers/Counselors Mass Media Social Marketing
Truckers (M)	Reduction of non-regular partners Referral Knowledge of prevention methods	Truck stops Customs posts Transport routes	NGO BCC Initiatives Mass Media Bill boards
Ticket Vendors (M)	Same as Truckers	Same as Truckers	Same as Truckers
Ambulatory Vendors (M)	Same as Truckers	Same as Truckers	Same as Truckers
Bridging Groups			
Married Men	Reduction of non-regular partners Protect the family/Be faithful Condom use (with non-regular partner or if one partner is seropositive) Referral	High risk zones	Mass Media Providers/Counselors Mosque Sermons
Migrant Workers(M)	Same as Truckers –	Cotton plantations Gold mines	NGO BCC Initiatives Employers Mass Media
Youth			
Urban Youth (M&F)	Abstain/Delay Sexual Debut Be Faithful/Abstain until Marriage Reduction of Partners Knowledge of Prevention Methods Condom Use Referral	Urban Youth Clinics Youth Associations Youth in high risk zones	Peer Educators Mass Media – Radio/Television Entertainment (Popular Musicians, etc.) Grins (local youth groups)

Explanatory Notes:

Condom use: The program will promote correct and consistent use of condoms

Referral will be site specific depending on the facilities available and could include the following: VCT services, STI services, Counseling, Care and Support.

C. Key Intermediate Results and Illustrative Activities

The HIV/AIDS strategy results framework cuts across the four Intermediate Results (IR) of the Mission's Strategic Objective for Population, Health, and Nutrition. It plans to strengthen the enabling environment for STI/HIV/AIDS and increase demand and access to quality

STI/HIV/AIDS services and products. Each IR includes an illustrative list of essential program elements in accordance with the $4 million budget scenario.

1. Intermediate Result 1: Enabling Environment for STI/HIV/AIDS Services and Products Strengthened

a. Rationale: Despite a strong commitment from the GRM to an HIV/AIDS response, several key challenges hamper the development of a supportive environment for STI/HIV/AIDS prevention, care, treatment, and support. These challenges include the continuing absence of key service delivery norms and standards; poor national and regional coordination; poor engagement of key sectors in the fight against HIV/AIDS; heavy burden on the coordinating unit of the PNLS with respect to a limited available and capable staff; and limited organizational capability of local NGOs and networks.

b. Emphasis: This IR places emphasis on establishing service delivery norms, standards, and procedures for key HIV/AIDS services; enhancing mechanisms for coordination and collaboration; strengthening data analysis and its use for good decision making; and developing the leadership and capacity of the PNLS and NGO community to respond to selected challenges.

c. Essential Program Elements:

- Provide technical assistance to PNLS and the Ministry of Health (MOH) to develop, review, and disseminate documents concerning service delivery norms, standards, and procedures for key STI/ HIV/AIDS services. These may include counseling, voluntary testing and counseling, STI care, and ambulatory care for people living with HIV/AIDS (PLWHA).
- Provide technical assistance to implement the annual HIV antenatal sentinel surveillance, the three-year ISBS, and the five-year DHS. The assistance may also include support for data analysis, reporting, and dissemination.
- Support the integration of basic STI/HIV/AIDS reporting in the MOH's health information management system.
- Provide technical assistance to the MOH to develop and implement training and a supervision plan for dissemination and use of algorithms for STI diagnosis and treatment in public and private facilities in high risk zones, in collaboration with the Canada-supported STI project (SIDA 3) and CDC, as appropriate.
- Provide technical assistance to USAID Strategic Objective Teams 7, 8, 9, and 10 to understand the HIV/AIDS issues and opportunities for effective interventions in selected sectors. This assistance may include the completion of targeted assessments or secondary data analysis in each sector; support of advocacy interventions by targeting key players; and development of operational plans and resource mobilization activities for targeted priority HIV/AIDS interventions. Current priority needs include developing and implementing HIV/AIDS programs that target seasonal agricultural workers, miners, cattle raisers, and the military. Also important is the engagement of key Ministry of Education stakeholders in the fight against HIV/AIDS.
- Provide technical assistance to build the capacity of a select group of national and regional stakeholders (PNLS, selected networks of NGOs, associations of religious leaders, High Council on HIV/AIDS, relevant regional and communal authorities, planning departments of selected ministries) to develop and use support materials and

tools, such the AIDS Impact Model (AIM) or Goals Model, for effective advocacy and program development.

- Support regional HIV/AIDS coordination and collaboration in one model region.
- Provide grants to local NGOs to implement BCC interventions that target core transmitters and related sexual networks, and to develop networking, reporting, and monitoring systems for local NGOs.
- Develop management, administrative, and financial systems for key NGO partner, using local available technical support.
- Support regular performance review of local NGOs and their reporting to PNLS.

d. Additional Program Elements Pending Availability of Extra Resources:

- Complement the technical assistance of the Joint United Nations Programme on HIV/AIDS (UNAIDS) for regular review of program coverage and performance at the national level and at targeted regions and locations.
- Support the development and implementation of training and supervision plans for HIV testing at a select group of public and private laboratories.
- Work with UNAIDS to advocate for an operational Secretariat of the High Council on AIDS to provide attention to the multisectoral response to HIV/AIDS.

2. Intermediate Result 2: Demand for HIV/AIDS Services and Products Increased

a. Rationale: There are several challenges related to poor specific knowledge of HIV/AIDS among youth and rural women, in particular; a low perception of risks and limited responsiveness among the general population, youth, and married men to the first generation of HIV/AIDS interventions; limited awareness of the benefits of seeking counseling services and early and effective treatment for STI- and HIV/AIDS-related opportunistic infections.

b. Emphasis: IR2 focuses on improving specific knowledge and risk perception of HIV/AIDS; encouraging the use of preventive measures and services for early STI diagnosis and treatment, and appropriate access to basic care, treatment; and support services for PLWHA. This IR builds on the current activities implemented by USAID partners and focuses on essential program elements. The focus of BCC efforts will be on high risk groups in high risk locations and on bridging populations.

c. Essential Program Elements:

- Strengthen interventions that target high-risk groups along major transportation routes; and expand BCC interventions to include seasonal agricultural workers, miners, cattle raisers, and the military.
- Develop advocacy and communication interventions to improve risk perception among high risk youth and married men, especially interventions that engage men in and prepare youth for protecting the family unit from HIV/AIDS.
- Direct high risk groups to facilities and networks that can provide counseling services; voluntary testing and counseling; effective STI treatment; and basic ambulatory care, treatment, and support services for HIV/AIDS-related opportunistic infections.

- Expand the mix of HIV/AIDS-related interventions that target seasonal workers, miners, the military and high-risk sites along the underserved, major transportation routes in the northern Mali (Gao-Niamey) and the Guinea road.

d. Additional Program Elements Pending Availability of Extra Resources:

- Develop and implement a comprehensive BCC program for the Kayes region, which accounts for the largest proportion of households with migrants who travel extensively and often to countries with high HIV prevalence.
- Engage religious leaders in education and counseling activities. Develop and implement innovative and culturally sensitive counseling services and simple monitoring systems at mosques, churches, workplaces, and municipalities to target newly married couples for improving risk perception and commitment to protecting the family unit.
- Conduct qualitative research to expand the body of knowledge and understanding around HIV transmission and issues of discrimination and stigmatization.

3. Intermediate Result 3: Access to HIV/AIDS Services and Products Increased

a. Rationale: Sustained availability and accessibility of affordable male condoms have been essential to the significant achievements in HIV prevention in Mali to date. However, the availability and accessibility of voluntary counseling and testing (VCT) services, important elements for the second generation of effective HIV/AIDS responses, remain limited. Utilization of health services also remains extremely low (with 0.17 new visits per resident per year, according to MOH Report, 2001) for several reasons, including limited qualified and motivated health personnel and costs of services and drugs. This low use of services adversely affects access to counseling; STI treatment; and basic care, treatment, and support services for tuberculosis and other HIV/AIDS-related opportunistic infections.

b. Emphasis: IR3 focuses on maintaining the broad availability of male condoms; improving the accessibility of female condoms among high risk groups; and improving VCT services and basic products for STI management.

c. Essential Program Elements:

- Redirect social marketing to support development and implementation of the second generation of HIV/AIDS responses by:
  - Strengthening nationwide availability and accessibility of affordable condoms targeting in particular high risk groups.
  - Strengthening social marketing interventions that target specific high risk groups, including seasonal agricultural workers, miners, cattle raisers and the military.
  - Introducing innovative social marketing interventions that target married men and clandestine sex workers (e.g., ambulatory sellers).
  - Expanding availability and accessibility of female condoms among relevant high risk groups, especially commercial sex workers.
  - Contributing to increasing perception of risk among high risk youth and married men.
  - Contributing to the promotion of existing facilities that comply with basic standards for counseling, VCT, STI care, and ambulatory care for PLWHA, as negotiated with other implementing partners.

- Contributing to the mobilization of resources and leveraging for scaling up the level of interventions.
- Strengthening operational collaboration with networks of local NGOs and advocacy groups.

- Develop linkages with local NGOs and innovative use of their community-based interventions to target specific high risk groups.
- Develop linkages with reproductive health interventions.

d. Additional Program Elements, Pending Availability of Extra Resources:

- Expand networking with local NGOs and radio stations to improve coverage of critical high risk groups with products and services.
- Support the development and implementation of training and supervision plans for HIV testing at selected public and private laboratories.

4. Intermediate Result 4: Quality of STI/HIV/AIDS Services and Products Improved

a. Rationale: Several gaps in quality limit the effectiveness of HIV/AIDS interventions. These gaps result from a range of interrelated challenges, including the absence of established standards for key HIV/AIDS services and/or limited compliance with existing standards; limited understanding of the sexual networks among high risk groups, bridging populations, and general populations; disproportionate reliance on knowledge-based approaches to behavior change; disconnects between social marketing interventions, advocacy, BCC, and community-based interventions; and limited understanding of the poor responses to the first generation of HIV/AIDS interventions by a range of subpopulation groups, including adolescents (ages 15–19), rural women, and less educated married men. Limited availability and supervision, as well as frequent turnover, of qualified health providers in key HIV/AIDS areas (counseling; STI care; STI/HIV/AIDS surveillance and reporting; and treatment of HIV/AIDS-related conditions) continue to adversely affect the quality of HIV/AIDS services.

b. Emphasis: The objectives of the IR4 are to encourage the use of standards; strengthen linkages among HIV interventions; and inform interventions with sound qualitative research.

c. Essential Program Elements:

- Support qualitative research to improve the quality of BCC interventions targeting high risk youth, with special emphasis on strategies for encouraging and promoting the delayed sexual debut of youth in urban areas and the reduction of sexual partners.
- Provide technical assistance to model VCT centers on quality control related to HIV testing, monitoring, and counseling standards; and procedures and protocols.
- Support the dissemination of service-delivery norms, standards, and protocols for counseling, VCT, and basic ambulatory services for PLWHA to targeted public and private facilities.
- Develop and strengthen model, user-friendly centers for STI treatment and counseling of adolescents and commercial sex workers in high risk zones, while making sure that these centers provide appropriate and effective treatment (e.g. no provision of syndromic management of vaginal discharge).

- Strengthen capacity of the National Reference Public Health Laboratory to provide STI/HIV/AIDS-related diagnosis, surveillance, and operations research.
- Strengthen the three model VCT sites in Bamako, Segou, and Kayes targeting high risk groups.

d. Additional Program Elements, Pending Availability of Extra Resources:

- Commission case studies and in-depth qualitative research of a comprehensive set of on-going HIV/AIDS interventions.
- Support targeted secondary analysis of DHS, ISBS, and HIV annual surveillance data linked to other complementary sources of data.
- Support the development of a second generation of the Behavior Change Communication Strategic Plan.
- Support the development and implementation of a quality improvement system in selected public and private health facilities, in collaboration with one regional Directorate for Health.

D. Critical Assumptions

The proposed strategy is built on the following interrelated critical assumptions.

1. Recognition among GRM, USAID, and other donors that the risk of a rapid escalation of the epidemic exists in Mali.

The proposed HIV/AIDS strategy assumes key HIV/AIDS stakeholders in Mali are aware of the risks of a crisis HIV/AIDS epidemic, despite the relative low HIV seroprevalence. Complacency will send the wrong messages to the general population and will complicate interventions to improve risk perception among youth and married men, in particular.

2. USAID commitment to sustaining and expanding current momentum

Past investments in HIV/AIDS have proven to be effective, and recent USAID initiatives have built a strong foundation for the development and rapid implementation of the second generation of HIV/AIDS responses. The HIV/AIDS strategy assumes that USAID will sustain and expand the current momentum for the rapid development of the second generation of HIV/AIDS responses.

3. No decrease in the commitment and collaboration of key stakeholders to support HIV/AIDS interventions.

Key HIV/AIDS interventions currently rely exclusively on donor funding and technical assistance. Flexible donor financing and technical support have been essential to achievements to date and the current momentum. The HIV/AIDS strategy is predicated on donor funding remaining at current levels. The strategy also assumes improved programmatic collaboration and co-financing will lead to expansion of effective interventions. Poor attention to and investment in fostering collaboration among donors and implementing partners will be detrimental to delaying a crisis HIV/AIDS epidemic. Most importantly, any decrease in funding or HIV/AIDS resources

channeled through government disbursement mechanisms will adversely affect the HIV/AIDS situation.

E. Implementation Modalities

1. Technical Assistance Needs

Technical assistance is most needed in the following priority areas:

- Development and implementation of service delivery norms, standards, and protocols. Priority areas include counseling; VCT; STI diagnosis and treatment, and a basic package of care, treatment, and support for PLWHA.
- Improvement of NGO development. Priority needs include management and leadership; financial and administrative systems; grant management; and monitoring and reporting systems.
- Development of coordination and collaboration systems, including national and regional monitoring and reporting systems.
- Qualitative research.

USAID and other donors have relied mostly on UNAIDS to assist Mali's PNLS in fostering national and regional coordination and collaboration; and mobilizing key sectors in the fight against HIV/AIDS. However, as additional resources become available, USAID may wish to assist UNAIDS in strengthening coordination and collaboration mechanisms and in mobilizing other sectors.

It is also critical that USAID foster collaboration among future implementing partners, reduce missed opportunities, and encourage peer review of key interventions by supporting:

- Development of a strategic plan for BCC.
- Development of mechanisms and systems for regular joint monitoring and reporting of key interventions.
- Development and implementation of a research agenda and peer review mechanism for key interventions to inform quality and performance improvements.

2. Recommendations for implementation modalities through the next five years (FY 2003–FY 2008)

Below are the proposed consolidated program elements to be managed by the partners selected by USAID/Mali.

Technical support in STI surveillance and capacity building of PNLS in STI management (currently CDC)

- Provide technical assistance to PNLS and MOH to develop and review documents on service delivery norms, standards, and procedures for key STI/ HIV/AIDS services. The services would include counseling, VCT, STI care, and ambulatory care for PLWHA.

- Support the dissemination of service-delivery norms, standards, and protocols for counseling, VCT, and basic ambulatory services for PLWHA to targeted public and private facilities.
- Provide technical assistance to the MOH to develop and implement training and supervision plans for dissemination and use of algorithms for STI diagnosis and treatment in selected public and private facilities, in collaboration with the Canada-supported STI project (SIDA 3) and the USAID grantee, as appropriate.
- Continue to provide technical assistance to implement the annual HIV antenatal sentinel surveillance, triennial ISBS, and quinquennial DHS. This assistance may include support for data analysis, reporting, and dissemination.
- Support the integration of basic STI/HIV/AIDS reporting in the MOH information management system.
- Provide technical assistance to model VCT centers on quality control related to HIV testing, monitoring, and counseling standards; and procedures and protocols.
- Continue to develop and strengthen model user-friendly, STI treatment centers for adolescents and commercial sex workers in selected locations.
- Continue to strengthen the capacity of the National Reference Public Health Laboratory to conduct STI/HIV/AIDS-related diagnosis, surveillance, and operation research.

Should additional resources become available, additional activities could include:

- Complement technical assistance provided by UNAIDS for regular review of program coverage and performance at the national level and at targeted regions and locations. This review may provide support for the mapping of high-risk zones and HIV/AIDS interventions; development of a simple guide and job aides for monitoring and reporting HIV/AIDS activities and results; installation or strengthening of HIV/AIDS databases at PNLS coordinating unit, key NGO partner, and High Council on AIDS.
- Support the development and implementation of training and supervision plans for selected public and private laboratories that provide HIV testing.
- Support the development and implementation of a quality improvement system in selected public and private health facilities, in collaboration with one regional Directorate for Health.

b. Policy and advocacy (Currently POLICY Project)

- Provide technical assistance to USAID Strategic Objective Teams 7, 8, 9, and 10 to strengthen understanding of HIV/AIDS issues and opportunities for effective interventions in selected sectors. This assistance may support the completion of targeted assessments or secondary data analysis in each sector; advocacy interventions that target key players; and development of operational plans and resource mobilization activities for targeted priority HIV/AIDS interventions (see additional details in the V. Special Concerns). Current priority needs include development and implementation of HIV/AIDS programs that target seasonal agricultural workers, miners, cattle raisers, and the military. It is also important to engage key stakeholders in the Ministry of Education in the fight against HIV/AIDS.
- Provide technical assistance to build the capacity of selected national and regional stakeholders (PNLS, selected networks of NGOs, associations of religious leaders, High Council on HIV/AIDS, regional and communal authorities, and planning departments of

selected ministries) to develop and use pertinent support materials and tools, such as AIM or Goals, for effective advocacy and program development. As capacity to use AIM develops, policy may shift emphasis to program development, collaboration, and data analysis for operational advocacy.

- Support regional HIV/AIDS coordination and collaboration in one model region. This support may include funding a full-time local regional coordinator and engaging key NGO partner to assign coordination roles to specific members of its network.
- Support the use of traditional communicators in advocacy.

Should additional resources become available, additional activities could include:

- Work with UNAIDS to advocate for an operational Secretariat for the High Council on AIDS, and thereby provide necessary attention to the multisectoral responses to HIV/AIDS. This response may include:
  - Sponsoring of study tours to review current experiences in enhancing multisectoral responses.
  - Clarifying the respective mandates and roles that can exist between the PNLS coordinating unit and the Secretariat.
  - Determining worthwhile options for cost-effective operations of the Secretariat, such as staffing requirements and an appropriate *modus operandi*.
  - Exploring options for increasing the availability and accessibility of HIV/AIDS funding by NGO community, civil society, and decentralized structures.

c. HIV prevention in high risk and bridging populations (Currently PSI)

- Build capacity of and transfer responsibilities to key NGO partner for managing, with local NGOs and community organizations, proven BCC interventions that target high-risk sites and groups along major transportation routes. Provide technical oversight and support to key NGO partner to ensure quality of its interventions and linkages with other relevant HIV/AIDS activities.
- Initiate and expand BCC interventions that target seasonal agricultural workers, cattle raisers, miners, and the military.
- Support qualitative research to inform BCC interventions that target high risk youth, with special emphasis on strategies that encourage and promote the delayed sexual debut of urban youth and the reduction of sexual partners.
- Develop advocacy and communication interventions to improve risk perception among youth and married men. The interventions will attempt to engage men in and prepare youth for protecting the family unit from HIV/AIDS. This scenario may include encouraging prenuptial HIV counseling and testing for men and couples.
- Strengthen the model VCT sites in Bamako, Segou, and Kayes.
- Direct targeted populations to existing facilities and networks that provide counseling services; VCT; effective STI treatment; and basic ambulatory care, treatment, and support services for HIV/AIDS-related opportunistic infections.
- Develop linkages with local NGOs and innovative use of their community-based interventions to target specific high risk groups.

Should additional resources become available, additional activities could include:

- Expand interventions that target high-risk sites and groups to include seasonal workers, miners, and the military, and high-risk sites along underserved, major transportation routes in northern Mali (Gao-Niamey).
- Develop and implement a comprehensive BCC program for the Kayes region, which accounts for the largest proportion of households that have migrants who travel to countries that have very high HIV-seroprevalence rates.
- Engage religious leaders in educational and counseling activities. Develop and implement, in collaboration with religious leaders, innovative and culturally sensitive model counseling services and a related monitoring system at mosques, churches workplaces, and municipalities to target newly married couples, and, thus, to raise both risk perception and commitment to protecting the family unit.

d. Social Marketing (Currently PSI)

- Support development and implementation of the second generation of HIV/AIDS responses by:
  - Strengthening nationwide availability and accessibility of affordable condoms targeting in particular high risk groups.
  - Supporting social marketing interventions that target additional high risk groups, including seasonal agricultural workers, miners, and the military.
  - Introducing innovative social marketing interventions that target bridging populations, including married men
  - Expanding availability and accessibility of female condoms among relevant high risk groups, especially commercial sex workers.
  - Contributing to increasing the risk perception among high risk youth and married men.
  - Contributing to marketing of existing facilities that comply with basic standards for counseling, VCT, STI care, and ambulatory care for PLWHA, as negotiated with other implementing partners.
  - Contributing to resource mobilization and leveraging for scaling up the level of interventions.
  - Strengthening operational collaboration with networks of local NGOs and advocacy groups.
- Develop linkages with reproductive health interventions such as the provision of as many FP methods as feasible in order to reduce MTCT.

Should additional resources become available, additional activities could include:

- Expand networking with local NGOs and radio stations to improve coverage of critical bridging populations with products and services.

e. Key NGO partner (Currently Groupe Pivot Santé Population)

- Support partnership interventions between local NGOs and other USAID partners to develop and implement BDD programs for high risk groups.
- Strengthen management, administrative, and financial systems of key NGO partner, using local available technical support.
- Develop networking, reporting, and monitoring systems of local NGOs.

- Support regular performance review of local NGOs and their reporting to PNLS.

Should additional resources become available, additional activities could include:

- Provide key NGO partner with additional technical support on organizational development through existing field support or other competitive contractual mechanisms.

3. Recommendations for Implementation Modalities after FY 2008

USAID/Mali will support an external evaluation of the HIV/AIDS situation and programs in 2007. At that time, USAID will have a range of data, including follow-up data from the ISBS, sentinel surveillance, and DHS, as well as qualitative data, to make informed decisions about implementation modalities.

III. Results and Reporting

As part of USAID's expanded response to HIV/AIDS, the Agency has established reporting requirements for Missions in all Rapid Scale-Up, Intensive Focus, and Basic countries receiving $1 million or more per year. USAID/Mali is well positioned to measure and report on a range of core and performance indicators under the current support to GRM through:

- An Integrated STI/AIDS Prevalence and Behavior Survey (ISBS) that monitors changes in the most at-risk populations (commercial sex workers, truckers, ticket vendors, ambulatory sellers) every three years.
- A biennial sentinel surveillance study of pregnant women attending antenatal services.
- A national Demographic and Health Survey (DHS) every five years that includes an HIV/AIDS module and a national seroprevalence survey that monitors changes in the general population.

As additional resources become available, the second generation of ISBS could be expanded to include additional sentinel populations, including agricultural seasonal workers, miners, and the military. As national capacity develops and additional resources become available, the annual sentinel surveillance of pregnant women could also be expanded to include STI clients and tuberculosis patients.

Key partners of USAID also report regularly on a range of program-level and service core indicators that are available to monitor volume, coverage, and quality of HIV/AIDS responses. The reporting of AIDS and STI cases by MOH's Health Management Information System, however, needs to be strengthened.

The selection of indicators such as those listed below would largely cover the reporting requirements for a "Basic Country," such as Mali, and inform on program development and implementation by the Government of the Republic of Mali, nongovernmental organizations, decentralized structures, USAID, and other donors.

A. Development context indicators

- Median age at first sex (youth, disaggregated by gender and 15-19 and 20-24; DHS)
- HIV prevalence among pregnant women aged 15-24 years old (disaggregated by age 15-19 and 20-24; sentinel surveillance)
- HIV prevalence among high risk populations (truck drivers, ticket touts, ambulatory vendors, sex workers; ISBS).

A. Strategic Objective

- Non-regular sex partners (married men, DHS; high risk groups, ISBS)
- Condom use with last non-regular sex partner among select high risk groups (truck drivers, ticket touts, ambulatory vendors, sex workers; ISBS)
- Condom use with last non-regular sex partner among married men (DHS)
- Mean number of non-regular sex partners among men not in union at ages 25-29 (DHS)

B. Intermediate Result 1: Enabling Environment Improved

- VCT policy environment enabled
- MOH Health Information System updated for reporting on STI/HIV/AIDS cases
- Number of civil society institutions' capacities strengthened to implement HIV/AIDS prevention and/or care and support activities.

C. Intermediate Result 2: Demand for STI/HIV/AIDS Services and Products Increased

- Condom sales
- STI clients served
- VCT clients served
- USAID assisted STI clinics
- Knowledge of STI symptoms
- Knowledge of 2 prevention methods

D. Intermediate Result 3: Access to STI/HIV/AIDS Services and Products Increased

- Number of counselors trained
- Proportion of high risk group traveling 5 minutes or less to obtain a condom

E. Intermediate Result 4: Quality of STI/HIV/AIDS Services and Products Improved

- VCT centers meeting established norms, standards, and procedures
- Targeted laboratories meeting quality control standards for HIV testing

IV. Budget and USAID Management

A. Funding

Table 1 presents a summary of the estimated budget for proposed implementation mechanisms through the next five (5) years, in accordance with a $4 million.

Table 1. Proposed funding scenarios by funding category.

Funding Categories	**Scenario 1** $
HIV/STI surveillance and capacity building of PNLS	1,283,000
Policy and Advocacy	500,000
HIV/STI prevention in high risk and bridging populations	1,797,000
Condom Social Marketing[4]	300,000
USAID Program Staff	120,000
Total	**$4 million**

The above budget for $4 million represents the current funding level and is consistent with the strategy's proposed package of essential program elements. Although some technical adjustments may be necessary to strengthen the quality of current interventions, the proposed package of essential program elements is consistent with the current level of efforts.

A key conclusion of the HIV/AIDS review conducted as a prelude to the HIV/AIDS Strategy development is that USAID's current annual funding level of $4 million is inadequate for leading the efforts necessary to divert the emergence of a crisis HIV/AIDS epidemic during the next 10 years. USAID/Mali estimates an additional $2 million per year would allow USAID and key implementing partners to engender the necessary collaborative efforts, expand the coverage of HIV/AIDS risk zones, and target crucial high risk groups with effective HIV/AIDS interventions. However, under the Agency's approach for programming HIV/AIDS funds, Mali has been classified as a basic programming country. USAID/Mali will continue to monitor the epidemic through sentinel and other surveillance and request a change in status if prevalence data increases.

B. USAID Management and Technical Assistance Needs

Under the basic $4 million budget, the current Mission staffing pattern for the HIV/AIDS program is appropriate. One full-time TCN manages the current USAID HIV/AIDS portfolio under the supervision of the U.S. direct-hire Population, Health and Nutrition (PHN) officer. The Mission also recently hired a TAACS, who will focus primarily on implementing the Mission's

[4] The amount above represents the amount of HIV/AIDS funds to be allocated to a social marketing instrument which markets several products and uses POP and CS funds

main support mechanism for the PHN sector under the PHN's strategic objective but will also provide guidance to the HIV/AIDS program.

Should the funding level exceed $5 million, additional program staff may be warranted. USAID can recruit local consultants and/or buy into existing field support mechanisms for additional technical assistance to support quality implementation, monitoring, and reporting of HIV/AIDS interventions.

V. Special Concerns

A. Collaboration Between People Living with HIV/AIDS and Religious Leaders to Reduce Stigma

An important recent breakthrough has been the increasingly active participation of religious leaders and people living with HIV/AIDS (PLWHA) in the fight against AIDS in Mali. In Mali, many PLWHA are organizing themselves into associations, engaging in prevention activities, and improving their access to better services for the prevention and management of opportunistic HIV/AIDS-related conditions. They are forming support networks and participating in awareness-raising activities through testimonies at the community level and on radio and national television. The main organization, Association of Person Living with HIV/AIDS/Association of Assisting HIV/AIDS-related Orphans and Widows (AMAS/AFAS), is currently composed of about 300 people living with HIV/AIDS, the majority being women. They are changing the perception of Malians and community leaders about PLWHA, and showing a diverse profile of PLWHA, as most of them have not engaged in high-risk sexual behaviors.

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Several Muslim organizations decided to create the National Islamic Committee for the Fight Against HIV/AIDS to engage in advocacy; train religious leaders, teachers, and preachers; and provide support to PLWHA, orphans, and widows. The religious leaders are developing their own vision and strategies and have made powerful public statements about protecting life, changing harmful cultural practices, encouraging discordant couples to use condoms, and persuading at-risk individuals to seek voluntary counseling and testing (VCT) services.

Most importantly, these leaders have joined PLWHA to educate the general population and fight ignorance, stigma, and discrimination. This on-the-ground collaboration is helping to dispel many misconceptions and doubts about HIV/AIDS and to address stigma and discrimination. In Mali, interventions related to HIV/AIDS prevention, care, treatment, and support continue to be affected by the stigma associated with HIV/AIDS. Ignorance of HIV/AIDS and the disproportionate focus on high-risk populations and core transmitters have strengthened stigma in Mali and continue to affect the fight against HIV/AIDS negatively. PLWHA and women, in particular, are subject to discrimination by their families; most of the time, they are rejected. This negative environment forces PLWHA underground until a late stage of the disease, which strengthens the chain of transmission. At the USAID-supported voluntary counseling and counseling centers, data indicate that neither partner practices disclosure. The USAID/Mali HIV/AIDS advisor reported, "Women who have secretly discovered their husband's positive serostatus are undergoing daily rape in their marriages and, according to tradition, they can't refuse it. They feel they are being condemned to a death sentence after every sexual intercourse."[5]

Maintaining collaboration between religious leaders and PLWHA and supporting their agenda and organizational development are priorities for the Government of the Republic of Mali (GRM), USAID, and all development partners. The joint implementation of HIV/AIDS-related educational interventions by PLWHA and religious leader is emerging as an operational strategy to reduce stigma. Accordingly, supporting greater involvement of PLWHA and religious leaders

[5] Personal communication from Ms. Aida Lo, USAID/Mali HIV/AIDS advisor.

in the fight against AIDS is critical. Supporting mass communication campaign can also help reduce the stigma. These campaigns may focus on improving knowledge of HIV/AIDS, documenting and broadcasting testimonies of religious leaders and PLWHA in collaboration with traditional communicators, and raising awareness regarding the benefits of voluntary counseling and testing.

B. Global Funds and Access to Available HIV/AIDS Resources by Local NGOs and Civil Society

The GRM's Ministry of Health (MOH) recognizes the pivotal role of NGOs and civil society in the fight against HIV/AIDS, and it has dedicated resources to support partnership interventions for local responses to HIV/AIDS. The Global Fund may provide an opportunity for additional HIV/AIDS funds; however, there are ongoing uncertainties about the availability and timely disbursement of Global Funds.

Mali has already received approval for $2,592,991 for malaria prevention and control activities in 2002–2005. The coordinating unit of the National AIDS Control Program (PNLS) was recently notified that their proposal to the GFATM was not accepted. Therefore the PNLS, with support from UNAIDS and USAID, will revise the proposal for re-submission for 2004 funding cycle. Although the entire Global Fund amount will be channeled through government funding and accountability procedures, GRM plans to allocate more than 40% to NGOs and community interventions and 1.4 % to interventions driven by PLWHA. The remaining funds will support government-driven interventions. However, access to the existing HIV/AIDS resources controlled by GRM, local NGOs, and civil society remains a challenge because the current GRM's systems and procedures are too cumbersome to support an expanded response to HIV/AIDS. Mechanisms for disbursement and accountability of HIV/AIDS resources must be developed or streamlined. USAID/Mali should include this important topic in its advocacy agenda and explore with the GRM/MOH and other development partners options for establishing mechanisms that facilitate access to HIV/AIDS resources provided by local NGOs and civil society. These options may include establishing a Secretariat position on the High Council on AIDS and empowering the Secretariat to develop a mechanism for increasing access to the HIV/AIDS resources of the NGO community and civil society.

C. Synergy with other Strategic Objective Teams and Multisectoral Approaches.

USAID/Mali is cognizant of the multisectoral aspects and consequences of HIV/AIDS. The Mali Country Strategy Plan emphasizes linkages within the Mission strategy and mandates that the strategic objective components contribute to the accomplishments of other strategic objectives. This policy decision is important for developing mutually supportive HIV/AIDS-related activities across the various USAID strategic objective teams and partners. USAID/Mali will also be in a more credible position to advocate for a multisectoral approach to HIV/AIDS, if it mobilizes its own multisectoral resources for contributing to HIV/AIDS prevention, care, treatment, and support.

The proposed strategy advocates for the provision of technical assistance to USAID Strategic Objective (SO) Teams 7, 8, 9, and 10 to improve their understanding of HIV/AIDS issues and determine opportunities for effective HIV/AIDS-related interventions in their respective sectors.

SOs would provide their own funding for HIV/AIDS activities taking place under their auspices and would be supported in these efforts through the provision of technical assistance and guidance from the SO6 team and its partners. This technical assistance may include conducting targeted assessments or secondary data analysis in each sector, advocacy interventions that target key players in each sector, and developing operational plans and resource mobilization activities for targeted priority HIV/AIDS interventions. Illustrative priority activities are presented below for SOs 7, 8, 9, and 10.

Improved Quality of Basic Education (SO7): SO7, through collaboration with HIV/AIDS implementing partners, could:

- Integrate HIV/AIDS topics into school-based training materials, radio educational programs, and study guides for teachers, educational advisors, and school directors as they build an appropriate comfort level for discussing HIV/AIDS with school children and parents.
- Include relevant HIV/AIDS topics in the curriculum for school children and selected Ministry-of-Education teacher training institutes, and in the training-of-trainers curriculum of pedagogic centers.
- Take advantage of the planned school-management training of community schools and associate public schools to engage parents and selected vulnerable communities about HIV/AIDS.
- Take advantage of its planned support for use of the Education Management Information Systems to establish a database that records and monitors chronic diseases and deaths among teachers in selected regional Directorates of Education to document the adverse consequences of HIV/AIDS in the sector.

Shared Governance through Decentralization (SO8): The empowerment of decentralized structures and communities is a critical component of the second generation of the HIV/AIDS responses. Through collaboration with HIV/AIDS implementing partners, SO8 could take advantage of its planned activities with key regional- and community-level participants, including women's groups to:

- Improve understanding of HIV/AIDS.
- Establish an improved political environment for HIV/AIDS prevention and care.
- Foster allocation of financial resources for HIV/AIDS at the regional and community level.

Accelerated Economic Growth (SO9): Through collaboration with HIV/AIDS implementing partners, SO9 could take advantage of its linkages with selected agroindustrial sectors, particularly in the office du Niger zone, to engage their key private and public actors in STI/HIV/AIDS prevention and care in rural areas. The proposed strategy recommends giving priority attention to seasonal agricultural workers, who are most vulnerable to HIV/AIDS and could become core transmitters of HIV in the general rural population.

SO9 does not focus, however, on other subsectors of the Mali economy critical to HIV/AIDS prevention and care. HIV/AIDS implementing partners will also have to develop linkages with the Cotton/Textiles Marketing Company of Mali (CMDT), an important player in the agroindustry of Mali that employs many seasonal agricultural workers in its 19 sites. CMDT

already provides discreet STI/HIV/AIDS education and services for its employees through a network of workplace clinical services. Finally, collaboration with Anglo Gold will also provide opportunities to strengthen and improve coverage of interventions that target mining zones.

Communication for Development (SO10): Collaboration between SO6 and the Mission Special Objective 10, Communications for Development, has provided several opportunities for joint communication for BCC interventions through local radio stations. The proposed strategy recommends continuing this effective collaboration, and emphasizes building the capacity of local radio stations to develop and monitor educational programs to maximize the quality and coverage of interventions for BCC and advocacy.

Annex 1:
List and Categorization of High-Risk Sites According to Volume of Sustained Interventions

Definitions:

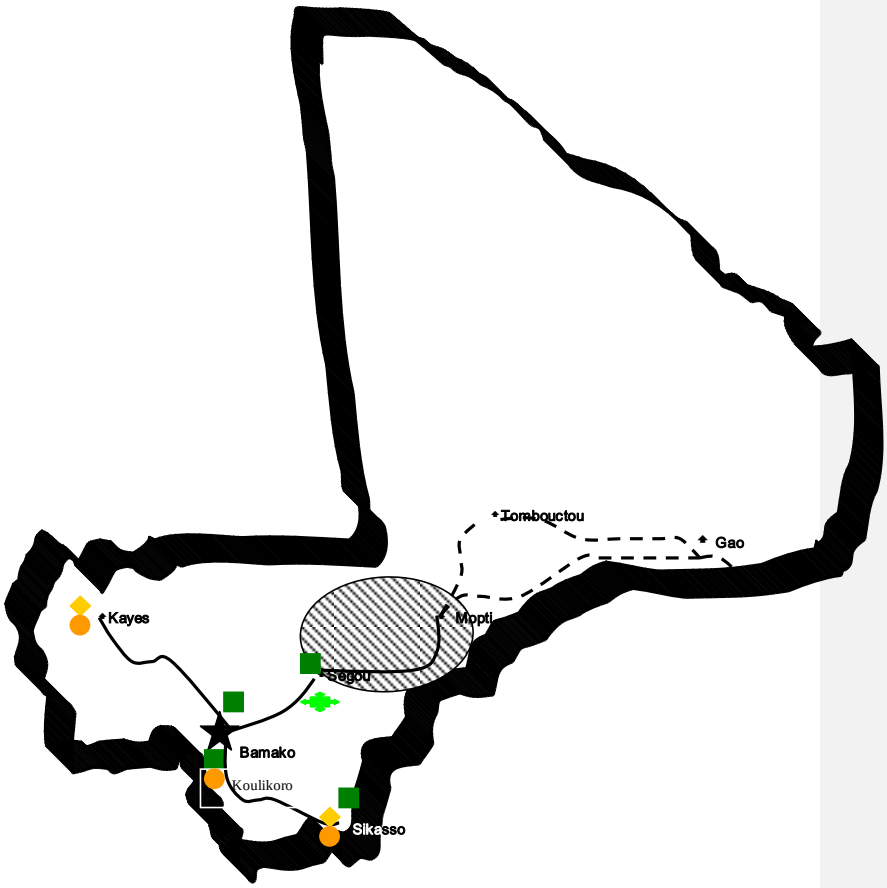
1. No HIV/AIDS interventions: No NGO conducts HIV/AIDS interventions targeting high-risk zones and related networks.
2. Low Volume of HIV/AIDS interventions: At least one NGO operates in the zone and conducts ad hoc interventions, but does not have funding dedicated to HIV/AIDS interventions that target high-risk zones.
3. Medium Volume of HIV/AIDS interventions: At least one NGO operates in the zone, has dedicated funding, and conducts regular activities.
4. High Volume of HIV/AIDS interventions: At least two NGOs operate in the zone and have dedicated funding.

High-Risk Locations	**No HIV/AIDS Interventions**	**Low Volume of HIV/AIDS Interventions**	**Medium Volume of HIV/AIDS Interventions**	**High Volume of HIV/AIDS Interventions**
A. Locations along transportation routes				
Bamako				*****
Oulessebougou		**		
Bougouni		**		
Koumantou	*			
Niena	*			
Sikasso Town				*****
Zegoua				*****
Bamako				
Fana				*****
Konobougou		**		
Segou Town				*****
Bla				*****
San		**		
Mbopti				*****
Douentza		**		
Gossi	*			
Gao	*			
Ansongoa	*			
Labezanga	*			
Segou				
Koutiela			***	
Sikasso				

High-Risk Locations	No HIV/AIDS Interventions	Low Volume of HIV/AIDS Interventions	Medium Volume of HIV/AIDS Interventions	High Volume of HIV/AIDS Interventions
A. Locations along transportation routes				
Bamako				
Kita		**		
Mahina		**		
Kayes			***	
Diboli	*			
Bamako				
Kangaba	*			
Kenegue	*			
Guinea Border				

B. 19 Sites of Cotton/Textiles Marketing Company (CMDT)				
Kita	*			
Dioila	*			
Fana	*			
Oulessebougou	*			
Sikasso	*			
Koutiala (4 sites)	*			
Karagana	*			
Kimparana	*			
Koumantou	*			
Kignan	*			
Bougouni	*			
San	*			
Segou	*			
Bamako	*			
OHVN (Kangaba)	*			
Office du Niger (Niono)	*			

High-Risk Locations	No HIV/AIDS Interventions	Low Volume of HIV/AIDS Intervention	Medium Volume of HIV/AIDS Interventions	High Volume of HIV/AIDS Interventions
C. Mining Zones				
Morilla/Sanso			***	
Siama/Fourou	*			
Kalana	*			
Yatela	*			
Keneiba	*			
D. Six Military camps	*			
E. Kayes Region High Proportion of Migrants to Countries with High HIV Prevalence	*			
Nioro du Sahel	*			
Bafoulabe	*			
Kanieba	*			
Diema	*			
Kayes	*			



LEGENDE

Usines CMDT
Bamako

Région de Kayes :
- Kita

Région de koulikoro :
- Ouélessebougou

Région de Ségou:
- Ségou Ville
- Karagana
- Yorosso
- Koury

Région de Sikasso :
- Sikasso Ville
- Bougoun
- Koumantou
- Koutiala
- Kiparana / San

SUCRERIE
Région de Ségou:
- Dougabougou
- Seribala

Huileries

Région de Kayes :
- Kita

Région de Koulikoro :
- Koulikoro Ville

Région de Sikasso :
- Koutiala

Office du Niger :
Couvre 212 villages qui possèdent chacun des petites unités de décortiqueuse . Par contre les quatre (4) Usines sont fermées

Mines D'or
Région de Kayes :
- Sadiola
- Yattele
- Tabakoto

Région de Sikasso :
- Morila
- Siama
- Sanso

Current Axes

Proposed Extension Axes

9/10/03

Annex 2:

USAID/MALI HIV STRATEGY TARGETS AND BASELINES (PROVISIONAL*, NOVEMBER 2003)

Indicator	Population	Baseline (year)	Target (year)	Data Source
Non-regular sex partners				DHS
- last 6 months	Truck drivers	24.7% (2000)		ISBS
- last 6 months	Ticket touts	24.7% (2000)		ISBS
- last 6 months	Ambulatory vendors	8.1% (2000)		ISBS
Condom use with last non-regular sex partner – high risk groups	Truck drivers	48.5% (2000)		ISBS
	Sex workers (clients)	96.5% (2000)		ISBS
	Ticket touts	51.1% (2000)		ISBS
	Ambulatory vendors	30.2% (2000)		ISBS
Condom use with last non-regular sex partner – Bridging populations	Married men with non-regular partners	32.7% (2001)		DHS
Mean number of sex partners	Men not in union ages 25-29	1.3 (2001)		DHS

*USAID/Mali is waiting for the results of several surveys conducted in the latter half of 2003 in order to update baseline figures and estimate realistic targets. Results should be available in January 2004.

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