USAID DISTRICT LEVEL HEALTH PROGRAM / KENEYA CIWARA

FINAL PERFORMANCE REPORT (October 2003 – September 2008)

A girl from Kalifabougou village (Kati district) thanks all partners for the quality improvement of Kalifabougou CSCOM during the accreditation ceremony.

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Subcontract Number:	**N° 688-A-00-03-00063**
Reporting period:	**October 1, 2003 – September 30, 2008**

Table of Contents

Acknowledgments

The Keneya Ciwara team is really grateful to the USAID/Mali health team and thanks them for their skilful and timely advice and guidance. Their site visits were a good way not only to obtain direct insights, but also bring credibility to the program.

USAID Mali's health team in field visit in Kalifabougou (Kati cercle)

The results covered in this final report are a testament to the hard work and dedication of our partner NGOs and the field teams of animators and supervisors in each district. The Keneya Ciwara team would like to take this opportunity to thank all its partners at national, regional and district and community levels for their hard work, dedication, and expertise in implementing project activities.

List of Acronyms

ANC	Antenatal Care
ASACO	Association de Santé Communautaire
ATN	Assistance Technique Nationale
BCC	Behavior Change Communication
BLOC	Brand name of insecticide kit
CARE	Cooperative for Assistance and Relief Everywhere
CAREF	Centre d'Appui à la Recherche et à la Formation
CBD	Community–Based Distribution
CHW	Community Health Worker
CS	Child Survival
CSCOM	Centre de Santé Communautaire
CSRef	Centre de Santé de Référence (District-level hospital)
DG	Democratic Governance
EPI	Expanded Program on Immunization
FAF	Fer et Acide Folique (Iron and Folic Acid)
FPOL	Family Planning Opinion Leader
GATPA	Gestion active de la troisième phase de l'accouchement
GP/SP	Groupe Pivot/Santé Population
GRM	Government of the Republic of Mali
HEHP	Household Essential Health Practices
HMIS	Health Management Information System
ICPM	Infirmier Chef de Poste Médical
IPC/C	Interpersonal Communication / Counseling
IPT	Intermittent Preventive Treatment
INTRAHEALTH	International Training Health
ITN	Insecticide-Treated Net
JHU / CCP	Johns Hopkins University Center for Communication Programs
JNV	Journée Nationale de Vaccination (National Vaccination Day)
KAP	Knowledge, Attitudes and Practices
KC	Keneya Ciwara
MFL	Men for Life
MQI	Mali Quality Improvement
MOH	Ministry of Health
MPA	Minimum Package of Activities
NGO	Non Governmental Organization
NID	National Immunization Day
ORT	Oral Rehydration Therapy
PDDSS	Plan Décennal de Développement Socio-Sanitaire
PIC	Plan Intégré de Communication
PGP	Programme de Gouvernance Partagée
PNP	Policy, Norms and Procedures
PSI	Population Services International
RH	Reproductive Health
SIAN	Semaine d'intensification pour l'alimentation et la nutrition
SO	Strategic Objective
SP	Sulfadoxine Pyriméthamine
TDY	Temporary Duty Assignment
TT	Tetanus Toxoid
USAID	United States Agency for International Development

Executive summary

Keneya Ciwara is a five-year community health program funded by USAID implemented by CARE and a consortium of partners. The project began implementation in August 2003 and ended in September 2008. As a part of USAID/Mali's health program, and working with the Government of Mali's health program (PRODESS), the project aims to increase access to and use of high-impact health services, improve household level health behaviors, and improve the quality of services available. The project is active in 375 health zones: 13 *cercles* (or districts) and 2 Communes of Bamako.

The work of the program has been accomplished through several networks of actors, starting with USAID, the Government of Mali, and a consortium of key members including: CARE, John Hopkins University/Center for Communications Programs (JHU/CCP), IntraHealth International, and Groupe Pivot/Santé Population (GP/SP). The consortium works with the project management team to coordinate project planning and implementation with the other actors in the process. Other actors include 17 local NGOs, 12 district-level field coordinators, and the district-level health teams of the Malian health infrastructure. Partner NGOs, field coordinators, and district teams work with ASACOs managing 236 local health centers, and a system of nearly 4,000 *relais* to carry out the activities of the program.

Together, all of these actors delivered activities that target high-impact services related to child survival and family planning and reproductive health on three levels of intervention: households, service providers, and communities. The program has worked to ensure individual behavior change in order to raise awareness of essential household health practices and increase the client *demand* for high quality health services. It also has been working to increase the *supply* of health care by improving the quality and availability of services provided at the centers and among health workers. Finally, the project has been working to raise community awareness of important health practices, and works with community groups to create an enabling environment for healthy practices and quality care. The more informed a community is about its rights and responsibilities toward health services, the easier it is for individuals to change their own behaviors.

Major Achievements

High Impact Health Indicators – KC has been especially successful in achieving high impact health indicators such as strengthened delivery of community health services through increasing customer demand for, and utilization of, maternal and child health (MCH), family planning and reproductive health services; and increased supply of quality MCH/FP/RH services by ensuring CSCOMs have a minimum set of medical equipment in order to provide quality services.

From October 1, 2003 to September 30, 2008 compilation of routine data shows that progress has been consistently made to improve the process as well as the outcome indicators (See appendices, Table 1: KC Five Years Key process and outcome Indicators)

Process Indicators:

- 520 relais trainers trained.
- 4,053 relais trained and equiped compared to the target of 4,000.
- 5,549,527 people were reached through community-education sessions organized by the NGO/relais.
- 75% of outreach visits have been accomplished as planned.
- 3,443 relais are functional
- 12 CSCOM were accredited as "CSCOM Ciwara d'Or" as planned.

Outome Indicators:

- 397,199 children (0-11 months) have received DTCP3 or Pentavalent3 i.e. 84% (397,199/472855) as compared to 80% target.
- 184,472 children (6-11 months) have received vitamin A i.e. 53% (184,472/348060) as compared to 80% target.
- 259,294 pregnant received at least 2 doses Intermittent Preventive Treatment (ITP) of *Sulfadoxine Pyriméthamine* (SP).
- 155,443 new family planning users reached.
- 607,279 new pregnant women registered for the antenatal care service.
- 732,576 insecticide treated nets (ITNs) distributed as compared to the five year objective of 500,000.

The following table highlights the changes that took place in the project in terms of health indicators from the baseline survey conducted in 2004, the mid-term evaluation completed in 2006 and the final Evaluation completed in 2008. Except the ORT, all key indicators have greatly improved.

INDICATOR DEFINITION	Baseline 2004 Survey results	Mid-Term 2006 Survey results	Final Ev 2008 Survey results
1. % of children 12-23 months having received DPT3 before 12 months of age	50%	66.80%	61.2%
2. Percent of children (6-59 months old) receiving Vitamin A supplementation in the last 6 month	30.70%	61.10%	62.2%
3. Percent of women receiving recommended doses of folate/iron during pregnancy	34.50%	46.40%	50.8%
4. Percent of pregnant women sleeping under insecticide-treated bed nets	6.80%	20.40%	32.4%
5. Percent of children under 5 years sleeping under Insecticide-treated bed nets	9.70%	23.50%	41.5%
6. % of pregnant women receiving 2 doses of SP As intermittent Presumption Treatment (IPT) for malaria	.30%	8.70%	22.5%
7. Percent of children 0-59 months with diarrhea receiving ORT	19.40%	28.40%	18.1%
8. Contraceptive prevalence rate for modern Methods among women of reproductive age	6.90%	8.80%	9.4%

Number of *relais* trained – KC increased household knowledge and adoption of healthful practices for MCH/FP/RH as more than 4,000 *relais* were trained and equipped to carry outreach activities into households. KCI also trained 48 nomadic *relais* to work with nomadic and semi-nomadic pastoralists and developed a strategy for serving hard to reach northern nomadic populations.

Number of individuals targeted - Overall, KC has been able to touch more than three million people in community information sessions, distribute hundreds of thousands of mosquito nets, and register measurable behavior change among households in its interventions zones.

BCC materials developed and distributed - In its five years of activity, KC has made great strides in providing quality BCC materials for use at the community level. Because all of these materials were developed and pre-tested locally, they are both understandable and culturally appropriate to the context in which they are used.

Professional development in service providers - KC has conducted many activities in order to increase the quality of care provided, and the abilities of health care providers to interact with their communities and give quality service. Many partners have noted improved supervision and monitoring by district health teams, ASACOs, and CSCOMs, and site this as one of the major successes of the project.

Capacity building of partner NGOs - The project activities and broad interventions have reinforced ties between NGOs and the communities they work in. They have greater skills and have built greater trust in their activities with the local population. This allows them both to better conduct activities and to be more aware of local needs.

Ciwara d'Or Accreditation - KC accredited 12 CSCOMs and many more CSCOMs have started the process of improving their services by opening dialogues with their communities, and creating improvement teams and Quality Improvement plans. Over 190 communities and centers have started the process of the Quality Improvement Initiative. Several CSCOMS in each of the KC districts have been pre-selected to compete for the recognition of being a Ciwara d'Or site. This represents an accomplishment in terms of improving services and reinforcing links between the community and the health structures. The accreditation process was a sense of pride for selected communities and was successful in promoting community ownership regarding the health care system.

Increased functionality of CBOs - The project has been able to create and reinforce approximately 750 CBOs (women's groups and men's *grins*) that take an active role in their health and have the resources to support it. Their successful example has prompted the community-led formation of many similar groups without KC assistance in many villages.

Despite these encouraging results achieved, KC has been facing the following major challenges:

- Dealing with insecurity environment, reinforcing and expanding the program in the North with strategies that involve nomadic *relais.*
- Meeting the appropriate number of *relais* in each cercle, with 2 *relais* per village or having a *relais* adequately cover 35 households is really challenging.
- Ensuring the availability of supplies in services delivery sites: SP, contraceptives, iron / folic acid, vitamin A for routine activity, and ITNs.
- Improving the performance of the ASACOs in supporting CSCOM activities on a continuous basis.
- Reinforcing and expanding the program in the North with strategies that involve nomadic *relais.*

Introduction

The USAID Cercle-Level Health Program/Keneya Ciwara (USAID/KC) is a 5-year program funded by the United States Agency for International Development (USAID). This program falls within USAID/Mali's health program, which aims to increase the use of high impact health services and improved health practices. As an integrated part of the Malian Government's health program (PRODESS II), the Keneya Ciwara Program aims to improve the access, quality and use of high impact services and ensure the adoption of key health practices by households in 13 cercles and the districts of Bamako (375 CSCOMs). These high impact services are related to child survival (vaccination, malaria, diarrhea disease, nutrition and vitamin A), family planning and reproductive health (CS/FP/RH).

The Keneya Ciwara program was implemented by a consortium led by CARE Mali. Key partners in the consortium include: the Johns Hopkins University Center for Actin against Hunger (for the first 3 years only) Communication Programs (JHU/CCP), IntraHealth International, and Groupe Pivot/Santé Population (GP/SP).

- *CARE* has primary responsibility for the overall implementation of USAID/KC, including all aspects of program management, planning, reporting/liaising with USAID and the GRM.
- *JHU/CCP* has a subcontract for behavior change communication (BCC) component of the program and geographic coverage of Kati, Sikasso and Kadiolo cercles.
- *IntraHealth International* has a subcontract for clinical training component of the program.
- *Action Against Hunger* was in charge of coordinationg Keneya Ciwara intervention in Gao and Kidal during the first 3 years from 2004 to 2006
- *Groupe Pivot/Santé-Population* has a subcontract for the capacity building of NGOs and community organizations.

This report covers the following sections for the period from October 1, 2003 through September 30, 2008:

- **Section 1**: **key results achieved** for each *high impact service*: Immunization, Malaria prevention, Nutrition, Maternal Health and Family Planning, Diarrhea Disease Control.
- **Section 2**: **Cross-cutting interventions accomplishments:** training of community health workers (*relais*); Behavior Change Communication (BCC) interventions and production of support materials; strengthening of outreach activities; Mali Quality Improvement Initiative "*Ciwara d'Or*"; Mobilization of community networks (women and men's groups, ASACOs and *relais* for quality services; building partnership and synergy for child and maternal health; and program mid-term evaluation.
- **Section 3**: Lessons learned.
- **Section 4**: Conclusion and Key recommendations

Section 1: Key results achieved over the last five years for each *high impact health service*:

Routine data (see appendices, table 1) and the final evaluation report (see appendices, table 2) have shown that Keneya Ciwara made consistent progress toward the achievement of all indicators except the ORT. It can be noticed from KC final evaluation report that except the ORT, all key indicators have greatly improved.

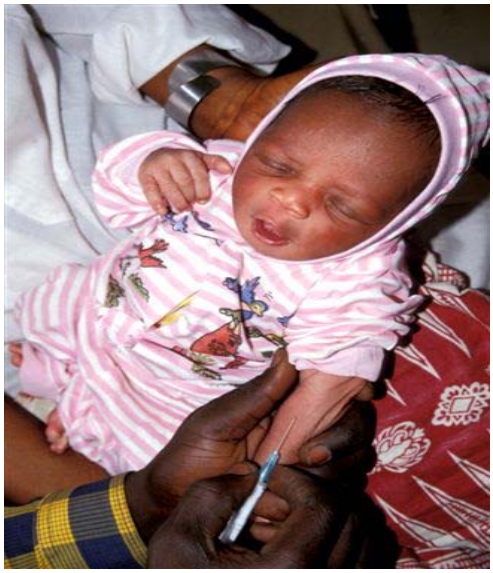
1.1 Child Immunization Services

Introduction
Increasing access to child and infant immunization services constitutes an important pillar in the Keneya Ciwara program. Child and infant immunization services were provided as part of the Minimum Package of Activities (MPA) through CSCOM-based, community outreach and mobile teams. Keneya Ciwara greatly contributed to the improvement of the child immunization coverage by paying a daily stipend for outreach activities *("strategies avancées et mobiles")*.

2008 Target for Immunization: By June 2008, 80% of children aged 12-23 months should be fully immunized by the time of their first birthday (DTCP or Pentavalent 3 vaccine is the proxy indicator).

Key Interventions:

- *Revision of Microplans. M*icroplans helped to determine for each CSCOM, the level of program inputs including: vitamin A, iron/folic acid, sulfadoxine pyrimethamine (SP), insecticide treated nets (ITN), and even the number and periodicity of outreach activities in the communities.
- *Involvement of ASACOs in developing microplans*. This micro planning process was an opportunity to obtain the commitment of ASACOs towards covering costs of outreach activities, mainly fuel for motorcycles and refrigerators containing vaccines.
- *Provision of financial support for outreach activities.* USAID/KC continued to provide financial support outreach activities with per diems for vaccinators and money for fuel costs.
- *Participation in the Integrated Health Campaign*. In December 2007, the Malian government (with the help of USAID/KC, ATN, the Canadian Red Cross, and other partners) conducted the Integrated Health Campaign, that targeted children from six months to five years for five health interventions, including:



Vitamin A, Polio, Yellow Fever, and Measles vaccines, Albendazol for de-worming, and the distribution of ITNs. USAID/KC members participated in this project, from the relays at the local level helping to distribute medicines to regional groups helping with supervision and national members working to accommodate international visitors.

Key Results:

All 242 functional CSCOM of KC zones offer the Minimum Activities Package and Outreach vaccination services.

Routine data has shown that:

- 397,199 children (0-11 months) have received DTCP3 or Pentavalent3 i.e. 84% (397,199/472855) as compared to 80% target.
- 184,472 children (6-11 months) have received vitamin A i.e. 53% (184,472/348060) as compared to 80% target.

Household survey data from the final evaluation has shown that:

- 61.2% of children 0-11 months received DTCP3 or Pentavalent3.
- 62.2% of children 6-11 months received vitamin A twice a year.

Analysis and discussion

Although less that the target of 80%, immunization and vitamin A coverage remained high in the Keneya Ciwara intervention zones. Using community and household education about child immunization along with strengthened outreach interventions have contributed to achieve this coverage level. If this trend is sustained, immunization interventions will surely lead to a reduction to infant morbidity and mortality. However, a lot has to be done to improve the situation in districts in Northern Mali which are still far behind in immunization coverage. Specific effort should be made to continue to support outreach interventions in specific areas and targeting Northern populations.

The final evaluation result showed a decrease in the percentage of children immunization 61.2% as compared to 66.8% in the mid-term evaluation. This is partly due to decline in KC support during in FY'08 (The final evaluation was conducted in April 2008). A reduction during fifth year (FY'08) in the stipend and fuel costs that Keneya Ciwara covers as part of these activities may have contributed to this reduction. By strengthening the capacity of ASACOs in management and financial skills, they will be able to sustain payments of daily stipends; and also they will be able to mobilize resources in and outside of the health sector for health activities. However some ASACO in difficult financial situation may still need final support

1.2 Malaria Prevention Services

Introduction

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

2008 Targets for Malaria prevention:

- Percent of pregnant women sleeping under insecticide-treated bed nets (30%).
- Percent of children under 5 years sleeping under insecticide-treated bed nets (30%).
- Percent of pregnant women in program sites receiving 2 doses of SP as IPT for malaria (45%).

Key Interventions implemented:

- Strengthen *"no pregnant woman left out of a bednet"* approach in prenatal services.
- Strengthen *"no-completely-vaccinated child left out of a bednet"* approach in service sites.
- Educate households to use bednets.
- Educate households to seek prompt treatment for malaria.
- Educate pregnant women to receive 2 doses of SP during prenatal services at the CSCOM.
- Refer pregnant women for malaria prevention along with antenatal care at the CSCOM.
- Distribute ITN re-treatment kits and educate households on their use
- Produce brochures on malaria prevention for service providers.
- Produce and distribute counseling cards for relays to educate families about malaria treatment (CTA).

Key Results:

Routine data has shown that:

- 732,576 insecticide treated nets (ITNs) distributed as compared to the five year objective of 500,000.
- 259,294 pregnant received at least 2 doses Intermittent Preventive Treatment (ITP) of *Sulfadoxine Pyriméthamine* (SP).

Household survey data from the final evaluation has shown that:

- 32.4% of pregnant women were sleeping under ITN.
- 41.5% of children under 5 were sleeping under ITN.
- 22.5% of pregnant women received 2 dose of SP as intermittent presumption treatment for malaria.

Tenfold increase in service use: the availability of ITNs through the KC service-based strategy (ANC, PNC and immunization) greatly increased pre- and post natal services use in CSCOMs.

Analysis and discussion

Pregnant women and their unborn children are extremely vulnerable to malaria, which is a major cause of perinatal mortality, low birth weight, and maternal anemia. Therefore, making bed nets and re-treatment kits available in the CSCOM has guaranteed access to pregnant women and under-5 children. The 2008 Final evaluation observed a remarkable achievement. More than 32% of pregnant women were sleeping under insecticide-treated bed nets as compared to the 2006 mid-term evaluation of 20%. More than 41% of children under-5 years were sleeping under insecticide-treated bed nets as compared to the 2006 mid-term evaluation of 23.5%. During the life of KC 259,294 pregnant women received 2 doses of SP as IPT for malaria prevention.

The disponibility of ITNs at CSCOM level and the mobilization of communities with respect to ITNs through community radios, community networks and household education has led to increased attendance and use of antenatal and post natal services.

1.3 Nutrition Services

Introduction

In Mali, as well as around the world, people want to lead healthy lives, raise well-nourished children and provide them with opportunities for the future. Keneya Ciwara initiatives are designed with its partners to support the GRM/Nutrition services in implementing its strategic plan. In doing so, we hope to prevent malnutrition effectively through the promotion at community and household levels of exclusive breastfeeding up to 6 months of age, promote timely introduction of food supplements, vitamin A supplement from 6 months in order to achieve universal coverage in children between 6 and 59 months of age, Iron/ folic acid supplements for pregnant women, and also promote food hygiene in Mali.

2008 Nutrition Target: By June 2008, 80% of children (6-59 months) in contact with the CSCOM or outreach activities should have received Vitamin A supplementation in the previous 6 months.

Key Interventions:

- *Promotion of exclusive breastfeeding up to 6 months and the timely introduction of food supplement.* KC produced behavior change communication (BCC) materials (counseling cards) for community and household education by *relais* on exclusive breastfeeding and the introduction of food supplements at age 6 months. Keneya Ciwara introduced and trained more than 400 leaders of saving and credit women's community groups (Musow ka Jigiya Ton or MJT) on the use of the materials in counseling women. Leaders of (MJT) saving and credit women's groups provide basic communication on health and make referral to their peers who need services at the CSCOM.
- *Promotion of Vitamin A supplementation.* USAID/KC implemented a two-prong strategy; first, the extension to the community level of the national vitamin A campaigns in its geographic zones; and second, intensification of routine Vitamin A supplementation of children in the CSCOMs and through outreach. About four thousand (4,000) Community *Relais* in Keneya Ciwara geographic areas mobilized communities to vitamin A supplementation sites and provided logistic support (vehicles, fuel, and social mobilization). KC actively reinforced routine vitamin A supplementation in the CSCOM and during the SIAN activities.
- *Testing of Salt for Iodine.* USAID/KC relays have testing kits to check salt in households for iodine supplementation and educate families about the importance of iodized salt.
- *ANC with iron/ folic acid intake for pregnant women.* In a bid to reduce the effects of iron deficiency anemia in pregnancy, KC produced and disseminated community and household education support materials aimed at informing pregnant women on the health benefits of iron and folic acid supplementation during pregnancy. About four thousand (4,000) community relais, reinforced by over 400 women community group leaders representing about 12,000 women used the materials for interpersonal communication sessions on iron and folic acid supplementation.
- *Relay Participation in SIAN (Nutritional Activities Intensification Week).* In December, 2007, as part of the integrated health campaign, relays helped administer doses of Vitamin A from children aged 6 months to 5 years.

Key Results:

Routine data has shown that :

- 184,472 children (6-11 months) have received vitamin A i.e. 53% (184,472/348060) as compared to 80% target.

Household survey data from the final evaluation has shown that:

- 62.2% of children 6-11 months received vitamin A twice a year.

Analysis and discussion

Breastfeeding, especially exclusive breastfeeding, provides the best possible nutrition for both physical and mental development, supplying all the nutrients and fluids most infants need for the first six months of life. It also provides protection against diarrhea and common life-threatening infectious diseases. Emphasis is put on the promotion of exclusive breastfeeding up to 6 months and the timely introduction of food supplement. Breastfeeding is also good for women's health and welfare; it complements family planning and saves money. Breast milk is the least expensive food for infants and the best.

Promotion of exclusive breastfeeding up to 6 months and the timely introduction of food supplement.

Routine vitamin A supplementation is promoted in the CSCOM and during outreach in the community. Vitamin A supplementation through routine immunization interventions just covers 6 to 11 month old children and leaves out children of other age groups. This argues strongly for the use of vitamin A campaigns which unfortunately are costly. To secure appropriate vitamin A coverage of the target population, both vitamin A campaign and routine supplementation are used in the KC area. The vitamin A coverage of children 6-56 months as shown in the final evaluation of KC (July 2008) is 62% in KC areas which is still low compared to the 80% target of 2008. The scarcity of vitamin A tablets for routine activities poses a major problem to cover adequately children aged 6-11 months and postpartum women in Mali. The current interruptions in vitamin A supply in a good number of cercles for routine interventions calls for an urgent response to meet the need for vitamin A in Mali. There is an urgent need to solve the lack of vitamin A for routine interventions.

1.4 Maternal Health and Family Planning Services

Introduction

KC is supporting the efforts of the GRM to improve services in maternal health, as well as to sustain impacts of the national FP campaign and to continue generating demand and increasing use of modern contraceptive methods as necessary steps to reposition family planning. Services in maternal health include, among others, prenatal care, tetanus toxoid (TT) vaccine, assisted child delivery, and post partum care all of which are strongly linked to the ITN distribution strategy.

Enhancing the development of microplans helped determine for each CSCOM, the level of program inputs including: vitamin A, iron/folic acid, sulfadoxine pyrimethamine (SP), insecticide treated nets (ITN), and even the number and periodicity of outreach activities in the communities. The micro planning process elicited commitment of ASACOs towards covering costs for the outreach activities, mainly fuel for motorcycles and refrigerators containing vaccines.

Maternal Health and Family Planning Targets by September 2008

- 10% of contraceptive prevalence rate for modern methods among women of reproductive age.
- 80% of pregnant women should received recommended doses of folate/iron during pregnancy.

Key Interventions

- *Increase Family Planning services in the districts*: Through supervision and training activities, Keneya Ciwara focused on improving quality and access of FP services in the program districts. Provider skills were updated in interpersonal communication and counseling (IPC/C) and contraceptive technology.

- *Utilization of high quality family planning behavior change communication materials:*
- In collaboration with Georgetown University, the community relais were trained provided samples for the promotion of "the Fixed days Method" (Methode de Jours fixes).
- *Validation of Job Aids:* In collaboration with ATN and MOH, Keneya Ciwara participated in designing Job Aids for CSCOM service providers.
- *Supervision of trained service providers:* Keneya Ciwara conducted formative supervision in all its intervention health districts;

Key Results:

In addition to maternal health intervention related to malaria prevention mentioned in previous section following were achieved:

Routine data has shown that:

- 101 health services providers received family planning communication and technology training.
- 573 health services providers received Active Management of the Third Stage Labor (AMSTL).
- 607,279 new pregnant women registered for the antenatal care service.
- 155,443 new family planning users reached.
- 44,673 women received Active Management of the Third Stage Labor (AMSTL).

Household survey data from the final evaluation has shown that:

- 50.8% of women received recommended doses of folate/iron during pregnancy.
- 9.4% of contraceptive prevalence rate for modern methods among women of reproductive age achieved.

Analysis and discussion

Despite regular stock outs of contraceptive commodities, sustained community and household communication as well as client referral played key roles in registering 607,279 new pregnant women and 155,443 new family planning users. The final evaluation of KC has shown a remarkable regular increase from 6.9 % in the base line in 2006, to 8.8%% in the mid-term evaluation, and to 9.4% in the final evaluation.

It is really impressive to report that 44,673 women received Active Management of the Third Stage of Labor. However stock out of key commodity at certain delivery points is a big challenge: 222 service delivery points (SDP) have experienced stock outs with regards to any contraceptive commodity during the five year life of KC. MOH should define and apply appropriate strategy in order to reduce stock outs.

1.5 Diarrhea Disease Control

Introduction

Various data sources concur that diarrhea disease is one of the top five killer diseases of children in Mali. Efforts in the Keneya Ciwara program are directed towards community and household education on signs of acute diarrhea, hand washing, food and water protection and the promotion of oral rehydratation treatment (ORT) in the household.

Key Interventions

- *Home and community education on ORT and hand washing in the household:* Keneya Ciwara has trained over 4,000 *Relais* who are equipped with BCC support tools and FP supplies needed for home visits and health education sessions. A community health worker organizes 50 home visits a month during which he or she gives health talks including diarrhea disease control, and observation of essential household health behaviors.
- *Referral of children with acute diarrhea:* The community health workers, leaders of women's community groups and NGO animators received education on signs of acute diarrhea and support materials for referral of the sick child. Each community health worker (CHW) or *relais*, leader of women's group and NGO animators is provided 50 referral slips as part of his/her resource kit.
- *Food hygiene and protection in the household.* To reduce the impact of foodborne and other hand-to-mouth infections, the Keneya Ciwara team produced community educational materials for *relais* and leaders of women's community groups as wells as NGO community animators. These actors actively promoted food, water, personal and environmental hygiene through organized community and household education sessions.

Key Results:

- Household and community education sessions were organized by community health workers and NGO animators.
- Referral of children with acute diarrhea to health facilities: the number of children referred to CSCOMs for diarrhea disease has increased.

- Utilization of 4,500 counseling cards produced for relays on handwashing and also on acute signs of diarrhea.
- 18.1% of children 0-59 months with diarrhea received ORT.

Analysis and Discussion

Diarrhea disease is a very common childhood disease that can be controlled with appropriate water and food hygiene as well as case management. With sustained home and community education, mothers become informed about household case management, the danger signs of diarrhea, and when to take a child to the CSCOM. With the referral system through *relais* and women's community groups, the number of diarrhea cases reported in CSCOMs increased, suggesting increased awareness of the risks. However, the % of children 0-59 months with diarrhea receiving ORT is very low. Only 18.1% of children 0-59 months suffering from diarrhea disease in KC areas received ORT as shown in KC final report. According to DSH (2006) only 24% of children with diarrhea have received ORT. There is a real need to work nationwide for the increase of ORT use in the management of diarrhea for children 0-59 months.

Section 2: Accomplishment of cross cutting interventions

2.1 Strengthening of Outreach Services

Introduction

In addition to promoting integrated service delivery at fixed sites, USAID/Keneya Ciwara works to expand the availability and quality of the community relais network in each village of the program catchment areas. USAID/Keneya Ciwara has provided training for ASACOs through partner NGOs. This training provides them with skills to mobilize their communities to take advantage of quality high impact services, and to provide more consistent and comprehensive outreach services at the village level.

Key Interventions

USAID/Keneya Ciwara has strengthened outreach services with trained personnel, improved planning, reinforcement of health package and service support materials at all levels. The project has also reorganized the services in each district as follows:

- *District Team Supervision of Activities:* The district-level team undertakes outreach activities to the various CSCOMs each month. USAID/Keneya Ciwara has strengthened the supervision skills of the team and provided the teams with logistic and financial support in the previous semester.
- *CSCOM-level outreach services to the community:* Keneya Ciwara provided nurse, midwife or matron training in the delivery of the minimum package of services, including during outreach. Keneya Ciwara has improved outreach activities through the development of microplans and by obtaining the buy-in of the ASACOs in the implementation of the microplans. Consequently, outreach activities in various CSCOMs constitute a partnership venture between the ASACO and USAID/Keneya Ciwara which provides financial support to the nurse while the ASACO provides fuel for CSCOM motorcycles.
- *Community-Home outreach:* To a large extent, the community *relais* carries outreach activities into the various households. Each trained community *relais* carries out home visits during which services are delivered, and counseling on essential health behaviors and referral of cases takes place.
- *Outreach Package of services*: To guarantee that each mother or child in the community gets access to services, USAID/Keneya Ciwara has reinforced the package of outreach services to include ANC and other related MCH services.

Key Results

- Improved regular monthly visits from CSRef to the CSCOM. Bamako and Timbuktu districts carried out 100% of planned outreach trips. Our overall current average stands at 80%.
- ASACOs report a 30% improvement in the ability to plan, carry out, and resolve difficulties with outreach activities.
- Regular visits from CSCOMs to villages for outreach activities were organized: 78% of planed outreach visits were accomplished.

- Trained and equipped community *relais* extend outreach into households. Each relais visits an average of 50 households a month.

Analysis and Discussion
Community outreach is one of the key strategies used in the Keneya Ciwara program to deliver high impact services in hard-to-reach areas in a CSCOM catchment area. With support from Keneya Ciwara and from the ASACOs, there has been a steady increase in outreach trips effectively carried out in program districts. The outreach package in the USAID/Keneya Ciwara areas includes immunization, ANC, client education and counseling, and other services. These monthly outreach activities have brought health services closer to communities and impacted on service utilization.

2.2 Mali Quality Improvement Initiative

Introduction
The Mali Quality improvement initiative mobilizes community members and local health care providers to work together to improve their centers by focusing on what the center needs and developing plans to meet community and center needs. Standards to win the Gold Ciwara standard include: improving provider performance, and reducing stockouts of commodities (iron/folic acid tablets, *sulfodoxine-pyrimethamine* tablets (SP), ITNs, and family planning commodities such as pills, condom, injectables and spermicides). The Quality Improvement Initiative is implemented in all CSCOMs in Keneya Ciwara program districts.

Key Interventions
- *Creation of community and provider dialogue groups on quality:* Community representatives organized a series of community consultative meetings to select 10 or more of their members to dialogue with the health center team of about 4 or 5 staff about quality services.
- *Organization of community meetings to develop action plans on quality*: The community dialogue groups developed a consensus quality action plan which engaged support from local authorities, the community, CSCOM, CSRef and USAID/Keneya Ciwara.
- *Creation of CSCOM quality action team:* The execution of the plan requires a quality action team at the CSCOM. The quality action team is generally made up of about ten people chosen from among the members of the dialogue groups.
- *Implementation of Quality Action Plan:* Most of the current action plans required 4 to 6 months to implement. Engaging local authorities and communities, the Quality Action Team ensures that the activities in the plan are completed, positioning the CSCOM for accreditation.
- *Diagnosis of quality services:* During the course of implementing the quality action plan, the CSRef quality improvement team accompanies the CSCOM Quality Action Team. The team supervises the action plan using the Quality Diagnostic Tool and certifies the completion of the action plan, as a pre-requirement for the accreditation of the CSCOM.

- *Formal Accreditation Ceremony:* Accreditation ceremonies serve as a way to reward the communities, and allow the community to recognize the importance of their own accomplishments. Between 2,500 and 3,000 people were involved in each accreditation ceremony, just as attendees. ORTM (the national television station) as well as many national and local radio stations broadcast the events across Mali, letting other areas learn about the process and its accomplishments.

Key Results

- 114 community dialogue groups created in the districts to define quality services.
- 114 quality teams created in the districts.
- 57 CSCOM were selected to compete for the accreditation.
- 12 CSCOM were accredited since the project began.
- A guide for community dialogue groups on quality services has been produced.
- A revised Quality Diagnostic Tool for the supervisory team is available.
- A guide on the criteria and selection of Ciwara d'Or CSCOMs is available.

Analysis and Discussion

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

2.3 Mobilizing Communities for Health

Introduction

Many communities in the CSCOM catchment areas do not know about the different high impact services available in the CSCOM or the quality improvement process occurring in the CSCOM. By being part of the process, communities actually take over ownership of mobilizing itself for quality and making resources available for health.

Key Interventions

- *Women's MJT or Terikunda groups*: Keneya Ciwara trained 248 leaders of women's groups in basic communication on health and in making referrals of their peers who need services to the CSCOM.
- *Men for Life Initiative:* This network of men's groups works to improve access to health by their peers and family members. The initiative seeks to involve men in both reproductive and child health, and also to improve their personal health.
- *Community Relais Networks*: There are about 4,000 trained community *relais* in the program now. They constitute a crucial network for mobilizing households for high impact services.
- *Community Radios:* USAID/Keneya Ciwara works with partner community radio stations in the program districts to mobilize and disseminate messages to the populations.
- *ASACO Network*: This network of 242 ASACO has been mobilized to integrate discussions on FP and maternal and child health into their monthly statutory meetings.

Key Results

- Leaders or animators of 248 women's community groups are trained and they are reaching women in local groups with health messages.
- 41 male groups are promoting ANC services in Sikasso.
- Over 4,000 trained *relais* and 132 animators are implementing project activities.
- Relays have conducted 22,852 educational sessions in the 72 health zones Kati, Sikasso, and Kadiolo;
- Technical health teams conducted 5,288 counselling sessions ;
- Relays visited 77,113 households to transfer health information ;
- More than 4,527 individual interviews took place ;
- More than 867 women were referred to health centers by community relays ;

Analysis and Discussion

Mobilizing communities for high impact services is one of the central activities of USAID/Keneya Ciwara. Using community networks is one of the low-cost and effective ways that the Keneya Ciwara program has made the contacts necessary for community mobilization. Mobilizing communities using these networks builds the confidence of participants in the networks to sustain the interventions and play lead roles as partners of the program in the community. Building upon some of the community networks like the women's groups, ASACO, *"crieurs"*, and community radio stations can sustain activities long after the program Keneya Ciwara comes to an end.

2.4 Strengthening the Capacities of Community Partners (ASACOs and NGOs)

Introduction

One of the keys to the project's success has been the work with local partners that allows a national program to reach even the smallest of villages in a way that is locally appropriate. PKC has seventeen partner NGOs who function at the district level to ensure that the project can be adapted to meet local needs, and can have supervision and activity directly related to each district's situation. In addition to the NGOs, USAID/KC has worked with 242 local community health associations (ASACO) that are an integral part of CSCOMs in Mali. A major challenge to providing quality health care in Mali lies in the fact that these ASACOs are often made up of members with little or no training, low literacy, and low access to resources. USAID/KC's work has focused on improving the capacity and functionality of both NGOs and ASACOs to ensure the sustainability of project gains.

Key Interventions

- Workshop was organized with NGOs and ASACOs to review key activities and plan further interventions in Ségou (20-23 December 2006). Six months later in June 2007, similar workshop was organized with the same key players.
- In January and February, 2008, ASACOs conducted self-evaluations to monitor their own progress and determine their next steps.
- A guide to train ASACOs in financial and personnel management was developed, validated, and distributed between October 2007 and March 2008.
- NGO supervisors and animators were trained in the use of Rapid Assessment Tool (LQAS).
- ASACO members were trained in self-evaluation and micro planning to ensure quality services.
- NGOs were trained in accounting and activities reporting.
- ASACO members start implementing their institutional plans.
- The ASACO capacity building and computerizing data collection tools were pre-tested and finalized.
- ASACO members were trained in financial management.
- Training of leaders of community men's groups in reproductive health and child survival was conducted.

Key Results

- Evaluation results show that ASACOs are on average 17 % more effective in general, and 27% more effective at planning activities since the start of PKC.
- All ASACOs in the project surveyed pointed to PKC-trained relays as raising awareness and volunteerism for health center projects and needs.
- USAID/KC's manual for training ASACOs in financial and personnel management has been validated by the national health system.
- Partners have been able to successfully apply for funding from outside organizations—such as AMPRODE Sahel and Catholic Relief Services (CRS)—as a result of their increased reporting, planning, and monitoring and evaluations skills.
- ASACOs demonstrate noticeable improvements, particularly in the areas of planning, governance, and community relations.

- 91 NGO animators were trained in the use of the Cycle Bead family planning method
- Periodic workshops reinforce the NGO network and lobbying capabilities.
- ASACO members cite a better understanding of their responsibilities toward the center, better ability to plan and manage activities, and the increase of women in their governing bodies as improvements that they notice resulting from project activities.
- Project stakeholders have note improved community integration and cooperation with ASACOs.
- Seventeen (17) NGO supervisors, 91 NGO animators and supervisors reviewed their work plans.
- Prototype data entry software developed. The project has planned to train coordinators in using it.
- 41 leaders of men's groups trained by ASACO and CPM in reproductive health and child survival.

Analysis and Discussion

Strengthening ASACOs and local NGOs is necessary to sustain impact of the project interventions. . The capacities that PKC has helped to build with its partners will allow NGOs to continue work to promote health care in Mali, and to use their increased credibility to mobilize international donors and Malian officials to increase the use of high impact health care among vulnerable populations. Periodic workshops and discussion of project activities and health goals has strengthened the NGO network, thereby reinforcing Malian civil society by helping parties interested in improving national health indicators band together and influence national policy, better connecting the national government and the village needs.

The capacity-building activities of PKC have made a demonstrable improvement in the ability of communities and ASACOs to assess, plan, and carry out necessary health activities that meet the needs of a community that buys into its local health center. As they become more credible and capable, ASACOs have been able to mobilize more resources, and other community groups—such as the Mayor's Offices, local entrepreneurs' organizations, and local women's groups—have started contributing money to the center's activities budgets and overall functioning. Better ASACOs have led to higher community buy-in, and therefore higher quality services. These gains will stay with the community and promote higher quality services even when project activities cease. The communities themselves now have the skills to continue improving their health.

2.5 Expanding Activities in the North

Introduction

The far North of Mali—comprised of the regions of Timbuktu, Gao, and Kidal, has consistently posed challenges for health activities. A harsh landscape, low population densities, and nomadic tribes, combined with an unsettled security situation have made it difficult to consistently provide services to those in need. Keneya Ciwara has experienced difficulties with the relay approach in these areas, with many of the relays stopping service in 2006. In this context, Keneya Ciwara has worked with local authorities, health care providers, and communities to come up with appropriate intervention strategies in these areas.

Key Interventions

- Workshop was organized in Gao to developp a strategy document for nomadic relais of the northern parts of Mali (Tombouctou, Gao, and Kidal).
- Selestion of 50 nomadic relais using the strategy document
- Training of nomadic relais using the strategy document for nomadic relais

Key Results

- A strategy document on nomadic relais was developed.
- 50 new relays were chosen in the Northern regions of Mali: 10 in Kidal, 20 in Gao, and 20 in Timbuktu.
- Of the 50 nomadic relays chosen, 48 were trained 20 for Timbuctu an 18 for Gao. Security concerns in Kidal have temporarily prevented these activities in that region.

Analysis and Discussion

The relais approach in nomadic zones of northern Mali should be based on the sound knowledge of the life style and organization of pastoralist nomadic people in order to adapt high health impact services provision to their live style and needs. The lessons to be learned from the training, equipment and supervision of 50 nomadic relais using the strategy document for nomadic relais will help to better understand this specific group living social and economic conditions.

Section 3 : Lessons learned

1. Support and promotion of Household Essential best Health Practices (HEHP) can be effective through trained relais and community women association ("MJT"). The role of community relais, women groups in the promotion and provision of HEHP services has greatly increased the utilization of high impact services as shown in KC final evaluation report.

2. Solving the problem of prolonged SRO stock outs in the CSCOM will increase demand for ORT and desired behaviors with respect to home care of childhood diarrhea. More ORT will be used if potable water and ORS are available.

3. Involvement and active participation of the ASACO in the micro planning process of outreach activities increases the rate of carrying the activities. Indeed, well organized and executed outreach activities contribute to greater service utilization and greater service coverage. Outreach interventions increased by 30% the immunization coverage. Moreover, integrating a package of services has more value added than just carrying outreach on one service.

4. Relays need high levels of motivation and supervision in order to continue carrying out their activities effectively. It is best to tie these activities in closely with the CSCOM and ASACO structure. In areas where the CSCOM and ASACO took an active role in the management and supervision of relays, the project overall was more successful. This will also have the effect of making the project's impact more durable, since CSCOM staff is likely to continue making use of the relay system if they already feel ownership over the process and are accustomed to working with relays.

5. ASACO members do get more involved in activities when they better understand their roles and responsibilities, and when they have better skills in management and good governance. After being trained in self-evaluation and micro planning, 80% of ASACOs began contributing financial resources to outreach activities at their CSCOM.

6. The disponibility of ITNs at CSCOM level and the mobilization of communities with respect to ITNs through community radios, community networks and household education has led to increased attendance and use of antenatal and post natal services.

7. The accreditation process was a sense of pride for selected communities and was successful in promoting community ownership regarding the health care system. The implementation of quality action plans in the community develops community ownership of the process and mobilizes resources for it.

Section 4 : Conclusion and key recommendation:

Except the ORT, all key indicators have greatly improved.
Relays and women associations played a great role in the promotion of household essential health practices and community mobilization for the demand and use of quality health services. However the relays need high levels of motivation and supervision in order to continue carrying out their activities effectively.
As they become more credible and capable, ASACOs have been able to mobilize more resources, and other community groups—such as the Mayor's Offices, local entrepreneurs' organizations, and local women's groups—have started contributing money to the center's activities budgets and overall functioning. Better ASACOs have led to higher community buy-in, and therefore higher quality services.

The implementation of following recommendation will improve community mobilization for demand and use of quality community health services:

1. By **strengthening the capacity of ASACOs** in management and financial skills, they will be able to sustain payments of daily stipends; and also they will be able to mobilize resources in and outside of the health sector for health activities. However some ASACO in difficult financial situation may still need final support.
2. There is an urgent need to **solve the lack of vitamin A for routine interventions**. The current interruptions in vitamin A supply in a good number of cercles for routine interventions calls for an urgent response to meet the need for vitamin A in Mali.
3. 222 service delivery points (SDP) have experienced stock outs with regards to any contraceptive commodity during the five year life of KC. **MOH should define and apply appropriate strategy in order to reduce stock outs**.
4. There is a real need to work nationwide for the **increase of ORT use** in the management of diarrhea for children 0-59 months.
5. **Synergy interventions** between key players at all levels (national, regional and community) should be encouraged for better coordination, and impact. A good coordination and synergy helps to avoid duplication and leveraging of complementary financial and material resources.

Appendices:

Table 1: KC Five Years Key process and outcome Indicators

Table 2: Main findings of KC final evaluation

Rapport Final CCP : Communication pour le Changement de Comportement du Programme Santé USAID/Keneya Ciwara

Rapport Final IntraHealth International

Programme Santé USAID/Kenya Ciwara :
Rapport d'Analyse de l'Enquête d'Evaluation Finale

Table 1: KC Five Years Key process and outcome Indicators:

N	INDICATORS	DATA SOURCE	FY04	FY05	FY06	FY07	FY08	Total
	PROCESS INDICATORS							
1	**# of Master Trainers Trained**	**KC Report**	102	NA	NA	NA	NA	**102**
2	**# of Relais trainers trained**	**KC Report**	141	379	NA	NA	NA	**520**
3	**# of Relais trained**	**KC Report**	134	3 811	60	NA	48	**4 053**
4	**# of Relais equipped and functional**	**KC Report**	0	3 109	3 770	3 443	3 449	**3 443**
5	**# of supervisors trained in quality improvement**	**KC Report**	84	99	18	NA	NA	**201**
6	**# of trained su-pervisors using quality improve-ment tools**	**KC Report**	65	129	231	116	108	**146**
7	**# of cercle-level health campaigns organised**	**KC Report**	11	126	59	51	41	**288**
8	**# of people reached through community edu-cation sessions**	**KC Report**	12 628	828 553	1 515 200	2 307 077	886 069	**5 549 527**
9	**# of communication sup-port materials produced and distributed**	**KC Report**	5	6	45	83	174	**313**
10	**# number of Ciwara d'Or sites certified**	**KC Report**	0	NA	5	4	3	**12**
11	**Key commodity stock-outs in PKC zones**	**KC Report**	2	17	12	47	144	**222**
12	**% of Outreach visits ac-complished as planned**	**KC Report**	57%	81%	77%	83%	76%	**75%**
	OUTCOME INDICATORS							
13	**# of new family planning users**	**SIS Data**	9 324	28 715	40 578	48 154	28 672	**155 443**
14	**# of new pregnant women registered for antenatal care**	**SIS Data**	62 162	142 312	145 074	167 695	90 036	**607 279**
15	**# of ITNs distributed**	**KC Report**	35 888	168 914	191 889	184 851	151 034	**732 576**
16	**# of insecticide kits distributed**	**PKC Report**	47 011	72 942	59 763	24 608	20 812	**225 136**
17	**# of pregnant women receiving at least 2 doses of IPT**	**SIS Data**	8 722	48 271	73 695	80 644	47 962	**259 294**
18	**% of children 0-11 months having received Pentavalent 3 before 12 months of age**	**SIS Data**	56%	90%	97%	93%	83%	**84%**
18a	**# of children 0-11 months having received Pentavalent 3 before 12 months of age**	**SIS Data**			157 119	164 626	75 454	**397 199**
19	**Immunization coverage for pregnant women (TT2 vaccine)**	**SIS Data**	30%	42%	56%	55%	63%	**49%**
19a	**# of pregnant women immunized (TT2 vaccine)**	**SIS Data**			112 949	126 498	71 475	**310 922**
20	**Vitamin A coverage for children 6-11 months**	**SIS Data**	63%	33%	66%	49%	52%	**53%**
20a	**# of children 6-11 months who taken Vitamin A**	**SIS Data**			68 126	75 365	44 981	**188 472**

*** FY'08 data are uncompleted**. Field staff was not available during the last semester of FY'08 to collect the data.

** FY'08 last semester data are missing. NGO contracts were suspended in Mars 2008.

Table 2 : Main findings of KC final evaluation.

	Année	2001	2004	2006			2008				
	Source	Mali-DHS	PKC Baseline	Targete	PKC Mid-Term	Mali-DHS	Target	PKC Final Evaluation			
	Zone géographique Indicateur	Mali	PKC intervention Zone			Mali	PKC Zone	PKC Zone	Bamako	PKC Zone with relais	PKC Zone without relais
1	1. % of children 12-23 months having received DPT3 before 12 months of age	34%	50.0%	60.0%	66.8%	67,6%	80%	61,2%	68,3%	66,7%	54,0%
2	2. Percent of children (6-59 months old) receiving Vitamin A supplementation in the last 6 month	32%	30.7%	48.0%	61.1%	72,0%	80%	62,2%	51,9%	64,4%	62,1%
3	3. Percent of women receiving recommended doses of folate/iron during pregnancy	N/A	34.5%	50.0%	46.4%	60,8%	80%	50,8%	59,0%	55,0%	44,1%
4	4. Percent of pregnant women sleeping under insecticide-treated bed nets	N/A	6.8%	12.0%	20.4%	28,9%	30%	32,4%	47,6%	34,7%	26,7%
5	5. Percent of children under 5 years sleeping under Insecticide-treated bed nets	N/A	9.7%	15.0%	23.5%	27,1%	30%	41,5%	54,3%	43,1%	37,2%
6	6. % of pregnant women receiving 2 doses of SP As intermittent Presumption Treatment (IPT) for malaria	N/A	0.3%	25.0%	8.7%	11,2%	45%	22,5%	24,5%	27,2%	16,6%
7	7. Percent of children 0-59 months with diarrhea receiving ORT	30%	19.4%	37.0%	28.4%	24,3%	50%	18,1%	28,6%	17,6%	15,0%
8	8. Contraceptive prevalence rate for modern Methods among women of reproductive age	5.7%	6.9%	8.0%	8.8%	6,2%	10%	9,4%	16,8%	8,4%	8,8%