AWARENESS Project
Mali Country Report
2006–2007

Submitted by:
The Institute for Reproductive Health
Georgetown University
January 2008

© 2008. Institute for Reproductive Health, Georgetown University
Recommended Citation:
Mali Country Report: 2006–2007. January 2008. Washington, D.C.: Institute for Reproductive Health, Georgetown University for the U.S. Agency for International Development (USAID).

The *Institute for Reproductive Health*, affiliated with Georgetown University in Washington, D.C., is a leading technical resource and learning center committed to developing and increasing the availability of effective, easy-to-use, natural methods for family planning.

The purpose of the AWARENESS Project was to improve contraceptive choices by expanding natural family planning options and developing new strategies and approaches to increase the reproductive health awareness of individuals and communities in developing countries.

This publication was made possible through support provided by the United States Agency for International Development (USAID) under the terms of the Cooperative Agreement No. HRN-A-00-97-00011-00. The contents of this document do not necessarily reflect the views or policies of USAID or Georgetown University.

The AWARENESS Project
Institute for Reproductive Health
Georgetown University
4301 Connecticut Avenue, N.W., Suite 310
Washington, D.C. 20008 USA
Email: irhinfo@georgetown.edu
URL: www.irh.org

TABLE OF CONTENTS

Acronyms .... *i*

Country Program Summary .... *ii*

I. Introduction **1**

II. Objectives and Strategy **1**

III. Activities and Accomplishments **2**

- **A. Building awareness of and support for SDM** **4**
- **B. Developing the capacity of local organizations** **5**
- **C. Incorporating the SDM into reporting systems** **7**
- **D. Incorporating the SDM into the logistics system** **7**
- **E. Status of the SDM and LAM in Mali** **8**

IV. Challenges **8**

V. Lessons Learned **9**

VI. Future Plans **10**

Acronyms

ASDAP	Association de Soutien au Développement des Activités de Population/ (Association to Support the Development of Population Activities)
AMPPF	Malian Association for the Protection and Promotion of the Family
ATN	Assistance Technique Nationale (National Technical Assistance Program)
BCC	Behavior Change Communication
CA	Cooperating Agency
CBD	Community-based Distribution/Distributor
CPT	Contraceptive Procurement Table
CSCom	Centre de Santé Communautaire (community health center)
CSRef	Centre de Santé de Référence (regional health center)
DPM	Direction de la Pharmacie et du Médicament (Directorate of Pharmacy and Medicine)
DRS	Direction Régionale de la Santé (Regional Health Directorate)
FAB	Fertility Awareness-based Method
IPPF	International Planned Parenthood Federation
IRH	Institute for Reproductive Health
JSI	John Snow, Inc.
KIT	Knowledge Improvement Tool
LAM	Lactational Amenorrhea Method
MIS	Management Information System
MOH	Ministry of Health
NGO	Non-governmental Organization
PKC	Projet Kénéya Ciwaara (Keneya Ciwaara Project)
PSI	Population Services International
SDM	Standard Days Method®
SIS	National Management Information System
USAID	United States Agency for International Development

The AWARENESS Project

Expanding Family Planning Choices Worldwide

Country Program Summary
Mali

November 2007

Country Context

Mali, a large, landlocked country in western sub-Saharan Africa, has high fertility and low contraceptive use. Only 8% of married women use any method of contraception, with 6% using modern methods.[1] Its approximately 13 million people are mainly Muslim (90%), and 80% live in rural areas with limited access to family planning services. The total fertility rate was seven children per woman in 2006, compared to an average of five in Africa.[2] The government of Mali (GOM) actively promotes family planning and contraceptive security as part of improving quality of life. Unlike other countries in the AWARENESS Project, the GOM committed to national integration of the Standard Days Method® (SDM) without undertaking a pilot study. A relative newcomer to the AWARENESS Project, Mali began implementing project activities in 2006, utilizing the SDM and LAM as an approach to repositioning family planning.

Approach

- Increase the availability and use of quality family planning services by building capacity and commitment of public- and private-sector organizations to offer FAM services.
- Increase the use of modern family planning methods by developing the capacity of the Ministry of Health (MOH) to fully integrate the SDM and the Lactational Amenorrhea Method (LAM) into the contraceptive mix.
- Take the SDM to national scale, while piloting LAM in one region of the country.

Approach/Key Activities

- Integrating the SDM into health systems in the geographic area covered by USAID (40% of health services) while piloting LAM in the province of Koulikoro.
- Integrating the SDM and LAM into national norms and reference documents; pre-service and in-service training curricula; and supervision, management information (MIS), and procurement and distribution systems.
- Strengthening the capacity of health providers at village, district, regional hospital, and national reference level to offer the SDM.
- Introducing CycleBeads® into pharmacies and creating demand through mass media and BCC/IEC activities.
- Developing strong partnerships with the MOH, USAID family planning cooperating agencies (CAs), and local NGOs.
- Leveraging the human and financial resources of partner organizations for training and post-training programming to serve hard-to-reach segments of the population.
- Ensuring quality services through regular supervision and on-site training updates.

USAID
FROM THE AMERICAN PEOPLE

Institute for Reproductive Health
Georgetown University

Key Results

The SDM and LAM are offered through government and NGO clinics as well as through community distribution channels in Mali. Over 300 trainers from the MOH and NGO partners have been trained on the SDM, and together they have trained more than 1,200 providers in 400 sites. After eight months of service delivery, the Mali program has registered over 2,000 SDM users, with additional users obtaining the method through channels that have not yet reported their results (e.g., pharmacies).

LAM was introduced in nine districts in the province of Koulikoro, where the program has trained 42 trainers and over 500 providers from 131 community health centers.

Critical partnerships with USAID CAs and local NGOs led to the integration of SDM and LAM into large, multimethod service delivery programs, pre-service and in-service training materials, and BCC/IEC media and materials. These partnerships also resulted in the integration of CycleBeads into forecasting, logistics and distribution systems. IRH has been working with the MOH to integrate the SDM and LAM into the national family planning MIS tool and procedures.

Although IRH initially covered most training costs, partner CAs and local agencies plan to incorporate most post-training service delivery (e.g., supervision, IEC, data collection, CBD training) into their workplans and budgets, with some covering all costs.

Lessons to Guide Future Programming

> *Family planning programs have existed for many years in Mali but the contraceptive prevalence has remained low. With the introduction of these natural methods, all our hopes are up. We must now overcome this low prevalence issue with the arrival of the SDM.*
>
> ***Ministry of Health Official***

- The commitment and capability of the well-organized MOH and the strong partnerships built with USAID CAs and local family planning service delivery NGOs should be the foundation for any future programming.
- The private sector's rapid response to demand that emerged with the mass media campaign activities has demonstrated the need for continuing awareness-raising activities. In addition, forecasting, logistics, and distribution systems should be monitored to avoid stockouts.
- The program should continue to tap into partners' willingness to address accessibility not only in clinics but through community-based and commercial services.
- Currently, SDM and LAM data are captured under "other" on client registers and reporting forms. Consequently, SDM and LAM data must be compiled manually and reported separately from family planning electronic reporting, leaving a possibility of data loss. More emphasis is needed on fully integrating these methods into national reporting systems.
- The MOH and USAID intend to make the SDM available nationwide. To be strategic, the program should finish training clinic-based providers with current partners, and then expand to other partners and non-clinical service-delivery modes.
- Assessment and documentation of the LAM pilot experience can guide expansion.

---

[1] *2006 Population Data Sheet, Population Reference Bureau (PRB)*

[2] *2006 Population Data Sheet, PRB*

Institute for Reproductive Health

Georgetown University

4301 Connecticut Avenue, NW

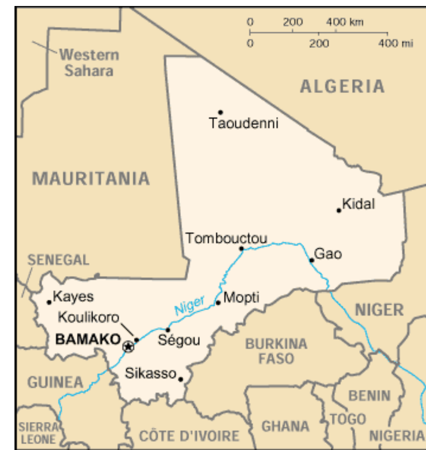
Suite 310

Washington, DC 20008 USA

www.irh.org

This publication is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under terms of cooperative agreement HRN-A-00-97-00011-00. The information contained in this publication does not reflect the views of USAID or Georgetown University.

I. Introduction



Source: CIA World Factbook 2008

Mali is a large, landlocked country in western sub-Saharan Africa with high fertility and low rates of contraceptive use. Only eight percent of married women use any method of contraception, with six percent using modern methods.[1] Its approximately 13 million people are mainly Muslim (90%), and 80% live in rural areas with limited access to family planning services. In Mali, the total fertility rate was seven children per woman in 2006 compared to an average of five in Africa.[2] Half of all mothers have their first child before the age of 19, with 16 the average age at marriage for women.[3] Sociocultural and economic considerations underlie widely held pronatalist attitudes including the social prestige related to numerous offspring and the economic value of children, who represent a significant work force in rural areas. The government of Mali is actively committed to promoting family planning and contraceptive security to improve the quality of life.

In 2004, the Ministry of Health (MOH) in Mali contacted the Institute for Reproductive Health (IRH), Georgetown University, to introduce the Standard Days Method® (SDM) and the Lactational Amenorrhea Method (LAM) in the country. At that time, IRH provided long-distance technical assistance and support materials. The MOH then took the lead in incorporating the SDM into national reproductive health policies and norms. In addition, the Policy Project (Constella Futures) started using CycleBeads®, a visual SDM tool, in its awareness and advocacy campaigns to expand access to and use of family planning services, and to engage religious leaders and men in support of family planning. In August 2006, USAID/Mali allotted funds to the AWARENESS Project for IRH to help the MOH and other partners further integrate the SDM and LAM into the method mix. With strong support and interest from the MOH, IRH was given a mandate to take the SDM immediately to a national scale, while piloting LAM in one region of the country. IRH hired limited staff and opened a local office co-located with a partner, the USAID National Technical Assistance Program (ATN), led by Abt Associates.

II. Objectives and Strategy

The overall purpose of the AWARENESS Project's activities in Mali was to increase the availability and use of quality family planning/reproductive health services. Specifically, IRH aimed to increase the use of modern family planning methods by developing the capacity of the MOH to fully integrate the SDM and LAM into the method mix. IRH's efforts also contributed to USAID/Mali's 2003–2012 High-Impact Health Services Strategic Objective.

---

[1] 2006 Population Data Sheet, Population Reference Bureau http://www.prb.org/pdf06/06WorldDataSheet.pdf

[2] 2006 Population Data Sheet, PRB.

[3] N'Djim, Hamady, et al. 1998. "Mali: Population and Water Issues", in *Water and Population Dynamics: Case Studies and Policy Implications.* Victoria Dompka, editor; Alex de Sherbinin, contributing author. Washington, D.C: American Association for the Advancement of Science.

The project introduced SDM and LAM through four service delivery levels in the Malian health system: the referral hospital, providing clinical services in Bamako; regional hospitals, located in each regional capital; CSRefs, health centers operating at a district, or "circle," level; and through CSComs, community health centers providing services at the village/community level. LAM services were concentrated in the province of Koulikoro, in order to closely monitor services and conduct research, with the intention of expanding LAM services to the national scale over time. IRH worked with the MOH to coordinate all training of trainers and service providers—whether public or private sector—with the relevant level in the MOH. IRH also worked with the Keneya Ciwaara Project (PKC), Save the Children, Group Pivot, and the Association to Support the Development of Population Activities (ASDAP) to plan the training of over 5,000 community-based distributors (CBDs).

In order to introduce the SDM on a national scale without the benefit of a pilot study, USAID/Mali suggested that IRH begin in the regions covered by the in-country bi-lateral, the Keneya Ciwaara Project (PKC), led by CARE, and gradually add partners and sites over time. Simultaneously, IRH worked with the MOH and partners to start integrating the SDM and LAM into all other aspects of national service delivery, including behavior change communication/information, education, and communication (BCC/IEC) activities; norms and reference documents; training curricula; and supervision, management information (MIS), and procurement and distribution systems.

The MOH wanted to introduce LAM for effective birth spacing as well as a transition to other family planning methods for interested breastfeeding women. IRH and the mission chose to integrate LAM as a pilot project in one region, with the MOH as sole partner, in order to closely monitor services and conduct research prior to expanding LAM services to a national scale over time. IRH, the MOH, and USAID/Mali chose Koulikoro region, with a population of 1,800,000 and a contraceptive prevalence of two percent, as the pilot site for the introduction of LAM into approximately 120 health centers in all nine districts of the region. The program trained regional trainers on LAM and then began training providers, following the same cascade training model as the SDM. IRH worked with the regional MOH to ensure the quality of training, to conduct supervision, to collect data, and to promote the method via BCC/IEC activities.

III. Activities and Accomplishments

Under the overall leadership of the MOH, IRH coordinated with USAID cooperating agencies (CAs) and local organizations to integrate the SDM at a national scale. IRH worked with those partners to ensure that their own organizational supervisors, in addition to the public-sector providers, were trained in the SDM and understood what supervision would entail. The team followed the same process with local organizations including ASDAP and Groupe Pivot, an umbrella organization grouping 166 of Mali's most effective NGOs working in community health.

Table 1: Summary of Partners, Roles, and Accomplishments

Collaborating organizations	Activities undertaken	Partner's Role	IRH's role	Accomplishments
Ministry of Health (MOH)	• Training of trainers • Training of	• Schedule and coordinate activities/	• Finance some activities	• SDM in the national norms

Collaborating organizations	Activities undertaken	Partner's Role	IRH's role	Accomplishments
	providers • Method integration into national norms, training and reference materials • Integration into the national MIS • Coordination of all research activities • Supervision	logistics • Share training logistics costs • Help with data collection • Lead supervision visits • Approve research protocols	• Coordinate trainings with the MOH • Provide all materials for trainings, including CycleBeads • Provide TA for trainings (IRH local staff)	• SDM in the contraceptive procurement table (CPT) • Cadre of 288 SDM trainers available • Over 1,200 providers trained in SDM Number of SDM users increasing
Association to Support the Development of Population Activities (ASDAP)	• Training of CBDs on SDM and LAM • Development of CBD materials	• Test and refine BCC/IEC materials and CBD tools for SDM and LAM • Train providers	• Train ASDAP trainers and supervisors • Supply materials • Co-finance activities	• Eighteen CBD workers trained and offering SDM
Save the Children	• Training of supervisors • Training of CBDs • Supervision of CBDs	• Allow supervisors to participate in SDM trainings • Organize and conduct subsequent trainings for CBDs • Supervise CBDs • Distribute CycleBeads	• Train Save supervisors • Supply CycleBeads and provider materials	• Supervisors trained in region of Segou
Groupe Pivot Santé Population	• Same as above	• Same as above	• Same as above	• Supervisors trained in region of Bamako
Keneya Ciwaara (PKC)/CARE	• Training of health center staff in SDM • Training of CBDs • Supervision of CBDs	• Same as above	• Train health center staff • Supply CycleBeads and provider and CBD materials	• Health center staff trained in seven regions
Health Policy Initiative/ Constella Futures	• Advocacy meetings with religious and opinion leaders	• Identify opportunities and coordinate programs to increase awareness of SDM	• Orient Health policy project "ambassaders" on the SDM • Supply CycleBeads and other materials	• Orientation sessions held with Islamic groups
National Technical Assistance Program (ATN)/Abt Associates	• Incorporation of SDM and LAM into national reference materials	• Assure that SDM and LAM are included in reference documents	• Provide ATN with correct information for reference documents	• National norms corrected and information updated • SDM and LAM included in family planning participant notebook for "matrons" • SDM and LAM included in flipchart for CBDs

Collaborating organizations	Activities undertaken	Partner's Role	IRH's role	Accomplishments
Capacity Project/ IntraHealth	• Incorporation of the SDM and LAM into pre-service curriculum	• Explore inclusion of SDM and LAM in pre-service curricula of universities, nursing schools, etc.	• Provide IntraHealth with correct information to include in pre-service curricula	• SDM and LAM included in draft pre-service curricula for the Gao nursing and midwifery school
DELIVER Project/John Snow (JSI)	• Inclusion of CycleBeads in CPT	• Support the MOH in including CycleBeads in the CPT	• Provide information as necessary to DELIVER to include CycleBeads in the CPT	• CycleBeads included in the 2007 CPT
Population Services International	• Development of a national IEC campaign on SDM • Introduction of SDM in pharmacies and private clinics	• Develop SDM TV and radio spots • Co-train pharmacists and privates clinicians to offer SDM	• Provide CycleBeads to the private sector • Co-train pharmacists and private clinicians • Conduct follow-up visits in pharmacies and private clinics	• CycleBeads introduced into over 50 pharmacies • SDM introduced into the ProFam network – a grouping of franchised for-profit medical clinics • Demand for the SDM increased as a result of TV and radio spots

A. Building awareness of and support for SDM

> *"Family planning programs have existed for many years in Mali but the contraceptive prevalence has remained low. With the introduction of these natural methods, all our hopes are up. We must now overcome this low prevalence issue with the arrival of the SDM".* **– Ministry of Health Official**

SDM integration in Mali is a unique experience for IRH because the MOH was informed about and supportive of the SDM prior to IRH beginning work in the country. The MOH heard of the SDM during a regional conference in Benin and decided to integrate the method, beginning first by including it in the national reproductive health norms. IRH collaborated with the MOH and ATN to correct and complete the initial information included in the national norms and policy. The MOH was sufficiently supportive of the SDM that it chose to integrate the method nationally, without a pilot phase.

Despite the national MOH's keen interest, the SDM was still a new method for the rest of the country. Thus, IRH began by holding several orientation meetings with key personnel from the national and regional levels of the MOH and partner organizations. IRH also regularly participated in meetings with the MOH and partners in order to build consensus around including the SDM and LAM in national reference documents, guidelines, training manuals, and administrative tools. These awareness-raising efforts continued among providers during the SDM trainings.

To inform potential clients and the general population, IRH developed messages to incorporate into clinic posters and local radio programs and presented on the SDM at health fairs, community

events, and conferences. IRH also partnered to include information about the SDM and LAM in CAs' and other partners' communication strategies. Population Services International (PSI) took the lead in developing a national-level promotional campaign on the SDM, broadcasting a two-part spot on national radio and TV stations in local languages to increase awareness of the SDM as a new, natural method available in local health centers. In collaboration with the Policy Project (Constella Futures) and other CAs, IRH conducted sessions about the SDM and LAM to inform men, religious groups, and opinion leaders about these methods.

During this period, as IRH focused on fulfilling its primary mandate of training health center personnel in PKC zones, the project team conducted promotional activities on an ad-hoc basis. Once it established the program and clarified its promotional role in relation to other CAs, IRH began awareness-raising activities through local radio stations, promotional posters, and community organizations and networks already engaged in other issues.

B. Developing the capacity of local organizations

To build SDM capacity within the country, IRH first trained a cadre of 54 national and regional trainers. National trainers included staff from the National Office of Family Health and international and local nongovernmental organizations (NGOs). These national and regional trainers oversaw the training of trainers and providers in the districts supported by PKC, following a cascade model and under the guidance and supervision of regional trainers and IRH/Mali. IRH also included staff from health centers supported by Save the Children, Groupe Pivot, and ASDAP in order to further expand SDM integration and encourage sustainability and the transfer of capacity to the national, regional, and district levels. As of August 2007, the program had trained 1,176 providers from PKC and Save the Children districts in eight regions on the SDM, as well as 18 providers working for ASDAP. (See Table 2.) Table 2 shows relatively small numbers of SDM users in government sites given the number of providers trained as many providers had not been offering the method long enough for data to appear in reports. Also, some sites had only received CycleBeads the week preceding a routine monitoring visit conducted by IRH in mid-September 2007. In addition, the region of Bamako accounted for almost all 1,801 users reported in government sites due to the difficulty in obtaining reports from other sites. Adequate data collection will likely be problematic until the SDM is included in the MIS. All aspects of the *système d'information sanitaire*/national management information system (SIS) including client cards, registers, and the computerized system will be modified within the next few years. Meanwhile, IRH is considering collecting data through sentinel sites to measure levels and trends of LAM and SDM use in relation to the overall method mix, while working with the MIS division of the MOH to ensure full integration of SDM and LAM indicators into the ongoing system.

Training of midwives during the "National Day of Midwives".

SDM use is not currently recorded on existing clinic data collection forms or in the software used to compile CSCom contraceptive use data at the CSRef level. IRH and the MIS office at the MOH agreed that a separate form be developed to record SDM and LAM users. This form would be used in a process that mirrors one that the prevention of mother-to-child transmission of HIV program has recently initiated to access the MIS system. SDM and LAM users will be recorded in the "other" column on the client card and in provider registers. At the CSRef level, where all information is computerized and sent to the national level, staff will record these methods manually on a separate (Excel) form and send them to the national level for computation. This temporary measure will require extensive follow-up on the part of IRH/Mali staff and cooperation on the part of providers to ensure that data are not lost.

IRH worked with PKC, Save the Children, Groupe Pivot, and ASDAP to train CBDs to offer the SDM. Partners agreed that IRH would provide them with appropriate training tools and provider materials and assist with initial trainings. IRH also began exploring a partnership with other local NGOs to integrate the SDM and LAM into their community-based services.

In addition to training, IRH provided its Knowledge Improvement Tool (KIT) to the MOH and NGO partners to improve supportive supervision for SDM and LAM services and contributed to the joint development of a standard family planning supervision tool that would include the SDM and LAM. IRH also accompanied MOH and partner personnel on supervision visits in order to demonstrate use of the KIT.

Table 2: Building SDM Capacity Within Partner Organizations

Name of Organization	Number of Providers Trained	Number of Sites with Trained Providers	Number of Trainers Trained	Number of SDM Acceptors (Jan.–Aug. 2007)
MOH*	1,001	345	243	225
ASDAP	18	18	8	600
Groupe Pivot Santé Population	42		30	490
AMPPF/IPPF affiliate	3	3	5	460
PSI (ProFam Clinics)	12	16	2	32
Total	**1,176**	**382**	**288**	**1,807**

***includes data for PKC and Save the Children which support the MOH**

As with the SDM, LAM followed a cascade training format in Koulikoro region, reaching some 42 trainers and 325 providers from 131 CSComs as of August 2007.

IRH strategically formed collaborations with the above organizations to maximize expertise, geographic coverage, and access to specific population groups. These partnerships consistently involved an exchange of services, e.g., cost sharing and in-kind donations. While IRH covered most costs, including trainer and participant per diems and transport, materials, etc., partners often made contributions such as staff time, training venues, or refreshments, depending on the context. Several partners—PKC, Save the Children, and Groupe Pivot—financed all additional aspects of SDM integration (supervision, BCC/IEC, data collection, CBD training) beyond the initial provider trainings.

To further ensure long-term SDM and LAM capacity, IRH worked with IntraHealth to include these methods in a model pre-service curriculum being tested in one nursing school, for eventual expansion to other regions. IRH also worked with partners including ATN, ASDAP, and the MOH to include the SDM and LAM in in-service training curricula, as appropriate and feasible. In Mali, the national reproductive health norms, which include the SDM and LAM, are occasionally used for family planning training. More often, a set of three documents—a trainer's guide, a reference manual, and a participant notebook—is used to train nurses and midwives in family planning. Neither the SDM nor LAM is included in those documents and there are no current plans to revise them. However, another tool similar to the family planning participant notebook, but simplified, is used to train lower-level clinic-based family planning providers. ATN worked with IRH to include the SDM in this document. Finally, three tools exist to train CBDs—a trainer's guide, a participant notebook, and a flipchart—and IRH began working with the MOH and partners to include both methods in those tools. Thus, in the near future, the SDM and LAM will be represented in three out of four major sets of tools used for in-service family planning training. IRH is exploring avenues for adding modules on the SDM and LAM into the fourth training tool.

C. Incorporating the SDM into reporting systems

In general, family planning use data are sent monthly from health centers to the district hospitals in hard copy form. District hospitals compile the data on a quarterly basis, enter it into a computerized database, and send it to the region (in electronic and hard copy form). The region sends compiled data to the national level. During SDM and LAM training, because the methods are not included on current reporting forms, providers were asked to note SDM and LAM users by hand in their family planning registers and in their monthly reports. However, it is very unlikely that reliable data will reach any level beyond the district hospitals, and collecting this data will be time-consuming. Therefore, IRH began exploring more effective means to collect service statistics including working with the SIS (national MIS) to include the SDM and LAM in revised data collection tools and to revise the computerized database. Discussions with the Ministry and the MIS office continue, and it is likely that the upcoming year will see a combination of data collection from sentinel sites along with efforts to fully integrate the collection of SDM and LAM into national reporting systems.

D. Incorporating the SDM into the logistics system

Initially, IRH was to purchase CycleBeads for the first two project years. After purchase, IRH supplied them directly to the National Pharmacy Directorate (DPM), which dispatched an initial stock to the field and partners, along with information on price and restocking. Health centers and regional hospitals use the same procedure to order CycleBeads that they currently use for other contraceptives. IRH, the MOH, and the DELIVER Project (JSI) integrated CycleBeads into the CPT and agreed to include them in all future commodity procurement activities. It is expected that after the first two project years, CycleBeads will be included in the overall contraceptive commodities request that the government of Mali submits to donors. Discussions with USAID/Mali continue about including a budget line for CycleBeads and a requirement that the SDM and LAM receive the same attention as other methods in future family planning awards.

E. Status of the SDM and LAM in Mali

SDM and LAM introduction efforts enjoy a sustained level of interest and support from policymakers and program managers. Policymakers appreciate IRH's support in adding two new methods to the range of contraceptive methods available. Continued advocacy sustains political commitment and support to help ensure that both methods are included in national reproductive health policies and guidelines. Program managers within partner organizations are beginning to think routinely about including the SDM in their activities. Providers are enthusiastic about new method choices to offer clients.

By June 2007, the program had introduced SDM into the health centers supported by the Keneya Ciwaara Project in eight regions, including training personnel, providing promotional and provider materials, distributing CycleBeads, and conducting supervision visits. In addition, staff in health centers supported by Save the Children, ASDAP, and PSI were also trained and provided with materials and CycleBeads.

IRH worked closely with the DPM to ensure that CycleBeads' distribution runs smoothly, avoiding stockouts, and with the national MIS department to strategize on how best to collect representative services statistics from sentinel sites or develop tools to capture SDM services. The program introduced CycleBeads into pharmacies and incorporated relevant messages into BCC/IEC activities implemented at the national level with PSI and at the local level through IRH's partners. PSI is enthusiastic about the potential of the SDM in Mali and is ready to continue program expansion as resources and Mission priorities allow.

LAM introduction began in the region of Koulikoro, training a total of 42 trainers and supervisors. At the time of this report, the training of district trainers and providers in all nine districts is well underway. IRH distributed client and provider tools and held discussions with the regional health directorate in Koulikoro (DRS-Koulikoro) on possible awareness-raising activities in support of LAM. IRH also began working with the DRS-Koulikoro on how best to collect valid service statistics. IRH, the MOH, and the Population Council are assessing the effectiveness and feasibility of two different training strategies for LAM and SDM, which are being introduced simultaneously in Koulikoro. This has involved testing two approaches, more specifically 1) interval: training providers first on LAM, and then on the SDM three months later; and 2) back-to-back: training providers on the SDM and LAM over two consecutive days. Indicators include provider knowledge and performance, cost-effectiveness, and method integration.[4]

IV. Challenges

The main challenge in Mali was introducing the SDM at a national scale, without a pilot introduction, especially given the large size of the country and the dispersed population. IRH and partners must work to create awareness of and demand for this new method, while simultaneously building capacity within the country to offer the method over the long term by integrating it into all national health systems.

[4] A more detailed study protocol is available from IRH.

Although the MOH is committed and fairly well organized, certain systems and structures lack clarity and efficiency, particularly the supervision system and the MIS. Maintaining strong ties to partners and leveraging their human and financial resources can greatly enhance both expansion and sustainability. Furthermore, although IRH is not conducting a pilot study, there is a need to gather data about the SDM introduction in order to assess program progress and indicate necessary adaptation. IRH will work with the MOH and partners to identify sentinel sites from which routine data can be collected.

Working through partners to integrate the SDM and LAM is imperative, although aligning different organizations' objectives and timetables can be difficult and requires ongoing dialogue. Also, in some cases, partners who did not include the SDM and LAM in their initial planning have been reluctant to expand their work scope mid course and include these methods.

Another set of challenges for both the SDM and LAM relates to the perceived traditional or conservative attitudes and beliefs of the Malian population. As Malian men and religious leaders play key roles in family planning decisionmaking, they must be reached by BCC/IEC efforts in order to increase contraceptive prevalence. IRH is pursuing creative outreach strategies for these audiences in collaboration with the Health Policy Initiative and other partners.

V. Lessons Learned

In just a short period of project implementation, IRH has gleaned some key lessons which will inform future work in the country.

- Demand for the SDM and LAM exists in Mali. While data collection from most partners was incomplete, ASDAP registered over 400 users in a little over one month. As soon as spots were broadcast on local radio and television stations, pharmacies and wholesalers began to place orders for CycleBeads, resulting in a rapid filling of the private-sector pipeline.
- Data collection will be difficult until authorities include the SDM and LAM in regular data collection tools and systems. It will be extremely important to work with the national MIS to make these adaptations. In the meantime, it will be important to identify sentinel sites from which data can be collected directly.
- Communication efforts to increase awareness of the SDM and LAM are critical, given that these are relatively new and underused methods that are not familiar to the population. In light of low literacy rates, emphasis should be placed on oral communication including radio, television, and community-based mobilization efforts (including CBD).
- Having the CycleBeads insert and other client-focused materials available in Bambara would be a relatively low-cost intervention that would likely increase the quality of service delivery.
- Partners are committed to integrating the SDM and LAM, not only in clinics but also via CBDs, retail outlets, community centers, places of employment, and community networks.
- Close collaboration with partners and the MOH is key to encourage sustainability and true integration into national systems. In particular, close communication with the DPM helps ensure that CycleBeads move freely through the distribution system without stockouts.

- Strong support from the top levels of government and USAID has helped assure adequate resources for programs and opportunities to integrate the methods into national systems as they are updated.
- Well-qualified staff of IRH/Mali has enabled a smooth project start-up and successful growth.

VI. Future Plans

The MOH and USAID intend to assure national availability of the SDM, making the continued process of scaling up a priority. Systematic scale up would include finishing training clinic-based providers with PKC, Save the Children, and ASDAP, and then including additional partners. CBD trainings should begin in the near future to further expand access to the SDM, particularly in rural areas. PSI has introduced CycleBeads into pharmacies and IRH is working on follow-up modalities to ensure quality services. IRH is also developing reference materials for pharmacists. Collaboration should continue to determine the best mechanism for equipping pharmacists to sell CycleBeads and to provide simple, key messages to potential clients.

To expand access to the SDM, awareness-raising efforts must be implemented. These efforts should be undertaken with local partners and informed by formative research to identify themes and images that are comprehensible and attractive to potential audiences. Awareness-raising should reach the community level as well as "special" audiences, including men, religious leaders, youth, and at-risk populations.

National health systems must be adapted and updated to integrate the SDM. IRH will closely monitor the revision of data collection tools to incorporate SDM and LAM data into national reproductive health results. It will also work with the DPM to ensure that all tools tracking commodity usage and demand include the SDM. Efforts to integrate the SDM into pre-service and in-service curricula and guides and national reference documents must continue in order to build sustainable long-term capacity in health care providers. Finally, the SDM should be integrated into standardized supervision tools and protocols.

IRH recommends that the scaling-up process be documented and that strategies and approaches be both researched and evaluated. IRH recommends collaborating with an established research institution, such as the Population Council, which is already familiar with the SDM integration process in Mali. Other issues such as the transition from LAM to the SDM, fertility awareness-based methods in a polygamous environment, and the impact of SDM use on gender dynamics and women's empowerment could also be examined. Special studies regarding correct use and use continuation would also be valuable to both improve program quality and address skeptics' concerns.

For LAM introduction, IRH recommends completing the training of providers in the region of Koulikoro. Simultaneous efforts should be made to integrate LAM into regional data collection and supervision processes. Awareness-raising activities should reach potential users. After trained providers have offered the method for a period of time, the pilot intervention should be assessed, using qualitative and quantitative techniques. At that point, the MOH and partners could begin strategic planning for scale up to other regions. Efforts to routinely offer LAM at maternity centers, and to monitor whether this is happening (using techniques like exit interviews) would also be of value to the program.