SCALE-UP OF STANDARD DAYS METHOD® IN MALI

COUNTRY BRIEF

USAID FROM THE AMERICAN PEOPLE

FAM PROJECT
IRH GEORGETOWN UNIVERSITY

Since the early 2000s, the Institute for Reproductive Health at Georgetown University (IRH) has introduced and tested the Standard Days Method® (SDM) in a variety of service delivery settings around the world. IRH and partners are now scaling up SDM services in family planning (FP) programs in several African countries, India, and Guatemala. This report summarizes the choices, approaches and results of a systematic and successful scale-up effort in Mali, complemented by related research, from 2007 through early 2012.

Mali's Ministry of Health (MOH) learned of and incorporated SDM into several of its normative documents in 2005. It was not until late 2006, however, that IRH and USAID formally introduced the method in Mali and that an initial lot of 60,000, requested by the MOH, CycleBeads® arrived in country.

The impetus of the MOH (specifically, its Division of Reproductive Health or DSR) was to expand the range of modern methods available to a population that experiences socio-cultural, religious, economic and logistical constraints to addressing their FP needs. Historically, large families with numerous children have met livelihood needs as well as conferred social status on both men and women. Men are generally accorded absolute power over reproductive decisions, and women's use of FP may be considered a sign of infidelity in a society that values women's monogamy and fertility.

Mali's decentralization process over two decades has granted greater autonomy to district governments and their social services, and community management and oversight of those services. Still, the country's vast size, limited infrastructure, and widespread poverty pose formidable logistics constraints to the delivery of health services including FP. The MOH/DSR favor birth spacing and the use of modern contraception as a means of improving women's and children's health.

In March 2012, Mali experienced a coup d'état and an escalation of war in its northern regions. IRH's work in Mali was curtailed and the project closed prematurely.

Map: Adapted from University of Texas Libraries

MALI AT-A-GLANCE

CURRENT POPULATION:	15.8 million
POPULATION GROWTH RATE:	3% per annum
GDP PER CAPITA, 2011:	$684
POPULATION ENGAGED IN AGRICULTURE:	80%
TOTAL FERTILITY RATE, 2011:	6.2
CONTRACEPTIVE PREVALENCE RATE, WOMEN AGES 15-49, 2006:	8.2
UNMET NEED FOR CONTRACEPTION, MARRIED WOMEN AGES 15-49, 2006:	31.2%
MATERNAL MORTALITY RATIO PER 100,000 LIVE BIRTHS:	460
INFANT MORTALITY RATE PER 1,000 LIVE BIRTHS:	98.2

Source: World Bank World Development Indicators

INTRODUCTORY PHASE 2006-2007

In late 2006, USAID, IRH, and the MOH formally introduced SDM in Mali, resulting in the method's 2005 inclusion in reproductive health policy, norms, and procedures. IRH initially collaborated with the large-scale *Projet Keneya Ciwara*[1] to integrate SDM into health activities in 11 districts plus Bamako. Altogether, this area was home to almost one-third of Mali's population. By the end of one year of IRH technical assistance, over 300 MOH and NGO master trainers had trained more than 4,000 service providers from central to district levels, and NGOs were training *relais* (community health workers) to promote and deliver CycleBeads in communities. SDM had been further integrated into national documents, including health supervision guides and contraceptive acquisition tables. Population Services International (PSI) had begun socially marketing CycleBeads.

SCALE-UP PHASE 2007-2012

IRH's strategic objective was to strengthen SDM integration in 90 percent of service delivery points—public sector, private sector and community—in all Mali's regions and Bamako.

SDM scale-up in Mali began in late 2007 and was planned to last five years. IRH's strategic objective was to *strengthen SDM integration in 90% of service delivery points—public sector, private sector and community—in all Mali's regions and Bamako*. The role IRH played was that of technical assistance provider (advocacy, coordination, training and resources), while the MOH/DSR led actual service provision with the support of donors, national and international NGOs.

In late 2008, IRH introduced the ExpandNet framework to guide SDM scale-up in Mali. An introductory and strategy-setting meeting positioned MOH/DSR as leader and coordinator of the scale-up process and resulted in a multi-organizational plan for actions, roles, responsibilities, and objectives along both the horizontal and vertical axes of the ExpandNet framework. The MOH/DSR convened annual review and planning meetings thereafter.

HOW SUCCESSFUL WAS SCALE-UP OF SDM IN MALI?

As of March 2012:

SERVICE EXPANSION

SDM services available in an estimated 88% (1,273) of service delivery points and in all eight regions of Mali

19 organizations including the MOH able to build others' capacity to offer SDM

INSTITUTIONALIZATION

SDM fully integrated into national FP program and these sub-systems:

- Norms, policies, guidelines
- HMIS reporting system
- Some pre service training curricula
- Logistics system
- National surveys
- MOH-sanctioned IEC materials

SDM USERS & KNOWLEDGE OF SDM OPTION

IRH was unable to conduct most endline research in Mali, including household surveys on knowledge and use of SDM.

New SDM users comprised between 1 and 3 percent of new modern FP users in three regions (2007-early 2011).

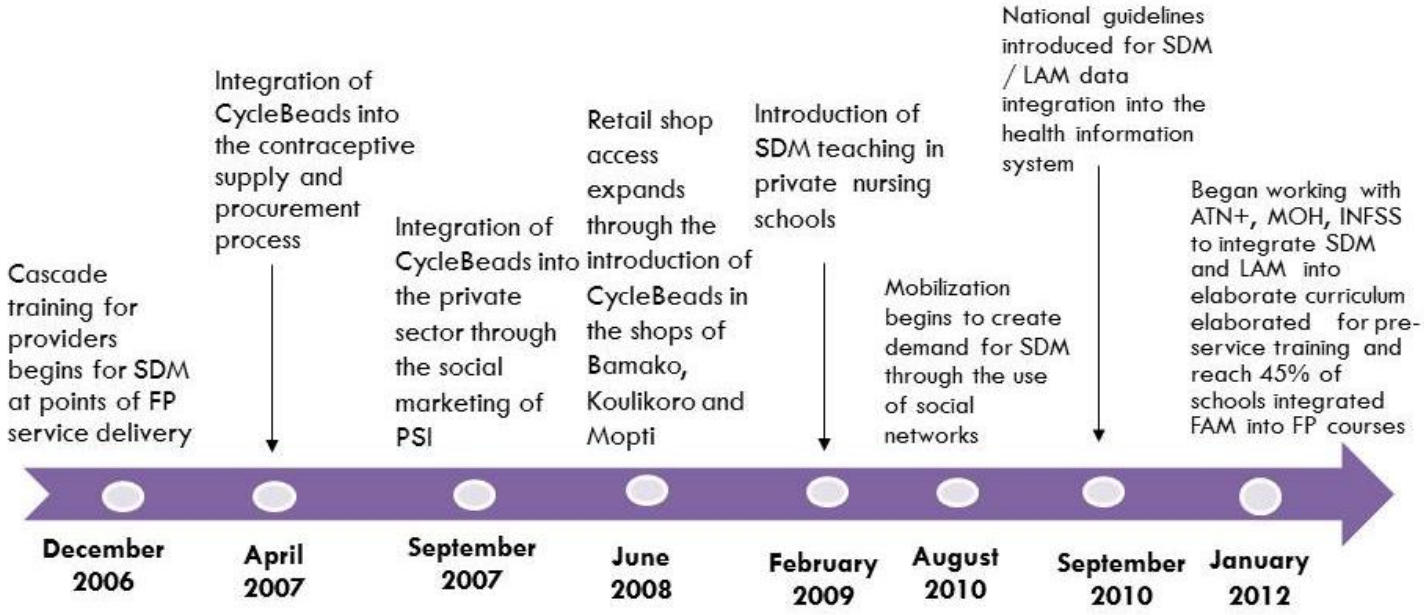
A client follow-up survey found 100% satisfaction with SDM; 75% of clients correctly demonstrated use of CycleBeads, and 94% verified correct placement of ring by referencing markings on their calendar).

Partial service delivery point data indicated at least 31,400 CycleBeads dispensed at public, private facilities.

[1] Managed by CARE, funded by USAID, PKC supported the decentralization process by helping communities manage, oversee, use and promote health services and improve household health practices.

USING DATA TO GUIDE SCALE-UP

Routine monitoring data, punctuated by several types of research, helped IRH, the MOH/DSR, and other key actors track SDM scale-up, detect successes, identify problems, and design solutions.



SITUATIONAL ANALYSIS/BASELINE (2009): This multi-component research captured SDM integration to date, and served as a form of baseline against which subsequent changes were compared. Stakeholder interviews revealed that IRH partner organizations had largely integrated SDM into their program planning, supervision, training, and budgets. Interviewees felt that work to date was well targeted and of high quality, but *more* of all components—awareness-raising, provider training, funding—was needed to ensure sustainable scale-up. Service provider interviews revealed that only 37% of providers had offered SDM to clients, although 100% claimed to have been trained to offer it. Only a quarter of health facilities had CycleBeads in stock at the time of the research. Household interviews confirmed men's reluctance to use or condone spouses' use of any FP method, men and women's desire to have numerous children, and low understanding of the benefits of FP and/or birth spacing.

ROUTINE MONITORING: IRH annually monitored indicators against benchmarks; periodically collected data at service delivery points on availability and use of SDM; twice applied the Knowledge Improvement Tool (KIT) with service providers; and undertook one follow-up survey with SDM users. Further, IRH and the MOH organized supervision and data collection quarterly at district level and semi-annually at regional and central levels.

ENDLINE RESEARCH (2012): Political events in Mali precluded two of three planned endline studies, and delayed the third—stakeholder interviews—until late 2012. Interviews were held to determine stakeholder perceptions of the scale-up process and recommendations for ensuring SDM's sustainability in the national FP program in the future. The nine respondents expressed a favorable attitude toward the SDM scale-up process, and toward the niche that SDM fills in the national method mix. Yet they also expressed concerns about lingering provider bias against the method (due to doubts about its effectiveness) and about MOH/DSR leadership abilities (including the ability to overcome provider bias). Interviewees recommended that funding be made available to MOH/DSR to complete the curtailed scale-up activities, to continue SDM promotion through IEC channels, and to continue to work with religious leaders using SDM as a gateway to broader discussions of birth spacing and FP.

IRH had organized collection of data on new SDM users as a proportion of all FP users (2007 to early 2011) from MOH health facilities in three regions in late 2011, and PSI sales data were also available (2007 through 2012).

Combined with monitoring data, these present a partial picture of SDM uptake in Mali. PSI reports that it dispensed a total of 25,810 CycleBeads between 2007 and early 2012 in private pharmacies, clinics, small retail outlets and community-based sales.

REGION	NEW FP USERS	NEW SDM USERS	% OF SDM USERS
Koulikoro	99,193	3,050	3.1
Ségou	131,552	1,196	0.9
Sikasso	149,857	1,374	0.9

The relative contribution of SDM use to all new FP use in the public section in three regions ranges from one to three percent.

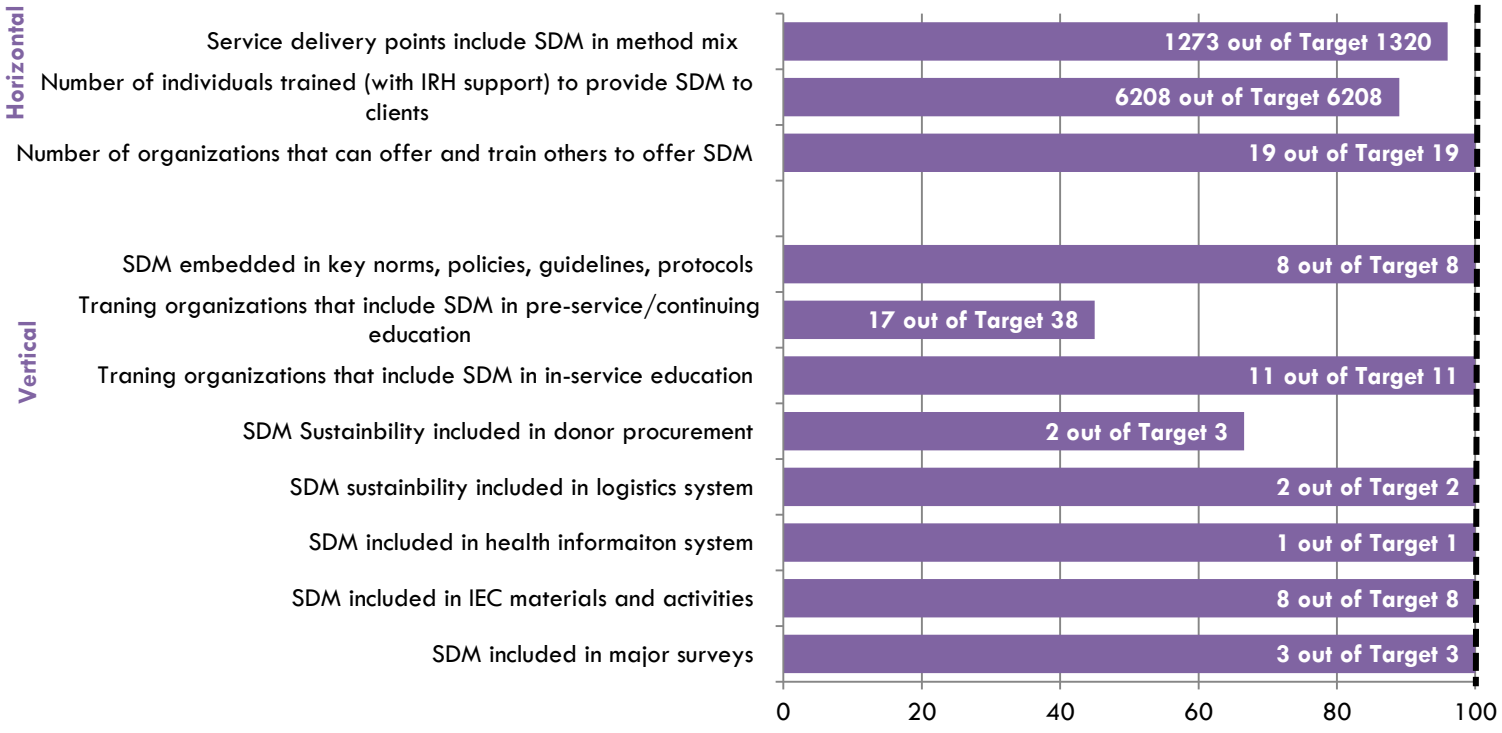
ACHIEVEMENT OF SDM BENCHMARK TARGETS

The figure below shows IRH's overall achievement of its benchmark targets, on both horizontal and vertical axes, in Mali. Despite the abrupt and early end to scale-up activities, only four of 11 benchmarks fell short of target.

IRH's work along the *horizontal* axis increased availability of and provider capacity to offer SDM across Mali's eight regions plus Bamako. By the end of scale-up, 1,273 service delivery points (96% of target) included SDM in their method mix. In March 2012, most health personnel in 43 of Mali's 49 districts plus Bamako were trained to provide SDM in most service delivery points. Only six districts had no SDM capacity.

IRH directly or indirectly supported the training of more than 6,200 health workers to offer SDM. This number does not include *relais,* of whom approximately 13,000 were trained by PKC.

PROPORTION OF BENCHMARKS ACHIEVED IN MALI



SCALE-UP SUCCESSES AND ACHIEVEMENTS IN MALI

As of March 2012:

- 1,273 service delivery points included SDM in their method mix.
- Most health personnel in 43 of Mali's 49 districts plus Bamako were trained to provide SDM.
- More than 6,200 health workers were trained to offer SDM.
- Approximately 13,000 *relais* were trained by PKC to offer SDM.
- Nineteen entities, including the MOH, gained the capacity to undertake the full range of SDM service provision.
- SDM was integrated in FP policies, norms, and protocols
- IRH and the MOH developed a standardized curricula covering all FP methods, which was partially rolled out before the project was disrupted.
- IRH advocacy with Mali's stakeholders in community logistics system led to fewer stockouts of CycleBeads.
- SDM/Cyclebeads was included as a discrete FP method in the health information system tools.
- SDM was included as a unique category in three planned national surveys.

Nineteen entities including the MOH gained the capacity to undertake the full range of SDM service provision including training and/or supervising others to offer the method. In ExpandNet terminology, these are resource organizations, and they are important for the sustainability of a health innovation. In addition to the MOH, resource organizations in Mali include: PSI, Groupe Pivot Santé/Population (an influential Malian health networking/umbrella NGO), multilaterals such as WHO and UNICEF, and several international NGO consortia that manage large scale health programs with the MOH.

Activities on the *vertical* scale aimed to achieve the sustainable institutionalization of SDM in Mali. SDM was successfully integrated into FP policies, norms, and protocols. In fact, much of this integration occurred at the instigation of MOH/DSR prior to scale-up. Integration of the method in pre-service training curricula was complex in Mali, and IRH ultimately only partially achieved its aims. SDM was incorporated quite rapidly into curricula at the *Institut National de Formation en Science de la Santé* (Faculty of Medicine) and several private schools in Bamako. IRH's collaboration with Intrahealth to develop a comprehensive reproductive health and FP curriculum for nursing students progressed to the rollout phase before running into funding roadblocks. IRH then joined the MOH and others to develop a standardized set of curricula covering all FP methods, with components tailored to fit the types of providers being trained. IRH intended to accompany rollout of these curricula in 38 schools during 2012, but the political crisis prevented this. In the end, IRH achieved 45% of targets for the pre-service curriculum indicator.

IRH aimed to include SDM in three donor procurement systems: MOH, USAID and UNFPA. At present in Mali, only donors procure FP supplies, but MOH is included in this indicator because it (a) must formally request items before donors will order them, and (b) will eventually begin to procure some commodities with its own funds. Both MOH and USAID agreed to include CycleBeads in their FP requests or orders. That said, Mali is still drawing from the initial stock of 60,000 CycleBeads from 2006. In reality, therefore, no further donor procurement has taken place in Mali.

The 2009 situational analysis/baseline found that 22% of service delivery points surveyed had experienced stockouts of CycleBeads in the three previous months. Following extensive IRH advocacy with stakeholders in both of Mali's commodity logistics systems—the public and the private—a 2011 survey found a greatly improved situation. IRH counts full achievement of this target, while acknowledging that Mali's overall health logistics systems are subject to problems far larger than any single project could resolve.

The MOH revised its health information system tools in 2011/2012, and IRH took the opportunity to ensure that SDM appeared throughout the system as a discrete FP method. (Until that time, service providers had been trained to write 'SDM' or 'CycleBeads' into the 'other' column of their FP registers.) Specifically, IRH provided technical assistance in MOH workshops in which the primary and secondary HMIS tools for reproductive health and FP were revised. These tools were then to be integrated into an electronic system at national level, but this step was interrupted by the crisis of March 2012.

Finally, IRH advocacy led to SDM's inclusion as a unique data category in all of three planned surveys. These included the 2008 *Etude d'Analyse Situationnelle* (MOH and USAID), the 2009-10 Multiple Indicator Cluster Survey (UNICEF) and the Demographic and Health Survey planned for 2012. (The 2006 DHS in Mali had no clear place to record SDM; responses may have been marked as 'male condom,' 'periodic abstinence,' or unspecified traditional methods.) The 2012 DHS was suspended due to the March crisis.

SCALE-UP AND THE MALI ENVIRONMENT

Mali's MOH and especially the DSR showed consistently strong support of SDM, beginning with spontaneous adoption of the method. The MOH supported SDM's inclusion in large-scale projects with major institutional partners. Within the framework of these projects, important work such as service provider training and integration of SDM into *relais*' activities and national IEC took place.

Factors that Facilitated SDM Scale-Up in Mali:

- The MOH and especially the DSR showed consistently strong support of SDM.
- The MOH supported SDM's inclusion in large-scale projects with major institutional partners.

Factors that Limited SDM Scale-Up in Mali:

- Global donor trends that favored long acting methods
- The influence of pro-natalist trends and low levels of formal education among Malians

IRH's subjective impression is that global donor trends in favor of long-acting methods took their toll on SDM scale-up in Mali. There was no overt pressure to curtail SDM promotion, but the emphasis on increasing contraceptive prevalence rates (which is most easily or rapidly done by promoting long-acting methods) was felt by the MOH and other organizations that collaborated with IRH.

The strong influence of pro-natalist traditions inhibited uptake of FP methods including SDM, as did the relatively low level of formal education among Malians and especially Malian women. IRH and partners used a social network approach to design and implement several activities to make use of peer influence and provide support for FP use. These included trainings for networks of religious leaders to present general FP concepts and dispel myths; broadcasting radio spots and organizing home visits to encourage men to support their wives' use of FP; and reaching secondary school students with education on human reproduction, the menstrual cycle, and FP. In one particularly successful collaboration, IRH worked with *Coalition des Femmes du Mali* to use social diffusion via leaders of women's savings and loan groups. In three districts, the number of new FP users (any modern method) rose by 23% in the three months after social diffusion, compared to the three months prior to the activity.

RESOURCE AND USER ORGANIZATIONS

As noted, a resource organization is one that promotes and facilitates wider use of a health innovation—in this case, SDM—while a user organization is one that implements an innovation. The majority of IRH's 19 partner organizations in Mali played both roles during scale-up. In addition to MOH/DSR, the resource organizations PKC, ATN+, and PSI were of particular strategic importance to scale-up in Mali.

- **PKC** integrated SDM into its substantial IEC repertoire, trained service providers in 13 districts, and trained more than 13,000 *relais* to offer the method in communities.

- **ATN+** (*Assistance Technique National Plus*, a USAID-funded program for technical assistance to the health system at national and district levels) contributed to SDM integration in certain normative documents, and extended service provider training in FP and SDM throughout the country.
- **PSI** and its social marketing program integrated SDM and provider training in clinics, pharmacies, small retail outlets, and community sales agents, and aired radio and television spots.

STRATEGIC CHOICE AREAS

CAPACITY BUILDING & TECHNICAL ASSISTANCE

- Cascade trainings from national to regional to district to community levels
- SDM woven into MOH's family planning supervision documents
- Participatory approach built capacity among partner organizations

DEMAND CREATION

- IEC materials and communication tools adapted for use in MOH health facilities
- PSI's social marketing program included SDM in materials for private clinics and pharmacies
- IRH and Coalition des Femmes du Mali trained leaders of 170 women's associations to provide peer education on SDM and FP

ADVOCACY

- SDM included in private and public logistics systems
- SDM included in two donor procurement systems

MONITORING & EVALUATION

- Analysis of progress towards benchmarks guided decision-making
- A variety of tools were used to collect data and assess progress
- IRH periodically collected data on the sale and use of CycleBeads

RESOURCE MOBILIZATION

- IRH collected information on partners' use of their own resources to promote SDM scale up. IRH esitmates that $613,100 was leveraged for SDM scale up from 2007- March 2012.

The ExpandNet framework guided IRH to make strategic choices in several areas based upon a careful analysis of the operating environment in Mali. These areas, as they applied to SDM scale-up, are briefly summarized here.

CAPACITY BUILDING AND TECHNICAL ASSISTANCE: IRH provided capacity building and technical assistance in various forms to its partner resource organizations, which in turn promoted SDM scale-up within their own purviews. This allowed rational and balanced progress along the horizontal and vertical axes of the ExpandNet framework.

Training throughout scale-up was done in cascade via MOH structures, directly and via large-scale programs (PKC, ATN+) that supported those structures. As the cascade proceeded from national to regional to district to community levels, IRH made several adjustments to the SDM training module. First, it was simplified and shortened, and thereby made more readily useable with service providers of all types. Next, at MOH request, IRH oversaw the integration of the SDM module into existing FP training materials that covered the entire, MOH-approved FP method mix. IRH also made sure that revisions to training curricula at one level (nurses, for example) were followed by corresponding revisions at other levels (*relais*, leaders of women's groups).

SDM was woven into the MOH's FP supervision documents, including the FP-specific supervision manual and the integrated supervision manual. IRH supported district health teams' ability to follow up on the quality of SDM service provision by using its KIT with selected service providers. The KIT both measures service provider knowledge and skills and offers opportunity for on-the-spot refresher training.

IRH in Mali also judges that its participatory approach to scale-up was a valuable means of building capacity among partner organizations. The original strategy-setting for scale-up along horizontal and vertical axes, activity implementation, monitoring and analysis of progress, and re-strategizing: all these, over time, strengthened not only SDM scale-up but the skills of implementers throughout Mali's public and private health service structure.

KIT findings among 33 providers in 2012

- 22 sages femmes, 9 nurses, 2 doctors):
- 70% of all 33 providers were able to correctly instruct women to use CycleBeads
- 82% of the 22 sages femmes were able to correctly instruct women – a higher proportion than of all providers combined.
- CycleBeads were available at service points in all seven districts where KIT was used.

DEMAND CREATION: IRH and partners developed or adapted IEC materials and communication tools for use in MOH health facilities and in communities, and PSI's social marketing program incorporated SDM in materials for private clinics and pharmacies. With IRH and the MOH, PSI also produced radio and television spots on SDM and the menstrual cycle. As noted, IRH and the *Coalition des Femmes du Mali* trained the leaders of 170 women's associations to provide peer education (social diffusion) on SDM and FP. Yet IRH and partners ultimately were frustrated by limited financial resources for IEC. A secondary constraint came in the form of donor policies that increasingly favored long-acting methods and their effect on health activities funded by those donors. Service providers received bonuses for signing up new users of long-acting methods, for example, but not other methods including SDM. ATN+, PSI and others' training sessions on FP and FP counseling concentrated more heavily on long-action methods and less on other methods including SDM.

ADVOCACY: IRH continuously advocated and collaborated with the MOH and other service providers to ensure SDM's inclusion in FP programs. The MoH and other partner FP programs have taken ownership of SDM as a result of their participation in scale-up work. SDM was successfully included both Mali's public and private logistics systems. As of early 2012, CycleBeads were integrated into two of three planned donor procurement systems, and IRH was working with the MOH to include SDM in SIS tools as the MOH revised its recording tools and transitioned to an electronic system. The March 2012 crisis, however, prevented IRH and others from taking the final, formal steps of integrating CycleBeads into these last two categories.

MONITORING & EVALUATION: The benchmarks that IRH defined at the beginning of the project were the foundation for results monitoring. Regular analysis of progress towards the benchmarks guided decision making and strategic planning. A variety of tools were used in the M&E process, including statistical data, the KIT, SDM Client Follow-Up, Most Significant Change Stories, and Global Surveys. Review meetings with partners and periodic

supervision of service providers served as additional sources of information. Since SDM did not appear as a unique category in Mali's SIS, IRH undertook periodic data collection on the sale and use of CycleBeads to gage the number of users.

RESOURCE MOBILIZATION: IRH collected information on leveraging, or partners' use of their own resources to promote some aspect of SDM scale-up. For example, PKC used its own funds to train thousands of *relais* in FP including SDM; other instances involved supervision, promotion activities, or providing CycleBeads. IRH estimates that $613,100 were leveraged for SDM scale-up from 2007 to March 2012.

KEY ELEMENTS THAT FACILITATED SCALE-UP IN MALI

1	2	3	4
Formulating multiple, compatible partnerships among the spectrum of organizations involved in Mali's health sector	Continued leadership of the MOH/DSR in promoting FP	Using and sharing evidence-based research and M&E of current activities for planning as well as to attract and engage partners	IRH's ability to offer an array of technical assistance

Reflecting on its experience in Mali and on results obtained, IRH notes the valuable role of the following in facilitating scale-up.

1. Formulating—from the beginning—multiple, compatible partnerships from among the spectrum of organizations involved in Mali's health sector, and offering attractive opportunities for collaboration throughout the scale-up period.
2. Continued leadership of MOH/DSR in promoting FP, and its coordinating role with all organizations to address FP gaps and services, which helped to ensure a certain level of accountability in SDM scale-up.
3. Using and sharing evidence-based research, and M&E of current activities, not only for planning but for attracting and engaging partners. Examples are the joint reviews of the 2008 strategic plan recommendations and the 2009 baseline study results; the Most Significant Change story collection report; and briefs on project successes in Mali and other countries.
4. IRH's ability to offer an array of technical assistance was very important for maintaining equilibrium between advances on the two scale-up axes.

SUSTAINABILITY OF SDM IN MALI

Significant progress has been made across the various components of scaling up SDM at the national level. To assure that these achievements are sustained and/or advanced upon the end of the FAM project, however, there is a need to identify key actors and strategies that will move SDM forward in terms of advocacy, capacity building, logistics and procurement, IEC, and HMIS and M&E.

SCALE-UP COMPONENT	ACTION FOR SUSTAINABILITY	RESPONSIBLE PARTY
ADVOCACY	• Advocate for inclusion of SDM in next DHS.	USAID
CAPACITY BUILDING	• Continue including SDM in FP training and supervision. • Include SDM as part of the FP activity focus in new USAID bilaterals. • Maintain SDM as part of the national FP training programs/curriculum for facility and CBD-based services.	MOH and current USAID bilaterals (PKC and ATN+) USAID MOH
LOGISTICS AND PROCUREMENT	• Include CBs in the FP product line in the private sector to replace IRH-funded PSI CB promotion. • Assess CB procurement need for two to five years (in light of oversupply of CB at the end of the Awareness Project).	USAID and other private sector FP donors MOH
IEC	• Finance TV and radio male involvement in SDM promotion campaign (created by PSI) to maintain increased sales under retail promoters.	USAID and other donors
HMIS/ MONITORING & EVALUATION	• Monitor that SDM information is completely and correctly recorded in revised HMIS. • Include SDM opt-in module in next DHS following resolution of the political crisis.	MOH MOH with USAID