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USAID SERVICES DE SANTÉ À GRAND IMPACT

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LIST OF ABBREVIATIONS AND ACRONYMS

ACT	Artemisinin-based Combination Therapy
AIDS	Acquired Immunodeficiency Syndrome
AMCP-SP	<i>Alliance Médicale Contre le Paludisme et Santé Publique</i> (local NGO)
AMPRODE	<i>Association Malienne pour la Protection et le Développement de l'Environnement au Sahel</i> (local NGO)
AMTSL	Active Management of Third Stage of Labor
ANC	Antenatal Care
ASACO	<i>Associations de Santé Communautaire</i> (Community Health Association)
ASC	<i>Agents de Santé Communautaire</i> (Community Health Worker)
BEmONC	Basic Emergency Obstetrical and Neonatal Care
CAC	Community Action Cycle
CAG	Community Action Group
CAM	<i>Convention d'Assistance Mutuelle</i> (Mutual Assistance Agreement)
CECAP	Cervical Cancer Screening and Treatment Program
CEmONC	Comprehensive Emergency Obstetrical and Neonatal Care
CFA	<i>Communauté Financière Africaine Franc</i> (West African Franc)
CHX	Chlorhexidine
CLTS	Community Led Total Sanitation
CPS	Seasonal Malaria Chemoprevention Strategy
CSCom	<i>Centre de Santé Communautaire</i> (Community Health Center)
CSRef	<i>Centre de Santé de Référence</i> (District Referral Hospital)
DGSHP	<i>Direction Générale de Santé et l'Hygiène Publique</i> (National Health and Public Hygiene Directorate)
DHIS2	District Health Information System (version 2)
DHS	Demographic and Health Survey
DPM	<i>Direction des Pharmacies et Médicaments</i> (Pharmacy and Medicines Directorate)
DRS	<i>Direction Régionale de la Santé</i> (Regional Health Directorate)
DTC	<i>Directeur technique du centre</i> (Health Center Technical Director)
EmONC	Emergency Obstetrical and Neonatal Care
ENC	Essential Newborn Care
FELASCOM	<i>Fédération Locale des Associations de Santé Communautaire</i> (Local Federation of Community Health Associations)
FENASCOM	<i>Fédération Nationale des Associations de Santé Communautaire</i> (National)
FERASCOM	<i>Fédération Régionale des Associations de Santé Communautaire</i> (Regional)
FP	Family Planning
GP/SP	<i>Groupe Pivot Santé et Population</i> (National Association of local NGOs)
GSAN	<i>Groupe de Soutien aux Activités de Nutrition</i> (Nutrition support group)

HIHS	High Impact Health Services
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IPC	Infection Prevention and Control
IPTp	Intermittent Preventive Treatment of Malaria in Pregnancy
IUD	Intra Uterine Device
IYCF	Infant and Youth Children Feeding
KJK	USAID <i>Keneya Jemu Kan</i> (SBCC and social marketing bilateral project)
KMC	Kangaroo Mother Care
LARC	Long Acting and Reversible Contraceptive
LBW	Low Birth Weight
LMIS	Logistics Management Information System
LOP	Life of Project
M&E	Monitoring and Evaluation
MHSD	Ministry of Health and Social Development
MIP	Malaria in Pregnancy
MNCH	Maternal, Newborn, and Child Health
MSAS	Ministry of Health and Social Affairs
MSI	Management Systems International
MSIM	Marie Stopes International Mali
NGO	Non-Governmental Organization
ODF	Open Defecation Free
OTSS	Outreach Training and Supportive Supervision
PAC	Post-abortion Care
PANB	<i>Plan d'Accélération Nationale Budgetisé</i> (National Budgeted Action Plan)
PMTCT	Prevention of Mother to Child Transmission of HIV
PNC	Postnatal Care
PPFP	Postpartum Family Planning
PPIUD	Postpartum Intra Uterine Device
PRODESS	<i>Programme de Développement Sanitaire et Sociale</i> (National Health and Social Development Program)
PSI	Population Services International
RDT	Rapid Diagnostic Test
RH	Reproductive Health
RM	Rural Maternity
SBCC	Social and Behavior Change Communication
SEC	<i>Soins Essentiels Communautaire</i> (Community Health Package)
SMC	Seasonal Malaria Chemoprevention

SSGI	<i>Services de Santé à Grand Impact</i> (High Impact Health Services)
SVA	Single Visit Approach
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHSF	Village Health Solidarity Funds
VIA/VILI	Visual Inspection of the Cervix with Acetic Acid and Lugol's Iodine
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

EXECUTIVE SUMMARY

The United States Agency for International Development (USAID)-funded *Services de Santé à Grand Impact* (SSGI) project aimed to reduce or eliminate maternal, newborn, and child deaths in Mali. SSGI worked closely with government and community structures at all levels of the health system to ensure that activities aligned with the National Health and Social Development Program (PRODESS). The project also worked closely with other USAID health, health systems and governance projects, United Nations (UN) agencies, and supported bilateral cooperation to create, synergize, and maximize efforts and achieve greater results for Malian families.

The SSGI project partnered with the Ministry of Health and Social Development (MHSD) to improve access to high impact quality health services, health practices and care-seeking, and health information, logistics and governance systems at national, regional, district, community and household levels. In total, the project supported 37 health districts in the regions of Kayes, Sikasso, and Koulikoro, the Districts of Bamako and Gao, with a total of 807 community health centers (CSCoM), and 1,150 community health workers (ASC), among whom SSGI paid the monthly motivation for 798. The project provided technical support to different technical working groups at national level and to four regional directorates of Kayes, Koulikoro, Sikasso and the district of Bamako.

Throughout its project life, SSGI provided support to the scale-up of priority interventions to prevent maternal, newborn and child deaths and improve the quality of facility-based care while seeking to transition and render sustainable its actions. To meet this goal, SSGI established three objectives:

1. To improve demand for quality health services and products and adoption of healthy behaviors at the individual, household, and community levels.
2. To improve access to, and quality of, integrated high impact health services (HIHS) and appropriate referrals.
3. To improve health systems management, functioning, and accountability at the community, district, and regional levels.

The below summarizes key accomplishments under each of these objectives for the period December 2014 to September 2020, when the majority of implementation concluded.

Result 1: Improved demand for quality health services and products and adoption of healthy behaviors at the individual, household, and community levels.

- 257 Community Action Groups (CAGs) established, trained and strengthened in 28 districts.
- 720 Village Health and Solidarity Funds (VHSF) established to facilitate transportation and care at a health facility for pregnant women, newborns and sick children.
- 884 nutrition support groups (GSANs) established (230 in Sikasso, 292 in Kayes and 362 in Koulikoro). By March 2020, 67% of these GSANs self-funded their nutrition demonstrations and education activities.

- 129 villages (93% of triggered villages) declared open defecation free (ODF) status.
- 141 water, sanitation and hygiene (WASH) committees established and supported to implement their action plan.
- 238 masons trained and provided with a mold (Sanplat) to make latrine slabs.
- 798 ASCs supported through payment of a monthly incentive; 961 ASCs supervised, and 1,150 ASCs trained and provided with consultations forms, registers and reporting forms.
- 1,150 ASCs trained on the community health package (SEC) including the provision of data collection and reporting tools. Among them, 961 received direct supervision from the project and 798 were paid by SSGI the monthly incentive payment.
- 1,130 ASCs in 26 health districts conducted an annual average of 103,848 consultations. They contributed to management of 28% of diarrhea cases, 18% of pneumonia cases and 15% of malaria cases among children under five years old.

Result 2: Improved access to, and quality of, integrated high impact health services and appropriate referrals.

- 1,554 health providers trained on integrated package for pregnancy, childbirth and postnatal care.
- 382 health providers trained in the prevention of mother to child transmission (PMTCT) of Human Immunodeficiency Virus (HIV) from 446 health facilities (120 PMTCT sites created by the project).
- 912 providers trained in kangaroo mother care (KMC) for managing low birthweight babies and 431 facilities reinforced to offer KMC services.
- 307 CSComs upgraded to provide Basic Emergency Obstetric and Neonatal Care (BEmONC) services with 503 providers trained in BEmONC and 692 structures equipped with essential equipment, newborn resuscitation mannequins and job aids.
- 38% of targeted health facilities in Bamako and Koulikoro reached Clean Clinic status.
- 542 providers trained in family planning (FP); 528 on long-acting reversible contraceptives (LARC) and 249 on postpartum intra uterine device (PPIUD) (coaching in-situ).
- 1,492 health providers oriented on the use of chlorhexidine (CHX) for newborn cord care.
- 626 health facilities supervised (590 CSCom and 36 district referral hospitals (CSRef)), among which 263 are BEmONC sites supervised by regional and district teams.
- 6,896 (5,204 community volunteers and ASCs; 769 health center technical director (DTC) and/or adjuncts and 923 test administrators) trained for the seasonal malaria chemoprevention campaigns.
- 6,137 health workers (843 DTC and/or adjuncts and 5,294 ASCs/relais) trained on malaria case management with artemisinin-based combination therapy (ACT).
- 1,920 providers, including 91 laboratory technicians trained on malaria diagnostic (microscopy and rapid diagnostic test (RDT)).
- 313 facilities (288 CSCom and 36 CSRef) benefited from Outreach Training and Supportive Supervision, (OTSS) reaching 1,608 health providers.
- 720 VHSF amassed nearly 34 million CFA (West African francs) (\$58,000) to cover costs of evacuation

of women in children with health emergencies.

- 1,389 health workers trained on infant and young child feeding (IYCF).

Result 3: Improved health systems management, functioning, and accountability at the community, district, and regional levels.

- 682 ASACOs conducted institutional capacity self-assessments.
- 251 ASACOs received management training.
- 252 ASACOs evaluated show that over 78% evolved from start-up to mature phase.
- Score card developed and used by 288 joint committees.
- 72% joint committees coached on the Mutual Assistance Agreement (CAM) scorecard have a fully executed CAM agreement.
- 1,333 health management information system (HMIS) officers/CSCoM staff trained on revised HMIS tools, including District Health Information System (version 2) (DHIS2).
- 237 health facilities equipped with laptops and internet keys.
- 80 tablets provided to regional and district health teams for on-the-job training/supervision.
- Between 2017 and 2019, the timeliness of data reporting increased from 36% to 69%.

CONTEXT

Over the last decade, Mali has demonstrated progress in improving the health and survival of women and children. Use of modern contraceptives, care-seeking for antenatal care, and births in health facilities have increased. Malnutrition rates have declined. However, despite these achievements, maternal, newborn, and children mortality rates remain alarmingly high. According to the 2018 report of the Demographic and Health Survey (DHS), Mali has one of the highest total fertility rates in the world (6.3), and a modern contraceptive prevalence rate (CPR) of 16% with an unmet need for FP among 24% of women of reproductive age (WRA) and 79% of women during their first year postpartum. Pneumonia, diarrhea and malaria—all preventable and treatable—remain leading causes of death for Malian children under 5, while stunting and chronic malnutrition are found among 27% and 9% of this age group, respectively. Neonatal deaths—the majority of them within the first week of life—make up 33% of Mali’s child mortality, with premature and low birth weight (LBW) neonates at the highest risk. In 2013, the HIV mother-to-child transmission rate was estimated at 2.26% with HIV prevalence among pregnant women attending antenatal care (ANC) at 2.9%.

In spite of volatile political, security, and climate circumstances, the MHSD, with partners including USAID, has successfully achieved steady maternal and child mortality rate decreases over the past decades. Recent national commitments to health reform, which include attention to community health services, inclusive of plans for free primary care, demonstrate the government’s commitment to health and offers promise of increased access. USAID is a long-standing partner contributing to improving MCH and combating infectious disease by increasing use of high-impact health services and adoption of healthy behaviors.

The USAID-funded SSGI project (2014-2020) aimed to reduce or eliminate maternal, newborn, and child deaths in Mali. SSGI worked closely with government and community structures at all levels of the health system to ensure that activities align with the PRODESS. The project also worked closely with other USAID health, health systems and governance projects, UN agencies and supported bilateral cooperation to create, synergize, and maximize efforts and achieve greater results for Malian families.

PROGRAM DESCRIPTION

Goal and Objectives

Through innovative, evidence-based, high impact maternal, newborn and child (MNCH), FP, malaria, HIV/Acquired Immunodeficiency Syndrome (AIDS) (with a focus on the prevention of mother to child transmission of HIV, or PMTCT), nutrition, and WASH services, over the life of SSGI the project aimed to improve the survival and nutritional status of mothers, newborns, and children under-five in Mali.

To meet this goal, SSGI established the following objectives:

1. To improve demand for quality health services and products and adoption of healthy behaviors at the individual, household, and community levels.
2. To improve access to, and quality of, HIHS and appropriate referrals.
3. To improve health systems management, functioning, and accountability at the community, district, and regional levels.

Beneficiaries and Coverage Zone

SSGI targeted a population of over 2.6 million women of reproductive age and 2.4 million children under five annually in the 37 target health districts in the regions of Kayes, Koulikoro, Sikasso, in Bamako's six communes and in one district of Gao (in project years 2-5). A package of integrated health interventions and services formed the core of SSGI's approach and were delivered from the household to the hospital in targeted communities using the CSCom as the cornerstone for program cohesion and expansion.

Partnership

Under the leadership of the Mali MHSD, SSGI was led by Save the Children and implemented in partnership with Jhpiego, Marie Stopes International Mali (2015-2017), Population Services International (2017-2019), Management Systems International, *Group Pivot Santé Population*, the National Federation of Community Health Associations (FENASCOM), and seven local non-governmental organizations (NGOs). Together consortium partners supported the MHSD to scale up increased and sustained use of high impact health services and healthy behaviors by providing the financial and technical resources to attain these objectives. SSGI collaborated closely with other USAID bilateral and global projects, as well as other health partners in Mali.

Implementation mechanisms included working with local NGOs for community strengthening and mobilization, providing capacity building to health providers at the community level (the *Agents de Santé Communautaire* or ASC), community primary health care facilities (CSComs) and district health teams and CSRefs. SSGI supported partner coordination efforts at all levels of implementation, with focused efforts at the regional and national levels (e.g., through national technical working groups) to ensure synergy and avoid duplication of efforts.

MAJOR ACHIEVEMENTS

Result 1: Improved demand for quality health services and products and adoption of healthy behaviors at the individual, household, and community levels

Community groups promoted adoption of healthy behaviors at the individual, household and community levels. SSGI strengthened existing community groups and established new ones such as nutrition support groups (GSAN), Community Action Groups (CAG) and WASH committees as platforms to integrate community interventions through a variety of approaches, including incorporating social and behavior change (SBC) into all community-based MNCH and nutrition activities. SSGI collaborated with the USAID funded *Kenya Jemu Kan (KJK)* project¹ and developed an integrated booklet of key messages that various community groups used as reference for community conversations on various health topics.

SSGI's local non-governmental organization (NGO) partners trained community leaders on SBC techniques and equipped GSANs with nationally approved job aids and counseling materials focused on an integrated range of health practices related to reproductive health (RH) and pregnancy, nutrition, child and newborn survival. GSANs organized nutrition education sessions, cooking demonstrations, and each group received a measuring tape to measure a child's middle upper arm circumference (MUAC) (a "Shakir band") to conduct malnutrition screenings at regular intervals (monthly or quarterly) in each community and/or at the household level. In addition, GSANs focused on practices to improve nutrition. They learned how to prevent malnutrition, treat moderately malnourished children in the community, refer severely malnourished children to the health center and follow up on recovered cases at the community level. GSAN members also educated family members on danger signs for pregnant women and newborns so they could be transported to the health center without delay, and promoted MNCH services such ANC, immunization, and FP. Taken collectively, these activities contributed to increased demand for quality health services at the individual, household and community levels.



The WASH Committee of Famorila village, Kolondieba district.

SSGI also supported WASH committees to engage in community-led total sanitation (CLTS) efforts to improve sanitation and hygiene in villages. The WASH committees also directed regular community clean-up events to keep the environment free of feces. To improve latrines, SSGI trained masons and equipped them with molds for building latrine slabs. The project worked with community health workers (the ASC) and GSAN members to promote the adoption of healthy essential WASH behaviors that included handwashing with soap before touching food or after toileting, breastfeeding, treating drinking water and storing it safely and safely disposing of infant feces in a latrine.

¹ The USAID-funded Kenya Jemu Kan (KJK) project was SSGI's sister project that focused on social and behavior change communication, mass media, demand creation and social marketing in the same regions as SSGI. The two projects had a joint implementation plan.

SSGI worked closely with ASCs to promote behavior change and help community group leaders conduct cooking demonstrations, malnutrition screenings and CLTS activities. USAID requested SSGI to support the monthly ASC incentive payments in Kayes and Sikasso regions. SSGI trained and supported ASCs to conduct home visits to identify pregnant women, newborns and sick children and to help families adapt healthy behaviors related to antenatal care, facility births, immunization, and nutrition.

SSGI provided financial and logistical support for ASCs and community groups to mobilize their communities around internationally recognized days for particular health issues such as World Malaria Day/African Malaria Week, Global Handwashing Day, World Toilet Day, World Prematurity Day and World Breastfeeding Week. The same was completed for national nutrition, immunization, FP and malaria prevention campaigns. These days helped to galvanize the population and contribute to the adoption of healthy behaviors related to these particular health issues.



Photo credit: Save the Children.

MUAC measurement using a “Shakir band” in Kongola.

Improved demand for quality health services and products.

To build synergies between the community and the health center, SSGI built the capacity of villagers to identify and solve their priority health problems using a community mobilization approach based on the Community Action Cycle (CAC). Composed of 10-15 members (55% women) representing ASCs, health facility staff, health facility management committee (ASACO) members, and community leaders from each village of the health area, the CAG conducts a community diagnosis to identify and prioritize health issues and determine the root causes of these health issues. The CAG then creates an

action plan to tackle priority health issues and measure progress over time. All villages send representatives to validate the CAG’s plan and to review progress. Monthly meetings help CAGs understand whether proposed activities are working and whether they need to be adapted to meet actual community needs. This integrated and collaborative approach promoted realistic and effective planning, social support among community members, health practitioners and government stakeholders and increased the capacity of community members to lead their own development process. CAGs leveraged partnerships with GSANs to improve the nutrition status of children under five and pregnant women; with WASH committees to improve individual, household and community WASH practices; with ASCs for integrated community case management (iCCM), and VHSF committees for referral of obstetric and newborns emergencies. Together, all of these community groups collaborated to improve MNCH and nutrition in the community.

The 257 CAGs established in 28 health districts have become a functional community mobilization arm of the ASACO, which before SSGI arrived was a non-functional mandate of the ASACO. Now ASACOs undertake routine community mobilization activities in communities. Through SSGI’s support, these efforts helped build maternity wards, provided a source of clean water, increased number of technical staff in health facilities and increased referral and evacuations systems for health emergencies from household to CSCom. CAGs have helped create or revitalize many of the solidarity funds created for emergency evacuation from the CSCom to CSRef, as described in the text box. The VHSF are typically used for health emergencies; however, they also supported the costs of GSAN cooking demonstrations, transportation costs and fees for

ANC visits for pregnant women. In some villages, the CAG built simple huts to ensure confidentiality during ANC services conducted by mobile outreach teams.

“The fund provided me 35,000 CFA (63 USD) which I don’t need to pay back, allowing my wife to be evacuated from the village to CSCom and then to district hospital. I can say that the fund saved my wife’s life. Without these funds, I would have searched all around looking for money while my wife was in pain. My wife was quickly evacuated thanks to the ambulance and we avoided the worst. My wife delivered our baby by caesarean section and both are doing well. I will volunteer to educate people to contribute to the fund.”

–Tiewassa Traore, married to Mariam Diarra.

The end of project evaluation found that community actors (CHWs, CAG and GSAN members) recognized that the actions developed with the support of the SSGI project contributed to improving the knowledge of the populations on health issues. A member of a GSAN shared:

“It must be said that before the project, very few awareness-raising activities were organized in the villages. Which made it difficult for people to learn new things. Many women in our intervention villages did not know how to prepare a good porridge for their children with local cereals. People thought that in order to feed children well, you need products or foods that come from the city. We can see with the actions of the project that the women have learned a lot about nutrition and hygiene.”

–GSAN Member (CAG-GSAN_005).

The end of project evaluation documented that community activities led by SSGI also contributed to improving knowledge about pregnancies. End of project evaluation results indicated that prior to SSGI’s intervention, many women in the project intervention area reported having very poor knowledge of the danger signs associated with pregnancy, did not know of the importance of ANC and their benefits, and were not aware of safe and unsafe behaviors and tasks women should be aware of during pregnancy. Like women, many men were also unaware of safe and unsafe behaviors, and therefore could not be of help, or provide support, to their pregnant wives. In the villages, as noted by CHWs, CAG members, and GSANs, a large portion of the populations did not have enough knowledge about pregnancy management before the start of the project. SSGI used this opportunity to provide important and vital health related information to the general public.

RESULT 1: KEY ACHIEVEMENTS, DECEMBER 2014–SEPTEMBER 2020

- 257 CAGs established, trained and strengthened in 28 districts.
- 720 VHSF established to facilitate transportation and care at a health facility for pregnant women, newborns and sick children.
- 884 GSANs established (230 in Sikasso, 292 in Kayes and 362 in Koulikoro). By March 2020, 67% of these GSANs self-funded their nutrition demonstrations and education activities.
- 129 villages (93% of triggered villages) declared ODF status.
- 141 WASH committees established and supported to implement their action plan.
- 238 masons trained and provided with a mold (Sanplat) to make latrine slabs. These masons built 829 slabs, selling them for a total of 6,512,000 CFA (US \$11,670).
- 798 ASCs supported through payment of a monthly incentive; 961 ASCs supervised, and 1,150 ASCs trained and provided with consultations forms, registers and reporting forms.
- 1,150 CHWs trained on SEC package including the provision of data collection and reporting tools. Among them, 961 received direct supervision from the project and 798 CHWs were paid by SSGI the monthly incentive payment (30 000 CFA in Sikasso and 40 000 CFA in Kayes).
- 1,130 CHWs in 26 health districts conducted an annual average of 103,848 consultations. They contributed to management of 28% of diarrhea cases, 18% of pneumonia cases and 15% of malaria cases among children under five years old.
- Community groups reached community members multiple times with messages promoting behavior change as follows: (i) 1,874,159 contacts for nutrition messages (85% female); (ii) 3,815,980 contacts for MNCH (79% female); (iii) 1,256,059 contacts for FP (74% female); (iv) 4,054,601 contacts for malaria (76% female); and (v) 1,874,159 contacts for WASH (66% female).
- Increased the number of women who sought ANC services. ANC1 increased from 56% to 82% (October 2016 to September 2019); in 2020, ANC1 reduced slightly to 78%. For the same period, ANC4 increased from 19% to 30%, with a reduction to 28% in 2020. Intermittent preventive treatment of malaria in pregnancy (IPTp) increased from 27% to 48%, decreasing to 44% in 2020. Generalized reductions in 2020 should be considered in the context of COVID-19's impact on service availability and use.
- Increased the number of new users of FP modern methods, with the FP prevalence increasing from 19.4% to 28.14% from 2015 to 2019.

Result 2: Improved access to and quality of integrated high impact health services and appropriate referrals

Successfully addressing integrated supervision. SSGI facilitated regional and district health teams to conduct integrated supervision rather than focus on one specific technical area. National guidelines for integrated health supervision combined technical, administration, finance and SBC. This approach was challenging, as it required two or more days per facility and at least four multi-functional staff. To respond to this challenge, the project identified three technically focused yet integrated packages for different supervision teams to monitor:

- 1. Maternity services:** ANC, malaria in pregnancy, obstetric and neonatal care, FP/Postpartum Family Planning (PPFP), PMTCT and infection prevention;
- 2. Pediatric services:** Immunization, nutrition and WASH plus community nutrition monitoring of ASCs and GSANs; and
- 3. Health systems strengthening:** HMIS/DHIS2, supply chain management (LMIS), and ASACO/ CSCom capacity building.

These “integrated-lite” supervisions enabled a more concerted review of a health center’s services that one or two technical experts could address with one facility per day. Greater numbers of supervisions were conducted using this approach, promoting improved quality of integrated HIHS.

Strengthened primary health care facilities offer integrated and improved services. To achieve quality integrated and improved services, SSGI supported training, coaching and supportive supervision of health providers in CSRefs and CSComs across multiple technical areas used nationally approved curriculum and tools. For clinical topics in maternal and newborn health, malaria, FP and reproductive health, WASH in health care facilities and PMTCT, SSGI was guided by distinct yet complementary strategic objectives, promoting effective demand creation and service delivery approaches along the household to hospital continuum of care as next described.

Maternal and Newborn Health

Improved quality of services for ANC, delivery and postnatal care and increase utilization by women. SSGI undertook a series of activities to improve women’s use and quality of ANC, delivery and postnatal activities.

- Improved and updated national health policies and protocols, including, e.g., BEmONC modules (2015); National Policies, Norms and Protocols for reproductive health (2018); and developed reference booklet for frontline health workers focused on clinical and operational recommendations, including treatment algorithms.
- Introduced client rights and integrated principles of respectful maternity care (RMC) into training and supervision activities. RMC created vibrant debate as the approach challenged nurses and midwives to reconsider their assumptions and behaviors with clients.
- Trained health providers on ANC service delivery using onsite coaching supervision approach to reinforce HP competencies including IPTp.
- Brought critical HIHS closer to the communities by strengthening CSComs’ capacity to offer

BEmONC services. SSGI supported CSCComs to offer BEmONC services through training 483 skilled providers, conducting post-training coaching visits, and providing instruments, medical materials, and job aids to support clinical decision making. SSGI created 40 BEmONC and supervised, monitored, and provided algorithms to 253 sites. SSGI also provided essential BEmONC equipment to 118 health facilities to support health providers in timely and effective decision-making and monitored their availability and use to manage obstetric and neonatal emergencies (see Figure 1, next page).

- Provided technical and financial support to annual or semi-annual emergency obstetrical and neonatal care (EmONC) data reviews at national and regional level related to the active management of third stage of labor (AMSTL), essential newborn care (ENC) and PMTCT.
- Supported CSCComs to improve management of labor, delivery and the immediate postpartum period through training on a Care on the Day of Birth package of skills, along with post-training supervision visits, and material provision to improve quality of services. These activities reached 590 CSCComs and 1,554 providers, mostly matrones, in the SSGI supported regions.
- Engaged with rural maternities to reinforce collaborations with CSCComs (see text box, below).

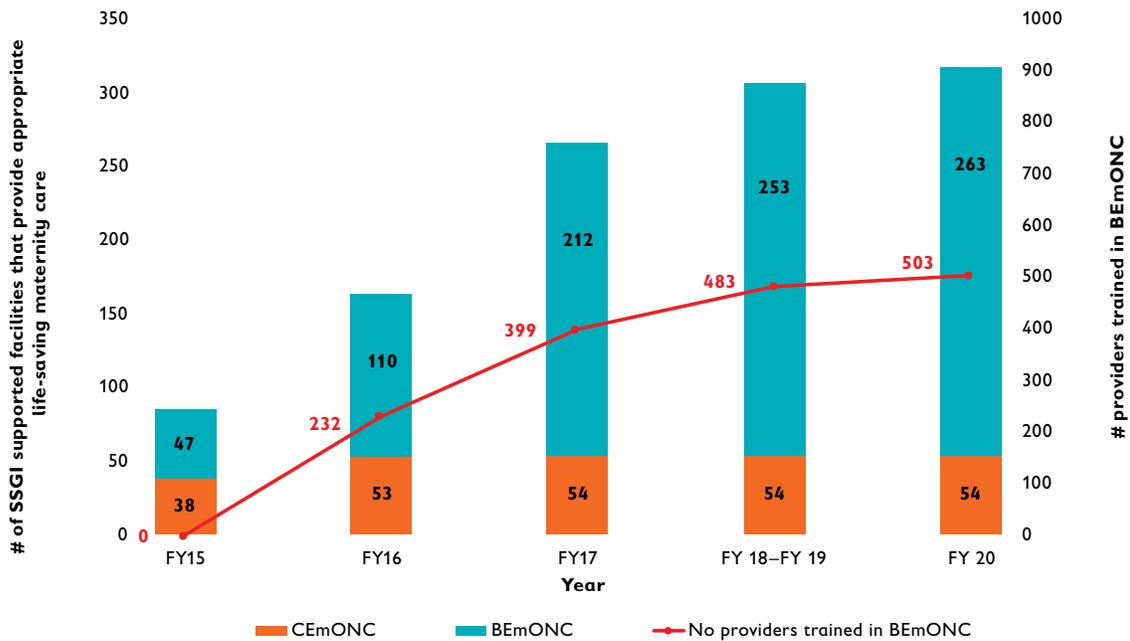
TEXT BOX 1: STRENGTHENING RURAL MATERNITIES

In several communities in Mali, particularly in Sikasso, rural maternities (RM) were opened so women could seek care during pregnancy closer to home. Local government has used its resources to establish RMs that are staffed by a matron and one or two nurses. The RMs function as a private facility and rarely interact with the nearest CSCCom. RM are not yet integrated in the national health system.

In 2018, the Ministry of Health and Social Affairs (MSAS) attempted to bar the formation of rural maternities, but they continued to operate. Health managers wanted to engage with RMs to improve coordination, referral and quality. District and regional managers began to notice that ANC and delivery numbers from CSCComs were declining in some catchment areas. RMs did not report service delivery data to the CSCCom or the district. Maternal death audit reviews, indicated that in some cases RMs delayed referring woman to the CSCCom, which could have exacerbated the deaths.

The Sikasso Regional Health Directorate (DRS) asked SSGI to help inventory the RMs and to formulate a framework for collaboration. The Sikasso region has 459 RMs and 245 CSCComs, while Bougouni district has 182 RMs (40%) and 45 CSCComs. SSGI supported the regional and district health teams to conduct a rapid analysis of the RMs in 2019. They reviewed staffing, services offered, and organized and conducted orientation and skill building sessions for providers from 98 rural maternities in Bougouni district. In addition to reviewing key skills and case studies in local language and conducting simulations, the RM staff received job aids to help them recall key steps in care and national standards of care. Since the orientations, CSCCom staff hold monthly meetings with RM staff to review and collect monthly data, restock medications and supplies, and discuss case management and best practices for ongoing skills building. Local mayors to regional health managers and other stakeholders are satisfied with this approach, as reducing maternal and newborn mortality is a challenge that involves everyone's involvement.

Figure 1: Evolution of BEmONC and Comprehensive Emergency Obstetrical and Neonatal Care (CEmONC) facilities per year in SSGI zones

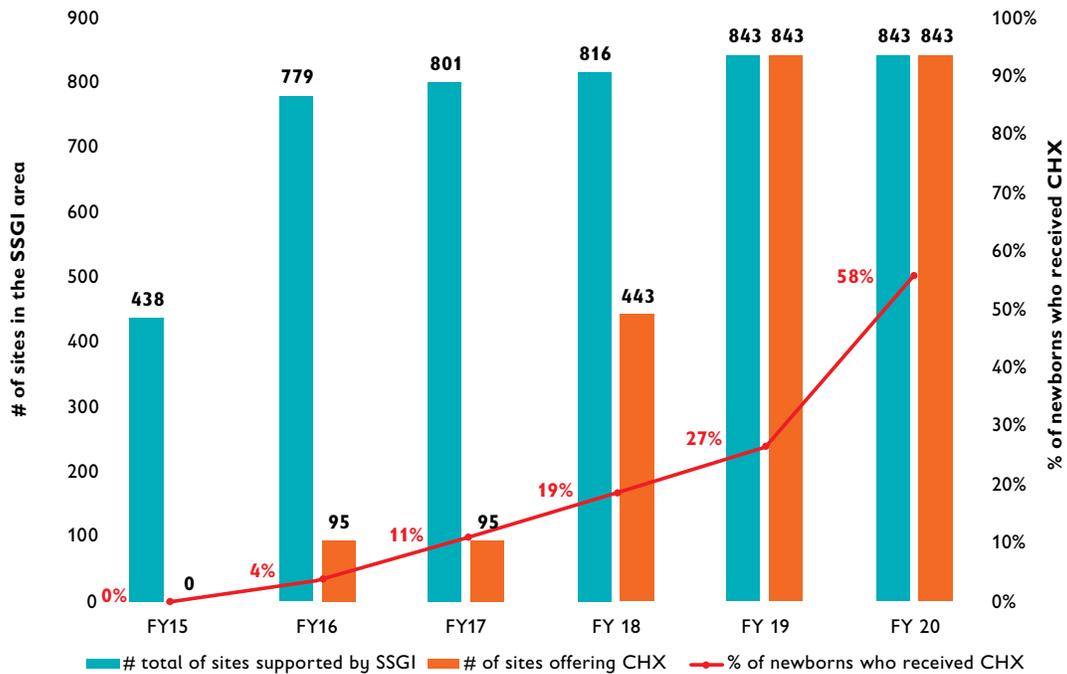


(Source: MHSD-DHIS2.)

Improved quality of essential newborn care and postnatal care. SSGI undertook the following activities to improve the quality of essential newborn care and postnatal care.

- Provided technical and financial support to the Newborn Health Technical Working Group to become a national vehicle to support newborn health beyond the life of the SSGI project.
- Through annual WPD organized at national and district levels, maintained focus on the contribution and importance of addressing LBW/prematurity to improve newborn survival.
- Introduced and scaled up CHX for cord care in all 37 SSGI-supported districts. By the end of the project, SSGI had trained 1,492 health providers from 779 health facilities, monitored CHX availability and use in the districts, oriented radio broadcasters on CHX messaging, and sensitized communities on CHX use (and misuse). CHX use was temporarily suspended due to reported cases of misuse in the eyes in 2019. SSGI conducted a study with IOTA to understand the factors influencing the misuse and evolution of the cases. Recommendations have been made to minimize misuse in the future. Figure 2 shows the introduction of CHX during scale-up and the concomitant percentage of facility births receiving at least one dose of CHX: the percentage of newborns born in facilities who had chlorhexidine gel applied to their umbilical cord increased from 0% to 58%.

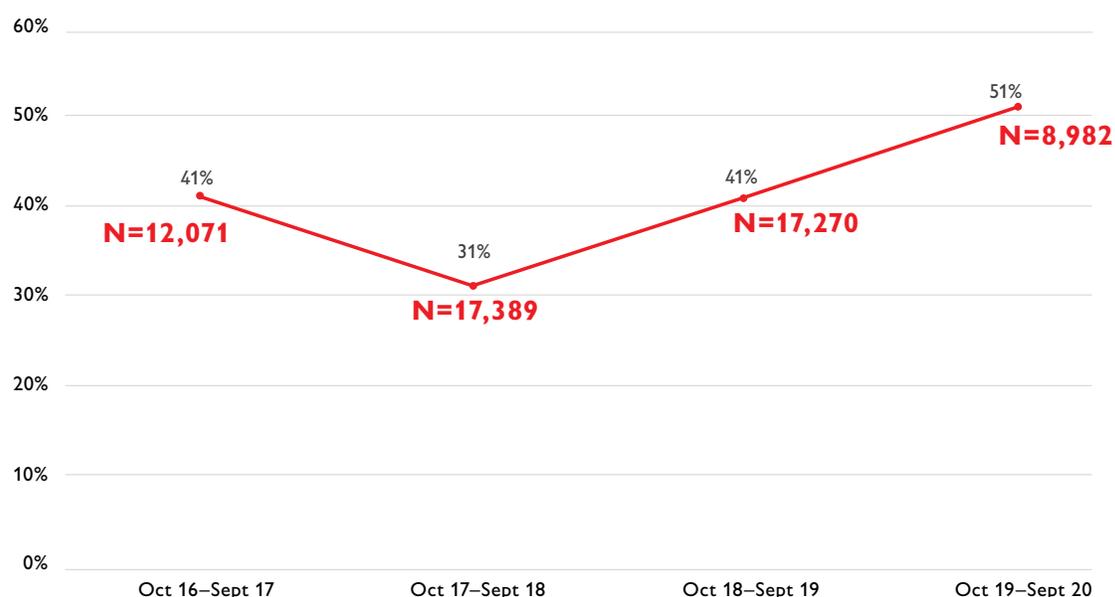
Figure 2: Chlorhexidine introduction: use of CHX in 33 districts during scale-up; % of facility births receiving at least one dose of CHX



(Source: MHSD-DHIS2, extracted on November 20, 2020.)

- Conducted, in collaboration with the Association of Malian Pediatrics, intensive one-week on-the-job coaching sessions in 20 CSRefs, selected based on performance indicators, to strengthen maternity and pediatric provider capacity to deliver quality newborn care services and manage newborn complications in particular.
- Expanded capacity to manage LBW/prematurity by training 912 providers in 431 facilities, mainly CSCoMs in KMC, enabling families to access care closer to their communities. Indeed, the proportion of low birthweight babies (<2500 g) initiated on KMC increased from 41% to 51%, as shown in Figure 3.

Figure 3: Number and proportion of LBW babies initiated on KMC, October 2016 to September 2020



(Source: MHS-DHIS2, extracted on October 14, 2020.)

Table 1: Proportion of births with AMTSL and hemorrhage rates after AMTSL, by region and fiscal year (October 2015-September 2020)

REGION	PROPORTION OF FACILITY BIRTHS WITH AMTSL					PROPORTION OF WOMEN EXPERIENCING PPH AFTER USE OF AMSTL				
	Oct 2015 to Sept 2016	Oct 2106 to Sept 2017	Oct 2017 to Sept 2018	Oct 2018 to Sept 2019	Oct 2019 to Sept 2020	Oct 2015 to Sept 2016*	Oct 2016 to Sept 2017	Oct 2017 to Sept 2018	Oct 2018 to Sept 2019	Oct to Sept 2020
Bamako	87	95.6	96.6	97.8	100	Not available	1.7	1	2.1	1.3
Kayes	84	89.5	90.9	94.4	94	Not available	1.3	1.1	1.1	1.2
Koulikoro	92	93.8	93.8	94.7	94.9	Not available	1.9	1.4	1.1	0.97
Sikasso	87	92.2	91	92.9	96.2	Not available	2.2	1.6	1.4	1.8
Average	87.5	92.8	93.1	95.0	96.3	Not available	1.8	1.3	1.4	1.3

*Before 2016, this indicator was not yet integrated in national HMIS.
(Source: DHIS2-MHSA, extracted November 20, 2020.)

From January 2016 to September 2020, SSGI supported 843 facilities with multi-faceted MNH interventions, demonstrating many improvements in labor, delivery and postnatal care best practices for women and newborns. The highlights below provide a snapshot of the quality of care process indicator results aggregated across the 843 sites for a total of 1,677,382 deliveries. Over the January 2016 to September 2020 period:

- Percentage of women receiving an immediate prophylactic postpartum uterotonic to prevent PPH increased from 88% to 96%.
- Proportion of postpartum hemorrhage cases among births with AMTSL application decreased from 1.8% to 1.3%, as shown in the table above.

Improved organization of services to manage referrals and evacuation at community and facility levels. SSGI's strategy to strengthen the referral and evacuation for health care emergencies focused on reducing the three delays to care, improving access to and quality of care.

- Integrated into all community activities the knowledge and recognition of danger signs and decision-making to seek appropriate care. Through the different community platforms, SSGI sensitized communities about maternal and newborn danger signs during pregnancy, delivery and postpartum, reaching 1,824,507 (19% males) individuals since 2015. They established 720 VHSFs to address the first delay in the decision to seek appropriate care and provide community members with the means for referral evacuation. At the end of September 2020, 79% of functional VHSF collected 44 million CFA to manage obstetrical and newborn emergencies. A significant and lasting challenge has been to ensure that women and children needing urgent care and/or referral use the funds. SSGI highlights this as a weak link within the system for continued efforts on the part of the MHSD and partners.
- Organized district workshops to review the referral and evacuations systems and develop action plans to improve the systems' overall performance and disseminate the monitoring results of these workshops for enhanced accountability.
- Organized district-level workshops to review maternal and newborn death audits, and orient district staff on how to conduct verbal autopsies. Maternal and Perinatal Death Audits: SSGI assisted health managers to improve the use of death audits as a tool to review quality of care. Orientations in 16 districts helped to develop the skills of 462 providers to use the audit tools. Some were also trained on verbal autopsy for community level learning on the causes of a death. With project support, 203 audits, mainly maternal deaths were undertaken. Sustaining MPDAs without project support is a challenge, with only 53 audits undertaken in Y5. Capacity and commitment to conduct newborn death audits remains a challenge; very few verbal autopsies were reported despite nationally stated priority for these two quality analysis tools.
- Established 720 Village Health Solidarity Funds (VHSF) to address the first delay in the decision to seek appropriate care and provide community members with the means for referral evacuation.

Capacity building in an integrated BEmONC and Day of Birth package. Over the course of the project implementation, SSGI trained 929 healthcare providers on maternal and newborn health care, including 483 trained on BEmONC, and 446 providers trained on the integrated Day of Birth package. Among the 746 CSCom in the SSGI supported regions, the availability of BEmONC improved from 11% of health centers to 34% and another 30% of facilities benefitted from capacity building efforts to improve mother and newborn care.

Malaria

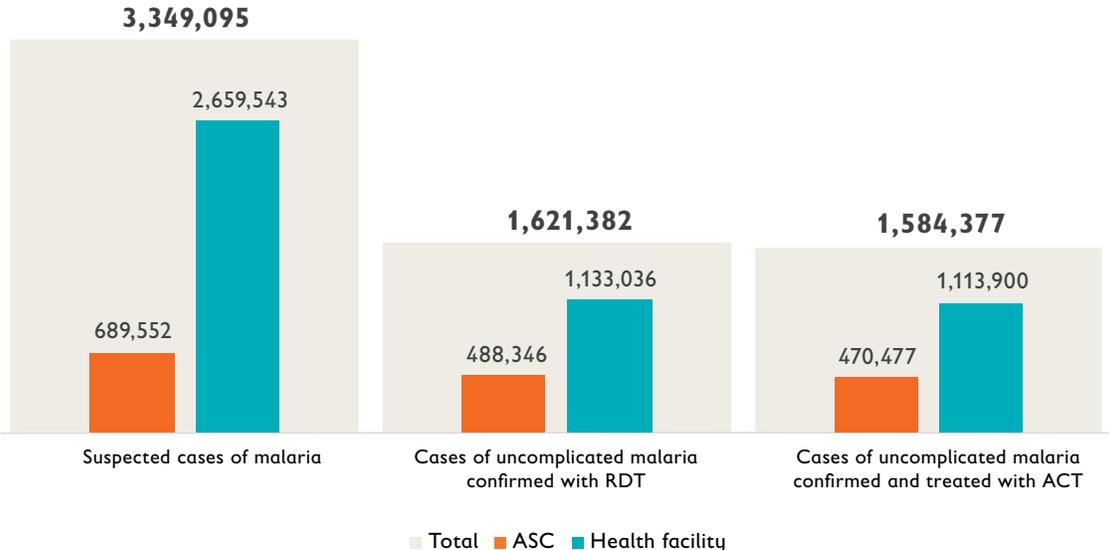
To improve the quality of diagnosis and management of malaria cases, SSGI in collaboration with the NMACP supported the following activities.

Review of national guidelines and algorithms for the management of malaria cases. One of the major revisions to national malaria management guidelines has been the use of injectable artesunate in pregnant women as the first choice antimalarial. The guidelines on the distribution of SP IPT in pregnant women have also been updated; guidelines on the management of malaria cases; and algorithms and memory aids for the diagnosis and treatment of malaria. After validation, the project provided 846 health structures (37 CSRef and 809 CSComs) with algorithms for the management of malaria cases.

Training of providers on malaria diagnosis. All providers of health facilities have been trained on malaria diagnosis using rapid tests. To this must be added the training of laboratory microscopists for the diagnosis under a microscope (thick drop or blood smear) of the parasite responsible for malaria.

Improved management of uncomplicated malaria cases at the community level. As part of the community management of childhood illnesses (iCCM), SSGI supported training and supervision of community health workers on the diagnosis and management of malaria cases in families. See figure below for further details.

Figure 4: Malaria cases managed by health structures and ASC sites, October 2016 to September 2020



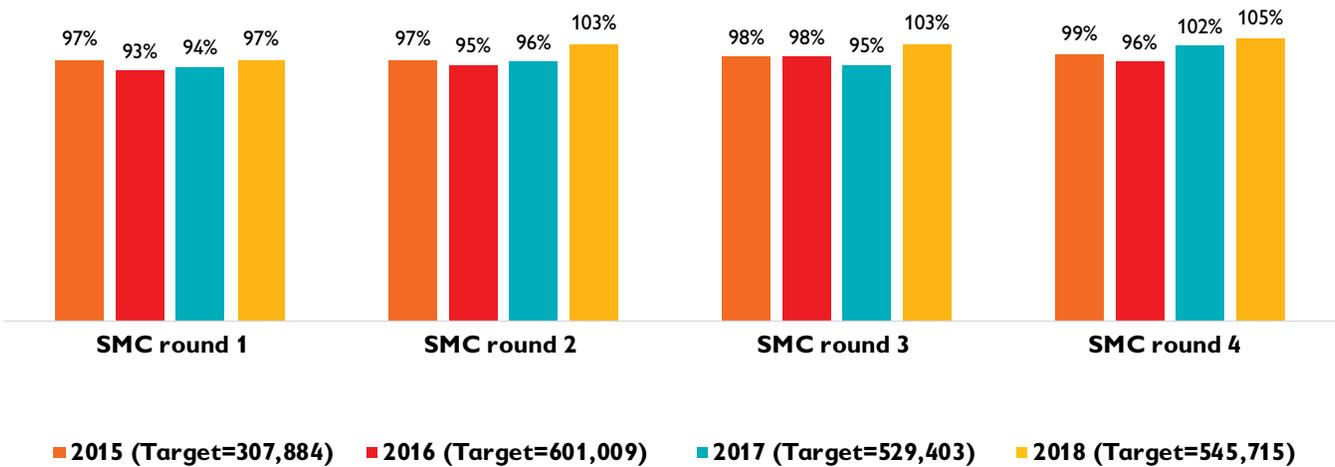
(Source: DHIS2-MHSD 2020, extracted on October 25, 2020.)

Outreach Training and Supportive Supervision, or OTSS. SSGI analyzed the results of the various health structures in supported catchment areas to strengthen them through outreach training and supportive supervision. OTSS has improved the performance of providers in relation to the management

of malaria cases (case management and correct performance of laboratory tests). From October 2017 to March 2020, 309 supervisors were trained on the OTSS tool and 1,608 providers were supervised. Site performance increased steadily between supervisory visits. The CSRef and regional health staff mastered this process and now conduct supervisions without external support.

Implementation of the seasonal chemoprevention malaria campaign. The seasonal malaria chemoprevention strategy (SMC) combining two molecules sulfadoxine-pyrimethamine (SP) and Amodiaquine (AQ) was recommended in 2011 to Sahel countries by the World Health Organization (WHO), and adopted by Mali and its partners in 2012 to cover the whole country rapidly. In 2015, SSGI supported the SMC campaign in four health districts that expanded to 12 districts from 2016 to 2018. The health districts technically and financially supported by SSGI exceeded the national campaign target of 90%, as shown in the figure.

Figure 5: Proportion of children 3 months to 5 years old reached with seasonal malaria chemoprevention, by passage and by year (2015–2018)



(Source: SMC campaign results from different regions.)

Malaria in pregnancy (MIP). SSGI participated in the MIP working group and provided national level technical support for updating directives and MIP indicators in the health management information system. Capacity building for MIP focused on integration of services and using a variety of different opportunities to update providers on changes in the MIP protocols, particularly global guidance on earlier initiation. Once national level consensus on implementation of the new global guidance was achieved in 2016, SSGI updated 82 trainers and supervisors who cascaded orientation to 502 providers in Kayes and Koulikoro on the updated protocols in the same year.

Family Planning and Reproductive Health

Over the life of the project, SSGI trained 1,184 public sector healthcare providers on FP counseling and method provision, with a specific focus on LARC methods and the integration of FP into maternity services. See Table 2 on the next page for further details.

Table 2: Public sector providers trained on family planning by topic

TRAINING TOPIC	Y1-2015	Y2-2016	Y3-2017	Y4-2018	Y5-2019	TOTAL
Contraceptive technology/ PFP counseling (REDI)	24	53	121	181	–	379
PPIUD insertion (qualified providers)	13	–	45	89	16	163
LARC	–	535	48	–	–	563
Post-abortion care (PAC) and LARC	–	–	19	40	–	59
Total per year	37	588	233	310	16	1184

(Source: Project report.)

Long-acting and reversible contraception. SSGI focused on expanding the method mix available in public health facilities for interval FP adoption and trained 583 providers to add these methods to those offered. The LARC methods introduced include contraceptive implants and the intrauterine device (IUD). Increases in the availability of LARC insertion contributed to increasing adoption of IUD adoption 34% and implant adoption 60%, between 2017 and 2018 in 358 facilities.

SSGI, with the technical support of Marie Stopes International Mali (MSIM), provided technical leadership in the provision of FP services with focus on LARCs through mobile outreach services, MS Ladies and social franchise services working with the public and private sector from start of project through May 2017. From October 2017 to June 2019, Population Services International (PSI) replaced MSIM, and implemented FP activities through mobile teams and social franchises with private clinics (PROFam), and reached more adolescent and reproductive youth. Activities through MSIM and PSI contributed to improved access to and quality of FP/RH services and appropriate referrals through:

- Three rural mobile outreach teams for the regions of Kayes, Koulikoro, and Sikasso and one urban and peri-urban mobile team in the district of Bamako;
- 105 qualified healthcare providers trained from 75 equipped clinics (25 New BlueStar social franchises, 50 PROFam clinics and 25 CSComs) working with the public and private sector in the region of Sikasso, to complement the provision of short-term methods already widely available in the public sector;
- 100 trained peer educators who reached, through 13,792 sessions, 16,833 young people aged 15 to 26 (8,978 men and 7,855 women) with 12,075 young people referred to FP/RH services;
- Contributions to expanding urban approaches and efforts to roll out and conduct a pilot approach on service delivery by six MS Ladies in underserved areas of the six communes of Bamako, in replacement of the urban and peri-urban mobile team; and
- 14 social marketing agents implementing community voluntary FP sensitization activities.

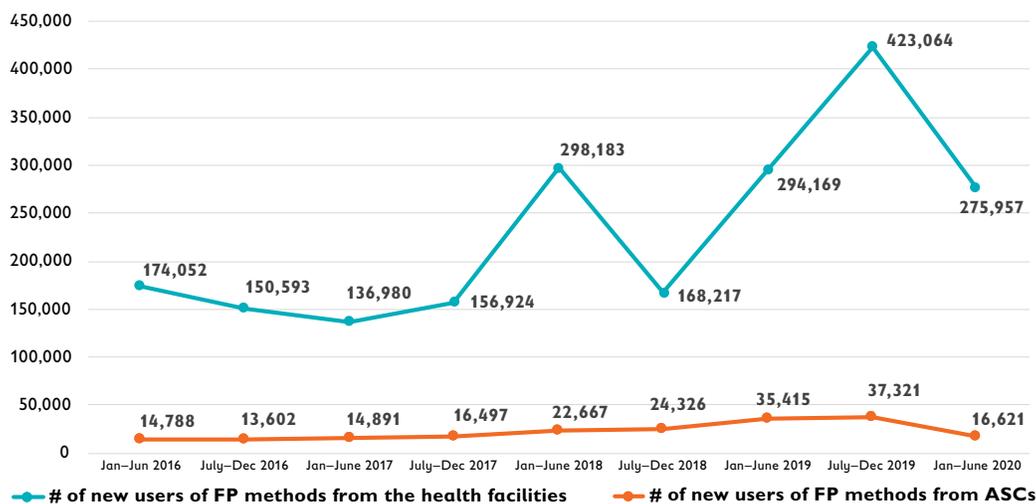
Over the course of MSIM and PSI's involvement in the project, SSGI delivered a total of 80,909 voluntary FP methods through rural mobile outreach teams, MS Ladies and BlueStar social franchises, and PROFam reaching a total of 68,672 users, of whom 43% were under 20 years old, and 33% first-time users. Voluntary FP methods delivered included 45,653 implants (5 year), 1,048 implants (3 year)¹, 5,236 IUDs and 934 voluntary tubal ligations.

Postpartum Family Planning (PPFP). SSGI also integrated postpartum family planning counseling and services into antenatal care and postpartum services, training 379 providers on PPFP Counseling and 163 providers on PPIUD insertion. SSGI provided each facility with one or more instrument kit for PPIUD (depending on volume of deliveries), a PPFP register to be kept in the maternity and a stamp that is used to note a woman's PPFP method choice on her ANC card.

Postabortion Care (PAC). SSGI also worked to improve the availability and quality of PAC care with a focus on CSRef level facilities. The project trained 59 providers on an integrated PAC/LARC package in the third and fourth year. SSGI also provided technical assistance to FP coordination and policy efforts at national and regional levels. SSGI called together meetings and/or assisted the DNS/DSR to organize bi-monthly meetings of USAID FP partners and quarterly RH/FP Technical Working Group (TWG) meetings, contributing substantively to policy and guidance development/updates, such the four-year National Budgeted FP Action Plan (PANB-PF) as well as the Protocols, Norms and Procedures for Reproductive Health (PNP-SR) and the annual National FP Campaign.

SSGI inputs and outputs to reinforce and expand FP services contributed to positive trends in FP outcomes, particularly new FP users and important growth in couple-years protection with increased adoption of long-acting methods. The project documented more than two million new FP users in the four SSGI-supported regions between January 2016 and March 2020.

Figure 6: New users of modern FP methods, age 15-49, by source of FP service, 2016–2020



(Source: DHIS2-MHSD.)

¹ The Implanon 3-year implant was introduced in Mali at the end of 2016 and MSIM teams started to deliver it in February 2017, after all the health providers were trained.

The growth in new users of FP shown in the figure is variable by semester but on an upward trend overall. The notable jumps in January to June 2018 and July to December 2019 can be linked to annual FP campaigns; not only the effort of the campaigns to reach more of the population but also improvements in the data collection from the campaigns compared to previous years. Other factors influencing the fluctuations in new users may include stock availability as well as other initiatives outside of SSGI.

Integration of cervical cancer screening and treatment in FP/RH services. Beyond improving the availability and quality of FP services, SSGI worked to improve access to other reproductive health services such as cervical cancer screening. Beginning in September 2018, SSGI introduced cervical cancer prevention (CECAP) in public CSRef in Mali focused on the visual inspection of the cervix with acetic acid and Lugol's iodine (VIA/VILI) and Single Visit Approach (SVA). This complemented services provided in the private sector, franchise clinics and mobile clinics also supported by SSGI. By developing the skills for CECAP services of 58 providers, along with provision of cryotherapy units (approximately \$1800 each), instruments for exam and the carbon dioxide bottles to operate the cryotherapy units, 17 public hospitals in Sikasso and Koulikoro, are now able to offer CECAP services within routine services, as well as mobilize for outreach campaigns with support of partners. SSGI originally planned to introduce CECAP services in 16 districts only, but at the request of the Koulikoro DRS, organized to conduct on-site training at Banamba, Kangaba, Ouellessebouyou, and Kolokani CSRef in collaboration with the mobile clinic teams.

In the year and a half that CECAP services have been available in Sikasso and Koulikoro, 5,676 women have benefitted from cervical cancer screening. 298 women tested positive for precancerous lesions (positivity rate = 5.2%) and 94 women had the lesion removed the same day for an SVA rate of 33%. The SVA rate should ideally be far higher and indicates challenges with the cryotherapy units, whether availability of CO2 gas, or maintenance issues, both of which should be addressed to facility managers.

Another 232 women who had larger lesions (n=80) that could not be treated with cryotherapy, who required biopsy (n=120) and with suspect cancer (n=32) were referred for more advanced care. 485 women benefitted from treatment of other conditions such as cervicitis and sexually transmitted infections. During one of the early training sessions, providers paired the offer of HIV counseling and testing with CECAP, and 77 women agreed to screening (68% of women seen during the training). The majority of care has been provided within routine services, with one screening event organized as part of the annual FP campaign in 2019; the annual review of FP campaign achievements recommended that cervical cancer (education and screening) become a routine part of the annual FP campaigns.

WASH in Health Care Facilities

Improved Infection Prevention and Control (IPC) at B/CEmONC sites in Koulikoro and Bamako.

SSGI introduced the Clean Clinic Approach (CCA) to encourage health facilities to make and maintain incremental WASH and IPC improvements in support of broader quality of care improvement efforts and enhanced health outcomes. The approach was added to B/CEmONC sites as an integrated component to reinforce IPC and increase service use. The approach encouraged health system actors at each level (health area/commune/district) to take responsibility for WASH and infection prevention and control management. By complying with standard hygiene, cleaning and disinfection protocols and maintaining the WASH infrastructure, SSGI's Clean Clinic Approach rendered facilities more attractive with the aim of increasing use and attendance. By the end of the one-year Clean Clinic Competition, 93% of the 29 sites in Koulikoro and 95% of the 64 sites in Bamako had improved WASH and infection prevention efforts and 38% of sites in both areas had reached Clean

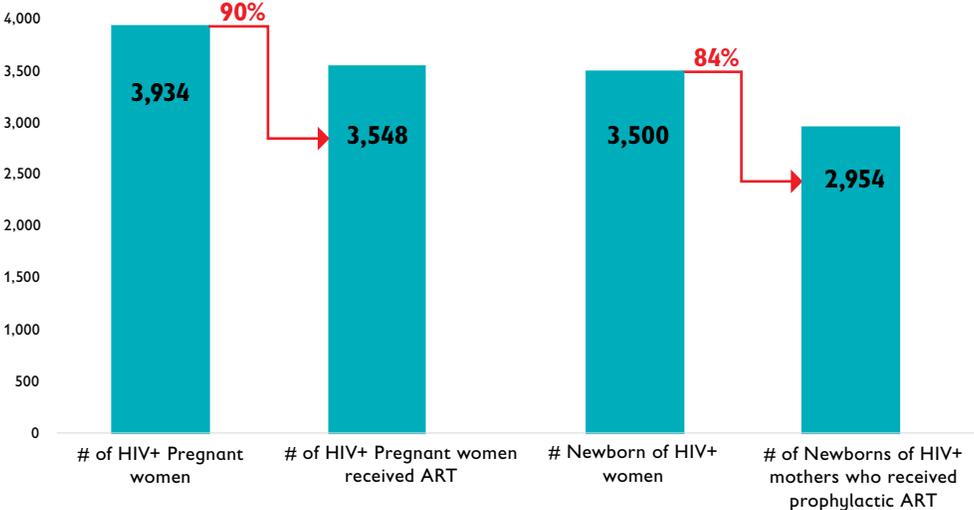
Clinic status. SSGI also conducted two post-competition inspections that demonstrated that the facilities in both Koulikoro and Bamako had either maintained their status or improved further, indicating the sustainability of this approach and the commitment of facilities to improving and maintaining WASH and IPC.

Prevention of Mother to Child Transmission of HIV

Improved the integration and quality of PMTCT services within a broader integrated package of health services (e.g., ANC, delivery, postnatal care and pediatric services). To contribute to the elimination of mother to-child transmission of HIV in Mali, SSGI used the following approaches to integrate and improve access to and quality of PMTCT services into the broader package of maternal and neonatal health care:

- Created 120 new PMTCT sites with 382 providers trained on PMTCT and upgraded 326 existing PMTCT to B+ services to increase service access and use, as shown in the figure below.
- Supported the DRS to conduct supportive supervision visits reaching 515 PMTCT sites across Sikasso and Koulikoro regions and the Districts of Bamako.
- Organized PMTCT services review workshops and integrated into EmONC review workshops in Koulikoro, Sikasso and Bamako regions to improve the quality of PMTCT services.

Figure 7: Use of PMTCT services, October 2016-September 2020



(Source: DHIS2-MHSD.)

RESULT 2: KEY ACHIEVEMENTS, DECEMBER 2014-SEPTEMBER 2020

- 1,554 health providers trained on integrated package for pregnancy, childbirth and postnatal care.
- 382 health providers trained in PMTCT from 446 health facilities (120 PMTCT sites created by the project).
- 912 providers trained in KMC for managing low birthweight babies and 431 facilities reinforced to offer KMC services.
- 307 CSCComs upgraded to provide BEmONC services with 503 providers trained in BEmONC and 692 structures equipped with essential equipment, newborn resuscitation mannequins, and job aids.
- 38% of targeted health facilities in Bamako and Koulikoro reached Clean Clinic status.
- 542 providers trained in FP; 528 on LARC and 249 on PPIUD (coaching in-situ).
- 1492 health providers oriented on the use of chlorhexidine for newborn cord care.
- 626 health facilities supervised (590 CSCCom and 36 CSRef), among which 263 are BEmONC sites supervised by regional and districts teams.
- 6,896 (5,204 community volunteers and ASCs; 769 DTC and/or adjuncts and 923 test administrators) trained for the seasonal malaria chemoprevention campaigns.
- 6,137 health workers (843 DTC and/or adjuncts and 5,294 ASCs/relais) trained on malaria case management with artemisinin-based combination therapy (ACT).
- 1,920 providers, including 91 laboratory technicians trained on malaria diagnostic (microscopy and RDT).
- 313 facilities (288 CSCCom and 36 CSRef) benefited from OTSS, reaching 1,608 health providers.
- 720 VHSF amassed nearly 34 million CFA (\$58,000) to cover costs of evacuation of women in children with health emergencies.
- 1,389 health workers trained on IYCF.

Result 3: Improved health systems management, functioning, and accountability at the community, district, and regional levels

Improved planning, management and accountability systems at the CSCCom/ASACO, district and regional levels

Strengthened ASACO and joint committee capacity to manage community health facilities improves services. SSGI strengthened the performance and accountability of ASACOs using an open systems approach that emphasized transparency and communication to produce clear and shared

expectations for both health providers and consumers. The project targeted system-wide functionality, accountability mechanisms, drug availability, and the use of quality data to enhance ASACO and CSCoM management capacity to support MNCH services. As a result, 682 ASACOs and CSCoMs in 36 health districts have improved their health service delivery, management of services and ASACO governance.

Evolutionary path of ASACO and CSCoM institutional development profiles regarding good internal governance of ASACOs. In 2017, SSGI developed and rolled out a database to track the evolution of institutional development profiles of ASACOs based on ratings of organizational characteristics during initial self-assessment sessions and then reassessments during coaching visits. The results of the analysis of the data available and entered into the database from 2015 to the end of September 2019, for the four project regions (Kayes, Koulikoro, Sikasso and Bamako) revealed notable progress of ASACOs in their institutional development continuum and in terms of good governance. The table below shows the evolution, before SSGI intervention, until September 2019, of the institutional profiles of 252 ASACOs, by region, whose data are available in the database.

Table 3: Institutional development profile evolution of ASACOs regarding good governance

REGION	# OF ASACO REEVALUATED (TOTAL OF / % OF)	% OF ASACO PROGRESSED FROM START UP PHASE TO GROWTH PHASE	% OF ASACO PROGRESSED FROM START-UP PHASE TO MATURE PHASE	% OF ASACO PROGRESSED FROM GROWTH PHASE TO MATURE PHASE	% OF ASACO WITH GOOD GOVERNANCE
Bamako	55 (60/92%)	18%	74%	66%	66%
Koulikoro	72 (222/32%)	11%	75%	66%	76%
Sikasso	103 (238/43%)	29%	68%	74%	98%
Kayes	22 (235/9%)	29%	58%	80%	70%
Total	252 (755/33%)	21.29%	70.97%	70.97%	78%

(Source: Database ASACO/SSGI, date of last update: September 2019.)

The self-assessment process has led to proper functioning of ASACO internal coordination bodies, such as regularly holding required meetings, through discussions that allow for issues to be identified in a consultative manner and to identify appropriate solutions. The data show that from the reassessment of 252 ASACOs in all four regions, 63% or 159 ASACOs evolved to the mature phase compared to just 6% or 15 ASACOs at project start. The mature status refers to the highest score in terms of regularly holding statutory meetings (i.e., monthly management committees meeting and quarterly board of directors meetings) with minutes kept and shared with the municipal government.

Health area management board meetings. Between 2017 and 2018, data from the self-assessment reports and the coaching sessions showed that of the 423 ASACOs coached, none of the ASACOs regularly held management meetings with the council before the ASACO capacity strengthening process was put into place. Upon reassessment, for all regions, the number of ASACOs increased remarkably from an initial 0% to 27%, or 115/423 of ASACOs who regularly held meetings between 2017 and 2018 as measured in



Photo credit: Save the Children.

The deputy mayor of Koumantou Town Hall showing the CAM score card.

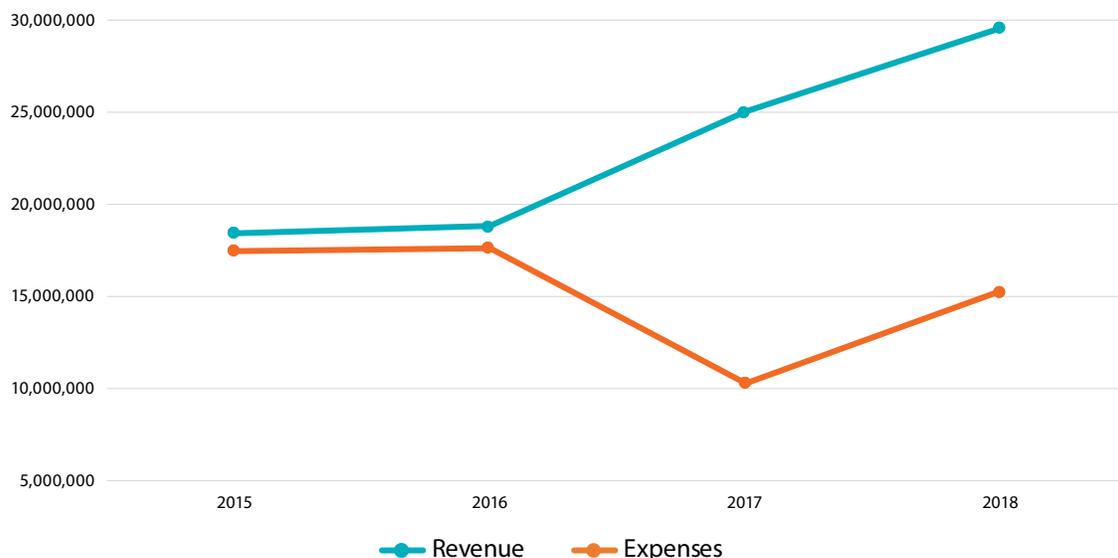
the 423 ASACOs coached. This performance represents 17% of all ASACOs (115/682) who went through the self-assessment process. This remarkable change is due to the introduction of the self-assessment process and coaching sessions and the guidelines for holding council meetings introduced in the ASACOs during implementation of the ASACO strengthening process. This bodes well for strengthening accountability

at the community level, despite the financial difficulties expressed by most local-level actors (ASACO and municipality).

Participatory process, analysis, and sharing of CSCCom data for decision-making to increase service delivery. Using self-assessment scores taken from the ASACO database, the results of monitoring the evolution or progression of this organizational development characteristic showed that the number of ASACOs that evolved to the mature phase by applying the participatory process, through analysis, and then sharing CSCCom technical and financial data for decision-making to increase service delivery, increased significantly from 6% or 15/252 in 2017 to 74% (186/252) in 2019 for all four regions. This means that participatory data sharing and analysis meetings undertaken as a direct result of the self-assessment process improved ASACO capacity to make decisions based on evidence to improve organizational actions on service delivery and other management solutions. The analysis of this remarkable progress by region, showed that the Koulikoro region stands out among other regions with improvements in their organizational performance at 81%. Improvements are also seen following regular supervision and coaching carried out in these ASACOs/CSCComs by the EDC and with firm commitments by DTCs when applying the data analysis tool after training on the tool.

Revenue improvement and expenditure control and the use of management tools. ASACOs reach the mature phase in financial management if financial reports are kept and shared with the ASACO's management bodies and are in compliance with procedures as well as properly using management documentation. The results of the analysis of the information available in the database, relating to this organizational development characteristic, showed that in Sikasso, 72% or 74/103 ASACOs that were in the start-up phase evolved to the mature phase. In Kayes, 15/22 or 68% of ASACOs evolved from start-up to the mature phase. In Koulikoro, the rate is 76% or 55/72, and lastly in Bamako, the rate is 75% or 41/55 of ASACOs. The progress in organizational status corroborates with the data analysis of additional coaching visits of 48 other ASACOs, with an overall 67% of ASACOs (32/48) who progressed from the start-up phase to the mature phase. Of these ASACOs, 67% also showed an improvement in their financial resources and control over their expenses as a central factor, as illustrated by the cases of the Blendio CSCCom in Niéna district, Sikasso region.

Figure 8: Financial management improvement: revenues from point of service for care and from medicines, by year. Blendio CSCoM, Niena District, Sikasso Region



	2015	2016	2017	2018
	REFERENCE YEARS		YEARS POST SELF-ASSESSMENT	
Revenue (CFA)*	18,450,350	18,800,000	25,004,530	29,548,236
Expenses (CFA)	17,450,000	17,610,940	10,264,893	15,230,789

*Approximate rate of 500CFA per US \$1.

MOST SIGNIFICANT CHANGE STORY: “CAM SCORECARD IMPROVES ASACO AND MUNICIPALITY RELATIONSHIP AND CSCOM FINANCING AND MANAGEMENT”

“The training we received on the CAM scorecard has considerably improved our relationship with Town Hall. Before, we didn’t have the necessary knowledge about getting resources transferred by the government to the municipality for communities for health needs. Today, this is no longer the case; we receive the information on time and the funds are regularly received every six months. Through this framework, we have acquired 5 million CFA / 8,405 USD in funding, as well as beds and medical equipment worth 800,000 CFA / 1,345 USD. Problems related to electricity and water access were also resolved. A while ago, as ASACO president, Town Hall’s council member in charge of health, talked to me about the high costs of prescriptions at the health center. Together, we brought up this issue to the CSCoM vis-à-vis certain aspects (following the director of procurement’s structure and controlling the purchasing price of drug sales). These inquiries resulted in more appropriate drug prices and applying a correct structure for procurement of medicines. By resolving this issue, with the help of Town Hall, it allowed us to more effectively use of the health center.”

–ASACO President of Tombola, Kangaba District

Joint management and local funding of CSCComs strengthened through CAM scorecard use.

The CAM is a partnership agreement between municipalities and ASACOs that describes the roles and responsibilities of each member for improving governance and management of CSCComs. However, stakeholders are not aware of this agreement and typically do not adhere to it. The SSGI/HSS team developed a CAM monitoring and evaluation scorecard for the joint committees, monitoring CAM commitments, to use as a living tool to encourage collaboration between municipalities and ASACOs. When used correctly, the CAM scorecard is reviewed quarterly and progress is tracked with new actions intended to resolve identified issues.

Data analyzed and used to plan, monitor and respond to health needs

Improving data quality and reporting for decision-making. SSGI worked with government health services to strengthen health information management systems to increase the quality of data and the accuracy and timeliness of reporting. The project supported the introduction and scale-up of the DHIS2 online platform for data entry and analysis at community health centers. See data quality assessment section below.

Improved management process to increase access, availability and affordability of health care products and commodities

Strengthening supply chain management and commodity security. The project worked closely with the MHS, the Directorate of Pharmacies and Medicines (DPM) and the USAID funded SIAPS and then Global Health Supply Chain-Procurement and Supply Management (GHSC-PSM) project to strengthen implementation of the Logistics Management Information System (LMIS) for drugs at the regional, district, CSCCom and ASC levels. Through central, regional and district teams, the project worked with districts to integrate LMIS for drugs into monthly meetings between district teams and all DTC with focus on reducing stock-outs. SSGI supported on-the-job training during supervision visits to strengthen CSCCom and district level pharmacists' capacity to use LMIS tools and improve product management. At regional level, SSGI monitored drug availability in all districts and at the CSCCom level.

Table 4: Distribution of LMIS use by target, regions, and annual average and progress

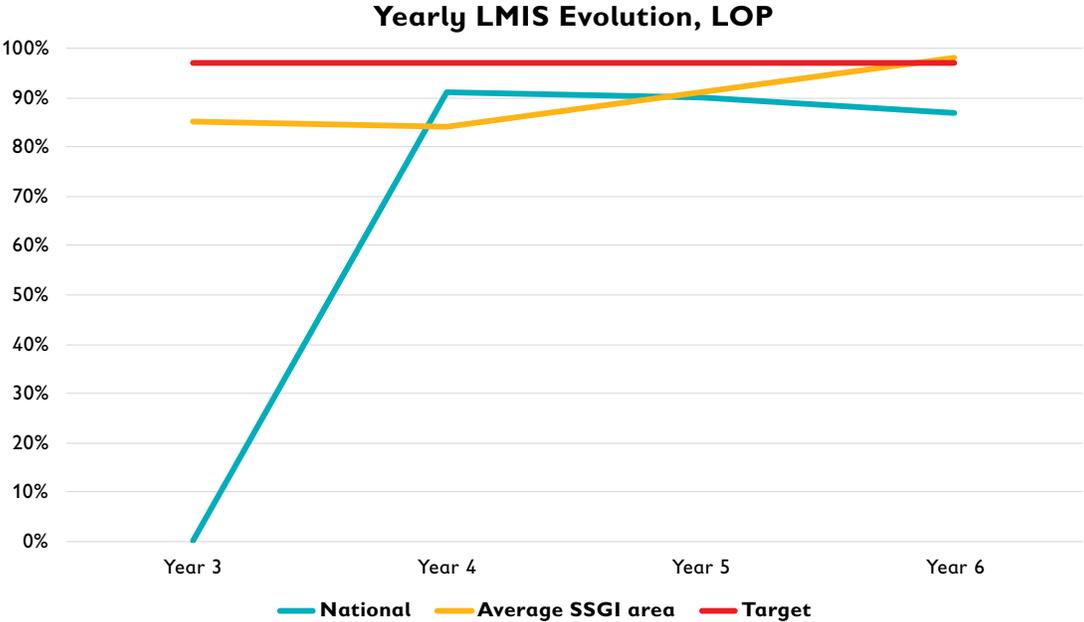
REGIONS	ANNUAL TARGET	RESULTS					% PROGRESS
		YEAR 3	YEAR 4	YEAR 5	YEAR 6	AVERAGE	
National	97%	N/A	91%	90%	87%	67%	69%
Bamako	97%	81%	67%	86%	97%	83%	85%
Kayes	97%	78%	80%	84%	99%	85%	88%
Koulikoro	97%	87%	90%	97%	99%	93%	96%
Sikasso	97%	93%	98%	96%	99%	96%	99%
Average		85%	84%	91%	98%	89%	92%

By the fifth year of the project, the monthly district meetings on logistical management of drugs became well-instituted requiring little or partial support and/or often without financial support from a technical and financial partner. Through orientation sessions for DOs and other project staff involved directly or indirectly in monitoring the OSPSanté tool, and by making internet access codes and platform usernames

available, the rate at which the local CSCom and CSRéf structures now actively use the LMIS for managing health products has increased considerably over the life of the project, as shown in the table above.

SSGI monitored and analyzed monthly and quarterly OSPsanté data at all levels to assess the availability of health products in project intervention areas. By supporting DOs in using OSPsanté at the district level, and the Directorate of Pharmacy and Drugs (PPM) at the national level, DOs have submitted monthly stock-out reports for tracer products since May 2017, as shown in the figure.

Figure 9: Evolution of yearly LMIS use by target, national rate and by SSGI areas life of project (LOP)



	YEAR 3	YEAR 4	YEAR 5	YEAR 6
National	0%	91%	90%	87%
Average SSGI area	85%	84%	91%	98%
Target	97%	97%	97%	97%

SSGI’s data analysis greatly contributed to how LMIS tools are monitored and used for tracking the availability of tracer products at each level: by CSComs at the local level as well as at the national and regional levels, which contributed to the continuum of care. The proportion of facilities that had all tracer medicines and commodities in stock increased from 55.7% in 2017 to 82% in 2019.

The availability of essential drugs in all CSComs supported by SSGI improved significantly from 54% in YR3, to 64% in YR4, to 82% in YR5, to an average of 86% for LOP, above the 74% national average. This impressive achievement can be attributed to different strategies put in place, including monthly monitoring of medicine availability by district officer teams, placed in districts and thus able to monitor availability at each structure by using the checklist.

Figure 10: Percentage of facilities that had all FP tracer medicines and commodities in stock in the previous three months

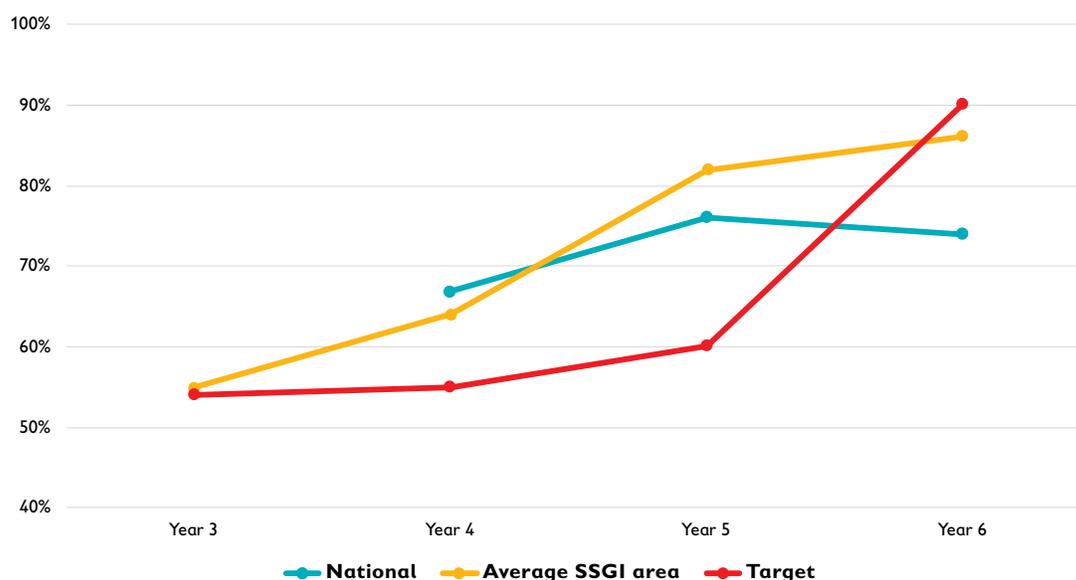


Table 5: CSCCom-level monthly follow-up of LMIS data management and availability of tracer products by district officers

REGIONS	ANNUAL TARGET	RESULTS					% PROGRESS
		YEAR 3	YEAR 4	YEAR 5	YEAR 6	AVERAGE	
Malaria	60%	54%	56%	78%	80%	67%	111%
FP	60%	64%	68%	83%	82%	74%	123%
MNCH	60%	59%	65%	83%	83%	72%	120%
Essential Drug Basket	60%	56%	62%	84%	76%	69%	116%
Average	60%	58%	63%	82%	80%	71%	118%

The availability of essential medicines by domain (e.g., FP, malaria, etc.) in all structures supported by the project improved during LOP; initially at 58% in YR3, then increasing dramatically to 82% by YR5, exceeding 60% target set. The slight drop in Y6 can be explained by a high consumption of health products and changes arising from the COVID-19 pandemic.

Adapt ASACO/CSCCom coaching tools to integrate assessment of facility-WASH/IPC practices.

In the context of COVID-19, SSGI changed and adapted project activities. The coaching activities of the ASACO and CSCCom were used to strengthen the capacities and commitment of the ASACOs in order to ensure infection control and prevention measures at the CSCCom level using local means. Therefore, the coaching tools of ASACOs and CSCCom were adapted to the elements of infection prevention and control

and tested in a district (Ouelessebougou), to strengthen the aspects of IPC at the level of CSCCom. Then, the tool was shared with partner NGOs and district teams to use. Coaches reported positive findings in the application of IPC measures in CSCComs as well as the involvement of ASACOs in supporting CSCComs to obtain IPC elements for CSCCom staff and raising awareness of COVID-19 in the community.

TEXT BOX 2: MOBILE PAYMENTS

To improve financial risk management and reduce cash payments, SSGI introduced direct electronic payment via mobile money (Orange Money). This funding mechanism was initially limited to ASC incentive payments, and was gradually extended to include beneficiaries, community volunteers, health providers, and other participants of workshops, conferences, trainings, and learning sessions. However, this direct payment system was first met with resistance and frustration from regional and district health authorities, contributing to delays in activity implementation. This was a shift from the common practice where government counterparts and beneficiaries were accustomed to direct cash payment; the majority of financial partners in Mali transferred funds to government accounts or provided cash to government accounts to directly pay beneficiaries. With clear communication and advocacy meetings about the benefits of direct electronic payment at national level, SSGI succeeded in getting electronic payments accepted through Orange Money. This likely also contributed to increasing the number of Malians who now use a mobile money banking system; particularly at the peripheral level.

Electronic payment was a successful mechanism for ensuring funds made it into beneficiary and supplier hands and reducing the risk associated with the transport of large sums. Over the life of the project, SSGI reached 6,137 ASC participating in the SMC campaign and malnutrition screening; 4,015 distributors during the Intensified Nutrition Activity Week; 1,920 providers trained and others who participated in various coordination, conferences, and review workshops supported by the project. SSGI recommends that USAID, its partners, and the government continue supporting and using this low-risk electronic payment.

RESULT 3: KEY ACHIEVEMENTS, DECEMBER 2014-SEPTEMBER 2020

- 682 ASACOs conducted institutional capacity self-assessments.
- 251 ASACOs received management training.
- 252 ASACOs evaluated show that over 78% evolved from start-up to mature phase.
- Score card developed and used by 288 joint committees.
- 72% joint committees coached on the CAM scorecard have a fully executed CAM agreement.
- 1,333 HMIS officers/CSCCom staff trained on revised HMIS tools, including DHIS2.
- 237 health facilities equipped with laptops and internet keys.
- 80 tablets provided to regional and district health teams for on-the-job training/supervision.
- Between 2017 and 2019, the timeliness of Mali HMIS data through national DHIS2 reporting increased from 36% to 69%.

PARTNERSHIP AND PROGRAM MANAGEMENT

The SSGI consortium brought together organizations with complementary strengths to achieve a common set of goals as outlined in the below table. All consortium partners played critical roles in project planning, implementation, technical support and monitoring. Marie Stopes International (MSIM) was part of the consortium until 2017 after Mexico City Policy was reinstated in January 2017. Population Services International (PSI) joined the SSGI project as a new partner to assume responsibility for select FP activities in September 2017, and left the consortium in 2019.

CORE PARTNER	ROLE
Jhpiego	Jhpiego led in the technical areas of maternal health and FP. Jhpiego provided technical leadership in FP, reproductive health and provision of LARC in static facilities in the public sector; maternal health; malaria in pregnancy; and infection prevention and control.
Management Systems International	MSI provided technical assistance to improve health systems management and functioning and accountability at the community, district and regional levels. MSI also coordinated activities with regard to health commodities and supply chain logistical issues.
Population Services International	Population Services International provided technical leadership in the provision of FP methods through mobile outreach services and private social franchises through interpersonal communication agents, mobile video units, and local radios, improved RH/FP knowledge and practices among youth adolescents, women (including in postpartum) and men, as well as foster gender-equitable social norms that favor healthy behaviors.
Groupe Pivot Santé et Population (GP/SP)	A national forum of NGOs working in health and FP led on NGO capacity building and mentoring to ensure that local implementing partners have the organizational capacity and technical skills required to contribute to project objectives.
La Fédération Nationale pour les Associations de Centres de Santé Communautaire (FENASCOM)	FENASCOM complemented the capacity building work of GP/SP in the NGO sector by strengthening the capacity of its member organizations—ASACOs, local federation of community health associations (FELASCOMs) and regional (FERASCOMs)—to improve health services through good governance.

SSGI had three sub-grant agreements with international NGOs; eight sub-grant agreements with national NGOs—FENASCOM and GP/SP as consortium members; and six others strategically placed to carry out service delivery strengthening at CSComs, social and behavior change communication (SBCC) and community interventions activities in the regions of Kayes, Koulikoro, Sikasso and in Gao district. The local implementing partners included:

- *Association Conseil pour le Développement (ACOD)* for activities in Sikasso region;
- *Association Malienne pour le Développement Communautaire (AMADECOM)* for activities in Kayes region;
- *Alliance Médicale Contre le Paludisme (AMCP)* for activities in Koulikoro region;
- *Association pour la Protection et la Promotion de la Famille (APPF)* for activities in Kayes region;
- *Association Malienne pour la Protection et le Développement de l'Environnement au Sahel (AMPRODE Sahel)* for activities in Sikasso region; and
- *TASSAGHT* to support implementation of activities in Gao District.

SSGI supported partner coordination efforts at all levels of implementation. SSGI collaborated with several USAID-funded implementing partners to improve coordination. USAID health partners, namely, SSGI, HRH-2030 and PSM worked closely to plan for the 2020 FP campaign. SSGI held monthly meetings with the USAID Procurement and Supply Management (PSM) program to discuss CHX scale-up, CHX misuse mitigation, regional supply chain management meetings and coordination of supply chain activities. In light of the challenges associated with the transition of ASC payments to national resources (following the end of payments made through the SSGI project), SSGI continued to meet and exchange with HP+ to mobilize local initiatives to maintain ASC payment using local solutions.

Moreover, SSGI collaborated with USAID partners on COVID-19 response, participating in USAID-organized implementing partner meetings as well as the established sub-committees for risk communication and community engagement (led by Breakthrough Action), Infection prevention and control (led by MTaps) and laboratory diagnostics and case treatment (led by HRH-2030). SSGI worked with HRH-2030 to develop a template to provide guidance by thematic areas on key actions to increase health service use in the COVID-19 context. SSGI led the development of the guidance for MNCH and contributed to the nutrition, WASH and health system strengthening guidance. SSGI also worked with Breakthrough Action on updating radio spots developed by the USAID/Keneya Jemu Kan project on ANC, vaccination, and FP, to include messages on the importance of continued care seeking despite COVID-19.

SSGI was an active participant in the following national Technical Working Groups:

- Newborn Health
- Family Planning/Reproductive Health
- Malaria
- COVID-19
- LMIS

COMPLIANCE

Environmental Mitigation and Monitoring

SSGI ensured that all consortium members and implementing partners complied with Environmental Mitigation and Monitoring. During supervision and post-training follow-up visits to facilities, the SSGI technical team emphasized waste management, and the importance of adherence to infection prevention measures for environmental protection. Waste management and infection prevention practices are also integrated into the training curriculum for all service delivery strengthening activities. Environmental protection and mitigation was considered during WASH activities, including training on WASH in health care facilities, the launch and implementation of the Clean Clinic Approach, and the purchase and delivery of medical waste management kits.

Family Planning and Protecting Life in Global Health Assistance (PLGHA) Compliance

Family planning compliance activities were integrated into all relevant training and supervision/coaching activities. During training of rural maternities, post-training follow-up, integrated and FP specific supervision described elsewhere, supervisors guided providers on FP compliance and checked for the FP compliance materials in the facilities visited, signaling to the project if additional copies needed to be distributed. Review of FP counseling was included in all integrated supervision and FP specific supervision to reinforce the importance of providing comprehensive counseling.

Throughout the life of the award, facilities and providers, including ASC, were oriented on FP compliance and each facility was evaluated in accordance with USAID FP and abortion rules and regulations compliance. Using a checklist, supervisors documented the presence of the FP Tihart poster, availability of all methods, counseling practices, as well as ensured that no quotas were set or incentives provided for FP service provision. The notion of informed and voluntary choice was reinforced. Supervisors, MHSD and SSGI staff who were part of the supervision teams confirmed the following on a routine basis:

- Availability of all FP methods in all supervised sites in Kayes, Sikasso and Koulikoro regions
- Availability of FP (Tihart) poster
- FP reporting tools correctly completed
- Correct completion of FP consultation registers
- SSGI staff orientation on Protecting Life within Global Health Assistance (PLGHA) and USG Abortion and Family Planning Compliance Regulations

On a regular basis throughout the life of the award, all project staff (SSGI central, regional and district teams), including consortium and local NGO partner staff, completed two online courses from the Global Health e-Learning Center on FP and PLGHA regulations. More specifically these are the English or French versions of the following trainings:

- US Abortion and FP Requirements – 2020 (currently revision 5)
- Protecting Life in Global Health Assistance and Statutory Abortion Restrictions 2020 (currently revision 3)

Data Quality Assessments

To improve data quality, SSGI undertook several measures, including a new data entry system introduced through the adaptation and establishment of a community electronic data management system to track community mobilization and communication on social and behavioral change on maternal, newborn and child health, nutrition and WASH through the DHIS2.

SSGI made adjustments to the data processing system (data flow, data cleaning, report filing, etc.) along with the development and introduction of training database (TraiNet) that enabled counting training participants and reviewing electronic reporting system used for the supervisions conducted. All project staffs involved (District Officers along with local NGOs) received computers and were trained and coached to facilitate data entry and management.

Community level through project supported NGOs.

- Quality assurance checks were conducted each quarter through site visits and data verification;
- Extraction of the data sets with joint review by project regional and NGO technical teams, followed by corrections in the database (as needed) prior to the production of the quarterly and annual project reports;
- Project regional MEAL conducted quarterly visits at the regional and community levels to verify, discuss and coach the data collectors on the data quality.

CSCCom and district levels. To ensure effective use of the data for decision-making, the project supported the dissemination and trainings/coaching of HMIS management procedure manuals and the module for analysis and interpretation of health data to service providers. The project also provided ongoing support through establishment of the data review forum where the project provided technical and financial support to districts for data and performance review meetings with all key technical staff and partners to validate results, identify areas of program improvement and strategies and inform improvement of monitoring and evaluation (M&E) systems to address gaps identified.

Support to the regions to conduct Routine Data Quality Assessment. The project in collaboration with the Ministry of Health/DGS and MEASURE Evaluation supported the establishment of participatory Routine Data Quality Assessment (RDQA) mechanisms. The project supported regions to conduct data quality assessments (at least twice a year for each region in selected CSCComs, which were ranked as low performance based on their data completeness, and timeliness in DHIS2) and jointly monitored and strengthened implementation of action plans to improve data quality. The data quality assessment visits were conducted based on standards criteria (the reliability, validity, timeliness, completeness, integrity and accuracy of data). By the end of the project, there was noted improvement in data quality across all supported regions such as the availability of at least one staff available and trained in data management processes and tools including DHIS2; the availability of primary data collection tools; knowledge and mastery of key indicators by users and consistency on the recount of data reported in the electronic system (DHIS2) and the source facility across the selected indicators assessed.

Branding and Marking Compliance

SSGI complied with the approved branding and marking plan, requesting waivers in instances of political, safety and/or security concerns only, such as security concerns in Gao and in the course of the recent attempted *coup d'état* in 2020.

CHALLENGES, LESSONS LEARNED, RECOMMENDATIONS AND CONCLUSION

Challenges and Constraints

COVID-19. On March 17, 2020, the President of the Republic of Mali announced the closure of schools and restrictions on public gatherings as a means to reduce the spread of the COVID-19 virus in Mali. In this respect, several SSGI activities could not be conducted as planned; some of these activities were postponed and eventually held; others were canceled. Community level activities that brought many people together were either suspended or adjusted. While some technical working groups continued to meet, the government's focus at the national and regional levels throughout 2020 turned to putting in place COVID-19 response action plans. COVID-19 affected service use, particularly childhood vaccinations in the months of March to May 2020.

In this context, SSGI identified ways to reorganize activities so that health managers, providers and staff could respect physical distancing and infection prevention practices to reduce the virus transmission risk. Smaller gatherings of people, with adequate distancing between chairs, allowed key discussions to be held. Local NGOs adjusted certain activities, such as general assemblies and nutrition demonstrations to small group discussions and home visits. By the fourth quarter of 2020, and a COVID-19 situation that was not as dire as expected, activities continued with minimal impact and key health indicators began to trend in a positive direction.

Chlorhexidine scale-up. The scale-up of CHX in Mali was suspended for six months (January to June 2019, which was lifted by the MHS in July 2019) due to 20 reported cases in total of CHX misuse in the eyes, resulting in blindness in some cases. SSGI supported the CHX working group, working closely with KJK, to mitigate the incident. An emergency communication plan was developed and implemented. In Quarter 4 of 2019, CHX distribution was resumed in all 37 SSGI supported districts and the PPM also sent stocks to non-SSGI-supported regions in the North and Central regions of Mali (Segou, Mopti, Tombouctou, Gao, Kidal, Menaka and Taoudeni). At the end of SSGI implementation, all districts were not yet supported to scale-up CHX due to financial partners' availability to support the introduction. In addition, the country has not taken clear procurement mechanism of the chlorhexidine to avoid the stock out. Lastly, not all newborns in health facility receive CHX and there is a need to ensure access for newborns born at home.

ASC payment transition to domestic resources. The interruption of ASC incentive payments at the end of September 2019 impacted SSGI and ASC performance. Despite the combined efforts made by SSGI, HP+ and USAID to find a solution of incentive payments using local resources, at the end of SSGI, there is no plan in place to continue the payments of ASCs in Kayes and ASCs in Sikasso regions. Few municipalities or ASACOs have committed to ensure the payment of their ASC. The lack of a clear payment mechanism is adversely affecting SEC activities, as evidenced by an observed decrease in SEC activities.

Referral/evacuation from community to CSCoM. Despite communities' demonstrated resource mobilization, use of the VHSF remains low for maternal and newborn evacuations in communities. SSGI's documentation efforts showed that this can be partially attributed to social norms and perceptions. For

example, certain localities reported that if a moto ambulance is used for evacuation, “everyone in the village knows that there is a serious issue in the family.” Seeking use of the VHSF may also be perceived as being “too poor” to pay oneself.

Lessons Learned

Partnership and partner coordination maximizes results. Introducing and scaling up DHIS2 in Mali succeeded because multiple partners contributed collaboratively and each had a clearly defined role and/or geographic coverage. MEASURE Evaluation led the conceptualization with the national government while partners such as the USAID funded SSGI, ASSIST, and HRH-2030 projects, United Nations Children’s Fund (UNICEF), and PSI/Global Fund, provided equipment, training, and supervision either by type of activity or by operating in a dedicated geographic zone. All public health facilities in Mali were using DHIS2 within one year of its introduction. Further, Mali’s impactful health campaigns have rolled out successfully because each partner brings its technical contribution or geographic focus. Tangible examples of success are the national FP campaign and the national seasonal malaria chemoprevention campaign.

On-site coaching enhances effectiveness and efficiency. SSGI focused its capacity strengthening on building effective teams in each facility ensuring that a facility is not dependent on a single person to effect the learning gained. On-site coaching enabled staff to practice in real time the lessons they gained without leaving their posts. When several people from one facility gained new competencies, they supported each other to maintain the practices and to ensure quality. Finally, by establishing a whole system improvement approach, the health center is better able to weather the disruption when staff are moved. The on-site coaching was used for different technical capacity building including focused ANC, PFP, newborn care, and BEmONC services.

Community advocates can mobilize resources to improve their health. Using a facilitated approach SSGI demonstrated that community actors have the capacity and the desire to mobilize resources to support health activities. GSANs worked with their communities to collect foodstuffs to use for cooking demonstrations. CAGs advocated to commune and district government leaders for improved water systems, building infrastructures and the capacity of additional health workers in the health facilities, and VHSF committees mobilized funds from community members to use for referral and evacuation during health emergencies and purchase of motorcycle ambulances.

Effective and transparent communication accompanying policy change creates trust. SSGI worked closely with government partners to revise payment systems that increased efficiency and improved accountability. While initially rejected, participants ultimately understood that the use of mobile payment systems improved organizational transparency and procedures and enabled project supported supervisors, distributors, and activity participants to receive per diem and travel funds directly. They accepted this practice because SSGI provided open and transparent communication with partners that led them to trust the process.

ASACO/CSCoM organizational development. SSGI’s ASACO and CSCoM capacity building strategy facilitates and contributes to the sustainability of these entities in a fundamental way. The self-assessment process offers an approach to institutional development based on ownership and progression along a continuum of organizational development and good governance. Supporting, training, coaching, and supervising the broader actors has proven to be necessary for maintaining statutes acquired by ASACOs/

CSCComs, particularly at the district-level. The continued use and indeed ramping up of CAM scorecard activity continues to be positively received at commune level.

Joint Committees. The MOH considers the CAM scorecard a key tool and promotes it as a MOH-sanctioned tool. Joint Committees continue to successfully reinforce their capacity and understanding of the CAM scorecard tool. Indeed, the CAM scorecard stimulates CSCCom co-management by key community actors and increases the mayors/communes participation in CSCCom management and funding of community health activities. The CAM scorecard is helping to reinvigorate enthusiasm and the commitment of these community actors, particularly in improving CSCCom local governance, as evidenced by the actions and immediate decisions made by Joint Committee members and the mayor of some supported communes.

Clean Clinic Approach. The CCA depends on the commitment and ownership of different stakeholders, including the Ministry of Health, district authorities, the CSCCom, the ASACO, communities and community members. The sites reaching “Clean Clinic Status” (over one-third of sites in both Koulikoro and Bamako involved in the competition) are those that have established positive, collaborative relationships among these stakeholders. Regular and continuous monitoring by government officials at the regional and district levels will help facilities maintain their progress and encourage them to improve or maintain their achievements.

Sustainability

Over the past six years, SSGI supported the Government of Mali, working with and through the national system, an approach explicitly intended to build capacity and sustainability. SSGI-supported training activities used nationally approved materials (e.g., training modules, national policies, guidelines and standards) and with government facilitators leading training sessions. SSGI supported on-site coaching in health facilities to reach greater numbers of clinical staff. To ensure smooth transfer of capacities, SSGI worked with professional institutions for select activities such as KMC and EmONC training, supervision and coaching. The National Health and Public Hygiene Directorate (DGSHP) lauded this approach, as have the health facility staff themselves. SSGI discussed with the technical group on health system reform tasked with operationalization to integrate this approach of onsite training and coaching in the national guidelines, especially as it reduces the time staff are away from their facilities at off-site trainings, reaching more staff on the job. SSGI collaborated with government entities in all supervision activities. National tools are used. All technical teams were well trained to conduct quality supervision.

Recommendations and Way Forward

Based on SSGI’s experience over the last six years, the project offers the following recommendations to future projects and the Government of Mali as it continues in its journey to self-reliance.

- Supporting integrated services does and should not imply that all technical areas are to be integrated into one package. In reality, many possible permutations exist. However, there are economies of scale when integrating interventions and activities that target the same target group or structures.
- Institutionalize on-site training in health facilities and community groups (ex., GSANs) in lieu of classroom-based training, allowing limited interruption to services and enabling a greater number of providers, increasing service continuity in the event of staff transfers.

- Fix a date for the annual national FP campaign. This will help all stakeholders to be better prepared to cover all villages and reach all clients in need.
- For national newborn technical working group: used data generated from SSGI to revise/update the national chlorhexidine guidelines. Strategic elements to consider include: covering the remaining districts for country coverage, community distribution including through private sector, changing the packaging to minimize the misuse in eyes, defining national procurement system to avoid potential stock out, and increased communication, including reaching all health providers to increase community awareness on the use of CHX. However, we also need to balance rapid scale up, enabling to reach every newborn who needs CHX, with adequate orientation of mothers and caregivers on safe use of CHX for cord care. It's therefore critical that we continue to orient providers and caregivers at all levels (facility and community) to promote/support safe use of CHX for cord care.
- Extend the SMC to 5–10 year olds.
- Extend BEmONC services and improve their quality, especially in rural areas. Using in-situ training approach can increase the number of providers trained and ensure continuum of services in case trained personnel leave the site.
- Use online tools for health services supervision that can help to monitor health facility improvement over time.
- Urgently integrate rural maternities in the national health system, including support planning.
- Intensify PFP and make FP more affordable.
- Integrate other child health services to SMC such as malnutrition screening and Vit A distribution.
- Intensify coaching to community groups with an emphasis on identifying local initiatives for mobilizing resources to resolve community health problems.
- Put in place a sustainable solution to CHW incentive payments. One promising and long-term solution is to revise the national SEC policy and include ASCs under ASACO/CSCoM management schemes including their supervision, performance assessment and incentive payment.
- Integrate data from ASACOs, community groups and rural maternities into the national HMIS to provide a better picture of health governance, health promotion and service delivery activities conducted in a health catchment area.
- Train and coach ASACO and municipalities to increase the CAM application through the use of the CAM scorecard and coaching. When roles and responsibilities of each party are clear and the contents of the CAM are well understood by each party, collaboration improves, including the disbursement of funds from the Town Hall to the ASACO.
- Use all mechanisms to improve data quality from the source, such as the CSCoM, rural maternity, private clinics, CHW, and community groups. Institutionalize monthly data reviews at CSCoM level with local stakeholders' participation —technical staff, ASACO, CHW, CAG; use dashboard for districts to monitor data quality improvement at the CSCoM level and immediate correction of errors observed.

Conclusion

For more than six years, SSGI implemented and supported a range of integrated interventions in fulfillment of its three objectives. SSGI was privileged to have collaborated closely with national partners in joint efforts to improve the lives of mothers and newborns. To maintain the results achieved and ensure the sustainability of these approaches, regular support to CSRef providers and from districts to CSComs with community engagement for behavior change and local initiatives and solutions will need to be reinforced.

ANNEXES

- IV.** Indicator table
- V.** List of presentations at national and international conferences and fora
- VI.** List of products, tools and policies developed or adapted by SSGI
- VII.** List of success stories submitted to USAID



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