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CASE STUDY

MALI



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ProFam Urban Outreach
*A High Impact Model for
Family Planning*

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To access the capabilities of SIFPO, USAID missions and bureaus can buy into the cooperative agreement.

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EXECUTIVE SUMMARY

In 2009, Population Services International (PSI) launched an innovative family planning (FP) outreach model in collaboration with the Malian Ministry of Health's (MOH's) Department of Reproductive Health (DSR) and the Bamako Regional Department of Health (DRS). This high-impact model, currently supported by the Dutch Government's Choices and Opportunities Fund and USAID's Maternal and Child Health Integrated Program (MCHIP), is designed to increase women's access to postpartum FP, particularly long-acting reversible contraception.

Mali's modern contraceptive prevalence rate (CPR) of 6.9% is one of the lowest in the world and has stagnated since 2001, despite an unmet need of 31% among Malian women. Malian women have an average of 6.6 children in their lifetimes. One in 33 women in Mali will die from pregnancy-related causes, while one in 10 infants will die in their first year of life.¹ The use of FP to prevent unintended pregnancies and to time and space intended pregnancies has been shown to significantly reduce maternal mortality and morbidity and lessen the chances of infant and child death. Therefore addressing Mali's unmet need for FP is vital to saving women's lives and improving health.

Long-acting reversible contraceptives (LARCs) provide many benefits—both from the perspective of the individual user as well as from a larger public health perspective. LARCs provide long-term, low-cost protection from unintended pregnancy with very low failure rates. While offering a range of contraceptive options is critically important to meeting the diverse FP needs of women of reproductive age (WRA), short-acting methods have higher user failure discontinuation rates in comparison with LARCs. In addition, they carry the added burden of repeat visits to the clinic for each new cycle. Despite these differences, the 2006 Demographic Health Survey found that LARC use in Mali was particularly low, with less than 1% (roughly 2 out of every 1,000 women) using a LARC method.

In 2008, PSI, a leading non-profit social marketing and social franchising organization, began working to increase Malian women's access to LARCs under a grant provided by the Dutch Government. Applying a strong social marketing lens to the LARC landscape and drawing on lessons learned from PSI LARC programs in other countries, PSI/Mali piloted an urban outreach model designed to reach WRA with modern method counseling and high-quality, subsidized LARC products and services. The model was initially piloted in the private sector in a model that integrates FP counseling and services with routine immunization services to reach the largest possible number of women with unmet need. Recognizing the success of the model and the need for increased LARC services

1 Salif Samake, et al. Mali: DHS, 2006- Final Report (French). CPS/MS/DNSI/MEIC Bamako, Mali and Macro International Inc., Calverton, Maryland, USA.

ABBREVIATIONS AND ACRONYMS

ASACO	Local Community Committee
CFA	Communauté Financière Africaine
CPR	Contraceptive Prevalence Rate
CSCOM	Community Health Center
CSREF	Referral Center
CYP	Couple-Years of Protection
DALY	Disability Adjusted Life -Years
DRS	Bamako Regional Department of Health
DSR	Malian Ministry of Health Department of Reproductive Health
FP	Family Planning
GDP	Gross Domestic Product
GHI	Global Health Initiative
IPC	Interpersonal Communication
IUD	Intrauterine Device
LARC	Long-acting Reversible Contraceptive
MCHIP	Maternal and Child Health Integrated Program
MDG	Millennium Development Goal
NGO	Non-Governmental Organization
MOH	Ministry of Health
PPM	Pharmacie Populaire du Mali
PSI	Population Services International
SALIN	Strategic Alliance with International Nongovernmental Organizations
USD	United States Dollar
WRA	Women of Reproductive Age

in the public sector, PSI/Mali, the DSR and the DRS expanded the model to public sector community health centers in Bamako with funding support from the Dutch Government and US-AID. Leveraging public-private partnerships and integration of services to strengthen health systems and increase postpartum FP, this urban outreach model addresses five of the seven Global Health Initiative (GHI) principles. The model:

- Implements a woman- and girl-centered approach, improving health outcomes for women and recognizing that women are central to the health of families and communities;
- Increases impact through strategic coordination and integration for patients and for those involved in providing or paying for services;
- Builds sustainability through health systems strengthening;
- Supports country ownership and country-led plans; and
- Promotes research and innovation to identify what works.

As a result, between 2009 and the close of 2011, over 41,000 women in Mali received a LARC method. This represents an incredible increase over the 5,543 women estimated to be using a LARC method in 2006. In addition, 149 public sector providers from 73 community health centers (CSCOMs) were trained and certified in LARC counseling and service delivery; PSI, the DRS and DSR successfully advocated for a reduction in price of LARCs at the government's central medicines store; and expansion of long-acting reversible contraception was designated as the top priority in Mali's national strategic plan for FP.

Drawing from field visits, interviews with various key stakeholders and document review, this case study examines the key components of the model and highlights the model's impressive impact in the areas of contraceptive uptake and health systems strengthening. It further provides an analysis of the model's strengths and weaknesses and discusses opportunities for expansion and current and future challenges.

THE CONTEXT

Kadia Bagayogo is a 39-year-old Malian woman. She lives with her husband Seyba and their nine children in a single room

habitation, part of a larger multi-family commune in Banconi, a poor neighborhood in Mali's capital city, Bamako. Kadia was 14 years old when she and Seyba married in 1985. Since then, Kadia has been pregnant 11 times,² including two sets of twins and a miscarriage. Like many Malian women, Kadia is aware of the importance of antenatal care, but has rarely attended antenatal care visits during her pregnancies. This is not uncommon in Mali where only 69% of women attend at least one antenatal visit, and far fewer, 35%, complete the recommended minimum of four visits per pregnancy. A startlingly low percentage of women, 27.8%, receive postnatal care.³



Kadia, on the right, with her husband and six of their children.

Of Seyba and Kadia's nine living children, the youngest of whom is 45 days old, none attend school. The couple cites poverty as the reason. Seyba is a chauffeur, but is currently unemployed. Kadia works in the home and sometimes sells charcoal to help make money for the family. Seyba and Kadia's economic circumstances are not atypical in Mali, which is one of the 25 poorest countries in the world. An estimated 36% of the total population lives below the poverty line, and annual GDP was estimated at \$1,136.27 per capita in 2007.⁴

Like many WRA in Mali, Kadia does not use a contraceptive method. Only 6.9% of WRA use modern contraceptives in Mali, despite an unmet need of 31% nationwide and 37.6% in Bamako. One of the lowest CPRs in the world, this number has stagnated since 2001. Perhaps owing in part to rapid population growth, the CPR in Bamako actually decreased from 19.6% in 2001 to 16.9% in 2006. However, for Kadia and Seyba, after two

² Total fertility rate is 6.6 births per woman in Mali. (Ibid.)

³ Salif Samake, et al. Mali: DHS, 2006- Final Report (French). CPS/MS/DNSI/MEIC Bamako, Mali and Macro International Inc., Calverton, Maryland, USA

⁴ The World Factbook 2009. Washington, DC: Central Intelligence Agency, 2009.

successive infant deaths⁵ and a miscarriage, they are interested in FP and want a contraceptive that fits their needs.

Table 1. Unmet Need and Percentage of Women Using a Modern Contraceptive

Unmet Need		% of Women Using a Modern Contraceptive		
Location	% of Women	Modern methods	IUD	Implant
Bamako	37.6	16.9	0.3	0.6
Other Cities	28.7	10.3	0.1	0.1
Rural	30.7	4.2	0.0	0.0
National	31.2	6.9	0.1	0.1

The closest health center for the couple is the CSCOM of Banconi. CSCOMs are the most prevalent type of health care facility in Mali's limited health care infrastructure.⁶ At the end of 2010, CSCOMs numbered 1,024 for a population that is now over 15 million.⁷ Each of these public sector primary health centers is community-based and managed by a local community committee (ASACO), which is responsible for paying staff salaries and replenishing drugs and equipment. CSCOMs in Bamako are typically staffed with one doctor and several midwives and nurses. Together these staff members provide the national minimum package of services, including immunization, antenatal and delivery services and FP. In line with the "Bamako Initiative" for cost recovery, CSCOMs generate revenue through the sale of essential drugs and products and fees for services. CSCOMs are increasingly being asked by the central government to provide certain products and services for free. However, FP has not been added to the list of free products and services to-date.

If Kadia and Seyba were to visit the Banconi CSCOM in 2008, this is what they would have likely experienced: Kadia would have waited an hour or more to meet with a CSCOM staff member for FP counseling. The counselor may have provided an overview of all modern contraceptive methods. However, he or she would have likely focused exclusively on short-acting methods, which were the only methods available at the clinic at that time. In 2008, intrauterine devices (IUDs)

and implants would not have been available at the Banconi CSCOM. These methods would have been out of stock at the CSCOM pharmacy, and in all likelihood, the CSCOM providers would not have had formal training or practical experience in inserting either product. If Kadia wanted an IUD or an implant, she would most likely have been referred to the nearest referral center (CSREF), where LARCs, if available, would typically cost between 4,000 and 10,000 CFA (\$8 to \$20 USD). Some private sector clinics also offered IUDs and implants at that time. However, given Kadia and Seyba's economic circumstances and the barriers to accessing a LARC in the public health system, the couple would most likely have selected a short-acting method. Short-acting methods, for all of their benefits, carry the disadvantages of higher discontinuation rates, higher user failure rates and the added burden of repeat visits to the clinic for each new cycle. Kadia would have paid 300 CFA (\$0.60 USD) for an injectable, plus 200 CFA (\$0.40 USD) for the injection or 100 CFA (\$0.20 USD) for a pack of pills, plus an additional 200 to 300 CFA for the provider visit and service. Kadia would pay these costs again, along with the cost of transportation to and from the clinic, each time she needed a new cycle of coverage. In addition, even for short-acting methods, commodity availability is unreliable in the public sector. It is conceivable that on one or more occasions, Kadia would arrive at the

Long-acting reversible contraceptives have many benefits. Because there is no action required of the user, LARCs facilitate consistent and correct use. The IUD provides protection from unintended pregnancy for up to 12 years, while the contraceptive implant provides coverage for up to five years. LARC methods can be good options for women who have discontinued using a short-acting method due to side effects or who have difficulty returning to a clinic for re-supply. Additionally, during one year of typical use, the pregnancy rate associated with oral contraceptives, a short-acting method, is 8% compared to 0.8% with the IUD. Despite the many advantages of LARCs, the 2006 DHS reported use in Mali at 0.2%, roughly 5,500 women in a population of 2,771,735 women of reproductive age.

5 In Mali, 1 in 10 infants will die in their first year of life. (Salif Samake, et al. Mali: DHS, 2006- Final Report (French). CPS/MS/DNSI/MEIC Bamako, Mali and Macro International Inc., Calverton, Maryland, USA).

6 Mali has 1 doctor for every 10,000 people. Comparatively, the United States has 27 doctors for every 10,000. (WHO, World Health Statistics 2011, available at: <http://www.who.int/whosis/whostat/2011/en/index.html>.)

7 USAID/Mali 2011. Best Action Plan.

CSCOM only to find that her short-acting method of choice was not available.

Instead, Kadia and Seyba had a very different experience. They came to the Banconi CSCOM in 2010, during a PSI-led *ProFam* urban outreach activity. They could obtain FP counseling on a comprehensive range of modern methods, and chose to receive a low cost LARC from an experienced PSI midwife and a CSCOM provider newly trained in LARC service provision.

PSI IN MALI

PSI/Mali was founded in 2001, with a focus on the use of commercial marketing strategies to improve reproductive health and child survival and to reduce new HIV infections. Over the years, PSI/Mali has collaborated with the MOH and a number of partners to expand its reproductive health programming and to launch additional programs in malaria prevention and treatment, safe water and the reduction of female genital cutting.

Currently, PSI/Mali's socially marketed FP products consist of both short-acting and long-acting reversible contraception. In the private sector, PSI promotes and distributes short-acting methods, including the oral contraceptive *Pilplan-d*, a Depo-Provera™ injectable contraception branded *Confiance*, and *CycleBeads*™. PSI also markets and distributes male condoms branded Protector Plus and female condoms branded *Protectiv*. PSI also makes available LARCs, including the copper IUD branded *N'Terini*⁸ and the 5-year implant *Jadelle*™, known as *alimètikisèni*,⁹ in both the public and private sectors through the *ProFam* service network.

PSI/Mali leads a social franchising network of 77 private sector clinics branded under the *ProFam* name. The PSI social franchising model aims to deliver reliably high-quality services through a network of pre-existing providers and facilities, increasing long-term sustainability and impact. With the *ProFam* social franchise network, PSI/Mali leverages brand recognition, training and tools to expand and improve provider practices. Franchisees receive training provided jointly by master trainers from the MOH's DSR and PSI; subsidized products and

equipment; monitoring and supervision; and on-site coaching from PSI/Mali. In addition, PSI/Mali brands the franchisee's clinic as part of the *ProFam* network, and promotes the brand as offering high quality, affordable services through interpersonal and mass media communications, which results in increased client flows to the provider. In turn, the franchisee commits to meeting PSI's service delivery quality standards and to honoring agreed consumer prices. PSI believes that strengthening the private sector also helps strengthen Mali's overall health system, enabling more women and couples to obtain high quality FP products and services.



In 2011, PSI received FP program funding from three donor sources: the Dutch Government's Choices and Opportunities Fund, USAID's MCHIP and a large anonymous donor. Each donor's funds

were used to support complementary components of PSI's FP work. PSI estimates that in 2011 alone its FP products and services generated 414,791 couple years of protection in Mali, averting 887 maternal deaths, 141,877 unintended pregnancies and 107,508 reproductive health DALYs. Combined, PSI/Mali's programs in Malaria Control, HIV/AIDS prevention, Reproductive Health and Child Survival are estimated to have averted a total of 9.57% of Mali's national burden of disease in 2011.

PSI/MALI LARC PROGRAMMING: THE EARLY DAYS

In 2008, PSI/Mali began working to increase access to IUDs and implants under a grant provided by the Dutch Government under the Strategic Alliance with International Nongovernmental Organizations (SALIN). PSI/Mali trained providers in its *ProFam* network of private clinics and encouraged them through periodic supervision and medical detailing¹⁰ visits to offer LARC counseling and services to their clients in addition to the short-acting method services already provided. A year into the program, initial results were mixed. Overall LARC service provision was low (roughly 330 insertion services provided across 33 clinics in 12 months), and it was clear that while some clinics had embraced LARCs and were offering service routinely, others had not. Based on this outcome, PSI/Mali decided to take a broader look at the LARC landscape in

8 In English, "n'terini" is interpreted as "my intimate friend" or "my accomplice."

9 In English, "alimètikisèni" is interpreted as "match sticks."

10 An activity conducted by hired staff with clinical or health and sciences related backgrounds, wherein the representative—"detailer"—provides details or scientific information on a product's potential uses, benefits and side/adverse effects.

Mali, applying a stronger social marketing lens and looking to PSI FP programs in other countries for lessons learned on LARC promotion and service delivery.

ASSESSING THE LARC LANDSCAPE THROUGH A SOCIAL MARKETING LENS

Marketing strategies are typically formulated around four key elements known as “the 4 Ps”: product, price, place and promotion. While the Promotion P, is perhaps the most widely known and associated with marketing, product, price and place also impact individual decision-making and are therefore critical elements to any good marketing strategy. Product refers to the actual product or service. Price refers not only to the monetary consideration but also to the emotional or psychological incentives and barriers to purchasing and using a product. Place refers to where the customer can access the product and service and the intermediaries who can facilitate that access.

LARCS AND “THE 4 Ps”

Place

PSI/Mali realized that it needed to increase the number of places where women could access LARCs. While the majority of women and couples seek FP counseling and services at public sector CSCOM clinics, LARCs were only available in the higher level public sector referral clinics (CSREFs), and at a very limited number of CSCOMs and private clinics, including the *ProFam* clinics. In Mali, private sector facilities are largely perceived to have higher quality services and products; however, they are also perceived to be higher cost. This, along with the fact that the private sector is not typically included in most national maternal and child health campaigns, perhaps explains in part why most women seek services in the public sector.

In considering how to expand the number of service delivery points, PSI recognized that not just any place would be appropriate for LARC services. An exam table, ability to sterilize equipment, a degree of privacy and confidentiality for the patient and a system for managing complications, post-service counseling and removals are all necessary minimum requirements for LARC service delivery. This dictates in large part the type of place where services can be offered.

Price

PSI determined that increasing access would require a reduction in the total price to the consumer. At 4,000-10,000 CFA (\$8-\$20 USD) in both public and private sectors, the cost of an IUD or implant was well out of reach for most women and couples in Mali. The high cost of LARCs versus short-acting methods was perceived as a disincentive for women to choose a LARC despite their long-term cost effectiveness. For poor women and couples, paying 500 CFA every 3 months for an injectable contraceptive is more feasible than a one-time payment of 10,000 CFA for an IUD or implant. A much lower price would be needed to make an IUD or implant an affordable and realistic option for Malian women.

PSI’s provider studies in several other countries determined that price to the provider was often an additional barrier. The cost to the provider includes not only the price of the product itself, but also the cost of consumables, insertion equipment and the real or perceived opportunity costs associated with the time it takes to provide a LARC method. Providers are often not willing to stock LARC methods because of the perception that they are low-demand, high-cost products. The relative ease of administration and recurring client payments associated with short-acting methods also create a disincentive for providers to offer LARCs. As a result, PSI decided to initially by-pass willingness-to-stock barriers at the clinic level by providing all products, equipment and consumables. In addition, PSI would pay clinics per insertion, as a reimbursement for the provider’s time and the use of the facility.

Product/Service

Although quality products were available in Mali, trained and experienced LARC providers were in short supply. Most CSCOM providers lacked formal training and practical experience in LARC insertion, and those who were skilled often lacked the time to provide the service, given heavy client flows and other competing demands. To increase women’s access to LARCs, PSI would need to address this shortage of trained and experienced IUD and implant providers.

In PSI’s work it was also evident that many providers held biases against LARCs, the IUD in particular. Even those trained in LARC insertion often had low self-efficacy and lacked confidence in providing the service. Provider biases are easily passed on to clients and impact the overall availability of the products and insertion services. PSI determined that it would

be best to begin activities with a core group of providers who could serve as LARC champions, promoting the benefits of the methods not only to clients but also within the provider community.

Promotion

Research shows that women and couples hold many fears and misconceptions about contraception in general, and particularly about IUDs. PSI/Mali's research among WRA found that only 3% had a comprehensive understanding of IUDs: They understand where the method goes and how it works, and they reject false statements about the product. Non-users of LARCs were found to hold a number of misperceptions about the methods, including a fear that LARCs cause infertility, concerns that the methods migrate to other parts of the body and fears that LARCs cause illness or infection, including vomiting, dizziness and headaches.

In several other countries, PSI interpersonal communication (IPC) workers conduct door-to-door home visits or visit women's activity groups to connect with WRA. Initially this was not thought possible in Mali; yet IPC seemed to be the right channel for providing the depth of information needed to respond to the common fears expressed by women and couples. The PSI/Mali team brainstormed where and when they might be able to reach large groups of women with interpersonal information.

Infant immunization days draw a large clientele for clinics. Between 2001 and 2006, the number of children aged 12-23 months who received all of their required vaccinations grew from 29% to 48%.¹¹ Therefore, infant immunization presented an opportunity to reach large groups of WRA. In addition, it presented a means of combining both the "place" and "promotion" components of the strategy. Through immunization days, PSI could offer in-depth information about LARCS as well as access to quality, low-price services all at the same location and time.

PSI/MALI PROFAM URBAN OUTREACH

Building from this assessment and lessons learned from other PSI FP programs, in January 2009 PSI/Mali began

piloting "clinic event days" in five *ProFam* private sector clinics. Throughout the pilot, PSI's sole midwife worked closely with the *ProFam* clinics to prepare a FP counseling and service delivery "event" that coincided with each clinic's day for immunization services. On an immunization day, the midwife would travel to the identified clinic, and with assistance from clinic personnel, conduct a 30-minute FP presentation for the women waiting to have their children immunized. The midwife discussed the full range of modern contraceptives including LARCs, taking time to answer individual questions and discuss common misconceptions and myths. Immediately after the discussion, women could receive individual counseling, a physical exam, and if eligible and so desired, a LARC at a subsidized price of 500 CFA (\$1.00 USD). The PSI midwife typically provided the insertions, using PSI products, materials and equipment, while clinic personnel assisted. Short-acting methods were also available through the clinic pharmacy and were administered by the clinic staff.

This time the results were promising. At the first event day, the midwife provided five women with a LARC, out of a group of roughly 20 women visiting the clinic for immunization services that day. Over the course of the pilot, between January and April 2009, 14 event days were held in total, reaching 720 women with group counseling messages and providing 75 women (just over 10%) with a LARC.

Building off of the success of the initial pilot, over time PSI expanded the model, adding more champion midwives to PSI's core staff and included additional *ProFam* clinics in the event day activities. However, considering the success of the model and given that the majority of maternal and child health services are delivered through the public sector, it was clear that extending the *ProFam* outreach model to CSCOMs and strengthening public sector capacity for LARC services would have the largest potential for impact. Without this expansion, private sector service provision alone would not be enough to satisfy unmet need in Bamako or beyond.

ESTABLISHING A PUBLIC/PRIVATE PARTNERSHIP

Public/private partnerships in health care can be tremendously beneficial in helping address specific cost challenges in the

11 Salif Samake, et al. Mali: DHS, 2006- Final Report (French). CPS/MS/DNSI/MEIC Bamako, Mali and Macro International Inc., Calverton, Maryland, USA.

public sector, while increasing service provision and improving the quality of services. In order to establish such a partnership between *ProFam* and the public sector, PSI sought approval from the MOH and worked to generate commitment and buy-in at both the Ministry and clinic levels.



Midwives at a CSCOM.

PSI/Mali representatives met with the Director of the DRS¹² to discuss a potential partnership between PSI and the MOH's primary health care system. PSI proposed a partnership that would allow the MOH to expand CSCOMs' contraceptive offerings to include the two LARC methods, IUDs and implants, reaching more women in need at minimal additional cost. By expanding the *ProFam* brand and outreach model to the public sector, PSI hoped to leverage the *ProFam* name and reputation to inspire client confidence in the services provided. Additionally, PSI hoped to demonstrate to public sector providers the latent demand for these services, while training and coaching public sector providers to provide the services—effectively linking quality supply and latent demand at the service delivery points where most Malian women seek care.

The DRS recognized both the need for increased access to LARC services within the public health care system, as well as the successes of the *ProFam* outreach model in the private sector. The DRS agreed to pilot a partnership as long as a primary aim of the partnership was to generate increased capacity within the public health care system.

The basic model would be the same, with a core set of PSI/Mali midwives traveling to and working closely with selected

CSCOMs to provide FP counseling on a range of modern methods and LARC services during routine infant immunization days. CSCOM staff would be trained to assist and provide services while PSI/Mali would provide the IUDs, implants, insertion equipment and consumables on the day of the outreach event.

With this agreement in place, a representative from the DRS and from PSI began visiting CSCOMs and selecting clinics for initial inclusion in the partnership program. The criteria included having the necessary infrastructure to insure confidentiality, demonstrated respect for infection prevention protocols, existence of staff who could meet the criteria for performing LARC insertions, and a high client flow.

As CSCOMs were selected, each was asked to nominate an obstetric nurse or midwife to participate in a two-week training on contraceptive technology. As with the private sector outreach, for the initial phase of the public sector partnership, the CSCOM received 1000 CFA (\$2) for each LARC inserted by the PSI midwife. This money was meant to reimburse CSCOMs for the use of their facility and their providers' time during the event, as well as to cover the cost of any fee that would have been charged to clients who returned for follow-up counseling, management of complications and/or method removal.

Funding for the expansion of the *ProFam* outreach model to the public sector was provided by the Dutch Government's Choices and Opportunities Fund, and initially by USAID's Pathways to Health. In 2011, MCHIP took over USAID support for the model.

A CLOSER LOOK AT THE MODEL

Integrating Routine Immunization Days and FP Counseling and Service Delivery

In Mali, unmet need for FP is estimated to be highest among post-partum women (79%). While very few women seek post-natal care services, depending on the CSCOM anywhere from 50 to over 100 women will attend a typical immunization day. Most post-partum women in Mali are hoping to avoid "serre." This Bambara term refers to when a woman becomes pregnant with one child, while breastfeeding another. Several studies have shown that men and women in Mali understand the benefits of longer birth intervals and that those Malian women currently using or ever having used modern contraception frequently cite

12 The DRS is a technical branch of the Ministry of Health, responsible for managing public sector health facilities and initiatives in each region.

“birth spacing” as their reason for use.¹³ This also reflects and is consistent with overall government policy related to FP, which encourages birth spacing and use of contraception as a means of achieving desired spacing intervals.

However, despite understanding the benefits of longer birth intervals, men and women are often slow to apply this knowledge to their own personal circumstances.¹⁴ FP counseling provided by a health care provider at immunization days directly addresses this gap by providing essential information at the point in a woman’s reproductive life cycle in which she is perhaps most likely to transfer this knowledge into action. During the post-partum period, women in Mali have the highest unmet need for FP; however, as one CSCOM provider stated, “*Women do not come to post natal visits as often as to immunization days. They are encouraged to come, but they do not.*” Thus, integrating FP services with immunization days offers a way to reach the same population of women in greater numbers.

As discussed above, in Mali non-users of contraceptives frequently cite fear of side effects as a reason for non-use. Offering FP counseling and services during routine immunization days also provides an opportunity to address these fears. The health care provider talks in detail about potential side effects, clarifying and dispelling myths and misconceptions and talking in-depth with women about their questions.

Another typically cited reason for non-use is a lack of spousal support.¹⁵ It has been widely speculated that injectable contraception is the most popular contraceptive method in Mali and throughout many other parts of Sub-Saharan Africa because it can be used clandestinely. The integration of FP and immunization services likewise seems to provide some degree of cover and discretion for women who want to access contraception, but feel they must do so secretly.

Behavior Change Communication: Promoting LARCs While Maintaining Balanced Counseling and Choice

For years, FP programs and service delivery providers have emphasized short-acting methods, despite the many benefits of LARCs and many women’s preference for long-acting options. The reasons for this are many including: a lack of providers trained and confident in LARC service provision, negative

experiences with older LARC models, a lack of commodities and supplies, myths and misconceptions and price barriers. As a result, IUDs and implants have been chronically under-promoted, undervalued and underutilized.

According to the 2006 Demographic Health Services, LARC use in Mali was less than 1%. As mentioned above, in 2011 PSI/Mali qualitative research found that women hold a number of misperceptions about LARCs including a fear that LARCs cause infertility, concerns that the methods migrate to other parts of the body and fears that LARCs cause illness or infection.

All PSI FP programs embrace and promote firmly the standard of informed choice and volunteerism. At all service delivery and counseling sites, during all *ProFam* outreach activities, PSI ensures that clients receive counseling on all of the contraceptive methods available. However, given the uneven playing field, more in depth information on IUDs and implants is needed during counseling sessions if programs hope to reverse the trend of underutilization.

ProFam’s outreach events include two counseling sessions. The first is a group session with women waiting for immunization services for their children, and the second is individual counseling with women who express an interest in obtaining a method that day. During the group sessions, the PSI/Mali or CSCOM midwife takes additional time to outline the benefits of LARCs and to address specific known myths and misconceptions about the methods. Bear in mind that the PSI/Mali midwives are trained champions of the methods and personally believe in the benefits the methods offer. Several are even satisfied users. This personal belief in safety and efficacy of the methods allows the midwives to respond to client concerns with an increased degree of comfort and conviction.

In addition, PSI/Mali has worked to rebrand and reposition the IUD. Since implants are relatively new, they tend to carry less baggage about myths and misconceptions. The IUD, however, has been around longer and suffers from many myths and misconceptions. In addition, the intimate nature of the IUD insertion process discourages some women and providers from the method. Further, the Bambara word for “IUD” is the name of a wooden utensil used to stir stew—a reference to the method’s

13 Yoder, P. Stanley, Mouhamadou Guèye and Mamadou Konaté. 2011. *The Use of Family Planning Methods in Mali. The How and Why of Taking Action.* Calverton, Maryland, USA: ICF Macro.

14 Ibid.

15 PSI/Mali 2011 TRAC survey.

T-shape. These utensils, which range in size, do not conjure a comforting mental image for potential users. In 2011, the PSI/Mali team conducted a DELTA marketing workshop aimed at developing new social marketing strategies and plans for PSI/Mali's core products and services. During this workshop, PSI/Mali decided to rebrand the IUD with the Bambara term "N'Terini", which means "my accomplice." PSI/Mali's midwives as well as the CSCOM providers and all promotion campaigns now refer to the IUD in this way. With this new name, PSI aims to distance the product from the older IUD models and reposition it as a product that women can trust and think of as a reliable, intimate friend. The name "N'Terini" is meant to replace the unpleasant image of a large wooden utensil and give a positive spin on the intimacy of the method.

During the individual counseling sessions, each method is again discussed and providers answer any additional questions before a woman makes her final selection. In this way, PSI/Mali aims to ensure that each woman is informed of her options, truly understands the benefits and drawbacks of each—including LARCs—and can ably determine which method best suits her needs.



PSI/Mali midwife Madame Kouma inserting an implant.

midwife picks up IUDs, implants and consumables from the PSI office, which she then carries with her to each clinic.

PSI midwives are not only firm believers in the safety and efficacy of LARCs, they are skilled LARC service providers. It is not uncommon for a single midwife to insert as many as 30 LARCs in a day. It is important to note that part of the success of the program is due to the provision of these dedicated, LARC providers, who unlike the CSCOM staff, do not have competing duties or

pressures on their time. They are dedicated solely to the provision of FP counseling and LARC service delivery. LARC service provision, particularly IUD insertion, requires more time than the provision of short-acting methods. The PSI dedicated provider has the time to properly counsel women on what to expect with a LARC, as well as to complete the LARC insertion.

Role of the CSCOM Provider

A key component of the *ProFam* partnership is provider training. PSI and the MOH conducted formal classroom and practicum training for selected staff from the designated CSCOMs. The training was meant to pave the way for CSCOM providers to become confident and competent in providing IUD and implant insertion services without the guidance and assistance of PSI midwives. In addition, it was designed to ensure that CSCOM providers could provide post-service counseling and/or removal services for LARC clients who return during regular service hours. The 11-day training focused on modern contraceptive technology with an emphasis on IUD and implants, including complication and adverse event management and IUD and implant removal services. To receive a certificate of completion, providers had to successfully insert five IUDs and from implants under supervision from the PSI midwife.

ProFam outreach events provide PSI midwives and trainers with an opportunity to further mentor and coach CSCOM staff who are new to LARC counseling, insertion and removal. The PSI midwives work closely with the CSCOM staff to organize and execute the event. The CSCOM staff often assist in or lead the

SERVICE DELIVERY

Benefits of the Dedicated Provider

On the day of the *ProFam* event, each CSCOM must provide a room for individual client counseling and service delivery. Usually this is a small room with a desk, two chairs, an exam table, and occasionally a stool and a lamp for the provider to use during insertions. At times services are provided in an empty labor and delivery room. Should a woman go into labor and need the room, services are temporarily suspended or shifted to another area of the clinic.

To insure that a lack of equipment, consumables and/or product do not impede services, PSI has traditionally provided these materials during the outreach event. Each PSI midwife has her own kit with four sets of insertion equipment. Once a week, the

initial group counseling session and in individual counseling. Overtime, CSCOM providers become better at answering questions and addressing myths related to LARCs and in turn at building demand for these services. CSCOM providers also assist in service delivery by conducting the actual insertions when able. This allows the PSI/Mali midwives to observe the providers' technique and to offer on-the-spot advice and hands-on coaching. CSCOM providers are therefore able to build their confidence and skills under the direct tutelage of PSI/Mali's experienced LARC champions.

RESULTS

Contraceptive Uptake

After applying a strong social marketing lens to the LARC landscape, identifying key strategies related to price, product, promotion and place, and expanding those strategies to both the public and private sectors, PSI/Mali's reached 166,383 women with IPC messages on FP during urban outreach events between 2010 and 2011. Of those, 41,023 (24.6%) chose and received a LARC. Prior to the program, roughly two out of every 1,000 Malian women was using a LARC. Now, looking exclusively at the results of the *ProFam* private and public sector outreach program, that number has risen to 1 out of every 100 Malian women—a remarkable increase.

A sizeable proportion (48.4%) of women who received one of the two LARCs were not using contraception at the time of the visit. This implies a potential upward shift in the overall CPR for Mali, particularly when PSI/Mali's results are viewed together with the efforts and results of other LARC method programs recently implemented by partner groups such as Marie Stopes International and the Malian branch of the International Planned Parenthood Federation.

A total of 42.4% of acceptors shifted from use of a short-acting hormonal method (oral or injectable) in favor of an IUD or implant. This is significant because these women have now shifted to a more reliable and more cost-effective method. It also confirms that many women have been using short-acting methods despite a need for longer-term protection.

Data also reveal that the program is reaching a younger population of users with LARCs. Between 2010 and 2011, a majority of implant acceptors (48.4%) were young women under

the age of 25, while a growing number of IUDs users (40.9%) were 29 or younger.

Table 2. Method Used by Women before LARC Insertion

Previous Method Used	Percent of Women Choosing a LARC
None	48.4%
Condom	1.6%
Oral Contraceptives	19.2%
Injectables	23.1%
LARC	1.5%
Standard Method Days	0.1%
Other	0.1%
Unknown	5.9%

PSI and CSCOM providers alike have provided anecdotal reports of a growing number of young, unmarried, nulliparous women coming to the *ProFam* outreach events as well as to regular CSCOM service days in search of a LARC method. The 2010 and 2011 data capture this, revealing that while the majority of acceptors have at least one living child, a significant percentage (13.6%) are nulliparous women, the majority of which (97% vs. 3%) selected an implant. Among implant clients, 26% are unmarried, compared to only 7% of IUD clients. No specific campaigns targeting youth were carried out; the increased use among women under 25 comes mainly from word of mouth. In PSI's 2012 client exit interviews, 97% of women 15-20 and 99% of women 21-25 would recommend the provider to a friend.

Midwife, ASACO 1, Lafiabougou 1:

"We are seeing more young women, unmarried and without children. They come during the immunization day and say that they heard about the services. They ask for the implant. For young women FP is not as taboo as it is for some of the older women."

While IUD use is growing, with 880 acceptors in 2010 and 2,595 acceptors in 2011, the data seems to indicate a preference among Malian women for the contraceptive implant. In 2011, in every age category, the number of implant acceptors exceeds that of IUD users.

Table 3. Number of Women who Opted for Implant or IUD, by Age Group, 2011

Age Group	Implant Acceptors	IUD Acceptors
<20	4,365	199
20-24	4,514	433
25-29	3,803	581
30-34	2,429	552
35-39	1,542	401
40-45	552	184
>45	86	48

Client Satisfaction

In a 2012 PSI exit interview survey of 293 LARC clients in 30 CSCOMs in Bamako, 97% of clients were satisfied or very satisfied with the welcome they received from the provider, 99% were satisfied or very satisfied with the skill of the provider and 83% were satisfied or very satisfied with the wait time. When asked if they would recommend the service to a friend, 99% responded that they would recommend the CSCOM and 98% would recommend the provider. Primary reasons for choosing this CSCOM for FP services were reputation (40%), convenient location (39%) and familiarity (15%). In total, 85% of clients had visited the CSCOM in the past for other services.

Health Systems Strengthening

In 2008, LARC services were virtually unavailable at the CSCOM level. However, between 2009 and the close of 2011, over 40,000 women received a LARC at a public sector CSCOM facility. This would not have been possible without the strong commitment and continual support demonstrated throughout the project by the MOH's DSR and the DRS. The MOH advocated for the program at both district and community levels, emphasizing the importance of FP and opening doors for PSI/Mali's outreach activities. Simultaneously, PSI/Mali and the MOH focused on three key elements to promote the long-term sustainability of these services at the CSCOM level: provider training and mentoring in both FP counseling and service delivery, consistent access to low cost commodities and provision of insertion equipment.

Provider Training

Between 2009 and 2011, trainers from PSI, the DSR and DRS worked hand-in-hand to train 149 CSCOM providers in LARC counseling and service delivery. These providers came from 50

of Bamako's 55 CSCOMs, five in Kayes, six in Segou, seven in Sikasso and five in Koutiala. Each received additional mentoring and coaching during PSI/Mali's *ProFam* outreach events to increase provider self-efficacy and confidence in delivering these services. In addition, members of the DSR, DRS and the Malian Midwives Association conduct regular supervision visits to clinics in collaboration with PSI/Mali staff.

Increasing Consistent Access to Low Cost Commodities for Clinics and Women

While PSI/Mali provides the product and consumables during outreach events, CSCOMs must use their own stock for clients who request the product during regular service hours. Public and private sector facilities have access to IUDs and implants through the government's central medicines store, the Pharmacie Populaire du Mali (PPM). While the Malian government receives FP products free from donors USAID and the United Nations Population Fund, the PPM sells the products to those clinics who request them. In the public sector, the CSREF purchases directly from the PPM and then sells at a mark-up to CSCOMs. In 2011, PSI/Mali, the DSR, the DRS and other key stakeholders advocated for a reduction in the PPM's price for both the IUD and implant. The goal was two-fold: to reduce the price and slightly increase the margin for providers, and ultimately to reduce the overall price for the consumer. The PPM was selling at IUDs and implants at 1000 CFA (\$2) each. The PPM agreed to lower their price to 500 CFA (\$1) for LARCs.

Ensuring that the consumer price remains low requires not only a reduction in the commodity price at the PPM level, but also a commitment by the CSCOMs. In February 2012, PSI/Mali and the DRS organized a meeting with leaders of the CSCOM management structures to seek agreement on the maximum consumer price for both the IUD and the implant. The president of the ASACO, the head doctor and the focal point for FP from each CSCOM were invited to attend. During this meeting, chaired by the Director of Health of Bamako, participants discussed the pricing strategy for offering IUDs and implants interdependently of PSI/Mali's outreach program. Taking into account the cost of the products from the national pharmacy and consumables such as gloves, cotton and anti-septic, the group agreed on a client price of 2000 CFA (\$4) for insertion of either the IUD or implant and 1000 (\$2) for removal. A 2011 PSI/Mali study shows that 78% of women who have used implants or IUDs would be willing to pay this price in the CSCOM. In a 2012 PSI exit interview survey, 91% of clients who received a

LARC at a CSCOM paid 2000 CFA or less, and 89% said the price they paid was acceptable or low.

In working with the CSCOMs during *ProFam* outreach events, it was soon evident that many suffered a lack of LARC insertion equipment and consumables that could prove to be a barrier to LARC service delivery outside of *ProFam* service days. To address this and to further secure CSCOM commitment in respecting the maximum consumer price, PSI/Mali with funding from the Dutch Government provided each of Bamako's 55 CSCOMs with a full set of insertion equipment, consumables and a stock of 20 IUDs and 50 Jadelle implants. In return, each ASACO/CSCOM signed a memorandum of understanding that includes a commitment to honor the agreed maximum consumer price for IUD and implants.

Stakeholders at both the CSCOM and DRS level have indicated high levels of satisfaction with the partnership and the results it has delivered.

"The results of this program have been very good. It has strengthened the capacity of the CSCOM providers and of the sector. We are now reaching the population with these services and we anticipate that we will see a reduction in unmet need."

**-Fatima Sibi, Director
Bamako Regional Department of Health**

The role of DSR and DRS in reducing the price of LARCs at the PPM, and in garnering ASACO/CSCOM support for the maximum consumer price, demonstrates considerable country-level commitment to the promotion of LARCs and FP in Mali. Further, based on the success of the *ProFam* outreach program, the DSR and DRS actively encourage other NGOs in Mali to promote and provide LARCs. Expansion of LARCs have been designated the number one priority in the national strategic plan for FP and MDG 5.

ANALYSIS: STRENGTHS, WEAKNESSES, OPPORTUNITIES AND CHALLENGES

The strengths of the *ProFam* outreach model and its expansion to Mali's primary health care system are abundant. By taking the dedicated provider model and expanding it to CSCOMs, the program effectively links high quality supply with latent de-

mand at the service delivery points where most Malian women seek care. Also, by combining the venue for the delivery of behavior change communication messages with the venue for the delivery of LARC services, the model provides women with an immediate opportunity to translate increased knowledge into action. Further, the integration of immunization and FP services appears to cater to some women's need to access FP without the knowledge of their spouse and/or other family members. Finally, the tremendous results in terms of LARC use confirm that a gap in public sector services existed and is now being addressed by the model.

However, the model is not without weaknesses. If PSI/Mali attempted to replicate the model in a more rural setting, the cost and time for midwives to travel between clinics would be greatly increased and the overall client volume would likely be lower, increasing the overall cost per CYP. In addition, when extending into more rural areas, price sensitivity increases and women may be less willing or able to pay for products and services. As a result, this model may not be appropriate outside of urban and peri-urban geographic areas.

An additional weakness is that the involvement of CSCOM providers in both the group counseling session and in service delivery is mixed across facilities. In some instances the CSCOM provider does not have the time to participate, while in other cases, a lack of interest appears to be at play. This poses a challenge for the long-term sustainability of these services, which will be discussed momentarily.

While there may be limitations in terms of potential expansion of the model to Mali's most rural areas, expansion to peri-urban areas is one opportunity that PSI/Mali is currently pursuing. With newly launched operations in several regional capitals, PSI/Mali hopes to expand routine LARC access to those areas outside of Bamako where population is moderately dense and providers can expect a regular client flow and demand for LARCs.

The successful integration of FP and immunization services begs the question as to whether other information or services could be integrated into the same delivery point. Given the population of women who attend immunization services, it is conceivable that key messages and products related to nutrition, safe drinking water, exclusive breastfeeding and other neonatal and child health interventions could be integrated.

However, the desire to conduct further integration must be balanced with an awareness that integrating too many messages may result in over saturation, diluting the key messages and resulting in less impact.

The model has two primary challenges for the future. The first is to continue to increase informed demand for IUDs while increasing overall CPR. The second, and perhaps greater challenge, is ensuring the long-term sustainability of LARC services at the CSCOM level. The long-term sustainability of services is dependent on the degree to which CSCOM providers truly embrace and champion LARCs, the extent to which other demands on their time prohibit or allow them to provide LARC services and the degree to which CSCOMs will honor the agreed consumer price and whether additional increases in price will dampen consumer demand.

Many of the CSCOM providers and managers are already concerned that a maximum consumer price of 2000 CFA just barely allows the facility to cover costs. Since IUDs come in kits that include all of the necessary consumables, a client price of 2000 CFA provides a small margin of profit to support operational costs of the CSCOM. However, because the implant is sold as only the product and trocar, providers must purchase consumables separately. As a result, 2000 CFA only allows CSCOMs and providers to break even, without any support for staff time or other operational costs. These costs also imply a continued subsidy for certain products, particularly implants given their high unit cost.

In 2012, PSI/Mali will launch a USAID-funded operations research pilot in which a subset of 30 CSCOM clinics will be randomized into three groups that will receive varied degrees of support from PSI. All groups have received training, insertion material and initial stock of both IUDs and implants from PSI. During the pilot, the first group of clinics will receive supervision and a data collection visit once a month from PSI. No *ProFam* outreach activities will be conducted with this group and no further product or materials will be donated. The second group will receive weekly supervision and coaching from PSI staff during immunization day activities. However, PSI midwives will not conduct the counseling or actual service delivery of the methods. The third group will maintain the current model, with PSI midwives providing products and materials and conducting the outreach counseling and LARC service delivery with assistance from the CSCOM staff.

Results of the operations research will be evaluated on level of stock maintained, number of insertions, perceived quality from client exit interviews, service delivery quality based on supervision assessments and provider perceptions. Results will greatly inform how the MOH and PSI proceed in increasing the long-term sustainability of LARC services in Mali.