MCHIP Mali End of Project Report

October 2010 – June 2014

Submitted on:
August 1, 2014

Submitted to:
United States Agency for International Development
under Cooperative Agreement # GHS-A-00-08-00002-000

Submitted by:
MCHIP

The Maternal and Child Health Integrated Package (MCHIP) is the USAID Bureau for Global Health's flagship maternal, neonatal and child health (MNCH) program. MCHIP supports programming in maternal, newborn and child health, immunization, family planning, malaria, nutrition, and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health and health systems strengthening.

MCHIP brings together a partnership of organizations with demonstrated success in reducing maternal, newborn and child mortality rates and malnutrition. Each partner will take the lead in developing programs around specific technical areas:

Jhpiego, as the Prime, will lead maternal health, family planning/reproductive health, and prevention of mother-to-child transmission of HIV (PMTCT);

JSI—child health, immunization, and pediatric AIDS;

Save the Children—newborn health, community interventions for MNCH, and community mobilization;

PATH—nutrition and health technology;

JHU/IIP—research and evaluation;

Broad Branch—health financing;

PSI—social marketing; and

ICF International—continues support for the Child Survival and Health Grants Program (CSHGP) and the Malaria Communities Program (MCP).

This report was made possible by the generous support of the American people through the United States Agency for International Development (USAID), under the terms of the Leader with Associates Cooperative Agreement GHS-A-00-08-00002-00. The contents are the responsibility of the Maternal and Child Health Integrated Package (MCHIP) and do not necessarily reflect the views of USAID or the United States Government.

Country Summary

Selected Health and Demographic Data for Mali	
Total Population	14,517,176
GDP Per Capita (USD)	699
Maternal Mortality Ratio	464
Skilled Birth Attendance	59%
Neonatal Mortality Rate	35
Infant Mortality Rate	58
Under-Five Mortality Rate	98
Total Fertility Rate	6.1
Total Health Expenditure per Capita	42

Source: World Bank, Mali DHS 2006 and 2012-2013

Major Program Activities

- **Integrated MNCH/FP-N interventions spanning the household to hospital continuum of care (HHCC)**
  - ***Postpartum Family Planning (PPFP) including long acting reversible contraception (LARC)***
  - ***Active Management of the Third Stage of Labor (AMTSL)***
  - ***Essential Newborn Care (ENC)***
  - ***Helping Babies Breathe (HBB)***
  - ***Integrated Community Case Management (iCCM)***
  - ***Community-based distribution of family planning***
  - ***Postnatal Care Home-visits***
  - ***WASH***
  - ***Nutrition***
- **National level policy and strategy development support**

Program Dates	October 1, 2010 – June 30, 2014					
Total Mission Funding	$9,777,630					
Total Core Funding	$300,000					
Geographic Coverage	**No. (%) of Regions**	2	**No. of Districts**	7	**No. of facilities**	166
MCHIP In-Country Contacts	Aissata (Aida) Lo, Chief of Party, Aissatou.lo@savethechildren.org					
HQ Managers and Technical Advisors	Anita Gibson, agibson@mchip.net; Pat Taylor, ptaylor@mchip.net; Rebecca Levine, rlevine@mchip.net; Erin Fleming, efleming@mchip.net; Alyssa Om'Iniabohs, aominiabohs@mchip.net; Winnie Mwebesa, wmwebesa@savechildren.org; Karen Waltensperger, kwaltensperger@savechildren.org; Eric Swedberg, eswedberg@savechildren.org; Serge Raharison, sraharison@mchip.net; Nefra Faltas, nfaltas@mchip.net; Soo Kim, skim@mchip.net; Holly Blanchard, hblanchard@mchip.net; Anne Pfitzer, apfitzer@mchip.net; Tsigue Pleah, tsigue.pleah@jhpiego.org; Devon Mackenzie, dmackenzie@mchip.net; Bethany Arnold, Bethany.arnold@jhpiego.org; Ian Moise, imoise@savechildren.org; Aimee Dickerson, adickerson@mchip.net					

Table of Contents

List of Tables and Figures

Acronyms and Abbreviations

AMM	Malian Mayors' Association
AMTSL	Active Management of the Third Stage of Labor
ASACOS	Community Health Association
ASC	Community Health Worker
ATN- Plus	Assistance Technique National Plus
BCC	Behavior Change Communication
CBO	Community-Based Organizations
CHA	Community Health Agent
CNIECS	The National Center for Health Information, Education and Communication
CPR	Contraceptive Prevalence Rate
CSCOM	Community Health Center
CSO	Civil Society Organization
CSREF	Referral Health Center
DHS	Demographic Health Survey
DNS	National Directorate of Health
DSR	Department of Reproductive Health
DTC	Technical Director
ECOWAS	Economic Community of West Africa States
EDS	Demographic Health Survey
ENC	Essential Newborn Care
FANC	Focused Ante Natal Care
FBC	Facility-Based Care
FBIP	Facility-Based Integrated Package
FELASCOM	Federation of Local Health Associations
FENASCOM	National Federation of Community Health Associations
FERASCOM	Federation of Regional Health Associations
FP/PPFP	Family Planning/Post-partum Family Planning
GOM	Government of Mali
HBB	Helping Babies Breathe
HCI	Healthcare Improvement Project
HHCC	Household to Hospital Continuum of Care
HMIS	Health Management Information System
HPP	Health Policy Project
iCCM	Integrated Community Case Management
ICH/MUSKOKA	Improving Child Health/Muskoka Initiative
IP	Integrated Package
IUD	Intra-Uterine Device
KMC	Kangaroo Mother Care
LARC	Long-Acting Reversible Contraceptive
LBW	Low Birth Weight
LiST	Lives Saved Tool
LOP	Life of Project
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MCHIP	Maternal and Child Health Integrated Program
MCHIP/HQ	Maternal and Child Health Integrated Program Headquarters
MIP	Malaria in Pregnancy
MNCH	Maternal, Newborn and Child Health
MNCH/FP	Maternal, Newborn and Child Health/Family Planning

MOH	Ministry of Health
MSI	Management Systems International
NGO	Non-Governmental Organization
OC	Oral Contraceptive
ORT	Oral Rehydration Therapy
PKC II	Project Keneya Ciwara II
PLWHIV	People Living With HIV/AIDS
PMI	President's Malaria Initiative
PNC	Postnatal Care
POPPHI	Prevention of Post-Partum Hemorrhage Initiative
PPIUD	Post-Partum IUD
PRODESS	Policies, Norms and Procedures' in the 'Ten Year Plan for Social and Health Development
PSI	Population Services International
SEC	Essential Community Package
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SPS	Strengthening Pharmaceutical Systems
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water and Sanitation
WHO	World Health Organization

Acknowledgments

The Maternal and Child Health Integrated Package (MCHIP) is the U.S. Agency for International Development Bureau for Global Health's flagship maternal, neonatal, and child health program. MCHIP supports programming in maternal, newborn and child health, immunization, family planning, malaria, nutrition and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health, and health systems strengthening. Visit www.mchip.net to learn more.

This program and document were made possible by the generous support of the American people through the U.S. Agency for International Development, under the terms of the Leader with Associates Cooperative Agreement GHS-A-00-08-00002-00. The contents are the responsibility of MCHIP and do not necessarily reflect the views of the U.S. Agency for International Development or the United States Government.

The Maternal and Child Health Integrated Package (MCHIP) gratefully acknowledges the Malian Ministry of Health which has consistently provided leadership in the scale up of maternal, child and newborn health services, reproductive health and family planning. MCHIP also gratefully acknowledges USAID/Mali and USAID/Washington which have provided financial support and guidance to MCHIP in the implementation of this program.

MCHIP would also like to acknowledge the following staff in-country for their dedicated years of service:
Aida Lo, Houleye Diarra, Modibo Kanté, Tiguida Sissoko, Francine Buranga, Mohamed Traore, Drissa Ouattara, Djibril Kouma, Seydou Niamaly, Abdourahmane Coulibaly, Kassim Bengali, Mohamed Séga Sissoko, Nialen Kaba, Assiata Tandina Haidara, Kader Kouma, Fatoumata Fatoumata Traoré, Mariame Bougoudogo, Aissata Maiga, Fatoumata Diakite, AboubaKar Dokan Koné, Ibrahima Yoroté, Jeremie Goita, Mahamane Maiga, Modibo Kane Oumou Traoré, Jean Pierre Diarra, Djbril Barry, Bougou Coulibaly, Oumar Badjé Koné, Cheick Madani Coulibaly, Josué Kodio, Moussa Traore, Amidou Koné, Adama Coulibaly, Samaké Gniné, Tounkara Lassine, Adama Fadiga, Nouhou Dembelé, Keita Mamadi, Joseph Dembele, Moussa Diawara, Nantenin Traoré, Modibo Kamissoko, Salifou Kone, Oumar Koné, Yagaré Kanté, Mamadou Faba Traoré, Yacouba Ballo, Moulaye Diarra, Mahamadou Sidibé, Hasseye Seydou Cisse.

Executive Summary

The USAID-funded Maternal and Child Health Integrated Program (MCHIP) was launched in Mali in 2010 following the identification of the country as one of USAID's 30 priority maternal and child health countries for increased investment. MCHIP/Mali's vision was to significantly contribute to accelerated and sustainable improvement in maternal, newborn, and child health (MNCH) in Mali, through the scaling up of evidence-based, high-impact, integrated public health interventions. MCHIP/Mali worked strategically at the national, regional, and districts levels building and expanding on existing platforms to promote proven and effective maternal, newborn, and child health and family planning (MNCH/FP) programming.

From 2010 to 2014, MCHIP/Mali's activities were informed by the following objectives (which were refined during the course of the project):

> **Objective 1.** Contribute to improved national health strategies, policies, and programs that increase the population's access to an affordable integrated package of high impact MNCH/FP interventions;
>
> **Objective 2.** Improve access to and the quality and efficiency of, the essential community package (SEC) through implementation and monitoring and evaluation (M&E) support in the two Regions of Kayes and Sikasso;
>
> **Objective 3.** Improve access to and the quality and efficiency of facility-based integrated maternal, newborn health and family planning (MNH/FP) services;

In keeping with these objectives, MCHIP/Mali's key technical areas included:

- ***Maternal health:*** in order to reduce morbidity and mortality associated with pregnancy, labor and delivery, and the post-partum period;
- ***Newborn health:*** to reduce illness and death associated with newborn asphyxia, prematurity and low birth weight;
- ***Child health:*** to reduce morbidity and mortality associated with the most common causes of childhood illness including diarrhea, malaria, and pneumonia;
- ***Postpartum Family Planning:*** to reduce maternal, infant and child mortality and morbidity, avert unintended pregnancies, and support healthy pregnancy spacing;
- ***Cross-cutting*****:** capacity-building and training; monitoring and evaluation (M&E), health management information systems (HMIS), research; and health promotion, communication, and advocacy.

MCHIP's activities were designed to increase access to and utilization of quality, integrated, evidence-based MNCH/FP interventions across the Household to Hospital Continuum of Care (HHCC) and spanned the antenatal care period up to a child's fifth year of age, the prevent-protect-treat continuum, and the policy, health facility, and community levels.

MCHIP worked hand in hand with the Ministry of Health (MOH) and with other key partners, supporting activities at the national level as well as in select regions and districts. MCHIP began work in the Districts of Kita and Diéma in the Kayes Region and expanded to the Districts of Bougouni, Selingué, Kolondieba, Yanfolila and Yorosso in the Sikasso Region in 2013. Over the life of the project, MCHIP strengthened the quality of MNCH/FP services available, at the community and facility levels, to a population of over 1.49 million.

Critical to the success of many of MCHIP's activities was the forging of key strategic partnerships within the Malian public health community. From 2010-2014, the MCHIP team built strong relationships and formed close collaborations with numerous departments/units within the MOH as well as with other key partners and stakeholders including other USAID-support projects, international organizations such as UNICEF and WHO, NGOs and CBOs, and key professional societies and associations.

Through focused and consistent cooperation, coordination, and collaboration with these stakeholders, MCHIP realized several important program successes over the life of the project. Life of project performance is shown in Table 1 for select project indicators.

TABLE 1. Summary of Life of Project Performance by Select Project Indicators

Indicator	Baseline	LOP Performance	Notes
Number of national policies guidelines or documents developed or revised with MCHIP support	0	6	Includes both the SEC and Reproductive Health National Strategic Plans
Number of new family planning acceptors in the last 12 months in MCHIP supported districts	5,198	20,294	Figure includes both acceptors at the health facility level and via ASCs
Percentage of sick children with malaria receiving appropriate treatment by ASCs in MCHIP supported districts	61%	96%	Data collected during quarterly ASC supervision visits
Percentage of mothers with a postpartum/newborn visit within 2 days of birth by ASCs in MCHIP supported districts	33%	61%	Data source: Baseline and endline survey conducted in Kita and Diema (2011 and 2014)
Percentage of women delivering in MCHIP supported facilities receiving AMTSL	72%	85%	HMIS Data

Endline Survey Results

Noteworthy results from MCHIP's endline survey conducted in April 2014 in the Kayes districts of Kita and Diema are highlighted below:

- **Birth spacing:** Baseline and endline survey results suggest that women are now more aware of the need for adequate birth spacing. Indeed, the proportion of women who think there should be at least 24 months between two consecutive births rose from 50* in 2011 to 66% in 2014. Moreover, the tendency to rely on God for the number of children to have declined considerably from 33% at the start of the program to just 12% by the end.
- **Contraception:** Knowledge of contraceptive methods is almost universal (98% in 2104), with use of a modern method increasing from 11% in 2011 to 14% in 2014. Among those who used modern methods, findings showed women are more likely to use long term methods such as injectables and implants.

- **ANC & SBA:** While not statistically significant, increases were seen in the number of women attending ANC visits (74% to 80%) and those giving birth in a health facility (47% to 50%).
- **Essential Newborn Care Practices:** Findings show progress was made in delaying the first bath for newborns from 52% in 2011 to 61% in 2014. A noteworthy increase in the administration of colostrum was found with an increase from 79% at the start of the project to 89% by 2014.
- **Postnatal Care:** As highlighted above, postnatal care visits for mothers and newborns within 2 days of birth, increased dramatically from 33% in 2011 to 61% in 2014.
- **Management of Childhood Illness:** Feeding practices during an episode of diarrhea among children under 5 years of age showed positive change in the behaviour of mothers. There was a significant increase in mothers who reported giving more fluids or breast milk during an episode of diarrhea and those who reported administering ORS.
- **Exposure to MNCH/FP Messages:** Exposure to mass media messages related to maternal and child health increased dramatically amongst mothers interviewed from 24% in 2011 to 53% in 2014.
- **Health Facility Readiness:** Findings showed that the availability and stock of key commodities including oxytocin, vitamin K, and magnesium sulphate increased between 2011 and 2014. Of particular note in the increase in facilities with oxytocin available at the time of the survey, from 50% in 2011 to 100% in 2014.

Major Project Accomplishments Across the Household to Hospital Continuum of Care

- **MCHIP served as a major catalyst for improved national policies in support of MNCH/FP.** For example, MCHIP supported the updating, review, development, and/or finalization of several key MNCH policies and guidelines such as the National Reproductive Health Strategic Plan, the "Soins Essentiels Communautaires" (SEC) Implementation Guide and Strategic Plan, and focused antenatal care (FANC) guidelines to include revised WHO guidance on intermittent preventive treatment of malaria for pregnant women; and strengthened the leadership and stewardship role of the MOH at national, regional, and district levels.

- **MCHIP supported the development, roll-out, and implementation of the SEC.** At the community level, MCHIP supported the effective implementation of the "Soins Essentiels Communautaires" (SEC) which is delivered by a new cadre of salaried community health workers (Agents de Santé Communautaire or ASC) to extend simple preventive and curative services into communities located greater than five kilometers from a *Centre de Sante Communautaire*/Community Health Center (CSCOM). By identifying, training, equipping, and supporting ASCs in its target districts, MCHIP ensured a package of evidence-based

"The villagers call me 'Doctoro Muso' (Lady Doctor). I like my work – the villagers respect me! They always greet me properly and invite me to their baptisms and weddings. The fact that I am respected enables my messages to get through and helps me better care for people".

- *MCHIP trained ASC, Soulouba Village*

preventative and treatment focused interventions including integrated community case management of childhood illnesses (iCCM), postpartum and postnatal care visits for mothers and newborns, and family planning were available to vulnerable communities. Over the course of the project MCHIP trained 426 ASCs and 3,318 relais (community volunteers who conduct health promotion activities).

- **MCHIP supported scaling-up of under-utilized and newer MNCH interventions in target districts.** MCHIP supported the introduction or revitalization of several evidence-based, high-impact MNCH interventions including Kangaroo Mother Care (KMC) for managing low birth-weight (LBW) babies; Helping Babies Breathe (HBB) for newborn resuscitation; long acting and reversible contraception (LARC) such as implants and post-partum intrauterine devices (PPIUD) and integrated community case management (iCCM) for managing sick infants and children in the community.

- **MCHIP introduced an innovative, skills-based training approach to improve effectiveness of MNH/FP clinical training.** MCHIP introduced an integrated MNH/FP training approach at the regional and district level, which emphasized acquisition of skills and competencies for Active Management of the Third Stage of Labor (AMTSL), Essential Newborn Care (ENC) including the Helping Babies Breathe (HBB) newborn resuscitation training; and postpartum family planning with an emphasis on long acting methods. As part of this program approach, MCHIP developed training materials, prepared trainers and oriented supervisors to plan for and conduct post-training follow-up and provide supportive supervision. Between 2010 and 2014, MCHIP trained over 600 facility-based health care workers.

MCHIP trained midwife, counseling mother of an 8 hour old newborn on postpartum family planning options

> *"Nothing is insurmountable; it is just a matter of having the right competencies to get the work done. I would never have imagined that I would ever one day insert either an IUD or a Jadelle implant. Before, at the CSCom, we would only observe when teams would come out from Bamako to carry out Jadelle insertions"*
>
> – MCHIP trained midwife

- **MCHIP supported various program learning activities with documented results which have influenced national learning and policy.** Learning from various MCHIP led and/or supported studies including the National SEC Evaluation, SEC LQAS Household Survey, and SEC Qualitative Study, were utilized to inform national policy and practice. This includes, most notably, the National Strategic Plan for

the SEC recently developed by the Secretary General's office, which details the scale-up of the SEC throughout the nation and outlines the government's plan for financing the SEC which has been a key issue since the outset of the SEC initiative. MCHIP also implemented a demonstration study to assess the feasibility and safety of midwifery assistants (matrons) providing contraceptive implants at CSCOMs with the assumption that task-shifting long acting family planning methods to matrons will safely increase the availability and choice of family planning methods for all women, specifically during the first year postpartum.

Recommendations for the Way Forward

Mali, while showing some encouraging data gains in combatting mortality and morbidity, still has a long road ahead to reverse the unacceptably high mortality levels among women and children under five. Below are some key recommendations for the way forward based on MCHIP's experience and learning over the last four years of program implementation.

- Advocacy for/support provision of high-level coordination for MNCH/FP activities within the MOH in order to strengthen national-level strategic planning, coordination, and program implementation.
- Advocacy for inclusion and standardization of high-impact MNCH/FP packages and competency-based training approaches into pre-service education curricula.
- Strengthening MOH capacity in the area of health information systems and monitoring and evaluation.
- Strengthening supervision of ASCs through the integration of supportive supervision with other outreach activities to reduce the burden on the health system. And consideration of extending supervisory roles to other health cadres, including the nurses at the CSCOM level, rather than leave the responsibility solely on the head doctor in charge.
- Increased and improved community preparation and engagement for ASCs to ensure they are fully integrated into the community upon posting.
- Prioritize the capacity-building of civil society organization in an effort to strengthen their ability to mobilize communities for improved knowledge, access to, and utilization of MNCH/FP services. The capacity-building of local CSOs will foster further community engagement in health programs and facilitate sustainability and local ownership of community interventions.

Introduction

Mali is a landlocked country in West Africa with a population of 14.85 million people. It is ranked 182 out of 186 countries in the Human Development Index (UNDP 2013) with approximately half of the population living on less than $1 US a day. In 2013, spending on health was just $42 per capita (World Bank 2013). Despite recent improvements, most notably in under-five mortality, Mali's health indicators remain among the worst in the world. The risk of dying in the perinatal period is unacceptably high at 464 maternal deaths per 100,000 live births (DHS 2006). While dramatic declines in under-five mortality from 191/1000 in 2006 to 98/1000 in 2012/13 and infant mortality from 96/1000 in 2006 to 58/1000 in 2012/13 (DHS) have been seen, preventable and treatable diseases such as pneumonia, diarrhea, and malaria remain the leading causes of death among Malian children under five. Neonatal mortality according to the 2012/13 DHS was 35 per 1000 live births reflecting only a slight decline from 38 per 1000 five years previously. These rates are accompanied by high fertility - the Total Fertility Rate was 6.1 in 2012 having only barely declined from 6.6 in 2006. Fertility decline is impeded by low contraceptive use illustrated by a national contraceptive prevalence rate (CPR) of just 9.9% and a CPR of 6.8% in rural areas.

Further complicating the country situation was 18 months of political instability following the March 2012 coup d'etat that resulted in economic sanctions by the Economic Community of West African States (ECOWAS) and suspension of some donor funding to Mali.

MCHIP/Mali Goal and Objectives

In 2009, MCHIP submitted an initial concept paper for the introduction and/or scale-up of family planning, postpartum hemorrhage and newborn health interventions to USAID/Mali. In early 2010, USAID/Mali approved the MCHIP concept paper and communicated its intention to allocate additional field support funding for a three year program focused on evidence-based, high-impact, MNCH/FP interventions.

MCHIP's goal in Mali was to contribute to the reduction of maternal, newborn, and child mortality through increased access to and utilization of integrated, evidence-based packages of maternal, newborn, child health and family planning (MNCH/FP) interventions at both community and facility levels with a geographic focus on the Districts of Kita and Diéma in the Kayes Region and the Districts of Bougouni, Selingué, Kolondieba, Yanfolila and Yorosso in the Sikasso Region (beginning in January 2013).

From 2010 to 2014, MCHIP/Mali's activities were informed by the following objectives (which were refined during the course of the project):

> **Objective 1.** Contribute to improved national health strategies, policies, and programs that increase the population's access to an affordable integrated package of high impact MNCH/FP interventions;
>
> **Objective 2.** Improve access to and the quality and efficiency of, the essential community package (SEC) through implementation and monitoring and evaluation (M&E) support in the two Regions of Kayes and Sikasso;
>
> **Objective 3.** Improve access to and the quality and efficiency of facility-based integrated maternal, newborn health and family planning (MNH/FP) services;

In keeping with these objectives, MCHIP/Mali's key technical areas included:

- ***Maternal health:*** in order to reduce morbidity and mortality associated with pregnancy, labor and delivery, and the post-partum period;
- ***Newborn health:*** to reduce illness and death associated with newborn asphyxia, prematurity and low birth weight;
- ***Child health:*** to reduce morbidity and mortality associated with the most common causes of childhood illness including diarrhea, malaria, and pneumonia;
- ***Postpartum Family Planning:*** to reduce maternal, infant and child mortality and morbidity, avert unintended pregnancies, and support healthy pregnancy spacing;
- ***Cross-cutting*****:** capacity-building and training; monitoring and evaluation (M&E), health management information systems (HMIS), research; and health promotion, communication, and advocacy.

Implementation Strategies

MCHIP's program activities can be categorized into two key priority implementation strategies.

Soins Essential Communautaire: Community health services in Mali are currently delivered through a decentralized network of almost 900 primary health care clinics (Centres de Santé Communautaire, CSCOMs) which are owned and operated by community health management associations (ASACOs) who oversee the day to day management of the CSCOM and its links with the community. In recent years, the MOH, with support from various partners including MCHIP, developed a new community health worker strategy to increase the utilization and coverage of evidence-based, high-impact maternal and child health services at the community level.

The national essential community package (SEC) is delivered by a new cadre of salaried community health workers (Agents de Santé Communautaire or ASC) to extend simple preventive and curative services into communities located greater than five kilometers from a CSCOM. This package includes the treatment of uncomplicated malaria and acute respiratory infections (ARI), referral and accompaniment of severe cases of malaria and ARI, treatment of diarrhea, diagnosis and management of malnutrition, essential newborn care, and provision of family planning, including encouraging newly delivered mothers to exclusively breastfeed, use lactation amenorrhea method (LAM) and timely transition to other FP methods by providing community-based distribution of pills, condoms, and injectable contraception (Depo-Provera). The ASCs also provide behavior change communication (BCC) messaging to promote high-impact household practices, including use of skilled birth attendance, supervise relais, and collect routine data.

ASCs are supervised by the Directeurs Techniques du Centre (DTCs) – physicians who manage the CSCOMs and are responsible for the quality provision of services by midwives and nurses in their facilities. The DTCs are supervised by District and Regional health authorities.

Over the course of the project, MCHIP played a key leadership role at the national, regional, and districts levels to support the successful implementation of the community health strategy with the objective of improving the health of women, children, and their families.

Facility-Based Integrated Package of Care**:** In Program Year 1, MCHIP developed a women-centered "facility-based integrated package" (FBIP) of care to address some of the key gaps identified in health facilities in the Districts of Kita and Diema in an integrated manner.

The FBIP focused on improving the skills of health care providers in Active Management of the Third Stage of Labor (AMTSL), Essential Newborn Care (ENC), Helping Babies Breathe (HBB), and long acting reversible contraception (LARC) focused on postpartum women. The interventions included in the FBIP are described below in Figure 1. It is important to note that in Program Year 3 during the suspension period, MCHIP expanded the FBIP trainings to 80 secondary health centers that are not part of the formal government system.

Figure 1: Interventions Included in MCHIP's Facility-Based Integrated Package

- **AMTSL** includes the : (1) Administration of a uterotonic drug within 1 minute after the baby is born (oxytocin is the uterotonic of choice), (2) Controlled cord traction (CCT) with counter traction to support the uterus; and (3) Uterine massage immediately after delivery of the placenta.
- **ENC** includes immediate care to the newborn (thermal control (drying, wrapping and delayed bathing), immediate and exclusive breastfeeding, cord care, prevention of infection. Providers were also trained in identification and appropriate management of sick newborns to include asphyxia (neonatal resuscitation via HBB), infection (treatment with antibiotics), and preterm/low birth weight babies (Kangaroo Mother Care).
- **HBB** In June 2010, the Helping Babies Breathe (HBB) initiative was formally launched as the state-of-the-art approach for managing birth asphyxia in the developing world. MCHIP utilized the HBB training curriculum to ensure all skilled birth attendants at the CSCOM level were able to perform successful newborn resuscitation.
- **PPFP** includes counseling on immediate and exclusive BF, return to sexual activity, risks of unintended pregnancies, healthy spacing of pregnancies—for couples to wait at least two years before they try to get pregnant again, use of LAM and the transition to other methods compatible with breastfeeding, inclusive of long-acting methods such as IUDs, PPIUDs, and implants at the CSCOM. Family planning provision and services will reach out to women who have children younger than two years.

Coverage and Scope

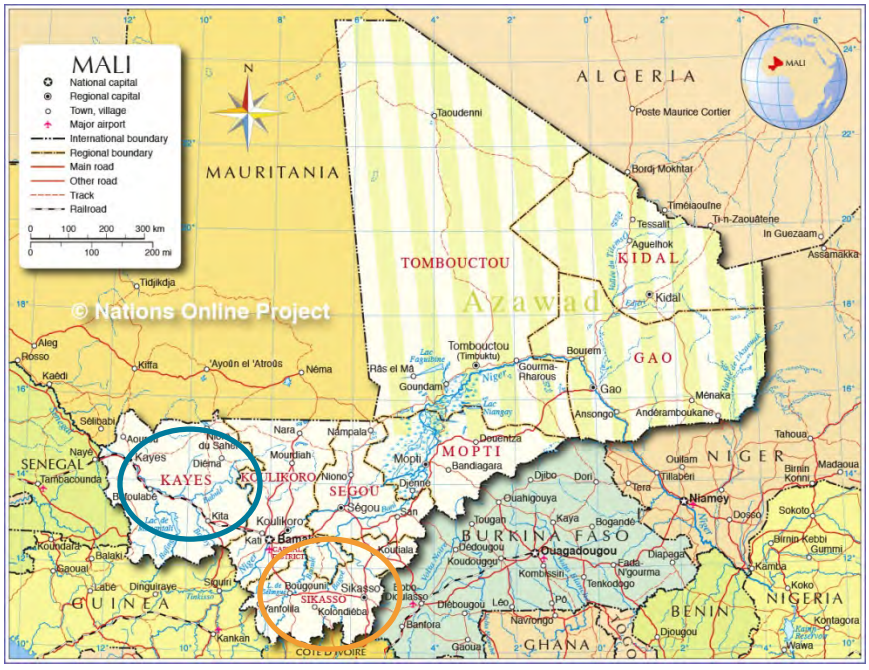
The coverage and scope of MCHIP's interventions ranged from substantive influence on national policy guidelines to the support of community health workers and local associations such as women's groups.

- **National Level:** Collaboration with the MOH (except during period of suspension), engagement/collaboration with FENASCOM, Associations and professional bodies such as the National Association of Midwives
- **Sub-National Level:** Implementation in two of Mali's eight regions (Kayes and Sikasso beginning in 2013). In Kayes, located in the western part of the country, MCHIP worked at the regional level and in the two districts of Kita and Diéma. Beginning in 2013, MCHIP worked in Sikasso (located in the south-east) in the five districts of Bougouni, Kolondieba, Yanfolila, Selingue and Yorosso. Across these seven districts MCHIP reached a total population of approximately 1.49 million including an estimated 336,000 women of reproductive age and 253,000 children under-five. Within these seven districts MCHIP worked in:
    - 11% of Referral Health Centers (CSREFs), or seven out of 60 nationally
    - 15% of CSCOMs, 159 out of 1050 nationally
    - 19% of ASC, 426 out of 2213 nationally
    - 3318 community health volunteers ("relais")

Figure 2: Map of Mali

MCHIP worked with the Regional Directorate of Health and the Kayes Referral Hospital (CSREF) in addition to implementing the SEC and Facility-Based Integrated Package in the two districts of Kita and Diéma in the region of Kayes

Beginning in January 2013, following the end of a three-year bilaterally funded USAID iCCM project, MCHIP began implementation in five districts of the Sikasso region: Bougouni, Kolondieba, Yanfolila, Selingue, and Yorosso



In the following sections, we describe in more detail some of the key initiatives and interventions that MCHIP/Mali supported during its life of project (October 2010 – June 2014) as well as highlights of the project's major accomplishments. This report concludes with lessons learned and recommendations for future project implementation.

Additional information contained in the Annexes include life of project results against our project targets (Annex 1); selection of project success stories (Annex 2); a list of presentations given by MCHIP/Mali staff at international conferences (Annex 3); and a list of materials and tools developed or adapted by the project (Annex 4).

Major Accomplishments

MCHIP/Mali worked hand in hand with the MOH and other partners, supporting activities at the national level as well as in select regional and district levels. MCHIP/Mali's strategic approach was guided by the following key principles:

- Scaling-up proven, evidence-based interventions;
- Maximizing resources through strategic integrated programming; and
- Building on existing efforts of programs and partners;

Critical to the success of the many of MCHIP's activities was the forging of key strategic partnerships within the Malian public health community. From 2010-2014, the MCHIP team build strong relationships and formed close collaborations with numerous departments/units within the MOH, as well as with other key partners and stakeholders including:

- Other USAID-supported projects and partners (ATN-Plus, PKC II, SPS, HPP, PSI, HCI, and others);
- NGOs and community-based organizations and associations (FENASCOM, FERASOM, FELASCOM, Save the Children, CARE, IntraHealth, Groupe Pivot, and others);
- Other technical partners (UNICEF, WHO, UNFPA, and others);
- Professional societies and associations (obstetrics/gynecology, midwifery, pediatric).

Through focused and consistent cooperation, coordination, and collaboration with these stakeholders, MCHIP realized several important program successes over the life of the project. Life of project performance is shown in Table 1 for select project indicators.

TABLE 2. Summary of Life of Project Performance by Select Project Indicators

Indicator	Baseline	LOP Performance	Notes
Number of national policies guidelines or documents developed or revised with MCHIP support	0	6	Includes both the SEC and Reproductive Health National Strategic Plans
Number of new family planning acceptors in the last 12 months in MCHIP supported districts	5,198	20,294	Figure includes both acceptors at the health facility level and via ASCs
Percentage of sick children with malaria receiving appropriate treatment by ASCs in MCHIP supported districts	61%	96%	Data collected during quarterly ASC supervision visits
Percentage of mothers with a postpartum/newborn visit within 2 days of birth by ASCs in MCHIP supported districts	33%	61%	Data source: Baseline and endline survey conducted in Kita and Diema (2011 and 2014)
Percentage of women delivering in MCHIP supported facilities receiving AMTSL	72%	85%	HMIS Data

Endline Survey Results

Noteworthy results from MCHIP's endline survey conducted in April 2014 in the Kayes districts of Kita and Diema are highlighted below:

- **Birth spacing:** Baseline and endline survey results suggest that women are now more aware of the need for adequate birth spacing. Indeed, the proportion of women who think there should be at least 24 months between two consecutive births rose from 50* in 2011 to 66% in 2014. Moreover, the tendency to rely on God for the number of children to have declined considerably from 33% at the start of the program to just 12% by the end.
- **Contraception:** Knowledge of contraceptive methods is almost universal (98% in 2104), with use of a modern method increasing from 11% in 2011 to 14% in 2014. Among those who used modern methods, findings showed women are more likely to use long term methods such as injectables and implants.
- **ANC & SBA:** While not statistically significant, increases were seen in the number of women attending ANC visits (74% to 80%) and those giving birth in a health facility (47% to 50%).
- **Essential Newborn Care Practices:** Findings show progress was made in delaying the first bath for newborns from 52% in 2011 to 61% in 2014. A noteworthy increase in the administration of colostrum was found with an increase from 79% at the start of the project to 89% by 2014.
- **Postnatal Care:** As highlighted above, postnatal care visits for mothers and newborns within 2 days of birth, increased dramatically from 33% in 2011 to 61% in 2014.
- **Management of Childhood Illness:** Feeding practices during an episode of diarrhea among children under 5 years of age showed positive change in the behaviour of mothers. There was a significant increase in mothers who reported giving more fluids or breast milk during an episode of diarrhea and those who reported administering ORS.
- **Exposure to MNCH/FP Messages:** Exposure to mass media messages related to maternal and child health increased dramatically amongst mothers interviewed from 24% in 2011 to 53% in 2014.
- **Health Facility Readiness:** Findings showed that the availability and stock of key commodities including oxytocin, vitamin K, and magnesium sulphate increased between 2011 and 2014. Of particular note in the increase in facilities with oxytocin available at the time of the survey, from 50% in 2011 to 100% in 2014.

Specific activities and achievements under each program objective are detailed below.

Objective 1: Contribute to improved national health strategies, policies and programs that increase the population's access to an affordable package of high impact MNCH/FP interventions.

Given the massive magnitude of need in Mali, MCHIP's strategic approach at the national level was forging and strengthening key partnerships and collaborations and providing high-quality technical assistance to influence the national public health dialogue. MCHIP sought to take on both a leadership and catalytic role by providing both technical and financial support to the MOH and its partners in planning; coordination; advocacy and resource mobilization; and policy, strategy, and national guideline development.

Specific MCHIP contributions included:

- Serving as secretariat for the two national mechanisms leading the management and governance of the SEC, the Group Ad Hoc and the Focal Points Group. In this role MCHIP help to achieve the following key results:
    - Development, finalization, and validation of the SEC Implementation Guide which includes training materials and curriculum, data collection and supervisory tools, and detailed roll-out and implementation plans;
    - Incorporation of the SEC into the National Policies, Norms, and Procedures in the Ten Year Plan for Social and Health Development (PRODESS);
    - Revision and validation of the national level training curriculum and manual for relais to detail their role in the SEC;
    - Drawing up of an accord between AMM and FENASCOM within PASEC framework (Project d'Appui au SEC) to ensure the sustainability of ASCs' salaries (via a mechanism whereby the Mayors' offices will transfer funds via the ASACOs);
    - Implementation of a comprehensive evaluation of the SEC to inform the final national strategy that included three specific studies:
        - The Lot Quality Assurance Sampling (LQAS), led by UNICEF, and completed in four MCHIP districts;
        - The assessment of the SEC implementation process completed in four districts (Bougouni, Diéma, Kita and Kolokani), in collaboration with UNICEF and SEC focal points;
        - The SEC qualitative study to dig deeper into some of the findings from the LQAS, particularly barriers to utilization.
    - Finalization and validation of a costed National SEC Strategic Plan developed based on findings from evaluations and learning from implementation phase. This Strategic Plan outlines the national scale-up of the SEC approach.
    - Greatly improved collaboration has been achieved between FENASCOM and AMM. FENASCOM is the national association of community health associations (ASACOS) that govern the management and finances of community health centers. AMM is the national association of Mayors' offices and coordinates local issues relating to policy, governance and accountability. The collaboration between the two organizations will ensure optimal coordination for sustainability and roll-out especially with regard to the AMM assuming responsibility for the future payment of ASCs' salaries. MCHIP facilitated the signing of a protocol between the two Associations in December 2013 which will increase collaborative support for the ASACOs and improve their relations with local Mayors' offices.

> ***"Because of MCHIP we are now at the heart of all child survival activities- before we facilitated and helped but now we play a key role as MCHIP has trained health workers and improved capacity for child survival. We are now playing the role that we should have always fulfilled!"***
>
> **M Toure, President, FENASCOM**

- Support for the revision, finalization, and validation of the National Strategic Plan for Reproductive Health and the National Strategic Plan for Family Planning
- Successfully raised the profile of postpartum family planning within the national reproductive health/family planning working group. In 2011, MCHIP effectively advocated for PPFP to be the focus area for annual national FP campaign;
- Establishment of national level technical working groups and responsible for advancing the national MNCH/FP agenda including PPFP and Malaria in Pregnancy (MIP);

- National and regional level advocacy, awareness-raising, health promotion, and health communications campaigns.

Objective 2: Improve access to and the quality and efficiency of the essential community package (SEC) through implementation and monitoring and evaluation support in the Regions of Kayes and Sikasso.

Identified as a key priority for both the Government of Mali and USAID, MCHIP supported the effective implementation at the regional level of the "Soins Essentiels Communautaires" (SEC) which is delivered by a new cadre of salaried community health workers (Agents de Santé Communautaire or ASC) to extend simple preventive and curative services into communities located greater than five kilometers from a *Centre de Sante Communautaire*/Community Health Center (CSCOM). By identifying, training, equipping, and supporting ASCs in its target districts, MCHIP ensured a package of evidence-based preventative and treatment focused interventions including integrated community case management of childhood illnesses (iCCM), postpartum and postnatal care visits for mothers and newborns, and family planning were available to vulnerable communities. Over the course of the project MCHIP trained 426 ASCs and 3,318 relais (community volunteers who conduct health promotion activities).

MCHIP's focus over the life of the project was to provide quality training of all SEC actors including regional and district level health officials, DTCs, ASCs, and relais; ensuring ASCs are adequately equipped with the required commodities and equipment; improving data collection and data use capacity of SEC actors; and increasing quality supportive supervision. MCHIP mobilized community engagement through regular radio broadcasts and health promotion fairs and through local community actors including "Women's Groups" to further encourage the acceptance of ASCs in the community and to promote complementary health messaging.

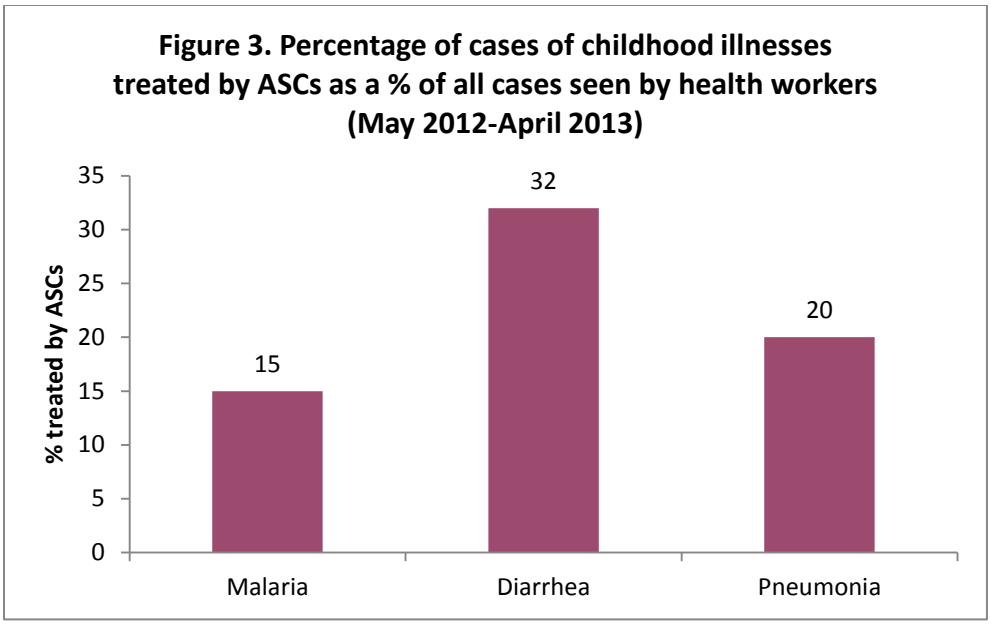
Over the life of the project, MCHIP:

- Trained 426 ASCs in the SEC package, including the updated nutrition curriculum, and data collection and reporting protocols;
- Trained 158 DTCs in the SEC package and supportive supervision;
- Trained 3,318 relais in Family Essential Practices including health promotion for improved nutrition and WASH practices and how to refer clients to ASCs;
- Distributed medical equipment in the 426 ASC sites to complement SEC activities including scales, thermometers and counters;
- Distributed complementary WASH equipment and supplies to 426 ASCs sites (for example, hand washing kits, waste bins, wwheelbarrows, rakes, etc.). These were linked to hygiene promotion activities that involved the ASCs, relais, women's groups and other village stakeholders in an integrated manner;
- In partnership with ATN plus, PKCII, Project Espagnol, organized a regional level workshop on child survival with an emphasis on SEC in Kayes involving all main actors including the state, civil society and local government representatives. This led to exchange and documentation around best practices and lessons learned. Fora involving the ASCs led to the exchange of tips for behavior change and to the 'imitation' of the most successful ASCs by others;
- Organized Annual Health Promotion Days (such as malaria, pneumonia and hand washing) involving integrated collaboration of all village actors (ASCs, 'relais', women's groups, etc.) and facilitating greater ownership of best practices and sustainable behavior change;
- Broadcasted preventive messages and the promotion of SEC serves through 15 local radio stations**;**

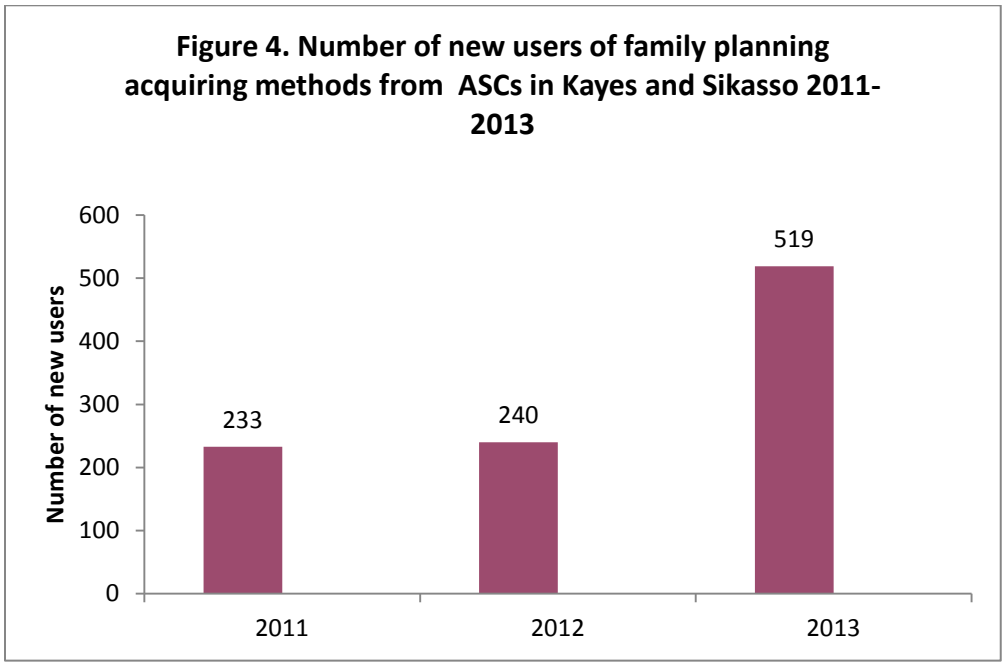
- Organized of seven health fairs (one in each district) to promote evidence-based preventive practices for MNCH/FP. An assessment to document the impact of these fairs was conducted and showed they both enhanced the utilization of ASCs and reinforced commitment of local MNCH/FP leaders who were rewarded for their leadership during the fairs.
- In collaboration with the Regional Directorates of Health and Regional Directorates of Hygiene, District teams trained 45 community agents in Selingue and Diema with regard to hygiene promotion and latrine use;
- Trained both leaders and members of 18 women's groups in Sikasso and Kayes in 'The Ten Commandments' for improved community health including the importance of ante-natal care, optimal food consumption during pregnancy, dangers signs in newborns, family planning, post-natal care, childhood nutrition and immunization and the importance of bed nets. The women already collaborated on small enterprise or gardening projects and could thus mobilize members' interest around health topics that had a natural synergy with the purposes of their existing groups to facilitate improved and cost-effective impact. The women's groups noted that they had increased their knowledge for behavior change, for example by gaining and transmitting new information about family planning, illness management and the importance of pre- and post-natal care. They recognized that changes in women's and children's health could not take place without the tacit or indeed overt involvement of men. MCHIP's capacity-building of their group had improved its cohesion and had subsequently allowed them to better leverage male involvement in maternal and child health.

Members of the women's group in the village of Solouba

Routinely collected data collected by the ASCs at the community level in Kayes and Sikasso and analyzed by the MCHIP M&E team indicated the significant contribution of ASCs in managing childhood illnesses. Figure 3 below shows that nearly one third of cases of childhood diarrhea were treated in the community by the ASCs compared with one fifth of cases of suspected pneumonia and 15% of cases of malaria. This represents a significant contribution by the ASCs and shows how they can provide faster, locally available and thus more effective care, as well as relieving the CSCOMs, and indeed clients, of additional costly consultations. The reason for the lower number of cases of pneumonia and diarrhea treated by the ASCs when compared with malaria may be due to the fact that malaria treatment of children under five is free whereas the treatment of other illnesses incurs costs for parents.



The ASCs also contributed to improved uptake of family planning with over 9,000 women receiving injectables, Pills, condoms or cycle beads from them in 2013 (it is important to note that MCHIP expanded into five new districts of Sikasso in 2013).



In addition to improving the uptake of short-term methods, the ASCs have been able to refer women to the CSCOMs for long- acting methods such as implants. They have also been able to address the socio-cultural factors which often act as barriers to family planning use, such as rumors and the negative attitudes and skepticism of men. In some settings, the ASCs and the community volunteers ("relais") work together to convince the community that family planning has social, economic and health benefits, not just for individual women but also for men and households as a whole. This successful collaboration therefore provides important support for behavior change (including gender-specific approaches) and improved health outcomes.

> ***"I help the ASCs with sensitization for family planning and MCHIP's training helped us address rumors. Some women think that if you use family planning it will make you sterile and often men do not like their wives to use it. So I give them correct information and help them see the benefits".***
>
> **Community outreach worker ("relais"), Soulouba**

The following important outcomes were also achieved through MCHIP's work under Objective 2:

- Training and post-training follow-up: The ASCs have been provided with intensive training and frequent follow-up to ensure that they retain and apply accurate information. Six weeks after their initial training they are followed up by the DTC and a support team from the District. This is a new and more intensive approach to local supervision than has been used previously in Mali.
- Mutual learning and support between the ASCs: This is achieved via the regular fora that have been organized to encourage the exchange of best practices and experiences.
- Data for Decision-Making: Workshops were organized in each District for the DTCs, the ASACO and Mayor in order to emphasize the concept of Data for Decision-Making. This enables the use of routinely collected data to orientate activities, community responses and to frame costing exercises.
- Women's groups: The women's groups noted that they had increased their knowledge for behavior change, for example by gaining and transmitting new information about family planning, illness management and the importance of pre-and post-natal care. They recognized that changes in women's and children's health could not take place without the tacit or indeed overt involvement of men. MCHIP's capacity-building of their groups had improved their cohesion and had subsequently allowed women to better leverage male involvement in maternal and child health.

- Improved individual capacity of ASCs to implement behavior change: ASCs improve their own self-confidence and command respect through their activities which, in turn, makes them more effective.

Objective 3: Improve access to and the quality and efficiency of facility-based integrated services in health facilities in MCHIP Districts.

A key component of MCHIP's approach was building the capacity of facility-based health workers to provide quality services across the antenatal to postpartum continuum of care. Rather than conducting traditional-style trainings (which tend to emphasize knowledge acquisition), MCHIP shifted the focus toward competency-based training which emphasizes the building of clinical skills. MCHIP's Facility-Based Integrated Package included Active Management of the Third Stage of Labor (AMTSL), Essential Newborn Care (ENC), Helping Babies Breathe (HBB), and long acting reversible contraception (LARC) focused on postpartum women.

Over the life of the project, MCHIP:

- Trained over 600 health-facility staff in AMTSL, ENC, HBB, and LARC;
- Trained 30 matrons in Diema in implant insertion (Jadelle). This is an innovative and important task-shifting initiative underscoring effective new national policy and making LARCs available to women at lower level facilities;
- Trained 15 Nurse-Obstetricians, Nurse Midwives trained in PPIUD in one District (Kita). PPIUD insertions were ground-breaking initiative supported by MCHIP as part of an integrated package responding to the need for a coordinated continuum of care integrating pre-natal, delivery and post-natal services;
- In collaboration with the Regional Health Directorate, trained 25 providers at Gabriel Touré (Bamako's teaching hospital) in PPIUD counselling. This important initiative at a leading national health facility (which sees both complex and urgent cases) has implications for the dissemination of learning to influence policy;
- Leveraging funding from The Global Fund, MCHIP financed the revision of the module of the management of malaria in pregnancy with the National Malaria Program and PSI Mali including data collection and reporting tools. This responds to PMI priorities and has important implications for global malaria policy. Subsequently, District trainers, DTCs and associated qualified personnel together with matrons were trained in the prevention and management of malaria in pregnancy.

Contraceptive prevalence in Mali increased from 6.9% (EDS Mali-IV 2006) to 10.3% (EDS-Mali IV 2012-13). In Kayes and Sikasso the 2012-13 prevalence was 6.4% and 10.8% respectively (from 5.1 and 6.0 in 2006). It is likely that MCHIP contributed, to some degree, to these In addition, matrons can now do implants and although it is too soon to talk of their influence on overall prevalence, it is likely that in future years, this initiative will make a significant impact especially among poorer women.

Figure 5 below shows, importantly, that the number of IUDs inserted by MCHIP-trained personnel in Sikasso and Kayes more than doubled from 2012-2013 to over 500. It should be noted that, MCHIP's contribution to overall regional prevalence of LARCs uptake is uncertain as the 2012-13 DHS report is only preliminary and does not yet break down contraceptive prevalence by method at a regional level.

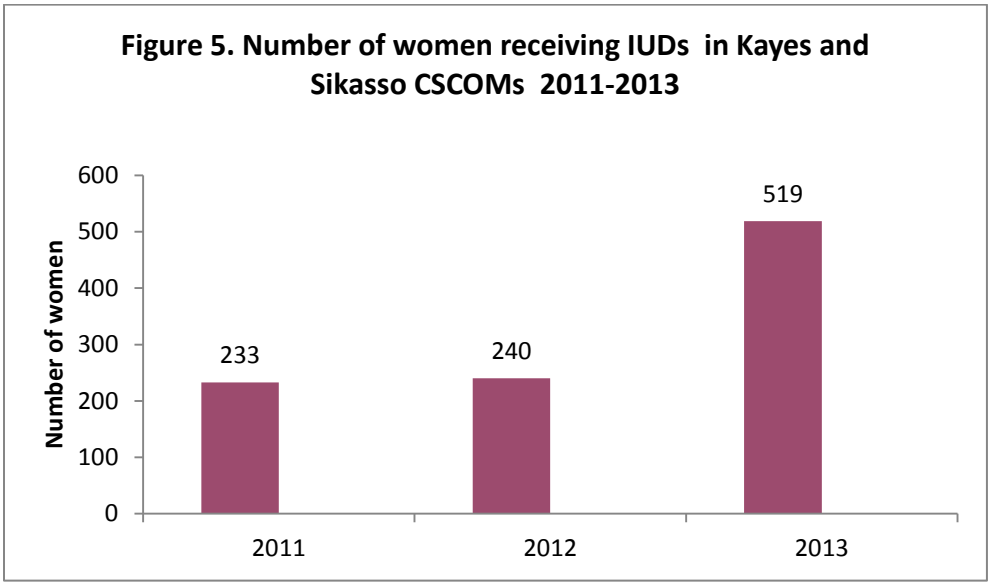
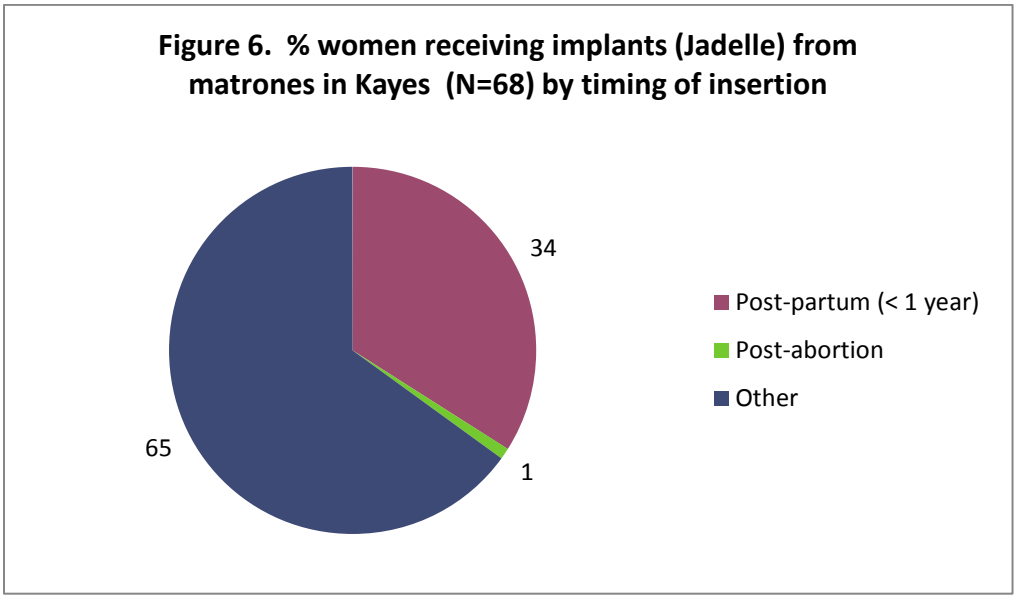


Figure 6 below shows that nearly one third of implant insertions by 68 trained matrons in Kayes were done in the post-partum period (one year after birth) contributing to the (Healthy Timing and Spacing of Pregnancy) as outlined in the Government's Norms and Procedures in Sexual and Reproductive Health. This is a very important result with implications for national policy and scale-up. Via this ground-breaking task-shifting initiative, MCHIP has clearly shown that matrons are capable of correctly inserting implants and adhering to quality standards. This is not only important for Malian reproductive health policy and on-the-ground provision, but also takes the field of reproductive health forward by providing internationally significant evidence in the domain of capacity building and community-level access with regard to LARCs.

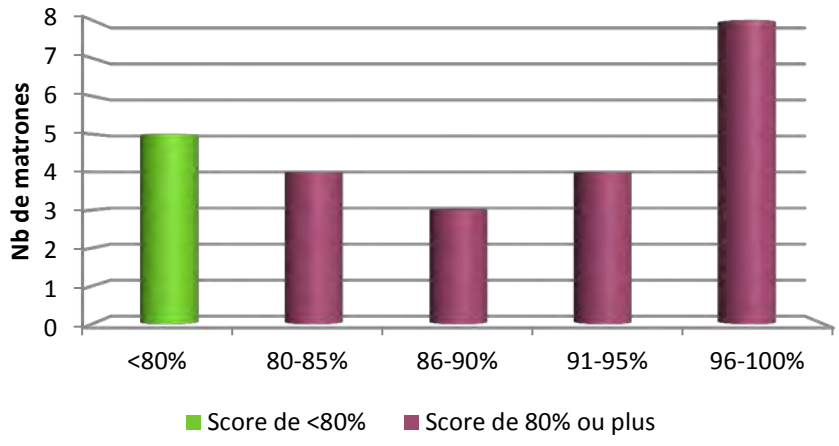


The following important outcomes were also achieved through MCHIP's work under Objective 3:

- Building of capacity of 1) The National Order of Midwives and 2) The National Association of Midwives via collaborative trainings with regard to PPIUD.
- In February 2014 MCHIP presented at an international conference (hosted by MCHIP and PSI) involving 11 countries in Ouagadougou. The presentation focused upon 'Scaling up Post-Partum IUD Services. As one of the first West African countries to implement PPIUD, MCHIP/Mali was able to share their innovative experience and lessons learned and thus build capacity among other countries yet to undertake the initiative.
- Increased ability of CSCOM personnel to respond to and provide appropriate neonatal and post-partum care and informed choice with regard to family planning.
- Improved ability and accountability of the ASACOs due to perceived evidence of improved CSCOMs' performance
- Wider impact of health personnel's advocacy skills gained through MCHIP training in other domains such as education.
- Proven ability of matrons to ensure quality with regard to implant insertions (see Figure 15 below). It should be noted that supportive supervision found that the quality of matrons' implant insertion was often better than that of qualified providers. Quality pertained to correct counseling, implant placement, pain management and follow-up (including appropriate systems for adverse events reporting and management).

"Since MCHIP intervened with the Integrated Package, the ASACO has performed better because the health personnel have been shown to be more effective in the eyes of the local population. - we no longer have to refer patients as often to higher level centers…In addition, I have been better able to communicate with patients using the IEC skills I gained through MCHIP's training – not just in health but in other areas - for example I am now better able to convince parents to send their children to school".
DTC, Keleya, CSCOM

Figure 7. Distribution of quality scores after supervision of matrons' insertion of implants one year after training (Juillet 2013) (n=24)



"As a matrone I am very proud to be able to insert Jadelle because before, for me, it was really only doctors and midwives who were able to do it".
Matrone Kounandi, Diouara CSCOM in Diema District

MCHIP had two additional objectives in the early years of the program. These were Objective 4: Increase access to AMTSL by facilitating the introduction of oxytocin in the Uniject device available on a national scale; and Objective 5: Contribute to the Organization of Islamic Conferences Framework in Mali through the development of a communication initiative addressing religious leaders support for maternal and newborn health and family planning.

Objective 4 was subsequently incorporated into Objective 3 which seeks to strengthen AMTSL training and provision. Uniject was not endorsed by the Malian Government and therefore dropped. Objective 5 was time-bound in Year 1 and successfully completed through activities with religious leaders in Kayes on Healthy Timing and Spacing of Pregnancy. In addition, in collaboration with the Health Policy Project, capacity-building among religious leaders was strengthened at national and District levels with regard to support for PPFP. Advocacy at the Organization of Islamic Conferences initiative in Mali in 2013 engaged religious leaders and civil society members to promote contraception for family well-being.

Cross-Cutting Themes

In addition to working across multiple technical areas, MCHIP was also designed to work across several cross-cutting themes. These included:

Equity
MCHIP prioritized increasing equity in health care access and utilization by targeting under-served populations, who are often amongst the poorest members of society. To enhance equity and access among such populations, MCHIP not only worked through the SEC to extend basic health care services to communities outside 5 km of a CSCOM but also worked with structures that were on the margins of mainstream health facilities, such as rural maternities, also known as 'secondary health centers'.

Scale-up
While MCHIP worked intensively in only the regions of Kayes and Sikasso, all MCHIP activities were designed with scale-up in mind. At the national level, MCHIP disseminated evidence of promising results and innovations and play a critical role in the development of various strategic plans that address national scale-up of MNCH/FP interventions including the SEC Strategic Plan and the Reproductive Health Strategic Plan.

Integration
MCHIP deliberately worked across the maternal and child continuum of care, and prioritized integrated of activities to the maximum extent possible. For example, MCHIP successfully advocated for the inclusion of other MNCH/FP interventions into the integrated SEC package of care including postnatal care visits. At the facility level, MCHIP developed an integrated, competency-based training package to ensure the health of women and their children from labor through postpartum care.

Community
MCHIP worked at the community level through the SEC, engagement with local community groups, and through extensive social and behaviour change activities. As part of SEC, MCHIP has succeeded in demonstrating and documenting a number of innovative and integrated community health approaches. Firstly, integration is a feature of the ASCs' successful collaboration with the relais who assist them with sensitization, orientation and follow-up as well as with introductions to village leaders and stakeholders in order to facilitate community support. Secondly, in the 426 intervention sites, ongoing and frequent supervision of the ASCs with feedback to local village stakeholders, such as women's associations, improves local participation and ownership.

Within the framework of social mobilization for behavior change, SEC organized health fairs. These aimed to promote both healthy practices and to allow the communities to better know the ASCs in their areas. In all, 7900 people were involved in the health fairs in seven Districts. The fact that they took place at a community level and involved local health personnel (ASCs and relais) as well as village stakeholders and actors (for example, young people's agricultural work groups) increased the cross-cutting nature of their impact and facilitated sustainability of community-based activities.

Service Quality
Under the SEC activities, service quality was improved among the 426 trained ASCs and the 158 associated community health centers (CSCOMs). In addition the relais also received additional training and quality issues were incorporated in National Implementation Plans for

both the relais and the ASCs. Furthermore, through MCHIP, additional training and community health initiatives around WASH and nutrition improved hygiene and the proximate determinants of child health outcomes. Quality was improved through the integrated SEC approach which both increased supervision frequency and engaged personnel at high levels of the health pyramid and health service structures as active members of supervision teams. With regard to Facility-based Care, quality was ensured by frequent post-training supportive supervision and on-the-job guidance. In particular, post-training observations of matrons revealed that the quality of their implant insertions was high. Importantly, the matrons, ASCs and other family planning providers placed great emphasis on informed choice. Those interviewed for this report said that they made sure that, during counseling, they presented clients with the full range of methods, even when women had come with a fixed idea about what method they wanted. All aspects of quality emerging from MCHIP have been appropriated by the Government as they are incorporated in the Implementation Strategy for SEC and into the revised norms and procedures for Reproductive Health.

Measurement and Monitoring

Measurement and monitoring was one of the cornerstones of MCHIP's work at the district level. Health workers were supported to develop skills to measure and monitor performance as a way of ensuring sustainability of quality service provision after MCHIP. For example via the ASCs' 'fora' MCHIP created "space" for an ongoing review of the SEC activities with input from local health structures and authorities at the Regional and District levels. Recently, MCHIP has provided training in 'Data for Decision Making' at the District level so that the SEC activities can better respond to local priorities and needs. Local tools and reporting systems are designed to collect timely and high quality data that can be used to inform local activities, responses (including human resource and training needs) and the ordering of commodities.

Lessons Learned and Recommendations

Mali, while showing some encouraging data gains in combatting mortality and morbidity, still has a long way to go to reverse the ever growing mortality crisis among women and children under five. Over the course of MCHIP's four year program in Mali, key lessons were learned that can help to inform future MNCH/FP programming in Mali.

Some of these key lessons learned include:

SEC

- The focus on practical demonstrations during the training of the ASCs improves knowledge acquisition and retention. Experiential learning techniques are better than the didactic approaches used in conventional health training.
- The reinforcing of capacity among the community volunteers ('relais') and the women's groups improve the ASCs' community mobilization. It creates synergies for community sensitization and catalyzes behavior change as the relais, women's groups and ASCs can work together to disseminate positive heath information.
- High quality supportive supervision improves the quality of care provided by the ASCs and increases the population's use of their services.
- The involvement of local focal points for health information systems in data analysis enhances local decision-making and the sharing of robust and harmonized health information at all levels. The health system can thus better respond to need and mobilize human resources and commodities accordingly.
- Making local-level data available to the District coordinators increases the completeness and timeliness of data submission, which, in turn, enhances data for decision-making
- Stock-outs of commodities and the turnover of ASCs negatively affect the use of services as clients become discouraged if they are unable to receive effective treatment of their children's illnesses. This can affect the position of the ASC in the community and the respect s/he generates. .
- The non-functioning of the coordination committees hampers problem solving and the correct implementation of activities and weakens both cost-effectiveness and potential for local evaluation and learning.
- The payment of the ASCs' consultation fees is a barrier to the service use. This is particularly well illustrated by the lower numbers of consultations for illnesses other than malaria which is treated for free.
- The 'fora' for ASCs facilitates the exchange of ideas and emulation of best practices.
- There is a demand among local population for additional services from the ASCs such as the administering of injections for adults, treatment of malaria in adults and assistance with delivery by ASCs who are also trained as matrons.
- The commitment on the part of the DTCs together with availability of the ASCs and the high quality of the care they offer increase the motivation of the local population to cover the community financial contribution.

Facility-Based Services

- Demand creation for LARCS needs to accompany the training of providers. In particular there is a need to better address rumors and misinformation about side effects. These particularly pertain to the use of the IUD which is not the method of choice in many areas due to a fear of sterility or fetal malformation.
- The providers mastered FBC as the training was delivered in stages. Their expertise was such that many went on, on their own initiative, to subsequently train others. Thus

cascade training and training of trainers has been shown to be an effective strategy for capacity building at the local level.
- The closely spaced supervision interval (every three months) leads to the improvement of service quality especially with regard to the matrons' insertion of implants. The supervision was supportive and led directly to sustained high quality.

Based on these learnings, MCHIP's recommendations for the way forward in Mali are:

Strategy, Policy and Programs
- To define the mechanism by which the ASCs' salaries will continue to be paid through a mechanism let by MOH in order to sustain donors investments in SEC. Ongoing discussions between MCHIP, PSI, UNICEF, Muskoka, Plan International, FENASCOM and the AMM to support MOH alternative plans for sustaining ASC salaries through a matching fund mechanism with the Global Fund who is willing to support the salaries of 3000 ASC over the next three years.
- To provide technical assistance for the roll-out of the child survival score card, LiST and the child survival road map
- To assist with the drawing up of the National Strategic Plan for SEC.
- To organize workshops for the sharing of best practice and of study results.

SEC
- Disseminate the implementation guide to all actors associated with the SEC package.
- Retraining of ASCs on the SEC package with an emphasis on family planning and newborn care.
- Increase supervision capacity of the DTCs by better integrating them into the supervision teams.
- Reinforce the supervision of the relais and the women's groups by the ASCs and the DTCs.
- Instigate micro-planning sessions for SEC at the 'aire de santé' (health area) level.
- Improve data for decision-making among ASACOs to asses cost effectiveness of SEC package.
- Put in place a harmonized data base for health information systems at Regional and national level to ensure timely data submission.
- Follow up with FENASCOM and AMM to ensure timely payment of ASCs' salaries via the ASACOS.
- Drawing up of the National Strategic Plan for SEC under the leadership of the National Directorate for Health and in collaboration with implementing partners including UNICEF, Plan Mali, PSI, Save the Children and civil society organizations (FENASCOM and AMM).
- Finalize sustainable system for the continuation and roll-out of SEC including working with FENASCOM and AMM to ensure payment of salaries.

Facility-Based Services
- Increase training activities with regard to LARCS with emphasis on training matrons to insert implants.
- Reinforce the capacity of the Regional and District supervision teams with regard to Facility-based Care and LARCS.
- Closer follow-up by DTCs and CSREFs (Regional Health Centers) for matrons who have not yet correctly mastered the technique of implant insertion.
- Post-training follow-up on PPIUD insertion with the technical assistants at head office.
- Increased supervision of health care providers trained in PPIUD insertion especially in Kita where training has taken place more recently.

- Workshop to harmonize training materials on PPIUD and to standardize PPIUD training approaches in Mali with the DSR, PSI, MSI in the Regions of Kayes, Koulikoro, Sikasso, Mopti.

Annex 1: Indicator Matrix

MCHIP/MALI Life of Project Performance Monitoring Plan (PMP): 2011 - 2014								
N°	**INDICATOR**	**DATA SOURCE / COLLECTION METHOD**	**FREQUENCY OF DATA COLLECTION**	**FY2011 DATA**	**FY 2012 DATA**	**FY2013 DATA**	**FY2014 DATA**	**Life of Project TOTAL**
Objective 1. Contribute to improved national health strategies, policies, and programs that increase the population's access to an affordable integrated package of high impact MNCH/FP interventions								
1.1	Number of guidelines or documents developed or updated with MCHIP support	Program records	Annual	2	2	2	1	**7**
1.2	SEC Focal Points Group Functional	Program records and meeting minutes	Quarterly		1	4	4	**9**
1.3	Number of Advocacy workshop organized with Civil Society to create awareness on maternal and newborn care and FP in Mali	Program records	Quarterly				1	**1**
Objective 2. Improve access to and the quality and efficiency of, the essential community package (SEC) through implementation and monitoring and evaluation (M&E) support in the two Regions of Kayes and Sikasso								
2.1.	Number of DTC and matrons trained on the SEC package in MCHIP supported districts	Training Information Management System (TIMS)	Quarterly				320	**320**
2.2.	Proportion of ASC who received at least 1 formative newborn/FP supervision visit in the prior 3 months in MCHIP supported districts	Supervision checklist	Quarterly				718/852 (84%)	**84%**
2.3.	Number of CSCOM providers (DTC) and MCHIP district officers oriented on the integrated supervision plan at the level of 7 districts in Kayes and Sikasso	Program records	Quarterly				166	**166**
2.4.	Proportion of CSCOM, ASCs and Relais in MCHIP supported districts who received at least 1 supervision visit during which registers	Supervision checklist	Quarterly				822	**822**

	and/or reports were reviewed in the past 3 months ****							
2.5.	Number of ASCs trained in the relais package (MNCH/FP services) in MCHIP supported districts	Training Information Management System (TIMS)	Quarterly			408		**408**
2.6.	Number of ASC who receive a monthly motivational stipend	Program records	Quarterly				326	**326**
2.7.	Proportion of radio stations that broadcast MNCH/FP, handwashing and hygiene related awareness messages	Program records	Quarterly				8/8 (100%)	**100%**
2.8.	Number of relais trained in MNCH/PF in MCHIP supported districts	Training Information Management System (TIMS)	Quarterly					
2.9.	Number of ASC sites with data collection systems and monitoring and supervision support	Program records	Quarterly			426	426	**852**
2.10.	Number of monthly meetings organized by the coordinator team in Sikasso and Kayes	Program records	Quarterly				12	**12**
2.11.	Number of workshops held on results of the SEC qualitative survey	Program records	Quarterly				5	**5**
2.12.	Proportion of ASC sites with a model of latrine with Sandlot slab	Program records	Annually				146	**146**
2.13.	Number of women trained on the preparation of enriched flour from local produce	Program records	Annually				114	**114**
2.14.	Number of ASCs trained on ACT case management in MCHIP supported districts	Training Information Management System (TIMS)	Quarterly			118		**118**
2.15.	Number of ASCs trained in the use of TDRs in MCHIP supported districts	Training Information Management System (TIMS)	Quarterly			118		**118**
2.16.	Number of fever cases seen by ASCs in MCHIP supported districts	ASC report	Quarterly			38,077		**38,077**

2.17.	Percent of fever cases tested by RDT or microscopy among children less than 5 years ©	ASC report	Quarterly			95%	34,933/ 39,124 (89%)	**92%**
2.18.	Number of RDTs examined for malaria from ASC patients in MCHIP supported districts	ASC report	Quarterly			36,315	34,933	**71,248**
2.19.	Number of RDT-confirmed ASC patient cases of malaria in MCHIP supported districts	ASC report	Quarterly			27,384	25,130	**52,514**
2.20	Number of children under 5, receiving ACTs for treatment of uncomplicated malaria in MCHIP supported districts	ASC report	Quarterly	1,693	5,753	29,146	29,321	**65,913**
2.21.	Percentage of sick children with malaria receiving appropriate treatment in MCHIP supported districts	Supervision checklist	Quarterly		66%	96%	92%	**85%**
2.22.	Proportion of malaria specific supervision visits conducted in MCHIP supported districts	ASC supervision	Quarterly		92%	56%		**74%**
2.23.	Number of cases of child diarrhea treated with ORS and ZINC in MCHIP supported districts	ASC report	Quarterly	658	1,863	8,377	9,271	**20,169**
2.24.	Percentage of sick children with diarrhea receiving appropriate treatment in MCHIP supported districts****	Supervision checklist	Quarterly		76%	89%	89%	**85%**
2.25	Number of cases of child pneumonia treated with AMOXICILLINE in MCHIP supported districts	ASC report	Quarterly	1,280	1,793	7,533	8,764	**19,370**
2.26.	Percentage of sick children with pneumonia receiving appropriate treatment in MCHIP supported districts ****	Supervision checklist	Quarterly		76%	88%	85%	**83%**
2.27.	Number of children <5 years old with moderate acute malnutrition (MAM) treated by the ASC	ASC report	Quarterly	371	1,753	6,789	9,104	**18,017**
2.28	Percentage of ASCs providing PFPP services in MCHIP supported districts	Supervision checklist	Quarterly		100%	100%	100%	**100%**
2.29	Number of new family planning acceptors through ASCs in MCHIP supported districts in the last 12 months	ASC report	Quarterly	280	2,538	9,479	9,666	**21,963**
2.30.	Couple Years Protected provided by ASCs in the last 12 months in MCHIP supported	ASC report	Quarterly	65	479	3,953	4,815	**9,312**

	districts							
2.31.	Number of women who received community level PF services in MCHIP supported districts	ASC report	Quarterly	11%	23%	19,142	21,861	**41,003**
2.32.	Number of women referred by ASCs to the facility for family planning services in MCHIP supported districts	ASC report	Quarterly	93	139	474	407	**1,113**
2.33.	Number of postpartum/newborn visits within 2 days of birth by ASCs in MCHIP supported districts	ASC report	Quarterly	695	1,489	19,954	9,604	**31,742**
2.34.	Percentage of SEC sites with all SEC commodities in stock in MCHIP supported districts****	Supervision checklist	Quarterly		62%	72%	65%	**66%**
2.35.	Proportion of ASCs a in MCHIP supported districts who received at least 1 supervision visit during which registers and/or reports were reviewed in the past 3 months ****	Supervision checklist	Quarterly		92%	39%	84%	**72%**
2.36.	Proportion of ASC sites with no expired or damaged medicine or diagnostics on the day of observation	Supervision checklist	Quarterly			87%	79%	**83%**
2.37.	Proportion of ASC who correctly managed waste	Supervision report	Quarterly			41%	81%	**61%**
2.38.	Number of ASC without ACT drug and RDT stock-out in last quarter	Supervision report	Quarterly			289	282	**571**
Objective 3. Improve access to and the quality and efficiency of facility-based integrated maternal, newborn health and family planning (MNH/FP) services								
3.1.	Number of health care providers trained in MNCH services (HBB and PI)	Training Information Management System (TIMS)	Quarterly	207	89	616	637	**1,549**
3.2.	Number of people trained through USG - supported programs****	Training Information Management System (TIMS)	Quarterly	356	89	4,782	1,252	**6,479**
3.3.	Proportion of CSCOM that received at least one supervision visit on Integrated Package in MCHIP supported district						43%	**43%**

3.4.	Number of new acceptors of FP methods in the last 12 months in MCHIP supported facilities	HMIS/service statistics/ facility records/FP registers	Quarterly	10,918	9,812	11,330	17,286	**49,346**
3.5.	Number of continuing users of FP methods in the last 12 months in MCHIP supported facilities	HMIS/service statistics/ facility records/FP registers	Quaterly			5,427	13,198	**18,625**
3.6.	Couple-Years Protection (CYP) in MCHIP supported CSCom and catchment areas	HMIS/service statistics/ facility records/FP registers	Quaterly	8,299	12,661	13,294	32,486	**66,740**
3.7.	Number of women receiving individual counseling sessions in immediate postpartum care and PAC for FP/RH in MCHIP supported facilities	Facility records/Delivery register/PAC register	Quaterly			11,291	13,449	**24,740**
3.8.	Percentage of women who receive individual counseling for FP/RH as part of PAC care in MCHIP-supported BEMOC structures in Kayes and Sikasso	Facility records/PAC register	Quaterly		88%	77%	89%	**85%**
3.9.	Percentage of women counseled in FP/RH in PAC service who accept a modern FP method	Facility records/PAC register	Quaterly			39%	81%	**60%**
3.10.	Percentage of MCHIP-supported facilities with delivery services that offer Active Management of the Third Stage of Labor	Supervision checklist	Quaterly	100%	97%	91%	100%	**97%**
3.11.	Percentage of women delivering in MCHIP-supported facilities receiving AMTSL	Facility records	Quaterly		94%	11,734	22,210	**33,944**
3.12.	Percentage of women who received a uterotonic immediately after birth in MCHIP-supported facilities	Facility records	Quaterly	97%	94%	86%	89%	**92%**
3.13.	Percentage of MCHIP-supported facilities with delivery services that offer Essential Newborn Care	Supervision checklist	Quaterly			91%	100%	**96%**
3.14.	Number of newborns receiving essential newborn care at MCHIP-supported facilities	Facility records	Quaterly		91%	12,249	22,708	**34,957**

3.15.	Percent of babies not breathing/crying at birth who were successfully resuscitated in MCHIP-supported facilities	Facility records	Quaterly		95%	96%	95%	**95%**
3.16.	Percentage of health facilities that received a supervision visit where correct adherance to biomedical waste standards were followed (as measured by use of medical waste box)	Supervion report	Quaterly			--	49%	**49%**
******USAID requested indicators for reporting**								

Annex 2: Success Stories

Matrons to Miracle Workers:
MCHIP SEC Training in Mali

In a small community in western Mali, an old African proverb has been revised:
It takes a village—and their community health worker—to raise a child.

As the sun rose over Baliani, a small community outside of Kita, Mali, a family of peanut farmers began to mourn. They were about to lose a child…again.

Kadiatou Dakite and her husband had lived in Baliani their whole lives. Since her 18th birthday, Kadiatou had given birth to four children. Only one had survived. During her fifth pregnancy, Kadiatou had attended her prenatal visits at the Madianbourgon CSCOM. When she was ready to deliver, Kadiatou's husband had driven her on his motor bike to the hospital. He had wanted her to deliver in a safe and healthy environment, and she did.

At first, this infant seemed healthier than her others had been. But on this morning, several days after the birth, Kadiatou wondered what more they could have done. She had tried for days to feed her child, but little Bayiri would not eat.

"I was very afraid for my child," Kadiatou says. "(My worry) gave me a stomach ache, and I could not sleep."

Kadiatou's husband and only other child, age eight, saw Kadiatou's distress, but no one knew what was wrong with the infant. Kadiatou's husband called for a local health worker and prayed for a miracle.

In Mali, the Dakite Family was not in unique circumstances. Mali has an under-five mortality rate of 128 deaths per 1,000 live births—the eighth highest under-five mortality rate in the world. Each year, 83,000 Malian children die before their fifth birthday. As a result, Malian women give birth to an average of 6.6 children during their lifetime. There are far more sick mothers and children than there are health workers to care for them. In fact, there are only 0.3 nurses and midwives per 1,000 population.

In 2009, USAID's flagship Maternal and Child Health Integrated Program (MCHIP) collaborated with Mali's Ministry of Health to develop a new community health worker strategy. The Soins Essentiels Communautaires (SEC) program was rolled out to train new community-based health workers to address the needs of women and children in the Kayes region of Mali. SEC training focuses on postpartum family planning (PPFP), integrated community case management (iCCM), and essential newborn care (ENC)—topics that collectively comprise the new national integrated essential community care package. In coordination with UNICEF and other partners, MCHIP has selected and trained over 400 community health workers. One of them was a young matron named Coumba.


Coumba Sidibe, MCHIP SEC trainee

In 2011, when Coumba Sidibe, then 21, learned that MCHIP was recruiting trainees for a new community-based health worker program in her village of Kita, she quickly applied and was

selected. Her husband was a metal smith, and she knew that the training would increase the salary she could bring home to her family. She was also eager to play a more prominent role in the health of others.

"I decided to become a health worker because I just did deliveries as a matron," Coumba says. "The training increased my skills. Now, I can follow a woman and her children (long after the birth)."

During her SEC training through MCHIP, Coumba was trained in a broad range of technical areas, including malnutrition, malaria, and family planning. Based on MCHIP and UNICEF studies, Coumba was able to determine the appropriate charges for her services. Coumba was then installed in the Baliani community by a local health center. For Coumba, the most challenging part of the process was bringing awareness of her services to the people of Baliani.

"At first it was difficult to teach everyone in the community what my job was—to let people know about the services I could provide," says Coumba. "So I went to each family to introduce myself and my services."

When Abou Tounkara, 74, the Chief of Baliani, learned of Coumba's arrival, he helped her spread the news of healthcare around the village. The chief was all too familiar with the obstacles that Baliani families faced when illness struck.

Abou Tounkara, Chief of Baliani

"Before (Coumba) arrived, the people needed to travel 12 kilometers to Kita for any sort of consultation or medical care. The only way to get there was on a potholed dirt role on a bicycle. It would take around an hour to get there," says the chief. "When people would get to Kita, they would wait a long time to be seen. This journey was especially difficult for the children."

According to Abou Tounkara, since Coumba's arrival, people of Baliani have spread the word of her services to nearby villages. Parents in Baliani and neighboring communities understand that Coumba had been trained to save their children's lives.

"Before there were many cases of disease, which could lead to the deaths of children," says the chief. "Since the health worker came here, there were no more cases of children's deaths, because when they became sick, they received medicine."

Indeed, on that sunny morning in Baliani, Coumba was summoned by Kadiatou's husband to visit the family's sick infant. When she arrived, Coumba immediately recognized that the child was close to death.

"I did not have the proper solution myself, so I brought the child to Kita on the husband's motorbike," says Coumba. "(The health facility) treated the child so it was soon healthy and feeding properly. If I had not been here, no one would have known what to do."

Since her child has grown healthy again, Kadiatou has been helping spread news about the MCHIP training that Coumba underwent. She hopes that other families will take advantage of this life-saving service in their communities.

"From my point of view, I would ask every woman to use the health worker's services," says Kadiatou. "She has the capability to take care of the woman and the child's health. And when

she doesn't have the solution, she can refer to the CSCOM (clinic), where more services can be given."

Kadiatou wishes that Coumba had been in her village in years past, when she lost her other three children. Still, she is grateful to Coumba and MCHIP's program for having saved Bayiri's life.

Kadiatou Dakite (left) and family

"If the health worker was not here," says Kadiatou, "the baby would have passed away."

In years to follow, MCHIP's achievements have continued to help villages like Baliani transform the health status of their mothers and children. As of December 2013, 92 percent of malaria cases among children in MCHIP-supported districts have received appropriate treatment. 2,727 children with diarrhea have been treated with ORS and ZINC—that's 89 percent of all cases. 85 percent of pneumonia cases among children in the region have been treated through MCHIP-trained community health workers. Over 3,300 children under the age of five have been treated for acute malnutrition. Through the hands of health workers like Kadiatou, thousands of lives have been saved.

Yet for Kadiatou, the current successes of MCHIP's SEC training programs in Mali are no reason to stop pushing for even greater progress in the future. Kadiatou aims to help bring all treatment rates to 100 percent, and to expand her services to cover vaccinations in order to avoid child illness in the first place.

"I would like even more capacity-building and training. That is why I wanted to become a (health worker)," says Coumba. "I decided to work in health care so I could do more in saving the lives of women and children."

Annex 3: List of Presentations at International Conferences and Publications

Presentation Title	Presenter Name & Title	Conference Name & Location	Date
"A Better Future for the Newborns of Mali" Poster	Dr. Nialen Kaba, Newborn Health Technical Advisor	Global Newborn Health Conference, Johannesburg, South Africa	April 2013
"Task-Sharing Matrons in Mali"	Aissata Tandina, Maternal Health & Family Planning Technical Advisor, MCHIP/Mali	Women Deliver, Kuala Lumpur, Malaysia	May 2013
"Health Information Systems and Monitoring of PPIUD Services"	Aissata Tandina, Maternal Health & Family Planning Technical Advisor, MCHIP/Mali	PPIUD Services: Start-up to Scale-up Regional Meeting, Ouagadougou, Burkina Faso	February 2014
"The Contribution of MCHIP to iCCM in Mali"	Dr. Ouattara Drissa, Child Health Technical Advisor, MCHIP/Mali	iCCM Evidence Review Symposium, Accra, Ghana	March 2014

Annex 4: List of Materials and Tools Developed or Adapted by the Program

Training Manuals and Materials
MCHIP Mali_Questionnaire Mid-Training on Integrated Package_French_May 2011
MCHIP Mali_Training Manual for providers on integreated MNCH_French_June 2011
MCHIP Mali_Training evaluation insertion of Jadelle implants_French_2012
MCHIP Mali_Training evaluation of insertion and removal of Jadelle and IUD_French_2012
MCHIP Mali_Mid-training questionnaire on implementation of Jadelle and IUD_French_2012
MCHIP Mali_Mid-term training questions for long-term methods_French_2012
MCHIP Mali_Mid-training questionnaire_French_2012
MCHIP Mali_Skills learning guide for implementation and removal of implants_French_2012
MCHIP Mali_Clinical skills learning guide for IUD_French_2012
MCHIP Mali_Screening questionnaire IUD implants_French_2012
MCHIP Mali_Training Manual for TBAs integrated MNCH_French_Nov 2012
MCHIP Mali_Trainer Manual Post-partum IUD_French_July 2013
MCHIP Mali_Participant Handbook Post-partum IUD_French_July 2013
MCHIP Mali_Reference Manual Post-partum IUD_French_July 2013
MCHIP Mali_Course Evaluation post-partum IUD_French_July 2013
MCHIP Mali_Training manual for TBAs integrated MNCH_French_May 2013
MCHIP Mali_Trainer Guide Essential Newborn Care_French_March 2009
MCHIP Mali_Reference Manual Essential Newborn Care_French_March 2009

MCHIP Mali_10 commandments for MCH for women's groups_French_2013
MCHIP Mali_Trainer's Guide for training community health volunteers_French_May 2013
MCHIP Mali_Training Manual for CHVs on key family practices for health promotion_French_May 2013
MCHIP Mali_National guide for essential community care_French_November 2010
MCHIP Mali_Quick Reference Sheet for medical eligability criteria (WHO)_ French_February 2012
MCHIP Mali_Verification list for implants_French_August 2012
MCHIP Mali_Participant workbook post-partum IUD_French_July 2013
MCHIP Mali_Trainer workbook post-partum IUD_French_July 2013
MCHIP Mali_Record of key family practices for health promotion_French_2013
Data Collection Tools
MCHIP Mali_Eligibility checklist of the client by CHW_French_September 2011
MCHIP Mali_FP registration by CHW_French_May 2011
MCHIP Mali_Checklist for IUD insertion_French_February 2012
MCHIP Mali_Notebook followup on essential family practices by CHVs_French_2013
MCHIP Mali_Guide for monitoring and supervision of CHVs_French_2013
MCHIP Mali_Checklist for eligibility of client by CHV_French_2013
MCHIP Mali_Self assessment for CHVs_French_2013
MCHIP Mali_Notebook Registration by CHVs_Bambara_2013
MCHIP Mali_Notebook recording child deaths 0-4 years_French_2013
MCHIP Mali_Notebook CHV Communication_Bambara_2013
MCHIP Mali_Counseling cards essential community care_French_2013
MCHIP Mali_Counseling cards essential community care_Bambara_2013

MCHIP Mali_Quarterly monitoring record for women's groups_French_2014
MCHIP Mali_Supervision guide of community health volunteers_French_May 2011
MCHIP Mali_Checklist for control and follow up in FP by CHW_French_May 2011
MCHIP Mali_Supervision skills form for qualified providers on implant insertion_French_February 2012
MCHIP Mali_Terms of reference for integrated supervision_French_2013
MCHIP Mali_Guide to systematic supervision_French_August 2013
MCHIP Mali_Registration for simple newborn care_French_December 2011
MCHIP Mali_Reference and contra reference sheet_French_May 2011
MCHIP Mali_Scorecard for child with maderate-acute malnutrition_French_May 2011
MCHIP Mali_Individual record of care of sick child_French_May 2011
MCHIP Mali_Registraion social and behavior change_French_February 2011
MCHIP Mali_Monthly activity report for CHWs_French_December 2011
MCHIP Mali_Inventory sheets materials medicines financial_French_December 2011