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Photo credit: Children watch as a woman and child practice hand washing in Mali. / WASHplus

Performance Evaluation of the High-Impact Health Services (SSGI) and the Social and Behavior Change Communication (KJK) Programs

Final evaluation report
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Prepared by:

Dr. Issakha Diallo, Evaluation Specialist/ Team Leader
M. Mamadou F. Camara, Research Coordinator and Quality Assurance Advisor
Dr. Arkia Diallo, MNCH/FP Technical Advisor
Dr. Mohamed Amadou Traore, Infectious Disease Technical Advisor
M. Sankaria Maiga, Behavior Change/Health, Communication Advisor
Dr. Elvira Beracochea, Technical Manager
Dr. Sarah Castle, Qualitative Data Specialist
Dr. John McCauley, Quantitative Data Specialist
KoitaConsulting: Local partner

Main contact:

M. Abou Kone, Program Manager, TMG, Inc., Washington, DC. Email: abouk@the-mitchellgroup.com
The Mitchell Group, Inc.
1816 11th Street, NW
Washington, DC 20001
Tel.: 202-745-1919

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ABSTRACT

Background:

Since December 2014, USAID has supported the High-Impact Health Services (Services de Santé à Grand Impact - SSGI) and Keneya Jemu Kan ((KJK) Social and Behavior Change Communication (SBCC) programs. This Mid-Term Evaluation explores whether these programs' activities are making progress toward planned results, and to what extent financial, management, and M&E systems are affecting implementation and achievement of results. The evaluation relied on document and data review, Key Informant Interviews, Focus Group Discussions, observation of program teams, and a randomized, 30-cluster sample survey of health facilities (30) and individual women (320).

Findings:

Though designed to work together, the two programs function separately. Both experienced delays due to difficulties setting up administrative processes; hiring and retaining qualified staff; and contracting with and strengthening local NGOs. KJK is on track to meet its program targets; however, Jigi, the local NGO contracted to sustain the activities, is not yet implementing SBCC activities. SSGI is on track to meet training targets and has improved performance at some facilities, but not yet consistently or sustainably. Both programs will require additional time to achieve planned results.

Recommendations:

1. USAID should extend both programs, creating a 3-month overlap with subsequent programs to ensure service continuity.
2. KJK should second technical staff to Jigi and the CNIECS in the remaining project period to build their capacity to continue SBCC after KJK ends. This should be prioritized over research.
3. SSGI should second its staff to regional and district offices in the remaining project period and focus on sustaining quality health service delivery and addressing barriers to access.
4. Both programs should work to strengthen the financial management capacity and accounting systems of the local NGOs with whom they work.

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ACRONYMS

ACT	Artemisinin-based combination therapies
AMTSL	Active management of third stage of labor
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ASACO	Association de Santé Communautaire (Community Health Association)
ASFM	Association des Sages-Femmes
ATN PLUS	Assistance Technique Nationale Plus (National Technical Assistance Plus)
BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CAG	Groupe d'action communautaire (Community Action Group)
CHW	Community Health Worker
CLTS	Community-led total sanitation
CNIECS	National Center for Health Information, Education and Communication
COP	Chief of Party
CPR	Contraceptive Prevalence Rate
CSCOM	Centre de santé communautaire (Community Health Center)
CSREF	Centre de Reference (Reference Health Center)
CYP	Couple Years of Protection
DHIS2	District Health Information System 2
DHS	Demographic and Health Survey
DP	Development Partner
EBF	Exclusive breastfeeding
EMMP	Environmental Mitigation and Monitoring Plan
ET	Evaluation Team
FENASCOM	Fédération Nationale des Associations de Santé Communautaire (National Federation of the Association of Community Health Groups)
FGD	Focus Group Discussion
FM	Finance Manager
FP	Family Planning
GoM	Government of Mali
GP/SP	Groupe Pivot Santé Population (Pivot Group for Health and Population)
GSAN	Groupe de Soutien à la Nutrition (Nutrition Support Group)
HIHS	High-Impact Health Services
HIS	Health Information System
HIV	Human Immunodeficiency Virus
IEE	Initial Environmental Examination
IMCI	Integrated Management of Childhood Illness
IPPF	International Planned Parenthood Federation
IR	Intermediate Result
IUD	Intra-Uterine Device
INW	Intensive National Nutrition Activity Week
IYCF	Infant and Young Child Feeding
JHU/CCP	Johns Hopkins University Center for Communications Programs
JIGISIGI	“Hope for Families” communication platform
KII	Key Informant Interview
KJK	Kenya Jému Kan
KMC	Kangaroo mother care
LAM	Lactational Amenorrhea Method

LARC	Long Acting and Reversible Contraceptives
M&E	Monitoring & Evaluation
MNCH	Maternal, Newborn, and Child Health
MPHH	Ministry of Public Health and Hygiene
MSH	Management Sciences for Health
MSI	Management Services International
MTE	Mid-term Evaluation
NGO	Non-Governmental Organization
PMI	President's Malaria Initiative
PMP	Program Monitoring Plan
PNC	Postnatal Care
PPT	PowerPoint Presentation
PRODESS III	Programme de Développement du Secteur Santé (Program for the Development of the Health Sector)
PSI	Population Services International
RDT	Rapid diagnostic test
RF	Result Framework
SBCC	Social and Behavior Change Communication
SEC	Socio-economic class
SIAPS	Systems for Improved Access to Pharmaceuticals and Services Program
SM	Social Marketing
SMC	Seasonal Malaria Chemo Prophylaxis
SNA	Social Network Analysis
SOW	Scope of Work
SSGI	Service de santé à grand impact (High-Impact Health Services)
TDC	Technical Director of the Centre
TMG	The Mitchell Group
USAID	United States Agency for International Development
USG	United States Government
WASH	Water and Sanitation Health
WBD	World Breastfeeding Day
WRA	Woman of Reproductive Age

EXECUTIVE SUMMARY

Background

The United States Agency for International Development in Mali (USAID/Mali) signed two five-year cooperative agreements (2014-2019) to implement two public health related programs: the High-Impact Health Services (HIHS) program, referred to as Services de Santé à Grand Impact or SSGI, and the Social and Behavior Change Communication (SBCC) program known as Keneya Jému Kan or KJK. The objective of the programs is to improve maternal and child health in Mali and help achieve the five intermediate results of USAID/Mali's health strategy:

1. Increased use of quality family planning, maternal, neonatal, and child health services.
2. Increased coverage and use of key malaria interventions.
3. Increased coverage of HIV/AIDS and other infectious disease prevention and treatment.
4. Improved nutritional status, water supply, hygiene, and sanitation.
5. Improved national, regional, district, and community management, and health systems.

The programs were created to operate in tandem and create synergies to improve the supply and demand for a number of high impact intervention in Maternal, Newborn and Child Health (MNCH), Family Planning (FP), malaria, HIV/AIDS, nutrition, and Water and Sanitation Health (WASH) services. Together, the programs cover a total of 13 districts and approximately 64% of Mali's population, including 2.7 million women of reproductive age (WRA) and 2.5 million children under the age of five.

Evaluation Purpose, Questions and Methodology

From August through December 2018, The Mitchell Group (TMG) and its local partner, Koita Consulting, conducted a mid-term evaluation (MTE) of SSGI and KJK in Mali. The evaluation was designed to answer four main questions:

1. To what extent are the activities of the programs implemented to date contributing towards the achievement of their planned results?
2. To what extent are the programs' financial, management, and M&E systems affecting implementation and the achievement of results?
3. To what extent have the programs complied with agency requirements, for environment, gender and branding and marking?
4. What are the recommendations for the time remaining in the current programs?

The MTE consisted of a document review and employed mixed quantitative and qualitative survey methods, including partially-embedded observation of both programs, Key Informant Interviews (KII), Focus Group Discussions (FGDs) and a randomized 30-cluster survey of health facilities together with household interviews. Data generated from each source was analyzed and triangulated to develop major findings, conclusions, and recommendations. A complete list of questions and sub-questions addressed in the evaluation can be found in Annex I. Per the scope of work (SOW), the evaluation team (ET) created a separate document with recommendations for future programs.

Findings

Question 1. To what extent are the activities of the programs implemented to date contributing towards the achievement of their planned results?

The MTE found that both programs have increased the adoption of health behaviors and increased the demand for and use of high impact health services in the evaluated districts. Importantly, the ET found that 79% of women in the study area took part in an initial antenatal care (ANC) visit prior to their last childbirth; while we cannot make a statistical comparison, this figure is slightly higher than the 74% rate found in the 2012 Demographic and Health Survey (DHS) data. The MTE found statistically-significant differences by region: Koulikoro had the highest rate at 90%, and Sikasso the lowest at 58%. FGDs in

Koulikoro revealed that more women were seeking facility-based antenatal care during their pregnancy as they view it as a reliable alternative to traditional medicine.

Overall, 60.6% of women surveyed reported giving birth in a health facility. For comparison purposes, the DHS 2012-13 rate for this practice country-wide is 55%. By region, 46.5% of respondents in Kayes; 83.9% in Koulikoro; 64.9% in Sikasso; and 28.6% in Bamako gave birth in a CSCOM. The lower figure in the few CSCOMs selected in Bamako commune suggests that mothers there have options other than the conventional CSCOMs, such as private clinics, CSREF and the hospitals. Women who made at least one ANC visit during their last pregnancy had a 70.2% likelihood of giving birth at a health facility. Conversely, women who did not use ANC services had only a 29.9% likelihood of doing so, a difference that is statistically significant at the 99-percent confidence level.

Reported use of FP services included 29.8% of respondents and differed by region: 37.8% in Sikasso, compared to just 17.2% in Kayes, a difference that is statistically significant at the 95-percent confidence level. Among the 90 out of 320 women surveyed who reported using FP methods, injectables are the most common, reported by 41.1% of those respondents. Implants are next in popularity at 31.1%, followed by pills at 16.7%. FGD participants were generally satisfied with FP services, though they expressed concerns that cost can be a barrier.

KJK Findings

IR1: Increased adoption of key health behaviors and increased demand for and use of HIHS and related health products at the community and household levels in USAID target areas.

There is consensus among key informants in the Ministry of Public Health and Hygiene (MPHH) that KJK is making an important contribution to maternal and child health in Mali. KJK conducted formative research and used monitoring and evaluation data to inform its SBCC activities (Sub-IR 1.1 Formative research, monitoring and evaluation conducted and informing SBCC activities), and they developed an effective SBCC strategy called Jigisigi (Sub-IR 1.2. SBCC messages, approaches, materials and tools developed and produced for use at different levels of the health system). The ET noted, however, that because it took almost three years to develop Jigisigi, there is not enough time left to implement it sustainably.

IR2: Demonstrated Malian capacity to conduct research, and design, test, implement and evaluate social and behavior change communication (SBCC) and social marketing (SM)

KJK is not on track to achieve this IR, largely because the local NGO due to take over the SBCC and social marketing (SM) activities was identified late and has only recently begun receiving technical training. There has not been enough time to develop its technical and business capacity (Sub-IR 2.1 Malian non-public SBCC entity identified and benefits from intensive technical and business management training to conduct research, design, test, and implement SBCC in support of High-Impact Health Services (HIHS) and products; and 2.3 Malian Social Marketing (SM) entity identified and benefits from intensive technical and business management training in social marketing, including SBCC for HIHS products, services, promotion, and sales). The first local NGO partner was eliminated due to audit problems and the second did not choose to sign the "Protecting Life in Global Health Assistance" policy. Key informants at the MPHH reported that KJK had effectively reinforced their capacity to conduct research and design SBCC services (Sub-IR 2.2 MOH capacity reinforced to conduct research, design, test, and deliver SBCC services nationwide). However, the MPHH has not allocated funding for these activities in its budget and lacks the resources necessary to sustainably apply these new skills and knowledge.

IR3: Increased availability of socially marketed HIHS related products and expanded non-public services in target geographic areas. This IR has met and/or exceeded targets (Sub-IR 3.1 Effective social marketing of USAID-supported products and nonpublic services for FP, ANC, MCH, HIV, WASH, and nutrition in targeted geographic areas). Commodities distributed by SSGI exceeded targets

(Sub-IR 3.2 New products and interventions identified and incorporated as appropriate into the social marketing program in target geographic areas), but uptake of modern methods remains low. The ET believes that the lack of use of these methods is due to widespread belief in myths and rumors, including those implying that implants and injectables can lead to sterility. This may be linked to the fact that, as discussed elsewhere in the report, KJK was delayed in its implementation due to the extended R&D period. Given the initial findings of the SBCC activities that finds them successful, the ET believes that, with additional time devoted to implementation, the demand for commodities would increase to meet the increased supply.

SSGI Findings

IR1: Improve demand for quality health services and products and adoption of healthy behaviors at all levels. The program has improved the demand for quality services. 94.4% of surveyed women report knowing about the services that are available at the CSCOMs (Sub-IR 1.1 Improved knowledge, attitudes, and practices among target populations), a figure that is relatively consistent across regions. The qualitative data also confirm increased knowledge and improved attitudes, and an increase in spousal communication and an appreciation of service quality, both of which generated demand (Sub-IR 1.2 Community social norms support the use of healthy behaviors and health services). SSGI has supported community action groups (CAGs), which have been instrumental in fortifying their local health associations (ASACOs) and helping to develop over 1,500 community development plans (Sub-IR 1.3 Community advocacy strengthens service provision, management and accountability processes). SSGI also supports hundreds of Community Health Workers (CHWs), who are paid electronically, meeting grant agreement requirements. All of these interventions are valued by the key informants interviewed.

IR2: Improve access to quality of integrated HIHS at the community level and appropriate referrals and improve health systems management, functioning and accountability at the community and district levels, and coordination at the regional level. SSGI has improved access to and availability of an integrated package of HIHS at the facility and community levels, as well as contributing to an improved system for referrals. Almost all high-impact services – excepting Integrated Management of Childhood Illnesses (IMCI) and selected FP methods – were available in the 30 CSCOMs surveyed in this evaluation (Sub-IR 2.1 Service delivery points consistently deliver priority HIHS according to MOH standards). A number of innovative interventions have been applied but not scaled up yet: e.g. Kangaroo Mother Care, umbilical cord care with chlorhexidine, and village health funds. Interventions related to CAGs and task-shifting to CHWs have been applied and scaled up in all program districts (Sub-IR 2.2 Effective service delivery approaches for various HIHS applied and scaled up). Data from our individual-level survey suggest that approximately 15% of women have received referrals for higher-level care from their CHW, and approximately 22% have been referred by their CSCOMs to a referral health center (Sub-IR 2.3 Referrals and follow-up strengthened between household, community, and facility for selected services).

IR3: Improve health systems management, functioning and accountability at the community and district levels, and coordination at the regional level. SSGI has supported ASACOs and CAGs to better plan their support to the local health facilities (Sub-IR 3.1 Improved planning, management, and accountability systems at the CSCOM/ASACO, district, and regional levels.) SSGI also assigned district officers in each district to better manage its district management support (Sub-IR 3.3). However, the ET found that SSGI is largely centrally-managed, so district officers lack the authority to make independent decisions, and staff retention is difficult. SSGI helped strengthen the health information system (HIS) by developing a community-based information system that uses the same DHIS2 platform, but this system is not yet integrated or sustained by the districts (Sub-IR 3.2 Data analyzed and used to plan, monitor and respond to health needs). It is currently SSGI-specific and has yet to be integrated into the national DHIS2. This integration is planned for Year 5 of the program, but the ET is concerned that this will not leave

enough time for the MPH and the target districts to adopt the system and thus sustain it after the life of the program. Stockouts of healthcare products and commodities were found in some of the sampled facilities, but in general, the supply of products and commodities was reported to have improved (Sub-IR 3.3 Improved management processes to increase access, availability, and affordability of health care products and commodities).

Question 2. To what extent are the programs' financial, management, and M&E systems affecting implementation and the achievement of results?

KJK Findings

No financial issues were reported or observed. KJK has faced challenges in the recruitment and retention of qualified staff, who have options to work with many other donors. Vacancies have delayed program implementation. Key informants reported that short-term contracts and long renewal processes have negatively affected the program's ability to effectively manage capacity-building and support to local NGOs. Informants also reported that KJK overemphasized research over the provision of technical and business support to the local NGOs. KJK uses three different kinds of software systems to monitor its activities, which is cumbersome. These systems are not yet integrated into an effective M&E system, which would allow KJK to track activities and make informed decisions.

SSGI Findings

SSGI has experienced financial, management, staffing, and M&E challenges. There were considerable delays setting up the electronic payment system for all payments, including to CHWs. The ET was unable to determine the cause of the high staff turnover that also affected KJK, beyond reports of "personal reasons" for staff departures. The ET found no evidence of a strategy to retain the staff until the completion of the program. SSGI had to add district staff, which had not been anticipated to implement the community-based health component. Human resource policies still need to be adjusted to empower and support this district staff. SSGI has also experienced delays in managing contracts to local NGOs and had several changes in key staff and consortium members; these challenges slowed program implementation. The ET found that SSGI's M&E system is effective for monitoring its activities.

Question 3. To what extent have the programs complied with agency requirements, for environment, gender and branding and marking?

KJK Findings

KJK's environmental monitoring and mitigation plan (EMMP) follows USAID regulations, and is well structured with a clear delegation of tasks to its regional representatives. Informants reported that they were told how to properly manage and recycle their waste. Expired products are disposed of in collaboration with the Department of Pharmacy and Medicines (DPM). KJK activities are gender-focused, and the Jigisigi approach focuses on women. Gender mainstreaming has just begun at the end of the fourth year.

KJK has complied with all branding and marking requirements at supported facilities, vehicles and printed documents, except with regard to the website. Although not in synergy with SSGI, KJK has an effective EMMP. KJK is implementing a gender strategy, but it is not yet mainstreamed; that will begin this year.

SSGI Findings

The ET found that SSGI has developed and implemented an EMMP that complies with USAID regulations. SSGI has also complied with gender requirements. It is not complying with branding and marking field offices or program vehicles due security reasons, though it has not yet applied for a waiver.

Overall conclusions

In summary, the MTE concludes that both SSGI and KJK programs have contributed to increasing the demand for and use of high-impact health services and have increased the adoption of healthy behaviors. Their contributions are appreciated by Malian counterparts. The number of women that receive antenatal care and deliver in health facilities, and the availability of emergency obstetric and neonatal care, appears to have increased during the life of the programs. The uptake of modern methods of family planning is also robust in program districts. Reported healthy behaviors, attitudes, and practices, and recognition of communicated health messages, confirm changes that can be attributed to both programs.

However, the ET identified two important shortcomings in the programs, a lack of sustainability, and a lack of synergy. First, while both programs have implemented successful interventions, these interventions are not yet sustainable, primarily because the capacity of the MPHHS and local NGOs has not been sufficiently developed to ensure ongoing high-quality standards. Second, the ET found that, while the programs were designed to be complementary – with SSGI increasing service supply and KJK creating demand for the same services – in reality, they work as very distinct programs. They share information, but do not have a well-articulated joint approach or an integrated strategy with the CSCOMs or local NGOs. They also lack a joint plan to help the MPHHS deliver better services through its regional offices.

Both programs had staff recruitment and retention problems that delayed implementation. For example, KJK did not select Jigi, its local NGO partner charged with implementing the SBCC and SM activities, until the fourth year of the program. Thus, little time remains to build Jigi's capacity to independently implement the SBCC and SM activities.

Recommendations for both programs

The full evaluation report details a number of recommendations for improving or strengthening the programs during the remaining implementation period. The broadest recommendations are listed here:

1. The communication strategy based on the local concept of Jigisigi, which uses multiple channels to reach local populations with specific health and related messages, is working well and should be continued by CNIECS and Jigi, the local NGO.
2. The SSGI interventions, including a number of recently implemented interventions (clean health facility, KMC, umbilical cord care, etc.), have increased the demand for and use of high impact health services. However, the regional and district health teams have not been empowered yet to consistently deliver and sustain these services at scale, nor is there a national financing strategy responsive to increased demand. The ET recommends that these interventions be scaled-up in all program districts and CSCOMs. Operational procedures for delivering the essential health package, including the new interventions, need to be documented and made available to all healthcare workers.
3. Electronic payments by mobile phone are likely to be the norm in the near future, given the current pace of development of mobile technology in Mali and the rest of Africa. Despite the initial difficulties encountered with its implementation, electronic payments should be continued. SSGI should implement an innovative advocacy plan targeting high-level state authorities, telecommunications companies, decision-makers, and health system actors at the national, regional, and district levels to institutionalize the system. This should be done whilst still offering alternative payment solutions for beneficiaries living in villages where conventional methods of mobile payment are not possible for the moment. The ET also recommends that USAID pool e-payments with other USAID-funded programs, so that it will be able to negotiate a significant reduction in the current high cost of transferring money.

Recommended changes that will help the programs to reach or exceed their intended results include (but are not limited to) the following:

4. To ensure the effective transfer of the Jigisigi communication strategy and research capacity to Jigi, KJK should second its staff to them for the remaining life of the program.
5. KJK should also second its technical staff to the National Center for Health Information, Education, and Communication (CNIECS) to help the MPHHS with the Jigisigi strategy and other policy and M&E aspects of the SBCC and SM interventions.
6. SSGI should second its staff to support regional and district teams to implement data-driven decision-making, in order to institutionalize the high-impact interventions and ensure their consistent delivery in all CSCOMs in the program areas. In this way, SSGI will be able to provide targeted support to develop and implement scaled-up work plans in each region, so that all target areas and facilities are reached.
7. Given the limited time available to accomplish the successful and sustainable transfer of the interventions of both programs, USAID/Mali may wish to consider an extension to ensure an overlap of at least three months with follow-on programming. This will allow for the adequate capacity-building of Jigi, which is responsible for continuing the SBCC and SM work.

I. INTRODUCTION

The United States Agency for International Development in Mali (USAID/Mali) signed two five-year cooperative agreements (2014-2019) to implement two public health related programs: SSGI and KJK. The programs were created to operate in tandem and create synergies in public health outcomes. The objective of the programs is to improve maternal and child health in Mali and help achieve the five intermediate results of USAID/Mali's health strategy:

1. Increased use of quality family planning, maternal, neonatal, and child health services.
2. Increased coverage and use of key malaria interventions.
3. Increased coverage of HIV/AIDS and other infectious disease prevention and treatment.
4. Improved nutritional status, water supply, hygiene, and sanitation.
5. Improved national, regional, district, and community management, and health systems.

EVALUATION PURPOSE

The evaluation was designed as a Mid-Term Evaluation (MTE). Conducted relatively late in year 4, its purpose was twofold: (1) to assess the KJI and SSGI activities together in terms of ongoing impact, and (2) to propose key actionable recommendations for USAID/Mali and the Implementing Partners (IPs), which should help to determine corrections for the remaining year of the programs and also contribute to the design, management, and implementation of future programs. The audience of the evaluation report is the USAID/Mali Mission, including the Health Office, and the IPs. The recommendations for future programming are provided in a separate document, as requested by USAID/Mali.

EVALUATION QUESTIONS

The Scope of Work (SOW) listed three main questions, each with several sub-questions; it also requested recommendations for changes for the remainder of the programs and for the design of future programs. The methodology, analysis and resulting report were based on these questions. Each program has its own Results Framework (RF), three Intermediate Results (IRs), and a number of Sub-IRs. Full details along with sub-questions can be found in Annex I. The key evaluation questions and components are as follows:

1. To what extent are the activities of the programs implemented to date contributing towards the achievement of their planned results?
 - a. Are the interventions leading to the intended results and sub-results?
 - b. Which interventions are having the greatest success, and which are having the least success?
2. To what extent are the programs' financial, management, and M&E systems affecting implementation and the achievement of results?
3. To what extent have the programs complied with agency requirements for environment, gender and branding and marking?
4. Recommendations for the current programs: suggested changes, if any, for these programs to reach or exceed their intended results:
 - a. What specifically is working well and should continue to be scaled up in these programs?
 - b. What level of integration is best among the different health elements?
 - c. Examples of best practices in program management and financial management
 - d. Strategies for resolving problems or weaknesses
 - e. How can the USAID Health Team's management of the programs facilitate achieving results?

II. PROGRAM BACKGROUND

The Malian health system is designed to fulfill the right to health care for all established in the country's constitution. The Ministry of Public Health and Hygiene (MPHH) is in charge of policies, regulations, and strategic program planning for the country's health system, and the National Health Directorate (DNS) is in charge of implementing the national health programs. The Malian health care system is organized into a four-tier system. At the top tier are the three national hospitals which provide specialized healthcare. At the second tier are the seven regional hospitals, which supervise the Referral Health Center (Centre de Santé de Centre de Santé de Référence -CSREF), the third tier. There is one CSREF in each district. The CSREF provides oversight to the Community Health Center (Centre de Santé Communautaire - CSCOM), the fourth and final tier. The CSCOMs provide the services required by the national essential health package: maternal, newborn, and child health; infectious diseases; family planning (FP) and water and sanitation (WASH) in their coverage area and are managed by the Community Health Association (Association de Santé Communautaire – ASACO). ASACO members are selected by the community. As in many countries, community health workers (Agents de Santé Communautaire) and volunteers (relais) play a crucial role in extending access to essential health services.

USAID's SSGI and KJK Programs were designed to improve the supply of and demand for high-impact health services in Mali, with the SSGI program focusing on improving the availability of and access to high-impact and quality health service delivery, and the KJK program focusing on increasing demand for these services and improving health behaviors through Social Marketing (SM). The two programs form a major portion of USAID's health portfolio in support of the GoM's goals to end preventable child and maternal deaths by strengthening care-seeking and healthy behaviors at the household and community levels, as well as improving accessibility, availability, and quality of essential, high-impact health service provision. They were intended to work in tandem through a joint work plan in four regions (Kayes, Sikasso, Koulikoro, and Bamako), and the district of Gao. KJK also works in the Mopti region. Other ongoing programs funded by USAID and the United States Government (USG) complement the SSGI and KJK programs by strengthening the supply and logistics for commodities, management of human resources for health, quality of care, and the development of a health information system.

SSGI, a consortium led by Save the Children (SAVE), originally included JHPIEGO, Management Systems International (MSI), Groupe Pivot Santé et Population (GP/SP), and the Fédération Nationale des Associations de Santé Communautaire (National Federation of the Association of Community Health Groups). MSI had withdrawn from the consortium by the time of the MTE. SSGI supports the delivery of an essential health care package of integrated malaria, family planning (FP), reproductive health (RH), HIV/AIDS, maternal and child health, nutrition, and water and sanitation services (WASH) delivered at the regional, district, and community levels.

The KJK consortium, led by the Johns Hopkins University Center for Communication Programs (JHU/CCP) and including Management Science for Health (MSH) and The Palladium Group, strengthens health systems for commodities and logistics, human resources for health, health services information, and quality of care. The KJK award supports the capacity-building of local NGOs and GoM entities in SBCC activities, as well as the social marketing of FP, HIV/AIDS prevention, safe drinking water, and safe motherhood products sold at commercial retail outlets and in community pharmacies.

The two programs target a total of 2.6 million women of childbearing age and 2.4 million children under five through 805 CSCOMs in 33 districts¹ with a total population of 12,239,787 inhabitants, or 64% of Mali's population. KJK also provides SBCC support to an additional 8 districts in the Mopti Region in

¹ in Sikasso, Kayes, and Koulikoro plus GAO and Bamako Districts

collaboration with other USAID Nutrition and WASH programs. KJK's implementation strategy has as its objective to build the capacity of a major local NGO that would in turn continue social marketing activities and assist and build SBCC capacity among several Malian NGOs and within the MPH. For reasons described below, this did not occur.

III. EVALUATION METHODS & LIMITATIONS

The evaluation used partially-embedded and mixed qualitative and quantitative methods. Data collection tools (see Annex VI) were designed in consultation with USAID/Mali and pre-tested. Data were analyzed and triangulated to answer evaluation questions and sub-questions. The methods used in the evaluation are described below.

METHODS

1. **Document Review.** The ET reviewed documents including program work plans; annual and quarterly reports; trip reports; operations manuals; formative research and survey reports; and M&E reports. The ET also reviewed relevant program websites; MCH/FP/RH, SBCC, WASH, nutrition, infectious disease and health systems management and training tools; documents from non-public entities and Non-Governmental Organizations (NGOs); policy documents from the MPH; and additional training reports and technical program documents. An “Evidence Extraction Form” was used by the evaluation team to structure the data collection for each evaluation question.
2. **Stakeholder Mapping and Selection of Key Informants.** Stakeholders, key informants, CSCOM personnel, NGOs, and key beneficiaries who have worked with either program at the national level and in each of the selected 30 sampled clusters were mapped to ensure representation of the main actors. Key informants were selected based on their familiarity with program activities; e.g., purposely rather than randomly. USAID/Mali, SSGI and KJK assisted the evaluation team in the identification of informants to ensure they all had in-depth knowledge of the activities. The evaluation team ensured that the list included actors from all levels of the health system, including those with potential positive and negative perspectives. Key informants were men and women, including adolescents. (A list of informants is included in Annex II.)
3. **Key Informant Interviews (KIIs).** The ET conducted KIIs in-person or by telephone, using structured interview forms with two members of the ET present whenever possible. All interview notes and forms were recorded confidentially in electronic files and saved for coding, analysis, and easy reference to the themes and patterns of evidence that emerged in each interview. Stakeholders such as GoM and NGO representatives were interviewed, along with program staff. KII respondents in the districts included community leaders such as village chiefs, religious leaders, and members of civil society. The objective of the KIIs was to note perceptions regarding program impact and observed changes related to health status and healthy behaviors, as well as the use, delivery, and quality of services resulting from SSGI and KJK interventions. Interviews were also used to understand social behavior changes resulting from SSGI and KJK interventions. The ET also used the assessments to gather information on the target population’s use of and demand for services and products related to the SSGI and KJK activities.
4. **Focus Group Discussions (FGDs)** were conducted with mothers, adolescent girls and boys, and community leaders (each in separate groups). Informed consent to record was obtained from participants. Thirty-two (32) FGDs were carried out among these groups, which included unmarried adolescents aged (15-19), women aged 15-49 (who had a child under age five) and community leaders (including village chiefs and religious leaders). Initial participants were selected with assistance from CSCOM staff, and ‘snowball sampling’ techniques were then employed to add additional participants. While the inclusion of initial participants identified by CSCOMs could have introduced bias, the snowball sampling of a greater number of participants not identified by CSCOM staff mitigated that threat to internal validity. While the snowball sampling methodology might have introduced some bias, it was agreed by the ET and USAID/Mali to be the most effective

sampling method considering distance and time limitations. The distribution of FGDs, by region and type of participant, was as follows:

Table 1: Number and type of focus group discussion by region

Region/ FGD Type	Adolescents	Women 15-49	Community Leaders
Bamako	1	1	2
Koulikoro	5	6	6
Kayes	2	1	3
Sikasso	2	2	1

All FGDs and KIs were conducted either in French or in Bambara and then transcribed in French. The analyses used a grounded theory approach to identify themes and patterns of evidence that emerged in each interview. Informed consent to record was obtained from participants.

5. **Health System Review:** The ET used Partially-Embedded Observation. All members of the ET accompanied SSGI and KJK teams for one week through various activities (meetings, staff trainings, coordination, supervision) to observe and assess program operations. The team leader accompanied the Chief of Party, and other ET members accompanied the staff in charge of particular areas. Using a checklist, team members accompanied program teams and observed them as they participated in staff meetings, individual task planning, implementation and reporting, supervision and support, time management, and field activities to assess opportunities and barriers related to their work plans. This enabled the MTE team members to understand the management and organization of each program in real time, identify bottlenecks and inefficiencies if any, and to triangulate that information with findings from reports and other documents.
6. **CSCOM Survey:** The ET conducted surveys at health facilities and in the communities that they serve. The health facility survey was conducted among a sample size of 30 CSCOMs. The 30 sites included in the survey were selected randomly from among a list of 805 CSCOMs in the four regions of study (Kayes, Koulikoro, Sikasso, and Bamako) using a random number generator. The random selection resulted in 8 CSCOMs selected in Kayes, 15 in Koulikoro, 5 in Sikasso, and 2 in Bamako, in keeping with the approximate distribution of beneficiary CSCOMs in the KJK and SSGI programs. At each CSCOM, the ET interviewed Community Health Workers (CHWs) working there on the day of the survey. If available, the CHW in the sampled community was also interviewed. The ET also recorded data from facility records. Guidelines and limitations regarding the analysis of the health facility data are outlined below.
7. **Individual-Level Survey:** The individual-level survey was conducted in the largest village community within a 1-2-hour drive from each CSCOM, resulting in 30 survey clusters. The survey was conducted among women aged 15-49 with a child under five years of age. The reason for the clustered sampling approach at this distance was to ensure a sample of respondents who take advantage of CSCOM services while also allowing the ET sufficient time to collect data from an adequate sample size. Within those 30 clusters, the ET drew seven households at random, by randomly selecting a direction from the center of the village and moving systematically from household to household in that direction. All women in those 210 households that met the selection criteria were interviewed across the 30-cluster sample, resulting in a sample size of 320 respondents for the individual-level survey. Limitations regarding the survey and its analysis are presented below.

8. **Health Information System (HIS) Indicators:** The MTE reviewed available statistical reports from the HIS of the MPHH to gather secondary data related to performance indicators for the SSGI and KJK programs. The ET also reviewed Data Quality Audits (DQAs) and program monitoring plan (PMP) data and developed a performance indicator table for each program. Data were collected from the CSCOMs regarding outcomes related to key program interventions such as the incidence and prevalence of infectious diseases; immunization and malnutrition rates; antenatal care visits and assisted deliveries; stock-outs of medicines, other medical supplies, and health products; infant and maternal deaths; facility productivity statistics; the number of patients seen per HW and CHW; etc.
9. **Review of MPHH and Program Websites and Facebook Traffic.** The ET also reviewed the digital presence and internet traffic statistics of the MPHH (<http://www.sante.gov.ml>) to assess management capacity. The team worked with SSGI and KJK webmasters to gather traffic statistics from websites relevant to the programs such as <http://www.projet-kjk.ml/> and <https://www.facebook.com/KeneyaJemuKan>, in order to assess trends and use by intended audiences.

LIMITATIONS

The evaluation process was conducted as planned and, apart from delays in the collection of data due to factors beyond the control of the evaluation team, no incidents occurred that may have undermined the credibility and reliability of the results or hindered the in-depth analysis of the data. Gao district was not included due to security concerns.

Sampling procedures: the ET used a 30-cluster model to assess coverage of the various interventions of both programs. This model is accepted by WHO as a practical way to assess the use and effectiveness of health interventions². The 30 clusters were selected randomly from all health zones assisted by the programs. The CSCOMs in the selected zones were then included in the survey. If there were two or more CSCOMs in a zone, one was selected at random. Drawing individual-level respondents from the largest village within a two-hour drive from the CSCOMs may have introduced mild bias in the results, due to easier access to CSCOMs among those communities compared to villages further away, and to the larger size of those villages. The ET does not view these decisions as severe threats to the internal validity of the study for two reasons. First, those at greater distances from our identified CSCOMs would, in most instances, have been closer to a different CSCOM not included in the study; individuals in those locations would thus have access to similar services from different facilities. Second, while we selected the largest village within a two-hour drive, those locations were still rural and somewhat isolated, so residents there would not have had lifestyles or access to resources that differed significantly from individuals in smaller villages. Furthermore, the village selection process also provided logistical advantages to allow for data collection in the time available.

Analysis: the survey and other data collection instruments that were developed and approved for use in this evaluation were cross-sectional in design, yielding information on the coverage of certain interventions at the time of the MTE. However, an independent baseline study was not conducted. The design also did not include comparison or control locations (i.e. individuals or facilities that did not benefit from program activities). Thus, we are limited in the extent to which we can make concrete statements about changes or improvement over time directly from the data collected. Instead, the data provide insights into the

² A simplified general method for cluster sample surveys of health in developing countries by Steve Bennett, Tony Woods; Winitha M. Liyanage & Duane L. Smith. [http://apps.who.int/iris/bitstream/handle/10665/47585/WHISQ_1991_44\(3\)_98-106_eng.pdf;jsessionid=AF226C5BADE608DB18D425CD22021453?sequence=1](http://apps.who.int/iris/bitstream/handle/10665/47585/WHISQ_1991_44(3)_98-106_eng.pdf;jsessionid=AF226C5BADE608DB18D425CD22021453?sequence=1)

processes and context which may catalyze improvements. We are also able to present correlations between key factors (from within our datasets) where appropriate.

In view of these design limitations, we have endeavored, where appropriate, to comment on changes over time by pointing to two alternative data sources: the implementing partners' (IP) baseline and midline studies, and the existing national-level DHS data from 2012. It is necessary to provide a number of clarifications here as to the interpretation of these comparisons. The statements we make regarding changes over time from the IPs' baseline to midline do not allow us to evaluate whether reported differences are statistically significant, as we were unable to obtain the actual raw data from the implementing partners (we requested the information, but the IPs did not oblige, expressing concerns that we fully understand). Similarly, we cannot directly compare our independent MTE findings to either the IPs' findings or the DHS findings; we can identify suggestive patterns, but we cannot infer statistical significance as we do not possess the raw data.

Security challenges: The ET did not evaluate the Gao district due to security concerns. Anticipated security challenges in other districts did not materialize.

Time delays: Some key informants were unavailable for interviews, and a broken-down vehicle that had to be replaced delayed data collection. However, the ET was able to overcome these challenges in a manner that did not significantly affect the results. The simultaneous evaluation of two partially-embedded programs took longer than anticipated, given the need to analyze results both separately and jointly. The data collection, data cleaning, and analysis also took significantly longer than expected, as the ET underestimated the challenges of evaluating two separate programs, despite their synergistic goals. The ET submitted a draft report by the deadline, and upon receiving additional time from USAID, was able to conduct further data analysis and submit this revised draft report.

IV. FINDINGS

The ET found that, while KJK and SSGI were funded with the objective of working “in tandem” on complementary activities, they in fact have separate results frameworks and operate as distinct programs managed by different IPs. They cover geographically similar areas and were envisioned to share work plans and coordinate implementation activities. They also target some of the same facilities and staff such as NGO personnel, health workers, and community health workers. Yet, the main finding by the ET is that the two programs have neither integrated their theories of change, timing, and sequence of implementation activities, nor collaborated on their monitoring and evaluation plans.

As the two programs, as well as other non-USAID donors and NGOs, address the same target populations and health facilities, the data collected related to behavior change and service delivery and utilization cannot be attributed discretely to the contribution of either KJK or SSGI. Therefore, the evaluation report is structured in the following way:

- 1) Findings are situated within the national context (using DHS data and Mali’s health development targets).
- 2) Evaluation Question 1 (EQ1) is then addressed using quantitative and qualitative data related to behavior change and service delivery and utilization in general.
- 3) Specific findings related to the IRs and sub-IRs, with references to the specific program intervention (KJK or SSGI) to the extent possible, are then added.
- 4) For the second and third EQs, for which the individual-level surveys and health facility data are less crucial than the qualitative data we gathered from stakeholders, the ET separated the findings of the two programs, addressing sub-questions under each EQ for KJK and then the same sub-questions for SSGI.
- 5) Overall conclusions and recommendations are provided at the end of the document.

FINDINGS RELATED TO NATIONAL AND GLOBAL INITIATIVES

It should be noted that at a national level, KJK and SSGI were viewed as enabling the GoM to work toward its goals in relation to maternal and child health and reproductive health outcomes, as outlined in the PRODESS III (Programme de Développement du Secteur Santé). This was emphasized in interviews with USAID personnel and Government partners.

The Government has a national health plan which is accompanied by the PRODESS – this plan seeks to reduce infant, neonatal and maternal mortality and to encourage the population to implement behavior change. The Government also has a family planning strategy – so I think that, through these programs, the Government, USAID, and their partners are working well towards implementing the different strategies. They have the same objectives and ultimately have an impact on family planning, maternal health, and household health.

In-depth interview, Representative from USAID-Mali

A Government representative noted appreciation with KJK's support to the institutional strengthening of NGOs and GOM structures, particularly CNIECS. “The KJK project has filled a gap in health communication”, said one respondent at the national level.

Government officials also noted their appreciation for KJK’s more specific, tactical support, such as its work on the national FP campaign. While many organizations contributed and were congratulated for their support of this campaign, SSGI’s and KJK’s support was appreciated by all stakeholders. “For the national FP campaign, it was KJK that supported the communication component – with appreciation by and congratulations from Mail’s first lady,” said a respondent from the MPH. In addition, the introduction

and promotion of Chlorhexidine was cited by stakeholders from the MPHH as one of the most successful activities of both projects.

SSGI assists with the implementation of the PRODESS in order to reduce infant and child mortality. Among the program's achievements, we noted that SSGI has improved the structure of global handwashing day; improved access to chlorhexidine; furnished equipment to maternity units in CSCOMs, provided training and carried out monitoring and evaluation. We participated in the planning of all these activities. KJK filled a gap with regard to health communication – it was KJK that supported the national annual family planning campaign and was congratulated by the First Lady for doing so. All the materials to support the national breastfeeding day were developed by KJK.

In-depth interview, MPHH representative

Nevertheless, from a national GoM perspective, the slow start-up and short implementation time make it difficult to concretely identify program effects that will likely take longer to fully come to fruition. This was reiterated by a representative of USAID's Measure Evaluation, who noted that the overall impact of KJK and SSGI is difficult to measure in the relatively short time frame. The MTE indicated that both programs are perceived by key informants as having made measurable progress in SBCC and service delivery improvements, but the timing of expected change remained an issue for numerous respondents:

Five years isn't enough to measure the results. More time is needed to roll out the strategies – it took a long time to start the programs up and their inter-connection was slow.

In-depth interview, Representative from Measure Evaluation, Mali

It is also important to note that KJK and SSGI contribute to Mali's potential achievement of regional and global goals and targets. For example, the programs contribute to the United Nation's Sustainable Development Goal (SDG) 3 (including preventable deaths of newborns and children under 5 years old) and to SDG 5.6 (ensure universal access to sexual and reproductive health services). Furthermore, Mali has made significant progress in improving family planning services and uptake via the Ouagadougou Partnership (OP)³, and both the supply and demand activities associated with the programs are likely to have contributed to this. In addition, Mali's FP2020 commitments include increasing the target contraceptive prevalence rate (CPR) from 15% in 2018 to 20% in 2020 within the acceleration phase (2016-2020) developed as part of the OP. Both SSGI and KJK are perceived by key informants as having positioned Mali to achieve these goals and have taken the field forward in terms of knowledge and learning, which can be shared with other countries. However, financial barriers to access care may have had a negative impact on the outcomes of both programs:

In our CSCOM, the price of antenatal care is expensive. I myself received ANC for the first time and it cost US\$6.93, the second time it was US\$7.80, and the third time, US\$8.67. The welcome you receive is warm, but the price of the medicines they prescribe is high.

Focus Group Discussion, Women aged 15-49, Skies

EQ 1: To what extent are the activities of the programs implemented to date contributing towards the achievement of their planned results?

This section is organized as follows:

- a. Behavior Change and Related Service Delivery and Utilization Findings
- b. KJK Findings by IRs and sub-IRs
- c. SSGI Findings by IRs and sub-IRs

³ The Ouagadougou Partnership <https://partenariatouaga.org/en>

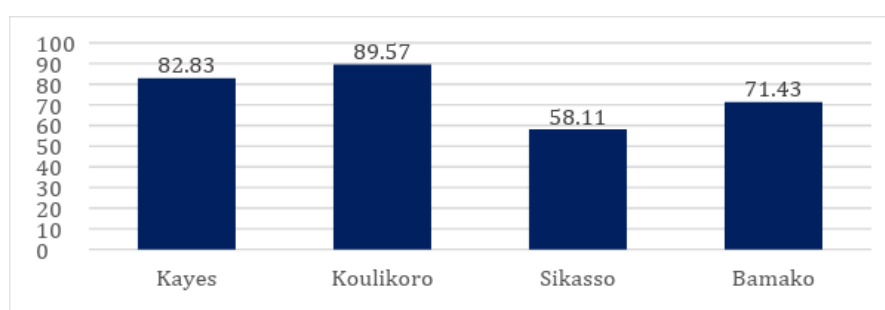
a. Behavior Change and Related Service Delivery and Utilization

This section presents quantitative data from the CSCOM and individual-level surveys. First, we collected individual-level data from households in regions served by both KJK and SSGI. From the household survey of women aged 15-to-49, we evaluated knowledge, attitudes, and practices regarding five key issues: 1. ANC; 2. births in health facilities; 3. FP; 4. spousal support; and 5. knowledge and reported utilization of services provided by their local CSCOMs. Second, the MTE also presents findings related to service delivery from the survey of 30 CSCOMs. Key findings from this CSCOM survey are presented in Table 2 in Annex IV. Qualitative data from in-depth interviews and FGDs provide complementary in-depth information regarding the context of behavior changes that may help to improve health outcomes.

Maternal Health and Family Planning

According to the National Health Strategy, MCH and FP services are integrated into the CSCOMs. First, the ET found that 78.8% of respondents reported taking advantage of ANC services from their CSCOM at least once. This is somewhat higher than the rate of 74% in the 2012 DHS survey, though we stress that we are unable to make statistical comparisons to DHS findings. The reported ANC utilization differs by region: as Figure 1 illustrates, more than 89% of women surveyed in Koulikoro reported using ANC services during their most recent pregnancy, whereas just 58% of women in Sikasso reported doing so ($p < .05$). The ET did not find any explanations from its data to explain the regional differences.

Figure 1. Percentage of Women Receiving Antenatal Care (ANC) Services at the Health Facility during Most Recent Pregnancy, by Region.



As the MTE data is cross-sectional; for evidence of change over time, we can point to the baseline and midline summary results from the IP, which indicate the following:

Table 2. IP Findings regarding the Share of Women who Take Part in Antenatal Care Visits

Indicator	Baseline	Midline
ANCI	86%	89%
ANC4	49.8%	55.7%

The IP baseline and midline data, based on a sample size of 4000, suggest a modest increase in both ANCI and ANC4, with ANCI reported at a higher rate than the MTE's sample. Again, the ET is unable to draw statistical comparisons as we do not possess the raw data from the IP's surveys.

The focus group discussions in Koulikoro revealed that many women there have sought antenatal care as a reliable alternative to traditional medicine during their pregnancy.

The health center is attended by women for antenatal care and during labor. Before they used traditional medicine – this has become rare nowadays.

Focus Group Discussion, Community Leaders, Koulikoro

Many women appeared to better understand the purpose of ANC and were more willing to use it.

Respondent 5:

Women weren't going for antenatal care as they thought the health workers were just messing around.

Focus Group Discussion, Women aged 15-49, Kayes

Respondent 7:

Yes, that's what they thought before. But not now. They are starting to understand. A lot of them now go for antenatal care.

Focus Group Discussion, Women aged 15-49, Kayes

Second, the ET evaluated the utilization of health facilities with the assistance of a trained professional for childbirth. Overall, 60.6% of surveyed women reported giving birth in the local CSCOM. For comparison purposes, the DHS 2012-13 rate for this practice is 55%. By region: 46.5% of respondents in Kayes gave birth at the CSCOMs, compared to 83.9% in Koulikoro, 64.9% in Sikasso, and 28.6% in Bamako. The lower figure in the capital, Bamako, suggests that expectant mothers there have options other than the conventional CSCOMs, such as giving birth in private clinics, or using higher-level services such as CSREFs. Studying the patterns of delivery in various regions is beyond the scope of this evaluation, but this finding might indicate the need of further study and interventions by future programs.

Before, we gave birth at home but now we have stopped all that. We go and give birth at the health center and the health workers deal with all the problems that mothers and babies can encounter during labor.

Focus Group Discussion, Women aged 15-49, Koulikoro

The ET evaluated the correlation between ANC visits and women giving birth at the health facility. As the correlation matrix in Table 3 below indicates, women who made at least one ANC visit during their last pregnancy had a 70.2% likelihood of giving birth at a health facility. Conversely, women who did not take advantage of ANC services had only a 29.9% likelihood of giving birth at a health facility, a difference that is statistically significant at the 99-percent confidence level.

Table 3. Correlation between ANC Services and Health Facility Deliveries (p = 0.000)

Indicator		ANC	No ANC	Total
Gave birth in a health facility				
Yes	N	167	16	183
	%	70.17	25	60.6
No	N	71	48	119
	%	29.83	75	39.4
Total	N	238	64	302
	%	100	100	100

The results reported in the IP's baseline and midline reports are somewhat higher than the 60.6% found by the ET, and suggest a modest increase, as noted below. The ET is unable to comment on the statistical significance of that increase, but we provide the information for reference:

Table 4. IP Findings Regarding the Share of Deliveries in Health Facilities

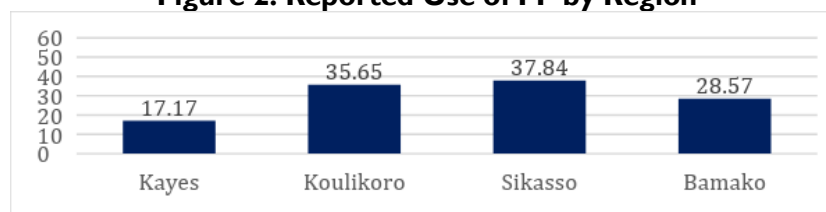
Indicator	Baseline	Midline	MTE
Pregnant women who delivered in a health facility	74%	78%	60.6%

The MTE revealed that in the majority of the 30 CSCOMs visited, Basic Emergency Obstetric and Newborn Care (BEmONC) equipment was available, but the team was not able to observe its use due to the lack of adverse events during the observation period that would have required such use. The health facility survey revealed stock-outs of magnesium sulfate (MgSO₄) in 80% of facilities. This should be explored further to determine whether this shortage is systematic across CSCOMs, as this drug is essential to treating pre-eclampsia and eclampsia, a major cause of maternal and infant deaths.

Third, the ET evaluated outcomes regarding family planning. Respondents in the individual-level survey were asked, "Do you use FP services from the CSCOM?" Overall, 29.8% of respondents reported doing so. Regarding types of family planning, the evaluation focused on female-used FP methods, so the ET does not have data on condom use. The ET is also unable to determine the share of women who may use contraceptive methods obtained from other sources outside of the CSCOM. Due to these factors, the ET assumes that its estimates about contraceptive use are conservative, and that the rate of use is likely higher than the reported figures. Furthermore, many women in Mali use family planning methods surreptitiously due to spousal and community disapproval, which may also lead to underreporting.

Use of FP services differed by region. As Figure 2 shows, 37.8% of respondents in Sikasso reported taking advantage of such services, compared to just 17.2% in Kayes, a difference that is statistically significant at the 95-percent confidence level. The ET surmises that a reason for the lower rates of usage in Kayes may be due to relatively high levels of male out-migration there.

Figure 2. Reported Use of FP by Region



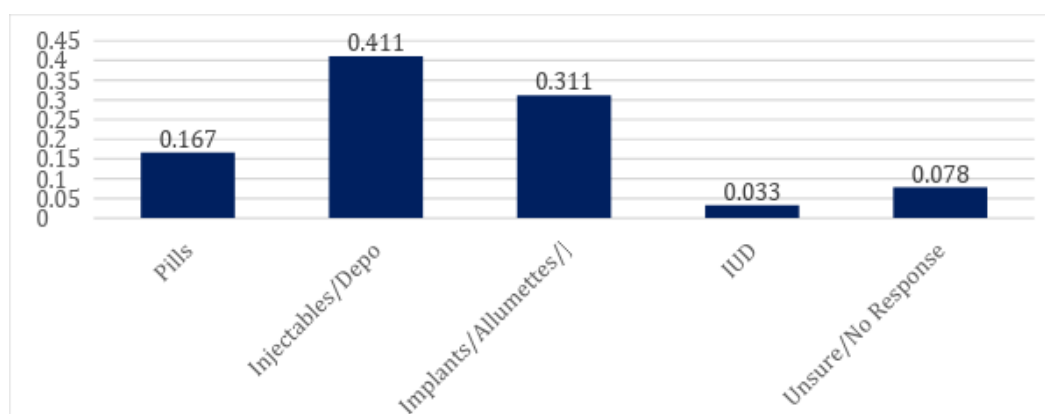
Among the 90 out of 320 women who reported using family planning methods from the CSCOM, injectables (also reported as Depo) are the most commonly used, noted by 41.1% of respondents. Following injectables in popularity are implants (also reported as allumettes or Jadelle) at 31.1%, then pills at 16.7%. (See Figure 3, below.) The study on ideation factors and behaviors related to MCH, FP, WASH, and HIV/AIDS in Mali, conducted by KJK in December 2015, revealed that factors such as involving the husband in making decisions about FP, discussing the use of FP methods with the husband, and getting his support are all critical to increase the uptake of FP methods in Mali. In addition, the perception and attitude toward FP of people close to the couple, such as the mother-in-law was found to be a factor determining the use of FP. We do not have evidence to explain the difference.

By age group, the MTE found that the youngest category (15-24-year-olds) reported a usage rate of 26.4%, while those aged 25-34 reported a usage rate of 31.5%. Among women in the 35-49-year-old group, 32.7%

stated that they use family planning services from the CSCOM. The ET notes a mild increase in usage with age, though we stress that the differences are not statistically significant ($p = 0.606$).

The overall figure of 29.8% who reported using a modern method of family planning compares favorably to the DHS 2012 rate of 8.1%. Furthermore, the IP's internal midline survey indicates that 99% of women are now knowledgeable about modern FP methods (whether or not they use them), a reported increase of six percentage points from their baseline study.

Figure 3. Modern FP Methods Used by MTE Respondents.



FGD participants were in general satisfied with FP services:

Family planning methods are available at the CSCOM- you can buy them if you have the financial means.
Focus group discussion, Women aged 15-49, Koulikoro

I have noted that there has been a reduction in unwanted pregnancies during the last three years thanks to the information we have received.
Focus group discussion, Adolescents aged 15-19, Koulikoro

Fourth, we evaluated spousal support for expectant mothers, a key attitudinal measure that implicates both the expectant mothers themselves and their partners' involvement in a process of communication and collaboration in the pre- and post-natal period. The individual-level survey data suggest that, overall, 95.4% of women report receiving support from their spouses before, during, and/or after childbirth. Importantly, we found that having spousal support is a strong correlate of making ANC visits: 79.9% of those who report having support from their husbands are likely to make ANC visits, compared to just 57.1% of those who report not to have the support of their husbands, a difference that is significant at the 95-percent confidence level. (See Table 5, below.)

Table 5. Relationship between Spousal Support and Making ANC Visits (P=0.042)

Indicator		Spousal Support	No Spousal Support	Total
Yes, ANC Visit	n	230	8	238
	%	79.86	57.14	78.81
No ANC Visit	n	58	6	64
	%	20.14	42.86	21.19
Total	n	288	14	302
	%	100	100	100

The qualitative data revealed that the support from husbands for women wishing to make ANC visits was extremely important from both the practical and psycho-social perspectives.

Our husbands are starting to understand – if they're not in agreement, you can sensitize them and go to the health center. The health workers give advice on reproductive health and also give us bed nets – in this case, the birth will go well and you will feel at ease.

Focus group discussion, Women aged 15-49, Sikasso

Husbands who encouraged antenatal care also appeared more willing to provide support for both the mother and child during the post-natal period.

My husband helped me during my pregnancy. He bought me any kind of food I wanted – meat, vegetables, and fruit. He paid for all of my medicines. He made me go for ANC and often accompanied me or asked someone to go with me. During the forty-day period (of seclusion) after the birth, he brought me nutritious food. He made me go and receive post-natal care. He told me to ask the doctor which medicines were good for the baby after the vaccination and he bought them. It's my first child and I don't lack anything!

Focus group discussion, Women aged 15-49, Koulikoro

The project appeared to be changing men's attitudes and encouraging greater involvement from them during the antenatal period.

Fifth, we reviewed respondents' knowledge of CSCOM services. Overall, 94.4% of women surveyed report knowing what services are available at the CSCOMs. Those figures are relatively consistent across regions, though respondents in Bamako have lower knowledge of services offered at CSCOMs; in Bamako, 77.8% of women report knowing what services are offered compared to 91.7% in Kayes, 95.8% in Koulikoro, and 100% in Sikasso. Again, this may be a function of women in Bamako relying on other outlets, such as private clinics, for health services.

The qualitative data revealed that the barriers to using the CSCOMs were largely due to a lack of financial resources and difficulties associated with geographical access.

I find that the cost of medicines is very high at the CSCOM- we don't have enough money. People prefer to go to traditional healers than to go to the health center because of the high price of medicine.

Focus group discussion, Women aged 15-49, Koulikoro

We'd like to go to the health center, but it is so far away. When you accompany someone, you can't go and work in your field for a whole day because there is such a long queue when you get there.

Focus group discussion, Community Leaders, Sikasso

Newborn Care, Nutrition, and Child Health

The IP's SSGI midline data indicate that the percentage of women seeking newborn care delivered in CSCOMs is 60.6%. That figure is slightly higher than the 55% rate reported in the latest DHS report. Breastfeeding (BF) is near universal among Malian women, as revealed by most studies (97% in EDS 2012, 98% in the KJK/SSGI baseline study, and 98% in the 2017 SMART-Mali). However, the rate of exclusive BF (EBF) in the first six months is only 37.3%, according to the SMART study 2017⁴. Key informants reported that breastfeeding promotion materials were provided by KJK during the organization of World Breastfeeding Day in 2017. The advantages of EBF were also clearly articulated by women in FGDs, as illustrated below.

I can confirm that I exclusively breastfed for the first six months. I won an award for this from the health center - the event at which I was presented with it was on the TV and in the newspapers. My neighbors were proud of me!

Focus group discussion, Women aged 15-49, Bamako

Rates for child malnutrition reported by the CSCOMs are low; 5.3% for moderate and severe malnutrition combined. The referral rate for child malnutrition is 3.5% from the CSCOM survey data. Knowledge about malnutrition and its treatment were reported in the FGDs:

If the child is under five years of age, they give us advice about how to prevent malnutrition in children. If a child becomes malnourished, they show us how to make fortified porridge or 'Plumpynut' to help him/her get better.

Focus group discussion, Women aged 15-49, Kayes

Regarding child health services, 8.2% of infants aged 0-11 months were referred to the CSCOM for illness management. Among them, a recovery rate of 84.3% was reported from the health facility data.

The ET noted that some services are provided to families outside of the CSCOM catchment areas who nevertheless come for services. This explains why some services, such as complete vaccination of children and the distribution of insecticide-treated mosquito nets (ITNs) surpass 100% provision rates. Refer to Table 2 in Annex IV for full details on service provisions.

Sexually-Transmitted Infections (STIs) and HIV/AIDS

The MTE found that, based on statistics collected in the 30 sampled CSCOMS, the STI rate is 3.1%, and the HIV test rate in the sampled facilities (as a proportion of consultations) is 1.2%. Our random sample does not make it possible to classify CSCOMS into PMTCT or non-PMTCT sites; however, the CSCOM survey showed that most pregnant women (83%) attending antenatal services were tested for HIV/AIDS. Stockouts of test kits was an issue in some facilities. The indicator of HIV testing of pregnant women is not among those documented in the 2015 baseline survey report, so we cannot compare. Additionally, prevention methods against STIs and HIV/AIDS, especially male condoms, were available in only 63.3% of the visited CSCOMS.

⁴ Previous studies in Mali have noted that EBF is likely to be over-estimated as women do not consider water, animal milk, gruel or herbal medicines (often given with butter or oil) as 'food'.

Malaria prevention and treatment:

The extent of ITN distribution depends on the population targeted by CSCOMs. For example, if ITNs were to be distributed only to pregnant women (as the denominator), the CSCOMs surpass 100% provision in their catchment areas. However, if distribution is intended for all women aged 15-49 in their catchment areas, the provision rate is 24.3%. The ET found this is in alignment with the national policy as noted in the 2015 Malaria indicators survey. According to the IP reports, the proportion of pregnant women taking preventative anti-malarial drugs increased from 85% to 90% from baseline in 2015 to mid-term in 2018. According to findings from the FGDs, the use of ITNs and anti-malarial drugs is now widely understood in the program areas:

Malaria is transmitted by mosquitos – you have to sleep under a mosquito net. We were told this by the health workers – we also heard it on the radio.

Focus group discussion, Women aged 15-49, Kayes

The KJK project gave us a talk about malaria prevention. We learned a lot – they explained to us that it is the female mosquito which transmits malaria. We also learned about the advantages of using mosquito nets.

Focus group discussion, women aged 15-49, Sikasso

Some of these benefits also seem to have impacted the behavior of community members in targeted areas. The potential impact by sub-IR is presented below.

Sub-IR 1.1: Formative research, monitoring and evaluation conducted and informing SBCC activities.

KJK has conducted four main research studies:

- For monitoring and evaluation purposes, KJK conducted baseline and mid-term studies on the ideation factors and behaviors related to MCH, FP, WASH, and HIV/AIDS. The baseline results were used to design and evaluate the Jigisigi communication program.
- Two main formative studies were conducted:
 - Literature Review on Situational Analysis of Nutrition and WASH Interventions in the Mopti Region. The results were used by KJK to focus its messages on nutrition education and awareness in the Mopti Region.
 - Qualitative research on factors that influence the use of maternal and child health services. The research provided data to inform the development and implementation of effective SBCC and Social Marketing interventions that promote the use of health and social services and maternal and child health.

The ET reviewed these studies and found that they informed KJK's main SBCC communication strategies, namely the "Jigisigi" strategy. This strategy is centered on using the woman as a pillar of the "extended family". Key informants reported that this focus on women has helped develop an effective communication approach for behavior change and change social norms. However, key informants also reported that the development of the Handerey and Jigisigi approaches required considerable formative research, taking more than two years to develop, and that the activities did not start until the program's fourth year. It is unclear if there will be sufficient time remaining in the program to scale up either of these approaches. The M&E of the KJK program monitors SBCC implementation by district, health area, and by NGO partners as sub-grantees (See Table 6, below).

Table 6. Regions, Districts and Health Areas Covered by KJK and Partners at Year 4 of the Program Implementation

Regions	# Districts covered by KJK (MASS-MEDIA)	# Districts Covered by NGOs KJK Sub-grantees	# Health Zones covered by KJK (MASS-MEDIAS)	# Health Zones covered by NGOs KJK partners
Kayes	10	10	229	76
Koulikoro	10	4	212	71
Sikasso	10	10	243	81
Mopti	6	5	142	47
Gao	1	1	24	8
Bamako	6	3	57	19
Total	43	33	907	302

Sub-IR 1.2: SBCC messages, approaches, materials and tools developed and produced for use at different levels of the health system

The evaluation team found that the SBCC approaches that KJK put in place focused on MNCH and FP through the Jigisigi strategy and the gender-based Handerey approach. Table 7 (below) presents the main messages used at the facility and community levels in the health system both for rural and urban communities.

Table 7: Messages and Tools Developed under KJK

KJK Messages	Tools developed
Jigisigi platform (Jigisigi campaigns around FP Jigisigi Kènè, Jigisigi wedding party): Communication within the couple, effective antenatal care; beliefs about pregnancy; communication between mother-in-law and daughter-in-law; and service quality standards.	Audio materials on the radio, video material on the TV, mini-series, visual aids: poster, booklet and social networks (Facebook, twitter, YouTube, SMS), videos in Bambara using portable video projectors
Handerey approach: Promotion of a tolerant society where men and women respect each other, critically examine gender inequalities, and participate equitably in decision-making and resource allocation.	Mini-series projected using a portable overhead projector
Jigisigi Community Communication is based on HCD (Human-Centered Design): Teach pregnant women, husbands, and grandmothers (mothers-in-law about the danger signs during pregnancy and childbirth, the importance of going quickly to the health facility if the woman shows these signs, and benefits of antenatal consultations, giving birth in a health facility and postnatal consultations.	Various tools such as songs, health worker aids, posters, etc.

The Jigisigi platform and support provided by KJK to national campaigns are considered successful according to key informants. The Community Action Group (CAGs) and Nutrition Support Groups (GSANs) are also used to convey messages and, according to the implementers of the two programs, these strategies have potentially made it possible to increase the rate of handwashing with soap, to

improve hygiene and sanitation in the health structures, for villages to increase the rate of attendance at health centers, and to decrease malnutrition rates. However, as described above, the evaluation lacks quantitative data to verify these assertions, but FGDs provide supportive evidence. A sentiment stated in numerous FGDs was the following:

We now wash our hands with soap when we come out of the toilet and before eating.

Focus group discussion, Women aged 15-49, Sikasso

KJK has also focused on communication through social networks and radio to reach as many people as possible. KJK reported that of the three million people to be reached by the fourth year of the program, 2.5 million people were reached with messages on various topics through these different approaches.

Their radio programs educate us because KJK always gives us solutions to our health problems and we apply them with regard to malaria, family planning, ante-natal and post-natal care.

Focus group discussion, women aged 15-49, Kati

KJK has also supported national campaigns such as the Jigisigi FP campaign, SMC (Seasonal Malaria Chemo Prophylaxis) campaign, the National Nutrition Week (SIAN— “Semaine Intensification Activités de Nutrition”) and World Breastfeeding Week, to the satisfaction of the highest authorities interviewed. At the community level, KJK conducted the capacity-building of 24 FM radio stations to disseminate messages about nutrition and breastfeeding and reached almost all of the communities in Mali. Among the 19 health areas where KJK is known, respondents in 17 areas reported being aware of the program’s interventions, and respondents cited radio and TV as the main sources of this information. The radio messages are reported to have had a significant impact on the amount and quality of information available to communities, helping to strengthen awareness and behavior changes as mentioned above. For example:

If the community is involved in the execution of certain activities – they could be sustained. For example, the GSN could work in the long-term if they conformed to the national policy on nutrition. These groups could take on board the activities after the partner has left.

In-depth interview Regional representative of the Ministry of Health

IRI Conclusions

The MTE concludes that, based on the evidence gathered, KJK is increasing the adoption of healthy behaviors in the sampled regions. It has designed and implemented a number of effective SBCC activities informed by extensive formative research. The ET observed the widespread availability of SBCC-related materials at the sampled facilities and communities.

IR2 Demonstrated Malian capacity to conduct research, and design, test, implement, and evaluate SBCC and SM

In addition to Jigi, the main local NGO, KJK has also strengthened the SBCC capacity of 543 local personnel working for NGOs, and has built the SBCC capacity of pharmacies, retailers, members of women's groups, traditional healers and 1,837 health workers (117.3% of the expected target). Participants in FGDs and KIIs reported that they have received training in all program areas, including the USG “Protecting Life in Global Health Assistance Policy.”

KJK had a robust research agenda and conducted a great deal of research, much of which informed the eventual Jigisigi SBSS campaign which, while it is still early, given that implementation of SBCC activities was delayed due to the lengthy research and development period is showing decent results. That said, however, the research was conducted by KJK itself. The program largely did not meet its IR2 goal of increasing the capacity of Malian groups to conduct research, and design, test, implement, and evaluate SBCC and SM.

Sub-IR 2.1: Malian non-public SBCC entity identified and benefits from intensive technical and business management training to conduct research, design, test, and implement SBCC in support of HHS and products.

The MTE found that KJK had identified Jigi, a non-public entity Malian NGO, to train and continue the SBCC activities upon completion of KJK, but their involvement has come too late in the life of the program to fully build their capacity to conduct research, and design, test, implement, and evaluate SBCC and SM. The delay occurred because KJK selected first one NGO that did not meet the financial management standards, and another did not accept to comply with statutes of the “Protecting Life in Global Health Assistance Policy”. It is not clear why several candidates were not assessed simultaneously to meet the deliverable in a timely manner. Consequently, the sustainability of the activities is uncertain because KJK has not yet been able to provide technical support to transfer these activities to Jigi. The KJK team recognizes this challenge:

The communication is a positive aspect (of the program) – there is a team which does ‘coaching’ and this will lead to greater sustainability. However, we need to assess the capacity and stability of the partner NGOs – we do this but there is a lot which remains to be done. It will require financial support at the opportune moment

In-depth interview, Representative of KJK

Despite this need, instead of empowering Jigi to conduct research, the work plan indicates that KJK still plans to conduct the research activities themselves.

KJK has also trained staff from local organizations (CNIECS, AMPPF, Group Pivot / Population Health, Jigi, ACOD, the Association of Midwives (Association des Sages-Femmes (ASFM)) etc.) on how to monitor training, conduct an institutional capacity analysis (using the PROGRESS tool), and develop strategic plans. KJK has also trained its partner sub-grantees on the design and implementation of SBCC approaches to improve MNCH, malaria, HIV/AIDS, and RH and FP services. Respondents reported to the ET that, while beneficiaries greatly appreciate the training, the development of strategic plans has not yet been achieved because of a lack of resources. The strategic plan of CNIECS, which is in charge of conducting, funding, and approving SBCC for the MPH, was not completed by the time of the MTE, so the ET was not able to review it. In the project’s last year, KJK plans to work with CNIECS in the area of operations research to strengthen the capacity of the agency to identify barriers to desired behavior changes. The last year of a program should be focused on sustaining capacities built and ensuring the continuity of activities, rather than building new capacities.

In addition, high staff turnover was also seen a problem with regard to sustainability.

It is a challenge- there are a lot of factors which act as a barrier to sustainability – nevertheless the field agents have been trained and have the necessary tools, but there needs to be technical and financial support from partners- this is very important. This will limit, how shall I say? The ‘professional mobility’ which is a problem with regard to human resources and which blocks the development of skills.

In-depth interview, Representative from KJK

Sub-IR 2.2: MOH capacity reinforced to conduct research, design, test, and deliver SBCC services nationwide.

Key informants report that KJK has started to strengthen the capacity of the CNIECS. For example:

We know KJK better than SSGI and I learned very quickly that we could have a good collaboration with KJK. KJK reinforced the capacity of CNIECS in terms of communication and social marketing – we partnered the program and developed a strategic plan with them. This partnership helped us firm up our priorities and vision and these formed part of the PRODESS and the national policy for communication for development.

In-depth interview, Representative of CNIECS

However, key informants reported that CNIECS lacks resources to implement research and apply the training received. Financing of SBCC activities was not part of the strengthening of the MPH capacity; KJK focused on technical capacity only and did not find ways to include this activity in the MPH's next annual work plan and budget.

Sub-IR 2.3: Malian SM entity identified and benefits from intensive technical and business management training in social marketing, including SBCC for HIHS products, services, promotion, and sales.

Jigi, the local NGO expected to continue the work of KJK, was selected only in the program's fourth year. It is currently being trained by KJK to develop its capacity in order to take over the strategic SBCC and SM support to local NGOs that the program is currently providing and to become the national champion. Jigi is likely to succeed if given the time and support required. However, Jigi does not yet have the organizational development and management capacity to continue the work initiated by KJK. According to a representative from Jigi, the first service contract was signed on February 2, 2017 for three months; it was related to communication activities and health promotion. Two health educators acted as focal points for collaboration with KJK on activities including theater productions, educational talks, and radio shows. Only two Jigi facilitators were trained to use the PROGRES tool to conduct an institutional analysis of their organization. Through this analysis, Jigi was able in Year 4 to identify its weaknesses and develop its strategic plan, the first time it had ever done so by itself. The capacity of the Jigi staff still requires much development if it is to assume the SBCC and SM responsibilities of KJK. The MTE did not find evidence of effective handover of other responsibilities aside from the ability to conduct strategic analysis and planning.

IR2 Conclusions

The ET concludes that KJK has identified a Malian NGO but has not developed its organizational and technical capacity to be able to independently conduct research and design and implement SBCC and SM activities. The MPH capacity has been developed technically, but their budget and organizational structure have not been sufficiently reinforced to enable them to implement SBCC programs nationwide.

IR3 Increased availability of socially-marketed related products and expanded non-public services in target geographic areas.

Sub-IR 3.1: Effective social marketing of USAID-supported products and nonpublic services for FP, ANC, MCH, HIV, WASH, and nutrition in targeted geographic areas.

In addition to its public marketing of projects and activities, KJK developed various effective private SM strategies, including working directly with private pharmacies, women's groups, midwives' associations, and the field doctors' association to ensure the distribution of social marketing products. It is important to note that the project measured the commodities distributed to these private channels rather than the commodities actually purchased. Ultimately, the use of social marketing products exceeded the expected results for all nine products. By way of illustration, the achieved rate of CYP exceeds 455,745, representing around 14% of the market targeted by SM, which is estimated to be comprised of 75% of women of childbearing age.

Sub-IR 3.2: New products and interventions identified and incorporated as appropriate into the social marketing program in target geographic areas.

KJK started in 2015 with the distribution of three products for sale: male condoms (3,258,080 sold in 2015), oral contraceptives (Pilplan) (102,400 sold), and water purification tablets (Aquatabs) (1,424,000 sold); they also added additional products, bringing the total up to nine products in Year 4 with an additional product to be launched in Year 5⁵. KJK has been effective in introducing new products and reported that sales are on track (See Table 8, below). The ET was not able to gather denominator data to demonstrate whether KJK can monitor its market share yet.

Table 8. Results of the Distribution/Sale of Social Marketing Products. (Source KJK)

KJK Program Life thru July '18	Objective	Sales Achieved	Variance %	CYP	Objective PY5 Oct 18-Sept 19
Male Condom	39,627,823	52,142,032	31.58%	434,517	22,919,504
Protective	13,136	2,0870	58.88%	174	5,208
Pilplan-d	2,894,756	3,007,378	3.89%	200,492	1,092,281
Confiance	1,158,206	1,661,946	43.49%	415,487	594,770
DIU	25,715	42,298	64.49%	196,263	9,587
Jadelle	34,061	81,559	139.45%	309,924	3,600
Collier	1,709	8,409	392.04%	12,614	5,188
Aquatabs	21,280,715	27,091,920	27.31%	NA	9,150754
Oral Zinc	520,418	661,940	27.19%	NA	351,441
Total CYP achieved				1,569,470	

The ET did not find evidence that KJK supported new innovations by SSGL, such as KMC or the umbilical cord care interventions.

IR3Conclusions

The ET concludes that the KJK program is implementing an effective SM portfolio of products through non-public (or private) services such as those described above, and new products have been incorporated, but this activity has not been sustainably transferred to the Jigi NGO yet.

Sub question 1 a. Are the interventions being implemented leading to the intended results and sub-results?

Yes, the conclusions above indicate that KJK is implementing interventions that are leading to intended results. However, KJK was not able to identify and develop the capacity of the local NGO and nor to find ways of sustainably strengthening the MPHH in a timely manner.

⁵ Source: KJK program manager.

Sub question 1b: Which interventions are having the greatest success, and which are having the least success?

Jigisigi is the intervention that has had the greatest success. It is centered on the woman as the pillar of the family, and its programmatic focus is on MNCH and FP, through a number of approaches that include: Jigisigi FP, Jigisigi wedding party, the gender-based Handerey approach and couple's communication management.

Jigisigi is personified by a couple who is informed about health and decides together to adopt favorable health behaviors. SM has also been successful in distributing oral rehydration salts (ORS) and Aquatabs in addition to FP products. These products are promoted as products for "the hope of the Jigisigi family". Key informants repeatedly expressed that this approach has been embraced by participants and is effectively serving program goals.

The least successful intervention has been the development of a Malian NGO with the demonstrated capacity to implement SBCC and SM activities, due to delays by KJK.

Sub question 1c. What specific barriers are impeding the attainment of certain results?

The qualitative research identified a number of barriers to the use of services. These barriers are related to socio-cultural factors and to logistical and administrative constraints in the following intervention areas:

Family planning

The ET identified a number of social barriers to FP use:

Some girls hide their family planning use – they are ashamed as their mothers will know that they are having sex! Before, we didn't use family planning because our mothers told us not to, but now young girls, because they are educated, use it without their parents' knowledge.

Focus group discussion, Women aged 15-49, Sikasso

Here men are against family planning – if a woman wants to space her children she has to use it in secret.

Focus group discussion, Women aged 15-49, Kayes

It has been noted above that the widespread secret use of family planning methods due to social taboos, may mean that its uptake is under-reported by survey respondents.

Supervision

The isolated nature of many communities and the lack of accessible and well-maintained roads means that effective and regular supervision is difficult.

Doing supervision on motorbikes is difficult. We suggested that we should have vehicles but there weren't sufficient financial resources to pay for them.

In-depth interview, representative from ACOD, Partner NGO (Sikasso)

Leadership and Partners

Institutional factors relating to political priorities mean that there is sometimes a lack of synergy between the projects' focus and those of local government offices. In addition, the complexity of the intervention has left insufficient time to set up and implement the different elements. These delays were further compounded by high staff turnover.

*The priorities of the regional directorate of health are not met and this can lead to frustration.
The amount of time allowed to design new approaches and execute them was not sufficient.
The change in project leadership (KJK) also had an impact.*

In-depth interview KJK Coordinator, Bamako and Koulikoro

Remuneration

A major barrier to staff motivation was the fact that per diems paid to project staff were less than those paid to Malian government employees in the same role.

SSGI is under the auspices of Save the Children whose system is very 'heavy', and this doesn't help the activities to start up easily. There needs to be recommendations or solutions to get over these difficulties – for example, their per diem needs to be at least as much as that paid by the Malian government.

In-depth interview, Representative from USAID

With KJK, it (the remuneration) is poor. The (complex) administrative procedures required by Save the Children lead to problems with our technical services - the per diem rate is low and money for activities is not sent into the field. The staff neglect our field activities and no one facilitates relations between the NGO and the CSREF. The fact that payments are done by Orange Money is not liked at all and is a source of demotivation.

In-depth interview, Representative from ACOD (NGO)

Coordination

A further barrier to success was the apparent lack of effective coordination between KJK and SSGI. This pertained not only to behavior change communication (as described above), but also to coordinating the ordering and distribution of commodities. This appears to lead to stock-outs, which were poorly received by the population.

KJK creates the demand and SSGI coordinates complementary activities to provide the supply of those services. However, there have been some difficulties in connecting with the social marketing activities which are part of SSGI. There is a confusion about who is doing what activity. KJK should be furnishing local NGOs with Aquatabs, but SSGI hasn't ordered them. The local NGOs haven't signed contracts, let alone been supplied with commodities. This delay is linked to factors at Johns Hopkins.

In-depth interview, KJK team member

We have trouble getting hold of the medicines at the health center because there are no medicines in our pharmacy – sometimes we have to go to Gakoura to find them. Stockouts are frequent - they discourage people.

Focus group discussion, Adolescents 15-19 years old, Kayes

Access

Although the referral system has been strengthened for the transfer of women with obstructed labor or very sick children requiring diagnosis and treatment, the lack of transport to higher-level facilities still presents a major problem. Hence the importance of having a sustainably funded transport scheme, community health workers and timely referrals.

The problem is the lack of an ambulance – when a woman is in labor she can take over an hour to arrive at the Dogofri health center – she can even give birth en route!

Focus group discussion, Community leaders, Sikasso

Cost

FGD respondents testified that the cost of specific services and medicines were often too high for them, which has led them to either not seek treatment or, instead, to seek the assistance of traditional healers.

For those that go to the health center and the provider gives a prescription, for example, for intravenous medication or an injection – there is then a problem as often the sick person cannot afford either the medicine or the cost of the transport to and from the health center. This means that the treatment is not given at regular intervals and the patient stops getting better.

Focus group discussion, Community leaders, Sikasso

For me, a lack of money is a barrier – that's why we start with traditional medicines for whatever illness we have. If it gets worse, then we go to the health center.

Focus group discussion, Adolescents 15-19 years old, Kayes

b. SSGI Specific Findings by IR and Sub-IR

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

Sub-Result 1.1 Improved knowledge, attitudes, and practices among target populations.

As noted earlier, 94.4% of surveyed women report knowing about the services that are available at the CSCOMs. This figure is relatively consistent across regions, although respondents in Bamako have lower CSCOM knowledge: there, 77.8% of women report knowing the services offered at CSCOMs, compared to 91.7% in Kayes, 95.8% in Koulikoro, and 100% in Sikasso. The qualitative data also confirms widespread knowledge and improved attitudes and practices in the evaluated regions.

Sub-Result 1.2 Community social norms support the use of healthy behaviors and health services.

Community support for the use of health services appears to be reinforced by an increase in spousal communication and an appreciation of service quality, both of which generated demand.

Before, in my family, women only listened to the orders of their husbands – they couldn't make a decision on any subject. But times have changed and women are central to all our decisions – we decide about household spending on health together.

Focus group discussion, Community leaders, Bamako

For me, the CSCOMs are like schools in relation to their importance for health. When you have a consultation, you can better know the cause of your illness and how to protect yourself. Going to the health center means that women and children will be in good health and households will be happy.

Focus group discussion, Community leaders, Koulikoro

The qualitative data indicate that these health seeking behaviors are mostly uniform across the evaluated regions.

The KIs show that nutrition groups (GSAN), which organize cooking demonstrations in the communities, have been successful in both improving nutritional practices through its trainings as well as helping to identify cases of malnutrition in the community. The setting up of CAGs, which are specific mandates entrusted to NGOs implementing the program, and have been essential in building on community social norms. For example, 62 CAGs were set up by the program in the Koulikoro region, as well as 89 village solidarity funds to take care of patient referrals in case of emergencies.

The functionality of these CAGs is an effective instrument for the institutional development of Community Health Associations (ASACOs). The CAGs are also a means of community-based management of obstetric, neonatal, and infant emergencies. SSGI reporting states that the program set up 360 CAGs in the six intervention districts of the program, including 80 in Fana, 40 in Koulikoro, 60 in Kati, 50 in Kangaba and 40 in Ouélessebouyou. According to key informants, the setting up of these CAGs also helped to prevent malnutrition at the program sites. However, it is important to note that these actions were only carried out starting in Year 3 of the program as the MTE found in the approved work plans; the ET was unable to ascertain the reason for starting this strategy.

Sub-Result 1.3 Community advocacy strengthens service provision, management and accountability processes.

Key informants reported that SSGI helped to develop 1563 (66.6% of the target) community action plans to address identified health issues, including hygiene and sanitation. The ET does not have individual-level data on support for ASACOs. However, respondents were asked who took care of them during their most recent health facility visit, with CHW as one of the options. Only five respondents reported that they were serviced by a CHW; of those, all five reported that they were “Satisfied” with the services they received. This compares to an overall rate of 90.1% who expressed that they were “satisfied” or “very satisfied” with the services they received, regardless of the type of service provider. The subset is too small to evaluate the difference statistically.

The community health workers come and chat to us – and due to these exchanges, we now understand a lot of things.

Focus group discussion, Women aged 15-19, Koulikoro

The projects give the health workers a lot of training and they, in turn, train the community health workers, who give the village population all the information they need about water and hygiene.

Focus group discussion, Community Leaders, Kayes

By the end of the fourth year, the SSGI program had created 257 CAGs in the five program regions to improve information, awareness, and the education of the populations. The effectiveness of the CAGs lies mainly in the fact that they are composed of all segments of the community, and that they have include both men and women. CAGs thus proved to be an ideal instrument for the social and behavioral change targeted by the two programs concerning the following technical information: MNCH/FP, malaria, nutrition, WASH, and HIV/AIDS. The MTE does not allow a precise determination of the contribution made by the CAGs to the level of knowledge and information of the population with regard to the technical fields covered by the program. However, the ET found that knowledge of the services provided was high, reaching 99% in some areas (in the case of FP), and people in all focus groups – women, community leaders, and adolescents – report being satisfied with the supplied information.

To glean additional insight on the importance of community level outreach, the ET obtained more information from one very successful CSCOM – the Ntobougou Center – that showed the highest ANC coverage. The ET interviewed the Center’s head, Mr. Honoré Coulibaly, in order to understand what they have done to ensure that, of the 372 pregnant women who had their first ANC visit, 316 (85%) attended all of four ANC consultations. Mr. Coulibaly explained that this result was due to five trained “matrons” attached to the CSCOMs operating at the level of rural maternity units. The matrons are able to raise awareness among women to come early for their first visit and, once they start, these matrons follow the women very closely until the fourth visit. He said that women whose deliveries were attended to by these matrons reported being pleased by their services. The deliveries those matrons assist with were also reported to be more personally acceptable to women because matrons provide continuous support throughout the pregnancy and are well known and trusted. This practice deserves more research

and documentation but shows how using CSCOM performance indicators, might help identify and sustain effective practices.

IRI Conclusions

The ET was able to demonstrate that SSGI has increased demand for HIHS. The creation of numerous CAGs and the support to the ASACOs have proven effective as well. However, these interventions are not sustainable yet because no sustainable strategy has yet been developed. More time is required to make HIHS sustainable. The ET believes that the transfer of tools, and the whole process of training, coaching, supervising, monitoring and evaluating these structures within the districts and regional health teams are the surest way to ensure their sustainability.

IR 2: Improved access to and quality of integrated HIHS at the community level and appropriate referrals.

Sub-Result 2.1 Service delivery points consistently deliver priority HIHS according to MOH standards.

The MTE found that most CSCOMs have the capacity to deliver the package of essential healthcare services⁶, though IMCI and long-term FP methods are less widespread, and all CSCOMs had basic infrastructure. The ET found wide variation in the performance of CSCOMs in terms of service delivery. As a means of quantifying those differences, the ET calculated and ranked the average provision rate across the 38 different services listed in the health facility survey for each CSCOM. That is to say, the ET calculated the rate of delivery of each of the 38 services for a single CSCOM (using the number of times the CSCOM reported providing that service divided by the appropriate demographic denominator), and then took the average rate of delivery across all 38 services for that CSCOM. In Table 9, the ET lists the top- and bottom-performing CSCOMs in the sample of 30, along with their average provision rate, excluding Karan due to outlier responses of well over 100% provision for many services, and Didieni due to excessive missing data. The performance of all the 30 surveyed CSCOMs is in table 3 in Annex IV.

Table 9. List of Highest- and Lowest-Performing CSCOMs

Top-Performing CSCOMs	Avg. Provision Rate	Lowest-Performing CSCOMs	Avg. Provision Rate
Diamou	0.493607	Fourou	0.148994
Samakele	0.444779	Kaboila	0.141383
Ouezzindou	0.404796	Lattakaf	0.128025
Didieni	0.366821	Keleya	0.087177
Mambiri	0.362819	Dogofri	0.062762

Whereas the CSCOM in Diamou achieved almost a 50% rate of provision across all of the listed services, those in Dogofri and Keleya reached less than a 10% rate of provision. In discussions with personnel at

⁶ The essential healthcare package includes: management of childhood diseases diagnosis (acute respiratory infection, diarrhea, malaria) through IMCI, antenatal and post-natal care, delivery including active management of the third stage of labor (AMTSL), essential newborn care, WASH, malaria, PMTCT, HIV / AIDS, and prevention and treatment of malnutrition.

some of these CSCOMs, key reasons for the differing rates of provision tend to be staffing differences and the availability, or lack thereof, of appropriate supplies and medications.

Sub-Result 2.2 Effective service delivery approaches for various HIHS applied and scaled up.

To improve access to and the quality of health services, SSGI has ensured that MNCH/FP services are delivered and has also introduced a number of interventions to improve MNCH/FP, malaria, nutrition, and WASH services. Table 9 above and Table 2 in Annex IV show the varied degrees of performance achieved by the CSCOMs included in the MTE. The findings indicate that SSGI has not yet achieved consistent performance or sustainability in the target regions. In addition, SSGI introduced the following new interventions, which have not yet been scaled-up:

1. **Kangaroo mother care program (KMC).** SSGI is reported to have trained health care providers in KMC and increased the coverage rate of this intervention by 53.4%; that is, an additional 113 new sites now provide KMC services. We do not have aggregated data about the number of babies' lives saved through the KMC coverage, but considering that none of these facilities had KMC capability to properly handle pre-term and low birthweight cases before, if well-implemented and monitored, this intervention may lead to a reduction in infant mortality. SSGI has also equipped the CSCOMs with algorithms for the management of neonatal sepsis and for the care provided to premature and low birthweight infants. The evaluation found that SSGI has not yet developed a plan to scale-up and transfer a new and improved newborn care program to the districts.
2. **Umbilical cord care with chlorhexidine (UCC).** SSGI introduced the use of 7.1% chlorhexidine gel or solution for umbilical cord care in 4 districts (Ouellessoubougou, Koutiala, Kenieba, and Commune I of Bamako). However, the ET found that the solution/gel of chlorhexidine at 7.1% was only available in 36.7% of CSCOMs visited, and a national level scale-up strategy is not yet in place because the MPH has not included chlorhexidine in its medicine budget. Despite this, SSGI reported it has demonstrated its effective application in Mali. Key informants reported positive results and have encouraged scaling the program up at the national level, which is expected to take effect in 2019.

One occasion when I saw the two projects work really well together was around the launch of the Chlorhexidine intervention. Both projects participated – whereas normally one was doing one thing, and one another.

In-depth interview, UNICEF representative

3. **Task shifting to CHWs and “relais” for the management of simple cases of diseases at the village level.** Through the community action groups (CAGs) and nutrition support groups (GSANs), key informants report that SSGI has empowered CHWs and relais to manage uncomplicated cases of diseases at the village level and the referral of complicated cases to the CSCOM. SSGI paid 871 CHWs in Kayes and Sikasso to support this program. The ET found that informants believe referral by CHWs and the role of CHWs in C-IMCI and condom and pill distribution to be effective. However, government respondents are concerned about the sustainability of this program because it is too expensive for the GoM to pay CHWs and maintain the CHW-based interventions. SSGI reported that they are currently exploring ways in which local communes could take over this payment. It is also a question of political will to explore various financing options.

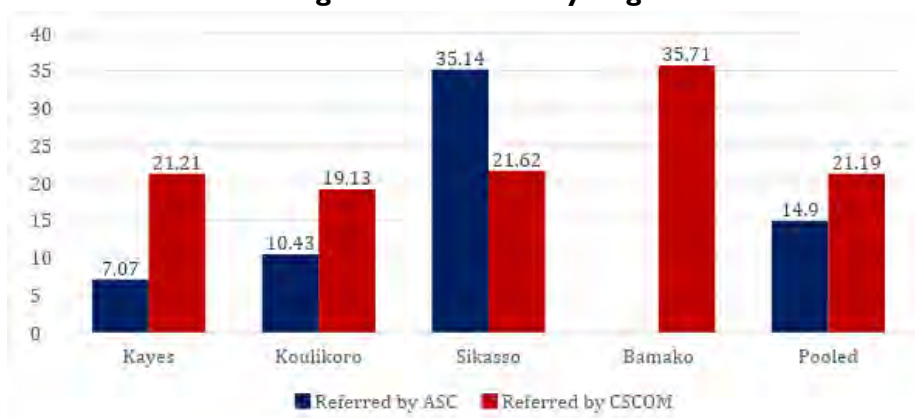
To strengthen the capacity of CSCOMs, key informants reported that SSGI has developed the following approaches:

1. **Community Action Groups (CAGs).** By the end of the 4th year, SSGI had created 257 CAGs in the five program regions to improve community awareness and mobilization, with the goal of increasing the use of services and the awareness and the education of the populations in the program's various technical fields. of services among women in the program area; for example, we noted that 99% of respondents reported knowing the FP services available. CAG informants shared that their role is important in promoting FP services and the results achieved through the awareness activities they carried out. The target community where CAGs operate is composed of predominantly illiterate populations (62.2%), where oral knowledge and interpersonal communication play a very important role in society in the promotion of primary health care services (PHC), which aim to improve the information available to and education of populations (Adamawa, Cameroon, 2005).
2. **Referral System Monitoring and Mapping.** The ET found that the referral system has been strengthened; referrals by CHWs for neonatal and childhood illness occurred in 76.7% of cases, while referrals from CSCOMs to reference health centers related to pregnancy, childbirth, and abortion-related complications occurred in 93.3% of cases. Strengthening referral and evacuation systems between villages and CSCOMs is part of the integrated approach used by SSGI's community mobilization activities. Monitoring and mapping referral data helps districts strengthen the quality of care at CSCOM level and ensures that the timeliness and quality of care standards are consistently met every time. Informants confirmed that data are used in the capacity-building of ASACOs and general community health activities to help strengthen referrals and service delivery.
3. **Village Solidarity Funds.** SSGI is reported by key informants to have enabled the community health associations (ASACOs) and the communities they serve to set up village solidarity funds for the referral and evacuation of individuals requiring health services. SSGI helped set up 558 village health funds (320 by the end of Year 3 and 238 in Year 4 alone). The ET did not find a plan for sustaining this financing mechanism, which seems to have the potential to help mobilize local resources. SSGI has not yet developed a way to institutionalize and scale up this mechanism.

Sub-Result 2.3 Referrals and follow-up strengthened between household, community, and facility for selected services.

Overall, the data from our individual-level surveys suggest that approximately 15% of women have received referrals for higher-level care by their community health workers (CHW), and approximately 22% have been referred by their CSCOMs. The key informant interviews and the reports reviewed indicated that SSGI conducted an effective mapping of health areas with available emergency transport (vehicle or moto ambulances) for maternal and newborn evacuations between the village and the CSCOM. SSGI encouraged the CAGs to use cellphones to better connect actors in the referral system, and they set up or revitalized the village solidarity health funds to pay for transport and monitored their use. In addition, SSGI integrated the recognition of danger signs into all health worker trainings and community-based health promotion activities to ensure timely referrals. Access to cell phones is being used strategically to facilitate this reference-evaluation system from community to CSCOM and from CSCOM to Reference Health Centers. As illustrated in Figure 4 (below), 35% of women in Sikasso reported receiving referrals from their CHW, whereas just 14% did in Koulikoro. That no women in Bamako reported such referrals is a function of the easier access to health care in the capital region, where women tend to deliver in private facilities or refer themselves directly to CSREFs

Figure 4. Referrals by Region



Most referrals are for acute maternal and infant cases. Geographic access to services is a major barrier to access to care. On average, 37.1% of the 320 women interviewed reported traveling more than one hour to a CSCOM, with 45.2% of those in Koulikoro reporting such travel times⁷. Geographic access was not a problem in Bamako. In addition to long travel times in the other districts, illiteracy and cultural factors have also been reported to have played a role as a barrier to access to services. In addition, the indicator of completeness of the four required ANC's (i.e. whether or not women attend all four ANC's) is not subject to systematic monitoring by the service providers and, as mentioned above, the attrition rate from ANCI to ANC4 is 59 percentage points. These rates do not appear in the SSGI-PMP for regular monitoring, and SSGI has not sought ways to fix the high attrition rate.

Referrals around the medical evacuation system worked well. SSGI put in place a village savings fund and a means of transport to evacuate sick children and pregnant women – it works routinely now.

In-depth interview, Representative from regional health directorate, Sikasso

IR2 Conclusions

SSGI has improved access to and quality of care of HIHS interventions, but these are not being consistently implemented in all of the CSCOMs in the evaluated regions. A number of effective practices have been implemented but have not yet been scaled-up. The number of referrals has increased.

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

Sub-Result 3.1 Improved planning, management, and accountability systems at the CSCOM/ASACO, district, and regional levels.

To increase accountability, SSGI developed a community-based information system using the same platform as the DHIS2. It is specific to SSGI and has not yet been integrated into the national DHIS2 system. Integration is planned for Year 5, but the ET is concerned that there will not be enough time for the District and Regional authorities to learn to use the information to make management decisions and for the MPHH and the target districts to sustain the system after the program ends.

⁷ 30-cluster survey 2018: 45.2% of women in Koulikoro region, 31.3% in Kayes, and 39.2% in Sikasso.

The ET found that, working in collaboration with district health authorities and local NGO partners, SSGI empowers service users to tackle local health issues. Using the Community Action Cycle (CAC), communities link to the formal health care system and engage with ASACOs and other health governance bodies to drive demand and to ensure the sustained delivery of quality health services. The CAC builds the analytical, planning, and evaluation skills of community-level actors, preparing them to identify root causes of health challenges and to take action together to find solutions and increase community support for health, Nutrition and WASH. SSGI also works with districts, ASACOs, health facilities and community leadership to ensure the safety and working conditions of ASACOs and volunteers. To enable CSCOMs to provide better quality health services, SSGI supports the institutional development of ASACOs to improve CSCOM management. SSGI supports ASACOs and CSCOMs to assess their own institutional capacities and to develop and carry out capacity-building improvement plans based on those assessments.

Since Year 2 of the project, SSGI has supported planning and management at the community level through 257 CAGs and 1,000 GSANs across all districts of Sikasso region, 8 districts of Kayes region, and 6 districts in Koulikoro. SSGI has also supported 139 WASH committees in two districts of Sikasso. An additional 144 CAGs and 30 WASH committees planned for Year 4 have been completed. SSGI's planning and accountability management approaches with these community organizations are primarily built around the local NGOs. In fact, once recruited, the NGO informants reported that they help the CAGs and other community groups to develop an action plan to support the ASACOs. It is the NGOs' priority to assist all basic community structures: CAG, GSANs, and community stakeholders such as CHWs, staging posts, and others. Among the many advantages of the local NGOs, as reported by SSGI key informants, are their visibility and proximity to the local populations, their understanding of the environment, their experience with communities, and their valuable expertise and know-how.

According to SSGI's latest annual report, through local NGOs, the program has organized hundreds of orientation sessions for CAGs and GSANs at the village level on various topics, including supporting the existing community health care structures (CSCOM, CSREF and ASACOs) and SBCC messages on the importance of using them not only for curative activities, but also for promotional and preventive activities (ANC, delivery, PNC), exclusive breastfeeding, family planning, etc.

SSGI has developed important social capital in these NGOs and community organizations on which to build its sustainability strategy. The sustainability of community activities is based on the role of NGOs facilitating community liaisons between CHWs, and health facility staff and traditional leaders, village chiefs, opinion leaders, traditional communicators, and Imams. These local leaders reported to help families understand the importance of visiting the health care centers for essential services.

Sub-Result 3.2 Data analyzed and used to plan, monitor and respond to health needs.

Working closely with MEASURE Evaluation, SSGI supports approaches that improve data quality at all levels of the health system, especially the community-level, including support to roll out and use the DHIS2 as the new HMIS platform. The SSGI project has achieved a physical presence in 37 districts through 28 District Officers based in the Kayes, Koulikoro and Sikasso, one district of Gao, and local NGO partners in all districts except the 5 districts of Koulikoro supported by the Canadian and Malian Red Cross. However, key informants report that data do not seem to be used to make management decisions at the regional, district and CSCOM levels.

SSGI has a large target area: the covered CSREFs have a combined total of 805 CSCOMs and 1,333 functional CHW sites. SSGI's target population includes an estimated 2,620,842 women of reproductive age (WRA) and 2,382,583 children under 5, with an estimated 595,646 newborns in the target districts at any given time. SSGI does not have a targeted flexible and data-driven approach and seems to treat every district and CSCOM in the same way. The ET found that SSGI does not use data to compare the

performance of each district to identify highest- and lowest-performers or to implement targeted remedial solutions, because SSGI does not monitor their performance in this way.

Sub-Result 3.3 Improved management processes to increase access, availability, and affordability of health care products and commodities.

The SSGI program has worked closely with the MPHHS, the Directorate of Pharmacies and Medicines and USAID/SIAPS (Systems for Improved Access to Pharmaceuticals and Services Program) until the program ended and now is working with the GHSC-PSM (Global Health Supply Chain and Pharmaceutical Supply Management) program to strengthen implementation of the Logistics Management Information System (LMIS) at the regional, district, CSCOM and CSREF levels. Informants report that SSGI works to improve data quality and systems; institutionalize evidence-based decision-making as related to forecasting, budgeting, and ordering; and apply process analysis to identify logistics bottlenecks. Focus is placed on reducing stock-outs at CSCOM and CHW levels. These interventions have certainly contributed to the improvement in the availability of equipment, products, and drugs observed at the 30 CSCOMs visited. Importantly, from Years 1 through 3, SSGI has provided materials and equipment to strengthen the technical platform of BEmONC, as well as FP services in 80 BEmONC CSCOMs, 714 non-BEmONC CSCOMs and 36 CSREFs. However, the MTE found the following stockouts: magnesium sulfate missing in 80% of CSCOMs; male condoms missing in 37% of CSCOMs; 43% missing female condoms; gentamycin missing in 80% of CSCOMs; zinc sulfate missing in over half of CSCOMs (50% missing 20mg pills; 93% missing 10mg syrup); 63% missing chlorhexidine; and approximately 35% missing Arthemeter and Lumefantrine. None of the surveyed CSCOMs had M2000 RT qualitative amplification reagent in stock, which is necessary to measure viral load, and only one had First Response, which is a test used to measure HIV antibodies.

Sub question 1 a. Are the interventions being implemented leading to the intended results and sub-results?

Based on the findings above, the SSGI interventions are leading to the intended results, but the program needs more time and a targeted approach in each region and district to address individual performance problems identified, and to make systematic use of available data and integrating with national HMIS.

Sub question 1 b. Which interventions are having the greatest success, and which are having the least success?

Though the MTE data are only cross-sectional, we are able to draw from various other evaluation materials to provide some insight into more- and less-successful program activities, as outlined in Table 10 below. Some successful interventions include the increased rate of first ANC, though data from CSCOMs regarding the completion of all four ANC visits and facility deliveries suggest that work needs to be done to ensure continuity of care. Medication for Active Management of Third Stage of Labor (AMSTL) implants and post-partum IUDs, and HIV care are generally available, though some HIV medicines and tests are out of stock. Reported malnutrition rates are quite low and these data need further study to confirm the causal factors. Improved sanitation and hygiene practices have become common in the surveyed areas. The referral system has been strengthened but is not yet sustainable.

On the less successful side, in addition to the attrition in ANC visits after the initial one, and the lack of some HIV medications, the evaluation team found shortcomings in IMCI provision. SSGI has not helped the MPHHS to budget for additional service delivery costs related to increasing the delivery of high impact health services, or to find ways to sustain increased service delivery in their subsequent fiscal year budgets.

The organizational development of local NGOs has also been less successful. Despite extensive technical training, NGOs reported that they need organizational development to grow and continue working. Short

contracts and delays in contract renewals were major constraints to their ability to provide continuous services.

Healthcare providers at CSCOMs reported in KIs that formative supervision and coaching was a successful intervention, in that it helped them to apply new knowledge and skills. They also reported that formative supervision increased supervisees' motivation and reduced the need for organizing refresher training workshops. Despite the strong support for formative supervision expressed by key informants related to capacity-building and provider motivation, and ultimately the impact on improved performance, districts have not been helped yet by SSGI to implement systematic supervision and coaching to improve provider performance.

SSGI has conducted numerous training workshops but it has not yet determined if and how training will be handed over to the local training institutions such as the National Health Sciences Training Institute (Institut National de Formation en Sciences de la Sante- INFSS) to improve pre-service and in-service training and ensure that future generations of health professionals are prepared to deliver the essential healthcare package according to quality standards.

Table 10. Evidence of Most- and Least-Successful Interventions

SSGI Interventions	Most-Successful	Least-Successful
ANC	1st ANC at 78.8%	Continuity of care: 59% (ANCI/ANC4) attrition rate
AMTSL=Active management of third stage of labor	Availability and use of AMTSL: 100% of CSCOMs have oxytocin for AMTSL	
IMCI	Reported to be provided in 80% of CSCOMs	Coverage is not complete: 20% of CSCOMs were not providing IMCI the day of data collectors visit
Nutrition	93.3% of malnutrition cases detected (moderate and severe) were being treated	Proper weaning and malnutrition prevention
WASH	FGD indicated that handwashing has become a common practice in households due to education messages and handwashing material distributed	
FP and Long-Acting and Reversible Contraceptives (LARC): Implants and Post-partum IUD	LARC are available in 56% of CSSCOMs visited. Implants are being used by 22.2% of the 320 women interviewed	3.3% are using IUDs, despite the difficulties of promoting these methods. Availability of tubal ligation and vasectomies has not spread
Mother Kangaroo		Introduced but not yet scaled-up.
Umbilical Cord Care (Chlorhexidine)	Chlorhexidine was available in 11/30 CSCOMs visited, and the scaling-up is in progress	

SSGI Interventions	Most-Successful	Least-Successful
HIV and Condom Availability	The rapid HIV screening test, SD Bioline HIV1 + 2.3.0-Box/25, was available in 36.7% of the structures visited. Male condoms were available in 63.3% of the structures visited. Female condoms were available only in Kayes (87.5%) and Koulikoro (66.7%). Sikasso and Bamako were out of stock at the time of the survey. HIV/STI test cases were provided to all pregnant women when tests were available	The rapid test screenings (Comb direct HIV 1/2 B/20 tests) were out of stock in Sikasso, the First response-Box/30 tests were out of stock in Koulikoro, Sikasso, and Bamako Tenofovir Medications (TDF)/Lamivudine (3TC)/Efavirenz (EFV) 300/300/600 mg tablet B/30, Lopinavir/Ritonavir (LPV/r) 200/50 mg tablet B/120, Abacavir (ABC)/Lamivudine (3TC) 60/30 mg tablet B/60) were out of stock in Kayes and Sikasso.
Malaria	Rapid Diagnosis Malaria Tests were available in 93.3% of the structures visited. Long-lasting insecticide-treated mosquito nets were available at 90% of CSCOMs visited. Sulfadoxine and Pyrimethamine 500mg + 25mg tablets were available in all 30 structures (100%). 83.1% of malaria cases in children ≤ 5 years screened in outpatient sites were treated. 88.9% of cases of malaria cases in pregnant women screened in outpatient sites were treated.	Malaria medicine availability ranged from 60%-83.3% in the surveyed CSCOMs.
CAG	CAGs are reported to help in changing behavior and social norms.	
Referrals and Village Solidarity Funds	Referrals CSCOM-CSREF: 1,510 cases for pregnancy, childbirth, and complications related to abortion from the 30 CSCOMs visited were referred to CSREFs CHWs referral from village to CSCOM: 1,609 cases for neonatal and infantile diseases from the 30 health areas visited were referred to CSCOMs.	Not sustainable yet
Paid CHWs and Relais	Reported increased access	All CHWs in the SSGI-covered districts are paid by the program. Community-supported payments are being initiated in one district in Sikasso region.
Local NGO development		Short contracts and delays in renewal are major constraints reported by NGOs interviewed.

Sub question 1c. What specific barriers are impeding the attainment of certain results? The evaluation found that a major barrier impeding the attainment of results included SSGI's staffing problems, mostly related to delays in recruiting program personnel and NGOs implementers, and to the burdensome management procedures required to implement electronic payments across all program domains. The

location of all project vehicles in Bamako was also a barrier for SSGI staff, preventing the timely and effective implementation of supervision and support.

From a programmatic standpoint, all of SSGI's technical areas (malaria, PMTCT/HIV/AIDS, WASH, maternal, newborn, child health, FP, and nutrition) are important ones. However, trying to implement them all at the same time everywhere is a barrier to effectiveness because it stretches the staff too thin for impact. The SSGI program team reports that they manage and fund all of their technical activities in each of the districts at the same time. Support is not targeted or based on the performance of each CSCOM and District to achieve desired results. Some CSCOMs proved to be performing better than others in certain technical areas; reinforcing what is working well and focusing on a few areas of improvement at a time, tailored to the needs of each CSCOM, has not yet been tried.

Barriers to the uptake of FP in Mali are often related to a fear of side-effects and to a perceived link with sterility. According to one FGD participant who shared a perspective that the ET heard from several respondents:

People say that an implant can disappear into your body. A lot of women don't use them for this reason.
Focus Group Discussion, Women aged 15-49, Sikasso

Given the widespread nature of comments such as this one in our FGDs and KIs, there is reason to suspect that fears related to lack of information and associated cultural perceptions continue to affect the attainment of some results, particularly related to the use of family planning methods.

Finally, systemic shortcomings in the Malian health system have not been addressed in such a way as to reinforce program impacts yet. These areas include the development of the health information system, the health financing system, and financial protection services (which goes beyond the health sector and is outside the scope of work of the current program). In addition, smooth coordination with other USAID-funded programs has not been achieved. The results of SSGI regarding the delivery of malaria interventions are encouraging; for example, the use of Artemisinin combination therapies (ACT) went from 7% to 2.3%. However, SSGI reported that use of Insecticide-Treated Nets (ITNs) fell from 87% to 70%. SSGI is not directly responsible for this issue; it is simply assisting with the distribution and proper use of bed nets in partnership with the National Malaria Control Program and PSI, which are the organizations responsible for uptake of ITNs. Aside from in Koulikoro, where the two regional representatives of KJK and SSGI share the same office, the two programs work separately in other regions. Smooth coordination should address these challenges. Another service conducted by KJK was the Interactive Voice Response (IVR) which used voice and text messages to reach the most pregnant women possible to remind them of the benefits of ANC services. The project conducted a pilot in Yirimadio, which is in commune 6 of Bamako. During Year 5 of the project, KJK plans to send pregnant women in the intervention districts 60,000 voice messages about malaria during pregnancy. The calls will provide information and attempt to motivate positive behaviors such as taking SP tablets, sleeping under ITNs and seeking medical care in case of fever.

IR 3 CONCLUSION

The MTE showed that, while the availability of essential health services has improved, there are management issues that affect the coverage and quality of healthcare services (presented above in Table 10). For example, using coverage data on antenatal and postnatal care as well as delivery services could help districts to improve their coverage and find ways to reduce attrition rates from ANC1 to ANC4 visits, which has not yet been addressed.

Family planning coverage has improved, but is still low. Data on and strategies to better address misconceptions and management of side effects could improve program management. SSGI has improved

health system management but coordination in the supply chain has not been completely addressed yet. SSGI has implemented a number of innovations, but these are not yet working at scale and regional and district teams need more support. Interventions have not yet been transferred to local NGOs to sustain them beyond the life of the program.

EQ 2: To what extent are the programs' financial, management, and M&E systems affecting implementation and the achievement of results?

a. KJK Program

2.a. Staffing: Are the programs adequately staffed, or are there gaps in the necessary management, technical, and administrative expertise?

The ET found that the program was adequately staffed, but that there is high turnover. The program lacks an effective human resource recruitment and retention strategy, though this does not seem to have affected the program, except in the selection and support of Jigi, the local NGO. The first Chief of Party (COP) left and had to be replaced; the program's Home Office back stop was then brought in to serve as acting COP. The Finance Manager (FM) also had to be replaced and the new one has only recently been recruited. KJK is receiving support from its home office and has a network of experts to draw on as necessary. They were not able to articulate how home office support complements their field team's expertise; it seems to be responsive – staff said that if they identify a need, they can ask for support.

Are the programs receiving sufficient support from their home offices to strengthen or complement the staff expertise? Yes. While the program was recruiting a new COP, the home office sent an acting one. The same was true for the FM, with whom the evaluation team met. To achieve desired results, whenever there was a vacant key position, the home office immediately sent qualified staff (as was the case with the first COP and the FM). This allowed the program to continue to operate in spite of key personnel vacancies that would have otherwise jeopardized the program's results.

How has this affected the programs' ability to achieve their desired results? The ET did not find any evidence that these staffing issues affected program implementation, except maybe the selection of the local NGO.

What actions have been applied to ensure the necessary staff levels and skills, and how effective has this been? KJK reported that it conducts regular training of staff prior to every coordination meeting to ensure that all personnel are up to date and have the right skills to do their jobs.

2.b. Management: How do the two programs coordinate planning and implementation of activities between themselves, with USAID, and with government counterparts? How effective are these efforts? How are issues identified and addressed?

The embedded observation found that KJK personnel spent more than 50% of their time attending meetings, which they used to identify and discuss ways to address implementation issues. On one hand, those meetings appeared to be important to ensure effective collaboration with USAID, the other IPs, and their government counterparts. On the other hand, the amount of time spent in meetings could detract from actually implementation in the field. We noted above that KJK spent most of the first three years in formative research.

2.c. Financial: SSGI has faced certain financial challenges, including difficulties with the use of mobile money and being unable to pay health workers on time.

The MTE did not find any problems in the financial management of KJK. They were not required to use e-payments as SSGI was.

2.d. Administrative: What logistical factors (including security concerns) have limited the programs' ability to achieve results?

The ET did not find that logistical or security issues are fundamentally undermining the success of the program. Insofar as activities have been concentrated in areas not susceptible to some of the most severe security challenges in Mali, operations have been able to continue as planned.

How have each program's administrative practices (related to logistics, accounting, reporting, etc.) impacted results, both positively and negatively? Management of contracts to local NGOs: KJK reported several difficulties in the recruitment of Jigi, the NGO intended to sustain the results of the program. Before any NGO could be recruited, KJK recruited an independent audit firm in accordance with usual tendering processes to audit institutional capacity, management, and accounting systems of any potential NGO. The audit evaluated the consistency of the NGO's financial and accounting procedures against US requirements. This was a lengthy process that lasted a significant portion of the program's startup period. The first NGO was disqualified after the audit. The second NGO benefited from training and orientation, but was not chosen; it is an International Planned Parenthood Federation (IPPF) affiliated organization and thus, days before the contract was to be signed, declined to sign the award because of the aforementioned "Protecting Life in Global Health Assistance" conditionality attached. In the meantime, in the absence of a local NGO due to these recruitment delays, KJK leadership had no choice but to do the work themselves and to collaborate directly with the women's groups, the association of midwives, and the association of field doctors to ensure the distribution of the social marketing products. While this decision ensured that the work was completed, it did not contribute to the local capacity-building goal.

Respondents from the NGO sub-grantees that work with KJK reported that, at the beginning of the program, it was difficult to implement activities given the short duration of the contracts (3-months at a time) and the long, tedious renewal process. At the program's outset, KJK reported that they gave short-term contracts to ensure that the NGOs were able to deliver and meet their objectives. Now, KJK gives two-year contracts, making it easier for the NGOs to manage their staff and cash flow.

Another problem that causes confusion is the different per diem rates paid by each program and the different mechanisms for payment. KJK makes payments in cash while SSGI does so electronically.

How can these be improved? The length of contracts has improved, but the sustainability of the NGO services remains a concern. Additionally, the differences in per diem amounts and payment systems have not yet been addressed. Having one local per diem and payment policy for all USAID-funded activities would help.

2.e. M&E Systems: How accurate is the attribution of results to a specific program's interventions? The ET found that the program's least successful program element appears to be its M&E mechanism. For example, the ET found that the failure to track attrition in the use of ANC services and other HIHS measures as indicators to monitor progress and create messages toward the attainment of the SSGI program's IRs constitutes a weakness of the KJK M&E system. Indeed, completion of all four prenatal visits is an essential step for ensuring the protection of the woman and her fetus during pregnancy. It is during these visits that the common problems and issues are identified and treated, and the crucial preventive measures are taken. Thus, the prenatal visits are one of the most important means of combating maternal mortality.

The KJK program uses three different software packages to track its interventions; first KJK worked with Excel and then DEV-info and KOBO to monitor program activities, and they used the SIRA system to monitor social marketing. The ET learned that the use of multiple packages was a function of different

tools being better suited for different tasks. The SIRA system is reported to be working well but the DEV-info and KOBO systems are reportedly not working as well as they should because it is difficult for KJK to accurately measure the effects of each intervention. Key informants reported that to compensate for somewhat ineffective M&E systems, the program has placed emphasis on the research activities to gather the required information throughout the life of the program. During the fifth and final year of the program, KJK still anticipates conducting extensive research in order to meet M&E requirements. The ET maintains that, in lieu of conducting this planned research itself, the program should be building the capacity of local NGOs to manage and monitor the SBCC and SM activities. It is not clear how NGOs would use any of these systems after the end of the program.

The program's M&E plan includes a matrix of key indicators. The program's performance framework effectively allows for the monitoring of inputs in areas such as training, the development of materials and the roll out of campaigns. However, the M&E plan does not track outcomes as effectively. The population reached is an estimation, as mentioned above, and monitoring is computerized at the community level using tablets. These data were evaluated and found to be accurate and complete, though.

In order to monitor the effects of the SBCC and SM activities, the program is tentatively using the DHIS2 data at the end of the last quarter of 2018. KJK used the data from DHIS2 in the last quarter and will continue to use it throughout the year to measure progress and compare that progress to communication process indicators they collect. It is not clear how KJK uses M&E data to inform its decisions; despite its inquiries, the ET did not obtain evidence or information regarding KJK's use of data to make updates.

One downside to the current approach is that the DHIS2 data are not specific to the program and do not necessarily allow conclusions to be drawn as to the level of service utilization. The use of this information is a function of the incompleteness of the data and the fact that indicators on HIHS utilization are determined by various inter-related factors and interventions not solely conducted by KJK. In addition, the two programs work with the same NGOs in the same areas and are meant to complement each other, making attribution difficult, though the contributions of each are possible to measure.

In addition, the longitudinal survey designed in a cohort study format which aimed to estimate the level of indicators at program start-up, the mid-term follow-up, and the end of the program, used a nonstandard indicator age range for women of reproductive age (WRA) of 18-44, which will likely create difficulty when comparing the findings to the latest Demographic and Health Survey (DHS) results of 2018 in Mali. KJK staff made a decision to focus on the most-likely age range for mothers of newborns, excluding the youngest (15-17) and oldest (45-49) age groups. However, this represents another example of a measure that was approved and implemented without consideration for public health norms.

Are data collection processes in place to help avoid duplication of indicators?

The indicators used by KJK are missing key elements to monitor the demand for HIHS and the new interventions of SSGI, as noted. The use of data for decision-making remains a challenge, as it is not integrated into the management culture of the public health system. Also, the use of tablets to collect data is donor-dependent and is therefore not sustainable. Other digital health solutions have not yet been explored.

How should M&E be improved in the future?

Data collection tools for M&E work should be designed with key MPH and WHO indicators and guidelines in mind so that changes over time can be compared to well-established baselines. KJK now has access to DHIS2, so they should be able to use comparable methods and generate district-level comparisons. Digital health solutions, including electronic medical records, should be considered in the future to facilitate data collection and avoid time-consuming data collection.

Is the programs' compliance to various Agency requirements (Gender, Environment, etc.) being monitored internally?

Yes, despite systemic difficulties, KJK monitors compliance with gender and environmental requirements.

EQ2 KJK Conclusion

The program's financial and management systems are in order. Some shortcomings exist in the M&E system and indicators, but those issues have not had a serious bearing on program activities. The delay in recruiting Jigi has prevented the institutionalization and sustainability of M&E activities. The use of data for decision-making is a challenge for both KJK and SSGI, one that is systemic and has not been effectively addressed. SSGI has therefore developed its own information system that would need to be integrated to the official national one (DHIS2) by the end of the project.

EQ2 KJK Main Recommendation

KJK should second its staff to Jigi and CNIECS to develop capacity and sustain the SBCC and SM interventions.

b. SSGI Program

Question 2: To what extent are the programs' financial, management, and M&E systems affecting implementation and the achievement of results of the SSGI program?

2.a. Staffing: Are the programs adequately staffed, or are there gaps in the necessary management, technical, and administrative expertise? Are the programs receiving sufficient support from their home offices to strengthen or complement the staff expertise? How has this affected the programs' ability to achieve their desired results? What actions have been applied to ensure the necessary staff levels and skills, and how effective has this been?

The ET reviewed SSGI's organogram and determined that the program is adequately staffed. SSGI reported that they suffered from the departure of a key member of its consortium (MSI) and a high turnover of staff that they trained at the district level. These challenges have hampered SSGI's efficiency and effectiveness by undermining the team's morale and the continuity of the activities; they have also caused delays as mentioned above in the recruitment of local NGOs and in the application of e-payments. SSGI addressed the issue by conducting new trainings for the newly-hired staff.

SSGI reported that they were able to limit the negative effects of these difficulties thanks to the constant support of its home office. While this was reported to be helpful, it undoubtedly incurred additional, unanticipated expenses. Each technical member of the program management team is supported by a senior specialist from the program's home office. They put in place an almost-continuous communication system and quarterly meetings that involved all members of the consortium in order to provide to SSGI the technical, administrative, and financial support it needed. The ET was not able to quantify the additional cost of these supports, but we suspect that the expense is not trivial.

In addition to the support from the home office based in DC, the program reported that it has been supported extensively in finance and administration by Save the Children's office in Bamako. This office has been in place for decades and has developed proven procedures and methods, but it also represents a significant additional cost. This support is credited with helping the program face various challenges including the systematization of electronic payments in the 33 districts.

SSGI also reported that it has had to support many interventions, both technically and financially, that were not in the original proposal of the program, including the deployment of the program's district staff,

known as district officers (DOs), the activities of the CLTS, and the payment of 871 CHWs in Kayes and Sikasso. The DOs were reported to be necessary for the program to implement activities at the community-level. Without the DOs, the program management confessed that they would not be able to deliver the technical support necessary to the local NGOs that assisted the CSCOMs and the community organizations. The payment of the CHWs was critical for their motivation and retention.

2.b. Management: How do the two programs coordinate planning and implementation of activities between themselves, with USAID, and with government counterparts? How effective are these efforts? How are issues identified and addressed?

The SSGI and KJK programs were designed as separate programs, yet they were asked to work in tandem and should be seen as complementary, because one mainly deals with demand creation and the other with the supply of high-impact interventions. Communication for social and behavior change is crucial in Mali, but the duplication of this activity in both programs was not desirable, especially since both programs are involved in conducting SBC activities during the same period, in the same districts, and with the same local NGOs. This has caused confusion as to who is doing what, and has added difficulties in terms of M&E and the attribution of results. That the two programs use different payment systems – SSGI uses e-payments, which were not always accepted, and KJK pays in cash – adds further confusion.

The ET views such duplication as counterproductive and recommends that it be avoided in the future. In addition, the ET found that the two programs work as very distinct and separate programs that share information but that do not have a concerted, well-articulated joint strategy to help the MPH deliver better services through its programs and CSCOMs. Below are four areas where the two programs have so far shown weaknesses:

1. **Joint planning: Both programs reported doing joint planning.** However, the MTE found that the joint planning has become a long process of simply combining both work plans into one document, not of creating a joint work plan. In addition, each program uses its own resources and reports on its own specific indicators to monitor their plans, and there is duplication of SBCC activities. Also, in the area of SBCC that both programs share, there was no real integration, but rather a summation of activities to be carried out. This means they merely added each program's planned activities into one master document, instead of creating new, integrated work plans. The planning process was reported to be very time-consuming, because all staff from both programs were gathered together for several working days. The large size of the group made discussions lengthy and difficult to manage, as all technical areas of both programs were discussed together. Consequently, the plan is ultimately too long (the last was 186 pages), making it difficult to implement and for other partners to review and use.
2. **Coordination and integration of the activities of both programs:** Both the SSGI and KJK program staff attend multiple coordination meetings together at the central and regional and levels in addition to quarterly coordination meetings. However, the embedded observation found that meetings are not always managed efficiently and staff spend too much time in meetings, at least 50% of their time. At the regional level, the ET found that, except in Koulikoro where the two regional representatives of the programs share the same office, each program works separately. In addition, only the SSGI program has representatives at the district level. Regional coordination meetings are reportedly not held regularly, and in some regions such as Sikasso and Kayes, they are no longer conducted at all. Even the attempt to conduct the same performance monitoring survey for the two programs did not succeed, because each program is required to report separately on its own M&E plan and indicators. In addition, the June 2018 mid-term survey did not incorporate most indicators of interest for SSGI.

Key informants reported that this situation has resulted from a lack of consensus over a joint plan and joint M&E and a lack of effective communication. The programs never found a way to merge and develop one joint results framework to guide their joint work. Thus, whether it is supervision, training or research, coordination has not led to the streamlining of resources and approaches by both programs as they focus on their individual IRs and objectives. Similarly, the way they work has not allowed for an effective integration of activities to maximize the efficiency of their interventions and to make it easier for the MPHH to receive support from the programs.

3. **Coordination of joint social mobilization campaigns:** KJK collaborates with ten local NGOs to implement the community mobilization component through the Jigisigi strategy, and SSGI works with seven of these NGOs. The use of the same NGOs by both programs initially seemed to be a good opportunity for coordination and synergy, because it would shorten the evaluation and interview time of these NGOs. Practically, however, this has proved to be more complex. Due to the lack of joint planning and synergy, there has been confusion in reporting the results to each program. These NGOs have essentially conducted the same activities for both programs, all of which involved communication, which causes problems of attribution. Each program has its own way of working with the local NGOs, which adds more confusion and work for the NGOs. The ET found that having a communication component in both programs has not brought any benefit or facilitated the implementation of the Jigisigi strategy or the collaboration between the two programs. The ET therefore concludes that program intervention would have benefited from a joint results framework with separate areas of responsibility for each program, designed to complement each other.
4. **The two programs used the same community workers and facilities (CHWs, “relais,” CAGs, Nutrition Support Groups):** The fact that both programs rely on the CAGs for community actors to share information and raise awareness on a number of health topics has not been helpful; instead, it causes confusion and represents a duplication of efforts. Both programs use the CAGs with other community workers and structures as channels to convey their educational messages. This situation exposes both programs to the risk of not being able to measure the results of the SBCC activities that the NGOs are implementing for both programs. The fact that the NGOs run the same types of activities, in the same areas, with the same community organizations and CHWs and “relais,” but with separate budgets, complicates accounting for the local NGOs and does not help build capacity.

2.c. Financial: SSGI has faced certain financial challenges, including difficulties with the use of mobile money and being unable to pay health workers on time. Key informants reported that before deciding who to pay, the program must receive the report of the given activity, evaluate the participants, and decide on the payment. This procedure takes long time. What impact has this had on the results of the program? What barriers has the program faced in mobilizing funds? How can this be improved now and in the future?

The payment of partners and CHWs through Mobile Money, which was put in place for all payments for the sake of transparency and traceability, proved to be impractical and inconsistent with the socio-economic realities in some of the intervention areas. It is impossible to provide electronic payments to individuals in rural areas who are not connected by smart phones or the internet. In addition, the ET found that the processing cost imposed by the local telephone company was high (50,000 CFA per 1 million CFA transferred), making it unsustainable for the GoM. However, the ET concluded that, while Mobile Money had challenges in the beginning, it is the best option among a number of flawed alternatives for managing payments and money transfers. Indeed, it is the most transparent approach, the fastest, and the easiest to follow for evaluation. It allows the recipients to receive directly from the project, which removes any arousal towards intermediaries. It is expected that the system will improve as connectivity improves, as has happened in other countries in Africa.

These problems seem to affect, in turn, the sustainability of the SSGI activities, as staff frustration with oversight and timeliness of payments can undermine their capacity to effectively carry on after the program ends. Some CHWs noted that they incur additional costs in order to get paid.

Key informants also raised questions about the program's sustainability due to the financial management issues caused by the costly e-payment system. SSGI pays between 2.6% and 5% of the amount to be transferred in fees. This cost is covered by the grant agreement, but poses a problem after the end of the program. MPHHS informants reported that cumbersome administrative and financial procedures are complicating their efforts to integrate SSGI activities into government planning. For example, the use of 871 CHWs in rural areas to perform critical tasks and thus increase basic health coverage among the population is well-established and highly-appreciated. Yet, CHWs are motivated by the salary they receive, so it is unclear whether and how their support will be sustainable unless the cost of their salaries is integrated into MPHHS budgets. Given the added benefit of the CHWs to improving health outcomes at the community level, and the relative expense of the e-payment system, it's important that SSGI immediately begins to start working with the GoM and the MPHHS at local and national levels to help them find solutions to these issues. Improving the use of data to make decisions may strengthen the case for more GoM resources to be allocated.

Finally, the internal management of resources is not efficient. Informants reported that the SSGI staff who work in the districts and are in charge of implementing the interventions often do not have the funds to do so due to the fact that the budget is managed by actors at the central level who do not see the necessity of approving funds in a flexible way. Informants working on SSGI reported often needing additional resources to complete activities already underway, but their requests are rejected by actors at the national level, and are often required to wait so that already-planned activities can be funded by the program's HQ in Bamako before any additional funds can be disbursed. This has caused delays in the implementation of field activities and frustration among field staff.

2.d. Administrative: What logistical factors (including security concerns) have limited the programs' ability to achieve results? How have each program's administrative practices (related to logistics, accounting, reporting, etc.) impacted results, both positively and negatively? How can these be improved?

Among the administrative deficiencies that KII respondents cited were the centralization in Bamako of all decisions, and the logistics for supervision, in addition to the challenges of electronic payments. In fact, these issues seem to be interrelated and due to the centralized nature decision-making, as well as the cap on local budgets for district staff. The program managers in Bamako put a limit on local budgets, which were reportedly developed by HQ without the input of district staff. The systematization of electronic payments has also made it difficult for payees in rural areas to be paid on time. Furthermore, vehicle fleets dedicated to supervision in the districts are concentrated in Bamako, making requesting transport difficult and also making timely monitoring and supervision difficult. At the grassroots level, actors reported not receiving adequate explanations regarding shortcomings in supervision. The ET concluded that the program's neglect of these concerns prevented better involvement in and ownership of the program activities by staff at the regional and district levels.

The GoM has an integrated supportive supervision system at the district level to supervise all CSCOMs in the district, but they lack resources to conduct all of their planned visits. In theory, supervision should occur from the District to CSCOMs and from CSCOMs to community CHWs, but key informants noted that this does not often happen. They reported that support for supervision was limited due to the fact that SSGI vehicles were all located in Bamako rather than in the districts, and they do not have timely access to vehicles. They also reported that SSGI supervisors cannot support districts because they are

overstretched in their coverage areas. The centralization of all vehicles is in contrast with KJK, which has vehicles in every region. The lack of a shared vehicle pool for both programs is another indication of a lack of coordination in terms of logistics.

Security concerns were reported to have affected implementation. For example, due to security concerns in Gao, the region was not included in the project's 2015 baseline survey, and security concerns in Gao meant that much of the public outreach was limited to radio, internet or telephone/SMS instead of in-person activities, trainings or services.

The field staff reported that they have had delays receiving the funds to conduct their operations. While not possible to measure precisely, it is obvious that the impact of these difficulties on the management of the programs is affecting their respective performance, despite the efforts of both teams to overcome them.

In addition, informants reported program quality has suffered due to a rush and pressure to meet deadlines. It is not clear why there is a rush, except that the staff were observed to spend a lot of time in meetings leaving little time for implementation.

2.e. M&E Systems: How accurate is the attribution of results to a specific program's interventions? Are data collection processes in place to help avoid duplication of indicators? How should M&E be improved in the future? Is the programs' compliance to various Agency requirements (Gender, Environment, etc.) being monitored internally?

The ET found that SSGI's M&E system is not adequate for tracking changes and improvements across such a broad range of interventions. It is difficult to attribute results to one specific program, because there are many donors and partners that work in the same areas, but an effective M&E system might better demonstrate the contributions that each intervention is making to improve health care outputs and outcomes if each program had their one technical area of responsibility. As mentioned above, there is overlap in SBCC activities.

SSGI reported that they could not make use of the DHIS2 data because the system does not provide information on a number of new interventions such as kangaroo mother care (KMC) and umbilical cord care. The ET did not find evidence that SSGI has made efforts to improve data collection and use to help regional and district management teams make programmatic and management decisions. Data-driven decision-making should be improved in the remaining life of the program. The SSGI information system is now largely linked to the national health information system (DHIS2 of the MHHP). Most of their indicators are populated through the community DHIS2 data, including some indicators from their PMP. SSGI was supposed to work with Measure Evaluation and other programs to improve DHIS2 data collection and use in its districts, and they have reported to have done so but they just did not have enough time to complete the work yet.

To address indicators that are not included in the DHIS2, the SSGI program has its own DHIS2 (Local TraiNet- SSGI) which it uses for outcomes at the community level. However, key informants reported that the Local TraiNet- SSGI system is not yet connected to the national DHIS2 system, so it currently functions as a parallel system rather than an integrated one. The ET noted a number of problems resulting in slow reporting of indicators. For example:

- Data entry for DHIS2 has suffered from shortcomings in completeness and promptness. The "Local TraiNet- SSGI" system has encountered the same difficulties. In particular, there are difficulties in monitoring the feedback of data at the community level, and the number of community agents deployed is insufficient to effectively monitor the regular data entry. These factors cause delays in the reporting of indicators as reported by the SSGI M&E and regional staff.

However, they reported that they took corrective action in Year 4 to make up for these shortcomings and that, as of late, the reporting of indicators is now being improved. The ET was unable to document evidence of this change.

- The M&E system does not address gender, the environment, training, and other issues for which data is not routinely collected at the facility level, as required by SSGI in relation to branding, advocacy, and communication and social behavior change. The program's design did include strengthening the DHIS2 system and the Health Information System as a whole, though smooth coordination with other USAID programs would be essential to improve health outcomes. Coordination has been a challenge. SSGI did develop an information system to track community-based activities, and this system uses the same platform as DHIS2. However, it has not been integrated with DHIS2, and it is not likely that such integration will be able to occur during the remaining life of the program.

The ET did not find data collection processes in place to avoid duplication in data and indicators. The ET noticed that each of the two programs aimed to collect and monitor a large number of indicators. These indicators are not all necessary for the daily monitoring of program progress. In addition, there are many indicators in the internal monitoring system that the team finds very cumbersome and thus somewhat counterproductive in terms of providing useful information and data-driven decision-making. One internal M&E practice that was reported to work was the SSGI's use of self-evaluations to help NGOs review their performance. They organized 34 self-evaluation sessions for community health associations and health centers, respectively, in four districts in Koulikoro and three districts in Sikasso. Following the self-assessments, the community health associations and health center teams developed 34 institutional capacity-building plans. A total of 535 community health associations and health centers out of the 736 planned for the life of the program benefited from at least one self-assessment session, representing a completion rate of 73% by the end of the third year. As a result of these self-assessments, 33 institutional capacity-building plans were developed by the community health associations and health center teams. It is not clear, however, how SSGI is monitoring these plans.

EQ2 SSGI Conclusion

The ET found that the SSGI program had to adapt to several staffing challenges and found ways to cope, but we did not find evidence that they have a strategy for retaining their staff through the end of the program. Furthermore, SSGI seems not to have anticipated the need to have staff at the district level to implement the community-based health component of their program and although they hired the staff, they did not decentralize their management to empower them. As the MTE is a cross-sectional view of the program, we cannot infer what may have happened and were not given an answer during KIIs. Data collection and use have not improved at regional, district and CSCOM levels yet.

EQ2 SSGI Recommendation

SSGI should second its staff to regional and district offices to assist in the implementation of MNCH/FP management and disease control program procedures. This will ensure consistent and sustainable health system-strengthening at those levels, as well as improved monitoring and data-driven management of HIHS. SSGI should also develop a plan to support the transition of its staff at the end of the program.

EQ3: To what extent have the programs complied with agency requirements, for environment, gender, and branding and marking?

a. KJK Program

Environment: KJK's Environmental Management and Mitigation Plan (EMMP) is appropriate and meets USAID requirements. It includes a number of indicators to monitor progress with sources of data from the program's M&E system, which they report on quarterly to USAID. The local NGO in charge of monitoring prepares the report and sends it to the district focal person. A focal person in each district

compiles the data for a regional focal person at monthly meetings, and quarterly for the national team. The main difficulty is supervising compliance on a daily basis. The EMMP procedures include: 1) training and orientation of program staff and implementing partners on environmental issues and plan mitigation, 2) reuse of clean and safe materials wherever possible; 3) proper recycling of safe materials; 4) provisions for the transport of solid and hazardous waste to appropriate management centers or disposal areas; and 5) the installation of separate and labeled bins for recyclable materials. The program also developed and printed materials on essential hygiene practices and posters for health districts and the CSCOMs. All KJK partners (including transport companies and warehouse employees) are, according to KILs, made aware of how to properly dispose of and recycle their waste. KJK provides for the transport of solid and hazardous waste to appropriate waste management centers or disposal areas and uses incinerators in the warehouses of KJK's implementing partners, including the CSCOMs.

Regarding waste management at CSCOMs, the ET found during its observation that labelled cardboard bins to dispose of medical waste materials are being used properly in all visited CSCOMs.

Gender: KJK's gender policy is consistent with USAID gender policies and Mali's national gender policy. The program considers women's participation in activities, training courses and the composition of the ASACOs. Program data is disaggregated by sex. KJK recommends that husbands be supportive and communicative with their wives about health matters.

A gender mainstreaming guide has just been developed by the two programs. The Handerey approach, which is purely gender-based, has just been launched, so it is important to accelerate the implementation of USAID's gender mainstreaming guide before the end of the program.

Branding and Marking: All tools, documents, and even T-shirts and caps are properly branded. KJK reported that all activities and products have 100% USAID branding (posters, spots, etc.), which was consistent with ET observations. However, the ET found that the KJK website does not include the USAID LOGO as one would expect, as only USAID/Mali-funded activities are described in this site. (<https://ccp.jhu.edu/projects/keneya-jemu-kan/>)

EQ3 KJK Conclusions

The evaluation concludes that KJK did meet the agency environmental and gender requirements but is not fully in accordance with the branding and marking requirements.

b. SSGI Program

Environment: Are the programs following all USAID environmental compliance requirements (Environmental Mitigation and Monitoring Plan (EMMP) in place, implementation, monitoring and reporting on EMMP)?

Yes, SSGI is following the USAID environmental requirements. It has an EMMP in place.

Are the programs implementing any activities that are not covered by the governing Initial Environmental Examination (IEE)?

No. SSGI is only implementing activities outlined in the IEE.

What are the steps taken to address environmental issues?

SSGI assessed each CSCOM for biomedical waste management practices and existing infrastructure. They provided training to CSCOM staff to dispose of medical waste appropriately, and they placed disposal containers in maternities.

Are any activities implemented in the Inner Niger Delta having negative impacts on the local ecosystem?

No, SSGI is not implementing activities in the Inner Niger Delta.

Are there any technical or managerial gaps impacting environment compliance?

The ET did not find gaps in the environmental compliance plan. Implementation of the SSGI EMMP plan started by identifying existing biomedical waste management practices and infrastructure at the facility level. This assessment was followed by the training of 142 health providers on infection prevention and control, including biomedical waste management. The program purchased 30 biomedical waste management kits for BEmONC sites in Bamako to fill shortages in biomedical waste management equipment, as the family planning mobile teams are using disposal bins and buckets for decontamination. Knowing that latrine leakage may contaminate surrounding areas, including ground water, with bacteria and parasites harmful to health, SSGI trained 48 masons on SanPlat – slab construction – to meet latrine construction standards. The program thus provided training in SanPlat slab-making molds.

The program launched its Clean Clinic Approach in 57 BEmONC and 6 CEmONC facilities in the Bamako district and conducted clean clinic inspections in both Koulikoro and Bamako. The ET observed tangible success, particularly in center cleanliness, the availability of safe drinking water and the management of wastewater and low-levels of excreta in the sample of 30 CSCOMs that the ET visited.

Gender: How have gender issues affected the achievement of sustainable results? How have activities affected the relative status of men and women?

As noted earlier, the ET found SSGI has focused on addressing gender issues that affect the relative status of men and women. The ET found a strong correlation between spousal support and maternal health and FP outcomes; approximately 80% of those who express having spousal support engage in an ANC visit, while only 20% of those without spousal support do so.

Furthermore, the ET evaluated the relationship between spousal support and FP. The findings indicate that those with the support of their spouses have a 30.2% likelihood of using family planning services, while only 24.4% of those who do not report having the support of their spouses use FP services. We stress that the difference is not statistically-significant at conventional levels, but the findings are suggestive of the importance of spousal communication, and presumably better gender equity, in promoting FP use.

In all of its interactions with partners and providers, SSGI emphasizes the participation of women. This policy is consistent with the USAID and national gender policy of Mali. The program is promoting gender equity in mobilizing young women as regional facilitators for the application of self-assessment tools in ASACOs and CSCOMs.

Issues of gender and socioeconomic and cultural barriers that women face when using FP services are discussed during meetings with NGOs, ASACOs, couples and husbands. All FP activities focus on the client and improve women's health and reproductive health. SSGI also addresses key challenges related to men's participation in FP and will continue to ensure that gender issues are considered in community outreach and the provision of high-quality voluntary FP services. Although ASACO's institutional capacity-building efforts focus on gender and more women's representation, women leaders still account for only 8% of the total trained ASACO Management Committee members. Gender mainstreaming in health system-strengthening continues to be a challenge. Indeed, according to interviewees, the KJK project theoretically has a gender component. In practice, however, gender is poorly considered. The gender mainstreaming guide has just been developed. The Handerey approach, which is purely gender, has just been launched at the time of the evaluation. Accelerating the implementation of the gender mainstreaming guide before the end of the project appeared to the ET as an urgent necessity.

Maternal health, FP, and Gender: From the individual-level survey, the ET noticed the prevalence of early marriage: 97.5% of respondents reported being married, whereas a greater share than 2.5% of respondents are under 18. The majority of respondents in the focus groups say that husbands are increasingly supportive of their wives going to community health centers for various services, especially ANC.

Literacy is a barrier. Among all of the women in the survey, 62.2% were illiterate; 30.9% attended primary school, 5.9% completed at least secondary school, and 3.4% had received education beyond high school. Women's Participation: The ET found that the gender policy of both programs is consistent with USAID and Mali's national gender policy. As noted, the program promotes gender equity in mobilizing young, female regional facilitators for the application of self-assessment tools among ASACOs and CSCOMs.

The evaluation team observed that in the program areas, women participate in the ASACO committee meetings in 90% of visited CSCOMs, with minutes of meetings available in 50% of cases.

Informants note that progress is being made in women's participation in decision-making processes. They state that women are involved in all decision-making processes, especially in urban areas. They believe that this progress must be attributed to "NGO interventions":

I think that it is because of the presence of the programs in the villages that the behavior of the men towards the women has changed because the programs intervene much in the villages. Program interventions have greatly improved villagers' knowledge of the realities of life and the need to communicate with women.

Participants in the rural Koulikoro women's focus group.

Branding and Marking: To what extent are the programs complying with branding and marking requirements?

SSGI complied with all branding and marking requirements in the award. The posters and program documents and vehicles have the logos and meet the branding requirements. The program equipment also has the USAID logo. The only exception is that the regional and district offices are not marked due to security reasons, as mentioned above, and the project has not applied for a waiver. At the local level, the visibility of the program, and especially of USAID, is very modest at the level of health centers and in the community. The ET noticed that SSGI display boards and posters are not very visible in the program areas, but the majority of people interviewed said they know about the program's interventions through rural radio programs and educational chats. In half of the health center locations included in the evaluation, the respondents interviewed in KIIs and FGDs were not able to identify the program's interventions by name.

All malaria-related products include the President's Malaria Initiative (PMI) logo, and the program has a branded standard presentation template. When the program printed a set of national nutrition cards for the 1,000 GSANs (community nutrition groups), it added a branded cover page. All NGO and field staff were provided with t-shirts and khaki vests branded with USAID and SSGI logos.

The SSGI program has complied with most branding and marking policies. However, the ET noted that, in Gao, motorcycles purchased for SSGI and the Save the Children offices where the project is hosted, do not have the USAID logo. Field staff told the ET that this was due to security concerns. However, the project team has not requested a waiver. The ET is only able to report on what the evaluators observed in the field and on what was told to them by the KJK and SSGI project management team.

EQ3 Conclusion

SSGI has met all environmental and gender requirements and, save for a lack of branding of motorcycles and the Save the Children field office in Gao, has met the branding and marking requirements.

EQ3 Recommendations

Through its seconded staff, SSGI should institutionalize the Clean Clinic Approach in every region and district and ensure that funding required to support the approach is included in their next annual budget. SSGI should assist every district and CSCOM to use data available to scale up a gender strategy that involves men across all interventions.

1. SSGI must institutionalize the representation of women in management bodies such as ASACOs and CAGs.
2. SSGI should apply for waivers when it does not intend to comply with branding and marking policies due to security concerns.

V. CONCLUSIONS AND RECOMMENDATIONS

In summary, the MTE concludes that both SSGI and KJK programs have been contributing to increasing the demand for and use of high-impact health services. This contribution is appreciated by Malian counterparts. The number of women receiving antenatal care and delivering babies in health facilities is increasing as well as the availability of emergency obstetric and neonatal care. The use of modern family planning techniques has also increased in program districts. The adoption of healthy behaviors, attitudes, and practices reported by beneficiaries can be attributed to both programs. While both programs have implemented successful interventions, these are not yet sustainable, because the capacity of the MPH and local NGOs has not been built to allow them to deliver these interventions consistently and according to quality standards.

The local NGO Jigi, which was selected to continue the SBCC and SM activities done by KJK, was not identified and contracted until the fourth year of the program, so there is not much time left to ensure that its capacity has been sufficiently developed to allow it to assume ownership of the programming.

SSGI has not strengthened the delivery of HIHS consistently across all the CSCOMS in the program districts and has not yet strengthened the district and regional teams to use information to manage and sustain the HIHS.

Both programs faced staffing problems that created implementation delays. These problems were effectively addressed by HQ staff and continuous hiring of new staff. SSGI faced financial management problems related to establishing a new e-payment system; these problems, too, had been effectively addressed as well by the time of this evaluation.

Both programs have met environmental, gender, and branding and marking requirements in general, except SSGI, which has not branded its office and vehicles due to security concerns but has not yet applied for a waiver from USAID.

Recommendation for current programs:

The recommendations below are designed to answer the specific questions posed by USAID. They are based on the MTE's findings and were developed considering the fact that both programs are scheduled to end in nine months.

What specifically is working well and should continue to be scaled up in these programs?

1. The SSGI interventions, including a number of new interventions implemented (clean health facilities, KMC, umbilical cord care, etc.) at the CSCOMS have increased the demand for and use of high-impact health services. However, the regional and district health teams cannot yet consistently sustain these services at scale. These interventions should be scaled-up in all program districts and CSCOMS. The operational procedures needed to enable the delivery of the essential health package should be thoroughly documented and made available to all healthcare workers.
2. The communication strategy, which is based on the local concept of “Jigisigi” and uses a multitude of channels to reach target audiences with specific health and related messages, is working well. The strategy should be well-documented and the capacity of Jigi should be developed specifically related to Jigisigi in order to continue implementing it after the KJK program has ended.

3. The support provided to CAGs and ASACOs is working well and has resulted in improved utilization of services and corresponding healthy behaviors. This support should be institutionalized and continued by continuing the support of local NGOs.
4. Electronic payments via mobile phone are likely to increase in popularity in Mali as has been the case in other countries in Africa. SSGI should implement an innovative advocacy plan that will target high-level state authorities, decision makers, and health system actors at the national, regional, and district levels to institutionalize the system, while still offering alternative methods of payment for CHWs and those beneficiaries who do not have access to mobile technologies. USAID should consider pooling e-payments with other USAID-funded programs in order to be able negotiate a substantial reduction in the high fees imposed to transfer the money and sustain the support to CHWs until the system can be funded by local sources.
5. USAID/Mali should consider developing the GoM/MPHH's capacity to manage e-payments so that it can use the system to make all payments in the health sector nationwide. USAID should also assist the GoM/MPHH to negotiate price reductions with the service provider.

What changes, if any, would stakeholders and the evaluation team suggest for these programs to reach or exceed their intended results?

6. KJK should second its staff to Jigi to continue KJK's SBCC and SM activities for the remainder of the life of the program, in order to ensure the effective transfer of the Jigisigi communication strategy and research capabilities. This will allow time to build the technical, business and organizational capacity of Jigi so that it can assume responsibility for at least a number of SBCC, SM and research interventions and activities. The rest can be developed by the follow-on program.
7. The KJK program should not initiate any new research in the program's remaining time. Rather, all activities should be focused on strengthening the capacity of the regional and district teams and local NGO to sustain the high-impact health interventions and the SBCC and SM programs.
8. KJK should second technical staff to the CNIECS to help the MPHH support its components of the Jigisigi strategy and other policy and M&E aspects of the SBCC and SM interventions.
9. SSGI should second its staff to support regional and district teams to implement data-driven decision-making to institutionalize the high-impact interventions and to ensure their consistent delivery in every CSCOM in the program area. In this way, SSGI will be able to provide targeted support to develop and implement work plans in each region so that all targeted areas and facilities are reached. This type of joint work and planning was reported to have happened only informally and inconsistently during the program's first four years.
10. SSGI should also second staff to assist national MNCH/FP managers to integrate their HIHS into their policies, manuals, work plans, and budgets.
11. Given the limited time available to accomplish the successful and sustainable transfer of the interventions of both programs, USAID/Mali may want to consider granting a time extension to ensure an overlap of at least three months with the next program.

What level of integration is best among the different health elements?

12. It is desirable for different health interventions to be integrated in order to strengthen the health system. However, given the time available, the ET recommends that integration take place at district and regional levels by seconded staff working side by side with district and regional teams to manage the implementation of the HIHS.
13. Seconded SSGI staff should assist the district health teams to help ASACOs develop strategic plans and ensure that they can continue to support HIHS. They can also help to ensure that village solidarity funds are sustained and scaled up. The ASACO's performance should be monitored by district teams and assisted as necessary to ensure that they are providing adequate support to the CSCOMs.
14. SSGI should work with other USAID-funded programs and district and regional teams to address the supply chain management and stock-outs. The problems in commodity supplies found by the ET should be shared with MPHHS and donor representatives to find solutions to procurement and management issues.
15. SSGI seconded staff should assist regional teams to conduct quarterly meetings to analyze and problem-solve around factors impeding the uptake of MNCH/FP methods should be held and documented, starting with ANCI/ANC4 attrition and other problems identified in the MTE.

What strategies can be suggested for resolving problems or weaknesses (including compliance issues) found in these programs?

16. The MTE found a large variation in performance among the CSCOMs evaluated. Seconded staff should work with district and regional teams to monitor and address inconsistent performance. Effective and timely use of M&E and HIS data should inform regular planning and implementation decisions. Twinning better performing districts with those that need improvement should also be supported by seconded staff.
17. USAID/Mali should have access to quarterly performance indicators by CSCOM, district and region that measure whether its programs are moving the needle in the targeted areas. In this way, by identifying which CSCOMs and which districts are performing better and why, IPs can work to ensure targeted and effective improvements are used to solve the performance issues found in low performing facilities and districts. In addition, USAID will be able to monitor the consistency of improvements as they occur.
18. Until the health information system in Mali is improved, programs should consider using rapid assessment methods such as Lot Quality Assurance Sampling (LQAS), which some of the program(s) partners have used in the past, to assess coverage, supervise implementation and make program management decisions.
19. Strengthening the DHIS2 and other digital health innovations will improve data collection and use. However, making use of data already available such as the periodic DHS and other research is essential. KJK and SSGI and other USAID-funded programs should promote and facilitate data-driven decision making at the CSCOM, district and regional levels and support the national system instead of creating parallel systems.

How can the USAID health team's management of the programs facilitate them achieving their results?

20. The ET recommends extending the time period of the current programs to ensure continuity with the follow-on program(s). We also recommend that they overlap for at least 3 months to ensure continuity. The two programs should focus on the following specific, distinct goals:
- a. SSGI should focus on strengthening the support to regional and district teams so they can continue to supervise and monitor program implementation. Seconded staff should be given the authority and resources to assist regional and district managers to detect problems and weaknesses and to facilitate implementing and sharing timely solutions across districts and regions.
 - b. KJK should use the extension period to ensure the effective capacity-building of CNIECS and prepare Jigi for the handover of all SBCC and SM activities.

ANNEXES

ANNEX I:	Evaluation Scope of Work
ANNEX II:	List of Key Informants
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ANNEX I: Evaluation Scope of Work

I. SCOPE

The Contractor will assess the management and technical progress made by the SSGI and the KJK programs from award date to the present. This evaluation is intended to determine what aspects of the two programs are working well and why, which are not working well and why not. The evaluation will also determine what mid-course corrections are needed as well as inform the design of future programs. The primary intended audience for this evaluation is USAID/Mali, which will use the results to improve the performance of the current programs as well as to plan for future programs. The implementing partners managing the health programs being evaluated are also an important audience. The findings of the evaluation will also be used by the Ministry of Health (as applicable) and by USAID/W to provide appropriate types of support to the USAID/Mali health team.

II. EVALUATION QUESTIONS

This evaluation seeks to address the following questions regarding the performance of the two programs and recommendations for future USAID/Mali programming:

- I. To what extent are the activities of the programs implemented to date contributing towards the achievement of their planned results?
 - a. Are the interventions being implemented leading to the intended results and sub-results? Which interventions are having the greatest success, and which are having the least success?
 - b. What specific barriers are impeding the attainment of certain results? What are the recommendations to overcome these barriers?
 - c. The programs were supposed to expand health service coverage to a certain number of districts over five years. Is coverage being expanded as planned? What is the package being offered through USG support in each district?
 - d. How do community members and beneficiaries view the results that have been achieved? What impact have the programs had on beneficiaries' lives?
 - e. What specific mid-course corrections are needed to achieve the intended results by the end of the program? What results have been successful, and what issues have been identified that have impeded the achievement of results?
- II. To what extent are the programs' financial, management, and M&E systems affecting implementation and the achievement of results?
 - a. Staffing: Are the programs adequately staffed, or are there gaps in the necessary management, technical, and administrative expertise? Are the programs receiving sufficient support from their home offices to strengthen or complement the staff expertise? How has this affected the programs' ability to achieve their desired results? What actions have been applied to ensure the necessary staff levels and skills, and how effective has this been?
 - b. Management: How do the two programs coordinate planning and implementation of activities between themselves, with USAID, and with government counterparts? How effective are these efforts? How are issues identified and addressed?
 - c. Financial: SSGI has faced certain financial challenges, including difficulties with the use of mobile money and being unable to pay health workers on time. What impact has this had on the results of the program? What barriers has the program faced in mobilizing funds? How can this be improved now and in the future?
 - d. Administrative: What logistical factors (including security concerns) have limited the programs' ability to achieve results? How have each program's administrative practices

- (related to logistics, accounting, reporting, etc.) impacted results, both positively and negatively? How can these be improved?
- e. M&E Systems: How accurate is the attribution of results to a specific program's interventions? Are data collection processes in place to help avoid duplication of indicators? How should M&E be improved in the future? Is the programs' compliance to various Agency requirements (Gender, Environment, etc....) being monitored internally?
- III. To what extent the programs have complied with agency requirements, for environment, gender and branding and marking
- a. Environment: Are the programs following all USAID environmental compliance requirements (Environmental Mitigation and Monitoring Plan (EMMP) in place, implementation, monitoring and reporting on EMMP)? Are the programs implementing any activities that are not covered by the governing Initial Environmental Examination (IEE)? What are the steps taken to address environmental issues? Are any activities implemented in the Inner Niger Delta having negative impacts on the local ecosystem? Are there any technical or managerial gaps impacting environment compliance?
 - b. Gender: How have gender issues affected the achievement of sustainable results? How have activities affected the relative status of men and women?
 - c. Branding and Marking: To what extent are the programs complying with branding and marking requirements?
- IV. Recommendations:
- a. Recommendations for the current programs:
 - a. What changes, if any, would stakeholders and the evaluation team suggest for these programs to reach or exceed their intended results?
 - b. What specifically is working well and should continue to be scaled up in these programs?
 - c. What level of integration is best among the different health elements?
 - d. What are examples of program management and financial management and compliance best practices, including recognizing and rewarding success, as well as problem identification and problem solving?
 - e. What strategies can be suggested for resolving problems or weaknesses (including compliance issues) found in these programs?
 - f. How can the USAID health team's management of the programs facilitate them achieving their results?
 - b.1 Recommendations for future programs: (To be included as a separate SBU annex to the evaluation report, not in the report itself)
 - b.2 What lessons learned from the current programs (what has and hasn't worked) should be considered in the design of future programs?
 - b.3 What changes do key stakeholders (including the government of Mali, other donors, beneficiaries, and implementing partners) think should be made to future USAID health programs?

ANNEX II: LIST OF KEY INFORMANTS

No.		Organization	Name	Title
1	National	MSHP-Cabinet	Mama Coumare	Secrétaire Général du MSHP (SEGAL)
2		MSHP-DNS	Ousmane Dembele	Directeur National de la Santé
3		MSHP-PNLP	Dr. Vincent Sanogo	Chef de Division Prévention paludisme
4		CNIECS	Dr. Sidibe Fatouma Maguiraga	Chef de Département, Production et Documentation (point focal pour KJK)
5		USAID	Mariama Ciré Ba	AOR SSGI et KJK
6		USAID	Jules Mihigo	AAOR SSGI et KJK
7		USAID	Madina Bah	
8		USAID	Souleymane Sogoba	M&E responsable
9		USAID	Ibrahima Dolo	M&E Officer
10		USAID/SSGI - Save the Children	Protas Ndabamenye	Chief of Party
11		USAID/SSGI - Save the Children	Nathalie Gamache	Deputy Chief of Party
12		USAID/SSGI - Save the Children	Drissa Ouattara	STA-Integrated Health Services
13		USAID/SSGI - MSI	Sekou Traore	STA-Health Systems Strengthening
14		USAID/SSGI - Save the Children	Philbert Ndaruhutse	M&E Officer
15		USAID/SSGI - Jhpigo	Charles Amoussou	STA-Maternal Health and Family Planning
16		USAID/SSGI- SC/US, Washington DC	Winnie Mwebesa	Director, Reproductive Health (Responsible for SSGI at SCUS)
17		USAID/KJK - JHU-CCP	Issiaga Daffe	Chief of Party
18		USAID/KJK - Palladium	Badara Konate	Team Leader - Palladium - Marketing Social
19		USAID/KJK - MSH	Hammouda Bellamine	Team Leader - Renforcement Institutionnelle

20		USAID/KJK - JHU-CCP	Mohamad Sy-ar	Sr. Program Officer (HQ Backstop) (au Mali jusqu'au 25 aout)
21		USAID/KJK - JHU-CCP	Aoua Konaré	M&E Officer
22		MEASURE Evaluation	Aminata Traore	Chief of Party
23		PSM/SIAPS	Safoura Berthe	Technical Director
24		UNICEF	Samba Diarra	Conseiller Sante
25		Groupe Pivot Sante Population	Souleyemane Dolo	Executive Director
26		ONG JIGI	Sekou Barry	Executive Director
27	Regional	DRS-Koulikoro	Dr. Coulibaly Youssouff	Chef de division
28		USAID/SSGI	Bruno Job Keita	Regional Manager, Koulikoro/Bamako (interim)
29		USAID/KJK	Oumou Diabate	Regional Coordinator, Koulikoro/Bamako
30		FERASCOM	Diadji Diarra	President
31		AMCP	Amy Kayo	Directrice de Developpement Institutionnel
32		AMCP	Massedou Traore	Spécialiste Santé (Charge de Mise en Oeuvre au Quotidien)
33		DRS-Sikasso	Dr. Dramane Traore	Directeur Régional de la Santé
34		USAID/SSGI	Mahamane Maiga	Regional Manager, Sikasso
35		USAID/KJK	Mamadou Sanogo	Regional Coordinator, Sikasso
36		FERASCOM	Aissata Goita	President
37		ACOD	Elisee Sidibe	Directeur Executive
38		ACOD	Kani Damba	Spécialiste Santé (Charge de Mise en Oeuvre au Quotidien)
43	District	USAID/SSGI	Lassina Togola	District officer
44		CSRef	Mamoutou Diarra	Charge de la Surveillance Epidemiologique et Appui SIS Note: Lassina Sissoko est le Medecin Chef mais il est nouveau donc nous suggerons Dr. Diarra

45		Promotion de la Femme	Amadou Dembele	Chef de service
46		ONG ACOD	Felix Ballo	Conseiller Communautaire
		Program Focal Points for the Mid-Term Evaluation Team		
	National	USAID/SSGI - Save the Children	Nathalie Gamache	Deputy Chief of Party
		USAID/SSGI	Philbert Ndarahutse	STA-M&E
		USAID/KJK	Aoua Konare	STA-M&E
	Regional	USAID/SSGI	Bruno Job Keita	Regional Manager, Koulikoro/Bamako (interim)
		USAID/KJK	Oumou Diabate	Regional Coordinator, Koulikoro/Bamako
		USAID/SSGI	Mahamane Maiga	Regional Manager, Sikasso
		USAID/KJK	Mamadou Sanogo	Regional Coordinator, Sikasso

ANNEX III: BIBLIOGRAPHY OF DOCUMENTS REVIEWED

N	Title of the Document	Type of document	Author	Date of publication
1	USAID Services de Santé à Grand Impact Cooperative Agreement No. AID-688-A-15-000002 Quarterly Program Report January 1- March 31, 2018	Rapport d'activités	USAID Services de Santé à Grand Impact	4/30/2018
2	USAID Communication et Promotion de la Santé Keneya Jemu Kan Cooperative Agreement: AID-688-A-15-00001 FISCAL YEAR 4 MSH QUARTERLY REPORT – QUARTER 2 PERIOD OF PERFORMANCE: January 1 – March 31, 2018	Rapport d'activités	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	4/15/2018
3	USAID Keneya Jemu Kan Number of Cooperative Agreement: AID-688-A-15-00001 FISCAL YEAR: 2017 PERIOD OF PERFORMANCE: OCTOBER 1, 2016-DECEMBER 31, 2016	Rapport d'activités	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	1/31/2017
4	Revue de la littérature sur l'analyse situationnelle sur les interventions en nutrition et WASH -dans la région de Mopti au Mali.	Rapport de recherche	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	2/1/2017
5	USAID Services de Santé à Grand Impact Cooperative Agreement No. AID-688-A-15-000002 Quarterly Program Report January 1 – March 31, 2017	Rapport d'activités	USAID Services de Santé à Grand Impact	4/30/2017
6	USAID Services de Santé à Grand Impact Cooperative Agreement No. AID-688-A-15-000002 Quarterly Program Report April 1- June 30, 2017	Rapport d'activités	USAID Services de Santé à Grand Impact	7/30/2017
7	USAID Keneya Jemu Kan Number of Cooperative Agreement: AID-688-A-15-00001 FISCAL YEAR: 2017 PERIOD OF PERFORMANCE: APRIL 1, 2017- JUNE 30, 2017	Rapport d'activités	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	7/31/2017

N	Title of the Document	Type of document	Author	Date of publication
8	USAID Keneya Jemu Kan Number of Cooperative Agreement: AID-688-A-15-00001 FISCAL YEAR: 2017 PERIOD OF PERFORMANCE: OCTOBER 1, 2016- SEPTEMBER 30,2017	Rapport d'activités	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	10/30/2017
9	USAID Services de Santé à Grand Impact USAID Communication et Promotion de la Santé/Keneya Jemu Kan Joint Workplan – Year 4 October 1, 2017 – September 30, 2018	Plan de travail	USAID Services de Santé à Grand Impact USAID Communication et Promotion de la Santé/Keneya Jemu Kan	10/30/2017
10	USAID Keneya Jemu Kan Number of Cooperative Agreement: AID-688-A-15-00001 FISCAL YEAR: 2017 PERIOD OF PERFORMANCE: OCTOBER 1, 2016- SEPTEMBER 30,2017	Rapport d'activités	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	10/30/2017
11	USAID Services de Santé à Grand Impact Cooperative Agreement No. AID-688-A-15-000002 Annual Program Report 1 October 2016 – 30 September 2017	Rapport d'activités	USAID Services de Santé à Grand Impact	11/7/2017
12	USAID Communication et Promotion de la Santé / Keneya Jemu Kan Number of Cooperative Agreement: AID-688-A-15-00001 FISCAL YEAR: OCTOBER 1–SEPTEMBER 30 2016 YEAR 2 PERIOD OF PERFORMANCE: OCTOBER 1–DECEMBER 31, 2015	Rapport d'activités	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	1/31/2016
13	PROJET COMMUNICATION ET PROMOTION DE LA SANTÉ: USAID KENeya JEMU KAN PLAN DE SUIVI/EVALUATION	Plan de S/E	USAID KENeya JEMU KAN	Mar16

N	Title of the Document	Type of document	Author	Date of publication
14	USAID Services de Santé à Grand Impact Cooperative Agreement No. AID-688-A-15-000002 Quarterly Program Report January 1- March, 31, 2016	Rapport d'activités	USAID Services de Santé à Grand Impact	4/30/2016
15	USAID Communication et Promotion de la Santé / Keneya Jemu Kan Number of Cooperative Agreement: AID-688-A-15-00001 FISCAL YEAR: OCTOBER 1–SEPTEMBER 30 2016 YEAR 2 PERIOD OF PERFORMANCE: January 1 to March 31, 2016	Rapport d'activités	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	4/30/2016
16	USAID Communication et Promotion de la Santé / Keneya Jemu Kan Number of Cooperative Agreement: AID-688-A-15-00001 FISCAL YEAR: OCTOBER 1–SEPTEMBER 30 2016 YEAR 2 PERIOD OF PERFORMANCE: April 1st to June 30, 2016	Rapport d'activités	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	7/31/2016
17	USAID Services de Santé à Grand Impact USAID Communication et Promotion de la Santé/Keneya Jemu Kan Joint Workplan – Year 3 October 1, 2016 – September 30, 2017	Plan de travail	USAID Services de Santé à Grand Impact USAID Communication et Promotion de la Santé/Keneya Jemu Kan	9/1/2016
18	RECHERCHE QUALITATIVE SUR LES FACTEURS QUI INFLUENCENT L'UTILISATION DES SERVICES DE SANTE MATERNELLE NEONATALE ET INFANTILE AU MALI	Rapport de recherche	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	9/16
19	USAID Keneya Jemu Kan Number of Cooperative Agreement: AID-688-A-15-00001 FISCAL YEAR: 2016 PERIOD OF PERFORMANCE: OCTOBER 1, 2015-SEPTEMBER 30, 2016	Rapport d'activités	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	10/30/2016

N	Title of the Document	Type of document	Author	Date of publication
20	USAID Keneya Jemu Kan Number of Cooperative Agreement: AID--688--A--15--00001 FISCAL YEAR: 2016 PERIOD OF PERFORMANCE: OCTOBER 1, 2015- SEPTEMBER 30,2016	Rapport d'activités	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	10/30/2016
21	USAID Services de Santé à Grand Impact Cooperative Agreement No. AID-688-A-15-000002 Annual Program Report 1 October 2015 – 30 September 2016	Rapport d'activités	USAID Services de Santé à Grand Impact	10/30/2016
22	USAID Services de Santé à Grand Impact Monitoring & Evaluation Plan Narrative December 9, 2014 – December 9, 2019	Plan de S/E	USAID Services de Santé à Grand Impact	12/ 8/2016
23	USAID Services de Santé à Grand Impact USAID Communication et Promotion de la Santé/Keneya Jemu Kan Joint Workplan – Year 2 October 1, 2015 – September 30, 2016	Plan de travail	USAID Services de Santé à Grand Impact USAID Communication et Promotion de la Santé/Keneya Jemu Kan	10/9/2015
24	USAID Services de Santé à Grand Impact First Year Work Plan December 9, 2014 – September 30, 2015	Plan de travail	USAID Services de Santé à Grand Impact	1/23/2015 (revised 3/ 6/ 2015)
25	USAID Services de Santé à Grand Impact USAID Communication et Promotion de la Santé/Keneya Jemu Kan Joint Workplan – Year 1 December 2014 – September 30, 2015	Rapport d'activités	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	4/26/2015
26	USAID Services de Santé à Grand Impact Cooperative Agreement No. AID-688-A-15-000002 Quarterly Program Report December 9, 2014 – March 31, 2015	Rapport d'activités	USAID Services de Santé à Grand Impact	4/30/2015

N	Title of the Document	Type of document	Author	Date of publication
27	Social Behavior Change Communications/Social Marketing in Mali Number of Cooperative Agreement: AID-688-A-15-00001	Rapport d'activités	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	7/31/2015
28	MINUTES OF FIELD VISIT/ TOPIC: USAID Data Quality Assessment (DQA) for 2015- SAVE The Children Services de Santé à Grand Impact (SSGI) and Projet Nutrition et Hygiene.	Rapport	USAID	9/2/2015 8/30/2015
29	USAID Services de Santé à Grand Impact Cooperative Agreement No. AID-688-A-15-000002 Annual Program Report 9 December 2014 – 30 September 2015	Rapport d'activités	USAID Services de Santé à Grand Impact	10/30/2015
30	USAID Communication et Promotion de la Santé Keneya Jemu Kan in Mali Number of Cooperative Agreement: AID-688-A-15-00001 FISCAL YEAR: I JANUARY – 30 SEPTEMBER 2015 YEAR I PERIOD OF PERFORMANCE: I JANUARY – 30 SEPTEMBER 2015	Rapport d'activités	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	10/30/2015
31	USAID Communication et Promotion de la Santé Keneya Jemu Kan Number of Cooperative Agreement: AID-688-A-15-00001 FISCAL YEAR: I JANUARY – 30 SEPTEMBER 2015	Rapport d'activités	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	10/30/2015
32	Etude de base du niveau de prestation des services de santé maternelle, néonatale et infantile dans les sites d'intervention des régions cibles du Projet SSGI	Rapport d'enquête	USAID Services de Santé à Grand Impact	September - November 2015
33	Planification familiale/ Santé Maternelle et Infantile Paludisme/VIH/Sida/Nutrition/Eau/Hygiène/Assainissement Analyse secondaire des données de l'Enquête Démographique et de Santé du Mali 2012-2013	Rapport de recherche	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	Dec-15

N	Title of the Document	Type of document	Author	Date of publication
34	Analyse des interventions en santé et les défis du changement de comportement au Mali	Rapport de recherche	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	12/15/15
35	Étude de base sur les facteurs d'idéation et les comportements liés à la santé maternelle et infantile, la planification familiale, l'eau/hygiène/assainissement et le VIH/sida au Mali.	Rapport d'enquête	USAID Communication et Promotion de la Santé/Keneya Jemu Kan	12/15/15
36	USAID Services de Santé à Grand Impact - Organizational Structure	Organigramme	USAID Services de Santé à Grand Impact	
37	DQA FEEDBACK TO SAVE THE CHILDREN SSGI Title of Performance Indicators: See list of indicators attached	Liste d'indicateurs clés	USAID Services de Santé à Grand Impact	
38	Country Development Cooperation Strategy Mali Forward 2016-2020	Stratégie de coopération	USAID	
39	PROGRAMME DE DEVELOPPEMENT SOCIO-SANITAIRE 2014-2018 (PRODESS III)	Politique	SECRETARIAT PERMANENT DU PRODESS CELLULE DE PLANIFICATION ET DE STATISTIQUE SECTEUR SANTE, DEVELOPPEMENT SOCIAL ET PROMOTION DE LA FAMILLE	
40	KJK Program description		USAID Communication et Promotion de la Santé/Keneya Jemu Kan	

N	Title of the Document	Type of document	Author	Date of publication
41	AID-688-A-15-00002 – Mali High-impact Health Services II	SSTI Program description	USAID Services de Santé à Grand Impact	
42	FACT SHEET, COMMUNITY MOBILIZATION	Abstract	USAID Services de Santé à Grand Impact	
43	USAID Services de Santé à Grand Impact USAID Communication et Promotion de la Santé/Keneya Jemu Kan Joint Workplan – Year 5 October 1, 2018 – December 6, 2019	Plan de travail	USAID Services de Santé à Grand Impact USAID Communication et Promotion de la Santé/Keneya Jemu Kan	9/1/2018
44	Cadre de performance		USAID Communication et Promotion de la Santé/Keneya Jemu Kan	
45	KJK Social Marketing in Mali Named “Best Program” Among 100 Programs Compiled in Global Report		USAID Communication et Promotion de la Santé/Keneya Jemu Kan	
46	Environmental Mitigation Report with key environmental mitigation activities carried out during the quarter			

ANNEX IV: ADDITIONAL TABLES

Table 1. SSGI Intervention districts, by program year and districts selected for the evaluation

Region	Districts ad CSCOMS Surveyed		Year 1	Year 2	Year 3	Year 4	Year 5
Kayes 8 CSCOMs	Kayes	Koniakary, Diboli, Diamou,	X	X	X	X	X
	Nioro	Tintiba	X	X	X	X	X
	Yelimane	Dogofri	X	X	X	X	X
	Kita	Mambiri; Kokofata	X	X	X	X	X
	Sefeto (part of Kita in Yr1)			X	X	X	X
	Sagabary (part of Kita in Yr1)			X	X	X	X
	Diema	Latakaff	X	X	X	X	X
	Bafoulabe		X	X	X	X	X
	Oussoubidiagnia		X	X	X	X	X
	Kenieba		X	X	X	X	X
Koulikoro 15 CSCOMs	Koulikoro	Sinzana	X	X	X	X	X
	Ouelessebougou		X	X	X	X	X
	Kangaba	Karan	X	X	X	X	X
	Kati	Ouewwindougou, Moribabougou, Sonikeyi		X	X	X	X
	Dioila	N'tobougou		X	X	X	X
	Banamba	Samankele, Banamba, Ouest		X	X	X	X
	Kolokani	Guihoyo, Tioribougou, Nossombougou, Diedieni		X	X	X	X
	Fana	Diele		X	X	X	X
	Kalabankoro	Kalabancoro, Koulouba, Kalabancoro Adeken		X	X	X	X
	Nara			X	X	X	X
Sikasso 5 CSCOMs	Bougouni	Kéléya, Kaboila, Foh	X	X	X	X	X
	Kolondieba		X	X	X	X	X

Region	Districts ad CSCOMS Surveyed		Year 1	Year 2	Year 3	Year 4	Year 5
	Yanfolila		X	X	X	X	X
	Niena		X	X	X	X	X
	Yorosso		X	X	X	X	X
	Selingue		X	X	X	X	X
	Sikasso			X	X	X	X
	Koutiala	Mièna		X	X	X	X
	Kadiolo	Fourou		X	X	X	X
	Kignan			X	X	X	X
Bamako 2CSCOMs	Commune 5		X	X	X	X	X
	Commune 6		X	X	X	X	X
	Commune 1	Asacoba; Asacokosa		X	X	X	X
	Commune 2			X	X	X	X
	Commune 3			X	X	X	X
	Commune 4			X	X	X	X
Gao	Gao	Not surveyed			X	X	X
Total	16	30	19	36	37	37	37

Table 2. Services delivered by surveyed CSCOMS

Q37	Service/Outcome	HFs with Data	Health Facility Mean	Std. Dev	Min	Min CSCOM	Max	Max CSCOM
1	Prenatal visit ANC – 1 (among pregnant women)	30	0.784	0.290	0.297	Keleya	1.674	Ouezzindou
2	4+ Prenatal visits ANC-4 (among pregnant women)	30	0.284	0.330	0.070	Nossombougou	1.906	Didieni
3	3 doses of SP (among pregnant women)	30	0.388	0.202	0.098	Keleya	0.932	Ouezzindou
4	Complete vaccination of children (0-11 mos.)	30	1.096	0.902	0.086	Diboli	5.128	Didieni
5	Malaria rate, detected in outpatients (0-5yrs)	30	0.329	0.331	0.001	Nossombougou	1.295	Samakele
6	Malaria rate, treated in outpatients (0-5yrs)	30	0.272	0.308	0.001	Dogofri	1.291	Samakele
7	Malaria rate, detected in pregnant women	28	0.245	0.211	0.000	Dogofri	0.839	Ouezzindou
8	Malaria rate, treated in pregnant women	28	0.208	0.265	0.000	Dogofri	1.318	Tintibi
9.1	ITN net distribution (among pregnant women)	30	1.043	0.612	0.096	Kaboila	2.344	Adeken
9.2	ITN net distribution (among all 15-49yo women)	30	0.243	0.143	0.022	Kaboila	0.533	Adeken
10	Births by qualified personnel (pregnant wmn)	30	0.402	0.330	0.007	Lattakof	1.494	Ouezzindou

Q37	Service/Outcome	HFs with Data	Health Facility Mean	Std. Dev	Min	Min CSCOM	Max	Max CSCOM
11	3 rd trimester GATPA (among qualified births, #10)	30	0.667	0.628	0.096	Kaboila	3.573	Tintiba
13	Family planning consultations (among 15-49yrs)	30	0.198	0.139	0.010	Tintiba	0.688	Foh
14.1	Contraceptive pill rate (as % of those receiving FP)	30	0.157	0.142	0.004	Nossombougou	0.657	Milna
14.2	Contraceptive pill rate (as % of all 15-49yrs)	30	0.031	0.034	0.000	Nossombougou	0.130	Foh
15.1	Standard Days rate (as % of those receiving FP)	24	0.147	0.684	0.000	Nossombougou	3.357	Tintiba
15.2	Standard Days rate (as % of 15-49yrs)	24	0.003	0.008	0.000	Nossombougou	0.035	Tintiba
16.1	Injectable rate – Depo (as % of those receiving FP)	30	0.377	0.254	0.000	Diele	1.209	Kaboila
16.2	Injectable rate – Depo (as % of 15-49yrs)	30	0.061	0.049	0.000	Diele	0.218	Foh
17.1	IUD rate (as % of those receiving FP)	28	0.164	0.683	0.000	Diamou	3.643	Tintiba
17.2	IUD rate (as % of 15-49yrs)	28	0.007	0.010	0.000	Diamou	0.038	Tintiba
18.1	Implant rate (as % of those receiving FP)	30	0.328	0.311	0.002	Diamou	1.225	Mouribagougou
18.2	Implant rate (as % of 15-49yrs)	30	0.052	0.050	0.000	Tintiba	0.237	Mouribagougou

Q37	Service/Outcome	HFs with Data	Health Facility Mean	Std. Dev	Min	Min CSCOM	Max	Max CSCOM
19.1	Surgical contraception (as % of those receiving FP)	17	0.004	0.007	0.000	Tintiba	0.028	Tioribougou
19.2	Surgical contraception (as % of 15-49yrs)	17	0.000	0.001	0.000	Tintiba	0.003	Tioribougou
20.1	STI rate (as % of consultations, #12)	29	0.031	0.034	0.000	Tintiba	0.126	Diele
20.2	STI rate (as % of total pop)	29	0.009	0.008	0.000	Tintiba	0.032	Samakele
21.1	Confirmed TB rate (as % of consultations, #12)	19	0.001	0.002	0.000	Tintiba	0.007	Diamou
21.2	Confirmed TB rate (as % of total pop)	19	0.000	0.001	0.000	Tintiba	0.003	Karan
22	TB cases under treatment (among confirmed #21)	5	4.199	7.827	0.269	Asacoma	18.189	Diamou
23.1	HIV/STI test rate (as % of consultations, #12)	20	0.012	0.032	0.000	Tintiba	0.142	Fourou
23.2	HIV/STI test rate (as % of total pop)	20	0.004	0.010	0.000	Tintiba	0.040	Fourou
24	HIV/STI test rate among pregnant women	25	0.332	0.335	0.000	Tintiba	0.838	Mouribagougou
25	Referral rate for pregnancies (among pregnant)	28	0.060	0.156	0.000	Dogofri	0.835	Diamou

Q37	Service/Outcome	HFs with Data	Health Facility Mean	Std. Dev	Min	Min CSCOM	Max	Max CSCOM
26	Referral rate for infant illness (among 0-11 mos) ⁵	23	0.082	0.240	0.000	Dogofri	1.099	Didieni
27	Respiratory illness (among 0-5yrs)	30	0.270	0.354	0.022	Bouya Kane	1.528	Samekele
28	Diarrhea (among 0-5yrs)	30	0.084	0.102	0.000	Sognikeni	0.429	Samekele
29	Moderate malnutrition rate (0-5yrs)	30	0.025	0.048	0.000	Diele	0.267	Samekele
30	Severe malnutrition rate (0-5yrs)	29	0.028	0.024	0.002	Keleya	0.097	Sinzani
31	Malnourished recovery rate (mod and severe)	28	0.843	1.219	0.000	Sognikeni	6.770	Nossombougou
32	Referral rate for malnutrition (mod and severe)	20	0.035	0.058	0.000	Sognikeni	0.167	Kalabancoro K.
33	Maternal death rate (among pregnant women) ⁶	16	0.000	0.000	0.000	Sogikeni	0.002	Diboli
34	Infant death rate (among 0-11 mos)	19	0.003	0.006	0.000	Fourou	0.024	Karan
35	Neonatal death rate (among pregnant women) ⁶	21	0.005	0.011	0.000	Dogofri	0.040	Karan
36	Stillborn rate (among pregnant women) ³	23	0.005	0.008	0.000	Dogofri	0.031	Ouezzindou
37	Child death rate (among 0-5yrs)	16	0.000	0.000	0.000	Dogofri	0.001	Karan

Q37	Service/Outcome	HFs with Data	Health Facility Mean	Std. Dev	Min	Min CSCOM	Max	Max CSCOM
38	Child death rate due to respiratory (% cases, #27)	15	0.002	0.006	0.000	Dogofri	0.024	Asacoba

The table below represents the full list of CSCOMs surveyed in the health facility survey, along with the rate of service provisions for each. To calculate the service provision rate, we calculated the rate of delivery of each of the 38 services for a single CSCOM (using the number of times the CSCOM reported providing that service divided by the appropriate demographic denominator), and we then took the average rate of delivery across all 38 services for that CSCOM.

Table 3. Evaluated CSCOMs ranked by provision rate

CSCOM	SERVICE PROVISION RATE
Adeken	0.27
Asacoba	0.16
Asacokosa	0.29
Bouya Kane (university)	0.20
Diamou	0.49
Diboli	0.20
Didieni *	0.10
Diele	0.23
Dogofri	0.06
Foh	0.25
Fourou	0.15
Guihoyo	0.12
Kaboila	0.14
Kalabancoro Koulouba	0.24
Karan **	0.76
Keleya	0.09
Kokofata	0.21
Lattakaf	0.13
Mambiri	0.36

CSCOM	SERVICE PROVISION RATE
Milna	0.25
Moribabougou	0.29
Nossombougou	0.25
N'Tobougou 1	0.23
N'Tobougou 2	0.25
Ouezzindou	0.40
Samakele	0.44
Sinzani	0.21
Sognikeni	0.26
Tintiba	0.34
Tioribougou	0.12

Notes: * Didieni was missing data for all but 8 of the services; ** Karan represents an outlier whose data raise questions; they reported provision rates above 100% for 8 of 38 services, some as high as 700%.

ANNEX V: LIST OF SELECTED CSCOMs AND TARGET POPULATION

Health Zone #	Sampling #	Name of Health Zone	District	2018 Population (Estimated)
1	137	Kouloun	Kayes	14,182
2	152	Diéoura	Diéma	14,896
3	167	Yerere	Nioro	15,382
4	182	Kokofata	Kita	15,815
5	197	Koungo	Diéma	16,242
6	212	Hamakouladji	Gao	17,158
7	227	Boutinguisse	Kayes	17,914
8	242	Diaye Coura	Nioro	18,460
9	257	Lobou	Gao	19,285
10	272	Lofigué	Kadiolo	20,272
11	287	Siby	Kati	21,160
12	302	Kangaba Central	Kangaba	22,060
13	317	Wayerma 2	Sikasso	23,466
14	332	Asacocy	Commune VI	25,113
15	347	Dilly	Nara	27,820
16	362	Diéma Central	Diéma	29,609
17	377	Asacko Nord	Commune I	32,901
18	392	Asacome	Commune II	36,908
19	407	Kolondiéba Central	Kolondieba	41,076
20	422	Ouélessébougou	Ouelessebougou	49,056
21	437	Asacotoqua	Commune V	67,022
22	8	Toutiala	Kolondieba	10,183
23	23	Koronga	Nara	10,617
24	38	Gory-Gopela	Kayes	11,115
25	53	Somankidi	Kayes	11,604
26	68	Garasso	Koutiala	12,073

Health Zone #	Sampling #	Name of Health Zone	District	2018 Population (Estimated)
27	83	Bongosso	Koutiala	12,427
28	98	Tougouni	Koulikoro	12,677
29	113	Madiga Sacko	Diéma	13,389
30	128	Sibikily	Kita	13,777

ANNEX VI. DATA COLLECTION TOOLS

1. Document Review Form
2. Key Informant Interview
3. Embedded Observation Form
4. FGD Adolescents
5. FGD Women
6. FGD Community Leaders
7. CSCOM Survey
8. Household survey

Document Review Form		
Project name (SSGI or KJK)		
Document Title & references:		Reviewer:
Date & day of the review:		
Objectives addressed in this document	Evaluation Questions	Facts and Evidence (quote, reference and/or page #)
Objective 1	Key Results achieved	
	Gaps identified in relation to objective 1	
Objective 2	Key Results achieved	
	Gaps identified in relation to objective 2	
Objective 3	Key Results achieved	
	Gaps identified in relation to objective 3	
Objective 4	Key Results achieved	
	Gaps identified in relation to objective 4	
Objective 5	Key Results achieved	

	Gaps identified in relation to objective 5	
Continued review		
Examples of flexibility & innovations		
Examples of lack of flexibility		
Effectiveness		
Project design issues		
Manner of implementation and processes		
Return on investment		
Evidence of sustainability and ownership		
Recommendations for future MNCH program		
Other observations		

Key Informant Interview Form

Instruction: This interview guide is to be used for key informants surveyed at all levels: national, regional and district. However, it must be adapted to the interviewee profile and position. Therefore, the focus will be on the political and strategic aspects at national and on operational aspects at regional and district level. Every question will depend on his/her level of involvement to the two projects design and/or implementation. This aspect will be appreciated after the response received from the first question which will be asked equality to all key informants. Regarding the staff of both projects, the questions will be about the project that concerns them.

Interview Agenda and Minutes	Date:
Interviewee's Name: Email: Phone: Cell: Time at start Time at end	Interviewer(s):
Questions / Topics	"Quote" and Notes
Effectiveness	
Could you briefly describe for me what you know about the two projects SSGI et KJK (objectives, strategies, activities, major achievements etc.)?	
To what extent do the project's priorities and objectives align with government's priorities and policies? <i>(all levels)</i>	
How appropriate and realistic are the project's design, strategies and interventions, considering the health needs and socio-economic and political environment in the country? <i>(national)</i>	
With the support of the projects SSGI and KJK what interventions are having a great success in your opinion? <i>(all levels)</i>	
What interventions are having less success at national / Region/district/village level thus far? <i>(all levels)</i>	
In your opinion, has the project achieved its expected results? What makes you say that? <i>(all levels-be more specific with USAID staff)</i>	
What are the main factors that contributed to the achievement or non-achievement of the expected results? <i>(all levels)</i>	

Can you provide specific examples of how the project implementation strategies are working well? • At national level • At regional • At district level • Village level (<i>all levels, particularly project staff</i>)	
Efficiency: To what extent have the program inputs (human, technical, and financial) been used efficiently? (<i>National projects' staff</i>)	
Flexibility (= ability to make the necessary changes at any time to achieved the best results possible on time)	
How flexible has the Project been in addressing the needs of the government at national, regional, district and village levels? (<i>USAID and Projects staff at national level to be adapted at regional and district level</i>)	
What is the general perception regarding the project's ability to address required changes among implementing partners and counterparts?	
Gaps (=differences between what was planned and expected and what has been achieved or observed)	
What are the shortcomings of the project – Are there any unintended outcomes – positive or negative? (<i>all levels</i>)	
How the project's investments could contribute to the reduction of maternal and child mortality? (national level)	
What are major risks faced by project, now and in the future? (<i>all levels</i>)	
What opportunities and possible solutions to address the gaps and improve the project's performance? (<i>all levels and more specifically project staff</i>)	
Gender	

In terms of improving the use of the services implemented by the two projects for people at risk and vulnerable groups, how did they take into account the gender aspect at national, regional, district and village level, more specially the following aspects: • Financial barriers • Distance • Transport • Social/gender barriers • Social discriminations • GBV <i>(Projects' staff at all levels)</i>	
Has the project proved effective in realizing gender through its activities? What impact has been made among the most at risk and vulnerable groups? Please provide evidences and best practices, if available (projects staff at all level).	
Has MPHH's policy on gender been taken into consideration in the project's design and implementation? <i>(Projects staff at all level focusing more at regional & district levels)</i>	
Management	
What are the strengths and weaknesses of project's management? <i>(the two projects at all levels)</i>	
To what extent has management supported/hindered the progress of implementation of the two projects? <i>(The two projects staffs at all levels and USAID team)</i>	
What have been some major management issues and how were these resolved? How could management have been improved? <i>(two projects staff at all levels and USAID staff)</i>	
How do you assess the quality of the coordination of the two projects not only with USAID, the technical services of MSHP, but also with the other Implementing Partners? • What is your opinion about the effectiveness of this coordination? • What are the major challenges facing this coordination? • What would you propose in terms of strategies to strengthen it? <i>(staff of both projects at all levels)</i>	
Sustainability	
To what extent and in what ways has the project contributed to enhance national capacities in government, civil society and NGOs? <i>(national level MOHH, USAID, national staff of the two projects)</i>	

To what extent are the project's interventions owned and led by the government? <i>(MOHH technical staff involved in the two projects at all levels)</i>	
To what extent are counterparts willing and able to continue project's activities on their own? <i>(MOHH technical staff involved in the two projects at all levels)</i>	
Other questions or comments (specify):	

Embedded Observations Form

Person observed COP/DCOP M&E advisor MNCH/FP Advisor ID Advisor BC/HC Advisors Other		Observer
Question	Observation: Observed behaviors, practices and procedures followed	Findings: document evidence, photos, gather documents, record quotes, etc.

. Extent to which the SSGI/KJK activities have contributed to achievement of planned results	● Job description in relation to specific IR ● Individual work plan with targets and standards, for the quarter, month, week ● Daily plan? ● Regular supervision ● Attendance to staff meetings ● Relationships with counterparts ● Achievements ● Concerns	● Does the JD specifically show how this person's work contributes to one or more IRs? How well? ● How well does this person plan and implement her work? ● How does this person contribute to improve the Malian Health System? ● How well does this person work as part of the team and support and complement each other? And with Twin project staff? ● Are there compatibility problems between staff from prime and sub? ● How well does this person relate and build the capacity of counterparts? ● What are the "visible" signs of this person's achievements? ● What are his/her concerns about the achievement of the project's results? ● Is this person qualified for the position? Demonstrates capacity?
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2. Extent to which financial, management and M&E systems are affecting the achievement of results.	• Financial • Management • M&E	• How does this person make use of project's resources? How well? How accountable is this person? • What management tasks does this person perform? How well? • How does this person contribute to project's M&E? Up to date reporting? Awareness of DQA? Problems solving skills in action?
3. Extent to which gender, environment and B&M requirements are met	• Gender • Environment • B&M	• How well does this person address gender requirements? • How well does this person address environment requirements? • How well does this person address B&M requirements? • Are there written guidelines? Are procedures followed? Missed opportunities?
Recommendations for the LOP		
IRs	What IR(s) does this person contribute to? How?	Examples observed
Scalable	What interventions did you observe this person involved in?	What evidence did you observe that the interventions are scalable?
Integration	How well are activities integrated in the Malian Health system? How well are the project activities part of regular health care delivery processes?	What evidence did you observe that the interventions are integrated? What evidence did you observe of synergy and integration with twin project?
Best practices	What BP were observed?	Degree of development: pilot, testing, scalable?

How can project address problems/weaknesses	Problem/weakness reported by staff Problem/weakness observed but staff not aware	Solutions proposed by staff Solutions proposed by TMG team
How can USAID/Mali help?	Views from Staff Views from TMG team	Feasibility within current LOP? Likelihood of success?
Recommendations for the future		
Lessons for future projects		
Changes in the context of CDCS and HSS priorities		

FGD FOR ADOLESCENTS (Boys and girls, students and out-of-school youth)

District: _____ Village _____

Name of the health center: _____ Date: _____

Welcome to the participants ... and the focus group facilitator should introduce themselves (and their team members – i.e. Note taker) to the participants. Thank the participants for agreeing to participate in the discussion. Note that their answers are very important because they will help us make our program in the region more efficient in the future. (Please refer to the DFG Guide for additional guidance.)

Read: In collaboration with the Government of Mali, USAID has been implementing since 2014 a program to facilitate sustainable improvement in health through the increased use of high impact services and the adoption of behaviors. healthy through the KJK (Keneya Jemukan) and the SSGI (High-Impact Health Services) projects in the Bamako District, Kayes Koulikoro Sikasso Mopti regions and the Gao Health District. As part of this program, an evaluation is underway to measure the impacts of behavior change interventions and social norms. To this end, I would like to gather your views on the health care currently available to pregnant women and adolescent girls in your community.

INTRODUCTION: To begin, ask boys and girls to introduce themselves

GENERAL INFORMATION

N.	Name	Ethnic group	Sex	Travel time to go to health facility	Age

A. Access and quality of services

1. Where did you get information on these two projects?
2. What kind of things do young people do in this part of the village? Where do they go when they get sick? What are the different types of services offered to young people in this region? Do young people like it?
3. Can you indicate the specific youth-friendly services available in this CSCOM () - boys and girls, marginalized?
If not, what are the barriers (lack of privacy, inadequate service providers, social discrimination, economic referrals, inadequate referrals, attitude of service providers, etc.)? Are there other places where you can go to get better, youth-oriented health care (ASRH information, referrals, child marriage, etc.)?
4. Has there been new support (funds / IEC materials / referrals, etc.) from the health center, schools or other NGOs and associations in your area to meet the needs of young people in Sraji? If yes, how did you use it?
5. Do you know of any recent information / materials (IEC materials / guidance for young people (men and women) - marginalized and others - that have improved the knowledge of youth and adolescent groups and their access to health services?) child marriage, nutrition, uterine prolapse, gender-based violence, delayed marriage, etc.
If yes, which ones?

6. What do you think about the quality of PLAR / HIV information shared by teachers in schools (for students), in grins and other youth gathering locations, or by KJK facilitators, peer educators?

7. Have you noticed positive changes among youth in your community in recent years? (e.g., contraceptives, delayed marriage, delayed pregnancy, GBV reduction, increased level of knowledge, rate reduction, dowry, etc.)

8. What change(s) did you notice about the health care / information provided in this VAC during the past year? Have you already received information received by SMS? Has anyone ever advised you / shared information about child marriage / Crisis Management Centers (CMCs) / Nutrition Rehabilitation Centers / NGOs specifically dealing with the rights and needs of young people, etc.?

9. What can be improved or would you like to see changes in programs for youth?

10. Is it common in your community for girls to marry before the age of 18?

- At what age do girls usually marry?
- Why do girls get married before 18?
- What do you think about the marriage of girls under 18?

11. Did you participate in a communication and screening campaign on STIs and HIV? If so, what did you remember as messages?

12. Do you recognize the signs of Sexually Transmitted Infections (STIs)?

13. How to protect yourself from STIs and HIV?

14. In case of STIs what do you do?

B. Non-users' point of view

15. In your opinion, why do young people not use long-term FP methods? Please explain the reasons? Who are the young people in your community who least access this facility?

16. How can we bring them to the health facility?

Thank you

Focus Group Discussion WOMEN AT REPRODUCTIVE AGE

Targeted groups:

- Adolescent girls of childbearing age (married) (15-19 years)
- Women (20-49 years) with children under five

Welcome to the participants ... and the focus group facilitators should introduce themselves (and their team members – i.e. Note taker) to the participants. Thank the participants for agreeing to participate in the discussion. Note that their answers are very important because they will help us make our program in the region more efficient in the future. (Please refer to the FGD Guide for additional guidance.)

Read: In collaboration with the Government of Mali, USAID has been implementing since 2014 a program to facilitate sustainable improvement in health through the increased use of high impact services and the adoption of behaviors. healthy through the KJK (Keneya Jemukan) and the SSGI (High Impact Health Services) projects in the Bamako District, Kayes Koulikoro Sikasso Mopti regions and the Gao Health District. As part of this program, an evaluation is underway to measure the impact of interventions in terms of service provision and behavior change. To this end, I would like to gather your views on the health care currently available to pregnant women and adolescent girls in your community.

GENERAL INFORMATION: (fill this form before the focus group)

N	Name First name	Age	Ethnic group	Marital status	Pregnant or not

To start FGD, ask women to introduce themselves.

QUESTIONS:

1. Ask participant where people usually go in case of illness?
2. Could you tell us about the different types of services offered to teenage girls, mothers and newborns?
3. What is your opinion about the services offered at your CSCOM? Explain
4. What would you consider to be potential difficulties that may prevent women and adolescent girls from accessing health services in general and reproductive health in particular?

Check: cultural practices / religious taboos / myths / beliefs; restriction of health decision-making authority; lack of financial independence; low level of education; husbands preventing teenage girls from safety issues, behavior of health workers, time the services are offered, waiting time, location of the health facility, lack of qualified health personnel, security issues, etc.

5. During your pregnancy or after the birth of your child, what type of support did you receive from your husband if any? Ask participants discuss the type of support.

Check: help with housework and / or farming take care of the children; give financial support / buy all that is needed for childbirth; organize transportation to the health facility; accompany the wife to the health facility; support women's decision-making in maternal and newborn health (including reproductive health)

6. Within the household, how are decisions made about the number and spacing of children?

Check: Who is responsible for making decisions? Do spouses and their wives together make these decisions?

7 Ask women about their experiences and perspectives on FP (use, constraints and challenges, and possible supports)

8. Why do not some women and girls in your community use FP methods?

Check: it's taboo; women / adolescent girls are not allowed to make decisions about FP or contraception; refusal of husband / family / in-laws, husband wants more (more) children; wife / husband wants (more) children; religion / culture; too expensive; currently pregnant; contraception is not available, contraception is not safe / has negative side effects, only women / adolescents who are immoral / promiscuous use contraceptives

9. Do you know transmission mode and means for prevention HIV/AIDS?

10. What about your sources of information regarding services such as: FP, HIV, malaria, nutrition, water and sanitation? (Did this information help you improve your knowledge and use of the services to your satisfaction?

Check: Campaign, radio broadcasts, flyers, information by ASC, CSCOM, friends, neighbors, relatives, others (specify)

11. What kind of liquid is given to a child at birth in your community?

Check: water, sugar water, herbal tea and other liquids

12. What are the advantages for your child of exclusive breastfeeding during the first 6 months?

13. What dietary supplements do mothers give to their children after the first 6 months?

14. What are the malnutrition signs that you can recognize in a child?

15 What do you do in case of malnutrition?

16. What do you do to prevent child malnutrition?

17. How would you feel when you see a woman or girlfriend being beaten or abused by her husband or male partner? Is this a common behavior in your community? What can be done at the household level to prevent this from happening? What can be done at the community level?

18 What are the signs of malaria? Where do you go when affected by malaria? What do you do to protect yourself and your children against malaria?

19. In your community, did you hear about KJK and SSGI projects?

19a. How did their interventions meet your expectations?

19b. In what areas did they improve your knowledge and practices? (MCH, FP, HIV, malaria, water and sanitation, nutrition, Gender).

20. How do you supply water? who manages it?

21. What is the nearest water point?

23 Is hand washing part of your daily practice?

23. What can be improved or would you like to see changes in women and adolescent girls programs?

Thank the participants of Focus Group

FGD FOR COMMUNITY LEADERS (customary leaders, religious, associative, teachers)

District: Village

Date: _____

Welcome to the participants ... and the focus group facilitators should introduce themselves (and their team members – i.e. Note taker) to the participants. Thank the participants for agreeing to participate in the discussion. Note that their answers are very important because they will help us make our program in the region more efficient now and in the future. (Please refer to the DFG Guide for additional guidance.)

Read: In collaboration with the Government of Mali, USAID has been implementing since 2014 a program to facilitate sustainable health improvement through the increased use of high impact services and healthy behavioral change through the KJK (Keneya Jemukan) and the SSGI (High Impact Health Services) projects in the Bamako District, Kayes Koulikoro Sikasso Mopti regions and the Gao Health District. As part of this program, an evaluation is underway to measure the impacts of behavior change interventions and social norms. To this end, I would like to hear your thoughts on the involvement of men in promoting the health of women, children and adolescents in your community.

GENERAL INFORMATION (fill this form prior to the start of the Focus Group Discussion)

N.	Name	Ethnic group	Sex	travel time to go to health facility	Age

Introduction: To begin, ask men to introduce themselves.

QUESTIONS

1. Sometimes a husband is annoyed or irritated by what his wife does, what would he do? Explain

2. How are women involved in decision-making at the community level?

3. In the household, how are decisions made about the number of children and their spacing?

Check: Who is responsible for making decisions? Do spouses and their wives together make these decisions?

4. What do you think about the attendance of health centers by your wives? For which services? what is your opinion about the services offered? What are the obstacles in your opinion?

Check: poor reception, lack of privacy, incompetent staff, unavailability, social discrimination, high cost, corruption, etc.?

5. What are the benefits of births spacing for women, children and families? What is your opinion on birth spacing? Explain why.

6. What are your sources of information regarding services such as: FP, HIV, malaria, nutrition, water and sanitation?

Check: campaign, radio broadcasts, information by ASC CSCOM etc.

7. Speaking about nutrition ask men their views on exclusive breastfeeding during the first 6 months?

7a. Do you recognize signs of malnutrition in a child? Which ones?

7b. What are you doing to prevent child malnutrition?

8. About malaria, how are the signs?

8a. How do you protect yourself from malaria?

8b. What do you do when a family member is sick?

9. What about the marriage of girls before the age of 18 in your community?

9a. Why do girls get married before 18?

9b. What do you think about the marriage of girls under 18? Explain

10. In your community, did you hear about KJK and SSGI projects?

10a. How did their interventions meet your expectations?

10b. In what areas did they improve your knowledge and practices?

Check: SR / FP, HIV, malaria, water and sanitation).

10c: What are these knowledge and practices? What was the source of information?

Check: campaign, NGO outreach activities, radio broadcasts...

11. What do you think could be improved, or would you like to see changes in programs for women and adolescent girls?

Thank the participants

CSCOM Survey INSTRUCTIONS TO DATA COLLECTOR

This checklist should be completed by observing the facility in the selected cluster and through discussions with the person in charge of the facility on the day of the visit. In all cases you should verify that the items exist by actually observing them yourself - if you are not able to observe them, then code accordingly. Remember that the objective is to identify the facilities that currently exist and not to evaluate the performance of the staff or clinic.

For each item, circle the response or describe as appropriate.

1. CSCOM Visited (Name) _____
2. District: _____
3. Name of Researcher: _____
4. Name of the respondent and contact no: _____
5. Checked by QA SUPERVISOR: _____
6. Opening days in a week: – M – T – W – Th – F – S – Su
Hours of operation: _____ from _____ to _____
7. Are the following services available?

	Services	Yes	No
	OPD	1	2
	IMCI	1	2
	Well-baby care, vaccination and growth monitoring	1	2
	ANC	1	2
	Delivery	1	2
	PNC	1	2
	Contraceptives (condoms, pills, injectable)	1	2
	Long acting contraceptive (IUCD, Implantation)	1	2
	VSC	1	2
	Laboratory services: Rapid test, HIV testing, other: _____	1	2

8. Is a staff member always available at night for official call? (Applicable to PHC and hospital only)

Yes 1 (Go to Question 8)
No 2 (Skip to Question 11)

9. If yes, does that staff member live or stay at this health center when on night call?

Yes 1
No 2

10. Is there a waiting area in this facility?

Yes ___1

No ___2

Comment _____

11. What is the main source of water for the facility? (Note to interviewer: the water source that is relied upon for most of the year for most of the water)

Tank water ___1

Well ___2

River/stream/spring ___3

Piped water ___4

Bore water ___5

Other rainwater collection ___6

Other stored water ___7 (collected from somewhere else and stored)

Other ___8

No water source ___9 (Skip to question 19)

Comment _____

12. Is the drainage for water adequate? (Adequate means that there is no flooding of water, no leaking pipes, no blockages, and the water drains away from the health center)

Yes ___1

No ___2

Comment _____

13. Toilets: a) Are toilets available for patients?

Yes ___1

No ___2 (If no skip to question 19)

b) Are these toilets able to be used at present?

Yes ___1

No ___2

Comment _____

14. What is the source of power for the health center? (More than one answer is allowed)

a. Electricity grid ___1

b. Generator ___2

c. Kerosene ___3

d. Bottled gas ___4

e. Solar ___5

Chinese Lamp ___6

g. Other ___7

Please specify _____

h. No energy source ___8

15. Is there a place for counseling?

Yes 1
No 2

Comment _____

16. Do you have a place where you can talk with a patient and others CANNOT hear the conversation?

Observe the facility. (Privacy level).

Yes 1
No 2

Comment _____

17. Is there a separate room /area for examinations?

Yes 1 (Skip to Question 21)
No 2 (Go to Question 24)

Comment _____

18. (Note to interviewer: Please go to the examination room and check the answer to this question yourself). Is the examination area clean?

(NOTE: "Clean" means fresh linen at start of day, floors swept and mopped, no dust on window sills and tables, rubbish bins empty)

Yes 1
No 2

Comment _____

(Note to interviewer: Please go to the examination room and check the answer to this question yourself)

19. Is there an adequate source of light in the examination area?

(NOTE: "Source" is any source of light. Adequate means a functioning electric light, hurricane lamp, torch, candles, or sufficient natural light).

Yes 1
No 2

Comment: (Including what is the source of light e.g. sunlight, torch, angle poised lamp, etc.)

SECTION III.

EQUIPMENT AND COMMODITIES INVENTORY

CAT. NO.	TYPE OF EQUIPMENT/SUPPLIES	HOW MANY IN STOCK (a)	NUMBER IN WORKING ORDER (b)	Is it reliable? (Write Yes, No, or DK for don't know) (c)
	1. Airway Infant			
	2. Airway Resuscitation			
	3. Albumin sticks for testing urine for protein			
	4. Ambubag (resuscitation bag)			
	5. Auroscope			
	6. Autoclavable sealing tape			
	7. Cylinder regulator oxygen flow meter			
	8. Obstetric Vacuum Extractor			
	9. Foley catheter (urine collection)			
	10. Fridge / Freezer Electric, Gas, Kerosene or Solar			
	11. Gloves Surgeon Size 6			
	12. Hurricane Lamp – Kerosene Operated			
	13. Microscope			
	14. Scale Adult			
	15. Scales Infant Weighing Hanging Spring Type			
	16. Sterilizer Pressure Cooker			
	17. Thermometer Clinical			
	18. Vaccine cold boxes			
	19. Vaccine ice packs			
	20. Vaccine carrier			

	MNCH	Indicate as a tray or as separate items		
Other large or important equipment				
	Fetoscope			
	Stethoscope			
	BP machine			
	Adult weighing scale			
	IV sets			
	Speculum in three sizes			
	Episiotomy set			
	Oral thermometer			
	Sharps container			
	Autoclave			
	Wall clock			
	Cervical repair set			
	Emergency light			
	Electric/manual suction equipment			
	Momo steamer			
	Portable light			
	Measuring tape Oxygen cylinder			
	Instrument trolley			
	Drum for disposing of gloves			

20. Where is equipment sent for repairs?

- | | |
|---|----------------------------|
| Repaired here | ___1 |
| Sent to the nearest health office | ___2 |
| Sent to the district health office | ___3 |
| Sent to the district health office | ___4 |
| Sent to the regional health directorate | ___5 |
| Sent to private/commercial workshop | ___6 |
| Not sent for repairs | ___7 (Skip to question 38) |
| Don't know/cannot remember | ___8 (Skip to question 38) |

21. How long, on average, does it take from being to send and returning from repairs?

(Note to interviewer: Fill in one of the two –DAYS OR WEEKS)

A. _____ days OR
B. _____ weeks

22. May I see your equipment? I need to check how many of each of the following types of equipment are available for health services. To be reviewed.

(Note to interviewer: Please walk with someone into each room and check the list against the equipment available in that room. If they have an item extra, please list it at the end of the table. If it appears in a room different from that listed in the table, please fill in the details but place into the table where it is presently is marked)

23. Are the following drugs and supplies available for health services? (Please note the level of services at which you are working) A. For stocking by hospitals.

Code	Drug	Available (a)	Expired (b)	Was there a stock out in the last six months? (no/yes/ don't know/not applicable)(c)
	Albendazole	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Aluminum hydroxide	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Magnesium hydroxide	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Amoxicillin Tab(500mg)	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Amoxicillin injections 250mg	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Chloramphenicol	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Chlorhexidine	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3

	Chlorpheniramine Tab	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Ciprofloxacin Drops	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Ciprofloxacin Ointment	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Compound solution of Sodium lactate (Ringers' Lactate) Inj.	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Ferrous salt + Folic acid Tab.	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Gamma benzene hexachloride cream	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Gentamycin Inj.	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Lignocaine Inj.	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Magnesium Sulfate Inj.	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Metoclopramide Inj.	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Amoxicillin 250 mg tablets	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Amoxicillin 500 mg tablets	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Amoxicillin 250 mg tablets	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3

	Metronidazole Tab., Sus.	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Oral Rehydration Solution (ORS) Powder	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Oxytocin Inj.*	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Paracetamol Tab., Inj., Syp.	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Sulfamethoxazole + Trimethoprim Tab., Sus.	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Vitamin B complex Tab.	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Atenolol Tab.	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Atropine Inj.*	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Benzoic acid + Salicylic acid cream	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Charcoal activated powder	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Ciprofloxacin Tab	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Dexamethasone Inj.	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Frusemide Tab.	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3

	Promethazine Tab.	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Salbutamol Tab.	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Sodium chloride Inj.	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Male Condoms (number of single pieces) _____	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Contraceptive, injectable	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Contraceptive, pills,	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Contraceptive, IUCD	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Contraceptive, Implant	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
other				

24. Are the following vaccine stocks available? (in case of DHO and sub centers)

Code#	Vaccine	Available (a)	Useable (that is not expired) (b)	Was there a stock out in the last six months? (No/Yes/ Don't know/Not applicable) (c)
	BCG	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Pentavalent (DPT, Hep B, Hib	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	MR	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3

	Polio	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3
	Tetanus toxoid	Yes ___1 No ___2	Yes ___1 No ___2	Yes ___1 No ___2 Don't know ___3

25. (If there is a storage facility, including cupboard) Are storage facilities for commodities adequate?

Note to Interviewer: adequate means no exposure to rain and sun, protected from rats and pests, off the floor, floors and shelves kept clean, boxes dry, secure, rubbish bins empty)

Yes ___1

No ___2

Comment _____

26. How often does the facility get fresh supplies of drugs?

Every month ___1

Every 2 months ___2

Every 3 months ___3

Every 4 months ___4

Every 5 – 6 months ___5

Once – 2 a year ___6

Irregular, cannot say ___7

Cannot recall last time received ___8

Don't know ___9

27. How often does the facility get fresh supplies of vaccines?

Every month ___1

Every 2 months ___2

Every 3 months ___3

Every 4 months ___4

Every 5 – 6 months ___5

Once – 2 a year ___6

Irregular, cannot say ___7

Cannot recall last time received ___8

Don't know ___9

28. Are consumables like disinfectant, cotton wool, gauze, soap and gloves available?

Yes ___1

No ___2

Comment _____

29. Have you had to interrupt services in the last 6 months?

Yes ___1

No ___2

29. What was the reason?

Reason	Has this been fixed?
1 Shortage of kerosene	Yes ☐ 1 No ☐ 2 Don't know ☐ 3
2. Electricity	Yes ☐ 1 No ☐ 2 Don't know ☐ 3
3 Shortage of vaccines	Yes ☐ 1 No ☐ 2 Don't know ☐ 3
4 Shortage of needles and syringes	Yes ☐ 1 No ☐ 2 Don't know ☐ 3
5 Shortage of petrol/diesel	Yes ☐ 1 No ☐ 2 Don't know ☐ 3
8 Shortage of vaccine carriers or ice packs	Yes ☐ 1 No ☐ 2 Don't know ☐ 3
9 Shortage of drugs 2	Yes ☐ 1 No ☐ 2 Don't know ☐ 3
10 Lack of transport	Yes ☐ 1 No ☐ 2 Don't know ☐ 3
11 Fridge breakdown	Yes ☐ 1 No ☐ 2 Don't know ☐ 3
12. No care provider	Yes ☐ 1 No ☐ 2 Don't know ☐ 3
10. Participation in a training	Yes ☐ 1 No ☐ 2 Don't know ☐ 3
11. Illness	Yes ☐ 1 No ☐ 2 Don't know ☐ 3

12. Vacations	Yes __1 No __2 Don't know __3
13. Others	

30. Were PHC outreach activities carried out by the health center in the past 3 months?

Yes __1
 No __2
 How many? __
 Comment _____

31. Was a "health education session" (group lecture or discussion with clients) held today?

Yes __1
 No __2 (Skip to question 57)
 Comment _____

32. Is some record maintained for each PHC CSCOM?

(NOTE for interviewer only: Obtain and attach an example of a client record form and of the reporting forms used.)

Yes __1
 No __2
 Comment _____

33. Is this record updated?

Yes, for all PHC CSCOM service offered __1
 Yes, for some PHC CSCOM service offered __2
 No __3
 Comment _____

34. Are any of the following?

34.1	Medical Records	Yes	__1
		No	__2
34.2	Immunization record	Yes	__1
		No	__2
34.3	Obstetric Register	Yes	__1
		No	__2
34.4	Child register	Yes	__1
		No	__2
34.5	Other	Yes	__1
		No	__2

35. In what condition is the record card system? (Note to interviewer: Please examine the system yourself to answer this question)

No records _____ 1
 Well-ordered _____ 2
 Partially ordered, still useable _____ 3
 Disordered, not useable _____ 4

Comment _____

36. Who is responsible for keeping client records?

All health staff _____ 1
 One person _____ 2 (specify position) _____
 Don't know _____ 9

37. If records are used to send reports, is feedback received on reports?

Yes, always _____ 1
 Yes, sometimes _____ 2
 No _____ 3

Comment _____

38. Is there a daily activity register?

Yes _____ 1
 No _____ 2

Comment _____

39. What is the target population covered by the center?

1. Children aged 0 – 11 months	_____	Don't Know	999
2. Children aged 1 – 59 months	_____	Don't Know	999
3. Women aged 15 – 49 years	_____	Don't Know	999
4. Expected pregnant women	_____	Don't Know	999
5. Catchment population	Total _____	Don't Know	999

40. Gather and record the following health statistics for the last complete month

FOR THE MONTH OF _____ YEAR 200_____

Health services provided	Available		Number
1. Antenatal visits (ANC)	Yes	No	
2. Immunizations of children	Yes	No	
3. MALARIA cases in outpatients	Yes	No	

4. Number of deliveries	Yes	No	
5. TOTAL OPD attendances	Yes	No	
6. Family planning consultations	Yes	No	
7. Contraceptive pills	Yes	No	
9. INJECTABLE (Depo)	Yes	No	
10. IUCD	Yes	No	no
11. Implant	Yes	No	no
11. VASECTOMY /Mini Lap	Yes	No	no
12. STI	Yes	No	
13. TB cases confirmed	Yes	No	
14. Referrals for pregnancy or delivery -abortion related complications	Yes Yes	No	
15. Referrals for neonatal and childhood illness	No		
Death records			
16. Maternal deaths	Yes	No	
17. Infant deaths (0-11 months)	Yes	No	
18. Child deaths (12 to 59 months/under 5)	Yes	No	

Comment (include here if data not available and why, if it was an average month, if it was an unusual month and why):

41. Abstract and record the following immunization data for the last 4 months

(Note to interviewer; if it is recorded for some other time period, please list the duration of that time period here now: _____)

Immunization	Available	Number
1. BCG	Yes No	
2. Pentavalent (DPT, Heb B, Hib) 1	Yes No	
3. Pentavalent 2	Yes No	
4. Pentavalent 3	Yes No	
5. Polio 1	Yes No	
6. Polio 2	Yes No	
7. Polio 3	Yes No	
8. TT 1	Yes No	
9. TT 2	Yes No	
10. TT 3	Yes No	
11. TT 4	Yes No	
12. TT 5	Yes No	
13. Measles	Yes No	

42. Abstract and record the following health statistics for the last complete year

FOR THE YEAR 20_____

Health services provided	Available	Number
1. Antenatal visits (ANC)	Yes No	
2. Immunizations of children	Yes No	
3. MALARIA cases in outpatients	Yes No	
4. Number of deliveries	Yes No	
5. TOTAL OPD attendances	Yes No	
6. First Time Family Planning consultations	Yes No	
7. Contraceptive pills	Yes No	
9. INJECTABLE (Depo)	Yes No	
10. IUCD	Yes No	

11. Implant	Yes	No	
11. VASECTOMY /Mini Lap	Yes	No	
12. STI	Yes	No	
13. TB cases confirmed	Yes	No	
14. Referrals for pregnancy or delivery -related complications	Yes	No	
15. HIV/AIDS tests	Yes	No	
16. TB cases under treatment	Yes	No	
Death records	Yes	No	
17. Maternal deaths	Yes	No	
18. Infant deaths (0-11 months)	Yes	No	
19. Pneumonia deaths in children under 5	Yes	No	

44. Are the following materials available (observe)

Clinical protocol	Yes	No
Case management guidelines	Yes	No
Partograph	Yes	No
Other: _____		

45. Human resources

	Approved	Filled	Vacant	Stationed
Medical Officer				
HA/Sr. AHW				
Staff nurse				
Lab. Tech				
Radiographer				
ANMs				
Others				
Contracted person				
Total				

46. Training

	Total	Total Trained on MNCH	Trained project by	Remarks
Medical Officer				
HA/Sr. AHW				
Staff nurse				
Lab. Tech				
Radiographer				
Axillary Nurses/Midwives (ANMs)				
Others				
Contracted person				
Total				

End of Interview:

Thank you for your assistance in this survey. The results will be analyzed and a summary, without names or identifying characteristics will be sent to you and to the managers of the services at district and provincial level.

Do you have any questions or other comments? Please feel free to ask them or talk about them now.

Next meet with other community members and committee members to gather the views and progress.

B. Governance function by Health Facility Management Committee members

I. Inclusiveness (Member of Health Facility Management Committee)

	Total	Male	Female
Village 1			
Village 2			
Village 3			
Village 4			
CHW			
Staffs			
Total			

2. Frequency of the HF Management Committee meeting: Weekly, Bi-monthly, Monthly, Quarterly, Yearly

Functionality and accountability

Criteria	Yes	No
Meeting on regular basis (check minutes)		
Meeting schedule and agenda in advance		
Participation of women and Dalits in the meeting		
Provision of service in regular hours (10:00-13:00)		
Social audit conducted		
Were social audit findings fed into work plan?		

3. Quality improvement committee planning and review meeting minutes available?

Yes ___1

No ___2

4. Financial resources

Source	Year				
MPHH					
Local decentralized Government					
Village committee					
Community					
Total					

COMMUNITY INTERVIEW WITH MOTHERS OF INFANTS

Directions for interviewers: Start at the health post to the right and check every third household on your left for women with children under 12 months of age. If yes, conduct interview. If not, continue to the next third household always turning to the left. When you reach the end of the village, turn back and continue checking every third household on your left for women with infants. Complete 15.

Introduction: My name is (_____); I am conducting an evaluation of the project that has been working to improve healthcare for mothers and children in this district. We are interviewing mothers that bring their children to the local health post to find out if they have noticed improvements and get their views on what they need to take care of their children.

Have you visited the local health post in the last month? If yes, ask for consent and go on with interview. If not, thank and go on.

Confidentiality and consent: I am going to ask you questions some of which may be very personal. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You may need to know that this exercise is also taking place in other health facilities that are involved in the project in Nepal. I would greatly appreciate your help in responding to this survey.

I. Identification

Questionnaire number: _____ (Skip this question)

District: _____

VDC: _____

Ward: _____

Facility (CSCOM): _____

Location: Rural ----- 1, Urban-----2

Name of the interviewer: _____

II. Background Characteristics

1. Age: _____

2. Marital status: Single: -----1, Married: -----2, Separated: -----3, Divorced: ---4, widowed: -----5

3. Education: how many years of education have you completed? Illiterate-----1. Primary -----2, Secondary-----3, post-secondary-----4, Graduate-----5

4. Occupation: Schooling-----1, Unemployed----- 2, Housewife----- 3, Trading/Farming-----4, Professional-----5

III. Quality and Results

5. How do you know about the services provided in this CSCOM?

Radio-----1, Television-----2, Relatives-----3, Friends-----4, Community awareness activities-----5, FCHVs-----6, Others (Specify) _____7

6. How far do you walk to get to the health post from your house?

Less than 15minutes---1, 15 to 30 minutes---2, 30 min. to 1 hr.-----3, more than 1 hr.---4

7. What kind of services did you receive the last time you visited this CSCOM? (Circle as many as appropriate)

Maternal Health (ANC/PNC) -----1, FP-----2, IMCI (ARI/CDD)-----3,

Nutrition-----4, Immunization-----5, Others (Specify)_____6

8. Who attended to you on your services: (Circle as many as appropriate)

Nurse-----1, HA/Sr. AHW-----2, MCHW-----3, Others (Specify) _____4

9. How long did you have to wait for the given services?

Less than 15 Minutes-----1, 15 to 30 Minutes-----2, 30min to 1 hr.---3, More than 1 hr.-----4

IV. Client Satisfaction

10. Are you happy or unhappy with the services you received in the CSCOM?

Very satisfied----1, Satisfied-----2, Dissatisfied-----3, Very dissatisfied-----4

11. Would you please tell me what made you say that?

12. Did the service provider/s explain your problems properly?

Yes-----1, No-----2, Don't know-----3

13. Was the Service Provider easy to understand when s/he explained things?

Easy to understand-----1, Difficult to understand-----2, Don't know-----3

No answer-----4

14. How was the staff's attitude toward you?

Friendly-----1, partially friendly----3, Not friendly-----4, Don't know-----4, No information-----5

Please describe_____

15. Will you encourage your friends or relatives to visit this CSCOM for services?

Yes-----1, No-----2, Undecided-----3

16. Do you have any suggestions for the improvement of services offered in this facility?

Yes-----1, No-----2,

If yes, what are your suggestions?

17. Did you receive any referrals?

Yes-----1, No-----2,

On what? Please probe

V. Gender Concerns

18. Did you receive antenatal care in this health post?

Yes-----1, No-----2 why not?

19. Did you deliver your child in the health post birthing center?

Yes-----1, No-----2 if not, where? _____

20. Was there privacy for women for the examination?

Yes-----1, No-----2

21. Did you feel you were treated differently from other mothers? (some probable causes: because of sex, ethnicity and caste, language, culture, economic status, distance)

Yes-----1, Never-----2, I did not notice it -----3.

22. If yes, would you tell me what makes you say that?

23. Are you using the family planning services in the health post?

Yes-----1, No-----2,

If yes, what method? If not, why not? Please probe _____

24. In your experience, do men have a role in supporting their partners before, during, and/or after child birth?

Yes-----1, No-----2, don't know-----3

If no: why don't men have a role in supporting their partners before, during and/or after child birth?

Thank you for your time and attention!

**U.S. Agency for International Development
USAID/Mali
c/o American Embassy
Rue 243 Porte 297 ACI 2000
B.P. B.P. 34 Bamako, Mali**