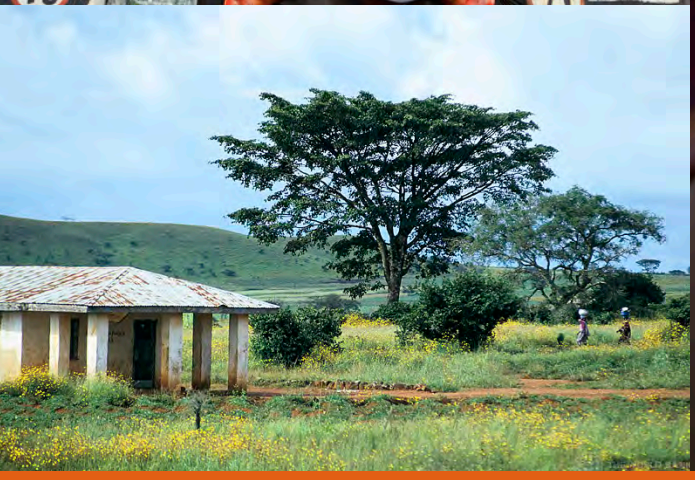
ADVANCING PARTNERS & COMMUNITIES

COMMUNITY HEALTH SYSTEMS CATALOG
COUNTRY PROFILE: MALI

SEPTEMBER 2016



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Recommended Citation
Kristen Devlin, Kimberly Farnham Egan, and Tanvi Pandit-Rajani. 2016. *Community Health Systems Catalog Country Profile: Mali.* Arlington, VA: Advancing Partners & Communities.

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JSI RESEARCH & TRAINING INSTITUTE, INC.
1616 Fort Myer Drive, 16th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Email: info@advancingpartners.org
Web: advancingpartners.org

ACRONYMS

APC	Advancing Partners & Communities
ASACO	association de santé communautaire (community health association)
ASC	agent de santé communautaire (community health agent)
CHS	community health system
CSCOM	centre de santé communautaire (community health center)
CSRef	centre de santé de référence (referral health center)
DHMT	district health management team
DNS	direction nationale de la santé (national health directorate)
DRS	direction régionale de la santé (regional health directorate
DTC	directeur technique du centre (health center technical director)
FELASCOM	Fédération local d'associations de santé communautaire (Local Federation of Community Health Associations)
FENASCOM	Fédération national d'associations de santé communautaire (National Federation of Community Health Associations)
FERASCOM	Fédération régional d'associations de santé communautaire (Regional Federation of Community Health Associations)
FP	family planning
GSAN	groupe de soutien des activités de la nutrition (nutrition support group)
IUD	intrauterine device
MPFEF	Ministère de la Promotion de la Femme de l'Enfant et de la Famille (Ministry of Women, Children, and Family)
MSAHRN	Ministère de la Solidarité, de l'Action Humanitaire et de la Reconstruction du Nord (Ministry of Solidarity, Humanitarian Action, and Reconstruction of the North)
MSHP	Ministère de la Santé et de l'Hygiène Publique (Ministry of Health and Public Hygiene)
NGO	nongovernmental organization
PDDSS	Plan Décennal de Développement Sanitaire et Social (Decennial Health and Social Development Plan)
PRODESS	Programme Décennal de Développement Sanitaire et Social (Decennial Health and Social Development Program)
SEC	soins essential dans la communauté (essential community health care)

TB	tuberculosis
USAID	Unites States Agency for International Development
WASH	water, sanitation, and hygiene

INTRODUCTION

This Community Health Systems (CHS) Catalog country profile is the 2016 update of a landscape assessment that was originally conducted by the Advancing Partners & Communities (APC) project in 2014. The CHS Catalog focuses on 25 countries deemed priority by the United States Agency for International Development's (USAID) Office of Population and Reproductive Health, and includes specific attention to family planning (FP), a core focus of the APC project.

The update comes as many countries are investing in efforts to support the Sustainable Development Goals and to achieve universal health coverage while modifying policies and strategies to better align and scale up their community health systems.

The purpose of the CHS Catalog is to provide the most up-to-date information available on community health systems based on existing policies and related documentation in the 25 countries. Hence, it does not necessarily capture the realities of policy implementation or service delivery on the ground. APC has made efforts to standardize the information across country profiles, however, content between countries may vary due to the availability and quality of the data obtained from policy documents.

Countries use a wide variety of terminology to describe health workers at the community level. The CHS Catalog uses the general term "community health provider" and refers to specific titles adopted by each respective country as deemed appropriate.

The CHS Catalog provides information on 136 interventions delivered at the community level for reproductive, maternal, newborn, and child health; nutrition; selected infectious diseases; and water, sanitation, and hygiene (WASH). This country profile presents a sample of priority interventions (see Table 6 in the Service Delivery section) delivered by community health providers and for which information is available.

APC regularly updates these profiles and welcomes input from colleagues. If you have comments or additional information, please send them to info@advancingpartners.org.

MALI COMMUNITY HEALTH OVERVIEW

Mali's community health system is guided by multiple complementary policy documents that contribute to a single community health strategy. Developed at the end of 2015, the *National Implementation Guide for Essential Community Health Care* (SEC) is the main community health document. The guide outlines the community-level service delivery package, roles and responsibilities of community health providers and other community actors, and the processes by which services are organized, managed, and delivered.

The SEC is just one component of the country's overarching national health and social development program, which is outlined in the *Decennial Health and Social Development Program 2014–2018 (PRODESS III)*. PRODESS III is a multi-sectoral effort to improve health and social development, led by the Ministries of Health and Public Hygiene (MSHP), Solidarity, Humanitarian Action, and Reconstruction of the North (MSAHRN), and Women, Children, and Family (MPFEF). The program builds on lessons from previous PRODESS iterations and emphasizes universal access to health care, better quality of services, and improved health indicators—including at the community level.

The *Decennial Health and Social Development Plan 2014–2023 (PDDSS)* provides an implementation framework for PRODESS III. It outlines 11 strategic objectives focused on health systems strengthening, including offering better quality health services, products, and commodities; strengthening human resources for health; improving health data collection, analysis, and use; and ensuring better health system financing and governance. The document also emphasizes community participation in health.

Table 1. Community Health Quick Stats

Main community health policies/strategies	*Decennial Health and Social Development Plan (Plan décennal de développement sanitaire et social (PDDSS) 2014–2023)*	*Decennial Health and Social Development Program (Programme du développement sanitaire et social (PRODESS III) 2014–2018)*	*Essential Community Health Care: ASC Handbook (Soins essentiels dans la communauté (SEC) : cahier/ directives de l'agent de santé communautaire (ASC))*	*SEC National Implementation Guide (SEC : Guide national pour la mise en œuvre)*
Last updated	No date[1]	No date[1]	2015	2015
Number of community health provider cadres	2 main cadres			
	Community health agents (ASC)		Relais communautaires (relais)	
Recommended number of community health providers	*Information not available in policy*		*Information not available in policy*	
Estimated number of community health providers	At least 2,317 ASC[2]		26,939 relais	
Recommended ratio of community health providers to beneficiaries	1ASC : 700 people (southern Mali) 1 ASC : 100–500 people (northern Mali)		1 relais : 50 households	
Community-level data collection	Yes			
Levels of management of community-level service delivery	National, regional, health district, health zone, community			
Key community health program(s)	Various national health programs in multiple health areas (e.g., FP, malaria, TB)			

[1] These documents do not include a publication date; however, they were likely developed in 2013 or 2014.
[2] Data from 2014 shows that 2,317 ASC were trained in community integrated management of childhood illness. Data on the total number of ASC is not available.

The MSHP has also issued a number of ministerial decrees to construct, organize, and improve community health, such as a decree from 2002 that formally defined and established a network of community health centers (CSCOM). Other strategies direct national health-specific programs that incorporate service delivery and management at the community level.

Table 2. Key Health Indicators, Mali

Total population[1]	17.3 m
Rural population[1]	60%
Total expenditure on health per capita (current US$)[2]	$48
Total fertility rate[3]	6.1
Unmet need for contraception[3]	26.0%
Contraceptive prevalence rate (modern methods for married women 15–49)[3]	9.9%
Maternal mortality ratio[4]	587
Neonatal, infant, and under 5 mortality rates[3]	34 / 56 / 95
Percentage of births delivered by a skilled provider[3]	40.1%
Percentage of children under 5 years moderately or severely stunted[3]	38.3%
HIV prevalence rate[5]	1.3%

[1]PRB 2016; [2]World Bank 2016; [3]Cellule de Planification et de Statistique (CPS/SSDSPF), Institut National de la Statistique (INSTAT/MPATP), INFO-STAT and ICF International 2014; [4]World Health Organization 2015; [5]UNAIDS 2015.

Together, these policies provide comprehensive guidance on community health across many health areas, such as FP and tuberculosis (TB). They also describe the roles of Mali's community health providers—*agents de santé communautaire* (ASC) and *relais communautaires* (relais)—and the processes and mechanisms, including supervision, reporting, incentives, selection, and training, that support them. Specifically, the ASC handbook for the SEC package provides detailed information about the services that ASC are expected to deliver. However, there is no specific guidebook for relais, and guidance for community health providers within each of the health area-specific strategies is not always explicit or consistent with the SEC package.

Community health policies in Mali address gender issues; for example, the *PDDSS* calls for female representation in community health management bodies. Policies also provide information about the role of community groups in the community health system. Nutrition support groups (GSAN), for instance, comprise 10–12 community members who may include traditional midwives, presidents of women's associations, pregnant women, nursing women, grandmothers, caretakers of children, young girls, fathers, and traditional healers. GSAN support ASC and relais in conducting health and nutrition promotion and activities. Other community groups, such as cooperatives, youth sports organizations, and women's organizations, may conduct FP awareness-raising activities.

ASC and relais are Mali's two main cadres of community health providers. ASC are salaried, have had previous training as nurses aides or auxiliary midwives, and deliver basic reproductive, maternal, newborn, and child health, nutrition, and WASH interventions within their coverage areas, known as ASC sites. Relais are volunteers who assist the ASC in health promotion, community mobilization, and service delivery. Both cadres collaborate with GSAN.

Mali has a comprehensive strategy that guides community health and includes detailed information on the roles and relationships between community actors.

Numerous national programs related to health areas like FP, malaria, HIV, and TB operate at the community level and are guided by the country's overarching community health strategy—the SEC. Services are delivered through the CSCOM, which is created, managed, and supported by a civil society group called the community health association (ASACO). The national health area programs are updated approximately every five years and operate in urban, peri-urban, and rural areas. They are funded by both the public and private sectors through collaborations between the government of Mali, the MSHP, donors, and nongovernmental organization (NGO) partners. Donors and partners often focus efforts in the northern regions of Mali in particular, an area of conflict where community health structures and service delivery systems are weak or nonexistent.

LEADERSHIP AND GOVERNANCE

Community-level service delivery in Mali is managed and coordinated across the national, regional, health district, health zone, and community levels. Each level has a distinct role in supporting policy and program efforts.

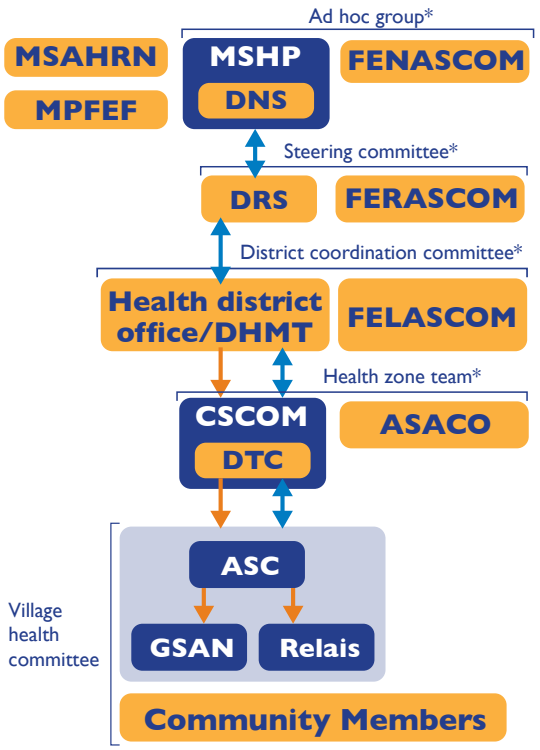
- At the **national level**, the MSHP collaborates with the MSAHRN and the MPFEF to develop policies, strategies, and implementation guides, mobilize resources, establish and maintain a system to collect and analyze community data, and ensure overall health system functioning related to the SEC. The National Federation of Community Health Associations (FENASCOM)[1] liaises between the MSHP, community actors, and civil society and advises on community health matters. An ad-hoc group within the MSHP develops and updates policies, guides, and tools; allocates resources; and monitors implementation for the SEC. This group includes representatives from the National Health Directorate (DNS) within the MSHP, the FENASCOM, and technical and financial partners.
- The **regional** health directorate (DRS) implements the SEC with assistance from other regional actors. The DRS ensures availability of commodities; supports community health provider training, monitoring, and supervision; and documents and evaluates SEC activities. A regional steering committee—with representation from the DRS, civil society, regional councils, and NGOs and associations—provides technical and financial support to the DRS and the health districts related to SEC guidance, training, monitoring, and supervision.
- The **district** health management team (DHMT) implements the SEC and establishes and oversees health zone teams. A district coordination committee—comprising representatives from the DHMT, the social and economic development sectors, NGOs, health cooperatives, and others—lends technical and financial support to the health zones, giving guidance on training, monitoring, and periodic evaluation.
- ASACO create and manage CSCOM at the **health zone level**. A health zone team—with representation from the ASACO, the CSCOM, the mayor, the social and economic development sectors, NGOs, and health cooperatives—plans and implements SEC activities, including identifying service delivery points, selecting and monitoring ASC, and interacting with the community.[2] The ASACO and CSCOM technical staff supervise ASC, relais, GSAN, and organizations that implement SEC activities. CSCOM staff also provide advice and continued training for ASC under the supervision of the DHMT.
- The village health committee supports **community** mobilization and manages SEC activities at the ASC sites, or the areas where ASC work. The committee comprises village leaders, religious leaders, traditional healers, women and youth organizations, ASC, relais, education management committees, and local partners. The ASC provide services and oversee community activities, including supervising relais and GSAN.

Figure 1 portrays Mali's health structure, including management bodies, service delivery points, and key actors and their relationships at each level.

1 The FENASCOM's counterparts at the regional and district levels are the Regional Association of Community Health Associations (FERASCOM) and the Local Federation of Community Health Associations (FELASCOM). They play similar roles as the FENASCOM at their respective levels. The FELASCOM also supports ASACO.
2 In northern areas where health zones don't exist, the DHMT fills this role.

Figure 1. Health System Structure

Level	Managing Administrative Body	Service Delivery Point	Key Actors and Their Relationships
National	MSHP (DNS), MSAHRN, MPFEF, FENASCOM, Ad hoc group	National Hospital	
Regional	DRS, FERASCOM, Steering committee	Regional Hospital	
Health District	DHMT, FELASCOM, District coordination committee	CSRef	
Health Zone	ASACO, CSCOM staff, Health zone team	CSCOM	
Community	Village health committee, ASC	ASC RC	



* Also includes representatives from NGOs, local government actors, local divisions of the MSAHRN and the MPFEF, civil society, and other financial and technical partners.

Supervision
Flow of community-level data

HUMAN RESOURCES FOR HEALTH

In Mali, ASC and relais are the main providers of community health interventions. ASC distribute selected FP methods; offer basic newborn care services; conduct community integrated management of childhood illness for malaria, acute respiratory infections, and diarrhea; manage moderate malnutrition and uncomplicated severe acute malnutrition; participate in immunization campaigns; deliver health information, education, and communication; and mobilize communities.

Relais assist ASC in health education and promotion, provide FP methods, refer clients to the ASC or the CSCOM for services they do not offer, and conduct follow-up as needed. GSAN also support ASC, promoting nutrition among women, infants, and young children. About half of the 12 GSAN members receive a brief training from CSCOM staff, however, the GSAN is considered a community group, not a community health provider cadre. ASC supervise relais and GSAN.

The *SEC National Implementation Guide* briefly refers to a third, informal community health provider cadre; retrained traditional midwives, but does not provide much information on their role beyond helping ASC provide basic health education.

Together, these community health providers implement the SEC in communities. The health zone team orients other key actors—including CSCOM staff, ASACO members, and elected community officials—to their roles in implementing the SEC, including how they are expected to support ASC and relais. The team also organizes meetings to introduce communities to the ASC.

Table 3 presents an overview of ASC and relais in Mali.

Table 3. Community Health Provider Overview

	ASC	Relais
Number in country	At least 2,317 ASC[1]	26,939 relais
Target number	*Information not available in policy*	*Information not available in policy*
Coverage ratios and areas	1ASC: 700 people (southern Mali) 1 ASC: 100–500 people (northern Mali) Each ASC is responsible for between 1 and 3 villages, which constitute an ASC site. The ASC site's geographical boundaries are determined by village authorities and preset guidelines. In southern areas, the site should span a geographical area of 3 kilometers and should be more than 5 kilometers from a CSCOM or in a hard-to-access area. In northern areas, the site should span a geographical area of about 25 kilometers in areas that have a fixed functional health facility, and about 60 kilometers in areas that are serviced by mobile medical units.[2] Operate in urban, rural, and peri-urban areas.	1 relais: 50 households at the village level. Operate in urban, rural, and peri-urban areas.
Health system linkage	ASC are part of the public health system under the MSHP. They are linked with the CSCOM and receive salaries.	Relais are part of the public health system under the MSHP. They are volunteers and are linked with the CSCOM.
Supervision	ASC are under the supervision of the DTC at the CSCOM, generally a doctor or a nurse, and the health district's head doctor. ASACO members conduct administrative supervision of ASC on a monthly basis, sometimes in collaboration with representatives from the social development sector. Representatives from the district, regional, and national levels of the health system provide technical support to strengthen supervision at the CSCOM. ASC supervise relais and GSAN.	ASC supervise relais on a day-to-day basis, and the DTC also conducts periodic technical supervision. Representatives from the district, regional, and national levels of the health system provide technical support to strengthen supervision at the CSCOM. ASACO members conduct administrative supervision of relais on a monthly basis.
Accessing clients	On foot Bicycle	On foot Bicycle

Table 3. Community Health Provider Overview

	ASC	Relais
Selection criteria	Must have at least a 9th grade education and a minimum of a certificate as a nurse's aide or auxiliary midwife. In northern areas, the ASC must have passed exams for entry into secondary school, have a minimum of a certificate as a nurse's aide certificate, an auxiliary midwife, or a health technician. ASC must also: Have status as a Malian national Be at least 18 years old Be fluent in the local language Be available and active Accept working and living in the community Have community mobilization experience (preferred) Be able to drive or be driven (preferred)	Know how to speak, read, and write the local language and any other language necessary to do the job From the local area Selected by the local community Available and engaged Accepted the volunteer position Have a source of income Experienced (e.g., as an organizer or leader) Credible, honest, respectful, social, and tolerant
Selection process	Recruitment is organized by a CSCOM committee, which includes the ASACO and the CSCOM technical team, in collaboration with the DHMT. First, the ASC site is determined through a mapping exercise of the village or hamlet, followed by community consensus and in accordance with the preset selection criteria. Adherence to these criteria is documented on a site selection form. ASC must submit an application to the health district's head doctor containing a handwritten and stamped request; a copy of their birth certificate; a certificate attesting they have met the necessary professional credentials; medical documents; acurriculum vitae; and a nationality certificate. ASC then must pass a written test on the SEC package and undergo an interview to assess their communications skills. Candidates must score at least 10 of 20 total points. ASC are confirmed in their new role after a waiting period of 3 months. The health zone team orients and introduces them first to the CSCOM staff, ASACO members, and community leaders and members.	Relais are selected through a participatory and consensual process by the population in the village in which they live. More specific guidance is not provided in policy.

Table 3. Community Health Provider Overview

	ASC	Relais
Training	ASC are trained in groups of 25 for 21 days. The health district decides further trainings are needed. ASC may participate in donor-supported training for specific health areas, such as malaria.	Relais are trained in groups of 25 for 8 days by the CSCOM team. Policy does not specify whether training happens at once or over time. Relais may undergo additional training for disease-specific programs. For instance, the *National TB program (2013–2017)* indicates plans to train 2,000 relais per year on TB screening, follow-up, and awareness-raising.
Curriculum	*Essential Community Health Care (SEC) : ASC Handbook* (2015). Includes sections on FP; communication; WASH; community integrated management of childhood illness; basic newborn care; and infant and young child feeding.	The relais curriculum is not available, but the SEC provides general information about the topics on which they are trained.
Incentives and remuneration	Financial incentives include per diems; cash payments; rebates or kickbacks from sale of certain health products; performance-based bonuses; and a monthly indemnity equal to or more than the Interprofessional Guaranteed Minimum Wage, which as of January 2016 is 40,000 West African CFA francs or about $69 US. Nonfinancial incentives include free or discounted health care; bicycles; opportunities for career advancement; attendance at an annual forum on community health at the district level; and in-kind goods, like crops. Incentives are covered by a combination of funds from the MSHP, NGOs, the health district, and the community.	Financial incentives include per diems; cash payments; and rebates or kickbacks from sale of certain health products. Nonfinancial incentives include free or discounted health care; bicycles; t-shirts; formal recognition of service like annual days to celebrate relais; and in-kind goods, like crops. Incentives are covered by a combination of the MSHP, NGOs, the health district, and the community.

[1] Data from 2014 shows that 2,317 ASC were trained in community integrated management of childhood illness. Data on the total number of ASC is not available.
[2] Policy does not explicitly indicate how ASC working in northern areas would reach communities spanning 25 to 60 kilometers; however, a preferred selection criterion for ASC in northern areas is that they are able to drive or be driven.

HEALTH INFORMATION SYSTEMS

Mali has a health information system that brings local data from communities and community-level health facilities to the national level. The local data is also shared with communities and used for decision-making.

ASC and relais collect data using a variety of tools, such as consultation registers, stock management registers, growth records, FP eligibility forms, FP follow-up forms, notebooks for recording health-related activities, and monthly report templates. They aggregate the data into monthly reports and submit them to the DTCs, who are their supervisors at the CSCOM. The DTC and other CSCOM staff review and verify the data and send it electronically, along with other data collected at the CSCOM, to the health district office. Data is also used by the CSCOM and community to improve the quality of interventions. Every trimester, the DTC is expected to share data with local health structures, the mayor, the ASC, and the ASACO.

The health district data manager collects and verifies data from CSCOM, reference health centers (CSRef), and other health private-public and faith-based facilities, compiles it, and sends it to the regional level every trimester. The DRS in turn assembles data from the health districts and sends it to the DNS within the MSHP for compilation and review. The DNS also publishes annual reports with the aggregated data. Data then flows back down the health system in the form of reports from the national level to the CSCOM.

This system, known as the local health information system, is a subsystem of the national health information system (SNIS). It focuses on data from CSCOM, CSRef, and communities and aims to strengthen interventions and health facility management. Other health information, such as hospital data and disease surveillance data, are collected through respective information subsystems of the SNIS. Figure 1 depicts the flow of community-level data.

HEALTH SUPPLY MANAGEMENT

After they receive training, community health providers receive a start-up package of commodities and supplies from the ASACO. Thereafter, they may complete and submit a stock form to replenish their supplies at the CSCOM, which is managed by the ASACO. Community health providers distribute many products—such as artemisinin combination therapy to treat malaria—to clients for free; others they may sell according to set regulations: e.g., they may not charge more than the CSCOM does for the same products, and they give a percentage of the sales to the ASACO, which uses the funds to restock supply. ASC are expected to maintain a monthly inventory of supplies and discard products that have expired.

Policies do not stipulate neither the process by which community health providers might obtain back-up emergency supplies nor how they should dispose of medical waste.

Table 4 shows selected medicines and products included in Mali's *National List of Essential Medicines* (2012).

Table 4. Selected Medicines and Products Included in Mali's *National List of Essential Medicines* (2012)

Category		Medicine / Product
FP	☑	CycleBeads®
	☑	Condoms
	☑	Emergency contraceptive pills
	☑	Implants
	☑	Injectable contraceptives
	☑	IUDs
	☑	Oral contraceptive pills
Maternal health	☐	Calcium supplements
	☑	Iron/folate
	☑	Misoprostol
	☑	Oxytocin
	☑	Tetanus toxoid
Newborn and child health	☑	Chlorhexidine
	☑	Cotrimoxazole
	☑	Injectable gentamicin
	☑	Injectable penicillin
	☑	Oral amoxicillin
	☑	Tetanus immunoglobulin
	☑	Vitamin K
HIV and TB	☑	Antiretrovirals
	☑	Isoniazid (for preventive therapy)
Diarrhea	☑	Oral rehydration salts
	☑	Zinc
Malaria	☑	Artemisinin combination therapy
	☐	Insecticide-treated nets
	☑	Paracetamol
	☐	Rapid diagnostic tests
Nutrition	☑	Albendazole
	☑	Mebendazole
	☐	Ready-to-use supplementary food
	☐	Ready-to-use therapeutic food
	☑	Vitamin A

SERVICE DELIVERY

Mali's main community health service delivery package is outlined in the SEC, which was last updated in December 2015. The ASC and relais packages are subsets of the SEC package, which include the FP, maternal health, newborn care, child health and nutrition, TB, HIV, malaria, and WASH services described in the Human Resources for Health section and in Table 6.

Community health providers administer clinical services, disseminate health education, and mobilize communities. Table 5 provides information about the channels through which they conduct these activities.

ASC and relais refer clients to the CSCOM for services they are not trained to provide. Relais may also make referrals to ASC. Facilities counter refer to ASC and relais for follow-up if needed.

Table 5. Modes of Service Delivery

Service	Mode
Clinical services	Door-to-door
	Periodic outreach at fixed points
	Health posts or other facilities
	Special campaigns
Health education	Door-to-door
	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups
Community mobilization	Health posts or other facilities
	Community meetings
	Mothers' or other ongoing groups

Using FP as an example, relais may provide condoms, oral contraceptive pills, and CycleBeads® to clients. They may also refer clients to:

- ASC for the same methods relais may administer and injectable contraceptives. In the northern regions, ASC may also be trained to provide implants.
- CSCOM for the same methods ASC may provide, implants, intrauterine devices (IUDs), and postpartum FP services.
- CSRef and hospitals for the same methods available at the CSCOM and permanent methods.

Policy does not indicate where community health providers should refer clients for information about natural FP methods like the Standard Days Method or emergency contraceptive pills.

Table 6 details selected interventions delivered according to policy by ASC and relais in the following health areas: FP, maternal health, newborn care, child health and nutrition, TB, HIV, malaria, and WASH.

Table 6. Selected Interventions, Products, and Services

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
FP[1]	Condoms	ASC, relais	ASC, relais	ASC, relais	ASC, relais
	CycleBeads®	ASC, relais	ASC, relais	ASC, relais	ASC, relais
	Emergency contraceptive pills	Unspecified	Unspecified	Unspecified	Unspecified
	Implants	ASC, relais	ASC[2]	ASC, relais	ASC, relais
	Injectable contraceptives	ASC, relais	ASC	ASC, relais	ASC, relais
	IUDs	ASC, relais	No	ASC, relais	ASC, relais
	Lactational amenorrhea method	ASC		ASC, relais	ASC
	Oral contraceptive pills	ASC, relais	ASC, relais	ASC, relais	ASC, relais
	Other fertility awareness methods	Unspecified		Unspecified	Unspecified
	Permanent methods	ASC, relais	No	ASC, relais	ASC, relais
	Standard Days Method	Unspecified		Unspecified	Unspecified
Maternal health	Birth preparedness plan	ASC, relais	ASC	ASC, relais	ASC, relais
	Iron/folate for pregnant women	ASC, relais	ASC[3]	ASC, relais	ASC, relais
	Nutrition/dietary practices during pregnancy	ASC, relais		ASC, relais	ASC, relais
	Oxytocin or misoprostol for post-partum hemorrhage	No	No	No	No
	Recognition of danger signs during pregnancy	ASC, relais	ASC, relais	ASC, relais	ASC, relais
	Recognition of danger signs in mothers during postnatal period	ASC, relais	ASC, relais	ASC, relais	ASC, relais
Newborn care	Care seeking based on signs of illness	ASC, relais			ASC, relais
	Chlorhexidine use	ASC, relais	ASC	ASC, relais	ASC, relais
	Managing breastfeeding problems (breast health, perceptions of insufficient breast milk, etc.)	ASC		ASC	ASC
	Nutrition/dietary practices during lactation	ASC, relais		ASC, relais	ASC, relais
	Postnatal care	ASC, relais	ASC	ASC, relais	ASC, relais
	Recognition of danger signs in newborns	ASC, relais	ASC, relais	ASC, relais	ASC, relais

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
Child health and nutrition	Community integrated management of childhood illness	ASC	ASC	ASC	ASC
	De-worming medication (albendazole, mebendazole, etc.) for children 1–5 years	ASC, relais	ASC, relais[4]	ASC, relais	ASC, relais
	Exclusive breastfeeding for the first 6 months	ASC, relais		ASC, relais	ASC, relais
	Immunization of children	ASC, relais	ASC[5], relais[5]	ASC, relais	ASC, relais
	Vitamin A supplementation for children 6–59 months	ASC, relais	ASC, relais[4]	ASC, relais	ASC, relais
HIV and TB	Community treatment adherence support, including directly observed therapy	Unspecified	Unspecified	Unspecified	Unspecified
	Contact tracing of people suspected of being exposed to TB	Relais	Relais	Relais	Relais
	HIV testing	Unspecified	Unspecified	ASC	Unspecified
	HIV treatment support	Unspecified	Unspecified	Unspecified	Unspecified
Malaria	Artemisinin combination therapy	ASC	ASC	ASC, relais[6]	ASC, relais[6]
	Long-lasting insecticide-treated nets	ASC, relais	ASC, relais	ASC, relais	ASC, relais
	Rapid diagnostic testing for malaria	ASC	ASC	ASC, relais	ASC, relais
WASH	Community-led total sanitation	ASC, relais	ASC		
	Hand washing with soap	ASC, relais			
	Household point of use water treatment	ASC, relais			
	Oral rehydration salts	ASC, relais[6]	ASC, relais	ASC, relais[6]	ASC, relais[6]

[1] Relais may provide information, education, and counseling on all methods that a 'modern couple' might use, refer for methods they cannot provide, and follow up with FP users. Policy does not specify these methods by name. GSAN may also communicate about FP very generally.
[2] ASC may be trained to administer implants in the northern regions by NGOs.
[3] ASC may also give iron/folate to children to treat them for malnutrition.
[4] Relais may administer this intervention during mass campaigns.
[5] ASC and relais may administer vaccinations for measles, polio, and other, unspecified diseases during mass campaigns.
[6] Only specified for children under five years.

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ADVANCING PARTNERS & COMMUNITIES
JSI RESEARCH & TRAINING INSTITUTE, INC.

1616 Fort Myer Drive, 16th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Web: advancingpartners.org