Assessment of 2017 National Campaign **for the Promotion of Family Planning** in Mali

June 2018

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MEASURE Evaluation

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TABLES

ABBREVIATIONS

AMPPF	Association Malienne pour la Protection et la Promotion de la Famille/Malian Association for the Protection and Promotion of the Family
BKN	Banguè kolossi nyeta (BKN)
CFA	West African franc
DNS	Direction Nationale de la Santé/National Health Directorate
DRS	Direction Régionale de la Santé/Regional Health Directorate
DSR	Division de la Santé de la Reproduction/Reproductive Health Division
FGD	focus group discussion
FP	family planning
INSRP	Institut National de Recherche en Santé Publique
IUD	intrauterine device
KII	key informant interview
KJK	Keneya Jemu Kan
MSI	Marie Stopes International
NGO	nongovernmental organization
OSPSANTE	health commodity dashboard
PSI	Population Services International
RH	reproductive health
SSGI	Service de Santé à Grand Impact/High-Impact Health Services
UNC IRB	University of North Carolina Institutional Review Board
USAID	U.S. Agency for International Development

BACKGROUND

The Republic of Mali has one of the world's lowest modern contraceptive prevalence rates (9.9%) [1] This low rate contributes not only to high fertility and rapid population growth, but also to high rates of infant and maternal mortality. The government of Mali has made strides to improve these conditions by repositioning family planning (FP) as an essential public health and development intervention. Mali is also actively participating in global FP initiatives, such as the Ouagadougou Partnership and FP2020. Mali's National Strategic Plan for 2014–2018 identifies four priority areas—demand, supply, enabling environment, and the reliability of the monitoring and coordination system—to reach the goal of increasing the contraceptive prevalence rate to 15 percent by 2018 (Ministère de la Santé et de l'Hygiène Publique, 2014).

As part of the National Strategic Plan, the Malian government organizes an annual FP campaign. In 2017, MEASURE Evaluation was hired by USAID/Mali to conduct an evaluation of the 2016 national campaign. The objective of the evaluation was to assess how well the campaign's activities were implemented and to highlight required adjustments that should be made to improve future FP campaigns and interventions. The assessment focused on the five target intervention districts of Diéma, Bougouni, San, Koro, and Nara. The findings were presented to local stakeholders in a written report[2] and at a dissemination workshop. The final version of the evaluation report on the 2016 national campaign to promote FP identified many strengths and weaknesses in the campaign. Based upon these observations, the following recommendations were made:

- Closely reexamine the objectives, expected results, and planned activities of the campaign to ensure that implemented activities help reach the goal of increasing FP use in Mali.
- Document the campaign activities and consider the use of standard forms.
- Identify staff to monitor and evaluate campaign activities and the availability of FP supplies and methods throughout the campaign.
- Improve logistics management to ensure the availability of supplies.
- Strengthen the information system so that validated data on FP service delivery is available.
- Continue to explore the use of social media to meet target audiences with FP messages.
- Integrate subnational FP stakeholders into the planning and organizational process of the campaign.
- Consider the best use of resources for increasing FP use in Mali.

In 2017, Mali launched its thirteenth national FP campaign on August 24, 2017, with a theme of "A responsible and engaged youth committed to FP in Mali, a way to reach the demographic dividend." Due to a variety of factors, the campaign was postponed from its typical April launch to an August launch and was implemented over a period of approximately nine weeks, ending on October 22, 2017 (extended from the initial end date of September 23). Importantly, one reason for the delay was to consider some of the findings from the 2016 evaluation; namely, to strengthen contraceptive supply and logistics management in order to avoid stockouts and to add indicators to the health information system in order to monitor the campaign activities. This assessment of the 2017 campaign activities and outcomes aims to provide the opportunity to determine whether improvements were made, to assess whether the campaign achieved its intended outcomes, and to formulate other recommendations.

[1] Cellule de Planification et de Statistique, Institut National de la Statistique, & ICF International, 2014; STATCompiler, 2016.

[2] The report can be found at: https://www.measureevaluation.org/resources/publications/tr-17-162-fr/

PURPOSE AND OBJECTIVES

General objective

Assess the implementation and the results of the 2017 national campaign for the promotion of FP.

Specific objectives

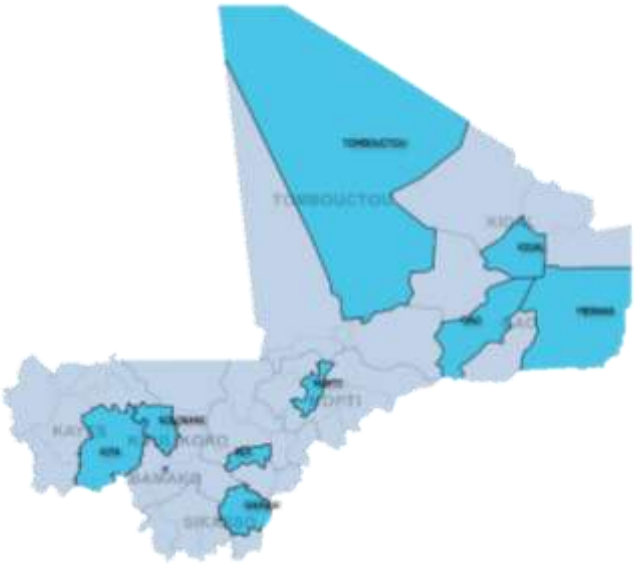
- Provide information to determine which activities were implemented
- Provide information to determine how the activities were implemented
- Determine if some improvements and adjustments were made based on the results and recommendations of the 2016 evaluation

METHODOLOGY

Region

The assessment focused on the national level and 10 health districts targeted by intensive intervention: Kita (Kayes), Kolokani (Koulikoro), Bla (Ségou), Sikasso (Sikasso), Tombouctou (Tombouctou), Mopti (Mopti), Gao (Gao), Menaka (Menaka), Taoudénit (Taoudénit), and Commune 1 (Bamako). These target districts were selected based on criteria established by the campaign's Technical Committee and had low contraceptive prevalence rates.

Figure 1. Ten intensive intervention districts



Design

The assessment used quantitative and qualitative data drawn from processes and results. This design helped answer questions such as:

- Which activities took place during the campaign in the intensive intervention districts?
- To what extent were planned activities implemented?
- To what extent are results and recommendations from the 2016 evaluation reflected in the planning and implementation of the 2017 campaign? To what extent did results and recommendations from the 2016 evaluation improve the implementation of the 2017 campaign?
- What were the outcomes of the activities of the 2017 campaign (assessed to the extent possible)?
- How well did the campaign address the target audience of youth?
- What were the barriers to campaign delivery?
- What were the strengths and weaknesses of the campaign?

The evaluation process after the intervention focused on result indicators and relied both on quantitative and qualitative data. The following data-collection methods were used:

- Document Review

This method allowed for the review of documents related to campaign planning, implementation, and results. The review of documents was predicated upon information being available, meaning that it was both documented through paper or electronic copies and shared with the assessment team.

- Routine health information system review

For the 2017 campaign, collection tools were developed by the technical committee in charge of the organization of FP with technical support from MEASURE Evaluation to track campaign indicators. These data collection tools were filled out by health facilities and submitted to the district health data manager. In most cases, data was then entered into DHIS 2 (the country's routine health information system), in health centers while in some cases the data was sent to the district for entry. A review of the information collected through DHIS 2 provided information on the provision and availability of methods during the campaign, and other indicators useful to monitor the campaign.

- Key informant interviews (KIIs)

Interviews with individuals involved with the campaign helped collect information on perceptions of the effectiveness of campaign activities and to identify barriers to its implementation.

- Focus group discussions (FGDs)

FGDs were used to gauge exposure to the campaign, attitudes about the annual campaign and broadcasted campaign messages, as well as common barriers to the use of FP among young women and men living in the districts where the intensive intervention was implemented.

Period of Study

The evaluation was conducted from November 2017 through April 2018, and comprised data collection, analysis, and preparation of the report.

Population Targeted by the Study

Criteria for inclusion

KIIs: USAID/Mali and the members of the organizational committee of the national campaign were asked to identify the persons who should participate in the KIIs. The potential participants included members of the organizational committee, regional officers, community leaders, health directors in the intensive intervention districts, and representatives from structures intervening in FP such as Marie Stopes International (MSI), Population Services International, the Association Malienne pour la Protection et la Promotion de la Famille (AMPPF), or the Réseau Islam Population et Développement. Additional interviews were conducted using a "snowball" approach after meetings with key informants.

FGD: The criteria for inclusion targeted women and men age 18–24 living in the intensive intervention districts selected for the FGD: Kita, Kolokani, Bla, Sikasso, Tombouctou, Mopti, Gao, Ménaka, Taoudéni, and Commune 1 (Bamako). Participants were also required to speak the language used in the discussion group, either French or Bambara.

Exclusion criteria

KIIs: The persons who were not included in the KIIs were those who were not involved in the campaign as planners, implementers, donors, media professionals, or targeted individuals such as community leaders.

FGDs: The persons who were excluded from the FGDs were women and men under 18 years or older than 24 years of age and any person who lived outside the intensive intervention districts. Individuals could be excluded if they lived in an intensive intervention zone that was identified as too dangerous for data collectors. The inability to provide consent was also a basis for exclusion.

Sample size

A total of 17 KIIs were conducted. A total of 95 young women and men participated in the 10 FDGs.

Indicators

The process and outcome indicators selected for the assessment were based on the 2016 evaluation and were updated as needed, based on preliminary drafts of the campaign's strategy documents. These indicators are listed in Table 1. In addition to these indicators, qualitative information on the effectiveness of campaign messages— whether recommendations from the previous evaluation were followed, the targeting of youth living in priority areas, barriers to the implementation of planned activities, barriers to the use of FP for young women and men, and needed actions for improvement of campaign implementation—were assessed.

Table 1. List of process and outcome indicators used for assessment

Indicators
Process: National Level
1. Number of weekly coordination meetings held
2. Number of supervisory visits completed during the campaign (by region or district)
3. Standard data collection forms for campaign activities developed (Y/N)
4. Family planning indicators added to the DHIS 2 (Y/N)
5. Percent of regions (or partners) submitting standard data collection forms, if possible
6. Family planning information from DHIS 2 checked for accuracy, if applicable
7. Documented effort to improve logistics management
8. Number of campaign messages developed
9. Launch of campaign by First Lady or Minister of Health (Y/N)
10. Number of press briefings held
11. Number of journalists attending press briefings (total)
12. Number of radio spots aired
13. Number of TV spots aired
14. Total amount of funds spent on the campaign
15. Average number of days of stockouts of contraceptive methods during the campaign at facilities in intensive intervention districts (by pill, injectable, condom (male and female), implant (Jadelle and Implanon), cycle beads, and IUD)
Process: Intensive Intervention Level
16. Number of campaign meetings held
17. Number of speeches delivered

18. Number of communication materials distributed (by type of material: t-shirt, caps, banner, pagne cloth)
19. Synchronous launch by governor or community leader (Y/N)
20. Number of special events completed (by type of event: talks at health centers; talks in the community; advocacy sessions with religious leaders or others; movie projections; conferences or other)
21. Number of religious leaders who have received at least one campaign message
22. Number of non-religious opinion leaders who have received at least one campaign message
23. Number/% of (public and private) facilities participating in "Open Days"
24. Number of "Open Days" held
Outcomes: National Level and Intensive Intervention District Level
25. Number of articles mentioning the national campaign in the media (by type of media: newspapers, online blogs, and social media)
26. Number of people reached by media coverage (estimated coverage) (by type of media: radio, television, newspaper, social media, and other)
27. Number of first-time users ("new acceptors") during the campaign at facilities in intensive intervention districts (By youth ≤19 and 20–24 years; by method (pill, injectable, condom, implant, and IUD)
28. Number of beneficiaries of FP counseling in intensive intervention districts (by sex; by age)
29. Number of first time users ("new acceptors") during campaign at facilities in intensive intervention districts (Total and/or by youth ≤24 years; by method (pill, injectable, implant, condom, and IUD))
30. Number of methods distributed during the campaign in intensive intervention districts as compared to the same time period in 2016 (by method: pill, injectable implant, condom and IUD)
31. Number of first time users ("new acceptors") during the campaign in intensive intervention districts as compared to the same time period in 2016 (by district; by method: pill, injectable implant, condom and IUD)

Data Collection

Documentation

Materials used to plan and implement the campaign were collected and reviewed. These included the national campaign action plan, the 2016 campaign final report, reports of campaign activities and events occurring in the intensive intervention districts, service statistics from the national health information system, information collected during the campaign, and materials produced and distributed by the campaign. Instances where documentation was not available are noted in the report. A list of documents reviewed for the assessment is included in Appendix 1.

KIIs

A consultation meeting with members of the organizational committee for the national campaign helped identify individuals for the initial KIIs. Additional interviewees were identified through use of the "snowball" technique. In addition to National Campaign Committee members, interviewees included regional and district community leaders, religious leaders, FP specialists, health directors in the intensive intervention districts, FP stakeholders—such as MSI and AMPPF—and other opinion leaders and organizations involved in the campaign. A total of 17 KIIs were conducted and analyzed for the report (KII affiliations are listed in Appendix 2). Interviews lasted approximately 30 to 45 minutes and elicited feedback on the perceived strengths of the campaign, the resources provided, the effectiveness and quality of campaign messages, the targeting of youth

and women and men living in priority areas, the barriers to the implementation of planned activities, and the actions that needed to be implemented to improve campaign implementation.

FGDs

A total of 95 women and men ages 18–24 participated in FGDs in the intensive intervention districts of Kita, Kolokani, Mopti, Sikasso, and Tombouctou (ten focus groups in total; two in each of these districts). The participants reflected the target audience of the FP campaign (by age and area of residence). They were recruited at the community level in each of the five districts. Staff of the health districts helped to coordinate recruitment and identify meeting space for the discussion groups.

Discussions took place in a nongovernmental organization (NGO) office, a government-sponsored health facility or an outdoor program space in the selected community. Each FGD lasted about 45 minutes to one hour. Participants were asked about their exposure to the campaign, attitudes about the annual campaign and the campaign messages, and common barriers to the use of FP for young women and men in their community.

Tools for the document review, KIIs, and FGDs are included in Appendix 3.

All activities were directly implemented by MEASURE Evaluation (technical manager of the study) and its consultants (CECO FORME) in collaboration with health district agents, regional directorates, the team of the reproductive health division of the National Health Directorate (Direction Nationale de la Santé, or DNS), and USAID/Mali.

Ethical Considerations

The protocol and draft data-collection tools were submitted to the University of North Carolina Institutional Review Board (UNC IRB) and the Institut National de Recherche en Santé Publique (INSRP) for ethical review. An ethics exemption was received from the UNC IRB on October 24, 2017. Ethics approval from the INSRP was received on November 22, 2017.

Written informed consent was administered to all participants. To maintain the confidentiality of key informants, names and titles do not appear in the report. Furthermore, results from the interviews are presented with the intent to learn from current practices to strengthen the FP campaign, and not to negatively affect the reputation of individuals or agencies involved with the campaign or the assessment.

The FGD consent form is attached in Appendix 4. Certain discussion topics may have been sensitive and could have embarrassed FGD participants. To reduce this risk, it was made clear that participation was entirely voluntary and that participants could choose not to participate at any time.

Fieldwork

A scoping meeting with members of the FP campaign's multisector committee was organized.

The meeting's objectives were to introduce the consultants to the committee and share with committee members the assessment protocol, the data-collection tools, and the assessment timeline. Appointments were then made for first interviews with key informants. A timeline was sent to the DNS so that appointments could be made at the regional level to prepare and facilitate data collection.

Messages were mailed to the regions so they could inform the districts of the mission's arrival. The DNS took steps to inform all national and regional actors (the Ministry of Health, political and administrative authorities, partners, etc.) that the campaign assessment team would be coming through their area.

The data collection was conducted between January 22 and February 15, 2018 and included all 10 intensive interventions districts. The KIIs and FGDs were conducted in Bamako and five districts: Tombouctou, Mopti, Sikasso, Kolokani and Kita; however, other intensive intervention districts and some national entities were

asked to transmit paper or electronic documentation and information to the consultants. The first step for the data-collection team in each region was the office of the Regional Health Directorate (Direction Régionale de la Santé, or DRS), which assisted with coordination, gathering of documentation, and identification of key informants. The data collectors met with many resource people in the regions, intervention districts, and Bamako to collect information on the campaign. DHIS 2 data on FP indicators for August, September and October were accessed for 2016 and 2017, using the 2016 data as a baseline for comparison.

District health staff and their partners assisted with recruiting women and men for the focus groups. The FGDs were conducted in Bambara and in French so that all participants could better participate.

Timeline

The timeline for the assessment is shown in Table 2.

Table 2. Timeline for assessment

Activity	Completion date
Finalize evaluation protocol and data collection tools	September 11, 2017
Submit protocol to UNC IRB	September 29, 2017
Submit protocol and data collection tools to the National Ethics Committee of Mali	October 15, 2017
Ethics approval received from Mali and UNC	November 22, 2017
Subcontract with data collection team	December 31, 2017
Meet with campaign staff and key stakeholders to:	January 31, 2018
- Share evaluation plan and timeline	
- Identify list of KIIs and schedule interviews	
- Obtain campaign records and documents	
Conduct FGDs and KIIs	February 16, 2018
Conduct facility record reviews after the campaign	February 16, 2018
Provide USAID/Mali with an update on the evaluation process	March 31, 2018
Prepare draft report/submit to DNS and USAID/Mali	April 15, 2018
Obtain comments and suggestions from USAID/Mali and DNS on draft report	April 30, 2018
Release final report	May 31, 2018
Organize dissemination meeting on the results	May 31, 2018

Analysis

The evaluation of the 2017 national campaign included an assessment of process and outcome indicators, combined with an analysis of information collected through the KIIs and FGDs. Information was triangulated to identify and assess the lessons learned from the campaign and its implementation; the barriers to implementation of the campaign (or barriers to specific campaign activities); the degree to which the campaign incorporated recommendations from the previous evaluation; the perceptions of whether the campaign successfully targeted youth living in intensive intervention areas; and perceptions of whether the campaign was successful in reducing barriers to contraceptive use among target populations.

RESULTS

The campaign was launched on August 24 and ran through October 22, 2017. The campaign sought to mobilize leaders and political decision makers constructively in support of FP to help target groups, with the aim to better take into account the needs of current and future generations and to ensure sustainable development. The campaign also aimed to engage all actors, including NGOs and associations, civil society leaders, national and international decision makers, media figures, and religious leaders. The campaign received a high-profile launch from the First Lady of Mali in Bamako. Campaign documents highlight one of the themes of the campaign, "a responsible and engaged youth committed to FP in Mali, a way to reach the demographic dividend" which targeted young men and women of reproductive age, leaders, and health workers to ensure they would receive this message and other related ones.

The slogan chosen for the campaign was "All walk in favor of family planning." The eight specific objectives were mainly the same as for the 2016 campaign, with the addition of an objective to "strengthen the commitment and responsibility of young people for family planning" in line with the 2017 theme. A 2016 campaign objective related to the constructive engagement of leaders and decision makers was removed. Expected results of the 2017 campaign, such as the engagement of community and religious leaders in FP, the mobilization of young people and women, and the accessibility and availability of FP services, were also the same as in 2016. Planning documents stated that the 2017 campaign "will address some of the shortcomings of the previous campaign"; terms of reference for the campaign stated that the shortcomings of the 2016 campaign should be shared with stakeholders. The planning and implementation structures were similar to those of the previous campaign.

Over 1,500 documents were collected and submitted for the assessment, including a number of copies and duplicates. The following process and outcome indicators were based on a review of these, to the extent possible, given the multitude of documents to organize and process.

Results of Process Indicators: National Level

This section presents information collected at the national level for each of the process and outcome indicators selected for the assessment.

1. Number of weekly coordination meetings held

A total of 21 coordination meetings were held at the national level for the 2017 campaign, between February 8 and October 4, 2017; no meetings were held during the months of March, April and May due to the postponement of the campaign. The meetings continued during the campaign, using a discussion forum to debate highlights and challenges of the campaign and identify recommendations to address the identified challenges.

2. Number of supervisory visits completed during the campaign (by region or district)

A number of supervisory reports were completed by the campaign officials and submitted to the evaluation team. The data collection team reported that 37 were completed by the national-level team and that additional reports were completed at the regional level.

3. Standard data collection forms for campaign activities designed (Y/N)

Yes. Data collection forms collected data on the number of new users (by method), inventory and stockouts (by method), number of FP counseling recipients during the campaign (by age: 10–14, 15–19, 20–24, 25+; by sex: M/F), number of people sensitized during the campaign (by type: advocacy, health center talks, talks in the community, meetings, and films; by sex: M/F), and source of information about the campaign from clients (by type: radio, television, health center, friend or acquaintance, community health talks, community relay, or "other"; by age: 15–24, 25+).

However, standard data collection forms to capture campaign activities happening outside of the healthcare environment were not developed. Such activities include the distribution of campaign materials, outreach events targeting religious or other opinion leaders, or other special events taking place at the region or at district level.

At the regional and district level, forms consisted in the weekly reporting form and monthly activity reports from health centers.

4. **Family planning indicators added to the DHIS 2 (Y/N**)

Yes. Family planning indicators were added to the DHIS 2 based on forms described above (indicator #3).

5. Percent of regions (or partners) submitting standard data collection forms, if possible

The DNS campaign evaluation reports "insufficient compilation and weekly transmission of health area data to DHIS 2; likewise with regards to data entry at the district level." Indeed, data from Menaka, Taoudenit, and Tombouctou were not collected by the DHIS 2. This resulted in an overall 70 percent (7 of 10) reporting rate from intensive intervention districts. It must also be noted that no report forms were filled out in any of the 10 districts for the whole duration of the campaign (9 weeks).

6. Family planning information from DHIS 2 checked for accuracy, if applicable

Data collected through the DHIS 2 were assessed to ensure that all were indeed submitted in a timely manner. Over the course of the campaign for the months of August, September, and October, only Bamako Commune I and Sikasso had more than 70 percent coverage of facilities. The overall reporting rate was 38.2% percent. This means that the data in the DHIS 2 were not necessarily representative of all facilities providing FP services in the intensive intervention districts. It only provides a "snapshot" of the indicators. An assessment of timeliness shows that overall, less than 1 percent of reports from these districts were filed on time for the months of August, September, and October. The reporting rate may have increased over the following months, as some reports became available after the evaluation was over.

District	Reporting rate (%)	Reporting on time (%)
Bamako Commune I	74.1	7.0
Bla	37.2	0.0
Gao	9.7	0.0
Kita	28.2	1.4
Kolokani	55.7	0.4
Mopti	48.9	0.0
Sikasso	71.9	1.1
TOTAL	38.2	0.8

7. Documented effort to improve logistics management

A PowerPoint presentation entitled, "Contraceptive situation in the country and forecast for 2017 FP campaign preparations" documents the effort to assess the level of stock of FP methods and supplies so as to reduce the stockout rate. Data for the assessment came from monthly average consumption and stock availability by region from January 2017 reported in the OSPSANTE health commodity dashboard and the quantity of products used during the 2016 campaign. Findings indicate anticipated stock gaps for the implant Jadelle in three regions (Bamako, Sikasso, and Koulikoro); gaps for Implanon in two regions (Sikasso and Kayes); for the IUD in Bamako; and stock gaps for injectables in most of the regions with data (six of eight). For example, gaps of Depo Provera were estimated to range from -14,536 in Bamako to -29 in Gao. Estimates of product needs by method and region were prepared and sent with requested orders.

8. Number of campaign messages developed

Seven messages were developed for the 2017 campaign.* These were:

French	English
1. Jeunes du Mali, votre engagement en faveur de la planification familiale est important pour la capture du dividende démographique et un développement durable	1. Youth of Mali, your commitment to family planning is important for capturing demographic dividends and for sustainable development
2. Prestataires des centres jeunes, soyez accueillants, disponibles et discrets pour offrir des services de qualité en sante de la reproduction / planification familiale	2. Providers at youth centers, be welcoming, available, and discreet to provide quality services in FP/RH
3. Jeunes, défendez vos droits en matière de santé de la reproduction / planification familiale pour faciliter l'accès aux services adaptes à vos besoins	3. Youth, advocate for FP/RH rights to facilitate access to services tailored to your needs
4. Pairs éducateurs, encouragez vos camarades à utiliser les différents services de planification familiale pour préserver leur sante	4. Peer educators, encourage your companions to use the different FP services to maintain their health

5. Jeunes scolaires et universitaires, pour vous mettre à l'abri des grossesses non désirées et mieux pour suivre vos études, utilisez les services de planification familiale	5. Youth in school and university, use FP services to protect yourself from unwanted pregnancies and better follow your studies
6. Jeunes, pour assurer votre plein épanouissement, utilisez les services de santé de la reproduction	6. Youth, use RH services to ensure your full development
7. Jeunes, rendez-vous dans les centres de santé pour y recevoir plus d'informations sur la sante de la reproduction et la planification familiale	7. Youth, visit the health centers for more information on FP/RH

*Campaign strategy PowerPoint presentation by Keneya Jemu Kan (KJK), dated August 11, 2017

9. Launch of campaign by the First Lady or the Minister of Health (Y/N)

Yes. The launch of the campaign was conducted at the Palais de la Culture in Bamako on August 24, 2017 by Madam Aminata Maiga Keita, First Lady of Mali. Dignitaries, and community and religious leaders also participated in the well-attended event. The event was video recorded and photographed by KJK.

10. Number of press briefings held

Many informational materials were produced for the press, including dossiers with information about the campaign and the messages of the campaign. At the national level, a large press conference was held on August 23, the day before the campaign's launch. Prior to this, a press orientation was held in the regions of Kayes, Sikasso, and Mopti.

11. Number of journalists attending press briefings (total)

No documentation on the estimated number of journalists at the launch press meeting was available.

12. Number of radio spots aired

According to campaign documents, campaign messages were widely aired by radio. Messages for the radio program included defining FP, explaining the benefits of FP, describing the different contraceptive methods and their side effects, dealing with rumors, and explaining the importance of engaging leaders in FP. A total of 75 uniquely named audio files (MP3) were submitted for this evaluation. For example, KJK reports airing the "jigisigi PF" spots 342 times, at the rate of 3 per day in the Sikasso region; these spots were estimated to reach 358,242 people (Sikasso region campaign report). In Kayes, KJK reported airing radio spots 2,538 times, reaching an estimated 576,283 people.

13. Number of TV spots aired

A number of TV spots also aired during the campaign. These included campaign promotions in French and Bambara, films on the launches in Timbouctou and Kayes, a video on highlights of the campaign in Bamako, camp, and three episodes of a TV series (9 total were submitted for the evaluation in MP4 format).

14. Total amount of funds spent on the campaign

Through the collected data, the total planned budget for the campaign was CFA 176,791,028 (US$331,262). This included CFA 31,854,960 (USD $59,688) for the planning phase; CFA 104,704,208 (USD $196,189) for the launch and implementation; and CFA 40,231,860 (USD $75,384) for post-campaign work (Source: Campaign budget draft dated February 20, 2017). Some regions shared their prepared budgets as well, including Mopti (CFA 51,870,300; USD $97,516), Sikasso (CFA 46,395,420; USD $87,687) and Tombouctou (CFA 12,300,000; USD $23,000). Funds at the regional level were planned from a wide range of NGOs and partner stakeholders including AMPPF, Banguè kolossi nyeta (BKN), Care, Debbo Alafia, USAID/KJK, MSI, PSI Mali, USAID/ASSIST, and UNFPA, among others. The evaluation team was not able to access the documentation on mobilized funds and justified spending even at the level of the Direction des Finances et du Matériel.

15. Average number of stockout days of contraceptive methods during the campaign at facilities in intensive intervention districts (by pill, injectable, condom (male and female), implant (Jadelle and Implanon), cycle beads, and IUD)*

The average number of stockout days of contraceptives in facilities in intensive intervention districts during the campaign was calculated by dividing the number of stockouts reported in the DHIS 2 for the campaign period by the number of facilities in each district. Stockouts are likely to be higher than what was captured in the DHIS 2, due to the low percentage of reporting. However, with the data provided it is clear that Bla and Sikasso had stock issues with all methods over the months of the campaign. Stockouts were particularly troublesome for Jadelle and Implanon in Bla and Kolokani; and Implanon and the IUD in Taoudenit. Stock in Tombouctou was often reported to be at "0" availability, but stockouts were also reported as "0"— indicating a potential issue with stockouts as well as the data collection process (and a need for additional training). Stockouts are not reported here for spermicide: this method tended not to be in stock during the campaign (only three districts reported stocks of spermicide).

District (# facilities)	Pill	Injec-table	Condom (m)	Condom (f)	Implant (Jadelle)	Implanon	Cycle Beads	IUD
Bamako Commune I (12)	1.8	1.3	0.9	1.8	2.3	2.0	1.2	0.6
Bla (31)	2.7	2.3	9.2	5.9	22.0	25.9	5.6	8.8
Gao (27)	0.0	0.0	0.0	3.7	0.0	0.8	3.6	0.0
Kita (37)	0.0	0.2	0.4	0.0	0.0	0.0	0.0	0.0
Kolokani (22)	0.0	0.0	8.1	0.0	15.5	11.4	0.6	0.0
Menaka (10)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mopti (27)	1.6	0.0	2.3	4.3	0.8	0.0	4.6	0.0
Sikasso (41)	8.9	7.2	7.7	5.7	8.7	6.4	7.2	6.8
Taoudentit (1)	0.0	0.0	0.0	0.0	0.0	**	0.0	**
Tombouctou (14)	0.0	0.0	0.0	0.0^	0.0^	0.0^	0.0^	0.0^

* Partial data for Menaka (September 20–23 and 24–30 for Ander and October 1–7 and 8-9 for Tidermene), Taoudenit (August 9 through October 3), and Tombouctou (October 5–25) was collected by spreadsheet.

** All days of the campaign
^Both "0" stock and "0" days stockout reported

Results of Process Indicators: Intensive Intervention District Level

Information on intensive intervention districts submitted for the evaluation was variable. Some districts submitted many documents related to the activities of the campaign, including planning documents, meeting reports, launch reports, photos, videos, budget documents, supervisor visit forms, reports from implementation partners, weekly FP service statistics data, etc. In contrast, some districts did not provide any of this material. The following indicators are assessed with information made available to the evaluation team. Other than weekly FP service statistics data, very little additional information was available from Gao, Manaka, Taoudenit, and Bamako Commune I. In general, wherever the campaign was organized or facilitated by an NGO, it was easy to access documentation.

16. Number of campaign meetings held

All of the intensive intervention districts providing this information held campaign planning meetings, ranging from at least two (Kita) to 13 (Mopti). Sikasso reported eight campaign planning meetings, Tombouctou reported four, Kolokani and Bla each reported three. In many areas, additional meetings were held at the regional level and/or in other districts within the region.

17. Number of speeches delivered

More than 20 speeches were given in the six intensive intervention districts reporting this information. These speeches all occurred during the launch events, for which between three and five officials gave speeches. These officials included mayors, governors or their delegates, program directors for NGOs and FP implementing partners, including community leaders.

18. Number of communication materials distributed (by type of material: t-shirt, caps, banner, pagne cloth)

Documentation of the distribution of campaign materials indicates that the following materials were distributed in the intensive intervention districts:

District	T-shirts	Caps	Banners	Pagnes
Kita*			3	10
Kolokani	12		3	10
Mopti	400	400	4	
Sikasso	40	20	3	2
Tombouctou	250	30	4	30

*Kayes reported 90 t-shirts, 90 caps, and 10 banners

Banners were the most commonly found materials in the intensive intervention districts; cloths for pagnes and t-shirts were also available. Please note that these numbers differ from those reported at the regional level, as additional materials for the campaign were often available at the regional level and for other districts. Overall, the team of consultants had access to few delivery slips for DNS and DRS material. There was more

communication material distributed in the regions that were supported by one or several NGOs. The latter directly finance the purchase of this material.

19. Synchronous launch by governor or community leader (Y/N)

Yes. Sikasso, Kayes, Koulikoro (and Bamako Commune I) held a synchronous launch of the campaign by the governor or another local community leader on August 24, 2017. Other regions held a launch by a community official/leader but at a later date. For example, the launch of the campaign in Tombouctou occurred on September 26, 2017, near the end of the original campaign period.

20. Number of special events completed (by type of event: talks at health centers; talks in the community; advocacy sessions with religious leaders or others; conferences; movie projections; other)

Intensive intervention districts with information on special events available to the evaluation team reported the following data:

District	Discussions/round tables/meetings	Counseling sessions	School events	Conferences/ educational talks	Other
Bamako Commune I	45				
Kita	2				
Mopti	2	120		18	132 debates; 3 skits
Sikasso	5			35	
Taoudenit		*		*	*
Tombouctou		6	5	87	366 "awareness activities"

*Taoudenit did not report the number of events, but rather the number of individuals reached through advocacy (39 men and 79 women), community talks (49 men and 77 women), and counseling at health centers (18 men and 31 women).

Additional events in the districts included a press orientation and outreach through SMS messages in Kayes. In Mopti, a training workshop for 30 radio hosts; a training of 13 community, political, administrative, or religious leaders; and campaign-related contests were held. Sikasso also reached individuals through conferences with women's committees, information provided by radio hosts and youth, information to healthcare providers, and educational talks with women's associations. Tombouctou awareness activities included several mass events, 42 canvassing events, and more than 200 home visits.

21. Number of religious leaders reached with campaign message(s)

The number of religious leaders reached through the campaign was not noted in most districts, with the exception of Kita (reaching out to eight religious leaders, six from large mosques and two from churches) and Bla (one imam and one priest). Religious leaders apparently participated in many of the campaign launches; however, outreach to religious leaders did not appear to be the main activity of the 2017 campaign.

22. Number of non-religious opinion leaders reached with campaign messages(s)

As with religious leaders, the number of opinion leaders reached with campaign messages was not one of the main activities of the 2017 campaign. Other than leaders taking part in launch activities, this information was not collected by the districts. In Mopti it was noted that signed commitment messages were obtained from regional leaders, similar to what was done in the 2016 campaign.

23. Number/% of (public and private) facilities participating in "Open Days"

No data were obtained on this topic. However, the Sikasso region reported three open days in the district of Kadiolo.

24. Number of "Open Days" held

No data were obtained on this. However, the review of communication documents and the men's FGD indicate that the launch ceremony in Mopti was coupled with Open Days.

Results of Outcome Indicators: National and Intensive Intervention Districts

25. Number of articles mentioning the national campaign in the media

Two articles were specifically listed: an article written by Diakalia M. Dembélé on the internet August 24, 2017 and in *le Journal* on September 22, 2017. There was also a Facebook share and tweeted article by Mamdou Togola. KJK reports a total of seven articles produced in Bamako. A website for the campaign was also designed (maliweb.net).

26. Number of people reached by media coverage (estimated coverage) (by type of media: radio, television, newspaper, social media, and other)

Social and behavior coordination and communication activities at the central and regional level were estimated to have reached 4,352,138 people, as reported in by KJK in a synthesis of campaign activities. It is estimated that the majority of individuals were reached by radio spots (3,366,631), online campaigns (895,115), and SMS messages (90,000).

According to information captured by the DHIS 2, a total of 58,435 individuals were reached through health center talks (31,000 people, or 53%), community talks (25,031 people or 43%), advocacy (1,799 people, or 3%), conference (514 people, or 1%) and films (91 people, or <1%) in the intensive intervention districts.

The DHIS 2 also reported that most clients at health facilities in the intensive intervention districts heard about the campaign from health center talks (60%), community health workers or community relay agents (14%), friends and family members (11%), radio (8%) television (7%), or other means (1%).

27A. Number of first-time users ("new acceptors") during the campaign at health centers in intensive intervention districts (youth <19 years and 20–24 years)*

Information on the age of new users was incomplete. The information below was obtained from weekly data reports on the campaign, compiled and submitted to the evaluation team. Many of the reports were missing and/or had missing data elements. Data on the age of new users was not obtained from Bla, Gao, Kita, Kolokani, or Sikasso. In places that included the 10–14 age group, very few clients were reported. The numbers

shown here are much lower than DHIS 2 data regarding the total number of new users having received FP counseling during the campaign.

District	Females		Males		Total
	<19	20–24	<19	20–24	15–24
Bamako Commune I	62	124	25	57	268
Menaka	11	10	0	0	21
Mopti	*	*	*	*	1,138
Taoudentit	24	44	1	6	75
Tombouctou	25	88	0	1	114

*Mopti only reported the total.

27.B. Number of first-time users ("new acceptors") during the campaign at facilities in intensive intervention districts (by method: pill, injectable, implant, condom, and IUD)*

Data from DHIS 2 show that for the months of August, September, and October, a total of 33,718 new users received FP methods in the intensive intervention districts. Overall, male condoms were the most commonly provided method to new users, followed by injectable, pills, and implant/Jadelle. By district, Sikasso reported the highest number of new users (10,086), followed by Bamako Commune I (7,234), and Kita (5,745). Following are numbers from the DHIS 2, supplemented by weekly data reports when DHIS 2 data was not available, organized by intensive intervention district and method for the six most common long- and short-term methods. Methods not shown are female condom, cycle beads, and spermicide, which have very low use in these areas.

District	Pill	Injectable	Implant (Jadelle)	Implant (Implanon)	Condom	IUD	Total
Bamako Commune I	360	923	954	1,214	3,252	478	4,181
Bla	685	1,095	170	0	321	6	2,277
Gao	25	59	48	0	94	0	226
Kita	857	1,128	836	267	1,712	46	4,846
Kolokani	436	899	718	12	585	5	2,655
Menaka	8	24	8	0	0	0	40
Mopti	685	1,017	523	513	1,384	59	4,181
Sikasso	997	1,793	846	348	2,908	293	7,185

Taoudenit	63	26	2	0	9	0	100
Tombouctou	389	290	87	84	808	1	1,659

* DHIS 2 data; data for Kita, Menaka, Taoudenit and Tombouctou from weekly data reports

28. Number of beneficiaries of FP counseling in intensive intervention districts (by sex; by age)

In addition to new users, the number of beneficiaries of FP counseling was collected by the DHIS 2. According to this data, a total of 33,196 individuals in the seven districts that submitted data received counseling on FP during the months of the campaign. Of these, 23,880 (72%) were female and 9,316 (28%) were male. By age group, 1,382 (4%) were 10–14 years old; 6,976 (21%) were 15–19 years old; 10,762 (32%) were 20–24 years old and 14,076 (42%) were 25 or older. The most common age group was age 25 or older, while the least common was age 14 and below. By age and sex, the most common beneficiaries of the campaign were females age 25 and older, who accounted for 30 percent of all beneficiaries. The next most common were females age 20–24, who accounted for 23 percent of all beneficiaries.

Beneficiaries of counseling	10–14	15–19	20–24	25+	Total
Females	861	5,153	7,725	10,141	23,880
Males	521	1,823	3,037	3,935	9,316

29. Average number of first time users ("new acceptors") during the campaign in intensive intervention districts (by method: pill, injectable, implant, condom, and IUD)*

The average number of new clients by method per facility was calculated from DHIS 2 and weekly data reports, as available. Overall, facility averages of new clients in centers were low in Menaka and Gao. Bamako Commune 1 had high facility averages for new users of condoms (271.0) and Implanon (101.2) By method, facility averages of new users in health centers were highest for condoms, injectables and pills, slightly lower for implants (Jadelle and Implanon), and lowest for the IUD.

District (# facilities)	Pill	Injectable	Implant (Jadelle)	Implant (Implanon)	Condom	IUD
Bamako Commune I (12)	30.0	30.8	79.5	101.2	271.0	39.8
Bla (31)	22.1	35.3	5.5	0.0	10.4	0.2
Gao (27)	0.9	2.2	1.8	0.0	3.5	0.0
Kita (37)	23.2	30.5	22.6	7.2	46.3	1.2
Kolokani (22)	19.8	40.9	32.6	0.5	26.6	0.2
Menaka (10)	0.8	2.4	0.8	0.0	0.0	0.0
Mopti (27)	25.4	37.7	19.4	19.0	51.3	2.2
Sikasso (41)	24.3	43.7	20.6	8.5	70.9	7.1

Taoudenit (1)	63.0	26.0	2.0	0.0	9.0	0.0
Tombouctou (14)	27.8	20.7	6.2	6.0	57.7	0.1

* DHIS 2 data; data for Kita, Menaka, Taoudenit and Tonbouctou from weekly data reports

30. Number of methods distributed during the campaign in intensive intervention districts as compared to the same time period in 2016 (by method: pill, injectable implant, condom and IUD)

A comparison of the number of methods distributed in the 10 intensive intervention districts in August, September, and October 2016 and 2017 (hence not during the 2016 campaign) shows increases for only two of the methods, the Implant and IUD. The comparison indicates there were fewer distributions of the pill, the injectable, and condoms. Overall, fewer than 85,000 methods were distributed (mostly condoms) in these districts in 2017 than in 2016, according to the available DHIS 2 data.

Method	2016	2017	Difference 2016 to 2017
Pill	12,598	3,634	-8,964
Injectable	7,709	5,900	-1,809
Implant (Jadelle and Implanon)	4,117	5,048	+931
Condom	195,468*	119,494	-75,974
IUD	832	838	+6

*Mopti and Sikasso reported very high numbers of condoms distributed in 2016.

31. Number of first time users ("new acceptors") during the campaign in intensive intervention districts as compared to the same time period in 2016 (by district; by method: pill, injectable implant, condom and IUD)

In all districts reporting data to the DHIS 2, there was an increase in the number of new users from August, September, and October 2017 compared to the same period in 2016. The greatest overall increase in numbers was seen in Sikasso (+7,643), Bamako Commune I (+5,365), and Kita (+4,040). The largest percentage increase was seen in Sikasso (313%) and Kolokani (305%).

District	2016	2017	Difference 2016 to 2017	Percent increase
Bamako Commune I	1,869	7,234	+5,365	287%
Bla	813	2,571	+1,758	216%
Gao	240	325	+85	35%
Kita	1,705	5,745	+4,040	237%

Kolokani	850	3,441	+2,591	305%
Menaka	34	--	--	--
Mopti	2,826	4,316	+1,490	53%
Sikasso	2,443	10,086	+7,643	313%
Taoudenit	--	--	--	--
Tombouctou	443	--	--	--
Total	11,223	33,718	22,972	205%

Data are compared for the same period in 2016 and 2017; the 2016 data hence do not correspond to the period of the campaign.

Results from Key Informant Interviews

A total of 17 KIIs were conducted in Bamako and the five intensive intervention areas. The interviewees included national campaign committee members, regional community leaders, religious leaders, FP specialists, health directors in intensive intervention districts, and technical and financial FP partners (see Appendix 2 for interviewee affiliations). The interviews were conducted to obtain key thoughts and opinions from campaign stakeholders regarding the campaign. These investigations collected responses to specific questions regarding the campaign, including to what extent the campaign reached its objectives of sensitizing youth, men, religious leaders, and persons living in the intensive intervention districts. The goal was also to obtain their points of view on areas of improvement.

1. *Was this year's campaign an improvement over last year's campaign? Why or why not?*

Overall, informants at the national level had a more negative opinion of the 2017 campaign than informants at the regional or district level. A large number of key informants were under the impression that the 2017 campaign brought improvements in some elements of the campaign—in particular in the planning phase. Improvements included more attention to action plans at the regional and district level, more tools for collecting data, and improved coordination between the national planning committee and regional planning committees. Some informants also felt there was more financial support for the 2017 campaign. One informant mentioned that there were more women opting for long-term methods as opposed to usual natural short-term methods. However, despite these positive comments, informants also expressed their views that there were continued shortcomings related to budgets and stockouts of contraceptive products. Some also felt that some elements of the 2016 campaign were better, including the timing of the campaign, the launch in a local community rather than in Bamako, and more visible support from political figures. One respondent at the national level felt the 2016 campaign "succeeded more than the 2017 campaign" for reasons related to the problems linked to the delayed launch and to insecurity, which led regions not to receive inputs in due time. The delay of the campaign received mixed reviews; some people viewed it as giving more time to get resources in place for the campaign while others emphasized that the delay interrupted preparations and momentum for the campaign. Generally, informants at the national level had a more negative opinion of the 2017 campaign than informants at the regional and district level.

2. *How well did the campaign reach the youth audience?*

Many of the key informants felt that the campaign successfully reached a young audience by incorporating young people into the campaign itself. They mentioned regrouping some youth to serve as ambassadors for their peers, youth outreach activities, the inclusion of young people in the development of communication messages and at the launch through mobilization efforts, and generally "giving them tasks" to support the campaign. Informants also mentioned social media as an effective means of reaching youth, during and after the campaign. An informant also suggested that the targeting of youth was successful because he saw young people sneak into the maternity ward during the period of the campaign. A few informants added that despite this inclusion, there is no clear information on what kind of training youth ambassadors received, no comprehensive description of their activities, and no evaluation of their impact. Informants at the national level expressed uncertainty as to whether the campaign actually influenced young people to use FP. At the district level, one informant stated:

> Some things have improved, but there is a lot to be done at the youth level. We must involve everyone because it is not a question about being present, but rather going out to meet young people. Young people must be encouraged by the things that interest them.

3. *To what extent did the campaign reach men?*

Informants felt that men were included because young people as a group were targeted. However, communication strategies were not tailored to reach men, whether at the planning level or the "ground" level. One district-level informant asserted that the focus was broader: "In general, it's mostly teenagers, it's at school level." One district-level informant mentioned a specific activity focused on targeting men through religious leaders. At the national level, one informant felt that the provision of free condoms was a way to effectively reach men, saying: "When asked, the majority of men justify their non-use of FP by being asked to pay each time they go to a health center for FP. They often do not have the money."

4. *To what extent did the campaign reach individuals living in the ten priority districts?*

Informants felt that the campaign was implemented more strongly in some districts than in others. Informants at the national level stated: "In general, half of the intensive intervention districts carried out the campaign" and "In these districts, we know that some providers did their best …but in others, they did nothing at all." One informant felt that "only the committed follow what we tell them. <Other> ones are hostile to the messages and media ads. They think that it is tantamount to pushing children to promiscuous sex." There were some coordination issues noted, such as delays in the launch, difficulty mobilizing financial resources, and difficulty in procuring contraceptive methods and supplies.

5. *How effective was the campaign in reaching religious leaders?*

Some interviewees felt that the campaign was not effective in this regard. One informant felt that reaching out to religious leaders was not really taken into account during the 2017 campaign. Another felt that "compared to the 2016 campaign, religious leaders have not been much involved in the 2017 campaign…I think we need to be really inspired by the example of the involvement of religious leaders in the 2016 campaign for future campaigns." Many informants emphasized the important role religious leaders will be able to play in influencing attitudes about FP. For example,

> If an imam incorporates such messages into his sermons or preaching, this has more impact than the media. Some <people> even turn off their <radio or TV> when they see such ads.
>
> Upon my arrival in <this district>, we were first welcome by the area director at the DRS. And he notified us that the campaign was timid in his locality because of the religious leaders. As you know in the north of Mali, talking about FP is perceived as an incentive, an encouragement, for women to commit adultery. Apparently, every time we send a message of awareness on FP, immediately a preacher replies by telling people not to adopt FP… apparently this is why the campaign is rather timid in <this district>."

A few religious leaders pretended being open to FP by attending official ceremonies during the launch. But this is more of a political move—the same leaders organize campaigns against FP. Other informants shared anecdotes regarding religious leaders who are open to FP messaging but also mentioned resistance among older religious leaders. One mentioned the potential support of religious leaders, as long as FP advocates could reassure them that the use of FP does not lead to immoral behavior.

Some informants suggested tools required to help them engage religious leaders, such as "credible arguments for the faithful," key messages about birth spacing, and tools to help them sensitize preachers and answer their questions. However, others expressed frustration regarding the fact that some religious leaders had become obstacles to the adoption of FP:

> But if religious <leaders> are invited to an activity on FP, if they participate, they pocket the per diem (snack). On their return from the event, they organize preaching to encourage people not to use FP. I do not have any ideas to offer…that can lead these religious <leaders> to understand that FP is for the well-being of their communities. We have used all the means available to make them change their minds: we have organized training workshops, communications, we have pleaded with them, we have appealed to experts of the Koran to come and explain [FP] to them, but to no avail. They think that these people do not believe in God or do not know the Koran."

6. *Were sufficient resources (funds, time, and effort) allocated to the campaign?*

Despite more emphasis on budgetary planning, some informants felt it was difficult to mobilize financial resources. Many regions were able to prepare planned budgets, but they were not all sufficient to cover planned activities. Some regions did not prepare budgeted plans, and as a result, they were not able to implement some of the campaign activities in their zones.

Regarding the time of the launch, many informants felt that the delay of the launch had negative consequences, because it took place during an inconvenient time of the year for many regions, due to weather, harvest work for farmers, and/or agenda conflicts. One informant mentioned a poorly attended launch event because of the weather. Other informants mentioned that the delay had caused funds for the campaign to be re-allocated to other line items or spent before the actual campaign began.

In terms of effort, some informants mentioned several shortcomings. These included the concern over a lack of qualified providers, security issues that inhibited the implementation of campaign activities in some areas, and low participation by campaign actors in some areas due to their ambivalence about FP use, especially for youth.

Contraceptive commodities were also a source of discussion. Despite estimates of stock needed for the campaign, one informant felt that the estimates were made too late. Another reported that the evaluations were made at random by the DNS, without any involvement of regional pharmacists, districts, and pharmacies in

Mopti and Tombouctou. Following such comments, an informant underlined the need to bring male and female pharmacists up to par.

> If we refer to inputs, I think that there are still efforts to be made… especially at the level of supplies, because the estimate of contraceptive supplies was made at the last minute, because we had resource issues, because we did not know who was going to pay… even with the issue of free contraceptives, due to the provision of products, we were not really sure if the products would be free or not."

7. *What are areas where the campaign could be improved? What actions would be needed to make these improvements?*

When asked to consider ways in which the campaign could be improved, the informants had many suggestions. In terms of *planning*, informants suggested:

- Make sure that sufficient time is given to plan campaign events. "We must give <regional levels> as much time as possible to prepare the campaign at community and circle levels." This includes the engagement of community leaders. One of the local governors told an informant, "if only I had been involved earlier, I see a lot of inadequacies that I could have corrected."
- Focus on a few priority actions for the campaign to meet key objectives.
- All the subcommittees in charge of the campaign organization should hold regular briefings prior to the launch of the campaign in order to prepare it properly.
- At the regional and district level, action plans should include all actors and be funded.
- Involve administrative authorities (governor; head of region) by giving them a position as head of the committees or subcommittees for organizing the FP campaign.
- Avoid organizing campaigns during times in the winter when most of the population is busy working in the fields.

In terms of *resources*, informants suggested:

- Include trainings for providers on the organization of the campaign and the collection of data needed for the campaign. Include trainings of providers on all methods, especially long-acting methods and on the removal of certain methods.
- There is a need for technical and financial support to ensure that activities can be carried out. This requires strong commitment from all stakeholders. Provide technical support and funds for the campaign at regional and district levels. Continue to support, if not strengthen, supervisory activities.
- Improve the supply of contraceptives and ensure sufficient resources, especially in areas of high demand.
- Expand communication efforts. "Because communication is expensive, people neglect it."
- Ensure consistent funding.

In terms of *data*, informants suggested:

- Improve understanding of data on stock.
- Clarify whether methods are supposed to be free or not.
- Ensure the existence of a monitoring committee, especially to provide feedback on data reporting. "One of the problems of the 2017 FP campaign was the feedback and return of data. The rate of the reported data was so low that it can impact the results of the campaign."
- Train people to collect data and improve the quality of the data.

- Train agents in regions, districts, and service centers to enable them to use DHIS 2.
- Emphasize the importance of evaluation and learning to improve future projects.

In terms of *stakeholder engagement*, informants suggested:

- More effective engagement of the religious community is needed. "I find that campaign activities are opportunities to better engage religious leaders. It's true that the campaign is about youth, but we really need to involve religious leaders. Young people do not receive much consideration, but religious leaders are highly regarded in the community." "It happens that religious leaders are sometimes kept aside during campaigns... Religious leaders are the ones who create obstacles and we have to target them in a specific way."
- Strengthen collaboration with private health providers.
- Early engagement with community leaders is needed.
- Engage local administrators into planning the campaign. A governor told us "I know that if a governor or a head of region was the chair of the organizational committee, it would be easier to get everyone to participate, as he would convene them to."

Finally, one informant suggested making contraceptive methods free all the time and not only during the campaign.

8. *Any additional thoughts about the campaign that you would like to share with us in the context of this assessment?*

The most common response was that FP stakeholders—especially the ones who help share information on the benefits of FP—need to do a better job of getting FP messages to potential FP users. They mentioned the suffering of women who could benefit from information and advocacy on FP. One informant also addressed harmful messages that sometimes emerge during the campaign (such as the message that FP is a Western tool to control African populations), and the importance to address them. Informants also noted that improved access to FP in rural areas is the absolute priority, underlining that specific strategies could be designed to reach communities living in rural zones that are very difficult to access.

Another theme was the issue of staff attitudes and the fact that some campaign staff do not fully embrace FP messages, making the latter less effective as health promoters. To address this, it was suggested that more work at the community level could help normalize FP and that additional supervision could help uncover strategies to deal with the problem.

Finally, it was noted that youth engagement must be more efficient. To do so, it is not enough to invite young people to seminars and talks; strategies must be designed that take into account their specific constraints.

> We must know how to present things to young people because it is not a matter of organizing seminars or workshops just to talk. We have to present things that are a little shocking for young people to give more weight to the actions that target them.

Results from Focus Group Discussions

A total of 10 FGDs were held with women and men ages 18–24: two each in Kita, Kolokani, Mopti, Sikasso, and Tombouctou. As shown in Table 3, each of the ten FGDs had between eight and ten participants, with a sum total of 95 people (50 women and 45 men). The average age of participants was 20.0 years for women and 20.5 years for men.

Table 3. Summary of Focus Group Participants

Focus Group Participants				
	Women		Men	
	Number	Average age	Number	Average age
Kita	10	18.8	9	19.7
Kolokani	10	20.2	9	21.0
Mopti	10	21.1	9	20.7
Sikasso	10	19.8	8	20.6
Tombouctou	10	20.2	10	20.4
Total	50	20.0	45	20.5

Focus group participants were first asked whether they were aware of the FP campaign that took place during the months of August to October 2017. Though the majority of the female participants had not heard of the campaign, some women in Mopti and Tombouctou mentioned hearing about it through a presentation at school or from the TV and radio spots. A few others mentioned skits they had seen. Similarly, many men had never heard about the campaign, but some were directly involved in some campaign events or had heard about it on TV or on the radio. Others, notably the ambassadors in Mopti had taken part in some activities—organizing a march through the city to sensitize and mobilize the population to participate in mass in the campaign launch.

When probed, women who had first learned about FP from the campaign mentioned having learned things about long-acting methods, such as Jadelle. They also felt that it helped them learn more about birth spacing and how younger women can prevent undesired pregnancies. These women felt that the campaign messages had managed to change attitudes about FP among both women and men.

> *The campaign has allowed some to space their births. I had an aunt who had just given birth. But thanks to the campaign, she knew how to space her births. She is currently using Jadelle.*
>
> —Female, Mopti

> *After the campaign, many men understand that their companions start to plan. The very purpose of planning is to balance income and expenditures with the well-being of women. Now these men are the same ones who advise women to adopt FP.*
>
> —Females, Tombouctou

Men felt messages about women's health, specifically related to child spacing and outreach to youth were what other men in their communities were likely to want to learn during the campaign. They also felt that the campaign likely led to more couples practicing FP.

However, problems with side effects, especially changes in menstrual patterns, worries about method failure, and rumors about methods, continued to be a concern for women despite the campaign messages. The men's groups also brought up the issue of side effects, particularly infertility.

> *Some talk about the harmful consequences of FP. I did not understand this aspect because I had always said that it was meant to protect women. If it can cause other worries, it is inexplicable.*
>
> —Male, Sikasso

Compared to the awareness of the campaign, most women had heard of FP, stating they had heard about it on TV and radio, or knew of health promotors giving talks about FP options in their communities. Other women said they had first heard about FP from their doctors after giving birth, remarking that "when we give birth, the doctors ask us if we want to do family planning" (Kita). Finally, women mentioned learning about FP through family members (particularly sisters) who either practice FP themselves or are supportive of FP.

When asked if women in their community discuss FP, women respond that FP was deemed a very sensitive topic. However, they expressed interest in learning more about FP in order to be able to make a choice about whether to use a method or not. One women in Tombouctou said,

> *Many <people> talk about it, but in a negative way. That's why I avoid it in debates. Otherwise, I know that many would like to adopt it. We especially like participating in FP training sessions to learn about its advantages and disadvantages.*
>
> —Female, Tombouctou

Women felt that FP is more likely to be discussed by younger women (as compared to older women), especially by those who are still in school. They believed that younger women tend to be more motivated to avoid pregnancy and abortion.

> *We <women aged 18–24> are talking about it more, because we are not the same. We are girls, those who are older than we are, are married and can have children whenever they want while married. On the other hand, if we do not use planning, we can get pregnant without wanting to and it can set us back in our career. That's why we talk about it and we protect ourselves.*
>
> —Female, Kita

Some men expressed the opinion that men in their communities refused to listen when approached about FP, because they consider it is a "woman's issue" or a "Western idea."

> *There are also men who, even if they are aware of the FP campaign, do not want to know more. In some locations here, if you speak of FP, you risk getting beaten. People living in such places believe that FP gives bad Western ideas to our wives and daughters.*
>
> —Male, Mopti

Focus group participants were also asked to reflect upon the theme of the campaign. Women generally liked the theme of the campaign. They said that it expressed the idea that young people are the future of Mali and that FP gives them more opportunities to be engaged in the country's initiatives. They also felt the theme expressed the idea that women had more opportunities to contribute to society and continue their education with the use of FP.

> *I think that's a good thing because family planning protects young people against unwanted pregnancies, allows them to continue their studies; and the country will go forward because young people are the ones who embody the future of the country. They can do everything they want to allow for a better management of the country.*
>
> —Female, Sikasso

> *The use of FP promotes the professional and social integration of girls because it allows girls to study, to start small business ventures, sewing, and hairdressing activities without any problem. FP is therefore a way for girls to carry out an income-generating activity.*
>
> —Female, Kolokani

Men agree that it is important to reach young people during FP, as young people make up a significant proportion of the population.

> *Once young people have understood and mastered contraceptive methods, the future will be bright for FP.*
>
> —Male, Mopti

Men also expressed the opinion that the campaign should try to reach out to a variety of age groups, not just young people, because it is an issue that affects everyone.

When asked about the attitudes among religious leaders in the community, young women dealt with two main themes. First, some religious leaders support FP as a way to prevent abortion. Others felt that religious leaders were against FP because they believe it is up to God to decide how many children a woman must have, that women should not do anything to stop their natural menstruation cycle, that it promotes promiscuity in women, or that it is a means used by white people to control the African population. Men also raised similar issues, expressing that most religious leaders are against FP because it promotes adultery and that it is up to God to decide how many children a couple must have. However, men also noted that some religious leaders understand the health benefits of birth spacing.

> *During the campaign I was listening to the radio; they were talking about FP. There was even a debate, and they had invited a holy man. He gave his point of view regarding family planning. According to him, birth spacing ensures the woman's health, and having children too soon is very tiring for women. He was with the agents of AMSES, a local NGO that is in Tombouctou. And a debate with religious figures on the radio is what can really be effective. Otherwise, in public or in front of the mosque, it will not work.*
>
> (Male, Tomboktou)

When asked about the reasons women and their husbands do not practice FP, women most often mentioned a lack of awareness about FP, religious doctrines against FP, men not trusting their wives to be faithful (and therefore not allowing them to use FP), and a fear of side effects from the use of hormonal methods.

> *There is a lack of awareness. If you do not listen to information, it's very difficult for you to plan.*
>
> —Female, Sikasso

> *There are also husbands who are ready to divorce their wives if they adopt family planning. So their wives abstain from the practice of planning for fear of their husbands divorcing them.*
>
> —Female, Kita

The men's groups most often mentioned the need to have as many children as possible to help their parents when they get older, religious doctrines against FP, and the fear that the use of FP can lead to infertility or cause other side effects.

When asked to reflect about barriers to FP use and the national FP campaign, women felt that the awareness campaigns at the health centers were not enough and did not provide sufficient information to women interested in FP. They suggested that, messages needed to target older as well as younger people during the campaign to allow for a mutual understanding of the benefits of FP.

> *Trainers only train young people or children. Focus on training old people. Old people <need to> understand that FP is not a bad thing in and of itself.*
>
> —Female, Tomboktou

Men mentioned the need for more focus on birth spacing and that the campaign still has "a long way to go" before reaching its objectives. Men suggested more emphasis on social media, as they are "the best information channels for young people nowadays." Men also noted that the FP actors (those

doing demonstrations and skits) and agents should be better trained in order to share the messages more effectively so that they can better answer questions. They recommended providing more information on side effects (the disadvantages) of FP methods, and not to remain silent on the issue, as well as to address how FP can affect a family's health and finances.

> *You know, FP is nothing more than birth spacing. It is the starting point that leads to other aspects related to development, economy, health, among others.*
>
> —Male, Mopti

Women felt that the focus on raising awareness during the FP campaign should not be limited to a few months of the year but should be ongoing. They think that the side effects (or disadvantages of FP) should be discussed and explained. They emphasized that FP can reduce the number of abortions, especially among very young girls, but also for any women who are fearful of complications due to pregnancy. Finally, they recommended engaging highly regarded (qualified) "wise women," elders, or mother educators from within the community and involving them in the campaign to encourage FP use: "In some neighborhoods, there are associations that strive to ensure the well-being of their communities" (Female, Tomboctou).

ASSESSMENT OF RESULTS

Improvements and Adjustments Compared to the 2016 Campaign

The campaign made important adjustments to planning activities, especially following the recommendations made in the 2016 evaluation. These adjustments include the following:

- The **challenges and recommendations stemming from the 2016 campaign were added to the Terms of Reference** for the 2017 campaign. In the 2017 Terms of Reference, it was noted that: "Despite the < 2016> results, some difficulties remain, namely: the breakdown of inputs, insufficient monitoring and communication, insufficient data collection, and the lack of respect of the selection criteria of certain flagship districts for security and accessibility reasons."
- **Some actions were undertaken to improve communication with regional and district-level campaign implementers**. Campaign documents indicate that "pre-campaign visits were organized to make contact with health, administrative, and local authorities at all levels to ensure greater participation and engagement of the communities..." Documentation regarding the visits was also available to the evaluators.
- **Some efforts were made to strengthen the supply of FP products**. Projections were made based on the 2016 distribution of methods. Pre-campaign visits were used as an opportunity to check the availability of FP products in order to ensure adequate product availability. The lack of available products was one of the reasons raised for the postponement of the 2017 campaign.
- **Results and recommendations from the 2016 campaign evaluations were shared** among the implementers at national, regional, and district level. Sharing the evaluation findings supported transparency, encouraged buy-in at all levels, and could produce positive responses to the challenges identified.
- **Data collection forms were created for input into DHIS 2** to track indicators that were relevant to campaign stakeholders.

- **More information was made available to campaign evaluators**. The willingness to share data and documentation shows a willingness to learn if, where, and how improvements can be made. In fact, the amount of documentation that came in from the field was so overwhelming that it was difficult for the evaluation team to sort through and assess it.

Remaining challenges

Despite the encouraging results documented in this report, the evaluation unearthed some difficulties. The main challenges found during the evaluation included:

- **Problems with contraceptive stock** and getting resources on time (including financial resources). Additionally, there was a lack of clarity regarding "open days" and whether methods would be offered for free.
- **Incomplete data collection and reporting** through the DHIS 2.
- **Insufficient time between notification of local campaign activities and expected implementation**, despite the delay in the launch date.

Additional challenges arose, including the following:

- **Variable implementation of the campaign at the regional and district levels**. Reasons suggested in the documents provided by this assessment include the consequences of the delay in the campaign launch, insufficient stock in contraceptive methods, insufficient planning and organization, and ambivalent attitudes about FP and the goals of the campaign itself. Attention to campaign activities also appears to decline after the launch events.
- According to the focus group participants, general awareness of the campaign was still low. Additionally, **FP is not fully embraced by communities.** A certain number of attitudes were identified as barriers to the acceptance of FP by communities. These included the perception of FP as a Western way to limit the African population; that FP leads to promiscuity and unfaithfulness; that FP is a "woman's issue"; and that the practice of FP is not in accordance with religious beliefs.
- **Lack of information on the role of youth ambassadors during the campaign**. It is not clear how these ambassadors contribute to the campaign, how they are selected, what type of training they received, or whether their work is effective. It is not clear whether this work varies from region to region. It is possible that ambassadors (and other campaign staff) do not fully support family planning messages, as suggested by data drawn from focus groups and interviews.
- **The success of the campaign at the district level can be hard to determine.** This is because in some of the selected locations, information on campaign activities was collected and compiled only at the regional level.

Limitations of the Assessment

The assessment followed a process and outcome evaluation design and therefore could not produce information on the impact of the national FP campaign on FP behaviors, such as changes in attitudes or contraceptive prevalence. However, the assessment did include selected outcome measures, and thus provides useful information to determine the reach of the campaign, as well as guide implementation of future campaigns and interventions in FP.

The availability of campaign documents and records was a limiting factor for the 2016 assessment. This was not the case for the 2017 assessment. The difficulty for the 2017 evaluation team was to find key information in the overwhelming number of documents submitted. Due to the large number of documents to review, it is possible that information was missed, and therefore what is reported could be incomplete. However, every effort was made to ensure that the information reported in the report was as complete as possible. The ability to triangulate information through the use of multiple data-collection methods—document review, DHIS 2 data, informant interviews, and FGDs, helps correlate the findings reported.

Security issues in some regions of the country influenced data collection, both by the evaluation data collectors as well as by campaign staff. This could explain why some regions (notably the ones located in the north of Mali) had little documentation on campaign activities.

RECOMMENDATIONS

Many recommendations were made thanks to the documentary review, interviews with key informants, and discussions with young men and women living in intensive intervention districts, namely:

- Continue to **strengthen information and communication systems** so that information on FP service delivery is available throughout the year. This work should be ongoing, though a few indicators specific to the FP campaign could be added if or when needed. Data collection at the facility level, as well as the process of entering facility-level data into the DHIS 2, should be prioritized. The campaign data may provide a learning opportunity for regional, district, and facility-level staff to help them understand that decisions are being made about FP programs, though less than 40 percent of facilities were represented. More complete data entered into the system would help improve the ability of planners at all levels to make decisions that are in line with the reality "on the ground."

- All the information about the campaign should not come only from the DHIS 2 system. DRS health officers could **compile basic information about the campaign**, by determining the most salient elements. A simple, standardized form (or report) may help to document the completion of key campaign events at the regional level. Suggestions may include the number of campaign events that occur, the number and content of training events, the number of products distributed, or any other information that is not captured elsewhere.

- Continue to **improve logistics management** to ensure that contraceptive methods and supplies are available at all distribution points. This work should be ongoing throughout the year. It is necessary to give clear information regarding the location of Open Days and whether contraceptives will be provided for free.

- **Collect regional reports of the campaign,** as these provide information on the main successes and challenges experienced at the local level. These should be consistently compiled in every region.

- Identify national and regional DNS staff to **monitor and evaluate campaign activities** and the availability of FP supplies and methods throughout the campaign. Document problems and work to make necessary adjustments throughout the campaign.

- The campaign must include **sound leadership and coordination** to reach a documented result. Communication should be improved, given the real problem of communication between central and local levels.

- There is a need to **address rumors and concerns about FP** and contraceptive side effects at the community level. FGDs revealed a number of negative attitudes about why FP is promoted and the consequences of FP use. These issues should be addressed programmatically as well as by future campaigns.
- **Actively engage religious leaders in the FP campaign.** Religious barriers against FP use are still significant. Such outreach may require specific messages targeting certain religious beliefs or practices and may call for the design of additional training tools or guides. Religious leaders must be involved as partners and not only as mere guests.
- **Expand FP to other health services**, in order to generate a more integrated approach so as to widen expand access and ensure the sustainability of FP programming. It was suggested that this could include training more providers so they could provide FP advice and services. It was also suggested that FP should receive continuous attention, beyond the few months of the campaign.

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APPENDIXES

Appendix 1. Documentation Sources

- DNS campaign report
- Campaign planning documents
- Service statistics from DHIS 2, regional and district level
- Copies of weekly service statistics forms from health facilities; copies of weekly FP registry entries from health facilities
- Regional campaign reports
- Launch reports
- Supervision chronogram and completed supervision checklist
- FP reports from regions
- Commission reports
- Meeting reports from the organizing committee
- Letters, communications
- Follow-up mission reports
- KJK communications report
- PowerPoint presentation on method stock
- Campaign budget plans

Appendix 2. List of Key Informant Affiliations

AMPPF in Bamako (1)

National Center for Health Information, Education and Communication in Bamako (1)

Coalition on Information, Education and Communication for FP in Bamako (1)

Consultant in Kita (1)

DNS (2)

District Sanitaire in Sikasso (1)

FP project staff in Mopti (1)

Government official in Bamako (2)

KJK in Bamako (1)

KJK in Sikasso (1)

MSI in Tombouctou (1)

National Union of Muslim Women (1)

Pharmacist in Mopti (1)

Projet Jeunes in Bamako (1)

Service de Santé à Grand Impact (SSGI) in Bamako (1)

Appendix 3. Data-Collection Tools

Tool: Document Review

Instructions: Collect all campaign-related materials: campaign action plan, records of campaign activities and events, information collected during the campaign (especially campaign monitoring information), materials produced and distributed by the campaign, etc. Specific documents may be requested from the Ministry of Health, regional and district health offices, partner organizations, media outlets, and/or other stakeholders, as needed.

If documentation is not available for review, request information from the person(s) in charge. Send all obtained information, lists, notes, and supporting documents to Janine Barden-O'Fallon: measure@unc.edu. If any information is obtained verbally, please make note of it.

Make sure to collect all documents/information that related to the campaign, even if they are not specifically mentioned on this form.

Add extra rows in this form as needed to ensure that all information is accounted for.

One national level form will be completed:

List of documents	Status	Comments
Minutes from weekly coordination meetings (we have the minutes for the first 6 meetings)	Obtained: YES NO Number = _____	
Completed supervisory forms or reports	Obtained: YES NO Number = _____	
Completed standardized data collection forms	Obtained: YES NO Number = _____	
List of FP indicators included in the DHIS2	Obtained: YES NO	
Evidence of accuracy or quality checks on DHIS 2 FP indicators	Obtained: YES NO	
Report of Launch	Obtained: YES NO	
Documentation of press briefings held in Bamako during the campaign	Obtained: YES NO Number = _____	
Documentation of number of journalists attending the press briefings	Obtained: YES NO	

Documentation of number of radio spots aired during the campaign (Total per Station)	Obtained: YES NO	
Documentation of number of TV spots aired during the campaign	Obtained: YES NO	
Documentation of funds spent during the campaign	Obtained: YES NO	
Articles mentioning the national campaign in the media	Number in newspaper:_____ Number in online blogs: _____ Number in other (please list): _____ _____ _____	
Number of people reached by media coverage of the campaign (estimated coverage) (Details must be included on how estimations are made. For example, with the number of "likes", tweets, and retweets)	Radio audience of stations playing campaign spots:_____ TV audience of stations playing campaign spots:_____ Newspaper circulation for print articles:_____ Social media:_____	
List of names of religious and non-religious opinion leaders wo have given documented public statements in support of Family Planning during the campaign	Include list of names and type of opinion leader	
	Obtained: YES NO	

DHIS2 information on FP services during the campaign Ensure that the information contains the number of contraceptive methods distributed during the campaign divided by: Intensive Intervention District First Time User status Youth under age 24 Method		

One intensive intervention district form will be filled out for each district:

Name of District:_____

List of documents collected	Status of documents collected	Comments
Forms for keeping track of campaign activities	Obtained: YES NO	
Number of campaign planning meetings held	_____	
Number of speeches delivered Who gave them: 1. 2. 3. 4.	_____	
Number of communication materials distributed	T-shirts:_____ Caps:_____ Banners:_____ Pagne cloth:_____ Other (please specify):_____	

	_____	
Launch by governor or community leader	YES NO	
Number of local debates conducted	_____	
Number of special events completed	School lectures:_____ Community talks/dramas:_____ Advocacy sessions with religious leaders:_____ Other (please specify):_____ _____ _____	
Number of religious leaders reached by message(s) delivered during the campaign	_____	
Number of non-religious opinion leaders reached by message(s) delivered during the campaign	_____	
Number of health centers participating in "Open Days"	_____	
Number of health centers not participating in "Open Days"	_____	
Total number of "Open Days" held in District	_____	

Articles mentioning the national campaign in the local media	Number in local newspaper:_____ Number in other categories (please list): _____ _____ _____	
Number of people reached by local media coverage (estimated coverage) (Detail must be included on how estimated are made)	Newspaper circulation for print articles:_____ Other (please specify):_____	
List of names of religious and non-religious opinion leaders who gave documented public statements in support of Family Planning during the campaign	Include list of names and type of opinion leader	

Tool: Key Informant Interviews

Name of Key Informant:_____

Title of Key Informant:_____

Organization Represented:_____

Date of Interview:_____

Note to Interviewer: The conversation should flow naturally. Use this guide to ensure that all topics are covered and that necessary information is obtained. Some informants may not be able to answer all the questions, given heir role in the campaign. You may read or summarize the introduction.

Introduction

As you will recall, the 2017 National FP campaign was implemented from August to October 2017. Its theme was "A responsible and engaged youth in favor of FP in Mali, a way to reach the demographic dividend".

The purpose of the interview today is to elicit your input and feedback as an important stakeholder in the campaign. This information will help assess the implementation of the campaign and improve future campaigns and other FP activities.

This interview will last about 30 minutes. I will be recording the interview and taking notes so that no information is lost. Once we have a complete transcript of the discussion, the recording will be destroyed.

1. Please describe your role in the 2017 National Campaign to promote FP.

2. Were you involved in the 2016 campaign as well? If so, did you feel this year's campaign was an improvement, was about the same, or was not as good, as last year's campaign? Why do you feel this way? If you were not involved, why did you become involved in this year's campaign?

3. Are you aware of the evaluation of the 2016 national FP campaign? Do you know if any changes were made to the planning or implementation of the 2017 campaign based on the evaluation findings? (Please describe the changes made)

4. One of the main objectives of the 2017 campaign was to target youth. How well do you think the campaign reached the youth audience? (Probe to explain)

5. Another main objective was to target ten intensive intervention districts, namely Kita (Kayes), Kolokani (Koulikoro), Bla (Ségou), Sikasso (Sikasso), Tombouctou (Tombouctou), Mopti (Mopti), Gao (Gao), Ménaka (Ménaka), Taoudéni (Taoudénit), et la Commune 1 (Bamako). To what extent do you think the campaign reached young people living in these priority areas? (Probe to explain)

6. The campaign also aimed to reach young men, in addition to young women. What did the campaign do to reach young men and do you think it was effective?

7. How effective was the campaign in reaching religious and community leaders? (Probe to explain) (Do you know if any religious leaders incorporated the campaign messages in their sermons?)

8. In your opinion, were sufficient resources (time, effort, and funds) allocated to the campaign? If not, why not?

9. Are there areas where the campaign could be improved? If so, what are these? (Probe: objective, planning, target populations, intensive implementation sites, and implementation of the campaign plan.) Which actions are needed to make these improvements?

10. Do you have any final thoughts on the campaign that you would like to share with us within this assessment?

Please note that we will not list your name nor your title in the evaluation report. They are only written here for our own record keeping and for any potential follow-up.

This completes the interview. May I contact you in the future in case I have questions after reviewing my notes?

Thank you very much for your time. Your input is very much appreciated.

Tool: Women's Focus Group Discussions

Notes to Discussion Leader: The conversation should flow naturally. Use this guide to ensure that all topics are covered and that necessary information is obtained. You may read or summarize the introduction. Privately obtain written consent for participation in the FGD from all participants before beginning the introduction and welcome.

In your notes, please record: Name of District

Date of FGD

Number of Participants

Introduction & Welcome

Welcome and thank you for volunteering to take part in this discussion. You have been asked to participate because your point of view is important. I realize you are busy and I appreciate the time you are giving us.

As you may recall, the 2017 National FP campaign was implemented from August to October 2017. Its theme was "A responsible and engaged youth in favor of FP in Mali, a way to reach the demographic dividend".

The purpose of this discussion is to learn if women in this community knew of the campaign, and if so, what they thought about it. We are also interested to know what women in this community think of family planning in general.

The discussion will take no more than 1 hour.

Please know that your participation in this discussion is voluntary. I asked you to sign a consent to participate, but I will not attach your name to your comments nor to our report. Please do not discuss the comments of the other individuals outside of the group. If there are any questions that you do not wish to answer or participate in, you do not have to do so. However, please try to participate and be as involved as possible.

Please also know that it is important that only one person speak at a time. However, you do not have to speak in any particular order. If you have something to say, please do so. You do not have to agree with the views of other women in the group.

May I record the discussion so that no information is lost?

Do you have any questions before we begin?

First, I would like to go around and have everyone tell us their age and how many children they have.

Now I am going to give you a minute or two to think back to August and October and to remember what you saw, heard, read, or talked about re family planning with regards to the national campaign.

Discussion questions:

- Did you know about the national FP campaign that took place in August through October of this year? How did you know about it (i.e. heard speeches, radio, community events, etc.)?

- Did most women in this community know about the campaign? If yes- how did they know about it (i.e. heard speeches, radio, community events, etc.)? Did women discuss FP and the campaign in

gatherings? Do you think women your age generally know about or discuss family planning more than older women (or less than older women)?

- Did the women in this community learn something new about family planning from the annual campaign? If so, what did they learn?

- Did the campaign messages change women's (and men's) attitudes about the use of family planning? If so, in what ways? Do you know of any woman who decided to use a family planning method because of something she heard during a campaign?

- What do you think of the campaign's theme, "A responsible and engaged youth in favor of FP in Mali, a way to reach the demographic dividend"? Do you think the campaign tried to reach people your age? If so, how?

- In general, what are the attitudes expressed by religious leaders in this community about family planning?

- There are many reasons why women and their husbands do not use family planning. What are the main reasons that couples in this community put forward to support their choice not to use family planning?

- Do you think the national campaign messages can help to address some of these reasons? Why or why not?

- Are there some things that the campaign could do differently to improve couples' attitudes about family planning?

- Does anyone have any final thoughts that they would like to share about the campaign or about family planning in general?

Thank you for participating. This has been a very useful discussion. We hope you found the discussion interesting.

Tool: Men's Focus Group Discussions

Notes to Discussion Leader: The conversation should flow naturally. Use this guide to ensure that all topics are covered and that necessary information is obtained. You may read or summarize the introduction. Privately obtain written consent for participation in the FGD from all participants before beginning the introduction and welcome.

In your notes, please record: Name of District

Date of FGD

Number of Participants

Introduction & Welcome

Welcome and thank you for volunteering to take part in this discussion. You have been asked to participate because your point of view is important. I realize you are busy and I appreciate the time you are giving us.

As you may recall, the 2017 National FP campaign was implemented from August to October 2017. Its theme was "A responsible and engaged youth in favor of FP in Mali, a way to reach the demographic dividend".

The purpose of this discussion is to learn if men in this community knew of the campaign, and if so, what they thought about it. We are also interested to know what men in this community think of family planning in general.

The discussion will take no more than 1 hour.

Please know that your participation in this discussion is voluntary. I asked you to sign a consent to participate, but I will not attach your name to your comments nor to our report. Please do not discuss the comments of the other individuals outside of the group. If there are any questions that you do not wish to answer or participate in, you do not have to do so. However, please try to participate and be as involved as possible.

Please also know that it is important that only one person speak at a time. However, you do not have to speak in any particular order. If you have something to say, please do so. You do not have to agree with the views of other men in the group.

May I record the discussion so that no information is lost?

Do you have any questions before we begin?

First, I would like to go around and have everyone tell us whether they are married and how many children they have. (Or similar ice-breaker question appropriate for men)

Now I am going to give you a minute or two to think back to August to October and to remember what you saw, heard, read, or talked about re family planning with regards to the national Campaign.

Discussion questions:

- Did you know about the national FP campaign that took place in August to October of this year? How did you know about it (i.e. heard speeches, radio, community events, etc.)?

- Did most men in this community know about the campaign? If yes- how did they know about it (i.e. heard speeches, radio, community events, etc.)? Did men discuss FP and the campaign in gatherings?

- Did the men in this community learn something new about family planning from the annual campaign? If so, what did they learn?

- Did the campaign messages change men's (and women's) attitudes about the use of family planning? If so, in what ways? Do you know of any man who decided to use family planning because of something he heard during a campaign?

- What do you think of the campaign's theme, "A responsible and engaged youth in favor of FP in Mali, a way to reach the demographic dividend"? Do you think the campaign tried to reach people your age? If so, how?

- In general, what are the attitudes expressed by religious leaders in this community about family planning?

- There are many reasons why men and their wives do not use family planning. What are the main reasons that couples in this community put forward to explain their choice not to use family planning?

- Do you think the national campaign messages can help to address those reasons? Why or why not?

- Are there some things that the campaign could do differently to improve couples' attitudes about family planning?

- Does anyone have any final thoughts that they would like to share about the campaign or about family planning in general?

Thank you for participating. This has been a very useful. We hope you found the discussion interesting.

Appendix 4. Informed Consent for Focus Group Discussions

Title: Evaluation of the 2017 FP national campaign

Region:

District:

Date:

Name and given name:

Introduction

The National Directorate of Health in collaboration with USAID/Mali through MEASURE Evaluation is conducting an assessment of the 2017 national campaign for the promotion of family planning in Mali. You are invited to participate in this evaluation to help determine what young men and women at community level think of the campaign and of family planning in general and also to help use the results to improve future family planning campaigns and programs.

Your participation is entirely voluntary. You may withdraw from the discussion at any time without penalty.

Procedures: If you agree to participate in this assessment, you will be in a group of approximately 8 – 10 women (OR: 8 -- 10 men). A facilitator will ask you questions and facilitate the discussion. The discussion will be recorded so that the facilitator does not have to write down everything that is said.

Benefits and Risks: Your participation may benefit you and other men and women by helping to improve future family planning campaigns and programs over the years to come. No risk greater than those experienced in ordinary conversation is anticipated. Everyone is asked to respect the privacy of the other group members. All participants will be asked not to discuss anything said with others outside of this group. However, it is important to understand that other people in your group may not keep all information private and confidential.

Confidentiality: No individual participant will be identified or linked to the comments derived from this discussion. The results of the discussion will be part of a report which may be presented at meetings. However, we will make no mention of your identity. All the information obtained from this discussion will be kept strictly confidential. The notes and recordings will be stored in a secure office and access to files will be restricted to paid professional staff.

Written Consent:
By signing your name to the sign-up sheet, you are indicating that you fully understand this information and consent to participate in this focus group.

If you have any questions pertianing to this study, you can contact:
The INRSP ethics committee by writing to its Vice-President: Sidibé Diaba Camara, Tel : 66766337, email : ladiabe@yahoo.fr or to its permanent Secretary, Tel : 78181260 email : tatadiakite@yahoo.fr
The main co-investigator: Dr Aminata Traoré, Tel : 66828797 ; email : aminata_traore@gmail.com

Investigator
(Read and approved)

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