

OXFAM
External Evaluation Report

SAVING FOR CHANGE + REPRODUCTIVE HEALTH

SEGOU REGION, MALI

Mamadou Faramba Camara
April 2018



OXFAM

This is an evaluation of Oxfam America's Saving for Change + Reproductive Health program. The program has been operating in one country, Mali, since 2017 and this evaluation covers the work undertaken between 2017 and 2018.

The evaluation was commissioned by Emma Fawcett, Evaluation, Learning & Effectiveness Advisor with funding from Oxfam America. The major evaluation activities took place between January and March 2018. The evaluation was carried out by Mamadou Faramba Camara of IMRSS Consulting through a competitive bidding and reflects the findings as reported by him. The evaluation process was managed by Emma Fawcett, Evaluation, Learning & Effectiveness from Oxfam America. The evaluation was translated from the original French by Pramila Kolekar of Boston College.

For additional information regarding the evaluation TOR, please refer to the report appendices.

CONTENTS

Preface	3
List of Tables.....	4
List of Figures.....	4
Abbreviations and Acronyms	5
Executive Summary	6
Overview of Intervention Evaluated	6
Evaluation Brief Description.....	7
Evaluation Methodology	7
Summary of Findings/Conclusions	8
Main Recommendations	9
Introduction	10
Overview of Saving for Change + Reproductive Health	10
Overview of the Intervention Goals	10
Intervention Context.....	11
Geography and Environment	12
Key Stakeholders and Primary Change Agents	13
Evaluation Framework	14
Evaluation Purpose	14
Evaluation Methodology	14
Evaluation Limitation	16
Evaluation Findings	18
Relevance	20
Cost Effectiveness.....	21
Efficacy.....	23
Impact	27
Durability	32
Conclusions and Recommendations	33
References	35
Appendix 1	36

LIST OF TABLES

Table 1. Knowledge of contraceptive methods, % of respondents	18
Table 2. Beliefs related to contraceptives	28
Table 3. Beliefs related to decision-making	31

LIST OF FIGURES

Figure 1. Methods used by socioeconomic status	24
Figure 2. Methods used by age group	25

LIST OF ABBREVIATIONS AND ACRONYMS

AMPPF	Malian Association for Family Protection and Development (Association Malienne pour la Protection et la Promotion de la Famille)
ASACO	Community Health Associations (Associations de Santé Communautaire)
CSCOM	Community Health Centers (Centres de santé Communautaire)
VCT	Voluntary Counseling and Testing
DBC	Community-Based Distribution (Distribution à Base Communautaire)
IUD	Intra-Uterine Device
DHS	Fifth Mali Demographic and Health Survey (Enquête Démographique et de Santé du Mali cinquième passage)
SfC	Saving for Change
STI	Sexually Transmitted Infections
G-FORCE	Training, Consultation, and Study Group (Groupe de Formation, Consultation et Étude)
LAM	Lactational Amenorrhea Method
MSI	Marie Stopes International
NGO	Non-Governmental Organization
SLIS	Local Health Information System (Système Local d'Information Sanitaire)
SRH	Sexual and Reproductive Health
ICT	Information and Communication Technology

EXECUTIVE SUMMARY



Fatou Traore/Oxfam in Mali

OVERVIEW OF SAVING FOR CHANGE + REPRODUCTIVE HEALTH

In January 2017, Oxfam and its local implementing partner G-FORCE launched Saving for Change (SfC) + Reproductive Health in the Segou region of Mali. SfC is a grassroots approach to poverty alleviation and poverty, and the program has operated in Mali since 2005 and subsequently expanded to Cambodia, Senegal, Guatemala and El Salvador.

SfC + Reproductive Health is a one-year pilot project implemented in the Bla health district, located in the Segou region of Mali, to reach approximately 7,200 adolescent girls and women from at least 360 Saving for Change groups. The project focuses on increasing women's and girls' knowledge about their reproductive health, as well as their access to adequate health services.

The intervention seeks to mobilize of the community power of SfC groups in the Segou region to increase women's and girls' access to information, education, and family planning services, by responding to what is currently an unfulfilled

need. Mali has one of the highest fertility rates in the world, at 6.1 children per woman. The country's population of 18.3 million also skews very young: 53% are under 18, and 18.3% are ages 15-24. The high rate of population growth (3.6%), combined with drought, has increased food insecurity, poverty and instability. Two-thirds of 19-year-old women are already mothers. There is low use of family planning services, with the contraceptive prevalence rate at 9.9%.

There are a number of socio-cultural barriers to family planning. Men often refuse to use contraception, and remain hopeful that they will be able to provide for large numbers of children in the future. Many Malians hold religious beliefs that children are a divine blessing that should not be prevented. There is also prejudice against and embarrassment about using family planning, and widely held misconceptions about certain methods (e.g. that the IUD causes abortions or can float around the body, or that the pill results in sterilization and causes birth defects). There are barriers to access, also; in remote areas there is low service quality and availability, and a lack of financial means to use certain methods.

EVALUATION BRIEF DESCRIPTION

At the end of SfC + Reproductive Health, Oxfam and its partners wanted to carry out a final evaluation that would be both formative and summative. This final evaluation reviews the achievements of the project with reference to the objectives and the detailed results set out in the project documents, as well as the long-term effects on the utilization of reproductive health services and family planning in the Bla health district through the influence of SfC groups. More precisely, the principal goal of this evaluation is to help Oxfam and its partners in taking strategic decisions with regard to the direction and the range of future programs in Mali and elsewhere.

EVALUATION METHODOLOGY

A mixed research approach (qualitative and quantitative) was used to respond to the evaluation questions, and followed by an analysis of the logic of program intervention, results, and impact. The evaluation was carried out in two stages. The first stage consisted of collecting qualitative data through individual interviews and group discussions with community beneficiaries and the principal players involved in the process of project implementation.

A mixed research approach (qualitative and quantitative) was used to respond to the evaluation questions, and followed by an analysis of the logic of program intervention, results, and impact. The evaluation was carried out in two stages. The first stage consisted of collecting qualitative data through individual interviews and

group discussions with community beneficiaries and the principal players involved in the process of project implementation.

The second stage consisted of conducting a survey on reproductive health to capitalize on the impact of the project and the evolution of project indicators.

FINDINGS/CONCLUSIONS

This intervention adequately addresses problems related to family planning and reproductive health faced by the women in their community due to sociocultural barriers. The women have been trained through chat sessions on reproductive health to develop their level of knowledge of family planning (FP), their self-efficacy in using contraceptives and, above all, their capacity to convince their partner to use FP. The project also worked on facilitating access to quality family planning products and services.

- Women participants had a **significant increase their level of knowledge**. More of the women are now better aware of the different types of contraceptive methods.
- An **increase in the use of contraceptive methods** has been found in project intervention zones.
- While there is some evidence of **shifting attitudes towards fertility in more urban areas, among rural women, 78.9% want another child**.
- The project certainly answers the needs of the community, in the sense that it was an opportunity to improve the level of women's knowledge of reproductive health; **but it only addresses women, even though, in the cultural context, the use of a family planning method is a decision that requires permission from husbands/partners**. Thus, raising men's awareness could not only make the women's task easier, but could also increase the rate of adoption of family planning methods (FP). The interventions were directed only at women through SfC groups. There was, however, a module for young people and the gender module for men, but the men did not participate in the chat sessions with the women.

MAIN RECOMMENDATIONS

On the whole, ground activities were not monitored rigorously enough. Ground agents raised awareness among many women and directed them to health units, such as MSI mobile units and other structures, but the project does not possess

any data on these activities. It is therefore important to reinforce the monitoring mechanism to give more visibility to interventions;

The intervention has, without a doubt, proved itself with women's groups; however, the results could have been greatly improved if the men had been involved. This is because the analysis makes it clear that the man's opinion remains the determining factor for the woman's choice. Oxfam and its partners should therefore include an activity packet intended for men.

A peer education strategy could solve the durability issue. It is not only important to train the women from SfC groups rigorously, to make them responsible, and to put a monitoring system in place to build on their activities, but also to evaluate the capabilities of people trained.

There are gaps in the modules used to train the women: the women find more illustrations necessary in the content of the modules.

The pilot project has definitely had a certain amount of impact on the attitudes and behavior of the women beneficiaries; but, unfortunately, there is no clear possibility of ensuring the durability of benefits. Creating a plan for durability is thus a priority.

Oxfam and its partners should implement a similar project of large scope in the long term to better influence mindsets and have a more durable impact on attitudes and behavior regarding reproductive health and family planning.

INTRODUCTION

OVERVIEW OF SAVING FOR CHANGE + REPRODUCTIVE HEALTH

In January 2017, Oxfam and its local implementing partner G-FORCE launched Saving for Change (SfC) + Reproductive Health in the Segou region of Mali. SfC is a grassroots approach to poverty alleviation and poverty, and the program has operated in Mali since 2005 and subsequently expanded to Cambodia, Senegal, Guatemala and El Salvador.

The basic methodology is simple: SfC empowers groups of 20 to 25 members – typically women – to meet weekly and save small amounts of money in a metal lockbox, ranging from a few cents to a few dollars. With initial training provided by Oxfam and local partners, members learn to self-manage, collectively establishing group rules on savings, loans, fines and repayment. When members meet, they also develop bonds of mutual assistance and solidarity, which builds social capital. Today, the program reaches more than 730,000 members who have collectively saved \$55 million USD.

Initially created to provide basic financial services to their members, SfC groups have shown themselves to be powerful platforms for reaching women and providing complementary services and training. Starting in 2012, Oxfam began to address requests from members through a new suite of services, trainings and products, called “SfC+”, including SfC + Agriculture, SfC + Business, SfC + Active Citizenship, and more.

Overview of Intervention Goals

SfC + Reproductive Health is a one-year pilot project implemented in the Bla health district, located in the Segou region of Mali, to reach approximately 7,200 adolescent girls and women from at least 360 Saving for Change groups. The project focuses on increasing women’s and girls’ knowledge about their reproductive health, as well as their access to adequate health services.

As noted, Oxfam’s experience with SfC has demonstrated that, in addition to reinforcing beneficiaries’ abilities and making it possible for them to mobilize their own savings and obtain attractive loans, the program has a direct impact women’s standard of living, especially in poor rural zones. SfC also helps participating women to make beneficial behavioral changes (e.g. as demonstrated in previous SfC + Health programming focused on Ebola and malaria prevention). In Mali, family planning and reproductive health are persistent needs, and given that SfC

has been firmly established in the country for more than ten years, Oxfam decided to use this platform to respond to these needs. The budget for the pilot was \$43,933 over a one-year period.

The intervention seeks to mobilize of the community power of SfC groups in the Segou region to increase women's and girls' access to information, education, and family planning services, by responding to what is currently an unfulfilled need. More specifically, key objectives include:

1. Ensuring an increase in women's and adolescents' knowledge of their reproductive health in the project zone
2. Identifying and selecting villages and SfC groups for participation in the project, based principally on the likelihood of members replicating it;
3. Promotion of the project concept to local and traditional authorities to ensure their support;
4. Developing or adapting a reproductive health and family planning module for SfC group members;
5. Recruiting and training a team of 1 supervisor and 6 animators;
6. Training and support of at least 7,200 women from 360 SfC groups on reproductive health and family planning;
7. Raising awareness, increasing behavioral changes and decisions to seek family planning services;
8. Facilitating access to reproductive health and adequate and affordable family planning services;
9. Facilitating interaction between SfC groups and family planning service providers so women can choose the services that they want;
10. Negotiating with service providers (MSI or AMPPF) to offer affordable services to women and girls.

Intervention Context

Mali has one of the highest fertility rates in the world, at 6.1 children per woman. The country's population of 18.3 million also skews very young: 53% are under 18, and 18.3% are ages 15-24. The high rate of population growth (3.6%), combined with drought, has increased food insecurity, poverty and instability. Two-thirds of 19-year-old women are already mothers. There is low use of family planning services, with the contraceptive prevalence rate at 9.9%.

There are a number of socio-cultural barriers to family planning. Men often refuse to use contraception, and remain hopeful that they will be able to provide for large numbers of children in the future. Many Malians hold religious beliefs that children are a divine blessing that should not be prevented. There is also prejudice against and embarrassment about using family planning, and widely held misconceptions about certain methods (e.g. that the IUD causes abortions or can float around the body, or that the pill results in sterilization and causes

birth defects). There are barriers to access, also; in remote areas there is low service quality and availability, and a lack of financial means to use certain methods.

Geography and Environment

Situated in the south of the Segou region, the Bla Cercle is bounded on the north by the Bani River which separates it from the Segou Cercle, on the south by the Koutiala and Dioïla Cercles, on the east by the San Cercle, and on the west by Barouéli Cercle. The Bla Cercle covers a surface area of 6,200 square kilometers with a population of 348,226 inhabitants, of whom 81,833 are women of childbearing age (SLIS Directory 2015). The Cercle has 17 rural communes: Bla, Béguéné, Niala, Tiéména, Dougouolo, Kéméni, Somasso, Samabogo, Diaramana, Kazangasso, Korodougou, Koulandougou, Fani, Yangasso, Touna, Diéna, Falo. According to the data from the General Population and Habitat Census (Recensement Général de la Population et de l'Habitat (RGPH)) of 2009, the population living in rural areas in Bla is estimated at 222,325 people, with 61,338 people living in urban areas. Bambaras, Miniankas, Peulhs, Bwas and Dogons form the principal ethnic groups. The Cercle registered a high rate of rural migration with the movement of the workforce towards urban centers and outside Mali.

The landscape consists of plains and ocean banks. Rainfall varies between 600 and 1,000 mm per year. The climate is of Sudanese type. The vegetation, which was once quite dense, is increasingly thinning. The Bani River is the principal waterway of the Cercle.

Agriculture is the principal economic activity of the villages. The Cercle's gross production of grain is estimated at 114,707 tons (2007/2008 Campaign, Regional Agricultural Directorate) of which millet was 58,128 tons, sorghum was 30,130 tons, fonio was 522 tons, maize was 19,082 tons and rice was 6,845 tons. The need for cereals was estimated at 56,095 tons in the year 2008; the need is calculated on net production on the basis of 214 kg per person per year, with the Cercle's population estimated at 262,127 inhabitants in 2008. Peanuts, watermelons, Bambara groundnuts (voandzou) and cowpeas are cash crops, and animal breeding (cattle, sheep, goats and poultry) is the second main economic activity. The presence of the Bani River promotes fishing among the riverside populations, especially with the construction of the Talo dam. Picking shea nuts is the principal harvesting activity. The artisanal activities found in the Cercle are weaving, pottery, foundry work, jewelry making, and mechanic shops. Two asphalted national routes cross the Cercle for a distance of 120 km.

KEY STAKEHOLDERS AND PRIMARY CHANGE AGENTS

Oxfam initially chose five partners to implement and scale the project: Marie Stopes International (MSI); the Malian Association for Family Protection and Development (AMPPF); G-FORCE (Training, Consultation, and Study Group); VOTO Mobile; and Family Care International.

- MSI is an important provider of family planning services in Mali. For many years MSI has offered several kinds of contraceptives at affordable prices both in cities and in the most remote rural localities through its social franchise network and its mobile teams.
- AMPPF has experience in offering family planning services in sexual and reproductive health (SRH), in counseling, neonatal health, gynecology, postnatal and post-abortion care; the prevention and management of HIV and AIDS, particularly voluntary counseling and testing (VCT) and community-based distribution (DBC) of contraceptive products.
- G-FORCE, a Malian NGO, supports basic efforts related to socio-economic and environmental development communities. G-FORCE is the executive partner in this project, supporting Oxfam in appropriately training ground agents and in collaborating with other Oxfam partner organizations during the development of family planning training modules.
- VOTO Mobile is the promoter of a successful mobile education/information program that adequately reaches women in rural zones to educate them on health.
- FCI has been operating in Mali since 2002 and has been internationally recognized for its advocacy work and programs that promote sexual and reproductive health, especially for adolescent girls.

However, not all of the intended partners participated in the pilot phase; the active stakeholders were Oxfam, G-FORCE, AMPPF, MSI and VOTO Mobile. Oxfam created training modules intended for SfC groups, and AMPPF provided technical support (information on family planning and reproductive health). Oxfam also ensured the training of the project team. G-FORCE executed the project in the Bla health district, i.e. by training women's groups. MSI and CSCom ensured the provision of FP services; MSI, in particular, allowed many women in the Bla health district to have access to long-term methods such as implants and IUDs. It must be noted, however, that collaboration with MSI was mainly ad hoc, since Oxfam and MSI were not able to formalize their partnership during this phase. During the project, VOTO Mobile broadcast educational information on family planning and reproductive health via mobile networks in the intervention zones.

EVALUATION FRAMEWORK

EVALUATION PURPOSE

At the end of SfC + Reproductive Health, Oxfam and its partners wanted to carry out a final evaluation that would be both formative and summative. This final evaluation reviews the achievements of the project with reference to the objectives and the detailed results set out in the project documents, as well as the long-term effects on the utilization of reproductive health services and family planning in the Bla health district through the influence of SfC groups. More precisely, the principal goal of this evaluation is to help Oxfam and its partners in taking strategic decisions with regard to the direction and the range of future programs in Mali and elsewhere.

The evaluation addressed the following questions:

1. To what extent was the project approach appropriate for improving women's knowledge on reproductive health and family planning in the communities benefiting from the project? To what extent has the project initiative contributed to the fulfillment of program objectives? (Relevance)
2. Did the project function well and were the resources well mobilized? Under what conditions of quality, cost and time were the expected results obtained? (Efficiency)
3. What changes in family planning behaviors, attitudes and practices did people adopt the most, following project interventions? To what extent was the level of women's knowledge on family planning and STIs improved? (Impact)
4. To what extent could the involvement and the effects of increased capacity of the players continue to remain after the project? What are the lessons to be learned for a similar intervention? (Durability)

EVALUATION METHODOLOGY

A mixed research approach (qualitative and quantitative) was used to respond to the evaluation questions, and followed by an analysis of the logic of program intervention, results, and impact. The evaluation was carried out in two stages. The first stage consisted of collecting qualitative data through individual interviews and group discussions with community beneficiaries and the principal players involved in the process of project implementation.

The second stage consisted of conducting a survey on reproductive health to capitalize on the impact of the project and the evolution of project indicators. To do this, we consulted the Malian Demographic and Health Survey of 2012-2013 and used a large part of the questions of the survey. This choice can be explained, on the one hand, by the absence of a control group for this pilot project; it had a high chance of being “contaminated” because of the conflict and instability in the country. Thus, aligning with the DHS allowed us to compare our program participant population to a nationally representative Malian sample. Furthermore, given the huge presence of SfC groups in Mali and the country’s unmet family planning needs, understanding our results in the national context helps us better grasp possible opportunities for scalability. To this end, a large part of the DHS questionnaire relative to socio-demographic characteristics, reproductive health, and family planning and gender issues, was borrowed and used during this evaluation for comparison with project results.

Data Processing and Analysis

The qualitative data was captured in Microsoft Word, and subsequently coded and synthesized in a matrix created in Microsoft Excel. Content analysis was used to identify and compare key concepts with the coded data clusters, depending on the type of respondent. Data analysis by triangulation was used to identify only those concepts which could be validated through a combination of data sources such as different interviews and group discussions. Quantitative data was imported in SPSS 23 to be cleaned and analyzed. The analysis consisted of highlighting the relevance, efficiency, efficacy, impact, and durability of project interventions, given their objectives. A summary description of the evaluation criteria and rating methodology is provided in the Annex.

Sample Description

For the qualitative portion of the evaluation, the team originally planned to conduct 11 individual interviews (4 with SfC program staff, 3 with implementation partners, and 4 with community leaders and local authorities). The team also planned 8 group discussions with SfC members in the 15-45 age group. However, the evaluators were able to carry out 9 interviews, and held 8 group discussions (2 with male participants and 6 with female participants). The minimum age of participants in the qualitative section was 19, and the maximum was 64 years. Other than some participants who had some level of primary education, the majority had no education. The choice of participants was made based on their knowledge of or their involvement in the project implementation. For the quantitative section, a survey with a total of 1,073 individuals was planned, with 1,000 women between 15-49 years of age and 73 men in a total of 23 sample villages. At the end of the data collection, 1,039 individuals were surveyed, with 1,027 women representing 98.8% of the sample, and 12 men, i.e. 1.2%.

The average age of the persons surveyed was 30.37 years, and a minimum age of 15 and a maximum of 49. Grouping the survey respondents by age, we see that those between the ages of 15-19 years represent 4.9%, between 20-24 years 19.6%, between 25-29 years 23.9%, 30-34 years 18.6%, 35-39 years 17.7%, 40-44 years 11% and 45-49 years 4.3%. With regard to place of residence, 82.3% of the persons surveyed came from rural areas and 17.7% from an urban area, the city of Bla. 52.8% of the respondents were members of SfC groups. The majority of the respondents had never been to school (82.8%). In the project intervention zone, the majority are of Bambara ethnicity (74.2%), followed by Minianka/Sénoufo (16.2%); all the other ethnic groups of the country live there, but each of them constitutes less than 2% of the population. Among those surveyed, 97.3% are Muslims, 1.2% do not practice a religion, 1% is animist/other.

Data Collection Process

Data collection took place in the Bla Cercle during the period 17th January to 6th February 2018. Two teams of 5 agents each collected data, with one supervisor and four research assistants in each team. For collecting quantitative data, the collection agents used a tablet, with the questionnaire configured on the KOBO Collect application. For qualitative data, they used digital recorders and proceeded to take notes used for data collection. The collection started every morning around 7 am and often ended late in the night. The quantitative data was systematically saved on a server after the interview was recorded, and the qualitative data was recorded and saved on the server as well. On the ground, the collection agents often went door to door, or went to the fields to find eligible people.

EVALUATION LIMITATIONS

It was initially planned to carry out surveys of 1,073 subjects, 1,000 women who were members of SfC groups and 73 men, in a total of 34 villages. But this quota was not reached as only 1,039 individuals could be polled. This can be explained by the fact that the majority of men approached did not wish to participate in the survey, on the grounds that they did not know anything about project activities. The evaluators' hypothesis is that the men do not feel connected to SfC groups and their activities, since they were not associated with them previously. For this reason, the assessors find it more relevant to focus data analysis on the women surveyed.

Moreover, as a result of the implementation, project activities have been extended to other women of the community who are not members of SfC groups, in order to reach more women of childbearing age. Thus, the sample includes both SfC group members and non-members.

Due to a lack to time, the number of interviews planned for the qualitative phase could not be completed; 9 interviews were carried out instead of 11.

Initially, at the village level, the evaluators were expected to create a list of all the members of SfC groups, and randomly draw the number of respondents required. This procedure could not be carried out because of the women's mobility. Reaching the quota of women to survey was difficult throughout the collection and in every locality. Because of this, the collection agents were obliged to give priority to the eligible women available before spreading out to search for the remainder.

Since there is no list of indicators for activities and a lack of baseline survey data, it is not easy to objectively appreciate the progress made. The results of this evaluation have therefore been compared to DHS urban and rural data from the Segou region to which Bla belongs, because the DHS database to which the evaluator had access is not broken down to the Cercle level. In certain cases, these results have been compared to DHS at the national rural level, since it was not possible to do so with rural Bla and the region. In addition, it is not possible to systematically compare certain variables from our survey to those of DHS, since they are not expressed in the same manner.

EVALUATION FINDINGS

This intervention adequately addresses problems related to family planning and reproductive health faced by the women in their community due to sociocultural barriers. The women have been trained through chat sessions on reproductive health to develop their level of knowledge of family planning (FP), their self-efficacy in using contraceptives and, above all, their capacity to convince their partner to use FP. The project also worked on facilitating access to quality family planning products and services.

The results of this survey show early sexual activity in the studied localities. The average age for the first sexual intercourse is 16.7 years for all of the women, and an average of 15.5 for the segment 15-19 years. At least 35.1% of the women interviewed had had sexual relations for the first time between 9 and 15 years of age, of whom 2% were aged between 9 and 12 years.

Table 1: Knowledge of contraceptive methods, % of respondents

Method, knowledge of	Oxfam Participants	Malian Population (DHS)
Female sterilization	76.1%	37.5%
Male sterilization	38.4%	20.4%
Birth control pill	98.1%	78.3%
IUD	91.1%	46.8%
Injection	99.4%	74.7%
Implant	99.4%	65.8%
Male condom	97.1%	63.3%
Female condom	82.7%	35.4%
Lactational amenorrhea (LAM)	68.5%	43.9%
Morning after pill	52.7%	18.9%
Withdrawal	51.3%	30.7%
Rhythm method	89.1%	49.6%

The average age for first marriage is estimated at 17.6 years. At least 24.3% of the women participating in this study were married before the age of 16 (between 12 and 12 and 15 years of age). Almost all of the women interviewed (99.3%) during this evaluation were married, and 52.6% of these women are in a polygamous marriages.

At the end of this evaluation, women participants had a significant increase their level of knowledge. More of the women are now better aware of the different types of contraceptive methods. The following comparison

between the results of this evaluation and those of Demographic and Health Survey (DHS) shows that the percentage of women supervised by the project who

know each type of method now is higher than the percentage of women who knew the types of methods during DHS 2012-2013.

An increase in the use of contraceptive methods has been found in project intervention zones. Compared to the results of DHS, the rate of injectable use grew from 4.1% to 44.7%, implants from 2% to 28.7%, the pill from 3.4% to 15.2% etc.

In order to facilitate access to family planning products and services, project agents have served as intermediaries between CSCoM, the MSI mobile team and the women in the supervised villages. Thanks to this synergy of action, many women have been able to make use of quality contraceptive methods. The observations made during this study show that the principal sources of supply for contraceptive products for the women of the Bla healthcare district, were, respectively, mobile teams (40.3%), CSCoM (14.2%), ground agents/community agents (12.2%), medical services of other NGOs (12%), public health centers (11.7%), pharmacies (6%), private medical practitioners (3%) and clinics (0.4%).

Nevertheless, a lot of effort remains to be made to tackle the challenges involved in making the knowledge gain sustainable. It is regrettable that there is, firstly, a lack of consistency in the training of peer educators, and secondly, the lack of an adequate monitoring mechanism to capitalize on the project's efficacy in directing the women towards structures specialized in offering services.

The data on fertility preferences should demonstrate the impact of the project, given that the principal objective is to influence the beneficiaries' attitudes and perceptions on reproductive health and family planning. Some fertility data from this study could be perceived as an indicator of a mindset change. But this indicator of change is noted uniquely in the urban areas of Bla where 50% of the women questioned would have liked to have another child, while this rate was 70% among DHS respondents. Also, the percentage of women who did not wish to have more children is 50% in urban areas of Bla district, and 9.9% for the Segou region, according to DHS. This aspiration to limit births is most prevalent among women in their late 30s (25% of women between the ages of 35-39 years).

Contrary to the hope of change noted in the urban areas, the results lead us to believe that mindsets have not changed with regard to fertility in rural areas. The women in the project intervention zones experience a stronger than ever desire to procreate. The percentage of women who wished to have another child during the DHS survey was 70% for the Segou region, but the current evaluation shows a percentage of 78.9. The percentage of women who do not want more children is estimated at 18.3% with only 13.2% for SfC, and the number of undecided women has moved from 6.2% to 8%. It is, however, difficult for the pilot project to have had a strong impact on fertility in such a short time.

RELEVANCE OF PROJECT ACTIVITIES AND RESULTS

Score: Satisfactory ★★★★★

The principal goal of the project was to inform women about contraceptive methods, the importance of family planning, the prevention and treatment of Sexually Transmitted Illnesses (STIs), and the importance of communication between the couple. Implementation of the project was carried out in three stages: 1) recruiting and training agents, 2) launch, and 3) activities on the ground. In accordance with specific objectives 4 and 5, G-FORCE and Oxfam recruited a supervisor and 6 ground agents at the end of a selective process. These agents underwent a 10-day training on animation techniques and the utilization of support modules developed by Oxfam for training women. The goal of this training was to get the agents to perfectly master the 7 support modules in order to be able to replicate them.

On the ground, the goal assigned to each agent consisted of identifying 15 groups of women in each commune for training in the 7 modules. At the end of the project term, all the agents exceeded this initial goal. The project team worked to exceed the goals both in terms of number of groups led as well as the number of women trained at the village level. Initially, the goal was to train at least 7,200 women coming from 360 SfC groups on reproductive health and family planning. But at the end of this evaluation, the assessment showed that 433 SfC groups were supervised, 10,593 women reached, and 6,417 peers educated.

“I had to supervise 15 groups and I exceeded the number everywhere. Because in some localities, there are more groups than envisioned and it is not possible to choose some and drop others. That is why I supervised all of them.” - Project Staff

All the stakeholders in this evaluation endorse the relevance of the program, which they see as an opportunity to address family planning and reproductive health problems that the women of their community face; the needs of these women, like so many other women in Mali, were not met because of socio-cultural barriers that do not encourage discussions on these subjects, let alone access to these services.

The project owes its success largely to the implementation strategy adopted to roll out its activities. During the project creation process, G-FORCE involved different players, and at all levels. At the district level, the project was introduced to the administrative authorities and the Health departments' technical services. At the Commune level, it was introduced both to Commune and traditional authorities, CCom health agents, leaders of women's groups and representatives. All were involved, based on level, in identifying intervention villages. Above all, the project

was able to properly exploit the mobilization capacity of local players such as community representatives, women leaders and village chiefs.

"Since that day, they decided to involve community leaders (collectives, women leaders and traditional authorities) through meetings; to inform them first about project goals... Me, personally, I focused on community representatives who are very important in villages. After that, we search for the women's president and representatives so that they mobilize the women.... The women generally listen to the presidents of the women's associations.... There are also certain village chiefs who, seeing the low productivity of their representatives, get involved and achieve a large mobilization." - Project Staff

The process aimed to obtain a commitment from stakeholders at all levels, as anticipated in specific objectives 2 and 3 of the project document. These are about identifying and selecting villages and SfC groups, and promoting the project concept to local and traditional authorities to ensure their support, an advantage for the project. The district-level partners facilitated the introduction of the project at the communal level. According to the different data sources, the partners at the local level, i.e. village chiefs, leaders of women's groups and community representatives, supported the animators in their activities. At the village level, these players were effectively involved in mobilizing women to make them participate in conversations. Thus, based on qualitative work, we can conclude that all the obstacles to accessing training were sufficiently overcome.

The evaluators find that the different activities deployed within the implementation framework are all in accordance with the specific objectives 1, 2, 3, 4 and 5 listed above. Triangulating the data showed consistency in the information collected from the different players involved in the implementation, with all of them agreeing unanimously as to the relevance of the activities carried out. Thanks to objectives and activities being in harmony, and the consistency between the different sources of information, project relevance obtains a satisfactory score estimated at five stars.

COST EFFECTIVENESS

Score: Attention Required ★★★

One of the evaluation questions was about the assessment of human resources and materials allocated to this project. The evaluators noted an acceptable assessment by G-FORCE staff, who found that the resources allocated allowed them to successfully complete the mission assigned to them. Nevertheless, satisfaction with the resources allocated for activities was not up to the level desired. For example, some agents were not satisfied with the quality of motorcycle helmets, and the lack of rain gear for riding motorcycles in the rain.

Others regret the lack of a budget line for communication, since they make a lot of telephone calls to plan activities; or they would better like an increase in salary.

In addition, the time allocated for project implementation by ground agents is not found to be fully satisfactory, and discrepancies are seen. In fact, some people were not convinced that the allocated time was sufficient for the modules to be well absorbed by the beneficiaries, given the difficulties in mobilizing women.

The project certainly answers the needs of the community, in the sense that it was an opportunity to improve the level of women's knowledge of reproductive health; but it only addresses women, even though, in the cultural context, the use of a family planning method is a decision that requires permission from husbands/partners. Thus, raising men's awareness could not only make the women's task easier, but could also increase the rate of adoption of family planning methods (FP). The interventions were directed only at women through SfC groups. There was, however, a module for young people and the gender module for men, but the men did not participate in the chat sessions with the women.

"It is important to train men as well; often, when I'm organizing, they come and ask me why they are told that it is only the women who should take part in activities, and they suggest to us that they be involved as well." - Project Staff

The participants raised an additional aspect that the project should have considered, the pictorial illustrations contained in the training materials; i.e., the women did not like the fact that only the first module was illustrated with an image, while the others did not have any. The women continued to ask for images for the other modules.

The project trained women from the SfC groups beyond the fixed goal; nevertheless, there was no mechanism in place to test the quality of the completed training. In other words, there is no data which allows the level and the proficiency of the peer educators trained by the project agents to be evaluated.

There were a lot of complaints about the resources deployed. The ground agents deplored the lack of a communication budget and the lack of adequate protective equipment. In addition, the assessment revealed a lack of support in monitoring women's referrals to other organizations and evaluating the level of people trained by the project, especially the peer educators who are meant to replicate knowledge in the community. Based on these statements the evaluation team gives a score of three stars, "Attention Required," for project efficiency.

EFFICACY

Score: Satisfactory ★★★★★

Objectives 8, 9, 10 of the SfC project consisted of facilitating access by women of childbearing age from the beneficiary communities to reproductive health services and adequate family planning services, facilitating interaction between SfC groups and the suppliers of family planning services in order to choose the appropriate services desired, and negotiating with the service providers (MSI or AMPPF) to offer affordable services to women and girls. All these objectives were largely covered in the project implementation.

The flexibility of the project in adapting to on-the-ground realities proved the project's efficiency in reaching these objectives. The ground agents needed to identify 15 groups at the level of each commune in the priority target group i.e. the SfC groups, and train the women of childbearing age (15-49 years) in these groups on different family planning and reproductive health techniques, but the on-the-ground reality was completely different. There were few women of childbearing age within the SfC groups, as the majority of them had crossed this age bracket. Thus, G-FORCE was forced to rethink its strategy in order to reach women of childbearing age in the communities. First, while still keeping the women who had crossed childbearing age, they opened the chat sessions to all groups and to all women who belonged to the required age group. The ground agents were able to convince many women's groups that were affiliated with SfC groups on the different types of contraceptive methods and the importance of contraceptive family planning products. They also directed the women towards organizations that specialized in offering services, such as CSCom and Marie Stopes International etc.

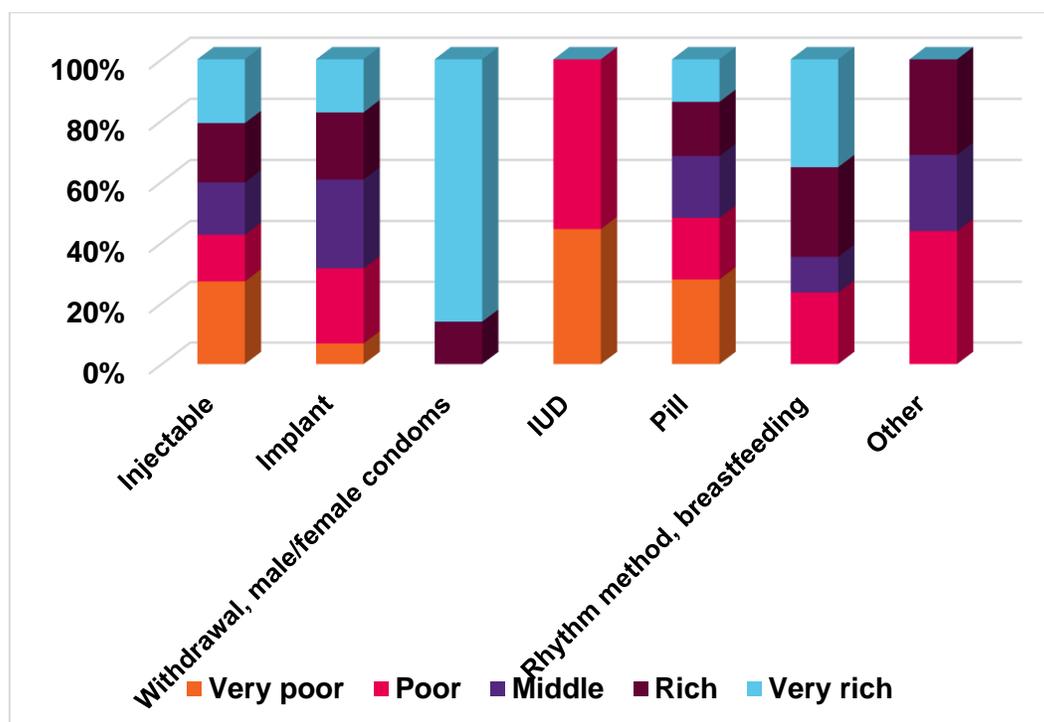
The project's principal mission was to inform women about the advantages of contraceptive products, to get them to use these appropriately, and to inform them about Sexually Transmitted Infections (STIs); the project, however, does not offer services. Because of this, it collaborates closely with the Community Health Services (CSCom) to facilitate women's access to contraceptive products and refers them to appropriate treatment for STIs. Similarly, G-FORCE came to collaborate with the mobile unit of Marie Stopes International. That is, in the course of their activities, the G-FORCE animators make a list of women who wish to adopt a contraceptive method and coordinate with the mobile unit of Marie Stopes which provides the services. In this manner, the project agents served as facilitators between the women of the villages served and MSI. This synergy of action facilitated women's access to FP methods, and allowed Marie Stopes to access beneficiaries; in return, the project also gained the women's confidence.

A significant increase in the use of contraceptive methods has been noted in the project intervention zones. The contraceptive methods currently used by the

women in the intervention zones of the project are, respectively, injectables (44.7%), implants (28.7%), the pill (15.2%) and other methods (traditional in general) used by 4.6% of the responders. The rate of utilization of the LAM method, the rhythm method and IUDs is 1.8% for each of these methods. The male condom is used by 0.7% of the women interrogated, the female condom by 0.4%, and the withdrawal method by 0.4% as well.

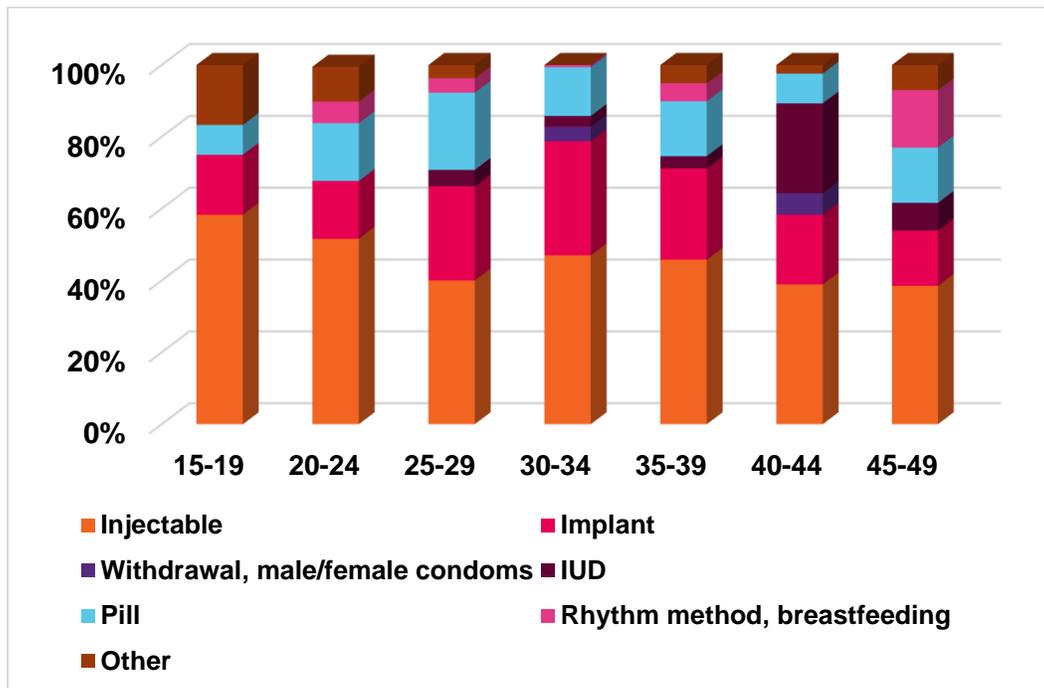
This information can be analyzed according to certain socio-demographic characteristics such as age, areas of residence, and the kind of household.

Figure 1 - Methods used by socioeconomic status



According to age, we see that the injectable method is used by more than half the women: in the age group 15-19 years and 20-24 years, the rate is 58.3% and 51.6%, respectively. It is used a lot more by a large section of women in households that are classified as very poor (68.5%). The results of this analysis show that unlike injectables, the rate of usage of implants is quite low with women in the age group 15-19 years and 20-24 years. Women from urban areas use the pill more than those from rural areas (26.1%, against 14.3%). In addition, the proportion of women using other methods is higher with women in the age group 15-19 years and 20-24 years. The male condom is used more in urban areas (8.7%), and by women coming from households considered as very rich (11.1%).

Figure 2 – Method used by age group



The methods used the most, according to DHS, were: injectables (4.1%), the pill (3.4%), implants (2%), IUDs (0.2%), condoms (0.1%) and other methods (0%). A comparison between data from DHS and data from this evaluation shows a remarkable development in the rate of use of different types of available contraceptive methods. The rate of use of the types of methods in the DHS survey for the Segou region is significantly lower than the current rate in the SfC zones. In addition to the growth in the rate of use, we also see that implants are becoming the second-most used contraceptive method after injectables in rural and urban areas.

During DHS, the sources of supply for contraceptives were, in order of importance, CSCom (61.3%, of which 64.2% in rural areas and 50% in urban areas), pharmacies (14%), CSRèf (referral health centers) (6.4%), dispensaries/maternity units (5.2%), mobile vendors (5%), Community-Based Agents (ADBC) (4%). Of the other equally important sources, these were listed: private doctors (1%), other private medical sector (1%), care centers (1%), friends/family (1%), national hospitals (0.6%) and regional National (0.6%). According to the same source (DHS), the referral health centers (CSRèf) and pharmacies were the most important sources for persons living in urban areas.

From these results, we observe a remarkable change in the access to contraceptive products. The principal sources of supply for contraceptive products for women in the health district of Bla were, respectively, mobile teams (40.3%), CSCom (14.2%), Ground agents/community agents (12.2%), medical services of

other NGOs (12%), Public Health Centers (11.7), Pharmacies (6%), private medical practitioners (3%) and clinics (0.4%). An analysis based on the type of residence proves that mobile units are currently the first source of supply for women residing in rural areas (41.6% against 7.1%). On the contrary, CSCom (39.3% and 13.3%), Public Health Centers (25% et 11.1%) and private medical practitioners (25% et 2.3%) were the most common sources for residents in urban areas. See the table below.

This progress could be attributed to the SfC project, which, in accordance with one of its objectives, aimed to improve the knowledge of people living in the health district of Bla, and to solve their unmet FP needs by giving them the right information and facilitating their access to quality contraceptive products. The increase in the rate of implants, for example, is doubtless a result of the synergy of action between G-FORCE and the mobile units of MSI on the ground.

Almost all the women (99.1%) in the project zones had already heard of HIV/AIDS. The current level of knowledge on the means of transmission of HIV has not practically changed since DHS. More than 30% of women think that HIV can be transmitted through mosquito bites, while more than 20% believe that HIV can be contracted by eating with an infected person. As for prevention, many women mentioned the use of condoms and fidelity, for the most part. On the whole, a lot of effort remains to be done to improve the level of people's knowledge with regard to HIV prevention and transmission methods.

96.3% of women did not use a condom during their first instance of sexual intercourse. For their last sexual intercourse, only 2.1% of SfC responders had used condoms. The Sexually Transmitted Infections (STIs) most known by women of SfC groups, classed in decreasing order: Trichomoniasis (47.0%), Gonorrhoea (24.6%), Syphilis (21.3%), Chlamydia (5.0%), Chancre (2.1%). According to the women, the methods to prevent STIs are: good management of sexual relations (58.7%), use of condoms (20.8%) and hygiene (20.5%).

The results obtained are in harmony with the objectives 8, 9,10. The collaboration with CSCOM and MSI seems to have worked well, but this referral system was not documented due to the lack of a monitoring mechanism. There is no data available on the number of women referred to CSCom and to Marie Stopes. Thus this evaluation does not have enough elements to estimate its efficacy objectively. The quantitative and qualitative data together substantiate an evolution in knowledge and attitudes. Efficacy is judged to be satisfactory and gets five stars.

IMPACT

Score: Satisfactory ★★★★★

The implementation of this project was challenging because of the sociocultural context of the intervention zones. According to G-FORCE agents, one of the challenges was the acceptance of the program by the beneficiary communities, because of the taboo existing around the themes tackled and the men's reluctance towards family planning. First of all, subjects related to sexuality were taboo: they could not be discussed with everyone, even less publicly during chat sessions. A potential exchange project on family planning and reproductive health was immediately found to be awkward. They also had negative ideas about planning because of erroneous information that they had on modern methods of family planning.

"In certain villages, the men did not much like our talking about planning... The women had information on family planning. But they did not practice it, because of negative and unfounded rumors.... Some pockets of resistance were everywhere, except in one village where one directly felt that the people did not like it at all." - Project Staff

Communication between partners on family planning is not an easy thing. In fact, during group discussions when the women were asked about the different circumstances under which women could talk about spacing births with their husband, a large section of the respondents generally felt that it is not possible to broach the subject until after a sad event is experienced by the couple due to the consequences of close births, such as postnatal mortality or financial difficulties. They find that under such circumstances, it is the woman who is obliged to initiate the debate.

2 A: Men don't have think about it the same way. Our husbands are proud of having many children, they say that before the hospitals arrived, childbirth happened anyway. They don't give in unless there are serious problems.

2 F: If we can't afford more children.

2 J: For us, they have to really feel the problems before they'll agree to family planning.

- Excerpts from a women's focus group

At this point, all the respondent categories for the qualitative section of this evaluation, i.e. women from SfC groups, leaders, project staff, are convinced that the chats had the effects hoped for. They confirm that the chat sessions allowed the women to be better informed on the different FP methods and how to access them. They also find that the women became aware of the scourge of STIs, which

they had not known of as diseases. The staff finds that the women's knowledge has improved with regard to the recognition, methods of prevention, and treatment of STIs. These impressions are partly confirmed by the quantitative information. The table below gives us an overview of current perceptions of contraceptive methods.

Table 2 - Beliefs related to contraceptives

Belief	Completely agree	Do not agree at all	Do not agree	Agree
It is acceptable that a woman initiates the conversation with her husband about the use of contraceptives	65.2	1.3	5.9	27.7
People who use family planning methods end up having health problems	3.9	31.1	39.7	25.3
Contraceptives can cause damage to your uterus	3.0	38.3	43.9	14.8
Contraceptives reduce a woman's libido	2.8	47.4	36.2	13.6
Contraceptives can cause cancer	2.0	44.2	44.3	9.5
Contraceptives are dangerous to health	11.9	33.0	39.7	15.3
Women who use family planning /spacing of births can become promiscuous	2.0	66.1	21.1	10.8
A man should accompany his wife to the health center for family planning	65.9	2.7	10.0	21.4
You could initiate a conversation with your partner about family planning/ spacing of births	67.4	2.9	3.6	26.2
You could convince your spouse/partner to use a family planning method/spacing of births	55.1	3.4	10.9	30.6
You could get yourself to a site where family planning methods/spacing of births is offered if you want to use one of these	55.5	0.7	5.4	38.4
You could obtain a family planning method/spacing of births if you decide to use one of these	50.1	1.1	6.2	42.6
You could use a family planning method/spacing of births, even if your partner does not wish it	17.4	48.9	17.7	16.0
You could use a family planning method/spacing of births, even if none of your friends or your neighbors use them	63.0	3.6	3.3	30.1

You could use a family planning method/spacing of births, even if your religious authority does not think that you should use them	58.5	4.4	7.4	29.6
You could continue to use a family planning method/spacing of births, even if you experienced side effects	9.2	33.6	34.7	22.4

The data in this table, in fact, indicates that communication between partners has taken off. For example, 67.4% of women affirm that they are completely capable of initiating a conversation with their partners on family planning/spacing of births, 26.2% are also in agreement, 55% of women completely in agreement, 30.6% agree that they could convince their spouse/partner to use a family planning method/spacing of births. This information allows us to also understand that the women are less influenced by their religious leaders and by their family members. Despite the strengthening of women's self-efficacy, they remain largely dependent on their spouse's opinion about adopting a contraceptive method. A large majority of women (66.6%) do not think they are able to use a family planning method/spacing of children if their partner does not wish it. Besides, the capacity of the women to resist the problems caused by side effects is also low; 68.3% of women don't feel able to continue using a family planning method/spacing of births, after having experienced side effects. Contraceptive methods currently abandoned in SfC zones are: injectables in 63.3% of cases, implants 16.6%, maternal breastfeeding 14.8%, male condom 3.3%, IUD 1%, rhythm method 0.5, withdrawal method 0.5%. The first reason evoked by 51.2% of these women is that they abandoned the method because they wanted to have a child, 14.3% decided to abandon it because of side effects (uninterrupted/prolonged periods, abdominal pain), the same proportion because of complications, 14% for other, unspecified reasons, and only 6% stopped because they intended to change the method.

To estimate the self-efficacy of women in procuring a contraceptive method for themselves, during data collection they were invited to make a choice between these response modalities: "A little confident," "Very confident," "Not very confident," "Not confident at all" as a response to the question "*How convinced are you of your ability to obtain a contraceptive method?*" From the responses collected, we can deduce that the women's self-efficacy has strengthened, since 61.9% of women declare that they are *very confident* of obtaining a contraceptive method, 27.4% of them estimated that they were *a little confident*, 6.5% are *not very confident* and 4.2% are *not confident at all*. This analysis reveals a link between capability and women's buying power. The women from rich and very rich households have more confidence, they are *very confident* at 94.7% and 68.2%.

Among the women aged between 15-49 years, who had already had sexual relations, the percentage who declared having had STI symptoms was high in the SfC zones. Those who had abnormal and malodorous vaginal discharges were

estimated at 34%, and 20% had a sore or a genital ulcer. The data for rural areas in DHS for the same symptoms shows 20% and 25%. Among the project beneficiary women who declared they had had an STI, 58.2% sought a consultation in a health establishment or with a health agent. The majority of women, i.e. 56%, went to a CSCoM, 18.1% went to a public hospital, 7% consulted a ground agent/Community Health Agent.

With regard to behavior, we observe a discrepancy: of 94.4% of women who declared having had sexual relations during the last 12 months, only 2.1% had used a condom.

The results of this evaluation on the poverty threshold make a clear statement. Data interpretation clearly shows that the rate of SfC households classed as rich is distinctly higher in rural areas (38.4%) than urban areas (35.3%). It is the same for average households, 17.4% and 13.7%. The rate of poor households is also higher in urban areas of the district (27.5% against 24.3%). As for the rate of very poor households, it is a little bit higher in rural zones (13.3 % vs. 12.7%). These results give a ray of hope for the economic development of women. A large majority of the respondents undertake some revenue making activity, and only 3.8% of the people surveyed did not have any revenue generating activity. The most important revenue-generating activities of the women in this locality are, among others, commerce (37.2%), agriculture (29.6%) and truck farming (24.5%). At least 50% of the women in the group manage their revenue autonomously. Some women involve their spouse in the management of their revenue, i.e., at least 23% of women; for 24.4%, it is squarely their spouse who makes the decisions. In contrast, 20% of them are involved in the decision-making process in the use of their husband's resources. Some relevant observations surface from this analysis. First of all, the percentage of women who manage their own revenue alone has reduced in comparison with DHS (74%); on the other hand, the rate of women who make decisions along with their spouse has increased in the SfC zones (23% against 5.4%). 65% also think that the woman should play a role in making decisions within the community and in the household.

Furthermore, we see that the women give more importance to men's role in society. The majority of women, almost 87%, *Completely Agree* that the man should have the last word in decisions concerning the use of health services by members of his family, 73.5% find that the man should have the last word concerning his children's education, 27.2% find that it is more important to enroll boys in schools rather than girls.

Table 3 – Beliefs related to decision-making

	Opinions			
	Agree a little	Completely agree	Don't completely agree	Don't agree at all
It is more important to enroll boys in school than girls	6.3	27.2	29.9	36.6
A man should have the last word concerning his children's education	3.8	73.5	18.9	3.8
A woman should play a role in community decision making	21.5	64.8	10.5	3.3
A woman's work is essentially to take care of the house and to cook for her family	13.6	43.0	24.5	18.9
The man should have the last word in decisions concerning the use of health services by his family members	4.1	86.8	7.8	1.3
A woman should play a role in decision making concerning the household	21.8	64.9	10.4	3.0

The project's impact is visible with regard to the improvement in the knowledge level of the beneficiaries on the types of contraceptive methods and STIs. It is similarly felt in the use of contraceptive methods, particularly long-term methods. The impact is additionally visible in the use of appropriate health services for obtaining a family planning product and for the treatment of STIs. These results conform to the project goals as well, and are confirmed by the different data sources. The impact can be judged satisfactory, meriting five stars.

DURABILITY

Score: “Problematic”★★

Long-term perspectives are not consistent; they do not conform to any mechanism. According to the players questioned, Oxfam and G-Force can rely on the commitment of opinion leaders such as village chiefs, community representatives and women leaders.

They also rely on the competency of peer educators, that is, the women beneficiaries charged with transmitting the information received in the chat sessions to their near ones. This is because, according to the project agents, the women beneficiaries could bring other women whom they could sensitize from the eighth session onwards. These women were chosen based on their ability to acquire basic knowledge.

The G-FORCE players on the ground also think that the intervention has kindled growing enthusiasm among women in favor of family planning methods.

The communities do not feel well enough trained to do without project support as they say that the great majority of the communities, especially the men, have not yet understood the issues. Peer educators need more training to be able to assimilate all the modules well.

Throughout the collection, the evaluators did not identify either medium or long-term durability processes. The efficacy of the peer education system implemented remains to be proved. From this analysis, we can deduce that durability perspectives are practically nonexistent. Project durability is considered as problematic, meriting two stars.

CONCLUSIONS AND RECOMMENDATIONS

Generally speaking, there was no major problem in the implementation of the project. The intervention conforms to the objectives established in the project documents; the different stakeholders confirmed the relevance of the activities carried out. Mobilizing and involving resources such as community leaders, traditional authorities, and local collectivities during the process of identifying villages for interventions and groups was an advantageous move.

The observations from this evaluation show an improvement in the knowledge level of the women targeted by the project. There is an increase in access to quality services and in the utilization of contraceptive products, particularly implants. Nevertheless, the different activities lacked adequate monitoring. This evaluation underscores the lack of support in gathering and capitalizing on information from project participants. Similarly, there was no consistent training for the peer educators who were supposed to inform the other members of their community, and even less support for monitoring their activities.

The approach, intended to sensitize members of groups and women of childbearing age in general, was efficient in improving knowledge, attitudes, and practices regarding family planning. Beneficiaries were able to influence their family circles, especially those who were married. This influence is visible through the improvement in communication between spouses.

Nevertheless, the evaluators recognize that this project is in an embryonic stage, and therefore, the gains are fragile and need improvement. In addition, despite the results obtained, we see that mindsets have not changed much with regard to fertility. More than ever, the project beneficiary communities support having a large number of children. The percentage of women who wish to have another child during the DHS survey was 70% for the Segou region, but this evaluation demonstrates that 78.9% of women participating in this project feel the same. A project of larger scope will need to be implemented if we hope to influence mindsets more profoundly.

RECOMMENDATIONS

On the whole, ground activities were not monitored rigorously enough. Ground agents raised awareness among many women and directed them to health units, such as MSI mobile units and other structures, but the project does not possess

any data on these activities. It is therefore important to reinforce the monitoring mechanism to give more visibility to interventions;

The intervention has, without a doubt, proved itself with women's groups; however, the results could have been greatly improved if the men had been involved. This is because the analysis makes it clear that the man's opinion remains the determining factor for the woman's choice. Oxfam and its partners should therefore include an activity packet intended for men.

A peer education strategy could solve the durability issue. It is not only important to train the women from SfC groups rigorously, to make them responsible, and to put a monitoring system in place to build on their activities, but also to evaluate the capabilities of people trained.

There are gaps in the modules used to train the women: the women find more illustrations necessary in the content of the modules.

The pilot project has definitely had a certain amount of impact on the attitudes and behavior of the women beneficiaries; but, unfortunately, there is no clear possibility of ensuring the durability of benefits. Creating a plan for durability is thus a priority.

Oxfam and its partners should implement a similar project of large scope in the long term to better influence mindsets and have a more durable impact on attitudes and behavior regarding reproductive health and family planning.

REFERENCES

Termes De Références : Évaluation du projet « Épargner pour le Changement comme plate-forme pour améliorer la Santé reproductive des femmes et des filles dans la région de Ségou (Mali) ». OXFAM. (Juin 2017)

<http://docplayer.fr/35710190-Region-de-segou-cercle-de-bla.html> : « Synthèse des plans de sécurité alimentaire des communes du cercle de Bla 2008-2012 » Bla (2012)

Enquête Démographique et de Santé (EDSM V) 2012-2013. Cellule de Planification et de Statistiques (CPS/SSDSPF) Institut National de la Statistique (INSTAT) Centre d'Études et d'Information Statistiques (INFO-STAT) Bamako, Mali. ICF International Rockville, Maryland, USA (Mai 2014)

Annuaire SLIS 2015. Annuaire du Système Local d'Informations Sanitaire. Ministère de la Santé et de l'Hygiène Publique de la République du Mali ; Secrétariat Général, Direction Nationale de la Santé (DNS). (Juin 2016)

Concept note du « Programme Épargner pour le Changement: Promotion de la Planification Familiale à Travers les Groupes d'Épargne au Mali » OFAX America, (2017)

APPENDIX 1

Basis for Evaluation Criteria

Number of points	Assessment	Justification
★★★★★	Excellent	Intervention conforms to all the project documents. Evaluation mechanism exists and is reliable. The results conform to objectives and are satisfactory.
★★★★	Satisfactory	Intervention conforms to certain project documents. Evaluation mechanism exists but is not reliable. Results conform to objectives and are satisfactory.
★★★	Attention Required	Intervention conforms to certain project documents. Evaluation mechanism nonexistent or not reliable. Results are greater than or conform to objectives but not satisfactory.
★★	Problematic	Intervention conforms to certain project documents. Evaluation mechanism nonexistent. Results are greater than or conform to objectives but not at all satisfactory.

Oxfam is a global organization working to end the injustice of poverty. We help people build better futures for themselves, hold the powerful accountable, and save lives in disasters. Our mission is to tackle the root causes of poverty and create lasting solutions. Join us.

www.oxfamamerica.org



US HEADQUARTERS

226 CAUSEWAY STREET, 5TH FLOOR
BOSTON, MA 02114-2206
(800) 77-OXFAM

US POLICY & ADVOCACY OFFICE

1101 17TH STREET, NW, SUITE 1300
WASHINGTON, DC 20036
(202) 496-1180

www.oxfamamerica.org

© 2018 Oxfam America Inc. All rights reserved. Oxfam is a trademark of Oxfam America Inc., and the Oxfam logo is a registered trademark of Stichting Oxfam International. None of the trademarks may be used without permission of the owner.

