

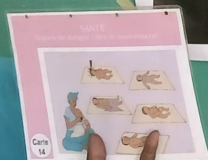
OUCHE



PROJET : « partenariat pour la résilience aux situations d'urgence par la transformation de la santé et des droits sexuels et génésiques. »

**ATELIER DE FORMATION DES ACTEURS COMMUNAUTAIRES
SUR L'EDUCATION SANITAIRE ; L'HYGIENE ; LA SSR ET LES IST
AU NIVEAU DE 07 STRUCTURES DE SANTE COMMUNAUTAIRE
ET LE TENENKOU**

DATE: 17 SEPTEMBRE 2025
LIEU: DISTRICT DE TENENKOU



Awareness-raising on warning signs in newborns by a community liaison from the Tenenkou CSCoM, supervised by a midwife from an IRC partner NGO (ASDEMIN). Photo credit: Youssouf HAÏDARA, SRH Officer, IRC.



Connecting Care

Eliminating Service Siloes Through
Integrated Reproductive Health and GBV
Programming in Tenenkou, Mali

SEPTEMBER 2026

The Problem

In Mali, giving birth is statistically more dangerous than living through a war. The picture is equally stark when it comes to reproductive health access more broadly. Many women — especially in rural areas — have little or no access to birth control, contributing to high fertility rates and unplanned pregnancies that increase health risks for mothers and children.

The Tenenkou district in the Mopti Region sits at the heart of Mali's deepest crisis. For more than a decade, armed conflict has reshaped daily life beyond recognition. By the orders of armed non-state actors, schools have shuttered across nearly all villages in the district. Movement is controlled by irregular checkpoints. The WHO estimates that 116 healthcare centers have closed nationwide because of violence, and those that remain open struggle to operate due to a lack of resources and qualified personnel, who armed groups regularly target. A national fuel crisis has compounded these conditions, further limiting the mobility of both populations and humanitarian workers.

In this context, accessing sexual and reproductive health (SRH) care is not simply difficult, it is nearly impossible. Pregnant women face deliveries without skilled attendants. Survivors of gender-based violence (GBV) have no clear pathway to care or justice. Family planning services are scarce, supplies are unreliable, and abortion care is highly inaccessible. The social norms that govern women's lives in the district compound these structural failures. Reproductive health remains a taboo topic in many communities, and GBV is underreported and frequently met with pressure to remain silent.

Mali SRHR Data

- Maternal mortality ratio is 440 deaths per 100,000 live births¹
- In 2017 alone, childbirth killed more Malian women and girls than the security crises had in all 6 preceding years combined²
- More than 80% of these maternal deaths are preventable³
- Contraceptive prevalence rate is ~16%⁴
- More than half of girls in Mali are married before the age of 18, contributing to obstetric complications associated with adolescent pregnancy⁵
- Female genital mutilation affects approximately 89% of women in the country⁶
- 25% of women complete postnatal care⁷



1 United Nations Population Fund (UNFPA). *Mali conflict carries heavy toll for pregnant women amid rising insecurity*. 2023. Available at: <https://www.unfpa.org/news/mali-conflict-carries-heavy-toll-pregnant-women-amid-rising-insecurity>

2 Institute for Security Studies. *Maternal mortality in Mali: a forgotten tragedy*. Available at: <https://issafrica.org/iss-today/maternal-mortality-in-mali-a-forgotten-tragedy>

3 Aboagye RG et al. *Individual and contextual factors associated with maternal healthcare utilisation in Mali: a cross-sectional study using Demographic and Health Survey data*. PMC, 2022. Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC8867328/>

4 AEHO Foundation. *Understanding Reproduction, Infant and Maternal Mortality, and Morbidity in Mali*. 2024. Available at: <https://aehofoundation.org/understanding-reproduction-infant-and-maternal-mortality-and-morbidity-in-mali/>

5 Healthy Newborn Network. *Mali Country Profile*. February 2025. Available at: <https://healthynewbornnetwork.org/country/mali/>

6 Ibid

7 Aboagye RG et al. *Individual and contextual factors associated with maternal healthcare utilisation in Mali*. PMC, 2022. Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC8867328/>

The scale of gender-based violence in the region compounds this picture. The Mopti region recorded 747 incidents of GBV during January 1 and December 31, 2025.

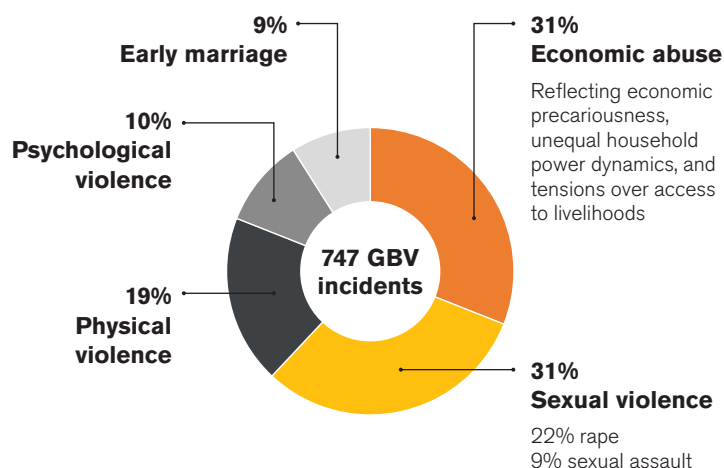
The communities of Tenenkou are confronting a crisis within a crisis — a humanitarian emergency layered onto deeply entrenched inequalities, leaving women and girls uniquely exposed.

The Solution

In most humanitarian settings, SRH and GBV services are funded, staffed, and delivered through separate systems. Women experiencing obstetric complications seek care in one location, while survivors of violence are referred elsewhere — often through weak or inconsistent referral pathways. In conflict-affected areas such as Tenenkou, where women and girls must navigate insecurity, armed checkpoints, fuel shortages, and deep social stigma, every additional step in the care process increases the likelihood that they will forgo support altogether.

Integrating SRH and GBV services addresses this fragmentation by creating coordinated, survivor-centered pathways to care. Rather than strengthening SRH and GBV programming in parallel, integration establishes active connection points between health providers and protection actors so that women and girls can access multiple forms of support through a single trusted entry point. A woman attending antenatal care, for example, can also be safely screened for GBV risks, receive psychosocial first-line support, and be referred for specialized care during the same visit. Adolescent girls can access family planning information alongside protection programming through shared community platforms.

Tenenkou was a prime location for SRH/GBV integration. Health facilities faced severe shortages of qualified personnel, making parallel and siloed service delivery models difficult to sustain. At the same time, many healthcare providers had limited knowledge of GBV identification and response, leaving survivors invisible within routine clinical services. IRC, under the PRET-SRHR project (Partnering for Resilience to Emergencies through Transformation of Sexual and Reproductive Health Rights), funded by Swedish International Development Cooperation Agency (Sida) implemented an SRH/GBV integration approach in Tenenkou that embedded GBV competencies within



the existing SRH workforce rather than relying on separate specialist structures that were unlikely to be feasible in remote humanitarian settings.

The approach implemented in Tenenkou was grounded in IRC's broader global work on SRH/GBV integration. Across humanitarian contexts, IRC has developed and tested a range of integrated service delivery models designed to strengthen coordination between the health and protection sectors while adapting to different operational realities. These models range from basic coordination between services, provided by mobile staff, to full integration of SRH and GBV services in the same space. The Tenenkou intervention most closely aligned with IRC's expanded cross-sectoral "host and visitor" model, in which health facilities serve as the primary service delivery point while integrating expanded GBV services and referral mechanisms within routine SRH care. This model emphasizes women- and girl-centered care, dedicated private spaces, coordinated staffing, and continuous availability of services. Mali was also one of the focus countries informing IRC's global SRH-GBV integration toolkit, making the Tenenkou experience part of a broader body of operational learning shaping practice across humanitarian settings.

This project provided an important opportunity to translate both national policy commitments and global evidence into district-level implementation. The National Office of Reproductive Health (ONASR), which is the national institution responsible for reproductive health, had already initiated efforts to pilot integrated maternal and child health approaches, including GBV. Building on this momentum, IRC supported health facilities in Tenenkou to assess service readiness, train providers on integrated SRH/GBV care, strengthen referral systems, and establish clinical care protocols for survivors of violence.

WHAT DID SRH/GBV INTEGRATION LOOK LIKE IN PRACTICE?

At facility level	On the health system side, the program supported seven health facilities to provide free care for pregnant women, girls of reproductive age, and people with sexually transmitted infections. ■ Facilities were equipped with delivery tables and family planning supplies, addressing longstanding gaps in basic obstetric infrastructure. ■ Health staff (including midwives and maternity staff) received training in SRH clinical protocols and in the clinical management of rape and intimate partner violence (CMR-IPV), giving providers the tools to respond not just to medical presentations but to the hidden consequences of conflict and GBV. ■ During routine SRH consultations — antenatal visits, deliveries, postnatal check-ins — trained health providers were able to identify GBV risk indicators, deliver first-line clinical and psychosocial support, and initiate referrals to protection services where needed. A woman did not need to present as a GBV survivor to receive protection-sensitive care; that care was embedded into the clinical encounter itself.
At community level	IRC trained community actors in GBV identification and response, and deployed two evidence-based behavior change approaches — EMAP (Engaging Men through Accountable Practice) and Girl Shine — to reach men and adolescent girls respectively with programming designed to shift harmful norms. ■ Community dialogues on social norms created structured spaces for communities to examine and question the attitudes and practices that sustain gender inequality and restrict women's autonomy. ■ GBV focal points drawn from women-led organizations, religious leadership, and community structures were trained and connected to the formal referral network. These focal points served as trusted entry points — particularly for women who would not approach a health facility directly — and channeled cases through jointly defined referral pathways to the appropriate clinical or psychosocial services. ■ Monthly coordination meetings between health, protection, NGO, and government actors maintained the integrity of those pathways, ensuring continuity of care, confidentiality, and consistent application of survivor-centered principles.
At institutional level	■ Joint supervision missions with government technical services aligned program activities with official health priorities and built the local ownership. ■ Integration registers were developed to track service delivery across the combined SRH-GBV pathway, providing a practical tool for monitoring and for the eventual scale-up of the model across additional facilities. ■ Government agencies and services involved: Ministry of Women, Children, and Family Affairs; Ministry of Health and Decentralized State Services (Regional Directorate for Women, Children, and Family Affairs).

Protecting confidentiality was a foundational commitment throughout.

- Survivors' data was codified and stored separately — anonymized records kept apart from identifying documents, both locked securely.
- Digital records were password-protected. Information was shared strictly on a need-to-know basis and only with the survivor's informed consent.
- Community focal points and health staff alike received training on these protocols, reinforced through continuous supervision and support.

Girl Shine

Girl Shine is an IRC-developed program model that seeks to support, protect, and empower adolescent girls in humanitarian settings. It provides girls with skills and knowledge on GBV and how to seek support services, supporting them as they navigate a safe and healthy transition into adulthood. The program also provides life skills that strengthen social and emotional learning, as well as information on adolescent sexual and reproductive health.

In Mali, Girl Shine under PRET-SRHR has reached 50 adolescent girls across two sites in Tenenkou and Diaka. Sessions gave young women a structured space to discuss topics that are often considered taboo within families — including menstrual hygiene management, access to family planning services, and GBV. Participants gained practical knowledge on identifying different forms of GBV, navigating available services, and using referral pathways. By the end of the program, participants had taken on community leadership roles, guiding other adolescent girls and sharing what they had learned with their peers.

Engaging Men through Accountable Practice (EMAP)

EMAP is an IRC-developed, evidence-based approach to preventing violence against women and girls, implemented for more than 20 years in humanitarian settings worldwide. It runs separate women's and men's group sessions: women meet to define their key priorities and concerns, which directly inform the curriculum used with men, who engage in structured discussions designed to challenge harmful beliefs about masculinity, gender, and power.

In Tenenkou and Diaka, EMAP under PRET-SRHR reached 120 participants — 60 men and 60 women — across two cohorts. The sessions worked to challenge harmful beliefs, reduce violent behaviors, and improve women's and girls' access to SRH and GBV services. By the end of the program, all 60 male participants had been identified as role models, actively promoting positive masculinity and improved communication within couples, and involving women more meaningfully in household decision-making. These men continue to carry the program's messages to other men in their communities, extending its reach well beyond the structured sessions. Positive behavioral change is already clearly visible across participating communities.

Approaching Key Challenges

Implementing this program in Tenenkou demanded constant adaptation. The security environment was the most pervasive constraint: armed group activity restricted movement across much of the district, making both staff travel and community mobilization unpredictable. Irregular checkpoints slowed logistics, and some areas remained entirely inaccessible at certain times. The national fuel crisis added a further operational layer, limiting the mobility of vehicles and the ability to conduct regular supervision and outreach. Supply-side challenges created gaps even when demand existed. Family planning commodities were frequently unavailable from suppliers, meaning that awareness-raising and demand sometimes outpaced the system's ability to respond.

Perhaps the most structurally significant challenge was the set of social norms that shaped and constrained virtually every aspect of the program. Reproductive health remains a taboo topic in many parts of the district. GBV is widely underreported, and survivors face profound risks of stigma and community rejection if they seek care. These norms could not be addressed through service delivery alone. They required sustained, community-grounded engagement with religious leaders, with men and boys through EMAP, with adolescent girls through Girl Shine, and with communities as a whole through structured dialogue.

Results and Impact

The program has generated measurable improvements in both health system capacity and community-level outcomes. Health coverage in the district has improved, and facility governance has been strengthened through joint supervision and community accountability mechanisms.

- The provision of medical equipment and emergency neonatal supplies has strengthened the technical capacity of each facility, and continuous provider training on family planning methods, post-abortion care, and STI management — reinforced through joint IRC and district health supervision — has raised the standard of care.

Service delivery and quality improvement

- Across seven supported health facilities, free reproductive health services — including deliveries, family planning, STI treatment, post-abortion care, and medical evacuations — are now available to women and girls who previously had no access to these services.
- The quality of those services has also improved. Monthly motivation incentives supported facilities in recruiting qualified maternity personnel, and as a result all assisted deliveries are now conducted by trained staff — a significant shift from earlier practice, when deliveries were largely handled by traditional birth attendants without clinical training.

Training and support for staff

- Across the supported facilities, clinical and protection staff trained included:
 - ✓ 7 district technical advisors
 - ✓ 7 maternity ward supervisors
 - ✓ 3 staff from local partner organizations
 - ✓ 2 staff from the primary district hospital
 - ✓ 2 Safe Space Officers
 - ✓ 3 IRC staff
 - ✓ These training efforts directly strengthened the system's capacity to respond to sexual violence: 16 cases of rape were managed in health centers during the period, including 12 treated within the critical 72-hour window.

- 100 community actors trained in GBV basics are now equipped to identify risk, conduct awareness-raising sessions, and refer survivors to appropriate care.
- The psychosocial support program has enabled survivors of GBV — including those navigating the most severe violations — to access care, referral pathways, and the holistic support they need to reintegrate into their communities without fear of rejection.

Systems change and accountability

- At the policy level, the progress observed also benefited from the support of the complementary She Responds project, funded by The William and Flora Hewlett Foundation. A workshop organized in Dakar strengthened the capacities of regional SRH coordinators to lead the coordination meetings of the
- SRH working group. This initiative enabled the region to develop an SRH work plan and institutionalize monthly working group meetings, thereby contributing to strengthening regional coordination and health system accountability.
- Training sessions on maternal mortality audits, combined with regional-level supervision of Tenenkou district on accountability indicators, have secured strong and sustained involvement from health authorities in the project's implementation.
- The sharing of results from the SRH-GBV integration model at the regional level has enabled the region to actively advocate to other NGO and government stakeholders for the extension of the Tenenkou approach to other districts.

ANNUAL TRACKED INDICATORS

Prenatal consultations	4,850 (2021) → 7,310 (2024 peak) → partial decline (2025)	+51% by 2024
Assisted deliveries	2,766 (2021) → 3,875 (2024 peak)	+40% by 2024
GBV survivors receiving care	39 (2022) → 94 (2024 peak) → 87 (2025)	+ 141% by 2024

CUMULATIVE TOTALS (FIRST TWO PROJECT YEARS)

Total assisted deliveries	7,329
Women attending first ANC visit	12,742
Individuals treated for STIs	5,514
Couple years of protection (CYPs) delivered	8,095

Note: 2025 decline attributed to the blockade of Diafarabe and closure of the Malemana CSCoM. Year 2 targets were still exceeded overall.



The Way Forward

It is clear from the Tenenkou case that contexts where conflict, insecurity, and deep social norms combine to exclude women and girls from essential care, integrated programming that bridged clinical services, community engagement, and norm change is the best approach to reach those most left behind.

The next phase focuses on consolidating and scaling this model. **Integration registers have been developed by ONASR for all health facilities in Mali as part of their integrated SRMNAH-Nut (Reproductive, Maternal, Newborn, Child, Adolescent Health, and Nutrition) approach.**

The experience in Mali is also contributing to IRC's broader global efforts to strengthen integrated SRH-GBV programming in humanitarian settings. Building on operational learning from countries including Mali, **IRC**

has developed a global SRH/GBV integration toolkit designed to support humanitarian actors in adapting and implementing integrated service delivery models across diverse contexts. The toolkit will be rolled out in collaboration with UNFPA, creating an important opportunity to standardize good practice, strengthen inter-agency learning, and promote greater adoption of survivor-centered and rights-based integration approaches globally. Insights from Tenenkou — particularly around community engagement, provider capacity-building, and service coordination in insecure settings are helping **to inform this wider process and shape how integrated programming is operationalized across the humanitarian sector.**

Several conditions must be in place to sustain what has been built in Mali. **The supply chain for family planning commodities requires consistent**

attention. Security conditions permitting, supervision and support to trained community actors must be maintained to preserve skill and motivation. The progress made in engaging religious leaders and community governance structures around SRHR and GBV norms must be reinforced so that behavioral change outlasts the project cycle.

Looking beyond Tenenkou, the program's integrated model — combining health system strengthening, rights-based service delivery, community-based norm change, and practical economic empowerment tools —

offers a replicable framework for other conflict-affected areas of Mali and across the Sahel.

Through the PRET-SRHR project, IRC combined health systems strengthening, protection expertise, and community-based behavior change within a single operational model. In doing so, the project not only improved service delivery in Tenenkou, but also contributed to a growing evidence base influencing how integrated SRH-GBV programming is designed, adapted, and scaled across humanitarian contexts globally. 