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MID-TERM PERFORMANCE EVALUATION OF THE MALI NUTRITION AND WASH PROGRAMS

MARCH 2, 2018

This publication was produced at the request of the United States Agency for International Development. It was prepared by Management Systems International, a Tetra Tech Company. It was authored by Akory Ag Iknane, Boubacar Maiga, Joseph Limange, Iain McLellan, Raymond Gervais, and Amadou Fofana. The views expressed in this report do not necessarily reflect the views of the United States Agency for International Development or the United States Government

MIDTERM PERFORMANCE EVALUATION OF THE MALI NUTRITION AND WASH PROGRAMS

Contracted under AID-688-15-I-00006 Task Order No. 72068818F00001

Mali Evaluation of the Nutrition and WASH Programming

CONTENTS

ACRONYMS

APS	Annual Program Statement
CARE	Care International
CCOCSAD	Comité Communal d'Orientation de Coordination and Follow-up of Development Actions
CLOCSAD	Local Committee of Orientation for Coordination and Monitoring of Development Actions
CROCSAD	Regional Steering Committee for Coordination and Monitoring of Development Actions
CEHA	Committees for Establishment of the Water, Hygiene and Sanitation
CLTS	Community-Led Total Sanitation
CPS/SSDSPF	Cellule de Planification et de Statistique du Secteur Santé, Développement Social et Promotion de la Famille (Planning and Statistics Unit of the Health, Social Development and Family Promotion Sector)
CSCOM	Centre de Santé Communautaire (Community Health Center)
CSO	Civil Society Organization
CSREF	Centre de Santé de Reference (District Health Center)
DDS	Dietary Diversity Score
DEC	Development Experience Clearinghouse
DHS	Demographic and Health Survey
DNACPN	National Directorate of Sanitation and Pollution Control and Nuisances
DRACPN	Regional Directorate of Sanitation and Pollution Control and Nuisances
EDSM	Enquête Démographique et de Santé (Demographic and Health Survey)
FGD	Focus Group Discussion
GOM	Government of Mali
GSAN	Groupe de Soutien aux activités de Nutrition (Nutrition Activity Support Group)
Hb	Hemoglobin
ICF	Inner-City Found
INSTAT	Institut National de la Statistique/ National Institute of Statistics
IP	Implementing Partner
IRP	Integrated Rural Program
KII	Key Informant Interviews
KJK	Keneya Jemu Kan
MSI	Management Systems International
MUAC	Mid-Upper Arm Circumference
NGO	Non-Governmental Organization
ODF	Open Defecation Free
Save	Save the Children

SANPLAT	Sanitation Platform
SBC	Social and Behavior Change
SBCC	Social and Behavior Change Communication
SLIS	Local Health Information System
SNV	Stichting Nederlandse Vrijwilligers (Netherlands Development Organization)
USAID	United States Agency for International Development
VSLA	Village Savings and Loans Association
WASH	Water, Sanitation and Hygiene
YA-G-TU	Yam-Giribolo-Tumo (Promoting Women in Dogon)

ABSTRACT

The United States Agency for International Development's Mali Mission (USAID/Mali) contracted MSI to conduct the midterm performance evaluation (MPE) of the Integrated Rural Program to Improve Nutrition and Hygiene (IRP) in Mali, which consists of two cooperative agreements under an Annual Program Statement (APS) with a performance period from October 1, 2013, to September 30, 2018. The aim of this evaluation is to assess the effectiveness of IRP's integrated nutrition strategy of combining nutrition, agriculture and water, sanitation and hygiene (WASH) to improve the nutritional status of pregnant and lactating women and of children younger than 2 years. Overall, the evaluation team found the integrated approach to have mixed results. In the areas of anemia, dietary diversity, stunting, wasting, and underweight children between 6-23 months, the evaluation found no significant differences in the outcomes for those who received all three interventions (nutrition, WASH, and agriculture) versus those who received only two of the three. In the WASH area, there is, however, a significantly higher proportion of those households who received the full set of interventions who demonstrate improved WASH practices, versus those who did not receive the full set of interventions. Overall, the results of the agriculture components were less notable than those in nutrition and WASH areas. USAID/Mali will use the findings of this evaluation to inform the implementation of the current integrated strategy and the development of future projects. USAID/Mali will further share the report with the Government of Mali (GOM) and development partners who may use it to inform their nutrition-related strategies.

EXECUTIVE SUMMARY

The United States Agency for International Development's Mali Mission (USAID/Mali) contracted MSI to conduct the midterm performance evaluation (MPE) of the Integrated Rural Program to Improve Nutrition and Hygiene (IRP) in Mali, which consists of two cooperative agreements under an Annual Program Statement (APS) with a performance period from October 1, 2013, to September 30, 2018.

PURPOSE

The aim of this evaluation is to assess the effectiveness of IRP's integrated nutrition strategy of combining nutrition, agriculture and water, sanitation and hygiene (WASH) to improve the nutritional status of pregnant and lactating women and of children younger than 2 years. USAID/Mali will use the findings of this evaluation to inform the implementation of the current integrated strategy and the development of future projects. USAID/Mali will further share the report with the Government of Mali (GOM) and development partners who may use it to inform their nutrition-related strategies.

EVALUATION QUESTIONS

The evaluation questions were:

1. What effect have the projects had on the improvement of nutritional status in their target zones? Specifically, how have the following indicators been affected, and how could achievements be accelerated in the future?
    a. Reduction of the prevalence of stunting, wasting, underweight and anemia among children under 2 years of age in USAID-supported districts;

b. Reduction of the prevalence of underweight and anemia among women of reproductive age in USAID-supported districts;
c. Increasing the prevalence of children aged 6–23 months receiving a minimum acceptable diet and increasing the average number of food groups consumed by beneficiary women; and
d. Improving nutrition-related behaviors such as exclusive breastfeeding and appropriate complementary feeding for children aged 6–23 months.

2. How can strategic engagement in the WASH sector sustainably improve the way WASH services are delivered at the household level?
   a. How can systems and capacity be built to ensure the sustainability of functioning water and sanitation services?
   b. How can open defecation free (ODF) status be maintained once it is achieved?
   c. What results provide actionable evidence-based items to improve current projects and inform future designs?

3. What are the (positive and negative) factors contributing to the results achieved (or not achieved)? How did the projects integrate the nutrition, WASH and agricultural sectors? How effective was the integration approach?

4. To what extent are results achieved by IRP likely to continue after the end of the projects?

5. Are there any environmental issues? What steps were taken to address these issues? What additional steps are needed? How well have the programs been monitoring environmental compliance.

PROGRAM BACKGROUND

The malnutrition rate and the factors influencing anemia and malnutrition are still high in Mali. Overall, 38 percent of children suffer from chronic malnutrition and 19 percent experience a severe form. In the case of anemia at the national level, USAID's 2012–2013 Demographic and Health Survey (DHS) report notes that 13.3 percent of women suffered from moderate levels and 1.3 percent from severe forms. Among children, 81 percent had one form of anemia, with the national percentage of children at 51.5 percent for moderate and 9.3 percent children suffering from severe forms. The 2010 report on the nutritional profile of Mali clearly set out the issues of linking agricultural production and the potential to lower undernourishment.

To address these challenges and reduce stunting, USAID/Mali awarded two cooperative agreements to Care International (CARE) and Save the Children (Save) to implement integrated rural program projects from October 2013 until September 2018. The five-year program had a total budget of $24,694,427. The purpose of IRP was to support integrated nutrition, agriculture and WASH activities in the regions of Sikasso, Mopti, Segou and Koulikoro through four main categories of interventions:

- Increase access to and consumption of diverse and quality foods;
- Improve nutrition and hygiene-related behaviors;
- Increase utilization of high-impact nutrition and WASH promotion and treatment services; and
- Reinforce and scale up community-led total sanitation (CLTS) through the implementation of a national strategy and strengthen the institutional capacity of the National Sanitation Department.

This evaluation covered only the Mopti and Sikasso regions.

METHODOLOGY

The evaluation team adopted three complementary approaches to data/information gathering:

- Documentation-based context analysis and implementation narrative involving approximately 100 documents;
- Qualitative data collection with a total of 388 persons met through key informant interviews and focus group discussions; and
- Quantitative mini survey gathering of 400 women beneficiaries with their 359 children between 0 and 23 months. Women were the specific targets (80 percent) as part of the beneficiary category.

The challenges the team overcame included the absence of data on anemia for comparison as baseline, and security conditions that forced changes in some sampled communities.

FINDINGS & CONCLUSIONS

QUESTION 1 FINDINGS: PROJECTS' EFFECT ON NUTRITIONAL STATUS

According to the results of the mini-survey as it compared to the two baselines, among children under 2 years, the projects contributed to reducing underweight from 29.2% to 13.6% and wasting from 17.0% to 7.5%, exceeding their targets of 30 percent reduction. Exclusive breastfeeding increased from 34.4% to 63.3%, also exceeding its 50 percent target. However, the stunting level worsened from 19.6% to 23.3% and therefore is not likely to be achieved by the end of the project.

The proportion of children aged 6–23 months with an acceptable dietary diversity score increased from 16.7% to 56.1% and could attain the project's objective of achieving 250 percent increase with intensification of effort. The survey found the anemia rate among children under 2 years to be 68.0%. However, there is no basis for comparison of this as baseline surveys did not measure anemia. For women of reproductive age, underweight prevalence declined from 9.4% to 6.8%, exceeding the 20 percent target. Anemia among women of reproductive age was found to be 31.8%; however, there was no basis for comparison as baseline surveys also did not capture anemia among women of reproductive age.

QUESTION 1: CONCLUSIONS

Most indicators for children under 2 years old — wasting, prevalence of underweight and exclusive breastfeeding — largely met and exceeded initial expectations. The projects are also on course to achieve the targets on dietary diversity score. However, the target on stunting is not likely to be reached during the life of the projects. In women of childbearing age, the underweight prevalence also exceeded the initial objectives the projects set. The evaluation found no baseline data on anemia for comparison.

QUESTION 2 FINDINGS: STRATEGIC ENGAGEMENT IN WASH

In regard to water, sanitation and hygiene, the rehabilitation of water points was limited, but the team noted a net increase in home water treatment compared to the 2014 baseline survey (46 percent), although not at the expected level of 200 percent. The CLTS efforts increased latrine

construction by households and the promotion of hand-washing with soap, which exceeded its target of 150 percent by a wide margin, reaching 600 percent. The opportunity to earn certificates of Open Defecation Free (ODF) status motivated communities to take action in sanitation. In addition, the National Directorate of Sanitation and Pollution Control and Nuisances (DNACPN) developed a post-ODF strategy to sustain the gains with support from the implementing partners (IPs). Regional and district offices play key roles in sustainability.

QUESTION 2: CONCLUSIONS

- Communities were inspired to change water and sanitation behaviors through collective actions, such as community-wide sweeping and cleaning; individual behavior changes like hand-washing with soap; and household behaviors like the treatment and hygienic storage of water.
- Seeing the health impacts of positive behavior changes inspired communities to maintain their positive behaviors.
- The projects have seen progress with the increased use of cement in creating latrine bases, but room for improvement remains in the number and quality of latrines.
- Access to water remains a challenge that could be rectified by increased refurbishing of water sources, especially piped water through a summary water supply.
- The post-ODF strategy has proven its worth in consolidating WASH achievements, as well as in ensuring sustainability.

QUESTION 3 FINDINGS: FACTORS CONTRIBUTING TO RESULTS

The survey found the most important influencers in Sikasso to be the Women Leaders, WASH Committees and Community Health Agents. However, in Mopti, the key influencers were Community Health Agents, WASH committees and Nutrition Support Groups. All stakeholders said that integration added value to their overall achievements, especially when making a link between interventions and positive health outcomes. The three components were found to have been more integrated in Mopti; however, in Sikasso, the evaluation found less integration.

QUESTION 3: CONCLUSIONS

Women Leaders, Community Health Agents, WASH committees and Nutrition support groups were found to have the most influence in changing the behavior of beneficiaries. The project was more integrated in Mopti Region and less so in Sikasso Region.

QUESTION 4 FINDINGS: SUSTAINABILITY OF RESULTS

Survey informants considered nutrition and WASH most likely to continue. All levels of stakeholders from village WASH committees and women leaders to both female and male beneficiaries showed a high level of motivation for sustaining the positive changes in behavior. Mobilization by community agents is expected to have a continuing impact. Stakeholders expressed a general perception that the actions have resulted in improved family health.

QUESTION 4: CONCLUSIONS

Beneficiaries perceive that interventions have resulted in improved family health and lowered expenditures for medicines. This belief is the most important motivator of beneficiaries to sustain the achieved results. Other key motivational factors were beneficiaries' gains from implementing the

interventions and the existence of community mobilization structures, such as women leaders who would continue to educate beneficiaries.

QUESTION 5 FINDINGS: ENVIRONMENTAL ISSUES

The program has developed a plan for monitoring actions to mitigate the environmental impact of its activities. It is promoting environmentally friendly farming techniques for women without the use of genetically modified seeds. Farm schools introduced soil and water conservation methods, especially for use during drought periods, and erosion control techniques for the rainy season.

QUESTION 5: CONCLUSIONS

The proposed mitigation actions can reduce risks in the area of agriculture. Installation of latrines is worth following at various levels. The implementation of CLTS has led to the rehabilitation, construction and use of latrines.

RECOMMENDATIONS

PROJECT EFFECT ON NUTRITIONAL STATUS

Strengthen nutrition demonstrations and behavior change through nutrition-sensitive agriculture by promoting local products, and encourage household consumption of diversified foods.

STRATEGIC ENGAGEMENT IN WASH

Strengthen the involvement of the Collectivités Territoriales[1] (CTs) in the management of WASH issues. Continue to promote the clean village contest post ODF. Continue promoting WASH marketing through the installation of sanitation shops to facilitate access to WASH services and products. Develop the system for WASH marketing during the CLTS process. Continue to promote CLTS and post ODF activities through village level competitions and WASH marketing. Rehabilitate water points for villages certified as ODF. Continue strengthening the technical and institutional capacities. Involve already-existing systems in the selection of project intervention zones and villages. Continue capacity building of the various actors involved in WASH.

FACTORS CONTRIBUTING TO RESULTS

- Integrating the various components of the programs (Nutrition, Agriculture and WASH) in the beneficiary geographic areas.
- Promoting of home gardening to produce foodstuffs that could contribute to improving the nutritional status of the family as well as ensuring food security.
- Building the capacity of communities, elected officials and technical services on the integrated approach.

SUSTAINABILITY OF RESULTS

Strengthen the coordination between the Nutrition, Agriculture and WASH components through existing structures. Strengthen grassroots community mobilization structures such as Mama Leaders and WASH Committees. Strengthen the capacity of elected officials in their roles and responsibilities.

[1] Local Authorities

ENVIRONMENTAL ISSUES

Ensure joint monitoring of the implementation of the Post-ODF strategy on techniques for sealing pit latrines, stabilizing them, and securing settlements. Strengthen the capacity of WASH committees and communities in building standards for environmentally friendly latrines. Strengthen the CAP Post certification survey.

INTRODUCTION

USAID/Mali contracted MSI to conduct the midterm performance evaluation (MPE) of the Integrated Rural Program to Improve Nutrition and Hygiene (IRP) in Mali, which consists of two cooperative agreements under an Annual Program Statement (APS) with a performance period from October 1, 2013, to September 30, 2018. The IRP aims to improve the nutritional status of women and children under 2 years old through the implementation of integrated water, sanitation, hygiene and nutrition activities at the community level. This MPE aims to identify needed improvements in the current awards, as well as to inform the design of future nutrition and water, sanitation and hygiene (WASH) programming.

EVALUATION PURPOSE AND QUESTIONS

The aim of the evaluation is to assess the effectiveness of IRP's integrated nutrition strategy of combining nutrition, agriculture and water, sanitation and hygiene (WASH) to improve the nutritional status of pregnant and lactating women and of children under 2 years old. USAID/Mali will use the findings of this evaluation to inform the implementation of the current integrated strategy and the development of future projects. USAID/Mali will further share the report with the Government of Mali (GOM) and development partners, who may use it to inform their nutrition-related strategies. The evaluation specifically intends to determine which IRP components and project aspects are working well and why, and which are not working well and why not, as well as identify potential modifications to the current projects and to future projects in the nutrition and WASH sectors. The evaluation should also assess whether the projects have been compliant with USAID environmental regulations and identify opportunities to further mitigate potential negative impacts on the environment.

The evaluation questions were:

1. What effect have the projects had on the improvement of nutritional status in their target zones?[2] How could achievements be accelerated in the future?

2. How can strategic engagement in the WASH sector sustainably improve the way WASH services are delivered at the household level?

    a. How can systems and capacity be built to ensure the sustainability of functioning water and sanitation services?

[2] Specifically, the effects of the program on core indicator: Reduction of the prevalence of stunting, wasting, underweight and anemia among children under 2 years of age in USAID-supported districts; reduction of the prevalence of underweight and anemia among women of reproductive age in USAID-supported districts; increasing the prevalence of children aged 6-23 months receiving a minimum acceptable diet and increasing in the average number of food groups consumed by beneficiary women; and improving nutrition-related behaviors such as exclusive breastfeeding and appropriate complementary feeding for children aged 6–23 months.

b. How can open defecation free (ODF) status be maintained once it is achieved?

c. What results provide actionable evidence-based items to improve current projects and inform future designs?

3. What are the (positive and negative) factors contributing to the results achieved (or not achieved)? How did the projects integrate the nutrition, WASH and agricultural sectors? How effective was the integration approach?

4. To what extent are results achieved by IRP likely to continue after the end of the projects?

5. Are there any environmental issues? What steps were taken to address these issues? What additional steps are needed? How well have the programs been monitoring environmental compliance?

PROGRAM BACKGROUND

The malnutrition rate and the factors influencing child anemia and malnutrition are still high in Mali, despite efforts by its Ministry of Health and donor partners through the various programs targeting infant and young child feeding. According to the 2012-2013 DHS, the incidence of infants weighing less than 2500 grams (about 5.5 pounds) is currently 3 percent and Children under 5 months old with moderate or severe weight loss constitute 33 percent of the child population; for children under 5 years, the figure is 11 percent. According to the most recent Demographic and Health Survey (DHS)[3] survey in Mali (2012–2013), the infantile-juvenile mortality rate was 98 percent for all Southern regions.[4] In those targeted regions, 38 percent of children younger than 5 years suffer from chronic malnutrition.[5] Acute malnutrition[6] levels in the country are at 12.7 percent. Underweight levels follow the same trends: national levels at 25.5 percent, 32 percent in Mopti, 27 percent in Sikasso, 26 percent in Ségou and 24 percent at Koulikoro. Overall for Mali, 38 percent of children suffer from chronic malnutrition, and 19 percent experience a severe form.

Although baseline and midterm reports from the implementing partners (IPs) did not measure anemia levels, the 2012–13 DHS report offered insights on percentages of women and children. At the national level, 13.3 percent of women suffered from moderate levels and 1.3 percent of severe forms.[7] Among children (6-59 months), 81.7 percent had one form of anemia, with the national percentages of children at 51.5 percent for moderate and 9.3 percent for severe forms of anemia.[8]

In that DHS report, the prevalence rate of diarrhea in children under 5 years is estimated at 28 percent. Despite this, only 32 percent of breastfed infants begin breastfeeding within an hour of delivery and 18 percent begin within a few days later. Only 26 percent of children under 6 months old breastfeed exclusively. The level of stunting increases rapidly with age, rising from 15 percent in

[3] Cellule de Planification et de Statistiques (CPS/SSDSPF), Institut National de la Statistique (INSTAT), Centre d'Études et d'Information Statistiques (INFO-STAT), and ICF International. 2014. Enquête démographique et de Santé (EDSM-V) 2012-2013. Rockville: ICF.

[4] Rates for regions were: Kayes, 96 percent; Koulikoro, 96 percent; Sikasso, 121 percent; Ségou, 116 percent; Mopti, 111 percent; and the District de Bamako, 59 percent.

[5] With Mopti at 46 percent, Segou at 40 percent and Sikasso and Koulikoro at 39 percent.

[6] Levels are: 14 percent in Mopti, 13 percent in Sikasso, 12 percent in Segou and 11 percent in Koulikoro.

[7] Moderate: Sikasso, 15 percent, and Mopti, 13.7 percent; severe: Sikasso and Mopti at 1.1 percent each.

[8] Moderate: Sikasso, 53.4 percent, and Mopti, 58.6 percent; severe: Sikasso, 10.3 percent, and Mopti, 15.5 percent.

children under 6 months to 24 percent in those aged 9 to 11 months, then to 48 percent at 18 to 23 months. It remains at a high level after in children age 2 years and older.

A 2010 report on the nutritional profile of Mali[9] clearly set out the issues of linking agricultural production and the potential to reduce undernutrition. Undernourishment affected about 10 percent of the population, a slight decrease over the previous decade. Although food security was improving, households remained vulnerable and chronic food insecurity was persisting.

Diets remain low in consumption of diverse foodstuffs, such as green vegetables, fruits and proteins, and they are deficient in essential micronutrients. The average diet mainly revolves around cereals (millet, rice, sorghum, maize), to which consumers add dairy products and, to a lesser extent, legumes (cowpea), roots and tubers (sweet potatoes, yams, cassava) and fruits and vegetables. Cereals account for more than two-thirds of food energy supplies.

The report concluded, "Reinforcement of short-term interventions is needed to improve the nutritional status of the population. Supported by the strong development of the agricultural sector and the observed improvement in food security, Mali currently has opportunities to improve the diversity of agricultural produce and the nutritional quality of food."[10]

To address these challenges and reduce stunting, USAID/Mali, under Annual Program Statement (APS) No. APS-688-13-000001, awarded in October 2013 (effective until September 2018) two cooperative agreements to CARE (AID-688-A-13-00003) and Save the Children (AID-688-A-13-00004) to implement the IRP. The five-year program had a total budget of $24,694,427. The purpose of IRP was to support integration of nutrition agriculture and WASH activities in the regions of Sikasso, Mopti, Segou and Koulikoro[11] through five main categories of interventions:[12]

- Increasing access to and consumption of diverse and quality foods through, for example, support to introduction of new foodstuffs and culinary demonstrations;
- Improving nutrition and hygiene-related behaviors:
    - Household water treatment;
    - Promotion of hand-washing with soap;
    - Screening for malnutrition; and
    - Promotion of exclusive breastfeeding.
- Increasing utilization of high-impact nutrition and WASH promotion and treatment services:
    - Support to the community health centers' (CSCOMs') treatment of malnutrition protocols;
    - Promotion of open defecation free zones through CLTS certification;
    - Rehabilitation of water points (no new water supply was envisioned under the APS); and;
    - Mobilization of communities to develop WASH and nutrition responses.
- Reinforcing and scaling up CLTS through the implementation of a national strategy and strengthen the institutional capacity of the National Sanitation Department:
    - Promotion of open defecation free zones through CLTS certification; and
    - Support for capacity building and institutional development.
- Agriculture:

[9] République du Mali and Organisation des Nations Unies pour l'Alimentation et l'Agriculture. 2010. Profil Nutritionnel de Pays. Bamako: République du Mali.

[10] Idem, p. 3.

[11] The evaluation covered only the Sikasso and Mopti regions, and their districts, at USAID's request.

[12] A sample of village and institutional level actions are offered.

- Support to women's market gardens producing vegetables and fruits; and
- Training in farming skills.

Save the Children and CARE outline their social and behavior change communication (SBCC) approaches in their two strategic plans. Save did not write its SBCC strategy until 2016, when project activities had already started.[13] Save's SBCC strategy is based on the social ecological model, which "understands the multi-faceted and interactive effects of personal and environmental factors on certain health behaviors" and the stages of behavior change theory, which describes the process of behavior change. The CARE document titled Operational Communication Strategy does not express a theoretical framework beyond "permitting a strategy that is coherent and rigorous for the pacification of activities relative to social and behavior change communications."

The two implementing partners have long-standing relationships with USAID. Paid field staff or project community mobilization workers led efforts to mobilize communities in both program zones, intervening in 10 to 20 villages each. They were the catalysts for the initial engagement of village chiefs and their counselors, creating or engaging committees (WASH, nutrition, health and groups for conducting outreach, like women leaders and *Mamans Leaders Animatrice)*. The project community mobilizers were called "social and behavior change assistants" in Sikasso and "community development agents" in Mopti.

The projects were instrumental in training all of the community-level volunteers, including the community health volunteers (*relais*), who then reached out to the beneficiaries. At the start of the project in Mopti, the NGO Ya G Tu hired 15 project community mobilizers to serve 600 villages, a number they later determined to be insufficient. The NGO then increased the number of agents to 38 and the number of villages served by each decreased to between 15 and 20. The staff includes eight supervisors and one coordinator. In Sikasso, Save directly engaged 20 social and behavior change assistants who serve 10 to 15 villages each for a total of 237 villages. Two SBC officers and a technical coordinator supervise them. In both zones, the project community mobilizers live in the commune where they work and travel between villages on motor bike.

CARE had the added advantage of having previous experience with farm field schools, a nutrition project that included the promotion of WASH behavior change, exclusive breastfeeding, cooking demonstrations and enriched porridge for complementary feeding in the geographic locations in which they were implementing the IRP. CARE hired project community mobilizers from the past and revised existing support materials. Save identified the project community mobilizers assigned to them to support villages in 2014. They first assisted in the development of the baseline study and community diagnostic. The next year, they helped form committees and trained community leaders such as WASH committees and women's group leaders, including the certification of villages that were ODF zones, screening for malnourished children, the cooking demonstrations and many other interventions.

The engagement and motivation of local leaders and community volunteers at the village level was a significant factor in the achievement of results of the Integrated Rural Program. This was done using participatory approaches led by the project community mobilizers. Through training, the community leaders came to understand and appreciate the value of the relatively complex and diverse interventions and the benefits they brought. "Our community is very invested in the project. All actors are involved, which is good for continuing what we are doing for a long time," a village chief in Sikasso said in a KII.

[13] Human resource management issues prevented Save from developing a SBCC strategy at the outset.

EVALUATION METHODS AND LIMITATIONS

The MSI evaluation team adopted three complementary approaches to data/information gathering:

- Documentation-based context analysis and implementation narrative;[14]
- Qualitative information collection; and
- Quantitative sampling-based data gathering.

The evaluation team reviewed and analyzed information directly related to IRP implementation through multiple internal and external sources: monitoring reports, administrative documentation and sector-specific analyses. The team analyzed documents on the design of the two programs, results frameworks and monitoring data that enabled a thorough assessment of the implementation objectives, intended results, strategies, target sectors, technical approaches and identification of changes that occurred.

The team used a purposive sampling method to select and interview key informants, including USAID staff, key Government of Mali employees, Save the Children staff, CARE International staff, civil society organizations (CSOs) and related support groups and opinion leaders in the communities, as well as beneficiaries. The team developed and used the data collection tools (see Annex II) to perform key informant interviews (KIIs) and focus group discussions (FGDs). In some villages, the heterogeneous composition of the interviewed group disqualified it from being considered a FGD. In those cases, the team held a more informal group meeting. Table 1 presents the number of informants by type of interviews and IRP sector.

TABLE 1: NUMBER OF INFORMANTS BY TYPE OF INTERVIEWS AND IRP SECTOR

Types of Data Collection and Gender of Participants	Beneficiaries	Key Informants	Totals by gender	
			Females	Males
Key Informant Interviews				
Females		11	11	
Males		43		43
Focus Group Discussions				
Females	163	57	220	
Males	39			39
Group Meetings				
Females		14	14	
Males	6	14		20
Mini-Survey				
Females	400		400	
Total Adults	608	139	645	102
Children 0-23 m.			359	
		Grand Total	**1106**	

[14] See Annex IIIB: List of Documents

TABLE 2: NUMBER OF INFORMANTS BY ORGANIZATION AND SECTORS

Implementing Organizations		Village Partners		Core Sectors	
USAID	6	Chiefs and advisors	16	Health / CSCOM	23
CARE/Y-AG-TU	14	Community Health Volunteers (relais)	7	WASH related	10
Save the Children / SNV	31	Maman leaders (Sikasso)	50	Communications	5
				Agriculture	29

Table 2 offers another perspective, as it breaks down informants by categories. Regional authorities and technicians fall in the core sectors column.[15] For qualitative data collection, the MSI evaluation team developed focus group discussion guides and key informant interview questions to conduct FGDs and KIIs with beneficiaries in a sample of beneficiary populations. For key informants interviewed in the communities, the evaluation team used a purposive sampling technique to select the project community mobilizers they interviewed. The team paid particular attention to selecting women community mobilizers, as they form part of the beneficiary category. For quantitative data collection, the identification criteria included beneficiaries who were pregnant or lactating or have children between 0 and 23 months. FGDs were organized to interview: female beneficiaries, spouses of female beneficiaries and male and female community leaders, who were also part of beneficiary category.

For the quantitative portion of the data collection, the team designed and implemented a mini-survey that yielded important quantitative data to triangulate the qualitative information gathered from the KIIs and FGDs. Set in rural communities in the four districts of Bougouni and Sikasso District in the Sikasso Region, and Bandiagara and Mopti districts in the Mopti Region, the survey was approved by the National Institute of Research in Public Health of the GOM, and did not meet with resistance from the beneficiary females. The team conducted the quantitative portion of the data collection using a two-stage, stratified survey. First, the project clustered beneficiaries into regions, which coincides with the two intervention zones:

- Care International intervention zone: Mopti Region
- Save the Children intervention zone: Sikasso Region

Second, the team purposively selected two districts from each intervention zone/region. The selected districts are Mopti and Bandiagara districts in the Mopti Region and Sikasso and Bougouni districts in the Sikasso Region. In selecting the districts, the team considered those that have received the full range of interventions to ensure ascertainment of the true effect of integration.

In each health district, at the first level, the team used a computer-generated random sampling method to choose 10 villages among those that received the intervention. At the second level, the team selected 10 women of reproductive age (age 15 to 49 years) from each community using the following criteria: pregnant women and those with children under 2 who have lived for a minimum of six months in a sector of IRP's interventions. Therefore, 20 villages in each strata and 200 women in the reproductive age group took part, for a total of 40 villages and 400 women in the selected categories.

[15] See Annex IIIA for details.

To identify the 10 respondents in each community, the team selected households using a stratified random sample. In each selected village, the team sought 10 households with a woman of within the ages of 15-49 years who had a child younger than 2 years, or who was pregnant, or both. Using the village center as a landmark, the team tossed a ballpoint pen and followed the direction the pen was pointing when it landed. The team then numbered the houses on both sides to the end of the village. Using a simple random draw, the team chose one household at the starting point and visited households until they obtained 10 with a woman who met the selection criteria.

In each selected household, the team interviewed the woman, screened her for anemia using the Hemocue Hemoglobin Analyzer and measured her height and weight. However, pregnant women were only screened for anemia. They also screened all children under 2 living in the household using anthropometric measurement and Hemocue anemia screening. To ensure accurate measurement, the research assistants were taken through two days training by a medical professor and nutrition specialist for the evaluation. The training also included field practice to ensure the research assistants had both theoretical and practical knowledge.

TABLE 3: DISTRIBUTION OF THE SAMPLE OF 0- TO 23-MONTH-OLD CHILDREN, SURVEYED BY STUDY AREA

Age Groups	Mopti		Sikasso		Both regions	
	Number	%	Number	%	Number	%
Less than 6 months	56	31,2	31	17,1	87	24,2
6 to 11 months	68	38,1	66	36,5	134	37,4
12 to 23 months	54	30,7	84	46,4	138	38,4
Total	**178**	**100**	**181**	**100**	**359**	**100**

The 400 female beneficiaries who participated in the mini-survey included 359 children aged 0 to 23 months. Forty-one of the pregnant women of childbearing age did not yet have children. The number of children aged 0 to 23 months in the study was 359, with 178 in the Mopti Region (49.6 percent) and 181 in Sikasso (50.4 percent).

Children of the age groups of 6 to 11 months and 12 to 23 months made up 37.4 percent and 38.4 percent of the total sample respectively. Children under 6 months accounted for 24.2 percent, with 31.2 percent in Mopti and 17.1 percent in Sikasso.

Limitations

The evaluation could not find data on anemia from the baseline surveys that were conducted by the implementing partners before the commencement of the projects in 2013. This made it impossible to establish bases for comparison and identify the changes in the status of anemia for both children under two years and women of reproductive age. The evaluation therefore presented analysis on anemia identifying the current status, but not comparing the effect of project intervention as required by the evaluation question.

Security issues impacted the Mopti team's capacity to randomly select communities.[16] The communities selected and interviewed were those with relative peace, limiting the level of randomization of the communities and, by extension, the respondents. In some cases, communities

[16] This was more clearly the case in the Mopti District, less so in Bandiagara.

that were sampled had to be changed due to changes in the security situation in those geographic locations.

EVALUATION FINDINGS

QUESTION 1: PROJECTS' EFFECT ON NUTRITIONAL STATUS

What effect have the projects had on the improvement of nutritional status in their target zones? Specifically, how have the following indicators been affected, and how could achievements be accelerated in the future?

• Reduction of the prevalence of stunting, wasting, underweight and anemia among children under 2 years of age in USAID-supported districts;
• Reduction of the prevalence of underweight and anemia among women of reproductive age in USAID-supported districts;
• Increasing the prevalence of children aged 6-23 months receiving a minimum acceptable diet and increasing in the average number of food groups consumed by beneficiary women; and
• Improving nutrition-related behaviors such as exclusive breastfeeding and appropriate complementary feeding for children aged 6 months-23 months.

FINDINGS: CHILDREN UNDER 2 YEARS

CHILDREN'S STUNTING RATES

TABLE 4: DISTRIBUTION OF STUNTING IN CHILDREN AGED 0–23 MONTHS, BY AREA OF INTERVENTION

Stunting (T/A)	Mopti	Sikasso	Total
	%	%	%
Severe stunting (T/A<-3ET)	2,8	8,8	5,8
Moderate stunting (T/A ≥-3 et <-2ET)	12,9	22,1	17,5
Total Stunted	***15.7***	***30.9***	***23.3***
Baseline Status	***20.5***	***18.6***	***19.6***
Difference over Baseline	***-4.8***	***12.3***	***3.7***
Percentage Achieved	***-23.4***	***66.1***	***18.9***
Risk (T/A ≥ -2 et <-1 ET)	22,5	26,5	24,5
Normal (T/A≥-1 et <1ET)	48,9	35,9	42,3
Risk of overweight (≥1 et <2 ET)	8,4	5,0	6,7
Overweight (≥ 2 ET)	4,5	1,7	3,1
Total	100,0	100,0	100,0

The prevalence of **stunting** for the entire sample is 23.3 percent, with 5.8 percent experiencing the severe form. In Mopti, the prevalence is 15.7 percent (2.8 percent severe). In Sikasso, the prevalence is 30.9 percent (8.8 percent severe).

The baselines in 2013 found stunting to be 19.6 percent overall; it is currently 23.3 percent. This indicator, whose projected target for 2018 provides for a reduction of 25.0 percent, has not yet been achieved and it is not likely to be achieved by the end of the project. Overall, stunting has gotten worse by 3.7 percent over the population of the two Regions, or 19.4 percent of the baseline status. To be able to achieve the target set for end of 2018, a 44.4 percent decrease will be needed to reach the initial target, which the evaluation team understands is impossible. The Mopti Region, however, saw a reduction in stunting in 4.8 percent of the general population, a decrease of 23.4 percent of the baseline status. The 25.0 percent reduction target for Mopti could therefore be achieved by end of 2018; however, there are some 22.2 percent who are at risk of getting stunted.

In the Sikasso Region, however, the stunting situation worsened and they experienced a 12.3 percent increase over the general populations, translating into a 66.1 percent increase of the baseline status. To achieve the planned reduction of 25.0 percent of the baseline by end of 2018, the project needs to decrease the current state by 91.1 percent of the baseline status, which is impossible to achieve by the end of 2018. Another 26.5 percent of the children under 2 years are at risk of becoming stunted. Further efforts are therefore needed to prevent these children from stunting, while also improving the status of those who are already stunted.

CHILDREN'S UNDERWEIGHT RATES

TABLE 5: DISTRIBUTION OF UNDERWEIGHT IN CHILDREN AGED 0–23 MONTHS BY AREA OF INTERVENTION

Underweight (T/A)	Mopti	Sikasso	Total
	%	%	%
Severe underweight (T/A<-3ET)	2,2	5,0	3,6
Moderate underweight (T/A ≥-3 et <-2ET)	9,0	11,0	10,0
Total Underweight	***11.2***	***16.0***	***13.6***
Baseline Status	***37.8***	***20.5***	***29.2***
Difference over Baseline	***-26.6***	***-4.5***	***-15.6***
Percentage Achieved	***-70.4***	***-22.0***	***-53.4***
Normal (TA≥-1 et <1ET)	57,3	45,3	51,3
Risk of overweight (≥1 et <2 ET)	7,3	5,0	6,1
Overweight (≥ 2 ET)	1,7	100,0	0,8
Total	**100,0**	**100,0**	**100,0**

The prevalence of **underweight** for the whole sample is 13.6 percent, with 3.6 percent experiencing the severe form. For the Mopti Region, the prevalence is 11.2 percent (2.2 percent severe). In Sikasso, the prevalence is 16.0 percent (5 percent severe). See Table 5.

The baseline in 2013 found underweight to be 29.2 percent overall and the endline found the current status as 13.6 percent, a reduction of 15.6 percent, or an achievement of the 2018 target. The current status is a decrease of 53.3 percent or the baseline status, exceeding the 2018 target of 30 percent reduction. This situation is observed in the two study areas with a much larger reduction of 70.4 percent in Mopti. In Sikasso, the proportion of children below 2 years who are underweight has dropped by 22.0 percent of the baseline status. Even though this is short of the 30 percent target, the project could achieve that by the end of 2018 if it continues its current rate of progress.

CHILDREN'S WASTING RATES

TABLE 6: PREVALENCE OF WASTING IN CHILDREN UNDER 2 BY INTERVENTION AREA

Wasting (Index P/T)	Mopti	Sikasso	Total
	%	%	%
Severe (P/T<-3ET)	2,2	2,2	2,2
Moderate (P/T ≥-3 et <-2ET)	6,2	4,4	5,3
Total Wasting	***8.4***	***6.6***	***7.5***
Baseline Status	***24.1***	***11.2***	***17.7***
Difference over Baseline	***-15.7***	***-4.6***	***-10.2***
Percentage Achieved	***-65.1***	***-41.1***	***-57.5***
Risk (P/T ≥ -2 et <-1 ET)	15,2	26,5	20,9
Normal (PT≥-1 et <1ET)	58,4	59,7	59,1
Risk of overweight (≥1 et <2 ET)	14,0	5,0	9,5
Surcharge (≥ 2 ET)	3,9	2,2	3,1
Total	**100,0**	**100,0**	**100,0**

Wasting in children aged 0 to 23 months is 7.5 percent overall with 2.2 percent in severe form for the entire sample. For the region of Mopti, it is 8.4 percent (2.2 percent severe). For the Sikasso region, the prevalence of wasting is 6.6 percent (2.2 percent). In both regions, more than half (59 percent) of children under 2 years have a normal nutritional status, with 58.4 percent in Mopti and 59.7 percent in Sikasso.

The baseline in 2013 found wasting to be 17.7 percent overall; it is currently 7.5 percent, representing an overall reduction of 10.2 percentage points. The projects had targeted a reduction in wasting of 30 percent of the baseline status by the end of 2018; however, the projects have been able to exceed this target, recording a 57.5 percent reduction of the baseline status. The team observed this situation in the two study areas, with Mopti recording a 65.1 percent reduction and Sikasso recording a 41.1 percent reduction.

CHILDREN'S ANEMIA

TABLE 7: PREVALENCE OF ANEMIA IN CHILDREN AGED 6–23 MONTHS BY STUDY AREA

Anemia	Mopti	Sikasso	Total
	%	%	%
Severe (<7g)	10,7	7,2	8,9
Moderate between 7 and 10g)	63,6	55,1	59,1
Total Anemia	**74.3**	**62.3**	**68.0**
***Percentage Achieved* (50%)**			**?**
Light (between 10 and 12g)	22,3	34,8	1,9
No anemia (>12g)	3,3	2,9	3,1
Total	100,0	100,0	100

The prevalence of **anemia** in children aged 6 to 23 months for the entire study sample is 68 percent with 8.9 percent severe form. This prevalence is 74.3 percent in Mopti, of which 10.7 percent severe

form, and 62.3 percent in Sikasso, with 7.2 percent severe form. As stated in the limitations to this evaluation, the baseline surveys did not collect data on anemia. There is therefore no baseline to compare the current status and identify the extent of achievement of the project's target.

EXCLUSIVE BREASTFEEDING PREVALENCE

TABLE 8: DISTRIBUTION OF EXCLUSIVE BREASTFEEDING IN CHILDREN UNDER 6 MONTHS, BY STUDY AREA

Exclusive Breastfeeding	Mopti	Sikasso	Total
	%	%	%
Midterm	62,9	63,7	63,3
Baseline	33.5	35.3	34.4
Difference over Baseline	29.4	28.4	28.9
Percentage Achieved	87.8	80.5	84.0

Exclusive breastfeeding is practiced by 63.3 percent of the whole sample, with 62.9 percent in Mopti, and 63.7 percent in Sikasso. Exclusive breastfeeding was 34.4 percent overall at the start of the projects, according to the 2013 baseline study, and currently stands at 63.3 percent, an increase of 28.9 percent translating into 84.0 percent of the baseline figure. Compared to the projects' planned target of 50 percent increase within the project life, this target has already been exceeded. The level of performance achieved by the two regions varies from 29.4 percent in Mopti, translating into 87.8 percent of the baseline, and 28.4 percent increase in Sikasso translating into 80.5 percent increase over the baseline. The means the targets have been achieved in both zones.

CHILDREN'S MINIMUM DIETARY DIVERSITY

TABLE 9: DIETARY DIVERSITY SCORE IN CHILDREN 6-23 MONTHS, BY STUDY AREA

Dietary diversity score	Mopti	Sikasso	Total
	%	%	%
Weak dietary diversity score (< 4 food groups)	45,3	42,6	43,9
Acceptable dietary diversity score (4 or more foods groups)	54,7	57,4	56,1
Baseline Status	**20.1**	**13.2**	**16.7**
Difference over Baseline	**34.6**	**44.2**	**39.4**
Percentage Achieved	**172.1**	**334.8**	**235.9**

The **dietary diversity score** of children aged 6 to 23 months for the entire sample is acceptable for 56.1 percent of children in this age group, as they consume between four and five food groups per day. The proportion of children aged 6 to 23 months receiving a minimum dietary diversity in Mopti is 54.7 percent. In Sikasso, the evaluation found the proportion to be 57.4 percent.

The minimum dietary diversity for children aged 6 to 23 months was 16.7 percent in 2013 and is now 56.1 percent, an overall performance increase of 39.4 percent compared to the baseline level, reflecting a substantial increase of 235.9 percent of the baseline status, which is less than the 250 percent target set for 2018 but close enough to be achieved within project life. In Sikasso, the project contributed to an increase of 13.4 percent prevalence over the baseline to 57.4 percent, a difference of 44.2 percent — translating to 334.8 percent of the baseline figure and exceeding the

target increase of 250 percent. However, in Mopti, the proportion of children receiving minimum dietary diversity increased from 20.1 percent in 2013 to 54.7 percent in 2017, an increase of 34.6 percent, which translates into 172.1 percent of the baseline status. The Mopti project is therefore far from achieving the 250 percent target and it's not likely to be able to achieve that by end of 2018 as planned.

TABLE 10: LEVEL OF SIGNIFICANCE IN DIFFERENCE BETWEEN CHILDREN 6-23 MONTHS WITH COMPLETE BENEFICIARY PARENT AND THOSE WITH INCOMPLETE BENEFICIARIES PARENT

	Complete Beneficiaries[17]		Incomplete Beneficiaries		*p*
	Respondents	%	Respondents	%	
Wasted (n=312)	16	12,3	29	15,9	*0,416*
Not wasted	114	87,7	153	84,1	
Stunted (n=312)	29	23,3	49	26,9	*0,426*
Not Stunted	101	77,7	133	73,1	
Underweight (n=312)	7	5,4	14	7,7	*0,286*
Normal weight	123	94,6	168	92,3	

The survey found that among children of complete beneficiaries below 2 years, 12.3% are wasted, compared to 15.9% of children of incomplete beneficiaries. It further found 23.3% of children of complete beneficiaries being stunted compared to 26.9% of children of incomplete beneficiaries and 5.4% of children of complete beneficiary parent being underweight compared to 7.7% of children of incomplete beneficiary parents. At 95% confidence and +/-5% margin of error, the evaluation found no significant difference on stunting, wasting, and underweight between children 6-23 months whose parent benefited from the complete project package when compared with those whose parent did not benefit from the complete project package but benefited partially.

[17] Complete beneficiaries are parents who benefited on Nutrition, WASH and Agriculture. However, beneficiaries who benefited from two or less components of the project such as Nutrition and WASH or Nutrition and Agriculture are classified as incomplete beneficiaries.

TABLE 11: LEVEL OF SIGNIFICANCE IN DIFFERENCE BETWEEN CHILDREN 6-23 MONTHS WITH COMPLETE BENEFICIARY PARENT AND THOSE WITH INCOMPLETE BENEFICIARIES PARENT

	Complete Beneficiaries		Incomplete Beneficiaries		*p*
	Respondent	%	Respondent	%	
Exclusive breastfeeding (n=260)	54	43,9	43	31,9	*0,037*
Non exclusive breastfeeding	69	56,1	94	68,6	
Anemic (n=137)	32	34,8	37	27,0	*0,134*
Non- anemic	60	65,2	100	73,0	
Acceptable dietary diversity score (n=221)	52	55,3	72	61,5	*0,220*
Weak dietary diversity score	42[a]	47,7	45	38,5	

At 95% level of confidence and +/-5% margin of error, the survey found a significant difference between the proportion of complete beneficiaries practicing exclusive breastfeeding and incomplete beneficiaries practicing exclusive breastfeeding, with a p-value of 0.037. However, no significant differences were established on anemia and dietary diversity score between children (6-23 months) of complete beneficiaries and those of incomplete beneficiaries.

FINDINGS: WOMEN OF REPRODUCTIVE AGE

WOMEN'S ANEMIA

TABLE 12: PREVALENCE OF ANEMIA IN WOMEN OF CHILDBEARING AGE, BY AREA OF STUDY

Anemia	Mopti	Sikasso	Total
	%	%	%
Severe (<7g/l)	16,3	9,9	13,1
Light (between 7 and 10g/l)	17,4	19,9	18,7
Total Anemia	***33.7***	***29.8***	***31.8***
Project Target (50%)			**?**

The prevalence of **anemia** for the whole study area is 31.8 percent, of which 13.1 percent is severe. For the region of Mopti, the prevalence is 33.7 percent, of which 16.3 percent is severe. For Sikasso, the prevalence is 29.8 percent, of which 9.9 percent is severe. The baseline did not measure anemia, therefore there is no basis for comparison to determine if the project is on target to achieve its target of 50% reduction is the prevalence rate.

WOMEN'S UNDERWEIGHT

TABLE 13: PREVALENCE OF UNDERWEIGHT AMONG NON PREGNANT WOMEN OF CHILDBEARING AGE, BY AREA OF STUDY

Underweight	Mopti	Sikasso	Total
	%	%	%
Midterm Underweight (BMI<18,5)	7,6	6,6	6,8
Baseline Status	*10.2*	*8.6*	*9.4*
Difference over Baseline	*-2.6*	*-2.0*	*-2.6*
Percentage Achieved	*-25.5*	*-23.3*	*-27.7*
Normal (BMI between 18.5 and 25)	71.4	76.6	72.2
Overweight (BMI > 25)	21,0	16,8	18,3
Total	**100,0**	**100,0**	**100,0**

The prevalence of **underweight** among women of reproductive age is 6.8 percent overall with 7.6 percent in Mopti and 6.6 percent in Sikasso.

The prevalence of underweight among women of childbearing age was 9.4 percent overall in 2013 before the start of the projects, compared to 6.8 percent for the present study, a 2.6 percent difference translating into a reduction of 27.7 percent of the baseline status. The projects had planned to achieve a 20 percent reduction over the baseline status; thus, the target has been met. The trends are the same in both regions, with a reduction of 2 percent in Sikasso and 2.6 percent in Mopti, translating to a reduction of 23.3 percent of the baseline proportion in Sikasso and 25.5 percent in Mopti. Both regions have achieved their targets ahead of schedule.

TABLE 14: EVOLUTION OF NUTRITIONAL INDICATORS OF CHILDREN YOUNGER THAN 2 YEARS AND WOMEN OF CHILDBEARING AGE, AND THE PERFORMANCE GAP

	Baseline (2013)			Midterm evaluation, January 2018				Variation (Performance)				Level Achieved Objective	
Nutrition indicators	Sikasso	Mopti	Both	Sikasso	Mopti	Both	Expected Value	Sikasso		Mopti			
	A	B	C	D	E	F		gain	progress	gain	progress	Gain	Set objective
								G= (D-A)	H=(G/A)*100	I= (E-B)	J=(I/B)*100	K=(F-C)	L=(K/C)*100
Underweight	20,5	37,8	29,2	15	11,2	13,6	-30%	-5,5	-26,8	-26,6	-70,4	-15,6	**-53,3**
Wasting	11,2	24,1	17,7	6,6	8,4	7,5	-30%	-4,6	-41,1	-15,7	-65,1	-10,2	**-57,5**
Stunting (children < 2 years)	18,6	20,5	19,6	30,9	15,7	23,3	-25%	12,3	66,1	-4,8	-23,4	3,8	19,2
Anemia among (children < 0-23 months) *	83,5	88,6	86,1	62,3	74,3	68	-30%	*-21,2*	*-25,4*	*-14,3*	*-16,1*	*-18,1*	-21,0
Exclusive breastfeeding	35,3	33,5	34,4	57,4	58	56,1	50%	22,1	62,6	24,5	73,1	21,7	**63,1**
Minimum dietary diversity (child 6-23 months)	13,2	20,1	16,7	57,4	58	55	275 %	44,2	334,8	37,9	188,6	38,4	230,3
Underweight of women	8,6	10,2	9,4	6,6	7,6	6,8	-20%	-2	-23,3	-2,6	-25,5	-2,6	**-27,7**
Prevalence of anemia among women[18]	52	56,9	54.5	29,8	33,7	31,8	-20%	-22,2	-35,6	-23,2	-40,8	-22.7	-41.65

[18] The baseline figures for anemia were taken from the 2012–2013 DHS.

QUESTION 2: STRATEGIC ENGAGEMENT IN WASH

How can strategic engagement in the WASH sector sustainably improve the way WASH services are delivered at the household level?

How can systems and capacity be built to ensure the sustainability of functioning water and sanitation services?

How can open defecation free (ODF) status be maintained once it is achieved?

What results provide actionable evidence-based items to improve current projects and inform future designs?

FINDINGS

A: How can systems and capacity be built to ensure the sustainability of functioning water and sanitation services?

Rehabilitation of water points limited. Although there were no targets for rehabilitation of water points, in the CARE program area, the projects rehabilitated a total of 48 water points between 2016 and 2017. In Mopti, they rehabilitated six water points, with another 20 in Bandiagara. To improve future maintenance, 19 local repairmen received training in pump repair and nine municipalities received toolboxes in the Mopti survey zone. In Sikasso, many of the 200 community action plans included pump repair, but in the end, only 15 water points were rehabilitated by a private company hired by Save the Children. In one commune, six villages sought to have their pumps repaired by the project, but only one received funding from Save.

Progress in household treatment of water. The promotion of treatment of household drinking water resulted in increased use of bleach and aquatabs to treat water. Households used both locally produced and imported bleach such as the brand MADAR. The mission did not find the use of chlorine product Sur'Eau in the field. The survey found that bleach and aquatabs were the most popular means of purification.[19] The mini-survey (see Tables 13) revealed a net increase in home treatment compared to the 2014 baseline survey. In Mopti, 72.4 percent of women beneficiaries reported treating water compared to 47.2 percent in the baseline. In Sikasso, the increase was to 67.5 percent from 43.8 percent. In 8 of the 20 focus group discussions with women beneficiaries, community volunteers conducting outreach, including Mobilizers and leaders of women's groups, were viewed as influential in promoting 100 percent treatment of water. Program-supported outreach also focused on hygiene of the water chain, the collection, transport, treatment and good conservation of the water. Closed containers for transporting and storing water were also distributed on a limited basis during events such as the celebration of the national WASH day. Awareness of risks associated with unsafe drinking water and the importance of preserving the quality of drinking water was raised in all 20 FGDs with both women and men.

[19] The socially marketed water treatment product Aquatab, was found to be available but used by a small percentage of respondents.

ACHIEVEMENT OF WASH INDICATORS

TABLE 15: PREVALENCE OF HOUSEHOLDS PRACTICING CORRECT USE OF RECOMMENDED HOUSEHOLD WATER TREATMENT TECHNOLOGIES

Regions	Baseline	Midterm	% Difference over Baseline
Sikasso	43,8	67,50	23,70
Mopti	47,20	72,40	25,20
Total	**45,50**	**70,8**	**23,30**

Both projects recorded increases over their baseline status. At Sikasso, the evaluation team found 67.5 percent of respondents practicing the recommended household water treatment technology. This is 23.70% above the baseline status of 43.8%. A similar trend is found in Mopti, where the project recorded a 25.2 percent difference over the baseline status with the current status being 70.8% of households surveyed practicing the recommended water treatment.

TABLE 16: PERCENTAGE OF HOUSEHOLDS WITH SOAP AND WATER AT A HAND-WASHING STATION COMMONLY USED BY FAMILY

Location	Baseline	Midterm	% Difference over Baseline	Project Target (%)	% Achieved
Sikasso	8,50	77.6	68.7	150,00	808.2
Mopti	29,70	80.4	50.7	150,00	183.1
Total	**19,1**	**78.8**	**59.7**	**150,00**	**312.6**

The evaluation found that 77.6 percent of households in Sikasso and 80.4 percent in Mopti have hand-washing stations with soap and water. The secondary baseline proportion that the evaluation found for Sikasso was low (8.5 percent) and therefore the increase resulted in 808.2 percent of the baseline figure. For Mopti, which had a more realistic baseline, the midterm performance indicates an increase of 312.6 percent of the baseline status. Both projects have therefore exceeded their project life target of 150.0 percent already with about a year of implementation yet to be completed.

TABLE 17: NUMBER OF COMMUNITIES CERTIFIED AS OPEN DEFECATION FREE AS A RESULT OF USG ASSISTANCE

Location	Baseline	Midterm	Target	Difference	% Achieved
Sikasso	0,00	185	300	- 115	61.7
Mopti	0,00	185	300	- 115	61.7
Total	0,00	370	600	- 230	61.7

Each project had planned to support 300 communities to attain ODF status during the project lifetime. Even though the projects still have about a year to go, they are not likely to achieve their targets. The evaluation team found that about 185 communities (61.7 percent) have been certified in Sikasso Region with 185 (61.7 percent) certified in Mopti Region. These data mean that to achieve the projects' targets, there is the need for the certification of 230 more communities in Sikasso and Mopti. This would be difficult to achieve within the short period left. Factors that hindered the

achievement of CLTS targets include: the security situation, high attrition rate among IPs, inadequate human resources in sanitation services, nomadic fishing populations and the difficulty of conducting CLTS in large villages.

TABLE 18: COMPARISON OF COMPLETE AND INCOMPLETE BENEFICIARIES ON USE OF RECOMMENDED WATER TRATEMENT METHODS

	Complete Beneficiaries		Incomplete Beneficiaries		p
	Respondents	%	Respondents	%	
Use recommended water treatment method	133	55.9	62	44.3	
Use unrecommended water treatment method	105	44.1	78	55.7	0.0292
Total	**238**	**100,0**	**140**	**100,0**	

The survey found that 55.9% of complete beneficiary householders used aquatabs to treat their water. However, among incomplete beneficiary households, the proportion is 44.3%. A test of significant found a p-value of 0.0292 indicating that a significant proportion of complete beneficiary households use the recommended water treatment technology when compared to the incomplete beneficiary households.

TABLE 19: COMPARRISON OF COMPLETE AND INCOMPLETE BENEFICIARY HOUSEHOLDS ON AVAILABILITY OF HAND WASHING STATIONS

	Complete Beneficiaries		Incomplete Beneficiaries		p
	Respondents	%	Respondents	%	
Household with Handwashing station	123	86.6	68	68.0	
Household without Handwashing station	19	13.4	32	32.0	0.04
Total	**142**	**100**	**100**	**100.0**	

For households with a hand washing station that includes water and soap, the survey found 86.6% of complete beneficiary households have such hand washing stations. However, among incomplete beneficiary households, the survey found the proportion to be 68.0%. A p-value of 0.04 was found when a test of significance was conducted, indicating that the difference is significant. Therefore, households that benefited from the complete package are more likely to have a handwashing station than households that benefited from two or less components.

Community-Led Total Sanitation (CLTS) efforts increased latrine construction. According to FGDs and KIIs**,** communities worked hard in building new latrines and rehabilitating others to meet the Open Defecation Free zone status and get their village certified. Eighty-eight percent of the women in the mini-survey said they now had access to a latrine; this was confirmed during FGDs. According to the mini-survey, 36.4 percent of women beneficiaries in Mopti said their latrines were built with concrete slabs and 28.6 percent in Sikasso. 59.1 percent of respondents in Mopti and 71.4 percent in Sikasso said

their latrines were traditional with bases of clay or wood and gravel. The project facilitated the construction of the latrines through community mobilization without providing financial support to the communities to construct. The community WASH committees, supported by village chiefs, promoted latrine construction and threatened fines for non-compliance. "The WASH committee chairman noticed some households were slow to build latrines and asked me to order fines for those who don't build or repair," a village chief in Sikasso said in a KII.

Masons trained in concrete slab construction. With the goal of increasing access to cement latrine bases, IPR trained some 479 masons in latrine construction and encouraged them to use molds to create SANPLAT slabs that were round or square with a five-inch hole in the center. The intention was for masons to construct the slabs locally and market them in their community. Only 7 out of 200 women beneficiaries in the mini-survey reported having a SANPLAT concrete slab in Mopti and none in Sikasso though there were 2 FGD women participants in Sikasso who had seen SANPLAT slabs for sale in the market. These activities started not long ago. In Mopti, for example, the activities were carried out as part of an action research project in the context of WASH marketing with the installation of 12 pilot centers for sanitation shops run by women's groups of Musa Ka Jiguya Ton (MJT).

B. How can open defecation free (ODF) status be maintained once it is achieved?

Open defecation free certificates and community motivation. When comparing the baseline with the midterm data, both Sikasso and Mopti showed some increases in the number of villages certified as a result of USG assistance. Both Regions went from 0 in the baseline to 185, achieving 61.7% of the planned target. In Mopti and Bandiagara districts, 28 IRP villages were certified in 2016. In Sikasso, 72 IRP villages were certified the same year. The mini survey found that 86.8 percent of beneficiaries from communities that have been certified were aware of the certification of their village. The same survey found that 98.5 percent of women respondents in Sikasso and 78.4 percent in Mopti reported having a latrine, another certification criteria. Community leaders, including chiefs and WASH committee members, in FGDs and KIIs uniformly expressed pride in being awarded the certificate and in the impact a more hygienic village had on health.

Post-ODF strategies contribute to maintaining vigilance. To sustain the gains, a Post-ODF strategy was developed by the National Directorate of Sanitation and Pollution Control and Nuisances (DNACPN) with the support of the Implementing Partners. Dissemination workshops of the post-ODF strategy took place in the regions. To support post-ODF activities, clean village competitions are underway to create enthusiasm and competition between villages in hygiene and sanitation. Communities that achieved ODF were supported to develop village level action plans that the villages would implement to ensure sustainability of ODF.

Regional and District Offices play key role in sustainability. The WASH government offices have been actively involved in supervision of WASH activities and village certification. A partnership agreement between CARE and the National Directorate of Sanitation and Pollution Control and Nuisances (DNACPN) calls for capacity building and institutional support focused on:

- The institutional diagnostic study of the DNACPN and its divisions, which allows the partners to see the strengths and the weaknesses;
- Preparation of the manual of administrative and accounting procedures;

- Vehicle donated by CARE to the DNACPN to support in supervision of WASH activities
- Computer hardware support to the DNACPN and the DRACPNs of Koulikoro, Ségou, Kayes and Mopti;
- Support for toilet day celebrations and conference attendance;
- Support for setting up a sanitation database on the web

All activities were implemented: a diagnostic study was done that assessed the strengths and weaknesses of the DNACPN; the manual improved the management of funds allocated to DNACPN by development partners; the computer material served to manage the sanitation database which in effect had been supported through the agreement[20]. Save provided technical assistance directly to the Sikasso Regional Directorate for Sanitation and Pollution Control and Nuisance (DRACPN) with the goal of sustaining IRP WASH interventions.

C. What results provide actionable, evidence-based items to improve current projects and inform future designs?

Empowerment of communities through CLTS to develop WASH responses. IRP-supported CLTS[21] was not only the entry point of the other IRP components, but because of its mobilizing power, was also the backbone of the revitalization of hygiene and sanitation activities at the community level. It helped increase communities' awareness of the health risks associated with poor management of excreta. CLTS has also empowered leaders, community mobilizers and the public to identify and deal with problems of access to drinking water, hygiene and sanitation through the elaboration and monitoring of the implementation of village level action plans to sustain their ODF status. CLTS has been inclusive because it involves several actors such as technical services (health, water, sanitation), project leaders of implementing agencies, elected municipal officials and local radio operators. As a result, different stakeholders have been involved in ensuring its success. CLTS promoted the establishment of the water, hygiene and sanitation (CEHA) committees, which organize the community to clean the village at least once a week. In the 40 villages surveyed during the mini-survey and the meetings, there is evidence of a strong collective community response to WASH challenges inspired by community development agents and CLTS members.

Perceived Reduction in incidences of diarrhea. In the 20 FGDs and 10 KIIs in villages, there was a general perception that the incidences of diarrhea had been dramatically reduced in their communities since the collective response to WASH was started. According to the Local Health Information System (SLIS) database, there was a drop in diarrhea incidence in Mopti and Sikasso from 16 cases per thousand in 2015 to 13.9 cases in 2016. The biggest drop was in Mopti from 16.8 cases to 11.1 cases. Sikasso levels were stable.

QUESTION 3: FACTORS CONTRIBUTING TO RESULTS

[20] KII with Care and staff from DNACPN (See Annex IIIA).

[21] All 164 certified villages are required to have CLTS that have proven their effective management of sanitation in their villages (See Table 5).

What are the (positive and negative) factors contributing to the results achieved (or not achieved)? How did the projects integrate the nutrition, WASH and agricultural sectors? How effective was the integration approach?

FINDINGS

POSITIVE FACTORS CONTRIBUTING TO RESULTS IN COMMUNITY MOBILIZATION

Women leaders are key influencers in Sikasso Region. As Table 18 shows, 87 percent of respondents in Sikasso say women leaders have the most influence; however, they do not have the same level of influence in Mopti, where only 30 percent of respondents identified them as important influencers. In total, more than half (56 percent) of respondents identified them as important influencers.

TABLE 20: PERCENTAGE OF RESPONDENTS WHO CHOSE AMONG MOST IMPORTANT INFLUENCERS

Influencers	Sikasso	Mopti	Both Regions
Women leaders (including Mamans Leader Animatrices)	87	30	56
Community Health Agents (Agents de santé communautaire)	27	60	45
WASH committee	39	45	42
Nutrition support group	22	42	33
Agriculture Extension Agent	7	21	15
Savings and Loans Associations	10	17	14
Radio	14	11	12
Grandmothers	7	0	3
Posters	0	3	1
Television	1	2	1

**Under "other" the most common write in influencer was "project community mobilizer" with 17 mentions. Next was "community health volunteers (relais)" with 10 mentions, followed by "village chiefs" with 5.*

Community Health Agents. In Mopti, community health agents are seen as the most important influencers. The survey found that 60 percent of the respondents in Mopti view them as influential; in Sikasso, however, only 27 percent of respondents viewed them as influential.

Apart from women leaders and community health agents, no other group of influencers were accepted by up to half of the respondents as influential. There were, however, other groups that could have a measure of influence on sizeable proportion of the population, particularly in Mopti. These are mainly WASH committees (45%) and nutrition support groups (42%).

NEGATIVE FACTORS INFLUENCING RESULTS IN COMMUNITY MOBILIZATION

Slow start to project implementation. More could have been achieved in both Sikasso and Mopti if the social mobilization had occurred more rapidly and activities had started sooner. According to at least four governmental and NGO partners and four project community mobilizers interviewed in KIIs, Save's overly complex procedures and slow bureaucratic response approving and funding activities greatly slowed down implementation. It took two years to develop community action plans in Sikasso. "Action plans took a long time to prepare," a Save SBC assistant said in a KII, "because Save review procedures were too heavy they were never financed or realized causing disappointment and lost

confidence." A WASH government official said in a KII: "Not one organization we work with is more complicated than Save. Things were slowed by its bureaucracy."

The low ratio of project mobilizers to villages in Mopti limited early impact. A low ratio of those conducting the social mobilization for the project to the number of villages they were intended to serve, restricted what could be accomplished in each village. The ratio was one to 40 at first, then lowered to one to 10 or 15, which increased the speed of the Community Mobilization. The ratio was one to 10-15 from the start in Sikasso. "The low ratio of project field staff for the large number of villages made it more difficult to cover the villages," an NGO director in Mopti observed.

POSITIVE FACTORS CONTRIBUTING TO RESULTS IN AGRICULTURE

Those conducting agriculture technical assistance transferred farming skills. Save partner SNV was responsible for agriculture in Sikasso. CARE and its NGO partner Ya G Tu were responsible for agriculture extension in Mopti. In both zones, government agricultural technical services coordinated with the 16 project extension agents, who in turn, trained peer farmers. Each peer farmer mentored 10 women farmers in their village. Women in Sikasso were frustrated that they couldn't create gardens because of insufficient inputs, according to the 5 FGDs with the women agriculturalists. A major success, according to KIIs with government agriculture officials, was the establishment of "food banks" introduced by IRP to increase access to nutrient-rich foods through the planting of baobab and moringa trees.

Farm field school appreciated by women farmers. Two women each from 10 villages were brought to a central village within 15 kilometers to attend Farm Field School and "learn by doing." One attendee noted, "We enjoyed meeting other rural farmers who had the same problems as us." In Sikasso, when transport compensation ended, the women farmers said, attendance dropped off. The idea was for the two women who received training to share new skills with the eight other women in their farming group. Improved agricultural skills, such as the optimum distance to plant peanuts seedlings, were passed on to the women agriculturalists, according to the five FGDs with the women.

Saving and loan associations financed women farmers. Moving beyond traditional agricultural activities, IRP created and enhanced women's credit groups. More than 72 women's groups were supported to self-manage savings and loan activities. According to commentary in the FGDs with women beneficiaries and woman agriculturalists, the women found it easier to get credit to invest in agriculture. "We were enthusiastic about being able to get money discreetly and without humiliation from other lenders," one woman agriculturalist said in a Sikasso FGD.

TABLE 21: AGRICULTURE SERVICES RECEIVED BY FEMALE BENEFICIARIES

Services Received	Mopti (N=170)	Sikasso (N=71)
Provision of farming equipment	62%	18%
Training of farmers on crop cultivation	53%	66%
Provision of improved varieties of seeds	76%	83%
Provision of agricultural inputs (fertilizers and/or chemicals)	9%	37%
Water conservation techniques	23%	0%

Agriculture services received. There is evidence of an imbalance of the impact of the agriculture in IRP between the CARE and Save programs, according to the mini-survey of female beneficiaries. Of the 200 respondents in each zone, 170 women in Mopti reported receiving agricultural services and only 71 in Sikasso. Of those who responded, training in crop cultivation and some provision of seeds were the most common services mentioned in both zones. Four times as many women in Mopti as in Sikasso mentioned provision of farm equipment. Another difference was in water conservation techniques, like limiting runoff in Mopti. There were no mentions in Sikasso. (See Table 21)

NEGATIVE FACTORS AFFECTING RESULTS IN AGRICULTURE

Agriculture was the weakest of the three IRP elements. The full benefits of market gardens were limited to half of the villages in Mopti. The agricultural specialist at SNV suggested in KIIs that limited access to land, seeds and water severely limited productivity. FGDs with women agriculturalists revealed great enthusiasm for developing market gardens in Sikasso, but frustration with the limited support to create them.

Adding value to produce through processing missed opportunity. Techniques for harvesting, conservation and food processing (grinding into powder, drying, transformation) have great potential according to all nutrition and agriculturalists interviewed in KIIs because it expands the availability of produce well beyond the rainy season, but the techniques were underused by IRP, particularly in Sikasso. There was some drying of produce with IRP-supplied dryers in Mopti and processing of Soya into milk and powder in one village in Sikasso, but very little beyond that.

Save procedures restrictive. According to SNV, the Save partner for implementing agricultural programing in Sikasso, delays were caused by slow moving bureaucracy on the part of Save. The cascading sub-contracting of outreach work from Save to SNV to a local NGO was also found to be problematic in ensuring a balanced response between nutrition, WASH and agriculture.

HOW EFFECTIVE WAS THE INTEGRATION APPROACH?

Solid coordination structures from the start was a core factor in the integration of IRP. KIIs with those working in each of the three sectors for the programs, the government and the NGO partners were the primary sources of information for the analysis of this evaluation question. These data were complemented by quantitative data from the mini-survey with women beneficiaries and KIIs and FGDs with community-level beneficiaries.

IRP protocols were signed between IRP and the regional offices of Health, WASH and, at a slightly later date, Agriculture. An administrative framework for IRP was established in both zones. The Regional Directorate for Sanitation established the platform for supervision and regular meetings which were

used to develop work plans, implement the work plan and coordinate actions. "It has been a learning experience in finding ways to coordinate and engage," a regional WASH official in Sikasso said in a KII. "It is no longer a dialogue with always the same actors. We all had to come together on the same wave length." A regional health director agreed: "The challenge was to coordinate. It took good dynamic leadership." The framework that permitted NGOs and government technical services to work together on supervision and activities in the field was particularly appreciated by one NGO head in Mopti.

Integration of Nutrition, WASH, and Agriculture adds value. There was consensus among the many and diverse stakeholders that integrating nutrition, WASH and agriculture has positive benefits. "Can't talk about WASH without the others. All aspects are essential for good health," a District level WASH director said in a KII. "It is a very good approach. More can be achieved when the three sectors are taken into consideration together." There was a general appreciation of complementing skills and experience. "The project brought together, at the same time, actions that were complementary in WASH, nutrition and agriculture with a vision focused on success," the head of the NGO Ya G Tu said in a KII in Mopti. "There was a synergy in the actions by the different actors and their specific skills and knowledge."

Village-level integration was seamless. According to community leaders interviewed in KIIs in 20 villages, working on nutrition, WASH, and agriculture at the same time makes sense as they are well aware of the inter-relationships of the three elements in their daily lives. Better hygiene and clean water impacts nutrition. Better nutrition equates reduced illness. Working on the three sectors at the same time is no problem, according to half of those interviewed, because all citizens are affected by all elements. As the initiatives are introduced and promoted primarily by the project community mobilizer assigned to each village, there is cohesion in the approach. The creation of local plans also helped communities focus on collective action as a whole, rather than in component parts. "Integration is very important at our level," a District extension agent said in a KII. "It speeds up improvements. Villages tend to cultivate things just to eat and are slow to improve nutrition. There are more elements being worked on now in the village (nutrition, WASH, agriculture). We already see results."

High degree of satisfaction with integration among female beneficiaries. The mini survey found a fairly balanced level of satisfaction of the three components in Mopti. Among beneficiaries interviewed, 39.9% were very satisfied with 40.4% and 42.3% of beneficiaries interviewed being very satisfied in WASH and Nutrition respectively. The survey also found that 48.0% of beneficiaries interviewed were satisfied in Agricultures, 52.3 in WASH and 54.6% in Nutrition. In Sikasso, however, the survey found that whilst 46.3% and 65.9% of beneficiaries interviewed were very satisfied with WASH and Nutrition respectively, only 22.6% were very satisfied in Agriculture. Of those who indicated that they were satisfied in Sikasso, 46.7% were satisfied in WASH, 31.1% in Nutrition and 27.4% in Sikasso. (See Table 22.)

TABLE 22: DEGREE OF SATISFACTION IN RELATIONSHIP TO THE THREE PROGRAM ELEMENTS

Level of Satisfaction	Mopti			Sikasso		
	Agriculture	WASH	Nutrition	Agriculture	WASH	Nutrition
Very satisfied	39.9	40.4	42.3	22.6	47.3	65.9
Satisfied	48.0	52.3	54.6	27.4	46.7	31.1
Bit Satisfied	3.5	6.7	2.0	14.5	4.8	1.8
Not Satisfied	8.7	.5	1.0	35.5	1.2	1.2
Total	100,0	100.0	100.0	100.0	100.0	100,0

Stakeholders convinced effective integration brings results. Stakeholders in general are positive about the results an integrated approach has brought to communities. A doctor at a CSREF in Mopti credits the integration of nutrition and WASH activities with concrete results. "The complementarity has notably reduced diarrheal disease and the cause of severe malnutrition." A regional health official in Sikasso also found progress was made. "The goal of enabling collaboration by improving the visibility of the interventions through the sharing of information, challenges and eventually finding solutions was met."

Integration permitted communities to make the link between behavior change and health. It is clear from the FGDs with women beneficiaries in the FGDs that they now see the link between general hygiene and less sickness. This was mentioned in almost all the FGDs. They also said they see the impact of improved diets on good health and reduced malnutrition. "It is helpful when communities see the benefit of integrating WASH, nutrition and agriculture," a project community mobilizer in Sikasso said in a KII. "They came to understand that agriculture production is needed to serve foods with good nutrition. Before they didn't know hygiene impacted on health and they have learned to do it." A Village Health Volunteer (*relais*) finds there is no problem with integration at all: "It is not complicated when people see the results are good for children and fewer of them are getting sick."

QUESTION 4: SUSTAINABILITY OF RESULTS

To what extent are results achieved by IRP likely to continue after the end of the projects?

FINDINGS

Question on sustaining results achieved asked in all KIIs. A total of 95 KIIs took place with CARE and Save staff; IRP government partners, including from health, WASH and agriculture; and key stakeholders, including NGOs and community leaders. Each respondent answered the following question: To what extent are results achieved by IRP likely to continue after the end of the projects? The pattern of responses was similar across the range of respondents: Achievements in nutrition and WASH are perceived to be likely to be sustained and agriculture remains more doubtful since progress has been less significant. It should be noted that no studies were done by the IPs that attempted to make links between specific indicators and community mobilization, outreach and other SBCC interventions that may have inspired behavior changes.

TABLE 23: TYPES OF INTERVENTIONS RECEIVED

Regions	Services	Numbers	%
Mopti	Nutrition, WASH and Agriculture	126	63
	Nutrition and WASH	36	18
	Non-beneficiaries	24	12
	Nutrition	9	4,5
	Nutrition and Agriculture	5	2,5
	Total	**200**	**100**
Sikasso	Nutrition and WASH	89	44,5
	Nutrition, WASH and Agriculture	77	38,5
	Non-beneficiaries	30	15
	Nutrition and Agriculture	3	1,5
	Nutrition	1	0,5
	Total	**200**	**100**

TABLE 24: OCCURRENCES OF RESPONSES AND % OF RESPONDENTS TO: WHAT INTERVENTIONS WILL SURELY CONTINUE AFTER THE END OF THE PROJECT?

Elements	Occurrences	%
WASH	327	82
Nutrition	291	73
Agriculture	36	9

Nutrition and WASH are considered most likely to continue. The mini-survey asked 400 female beneficiaries what IRP interventions will surely continue after the project ends. WASH had the largest number of mentions by the respondents (82 percent), followed closely by nutrition (73 percent). Agriculture started later and achieved less than hoped. Only 9 percent of respondents considered it likely to continue, as Table 24 shows.

TABLE 25: IF THE INTERVENTIONS (NUTRITION, WASH, AGRICULTURE) DO CONTINUE, WHAT ARE THE REASONS FOR THE SUSTAINABILITY (IN PERCENTAGES)?

Reasons	Occurrences	Percentage of respondents
Improved health	234	64

Reasons	Occurrences	Percentage of respondents
Benefits	180	49
Community Mobilization	169	46
Motivation	133	36
Development of Local Capacity	73	20
Leadership	17	5
Action Plan	16	4
Others*		

**Improved knowledge, reduced infant mortality, less expenditures in health, less sickness*

Seeing improved health and other benefits inspires continuation. In the mini-survey, better health (64%) and seeing benefits to communities (49%) were found to be reasons for continuation. In all of the 16 FGDs with women beneficiaries, improvements in family health were mentioned and given as a reason to continue with the positive behaviors adopted. "If the project ends, we will continue to practice what we have learnt and we will keep up our good habits," a woman beneficiary said in a Sikasso FGD. "We will still have groups working on different aspects of the project." This was confirmed in the 6 KIIs with Project Community Mobilizers. "There will be no problem continuing," a Social and Behavior Change Assistant in Sikasso said in a KII. "They see that good hygiene has an impact on their lives. Mothers see that good nutrition makes their children healthy. With exclusive breastfeeding and enriched complementary foods, children are healthier and sick less often." In fact, exclusive breastfeeding, introduction of enriched complementary foods, community hygiene and latrine upkeep were the behavior changes most likely to be maintained according to FGDs with women beneficiaries. There has been some effort to use "champions" or people who have adopted positive behaviors to inspire those in other villages through local radio stations and site visits.

Economic Benefit. Approximately half of the respondents believe that they would be motivated by the economic benefits they are deriving to sustain the actions they learn. The mini survey found that 49 percent of respondents believe that would be a highly motivational factor. Participants in the FGD explained that the benefit is motivational because, apart from enabling them to gain food, they would also be able to gain some funds to cater for their families.

Community Mobilization. Beneficiaries also believe that community mobilizations would be a motivational factor for them to continue practicing the lessons learnt. Some 46 percent of respondents to the survey believe the continued support from the community mobilizers would ensure that they do not reverse the trend in implementing the newly acquired knowledge and skills.

QUESTION 5: ENVIRONMENTAL ISSUES

Are there any environmental issues? What steps were taken to address these issues? What additional steps are needed? How well have the programs been monitoring environmental compliance?

The answers to these questions come from the analysis of the potential impacts of certain activities detailed in the project documents such as small-scale agriculture and micro-irrigation, drinking water supply and sanitation activities as well as direct field observation of the activities.

FINDINGS

Are there any environmental issues?

The implementation of CLTS has led to the construction, proliferation and use of latrines in the areas of intervention. In Bandiagara the toilets are built high because the place is rocky and very hard to dig. The evaluation found that some of the latrines are not watertight and can leak feces that may pose a risk to the environment if they are used upstream. Pit latrines also generally lack a physical barrier, such as concrete, between stored excreta and soil and groundwater, so excreta can potentially reach groundwater, which also poses a threat to human health.

What steps were taken to address these issues? How well have the programs been monitoring environmental compliance?

Alternative strategies with women farmers. Alternative strategies have been adopted for the respect of the environment. In the villages we found that the IRP project team promoted environmentally friendly farming techniques for women farmers. Women farmers are using organic manure and compost as fertilizer for cowpea, groundnuts and soybeans. Training sessions were held on composting techniques and recycling of household waste at the village level. Chemical fertilizer has been used in the micro-dose technique, such as fertilizer deep placement, where the farmer drills a hole and buries the fertilizer close to the crop rather and leaving it atop the soil out in the open.

No genetically modified seed was promoted. Only the improved local seeds adapted to local conditions approved by the Malian Ministry of Agriculture have been promoted with the support of the Institute of Rural Economy which is also the seed certification structure.

No chemical pesticides were used for crops and for crop conservation techniques. The project mainly promoted the use of natural pesticides such as Neem (Azadirachta indica) during training sessions for women producers. In Sikasso, for example, 99 percent of the 2,000 women producers attended these trainings at the village level.

Soil water conservation techniques used. Soil and water conservation techniques, especially during drought periods, and erosion control techniques were taught. Beneficiaries were trained in the proper management of irrigation water in vegetable gardens.[22]

Farming systems. The project contributed to the improvement of the overall farming system through the promotion of crop rotation and the introduction of alternate crops and intercropping with legumes or other nitrogen-fixing species. In Mopti, for example, 9,450 people were trained in new farming

[22] Save the Children. 2017. PNH - Year 4 EMMP. Bamako: Save the children

technologies, including 2,299 women. 4,000 baobab and moringa plants were distributed and planted in 2017.[23]

IRP promotes open defecation free (ODF) villages. The project team supports WASH committees for the construction of latrines, the project developed guides and trained local masons on good construction techniques and compliance with regulatory distances to wells. Beneficiaries received training on drinking water treatment and preservation techniques with the promotion of aqua tab tablets.

Concerning the supply of drinking water, the rehabilitation of wells, boreholes and water towers was done in partnership with the government's regional technical services. Partnership protocols with the Regional Water Laboratory are available as part of the monitoring of water source activities. In Mopti 72.4 percent of women beneficiaries reported treating water compared to 47.2 percent in the baseline. In Sikasso the increase was to 67.5 percent from 43.8 percent.

[23] USAID Nutrition and Hygiene Project / Progress Report FY 17 Annual Report (October 1, 2016 – Sept 30, 2017)

EVALUATION CONCLUSIONS

PROJECT EFFECT ON NUTRITIONAL STATUS

For children under 2 years, the projects achieved their targets for underweight, wasting and exclusive breastfeeding for the two regions combined. For individual regions, however, underweight, in Mopti targets were achieved for wasting and exclusive breastfeeding, and in Sikasso targets were achieved for wasting, exclusive breastfeeding and minimum acceptable diet.

The projects are also on course to achieve their targets for dietary diversity for the two regions combined for children under 2 years. If progress continues at the same rate, these targets will be achieved by the end of 2018. Even though Sikasso Region has yet to achieve the targets for underweight, it will likely achieve them during the life of the project. Mopti is also likely to achieve its target on stunting by the end of project implementation.

The projects are, however, failing to achieve their target on stunting for the two regions combined, with Sikasso facing the biggest challenge. Should progress remain as it is now, the Sikasso Region will not be able to achieve its target on stunting. The Mopti Region is also not likely to achieve its target on dietary diversity for children under 2 years if the progress remains at it is currently.

Both Sikasso and Mopti regions achieved the targets for underweight among women of reproductive age. The combined regional performance therefore exceeded the target on the indicators.

As baseline surveys did not measure anemia for both children under 2 years and women of reproductive age, consequently the evaluation is unable to identify the extent to which the status on anemia changed during the life of the project.

STRATEGIC ENGAGEMENT IN WASH

Collective actions such as community-wide sweeping and cleaning, individual behavior changes such as hand-washing with soap, and household behaviors like treating and hygienic storing of water inspired communities to change their behaviors related to water and sanitation. Seeing the health impacts of positive behavior changes inspired communities to maintain these positive behaviors.

While progress has occurred in the increased use of cement in creating latrine bases, there is still room for improvement in both the number and quality of existing latrines. Additionally, access to water remains a challenge that could be rectified by increasing the refurbishment of water sources, especially of piped water through the summary water supply.

The post-ODF strategy has proven its worth in consolidating WASH achievements, but also in ensuring sustainability.

FACTORS CONTRIBUTING TO RESULTS

COMMUNITY MOBILIZATION

The community mobilization model worked well for engaging and motivating communities. Indeed, project community mobilizers were particularly effective in engaging communities through community mobilization. For successful and accelerated community mobilization, a ratio of one project community mobilizer to 10-15 villages proved to be the optimum; furthermore, community mobilization activities depend on motivated community volunteers. Support materials certainly have proven value in community outreach, though they need updating in style and content. Finally, slow and bureaucratic procedures are a handicap in mobilization.

AGRICULTURE

The late start of the agriculture component and limited inputs available to women farmers in Sikasso such as land, water, seeds and fencing resulted in more limited progress than anticipated. Without the support of such inputs it was difficult to develop women's farming skills as it limited their ability to implement most of the technologies they were taught. Despite this, women farmers supported by IRP responded well to trainings by practicing the techniques they learned, particularly techniques for the production of peanuts, cow peas and soya, onion transplantation and seed multiplication. Technologies that required the use of locally available resources and less expensive technologies were also effectively implemented.

Establishing Village Saving and Loans Association (VSLA) provides women farmers with money to invest in farming.

Food banks that include baobab and moringa trees increased the availability of green leaves rich in vitamin A.

Lastly, techniques for harvesting, conservation and food processing (grinding into powder, drying, transformation) have great potential, but IRP underused them, particularly in Sikasso.

INTEGRATION

Community mobilization is a catalyst for the integration of three elements at the community level resulting in positive behavior changes.

The mini survey found a much higher level of integration of Agriculture, WASH and Nutrition in Mopti. However, in Sikasso, there was better integration between WASH and Nutrition but not much with Agriculture.

The culinary demonstrations provided a direct link between nutrition and agriculture as women were introduced to new locally grown foods like soya and sweet potatoes.

RESULTS SUSTAINABILITY

Improving the understanding of the link between the behaviors and improved health is key to sustainable behavior change.

High levels of motivation among community volunteers to help improve community well-being and health inspired them to continue their outreach work. Additionally, the IRP creation of strong and motivated support groups (GSAN, WASH Committee, Women's Groups) increased confidence in community action and continued the work started. Subsequently, the acquisition of competence at the local level (volunteers, women groups, committees, beneficiaries) created a critical mass of people interested in sustaining gains.

Any plans for an expansion of the IRP model to new villages can benefit from the positive experience of existing IRP villages with community mobilization through site visits, and success stories told on radio and in picture books.

ENVIRONMENTAL ISSUES

The proposed mitigation actions of promoting the use of organic fertilizer and avoiding the use of chemical herbicides have reduced the risks of impacting negatively on the environment, particularly in the areas of agriculture and access to drinking water. Despite this, the installation of latrines has not routinely followed best practices.

EVALUATION RECOMMENDATIONS[24]

These recommendations were developed jointly with USAID, the Implementing Partners, other stakeholders, and the MSI team during an interactive recommendations workshop, held in Bamako on 26 February 2018.

PROJECTS' EFFECT ON NUTRITIONAL STATUS

Strengthen nutrition demonstrations through nutrition-sensitive agriculture by promoting local products such as groundnuts, cowpeas, soybeans, orange sweet potatoes, etc., and encourage household consumption of diversified foods to improve their nutritional status.

Strengthen behavioral change intervention in favor of nutrition using the thousand-day window of opportunity through the promotion of both exclusive breastfeeding for children below 6 months and adequate complementary feeding for children between 6-23 months.

STRATEGIC ENGAGEMENT IN WASH

Strengthen the involvement of the Collectivités Territoriales 25 (CTs) in the management of WASH issues. For example, promote dialogue between CTs and citizens for the promotion of WASH related issues. The partners should ensure that the authorities in charge of local and regional administrations are interested in WASH issues and become more involved in them. This will ensure local and community ownership of the project by local leaders and the communities.

Continue to promote the clean village contest post ODF. For instance, the region can hoist the national flag in a community that continues to keep the village clean post ODF. Doing so could ensure the commitment and enthusiasm of communities for the promotion of hygiene and sanitation activities. Clean and non-clean village competitions could be organized to educate other communities to emulate the clean communities and motivate clean communities to maintain their status.

Continue promoting WASH-Marketing through the installation of sanitation shops to facilitate access to WASH services (make WASH Aquatab products available, SANPLAT slab, slab closure, etc.). Women's groups can play an important role in promoting sanitation shops. WASH-Marketing can make products such as Aquatabs for water disinfection, detergents, SANPLAT slabs for latrines, and also handwashing devices with soap available on a family scale. To this end, sanitation shops should be created and women's tontines will play a key role in promoting these WASH products at the community level. The actors involved should be trained in WASH-Marketing and marketing activities should be developed to generate demand for these products.

Continue to promote CLTS and post ODF activities through village-level competitions and WASH marketing. Ensure sustainability through a conducting a diagnostic study of the hygiene and sanitation situation, developing a WASH action plan and monitoring its implementation. This would maintain momentum and enthusiasm within communities for hygiene and sanitation activities. Support groups

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[24] In line with the contractual requirement all procurement sensitive recommendations have been taken out of this report and presented separately to USAID.

[25] Local Authorities

such as the Water, Sanitation and Hygiene Committees (WASH) can provide support through social mobilization.

Continue the promotion of good hygiene practices (hand washing, home water treatment, etc.). The aim is to continue awareness-raising activities through community mobilizers, health workers, project leaders, water, hygiene and sanitation committees and local radios for adoption of good practices. The focus will be on home water treatment, hand washing with soap, use and maintenance of latrines.

Continue strengthening the technical and institutional capacities of the National Directorate of Pollution Control and Nuisance Control (DNACPN) and its divisions. An example of this support could be the stabilization of the Mali SANIYA database. This can be done through logistical support such as computer and office resources and also the development of tools. Other areas of support include developing operational strategies for implementing sanitation activities, holding meetings of consultations and exchanges and celebrating WASH days.

Involve already existing systems such as Regional Steering Committee for Coordination and Monitoring of Development Actions (CROCSAD), Local Committee of Orientation for Coordination and Monitoring of Development Actions(CLOCSAD) and Comité Communal d'Orientation de Coordination and Follow-up of Development Actions(CCOCSAD) in selecting project intervention zones and villages. The involvement of these bodies in the process would help actors take into account already existing interventions in the various development plans at all times. It would also serve as advocacy to motivate the officials responsible for decision-making to become involved in WASH activities.

Support capacity building to sustain WASH services at the community level effectively; this includes training local masons and local artisans on latrine construction techniques and on maintenance of water points.

FACTORS CONTRIBUTING TO RESULTS

Effectively integrate the various components of the programs (Nutrition, Agriculture and WASH) in the beneficiary geographic areas with particular attention to Sikasso where the integration seems much weaker. Integration should occur through collaboration with local authorities in coordinating and monitoring development actions.

RESULTS SUSTAINABILITY

Use existing structures such as COCSAD at the commune level, CLOSAD at the circle level, and CROSAD at the regional level to strengthen the coordination between the Nutrition, Agriculture and WASH components. Promote joint supervision in the field involving different technical structures and communities.

Strengthen grassroots community mobilization structures such as Village Savings and Loans Associations, Mama Leaders, WASH Committees, Local Masons, Community Mobilizers, and Restorative Artisans in relation to monitoring and execution of community level activities.

ENVIRONMENTAL ISSUES

Strengthen the capacity of WASH committees to understand and follow building standards for environmentally friendly latrines. To prevent possible discharge of wastewater and excreta from the latrines, the actors involved, especially the masons and the latrine artisans should be trained in latrine construction standards that respect the environment.

ANNEX I: POST EVALUATION ACTION PLAN

USAID INTEGRATED NUTRITION PROGRAM AND WASH MIDTERM EVALUATION

Recommendations	Partner Responsible for Recommendation	Actions to Address the Recommendations	Technical Office in Support of Implementing the Action	Technical Office for the Accountable Person Action	Technical Office Person Responsible for the Action	Intended Use of the Action	Timeline	Program Office Person Responsible for the Action	Resources Required	Status	Comments
Strengthen nutrition demonstrations through the cultivation of crops the can improve nutrition by promoting local products: groundnut, cowpea, soybean, orange flesh sweet potatoes, etc.	Implementing Partners	Continue with community stakeholder nutritional demonstration sessions based on local foods and more specifically those from vegetable gardens, in households, villages etc.	Health and AEG	Nutrition/WASH C/AOR/AM/M&E	Health and AEG Office Directors	Increase consumption of local foods and more specifically those from vegetable gardens, in households and villages	May 2018 - September 2019	MEL Program Specialist	To be determined		
Provide women with children under 5 years with Shakir strip bands for routine screening of their children.	Implementing Partners	Make a request, through the National Directorate of Health, to UNICEF for the acquisition of shakir strip bands.	Health and AEG	Nutrition/WASH, PDG, and AG C/AOR/AM/M&E	Health and AEG Office Directors	Establish screening for malnutrition at the household level through the measurement of mid-upper arm circumference	May 2018 - September 2019	MEL Program Specialist	To be determined	USAID support to facilitate acquisition in a short time	
	Implementing Partners	Train households on the use of shakir tapes and distribute them.	Health and AEG	Nutrition/WASH, and PDG C/AOR/AM/M&E	Health and AEG Office Directors			MEL Program Specialist	To be determined		
Strengthen the promotion of change in nutrition-related behavior by promoting the 1000 days as the window of opportunity for the promotion of exclusive breastfeeding and adequate complementary feeding.	Implementing Partners	Continue raising awareness through the use of toolboxes.	Health and AEG	Nutrition/WASH and AG C/AOR/AM/M&E	Health and AEG Office Directors	Increase the practice of exclusive breastfeeding of children from 0-6 months Increase the practice of complementary feeding suitable for children 6-23	May 2018 - September 2019	MEL Program Specialist	To be determined		
	Implementing Partners	Continue to raise awareness about exclusive breastfeeding and organize home visits.	Health and AEG	Nutrition/WASH and AG C/AOR/AM/M&E	Health and AEG Office Directors			MEL Program Specialist	To be determined		
	Implementing Partners	Strengthen actions on positive deviance.	Health and AEG	Nutrition/WASH and AG C/AOR/AM/M&E	Health and AEG Office Directors			MEL Program Specialist	To be determined		

Strengthen the involvement of CT (Local Authorities) in the management of WASH issues. For example, promote frameworks for dialogue between CT and Citizens on WASH issues.	Implementing Partners	Establish a dialogue framework in the Open Defecation Free (ODF) villages between community leaders and communities to take WASH related issues into account in the PDSECs.	Health and PDG	Nutrition/WASH, PDG and AG C/AOR/AM/M&E	Health and PDG Directors Office	Take into account and implement the WASH component in the PDSECs	May 2018 - September 2019	MEL Program Specialist	To be determined		
	Implementing Partners	Strengthen the capacities of local elected representatives in the management of WASH.	Health and PDG	Nutrition/WASH, PDG and AG C/AOR/AM/M&E	Health and PDG Directors Office	Capability of managing local WASH activities	TBD	MEL Program Specialist			
Continue to promote the post ODF (open defecation free) village cleanliness contest. For example, a national flag could be hoisted in the community that comes first.	Implementing Partners	Continue organizing clean-town competition in ODF villages.	Health	Nutrition/WASH C/AOR/AM/M&E	Health Directors Office	Ensure the sustainability of the ODF status of villages	May 2018 - September 2019	MEL Program Specialist	To be determined		
Continue to promote WASH-Marketing through the system of sanitation shops to facilitate access to WASH services and products (such as aquatabs, closing slabs etc.). Women's groups could play an important role in the advancement of sanitation shops.	Implementing Partners	Continue to set up sanitation shops in FDAL villages.	Health	Nutrition/WASH and AG C/AOR/AM/M&E	Health Office Director	Ensure the sustainability of ODF status and other achievements	May 2018 - TBD	MEL Program Specialist	To be determined		
	Implementing Partners	Develop other products (Slabs and slab hole covers) better adapted to the realities of the project areas.	Health	Nutrition/WASH and AG C/AOR/AM/M&E	Health Office Director	Promote technologies (low-cost latrine hole slabs and pit lids), which can be easily replicated locally	May 2018 - TBD	MEL Program Specialist	To be determined		
Rehabilitate water point for certified villages (ODF villages).	Implementing Partners	Continue rehabilitation of water points in certified villages.	Health	Nutrition/WASH and AG C/AOR/AM/M&E	Health Directors Office	Improve access to drinking water and sustainability of ODF	May 2018 - September 2019	MEL Program Specialist	To be determined		

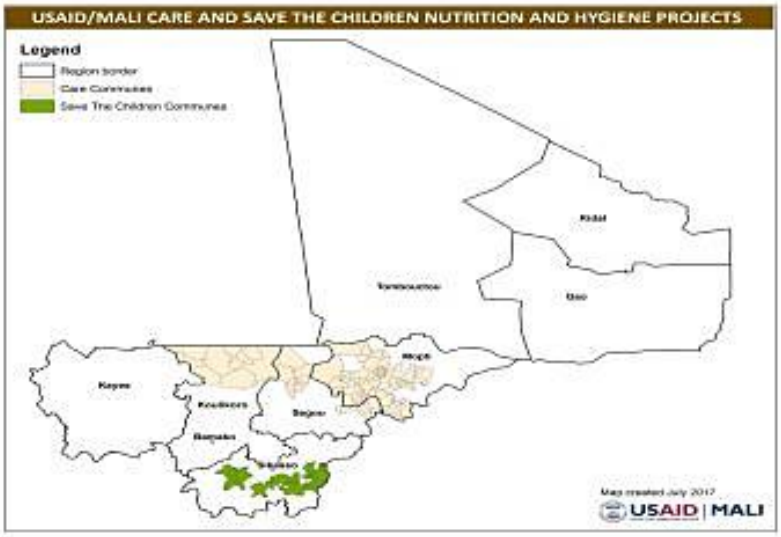
Continue the promotion of good hygiene practices (washing hands Including Tippy Tap) Water treatment at home, etc ...	Implementing Partners	Promote high impact hygiene practices (use and maintenance of latrines, hand washing with soap and safe water consumption) through mass campaigns during the celebration of institutionalized international days.	Health	Nutrition/WASH and AG C/AOR/AM/M&E	Health Office Director	Promote actions for positive behavioral change	May 2018 - September 2019	MEL Program Specialist	To be determined		
	Implementing Partners	Promote the manufacture of soap through the planting of jatropha in hedges around perimeters of domestic gardens to support the promotion of hand washing (Training of MJT groups to use saponification techniques with seeds of jatropha, to produce low cost soaps).	Health and AEG	Nutrition / WASH and AG C / AOR / AM / M & E	Health and AEG Office Directors	Promote behavior change through local support actions and the promotion of income-generating activities	May 2018 - September 2019	MEL Program Specialist	To be determined		
Continue strengthening the technical and institutional capacity of DNACPN (National Directorate of Sanitation and Pollution Control Nuisance) and Its components (eg reviewing and completing the development of the database Mali SANIYA etc.).	Implementing Partners	Continue institutional support for the stabilization of the SANIYA database.	Health	Nutrition / WASH C / AOR / AM / M & E	Health Office Director	Promote available functional sanitation database	May 2018 - September 2019	MEL Program Specialist	To be determined		
Involve key partners such as Regional Steering Committee for Coordination and Development Actions Tracking (CROCSAD), Coordination Committee of Local Orientation and Development Monitoring of Shares (CLOCSAD) and Communal Orientation Committee Coordination and Development Actions Tracking (CCOCSAD) for the selection of areas and villages for project intervention.	Implementing Partners	Educate and share experiences of integregated rural development program in various meetings.	Health, PDG and AEG	Nutrition / WASH, PDG, and AG C / AOR / AM / M & E	Health, AEG, PDG and Office Directors	Use existing consultation spaces at municipal, local and regional level for coordinating and monitoring the actions of the Integrated Rural Development Program	May 2018 - TBD	MEL Program Specialist	To be determined		

Continuously build capacity of operational actors (local masons, craftsmen, Elected Officials, technical services) in promoting WASH services to facilitate community resilience.	Implementing Partners	Continue building the capacity of operational actors (local masons, craftsmen, elected officials, technical services) in promoting the WASH service to facilitate community resilience	Health and PDG	Nutrition / WASH and PDG C / AOR / AM / M & E	Health and PDG Directors Office	Empower and build capacity of local actors to ensure sustainability of project actions	May 2018 - TBD	MEL Program Specialist	To be determined		
Promote domestic agriculture on a small scale (family garden and community gardens) in the program areas to promote the production of nutrtion rich foods for household food security.	Implementing Partners	Pursue efforts in the area of awareness and information on the importance and benefits of community and family gardens in the fight against malnutrition.	Health and AEG	Nutrition / WASH and AG C / AOR / AM / M & E	Health and AEG Office Directors	Facilitate existence of community and family gardens Support in the acquisition of seeds and planting of tree species, especially cash crops with high nutritional value (moringa, baobab) Build capacity for small-scale vegetable production techniques	May 2018 - TBD	MEL Program Specialist	To be determined		
Strengthen supervision of project interventions by involving the various technical structures and communities.	Implementing Partners	Organize joint supervisions on integrated technical services on Nutrition, WASH, Agriculture and Local Authorities.	Health and AEG	Nutrition / WASH and AG C / AOR / AM / M & E	Health and AEG Office Directors	Document and share experiences	May 2018- September 2019	MEL Program Specialist	To be determined		
Strengthen the basic structures for community mobilization such as: GSAN, VSLAs / MJT Mama Leaders, ASACO, Ops, WASH committees, local Masons, Relays, Artisans, and repairers in relation to monitoring and execution.	Implementing Partners	Establish an inter-community dialogue framework to sensitize local actors on mobilization and responsible management of resources.	Health and AEG	Nutrition / WASH and AG C / AOR / AM / M & E	Health and AEG Office Directors	Create inter-community dialogue, information on the mobilization and the responsible management of resources-	May 2018- September 2019	MEL Program Specialist	To be determined		

Strengthen the capacity of elected representatives in their roles and responsibilities especially as it relates to the promotion of Nutrition and WASH activities.	Implementing Partners	Pursue efforts to identify and build the capacity of local actors in relation to the areas of intervention of the projects.	Health, PDG	Nutrition / WASH, PDG and AG C / AOR / AM / M & E	Health, PDG and Office Directors	Build capacity of local elected representatives on their roles and responsibilities in development	TBD	MEL Program Specialist	To be determined		
Establish a framework for dialogue between elected officials and communities in relation to the activities in their jurisdiction.	Implementing Partners	Strengthen the capacity of elected officials to report to communities (accountability).	Health, PDG and AEG	Nutrition / WASH, PDG and AG C / AOR / AM / M & E	Health, AEG, PDG and Office Directors	Establish room for dialogue and collaboration between communities and local elected representatives to promote the culture of accountability	TBD	MEL Program Specialist	To be determined		
Ensure seal monitoring of the implementation of the Post ODF strategy on technical sealing pits for latrines, and securing their stabilization settlements.	Implementing Partners	Strengthen joint monitoring of the implementation of the ODF strategy.	Health	Nutrition / WASH C / AOR / AM / M & E	Health Office Director	Put in place a mechanism for monitoring and evaluating the implementation of the actions of the post ODF strategy	May 2018 - September 2019	MEL Program Specialist	To be determined		
Strengthen the capacity of WASH committees and communities on building environmentally friendly latrines.	Implementing Partners	Promote innovative latrine construction techniques including successful models of defecation hole lids.	Health	Nutrition / WASH and AG C / AOR / AM / M & E	Health and AEG Office Directors	Strengthen the capacity of WASH committees and communities to build standard latrines	May 2018 - September 2019	MEL Program Specialist	To be determined		
Reinforce the CAP post ODF certification survey by including issues related to the scaling up of structures to encourage communities to undertake actions to sustain the achievements of CLTS.	Implementing Partners	Continue the development and implementation of post-certification community action plans with a focus on the promotion of high impact hygiene practices, environmental health, wastewater management, animal husbandry.	Health	Nutrition / WASH and AG C / AOR / AM / M & E	Health and AEG Office Directors	Strengthen CAP Certification After the survey, include issues related to scaling up structures to encourage communities to engage in actions to enhance CLTS achievements	May 2018 - September 2019	MEL Program Specialist	To be determined		

Enhance integration with cash crops to diversify sources of income and access to nutrient rich commoditites (foods). Some crops that could be promoted include Baobab, Moringa etc ...	Implementing Partners	Promote the integration of agroforestry and sensitive nutrition for food diversification.	Health and AEG	Nutrition / WASH and AG C / AOR / AM / M & E	Health and AEG Office Directors	Information and awareness of communities on environmental protection and conservation of soils in agricultural areas. Train communities in composting techniques for soil fertilization. Distribution of highly nutritious plants (moringa, baobab) Promoting good practice agroforestry promote good agro-sylvo-pastoral practices to ensure the diversity of food products locally	April 2018 to September 2019	MEL Program Specialist	To be determined		
Promote agroforestry to mitigate the effect of human activities.	Implementing Partners	Pursue efforts in agroforestry.	Health and AEG	Nutrition / WASH and AG C / AOR / AM / M & E	Health and AEG Office Directors	Produce training in good agroforestry practices (live hedge, assisted natural regeneration (ANR), improved fallow, improved clearing) information and sensitization of communities on the adoption of agroforestry good practice	May 2018 - TBD	MEL Program Specialist	To be determined		
Approved by:	**COR / AOR**		**Approved by:**	**Health Office Director**	**Signature**	**Dated**		**Approved by:**	**Supervisory Program Officer**		
Name	**Fatimata Ouattara and Amadou Diane**		**Name**	**Shanda Steimer**				**name**	**Scott Stofel**		
Signature				**AEG Office Director**				**Signature**			
Dated			**Name**	**Kurt Low**				**Dated**			
			Name	**PDG Office Director**							
				Moussa Bambara							

ANNEX II: SCOPE OF WORK



C.3 SCOPE

C.3.1 Evaluation Rationale

The aim of the MPE is to evaluate the effectiveness of IRP's integrated nutrition strategy of combining nutrition, WASH, and agriculture to improve the nutritional status of pregnant and lactating women and of children under two years of age. USAID/Mali will use the findings of this evaluation to inform the implementation of the current integrated strategy and the development of future projects. USAID/Mali will further share the report with the Government of Mali (GoM) and development partners who may use it to inform their nutrition-related strategies. The MPE is specifically intended to determine what IRP components and project aspects are working well and why, which are not working well and why not, and to identify potential modifications to the current projects and to future projects in the nutrition and WASH sectors. The evaluation should also assess whether the projects have been compliant with USAID environmental regulations and identify opportunities to further mitigate and potential negative impacts on the environment.

C.3.2 Key Questions

The contractor's evaluation must respond to the following questions:

a. What effect have the projects had on the improvement of nutritional status in their target zones? Specifically, how have the following indicators been affected, and how could achievements be accelerated in the future?

   i. Reduction of the prevalence of stunting, wasting, underweight, and anemia among children under two years of age in USAID-supported districts

   ii. Reduction of the prevalence of underweight and anemia among women of reproductive age in USAID-supported districts?

iii. Increasing the prevalence of children 6-23 months receiving a minimum acceptable diet and increasing in the average number of food groups consumed by beneficiary women

iv. Improving nutrition-related behaviors such as exclusive breastfeeding and appropriate complementary feeding for children aged 6 months-23 months

b. How can strategic engagement in the WASH sector sustainably improve the way WASH services are delivered at the household level?

   i. How can systems and capacity be built to ensure the sustainability of functioning water and sanitation services?

   ii. How can ODF status be maintained once it is achieved?

   iii. What results provide actionable evidence-based items to improve current projects and inform future designs?

c. What are the (positive and negative) factors contributing to the results achieved (or not achieved)? How did the projects integrate the nutrition, WASH, and agricultural sectors? How effective was the integration approach?

d. To what extent are results achieved by IRP likely to continue after the end of the projects?

e. Are there any environmental issues? What steps were taken to address these issues? What additional steps are needed? How well have the programs been monitoring environmental compliance?

C.3.3 Suggested Evaluation Design and Methodology

Suggested Key Data Sources and Data Collection Methods

While the data collection methods below are suggested, the evaluation team may also propose its own methodology.

The evaluation team should start a document review of all relevant project materials. The source of information for the evaluation shall include the following but not limited to:

- Cooperative Agreements.
- Relevant award modifications.
- Baseline survey report.
- Mid-term survey reports.
- Annual Project Reports.
- Environmental documents including the initial environmental examination (IEE), environmental mitigation and monitoring plan (EMMP), and environmental mitigation and monitoring report (EMMR)

- Quarterly project reports.
- Monitoring and Evaluation Plan.
- Project data collection tools.
- Project storage database.
- Project Special Reports.
- Interviews with beneficiaries, stakeholders, community health workers, community volunteers.

In addition to these sources, the contractor will utilize additional information from other credible publications and sources including the USAID DEC website with the link below:
https://www.usaid.gov/results-and-data/information-resources/development-experience-clearinghouse-dec

The evaluation team shall also be prepared to conduct interviews with a representative selection of stakeholders at all levels. The contractor is expected to collect a mix of qualitative and quantitative information to inform a rigorous analysis for this evaluation. Some proposed methods are as follows:

Desk Review: The contractor shall review various documents and data from USAID and implementing partners for both quantitative and qualitative information to inform the design of the evaluation and guide data collection. Data from this review could also form part of the analysis for the findings if the contractor chooses.

Key Informant Interviews (KII): The contractor shall interview key stakeholders as key informants to solicit information in response to the evaluation questions. Some key informants expected to be interviewed include:

- USAID Mission Staff.
- Prime Implementing Partners, Sub Partners and Sub Grantees.
- Other development partners working in the area of Nutrition, WASH and Agriculture.
- Key staff from Ministry of Health at National, Regional and Sub Regional levels.
- Key staff from Ministry of Agriculture at National, Regional and Sub Regional levels.
- Key staff from Ministry of Water & Energy at National, Regional and district levels.
- Beneficiaries, including community stakeholders.

Focus Group Discussions (FGD): The contractor shall also conduct a series of FGD among beneficiaries and non-beneficiaries to solicit more qualitative information to complement the quantitative information collected from the mini survey in drawing conclusions and making recommendations.

Direct Observation: Evaluators are expected to use direct observation to identify other information that might not have been provided by respondents but that are observable and authentic. Such information could include status of facilities such as latrines, boreholes, hand-dug-wells, tippy-taps and behavior change communication materials as well as behavior of beneficiary communities and non-beneficiary communities such as open defecation, rubbish dumps, water storage containers etc.

The Mission is looking for new, creative suggestions regarding this evaluation, and it is anticipated that the contractor will provide a more detailed explanation of the proposed methodology for carrying out the work.

Evaluation Design
The contractor shall propose a design appropriate for answering the research questions.

Data Analysis Methods

The contractor shall present a data analysis plan on how quantitative and qualitative analysis will be conducted in responding to each evaluation question.

In conducting analysis in response to evaluation questions, the contractor shall use highly rigorous analyses that can demonstrate the contribution of USG nutrition and WASH interventions to results achieved in USG-supported zones.
The contractor shall propose a method for analyzing all qualitative data collected and may choose to use qualitative software such as Atlas.ti, NVIVO, or MAXQDA. The contractor may also choose to analyze qualitative data manually.

For each evaluation question, the contractor shall indicate the type of quantitative analysis that will be conducted in responding to the questions and the software that shall be used in conducting the analysis. The contractor shall also indicate the qualitative questions that will be used in complementing the quantitative analysis.

The contractor shall explain the strengths and the weaknesses for the evaluation methodology proposed under this SOW. In explaining the limitations, the contractor shall further explain factors contributing to the selection of the proposed methodology despite its limitations, and the means to be employed by the contractor to mitigate the potential effects of the limitations.

C.3.4 Suggested Timeline

Evaluation Activity	**Deadline for Completion**	**Responsible Party**
Review of relevant document and literature	10 working days after award	Contractor
Development of inception report, work plan and data collection tools	10 working days after award	Contractor
Inception debriefing	6 working days after submission of inception report	Contractor
Review of inception report, work plan and data collection tools by USAID and provision of comments to evaluators	2 working days after inception debrief	USAID
Submission of revised and finalized work plan and data collection tools	5 working days after receipt of comments from USAID	Contractor
Review and approval of final work plan and data collection tools	3 working days after submission of final work plan and data collection tools	USAID
Data Collection Updates	Weekly – from receipt of approval of final work plan and data collection tools	Contractor
Data cleanup, analysis, development & submission of Draft Evaluation report and PPT of findings, conclusions and recommendation	45 working days after receipt of approval of work plan and data collection tools	Contractor
Dissemination of Draft report to USAID	4 working days after submission of draft evaluation report and PPT	Contractor
Dissemination of Draft report to Implementing Partners (IPs)	6 working days after submission of draft evaluation report and PPT	Contractor
Submission of consolidated comments on draft report from USAID, IPs, Funding partners and key stakeholders to Evaluators	10 working days after submission of draft evaluation report and PPT	USAID
Stakeholder workshop for the development of practical recommendations based on evaluation findings.	3 working days after the receipt of comments from USAID	Contractor

Finalization and submission of Evaluation Report	10 working days after receipt of consolidated comments from USAID	Contractor
Preparation of PPT for final report and submission to USAID	5 working days after submission of final report	Contractor
Final Report dissemination workshop	10 working days after receipt of approval of evaluation report and stakeholder dissemination PPT	Contractor
Submission of all logistics, data, reports, interview notes, software and all materials collected during the evaluation to USAID.	Not later than 2 working days after evaluation	Contractor

ANNEX III: DATA COLLECTION INSTRUMENTS

Key Informant Interviews Guide (English version)

English Version

This questionnaire has two parts. The first part includes specific questions to be asked the five different groups of stakeholders. The second part includes questions covering specific sectors and topics that can be added to the part A questions when deemed appropriate.

PART A: KIIs questions for specific stakeholder respondents

A. USAID staff: COR, AOR, technical team members in Nutrition, WASH, Agriculture

(Challenges; strategies; present and resolution; international perspective)

A.1 What were the advantages of integrating Nutrition, WASH and Agriculture in IRP?
A.2 What were the challenges in integrating Nutrition, WASH and Agriculture in IRP from USAID, the Implementing Partner and the government perspectives?
A.3 What were the advantages and weaknesses of integration with two different IPs (CARE and Save) with two slightly different approaches?
A.4 What approaches were most successful and what approaches were not successful in achieving results?
A.5 What would you recommend for the future to enhance project results?
A.6 What examples exist in other settings that have successfully integrated Nutrition, WASH and Agriculture?
A.7 What accounted for their success?
A.8 How can future integrated programs be brought to scale?
A.9 What can be done to ensure that nutrition, WASH, and agriculture programs are sustainable, through integration or not?

B. Project staff: CARE AND SAVE COP, DCOP, technical directors, M&E officer, BCC advisor, department heads

(Design, implementation and monitoring; interpretation quantitative data, most effective responses to USAID, target population dynamics, locations of partners and beneficiaries)

B.1 What were the advantages of USAID's integrating Nutrition, WASH and Agriculture in IRP?
B.2 What were the challenges in integrating Nutrition, WASH and Agriculture in USAID's IRP?
B.3 What were the advantages and disadvantages of integration with two different IPs (CARE and Save) with two slightly different approaches?
B.4 With so many different levels of intervention and governmental, non-governmental and community partners how difficult was it to truly integrate and coordinate?
B.5 What approaches were most successful and what approaches were not successful in achieving results??
B.6 In terms of cost-effectiveness has the USAID integrated strategy produced the expected results?
B.7 What were the forces at work in the target populations that abetted or handicapped implementation?
B.8 What was the impact on USAID's IRP implementation of targeting rural populations in Sikasso and Mopti Regions?

B.9 What were the advantages of working with existing partners on the ground in the two regions?
B.10 What can be done to ensure that nutrition, WASH, and agriculture programs are sustainable, through integration or not?

C. Government staff: Ministries of Health, Agriculture, Water and Energy at national, regional, sub regional, circle and commune levels—Village Nurse, Nutrition Office, Ag extension, community water and sanitation staff

C.1 What were the challenges at the Regional and District level for the integration and coordination of the different Ministries and technical services intervening in Nutrition, WASH and Agriculture?
C.2 What were the challenges at the community level for the integration and coordination of the different Ministries and technical services intervening in Nutrition, WASH and Agriculture?
C.3 What could be done in the future to better integrate and coordinate?
C.4 To what extent has the USAID IRP / (Integrated Rural Program) strategic plan been well thought out to ensure harmonious integration and coordination?
C.5 Is there sufficient support and structures to ensure integration and coordination at the regional, district and community levels?
C.6 How satisfied are you with the fact that the various components have been well integrated and have resulted in a greater number of achievements than their separate contributions? Why?

D. Key stakeholders: Nutrition, WASH, and Agriculture: Bilateral, Multilaterals, development organizations, NGOs (working with IPs or with similar goals)

D.1 What has been your experience with integrated programming in Nutrition, WASH and Agriculture in other settings?
D.2 What are the challenges faced in achieving WASH and nutrition results?
D.3 From your perspective, what have been the achievements and the challenges faced by the Integrated Rural Program?
D.4 What can be done in the future to develop strategies to ensure better WASH and nutrition results?
D.5 What can be done to avoid duplication of activities and to better leverage each other's' interventions?

E. Community-level stakeholders: Community leaders including chiefs, opinion leaders, community groups

E.1 What has been your experience with the USAID's Integrated Rural Programme (IRP) to Improve Nutrition and Hygiene?
E.2 To what degree has it been successful improving the communities' nutrition status and WASH behaviors?
E.3 How successful has USAID's IRP been in inspiring community level involvement such as the formation of groups working on nutrition and hygiene?
E.4 Will these groups be sustainable after the end of the project and what can be done to make them sustainable?
E.5 What additionally could be done to better integrate and coordinate at the community level and to improve the sustainability of the interventions?
E.6 How has the project worked with the government to achieve nutrition and WASH results? What could be done to improve results in the future?
E.7 What additional methods can be taken to better integrate and coordinate the community, local government workers and USAID's Implementing Partners like CARE and Save the Children to ensure effective interventions?
E.8 To what degree were you satisfied with the nutrition component of the program and why?

E.9 To what degree were you satisfied with the WASH component of the program and why?
If satisfied, why?
If not satisfied, why?
What can be the levers for sustaining the project's achievements?

E.10 To what degree were you satisfied with the agriculture component of the program and why?

E.11 To what degree do you have confidence that the components will continue in your community after the program ends?

E.12 Who and what groups were the most influential in inspiring behavior change in the community and why?

PART B: KII Questions covering specific sectors and topics for technical area specialists

NUTRITIONAL STATUS

1.0 To your knowledge, what improvements in nutritional status have occurred under IRP?

1.1 What has been accomplished by USAID's IRP in improving the following indicators:

- Reduction of the prevalence of stunting, wasting, underweight and anemia among children under 2 years of age in USAID-supported districts
- Reduction of the prevalence of underweight and anemia among women of reproductive age in USAID-supported districts
- Increasing the prevalence of children aged 6-23 months receiving a minimum acceptable diet and increasing in the average number of food groups consumed by beneficiary women
- Improving nutrition-related behaviors such as exclusive breastfeeding and appropriate complementary feeding for children aged 6 months-23 months

1.2 How might achievements be accelerated in the future?

IMPROVED WASH SERVICES

2.0 What can be done to improve the way WASH services are delivered to households?

- How can they be made sustainable?
- How can systems and capacity of functioning water and sanitation services be built to ensure sustainability?

2.1 How can open defecation free (ODF) status be maintained once it is achieved?

2.2 What are the obstacles to not achieving ODF?

2.3 What results provide actionable evidence-based items to improve current projects and inform future designs?

2.4 What were the challenges in installing, using and maintaining hand-washing stations?

FACTORS

3.0 What positive factors contributed to the results' achievements?

3.1 How can these positive factors be used for improving results and sustainability?

3.2 What negative factors contributed to results not being achieved?

3.3 What mitigating approaches would reduce the effects of negative factors?

3.4 How did the projects integrate the nutrition, WASH and agricultural sectors?

3.5 How effective was the integration approach?

3.6 What other approaches might be effective for improving results?

SUSTAINABILITY

4.0 To what extent are results achieved by USAID's IRP likely to continue after the end of the projects?

4.1 What needs to be done to improve sustainability?

4.2 Which intervention areas are most likely to be sustained (breastfeeding, complementary feeding, balanced diet, improved farming, latrine, etc.?

ENVIRONMENT

5.0 Has the projects' Environmental Mitigation and Monitoring Plan been followed?
Degree of implementation of environmental risk mitigation plans?
Challenges / difficulties
5.1 What improvements are needed in terms of environmental impact?
5.2 What environmental concerns might be related to IRP (clean water, fertilizer use, burning refuse, etc.)?
5.3 What steps were taken to address these issues?
5.4 What additional steps are needed?
5.5 How well have the programs been monitoring environmental compliance?

WASH

6.0 In terms of WASH what USAID's IRP interventions were the most successful and why (handwashing, clean water, latrine construction, maintenance of community water systems, etc.)?
6.1 What has been the impact of Community-led Total Sanitation Plus (CLTS) (Assainissement total piloté par la communauté ATPC)?
6.2 What has been the impact of the effort Open Defecation Free (Fin de la defication a l'air libre) community certification?
6.3 What has been the availability of WASH related commodities and how has it impacted communities (Sansplats slabs, water purification products, tippy taps, etc.)?
6.4 What were the primary influences for the adoption of WASH behaviours (Community WASH committee, District Sanitaire, community leaders, etc.)?
6.5 Did WASH support materials have an impact on people's perceptions of WASH issues?
6.6 What could be done to better influence the adoption of WASH behaviours?

AGRICULTURE

7.0 In terms of agriculture, which USAID's IRP interventions were most successful and why (increased production and access to nutrient-rich foods, strengthened producer groups, improved farm management, increased access to inputs, increased access diversified and quality foods, etc.)?
7.1 What has been the impact of increased production of iron-rich foods (peanuts, beans, moringa, and soybeans)?
7.2 What has been the impact of increasing vitamin A rich foods (spinach)?
7.3 What has been the impact of promoting greater vegetable production such as tomatoes, salad lettuce, spinach?
7.4 What has been the impact of promoting the planting of baobab trees and moringa etc., of vegetables such as okra and amaranth or amaranth for local consumption?
7.5 What has been the role of market gardening micro-gardens, intercropping and family plots in increasing production?
7.6 What has been the impact of training on production, harvesting, drying and storage and preservation techniques?
7.7 What were the main influences on the introduction of new products and methods (Farm-Friendly Schools Schools, agricultural extension agents, food demonstrations, peer farmers)?
7.8 What have been the results of the specific assistance provided to women farmers, including training, cooking demonstrations and the supply of seeds and other inputs to agricultural inputs (improved seeds, etc.).

7.9 What has been the impact of encouraging communities to grow improved vegetable seeds to make them available on a permanent basis?
7.10 What nutrition support materials have been reproduced or produced by USAID's PRA (posters, flipcharts, etc.)?

NUTRITION

8.0 In terms of nutrition, what USAID PRA / (Integrated Rural Program) interventions have been most successful and why (identify and treat acute malnutrition, increase access to diverse and quality foods, breastfeeding) exclusive up to six months, introduction of weaning foods diversified quality supplements based on local foods available)?
8.1 What has been the impact of improving the management structure / CSCom and the ability to support CMAM (Community-based Management of Acute Malnutrition)?
8.2 What has been the impact of improving the capacity building of health workers to manage acute malnutrition?
8.3 What has been the impact of improving the capacity and capacity of health workers to advise and negotiate with clients?
8.4 What has been the impact of the training of Nutritional Support Groups (GSAN)?
8.5 What has been the impact of introducing diverse and quality foods through nutrition demonstrations, recipe sharing and food products?
8.6 What were the main influences for the adoption of varied and quality foods (Community Health Officers / CHWs, Community Mobilizers, Leader Leader Mothers, GSAN)
8.7 What has been the impact on nutrition of introducing diverse and quality foods through agricultural inputs (nutrition-sensitive agriculture)?
8.8 What has been the influence of cooking classes (cooking demonstrations) on positive changes in nutritional behavior?
8.9 What has been the result of strengthening the skills of the District Nutrition Officer (District Health Officer) and Community Health Center staff in the fight against malnutrition?
8.10 What has been the impact of strengthening the identification system for the detection and treatment of malnourished children (management of malnourismalnutris children)?
8.11 What has been the result of capacity building to increase the capacity of health workers to advise and negotiate with clients?
8.12 What has been the impact of strengthening the management / health structure (CHC) and community-based capacity for acute malnutrition?
8.13 What progress has been made in promoting exclusive breastfeeding for women of childbearing age (pregnant and lactating) and how has this been achieved?
8.14 What has been done to increase the participation of fathers, grandparents and mothers of children under 6 years of age in nutrition issues and what has been the result, including nutrition? diversified and quality diversified and quality children?
8.15 What has been done to increase grandmothers' participation in nutrition issues and what has been the result, including diversified, high-quality, diversified and high quality nutrition?
8.16 What were the main influences on the adoption of positive nutritional behaviors (GSAN, community Mobilizers, district health nutrition officers, community health workers, Maman Leader Animator, etc.)?
8.17 What nutrition support materials have been replicated or produced by USAID's IRP / (Integrated Rural Program) (posters, flipcharts, communication toolboxes, etc.)?
8.18 What could be done to better influence the adoption of good nutritional behaviors?

SBCC

9.0 To what extent have SBCC interventions been balanced and successful in reaching the target populations (community mobilization, advocacy, marketing, interpersonal communication, mass / community media)?
9.1 What was the role of social workers and behavior change and what was their impact?

9.2 What has been the experience of developing supporting materials (flipcharts, posters, etc.) and their distribution and use?
9.3 How would you evaluate the overall strategy of SBCC to ensure the development and implementation of SBCC activities?

INTEGRATION

10.0 What actions have been taken to integrate the various USAID IRP components (WASH / WASH, agriculture, nutrition)?
10.1 What have been the challenges for normally separated intervention areas by cooperating and working together?
10.2 What are the benefits of the three elements of the USAID PIA in coordination and collaboration?
10.3 To what extent has the USAID IRP been successful in coordinating the three components of the IORP at the community level?
10.4 What could be done to improve the level of coordination of the three components of the program?
10.5 To what extent has the District Health District been used as a multisectoral platform?

French version

Informant Interview Guide (French version)

This questionnaire has two parts. The first part includes specific questions to be asked the five different groups of stakeholders. The second part includes questions covering specific sectors and topics that can be added to the part A questions when deemed appropriate.

PART A: KIIs questions for specific stakeholder respondents

A. USAID staff: COR, AOR, technical team members in Nutrition, WASH, Agriculture

(Challenges; strategies; present and resolution; international perspective)

A.1 Quels ont été les avantages de l'intégration de la nutrition, WASH/EAH (Eau, Assainissement et Hygiène) et de l'agriculture dans l'IRP Programme Rural Intégré) de l'USAID?
A.2 Quels ont été les défis liés à l'intégration de la nutrition, de l'EAH et de l'agriculture dans l'IRP/(Programme Rural Intégré) de l'USAID, du partenaire d'exécution et des perspectives gouvernementales?
A.3 Quels ont été les avantages et les insuffisances de l'intégration avec deux partenaires d'exécution différents (CARE et Save the Children) avec deux approches légèrement différentes?
A.4 Qu'est-ce qui aurait pu être fait différemment pour que cela fonctionne mieux?
A.5 Que recommanderiez-vous pour l'avenir pour améliorer l'intégration?
A.6 Quels exemples existent dans d'autres contextes ayant intégré avec succès Nutrition, WASH/EAH et Agriculture?
A.7 Qu'est-ce qui explique leur succès?
A.8 Comment les futurs programmes intégrés peuvent-ils être mis à l'échelle?
A.9 Que peut-on faire pour s'assurer que les programmes intégrés sont durables?

B. Project staff: CARE AND SAVE COP, DCOP, technical directors, M&E officer, BCC advisor, department heads

(Design, implementation and monitoring; interpretation quantitative data, most effective responses to USAID, target population dynamics, locations of partners and beneficiaries)

B.1 Quels étaient les avantages de l'intégration de la nutrition, WASH/EAH et de l'agriculture dans l'IRP/ (Programme Rural Intégré) de l'USAID?
B.2 Quels ont été les défis liés à l'intégration de la nutrition, de WASH/EAH et de l'agriculture dans le programme IRP/(Programme Rural Intégré) de l'USAID?
B.3 Quels ont été les avantages et les inconvénients de l'intégration avec deux partenaires d'exécution différents (CARE et Save) avec deux approches légèrement différentes?
B.4 Avec autant de différents niveaux d'intervention et partenaires gouvernementaux, non gouvernementaux et communautaires, à quel point était-il difficile de vraiment s'intégrer et de se coordonner?
B.5 Dans quelle mesure les données quantitatives ont-elles effectivement mesuré le changement positif?
B.6 En termes de rentabilité, la stratégie intégrée de l'USAID a-t-elle produit les résultats escomptés?
B.7 Quelles étaient les les forces à l'œuvre dans les populations cibles qui ont favorisé ou handicapé la mise en œuvre?
B.8 Quel a été l'impact sur la mise en œuvre de l'IRP/(Programme Rural Intégré) de l'USAID du ciblage des populations rurales dans les régions de Sikasso et de Mopti?

B.9 Quels ont été les avantages de travailler avec les partenaires existants sur le terrain dans les deux régions?

C. Government staff: Ministries of Health, Agriculture, Water and Energy at national, regional, sub regional, circle and commune levels—Village Nurse, Nutrition Office, Ag extension, community water and sanitation staff

C.1 Quels ont été les défis au niveau régional et du district pour l'intégration et la coordination des différents ministères et services techniques intervenant dans la nutrition, WASH/EAH (Eau, Assainissement et Hygiène) et l'agriculture?
C.2 Quels ont été les défis au niveau communautaire pour l'intégration et la coordination des différents Ministères et services techniques intervenant dans la Nutrition, WASH/EAH (Eau, Assainissement et Hygiène) et l'Agriculture?
C.3 Que pourrait-on faire à l'avenir pour mieux intégrer et coordonner?
C.4 Dans quelle mesure le plan stratégique de l'IRP/(Programme Rural Intégré) de l'USAID a-t-il été bien pensé pour garantir une intégration et une coordination harmonieuses?
C.5 Y a-t-il suffisamment de soutien et de structures pour assurer l'intégration et la coordination aux niveaux régional, de district et communautaire?
C.6 Dans quelle mesure êtes-vous satisfait que les différentes composantes ont été bien intégrées et ont donné lieu à une somme de réalisations supérieures à leurs contributions distinctes? Pourquoi?

D. Key stakeholders: Nutrition, WASH, and Agriculture: Bilateral, Multilateral, development organizations, NGOs (working with IPs/Implementing Partners or with similar goals)

D.1 Quelle a été votre expérience avec la programmation intégrée en Nutrition, WASH/EAH et Agriculture dans d'autres contextes?
D.2 Quels sont les défis rencontrés lors de l'intégration et de la coordination de composantes d'intervention auparavant séparées?
D.3 De votre point de vue, quelles ont été les réalisations et les défis du Programme rural intégré?
D.4 Que peut-on faire à l'avenir pour élaborer des stratégies favorisant une intégration et une coordination efficaces?

E. Community-level stakeholders: Community leaders including chiefs, opinion leaders, community groups

E.1 Quelle a été votre expérience avec le Programme Rural Intégré (IRP) de l'USAID pour améliorer la nutrition et l'hygiène?
E.2 Dans quelle mesure a-t-il réussi à intégrer les interventions Nutrition, WASH et Agriculture?
E.3 Dans quelle mesure l'IRP de l'USAID a-t-il réussi à inspirer la participation de la communauté, comme la formation de groupes travaillant sur la nutrition et l'hygiène?
E.4 Que pourrait-on faire de mieux pour améliorer l'intégration et la coordination au niveau communautaire?
E.5 Dans quelle mesure les différents fonctionnaires de votre communauté ont-ils été intégrés et coordonnés?
E.6 Quelles autres méthodes peuvent être prises pour mieux intégrer et coordonner la communauté, les agents des gouvernements locaux et les partenaires d'exécution de l'USAID comme CARE et Save the Children pour garantir des interventions efficaces?
E.7 Dans quelle mesure étiez-vous satisfait de la composante nutrition du programme et pourquoi?
E.8 Dans quelle mesure étiez-vous satisfait de la composante WASH/EAH du programme et pourquoi?
E.9 Dans quelle mesure étiez-vous satisfait de la composante agricole du programme et pourquoi?

E.10 Dans quelle mesure avez-vous confiance que les composantes continueront dans votre communauté après la fin du programme?
Si satisfaits, pourquoi?
Si non satisfaits, pourquoi ?

E.11 Quels peuvent être les leviers de pérennisation des réalisations du projet ?

E.12 Qui et quels groupes ont le plus influencé le changement de comportement dans la communauté et pourquoi?

PART B: KII Questions covering specific sectors and topics

NUTRITIONAL STATUS

1.0 À votre connaissance, quelles améliorations de l'état nutritionnel ont eu lieu dans le cadre de l'IRP?

1.1 Qu'est-ce qui a été accompli par IRP de l'USAID dans l'amélioration des indicateurs suivants:

- Réduction de la prévalence du retard de croissance, de l'émaciation, de l'insuffisance pondérale et de l'anémie chez les enfants de moins de 2 ans dans les districts soutenus par l'USAID
- Réduction de la prévalence de l'insuffisance pondérale et de l'anémie chez les femmes en âge de procréer dans les districts soutenus par l'USAID
- Augmenter la prévalence des enfants de 6 à 23 mois recevant un régime minimum acceptable et augmenter le nombre moyen de groupes alimentaires consommés par les femmes bénéficiaires
- Améliorer les comportements liés à la nutrition tels que l'allaitement maternel exclusif et une alimentation complémentaire appropriée pour les enfants âgés de 6 mois à 23 mois

1.2 Comment les réalisations pourraient-elles être accélérées à l'avenir?

IMPROVED WASH SERVICES/services de WASH/EAH améliorés

2.0 Comment peut-on améliorer la manière dont les services WASH/EAH sont fournis aux ménages?

- Comment peuvent-ils être rendus durables?
- Comment les systèmes et la capacité des services d'eau et d'assainissement peuvent-ils être kintégrés pour assurer la durabilité?

2.1 Comment peut-on maintenir la fin de la défécation à l'air libre (FDAL/ODF) une fois atteint?

2.2 Quels résultats fournissent des éléments concrets fondés sur des données probantes pour améliorer les projets actuels et éclairer les conceptions futures?

FACTORS/Facteurs

3.0 Quels facteurs positifs ont contribué aux réalisations?

3.1 Comment ces facteurs positifs peuvent-ils être utilisés pour améliorer les résultats et la durabilité?

3.2 Quels facteurs négatifs ont contribué à l'absence de résultats?

3.3 Quelles approches atténuantes réduiraient les effets des facteurs négatifs?

3.4 Comment les projets ont-ils intégré les secteurs de la nutrition, WASH et agricole?

3.5 Quelle a été l'efficacité de l'approche d'intégration?

3.6 Quelles autres approches pourraient être efficaces pour améliorer les résultats?

SUSTAIN/Durabilité

4.0 Dans quelle mesure les résultats de l'IRP de l'USAID sont-ils susceptibles de se poursuivre après la fin des projets?

4.1 Que faut-il faire pour améliorer la durabilité?

4.2 Quels sont les domaines d'intervention les plus susceptibles d'être soutenus (allaitement maternel, alimentation complémentaire, alimentation équilibrée, agriculture améliorée, latrines, etc.

ENVIRONMENT

5.0 Le plan d'atténuation et de suivi environnemental des projets a-t-il été suivi?
Degré de mise en œuvre des plans d'atténuation des risques environnementaux?
Défis / difficultés
5.1 Quelles améliorations sont nécessaires en termes d'impact environnemental?
5.2 Quelles préoccupations environnementales pourraient être liées à l'IRP de l'USAID (eau propre, utilisation d'engrais, déchets incinérables, etc.)?
5.3 Quelles mesures ont été prises pour résoudre ou mitiger ces problèmes?
5.4 Quelles étapes supplémentaires sont nécessaires?
5.5 Dans quelle mesure les programmes surveillent-ils la conformité environnementale?

WASH

6.0 En ce qui concerne WASH/EAH, quelles sont les interventions IRP de l'USAID les plus réussies et pourquoi (lavage des mains au savon aux moments critiques, technologies de traitement de l'eau pour avoir une eau potable, construction de latrines améliorées dans les ménages, fin de la défécation à l'air libre,réhabilitation des sources d'eau, etc.)?
6.1 Quel a été l'impact de l'Assainissement Total Piloté par la Communauté (ATPC)?
6.2 Quel a été l'impact de l'effort de certification communautaire Fin de la Défécation à l'Air Libre FDAL)/Open Defecation Free?
6.3 Quelle est la disponibilité des produits liés à WASH/EAH et comment a-t-elle impacté les communautés (dalle sanplat, produits de purification de l'eau (aquatabs), tippy-tap, etc.)?
6.4 Quelles ont été les principales influences de l'adoption des comportements améliorés en WASH/EAH (comité WASH/EAH communautaire, District Sanitaire, leaders communautaires, etc.)?
6.5 Quels matériaux d'appui WASH/EAH ont été reproduits ou produits par les projets (affiches, tableaux à feuilles mobiles, etc.)?
6.6 Que pourrait-on faire pour mieux influencer l'adoption des comportements améliorés en WASH/EAH?

AGRICULTURE

7.0 En termes d'agriculture, quelles interventions IRP ont été les plus réussies et pourquoi (augmentation de la production et accès à des aliments riches en nutriments, renforcement des groupements de producteurs, amélioration de la gestion agricole, accès accru aux intrants, accès accru aux aliments diversifiés et de qualité, etc.) ?
7.1 Quel a été l'impact de l'augmentation de la production des aliments riches en fer (arachides, haricots, moringa, et soja)?
7.2 Quel a été l'impact de l'augmentation des aliments riches en vitamine A (épinards)?
7.3 Quel a été l'impact de la promotion d'une plus grande production de légumes comme les tomates, la laitue, les épinards?
7.4 Quel a été l'impact de la promotion de la plantation d'arbres de baobab et de moringa etc., de légumes comme le gombo ou l'amarante pour la consommation locale?
7.5 Quel a été le rôle des jardins maraichers, des cultures intercalaires et des parcelles familiales dans l'augmentation de la production?
7.6 Quel a été l'impact de la formation sur les techniques de production, récolte, de séchage et de stockage?

7.7 Quelles ont été les principales influences sur l'introduction de nouveaux produits et méthodes (champs écoles, agents de vulgarisation agricole, démonstrations alimentaires, agriculteurs pairs)?
7.8 Quels ont été les résultats de l'aide spécifique apportée aux agricultrices, y compris la formation, les démonstrations culinaires et la fourniture en intrants agricoles (semences améliorées etc.).
7.9 Quel a été l'impact de l'encouragement des communautés à multiplier les semences améliorées de légumes pour les rendre disponibles en permanence?
7.10 Quels matériels de soutien à la nutrition ont été reproduits ou produits par l'IRP de l'USAID (affiches, tableaux à feuilles mobiles, etc.)?

NUTRITION

8.0 En termes de nutrition, quelles sont les interventions IRP/(Programme Rural Intégré) de l'USAID les plus réussies et pourquoi (identifier et traiter la malnutrition aiguë, augmenter l'accès à des aliments divers et de qualité, allaitement maternel exclusif jusqu'à six mois, introduction d'aliments de compléments diversifiés de qualité à base d'aliments locaux disponibles)?
8.1 Quel a été l'impact de l'amélioration de la structure de gestion/CSCom et de la capacité à soutenir la CMAM (Prise en charge de la malnutrition aigüe à base communautaire/Community-based Management of Acute Malnutrition)?
8.2 Quel a été l'impact de l'amélioration du renforcement des capacités des agents de santé à gérer la malnutrition aiguë?
8.3 Quel a été l'impact de l'amélioration du renforcement des capacités des agents de santé à conseiller et à négocier avec les clients?
8.4 Quel a été l'impact de la formation des Groupes de Soutien aux Activités de Nutrition (GSAN)?
8.5 Quel a été l'impact de l'introduction d'aliments divers et de qualité par le biais de démonstrations nutritionnelles, de partage de recettes et de produits alimentaires?
8.6 Quelles ont été les principales influences pour l'adoption d'aliments variés et de qualité (Agents de Santé Communautaire/ASC, relais communautaire, Mamans Leader Animatrice, GSAN)
8.7 Quel a été l'impact sur la nutrition de l'introduction d'aliments divers et de qualité à travers les intrants agricoles (agriculture sensible à la nutrition)?
8.8 Quelle a été l'influence des démonstrations culinaires sur les changements positifs dans le comportement nutritionnel?
8.9 Quel a été le résultat du renforcement des compétences de l'agent de nutrition de district (chargé de la nutrition des districts sanitaires) et du personnel du centre de santé communautaire dans la lutte contre la malnutrition?
8.10 Quel a été l'impact du renforcement du dépistage et de traitement des enfants mal nourris (prise en charge des enfants malnutris)?
8.11 Quel a été le résultat d du renforcement des compétences des agents de santé à conseiller et à négocier avec les clients?
8.12 Quel a été l'impact du renforcement de la structure de gestion/sanitaire (CSCom) et de la capacité de prise en charge communautaire de la malnutrition aiguë?
8.13 Quels progrès ont été réalisés dans la promotion de l'allaitement maternel exclusif auprès des femmes en âge de procréer (enceintes et allaitantes) et comment cela a-t-il été réalisé?
8.14 Qu'est-ce qui a été fait pour accroître la participation des pères, des grands parents et des belles mères d'enfants de moins de 5 ans aux questions de nutrition et quel en a été le résultat, y compris l'alimentation diversifiée et de qualité des enfants?
8.15 Qu'est-ce qui a été fait pour accroître la participation des grands-mères aux questions de nutrition et quel en a été le résultat, y compris l'alimentation diversifiée et de qualité des enfants?

8.16 Quelles ont été les principales influences sur l'adoption de comportements nutritionnels positifs (GSAN, les relais communautaires, les chargés de Nutrition des districts sanitaires, les agents de santé communautaires, Maman Leader Animatrice, etc.)?
8.17 Quels matériaux d'appui à la nutrition ont été reproduits ou produits par l'IRP/(Programme Rural Intégré) de l'USAID (affiches, tableaux à feuilles mobiles, boites à outils de communication etc.)?
8.18 Que pourrait-on faire pour mieux influencer l'adoption de bons comportements nutritionnels?

SBCC (Communication pour le Changement Social et de Comportement/CCSC)

9.0 Dans quelle mesure les interventions de CCSC ont-elles été équilibré et ont-elles réussi à atteindre les populations cibles (Mobilisation communautaire, plaidoyer, marketing, communication interpersonnelle, médias de masse / communautaires)?
9.1 Quel était le rôle des assistants sociaux et du changement de comportement et quel était leur impact?
9.2 Quelle a été l'expérience de l'élaboration de matériel d'appui (tableaux à feuilles mobiles, affiches, etc.) et de leur distribution et utilisation?
9.3 Comment évalueriez-vous la stratégie globale de CCSC pour assurer le développement et la mise en œuvre des activités CCSC?

INTEGRATION

10.0 Quelles actions ont été menées pour intégrer les différentes composantes IRP USAID (WASH/EAH, agriculture, nutrition)?
10.1 Quels ont été les défis pour les zones d'intervention normalement séparées en coopérant et en travaillant ensemble?
10.2 Quels sont les avantages des trois éléments de l'IRP USAID dans la coordination et la collaboration?
10.3 Dans quelle mesure l'IRP USAID a-t-il réussi à coordonner les trois composantes de l'IRP au niveau communautaire?
10.4 Que pourrait-on faire pour améliorer le niveau de coordination des trois composantes du programme?
10.5 Dans quelle mesure le District sanitaire du district a-t-il été utilisé comme plate-forme multisectorielle?

Focus Group Discussion Guide

English version

The Integrated Rural Program (IRP) to Improve Nutrition and Hygiene in Mali is a USAID-funded project implemented by CARE in Mopti region and Save the Children in Sikasso region. We are interested in learning about your experience with this program and all its components.

WASH

Main question: What do you know about USAID's IRP WASH activities? What specific WASH results have been achieved at the community level? Are the community WASH activities sustainable after the end of the project? How can they be made more sustainable?

Added talking points:

- Are the community WASH activities sustainable after the end of the project? How can they be made more sustainable?
- What participants have done: hand-washing, open defecation control, and water purification/treatment
- What participants have observed: reduction of open defecation, improved latrine construction, rehabilitation of water sources

Main question: What influence has the Community-led Total Sanitation Plus (CLTS) (Assainissement Total Piloté par la Communauté ATPC) had on the community, if any? Is the community satisfied with its impact?

Added talking points:

- Identifying organization or person that has been the most influential in improving sanitation and hygiene in your household and community
- Sustainability of WASH improvements
- Identifying responsible for keeping community water sources clean at the community level
- Explore the reasons for expressions of satisfaction/dissatisfaction.

Main question: What more can be done to increase sanitation and hygiene in your household and community and to ensure sustainable access to clean drinking water?

Added talking points:

- Support materials (flipcharts, posters, etc.) have you seen promoting better hygiene and sanitation?
- Do these materials have any effect on people's behaviors? What is the best way of promoting improved WASH behaviors?

AGRICULTURE

Main question: What new agricultural products have been produced that have increased your access to them?

Added talking points:

- New products participants produced for their families. Origins
- Initiators individual or the groups which encouraged the production of these products
- Is the process sustainable?

Main question: What has been your experience in obtaining rich foodstuffs?

Added talking points:

- Include in foodstuff list: beans, groundnuts, soy, spinach, tomatoes, eggplant, and lettuce
- Identify experiences of planting trees: baobab, moringa, or plants.

Main question: In general, what support has been offered for the improvement of agricultural techniques? Is the focus group satisfied with this support?

Added discussion points:

- Training, demonstrations, visits, time spent in fields.
- Mention improved seed supply, production techniques and planting techniques, seedling treatment technique
- fertilizers and seeding methods
- Small Gardening Equipment etc.
- Improved harvest and surplus marketing (preservation, drying, storage and marketing)
- Explore why expressions of satisfaction or dissatisfaction.

Main question: In general, what support has been offered for the improvement of agricultural techniques? Is the focus group satisfied with this support?

Added discussion points:

- Training, demonstrations, visits, time spent in fields.
- Mention improved seed supply, production techniques and planting techniques, seedling treatment technique
- Fertilizers and seeding methods
- Small Gardening Equipment etc.
- Improved harvest and surplus marketing (preservation, drying, storage and marketing)
- Explore why expressions of satisfaction or dissatisfaction.

NUTRITION

Main Question: What has been done to increase your access to diverse and quality foods for you and your children?

Added discussion points:

- Identify new foods not consumed in the past
- Impact of cooking demonstrations (soy, peanuts, vegetables, green-dark leaves etc.) sharing cooking recipes and introduction of new food products
- Impact on local consumption of new food products: soy, soy, peanuts, spinach, tomatoes, lettuce, moringa, okra and amaranth. etc.

Main Question: What is the Nutrition Support Group (GSAN) in your community? Is the focus group satisfied with GSAN's work?

Added discussion points:

- Influence in the community
- Cooking demonstrations, community mobilization
- Sustainability of groups
- Explore why expressions of satisfaction / dissatisfaction.

Main questions: What is your experience with exclusively breastfeeding for six months? What is your experience of the introduction of complementary food among children 6 to 23 months?

Added talking points:

- Possibility of being encouraged
- Advantages and challenges of breastfeeding
- Complementary feeding period: issues and solutions
- Possibility of being encouraged
- Advantages and challenges of breastfeeding. What can be done to reduce barriers to exclusive breastfeeding?
- Weaning period: issues and solutions
- Influence of Maman Leader Animatrice, relais communautaires, agents de santé communautaires, fathers, grandmother if any, on introducing diverse and quality foods.

Main question: What was your community's experience in screening for and treating acute malnutrition?

Added discussion points:

- Actions taken against acute malnutrition in the community, by whom?
- What needs to be done to improve the management of malnutrition
- The impact of community-based management of severe malnutrition in your community
- Role of health staff in managing severe malnutrition: degree of satisfaction. Why ?

Main question: What has been done to increase the participation of fathers of 0-2 years old children in improving food quality?

Added discussion points:

- Impact of fathers and grandfathers grandparents, grandmothers, mothers-in-law, or other caregivers at the household level

Main question: What could be done to better to influence the adoption of good nutrition behaviours? What have been the perceived effects of activities on nutrition?

Added talking points:

- Nutrition support materials duplicated or produced by the IRP: effects
- Perceived effects

INTEGRATION

Main question: Does integration help achieve improved results? Which project components should be integrated and which should not be integrated??

Added talking points:

- Work in the three areas been well organized and complete?
- Advantage and challenges of integration
- Degree of success in which components
- How can it be improved?
- Can it be continued?

SBCC

Main question: To what extent were the interventions in the Behavior Change strategy balanced / adapted and successful in reaching the target populations? Is the focus group satisfied with these interventions in the Behavior Change strategy?

Added discussion points:

- Forms of SBCC: community mobilization, advocacy, marketing, interpersonal communication, communication through mass-medial mass-media (radio etc.)
- Role of SBCC assistants
- Role of communities and mass-media-media (radio and TV)
- Experience developing communication media, their dissemination and use. use. Exploring why expressions of satisfaction or in / dissatisfaction.
- To what extent do the various communication activities for behavioral change (interpersonal communication, peers, change agents, etc.) contribute to the achievement of results?

NUTRITIONAL STATUS

Main question: Overall, to what extent have there been general improvements in the nutritional status of your family and community? Is the focus group satisfied with these interventions in the sector?

Added discussion points:

- Specific improvements on the quality of food supplied at 6-23 months
- Overall situation in the family: Increase of different numbers of quality foods, reduction of stunting, underweight and anaemia in children 0-2 years of age reduction of underweight in women in reproductive age
- Explore the reasons for expressions of satisfaction / dissatisfaction.

Main question: What can be done to improve results and sustainability?

Added talking points:

- Influences of positive changes
- Contraints to positive changes.

French version

Le programme rural intégré pour l'amélioration de la nutrition et l'hygiène (IRP) au Mali est un projet financé par USAID et mis en œuvre par CARE dans la région de Mopti et par Save the Children dans la région de Sikasso. Nous sommes intéressés par votre expérience dans ce programme.

WASH

Question principale : Quel est le résultat spécifique en matière d'accès à l'eau potable, hygiène et assainissement (EHA=WASH) ? Ces activités communautaires WASH seront-elles pérennes après la fin du projet? Comment peut-on les rendre plus pérennes?

Points de discussions ajoutés :

- Qu'est-ce que les participants ont fait : lavage des mains au savon, arrêt de la défécation à libre, et le traitement de l'eau.
- Qu'est-ce que les participants ont observé : réduction de la défécation en plein air, amélioration des latrines, amélioration des points d'eau etc..?

Question principale : Est-ce que l'ATPC (Assainissement total piloté par la communauté) a eu un impact sur la communauté ? si oui Lequel ? La communauté est-elle satisfaite de l'impact?

Points de discussions ajoutés :

- Identifier les organisations ou les personnes qui ont eu le plus d'influence dans l'amélioration des conditions et pratiques d'hygiène et d'assainissement dans les ménages et dans les communautés
- Pérennité de ces améliorations
- Identifier les responsables chargés de l'hygiène autour des points d'eau ?
- Explorer le pourquoi des expressions de satisfaction/insatisfaction.

Question principale : Que peut-on faire en plus pour améliorer l'hygiène et l'assainissement dans votre ménage et dans la communauté et en assurant l'accès à une eau potable ?

Points de discussions ajoutés :

- Supports de formation (flip chart, poster, etc.) que vous avez vus pour la promotion de l'hygiène et l'assainissement dans votre ménage et communauté ?
- Est-ce que ces supports éducatifs ont eu un effet sur le changement des comportements et pratiques d'hygiène et d'assainissement. Quelle est la meilleure approche pour promouvoir les comportements et pratiques d'hygiène et d'assainissement?

AGRICULTURE

Question principale : Quels sont les nouveaux produits agricoles récoltés permettant un meilleur accès à ceux-ci?

Points de discussions ajoutés :

- Nouveaux produits agricoles produits pour leurs familles : Origines
- Les initiateurs individuels et les groupes qui ont encouragé ses produits
- Est-ce que l'approche est durable?

Question principale : Quelle a été votre expérience afin d'obtenir des aliments riches ?

Points de discussions ajoutés :

- Inclure dans la liste des produits alimentaires: haricots, arachide, soja, épinard, tomates, et laitue, moringa, le gombo et l'amarante.
- Identifier les expériences de plantations d'arbres : feuille de baobab, moringa ou plantes : le gombo et amarante

Question principale: Quelles organisations ont été les principales influences pour la culture d'aliments variés et de qualité (ASC, Écoles Amies des Fermes, agents de vulgarisation agricole, démonstrations alimentaires, pairs-agriculteurs, etc.)?

Points de discussion ajoutés:

- Identifier les expériences avec les micro-jardins, les cultures intercalaires et les parcelles familiales
- Aide spécifique donnée (ou non) pour aider les agricultrices avec leur intrigue collective ou individuelle
- Le groupe est-il satisfait du soutien reçu? Explorer les raisons de la satisfaction / insatisfaction

Question principale : En général, quels appuis ont été offerts pour l'amélioration des techniques agricoles? Le groupe de discussion est-il satisfait de cet appui ?

Points de discussions ajoutés :

- Formations, démonstrations, visites, temps passé dans des champs.
- Mentionner fourniture de semences, fertilisants et méthodes d'ensemencement

- Équipement
- Amélioration de récolte et commercialisation (conservation, séchage, stockage et commercialisation)
- Explorer le pourquoi des expressions de satisfaction/insatisfaction.

NUTRITION

Question principale : Qu'est-ce qui a été fait pour accroitre votre accès à des aliments diversifiés et de qualité pour vous et vos enfants?

Points de discussions ajoutés :

- Identifier les nouveaux aliments non consommés dans le passé
- Impact des démonstrations culinaires (soja, arachides) partage des recettes de cuisine et l'introduction de nouveaux produits alimentaires
- Impact sur la consommation locale des nouveaux produits alimentaires : soja , arachides, etc.

Question principale : Qu'est-ce que le Groupe de Soutien aux Activités en Nutrition (GSAN) fait dans votre communauté ? Le groupe de discussion est-il satisfait de travail du GSAN ?

Points de discussions ajoutés :

- Influence dans la communauté
- Démonstrations culinaires
- Durabilité des groupes
- Explorer le pourquoi des expressions de satisfaction/insatisfaction.

Question principale : Quelle est votre expérience avec l'allaitement maternel exclusif pendant six mois ? Quelle est votre expérience d'introduction d'aliments complémentaires pour les enfants de 6 à 23 mois?

Points de discussions ajoutés :

- Possibilité d'être encouragé
- Avantages et défis de l'allaitement
- Période de l'alimentation complémentaire: Problèmes et solutions
- Période de sevrage : Problèmes et solutions
- Influence de Maman Leader Animatrice, relais communautaires, agents de santé communautaires, pères, grand-mères le cas échéant, sur l'introduction d'aliments diversifiés et de qualité.

Question principale: Quelle était l'expérience de votre communauté dans le dépistage et la prise en charge de la malnutrition aigüe?

Points de discussions ajoutés :

- Actions prises contre la malnutrition aigüe dans la communauté, par qui?
- Qu'est-ce qui doit être fait pour améliorer la prise en charge de la malnutrition
- L'impact de la prise en charge à base communautaire de la malnutrition sévère dans votre communauté
- Rôle du personnel de santé dans la prise en charge de la malnutrition sévère : degré de satisfaction. Pourquoi ?

Question principale : Qu'est-ce qui a été fait pour accroître la participation des pères des enfants de 0-2 ans dans l'amélioration de la qualité des aliments ?

Point de discussions ajoutés :

- Impact des pères et grand-pères

Question principale : Qu'est-ce qui pourrait être fait pour mieux influencer l'adoption des bonnes pratiques nutritionnelles ?

Point de discussion ajouté :

- Supports de formation produits et multipliés par IRP :
- Effets perçus

INTEGRATION

Question principale : Est-ce que l'intégration aide l'atteinte de résultats améliorés? Quelles composantes du projet devraient être intégrés ? Le groupe de discussion est-il satisfait des efforts d'intégration ?

Points de discussion ajoutés :

- Est-ce que le travail dans ces trois domaines a été bien organisé et complet ? Explorer le pourquoi des expressions de satisfaction/insatisfaction.
- Avantages et défis de l'intégration
- Degré de succès
- Comment peut-il être amélioré

- Peut-il être poursuivi

SBCC

Question principale: Dans quelles mesures les interventions de la stratégie de Changement de comportement étaient-t-elles équilibrées et avaient permis d'atteindre avec succès les populations cibles ? Le groupe de discussion est-il satisfait de ces interventions de la stratégie de Changement de comportement ?

Points de discussion ajoutés :

- Formes de SBCC : Mobilisation communautaire, plaidoyer, marketing, communication interpersonnel, communication mass-média
- Rôle des assistants SBCC
- Rôle des communautés et des mass-medias (radios et TV)
- Expérience de développement des supports de communication, leur diffusion et leur utilisation . Explorer le pourquoi des expressions de satisfaction/insatisfaction.
- Dans quelles mesures les différentes activités de communication pour le changement des comportements (communication interpersonnelle, pairs, agents de changement) contribuent à l'atteinte des résultats?

STATUT NUTRITIONEL

Question principale : Dans l'ensemble, jusqu'à quel degré y a-t-il eu des améliorations en général sur l'état nutritionnel de votre famille et de votre communauté ? Le groupe de discussion est-il satisfait de ces interventions dans le secteur ?

Points de discussion ajoutés :

- Améliorations spécifiques sur la qualité des aliments fournis au 6-23 mois
- Situation globale dans la famille : Augmentation des différent nombres d'aliments de qualité, réduction du retard de croissance, l'insuffisance pondérale et l'anémie chez les enfants de 0-2 ans la réduction de l'insuffisance pondérale chez les femmes en âge de procréer
- Explorer le pourquoi des expressions de satisfaction/insatisfaction.

Question principale : Que peut-on faire pour améliorer les résultats et la durabilité ?

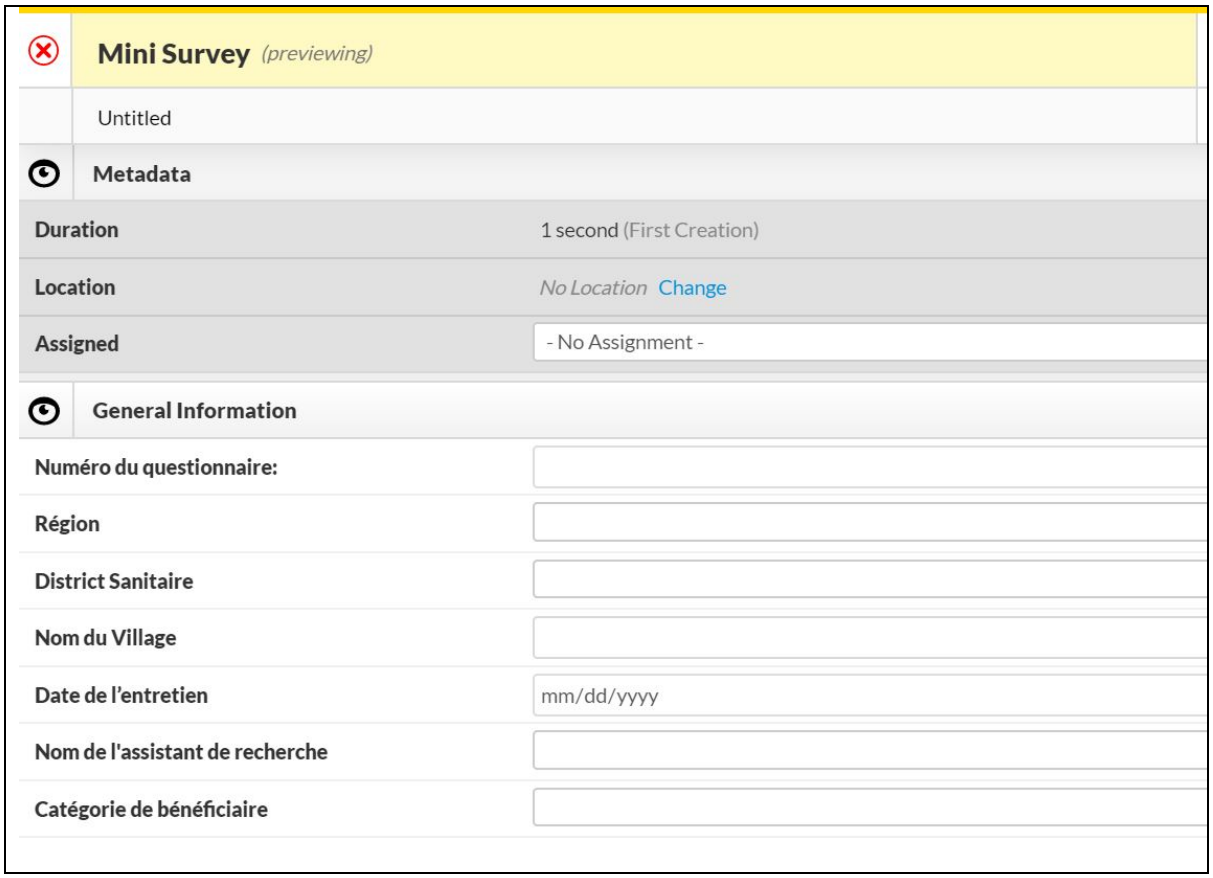
Points de discussion ajoutés :

- Influence des changements positifs
- Contraintes aux changements positifs

Mini-Survey Questionnaire

French Version

Presentation of the Mini-Survey French Questionnaire Administered through the Fulcrumapp Platform on Smartphones



Eau et assainissement

L'eau consommée dans le ménage est-elle traitée?	**Yes** / No
Si oui, comment cette eau est-elle traitée? (une seule réponse)	
Est-ce qu'il existe des latrines dans le ménage ?	**Yes** / No
Si oui quel type de latrines dans le ménage ?	
Est-ce que les latrines sont utilisées par tous les membres de la famille ?	Yes / **No**
Si non quels sont les membres qui ne les utilisent pas ?	Les hommes Les femmes Les enfants
Le village est-il certifié sans défécation à l'air libre (FDAL)?	Oui / Non / Ne sait pas
Y a-t-il un endroit pour le lavage des mains dans le ménage?	**Oui** / Non
Est-ce que la répondante se lave les mains aux moments critiques?	Yes / No
Résultat de l'observation du lavage de main	Eau et savon Savon ou détergent Robinet Tippy tap Other
Quels services ont été fournis par Care ou Save the children à votre village ?	Nutrition Eau, assainissement et hygiène Agriculture (y compris jardins individuels et communautaires)
Quels services ont été fournis par Care ou Save the children à votre village en agriculture ?	Fourniture de petits équipements de jardinage Formation en productions agricoles (céréales et légumes) Fourniture d'intrants (semences améliorées, fertilisants, pesticides) Techniques de conservation du sol Techniques de conservation des céréales Other
Quel est votre degré de satisfaction par rapport au volet agriculture ?	

Quels services ont été fournis par Care ou Save the children à votre village en WASH ?	Disponibilité de dalles de ciment pour latrines Appui à construction de latrines amélorées Appui à la réhabilitation des points d'eau Promotion du traitement de l'eau à domicile Promotion du lavage des mains au savon Disponibilité des produits WASH (aquatab et Javel) Other
Quel est votre degré de satisfaction par rapport au volet WASH ?	
Quels services ont été offerts par Care ou Save the children à votre village en nutrition ?	Dépistage de la malnutrition Référence pour la prise en charge de la malnutrition aiguë Démonstration culinaire Promotion de jardins maraîchers Accroissement de la disponibilité d'aliments diversifiés Promotion d'une alimentation diversifiée, combinant différent aliments Conservation des aliments Promotion de l'allaitement maternel Promotion de l'alimentation complémentaire avec des produits locaux Other
Quel est votre degré de satisfaction par rapport au volet nutrition ?	
Quelles ont été les ressources influentes les plus importantes en nutrition, agriculture, eau, assainissement et hygiène?	Agents de santé communautaire Maman leaders Grands-mères Groupe de soutien en nutrition Comité d'eau, d'hygiène et assainissement Agents de vulgarisation agricole Tontines de village Affiches et poster Radio Télévision Other
Quel est votre degré de satisfaction par rapport à ces ressources influentes?	

Quelles sont les actions qui continueront sûrement après le projet?	Eau et assainissement Nutrition Agriculture Changement de comportement
Si elles continuent, quelles sont les raisons de cette pérennisation?	Mobilisation communautaire Plan d'action Développement de capacités locales Motivation Leadership Bénéfices Amélioration de la santé Note: Autres moins de 16 caractères Other

Mesures anthropométriques: Mères d'enfants de moins de 2 ans (allaitant ou non) et des femmes enceintes

Poids (Kg)	
Taille (cm)	
Résultat du test d'anémie de mères d'enfants de moins de 2 ans et de femmes enceintes	

Veuillez inclure un enregistrement pour chaque enfant de 0-23 mois — 0 Items

Metadata

Duration	1 second (First Creation)
Location	*No Location* Change
Présentement, cet enfant est-il le plus âgé ou le plus jeune enfant de 0-23 mois?	
Âge de l'enfant (mois)	
Poids (Kg)	
Taille (cm)	
Résultat du test d'anémie d'enfant de 6-23 mois	

Aliments

Durant les dernières 24 heures, votre/vos enfant(s) de moins 2 ans ont-ils mangé?	Yes / No

Durant les dernières 24 heures, avez-vous donné à votre/vos enfant(s) âgés de moins de 2 ans tout aliment suivant:

Céréales, tubercules ou racines	Blé Fonio Igname Manioc Maïs Mil Patates douces Pommes de terre Riz Sorgho Other
Protéines	Légumineuses (pois chiches, doliques, niébé, arachide, soja) Oeufs Poisson Produits Laitiers Viande Volaille Other
Légumes	Aubergine Gombo Carotte Feuilles vertes pour sauces Moringa Haricot vert Tomate Other
Fruits	Banane Mangue Orange Papaye Autres Other
Corps gras et huiles	Beurre de karité Gras animal Huile de palme Huile d'arachide Other

English Version

	METADATA	**Code**
	Duration	
	Location	
	Assigned	
	GENERAL INFORMATION	
	Questionnaire Number	
	Region	01= Mopti 02= Sikasso
	Circle or District	11= Mopti 12= Bandiagara 13= Sikasso 14= Bougouni
	Village	
	Interview date	_____/_____/ **2017**
A06	**Name of research assistant**	List of names
	Beneficiary category	1= Non Beneficiary 2 = Beneficiary
	If beneficiary, type of benefits received	1=Nutrition Only 2= Nutrition and WASH 3= Nutrition and Agriculture 4= Nutrition, WASH and Agriculture 5= Other
	Age of respondent (in years)	_____
	Are you presently pregnant?	1= yes 2= no
	Do you have a child 0-23 months?	1= yes

		2= no
	If yes, how many children under 0-23 months do you have?	_____
	If yes, how old in months is the child?	_____
	Are you presently breastfeeding your child 0-23 months?	1= yes 2= no
	Did you give this child liquid or solid food other than breast milk before the age of 6 months?	1= yes 2= no
	If yes, what liquids	Water Sweetened water Traditional mixtures Porridges Other
	How old is your youngest child less than 2 years?	_____
	WASH	
	Is water consumed in your household treated?	1= yes 2= no
	If yes, how is water treated in your household? (single response)	1= bleach 2= aquatab 3= straining cloth 4= boiling 5=other method

	Is there a toilet in your household?	1= yes 2= no
	If so, what kind of toilet in your household?	_____
	Are toilets used by all members of the household?	1= yes 2= no
	If not, which family members don't use them?	The men The women The children
6	Is your village certified as being free of open defecation (FDAL)?	1= yes 2= non 3= don't know
7	7.1 Is there a hand-washing station in your household?	1= yes 2= no
	Does the woman wash her hands in critical moments	1= yes 2= no
	Observe the hand-washing station	1= soap and detergent or ashes 2= tap 3= tippy tap 4= other
	SERVICES PROVIDED	
	What services were provided by CARE or Save the Children in your village?	1= Nutrition 2= WASH

		3 Agriculture (including community and individual gardens)
	What initiatives have been offered by CARE or Save the Children in your community in agriculture? (*multiple response possible)*	1= provision of farming equipment 2= training of farmers on crop cultivation 3= provision of improved varieties of seeds 4= provision of agricultural inputs (fertilizers and/or chemicals) 5= water conservation techniques 6= post harvest techniques 7= harvest conservation techniques 8= other
	To what degree are you satisfied with those agriculture initiatives?	1= very satisfied 2= satisfied 3= somewhat satisfied 4= not satisfied
	What initiatives have been offered by CARE or Save the Children in your community in WASH? (*multiple response possible)*	1= availability of cement slabs of improved latrines 2= support in construction of latrines 3= support for improved wells 4= promotion of hand-washing with soap 5= Availabiliy of WASH products (aquatab, bleach) 6= other
	To what degree are you satisfied with those WASH initiatives?	1= very satisfied 2= satisfied 3= somewhat satisfied 4= not satisfied

	What initiatives have been offered by CARE or Save the Children in your community in Nutrition? (*multiple response possible)*	1= malnutrition screening 2= referral for acute malnutrition treatment 3= cooking demonstrations 4= promotion of vegetable gardens 5= increase availability of food varieties 6= promotion of combining different foods for balance diet 8= promotion of exclusive breastfeeding 9= promotion of complementary feeding of local foods 10= others
	To what degree are you satisfied with those Nutrition initiatives?	1= very satisfied 2= satisfied 3= somewhat satisfied 4= not satisfied
	What are the most important influences on you regarding nutrition, agriculture, water sanitation and hygiene? (*multiple response possible)*	1= community health volunteers 2= mother leader animators 3= grandmothers 3= nutrition activity support groups 4= agriculture extension agents 5= flip charts 6= radio 7= television 8= others
	To what degree are you satisfied with the work of influencers ?	1= very satisfied 2= satisfied 3= somewhat satisfied 4= not satisfied

	What interventions will surely continue after the end of the project?	1= WASH 2= Nutrition 3= Agriculture 4= SBCC
	If they do continue, what are the reasons for the sustainability?	1=Community mobilization 2=Action plan 3=Development of local capacities 4=Motivation 5=Leadership 6=Benefits 7= Improvement in health
	Anthropometric measures: Motehers of children less than 2 years old (breastfeeding or not) and pregnant women	
	Weight (Kg)	
	Height (cm)	
	Results of the anemia test	
	METADATA	
	Duration	

	Location	
	Presently, this child is the oldest of the youngest child 0-23 months?	1= oldest 2= youngest
	Child's age in months	_____
	Weight (kg)	_____
	Height (cm)	_____
	FOODS	
	Within the last 24 hours have you fed your child/children 6-23 month old?	1= yes 2= no
	Within the last 24 hours have you fed your child/children 6-23 months old cereals, tubers or roots?	wheat fonio yam cassava corn sweet potato potato rice sorghum other

	Within the last 24 hours have you fed your child/children 6-23 months old proteins?	beans (chickpeas, cowpeas, peanuts, soja) eggs fish milk products poultry meat other
	Within the last 24 hours have you fed your child/children 6-23 months old vegetables?	egg plant okra carrot sauce green leaves moringa green beans tomato other
	Within the last 24 hours have you fed your child/children 6-23 months old fruits?	bananas mangos oranges papayas other
	Within the last 24 hours have you fed your child/children 6-23 months old oils and animal fats?	shea butter animal fat palm oil peanut oil other

ANNEX IV: SOURCES OF INFORMATION

A. LIST OF PERSONS INTERVIEWED IN A MISSION AGENDA

Date	Organization	Participants
12/14/2017	USAID	Sector staff
12/15/2017	Care - Mali	Sahada Traoré : Chief of Party Yawo Douyon : Country Director Ousman Teme : WASH advisor Robert Dembélé: Infrastructure Advisor
12/19/2017	Save the Children	Oumou Sangaré: Community organizer Mahamadou Traoré: M&E Adviser N'Tji Coulibaly: Deputy Chief of Party
12/20/2017	DNACPN	Nia Fatoumata Directrice Adjointe
12/20/2017	World Veg	Caroline Sobgui: Nutrition et WASH Omar DIOUF: Chef de projet Edoh Ognakossan Kukom: agriculture
12/20/2017	SNV	Amadi Coulibaby : Project officer Mamadou Coulibaby : Manager of IRP project in Sikasso Oumou Traoré : Agro-economist advisor
12/20/2017	USAID	Fatimata Ouattara: Project Management Specialist: Nutrition and WASH Amadou Diané: Agriculture Specialist Aminata Kanta: Contract Specialist Karen Kaprince: Nutrition Specialist
12/21/2017	UNICEF	Kalifa Keita: WASH expert
12/21/2017	KJK communications	Haleimata Maïga: CCSC SMNI/Nutrition/WASH Mohamed Sangaré : Chef d'équipe SBCC
12/22/2017	Research Assistants training	Galadiè Konaté Ousmane GANA Ba-OumouSANGARÉ Fanta Dicko Awa Sanogo Adama DOUMBIA Aïssa Cissé Assata KONE Achatou Bagayoko André DRABO
12/23/2017	Research Assistants pre-test: Diago	Same
12/23/2017	Presentation of research information fact sheet to Ethics Committee of INRSP-Mali	Mme Sidibé Diaba CAMARA, Vice présidente du comité éthique Dr Alpha Dembélé, CSREF Commune V, représentant des églises Dr Adama DAO, représentant de l'Ordre des Médecins Dr Mamadou BOUARE, DNS, Dr Mamadou COULIBALY, ISH Pr SISSOKO Mamadou, Faculté de droit Mme DIAKITE Kamissa TOUNKARA, Secrétaire du Comité Éthique
12/26/2017	USAID: follow-up	Fatimata Ouattara: Project Management Specialist: Nutrition and WASH Mamoutou Diarra: Water, Irrigation and land Development (Agriculture and Economic Growth) Amadou Diané: Agriculture Specialist

Date	Organization	Participants
12/28/2017	USAID: follow-up	Fatimata Ouattara: Project Management Specialist: Nutrition and WASH Karen Kaprince: Nutrition Specialist Ibrahima Dolo: M&E Health advisor
12/29/2017	USAID: follow-up on translation of questionnaire in local language	Fatimata Ouattara: Project Management Specialist: Nutrition and WASH Ibrahima Dolo: M&E Health advisor Mamoutou Diarra: Agriculture Research assistants: Galadiè Konaté Ousmane Gana Ba-Oumou Sangaré Fanta Dicko Awa Sanogo Adama Doumbia Aïssa Cissé Assata KONE Achatou Bagayoko André Drabo
01/02/2018 to 01/04/2018	MSI evaluation team Adjustments to information and data gathering tools. Adjustments to the inception report	
01/05/2018	MSI evaluation team. Departure to the field in two teams: Mopti and Sikasso.	
	Sikasso team pre-departure security briefing by Securicom	Raymond Gervais: team leader Iain McLellan: coordinator for Sikasso Amadou Fofana: sector expert for agriculture Research assistants: Achatou Bagayoko Fanta Dicko André Drabo Galadiè Konaté
01/05/2018	Sikasso Team	
	Coordination briefing: consultants and research assistants	Raymond Gervais: team leader Iain McLellan: coordinator for Sikasso Amadou Fofana: sector expert for agriculture Research assistants: Achatou Bagayoko Fanta Dicko André Drabo Galadiè Konaté Ba-Oumou Sangaré
	Save the Children Sikasso meeting	Raymond Gervais: team leader Iain McLellan: coordinator for Sikasso Amadou Fofana: sector expert for agriculture Mahamadou D. Traoré: PNH - M&E advisor Oumou Sangaré: PNH - SBCC advisor Mamadou Coulibaly : PNH – agriculture advisor Mahamadou Talil: PNH – health N'Tji Coulibaly: PNH - director
01/06/2018	Field work in Gnirwani, Farakala Commune	Received complete package of interventions
	FGD session with beneficiary women	Group of 9 women who had children between 0-23 months. Approx. 10 other women observers

Date	Organization	Participants
	FGD session with Mamas Leaders Animatrices	FGD with 8 women
	Group meeting with male community leaders	6 men, including the interim village chief
	KII with Adama Coulibaly, community relay	KII: 1 male
	KII with Fatimata Diarra, Save the Children Behavior Change Agent	KII: 1 female
	KII meeting with peer farmers: Souleymane M. Sanogo and Konimba Sanogo	KII: 2 males
	Mini-survey administered	10 women
01/06/2018	Field work in Fokognoumadiassa, Farakala Commune	Received complete package of interventions
	Mini-survey administered	10 women
01/07/2018	Field work in Siani, commune of Kléla	Received partial package of interventions
	KII meeting with chief of village: Cléma Diarra, and advisors: Kloussama Diarra, President of Villagers Association; Madou Diarra, Advisor	KII: 3 males
	KII with Yacouba Sankaré, chief of community Mobilizers	KII: 1 male
	FGD session with female beneficiaries	Group of 8 women with children approx. Less than 23 months old
	KII with Siaka Keita Medical doctor of Klela CSCOM	KII: 1 male
	Mini-survey administered	10 women
01/07/2018	Field work in Deh, commune of Gongasso	Received partial package of interventions
	Mini-survey administered	10 women
01/08/2018	Field work in Zérèlaba, commune of Pimerna	
	KII meeting with chief of village: Mamadou Diamoutene; Kalifa Diamoutene; Yafini Diamoutene, Advisors	KII: 3 males
	FGD session with Maman Leader Animatrices	10 women
	KII with Fatoumata Samaké: Assistant SBC with Save the Children	KII: 1 woman
	FGD session with female beneficiaries	10 women
	KII with Karim Zanga Diamouténé, village agriculture peer farmer	KII: 1 male
	Yacouba Diamouténé, secretary to village WASH committee	KII: 1 male
	Follow-up meeting with Save the Children	Raymond Gervais: team leader Iain McLellan: coordinator for Sikasso

Date	Organization	Participants
		Amadou Fofana: sector expert for agriculture Soumaïla Koné: SNV – WASH advisor Oumou Sangaré: PNH - SBCC advisor Mamadou Coulibaly : SNV – agriculture advisor Mahamadou Talil: PNH – health N'Tji Coulibaly: PNH - director
	Mini-survey administered	10 women
01/08/2018	Field work in Ouofina, commune of Pimerna	
	Mini-survey administered	10 women
01/09/2018	Field work in Molasso, commune of Farakala	
	FGD session with female beneficiaries	6 women
	FGD session with Maman Leaders Animatrices	12 women
	KII meeting with male leaders: Maisso Sanogo, chief of village; Yacouba Sanogo, advisor; Souleymane Sanogo, president of the coordination committee; Mamadou Sanogo, member of the WASH committé; Abdou Sanogo, member of the WASH committee.	KII: 5 males
	KII with Adama Sanogo, peer farmer	KII: 1 male
	Mini-survey administered	10 women
01/09/2018	Field work in N'Tiosso, commune of Kapolondougou	
	Mini-survey administered	10 women
01/09/2018	KII meeting with CSCOM staff in N'Kouroula: Mamadou Coulibaly, DTC; Abdelrahamane Keita, Youba Traoré	KII: 3 males
01/09/2018	KII in Sikasso with SNV sector experts.	Raymond Gervais: team leader Iain McLellan: coordinator for Sikasso Amadou Fofana: sector expert for agriculture Mamadou Coulibaly :PNH – agriculture advisor Soumaïla Koné: SNV – WASH advisor
01/10/2018	Field work in Farako, commune of Finkilo	
	Mini-survey administered	10 women
01/10/2018	Field work in Badakourabougou, commune of Finkilo	
	Mini-survey administered	10 women
01/10/2018	KII with Ibrahim Kone, Sikasso District Centre de Santé Référence, Nutrition focal point	KII: 1 male
	KII with Shery Baly, Sikasso Direction Régionale d'assainissement et de la Control de la Pollution et de	KII : 1 male

Date	Organization	Participants
	nuissances (DRACPN), central coordinator and focal point regional for Assainissement Total Piloté par la Comunauté (ATPC)	
	KII with Oumar Touré, Skikasso Direction Régionale de l'Agriculture, Statistics, monitoring and evaluation chief	KII : 1 male
	KII with Dramane Traoré, Sikasso Direction Régionale de la Santé, Planning chief	KII : 1 male
	KII with Dan Coulibaly, Radio Mamalon, director	KII: 1 male
	KII with Francois Mgirin Shuti, Save the Children Sikasso Office, Financial manager	KII: 1 male
	KII with Aissata Diarra, Save the Children Sikasso Office, Field Manager	KII: 1 woman
01/11/2018	Travel to Bougouni	
	Group meeting in Bounouni with Save the Children personnel in Sikasso and Bougouni districts	Ali Thienou, Save the Children, Social and Behavior Change Officer, Bougouni Oumou Traoré, SNV, Local Capacity Builder, Sikasso N'Tji Coulibaly, Save the Children. Sikasso Traoré Badoua, Social and Behavior Change Assistant, Bougouni District Gaoussou Sissoko, Social and Behavior Change Assistant, Bougouni District Sidiki Coulibaly, Social and Behavior Change Assistant, Bougouni District M'bo Boriya, Social and Behavior Change Assistant, Bougouni District Mariama Boullie, Social and Behavior Change Assistant, Bougouni District Kafouné Keita, Social and Behavior Change Assistant, Bougouni District Madiatou Camara, Social and Behavior Change Assistant, Bougouni District Oumau Traoré, Social and Behavior Change Assistant, Bougouni District N'ji Tiemoko Coulibaly, Social and Behavior Change Assistant, Bougouni District Moussa Kone, Social and Behavior Change Assistant, Bougouni District Astou Diawara, Social and Behavior Change Assistant, Bougouni District
01/11/2018	Field work in Bougoula, commune of Zaniébougou	
	Mini-survey administered	10 women
01/11/2018	FGD session with female beneficiaries	10 women
	FGD session with Mamans leaders animatrices	7 women

Date	Organization	Participants
	KII with Ousmane Koné, Peer farmer	KII: 1 male
	Group meeting with women agriculturists and peer farmers	8 women
	KII with Adama Koné, chief of village and Amadou Koné, chairman of WASH committee	KII: 2 males
	KII with Oumar Traore, Save the Children, Assistant SBC officer	KII: 1 male
	KII with Aboulaye Dembele, Technical director, Infirmier d'état, CSCOM	KII: 1 male
	KII with Maimouma Ouattara, Agente de santé communautaire	KII : 1 woman
	KII with Amadou Dielolé, community relay in Sountu village	KII : 1 male
01/11/2018	Field work in Kimi, Commune of Zantiébougou	
	Mini-survey administered	10 women
01/12/2018	Field work in Flokolon, Commune of Zantiébougou	
	Mini-survey administered	10 women
01/12/2018	FGD session with beneficiary women in Flokolon	11 women
	FGD sessions with Mamans leaders animatrices	7 women
	KII group meeting with Zoumana Doumbia, chief; Moussa Doumbia n°1; Moussa Doumbia n°2, advisors	KII: 3 males
	FGD session with women agriculturalists	7 women
	KII with Chaka Doumbia, Animateur Paysan	KII: 1 male
	FGD session with husbands of female beneficiaries	10 males
01/12/2018	Field work in Dié, commune of Zantiébougou	
	Mini-survey administered	10 women
01/13/2018	Field work in Solo, commune of Sido	
	Mini-survey administered	10 women
01/13/2018	KII group meeting with Kadia Kouyaté and Sanaba Coulibaly, women agriculturists	KII: 2 women
	KII with Ousmane Doumbia, animateur paysan	KII: 1 male
	FGD session with mothers in law of female beneficiaries	5 women
	FGD session with female beneficiaries	8 women

Date	Organization	Participants
	KII with Maiga Kadidiatou Samaké, extension agent	KII: 1 woman
	KII with Kafoune Keita, Save SBC assistant	KII: 1 woman
	KII with Sanaba Coulibaly, technical director of CSCOM	KII: 1 male
	KII with Mohammed Gadiaga, community health agent for nutrition	KII: 1 male
	FGD session with husbands of female beneficiaries	5 males
01/13/2018	Field work in Sido, commune of Sido	
	Mini-survey administered	10 women
01/14/2018	Field work in Bougoulafara, commune of Sido	
	Mini-survey administered	10 women
01/14/2018	Ggroup meeting with women agriculturists	6 women
	KII with Drissa Coulibaly, peer farmer	KII: 1 male
	KII with Seydou Coulibaly, advisor to the chief	KII: 1 male
	KII with Memè Coulibaly, community relay	KII: 1 male
	KII With Gaoussou Sissoko, assistant SBC	KII: 1 male
	FGD with female beneficiaries	10 women
	FGD session with Maman leaders animatrices	6 women
01/14/2018	Field work in Tinkolé, commune of Sido	
	Mini-survey administered	10 women
01/15/2018	Field work in Klebaugouda, Commune of Kola	Received partial package of interventions
	Mini-survey administered	10 women
01/15/2018	Field work in Klessokoro, Commune of Kola	Received partial package of interventions
	Mini-survey administered	10 women
	KII with Sekou Diarra SNV/YIRIWASIRA extension agent Zantiebougou	KII : 1 male
	KII with Somatié Togola, SNV/ YIRIWASIRA extension agent	KII : 1 Male
	KII meeting with Soumaila Traoré, technical director, CSCOM Koumantou and Minata Konaté, nutrition focal point	KII : 1 Male 1 Female
	Bougouni District level KIIs	
01/15/2018	KII with Alkassoum Barka, chief of agriculture, Bougouni District Agriculture office	KII: 1 male
	KII with Elise Goita, responsible for program,	KII : 1 male

Date	Organization	Participants
	Bougouni District Agriculture office	
	KII with Diarra Souleymane, interim chief doctor, Centre de santé référence, Bougouni District	KII : 1 male
	KII with Moussa Kone, superviseur, Acute malnutrition supervisor, Centre de santé de référence, Bougouni District	KII : 1 male
	KII with Bah Aboloulaye Yattara, chief, Service de l'assainissement et du contrôle des pollutions et nuissances de District de Bourgouni	KII : 1 male
	KII withy Diarra Fatoumata, producer, Community Radio Kafo Kan, Bourgouni	KII : 1 female
	KII with Honore Traore, chief communications, CARE Mopti	KII 1 male
01/05/2018	Mopti Team	
	Travel to San: major logistics and security constraints imposed stopover in San for the night.	Pr Akory Ag Iknane: sector expert for nutrition Boubacar Abida Maiga: sector expert for WASH Research assistants: Adama Doumbia Ousmane Gana Awa Sanogo Aissa Cissé (FGD) Assata Koné
01/06/2018	Arrival in Mopti: security briefing by Securicom	
	Briefing meeting with Care Mali representative Sahada Traoré	1 male
	Coordination briefing by the Mopti team: decision made to begin data gathering (01/07) in the Bandiagara district with the 3 villages of Tilé, Pouraly, and Diomboly and 3 Focus groups. Under advisory of Care coordinator Soumeyla SAYE.	Pr Akory Ag Iknane: sector expert for nutrition Boubacar Abida Maiga: sector expert for WASH Research assistants: Adama Doumbia Ousmane Gana Awa Sanogo Aissa Cissé (FGD) Assata Koné
	KII with Aguissa Maiga, health regional director for Mopti	KII: 1 male
01/07/2018	Field work in Pouraly, commune of Dandoli	
	FGD session with female beneficiaries	7 women
	Mini-survey administered	10 women
01/07/2018	Field work in Diomobolo Ley, commune of Doucombo	
	FGD session female beneficiaries	10 women
	Mini-survey administered	10 women

Date	Organization	Participants
01/07/2018	Field work in Tillé, commune of Doucombo	
	FGD session with female beneficiaries	12 women
	Mini-survey administered	10 women
01/08/2018	Field work in Kagnantaga, commune of Dourou	
	Mini-survey administered	10 women
01/08/2018	FGD session with female beneficiaries	7 women
01/08/2018	Field work in Idiely Do, commune of Dourou	
	Mini-survey administered	10 women
01/08/2018	Field work in Diombolo Do, commune of Doucombo	
	Mini-survey administered	10 women
01/09/2018	Field work in Bandiougou, commune of Pignari Bana	
	KII with Sekou Karambé, Community health worker	KII: 1 male
	Mini-survey administered	10 women
01/09/2018	Field work in Somoly, commune of Kendie	
	Mini-survey administered	10 women
01/09/2018	Field work in Bandiagara	
	KII with Soumeïla Saye, ADC coordinator of Mopti and Bandiagara districts, YA-G-TU	KII: 1 male
01/10/2018	Field work in Tintimboly, commune of Soroly	
	FGD session with male community leaders	8 males
	Mini-survey administered	10 women
01/10/2018	Field work in Singama, commune of Pignari Bana	
	Mini-survey administered	10 women
01/10/2018	Field work in Bandiagara	
	KII with Moussa Kebe, Nutition focal point, Bandiagara Centre de Santé de Reference (CFREF)	KII: 1 male
	KII Mamadou TRAORE, Medical adjunct chief CSREF	KII: 1 male
	KII with Korko GORO, Responsible of WASH CSREF	KII: 1 male
	KII meeting with Yaïguéré TEMBELY, Director of YA-G-TU NGO; Hamadou CISSE, Technical coordinator, YA-G-TU, NGO	KII: 1 female + 1 male
	KII with Abdoulaye Ould Bouya, Centre technical director, Central CSCOM	KII: 1 male
	KII with Allaye Banou, Program director, Toguna Radio	KII: 1 male

Date	Organization	Participants
	KII with Amadou Maïga, Control of pollution, local office, Minister of Environment and Sanitation	KII: 1 male
01/11/2018	Travel Bandiagara to Mopti	
	Planning meeting with Ousmane Teme, interim director of Care, Dr Tiemoko Berthe, CARE Nutrition advisor	2 males
01/11/2018	KII meeting with Dramane Coulibaly, interim regional health director, Ministry of Health and Public Health	KII: 1 male
	Mamadou Konate, regional WASH director, Minister of Environment and Sanitation	KII: 1 male
01/11/2018	Field work in Primpin, commune of Sio	
	Mini-survey administered	10 women
01/11/2018	Field work in Sirakoro, commune of Sio	
	Mini-survey administered	10 women
01/11/2018	KII meeting with CSREF in Mopti: Drissa Toure, Meldical chief, Kassim Sanago, WASH focal point; Jean Dako, Nutrition focal point	KII: 3 males
	KII with CSCOM in Sokoura with Anne Kodio, medical chief	KII: 1 female
	KII meeting with Souleymane Touré, M&E advisor and Daouda Traoré, chef WASH division, DNACP	KII: 2 males
01/12/2018	Field work in Bacoro, commune of Socoura	
	Mini-survey administered	10 women
01/12/2018	FGD session with female beneficiaries	7 women
	KII with Becema Tapily, community relay	KII: 1 male
01/12/2018	Field work in Sinakoro, commune of Socoura	
	Mini-survey administered	10 women
01/12/2018	FGD session with female beneficiaries	12 women
01/12/2018	Field work in Sévaré: KII with Care staff	
	KII with Ousmane Témé, Interim Chief of Party of Care in Mopti	KII: 1 male
	KII with Moussa Marc Keita, Agriculture advisor Feed the Future/Care	KII: 1 male
	KII meeting with Ousmane Témé, WASH advisor and	KII: 2 males

Date	Organization	Participants
	Robert Dembélé, Water and Infrastructure advisor, Care	
	KII with Tiémoko Berthe, Nutrition advisor, Care	KII: 1 male
01/13/2018	Field work in Gniminitogo, Commune of Socoura	
	Mini-survey administered	10 women
01/13/2018	FGD session with male community leaders	8 males
	KII of Aissata Yattera, community relay	KII: 1 woman
01/13/2018	Field work in Sina, Commune of Socoura	
	Mini-survey administered	10 women
01/13/2018	FGD session with male community leaders	8 males
01/14/2018	Field work in Thy, Commune of Fatoma	
	Mini-survey administered	10 women
01/14/2018	Field work in Pare, commune of Socoura	
	Mini-survey administered	10 women
01/14/2018	FGD session with female beneficiaries	11 women
01/15/2018	Field work in Sabe, commune of Fatoma	
	Mini-survey administered	10 women
01/15/2018	Field work in Sangobaka Djeneri	
	Mini-survey administered	10 women
01/15/2018	KII with Bakabu Tamboura, chief of village	KII: 1 male
01/16/2018	KII with Yaran Mounkoro, Director of Radio Kounari in Sevare	KII: 1 male
	KII with Mamourou Sidibé, Director of ORTM in Mopti	KII: 1 male
01/16/2018	Return of teams from Sikasso and Mopti	
01/17/2018	Return of the team leader from Mopti	

ANNEX V : LIST OF DOCUMENTS

Ahgren B, and Axelsson R. 2005. Evaluating integrated health care: a model for measurement. International Journal of Integrated Care 5: 1-9.

Ahner-McHaffie TW, Guest G, Petruney T, Eterno A, and Dooley B. 2017. Evaluating integrated development: are we asking the right questions? A systematic review. Gates Open Research 1 (2): 1-10.

Alzua, M. L., Pickering, A. J., Djebbari, H., Lopez, C., Cardenas, J. C., Lopera, M. A., Osbert, N., Osbert, N., and Coulibaly, M. 2015. Rapport final : évaluation d'impact des programmes d'Assainissement Total Piloté par la Communauté (ATPC/CLTS) dans les zones rurales du Mali. Bamako: UNICEF.

AVRDC, the World Vegetable Center and Save the Children. 2015. Protocole d'Accord (draft). Bamako: AVRDC and Save the Children.

Bessan SARL. 2017. Évaluation à Mi-Parcours. Bamako: Consortium Save the Children International / S N V.

Care International. 2014. Progress Report FY14 Quarter 4 and Year 1. October 1, 2013 - September 30, 2014. Bamako: Care International.

Care International. 2014. Progress Report FY15 Quarter 1. October 1, 2014 - December 31, 2014. Bamako: Care International.

Care International. 2014. Progress Report FY14 Quarter 3. April 1, 2014 - June 30, 2014. Bamako: Care International.

Care International. 2014. Progress Report FY14 Quarter 2. January 1, 2014 - March 31, 2014. Bamako: Care International.

Care International. 2015. Progress Report FY15 Quarter 2. January 1, 2015 - March 31, 2015. Bamako: Care International.

Care International. 2015. Progress Report FY15 Quarter 4 and Year 2. October 1, 2014 - September 30, 2015. Bamako: Care International.

Care International. 2015. Progress Report FY16 Quarter 1. October 1, 2015 - December 31, 2015. Bamako: Care International.

Care International. 2015. Progress Report FY15 Quarter 3. April 1, 2015 - June 30, 2015. Bamako: Care International.

Care International. 2016. Progress Report FY16 Quarter 2. January 1, 2016 - March 31, 2016. Bamako: Care International.

Care International. 2016. Progress Report FY16 Quarter 3. April 1, 2016 - June 30, 2016. Bamako: Care International.

Care International. 2016. Progress Report FY16 Quarter 4 and Year 3. October 1, 2015 - September 30, 2016. Bamako: Care International.

Care International. 2016. Diagnostic institutionnel de la Direction Nationale de l'Assainissement du Contrôle des Pollutions et des Nuisances (DNACPN et ses démembrements) dans le cadre de la mise en œuvre de la phase post-FDAL de l'ATPC. Bamako: Care International.

Care International. 2016. Stratégie opérationnelle de communication révisée de mise en œuvre du projet uUSAID / nutrition & hygiène. Bamako: Care International.

Care International. 2017. Rapport final - juin 2017. Evaluation de base "dans les zones de Feed the Future" nouvellement attribuées au projet USAID/nutrition et hygiène, région de Mopti, Mali. Bamako: Feed the Future.

Care International. 2017. Progress Quarterly Report FY17 (January 1, – March 31, 2017). Bamako: Feed the Future.

Care International. 2017. Progress Report FY17 Quarter 1. October 1, 2016 - December 31, 2016. Bamako: Feed the Future.

Care International. 2017. Progress Report FY17 Quarter 3. April 1, 2017 - June 30, 2017. Bamako: Feed the Future.

Care International. 2017. Progress Report FY17 Quarter 4 & Year 4. (October 1, 2016 – September 30, 2017). Bamako: Feed the Future.

Care International. 2017. Projet-USAID nutrition hygiène/Care - base de données de l'assainissement total piloté par la communauté. Bamako: Care Mali.

Care International. 2017. Boîte à images Care 2017. Bamako: Care International.

Care International. 2017. Cahier du participant - Formation intégrée maçons et femmes leaders. Bamako: Care International.

Care International. 2017. Guide de mise en œuvre de l'Assainissement Total Piloté par la Communauté au Mali. Bamako: Care International.

Care International. 2017. Guide à l'utilisation de la Boite à Outils. Bamako: Care International.

Care International. 2017. Rapport de formation des cadres de la DNACPN et de ses démembrements régionaux sur le manuel de procédures administratives, comptables et financières. Bamako: Care International.

Cellule de Planification et de Statistiques (CPS/SSDSPF), Institut National de la Statistique (INSTAT), Centre d'Études et d'Information Statistiques (INFO-STAT), and ICF International. 2014. Enquête démographique et de Santé (EDSM-V) 2012-2013. Rockville: ICF.

Cole DC, Levin C, Loechl C, Thiele G, Grant F, Girard Webb A, Sindih K, and Low J. 2016. Planning an integrated agriculture and health program and designing its evaluation: Experience from Western Kenya. Evaluation and Program Planning (56): 11-22.

Consortium Care International au Mali, YA-G-TU IRC FHI360. 2017. Monitoring and Evaluation Plan. Integrated Rural Program to Improve Nutrition and Hygiene in Mali in the Regions of Koulikoro, Segou and Mopti. Bamako: Care International.

Consortium Care International au Mali. Projet USAID/Nutrition et Hygiène dans 8 districts sanitaires des régions de Mopti, Ségou et Koulikoro. 2014. Enquête de base. Annexes du rapport d'analyse. Bamako: Care International.

Consortium Care International au Mali. Projet USAID/Nutrition et Hygiène dans 8 districts sanitaires des régions de Mopti, Ségou et Koulikoro. 2015. Enquête de base. Rapport d'analyse. (Version finale, 31 mars 2015). Bamako: Care International.

Consortium Care International au Mali. Projet USAID/Nutrition et Hygiène dans 8 districts sanitaires des régions de Mopti, Ségou et Koulikoro. 2017. Evaluation à mi-parcours. Enquête quantitative réalisée auprès des ménages. Rapport d'analyse. Version révisée finale du 04 septembre 2017. Bamako: Care International.

Consortium Care International au Mali. Projet USAID/Nutrition et Hygiène dans 8 districts sanitaires des régions de Mopti, Ségou et Koulikoro. 2017. Liste de villages. Bandiagara, Mopti. Bamako: Care International.

Consortium Save the Children International/ SNV.Projet USAID Nutrition et Hygiène dans la région de Sikasso. Districts sanitaires de Sikasso, Bougouni Niena Sikasso Kadiolo Kignan et Koutiala. 2014. Enquête de base (Avril/Mai 2014). Rapport d'analyse. Bamako: Save the Children et SNV.

Consortium Save the Children International/ SNV.Projet USAID Nutrition et Hygiène dans la région de Sikasso. Districts sanitaires de Sikasso, Bougouni Niena Sikasso Kadiolo Kignan et Koutiala. 2017. Liste des villages USAID PNH. Bamako: Save the Children.

Direction Nationale de l'Assainissement et du Contrôle des Pollutions et des Nuisances (DNACPN). 2014. Guide de mise en œuvre de l'Assainissement Total Piloté par la Communauté au Mali. Bamako: DNACPN.

Direction Nationale de l'Assainissement et du Contrôle des Pollutions et des Nuisances (DNACPN). 2014. Assainissement Total Piloté par la Communauté (ATPC) . Stratégie Nationale Post-Certification. Bamako: DNACPN.

Direction Régionale De l'Agriculture de Sikasso. Secteur de l'Agriculture de Bougouni. 2017. Rapport de la Mission de Supervision des Banques Alimentaires et des Jardins Potagers du Projet USAID Nutrition et Hygiène (PNH) dans le Cercle de Bougouni. Du 08 au 11 février 2017. Sikasso: DRA.

FHI 360. 2016. Guidance for Evaluating Integrated Global Development Programs. Durham: FHI 360.

FHI 360. 2016. Integrated Development in Action: Responsive Learning and Adaptation in APHIAplus. Durham: FHI 360.

FHI 360. 2016. Integrated Development in Action: Empowerment and Sustainability in Pamoja Tuwalee. Durham: FHI 360.

FHI 360. 2016. Integrated Development in Action: Innovation and Collaboration in Community Connector. Durham: FHI 360.

Management Systems International. 2017. Evaluation of the USAID/Mali Nutrition and WASH Programs. Technical Proposal. USAID/Mali. SOL-688-17-000009. Arlington: MSI.

Masters WA, Webbb P, Griffiths JK, and Deckelbaum RJ. 2014. Agriculture, nutrition, and health in global development: typology and metrics for integrated interventions and research. Annals of the New York Academy of Science (1331): 258-269.

Ministère de l'environnement, de l'assainissement et du développement durable. Direction Nationale de l'Assainissement du Contrôle des Pollutions et des Nuisances. 2016. Protocole de partenariat stratégique dans la cadre du projet USAID nutrition et hygiène. No DNACPN 01/USOUE/FY16. Pour l'appui à la Direction Nationale de l'Assainissement et du Contrôle des Pollutions et des Nuisances (DNACPN). Bamako: DNACPN.

Projet USAID nutrition et hygiène. 2017. Cahier du participant à la formation intégrée des maçons locaux et des femmes leaders en démonstration nutritionnelle et réalisation des latrines traditionnelles. Bamako: Care International.

Projet USAID Nutrition et Hygiène dans la région de Sikasso. Mise en œuvre par Save the Children, en partenariat avec SNV. Districts sanitaires de Sikasso Bougouni Nièna Sikasso Kadiolo Kignan et Koutiala. 2017. Evaluation à mi-parcours. Rapport final. Bamako: Save the Children.

République du Mali and Organisation des Nations Unies pour l'Alimentation et l'Agriculture. 2010. Profil Nutritionnel de Pays: République du Mali. Bamako: République du Mali.

République du Mali. 2013. Politique de développement agricole (PDA). Bamako: République du Mali.

République du Mali. Ministère de l'environnement, de l'eau et de l'assainissement. Direction nationale de l'assainissement et du contrôle des pollutions et des nuisances DNACPN. 2017. Assainissement Total Piloté par la Communauté (ATPC). Guide de mise en œuvre du post-FDAL de l'ATPC au Mali. Bamako: DNACPN.

République du Mali. Ministère de l'environnement, de l'eau et de l'assainissement. Direction nationale de l'assainissement et du contrôle des pollutions et des nuisances DNACPN. 2017. Manuel de procédures administratives, financières et comptables. Bamako: DNACPN.

Rowe WE, and Jacobs NF. 1998. Principles and Practices of Organizationally Integrated Evaluation. The Canadian Journal of Program Evaluation 13 (1): 115-138.

Save the Children. 2013. Save the Children. PNH Objective (excerpts). Bamako: Save the Children.

Save the Children. 2013. Projet USAID Nutrition et Hygiène. Bamako: Save the Children.

Save the Children. 2013. Quarterly Performance Report. Year 1 Quarter 1. October 1, 2013 – December 31, 2013. Bamako: Save the Children.

Save the Children. 2014. Annual Report. October 1, 2013 – September 30, 2014. Bamako: Save the Children.

Save the Children. 2014. Quarterly Performance Report. July 1, 2013– September 30, 2014. Bamako: Save the Children.

Save the Children. 2014. Quarterly Performance Report. Year 1 Quarter 2. January 1, 2014 – March 31, 2014. Bamako: Save the Children.

Save the Children. 2014. Quarterly Performance Report. Year 1 Quarter 3. April 1– June 30, 2014. Bamako: Save the Children.

Save the Children. 2015. Annual Report. October 1, 2014- September 30, 2015. Bamako: Save the Children.

Save the Children. 2015. Quarterly Performance Report. Year 2 Quarter 1. October 1 – December 31, 2014. Bamako: Save the Children.

Save the Children. 2015. Quarterly Report. Year 2 Quarter 1. January 1 - March 31, 2015. Bamako: Save the Children.

Save the Children. 2015. Quarterly Report. Year 2 Quarter 1. April 1, 2015- June 30, 2015. Bamako: Save the Children.

Save the Children. 2015. Démarche de mise en place du système d'épargne crédit dans les villages. Bamako: Save the Children.

Save the Children. 2015. Document de Base: Formation sur le Maraîchage Sensible à la Nutrition. Bamako: Save the Children.

Save the Children and SNV-Mali. 2015. Formation sur « La Gestion d'un Système Autogéré d'Épargne et de Crédit pour Soutenir les Activités Agricoles des Femmes »: Période du 12 au 14 Octobre 2015 à Sikasso. Bamako: SNV-Mali.

Save the Children. 2016. Annual Report. October 1, 2015- September 30, 2016. Bamako: Save the Children.

Save the Children. 2016. Quarterly Performance Report. October 1, 2016- December 31. Bamako: Save the Children.

Save the Children. 2016. Social & Behavior Change Communication (SBCC) Strategy. Bamako: Save the Children.

Save the Children. 2016. Séance d'animation villageoise sur l'introduction du maraîchage sensible à la nutrition. Bamako: Save the Children.

Save the Children and SNV-Mali. 2016. Fiche N°0 : présentation du système d'épargne et de crédit. Bamako: SNV-Mali.

Save the Children and SNV-Mali. 2016. Fiche N°1 : Démarche de mise en place du système d'épargne et de crédit dans le village. Bamako: SNV-Mali.

Save the Children and SNV-Mali. 2016. Fiche N°2 : plan d'action pour la mise en place du système d'épargne crédit dans les villages. Bamako: SNV-Mali.

Save the Children and SNV-Mali. 2016. Fiche N°3 : Constitution du groupement de femmes : modalités. Bamako: SNV-Mali.

Save the Children and SNV-Mali. 2016. Fiche N°4 : Mobilisation de l'épargne : modalités. Bamako: SNV-Mali.

Save the Children and SNV-Mali. 2016. Fiche N°5 : Octroi et remboursement des prêts : les critères. Bamako: SNV-Mali.

Save the Children and SNV-Mali. 2016. Messages Relatifs à l'Épargne Crédit Sensible à la Nutrition. Bamako: SNV-Mali.

Save the Children. 2016. Rapport de Formation. Épargne Crédit Sensible à la Nutrition (VSLA). Agents de Vulgarisation Agricole (AVA). Bamako: Save the Children.

Save the Children. 2017. Annual Report. October 1, 2016- September 30, 2017. Bamako: Save the Children.

Save the Children and SNV-Mali. 2017. PNH - Year 4 EMMP. Bamako: Save the children.

Save the Children. 2017. Quarterly Report. April 1 - June 30, 2017. Bamako: Save the Children.

Save the Children. 2017. Quarterly Report. Jan, 1 - March 31, 2017. Bamako: Save the Children.

Save the Children and SNV-Mali. 2017. Plan Action Environmental Monitoring and Management Plan: Oct 2017-Sept 2018. Bamako: Save the Children.

Save the Children and SNV-Mali. 2018. Rapport de formation sur « la Gestion d'un système autogéré d'épargne et de crédit pour soutenir les activités agricoles des femmes ». Bamako: SNV-Mali.

SNV-Mali and Save the Children. 2016. Rapport de missions d'appui au processus de formalisation des groupements VSLA du Cercle de Bougouni Août - Septembre 2016. Bamako: SNV-Mali and Save the Children.

SNV-Mali and Save the Children. 2016. Rapport de la mission de vulgarisation de la technique de mise en place de la banque alimentaire et d'évaluation du client dans certains villages des aires de santé de Sikasso et de Bougouni. Bamako: SNV-Mali and Save the Children.

SNV-Mali. 2017. Annual Report – Financial Year Four: Oct. 1, 2016 – Sept. 30, 2017. Bamako: SNV-Mali.

USAID and Maternal and Child Health Integrated Program. 2013. Indicator Guide. Monitoring and Evaluating Integrated Community Case Management. Washington: USAID.

USAID. 2013. ADS Chapter 204. Environmental Procedures. Washington: USAID.

USAID. 2013. Annual Program Statement (APS) No APS-688-1 3-000001. Integrated Rural Program to improve Nutrition and Hygiene in Mali. Bamako: USAID.

USAID and Care International. 2015. AiD-688-A-13-00003 - Integrated Rural Program to improve Nutrition in Mali - CARE. Attachment A - Schedule. Washington: USAID.

USAID and Save the Children. 2015. AID-68844300004 - Integrated Rural Program to improve Nutrition in Mali - SAVE. Washington: USAID.

USAID. 2015. Country Development Cooperation Strategy. Mali Forward 2015-2020. Bamako: USAID.

USAID. 2015. Care International. Agreement Document (excerpts). Bamako: USAID.

USAID. 2016. Uganda Community Connector Project: Barriers and Facilitators to the Uptake Of CC See 10 Elements. Washington: USAID.

USAID. 2016. Care International. Agreement Document (excerpts). Bamako: USAID.

USAID. 2017. Task Order: Evaluation of the Nutrition Programming. Bamako: USAID.

USAID. 2017. 22 CFR 216 Agency Environmental Procedures. Washington: USAID.

USAID Global Health. 2014. Mali: Nutrition Profile. Bamako: USAID.

Wilson-Grau, R. and Britt, H. 2013. Outcome Harvesting. Cairo: Ford Foundation.