MIDTERM EVALUATION REPORT
SYNERGY AND ACTION FOR NUTRITION+ PROJECT (SAN+)

Koulikoro region in MALI October 2005 – September 2009

Cooperative Agreement #
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LIST OF ACRONYMS

ANC	Antenatal Care
ASACO	Community Health Associations
ATN	National Technical Assistance Project – USAID Mali
BCC	Behavior Change Communication
CNIECS	National Center for Health Information, Education and Communication
CROCEP	Regional Committee for Orientation, Coordination and Evaluation of
CSCom	Community Health Centers
CSHGP	Child Survival and Health Grants Program
CSRef	Reference Health Center
CSTS	Child Survival Technical Support
DESAM	MOH developed software system
DIP	Detailed Implementation Plan
DNS	National Health Directorate
DRDSES	Regional Directorate for Social Development and Economic Solidarity
DRS	Regional Health Directorate
ENA	Essential Nutrition Actions
FINSA	International Training in Nutrition and Food Sciences
GAIN	Global Alliance for Improved Nutrition
HFA	Health Facility Assessment
HIS	Health Information System
HKI	Helen Keller International
HQ	Head Quarters
IEC	Information Education Communication
IFA	Iron+Folic Acid
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Preventive Treatment
ITN	Insecticide Treated Nets
KPC	Knowledge, Practice and Coverage (Survey)
LAM	Lactation Amenorrhea Method
LQAS	Lot quality Assurance Sampling
M&E	Monitoring and Evaluation
MI	The Micronutrient Initiative
MOH/SD	Ministry of Health and Ministry of Social Development
MOU	Memorandum of Understanding
MTE	Midterm Evaluation
NCHS	National Child Health Survey
NGO	Non-Governmental Organization
OFDA	Office of Foreign Disaster Assistance (USA)
ORTM	Malian Office of Radio and Television Broadcasting
PKC	Projet Kénéya Ciwara
PRODESS	Mali's 10-year Health and Social Development Program
PVO	Private Voluntary Organization
RUTF	Ready to use therapeutic food
SAN+	Synergy and Action for Nutrition+
SASDE	UNICEF-implemented Accelerated Child Survival and Development project
SC	Save the Children (US)
SIAN	*Semaine d'Intensification des Activités de Nutrition* (National Nutrition Week)
SP	Sulfadoxine-pyrimethamine
TBA	Traditional Birth Attendant

TOT	Training of Trainers
UNICEF	United Nations Children's Fund
URTEL	Mali Union of Free Radios and Televisions
USAID	United States Agency For International Development
VAC	Vitamin A Capsule
WFP	World Food Program
WHO	World Health Organization
WRA	Women of Reproductive Age

A. Summary

The overall project goal of the Mali Synergy and Action for Nutrition + Project (SAN +) is to improve the nutritional status to reduce morbidity, and mortality in children 0-23 months and women of reproductive age (WRA) in the Koulikoro Region. HKI and its partners are implementing nutrition and breastfeeding as the child survival technical interventions **(**80% nutrition and 20% breastfeeding). HKI works primarily with health facilities (CSComs) and community health committees (ASACOs).

General Objectives include: Improve nutritional status of children 0-23 months; Improve nutritional status of pregnant women; Improve nutritional status of postpartum women; Improve access and availability of nutrition services; Improve quality of key nutrition services. The SAN+ project is applying 4 cross-cutting strategies 1) joint design, implementation, and evaluation of approaches to deliver a minimum package of essential nutrition services consistent with MOH/SD standards and protocols; 2) capacity-building and training to improve access, availability, and quality of facility-based services; 3) community mobilization to improve demand for, and use of, key health services; and 4) tailored BCC and advocacy to improve key household behaviors and care-seeking practices and commitment of local decision makers

Main Accomplishments

1. Contribution to the development of key messages, technical guidelines and a national strategy to prevent and treat malnutrition and micronutrient deficiency in Mali.
2. Successful re-integration of nutrition and micronutrients into the minimum package of primary health services: routine service provision in the form of IEC and counseling which is recorded in health registers; annual planning and budgeting for bi-annual micronutrient campaigns.
3. Capacity building of health providers in essential nutrition actions and successful 'repositioning' of the importance of breastfeeding and nutrition in health providers' perceptions and practices.
4. Support for integration of de-worming into routine health services and campaigns as a key nutrition intervention nationwide.
5. Implementation of a successful radio program with the collaboration of 29 community radio stations.
6. Important contribution to increased knowledge and behavior change in the target population in the area of breastfeeding, complementary feeding with foods rich in micronutrients, hygiene and care-seeking during illness.
7. Increased availability and coverage in micronutrient supplementation for the target population: Vitamin A for postnatal mothers and children over 6 months of age and iron for pre and post natal mothers.
8. Leveraging of resources to supplement child survival funding, strengthening project activities and achievements (CTC, Vitamin A supplementation, Communication for Development, fortification of cotton oil, sorghum and maize)

Challenges

- Large size of intervention area – Region-wide project covers 150 + CSComs, with some located as far as 200 km away from district headquarters.
- High MOH staff turnover, especially among the heads of CSComs
- Lack of success in support and advocacy for use of zinc supplementation for diarrhea case management (limited health staff knowledge and management of source: product introduced to region was on the point of expiring).
- Insufficient funds for pursuing potential operations research opportunities as hoped at the time of the development of the DIP, i.e. research on anemia.

In terms of the capacity-building effects of the project, although still somewhat seen by MOH partners as the HKI domain, nutrition/micronutrient has been fully integrated into existing services and health providers and clients report such that this is now routine. This is also the case with planning at the district and regional levels. Advocacy for the integration of nutrition with the regional and district MOH has been quite successful, and nutrition interventions such as the bi-annual National Nutrition Week (SIAN) and micronutrient supplementation are very much included in their respective annual plans. The partnership and capacity-building focus of the project makes sustainability of the above more feasible.

Gaps so far have been related to the MOH inability to conduct supervision due to their budget constraints, and the fact that SAN+ did not prioritize and budget for this. With supplementary project funding (OFDA funded CTC), HKI will be able to begin funding joint supervisions during the second half of the project. Nevertheless it is clear that future consistent support of health workers on the part of local partners will depend on their ability to mobilize funding for this, and ability to provide adequate support to these interventions during integrated supervisions visits.

Conclusions and recommendations

In addition to the achievements highlighted above, some specific strengths and weaknesses were also identified.

Strengths

- Considerable strengthening of technical and policy capacity of MOH partners at the district, regional and national levels
- Good collaboration with UNICEF in the region reinforcing project reach and impact

Areas of Weakness

- Lack of follow-up on the Quality Assurance component of project, e.g. recommendations were developed during a QA Workshop but there has been poor documentation and dissemination of these and no action taken.
- Lack of budget for strategic activities such as joint supervisions and coordination meetings with government counterparts.
- Gap in community-level interpersonal communications activities for ENA in communities not being supported by other projects such as Keneya Ciwara (thus synergy is uneven across the region, and no specific work has been done with women's associations as discussed in the DIP).

Key Recommendations

Community level

1. Encourage message dissemination within women's associations via CSCom matron's participation in these groups.
2. Encourage women to organize themselves to bring together ingredients for the implementation of cooking demonstrations.
3. Gain the support of grandmothers in new nutrition practices through regular group contacts organized by matrons.
4. Develop linkages with government and non-government institutions to support communities with the promotion of vegetable gardening and the production of soya beans.
5. Implement strategies already identified to follow up and support CHWs, i.e. participate in outreach activities being carried out by the health facilities every month.
6. Involve the ASACOs and mayors office during supervision activities.
7. Mobilize additional resources to adequately support the radio program component.

Health Facility level

8. Encourage the mayor's office, the communities and their partners to ensure the support of outreach activities.
9. Ensure the completion of training for health personnel in the Nara and Kolokani districts emphasizing feeding during childhood illness and maternal nutrition.
10. Strengthen collaboration with grandmothers as key to the adoption of new nutritional practices in the household.

District level

11. Ensure that funding is allocated for joint supervision of the nutrition interventions.

Regional Level

12. Support joint supervision missions with the regional health team twice a year.
13. Strengthen the collaboration with the regional team on the management of project activities.
14. The project should continue to encourage the Regional Directorate of Health's involvement in Nutrition activities and support the integration of the ENA (prevention) and CTC (treatment) approaches

National Level

15. Accelerate the local production of flour enriched with Vitamin Mineral Complex.
16. Support joint supervision missions with the national nutrition division once a year.
17. Be proactive as a member of the Nutrition Working Group to stimulate increased products and investment in the fight against malnutrition and micronutrient deficiency.

HKI Management

18. Develop posters on ENA to display at health facilities
19. Advocate for increased MOH responsibility in the provision of Vitamin A to maintain the high levels of coverage achieved, as part of the project's phase-out strategy in 2009.
20. Review and follow-up on the QA recommendations developed during the 2007 workshop and adapt and implement with the regional and district teams as needed and feasible.
21. Strengthen project staff capacity for using project-related data for management and decision-making.

An MTE action plan, addressing recommendations is included in the annex.

B. Assessment of the progress made toward achievement of project objectives

1. Technical Approach

a. Overview

The Mali Synergy and Action for Nutrition + Project (SAN +) targets malnutrition as one of the primary underlying causes of child mortality in one of the most densely populated and least resourced regions of the country. As outlined in the situational analysis, a number of factors contribute to the high rates of malnutrition in the region. Most directly, sub-optimal infant and child feeding and poor maternal health and nutrition are important causes of malnutrition in Mali. The overall project goal is to improve the nutritional status and reduce morbidity and mortality among children 0-23 months and women of reproductive age (WRA) in Koulikoro Region. HKI and its partners are the following child survival technical interventions: 70% nutrition, 10% control of diarrheal diseases, 10% malaria, 10% breastfeeding. SAN+ includes maternal nutrition, breastfeeding, complementary feeding, nutritional management of early childhood illness, micronutrient malnutrition, and anemia control for mothers and children. HKI works primarily with health facilities (CSComs) and community health committees (ASACOs).

General Objectives

- Improve nutritional status of children 0-23 months
- Improve nutritional status of pregnant women
- Improve nutritional status of postpartum women
- Improve access and availability of nutrition services

- Improve quality of key nutrition services

The SAN+ project is applying 4 cross-cutting implementation strategies 1) joint design, implementation, and evaluation of approaches to deliver a minimum package of essential nutrition services consistent with MOH standards and protocols; 2) capacity-building and training to improve access, availability, and quality of facility-based services; 3) community mobilization to improve demand for, and use of, key health services; and 4) tailored BCC and advocacy to improve key household behaviors and care-seeking practices and commitment of local decision makers.

HKI aims to apply intervention approaches focused on:

- Using integrated (nutrition and health) delivery strategies at health facilities
- Expanding coverage through improved delivery at community level (National Nutrition Weeks or vaccination campaigns) as a complement to health system-based services
- Promote synergies through regional planning processes among HKI and other regional and national partners operating various projects in the region and other child survival projects/programs in other regions.
- Capitalizing on various experiences of HKI in Mali and others countries

b. Progress report by intervention area

i. Activities related to specific interventions as proposed in DIP.

Activities outlined in the DIP work plan under are discussed under objectives as presented below:

Objective 1: Improve nutritional status through the decrease of the prevalence of underweight children under two.

The project successfully trained 162 rural (auxiliary) midwives in the Essential Nutrition Actions (ENA) framework and in using behavior change communications (BCC) techniques to promote the seven key actions[1] together with appropriate hygiene practices. They were also able to provide an orientation on key program areas to the chief clinician in each community health center (CSComs). Although the training did not cover the entire number of midwives in the Koulikoro region, per midterm evaluation interviews many of the others have learned from their colleagues. This was not through a concerted effort by the latter, but rather through observation.

As a result of the project training, and ensuing support from the SAN+ supervisors based in each of the districts, at the time of the midterm it was clear that the health providers in this region have fully integrated nutrition as part of the minimum package of activities at

[1] Breastfeeding within one hour of birth and exclusively for six months; continued breastfeeding with nutritionally appropriate complementary feeding through 24 months and beyond; maternal nutrition; nutritional care of the sick and malnourished child; integrated control of anemia and control of vitamin A and iodine deficiencies.

the health centers. This includes regular health education sessions covering nutrition topics an average of two times a month or more, and individual counseling of clients coming in for child health and antenatal care (ANC). Midwives report having frequent contact opportunities with clients, although this is limited to contacts in the health facility and during the special outreach activities *(Stratégie Avancée)*. When asked, they were able to correctly explain the steps in counseling. Mothers interviewed during FGDs confirmed that they have regular contact with health providers and receive health information from them. Although the heads of the CSComs were not able to receive training on the essential nutrition actions (ENA) as were the rural midwives, (due to budget constraints already envisaged at the time of the DIP), the former were still able to supervise this activity and periodically provide support to midwives when they conduct group health education (prior to ANC, vaccination and growth monitoring activities).

The project fell a little behind in the area of IEC message development for counseling cards specifically, because they wanted to work with the national stakeholders to develop a consensus around the wording of all the key ENA messages to be disseminated. Nevertheless, they did go ahead and develop counseling cards for Vitamin A after their BEHAVE workshop. Counseling cards were provided to health centers as education guides for the midwives. These cards include information about foods rich in vitamin A (such as as liver, milk, fish, mangoes, papaya, wild fruit, and green leafy vegetables) and complementary feeding for children above the age of six months. The importance of using iodized salt is also being promoted using a poster developed by UNICEF. At the time of the MTE, a group of Malian stakeholders were leaving to attend a regional ENA/BCC workshop, where they hoped to complete the development of the remaining key messages for the counseling cards. With the completion of this activity, other projects working in nutrition, such as the National Technical Assistance Project funded by USAID Mali (ATN) and UNICEF, as well as government health agents, will also be able to contribute to the dissemination of these messages through counseling cards used nationwide. The development of the aforementioned counseling cards is a key strategy that the project identified to promote optimal breast-feeding practices, Vitamin A and iron supplementation and the consumption of nutrition-rich foods.

Despite the delays in development of the counseling cards, rural midwives and radio agents did receive training on nutrition and health themes. This included the following: the advantages of immediate breastfeeding and colostrom; advantages of exclusive breastfeeding; nutrition during pregnancy; feeding during episodes of childhood illness; advantages of prenatal consultation and iron supplementation; importance of vitamin A supplementation during the immediate postpartum period and for children 6 to 59 months; the advantages and content of appropriate complementary feeding from the age of six months; the importance of systematic de-worming of children every six months; and the importance of hand washing with soap for the prevention of diarrhea.

A key strategy outlined in the DIP as a means to reach the population with this information, was to broadcast messages through a rural radio program. SAN+ was able to start this initiative in mid 2007 with 3-month contracts. They identified 29 rural radios across the program area and subsequently conducted two-day training sessions for 29

radio broadcasters. The training provided the broadcasters with an orientation on nutrition and ENA, prevention of malaria for pregnant women and children and the promotion of hand washing. This training was aimed at ensuring that radio broadcasters would gain enough knowledge and understanding to be in a position to respond to phone call questions and inquiries coming from community members after project-developed, pre-recorded programs were aired. Based on interviews undertaken in several sample radio stations across the program area during the MTE activity, it is clear that this component has seen a tremendous amount of success. Radio agents interviewed spoke about the immense popularity of these radio programs and the very enthusiastic response from community members. They have also undertaken radio competitions, which they say are very popular, and developed dynamic initiatives such as radio theater and debates that have elicited a lot of interest and questions on the part of community members. One radio agent estimated that 80% of women answered correctly the questions posed during a radio contest the station implemented. The radio programs, on average, are broadcast as many as four to five times a week for half an hour. The frequency and consistency of these radio programs have clearly been a very important factor in the achievements seen, i.e. increased knowledge about health and nutrition and increased demand for health services; both evident in the MTE qualitative interviews. Most radios broadcast to a 50-km radius. Mothers interviewed during FGDs confirmed that the radio is a major source of health information.

Although the SAN+ project is focused primarily on district and health facility level support (mostly benefiting the population within a 5 km. radius and thus with relatively easy access to the CSCom), communities located more than 5 km from a health facility do received services through monthly or periodic outreach activities (S*tratégie Avancé*). Thus in this way, they also benefit from project-supported IEC/BCC nutrition messages. The frequency of these visits depends on the number of eligible children in a given community, and the budget available to the health center for this activity (normally funded out of the Community Health Association – ASACO – budget).

Despite the fact that the project did not have staff on the ground to work directly with communities, as outlined in the DIP, they did have the intention of getting communities to mobilize for such things as the National Nutrition Week activities (SIAN). The latter are biannual activities implemented on a national level, usually involving polio vaccination and vitamin A distribution. In May, 2006, the project and its government partners successfully tested integrating the deworming of children 12-59 months into SIANs in the Koulikoro district; since then, deworming has been included at the national level. With the involvement of the multiple partners, in December, 2007 the SIAN was expanded to become an integrated campaign, adding measles vaccination and insecticide-treated bednet (ITN) distribution to the three other interventions. As a primary stakeholder for nutrition and key partner in the Koulikoro region, HKI was well placed to implement this pilot activity. The project support for the integrated SIAN has included financing radio messages around the activity, the training of community members who help carry out the activity, supporting the preparation of the equipment, and the supervision of the activity with the provision of vehicles and participation of project staff.

The SIAN is normally implemented by a national team accompanied by the regional team. Districts teams also carry out support activities.

It is important to note that SAN+ has also been encouraging and supporting the use of de-worming during routine treatment as part of the package of nutrition services.

Another activity outlined in the project DIP was the development of small-scale and in-home food fortification using multi-micronutrient sachets. HKI was not able to secure the funding it expected and have not been able to undertake this activity. It has also been constrained by the international concerns about iron supplementation of children under 5 in malaria endemic areas.

The project has supported the government's working group for nutrition. Staff has participated in a couple of meetings, but it should be noted that these meetings have not been held consistently and thus need to be revitalized. They are supposed to be held once every quarter, lead by the MOH Division of Nutrition, and with the participation of various organizations such as UNICEF, HKI, Save the Children, WFP, CRS, ATN, and World Vision.

With regard to quality assurance for nutrition, SAN+ supported the organization of a quality assurance workshop at the Koulikoro region, which included the participation of a select number of health facility providers as well as some district representatives. This workshop was facilitated by the regional health team (who received technical assistance from the University Research Corporation (URC). Although the workshop participants went so far as to develop process indicators for quality assurance, to be shared and used for purposes of supervision, nothing has, in fact, been implemented. There has been no follow-up to this workshop activity, and no quality assurance monitoring implemented by the SAN+ Bamako based staff (Coordinator, Deputy and a Mickey Leland Hunger Fellow attached to the project) or the MOH district and regional staff. In theory, this follow-up would be the responsibility of the SAN+ project supervisors under the guidance of the Coordinator and Deputy, as most of their time is dedicated to the technical support of CSComs in their efforts to re-integrate nutrition as a key component of their daily tasks.

Although the standards have been established and communicated, QA is an area that needs more attention on the part of the senior project staff and district/regional staff. Both the districts and the region have supervisory responsibilities, but problems related to the budget have prevented them from carrying them out. The one UNICEF-supported monitoring activity for 2007 was eventually not funded because of issues and delays with the request. According to observations about quality assurance related by SAN+ supervisors from routine supervision visits, one health service provider has multiple responsibilities and consequently conflicting priorities and demands, leading him or her to skip or rush through activities.

The project hoped to conduct some research on anemia. This has not been undertaken yet, and there is concern that the $1500 budgeted is inadequate for such an activity.

Nevertheless, the staff has been in dialogue with the University of Mali and may be able to participate in a regional study designed to compare the incidence of malaria in two groups (one supplemented with Vitamin A, and the other with Vitamin A and Zinc 5 days per week). The study will look at incidence of diarrhea and ARI in these two cohorts.

Objective 2: Improve the nutritional status of women

Activities specific to this objective include the promotion of prenatal care. Not surprisingly, the project again chose to work primarily through the rural midwives (this is the case for all the intervention areas). Maternal health is included as a component of the ENA training supported by the project, which encourages the use of iron folic acid supplements, insecticide treated nets (ITNs), Intermittent Preventive Treatment (IPT) of malaria during pregnancy, and maternal nutrition. It should be noted that CSCom staff have also benefited from similar training provided by the national malaria and reproductive health programs.

Per interviews with health providers, the supply of free iron tablets for antenatal care is sporadic. Many health facilities write a prescription and women are asked to fill this at the local pharmacy. That they cannot receive IFA at the health facility itself, and have to pay for it are both likely to create impediments to compliance. SAN + is not directly supporting the distribution of ITNs, but the distribution by UNICEF and PSI has made for excellence synergy. Sulfadoxine-pyrimethamine (SP) for the intermittent treatment of malaria is provided by CSComs. Women attending ANC clinics are also given advice on maternal nutrition, e.g., the importance of eating dark green leafy vegetables, liver and other meat products during pregnancy. These messages are also disseminated through the radio as discussed above.

To promote postnatal care, the project has reinforced the distribution of Vitamin A and iron to postpartum mothers. Again, this component is included in the ENA training and is further supported by the SAN+ supervisors who monitor stocks in the CSComs and help to expedite requests for supplies from the district (as they often frequent the health centers more than the district staff themselves). Vitamin A is provided to postpartum mothers primarily when they come back to the health center for child health services. There is no distribution immediately after delivery for those who deliver at home. Women attending ANC clinics are encouraged to plan for delivery at the health facility; indeed, there is often the threat of a fine imposed on those who choose to deliver at home. But it should be noted that for those not residing in the village where the CSCom is located, delivering at the center is not a general practice because of the distance.

Objective 3. Improve nutritional status through breast-feeding

Many of the activities to promote this objective have been discussed above. This includes supporting community health education sessions at the CSComs, broadcasting radio messages, promoting nutrition-rich foods and supporting the SIAN activities (all activities specifically highlighted as DIP work plan activities). In addition, the project supported community mobilization during World Breastfeeding Week. These events also

included supporting three community celebrations for the certification of baby friendly hospital initiatives. The project has also advocated with UNICEF and MOH for the inclusion of other CSComs in the baby friendly hospital initiative. The project hopes to encourage CSComs to work with groups of grandmothers and women leaders and enhance their involvement in the promotion and support of immediate and exclusive breastfeeding practices.

One activity that SAN+ had not yet undertaken at the time of the MTE was that of strengthening women's associations. Staff and partners will dedicate some time to this during the second half of the project.

Objective 4 – Reduce mortality from malaria

Many of the activities outlined for this objective have already been discussed. This includes developing and broadcasting messages on the radio and during community health education sessions. Again, the counseling cards for malaria prevention and case management have not yet been developed and distributed. Making full use of the opportunities for synergy (for which the project is titled), the SAN + program area benefited from other partner-supported distributions of long-lasting ITNs. This included UNICEF and PSI who launched campaigns to promote ANC clinic attendance and the complete vaccination of children under one. Nets were distributed to ANC clients and all children who completed their vaccinations. The MOH national malaria program has trained all the heads of health centers on the management of both severe and moderate malaria, and they have also provided the CSComs with a large drug stock to manage cases. Rural midwives were also trained on the use of Sulfadoxine-pyrimethamine (SP) for intermittent treatment and prevention (ITP) of malaria in pregnant women. With support from the Global funds, Artesunate Combined Treatment (ACT) is provided free of charge for all children under five. Pregnant women are treated with quinine.

The HKI Country Director has been participating in the Technical and Financial Partners Group malaria group meetings. They meet once a month and discuss achievements, experiences and program strategies.

Obj. 5 - Reduce mortality from diarrheal diseases

The diarrhea component has also been discussed above. Although not yet included in the counseling card messages, the priority message was hand washing with soap and was covered during the training of midwives and radio broadcasters. This message is also being prioritized on a national level. For the management of diarrhea episodes, the project disseminated messages about increasing the number of meals and liquids during illness. The project made a special effort to introduce and promote zinc as part of facility-based, case management of diarrhea. This was included in the ENA training to providers, and the project supported the region with the purchase of an initial stock of zinc. Unfortunately this stock was close to the expiration date at the time of its arrival in country, and thus it was not available for a long duration. Some district partners interviewed during the MTE mentioned that they had to dispose of part of that stock, and

the government has no immediate plans to purchase more. Another issue raised during MTE interviews was the fact that, although HKI provided some zinc, use of oral rehydration salts (ORS) has fallen because UNICEF is not currently providing the new formulation. Thus although zinc would normally be provided as a complement to ORS, this is not currently the case.

Highlights of Monitoring and Evaluation, Partnership and Capacity Building Activities

Most activities outlined under these cross-cutting areas were implemented, including baseline studies, development of project M&E, supervision, signing of MOU etc. With regard to quarterly regional meetings in Koulikoro, these were not held systematically. Bi-annual technical updates for partners were not held. Annual review of progress on DIP was not conducted formally with the MOH partners, but the partner does integrate HKI in its annual plans. HKI participates in the MOH's bi-annual and quarterly reviews and planning, and the project staff developed a work plan for Year 2.

As discussed later in this report, the project achieved more or less all training objectives. It did not conduct a separate training in M&E for the partners; however, the ENA and CTC trainings conducted included an M&E and communications component. (CTC training was conducted in two districts during this project period and preparations for the scale-up to the seven other districts have been underway). And although the CSCom Certification Committee was established to support the creation of nutrition-friendly health centers, the project saw that it made more sense to work with the existing baby friendly initiatives first.

ii. Progress toward benchmarks or intermediate objectives.

The HKI SAN+ project did not set specific quantitative objectives for the midterm. All indicators have an end of project target. The project has access to other data from the SIAN activities, as well as the routine districts data as indicated in the following table.

DISTRICT CHILD HEALTH DATA (distribution outside of campaigns)			
	Total	**Target**	**Rate**
# of children from 6 -11 months who received one dose of vitamin A	44,522	45,477	98%
# of children from 12-59 months who received one dose of vitamin A	25,304	79,584	32%
# of children from 12 -59 months who received two doses of vitamin A	29,309	79,584	37%
#of children who received insecticide treated bed nets	23,974	98,440	24%

DISTRICT WOMEN'S REPRODUCTIVE HEALTH DATA			
	Total	**Target**	**Rate**
Number of pregnant women who attend at least three ANC sessions	17061	73830	32%
Number of pregnant women who receive ITNs	28289	73830	38%
Number of pregnant women who received one dose of SP	43003	73830	58%
Number of pregnant women who received two doses of SP	28881	73830	28%
Number of pregnant women who received iron folic acid	69056	73830	94%
Number of women in the immediate postpartum period who received vitamin A capsule	20259	73830	27%

Of the several indicators identified in the above district data, those for routine de-worming coverage are not available. The project has been encouraging deworming as part of routine services, but for the most part, coverage of both VAS and deworming have been assured through the SIAN, most recently implemented in June and December 2007. For example, in the integrated campaign held in December 2007, VAS coverage for the region was: infants 6-11 months: 60,479 (85%); children 12-59 months: 362,819 (93%); while coverage with deworming medication among children 12-23 months was 292,271 (95%).

Unfortunately it is difficult to compare the above data with the KPC baseline, e.g. the age group for Vitamin A in the project is 6-23 months, and not 6-11 months. But it is very encouraging nevertheless, as the project baseline was 31%, and thus a dramatically lower coverage than the above, regardless of the bigger age group. The project indicator for IFA specifies consumption in the last 24 hours, versus the above IFA 'received' during pregnancy. The baseline KPC result for postpartum Vitamin A coverage was very high (65%), compared to the above 27% for routine district health data. This difference may be attributed to the additional impact of national campaigns on coverage levels. Coverage during national campaigns is very effective. Coverage outside of the campaigns is considered to be supplementary.

SAN+ will have the opportunity to conduct a study in August 2008 for their OFDA funded CTC project (a project that also serves to provide good synergy to the child survival activities). UNICEF reports that it will also be conducting a nutrition survey in the coming months.

From a qualitative standpoint, there appears to have been a great deal of progress in the area of immediate breastfeeding. This was reported by mothers during FGDs, as well as health providers. The purported increased adoption of this practice may be attributed to various project and other interventions: the increased deliveries in health facilities; the vibrant radio program; television media supported by the national program; and interpersonal and group communication sessions conducted by rural midwives. Exclusive breastfeeding was also discussed during qualitative interviews, and this also appears to have seen some progress. This may be attributed to the strong synergy among the national program efforts in this area. That is to say, there has been considerable

investment in the promotion of exclusive breastfeeding through television advertisements and skits. These are aired nationwide, and although not all community members have access to television, community members in the intervention area had seen them. So it appears that television has been a medium for reaching the population. Both men and women interviewed reported that people no longer give young infants water, although a few conceded that the traditionally common practice of giving young infants concoctions has not been completely erased. This suggests there is still some work to be done in this area.

In most of the program villages sampled, women also reported that they give much more attention to personal and environmental hygiene than they used to. They spoke about washing their hands with soap prior to eating, after using the toilet, after cleaning an infant who has defecated, and before cooking. They were also able to identify that this helps to avoid diarrhea. Some mentioned reducing stomach pains and vomiting. There is a national initiative to encourage community clean-up activities every Saturday, and people mentioned this during interviews. Some mothers reported that as a result of these various changes, cases of diarrhea among children have decreased. Mothers mentioned in the FDGs that they pay attention to the importance of preventing dehydration during illness, through increased fluids and increased feedings.

During interviews with men in the program communities, many raised the point that women follow advice they're hearing in taking care of the children. They reported that the less a child gets sick, the better it is for them because it is cost-saving and reduces the burden on the family. This was mentioned in relation to exclusive breastfeeding, complementary feeding, and hygiene in particular.

Progress with regard to building partnerships can be seen clearly in the rural radio collaboration with SAN+. At the time of the MTE, the initial three-month contract with these radio stations had come to an end, and there had been a multi-month delay in the renewal of these contracts. Despite this, most of the radio stations were still broadcasting recorded tapes several times a week, and said that they expected to continue doing so even if there are no contracts forthcoming. A major reason is that demand has been created for these programs. The public likes to hear the broadcasts and complains if they are canceled. One rural radio station reported that thanks to their relationship with the HKI project, their status has been elevated and they have been able to attract other NGOs (PSI, PACT and Plan) and obtain more contracts to help support the radio.

iii. Effectiveness of the interventions

Focusing the primary training efforts and supportive supervision on the rural midwives has been an effective strategy, as these MOH personnel are less mobile, i.e. they do not transfer as often as the heads of the CSComs. Moreover, these midwives appear to be dramatically improving the quality of service provision. This was ascertained during the key informant interviews with midwives as well as the heads of the health centers. Both groups spoke about the activities the midwives have undertaken since the support of HKI, and how the project training has helped them increase their knowledge in the areas of

nutrition, breastfeeding and health. Several of those interviewed mentioned that prior to the training they knew the information in general terms, but were unable to provide details when conducting health education or giving advice to mothers. Thus the training has helped them improve their knowledge, counseling and has raised their self-confidence. And because the project places importance on clients and services, providers also report that SAN+ has contributed to improving client-provider relationships. This is also confirmed by mothers, who say that services have improved, they feel welcomed, and health providers are approachable. Mothers in one FGD mentioned that in the past they did not like to frequent the health facility because health providers often treated them badly.

From all accounts, it appears that the rural radio program strategy has also been very effective. It has a large audience and listeners report very much enjoying the learning opportunity and subject matter (per FDG's and the feedback that radio agents reported). The interesting initiatives such as competitions and contests have drawn active participation and enthusiasm from the communities, and appear to have had a big impact. The effectiveness of radio is strengthened by the training strategy, which has reinforced the knowledge of project messages among key sources of information in the community. This makes for very good synergy, further reinforced by the periodic television campaigns. It is important to mention that for the most part, rural radios have a weekly slot allocated to the local health authorities for public health programming. Thus some of the health providers already have a relationship with the radio and can communicate with the public through this avenue. When health staff is not on the air, some of the radios have taken advantage of the cassettes provided by SAN+ to fill that space.

The effectiveness of the interventions in terms of the contributions that interpersonal communications can make towards behavior change can only be estimated among the populations living within a 5 km radius of the CSComs. As designed, the project does not intend to have the same impact in communities beyond this area, which are not considered the target population. The more remote population does not have as much access to the CSComs and receives limited outreach services. As previously mentioned, SAN+ staff have organized only limited activities beyond the CSComs. HKI has recently increased these efforts, with a decision to actively participate in outreach activities that are implemented in communities beyond the 5 km radius. These outreach activities cover vaccination, antenatal services, IEC and, with OFDA funding, will also include follow up with the community health workers (CHWs) who will be trained in the identification and case management of malnutrition. CHWs will screen children using MUAC measurements and health providers can verify the diagnosis by taking weight and height measurements during the outreach activities.

Overall, SAN+ has been quite effective in maximizing the potential for synergy. The collaboration that HKI has with several NGOs, projects and institutions has greatly increasing the opportunities for the populations in the Koulikoro region the project targets. The collaboration with UNICEF at the regional level is very good. UNICEF provides the region with ITNs, SP and Vitamin A used to support routine service provision and has also contributed equipment such as weighing scales, height

measurement, mid upper arm circumference (MUAC) measurements tapes, and drug kits. HKI, in turn, often assists with the transportation of these materials to the CSComs. UNICEF will be further supporting the CTC activity with the F100 and F75 milk, as well as antibiotics.

HKI is also part of the USAID/Mali-funded ATN project, and the partners collaborated in piloting the integration of additional interventions into the SIAN starting in 2006 (that year ATN provided the albendazole and SAN+ was the implementing partner). The presence of the USAID/Mali-funded Keneya Ciwara health project implemented by CARE in various communities of the region with CHWs and community health committees (ASACOs) has also been beneficial because SAN+ does not have staff based and working within the communities. HKI became a partner in the Micronutrient Initiative (MI) and along with UNICEF assists with the provision of Vitamin A capsules. Thus in some districts and communities, several projects have been contributing to the prevention and treatment of malnutrition and micronutrient deficiency. HKI itself is implementing the OFDA-supported CTC project, which is allowing for the training of all the heads of health centers, and will provide some support to CHWs. In addition, HKI has the An be Jigi (hope for All) project which focuses on improving nutritional intake in two districts of Koulikoro through the participatory testing of iron- and zinc-rich varieties of millet and sorghum and promoting dietary changes to increase bioavailability of these elements. This project has engaged the support of a Peace Corps Volunteer and is funded by the McKnight Foundation.

District health staff interviewed during the MTE stated that it is due to HKI that the nutrition program has been strengthened, properly re-integrated into the minimum package of services, and that Vitamin A distribution has become an important priority. Although the government ensures a part of the supply, the region gets a lot of support from the project as well. Assuring the supply of Vitamin A, while emphasizing its importance, has also contributed to the effectiveness of this intervention. The presence of a project supervisor in each district who dedicates 100% of his/her time to nutrition has given nutrition a high profile and the attention needed to get it 'repositioned' in the eyes of the regional, district and health facility staff.

iv. Changes in the technical approaches outlined in the DIP and rationale.

There are no changes in the technical approaches outlined in DIP.

v. Special outcomes, unexpected successes or constraints.

Although the project did not specifically define any special outcomes, the synergy that the project has been able to bring about is remarkable. For example, although SAN+ is not working beyond a 5 km radius of health facilities (outside of the great reach of the radio program), UNICEF, Keneya Ciwara and others have been providing this support. HKI also leveraged OFDA funding for a CTC activity, which provides training in the identification and treatment of malnutrition as well as for its prevention. The CTC project

is integrating these complementary activities and building community linkages region-wide.

vi. Follow-up and next steps.

The follow-up and next steps discussed during the midterm evaluation are articulated in the recommendations and action plan developed. This includes emphasizing certain aspects of BCC, working with women's groups and associations, increasing contact with the *Musokoroba,* or grandmothers, and strengthening the district and regional partnerships with increased joint supervision and monitoring of the nutrition integration process. Next steps also include taking advantage of the OFDA funding to provide more training on ENA to the heads of health facilities and to community health volunteers. The project leadership will also prioritize completing the development of counseling cards that highlight the other important key ENA messages, and support the follow-up of Quality Assurance (QA) recommendations developed during the workshop held.

c. New tools or approaches, operations research

In its complementary CTC project (implemented by the SAN+ team), HKI helped the MOH elaborate a protocol and develop a training module for the community-based management of acute malnutrition. They also worked with the Ministry to develop data collection tools adapted from the standard tools. This activity will benefit the SAN+ goals because it gives health providers increased skills and knowledge in the area of nutrition, and emphasizes both the treatment and prevention of malnutrition as priority health activities. SAN+ also developed a one-page guideline for de-worming activities and supported the integration of de-worming into SIANs. This guideline used by health workers highlights the importance of de-worming, which kind of medications should be prescribed, target groups (children 12-59 months and pregnant women) and the treatment protocol. The project also developed a one-page guideline for Vitamin A supplementation, and can be given credit for helping the MOH to modify the registry for Vitamin A and de-worming used during campaigns (routine services use their own registers).

As previously mentioned, SAN+ has been in dialogue with medical faculty at the University of Mali who will be implementing a study that will be conducted as part of a West Africa regional project to compare the incidence of malaria, diarrhea and ARI in two groups: one supplemented with Vitamin A, and the other with Vitamin A and Zinc. There is a strong likelihood that this study will be conducted in Koulikoro, in collaboration with HKI. HKI can provide technical assistance to the study, but funding is still needed. Results in Burkina Faso have been encouraging, reportedly suggesting that daily zinc and a single large dose of Vitamin A reduced the incidence of malaria by 30% and delayed subsequent attacks. There is an interest in seeing this replicated in Cameroun, Mali and Ghana with larger sample sizes.

2. Cross-cutting approaches

a. Community Mobilization

i. Community mobilization activities

For community mobilization, the project undertook one major activity: advocacy workshops in which administrative, communal, religious and female leaders and a representative of each of the over 150 ASACOs were invited into a dialogue to promote community participation in health and nutrition develop strategies to increase food production/availability, and encourage active community mobilization through outreach activities and campaigns. Unfortunately, these communal representatives (ASACOs) are limited to working within their five-year annual plans, and their budgets are usually very tight. It is important to acknowledge, however, that they do contribute to health service strengthening. They tend to focus on providing support for health infrastructure development such as maternity sections in CSComs, and they often support vaccination and SIAN campaign activities as well.

ASACO members interviewed in various sample communities during the MTE appear to be very active and have a good working relationship with Ministry of Health personnel. They report that they hold regular meetings, discuss health and nutrition, and support the dissemination of health and nutrition messages. Traditional leaders interviewed were, likewise, clearly very knowledgeable on health and nutrition. They were aware of key messages and health information being transmitted in the community: exclusive breastfeeding, complementary feeding, hygiene and sanitation. When asked, these community leaders responded that they play a supportive role in community mobilization for the aforementioned activities.

Aside from the advocacy workshops, the project did not work directly in the area of community mobilization, although some of the populations in 4 of the 9 districts of the Koulikoro region have benefited from the activities of the CARE Keneya Ciwara project, which is now ending. This project provided support to the SAN+ by working with ASACOs and CHWs linked to health providers who are also working in partnership with HKI. HKI has seen the need to do more in this area, and would like to provide more concrete support to health providers implementing community outreach activities. SAN+ field staff begun to include this in their monthly schedules prior to the midterm.

ii. Community response

Interviews with men, women, village chiefs and community health committees (ASACOs) indicate that the community has responded well to the project efforts. While the project's principal partner is the MOH at the district and health facility levels, the involvement of the ASACO in the management of the CSComs extends that partnership to these community representatives. The latter speak about the fact that as a result of HKI's presence, nutrition has been given more importance. It is a regular topic of discussion during their monthly meetings with the health providers. Many communities also have general community meetings, and this has been an opportunity for key

messages to be disseminated to regular community members, especially men. It is common practice for men to attend these meetings, while more women are reached when attending the CSCom, and through the outreach or campaign activities.

Where there are CHWs who have been developed and trained by other programs (sometimes in collaboration with SAN+), these individuals also disseminate ENA messages during home visits, and during health education sessions. This creates the synergy that was the vision of the child survival project at the time of the design. Some rural midwives interviewed also mentioned that they participate in the women's '*tontins,*' which are cooperatives where members are able to benefit from monthly collections to cover individual expenses or collective activities. These groups provide midwives the opportunity to reach numbers of women with health/nutrition messages. Some midwives reported that when they do not participate in the '*tonins,*' they become socially isolated.

So, based on the above, it appears that project activities (training of midwives and supporting message development and dissemination by community partners) have both contributed to, and taken advantage of existing social cohesion in the target population to disseminate messages. The project supports at least one urban-based health facility in each of the nine districts in which it works (some have more than one), and health staff also reach urban women through similar cooperatives, which meet weekly or two to three times per month. Nevertheless, health providers report that women in urban areas are difficult to reach outside of the ANC and child health clinic sessions because they are very busy and because cooperatives tend to be less cohesive in the urban areas.

iii. Refining of project implementation.

There have been no particular changes or modifications made to initial project plans.

iv. Barriers to prevent members of the community from benefiting from the project

The major barrier to community members benefiting from the project is the fact that in general, health personnel do not have resources to provide services outside the health facilities. Routine home visits or community level visits are not activities that MOH staff can really undertake. Needless to say, those communities located in the outer areas of the health facility catchment area are dealing with distance as a barrier, and do not have easy access to the CSCom. But the new emphasis on the quality of outreach services, and being able to maximize this as a health and nutrition intervention, is increasing community access. In urban settings, CSCom staff report that the barrier is mainly that people are very busy.

v. Impact of community and other factors on project implementation

During the MTE discussions, among the factors identified as having impacted the project's ability to mobilize the community were those of the long-distances involved, i.e. some villages are as far as 200 km from the district centers (although it should be noted

that the average distance of most health facilities from the district is approximately 50 km). This reduces the frequency with which a project supervisor can support program activities in those areas. Some districts have a greater number of health facilities than others; e.g. the Kati district has 42 health facilities, while some have 11 and 12. Several supervisors also mentioned the fact that new CSComs are constantly in development, which changes the workload of supervisors and coverage. They report that approximately 19 new CSComs have been opened in the region since the DIP was approved, so virtually all of the SAN+ supervisors are working with more facilities than was initially planned. And in addition to this, the frequent CSComstaff turnover makes the supervisors' work even more challenging. Of the 120 health centers covered by HKI supervisors interviewed, 32 had seen a change in the head of the center, i.e. 27% (with two of those on their second change of staff). There are no real problems related to security, except for the fact that when traveling through isolated areas supervisors have to be vigilant for potential robbery.

b. Communication for Behavior Change

i. Existence of Behavior Change strategy

The project's behavior change strategy is via radio programming, as mentioned above, and through work with health providers as channels of communication. The ENA training modules used to train the midwives in the region, and, which will be expanded in the second half of the project to include CSCom heads, has interpersonal BCC methods (negotiating for behavior change) integrated into the program. Thus ENA and BCC are considered linked strategies. Synergy for behavior change is also provided by other projects implemented in the region, and national campaigns via the television etc.

ii. Appropriateness and effectiveness of project's approach to behavior change

Where there is the prior mentioned complementary coverage, i.e. in the 4 districts where the Keneya Ciwara project was being implemented, the project approach was certainly appropriate and effective. However, due to the vastness of the districts targeted by the Keneya Ciwara project, only a portion of the total communities in these four districts were able to benefit from this project. On the other hand, where Keneya Ciwara was present, there was no duplication of effort and all activities contributed to great synergy and potential impact. There are districts in Koulikoro with no organizations, local or international, working at the community level. In such cases, one can argue that program efforts have not been sufficient, i.e., the radio program does not provide for interpersonal communication and dialogue, and health workers are not able to spend much time in outreach beyond the health facility.

The project implemented community advocacy workshops in each district, which had the potential to contribute to behavior change. But these only had the potential to have impact in areas where community mobilization through Keneya Ciwara encouraged these leaders to become more active champions for health and nutrition. Evidence of how much of an influence or impact these workshops had is not clear because there was no follow-

up. ASACOs who speak about their activities tend to emphasize that this is a result of their collaboration with the health workers rather than an outcome of the advocacy workshop.

iii. Message quality

The messages being used by the project are technically up-to-date, and have been developed in collaboration with the National Center for Health Education and Information (CNIECS). These are the same messages prioritized in other programs. As mentioned, SAN+ is working with the other nutrition stakeholders to complete the development of tools promoting the other key ENA messages. They are also interested in reviewing the data from a BEHAVE workshop hosted by the SAN+ project in Mali in January 2007, where secondary groups were identified; and may adapt or add messages to take those into consideration.

iv. BCC messages teaching skills, negotiating changes and influencing social and behavioral norms

Health staff interviewed mentioned that cooking demonstrations they were able to implement through previous programs and the support of WFP foods, for example, were always a big help in putting nutrition knowledge to practice. This activity used to be conducted about once a week, and after cooking together, everyone would eat together. Some communities with the help of the ASACO, have also taken the initiative to bring food for cooking demonstrations. These initiatives will likely to be undertaken again through the HKI CTC activity. In communities where a strong effort is being made to encourage mothers to deliver in CSComs, immediate breast-feeding is put into practice by the health provider. Mothers report that as a result of all the education they have received, a lot of traditional practices such as feeding the newborns concoctions have been abandoned. During FGDs, mothers in various communities spoke about how they have fewer cases of illness such as diarrhea, and that this is a direct result of the hand-washing and hygiene practices that they have learned and adopted.

v. Effects of the behavior change activities and tools used

The project planned for a baseline and the final KPC survey at the end of the four year period to measure the effects of behavior change activities. Outside of this, as it is a project that covers an entire region and is not a community-based project per se, the effects of the behavior change activities such as the radio broadcast program and the counseling that teaches skills in negotiation etc, is generally only measured qualitatively through informal reports from health facility staff and radio program agents – all of which have been very positive. The project has not chosen to do any close or routine monitoring of health facility data as a means to measure the effects of the aforementioned behavior change activities, although they do monitor the results of each SIAN which also confirms the population's positive response to project-supported activities.

As already mentionned, the project assisted the MOH to develop Vitamin A and de-worming data collection tools that are now used during campaign activities.

vi. Use of data

The data gathered are used by CSComs and Districts. When interviewed, staff were able to speak about progress and improvements, i.e. reduced cases of illness and deaths. The regional health office stated that they had lower coverage statistics because they were not able to provide health facilities with supervisions and support in 2007 (funding problems). Per interviews, communities with CHWs collect and use data as well. But those without CHWs, or with inactive CHWs, don't have access to data or use it. It should be noted that community members have a good idea of what is happening too. Their discussions of observations of changes included reduced cases of illness, mortality etc, as a result of HKI and other program support.

vii. Innovative approaches successful in changing behavior

The project intended to use a grandmother (*Musokoroba)* approach, implemented under previous HKI Mali child survival project. Thus far staff has not been able to implement this due to limited resources and the geographic scope of the project, spread across 9 districts (region-wide).

c. Capacity Building Approach

i. Strengthening the Grantee Organization

- **Progress**

The progress made in terms of capacity building objectives was good. More or less all activities that were in the DIP training plan were implemented, and clearly appear to have contributed to staff capacity to manage and implement this program. Other capacity building activities undertaken by the project include the training of project staff in interview techniques for the KPC survey and for Health Facility Assessments as well as hemoglobin assessment. Staff also benefited from training in ENA, M&E, and the BEHAVE model for BCC. The first project Coordinator was able to travel to Benin for ENA training, and both the current Coordinator and Deputy were able to travel to Senegal for training in BCC and M&E respectively.

Staff also benefited from training by URC in Quality Assurance (QA), although, as noted, impact has been reduced by lack of follow up in applying supervision tools and checklists developed in the workshop. Playing a supportive role, rather than implementing directly, has also increased project staff skills in support and supervision. It should also be noted that the team has gained substantial experience in the area of revitalization/integration of nutrition into existing services.

One area of weakness that does stand out in the area of progress and growth of the country team, is the lack of systematic, periodic and routine documentation, reporting and information-sharing for the project. Data coming in from field staff is supposed to be entered into the database, and then used for analysis and decision-making. It is not clear that these data are routinely shared and discussed among the project leadership. Reports

written or documentation of training, workshop and other activities is entirely dependent on the MOH partner, who rightly plays a leadership role in these events. But as a result, this documentation is sometimes missing at the project office level (even though, being activities that are funded or supported by the project, the project is responsible for reporting on these activities), e.g. in the case of the QA workshop, the meeting notes including indicators developed and follow-up activities outlined were not available at the time of the MTE because they could not be found in the office.

- **Approaches and tools used to assess capacity**

Pre- and post-tests tools are generally used for training activities, although not for the trainings for project staff. During staff meetings and technical updates, discussions and participation from staff enable the project leadership to assess staff capacity to implement the program.

- **Activities related to organizational capacity building**

Please refer to the above as it pertains to in-country staff training. No capacity building activities were undertaken for the HQ level aside from routine participation in the CORE group.

- **Indications that the project has increased organizational capacity**

From all accounts implementing the 'scale- up' SAN+ project has been an opportunity for HKI in-country to increase staff skills in capacity building, quality improvement of services and ability to work region-wide. Feedback given to the MTE teams by project partners at the district and health facility level was very positive. The regional team noted that when health districts with NGO support are performing better than those without, it becomes very difficult for the regional team to manage the varying needs and disparity. The regional approach of SAN+ helps with uniformity and equity, which is particularly important in this case because the intervention is the re-integration and strengthening of a key component of the minimum package of services.

ii. Strengthening Local Partner Organizations

- **Organizational capacity building efforts with the local partners**

The main organizational capacity building efforts conducted by the project for the primary local partner were the following: Training of Trainers (TOT) in ENA/BCC, and subsequent support for training of district and health facility staff in ENA/BCC; an attempt to introduce quality assurance by supporting a workshop to which several district and health facility staff were invited to participate; and more recently, under the parallel Community Therapeutic Care (CTC) funding, a TOT for CTC. The main participants for these aforementioned activities have been the district and CSCom staff, although the regional office has had representatives participate in all activities. To begin MOH staff capacity building process, the project in fact, organized an advocacy meeting at the

Koulikoro regional level where different government representatives and ministries were invited to participate.

As previously mentioned, the QA workshop does not appear to have been very effective as there has been no follow up of the workshop recommendations (indicators to be used etc). Again, it should be noted that the project does use supervision tools/checklists that measure the quality of IEC and counseling services being provided at the health facility level, as well as growth monitoring of children. But as mentioned earlier, many district teams do not manage to participate in supervisions conducted by the project staff. There has been a major problem at the ministry level with funding for supervision activities. Both the region and districts report that they are dependent on outside agencies to support these activities; primarily because these are not budget expenses that seemed to be approved at the national level. In Koulikoro, UNICEF appears to be the only entity that supports supervision (an annual supervision/monitoring activity conducted by the regional team and a separate one by the district team, covering each health facility). But the approval processes for this is generally accompanied by delays, and sometimes no funding, as was the case in 2007.

The radio network is another local partner that has been strengthened. The project collaboration was an opportunity for these community radios to strengthen their skills in broadcasting for health, build up existing materials and content for health and nutrition programs, and become active champions in this area. Their ability to develop interesting and creative health programs is evidence of this, as well as the ability of at least one of the rural radios interviewed to attract other contracts.

- **Roles and responsibilities of each of the local partners**

The regional health directorate of Koulikoro provides technical guidance to districts, supports strategic planning and the dissemination of norms and standards etc. Districts health offices have more of a supervisory role in the implementation of health services, although they do not manage to reach most CSComs on a regular basis. They aggregate statistics collected at the CSComs and monitor progress on key indicators. When they have the resources, they organize trainings and meetings for district-wide staff. In the case of SAN+, HKI has financed specific training activities with the districts, and the regional staff participated in TOT activities and took a leadership role in training. Aside from training, the district and regional staff involvement has been limited to occasional meetings and supervision, as they have tended not to have an adequate budget to cover the latter. Although project field staff would have liked to be accompanied by their counterparts (who could ride out on the back of the motorcycle with them) during visits to health facilities, this solution is undermined by the lack of per diem; it is often difficult to get MOH staff participation without this. The child survival project budget is particularly stretched because it is a region-wide project covering nine districts. One of the issues discussed during the MTE was the lack of project budget for joint supervision activities. These activities were generally not undertaken during the first half of the project, but HKI recognizes that this needs to be remedied in order to assure not only the

involvement of the government counterparts, but to facilitate the process by which these local health authorities take more responsibility for the nutrition integration activities.

The ability of the local MOH partners to carry out their job responsibilities is very much a challenge, as they will readily tell anyone who broaches the subject. The regional and district teams are usually balancing priorities and donor activities. Many districts are understaffed and/or dealing with issues of low motivation. All health facility staff interviewed stated that they had received more visits from the HKI team than they had from their own districts health teams in the previous year. They have a lot of appreciation for the support that they have received from the project, and feel less isolated as a result; nevertheless, a solution that would permit more government supervision is desirable and more sustainable after the project ends.

- **Outcomes of any assessment**

The project conducted a health facility assessment at the time of the DIP development and will be conducting a follow-up assessment at the end of the project period. Aside from this, project staff report that they conduct pre- and post-test knowledge assessments at every training workshop. For the ENA training for example, staff reports verbally that the lowest mark in the post tests was higher than the average mark in the pretest, but has not written up the summary and discussion of these results.

- **Changes in local partner organizational capacity**

Per interviews, local partners at every level feel that they have increased their capacity as a result of the project. Health providers across the board report that their knowledge went from being general to specific. Some of their practices have also changed. For example, they now provide two capsules of (200,000 IUs) Vitamin A to postnatal mothers rather than one. Health providers and SAN+ supervisors report that IEC now includes a strong focus on ENA, with key messages to encourage behavior change (as noted in the IEC books kept by the midwives to document these sessions). Health providers can cite specific steps in counseling for behavior change, and systematically include nutrition and micronutrient supplementation in their routine mother and child health activities. During outreach activities, there is now a stronger focus on education around key nutrition and health messages. It is apparent that the project has had a big impact with regard to the integration of nutrition into basic health service provision at the health facility level. And this is also the case at the district and regional levels where nutrition is now systematically included in annual planning; usually the provision for Vitamin A supplementation through biannual campaigns, and seeking partners to finance training and technical updates for new and existing staff.

- **Challenges in further building the capacities of partners**

Among the challenges that the project will continue to face is the fact that there are always more needs in training than resources. Although the CTC project funding offers a considerable opportunity for further training, facilitating the engagement of more CSCom

staff, there are still limits to the project's capacity to meet all training needs in a region-wide project. Per project staff, and also reflected during MTE interviews, everyone wants to have the opportunity to participate in a training activity (although they also conceded that they generally learn from others who have received training, and share information among themselves during staff meetings as well). Training is considered a perk and privilege, and sparks discussions around inequity when some receive training and others do not.

Challenges related to building the capacity of community partners are similar. Per MOH guidelines and requirements discussed during interviews, the project should train one CHW for every 33 households or 250 inhabitants across the region. But even with the additional CTC program budget, the project cannot cover this expense. Moreover, some communities do not currently have enough CHWs; others have not had recent NGO support. All of these factors have to be taken into consideration. According to project staff, each district has a different situation. Some CHWs have received training in nutrition but not in IMCI, and vice versa. (The training proposed under the OFDA-funded project will be in C-IMCI, and include CTC in that module). One advantage, as was mentioned before, is the presence of UNICEF, whose priorities also include the training of CHWs in C-IMCI. So the two organizations will be able to again join forces in supporting the MOH with this endeavor.

iii. Health Facilities Strengthening

- **Appropriateness and effectiveness of health facility strengthening activities**

As discussed above, by all accounts, the HF strengthening activities have been successful. All training was followed up by supportive supervision, conducted by HKI field staff and this particular strategy enabled rural midwives, in particular, to improve their knowledge and skills in nutrition, health education and counseling, and facilitated the overall re-integration of this as part of minimum package of services. The one missing component of this activity was the close involvement of the districts in support and supervision. But this does not seem to have had an adverse impact on the successful integration process. Health facility heads are quite used to working independently and managing the CSCom team. Interviews with different representatives of this cadre suggest they have bought into the importance of nutrition interventions, and have been providing their support by supervising rural midwives with periodic observation of group health education sessions being conducted at the health center, and discussions/review during their weekly meetings.

- **Tools used for health facility assessments**

For the baseline and final HFA, the project is using the standard tool. In addition to this, SAN+ uses a checklist for assessing education sessions and a checklist for assessing growth monitoring and counseling. Monthly activity reports from the project supervisors, require the monitoring of health facility stocks (IFA, SP, Vitamin A etc.); and the number of IEC sessions and counseling, as well as participants and content of these sessions.

These checklists are used by the nine project supervisors based in the districts. The checklist for education sessions looks at a list of 17 elements related to the method used by the health provider, and an additional 11 points covering the discussion itself and thoroughness on content. The guide also assists supervisors with how to conduct feedback. It uses a participatory method whereby the health provider does an auto critique, and together they come up with points to strengthen and actions to be taken. The checklist for growth monitoring and counseling consists of a list of 19 items covering the steps that the health provider should be following, and the interaction that he/she has with the client.

The MOH uses a monitoring guide every six months to assess progress made at the health facility level. SAN + is negotiating with the Health Directorate to include more nutrition related indicators in these guidelines (Vitamin A is already included).

The above tools are appropriate and have reportedly been very effective, as health providers unanimously report that HKI supervisor visits are useful and serve as learning opportunities for them. When supervisions are conducted by the Bamako-based project leadership, they typically develop terms of reference based on priority areas, training provided and/or gaps previously identified (as does the MOH). The terms of reference serves as a tool for that particular supervision and is changed or modified when planning for every new supervision activity.

It should be noted that the project team in Bamako has not been conducting field supervisions and assessments as frequently as they had initially expected to be doing. This first half of the project has involved a lot of coordination and collaboration with the Nutrition Division at the national level, (including providing technical assistance to the development of policy norms and procedures for the nutrition program which has also involved USAID and other stakeholders). HKI also participates in stakeholder meetings, as a major partner, and the project leadership has spent a lot of time and effort leveraging additional support for health and nutrition, e.g. the MI and CTC programs.

- **Discuss linkages between these facilities and the communities.**

Rural midwives have a lot of contact with women and family members frequenting the CSCom. They conduct the ANC clinics, as well as growth monitoring, family planning and counseling. They report having contact with grandmothers, who often accompany clients to the health centers for their first ANC visit or when they are ready to deliver. In addition, as mentioned before, health providers, and specifically midwives, also have contact with communities during the outreach activities, when they are conducted. The presence of community health committees (ASACOs) at each CSCom also facilitates communication with communities, because these community leaders work with the health team in the management of the community health center and then carry information into their communities.

Per the interviews held with both midwives and women, it is clear that linkages with communities are stronger now, and have been influenced by the project training and

support of health providers in improved service provision and nutrition integration. The radio program dissemination of key messages has also encouraged more prompt care seeking behavior and communication with health providers.

iv. Strengthening Health Worker Performance

Please refer to the above sections for details on strengthening health worker performance. Again, performance is assessed during supervision visits conducted by HKI supervisors based in the districts. The focus of their visits has either been on post training support for practice of new knowledge and skills, or specifically revolves around correcting areas of weakness. SAN+ has been using this strategy of consistent support to try to address the gaps between performance standards and actual performance. In addition to this, MTE findings highlighted the fact that there is a need for project leadership to participate more actively in district level coordination meetings, taking advantage of such opportunities to review, discuss and problem solve with the team of HF heads and their district supervisors.

v. Training

- **Training strategy, and its effectiveness**.

Again, the training strategy used under this project was that of TOT for select regional and district participants, and support for the training of rural midwives. This was effective in that a large number of MOH personnel were able to receive training, and the training was conducted by district and regional supervisory staff who at the end of the project will be the stakeholders responsible for ensuring the sustainability of these activities.

- **Progress on objectives**

Overall the project achieved most of its training objectives. In addition to the training of midwives, they were able to carry out nutrition orientation activities with heads of health centers, conduct advocacy with community leaders, train radio broadcasters on key messages and communication techniques, and undertake a BEHAVE workshop to develop a BCC strategy. While they did conduct a quality assurance workshop as well, as mentioned, there has been no follow up. During the workshop there was some brainstorming on criteria and assessment methods for QA, along with the development of a list of indicators to use in assessing quality of health services, but these were not implemented. Thus this is one activity staff will need to undertake during the second half of the project. And although the DIP states, “HKI will take a pro-active approach to incorporate gender into all aspects of SAN+,” the training strategy did not have specific focus on gender (project staff report that it is more or less integrated in all their activities).

- **Evidence that training implemented has given results.**

Please refer to previous comments made with regard to this point. In addition, from a monitoring standpoint, project supervisor monthly reports provide supportive evidence that project training and supportive supervision have resulted in increased knowledge and skills among health staff trained, as well as among those who did not participate in training. In addition to the HKI reporting, the MTE discussions with project supervisors, and interviews with quite a number of health center heads confirmed this finding. Health facilities are also able to provide documentation of their activities through the IEC books, which record all of the education sessions that they undertake; including the subjects covered and the number of participants. The micronutrient supplement coverage reports also show progress in this regard (VAS 6-11 months 85%; VAS 12-15 months 93%; deworming 12-23 months 95% in the December 2007 integrated campaign).

d. Sustainability Strategy

i. Progress on meeting sustainability objectives

Per the project DIP, the SAN+ project approach was basically 'not to create something new' but rather strengthen the existing system and help solve bottlenecks and barriers to the proper functioning of health services and community access to the services. The sustainability section of DIP specifically outlines the following:

Sustainability will be assured through:

- Reliance largely on *existing* personnel, relationships, and structures;
- Responding to needs identified by Regional Health Directorate and other implementing partners;
- Strategies and activities consistent with MOH/SD policy or modification of policies where appropriate;
- Joint assessment, planning, implementation, monitoring, and evaluation;
- Community Health Associations, ASACOs, with increased capacity to assess, plan, implement, monitor, evaluate and manage CSComs (facility and outreach);
- CSComs with increased capacity to deliver the Nutrition+ package;
- District Health Officers /Reference Health Centers with increased capacity to assess, supervise, coach, monitor;
- Regional Health Directorate with increased capacity to assess, plan, monitor and evaluate;
- MOH/SD at national level with increased capacity to adopt state-of-the-art policies, strategies, approaches and translate these policies into programs;
- Rural radios with increased capacity to design and disseminate effective, accurate messages promoting utilization of CSComs and improved household practices for infant and young child feeding;
- Communal and *cercle* councils with increased understanding of health and nutrition issues and provision of increased investments in health and nutrition;
- Mali URTEL, ORTM, and local, regional and national ASACO associations with increased capacity to support member organizations programmatically.

The MTE process involving FGD's and key informant interviews across several districts and region and the national levels was an important opportunity for the external consultant, HKI headquarters staff, project staff and partners to review progress towards achieving the above. As discussed throughout the report, SAN+ is very much on track as it relates to its intervention-related and capacity building objectives. Sustainability objectives as articulated above, were an integral part of the program design. When referring to the above list, overall the project appears to have made excellent progress in terms of process and coverage. (Some of the district indicators look better than others, but SIAN campaign coverage has been very good as noted on the previous page). The area of weakness again, is that of joint assessment, planning, implementation, monitoring, and evaluation.

The district teams interviewed displayed evidence of relatively strong technical and management capacity, and have a system in place for supervision and monitoring. The regional team's focus seems to be more on juggling priorities, overall management and leveraging financial support from the various partners. It could be argued that the program did not necessarily need to dedicate effort in the area of technical capacity building for planning, supervision, assessment and monitoring. But the project has not yet explored how it might strengthen district health officers /reference health centers capacity to assess, supervise, coach, monitor, and regional health directorate capacity to assess, plan, monitor and evaluate. Instead, the project has prioritized health service provision during this first two years of activities, and project staff has been completely taken up by this. In addition, there are approximately 19 new health facilities since the development of the DIP. This dramatically increases the effort the project has to make at this level. During the MTE interviews, the main complaint of these program partners is that HKI was not helping to finance joint supervisions to support district and regional staff involvement in the above.

ii. Groundwork for the phase-out

The program strategy is one of partnership and sustainability. Not many resources other than staff technical support and training have been provided, and this should facilitate phase-out. But the success of the nutrition re-integration has primarily been due to the support and supervision provided by the HKI supervisors. It was starkly clear from interviews with health providers indicating they have not received many visits from their supervisors in the district during this first two-year period. This is a big gap that will need to be addressed prior to the phase-out of HKI support.

iii. Approaches to building financial sustainability

The SAN+ project has not undertaken any specific work to build financial sustainability. But certainly it should be noted that in the area of Vitamin A (which has been an important contribution of HKI's in Mali), HKI has contributed to making this a national priority. The MOH Division of Nutrition is now purchasing Vitamin A to support the bi-annual campaigns nationwide. This is also considered a priority by the regional team; something that has become part of the annual planning and budgeting. So the MOH

expects to continue mobilizing resources to get the supplies needed. The project staff should continue its dialogue with the national and regional health divisions about budgeting for appropriate supervisory visits and for micronutrient supplies needed for both routine service delivery and periodic campaigns.

iv. Community capacity to sustain project services

As previously mentioned, there has not been a lot of effort put towards community mobilization, as the main strategy of SAN+ has been to work at the health facility level. But advocacy with community leaders was very much geared towards encouraging them to take initiatives and responsibility for supporting improved health and nutrition in their communities. Communities that have been working with the Keneya Ciwara CARE project have a clear advantage in this regard as community leaders and volunteers are already active and have demonstrated a good level of commitment to sustaining activities. ASACOs sometimes collect money from community members or mobilize the support of the commune to undertake specific activities. But there is no doubt that identifying alternate funding sources will remain a challenge for communities.

v. Sustainability design methodology

NA

C. Project Management

1. Planning

a. Groups involved in project planning

Project funding is led by the project coordinator in consultation with the MOH national, regional and district health teams. As this is a partnership project, the SAN+ team cannot undertake any activities without the collaboration and coordination of its primary partner. It is also important to note that maximizing impact by creating synergy has involved a lot of communication, collaboration and coordination with other projects such as ATN, UNICEF and other stakeholders working in nutrition and micronutrients interventions.

b. Work plan in DIP on schedule

The project has done a good job of sticking to the work plan submitted in the DIP. There have been no major delays in the implementation of activities outlined in the DIP work plan.

c. Knowledge of project's objectives

Project objectives are understood by field and headquarters staff as well as local level partners, and community leaders.

d. Copy of the project's objectives and the monitoring and evaluation plan

Program partners participated in the development of the project and have copies of project documents.

e. Use of project monitoring data for planning and/or revisions

Per interviews with the HKI team, they closely follow district and regional monitoring. The project leadership receives copies of the quarterly monitoring reports from each health facility, and review/discuss the data with both the health facility and the district. The data often elicit questions and discussions around coverage, and providers will often cite challenges such as the lack of budget for outreach activities, problems with logistics, fuel cost, cold chain, human resource/health personnel drop-outs etc. Although this information is available to the project and its partners, staff report that because of the budgetary constraints of the project, these monitoring data have not been used to inform or revise program implementation. Thus the project staff use the data to assist in addressing problems on a piecemeal basis, but this approach does not address the gaps long-term. Data have been used to examine trends in coverage from quarter to quarter, identify problems, and, to the degree possible, solve those problems. This weakness may be addressed soon with the additional support of the OFDA funding and UNICEF. The SAN+ team expects to use these resources to train the heads of the CSComs to support their use of data for decision making and planning. The child survival project has targeted midwives for training because they are directly responsible for providing most of the MCH services. However, because most of the midwives do not have a high level of education, they may not have the capacity to use data for decision making. With the support of the center heads, who are responsible for planning, making revisions to services and supporting and supervising these midwives, the use of data may improve.

2. Staff Training

a. Effectiveness of the process for continual improvement of the project's staff

HKI has invested in the training of its staff, as discussed above, including sending people to neighboring countries and workshops. Even the administrative/financial staff person reported having received training. New and existing SAN+ field staff have been provided with technical updates every few months relating to new activities and interventions that the project was undertaking. Periodic staff meetings between animators and project leadership have been opportunities for new animators to learn from existing field staff, as part of their orientation to program priorities and efforts. The project has not conducted any specific staff training needs assessments or follow-up assessments. In addition, there has been relatively limited supervision of staff at the field level by the Coordinator and Deputy due to conflicting priorities, requirements for collaboration and coordination at the national level, budgetary constraints, etc. There were budget problems due to the serious underestimation of certain costs at the time of the project design. HKI had never worked on such a big scale before in Mali (the previous CSP covered only three districts). The increasing cost of fuel and the devaluation of dollar have contributed to this problem.

As a result of the above, it is not clear just how sure the project coordinators can be of field staff performance as it relates to their specific job responsibilities. These aspects are discussed during periodic meetings, or when field staff comes to Bamako monthly to

collect salaries. But as the Coordinator and Deputy are not able to be consistently present in the field, observing and supporting the animators at work, they may have limited ability to assess specific qualitative aspects of field staff job performance. Again, the complementary funding from OFDA has facilitated increased contact between the project staff and field supervisors in the two pilot districts. As this component is expanded to cover the other 7 districts during the second half of SAN+, animators will benefit from more field supervision and support for continual performance improvement.

b. Monitoring of trainee performance

Monitoring of trainee performance is not done for HKI staff.

c. Resources dedicated to staff training

During MTE interviews, all staff reported that they feel adequate resources have been dedicated to staff training. Many of the project staff had prior experiences in NGO projects or in HKI projects. This was one advantage going in, and staff feels that they have been adequately prepared to undertake their job responsibilities.

3. Supervision of Project Staff

a. Effectiveness of process of directing and supporting staff

An annual performance evaluation system is in place, and includes a feedback process etc. Please refer to the above comments on supervisory methods and training as it relates to staff. Joint work planning and problem solving as an entire team takes place once every few months; when the team meets for a specific technical update or orientation activity. But the Bamako-based project leadership (Coordinator, Deputy and Mickey Leland Hunger Fellow) works very closely as a team in the planning and coordination of all program activities and problem solving.

b. Numbers, roles, and workload of personnel and frequency of supervisory visits appropriate for the technical and managerial needs of the project

The workload is large because HKI Mali has multiple projects; several contribute to matching funds as well as synergy. HKI took the initiative of obtaining a Mickey Leland Hunger Fellow, as mentioned above, (also serving as match), who provides additional technical support, including help with documentation and report writing.

The CTC OFDA-funded project has brought a lot of extra work for the team, as it does not come with a whole separate staff, but was designed to become an integral part of the CSP. Despite the extra workload, the SAN+ staff is very appreciative of this added intervention and funding because it provides synergy and complementarity to SAN+ and lends more visibility to the project with its district and community level partners. The latter are very happy with the extra funds that will be available for staff and community volunteer training in health, ENA and the identification and treatment of malnutrition cases. Community members are always very grateful when they get support in the form

of therapeutic foods for the affected children as well. This added opportunity for community mobilization is a strong asset for the child survival project and will be of considerable assistance to the achievement of the SAN+ objectives.

The infrequency of supervisory visits for SAN+ and potential impact on the quality has already been discussed. It is not clear whether, had the project leadership been able to spend more time with the district and regional teams, there would have been more systematic involvement of these teams in the nutrition integration process. The country leadership realizes that it would be desirable in the future for project senior staff to do more in the area of facilitating regional and district engagement in quality assurance, and provide advocacy and support for community outreach. It is important to note that the OFDA budget, together with UNICEF support for new CTC activities, will allow the project leadership to do more of this now; including supporting joint supervision visits (with district and regional partners) and action-planning based on these. The staff now expects to be able to conduct joint supervisions of all health facilities every two months, and this will help meet some of the technical and managerial needs of the project.

The SAN+ team is trying to strengthen the relationship with the regional health directorate. They plan to increase contact and communication and hope that establishing a closer relationship will allow them opportunities to provide more support, e.g. increased participation in MOH regional meetings etc. The project budget does not include support for the cost of the regional meetings, however. Regional meetings are costly because they usually involve a 3-day trip for two to three technical staff from each district, and a chauffeur.

Per discussions and observations during the MTE, the MOH district teams (and the regional team as well) are certainly overloaded by the different programs and job responsibilities. When one representative goes to meetings or trainings at the regional level, feedback to the rest of the team is not necessarily immediate or systematic because everyone is busy. From discussions, it appears that some of the district teams manage to share and discuss issues more than others. And sometimes, as is the case with some health facility personnel, colleagues are not receptive because they feel that they have a right to have their own training opportunities. The MOH is reportedly looking at trying to manage the issue of workload with restructuring; i.e., the development of two teams at the district level (one for public health and one for medical) so that technical and managerial responsibilities can be better handled.

3. Human Resources and Staff Management

a. Personnel management system and changes

The personnel management system has not changed. All posts are filled.

b. Presence of personnel policies and procedures, job descriptions, and work with partners

All staff have copies of their job descriptions, and are briefed on policies when they are hired. Manuals and policies are available on the HKI intranet. An MOU has been signed with UNICEF for the CTC activity, articulating the nature of the relationship. HKI also has one with the Koulikoro regional health directorate ensuring commitment, partnership and the complementarity of efforts.

c. Morale, cohesion and working relationships of project personnel

There is very good team spirit among the staff. The staff is motivated. There is cohesion and good communication, sharing of tasks based on individual skill set and availability. The Bamako team has participated in the TOTs that have been organized by the project, and project supervisors always participate in the trainings at the district level. This has had a positive impact on project implementation.

d. Staff turnover and impact on project implementation.

Although the project did lose its first coordinator to WFP, this has not had a negative impact on project implementation. Despite the fact that HKI was not able to ensure a handover and overlap at the time of the first coordinator's departure in July of 2007, the new project coordinator is extremely qualified, and SAN+ has continued to make achievements since the staffing change. It should be mentioned that there was a change in HKI country directors during the same period; and no overlap between the old and the new in that case either. But HKI was fortunate enough to bring on an individual who had been living and working in Mali for a number of years, and so this was not particularly problematic.

The loss of a project supervisor who resigned in August 2007 to pursue further studies did, however, have a significant impact on the continuity of support and supervision to the health facilities in that district. When asked how many supervision visits they had received in the last year by the project, CSComs visited in this district during the MTE generally responded that they had only received one, as compared to others who had received between two and four visits on average. (It is important to note though that a good part of the previous year had been dedicated to staff and partner training, and thus support and supervision activities had only really been taking place for about six months or so prior to the midterm). HKI was unable to replace this staff person until a full six months after his departure, and explained that this was due to difficulties finding someone with an appropriate background. Although other supervisors were not nutrition specialist when hired, they had a lot of field experience.

HKI Mali does not report using specific strategies for staff retention.

e. Facilitating staff transition to other paying jobs when the project ends

When HKI develops new projects, staff usually transfers to those. They have been able to do this relatively successfully in the past with different staff. But this is very much dependent on funding and projects.

5. Financial Management
Management and accountability for project finances, planning for sustainability

Each HKI country office and the headquarters develop annual and monthly budgets. Money is sent to the Mali country office from the headquarters in New York, and budget reviews are conducted every six months. The Mali office administrator and assistant, both of whom participated in the project design and budget development, also assist with this review. This administrative team, led by the country director, verifies and authorizes routine expenditures and produces monthly financial reports.

Again the strategy for SAN + was one where limited material inputs would be provided. The project did not want to encourage too much dependence by introducing and developing programs that could not be sustained. Remaining true to the project's name, Synergy and Action for Nutrition plus, in addition to benefiting from the presence of other NGO projects, HKI has been able to obtain a lot of different funding for various types of nutrition-related activities (the office has about 14 donors). This includes OFDA support, the Micronutrient Initiative grant for the provision of Vitamin A during SIAN campaigns; and the Global Alliance for Improved Nutrition (GAIN), which entails the fortification of cotton oil with vitamin A. The project coordinator for the last has been contributing approximately 16% of his level of effort to the SAN+ project. HKI Mali was also able to get support from the McKnight Foundation to implement nutritional bio-fortification of sorghum and maize.

6. Logistics

a. Impact of logistics on the implementation of the DIP

HKI contributed one vehicle and nine motorcycles as match funds. They have not encountered any problems with logistics. They have purchased an additional vehicle with the OFDA funded project, which is integrated into the Child Survival project.

b. Logistics challenges during the remainder of the project

The devaluation of the US dollar will continue to have a negative impact on the project budget and availability of funds to work across nine districts. Program staff will continue to have to be very careful in the allocation of expenditures for logistics.

7. Information Management

a. System to measure progress towards project objectives

Project data is collected through the existing Ministry of Health system. This is primarily related to Vitamin A coverage for children under five and postnatal mothers, de-worming, SP and IFA for pregnant women. Thus in the area of coverage, the project is able to measure progress towards objectives. In addition to the routine health facility data, as mentioned before, the project has bi-annual SIAN data available. This system of measuring data is effective and sustainable as there is no duplication of effort. The project has supported the region for the modification and improvement of Vitamin A and de-worming campaign data collection tools. Behavior change objectives will be measured at the time of the final evaluation through a KPC survey.

b. Collection, reporting and use of data

Data are used at three levels: the CSCom, district and region. At the CSCom level those providers interviewed in the sample health centers visited during the MTE, spoke about improved coverage and strengthening of nutrition activities. Project supervisors also provide this staff with feedback when they have questions about the data/reports. With this continuous attention and support, providers have become very aware of the importance that is now being accorded to coverage in micronutrients supplementation, IFA, SP etc.

Health facility data is compiled at the district level using a computer data system. A copy of this report is then sent to the region, and also shared with the project. The region subsequently consolidates data received from all nine districts. This data is discussed in quarterly coordination meetings at both the district and regional levels.

c. Types of data, frequency and method(s) of data analysis

Please refer to the above.

d. Project use and support of government data collection systems

The project is working and supporting the existing MOH data collection system (already discussed).

e. Use of data to inform management decision-making

As noted previously, despite the project's access to MOH data, there does not appear to have been consistent sharing and discussion/analysis of these data on a monthly or quarterly basis between the project leadership, and documentation is weak. There are also no routinely scheduled monthly or quarterly SAN+ staff meetings taking place. Contact with the field staff is often ad hoc. Meetings tend to be scheduled only when there is the need to provide technical updates, or when there is something specific taking place. Although supervisors do use project data as they try to support health providers, it is not

clear to what degree data have been used to inform management decision-making. The project leadership reiterated that budget constraints prior to the start up of the CTC activities did limit the flexibility of the project and frequency of meetings to discuss and use data for decision-making. As this project is working region wide, and not just in one or two districts, even uniting staff on a quarterly basis (let alone monthly as many projects do), has been a difficult.

f. Purpose, methods, findings and use of any assessments

Aside from baseline KPC and HFA activities, at the time the MTE, the project had not conducted any other types of assessments.

8. Technical and Administrative Support

a. Types and sources of external technical assistance

The Child Survival Collaborative group provided technical assistance with a BEHAVE workshop, to help the project develop a BCC strategy and key messages. None of the project staff had prior experience in this area. The deputy coordinator was also able to attend M&E training in Dakar, and the first project coordinator received nutrition training in Benin. The project also received technical assistance from the University Research Cooperation in Quality Assurance. URC assisted with the implementation of the workshop at the Koulikoro region. Some of the external assistance provided to the project has not yet led to direct action on the part of the project and it's partners, i.e. the project delayed the use of some of the results from the BEHAVE workshop for reasons discussed above, and mentioned, there was no follow-up after the QA workshop.

b. Anticipated technical assistance needs

SAN+ does not anticipate the need for more technical assistance.

c. Country Office, Headquarters and Regional support of the field project

The Mali Country Director reports dedicating approximately 25% of her time to the SAN+ and CTC projects. She provides organizational support to the team, and has helped to clarify the roles of staff including the Fellow, and the integration of the new CTC activities into the CS project. The CD, again new to HKI, has made efforts to bring supervisors together more, and have team building. She recognizes that they have been left out on their own too much in the past, as discussed above.

The percentage level of effort from HKI regional staff is between 5 and 10 percent. Since her arrival in early 2007, the HQ technical advisor gives approximately 20% level of effort to the Mali project. She has provided support with the annual report, reviewed project documents and receives updates from the country office periodically.

9. Mission Collaboration

HKI maintains regular communication with the USAID Mission about program activities, achievements and strategies. The project's goals and objectives fit into the Mission's overall health objectives, demonstrated by the fact that the project also works very closely with other mission-funded stakeholders such as the ATN project, and provides synergy to the mission-funded Keneya Ciwara Project.

E. Conclusions and Recommendations

Strengths
Good collaboration with UNICEF in the region

Areas of Weakness

- Lack of follow-up on the Quality Assurance component of project, e.g. recommendations were developed during a QA Workshop; poor documentation and dissemination of these and no action taken.
- Project did not budget for strategic activities such as joint supervisions and coordination meetings.
- Gap in community-level interpersonal communications activities for ENA in communities not being supported by other projects such as Keneya Ciwara (thus synergy is uneven across the region, and no specific work has been done with women's associations and with the grandmother strategy as discussed in the DIP).

Recommendations - Community level

1. Emphasis on BCC messages needs to include feeding during illness and maternal nutrition.
2. Project BCC messages need to emphasize animal sources of micronutrients as particularly important.
3. The project should encourage message dissemination within women's associations via matron's participation in these groups.
4. Encourage women to organize themselves to bring together ingredients for the implementation of cooking demonstrations.
5. Gain the support of grandmothers in new nutrition practices through regular contact with the matrons.
6. Develop linkages with government and non-government institutions to support communities with the promotion of vegetable gardening and the production of soya beans.
7. Accelerate the planned training of CHWs in ENA to support the dissemination of messages in communities covering the entire health facility catchment area.
8. The project should implement strategies already identified to follow up and support CHWs, i.e. participate in outreach activities being carried out by the health facilities every month.
9. Increase advocacy with Community Associations (ASACO's) and mayors to get them to invest more resources for nutrition activities.
10. Involve the ASACOs and mayors office during supervision activities.

11. Mobilize additional resources to adequately support the radio program component.
12. Train additional radio agents to support and strengthen existing radio programs.

Recommendations – Health Facility level

13. Encourage the mayor's office, the communities and their partners to ensure the support of outreach activities.
14. It would be a good idea for the project to provide health facilities with the materials needed for cooking demonstrations, i.e. utensils to be able to conduct cooking demonstrations.
15. The project needs to collaborate with the districts to ensure that new staff receive training in ENA.
16. The project should ensure the completion of training for health personnel in the Nara and Kolokani districts emphasizing feeding during childhood illness and maternal nutrition.
17. Strengthen collaboration with grandmothers as key to the adoption of new nutritional practices in the household.
18. Encourage sharing and exchange between matrons on experiences and strategies related to collaboration with grandmothers.

Recommendations – District level

19. Ensure that funding is allocated for joint supervision of the nutrition interventions.

Recommendations - Regional Level

20. Support joint supervision missions with the regional health team twice a year.
21. Strengthen the collaboration with the regional team on the management of project activities.

Recommendations – National Level

22. Accelerate the availability of the Vitamin Mineral Complex through enriched flour.
23. Support joint supervision missions with the national nutrition division once a year.
24. Strengthen the collaboration with the national nutrition division on the management of project activities.
25. Be proactive as a member of the Nutrition Working Group to stimulate increased products and investment in the fight against malnutrition and micronutrient deficiency.

Recommendations – HKI Management

26. Develop posters on ENA to display at health facilities
27. Accelerate the production and dissemination of remaining ENA counseling cards for service providers.

28. Redistribute the supervisory allocation of health facilities in the Kati district to balance out workload for project supervisors
29. Strengthen project staff capacity for using project-related data for management and decision-making.
30. Advocate for increased MOH responsibility in the provision of Vitamin A to maintain the high levels of coverage achieved, as part of the phase-out strategy in 2009.
31. Review and follow-up on the QA recommendations developed during the 2007 workshop and adapt and implement with the regional and district teams as needed and feasible.
32. Follow up on the potential for involvement and collaboration in the malaria, vitamin A and zinc regional research project.

F. Results Highlight

None highlighted

MTE ACTION PLAN

SAN + Midterm Evaluation Action Plan - Cross-cutting activities covering all program objectives			
COMMUNITY LEVEL			
	Activity	**Persons Responsible**	**Timing**
1. Emphasis on BCC messages needs to include feeding during illness and maternal nutrition.	▪ Organize IEC discussions on specific ENA topics ▪ Radio broadcasts emphasizing specific ENA topics	Matrons, Supervisors, ESS Radio stations	Continuous Continuous
2. Project BCC messages need to emphasize animal sources of micronutrients as particularly important	▪ Organize IEC discussions on specific ENA topics ▪ Radio broadcasts emphasizing specific ENA topics	Matrons, Supervisors, ESS Radio stations	Continuous Continuous
3. Encourage message dissemination within women's associations via matron's participation in these groups	▪ Organize discussion groups on ENA among women's groups	Matrons, CHWs	Continuous
4. Encourage women to organize themselves to bring together ingredients for the implementation of cooking demonstrations	▪ Raise awareness of women about importance of contributing to/participating in cooking demonstrations	Matrons, CHWs, In-Charge, HKI Supervisors	Continuous
5. Gain the support of grandmothers in new nutrition practices through regular contact with the matrons	▪ Organize IEC discussions with Muso Korobas	Matrons	Continuous
6. Develop linkages with government and non-government institutions to support communities with the promotion of vegetable gardening and the production of soya beans.	▪ Seek complementary funding/partnerships	HKI	2008
7. Accelerate the planned training of CHWs in ENA to support the dissemination of messages in communities covering the entire health facility catchment area	▪ Train CHWs in ENA/BCC	HKI	2008
8. The project should implement strategies already identified to follow up and support CHWs, i.e. participate in outreach activities being carried out by the health facilities every month	▪ Supervise CHWs during outreach efforts	In-Charge, HKI Supervisors, Matrons, Vaccinators	Continuous (following training)
9. Increase advocacy with Community Associations (ASACO's) and mayors to get them to invest more resources for nutrition activities	▪ Organize advocacy meetings	District, HKI Supervisors	Continuous
10. Involve the ASACOs and mayors office during supervision activities	▪ Meet with Mayors and ASACOs during supervisions	Supervision teams	During each supervision

11. Mobilize additional resources to adequately support the radio program component	▪ Revise/reallocate project budget	HKI-with USAID approval	June 2008
12. Train additional radio agents to support and strengthen existing radio programs	▪ Provide training and refresher to radio broadcasters	HKI	Continuous
HEALTH FACILITY LEVEL (CSCOM)			
1.Encourage the mayors office, the communities and their partners to ensure the support of outreach activities	▪ Advocacy with mayors and other local authorities for funds to support nutrition outreach services	HKI, District Health Office	Beginning May 2008
2. It would be a good idea for the project to provide health facilities with the materials, i.e. utensils to be able to conduct cooking demonstrations	▪ Provide cooking equipment to CSComs for cooking demonstrations	HKI	May 2008
3. The project needs to collaborate with the districts to ensure that new staff receive training in ENA	▪ Train newly recruited health staff in ENA	HKI, National and Regional Health Directorates	May 2008
4. The project should ensure the completion of training for health personnel in the Nara and Kolokani districts emphasizing feeding during childhood illness and maternal nutrition.	▪ Complete ENA training of health staff in Nara and Kolokani	HKI, National and Regional Health Directorates	July-Sept 2008
5. Strengthen collaboration with grandmothers as key to the adoption of new nutritional practices in the household.	▪ Organize formal discussion groups of Muso Koroba* ▪ Organize monthly discussion groups with Muso Koroba	HKI, CSComs HKI, CSComs	
6. Encourage sharing and exchange between matrons on experiences and strategies related to collaboration with grandmothers.	▪ Facilitate sharing of experiences of matrons successfully working with Muso- koroba	HKI/District	May –June 2008

*Muso Koroba in the local language means grandmother

DISTRICT LEVEL			
1. Ensure that funding is allocated for joint supervision of the nutrition interventions	▪ Make resources available to the district team so that they can organize supervision visits	HKI, District	Starting August 2008
REGIONAL LEVEL			
1. Support joint supervision missions with the regional health team twice a year	▪ Make resources available to the regional team so that they can organize supervision visits	HKI, Region	Starting August 2008
2. Strengthen the collaboration with the regional team on the management of project activities	▪ Make resources available to reinstitute quarterly Coordination meetings between the region and its partners ▪ Joint planning and implementation of supervision and training activities ▪ Participation of project staff in bi-annual monitoring meetings and annual planning. ▪ Share reports and information on activities	HKI, Region	Starting August 2008 May 2008 May 2008
NATIONAL LEVEL			
1. Accelerate the availability of the Vitamin Mineral Complex through enriched flour.	▪ Continue negotiations with WFP to support the availability of complex vitamin mineral from the national nutrition division team.	HKI, Nutrition Division	Starting August 2008
2. Strengthen the collaboration with the national nutrition division on the management of project activities	▪ Make resources available to organize supervision visits with a representative ▪ Share reports and information on activities	HKI, Nutrition Division	Ongoing
3. Be proactive as a member of the Nutrition Working Group to stimulate increased products and investment in the fight against malnutrition and micronutrient deficiency.	▪ Pursue the collaboration with Nutrition Division and others stakeholders working in nutrition	HKI, Nutrition Division, NGO's	Ongoing

HKI MANAGEMENT			
1. Develop posters on ENA to display at CSComs.	▪ Work in collaboration with the Division of Nutrition to produce updated posters and distribute to 9 districts and all CSComs	HKI	October 2008
2. Accelerate the production and dissemination of remaining ENA counseling cards for service providers	▪ Complete design and production and distribute to 9 districts and all CSComs.	HKI	August 2008
3. Redistribute the supervisory allocation of CSCOMS in the Kati district to balance out workload for project supervisors	▪ Review and reallocate HFs between the project supervisors of Kati, Ouelessebougou and Kangaba	HKI	May 2008
4. Advocate for increased MOH responsibility in the provision of Vitamin A to maintain the high levels of coverage achieved, as part of the phase-out strategy in 2009.	▪ Pursue advocacy at all level	HKI	May 2008
5. Strengthen project staff capacity for using project-related data for management and decision-making	▪ Identify staff HKI/Mali or AFRO to mentor staff in lacking skills	HKI	Sept 2008
6. Review and follow-up on the QA recommendations developed during the 2007 workshop and adapt and implement with the regional and district teams as needed and feasible.	▪ Insert QA activities in the ToR of the joint supervision ▪ Conduct regular joint supervision	HKI/ Regional Directorate of Health/ CSRef	Sept 2008
7. Follow-up on the potential for involvement and collaboration in the malaria, vitamin A and zinc regional research project.	▪ Pursue collaboration with MRTC (Malaria Research Training Center) to conduct the study	MRTC/ HKI/ Nutrition Division	Aug 2008

Matching and Complementary Funding

Donor	Budget	Period	Title	Region of Mali
USAID/Office of Foreign Disaster Assistance (OFDA I)	$169,886	10/2006 – 9/2007	Capacity Building for preventing and treating Malnutrition in the Sahel Burkina Faso, Mali, Niger	Health districts of Nara and Kolokani
OFDA II (cost extension)	$420,637	10/2007 – 9/2008	Capacity Building for preventing and treating Malnutrition in the Sahel Burkina Faso, Mali, Niger	Health districts of Banamba, Koulikoro, Kangaba, Kati and Ouelessebougou
USAID	$1,052,305	1/2004-3/2008	Communications for Development	National
USAID through Abt	$505,442	10/2003-9/2008	National Technical Assistance (ATN)	National
The Richard and Rhoda Goldman Fund	$40,000	3/2007-3/2008	Community Therapeutic Care for Treatment of Malnutrition	Koulikoro Region
Monsanto Foundation	$399,485	6/14/2007 6/13/2010	Community Therapeutic Care for Treatment of Malnutrition	Kolokani and Nara districts in Koulikoro
Micronutrient Initiative	$347,380	3/2005-5/2008	National Vitamin A Supplementation for Child Survival	National

UNICEF provides in kind therapeutic foods: F100 (169 Cartons), F75 (46 Cartons), Plumpy-nut (138 Cartons), growth monitoring materials kits (33)

WFP provides in kind food: CSB 178.4 tons; Cooking oil 17.85 tons

IV. ATTACHMENTS

A. Baseline information from the DIP

Progress to date has not been measured against the baseline.

B. KPC survey for MTE

No KPC conducted

C. Evaluation Team Members and their titles

Evaluation Team Members
Marguerite Joseph, external consultant
Jennifer Nielsen, HQ Technical Advisor
Mrs. Diakite Maimouna, Koulikoro region
Dr. Tera Sinaly, National Nutrition Division
Mr. Kassoum Kone, Ministry of Social development koulikoro
Dr Sanagaré Anne Marie, Project Coordinator
Mr. Zoumana Berthe, Deputy Project Coordinator
Daniele Nyirandutiye, Fellow

D. Evaluation Assessment methodology

The evaluation was led by an external consultant with the assistance of the headquarters technical backstop. MOH partners also participated as evaluation team members, per the above list. The external evaluator and headquarters backstop person conducted all of the staff and higher level partner interviews. The team split into two groups and conducted FGDs and key informant interviews at the health facility and community levels, targeting health service providers, ASACOs (HF Management committees), women, men, village chiefs, mayors and the rural radios. A total of 4 out of the 9 districts were selected for the above, with an evaluation criteria included whether there was the integration of CTC, (Kolokani,) Distance and accessibility issues (Nara), a balance of top performing and not, a sample of urban as well as rural.

MTE Evaluation Schedule:

March/April	Day	Activity
Sunday 23rd		• Late evening arrival of Marguerite and Jennifer in Bamako
Monday 24th	Day 1	• Discuss/Finalize MTE schedule with country team, including interview schedule. • Planning for field visits/identification of sample sites and constitution of teams for field visits • Finalize interview schedule (confirm interviewee availability etc); • Gather additional project documentation (assessments, staff trainings, partner trainings, quantitative data etc);
Tuesday 25th	Day 2	• Finalize planning and coordination with partners/participants • Project Staff interview begins
Wednesday 26th	Day 3	• Interviews with project staff continue • Work on draft questionnaires
Thursday 27th	Day 4	• Interview with regional health team in Koulikolo • Interview with country office staff • Finalize draft questionnaires (Marguerite/Jen)
Friday 28th	Day 5	• Meeting with USAID, ATN 8:30 am • Orientation meeting for MTE team (9:30 am): review choice of sites, field schedule, draft interview questionnaires etc.) • Meeting/Interview with MOH Nutrition Division (4 pm)
Saturday 29th	Day 6	• Interview with Project Supervisors • Prepare team packages for field visits • Interview with Project Coordinators continue
Sunday 30th	Day 7	• Departure to Nara (Team 1) et Dioila (Team 2)
Monday 31st	Day 8	• Work in Nara (Team 1); Work in Dioila (Team 2)
Tuesday 1st	Day 9	• Complete Nara/Dioila work, and travel to Kolokani (Team 1) and Kati (Team 2)
Wednesday 2nd	Day 10	• Work in Kolokani (Team 1) and Kati (Team 2)
Thursday 3rd	Day 11	• Complete work in Kolokani and Kati, and travel back to Bamako
Friday 4th	Day 12	• Feedback from teams on field visits; Analysis/discussion • Action Plan Development begins
Saturday 5th	Day 13	• DAY OFF
Sunday 6th	Day 14	• Translation of action plan, key findings, recommendations • Consultant prepares final presentation for stakeholders
Monday 7th	Day 15	• Presentation of MTE findings to USAID and stakeholders. • Consultant Departs

MTE SAN +
Focus Group/Interview Discussion

Women

1. Do you know the HKI project? If yes, what do you know about the project?
2. Do you know the health workers? If yes, what do they do? What type of contact do you have with each of them?
3. Have you heard health messages? What messages and through what channels have you heard them? (Asked them to repeat messages that they have heard)
4. What do you think of the messages you have heard on the radio? (Try to understand if they were influenced to change their behavior)
5. Do you know the advantages to regular hand washing with soap? If yes, what illnesses would a mother avoid if she were able to put this into practice?
6. What do you give your children during an episode of diarrhea?
7. Do you and your children sleep under an insecticide treated net?
8. Have you noticed any change in the area of hygiene and sanitation since the beginning of the project? (What changes?)
9. Have you noticed any changes in service provision in the health facility? (What type of changes have you noticed?)
10. Did you immediately breast-feed after delivery? If yes, why? If no, why not?
11. In your opinion, what does a child need to keep this and drink during the first six months of its life?
12. Do you know the foods rich in micronutrients (Vitamin A and iron) that are appropriate for young infants between the age of six and 24 months? Give examples.
13. Do you know the advantages to child weighing?
14. In the area of nutrition have you noticed any change in behavior amongst the women in your community?

Men

1. Do you know the HKI project? If yes, what do you know about the project?
2. Do you know the health workers? If yes, what do they do?
3. Do you have contact with these individuals? If so what type of contact you have with them?
4. Have you heard health messages? What messages and through what channels have you heard them? (Asked them to repeat messages that they have heard)
5. What do you think of the messages you have heard on the radio? (Try to understand if they were influenced to change their behavior)
6. Have you discussed these messages with your wives? With other people? What subject did you discuss?
7. Do you know the foods rich in micronutrients (Vitamin A and iron) that are appropriate for young infants between the age of six and 24 months? Give examples.

8. Do you know the advantages to regular hand washing with soap? If yes, what illnesses would a mother avoid if she were able to put this into practice?
9. Have you noticed any change in the area of hygiene and sanitation since the beginning of the project? Have there been other types of changes? (Example: child feeding?)
10. As a father, what he you do to ensure the health of your wife and children?
11. Do you know the advantages to child weighing?

Local Authority/Village Chief/Mayor

1. Do you know the HKI project? If yes, what do you know about the project?
2. Have you heard health messages? What messages and through what channels have you heard them? (Asked them to repeat messages that they have heard)
3. What do you think of the messages you have heard?
4. As a local authority in your community, what role do you play in supporting health for this community?
5. Have you created a budget line item for nutrition in your annual health budget? (Question only to mayors).
6. In your village, what do men do to support the health of children?

Community Health Associations (ASACOs)

1. Do you know the HKI project?
2. What is your relationship with the HKI project?
3. What do you think of the partnership between HKI and the ASACO?
4. What is your opinion of the activities that you have participated in (presentation of the project, advocacy workshops)?
5. What are the activities that you undertake? With what frequency do you undertake these activities?
6. Does the health facility worker undertaken activities at the community level? If yes, what?
7. In your opinion, what are the achievements of the project?

Health Center staff

1. What are the tasks related to nutrition that you undertake every week/month?
2. Did the training that you received through the project help you fill your job responsibilities? If yes how?
3. In your opinion, what added value has the project for CTC provided? (Only ask Nara and Kolokani interviewees).
4. How many times have you been supervised or visited this year? (By HKI/district?), what did you think of the supervision/visits?

5. What do you think of the nutrition messages by the project? (ENA - exclusive breast-feeding, complementary feeding).
6. How do you conduct a counseling session with a client? (Example to promote exclusive breast-feeding).
7. What do you do to encourage good performance alone health staff at the health facility? (Ask health center heads only)
8. What do you do to encourage behavior change in nutrition with your clients? (Ask rural midwives).
9. How does the drug supply system work (specifically for the supply of micronutrient's such as vitamin A, iron folic acid, zinc and iodine kits)? Do you have problems with stock out?
10. What relationship do you have with the women's associations? Women leaders?
11. What do you think of working with the grandmothers to promote good nutrition practices?
12. What motivates you in your work? What are the difficulties that you encounter in your work/activities?
13. The HKI project ends in September 2009. In your opinion without the support of the project, will the nutrition promotion and services be given the same importance as they have now?
14. In your opinion, what are the changes in behavior that can be attributed to the project?
15. What are your recommendations for the second half of the project?

Community Radio

1. What do you think of the HKI project?
2. Did the training that you received from the HKI project of an impact on your services? If yes how?
3. What do you think of the nutrition and health messages?
4. How often were you able to defuse the messages? (Ask for the diffusion schedule).
5. What kind oh of response from the community have you noted? (Including behavior change)

District health team

1. Is nutrition taken into account in the annual operation plan of the districts? If yes, do you have a budget associated with this plan?
2. In your opinion, what has been the impact of the HKI project on service provision?
3. Has the project had an impact on the capacity building of the district personnel? If yes how?
4. In the context of the limited budgets of HKI and the district, in your opinion, what should the project and other partners to accelerate community mobilization for

behavior change in the area of nutrition? (Could grandmother as and community groups play an important role
5. In your opinion, have there been any changes in health worker performance as a result of the project?
6. What do you do during supervision to ensure the quality of this activity? Do you use tools for this? What are the difficulties that you encounter in implementing supervision?
7. What is your system for monitoring MCH activities? Do you use tools for this? What of the difficulties that you encounter in implementing monitoring activities?
8. How is the supply system for micronutrients (vitamin A, iron folic acid, zinc, iodine kits) working? Do you encounter stock outs?
9. What type of collaboration do you have with the HKI supervisor? (Do you have joint activities? Is there exchange or sharing of information?)
10. What are the recommendations for the second half of the project?
11. The HKI project ends in September 2009. In your opinion without the support of the project will the nutrition promotion and services be given the same importance?

Regional health team

1. Is nutrition taken into account in the annual operation plan of the districts? If yes do you have a budget associated with this plan?
2. In your opinion, what has been the impact of the HKI project on nutrition services? All and other elements of health services? Did the HKI project's have an influence on you way of promoting nutrition? If yes how?
3. Has the project had an impact on the capacity of the regional personnel? If yes how?
4. As a project had an impact on the capacity of personnel in the nine districts? If yes how?
5. In your opinion, have there been any changes in health worker performance as a result of the project?
6. What is your system for supervision and monitoring? What of the difficulties that you encounter in implementing these activities?
7. What are the recommendations for the second half of the project?
8. The HKI project ends in September 2009. In your opinion without the support of the project will the nutrition promotion and services be given the same importance?

Project Supervisors

1. What are the tasks that you undertake every week/month? What relationship do you have with the districts and the health facilities?
2. Did the training you received from the project help you in filling your job responsibilities? If yes how? If no, why not?

3. What easy to encourage improvement in service provision of the health facility? For example education sessions, growth monitoring, counseling?
4. In your work do you have the opportunity to encourage behavior change amongst members of the communities? If yes, how? If no, what prevents you from being able to do this?
5. What relationship do you have with women's associations? Women leaders?
6. What do you think about the idea of working with grandmothers for the promotion of good nutrition practices?
7. In your opinion, considering the current realities of the project, is there any way to work more with community members for the promotion of good nutrition practices?
8. In your opinion, what are the changes in behavior due to the project?
9. How often have you been supervised this year? What did you think of the supervision visits that you had?

E. List of persons interviewed and contacted

Koulikoro Regional Health Team

Dr Bakary KONATE
Dr Sidiki Kokaina – UNICEF, Koulikoro
Oumane Toure

CSCom heads - Dioila District
Moussa TRAORE CPM du CSCOM de Nantjila
Dr Ousmane Moussa TRAORE CPM du CSCOM de Banco
Brehima FOMBA CPM du CSCOM de Wacoro
Dr Soumaila Ballo CPM du CSCOM de N'Golobougou
Mohamed EL HAIDARA CPM du CSCOM de Kola

District Health Team - Dioila
Arafa Toure
Kadiatou Coulibaly
Mohamed D. Diakite
Siratigui K Diallo
Dr Abdoulaye Guido
Youssouf Tangara
Seydou Diarra

CSCom - Banco
Kalifa Fomba
Kalifa Mallé
Rokiatou Marico
Guimbala Keita
Nianantigui Marico
Mariam Mallé

CSCom Heads - Kati District
Dr Fousseyni Coulibaly - N'Gourouba
Tamba Konate - Moutougoula
Dr Ousmane Diarra - Sangarebougou
Abdoulaye Tianka- Safo
Dr Koké Diakite - Dialakorodji
Mamadou Camara - Neguela

District Health Team - Kati
Dr Amadou Coulibaly
Mme Coulibaly Simone Dembele
Dr Kouyate Fatoumata Diarra
Dr Maiga Sagadatou Maiga

CSCom - Malibougou
Mme Camara Debi
Oumou Diarra
Mme Camara Fatoumata
Fatoumata Doumbia
Mme Kone Korotoumou

CSCom - Siby
Mme Diarra Nana Camara

District Health Team - Nara
Dr DIARRA Dji Boubacar

CSCom - Dilly
Mr Maiga
Aly Toure

CSCom - Goumbou
Daouda Diallo
Aicha Traore
Brianthé Traore
Maya Doucoure
Fatoumata Kone
Aissa Kamissoko

Radios stations:
Radio de Dilly
Radio de Nara
Radio de Kolokani

SAN+ Supervisors
Coumaré Kadiatou Sanogo - Fana
Moussa Koné - Kangaba
Fama Konolo- Koulikoro
Amanatou Traoré -Ouélésseboug ou
Mamadou Keïta- Kati
Fakoro Koné- Banamba
Kalifa Soumaro- Kolokani

Management and SAN+ Senior staff
Marjon Tuinsma - Country Director
Dr Sanagaré Anne Marie - Project Coordinator
Zoumana BERTHE - Deputy Project Coordinator
Daniele Nyirandutiye, Fellow
Note: The above list is not exhaustive of all interviews conducted at the CsCom and community level.