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ACTION AGAINST HUNGER

INTEGRATED FIGHT AGAINST CHRONIC MALNUTRITION IN MALI

STUDY AND CAPITALISATION REPORT

Women's empowerment: an integrated approach to reducing chronic malnutrition in rural areas.

This **capitalisation** document, entitled **«Women's empowerment: an integrated approach to reducing chronic malnutrition in rural areas»**, is the result of collective work carried out with a view to learning, evaluating and promoting the experiences gained from implementing the **«Integrated Fight Against Chronic Malnutrition in Mali» project, funded by the Government of Canada**.

This document was prepared by **Action Against Hunger (ACF) Spain, Nutrition and Health Department, Technical Engineering Division**, in collaboration with the working group set up specifically for this purpose, the technical and operational teams, and the implementing partners, whose high-quality contributions, ongoing involvement and participation in successive reviews structured and enriched the entire capitalisation process.

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ACRONYMS AND ABBREVIATIONS

ACF	Action Against Hunger
AMADECOM	Malian Association for Community Development
ANC	Antenatal Care
ASACO	Community Health Association
CGS	School Management Committee
COFERSA	Convergence of Rural Women for Food Sovereignty
CPN	Postnatal Care
CSCom	Community Health Centre
CSRef	Reference Health Centre
EBF	Exclusive Breastfeeding
ENA	Essential Nutrition Actions
FAO	Food and Agriculture Organization
FP	Family Planning
FSL	Food Security and Livelihoods
GSAN	Nutrition Support Group
HDDS	Household Dietary Diversity Score
ICCM+	Integrated Community Case Management of Childhood Illnesses, including malnutrition
IYCF	Infant and Young Child Feeding
NGO	Non-Governmental Organisation
PDSEC	Social, Economic and Cultural Development Plan
PLW	Pregnant and Lactating Women
RGPH	General Population and Housing Census
SDG	Sustainable Development Goal
SLIS	Local Health Information System
SMART (SURVEY)	Standardised Monitoring and Assessment of Relief and Transitions Survey
SRH	Sexual and Reproductive Health
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VSLA	Village Savings and Loan Associations
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization

DEFINITIONS

Acute Malnutrition (Wasting):	Acute malnutrition, or emaciation, results from a recent and severe nutritional deficit. It manifests as low weight for height and/or bilateral oedema, and is measured by weight-for-height < −2 z-scores, upper arm circumference <125 mm, or the presence of oedema (WHO, 2023).
Advanced strategy:	A method of delivering primary health care that involves regularly sending a team from the CSCom (Community Health Centre) to remote villages. It ensures that essential care and services such as vaccination, nutritional monitoring, prenatal and postnatal consultations, family planning and health awareness-raising are provided directly at the community level [1].
Antenatal Care (ANC):	Medical monitoring of pregnant women throughout their pregnancy, aimed at protecting their health and that of the foetus, preventing and treating complications, and preparing for a safe delivery. The WHO recommends at least eight prenatal visits for a normal pregnancy. However, in Mali, the national protocol maintains the standard of a minimum of four essential ANCs, the first of which must be carried out during the first trimester of pregnancy, ideally before the 12th week of amenorrhoea (i.e. before three months of pregnancy).
Assisted delivery:	Childbirth attended by skilled personnel with the aim of reducing the risk of death/complications for a woman or her child during childbirth [2].
Chronic malnutrition:	A complex, chronic and cumulative condition that generally arises from conception and during the first months of life and manifests itself as stunted growth and development in children. A child is considered to be stunted or chronically malnourished when, during the first years of life, their height for age is more than two standard deviations below the median of the WHO child growth standards (height/age < −2 Z-score) [3].
Double burden of malnutrition:	The coexistence of undernutrition and overweight/obesity or other diet-related non-communicable diseases within the same individual, household, community or population [4].
Essential nutrition actions (ENA):	Priority nutrition and health intervention package, implemented in Mali through the health system and communities. These include the promotion of breastfeeding and young child feeding, micronutrient supplementation, vaccination, prevention and management of common diseases, hygiene, and early detection of malnutrition.
Family planning (FP):	Comprises the information, practices and services that enable individuals and couples to decide freely and responsibly on the number, timing and spacing of their children. This is based on access to safe and acceptable contraceptive methods, with respect for sexual and reproductive rights. FP is a pillar of sexual and reproductive health (SRH) and an essential component of primary health care. It contributes to maternal, newborn and child health, the prevention of unwanted pregnancies and the empowerment of women [5].

Food and nutritional security:	Food security exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food to meet their dietary needs and preferences (FAO, 2009). However, this condition is not sufficient to prevent malnutrition.
	Nutritional security goes beyond food: it also requires access to quality health services, a safe sanitary environment (water, hygiene, sanitation) and appropriate care practices, particularly for women and children (ACF, 2021). Only when these dimensions are combined is it possible to effectively prevent malnutrition in all its forms [6].
Gender:	The socially constructed roles, responsibilities and norms between women and men that influence their access to resources, decision-making power and opportunities. Unlike biological sex, gender is a social construct and is subject to change. Gender mainstreaming involves transforming the norms and structures that perpetuate inequalities in order to promote real equality [7].
Infant and Young Child Feeding (IYCF):	All optimal practices for breastfeeding and complementary feeding of children aged 0 to 23 months, based on exclusive breastfeeding for up to 6 months, followed by the introduction of safe and appropriate foods, combined with continued breastfeeding for up to 2 years or more [8].
Malnutrition:	Insufficient, excessive or unbalanced intake of energy and nutrients. This includes undernutrition (acute malnutrition, chronic malnutrition, underweight, micronutrient deficiencies) as well as overnutrition (overweight, obesity and diet-related non-communicable diseases) (WHO, 2024) [9].
Postnatal Care (PNC):	Medical follow-up of the mother and newborn during the first six weeks after delivery. This helps prevent and treat potential complications, supports breastfeeding and family planning (FP), and ensures vaccination and the well-being of the mother-child pair. Mali's policy recommends four PNC consultations: the first immediately after delivery, the second between the second and third days, the third between seven and 14 days, and the fourth before the end of the sixth postpartum week.
Quality of care:	Safe, effective, person-centred, timely, equitable and efficient care that improves health outcomes and meets the expectations of individuals and communities [10].
Triple burden of malnutrition:	The coexistence of undernutrition, micronutrient deficiencies and overweight/obesity within the same population, household or individual [11].
Women's empowerment:	The process by which women acquire the means, skills and decision-making power to exercise their rights, access and control resources, and participate fully in society on an equal footing with men. According to ACF, this combines building self-confidence, expanding choices and transforming the structures that perpetuate inequalities [12].

[1] Republic of Mali, Ministry of Health and Public Hygiene. (2017). National Health Policy and Strategic Guidelines 2017–2021. Bamako.
[2] https://iris.who.int/bitstream/handle/10665/272434/WHO-RHR-18.12-fre.pdf. Accessed 16 October 2024
[3] ACF. (2023). Chronic malnutrition: framework for action for a preventive and multisectoral approach. Madrid: ACF
[4] WHO. (2017). The double burden of malnutrition: policy brief. Geneva: WHO
[5] WHO. (2020). Family planning/contraception methods. Fact sheet. Geneva: WHO.
[6] FAO. (2009). Rome Declaration on World Food Security. Rome: FAO. ACF. (2021). Technical Policy on Nutrition Security. Paris: ACF.
[7] ACF. (2022). International Gender Equality Policy. Paris: ACF International Network.
[8] WHO & UNICEF (2003). Global Strategy for Infant and Young Child Feeding. Geneva: WHO
[9] WHO. (2024, updated March). Fact sheet: Malnutrition. Geneva: WHO
[10] WHO. (2018). Delivering quality health services: A global imperative for universal health coverage. Geneva: WHO, OECD and the World Bank
[11] FAO, IFAD, UNICEF, WFP & WHO. (2023). The State of Food Security and Nutrition in the World 2023. Rome: FAO
[12] ACF (2019). Gender Policy. Paris: ACF.


Source: © Action Against Hunger – Mali Mission

EXECUTIVE SUMMARY

This capitalisation report analyses a multisectoral programme implemented in Mali (2021–2026) by ACF, AMADECOM (Malian Association for Community Development) and COFERSA (Convergence of Rural Women for Food Sovereignty). It is based on a central premise: **women's empowerment is a major determinant of nutrition and an essential lever for maternal and neonatal survival**. It focuses on three interconnected outcomes: Sexual and Reproductive Health (SRH) (Outcome 1), Nutrition/Water, Sanitation and Hygiene (WASH) (Outcome 2) and the economic empowerment of women producers (Outcome 3), with the aim of strengthening the agency of women and adolescent girls and breaking the intergenerational cycle of chronic malnutrition.

A specific measurement framework has been developed to analyse the interrelationships between these three outcomes. It combines, in a single chain of outcomes, indicators of empowerment for women and adolescent girls. These indicators include decision-making power within the household, secure access to land, control over income, and participation in community structures (Outcome 3); indicators of SRH, maternal and child health (Outcome 1); and nutrition/WASH indicators (Outcome 2), such as dietary diversity for women and children, infant and young child feeding (IYCF) practices, breastfeeding and access to essential services in gender-sensitive WASH environments. This framework allows us to observe how transformations in autonomy and power relations in favour of women create conditions conducive to the adoption of improved health, hygiene and nutrition behaviours within households.

The outcomes show that the most significant progress occurs when women have direct influence over household decisions. In these areas, the use of SRH services (modern FP, comprehensive PNCs, assisted deliveries) is increasing, along with an improvement in the dietary diversity of women and children and more regular adoption of hygiene practices. These dynamics are strongly correlated with the active participation of women in ASACOs (Community Health Associations), water management committees, VSLAs (Village Savings and Loan Associations) and producers' groups.

These transformations – increased decision-making power, improved health and nutrition behaviours – converge to bring about a tangible improvement in maternal and neonatal survival. They reflect the cumulative effect of women's empowerment, which promotes faster and more systematic use of essential services in the mother-child continuum, thereby reducing preventable obstetric and neonatal complications. The impact assessment based on improvements in SRH and maternal health coverage suggests that the programme helps save several dozens of maternal and neonatal lives per 100,000 inhabitants each year in the intervention areas.

Economic levers play a structuring role in this dynamic. Secure access to land, productive inputs, income diversification, and savings and credit mechanisms supported by VSLAs strengthen women's position in intra-household negotiations. Where women have greater control over resources, they have a more direct influence on health expenditure, food choices and service use, with visible effects on food security, dietary diversity and household resilience.

A key lesson emerges: **sustainable improvements in nutrition and maternal and neonatal survival depend not only on the availability of services or infrastructure, but also on women's actual ability to access and use them and to influence decisions that affect them**. The capitalisation exercise recommends consolidating this integrated model by institutionalising women's participation in local governance, sustaining a dashboard that combines empowerment and nutrition indicators, and embedding gender-sensitive nutrition in local policies and plans. It shows that gender equality and women's empowerment are not secondary outcomes, but **the central condition for the sustainable reduction of chronic malnutrition**.

1 CONTEXT AND JUSTIFICATION OF THE CAPITALISATION STUDY

Chronic malnutrition, or stunting, affects nearly a quarter of Malian children under the age of five, with critical rates particularly in Sikasso. This deficit compromises physical and cognitive development, increases the risk of mortality and reduces children's long-term potential.

Ranked 188th out of 193 on the Human Development Index (UNDP, 2022), Mali is facing a multidimensional humanitarian crisis, where structural poverty (78.1% of the population), civil insecurity (conflict, violence and population displacement) and chronic food insecurity intersect. The latter is twice as high in female-headed households, revealing the extent of gender inequalities.

The nutritional situation illustrates a triple burden: the coexistence of chronic malnutrition (24.8% of children under 5), acute malnutrition (notably 4.8% among pregant and lactanting women (PLW), with more than 8% in Kayes) and emerging overweight/obesity, aggravated by persistent micronutrient deficiencies. This combination particularly affects women and children and perpetuates an intergenerational cycle of malnutrition, especially during the first 7,000 days from conception to the end of adolescence, which includes the critical 1,000 days[1] for growth and adolescence as a second opportunity for action.

There are many causes: limited access to drinking water, sanitation and health services, inappropriate dietary practices, discrimination and unfavourable social norms. Girls, especially in rural areas, face multiple disadvantages related to their age, gender and location[2]. Their nutritional needs are often neglected (eating last, in smaller quantities). UNFPA/SWEDD data (2023) reveals an average age at first marriage of 16.6 years and a first pregnancy at 18.9 years; 44% of women give birth before the age of 18 and 13% before the age of 15, with an adolescent birth rate of 139 births per 1,000. Combined with a very high fertility rate (7.6 children per woman), these factors increase obstetric risks, low birth weight and vulnerability to malnutrition in children.

This observation fully justifies the choice of an approach focused on women's empowerment as a strategic lever for reducing chronic malnutrition. In Mali, less than 15% of women own agricultural land and their participation in household financial decisions is less than 30% (FAO, 2023), limiting their ability to influence food production, processing and consumption. Yet they account for more than 70% of national food production and, when they control household resources, they invest primarily in nutrition, health and education for their children [3] ,[4]. Strengthening their access to productive resources, decision-making power and economic opportunities is essential to breaking the intergenerational cycle of malnutrition and achieving food and nutrition security.

[1] The first 7,000 days correspond to the period from conception to the end of adolescence (≈ 20 years) and include the first 1,000 days, from conception to the child's second birthday.

[2] https://openknowledge.fao.org/server/api/core/bitstreams/5e389412-1d63-4d13-a746-49479c64b2dd/content. Accessed on 14 October 2024 at 4:15 p.m.

[3] https://www.onufemmes.fr/nos-actualites/2021/1/18/l-autonomisation-economique-des-femmes-et-la-reduction-de-la-malnutrition-chronique-un-cercle-vertueux.

[4] Appui à l'autonomisation des femmes rurales au Mali - GCP/MLI/062/MNC

To address these challenges, the **«Integrated Fight Against Chronic Malnutrition in Mali»** project (2021–2026), implemented by ACF with AMADECOM, COFERSA and the support of Global Affairs Canada, is working in four Health Districts (Kayes, Kita, Bafoulabé and Sikasso) to:

1. Improve equitable and autonomous access for women and adolescent girls to primary health care and SRH services.

2. Promote the sustainable adoption of adequate hygiene, sanitation and nutrition practices.

3. Strengthen the economic autonomy and decision-making power of women producers.

After four years of implementation, the project sought to better understand the impact of the actions and tools that were most successful in bringing about change. To this end, the following analytical exercises were carried out. A capitalisation study assessed the project's contribution to women's empowerment and the reduction of chronic malnutrition, through two main questions:

1. How does the project contribute to improving women's empowerment (decision-making, financial independence, ability to adopt)?

2. How does the project contribute to improving the nutritional status of women of reproductive age and reducing chronic malnutrition through improved empowerment?

The central hypothesis is that:

- **Access** to knowledge resources, WASH infrastructure and health services tailored to their needs facilitates the sustainable adoption of care, hygiene and feeding practices among women and families, which would help reduce chronic malnutrition.

- **Access** for women producers to agricultural and market-gardening resources (training and equipment) contributes to increasing economic resilience, women's empowerment and the food and nutritional security of families.

- Women's **control** over the management of their own income and their autonomous decision-making power over the allocation of resources within households for their health, nutrition and that of their children, as well as women's autonomous management of resources, are key levers for reducing chronic malnutrition.

2 OBJECTIVES

OVERALL OBJECTIVE

Analyse the contribution of the «Integrated Fight Against Malnutrition in Mali» project to the empowerment of women of reproductive age and the improvement of their nutritional status, including children and adolescents.

SECONDARY OBJECTIVES

Develop a framework for measuring the project's contribution to women's empowerment and the prevention of chronic malnutrition:

- Evaluating project actions that have strengthened women's empowerment through:

- Community awareness-raising (School for Husbands, Terikunda Jekulu, School for Mothers) for decision-making in SRH.

- Strengthening GSANs (Nutrition Support Groups) and installing adapted school latrines to promote sustainable practices in nutrition and WASH.

- Economic support for women producers (secure access to land, material and training resources, strengthening of VSLAs).

3 METHODOLOGICAL APPROACH TO CAPITALISATION

The capitalisation methodology was structured around three main stages:

1. **Establishment of a working group**

UA dedicated group, entitled *"Integrated Fight Against Chronic Malnutrition in Mali Project Learning"*, was set up to ensure a comprehensive and consistent vision for the project. This group brings together ACF staff from offices in Mali, Spain, France and Canada.

2. **Development of a measurement and contribution framework**

The group worked together to develop a specific framework for measuring the project's contribution to women's empowerment and the fight against chronic malnutrition. This methodological framework is based on the **theory of change** and the l**ogical framework** of the implemented project.

3. **Definition of the complementary survey design**

Based on this framework, the group designed a complementary survey to deepen understanding of the results, document lessons learned and strengthen the evaluation of the project's impact.

DEVELOPMENT OF THE MEASUREMENT AND CONTRIBUTION FRAMEWORK

Analysis of the logical framework: identification of results and activities related to women's empowerment (economic, social, skills building), then organisation according to a coherent theory of change.

Construction of the measurement and contribution framework: development of a theory of change linking these activities to the fight against chronic malnutrition through women's empowerment (Figure 1).

OBJECTIVE	IMPROVING THE NUTRITIONAL STATUS OF WOMEN OF REPRODUCTIVE AGE AND REDUCING CHRONIC MALNUTRITION		
	INCREASED WOMEN'S AUTONOMY		
INTERMED. OUTCOMES	**1100 Increased use of primary health services and SRH** (Women and adolescent girls)	**1200 Sustainable adoption of nutrition/WASH practices** (Women and girls)	**1300 Autonomy, decision-making power and economic resilience** (Women's groups, decision-makers)
IMMED. OUTCOMES	1110 Increased empowerment of women and adolescent girls in decision-making regarding the use of SRH and FP services	1210 Increased and equitable access to WASH infrastructure that addresses gender inequalities and complies with the national standard for infection prevention and control	1310 Increased capacity for autonomous production of high-nutritional-value foods by women and women's groups
	1120 Improvement in the quality of SRH services provided to women and adolescent girls in health centres	1230 Increased knowledge among women, men, girls and boys on gender-sensitive good nutritional practices, in consultation with women and in a manner that addresses gender inequalities	1320 Increased capacity of women's groups to independently manage the economic aspects of their production and marketing activities
			1330 Increased integration of gender, nutrition and crisis resilience into local and national development plans
KEY ACTIVITIES	1112 FP awareness-raising sessions for community leaders 1113 Terikunda Jekulu approach implemented at community level in coordination with CHWs to drive behavioural change in FP 1114 School for Husbands to encourage men to recognise the importance of access to SRH care for women and adolescent girls School for Mothers	1222 Awareness-raising sessions on good gender-sensitive WASH practices conducted with women, girls, men and boys 1232 Awareness-raising sessions on IYCF best practices with the participation of community relays, CHWs, GSANs, and CSCom and CSRef staff 1233 Sessions to disseminate recipes with high nutritional value based on local agricultural and market garden produce 1234 Capacity-building sessions for existing GSANs (technical and organisational support, and awareness-raising on gender issues) 1213 School latrines built/renovated (and awareness-raising sessions on their use and maintenance in schools)	1311-1314 Women's secure access to agricultural land, with: - Technical training - Donation of tools, agricultural equipment, seeds, etc. - Distribution of poultry and goats 1321-1322 VSLAs 1332 Advocacy sessions conducted with communities and local authorities, with the active participation of women's groups, to improve women's access to land Number of advocacy sessions held with local authorities 1333 Advocacy sessions at national level with the active participation of representatives of women's groups, to ensure follow-up on government commitments

Figure 1. Proposed measurement framework for analysing the contribution of key project activities and outcomes.

SELECTION OF INDICATORS:

analysis of existing indicators and definition **of additional indicators (in purple)** to strengthen the measurement framework and better document the project's contribution to the changes observed.

Outcomes	Indicators
Ultimate outcome (1000): Improvement in the nutritional status of children under 5 and PLW	• Prevalence of chronic malnutrition (height-for-age z-score 0 to 59 months) • Prevalence of acute malnutrition among PLW
Intermediate outcome (1100): Increased use of health services and SRH	• Percentage of use of modern FP methods (15–49 years) • Percentage of adolescent girls reporting their SRH/FP needs are met • Percentage of pregnant women with ≥4 ANCs • Percentage of PNCs within 24 hours • Percentage of PNCs before the 6th week • Percentage of women with 4 PNCs
Immediate outcome (1110): Increased empowerment to use SRH and FP services	• Percentage of women aged 15 to 49 making decisions about their own health care (alone or jointly with their spouse) • Percentage of women who know where to obtain modern contraception
Immediate outcome (1120): Improved quality of SRH services	• Percentage of births attended by skilled personnel • Number of health centres with free and permanent FP products • Percentage of women satisfied with SRH services • Percentage of women satisfied with primary health care services
Intermediate outcome (1200): Sustainable adoption of nutrition/WASH practices	• Percentage of children aged 0–5 months who are exclusively breastfed • Minimum dietary diversity for women (MDD-W) • Minimum dietary diversity – Children aged 0 to 59 months (IDDS-child) • Percentage of women deciding on children's nutrition/care • Percentage of women represented in ASACOs
Immediate outcome (1210): Increased access to WASH infrastructure	• Percentage of schools with separate latrines adapted for girls • Number of existing and functional CGSs (School Management Committees) • Percentage of women represented in CGSs • Percentage of women represented in water management committees
Immediate outcome (1230): Increased knowledge of gender-sensitive nutrition practices	• Percentage of adults (>15 years old) aware of specific nutritional needs of PLW/children <5 years old • Percentage of women represented in GSANs
Intermediate outcome (1300): Economic autonomy and resilience of women producers	• Percentage increase in average monthly income for women (from the production of agropastoral and market-gardening crops) • Percentage of women participating in household purchasing decisions alone or in consultation with their spouse • Number of production/harvests per crop • Use/distribution of production (self-consumption, sale, etc.) • Household decision-making index • Women's control over their income • Allocation of resources within households (f/m) • Percentage of households supported with adequate dietary diversity score
Immediate outcome (1310): Increased food production capacity by women and groups	• Percentage of women producers familiar with ≥3 market-gardening/small livestock production techniques • Number of women producer groups with access to secure land • Land access status for women's groups • Number of hectares owned by women's groups
Immediate outcome (1320): Autonomous economic management of production activities	• Percentage of women familiar with ≥2 marketing networks for market-gardening and/or small-livestock production • Percentage of women proficient in economic management tools • Percentage of women proficient in processing equipment • Number of people benefiting from women's economic empowerment projects
Immediate outcome (1330): Integration of gender, nutrition and resilience into local plans	• Percentage of municipalities including nutrition and gender in Social, Economic and Cultural Development Plans (PDSECs) • Percentage of women participating in local development committees • Number of local development committees with ≥30% women

Table 1. List of indicators (additional indicators in purple and those already measured within the project in black)

DATA SOURCES AND COLLECTION METHODS

The data used in the analysis was collected from primary and secondary sources to construct the indicators.

Primary sources:

A household survey and focus group discussions were conducted. In the household survey, the first part of the questionnaire (household characteristics) was completed by heads of households, and the rest of the questionnaire was addressed to women aged 15 to 49 with children under 5 years of age.

Finally, focus group interviews were conducted with women's groups, ASACOs, management committees, VSLAs and GSANs to collect qualitative data using interview guides. A total of 76 focus groups were planned.

Secondary sources:

A literature review was conducted to collect available data from the project since 2021 (the year the project started): baseline study, initial and midline KAP survey, reports on project operations and results. The latest SMART rapid survey (2024) in Mali and the registers of Health Districts and health facilities were also used for certain data.

COMPLEMENTARY STUDY DESIGN

The analytical framework provided for a descriptive cross-sectional study integrating both quantitative and qualitative data from primary and secondary sources. This mixed approach provided a more comprehensive and exhaustive understanding of the situation under study.

The study was conducted over a period of six months (September 2024 to March 2025). It drew on project intervention data collected over the past four years to analyse the progress and impact of the actions carried out as part of the project.

The study was conducted among beneficiary populations living in the programme's intervention areas in the Health Districts of Kayes, Bafoulabé, Kita and Sikasso in Mali (figure 2).

STUDY POPULATION AND INCLUSION CRITERIA

The study population included children under 5 years of age, women of reproductive age, women's groups, men, health centres, ASACOs and local elected officials in the four target districts. This selection aimed to cover the main targets of the project and to obtain an overview of the stakeholders involved.

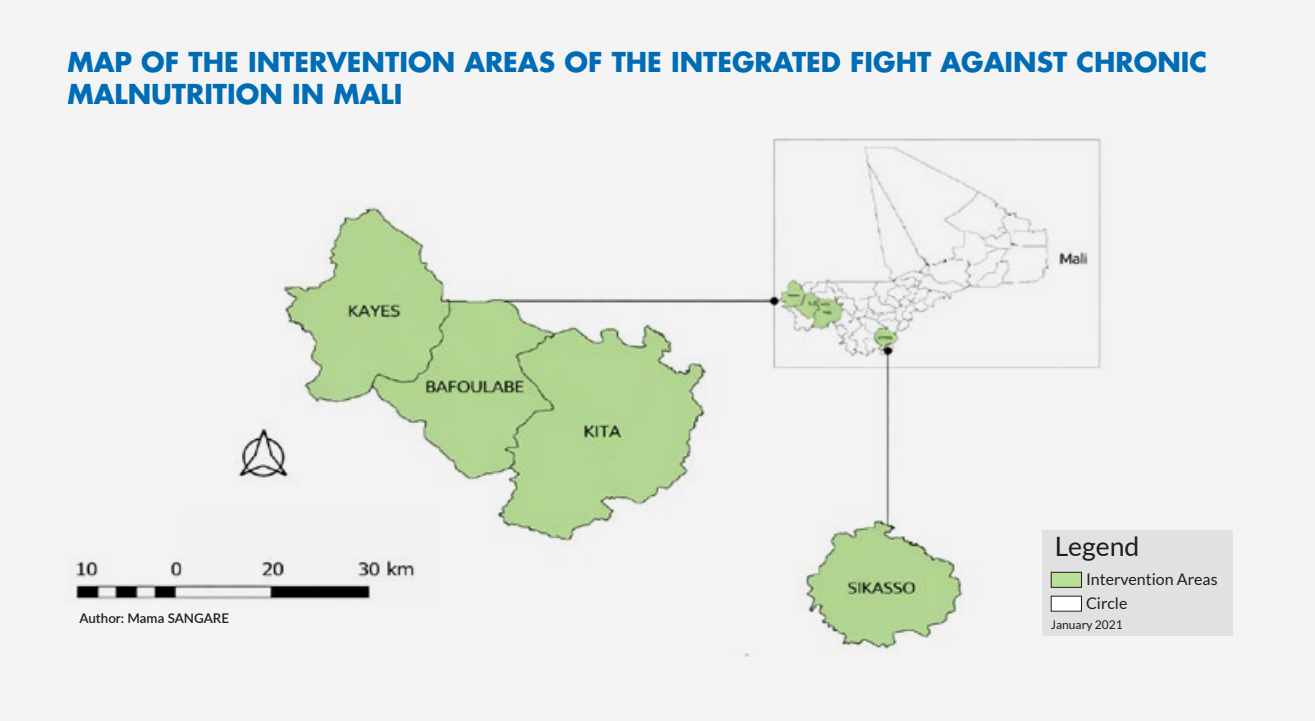

Figure 2. Map of the project's intervention areas.

SAMPLE SIZE

In order to determine the sampling procedure, two methods were used depending on the target groups. The first method concerns beneficiaries of health/nutrition and WASH activities, and the second method concerns beneficiaries of FSL activities.

Le nombre de ménages enquêtés est de 195 répartis entre les 4 districts d'intervention du projet selon la formule de Schwartz.

The number of households surveyed is 195, distributed among the four project intervention districts according to Schwartz's formula.

BENEFICIARIES OF HEALTH/NUTRITION AND WASH ACTIVITIES[5]

$$n = \frac{z^2 \times p(1-p) \times deff}{e^2}$$

n = sample size;

z = the value of the standard normal distribution with a given confidence level (here, z = 1.96 corresponding to a 95% confidence interval);

p = proportion of key variable sought (if unknown, it is set at 50%);

deff = the sampling effect due to the use of a multi-stage survey (here set at 2); and

e = the margin of error (here set at 10%).

Health District	Municipality	Village	Number of households
BAFOULABÉ	BAFOULABÉ	SORIYA	11
	KOUNDIAN	KAMA BAMBOUCK	10
	MAHINA	FATEA SAMEA	12
	NIAMBIA	KOULOUNGOULOU	11
	OUALIA	FANGALA	11
KAYES	KHOULOUN	SALLIAMBOUGOU	11
	LIBERTE DEMBAYA	KOBADA MEDINE	11
	SERO DIAMANOU	SERO	11
KITA	KOBRI	BANKO	11
	MAKANO	DIABALA	11
	SABOULA	DINDAN	11
	SEBEKORO	SOUNTY	12
SIKASSO	KAPOLONDOUGOU	MONKONKORO	9
	KLELA	MARO	10
	KLELA	ZERELANI	11
	LOBOUGOULA	M'BELLASSO	13
	LOBOUGOULA	ZIASSO	8
	ZANFEREBOUGOU	MAHADOUGOU	11
Total	**16**	**18**	**195**

Table 2: Details of the distribution of the number of households in the health/nutrition and WASH sample to be surveyed.

NB: A two-stage systematic random sampling technique was used to identify the households to be surveyed.

[5] These are the beneficiaries of health and nutrition activities, in particular the School for Husbands, Terikunda Jekulu, School for Mothers, beneficiaries of latrines in health centres and schools, and beneficiaries of community water points.

First stage: Primary units (villages) were selected by simple random sampling without replacement.

Second stage: In each selected village, secondary units (households) were identified by systematic sampling, using a sampling interval calculated on the basis of the total number of households and the number to be surveyed.

The RAND function in Excel was applied to the list of villages benefiting from FSL activities. A total of 143 households were surveyed, spread across the districts of Kayes, Bafoulabé, Kita and Sikasso.

BENEFICIARIES OF FSL ACTIVITIES

Beneficiaries were identified using a stratified random sampling technique. The sample size was estimated using the following formula:

$$Taille\ de\ l'échantillon = \frac{\frac{z^2 \times p(1-p)}{e^2}}{1 + \frac{z^2 \times p\,(1-p)}{e^2 N}}$$

Where:

n = population size (i) | **z =** reduced centred normal distribution value for a given confidence level (1.96 for a 95% confidence level)

p = estimated proportion of the vulnerable population is 50%; and **e =** the expected margin of error is 5%.

Health District	Municipality	Village	Number of households
BAFOULABE	GOUNFAN	BAI	6
	GOUNFAN	DONGO DATIAKA	6
	KOUNDIAN	MADINA GOUNGOU	6
	KOUNDIAN	SOLONKOTO	6
	MAHINA	FATEA SAMEA	5
	MAHINA	SANTANKOTO	6
	MAHINA	TAMARANA	6
	NIAMBIA	BOUNTOUN	5
	NIAMBIA	KOULOUNGOULOU	1
KAYES	BANGASSI	GUEMOU	6
	HAWA DEMBAYA	KEGNOU	6
	KHOULOUN	LOUPOUROU	6
	LIBERTE DEMBAYA	KOBADA MEDINE	6
BAFOULABE	MAKANO	DJEGUILA	6
	MAKANO	KARI	6
	MAKANO	SANANSABA	6
	SABOULA	BASSIBOUGOU	7
	SABOULA	SONSSON	5
KAYES	KAPOLONDOUGOU	MONKONKORO	9
	KLELA	DOUNA OUNA	11
	KLELA	ZERELANI	11
	ZANFEREBOUGOU	MAHADOUGOU	11
Total	**13**	**22**	**143**

A total of 143 households were surveyed across Kayes, Bafoulabé, Kita and Sikasso.

The sample selection, based on a double probabilistic sampling method, ensured adequate representation of households and key actors in the four districts studied. The approach, which combines a two-stage systematic survey for the health/nutrition/WASH components and stratified random sampling for FSL activities, ensures both statistical rigour and adaptation to the operational context. This approach produces reliable estimates with a 95% confidence level, while ensuring balanced coverage of the different target groups and intervention areas. It thus contributes to strengthening the internal and external validity of the study, minimising selection bias and allowing for the cautious generalisation of results to all project beneficiaries.

DATA COLLECTION AND ANALYSIS TOOLS

Quantitative data was collected using an electronic questionnaire on smartphones, via the ODK Collect/KoboCollect application, and then exported to Excel for processing and analysis. Univariate and bivariate descriptive analysis methods were used to highlight trends.

In addition, content analysis was applied to the qualitative data to facilitate interpretation.

ETHICAL ASPECTS

Once the protocol was approved, ACF in Mali informed local and regional health authorities and community representatives. The objective and methods of the study were explained to the participants. All participants had the right to refuse to take part in the study.

The study protocol was validated by the "Integrated Fight Against Chronic Malnutrition in Mali Project Learning" group.[6]

Declaration of conflicts of interest: The research team's sole interest is to contribute to improving the nutritional status of women of reproductive age and children under 5 years of age through the empowerment of women.

Each participant was asked to read the voluntary and informed consent form in its entirety and in their local language.

In terms of the risks associated with conducting the study, the main risk factors identified that could hinder its completion were as follows:

- The deterioration of the security situation (robberies on main roads, kidnappings, patrols by the Malian Armed Forces (FAMa)). To this end, ACF set up a permanent monitoring system to track developments in the security situation.

- Lack of access to certain areas due to the rainy season and flooding.

However, apart from the insecurity that led to the replacement of certain villages, no other risks hindered the successful implementation of the study.

LIMITATIONS OF THE STUDY

Despite the wealth of information collected and the rigorous methodology adopted, the study has certain limitations that should be highlighted:

- The replacement of certain localities initially targeted by the household survey due to insecurity and access difficulties.

- Lack of baseline data for certain additional indicators, making it difficult to analyse the progression or direct impact of the project on these variables.

- Lack of comparisons with control locations, which limits the possibilities for comparative analysis to reinforce the robustness of the findings.

These limitations do not affect the overall relevance of the results, but they must be taken into account when interpreting and using the data from the study.

CHARACTERISTICS OF THE EVALUATION AND SURVEY METHODS

Household survey:

The specific quantitative survey was conducted among 301 households. In each household, the first part of the questionnaire (household characteristics) was submitted to the heads of household, then the rest of the questionnaire was presented to women aged 15 to 49 with children under 5 years of age.

A total of 602 people were interviewed. In the sample as a whole, the majority of heads of household are men, with

[6] Group composition: Experts and technical staff in health and nutrition, FSL, WASH, advocacy and gender, project monitoring, and monitoring and evaluation from ACF Mali, Spain and Canada.

a ratio of 297 men to 4 women. The majority of these heads of household (45%) are aged between 50 and 65.

In the households surveyed, polygamy is the dominant form of marriage, particularly in Sikasso (82%). The number of widows and divorcees is very low.

Agriculture remains the main economic activity of heads of households in all Health Districts, with very high percentages (between 95% and 98%).

In demographic terms, the average number of women per household is four overall. At the district level, the average number of women is four per household in Kayes and Kita, compared to three in Bafoulabé and two in Sikasso. Children aged 0 to 5 years old represent an average of more than five (5) children per household. There are on average two adolescent girls per household.

The largest number of respondents to the survey was recorded in the Bafoulabé Health District, with 102 households surveyed and 202 people interviewed, including 102 women. By contrast, the smallest sample was in the Kayes DS, with 51 households surveyed and 101 people interviewed, which has the lowest number of participants among the four Health Districts studied.

Focus groups:

The qualitative part consisted of 76 focus groups of 6 people each, for a total sample of 456 people, including 304 women, spread across the four districts covered by the project.

The people interviewed in these focus groups have the following characteristics (leaders and members of agricultural and market-gardening groups, members of CGSs, VSLAs, local elected officials, members of ASACOs, members of CGPE (Community Water Point Management Committees), leaders of CGSs, and members of GSANs).

Multisectoral survey:

The capitalisation study was based on the results of internal multisectoral surveys conducted between March and August 2024, covering all areas of the project's scope. In order to supplement this data and provide information for the additional indicators included in the measurement framework, a household survey complementary to the initial project (as mentioned above) was conducted in December 2024 in the Health Districts of Kayes, Bafoulabé, Kita and Sikasso, among a representative sample of beneficiary households.

At the same time, a series of individual interviews and focus group discussions were conducted with various stakeholders: women aged 15 to 49, children under 5 years of age, PLW, adolescent girls, women's groups, health workers, municipal authorities, GSANs, CGPEs, ASACOs and CGSs.

Finally, data from regular project monitoring was also included in the analysis to strengthen source triangulation and ensure a comprehensive understanding of the effects and changes observed in the intervention areas.

4 OUTCOMES

The outcomes are presented according to the structure of the theory of change, based on three axes, and the outcomes of each axis's scope of application are represented:

1. Use of primary health care and SRH services (immediate outcome 1100).

2. Sustainable adoption of adequate nutrition and WASH practices (immediate outcome 1200).

3. Women's autonomy, decision-making power and economic resilience (immediate outcome 1300).

01. USE OF PRIMARY HEALTH CARE AND SRH SERVICES (OUTCOME 1100):

Outcome 1100 is the project's first intermediate outcome. Access to and use of basic health services, particularly SRH services, which are an essential lever for improving the health of women and children, while contributing to the reduction of chronic malnutrition.

In this context, the project has implemented several awareness-raising activities designed to improve access to information, women's decision-making power and ef-

INCREASED USE OF PRIMARY HEALTH SERVICES AND SRH (1100)	
(Women and adolescent girls)	
Increased empowerment of women and adolescent girls in decision-making regarding the use of SRH and FP services (1110)	Improvement in the quality of SRH services provided to women and adolescent girls in health centres (1120)
KEY ACTIVITIES	
• FP awareness-raising sessions for community leaders • Terikunda Jekulu approach implemented at community level in coordination with CHWs to drive behavioural change in FP • Schools for Husbands to encourage men to recognise the importance of access to SRH care for women and adolescent girls • School for Mothers	

Figure 3: Overview of activities for outcome 1100.

fective use of health services. The number of people who participated in the activities is as follows:

- ***FP awareness-raising sessions*** for community leaders: during the project, 1,309 community leaders (68% – 887 men and 32% – 422 women) participated in the promotion of FP and/or SRH care.

- ***Terikunda Jekulu approach***[7] at community level, in coordination with CHWs to drive behavioural change in FP: 12,160 FP sessions were held with 142,327 participants (38% – 53,956 men and 62% – 88,371 women).

- ***Schools for Husbands*** to encourage men to recognise the importance of access to SRH care for women and adolescent girls, with awareness raised among 139,225 male heads of household.

- ***Schools for Mothers*** to strengthen women's knowledge and decision-making power in FP and SRH, with a total of 4,628 participating mothers.

Immediate Outcomes

Increased empowerment of women and adolescent girls in decision-making regarding the use of SRH and FP services (1110):

The findings show an improvement in women's decision-making autonomy regarding health (Figure 4). The proportion of women aged 15 to 49 who report making decisions about their own healthcare, either alone or jointly with their spouse, increased from 4% at baseline to 23% at midline (n=228). Despite this notable progress, the vast majority of decisions continue to be made by the husband or another male member of the household. This dependence on male decision-making still limits women's ability to access care and fully exercise their health rights.

Regional disparities are apparent: autonomy is particularly low in Sikasso (18%), while Kita (38%) and Kayes (35%) show higher levels, but still remain in the minority. These differences suggest that local social and cultural norms strongly influence women's ability to make decisions for themselves.

This finding is all the more striking given that services are widely available: 98% of women report the existence of a FP service[8] in their health area. In other words, the main barrier is not physical access to services, but rather women's decision-making power to use them.

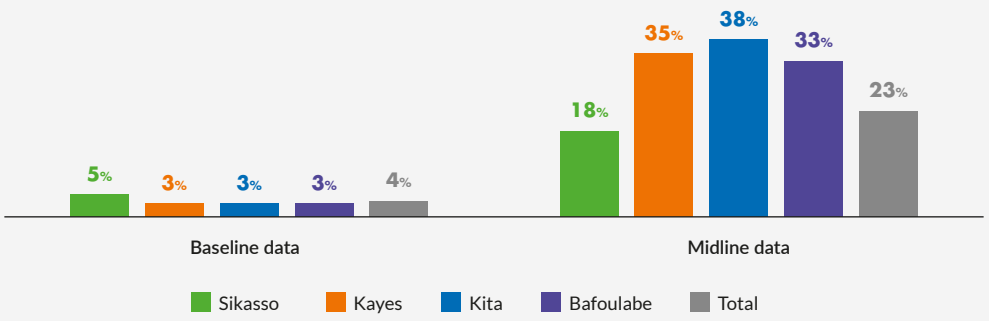

Figure 4: Percentage of women aged 15 to 49 who make decisions about their own health care either alone or jointly with their spouse (n=228). Source: multisectoral household assessment survey.

[7] Terikunda Jekulu is a participatory community-based approach that relies on peer groups (men, women, leaders, young people) to transform social norms that limit women's and adolescent girls' access to SRH, FP and maternal health services.

[8] The contraceptive methods offered by FP services in Mali include modern methods (pills, injections, implants, IUDs, condoms) and natural methods, all of which are recognised by the WHO and international FP guidelines. The latter include the calendar method (a method based on knowledge of fertility) and the LAM method (Lactation Amenorrhoea Method), which is only effective when breastfeeding is exclusive, postpartum amenorrhoea persists, and the child is less than six months old. Natural methods require individualised advice, as their effectiveness depends heavily on the conditions of use and they must generally be supplemented by a modern method.

Improvement in the quality of SRH services provided to women and adolescent girls in health centres (1120):

Availability, use and free provision of supplies and services:

The use of modern FP methods has increased. While initially only 28% of women aged 15 to 49 used them, now an average of 66% use them. This trend reflects the growing adoption of modern methods, even though non-modern methods remained in use (33%).

Regional disparities are apparent: Sikasso has the highest use of modern methods (84%), followed by Bafoulabé (64%) and Kayes (61%), while Kita lags behind with only 50% of users. By contrast, the use of non-modern methods remains particularly high in Kayes (39%) and Kita (36%), reflecting different local dynamics in the uptake of services (Figure 5).

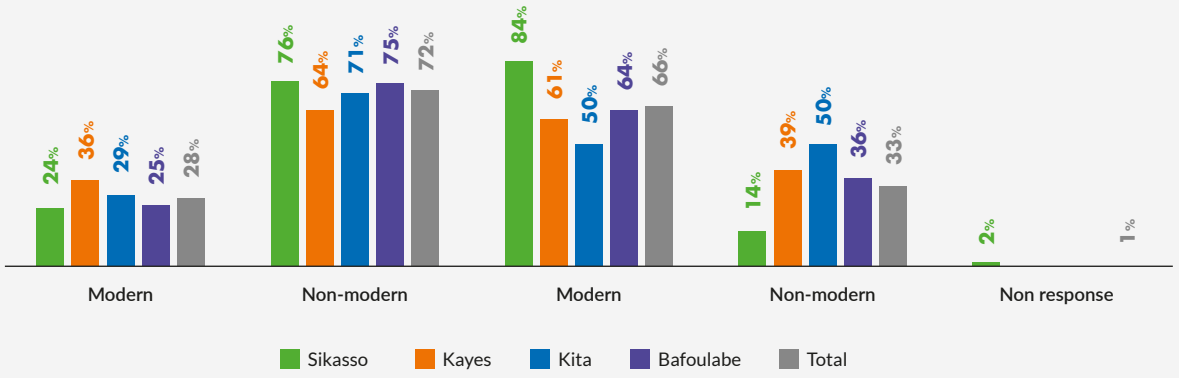

Figure 5: Rate of use of modern FP methods among women aged 15 to 49 (n= 181). Source: Household survey.

Modern contraceptive method use is heavily concentrated on Depo-Provera hormonal injectables (63%) and Jadelle hormonal implants (31%), while other options (CycleBeads®, IUD, male condom, LAM) remain marginal (Fig. 6). Depo-Provera dominates mainly because it is available, inexpensive, easy to use and, above all, discreet (3-month intramuscular injection), allowing women to use it without the explicit consent of their husband or family, in a context of limited autonomy. Jadelle, despite its effectiveness and duration of action (5 years), is less popular because it is visible (implant under the skin) and medically more restrictive to insert and remove.

On the other hand, the low rates of IUD use can be explained by socio-cultural barriers and negative perceptions: fear of irreversible sterility, perception of a dangerous "foreign body", concerns about bleeding and reluctance on the part of husbands and in-laws. Male condoms are also rarely used, as they are often associated with suspicion of infidelity and a lack of trust in the couple, and are reserved for casual relationships rather than marital ones. The LAM method remains virtually non-existent because its restrictive criteria (exclusive breastfeeding, amenorrhoea, child <6 months) are difficult to maintain over time. Finally, the CycleBeads® method remains poorly disseminated and faces several constraints: it is considered less effective for women with irregular cycles, it requires cooperation from the male partner to respect periods of abstinence, and it remains poorly known, undervalued, and less available than medical methods.

However, the Kita district stands out for higher use of Jadelle (47.6%), ahead of Depo-Provera (42.9%), while the remaining users use CycleBeads®.

Finally, free FP supplies remain very limited (Figure 7): only 15% of respondents report having benefited

Women in a healthcare facility Source © Action Against Hunger – Mali Mission

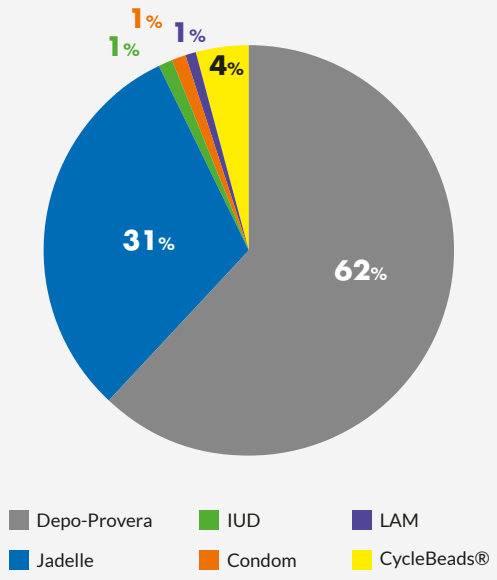

Figure 6: Distribution of women according to the FP method used (n=120). Source: Household survey.

from them. Regional disparities are significant: Kayes reached 30%, while Kita was at 0%.

This free provision, which is often ad hoc and limited to certain campaigns, covers most contraceptive methods except for irreversible ones. Its intermittent nature, combined with recurring stock shortages observed in several health centres (Kayes, Bafoulabé, Kita, Sikasso), reflects the uneven and generally poor implementation of the free provision policy, maintaining financial barriers and inequalities in access between regions.

Satisfaction with health services: SRH and primary health care

Overall, women and adolescent girl beneficiaries express very high satisfaction with FP, SRH, and primary health care services, confirming the relevance and acceptability of the services provided.

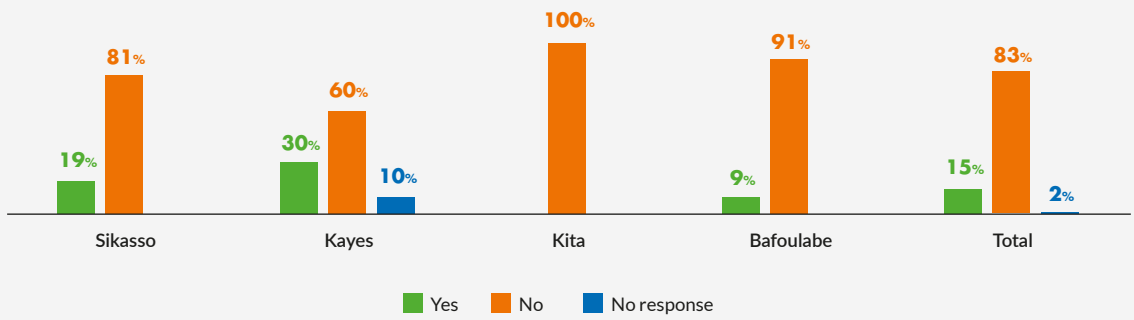

Figure 7: Free access to FP methods in health facilities (n=120). Source: Household surveys.


Visit to a maternity ward (School for Mothers) © Action Against Hunger – Mali Mission

However, there are notable differences between groups and areas. Satisfaction is almost unanimous among adolescent girls (97% overall, with 100% in Sikasso, Kita and Bafoulabé, and 92% in Kayes), reflecting a particularly positive perception of SRH/FP (Figure 8).

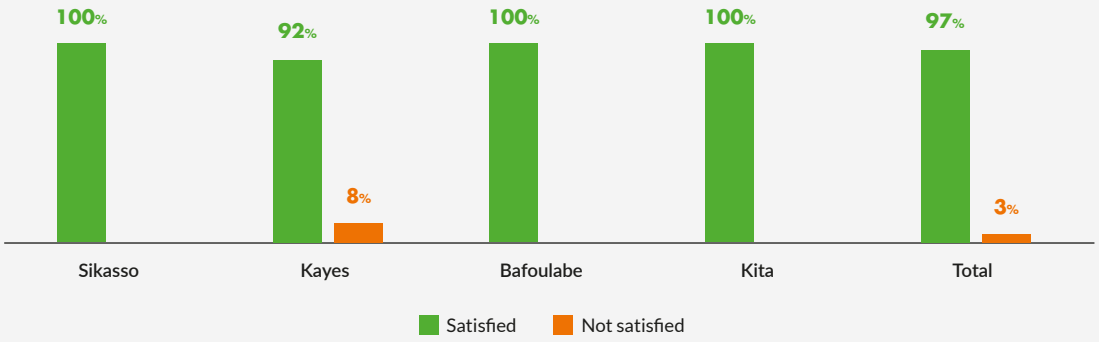

Figure 8: Percentage of adolescent girls among women aged 15 to 49 who report that their SRH and FP needs are met. Source: multisectoral household assessment survey.


School for Mothers © Action Against Hunger – Mali Mission


School for Husbands © Action Against Hunger – Mali Mission

For women, satisfaction with FP has increased and is high overall (83%). However, this progress masks significant disparities: satisfaction levels reach 95% in Kita and 100% in Bafoulabé, and remain high in Sikasso (79%). In Kayes, on the other hand, only half of women report being satisfied (Figure 9).

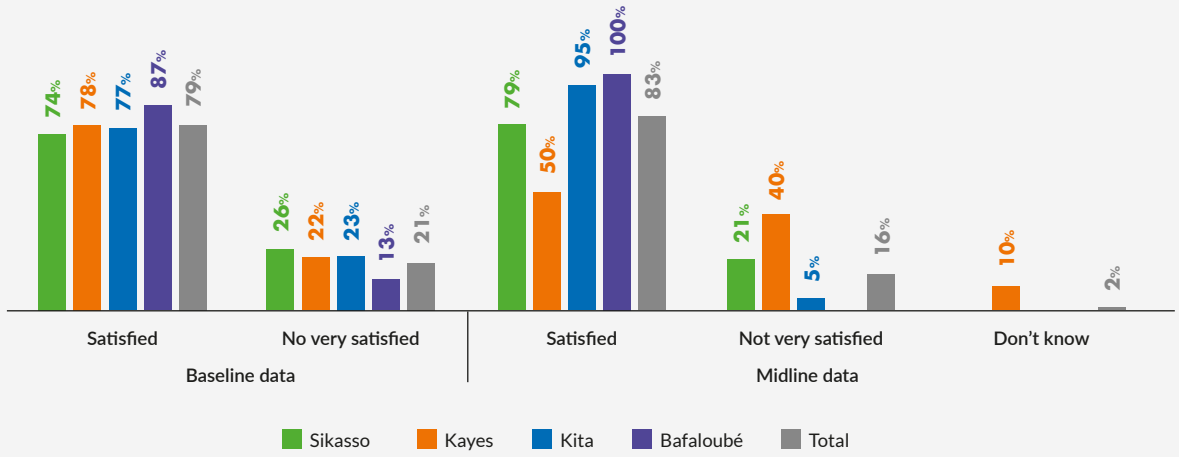

Figure 9: Women's satisfaction with FP services (n=120). Source: household survey.

Finally, in terms of primary health care, overall satisfaction stands at 93% on average, compared with 61% at the start of the project (Figure 10). However, a significant proportion of women still report low satisfaction in Kayes (14%) and Bafoulabé (14%), highlighting local disparities despite the very positive overall trend.

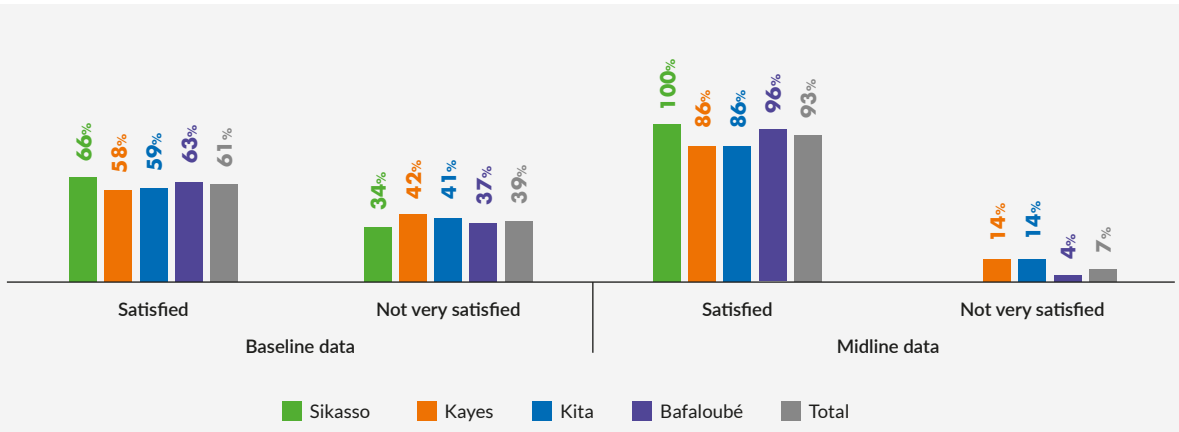

Figure 10: Percentage of women reporting satisfaction with primary health care services. (n=155). Source: Multisectoral household assessment survey.

Knowledge and practices regarding perinatal care (ANC, PNC and place of delivery)

Overall, the vast majority of women (88%) report knowing the recommended number of ANCs (minimum 4) (Figure 11), confirming that information is being disseminated effectively. Some regions even show near-unanimous agreement, such as Bafoulabé (100%), Sikasso (96%), and Kita (89%). By contrast, the Kayes region stands out, with a higher proportion of women reporting that they do not know the recommended number of ANCs (22%), compared to 76% who report knowing it.

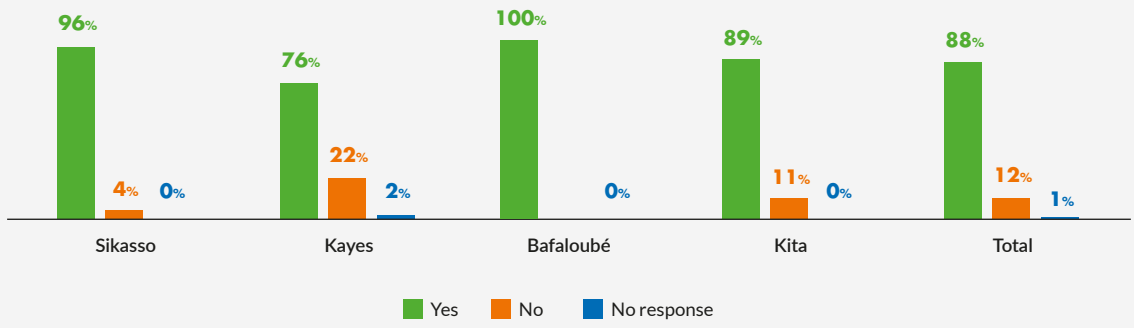

Figure 11: Women's knowledge of the number of ANCs to be made during pregnancy (n=156). Source: multisectoral household assessment survey.

With regard to ANCs, more than nine out of ten women had at least one visit during their last pregnancy, reflecting good initial adherence to maternal health services. However, completion of the four recommended ANC visits remains more challenging, although it has increased sharply: from an average of 26% at baseline, it now reaches 75% at midline. This progress is significant, but regional disparities remain marked. Kita (88%) and Bafoulabé (86%) show the best outcomes, Sikasso (75%) is around the average, while Kayes (67%) still lags significantly behind (Figure 12).

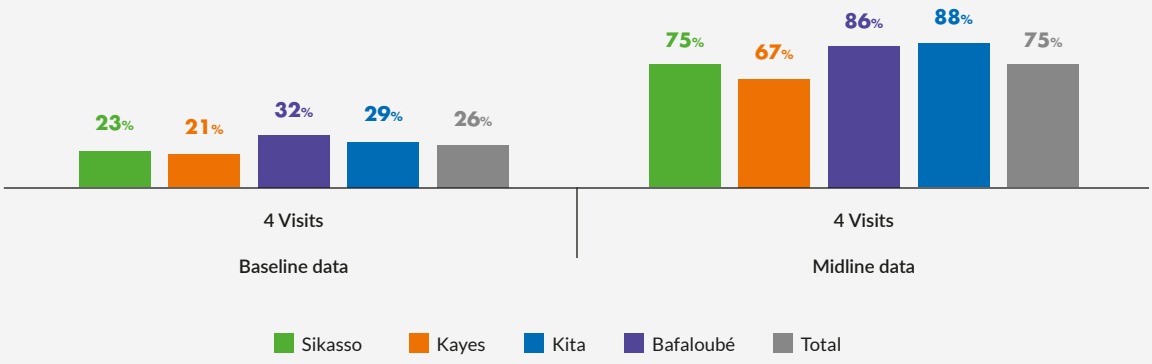

Figure 12: Percentage of women who had four ANCs during their last pregnancy. (n=149). Source: household survey.

The vast majority of women deliver in a health facility (88%), confirming high use of "modern" obstetric services and delivery by skilled personnel (Figure 13). This rate has increased compared to the baseline (82%), reflecting improved access to and uptake of services. Nevertheless, 12% of births continue to take place at home, with marked regional disparities.

While Sikasso and Kayes show very high coverage, Bafoulabé (85%) and especially Kita (76%) report lower levels, with significant proportions of home deliveries (15% and 24% respectively). This continued reliance on home delivery may be explained by insecurity, fear of costs, delays in decision-making and transport constraints.

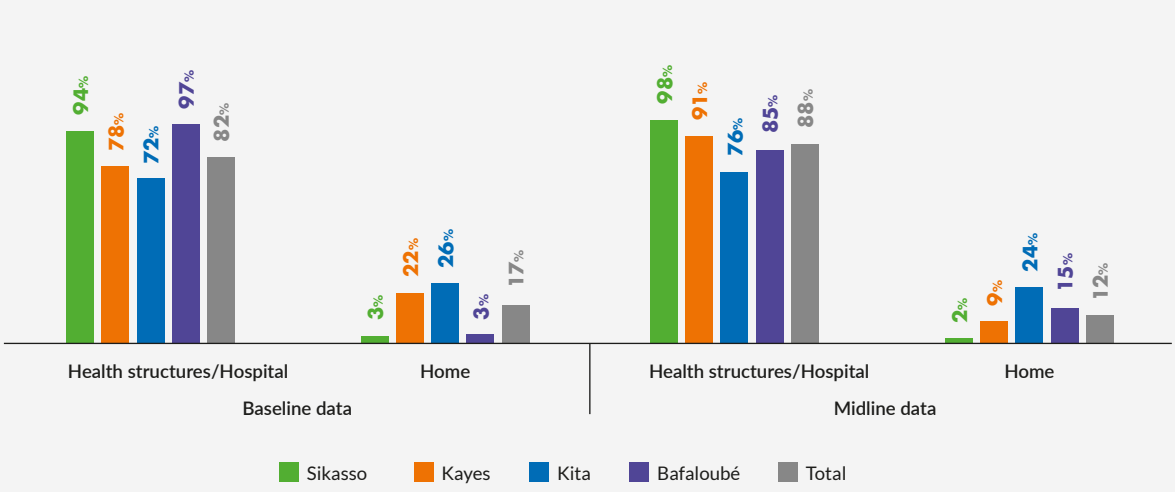

Figure 13: Place of delivery at the end of the last pregnancy (n=189).
Source: Household survey.

The assessment of PNCs shows high coverage in all districts studied, but with notable disparities.

Three complementary indicators refine this analysis. The first, PNC within 24 hours of delivery, corresponds to the WHO benchmark indicator for maternal and neonatal safety: more than 95% of women benefited from this, reflecting the responsiveness of the health system.

The second measures the proportion of women who received at least one PNC in the first six weeks after delivery. Overall coverage (96%) is very high, but Kita stands out with a concerning delay: more than one in ten women did not receive any postnatal follow-up during this period. (Table 4)

Health District	Yes	No
SIKASSO	98%	2%
KAYES	100%	0%
KITA	89%	11%
BAFOULABÉ	96%	4%
Total	**96%**	**4%**

Table 4: Percentage of women who received at least one consultation in the first six weeks after giving birth. (n=186). Source: household survey.

Finally, the distribution of the number of consultations (Table 5) sheds light on the quality and completeness of postnatal follow-up. While the majority of women had two visits (58%), Kayes and Bafoulabé had more intensive follow-up (three or more visits). The combined analysis of these indicators therefore highlights an overall positive situation, while emphasising the need to strengthen the equity and continuity of follow-up, particularly in Kita.

Health District	1 time	2 times	3 times	4 times	More than 4 times
SIKASSO	7%	82%	11%	0%	0%
KAYES	30%	15%	33%	21%	0%
KITA	8%	59%	15%	18%	0%
BAFOULABE	0%	59%	24%	10%	8%
Total	**10%**	**58%**	**20%**	**11%**	**2%**

Table 5: Distribution of women according to the number of PNCs before the end of the sixth week after delivery (n=178). Source: household surveys.

Outcome 1 highlights significant progress in the use of SRH and primary health care services. Services are perceived as widely available, and the adoption of modern contraceptive methods has increased significantly. However, this positive momentum still rests on a fragile foundation: free-of-charge services remain unevenly implemented, stock-outs are recurrent, and contraceptive choice remains limited, leaving women and adolescent girls highly vulnerable in the event of supply shortages.

In maternal health, initial adherence to ANCs and PNCs is very high, but follow-up remains insufficient and there are significant regional disparities. Health facility-based deliveries are increasing, but some areas still lag behind, as does user satisfaction, which shows major variations across districts.

One key lesson emerges: despite the progress made, women's decision-making autonomy remains insufficient. Even though women are increasingly involved in decisions related to their own care, most major choices continue to be made by men. This imbalance reflects the continued influence of patriarchal social norms, compounded by negative perceptions of several contraceptive methods and by structural factors such as early marriage, which limit adolescent girls' and young women's ability to use SRH and primary health services regularly.

Community-based approaches in decision-making – Schools for Husbands, Terikunda Jekulu, Schools for Mothers – have nevertheless shown their potential as levers for social change. By engaging men, building women's self-confidence, and collectively addressing gender norms, these approaches help make services more acceptable and reduce certain social and economic barriers. The impact assessment based on observed improvements in FP, antenatal care, assisted deliveries and postnatal care suggest that the programme's combined interventions could help prevent between 40 and 53 maternal and neonatal deaths per year per 100,000 inhabitants[9]. These outcomes reflect the combined effect of improved access, quality and acceptability of SRH services, as well as the empowerment of women in decision-making.

In conclusion, SRH and primary health services are widely accessible and increasingly used; however, their impact remains constrained by three structural challenges:

- decision-making autonomy remains insufficient for women and adolescent girls ;
- incomplete implementation of free services and recurrent stock-outs weaken effective access and limit contraceptive choice ;
- persistent regional disparities continue to undermine equity for women and girls living furthest from essential services.

[9] Indirect estimate based on WHO, Guttmacher and UNFPA standards. Based on a reference population of 100,000 inhabitants and on the maternal mortality rate (325/100,000 live births) and neonatal mortality rate (33/1,000 live births) observed in Mali. Increases in coverage – modern FP (28%→66%), ANC4 (26%→75%), births in health facilities (82%→88%) and PNCs ≤24h (≈95%) – were integrated using a sequential approach applying conservative risk reduction coefficients, resulting in a conservative estimate of 40 to 53 lives saved per year.

02. SUSTAINABLE ADOPTION OF NUTRITION AND WASH PRACTICES (OUTCOME 1200)

Outcome 1200 focuses on improving nutritional practices and access to a healthy environment, in particular by strengthening hygiene and sanitation practices and organising cooking demonstration sessions at community level. This pillar complements outcome 1100 by creating a healthier and more favourable living environment to prevent infectious diseases and various forms of malnutrition, particularly among children under 5 years of age and PLW.

SUSTAINABLE ADOPTION OF NUTRITION AND WASH PRACTICES (1200)	
(Women and girls)	
Increased and equitable access to WASH infrastructure that addresses gender inequalities and complies with the national standard for infection prevention and control (1210)	Increased knowledge among women, men, girls and boys on gender-sensitive good nutritional practices, in consultation with women and in a manner that addresses gender inequalities (1230)
KEY ACTIVITIES	
• Awareness-raising sessions on good gender-sensitive WASH practices conducted with women, girls, men and boys • Awareness-raising sessions on IYCF best practices with the participation of community relays, CHWs, GSANs, and CSCom and CSRef staff • Sessions to disseminate recipes with high nutritional value based on local agricultural and market garden produce • Capacity-building sessions for existing GSANs (technical and organisational support, and awareness-raising on gender issues) • School latrines built/renovated (and awareness-raising sessions on their use and maintenance in schools).	

Figure 14: Overview of activities for outcome 1200.

As part of the framework for measuring contributions to women's empowerment, the project has implemented several concrete actions aimed at strengthening access to information, gender-sensitive WASH and nutritional practices, and a healthier living environment. The achievements are as follows:

- **Awareness-raising sessions** on good gender-sensitive WASH practices conducted with women, girls, men and boys, with the participation of 140,775 people.

- **Awareness-raising sessions** on IYCF best practices with the participation of community relays, CHWs, GSANs, and CSCom and CSRef (Reference Health Centre) staff; 440 community relays, including 167 women and 273 men.

- **Cooking demonstrations** to promote recipes with high nutritional value based on local agricultural and market garden produce: 1,164 sessions held with 93,133 participants, including 36,616 men and 56,517 women.

- **Capacity building** for GSANs: 117 GSANs benefited from enhanced technical and organisational support and in-depth awareness-raising on gender issues.

- **Sanitation infrastructure** in schools: 84 separate school latrines adapted for girls were built or renovated in 30 schools, accompanied by 455 awareness-raising sessions on their use and maintenance.

Improved latrine in a school

Immediate outcomes

Increased and equitable access to WASH infrastructure that addresses gender inequalities and complies with the national standard for infection prevention and control (1210).

In the four Health Districts of Kayes, Bafoulabé, Kita and Sikasso, 100% of the 30 targeted schools have separate school latrines for girls and boys. The project has built separate school latrines for girls and boys in 30 schools across the Health Districts covered by the initiative. These improved sanitation facilities allow girls to enjoy sufficient privacy, particularly when washing themselves and using their menstrual hygiene products in appropriate conditions.

Health District	Number of schools	Number of latrines per school (separate for boys and girls)	%	Representation of women on management committees (%)
BAFOULABÉ	7	20	100%	16%
KAYES	7	20	100%	14%
KITA	8	22	100%	30%
SIKASSO	8	22	100%	28%
Overall average	**30**	**84**	**100%**	**22%**

Table 6: Percentage of schools with improved latrines and representation of women on WASH management committees.

Functionality and representation (%) of women in WASH Infrastructure CGSs:

In the 30 targeted schools, the listed CGSs are all functional. This means that these committees hold regular meetings and monitor school activities, particularly those related to WASH infrastructure.

The average representation of women in CGSs is 22%, which is still insufficient to ensure equitable participation of women in decision-making bodies.

Representation (%) of women in decision-making positions in water point management committees (community level):

At the community level, 41% of decision-making positions in water point management committees are held by women in general. In the district of Bafoulabé, the percentage rises to 87%.

Increased knowledge among women, men, girls and boys on gender-sensitive good nutritional practices, in consultation with women and in a manner that addresses gender inequalities (1230)

Knowledge of the specific nutritional needs and essential foods of PLW

Overall, the outcomes (Figure 15) show an improvement in knowledge, although less than one in two people (45%) say they are aware of the specific nutritional needs of PLW. However, this average masks significant gender disparities: nearly two in three men (61%) recognise these needs, compared with less than one in three women (29%).

This paradox highlights a twofold constraint: overall awareness-raising remains insufficient, and women's access to information remains limited, despite their majority participation in IYCF groups. Women's low level of education may also make it more difficult for them to understand and retain certain awareness-raising messages. Therefore, women's presence in these spaces does not necessarily guarantee full uptake of knowledge, possibly due to time constraints, competing priorities, or unequal sharing of information within the household.

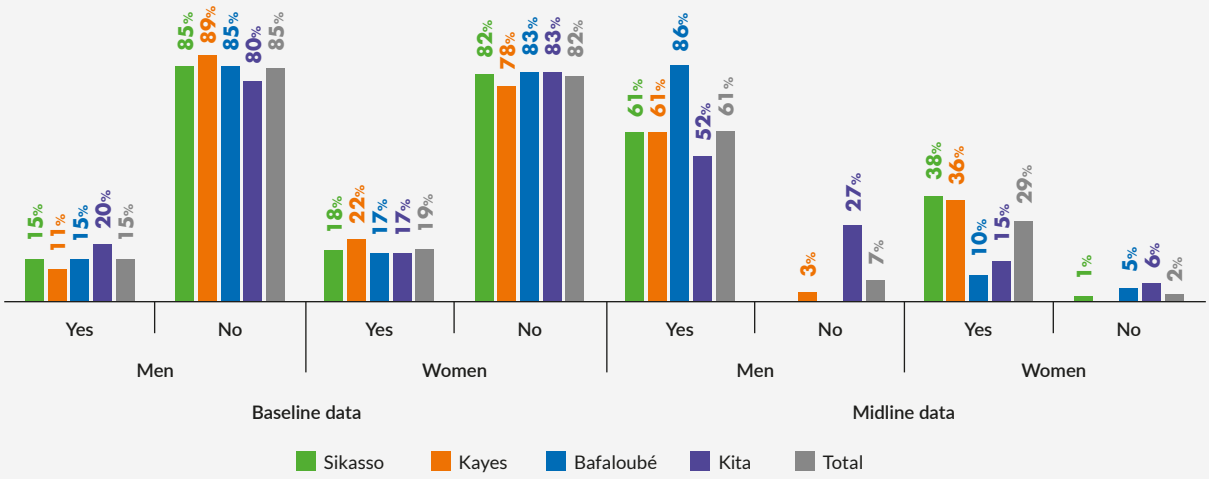

Figure 15: Knowledge of the nutritional needs of PLW (n=210). Source: Multisectoral household assessment survey.

The outcomes show that knowledge of essential foods for PLW is generally focused on cereals (93%) and fish (79%). However, micronutrient-rich foods, which are crucial for maternal and child health, remain largely unknown: only 33% mention vitamin A-rich fruits, 24.2% mention legumes and seeds, 20% mention dairy products and 13% mention iron-rich offal. Regional disparities also emerge: Kayes stands out for its more diverse knowledge (meat, eggs, offal), while Bafoulabé and especially Kita show very low levels for several food groups, particularly animal products. In Sikasso, known as the "breadbasket of Mali", the outcomes partly confirm this reputation: the majority cite cereals (89%) and fish (82%), and knowledge of dark green leafy vegetables (61%) is higher than in other regions. However, the local agricultural wealth does not fully translate into good nutritional knowledge of protective foods: only 33% mention vitamin A-rich fruits, and the proportion remains low for offal (7%) and milk (31%). The importance given to fish illustrates this distinction between knowledge and practice: its dominant position reflects its promotion in health messages and its availability in dried or smoked form, but does not necessarily mean that households consume it regularly. These outcomes therefore serve as a reminder that this is a measure of declared knowledge, not actual consumption, and highlight the need to raise awareness of protective foods that are essential for preventing nutritional deficiencies.

Health District	Sikasso	Kayes	Bafoulabé	Kita	Total
Cereals	89%	90%	95%	65%	**93%**
Vitamin A-rich vegetables and tubers	36%	49%	67%	48%	**51%**
White tubers and roots	43%	39%	10%	19%	**36%**
Dark green leafy vegetables	61%	33%	48%	38%	**50%**
Other vegetables	32%	36%	10%	6%	**28%**
Vitamin A-rich fruits	33%	36%	24%	17%	**33%**
Other fruits	8%	25%	10%	4%	**14%**
Iron-rich offal	7%	28%	5%	0%	**13%**
Meat	50%	73%	24%	23%	**54%**
Eggs	50%	54%	38%	19%	**47%**
Fish	82%	81%	57%	50%	**80%**
Legumes, nuts and seeds	39%	23%	5%	2%	**24%**
Milk and dairy products	31%	22%	5%	2%	**21%**
Oils and fats	15%	15%	0%	2%	**12%**
Sweets	7%	30%	5%	8%	**16%**
Oil, butter	1%	15%	0%	0%	**6%**
Beverages	8%	16%	14%	4%	**12%**
Spices, condiments	11%	22%	0%	4%	**13%**

Table 7: Knowledge of essential foods for PLW (n=210). Source: multisectoral household assessment survey.

Knowledge of the specific nutritional needs and essential foods of children under 5 years of age

Knowledge of the nutritional needs of children aged 6 to 59 months is clearly higher among men than among women: overall, 64% of men report being informed, compared with 31% of women. Among men, the level peaks in Bafoulabé (86%), followed by Kayes (64%), Kita (60%) and Sikasso (60%), with a notable proportion responding "No" in Kita (19%). Among women, the highest levels are observed in Sikasso (40%) and Kayes (36%), while Bafoulabé (14%) and Kita (17%) lag behind.

Table 8 shows that knowledge of foods suited to the nutritional needs of children under 5 years old is largely focused on cereals (77%). The importance of animal proteins (fish, meat, eggs) is relatively well known, while legumes, nuts, and seeds have been mentioned infrequently (11%). Offals, particularly liver, although rich in proteins, iron, and essential vitamins such as vitamin A and vitamin B12, are poorly known (8%), highlighting a lack of awareness of their high nutritional value, which is crucial for children's growth and health. Knowledge of the importance of consuming micronutrient-rich foods such as vegetables and fruits is limited. Dairy products and fats are also insufficiently mentioned. Finally, nearly 15% of respondents consider sweets (mainly white sugar) important in children's diets, although their low nutritional quality makes them a less beneficial choice.

Health District	Sikasso	Kayes	Bafoulabé	Kita	Total
Cereals	61%	73%	100%	77%	**77%**
Vitamin A-rich vegetables and tubers	25%	22%	29%	17%	**24%**
White tubers and roots	40%	28%	10%	8%	**27%**
Dark green leafy vegetables	10%	25%	19%	6%	**16%**
Other vegetables	17%	25%	5%	0%	**15%**
Vitamin A-rich fruits	31%	33%	10%	0%	**24%**
Other fruits	4%	13%	0%	2%	**7%**
Iron-rich offal	4%	17%	0%	2%	**8%**
Meat	50%	65%	19%	27%	**50%**
Eggs	47%	61%	29%	23%	**47%**
Fish	60%	73%	62%	60%	**68%**
Legumes, nuts and seeds	19%	9%	0%	2%	**11%**
Milk and dairy products	31%	25%	10%	6%	**22%**
Oils and fats	8%	13%	10%	2%	**9%**
Sweets	11%	29%	0%	2%	**15%**
Oil, butter	3%	10%	5%	0%	**5%**
Beverages	29%	9%	10%	4%	**16%**
Spices, condiments	3%	10%	0%	0%	**5%**

Table 8: Knowledge of Essential Foods for Children Under 5 Years Old (n=210). Source: Household Survey.

With regard to nutritional knowledge and needs, the outcomes are broadly consistent: knowledge focuses on staple foods (cereals, fish), while key protective groups for PLW and children aged 6 to 59 months (vitamin A, iron/offal, legumes, dairy products) remain little known. This gap is gendered (men are more informed than women) and uneven across districts (Kayes is more diverse; Bafoulabé and especially Kita lag behind; and Sikasso is only partially aligned with its agricultural potential). This is declared knowledge (≠ consumption), which suggests difficulties in achieving an acceptable level of dietary diversity among women and children.

Exclusive breastfeeding (EBF)

EBF among children aged <6 months stands at 43% overall, which is an improvement on the baseline (32%) but below the international benchmark (WHO, Global Nutrition Targets 2025) of at least 50%. The gaps are marked: Kayes reaches 64%, while Sikasso and Kita remain below satisfactory levels, and Bafoulabé records the lowest level (25%).

The stronger performance observed in Kayes may be explained by better coverage of community interventions, increased awareness-raising, and previous tar-


Group awareness-raising sessions © Action Against Hunger – Mali Mission

geted programmes. By contrast, the low rate in Bafoulabé may result from a combination of factors, including limited access to care, deeply rooted traditional practices, and the absence or limited presence of community support groups (GSANs, CHWs) to accompany and advise mothers (Figure 16).

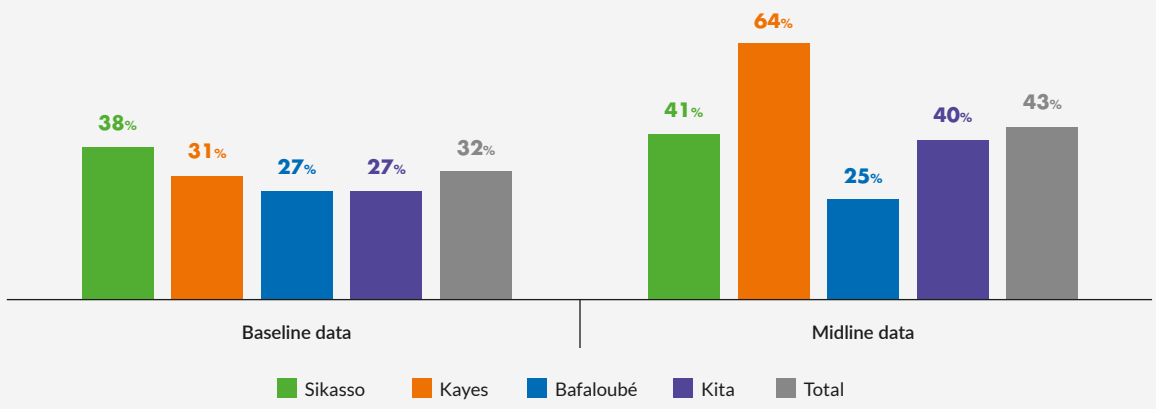

Figure 16: Proportion of EBF among children under 6 months of age (n=146). Source: Multisectoral household assessment survey.

Women's Dietary Diversity Score (W-DDS)[10]

The graph (Figure 17) shows the minimum dietary diversity of women (MDD-W), based on consumption over the last 24 hours (≥5 groups/10). Across all four districts, 66% of women surveyed have adequate dietary diversity, leaving 34% with medium or low dietary diversity (less than 5 food groups consumed by women on the day before the survey): Bafoulabé stands out as the most vulnerable district, with 49% of women having low or medium dietary diversity.

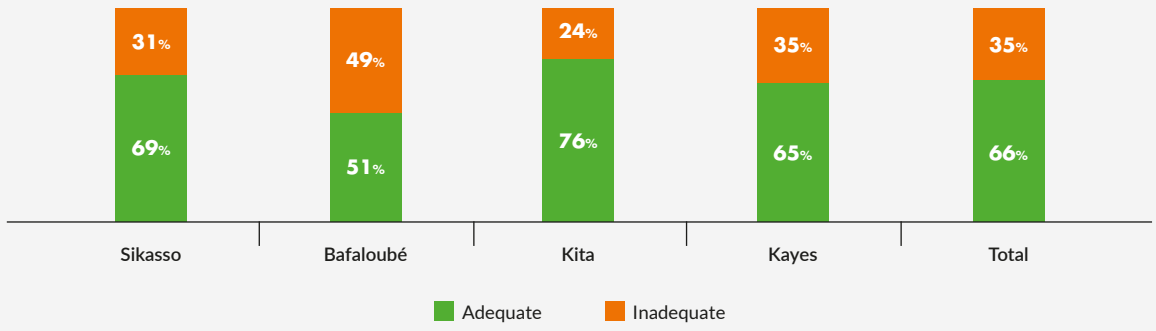

Figure 17: Dietary Diversity Score (DDS/MDD-W) for women. (n=228). Source: Multisectoral household assessment survey.

Food groups	Kayes	Kita	Sikasso	Bafoulabé	Total
Cereals and grains	97%	100%	100%	100%	**99%**
White roots and tubers	13%	12%	5%	22%	**12%**
Legumes	43%	50%	12%	56%	**39%**
Nuts and seeds	88%	100%	66%	76%	**82%**
Milk and other dairy products	42%	43%	34%	16%	**35%**
Meat, poultry, offal	13%	24%	20%	27%	**21%**
Fish and seafood	43%	45%	91%	27%	**54%**
Eggs	15%	9%	18%	2%	**12%**
Dark green leafy vegetables	98%	100%	94%	100%	**98%**
Vitamin A-rich vegetables, roots and tubers	48%	52%	8%	42%	**36%**
Vitamin A-rich fruits	17%	31%	8%	29%	**20%**
Other vegetables	27%	45%	94%	31%	**51%**
Other fruits	0%	0%	15%	0%	**4%**

Table 9 Proportion of food groups consumed by women.

[10] The WDD-S is an indicator that measures the quality of the diet of women aged 15 to 49. It is achieved when a woman consumes at least 5 out of 10 food groups in the last 24 hours, reflecting a higher probability of adequate micronutrient intake.

Dietary Diversity Score for children aged 6 to 23 months (IDDS-6-23 months)[11]

Most children aged 6 to 23 months (76%) meet minimum dietary diversity. However, nearly one quarter (24%) remain exposed to insufficient dietary diversity, with marked regional disparities that are particularly concerning in Bafoulabé, where nearly one in two children does not have a diverse diet (43%). This gap appears to be linked to limited access to services, persistent traditional practices and the limited presence of community support groups (GSANs, CHWs) to support mothers. By contrast, Sikasso stands out positively, with 100% of children meeting adequate dietary diversity. This exceptional outcome is likely explained by greater food availability and higher agricultural diversity in the region, as well as stronger GSAN activities, which carry out more nutritional demonstrations there.

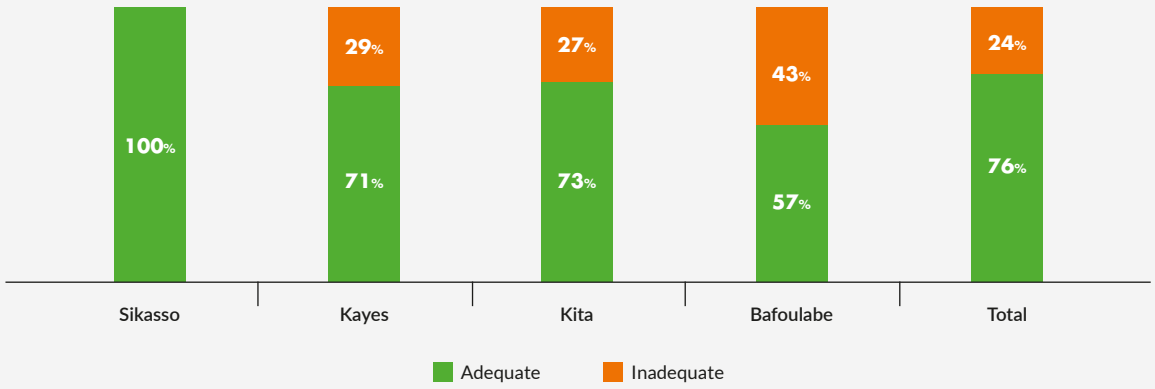

Figure 18: Dietary Diversity Score (DDS) for children aged 6 to 23 months (n=72). Source: Household survey.

Analysis of dietary diversity by Health District

Shows that EBF is almost universal (99%), providing a solid foundation for infant nutrition. However, complementary feeding practices appear uneven and, in some cases, insufficiently diversified. The consumption of cereals, roots and tubers remains acceptable overall (68%), except in Bafoulabé (48%) and Kita (53%). This district also shows the lowest levels of consumption of legumes and nuts (38%) and dairy products (48%).

Consumption of dairy products varies greatly: while Sikasso reaches 100%, rates drop to 48% in Bafoulabé and 57% in Kayes. Meat and fish are consumed by 61% of children, with a peak in Kayes (86%) but a low level in Sikasso (45%).

Eggs appear to be the least consumed group, with an average of 33%, except in Kita, where consumption reaches 60%. By contrast, consumption of vitamin A-rich fruits and vegetables is high overall (79%), with full coverage in Sikasso, but it drops to 57% in Bafoulabé. Finally, other fruits and vegetables are well represented (78%), ranging from 95% in Sikasso to 62% in Bafoulabé.

These outcomes highlight the need to increase dietary diversity, particularly access to eggs, legumes and dairy products, especially in the Kita and Bafoulabé areas.

[11] *The Infant Dietary Diversity Score (IDDS) measures the number of food groups consumed by children aged 6 to 23 months in the past 24 hours. According to the WHO and UNICEF, minimum diversity is achieved when at least 5 out of 8 groups are consumed, reflecting a higher probability of adequate micronutrient intake. This indicator is essential for assessing the quality of complementary feeding during the critical period of early childhood.*

Health District	Breast milk	Cereals, roots, tubers and plantains	Legumes and nuts	Dairy products	Meat and fish	Eggs	Vitamin A-rich fruits and vegetables	Other fruits and vegeta-bles
Sikasso	100%	77%	64%	100%	45%	14%	100%	95%
Kayes	93%	100%	50%	57%	86%	14%	86%	71%
Kita	100%	53%	53%	73%	60%	60%	73%	80%
Bafoulabe	100%	48%	38%	48%	62%	48%	57%	62%
Total	**99%**	**68%**	**51%**	**71%**	**61%**	**33%**	**79%**	**78%**

Table 10: Proportion of food groups consumed by children aged 6 to 23 months.

Decision-making in nutrition and health

On average, 77% of women participate in decision-making regarding their children's feeding (Figure 19).

The situation in Sikasso is concerning, as most decisions are made by men (67%), which may limit women's autonomy in relation to child nutrition.

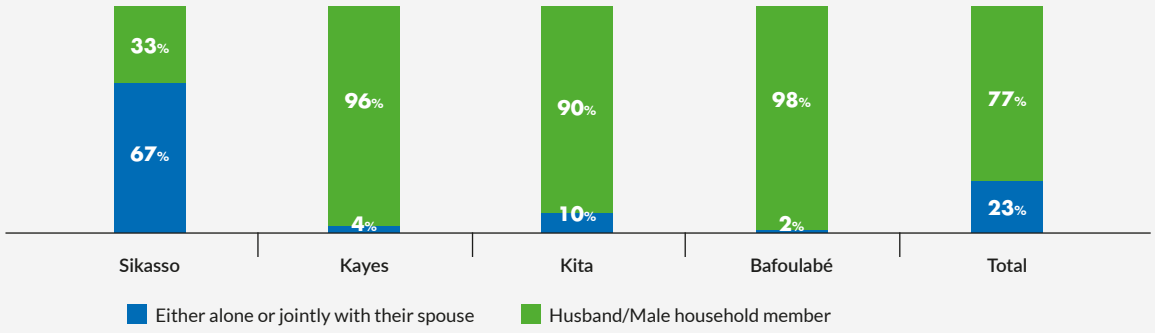

Figure 19: Percentage of women involved in decision-making regarding children's nutrition (n=143). Source: Household survey.

Decision-making on the type of treatment for the child

On average, 66% of women participate in decision-making on the type of treatment (traditional or medical) received by the child, either alone or jointly with their husband. However, there are still significant disparities between districts (Figure 20).

Kita stands out for the high level of involvement of women in decision-making (93% in conjunction with their husbands or alone), while in Sikasso, this involvement is lower (36%).

Representation of women in GSANs and ASACOs:

Overall, 67% of GSAN members are women. This proportion is particularly high in the districts of Bafoulabé (91%) and Sikasso (67%).

Despite this overall under-representation, it is important to note that women hold key positions in the management bodies of most ASACOs. Among the positions held are: Vice-Chair of the Board of Directors, Treasurer, Administrative Secretary, Deputy Secretary in charge of conflict resolution, Mobilisation Secretary and Accounts Secretary.

With 30% of its members being women, ASACOs meet the national quota of 30%, reflecting progress in terms of female inclusion in local health governance. Their role is crucial, as these structures manage CSComs and directly influence the provision of primary health services.

Outcome 2 highlights an overall positive trend in the adoption of sustainable practices in nutrition and WASH. Gains are particularly visible in terms of dietary diversity: the proportion of women and children

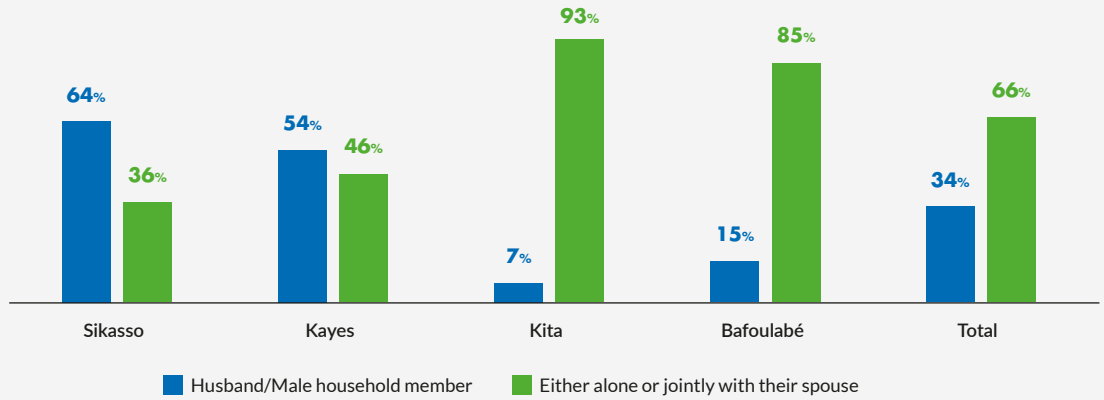

Figure 20: Decision-making on the type of treatment (traditional or medical) received by the child when they are ill (n=143). Source: Household survey.

achieving adequate minimum dietary diversity has increased significantly and now far exceeds national averages, suggesting a significant contribution from project interventions (market gardens, livestock support and cooking demonstrations). However, some districts, such as Bafoulabé, are lagging behind, with a significant proportion of women and children still lacking dietary diversity.

In terms of EBF, outcomes are improving but remain insufficient compared to international benchmarks. Performance remains uneven across districts, with some areas showing clear progress and others in a critical situation, highlighting the need for more targeted strategies in the most vulnerable contexts.

In terms of WASH, the achievements are solid: all targeted schools now have separate latrines adapted to the needs of girls, helping to improve privacy and reduce absenteeism related to menstruation. CGSs are functional, but female representation remains limited, reflecting a lack of equitable participation in local WASH governance. By contrast, community water management committees offer women more decision-making opportunities, opening up concrete possibilities for empowerment at the community level.

One key finding stands out: access to nutritional information remains highly gendered. Men are significantly better informed about the nutritional needs of PLW than women themselves. This asymmetry reflects both the weight of institutional communication channels geared towards male leaders and the limitations of collective awareness-raising approaches, which disseminate messages without always ensuring their individual uptake by women and adolescent girls. By contrast, GSANs, which are largely composed of women, play a key role in promoting good dietary practices and mobilising communities, even though their effects remain uneven across districts.

EBF is a good example of these limitations: despite the increase in awareness-raising sessions, social norms, domestic responsibilities and the low visibility of protective foods (rich in micronutrients) continue to hinder the adoption of optimal practices, particularly for PLW and young children.

Community strategies, including the involvement of GSANs and the participation of women in ASACOs, have strengthened the role of women in family nutrition and local health governance. Female representation in these bodies is increasing, in line with national quotas, but efforts are still needed to ensure that this presence translates into real power to influence nutritional and WASH choices at the community level.

Beyond coverage rates, an impact assessment helps to objectively assess the programme's contribution to maternal and neonatal survival. Based on causal relationships established in the international literature (WHO, UNICEF, Lancet Nutrition Series, Guttmacher) and improvements observed in WASH, nutrition and gender (EBF, dietary diversity, gender-sensitive infrastructure, female participation), the model suggests that the project's combined interventions could contribute to saving

several dozen maternal and neonatal lives each year for a population of 100,000 inhabitants[12]. This estimate remains conservative, but it illustrates the potential scale of gains from improved nutritional practices in WASH environments that are more favourable to women and children.

In conclusion, nutritional and WASH practices are making significant progress, but their impact remains hampered by three major constraints:

- persistently low levels of EBF and consumption of protective foods, particularly among PLW and young children ;
- persistent asymmetry in access to nutritional information between men and women, to the detriment of the autonomy of women and adolescent girls ;
- marked regional inequalities, particularly in Bafoulabé and Kita, which further expose women, girls and young children in the most disadvantaged areas.

03. ACCESS TO RESOURCES AND ECONOMIC EMPOWERMENT OF WOMEN (1300)

Outcome 1300 aims to increase the autonomy, decision-making power and economic resilience of women who produce, process and trade high-nutritional-value agricultural products in the targeted Health District. This pillar complements outcomes 1100 and 1200: It is based on the assumption that strengthening the capacities of rural women's groups in production, marketing and autonomous economic management contributes to their economic independence and improved household food security.

AUTONOMY, DECISION-MAKING POWER AND ECONOMIC RESILIENCE (1300)		
(Women's groups, decision-makers)		
Increased capacity for autonomous production of high-nutritional-value foods by women and women's groups (1310).	Increased capacity of women's groups to independently manage the economic aspects of their production and marketing activities. (1320).	Increased integration of gender, nutrition and crisis resilience into local and national development plans (1330).
KEY ACTIVITIES		
• Women's secure access to agricultural land, with: - Technical training - Donation of tools, agricultural equipment, seeds, etc. - Distribution of poultry and goats • VSLAs • Advocacy sessions conducted with communities and local authorities, with the active participation of women's groups, to improve women's access to land • Advocacy sessions at national level with the active participation of representatives of women's groups, to ensure follow-up on government commitments		

Figure 21: Overview of activities for outcome 1300.

[12] Indirect estimate applied to a standard population of 100,000 inhabitants, using Mali's national reference values (maternal mortality rate 325/100,000 live births; neonatal mortality rate 33/1,000 live births). The progress observed – increased access to gender-sensitive WASH services; increase in EBF (32%→43%); improvement in dietary diversity among women (28%→66%) and children (32%→76%); and increased female representation in community decision-making bodies – was translated into survival impacts using risk reduction coefficients from the international literature. These coefficients indicate, in particular: a decrease of approximately 12% in infant mortality for every 10-point increase in EBF coverage; a 6–8% reduction linked to a moderate improvement in dietary diversity; a 10–15% decrease in deaths attributable to diarrhoeal diseases with sustainable access to water and sanitation; and an additional 3–5% reduction in risks to maternal and child health associated with greater participation by women in local decision-making structures.

The actions selected for their contribution to women's autonomy include:

- **Support for productive resources:** organising technical training and providing groups with tools, agricultural equipment, seeds, as well as poultry and goats.

- **Capacity building and governance strengthening for VSLAs** in management, transparency and decision-making.

- **Community and institutional advocacy:** conducting advocacy sessions at local, regional and national levels with the active participation of women's groups, to improve women's access to land and monitor public commitments.

- **Reducing the domestic burden and sharing tasks:** carrying out 491 awareness-raising campaigns to promote a more equitable sharing of domestic tasks and strengthen women's participation in decision-making.

Immediate Outcomes

Increased capacity for autonomous production of high-nutritional-value foods by women and women's groups (1310).

Improved means of production and secure access to land are key determinants for significantly increasing the productivity of the agricultural farms run by women's groups supported by the programme, and for strengthening the economic empowerment of their members. The programme's activities and the data collected show that a significant proportion of the women's groups supported have autonomous, functional and sustainable production capacities and means (inputs, seeds, tools, processing equipment, technical and organisational skills, etc.).

The programme has increased the total area of land farmed by women's groups. The total area of land farmed by women's groups (n=11) in the Health Districts of Bafoulabé, Kayes, Kita and Sikasso averages 3.8 hectares (source: Summary of focus groups with the groups).

Thanks to the support provided, women's groups have been able to develop mechanisms for supplying agricultural inputs, particularly seeds, which are an essential factor in boosting yields. Indeed, the use of quality seeds can contribute to an increase in yield of up to 40%. As a result, women's groups ensure access to high-quality seeds by purchasing them on the market or from agricultural technical services, using the proceeds from the sale of harvests from previous seasons. This operational autonomy demonstrates a degree of capacity to sustain and develop their income-generating production activities, and thus a minimum level of economic resilience.

Assessment of land access status among women's groups supported by the programme:

With regard to access to land, the analysis distinguishes between different levels of access.

Secure access (legal ownership). The vast majority (84%) of the groups supported by the programme have and cultivate land that is legally registered, with documents attesting to ownership, notably allocation letters. These allocation letters – prepared through consultation with all stakeholders, including CoFos (Land Commissions), landowners, community leaders and local authorities – provide guarantees for sustainable access to agricultural land. This legal recognition gives owner groups land security, enabling them to invest over the long term in developing their productive and income-generating activities.

Access which is considered only partially secure. This refers to situations where groups cultivate land through borrowing arrangements. Through community consultations, some landowners have agreed to make their agricultural land available to certain women's groups on a loan basis. This approach gives women temporary access to land without any guarantee of its sustainability. Landowners may reclaim land at any time, thereby depriving women of land to cultivate. In total, 16% of groups have this type of land access. Although these land tenure arrangements provide a degree of stability, they limit short- and medium-term development and investment plans, as they do not guarantee long-term access to land and remain dependent on landowners.

Through advocacy efforts, these two land-access mechanisms have enabled 5,258 women to gain permanent or temporary access to agricultural production spaces.

Analysis of Table 11 that advocacy efforts have enabled the majority of women's groups (84%) to gain long-term access to agricultural land. Furthermore, awareness-raising activities have promoted awareness of the importance of women's access to land as a determining factor in their empowerment. These women now have direct access to land that they control and cultivate to meet their own needs. This represents a significant step forward in strengthening women's land rights.

Health District	Number of existing groups	Number of groups with secure access to land	Percentage of groups with secure access to land	Number of groups with partially secure access to land	Percentage of groups with partially secure access to land
Kayes	14	6	43%	8	57%
Kita	14	14	100%	0	0%
Bafoulabé	11	11	100%	0	0%
Sikasso	11	11	100%	0	0%
Total	**50**	**42**	**84%**	**8**	**16%**

Table 11: Number of women producer groups with secure access to land. Source: Database monitoring groups' secure access to land_March_2025. (n=50). NB: Some groups carry out two agricultural production cycles (rainy-season and dry-season).

Strengthened coordination and partnerships with local authorities, land governance bodies and territorial stakeholders – combined with capacity building for women's groups in leadership, internal governance, financial management and mastery of the legal and administrative aspects of land management – have been instrumental in achieving these outcomes.

The programme's performance therefore reflects the effectiveness of the interventions implemented and demonstrates a tangible improvement towards land equity, empowerment and the integration of women's groups as key socio-economic actors within their communities.

Testimonials: *women's perceptions of the project activities that contributed to this outcome.*

Ms Alima Bamba, President of the Maro women's group (Sikasso). *"Strengthening my advocacy and leadership skills has given me confidence in myself. I now feel comfortable in my role as a woman leader. I was able to speak out in front of decision-makers and traditional authorities in my village to negotiate and secure cultivable land for the women in my group."*

Analysis of production and harvest levels generated by women's groups:

Support provided to women and men producers aims to strengthen the production of staple and market garden crops that serve both as cash crops and as nutrition-sensitive crops. This dual approach helps to strengthen household livelihoods by generating added value and income from processing and selling agricultural production. It also improves food and nutritional security through the availability of diverse and nutrient-rich foods. By promoting this combination, producers benefit from an integrated production strategy that helps to increase economic resilience while meeting the nutritional needs of families, particularly women and children. This model responds to the challenges and issues of resilience and malnutrition by creating synergies between socio-economic development, food security and the positive social impact of empowering women producers.

The women's groups supported have demonstrated their ability to diversify and increase their production through improved mastery of technical crop management practices. This has resulted in a notable improvement in yields for certain crops (maize, peanuts), which are now close to their productive potential or showing very good yields. The outcomes recorded in terms of production reflect strong performance in the adoption and technical mastery of agricultural practices. As such, technical support has significantly enabled better uptake of good agricultural practices, with direct effects on improving yields and production.

The programme's performance is generally satisfactory. The outcomes, support and regular monitoring carried out during the implementation of the programme have shown good momentum and prospects in terms of production, despite some performance shortcomings in sesame and cowpea production and persistent technical constraints. Indeed, even when effective, the adoption and application of agricultural techniques require time for their effects to have a significant and lasting impact on yields.

Crop	Category	Bafoulabé	Kayes	Kita	Sikasso	Groups Average	Average yield by area* (kg/ha)	Observations
Peanuts	Production (kg)	1050	500	1200	8450	**2629**		Very good yield
	Area (ha)	1,5	1	2	5	**2**		
	Yield (kg/ha)	700	500	600	1690	**873**	**700 à 900**	
Cowpea	Production	200	50			**125**		Significantly below potential. Low yield.
	Area (ha)	1	0,5			**0,8**		
	Yield (kg/ha)	200	100			**150**	**500 à 900**	
Sesame	Production	250				**250**		Below potential
	Area (ha)	1				**1**		
	Yield (kg/ha)	250				**250**	**400-700**	
Maize	Production			4250	6600	**5425**		Good yield
	Area (ha)			0,4	5	**2,7**		
	Yield (kg/ha)			1572	1320	**1446**	**1500-2500**	

Table 12: Yields of the main crops grown by the groups. Source: Production cycle monitoring database, focus group summary. Source*: IER (Mali Institute of Rural Economics), FAO, DNGR (General Directorate of Rural Engineering), INSAT statistics 2019-2023.

Other factors also affect performance: (i) the land ceded by landowners to women's groups is generally the least fertile, which they consider unsuitable for profitable agricultural production; (ii) in terms of fertilisation, the production techniques used rely mainly on organic fertilisers, whose effect on productivity is cumulative over the years; (iii) the effects of climate change, particularly changes in rainfall patterns, leading to poor distribution of rainfall, episodes of water stress and, in some areas, flooding, have disrupted crop development and compromised yields. It should be noted that the Kayes, Bafoulabé and Kita districts have been particularly affected by these climatic shocks during recent agricultural seasons.

With regard to market-gardening production, the programme's support has enabled women's groups to develop several crops (Table 12). The programme's support – through the provision of inputs, development of market-gardening sites, training and technical assistance – has aimed to improve yields and productivity among women's groups, while strengthening their food security and economic autonomy.

Overall, the programme's performance in improving market-gardening production is good. Training and close technical support have encouraged the application of appropriate agricultural practices and helped improve yields. Most crops have reached – or are approaching – the potential or average yield levels observed in the areas.

Collective organisation and strengthened governance have enabled the pooling of resources. Secure access to land has encouraged investment and enabled the implementation of planned production strategies that prioritise diversification and crop rotation. Overall, this has improved productivity and contributed to the development and resilience of local market-gardening production systems.

Crop	Category	Bafoulabé	Kayes	Kita	Sikasso	Groups Average	Average yield by area* (kg/ha)	Observa-tions
Tomato	Production (kg)	6540	1380	6631	4661	**4803**		Satisfactory yield
	Area (ha)	1,4	0,25	1,6	1,3	**1**		
	Yield (kg/ha)	4671	5520	4144	3585	**4480**	**6000-8000**	
Lettuce	Production (kg)	399	5377	1225	803	**1951**		Very good yield
	Area (ha)	0,49	1,35	0,29	0,40	**0,6**		
	Yield (kg/ha)	814	3983	4224	2024	**2761**	**2000-3000**	
Cabbage	Production (kg)	1600	1532	2400	812	**1586**		Significantly below potential
	Area (ha)	0,7	0,2	1,02	0,50	**0,6**		
	Yield (kg/ha)	2286	7660	2000	1635	**3395**	**6000-8000**	
African eggplant	Production (kg)	1395	670	5400	1187	**2163**		Significantly below potential
	Area (ha)	0,5	0,17	0,69	0,61	**0,5**		
	Yield (kg/ha)	2790	3941	6000	1931	**3666**	**7000-9000**	
Amaran-th	Production (kg)	750	1080	2800	500	**1283**		Satisfactory yield
	Area (ha)	0,21	0,2	0,6	0,1	**0,3**		
	Yield (kg/ha)	3571	5400	4666	5000	**4659**	**5000-7000**	
Okra	Production (kg)	550	1707	2244	613	**1279**		Very good yield
	Area (ha)	0,2	0,5	0,5	3	**1**		
	Yield (kg/ha)	2619	3414	4488	6600	**4280**	**3000-4500**	
Shallot	Production (kg)	2833	1050	3572		**2485**		Below potential
	Area (ha)	1,95	0,25	1		**1,05**		
	Yield (kg/ha)	1453	4200	3572		**3075**	**4000-5000**	
Onion	Production (kg)	14943	1137	8288		**8123**		Good yield
	Area (ha)	3,25	0,3	1,5		**2**		
	Yield (kg/ha)	4698	3790	7856		**5448**	**5000-8000**	

Table 13: Yields of the main market garden crops grown by the groups. Source: Production cycle monitoring database, focus group summary. Source*: Technical literature, data IER, FAO, DNGR, INSAT statistics and regional programmes (2019-2023).

Analysis of how agricultural production is distributed and used by women's groups (household consumption, sale as fresh produce, and sale as processed products)

The study also examined how agricultural and market-gardening production is used.

Data analysis shows varied use of agricultural and market-gardening production, reflecting differentiated strategies balancing food security and cash-income generation.

The significant share of production intended for sale (64%) indicates that women's groups and their members are focused on generating income and seek to secure cash resources to meet essential and immediate needs (food, health, debt repayment, schooling, micro-investment, savings, etc.). At the same time, household consumption of crops (around 23%) represents a smaller share. While it is not negligible and contributes to improving food availability and dietary diversity, it also reflects the economic pressure on households and the prioritisation of cash income over consumption.

Crop	Distribution of use	Bafoulabé	Kayes	Kita	Sikasso	Total
Peanuts	Household consumption	29%	40%	18%	5%	**24%**
	Sales	62%	20%	65%	95%	**58%**
	Processing	10%	40%	17%	0%	**18%**
Cowpea	Household consumption	0%	80%			**45%**
	Sales	100%	0%			**44%**
	Processing	0%	20%			**11%**
Sesame	Sales	84%				**84%**
	Processing	16%				**16%**
Maize	Household consumption			0%	21%	**9%**
	Sales			100%	70%	**87%**
	Processing			0%	9%	**4%**
Overall	**Household consumption**					**23%**
	Sales					**64%**
	Processing					**13%**

Table 14: Use/distribution of agricultural production (household consumption, sale as fresh produce, and sale as processed products) (n=11). Source: Summary of interviews with agricultural groups

Despite the provision of equipment and training under the programme, processing, which is essential for generating added value, remains low overall (13%), including for crops such as peanuts and sesame, whose processed products are nevertheless marketed in the intervention area.

For market-gardening production, on average across the seasons observed, household consumption is estimated at 20-25% of harvests, sales at 60-65%, and processing at 10-20%.

The programme's support has helped to initiate the development of local processing and a drive to promote agricultural products from small farms. However, several structural factors – such as irregular production levels, constraints in access to energy and complementary inputs, limited market access and low penetration of processed products in local markets, and weak commercial and logistical organization – affect economic results and hinder integration into the various agricultural value chains.

The programme's results show that women producers already play an important economic role and contribute significantly to the family economy and household income. The results also highlight a dependence on markets and a lack of added value in their production, which limits their income levels and exposes women producers to price volatility and fluctuations in demand, undermining the stability of their incomes.


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In general, while the strong focus on sales indicates genuine integration into economic circuits, the low share of household consumption raises food security concerns. In addition, the low level of processing – despite the programme's support – shows that the potential for value addition still needs to be strengthened. Support must be able to strengthen the performance of farms, integration into value chains and, above all, enable the identification and maximisation of economic development opportunities and market access for processed products.

Increased capacity of women's groups to independently manage the economic aspects of their production and marketing activities. (1320).

Proportion of members of supported groups who are proficient in the use of the economic management tools made available to them

Technical and organisational support was provided to the groups and their members in order to strengthen their skills in autonomous economic management. This support included training in simplified accounting and business management, and also promoted the establishment of VSLAs. In the programme's operational context, promoting VSLAs is an essential lever for economic empowerment, as it provides newly formed groups with a structured framework for managing their economic activities, savings, and access to credit. These activities have helped improve economic performance by reducing reliance on external funding to develop their activities. The approach has also contributed to increasing group members' financial independence and decision-making power and to strengthening solidarity within the groups, their households and their communities.

The VSLAs established have enabled women and groups participating in the programme – who are traditionally excluded from formal financial services – to access savings and credit.

The figures recorded during the various cycles of the 60 VSLAs in the four districts reveal the gains made by women in terms of financial management, particularly through guaranteed access to savings and credit mechanisms. Total cumulative savings amount to FCFA 33,276,300, nearly 40% of which comes from the Sikasso district, which records the highest contribution.

At the same time, members have been able to take out loans, mainly to cover health- and education-related needs, but also to diversify their sources of income by developing their economic activities, particularly agricultural production and small-scale trade. The total amount of loans taken out is approximately FCFA 8,448,000. However, borrowing has not been without risk, as shown by the penalties applied in the event of late repayment, which generated FCFA 231,135.

In addition, as a lever for social cohesion, each VSLA has a solidarity fund intended to support members during social events. The total amount mobilised through this fund reaches approximately FCFA 4,530,050.


Weekly meeting of a VSLA © Action Against Hunger – Mali Mission

Testimonials *(source: Summary of focus groups with VSLAs): women's perceptions about VSLA support activities.*

Barakissa BAKAYOKO, a member of a VSLA in the Kayes Health District*, shares her experience with emotion: « In the event of happy or unhappy events in a household, a lump sum is now allocated to the person concerned. This is important for providing support during difficult times. This kind of solidarity-based support did not exist before the project was launched. »*

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She adds proudly: « Today, thanks to the VSLA, I am able to cover my children's medical expenses when they fall ill. »

Another testimony from a member of the Loupourou women's group in Kayes: *"eing a member of the VSLA has been beneficial for me and my family. My child fell ill and I didn't have the money to buy medicine. Thanks to the VSLA, I had the money to buy medicine and today my child has recovered. I can't express how grateful I am to the initiators of this project, because if it weren't for the VSLA, my child could have died.":*

These testimonials clearly illustrate the positive impact of the project on social solidarity, resilience and women's economic empowerment.

The performance of these groups demonstrates the suitability of the approach and model, which are based on simple, endogenous mechanisms controlled by the women themselves. VSLAs provide a solid foundation for the sustainability of the programme's achievements and the emergence of more structured, autonomous and socio-economically successful women's organisations.

A total of 5,232 people, including 5,155 women, have benefited from these capacity-building measures. This has enabled women to exercise their economic rights

through technical support that strengthens the role of local associations in facilitating women's access to, use and ownership of the means of production.

The women who are members of VSLAs have benefited from technical and operational capacity building aimed at promoting their economic empowerment. According to the study findings, overall, 68.9% of participants reported having a good command of the economic management tools made available to them. However, a disaggregated analysis by Health District reveals disparities, likely linked to differences in education and literacy levels across the areas. This finding highlights the importance of literacy as an essential lever for sustainably strengthening women's empowerment.

Assessment of women's average monthly income from agro-pastoral and market-gardening production

The results show a notable improvement in the average monthly income of women who are members of the women's groups supported by the programme. Women's group members in the districts of Bafoulabé (FCFA 50,708 FCFA) and Kita (FCFA 51,507) report the highest average incomes. (Figure 22).

By contrast, Sikasso records the lowest income (FCFA 14,900), highlighting the importance of targeted initiatives to improve women's economic opportunities while taking into account the local realities of this district.

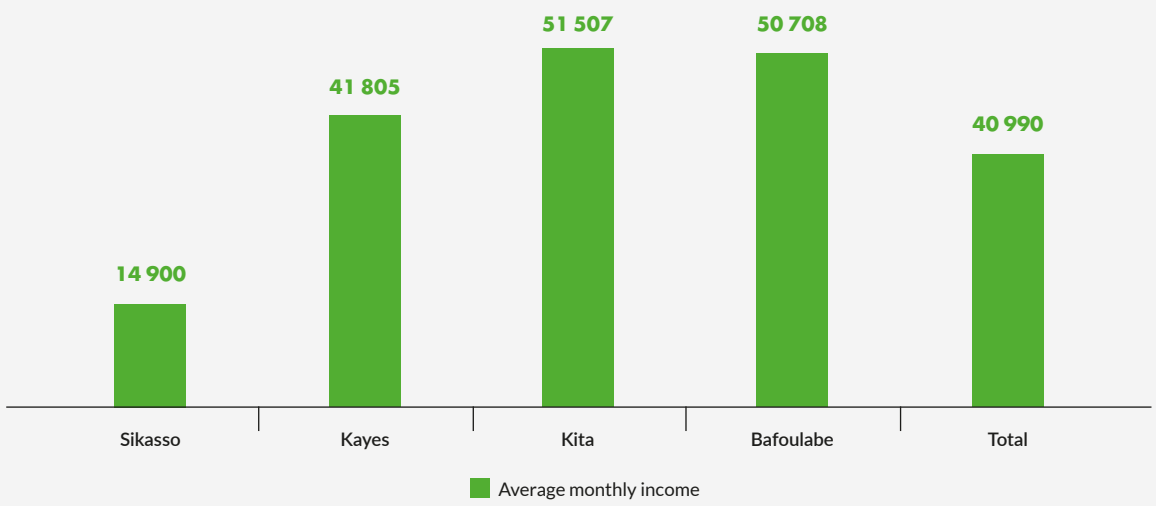

Figure 22: Average monthly income generated by women's productive activities (FCFA) (n=143). Source: Household surveys.

The average overall income is FCFA 40,990, which is higher than the values recorded and defined as the programme baseline, but slightly below the national average for the informal sector (FCFA 44,432) estimated in the Mali's 2022 statistical yearbook.

Region	Baseline data	Midline data	Final target	Variation (%)
Kayes	16495	41805	20%	153
Sikasso	15826	14900	20%	-6

Table 15: Change in monthly income among women members of women's groups. Source: Household surveys.


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In Kayes, income rose by 153%, from FCFA 16,495 to 41,805. By contrast, in Sikasso, a 6% decline was observed between the baseline (FCFA 15,826) and the midline (FCFA 14,900), indicating a regression from the targets.

The programme's results are encouraging and reflect tangible progress towards economic empowerment, marked by greater control over productive and income-generating activities.

WOMEN'S DECISION-MAKING AND CONTROL OVER RESOURCES

Women's participation in decision-making on the allocation of household resources

Figure 3 highlights a high degree of centralisation in decisions regarding the allocation of financial resources within households. Across all four districts, in 64% of the households surveyed, decisions on the allocation of household resources are made by husbands. Women's participation in these decisions remains limited, with only 33% of them reporting that they are involved in financial decisions and choices about budget allocation or distribution, either alone or jointly with their husbands. This highlights women's still limited decision-making power in household financial management, despite their significant and growing role in production and income generation, and therefore in the household economy.

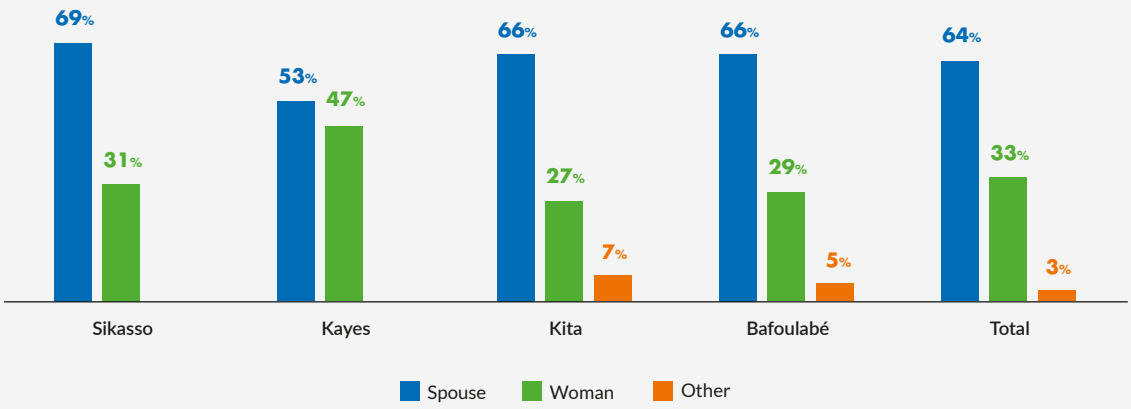

Figure 23: Use/allocation of resources in households. (n=143). Source: Household surveys.

Kayes and Sikasso have the highest rates of female participation in decision-making on resource allocation and major household purchases (47% and 31%), suggesting a more balanced couple dynamic in some households.

Women's decision-making and control over their own resources are crucial issues for gender integration, economic empowerment, rights and development.

Assessment of women's control over their own income:

Programme data shows a positive but still uneven trend in women's control over their income.

The data presented below (Figure 24) indicate that within the programme, 50% of women report controlling their own income, while 49% indicate that this responsibility lies with their spouse. These proportions

suggest that, although women may have autonomy and a degree of independence in some cases, unequal gender relations and decision-making power imbalances persist within households, including in the direct control that women have over their own income.

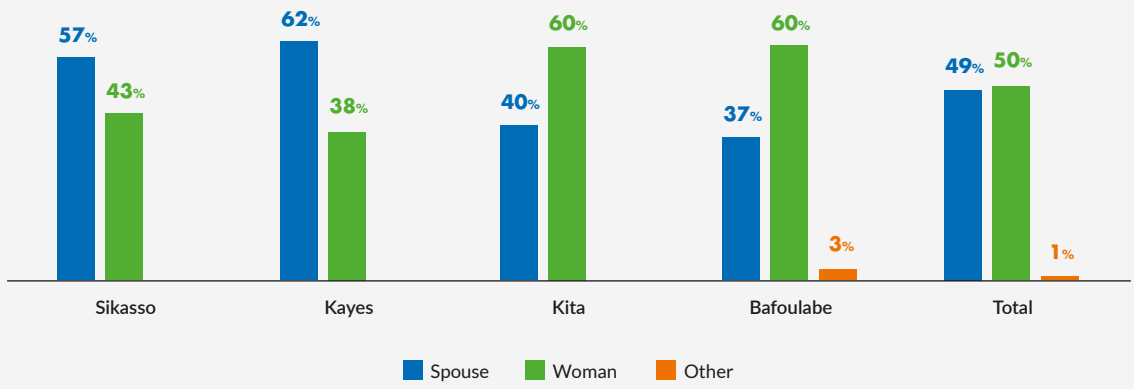

Figure 24: Women's control over their income. (n=143). Source: Household surveys.

The socio-economic development of women driven by the programme – through VSLAs, strengthened productive and marketing capacities for agricultural products, and networking among women to foster experience-sharing – has helped increase women's economic tole and influence within their communities and households. Effective control over income and participation in financial decisions remain a key lever for economic empowerment, which is still hampered by the persistence of certain gender norms.

The challenges here, in order to consolidate the gains made in terms of economic empowerment and changing gender norms, will be to strengthen women's economic governance through awareness-raising among communities, households and husbands, promoting dialogue within families and strengthening financial and entrepreneurial skills, in order to ensure effective and recognised control over women's income. This will enable women to invest, participate and contribute to household and local economies.

FOOD SECURITY OF HOUSEHOLDS SUPPORTED BY THE PROGRAMME:

Proportion of households supported by the project with an adequate dietary diversity score:

The household dietary diversity indicator is a key indicator of the programme. Measuring and analysing the levels of this indicator demonstrates the significant impact and contributions of the programme's actions and activities on household food security and dietary diversity in particular.

Data from surveys (Figure 26) shows a significant improvement in household dietary diversity. Across the four districts, the proportion of households participating in the programme with adequate dietary diversity increased from 56% to 88%, a 32-point increase, reflecting the impact of the programme.

Major improvements were observed in each district, particularly in Kayes (up 52%) and Bafoulabé, which achieved 100% adequate dietary diversity. Sikasso also recorded a sharp increase, rising from 70% to 95%. Only Kita experienced a slight decline (from 78% to 69%), suggesting specific local constraints related to seasonal accessibility and availability of food and commodities, and/or climatic shocks that impacted food crop production.

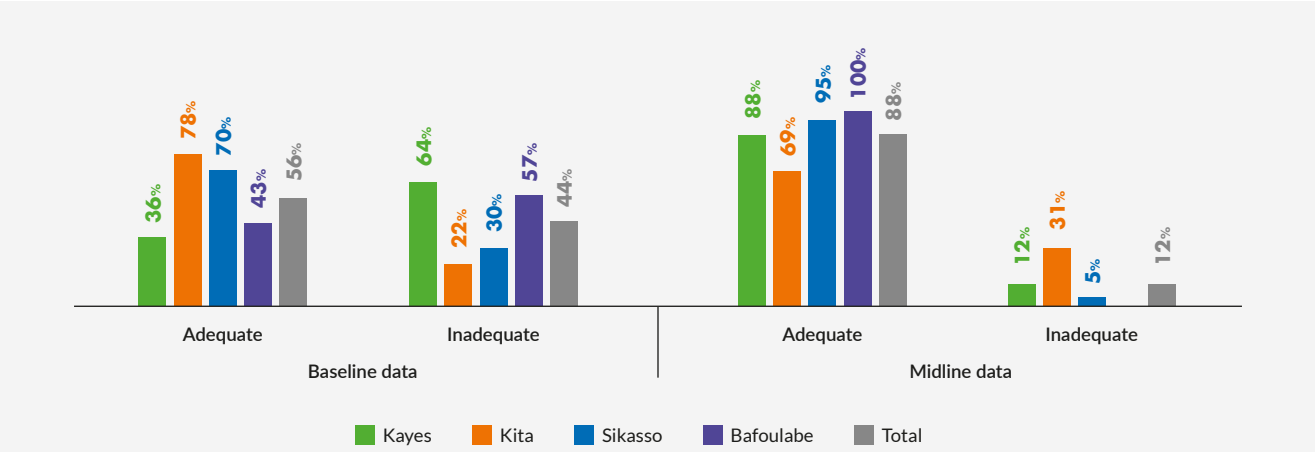

Figure 25: Proportion of households supported by the project with an adequate dietary diversity score. (n=261). Source: Multisectoral household surveys, 2024.

Table 15 below provides a qualitative analysis of household food consumption. The distribution of food groups consumed shows an overall satisfactory level of dietary diversity.

Health District	Cereals	Roots and tubers	Legumes	Milk and dairy products	Meat	Fish	Eggs	Leafy vegetables	Fruit	Oil	Sweets	Condiments
Kayes	95%	46%	56%	47%	52%	84%	17%	91%	30%	94%	92%	98%
Kita	98%	42%	68%	52%	38%	49%	12%	56%	23%	92%	89%	95%
Sikasso	100%	50%	17%	64%	34%	97%	3%	79%	33%	61%	77%	100%
Bafoulabé	98%	78%	84%	72%	35%	73%	25%	91%	41%	88%	92%	95%
Total	**98%**	**54%**	**56%**	**59%**	**40%**	**76%**	**14%**	**79%**	**32%**	**83%**	**88%**	**97%**

Table 16: Distribution of food groups consumed by households. Source: Household surveys.

The diet is characterised by high consumption of cereals (98%), the traditional staple food, supplemented by leafy vegetables (79%), oilseed products (83%) and fish (76%). The consumption of legumes (56%) indicates a relatively frequent intake of vegetable protein, enhancing overall nutritional quality, although the level remains below the potential observed in terms of availability in areas with high cowpea production. The relatively high consumption of dairy products (59%) supplements sources and intakes of animal protein.

The consumption of roots and tubers (54%) also contributes to diversifying energy intake, but their moderate consumption may reflect seasonal variations or variable availability depending on the district.

By contrast, consumption of meat (40%), fruit (32%) and especially eggs (14%) remains low. Consumption of these food groups – although essential sources of protein, vitamins and minerals – remains limited, mainly due to economic constraints, market fluctuations, dietary norms or low local availability.

The results show that the programme had a direct and measurable effect on food security and improved household dietary diversity. The data shows that the programme generated a notable and technically significant improvement in household dietary diversity, as a result of complementary interventions on food production, access and utilisation.

Increased market-garden and agricultural yields, as well as crop diversification, have strengthened the local and household availability of nutrition-sensitive foods. This increased availability has directly facilitated the better integration of micronutrient-rich products into the diets of households and individuals.

Increased production volumes and higher incomes generated by crop sales have improved households' economic access to better quality and quantity of food.

Nutrition awareness-raising activities have strengthened understanding of dietary needs and promoted the adoption of good dietary practices.

All of these interventions have had a combined effect on the availability, accessibility and utilisation of food, three key dimensions of food security.

Increased integration of gender, nutrition and crisis resilience into local and national development plans (1330).

Representation of women in local governance bodies and committees

Local Development Committees (CDLs) are participatory governance structures set up at the village, neighbourhood or municipality level. They serve as a framework for consultation between local authorities, communities and technical and financial partners to identify, plan, implement and monitor local development actions.

Women make up 44% of the members of CDLs. The breakdown by district shows that Sikasso has the highest female representation with 52%, followed by Bafoulabé (41%), Kayes (40%) and finally Kita, with 33 % (*table 16*).

In all targeted Health Districts, the threshold of 30% female representation has been reached, in line with standards for inclusive governance and commitments to gender equality. This compliance indicates the gradual integration of women into local decision-making bodies, although it remains limited to this assessment.

Health District	Percentage of women participating in local development committees
Bafoulabé	41%
Kayes	40%
Kita	33%
Sikasso	52%
Overall average	**44%**

Table 17: Percentage of women participating in CDLs. (n=9). Source: Summary of interviews with CDLs.

Outcome 3 shows that the programme has significantly strengthened women's access to productive resources and their economic empowerment. Overall, the levels of the indicators obtained for these immediate results clearly demonstrate that the programme has contributed to strengthening the economic empowerment, decision-making power, food security and resilience of women producers. This confirms the hypothesis that strengthening the technical, organisational and economic capacities of women's groups is a key lever for improving their autonomy and socio-economic inclusion within their communities and local areas.

Securing access to land for the vast majority of women's groups was an essential prerequisite: it enabled women producers to develop more diversified and better controlled agricultural and market-gardening activities and to invest sustainably in production. This secure land tenure, coupled with ongoing and tailored technical and organisational support, has led to higher yields and diversification of production and sources of income. These achievements have strengthened their capacity to produce high-nutritional-value food independently and contribute directly to the food security and economic resilience of their households.

However, several constraints remain in terms of production. Optimising technical production practices – whether through soil fertility management, varietal improvement, or cultivation techniques adapted to local conditions – requires time for learning, close follow-up, and regular access to advisory support in order to bring about changes in practices. Consolidating these practices is therefore key to strengthening the performance,

resilience and sustainability of local production systems led by women's groups.

The results of agricultural and market-gardening production seasons show that women's groups are now better integrated into local economic circuits. The strong focus on sales reflects a growing willingness and ability to secure monetary income to meet their families' basic needs. However, the low level of processing limits the creation of added value and thus the ability to generate more income, as well as socio-economic integration within local sectors.

The savings and credit schemes set up through VSLAs have been a major driver of empowerment. They have enabled thousands of women to access formal financial resources to cover health and education expenses and develop their income-generating activities, while strengthening internal solidarity through solidarity funds and the groups' cash-box system. At the same time, simplified management training has improved the majority of participants' mastery of economic tools, although significant disparities remain between districts in terms of literacy levels and access to local support.

On the social and decision-making front, the programme's support has enabled many women to increase their monthly income and thus strengthen their economic autonomy and gradually their decision-making power within their households, thereby creating the conditions for more active and legitimate participation in their communities. By consolidating their economic activities, skills and influence, the programme is helping to strengthen the role and position of women as key players in local socio-economic development.

The increased participation of women in local governance bodies – development committees, community management structures – is another important achievement. The fact that female representation meets or exceeds the benchmarks for inclusive governance is evidence of a real move towards institutional recognition of their role. Nevertheless, this quantitative presence does not yet guarantee full decision-making influence.

Overall, the programme's interventions have generated major progress in terms of production, income, food security, participation and decision-making power for women. By building their technical, economic and organisational capacities, as well as their personal leadership skills, the programme has laid the foundations for sustainable empowerment. These gains confirm women's central role in local socio-economic development, while highlighting the need to continue efforts to reduce persistent structural constraints, remove barriers and address inequalities that still limit women's full participation and economic autonomy.

5 CONCLUSIONS AND RECOMMENDATIONS

The project has been an overall success and provides strong evidence of the effectiveness of a gender-sensitive multisectoral approach. The combination of interventions in health and SRH, nutrition and WASH, economic empowerment and social transformation has generated measurable synergies that have improved maternal and child health, food security and gender equality. The progress observed – increased use of modern FP, significant improvement in ANC4, increase in deliveries in health facilities, enhanced dietary diversification and more inclusive school governance – places the project above national averages in terms of coverage, quality and equity.

The analysis shows that the three outcomes – health/SRH, nutrition/WASH, and economic empowerment – do not function as independent components, but as interdependent levers of the same system. The most significant changes occur when improved access to services is accompanied by strengthened practical skills and increased decision-making power for women. This finding is consistent with the frameworks of the WHO, the Lancet Women's Empowerment and Health Series (2023) and the FAO, which emphasise that sustainable reduction of malnutrition requires both accessible services and the transformation of social gender norms.

The data also confirms the central role of women's decision-making power: districts where women are more involved in key household decisions and community structures (e.g. Kita, Kayes) have better health, nutrition and economic participation indicators. By contrast, where patriarchal norms remain very strong (Bafoulabé, Sikasso), technical advances are limited by women's lack of control over resources and decisions, despite real improvements in production and income. Decision-making autonomy thus appears to be a cross-cutting determinant and an essential prerequisite for transforming access into sustainable use.

The integrated approach has also proven its relevance with regard to the «first 7,000 days»: the simultaneous improvement in indicators of maternal health, young child nutrition and gender-sensitive WASH environments confirms the importance of intervening across the entire pregnancy-early childhood continuum. These results are consistent with the recommendations of UNICEF and the Global Nutrition Report, which indicate that a combined health-nutrition-gender package can substantially reduce infant mortality and sustainably improve growth indicators.

Finally, economic empowerment and secure land tenure have played a catalytic role. Where women have their own income or stable land rights, investment in children's health, nutrition and education increases, in line with the literature (Smith & Haddad, 2015; FAO, 2022). These dynamics, reinforced by ACF's long-standing presence in certain districts, have led to deeper local ownership and greater stability of interventions.

Ultimately, the project shows that no single intervention can break the cycle of chronic malnutrition. Only a systemic approach – combining quality and local services, women's empowerment, land security, economic resilience, improved WASH environment, and transformation of social norms – can consolidate sustainable behavioural changes and improve the health and resilience of households and communities. The lessons learned from this capitalisation exercise have been translated into a coherent set of recommendations for Phase 2, aimed at strengthening the most decisive levers (decision-making power, production-nutrition integration, territorial equity, intensive behavioural change, resource security and local governance).

AREAS	RECOMMENDATIONS
Strengthen the quality of the continuum of health and SRH care	Standardise FP–ANC–delivery–postnatal protocols, secure supplies, improve formative supervision and systematise postnatal home visits to ensure continuous, high-quality care.
Consolidate women's decision-making power and leadership	Strengthen transformative gender approaches in existing mechanisms (Schools for Husbands, Schools for Mothers, Terikunda Jekulu), support their effective participation in community structures, and develop intra-household negotiation capacities.
Reduce territorial inequalities through a community-based Nutrition–SRH–WASH package	Deploy regular advanced strategies, home visits and iCCM+ in remote areas, with a minimum level of Nutrition–SRH–WASH services at household level to improve equity of access.
Increase adoption of practices through practical, structured and tailored learning	Move from awareness-raising to concrete, tailored learning: Nutritional Learning and Rehabilitation Centres (FARNs), mother-to-mother mentoring, family coaching, cooking and hygiene demonstrations, with a simplified curriculum and pre/post assessments to measure learning outcomes.
Link production, local processing and nutritional consumption	Align local food systems with the needs of the first 7,000 days, strengthen food processing and hygiene, integrate WASH into productive spaces and support local value added.
Consolidate women's economic empowerment and land security	Extend land tenure security, direct VSLAs towards productive financing linked to nutrition, and support local value chains so that women's incomes translate into investments in children's health and nutrition.
Institutionalise the integrated model in territorial governance	Incorporate achievements into municipal and health plans, harmonise local committees (GSANs, water, health, schools) and establish simplified public accountability to ensure the sustainability of the integrated model.


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