

I. ANNUAL RESULTS

During fiscal year 2010, Counterpart International in Mauritania (CPIM) has exponentially increased program activity and achievements. All 160 intervention sites have worked toward meeting program targets and implementing program components to mitigate future shocks of food security; CPIM is currently in the process of implementing recommendations from the midterm evaluation to strengthen its interventions. Moreover, since the program is entering its final year, CPIM has prioritized strengthening the sustainability of all program components.

Throughout 2010 key assumptions concerning priorities for the program remained. Almost all organizations implementing health and nutrition programs in Mauritania focus on treating acute severe malnutrition. Consequently, CPIM measured children using upper arm circumference bracelets and referred cases of severe malnutrition to state run regional and municipal rehabilitation centers. CPIM communities are ranked some of the poorest in Mauritania; the average community member lives off of livestock output and subsistence farming leading to high risk of food insecurity shocks during unexpected natural disasters and during the hot/dry season. This year, a large portion of CPIM's intervention zone was affected by floods exacerbating the malnutrition rate. CPIM CHWs continued to measure and diagnose chronic malnutrition. Children 6-59 months who have HAZ, WAZ, WHZ z-scores of -1.85 receive food rations for 6 months to ameliorate their nutritional status.

The health and nutrition activities continue to be a program priority and a large percentage of program inputs. While health and nutrition activities increase community capacity and offer short term food security solutions, microfinance and community development activities provide long-term more sustainable solutions to the food insecurity. Consequently, CPIM significantly developed its livelihoods component through pastoralism and increased microfinance activities to improve individual and household capabilities in preventing food insecurity shocks; CPIM also increased community capacity to prevent these shocks through trainings and construction of physical community infrastructure through community mobilization.

CPIM program achievements are bolstered by key partnerships from international and national organizations. The partnership formed in FY08 with the GOM's Commisariat à la Sécurité Alimentaire (CSA) has continued to facilitate our commodity component by: allowing CPIM to use its semi-trucks for commodity transport between Nouakchott and regional warehouses; stocking CPIM direct distribution commodities at its national and regional warehouses; and taking care of the commodities by cleaning and fumigating the warehouse and stacking commodities on pallets.

Within the health component, CPIM has partnered with UNICEF, the MOH, and ADICOR (a local NGO) to facilitate program activities. In collaboration with UNICEF, CPI held 3 workshops in regional capitals on "Assainissement Total Pilote par la Communauté" or Total Community Sanitation. These workshops trained 33 village representatives to encourage latrine construction and utilization. CPIM has also continued its partnership with a local microfinance institution to implement its microfinance activities; this partnership has been strengthened through regular meetings and CPI and the microfinance organization have developed several tools for microfinance together. In Hodh-el-Gharby, CPIM continues to partner with ACORD, a

local NGO for community development activities; meetings are held regularly at the field site in Hodh-el-Gharby and between the main offices in Nouakchott. By forming these strategic partnerships, not only has the CPIM program become more diverse in the program inputs offered, but it also connects the communities with other development organizations potentially offering CPIM communities future development assistance opportunities.

General Project Operations

Following the midterm evaluation in March, CPIM has prioritized implementing its recommendations. All of the senior staff including the country representative, program coordinator, regional office managers and technical managers had a meeting in Nouakchott to discuss the recommendations and create action plans for their implementation. In October, there was another meeting between senior staff to discuss constraints and revisions to the action plans for the midterm evaluation recommendations. Moreover, given that CPIM is currently in its fourth year of the program, CPIM is prioritizing strengthening the sustainability of all program components.

IR.1.1: Improved Caretaker Practices in Health, Nutrition and Hygiene

For the FY10 Annual Results Report, CPIM is using the FY2009/10 IPTT, not the May, 2010 IPTT submitted with the MTE report; the May 2010 IPTT was just approved in October, and consequently, CPIM had not revised its tracking system to reflect the new IPTT.

As previously mentioned during FY2009, CPIM focused on providing program inputs and strengthening capacity of its trained health agents. Essentially CPIM works to install a local health care system that complements and works synergistically with the local governmental health structures in the area of Maternal and Child Health and Nutrition (MCHN). The absence of mechanisms for the care of the rural poor and particularly for mothers and children is a significant challenge for Mauritania. To respond to this challenge, CPIM initiated a number of interventions to bring non-urgent health care resources to the community level. CPIM organized and trained at each program site a Village Development Committee (VDC) and a Community Health Committee (CHC) composed of Community Health Workers (CHW) and Community Health Facilitators (CHF). Along with CPIM trained state nurses and health animators, the CHC monitors and provides health assistance to all 160 intervention sites.

Strengthened Capacity of GOM Health Personnel to Plan, Implement, and Evaluate Care & Support Programs

Following the midterm evaluation, CPIM's partnership with the Ministry of Health to supervise trainings was found to be ineffective; nurses were too busy at their posts to participate effectively in CPI's program. Consequently, CPIM has discontinued this activity. The supervision visits of regional nurses to assess community health workers competencies and the training of 24 health educators on behavior change communication (BCC) was also not implemented for these reasons.

Capacity Building of Community Based Medical Staff **MOTIVATION OF CHWS**

CPIM's health strategy is to promote and facilitate community based health care. In order to achieve this, CPIM uses CHW and CHF to act as health practitioners in their communities. Each

CPIM intervention site has one trained CHW and two trained CHF, making up the Community Health Committee (CHC). The CHC committee is responsible for disseminating important health information from the supervising state nurse, lead health education sessions, carry out growth monitoring, provide non-urgent medical advice and sell pharmaceuticals, refer life threatening cases to the state run health posts or health centers, and to encourage children to be vaccinated and pregnant women to attend pre-natal visits. All 160 CHW and 320 CHF completed their training during FY 2009; following an evaluation in FY10, 16 were found to be nonfunctional and subsequently 16 new CHC's were formed. All CHW's and CHF's received additional training and animators continuously reinforce their capacity. Currently, all 160 CHC's have been formed and are overseeing the community MCHN program.

Program monitoring and reports show that all 480 CHW and CHF provide information in nutrition and preventative health care to the community. In addition to the CHW, CPIM trained 19 Traditional Birth Attendants (TBA) who are based in 19 different health posts and villages within the CPIM intervention zone. One TBA CPIM invited to the training workshop had a family medical emergency and had to leave the workshop. All TBAs trained are actively applying skills and training correctly. The CHW, CHF, and TBA training has contributed to strengthened community capacity in terms of health care and health care services.

CPI continues to investigate a sustainable CHW motivation and incentive structure to ensure the continuation healthcare service delivery within CPI communities. One option is to increase the percentage the CHW receives from the CPI funded pharmaceutical kits. Currently all money generated is evenly divided to: resupply the kit, provide the CHW a monetary incentive, and the third part is destined to the community for emergencies or health related purchases. CPI will look into increasing the percentage the CHW receives to increase his/her incentive. A second option involves a new national CHW initiative by the Ministry of Health. CPI has been an active participant in planning meetings for the new program. Representatives from the Ministry of Health have identified individuals to serve as government recognized and funded CHW. CPI submitted all literate CHW trained and active in CPI zones to be potential candidates for the new initiative.

CPIM target communities are located far from health posts and lack the means to travel to the posts to receive vaccinations or treatment for non life threatening diseases. For this reason, CPIM brings the vaccines and medicines to the population ensuring coverage across the far-reaching CPIM intervention areas.

Every three months, CHW conduct vaccination health education sessions, explaining the importance of vaccinations for infants under 1 year and for pregnant women. The MOH supplies vaccines and states nurses conduct mobile and advanced vaccination days within the CPIM intervention zone. CPIM provides gasoline and the CPIM health animator to assist with vaccination days. At the end of FY09 33% of children in CPIM intervention zone were found to be completely vaccinated or as it is listed in the IPTT: % of children receiving appropriate immunizations at correct times¹. The achieved result for this indicator was also 33% last year

¹ CPIM defined this indicator to be those infants 11 months or older that are completely vaccinated. The average mother does not know the date of birth for her infant therefore CPI interprets % of children receiving appropriate immunizations at correct times to be those who were completely immunized by 1 year old.

while the target for this indicator listed in the IPTT is 35%. CPIM believes that the actual percentage of children vaccinated is significantly higher than this, however, vaccinations are not properly reported. CPIM is in the process of working with its staff as well as the MOH to facilitate proper documentation of vaccinations.

Unique to the CPIM program, CHWs offer community members access to treatment using non-prescription medications. Each of the 160 CHW was trained using the *PCIME Communautaire* to diagnose and treat or refer cases of: Fever, Diarrhea, Malaria, Anemia, Parasites, Wounds, Pain, Schistosomiasis, Eye disease. CHW use registers and tools that display pictures of symptoms and other information to assist CHW in diagnosing and treating non-urgent cases of these illnesses while referring cases to state health facilities that are beyond her scope of knowledge. Using pharmaceuticals donated from outside sources, CPIM has furnished each CHW with a pharmaceutical kit to help facilitate her work. The CHW is trained on income management and separates the revenue in three portions: one to resupply the kit, one as a community health fund for emergencies, and one as the motivation for the CHW. On average each CHW has 10 consultations a month, over 19,000 consultations a year in CPIM intervention sites.

Growth Monitoring & Promotion (GMP) & Nutritional Surveillance

Growth Monitoring and Promotion as well as Nutritional Surveillance helps community members put value into watching their children grow and also to recognize signs of poor nutritional status. Every 6 months CHW and CHF carry out a door-door GMP campaign weighing and measuring all children 6-59 months. Those children found to be malnourished according to a z-score of -1.85^2 for HAZ, WAZ, WHZ are enrolled in the food supplementation program. Each month, CHW and CHF monthly weigh beneficiary children ages 6-36 months and quarterly children ages 6-59 months to monitor weight gain or loss to confirm those children who are malnourished are benefiting from the program.

Weighing and measuring of children and health monitoring of women

Each child weighed within the GMP program, regardless if receiving food rations, receives a health card that has vaccination information on one side and a growth chart on the other side. Ideally CHW and mothers use the growth chart to monitor a child's growth by marking the height and weight each time the child is measured. Following a recommendation by a FFP visit in September 2009, CPIM has reformatted growth charts and retrained community health workers on how to use growth charts to monitor a child's health advancement. At the time of the FFP visit growth charts were not being filled in. New colored growth charts have instructions (using drawings) how to mark height and weight. The new growth charts have listed z-scores, which facilitate the CHW ability to determine program beneficiaries. The GMP component has also been strengthened through systematically coupling GMP and ration distribution to communities.

In FY 2010, CPIM communities enrolled 13,637 children in GMP, exceeding its target. 35% of beneficiary children 6-36 months were found to be underweight (<-1.85 WAZ) and 30% beneficiary children 6-36 months were found to be stunted. While these percentages are

² CPIM lowered its z-score cut-off from -2 to -1.85 in order to catch children on the cusp of chronic malnutrition.

essentially the same as last year and do not show improvement, CPIM believes this is due to increased accuracy in measurement rather than a decrease in progress. This year, CPIM has significantly reinforced the GMP component which has increased the accuracy of its data; CPIM has added one additional health worker in all four regions and animators have increased their presence during GMP and focused on reinforcing the CHW and CHF's capacity to take measurements. Moreover, CPIM still reached its target for underweight children and is only .5% away from its stunting target.

Children that are found to be severely malnourished are referred to the state run rehabilitation centers for Nutritional Education and Rehabilitation of Children. While CPIM animators who find severely malnourished children encourage their mothers to visit the local health post, there is currently no mechanism in place to monitor if this happens. Consequently, CPIM is currently talking to the Minister of Health to see how to record this indicator. Additionally, in certain regions, CPIM is talking to other NGOs who treat malnourished children to create a system where they will follow-up with the children.

Pregnant and breast-feeding women are also monitored. Each woman has a card showing her vaccination schedule and pre-natal information. The CHW and CHF encourage pregnant women to attend to pre-natal visits and to take iron supplements. Each pregnant or breastfeeding mother with a child of less than 6 months receive monthly rations increasing their nutritional status during and after pregnancy.

De-worming & Micronutrient Supplementation

The MOH and UNICEF conduct bi-annual Vitamin A and de-worming treatment campaigns nationwide. CPIM uses its human and pharmaceutical resources to cover the CPIM intervention zone, ensuring that all CPIM beneficiary children are supplemented. The widespread of Vitamin A deficiencies contributed to high infant blindness, stunting, bone deformities and susceptibility to infection in the target areas. For this reason, Vitamin A supplementation has been provided to all children ages 6-59 months in CPIM intervention sites.

In FY10, 20,099 children from 6 to 59 months were provided with Vitamin A supplements, representing over 100% of all children in CPIM zones. The result listed in the IPTT is 50% of children under 5 regularly receiving vitamin A capsules. The FY 2010 target for this indicator is 98%, however, this target accounts for bi-annual vitamin-A campaigns resulting in children being "regularly" supplemented where-as in FY2010 only one campaign was carried out. In order to be counted for this indicator, the child must have received vitamin A within the previous 6 months, which according to responses from the KPC survey was 50%. Moreover, this is a significant increase from last year's indicator of 29%.

De-worming medicines have also been provided to the target children between 12 and 59 months. This led to their improvement in growth, reduction in the extent of malnutrition and increase in appetite. In FY10, 18,053 children from 12 to 59 months were given de-worming medication Albendazole.

During national Vitamin A and de-worming campaigns, CPIM ensures that 100% of its target population receives the appropriate supplementation. It has been noted that CPIM intervention zones are the only completely supplemented communities in the country.

Promoting Positive Behavior Change

Behavior change promotion is one of the most important sources of support for sustainable improved health and nutrition. CPIM Positive Behavior Change Communication (BCC) uses community level awareness-raising to influence long-term behavior change among beneficiaries. At the community level, the CHF have been provided a field-based participatory IEC (Information, Education and Communication) training. These trainings enable them to facilitate health education topics such as: importance of vaccinations, pre-natal care, exclusive breastfeeding, and hygiene, which includes hand washing, household cleanliness, and promotion of latrines. CPIM produced flip-charts on proper personal hygiene and proper food behaviors. The production of these flip-charts was significantly delayed because counterpart asked the consultant producing the flip-chart to revise the content several times to increase the quality of the flip charts. Consequently, Counterpart decided to delay the workshop for Counterpart staff health facilitators to Q1 FY2011 so that they could be trained on presenting the flip-charts. While Counterpart was planning on using local and national radio to disseminate BCC messages, local and national radio were asking prices that significantly exceeded the budget so the activity was cancelled.

Over 28,053 community members attended health education sessions, which influenced the following indicators:

- % of caregivers demonstrating proper personal hygiene: 13%
- % of caregivers demonstrating proper food hygiene behaviors: 17%
- % of children 0-6 months of age exclusively breastfed: 48%
- % of mothers with appropriate feeding practices for children 6-23 months: 24%
- % of mothers administering correct treatment for diarrhea: 33%

All of the results listed except exclusive breastfeeding are significantly lower than targeted. This is due to the inaccuracy of the baseline and LQAS results. However, almost all indicators have significantly improved in comparison to FY09 results. All of these results were collected using a modified KPC survey from a statistically representative sample of women with children less than 24 months in our intervention sites.

In CPIM intervention sites where there are no latrines, CPIM promotes latrine use by constructing one at the community's school. This provides an opportunity for community members to participate in its construction and also for children to learn about appropriate hygiene. Teachers provide soap outside the latrine and children wash their hands before re-entering the classroom. CPIM assisted with the construction of 13 latrines in FY2010.

IR 1.2: Increase Individual and Household-Level Livelihood Capacities

Training of Micro Credit Personnel

During FY 2010, CPIM continued its partnership with a local Mauritanian microfinance institution called Caisse d'Épargne et de Crédit Djikké-Mutuelle (CECD-M). 8 CECD-M agents and 4 CPIM microfinance animators were trained on portfolio development, client service development, financial procedures, microfinance education, and how to work with community members to initiate the microfinance program in their area. Four loan committees, made up of a CECD-M field agent, CPIM microfinance animator, CECD-M loan agent and the community VDC facilitate the loan process in each CPIM intervention region. The CECD-M agent has initial contact with community members interested in applying for small business loans. The CECD-M agent counsels community members and cooperatives how to write business proposals and assists in creating a business plan. CECD-M management makes quarterly visits to reinforce CECD-M field agent's knowledge and capacity to implement the microfinance program. By working with a local MFI, CPIM is providing a sustainable link for communities to have access to small business loans and have increased capacity to apply for loans.

Micro Credit Support Fund

Small business loans are given in order to increase individual or households capacity to avert food security shocks by increasing income to purchase food products. CPIM provides institutional support to CECD-M to work within CPIM intervention zone. After the CECD-M agent writes the business proposal with the community member, quarterly, the CECD-M and CPIM microfinance agents decide which proposals to fund depending on the business plan and the reputation and economic status of the person requesting the loan. Once a loan application is approved, the CECD-M loan committee disperses the loans.

In order to expand the coverage of microfinance activities and in compliance with midterm evaluation recommendations, loan amounts and periods have been capped at approximately \$385 with a maximum repayment period of ten months for first time individual borrowers. For group or cooperative borrowers, who have proven capacity to reimburse loans, they are given a limit of \$1900 and an extended loan repayment plan.

In FY 2010, 226 loan applications were approved and disbursed; CPIM and CECD-M planned to distribute an additional 80 loans which would have exceeded the target of 250, however, due to the inaccessibility of sites during the rainy season, the disbursement of these loans had to be delayed. All 226 loans given out transformed into an income generating activity. CPIM also targeted to distribute loans to 1500 women but only distributed loans to 865; this is also because of the delay in disbursement of the loan funds. CPIM and CECD-M tracked 149 business activities started with program support; this number is also lower than targeted because of delay in the disbursement of loans. When the disbursement that was scheduled for Q4 FY10 is completed in Q1 of FY11, CPIM expects to exceed all of its microfinance targets.

CPI microfinance animators follow-up with beneficiaries to provide technical assistance and counsel on income management. The loan repayment rate is above 90% in all regions and in one region it is over 100% meaning that beneficiaries are paying back their loans quicker than necessary. CPIM did not formally train community members in business development during FY2010 as projected. Following

the midterm evaluation, the contents of the program were revised and consequently, the training was delayed. The training will take place in Q1 FY2011. Training of the reimbursement committee was also rescheduled for Q1 FY11 due to logistical constraints within CECD-M.

Provide Livestock Services through PCAs

The pastoralism component which debuted in 2009, was strongly solicited by communities and CPIM responded by forming women on dried cheese production in all four regions. CPIM also expanded its activities in animal health and pastoral infrastructure and is engaging private entrepreneurs in capacity building of pastoralists. The CPIM pastoralist focused his monitoring missions on ensuring that women were using proper hygiene practices and following environmental mitigation procedures. The CPIM pastoralist also led animal fattening activities in 8 sites.

IR 1.3: Increased Capacity of Communities to Mitigate their Food Insecurity

Community Mobilization

The 160 VDCs have offered CPIM communities increased autonomy and capacity by forming a community governmental structure, a community action plan, and increased individual component knowledge: community health, microfinance, community development, and commodity management. There are 7 members of each VDC: president, secretary, treasurer, community health worker, microfinance agent, community development agent, and the commodity warehouse manager. Members of the VDC receive Food for Service as motivation for their work.

Following midterm evaluation recommendations, CPIM prioritized reinforcing capacity of its community action component by creating tools and action plans to strengthen village development committees. A guide detailing roles and responsibilities for the VDCs has been created and translated into French and Arabic and distributed to all 160 communities. At the time of distribution, the guide was explained and non-active members were replaced. Additionally, a guide has been developed specifically for CPIM field agents listing steps on how to work with VDCs and encourage active decision-making

In the intervention region, Hodh el Gharbi, CPIM partners with the international NGO ACORD. With supervision from the CPIM office manager, ACORD implements all community mobilization activities in that region.

Concerning the indicator: # of communities completing self-identified and directed activities, CPIM knows of six communities that have self-financed activities or solicited funding from other NGOs. CPIM found this indicator in its “status of sites” survey where it surveyed activities in all 160 sites.

Improvement of Community Infrastructure to Support Improved Food Security:

CPIM is committed to addressing the immediate food insecurity needs of the target communities, as well as strengthening long-term self-sufficiency. 75 communities have physical infrastructure listed in their community action plan, where as 54 of these communities have completed physical infrastructure during FY2009 and FY2010. Communities that do not have listed physical infrastructure in their CAP have listed capacity building, such as market garden training or

livestock assistance as support for improved food security. CPIM community development animators work with community members to facilitate these projects and provide technical assistance as needed. All community development activities that involve agricultural production, receive extension services including materials, seeds, and technical assistance. FY2010 projects included numerous fencing projects for agricultural production land, construction of 3 vaccination parks, a pastoral reserve, two sills to evacuate water from the road, construction of a community market.

Concerning the indicator # of months of adequate food provisioning, the target met for last year was three while this year's target met was nine. This time all sources of income and food were included. In the past, only household food production was included. It is important to note that last year's target was using the population based LQAS survey while this year's result was found using a modified KPC which only captures the program's direct beneficiaries. The indicator, % of households with significantly decreased vulnerability according to the Coping Strategies Index, which also increased significantly this year is also due to the different populations in the LQAS and the KPC.

Distribution of food rations

During FY10, to improve the nutrition state of CPIM beneficiaries, CPIM distributed 1,081,927 kgs of food rations. Children between the ages of 6-59 months who have a z-score of less than -1.85 WAZ and HAZ receive food rations of Corn Soy Blend (CSB), Vitamin-A fortified vegetable oil, and lentils. Pregnant and breastfeeding women with children under 6 months receive Vitamin-A fortified Vegetable Oil, Lentils, and CSB or Bulgur. Additionally, food was distributed to over 1,000 local facilitators from Food for Service rations and over 5,200 beneficiaries of Food for Work under the Community Development component.

2. PROPOSED MODIFICATIONS TO THE M&E PLAN, IPTT, AND/OR WORK PLAN
CPIM revised its IPTT and workplan following its midtem evaluation and submitted these documents with the FY11 PREP. The CPIM M&E system continuously is in the process of being improved and during FY11 it is anticipated that changes to the M&E system will be proposed.

3. SUCCESS STORIES

Please see supplemental materials.

4. CONSTRAINTS & LESSONS LEARNED

Constraints:

One of CPIM's greatest constraints in the implementation of its program is logistics in accessing intervention sites year round with the available resources CPIM has. The intervention sites are between 50-250 miles from the CPIM regional office, making it difficult to carry-out 3 component's activities and distribution of commodities with only 2 vehicles. FY2010 brought heavy rains and abnormal flooding to all four intervention zones, where CPIM animators could not access the intervention area for up to one month due to the washed out roads. Because the CPIM program focuses on community capacity building, it requires high presence from animators to monitor and assist community members in implementing activities in all three program components. Although animators have been moved to the advanced bases to be closer to the sites, accessing sites is still frequently challenging due to lack of transportation or

impassable roads, animators have lower presence in the field and are unable to keep up the momentum of community member's motivation.

CPIM has had significant staffing challenges during FY2010. Two out of four regional office managers were replaced; one office manager moved out of the country and another was not working effectively with office staff and regional authorities. The program coordinator for the last year and a half left in June and was replaced.

Additionally, CPIM's commodity manager passed away in a car accident in June. The commodity manager had significant experience in his domain and was with CPIM since the beginning of the program. Finding individuals with commodity experience is a significant challenge in Mauritania.

Security threats significantly constrain the movement of the two expatriate employees. Al Qaeda in the Islamic Maghreb has continued to attack western citizens in Mauritania and Hodh-el-Gharbi, one of CPIMs four regions is in close proximity to the insecure border region. Consequently, the two expatriates are unable to visit all program regions for security situations.

Lessons Learned

Following significant staff transition and the death of the commodity manager, CPI has learned that they must more codify staff roles and administrative and financial processes. Moreover, for all key positions, there should be a designated backup who can perform the role when necessary.

For the health component, the color-coded health card has significantly increased mothers' knowledge of GMP and staff have noted the importance of using visual aids when working with illiterate populations. Additionally, the coupling of GMP and ration distribution has increased beneficiaries awareness of why they are receiving rations.

Through its activities with regional nurses, CPI has ascertained that regional nurses are not sufficiently trained and do not have sufficient time to supervise community health workers activities and in the future, they will plan to provide nurses with refresher courses. Furthermore, CPI has discovered that for an effective partnership with regional nurses, they must have good communication with the medecin chefs.

CPI has learned that the motivation of community health workers after the completion of the project needs to be examined during project start-up. Talks with the government to employ community health workers following completion of the project have taken longer than expected.

During FY11, CPI will attempt to implement the majority of community development activities during the dry season. There were several construction delays in many projects and the majority of work had to be stopped when rains came, causing a serious delay in its projected completion.

Step by step guides and processes for working with village development committees have enhanced animators' effectiveness. Moreover, village development committees are more aware of their roles and responsibilities in community development. CPIM will also try to schedule the disbursement of all microfinance loans before the heavy rains.