

# Burundi Maternal and Child Health Program

End of Project Report

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**Pathfinder International**

With:

**Management Sciences for Health**

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## ***Acronyms and Abbreviations***

AMTSL:	Active Management of the Third Stage of Labor
ANC:	Antenatal care;
ACT:	Artemisinin combination therapy;
CCA:	Clinical and Community Action
CHW:	Community Health Worker;
C-IMCI:	Community Integrated Management of Childhood Illness
EmOC:	Emergency Obstetrical Care
ESD:	Extending Service Delivery Project
FARN:	Foyer d'Apprentissage et de Réhabilitation Nutritionnelle
HC:	Health Center
HIS:	Health Information System
HTSP:	Healthy Timing and Spacing Pregnancies
IEC/BC	Information-Education-Communication/Behavior Change
IMCI:	Integrated Management of Childhood Illness
IRA:	Acute Respiratory Infections
IPT	Intermittent Prevention Treatment
LLITN:	Long-Lasting Insecticide Treated Nets
MCH:	Maternal and Child Health
MOH:	Ministry of Health
MSH:	Management Sciences for Health
MUAC:	Middle Upper Arm Circumference
NASG:	Non pneumatic Anti shock Garment
NHIS	National Health Information System
PECADOM:	Prise en Charge à Domicile de la Malaria
PD/H:	Positive Deviance-Hearth
PNDS:	National Health Development Plan
PNSR:	Programme National de Santé de la Reproduction
PPH :	Post Partum Hemorrhage
RDT:	Rapid Diagnostic Tests
RED:	Reach Every District
TPS:	Health Promotion Technicians
WHO:	World Health Organization

## **BACKGROUND**

The Maternal Child Health (MCH) Program, an initiative of the Republic of Burundi as part of its bilateral cooperation with the United States Government, was designed to increase the utilization of quality maternal and child health (MCH) services.<sup>1</sup> The Program was funded by the United States Agency for International Development (USAID) and was implemented by Pathfinder International, in collaboration with Management Sciences for Health (MSH).

The main objectives of the MCH Program were to (1) assist the Burundian Ministry of Health to improve the quality of the package of basic maternal and child health services in the northern provinces of Kayanza and Muyinga; (2) to build the capacity of health center staff; (3) to build the capacity of national, provincial and district authorities to collect, analyze, disseminate and act on health information data; and (4) to provide targeted communities with the knowledge and skills to identify, prevent and address key MCH risks. Two main strategies were used to implement the MCH Program's activities. These strategies are to: (1) create demand for MCH services; and (2) build the capacity of the health system to effectively respond to demand with quality MCH services.

The MCH program accompanied the MOH with the first and the second National Health Development Plan (PNDS I & II) particularly in its new initiatives on decentralization of the management of the health system and the Performance-Based Financing (PBF), which are core key elements of the PNDS II.

The MCH Program supported, maintained, reinforced and expanded interventions at the community, clinic, and institutional levels.

These interventions include:

- I. Improve quality and availability of clinical health services
  1. Improve child health services
  2. Improve immunization (including polio) activities
  3. Improve maternal health services
  4. Improve nutrition situation
  5. Maintain communities' information, education and communication for behavior changes
- II. Institutional reinforcement of the health system: Health System Strengthening
  1. Support the health sector decentralization and health reforms
  2. Support the PBF approach
  3. Support the National Health Information System

The MCH Program ended activities on March 31, 2013. This report describes the activities and results produced over the five years program life.

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<sup>1</sup> This also responds to the Strategic Objective USAID's Program in Burundi and which is titled: Investing in People.

## I. IMPROVE QUALITY AND AVAILABILITY OF CLINICAL HEALTH SERVICES

### I.1. Improved Child Health Services

The MCH Program's approaches to treatment of childhood illnesses were based on three main strategies:

(1) support the MOH to maintain Integrated Management of Childhood Illnesses (IMCI) clinical and community activities; (2) strengthen ongoing activities and pilot new approaches in treatment of specific childhood illnesses (e.g., household treatment of malaria, prevention of diarrhea and acute respiratory infections); and (3) address the challenge of ensuring continuous availability of commodities.

#### I.1.1. Integrated Management of Childhood Illnesses (IMCI)

The holistic IMCI approach focuses on the overall well-being of the child rather than focusing on one specific health issue. Jointly initiated by WHO and UNICEF, the IMCI approach aims to reduce death, illness and disability, and promote improved growth and development among children under five-years of age. The approach is comprised of the following two components: (1) reinforcement of clinical services and health systems (often referred to as Clinical-IMCI); and (2) extension of health services to the communities via training of selected community health workers (often referred to as Community-IMCI).

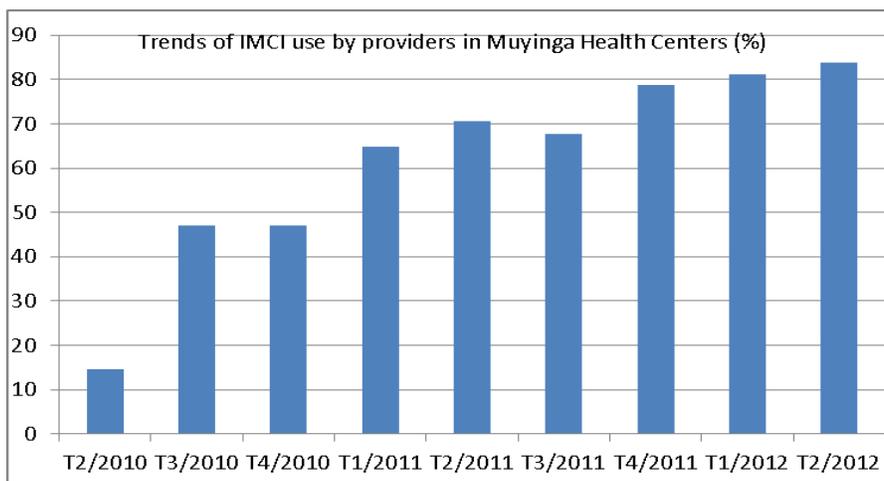
##### Clinical IMCI

The MCH Program supported the MOH to reinforce clinical services and health systems. At central level, a technical and financial support has been provided to develop/update IMCI documents, guidelines and tools. The following documents have been updated: (1) Clinical IMCI training manual, (2) IMCI strategic plan and (3) IMCI scaling plan.

In the two provinces of Muyinga and Kayanza supported by MCH Program, at least 1 nurse has been trained on Clinical IMCI.

In addition, updated documents and consultation registers have been made available in health facilities to guide health providers while receiving and treating children under five-years old. The MCH Program has also supported core district teams to conduct formative supervision.

Following these supports, the quality on the management of child health diseases has been improved as shown in the graph below.



### ***Community IMCI***

The community IMCI aims at extending health services to communities through appropriate prevention and curative services provided by trained CHWs. The strategy is focused on the good health practices in the community and families. In collaboration with partners, the MOH identified 19 health practices of which, 6 are regularly promoted.

At the central level, the MCH Program supported the MOH to develop both in French and Kirundi (local language) community IMCI documents.

In the two provinces of Muyinga and Kayanza, which were supported by the MCH Program, 978 CHWs have been trained on the 6 selected family practices and equipped with standard kits.

Due to initiatives undertaken by the trained CHWs through sensitization, home visits and demonstration in their respective communities, a substantial improvement in applying those practices have been observed.

As an example, the prevalence of diarrhea in children under five decreased from 45.0% to 35.5% between KPC I (2007) and KPC II (2010).



*CHWs evaluation meeting at Muyinga Hospital*

### **I.1.2. Pilot new approaches: *Home Based Management of Malaria (PECADOM)***

Malaria is the main public health issue in Burundi and is prevalent in endemic and epidemic form. It is the principal cause of morbidity and mortality among children under five years. Sixty percent of consultations in health facilities are malaria cases and 50% of mortality for children less than 5 years-age is due to malaria. Despite the efforts made, a high proportion of people are not reaching the health facilities in order to get appropriate care without delays. This is mainly due to the lack of transportation and long distances.

To face that issue, the MOH granted the MCH Program the authorization to pilot, at the community level, a community approach to deal with malaria cases: Home-Based Management of Malaria (PECADOM in French). This project was implemented since January 2011 and 402 CHWs were trained on home management of malaria.

The total number of malaria cases received by CHWs was 27394; among them, 71.45% were received within 24 hours and 80.25% were correctly treated.



*PECADOM Kirundi CHW's aid Manual*



*A CHW performing the RDT in Gashoho*

### **I.1.3. Improved Immunization (including Polio) Activities**

*Reinforcing immunization activities and services is an evidence-based strategy for reducing infant and maternal morbidity and mortality. The MCH Program's approaches to improve immunization services are based on three main strategies: (1) strengthen routine immunization activities; (2) support national and punctual immunization campaigns and (3) monitoring and surveillance of poliomyelitis, measles, and tetanus.*

#### **Strengthen routine immunization activities and surveillance of Poliomyelitis, measles and tetanus**

At the beginning of MCH Program, in the two provinces of Kayanza and Muyinga, immunization activities were facing several challenges due to different factors such as, poor knowledge and skills in applying guidelines on immunization, poor functioning of some refrigerators used to maintain cold chain for vaccines; even when refrigerators do function, health centers could have difficulty securing the gasoline to keep them running, and/or there are stock outs of vaccines and other commodities.

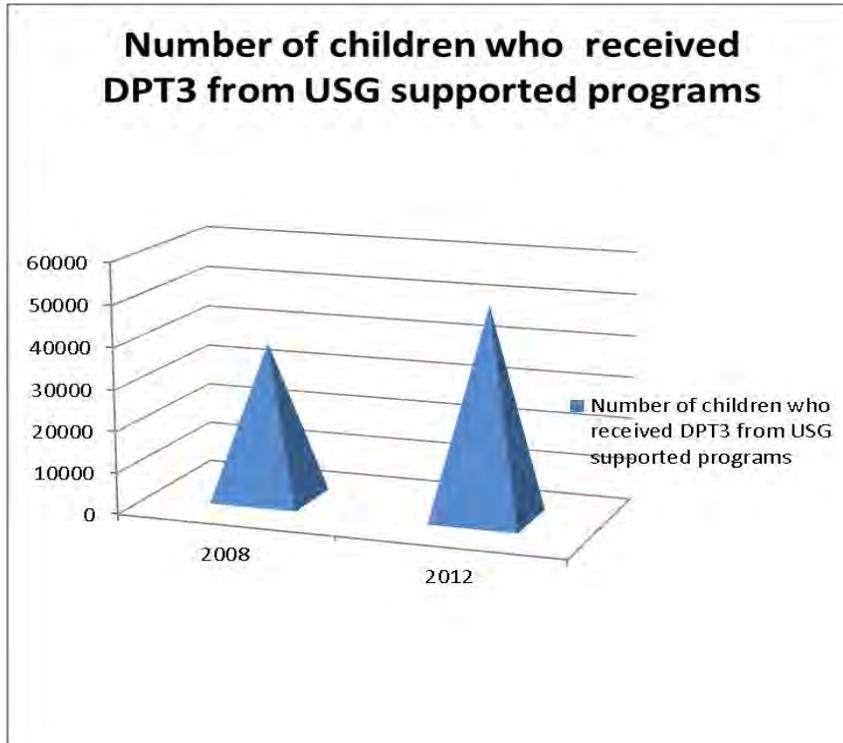
The MCH Program supported the MOH to address those challenges through advocacy to policy decision makers on immunization challenges; technical and financial support on: training of one health provider per health center on RED approach (Reaching Every District), provision and /maintenance /repairing of refrigerators, support in transporting vaccines and, surveillance of immunization implementation including the monitoring and surveillance of poliomyelitis, measles, and tetanus.

In addition, technical and financial support was provided to conduct national and punctual immunization campaigns.



*Sensitization of policy makers during the African Immunisation Day*

As a result of MCH support, the immunization coverage has increased in the two provinces.

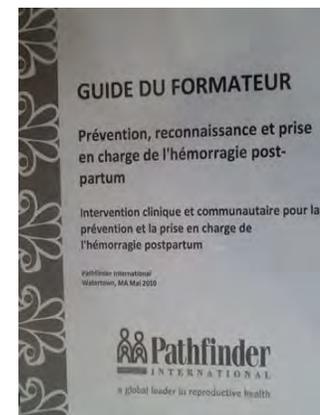


## I.2. Improved Maternal Health Services

*In Burundi, the maternal mortality rate (MMR) has not shown a significant decline since 1990 when the MMR was 400 deaths per 100,000 live births. In 2006, the early neonatal mortality rate (defined as deaths of a live born baby within 7 days after birth) was 37.6 per 1000 live births; one of the highest in the world. The stillbirth rate recorded in health facility level is 27.2 per 1000 live births. The rate of attendance of antenatal care (ANC) services during first quarter and the last month of their pregnancy is still low. The above indicators show the serious challenges related to maternal and newborn health that Burundi is faced with. The MCH Program contributes through various interventions to improve maternal and child health in Kayanza and Muyinga provinces at both the facility and community level.*

The MCH program supported the MOH at all levels in various ways to improve maternal health:

- At Central level: the MOH was supported to update and implement new policies: (1) Norms and Policies in Reproductive Health, (2) integration of Magnesium Sulfate and Misoprostol in the List of Essential Drugs, (3) Focused Antenatal Care and (4) Clinical, Community Action to Address Post-Partum Hemorrhage and Pre-eclampsia and Eclampsia.
- At intermediate and peripheral level: MCH program supported capacity building in EmOM, focused antenatal care, CCA/PPH+, etc. for health providers in health centers and hospital. Moreover, the referral system was supported with fuel for ambulances to ensure transportation of pregnant women from health centers to



*ToT module on PPH*

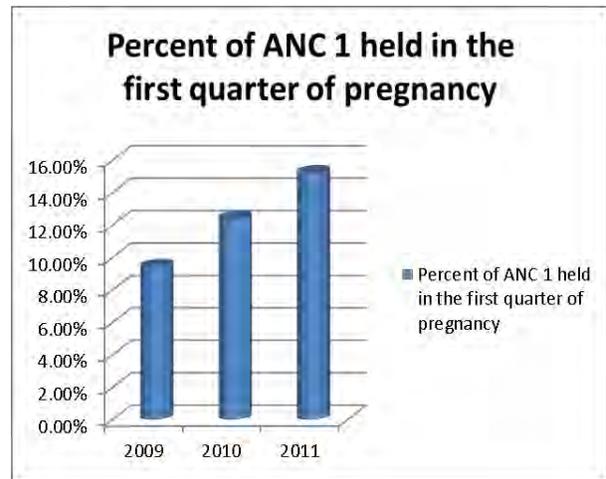
district hospital.

- At community level: CHWs were trained on the recognition of danger signs for early referral and outreach strategies were organized to reach women in remote areas, for antenatal care. These were conducted by a team composed of nurses from the nearest health center, a health promotion technician, and a CHW. Community mobilization was done on various topics, including the importance of institutional delivery versus home delivery, prevention of delays, and birth preparedness.

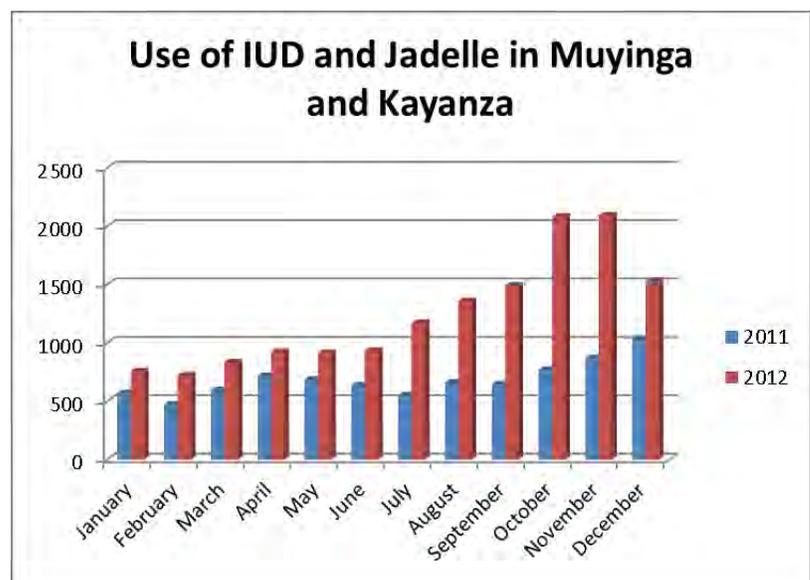


*Outreach activities for ANC (home visits to pregnant women)*

Following the activities above, maternal health services have been improved as shown by graphs below:



Better maternal health also encompasses access to freely chosen contraceptive methods by clients. The MCH program took a lead to help the MOH through protocol revision to include the use of Jadelle on the list of long lasting contraceptive methods in Burundi and improve the related training manuals. In addition, the MCH program maintained, trained and supported formative supervision on the use of FP methods and the delivery of quality services for family planning clients. This led to the increase in FP usage, including the evolution of Jadelle insertion and removal made by providers.



### I.3. Improve Nutrition Situation

Malnutrition remains a major public health problem in Burundi. It contributes substantially to the country's high level of morbidity and mortality, affects the growth and development of children, reduces their ability to learn, and debilitates the country's work force. According to the preliminary results of the Demographic and Health Survey (DHS-2010) the rate of chronic malnutrition reaches 58%, while the rate of underweight was 29%, in 2010.

In order to respond to this situation, the MCH program used the community based nutrition approach called Positive Deviance /Hearth approach. The positive deviance approach identifies and shares solutions/practices already being used by community members with well-nourished children who have no access to special resources: *positive deviance*. The MCH program has trained all the 30 TPS of the target zones, 83 health center in-charge nurses, and 1055 'Mamans Lumières' in both targeted provinces.

During the five years of MCH program life, the FARN/PD-Hearth activities screened 94,185 children under five years of age for malnutrition. Among these, 7,684, (i.e. a prevalence rate of 8.2%) who were moderately malnourished, were admitted to FARNs-PD/Hearths and 6455 of them recovered from malnutrition (this represents a recovery rate of 84%, far better than in a classical malnutrition management scheme).



*FARN session in Gasorwe*

#### Use of micro-nutrients

Deficiency of certain micro-nutrients and childhood diseases are highly connected and therefore integrated activities are required to limit the prevalence of diseases such as measles, acute respiratory infections and diarrhea. The most often used micro-nutrients are vitamin A, iron and iodine. The MCH program contributed to address the micronutrient deficiency by promoting the use of vitamin A supplementary and kitchen garden.

### I.4. Communities' information, education and communication for behavior change

*Maternal and child health issues could be addressed if families adopt healthy practices and seek appropriate services at health centers level for the children and their mothers. In that context, community mobilization and participatory communication activities are crucial to: (1) promote behavior change regarding family and community practices relating to child care and nutrition, (2) improve awareness and health seeking behavior relating to the common childhood illness, (3) improve uptake of preventive services such as immunization, vitamin A supplementation, etc.*

#### I.4.1. Using mobile cinema to sensitize communities on MCH issues

The CHWs and Health Providers need IEC/BCC materials as sensitization tools to support health education sessions. The MCH program produced 3 short videos on maternal breastfeeding, malaria and delivering at health facilities. Since December 2012, the videos have been shown through mobile

cinema at the community level in all communes of Kayanza and Muyinga Provinces. Each projection session was followed by discussions.

The audiences positively appreciated the films and gave testimonies on the health problems that occurred in households and communities relating to ANC and delivering at health facilities, malaria and breastfeeding.

Below are some comments raised by the participants at the film projection sessions, which demonstrate the success of the activity:

- “I understand now why many women are dying when they give birth. They do not access information on the risks they could encounter while delivering at home. Since today I am going to give this information to all pregnant women I know and encourage them to go to Health Center for ANC”.
- “I have a conflict with my mother-in-law every time I get pregnant. She tells my husband that I am a lazy woman who prefers to spend her time at the health center instead of doing agricultural and household activities. I prefer to conflict with her than experience Catherine’s problem in the film”.
- “I am shocked when I see people using mosquito nets for other purposes than malaria prevention: cultivation of tomatoes, house building, fishing... I wish I was an administrative authority just to punish such people. Unhappily I even ignore where I can report those cases”.



*Video Projection session in Gasorwe Commune*



*A woman giving her appreciation on the video at Mubanga*

#### **I.4.2. “Theatre for Development” to support Community dialogues**

Theatre can break through language and cultural barriers and is an extremely useful communication tool. Theatre for development has been used by the MCH Program since 2010 to sensitize communities on MCH issues.

Through theater performance, information was shared on various themes such as: (1) prevention of malaria, (2) hygiene and hand washing with soap, (3) prevention of mother to child transmission of HIV, and (4) exclusive breastfeeding, etc.



*Theatre performance on malaria in Gatara Commune*



*A woman interacting in theatre performance in Kayanza*

### **I.4.3. Community Led Total Sanitation (CLTS)**

CLTS aims to end “open” defecation and was a new approach in Burundi. It focuses on initiating a behavior change in sanitation rather than only building latrines. The approach is done through a process of social “awakening” stimulated by facilitators within or outside the community. The process started by selecting 13 communities, 7 in Muyinga and 6 in Kayanza provinces during the pre-triggering stage. Two sessions, one in Kayanza and another in Muyinga, have been conducted for 72 people from the selected communities to facilitate community appraisal and analysis and communities’ plans of action.



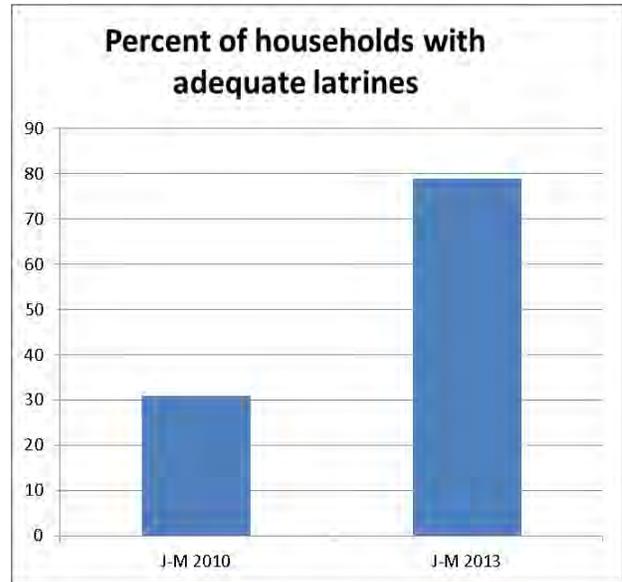
*Triggering session: community action plans*



*Feedback meeting after action follow-up*

The goal of these sessions was to help community members to see themselves that open defecation has harmful consequences and creates an unpleasant environment. It was then up to the community members to decide how to deal with the problem and to take action. Community action follow up on a monthly basis has been crucial to support community members to implement their action plans.

Following CLTS activities, an improvement of latrine construction was observed as shown by the chart.



## **II. INSTITUTIONAL REINFORCEMENT**

*The MCH Program strategy on the strengthening of the health system in Burundi is articulated as follows: (1) support the health system decentralization efforts by (i) ensuring that the 6 districts in Kayanza and Muyinga are functional; (ii) ensuring communities are involved in the management of the health system; and (2) support the national health information system and ensure that it responds to decision makers' needs.*

### **II.1. Supporting the Health System Decentralization**

The establishment of health districts came in a context of insufficient resources particularly in the Province of Muyinga. In Kayanza, two out of the three established districts physically existed, but in Muyinga province only one of three existed. By the end of the project, all these three districts were made functional by providing them support through equipment, renovation and extension of existing infrastructures, offices for the BDS and district referral hospitals. Currently, they offer the complementary package of service, caesarian section, transfusion, etc. On the other hand, the number of health facilities which could offer EmOC package, according to their level evolved from 5 at the beginning of the program to 78 at its end.



*Overview of Gabombo district hospital*



*View of Gashobo district offices*

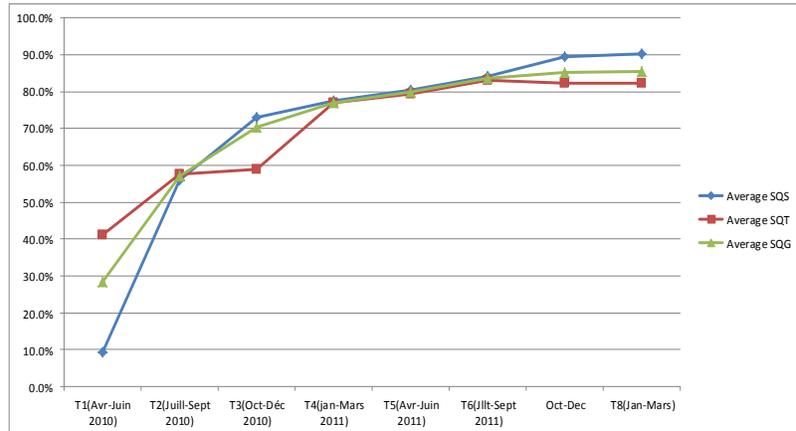


**Electrical aspirator distributed in Muyinga hospital**

## II.2. Supporting the Performance-Based Financing (PBF)

*For many years, the emphasis of health system management was on inputs. Recently, the emphasis has shifted to include the link between management and performance with the delivery of quality health services. The increased focus on systems and institutional capacity highlights the need for a comprehensive framework to improve quality, access, and demand for health services, particularly as services have been integrated and are often, therefore, more complicated to deliver.*

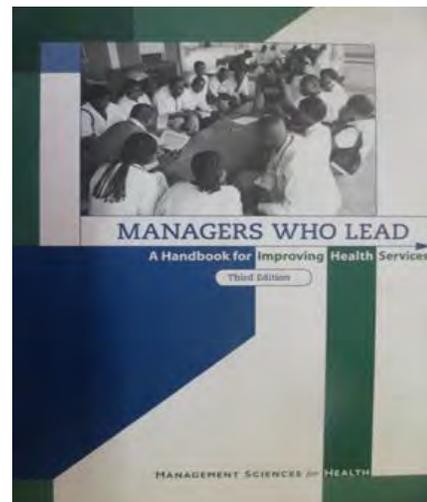
Throughout its life period, MCH program supported PBF through various activities which include: (1) full-time technical assistance in Monitoring & Evaluation; (2) supporting PBF activities at the field level and (3) supporting the CPPV. Moreover, the MOH was provided technical assistance to conduct the costing in order to adapt the indicators' prices. The support above contributed to improve the quality of care as shown by the graph.



*Average quality scores in Kayanza province*

## II.3. Leadership Development Program and coordination

The MCH Program, in collaboration with the Ministry of Health, developed a Leadership Development Program (LDP). The LDP is a structured participatory process that enables teams to apply leading and managing practices to challenges linked to the delivery of health services and to develop the competencies needed to achieve desired results. Different entities from the central level (CNTS, PRONIANUT, DPSHA, PNILMC, HPRC, INSP, DSNIS, PNIMTN), provincial and district level, both in the intervention area and outside, benefitted from LDP training. After a six month period of three training sessions and follow-up, different institutions reached their target. For example, blood demand satisfaction at CNTS improved from 75% to 83%.



*LDP training manual*

The MCH program also took the leading place among other provincial health stakeholders to support, both financially and technically, quarterly coordination meetings. The objective of the meeting was to bring together all stakeholders in order to discuss success and challenges encountered in the field, share experiences, increase partnership and avoid duplication.

## ***Challenges***

- Staffing: the limited number of nurses in the health facilities (an average of 2/HC), and frequent turnover, forced the Project to maintain huge training activities;
- Running water and electricity: access to reliable social services (clean water, electricity, etc.) is limited;
- Data collection: the in-charge nurses produce the monthly report in a hurry, and sometimes gaps are found between the reported data and what is currently in the registers. The MCH program organized a quarterly workshop to discuss challenges and possible solutions to produce quality data, reliable for decision making.

## ***Opportunities***

The notable support offered by the MOH includes (but is not limited to):

- The MOH national and provincial staff participated as trainers in most of the training activities.
- The existing MOH training curricula were made available and used during the training sessions.
- The Program's Office in Kayanza is hosted by the Provincial Health Bureau.
- The Government, in general, facilitated the process of exoneration of the Program's procurement.

## ***III. CONCLUSION***

The MCH program has provided a comprehensive support to the MOH at all levels of the health system: community, district, provincial and national level. This support has been provided through different interventions including (1) health system strengthening, (2) capacity building, (3) empowerment and community mobilization, (4) introduction of new strategies, and (5) renovation and equipment. This has led to the increase of health services utilization and quality in the intervention areas, thus contributing to the improvement of the population health status, especially maternal and child health.

## **Annex: Achievements analysis**

The MCH Program had 40 indicators including: Ten (10) Program indicators considered as contractual requirement; and thirty (30) process/impact indicators to ensure an effective internal monitoring and evaluation process and system. This annex section of the report presents the performance achieved by the MCH-Burundi Project during its life. For each indicator, basic information is presented for clarity. The information includes: (i) Name of the indicator; (ii) the composition and method of calculation; (iii) the performed achievements the beginning of the program and at its end; and (iv) source of the data.

**Indicator 1:** *Percent/Number of births attended by a skilled doctor, nurse or midwife (SBA) in USG-assisted programs (Indicator USAID A3-18)*

**Composition and Method of calculation:** This indicator represents the total number of deliveries with a skilled birth attendant.

Indicator	Achievements for 2007	Achievements for 2012
<i>Percent/Number of births attended by a skilled doctor, nurse, or midwife (SBA) in USG-assisted programs (Indicator USAID A3-18)</i>	15 370	39 597

**Source of Data:** DNSIS annual reports

**Indicator 2:** *Percent/ Number of children who received DPT3 from USG supported programs from USG-supported programs.*

**Composition and Method of Calculation:** This indicator represents the number of children less than 12 months of age who received during the year the immunization doses against the DPT3 in the target area.

The table below presents the progression of the indicator over the fiscal year:

Indicator	Achievements for 2008	Achievements for 2012
<i>Percent/Number of Children less than 12 months of age who received DPT3 from USG-supported programs.</i>	37 839	50 525

**Source of Data:** DNSIS annual reports

**Indicator 3:** *Percent/Number of children who have received the third dose of pneumococcal conjugate vaccine by 12 months from USG supported programs.*

**Composition and Method of Calculation:** This indicator represents the number of children less than 12 months of age who received during the fiscal year the immunization doses against the pneumococcal vaccine in the target area.

Indicator	Achievements for 2008	Achievements for 2012
<i>Percent/Number of children who have received the third dose of pneumococcal conjugate vaccine by 12 month from USG supported programs.</i>	N.A.	50525

***Source of Data:*** DNSIS annual reports

***Indicator 4:*** *Number of people trained in maternal/newborn health (MNCH) through USG supported programs (Indicator USAID: A3-17)*

***Composition and method of calculation:*** This indicator represents the number of people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in maternal or newborn health through USG supported programs.

These trainings included:

- Training in Obstetrical care (emergency, basic and comprehensive/complete) and AMTSL/PPH;
- Training in Prevention and Treatment of Malaria;
- Training in Integrated Management of Childhood Illnesses (IMCI, community and clinical);
- Training in Family Planning including the Healthy Timing and Spacing of Pregnancies (HTSP);

All the trainings had specific learning objectives, course outline or curriculum and expected knowledge, skills and/or competencies to be gained by participants.

***Source of Data:*** MCH Database

In order to facilitate the monitoring of training activities implemented by the MCH Program, a tool/form is developed to capture for each trainee identification number, name, profile (CHW, clinical health provider) place of work, gender, etc. After each training activity, the forms are filled in, collected, data entered in excel table, and protected within the project.

***Indicator 5:*** *Number of people trained in child health and nutrition through USG-supported health area programs (Indicator USAID A3-20);*

***Composition and Method of calculation:*** This indicator represents the number of people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in child health and nutrition care through USG supported programs. These training workshops aimed to improve and build the capacity of providers and community health workers in provision of quality child health and nutrition care services.

These trainings included:

- Training in Nutrition;
- Training of ‘Mamans Lumières’ in PD/Hearth Nutrition;
- Training in Integrated Management of Childhood Illnesses, IMCI (clinical and community);
- Training in Immunization process;
- Training in prevention and treatment of Malaria.

***Source of Data:*** MCH Database

**Indicator 6:** *Number of children under five years of age who have received Vitamin A during the period*

**Composition and Method of calculation:** This indicator represents the total number of children under five years of age who received vitamin A during routine distribution by health centers of vitamin A, but also during specific immunization and distribution of vitamin A campaigns.

The table below presents the progression of the indicator over the fiscal year:

Indicator	Achievements for 2008	Achievements for 2012
<i>Number of children under five years of age who have received Vit A during the period</i>	34 558	454 963

**Source of Data:** DNSIS annual reports

**Indicator 7:** *Number of children reached by USG-supported nutrition programs during the period*

**Composition and Method of calculation:** This indicator represents the total number of children enrolled in FARNs and PD-Hearth activities, including malnutrition screening activities.

The table below presents the progression of the indicator over the fiscal year:

Indicator	Achievements for 2008	Achievements for 2012
<i>Number of children reached by USG-supported nutrition programs during the period</i>	N.A.	94 185

**Source of Data:** MCH database

**Indicator 8:** *Number of functional health districts*

**Composition and Method of calculation:** This indicator represents the total number of functional health districts in the two provinces. The functionality is defined here by the fact the districts (1) have their own Offices; (2) have been staffed; (3) are performing supervision, two-ways referral, and HIS; and (4) have the stocks of medicines.

The table below presents the progression of the indicator over the fiscal year:

Indicator	Achievements for 2008	Achievements for 2012
<i>Number of functional health districts</i>	2	6

**Source of Data:** MCH database

**Indicator 9:** *Number of trainings of district health teams to support the new health reform*

**Composition and Method of calculation:** This indicator represents the total number of trainings conducted for health districts’ teams on decentralization and PBF

**Source of Data:** MCH database

***Indicator 10:*** *Number of women having received counseling on FP services*

**Composition and Method of calculation:** This indicator represents the total number of women having received counseling on FP in the health centers and/or hospitals.

The table below presents the progression of the indicator over the fiscal year:

<b>Indicator</b>	<b>Achievements for 2008</b>	<b>Achievements for 2012</b>
<i>Number of women having received counseling on FP services</i>	N.A.	78 387

**Source of Data:** The MCH Program internal database system and the NHIS.

***Indicator 11:*** *Number of district teams with the full complement of staffs*

When the MCH program started, only two of the six health districts covered had the full required staff available. As the program ends, all six health districts are fully staffed according to district’s norms.