

IRC Response to the Mid-Term Evaluation for the Kibungo Child Survival Program

Kibungo, Rwanda
March 15, 2004

Prepared by:
Edison Twagiramungu, Kibungo District Medical Officer
Diogene Dukuzuyesu, Kirehe District Administrator and Nutritionist
Francois Kamali, Rwinkwavu District Chief Supervisor
Eugene Twahirwa, Child Survival Coordinator
Annick Wajeneza, Child Survival Assistant Coordinator
Emmanuel d'Harcourt, Child Survival Technical Advisor

The Kibungo Child Survival Program’s management team, in collaboration with its partners, the Medical Officers for its four partner health districts, take note of the Mid-Term evaluation submitted by Bonnie Kittle. We agree with many of the findings and recommendations of the evaluation, and appreciate the effort put into the evaluation. In addition to the recommendations discussed below, we feel the mid-term evaluation report is filled useful observations and suggestions that we will use in the next two years. We also have some points of disagreement. The following report contains IRC’s response to the Mid-Term evaluation, as well as to related comments from an independent reviewer, received through the USAID Child Survival and Health Grants Program.

Table of Contents (Section A refers to the comments received from CSHGP; Section B-I refer to sections of the Mid-Term Evaluation)

A.	Summary and response to reviewer comments.....	2
B.	Main Accomplishments	2
C.	Main problems	4
D.	Capacity-building effects and sustainability	6
E.	Priority recommendations	6
F.	Intervention-related recommendations.....	8
G.	Cross-cutting recommendations.....	10
H.	Management recommendations.....	11
I.	Principal Conclusions and Recommendations.....	12

A. Summary and response to reviewer comments

The Mid-Term Evaluation conducted in September 2003 highlighted major achievements of the Kibungo Child Survival Program, as well as areas in which the program can improve substantially. In general, the evaluation showed significant improvements in key indicators, as well as a high potential for sustainability for many of the community activities. The evaluation identified quality improvement at community and facility level as a major focus for future improvement. It also recommended a major shift in nutrition strategy.

We agree with most of these findings, as detailed in the following report, and will implement them over the remaining 18 months of the program. Several recommendations are already been implemented. For example, a major quality assurance initiative to improve obstetric care has begun; an assessment was conducted in December of 2003. Our major disagreement is with the report's finding that the current nutrition strategy has not had the expected impact. We believe that both program and KPC data demonstrate the reverse. This disagreement is of limited consequence, however, since we agree with the report's nutrition recommendations, including the need to improve quality and supervision of activities. We also plan to pilot the hearth method as recommended, although we will do so at a much smaller scale than recommended.

We also feel the report failed to highlight major capacity-building effects of the program, most notably the use of participatory LQAS methodology for KPC surveys and the use of the "target-weight" method for community growth promotion. We feel both of these have had substantial impact on the involvement and performance of our MOH and community partners, and were not properly considered.

Although there is general agreement with the report's findings, we have concerns about the methodology of the evaluation. We feel the evaluation was not always as participatory as it could have been, and that recommendations were sometimes phrased in a way that was unnecessarily provocative to IRC staff and Ministry of Health partners. This is particularly regrettable since there is agreement on much of the content of the evaluation. As a result of these problems with the process, the IRC Child Survival Coordinator and Technical Advisor had to re-establish consensus with partners on all of the recommendations.

We also agree with the following three major recommendations from an independent reviewer transmitted through the CSHGP:

- 1. Under pressure from the provincial MoH IRC agreed to cover the entire Western Province of Rwanda, which means taking on the challenge of covering over 110.000 children under five and 160.000 women aged 15 to 49 (a population size four to five times that of an average CS project). IRC however has neither a bigger staff nor a larger budget than the average CS project, and has set ambitious targets. It is thus no great surprise that during the MTE it was suggested to lower some targets. Targets are expressed as a percentage of the target population, and it might thus still be possible that this project will have an impact on more women and children than the average CS project.*

Response:

- We have lowered the targets for two indicators (maternal vit. A and for early breastfeeding).

- For other indicators, we feel that the mid-term KPC showed we have reached or are approaching our final target. Many of those targets were relatively modest (e.g. 20% bednet coverage)
 - Two of the indicators cover only one district, because this is the only district in which community-based distribution of anti-malarial medication will be implemented.
2. *A disadvantage of dealing with a large population however is that IRC is forced to deal with big numbers of women and children and that quantity seems to be prioritized over quality. IRC staff has to cover large populations spread over a considerable physical areas and is not able to provide adequate and sufficient supervision of ongoing activities.*

Response:

- We agree that supervision is a challenge. However, we feel that supervision can be adequate if we increase the ability and motivation of health center staff to supervise community health workers. The action plan includes a series of working meetings with District and Health Center staff to explore obstacles and develop strategies to increase their involvement in supervision. This will also contribute to program sustainability.
3. *Moreover it is not clear if the remaining funds will be sufficient to cover all ongoing activities or start up new activities as suggested in the MTE.*

Response:

- Some projected expenses have been reduced. For example, the hearth program will be piloted in only one community, and technical assistance will come in-country and at low-cost from World Relief child survival staff. The CS team, after a detailed analysis of the budget and expenditures, has determined that the program needs an additional \$50,000 to function until the end of the funding cycle. The IRC development department, in collaboration with CS staff, has initiated a mailing campaign that is expected to raise \$100,000 for the CS program this summer.
4. *The MTE evaluation suggest IRC pilot test the Hearth method. Before embarking on hearth, IRC should carefully consider the severe malnutrition rates and village sizes or spread: will there be enough children in one geographical area to make this a worthwhile investment for/from the community. IRC could try to identify underlying causes for malnutrition and reasons for the apparent failing of the current strategy. This should lead to some rational OR activities to orient new directions rather than to embark on a new strategy without being able to compare it to the current MoH approach. E.g. IRC should try in one catchment area an improved/quality community based nutrition (MoH) model, with increased supervision and improved counseling, while also aiming to reach more children in the vulnerable age groups. This approach can then be compared with the Hearth model. Both models should be looked at keeping in mind several factors such as effectiveness in addressing malnutrition, costs, community preferences, sustainability.... Operational research will make it easier to convince the MoH of the potential and limitations of both methods and thus inform the need for changes.*

Response:

- Our staff has embraced this idea, which we will be implementing over the next few months. We will likely solicit technical assistance from CSTS or others as we do so.

B. Main Accomplishments

We concur with the Mid-Term Evaluation Report's findings of the following accomplishments:

1. Increased capacity of over 1,780 community health workers, leading to improved performance.
2. Strengthened link between health facility staff and community health workers, leading to increased use of services.
3. Increased access to nutrition services.
4. Development of a functional community-based information system.
5. Increase in utilization of hospital and health centers from 16% to 25% of obstetric deliveries.
6. Creation of sustainable associations of community health workers.
7. Sustainable manufacture and distribution of birthing kits now used in over half of home births in the province, reducing risks to both mother and traditional birth attendants.

We believe the following major accomplishments should also be noted:

8. Improvements at or beyond targets for most program indicators, including:
 - Increased proportion of children receiving Vitamin A
 - Increased proportion of children with a normal weight-for-age. We note that the baseline and LQAS figures given on page 11, paragraph 2 of the mid-term evaluation report are not accurate. The prevalence of low weight-for-age among children 0 to 23 months –the proper reference group– in the 1998 survey is 39.8%. The prevalence of low weight-for-age among children 0 to 23 months in the 2003 LQAS survey is 17.4%, with a 95% confidence interval ranging from 15.2% to 19.9%. Thus, the report's statement that "a significant challenge lies ahead to reduce malnutrition to the project target of 20%" is not supported by the evidence. In fact, the target has already been achieved.
 - Increased proportion of women receiving iron for at least a month during pregnancy
 - Increased proportion of women receiving at least 2 TT immunizations during pregnancy
 - Increased proportion of TBA deliveries transferred to health facilities
 - Increased number of cesarean sections done in area hospitals
 - Increased proportion of women and children receiving a post-natal visit
 - Decreased death rate from febrile illness among under-5 children in the one district where it has been measured since 2000
 - Increased proportion of children sleeping under a correctly-treated mosquito net.
9. Increased the capacity of the Ministry of Health, particularly the District Health Teams, to plan, implement, and monitor child survival activities:
 - Increase in the number of child survival interventions included in District annual plans.
 - High level of involvement of the District Health Teams with child survival interventions, and familiarity with coverage levels in their district. Each district has at least one team member assigned with following the community health worker networks.
 - Increased capacity of District Health Teams to conduct coverage surveys using LQAS methodology, as evidenced by the fact that District Health Team members have served as consultants to other US-based PVOs conducting surveys. Twenty-eight health center managers have also become familiar with the sampling and analysis methodology.

C. Main problems

1. We concur that the work area of the Kibungo program is very large. However, we feel that the program can be implemented well over that area with the resources at our disposal. We feel the program's achievements to date support this conclusion. This is principally because many of the activities are carried out by MOH partners; IRC serves principally as a technical, training, and monitoring resource. We also disagree with some of the specific statements within that finding:
 - "The ratio of field staff to community health workers is in excess of 1:200 and the number of activities is too great for project staff to supervise effectively." In fact, IRC field staff are not meant to supervise the community health workers directly. This would be unsustainable. Health Center staff are supposed to do this, with IRC staff building their capacity to do so. Therefore, we believe the basic problem is that, in many but not all health centers, IRC staff still play too large and health center staff too small a role.
 - "Health Center staff ... contact with CHWs is limited to monthly meetings and occasional contact during outreach activities." We believe that the word "limited" is misleading. Monthly contact with three categories of health workers over an entire province is extremely important and, indeed, a major accomplishment of the program and one of the key reasons behind the improved performance of community health workers. We find that nearly all community health workers know their health center manager personally, and vice-versa, with major consequences on communication and performance.

2. We feel that there is not enough evidence for us to definitively agree with the finding that "the Community-based Nutrition Program, the strategy chosen at the behest of the MOH, is probably not the most effective means to reducing the rate of malnutrition." We have carefully reviewed the reference given by the mid-term evaluator, a report by Save the Children, and spoken to its authors. The Save the Children report focuses on potential pitfalls of community growth monitoring as well as concerns with the way three national World Bank nutrition programs are being implemented. We feel some of the concerns about growth monitoring do indeed apply to the Kibungo program. In particular:
 - The low level of education of community nutrition agents makes training difficult, and as a result counseling is often inadequate.
 - Closer supervision is still needed.
 - Growth monitoring in itself cannot address major causes of malnutrition including food insecurity.

We agree that the major steps can be taken to improve the quality of the nutrition program as relates to training and counseling, although we feel that the program is working and has demonstrated an impact on key indicators and on malnutrition prevalence,

However, we feel other concerns from the Save the Children report do not apply to the Kibungo program:

- Excessive scale: the Kibungo program has been gradually expanded from a small pilot in two health centers. It has considerably evolved as a result of lessons learned.
- Integration: Nutrition activities in Kibungo are integrated with other preventive activities such as immunization. The system is built on the existing health infrastructure and is in no way a parallel program.

- Motivation: We feel that we have solved that problem in a sustainable way. Women are willing to pay a small sum –less than 10 cents– because they receive several services at once, and the total sum collected each month has proven enough to motivate the three community nutrition agents in each site. In fact, there is a waiting list of people eager to become community agents.
- Poor understanding of growth charts: We feel we have addressed this to a large extent by using the “goal-target” method developed by the Manoff Group. This non-graphic method build on mother’s good understanding of the concept of weight, and strong motivation to see their children grow. We feel the statement on page 12, paragraph 3 of the mid-term evaluation report that “the target weight card only serves to focus more attention on recording the desired weight and not on advising the mother what to do to achieve the weight gain” is not consistent with our experience. We feel the target weight method does not in practice lead to less (or more counseling). Its main advantage is that it is much better understood by caregivers.
- Addressing other causes of malnutrition: The integrated program as it currently exists has the potential to rapidly identify areas of food insecurity, and pass it on to national decision-makers who can act on this information. Furthermore, the integration of community treatment for diarrhea and malaria –and potentially in the future, for other diseases—will help the program address that cause of malnutrition.

We while we share the evaluator’s concern that growth monitoring as a “single intervention” may not be effective, the Kibungo program as it currently operates is far from a single intervention. Immunization, vitamin A distribution, ORS distribution, and deworming are also included. Malaria treatment and zinc distribution are likely to be added soon. This “one-stop shopping” approach was one of the recommendations of the Save the Children report.

D. Capacity-building effects and sustainability

We concur with the report’s finding that the program has had a significant impact on the competence of community health workers and district health staff. We also concur with the report’s finding that the Child Survival program has made significant strides towards sustainability through associations and other means.

E. Priority recommendations

1. Pilot-test the Hearth method in each of the four districts. If results are positive, adopt this strategy as the primary means to address moderate malnutrition.

We accept this recommendation, but we would like to pilot the method in one rather than four districts. Hearth methodology has been criticized just as growth monitoring has. In particular, there are concerns that it is extremely resource-intensive and may be difficult to scale-up. These concerns are borne out by the experience of World Relief managers, who have begun using the method and report that is costly in terms of both time and money. We

are concerned that such a resource-intensive activity may not be sustainable. However, we feel the method has potential and is worth piloting on a small scale. We feel that, even if it proves unrealistic for the entire Province of Kibungo, the hearth methodology may provide important information to IRC and MOH partners—information that may be transferable to other communities.

2. Begin immediately to shift responsibility for supervising growth promotion sites to the health center and district health teams.
We accept this recommendation. We will analyze the current situation to understand why this has not happened, despite our efforts, and will work to develop specific strategies to achieve this important goal.
3. Formally assess and classify growth promotion sites, so that project supervisors can focus their efforts on strengthening the weakest sites.
We fully accept this recommendation. We intend to use quality assurance methodologies to accomplish this.
4. Review current intermediate (process indicators) results (IR) and add IRs where necessary. Establish IR monitoring systems and track these on a quarterly basis. Monitor impact indicators only on a bi-annual basis (twice per year- this does not mean doing an LQAS twice per year.)
Please see proposed table of indicators and intermediate results. We agree with the proposed schedule. We propose doing one more LQAS-based KPC survey, as part of the final evaluation.
5. In collaboration with the Quality Assurance Project, assess the quality of obstetric care at all health centers in the Province. Then, in collaboration with District Health Teams develop in-service training opportunities geared toward up-grading the skills of health center staff responsible for conducting deliveries.
We fully accept this recommendation.

F. Intervention-related recommendations

<i>Recommendation / Response</i>
<p>1. <i>Change the Vitamin A indicator to match the current MOH policy</i> We fully accept this recommendation.</p>
<p>2. <i>The project should reduce the target objective from 60% to 40%.</i> We fully accept this recommendation.</p>
<p>3. <i>Increase target objective for Vitamin A consumption among children from 50% to 70%.</i> We fully accept this recommendation.</p>
<p>4. <i>Change malnutrition indicators to target children less than 2 years of age.</i> We fully accept this recommendation. The previous indicator was developed before we decided to include anthropometry into the KPC surveys. Also, we will change the indicator from “% of median” to z-scores to be consistent with the baseline and international norms. % of median figures will continue to be used when following monthly program data.</p>
<p>5. <i>Increase target objective for malnutrition (< 80% weight for age) from 20% to 25%.</i> As noted above, we believe this recommendation is based on inaccurate numbers. We believe the current target should be maintained of 20</p>
<p>6. <i>Standardize all indicators to read “percentage” rather than “proportion”.</i> We will change this to avoid any possible confusion. We are unclear about the usefulness of this recommendation, however. We believe that a percentage is a proportion (although not all proportions are percentages) and that the two terms can be used interchangeably in this context.</p>
<p>7. <i>Modify the CBNP supervision checklist and correct the flaws identified in this report. Train staff and health center personnel to use it correctly; Use the new checklist to assess the performance of nutrition animators and to organize on-the-job training and support.</i> We fully accept this recommendation.</p>
<p>8. <i>Train district health teams in the Hearth method as part of pilot tests in each district. Monitor and evaluate the pilot hearth activities and disseminate and discuss the results; determine if the approach should be implemented more widely in the Province.</i> We will do this in one district</p>
<p>9. <i>Up-date TBA training module so they accent the targeted behaviors, such as immediate and exclusive breastfeeding and need to post-natal consultations</i> We fully accept this recommendation. However, we believe that this indicator did not progress in part because of the phrasing of the KPC questionnaire.</p>
<p>10. <i>Refrain from measuring improved birth outcomes by promoting C-sections. Rather, use the percentage of facility births, percentage of women reporting having been attended by a trained TBA for their home birth, and the percentage of women who report using a birthing kit during their home birth as proxy indicators for improved birth outcomes.</i></p>

We feel that this indicator, which like nearly all obstetric indicators, has limits but is useful. A recent review in the WHO bulletin stated that “in settings where access to surgical services is very low, the majority of caesarean sections may well be carried out to save the life of the mother, and caesarean rates may be accurate tracers of the use of essential obstetric care services.”¹ Given that the caesarean rate in Kibungo Province is 2.8% for 2003 (up from 1.1% in 2001 but still very low) we feel this is a valid indicator. This opinion is shared by the District Medical Officers responsible for the two hospitals.

We do accept the recommendation regarding the other indicators, and will incorporate them.

11. *Move the “improved quality of obstetric care at health centers” indicator to the intermediate result position and remove altogether it as an impact indicator in the project’s matrix.*

We accept this recommendation to avoid any possible confusion.

12. *Project staff and the district health teams of each district assess the quality of obstetrical care at each health center with assistance from the Quality Assurance Project (located in Kigali). Following the assessment, approaches to address the weaknesses revealed should be identified and implemented within the shortest timeframe possible.*

We fully accept this recommendation.

13. *Project staff deliberately identify missed opportunities, and begin to promote the key messages and behaviors at every possible moment*

We fully accept this recommendation.

14. *The alternative objectives and indicators for the malaria prevention component sited in the evaluation report should be reviewed and considered by the project staff; if approved they should officially replace those in the DIP.*

We accept the second (bednet use, which is already an indicator), third (awareness of symptoms), and fourth (treatment within 24 hours) indicators mentioned. The last two are indicators of the CORE group and USAID mission-support initiative to pilot community-based distribution of antimalarials.

¹ Ronsmans et al, “Questioning the indicators of need for obstetric care”, Who Bulletin, 80 (4), 317-324.

G. Cross-cutting recommendations

<i>Recommendation / Response</i>
<p>1. <i>Project staff make a greater and more consistent effort to involve community leaders in the project and to more assertively promote participation in the project's activities through these leaders.</i></p> <p>We concur that this is an area of great importance, and generally agree with the recommendation. The field team feels considerable efforts are already being made. For example, community leaders are routinely involved in the planning of community nutrition clinics.</p>
<p>2. <i>Focus more on monitoring the <u>process</u> of project implementation and less on measuring the impact of the project.</i></p> <p>We generally agree with this recommendation, although we feel that we are already looking at a number of process indicators, such as attendance at nutrition clinics, newborns weighed, and bednet sales.</p>
<p>4. <i>Identify how many of each type of health worker/ animator remains to be trained and design a training plan to complete the training.</i></p> <p>We feel we cannot commit to this recommendation, which apparently conflicts with the earlier finding that the program was overextending. Before committing to any further training, the IRC team will work with each health district to insure that current supervision is adequate. Before committing to any further training.</p>
<p>5. <i>Develop a standard format for module design (or borrow one) and have each trainer follow the format when s/he is designing a module; compile all of the modules into one document, review the document together (all of the trainers) to make sure the course content addresses all of the course objectives (and nothing else). Keep the training curriculum as a record of the course.</i></p> <p>We feel there was a misunderstanding. Trainings are already done using standard modules. The problem is that some of the modules –particularly for TBA training– is out-of-date, and trainers have to add to them. We are working with the MOH to update the TBA and malaria modules.</p>
<p>6. <i>Collect, design, visual aids to be used during the training; reference training documents to discover more varied participatory training methods, especially ones for illiterate participants.</i></p> <p>We fully accept this recommendation. We have already begun to identify visual aids for community nutrition clinics.</p>
<p>7. <i>Assign targets for each of the sustainability indicators and set up systems to monitor progress toward them</i></p> <p>We fully accept this recommendation.</p>
<p>8. <i>Starting in the second half of the project, more emphasis should be placed on district and health center staff taking responsibility for supervising CHW activities, outside the health facility.</i></p> <p>We fully accept this recommendation, although we feel it could be made more specific. We need to identify why this has not happened already despite efforts.</p>

H. Management recommendations

<i>Recommendation / Response</i>
<p>1. <i>Decide whether it is worth investing more time in training/supervising the weaker staff members, or whether it would be more expedient at this time to hire field staff with a health profile</i></p> <p>We believe strongly that the child survival program will be more effective if the staff have strong incentives to perform, but also a sense of stability, security, and caring. Staff dismissal will have an extremely negative impact on morale and commitment.</p> <p>We acknowledge that some aspects of the program –particularly facility-based interventions, which need to be more involved– would be easier for staff with a health background. However, we believe that, with appropriate management, current staff can improve their performance to appropriate levels. We also feel that the time needed to orient new hires will be an obstacle given the short time left.</p> <p>Consequently, we propose:</p> <ul style="list-style-type: none"> - To re-formulate job descriptions based on the revised objectives and recommendations of this evaluation. This job description will be done with input from our MOH partners. - To do a formal evaluation of each staff in six months(September 2004), based on the above job descriptions. - Re-evaluate the recommendation based on the findings of this evaluation.
<p>2. <i>Staff Supervision at all levels needs to be more formalized so that staff get regular feedback regarding their work and official records can be kept. Checklists should be developed that correspond to the given position and official supervisory visits should be made to field-based staff every 3-4 months. When writing performance appraisals reference should be made to the completed supervisory forms.</i></p> <p>We fully accept this recommendation.</p>
<p>3. <i>Shift responsibility for CBNP supervision to health center and DMT staff</i></p> <p>We fully accept this recommendation. See comments above.</p>
<p>4. <i>Reduce staff meetings (that include supervisors) to once per month</i></p> <p>We have decided to try meeting every two weeks. We will try this for three months and make a decision about further spacing.</p>
<p>5. <i>Fluency in French or Kinyarwanda, in addition to fluent English should be criteria for hiring international staff to work on the project.</i></p> <p>We fully accept this recommendation.</p>
<p>6. <i>PVOs operating in high-prevalence countries need to have a HIV/AIDS in the workplace policy in place and it should be discussed openly with project staff. Staff should be encouraged to be tested and receive counseling and to share their status with senior management so that appropriate support can be provided.</i></p> <p>“Encouraging” or otherwise pressuring staff to be tested poses serious ethical issues. A workplace HIV/AIDS policy is currently being developed and will include access to testing as well as to anti-retroviral treatment.</p>

<i>Recommendation / Response</i>
<p>7. <i>The IRC/Rwanda finance controller participates in the development of the action plan (that will be developed as a follow on to this evaluation process). As activities are being planned she can be associating the costs tied to each activity, so that programming and budgeting can be done simultaneously.</i></p> <p>We fully accept this recommendation.</p>
<p>8. <i>IRC headquarters seek out matching funds that can be used to support the operational costs of the project</i></p> <p>According to IRC policy, this is primarily the responsibility of the Kigali office. However, the New York office and the Technical Advisor are also involved. The IRC development department will dedicate funds from its summer mailing campaign to support the Kibungo Child Survival Program. This campaign should raise enough to cover all operational costs, based on the experience of previous campaigns.</p>

I. Principal Conclusions and Recommendations

1. *Conclusion: The Project has made a lot of progress in establishing the community-based nutrition program and there are many real and potential benefits of the strategy. However, it is not as yet having the desired effect on reducing malnutrition in the project zone, and by some accounts does not appear likely to result in reduced levels of malnutrition.*

Recommendation: a) train project staff in the Hearth Method; b) train ECD in each district in the Hearth Method; c) implement the Hearth Method in 1 pilot site in each of the 4 districts; d) monitor results/ study and disseminate results; e) based on results, (f) decide whether or not to continue with the Hearth Method.

See comments above. Malnutrition has in fact plummeted in the province. We will pilot a Hearth Program in one site.

2. *Conclusion: The ratio of supervisors to CHW and to the size of the intervention area is too great for the Supervisors to adequately monitor the current community-based activities. The CBNP supervision checklist does not enable the project to classify the CBNP sites by performance, and therefore justify concentrating their capacity-building efforts on fewer sites, thereby reducing their workload.*

Recommendation: a) IRC and DMT review and revise the CBNP checklist according to MTE report suggestions; b) IRC/DMT train health center and district staff in it's use; c) together IRC/DMT/HC make a supervision schedule that will permit them to supervise (assess performance) all of the sites twice; d) staff supervise all of the CBGM sites and evaluate their performance using the checklist; d) using the checklist, classify all of the CBGM sites into categories according to performance; e) IRC/ DMT/ HC divide up supervisory responsibilities that enables the IRC supervisors to concentrate their efforts on those CBGM site that need the most assistance.

Generally, we accept these recommendations. See comments above.

3. Conclusion: *Knowledge among some CHWs on certain subjects is not adequate. Opportunities to strengthen their knowledge exist in the monthly meetings.*

Recommendation: *The health center staff presents health topics during all monthly meetings – TBA, nutrition animators and Health Animators. The activity will not only increase knowledge, but will model appropriate IEC approaches. Health Center staff should use visual aids during these times to help communicate the key messages.*

We accept these recommendations.

4. Conclusion: *Opportunities are being missed to strengthen the skills of the TBAs in pre- post natal consultations, while waiting for the MOH to finalize the training curriculum and forms related to pre- and post natal services.*

Recommendation: *While waiting for the MOH to finalize the curriculum and the forms, the project will finish it's TBA supervision checklist and will begin supervising the TBA's participation in pre-natal consultations, beginning with the IEC component.*

We accept these recommendations.

5. Conclusion: *Obstetrical services at the health centers in Kibungo Province are not up to standard. Giving birth at a health center does not guarantee quality care.*

6. Recommendation: *In collaboration with the Quality Assurance Project, project staff and the District Health Team should implement a facility assessment focusing on obstetrical care. Using these results, the project and DHT should organize in-service training opportunities for the weakest health centers. Checklists for pre- and postnatal service should be developed (following the design of the revised CBNP checklist) by the project and DMT and pilot tested.*

We feel the mid-term evaluation did not gather enough information to justify this statement. We feel individual interviews, which the interviewees have adamantly refused to corroborate, do not form a solid enough basis for this conclusion. However, we agree that a systematic assessment should be made and, if necessary, quality improvement steps taken.

7. Conclusion: *Even though the relationship between the MOH and the project is very strong and even exemplary, this close rapport has its advantages and disadvantages. The MOH does not appear to appreciate that one of the disadvantages of working with an NGO is that the NGO's resources and time are limited. One risks not achieving the project objectives, for example, if one needs to wait for the Ministry's permission to develop or make any changes to a*

curriculum. One also risks not taking advantage of the benefits of working with an NGO, that is, their ability to test new strategies in a limited intervention area.

Recommendation: Share MTE results with MOH authorities pointing out where collaboration with the MOH has facilitated or improved achievements and where it has delayed or compromised the quality of certain activities. Discuss with authorities how the delays can be minimized during the second half of the project so that the project objectives can be met; such as allowing the Project to pilot test certain activities. For example, TBA distribution of iron; prenatal and post natal data collection forms, supervisory checklists, and the Hearth Model.

We agree with this recommendation, although we would like to emphasize that collaboration with District Health Teams and other MOH partners has advanced the program much more than it has hindered it. But we agree that work can be done to reduce some of the delays.